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EUROPEAN SOCIAL CHARTER

3rd National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF HUNGARY

(Articles 3, 11, 12, 13 and 14)
for the period 01/01/2008 – 31/12/2011)

Report registered by the Secretariat on 26 July 2013

CYCLE 2013

National Report

Ninth National Report

on the implementation of the obligations set forth in the European Social Charter and the Revised European Social Charter

(Third National Report

on the implementation of the Revised European Social Charter)

Submitted by

the Government of Hungary

covering the period from 1st January 2008 until 31st December 2011

Budapest, June 2013

Under the reporting procedure set out in Article 21 of Part IV of the European Social Charter, the reporting obligation extends to the accepted articles of the European Social Charter. Pursuant to Article C of Part IV of the Revised European Social Charter, the rules of the European Social Charter shall apply to auditing the implementation of the commitments undertaken in the Charter. On the basis of Resolution CM (2006) 53 of 3 May 2006 of the Committee of Ministers of the Council of Europe, the National Report of the year 2012 covers the thematic group "Health, social security and social protection".

The Report covers the implementation of the following articles of the European Social Charter and the Revised European Social Charter, ratified and approved by Hungary, with regard to the reporting period indicated in the Table:

Provision	Reference period covered by the Report
Paragraph (1) of Art. 3	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011 (Revised Charter)
Paragraph(2) of Art. 3	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011 (Revised Charter)
Paragraph (3) of Art. 3	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011 (Revised Charter)
Paragraph (4) of Art. 3	1 June 2009 - 31 December 2011 (Revised Charter)
Paragraph (1) of Art. 11	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph(2) of Art. 11	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph (3) of Art. 11	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph (1) of Art. 12	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph(1) of Art. 13	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph (2) of Art. 13	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph(3) of Art. 13	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph (4) of Art. 13	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph (1) of Art. 14	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)
Paragraph(2) of Art. 14	1 January 2008 - 30 May 2009 (Charter), 1 June 2009 - 31 December 2011(Revised Charter)

With the exception of Sect. (4) of Art. 3, Hungary met its reporting obligation as concerns the implementation of the above provisions within the period from 1 January 2005 to 31 December 2007 in its Sixth National Report. This is the first report from Hungary on Sect. (4) of Art. 3 of the Revised European Social Charter, while the information provided on the further provisions in the referenced report are updated and complemented.

This National Report is based on the questionnaire approved by the Committee of Ministers of the Council of Europe on 26 March 2008, and it incorporates the answers of the

Government to the questions raised by the European Committee of Social Rights (hereafter: ECSR) concerning the implementation of the above articles, contained in Conclusions XIX-2 of 2010. Additionally, the National Report contains the answers to the statements made about Conclusions XIX-2 (2009) by the Government Committee for the Charter, in its report dated 14 February 2011 [Sect. (1) of Art. 3, Sect. (1) of Art. 11 and Sect. (1) of Art. 12].

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

List of referenced legislation

- Fundamental Law of Hungary
- Act XX of 1949 on the Constitution of the Republic of Hungary
- Act LXV of 1990 on Local Governments
- Act IV of 1991 on the Promotion of Employment and Provisions to the Unemployed
- Act XXII of 1992 on the Labour Code
- Act LXXIX of 1992on the Protection of Foetal Life
- Act III of 1993 on Social Administration and Social Services
- Act LXXIX of 1993 on Public Education
- Act XCIII of 1993 on Occupational Safety
- Act XLV of 1994 on Assistance to War Veterans
- Act CXVI of 1996 on Nuclear Energy
- Act XXXI of 1997 on the Protection of Children and on Guardianship Administration
- Act LXXX of 1997 on Eligibility for Social Security Benefits and Private Pensions and on the Funding for These Services
- Act LXXXI of 1997 on Social Insurance Pensions
- Act LXXXIII of 1997 on Statutory Health Insurance Provisions
- Act CLIV of 1997 on Health
- Act LXXXIV of 1998 on Family Support
- Act LXII of 1999 on the Protection of Non-Smokers
- Act XXV of 2000 on Chemical Safety
- Act I of 2004 on Sports
- Act CXL of 2004 on the General Rules for Public Administrative Proceedings and Services
- Act LXXV of 2010 on Simplified Employment
- Act XCVII of 2006 on Professional Chambers in Healthcare
- Act XCVIII of 2006 on the Safe and Economical Supply of Medicinal Products and Medical Devices and the General Rules for Medicine Distribution
- Act CXVI of 2006 on the Official Supervision of Health Insurance
- Act CXXXII of 2006 on the Development of the Healthcare System
- Act II of 2007 on the Entry and Residence of Third-Country Nationals
- Act LXXX of 2007 on Asylum
- Act LXXXIV of 2007 on Rehabilitation Benefits
- Act CIII of 2011 on 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 CXCI of 2011 on Benefits for Persons with Reduced Working Capacity and the Amendment of Certain Other Acts
- Act CCIX of 2011 on Water Utility Services
- Government Decree 89/1995 (Jul. 14) on the Occupational Health Service
- Government Decree 102/1995 (Aug. 25) on the Medical Assessment of Disability and Ability to Work, and on the Supervision Thereof

- Government Decree 195/1997 (Nov. 05) 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 217/1997 (Dec. 01) on the Implementation of Act LXXXIII of 1997 on Statutory Health Insurance Provisions
- Government Decree 284/1997 (Dec. 23) on the Fees for Certain Healthcare Services which are not available Free of Charge
- Government Decree 223/1998 (Dec. 30) on the Implementation of Act LXXXIV of 1998 on Family Support
- Government Decree 218/1999 (Dec. 28) on Certain Offences
- Government Decree 275/2002 (Dec. 21) on the Control of National Radiation Conditions and Concentrations of Radioactive Substances
- Government Decree 63/2006 (Mar. 27) on the Detailed Rules of Applying for, Assessing and Disbursing Cash and In Kind Social Services
- Government Decree 287/2006 (Dec. 23) on the Detailed Rules for Healthcare Services Provided on the basis of a Waiting List
- Government Decree 114/2007 (May 24) on the Implementation of Act II of 2007 on the Entry and Residence of Third-Country Nationals
- Government Decree 213/2007 (Aug. 07) on the National Rehabilitation and Social Expert Institute and its Detailed Rules of Procedure
- Government Decree 217/2007 (Dec. 01) on the Implementation of Act LXXXIII of 1997 on Statutory Health Insurance Provisions
- Government Decree 289/2007 (Oct. 31) on Social Subsidies for Household Piped Gas Consumption and the Use of District Heating Services
- Government Decree 301/2007 (Nov. 09) on the Implementation of Act LXXX of 2007 on Asylum
- Government Decree 321/2007 (Dec. 05) on Complex Rehabilitation
- Government Decree 337/2008 (Dec. 30) on the Implementation of Act CXXXII of 2006 on the Development of the Healthcare System
- Government Decree 136/2009 (Jun. 24) on the Support of Persons in Crisis
- Government Decree 321/2009 (Dec. 29) on Licensing and Supervising the Operations of Social Service Providers and Institutions
- Government Decree 354/2009 (Dec. 30) on the Activities of Occupational Safety Experts
- Government Decree 323/2010 (Dec. 27) on the National Public Health and Medical Officer Service, the Fulfilment of Public Health Administration Tasks and on the Designation of the State Administrative Body of Pharmacology
- Government Decree 35/2011 (Mar. 21) on the Professional Rules and Conditions Governing Birth Outside an Institution and the Causes Excluding the Possibility of Such Birth
- Government Decree 59/2011 (Apr. 12) on the National Institute for Quality and Organisational Development in Healthcare and Medicines
- Government Decree 291/2011 (Dec. 22) on the Labelling of Tobacco Products and the Detailed Rules for Imposing Health Protection Penalties

- Decree 27/1996 (Aug. 28) of the Ministry of Public Welfare on the Reporting and Investigation of Occupational Diseases and High Exposure
- Decree 14/1997 (Sep. 03) of the Ministry of Transport, Communications and Water on the Transportation, Shipping and Packaging of Radioactive Substances
- Decree 51/1997 (of 18.12.) of the Ministry of Public Welfare on Healthcare Services Aimed at the Prevention and Early Diagnosis of Diseases, which are available under Compulsory Health Insurance, and on the Certification of Screening
- Decree 33/1998 (Jun. 24) of the Ministry of Public Welfare on Medical Examinations for and Assessments of Occupational, Professional and Personal Hygiene Fitness
- Government Decree 43/1999 (Mar. 03) on the Detailed Rules for Financing Healthcare Services from the Health Insurance Fund
- Decree 50/1999 (Nov. 03) of the Ministry of Health on the Minimal Occupational Health and Safety Requirements of Working in Front of a Monitor
- Decree 61/1999 (Dec. 01) of the Ministry of Health on Protecting the Health of Employees Exposed to the Effects of Biological Factors
- Decree 65/1999 (Dec. 22) of the Ministry of Health on Minimal Occupational Health and Safety Requirements for the Use of Personal Protective Equipment by Employees at the Workplace
- Government Decree 134/1999 (Aug. 31) on the Settlement and Disbursement of Subsidies Granted to the Price of Medicines, Medical Devices and Medicinal Spa Services Prescribed in Outpatient Treatment
- Decree 16/2000 (Jun. 08) of the Ministry of Health on the Implementation of Certain Provisions in Act CXVI of 1996 on Nuclear Energy
- Joint Decree 25/2000 (Sep. 30) of the Ministry of Health and the Ministry of Social and Family Affairs on Chemical Safety at Work
- Joint Decree 41/2000 (Dec. 20) of the Ministry of Health and the Ministry of Environment Protection on the Limitation of Activities Related to Certain Hazardous Substances and Hazardous Products
- Decree 44/2000 (Dec. 27) of the Ministry of Health on the Detailed Rules for Certain Procedures and Activities Related to Hazardous Substances and Hazardous Products
- Decree 30/2001 (Oct. 03) of the Ministry of Health on the Protection of External Employees from Occupational Radiation
- Joint Decree 3/2002 (Feb. 08) of the Ministry of Social and Family Affairs and the Ministry of Health on the Minimal Standards of Occupational Safety at the Workplace
- Decree 8/2002 (Mar. 12) of the Ministry of Health on the Establishment and Operation of a Radiological Measurement and Data Supply Network in the Healthcare Sector
- Decree 60/2003 (Oct. 20) of the Ministry of Health, Welfare and Family Affairs on Professional Minimal Requirements Underlying the Provision of Healthcare Services
- Decree 14/2004 (Apr. 19) of the Ministry of Employment and Labour on the Minimal Safety and Health Requirements for Work Tools and their Utilisation
- Decree 22/2005 (Jun. 24) of the Ministry of Health on the Minimal Health and Occupational Safety Requirements Applicable to Employees Exposed to Vibration
- Decree 12/2006 (Mar. 23) of the Ministry of Health on the Protection of Workers from Risks Related to Exposure to Asbestos

- Decree 66/2005 (Dec. 22) of the Ministry of Health on the Minimal Health and Safety Requirements Concerning Employees' Exposure to Noise
- Decree 34/2007 (Dec. 21) of the Ministry of Social Affairs and Labour on the Assessment Underlying Exemption from the Obligation to Pay Contributions for Early Retirement and the Professional and Authority Fees of the Exemption Procedure
- Decree 32/2009 (Dec. 23) of the Ministry of Social Affairs and Labour on the Detailed Rules of Using Occupational Safety Penalties for Tendering and Information Purposes
- Decree 14/2010 (Apr. 28) of the Ministry of Social Affairs and Labour on the Administrative Service Fees Payable in the Licensing Procedure for Occupational Safety Experts
- Decree 22/2010 (May 07) of the Ministry of Health on the Minimal Health and Safety Requirements Concerning Employees' Exposure to Artificial Optical Radiation
- Decree 31/2010 (May 13) of the Ministry of Health on Financing Procedures
- Decree 4/2011 (Jan. 14) of the Ministry of Rural Development on the Limits of the Air Burden Level and the Emission Limits of Fixed Sources of Air Pollution
- Decree 63/2011 (Nov. 29) of the Ministry of National Resources on the Rules of Continuous Training for Healthcare Specialists
- Decree 64/2011 (Nov. 29) of the Ministry of National Resources on the Continuous Extension Training of Physicians, Dentists, Pharmacists and Specialists with Tertiary Healthcare Qualifications
- Decree 20/2001 (Mar. 30) of the National Assembly on the National Programme for Occupational Safety
- Decree 47/2007 (May 31) of the National Assembly on the "Making Things Better for Children" National Strategy (2007-2032)
- Decree 65/2007 (Jun. 27) of the National Assembly on the 21st National Sport Strategy
- Decree 96/2009 (Dec. 09) of the National Assembly on the National Environment Protection Programme for the period 2009-2014
- Government Decree 1208/2011 (Jun. 28) of the Ministry of Health on the Semmelweis Plan, the Tasks Accompanying Healthcare Restructuring under the Semmelweis Plan and on Measures for the Performance of the Key Tasks
- Government Decree 1257/2011 (Jul. 21) on the Strategy for Deinstitutionalising the Capacity of Social Institutions Caring for the Disabled and on Government Responsibilities Related to its Implementation

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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

For the first time, Decree 20/2001 (Mar. 30) of the National Assembly on the National Programme for Occupational Safety set long-term objectives for the government until 2007, whereby it called upon employers, employees, social organisations and citizens to participate. Following this stage, the National Policy on Occupational Safety, a policy prepared in 2009, duly debated but not since passed, would have laid down the responsibilities in occupational safety until 2013, in compliance with the expectations of the European Union, considering the conditions in the country, and after agreeing with the employers' and employees' interest advocacy organisations. Thus, Hungary does not at present have a national policy on occupational safety in force.

Pursuant to the relevant provisions of the Act on Occupational Safety, national interest reconciliation concerning safe work that is not harmful to health was performed by the Occupational Safety Committee, made up of representatives of employees' and employers' interest advocacy organisations and the Government, and operated under the National Council for the Reconciliation of Interests in the reporting period.

As regards the status of interest reconciliation, the regulatory background is in place for national interest reconciliation. The venues of reconciliation are the sectoral dialogue panels at the medium level, and, as before, the representatives for occupational safety, the occupational safety committees and the parity occupational safety bodies at the corporate level. The relevant provisions of the Labour Code apply to the representatives' protection under labour law.

In view of raising social conscience and awareness, the Hungarian Labour Inspectorate (hereafter: OMMF) is open to employers and interest advocacy organisations, via its initiative "Partnership for occupational safety," ensuring collaboration, rested on mutual trust, between the authority and the employers that agree to the partnership conditions.

The work of the authority does not in itself have a satisfactory impact on awareness. In spite of controls and sanctions by inspectors, some shortcomings keep recurring.

The initiative has contributed to improving confidence and mutual respect among all parties on the labour market, to preventing violations of the law and accidents, and to protecting employees.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION; KEY DATA AND STATISTICS

As Hungary did not have a national policy in force during the reporting period, no information can be supplied in this Section. For the relevant information see Part 1).

3) ANSWERS TO THE QUESTIONS OF ECSR REGARDING THIS PARAGRAPH

- ***The ECSR asked for information about measures for asbestos removal in Hungary.***

The obligation stipulated in Directive 87/217/EEC on the Prevention and Reduction of Environmental Pollution by Asbestos calls for its demolition and neutralization in accordance with the rules. Under the Directive, Member States must take all necessary measures to reduce or prevent the emission of asbestos into the air and water environment and the volume of solid asbestos waste in the place of origin, as far as reasonable. The provisions of this Directive are transposed into Hungarian law in Decree 12/2006 (Mar. 23) of the Ministry of Health on the Protection of Workers from Risks Related to Exposure to Asbestos.

Joint Decree 41/2000 (Dec. 20) of the Ministry of Health and the Ministry of Environment Protection on the Limitation of Activities Related to Certain Hazardous Substances and Hazardous Products introduced prohibition of the distribution and use of crocidolite, amosite and anthophyllite asbestos, actinolite asbestos, tremolite asbestos, crisotile fibres and products containing such fibres.

The second National Waste Management Plan (OHT-II), currently in force, defines the technical frameworks and objectives, and the means of implementation with regard to, among others, asbestos removal, for the 2009-2014 period of waste management. The Plan is connected to the 3rd National Environment Protection Programme[1] ratified by the National Assembly in December 2009. OHT-II accords with the above as it lays down the responsibilities in waste management which are necessarily expected to contain the measures underlying the implementation of the new Waste Framework Directive, which entered into force on 12 December 2008.

The results achieved are summarised below:

- A survey was carried out in residential buildings in 1999-2007, focusing on the volume of built-in asbestos-containing fireproof plasters and insulation layers. The survey found that approx. 172,000 m2 of harmful material is built in.
- 1.2 million m3 of the 150 million m2 roofing built in the past, and about 900,000 m3 lump waste originating from the demolition of 86 million linear metres of pipe (aggregate mass: approx. 1.6 million tons) is anticipated to be disposed of by about 2030.
- Several projects for asbestos removal have been completed, supported by state subsidies to local governments. Over 20% of the total asbestos insulation surveyed in residential buildings has been removed.

[1] Decree 96/2009 (Dec. 09) of the National Assembly on the National Environment Protection Programme for the period 2009-2014

- Industrial facilities which close down permanently are routinely neutralised and demolished.

Still, while the national survey of buildings built using diffused asbestos has been completed in the range of residential buildings, industrial and public buildings are still being surveyed, so we do not have final information about the total volume of waste, which poses a major problem.

No accurate statistics are available about the number of diseases due to asbestos, though this is a notifiable occupational disease. Just a few cases are reported each year.

Outcome of inspections:

In the experience of the occupational safety inspectorate, companies specialised in removal and with special expertise in occupational safety are in general assigned in major works. Minor works involving the demolition and renovation of mainly slate roofs are performed by the company contracted for demolition, in many cases without any advance notification or any expertise in occupational safety and environment protection, which therefore endangers both employees and the environment at large.

With the aim of reducing the number of diseases due to asbestos, the OMMF attempts, over and beyond its official work, to raise the awareness of society about occupational safety so as to improve the efficiency of prevention. To this end, it supplies all the necessary information to employers, employees, their interest advocacy bodies and any persons interested in occupational safety regulations. Since 2007, the OMMF has run the Occupational Safety Consultancy Service, which is available to employers and employees.

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. Regulatory background

- **Constitution and Fundamental Law**

In the reporting period, the Constitution of the Republic of Hungary, i.e. Act XX of 1949, stipulated the following provision: *"Everyone living in the territory of the Republic of Hungary has the right to the highest possible level of physical and mental health. The Republic of Hungary shall implement this right through institutions of occupational safety and health care, through the organisation of medical care and the opportunities for regular physical activity, as well as through the protection of the urban and natural environment."*

The Parliament of Hungary adopted the new Fundamental Law of Hungary on 25 April 2011, which entered into force on 1 January 2012. Article XX of the Fundamental Law provides as follows:

"(1) Every person shall have the right to physical and mental health.

(2) Hungary shall promote the exercise of the right set out in Paragraph (1) by ensuring that its agriculture remains free from any genetically modified organism, by providing access to healthy food and drinking water, by managing industrial safety and healthcare, by supporting sports and regular physical exercise, and by ensuring environmental protection."

In accordance with Article XVII of the Fundamental Law:

"(1) Employees and employers shall cooperate with each other in order to guarantee jobs and to make the national economy sustainable, and for other community goals.

(2) Employees, employers and their representative bodies shall have a statutory right to bargain and conclude collective agreements, and to take any joint action or hold strikes in defence of their interests.

(3) Every employee shall have the right to working conditions which respect his or her health, safety and dignity.

(4) Every employee shall have the right to daily and weekly rest times and annual paid leave."

- **Labour Code**

The labour code in effect in Hungary in the reporting period was Act XXII of 1992 on the Labour Code (hereafter: Labour Code). The Labour Code regards the employee's legal interest in occupational safety as a right originating from the labour relation, while the Code

also gives a detailed account of the conditions for electing the occupational safety representative controlling the employer's observation of this interest.

- **Act XCIII of 1993 on Occupational Safety** (hereafter: Occupational Safety Act), containing the fundamental rules for occupational safety.

- **Ministerial decrees**

  - The detailed rules of occupational safety are provided in the regulations issued by the Minister Responsible for Employment Policy, based on the authorisation in Act XCIII of 1993 on Occupational Safety [e.g. Decree 14/2004 (Apr. 19) of the Ministry of Employment and Labour on the Minimal Safety and Health Requirements for Work Tools and their Utilisation] and in other special legal regulations [e.g. Decree 65/1999 (Dec. 22) of the Ministry of Health on the Minimal Occupational Health and Safety Requirements for the Use of Personal Protective Equipment by Employees at the Workplace].

  - Sector-relevant ministerial decrees on issuing special sectoral procedures for certain dangerous activities (e.g. Hoist Safety Procedure; Welding Safety Procedure).

  - Most frequently, ministerial decrees provide the detailed rules of implementation supporting the transposition of certain EU directives into Hungarian legislation.

- **Standards**

In pursuance of the Occupational Safety Act, national standards concerned with occupational safety shall also be treated as occupational safety regulations insofar as, where a solution that differs from what is contained in the Hungarian national standard is used, the employer shall be liable to prove - in the event of a dispute - that the solution used offers the same or better protection in terms of occupational safety as the requirement or solution contained in the standard.

- **Employer's internal regulations and procedures**

Additionally, pursuant to the Occupational Safety Act, the employer's internal procedure or provision concerning the mode of fulfilling the requirements of safe work that is not harmful to health is also a rule on occupational safety:

- development of a comprehensive strategy for prevention;
- occupational safety procedure;
- risk assessment;
- internal rules for providing personal protective equipment;
- rules for medical fitness tests, etc.

- **Directly effective regulations of the European Union**

- Regulation (EC) No 1338/2008 of the European Parliament and of the Council of 16 December 2008 on Community Statistics on Public Health and Health and Safety at Work.

- Regulation (EC) No 1893/2006 of the European Parliament and of the Council of 20 December 2006 on Establishing the Statistical Classification of Economic Activities NACE Revision 2.
- Regulation (EC) No 1907/2006 of the European Parliament and of the Council of 18 December 2006 Concerning the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH), Establishing a European Chemicals Agency, Amending Directive 1999/45/EC and Repealing Council Regulation (EEC) No 793/93 and Commission Regulation (EC) No 1488/94 as well as Council Directive 76/769/EEC and Commission Directives 91/155/EEC, 93/67/EEC, 93/105/EC and 2000/21/EC.
- Commission 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.

II. Regulatory changes in the reporting period

The Occupational Safety Act did not fundamentally change compared with the period of the Sixth National Report. The modifications contain some adjustments to the changes taking place in the interim in public administration and some minor changes on some points.

Outline of main changes:

The rule under which the Occupational Safety Committee also negotiates and presents its opinion, in the cases delegated to it by the National Council for the Reconciliation of Interests within the framework of its interest reconciliation activity concerning safe work that is not harmful to health, was deleted in the course of amendments to the Act. Pursuant to the effective regulation, the Committee: *"negotiates and presents its opinion and recommendations concerning occupational safety issues presented by the negotiating parties."* [Par. c) of Sect. (1) of Art. 79; Repealed from 1 January 2012]

The Act was completed with the provision whereby *"measures shall be taken to make occupational hygiene tests regulated with the permissible values and related to occupational aetiological factors."* [Par. f) of Art. 42; Effective from 1 January 2008]

The Act was completed with the provision whereby the state shall *"report on the implementation of community rules affecting the safety and health of employees."* [Sect. (2) of Art. 14; Effective from 1 January 2008]

As a new rule, the following provision was integrated into the Act: *"Work shall only be performed under the working conditions and in the period that do not harm the health or bodily integrity of the employee. The special regulation shall apply to work performed in a period that increases the risk of damage to health (extraordinary work, overtime etc.)."* [Sect. (3) of Art. 44; Effective from 1 January 2008]

As a new rule in the Act, the requirements that the employer is expected to consider are extended with the following: *"the human factor shall be taken into consideration when setting up the workplace, and when selecting the work equipment and procedures, with particular regard to reducing the amount of work time spent on monotonous or frequently repeated*

procedures and the detrimental effects thereof, to scheduling work time and to avoiding the psycho-social risks of work." [Par. d) of Art. 54; Effective from 1 January 2008]

The provision on risk assessment is supplemented, stating that the rule shall be applied under the law *"unless regulated to the contrary"* and that a risk assessment shall be also carried out or revised instantly if *"the risk assessment did not cover the criteria identified in a special regulation."* [Sect. (3) of Art. 54; Effective from 1 January 2008]

Prior to the introduction of any new technologies, the employer was obliged to discuss the consequences of this introduction on health and safety with the employees and their occupational safety representatives in due time, which is modified stating that *"in the planning phase at the earliest."* [Par. d) of Sect. (7) of Art. 54; Effective from 1 January 2008]

According to the existing provision *"The occupational safety authority shall be in charge of the technical management of the occupational health service in the scope of occupational safety responsibilities."* This is supplemented with the following provision: *"Technical management comprises the determination of the mode of correct practice and the enforcement thereof."* [Sect. (4) of Art. 58; Effective from 1 January 2008]

In accordance with a provision integrated in the Act as an essential modification, the worker may, in case of occupational disease or upon the suspicion of high exposure, turn to the regionally competent occupational safety authority even if the affected employee lodges a complaint for failure to report the occupational disease or the incident of high exposure. [Sect. (1) of Art. 68; Effective from 1 January 2008]

Following the modification, the relative of the person injured in an occupational accident shall be a client in the procedure stipulated in the law, in lieu of the former "person exercising rights". [Sect. (2) of Art. 68; Effective from 1 January 2009]

The occupational safety inspector's competence is extended with the following options:

- for inspection purposes, to ask for information from the person staying in the workplace and to request this person to certify his or her identity;
- to resort to the police if an inspection is obstructed;
- to order occupational hygiene tests to be carried out. [Par. m) of Sect. (1) of Art. 84; Effective from 1 January 2008]

New terms defined in Article 87 of the Act as of 1 January 2008:

1/G. Public road traffic: movement on water, rail, public road, in air and on any underground or above-ground local and interurban scheduled line.

1/H. Psycho-social risk: totality of effects (conflicts, uncertainty of work organisation, work schedule, employment relations, etc.) which affect the employee in his or her workplace and influence his or her response reaction to these effects and, in correlation therewith, may lead to stress, occupational accident, or organic (psychosomatic) mental illness.

5/A. Occupational hygiene tests: procedures suitable for detecting the aetiological (physical, chemical, biological, ergonomic, psycho-social) factors inherent in the working environment, for determining their level and the volume of burden stemming from the work performed and the effects of the working environment, as well as tests, upon which a proposal can be made

to manage (mitigate) the health-damaging risks that originate from work and the working environment.

11. Hazardous: the facility, working tool, material/preparation, work process, technology (including activities that entail exposure to physical, biological, or chemical aetiological factors) wherein the employees' health, bodily integrity and safety may, if not properly protected, be subject to a damaging effect.

The necessary modifications to the terms used before 1 January 2008 have all been transposed. For instance, the term "employer" is supplemented as follows: *"For a foreign employer with no Hungarian tax number, the employer is the person or organisation who/which exercises actual management or holds main responsibility for the workplace or, in the absence of the above, in whose area the work is being performed."*

Modifications to legal regulations meeting the requirements of safe work that is not harmful to employees' health, in the reporting period

- **Act XXV of 2000 on Chemical Safety**

In Article 35, the Act stipulates the provisions that support compliance with EU legislation. The Act, entering into force in January 2001, has been continually updated in line with EU regulations since 1 July 2008:

- *"Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on Services in the Internal Market, integrating Article 9 (Art. 33/A of the Act), and*
- *Directive 2008/112/EC of the European Parliament and of the Council of 16 December 2008 Amending Council Directives 76/768/EEC, 88/378/EEC, 1999/13/EC and Directives 2000/53/EC, 2002/96/EC and 2004/42/EC of the European Parliament and of the Council in Order to Adapt them to Regulation (EC) No 1272/2008 on Classification, Labelling and Packaging of Substances and Mixtures, incorporating Articles 4 and 5 (Par. c) and d) of Art. 1 of the Act) and the following provision:*
- *This Act, including its executive decrees issued on the basis of the authorisation in Par. b) of Sect. (3) of Art. 34, Point aj) of Par. a) of Sect. (4) of Art. 34 and Sect. (5) of Art. 34, stipulates the provisions for implementing*
    a) *Regulation (EC) No 1907/2006 of the European Parliament and of the Council of 18 December 2006 Concerning the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH), Establishing a European Chemicals Agency, Amending Directive 1999/45/EC and Repealing Council Regulation (EEC) No 793/93 and Commission Regulation (EC) No 1488/94 as well as Council Directive 76/769/EEC and Commission Directives 91/155/EEC, 93/67/EEC, 93/105/EC and 2000/21/EC,*
    b) *Regulation (EC) No 1272/2008 of the European Parliament and of the Council of 16 December 2008 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."*

- **Joint Decree 25/2000 (Sep. 30) of the Ministry of Health and the Ministry of *Social and Family Affairs on Chemical Safety at Work.***

The following major modifications were made to the Decree in the reporting period:

The employer's obligations to inform the employee and the range of hazardous materials subject to a limit in occupational air space have both been expanded within the modifications of the Decree.

The concept of airborne dust has been clarified and the notions of respirable fraction, thoracic fraction, biological exposure index and biological impact index have been defined. The Decree stipulates that only the laboratories accredited by the National Accreditation Board within the range of chemicals subject to measurement, or the laboratories effectively taking part, as certified in writing, in national or international routine tests, are authorised to do any tests aimed at the measurement of biological exposure indices and biological impact indices. The conditions underlying, and the laboratories in charge of, the determination of chemicals with a limit value were integrated in the Decree concurrent with this modification.

- **Joint Decree 3/2002 (Feb. 08) of the Ministry of Social and Family Affairs and the Ministry of Health on the Minimal Standards of Occupational Safety at the Workplace**

Several clarifications have been transposed in this Decree (e.g. shower instead of lavatory, character of work instead of type of activity performed).

- **Decree 32/2009 (Dec. 23) of the Ministry of Social Affairs and Labour on the Detailed Rules of Using Occupational Safety Penalties for Tendering and Information Purposes**

The Decree entered into force on 24 December 2009. Prior to this date, this issue was regulated by Decree 5/2002 (Nov. 12) of the Ministry of Employment and Labour on the Use of Occupational Safety Penalties for Tendering and Information Purposes. Based on the regulation, half the amount of paid penalties was available, through public tendering, for supporting the aims of safe work that is not harmful to health, and the remaining part could be used for the continuous operation of the public state Occupational Safety Information System (hereafter: MIR System) until 31 December 2011. After entering into force, the Decree was modified on several occasions:

- Modifications concerning the operation of the Occupational Safety Information System:

For reasons of organisational changes, the responsibilities of personal information supply and consultancy were transferred from the regional occupational safety inspectorates to the OMMF, which performs this activity as published on its website. Concurrently, the rule stipulating the following was deleted: *"...personal information supply and consultancy may also be provided in the employer's registered seat or the working area determined by it. In the course of making preparations for on-site consulting, the occupational safety consulting inspector shall inform the employer that it may promote the occupational safety representative's attendance in the counselling meeting."* [Sect. (3) of Art. 17; Effective from 1 January 2011].

- Changes affecting the rules of tendering:

Following some modifications to participation in tenders and the conditions of inviting tenders, support may be granted to legal entities that have *been in operation for at least one calendar year at the time of submitting the tender*; moreover, the Decree also applies to other unincorporated organisations (unincorporated business associations have been removed from the Decree). [Sect. (1) of Art. 3; Effective from 15 October 2011]

The rules applicable to the tendering procedure and the tender management organisation have been changed, following, on the one hand, Sect. (1) of Art. 107 of the Treaty on the European Union, and on the other, the changes in the Hungarian tender management body. [Sections (1), (4)-(5) of Art. 6; Effective from 15 October 2011]

Compared to the previous rules, it is now easier for the tender management body to assign the expert in charge of making a professional assessment of the tenders. [Sect. (3) of Art. 7; Effective from 15 October 2011]. The Decree is supplemented with the following provisions:

The following persons are entitled to take part in the professional assessment of tenders: those who, in a field corresponding to the topic of the specific tender, have

a) an occupational safety or occupational healthcare expert's permit, on the basis of the Decree on the Occupational Safety Expert's Activity or the Decree on Certain Issues Related to the Healthcare Expert's Activity, or
b) a tertiary professional qualification and at least 3 years' technical practice corresponding to this qualification.

(5) Prior to the expert's assignment, the tender management body is obliged to make certain that the expert meets the conditions in Section (4), by way of asking the expert for the expert's permit, under Par. a) of Sect. (4) or any of the below documents:

a) duplicate of the diploma or certificate certifying tertiary technical qualification, certified Hungarian translation of the diploma issued by a foreign tertiary institution and the document on its naturalisation;
b) detailed description of the specialist internship;
c) document certifying the specialist internship, in particular the legal employment relation or the performance of a business activity. [Sections (4)-(5) of Art. 7; Effective from 15 October 2011]

In connection with the tender management body's responsibilities, a further addition is made to the Decree, stating that, by sending the registration, the tender management body *"shall concurrently inform the occupational safety and occupational directorate about the tenders where the test under Sections (1) and (2) concluded that the conditions of taking part in the tender are not met or the conditions of support are not satisfied."* [Sect. (5) of Art. 8; Effective from 15 October 2011]

The Decree comprises some modifications in order to transpose the changes in provisions stemming from organisational changes and related to publication. [Sect. (7) of Art. 9; Effective from 15 October 2011]

- **Decree 34/2007 (Dec. 21) of the Ministry of Social Affairs and Labour on the Assessment Underlying Exemption from the Obligation to Pay Contributions towards Early Retirement and the Professional and Authority Fees of the Exemption Procedure**

In place of the Hungarian Institute of Occupational Hygiene and Health (hereafter: OMFI), the organisation for occupational hygiene and health has been appointed to manage the procedure for exemptions from the obligation to pay contributions towards early retirement, due to organisational changes. [Art. 2, Annex 2]

The integration of occupational healthcare and occupational safety (earlier represented in two separate organisations) before the reporting period led to the creation of uniform occupational safety. The integration induced statutory changes, considering that the new and now uniform occupational safety organisation (OMMF) was incorporated in the legal regulations comprising provisions on occupational healthcare, which used to function separately from occupational safety.

- **Decree 12/2006 (Mar. 23) of the Ministry of Health on the Protection of Workers from Risks Related to Exposure to Asbestos**

Due to organisational change, the OMMF has taken over from the National Public Health and Medical Officer Service (hereafter: ÁNTSZ), while the regional occupational safety inspectorate functions in place of the regionally competent municipal or metropolitan district institutes [Sect. (1) of Art. 4]. In line with a concurrent change, the duplicate of the healthcare documentation is to be presented to the occupational safety inspectorate, instead of to the healthcare authority.

Due to the organisational changes, the occupational safety inspectorates of the metropolitan and county government offices take over the role of the OMMF [repeated change in Sect. (1) of Art. 4].

The following provision has been repealed: *"The Hungarian Institute of Occupational Hygiene and Health shall make up a practical guide to determine occasional and low intensity exposure. OMMF shall also publish the guide in an electronic form."* [Art. 19]

Deregulatory deletion of references made for compliance with EU legislation.

In addition to products containing asbestos, substances containing asbestos are also identified, moreover, the term *"actually or presumably exposed (to asbestos)"* is replaced with "is or may be subject to risk stemming from an activity with products containing asbestos" [Sect. (1) of Art. 1; Effective from 1 April 2010].

Concurrently, the legal regulation also prohibits the use of asbestos through vaporisation and the performance of activities entailing the use of low (less than 1 g/cm3) density insulation or sound-proofing materials containing asbestos. As an additional prohibition in the legal regulation, it is prohibited to perform any activities whereby employees are exposed to asbestos fibres during asbestos mining, the production and processing of asbestos products or the production and processing of products that contain intentionally added asbestos fibres, excluding the management and neutralisation of products that originate from demolition and asbestos removal [Sections (2)-(3) of Art. 1].

- **Decree 22/2005 (Jun. 24) of the Ministry of Health on the Minimal Health and Occupational Safety Requirements Applicable to Employees Exposed to Vibration**

The text "from the occupational safety inspectorate" is included to replace the wording "from the healthcare authority", due to organisational changes. [Par. i) of Sect. (6) of Art. 4 and Sect. (3) of Art. 7; Effective from 1 January 2011]

The OMMF is identified instead of ÁNTSZ, due to organisational changes. With regard to exemption from the limit value, the technical term "public health" is replaced with "occupational health", moreover, the legal regulation subjects exemption to an application. A subsequent provision in the Decree replaced the OMMF with the occupational safety and occupational directorate of the National Labour Affairs Office (hereafter: NMH), due to organisational changes. [Sect. (2) of Art. 8; Effective from 1 January 2010]

Deregulatory deletion of the reference to a legal regulation lapsed concurrently with the entry into force of the Decree. [Sect. (3)-(4) of Art. 10; Repealed from 16 May 2008]

With regard to the National Health Insurance Fund (hereafter: OEP), the "technical administrative body, with health insurance fund-related responsibilities, of the metropolitan and county government office" is stated instead of "directorate organisations". [Par. d) of Sect. (3) of Art. 4; Effective from 1 January 2011]

- **Decree 27/1996 (Aug. 28) of the Ministry of Public Welfare on the Reporting and Investigation of Occupational Diseases and High Exposure**

Due to organisational changes, the occupational safety inspectorate under the occupational safety and occupational administrative body of the metropolitan and county government office replaces the OMMF. Moreover, the following addition was made as a further modification: *"The occupational safety inspectorate shall forward any reports received in connection with the suspicion of occupational disease to the occupational safety and occupational directorate of the National Labour Affairs Office (hereafter: Occupational Safety and Occupational Directorate) within one business day."* [Sect. (1) of Art. 3; Effective from 1 January 2011]

Instead of OMFI, the Occupational Safety and Occupational Directorate is identified, due to organisational changes. [Sect. (1) of Art. 4]

Due to organisational changes, the ÁNTSZ is replaced (as the body responsible for determining whether an illness is an occupational illness) by "the Occupational Safety and Occupational Directorate at the township (metropolitan district) public health institute of the township (metropolitan district) office of the metropolitan and county government office (hereafter: Township Public Health Institute) and at the occupational safety inspectorate." [Sect. (1) of Art. 5; Effective from 1 January 2011]

Instead of the regionally competent institute of the ÁNTSZ, the Township Public Health Institute is identified, due to organisational changes. [Sect. (1) of Art. 6; Effective from 1 January 2011]

Annex 4 to the Decree (Report on occupational disease (poisoning) and high exposure) has been updated. [Annex 4; Effective from 1 January 2011]

- **Decree 50/1999 (Nov. 03) of the Ministry of Health on the Minimal Occupational Health and Safety Requirements of Working in Front of a Monitor**

Instead of the OMMF, the occupational safety inspectorate of the metropolitan and county government office is identified, due to organisational changes. [Art. 9; Effective from 1 January 2011]

- **Decree 61/1999 (Dec. 01) of the Ministry of Health on Protecting the Health of Employees Exposed to the Effects of Biological Factors**

In connection with reporting, the occupational safety inspectorate under the occupational safety and occupational administrative body of the metropolitan and county government office is identified instead of the occupational safety inspectorate of the OMMF, due to organisational changes. [Par. b) of Sect (4) of Art. 3; Effective from 1 January 2011]

The occupational safety inspectorate of the metropolitan and county government office is included in the scope of the employer's information obligations, moreover, the township (metropolitan district) public health institute of the township (metropolitan district) office is identified instead of ÁNTSZ, due to organisational changes. [Sect. (2) of Art. 7, Sect. (7) of Art. 13, Sect. (3) of Art. 14, Sect. (2) of Art. 16; Effective from 1 January 2011].

The "Immunisation book for persons over 14 years of age" is introduced instead of "Immunisation Book". Moreover, in accordance with the modification, (an immunisation that has been administered) "shall be recorded in the "Immunisation data sheet" of a Healthcare Book issued after 1 September 2009, which is to be presented to the employer and, upon request, to the occupational safety inspectorate, and shall be delivered to the township public health institute, at the latter's request." [Sect. (6) of Art. 13; Effective from 1 January 2011]

- **Decree 65/1999 (Dec. 22) of the Ministry of Health on the Minimal Occupational Health and Safety Requirements for the Use of Personal Protective Equipment by Employees at the Workplace**

Instead of the ÁNTSZ and the county (metropolitan) occupational and occupational safety inspectorates, the occupational safety inspectorates of the metropolitan and county government offices take measures to observe the provisions of the Decree. [Art. 10; Effective from 1 January 2011]

- **Decree 66/2005 (Dec. 22) of the Ministry of Health on the Minimal Health and Safety Requirements Concerning Employees' Exposure to Noise**

In case of termination of the employer without a legal successor, the records previously had to be delivered to the competent municipal (metropolitan district) institute of the ÁNTSZ, based on a former provision, which is now replaced by the occupational safety inspectorates under the occupational safety and occupational administrative body of the metropolitan and county government office, due to organisational changes. [Sect. (2) of Art. 6; Effective from 1 January 2011]

According to the former regulation, the records, in the event of any remarks, could be sent to the competent ÁNTSZ institute. The competent ÁNTSZ institute took the opinion of the competent ÁNTSZ regional noise test laboratory into account when it passed a Decree to repeat a noise measurement. On account of the organisational changes, the regulation has

been modified whereby the records can be sent to the occupational safety inspectorate. The occupational safety inspectorate takes the opinion of the occupational hygiene and health organisation into account when it passes a Decree to repeat the noise measurement. [Sect. (3) of Art. 6; Effective from 1 January 2011]

Pursuant to the regulations prior to 1 January 2008, the Office of the Chief Medical Officer of State (hereafter: OTH) was authorised to permit any deviation from Sect. (1) of Art. 9 of the Decree. Following an interim modification, the permission could be issued with regard to an advance expert opinion of the OMFI. As of 24 December 2011, based on the regulation, the occupational safety and occupational directorate of the NMH may permit any deviation from Sect. (1) of Art. 9 [Sect. (1) of Art. 14; Effective from 24 December 2011].

- **Government Decree 89/1995 (Jul. 14) on the Occupational Health Service**

The following provisions are deleted from the Decree:

Art. 2 (2) Within two months of commencing its operation, the employer (excluding the private individual as employer) shall be obliged to report, to the regionally competent occupational safety inspectorate of the Hungarian Labour Inspectorate (hereafter: the Occupational Safety Inspectorate):

a) the address of its registered seat and premises;
b) its activities;
c) the name and address of the healthcare provider providing occupational healthcare services to it;
d) the number of employees on the staff using occupational healthcare services and their classification by occupational healthcare class.

(3) The employer identified in Sect. (1) is obliged to report any changes in the data in Sect. (2) to the Occupational Safety Inspectorate at annual intervals, by 15th February each year.

(4) Notwithstanding Sect. (3), the employer is obliged to report

a) the termination of the agreement between itself and the occupational healthcare provider in the subject of provision of services, indicating the date of termination, and
b) any change in the person of the doctor providing the service, indicating the starting date thereof,

to the Occupational Safety Inspectorate within three business days of the change. [Sections (2)-(4) of Art. 2; Repealed from 1 January 2011]

"Employers that do not have a service, moreover, labour centres, the local governments of settlements and vocational institutions shall, unless otherwise agreed to the contrary, pay the fee stipulated in Annex 1 to the service provider, in return for the performance of the examinations identified in the special regulation." [Sect. (6) of Art. 2; Repealed from 1 January 2010]

"Along with the concurrent information of the operator of the service, the manager of the service shall report the following to the occupational safety inspectorate with competence for the registered seat of the service:

a) *the data (in a form unsuitable for personal identification) stipulated in Annex 2 about the employees treated, broken down according to each employer, by 30 June and by 31 December each year;*
b) *the commencement, termination, temporary suspension of its activity, within eight business days of the change.*

On the basis of the data in Sect. (1), the occupational safety inspectorate supplies information, at the employer's request, about the local possibilities of using the occupational healthcare service." [Sect. (1)-(2) of Art. 4; Repealed from 1 January 2011]

"The data provision obligation as per Par. a) of Sect. (1) of Art. 4 shall for the first time be met by 30 September 1995." [Sect. (2) of Art. 7; Repealed from 1 May 2008]

"4. delivery of expert opinion on employability is HUF 3000/person/case." [Point 4 in Annex 1; Repealed from 1 April 2010]

The following provision was integrated in the Decree:

"The categorisation under Sect. (1) is made by the employer, considering the opinion of the service or the occupational safety inspectorate.

(3) The occupational safety inspectorate exercises the official controlling power related to the availability of the occupational health service." [Sect. (2)-(3) of Art. 6; Effective from 1 January 2011]

- **Decree 33/1998 (Jun. 24) of the Ministry of Public Welfare on Medical Examinations for and Assessments of Occupational, Professional and Personal Hygiene Fitness**

The rule stating that "The examination for the employability of a casual employee shall be repeated annually." has been deleted. [Sect. (6) of Art. 6; Repealed from 1 April 2010]

The term 'unemployed' is changed to 'jobseeker' [Par. b) of Sect. (1) of Art. 3: effective from 16 May 2008; Sect. (4) of Art. 3, Par. c) of Sect. (2) of Art. 4; Effective from 1 May 2010].

Instead of the OMMF, the occupational safety inspectorate of the metropolitan and county government office is identified, due to organisational changes. [Par. d) of Sect. (3) of Art. 7; Effective from 1 January 2011]

The rule stating that "The specialised occupational healthcare facility shall deliver its opinion about the casual employee's employability on the form under Annex 16/A." has been deleted. [Par. c) of Sect. (5) of Art. 15; Repealed from 1 April 2010]

The following rule has been incorporated:

"Expert opinion on employability, for simplified employment

(1) In case of seasonal work or casual work within the range of simplified employment, the employee's examination for employability shall be conducted at the initiative of

a) *the employer, or*
b) *the natural person intending to be employed in seasonal work or casual work within the range of simplified employment.*

(2) As regards the examination for employability,

a) the occupational healthcare provider contracting with the employer,
b) the service provider providing primary occupational healthcare service or special occupational healthcare treatment, or
c) the general practitioner selected by the person intending to be employed and providing, among others, occupational healthcare services

shall issue an expert opinion on employability on the form in Annex 16/A.

(3) The fee for the issuance of the expert opinion on employability is borne by the party initiating the examination, based on the regulation on the fees for certain healthcare services which are not available free of charge." [Art. 16/A; Effective from 1 May 2010]

This provision is extended with the following additional requirement: "(4) The expert opinion on employability shall be effective for one year from its date of issue." [Effective from 1 August 2010]

III. Statutory changes relevant to this topic but affecting the responsibilities and competence of the public health administration organisation

- **Decree 22/2010 (May 07) of the Ministry of Health on the Minimal Health and Safety Requirements Concerning Employees' Exposure to Artificial Optical Radiation**

The Decree importantly states that the employer is obliged to have a risk estimate that is based on the estimation, measurement and calculation data determined under Art. 5, which stipulates the measures. It is important to note that if the employee's burden of artificial optical radiation exceeds the exposure limit, the employer is obliged to take immediate measures, with regard to the findings of the prompt risk assessment, to reduce the level of exposure to below the limit.

The occupational health service is obliged to make a prompt medical examination of the employee exposed to artificial optical radiation (based on the Act on the Handling and Protection of Health Data and Related Personal Data, and in accordance with the regulation on medical examinations for and assessments of occupational, professional and personal hygiene fitness) and to inform the employee and the physician of the occupational health service about the results. Any disease and occupational accident caused by artificial optical radiation shall be subject to examination under the rules on occupational safety, and be reported and registered.

IV. Legal regulations repealed

- **Decree 2/1987 (Feb. 17) of the Ministry of Industry on the Publication of the Security Procedure in the Explosives Sector**

Repealed from 1 January 2009

The regulation with effect from 3 April 2010 is provided in Decree 13/2010 (Mar. 04) of the Ministry of Transport, Communications and Energy on the General Explosion Security Procedure. Decree 13/2010 (Mar. 04) greatly follows the content of Decree 2/1987 (Feb. 17) but gives a more detailed account of professional requirements.

The scope of the Decree covers civil explosion activities. The scope of the Decree does not cover the manufacture, storage, use and destruction of

a) explosives and ammunition possessed by the Hungarian Defence Force, the organisations of law enforcement and the armed forces stationed in the territory of the Republic of Hungary;
b) pyrotechnic products for civil use; and
c) ammunition for civilian use.

V. Decrees entering into force in the reporting period

- **Government Decree 354/2009 (Dec. 30) on the Activities of Occupational Safety Experts**

Entered into force on 1 January 2010.

- **Decree 14/2010 (Apr. 28) of the Ministry of Social Affairs and Labour on Administrative Service Fees Payable in the Licensing Procedure for Occupational Safety Experts**

Entered into force on 13 June 2010.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION; KEY DATA AND STATISTICS

The professional management of OMMF believes that, in addition to the performance of daily tasks, it is important for each inspectorate to control specific pre-determined sectors or activities with a target-oriented approach, within an identical period and based on uniform criteria. In order to achieve these objectives, the OMMF orders target controls and audits and campaign-type controls each year. The inspectors took part in national-scale target controls and campaign controls in certain topics.

The occupational safety inspectorate carried out the following national campaign and target controls in the reporting period:

In 2008:

- Csillagszóró II [in English: Sparkler II]
- (control of Christmas campaigns)
- Mining review
- Review of student work
- Priority audit of the Formula 1 event
- Control of medicinal and wellness service providers
- Kánikula 2008 [in English: Heat Wave 2008]
- (control of summer campaigns)
- Kikelet 2008 [in English: Springtime 2008]
- (control of Easter campaigns)
- Priority audit of the Sziget Festival event
- Non-ferrous metal, scrap metal purchasing plants
- Control of harvest works and festivals

In 2009:

Target controls and audits

- National target controls, based on collaboration among partner authorities
- Kikelet II. [in English: Springtime II] (2009)
- Kánikula II. [in English: Heat Wave II] (2009)
- Téli célvizsgálat [in English: Winter target control] (2009)
- Targeted audit of mining workplaces, for occupational healthcare (2009)
- Supplementary target control of open-air swimming pools (2009)
- Target controls related to Budapest festivals (2009)
- Complex targeted audits of social employers (2009)

Campaign controls:

- Whitsun campaign control (2009)
- Campaign control of harvest celebrations and festivals (2009)

In 2010:

Target controls and audits

- Tavaszi célvizsgálat [in English: Spring target control] (2010)
- Téli célvizsgálat [in English: Winter target control] (2010)
- Repeated targeted audit of mining workplaces, for occupational healthcare (2010 and 2011)
- Target control of the use of hazardous materials (SLIC) (2010)
- Target control of activities related to maintenance (2010-2011)

In 2011:

Target controls and audits

- National target controls, based on collaboration among partner authorities:
- Target control, by partner authorities, of places of entertainment, ordered in connection with the early 2011 disco accident

Campaign controls

- Campaign control of the Easter-related activities of meat industrial and meat processing enterprises
- "Control of healthcare and social institutions" national occupational safety campaign control
- "Prevention of unfavourable climate environment - campaign control" (in August 2011, at the time of degree 2 and 3 heat alarms)
- National campaign control of hypermarkets, for occupational safety

The table below enumerates the topics of target controls and campaign controls held in the reporting period, indicating the target areas of the controls, the audit criteria and the data of the controls.

Target controls, campaign controls

Name	Target area	Control criteria	Number of controlled employers (qty))	Inspectors involved in control (persons)
National target controls based on collaboration among partner authorities - "Spring time II" (2009) - "Heat wave II" (2009) - "Winter target control" (2009) - "Spring target control" (2010) - "Winter control" (2010)	Construction industry, Processing industry, Catering, Trade	– existence of occupational medical examination; – risk assessment; – rules on the provision of personal protective equipment; – safety equipment of machines; – electric safety conditions; – existence of protection against falling from heights and the risk of falling in	6091	175
Whitsun campaign control (2009)	Medical and wellness services	– existence and compliance of operating regulations; – development of servicing rooms; – storage of hazardous materials; – technological processes; – electric equipment.	70	17
Target audit (2009) and repeated targeted audit (2010 and 2011) of mining workplaces, for occupational healthcare	Open-pit mining	– existence of occupational medical examination; – risk assessment; – rules on the provision of personal protective equipment; – general occupational hygiene conditions	51	21
Supplementary target control of open-air swimming pools (2009)	Supplementary control in relation to accidents in adventure pools		162	77
Controls related to Budapest festivals (2009)	Controlling the safety conditions of construction sites and road renovation areas	Protection of persons staying in the range of construction and demolition areas in the vicinity of the most frequented sites (fencing working pits, installing access boards and tower cranes)	29	10
Campaign control of harvest celebrations and festivals (2009)	Control of processing activities connected to the collection of grapes and other fruits	– technological processes; – safety equipment of machines and equipment; – personal protective equipment	303	102

Name	Target area	Control criteria	Number of controlled employers (qty))	Inspectors involved in control (persons)
Complex audit of social employers (2009)	Review of the condition of social institutions	Complex occupational safety and occupational control.	227	85
Target control of the use of hazardous materials (SLIC) (2010)	Timber and furniture industry	Requirements applicable to the in-work use of hazardous materials	31	29
Target control of activities related to maintenance (2010-2011)	Maintenance-related activities (welding, refining, polishing, grinding, surface cleaning, etc.)	– organisation and management of maintenance work; – personal conditions; – risk assessment; – specific priority preventive measures based on risk assessment; – safety of workplaces; – satisfactory working tools; – provision of personal protective equipment, etc.	1173	178
Target control, by partner authorities, of places of entertainment, ordered in connection with the early 2011 disco accident	Places of entertainment	general requirements of occupational safety	403	102
Campaign control of the Easter-related activities of meat industrial and meat processing enterprises	Meat industrial, meat processing enterprises	– medical examination of occupational fitness; – risk assessment; – provision of personal protective equipment; – safety of working tools; – electric equipment; – first aid at work – Additional control areas: – activity in unfavourable climate environment; – social facilities; – control of drinking water supply and waste management at work	189	99
"Control of healthcare and social institutions" national occupational safety campaign control	Social institutions treating inpatients and caring for the elderly	– medical examination of occupational fitness; – risk assessment and specific priority preventive measures based on risk assessment; – provision of personal protective equipment; – safety of working tools; – vaccination; – electrical safety of controlled working sites	49	32

Name	Target area	Control criteria	Number of controlled employers (qty))	Inspectors involved in control (persons)
		(departments)		
"Prevention of unfavourable climate environment - campaign control" (in August 2011, at the time of degree 2 and 3 heat alarms)	Open-air work sites: building, road and utility construction; agricultural activity; conduit maintenance; mowing; park maintenance. Indoor work sites: bakehouse and bakery facilities; kitchen facilities; manufacture of construction materials; textile industry; manufacture of clothing products; motor car repair; urban passenger transport; metal processing; metal working, storage.	Labour safety regulations for preventing the impacts of unfavourable climate conditions (e.g. protective drink, rest time, proper rest place/area, risk assessment of unfavourable climatic conditions, training in occupational safety).	452	105
National campaign control of hypermarkets, for occupational safety	Hypermarkets	– personal conditions; – risk assessment; – specific priority preventive measures based on risk assessment; – unfavourable climate environment; – safety of workplaces, machines and equipment; – satisfactory working tools; – provision of personal protective equipment, etc.	58 units of 5 chain stores	74

The OMMF assessed the target controls and campaign controls on the basis of the reports and the cumulative data. The dedicated target controls and campaign controls were adjusted to social habits and priority events in the life of the employers (e.g. heat wave). The aim of these control forms is to draw the employers' attention to such events and to prevent or mitigate the extent of occupational events with an unfavourable outcome.

As a general statement, these methods of control reached their target: the experience gained significantly contributed to an understanding of the current occupational safety conditions of specific sectors and activities and to increasing prevention by way of taking the necessary measures.

3) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR asked for information as to whether Act XCIII of 1993 on Occupational Safety regulates the condition of self-employed and domestic workers.***

The scope of the Occupational Safety Act applies to organised employment. Organised employment is classified as work performed in

- an employment relationship, excluding work in the household of a natural person as an employer, within the frames of simplified employment;
- public employment, government service, public service and public employee legal relations, in the judge's service relation, in judicial employees' servicing legal relation, and in the service relation in the prosecutor's office;
- employment-type legal relationships in the case of cooperative membership;
- the framework of students' legal relationships in vocational schools while meeting the requirements of their professional training, as well as in students' legal relations during practical training, based on the student contract;
- the legal relationship of a penal institution (in pre-trial detention, as a convict), in service legal relation, on the basis of an administrative order or minor offence decision, at the Hungarian Defence Force, the Military National Security Service, the organisations of law enforcement and the fire departments of local governments; and
- voluntary activity in the public interest, under the Act on Voluntary Activities in the Public Interest, and volunteer work organised (initiated, managed or approved) by the employer.

Additionally, work performed with the personal participation of a natural person member of a business association not employing the employee, at a workplace where employees hired by various employers are employed concurrently, is considered as organised employment.

Following from the above, the scope of the Occupational Safety Act does not cover independent entrepreneurs and household workers.

- ***The ECSR asked for information about the reasons for the rapid decrease in occupational diseases and about occupational diseases excluding poisoning and high exposure (e.g. locomotor disorders).***

The report on occupational diseases does not reflect the actual circumstances, based on current Hungarian conditions. As a major factor in the decreasing number of cases, all the parties have adverse interests in detecting occupational diseases: the employer may be fined, the occupational medical doctor is financially dependent on the employer, the employee is afraid of losing his or her job. Moreover, classical occupational diseases are being confined as heavy industry is disappearing. The number of cases cannot be expected to approximate the real value until the financial scheme of occupational safety is modified. Additionally, the diseases reported these days still apply to great numbers of pensioners who have not worked for decades now and who developed their (generally moderate) occupational disease in industrial branches since terminated (silicosis cases of Mecsek mineworkers), which modulates the overall picture.

The indicated numbers of cases include all the registered occupational diseases in every case. The term “poisoning” in brackets means that the item includes these cases as well, so they are

not included among accidents. Accordingly, there are also some locomotor disorders as the list of Hungarian occupational diseases is open.

- ***The ECSR asked for information about the reason for a decline in 2007 in official activity in the period of merger of the occupational healthcare and occupational safety fields in 2007 and the period preceding the Hungarian introduction of the new, now uniform occupational safety official controls, and also expects to get an answer as to what trends the number and efficiency of controls showed in the subsequent period, with particular regard to the field of occupational healthcare.***

The fields of occupational healthcare and occupational safety were fully integrated in Hungary by 2008 and the authority conducted uniform occupational safety controls (by occupational safety inspectors trained for controlling both fields) in the reporting period. The detailed description, in tables, of the completed official controls is provided in Part 2).Each official control in the reporting period covered both occupational safety and occupational health ('occupational safety' in Hungary in the reporting period), so all the data in the table in Part 2) are interpreted as a uniform control.

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

Occupational safety supervision was subject to major reorganisation in the reporting period. The integration of occupational healthcare and occupational safety was fully completed by 2008 (occupational healthcare used to belong to ÁNTSZ prior to this period) and controls based on a uniform approach could also be implemented in practice. Inspectors once proficient in occupational safety and those skilled in occupational healthcare were trained in occupational healthcare and occupational safety, respectively. The newly entering inspectors underwent integrated technical training and could commence occupational safety controls after a necessarily uniform examination covering both fields.

From April 2007, the uniform occupational safety authority (OMMF) was responsible, with the participation of OMFI, for the technical management of the occupational safety duties (stipulated in the Occupational Safety Act and special regulations) of occupational health services. According to the government decree on OMMF, OMMF was a central office (self-controlled central budgetary institution) managed by the Minister for Employment Policy. The OMMF was led by the president appointed by the Minister, and the Minister exercised employer's rights over this official. The regional units of the OMMF were the regional occupational safety and occupational inspectorates managed by the director and staffed by occupational safety and occupational inspectors. In terms of occupational healthcare, OMFI performed tasks related to professional methodological management, the preparation of legal regulations, technical training and extension training, and maintained relations with national and foreign partner institutions. It was mainly responsible for examining and treating the assigned occupational in- and outpatients and diagnosing any occupational diseases reported in the country.

As part of a reform in public administration, relying on Act CXXVI of 2010, regional occupational safety inspectorates were transferred from the OMMF structure to the organisation of metropolitan/county government offices as of 1 January 2011. Starting from this date, the OMMF has been incorporated in occupational safety organisation both as a professional leader and an authority of second instance.

OMFI was integrated in the OMMF structure as of 1 December 2011.

The organisational change taking place in authority supervision of occupational safety from 1 January 2011 had an impact on the responsibilities of occupational safety inspectorates. The number of occupational safety inspectors dropped in the occupational safety inspectorates. The average number of inspectors (149.3 persons) in 2010 lowered to 123.5 persons for the whole year of 2011. Despite the approx. 17% decrease in the average number of inspectors, the number of employers subject to control and the number of measures went down by merely

10% and 13%, respectively, in 2011, which reflects the improved efficiency of control work on the one hand and a decrease in employers' voluntary compliant conduct, on the other.

2) MEASURES FOR THE IMPLEMENTATION OF LEGAL REGULATIONS; KEY DATA AND STATISTICS

Occupational safety controls in Hungary, 2008-2011

Year	Number of visits	Number of controlled employers	Number of employers affected by irregularity	Number of persons visited (data from the visit sheet)	Controlled number subject to irregularity
	qty	qty	qty	persons	persons
2008	39 631	25 171	21 217	425 576	265 177
2009	37 965	21 660	18 730	569 173	335 349
2010	38 281	22 169	18 523	535 946	298 361
2011	34 226	19 938	16 502	484 026	287 381

Occupational safety-related measures, 2008-2011

Year	Prescribing the termination of deficiencies		Prohibiting employment		Suspending use			Suspending activity		
	decisions	measures	decisions	persons affected	decisions	working tools	persons affected	decisions	activities	persons affected
2008	14 360	59 860	6 295	15 977	7 599	16 572	18 104	5 656	9 544	15 479
2009	15 531	69 922	5 106	13 641	7 319	18 115	20 569	5 004	10 564	17 032
2010	16 585	96 659	4 536	11 931	6 556	17 587	18 936	4 733	10 768	16 709
2011	15 053	86 923	3 587	8 990	5 196	15 021	16 516	3 717	9 027	14 915

Year	Occupational safety fine			Administrative fine		On-the-spot fine		Procedural fine	
	decisions	HUF	persons affected	decisions	HUF	qty	HUF	qty	HUF
2008	3 172	1 137 620 000	9 741	1 827	73 524 000	5 667	61 305 000	374	41 345 000
2009	1 893	665 325 000	6 457	1 258	51 720 000	4 010	45 572 000	349	40 335 000
2010	1 106	357 450 000	4 080	732	28 345 000	2 602	29 677 000	195	28 445 000
2011	423	111 195 000	1 593	400	14 775 000	1 509	16 792 000	191	22 385 000

Number of occupational accidents, 2008-2011

Changes in the number of occupational accidents					
Year/distribution			2008	2009	2010	2011
Total			22 217	18 454	19 948	17 295
	Total severe		218	173	173	158
	Of which	Fatal	116	99	95	80
		Severe mutilation	57	33	38	30
	Mutilations (total)		306	201	211	190

Number of occupational accidents and their incidence per 1000 employees, 2008-2011

Year	Number of occupational accidents	Frequency index per 1000 employees	Total number of fatal occupational accidents	Frequency index per 100,000 employees	Number of employees (Central Statistical Office data)
2004	23 872	6.1	160	4.1	3 900 400
2005	23 971	6.1	125	3.2	3 901 500
2006	22 685	5.8	123	3.1	3 930 100
2007	20 922	5.3	118	3.0	3 926 200
2008	22 217	5.7	116	3.0	3 879 400
2009	18 454	4.9	99	2.6	3 781 900
2010	19 948	5.3	95	2.5	3 781 200
2011	17 295	4.5	80	2.1	3 811 900

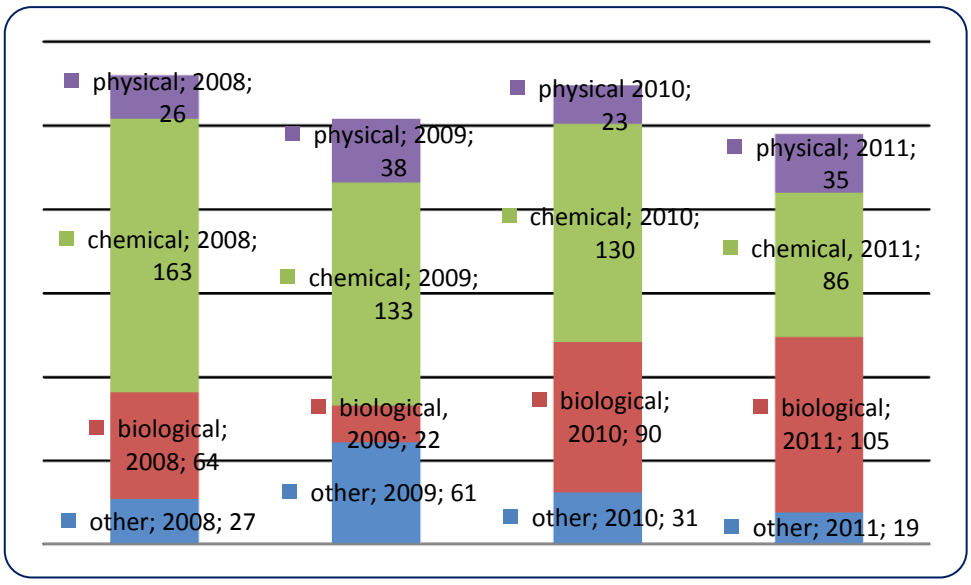
*The data cover the occupational accidents processed by OMMF

Number of registered occupational diseases, 2008-2011

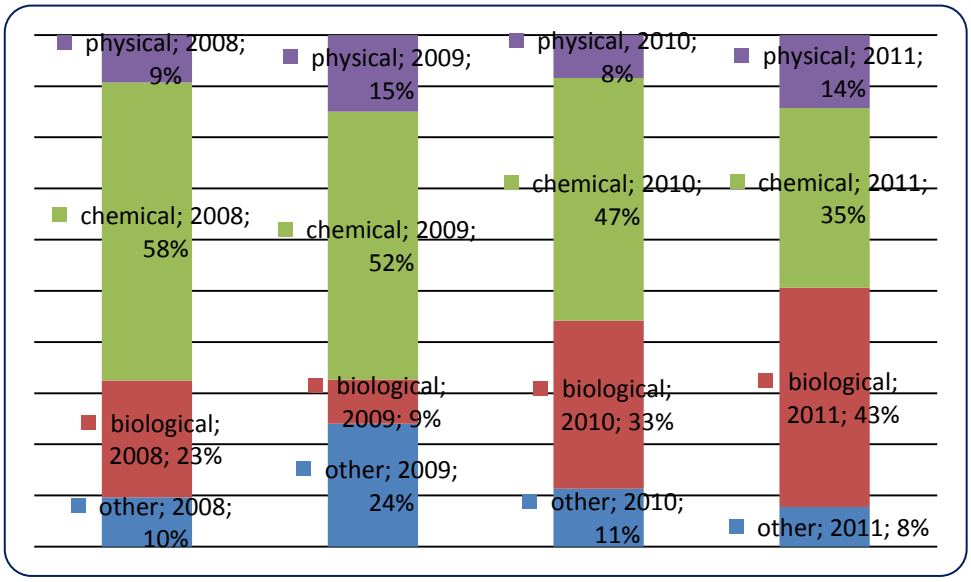
	2008	*2009*	*2010*	*2011*
Number of registered occupational diseases (persons)	**280**	**254**	**274**	**245**
inc. fatal	2	5	2	2
number of mass occupational diseases*	5	2	6	6
number of employees subject to mass occupational disease (persons)	36	22	68	75

**mass occupational illness: identical acute occupational disease affecting 5 or more employees in the same workplace and developing at the same time*

Case numbers of registered occupational diseases (persons) by the main groups of aetiological factors, 2008-2011



Breakdown of registered occupational diseases (%) by the main groups of aetiological factors, 2008-2011



The data concerning changes in the number and amount of fines levied in accordance with Government Decree 218/1999 (Dec. 28) on Certain Offences (hereafter: COD) are provided in the tables below.

Changes in the number and amount of on-the-spot fines in annual breakdown, 2008-2011

Title	2008		2009		2010		2011	
	qty	HUF	qty	HUF	qty	HUF	qty	HUF
COD Art. 94(2) Employment in a job subject to medical examination, without any results from the prescribed occupational fitness examination	48	660 000	72	1 089 500	38	446 000	32	360 000
COD Art. 98(1)a) Violation of rules concerning the healthy and safe performance of work and the control thereof	4935	52 420 500	3 595	39 936 000	2 311	26 095 000	1 338	14 904 500
COD Art. 98(1)b) Failure to meet the registration, investigation, recording and reporting obligation in connection with the occupational accident	32	306 000	14	177 000	16	192 000	14	170 000
COD Art. 99(1) Obstruction of the occupational safety representative	3	35 000	3	50 000	1	5 000	2	30 000
COD Art. 100(1)a) Operation of production or safety equipment without the prescribed preliminary	27	295 000	11	116 000	9	103 000	9	135 000

test								
COD Art. 100(1)b) Violation of security rules concerning the operation and maintenance of production and safety equipment	90	1 091 000	71	920 000	40	482 000	22	261 000
COD Art. 100(2) Removal of fittings (required in safety procedures and standards prescribed by law) of production and safety equipment or keeping them out of order	32	342 000	19	276 000	23	324 000	1	10 000
COD Art. 103(1) Failure to attend the medical fitness examination prescribed in the law, or unfit qualification	102	1 217 000	66	764 500	39	488 000	15	158 000
COD Art. 131(1)a) Manufacture of electric equipment, appliances, consumer equipment without safety approval, their import and marketing	4	50 000	2	30 000	1	10 000	2	30 000
COD Art. 131(1)b) Violation of safety regulation concerning the installation and operation of electrical equipment and appliances	104	1 131 000	34	313 000	15	195 000	13	155 500
COD Art. 132(1)b) Non-observation of safety rules concerning the operation of boilers, pressure equipment or storage tanks	3	60 000	0	0	0	0	1	5 000
COD Art. 139 Violation of safety rules pertaining to construction works	310	3 780 500	151	1 915 000	127	1 337 000	69	613 000

Changes in the number and amount of administrative fines in annual breakdown, 2008-2011

Title	**2008.**		**2009.**		**2010.**		**2011.**	
	qty	**HUF**	**qty**	**HUF**	**qty**	**HUF**	**qty**	**HUF**
COD Art. 94(2) Employment in a job subject to medical examination, without any results from the prescribed occupational fitness examination	41	1 310 000	41	1 270 000	45	1 350 000	32	588 500

COD Art. 98(1)a) Violation of rules concerning the healthy and safe performance of work and the control thereof	1801	68 174 000	1 307	46 955 000	802	25 781 250	539	13 326 500
COD Art. 98(1)b) Failure to meet the registration, investigation, recording and reporting obligation in connection with the occupational accident	40	1 555 000	38	1 205 000	16	365 000	11	320 000
COD Art. 99(1) Obstruction of the occupational safety representative	0	0	0	0	0	0	1	20 000
COD Art. 100(1)a) Operation of production or safety equipment without the prescribed preliminary test	10	300 000	8	300 000	4	150 000	1	0
COD Art. 100(1)b) Violation of security rules concerning the operation and maintenance of production and safety equipment	18	595 000	17	730 000	1	0	0	0
COD Art. 100(2) Removal of fittings (required in safety procedures and standards prescribed by law) of production and safety equipment or keeping them out of order	3	100 000	1	60 000	1	30 000	1	0
COD Art. 103(1) Failure to attend the medical fitness examination prescribed in the law, or unfit qualification	16	495 000	25	715 000	12	173 750	7	115 000
COD Art. 131(1)b) Violation of safety regulation concerning the installation and operation of electrical equipment and appliances	8	215 000	6	145 000	5	175 000	1	40 000
COD Art. 132(2) Keeping boilers, pressure equipment and storage tanks out of order	1	40 000	1	20 000	1	25 000	1	20 000
COD Art. 139 Violation of safety rules pertaining to construction works	23	550 000	4	60 000	3	45 000	1	30 000

As part of the management of occupational safety, the Occupational Safety Act defined, inter alia, the development and operation of the Occupational Safety Information System

(hereafter: MIR System) as a state responsibility. [Par. e) of Sect. (1) of Art. 14] The consulting activity was carried out by the occupational safety information and consulting services (independently set up in the organisational structure of the authorities but separated from the official activities) of the occupational safety authorities.

The aim of information supply within the MIR System was to outline the rights and obligations related to safe work that is not harmful to health, primarily adjusted to the information needs of employees performing organised work, employers and their interest advocacy organisations. The consulting services are responsible for achieving the above objectives and, accordingly, performing occupational safety-related information, consulting and awareness raising activities, which are carried out with the application of the relevant statutory regulations and technical rules and based on the experience gained during operations.

The OMMF launched its occupational safety information service (hereafter: MISZ Service), accessible on the toll-free green telephone line, in 2003, while its consulting activity was expanded from 2008, when it established its Occupational Safety Consulting Service (hereafter: Service), wherein it performed consulting responsibilities only, relying on the altogether 21 consultants in the regional occupational safety inspectorates, thereby giving plenty of scope for personal consultancy. Naturally, the MISZ Service remained in operation, alongside the regional consultancies. The establishment of county government offices by 1 January 2011 brought about major changes in the operation of the Service as consulting activity was also transferred from the regional level to the county level.

Change in the number of consulting cases, 2008-2011

Change in the number of consulting cases between 2008-2011				
Occupational Safety Consulting Service	**2008** consulting cases	**2009** consulting cases	**2010** consulting cases	**2011** consulting cases
Regional occupational safety consultants	10 478	10 764	12 722	12 228
MISZ Service	6 645	6 550	9 823	8 323
Total	**17 123**	**17 314**	**22 545**	**20 551**

The Service was accessible by phone, in person and in writing (letter, email). Altogether 77,533 contacts were registered in the four years.

Due to the toll-free green number, the most typical consulting mode was information on the phone. Personal consulting was only done by regional occupational safety consultants, while the supply of written information was evenly distributed across the regions.

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

There were no actual changes in the operations of the occupational health services in the reporting period, only some organisational changes which entailed transferring responsibilities among the supervisory bodies (as mentioned in other sections). The impact on their everyday work was insignificant.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION; KEY DATA AND STATISTICS

Hungary created the legal framework as early as in 1993 and 1997, via the relevant legal regulations. Consequently, employers are obliged to provide, free of charge, occupational healthcare services to every worker they employ. The legal framework has not changed substantially since then. Comprehensive occupational healthcare services are available to the unemployed for a small fee, noting that certain examinations may be made to the debit of social security in regional special medical facilities and at the third (national) treatment level. The unemployed do not typically use the occupational healthcare services.

Key data from the annual reports (based on self-assessment) (OSAP National Statistical Data Collection Program) of occupational health services, 2008-2011

	2008	**2009**	**2010**	**2011**
Number of doctors in primary occupational health services	3 061	2 588	2 556	2 686
Inc. number of occupational healthcare specialists	2 499	2 132	2 218	2 340
Number of nurses in primary occupational health services	3 073	2 646	2 844	2 806
Inc. number of occupational healthcare specialised nurses	2 248	2 034	2 249	2 179
Number of business units served	120 265	96 824	100 298	103 097
Number of employees served	2 387 621	2 025 986	2 063 709	2 173 054
Number of job-specific and other fitness examinations	2 288 819	1 737 249	1 907 417	1 971100
Number of measures for rehabilitation	10 590	9 713	7 393	6 536
Number of examinations at work	123 244	48 513	51 000	37 469
Number of consultancy cases in labour hygiene	295 119	243 786	260 521	278 425
Attendants' activity	540 161	412 534	403 935	400 674
Total case number in occupational healthcare service facilities	51 738	73 280	60 094	74 014

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

Legal regulations on healthcare were subject to the following changes in the reporting period.

I. Changes affecting the organisation of the healthcare system

Measures in 2009

1. The administrative burdens of healthcare providers were mitigated in the following field:

- Issuing accounting statements in one copy, instead of the former duplicate, represents improvements for healthcare providers both in financial and administrative terms (no need to have it signed and to archive the signed duplicate for years).
- Medicinal service providers (thermal baths), medical device distributors and pharmacies were exempted from the obligation to verify legal relations. Since controls are conducted at the financed healthcare providers when the healthcare services provided by them are prescribed, double control procedures were applied in most cases.

The above involved amending the following regulations:

- Act LXXXIII of 1997 on benefits under the statutory health insurance scheme (hereafter: Health Insurance Act);
- Government Decree 217/1997 (Dec. 01) on the Implementation of Act LXXXIII of 1997 on benefits under the statutory health insurance scheme;
- Government Decree 43/1999 (Mar.03) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund;
- Government Decree 134/1999 (Aug.31) on the Settlement and Disbursement of Subsidies Granted to the Price of Medicines, Medical Devices and Medicinal Spa Services Prescribed in Outpatient Treatment.

2. Modification of Act CXXXII of 2006 on the Development of the Healthcare System, to handle the problems that stem from the transfer of special healthcare tasks.

Measures in 2010

Following the promulgation of Decree 31/2010 (May 13) of the Ministry of Health on Financing Procedures, the process of codifying financial protocols in legal regulations was commenced.

In **2011**, several regulations with a structural impact on the healthcare system were modified or adopted, so each such legal regulation is individually described hereunder.

Changes broken down according to legal regulation

- **Act XCVII of 2006 on Professional Chambers in Healthcare**

Membership in chambers was voluntary in the previous reporting period. The chamber conducted ethical procedures in the competence of the chamber only with regard to doctors, dentists, pharmacists and healthcare specialists who were members of the chamber. With regard to non-chamber members, the rules of ethical procedures were regulated in Articles 140/A-140/E of Act CLIV of 1997 on Health (hereafter: Health Act): this was in the competence of County Ethical Councils in the first instance and the National Ethical Council in the second instance. From 1 June 2011, chamber membership is now repeatedly compulsory for doctors, dentists, pharmacists and healthcare specialists performing healthcare activities. The former County Ethical Councils and the National Ethical Council have ceased to exist. The code of ethics of the chamber applies to each member with compulsory effect. The power of chambers to deliver opinions has also been expanded with the entry into force of compulsory chamber membership.

- **Act CXVI of 2006 on Authority Supervision of Health Insurance**

The multi-fund health insurance system has not been set up. The Act lapsed on 26 September 2010, and the Health Insurance Supervisory Authority was terminated. Its competences and responsibilities were taken over by other offices. All complaints procedures against healthcare providers which had not been concluded by the Supervisory Authority were conducted by the National Public Health and Medical Officer Service (hereafter: ÁNTSZ), whereas any tasks related to waiting lists were subsequently performed by the National Health Insurance Fund (hereafter: OEP). The option of lodging an appeal against the inclusion of medicines and medical devices in social insurance subsidy was discontinued, though it is possible to appeal against a decision before a court.

- **Government Decree 1208/2011 (Jun. 28) on the Semmelweis Plan, the Tasks Accompanying Healthcare Restructuring under the Semmelweis Plan and on Measures for Performing the Key Tasks**

The Semmelweis Plan was aimed at the development of a new state-managed institutional system for healthcare management, which represented greater state responsibility and supported inter-institutional collaboration, restructuring and patient pathway management, and also aimed, via the above, at the implementation of necessary restructuring.

- **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 (integration in inpatient treatment)**

The healthcare institutions identified in the Act and operated by the Municipal Government of Budapest or by county local governments, the foundations, public foundations and business associations established and operated by the Municipal Government of Budapest, in charge of healthcare duties, held, in part or in whole, in the ownership of the Municipal Government of Budapest, as well as their properties and rights with property value were transferred into state

property on 1 January 2012; moreover, their founders' and operators' rights and obligations related to the property and the institutions were assigned to the National Institute for Quality and Organisational Development in Healthcare and Medicines (hereafter: GYEMSZI). The transfer of property rights and operator's rights does not affect the healthcare provider's regional servicing obligation, the size and technical composition of its existing tied-up capacities and its eligibility for funds, based on its valid financing contracts. Preparations were commenced in 2011 to organise healthcare services in healthcare regions. The healthcare region is an area responsible for the health care of 0.9-1.6 million insured persons and where, in healthcare institutions, healthcare services may be provided in the majority of professions eligible for financing, at each level of progressivity. The regions were identified in Government Decree 325/2011 (Dec. 28) amending Government Decree 337/2008 (Dec. 30). Accordingly, West-Central Hungary, Western Transdanubia, Northern Hungary, North-Central Hungary, Northern Great Plain, South-Central Hungary, Southern Transdanubia and Southern Great Plain regions were set up as of 1 January 2012. The districts of Budapest were integrated in West-Central Hungary, North-Central Hungary and South-Central Hungary regions.

- **Government Decree 59/2011 (Apr. 12) on the National Institute for Quality and Organisational Development in Healthcare and Medicines**

GYEMSZI was established on 1 May 2011 through the merging of several, previously independent organisations, rested on the foundations of the Institute for Healthcare Quality Improvement and Hospital Engineering (EMKI), from the merger of the National Institute for Strategic Health Research (ESKI), the National Institute of Pharmacy (OGYI), the Institute for Basic and Continuing Education of Health Workers (ETI) and the National Centre for Healthcare Audit and Inspection (OSZMK). In addition to maintaining the inherited responsibilities, it was basically given a central role in implementing the healthcare development concept of the Semmelweis Plan, in developing and operating regional healthcare management, and in the property management and maintenance of the state institutional system. The main responsibilities of GYEMSZI in the period until 31 December 2011:

a) to carry out the coordination, technical management and documentation of various tasks for healthcare quality improvement;
b) to coordinate technical supervision in the healthcare sector and, through the operation of the national supervisory network, and in collaboration with the Office of the Chief Medical Officer of State (hereafter: OTH), the county public healthcare administration organisations and the micro-regional public health institutions, to perform the technical supervision of healthcare providers;
c) to perform expert activities and render professional support in connection with the healthcare providers' medicotechnical and technological investments and the operation of medical techniques and technologies;
d) to perform pharmaceutical authority, specialist authority and controlling activities;
e) to carry out tasks for the development of a healthcare policy and for decision preparation, and tasks related to the arrangement of developments from subsidised sources;
f) to elaborate, prepare and supervise the professional and examination requirements of technical qualifications in healthcare;

g) to perform organisational, methodological management and technical pedagogical tasks in connection with vocational training and examinations in healthcare;
h) to perform IT activities in the healthcare sector, and draw up and continually update sectoral IT strategy;
i) to perform the tasks of development, analysis and assessment, research, expert and technical support in relation to healthcare and healthcare financing;
j) to collect and analyse statistical data within its statutory competence;
k) to act as an expert in technical issues defined by the Government;
l) to carry out compliance assessments and other tasks stipulated in the law, its deed of foundation or an official decree.

II. Changes affecting the healthcare system

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

The Act was modified on several occasions after the previous reporting period. The definition of certain terms in the Act, the rules of modifying and regrouping in- and outpatient service capacities, and the rules of determining healthcare providers' service areas were modified from 1 January 2009, and the special service capacities and professions eligible for funding by the health insurance company were identified in the Act. As of 1 January 2010, the Act laid down detailed rules for a healthcare contract between the healthcare provider and the organisation responsible for public healthcare services.

The notion of priority hospitals was cancelled from 1 January 2011: the Act no longer determined the number of beds for special institutions of national competence and priority hospitals in its annexes. In 2011, the rules related to the determination of capacities and the determination of the service areas were repeatedly changed, and the procedures resting on the new rules were conducted in 2012. Government Decree 337/2008 (Dec. 30) on the Implementation of Act CXXXII of 2006 on the Development of the Healthcare System was adopted in the reporting period.

- **Act XCVIII of 2006 on the Safe and Economical Supply of Medicinal Products and Medical Devices and the General Rules for Medicine Distribution**

A regulation reflecting the principle of need is enforced with regard to the establishment of pharmacies, in order to guarantee the safety of public medicine supply and the sustainability of pharmacies as an organic part of the healthcare system. From 2011, a public pharmacy may only be opened in a settlement where

- no public pharmacy is currently operated;
- the population served by the public pharmacy exceeds 4000, or 4500 in big settlements;
- there is at least 250 metres' distance between the entrance of the existing public pharmacies and the entrance of the new public pharmacy in towns with a population in excess of 50,000, or at least 300 metres in other settlements.

The requirement of majority ownership by pharmacists is reinforced, so as to guarantee that the technical rules of pharmacology are enforced in medicine supply.

- **Act CXCI of 2011 on Benefits for Persons with Reduced Working Capacity and the Amendment of Certain Other Acts**

The system of providing treatment to persons with reduced working capacity was changed on the basis of the Act. No disability pension, accident disability pension, rehabilitation allowance, regular social allowance, temporary allowance or mining workers' health impairment allowance can be allocated as of 1 January 2012, based on the statutory regulations. The benefit payable by the body designated by the Government to persons receiving group 1-2 disability or accident disability pension, group 3 disability or accident disability pension (for people who will reach the old-age retirement age limit within 5 years), regular social allowance or temporary allowance (for people who have already reached the old-age retirement age limit or will reach it within 5 years) on 31 December 2011 is disbursed as disability benefit from 1 January 2012.

The benefit payable by the body designated by the Government to persons receiving group 3 disability, accident disability pension or regular social allowance on 31 December 2011 is disbursed as rehabilitation allowance from 1 January 2012. If this person did not apply for a complex classification by 31 March 2012, his or her rehabilitation allowance shall be discontinued as of 1 May 2012.

- **Government Decree 35/2011 (Mar. 21) on the professional rules and conditions governing birth outside an institution and the causes excluding the possibility of such birth**

The legal regulation stipulating the legal conditions of giving birth outside healthcare institutions entered into force in 2011 in Hungary. The regulation applicable to births after 1 May 2011 offers an alternative to pregnant women giving birth, to select the place of giving birth. Accordingly, women of between their18 and 40 years of age may opt to give birth outside a healthcare institution (at home) between the 37th and 41st weeks of a pregnancy without complications, provided the foetus is in a head-end position. Grounds for exclusion include twin or multiple pregnancy, earlier Caesarean delivery, earlier problematic delivery and acute diseases. Only healthcare providers with a licence and liability insurance are authorised to provide childbirth services outside healthcare institutions, under pre-set hygienic conditions, facilitating access to a background hospital in financing-related contractual relation with OEP within 20 minutes, if necessary. Childbirth may be led by an obstetrician-gynaecologist specialist or a midwife with a diploma, at least two years' practice in a delivery room or, in the absence of the former, two years' professional practice and certified participation in at least fifty childbirths. Two healthcare professionals are obliged to attend the childbirth and the paediatrician's examination must be done within 24 hours. Social insurance does not finance childbirth outside healthcare institutions, though services provided by the paediatrician, the nurse and the background hospital are financed.

- **International legal obligations**

The Hungarian-Montenegrin Agreement (promulgated in Act LXXII of 2008) and the Hungarian-Bosnian Agreement (promulgated in Act II of 2009) entered into force in the audited period. These agreements define the applicable legislation, healthcare and pension services.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION; KEY DATA AND STATISTICS

I. Health condition of the Hungarian population

The health condition of the Hungarian population is, by international comparison, **extremely unfavourable**, and falls significantly short of what it should be, given the country's level of socio-economic development. The early mortality rate, which is very high by international standards, has long had a **detrimental effect on sustainable development and on Hungary's international competitiveness**.

Although the health condition of the Hungarian population has improved in the last two decades, almost every health index shows that Hungary is significantly worse off than most other Member States of the European Union. According to Eurostat data on life expectancy at birth, Hungary is in the fourth worst position in the EU. Of the 27 Member States, Hungary is in 23rd place for male mortality and 24th place for female mortality. In 2011, the average life expectancy at birth was 71.2 years for men and 78.7 years for women. The situation is even worse if we consider the healthy life years indicator.

Life expectancy at birth rose continuously in Hungary in the reporting period, but it is still below the EU average.

	Men	***2008***	***2009***	***2010***	***2011***
Hungary	***(year)***	70.0	70.3	70.7	71.2
EU average	***(year)***	76.4	76.7	77.0	77.4
	Women	***2008***	***2009***	***2010***	***2010***
Hungary	***(year)***	78.3	78.4	78.6	78.7
EU average	***(year)***	82.4	82.6	82.9	83.2

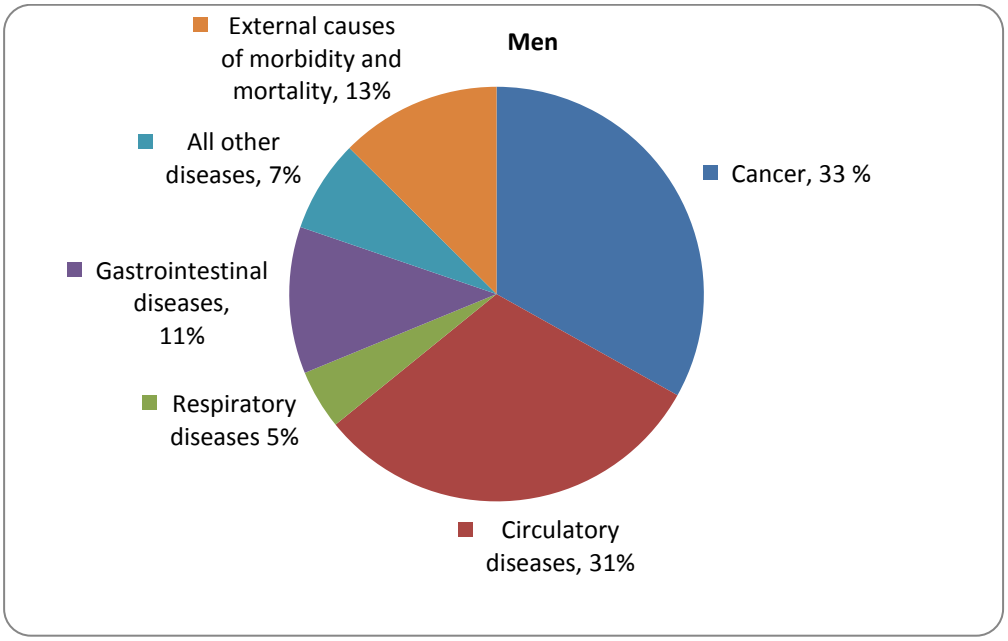
Source: EUROSTAT

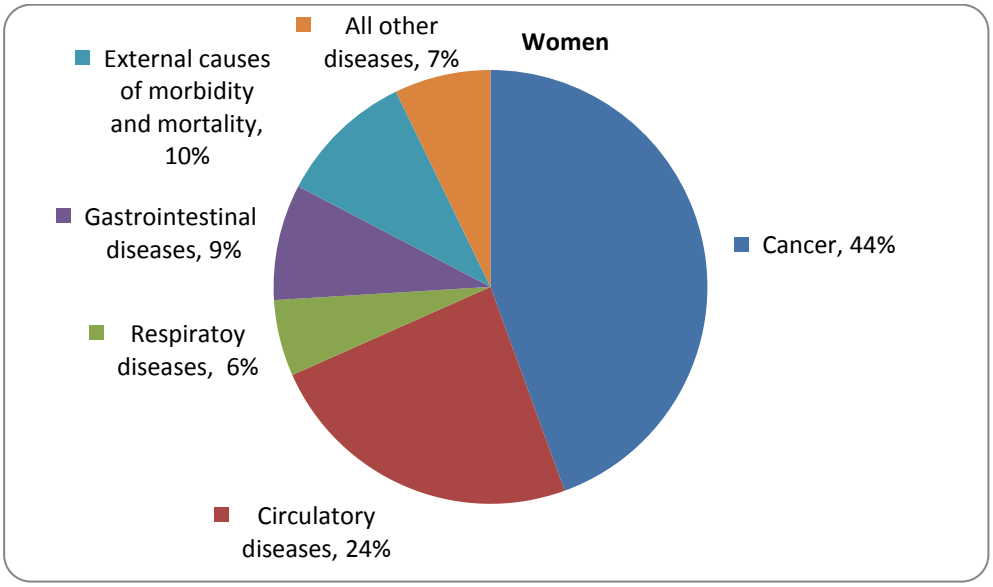
In Hungary, the standardised mortality rate per 100,000 population is 875.36, while the EU average is 591.66. This means that the rate in Hungary is one-and-a-half times that of the EU average. Based on this figure (projected for a population of 10 million), this represents excess mortality of around 28,000 persons per year.

Even today, more than 90% of deaths are accounted for by the five leading groups of causes of death (circulatory diseases, 49.9%; cancer, 25.8%; gastrointestinal diseases, 5.7%; respiratory diseases, 5.1%; external causes, 5.2%). The vast majority of the burden of disease is made up of chronic, non-communicable diseases. It should be noted that mortality due to the five leading groups of causes of death – except for cancer in women – has not risen in the past decade. In spite of the stagnation or reduction, mortality due to circulatory diseases among men is 1.9 times higher than the EU average in 2011, among women it is1.8 times higher, while for digestive diseases it is 2.1 times higher among men and 1.6 times higher among women (source: WHO HFA-DB).

One third of early deaths among men (0-64 years) were due to diseases and cancers of the circulatory system, 11-13% were due to gastrointestinal diseases and external causes, and 5% were due to respiratory diseases. Among women (0-64 years), it is of particular importance to note that 44% died of cancer, and that mortality due to gastrointestinal diseases was just 3% lower than the rate for men.

Leading causes of death among men and women in Hungary aged 0-64 (2011)





Source: Central Statistical Office

For a significant part of the burden of disease caused by chronic, non-communicable diseases lifestyle factors (smoking, alcohol consumption, unhealthy diet, lack of physical activity) are responsible for.

Infant mortality figures also improved in the reporting period, compared with the data from the previous report.

Infant mortality (under the age of one), by main groups of causes of deaths

Year	Infant mortaly total	Of which:				
		Infectious and verminous diseases (A00–B99)	Respiratory diseases (J00–J99)	Congenital developmental disorders (Q00–Q99)	Conditions from the perinatal period (P00–P96)	External causes of mortality and morbidity (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
			Infant deaths per 1000 live-born infants			
1970	35.9	0.3	3.9	6.1	21.8	0.3
1980	23.2	0.2	1.7	4.8	14.1	0.6
1990	14.8	0.2	0.9	3.3	8.8	0.4
2000	9.2	0.1	0.5	2.1	5.5	0.4
2001	8.1	0.1	0.3	1.9	4.9	0.3
2002	7.2	0.1	0.2	1.5	4.4	0.2
2003	7.3	0.1	0.3	1.6	4.4	0.2
2004	6.6	0.1	0.3	1.3	4.2	0.2
2005	6.2	0.1	0.3	1.6	3.4	0.2
2006	5.7	0.0	0.1	1.6	3.1	0.2
2007	5.9	0.1	0.1	1.5	3.5	0.1
2008	5.6	0.0	0.1	1.3	3.6	0.2
2009	5.1	0.0	0.0	1.4	3.2	0.1
2010	5.3	0.0	0.0	1.5	3.3	0.1
2011	4.9	0.0	0.0	1.4	2.8	0.1

*Deaths under the age of one year.

Source: KSH [Central Statistical Office])

1. Screening examinations

Pursuant to Art. 3 of the Health Act, a screening examination is an examination aimed at the early diagnosis of any potential disease or prophylactic condition (including risk factors that predispose to disease) of a person with no symptoms of a disease (asymptomatic person). Prevention and an adequate information supply play essential roles in the promotion of health. Art. 10 of the Health Insurance Act lays down which healthcare services are available to the insured person free of charge, including healthcare services aimed at the prevention and early diagnosis of diseases, in a breakdown to age groups. This includes:

- screening examinations prescribed for the newborn, the 0-6 year-old age group, the 6-18 year-old age-group and within in-school and youth healthcare services, up to the age of 18 (development of sense organs and locomotive organs, physical development, blood pressure measurement, orthopaedic screening), generally bi-yearly, and dental screening examinations once a year;
- and, above the age of 18:

- screening examinations identified in Decree 51/1997 (Dec. 18) of the Ministry of Public Welfare with regard to diseases induced by age and sex dependent risk factors (e.g. physical condition, cardiovascular test, elimination of renal disease and diabetes, stomato-oncological examination, lung screening);
- sports health examinations without regard to age, except for professional athletes' sports healthcare services.

In addition to the above, the insured is entitled to have examinations carried out which are aimed at the early diagnosis of the expected consequences and complications of his or her disease. The insured may have recourse to the screening examinations at his or her own initiative, during his or her healthcare provision, at the general practitioner's or specialist's referral or based on the notification of the healthcare provider carrying out the screening examination, in the frequency determined in a special decree (generally bi-yearly).

For targeted screening examinations for the purpose of public healthcare, the notification is sent by the healthcare provider carrying out the screening examination or by the healthcare state administrative body. Sections (3) and (4) of Art. 81 of the Health Act include provisions on attending screening examinations: from among age-related screening examinations, the screening of the newborn and of school-age children is compulsory in the case defined in the law. The legal representative is obliged to take measures to ensure the attendance at the screening examination of minors subjected to screening examinations.

If, even after a written notice, the legal representative fails to meet this obligation, the healthcare state administrative body prescribes the screening examination. Additionally, regulations may motivate attendance in other screening examinations through allowances or may withdraw allowances (that have no detrimental effect on health conditions) if a recipient fails to attend the screening examination.

1.1. The general practitioner's primary service (adults', children's and mixed practice) provides healthcare curative and preventive services, including screening examinations, to the entire population.

Measures in 2009

Development of a uniform set of GP indicators

A country-wide uniform indicator system taking measurements of professional work in general practitioners' (GP) services (with special regard to their role as a gatekeeper and to communications with the other levels in healthcare) has been set up. The indicators were introduced in a test form in the first year but had no effect on financing GP-related service providers.

The following indicators were defined in adults' medical practices:

- influenza vaccinations from the age of 65;
- GPs' screening activity;
- Blood lipid test among the 40-60-year-old insured population;
- Mammography breast screening among 45-65-year-old women;
- High blood pressure treatment in the 50-65-year-old population;
- Acute post-heart attack treatment;
- Diabetes mellitus follow-up treatment;

- Occurrence of stroke in the 50-74-year-old population;
- Referral pattern;
- Antibiotic treatment;

Indicators in children's medical practices:

- Pneumococcal vaccinations among children below the age of 2;
- GPs' screening activity;
- Referral pattern;
- Antibiotic treatment.

Measures in 2011

Transformation of the standard set of GP indicators

Relying on the practical experience of the past two years, the set of indicators designed to assess GPs' performance was reviewed in 2011. Instead of the former moving average figures, pre-set target values need to be achieved in some indicators to gain financial grants that prize high quality service. The new system is intended to motivate the GPs' preventive, curative, caretaking and medicine prescribing activity. Replacing the former 12, the present 15 indicators (incl. 4 for pediatric practices) are identified in the assessment of adults' and mixed GP medical practices. The indicators concerning medical products also cover a survey of more cost efficient medicine prescriptions. Six indicators, instead of the former four, are defined to assess children's districts.

1.2. Development in support of primary healthcare

Following the objectives of the Semmelweis Plan, the preventive and health educational role of those taking part in primary service needs to be reinforced, the preventive approach of GPs' healthcare services needs to be transformed, and a complex interest system is to be created through the involvement of other healthcare experts. This is supplemented by expanding nurses' preventive activities. Additionally, the unoccupied GP districts need to be occupied.

- **Practice Programme I and II**

The practice programmes of the National Institute of Primary Care (hereafter: OALI) are aimed at guaranteeing medical treatment in permanently unoccupied adult and mixed GP districts. These districts are mainly to be found in regions that are disadvantaged in other criteria as well. In the frames of Practice Programme I launched in January 2006, so far 80 doctors have entered the system, including 30 who work in a district that used to be permanently unoccupied in the most disadvantaged micro-regions. In Practice Programme II launched in June 2009, so far 105 doctors have entered the system and thereby obtained the right to practice the GP's activity. Under the system, 23 doctors work in the most disadvantaged micro-regions, including 8 in permanently unoccupied districts.

2. Public healthcare-oriented organised screening examinations

Pursuant to Sect. (1) of Art. 2/A of Decree 51/1997 (Dec. 18) of the Ministry of Public Welfare on Healthcare Services Aimed at the Prevention and Early Diagnosis of Diseases and Available in the Framework of Compulsory Health Insurance and on the Certification of Screening, the public healthcare-oriented targeted screening examination means a public healthcare activity covering specific age groups of the population and performed at

professionally justified intervals, applying the practice of personal invitation. According to Annex 3 of the Decree, public healthcare-oriented targeted screening examinations are as follows:

- triennial gynaecological oncological cervical screening in the 25-65 year-old age group, for public healthcare purposes, after any single screening examination with a negative result, with particular regard to the cell test (cytology) and colposcopy test of cervical changes;
- biannual breast screening (mammography) based on the X-ray test of the soft tissues of the breast in the 45-65 year-old age group, for public healthcare purposes..

- **Oncological screening for public healthcare**

Based on data from the Central Statistical Office, altogether 32,640 persons (18,032 men and 14,428 women) in 2010, and 32,670 persons (17,990 men and 14,680 women) in 2011, died of their malignant tumour disease. Mortality totalled 130,456 in 2010, including 65,137 men and 65,319 women. The total figure was 128,795 in 2011, including 63,883 men and 64,912 women.

The number of malignant tumours diagnosed and registered in 2010 was 67,398 (34,514 men and 32,884 women).

Most frequent deaths caused by malignant tumour in 1975-2011, by sex

year	total deaths from cancer	trachea, bronchia, lungs		Colorectal		lip-oral cavity		breast	cervix
		men	women	men	Women	men	women	women	women
1975	25 476	3 414	755	1 477	1 548	383	79	1 650	536
1980	27 550	4 167	992	1 718	1 820	585	114	1 800	669
1990	30 871	5 416	1 492	2 146	2 090	945	175	2 097	602
2000	33 280	5 727	2 097	2 514	2 372	1 413	275	2 316	481
2003	33 530	5 849	2 352	2 784	2 311	1 456	304	2 309	465
2008	32 111	5 597	2 733	2 563	2 190	1 364	287	2 108	418
2010	32 460	5 741	2 907	2 704	2 261	1 232	292	2 011	379
2011	32 670	5 558	2 975	2 835	2 219	1 213	281	2 138	414

Source: CSO

Most frequent new malignant tumour diseases reported in 2008-2011, by sex

year	total illnesses	C34 bronchus and lungs		C18-C21 colon, rectum		C00-C14 lips, oral cavity, pharynx		C50 breast	C53 cervix
		men	women	men	women	men	women	women	Women
2008	70 527	6 983	4 006	5 134	4 463	2 737	935	7 133	1 095
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

Source: National Cancer Register

The most promising strategy for decreasing tumour deaths in the short and medium term is early diagnosis and early treatment. The means facilitating the early diagnosis of tumour diseases are the periodic screening examinations of persons in the endangered age who are believed to be healthy and have no complaints or symptoms. Their efficacy is measurably proven through the decrease of deaths in the target illness. Although the capacity of organised cervical screening, rested on current special services, is satisfactory in volume and covers the entire country, the biggest problem still remains the low number of registered attendants.

The main reason for this seemingly low compliance is that the availability and accessibility of gynaecological test rooms is limited for those living in small settlements. The screening option needs to be "taken on site": this is systematically provided in so-called "screening by specialists", of which the first step is the nurses' pilot programme.

A Cervical Screening Pilot Programme by Nurses was launched in 2009, following some positive international examples. The screening was done by nurses trained for screening, in the nurses' consulting rooms, i.e. without any travel time and cost and any waiting time, based on reliance upon the nurse and the nurse's empathy. The nurses contacted (as far as possible) the women who were to be screened, informed them about the importance of screening, and did the screening in the consulting room at the scheduled time. For any non-negative smear results (inflammation, suspicion of tumour), the women were referred to gynaecologists for further tests and treatment. The nurses managed to convince women who had not been to a gynaecologist for 10 or more years.

Results of the Cervical Screening Pilot Programme by Nurses

year	Number of screening nurses (persons)	Settlements with screening tests by nurses (qty)	Women to be screened and reached by nurses (persons)	Women screened by nurses (persons)	Screened with the suspicion of tumour (persons)	Screened with the suspicion of inflammation (persons)
2009	108	168	13825	4873	23	417
2010	212	349	24349	6781	34	468
2011	181	300	13227	3771	15	98

Any further improvement in the efficiency of public healthcare screening programmes can primarily be attained through informing the public, developing local communities, involving local governments and introducing the GPs' indicator-based performance assessment.

3. Decrease in mortality rate

Measures in 2009

JESZ Program

The HUF 120 million call for tenders announced by the Ministry of Health in summer 2009 was aimed at the installation of semi-automatic defibrillators for resuscitation upon sudden cardiac death and the training of non-medical life-savers (in the form of non-reimbursable subsidies). 89 life-saving points were established, 826 teachers and 216 educators in other jobs were trained under the Programme. Based on the success of the tender, the Ministry of Health proposed the continuation of the programme: a new, HUF 50 million call for tenders was announced in December 2009.

Measures in 2010

JESZ Program

The HUF 50 million tender budget of JESZ Tender II was increased by HUF 5 million. As an outcome of the tender, 172 defibrillators (incl. 121 from tender grants and 51 from own resources) were installed in various points in the country and another 4,180 non-medical persons learnt about the basics of life-saving. Hungary had altogether 261 live-saving points and over 15,000 trained persons in spring 2010, owing to the two tenders (JESZ I, JESZ II).

Priority ranking in public financing of additional capacity

The Minister of Health determined the professional priorities underlying the acceptance of additional capacities as follows:

- "Közös kincsünk a gyermek" (in English: "Our common treasure is the child") - National Infant and Child Healthcare Programme: for the development of newborn treatment, expanding the capacities of Intensive Neonatal Departments (PIC II).
- National Programme Against Cancer: extension of capacities of colorectal screeners operating in mobile breast screening and gastroenterology stations.
- National Programme of Prevention and Cure of Heart and Vascular Diseases: developing the entire spectrum of high quality stroke treatment in stroke centres, and generating the capacities of level II and III rehabilitation.
- National Programme for Mental Health: expanding capacities in child psychiatric rehabilitation, expanding capacities for the drug treatment of youth between 14-18 years of age.

Measures in 2011

International cooperation

- The National Institute of Oncology became a member of EurocanPlatform which was established by European Oncology Institutions. The initiative is designed to create an integrated research network.
- A prior cooperation agreement was reached between the Hungarian National Blood Transfusion Service and Eurotransplant International Foundation whereby so-called special patients may get organs via the international organisation.

II. Executive measures related to the healthcare system

1. Modernisation of the healthcare system

Measures in 2009

Developments from European Union funds

HUF 120 billion EU assistance was approved for healthcare development in 2009. In Regional Operational Programme (hereafter: ROP) and Social Infrastructure Operational Programme (hereafter: SIOP) and in Social Renewal Operational Programme (hereafter: SROP) EU funds could be applied for to undertake primarily infrastructure development (development of primary medical services; establishment of local health houses;

establishment and development of outpatient care centres, consulting rooms, micro-regional outpatient medical centres; development of outpatient services replacing active hospital treatment; infrastructure development in "health poles"; improvement of emergency services; modernisation of tertiary healthcare services; infrastructure development in institutions providing oncological and paediatric oncological treatment) and for the support of employment in healthcare institutions, respectively. Grants were awarded for the following development aims in 2009, within the individual operational programmes:

In SIOP, assistance was approved for:

- the establishment and development of micro-regional outpatient medical centres (SIOP 2.1.2-08/1);
- the development of outpatient services replacing active inpatient treatment (2.1.3-08/1);
- infrastructure development in "health poles" (2.2.7-07/2F/2); and
- the development of emergency services (2.2.2-08/2).

In ROP, assistance was approved for the development of healthcare services, including:

- for the development of primary medical service and the establishment of local health houses (SGPOP 4.1.1/A, SGPOP 4.1.1/A-09, NGPOP 4.1.2/A, NHOP 4.1.2/A, CTOP 5.2.1/A, WPOP 5.2.1/A);
- for the development of micro-regional independent outpatient polyclinics (SGPOP 4.1.1/B, NGPOP 4.1.2/B, NHOP 4.1.1/B, CTOP 5.2.1/B, WPOP 5.2.1/B) and the development of outpatient medical centres (STOP 3.1.3/B);
- for the development of micro-regional special services for outpatients in the Central Hungarian region (CHOP 4.3.2);
- for the modernisation of healthcare institutions providing priority services (CHOP 4.3.1/A);
- for infrastructure development in institutions providing oncological and paediatric oncological treatment (CHOP 4.3.1/C).

From the assistance approved in 2009, the development of the primary medical service covers 137 settlements in the country, the development of special outpatient services applies to 41 locations and hospital infrastructure development to 21 locations. The number of service providers offering financed home-based hospice services rose from 29 in 2008 to 59 in 2009. This rise was also facilitated by a statutory change in 2008, given that it simplified and decentralised the establishment of home-based hospice services and contracting with health insurance.

Measures in 2010

Developments from European Union funds

Most infrastructure developments in healthcare were implemented from EU grants. HUF 109 billion EU assistance was approved for healthcare development in 2010. In ROP and SIOP tenders, applications could be made for the development of primary medical services, the establishment of health houses, the development of outpatient medical centres, the modernisation of special outpatient services, infrastructure development in special inpatient services, the development of emergency services, and the development of the IT system in

rescue and of rescue management. SROP applications facilitated the support of employment, the support of training programmes and competence development. Using the assistance, primary services, special outpatient services and the hospital infrastructure are being developed in 135 locations, 7 settlements and 40 locations, respectively. GPs' consulting rooms, outpatient centres and hospital infrastructure could be developed from the assistance received in recent years within the grant system of New Hungary Development Plan.

Grants were awarded for the following development aims in 2010, within the individual operational programmes:

In SIOP, assistance was approved for:

- the development of outpatient services replacing active inpatient treatment (SIOP 2.1.3-10/1);
- the development of emergency services (SO1 and SO2), including the support of paediatric emergency services (SIOP 2.2.2-08/2);
- infrastructure development supporting restructuring in special outpatient services (SIOP 2.2.4-09/1);
- the development of the rescue management system (SIOP 2.3.4-09/2);
- infrastructure development in "health poles" (SIOP 2.2.7-07/2F/2).

In ROP:

- for the development and modernisation of primary medical services and the establishment of local health houses (SGPOP 4.1.1/A-09, NGPOP 4.1.2/A-09, CTOP 5.2.1/A-09, NHOP 4.1.1/A-09, WPOP 5.2.1/A-09);
- for the development of integrated micro-regional primary healthcare and social service centres (STOP 3.1.3/A-2f);
- for the development of micro-regional special outpatient centres, the modernisation of special outpatient services and the development of micro-regional independent outpatient polyclinics (SGPOP 4.1.1/B-09, NGPOP 4.1.2/B-09, CTOP 5.2.1/B-09);
- for the development of primary and outpatient medical services in the most disadvantaged micro-regions managed within a complex programme (SGPOP 4.1.1/C-09, NHOP 4.1.1/C-09, NGPOP 4.1.2/D-09);
- for the development of healthcare IT in the Central Hungarian region (CHOP 4.3.3/B-09-2F).

In SROP:

- for the support of employment in healthcare institutions (SROP 6.2.4/A- 08/1/konv, SROP 6.2.4/A-09/1, SROP 6.2.4/A-09/1/KMR);
- for training programmes for healthcare employees, for training in high-demand vocations and for competence development (SROP 6.2.2/A-09/1, SROP 6.2.2/AKMR-09/1, SROP 6.2.2/A-KMR-09/2, SROP 6.2.2/B-09/1);
- for the support of training fees in institutions in the convergence regions (SROP 6.2.2/A-09/2 "A" component);
- for healthcare educational and awareness raising lifestyle programmes (SROP 6.1.2/A- 09/1, SROP 6.1.2/A-09/1-KMR, SROP 6.1.2/LHH-09/1).

Measures in 2011

Developments from European Union funds

A total of HUF 70.8 billion assistance was approved for the development of the Hungarian healthcare system from EU funds appropriated within the National Strategic Reference Framework in 2011.

In ROP:

- for the development of primary medical services and the establishment of local health houses (SGPOP 4.1.1/A-09, NHOP 4.1.1/A-09);
- for the development of healthcare services: the development of micro-regional outpatient medical centres, the modernisation of primary and outpatient medical services in the most disadvantaged microregions managed within a complex programme (SGPOP 4.1.1/C-10, NGPOP 4.1.2/D-10, NHOP 4.1.1/C-10);
- for the development of micro-regional independent outpatient polyclinics (NHOP 4.1.1/B-09, CTOP 5.2.1/B-09);
- for the modernisation of healthcare institutions providing priority services (CHOP 4.3.1/Afi2-09-2f);
- for infrastructure development in institutions providing oncological and paediatric oncological treatment (CHOP 4.3.1/Cfi2-09-2f);
- for the development of emergency and paediatric emergency services and the establishment of Perinatal Intensive Centres in Central Hungary (CHOP 4.3.1/B-11).

In SIOP:

- for the technical development of Perinatal Intensive Centres and Intensive Neonatal Departments (2.2.2/C;-10/1);
- for infrastructure development supporting restructuring in special outpatient services (2.2.4-09/1);
- for the development of an up-to-date regional oncological network (2.2.5-09/1).

In SROP:

- for training programmes for healthcare employees, for training in high-demand vocations and for competence development (6.2.2/A-KMR-09/2, 6.2.2/A-09/2 "A" component, 6.2.2/B-09/2);
- for healthcare educational and awareness raising lifestyle programmes (6.1.2/A-09/1, 6.1.2/A-09/1-KMR, 6.1.2/LHH-09/1, 6.1.2/LHH-09/2).

Medicinal Hungary - Health Industry Program

The Medicinal Hungary - Health Industry Programme was launched in 2011 within the New Széchenyi Plan: apart from the development of tourism and medical tourism services, applications could also be submitted for the development of regional blood transfusion centres, healthcare HR monitoring and rehabilitation services.

2. Issues related to HR supply

The operational capacity and efficiency of the healthcare sector and, in correlation therewith, patient safety are decisively influenced by the available human resources.

The age tree of those employed in the health service faithfully reflects the ageing tendency of society. This process is further exacerbated by insufficient numbers of new entrants, the tendency for people to leave this career early, and a lack of motivation to choose this career, the effects of which can be felt equally among doctors and nurses. The increased outward migration that has appeared since Hungary's accession to the EU also adds to the deficit. Doctors and other medical specialists frequently undertake work in other Member States. However, there are different reasons for migration among medical professionals: better career and training opportunities, or better salaries and working conditions.

There are no precise data available on the extent of migration from Hungary to other countries, but consequences can be drawn from the number of requests for authority permits to work abroad, and from the number of doctors registered abroad. The number of authority permits issued by the Office for Authorisation and Administrative Procedures clearly indicates the intention to migrate. The number of permits issued by the Office for work abroad in 2009-2011 was more than three times the figure for 2007-2008.

Profession	2009	2010
doctor	756	867
dentist	115	132
pharmacist	34	37
health professional	489	388
of which: nurse	382	282
of which: physiotherapist	72	63
clinical psychologist	3	2
Total	**1397**	**1426**

The minister responsible for health has taken several measures to maintain and improve the situation among health sector employees: the measures were mainly related to the workers' income position as a factor mostly motivating their stay in the country and in their profession.

The Semmelweis Plan, announced by the health sector and supported by the Government, dedicates a separate chapter to the issue of human resources in healthcare. The sector is making every effort, using the available means, to improve the working conditions for health workers and to move their financial circumstances in a positive direction, for these are the factors which are most decisive in influencing the decision of professionals to move abroad.

A key objective of the measures (utilising the acquired expertise in Hungary, making the most of national state funds invested in high quality training, maintaining skilled labour) contributes to the more effective operations in the sector and the economy and to providing healthcare services to the public at a high level.

To this end, the following measures were taken by 31 December 2011:

2.1. Measures of the government to keep resident doctors at home

- Deleting the resident doctors' "stay-at-home" status (2010)

A rule introduced earlier and providing the following has been deleted: those attending state subsidised resident medical training would have been obliged to perform healthcare activities at a public financed healthcare provider in Hungary for 4 years after passing their technical examination.

- The state subsidy granted on the grounds of a high-demand vocation was first paid to those starting their training in 2010.

In accordance with this measure, employers may apply for a state subsidy amounting to 50% of diploma holders' minimum wage (HUF 64,750/month) for residents who work in a vocation that the minister has determined to be high in demand, and who attend state financed training.

- Simplifying the system of specialist training

The rules in effect from 1 May 2011 loosened the once rigid system of specialist training in a number of criteria. These modifications improved the transparency of the specialist training process for healthcare providers, specialist candidates and tertiary healthcare institutions alike. Key components:

- creating continuity in entering specialist training (earlier, the possibility was granted once a year);
- ensuring the possibility of change in speciality during training;
- ensuring the possibility of change in healthcare provider during training;
- subsidy to reimburse specialist candidates for the material costs of training: HUF 100,000/year net amount.

- Launch of Scholarship-type Resident Support Programmes (Lajos Markusovszky Scholarship, Károly Than Scholarship)

In the frames of the Scholarship Programme, the specialist or special pharmacist candidate is expected to agree to work in Hungary after receiving his or her special qualification, for at least as long as the scholarship was paid to him or her, to perform a specialist's/special pharmacist's activity at a healthcare provider financed by social insurance, in full-time (or proportionately lengthened part-time) employment and not to accept parasolvency in any form in connection with the healthcare service provided by him or her. In return, the candidate is entitled to a HUF 100,000 monthly net scholarship during the special training period.

As an outcome of the Resident Support Programme, 600 successful applicants were announced in the Markusovszky Scholarship and all the scholarship positions were occupied. 16 successful applications were announced in the Károly Than Scholarship.

2.2. Modification of regulations on doctors' and healthcare professionals' continuous training

Decree 63/2011 (Nov. 29) on the Rules of Continuous Training for Healthcare Specialists, and Decree 64/2011 (Nov. 29) of the Ministry of National Resources on the Continuous Training of Physicians, Dentists, Pharmacists and Specialists with Tertiary Healthcare

Qualifications, modified the former system of extension training for healthcare professionals from several aspects. The main modifications are as follows:

- the cost of one compulsory theoretical training for physicians and specialists becomes subsidised;
- foreign work, the fulfilment (abroad) of the obligation of training are recognised so as to promote the returning doctors' re-adjustment to the healthcare system;
- an electronic registration system of specialists' training is set up to mitigate administrative burdens.

2.3.One-time wage supplement

In 2011, a benefit equal to nearly three months' sum of bonus (job supplement) was paid to the debit of the income from the public health product tax, in connection with the statutory job supplement due to those working in positions subject to high risk and major work load at healthcare providers. This one-time benefit applied to each healthcare professional, irrespective of the employer. According to the December 2011 data, from among those employed in full-time or part-time jobs in healthcare institutions operating in various economic forms, 68,100 persons received the wage supplement.

2.4.Provision of disadvantaged persons

A hospital-based community service programme financed from a budget of HUF 611 million was launched in 2010, helping 300-320 registered unemployed and those receiving regular social annuity to have a job.

3) ANSWERS TO THE QUESTIONS OF ECSR REGARDING THIS PARAGRAPH

- ***The ECSR asks for data concerning information supply to the public and prevention, with particular regard to the percentile coverage of the population.***

For detailed information to the question and the data, see sections II and III in Part 1.

- ***The ECSR noted that the mortality rate exceeds the European average, and apart from campaigns to promote breastfeeding, asks for information on the other measures taken to improve the situation.***

For detailed information to the question and the data, see sections II and III in Part 1.

- ***The ECSR asked for a list of medical services provided free of charge under the compulsory health insurance system. It also asked for information on waiting lists and the management of waiting lists in health care.***

I. <u>Services provided free of charge</u>

One of the fundamental aims of the solidarity-based Hungarian health insurance system is that people living in Hungary could, if possible without any exceptions, be entitled to healthcare services in return for the payment of some contribution or, if they cannot afford it, free of contributions. A distinctive feature in the system is that it avoids discrimination on the grounds of nationality as far as possible, given that the right to healthcare services is subject

to the existence of legal status as an insured person or to permanent residence, although several exceptional and non-general rules are stipulated with regard to foreign nationals. These divergent rules ensue partly from Hungary's membership of the EU, partly from bilateral socio-political and social-security agreements and partly from the application of alien policing regulations that lay down the length of migrants' stay and the possibility of establishing residence.

With regard to entitlement to healthcare services, Act LXXX of 1997 on Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services (hereafter: Social Security Act) establishes four categories in the audited period. The first category comprises the insured persons (Art. 5 of Social Security Act) who are eligible for all services in health insurance, based on their gainful activities and related contribution payments. The second category comprises the so-called persons eligible for healthcare services (Art. 16 of Social Security Act) who do not perform gainful activity but are not obliged to pay social contribution (e.g. minors, students, child-rearing parents, pensioners, etc.). These persons may only make use of in-kind services. The third category consists of those who pay healthcare service contributions: they are likewise eligible for in-kind services only. This includes persons who are classified as residents under the Social Security Act but who are not entitled under the two previous categories. They are obliged to pay healthcare service contributions under the Social Security Act. Finally, the fourth category embraces those who joined the health insurance system at their voluntary decision and are so-called agreement signatories [Sect. (10) of Art. 34 of Social Security Act]: for a monthly payment of contributions, they can acquire eligibility for in-kind services. The table below gives a summary of the above four-way division:

Person's status	In-kind healthcare services	Cash benefits
Insured person	X	X
Eligible for healthcare services (no special contribution payment)	X	-
Subject to the payment of healthcare service contribution	X	-
Agreement signatory	X *	-

* Non-eligible for certain services (e.g. application for foreign medical treatment).

The services provided in the healthcare system are basically financed in two forms by the state. There are services provided to eligible persons as a part of the so-called basic package: these are covered from the central budget. Additionally, there are services and cash benefits provided to eligible persons from the Health Insurance Fund (E-Fund). Furthermore, there are services not, in any part, reimbursed from the budget: these are services subject to a fee which is to be borne by the patient. Prior to the use of some healthcare service, the healthcare provider having a financing contract checks electronically and directly in the OEP register (on-line) if the specific person is listed in the register as a person eligible for healthcare services under the health insurance system. If, based on the results of this check, the person subject to eligibility control is not eligible for healthcare services under health insurance, according to the OEP register, the provider doing this check delivers the notification (downloaded from OEP website) to the person who is not eligible for the service. It is important to note that the result of this check does not affect the obligation to provide healthcare service, meaning that if the person belongs to any of the above mentioned categories under the Social Security Act, he or she is eligible for the service free of charge. If for instance the person belongs to the third category, i.e. is classified as a national and is

obliged to pay healthcare service contributions, the service will be provided to him or her free of charge even if the eligibility control finds that this person did not meet his or her contribution payment obligations. In this case, the person is obliged to settle his or her arrears in contribution payments only. The patient is obliged to reimburse the costs of the service either before using the service or afterwards, subsequently (without regard to the service) if he or she is not eligible for it in the manner detailed above or did not acquire relevant rights in other ways (e.g. international treaty, European Health Insurance Card). In pursuance of Sect. (9) of Art. 13 of the Health Act, the patient also needs to be informed: "Prior to the examination, the doctor is obliged to inform the patient (if the latter's condition permits so) that the fee of the examination and the subsequent service shall have to be reimbursed if no emergency applies according to the result of the examination and the cost of the service is not covered from the central budget or via the Health Insurance Fund." Accordingly, the healthcare provider is obliged to inform the service user about any financial consequences of receiving the service.

Eligible persons may receive in-kind healthcare services free of charge, with the restricted differences identified below. In terms of financing, the service provided by a publicly financed healthcare provider can be:

1. Compulsory and
    - fully financed (the service is free for the patient in this case) (such are the majority of services due under the Health Insurance Act); or
    - partly financed (partial or supplementary fee can be collected from the patient, in the cases identified in the regulation) (e.g. material cost of dental intervention, doctor selection, hospitalisation in nursing ward); or
    - non-financed (total fee can be required from the patient) (e.g. facultative vaccination required by the patient, service need resulting from extreme sports activity, various fitness tests).
2. Non-compulsory (not financed in any case, so the total fee may be collected from the patient, usually before the service, i.e. by advance payment) (e.g. cosmetic surgery for purely aesthetic reasons).

Eligible persons are entitled to receive the following services provided by specialists in the healthcare system for a fee in the insurance package:

- occupational hygiene screening and control examinations and additional outpatient services initiated as a part of these;
- basic occupational healthcare services if not required in consequence of the occupational disease or industrial accident of the insured person using the service, and additional outpatient services initiated as a part of these;
- delivery of a specialist's opinion about the mental condition of a patient in a procedure of placement under care, medical expert examinations and expert opinions prescribed by law, unless the examination and expert opinion is needed to state eligibility for social insurance or social welfare benefits, for allowances or health insurance services, as well as additional outpatient services initiated as a part of these;
- services required after an accident suffered during particularly dangerous sports (e.g. jet ski, gliding) or entertainment and leisure time activities, as well as additional outpatient services initiated as a part of these;

- professional athletes' sports healthcare services and additional outpatient services initiated as a part of these;
- healthcare service not for medication but exclusively for aesthetic or recreational purposes and healthcare services to treat any consequences or to restore the original condition, as well as additional outpatient services initiated as a part of these;
- intervention for artificial infertility not for health reasons, healthcare services to treat any consequences or restore the original condition, as well as additional outpatient services initiated as a part of these;
- services with basically no positive influence on the health condition and with no professionally proven efficiency, healthcare services to treat any consequences or restore the original condition, as well as additional outpatient services initiated as a part of these;
- use of a procedure, medication or medical device professionally approved in Hungary but not yet integrated in financing/subsidisation, use of an approved healthcare service in a way which deviates from its approval, excluding services supported on the grounds of equity, as well as additional outpatient services initiated as a part of these;
- services provided only under the framework of medical research, and additional outpatient services initiated as a part of this;
- accommodation and meals for the patient's attendant (except disabled patients) in the healthcare institution (for ill children younger than 14 years of age, the child's parent/legal representative and close relative staying with the child during the treatment is not an attendant and as such not subject to fee payment);
- vehicle drivers' fitness examinations and additional outpatient services initiated as a part of these;
- medical fitness examinations for holders of weapons licences and additional outpatient services initiated as a part of these;
- detoxification, if under the influence of alcohol or drugs;
- blood tests and urinalysis to determine the level of alcohol or drugs in official procedures;
- blood tests to determine the level of alcohol or drugs, and additional outpatient services initiated as a part of these;
- issuance of a diagnosis, and additional outpatient services initiated as a part of this;
- the patient's immunisation with a non-compulsory vaccine, and additional outpatient services initiated as a part of this (except vaccines which are free of charge).

For a partial fee, the patient is entitled to, for example, the right of doctor selection: therein the patient has the right to select a doctor different from the one assigned to serve the patient, observing the working hours of the healthcare institution. No partial fee is payable for doctor selection in the case of prenatal medical care and delivery services.

The rules for calculating the fees of certain services not available within health insurance and, in several cases, their exact amounts are stipulated in a legal regulation. [Annex 2 to Government Decree 284/1997 (Dec. 23) on the Fees for Certain Healthcare Services which are available for a Fee]

II. Waiting lists in healthcare – Government Decree 287/2006 (Dec. 23)

The regulation on services provided on the basis of a waiting list and the health conditions for setting up a waiting list order, and the option to deviate from these, were modified with effect from 24 February 2010. In its personal scope, the Decree was completed with those eligible for enrolment in the acceptance list and with the providers' obligation to determine the date of enrolment in the waiting list with an accuracy of calendar day at the least. Moreover, the legal regulation includes definite provisions with regard to regulating deletion from the institutional waiting list. The HUF 27.5 billion consolidation subsidy, which the representatives of the government and the institutions agreed on in October 2010, was accounted in the budget under Appropriations in the group of medico-preventive services. The State Secretariat for Healthcare identified the repayment of a part of overdue trade creditors and the shortening of waiting lists for elective haemodynamic interventions and open heart operations and for traumatological and orthopaedic operations as the goal of using the latter amount. In total, HUF 1.37-1.37billion was spent on shortening the waiting lists in each of the above fields.

III. Cash benefits

From 1 August 2009, the maximum period of sick pay that may be paid out after the termination of an insurance relationship was reduced from 45 to 30 days, and the legal recourse of passive sick pay came to an end from 1 July 2011.

The modification helping those on the sick list to receive the necessary healthcare service quicker through immediate referral has been in effect since 1 July 2011. In case of a complaint causing lack of earning capacity, the healthcare provider offering outpatient services is obliged, at the referring doctor's proposal, to receive the patient in diagnostic and therapeutic treatment out of turn.

- ***The ECSR asked for a description of patients' living conditions in hospitals, including psychiatric institutions and other care centres.***

The conditions of staying in hospitals are determined by professional rules in Hungary:

- This includes in particular patients' rights – this is a regulation regardless of the place where the patient receives provision and generally applies to everybody who employs a healthcare service; the main relevant provisions here are the right of maintaining contact, Sect. (2)-(7) of Art. 11 of the Health Act; in addition to contact with relatives, this also determines the cases of keeping in contact with relatives in special cases which the provider is obliged to observe (e.g. parent's option to be beside his or her child; right to use own clothes and personal belongings).
- Pursuant to Sect. (3) of Art. 27 of the Health Act, the method of exercising patients' rights shall be regulated by the operational rules of the provider (house rules of the medical institution), within the boundaries of the Act. This means that, based on the principle of subsidiarity, the Act delegates the rules concerning the specialities of the individual institutions in the regulatory competence of the institutions, i.e. certain institutions may have dissimilar provisions for the service provided by them, similar to the case when the institution handles the complaints "in the first round". The patients' rights advocate (and now, newly, the National Centre for Patients' Rights and Documentation) also helps exercise these rights.

- According to Art. 108 of the Health Act, healthcare services shall be provided only by parties in possession of an operational licence for the specific activity. There, the authority also checks the statutory material conditions, which mainly include conditions related to the professional activity. Evidently, however, they also have some elements in connection with the patients' "feeling of comfort." Decree 60/2003 (Oct. 20) of the Ministry of Health, Welfare and Family Affairs on the Professional Minimal Requirements underlying the Provision of Healthcare Services stipulates the following provisions concerning accommodation:

"Article 4 The following shall be provided in all healthcare providers offering continuous services for over 24 hours:

a) a room facilitating the patient's rest and overnight accommodation, comprising (in addition to the sickbed) some furnishing for eating and placing any personal belongings for everyday use, as well as hand-wash facilities with cold and hot running water;

b) sex segregated shower and lavatory opening from the room defined in Par. a), from its hall or the corridor connecting the individual rooms;

c) a wardrobe or a separately lockable wardrobe section for the patient's exclusive use, to hold his or her street clothes;

d) safeguarding the patient's cash (for everyday needs) and other property, at the patient's request or if the patient temporarily loses his or her capacity, in accordance with the healthcare provider's standard operating procedures;

e) facilities for the patient to drink liquid in the required quantity and continuously;

f) three main meals a day and one small meal a day for patients subject to standard, light-mixed and dietary nutrition;

g) the operation of a dietary and nutritional working group consisting of a dietetic coordinator and a person appointed from the fields of nursing and medication each, to guarantee the patients' proper diet.

Special rules applicable to eating:

a) standard nutrition in medical institution: nutrition covering the average energy and nutritive needs of an inpatient (in a medical institution) without any dietary needs;

b) light-mixed nutrition: protective nutrition covering the average energy and nutritive needs of an inpatient in a medical institution and where, upon determining the diet, the digestibility of the meals is a fundamental criterion in selecting the raw materials and the preparation procedures;

c) dietary nutrition: a diet comprised of meals that cover the average energy and nutritive needs of an inpatient in a medical institution and that can, with regard to their special composition or the unique procedure in preparation, satisfy the special nutritional needs of consumers whose special health condition demands the consumption of certain materials in controlled volume."

- Additionally, Annex 1 to Decree 60/2003 of the Ministry of Health, Welfare and Family Affairs stipulates some general requirements that are independent of any fields and are to be met during the service (e.g. proper cleaning, meeting due hygiene conditions, pest control, waste management, infection control, disinfection activities to avoid and stop the spread of infections, textile cleaning, management of dirty clothes etc.) - the relevant principles are laid down in the legal regulation, though, naturally,

other technical documents and recommendations are also available on the individual topics;

All the institutions providing services for psychiatric patients, thereby including social institutions, are classified as psychiatric institutes, under the Health Act.

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

Sport

The preventive role played by sport in healthcare is referred to in two pieces of legislation:

- Act I of 2004 on sport, and
- National Assembly Decree 65/2007 (Jun. 27) on the 21st National Sport Strategy.

In view of the reporting period, this response makes reference to the version of the Sport Act before its amendment of 1st January 2012.

The preamble to the Sport Act states: *"Citizens of the Republic of Hungary have the constitutional right to the highest possible level of physical and mental health. Physical culture is part of universal culture, an important instrument in healthcare (both prevention and recreation) and a socially useful way of spending leisure time. Physical education and sport play an important role in the moral and physical upbringing of youth, and in developing their personalities."*

section 49 c): The state *"promotes the establishment of the conditions for people to lead a healthy way of life and to do sport in their free time"*

section 51 (2) i): The sport administration body *"devises programmes to support leisure, child and youth sport, sport for women and families, disability sport, sport for disadvantaged social groups, sport in public and higher education, and the development of the sport market, ensures equal opportunities in these programmes, and devises the programmes in cooperation with the responsible ministry with the aim of efficiently enforcing popular health interests."*

One of the main objectives of the National Sport Strategy is to improve the quality of life of Hungarian citizens; to achieve improvements in the health of the population. The Sport Strategy "outlines the optimum direction for developing sport life in Hungary, and provides long-term guidance to state and sport sector players when it comes to organising sport-related activities. To implement the Sport Strategy, in addition to continuous monitoring, it is necessary to prepare a detailed action plan every two years, in line with the long-term development policy.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

The role of schools in promoting health - the health profession

Ensuring the healthy development of children is the right and obligation of parents. At the same time, protecting and preserving the health of children attending educational and training institutions is also the task of these institutions.

Before the new public education act entered into force, in accordance with Act LXXIX of 1993 on Public Education, which was valid until 2011:

*"**Article 10 (1)** Children and learners have the right to be taught and trained in educational and training institutions in a safe and healthy environment, and to have nursery daily timetables and school study timetables drawn up in accordance with their age and level of development, ensuring opportunities for rest time, leisure time, physical exercise, sport and eating."*

Schools are responsible for determining the tasks they have to do in connection with improving health, and the national framework syllabus also contains guidelines on this. Every educational and training institution must provide school health provision for the children (basic health provision). This provision is carried out in cooperation with the school doctor, the district nurse and a dentist and dental assistant. As part of school health provision, the school nurse performs a wide range of activities, including:

- health screening by a nurse every two years for children over the age of 6,
- inspection of the children's and students' personal hygiene,
- tasks related to vaccinations,
- providing first aid,
- participating in health education,
- participating in hygiene inspections of the school premises and environment and in dining facilities,
- maintaining contact with parents (parents' meetings, family visits).

For more about the other aspects of consultancy, see the details of the district nurse system in the preceding and following paragraphs.

In accordance with the amendment to the Health Act, which entered into force on 1st July 2011, fully comprehensive health development plans must be introduced and implemented in public education institutions, adjusted for each age group. The aim of the fully comprehensive health development plan is for every child to take part in regular health development activities as an everyday part of their lives in education and training institutions, which effectively improve their overall physical and mental well-being, their health and their health condition.

Sport

Health preservation and preventive activities that were carried out within the area of sport during the reporting period:

In order to improve the health condition of the population, the sport council launched the "Open Gate Facilities" programme, to ensure wide-ranging opportunities for regular physical exercise, that is, for recreational sport. Under the "Move, Hungary!" programme, support was granted to leisure sport events. The aim of the "10 000 Steps" programme is to promote the

spread of a way of living and attitude which includes moderate physical exercise, and which is therefore also suitable for older age groups. In December 2007, in order to set up a system of regional amateur competitions, an experimental project was launched in 133 microregions, which brought about support for disadvantaged districts, in particular multiple disadvantaged districts, launched sport programmes and assisted already existing programmes, with the involvement of the 6-12 age group (approximately 150 000 people).

In 2011, the Ministry announced 3 calls for proposals on the topic of leisure. These carried over into 2012, but the proposal period began on 1st July 2011.

- SPO-EJ-2011: Support for leisure sport activities which aim at improving health
- SPO-HH-2011: Support for leisure sport activities and events for sporting people with disability and for socially disadvantage groups
- SPO-SZALÉT-2011: Support for the construction, modernisation and renovation of sports grounds

3) KEY DATA AND STATISTICS

Sport

There are national surveys that can be referred to which assessed health in a complex way, including physical exercise and physical activity. The five-yearly results can be compared with each other, which, among other things, will make it possible to evaluate the impact of physical exercise.

The Central Statistical Office (KSH) took part in international projects related to the European Health Interview Survey (EHIS). The questionnaire and resource materials were drawn up with the cooperation of the National Expert Committee, made up of representatives from the KSH, as well as from the Health Ministry, medical universities, research institutes and national institutions (Hungarian Academy of Sciences, University of Debrecen, Semmelweis University, Loránd Eötvös University (ELTE), University of Pécs, National Office of the Chief Medical Officer, National Institute for Food and Nutrition Science, National Centre for Healthcare Audit and Inspection, National Institute for Health Development, TÁRKI Social Research Institute, etc.).

The National Centre for Healthcare Audit and Inspection (hereafter: OSZMK) carried out an online health survey on a representative sample in May-June 2009, at micro-regional level, which is not identical to the EHIS, although the themes are similar.

4) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested additional information about a programme which featured in the previous report, which involved 2877 disadvantaged people in 2006.***

For general information, see the answers given above which refer to this paragraph.

Supplementary information:

One of the key commitments made by Hungary during its presidency of the EU was to establish an EU Roma framework strategy. This was communicated by the European Commission on 5 April 2011, under the title "An EU Framework for National Roma

Integration Strategies up to 2020". On 19 May 2011 the Council approved the Council conclusions on this proposal, by which the Member States made the commitment to participate in the framework strategy, promising to submit their national Roma integration strategies or action plans up to the year 2020 to the European Commission by the end of 2011. Hungary was the first Member State to submit their National Social Inclusion Strategy and Action Plan.

In carrying out their work, the Government follows the principle of the life path, with the aim of establishing a chain of support, in which each link represents an age group. Its components are:

1. Programmes to create opportunities in education and social inclusion

In Hungary there is a strong correlation between students' learning opportunities, their performance at school, their later choice of career, their success in the labour market and the background socio-economic indicators of the individual and the family. Among the factors that define later participation in lifelong learning are a person's labour market status, their level of education, socio-cultural factors and place of residence. In line with the numerical objective for education in the EU 2020 strategy, great emphasis is placed on reducing early drop-out rates and on compensating for disadvantages. The objective of the areas of intervention and development trends is to reinforce the role of education and training systems in the struggle against social exclusion and in improving individual opportunities:

- priority support for learning opportunities for people of a socially disadvantaged status, including a reduction in the number of those who drop out or leave school early, a strengthening of inclusive education, and facilitation of integration into the labour market,
- a remedy for the disadvantages arising from the interpretation and consequences of regional inequalities in education and training,
- expansion of ability-based learning opportunities and forms, both within the school system (formal) and outside it (informal and non-formal).

The government strategic measures (National Social Integration and Roma Strategy, the "Legyen Jobb a Gyerekeknek" ("Making Things Better for Children") Strategy, the Roma Integration Decade Programme Strategic Plan) and the TÁMOP measures support the achievement of the objectives, and the National Reform Programme for implementing the objectives of EU 2020 pay particular attention to achieving the objectives.

In designing the programmes, the Government ensures the principle of the life path, establishing a chain of support, in which each link represents an age group.

- The early nurturing of talent among multiple disadvantaged young children, including Roma children, is supported in Hungary by the "Biztos Kezdet" ("Sure Start") programme, which gives, at the earliest possible stage, a chance to children under the age of 5 who are living in poverty, who are unable to attend nursery or benefit from other high quality services, due to their family's limited resources, the fact that they live in a disadvantaged region, or other socio-cultural factors. Using resources from the TÁMOP operative programme, there are currently 44 Sure Start Children's Houses in operation, most of them in disadvantaged micro-regions. The process of complex

development, professional reinforcement and organisation into a network is currently in progress.

- The promotion of success at school is served by the reinforcement of education in early childhood: Extension of compulsory nursery attendance from the age of 3 from the year 2014, projects launched at the end of 2011 to increase the number of nursery places (DAOP-4.2.1-11, ÉAOP-4.1.1/A-11, ÉMOP-4.3.1/A-11, KMOP-4.6.1-11), providing support for children from a multiple disadvantaged background to attend nursery, compulsory nursery attendance for children from a multiple disadvantaged background, and the nursery development programme.

2. Programmes and measures to support success at school

The Integrational Pedagogical System for nurseries and schools states the necessity of improving access to quality training and education, and of developing a differentiated and inclusive system of education and training which is based on individual differences and individual progress. The areas supported by measures and financial incentives aimed at countering disadvantages that derive from the social status and level of development of children and students are: integrated learning, institutional development, pedagogical renovation, support for personalised teaching of students from a multiple disadvantaged background, cooperation between the school and its social environment, and giving priority to keeping contact with parents.

The nursery and school integration programme has operated since 2007, and by the academic year 2011/2012 almost a quarter of public education institutes had joined the programme.

The National Syllabus places priority attention on improving the acquisition of basic skills, thereby improving later education results and reducing the risk of students dropping out.

When the new public education system is launched, under the "Híd" ("Bridge") Programme, implemented from September 2013 (Act CXC of 2011, paragraph 14), it will be possible to arrange a one-year catch-up year in order to help students to complete their primary education, to promote successful studies at vocational schools, to encourage the continuation of interrupted studies and to expand the range of people with professional qualifications.

The "After-school" programmes - non-formal learning spaces for the education of disadvantaged children - were created on a standardised model as a development supported by EU funding. The main objectives of the construction TÁMOP 3.5.5 - "Support for After-school Programmes" are to reduce school drop-out rates and to strengthen possible avenues for further education (studying in secondary schools which provide school-graduation qualifications, and if possible also in the higher education system) among multiple disadvantaged students, Roma students, students in child care and migrant students. The After-school is a form of education which can be freely selected by the children and their parents, designed to help learning and to adapt to the participants' personal learning needs, which increases the chances of integration into the formal school system. Under this programme there are currently 60 After-school projects which receive support.

The Arany János Dormitory Programme (AJKP) for Learners from a Multiple Disadvantaged Background currently encompasses 12 pairs of institutions, with the involvement of 890 students. The aim of the AJKP is to make use of the secondary school dormitory system in

order to provide opportunities for multiple disadvantaged children to study successfully at day schools, in secondary schools which provide school-graduation qualifications, as a result of which a greater proportion of them will be able to continue their academic careers in higher education. Under the programme, individualised development and study plans are drawn up, differentiated teaching is organised, and evaluations and assessments are carried out, in addition to which the programme is characterised by careers guidance, social support and close contact with the family. The results can be seen in the inclusive nature of the institutions, and in the way they operate as a network.

The Arany János Dormitory – Vocational School Programme for Learners from a Multiple Disadvantaged Background currently encompasses 7 pairs of institutions, with the involvement of 634 students in the academic year 2011/2012. The aim of this Programme is to create opportunities for marketable professional skills to be acquired by young people from a multiple disadvantaged background, who would probably not acquire these skills without participating in the Programme. Additional objectives are to provide an inclusive pedagogical environment within the framework of the dormitory so that the target group can pursue their vocational studies, to compensate for social disadvantages, and to provide effective support in reducing the drop-out rate. The drop-out rate in this Programme is well below the national average, at 13% over four years and 3% annually. This is a significant outcome considering the estimated national average drop-out rate at vocational schools is 30%.

The Arany János Talent Nurturing Programme for Learners from a Disadvantaged Background gives support to talented students from disadvantaged backgrounds, with the aim of creating opportunities and nurturing talent among layers of society whose members would not be able to attend higher education without the help of the programme. The programme places an emphasis on assisting talent, and on developing the abilities of talented students in a diverse and differentiated manner. The programme was launched in the year 2000, and by the academic year 2011/2012 the number of students participating had increased to 3000, and the number of pairs of institutions (secondary school and dormitory) had risen to 23. 82% of participating students (age 14-19) were accepted into higher education, 95% passed their driving test, 89% obtained an ECDL certificate and 93% passed a language exam.

The Higher Education Mentor Programme has operated since 2005 as an equal opportunities programme, aimed at promoting higher education studies among young people from a disadvantaged or multiple disadvantaged background. The objective of the programme is to promote the integration of the young people concerned into a higher education institution, to help them meet the requirements with success, and to increase their future chances of finding a place in the labour market.

3. Support from the "Second Chance" type of programmes

By increasing the number of "Second Chance" type programmes and improving the quality of their services, we expect the programmes to give a second chance to as many young people as possible who are above compulsory school age, but who missed out on secondary education, to continue their secondary school studies and to acquire marketable professional skills. Under the New Széchenyi Plan, a total of HUF 3.5 billion of EU funding is available for implementing TÁMOP 3.9.9/B-D – "Second Chance" type programmes.

4. Scholarship programmes:

Many state-funded and private scholarship programmes target the promotion of academic success for primary and secondary school students and participants in higher education who come from a disadvantaged background - including Roma children and young people.

The "Útravaló" ("On the Road") Scholarship Programme was launched in 2005, with the overarching aim of promoting equal opportunities for students with disadvantages, improving their chances of participating in further education and obtaining professional qualifications, school graduation qualifications and diplomas, and nurturing talented students who take an interest in the natural sciences. Through its system of material resources and mentors, the "Útravaló" programme supports primary school children on 7th and 8th grade and secondary school children. As part of the "Útravaló" programme, three equal opportunity programmes and one talent-nurturing sub-programme are in operation ("Road to Secondary School", "Road to Secondary School Graduation", "Road to Vocation" scholarships, "Road to Science" sub-programme), continuously involving approximately 20,000 students and almost 11,000 mentor-teachers. The strength of the programme lies in the fact that the material support is complemented with the support of a mentor.

It is important to mention the activities of the Romaversitas Foundation, which is not funded by the state or EU (but by private funds, including the Roma Education Fund), which has helped around 200 Roma students to complete their studies since the foundation was set up in 1996. In recent years, the rate of students participating in the programme who obtained a diploma has been above 80%. In the last five years, the Roma Education Fund has provided scholarships to almost 700 young people in Hungary.

Another important initiative is the Network of Christian Roma Special Colleges, which was set up in March 2011 jointly by the traditional churches and the Secretary of State with responsibility for Social Inclusion, with a programme for countering disadvantages. The special colleges, which now operate in five university cities, provide support to 100 students from Roma and disadvantaged backgrounds who are attending higher education institutions, in the form of a scholarship, personalised mentoring, and community, spiritual and identity reinforcing modules. An additional important element of Roma special colleges is that students live together.

5. School-Net

The School-Net looks for and supports model solutions and methods that transform the school as a whole, teaching attitudes and the teaching programme, in order to increase the chances of learners with multiple disadvantages to make progress at school. The programmes were implemented in the academic year 2011/2012.

6. Support for the development of public education institutions based on equal opportunities (TÁMOP 3.3.8)

The fundamental objective of this EU-funded programme is to make public education institutions suitable for providing successful education to children and students with multiple disadvantages, including Roma children and students, and to support their success at school. Under this programme, opportunities are created, on the one hand, to develop model projects which increase the success of students with multiple disadvantages at school, and to adapt

them for other institutions, and on the other hand, to adapt programmes which have proved successful, and to create the conditions for adapting them. The total budget available for proposals under this programme: HUF 4 billion.

Individual projects proposed under this programme are starting in 2013, and will continue for two academic years.

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

Legislation affecting public health

- **Act CIII of 2011 on the Public Health Product Tax**

In July 2011 an overwhelming majority of the National Assembly supported the introduction of a public health product tax on 1st September 2011. The aims of introducing the product tax are to impose taxation on products with a high salt or sugar content, and on certain products containing caffeine, which carry a demonstrable health risk,

- to reduce the consumption of foods which are undesirable from a health and nutrition aspect, and thereby to foster the consumption of healthy foods,
- to encourage the food industry to produce (reformulate) products with a (more) beneficial composition, and thereby to make healthier choices of foods available to the general public, and
- to improve financing for health services and programmes aimed at public health.

The public health product tax does not concern basic foodstuffs, and only applies to products for which a healthy alternative is available. The range of products covered by the public health product tax are:

- soft drinks,
- energy drinks,
- pre-packaged sugar sweetened products,
- salted snacks,
- condiments,
- flavoured beers, alcoholic refreshments,
- fruit jams.

During the drafting and amendment of the Act, the National Institute for Food and Nutrition Science (hereafter: OÉTI) regularly and continuously provided background information and data, based on the results of the OÉTI public nutrition surveys (such as the National Dietary and Nutritional Status (OTÁP 2009) investigation, surveys investigating children's consumption of energy drinks, the Schools nutrition and health environment survey (National School Canteen Review), the 2008 national examinations of public diet), and laboratory inspections of foods.

- **Amendment to Act XLII of 1999 on the Protection of Non-Smokers**

On 26 April 2011, the National Assembly passed an amendment to Act XLII of 1999 on the Protection of Non-Smokers (hereafter: Non-smoking Act). The aim of the amendment was to

protect smokers and non-smokers from the harmful effects of smoking, at the same time paying attention to the exercise of the constitutional rights to health and to a healthy environment.

Under the amendment, which entered into force on 1st January 2012, legislative provisions on the spatial restriction of smoking were made significantly more stringent.

The amendment of the Non-smoking Act ended the regulatory concept, which had proved unworkable in practice, of permitting smoking areas to be designated in enclosed areas, even in those in which non-smokers could be present, by using air technology separation. In accordance with the above, the main rule of the valid Non-smoking Act forbids smoking in enclosed areas – as there is no minimum concentration of tobacco smoke which is not harmful to health, and air technology is unable to isolate tobacco smoke completely, in enclosed areas, only a total smoking ban is acceptable. Consequently, smoking areas may only be designated outdoors, in the open air, at a distance of at least 5 metres from the entrance to public buildings.

The following main provisions of the Act concern spatial restrictions:

"Section 2(1) Except in designated smoking areas, it is forbidden to smoke

a) in premises which are open to the public in public institutions,
b) on public transport vehicles,
c) at the workplace,
d) (in the following areas) that are classified as public spaces

> *da) underpasses that are open to pedestrian traffic and other passageways and public spaces which are not in the open air, as well as public playgrounds, and within 5 metres around the perimeter of playgrounds,*
> *db) railway facilities which are used for the provision of public railway services, and areas of the railway facilities which are open to passenger traffic, bus stops and other waiting places and premises which have been built to enable people to use public transport vehicles, or have been designated as such, and, in the case of bus stops and other waiting places which are in the open air, within 5 metres of the external borders of such places, inasmuch as, if the external borders of the non-smoking area cannot be clearly determined, then smoking is forbidden within a 5-metre radius from the sign or other marking which indicates that the place is a bus stop or other waiting place.*

(2) (the following) ... cannot be designated as a smoking area
a) in enclosed premises of public institutions,
b) in enclosed premises of workplaces,
c) on local public transport vehicles, local trains, domestic intercity public transport buses operating according to a timetable, and passenger trains operating according to a timetable.
(4) In addition to the stipulations contained in section (2) a) and b), (the following) cannot be designated as a smoking area, even in the open air
a) public education institutions,
b) childcare and child protection institutions,
c) with the exception contained in section (5), at the health service, as defined in section 3 f) of Act CLIV of 1997 on Health."

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION, KEY DATA AND STATISTICS

1. Smoking

In order to increase social acceptance of the Non-Smoking Act, it was essential to ensure effective communication, with the involvement of the media; additionally, to provide the general public with precise information about the areas or premises subject to smoking restrictions, and about public spaces, designated smoking areas and non-smoking institutions or workplaces, it was essential to use "prominent", "clearly visible" or "obvious" notices or signs. Based on international experience, the amendment to the Non-smoking Act is expected to bring about significant changes in domestic attitudes to smoking and smoking habits. In order to be able to verify any change in smoking habits, it was necessary to gather data on the existing status at the start of the amendment to the Act entering into force.

According to the investigation by the National Health Development Institute [*source: Adult Smoking Survey 2012, OEFI-TÁRKI*

http://www.fokuszpont.dohanyzasvisszaszoritasa.hu/sites/default/files/17_evnel_idosebb_lakossag_dohanyzas_felmeres_honlapra_20130108.pdf] , the restrictions on smoking in health, public education and other public institutions, and in playgrounds, is supported equally by smokers and non-smokers. A majority of non-smokers (61%) agree that smoking should be banned in bars and pubs, and even a quarter of smokers also agree. When it comes to restaurants, public transport and the workplace, 80% of non-smokers and a half of smokers agree on the ban on smoking.

Taking the above criteria into consideration, the activities detailed below were carried out using resources provided by the Ministry for Human Resources (hereafter: MoHR) at project level in 2011-2012, with professional assistance from the Hungarian Focal Point for Tobacco Control of the National Health Development Institute .

- **Media campaigns**

In order to achieve the aims of the amendment to the Act, it is important to raise the general public's awareness of the Non-smoking Act to an appropriate level, and to form a positive attitude, which was done using a combination of the electronic media and printed information materials. Two short films were made, informing the public about the important details of the toughened laws in an easy-to-understand way, reaching a wide audience, and helping to reinforce a positive attitude towards the changes. The films were broadcast on national and regional television.

A "plain Hungarian version" of the toughened legislation was written, accessible electronically and issued in 192,000 printed copies. This enabled the toughened legislation to be communicated simply to the general public.

A media campaign titled "Don't suck it in any longer!" ("Ne szívj tovább"), against passive smoking, and providing information and motivation on giving up smoking (based on 88 media appearances, the total number of accesses was 20,234,613), was conducted in several stages, supported by the following thematic websites:

- "Ne szívj tovább!" ("Don't suck it in any longer!") http://neszivj.postr.hu/

- as well as the National Public Health and Medical Officer Service (ÁNTSZ) website, containing professional and up-to-date information https://www.antsz.hu/, and
- The Hungarian Focal Point for Tobacco Control website: http://www.fokuszpont.dohanyzasvisszaszoritasa.hu/.

The websites were designed to grab visitors' attention using video clips, humorous illustrations, pictures and animations. The campaign also included giant billboards in public places and other infocommunication tools. The campaign - with the help of the websites and the broadcast short films - not only communicated the changes in the legislation, but also drew attention to the health risks of smoking.

- **HORECA**

Besides the media campaigns, Horeca (hotels, restaurants and cafés) promotions of the amendment to the Non-smoking Act were also carried out in catering and entertainment establishments. In style they imitated the on-site, direct hostess promotions of tobacco products. The direct hostess promotions were carried out with the involvement of the entertainment and catering establishments, drawing attention to the harmful effects of smoking, using carbon monoxide meters to show smokers that the noxious gas is still present in their lungs even several hours after smoking, and motivating participants to quit the habit.

- **Developing a report book, and its annexes, for inspecting observation of the Non-smoking Act.**

Colleagues from the public health professional administration bodies operating in government offices and from the micro-regional institutions take part in inspections to check that the toughened laws are being observed. The report book and its annexes which are used during the inspections were developed in accordance with the amendment to the Act, and with their help, it is also an important criterion to process the data using information technology.

- **Development of software to support and monitor the administration of authority work carried out in relation to the amendment to the Non-smoking Act**

Comparisons which can be made using the data generated during the inspections of the observation of the Act must comply with different quantitative and qualitative criteria, which meant that new software needed to be developed for this purpose, aligned with the registration system.

- **Printing notices and signs in sticker format**

In accordance with the amended Non-smoking Act, it is compulsory to indicate areas, places and public spaces which have smoking restrictions, as well as designated smoking areas and non-smoking institutions and workplaces, with notices or signs (such as stickers) that inform people arriving in such areas and places in a "prominent", "clearly visible" or "obvious" way. The recommended stickers for notices and signs have been designed, and the aim is to make their use obligatory.

- **Blue (free phone) number providing help to people wanting to give up smoking**

One of the most suitable tools for providing the general public with the widest possible range of information, for forming opinions, and, in parallel with this, for motivating people to move

in the direction of giving up smoking, and offering them support in this, is to provide a telephone service which can offer information about methods and places which can help people to kick the habit, and which can also serve to receive comments about how the law is being observed.

The telephone number is given in the text of the warning notices, combined with images, on cigarette packets, and also in the text of the notices or other obvious signs, as provided for in the Non-smoking Act, placed in designated smoking areas and in areas where smoking is restricted.

- www.leteszemacigit.hu **web development**

In developing up-to-date content that meets the expectations arising from the new situation, it is essential to present a search interface for the national network of doctors' surgeries that offer help in quitting smoking, and to provide access to the recommended versions of the notices or other obvious signs set forth in the amended Act. The web address of "www.leteszemacigit.hu" (literally translated as "I'm giving up cigarettes") also appears on the warning notices, combined with images, on cigarette packets, and in the text of the notices and other obvious signs prescribed by the law.

2. Alcohol consumption

The main measures, health development projects and tenders directed at preventing alcohol problems, in conjunction with the National Addictology Centre (until mid-2008, the National Addictology Institute), are as follows:

Measures taken in 2008

"Development of local cooperation in providing for alcohol patients, problem drinkers and their families", with the development and collection of joint cooperation indicators. (Pilot project in 9 cities and microregions of the country - Győr, Zalaegerszeg, Csurgó, Eger, Szentes, and the 1st, 9th, 12th and 13th Districts of Budapest).

Measures taken in 2009

The document titled "Alcohol policy and strategy 2009" was brought up to date with professional input. During this, experts did work and collected data. Workplace alcohol programmes were implemented as pilot projects in cooperation with two partner institutions. The professional literature and training materials for the workplace alcohol policy were put together, and cooperation resulted in the creation of the two institutions' alcohol policy (MOL Zrt. – Százhalombatta site, Mór Kaposi Hospital – Kaposvár).

Alcohol prevention and early care in the health service. Micro-regional projects were implemented in 3 Hungarian microregions, in order to improve the level of preparedness in basic healthcare, the practice of brief intervention was expanded, and contact with local addictological/psychiatric out-patient provision was improved, with improvements in the cooperation with other members of the health provision system to improve the care activities of our-patient service providers (Cegléd, Siklós and Makó microregions). The structure of regular domestic alcohol reporting was developed, the systems for certain sections were developed, and the potential systems for data collection were reviewed, and feasibility practice was carried out. Care and prevention programmes for addicted pregnant women and

for newborns and young children at risk were conducted, in cooperation with Women's Clinic I at the Semmelweis University, and with childcare, addictology and low threshold care providers.

The training materials for quality assurance were compiled, training programmes were conducted for care workers in the addictology field, in order to prepare for addictological clinical audits, and a system of indicators was set up in the most important areas of health provision in order to be able to measure the effectiveness and standards of care. Cooperation was carried out with the professional medical network of the Centre for Healthcare Audit and Inspection (OMSZK, now the National Institute for Quality and Organisational Development in Healthcare and Medicines - GYEMSZI) and the Professional College of Addictology. Programmes to support the early treatment, reintegration and relapse prevention of young people with disadvantages who are unemployed, at high drug abuse risk or dealing with drug abuse problems, were implemented with the close cooperation of the health and labour affairs provision systems. In two counties (Tolna and Zala) pilot programmes were carried out, in cooperation with the county networks of labour affairs professionals.

Preventive and therapeutic programmes directed at young people living in children's homes, who have addiction problems or who are at high risk of drug abuse, were compiled and implemented as pilot programmes, in cooperation with live-in institutes dealing with severely underprivileged young people, and with cooperating child- and youth psychiatric professionals (Budapest, the "Béke" Children's Home - Vadaskert Foundation).

The methodology and good practices of early identification and treatment of problems, and their implementation in schools, were developed. Training materials were compiled for school nurses, teachers, educational advisers and school doctors in order to promote the early identification and treatment of problems, and training programmes were conducted in every region of the country (in a total of 7 venues), in cooperation with the József Fodor Society for School Health.

"Reducing the damage caused by alcohol - Means for local interventions" was the title of a national alcohol policy conference, which was organised and held in cooperation with the German Addictology Centre and the EU's DG SANCO.

Tender preparation training was organised and held for social and church organisations dealing with alcohol prevention and self-help, in cooperation with the Programme Office for Structural Funds and the National Institute for Health Development (hereafter: NIHD).

There was participation in European alcohol policy international development programmes, especially in the preparation of the WHO Global Strategy, together with WHO EURO, and in the development of the EU alcohol strategy, under the Swedish Presidency of the EU.

Targeted data collection was conducted, in cooperation with the National Institute for Chemical Safety, to compile and present data related to alcohol intoxication (EU DG SANCO)

Measures taken in 2010

Information report for the Parliamentary Committee on Health, titled "Domestic alcohol consumption habits - Public health burdens".

For people dealing with alcohol-related problems, the professional content of screening and early intervention that can be used in basic healthcare provision was incorporated into the relevant health professional protocols, professional cooperation was set up to support large-scale introduction of the procedure across the country, and the related financial measures and legislative changes were prepared - as part of the cooperation with the WHO BCA.

An alcohol policy conference was held, with the title "Reducing the damage caused by alcohol - brief intervention and early treatment in basic healthcare".

3. HIV / AIDS prevention

Measures taken in 2010

Continuous domestic monitoring of infections that are related to the use of intravenous drugs (HIV, HBV, HCV)

The investigation involved four needle-swapping stations and one treatment centre in Budapest, and five treatment centres, four NGOs and one youth drug centre in the regions, which sent 240 samples for laboratory tests by 31st December 2010.

As part of an **MSM project**, 610 assessable blood samples were received at the laboratories of the National Centre for Epidemiology (hereafter: NCE). The epidemiological investigation, coordinated by the department of epidemics, found **HIV prevalence** of 3.5% in the homosexual and bisexual male population of Hungary (21 persons infected with HIV).

HIV/AIDS counselling course – health workers specialising in skin and STD received theoretical and practical training as part of the project. A total of 29 experts took part in the training, from 10 counties and Budapest.

The Sziget Festival was held on the Hajógyári Island in Budapest between 11-15 August 2010, with the cooperation of the NIHD. The aim of the programme was to encourage the target group - young people - to pay more conscious attention to looking after their health, with regard to their sexual lives, harmful addictions or lifestyle issues. The slogan for the event was: 'LOOK AFTER YOUR HEALTH!'

On 8th December 2010, a call for tenders was announced, titled "HIV/AIDS prevention with non-governmental organisations". The aim of the call for tenders is to make members of groups with a high risk of HIV infection more aware of the risks, to reduce these risks, to encourage practices which help reduce the risks, to emphasise the importance of screening, and to implement activities in schools which help prevent HIV/AIDS and avoid sexually transmitted diseases.

Measures taken in 2011

HIV/AIDS prevention, education about family life, and organising programmes in school which educate young people about a safe sexual life

In the form of meetings and conferences held for public education institutions, the NIHD undertook to present and recommend HIV/AIDS prevention materials, which are suitable - both from a professional and a practical point of view - for students attending primary and secondary schools.

In addition to the information available on their website, the NIHD also ensured free access to publications dealing with the subject, in order to raise awareness of the programmes.

Under a programme supported by the MoHR, blood samples from 926 people were tested in the laboratories of the NCE. The epidemiological investigation, coordinated by the department of epidemics, found HIV prevalence of 4.1% in the homosexual and bisexual male population of Hungary (21 persons infected with HIV), with rates of 1.1% for HCV and 0.5% for HBV.

HIV screening and counselling in the Skin and STD network, in the anonymous HIV/AIDS counselling centres run by the National Public Health and Medical Officer Service (ÁNTSZ) and in NGOs

The training course, supported by the MoHR, created an opportunity for experts working in the treatment of skin and STD, in surgeries carrying out specialist care to out-patients, and in NGOs, to gain deeper and more up-to-date knowledge about the HIV infection and the practice of counselling.

2011 survey of the prevalence of intravenous drug abuse-related infections (HIV, HBV, HCV) in Hungary

The investigation involved five needle-swapping programmes and two treatment centres in Budapest, and eight needle-swapping programmes and three treatment centres in the regions, which sent 700 samples for laboratory tests at the NCE between 1st January and 31st May 2011, of which 666 samples were included in the statistical analysis. All 666 samples proved negative for HIV, 157 persons (24%) were found to be infected with hepatitis C, and three (0.5%) with hepatitis B. The drug abuse-related conclusions of the investigation were analysed by the NCE National Drug Focal Point and the Department of Epidemics of the NCE.

4. Measures taken in connection with drug abuse

Measures taken in 2008

- **Prevention at school**

The budget framework for the proposals to support health education and drug prevention programmes in schools in 2008, managed jointly by the Ministry of Social and Labour Affairs (SZMM) and the Ministry of Education and Culture (OKM), was HUF 170,000,000 (€676,617). Of the 327 applicants, 225 proposals were given grants. Under the programme, 30 090 students in primary schools (age 10-14), 54 860 students in secondary schools (age 14-18) and 9 453 students in schools of 6,8 or 12 grades (age 12-18) took part in prevention activities, totalling 94 403 students (in 2007 it was 116 794 students, and in 2006 it was 105 225 students), which is 9.5% of students aged between 10-18 who are studying in primary or secondary schools (SZMM 2009). In addition to the SZMM-OKM call for proposals, drug prevention activities were also carried out in schools with the help of other funds, or without any separate financing.

- **Prevention at the workplace**

In 2008, the SZMM announced a call for proposals titled **"Support for workplace drug prevention and health development programmes of organisations dealing with drug**

abusers and drug prevention", with a budget framework of HUF 30,000,000 (€119,403). Of the 10 valid proposals that were received, the Ministry awarded grants to 6 proposals, at a total value of HUF 14,878,040 (€59,216).

In the academic year 2007/2008, 94 403 students, that is 9.5% of students aged 10-18 in primary or secondary schools, took part in some kind of drug prevention activity, as part of the call for proposals announced for the support of health education and drug prevention programmes in schools, supported jointly by the SZMM-OKM.

During research directed at evaluating drug prevention programmes/services not operating within schools, 162 drug prevention service providers were identified, and in 66 cases there is detailed information available about their programmes. With regard to the target populations they intend to reach, the greater proportion of programmes/services mentioned young people with social problems, young people from problem families, the general population, and young people living in a bad environment. In comparison with the programmes operating within schools, the programmes/services that operate outside schools reported fewer objectives, and a higher proportion of objectives connected with alternative awareness-raising. In the recreational area, in 2008, 6 organisations provided harm reduction services in 8 cities/micro-regions of the country. During the year, the organisations participated in a total of 393 events, where they made contact with 9400 young people.

- **Budget**

During the year, 17 programmes were awarded individual grants, at a total value of HUF 72 million.

Operating as a support institution of the Ministry, the National Institute for Drug Prevention, functioning as a budgetary organ with partial powers within the organisational structure of the Institute for Social Policy and Labour, received HUF 216.141 million to implement the tasks delegated to the Institute.

In order to achieve the development objectives defined in the national strategic programme on dealing with the problem of drug abuse, a total of HUF 82.532 million was reallocated to ministries and to other state bodies.

- **EU calls for proposals**

There were two packages of programmes in the grant structures: the creation of prevention counselling offices in shopping centres, and the establishment of new community-based drug alternative programmes, with new content and at new venues, designed to prevent drug abuse.

The total budget available was HUF 490 million, and the single-round call for proposals received draft programme submissions from a total of 52 organisations. The amount awarded was HUF 301,816,463. After the rulings, a total of seventeen beneficiaries earned the opportunity to implement their programmes, "Alternatives" are expected to be set up in 2009 in the cities of Békéscsaba, Nyíregyháza and Debrecen, and a further thirteen organisations are launching innovative and complex drug alternative programmes across the country.

- **Calls for proposals**

In the KAB-KOM-08-A/B category, the aim of the call for proposals was to promote social communication in dealing with the drug problem, and to develop tools and programmes

whose content enabled objective, modern and effective communication of information and knowledge related to the phenomenon of drug abuse. The budget framework was HUF 25 million, and 25 proposals were successful in the category.

In the KAB-RE-08-A/B/C category, the aim of the call for proposals was to implement developments and programmes to promote the resocialisation and reintegration of clean addicts (relapse prevention). The budget framework was HUF 50 million, and 30 proposals were successful in the category.

In the KAB-PR-08-A/B/C category, support was made available for complex health maintenance and health development programmes, based on cooperation with local community stakeholders, in different areas (e.g.: families, childcare institutions, the information society, places of entertainment, penal institutes, leisure centres, etc.), which are related to drug prevention, provide a positive alternative to drug abuse, and present a harm reduction approach in their prevention activities. The budget framework was HUF 80 million, and 83 proposals were successful in categories A and B. At the end of 2008, it was possible to release HUF 62.021 million from the balance reserves to support additional complex programmes.

- **Individual grants**

In 2008, HUF 72 million was awarded to individual grant programmes in the following areas:

- **Harm reduction programmes and other institutional operations and investments**

With regard to the provision of healthcare to and resocialisation of patients treated for drug problems, the National Strategy defines a number of institutional requirements. The ministry provided special institutional budgets for this, as well as operational support for institutes providing care for drug patients without state normative funding. It must be noted that in many cases, normative funding did not cover the framework conditions for operations, so supplementary operational grants had to be provided.

The following received support:

- Drogambulancia (Drug Clinic) Foundation - supplementary grants to cover the operating expenses of the Drug Clinic in Miskolc
- Kompánia Foundation - supplementary grant for operating the organisation's programmes

- **Support for prevention programmes and events**

The majority of programmes supported by the ministry are successful projects with a multi-year history, with the objective of reaching a large number of young people, and of making expert information available at other cultural and leisure events.

- "Háló-Mozi" ("Net-Cinema") prevention activities (interactive class teacher lessons) were provided for secondary schools in Budapest;
- Sante Kft.– Egészségliget 2008;
- "Köztes Átmenetek" ("Intermediate Transitions"), a travelling interactive exhibition aimed at parents, which visited large towns in the regions;
- Organisation of Addictions Day – Sziget Kulturális Menedzser Kft.;

- Szakmai Középiskolásokért Kulturális Egyesület Közalapítvány (Expert Cultural Charity for Secondary School Children) - production of a radio show titled "Egyensúly" (Egészséges, drogmentes élet, hogyan?Diákszemmel) ("Balance" (How to lead a healthy life without drugs - through the eyes of students).

- **Supporting training programmes.**

The ministry also placed an emphasis in 2008 on the creation of new types of training pilot programmes, as well as on ensuring the continuation of programmes already up and running, and on providing further training for assistants working in the profession. The grants enabled professional dialogues and exchanges of opinion to be carried out, and to involve a broad range of the general public.

- INDIT Charity – Operating a network of school social workers in Baranya County;
- Interdiszciplináris Addiktológiai Fórum (Interdisciplinary Addictology Forum) Kht. – Publication of Year 7 of the scientific periodical titled "Addiktológia";
- "Megálló Csoport" Alapítvány Szenvedélybetegekért ("Stop Group" Foundation for Patients with Addictions) – Special Education Programme for Patients with Addictions;
- Leo Amici 2002 Addictology Foundation - drama therapy training at the Leo Amici rehabilitation institute;
- Bezerédi Kastélyterápia Alapítvány (Bezeréd Castle Therapy Foundation) - Support for the education development programme at the Szedres Special Home for Children;
- Méntelek-Hetényegyháza Református Társegyházközség Lelkészi Hivatala (Priests' Office of the Reformation Church Community of Méntelek-Hetényegyháza) - "Függő-játszma" - organisation of a national conference on addictology;
- Alkoholizmus Elleni Megyei Egyesületek és Klubok Országos Szövetsége (National Association of County Anti-Alcoholism Societies and Clubs) - Organisation of a conference (13-15 February 2009) and the publication of the "Club Newsletter";
- Pro Psychologia Foundation - Organisation of the 12th EASAR Conference (7-10 May 2009);
- Add a Kezed Nonprofit Prevenciós Célú Programszervező ("Give me your Hand" Non-profit Prevention Programme Organisation) Kft. - Production of a drug prevention film, and screenings in family doctors' surgeries.

- **Reallocations of funds**

In 2008, the following reallocations of earmarked budgets were carried out, charged to sub-section 40 (ÁHT: 228653), "Tasks related to the prevention of drug abuse" of section 16, Budget earmarked for chapter XXVI, Ministry of Social and Labour Affairs, in Act CLXIX of 2007 on the Budget of the Republic of Hungary in the year 2008:

- **The National Headquarters of the Hungarian Prison Service** – via the Ministry of Justice and Law Enforcement - received **20 million HUF** to screen ***volunteers prisoners in law enforcement institutes for infection with HIV, HBV and HCV***, to

develop programmes and services for prevention, alternative treatment and other therapies, to introduce new **harm reduction substitution therapy** (Suboxone) at the Forensic Observation and Psychiatric Institute, and to finance the operation of preventive groups.

- **Other programmes**

- **Media events and conferences**

Organised by the National Directorate for the Coordination of Drug-Related Affairs, and with their support, the following events were held in 2008: On 24-25 January 2008, the "Beyond 2008" forum, as part of a series of international regional consultations, was held in Budapest by the Hungarian Addictology Society, with the support of the SZMM. As part of an international process evaluating policies on drugs over the last 10 years at the UN, the conference brought together Hungarian and foreign NGOs.

Measures taken in 2009

- **Prevention at school**

In the academic year 2008/2009, 79,865 students, that is, 8.3% of students aged 10-18 attending primary or secondary schools, took part in some form of drug prevention activity, under the call for proposals to support health education and drug prevention programmes in schools, funded jointly by the SZMM-OKM. This showed a decrease on the previous year (in 2007/2008: 9.5%).

According to the results of research conducted into the prevention competencies and activities of public education institutes, the last five years have seen an increase in the proportion of schools where there is no institutional capacity for performing prevention and health development tasks, where there is currently no school psychologist, drug affairs coordinator, health developer, youth doctor or regularly attending school nurse.

In at least one of the three academic years during the period of investigation, 90.4% of primary and secondary schools conducted some kind of prevention or health development activity, and in individual academic years there was some form of prevention programme in 85-88% of schools. Whereas in previous years the priority target areas were mainly the abuse of legal/illegal substances, in school settings today, prevention interventions which deal with mental hygiene and with nutrition are present in the same proportion as drug prevention programmes.

In 2009, services offering harm reduction or prevention activities in recreational settings operated in 9 towns/microregions, the organisations took part in 550 events, and reached more than 16,000 young people.

- **Budget**

To implement the tasks for the year 2009 of the Ministry of Social and Labour Affairs (SZMM), with responsibility for coordinating drug-related affairs, sub-section 40, "Tasks related to the prevention of drug abuse" of section 16, Budget earmarked for chapter XXVI, Ministry of Social and Labour Affairs, in Act CII of 2008 on the Budget of the Republic of Hungary in the year 2009, was allocated HUF 1064.7 million.

In 2009, the SZMM announced calls for proposals in a total of 9 categories, in alignment with the professional priorities and development and provision requirements defined in the National Strategy. The value of the grants awarded on the basis of proposals totalled HUF 752 million. A total of 532 proposals were successful.

During the year, 10 programmes were awarded individual grants, at a total value of HUF41.36 million.

Operating as a support institution of the Ministry, the National Institute for Drug Prevention, functioning as a budgetary organ within the organisational structure of the Institute for Social Policy and Labour, received HUF 157,720,000 to implement the tasks delegated to the Institute. In order to achieve the development objectives defined in the national strategic programme on dealing with the problem of drug abuse, a total of HUF 78 406 million was reallocated to ministries and to other state bodies.

- **EU grant funding**

EU-supported programmes implemented under the "New Hungary Development Plan"

- **Within TÁMOP Priority 6 for health developments, measure 6.1, "Incentives for health development and health-conscious behaviour", has the direct objectives of increasing the expected number of years a person can spend in full health, improving the quality of life, and contributing thereby to an increase in competitiveness and employment.**

At the same time, the constructions with health development objectives support the fight against drugs under non-independent proposals. As part of the TÁMOP 6.1.2, "Lifestyle programmes for health education and changing attitudes to health" construction, the 2007-2008 Action Plan made HUF 6 billion of funds available, with an additional HUF 12 billion in 2009-2010, and a total of almost HUF 26 billion by 2013, for bidders to produce health plans to implement health development setting and action programmes, at local, regional and national level, to encourage health-conscious patterns of behaviour. Among the programmes that could bid for grants were those aimed at preventing harmful addictions, including drug abuse, and those targeting harm reduction and reductions in the frequency of drug abuse.

- **Within TÁMOP Priority 5, the drug affairs component of the construction "Integration programmes for children and young people" is at present the only planned component for this target group.**

As part of this component, support is already under way for shopping centre programmes, as well as drug alternative programmes to prevent deviancies. The objective of the EU grant component was to provide access, in a convenient and non-stigmatising way, to the help needed to prevent drug abuse and to combat emerging or existing drug addictions, to young people aged 14-25, who are the group most at risk from drug abuse. A total of 14 bidders were awarded grants for implementing programmes as part of the "drug alternative" package, for designing tailor-made, extra-curricular, community-based alternative programmes, and for holding thematic group activities. Three bidders were awarded grants to set up prevention offices in shopping centres (the "Plaza" programmes). The success of the call for proposals is indicated by the fact that more than HUF 300 million of grants will be paid out in the coming period.

- **Under the TÁMOP 5.3.1 construction, the "First Step" programmes, designed to empower people with low employment prospects and to help them lead independent lives, also feature the option of applying for grants for the social and labour market reintegration of addicts.**

Programmes that increase employability, and provide training, sheltered workplaces and halfway housing, may also apply for support. There is no independent component planned for this target group, so awareness of this resource will take place depending on the support for proposals. The total budget framework is HUF 6 billion.

- **Under the TÁMOP 5.4.1 construction, as part of the "Modernisation of social services, and reinforcement of central and regional strategic planning capacities" construction, pilot programmes are supported which provide cooperation and integrated services in social, drug affairs and other human service areas.** The total budget framework set aside for the construction is HUF 1.619 billion.

- **Calls for proposals**

In 2009, the SZMM announced calls for proposals in a total of 9 categories, in alignment with the professional priorities and development and provision requirements defined in the National Strategy.

Drug prevention, health development and health education activities in schools were promoted and received grants. The programmes receiving support are built on the school pedagogical programme, on the school health development and health education tasks, which are an integral part of the pedagogical programme, and on the drug strategy contained within it, all of which take into consideration and enforce the principles and priorities of the document titled "National strategy for combating the drug problem". The budget framework was HUF 145 million, and 188 proposals were successful in the category.

In the KAB-KP-09-A/B/C category, the objectives of the call for proposals were to make contemporary programmes as widely available as possible, to introduce in schools thematic subjects dealing with drug prevention, to organise scientific conferences on treating the drug problem, and to train experts. The budget framework was HUF 35 million, and 35 proposals were successful in the category.

- **Individual grants**

- **Support for prevention programmes and events**

The majority of programmes supported by the ministry are successful projects with a multi-year history, with the objective of reaching a large number of young people, and of making expert information available at other cultural and leisure events.

  - "Háló-Mozi" ("Net-Cinema") prevention activities (interactive class teacher lessons) were provided for secondary schools in Budapest;
  - "Köztes Átmenetek" ("Intermediate Transitions"), a travelling interactive exhibition aimed at parents, which visited large towns in the regions;
  - Egészség Szerviz Kft. – support for producing the film titled "Drogfutárok" ("Drug-runners");

- Érted Agria Foundation – Drug prevention programme titled "Tisztán Önmagadért" ("Clean - For Yourself");
- Szakmai Középiskolásokért Kulturális Egyesület (Expert Cultural Charity for Secondary School Children) (in cooperation with Hang - Szín Bt.) – "Egyensúly" ("Balance") – Dialogue for the effective implementation of the National Drugs Strategy.

- **Support for training programmes and scientific publications**

The ministry also placed an emphasis in 2009 on the creation of new types of training pilot programmes, as well as on ensuring the continuation of programmes already up and running, and on providing further training for assistants working in the profession. The grants enabled professional dialogues and exchanges of opinion to be carried out, and to involve a broad range of the general public.

- Egészségmonitor Nonprofit Közhasznú Kft. – Support for the research project titled " Follow-up study to analyse the results of diversion";
- Interdiszciplináris Addiktológiai Fórum (Interdisciplinary Addictology Forum) Kht. – Publication of Year 8 of the scientific periodical titled "Addiktológia";
- INDIT Charity – Operating a network of school social workers in Baranya County;
- Tiszta Jövőért Foundation – Support for further training of assistant experts dealing with addiction patients.

- **Reallocations of funds**

In 2009, the following reallocations of earmarked budgets were carried out, charged to sub-section 40, "Tasks related to the prevention of drug abuse" of section 16, Budget earmarked for chapter XXVI, Ministry of Social and Labour Affairs, in Act CII of 2008 on the Budget of the Republic of Hungary in the year 2009:

As the fee for providing prevention and information services in accordance with Joint Decree 42/2008 (Nov. 14) of the Ministry for Social and Labour Affairs and the Ministry for Health on the rules for curative treatment of drug addition, and for other provisions or prevention and information services in the treatment of drug abuse, HUF 5,006,000 was transferred to the Szabolcs-Szatmár-Bereg County Branch of the Northern Plain Regional Institute of the ÁNTSZ, and HUF 400,000 was transferred to the National Medical Rehabilitation Institute, bringing the total to HUF5,406,000 .

- **Other programmes**

25-26 June 2009: "ELLENSZER a szer ellen" ("ANTIDOTE to drugs") non-stop drug prevention event, organised by the Law Enforcement Association for Prevention.

Measures taken in 2010

In the year in question, a national survey was conducted among the general population, as part of the research titled "Health Behaviour in School-aged Children" (HBSC). Compared with the HBSC study of 2006, the proportion of students in grades 9-11 who are affected by drugs has increased roughly one-and-a-half-fold. The combined lifetime prevalence (LTP) rate for various banned and legal narcotics increased 10 percentage points to 30.7%, while the LTP

rate for marijuana abuse rose from 17.3% to 23.7%. The latter is primarily the consequence of an increase in the proportion of those in 9th grade who have tried the drug.

The greatest change was observed in amphetamine abuse, where the proportion of those who have tried it increased over one-and-a-half times. The LTP rate for marijuana and amphetamine is also high when compared with the data from ESPAD 2007 (calculated for students in grades 8-10), at around twice the rate. Boys and older age groups continue to abuse drugs at a higher proportion. The only exception was that pharmaceutical abuse was more prevalent among girls, but according to current data, this difference seems to have disappeared.

There was no major reorganisation of prevention activities in 2010. The amount of resources devoted to prevention activities in school settings shows a fall compared with the previous year. However, there is a perceptible increase in interest in relation to targeted prevention.

Progress has also been made in the development of the QA systems of targeted prevention activities, with the final versions of methodological sheets available from August 2011. Based on a survey aimed at identifying new phenomena among problem drug abusers, from the summer of 2010 there has been an increase in demand for treatment relating to mephedrone.

Among the reasons for the spread of new psychoactive substances, low prices and easy access are the main ones, in addition to novelty and perceived low risk. Several service providers, however, have reported that the harmful consequences of such substance abuse can develop rapidly. In addition to mephedrone, organisations have also mentioned the appearance of synthetic cannabinoids and other designer drugs which follow on from mephedrone - in particular MDPV.

On the basis of client data from needle-swapping programmes, the number of injected opiate abusers has fallen. In parallel with this, there have been increases in the rate of amphetamine abusers (39% to 45%) and of injectors of other substances (4% to 8%), the latter presumably as a result of the spread of mephedrone injection.

The national HIV, HBV, HCV prevalence study, conducted annually since 2006, was not conducted in 2010 among intravenous substance abusers, but from April 2010, 10 organisations offer continuous screening possibilities. The rate of HIV and HBV infection among Hungarian abusers of intravenous substances remains at a similarly low level compared with previous years.

In 2010, the rate of HCV infection measured among people treated by drug clinics and users of needle-swapping services was 21.4%, an insignificant change compared with the national cross-sectional investigations carried out in 2009 (24.4%). The rate of HIV and HBV infection in prisons remains very low.

Under the call for proposals to support developments that promote the resocialisation and reintegration of addiction patients, 34 programmes were awarded grants in the grant period which closed in 2010. 17 organisations received grants to implement relapse prevention and self-help programmes. 12 organisations implemented complex training programmes, and 5 organisations received infrastructural support to develop an institutional system of after-care.

- **General prevention**

With regard to prevention at schools, the largest financial resources and professional priorities were established by the call for proposals KAB-ME-10-IP, announced under drug affairs coordination. Under this support structure, proposals may be submitted for universal and targeted prevention programmes in school settings.

Only educational establishments can submit proposals in this category, and there were 110 successful proposals, receiving a total of HUF 100.215 million (€363,756). Family-oriented prevention has the main objective of providing expert, factual information on the drugs problem. In this category, 11 proposals were given grants totalling HUF 9.8 million (€ 35,571).

- **Prevention at the workplace**

The objectives of universal prevention activities at the workplace were to create a workplace environment which supports health, and to devise workplace drug policies and encourage their implementation. In this category 4 proposals received grants worth a total of HUF 5.6 million (€20,326). The majority of programmes for the internet and other media that were developed and that received grants were in connection with universal prevention.

These programmes communicate information and knowledge about drug abuse in an objective, modern and efficient way. 20 proposals were successful in this category, and HUF 20 million (€72,595) was available to support them. Universal prevention in child protection institutions primarily targets the strengthening of local community resources. In this category, 4 proposals were awarded grants totalling HUF 5.3 million (€19,237).

With regard to universal prevention services implemented in recreational settings, the objective of the programmes is to provide attractive alternatives to substance abuse, relying on local community resources. In this category, 14 proposals were awarded grants totalling HUF 13.2 million (€47,912).

- **Training experts**

The promotion of universal prevention activities in school settings was targeted by the initiative of the Ministry for Education and Culture, under which the former school drug affairs coordinators had the opportunity to take part in 1-day local training and consultation, and teachers and other experts who carry out health developments within public education institutes had the opportunity for training in other aspects. The training programmes were organised by the National Institute for Drug Prevention, in cooperation with the local Procurement and Supply Directorates, in a total of 18 venues, with the participation of 341 experts. The subject of the training was determined in accordance with a preliminary needs analysis, and after the session, participants were questioned about their level of satisfaction and their future training needs.

- **Programmes for women**

With the support of Budapest City Council, from march 2010 the Kék Pont Foundation organised programmes for women, ranging from prevention settings, through harm reduction services to clinical care. Coming under the title of "Nő létünkre" ("For us as women"), monthly presentations and open discussions were held, alongside interactive programmes.

The series of programmes was aimed at female addicts, at female relatives of addicts, and at women with an interest in the means for preventing the typical addictions and problems suffered by women.

- **Targeted prevention**

- **"Holdsugár" ("Moonbeam") Programme**

The aim of the Moonbeam Programme is to provide sport clubs on Friday and/or Saturday evenings for young people with disadvantages aged 12-25 who are otherwise roaming the streets, where, instead of facing the dangers of alcohol or drugs, they can find partners, enjoy a family-like atmosphere, find entertainment, develop their lifestyle and play table tennis in a cultured atmosphere where they are treated with dignity.

The programme receives support from the Secretariat of State for Sport worth HUF 18 million (€65,335), from which 33 clubs organised sports events. Of particular importance were 4 national championships, six regional competitions, and the annual professional conference, where club leaders exchanged experiences and developed methodologies.

- **Healthy Nightlife Toolbox project**

Conducted with international cooperation, the Healthy Nightlife Toolbox (HNT) has the aim of reducing the harm done by alcohol and other psychoactive substances among young people in recreational settings. Five Member States (UK, Belgium, Netherlands, Hungary and Spain) are taking part in the EU-funded project, with one institution participating from each Member State. Hungary's participation is coordinated by the National Institute for Drug Prevention.

The central tool for disseminating the knowledge and experiences acquired is the Healthy Nightlife Handbook, which contains models for effective programmes, a structured method for developing them, and information which can help to identify and carry out the interventions and guidelines that will be most effective in the given circumstances.

The objective of the project was to monitor and evaluate the practical application of the Handbook and the database.

Nine organisations (eight from Hungary and one from Italy, made up of party services and party assistance services) took part in implementing the programme, under the coordination of the National Institute for Drug Prevention. The organisations assessed the Handbook, and planned projects aimed at creating healthier recreational settings with the help of applying the Handbook and databases in practice.

During the process evaluation, opinions and recommendations for development were made concerning the Handbook, while during the outcome evaluation, the project plans were assessed with the help of independent experts.

Based on the findings of the investigation, the service providers also regard the Healthy Nightlife Toolbox as filling a gap.

According to the assessment criteria, the Handbook proved to be a well-structured, transparent, practical and easy-to-use tool, although the service providers considered that greater attention should be paid to cultural differences and to the topic of communication.

Based on the experiences of the outcome evaluation, the Handbook made the process of producing the project plans faster and easier, and had a positive influence on their results, as the project plans prepared with the help of the Handbook turned out to be better organised and more logical.

- **ReDNet project**

The ReDNet project is implemented as part of the Public Health Programme of the European Commission, with the support of the EAHC (Executive Agency for Health and Consumers) and the cooperation of prestigious institutes in Europe.

Hungarian participation is from the National Institute for Drug Prevention and its successor, the National Office for Drug Prevention.

The intention of the project is to create an integrated, ICT-based approach, relying on an already available database (Psychonaut Web Mapping Group, 2009; www.psychonautproject.eu) of novel psychoactive substances (NPS) which are less known to professionals and less familiar in professional literature, aimed at providing suitable information to people at risk, at preventing abuse of these substances, and at reducing problematic substance abuse.

In addition to people who are at risk, the project also has the objective of providing information about NPS to experts who deal with young people who abuse these substances.

[The project is supported by the European Union Public Health Executive Agency (PHEA) (2006345 – HNT).]

(The Handbook and the other results of the project are available at: http://www.hnt-info.eu/)

- **Recreational settings**

In 2010, programmes offering harm reduction/prevention activities operated at 16 recreational settings in the country: 13 city programmes, 1 regional and 2 national programmes. The party service in Mosonmagyaróvár was no longer operating in 2010.

In Eger and Budapest, however, after stopping in 2009, the party services recommenced, and in June 2010 a new programme was launched in Szeged.

Organisations took part in 613 events in 2010, reaching close to 25,000 young people, with an average number of contacts per event of 41 (in 2009: 29 contacts per event).

Based on data provided by the services: more than 2600 litres of mineral water was consumed, along with 14,400 condoms, 8640 leaflets, sucrose tablets, biscuits, vitamins and fruit.

The programmes in Szeged and Budapest held training for the operators and staff of the cooperating places of entertainment, about the safe conditions for healthy recreation. A similar initiative was started in Békéscsaba, but this was stopped due to low motivation among the target group.

- **National and local media campaigns**

- **Year of Moderation Campaign**

In 2010, the Year of Moderation Campaign continued, run by the Kék Pont Foundation. Close to five hundred people registered on the programme website over eighteen months.

The most frequently used illegal substance was cannabis, with users reporting 762 occasions, giving an average pleasure rating of 6.6 (on a scale of 10). The most frequently used legal substance was tobacco, with 7225 incidents of consumption, and a pleasure rating of 4.9. Among behavioural sources of pleasure, the internet was the most frequent, with a pleasure rating of 4.8.

The biggest national festivals were attended by the programme, using the name "Moderation Zones".

The closing event of the campaign was the conference titled "Troubled Destiny", held by the Kék Pont Foundation on 21 September 2010, on the subject of opportunities in Hungary for the responsible consumption of alcohol, and inviting many representatives from the recreation, education and corporate sectors, as well as from the alcohol distribution and marketing professions (Source: http://mertekletes.hu/).

- **Karmák Campaign**

As part of the Karmák (Karmas) campaign, the Északi Támpont Association began producing a series of films in 2010, featuring seven heroes who not only live with exemplary dedication, but who also come from the most disadvantaged layers of society.

During filming of the pilot episodes, eight parts of the series were completed.

In the first part, notable experts share their thoughts about the combined phenomena of poverty, after which the seven personal stories are presented.

Among the objectives of the Karmák Project, it is hoped that the films can provide tangible help to the people who feature in the films in fulfilling their missions.

The Karmák films are shown on television, the internet, at public showings and at festivals, in order to reach as many people as possible.

- **Journalism competition**

Under the international information-based project Addicted2Life, the Kék Pont Foundation organised a journalism competition. Bulgarian, French, Macedonian and Hungarian journalists were invited to take part in the competition.

The candidates had to show the social and health aspects of drug abuse, and it was advantageous if the journalist built up an image of the particular characteristic of amphetamine abuse.

Articles and reports already published, or in the process of being published, in the press, on radio or TV or online could be nominated for the competition between 1 March and 30 September 2010.

- **Regional and local campaigns**

In Békéscsaba, to coincide with World Drug Day, a one-week awareness-raising advertising campaign was organised, together with radio discussions.

- **Data collection**

Progress has been made in Hungary in the last few years in the area of data collection on drugs: the application of a constant yet anonymously generated code for the algorithm made it possible to connect different databases, which enables the appearances of problematic drug abusers to be monitored in different systems.

As a result of linking up the databases, estimates were made in 2010, defining the size of groups of problematic drug abusers.

- **Calls for proposals**

In 2010, the ministry with responsibility for drug affairs coordination announced calls for proposals in five categories, worth a total of HUF 506.21 million, to achieve the following objectives:

- The aim of the call for proposals titled ***"Development of healthcare capacity to promote the treatment of drug problems" (KAB-EL-10)*** is to take people struggling with drug issues into care and to promote the development of healthcare capacity. The budget framework was HUF 165.0 million. The call for proposals contained four sub-categories: supplementary operative support for organisations performing low threshold services, supplementary operative support for drug clinics, rehabilitation institutes and other drug patient institutes, the development and operation of services providing substitutional maintenance treatment, and the implementation of developments and programmes to promote the resocialisation and reintegration of clean addiction patients. A total of 157 proposals were submitted to the electronic proposal system, operated by ESZA Nonprofit Kft., and 72 successful bids were announced.

- The objective of the call for proposals titled ***"Support for drug prevention activities" (KAB-ME-10)*** is to support general, targeted and recommended prevention programmes, with a budget of HUF 250 million. The call for proposals contained seven sub-categories, which identified the most important prevention settings (families, schools, workplaces, recreational settings, internet and other media, child protection institutions, and prison institutions). A total of 533 proposals were submitted to the electronic proposal system, operated by ESZA Nonprofit Kft., and 235 successful bids were announced.

Measures taken in 2011

- **EU Presidency**

With regard to international affairs, the first half of 2011 saw Hungary holding the rotating presidency of the EU. The presidency was conducted with the involvement of the European

Commission and the Council, as well as Hungarian experts and experts from the European Monitoring Centre for Drugs and Drug Addiction.

Hungary's domestic drug affairs programme was the programme that was presented officially at the December session of the Horizontal Working Party on Drugs.

The drugs programme of the Hungarian presidency defined the following thematic debates:

- Standardisation in the field of drug prevention;
- Improving the efficacy of drug treatments; the establishment and development of treatment protocols;
- European responses to challenges presented by new types of drugs:
  - Novel psychoactive substances (NPS);
  - Sharing best practices of drug analysis laboratories;
- The drug problem in prisons.

The presentations and valuable exchanges of opinion that were heard in connection with the themes placed in focus by the Hungarian presidency contributed to the formulation and approval of European level responses in the areas of NPS, drug abuse in prisons, and the formulation of minimum quality standards in interventions aimed at reducing demand.

In connection with NPS, the Hungarian presidency created the opportunity, within the Working Party, for the best practices of laboratories to be presented, and for the theoretical and practical problems of controls to be debated.

- **Prevention at school**

The most important drugs policy development in 2011 was the establishment of the regulatory background and rules of procedure enabling the temporary registration and commercial restriction of NPS.

From 1st January 2012, 9 novel substances (4-FA, 4-MEC, MDPV, methylone, JWH-018, JWH-081, JWH-073, JWH-122, JWH-210) were entered on the register of substances which are subject to the same evaluation as narcotics, and consuming and trading in these substances are punishable under penal law.

The Hungarian data of the 2011 ESPAD survey showed a marked increase in the consumption of banned substances and substances used as drugs compared with 2007.

The lifetime prevalence rate for all (illegal and legal) substance abuse among the 16-year-old students questioned was 28.8%.

Among the substances investigated, the most widespread remained marijuana, as well as the consumption of medicines without a doctor's advice and the inhalation of organic solvents.

Based on the prevalence rates, fifth place was occupied by mephedrone, which was questioned for the first time in 2011, followed by amphetamines, other substances and ecstasy.

The proportion of those who had ever tried some kind of illegal substance increased to the greatest extent among girls, and among schools in rural areas.

In the field of drug prevention, calls for proposals continued to be announced which target professional developments in the area, with attention paid to the proposal priorities defined in previous years, but these developments often found themselves in difficulty due to late payments.

In the area of deaths caused in connection with drug abuse, the declining trend continued in 2011, especially in the number of deaths caused by opiates.

In 2011, there was a significant increase in the use of needle-swapping programmes, both in terms of the number of needles distributed and brought back/collected, and the number of clients and contacts, and the rate of swapping increased to 72%. The main reason for this is the spread of injecting NPS, as well as the more frequent injections which are typical of these substances.

The increased demand for sterile equipment meant that, for financial reasons, the programmes with the highest volume were forced on occasion to restrict the amount of syringes that could be taken away.

There are currently 14 therapy communities operating in Hungary, with a total number of 353 beds, based on the latest available data.

- **Calls for proposals**

In sum, HUF 369 million (€1,328,696) was distributed to a total of 369 proposals made under KAB. In 2011, HUF 14.2 million (€51,134) was paid out in the form of individual grants (EMMI 2012).

In the light of the tragedy at the "West Balkán" nightclub, the unregulated nature of music and dance events, and the lack of safety inspections at venues for such events came into focus.

The government decree on making music and dance events operate with greater safety entered into force on 16th March 2011. The aim of the decree is to ensure safety at music and dance events that are held regularly or on occasion, and to maintain the health, physical integrity and life of consumers.

During the year, the framework and professional priorities for prevention-related activities were established by the implementation of the (national and EU-funded) calls for proposals announced in 2010, and partly also by the drug-related calls for proposals announced by the Ministry of National Resources in 2011. Implementation of the majority of the latter proposals was not begun in 2011 due to late payments.

- **Environmental prevention**

As a new component, the following must be mentioned: the latest research data supports the evidence from social studies that the environment is a major influence on whether or not teenagers participate in risky patterns of behaviour. The related research indicates that the emphasis of prevention interventions targeting young people should be less on information and more on establishing norms and giving a sense of normality. Where prevention is concerned, important areas of focus are the school, family and recreational settings. This evidence supports above all the environmental approach to prevention, which relies more on changing the surroundings than on simply trying to convince.

The legislation for NPS was drawn up in 2011. Of the new synthetic substances, mephedrone was placed on the list of banned substances from the start of the year, and preparations were made to place a further nine chemicals (MDPV, 4-MEC, methylone, 4-FA and 5 synthetic cannabinoids) on the list, and to pass legislation for this. In addition, the government took the decision and drew up the legislative measures to introduce regulation based on master formulae and individual formulae. These legislative measures are intended to address the increasingly serious problem posed by NPS in the last few years, and to reduce the spread of the problem. An important part of this process is to stop the legal trade of novel substances.

- **General prevention**

Under the KAB-ME-11-A/B/C calls for proposals, an opportunity was created to support complex programmes, based on the cooperation of local community stakeholders, which are connected with the prevention of drug abuse, and designed to offer positive alternative examples instead of drug abuse.

In category KAB-ME-11-A, 91 school programmes received grants. The total amount of grants was HUF 55.071 million.

Proposal category KAB-ME-11-B created opportunities for supporting programmes to strengthen the family system and to development parental awareness, and 56 proposals were awarded grants in this category. The total amount of grants was HUF 56.575 million.

Call for proposals KAB-ME-11-C was designed to fund programmes and initiatives that build on local community resources, and which offer attractive alternatives to drug abuse in the settings of recreation, the workplace, the system of child protection institutions, the institutions of the prison service, and the internet and other media. 75 proposals received grants in this category. The total amount of grants was HUF 88.351 million.

- **Prevention at the workplace**

Under the call for proposals with the code KAB-ME-10-MM, in June 2011 the Kék Pont Foundation presented their workplace health programme, called the Health Agency, at a construction company. The programme interactively discusses topics such as alcohol consumption, drug abuse, games of fortune, the balance between work and private life, saving money, and stress in the workplace, and strives to encourage workers to make all their decisions with greater consciousness, and to encourage individuals and communities to economise with their resources in a more efficient and balanced way.

- **Targeted prevention in high-risk groups and settings**

Drug prevention activities of the Hungarian Armed Forces

In line with the Hungarian Armed Forces Drug Prevention Strategy, the following practical activities were implemented in 2011 (Hungarian Armed Forces 2012):

- *Cognitive transmission of knowledge, informative publications, visual demonstration*. Information sessions held as part of disciplinary meetings, attended by a total of 843 persons during the year. Programmes organised in community settings during major central and other military events, reaching 2192 people. Poster exhibition at two bases in Budapest and one in Szolnok.

- *Operating of the Hungarian Armed Forces Health Preservation Programme*, which was not limited to the transmission of knowledge concentrating on individual risk factors or patient groups, but a complex and comprehensive prevention programme focusing on health problems in relation to each other. Among the troops, small groups (20-25 people) took part in interactive group meetings, which took the demands and needs of the troops into consideration, with the participation of a total of 843 people.

- **Recreational settings**

In 2011, programmes offering harm reduction/prevention activities operated at 17 party service or recreational settings in the country: 6 city programmes, 5 micro-regional, 2 county 2 regional and 2 national programmes. The 17 reporting organisations took part in 603 events in 2011, reaching close to 22,500 young people, with an average number of contacts per event of 37 (in 2010: 41 contacts per event). Based on data provided by the services: 11,876 litres of mineral water was consumed, along with 17,391 condoms, 13,073 leaflets, 1376 packets of sucrose tablets, 5647 boxes of effervescent tablets, 5675 vitamins, and biscuits and fruit. 4 organisations held 8 training sessions for the operators and staff of the cooperating places of entertainment, about the safe conditions for healthy recreation.

The training sessions held by an organisation in Szeged focused on providing information about NPS. In 2011, the Professional Alliance Party Service Providers (PASSSZ) was established, with the aim of promoting active cooperation and exchanges of information among service providers offering harm reduction services in recreational settings.

In addition, the intention of the founding NGOs was to create an alliance that is capable of effectively enforcing safer professional guidelines and criteria for dance and entertainment events on the operators of places of entertainment, on government stakeholders and on the people attending such events. The alliance's professional guidelines are indicated in the methodology sheet that was produced in 2011. The ever growing alliance currently comprises 21 party service providers in 9 cities.

Rehabilitation services for drug abusers

Live-in care for drug abusers in Hungary is provided from the healthcare budget in hospital addictology and psychiatric wards, as well as in drug therapy institutes, financed from mixed (healthcare and social) budgets. The two types are not completely distinct, and from a regulatory and financial aspect there is no separate definition.

The programmes provided by hospital wards are traditionally and typically focused on treating patients for psychiatric and alcohol-related problems, and provision for drug abusers in these institutes is usually on a small scale.

In 2009, 13 institutions managed a total of 353 beds. During the reporting period, the number of therapeutic communities increased to 14.

The institutions have significantly broadened their range of therapy services, and even within their own organisations they have introduced low threshold and halfway house, after-care services; they are open to new client groups and have a substantial network of institutional connections. A large number of therapy institutions belong to the so-called third generation of therapy systems.

With regard to the arising needs for treatment, the capacity of drug therapy establishments can be described as good. During the year, the number of clients treated in domestic drug therapy institutions who had to be placed on a waiting list was 25 (3%, an average of 2.1 persons per institution). Bed occupation rates were between 90% and 100%.

The simultaneous capacity of drug therapy institutions is 353 persons (2009 data). Within this figure, 269 beds are financed by the National Healthcare Fund, and 340 are financed from the social budget (one bed may receive funding from more than one resource).

20/14/00/00 For the support of tasks related to the prevention of drug abuse
Budgetary funds available from 2008

2008	HUF 1 084 000 000
2009	HUF 1 064 700 000
2010	HUF 960 000 000
2011	HUF 512 100 000

Calls for proposals aimed at drug prevention
(community cooperation, prevention, treatment and care)
2008-2011

2008	HUF 781 680 000
2009	HUF 752 302 300
2010	HUF 486 000 000
2011	HUF 388 500 000

5. Protection of expectant mothers, children and teenagers

The district nursing system has existed in Hungary for almost a hundred years, offering preventive care to ensure basic healthcare provision, in order to maintain the health of children. The district nursing system is one of Hungary's treasures (a so-called "hungaricum") and deserves to be praised and maintained, as it clearly serves to ensure the right of the child to health. District nurses are highly qualified experts in the provision of prevention and healthcare, with training primarily in the area of prevention, who contribute to the health of women, mothers, infants, children, young people and families, and cooperate in tasks related to public health, epidemiology, health development and health education.

When performing their duties, district nurses maintain contact and work in close cooperation with family doctors, paediatricians, obstetric and gynaecological doctors, experts from hospital birth, infant care and childcare wards, school doctors, education establishments, child welfare services, experts from social and family welfare institutes, and NGOs.

As members of the alert system, district nurses also perform tasks to do with child protection. If signs are observed that a child is at risk, district nurses have the obligation to notify the child welfare services. District nurses perform their tasks in line with acts of law, protocols, guidelines and methodological instructions.

They are supervised by the professional district nurse supervisory agency, which operates under the public health professional administration bodies of government offices. The forms of care provided by district nurses are:

- local district nurse care,
- school healthcare,
- hospital district nurse care,
- and the Family Protection Service.

The network of local district nurse care covers the whole country. Its basic unit is the nursing district, which is based on locality. Basic healthcare is provided close to the population. District nurses provide equal opportunity care and access to the residents of the "district" and other people who live there and require district nurse care - whether in cities, villages or farmsteads. On the one hand, family visits occur in the homes of families, that is "on site", while on the other hand the services of the district nurse (screening, counselling) are also available at district nurse surgeries. In addition, district nurses also address wider sections of the population through group sessions and health maintenance programmes.

The health of mothers, children and families is protected with monitoring and support from the moment of conception until the child reaches reproductive age, ensuring continuity. The local district nurse is also a member of the child welfare alert system. Local district nurses are therefore present in family life at all the most important stages of life - pregnancy, welcoming the newborn into the home, developing family life, early childhood development, and nursery and school attendance. They also provide care in nurseries.

Those performing school district nurse healthcare (school nurses) participate in the provision of preventive healthcare at schools for children between the ages of 6-18 (full-time students attending primary and secondary schools).

School healthcare is provided jointly by the school doctor and the district nurse. Among the tasks performed by school nurses are individual and group health development activities, screening and health tests, in close cooperation with the workers at the school. Hospital district nurses typically work in birth and newborn wards, and take part in providing healthcare to expectant and new mothers, assisting breastfeeding, preparing mother and baby for the return home and health education.

It must be highlighted that Hungary protects the life of the child from conception - as stated in the Constitution: "...foetal life shall be subject to protection from the moment of conception." This overriding concept is observed in the provision of healthcare to pregnant women, and of basic healthcare to the born child - by family doctors, local district nurses and school healthcare workers. The maintenance of children's health is closely related to the activities of the child welfare system and to the "alerting activities" of the healthcare provision system (obligation to notify). If a child is observed or suspected to be at risk, workers in the healthcare provision system (including district nurses) have the obligation to notify the child welfare services.

5.1. National Strategies and Action Plans:

- **"Közös Kincsünk a Gyermek" ("The Child is our Common Treasure") National Infant and Child Health Programme**

The Programme is built on the concept that the period of life between conception and the age of 18 should lay the foundations for physical and mental abilities later in life, and for the chances of maintaining health and preventing disease.

- **"Legyen jobb a gyermekeknek" ("Making Things Better for Children") National Strategy (2007-2032) National Assembly Decree 47/2007 (May 31)**

The aim is to support families with children, in order to increase chances for children. Among the special basic guidelines it lays down with regard to the status of children are the principles of prevention, increased protection for people in disadvantaged situations and access to equal opportunities.

- **"Sure Start" Programme**

This programme is connected with the "Make Things Better for Children" National Strategy. The Sure Start programme is charged with the task of intervening effectively in order to prevent the re-emergence of the effects and consequences of poverty and exclusion. The Sure Start Children's Houses began operating in 2010.

The aim of the activities carried out by the Sure Start Children's Houses is to contribute to the development of skills among children, and to their later success at school. The Sure Start Children's Houses have to establish and maintain active partnerships with the experts in the given community who work with children aged 0-5, and with their parents and families.
Programme principles:

- Early childhood learning and care;
- The age principle - the programme focuses on the age group 0-7 (in particular 0-5);
- Local targeting: the primary target group consists of families living in disadvantaged microregions or in segregated parts of communities;
- Parent partnership: the parents are the child's first educators;
- Active parent participation, strengthened parental competencies, and if necessary, assistance in accessing other services;
- Inter- and intra-disciplinary cooperation.

- **Semmelweis Plan**

According to the professional concept of the Semmelweis Plan, basic healthcare provision - of which the regional network and the school nurse network are important parts - is the key component of the state healthcare system, and must be accorded priority status. As such, efforts must be made to increase the available capacity of basic healthcare provision units, in order to provide the necessary tools. The development of healthcare for infants and children in Hungary is a priority in the Semmelweis Plan. In Hungarian society, with its decreasing population and the need for it to deal with the economic crisis, it is vital for the physical, mental and social health of children to be a central pillar of government policy. The overall

aim of the development is to reduce disproportionality in regional and professional access, and to improve efficiency and quality.

5.2. Data collection and Neonatal Intensive Care Centres

The aim of the data collection is to provide an objective background for material and personnel developments in the profession, in order to improve the life prospects of premature babies and newborns who need intensive care.

The data collection was initiated by the Professional College of Infant and Child Medicine, and in the first years (2002-2004) of the project, the data collection was coordinated by Child Clinic I at the Semmelweis University. From 2005, the task of coordination was taken over by the National Institute for Child Health (hereafter: NICH). The data providers are the Neonatal Intensive Care Centres (hereafter: NICs) with level III classification. The system of NICs developed in Hungary in the 1970s-1980s. There are currently 21 NICs in Hungary. There are five in Budapest, two each in Pécs and Debrecen, and one in each of the county capitals (except in Békés County, where the NIC is run at the hospital in Gyula). Every NIC has agreed to take part in the data collection, so it may be regarded as comprehensive, and covering the entire country.

The method of data collection is modern, even by international standards. The content was decided by the neonatal profession, and consistent interpretation of the data is assisted by the "help" system which is built in to the programme. In addition to personal details, the range of data collected covers the circumstances surrounding pregnancy and birth, data from the first twelve hours of life, diagnoses of the first 72 hours of life, interventions that took place at the NIC, the status of any complications, and logistical issues. The data providers enter the data on the people under the care of their institution via an online data entry user interface. Between 2005-2009, information was received on 29,255 newborns who received nursing in NICs, and on 30,418 incidents of nursing. An annual average of 5.8% of all newborns in Hungary required neonatal intensive care. 19.9% of those cared for were born with a weight below 1500 grams, and a further 41% of them were born with a weight between 1500 and 2499 grams. The survival rate of all those cared for was 94.9%, which means that 1,478 children died during hospital care, in the five-year period of data collection. The survival rate is closely related to the time of gestation and birth-weight. While those born before the 24th week of pregnancy had a survival rate of 38.9%, by the 28th week the survival rate was above 90%. Between weeks 21 and 28, the chances of survival increase sharply, and between weeks 28 and 33 there are further, more moderate improvements. The chances of survival among babies born later than week 33 depend not on the gestation period, but on other diseases. In the 25th week, 8.2% of births result in no complications, and this figure is 35% in the 27th week, 82.2% in the 30th week, and over 95% after the 33rd week.

In 2010 the NICs provided information about a total of 6328 newborns and 6686 incidents of nursing care. In 2010, 7% of all births in Hungary required neonatal intensive care. Of those receiving care, 3715 (58.7%) were of low weight (<2500g), with 1213 (19.2%) below 1500g and 499 below 1000g. 37 babies were born with a weight below 500 grams. 37.8% of all nursing was made up of intensive care for babies born at full term. 19.5% of babies nursed in NICs were from multiple pregnancies. 30.4% of babies of low weight were twins.

In line with medical protocol, in cases where there is a risk of premature birth before the 35th week, corticosteroid is administered to the mother to promote maturity of the lungs. In spite of this, full prophylactic antenatal steroid treatment, carried out in line with the protocol communicated to the NICs, was administered in 30.6% of premature births before the 35th week, with partial prophylactic steroid treatment in a further 8.4% of cases.

Among the diagnoses made as reasons for nursing in NICs, the most frequent are breathing difficulties (62.2%), infection surrounding the birth (47.6%), intrauterine growth retardation (17.7%) and developmental disorders (16.1%). The most frequent risk factors were bacterial infections (15.8%), low blood-sugar levels (12.6%) and repetitive hypoxic apnoeas (12.4%). In 2010, 302 children died in NICs, which is 62.8% of the total number of registered infant deaths (481) in Hungary in 2010. Mortality among newborns being cared for in NICs showed a very close correlation with birth weight. The survival rate of all those receiving care was 95.2%, and was 81.1% among newborns of very low weight (<1500 g). Complications are a significant aggravating factor in infant mortality, their future life prospects, and their need for rehabilitation. The most frequent complication overall was patent ductus arteriosus (PDA), occurring in 8.5% of cases. Among babies born below a weight of 1500 grams, bronchopulmonary dysplasia was diagnosed in 27.3% of cases, PDA in 20.1%, severe subarachnoid haemorrhage in 13.4% and severe ROP in 9.0%. The rate of survival without complications among newborns of low weight was 54.3%

All of the medical investigations into infant mortality and the later quality of life of newborns show a strongly negative correlation with the gestation period of the newborn. The younger a newborn is, the greater the chance of mortality and, in the event of survival, of the appearance of symptoms of intraventicular haemorrhage, ROP, PDA, necrotising enterocolitis or bronchopulmonary dysplasia. The data make it possible to ascertain a realistic probability of these complications taken together with the present means of therapy. The NICs can therefore give a realistic, experiential information-based assessment of the expected prognosis to parents at the start of treatment. In order to do so, a chart has been complied of the probabilities of survival in each of the weeks of the pregnancy, and the incidence of severe complications among survivors.

In disadvantaged regions, there are very few paediatricians, and children are examined in mixed GP's districts, but there are unoccupied GP districts and nursing positions in many places. The data demonstrate that in these regions, more children and in worse medical conditions are taken into hospital, a lower proportion receive modern treatment in line with medical guidelines, baby food and voluntary vaccinations, the unjustified administration of antibiotics takes place more frequently, there is a greater tendency for children to miss out on proper clinical screening, the development help they need is given insufficiently, if at all, and so on. Access to medical care and to health services is not only problematic for families because of physical difficulties in accessing these services, but also because these services represent some degree of extra financial burden on the families. Research data show that almost a tenth (8%) of families with children in 2009 did not have enough money for medical treatment.

This obstacle made it impossible for 21% of families living in poverty, and 26% of Roma families, to ensure that their children received the proper medical care. In two disadvantaged microregions (Heves and Bátonyterenye), in a representative sample of families with children,

there was a much higher rate of exclusion (in 2011): almost a fifth (18%) of them could not allocate money for medical care. Among impoverished and Roma families, the rate was 29% and 30% respectively.

5.3. Nursery Sensory Motor Integration Pilot Programme

The Nursery Sensory Motor Integration Pilot Programme was drawn up by the NIHD in 2007. Under the NIHD desegregation programme, in the 8th District of Budapest, an evaluation of the level of sensory motor maturity among Roma children aged 5-9 from a background of multiple disadvantages was carried out, the screened children were given development, and the teachers dealing with them were given training. In the academic year 2010/2011, under the programme, implemented with the support of the Ministry of National Resources, a total of 172 children, mostly from disadvantaged backgrounds, received sensory motor development in 17 groups in 11 institutions. During the activities, specifically designed according to age and level of development, the children develop greater awareness and achievement of the task, and by combining verbal and sensory motor tasks, their ability to communicate and their physical awareness improve. Comparing the results of the development group with a control group, almost twice as many of those in the development group attained the level of "ready for school" as those in the control group. The nurseries and schools of the 8th District of Budapest that were involved in the desegregated health development pilot programme provide data which enable the NIHD to monitor the course of the programme.

In connection with the **Nursery Smoking Prevention Programme** (NIHD), 160 nurseries were involved in the programme, and 160 programme packages and 20,000 children's packages were produced and distributed to the nurseries. The results of the programme are being monitored.

As part of the further development of the **School Smoking Prevention Programme** (NIHD), new touchscreen devices (Portable Touchscreen Computers - known by the Hungarian acronym HÉSZ) were produced, and educational toolboxes, known as "James Bond cases", containing interactive tools, and adapted for Hungary on the basis of international models, were developed and tested in schools. Flash-based presentations (separately for children of grade 3-5 and grade 6-8) were produced for using the educational toolbox as a presentation, for communicating the professional content in a proper way and for ensuring it is implemented in an experiential way.

In 2007, the "Ciki a cigi" ("Ciggies are uncool") website was set up for three different target age groups (4-9, 10-15 and 15-20), receiving 7500 visitors per month.

6. Public health and epidemic safety

- **Vaccination programme**

There are presently age-based compulsory vaccinations for 10 infectious diseases (tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, anterior acuta, measles, rubella, mumps, invasive diseases caused by Haemophilus influenzae B, and hepatitis B), and the 13-valent pneumococcal conjugate vaccination for under-twos is also state financed and obligatorily recommended, but optional for families to decide.

The system of age-based compulsory vaccinations in Hungary, which has achieved outstanding levels of success, even by European standards, and the results attained in the area of diseases that may be prevented by vaccination, should be treated as a national treasure, and the costs of this system are our investment in the health of the next generation. The system of age-based compulsory vaccinations has resulted in a vaccination rate of ~99% of the population for whom vaccination is compulsory [for detailed statistics, see section 3), as the ECSR requested additional information in connection with the previous report]. The reduction in the number of infectious diseases that can be prevented by vaccination to its present level is a national treasure, which could be achieved with the development of medical science, the financial contribution of the different governments over the years, the commitment of health workers, and the support of the general public. Since the introduction of compulsory vaccinations - some 135 years ago - every government has been committed to maintaining the system of vaccinations, to applying it flexibly in line with the prevailing epidemiological situation, and to achieving further improvements and refinements in scientific progress.

Main principles of the system of age-based compulsory vaccinations:

- the vaccine is provided by the state free of charge to the population,
- the system is in line with the recommendations of the WHO and ECDC, the vaccines used are of exceptional quality, efficacy and safety, and the vaccinations are administered at the optimum age,
- access based on full equal opportunity is guaranteed, and
- state commitments and the stable regulatory background are provided.

- **Rapid reaction tasks**

The Office of the Chief Medical Officer of State (OTH) operates rapid reaction tasks in two areas, which are functionally and structurally distinct: the tasks of the Central Department for Rapid Reaction, and the tasks provided by the Department for Coordinating Emergency Patient Care - formerly the Central Hospital Bed management Department - which is outsourced. The rapid reaction activities - due to the nature of the task - are fully defined in the event of domestic crises and emergencies, or in the event of international emergencies which pose a threat to health. Tasks pertaining to dealing with the red sludge disaster were carried out as part of the domestic inter-sectoral tasks.

7. Equal opportunities for health

Since 2006, the National Disability Sport Alliance has held competitions for students with learning difficulties in four fields of sport, with the title "National Student Olympic Championships for students at schools providing education for people with learning difficulties".

- **"Crossing Bridges" (2011-2012) project**

The aim of the EU-supported NIHD project was to support the implementation of the concept of "Health in every professional policy", by formulating evidence-based methods and constructing capacity, and to promote inter-disciplinary cooperation in partner countries in order to foster health. Two working parties were formed to implement the complex

objectives. Hungary was represented on both working parties by the NIHD. Within the working party aimed at the methodological development of inter-disciplinary cooperation, in the "education" focus group, the partners, including the NIHD, prepared case studies on practices which came about through interdisciplinary cooperation and which take health criteria into consideration, and which also serve health objectives.

- **ENGENDER – Inventory of Good Practices in Europe for Promoting Gender Equity in Health**

Under this cooperation, involving eleven EU Member States, the task of the NIHD was to collect good practices of health development programmes undertaken in order to achieve gender equality, and to provide data about NGOs and their activities for compiling an international database. This contributed to international recognition for domestic good practices.

- **Equity Action**

The aim of this EU-supported NIHD project is to increase the knowledge base required in the struggle against health inequalities, and to foster cooperation among Member States. The project promotes the enrichment of professional experience in the struggle against health inequality, the mobilisation of domestic public healthcare resources, and the prioritising of the topic in professional decision-making processes in the health sector as well as other sectors.

8. Health development in everyday settings

The main health development programmes and competitions related to energy balance between 2008-2011 (NIHD)

2008	- 2nd "Közösen-könnyebben" ("Easier together") national lifestyle changing workplace team competition - Workplace energy balance / lifestyle changing pilot training - "Nagyranövök" ("I'm Going to Grow Up Big and Strong") internet forum for children about healthy lifestyles - Heart-Friendly Workplace competition, and related internet advice website - "Ten-thousand steps" NIHD Pilot Walking Club for pensioners living in the capital - Women's Running and Walking Club (pilot club in the capital)
2009	- 3rd "Közösen-könnyebben" ("Easier together") national lifestyle changing workplace team competition - Walking for healthier ageing (competition) - Workplace energy balance / lifestyle-changing training - "Nagyranövök" ("I'm Going to Grow Up Big and Strong") internet forum for children about healthy lifestyles - Heart-Friendly Workplace competition, and related internet advice website - "Ten-thousand steps" NIHD Pilot Walking Club for pensioners living in the capital - Women's Running and Walking Club (pilot club in the capital)
2010	- 4th "Közösen-könnyebben" ("Easier together") national lifestyle-changing workplace team competition - Walking for healthier ageing (competition) - Workplace energy balance / lifestyle changing training

	- "Nagyranövök" ("I'm Going to Grow Up Big and Strong") internet forum for children about healthy lifestyles - Heart-Friendly Workplace competition, and related internet advice website - "Ten-thousand steps" NIHD Pilot Walking Club for pensioners living in the capital - Women's Running and Walking Club (pilot club in the capital)
2011	- "Sport ambassador" training for sporty workplaces making an application - Workplace energy balance / lifestyle-changing training - "Nagyranövök" ("I'm Going to Grow Up Big and Strong") internet forum for children about healthy lifestyles - Heart-Friendly Workplace competition, and related internet advice website - "Ten-thousand steps" NIHD Pilot Walking Club for pensioners living in the capital - Women's Running and Walking Club (pilot club in the capital)

- **Health Development in the Workplace – "Közösen-könnyebben" ("Easier together") lifestyle changing workplace team competition (2008-2010)**

The aim of this programme, implemented in cooperation between the NIHD and the Society for Healthier Workplaces, is to support health development activities in workplace settings, and to reinforce the motivation among as wide a section of workers as possible to lead a healthy lifestyle.

Workplace energy balance training (2008-2011)

Under the NIHD training courses, workers found out about the balance between calorie intake (nutrition) and calorie expenditure (physical exercise) in workplace communities. The group at the workplace who took part in the training can influence other members of the workplace community in instigating lifestyle changes.

- **Programme for exercise among the elderly - health status improvements**

Common physical exercise, in the form of walking, as organised by the NIHD, reinforced more health-conscious attitudes among the ageing population in 2011. Before completing the distance, the event was supplemented with a variety of health-related programmes (presentations, counselling, health tests), and the events always involved local decision-makers, experts and the local media. In different parts of the country (e.g.: Budapest, Makó, Mágocs, Pusztaszabolcs, Győrújbarát) the organisation of the regional walking events was assisted by local pensioners' organisations and other NGOs, as well as experts from the public health professional administration bodies of the capital and county councils. Every event was an attention-raising step and a recruitment drive towards the creation of a national network of walking clubs for the elderly.

- **"Ten thousand steps" NIHD pilot Walking Club**

The NIHD Walking Club started out as part of the "Ten thousand steps Walking Programme", to provide an opportunity for the increasing number of elderly people among the population of Budapest to take part in walking together, in a club system to promote healthier daily lives. Club membership is free of charge, and open to every retired person. In order to promote a healthy lifestyle among the ageing population, the club activities begin with a common warm-

up, followed by walking at two different distances, completed with individual or group lifestyle counselling. Regular walking also promotes the realisation of self-help efforts.

- **The Move Europe (2006-2009) programme**

"Move Europe2 was the initiative of the European Network for Workplace Health Promotion (ENWHP), and approved by the European Commission. The project targeted the implementation of a comprehensive workplace health promotion campaign, and was supported by the EU Directorate General for Health and Consumers. In Hungary, the NIHD implemented the campaign, supported by professional and financial resources from the Ministry of Health. The European and national campaigns encouraged companies to achieve the objective of having "Healthy workers in healthy workplaces". The workplaces that completed the questionnaire were evaluated by an expert committee, who selected the best practices in workplace health promotion, as considered suitable in accordance with the criteria, which were translated into Hungarian. Workplaces receiving the title of best practice were awarded prizes in recognition of their achievements.

9. Nutrition policy

In line with the Public Health programme, and based on the WHO First Action Plan for Food and Nutrition Policy in Europe 2000-2005, the Hungarian National Nutrition Policy was issued in 2004. The primary objectives of the Nutrition Policy were set as reducing the risk of nutrition-related illness and improving the health status of the population. Building on the previous document, and in line with the priority nutrition and health objectives of the EU and WHO, the National Nutrition Policy Action Plan was drawn up, with the priority of a gradual reduction in child and teenage obesity, combined with a reduction in the incidence of non-infectious chronic conditions (mainly heart disease and blood circulation problems), for which obesity and being overweight are risk factors. Main areas of action:

1. making public canteen food more healthy;
2. improving the availability of healthy food options, and restricting the availability of foods which are not compatible with a healthy diet;
3. wide-reaching consumer information, and
4. monitoring and evaluation.

- **National roll-out of the HAPPY (Hungarian Aqua Promoting Programme in the Young) programme – the HAPPY Week (OÉTI)**

On the basis of the follow-up assessment of the Happy Programme, launched as a pilot programme in 2007 to promote the consumption of water, and targeting improvements in the awareness and fluid consumption habits of children, it was found that the intervention had achieved beneficial results in a relatively short period of time, both in the level of awareness among children and in their application of this knowledge in practice, regardless of socio-economic factors. The one-year follow-up assessment showed that positive changes had been maintained to a significant degree in the areas both of awareness and of nutritional habits, so the programme was rolled out more widely.

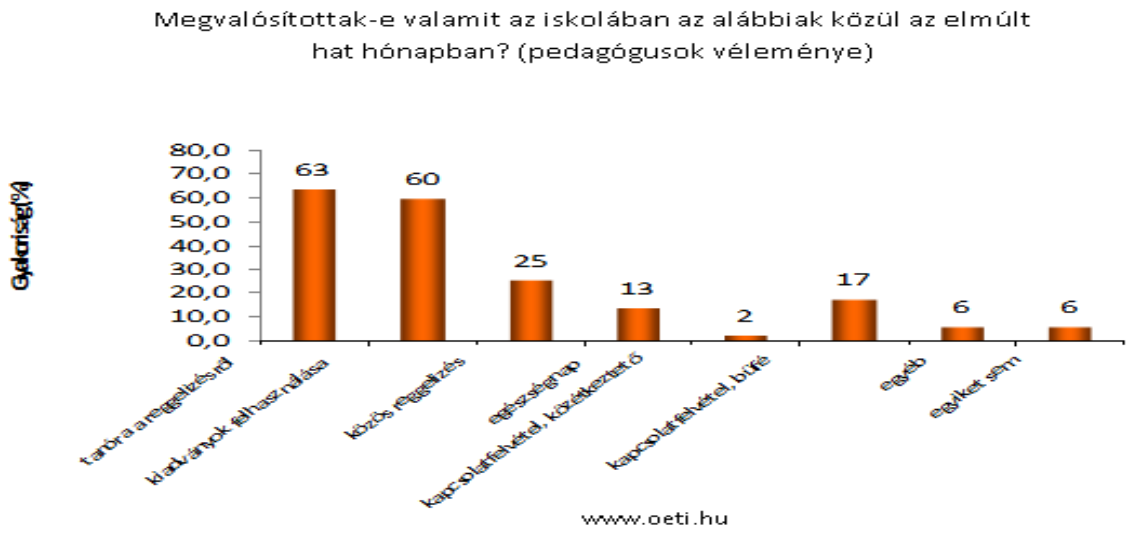
Between 2010-2011, the HAPPY Week advertised and coordinated by the OÉTI, was held on two occasions, with the objectives of reducing the excessive consumption of sugary drinks, which is one of the main risks to childhood obesity, and of popularising water as a drink,

among primary school children. The participants in the continuously expanding special health week can find out about the proper consumption of fluids with the help of 17 programme components - including interactive education packs - which can be downloaded from the OÉTI website. In 2010, 24,300 students took part in the programme, and 27,800 took part in 2011. Over the two years, supporters joining the programme provided drinking water facilities outside washrooms for 39,000 children during the HAPPY Weeks. According to the surveys conducted among teachers after the events, the HAPPY Week proved very popular among students, and almost without exception, schools judged the initiative as useful, and expressed a willingness to join the programme in future as well. Most of the components of the programme proved sustainable through self-financing (in the majority of participating institutions, even after the programme ended, training was given, drawing competitions were launched in the subject, and in a lot of places the restrictions in the canteen and drinks machines stayed in place); external support is only requested by institutions to provide free drinking water in the long term outside washrooms.

- **Formulation, pre-testing and follow-up of a school breakfast programme – The "Startolj reggelivel!" ("Start with Breakfast!") programme (OÉTI)**

In 2010 the OÉTI devised the pilot programme "Start with Breakfast!", which had the primary objective of effectively drawing attention to the importance of a healthy breakfast at national level, among primary school children. An additional objective was to assess the breakfast habits and awareness of students, their parents and their teachers, and to distribute basic nutritional information to parents, teachers and children. The 6-week programme was launched in September 2010, with the participation of students in 5th and 8th grades, and their teachers, in 14 intervention and 10 control primary schools, selected from 11 cities.

In line with earlier pilot programmes by the OÉTI, the "Start with Breakfast!" programme was built on education and on providing free, healthy options. Participants received uniform, 45-minute training from OÉTI dietary experts i the first week of the programme; the institutions received posters and leaflets, and over a six-week period, on every school day, students and their teachers together ate the free breakfasts put together by experts from OÉTI. The breakfasts were provided by 4 public canteen companies, in line with the conditions laid down by OÉTI. The closing event was held at the SYMA Hall, attended by 750 students and their teachers from 13 intervention schools. Over the six weeks, and at the closing event, more than 40,000 breakfast packs were distributed. The impact of the programme on awareness and on breakfast habits was evaluated before the programme, directly afterwards, and again six months later, using questionnaires. The evaluation that was conducted before the programme revealed some startling information about breakfast habits: on average, 20% of children consumed an energy drink for breakfast, but there were significant differences depending on the social status of schools. According to the survey, 40% of students and their families changed their breakfast habits as a result of the programme. The majority of the changes were the consumption of healthier breakfasts, a more varied diet, and taking breakfast several times a week. Teachers were able to implement a large part of the programme components in the subsequent period. The community building impact of the programme was highlighted frequently, as well as the fact that eating the same breakfast together eliminated the social differences among the students. In addition, the programme made a significant improvement to the amount of concentration shown by children in the morning lessons, and significantly reduced their complaints (hunger, headaches).



Legend to above chart:
TITLE: In the last six months, have any of the following taken place in your school? (teachers' answers)
VERTICAL: Incidence (%)
HORIZONTAL (FROM LEFT): lesson about breakfast; use of publications; common breakfast; health day; contact with the public canteen; contact with the buffet; other; none of these

- **STOP SÓ (STOP SALT) - National Salt Reduction Programme (OÉTI)**

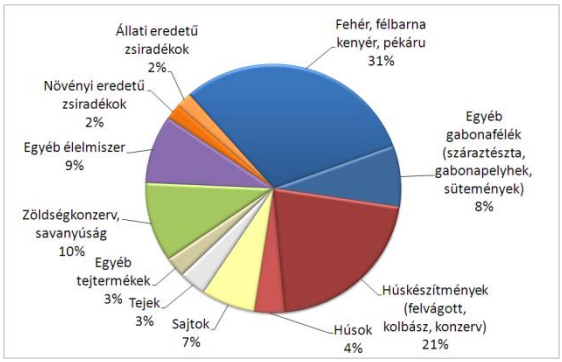
The correlation between high salt intake and cardiovascular disease is proven by a number of international studies. To reduce the incidence of nutrition-related diseases, it is essential to increase awareness among the population and - as an industrial social responsibility - to reduce the salt content in food. The present salt intake among the Hungarian adult population of 12-18 grams per day, three times the WHO recommended intake of 5 grams per day, is the highest rate among EU Member States. In 2008, therefore, Hungary joint the European Commission's salt reduction framework programme, and the National Salt Reduction Programme ("STOP SALT") was formulated under the coordination of the OÉTI. When joint the framework programme, Hungary made the commitment to achieve a 16% salt reduction within 4 years. To achieve this goal, it is necessary to conduct a nationwide situation analysis, to define the salt content of basic foodstuffs, to cooperate closely with industry and with public canteens, and to conduct a campaign of public information.

As part of the nationwide situation analysis, the OÉTI conducted a study on a non-representative sample of 200 people, with the aim of checking the data on salt intake among the adult (18-64) population produced by the National Nutrition and Nourishment Status Study of 2009 (OTÁP 2009), based on the internationally accepted "gold standard" of the amount of sodium excreted within 24 hours. The results of this study serve as a reference point for monitoring the effectiveness of the STOP SALT National Salt Reduction Programme. During the analysis, urine was collected over a 24-hour period, a one-day eating diary was kept, and a lifestyle questionnaire was completed. The results hardly differ from the Hungarian results of the Intersalt study conducted in the 1980s: salt excretion among men was 11.2g, and 9.6g among women.

Since the launch of the programme, data has been continuously collected on the salt content of food which is commercially available in Hungary, and food which is served in public canteens, in particular school canteens; on the basis of these data, the foods which play a significant role in population salt intake are being identified. Between 2009 and 2011, the Institute assessed the salt content in food samples from over 600 different product categories. It was found that the salt content of individual products varied greatly, even within categories. The salt content of bread and pastries, sliced meat and meat preparations is extremely high, even by international standards. The salt content of sauces, salad dressings, packet soups and spice mixes is extraordinarily high. The regularly updated list of foods measured for their salt content is available on the OÉTI website (www.oeti.hu), and on that of the salt reduction programme (www.stopso.hu).

As the main part of salt intake derives from processed foods and from meals served in public canteens, the OÉTI began negotiations with industry representatives, and is currently cooperating with several companies which market low-salt products, or which are considering their introduction, in the interests of commencing reformulation. So far, agreement has been reached with bakeries, who are committed to making a 10.7% reduction by 31 December 2014, and a further 5.3% reduction by 31 December 2017.

Proportion of processed foods in population salt intake



Legend to pie chart (clockwise from top): White or part wholemeal bread and pastries 31%; Other cereals (pasta, breakfast cereals, cakes) 8%; Processed meats (sliced meat, sausages, canned meat) 21%; Meat 4%; Cheese 7%; Milk 3%; Other dairy products 3%; Tinned and pickled vegetables 10%; Other foodstuffs 9%; Plant fats 2%; Animal fats 2%

In parallel with this, a public awareness campaign has also been organised, with the aim of promoting health-conscious shopping by giving information about the link between salt intake and hypertonia, and about recommended salt intakes. The awareness-raising campaign - conducted mainly through posters and leaflets, as well as free blood pressure tests combined with dietary counselling offered by colleagues of the OÉTI - has a continuous presence at events for professionals and the general public, including, among others, the screening truck stations of Hungary's comprehensive Health Protection Programme 2010-2020. The Institute has popularised the programme in Budapest and in Pest County on a number of health days and at professional events.

Among the significant measures taken to reduce population salt intake was the passing and enacting of Act CIII of 2011 on the public health product tax. The Act, drawn up using the professional background materials of the OÉTI, poses significant taxes on the manufacturers of foods with a high salt content. Another important milestone was the recommendation

issued by the Chief Medical Officer on 1st August 2011, titled "Nutritional health recommendation for public canteens on the organised supply of food which provides regular meals", which defines, among other things, the recommended daily salt limit to be used in public canteens.

- **Study of the rate of trans fatty acids**

Between 2008-2012, the OÉTI determined the content of industrially-produced trans fatty acids (TFA - derived from the partial hydrogenation of unsaturated fatty acids) in more than 700 foods and ready meals. Around 20% of the samples contained above 2g TFA per 100g of fat in the product, and in 7% the TFA content was extremely high, at more than 10g TFA per 100g of fat. It is typically low-priced foods and foods of low or medium quality, especially margarines, sweets and biscuits, that have significant industrially-produced TFA contents. Based on data from the National Nutrition and Nourishment Status Study (OTÁP 2009), conducted by the OÉTI, and on laboratory results, the estimated potential TFA intake of the Hungarian population may vary between 6mg and 6g (!). The estimated maximum TFA intake is higher than the WHO recommended daily intake (<2g), and in some cases is significantly higher than 5g/day, which poses a serious increase in the risk of CHD. It is known that the risk of cardiovascular disease that can be correlated with the consumption of trans fatty acids at a daily intake greater than 2E% is 4-5 times greater than the risk deriving from saturated fatty acids. The above data necessitated the drafting of legislation to set maximum limits on the amounts of TFA that may be used in foods. The draft legislation is currently undergoing public administrative and professional negotiations.

10. Preventing child accidents

Accidents in childhood and teenage pose a significant public health problem, because, as in other European countries, external causes of death, including accidents, are the leading cause of death in the 1-24 age group in Hungary. According to the 2012 report of the European Child Safety Alliance, in Hungary in 2009, 185 people aged 0-19 died as a consequence of an accident, and in 79 cases (43%), they would have survived if the child safety situation in Hungary were at the same level as that in the Netherlands, which is currently the safest country. It is known that the well-considered and consistent application of primary, secondary and tertiary prevention can significantly the number of child accidents, and moderate their severity and their consequences. The majority of accidents can be avoided with properly planned interventions. The high rate of death and the long-term consequences of accidents involving serious injuries drew the attention of international organisations to accident-prevention. Countless international experience and research proves that there is a way to significantly reduce the number of accidents involving serious injuries, and to moderate their consequences. For this reason, the WHO, the EU and the European Ministerial Conference on Environment and Health have for several years urged European countries to draw up national action plans, in line with the situation analysis of their country, to prevent child and youth accidents.

- **Hungary drew up the "National Child and Youth Safety Action Plan" in 2009, as part of the National Infant and Child Health Programme.**

Both planning and implementation presuppose multi-sector cooperation. The document is intended to prevent accidents in the 0-24 age group. It sets a target of a 30% reduction in accidental deaths over a ten-year period (2010-2019), and defines the tasks for the first three

years (2009-2012) as well as the method of measuring results. Mission: "National unity for better safety of children and young people." The programme is intended to more successfully prevent accidents with the most serious outcomes in a way which does not obstruct the healthy physical, psychological and social development of children. The action plan focuses on transport safety, safety in the home and in childcare institutions, safe toys and games, leisure and sport, and on harmonisation, monitoring and analysis of domestic accident-prevention activities. It is in line with the objectives of the Public Health Programme, the National Infant and Child Health Programme, the National Accident-Prevention Strategy and the Traffic Safety Action Programme, and its implementation also helps these programmes to achieve their aims.

- **Inter-ministerial Child Safety Council**

The Child Safety Council was set up in May 2011 to coordinate the work of the action plan.

- **Child Safety website**

A content providing child safety website was set up as part of the website of the NICH (National Institute for Child Health). The website provides information to four target groups (experts, parents, young people, children) on the frequency of various child accidents and on ways of preventing them. In addition to general information on child safety, the website deals separately with traffic accidents, focusing on accidents that may occur as a pedestrian, cyclist, motorcyclist, a car passenger and the driver of a vehicle. It provides information on ways of preventing suffocation, falling, burns, poisoning, choking and accidental strangling. It also provides information on accidents that can happen in the home, during sport and during play/leisure activities.

- **National Child and Youth Safety Action Plan website**

The website was created with the aim of informing both the professional and the general public about the aims of the action plan, the process of its preparation, its implementation, the work of the Child Safety Council and monitoring.

- **Child Safety Newsletter**

The aim of the Child Safety Newsletter is to provide information to professionals active in the different fields of child safety about the implementation of the National Child and Youth Safety Action Plan. The newsletter is distributed electronically to members of the Child Safety Council, who forward it to the experts practising in their own sectors, and it is also available on the NICH website.

- **Membership of the Global Road Safety Partnership**

For three years the NICH has participated in the work of the Hungarian GRSP organisation, which is the non-governmental umbrella organisation with an international network focusing on improving road safety. This year, a child safety working party was formed within the organisation. The working party is at present working on legislation to make it compulsory to wear a helmet while cycling, and on practical guidelines for operating KRESZ (Hungarian Highway Code, or road traffic rules) parks and mobile KRESZ parks.

Summary

The Child and Youth Safety Action Plan is a substantial product of domestic child safety activity, as it plans harmonised tasks for implementing inter-sector cooperation for ten years.

11. Environmental health

The following information is given about the work carried out under the "Decade for Health" Public Health Programme and the "Third National Environment Protection Programme 2009-2014":

11.1. Air quality

11.1.1. External air pollution

- **Situation analysis of air hygiene in Budapest and rural towns**

Since 1999, the ÁNTSZ (National Public Health and Medical Officer Service) has been responsible for regular studies of air pollution in towns from a public health aspect. The Department of Air Hygiene at the National Institute for Environmental Health (hereafter: NIEH) drew up a system of analysis with the aim of showing the expected health effects of brief exposure to continuously monitored air pollutants, in order to protect the health of the potentially affected population. In this way, advice can be given to people who suffer from cardiovascular and respiratory diseases, to the elderly, to children, and to people who react sensitively to deteriorations in air quality, in the hope that they will be able to plan their daily tasks with greater foresight. By observing the advice posted on the website, the expected acute health-damaging effects can be reduced.

The analysis of the air hygiene situation has been carried out daily since 2007 in Budapest, and since 2010 in 27 towns throughout the country, and the information is communicated to the public on the websites of the ÁNTSZ and of the Institute. The Air Hygiene Index (AHI) formulated and employed by them is an index defined on the basis of international and domestic professional literature and relevant legislation, showing the level of air pollution in the last 24 hours in terms of the basic pollutants, which are sulphur dioxide (SO2), nitrogen dioxide (NO2), carbon monoxide (CO), ozone (O3) and particulate matter (PM10). The calculation is based on the greatest concentration in 1 hour (SO2, NO2, CO), the maximum 8-hour mobile average (O3) and the 24-hour average concentration (PM10). The AHI system consists of four categories of air pollution. The first category (1) is acceptable, the second 82) is substandard, the third (3) is unhealthy and the fourth 84) is hazardous.

Ranges of individual categories (µg/m3)

AHI	SO_2	NO_2	CO	O_3	PM_{10}
1	0-249	0-99	0-9999	0-119	0-49
2	250-399	100-349	10000-19999	120-179	50-74
3	400-499	350-399	20000-29999	180-239	75-99
4	500<	400<	30 000<	240<	100<

Below EU threshold limits; Below notification threshold; Below alert threshold

Degree of expected health effects

AHI	air quality	colour code	expected acute health effects
1	**acceptable**		acceptable air quality, acceptable risk
2	**substandard**		slight effects, especially for people with air pollution sensitivity
3	**unhealthy**		significant effects, especially for people with air pollution sensitivity
4	**hazardous**		increased harmful health effects for anybody

Health advice for avoiding or reducing exposure

AHI	air quality	colour code	health advice
1	**acceptable**		No special advice
2	**substandard**		Restrict activity on busy routes
3	**unhealthy**		People with sensitivity may need to take personal protection (e.g. use of inhaler, reduction in time spent outdoors and avoidance of active physical exercise).
4	**hazardous**		Restrict time spent outdoors, and avoid outdoor exercise. Pay extreme attention to medical advice on taking medicines. Consult a doctor in case of any symptoms.

- **Smog alert decree**

In 2008, the NIEH Department of Air Hygiene drew up the notification and alert thresholds for smog alerts for particulate matter (PM10), which formed the basis of the recommendation prepared by the Institute on the threshold limits for an amendment to Joint Decree 14/2001 (May 09) by the Ministries for the Environment, for Health and for Agriculture and Rural Development on the threshold limits for air pollution and on the threshold limits for emissions from local sources of air pollutants. This work contributed to a reduction in the pollution of particulate matter (PM10), which is the main air pollutant in towns, during the period of air pollution episodes. The new regulation was contained in Decree 4/2011 (Jan. 14) of the Ministry for Rural Development on the threshold levels for air pollution and on the threshold limits for emissions from local sources of air pollutants, which entered into force on 15 January 2011.

As of 2011, 1 city in each of several counties of Hungary has its own smog alert decree: 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) and Szabolcs-Szatmár (Nyíregyháza 2010). Two counties have 2 cities each with their own smog alert Decrees: Győr-Moson-Sopron (Győr 2003, Sopron 2009) and Komárom-Esztergom (Tatabánya 2009, Dorog 2010). A smog alert decree was also approved in Veszprém in 2011.

In 2010, there were occasions when the mayors of the cities of Szeged, Miskolc, Salgótarján, Debrecen and Budapest used the local media (radio, TV, press) to inform the public about the local smog alert and the related restrictive measures (e.g.: reduction in the use of motor vehicles and of equipment that burns solid fuel and oil, suspension of work that causes emissions). Smog alerts were ordered in February and November 2011 in the majority of large cities (Pécs, Miskolc, Budapest, Szeged, Székesfehérvár, Győr, Debrecen, Eger, Nyíregyháza). The decrees most frequently stipulate the obligation to inform the public, but during alerts, they also contain bans on lighting fires, bans on demolitions, vehicle restrictions

and modernisation of fuel choices. Restrictions due to smog alerts were most often imposed in 2011 in Miskolc and Nyíregyháza. Information given to the public had a preventive effect on the health deterioration of population groups at risk.

- **Critical air pollutants**

The most typical pollutants in Hungarian towns and cities are nitrogen oxides (NO2, NOx) and particulate matter (smaller than 10 μm, PM10), and these are the pollutants whose values most frequently exceed permitted concentrations. A further problem is posed by ozone pollution, particularly in summer months. Measuring stations were set up mostly in areas where pollution is critical. While pollution levels can be significant close to busy routes, beyond a few hundred metres from them, concentrations are much lower. Where PM10 is concerned, today we know that its concentration is determined in many cases not by local, but by continental-regional processes, and combined with this, local conditions can also be described as very significant. Nitrogen dioxide emissions derive mostly from traffic, and to a lesser extent from power stations and (natural gas) burning. Emissions can be given in the format NOx, which, in the atmosphere, consist mostly of NO2. The formation of ozone pollution is a complex process, with peaks often occurring at significant distances from the sources of precursor emissions. The main source of these precursors is traffic.

Objective

With regard to nitrogen dioxide pollution, it is necessary to achieve the annual air hygiene standard, and with regard to particulate matter (PM10), the daily threshold limit should not be exceeded more than 35 times per year, and the annual pollution threshold limit should not be surpassed. For ozone, the long-term target figures should be achieved. Government Decree 1330/2011 (Oct. 12) on the inter-sectoral programme of measures for reducing small-size particulate matter (PM10) entered into force on 13 October 2011, and this Decree will help to reduce the rate of respiratory diseases caused by environmental particulate matter.

- **European Study of Cohorts on Air Pollution Effects-ESCAPE -2008-2012**

The NIEH Department of Air Hygiene carried out domestic air quality studies in line with the given protocol in 2010-2011 in the city of Győr. The regional work was conducted in three stages (winter, spring-autumn, summer), with samples taken of two fractions of particulate matter (PM10and PM2.5), and of nitrogen dioxide and nitrogen oxides. The PM study relied on samples taken at 20 points in every stage, while nitrogen compound samples were taken at 40 locations. Besides the air pollutant measurements, the tasks also comprised regular traffic counts, the definition of the coordinates of the measuring points, and the collection of data specified for the purpose of describing the environment surrounding the sample sites.

As a result of the combination of the stochastic model and the year-long regional measurements carried out under the ESCAPE project, the small-scale regional distribution of air pollution can be determined, which means - unlike previous practice - that current and retrospective air pollution levels in the residential environments of mothers taking part in the APREG programme can be determined, allowing a more precise estimate of the exposure of expectant mothers. It also means that scientific evidence is available for the review in 2013 of the healthy threshold limits for particulate matter.

- **Investigations carried out on air quality in areas of particular importance to children and youths who are particularly sensitive to air pollution: playground air environment study (2010-2011)**

The NIEH Department of Air Hygiene inspected the air environment of playgrounds in five different types of surroundings – close to roads with heavy traffic; far from roads with heavy traffic; close to roads with medium traffic, close to roads with light traffic, background. Nitrogen dioxide and benzene, which indicate the presence of traffic-originated air pollution, were used as the generally accepted indicators to classify the air quality. The inspections were carried out over a one-year period, with 2 one-week inspections carried out in each season. A total of 24 playgrounds were inspected in the Budapest area.

The results were evaluated in comparison with the level of burden and with the annual healthy threshold limits (NO2: 40µg/m3, benzene: 5µg/m3).

A comparison of the results of the inspections carried out on playgrounds in the five different types of surroundings found that the nitrogen dioxide burden is highest in playgrounds that are built close to roads with heavy traffic. The most favourable situation - as is to be expected - was found in playgrounds in surroundings which are close to roads with light traffic and in background surroundings. Exposure to benzene at levels which represent no risk to health was only measured in playgrounds located in background surroundings (green zones).

11.1.2. Indoor air quality

Scientific research in recent decades has drawn attention to the importance of indoor air quality, pointing out that under certain conditions, the air in homes, schools, offices and other community spaces (theatres, sports facilities, shopping centres, etc.) can be more polluted than environmental air. It is also highlighted that people spend 90% of their daily lives in buildings. Consequently, for many people, indoor exposure may pose a greater health risk than if they spent their time outdoors. Polluted indoor air poses a particular health risk to people who are already sensitive to air pollution, such as children, the elderly, and people suffering from chronic (especially respiratory and cardiovascular) conditions, because they tend to spend even more time than average inside buildings.

In accordance with section 4 (1) a) of Act XCVI of 1999, the ÁNTSZ is responsible for carrying out public health inspections of the air quality in enclosed spaces. In order to ensure the safe and healthy use of enclosed spaces, and to improve indoor air quality, under research programmes and individual inspections targeting the definition of threshold limits, and the formulation of minimum requirements for indoor air quality in new construction buildings, the Department of Air Hygiene at the NIEH carried out air quality measurements in different types of indoor spaces (office buildings, restaurants, homes and garages).

- **Coordination Action on Indoor Air Quality and Health Effects: ENVIE-2006-2008**

The Department of Air Hygiene at the NIEH evaluated, from a health policy aspect, the most important results of the research carried out under this project into the health effects caused by certain indoor air pollutants and mixes of pollutants. One objective was to assess the extent to which indoor air quality contributes to the increase in the number of people in Europe suffering from asthmatic and respiratory allergic diseases.

The analysis was grouped around three issues (exposure, health effects and sources of pollution). The analysis demonstrated clearly that tobacco smoke is a significant contributor to the indoor air burden of formaldehyde, aerosol particulates and polyaromatic hydrocarbons. Nicotine, regarded as an ETS indicator agent, is present in the greatest quantities in the air of discos. The lowest levels of nicotine exposure are faced by people in schools and passengers on public transport. It was found that without physical separation of space, there was no significant difference between the air pollution of designated smoking areas and that of non-smoking areas. The aerosol content of tobacco smoke was greater in workplaces than in homes. The greatest exposure was faced by family members who live and work together with smokers.

An important source of nitrogen dioxide in indoor air is gas cooking and heating equipment. Measurements taken inside homes show that the greatest concentrations were present in the kitchen. External sources had less influence on the air pollution of indoor spaces. Where carbon monoxide is concerned, the most exposed indoor spaces are garages. The lowest concentrations were measured in schools. Short-term peak concentrations varied within a wide range.

- **Indoor air quality in schools**

Research from the last few years has shown that the physical environment of schools may play an important role in the quality of children's performance at school. Leaking roofs, problems with the heating, ventilation and air conditioning, improper cleaning, or overuse of detergents and other materials used in maintenance, can all cause health problems - including asthma and allergies - which increase the risk of absence from school, and reduce students' performance. Improving the quality of the school environment can increase the performance and continued attendance of teachers and other staff.

Under targeted research programmes, the Department of Air Hygiene at the NIEH measures the air quality for epidemiological investigations, in order to assess exposure to indoor air pollution among children in educational establishments. The projects have the objectives of identifying the factors that pose a risk to health, and to limit and prevent effects which are detrimental to health, by examining the correlations between the indoor air quality of enclosed spaces where children spend a large portion of their day (schools and nurseries) and the health condition of children.

- **School Environment And Respiratory Health of Children: SEARCH-I.-2006-2009**

The objective of the project was to investigate the connections between exposure of children during lesson time and the respiratory health condition of children. Under the project, indoor air quality was inspected - in relation to environmental air pollution and identifying the most important sources of emissions. The programme was significant in that it marked the first occasion in Hungary when air quality measurements, combined with investigations into sources, were taken across such a wide spectrum in school environments, and also in the fact that the results could be assessed by international comparison.

10 nominated schools across the country took part in the programme, and inspections were carried out in a total of 43 classrooms. During the inspections, using a one-teaching-day monitoring method, the air of the classrooms was checked for concentrations of carbon

dioxide, carbon monoxide and particulate matter (PM10), and the temperature and relative humidity were also measured. 3-4 day average pollution of formaldehyde, nitrogen dioxide and aromatic organic hydrocarbons (BTEX) were determined using passive technology. At the same time as the indoor measurements were taken, the outdoor air quality was also measured. A task diary was kept to identify the causes of internal air pollution.

In the absence of indoor threshold limits, the inspection results were evaluated in comparison with environmental air pollution. The concentration of formaldehyde in classroom exceeded the level measured in environmental air in every case, but the measured values were very low (2-6µg/m3). The air of the classrooms under investigation was also only polluted at a low level (on average: 16µg/m3) by nitrogen dioxide, and - in all but two classrooms - around 80% of the level was made up of the external burden. A concentration of xylene below 10µg/m3 was measured in 80% of classrooms. The median was 2.9 µg/m3, but the upper limit of the pollution levels experienced was 69µg/m3, which can be attributed, to a high degree of probability, to the carpets covering the floor. The indoor xylene burden was considerably higher than the concentration measured in environmental air (average: 1.7µg/m3). The higher than average concentration of ethylbenzene (12.9 µg/m3 compared with an average of 1.6 µg/m3) also derived from the same source. The median value for toluene concentrations was 3.2µg/m3, in a range between 1.0 - 21.4 µg/m3. The highest level was measured in a classroom with a plastic floor covering. The indoor (0.4-5.9 µg/m3) and outdoor (0.3-4.8 µg/m3) concentrations of benzene pollution were at a similar level, except in one school, where an indoor concentration was measured which was 4.5 times higher than the environmental level, and where the walls had been painted in the previous year using oil-based paint. The particulate matter (PM10) burden in the air of classrooms varied within a very wide range (9-115µg/m3). The level of pollution depended (R=0.79) on the external burden. Concentrations of particulate matter were lower than 50µg/m3 in half of the classrooms, while in four classrooms, the average pollution registered during teaching time exceeded 100µg/m3. It was established that the level of pollution was determined primarily by the activity of the children (the greatest short-term value -200µg/m3 - was measured in the break between lessons). Carbon dioxide measurements, which provide information on the fresh air supply in the classroom, showed that even at the start of teaching, the quantity of carbon dioxide was higher in the air of the classrooms (1000ppm) than in that of the environment (440ppm). It was also found that the concentration of carbon dioxide depended not only on the efficiency of the ventilation, but on the headcount of children, the area of the classroom, the number of open windows and the length of time they were open. It was established that indoor air quality is significantly influenced by the material of the fittings, the activity and number of children, the environmental air, and the amount and frequency of ventilation. The recommendation was made that, during winter months, thorough ventilation at the end of the teaching period, and, the next day, opening the windows for a short time (5-10 minutes) in the breaks between lessons would be the best way of ensuring fresh air in classrooms. A high rate of ventilation reduces the spread of germs, and frequent ventilation is of especial importance during the influenza season. Carpeted floors, plastic floor coverings and oil-based wall paints should be avoided, and it is recommended to regulate heating both in order to conserve energy and in order to maintain a proper level of relative humidity. More efficient cleaning and the use of a change of footwear would promote reductions in the aerosol burden. More attention should be paid to using more moderate cleaning agents, and those which have a neutral chemical impact. Painting and the laying and renovation of

wooden floors should be done during the summer holidays, with intensive ventilation, with careful attention paid to the selection of paints, varnishes and adhesives.

- **Schools Indoor Pollution and Health: Observatory Network in Europe - SINPHONIE-2010-2012**

With the participation of 30 institutes from 24 countries, the project examines the role played by outdoor environmental and indoor sources of pollution in the formation of school indoor pollution; the objective is to investigate the links between the school environment and the health condition of children (in particular with regard to respiratory health) and to formulate recommendations for improving the quality of the school environment. In each country, 3 classrooms in 5-6 contrastively selected schools are measured for temperature, relative humidity, particulate matter (PM10 and PM2.5), NO2, formaldehyde, CO, CO2, benzene, xylenes, toluene, trichloroethylene, tetrachloroethylene, naphthalene, pinene, limonene, radon, ozone and BaP concentrations, the endotoxin content of settled particulates and the presence of mould, and an energy use report was prepared. The health condition of the children attending the classrooms that came under inspection was assessed partly from the questionnaires completed by their parents, and partly with the help of respiratory function and other functional tests. Evaluation of the results of the investigation took place in September 2012, after the full programme had been completed. This provided a transparent picture of the indoor concentrations of different air pollutants, as measured in approximately 360 classrooms in 120 schools in Europe, as well as an overview of the health condition of more than 7000 children aged 8-10, who attend the classrooms that came under inspection. Based on the findings and conclusions drawn about the links between the school environment and child health, guidelines were drawn up for a healthy school environment.

- **School Environment And Respiratory Health of Children: SEARCH-II - 2010-2013**

The aim of the project is to evaluate the links between the school environment and respiratory diseases among children, and to make recommendation based on the results in order to improve the school environment. The project promotes the implementation of the EU Environment and Health Action Plan and the regional priority goal 3 of CEHAPE. Expected results: A confirmation of the links found in the SEARCH-I project - indoor air quality is influenced significantly by the materials of the fittings, the number and activity of the children, the environmental air and the amount and frequency of ventilation - as well as an expansion of the recommendations formed as a result, and the provision of a scientific foundation for the indoor pollution threshold limits, to be incorporated into regulations governing institutions for children.

- **Results of the indoor air quality studies carried out in office buildings, catering industry establishments and homes/garages in Budapest**

In a majority of the studies, the following generally used pollutants and physical parameters were measured to determine indoor air quality. The measurements were taken at the breathing height of people present in the spaces, and care was taken to avoid the influence of direct effects on the site measurements and samples. Where justified, the air technology system was also inspected, and the health condition of the people concerned was also assessed.

- ✓ *Chemical components:* carbon-monoxide (CO), carbon-dioxide (CO2), nitrogen-dioxide (NO2), formaldehyde (HCHO), aromatic hydrocarbons: benzene, toluene, ethylbenzene, xylene (BTEX), atmospheric particulate matter (PM10)
- ✓ *Biological agents:* fungi, all bacteria, Legionella sp. bacteria
- ✓ *Physical parameters*: temperature (T), relative humidity (RH)
- ✓ *Air technology system inspections:* air movement, quantity of air coming in, the central air management work station, the condition and level of maintenance of certain components of the air management system
- ✓ *Health assessment:* situation analysis

Restaurants

At the initiative of the Health Ministry, in 2008, site inspections were carried out at 9 catering industry establishments (restaurants and cafés) in the central and Ferencváros districts of Budapest, to check that the provisions of the Non-smoking Act are being observed. Every establishment had smoking and non-smoking areas, and tobacco smoke extraction equipment. To provide uniform inspection conditions, the inspections all began by measuring the basic burden, and then 5-7 cigarettes were burned in order to provide a suitable level of smoke. While the cigarettes were burning, the aerosol concentration was measured, and measurements were taken again after ten minutes. The results were as follows:

- During the measurements, the basic burden of the fraction of particulate matter smaller than 10μm in indoor spaces ranged between 10-30μg/m3.
- It was found that, when 6-7 cigarettes were burning in smoking areas, a PM10 pollution level of 250-450μg/m3 was measured, which fell after ~10 minutes by 70-80% to a level of approx. 60μg/m3.
- It was observed that in small places with poor internal arrangement possibilities, the particulate matter (PM10) was constantly high, at around 200-400μg/m3.
- In non-smoking areas, there was a PM10 concentration of 40-80μg/m3, which decreased to half of that after ~10 minutes.

Offices

The following links were found between the indoor air quality of offices and the health condition of the people working there:

- The vast majority of common symptoms (those affecting many people with high regularity) are alleviated or disappear completely when outside the workplace, which indicates that the workplace circumstances play a role in causing or sustaining these symptoms.
- The most frequently occurring so-called neurotic symptoms among workers can be explained, with a high degree of probability, by the poor supply of fresh air. It is well known that as the air is breathed, it gets used up and its composition deteriorates: there is an increase in both the carbon dioxide concentration and the content of water vapour. In such places, people are less capable of concentration, become tired or exhausted more quickly, and experience headaches. These symptoms, however, are not directly correlated to the carbon dioxide content measured in such places, as only 13% of the pollutants found in indoor air derive from a human-originated source of pollution. The results of the measurements of carbon dioxide concentrations only permit conclusions concerning the efficiency of ventilation.

- The additional symptoms occurring among more than half of the workers (dry nose and throat, dry or itchy eyes and skin symptoms) are probably related to the low relative humidity. As far as health is concerned, the optimum relative humidity of air is 50%, and the further away from this level, both above and below, the higher the health risk.
- Certain non-specific, but still frequent, hypersensitivity reaction symptoms (dry cough, running nose, lacrimation) may also be caused or sustained, at least in part, by aromatic organic pollutants (e.g. formaldehyde, benzene, xylene, toluene) contained in certain insulation materials, adhesives and wall, floor and ceiling coverings.

Homes

The indoor air quality in homes is of particular importance to children, the elderly and the chronically ill, as they spent more than 90% of their time at home. It can occur, however, that an individual home can have a higher level of pollution than the environmental air. The Department of Air Hygiene undertook inspections of the air quality of living spaces on the basis of complaints reported by residents, with the aim of determining the indoor pollution related to the use of common garages. Among the aromatic organic hydrocarbons that were measured, the level of benzene pollution, which is of particular importance concerning health, in two homes (11.6-16.8 μg/m3) exceeded the related healthy threshold limit for environmental air (10μg/m3). In garages, benzene pollution ranged from 213-216μg/m3, toluene was between 514-524μg/m3, ethylbenzene was between 130-135μg/m3 and xylene concentration ranged from 436-448μg/m3. This is on average 100 times greater than the level of pollution in environmental air. It was clearly established that the aromatic organic hydrocarbons present in the air of living spaces entered the homes with the air coming from the commonly used garage of the residents - primarily through the stairwell. With closed windows and doors, with 3 cars parked, the carbon-monoxide burden was five times greater (49ppm) than the permitted level for environmental air. When another car arrived, this increased the carbon-monoxide concentration a further 10ppm. If windows were continuously open, the ventilation reduced the level of pollution; with two parked cars, and door and garage door closed, the average was 12ppm. On the 1st floor of the stairwell, similarly high levels of organic hydrocarbon pollution (benzene (176μg/m3), toluene (405μg/m3), ethylbenzene (102μg/m3) and xylenes (334μg/m3)) were experienced. These concentrations arose from the habitual use of the garage and the stairwell. The level of carbon-monoxide pollution in the stairwell was determined by the position of the doors and windows in the garage and the stairwell. With closed garage doors and windows, the carbon-monoxide concentration on the 1st floor was 15ppm, but when the windows in the garage and stairwell had been open, the concentration was below the lower limit. Based on the inspections, the recommendation was made that the air quality of homes above common garages should be inspected as part of the permit-granting process. The only solution for achieving an effective reduction in the indoor air pollution of garages is to include air quality criteria among the planning requirements for common garages.

- **Establishing air quality standards in enclosed places**

There is no domestic or EU legislation governing the concentration of air pollutants in the air of enclosed places. There are also no Decrees in force which include public health conditions concerning indoor spaces, or the building permits or operation of individual buildings, building work or construction activities. Because there is no legislation empowering them to

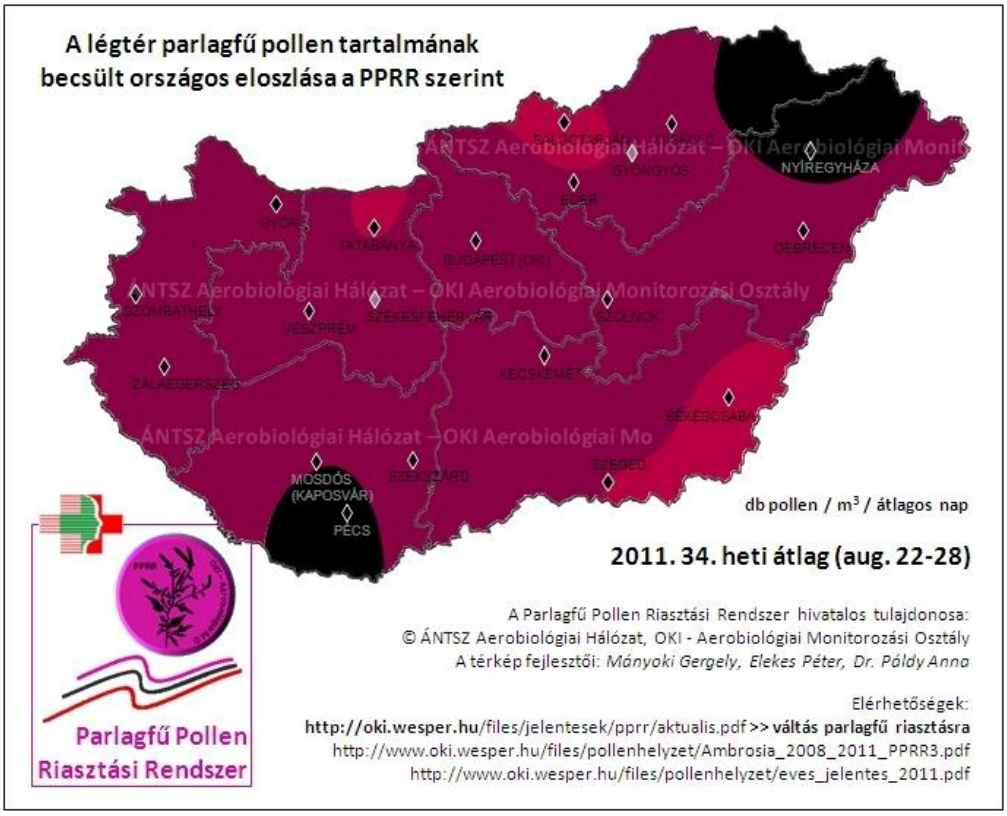
do so, public health authorities currently have no power to proceed as a professional authority, or to formulate an official public health opinion, with regard to public education institutes (nurseries, primary and secondary schools, vocational and grammar schools, dormitories) or during operating permit-granting procedures for residential and office premises. The draft Decree on the "public health requirements for the design, construction and operation of buildings", currently in preparation, contains, among other things, provisions for the threshold limits of indoor air quality, biological allergens in indoor places, the permitted quantity of bacteria in indoor places and air quality in vehicle storage areas.

11.2. Aerobiology

Aerobiological monitoring is done by collecting data using objective methods, and there are series of data from a number of years which give reason to assume that there is a direct correlation between the aerobiological data on the pollen content in the air and on population pollen exposure, on the one hand, and the risk to the population, on the other, as there is between the spread, mass and stages of development of ragweed (Ambrosia sp.). A comparison of the results of pollen monitoring studies shows a close link with the coverage of ragweed, so the pollen data were used to define the areas in need of intensified eradication of ragweed. Pollen monitoring data can be used to follow up and evaluate the efficacy of the ragweed eradication programme. Continuous aerobiological data collection is carried out by the Aerobiological Network, which covers the whole country, and in 2011, data on airborne allergens were collected, analysed and evaluated weekly at 18 stations. The data are also processed by the NIEH, who are also responsible for the publication of the official report on aerobiology (concerning pollen and fungal spores). The COST Programme EUPOL (ES0603) was concluded in 2011, which had the objective of studying the health effects of plants which produce allergenic pollen, as well as their spread, their pollen distribution, and their yield. The programme included the launch of a campaign for volunteer sufferers of ragweed allergy to keep a daily diary of their symptoms. The questionnaire was translated into Hungarian, which meant that data collection could also begin in Hungary in 2012. Further information about the questionnaire and the survey that is under way can be obtained on the website www.polleninfo.org. The indicators for monitoring the effects of climate change, devised in 2010 in cooperation with the WHO/ECEH Bonni Office, were further developed under the EC DG Sanco-supported UNIPHE programme. Four indicator taxons were selected for investigating the afore-mentioned correlations alder, birch, grasses and ragweed. The climate indicators present the start and end of the season, the duration of the season, the total annual pollen burden and the population-weighted pollen burden, and the data and analyses are available on the programme website. In 2012, the website became accessible at a new address, with some content in Hungarian (http://data.uniphe.eu).

The Ragweed Pollen Alert System (PPRR) was developed in 2011 in Hungary, and improved in 2012. This system enables more effective and more reliable estimates of the distribution of airborne ragweed pollen concentrations in the country, as well as at measuring stations which are close to the country's borders. The maps of the PPRR reports that appear every week during the season (showing the typical concentration distribution for the given week, with the week-on-week changes shown by displaying several maps together) show the average of the daily pollen concentration counts measured at the 19 stations of the ÁNTSZ Aerobiological Network. For people with an allergy to ragweed, the ragweed season begins when the daily concentration count reaches or exceeds the level at which symptoms appear.

To provide information to the general public, during the ragweed season, constantly updated pollen count information is posted on the website oki.antsz.hu. The report appeared on the website www.antsz.hu and also on Facebook (facebook.com/tisztiorvos). The Network provides detailed pollen data to the European Allergy Network (EAN), and the Hungarian data can also be read on the website www.polleninfo.org.



Airborne ragweed pollen concentrations, estimated national distribution (PPRR – Ragweed Pollen Alert System)

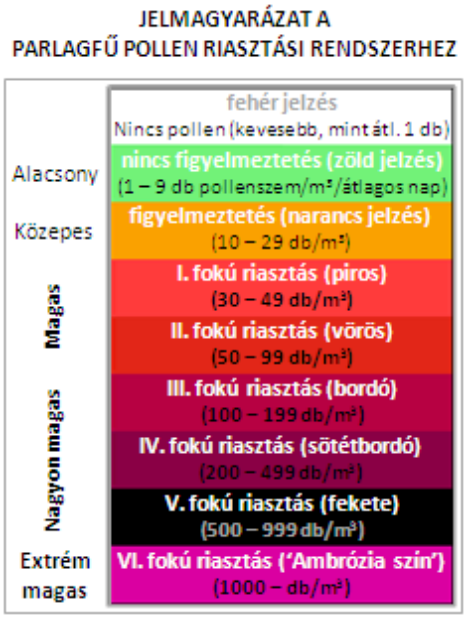
pollen count per m³ per average day

weekly average for week 34, 2011 (Aug. 22-28)

Official owner of the PPRR: © ÁNTSZ Aerobiological Network, NIEH Aerobiological Monitoring Department

Map developed by: Gergely Mányoki, Péter Elekes, Dr. Anna Páldy

Contact details: (three websites given)



KEY TO THE RAGWEED POLLEN ALERT SYSTEM
(pc. = pollen count)

left column	right column
	WHITE – No pollen (less than ave. 1)
Low	GREEN – no warning (1-9 pc./ m³/ave. day)
Medium	ORANGE – warning (10-29 pc./ m³)
High	PALE RED – alert level I (30-49 pc./ m³)
	BRIGHT RED –level II (50-99 pc./ m³)
Very high	BURGUNDY –level III (100-199 pc./ m³)
	DARK PURPLE –level IV (200-499 pc./ m³)
	BLACK – alert level V (500-999 pc./ m³)
Extremely high	'AMBROSIA'– level VI (1000+ pc./ m³)

11.3. Water quality

11.3.1. Drinking water

The most important regulations entering into force during the reporting period (including their expected or achieved effects)

- **Act CCIX of 2011 on water utility services**

The Act provides a new framework for authorising, monitoring and operating water utilities. The main public health benefit expected from the legislation derives from merging small water utilities, which will result in service providers being created which serve populations of a size of 200,000 people. This is expected to bring about higher levels of training and expertise among operators, and in consequence of this, stricter operating discipline.

Practical implementation of public health regulations (projects and programmes)

- **Safe drinking water for all**

The Programme to Improve the Quality of Drinking Water was launched in 2007 as part of the KEOP framework programme (KEOP-1.3.0 between 2007-2010, KEOP-7.1.0 from 2011). The objective of the Programme is to provide support to investments that use EU funds to improve the quality of the drinking water in towns and villages whose water quality is substandard from the point of view of the priority drinking water quality parameters. In the first round of the call for proposals, the intensity of the support was 90%, and under the terms of Government Decree 1224/2011 (Jun. 29), the state provided the 10% self-funded part, after which the support reached 100%. The support was awarded on the basis of a public health priority, and towns and villages were entitled to participate where the drinking water showed levels above the permitted thresholds for arsenic, boron, fluoride, nitrites and ammonium, as defined in EU directive 98/83/EC on drinking water. A total of 1286 towns and villages (approximately 2.5 million people) were affected by the Programme. At the end of 2011, investments to improve drinking water quality were already under way in 513 towns and villages (affecting a total population of 1.9 million). As a result of the interventions and the awareness-raising campaign, there has been a significant decrease, during the reporting period, in the number of towns and villages with substandard quality drinking water, and the number of people affected.

Changes in the number of towns and the population affected by substandard primary priority water quality in the reporting period:

	2008		2009		2010		2011	
Parameter	**Number of towns**	**Affected population**	**Number of towns**	**Affected population**	**Number of towns**	**Affected population**	**Number of towns**	**Affected population**
Arsenic	411	1425843	412	1235160	343	839706	305	755962
Boron	49	109012	37	78945	38	73744	25	52884
Fluoride	10	9394	5	3131	3	2595	3	2523

- **Nitrite Action**

The action was launched in 2007, and implemented in every year of the reporting period. As part of the programme, the public health authority ordered increased nitrite monitoring in towns and villages whose drinking water repeatedly showed unacceptable levels of nitrites. If the threshold limit was surpassed, the service provider was obliged to take correction measures (e.,. network cleaning, disinfection, technology review), to inform the population, and in justified cases, to provide sensitive population groups with healthy drinking water in the form of temporary water supplies. The Nitrite Action demonstrated that nitrite non-conformity is a problem that can be resolved temporarily with proper measures. There were no incidents of methemoglobinemia related to public utility drinking water during the reporting period. During 2011, the NIEH formulated a complex system of quality criteria, which uses a risk-based approach, for evaluating drinking water quality data. This system of criteria constitutes the basis for national drinking water quality reports. A review of the drinking water quality reporting system between water utilities, the public health authority and the central drinking water database was begun in 2011.

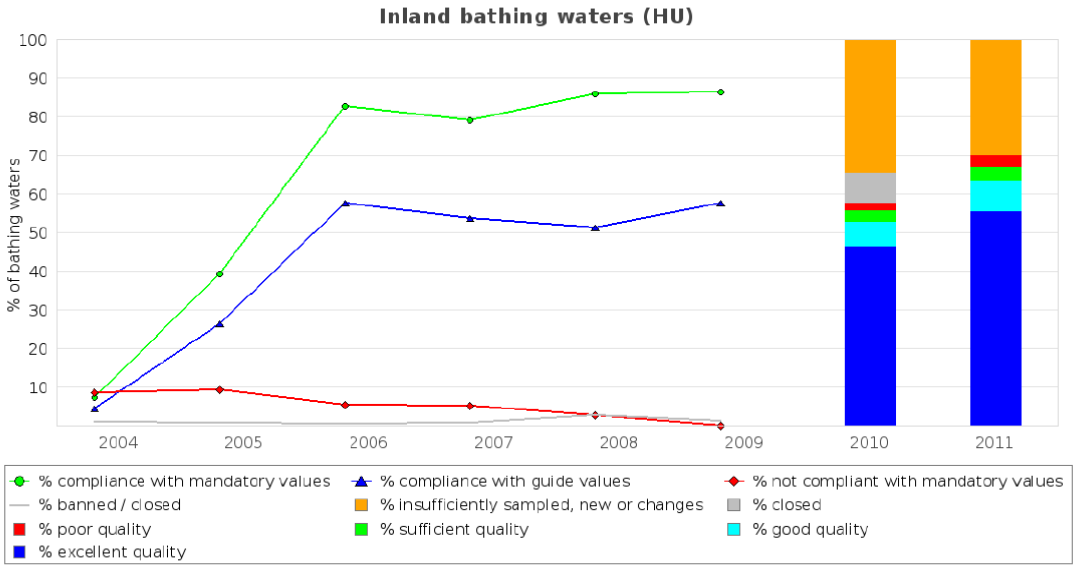
Other water-related activities

With the support of the GVOP framework programme for calls for proposals, a methodological toolbox was developed which enables previously untested water-borne pathogens (viruses, bacteria, protozoa) to be detected in the environment, and which forms the basis of an environmental (drinking and bathing water) surveillance system.

11.3.2. Bathing water

Government Decree 78/2008 (Apr. 03) transposes EU Directive 2006/7/EC on bathing water into Hungarian law. The monitoring system and water quality evaluation required by the Directive have been introduced. Bathing waters are designated in line with the Directive, and the bathing water profiles for every licensed bathing water site were prepared during 2011. In sum, the new regulation represents a comprehensive, risk-based approach to the surveillance of natural bathing waters. The quality of natural bathing water is reported to the EU every year via the WISE data collection system. The proportion of public beaches classified as excellent or good is growing continuously, although there are still shortfalls in the frequency of monitoring (fig. 1).

"Bathing water inventory" In 2008, the NIEH set up a national register of bathing water sites using the data provided by public health institutes. This register may form the basis of a future national quality database of bathing water sites.



The quality of natural inland bathing waters in Hungary 2004-2011. From the EEA 2011 Bathing Water Report

11.4. Soil and waste hygiene

In the most recent period - due mainly to support received from EU funds - significant improvements have been made in sewage treatment and communal waste management. Among the unfortunate consequences of the economic crisis, however, people living in disadvantaged social circumstances are increasingly frequently unable to pay their public utility charges, including the wastewater and refuse disposal charges. An increasing number of complaints are reported to the public health authorities concerning the improper attitude of a small section of the population (burning or dumping of communal waste, accumulating it on property, or treating it without a permit). A similar increase in such reports is experienced by the office of the Commissioner of Human Rights. The deterioration in local air and soil quality, caused by burning waste illegally and by burning waste which should not be burned, not only affects people living in disadvantaged social circumstance and their families - including young children, but also affects families in the wider community. In many cases, people living in disadvantaged social circumstances burn waste as a source of heating in winter.

- **Healthy environment at playgrounds**

In the last few years, the Department of Soil Hygiene at the NIEH has carried out several microbiological hygiene inspections at children's playgrounds, using soil samples taken from sandpits, and the results of these inspections clearly demonstrates the importance of carrying out microbiological hygiene tests. Several recommendations have been formulated as a result of these inspections:

- The builder and/or installer of a playground should ensure that the soil in the playground is at a suitable microbiological hygiene level, and the operator or maintainer of the playground should ensure continuous soil quality maintenance after the playground is opened.
- When selecting the site for a playground, preliminary public health monitoring of the site and a microbiological hygiene inspection of the soil of the planned site should be given high priority among the selection criteria.

- The sample at the planned site should only be taken and processed by a laboratory which has the required accreditation.
- When preparing the area for the playground, the area must be physically cleaned to a depth of 40 cm to remove glass fragments and other objects which can cause cuts and all branches and other objects which can cause falls and other accidents.
- Playgrounds should be constructed so that the soil is easy to manage and maintain from a public health aspect.
- Playgrounds should be surrounded by a perimeter fence and fitted with a lockable gate, which should be locked at the end of each day.
- Depending on the size of the playground, waste receptacles that can be easily emptied and cleaned should be placed within the playground, and they should be emptied daily by the maintainer.
- Dogs are not allowed in any part of the playground.
- Particular attention should be devoted by the maintainer and operator of the playground to the sand and soil of the sandpit, and to the sandy soil located beneath playground equipment for the purpose of reducing the impact of falls, to ensure the proper level of soil hygiene.
    - Sandpits should be fitted with a weather-resistant cover. When the playground is locked at the end of the day, the sandpit should be covered every day.
    - If justified by the exposure and condition of the soil in the sandpit, the sand and the soil in the sandpit must be changed immediately, but in order to preserve the health of the children playing there, it is recommended to carry out a microbiological hygiene inspection of the sand at least annually, at two different depths (close to the surface between 0-10 cm and at a depth of 10-20 cm).

11.5. Applying environment and health indicators

The Fifth Ministerial Conference on Environment and Health (Parma, 2010) agreed on the importance of harmonising the handling of data on the environment and health, and of producing regular overviews and evaluation reports based on environmental and health indicators. With the support of the EU and the significant contribution of the National Institute for Public Health (hereafter: NIPH), a regional level European information system was developed (UNIPHE) by 2012, which includes several indicators related to child health (e.g. infant mortality, traffic and other accidents, leukaemia). The system is also available in Hungarian at http://data.uniphe.eu, where data is presented alongside an overview of the legislation, strategies and action plans of selected topics.

3) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested detailed information about air pollution studies and on the results achieved in reducing air pollution.***

For detailed information and data, see section 11.1 in part 2).

- ***The ECSR requested information on whether there is any obligation to remove asbestos which has proved to be present in public buildings.***

Hungary, as an EU Member State, observes section 6 of Annex XVII of Regulation (EC) No 1907/2006 in the restriction of asbestos and of goods containing certain asbestos fibres. The manufacture, placing on the market and use of these fibres and of articles containing these fibres added intentionally is prohibited. However, member States may except the placing on the market and use of diaphragms containing chrysotile (point (f)) for existing electrolysis installations until they reach the end of the service life, or until suitable asbestos-free alternatives become available, whichever is the sooner. The use of articles containing asbestos which were already installed and/or in service before 1 January 2005 shall continue to be permitted until they are disposed of or reach the end of their service life.

- ***The ECSR requested further information on the issue of ionising radiation.***

Radiation protection means protecting humans from the harmful effects of the radiation burden deriving from ionising radiation, and the system of instruments for doing so. Radiation protection may not be directed at restricting useful activities, and radiation protection indeed promotes the application of useful activities in order to create security. The state is responsible for creating the regulatory background and authority system of radiation protection. In Hungary, the minister with responsibility for health is responsible for population and occupational radiation protection.

The majority of workplace radiation sources come from X-ray devices, with a smaller, but still significant part deriving from sealed radioactive sources of radiation. Open radioactive sources of radiation are used in isotope laboratories. A smaller, but important group of devices producing ionising radiation is that of accelerators. The unit number registration of workplace units that use ionising radiation, and their classification according to workplace and field of application, are carried out in line with Hungary's fundamental safety regulation, Decree 16/2000 (Jun. 08) of the Ministry of Health. Based on the authorities working report of 2011 on workplace radiation health activities, the number of registered workplace units was almost unchanged from 2010, at 6,078 units in 2011.

Among the fields of application, medical radiological diagnosis remained the dominant application, in terms of the number of units, the number of people employed there, and the population radiation burden deriving from artificial sources. Around 80% of registered units are in the field of medical applications of ionising radiation. In 2011, operating permits were held by 4639 doctor, dentist and veterinary surgeon X-ray workplaces, 26 therapeutic workplaces, 21 medical accelerators, and 154 medical isotope laboratory units. 20.5% of registered units (1246 units) are industrial workplaces. Among industrial applications, the main fields of application are: radiographic workplaces (297 units), measuring and regulating equipment operating with sealed radiation sources (170 units) and substance and fine structure examination equipment (136 units). There are smaller quantities of accelerators used for industrial and research purposes (31 units) and industrial irradiators (17 units).

The task of the radiation protection (radiological health) authorities is to grant permits for sources of ionising radiation, workplace applications and workplaces involving radiation, and to provide comprehensive monitoring and inspections. The county centres for radiological health, which carry out authority tasks related to workplace radiation protection and

radiological health, in accordance with Government Decree 323/2010 (Dec. 27), were transferred to the public health professional administrative bodies of the county and capital councils in 2011. The professional direction of the county centres is carried out by National Office of the Chief Medical Officer at the ÁNTSZ, with the involvement of the Frédéric Joliot-Curie National Research Institute for Radiobiology and Radiohygiene (hereafter: OSSKI). OSSKI performs professional advisory and consultation tasks in a variety of areas, on which authority decisions are based, and the National Radiological Health Stand-by Service and the National Personal Dosimetry Service also operate under OSSKI.

Part of the national infrastructure for radiological health is made up of the National Radiological Health Stand-by Service, which is ready, 24 hours a day, to receive reports of extraordinary events in any part of the country related to sources of ionising radiation, and to take the necessary measures. In 2011, the Service, operating within OSSKI, received 23 reports on the basis of alerts at the radiation gates established on the borders, of which three proved to have been caused by genuine sources of radiation or radioactive substances. In five instances, radioactive substances were transported to OSSKI. The Stand-by Service carried out radiation source identification in two cases, and also took proceedings in four additional cases.

The authority tasks related to public administration procedures initiated in connection with the use of atomic energy were carried out by the police, in line with previous years. When Government Decree 190/2011 (Sep. 19) entered into force, the police ceased their professional authority operations in radiological health procedures, and at the same time, the Hungarian Atomic Energy Agency (hereafter: HAEA) launched their independent physical protection permit procedure, which still prescribes the professional authority cooperation of the police. The number of professional authority procedures carried out centrally in connection with the use of atomic energy was 285. In 2011, two permits were granted for the transport of fresh nuclear heating rods, and three for the transport of highly reactive radioactive substances. The police conducted 18 on-site inspections, and completed four extraordinary events as part of public administrative proceedings.

Police authority tasks carried out in relation with the use of atomic energy constitute special tasks in police law enforcement, in particular the issuing of the police permits required for employing persons in facilities and positions specified by law, and conducting annual inspections of those in continuous employment, which covered more than 9000 persons in the last year. In the area of the use of atomic energy, the public security permits necessary for employment were withdrawn by police authorities in 13 cases, citing grounds for exclusion from employment, of which 3 cases went to appeal, although none were subject to judicial review.

1. Population radiation burden

The population radiation burden is made up, on the one hand, of the natural radiation burden, originating from cosmic and terrestrial sources, which is present everywhere, and on the other hand, of the artificial radiation burden, related to the use and operation of artificial sources of radiation, devices, facilities and radioactive substances, which includes above all the activities of medical X-ray and isotope diagnosis.

The average natural environmental radiation burden among the Hungarian population is approx. 3 mSv/year, which is higher than the global average (2.4 mSv/year, UNSCEAR 2000 Report). This is due to the fact that, for climate and civilisation reasons, the Hungarian population spends more time than the global average inside buildings, where there is a greater concentration of radon than in the open air. OSSKI operates a dosimetry network of passive detectors to check the domestic level of external natural background radiation that can be measured in the open air; the network comprises 115 measuring points across the country, with a further 39 measuring points in the vicinity of the Paks Atomic Power Station. The detectors are replaced and evaluated following quarterly exposure. The annual averages of the measuring results typically lie in the background range of 85-120 nSv/h, both in the national network and in that around Paks.

The greater part of the artificial radiation burden is derived from medical diagnosis of patients, primarily X-ray diagnosis. The average per capita medical radiation burden in Hungary approaches 1 mSv/year, of which close to 80% is the radiation burden from X-ray diagnosis. In order to evaluate and optimise the radiation burden deriving from medical applications, and to determine the national reference figures for patient radiation burdens, the OSSKI has, for many years, operated a national patient dose measuring programme. As part of this programme, measuring continued in 2011 in intervention radiological (cardiological) workplaces.

2. Occupational radiation burden

The National Personal Dosimetry Service, operating under OSSKI, carried out the central inspection of the occupational radiation burden of employees officially working in positions that expose them to an increased risk of ionising radiation. In 2011, a total of 86,786 test results were obtained during inspections of the radiation burden deriving from photon radiation, for 16,083 employees in 1150 workplaces. The employee distribution across the following occupational areas was:

- health: 52%,
- nuclear power station: 26%,
- industry: 12%,
- education: 9%
- research and development, other: 1%.

During inspections of the occupational radiation burden in 2011, the National Personal Dosimetry Service carried out investigations at authority level in 30 cases, and at workplace level in 68 cases. The occupational dose limit of 50 mSv/year was not exceeded by any employee.

Personal dosimetry inspections of the exposure to radon deriving from natural sources were carried out on a total of 14 employees in two workplaces in 2011. In accordance with the provisions of Decree 30/2001 (Oct. 03) of the Health Ministry on the occupational radiation protection of external employees, external employees are only permitted to carry out activities under proper personal dosimetry control. In 2011, the Service approved certification for Hungarian citizens to work as external employees abroad in 59 cases, and for foreign citizens to work as external employees in Hungary in 19 cases.

3. Environmental control systems

In order to monitor and reduce the population radiation burden, key facilities - including nuclear installations - have an obligation to operate an environmental control system or laboratory.

The competent ministries and authorities also operate national and regional systems for the independent control of emissions, environmental radiation conditions and radioactivity concentrations. Due to the low level of environmental radioactivity deriving from artificial sources, this form of radiation burden can only be determined through calculations. In the case of the population living in the direct vicinity of the atomic power station, the radiation burden deriving from atomic power station emissions is below 0.001 mSv/year. OSSKI has monitored the effects on Hungarian territory of the Mochovce atomic power station in Slovakia, close to the border with Hungary, since the power station began operations. Studies carried out in 2011 continued to show no environmental impact caused by the power station. Decree 8/2002 (Mar. 12) of the Health Ministry on the establishment and operation of a radiological monitoring and data acquisition network, regulates the health control activities to do with environmental radiation. Inspections are carried out by the county centres for radiological health which operate under the County Council Public Health Professional Administration Bodies, and by the Radiological Monitoring and Data Acquisition Network (RAMDAN, in Hungarian: ERMAH), operating under the NIEH.

3.1. The study of food, animal feed and environmental samples from agriculture - Radioanalytical Control Network

The study of food, animal feed and environmental samples from agriculture is carried out by the Radioanalytical Control Network, comprised of the accredited radioanalytical laboratories operated under the Central Agricultural Office (MGSZH). The laboratories are department-level organisational units of the Central Agricultural Office's Central Directorate for Food and Animal Feed Safety (MGSZHK ÉTbI), coordinated by the Radioanalytical Reference Laboratory. The network uses harmonised inspection methods and quality control systems, enabling the measuring results to be handled in a unified database. As in previous years, the radioanalytical studies in 2011 comprehensively encompassed the entire chain of food production, processing and commerce from the place of primary production to the finished product, in order to ensure the safety of food for the population and of food exports. Food imports are monitored by random inspections. The studies extend to inspections of pollution in agricultural produce, animal feeds, the waters used in the food industry and certain species of wild animals and plants. The laboratories determined current levels in accordance with the present EU regulation. Inspections and samples are carried out nationwide, and also cover the environment around the energy-generating atomic power stations which operate in Hungary and the neighbouring countries. 4377 samples from the food production environment and from inspections of agricultural production and the food chain were subjected to nuclide-selective measurements in the laboratories. No exceptionally high, harmful-to-health values were measured in the inspections carried out during the year.

3.2.Radiological studies of surface waters, sediment and the air

As part of the sphere of responsibilities belonging to the Secretary of State with responsibility for the Environment at the Ministry of Rural Development, environmental radiological

control tasks extend to radiological studies of surface waters, sediment and the air. Radiological monitoring of surface waters is carried out by the laboratories of the Inspectorates for Environmental Protection, Nature Conservation and Water Affairs, at specified locations and intervals. The data are collected and summarised by the Southern Transdanubia Inspectorate for Environmental Protection, Nature Conservation and Water Affairs, operating in Pécs, as the central office for the sector. Data are forwarded to the central office, and are published in the annual report of the National Environmental Radiological Monitoring System (hereafter: OKSER).

At 29 environmental radiological measuring stations, the National Meteorological Service carries out aerial gamma spectrometry tests. In addition, there are three automatic aerosol monitors in operation, at Napkor, Tésa and Nagykanizsa. After processing, the data are forwarded to users in Hungary and abroad. With regard to Block 1-4 of Paks Atomic Power Station and the Temporary Storage Facility for Spent Fuel Elements, based on the available measurements approved by the authority, the radioactivity emitted in 2011 can be certifiably calculated and compared with the threshold limits for emissions. The threshold limit criteria for emissions are low, as in previous years, so it can be stated that the facilities stayed well below the threshold limits for emissions imposed upon them. Based on the environmental control of the power station and the storage facility, as in previous years, the values measured in 2011 fall within the expected range, and demonstrate proper agreement between the facility and the authority.

Samples were taken for inspection from the surface waters (7 samples), the sediments of surface waters (2 samples), underground waters (12 samples), and ambient and sedimentary particulate matter (2 samples of each) from the area affected by the activity of the MECSEK-ÖKO Környezetvédelmi (Environmental Protection Company) Zrt. The inspectorate carried out gamma spectrometry measurements on the samples. The Measuring Centre of the Southern Transdanubian Inspectorate of Environmental Protection, Nature Conservation and Water Affairs, as the chief radiological laboratory for the sector, carries out tests in the fields of international cooperation on water affairs (Serbian-Hungarian Subcommittee on the Preservation of Water Quality and Serbian-Croatian Subcommittee on the Preservation of Water Quality), authority matters (Paksi Atomerőmű (Paks Atomic Power Station) Zrt., RHK Kft. Temporary Storage Facility for Spent Fuel Elements, MECSEK-Öko Zrt.) and environmental radiological monitoring. The radiological group carried out the pro rata monitoring tests that appear in the Working Plan on samples from surface water flows, underground water (observation well) and other media (mud, algae and fish).

3.3.University environmental measuring stations - Sector Information Centre

In 2011, 10 Hungarian universities operated 13 environmental measuring stations and 11 fixed location laboratories, in cooperation with OKSER and the National Radiation Monitoring, Signalling and Control System. The environmental gamma spectrometry performance is constantly monitored, but depending on the profile of the universities, environmental (air, water, soil, biological) samples are also processed and subjected to nuclide-specific analysis, as the need arises. Their activities are directed by the Sector Information Centre based at the Institute for Nuclear Technology at the Budapest University of Technology and Economics. The Centre continuously collects and processes the measurements. The summarised and batched measuring data for every day is forwarded to the

HAEA Centre for Crisis Management, Practice and Analysis. In 2011 the combined availability of the 13 measuring stations was 97%, a 0.4% increase on the previous year. Due to several changes in IT and personnel, further improvements are expected in the future. The fixed location stations are also used, depending on the profile of the university organisational unit, to perform a number of important measuring tasks related to environmental control and accident recovery, such as taking aerosol samples simultaneously with radioactivity measurements, and nuclide-specific analysis of samples of water, groundwater, soil and flora.

3.4.Authority Environmental Radiological Monitoring System

The radioactive emissions of the atomic power station under normal operations are governed by strict regulations, and constantly controlled by measuring systems. In addition to the plant radiation control system of the Paks Atomic Power Station, the Authority Environmental Radiation Control System has also been set up, under which the competent sectors of ministries - the health sector of the Ministry of National Resources, and the agriculture and environmental protection sectors of the Ministry of Rural Development - and the competent professional institutes and regional laboratories carried out coordinated measurements and controls within a 30 km radius of the power station. The system operated without disruption in 2011, and the annual evaluation report - in line with the practice of previous years - is prepared by the OSSKI Centre for Data Processing and Evaluation, with the involvement of the data providers. The preliminary evaluation of the data from 2011 shows no significant increase compared with previous years.

3.5. National Environmental Radiological Monitoring System (OKSER)

The regulatory basis for the operations of OKSER are contained in Government Decree 275/2002 (Dec. 21) on the monitoring of the nation's radiation status and of concentrations of radioactive substances. The national system is comprised of the professional institutes and industry networks of the ministries concerned and of the Hungarian Academy of Sciences, as well as the systems of Paksi Atomerőmű Zrt. (Paks Atomic Power Station Company) and the Nonprofit Organisation for the Treatment of Radioactive Waste. In accordance with this government Decree, the information centre of the system is operated by the OSSKI.

4. Security of nuclear and other radioactive substances

The transportation and shipping of radioactive substances is regulated by the provisions of the procedural agreements on the international transportation of hazardous - including radioactive - goods, and of their annexes and appendices.

Decree 14/1997 (Sep. 03) of the Ministry for Transport, Infocommunications and Water Affairs on the transportation, shipping and packaging of radioactive substances extends these international provisions to cover inland transportation and shipping. The IMDG Code on the implementation of Chapter VII of the SOLAS Convention, proclaimed by Act XI of 2001, governs the international maritime transportation of dangerous goods. In the instances provided for by international agreements on the transportation of hazardous goods, the HAEA has the authority duty to approve samples of radioactive substances and their packaging and to inspect the content of the permits, and to grant special permits for the transportation and shipping of radioactive substances and hazardous goods, as specified by the legislation. The HAEA is also responsible for issuing and receiving international notifications on this subject, and to initiate the necessary operative measures in the event of an extraordinary incident

occurring during international transportation. The transportation of radioactive substances by public road must be authorised by the public health professional administration bodies of the counties and the capital, operating under the respective county and capital councils, and the shipping of radioactive substances on public roads, on inland waters or by air, and transportation on inland waters, must be authorised by the National Transport Authority.

In 2011, the HAEA carried out authorisation procedures concerning the transportation or packaging of radioactive substances on five occasions, and issued permits on all five occasions. In addition, comprehensive investigations of the fulfilment of previously issued permits were carried out on two occasions.

Since Hungary acceded to the European Union, the tasks of the HAEA have expanded to include inspections of declarations made in accordance with Council Regulation (Euratom) No 1493/93 - concerning shipments of radioactive substances between the Republic of Hungary and other Member States. Following inspections based on the central register of radioactive substances, the HAEA issued certificates on 54 occasions in 2011. The International Atomic Energy Agency issues safety regulations to increase the safe use of atomic energy for peaceful purposes, which are drafted by committees of experts. In 2011, the representative from the HAEA took part in the work of the Transport Safety Standards Committee (TRANSSC), during which professional preparations began for the next issue.

- ***The ECSR requested additional information about trade and advertising of tobacco products, and on the legislation restricting smoking in public places and community areas.***

Smoking surveys

- **Population survey on the introduction in Hungary of health warnings with images, 2009**

The Fact Applied Social Science Research Institute was commissioned by the NIHD in April 2009 to conduct a questionnaire-based survey to test the health warnings, with images, to be placed on cigarette packets. As health warnings with images are intended to prevent smoking and to encourage people to give up smoking, the research was directed at two target groups:

- the adult (over 18) smoking population (400 people) and
- primary and secondary school students (aged 12-18) (600 people).

The survey questioned these two target groups for their opinions on the introduction of health warnings with images, and tested the images that were planned for introduction. 55.5% of the adult group tends to read the warning labels, and three fifths of the respondents were of the opinion that health warnings with images would have a preventive effect. Close to three quarters of students (72.7%) said that the health warnings with images would have a preventive effect. Also during the research, the images were identified that would have the greatest impact on the population, and those regarded as the most dissuasive. As a result of the research, covers for cigarette boxes were prepared, depicting the images considered by the population to be the most dissuasive, as part of the lobbying activity aimed at introducing graphic health warnings, and the covers were distributed to the Parliamentary Committee on Health and to political decision-makers and policy makers.

- **Opinions about the Non-smoking Act and the expected impact of its amendment - population survey, 2009**

Also as a part of the activities targeting a stricter amendment to the Non-smoking Act, the Medián Public Opinion and Market Research Institute was commissioned by the NIHD to conduct a multi-stage questionnaire-based survey of opinions on the planned changes to the legislation, which extended to the main target groups, which were those affected in the catering industry, in health and in public education. The majority of smokers said that the stricter laws would have no effect at all on their smoking habits. However, 3-7% of smokers asserted that they would give up smoking as a consequence of the stricter laws. One fifth to one third said that they would at least smoke less after the new restrictions entered into force.

- **Global Youth Tobacco Survey – GYTS**

Hungary took part in the survey in 2003 and 2008. Based on the results of the two surveys, it was found that there was an improvement in almost every smoking-related indicator in the period between them. There was also a beneficial change in the support among young people for the ban on smoking in communal areas. With the permission of the WHO and the cooperation and support of experts, the amendment to the law on the protection of non-smoking was included as one of the components of the research in Hungary in 2012.

The data from GYTS 2008 show that the frequency of the consumption of tobacco products in Hungary (23.4%) is above the average for the European region (EUR, 19.2%), although the difference is not significant. The figure for Hungary is alarming because the rate for the European region is twice the global average of 9.5%. One promising development is that the rate of non-smokers who are willing to begin smoking (18.6%) fell in the previous five years to the global average; this represented a significant change. This figure was significantly lower than the European average of 29.2%.

With regard to people who have tried smoking, almost 6 out of 10 students (57.9%) have tried smoking at least once in their lives (boys: 56.5%, girls: 58.4%), of whom 18% took their first drag of a cigarette before the age of 10. Approximately a quarter of students (23.2%) also smoke cigarettes at present (that is, have had a cigarette in the last 30 days), and there is no difference between genders, although the fact that the proportion of girls who smoke is higher than that of boys gives cause for alarm. 13.8% of students use other tobacco products (cigars, little cigars, cigarillos, water pipes, chewing tobacco, snuff) at present, with the moderate rate among boys significantly higher than that among girls (16.8% and 10.4% respectively).

Main results of a comparison of research into the smoking habits of young people aged 13-15 (three rounds so far: 2003, 2008, 2012):

- The rate of people who have tried smoking, combined for boys and girls, was 66%, 58% and 57% in the three rounds, and of cigarette smokers was 28%, 23% and 27%.

From 2003 to 2008, the number of people who use other tobacco products rose by around 5% (from 5.5% to 13.8), and the results of the 2012 survey show that use of cigars has risen since 2008 from 4% to 6%, and the use of hand-rolled cigarettes has increased from 6% to 9%.

For more detailed information and data, see part 1) and section 1 of part 2).

- ***The ECSR requested further information about accident-prevention measures taken and about accident statistics***

Please refer to point 10 in section 2).

- ***The ECSR requested further information about compulsory vaccinations and the rates of vaccination***

The NIEH, in cooperation with domestic authorities, the National Office of the Chief Medical Officer and the National Centre for Epidemiology, makes a number of efforts to maintain and continuously develop the system of compulsory vaccinations for children, which operates at a very high level, even by European standards.

The Hungarian system of vaccinations undergoes continuous review, and currently provides families, free of charge, with the means of offering protection against 11 infectious diseases. In addition to the programme of age-based, compulsory and free vaccinations, all other vaccines registered by the EU are available at pharmacies. During the reporting period, the following substantial changes took place in Hungary:

- From 1st October 2008, it became compulsory to recommend the free-of-charge pneumococcus conjugate vaccine (PCV-7Wyeth);
- From 2009, in addition to 14-year-olds, 13-year-olds were also vaccinated in schools with HBV vaccine (EngerixB/GSK), in alignment with the results of the HBSC (Health Behaviour of School Age Children) research, which indicated that children start a sexual life at an earlier age - this significantly reduces the risk of HBV infection;
- From 2009, instead of the di-te vaccination, 11-year-olds are administered dapT (Boostrix/GSK and Adacel/sanofi), which is a more modern vaccine;
- In 2010, the PCV7 vaccine was gradually replaced with PCV13 (Prevenar13/Pfizer), using up existing stocks, which results in combating diseases of the respiratory and central nervous systems that are picked up in children's communities, and supports parents' ability to work.

Compulsory vaccinations protect almost the entire age group, as shown in the tables below.

Fulfilment rate of age-based compulsory vaccinations, 2008-2009

Vaccine name	**Rate of vaccination (%)**	
	2008	**2009**
	Year	
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)	99.9	99.8
DTPa +IPV +Hib (18 months)	99.7	99.6
DTPa +IPV (3 years)	99.9	-
DTPa+IPV (6 years)	99.8	99.7
dT	99.5	-
MMR reinoculation	99.5	99.3
Hepatitis B I	[1]99.5	[2]99.4

Hepatitis B II	[2]99.4	[3]99.1

Legend:
BCG = Bacillus Calmette-Guérin / vaccine against tuberculosis
DTPa= diphtheria - tetanus and acellular pertussis
Hib = Haemophilus influenzae type B
IPV = inactivated poliovirus vaccine
MMR = measles, mumps, rubella
dT = diphtheria-tetanus booster

1 data on people vaccinated in academic year 2007/2008
2 data on people vaccinated in academic year 2008/2009
3 data on people vaccinated in academic year 2009/2010

Fulfilment rate of age-based compulsory vaccinations, 2010-2011

Vaccine name	Rate of vaccination (%)	
	2010	2011
	Year	
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)	99.9	99.9
DTPa +IPV +Hib (18 months)	99.7	99.7
DTPa+IPV (6 years)	99.6	99.7
dTap	99.3	99.3
MMR reinoculation	99.5	99.5
Hepatitis B I	[1]99.5	-
Hepatitis B II	[2]99.3	[3]99.4

Legend:
BCG = Bacillus Calmette-Guérin / vaccine against tuberculosis
DTPa= diphtheria - tetanus and acellular pertussis
Hib = Haemophilus influenzae type B
IPV = inactivated poliovirus vaccine
MMR = measles, mumps, rubella
dT = diphtheria-tetanus booster

**Reported in line with the criteria defined in the 2011 Vaccination Methodology Communiqué*
1 data on people vaccinated in academic year 2009/2010
2 data on people vaccinated in academic year 2010/2011
3 data on people vaccinated in academic year 2011/2012

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. General 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 provision,
- benefits in case of a workplace accident,
- family benefits (partially),
- maternity benefits (partially),
- invalidity pension,
- benefits for relatives.

Major statutes concerning social security:

- Act LXXX of 1997 on Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services (hereafter: Social Security Act), furthermore, Government Decree 195/1997 (Nov. 05) on the implementation thereof,
- Act LXXXI of 1997 on Social Insurance Pensions (hereafter: Pensions Act), furthermore, Government Decree 168/1997 (Oct. 06) on the implementation thereof,
- Act LXXXIII of 1997 on benefits under the statutory health insurance scheme (hereafter: Health Insurance Act), furthermore, Government Decree 217/1997 (Dec. 01) on the implementation thereof,
- Government Decree 284/1997 (Dec. 23) on the implementation thereof,
- Act XXXI of 1997 on the Protection of Children and on Guardianship Administration (hereafter: Child Protection Act),
- Act LXXIX of 1992 on the Protection of Foetal Life,
- Act CLIV of 1997 on Health (hereafter: the Health Act),
- Act III of 1993 on Social Administration and Social Services (hereafter: the Social Act).

Act IV of 1991 on the Promotion of Employment and Provisions to the Unemployed 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.

In addition to the insurance schemes provided by the state, it is also possible to take out insurance schemes for so-called supplementary voluntary benefits (pension benefits, health

treatment). In this context, the scope of services provided by voluntary mutual insurance funds is outstanding. Act XCVI of 1993 on Voluntary Mutual Pension Funds provides for the detailed rules of the supplementary pension insurance system. Voluntary funds may be established by natural persons in order to supplement, replace or substitute the benefits provided under social security. Employers may participate in the process of establishment as initiators, however, in this case, too, the fund will be established by natural person employees. As per the principle of self-governing operation, in the funds only the fund members are authorised to make any decisions on the fund, and the members adopt these Decrees in the general meeting. The employers have no decision-making powers regarding the management of the financial resources that they may be contributing to. Upon the termination of the mixed type pension system in 2011, the private pension funds also turned into voluntary funds. The funds are supervised by the prosecutor's office for legal compliance and by the Hungarian Financial Supervisory Authority as the representative of the state. As the main rule, the system of Hungarian social security regulations keeps every person living in the jurisdiction subject to the system, and as such, depending on their situation and status (such as the insured person, a dependent close relative) it grants various social security rights to and imposes various obligations on them.

Pursuant to Article 5 of the Social Security Act, every person engaged in paid employment in Hungary is obligatorily insured, pursuant to the provisions of the law. Article 16 of the Social Security Act specifies the scope of persons who are entitled to health service under a legal relationship of insurance that is not their own. Pursuant to Article 16 of the Social Security Act, in addition to the insured persons, the community of other eligible persons includes, for example, Hungarian citizens under 18 years of age having permanent residency in the territory of the Republic of Hungary, Hungarian citizen full-time students of secondary institutions of education and study, or institutions of higher education, retired persons, the needy and persons receiving family support and welfare benefits.

The provisions of the Social Security Act are applied according to the rules of application of Community regulations on the application of the social security systems to employees moving within the Community, sole traders and their family members, if the relevant persons are subject to these regulations, and to the rules of the convention in the case of persons subject to international conventions.

Citizens of third countries staying in Hungary are basically covered by insurance in Hungary with regard to their gainful employment. Article 11 of the Social Security Act removes certain categories of foreigners from the scope of persons with obligatory insurance coverage; persons belonging to this category also have the option of concluding agreements on becoming eligible for receiving health care services and pensions.

The following contributions must be paid to cover social security benefits and labour market objectives:

- the insured person pays in kind and cash healthcare contributions (together: healthcare contributions), labour market contributions and pension contributions; sole traders and members of economic partnerships engaged in supplementary activity pay pension contributions;

- employers and sole traders covered by insurance pay healthcare contributions and pension contributions (hereafter together: social security contributions), (changed to the social contribution tax after 1 January 2012);
- the contributions payable by sole traders engaged in supplementary activity, and by members of partnerships engaged in supplementary activity, are paid by the economic partnership, furthermore, persons not covered by insurance and not eligible for healthcare services pay healthcare service contributions;
- persons specified in a separate statute pay healthcare contributions to cover healthcare services,
- employers pay early retirement contributions for persons, defined in a separate statute, working in positions entitling them to early retirement, not qualified as pensioners in their own right, as well as members of economic partnerships not qualified as engaged in supplementary activity, furthermore, for sole traders covered by insurance and working in positions entitling them to early retirement.

These taxes must be paid according to the rates applicable when the income subject to contribution is disbursed. The contributions also fall due on any income subject to contributions paid (distributed, credited) after the termination of the legal relationship involving mandatory insurance.

The rates of pension insurance contributions were as follows in the reporting period:

Year	**Pension insurance contribution payable by the employer %**	**Soc. sec. pension contributions payable by the insured person (%)**		
		non-members of private pension funds	**members of private pension funds**	
			Soc. sec.	**membership fee**
2008	**24**	**9.5**	**1.5**	**8**
2009	**24**	**9.5**	**1.5**	**8**
2010*	**24**	**9.5**	**1.5**	**8**
2011	**24**	**10**	**10**	**-**

** Pursuant to Act CI of 2010 on the Amendment of the Law related to Payments into Private Pension Funds, in the period following 1 November 2010, until 31 December 2010, the membership fees of private pension funds had to be paid into the pension fund of social security.*

In addition to the insurance schemes provided by the state, it is also possible to take out insurance schemes for so-called supplementary voluntary benefits (pension benefits, health treatment), or to participate in other supplementary savings plans. Members of a private pension fund are required to pay pension contributions and a membership fee. In the period under examination the membership fee was 8%. After 1 November 2010, the membership fee of members of private pension funds was paid into the pension fund of the social security for 14 months, pursuant to the provisions of Act CI of 2010 on the Amendment of the Law related to Payments into Private Pension Funds. 97% of all members rejoined the state-supported system, from 2012 the membership fees of payments into private pension funds also must be paid into the Pension Insurance Fund, while membership in private pension funds remains voluntary.

Employed persons who are pensioners in their own right, as well as sole traders and members of economic partnerships engaged in supplementary activity, also pay personal pension contributions of 10%.

The rate of early retirement provision contributions payable by employers and sole traders is 13%.

II. A comprehensive presentation of the pension system

1. Old age pension provision

Eligibility for pension

Between 31 December 1997 and 1 January 2009, full old age pensions were granted to those at least sixty-two years old (hereafter: retirement age for old age pensions) and had amassed at least twenty years of service time. Men and women were also entitled to a full old-age pensions who were at least fifty-five or sixty years old, respectively, prior to 1 January 1991, and had amassed ten years of service time up to that date. Women and men were entitled to partial old age pensions if they had amassed a total service time of less than twenty years, however:

- were at least fifty-five or sixty years of age, respectively, after 31 December 1990 and prior to 1 July 1993, and had collected at least ten years of service time by that time, furthermore, those who
- have (had) reached the retirement age for old age pensions applying to him/her after 30 June 1993 and prior to 1 January 2009, and have (had) collected at least fifteen years of service time up to that time.

Departing from the above provisions, the retirement age for old age pensions for women was

- 55 years of age for those born before 1 January 1940,
- 56 years of age for those born in 1940,
- 57 years of age for those born in 1941,
- 57 years of age for those born in 1942,
- 58 years of age for those born in 1943,
- 59 years of age for those born in 1944,
- 60 years of age for those born in 1945,
- 61 years of age for those born in 1946.

The retirement age for old age pensions for men was 60 for those born prior to 1 January 1938, and 61 for those born in 1938. Those working in positions involving elevated strain on the human body or that is especially harmful to health were allowed to retire earlier.

At an age five years lower than the age limit of eligibility for old age pensions, but not earlier than the date when the applicant reached the age of fifty-five, women were entitled to early old age pensions who

a) were born after 31 December 1945, with at least 38 years,
b) were born in 1945, with at least 37 years,
c) were born in 1944, with at least 36 years,
d) were born in 1943, with at least 35 years,
e) were born prior to 1 January 1943, with at least 34 years

of service time.

At an age lower than the age limit of eligibility for old age pensions, but not earlier than the date when the applicant reached the age of sixty, men were entitled to early old age pensions who

a) were born prior to 1 January 1939, and amassed at least 37 years of service,
b) were born after 31 December 1938, and amassed at least 38 years of service.

Persons were entitled to an early old age pension at a reduced amount - including benefits according to the lowest amount of the old age pension - who had missed not more than five years of the service time necessary for an early pension, if they otherwise met the rest of the conditions for an early old age pension. The amount of the old age pension had to be reduced

- for persons with a completed service time shorter by 1-365 days, by 0.1 per cent as many times,
- for persons with a completed service time shorter by 366-730 days, by 0.2 per cent as many times,
- for persons with a completed service time shorter by 731-1095 days, by 0.3 per cent as many times,
- for persons with a completed service time shorter by 1096-1460 days, by 0.4 per cent as many times,
- for persons with a completed service time shorter by 1461-1825 days, by 0.5 per cent as many times, as was the number of units of 30 calendar days missing for reaching the age of eligibility for old age pensions.

Reaching the retirement age for old age pensions did not affect the reduction.

In contrast with the retirement age for old age pensions applying to persons who acquired the right to early retirement, they became eligible for early old age pensions at an age that is lower by as many years as was the number of years by which they would have become entitled formerly to an early old age pension without eligibility for early retirement. When determining eligibility for early old age pensions and the rate of pension reduction, the amassed service time must be taken into account increased by the duration of the reduction in years. The early and reduced early old age pensions were also available for persons eligible for early retirement from dates preceding the required age. When the service time is calculated, one year was added for each child (this benefit was available for up to three children), furthermore, one and a half years for each child who had been permanently sick or lived with a disability) as service time for any person who delivered a child or raised a child in his or her own household for a term of at least ten years. In terms of eligibility for early old age pensions and reduced early old age pensions, the term of payment of invalidity pensions and accident invalidity pensions also had to be considered as service time. (**From 2011 this rule was terminated**). From 1 January 2010, the retirement age has been gradually raised from 62 years to 65 years uniformly, regardless of gender. The age limit has been determined according to year of birth, implementing a raise of six months per year.

Pursuant to the amendment of the Pensions Act valid from 1 January 2010 (Act XL of 2009, Article 1):

The retirement age for old age pensions entitling the pensioner to old age pensions funded by social security

a) is 62 years of age for persons born prior to 1 January 1952,
b) is 183 days after reaching 62 years of age for those born in 1952,
c) is 63 years of age for those born in 1953,
d) is 183 days after reaching 63 years of age for those born in 1954,
e) is 64 years of age for those born in 1955,
f) is 183 days after reaching 64 years of age for those born in 1956,
g) is 65 years of age for those born in or after 1957.

Persons are entitled to full old-age pensions who have reached the retirement age for old age pensions corresponding to their year of birth and have amassed at least twenty years of service time, furthermore, on the day from which their full old age pension was determined they are not in any legal relationship involving insurance.

Measures implemented in 2011 in the social insurance pension system

A major change in the pension system maintained by social security was that from 1 January 2012, as a main rule, persons are classified as pensioners who have reached the retirement age for old age pensions; an exception to this rule is the option of early retirement for women, which grants entitlement to full old age pensions with an entitlement time of 40 years, regardless of the age limit. Another exception is those who were born before 1955 and receive a service (army) pension.

Any service time acquired by a legal relationship of social security existing under paid employment or an equivalent legal relationship, furthermore, acquired for time spent in prenatal allowance, child home care allowance, child-rearing allowance or nursing allowance with regard to a biological or adopted child living with a severe disability, is also considered entitlement time. No full old age pension may be determined to apply if the time covered by social security in paid employment or in any other equivalent legal relationship is less than thirty-two years, or in the case of women who received nursing allowance with regard to a biological or adopted child living with a severe disability, thirty years. In effect since 1 January 2011, this provision was introduced by Act CLXX of 2010.

If the eligible person raised five children in his or her household, the entitlement time is to be reduced by one year, and by another year for each additional child, but altogether by seven years at most. A child raised in a person's own household is defined as any child, whether related by blood or adopted, who has lived together with the claimant, and who was in his/her care regularly.

Persons are entitled to partial old-age pensions who have reached the retirement age for old age pensions and have acquired at least fifteen years of service time, furthermore, on the day from which their partial old age pension was determined they are not in any legal relationship involving insurance.

Amount of the pension

The amount of the old age pension depends on the acknowledged service time and the eligible amount of the average monthly salary. Based on the above, the amount of the old age pension will be the following:

Service time *Year*	*Percentage of* *monthly average salary*
10	33.0
11	35.0
12	37.0
13	39.0
14	41.0
15	43.0
16	45.0
17	47.0
18	49.0
19	51.0
20	53.0
21	55.0
22	57.0
23	59.0
24	61.0
25	63.0
26	64.0
27	65.0
28	66.0
29	67.0
30	68.0
31	69.0
32	70.0
33	71.0
34	72.0
35	73.0
36	74.0
37	75.5
38	77.0
39	78.5
40	80.0

2 percent for each additional year.

The full old age pension cannot be lower than the lowest amount of the old age pension, as defined in a separate statute. If the monthly average salary constituting the base of the full old age pension is lower than the amount of the old age pension, as defined in a separate statute, then the amount of the benefit will be identical with the amount of the monthly average salary constituting the base of the pension.

The partial old-age pension granted based on a service time of 10-19 years must be determined as a percentage of the monthly average salary constituting the base of the pension, depending on service time, if it is below the lowest amount of the old-age pension.

2. Invalidity pension

Persons who had lost their working capacity to a degree of 67% or higher, as a result of impairment of health, physical or mental disability, without any expected improvement in their condition for one year, were entitled to invalidity pension. Invalidity benefits are part of the Social Security system, and therefore the legal relationship of insurance is mandatory.

The following service times were necessary to qualify for invalidity pension:

- 2 years prior to reaching the age of 22,
- 4 years at the age of 22 to 24, or 3 years in positions entitling the applicant to early retirement,
- 6 years at the age of 25 to 29, or 4 years in positions entitling the applicant to early retirement,
- 8 years at the age of 30 to 34, or 6 years in positions entitling the applicant to early retirement,
- 10 years at the age of 35 to 44, or 8 years in positions entitling the applicant to early retirement,
- 15 years at the age of 45 to 54, or 12 years in positions entitling the applicant to early retirement,
- 20 years from the age of 54, or 16 years in positions entitling the applicant to early retirement.

Those who had amassed a service time within 180 days following the termination of their academic studies and had become disabled before the age of twenty-two were entitled to invalidity pension regardless of the length of their service time. A disabled person who had reached the age of forty-five or the age of fifty-five prior to 1 July 1993 and had amassed a service time of at least ten years, furthermore, those who reached the age of fifty-five after 30 June 1993 and had amassed a service time of at least fifteen years, were entitled to partial invalidity pension.

When determining the service time necessary for invalidity pension, the age reached by the applicant at the time of invalidity had to be taken into account. A person who could not amass the service time necessary according to his or her age at the time of becoming disabled was entitled to invalidity pension if he or she had amassed the service time required in the lower age group, and after that there had been no interruption exceeding thirty days in his or her service time until the date of invalidity. The time of incapacity for work did not apply as such a period of thirty days.

If the applicant had amassed both service time qualifying for early retirement and other service time, when the service time necessary for invalidity pension was calculated not exclusively on the basis of time qualifying for early retirement, every year spent in a position qualifying for early retirement was considered as one and one quarter of a year. Persons who became disabled preceding the start of their service time were entitled to invalidity pension if they had amassed the service time necessary according to the age reached at the time they submitted their claim, and had not worked regularly, or their wages had been substantially lower than prior to their application for pension.

The start date of eligibility for invalidity pension was the date on which the invalidity existed according to the opinion of the medical expert. If the medical expert expressed no opinion on

the time of disability, the day the claim was submitted was considered as the time of disability. If the applicant had not amassed the service time necessary for eligibility up to that time, he/she became entitled to invalidity pension on the day following the day when they amassed the necessary service time. If the applicant was employed on that day, the start date of his or her eligibility was the day on which he or she was no longer employed and not receiving sick pay or accident sick pay, or had not worked on a regular basis and had not received sick pay or disability sick pay, or worked in a position with a substantially lower wage.

When determining the monthly salary constituting the basis of the invalidity pension, the provisions applying to old-age pension were applied accordingly, with the difference that, if the service time necessary for eligibility for invalidity pension and the qualifying service time were shorter, even considered together, than the specified period for the calculation of the average, the invalidity pension was determined on the basis of the monthly average of the wage or income earned during the shorter period. In the absence of at least 30 days of earnings, that minimum wage - defined in a separate statute - was considered as the average monthly wage/salary in the calendar months preceding the date from which the pension was granted.

If the disabled person also paid membership fees into a private pension fund, and according to his or her own decision the funds on his or her personal account were not transferred to the Pension Insurance Fund, 75% of the amount calculated depending on their service time, the amount of their average wage and the level of disability was granted to him or her as invalidity pension. The amount of the invalidity pension depended on the age reached at the time of invalidity, the length of the service time amassed until the pension was granted and the level of invalidity. According to the level of invalidity:

- those belonging to invalidity group III are disabled but are not totally unable to work,
- those belonging to invalidity group II are totally unable to work but do not require care by others,
- those belonging to invalidity group I are totally unable to work and require care by others.

The amount of the invalidity pension must not be lower than 37.5%, 42.5% and 47.5% of the monthly average wage/salary, respectively, in the order of the groups of invalidity. The amount of the invalidity pension must not be higher than the average monthly salary constituting its basis. The amount of the invalidity pension was the same as the amount of the old age pension in invalidity group III after a service time exceeding twenty-five years. The amount of the invalidity pension was higher by 5% of the monthly average salary in invalidity group II, and by 10% thereof in invalidity group I, than in invalidity group III.

From 1 January 2008 the system of invalidity benefits was reformed. After that date, the medical committee did not determine the degree of the reduction of working capacity, but the measure of health impairment. For persons applying for invalidity pension who suffered a health impairment of at least 50% but were deemed by the committee suitable for rehabilitation and compliant with additional conditions of eligibility, rehabilitation allowance was granted pursuant to Act LXXXIV of 2007 on Rehabilitation Allowance (hereafter: Rehabilitation Allowance Act.).

Based on the rate of health impairment, the medical expert committee assigned the applicants to three different categories. Based on their ability to function independently, those with a health impairment of more than 80% were assigned to groups I or II, and those with a health impairment of between 50% and 79% to group III. When a health impairment of 50% - 79% was determined, the change in professional working capacity was also established, because persons eligible for rehabilitation who came from this group were granted rehabilitation allowance. During the payment of the allowance, the recipients also received employment rehabilitation according to a rehabilitation plan, which helped the recipients to return to the labour market after training or retraining and through the provision of assistance with job seeking, by the time the maximum term of 3 years for receiving the allowance was over.

Persons were entitled to rehabilitation allowance who

a) suffered a health impairment of 50-79 per cent, and related to that, were not suitable for employment in their current position or the one held prior to the health impairment, or in any other position matching their qualifications without rehabilitation, and
   aa) were not gainfully employed, or
   ab) whose salaries/wages are at least 30% lower than the monthly average of their salaries/ wages in the four calendar months before the health impairment, furthermore,
b) were able to be rehabilitated, and
c) had worked the necessary time to qualify for disability pension according to their age.

The term of the payment of the rehabilitation allowance could not exceed 3 years, but this could be extended (according to the amendment adopted in December 2010) once, for a term not to exceed 4 years. The amount of the rehabilitation allowance equalled 120% of the amount paid under an invalidity pension (invalidity group III). The lowest amount of the rehabilitation allowance equalled 120% of the lowest amount paid under an invalidity pension (invalidity group III). The rehabilitation allowance was reduced by 50% if, in the case of continued paid employment, the monthly average of the compensation and salary earned by the person receiving the rehabilitation allowance exceeded, in 3 consecutive months, 90% of the amount of the monthly average compensation serving as the basis for the invalidity pension, and after establishing the allowance, exceeded the amount adjusted by the regular pension increase(s), but at least the amount of the prevailing mandatory minimum salary/wage. When the amount of the rehabilitation allowance was determined, the provisions of the Pensions Act defining the amount of invalidity pension [the Pensions Act Article 28, Article 29, paragraphs (2)-(4) and paragraph (6)] were applied accordingly, providing that pursuant to Article 4 (2), the term of any invalidity or accident invalidity pension included in the service time necessary for eligibility was disregarded. The amount of the rehabilitation allowance was raised annually, and the annual raises were subject to the provisions of the Pensions Act (the Pensions Act Articles 62 and 63).

From 1 January 2012, Act CXCI of 2011 changed the system of invalidity pensions and the social security benefits of persons with disabilities.

3. Pensions for relatives

Pensions for relatives include widow's pensions, orphan's benefits and parent’s pensions. Pursuant to the Pensions Act, a spouse is entitled to widow's pension whose deceased spouse has acquired the service time necessary for invalidity pension or died while receiving old age

or invalidity pension benefits. Furthermore, a non-married partner is also entitled to widow's pension, although this is subject to more strict conditions compared to a spouse: a non-married partner is eligible if they lived together with his or her partner for at least one year without interruption and a child was born to them, or if they lived together for at least ten years without interruption. It is also a condition for the non-married partner to be eligible for widow's pension that the deceased person should have amassed the time necessary for old age or invalidity pension, or should have been receiving old age or invalidity pension upon his or her death. In the case of eligibility of a non-married partner for widow's pension, it is an additional restriction that the surviving non-married partner should not be a recipient of widow's pension or accident widow's pension during the term of cohabitation, for however short a time (this is true for everybody, including a spouse, therefore a widow's pension may only be granted with regard to one deceased person). Common-law marriage partnerships can be certified by, for example, a common address. A spouse may also receive a widow's pension if they were divorced from the deceased person, as well as non-married partners separated for longer than one year, if they are considered dependent, i.e. received alimony from the deceased person until his or her death, awarded alimony by a court ruling, regardless of whether the spouse or non-married partner had paid it. The benefits due to dependent, surviving spouses or non-married partners can be divided into two stages: first, a temporary widow's pension, and then a full widow's pension is paid.

The temporary widow's pension is intended to facilitate adaptation to the life situation of the recipient modified through the death of the provider. The temporary widow's pension is due for at least one year from the death of the spouse or a non-married partner, or in the case of widows raising a child younger than eighteen months, until the child reaches the age of eighteen months, or in the case of a disabled or permanently sick child until the child reaches the age of three years. The amount of the temporary widow's pension is 60% of the pension benefit of the deceased. After the expiry of the temporary widow's pension, the conditions of the widow's pension are tightened: only a surviving spouse is eligible for widow's pension who has reached the age of eligibility for an old-age pension, or is disabled, or is raising a child entitled to orphan's benefits in the right of the spouse, a permanently sick child or a child with a disability, or at least two children entitled to orphan's benefits. If someone is widowed, the rate of the temporary widow's pension is 60% of the old age, invalidity or accident invalidity pension that was or would have been due to the deceased person at the time of his or her death.

In the case of widows or widowers who have already reached the retirement age for old age pensions, or are disabled but are not receiving pension benefits in their own right, it is 60% of the old age, invalidity or accident invalidity pension that was or would have been due to the deceased person at the time of his or her death, while in the case of widows or widowers receiving pension benefits in their own right, or in the case of widows or widowers raising a child or children entitled to orphan's benefits, 30% of that amount. Instead of a widow's pension defined at 60%, a widow's pension defined at 30% must be granted from the time for which the widow or widower started receiving pension benefits in his or her own right. The widow's pension of 30% is due to the widow or widower without regard to the pension of the widow or widower received in his or her own right.

From 1 January 2007, the earlier rate of 55% has been raised to 60%, similarly to the rate of the temporary widow's pension that may be granted to widows or widowers of active age. The

entitlement to widow’s pension will remain until the end of the life of the surviving spouse, except if he or she gets married prior to reaching the retirement age, his or her invalidity ends, or when none of the dependent children is entitled to orphan's benefits any longer. If more than one person is entitled to widow's pension, it must be divided up in equal parts.

The dependent child of the deceased person is entitled to orphan's benefits, which are due to children by blood, as well as children born in a former marriage or common-law partnership, furthermore, to adopted children, if the provider died as an old age or invalidity pensioner or as a person entitled to such pension. The term of eligibility for orphan's benefits continues until the child reaches the age of 16, or the age of 25 in the case of children who are full-time students at a university or college; if the child becomes disabled before reaching the above-mentioned age, then the benefit remains due regardless of age, for any period of time. The rate of the orphan's benefits is 30% of the pension benefit due to the deceased person, and if the child loses both parents or the surviving parent is disabled, then it will be 60%. A parent’s pension is due to a parent whose child died after amassing the service time necessary for old age or invalidity pension, or as an old age or invalidity pensioner, if the parent was disabled or at least 65 years of age at the time of the death of the child, and the parent had supported the child for the most part in the period of one year preceding the death of the child. A foster parent is also entitled to a parent’s pension if they supported the child for a period of at least ten years. A parent’s pension is due for the term of the invalidity of the beneficiary. A parent who has reached the age of 65 may be considered disabled without a medical check-up. A parent who was not disabled at the time of the death of his or her child will only be entitled to parent’s pension if he or she becomes disabled within a period of ten years from the child's death and has no relative who is obliged and able to support him or her. These provisions are appropriately applicable to grandparents and grandchildren as well. Entitlement to parent’s pension will not be terminated if the pension benefits due to the person entitled to parent’s pension, in his or her own right or received as a relative, already exceeds, during the term of the payment of the parent’s pension and together with the annual raises, the currently applicable lowest amount of the old age pension. The rate of the parent’s pension is the same as the rate of 60 or 30 per cent described under the widow's pension. If more than one person is entitled to parent’s pension, it must be split up among them equally. If the number of entitled persons changes, the parent’s pension will have to be split up again.

4. Changes affecting the social insurance pension system

Measures between 2008 and 2011

The measures implemented in the reporting period and affecting the pension system were basically aimed at the role of the transformation of the pension system in fiscal consolidation, in the meantime several changes took place affecting the parameters of the social insurance pension system and the structure of the pension system. The raise of the retirement age announced in 2009 was completed in 2009, which set the obligatory retirement age at 62 for both men and women. In the same year, the decision was passed for the retirement age to be raised to 65, i.e. a gradual increase by 3 more years was implemented, which will be completed by 2022. The mixed pension system created in the framework of the structural pension reform announced in 1997 was transformed by the phasing out of private pension funds from the obligatory pension system in 2010 and 2011. This period is characterised by the gradual tightening of access to forms of early retirement or advance retirement, the

imposition of more strict conditions and the re-regulation of employment while receiving pension.

Between 2008 and 2011, the actual retirement age increased by one - one and a half years; in that period the expenditures on pension were as follows, as a percentage of GDP:

	2008	2009	2010	2011
Pension expenditures as percentage of GDP	10.8 %	10.9 %	10.6 %	10.8 %

- **Pension-related measures in 2008**

Reform of the invalidity pension system

In the employment situation that set in after the political changes, from the 1990s early retirement had become a generally accepted practice, and disability pensions were chosen to an especially high extent. This trend continued after the turn of the millennium as well. The modernisation of the care system for persons with disabilities started in Hungary from 2008, when provisions for disability pension were reformed and the rehabilitation allowance was introduced. The main objective of modernisation is to establish a system promoting employment, as well as social reintegration, laying the foundations of a practice based on the principle of "you must work if you are or can be made capable of working." The prerequisite for the successful social activation of employees with disabilities is successful employment, which enables an independent, autonomous lifestyle and also decreases public expenditures.

The aim of restructuring the *invalidity provision system* from a rehabilitation point of view was to provide support to people returning to the labour market by the successful rehabilitation of the retained working capacity, and to break with the former practice of encouraging the recipients to take advantage of passive benefits. For that purpose, a new, complex rehabilitation system was designed, which brought together health, employment, and social security criteria. The reform of the invalidity pension provision system from a rehabilitation point of view included the following:

- a new system of classification was devised, based on the remaining skills and competencies to be developed;
- an extensive, personal service-support system and new, motivating rehabilitation provisions for the programme period,
- the development of transitional benefit schemes for persons with partial reduction of working capacity, in invalidity group III, which creates - when supplemented by proper rehabilitation - a strong incentive for remaining in or re-entering the labour market;
- the restructuring of the rules for classification and monitoring in a way that prevents abuses and enables the implementation of more efficient methods of control for a revision.

(Having been launched in 2008, the process has not yet been completed, in 2011 further significant reforms to the system were implemented, which extend beyond the reporting period, scheduled to take effect as of 1 January 2012).

The point of the modernisation concept is that applicants for invalidity pension, who are put into invalidity group III by the rehabilitation expert organisation performing the complex certification, and who meet the eligibility requirements, are provided with rehabilitation

services organised by the National Employment Service for a maximum of 3 years (4 years from 2011), and receive rehabilitation allowance, in order to be able to finally obtain permanent employment in the labour market, without state aid.

The legal means of regulation are, in addition to the Rehabilitation Allowance Act.:

- Government Decree 213/2007 (Aug. 07) on the National Rehabilitation and Social Expert Institute and its detailed rules of procedure;
- Government Decree 321/2007 (Dec. 05) on Complex Rehabilitation.

Pursuant to the law, the committee assigned persons with impaired health and claiming disability pension to three different categories, according to the degree of their health impairment. Based on their ability to function independently, those with a health impairment of more than 80% are assigned to groups I or II, and those with a health impairment of between 50% and 79% to group III. In addition to health impairment, the change in professional working capacity was also determined.

- **Pension-related measures in 2009**

The implementation of the crisis-handling pension package of the year 2009 played an important role in keeping pension expenditures unchanged in the period under consideration, furthermore, the forecasts on the long-term sustainability of the Hungarian pension system have improved substantially. It was the need for stabilisation in the situation that developed as a result of the handling of the global financial and economic crisis that necessitated the implementation of these measures. Significant elements of the package:

- termination of the 13th month's pension;
- change of pension indexation, the rule of annual pension increases: i.e. the former mixed, Swiss-type indexation has been replaced by a ratio related to the percentage increase of GDP, the related difference ratio between the increase of consumer prices and net wage increase concerning the increase of pensions: pensions are raised according to the increase in consumer prices under 3 per cent, while over 5 per cent the increase is implemented according to Swiss indexation (50% for both components). (When the measure of pension increase is determined, inflation and the increase in the net average wage/salary must be taken into account in a ratio of 80 - 20 with a GDP increase of 3 or 4%; with a GDP increase of 4%-5% the split is 60-40);
- From 2012, the retirement age is increased by six months for every age bracket, gradually reaching 65 years of age. The increase of retirement age will first affect those born in 1952. The increase of the retirement age from 62, which applied to both men and women in 2009, will be completed by 2022. Those born in 1957 may retire at the age of 65 uniformly. Adapted to the increase of retirement age, the rules of early retirement have been further tightened.

Increase of retirement age

The increase in the retirement age for men in the period between 1998 and 2009 came to an end in 2001, while for women it lasted until 2009, with annual increases of two years, and it was from that time that a statutory retirement age of 62 years became uniform for both genders. The law amendment accepted by the National Assembly on 11 May 2009 (Act XL of 2009 on the Amendment of Act LXXXI of 1997 on Social Insurance Pensions) regulates the process of increasing the retirement age in accordance with the earlier practice, also in respect

of the relevant year of birth. Pursuant to that Act, the statutory age of retirement is 62 years for those born before 1952, 62.5 years (more precisely 62 years and 183 days) for those born in 1952, 63 years for those born in 1953, 63.5 years for those born in 1954, 64 years for those born in 1955, 64.5 years for those born in 1956, and finally, 65 years for those born in or after 1957. The measures aimed at increasing the statutory retirement age adopted in 2009 were complemented by stricter rules for early retirement, as compared with the ones introduced earlier, in 2007.

The table below shows the new statutory retirement age for people born in various years, furthermore, the last four columns of the table contain the increasingly tightened conditions of opting for early retirement, related to the new retirement ages. (The latter conditions ceased to be applicable after the adoption of the pension-related measures in 2012, see below).

Increases in the statutory retirement age for age groups born in various years

Year of birth	Retirement age, year	Date of retirement	Age for early retirement		Date of retirement	
			Women	Men	Women	Men
1951	**62**	**2013**	**57**	**60**	**2008**	**2011**
1952	**62.5**	**2014.5**	**59**	**60.5**	**2011**	**2012.5**
1953	**63**	**2016**	**59**	**61**	**2012**	**2014.**
1954	**63.5**	**2017.5**	**60.5**	**61.5**	**2014.5**	**2015.5**
1955	**64**	**2019**	**61**	**62.**	**2016**	**2017**
1956	**64.5**	**2020.5**	**61.5**	**62.5**	**2017.5**	**2018.5**
1957	**65**	**2022**	**62**	**63**	**2019**	**2020**
1958	**65**	**2022**	**62.5**	**63**	**2020.5**	**2021**
1959	**65**	**2022**	**63**	**63**	**2022**	**2022**

As can be seen in the table, the age requirement for old-age retirement for those born in 1957 (the first year of birth to which a retirement age of 65 is applicable) is fulfilled in 2022 on their birthday. Before them, those born in 1956 may retire at the age of 64.5 (64 years and 183 days), which may be in the second half of 2020 or in the first half of 2021, depending on which half year of 1956 the person concerned was born in. (If a person was born in the first half of the year of birth indicated in a given line, they may retire in the second half of the year corresponding to the year of retirement, while a person who was born in the second half of the year of birth indicated may retire in the first half of the year after)

Change in the rules of early retirement and retirement at an earlier age, in order to raise the actual retirement age.

After the turn of the millennium, retirement before reaching retirement age continued and became an increasingly common practice. This resulted in a situation where over 90% of the persons concerned retired at the earliest allowed age. Moreover, in addition to early old-age pension, further benefits were also available (early retirement, lower retirement age, pension schemes in certain branches of the economy, years deducted as a result of raising children), which promoted the spread of early retirement. As a result of the increase of the retirement age in 1997, the median age of retiring also increased by almost three years, but continued to fall short of the legal retirement age significantly (by 3 to 5 years). This situation carried significant sustainability risks, so from 2006 adjustments have been made in several steps, in an effort to tighten the rules of access to early retirement. After the pension-related measures of 2006, the rules were changed several times (in 2008, 2009, and then in 2010), and the most

recent measures, in effect since 1 January 2012, terminated the option - with the exception of some transitional rules affecting a small group of persons - of influx into the system under this legal title in the future. The table below illustrates the trends in the actual age of retirement over the past few years. As can be seen, in spite of a significant improvement, there is still a major difference compared to the statutory retirement age, currently 62 years, especially among women. The situation is expected to improve considerably in the future as the 2012 measures exert their effect, and as the increase in the retirement age is gradually implemented.

Trends in actual retirement age

	Old age and old age type pensions combined	Ö+R+RJ altogether*	Men Old age pension	Women Old age pension
1996	**55.8**	**53.1**	**58.7**	**54.3**
1998	**57.4**	**52.6**	**59.6**	**55.9**
2000	**57.4**	**52.6**	**60.0**	**55.9**
2003	**59.5**	**54.3**	**59.7**	**58.8**
2005	**58.6**	**55.4**	**59.9**	**57.7**
2008	**58.3**	**56.2**	**59.8**	**57.3**
2010	**60.3**	**56.0**	**60.2**	**60.7**
2011**	**59.1**	**57.5**	**60.4**	**58.4**

Source: ONYF (National Pension General Directorate)
** old age and old age type pensions, invalidity pension and allowance combined*
*** preliminary figure*

The measures aimed at increasing the statutory retirement age adopted in 2009 were complemented by stricter rules for early retirement, as compared with the ones introduced earlier, in 2007; however, these rules were significantly changed in 2011. From 2012 the option of early retirement under that title was practically terminated. During the transition, retirement at an earlier age was available subject to the following rules.

The rules of eligibility for early old age pension effective in 2009

a) Prior to reaching the retirement age for old age pension, men who reached the age of 60 and were born in 1950 and women who reached the age of 59 and were born in 1952 or 1953 were eligible for early old age pension, if
    - they had amassed a service time of at least 40 years (at least 37 years for the reduced early old age pension), and
    - on the day from which the early old age pension (reduced early old age pension) was granted, had no legal relationship of insurance pursuant to Article 5, paragraph (1), points (a) to (b) and (e) to (g) of the Social Security Act.

When determining the reduced amount early old age pensions, the measure of the reduction was, for persons who had a service time that was 1 to 365 days shorter for every unit of 30 days of the period starting from the date when the social insurance pension was granted until the date of reaching the retirement age for old age pension, 0.1% per month, for persons having a service time that was 366 to 730 days shorter, 0.2% per month, for persons having a service time shorter by 731 to 1095 days, 0.3% per month.

b) Two years prior to reaching the retirement age for old age pensions, men born prior to 31 December 1950 and women born prior to 31 December 1958 were entitled to early old age pension, if
    - they had amassed at least 37 years of service time, and
    - on the day from which the early old age pension was granted, had no legal relationship of insurance pursuant to Article 5, paragraph (1), points (a) to (b) and (e) to (g) of the Social Security Act.

The extent of the reduction of early old age pension claimed while meeting the conditions mentioned above will no longer depend on the length of service time, rather on the time between the early old age pension and the retirement age for old age pension when the claim is submitted for the early old age pension. Therefore, in the above case, the amount of the early old age pension must be specified in such a manner that the amount of the old age pension must be reduced by as many times

- 0.3% as is the number of units of 30 calendar days missing for reaching the retirement age for old age pensions, if the beneficiary is younger by at most one year than the retirement age for old age pension,
- 3.6%, plus as many times 0.4%, as is the number of units of 30 calendar days missing for reaching the age one year lower than the retirement age for old age pension, if the beneficiary is younger by more than one year than the retirement age for old age pension.

Reaching the retirement age for old age pension does not affect the reduction.

c) Men are also entitled to early old age pension who have amassed a service time of at least 42 years, were born in 1952 or 1953 and have reached the age of 60,
- were born in 1954 and have reached the age of 60 years and 183 days, furthermore
- on the day from which the early old age pension is granted, pursuant to Article 5, paragraph (1), points (a) to (b) and (e) to (g) of the Social Security Act, have no legal relationship of insurance.

But even in this case the ratio of the reduction must not exceed 8.4% of the amount of old age pension.

Persons who had reached the age necessary for full or partial old age pension by 31 December, 2009 and had amassed the required service time were authorised to apply for this entitlement at any time. In this case the age defined in the Pensions Act applicable on 31 December 2009 was considered as the retirement age for old-age pension. Persons who had reached the age required for taking reduced amount early old age pension and had amassed the required service time could apply for this entitlement at any time - if they obtained their entitlement after 31 December 2007 - by terminating the legal relationship involving insurance, as defined in Article 5, paragraph (1), points (a) to (b) and (e) to (g) of the Social Security Act. The reduction of the pension was subject to the rules and measures applicable at the time of obtaining the entitlement. Otherwise the amount of the early old age pension and the reduced amount early old age pension were determined pursuant to the provisions that are applicable to the date from which the pension benefit was granted.

Rules applicable in 2010

Men: In 2010, men born in 1950 or before (60 years of age or older) were allowed to retire with early old age pension if they had amassed a service term of 40 years and were not in a legal relationship involving insurance obligations. Application for early old age pension was also subject to the condition of eligibility that, in the case of EEA states or persons subject to the application of social security convention, the applicant must not be in any legal relationship involving insurance obligations in the contracting state, either.

Women: In 2010 the early retirement age for old age pension for women was 59 years, during the year, persons born in 1951 reached this age, but according to the formerly applicable rules they were allowed to retire in 2008, at the age of 57, with early old age pension. If they did not apply for that entitlement at that time, they are allowed to apply for it later on. The increase of the retirement age began with the 1952 age bracket in the case of women, but women who were born in 1952 and 1953 were allowed to retire with early old age pension at the age of 59 - in 2011 and 2012, respectively - if they had amassed a service time of at least 40 years and were not in any legal relationship involving insurance obligations in Hungary or abroad.

Reduced amount early old age pension

Men: In 2010, men aged 60 years or older were entitled to a reduced early old age pension, if they had a service time of at least 37 years and were not in any legal relationship involving insurance obligations, e.g. employment. The measure of the reduction depended on their age and the length of their service time. If a person applied for a pension from his 60th birthday and had amassed a service term of 37 years, then his pension was reduced by 7.2%; with 38 years this ratio was 4.8% and with 39 years it was 2.4%. In 2011, men born in 1951 were allowed only to take reduced early old age pension. A service time of at least 37 years needed to be proven for eligibility, and the measure of the reduction was mitigated by a longer service time than that. The measure of the reduction only depended on age, on how many months prior to the retirement age the beneficiary intended to retire. If the applicant had already reached the age of 61, his pension was reduced by as many times 0.3 per cent as the number of units of 30 days missing before reaching the age of 62. If the applicant had not yet reached the age of 61, the extent of the reduction was 3.6 per cent, plus as many times 0.4 per cent as the number of units of 30 days missing before reaching the age of 61. For example, if someone took early old age pension from his 60th birthday, his pension was reduced by 3.6 + 4.8 = 8.4 per cent. Persons belonging to the first age bracket affected by the raise of the retirement age were entitled to special benefits. Men who had amassed a service time of 42 years or longer and were born in 1952 could apply for reduced early old age pension 2.5 years earlier, those born in 1953 or 1954 three years earlier than the raised retirement age, in exchange for the pension reduction of 8.4% per cent defined for retiring two years earlier. Persons who were born in subsequent years could take reduced early old age pension two years prior to their respective retirement age.

Women: In the case of women, the age bracket of 1954 was the first one who could only receive reduced early old age pension. Those born in the years 1954, 1955, 1956, 1957 could take the reduced early old age pension 3 years prior to the raised retirement age applicable to them, those born in 1958 could take it 2.5 years earlier, in exchange for a capped reduction of 8.4% per cent, calculated for 2 years. Any legal relationship involving insurance obligations,

applicable in Hungary or abroad, also had to be terminated in the case of a reduced early old age pension. (the Pensions Act Article 18/A, Article 18/B)

- **Pension measures between 2010 and 2011**

Reorganisation of the statutory private pension pillar

In October 2010, the decision was made on the suspension of payments of membership fees into private pension funds for 14 months, and on the termination of the obligation to join private pension funds in the future. During that time, members of private pension funds also paid their full pension contributions to the Pension Insurance Fund. Members of the funds had a choice to make by 31 January 2011 on whether to return to the Social Security pillar or remain with the private pension fund. 97% of the members chose to return.

This measure was necessitated by the need to reduce the target deficit of the state budget, to decrease the high deficit of the Pension Insurance Fund, furthermore the expectation formulated in the pension system that a balance must be struck between the allowance payments and expenditures of the Pension Insurance Fund at all times. The negative experiences accumulated during the term of operating the private pension funds (including but not limited to expensive operation and low real returns on interest for an average term of 10 years) also contributed to the implementation of these measures. Through this measure, the pension system was transformed into a two-pillar system. One element is the state-sponsored pension system maintained with public funding, and the other is the one supplementing it, the system of institutions providing voluntary savings.

From 1 January 2012, the funding of the system changed: the beneficiary pays his or her contributions into the statutory social insurance pension system. Those who opted for a private pension fund also paid the contribution corresponding to their membership fee into the statutory system, and payment into the private pension funds has become a supplementary arrangement, although every fund defines the amount of the voluntary membership fee in its own Articles of Association.

- **Pension-related measures between 2011 and 2012**

Implementation of the "women forty" early retirement option

From 1 January 2011 women are entitled to old-age pension, regardless of age limit, if they have an entitlement time of at least forty years. In addition to the time of contribution payments, time spent raising children is also applied towards the entitlement time. As a main rule, at least 32 years of that period of 40 years must be service time based on the payment of contributions, and the longest qualifying service time related to child raising can be 8 years. In the case of persons raising 5 or more children, the term of contribution payment of 32 years will be reduced by one year for each child, but it must be demonstrated that the term of contribution payments on income derived from work is at least 25 years.

III. Changes in the health insurance system

Sickness insurance has two pillars: in kind and cash benefits. Persons gainfully employed receive the benefits free of charge, in exchange for the contributions paid by them. The benefits of sickness insurance are different depending on whether the sickness of the gainfully employed person is related to working. If so, it is regarded as a workplace accident or

occupational illness, and entails accident benefits; if not, general sickness insurance benefits are available, i.e. sick pay may be taken.

Sick pay

Insured applicants may receive sick pay who are incapable of work and have been registered by their GP as unable to work. During the first 15 days of incapacity for work, sick leave is paid, rather than sick pay, during which time the employer pays 70% of the absence pay. Sick pay falls due for a term not exceeding 1 year during the existence of the legal relationship of insurance, or in the case of nursing a sick child, the term is adapted to the age of the child (84 days per child between the ages of 1 and 3, 42 days between the ages of 3 and 6). From 1 August 2009 the measure of the sick pay was reduced from 70% of the applicable income to 60%, while with a continuous insurance relation of less than 2 years, in the case of in-patient treatment, it was reduced from 60% to 50%. The calendar daily amount of sick pay may not be more than one-thirtieth of 400 per cent of the minimum wage applicable on the start date of eligibility. From 1 May 2011, the amount of daily sick pay may not exceed one-thirtieth of 200 per cent of the minimum wage applicable on the start date of eligibility.
Average number of sick pay recipients:

2009: 90 thousand persons
2010: 76 thousand persons
2011: 62 thousand persons

Number of persons entitled to sick pay:

2009: 3 413 thousand persons
2010: 3 473 thousand persons
2011: 3 511 thousand persons

Source: National Health Insurance Fund (OEP)

If the health of the employee is impaired to an extent not exceeding 50% as a result of a workplace accident, he/she is entitled to in kind accident health services, cash benefits as accident sick pay or accident allowance.

Accident health service

When taking this benefit, the employee who suffered a workplace accident is entitled to all the health services that the beneficiaries are otherwise entitled to (e.g. outpatient care from the general practitioner, patient transport, hospital care - inpatient care, operations, medicines, dressings, X-ray examinations, travel costs refund, and medicines (drugs) prescribed by the general practitioner). In addition, the beneficiary also has some entitlements that make him or her eligible for a wide scope of benefits under health insurance. One hundred per cent social security support is due for the price of the medicines, medical appliances and curative treatment, even if the given benefit is otherwise not 100% supported. If teeth were also wounded, then the beneficiary is also entitled, for the purpose of masticatory rehabilitation, to the full service of dental prosthesis becoming necessary in direct relation to his or her workplace accident, free of charge.

Accident sick pay

Insured persons and other persons entitled to accident care are authorised to receive accident sick pay if they have become unable to work as a result of a workplace accident during the

existence of the insurance or on the third day following the termination of the insurance at the latest (including persons employed with a temporary work book). In this case the purpose of the social security service is rehabilitation and support for returning to work as soon as possible. Accordingly, as a main rule, *the benefits are provided for a term of 1 year, their amount is the amount of the income of the insured person constituting their health care contribution base, i.e. 100% of the income constituting the base of accident sick pay, or 90% in the case of a road accident*. If the term of one year is not sufficient for the restoration of working capacity, then after the expiry of this term, the term of the payment of accident sick pay may be extended by up to one year according to the expert opinion of the National Institute of Rehabilitation and Social Experts. Employees receiving accident sick pay may not be engaged in paid employment, since the fact that they are unable to work because of their illness is exactly the reason why they receive 90 to 100% of their former average salary.

Accident allowance

Persons are entitled to accident allowance who suffered a health impairment exceeding 13% as a result of a workplace accident, but the level of health impairment remains below 50%, i.e. the relevant employee is not yet entitled to the rehabilitation allowance available from the system of pension insurance or to accident invalidity pension. The amount of the accident allowance depends on the level of health impairment caused by the workplace accident. In the case of accident allowance, the basis of the benefits is the income earned in the last year directly preceding the workplace accident. The income serving as the basis of the accident allowance must be calculated according to the rules applying to pensions, with the departure that the income does not have to be reduced by the amount of the calculated tax. Accordingly, the calculation of the amounts of accident allowance results in relatively higher amounts of benefits than the pension benefits. In addition to receiving accident allowance, the beneficiary is allowed to work, there is no income ceiling that would exclude him or her from receiving his or her social security benefits. The following table shows the accident levels and amounts of the allowances.

Level	*Extent of health impairment*	*% of average monthly salary*
Accident level 1	14-20 %	8
Accident level 2	21-28 %	10
Accident level 3	29-39 %	15
Accident level 4	39-50 %	30

The beneficiary becomes entitled to accident allowance from the day on which the health impairment through accident exceeding 13% was determined. If the employee is receiving accident sick pay on this day, then he or she will become entitled to the accident allowance from the day following the expiry of the sick pay.

International legal obligations

The Hungarian-Montenegrin Agreement (promulgated in Act LXXII of 2008) and the Hungarian-Bosnian Agreement (promulgated in Act II of 2009) entered into force in the audited period. These agreements define the applicable legislation, healthcare and pension services.

IV. The system of family allowances

In the reporting period the following statutes regulated support to families:

- Act LXXXIV of 1998 on Family Support (hereafter: the Family Support Act)
- Government Decree 223/1998. (Dec. 30) on the implementation of Act LXXXIV of 1998 on Family Support

In addition to the above, Act XXXI of 1997 on the Protection of Children and on Guardianship Administration also prescribes benefits for families with children, however - considering the fact that these benefits are available for those in need - we will present them in section 13, in the system of welfare support.

A. The system of family support as of 1 January 2008

Support available under the Family Support Act

Hungarian citizens, immigrants or persons with resident legal status, furthermore, persons recognised by the Hungarian authority as refugees or stateless and - with the exception of maternity aid - persons belonging to the scope defined in Regulation (EEC) No 1408/71 of the Council of 14 June 1971 on the application of social security schemes to employed persons and their families moving within the Community, are eligible for family aid under the Family Support Act

No legal relationship of insurance is required for eligibility for the family support available under the Family Support Act. These benefits are not dependent on income.

The family benefits available under the Family Support Act are the following:

- family allowance
- child care support: child home care allowance and child raising support
- birth grant

1. Family allowance

This is a benefit paid monthly for the costs of education and schooling of the child.

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, foster parent, professional foster parent, guardian, furthermore, the person in whose custody the child was placed temporarily;
b) guardians with the right of asset management, temporary carer in charge of asset management with regard to a child (person) raised in a children's home, correctional institute or detained in a penitentiary, under child protection care;
c) head of a social institution operating in Hungary, with regard to a child placed in the institution;
d) a permanently ill or severely disabled person who is eighteen years of age or older, providing that a higher family allowance is paid with regard to him or her until he or she reaches the age of eighteen;
e) the person identified by the guardianship authority in a Decree authorising departure from the parental home.

Family allowance is due from the birth of the child until he or she becomes of age, and in the case of children studying in institutions of public education it is due until the end of the academic year during which he or she reaches the age of 23. Permanently ill, severely disabled persons [point d)] are entitled to family allowance without age restriction.

2. Child care support

A biological or adoptive parent raising the child, 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, foster parent, professional foster parent, guardian, furthermore, a foster parent or guardian, is entitled to child home care allowance or child-rearing allowance paid a on a monthly basis, with regard to the care of the child.

2.1.Child home care allowance (hereafter: GYES)

GYES falls due until the child reaches the age of three, in the case of twin children until the end of the year in which they reach the age of compulsory schooling, in the case of permanently ill or severely disabled children until they reach the age of 10. Grandparents are also entitled to child home care allowance when the child has reached the age of one, furthermore, the care and raising of the child takes place in the household of the parent, 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. Under the principle of weighing and deliberation, the head of the treasury may

a) grant eligibility for child home care allowance to a person raising a child, if the parents of the child are not able to raise the child for a term exceeding three months;
b) grant or extend the term of payment until the child starts his or her primary school studies, but not beyond the year in which the child reaches the age of 8, if the child cannot be placed in a children's day care institution because of illness.

Persons receiving child home care allowance - excluding grandparents - are not allowed to be engaged in paid unemployment until the child reaches the age of one, with the exception of the guardian of an underage parent. After the child has reached the age of one, paid employment may be taken up without any time limit. Grandparents receiving child home care allowance may be engaged in paid employment for a term not exceeding four hours per day after the child has reached the age of four, or without any time limit if they work in their home. The monthly amount of GYES equals the minimum amount of old age pension (between 2008 and 2011: HUF 28,500), in the case of twins it is twice the minimum amount of old age pension. Pension contributions are deducted from the amount, and the term of its payment is considered service time.

2.2.Child raising support (hereafter: GYET)

This means the provision of cash benefit for the home care of children to families where at least three children are raised and the youngest child is older than 3 years and younger than 8 years. Persons receiving GYET may take up paid employment for a term not exceeding four hours per day, or without any time limit if they work in their home. The monthly amount of GYET equals the minimum amount of old age pension (between 2008 and 2011: HUF 28,500), from which pension contributions are deducted, and the term of payment is recognised as service time.

3. Birth grant

The following persons are entitled to birth grant after childbirth:

- women who have attended pregnancy care on at least four occasions during their pregnancy, or once in the case of a premature delivery;
- adoptive parents if the adoption was permitted in a legally binding manner within 180 days following the birth of the child;
- guardians, if the child was placed in their custody within 180 days following the childbirth, pursuant to a legally binding court order.

Women having delivered a child are entitled to birth grant even if the child was stillborn. If the woman entitled to birth grant dies prior to collecting her birth grant payment, then the grant must be paid to the father living in the same household as the mother, or if there is no such person, to the person who takes care of the child. The amount of the birth grant, per child, equals 225% of the lowest amount of the old age pension valid at the time of the birth of the child (between 2008 and 2011 HUF 28,500), 300% in the case of twins. No birth grant is due if, before the birth of the child, the parents consented to the adoption of the child in a statement, or if the born child receives child protection care under the legally binding court order of the child welfare agency resulting in removal from the family. If the relevant application is submitted within 180 days after the childbirth, the birth grant falls due to the eligible person if the statement of consent to the adoption of the child has been withdrawn, or if the child protection care resulting in removal from the family is terminated, and from that point on the mother will raise the child.

B. Changes in the system of family support during the reporting period

From 1 September 2009

If the child is placed under protection, the family allowance may be provided partly in kind, provided that the child was placed under protection because of exposure to risks owing to the neglect of the child. The child welfare agency that brought the court order on the protection of the child will decide on the provision of the family allowance in kind. Up to 50% of the amount of the family allowance payable on children placed under protection may be provided in kind, for a term not exceeding one year, which may be ordered repeatedly, if justified.

From 1 May, 2010

The term of payment of the child home care allowance was reduced from the earlier term of three years to two years in the case of children born after 30 April 2010. For parents raising twins and sick children the term of payment remained unchanged. Also applying to children born after 30 April 2010, the child-rearing allowance could be paid from the time when the youngest child reached the age of two, as opposed to three.

From 30 August 2010

From 30 August 2010, family allowance has existed in two forms: child raising benefit from the birth of the child until the start date of compulsory education, after which schooling support is paid by the Hungarian State Treasury. Persons of age who are permanently sick or severely disabled will be entitled to child raising support in their own right after the expiry of

the schooling support. Since 30 August 2010, the payment of schooling support has been conditional on the fulfilment of compulsory education, and on regular school attendance.

The schooling support is suspended in the case of children missing at least 50 obligatory school classes. The suspended family allowance must be transferred to the family support current account maintained by the local government of the locality. The support must be provided to the most needy families that receive regular child protection allowance, even during the term of the suspension. In such cases the support is paid in kind, from the family support current account. If the schooling support is suspended, then the parent will only be allowed to access the support (with the exception of children entitled to regular child protection allowance) if the child has not missed one single class without justification. In this case the local government will provide the amount accumulated on its family support account in kind, spread over a period identical with the period of the suspension. From 30 August 2010, family allowance is only due, in the case of children studying in institutions of public education, until the end of the academic year in which the child reaches the age of 20 (as opposed to the former age of 23), or in the case of children with special educational needs but not receiving disability support, the age of 23. In the case of permanently ill, severely disabled children the higher amount family allowance continues to be due, regardless of age.

From 1 January 2011

The term of payment of child home care allowance was once again raised from two years to three. This amendment is retroactive, i.e. also applies to parents whose children were born between 1 May 2010 (the effective date of the reduction of the term of child home care allowance to 2 years) and 31 December 2010. The child raising support due to parents with two or more children once again falls due - related to the reinstitution of the term of payment of the child home care allowance from two years to three – until the child reaches the age of 3. The amount of the child home care allowance was modified depending on the number of children for those raising twins: while earlier in the case of twin children twice the amount of the minimum old age pension had been due, regardless of the number of children, from 1 January 2011 the amount has been the minimum old age pension multiplied by the number of children. i.e. in the case of triplets, the amount of the benefit is three times the minimum old age pension (HUF 85,500), for quadruplets it is four times (HUF 114,000 per month), for quintuplets it is five times (HUF 142,500 per month) and for sextuplets six times (HUF 171,000 per month). The rules on employment while receiving child home care allowance have also been modified.

From 1 January 2011, after the child reached the age of one, the performance of work has been allowed while receiving child home care allowance, for up to 30 hours per week (formerly no time restriction had applied to working after the child reached the age of one), there is no time restriction if work is performed in the home of the parent. These restrictions do not apply to persons raising permanently ill, severely disabled children, they are allowed to continue working in paid employment after the child has reached the age of one, without time limit.

Persons raising twin children may choose between working in paid employment exceeding 30 hours per week after the children have reached the age of one, and in this case they will only be entitled to the base amount of child home care allowance, or they may be engaged in paid employment for up to 30 hours per week, and will receive the higher amount of benefits due

to families raising twins. In the case of child raising support, as opposed to the time of 4 hours per day, paid employment is allowed for 30 hours per week. There is no restriction if the work is only performed in the home. In order to facilitate the adoption of children older than 3 years who have undergone several traumas, in Hungary, foster parent's child home care allowance may be claimed. The foster parent's child home care allowance entitles either of the foster parents, after the adoption of a child who has not yet reached the age of 10, to receive child home care allowance for a term of 6 months even if according to the general rules he or she would no longer be entitled to it (owing to the age of the child), or the term of entitlement would be shorter than 6 months. The amount of the foster parent's child home care allowance is the same as the general amount of the child home care allowance, i.e. HUF 28,500 per month. Recipients of this benefit may be engaged in paid employment for up to 30 hours per week.

In the case of parents who divided up the time of child care between themselves in alternating terms of equal length, the Treasury may now grant eligibility for family allowance to both parents, in a ratio of 50% each. The personal scope of the law on family support has been extended in respect of birth grant. Pursuant to the amendment, every woman legally staying in the territory of Hungary who has attended pregnancy care on at least four occasions during her pregnancy, or once in the case of premature delivery, in the territory of Hungary, is eligible for birth grant .

V. Unemployment benefits

Relevant statute: Act IV of 1991 on the Promotion of Employment and Provisions to the Unemployed (hereafter: the Employment Act).

Entitlement to unemployment benefits covers the entire community of persons employed in the legal relationships defined in the Employment Act. The protected persons are persons specified in Article 58 (5) of the Employment Act, who are employed under Hungarian law. Persons performing enterprising activities are also protected if they comply with their obligations to pay labour market contributions. If the entrepreneur has complied with his or her obligation to pay labour market contributions, then the term of enterprising activity shall be counted towards the time of entitlement to job-seeking allowance.

The following legal relationships are considered employment:

- employment,
- legal relationship in civil service,
- legal relationship in government service,
- legal relationship in public employment,
- service relationship in court, judicial agencies and the public prosecutor's office,
- legal relationship in public works schemes,
- insured outworker's legal relationship and equivalent outworker's legal relationship established prior to 1 June 1994,
- legal relationship of professional foster parent,
- employment type legal relationship aimed at the performance of work of members of cooperatives, excluding full-time student members of school cooperatives,
- carrier or contractual service relationship of members of armed forces and law enforcement agencies.

Job seekers are entitled, pursuant to the Employment Act, to job seeker's allowance, job seeker's aid before retirement and cost refunds, as job-seeking benefits.

Pursuant to Article 25 (1) of the Employment Act, the following persons are entitled to jobseeker's allowance:

- those who are seeking a job,
- have amassed an entitlement time of at least 360 days prior to becoming a job-seeker,
- wanted to find a job, but their independent job search activity was unsuccessful, and the public employment service (labour affairs centre) was also unable to offer them a suitable job.

The term of 360 days of employment shall exclude the term of unpaid leave exceeding 30 days, unless it was taken for any of the following reasons:

- care of a child below the age of three,
- if the employee is receiving child home care allowance for the purpose of caring for a child below the age of fourteen,
- home care of a sick child below the age of twelve,
- home care of a close relative,
- doing service as a voluntary reserve soldier.

The job offered by the labour affairs centre is considered adequate in the following cases:

- the job-seeker is suitable for the given job according to his or her medical condition,
- the expected wage is at least as much as the amount of the job seeker's allowance, or if the amount of the job seeker's allowance is lower than the mandatory minimum wage, it is at least as much as the amount of the mandatory minimum wage,
- the commuting time between the workplace and the place of residence does not exceed three hours by means of public transport, or two hours in the case of women raising a child or children under the age of ten, and in the case of men raising a child or children under the age of ten on their own,
- the job-seeker will work in employment.

In the case of job-seekers with disabilities, the above conditions are applicable with the difference that the job is considered adequate if the time of daily commuting between the workplace and the place of residence, using public transport available for the disabled job-seeker, does not exceed two hours.

Short term jobs may also be offered to the job-seeker, if they are qualified as adequate jobs based on the above criteria.

The amount of the allowance base and that of the allowance is the following, pursuant to Article (26) of the Employment Act:

The base of the job seeker's allowance must be calculated according to the former average wage/salary of the unemployed person, and no other factor, such as the number of dependants, may be taken into account. The amount of the job seeker's allowance must be calculated on the basis of the average monthly amount of the labour market allowance base, as defined in a separate statute, earned in the four calendar quarters preceding the time of becoming a job-seeker, in the legal relationships affected by these periods. When the average

monthly amount is calculated, the amount of the allowance base earned in this period must be divided by the number of months in which the job-seeker earned income constituting the allowance base. If the job-seeker has an allowance base not applying to the entire month in the given month, then in the calculation of the monthly average amount that month must be taken into account as a fraction of a month. If a 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 enterprising activity, or was employed but was also engaged in enterprising activity, then the amount of the job-seeking allowance must be calculated taking into account the allowance base earned at each employer or in each enterprising activity. If there is no base for the allowance in the preceding four calendar years, the calculation of the allowance must be based on the monthly average of the allowance base earned over a shorter period.

If the job seeker has no allowance base whatsoever in the preceding four calendar years, the job seeker's allowance must be determined based on 130 percent of the mandatory minimum wage in force on the first day of entitlement. The base of the calculation of the job-seeking allowance per one day is the one-thirtieth part of the amount calculated as defined above.

The daily amount of the job seeker's allowance is 60 per cent of the allowance base calculated in the manner presented above, not to exceed the daily amount of the mandatory minimum wage applicable on the start date of eligibility.

The term of payment of the job seeker’s allowance must be calculated based on the period of time spent by the job-seeker in legal relationship of public works during the term of three years preceding the date of becoming a job-seeker, or had been engaged in enterprising activity as a sole trader or a member of an economic association, assuming in this latter case, that during the performance of enterprising activity he or she complied with his or her obligation of paying contributions (entitlement time). The time during which the job-seeker received job seeker’s allowance or entrepreneur’s allowance shall not be applied to the term of entitlement time. The term of five years defined above shall be extended by the following terms, or part of the following terms, if during those terms no employment or legal relationship of public works applied, or if the job-seeker was not engaged in enterprising activity qualifying as job-seeking entitlement time.

The term of five years defined above shall be extended by the following terms, or part of the following terms, if during those terms no employment or legal relationship of public works applied, or if the job-seeker is not engaged in enterprising activity not qualifying as job-seeking entitlement time:

- military service as an enlisted or reserve soldier, or community service,
- illness involving incapacity for work,
- term of sick pay taken for the nursing of a sick child,
- term of payment of prenatal allowance, child home care fee, child home care allowance,
- payment of the benefits of persons with disabilities, rehabilitation allowance, invalid ity pension and accident invalidity pension, regular and social security allowance, furthermore,
- payment of the health impairment allowance of miners,
- pre-trial detention, incarceration and detention punishments,

- payment of nursing fee and child-rearing allowance,
- studying in a university or college as a full-time student.

When calculating the period of disbursement of the job seeker's allowance, five days of entitlement time correspond to one day of allowance payment. If fractions of a day result in the calculation, the rules of rounding shall be applied. The longest period of payment of the job seeker's allowance is 90 days.

The payment of job seeker's allowance must be terminated, if the job-seeker:

- requests so,
- is deleted from the registry,
- becomes entitled to benefits of persons with disabilities,
- takes up paid employment, with the exception of short-term activities, not exceeding ninety days,
- accepts the training option in which he or she receives a regular benefit that is at least as much as the amount of the mandatory minimum wage,
- is a full-time student in an institute of education,
- has died,
- has exhausted the time of payment of job-seeking allowance.

The payment of job seeker's allowance must be suspended, if the job-seeker:

- reports that she has been determined entitled to prenatal allowance child home care fee or child home care allowance,
- is in pre-trial detention, serving his or her time of deprivation of liberty or detention, unless the punishment of deprivation of liberty was imposed as a conversion of a monetary fine,
- is working in a public work scheme, as defined by law,
- becomes engaged in paid employment, not exceeding ninety days,
- receives salary compensation allowance,
- is on active voluntary military service, for the entire service term.

At the request of the job-seeker, pre-retirement job seeker's aid must be granted to

- a job-seeker who
- wants to find a job, but the independent job search activity was unsuccessful, and the public employment service was also unable to offer a suitable job,
- did not miss more than five years at the time of the submission of the application for reaching the retirement age for old age pensions (the age necessary for granting old age pensions) applying to him/her, and
- received job seeker's allowance for at least 45 days, or prior to the exhaustion of the term of payment, the payment of the job-seeking allowance is terminated owing to paid employment, and the job-seeker fails to become eligible for job seeker's allowance repeatedly, and
- has exhausted the term of payment of the job seeker's allowance, and
- reaches the age necessary for granting, within three years following the exhaustion of the payment of the job seeker's allowance or the termination detailed above, and
- has amassed the service time necessary for old age pension, and
- has not received, prior to reaching the required age, any service benefit, annuity of a ballet artist or temporary allowance of miners.

The amount of the job seeker's aid is determined by taking 40 per cent of the mandatory minimum wage applicable at the time of the submission of the application as the basis. The suspension and termination of the payment of job seeker's aid are subject to the same rules as in the case of the job seeker's allowance. The costs incurred related to the support of job-seekers (unemployment benefit) and those incurred related to job search (including commuting between the home and the state employment agency, as well as travelling necessary for obtaining the occupational health medical expert opinion initiated by the state employment agency), the costs of justified travel between localities using public transport must be refunded to the job-seeker.

Those who received a benefit without a legal basis must refund it, if they were mandated to do so in writing, within six months from the date of taking the benefit. After that time, the benefits received without a legal basis may be reclaimed if the payment without a legal basis was caused by the wrongful conduct of the beneficiary. If the beneficiary of the unemployment benefit is engaged in paid activity as an agricultural owner farmer, then he or she is required to refund the unemployment benefits taken in the tax year. Those who collected unemployment benefits without a legal basis after the death of the job seeker are required to refund them. If requested, the head of the labour affairs centre may waive the refund of the unemployment benefits taken without a legal basis and reclaimed, fully or partially, on the basis of deliberation. If the court has declared in a legally binding ruling that the employer terminated the employment of the employee unlawfully, the employer shall pay the amount of the job-seeking benefit and its taxes paid to the affected person until the time when the ruling of the court became legally binding, to the solidarity fund section of the National Employment Fund.

In the case of a reclaim no default supplementary charge may be imposed. The employer and other agencies are required to refund any benefits paid without a legal basis if payment of the benefit without a legal basis is a result of a failure to supply data or the supply of untrue data, and such benefits may not be reclaimed pursuant to the rules mentioned above.

The care system is funded from the social contribution tax. The social contribution tax is a payment obligation applying to the paying party concerning certain legal relationships with natural persons, to sole traders, agricultural owner farmers with regard to that legal status (on himself/herself), other persons pursuant to separate provisions of this chapter, in accordance with the obligation to contribute to fulfilling the common needs of society, defined as a percentage value.

In order to provide the necessary resources to cover the individual welfare benefits serving social security and the implementation of the right to mental and physical health, furthermore, to provide the funds for government finances necessary for the maintenance of the uniform state-funded pensions system, the revenues of government finances deriving from the tax are split up according to the ratios defined in the law on the central budget, between the individual funds of social security and the budget of the separate state funds defined by law.

2) KEY DATA AND STATISTICS

Additional significant data in addition to those presented above:

The amounts of the individual family benefits, 2008-2011

The amount of the family allowance by family type (2008-2011)	Amount (HUF/month/child)
Family with a single child	12 200
Single parent raising one child	13 700
Family with 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 ill or severely disabled child	23 300
Single parent raising a permanently ill or severely disabled child	25 900

Changes in the amount of family benefits, 2008 -2011.

Support	2008	2009	2010	2011
Birth grant*	64 125	has not changed		
- for twins	85 500	has not changed		
Child home care allowance	28 500	has not changed		
- for twins	57 000	has not changed		2 children: 57 000 3 children: 85 500 4 children: 114 000 5 children: 142 500 6 children: 171 000
Child raising support	28 500	has not changed		

**The benefits usually fall due on a monthly basis and regardless of the number of children, with the exception of birth grant which is a one-time support granted for each child in the case of twins.*

Headcount figures of family support benefits, 2008-2011

Year	Recipient of family allowance		Average number of families receiving child raising support per month	Birth grant, number of disbursements/year	Number of recipients of child home care allowance per month
	families	children			
	monthly average				
2008	1 246 640	2 028 947	41 631	95 028	167 021
2009	1 245 893	2 029 771	40 263	94 860	174 153
2010	1 224 042	1 993 850	39 275	87 048	178 532
2011	1 190 707	1 933 498	37 829	84 396	169 721

Figures related to the termination of job-seeking support, 2008

According to the data of the National Employment Service, number of job-seekers who had their job-seeking support terminated (persons)	
	2008
Did not accept the offered job	1068
Removal from the registry of job-seekers as a sanction	2 193

Note: in the case of the year 2008 it cannot be determined how many cases occurred when job-seeking benefit was terminated owing to the rejection of a job or training offer. A job-seeker is removed from the registry as a sanction if they fail to comply with his or her obligation of cooperation or did not accept the offered job, training

or labour market programme. (Failure to comply with the obligation of cooperation is the most frequently registered cause).

Figures related to the termination of job-seeking support, 2009-2011

According to the data of the National Employment Service, number of job-seekers who had their job-seeking support terminated (persons)			
	2009	**2010**	**2011**
does not meet the conditions necessary for employment	439	361	250
did not accept the offered job	230	159	146
failed to get employed	203	307	138
did not accept the offered job (sanction)	496	324	537
failed to get employed (sanction)	219	281	343
did not accept the offered job or training	52	145	76
did not agree to be involved in the labour market programme	33	13	2
failed to comply with the imposed reporting obligation	91	7	162
failed to comply with the obligation to show up	8756	10347	9513

3) ANSWERS TO THE QUESTIONS OF ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested information about the numbers and ratios of persons subject to the social security sectors.***

Number of persons entitled to health insurance care (thousand persons per month)

Description	2008	2009	2010	2011
Average number of insured persons*	3 941	3 809	3 844	3 893
Number of persons entitled to health care service (at year-end)	9 774.8	9 681.0	9 681.7	9 617.7
of that, number of those in need from a welfare aspect	40.0	42.5	29.6	29.4

* includes the data of persons contracted with the Health Insurance Fund and employed pensioners..

- ***The ECSR requested information for assessing the adequacy of the services.***

Two approaches are possible when the adequacy of the services is assessed. On the one hand, the development of the income of a given sector can be assessed, in comparison to other sectors or the entire population, on the other hand, the absolute indicators characteristic of the given sector could be evaluated.

Concerning the adequacy of pension services, it should be highlighted that each of the indicators describing the life conditions of pensioners (rate of substitution, income adequacy indicators, poverty risks of senior citizens and the chance of falling below the poverty threshold) has been constantly more favourable for people above the age of 65 in Hungary than the corresponding indicators of the population of active age. This characterises the general picture that the Hungarian social insurance pension system has performed well over the recent years concerning the adequacy of pensions. These indicators showed the development of the relative income position of senior citizens compared to those of active age.

In addition to the indicator of purchasing power value compared with the number of inhabitants, the aggregate substitution rate is used in international statistics for comparing the rates of pensions. This shows the ratio between the average salary of an employee about to retire and the average pension of a pensioner. (According to the methodology applied by EUROSTAT, this value is calculated by dividing the median pension of those between 65 to 74 years of age by the gross salary of those between 50 to 59 years of age.) Concerning this indicator, Hungary occupies the third-place in the ranking of Union member states in 2009, on a par with Luxembourg, after France and Austria, and Hungary registered the smallest difference between salary prior to retirement and the value of the pension. (Pensioners, pensions 2011, CSO).

The following data confirm the relatively favourable income position of senior citizens.

Risk of poverty and social exclusion in certain sections of the society, 2011

Description	Risk of poverty and social exclusion
Children (0-17)	**39.6**
Persons of employment age (18-64)	**31.7**
Senior citizens (over 65 years of age)	**18.0**
Employed	**19.5**
Not employed	**71.3**
Single man	**43.3**
Single woman	**35.6**
Single senior citizen (over 65 years of age)	**28.5**

Source: Eurostat (EU-SILC) 2012 National Social Report, Country Profile Hungary

In international comparison the relative median income rate of senior citizens also developed favourably, the values of which were around 0.9 to 1.0 between 2005 and 2011. Similarly, in the period under examination the theoretical substitution rates of pensions also developed favourably: In 2010 the net theoretical substitution rate stood at 83.3% in cases that may be considered average. At the same time, it is also true that in terms of the purchasing power value per one resident of the old-age pensions, constituting the largest part of services, we are one of the countries that provide a lower level of service, owing to our economic development: Calculated at purchasing power parity, in Hungary the value of old age pensions hardly exceeded one thousand Euros, which is only about half of the average value of the EU 27 countries.

Development of the lowest amounts of pension services between 2008 and 2011

The minimum pension is a service which guarantees that, if pension contributions were paid subject to the defined conditions, it is not possible to acquire a lower amount of benefit in the system, and its amount is not adapted to the costs of living. If we consider the development of minimum pensions as a percentage value of net average salaries, it can be concluded that after the political changes, this ratio has shown a strongly rising trend. As opposed to 42% in 1990, in 2000 the minimum pension only stood at about 30% of the average salary, and by 2005 it had further decreased to 24%. Between 2005 and 2011 it developed in the following way:

Minimum pensions as a percentage of net average wages, 2008 to 2011	
2005	**23.9**
2008	**23.3**
2009	**22.9**
2010	**21.5**
2011	**20.2**

The figures, expressed in the ratio of the (unofficial) subsistence figures published by CSO annually, compared to 54% and 62% in 2000 (relative to the values of one-person and two-person households over the age of 65, calculated for one person) decreased to 49% and 55.5% in 2008, then in 2010 to 40% and 47%, in 2011 to 38% and 44%, respectively. Obviously, minimum pensions are low, but through indexation the amounts of the pension benefits granted at the minimum level have been increasing constantly. For example, the amount of pension benefit granted at minimum old age pension level had increased by almost 20% by the fourth year following the year of retirement (from 2008 to 2012)

Example: Development of minimum old age pension 2008-2012; 2008=100%. If a given person retired in 2008, his or her initial pension equalled the lowest amount of old-age

pension, i.e. HUF 28,500. In the fourth year following retirement, together with the increases, his or her pension grew by 19.2% to almost HUF 34,000.

Year	Amount/HUF	Increase of pension
2008	**28.500**	
2009	29.385	3.1
2010	30.765	4.7
2011	32.090	4.3
2012	33.980	5.9

Because the social insurance pension system previously covered almost the entire population, the ratio of services around and below the minimum pension is extremely low, and in the case of old-age pensions and invalidity pensions it hardly exceeds 1%. This means that given the very low frequency, only a small number of derivative pensions paid for surviving relatives can be calculated according to the minimum pension, typically, the benefits paid to the relatives are calculated from a higher amount than that. This is reflected by the following data:

Ratio of benefits under HUF 25,000 within the total portfolio ratios, 1 January 2011

Type of benefit	Benefits under HUF 25 000	
	count	ratio %
Summarised pension benefits	34 651	1.3
Old age pension	11 968	0.7
Invalidity pension above retirement age	649	0.2
Invalidity pension below retirement age	1 396	0.4
Widow’s and temporary widow’s pension	14 036	11.1
Widow’s pension above retirement age	1 996	2.0
Orphan's benefits	6 535	6,7

Source: Statistical data on the number of persons receiving pension or benefits, National Pension Directorate, January 2011, major benefits

Orphan's benefits do have a minimum level, only the widow’s benefits do not have a guaranteed minimum, this is where low amount benefits have a higher ratio (11.1%). Most of the recipients of these are widow's pensioners under retirement age. Within this pool about half of the beneficiaries received a benefit lower than HUF 25,000 per month. However, if the widow or widower raises a child entitled to orphan's benefits, he or she will be entitled to a minimum orphan's benefit of HUF 24,500 per child under this title (with the exception of those cases when the insured person has not obtained full entitlement to pension).

As the Hungarian social security system basically takes the two-income model as a basis for the treatment of the benefits paid to surviving relatives, after the expiry of the temporary widow's pension provided for one year, the entitlement of the surviving spouse to the widow's pension is only recognised in certain cases (a surviving spouse is eligible for widow’s pension who has reached the age of qualification for old-age pension, or is disabled, or raises a child entitled to orphan's benefits in the right of the spouse, a permanently sick child or a child with a disability, or at least two children entitled to orphan's benefits. If the widow or widower raises a child (children) entitled to orphan's benefits, they will receive orphan's benefits).

Ratio of pensions granted in the applicant's own right in the given year (%)

Year	Pensions granted for reasons of employment policy	Old age pensions	Invalidity. accident invalidity pensions	Rehabilitation allowance	Own right pensions
1995	**24.1**	**33.1**	**42.8**	**-**	**100.0**
2000	**3.6**	**41.8**	**54.6**	**-**	**100.0**
2005	**3.1**	**62.4**	**34.5**	**-**	**100.0**
2010	**10.1**	**48.0**	**27.4**	**14.5**	**100.0**

Development of actual retirement age

	Old age and old age type pensions combined	Ö+R+RJ altogether*	Men Old age pension	Women Old age pension
1996	**55.8**	**53.1**	**58.7**	**54.3**
1998	**57.4**	**52.6**	**59.6**	**55.9**
2000	**57.4**	**52.6**	**60.0**	**55.9**
2003	**59.5**	**54.3**	**59.7**	**58.8**
2005	**58.6**	**55.4**	**59.9**	**57.7**
2008	**58.3**	**56.2**	**59.8**	**57.3**
2010	**60.3**	**56.0**	**60.2**	**60.7**
2011**	**59.1**	**57.5**	**60.4**	**58.4**

Source: ONYF (National Pension General Directorate)
** old age and old age type pensions, invalidity pension and allowance combined*
*** preliminary figure*

Average number of insured persons, 1995 to 2010

Year	Average number of insured persons *	Ratio of insured persons within the total number of inhabitants
	(thousand persons/month)	(%)
1995	4 232	41.0
1996	4 080	39.6
1997	3 889	37.8
1998	3 886	37.9
1999	3 818	37.3
2000	3 843	37.6
2001	3 836	37.7
2002	3 845	37.8
2003	3 900	38.5
2004	3 879	38.4
2005	3 881	38.5

2006	3 908	38.8
2007	3 904	39.0
2008	3 941	39.3
2009	3 809	38.0
2010	3 844	38.4

Source: National Health Insurance Fund, estimated figure on the number of insured persons in 2000 to 2007.

Includes the data of persons specially contracted with the Health Insurance Fund and employed pensioners.

Amounts of pension insurance contributions

Year	Ceiling of contribution payment (HUF)		Pension insurance contributions (%)	
	annual	daily	imdividual*	empl oyer **
1998	1 565 850	4 290	7	24
1999	1 854 200	5 080	8	22
2000	2 020 320	5 520	8	22
2001	2 197 300	6 020	8	20
2002	2 368 850	6 490	8	18
2003	3 905 500	10 700	8.5	18
2004	5 307 000	14 500	8.5	18
2005	6 000 600	16 440	8.5	18
2006	6 325 450	17 330	8.5	18
2007	6 748 850	18 490	8.5	21
2008	7 137 000	19 500	9.5	24
2009	7 446 000	20 400	9.5	24
2010	7 453 300	20 420	9.5	24
2011	7 665 000	21 000	10	24

** In the case of insured persons subject to the application of social insurance pension. A member of the mixed system paid, as part of the ratios indicated above, a private pension fund membership fee of 6% between 1998 and 2002, 7% in 2003, and 8% from 2004 until 31 September 2010*

*** Having been introduced in 2007, the ratio of the early retirement insurance contribution is an additional 13% on the earnings of persons employed in positions with an early retirement option.*

Lowest legally prescribed amounts of pension benefits

Year	Old age pension	Group III	Group II	Group I	Orphan's benefits
		invalidity pension			
	lowest amount (HUF/month)				
1998	13 700	13 700	14 400	14 900	11 700
1999	15 350	15 350	16 130	16 700	13 110
2000	16 600	16 600	17 420	18 040	14 160
2001	18 310	18 310	19 220	19 900	15 620
2002	20 100	20 100	21 080	21 830	17 140
2003	21 800	21 800	22 850	23 670	18 580
2004	23 200	23 200	24 290	25 160	19 750
2005	24 700	24 700	25 850	26 800	21 000
2006	25 800	25 800	26 960	27 950	21 900
01 Jan. 2007-14 Feb. 2007	26 830	26 830	28 040	29 070	22 780
15 Feb. 2007-31 Dec. 2007	27 130	27 130	28 340	29 370	23 080
2008	28 500	28 500	29 800	30 850	24 250
2009	28 500	28 500	29 800	30 850	24 250
2010	28 500	28 500	29 800	30 850	24 250
2011	28 500	28 500	29 800	30 850	24 250

Number of persons receiving pensions in their own right according to the amount of full benefit before the raise

Monthly benefit (HUF)	January 2010		January 2011	
	Count (persons)	(%)	Count (persons)	(%)
-19999	9 600	0.4	10 418	0.4
20000-24999	3 682	0.1	3 381	0.1
25000-29999	7 407	0.3	6 864	0.3
30000-34999	24 647	1.0	17 258	0.7
35000-39999	39 548	1.6	32 512	1.3
40000-44999	58 782	2.4	44 887	1.8
45000-49999	84 542	3.4	61 679	2.5
50000-54999	122 038	4.9	93 197	3.8
55000-59999	152 177	6.1	124 044	5.0

60000-64999	170 755	6.8	151 729	6.2
65000-69999	170 597	6.8	159 083	6.5
70000-74999	159 980	6.4	154 038	6.3
75000-79999	217 449	8.7	155 863	6.3
80000-84999	200 535	8.0	223 071	9.1
85000-89999	145 622	5.8	168 247	6.8
90000-94999	121 708	4.9	132 095	5.4
95000-99999	105 165	4.2	112 754	4.6
100000-109999	173 310	6.9	186 778	7.6
110000-119999	130 461	5.2	144 935	5.9
120000-129999	99 661	4.0	111 502	4.5
130000-139999	77 299	3.1	88 450	3.6
140000-149999	61 887	2.5	71 188	2.9
150000-159999	44 458	1.8	55 393	2.2
160000-169999	30 668	1.2	39 680	1.6
170000-179999	22 700	0.9	28 566	1.2
180000-189999	16 564	0.7	21 502	0.9
190000-199999	12 381	0.5	16 457	0.7
200000-	32 713	1.3	47 366	1.9
Total	**2 496 336**	**100.0**	**2 462 937**	**100.0**

- ***The ECSR requested information about why the dependant relative status was terminated on 1 April 2007 and what the impacts of this termination were.***

The definition of a dependant relative was previously provided in Article 4, point (s) of the Social Security Act, which was repealed from 1 April 2007, mainly in order to create independent eligibility. Article 16, paragraph (1) point (l) of the Social Security Act provides that every minor person resident in Hungary remains entitled to health care. After the termination of the dependant relative status, beneficiaries could obtain eligibility for health care services in another category of beneficiary (e.g.: payment of health care service contributions, the fact of being a recipient of social services).

- ***The ECSR requested information about the availability of any supplementary benefit for insured persons who do not have an insurance term of 2 years, which could be taken into account compared to this minimum.***

The amount of sick pay must be determined according to the calendar day average of the income earned in the calendar year directly preceding the start date of eligibility for sick pay, and constituting the base of monetary health care insurance contributions. In that scope no other monetary benefit can be taken into account. However, pursuant to Article 48 (5) of the Health Insurance Act, if the beneficiary did not have qualifying earnings because he/she had been receiving sick pay, prenatal allowance or child home care fee, the amount of the sick pay per calendar day must be defined in consideration of the amount constituting the basis of the formerly paid benefit, if that amount is more favourable.

- ***The ECSR requested information on whether the payment of job seeker's allowance is suspended if the unemployed person receives another form of social provision.***

The payment of both the job seeker's allowance and job seeker's aid must be terminated if the job-seeker becomes entitled to accident invalidity pension. (We note that invalidity and accident invalidity pensions are not welfare benefits, but benefits provided under social security). The payment of both job-seeking allowance and pre-retirement job-seeking support must also be suspended if the job-seeker reports that he or she has become entitled to pregnancy-confinement benefit, child care fee or child home care allowance. Suspension will take place, in the case of pregnancy-confinement benefit and child care fee, from the day following the day of determining eligibility, in the case of child home care allowance beginning on the day when eligibility was determined.

There is no welfare benefit that could be provided in parallel with the job seeker's allowance or the pre-retirement job seeker's aid.

- ***The ECSR requested information on whether the professional qualifications of the unemployed person are taken into account when training options are offered.***

When training opportunities are offered, professional qualifications are taken into account. On the one hand, from the following aspect: if someone has a professional qualification that is not acknowledged in the labour market, i.e. there is no vacancy that could be filled by a person with a that qualification, the labour affairs agency will offer training opportunities, if possible, in order to enable the unemployed person to obtain another qualification giving him or her better chances in the labour market. On the other hand, it may also happen that supplementary training is necessary for the existing qualification of the job-seeker, so that he or she can find an appropriate job in the labour market.

- ***The ECSR requested information on whether the decision terminating the payment of job seeker's allowance or pre-retirement job seeker's aid may be challenged, and if so, they request information about the case law of the procedure.***

Concerning the termination of the benefit due to job-seekers, there is relatively little information available on the practice of the courts on such matters. One of the reasons for this shortage of information is that only a few cases have reached the court stage, because the clients accepted the decision of the competent administrative agency. We are aware of a decision adopted by the Supreme Court which rejected the petition for review of the job-

seeker, and ruled that if persons receiving unemployment benefits (which is the former name of the job-seeking allowance) establish an economic association and fail to notify the labour authorities of their capacity as managing directors, the payment of the allowance must be terminated and the refund of the benefits taken without legal basis must be mandated.

We are also aware of a decision of the Supreme Court adopted on the aspects of the termination of unemployment allowance, which provided that in the case of termination because of paid employment, it is of no significance whether work is performed in the form of employment or any other legal relationship.

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

I. Social aid

Relevant legislation:

- Act III of 1993 on Social Administration and Social Services (Social Act),
- Act XXXI of 1997 on the Protection of Children and on Guardianship Administration (Child Protection Act), and
- Government Decree 136/2009 (Jun. 24) on the Support of People in Crisis.

The benefits granted on the basis of this legislation and the significant modifications related to the level and eligibility criteria of the benefits implemented during the reporting period are laid down below:

A. Benefits granted on the basis of the Social Act

Benefits granted on the basis of the Act can be grouped as follows:

- wage subsidising allowances,
- compensation of expenses,
- benefits related to a crisis situation.

Wage subsidising allowance is the last link in the system of social provisions 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 (regular social aid until 2009, regular social aid and availability allowance from 2009 fall into this category),
- old-age allowance,
- nursing fee.

Compensation of expenses provides support for people in need in order to bear their regular expenses that are recognised by society as necessary. The following benefits are included in this group:

- Home maintenance support,
- Debt management service,
- Public health care card system.

Benefits related to crisis situation are ad hoc allowances for the purpose of dealing with problems arising in crisis situations:

- temporary allowance,
- funeral allowance.

The personal scope of the Social Act (1st January 2008)

The Social Act applies to persons living in Hungary who are

- Hungarian nationals,
- migrants and settled persons,
- stateless persons,
- or persons recognised by the Hungarian authorities as refugees.

With regard to the temporary allowance, the Social Act also applies to nationals of the countries ratifying the European Social Charter who stay in the territory of the Republic of Hungary legally.

The Act applies to 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.

With regard to old-age allowance, the Social Act applies to persons belonging to the scope of Regulation No. 1408/71/EEC on the application of social security schemes to employed persons and their families moving within the Community, in case 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.

- ***Regular social allowance and support for persons of active age***

Regulations in force on 1 January 2008

The regular social allowance provides support for persons of active age who are disadvantaged in the labour market and 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 falls within the competence of the notary.

Regular social allowance can be granted to persons of active age who

a) suffer from health damage,
b) are unemployed and undertake to participate in a programme supporting their social inclusion,
c) or are supported job-seekers,

provided that their own and the families' subsistence cannot be ensured in any other manner.

Within a period of time, only one person in the family is entitled to regular social allowance.

People are considered to be of impaired health with regard to the establishment of eligibility for regular social allowance when

a) they have lost at least 67% of their working capacity or suffered an impairment of at least 50% or
b) receive personal allowance for the blind or

c) disability support.

People are considered to be unemployed with regard to the establishment of eligibility for regular social allowance if

a) they do not receive any unemployment benefit, job seeker's allowance, entrepreneurial allowance (hereafter together referred to as job-seeking support) or the period of disbursement of wage subsidising allowance has expired, and they do not receive any allowance encouraging job-seeking, or
b) due to the pursuance of income-earning activities, the disbursement of the job seeker's aid has been terminated before the expiry of the period of disbursement, and after the income-earning activities the person does not become eligible for job-seeking support under the Employment Act, or
c) within the two years before the submission of the application for the regular social allowance, the person has acted in cooperation for at least a year with any governmental employment body, or the competent body appointed by the local government of the settlement where the person lives or resides (hereafter: the body appointed for cooperation), or
d) the disbursement of nursing fee, child home care allowance, child raising support, regular social allowance, health impairment allowance for miners, temporary allowance, disability pension, accident disability pension, or temporary widow's pension has been terminated, or the disbursement of widow's pension has been terminated pursuant to Paragraph (3) of Article 52 of Act LXXXI of 1997 on Social insurance pension provision, and immediately before the submission of the application the person has acted in cooperation with any governmental employment body or body appointed for cooperation,
e) the disbursement of regular social allowance has been terminated due to any change in the extent of reduction of the working ability or the extent of health impairment,

and the person does not pursue income-earning activities, including public work or public benefit work (hereafter: referred to as public employment), and work with the use of the casual work certificate.

With regard to the establishment of eligibility for regular social allowance, the subsistence is deemed to be uncertain if the monthly income per consumption unit in the family does not exceed 90% of the minimum old-age pension in effect at any given time and the family has no property. (The minimum of old-age pension is HUF 28,500 as of 2011)

The unemployed person is obliged to engage in cooperation as a condition for receiving the regular social allowance, in the framework of which he or she is obliged to register him or herself at the appointed body and fulfil the requirements of the programme supporting his or her social inclusion. The monthly amount of the regular social allowance is the difference between the amount of the family income limit and the total monthly income of the family of the entitled person but it shall not exceed the net minimum wage. The family income limit is the same as the amount of the ratios belonging to the family consumption units multiplied by 90% of the minimum of the old-age pension in effect at any given time.

The *consumption unit* is a ratio representing the consumption structure of the family members within the family, where

a) the ratio of the first family member of full age is 1.0 with the condition that the ratio of a parent raising his or her child alone increases with 0.2;
b) the ratio of a spouse or non-married partner is 0.9;

c) the ratios of the first and second children are 0.8 per child;
d) the ratios of further children are 0.7 per child;
e) the ratio of a disabled child is 1.0 with the condition that the disabled child shall not be taken into consideration when applying sub-points c)–d);
f) the ratios under sub-points a)–b) increase with 0.2 when the person receives disability support.

The monthly income per consumption unit in the family is established by dividing the whole income of the family by the ratio appropriate for the structural unit of the family (e.g. by 2.7 in the case of two adults and a child). This amount states the monthly income per consumption unit in the family. If the amount calculated as a final amount does not exceed 90% of the minimum old-age pension in effect at any given time then the applicant and his or her family is entitled to regular social allowance.

If the amount of the regular social allowance does not reach HUF 1,000 a month based upon this calculation, an allowance of HUF 1,000 shall be established for the entitled person. The disbursement of the regular social allowance is not restricted to any time limit. If the person receiving regular social allowance has started income-earning activities that are not within the activities of public employment or work with the use of the casual work certificate, and has fulfilled his or her related notification obligation, then the regular social allowance shall be disbursed at a rate of 50% within the first three months after the starting date of the income-earning activities and at 25% for the following three months. The person of active age does not have any cooperation obligation during the period of further disbursement but the continuous existence of the income-earning activities must be verified every month.

Amendments

The provision system for persons of active age who are disadvantaged in the labour market has differentiated due to the amendment of the Social Act from **1st January 2009**. These persons are entitled to the so-called allowance for persons of active age instead of the regular social allowance from the 1st of January 2009, in the framework of which availability allowance or regular social allowance can be disbursed as a monetary benefit, depending upon whether the person is capable of work or not.

The notary establishes eligibility for allowance for persons of active age in case of persons of active age who

a) have lost at least 67% of their working capacity or suffered an impairment of at least 50% or
b) receive personal allowance for the blind or
c) receive disability support (persons under points a)–c) hereafter: referred to as people of impaired health) or
d) the period of disbursement of unemployment benefit, job seeker's allowance, entrepreneurial allowance (hereafter together referred to as job-seeking support) has expired or
e) due to the pursuance of income-earning activities, the disbursement of the job-seeking support has been terminated before the expiry of the period of disbursement, and after the income-earning activities the person does not become eligible for job-seeking support under the Employment Act, or
f) cooperated with the governmental employment body at least for a year within the two years prior to the submission of the application for allowance for persons of active age, or

g) the disbursement of nursing fee, child home care allowance, child raising support, regular social allowance, health impairment allowance for miners, temporary allowance, disability pension, accident disability pension, or temporary widow's pension has been terminated, or the disbursement of widow's pension has been terminated pursuant to Paragraph (3) of Article 52 of Act LXXXI of 1997 on Social Insurance Pensions, and immediately before the submission of the application the person acted in cooperation with any governmental employment body,

provided that their own and their family's subsistence cannot be ensured in any other manner, and they do not pursue any income-earning activities, including public employment and work with casual work certificate.

With regard to the eligibility for allowance for persons of active age, the livelihood is deemed to be uncertain if the monthly income per consumption unit in the family does not exceed 90% of the minimum old-age pension in effect at any given time and the family has no property. Persons eligible for the allowance for persons of active age who are under the age of 35 and have not finished their primary level education are obliged to participate in training aimed at completing their primary education or obtaining input competences, specified in separate legislation, required for starting their vocational school studies.

The availability allowance can be granted to persons who are capable of work. Participation in public employment, and particularly in employment for a public purpose, is the most pronounced element of the cooperation obligation in case of this allowance. The availability allowance is granted to persons eligible for the allowance for persons of active age for the period when the local government cannot ensure work for them or when they participate in training without any wage subsidising allowance. The amount of availability allowance is the amount of the minimum old-age pension in effect at any given time.

According to the legislative amendments in effect from 1 January 2009, persons eligible for the allowance for persons of active age receive **regular social allowance** if they are unable to work for any reason. A person is unable to work if they

a) are considered to be of impaired health, or
b) have reached the age of 55, or
c) raise a child under the age of 14 – provided that another person does not receive childcare allowance, childcare fee, maternity support under the Act on Family Support for other children living in the family – whose care cannot be ensured by institutions providing day care.

Within a period of time, only one person in the family is entitled to regular social allowance. The monthly amount of the regular social allowance is the difference between the amount of the family income limit and the monthly total income of the family of the entitled person but it shall not exceed the minimum of the personal basic wage of full-time employees in effect at any given time reduced by personal income tax, the employees' contribution, the health insurance contribution and the pension contribution. The family income limit is the same as the amount of the ratios belonging to the family consumption units multiplied by 90% of the minimum old-age pension in effect at any given time.

In the case of these persons, the cooperation obligation continues to exist – except for the persons of impaired health – towards the body appointed for cooperation by the local government of the settlement (typically the family assistance centres). But the person receiving regular social allowance can voluntarily agree to cooperate with the employment

body and participate in public employment based upon the agreement concluded with the local government.

If the person eligible for the allowance for persons of active age has started income-earning activities that are not within the activities of public employment or work with the use of the casual work certificate and has fulfilled his or her related notification obligation,

a) 50% of the minimum old-age pension for three months from the start of the income-earning activities, or in case of a person receiving regular social allowance – if the regular social allowance does not reach the amount of 50% of the minimum old-age pension – not more than the monthly amount of the regular social allowance,
b) 25% of the minimum old-age pension for three months from the end of the period specified in point a) or – if the regular social allowance does not reach the amount of 25% of the minimum old-age pension – not more than the monthly amount of the regular social allowance

shall be disbursed to the person, provided that the income-earning activities of the person eligible for the allowance for persons of active age is continuous.

From 15 November 2009 only one person in the family is entitled to the allowance for persons of active age within a period of time. As an exception to this rule, two persons in one family are entitled to the allowance for persons of active age at the same time if one person meets the conditions for the availability allowance and the other person meets the conditions for the regular social allowance.

From 1 January 2010 persons eligible for the allowance for persons of active age who meet the conditions specified in the local government decree are also entitled to receive regular social allowance.

From 1 January 2010 further disbursement of the allowance is not possible when the person eligible for the allowance for persons of active age has started to pursue income-earning activities.

From 1 April 2010 work carried out in employment established for a maximum period of 31 days on the basis of the Act on Simplified Employment – instead of the previous work with a casual work certificate – shall not be considered as income-earning activities with regard to the eligibility of the allowance for persons of active age.

From 1 January 2011 the availability allowance was replaced by the wage subsidising allowance and the system of public employment was reformed in order to ensure more rational use of the resources and simplification of the system.

From 1 January 2011 the local governments have the opportunity to make the disbursement of allowance in case of wage subsidising allowances subject to tidying up the living environment.

A regulation entered into force **on 1 January 2011**, according to which the eligibility for the wage subsidising allowance shall be terminated for persons who do not certify, at the annual review of their eligibility for allowance, that they have participated in one of the following activities at least for 30 days within one year prior to the date of the review during their eligibility period for the wage subsidising allowance:

- public employment,
- income-earning activities on the primary labour market (including household work and simplified employment),

- labour market programme,
- training announced for at least 6 months.

The following activities shall be added together when calculating the 30-day time period. If the entitled person cannot thus meet the conditions, the time period of his or her volunteer activities carried out in the public interest shall also be taken into consideration when calculating the 30-day time period.

From 1 January 2011 household work is not considered to be an income-earning activity with regard to eligibility for the allowance for persons of active age.

From 1 September 2011 the wage subsidising allowance is called the employment substitute support.

- **Old-age allowance**

Regulations in force on 1 January 2008

The old-age allowance provides support to elderly persons who do not have an income high enough to ensure their subsistence. Old-age allowance can be granted to persons who are over 62 years of age or have reached the applicable pension age limit, provided they meet the following conditions:

a) if the person is not single then he or she is eligible for the allowance if his or her monthly per capita income calculated on the basis of his or her income together with the income of his or her spouse or partner living in the same household does not exceed 80% of the minimum of the old-age pension in effect at any given time (HUF 22,800),
b) if the person is single and younger than 75 then he or she is eligible for the allowance if his or her monthly income does not exceed 95% of the minimum of the old-age pension in effect at any given time (HUF 27,075),
c) if the applicant is single and over 75 years of age then he or she is eligible for the allowance if his or her monthly income does not exceed 130% of the minimum of the old-age pension in effect at any given time (HUF 37,075).

The amount of the old-age allowance in case of persons without any income is

a) 80% of the minimum of the old-age pension in effect at any given time for persons who have reached the applicable pension age limit (HUF 22,800),
b) 95% of the minimum of the old-age pension in effect at any given time for single persons who have reached the applicable pension age limit but are under 75 years of age (HUF 27,075),
c) 130% of the minimum of the old-age pension in effect at any given time for single persons over 75 years of age (HUF 37,075);

The allowance for **entitled persons with their own income** is the difference between the above mentioned amounts and their monthly income. If the amount of the allowance disbursed to the entitled person with his/her own income does not reach HUF 1,000, an allowance of at least 1,000 HUF shall be established to the entitled person. The disbursement of the old-age allowance is not restricted to any time limits.

If the person meets the conditions specified in the Act, the notary grants old-age allowance to persons coming under Regulation No. 1408/71/EEC on the application of social security schemes to employed persons and their families moving within the Community, 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.

Amendments from 1 August 2011

If a third-country national possessing an authorisation entitling him or her to reside and work for the purposes of highly qualified employment (EU Blue Card) meets the conditions of the Social Act, he or she is eligible for old-age allowance provided that he or she has a registered residence or a temporary place of residence under the Act on the Registration of Personal Data and Address of Citizens.

- **Nursing fee**

Regulations in force on 1 January 2008

The nursing fee is a financial contribution to an adult relative undertaking to provide care for a person needing permanent care. The Social Act regulates the following three forms of the nursing fee:

- Persons can receive the normative-based basic amount of the nursing fee who 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 minimum old-age pension in effect at any given time.
- Relatives providing care for persons with severe disabilities in need of intensive nursing can also receive the normative-based nursing fee at a higher amount. This allowance has special characteristics in comparison with the basic amount of the nursing fee referred to in the previous point, and it is 130% of the amount of the minimum old-age pension in effect at any given time.
- The representative body of the local 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 amount of the minimum old-age pension in effect at any given time. The monthly family income limit per capita, with regard to establishing eligibility, is regulated in such a way that an income eligibility criterion less than the amount of the minimum old-age pension in effect at any given time, or in case of a single person, 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 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 limits. The disbursement period of the nursing fee does not qualify as a period of employment for the purposes of pension insurance. The person receiving the nursing fee is obliged to pay pension contributions and private pension fund contributions for the provision. The local government is obliged to pay the pension insurance contribution part of the social insurance contribution for the disbursement period of the nursing fee.

Amendments from 1 January 2011

The monthly amount of the nursing fee will not be determined in proportion to the amount of the minimum old-age pension in effect at any given time, but in proportion to the basic amount determined in the Act on the Annual Central Budget. From 1 January 2011:

- the basic amount of the nursing fee (in case of a normative-based nursing fee) is HUF 29,500;
- the amount of the nursing fee is 130% of the basic amount in case of providing care for relatives in need of intensive nursing;
- the nursing fee is 80% in case of a nursing fee established on grounds of equity.

- **Home maintenance support**

Regulations in force on 1 January 2008

The home maintenance support provides support to socially deprived persons and families in order for them 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 local government. 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 home. The Social Act regulates the following three types of the home maintenance support: All three types can be disbursed as a monetary benefit or a in kind benefit (credited to the account of the entitled person or in other forms such as fuel).

1. Every local government is obliged to provide home maintenance support on a normative basis for households where the monthly income per capita does not exceed 150% of the minimum of the old-age pension (HUF 42,750 in 2008) and the acknowledged monthly costs of home maintenance exceed 20% of the total household income in a month. The amount of the home maintenance support on a normative basis in a month is:

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) in case of a monthly income per capita exceeding the amount determined in point a), the acknowledged monthly costs of home maintenance multiplied by the rate of the support, but not less than HUF 2,500. The amount of the support is rounded up to the nearest HUF 100.

The following formula is used when calculating the rate of support (RS) determined in point b):

$$RS = 0.3 - \frac{I - 0.5\ MP}{MP} * 0.15$$

where I indicates the monthly income per capita in the household of the entitled person, and MP indicates the minimum amount of the old-age pension in effect at any given time. RS must be rounded up to the nearest HUF 100.

The acknowledged monthly costs of home maintenance in the case of home maintenance support on a normative basis shall be the product of the acknowledged size of the home and

the acknowledged cost per square metre. The acknowledged cost per square metre is HUF 425 in 2008.[2]

The rate of support is calculated using the formula in the Act. The acknowledged size of the home in case of home maintenance support on a normative basis is

a) 35 sqm if one person lives in the household,
b) 45 sqm if two persons live in the household,
c) 55 sqm if three persons live in the household,
d) 65 sqm if four persons live in the household; if more than four persons live in the household then the size of the home indicated in point d) plus 5 sqm for each additional person, but maximised at the size of the home the entitled person lives in.

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.

2. The aim of the *home maintenance support related to debt service assistance* is that, during the assistance period, debtors are able to cover their current home maintenance expenses in addition to repaying their arrears. Persons receiving home maintenance support under this title are not eligible for home maintenance support on a normative basis at the same time. The rules related to home maintenance support on a normative shall apply when calculating the amount of support.

3. Local home maintenance support (on grounds of equity) can be provided by local governments on grounds of equity according to conditions specified in the local government decree. The local home maintenance support can be provided as an independent benefit or as a supplementary benefit to home maintenance support on a normative basis, or related to debt service assistance. In case of local home maintenance support provided as an independent benefit, the Social Act defines a legal framework for the content – i.e. the eligibility criteria, the minimum amount of support, the application procedure – of the local government decrees regulating the support.

<u>Modifications</u>

The ratio the support is based on – the acknowledged monthly costs of home maintenance per square metre – increased from HUF 425 to 450 **from 1 January 2009**, thus the amount of the benefit also increased by 5.8 per cent, which was more than the expected annual inflation in 2009.

The system of home maintenance support regulated in the Social Act was augmented from **1 September 2011** simultaneously with the cancellation of the energy consumption support.

The income threshold of the support has significantly increased – from 150% to 250% of the amount of the minimum pension (HUF 71,250). Furthermore, the eligibility criterion concerning home maintenance expenses as a proportion of income was abolished. However, property verification has been introduced in order to make the support more targeted. The home maintenance support is primarily given in an in kind format, in accordance with the currently effective legislation.

[2] The amount is determined in the Act on the Annual Central Budget.

- **Debt management service**

Regulations in force on 1 January 2008

The debt management service provides 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 benefits in-kind and the service are 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 – 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 – who has received training of 120 hours – for developing good management practices, for using the support in a proper way and in the interest of prevention.

The operation of the service is obligatory only in settlements of over 40,000 inhabitants and in the districts of the capital city, otherwise it depends on the will of local governments whether they want to start operating the service (the service was available for people in circa 140 settlements in 2008, the service can be provided for people in small settlements by associations). The local government may provide debt management service for a family or a person

a) whose
   i. debt is over HUF 50,000 and whose debt is at least six months overdue, or
   ii. whose service has been shut 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 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, 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.

Modifications from 1 January 2010

The maximum amount of support for debt-discharging is HUF 300,000; in some cases of outstanding arrears on housing loans defined by law, it may be a maximum of HUF 600,000.

- **Social support for gas consumption and district heating**

Regulations in force on 1 January 2008

Government Decree 289/2007 (Oct. 31) entered into force on 1 November 2007, on the basis of which the consumer of piped gas and district heating for household purposes was eligible for energy consumption support, provided that at the time of the submission of the application, the monthly income per consumption unit in the given household did not exceed 3.5 times the amount of the minimum of the old-age pension.

Four income categories with different rates of support have been established within the group of persons eligible for support.

The reason behind the introduction of the support was the twofold increase in the price of gas between 2005 and 2008, and the fact that this price increase affected the budget of poorer households in a more significant way: whereas the energy expenses total up to 7% of household budgets on average, the rate is 10-14% in the group of households with the lowest incomes.

The support for the gas price is proportional to consumption, it may provide support up to a maximum annual consumption of 2,000 m3 – in case of large families up to 4,000 m3 – and the amount of support depends also on the type of heating (gas or district heating).

The compensation was established by the Hungarian State Treasury (hereafter: Treasury) and it was credited to the accounts of entitled persons by the service providers (as an in-kind benefit).

The applicants only had to declare their incomes, serving as the basis for their eligibility, and the accuracy of the data was verified ex-post (by means of a random check) by the Treasury. Eligibility was established for a year.

Amendments

From 1 October 2008 the amounts per unit of the support for district heating were increased in every category and a monthly allowance of HUF 1,150 was introduced during the heating period (6 months) for district heating users not receiving any social benefits, in order to compensate for the inherently higher and continuously increasing district heating expenses. Entitled persons were able to apply for the allowance for the district heating fee until December 2009.

From 12 March 2009 the amount of support per unit was modified in such a way that it follows the changes in the prices of gas and district heating, so the previous fixed-amount support was replaced by an amount of support aligned with the price of natural gas; the upper limit of which is the same as the previous fixed-amount support.

From 1 January 2010 the measures per unit were again established as a fixed amount next to a reduction of the amounts of support per unit concerning each group of entitled persons.

The application for establishing support could be submitted by **28 February 2010** at the latest, after this date the allowance could only be disbursed for persons whose eligibility had previously been established.

From 1 May 2010 the upper two categories were terminated, so 250% of the amount of the minimum old-age pension became the upper income threshold for eligibility for support (HUF 71,250). Furthermore, the amount of support per unit was further decreased in the remaining categories.

After the termination of this form of support, the home maintenance support on a normative basis regulated in the Social Act and augmented **from 1 September 2011** took over its 'place' in the system of provision from 1 September 2011.

- **Public health care card system**

Regulations in force on 1 January 2008

The public health care card system is a contribution provided for reducing the expenses of socially disadvantaged persons 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 system, free of charge, such as

a) certain medicines 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 the public health care card system are laid down in the Social Act:

1. Persons entitled to use the public health care card 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 retirement allowance and accidental disability retirement allowance based on invalidity category I and II;
   - persons who, or whose parents or guardians, receive family allowance at an increased amount.
2. Persons are also entitled to use the public health care card 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, or150% of the minimum in case of single persons.

3. Persons are entitled to use the public health care card 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 using the public health care card, and the rate of the monthly regular remedial treatment.

The notary shall determine entitlement to the public health care card. The eligibility is established for two years in case of persons entitled to benefits under point 1, and for one year in case of persons entitled to benefits under points 2-3. The eligibility can be repeatedly established if the eligibility conditions are 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 monthly medicine allowance is the amount of the monthly regular pharmaceutical expenses of the entitled person but it shall not exceed HUF 12,000.[3]

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 is the same as the ad hoc allowance.

Changes from 1 July 2011

The person holding the public health care card is entitled to receive certain services – as specified in separate legislation – covered by the social security system, free of charge, such as

a) certain medicines, including nutrition products for people with special dietary needs, specified in the Act on the General Rules of Safe and Economic Medicine and Medical Device Provision and the Distribution of Medicinal Products, which 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 the Act on the General Rules of Safe and Economic Medicine and Medical Device Provision and the Distribution of Medicinal Products; and
c) medical Treatment for Rehabilitation.

This modification reviewed the products that can be prescribed at the expense of the public health care in relation to the restructuring of the system of subsidies for medicines.

Previously, every supported product was available at the expense of public health care, but from 1 July 2011, out of the medicines with the same active ingredients, only those that fall within the preferred reference price band can be prescribed.

- **Eligibility for health care services**

Regulations in force on 1 January 2008

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.

An official certificate is issued by the notary for the verification of social deprivation.

The certificate is valid for a 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 point o) of Paragraph (1) of Article 16 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 (hereafter: the Act on Social Insurance).

[3] The highest amount of the individual medicine allowance and the amount of ad hoc allowance are determined by the Act on the Annual Central Budget.

Amendments

The regulation of eligibility for health care services has not changed significantly in the reporting period.

- **Temporary allowance**

Regulations in force on 1 January 2008

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, extended 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, the Social Act only constitutes the basic legal 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 amount of the minimum 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).

- **Funeral allowance**

Regulations in force on 1 January 2008

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, the Social Act only constitutes the basic legal 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 amount of the minimum 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.

A funeral allowance cannot be established for a person who receives funeral contribution under Act XLV of 1994 on the Care of Veterans.

Amendments

The regulation of temporary allowance and funeral allowance did not change significantly between 1 January 2008 and 31 December 2011.

- **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. (Article 26 of the Social Act)

B. Benefits issued on the basis of Act XXXI of 1997 on the Protection of Children and on Guardianship Administration

The aim of the 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, fulfilling parental duties and ensuring prevention and termination of endangerment of children, substituting lacking parental care and promoting social inclusion of the young adults leaving child protection care.

The personal scope of the Child Protection Act (1st January 2008)

The scope of the 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 persons recognised by the Hungarian authorities as refugees 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.

With regard to extraordinary child protection support, the Child Protection Act also applies to nationals of the countries ratifying the European Social Charter who stay legally in the territory of the Republic of Hungary.

The following cash and in kind benefits can be provided on the basis of the Child Protection Act.

- **Regular child protection allowance**

Regulations in force on 1 January 2008

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 July and in November) at an amount of HUF 5,500[4]

[4] The amount of allowance is determined by the Act on the Annual Central Budget.

- other benefits (school book subsidies, tuition subsidies) specified in separate legislation.

The aim of the regular child protection allowance is for socially deprived families – in accordance with children's rights – to provide care for the child at home.

Children are entitled to receive the allowance if, in their foster family, the per capita monthly income does not exceed 125% of the minimum 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. 135% of the minimum of the old-age pension in effect at any given time. Cases deserving 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 majority,
    - 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 do 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 old-age pension when calculated separately, or
b) seventy times the minimum amount of 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 are considered properties, and are not taken into consideration during the property verification.

Amendments

From 1 January 2009 the amount of the monetary benefit disbursed twice a year related to the regular child protection allowance is HUF 5,800 per disbursement.[5]

From 1 September 2009 the income thresholds for eligibility for the regular child protection allowance were modified.

From this date the person is only entitled to receive the allowance if the per capita monthly income in the foster family does not exceed 130% of the minimum of the old-age pension in effect at any given time, or 140% of the minimum of the old-age pension in effect at any given time in cases deserving special consideration.

From 1 January 2011 entitled persons receive the monetary benefit disbursed twice a year related to regular child protection allowance every August and November.

[5] The amount of allowance is determined by the Act on the Annual Central Budget

- **Supplementary child protection support**

Regulations in force on 1 January 2008

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 retirement allowance or accidental disability retirement allowance or pension-type regular social financial provision or old-age allowance.

The monthly amount of the supplementary child protection support is 22% of the minimum 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 July and November).

The amount of the supplement was HUF 8,000 in 2008.[6]

Amendments

From 1 January 2009 the amount of the monetary benefit disbursed twice a year related to the supplementary child protection support is HUF 8,400 per disbursement4.

From 1 January 2011 entitled persons receive the monetary benefit disbursed twice a year related to the supplementary child protection support every August and November.

- **Irregular child protection support**

Regulations in force on 1 January 2008

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 arise related to preparing for the child birth arise, 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 education arise.

The detailed eligibility criteria for irregular child protection support are specified by the local government decrees.

The support may be given in-kind (text books, school materials, food etc.) by the local government, particularly for children taken into child protection.

Amendments

The regulation of eligibility for irregular child protection support has not changed significantly in the reporting period.

[6] The amount of the supplement is determined by the Act on the Annual Central Budget.

- **Advancing child support**

Regulations in force on 1 January 2008

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 the double of the minimum old-age pension.

The guardianship office shall advance the amount ordered by the court in its final judgement for alimony, or the basic amount in case the amount ordered in the judgement is calculated on a percentage basis.

The guardianship office may determine a smaller amount than the previous ones 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 50% of the amount determined by the court.

Disbursement of child support in advance can last from the submission date of the application until the grounds on which the application is based are expected to cease to apply, up to 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.

The advance payment of child support can also be determined after the child has reached his or her majority, if the conditions are met, or the already determined child support can be further disbursed until the child finishes his or her full-time secondary education, but not longer than his or her twentieth birthday.

The state temporarily acts on behalf of the person required to pay alimony as a 'responsible person in the background' – in the interest of protecting the rights of children – during the advance payment period.

The person required to pay alimony is obliged to pay back the advance payment to the state.

Amendments from 1 September 2009

The advance payment of child support regarding the same child can be ordered by the court once again if the conditions are met – irrespectively of the result of recovery by taxes – and the disbursement can continue and be repeatedly ordered up to a maximum of an additional three years.

- **Home-start assistance**

Regulations in force on 1 January 2008

The aim of the 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 permanent access to housing.

The application for assistance can be submitted after the young adult has reached his or her maturity.

Young adults are entitled to home-start assistance whose

a) foster care, uninterrupted for at least three years – at the foster place – ended upon his or her majority 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.

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 the 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

a) after the applicant has reached his or her maturity but at the latest by the 24th birthday of the applicant,

b) until the applicant finishes his or her studies, but at the latest by the 25th birthday of the applicant, if the young adult who has reached his or her maturity still pursues studies at a secondary or higher education institution.

Amendments

From 1 September 2009 the home-start assistance can be used for participating in a home savings plan.

From 1 January 2010 the application for home-start assistance can be submitted by the applicant after reaching his or her maturity but before his or her 30th birthday.

From 31 March 2010 the eligibility criteria for home-start assistance changed so that the property of the entitled person does not exceed sixty times the minimum amount of the old-age pension when reaching maturity.

- **Kindergarten support**

Regulations in force on 3 July 2008

The regulations on kindergarten support came into effect on 3 July 2008.

The aim of introducing the kindergarten support was to motivate the parents of multiple 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, 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) from the date his or her child was signed up to kindergarten until the end of the child's kindergarten education – HUF 20,000 for the first time and HUF 10,000 for every subsequent time.

It can be specified in a local government decree that the child can be provided with in kind benefit instead of cash benefit for the first time.

According to the transitional provisions of the Child Protection Act, out of the new applicants, parents who signed up their three- or four-year-old children to kindergarten after 1 January 2009 can receive the kindergarten support.

The first support, at an amount of HUF 10,000, shall be disbursed in June 2009 to parents who signed up their three- or four-year old children before 1 January 2009.

Amendments from 1 January 2011

The kindergarten support can be disbursed for the first time two months after the child started to participate in kindergarten education.

- **Other benefits granted by local governments**

According to Paragraph (2) of Article 18 of the Child Protection Act, the representative body of the local government can 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.

C. Support in crisis situations

From 1 August 2009 a new support granted on grounds of equity was introduced for persons and families who were brought into a difficult situation by the economic crisis. This support provides them with a chance to mitigate the negative effects of the crisis on their families. The support for persons in crisis was implemented by Government Decree 136/2009 (Jun. 24).

A one-off, non-refundable grant could be established as a social allowance for persons of full age who had a registered residence or a temporary place of residence in the territory of the Republic of Hungary, if

a) the per capita monthly income in their families did not exceed the net amount of the minimum wage (HUF 57,815 in 2009) in the month prior to the submission of the application,
b) they did not receive retirement allowance according to Article 6 of the Act on Social Insurance Pensions, and
c) they were brought into a crisis situation seriously jeopardising the everyday subsistence of their families due to an unforeseeable event related to the economic crisis.

The crisis situation was considered as one seriously jeopardising everyday subsistence if the person

- lost his or her job after 30 September 2008, or
- his or her salary decreased by a rate of at least 20% in comparison to his or her salary in September 2008, or
- his or her payment obligation on their housing loan increased by a rate of at least 20% in comparison to the instalment in September 2008, or it is justified by his or her health status.

It is considered as a condition for special consideration if

- the salary of the person decreased by more than 30 % in comparison to his or her salary in September 2008;
- the monthly instalment on the housing loan of the person increased by more than 30%;
- the person provides for at least three children under 18 years of age.

The amount of the support is minimum HUF 20,000 and maximum HUF 50,000 but the maximum amount can go up to HUF 100,000 if a condition for special consideration is met. The application for establishing support could be submitted between 1 August and 30 November 2009. The support could be established once for one member of the family.

II. Benefits on grounds of equity (aid) in the health sector

The Hungarian social security system is based upon solidarity and includes the provision of allowances or services on grounds of equity up to a certain level. Aid is of special importance regarding a well-defined group of foreign people.

General aid for alleviating deterioration in health

In the interest of suitably applying the principle of solidarity, according to Article 26 of Act LXXXIII of 1997 on Statutory Health Insurance Provisions (hereafter: Health Insurance Act) the patient eligible for health care services can submit an application on grounds of equity to the competent metropolitan and county government offices' health insurance fund units. The primary eligibility criterion for qualifying for aid is that the life situation resulting in financial troubles is in connection with the allowances provided and financed by the health insurance fund. The income status of the applicant is assessed during the evaluation. It is a condition that the per capita income of the persons living in the same household should not reach double the amount of the minimum old-age pension in effect at any given time (28 500 Ft), or two-and-a-half times the minimum in the case of a single person, which may differ in cases deserving special consideration. The aid can only be granted once a year, unless there has been a visible deterioration in the health condition since the last application. The health insurance fund decides on the application within 30 days of receiving a complete application.

An application on the grounds of equity can be submitted to the health insurance fund for support for pharmaceutical expenses, and for a lowering of the in kind benefits and receiving cash benefits.

Support for pharmaceutical expenses can be given if a higher amount of medicines or medicines with high costs are required on a monthly basis to improve or maintain the health condition of the patient; if the regular monthly costs of the patient's medicines justified on medical criteria exceed 15% of the net income per capita, despite being subsidised by the social security fund. There is an opportunity for lowering the in kind benefits if the patient submitting his or her application on the grounds of equity for certain in kind health benefits (e.g. for subsidising various high-cost implants, laser treatment fees or expensive and/or not subsidised medicines and medical devices) cannot, for whatever reason, be granted benefits on the grounds of equity regarding his or her application (e.g. if the patient has previously received benefits applied for, or has already had their prescription filled). Temporary mitigation of the financial troubles of persons not entitled to monetary benefits can occur when sickness benefit, sickness benefit for nursing the child and child care fee cannot be granted, even on grounds of equity.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

Measures classified as health care assistance

- With the cooperation of the National Institute of Child Health (hereafter: NICH) the Hungarian versions of the professional material related to children's rights distributed internationally in the framework of the National Infant and Child Health Programme have been completed (recommendations of the Charter of European Association of Children in Hospitals (EACH) and of the Health Promoting Hospitals for Children and Adolescents on children's rights and health development). The recommendations (http://www.each-for-sick-children.org/each-charter.html), together with the national legislation and other Hungarian references, were disseminated on a CD among professionals and can be downloaded from the website of the institute. http://www.each-for-sick-children.org/each-charter.html (http://www.ogyei.hu/anyagok/Gyermekjog/inditas.htm)
- The self-evaluation model 'children's rights in hospital,' created by the working group of HPH-CA for hospitals, was also translated and disseminated among professionals by the NICH and can also be downloaded from the website of the institute. An international study with the participation of two Hungarian hospitals (Heim Pál-Madarász Hospital and Jávorszky Ödön Hospital) was accomplished by using this model. (http://www.ogyei.hu/upload/files/Gyermekjogok%20a%20k%C3%B3rh%C3%A1zban%20-%20%C3%96n%C3%A9rt%C3%A9kel%C5%91%20modell%20%C3%A9s%20munkaanyag%20(HPHCA).pdf) The availability of the original English version can contribute to international dissemination in neighbouring countries (http://www.sch.edu.au/policies/task-force_hph-ca_childrens_rights_in_hospital_self_evaluation_model_final_report.pdf http://www.ogyei.hu/upload/files/Gyermekjogok%20a%20k%C3%B3rh%C3%A1zban%20-%20%C3%96n%C3%A9rt%C3%A9kel%C5%91%20modell%20%C3%A9s%20munkaanyag%20(HPHCA).pdf

http://www.sch.edu.au/policies/task-force_hph-ca_childrens_rights_in_hospital_self_evaluation_model_final_report.pdf

- The plain Hungarian language version of the EACH Charter was made in poster and leaflet form. A survey was conducted on children's rights in Hungarian in-patient health institutions by formulating a questionnaire on parental satisfaction. Six children's hospitals and children's wards participated in the dissemination of the EACH Charter and the satisfaction study on patient's rights. The results have been presented in Hungary and at an international level. An international study has been started by the NICH with the help of this study. The questionnaire compiled by the NICH was received by the Task Force on Health on Health Promotion for Children and Adolescents in and by Hospitals (HPH-CA) of the International Network of Health Promoting Hospitals and Health Services, which is available in Hungarian and English and can be disseminated in further countries. (http://www.ogyei.hu/upload/files/Gyermekjogok%20%20Nemzetközi%20és%20magyar%20adatok%20összevetése.pdf).

The NICH has participated in preparing the UN report on children's rights at multiple levels. It therefore considers the background information related to aspects of the Social Charter important, primarily from the point of view of the right to social security:

Other programmes:

- Thanks to the international relations of the NICH, the publication **'Worried about a child?'**, originally published in English, has been published in Hungarian with the permission of the NSPCC (http://www.nspcc.org.uk/help-and-advice/worried-about-a-child/online-advice/online-advice_wdh85524.html). The publication helps parents to understand the processes related to appreciative communication and the mental maturity of the child. Good communication is a pre-requisite for preventing child abuse. The non-aggressive values have an important role in developing the self-evaluation of the child. The target groups of the publication are districts nurses, child rearing consultants and the related professions, and through them, the young adults concerned (http://www.ogyei.hu/upload/files/hogyan.pdf).
- The educational programme **'Never shake your baby'** was started in 2010 with the aim of bringing the attention of professionals and - through them - of parents to the possible severe complications caused by shaking babies and small children. The guide to the programme is an educational DVD and flyer that were made available by an Australian organisation. (http://www.archi.net.au/resources/workforce/nursing/shaking-baby).
- A series of professional conferences on this subject have been organised by the NICH. The presentations of the conference, the flyer for the parents and some details of the educational DVD can be found on the website of the institution. The educational material was received by approximately 4,000 professionals in different forms (practical professional presentations, invitations, conferences, via the written and electronic media) (http://www.ogyei.hu/upload/files/Sose%20rázd%20a%20kisbabádat%20szórólap.pdf).
- From 6 July 2011 the website www.gyermekbantalmazas.hu is available, which has also been created with the support of the National Infant and Child Health Programme. Several websites operated by governmental and non-governmental organisations in many countries deal with child abuse. These websites are primarily in English. This is the first website on this subject in Hungarian. The website can be used by

professionals, laymen, adults, adolescents and children so the subject of child abuse can reach a wide spectrum of society, divided into target and age groups. The website intends to reach the younger generation by using the services of several community websites. It offers another chance for professionals to get into contact with each other and to practise a common way of thinking. Several sub-pages dealing with very important subjects can be found on the website. 'Never shake your baby' is a separate site related to our programme of the same name. The information on the website can be understood by the Hungarian-speaking populations of neighbouring countries. http://www.gyermekbantalmazas.hu

3) KEY DATA AND STATISTICS

1. Number of persons receiving cash and in kind social and child protection allowances, 2008-2011

Name of the allowance	Number of persons receiving the allowance			
	2008	2009	2010	2011
Regular social allowance (average data on the number of persons)	213 436	71 816	35 894	50 647
Availability allowance/Wage subsidising allowance/ Employment substitute support (avg. data on the no. of persons)	–	167 287	174 539	209 918
Old-age allowance (average data on the number of persons)	6 149	6 034	5 802	5 907
Home maintenance support (related to normative basis and debt management)	n.a.	274 847	304 039	434 027
Local home maintenance support	n.a.	78 192	73 810	83 820
Support for debt-discharging	10 440	13 603	19 857	19 892
Nursing fee (under subjective right) (average no. of persons)	35 605	38 512	41 124	44 750
Nursing fee on grounds of equity (average data on the number of persons)	17 742	16 688	15 729	13 220
Public health care card system	373 100	361 383	371 080	369 211
Eligibility for health care services*	n. a.	64 392	70 942	85 357
Funeral allowance (number of cases)	49 317	47 588	45 254	38 677
Temporary allowance	418 126	442 589	426 057	353 259
Regular child protection allowance (avg no. of persons)	513 070	553 664	598 506	592 375
Supplementary child protection support (average data on the number of persons)	1 507	1 447	1 416	1 259
Irregular child protection support	194 353	184 761	186 912	153 587
Home-start assistance	834	972	927	893
Advancing child support	7 946	8 846	11 705	15 826
Kindergarten support	–	23 109**	38 766**	33 325***

*Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office; *Source: Reporting of the Hungarian Central Statistical Office; ** cumulative data, a child can be provided with allowance twice in a given year, the data collection filtered this in 2011 for the first time; *** Adjusted data 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, 2008-2011

Name of the allowance	Average monthly amount (HUF)			
	2008	2009	2010	2011
Regular social allowance	27 347	26 817	26 786	26 030
Old-age allowance	26 876	26 677	27 421	26 994
Nursing fee (subjective right)	29 516	29 692	30 679	31 251
Nursing fee on grounds of equity	22 646	22 247	23 047	23 200
Public health care card system*	5 811	5 735	5 631	5 559
Supplementary child protection support	6 212	6 376	6 539	6 402

Advancing child support	10 503	10 413	10 188	9 279

*Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office; * Average of monthly budget, source: National Health Insurance Fund*

2.2. Average annual allowances provided according to annual eligibility 2008-2011

Name of the allowance	Average annual amount of allowances (HUF)			
	2008	**2009**	**2010**	**2011**
Home maintenance support (related to normative basis and debt management)	n.a.	53 224	53 577	40 805
Local home maintenance support	n.a.	39 389	40 576	30 937
Support for debt-discharging	87 296	85 263	94 484	94 797
Kindergarten support	-	12 252	12 214	17 278

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

2.3. Amounts of ad hoc allowances

2.3. a) Average amount per occasion, 2008-2011

Name of the allowance	Average amount per occasion (HUF)			
	2008	**2009**	**2010**	**2011**
Funeral allowance	21 652	22 161	22 917	23 005
Temporary allowance	6 822	7 058	7 219	6 714
Irregular child protection support	5 670	6 139	6 303	5 797

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

2.3. b) Average annual amount per capita, 2008-2011

Name of the allowance	Average annual amount per capita (HUF)			
	2008	**2009**	**2010**	**2011**
Temporary allowance	11 255	11 808	12 483	11 765
Irregular child protection support	11 353	11 304	11 281	10 401
Home-start assistance	1 313 000	1 308 000	1 245 702	1 134 797

Source: Yearbook of Welfare Statistics, Hungarian Central Statistical Office

3. Poverty threshold, minimum wage, minimum old-age pension, 2008-2011

Indicator	Breakdown		2008	2009	2010	2011
Value of poverty threshold[7]	Single-person household	HUF	663 556	715 187	713 291	749 550
		EUR	2 640	2 844	2 544	2 721
	Household of two adults and two children	HUF	1 393 467	1 501 892	1 497 911	1 574 055
		EUR	5 544	5 972	5 343	5 714
Minimum wage	gross		69 000 HUF/month	71 500 HUF/ month	73 500 HUF/ month	78 000 HUF/ month
	net (without children)		56 190 HUF/ month	57 815 HUF/ month	60 236 HUF/ month	60 600 HUF/ month
Minimum old-age pension			28 500 HUF			

[7] A threshold value determined at 60% of the equivalent median income on the basis of data from the Hungarian Central Statistical Office.

4) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR asks for information with regard to the following: are socially disadvantaged persons eligible for health provision appropriate to their health condition?***

Based on our register, the number of socially disadvantaged persons is as follows:

Persons entitled to receive health services (at the end of the year)	9 774.8	9 681.0	9 681.7	9 617.7
Of which: the number of socially disadvantaged persons	40.0	42.5	29.6	29.4

Furthermore, it is important to emphasise that according to point o) of Paragraph (1) of Article 16 of the Act on Social Insurance, socially disadvantaged persons are entitled to receive health provision under Article 54 of the Social Act.

Under Paragraphs (1) – (3) of Article 54 of the Social Act, the notary establishes eligibility for health care services 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,
- or who lives alone on an income that does not exceed 150% of the minimum old-age pension, and whose family has no property.

A socially disadvantaged person can apply for a Hungarian social security number if he or she is regarded as resident pursuant to point u) of Article 4 of the Act on Social Insurance. An official certificate, valid for 1 year, is issued by the notary to verify social deprivation. The notary keeps a register of data on socially disadvantaged persons and has an obligation to notify the health insurance fund. Financial resources for these allowances are provided by the central budget.

Pursuant to Paragraph (2) of Article 6 of the Health Insurance Act, a person entitled to receive health care services has the same rights as an insured person with regard to the health care services provided by the health insurance fund (health care services for the prevention and early diagnosis of diseases, general medical provision, dental care, out-patient services, in-patient care in health institutions, obstetric care, medical rehabilitation, patient transport services, and rescue services).

- ***The ECSR asked for information with regard to the following: did persons eligible for temporary allowance receive the allowance at an amount of EUR 160 (150% of the minimum of old-age pension)?***

150% of the minimum of old-age pension plays a role in establishing eligibility for temporary allowance. The income threshold specified as an eligibility criterion for the allowance is regulated by local government decrees. The Social Act only determines that a lower income threshold cannot be specified by the local government decree. The amount of the temporary allowance is not specified in the Social Act. Entitled persons received temporary allowance at an average amount of HUF 10,402, according to the 2007 data of the Hungarian Central Statistical Office.

- ***The ECSR requested information on the eligibility criteria, disbursement period and minimum amount of regular social allowance.***

See the detailed information in section A) of part 1) I.

- ***The ECSR asked for information with regard to the following: are there appropriate remedies against decisions taken by the representative bodies of local governments and notaries with regard to matters of social administration?***

The following remedy exists under the current legislation with regard to decisions adopted by the representative bodies of local governments and notaries.

Regulations in force on 1 January 2008

Decisions adopted within the competence of the representative body

An appeal may not be lodged against a decision in an administrative case adopted by the representative body of the local government. The representative body may delegate some powers to the mayor, its committees, bodies of self-government subdivisions, bodies of local minority self-governments, or associations defined by law.[8]

An appeal may be lodged with the representative body against an administrative decision adopted under the authority of the local government by the mayor (chief mayor), the committee of the representative body, or the body of a self-government subdivision. A petition for review of the representative body's decision may be filed with the court within thirty days after the decision is communicated. Proceedings must be instituted against the local government. [See Articles 9 and 11 of Act LXV of 1990 on Local Governments (hereafter: Local Governments Act]

Decisions adopted within the competence of a notary

An appeal may be lodged against a decision in an administrative case adopted by the notary. The social and guardianship office acts as a superior body with regard to administrative cases coming at first instance within the competence of the notary [Paragraph (2) of Article 6/A of Government Decree 63/2006 (Mar. 27) on the Detailed Rules of Applying for, Assessing and Disbursing Cash and In Kind Social Services].

The decision may be upheld, overturned or annulled by the authority of second instance. If there is insufficient data to adopt a decision on appeal, or further clarification of the facts is required, then the body entitled to examine the appeal may order the court of first instance to institute new proceedings, or may conduct supplementary fact-finding proceedings on its own accord, in addition to the annulment of the decision. [See Article 105 of Act CXL of 2004 on the General Rules for Public Administrative Proceedings and Services (hereafter: Act on Administrative Proceedings)] A judicial review may be lodged after the right of appeal has been exhausted (Article 109 of the Act on Administrative Proceedings).

Status on 31 December 2011

Decisions adopted within the competence of the representative body

An appeal may not be lodged against a decision in an administrative case adopted by the representative body of the local government (Article 11 of the Local Governments Act).

[8] From 1 January 2012 the definition of local minority self-government was replaced by the definition of minority government. Legal regulation with regard to minority governments is included in Act CLXXIX of 2011 on the Rights of Minorities.

A judicial review may be lodged against the decision of the representative body (Article 109 of the Act on Administrative Proceedings). The representative body may delegate some powers to the mayor, its committees, bodies of self-government subdivisions, bodies of local minority self-governments, or associations defined by law (Article 9 of the Local Governments Act).

The examination of appeals against decisions in administrative cases adopted under the competence delegated to local governments and against decisions adopted by mayors under their independent legally accorded competence shall fall within the competence of the representative body of the local government (Article 107 of Act on Administrative Proceedings).

Decisions adopted under the competence of a notary

An appeal may be lodged against a decision in an administrative case adopted by the notary.

With regard to administrative cases coming at first instance within the competence of the notary according to the Social Act, the social and guardianship office acts as an authority entitled to examine the appeal. [Paragraph (2) of Article 6/A of Government Decree 63/2006 (Mar. 27) on the Detailed Rules of Applying for, Assessing and Disbursing Cash and In Kind Social Services]. The decision may be upheld, overturned or annulled by the body of second instance.

If there is insufficient data to adopt a decision on appeal, or new facts are discovered, or otherwise further clarification of the facts is required, then the authority of second instance may order the court of first instance to institute new proceedings, or may conduct supplementary fact-finding proceedings on its own accord, in addition to the annulment of the decision, and then may adopt its decision accordingly. (Article 105 of Act on Administrative Proceedings) A judicial review may be lodged after the right of appeal has been exhausted (Article 109 of Act on Administrative Proceedings).

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 providing cash and in kind social and child protection allowances is laid down in the following legislation:

According to Article 70/A of the Constitution of the Republic of Hungary (Act XX of 1949):

"(1) The Republic of Hungary shall respect the human rights and civil rights of all persons in the country without discrimination on the basis of race, colour, gender, language, religion, political or other opinion, national or social origins, financial situation, birth or on any other grounds whatsoever.
(2) The law shall provide for strict punishment of discrimination on the basis of Paragraph (1).
(3) The Republic of Hungary shall endeavour to implement equal rights for everyone through measures that create fair opportunities for all."[9]

Paragraph (2) of Article 3 of the Child Protection Act declares that the principle of equal treatment shall be observed in the course of child protection.

In accordance with Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunity (hereafter: Equal Treatment Act) the principle of equal treatment shall be observed by the Hungarian state, local and minority self-governments and the bodies thereof, and organisations exercising powers as authorities, in the course of establishing relationships, in their relationships, and in the course of their procedures and measures. (Article 4 of the Equal Treatment Act).

Article 24 of the Equal Treatment Act stipulates that the principle of equal treatment shall be enforced in respect of social security, particularly in the course of claiming and providing

a) benefits financed from the social security systems,
b) cash and in kind social benefits and child protection allowances, and provisions offering personal assistance.

[9] According to Paragraph (2) of Article XV of the Fundamental Law (25 April 2011), Hungary shall ensure fundamental rights to every person without any discrimination on the grounds of race, colour, gender, disability, language, religion, political or other views, national or social origin, financial, birth or other circumstances whatsoever. (The Fundamental Law of Hungary is in effect from 1 January 2012).

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

The system of social services has not changed significantly during the reporting period, access to the necessary information is ensured and personal assistance for people in need is also guaranteed.

2) KEY DATA AND STATISTICS

See the detailed data in Part 3) of Paragraph (1) of Article 14.

3) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested information on whether the provision of information on social services is ensured by the competent authorities, after the amendment of the Social Act which is in force from 1 January 2007, and whether the authorities possess the necessary means to perform these functions.***

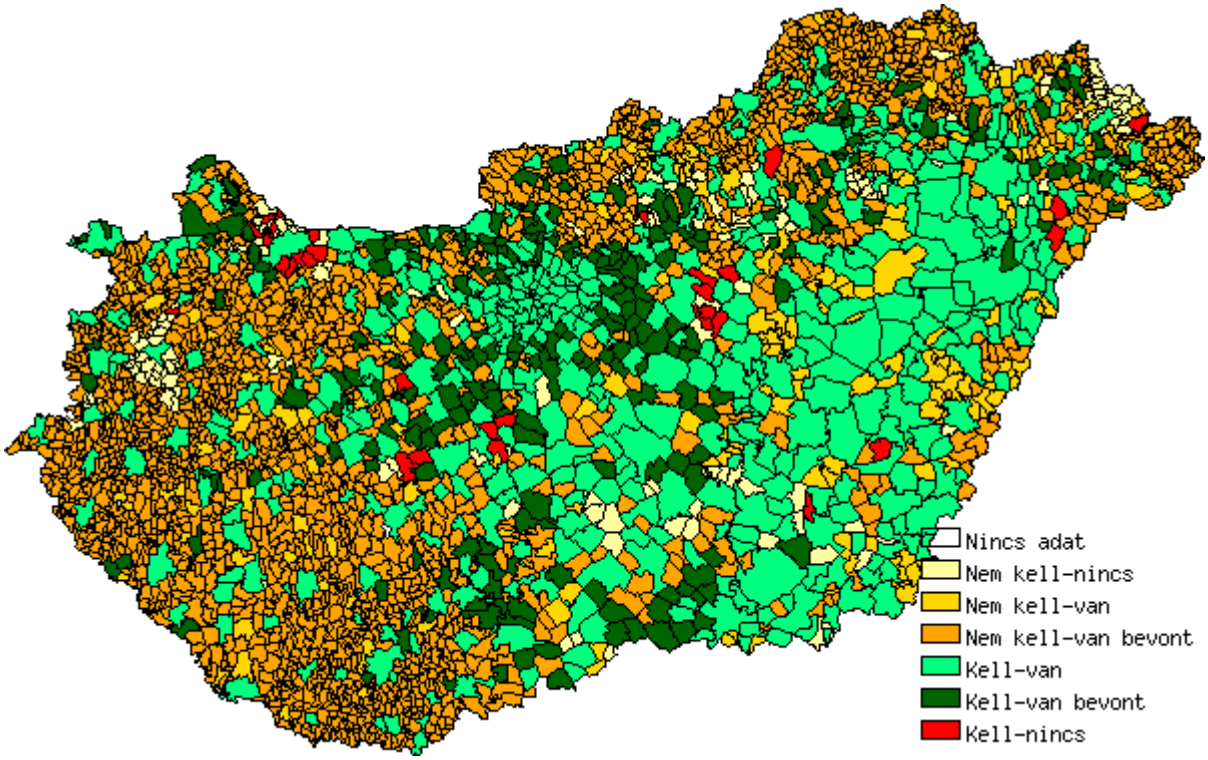
The services have a basic duty to ensure access to the information which applies to them. Ensuring access to information on social services is a primary task of family assistance, as a service pursuant to Paragraph (4) of Article 64 of the Social Act:

"(4) In the framework of family assistance, the following shall be ensured:
a) social, life management and mental hygiene consultancy,
b) organisation of access to cash and in kind benefits and to social services by persons facing financial difficulties,
c) family care to facilitate the management of family malfunctioning and conflicts,
d) organisation of community development programmes, as well as individual and collective therapeutic programmes,
e) consultancy to the long-term and young unemployed, persons afflicted by debt or housing problems, disabled people, chronically ill people, addicts, psychiatric patients, people with drug problems and other socially disadvantaged persons and their family members."

A warning system is also operated by the family assistance service in order to prevent crises among families and individuals who are at risk. One important part of this function is to inform members of the group at risk about accessibility and the available services.

Pursuant to the Social Act, family assistance services shall be operated in every settlement over 2,000 inhabitants and access to the services shall be provided in every settlement under 2,000 inhabitants. The local government is obliged by law to provide services but it can also fulfil its obligation through a non-governmental maintainer, such as a church, by concluding a supply contract with it.

As can be seen on the map below presenting the settlements providing family assistance services, the services are available in most settlements in the country (2011 data of the Hungarian Central Statistical Office):



Legend to above map (from the top down):
(white =) No data; (yellow =) Not needed – none; Not needed – exists; Not needed – exists and involved; (green =) Needed – exists; Needed – exists and involved; (red =) Needed – none

The village and homestead caretaker service, with approximately 1,200 members, also plays an important role in informing the people living in settlements under 600 inhabitants, as well as in outlying areas and homesteads.
The information obligation for persons applying to residential institutions is regulated by the Social Act, which defines the activities and tasks that ensure that the applicant is in the possession of all the information that is required to take a well-founded, prudent decision.

"Article 95 (1) The applicant shall be informed about the conditions of social provisions offering personal assistance at the time the application is submitted. The entitled person and his or her relative are notified about the earliest start date of the provision by the head of the institution.
(2) In case of provisions in long-term residential institutions, notification or information on the basis of Paragraph (1) shall include the following:

- *a) an eight-day deadline for the start of receiving care, and the procedure to be followed in case of missing this deadline;*
- *b) the rules of admission to the institution, official documents required for establishing an institutional legal relationship, personal items for use, declarations of relatives, personal appearance, and other conditions specified by law.*

(3) If the entitled person does not move into the residential institution within the period stated for starting the receipt of care, and he or she does not notify the head of the institution of the reasons for this, then the head of institution shall consult the competent notary in the settlement where the entitled person lives or resides.

(4) Information is given by the notary on the request made pursuant to Paragraph (3) about the following:

a) the location of the entitled person;
b) the reasons for not moving in;
c) the expected start date of receiving institutional care.

(5) If the entitled person was not able to start his or her institutional care due to reasons not attributable to him or her, according to the information by the notary, then the head of the institution provides for the placement of the person concerned within 30 days of the end of the circumstances justifying the impediment, if possible. The head of the institution initiates the end of placing in any other cases.

Article 96

(1) When being admitted to the institution, the entitled person and his or her relative are given information by the institution about

a) the content and conditions of care provided in the institution;
b) the records maintained by the institution;
c) the rules of communication between the entitled person and his or her relatives when being placed in the residential institution, particularly regarding visits, leave and return;
d) how to exercise their right to complain;
e) possible grounds for terminating the institutional legal relationship;
f) the house rules of the institution;
g) the fees to be paid and conditions to be fulfilled, and the consequences of failure to pay;
h) non-governmental organisations representing the rights and interests of the entitled person.

(2)

(3) When admitted to the institution, the entitled person and his or her relative are obliged to

a) declare that they acknowledge and respect the provisions laid down in the notification determined in Paragraph (1);
b) provide data for the records maintained by the institution on the basis of this Act;
c) declare that they will immediately inform the head of the institution of any changes in their eligibility criteria for social provision and of any changes in the natural identification data of the entitled person and/or close relative.

Article 96/A.

(1) In order to meet its obligation to provide information, the methodological institute prepares a guide on the social institutions that fall under its scope. The data are modified annually in the light of possible institutional changes. The guide includes data on the seat of the institution, its additional locations, the range of services, admission to the institution, the placement conditions, and the name and contact information of the person representing the rights of the person in care.

(2) The social institution provides the data determined in Paragraph (1) to the methodological institute, for it to perform this function. The methodological institute must be informed of any changes within 30 days of their occurrence."

The web portal on the social sector launched in August 2011 is an important tool for a far-reaching information campaign (www.szocialisportal.hu), and contains a great amount of information for people who intend to use the services, as well as for maintainers, service providers and other professionals. The content of the portal is continuously updated, and it is operated by the National Office for Rehabilitation and Social Affairs.

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

I. The personal scope of the Social Act (1st January 2008)

The Social Act applies to persons living in Hungary who are

a) Hungarian nationals,
b) migrants and settled persons,
c) stateless persons,
d) and persons recognised by the Hungarian authorities as refugees.

With regard to the temporary allowance, the Social Act also applies to nationals of the countries ratifying the European Social Charter who stay legally in the territory of the Republic of Hungary. The Act applies to persons entitled to free movement and residence if 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 the old-age allowance, the Act applies to persons belonging to the scope of Regulation No. 1408/71/EEC on the application of social security schemes to employed persons and their families moving within the Community, if 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.

Amendment in effect from 1 August 2011

With regard to the old-age allowance, the scope of the Act also covers any third-country national possessing an authorisation entitling him or her to reside and work for the purposes of highly qualified employment (EU Blue Card), provided that he or she has a registered residence or a temporary place of residence under the Act on the Registration of Personal Data and Address of Citizens.

II. The personal scope of the Child Protection Act (1st January 2008)

The scope of the 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 persons recognised by the Hungarian authorities as refugees or stateless persons.

b) persons entitled to free movement and residence if 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 extraordinary child protection support, the Child Protection Act also applies to nationals of the countries ratifying the European Social Charter who stay legally in the territory of the Republic of Hungary.

Amendment in effect from 1 September 2009

The scope of the Act also covers children and young adults recognised as being under subsidiary protection or stateless, and their parents.

Amendment in effect from 1 May 2011

In accordance with the Act on Asylum, the scope of the Act also covers foreign children under the age of 18 who applied for asylum and entered into the territory of Hungary without the company of a person of full age responsible for their supervision, on the basis of a rule of law or custom, or remained without supervision following entry, until they are transferred under the supervision of such a person – provided that the minor status of the child concerned is established by the refugee authority.

III. Provisions for third-country nationals residing illegally in the territory of Hungary

The following regulations apply with regard to provisions for third-country nationals who are not in detention and reside illegally in Hungary:

Pursuant to Point f) of Paragraph (1) of Article 62 of Act II of 2007 on the Entry and Residence of Third-Country Nationals (hereafter: Act on Third-Country Nationals) the immigration authority can order the confinement of a third-country national in a designated place if the third-country national has been expelled and lacks the financial and habitable conditions required for his or her subsistence. Pursuant to Paragraph (3) of Article 62 of the Act on Third-Country Nationals, the compulsory place of confinement is designated at community accommodation or a refugee centre if the third-country national is not able to support him or herself, does not have an adequate place of abode, financial resources or income, or a host who is compelled to provide support or a relative who can be compelled to provide support.

The regulations also specify a designated place of residence for persons who illegally reside in Hungary but who need special treatment, constituting a separate category. Pursuant to Point t) of Article 2 of the Act on Third-Country Nationals, "a person in need of special treatment: a minor without accompaniment or a vulnerable person – particularly a minor, an elderly person, a person with disability, a pregnant woman, a parent raising his or her child alone, or a person who has suffered torture, rape or other severe forms of psychological, physical or sexual violence – about whom it can be established, after individual assessment of his or her situation, that he or she has specific needs.

Pursuant to Points b), c) and g) of Paragraph (1) of Article 62 of the Act on Third-Country Nationals, the immigration authority can order the confinement of a third-country national in a designated place if the third-country national is a minor who should be placed under detention; or is an adult should be placed under detention and his or her minor child residing in the territory of Hungary with him or her would be left unattended if he or she were to be detained; or if the immigration authority would have the right to detain the third-country

national in accordance with Points a) or b) of Paragraph (1) of Article 54, and the detention would result in a disproportionately severe disadvantage – particularly taking into account the health status and age of the third-country national concerned.

In case of persons belonging to the first category, i.e. minors without accompaniment, on the basis of Paragraphs (1) and (2) of Article 56 of the Act on Third-Country Nationals, detention may not be ordered; in such a case placement is ordered, by decree of the immigration authority, in a child protection institution designated as a place of residence by the authority.

With regard to persons belonging to the second category, i.e. third-country nationals illegally residing in Hungary with a minor, or pregnant women, the immigration authority orders both the parents and the minors to be placed in community accommodation with common places and separate rooms for pregnant women where the families and pregnant women can live separately during the procedures of the immigration authority.

Persons belonging to the third category, i.e. persons whose detention would result in a disproportionately severe disadvantage due to their health status, are placed in a refugee centre where they can receive medical, and if necessary psychiatric care.

Foreign persons subject exclusively to procedures of the immigration authority and placed in community accommodation receive health care services according to Articles 138-140 of Government Decree 114/2007 (May 24) on the Implementation of Act II of 2007 on the Entry and Residence of Third-Country Nationals (hereafter: Government Decree on Third-Country Nationals), health care services for any third-country national who is detained shall be continuously provided at the guarded shelter [Paragraph (1) of Article 138 of the Government Decree on Third-Country Nationals].

If a third-country national detained or placed in community accommodation is not covered by social security, in the event of his or her illness, he or she shall be entitled to free medical services defined in Paragraph (2) and Points e) and i) of Paragraph (3) of Article 142 of the Health Act. [Paragraph (1a) of Article 138 of the Government Decree on Third-Country Nationals].

Pursuant to Paragraph (2) of Article 142 of the Health Act, the person residing in the territory of Hungary shall receive the following provisions as part of the basic package of services without previously confirming his or her legal relationship serving as a basis for the receipt of the services

a) from the epidemiological services
   aa) mandatory vaccination (except for vaccination required for travelling abroad),
   ab) screening tests performed for epidemiological purposes,
   ac) mandatory medical examinations,
   ad) epidemiological isolation,
   ae) transport of infectious patients,
b) rescue services, provided that the person is in the need of immediate care,
c) in case of instant need, provisions specified in separate legislation.

According to Point a) of Paragraph (3) of Article 142 of the Health Act, the central budget shall cover the costs of the above mentioned epidemiological provisions. The central budget shall only cover the costs that cannot be recovered from any source with regard to rescue services and provisions provided in case of instant need. Furthermore, the central budget covers the costs of autopsy and provisions in connection with medical procedures with regard to a deceased person, after the death of a person residing in the territory of Hungary, and health care services in disaster situations.

According to Paragraph (2) of Article 138 of the Government Decree on Third-Country Nationals, the third-country national placed in community accommodation is entitled to receive the vaccinations specified in separated legislation. According to Paragraph (1) of Article 139 of the Government Decree on Third-Country Nationals, general medical care shall be provided to third-country nationals at the guarded shelter or the community accommodation (hereafter referred to collectively as: immigration authority accommodation). Special medical care shall be provided by the health care provider responsible for the region in question. [Paragraph (2) of Article 139 of the Government Decree on Third-Country Nationals]. According to Paragraphs (1)-(2) of Article 140 of the Government Decree on Third-Country Nationals, the authority operating the immigration authority accommodation shall reimburse the costs of health care services, other than those described in Article 138, to the health care service provider carrying out the procedure, if Hungary has not agreed to compensate such costs under international treaty. Health care services may be received if the person is in the possession of a certificate of eligibility for provisions. Foreign persons who applied for asylum – as asylum seekers – are not considered to be illegal residents, but if circumstances defined in the related legislation exist, they are entitled to receive accommodation and provision.

Provisions and assistance received by asylum seekers is regulated by Act LXXX of 2007 on Asylum and its enacting decree, Government Decree 301/2007 (Nov. 09) (hereafter: Government Decree on Asylum). The person seeking asylum – if in need – shall be entitled to free provisions and assistance, as specified in the relevant legislation.

Pursuant to Article 18 of the Government Decree on Asylum, the person seeking asylum shall be deemed as being in need in terms of provisions and assistance provided, if the person seeking asylum, or his or her spouse or immediate relative living in the same household, does not have any property in Hungary to provide for his or her subsistence, and his or her per capita monthly income, taking into account the total income of his or her spouse and immediate relative living in the same household, does not exceed the minimum amount of the old age pension in effect at any given time.

A foreign person seeking asylum is placed in a refugee centre by the refugee authority.

Pursuant to Article 21-23 of the Government Decree on Asylum, the main components of placement at refugee centres and provisions are the following:

- accommodation;
- three meals a day (or a food allowance of equivalent value);
- tableware and toiletries for personal use (or a hygienic allowance of equivalent value, as well as clothes);
- monthly allowance of free use, the maximum amount of which is currently HUF 7,125 per capita per month;
- the applicants can also receive clothes, as necessary, at the refugee centre, primarily from donations.

Further provisions and assistance provided according to the Government Decree on Asylum:

The refugee authority, upon request by the person seeking asylum, shall issue a certificate for the use of transport discounts, if the person seeking asylum takes steps to settle his or her legal status with the competent authorities, or needs to travel for the purpose of using healthcare provisions, or for taking part in a programme operated by a non-governmental organisation taking over a state duty.

In case of children seeking asylum,

- the refugee authority reimburses the costs incurred during their stay at the refugee centre, in connection with their kindergarten and school education, i.e. ticket or season ticket used for local or interurban transport with the aim of travelling to the educational institution, in the interest of facilitating the participation of children seeking recognition in the kindergarten and full-time school education, and
- the expenses of meals incurred at the educational institution and the fee of placement at a boarding school.
- Once per academic year, a school start benefit can be provided at an amount of HUF 28,500 per child, which can be spent on school equipment for the child seeking asylum who is participating in full-time school education at an educational institution.

Pursuant to Article 26-28 of the Government Decree on Asylum, asylum seekers are entitled to health care services free of charge, including:

- examinations and medical treatment falling within the scope of care provided by general practitioners;
- out-patient services in case of emergencies and related examinations, medical treatment, as well as medication and bandages used in the course of treatment;
- in-patient care in health institutions in case of emergencies;
- emergency dental care and odontotherapy;
- prenatal care and obstetrics;
- mandatory vaccinations related to their age.

In accordance with these regulations, general practitioner care is provided at the refugee centre; special treatment such as dermatology is provided by the health care service provider with a territorial service obligation, according to the general rules.

In addition to the above, a person in need of special treatment is entitled to receive reasonable health care services, rehabilitation, psychological and clinical psychological care and psychotherapeutic treatment free of charge with regard to his or her health status, provided that the services are required according to his or he individual situation and medical opinion.

Provision of unaccompanied minors illegally entering the territory of Hungary

Under the legal provisions on refugees in force from 1 May 2011, an unaccompanied minor seeking recognition as a **refugee is placed in the framework of the child protection institutional system**, in line with child protection legislation.

Accordingly, the scope of the Child Protection Act covers unaccompanied minors seeking asylum, minors with a settled status, as well as minors recognised by the Hungarian authorities as refugees or in temporary protection. Accordingly, from 1 May 2011 an unaccompanied minor seeking asylum is placed in the framework of the child protection institutions. Between 1 May 2011 and 30 August 2011, every unaccompanied minor seeking asylum was placed in and cared for in the Home Of Unaccompanied Minors rented in the territory of the Bicske Refugee Centre by the Hungarian Ecumenical Aid Organisation on behalf of the Ministry of Human Resources. From 31 August 2011 every unaccompanied minor is placed in and cared for in the Károlyi István Children's Centre maintained by the government in Fót.

Unaccompanied children who do not seek asylum in Hungary are also placed in child protection institutions, in accordance with Paragraph (3) of Article 4 of the Child Protection Act.

Children's home specifically designed for the placement of such children was not established during the reporting period because their care could be provided at the empty places of the functioning children's homes.

Minors seeking asylum and those not seeking asylum placed in children's homes are provided with full care, irrespective of the type of maintainer, the components of which, in accordance with Articles 76-82 of Decree15/1998 (Apr. 30) of the Ministry of Welfare on the Professional Tasks and Operational Conditions of Child Welfare and Child Protection Institutions Providing Personal Care, include the following:

"Article 76 (1) At least five meals – including at least one hot meal – per day that are appropriate to the child's age and comply with the requirements of healthy nourishment shall be provided to a child in care, in accordance with the specifications laid down in legislation including recommendations of energy and nutrient intakes, as well as the use of food.
The daily costs of the five meals per day cannot be less than 2.4% of the minimum old-age pension in effect at any given time.
(2) If the health status of the child in care justifies it, then he or she shall receive meals according to the prescription of a doctor.
Article 77 (1) The clothing provided as part of the full services includes at least 6 changes of underwear and 3 changes of nightwear, and at least 2 changes of outerwear and shoes for everyday (home and street) use appropriate to the season, as well as casual and sport clothing.
The annual costs of clothing cannot be less than 250% of the minimum old-age pension in effect at any given time.
(2) Cleaning and repair of the clothing are provided by the service provider, the child in care is involved to such a degree that can be expected from him or her at his or her age.
(3) The purchase and change of clothing are provided by the service provider according to the needs of the child and the deterioration of the clothing.
Article 78 In order to ensure personal hygiene and provide textiles, every child shall receive at least
a) the conditions required for his or her daily bathing, personal hygiene and toiletries and body lotions, as well as textiles,
b) materials and tools required for the provision of infants and young children,
c) 3 changes of bed linen.
Article 79 (1) Tuition fees, textbooks, school materials, other school equipment and travel- or handbags required for obtaining the first qualification, as well as costs incurred in relation to his or her daily travel to school, shall be provided for the child in care participating in school education, vocational training, or higher education studies.
(2) Costs related to social inclusion and talent development of the child in care shall be provided.
(3) The child in care shall be provided with the means – particularly tickets or season tickets for travelling, postal costs for correspondence and phoning – for the child to stay in touch with his or her relatives or guardians.
Article 80 (1) In order for a child in care to spend their free time usefully, the equipment required for cultural activities, games and sport are provided by the service provider.
(2) The required and justifiable costs for the free time activities are provided by the service provider.
Article 81 The tools required and justifiable for the advancement, development, recovery, rehabilitation and therapy of a child in care who is in need of special treatment are purchased by the maintainer.

Article 82 (1) Children in care over the age of 3 shall be provided with monthly pocket money for the purpose of satisfying their personal needs, except for the case specified in Paragraph (3).
The monthly amount of pocket money cannot be less than
a) 5% (in case of a child between the ages of 3 and 10)
b) 13% (in case of a child between the ages of 10 and 14)
c) 18% (in case of a child above the age of 14)
of the minimum of old-age pension in effect at any given time.
(2) An amount of pocket money which is above the rate specified in Paragraph (1) shall be monthly established and disbursed by
a) the head of the institution, on the recommendation of the educator, in case of children placed in children's homes,
b) the foster parent, in case of children placed with foster parents,
taking into account the diligence and behaviour of the child.
(3) Children arbitrarily leaving (absconding from) the place of care are not entitled to receive pocket money during their abscondment.
(4) The educator or foster parent of the child in care keeps a register of the child's pocket money, as set out in Annex 3.
(5) The child in care can decide independently on the use of his or her pocket money.
(6) Pocket money is not paid out to children in care who are obliged to participate in development training or between the ages of 3 and 6, but the principle of personal use shall be ensured."

2) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested information on whether the temporary allowance is provided to persons – irrespective of their legal status or nationality – by the local governments in case of threats to life or bodily integrity, according to Paragraph (1) of Article 7 of the Social Act.***

In accordance with Article 3 of the Social Act, the scope of the Act applies as a general rule to persons living in Hungary who are

a) Hungarian nationals,
b) migrants and settled persons,
c) stateless persons,
d) and persons recognised by the Hungarian authorities as refugees.

With regard to provision specified in Paragraph (1) of Article 7 (temporary allowance in case of threats to life or bodily integrity) of the Social Act, in addition to the above mentioned personal scope, the Act also applies to nationals of the countries ratifying the European Social Charter who stay legally in the territory of Hungary (Paragraph (2) of Article 3 of the Social Act).

Nevertheless, the scope of the Social Act does not apply to persons who have a different status to those listed above, so the temporary allowance cannot be provided to them in case of emergency.

- ***The ECSR requested information on emergency care services provided for foreign persons in emergency situations who are illegally residing in the country.***

See the detailed information in point III of part 1).

- ***The ECSR requested information on whether every person in an emergency situation who is illegally residing in the country is entitled to receive emergency social provisions (accommodation, meals, clothing).***

These people are not entitled to receive a temporary allowance according to the personal scope of the Social Act. See the detailed information in point III of part 1).

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

I. Basic social services

- **Introduction of the assessment of the need for care by home help services – 2008**

From 1 January 2008, the provision can only be provided for the applicant if the specified need for care exists. The need for care is based upon the lack of a capability for self-sufficiency of the person, which depends on his or her health status, their need for nursing care and their ability for self-help. The daily need for care is established by the assessment of the need for care. A person is entitled to receive home help services if his or her need for care does not exceed 4 hours per day. Initially the assessment was performed by an expert committee, although currently it is performed by the head of the institution, based on certain pre-defined criteria and procedures. The rules on the assessment were specified in a government decree, and the detailed criteria of the assessment were determined in a ministerial decree.

The relevant provision of Act III of 1993 on Social Administration and Social Services (hereafter: Social Act):

"Article 63 (4) The need for care shall be assessed before providing home help services.

The assessment of the need for care shall be performed by the head of the institution or, in their absence, by the expert appointed by the notary, based on the application for provision.

(5)

(6) The need for care shall be assessed as defined by law, and the daily need for care shall be established by the head of the institution or, in their absence, by the expert appointed by the notary.

(7) The home help service shall be provided for the duration appropriate for the daily need for care, but at least for 4 hours per day.

If the home help service exceeds 4 hours per day, the applicant is informed by the head of the institution or, in their absence, by the expert appointed by the notary, about the possibility of residential institutional care; in this case the applicant is entitled to receive the home help service for 4 hours per day until he or she is placed in an institution."

This measure assists the long-term residential institutions providing care for elderly persons, in that their services are only used by persons who are genuinely in need of them.

- **Support services, community care, home help services relying on the warning system, and the introduction of a new financing system**

The 2007 amendment of the Social Act resulted in a significant change in the system of mandatory provisions, because from 1 January 2009 local governments are no longer obliged to provide support services and community care. At the same time, the state contribution on a normative basis was terminated. In its place – for the purposes of combating the regional differences in the field of community care, facilitating quality services and distributing the available resources in a professionally grounded way – these services are supported by the state in a financing system based upon performance, the point of which is that institutions wishing to provide services indicate the performance rate undertaken by them in their application. By introducing the new performance-based financing format, the emphasis was placed on the needs of the persons receiving services. Successful applicant organisations are granted inclusion for a three-year period, and state support is guaranteed during this period.

The system of calls for proposals provided an opportunity to align the regional needs with the required capacity, to decrease the unjustified number of state-supported services in specific areas, and to terminate state support for organisations providing poor-quality services.

From 1 January 2010, home help services relying on the warning system were included in the new financing system, which also affected the system of mandatory provisions laid down in the Social Act.

The relevant provision of the Social Act:

"Article 131/A. Support services, home help services relying on the warning system, community care and, from 1 January 2012, street social work, are financed by the state through funding agreements concluded with maintainers selected on the basis of the application procedure specified in separate legislation.

The funding agreement shall be concluded for a duration of three years, unless otherwise provided for by law."

II. Specialised social services

- **Introduction of the assessment of the need for care by elderly home services – 2008**

Services can only be provided for the applicant if the specified need for care exists. The need for care is based upon the lack of capability for self-sufficiency of the person, which depends on his or her health status, their need for nursing care and their ability for self-help. The daily need for care is established by the assessment of the need for care. A person is entitled to receive retirement home services if his or her daily need for care is more than 4 hours.

The relevant provision of the Social Act:

"Article 68/A. (1) The assessment of the need for care shall be performed by the head of the institution, based on an application for retirement home services.

If the person has been referred to the home for the elderly, then the assessment by the head of the institution is initiated by the referring body before the decision on referral is made.

(2) The need for care shall be assessed as defined by law, and the daily need for care and the existence of circumstances defined in legislation shall be established by the head of the institution.

(3) Home for the elderly services can be provided if a need for care exceeding 4 hours per day is determined, or based upon other circumstances specified in legislation.

(4) If the person applying for home for the elderly services has a need for care but this does not exceed 4 hours per day, and there are no other circumstances specified in legislation which justify the placement of the applicant in a home for the elderly, the head of the institution shall inform the applicant about the possibility of receiving home help services."

- **Deinstitutionalisation Strategy – 2011**

By adopting Government Decree 1257/2011 (Jul. 21) on the Strategy for Deinstitutionalising the Capacity of Social Institutions Caring for the Disabled and on Government Responsibilities Related to its Implementation, the government adopted the strategy of deinstitutionalisation, which provides a practical framework for placing persons with disabilities in integrated living environments.

The aim of this strategy is to set the long-term course for the transformation of institutions and the comprehensive reform of the service system provided for persons with disabilities. The deinstitutionalisation of the capacity of social institutions providing nursing and caring for persons with disabilities affects approximately 12,000 persons with disabilities, and implies reforming the whole system of provision.

The novelty of this strategy is that the complex services provided by the residential institutions until now will be shared out to services in support of an independent lifestyle (e.g. rehabilitation, development, care, transport) and housing services, on the basis of an assessment of need. As a result of the reform, persons receiving care will have a chance to establish an independent lifestyle at their place of residence, in addition to receiving services adapted to their needs, capabilities and skills. The purpose of the reform is to support housing and independent lifestyles instead of the current institutional care.

The implementation process has already begun, resulting in legislative amendments related to the scope of services, and facilitating the transformation of certain institutions with the help of community resources. The Government Decree includes the tasks for the first three years.

In the interest of implementing the strategy, the government ordered the professional content, personal and physical conditions of supported housing to be formally drawn up. To promote implementation of the strategy, call for proposals TIOP 3.4.1 on the deinstitutionalisation of live-in institutions has been announced, with a total available budget of HUF 7 billion. In order to execute the call for proposals, the regulatory background of the deinstitutionalisation process needs to be in place.

III. General changes affecting the system of social services

- **Introduction of the social administrative fine – 2008**

From 1 January 2008 the social administrative fine was included in the Social Act for ensuring the expected quality defined by law, as well as protecting the rights of the persons receiving care. Since its introduction, the body authorising the operation can impose a fine against the maintainer, the head of the institution and other offenders, in case of violation of the rights of the persons receiving care or other offences specified in separate legislation. The related rules were subsequently amended to include differentiation, both in the facts underlying the fine, and in the amount of the fine. The upper limit of the social administrative fine that can be imposed by the controlling authority in cases of provision of services without

authorisation was increased to HUF 500,000 from 2011, with the aim of reducing the number of illegal service providers and ensuring the provision of services of adequate quality (Articles 92/L and 92/M of the Social Act).

- **Overview of the administrative obligations related to services – 2010**

Legislative amendments were also required to significantly decrease administrative obligations and to make them more realistic, as well as to eliminate the duplications and anomalies in the regulations. The burdens of service providers have been eased as a result of the amendments, freeing up some of the human resource capacity, which can be used for performing the professional tasks of the provision and improving the quality of services, and thereby increasing satisfaction among maintainers and persons receiving care.

The rules on the registration system have been modified, and services can be applied for without formal requirements in the future. The process of inclusion in social care was simplified in cases of home help and home retirement services, and the relevant time period was significantly shortened by transferring the right to perform the assessment of need for care, which provides the basis for eligibility, from the expert committees to the heads of institutions.

- **Reform of the rules on usage fees – 2011**

The rules on the usage fees to be paid when using social services have been modified, thus facilitating more stable operations of the institutions. The point of the amendment is that in case of long-term residential institutions, any significant financial and real estate wealth owned by the person receiving care will be taken into consideration when establishing the personal usage fee. Furthermore, the income and property verification, which used to be performed by the notary, has also been transferred to the scope of the head of the institution, in case of home retirement services, which strengthens the institutions further. If the financial circumstances of the person receiving care or the relative allow, then he or she has the opportunity to voluntarily pay a higher amount than the established personal usage fee, even if the amount that they would like to pay does not reach the amount of the whole institutional usage fee.

The aim of these amendments is to create a simple, understandable, transparent sharing of the burden, which is fair or acceptable both to the institutions and to the persons receiving care. (Articles 114 – 119/B of the Social Act)

- **Stronger protection under penal law for providers of social services – 2011**

The number of persons providing public services in the social sector has increased. Additional groups of people – i.e. nurses working in institutional care, nurses who are heads of institutions, carers, social and mental hygiene professionals, and village and homestead caretakers – are now included in the category of people employed in positions with increased risk, which gives them increased protection from violent acts and underlines their value to society.

In accordance with Paragraph (2) of Article 94/L of the Social Act:

"The persons fulfilling the following positions are considered to be persons providing public services:

a) social workers providing home help services, including head social workers,
b) family carers,

c) *social carers providing support services and community care for psychiatric patients and addicts,*
d) *social assistants and street social workers providing care for homeless persons,*
e) *persons providing pre-institutional care,*
f) *nurses working in institutional care, nurses who are heads of institutions, carers, social and mental hygiene professionals,*
g) *village and homestead caretakers."*

- **Changes in the required qualifications – 2011**

Annex 3 of Decree 1/2000 (Jan. 07) of the Ministry for Social and Family Affairs on the Professional Duties and Working Conditions of Social Institutions Providing Personal Care, which includes the qualifications required for occupying positions in certain services, was significantly amended in content and format. The amendment was justified by the necessity to comply with the National Register of Vocational Qualifications (hereafter: OKJ) and the changes in the higher education system. The new annex of required qualifications defines the minimum levels of higher education and secondary level qualifications, complying with the OKJ and higher education qualifications that are in force, as well as other required special skills. Another requirement stipulated is the proportion of staff possessing higher education or secondary level qualifications.

- **Changes in the scope of operating licences – 2011**

From 1 January 2010 the system of procedures for providing operating licenses for social services was renewed. Government Decree 188/1999 (Dec. 16) on the Operating licences of Social Institutions Providing Personal Care and of Village Caretaker Services, and on the Authorisation of Social Entrepreneurs (hereafter: Government Decree on the Authorisation of Social Institutions) was amended several times due to the constant changes in social services. In 2009 the legislation underwent a thorough review, several different regulations on licensing were standardised (social service providers, day care institutions, residential institutions), superfluous administrative regulations were reviewed, and more efficient sanctions were established during the control process, harmonising the rules with the rules for child protection licensing.

As part of this review, the two areas governed by the previous decree - i.e. the process of granting operating licenses to social service providers and social institutions, and the normative state support for child welfare and child protection service providers and institutions - were split into two separate decrees.

The amendment resulted in substantial changes in the following areas:

- Instead of different procedures for granting licences to each specific service, as before, there are now basically uniform rules for licensing all social service providers and institutions.
- The two-stage licensing procedure was terminated. Previously, only the existence of the physical conditions was verified at the beginning of the licensing process for residential institutions, while the existence of the personal conditions was verified in the second stage.
- The rules on fixed-term operating licences (the institution meets all the conditions but the building is only in its use for a fixed-term) and temporary operating licences (the institution does not meet all the conditions but the licence can be issued by law) were also standardised between the two sub-sectors. Many regulations with regard to issuing licences were also clarified.

- Based on experience, every social, child welfare, child protection service provider and institution will in future be issued with a certificate, which must be posted in a clearly visible location in order to provide information to persons who are interested in using the services.
- Rules on reporting obligations, as well as on terminating licences of providers or institutions, were also clarified, with special regard to state maintainers with an obligation to provide services.
- Practice has shown that the sanctions defined by law are not an appropriate way of dealing with many offences. In the light of the experience gained, new legal consequences can be applied on the basis of the new Government Decree on the Authorisation of Social Institutions. For instance, the admission of new persons receiving care is prohibited until the deficiencies are removed, and ex-officio modification of the operating licence is permitted (which is significant if the maintainer has failed to request the modification of the operating licence, e.g. due to data changes. The institution shall not be summoned to request the modification subsequently, but any inaccuracy can be corrected by the office).
- Based on experience, the rules on institutions operating without a licence have also been modified.

From 1 July 2011 the scope of the social affairs and guardianship offices of metropolitan and county government offices was expanded: the social and guardianship offices act at first instance in relation to each case with regard to the authorisation and control of operating licences of social and child welfare services. The previous situation has changed, i.e. operating licences for basic services are no longer granted within the competence of the notary of the local government. The measure facilitates more uniform and more transparent administration. [Government Decree 321/2009 (Dec. 29)].

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

Announced/implemented calls for proposals in the reporting period (Total amount per construction with the announced/awarded budget):

Year(s) of call	Number and name of construction	Aim/Short description	Funding announced/ awarded (HUF million)
2007-2008	TÁMOP-5.4.5. Development of the professional background for designing physical and info-communicational accessibility	Dissemination of professional knowledge for designing physical and info-communicational accessibility and establishment of a mentoring network for the support of construction 3.4.1 (deinstitutionalisation)	934
2008, 2009	TÁMOP-5.3.1. "First step" – supporting programmes to enable persons with low employment chances to lead an independent lifestyle	To ensure programmes, training and support services for inactive persons with low employment chances, which strengthen their self-care capabilities and key competencies in order to strengthen their social integration.	7 140
2008	TÁMOP-5.3.2. Professional and methodological background for the social and labour market integration of homeless	To develop more efficient, complex and sustainable solutions that encourage independent housing and labour market integration, and enable the social reintegration of homeless people in order to contribute to the prevention and gradually elimination of homelessness in Hungary.	345

	people		
2008, 2010, 2011	TÁMOP-5.3.3. Support for programmes promoting the social and labour market integration of homeless people	Enabling institutions providing care to homeless people to admit people coming from the street and supporting independent housing for people living in the street whose institutionalisation is not justified, as well as improving employability in order to reduce the number of people living in the street.	2.192
2008	TÁMOP-5.4.1. Modernisation of social services, strengthening of the central strategic planning capacities, defining the background of social policy decisions	Modernisation of social services, strengthening of the central strategic planning capacities, defining the background of social policy decisions	1.027
2008	TÁMOP-5.4.2 Central social information developments	To upgrade the central electronic services required for modernisation of the social sector, for transparent operations, controls, planning and decision-making support for the services of this sector. As part of this, the central administration system of the sector is deployed and modernised, including the program and content development for establishing the administration system of the central electronic operating licence authorisation system, the central sectoral data provision and information system, the electronic register of the operational control system, and the sectoral service portal.	1.279
2008	TÁMOP-5.5.7./08/1 Development of the network of representatives of patients' rights, the rights of persons receiving care, children's rights and non-profit legal defence organisations.	Legal defence of patients and clients receiving social services, as well as children living in child protection care, to ensure equal opportunity of access to provision, to enable the enforcement of their rights, and to maintain respect for their human dignity, with special attention to extremely vulnerable social groups.	914
2009	TÁMOP-5.4.4-09/1/A KMR+KONV Central Hungarian Region and the Convergence Regions - Development of social training programmes, and training, advanced training and skills development of professionals, as well as strengthening local development capacities	Under this call for proposals, activities aimed at developing the quality of social training programmes can be supported, with special regard to establishing new training courses and forms of training, as well as disseminating best practices. EU funding can be requested for the establishment and institutional acceptance of competence-based, interactive, integrated, complex training programmes using modern methodology, built on an up-to-date philosophy and curriculum, as well as interdisciplinary and inter-professional training programmes, curricula and educational models.	1 335
2007, 2008, 2009,2010	TIOP-3.3.1. To establish equal opportunities for access to public services	To enhance the quality of life of persons with disabilities – and persons and children temporarily deprived of their ability to move or communicate for other reasons – by establishing equal opportunities for access to public services	2 123
2008, 2011	TIOP-3.4.2 Modernisation of residential institutions	Renovation of out-dated residential institutions, building, enhancement, purchase of real estate for reducing congestion	9 443
2011	TIOP-3.4.1 B Child protection component of the construction for replacing residential institutions	To replace a large number of child welfare and child protection institutions, to provide new places in child protection and child welfare service forms with insufficient capacity in order to ensure modern placement conditions that satisfy the conditions defined by law.	3 000

3) KEY DATA AND STATISTICS

Number of persons receiving home help services, by territorial unit

Territorial unit	1995	2000	2005	2006	2007	2008	2009	2010	2011
Central Hungary	**10 644**	**9 199**	**8 162**	**7 930**	**7 130**	**6 883**	**7 450**	**7 780**	**7 548**
Central Transdanubia	4 680	4 139	4 742	5 202	4 311	4 144	5 400	6 753	6 426
Western Transdanubia	5 099	3 812	4 091	4 492	4 695	4 897	6 028	7 385	7 598
Southern Transdanubia	3 341	3 359	5 200	5 815	6 023	6 779	8 206	9 025	9 508
Transdanubia	**13 120**	**11 310**	**14 033**	**15 509**	**15 029**	**15 820**	**19 634**	**23 163**	**23 532**
Northern Hungary	6 769	6 183	7 619	7 974	7 285	7 490	9 460	12 158	15 252
Northern Great Plain	7 058	7 226	8 571	8 970	7 956	8 746	15 185	17 637	23 716
Southern Great Plain	6 858	6 374	6 745	7 705	8 589	9 181	11 663	14 316	17 893
Great Plain and North	**20 685**	**19 783**	**22 935**	**24 649**	**23 830**	**25 417**	**36 308**	**44 111**	**56 861**
Country total	**44 449**	**40 292**	**45 130**	**48 088**	**45 989**	**48 120**	**63 392**	**75 054**	**87 941**

Data on territorial distribution of services in the area of social services

Source: KSH [Central Statistical Office]

Number of persons receiving social catering, by territorial unit

Territorial unit	1995	2000	2005	2006	2007	2008	2009	2010	2011
Central Hungary	**28 687**	**24 382**	**21 852**	**20 752**	**18 594**	**16 690**	**17 679**	**21 509**	**21 498**
Central Transdanubia	11 122	9 919	9 978	10 781	9 220	9 946	12 824	13 996	14 720
Western Transdanubia	12 669	10 804	11 701	11 816	11 077	12 016	13 779	15 618	15 635
Southern Transdanubia	10 389	9 366	11 100	11 346	11 397	13 638	16 351	18 298	18 669
Transdanubia	**34 180**	**30 089**	**32 779**	**33 943**	**31 694**	**35 600**	**42 954**	**47 912**	**49 024**
Northern Hungary	16 875	16 779	19 688	20 749	18 948	20 024	21 352	24 181	25 693
Northern Great Plain	15 858	15 236	19 312	19 797	18 299	20 583	23 783	28 935	32 264
Southern Great Plain	11 369	11 672	13 071	13 697	14 363	14 906	18 925	23 906	26 612
Great Plain and North	**44 102**	**43 687**	**52 071**	**54 243**	**51 610**	**55 513**	**64 060**	**77 022**	**84 569**
Country total	**106 969**	**98 158**	**106 702**	**108 938**	**101 898**	**107 803**	**124 693**	**146 443**	**155 091**

Number of persons receiving family support services, by territorial unit, 2011

Territorial unit	Total
Central Hungary	**91 507**
Central Transdanubia	45 800
Western Transdanubia	25 564
Southern Transdanubia	41 923
Transdanubia	**113 287**
Northern Hungary	66 612
Northern Great Plain	132 131
Southern Great Plain	60 342
Great Plain and North	**259 085**
Country total	**463 879**

Main data on village and homestead caretaker services, by territorial unit, 2011

Territorial unit	Number of persons employed as village caretaker	Number of persons employed as homestead caretaker
Budapest	–	–
Pest	2	49
Central Hungary	**2**	**49**
Fejér	2	3
Komárom-Esztergom	7	2
Veszprém	86	9
Central Transdanubia	**95**	**14**
Győr-Moson-Sopron	47	3
Vas	85	2
Zala	123	11
Western Transdanubia	**255**	**16**
Baranya	144	10
Somogy	92	26
Tolna	25	19
Southern Transdanubia	**261**	**55**
Transdanubia	**611**	**85**
Borsod-Abaúj-Zemplén	146	13
Heves	4	–
Nógrád	38	7
Northern Hungary	**188**	**20**
Hajdú-Bihar	8	19
Jász-Nagykun-Szolnok	4	24
Szabolcs-Szatmár-Bereg	36	33
Northern Great Plain	**48**	**76**
Bács-Kiskun	10	71
Békés	8	25
Csongrád	7	65
Southern Great Plain	**25**	**161**
Great Plain and North	**261**	**256**
Country total	**874**	**390**

Main data on day care of homeless people, by territorial unit [persons]

Territorial unit	Capacity of day care centres								Capacity of soup kitchens							
	2000	2005	2006	2007	2008	2009	2010	2011	2000	2005	2006	2007	2008	2009	2010	2011
Central Hungary	**1 607**	**2 455**	**3 170**	**3 068**	**4 505**	**3 951**	**4 184**	**4 954**	**2 190**	**1 846**	**2 030**	**1 930**	**2 030**	**2 030**	**3 373**	**4 505**
Central Transdanubia	308	530	575	495	715	696	667	643	560	400	350	255	435	440	440	745
Western Transdanubia	176	250	300	270	285	300	320	320	260	295	435	395	410	435	495	481
Southern Transdanubia	339	340	432	407	507	548	507	511	377	315	315	315	315	335	445	415
Transdanubia	**823**	**1 120**	**1 307**	**1 172**	**1 507**	**1 544**	**1 494**	**1 474**	**1 197**	**1 010**	**1 100**	**965**	**1 160**	**1 210**	**1 380**	**1 641**
Northern Hungary	290	435	485	450	527	509	510	560	800	750	590	625	670	590	610	610
Northern Great Plain	328	374	302	362	302	494	568	588	170	50	110	130	130	100	150	100
Southern Great Plain	356	386	524	583	667	687	765	632	380	380	490	530	400	470	1 270	845
Great Plain and North	**974**	**1 195**	**1 311**	**1 395**	**1 496**	**1 690**	**1 843**	**1 780**	**1 350**	**1 180**	**1 190**	**1 285**	**1 200**	**1 160**	**2 030**	**1 555**
Country total	**3 404**	**4 770**	**5 788**	**5 635**	**7 508**	**7 185**	**7 521**	**8 208**	**4 737**	**4 036**	**4 320**	**4 180**	**4 390**	**4 400**	**6 783**	**7 701**

Number of persons receiving day care, by service type and territorial unit

Territorial unit	day care for elderly people	day care for persons with disabilities	day care for psychiatric patients	day care for addicts	day care for mentally disabled persons	total
Central Hungary	**7 444**	**1 418**	**581**	**423**	**39**	**9 905**
Central Transdanubia	2 452	604	126	91	29	3 302
Western Transdanubia	2 830	435	282	65	45	3 657
Southern Transdanubia	3 767	669	61	176	656	5 329
Transdanubia	**9 049**	**1 708**	**469**	**332**	**730**	**12 288**
Northern Hungary	5 284	649	112	172	28	6 245
Northern Great Plain	8 122	1 752	800	1 034	332	12 040
Southern Great Plain	7 167	1 275	674	511	312	9 939
Great Plain and North	**20 573**	**3 676**	**1 586**	**1 717**	**672**	**28 224**
Country total	**37 066**	**6 802**	**2 636**	**2 472**	**1 441**	**50 417**

Number of persons receiving other basic social services, by territorial unit, 2011

Territorial unit	Home help service relying on the warning system	Community care for psychiatric patients	Community care for addicts	Support services
Budapest	1 650	1 108	1 292	1 004
Pest	1 907	193	254	1 131
Central Hungary	**3 557**	**1 301**	**1 546**	**2 135**
Fejér	757	155	100	667
Komárom-Esztergom	470	95	41	498
Veszprém	761	115	342	656
Central Transdanubia	**1 988**	**365**	**483**	**1 821**
Győr-Moson-Sopron	1 406	190	–	457
Vas	458	172	109	305
Zala	1 427	222	218	616
Western Transdanubia	**3 291**	**584**	**327**	**1 378**
Baranya	2 136	271	123	599
Somogy	1 458	173	58	327
Tolna	1 058	166	147	480
Southern Transdanubia	**4 652**	**610**	**328**	**1 406**
Transdanubia	**9 931**	**1 559**	**1 138**	**4 605**
Borsod-Abaúj-Zemplén	2 110	54	329	1 454
Heves	670	95	95	653
Nógrád	895	97	108	132
Northern Hungary	**3 675**	**246**	**532**	**2 239**
Hajdú-Bihar	1 316	554	629	2 191
Jász-Nagykun-Szolnok	855	150	122	931
Szabolcs-Szatmár-Bereg	2 718	406	537	2 532
Northern Great Plain	**4 889**	**1 110**	**1 288**	**5 654**
Bács-Kiskun	1 365	317	247	537
Békés	1 535	345	501	1 315
Csongrád	551	314	–	427
Southern Great Plain	**3 451**	**976**	**748**	**2 279**
Great Plain and North	**12 015**	**2 332**	**2 568**	**10 172**
Country total	**25 503**	**5 192**	**5 252**	**16 912**

Number of places in long-term residential social institutions, by type of institution and territorial unit, 2011

Territorial unit	Elderly	Psychiatric patients	Persons with disabilities	Addicts	Homeless	Total
	homes					
Budapest	7 774	1 326	2 345	136	197	11 778
Pest	5 090	879	2 086	256	–	8 311
Central Hungary	**12 864**	**2 205**	**4 431**	**392**	**197**	**20 089**
Fejér	1 708	321	699	35	–	2 763
Komárom-Esztergom	1 476	272	467	–	40	2 255
Veszprém	1 744	262	454	42	21	2 523
Central Transdanubia	**4 928**	**855**	**1 620**	**77**	**61**	**7 541**
Győr-Moson-Sopron	2 062	490	295	–	90	2 937
Vas	1 068	257	392	65	26	1 808
Zala	1 562	280	406	52	–	2 300
Western Transdanubia	**4 692**	**1 027**	**1 093**	**117**	**116**	**7 045**
Baranya	2 598	262	792	174	50	3 876
Somogy	1 975	280	512	282	20	3 069
Tolna	1 301	140	565	165	15	2 186
Southern Transdanubia	**5 874**	**682**	**1 869**	**621**	**85**	**9 131**
Transdanubia	**15 494**	**2 564**	**4 582**	**815**	**262**	**23 717**
Borsod-Abaúj-Zemplén	3 424	810	957	211	88	5 490
Heves	1 586	285	578	65	26	2 540
Nógrád	913	339	541	50	–	1 843
Northern Hungary	**5 923**	**1 434**	**2 076**	**326**	**114**	**9 873**
Hajdú-Bihar	2 440	665	970	99	–	4 174
Jász-Nagykun-Szolnok	2 445	303	735	91	–	3 574
Szabolcs-Szatmár-Bereg	3 510	467	1 279	102	50	5 408
Northern Great Plain	**8 395**	**1 435**	**2 984**	**292**	**50**	**13 156**
Bács-Kiskun	2 824	335	1 032	148	49	4 388
Békés	3 443	475	783	144	12	4 857
Csongrád	2 399	432	722	10	–	3 563
Southern Great Plain	**8 666**	**1 242**	**2 537**	**302**	**61**	**12 808**
Great Plain and North	**22 984**	**4 111**	**7 597**	**920**	**225**	**35 837**
Country total	**51 342**	**8 880**	**16 610**	**2 127**	**684**	**79 643**

4) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested information on whether certain social services are provided free; and how the price of services not provided free are calculated.***

Services for which no usage fee can be charged are listed in Paragraph (1) of Article 115/A. of the Social Act.

"Article 115/A. (The following) Shall be provided free of charge:
a) village and homestead caretaker service,
b)709 catering at the soup kitchen,
c) family assistance service,
d) community care,
e) street social work,
f) day care for homeless people,
g) care provided at night-time shelter."

For services not provided free of charge, a usage fee is payable, which depends on the expenses of the service provider related to the provision of the services, and the amount of state support provided for operating the service. The institution specifies its own costs of the service per capita on the basis of its expenses i.e. the amount that covers provision for one person receiving care, on the basis of which the usage fee is determined. This amount is reduced by the amount of state support per capita provided for performing the service. The amount thus calculated is the institutional usage fee.

This can be the maximum amount of the so-called personal usage fee to be paid by the person receiving care or by his or her relative determined by law in certain cases, but at the same time, in accordance with the law, limitations related to the income of the person receiving care are placed on determining the usage fee. The definition of income is precisely determined by Article 4 of the Social Act i.e. which revenues shall be taken into account when calculating the usage fee. A significant difference in cases of long-term residential institutions is that not only the monthly regular income of the person receiving care is taken into account when determining the usage fee, but also their real estate property and any significant financial assets.

In accordance with Article 117 of the Social Act:

"117 (2) The income proportion related to the person applying for provision shall be established when determining the personal usage fee to be paid for institutional care in case of long-term residential institutional care.
The income proportion cannot exceed the following percentage of the monthly income of the person receiving care:
a) 50% in case of placement in a residential home for rehabilitation,
b) 80% in case of other institutions providing long-term placement
not covered by point a).
(3) The amount of personal usage fee is the same as the institutional usage fee in case of long-term residential institutional care, provided that the income proportion reaches or exceeds the amount of the institutional usage fee.
(4) If the income proportion does not reach the amount of the institutional usage fee in case of long-term residential institutional care, and the person receiving care has significant financial assets, then the amount of the personal usage fee is the same as the institutional

usage fee, except that the difference between the income proportion and institutional usage fee shall be paid from the significant financial assets.
(5) If the income proportion does not reach the amount of the institutional usage fee in case of long-term residential institutional care, and the person receiving care does not have significant financial assets – with the exception of rehabilitation institutions and residential homes for rehabilitation – then the amount of the personal usage fee is the sum of the income proportion and one ninety-sixth part of the significant real estate property, but at a maximum of the same amount as the institutional usage fee.
(6) For the purposes of this Article, significant financial assets shall mean that part of a payment account with a positive balance, an asset under a deposit or savings account contract, and cash at the disposal of the person receiving care, which exceeds the annual amount of the institutional usage fee at the time of placement of the entitled person, or the review of the usage fee.
(7) For the purposes of this Article, significant real estate property means that part of the total value of the real estate property which exceeds forty times the minimum amount of the old-age pension in effect at any given time. The real estate owned by the person receiving care or applying for care at the time of the application or review, and the usable property rights on the real estate belonging to the person, as well as the real estate transferred free of charge to the person within 18 months prior to the review, provided that the total sale value does not exceed forty times the minimum amount of the old-age pension in effect at any given time, shall be considered as real estate property. The ownership rate shall be taken into consideration in case of undivided common property."

The Act protects the person receiving care through several measures, so that his or her income and property shall not be excessively reduced due to the usage fee that has to be paid for institutional care. Accordingly, the specified income proportion sets an upper limit to the administration fee that has to be paid for certain services. For instance, the monthly personal usage fee to be paid for social catering cannot exceed 30% of the monthly income of the person receiving care [Point a) of Paragraph (3) of Article 116 of the Social Act].

The amount of the usage fee to be paid by relatives capable of providing maintenance is also protected by the Act, because a relative can be obliged to pay only if *"the per capita income in the family exceeds two-and-a-half times the amount of the minimum old-age pension in effect at any given time while fulfilling the obligation of maintenance."* [Point c) of Paragraph (2) of Article 114 of the Social Act]

If the person required to pay the personal usage fee challenges its amount, he or she can appeal to the maintainer – in case of state maintainers – or to the court – in case of church and non-governmental maintainers. This is an important guarantee, so that the rules on the usage fee shall be complied with and consistently enforced. Access to provision is also supported by the rule which enables the maintainer of the institution to reduce or remit the personal usage fee, if the income situation of the person receiving care justifies it.

The important, relevant parts of the Social Act:

"Article 114 (1) Unless this Act stipulates otherwise, a usage fee shall be paid for provisions offering personal assistance.
(2) As specified in this Act, the following persons are obliged to pay a usage fee:
a) the entitled person receiving care,
b) the legal representative with parental custody rights,
c) the spouse, partner, immediate relative, adopted child, adoptive parent of the entitled person, in whose family the monthly income per capita exceeds two-and-a-half times the

amount of the minimum old-age pension in effect at any given time while fulfilling the obligation of maintenance,
d) the person who has contractually agreed to provide maintenance for the entitled person,
e) the person obliged to provide maintenance for the entitled person by the court [the persons under points c)-e) are hereafter referred to collectively as: person obliged and able to provide maintenance] [the persons under points a)–e) are hereafter referred to collectively as: obliged person].
(3) Free care is provided by the maintainer for the person receiving care who
a) does not have any income,
b)
and in case of residential care, does not have property for mortgage purposes within the meaning of Paragraph (2) of Article 119.
Article 115(1) the usage fee for social provisions belonging to personal assistance (hereafter: institutional usage fee) is the self-funded cost of the services and the normative state contribution, and in cases of support services and home help services relying on the warning system, the difference between the self-funded costs of the services and the support from the state budget, as specified in separate legislation.
Even in case of integrated institutions, the institutional usage fee shall be determined for each service by dividing the common cost items in proportion to the direct costs of each service.
In case of high-quality residential care, the institutional usage fee shall be calculated using the actual normative state contribution of the previous year.
(2) The amount of the usage fee to be paid by the obliged person (hereafter: personal usage fee) shall be determined by the head of the institution as a particular amount; prior to receiving care, the person applying for care shall be informed in writing on this amount.
The local government maintaining the institution can determine the personal usage fee in its decision.
The amount of the personal usage fee cannot exceed the amount of the institutional usage fee.
If calculating the institutional usage fee does not result in a positive number, then the amount of the personal usage fee is zero.
(3) The amount of the personal usage fee — in case of an institution of the local government — shall be reduced or remitted as laid out in the regulation of the maintainer, provided that the income and property situation of the obliged person justifies it.
(4) If the person receiving care, his or her legal representative or the person paying the usage fee challenges the amount of the fee or requests that it be reduced or remitted, then he or she can appeal to the maintainer within eight days of receiving notification, as per Paragraph (2).
The state maintainer determines the usage fee in its decision.
(5) If the person receiving care, his or her legal representative or the person paying the usage fee challenges the amount determined by a church or a non-governmental maintainer, then he can apply for the court to determine the usage fee.
The previously determined usage fee shall be paid until the final ruling of the court.
(6) The amount of the personal usage fee can be reviewed and modified twice a year, irrespective of the date of its determination, except when the income of the person receiving care
a) has been reduced to such an extent that he or she cannot satisfy his or her obligation to pay the usage fee defined by law;
b) has increased by more than 25% of the minimum old-age pension in effect at any given time.
(7) The maintainer shall decide on the payment date of the new personal usage fee determined during the review, with the proviso that the obliged person cannot be obliged to pay the new usage fee for the time period before the review.

(8) During the review of the personal usage fee, the regulations under Paragraph (4) shall apply as appropriate.
(9) The self-funded costs of the service shall be determined based on the data from the previous year, until 1 April of the year in question.
The self-funded costs of the service can be corrected once during the year, if it is justified by the processes in the current period.
If the service was not in operation in the previous year, then the planned costs for the year in question shall be considered as the basis for calculating the self-funded costs.
(10) The institutional usage fee can be determined by the maintainer at a lower level than the usage fee calculated on the basis of Paragraph (1) and documented as defined in separate legislation.
Article 116 (1) When determining the personal usage fee of the basic social services, the following shall be taken into consideration:
a) the regular monthly income of the person receiving the service,
b)
c) in case of a minor receiving the service, the regular monthly income per capita in the family.
(2) In case of services as per Paragraph (1) of Article 59/A,
the amount of the usage fee can be determined freely by the maintainer for a person who is not socially deprived.
(3) The personal usage fee – with the exception of the case provided for in Paragraph (2) – cannot exceed
a) 30% (in case of catering);
b) 25% (in case of home help services);
c) 30% (in case of home help services combined with catering and support services);
d) 20% (in case of support services provided to a minor);
e) 2% (in case of home help services relying on the warning system)
of the income specified in Paragraph (1).”

The Act provides for persons receiving care who do not have any income, for whom spending money at an amount of 20% of the minimum of old-age pension – or 30% if the property is encumbered by the usage fee – shall be provided in case of residential institutions, with the exception of temporary accommodation for homeless people and night-time shelter. In accordance with the Social Act:

"Article 117/A (1) In residential institutions – with the exception of temporary accommodation for homeless people and night-time shelter – spending money shall be provided for persons receiving care who are over 16 and do not have any income, for the purpose of satisfying their personal needs.
A person receiving care on behalf of whom the person obliged and able to provide maintenance pays the usage fee, as well as a person whose usage fee was determined on the encumbrance of his or her property, shall also be provided with spending money.
If spending money is established for a person receiving care who has property, then the amount of spending money shall be decided according to the rules on the usage fee.
The monthly amount of the spending money cannot be less than 20% of the amount of the minimum old-age pension – or 30% if the property is encumbered by the usage fee – in effect on 1st January of the year in question.
An income which is lower than this amount shall be made up to at least the amount of spending money.

(2) The usage fee to be paid by the person receiving care in a residential institution shall be determined so that the person keeps at least the amount of spending money specified in Paragraph (1).
(3) The basic medicines required for improving or maintaining the health condition of the person receiving care shall be provided free of charge by the residential institution, as specified in separate legislation.
In addition to this, the costs of individual needs for medicines are paid by the person receiving care, as specified in separate legislation."

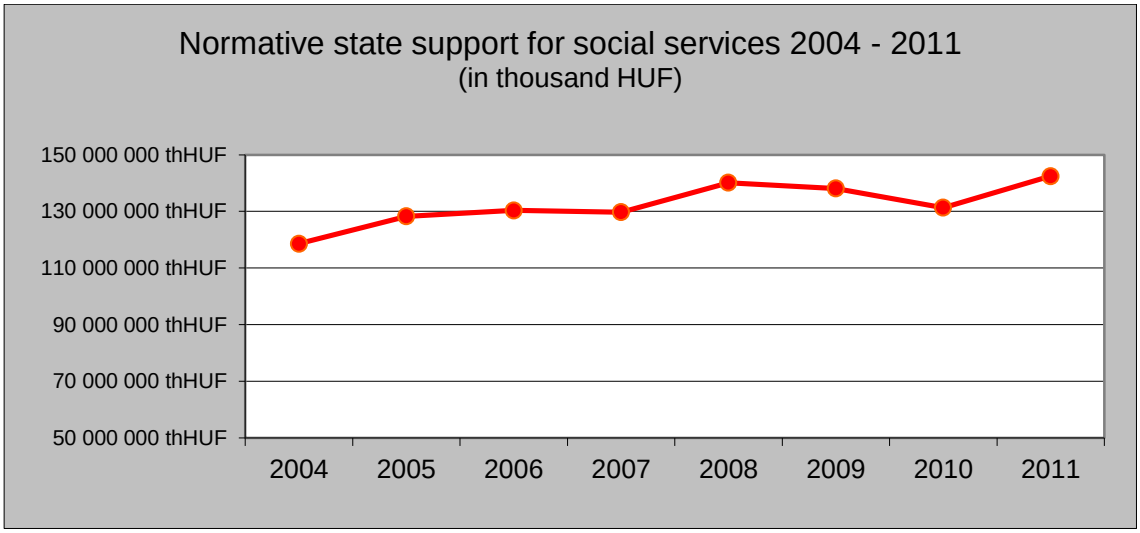
- ***The ECSR requested information on the total expenditure on social services***

The resources are shown in the following table:

	2008. év	2009. év	2010. év	2011. év
	(HUF, thousands)			
Social and child protection basic services	**43 304 359,4**	**43 160 974,8**	**42 508 282,2**	**39 081 698,8**
Family assistance and child welfare services	7 319 400,0	7 373 011,4	7 146 557,9	7 157 686,9
Child welfare centre	104 900,0	97 890,3	98 671,8	100 071,4
Social catering	8 445 843,5	8 692 754,2	7 639 495,1	7 826 443,7
Home help service	7 537 074,0	7 515 917,7	9 412 882,4	12 821 648,1
Home help service relying on the warning system	932 632,1	692 039,6	1 042 944,0	pályázat
Village and homestead caretaker service	2 184 869,7	2 520 903,1	2 520 265,0	2 566 867,8
Support service	4 282 610,0	3 897 383,0	3 848 960,0	pályázat
Community care	1 912 335,0	1 721 250,0	2 165 040,0	pályázat
Street social work	438 333,3	473 006,8	467 627,6	pályázat
Daytime institutional care for elderly people	5 495 372,5	4 899 020,6	2 914 479,2	2 808 801,6
Daytime institutional care for psychiatric patients and addicts	2 397 903,4	2 851 766,9	3 016 830,3	3 281 358,1
Daycare for persons with physical or mental disabilities	2 242 203,0	2 418 780,6	2 225 202,7	2 518 821,2
For children with disabilities placed in daytime institutions preferential catering is free of charge	10 882,8	7 250,8	9 326,2	0,0
Specialised social and child protection service	**79 925 102,5**	**79 662 075,4**	**73 610 929,3**	**74 631 307,3**
Specialised social service	***62 400 103,4***	***62 052 604,9***	***57 701 508,3***	58 666 681,8
Daytime institutional care of persons with disabilities, psychiatric patients and addicts	21 038 600,0	20 079 667,9	18 394 684,9	18 518 771,6
Residential institutional care for mentally disabled persons	5 607 832,0	6 628 565,2	6 765 032,7	7 211 178,8
Nursing-caring home care for elderly people	24 794 005,0	24 203 160,0	22 658 556,1	22 936 966,3
High-level residential care	2 714 427,1	1 702 185,3	962 647,7	848 096,5
Services providing temporary placement Nursing-caring home care for homeless people	4 316 686,5	5 331 246,4	5 005 621,1	5 082 676,5
Temporary institutions of homeless people	3 928 552,8	4 107 780,1	3 914 965,8	4 068 992,0
Specialised child protection service	***17 434 762,1***	***17 609 470,5***	***15 909 421,0***	***15 964 625,5***
Specialised child protection service for special children	6 025 731,5	6 394 028,8	5 667 738,2	5 886 490,8
Services providing a home	8 573 383,4	8 607 794,7	7 834 286,8	7 976 303,9
After-care provision	2 835 647,2	2 607 647,0	2 407 396,0	2 101 830,8
Provision of parents placed in temporary family homes	90 237,0	0,0	0,0	0,0
Day care for children	***11 646 389,4***	***12 396 763,5***	***12 084 327,8***	***13 201 785,7***
Crèche provisions	11 262 546,6	11 785 979,0	11 018 129,1	11 679 854,7
Day care for families	239 201,8	427 776,9	846 732,1	1 245 467,4
Institutional catering free of charge	144 641,0	183 007,5	219 466,7	276 463,6
Total (without church)	**134 875 851,2**	**135 219 813,7**	**128 203 539,3**	**126 914 791,8**
IV. Supplementary support for church institutions	5 278 234,0	8 520 439,0	10 153 984,1	15 528 578,4
V. TOTAL (I+II+III+IV)	**140 154 085,2**	**143 740 252,6**	**138 357 523,4**	**142 985 056,0**

(Source: Hungarian Treasury)

The chart below illustrates the annual budgetary allocations:



(Source: Hungarian Treasury)

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

Social services

The financing system of non-governmental and non-municipal maintainers has undergone changes in the reporting period, as described in Paragraph 1. There was, however, no radical change in relation to the maintenance legal relationship, so no changes can be reported with regard to that Paragraph.

2) MEASURES TAKEN TO IMPLEMENT THE LEGISLATION

Year(s) of call	Number and name of construction	Aim/Short description	Funding announced/awarded (HUF million)
2008, 2010	TÁMOP-5.2.5. Programmes promoting social integration of children and youths "ABC"	1. Involving persons receiving care from child welfare and protection institutions in programmes that develop their personality and strengthen their school and labour market career. 2. Development of services and tools aimed at the adolescent age group. 3. Establishment of the professional and methodological background of youth policy.	6 312
2008, 2009	TÁMOP-5.5.3. Support for organisations providing services to and developing non-governmental organisations	The aim of the call for proposals is the complex institutional development, strengthening and operational stabilisation of non-governmental organisations, for the purpose of improving operational efficiency and enforcing the interests of the not-for-profit sector, thus enabling them to participate actively in national and international development programmes.	939
2009, 2010	TÁMOP-5.4.3. Development of home help services	To promote part-time employment among persons receiving a nursing fee in the field of social basic services, primarily in home help services, as well as to increase the professional quality and volume of services in order to enhance the quality of life for persons receiving home help services.	453
2009, 2010, 2011	TÁMOP-5.5.2. Spread of volunteerism	To establish volunteer points complementing the network of voluntary centres that provide direct access to persons living in smaller settlements	1 830
2010, 2011	TÁMOP-5.5.1 Support for community initiatives and programmes	To establish family community initiatives and programmes, and services supporting families - to develop services assisting the creation of a healthy balance between maternity and work.	7 148

3) KEY DATA AND STATISTICS

Data on the organisations maintaining social services (Hungarian Central Statistical Office)

Data on social catering and home help service, by maintainer, 2011

Maintainer	Home help service					Social catering	
	no. of persons receiving care	no. of persons paying usage fee	number of carers	inclu. qualified	no. of persons per carer	no. of persons receiving care	no. of persons paying usage fee
Local government	21 162	13 438	3 008	2 369	7,0	82 797	76 405
County, capital government	244	105	28	23	8,7	365	295
Association of local governments for providing services	10 844	4 526	1 432	1 105	7,6	20 363	19 626
Multipurpose micro-regional association	21 297	9 125	2656	1852	8,0	27 404	26 575
Church	26 528	3 081	3 925	2 074	6,8	19 654	19 225
Non-profit business organisation	4 171	222	426	213	9,8	1 788	1 712
Foundation	1 417	357	159	110	8,9	1 502	1 005
Public foundation	10	4	2	2	5,0	117	114
Association	1 827	451	283	210	6,5	937	664
Sole entrepreneur	270	–	34	–	7,9	–	–
Common enterprise	171	28	22	20	7,8	164	161
Total	**87 941**	**31 337**	**11 975**	**7 978**	**7,3**	**155 091**	**145 782**

Number of persons receiving other basic social services, by maintainer, 2011

Maintainer	home help relying on the warning system	community care for psychiatric patients	community care for addicts	Support service	Street social work
Local government	6 777	1 006	253	2 560	589
County, capital government	61	–	40	232	23
Association of local governments for providing services	5 741	627	339	1 352	–
Multipurpose micro-regional association	9 914	1 231	687	2 500	228
Church	1 457	419	622	2 958	3 612
Non-profit business organisation	454	695	695	821	521
Foundation	486	718	1 311	2 311	2 399
Public foundation	–	–	–	38	187
Association	576	496	1 305	4 082	6 027
Common enterprise	37	–	–	–	–
Central state budget institutions	–	–	–	58	–
Total	**25 503**	**5 192**	**5 252**	**16 912**	**13 586**

Main data on day care of homeless people

Year, maintainer	Day care centres					Soup kitchens				
	no.	capacity	total average daily traffic	no. of workers	op. costs (HUF thou)	no.	capacity	total average daily traffic	no. of workers	op. costs (HUF thou)
2001	71	3 714	4 203	197	392 080	43	5 024	4 457	91	267 832
2002	68	3 612	3 854	216	529 903	40	4 375	3 974	81	218 798
2003	71	3 814	4 335	262	668 923	42	4 702	3 957	84	239 568
2004	76	4 385	5 006	239	831 005	39	4 525	3 838	71	284 991
2005	83	4 770	5 684	249	1 095 600	38	4 036	3 643	80	346 536
2006	95	5 788	7 049	293	1 231 131	39	4 320	3 786	76	359 723
2007	92	5 635	7 543	321	1 629 988	41	4 180	3 923	77	422 305
2008	103	7 508	8 531	391	1 941 586	38	4 390	3 952	76	466 585
2009	106	7 185	9 276	442	1 971 942	39	4 400	4 313	75	541 207
2010	110	7 521	10 499	451	2 151 803	44	6 783	4 928	69	526 753
2011	113	8 208	10 982	482	2 310 157	46	7 701	5 780	77	604 100
Maintainer										
Local government	21	957	1 126	60	212 055	15	1 191	1 078	19	126 270
County, capital government	5	590	908	29	148 128	–	–	–	–	–
Association of local governments for providing services	4	85	100	7	19 624	1	25	25	1	4 635
Multipurpose micro-regional association	9	375	535	24	123 327	2	230	230	3	35 029
Church	18	1 908	2 573	129	659 550	11	1 290	1 249	20	226 849
Non-profit business organisation	5	262	328	22	82 696	1	100	100	–	5 899
Foundation	12	1 490	1 545	62	311 542	7	3 725	1 954	15	108 235
Public foundation	2	160	192	4	21 598	–	–	–	–	–
Association	36	2 371	3 660	143	727 316	9	1 140	1 144	19	97 183
Common enterprise	1	10	15	2	4 321	–	–	–	–	–

Number of places in social institutions providing day care, by type of maintainer, 2011

Maintainer	Day care for elderly people	Day care for persons with disabilities	Day care for psychiatric patients	Day care for addicts	Day care for mentally disabled persons	Total
Local government	19 828	1 735	292	136	93	22 084
County, capital government	59	167	5	22	–	253
Association of local governments for providing services	5 889	485	130	110	70	6 684
Multipurpose micro-regional association	9 676	858	148	457	72	11 211
Church	3 603	1 049	455	759	59	5 925
Non-profit business organisation	662	431	216	50	28	1 387
Foundation	439	870	816	315	25	2 465
Public foundation	88	55	–	105	–	248
Association	234	1 578	305	549	48	2 714
Common enterprise	120	20	47	–	–	187
Central state budget institutions	–	30	–	–	–	30
Total	**40 598**	**7 278**	**2 414**	**2 503**	**395**	**53 188**

Number of places of social institutions providing long-term and temporary placement, by type of institution and maintainer, 2011

Maintainer	Elderly	Psychiatric patients	Persons with disabilities	Addicts	Homeless	Total
	homes					
Long-term residential institutions						
Local government	8 741	840	986	–	116	10 683
County, capital government	12 543	6 242	10 916	1 588	32	31 321
Association of local governments for providing services	1 894	40	120	–	–	2 054
Multipurpose micro-regional association	5 901	–	241	68	55	6 265
Church	12 485	444	1 668	92	74	14 763
Non-profit business organisation	5 616	1 147	988	74	26	7 851
Foundation	415	49	294	55	216	1 029
Public foundation	3 454	118	738	226	130	4 666
Association	103	–	28	24	35	190
Common enterprise	190	–	–	–	–	190
Central state budget institutions	–	–	631	–	–	631
Total	**51 342**	**8 880**	**16 610**	**2 127**	**684**	**79 643**
Institutions providing temporary placement						
Local government	1 295	6	74	–	1 487	2 862
County, capital government	71	25	–	10	2 100	2 206
Association of local governments for providing services	137	–	20	–	100	257
Multipurpose micro-regional association	326	–	–	–	592	918
Church	382	–	54	28	1 689	2 153
Non-profit business organisation	539	64	–	8	338	949
Foundation	125	–	20	12	1 932	2 089
Public foundation	323	16	96	81	1 123	1 639
Association	–	–	10	–	236	246
Common enterprise	107	–	–	–	10	117
Central state budget institutions	**3 305**	**111**	**274**	**139**	**9 607**	**13 436**
Total						
Local government	10 036	846	1 060	–	1 603	13 545
County, capital government	12 614	6 267	10 916	1 598	2 132	33 527
Association of local governments for providing services	2 031	40	140	–	100	2 311
Multipurpose micro-regional association	6 227	–	241	68	647	7 183
Church	12 867	444	1 722	120	1 763	16 916
Non-profit business organisation	6 155	1 211	988	82	364	8 800
Foundation	540	49	314	67	2 148	3 118
Public foundation	3 777	134	834	307	1 253	6 305
Association	103	–	38	24	271	436
Common enterprise	297	–	–	–	10	307
Central state budget institutions	–	–	631	–	–	631
Total	**54 647**	**8 991**	**16 884**	**2 266**	**10 291**	**93 079**

4) ANSWERS TO THE QUESTIONS OF THE ECSR REGARDING THIS PARAGRAPH

- ***The ECSR requested information on whether the equal and efficient access to social services provided by non-governmental service providers is guaranteed.***

In the Hungarian system there is no differentiation between services according to maintainers. The same professional rules apply to both services; the amount of state contribution on a normative basis provided for the operation is the same. All maintainers have equal opportunities when submitting applications in calls for proposals for support services, community care, home help services relying on the warning system and street social work. The church and non-governmental organisations are not restricted in other ways in operating their services and receiving the related operating licences from the relevant legislation.

- ***The ECSR again requests information on the steps made towards strengthening dialogue with civil society with regard to social services.***

Dialogue with certain groups of society is of extreme importance to the government, and this attitude is evinced by Act CXXXI of 2010 on Public Participation in the Drafting of Legislation. In accordance with the general provisions of the Act: *"the opinion of people is not a hindrance but the solution itself. With the sentence quoted above, the Programme of National Cooperation embraces the idea that – in connection with the principle of open governance – it is desirable in Hungary to provide an opportunity for the widest possible range of social segments to express their opinions, comments and recommendations with regard to the drafting of legislation, in order to promote the public good, as well as to take the public interest into account to the greatest extent possible. With this in mind, it is necessary to establish rules on public participation in the drafting of legislation, to ensure a constant framework within which the particular interests of different segments of society are enforced during the drafting of legislation, thus providing the adopted legislation with greater legitimacy, and ensuring that legislation of the highest possible quality is adopted, which complies with life conditions."*

There are two types of consultation procedures: online consultation, via contact points given on the website (general consultation), and consultation by involving persons, institutions and organisations invited by the minister responsible for a given area or topic (direct consultation).

"Article 5 (1) Draft
a) laws,
b) government decrees,
c) ministerial decrees
(hereafter jointly: draft) shall be submitted for public consultation.
(2) Prior to submitting a draft for public consultation, the concept of the draft may also be submitted for public consultation subject to the competent minister's decision.
(3) Legislative drafts on
a) payment obligations,
b) state subsidies,
c) the Budget and its implementation,
d) funding received from the European Union and international sources,
e) the promulgation of international treaties, and
f) the establishment of organisations and institutions,

do not have to be submitted for public consultation.
(4) A draft or concept must not be submitted for public consultation in the event that such consultation would compromise the protection of particularly important defence, national security, financial, foreign, nature conservation, environmental, or heritage protection interests of Hungary.
(5) A legislative draft does not have to be submitted for public consultation in the event that a prevailing public interest warrants its rapid passage."

The minister responsible for drafting legislation shall create strategic partnership agreements for the purpose of even more efficient consultation. Under these partnerships, it is possible to cooperate closely with organisations that cover broad segments of society. The organisations that concluded partnership agreements have a duty to represent the opinions of organisations engaged in other topics.

"Article 13 (1) The minister responsible for drafting the legislation shall create strategic partnership agreements.
By means of such agreements, the minister responsible for drafting the legislation may establish close cooperation with organisations which are prepared to engage in mutual collaboration and which represent a wide range of social interests in drafting legislation, or which carry out scientific activities, in the particular areas of the law (hereafter: strategic partner).
(2) Strategic partnerships may be established in particular with representatives of
a) non-governmental organisations,
b) churches,
c) professional and scientific organisations,
d) national minority self-governments,
e) interest representation organisations,
f) public bodies, and
g) higher educational institutions."

In the area of social policy, consultations on specific topics are wide-reaching, and the participants may vary depending on the given topic. Our partners are churches, associations of local councils, non-governmental organisations representing particular target groups, and groupings or organisations of professionals specialising in social policy.

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

ANNEX

Key legal regulations

In effect on 31 December, 2011

1993. évi III. törvény a szociális igazgatásról és a szociális ellátásokról

A törvény hatálya

3. § (1) A törvény hatálya – a (2)–(3) bekezdésben foglalt eltérésekkel – kiterjed a Magyarországon élő

a) magyar állampolgárokra,

b) bevándoroltakra és letelepedettekre,

c) hontalanokra,

d) a magyar hatóság által menekültként elismert személyekre.

(2) A törvény hatálya a 7. § (1) bekezdésében meghatározott ellátások tekintetében az (1) bekezdésben foglaltakon túlmenően kiterjed az Európai Szociális Kartát megerősítő országoknak a Magyar Köztársaság területén jogszerűen tartózkodó állampolgáraira is.

(3) A törvény hatálya kiterjed

a) a szabad mozgás és tartózkodás jogával rendelkező személyek beutazásáról és tartózkodásáról szóló törvény (a továbbiakban: Szmtv.) szerint a szabad mozgás és tartózkodás jogával rendelkező személyre, amennyiben az ellátás igénylésének időpontjában az Szmtv.-ben meghatározottak szerint a szabad mozgás és a három hónapot meghaladó tartózkodási jogát a Magyar Köztársaság területén gyakorolja, és a polgárok személyi adatainak és lakcímének nyilvántartásáról szóló törvény szerint bejelentett lakóhellyel rendelkezik, valamint

b) a 32/B. § (1) bekezdésében meghatározott időskorúak járadéka tekintetében a szociális biztonsági rendszerek koordinálásáról és annak végrehajtásáról szóló uniós rendeletekben (a továbbiakban: uniós rendeletek) meghatározott jogosulti körbe tartozó személyre,

amennyiben az ellátás igénylésének időpontjában az Szmtv.-ben meghatározottak szerint a szabad mozgáshoz és tartózkodáshoz való jogát a Magyar Köztársaság területén gyakorolja, és a polgárok személyi adatainak és lakcímének nyilvántartásáról szóló törvény szerint bejelentett lakóhellyel rendelkezik.

(4) A 32/B. § (1) bekezdésében meghatározott időskorúak járadéka tekintetében a törvény hatálya kiterjed a magas szintű képzettséget igénylő munkavállalás és tartózkodás céljából kiállított engedéllyel (EU Kék Kártya) rendelkező harmadik országbeli állampolgárra, feltéve, hogy rendelkezik a polgárok személyi adatainak és lakcímének nyilvántartásáról szóló törvény szerint bejelentett lakóhellyel vagy tartózkodási hellyel.

(5) E törvény meghatározza a pénzbeli, a természetben nyújtott és a személyes gondoskodást nyújtó szociális ellátások egyes formáit, a jogosultság feltételeit, annak megállapítását, a szociális ellátás finanszírozásának elveit és intézményrendszerét, a szociális ellátást nyújtó szervezet és a jogosult közötti jogviszony főbb elemeit, továbbá a fenntartónak a szolgáltatóval, illetve intézménnyel kapcsolatos feladat- és jogkörét, valamint a személyes gondoskodást nyújtó szociális, gyermekjóléti, gyermekvédelmi tevékenységet végző személy adatainak működési nyilvántartására vonatkozó szabályokat.

(6) E törvény hatálya nem terjed ki a társadalombiztosítás ellátásaira és a magánnyugdíjra jogosultakról, valamint e szolgáltatások fedezetéről szóló 1997. évi LXXX. törvény (a továbbiakban: Tbj.), a társadalombiztosítási nyugellátásról szóló 1997. évi LXXXI. törvény (a továbbiakban: Tny.), a magánnyugdíjról és a magánnyugdíjpénztárakról szóló 1997. évi LXXXII. törvény (a továbbiakban: Mny.), a kötelező egészségbiztosítás ellátásairól szóló 1997. évi LXXXIII. törvény (a továbbiakban: Eb.), a családok támogatásáról szóló 1998. évi LXXXIV. törvény (a továbbiakban: Cst.), a foglalkoztatás elősegítéséről és a munkanélküliek ellátásáról szóló 1991. évi IV. törvény (a továbbiakban: Flt.), a gyermekek védelméről és a gyámügyi igazgatásról szóló 1997. évi XXXI. törvény (a továbbiakban: Gyvt.), valamint a rehabilitációs járadékról szóló 2007. évi LXXXIV. törvény hatálya alá tartozó ellátásokra.

(7) A hadigondozottaknak, a hadkötelezettség alapján katonai vagy polgári szolgálatot teljesítőknek és hozzátartozóiknak járó különleges pénzbeli ellátásokról, a nemzeti gondozásról, valamint a foglalkozási rehabilitáció keretében nyújtott ellátásokról külön törvény rendelkezik.

Nem terjed ki a törvény hatálya a külön jogszabály alapján az egészségkárosodottak részére megállapítható pénzbeli ellátásokra.

(8) E törvény hatálya nem terjed ki azokra a lakhatást biztosító szolgáltatásokra, amelyek esetében

a) a szolgáltatást igénybe vevőnek,

b) hozzátartozójának [a Polgári Törvénykönyvről szóló 1959. évi IV. törvény (a továbbiakban: Ptk.) 685. § *b)* pontja],

c) a szolgáltatást igénybe vevő tartására jogszabály, szerződés vagy bírósági határozat alapján köteles személynek, vagy

d) a térítési díjat vagy az egyszeri hozzájárulást megfizető személynek

a szolgáltatás nyújtására szolgáló ingatlanon tulajdonjoga, haszonélvezeti joga, lakáshasználati joga vagy bérleti joga áll fenn (nyugdíjasház).

4. § (1) E törvény alkalmazásában

a) jövedelem: – az (1a) bekezdésben foglalt kivétellel, valamint figyelemmel az (1b)–(1c) bekezdésekben foglaltakra – az elismert költségekkel és a befizetési kötelezettséggel csökkentett

aa) a személyi jövedelemadóról szóló törvény szerint meghatározott, belföldről vagy külföldről származó – megszerzett – vagyoni érték (bevétel), ideértve a jövedelemként figyelembe nem vett bevételt és az adómentes jövedelmet is, és

ab) azon bevétel, amely után az egyszerűsített vállalkozói adóról, illetve az egyszerűsített közteherviselési hozzájárulásról szóló törvény szerint adót, illetve hozzájárulást kell fizetni;

b) vagyon: ha e törvény másként nem rendelkezik, az a hasznosítható ingatlan, jármű, továbbá vagyoni értékű jog, amelynek

ba) külön-külön számított forgalmi értéke, illetőleg összege az öregségi nyugdíj mindenkori legkisebb összegének a harmincszorosát, vagy

bb) együttes forgalmi értéke az öregségi nyugdíj mindenkori legkisebb összegének a nyolcvanszorosát

meghaladja, azzal, hogy a szociális rászorultságtól függő pénzbeli és természetbeni ellátások jogosultsági feltételeinek vizsgálatánál nem minősül vagyonnak az az ingatlan, amelyben az érintett személy életvitelszerűen lakik, az a vagyoni értékű jog, amely az általa lakott ingatlanon áll fenn, továbbá a mozgáskorlátozottságra tekintettel fenntartott gépjármű;

c) család: egy lakásban, vagy személyes gondoskodást nyújtó bentlakásos szociális, gyermekvédelmi intézményben együtt lakó, ott bejelentett lakóhellyel vagy tartózkodási hellyel rendelkező közeli hozzátartozók közössége;

d) közeli hozzátartozó:

da) a házastárs, az élettárs,

db) a húszévesnél fiatalabb, önálló keresettel nem rendelkező; a huszonhárom évesnél fiatalabb, önálló keresettel nem rendelkező, nappali oktatás munkarendje szerint tanulmányokat folytató; a huszonöt évesnél fiatalabb, önálló keresettel nem rendelkező, felsőoktatási intézmény nappali tagozatán tanulmányokat folytató vér szerinti, örökbe fogadott, illetve nevelt gyermek,

dc) korhatárra való tekintet nélkül a tartósan beteg, az autista, illetve a testi, érzékszervi, értelmi vagy beszédfogyatékos vér szerinti, örökbe fogadott, illetve nevelt gyermek, amennyiben ez az állapot a gyermek 25. életévének betöltését megelőzően is fennállt (a továbbiakban: fogyatékos gyermek),

dd) a 18. életévét be nem töltött gyermek vonatkozásában a vér szerinti és az örökbe fogadó szülő, illetve a szülő házastársa vagy élettársa;

e) egyedülélő: az a személy, aki egyszemélyes háztartásban lakik;

f) háztartás: az egy lakásban együtt lakó, ott bejelentett lakóhellyel vagy tartózkodási hellyel rendelkező személyek közössége;

g) szociális szolgáltató: az a személy vagy szervezet, amely kizárólag a 60–65/E. §-ban meghatározott szociális alapszolgáltatásokat nyújtja. Ha jogszabály másként nem rendelkezik, a szociális szolgáltatókra a szociális intézményekre vonatkozó szabályokat kell megfelelően alkalmazni;

h) szociális intézmény: az e törvényben meghatározott nappali, illetve bentlakásos ellátást nyújtó szervezet;

i) rendszeres pénzellátás: a táppénz, a terhességi-gyermekágyi segély, a gyermekgondozási díj, az öregségi nyugdíj, a rokkantsági nyugdíj, a rehabilitációs járadék, az öregségi járadék, a munkaképtelenségi járadék, az özvegyi járadék, a növelt összegű öregségi, munkaképtelenségi és özvegyi járadék, az özvegyi nyugdíj – kivéve az ideiglenes özvegyi nyugdíjat, továbbá a házastársa jogán árvaellátásra jogosult fogyatékkal élő, illetve tartósan beteg vagy legalább két árvaellátásra jogosult gyermek eltartásáról gondoskodó személy özvegyi nyugdíját –, a baleseti táppénz, a baleseti rokkantsági nyugdíj, a hozzátartozói baleseti nyugellátás, az Flt. alapján folyósított pénzbeli ellátás, az átmeneti járadék, a rendszeres szociális járadék, a bányászok egészségkárosodási járadéka, a rokkantsági járadék, a hadigondozottak és nemzeti gondozottak pénzbeli ellátásai, a gyermekgondozási segély, a gyermeknevelési támogatás, az időskorúak járadéka, a rendelkezésre állási támogatás, a bérpótló juttatás, foglalkoztatást helyettesítő támogatás,, a rendszeres szociális segély, az ápolási díj, a nemzeti helytállásért elnevezésű pótlék, valamint az uniós rendeletek alapján külföldi szerv által folyósított egyéb azonos típusú ellátás;

j) keresőtevékenység, ha e törvény másként nem rendelkezik: minden olyan munkavégzéssel járó tevékenység, amelyért ellenérték jár, kivéve a tiszteletdíj alapján végzett tevékenységet, ha a havi tiszteletdíj mértéke a kötelező legkisebb munkabér 30 százalékát nem haladja meg, valamint mezőgazdasági őstermelői igazolvánnyal folytatott tevékenységet, ha az abból származó bevételt a személyi jövedelemadóról szóló szabályok szerint a jövedelem kiszámításánál nem kell figyelembe venni; nem minősül ellenértéknek a fogadó szervezet által az önkéntesnek külön törvény alapján biztosított juttatás;

k) aktív korú: a 18. életévet betöltött, de a reá irányadó nyugdíjkorhatárt, illetőleg a 62. életévet be nem töltött személy ;

l) egyedülálló: az a személy, aki hajadon, nőtlen, özvegy, elvált vagy házastársától külön él, kivéve, ha élettársa van;

[…]

(1a) Az (1) bekezdés *a)* pontjában foglaltaktól eltérően e törvény alkalmazásában nem minősül jövedelemnek

1. a temetési segély, az alkalmanként adott átmeneti segély, a lakásfenntartási támogatás, az adósságcsökkentési támogatás,

2. a rendkívüli gyermekvédelmi támogatás, a Gyvt. 20/A. §-a szerinti pénzbeli támogatás, a Gyvt. 20/B. §-ának (4)–(5) bekezdése szerinti pótlék, a nevelőszülők számára fizetett nevelési díj és külön ellátmány,

3. az anyasági támogatás,

4. a tizenharmadik havi nyugdíj és a szépkorúak jubileumi juttatása,

5. a személyes gondoskodásért fizetendő személyi térítési díj megállapítása kivételével a súlyos mozgáskorlátozott személyek pénzbeli közlekedési kedvezményei, a vakok személyi járadéka és a fogyatékossági támogatás,

6. a fogadó szervezet által az önkéntesnek külön törvény alapján biztosított juttatás,

7. az alkalmi munkavállalói könyvvel történő munkavégzésnek, az egyszerűsített foglalkoztatásról szóló törvény alapján történő munkavégzésnek, valamint a természetes személyek között az adórendszeren kívüli keresettel járó foglalkoztatásra vonatkozó rendelkezések alapján háztartási munkára létesített munkavégzésre irányuló jogviszony keretében történő munkavégzésnek (a továbbiakban: háztartási munka) a havi ellenértéke,

8. a házi segítségnyújtás keretében társadalmi gondozásért kapott tiszteletdíj,

9. az energiafelhasználáshoz nyújtott támogatás.

(1b) Az (1) bekezdés *a)* pontjának alkalmazásában elismert költségnek minősül a személyi jövedelemadóról szóló törvényben elismert költség, valamint a fizetett tartásdíj. Ha a magánszemély az egyszerűsített vállalkozói adó vagy egyszerűsített közteherviselési hozzájárulás alapjául szolgáló bevételt szerez, a bevétel csökkenthető a személyi jövedelemadóról szóló törvény szerint elismert költségnek minősülő igazolt kiadásokkal, ennek hiányában a bevétel 40%-ával. Ha a mezőgazdasági őstermelő adóévi őstermelésből származó bevétele nem több a kistermelés értékhatáránál (illetve ha részére támogatást folyósítottak, annak a folyósított támogatással növelt összegénél), akkor a bevétel csökkenthető az igazolt költségekkel, továbbá a bevétel 40%-ának megfelelő összeggel, vagy a bevétel 85%-ának, illetőleg állattenyésztés esetén 94%-ának megfelelő összeggel.

(1c) Az (1) bekezdés *a)* pontjának alkalmazásában befizetési kötelezettségnek minősül a személyi jövedelemadó, az egyszerűsített vállalkozási adó, a magánszemélyt terhelő egyszerűsített közteherviselési hozzájárulás, egészségbiztosítási hozzájárulás és járulék, egészségügyi szolgáltatási járulék, nyugdíjjárulék, nyugdíjbiztosítási járulék, magán-nyugdíjpénztári tagdíj és munkavállalói járulék.

(2) E törvény 6. §-a és a II - III. Fejezet alkalmazásában hajléktalan a bejelentett lakóhellyel nem rendelkező személy, kivéve azt, akinek bejelentett lakóhelye a hajléktalan szállás.

(3) E törvény 7., 78., 84. és 89. §-ainak alkalmazásában hajléktalan az, aki éjszakáit közterületen vagy nem lakás céljára szolgáló helyiségben tölti.

(4) Ahol e törvény önkormányzati társulást említ, ott – eltérő rendelkezés hiányában – többcélú kistérségi társulást is kell érteni.

(5) Ahol e törvény jövedelmet említ, a családi pótlékot, az árvaellátást és a tartásdíj címén kapott összeget annak a személynek a jövedelmeként kell figyelembe venni, akire tekintettel azt folyósítják.

(6) A súlyos mozgáskorlátozott személyek közlekedési kedvezményeivel kapcsolatos közigazgatási hatósági eljárásokban a szociális hatóság által hozott elsőfokú döntés ellen nincs helye fellebbezésnek.

(7) A krízishelyzetbe került személyek egyszeri támogatásával kapcsolatos eljárásban hozott döntéssel szembeni jogorvoslatra a társadalombiztosítási nyugdíjrendszer keretében adható egyszeri segélyre vonatkozó rendelkezéseket kell alkalmazni.

Időskorúak járadéka

32/B. § (1) Az időskorúak járadéka a megélhetést biztosító jövedelemmel nem rendelkező időskorú személyek részére nyújtott támogatás. A települési önkormányzat, 2007. január 1-jétől a jegyző időskorúak járadékában részesíti azt

a) a reá irányadó nyugdíjkorhatárt betöltött személyt, akinek saját és vele együtt lakó házastársa, élettársa jövedelme alapján számított egy főre jutó havi jövedelme nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 80%-át,

b) az egyedülálló, a reá irányadó nyugdíjkorhatárt betöltött, de 75 évesnél fiatalabb személyt, akinek havi jövedelme nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 95%-át,

c) az egyedülálló, 75. életévét betöltött személyt, akinek havi jövedelme nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 130%-át.

(2) Az (1) bekezdésben megjelölt reá irányadó nyugdíjkorhatár alatt a Tny.-ben szabályozott nyugdíjkorhatárt kell érteni.

(3) A jegyző időskorúak járadékában részesíti a 3. § (3) bekezdés *b)* pontjában, valamint (4) bekezdésében meghatározott személyt, amennyiben az e törvényben foglalt feltételeknek megfelel.

(4) Nem állapítható meg az időskorúak járadéka, illetve a folyósítást meg kell szüntetni, ha a személy

a) előzetes letartóztatásban van, elzárás, illetőleg szabadságvesztés büntetését tölti;

b) 3 hónapot meghaladó időtartamban külföldön tartózkodik.

c) a 3. § (3) vagy (4) bekezdése alá tartozik, és – a határ menti ingázó munkavállalókat kivéve – tartózkodási joga megszűnt vagy tartózkodási jogának gyakorlásával felhagyott.

32/C. § (1) Az időskorúak járadékának havi összege

a) jövedelemmel nem rendelkező

aa) 32/B. § (1) bekezdésének *a)* pontja szerinti jogosult esetén az öregségi nyugdíj mindenkori legkisebb összegének 80%-a,

ab) 32/B. § (1) bekezdésének *b)* pontja szerinti jogosult esetén az öregségi nyugdíj mindenkori legkisebb összegének 95%-a,

ac) 32/B. § (1) bekezdésének *c)* pontja szerinti jogosult esetén az öregségi nyugdíj mindenkori legkisebb összegének 130%-a;

b) jövedelemmel rendelkező jogosult esetén az *a)* pont szerinti összegnek és a jogosult havi jövedelmének a különbözete.

(2) Ha az (1) bekezdés *b)* pontja szerinti támogatás összege az ezer forintot nem éri el, a jogosult részére akkor is legalább ezer forint összegű járadékot kell megállapítani.

(3)

(4)

32/D. § (1) A hajléktalan személy megállapított időskorúak járadéka esetén az erről rendelkező határozatot közölni kell a fővárosi főjegyzővel (a továbbiakban: főjegyző) részére.

(2) A főjegyző az időskorúak járadékában részesülő hajléktalanról a 18. §-ban szabályozott nyilvántartást vezeti, és gondoskodik az időskorúak járadékának a hajléktalan személy által meghatározott, határozatban foglalt címre történő folyósításáról.

(3) Ha a hajléktalan személy a (2) bekezdés szerint folyósított időskorúak járadékát három hónap időtartamon keresztül nem veszi át, a támogatás folyósítását a főjegyző szünetelteti, és erről szóló végzését a járadékot megállapító jegyzővel közli, amely dönt az ellátás fenntartásáról, illetve megszüntetéséről.

(4) Ha ugyanazon hajléktalan személy részére két vagy több önkormányzat jegyzőinek döntése szerint egyidejűleg kellene járadékot folyósítani, csak az utóbb megállapított járadék

folyósítható. Ilyen esetben a főjegyző közli a járadékot korábban megállapító jegyzővel az általa megállapított ellátás folyósításának megszüntetéséről.

(5) A főjegyző által az (1)–(4) bekezdés szerint folyósított időskorúak járadékának összegét a helyi önkormányzatokért felelős miniszter megtéríti a fővárosi önkormányzat részére.

32/E. § A fővárosban – ha a főjegyző és a kerületi önkormányzat jegyzője másként nem állapodik meg – a hajléktalanok számára nyújtott időskorúak járadékának megállapítása a főjegyző feladata.

Aktív korúak ellátása

33. § (1) Az aktív korúak ellátása a hátrányos munkaerő-piaci helyzetű aktív korú személyek és családjuk részére nyújtott ellátás. A jegyző aktív korúak ellátására való jogosultságot állapít meg annak az aktív korú személynek,

a) aki munkaképességét legalább 67%-ban elvesztette, illetve legalább 50%-os mértékű egészségkárosodást szenvedett, vagy

b) aki vakok személyi járadékában részesül, vagy

c) aki fogyatékossági támogatásban részesül [az *a)–c)* pont szerinti személy a továbbiakban együtt: egészségkárosodott személy], vagy

d) akinek esetében a munkanélküli-járadék, álláskeresési járadék, álláskeresési segély, vállalkozói járadék (a továbbiakban együtt: álláskeresési támogatás) folyósítási időtartama lejárt, vagy

e) akinek esetében az álláskeresési támogatás folyósítását keresőtevékenység folytatása miatt a folyósítási idő lejártát megelőzően szüntették meg, és a keresőtevékenységet követően az Flt. alapján álláskeresési támogatásra nem szerez jogosultságot, vagy

f) aki az aktív korúak ellátása iránti kérelem benyújtását megelőző két évben az állami foglalkoztatási szervvel legalább egy év időtartamig együttműködött, vagy

g) akinek esetében az ápolási díj, a gyermekgondozási segély, a gyermeknevelési támogatás, a rendszeres szociális járadék, a bányász dolgozók egészségkárosodási járadéka, az átmeneti járadék, a rehabilitációs járadék, a rokkantsági nyugdíj, a baleseti rokkantsági nyugdíj, az ideiglenes özvegyi nyugdíj folyósítása megszűnt, illetve az özvegyi nyugdíj folyósítása a Tny. 52. §-ának (3) bekezdése szerinti okból szűnt meg, és közvetlenül a kérelem benyújtását megelőzően az állami foglalkoztatási szervvel legalább három hónapig együttműködött,

feltéve, hogy saját maga és családjának megélhetése más módon nem biztosított, és keresőtevékenységet – ide nem értve a közfoglalkoztatást, az egyszerűsített foglalkoztatásról szóló törvény szerint létesített munkaviszony keretében végzett, valamint a háztartási munkát – nem folytat.

(2) Az (1) bekezdés alkalmazásában akkor nem biztosított a megélhetés, ha a családnak az egy fogyasztási egységre jutó havi jövedelme nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 90%-át és vagyona nincs. Az aktív korúak ellátása tekintetében fogyasztási egység a családtagoknak a családon belüli fogyasztási szerkezetet kifejező arányszáma, ahol

a) az első nagykorú családtag arányszáma 1,0, azzal, hogy a gyermekét egyedülállóként nevelő szülő arányszáma 0,2-vel növekszik,

b) a házas- vagy élettárs arányszáma 0,9,

c) az első és második gyermek arányszáma gyermekenként 0,8,

d) minden további gyermek arányszáma gyermekenként 0,7,

e) a fogyatékos gyermek arányszáma 1,0, azzal, hogy a fogyatékos gyermeket a *c)* és *d)* pont alkalmazásánál figyelmen kívül kell hagyni, továbbá ahol

f) az *a)* és *b)* pontok szerinti arányszám 0,2-vel növekszik, ha a személy fogyatékossági támogatásban részesül.

(3) Az (1) bekezdés *f)* és *g)* pontja szerinti előzetes együttműködés időtartamának számításánál az aktív korúak ellátásának megállapítására irányuló kérelmet benyújtó személy által ezen időtartam alatt folytatott keresőtevékenység időtartamát is figyelembe kell venni.

(4) Az aktív korúak ellátására való jogosultság

a) az (1) bekezdés *d)* pontjában foglalt esetben az Flt. alapján folyósított álláskeresési támogatás időtartamának kimerítésétől,

b) az (1) bekezdés *e)* pontjában foglalt esetben a keresőtevékenység megszűnésétől,

c) az (1) bekezdés *g)* pontja szerinti rendszeres pénzellátás folyósításának megszűnésétől

számított tizenkettő hónapon belül benyújtott kérelem alapján állapítható meg.

(5) Aktív korúak ellátására egy családban egyidejűleg – a (6) bekezdésben meghatározott kivétellel – csak egy személy jogosult.

(6) Egy családban egyidejűleg két személy abban az esetben jogosult az aktív korúak ellátására, ha az egyik személy a foglalkoztatást helyettesítő támogatás, míg a másik személy a rendszeres szociális segély feltételeinek felel meg.

34. § (1) Nem állapítható meg az aktív korúak ellátására való jogosultság annak a személynek, aki

a) előzetes letartóztatásban van, elzárás büntetését, illetve szabadságvesztés büntetését tölti,

b) a 3. § (3) bekezdése alá tartozik, és – a határ menti ingázó munkavállalókat kivéve – tartózkodási joga megszűnt vagy tartózkodási jogának gyakorlásával felhagyott,

c) gyermekgondozási segélyben, illetve gyermeknevelési támogatásban részesül,

d) gyermekgondozási segélyre jogosult, a gyermek egyéves korának betöltéséig,

e) az Flt. szerint az álláskeresési támogatás megállapításához szükséges munkaviszonnyal rendelkezik,

f) katonai szolgálatot teljesít,

g) közoktatási, illetőleg felsőoktatási intézményben nappali oktatás munkarendje szerint tanulmányokat folytat, vagy

h) az Flt. szerint képzési támogatásként keresetpótló juttatásban részesül.

(2) Meg kell szüntetni az aktív korúak ellátására való jogosultságát annak a személynek,

a) akire vonatkozóan az (1) bekezdés *a)–g)* pontja szerinti körülmények valamelyike bekövetkezett,

b) aki az aktív korúak ellátására való jogosultság feltételeinek vagy az annak keretében megállapított pénzbeli ellátás összegének felülvizsgálatára irányuló, a 25. § (4)–(6) bekezdése szerinti eljárást akadályozza,

c) aki keresőtevékenységet folytat, kivéve, ha a keresőtevékenység alapjául szolgáló jogviszonyt 90 napot meg nem haladó időtartamra létesítette, továbbá ide nem értve a közfoglalkoztatást, az egyszerűsített foglalkoztatásról szóló törvény szerint létesített munkaviszony keretében végzett, valamint a háztartási munkát,

d) akire vonatkozóan az aktív korúak ellátására való jogosultság fennállása alatt a munkaügyi hatóság a jogellenes munkavégzés tényét két éven belül ismételten jogerősen megállapította, vagy

e) akinek a 36. § (2) bekezdése alapján a foglalkoztatást helyettesítő támogatásra, vagy a 37/B. § (2) bekezdése alapján a rendszeres szociális segélyre való jogosultságát meg kell szüntetni.

(3) Az aktív korú személy részére az aktív korúak ellátására való jogosultság a megszüntetéstől számított harminchat hónapon belül – ide nem értve a (2) bekezdés *b), d)* és *e)* pontja szerinti megszüntetési eseteket – az előzetes együttműködési kötelezettség teljesítése nélkül ismételten megállapítható, amennyiben a jogosultsági feltételek egyébként fennállnak.

(4) A jegyző a jogellenesen munkát végző aktív korúak ellátására jogosult személy ellátásának folyósítását – a munkaügyi hatóságnak a jogsértés tényét első ízben megállapító jogerős és végrehajtható határozata alapján, a határozat jogerőre emelkedéséről szóló értesítés megérkezését követő hónap első napjától – egy hónap időtartamra felfüggeszti.

35. § (1) Az a személy, akinek az aktív korúak ellátására való jogosultságát megállapították – a 37. §-ban foglaltak szerinti kivétellel – foglalkoztatást helyettesítő támogatásra jogosult.

(2) A települési önkormányzat rendeletében a bérpótló juttatásra való jogosultság egyéb feltételeként előírhatja, hogy a kérelem benyújtója, illetve az ellátás jogosultja a lakókörnyezete rendezettségének biztosítására vonatkozó, a rendeletében megállapított feltételeket teljesítse. A lakókörnyezet rendezettségének biztosítása körében a kérelmező vagy jogosult által életvitelszerűen lakott lakás vagy ház és annak udvara, kertje, a kerítéssel kívül határos terület, járda tisztán tartása, az ingatlan állagának és rendeltetésszerű használhatóságának, valamint higiénikus állapotának biztosítására irányuló kötelezettség írható elő. A rendeletben megállapított feltételek teljesítésére a kérelmezőt, illetve a jogosultat megfelelő, de legalább ötnapos határidő tűzésével a jegyzőnek – az elvégzendő tevékenységek konkrét megjelölésével – fel kell szólítania.

(3) A foglalkoztatást helyettesítő támogatásra jogosult személy az állami foglalkoztatási szervnél kéri az álláskeresőként történő nyilvántartásba vételét, valamint köteles az állami foglalkoztatási szervvel együttműködni.

(4) A foglalkoztatást helyettesítő támogatás havi összege az öregségi nyugdíj mindenkori legkisebb összege.

(5) Közfoglalkoztatásban részt vevő személy esetében a foglalkoztatást helyettesítő támogatásnak a 25. § (4)–(6) bekezdése szerinti felülvizsgálatát a közfoglalkoztatás megszűnését követően kell lefolytatni.

36. § (1) Ha a jogosult

a) 90 napnál nem hosszabb időtartamra létesített jogviszony alapján keresőtevékenységet végez, a jogviszony fennállásának időtartama alatt,

b) közfoglalkoztatásban vesz részt, a közfoglalkoztatásban való részvétel időtartama alatt, vagy

c) olyan képzésben vesz részt, amelynek keretében képzési támogatásként keresetpótló juttatásban részesül, a keresetpótló juttatás folyósításának időtartama alatt

a foglalkoztatást helyettesítő támogatás folyósítása szünetel.

(2) A 34. § (2) bekezdésében foglaltakon túl meg kell szüntetni az aktív korúak ellátására való jogosultságát annak a foglalkoztatást helyettesítő támogatásra jogosult személynek

a) aki az állami foglalkoztatási szervvel való együttműködés keretében számára felajánlott, az Flt. 54. § (10a)–(10c) bekezdésében foglaltak szerinti munkalehetőséget nem fogadja el, vagy a közfoglalkoztatásra irányuló jogviszonyát jogellenesen megszünteti, továbbá, akinek a közfoglalkoztatásra irányuló jogviszonyát a munkáltató rendkívüli felmondással szüntette meg;

b) akit az állami foglalkoztatási szerv – neki felróható okból – törölt az álláskeresők nyilvántartásából;

c) aki az állami foglalkoztatási szervnél az aktív korúak ellátásának megállapításáról szóló határozatban foglalt határidőig nem kérelmezi az álláskeresőként történő nyilvántartásba vételét;

d) aki a 33. § (7) bekezdés szerinti feltételeknek – a felszólítás ellenére – nem tesz eleget; vagy

e) aki a foglalkoztatást helyettesítő támogatásra való jogosultságának a 25. § (4) bekezdés *b)* pontja szerinti éves felülvizsgálata során, a felülvizsgálat időpontját megelőző egy évben a

foglalkoztatást helyettesítő támogatásra való jogosultságának fennállása alatt legalább 30 nap időtartamban

ea) közfoglalkoztatásban nem vett részt, vagy

eb) kereső tevékenységet – ideértve az egyszerűsített foglalkoztatásról szóló törvény szerint létesített munkaviszony keretében végzett, valamint a háztartási munkát is – nem folytatott, vagy

ec) munkaerőpiaci programban nem vett részt, vagy

ed) az Flt. szerinti és legalább hat hónap időtartamra meghirdetett képzésben nem vett részt vagy ilyen képzésben való részvétele nincs folyamatban.

(3) A (2) bekezdés *e)* pontjában meghatározott 30 napos időtartam számításakor az *eb)–ed)* alpontok szerinti tevékenységeknek a felülvizsgálat időpontját megelőző évben teljesített időtartamát össze kell számítani. Amennyiben a jogosult az *e)* pont szerinti feltételt így sem tudja teljesíteni, a 30 nap számításánál a közérdekű önkéntes tevékenységének időtartamát is figyelembe kell venni.

36/A–36/D. §

37. § (1) Az az aktív korúak ellátására jogosult személy, aki az ellátásra való jogosultság kezdő napján

a) egészségkárosodott személynek minősül, vagy

b) az 55. életévét betöltötte, vagy

c) 14 éven aluli kiskorú gyermeket nevel – feltéve, hogy a családban élő gyermekek valamelyikére tekintettel más személy nem részesül a Cst. szerinti gyermekgondozási támogatásban, vagy gyermekgondozási díjban, terhességi-gyermekágyi segélyben – és a gyermek ellátását napközbeni ellátást biztosító intézményben [Gyvt. 41. § (3) bek.] nem tudják biztosítani, vagy

d) a települési önkormányzat rendeletében az aktív korúak ellátására jogosult személyek családi körülményeire, egészségi vagy mentális állapotára tekintettel meghatározott egyéb feltételeknek megfelel,

rendszeres szociális segélyre jogosult.

(2) Amennyiben az (1) bekezdés szerinti valamely feltétel az aktív korúak ellátására való jogosultság megállapítását követően következik be, a jogosult részére a rendszeres szociális segélyt a feltétel bekövetkezésének időpontját követő hónap első napjától kell megállapítani.

(3) Ha az (1) bekezdés *a), c),* illetve *d)* pontja szerinti valamely feltétel megszűnik, a feltétel megszűnését követő hónap első napjától a 35. § (1) bekezdése szerinti ellátást kell megállapítani és a 35. § (3) bekezdése szerinti, valamint – ha a települési önkormányzat erről a 35. § (2) bekezdése alapján rendelkezett – a lakókörnyezet rendezettségének biztosítására vonatkozó kötelezettséget kell előírni. A feltétel megszűnésének hónapjára – amennyiben az aktív korúak ellátására való jogosultság továbbra is fennáll – rendszeres szociális segély jár.

(4) A rendszeres szociális segély havi összege a családi jövedelemhatár összegének és a jogosult családja havi összjövedelmének különbözete, de nem haladhatja meg a teljes munkaidőben foglalkoztatott munkavállaló részére megállapított személyi alapbér mindenkori kötelező legkisebb összegének személyi jövedelemadóval, munkavállalói, egészségbiztosítási és nyugdíjjárulékkal csökkentett összegét. A családi jövedelemhatár összege megegyezik a család fogyasztási egységeihez tartozó arányszámok összegének és az öregségi nyugdíj mindenkori legkisebb összege 90%-ának szorzatával.

(5) Ha a rendszeres szociális segély összege a (4) bekezdésben foglalt számítás szerint a havi ezer forintot nem éri el, a jogosult részére ezer forint összegű ellátást kell megállapítani.

37/A. § (1) A 37. § (1) bekezdésének *b)–d)* pontja szerinti esetekben a rendszeres szociális segély akkor állapítható meg és akkor folyósítható, ha az aktív korúak ellátására jogosult személy nyilatkozatában az e § szerinti együttműködési kötelezettséget vállal a települési önkormányzat által erre kijelölt szervvel (a továbbiakban: együttműködésre kijelölt szerv). Az együttműködés keretében a jogosult

a) az együttműködésre kijelölt szervnél kérelmezi a nyilvántartásba vételét,

b) a beilleszkedését segítő programban való részvételről írásban megállapodik az együttműködésre kijelölt szervvel, és

c) teljesíti a beilleszkedését segítő programban foglaltakat.

(2) A beilleszkedést segítő program az önkormányzattal együttműködő személy szociális helyzetéhez és mentális állapotához igazodva kiterjedhet

a) az együttműködésre kijelölt szervvel való kapcsolattartásra,

b) az együttműködő személy számára előírt, az egyéni képességeket fejlesztő vagy az életmódot formáló foglalkozáson, tanácsadáson, illetőleg a munkavégzésre történő felkészülést segítő programban való részvételre,

c) a felajánlott és az iskolai végzettségének megfelelő oktatásban, képzésben történő részvételre, különösen az általános iskolai végzettség és az első szakképesítés megszerzésére.

(3) A települési önkormányzat rendeletben szabályozza az (1) és (2) bekezdés szerinti együttműködés eljárási szabályait, továbbá a beilleszkedést segítő programok típusait és az együttműködés megszegésének eseteit.

(4) Az (1) és (2) bekezdés szerinti együttműködés intézményi feltételeiről a települési önkormányzat elsősorban a családsegítő szolgálat útján gondoskodik.

37/B. § (1) Ha a jogosult

a) 90 napnál nem hosszabb időtartamra létesített jogviszony alapján keresőtevékenységet végez, a jogviszony fennállásának időtartama alatt, vagy

b) olyan képzésben vesz részt, amelynek keretében képzési támogatásként keresetpótló juttatásban részesül, a keresetpótló juttatás folyósításának időtartama alatt

a rendszeres szociális segély folyósítása szünetel.

(2) A 34. § (2) bekezdésében foglaltakon túl meg kell szüntetni az aktív korúak ellátására való jogosultságát annak a rendszeres szociális segélyre jogosult személynek, aki a rendszeres szociális segély folyósításának időtartama alatt az együttműködésre kijelölt szervvel fennálló együttműködési kötelezettségét neki felróhatóan két éven belül ismételten megszegi.

37/C. § (1) A hajléktalan személy részére megállapított aktív korúak ellátására való jogosultságról rendelkező határozatot közölni kell a főjegyzővel.

(2) A főjegyző az aktív korúak ellátására jogosult hajléktalanokról a 18. §-ban szabályozott nyilvántartást vezeti és gondoskodik a foglalkoztatást helyettesítő támogatásnak vagy a rendszeres szociális segélynek a hajléktalan személy által meghatározott, határozatban foglalt címre történő folyósításáról.

(3) Ha a hajléktalan személy a (2) bekezdés szerint folyósított ellátást három hónapos időtartamon keresztül nem veszi át, a főjegyző szünetelteti a folyósítást és az erről szóló végzését az ellátást megállapító jegyzővel közli, aki dönt az ellátás fenntartásáról, illetve megszüntetéséről.

(4) Ha ugyanazon hajléktalan személy részére két vagy több jegyző döntése szerint egyidejűleg kellene a (2) bekezdés szerinti ellátást folyósítani, csak az utóbb megállapított ellátás folyósítható. Ilyen esetben a főjegyző közli az ellátásra való jogosultságot korábban megállapító jegyzővel az általa megállapított ellátás folyósításának megszüntetéséről szóló határozatát.

(5) A fővárosban az aktív korúak ellátására való jogosultság megállapítása a hajléktalan személyek vonatkozásában a főjegyző feladata.

(6) A foglalkoztatást helyettesítő támogatásra jogosult hajléktalan személy együttműködési kötelezettsége az ellátást megállapító jegyző székhelye szerint illetékes állami foglalkoztatási szervvel áll fenn.

(7) A rendszeres szociális segélyre jogosult hajléktalan személy együttműködési kötelezettsége azzal a települési önkormányzat által együttműködésre kijelölt szervvel áll fenn, amely jegyzőjének határozata alapján a főjegyző a rendszeres szociális segélyt folyósítja.

(8) Amennyiben az aktív korúak ellátására való jogosultságot a főjegyző állapította meg, a (6)–(7) bekezdésben foglaltaktól eltérően

a) a foglalkoztatást helyettesítő támogatásra jogosult hajléktalan személy együttműködési kötelezettsége az általa megjelölt tartózkodási helye szerint illetékes állami foglalkoztatási szervvel áll fenn,

b) a rendszeres szociális segélyre jogosult hajléktalan személy együttműködési kötelezettsége a fővárosi önkormányzat által kijelölt szervvel áll fenn.

(9) A főjegyző által az (1)–(4) bekezdés szerint folyósított foglalkoztatást helyettesítő támogatás vagy rendszeres szociális segély, valamint a közfoglalkoztatás szervezéséhez a külön törvényben foglaltak szerint nyújtott támogatás összegét a helyi önkormányzatokért felelős miniszter megtéríti a fővárosi önkormányzat részére.

37/D. §

37/E. §

37/F. §

37/G. §

37/H. §

Lakásfenntartási támogatás

38. § (1) A lakásfenntartási támogatás a szociálisan rászorult személyeknek, családoknak az általuk lakott lakás vagy nem lakás céljára szolgáló helyiség fenntartásával kapcsolatos rendszeres kiadásaik viseléséhez nyújtott hozzájárulás. A települési önkormányzat lakásfenntartási támogatást nyújt

a) az e törvényben meghatározott feltételek szerinti jogosultnak (a továbbiakban: normatív lakásfenntartási támogatás),

b) az adósságkezelési szolgáltatásban részesülő személynek,

c) az önkormányzat rendeletében meghatározott feltételek szerinti jogosultnak (a továbbiakban: helyi lakásfenntartási támogatás).

(1a) A lakásfenntartási támogatást elsősorban természetbeni szociális ellátás formájában, és a lakásfenntartással összefüggő azon rendszeres kiadásokhoz kell nyújtani, amelyek megfizetésének elmaradása a kérelmező lakhatását a legnagyobb mértékben veszélyezteti.

(2) Normatív lakásfenntartási támogatásra jogosult az a személy, akinek a háztartásában az egy fogyasztási egységre jutó havi jövedelem nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 250%-át, és a háztartás tagjai egyikének sincs vagyona. Az egy fogyasztási egységre jutó havi jövedelem megegyezik a háztartás összjövedelmének és a fogyasztási egységek összegének hányadosával.

(2a) A lakásfenntartási támogatás tekintetében fogyasztási egység a háztartás tagjainak a háztartáson belüli fogyasztási szerkezetet kifejező arányszáma, ahol

a) a háztartás első nagykorú tagjának arányszáma 1,0,

b) a háztartás második nagykorú tagjának arányszáma 0,9,

c) a háztartás minden további nagykorú tagjának arányszáma 0,8,

d) a háztartás első és második kiskorú tagjának arányszáma személyenként 0,8,

e) a háztartás minden további kiskorú tagjának arányszáma tagonként 0,7.

(2b) Ha a háztartás

a) (2a) bekezdés *a)–c)* pontja szerinti tagja magasabb összegű családi pótlékban vagy fogyatékossági támogatásban részesül, vagy

b) (2a) bekezdés *d)* vagy *e)* pontja szerinti tagjára tekintettel magasabb összegű családi pótlékot folyósítanak,

a rá tekintettel figyelembe vett arányszám 0,2-del növekszik.

(2c) Ha a háztartásban gyermekét egyedülállóként nevelő szülő – ideértve a gyámot, a nevelőszülőt és a hivatásos nevelőszülőt – él, a rá tekintettel figyelembe vett arányszám 0,2-del növekszik.

(3) A normatív lakásfenntartási támogatás esetében a lakásfenntartás elismert havi költsége az elismert lakásnagyság és az egy négyzetméterre jutó elismert költség szorzata. Az egy négyzetméterre jutó elismert havi költség összegét – az energiaárak várható alakulására figyelemmel – az éves központi költségvetésről szóló törvény határozza meg.

(4) A normatív lakásfenntartási támogatás esetében elismert lakásnagyság

a) ha a háztartásban egy személy lakik 35 nm,

b) ha a háztartásban két személy lakik 45 nm,

c) ha a háztartásban három személy lakik 55 nm,

d) ha a háztartásban négy személy lakik 65 nm,

e) ha négy személynél több lakik a háztartásban, a *d)* pontban megjelölt lakásnagyság és minden további személy után 5-5 nm,

de legfeljebb a jogosult által lakott lakás nagysága.

(5) Az adósságkezelési szolgáltatásban részesülő személy a szolgáltatás időtartama alatt lakásfenntartási támogatásra jogosult. Az e jogcímen lakásfenntartási támogatásban részesülő személy egyidejűleg normatív lakásfenntartási támogatásra nem jogosult. A támogatás összegének kiszámítására a normatív lakásfenntartási támogatásra vonatkozó szabályokat kell alkalmazni. Azon személy esetében, akinél előrefizetős gáz- vagy áramfogyasztást mérő készülék működik, a lakásfenntartási támogatást vagy annak meghatározott részét természetben, a készülék működtetését lehetővé tévő formában kell nyújtani.

(6) A normatív lakásfenntartási támogatás egy hónapra jutó összege

a) a lakásfenntartás elismert havi költségének 30%-a, ha a jogosult háztartásában az egy fogyasztási egységre jutó havi jövedelem nem haladja meg az öregségi nyugdíj mindenkori legkisebb összegének 50%-át,

b) a lakásfenntartás elismert havi költségének és a támogatás mértékének (a továbbiakban: TM) szorzata, ha a jogosult háztartásában az egy fogyasztási egységre jutó havi jövedelem az *a)* pont szerinti mértéket meghaladja,

de nem lehet kevesebb, mint 2500 forint, azzal, hogy a támogatás összegét 100 forintra kerekítve kell meghatározni.

(7) A (6) bekezdés *b)* pontja szerinti TM kiszámítása a következő módon történik:

$$TM = 0{,}3 - \frac{J - 0{,}5\,NYM}{NYM} \cdot 0{,}15$$

ahol a J a jogosult háztartásában egy fogyasztási egységre jutó havi jövedelmet, az NYM pedig az öregségi nyugdíj mindenkori legkisebb összegét jelöli. A TM-et századra kerekítve kell meghatározni.

(8) A normatív lakásfenntartási támogatást egy évre kell megállapítani.

(9) A települési önkormányzat rendeletében határozza meg a helyi lakásfenntartási támogatás jogosultsági feltételeit, eljárási szabályait és a támogatás összegét. A helyi lakásfenntartási támogatást a települési önkormányzat a normatív, illetve az (5) bekezdésben meghatározott lakásfenntartási támogatás kiegészítéseként vagy önálló ellátásként nyújtja. Az önálló ellátásként nyújtott helyi lakásfenntartási támogatás esetében

a) a lakásfenntartási támogatásra való jogosultságnak a háztartásban az egy fogyasztási egységre számított havi jövedelmi határát úgy kell szabályozni, hogy az önkormányzat rendelete az öregségi nyugdíj mindenkori legkisebb összegének 250%-ánál alacsonyabb jövedelmet jogosultsági feltételként nem írhat elő;

b) a támogatás összegét úgy kell szabályozni, hogy annak az egy hónapra jutó, 100 forintra kerekített összege nem lehet kevesebb 2500 forintnál;

c) az igénylés menetét úgy kell szabályozni, hogy a kérelem évente legalább két alkalommal benyújtható legyen;

d) a lakásfenntartási támogatás megállapításánál figyelembe vett költséget úgy kell szabályozni, hogy az önkormányzat

da) az egy négyzetméterre jutó helyben elismert havi költség összegét határozza meg a (10) bekezdésben szereplő – a településen jellemző – költségek figyelembevételével, vagy

db) tételesen határozza meg a költség típusait, melynek során legalább a (10) bekezdésben szereplő költségeket figyelembe kell venni.

(10) Költségeken a helyi lakásfenntartási támogatás esetében lakbért vagy albérleti díjat, a lakáscélú pénzintézeti kölcsön törlesztő részletét, a távhő-szolgáltatási díjat, a közös költséget, a csatorna használati díjat, a szemétszállítás költségeit, valamint a villanyáram, a víz- és gázfogyasztás, valamint a tüzelőanyag költségeit kell érteni.

39. § (1) Lakásfenntartási támogatás ugyanazon lakásra csak egy jogosultnak állapítható meg, függetlenül a lakásban élő személyek és háztartások számától.

(2) Az (1) bekezdés alkalmazásában külön lakásnak kell tekinteni a társbérletet, az albérletet és a jogerős bírói határozattal megosztott lakás lakrészeit.

(3)

(4)

Ápolási díj

40. § Az ápolási díj a tartósan gondozásra szoruló személy otthoni ápolását ellátó nagykorú hozzátartozó részére biztosított anyagi hozzájárulás.

41. § (1) Ápolási díjra jogosult – a jegyes kivételével – a hozzátartozó [Ptk. 685. § *b)* pontja], ha állandó és tartós gondozásra szoruló

a) súlyosan fogyatékos, vagy

b) tartósan beteg 18 év alatti

személy gondozását, ápolását végzi.

(2) Az ápolási díjat – a 43/B. § (1) bekezdésében foglaltak kivételével – az ápolást végző személy lakóhelye szerint illetékes települési önkormányzat jegyzője állapítja meg.

(3) Az (1) bekezdés alkalmazása során

a) súlyosan fogyatékos személy az, akinek

aa) segédeszközzel vagy műtéti úton nem korrigálható módon látóképessége teljesen hiányzik, vagy aliglátóként minimális látásmaradvánnyal rendelkezik, és ezért kizárólag tapintó – halló – életmód folytatására képes,

ab) hallásvesztesége olyan mértékű, hogy a beszédnek hallás útján történő megértésére és spontán elsajátítására segédeszközzel sem képes és halláskárosodása miatt a hangzó beszéd érthető ejtése elmarad,

ac) értelmi akadályozottsága genetikai, illetőleg magzati károsodás vagy szülési trauma következtében, továbbá tizennegyedik életévét megelőzően bekövetkező súlyos betegség miatt középsúlyos vagy annál nagyobb mértékű, továbbá aki IQ értékétől függetlenül a személyiség egészét érintő (pervazív) fejlődési zavarban szenved, és az autonómiai tesztek alapján állapota súlyosnak vagy középsúlyosnak minősíthető (BNO szerinti besorolása: F84.0–F84.9),

ad) mozgásszervi károsodása, illetőleg funkciózavara olyan mértékű, hogy helyváltoztatása a külön jogszabályban meghatározott segédeszköz állandó és szükségszerű használatát igényli, vagy állapota miatt helyváltoztatásra még segédeszközzel sem képes, vagy végtaghiánya miatt önmaga ellátására nem képes

és állandó ápolásra, gondozásra szorul;

b) tartósan beteg az a személy, aki előreláthatólag három hónapnál hosszabb időtartamban állandó ápolást, gondozást igényel.

(4)–(5)

42. § (1) Nem jogosult ápolási díjra a hozzátartozó, ha

a) az ápolt személy két hónapot meghaladóan fekvőbeteg-gyógyintézeti, valamint nappali ellátást nyújtó vagy bentlakásos szociális intézményi ellátásban, illetőleg óvodai, gyermekvédelmi szakellátást nyújtó bentlakásos intézményi elhelyezésben részesül, vagy közoktatási intézmény tanulója, illetőleg felsőoktatási intézmény nappali tagozatos hallgatója kivéve, ha

aa) a közoktatási intézményben eltöltött idő a kötelező tanórai foglalkozások időtartamát nem haladja meg, vagy

ab) az óvoda, a nappali ellátást nyújtó szociális intézmény igénybevételének, illetőleg a felsőoktatási intézmény látogatási kötelezettségének időtartama átlagosan a napi 5 órát nem haladja meg, vagy

ac) az óvoda, a közoktatási, illetőleg a felsőoktatási intézmény látogatása, vagy a nappali ellátást nyújtó szociális intézmény igénybevétele csak az ápolást végző személy rendszeres közreműködésével valósítható meg;

b) rendszeres pénzellátásban részesül, és annak összege meghaladja az ápolási díj összegét, ide nem értve a (4) bekezdés szerinti esetet, valamint azt a táppénzt, amelyet az ápolási díj folyósításának időtartama alatt végzett keresőtevékenységéből adódó biztosítási jogviszony alapján – keresőképtelenné válása esetén – folyósítanak,

c) szakiskola, középiskola, illetve felsőoktatási intézmény nappali tagozatos tanulója, hallgatója;

d) keresőtevékenységet folytat és munkaideje – az otthon történő munkavégzés kivételével – a napi 4 órát meghaladja.

e)

(2) Az ápolási díjra való jogosultságot meg kell szüntetni, ha

a) az ápolt személy állapota az állandó ápolást már nem teszi szükségessé,

b) az ápolást végző személy a kötelezettségét nem teljesíti,

c) az ápolt személy meghal,

d) az ápolást végző vagy az ápolt személy tartózkodási joga megszűnt vagy tartózkodási jogának gyakorlásával felhagyott,

e) az (1) bekezdésben megjelölt jogosultságot kizáró körülmény következik be.

(3) Az ápolt személy halála esetén az ápolási díj folyósítását a halál időpontját követő második hónap utolsó napjával kell megszüntetni.

(4) Az ápolási díjra való, 41. § (1) bekezdésének *a)* pontja szerinti jogosultság továbbra is fennáll, ha az ápolási díjban részesülő személy számára a Tny. szerint saját jogú nyugdíjnak minősülő ellátást állapítanak meg, feltéve, hogy az ápolási díjat a nyugdíj megállapításának időpontjában több mint tíz éve folyósítják.

43. § (1) Az ápolási díj megállapítása iránti kérelemhez csatolni kell a háziorvos

a) igazolását arról, hogy az ápolt

aa) súlyosan fogyatékos, vagy

ab) tartósan beteg,

b) arra vonatkozó szakvéleményét, hogy az ápolt állandó és tartós gondozásra szorul.

(2) A háziorvos az (1) bekezdés *a)* pontjában foglalt igazolást

a) az orvosszakértői szerv orvosi bizottságának szakvéleménye, vagy

b) a megyei gyermek-szakfőorvos igazolása, vagy

c) a fekvőbeteg-szakellátást nyújtó intézmény vagy területileg illetékes szakrendelő intézet szakorvosa által kiadott zárójelentés, igazolás

alapján állítja ki.

(3) A háziorvos az (1) bekezdés *aa)* pontjában foglalt igazolást a tanulási képességet vizsgáló szakértői és rehabilitációs bizottság szakvéleménye alapján is kiállíthatja.

(4) Az ápolási díjat kérelmező személy, illetve az ápolási díjat megállapító szerv

a) az (1) bekezdés *a)* pontjában foglalt igazolás felülvizsgálatát az egészségügyi államigazgatási szerv által kijelölt, az ápolást indokoló diagnózis szerinti szakorvostól vagy szervtől,

b) az (1) bekezdés *b)* pontjában foglalt szakvélemény felülvizsgálatát az ápolt személy tartózkodási helye szerint illetékes módszertani intézmény által kijelölt szakértőtől

kérheti.

43/A. § (1) A települési önkormányzat jegyzője a fokozott ápolást igénylő súlyosan fogyatékos személy gondozását, ápolását végző személy kérelmére a 44. § (1) bekezdésének *b)* pontjában foglalt összegű ápolási díjat állapít meg.

(2) Az (1) bekezdés alkalmazása során fokozott ápolást igénylő az a személy, aki mások személyes segítsége nélkül önállóan nem képes

a) étkezni, vagy

b) tisztálkodni, vagy

c) öltözködni, vagy

d) illemhelyet használni, vagy

e) lakáson belül – segédeszköz igénybevételével sem – közlekedni,

feltéve, hogy esetében az *a)–e)* pontokban foglaltak közül legalább három egyidejűleg fennáll.

(3) A települési önkormányzat, 2007. január 1-jétől a jegyző a (2) bekezdésben foglalt feltételek fennállásáról az ápolt személy tartózkodási helye szerint illetékes módszertani intézmény által kijelölt szakértő szakvéleménye alapján dönt. A szakvéleményben meg kell jelölni annak hatályát, amely azonban nem haladhatja meg a tíz évet.

(4) Az ápolási díjról döntést hozó szerv a módszertani intézmény által kijelölt szakértőnek a (3) bekezdés szerinti szakvélemény elkészítéséért díjat fizet. A díjazás összegét az éves központi költségvetésről szóló törvény határozza meg.

(5) A (3) bekezdés szerinti szakvélemény felülvizsgálatát a szociális hatóság által külön jogszabály szerint kijelölt szakértő végzi.

43/B. § (1) A települési önkormányzat képviselő-testülete – az önkormányzat rendeletében meghatározott feltételek fennállása esetén – ápolási díjat állapíthat meg annak a hozzátartozónak, aki 18. életévét betöltött tartósan beteg személy ápolását, gondozását végzi. A jogosultság megállapítása szempontjából figyelembe vehető egy főre számított havi családi jövedelemhatárt úgy kell szabályozni, hogy az önkormányzat rendelete az öregségi nyugdíj mindenkori legkisebb összegénél, egyedülálló esetén annak 150%-ánál alacsonyabb jövedelmi jogosultsági feltételt nem írhat elő.

(2) Az (1) bekezdésben, valamint a 43/A. § (1) bekezdésében foglalt ápolási díj megállapítása során a 41–43. §-okban foglaltakat megfelelően alkalmazni kell.

(3) A települési önkormányzat rendeletében szabályozhatja, hogy az ápolást végző személy a kötelezettségét mely esetekben nem teljesíti [42. § (2) bek. *b)* pont], valamint a házi segítségnyújtást nyújtó szolgáltató, intézmény feladatait ezen kötelezettség teljesítésének ellenőrzésében.

44. § (1) Az ápolási díj havi összege az éves központi költségvetési törvényben meghatározott alapösszeg

a) 100%-a a 41. § (1) bekezdésében,

b) 130%-a a 43/A. § (1) bekezdésében, és

c) legalább 80%-a a 43/B. § (1) bekezdésében

foglalt esetben.

(2) Az ápolási díj havi összege a más rendszeres pénzellátásban részesülő jogosult esetén az (1) bekezdés szerinti összegnek és a jogosult részére folyósított más rendszeres pénzellátás havi összegének a különbözete. Ha a különbözet az ezer forintot nem éri el, a jogosult részére ezer forint összegű ápolási díjat kell megállapítani.

(3) Az ápolási díj folyósításának időtartama szolgálati időre jogosít. Az ápolási díjban részesülő személy – ide nem értve a Tbj. 26. §-a alapján nyugdíjjárulék fizetésére nem kötelezett személyt – az ellátás után nyugdíjjárulék és magán-nyugdíjpénztári tagdíj fizetésére kötelezett. A települési önkormányzat az ápolási díj folyósításának időtartamára a társadalombiztosítási járulék nyugdíjbiztosítási ágazatára jutó járulék fizetésére kötelezett.

(4)

Átmeneti segély

45. § (1) A települési önkormányzat képviselő-testülete a létfenntartást veszélyeztető rendkívüli élethelyzetbe került, valamint időszakosan vagy tartósan létfenntartási gonddal küzdő személyek részére a rendeletében meghatározott átmeneti segélyt nyújt. Átmeneti segély pénzintézeti segélynek nem minősülő kamatmentes kölcsön formájában is nyújtható.

(2) Az átmeneti segély esetén az ellátás megállapításánál figyelembe vehető egy főre számított havi családi jövedelemhatárt az önkormányzat rendeletében úgy kell szabályozni,

hogy az az öregségi nyugdíj mindenkori legkisebb összegénél, egyedülélő esetén annak 150%-ánál alacsonyabb nem lehet.

(3) Az átmeneti segély adható alkalmanként és havi rendszerességgel. Az alkalmankénti segély gyógyszertámogatásként, illetve az egészségbiztosítás által nem vagy csak részben támogatott egészségügyi szolgáltatás díjaként is megítélhető. A havi rendszerességgel adott átmeneti segély jövedelemkiegészítő támogatásként, rendszeres nevelési támogatásként, továbbá az önkormányzat rendeletében meghatározott más ellátási formaként is nyújtható.

(4) Elsősorban azokat a személyeket indokolt átmeneti segélyben részesíteni, akik önmaguk, illetve családjuk létfenntartásáról más módon nem tudnak gondoskodni, vagy alkalmanként jelentkező többletkiadások, különösen betegség, elemi kár miatt anyagi segítségre szorulnak.

(5) A fővárosban — ha a fővárosi önkormányzat és a kerületi önkormányzat másként nem állapodik meg — a hajléktalanok átmeneti segélyezése a fővárosi önkormányzat feladata.

Temetési segély

46. § (1) A települési önkormányzat a rendeletében meghatározott feltételek szerint temetési segélyt állapíthat meg annak, aki a meghalt személy eltemettetéséről gondoskodott annak ellenére, hogy arra nem volt köteles, vagy tartására köteles hozzátartozó volt ugyan, de a temetési költségek viselése a saját, illetve családja létfenntartását veszélyezteti. A jogosultság megállapítása szempontjából figyelembe vehető egy főre számított havi családi jövedelemhatárt az önkormányzat rendeletében úgy kell szabályozni, hogy az az öregségi nyugdíj mindenkori legkisebb összegénél, egyedülélő esetén annak 150%-ánál alacsonyabb nem lehet.

(2) Temetési segély nem állapítható meg annak a személynek, aki a hadigondozásról szóló 1994. évi XLV. törvény alapján temetési hozzájárulásban részesül.

(3) A temetési segély összege nem lehet kevesebb a helyben szokásos, legolcsóbb temetés költségének 10%-ánál, de elérheti annak teljes összegét, ha a temetési költségek viselése a kérelmezőnek vagy családjának a létfenntartását veszélyezteti.

III. Fejezet
TERMÉSZETBEN NYÚJTOTT SZOCIÁLIS ELLÁTÁSOK

47. § (1) Egyes szociális rászorultságtól függő pénzbeli ellátások egészben vagy részben természetbeni szociális ellátás formájában is nyújthatók. Természetbeni szociális ellátásként nyújtható

a) a rendszeres szociális segély, a (2) bekezdésben meghatározott mértékben és feltételek fennállása esetén,

b) a lakásfenntartási támogatás,

c) az átmeneti segély,

d) a temetési segély.

(2) Rendszeres szociális segély természetbeni szociális ellátás formájában akkor nyújtható, ha a családban a Gyvt. 68. §-a szerint védelembe vett gyermek él. A rendszeres szociális segély természetbeni szociális ellátás formájában történő nyújtásának eljárási szabályait, a természetbeni juttatás formáit a települési önkormányzat rendeletben szabályozza, azzal, hogy védelembe vett gyermekenként a rendszeres szociális segély megállapított összegének 20%-a, de összesen legfeljebb 60%-a nyújtható természetben.

(3) Természetbeni ellátás különösen az élelmiszer, a tankönyv, a tüzelő segély, a közüzemi díjak, illetve a gyermekintézmények térítési díjának kifizetése, valamint a családi szükségletek kielégítését szolgáló, gazdálkodást segítő támogatás.

(4) A (3) bekezdés alkalmazásában családi szükségletek kielégítését szolgáló, gazdálkodást segítő támogatásnak minősül különösen

a) a földhasználati lehetőség,

b) a mezőgazdasági szolgáltatások és juttatások,

c) a munkaeszközök és a munkavégzéshez szükséges forgó eszközök,

d) a szaktanácsadás, a szakképzés

biztosítása.

(5) A családi szükségletek kielégítését szolgáló gazdálkodást segítő támogatás nyújtására akkor van mód, ha a települési önkormányzat rendeletben szabályozza

a) a támogatás eljárási szabályait,

b) a támogatás formáit és értékét,

c) a támogatott jogait és kötelezettségeit, illetve a kötelezettség

megszegésének következményeit.

(6) A 32–32/A. § szabályait az e Fejezet szerinti ellátásokra – az 55/D. § szerinti kivétellel – alkalmazni kell.

Köztemetés

48. § (1) A haláleset helye szerint illetékes települési önkormányzat polgármestere önkormányzati hatáskörben – a halálesetről való tudomásszerzést követő harminc napon belül – gondoskodik az elhunyt személy közköltségen történő eltemettetéséről, ha

a) nincs vagy nem lelhető fel az eltemettetésre köteles személy, vagy

b) az eltemettetésre köteles személy az eltemettetésről nem gondoskodik.

(2) Az elhunyt személy elhalálozása időpontjában fennálló lakóhelye (a továbbiakban: utolsó lakóhely) szerinti települési önkormányzat a köztemetés költségét az (1) bekezdés szerinti önkormányzatnak megtéríti. A megtérítés iránti igényt a köztemetés elrendelésétől számított két hónapon belül kell bejelenteni.

(3) Az elhunyt személy utolsó lakóhelye szerinti települési önkormányzat

a) a költségeket hagyatéki teherként a területileg illetékes közjegyzőnél bejelenti, vagy

b) az eltemettetésre köteles személyt a köztemetés költségeinek megtérítésére kötelezi.

(4) A települési önkormányzat a rendeletében szabályozottak szerint a (3) bekezdés *b)* pontjában meghatározott megtérítési kötelezettség alól részben vagy egészben különös méltánylást érdemlő körülmények fennállása esetén mentesítheti az eltemettetésre köteles személyt.

(5) Ha az elhunyt személynek utolsó lakóhelye nem volt, vagy az nem ismert, úgy a temetési költséget viselő önkormányzat a (3) bekezdés szerint jár el.

Közgyógyellátás

49. § (1) A közgyógyellátás a szociálisan rászorult személy részére az egészségi állapota megőrzéséhez és helyreállításához kapcsolódó kiadásainak csökkentése érdekében biztosított hozzájárulás.

(2) A közgyógyellátási igazolvánnyal (a továbbiakban: igazolvány) rendelkező személy – külön jogszabályban meghatározottak szerint – térítésmentesen jogosult a társadalombiztosítási támogatásba befogadott

a) járóbeteg-ellátás keretében rendelhető egyes, a biztonságos és gazdaságos gyógyszer- és gyógyászatisegédeszköz-ellátás, valamint a gyógyszerforgalmazás általános szabályairól szóló jogszabályban meghatározott gyógyszerekre – ideértve a különleges táplálkozási igényt kielégítő tápszereket is – gyógyszerkerete erejéig,

b) egyes, a biztonságos és gazdaságos gyógyszer- és gyógyászatisegédeszköz-ellátás, valamint a gyógyszerforgalmazás általános szabályairól szóló jogszabályban meghatározott gyógyászati segédeszközökre, ideértve a protetikai és fogszabályozó eszközöket is, valamint azok javítására és kölcsönzésére, továbbá

c) az orvosi rehabilitáció céljából igénybe vehető gyógyászati ellátásokra [az *a)–c)* pont szerintiek a továbbiakban együtt: gyógyító ellátás].

(3) A (2) bekezdés *b)–c)* pontja szerinti esetben a közfinanszírozás alapjául elfogadott ár erejéig vehető igénybe térítésmentesen az ellátás.

(4) A gyógyszerkeret

a) a rendszeres gyógyszerszükséglet támogatását szolgáló egyéni gyógyszerkeretből, és

b) az akut megbetegedésből eredő gyógyszerszükséglet támogatását szolgáló eseti keretből tevődik össze.

50. § (1) Közgyógyellátásra jogosult

a) az intézeti elhelyezett, az intézeti és állami nevelt kiskorú;

b) a rendszeres szociális segélyben részesülő egészségkárosodott személy;

c) a pénzellátásban részesülő hadigondozott és a nemzeti gondozott;

d)

e) a központi szociális segélyben részesülő;

f) a rokkantsági járadékos;

g) az, aki I., II. csoportú rokkantsága alapján részesül nyugellátásban, baleseti nyugellátásban;

h) az aki, vagy aki után szülője vagy eltartója magasabb összegű családi pótlékban részesül.

(2) Közgyógyellátásra jogosult az a személy is, akinek esetében a havi rendszeres gyógyító ellátásnak az egészségbiztosítási szerv által elismert térítési díja (a továbbiakban: rendszeres gyógyító ellátás költsége) az öregségi nyugdíj mindenkori legkisebb összegének a 10%-át meghaladja, feltéve, hogy a családjában az egy főre jutó havi jövedelem nem éri el az öregségi nyugdíj mindenkori legkisebb összegét, egyedül élő esetén 150%-át. A rendszeres gyógyító ellátás költségének számításánál az Eb. 23. §-ának *b), d)* és *e)* pontja alapján fizetendő térítési díjat nem kell figyelembe venni.

(3) Az (1)–(2) bekezdésben foglaltakon kívül az a szociálisan rászorult személy is jogosult közgyógyellátásra, akinek esetében a települési önkormányzat rendeletében meghatározott feltételek fennállnak. Az önkormányzat rendeletében

a) az egy főre számított havi családi jövedelemhatárt úgy kell szabályozni, hogy az öregségi nyugdíj mindenkori legkisebb összegének 150%-ánál, egyedül élő esetén annak 200%-ánál alacsonyabb jövedelmet, továbbá

b) a havi rendszeres gyógyító ellátás költségének mértékeként az öregségi nyugdíj mindenkori legkisebb összegének 25%-át meghaladó összeget

jogosultsági feltételként nem lehet előírni; a szociális rászorultság további feltételeit az önkormányzat a helyi viszonyoknak megfelelően szabályozza.

(4) A közgyógyellátásra való jogosultságról a jegyző dönt. A jogosultság az (1) bekezdés szerinti jogosult esetében két évre, a (2)–(3) bekezdés szerinti jogosult esetében egy évre kerül megállapításra. A közgyógyellátásra való jogosultság kezdő időpontja – az (5) bekezdésben foglaltak kivételével – a jogosultságot megállapító határozat meghozatalát követő 15. nap.

(5) A közgyógyellátás iránti kérelem a jogosultság időtartama alatt, annak lejártát megelőző három hónapban is benyújtható. Amennyiben az eljárás a jogosultság lejárta előtt legalább 15 nappal korábban befejeződik, az új jogosultság kezdő időpontjaként a korábbi jogosultság lejártát követő napot kell megállapítani.

(6) Ha a (2)–(3) bekezdés szerinti jogosultsági feltételek alapján benyújtott, közgyógyellátás iránti kérelmet jogerősen elutasították, és az újabb kérelem benyújtásáig

a) a gyógykezelést szolgáló terápiában, illetőleg a gyógyszerek térítési díjában nem következett be olyan változás, amelynek következtében a havi rendszeres gyógyító ellátás költsége megnőtt, és

b) a kérelmező jövedelme nem változott,

a jegyző a kérelmet érdemi vizsgálat nélkül elutasítja.

50/A. § (1) A jogosult számára kizárólag a személyes szükségletének kielégítéséhez szükséges gyógyító ellátás rendelhető.

(2) A havi rendszeres gyógyító ellátási szükségletet a háziorvos, illetve – személyes gondoskodást nyújtó átmeneti és bentlakásos szociális intézményben vagy gyermek- és ifjúságvédő intézetben, nevelőotthonban elhelyezett jogosult esetén – az intézmény orvosa (a továbbiakban együtt: háziorvos) igazolja.

(3) Az igazolás tartalmazza a kérelmező természetes személyazonosító adatait, lakóhelyét és tartózkodási helyét, Társadalombiztosítási Azonosító Jelét, a tartósan fennálló betegségének a betegségek nemzetközi osztályozása szerinti kódját (a továbbiakban: BNO kód). Az igazolás tartalmazza továbbá az alkalmazandó terápiához szükséges gyógyító ellátások megnevezését, mennyiségét, gyógyszerek esetében a gyógyszer megnevezését és a külön jogszabályban meghatározott azonosító adatait, a gyógyszer formáját, mennyiségét, valamint a kívánt terápiás hatás eléréséhez szükséges napi mennyiségét és az adagolást. A csak szakorvos által vagy csak szakorvosi javaslatra rendelhető gyógyszereket az igazoláson a szakorvos nevének, pecsétszámának feltüntetésével külön meg kell jelölni. A szakorvos – a kérelmező igénye esetén – az általa rendelt havi rendszeres gyógyító ellátásokról a háziorvost tájékoztatja.

(4) A háziorvos igazolását a jegyző öt napon belül továbbítja az egészségbiztosítási szervnek. Az 50. § (2)–(3) bekezdése alapján közgyógyellátást kérelmező személy esetében az igazolást a jegyző csak akkor továbbítja, ha a kérelmező megfelel az előírt jövedelmi feltételeknek.

(5) Az egészségbiztosítási szerv megvizsgálja az igazolásban feltüntetett havi rendszeres gyógyító ellátás iránti szükséglet szakmai megalapozottságát. Ha az igazolásban feltüntetett gyógyító ellátás iránti szükségletet az egészségbiztosítási szerv nem tartja megalapozottnak, a szakhatósági állásfoglalást megelőzően adategyeztetés céljából megkeresi az igazolást kiállító háziorvost.

(6) Az egészségbiztosítási szerv az általa elismert gyógyító ellátási szükséglet alapján szakhatósági állásfoglalást ad a jegyzőnek a rendszeres gyógyító ellátások havi költségéről. A 49. § (2) bekezdésének *b)–c)* pontja szerinti esetben a közfinanszírozás alapjául elfogadott ár figyelembevételével számított térítési díjat kell alapul venni.

(7) A szakhatósági állásfoglalásban külön meg kell jelölni az egyéni gyógyszerkeret alapjául szolgáló gyógyszer térítési díjának – ideértve a külön jogszabály szerint kiemelt, indikációhoz kötött támogatásban részesített gyógyszerért dobozonként fizetendő díjat – összegét (a továbbiakban: gyógyszerköltség). A gyógyszerköltség meghatározásánál a kérelmező krónikus betegségéhez igazodó, egyhavi mennyiségre számolva legalacsonyabb költségű, külön jogszabályban meghatározott szakmai szabályok szerint elsőként választandó, legalacsonyabb napi terápiás költséggel alkalmazott készítményeket kell alapul venni. A gyógyszerköltség megállapítása során legfeljebb havi 6000 forintig vehetők figyelembe a nem csak szakorvos által, illetve nem csak szakorvosi javaslatra rendelhető gyógyszerek. Ha a kérelmező havi gyógyszerköltsége a 6000 forintot meghaladja, a 6000 forint feletti összeg a szakhatósági állásfoglalásban a csak szakorvos által, illetve csak szakorvosi javaslat alapján rendelhető gyógyszerek figyelembevételével, az egészségbiztosítási szerv vezetőjének döntése alapján állapítható meg.

(8) Az egyéni gyógyszerkeret összege a jogosult egyéni havi rendszeres gyógyszerköltsége, de 2006. évben legfeljebb havi 12 000 Ft lehet. A 2006. évet követően az egyéni gyógyszerkeret legmagasabb havi összegét az éves központi költségvetésről szóló törvény határozza meg. Amennyiben az egyéni rendszeres gyógyszerköltség a havi 1000 Ft-ot nem éri el, egyéni gyógyszerkeret nem kerül megállapításra.

(9) Az eseti keret éves összege 2006. évben 6000 Ft. A 2006. évet követően az eseti keret összegét az éves központi költségvetésről szóló törvény határozza meg. Amennyiben a közgyógyellátásra jogosult személy részére egyéni gyógyszerkeret nem kerül megállapításra, a gyógyszerkeret megegyezik az eseti kerettel.

(10) A jegyző nyolc napon belül dönt

a) a közgyógyellátásra való jogosultságról,

b) a közgyógyellátásra való jogosultság kezdő időpontjáról,

c) a jogosult gyógyszerkeretéről, külön megjelölve – a (6) bekezdés szerinti szakhatósági állásfoglalás alapján – az egyéni gyógyszerkeret összegét.

(11) Az 50. § (1) bekezdése szerinti jogosult esetében – amennyiben rendszeres gyógyszerköltség hiányában egyéni gyógyszerkeret megállapítását nem igényli – az eljárásra a (2)–(8) bekezdést nem kell alkalmazni.

(12) Ha az egyéni gyógyszerkeret legmagasabb havi összege, illetőleg az eseti keret összege a (8)–(9) bekezdés szerint, az éves központi költségvetésről szóló törvény alapján változik, a megváltozott összegeket a hatálybalépés időpontját követően megállapított új jogosultság esetében kell alkalmazni.

(13) Az igazolvánnyal rendelkező személy a gyógyszerkerete erejéig kiváltott, külön jogszabály szerint kiemelt, indikációhoz kötött támogatásban részesített gyógyszerért dobozonként fizetendő díjat a gyógyszerkerete terhére fizeti meg.

50/B. § (1) Az egyéni gyógyszerkeret és az eseti keret a jogosultság időtartamára kerül megállapításra. Az 50. § (2)–(3) bekezdése szerinti jogosultságot és a gyógyszerkeretet 18 hónapnál nem régebben kiadott szakhatósági állásfoglalás alapján lehet megállapítani.

(2) Amennyiben az ellátásban részesülő személy egészségi állapotában, a gyógykezelését szolgáló terápiában, illetőleg a keret megállapításakor figyelembe vett gyógyszerek térítési díjában olyan változás következik be, amelynek következtében havi rendszeres kiadása a gyógyszerkeret megállapításakor figyelembe vett gyógyszerköltséghez képest ténylegesen legalább 1000 forinttal megváltozik, az ellátásban részesülő személy kérelmére lehetőség van az egyéni gyógyszerkeret év közbeni felülvizsgálatára.

(3) A felülvizsgálat során az egyéni gyógyszerkeret újbóli megállapítására abban az esetben kerül sor, ha a gyógyszerköltség havi változásának összege az 1000 forintot eléri. Az eljárás során az 50/A. § szabályait kell megfelelően alkalmazni.

(4) A felülvizsgálat során megállapított magasabb egyéni gyógyszerkeret a határozat meghozatalát követő 15. naptól jár. A felülvizsgálat során megállapított alacsonyabb egyéni gyógyszerkeret a határozat meghozatalát követő 30. naptól jár. Ha a felülvizsgálat eredményeképpen a jogosultság megszüntetésére kerül sor, annak időpontja a határozat meghozatalát követő 30. nap.

(5) A jogosultság lejártát megelőző három hónapban az egyéni gyógyszerkeret felülvizsgálatát nem lehet kérni.

50/C. § (1) Az igazolványt az egészségbiztosítási szerv – a jogosultságot megállapító határozat alapján – az abban megjelölt időtartamra, hivatalból állítja ki.

(2) Az egészségbiztosítási szerv a közgyógyellátásra jogosult személy jogosultságáról, továbbá gyógyszerkeretének figyelemmel kísérése céljából hatósági nyilvántartást vezet.

(3) A nyilvántartás tartalmazza

a) a jogosult nevét, lakóhelyét és tartózkodási helyét,
b) a jogosult Társadalombiztosítási Azonosító Jelét,
c) a közgyógyellátásra való jogosultság kezdő és befejező időpontját,
d) a közgyógyellátásra való jogosultság megállapításáról döntést hozó szerv megnevezését és határozatának számát,
e) a jogosult betegségének BNO kódját,
f) a jogosult számára megállapított, a jogosultsági időtartam alatt még felhasználható és az 50/E. §-ban szabályozott időszakban még rendelkezésre álló gyógyszerkeretének összegét,
g) a jogosult közgyógyellátási igazolványának számát.

(4) A nyilvántartás adatainak megismerésére – a (3) bekezdés *e)* pontja szerinti adat kivételével – az 51. §-ban meghatározott módon és célból a működési engedéllyel rendelkező gyógyszertár jogosult.

(5) Az egészségbiztosítási szerv a tárolt adatokat a közgyógyellátásra való jogosultság megszűnését követő ötödik év elteltével törli a nyilvántartásból.

50/D. § Az egészségbiztosítási szerv ellenőrzi a háziorvos, illetve a szakorvos közgyógyellátással kapcsolatos tevékenységét. Ha az egészségbiztosítási szerv az ellenőrzés alapján indokoltnak tartja a közgyógyellátásra jogosult személy egyéni gyógyszerkeretének felülvizsgálatát, azt a jegyzőnél kezdeményezi.

50/E. § (1) Az egészségbiztosítási szerv az elszámolási-nyilvántartási rendszerében az egyéni gyógyszerkeretet három havonta, egyenlő részletekben – első alkalommal a jogosultság kezdő időpontjával – nyitja meg. Az egyéni gyógyszerkeret év közbeni felülvizsgálata esetén az egészségbiztosítási szerv a módosított egyéni gyógyszerkeretnek az időarányos, a jogosultság időtartamából hátra levő időtartamra eső részét nyitja meg három havonta.

(2) Az eseti keret összegét az egészségbiztosítási szerv a jogosultság kezdő időpontjával nyitja meg. Két évre megállapított jogosultság esetén az eseti keretet évente, a jogosultság kezdő időpontjával, illetve az attól számított egy év elteltével kell megnyitni.

(3) A gyógyszerkeret az igazolvány hatályosságának az ideje alatt használható fel.

51. § (1) A gyógyszertár a közgyógyellátás keretében történő gyógyszerkiadást megelőzően ellenőrzi, hogy a vényen feltüntetett személy szerepel-e a hatósági nyilvántartásban, továbbá tájékoztatást ad a jogosult részére még rendelkezésre álló gyógyszerkeret összegéről.

(2) A gyógyszertár a közgyógyellátás keretében térítésmentesen a gyógyszerkeretnek az egészségbiztosítási szerv nyilvántartása szerint az 50/E. §-ban meghatározott időszakban rendelkezésre álló összegéig ad ki gyógyszert.

(3) A gyógyszer térítési díját nem lehet részben gyógyszerkeretből, részben a jogosult saját költségéből fedezni. Amennyiben a gyógyszer térítési díját a az egészségbiztosítási szerv által a három hónapos tárgyidőszakra megnyitott gyógyszerkeret nem fedezi, azt – a (4) bekezdés szerinti kivétellel – a közgyógyellátott fizeti meg. A három hónapos tárgyidőszakban így megmaradt összeg – a jogosultsági éven belül – a következő három hónapos tárgyidőszakban megnyitott gyógyszerkeret összegét növeli.

(4) Az éves gyógyszerkeret kimerülése előtt a gyógyszerkeretből még rendelkezésre álló, a jogosult részére rendelt gyógyszer térítési díját el nem érő maradványösszeg a gyógyszer térítési díjának kiegészítésére is felhasználható, azzal, hogy a maradványösszeg és a gyógyszer térítési díja közötti különbözetet a közgyógyellátott fizeti meg.

52. § (1) A jegyző által a közgyógyellátottakról vezetett nyilvántartás a 18. § *a)–g)* pontjaiban foglaltakon túl tartalmazza a közgyógyellátott gyógyszerkeretét és igazolványa számát.

(2) A jegyző és az egészségbiztosítási szerv – kormányrendeletben szabályozott módon – a nyilvántartás adatait évente egyeztetik.

53. § (1) Az 50. § (3) bekezdése alapján kiállított igazolvány után a települési önkormányzat – a (2) bekezdés szerinti eltéréssel – térítést fizet. A térítés az igazolvány kiállítását követő egyéves időtartamra szól. A térítés összege a megállapított gyógyszerkeret éves összegének 30%-a, amelyet a jogosultság kezdetétől számított három munkanapon belül az egészségbiztosítási szervnek át kell utalni. Amennyiben az egyéni gyógyszerkeret év közbeni felülvizsgálata során fél évnél hosszabb időtartamra magasabb gyógyszerkeret kerül megállapításra, a különbözet 6 havi összegének 30%-át is át kell utalni az egészségbiztosítási szerv részére. Amennyiben a települési önkormányzat a jogosultság kezdetétől számított 30 napon belül fizetési kötelezettségének nem tesz eleget, az egészségbiztosítási szerv megkeresésére az állami adóhatóság adók módjára hajtja be a követelést az önkormányzat költségvetési elszámolási számlájáról.

(2) Amennyiben a közgyógyellátást igénylő személy az új jogosultság kezdetének időpontja előtt meghal, a települési önkormányzatnak nem kell térítést fizetnie.

(3) Amennyiben a közgyógyellátásra jogosult az igazolvány kiállítását követően fél éven belül meghal vagy elveszíti jogosultságát, az önkormányzat visszaigényelheti a befizetett térítési díj felét. Amennyiben az egyéni gyógyszerkeret év közbeni felülvizsgálata során fél évnél hosszabb időtartamra alacsonyabb gyógyszerkeret kerül megállapításra, az önkormányzat visszaigényelheti az egészségbiztosítási szervtől a különbözet 6 havi összegének 30%-át.

Egészségügyi szolgáltatásra való jogosultság

54. § (1) A jegyző az egészségügyi szolgáltatás igénybevétele céljából annak a személynek állapítja meg szociális rászorultságát,

a) akinek családjában az egy főre jutó havi jövedelem az öregségi nyugdíj mindenkori legkisebb összegének 120%-át,

b) aki egyedülélő és jövedelme az öregségi nyugdíj mindenkori legkisebb összegének 150%-át

nem haladja meg, és családjának vagyona nincs.

(2) A szociális rászorultság igazolásáról a jegyző hatósági bizonyítványt (a továbbiakban: bizonyítvány) állít ki. A bizonyítvány hatályossága 1 év. A bizonyítvány tartalmazza: a rászoruló személy nevét, lakcímét, Társadalombiztosítási Azonosító Jelét, a rászorultság tényét, az igazolás hatályosságát. A bizonyítvány az (1) bekezdésben megjelölt feltételek fennállta esetén ismételten kiállítható.

(3) A szociálisan rászorult személyekről a jegyző nyilvántartást vezet és a külön jogszabály szerint bejelentési kötelezettséget teljesít az egészségbiztosítási szerv felé.

54/A. §

Adósságkezelési szolgáltatás

55. § (1) Az adósságkezelési szolgáltatás a szociálisan rászorult személyek részére nyújtott, lakhatást segítő ellátás. A települési önkormányzat határozatában megjelölt időponttól adósságkezelési szolgáltatásban részesítheti azt a családot vagy személyt,

a) akinek

aa) az adóssága meghaladja az ötvenezer forintot, és akinek a (2) bekezdésben meghatározott adósságok valamelyikénél fennálló tartozása legalább hat havi, vagy

ab) a közüzemi díjtartozása miatt a szolgáltatást kikapcsolták, továbbá

b) akinek a háztartásában az egy főre jutó havi jövedelem nem haladja meg az önkormányzat rendeletében meghatározott összeghatárt, valamint

c) aki a településen elismert minimális lakásnagyságot és minőséget meg nem haladó lakásban lakik, feltéve, hogy vállalja az adósság és a települési önkormányzat által megállapított adósságcsökkentési támogatás különbözetének megfizetését, továbbá az adósságkezelési tanácsadáson való részvételt.

(2) Az (1) bekezdés alkalmazása során adósságnak minősül a lakhatási költségek körébe tartozó

a) közüzemi díjtartozás (vezetékes gáz-, áram-, távhő-szolgáltatási, víz- és csatornahasználati, szemétszállítási, több lakást tartalmazó lakóépületeknél, háztömböknél központi fűtési díjtartozás),

b) közösköltség-hátralék,

c) a lakbérhátralék,

d) a hitelintézettel kötött lakáscélú kölcsönszerződésből, illetve abból átváltott szabad felhasználású kölcsönszerződésből fennálló hátralék.

(3) Az (1) bekezdés *b)* pontjában említett összeghatárt úgy kell szabályozni, hogy az önkormányzat rendelete az öregségi nyugdíj mindenkori legkisebb összegének 150%-ánál, egyedül élő esetén annak 200%-ánál alacsonyabb jövedelmet jogosultsági feltételként nem írhat elő.

(4)

(5) Az adósságkezelési szolgáltatás időtartama – a (6) bekezdés szerinti eset kivételével – legfeljebb tizennyolc hónap, amely indokolt esetben egy alkalommal hat hónappal meghosszabbítható.

(6) Ha a (2) bekezdés *d)* pontja szerinti adósság az (5) bekezdés szerinti időtartam alatt nem kezelhető, az adósságkezelési szolgáltatás időtartama legalább huszonnégy, de legfeljebb hatvan hónap, amennyiben

a) az adósság összege meghaladja a kettőszázezer forintot,

b) a tartozás meghaladja a hitellel terhelt ingatlan forgalmi értékének 50%-át, és

c) az adós hozzájárul az adósságkezelés időtartamára a támogatás összegét biztosító jelzálogjognak, valamint elidegenítési és terhelési tilalomnak ingatlanára történő bejegyzéséhez, illetőleg feljegyzéséhez.

(7) A jelzálogjog bejegyzésének és az elidegenítési és terhelési tilalom ténye feljegyzésének kezdeményezéséről az adósságkezelési szolgáltatásra való jogosultságot megállapító határozat rendelkezik. A határozat az ingatlanügyi hatósággal közölni kell. Az ingatlanügyi hatóság a jelzálogjogot és az elidegenítési és terhelési tilalmat az önkormányzat javára az ingatlan-nyilvántartásba bejegyzi, illetőleg feljegyzi.

(8) A Magyar Állam az 1988. december 31-ét megelőzően hatályban volt jogszabályok alapján felvett egyes lakáscélú kölcsönökből eredő adósságok rendezéséről szóló kormányrendelet alapján megvásárolt követelésével összefüggésben történő befizetésről a hitelszerződéssel érintett ingatlan fekvése szerinti települési önkormányzat javára lemond.

(9) Adósságkezelési szolgáltatás ugyanazon lakásra csak egy jogosultnak állapítható meg, függetlenül a lakásban élő személyek és háztartások számától.

(10) A (9) bekezdés alkalmazásában külön lakásnak kell tekinteni a társbérletet, az albérletet és a jogerős bírói határozattal megosztott lakás lakrészeit.

55/A. § (1) Az adósságkezelési szolgáltatás esetén a jogosult

a) adósságkezelési tanácsadásban, és
b) adósságcsökkentési támogatásban
részesül, amelyet az adósságkövetelés jogosultjának kell folyósítani.

(2) Az adósságcsökkentési támogatás mértéke nem haladhatja meg az adósságkezelés körébe bevont adósság 75%-át, és összege legfeljebb háromszázezer forint, az 55. § (6) bekezdése szerinti esetben legfeljebb hatszázezer forint lehet. A támogatás – az 55. § (6) bekezdése kivételével – egy összegben vagy havi részletekben nyújtható az adós vállalásától függően.

(3) Azon személynek, akinek vezetékes gáz-, illetőleg áramszolgáltatási díjtartozása miatt a szolgáltatást kikapcsolták, a szolgáltatás visszaállítása érdekében előrefizetős gáz- vagy áramszolgáltatást mérő készülék is biztosítható, feltéve, hogy lakásfenntartási támogatásban részesül és tartozásának megfizetése érdekében megállapodást köt a szolgáltatóval, valamint legalább egyéves időtartamra vállalja a készülék rendeltetésszerű használatát.

(4) Az adósságcsökkentés címén nyújtott támogatás vissza nem térítendő szociális támogatásnak minősül.

(5) Az önkormányzat a lakhatást veszélyeztető mértékű adósság felhalmozódásának elkerülése céljából a követelés jogosultjával megállapodást köthet, melynek keretében – az adós írásbeli beleegyezése esetén – a követelés jogosultja az adós lakóhelye szerint illetékes település jegyzőjét félévente tájékoztatja a legalább három havi tartozást felhalmozó adósokról.

55/B. § (1) Az adósságcsökkentési támogatás tovább nem folyósítható, és a kifizetett összeget vissza kell téríteni, ha a jogosult
a) az adósságkezelési tanácsadást nem veszi igénybe, vagy
b) az általa vállalt adósságtörlesztés három havi részletét nem teljesíti, illetőleg
c) az adósságkezelési szolgáltatás igénybevételének időtartama alatt a lakásfenntartási kiadásokkal kapcsolatos fizetési kötelezettségének három hónapig nem tesz eleget.

(2) Az adósságcsökkentési támogatás (1) bekezdésben foglaltak szerinti megszüntetésétől számított 24 hónapon belül ismételten nem állapítható meg.

(3) Ugyanazon személy vagy háztartásának tagja az adósságkezelési szolgáltatás lezárásától – ide nem értve az (1) bekezdés szerinti megszüntetést – számított 6 hónapon belül nem részesülhet adósságkezelési szolgáltatásban.

55/C. § (1) A települési önkormányzat adósságkezelési szolgáltatást akkor nyújthat, ha
a) az adósságkezelési szolgáltatás működtetéséről önkormányzati rendeletet alkot,
b) adósságkezelési tanácsadást működtet, továbbá
c) az adósságcsökkentési támogatás és a 38. § (5) bekezdés szerinti lakásfenntartási támogatás nyújtásához saját forrást különít el.

(2) A fővárosi kerületi önkormányzat, valamint az a települési önkormányzat, amelyiknek területén negyvenezernél több állandó lakos él, köteles adósságkezelési szolgáltatást nyújtani.

(3) A települési önkormányzat a külön jogszabályban meghatározott feltételek szerint az adósságkezelési tanácsadást saját intézménye vagy más szerv útján biztosíthatja.

(4) Az önkormányzat rendeletében szabályozza az adósságkezelési szolgáltatás részletes szabályait, így különösen a helyben elismerhető lakásnagyságot és minőséget, az 55/B. § (3) bekezdésében meghatározottak közül az adósságkezelési szolgáltatásba bevont adósságtípusok körét és összegük felső határát, az adósságcsökkentési támogatás folyósításának módját, az adósságkezelési szolgáltatásra vonatkozó jövedelmi és vagyoni jogosultsági feltételeket, a hitellel terhelt ingatlan forgalmi értékének megállapítási módját, az eljárási szabályokat, az adósságkezelési tanácsadást végző intézmény által ellátandó feladatokat, az adósságkezelési tanácsadáson való részvétel módját.

Energiafelhasználási támogatás

55/D. § (1) Az energiafelhasználási támogatás (e § alkalmazásában a továbbiakban: támogatás) a gázfogyasztáshoz, a földgázalapú hőfelhasználáshoz és a távhőfelhasználáshoz külön jogszabályban meghatározottak szerint nyújtott támogatás. A támogatásra az I. Fejezet III. címét nem kell alkalmazni.

(2) A kincstár a támogatás megállapításával, érvényesítésével, a jogszerű igénybevétel ellenőrzésével és a jogosulatlanul igénybe vett támogatás visszakövetelésével kapcsolatos feladatainak teljesítése céljából nyilvántartást vezet. A nyilvántartás tartalmazza:

a) a támogatást igénylő személy, valamint a háztartása tagjainak természetes személyazonosító adatait;

b) a támogatást igénylő személy belföldi lakó-, illetve tartózkodási helyét;

c) a támogatást igénylő személy, valamint a háztartása tagjainak adóazonosító jelét;

d) a jogosultsági feltételekre vonatkozó, illetve a támogatás mértékének megállapításához – így különösen a fogyasztó, valamint a fogyasztási hely azonosításához, valamint a fogyasztó által felhasznált hőmennyiség megállapításához – szükséges adatokat;

e) a támogatást igénylő személy, valamint a háztartása tagjainak a jogosultság megállapításához szükséges jövedelmi adatait;

f) a támogatás megállapítására, megszüntetésére, illetve visszakövetelésére vonatkozó döntést.

(3) A (2) bekezdés *a)–e)* pontja szerinti adatokat a kincstár a támogatást igénylő személy adatszolgáltatása alapján gyűjti és tartja nyilván. A kincstár a támogatás jogszerű igénybevételének ellenőrzése céljából

a) a (2) bekezdés *a)–b)* pontjában foglalt adatok tekintetében a polgárok személyi adatainak és lakcímének nyilvántartását kezelő központi szervtől,

b) a (2) bekezdés *c)* és *e)* pontjában foglalt adatok tekintetében az állami adóhatóságtól, továbbá

c) a (2) bekezdés *d)* pontjában foglalt adatok tekintetében a támogatást igénylő személy részére szolgáltatási vagy közüzemi szerződés alapján gáz-, földgázalapú hő-, illetve távhőszolgáltatást nyújtó, a támogatás érvényesítésére a külön jogszabályban foglaltak szerint jogosult szolgáltatótól (e § alkalmazásában a továbbiakban: szolgáltató)

adatot kérhet.

(4) A (2) bekezdés szerinti nyilvántartásból a támogatás megállapítására jogosult szerv

a) a támogatás jogszerű igénybevételének ellenőrzésével kapcsolatos, külön jogszabályban meghatározott feladatainak teljesítése céljából az állami adóhatóságnak a (2) bekezdés *a)–c),* valamint *e)* pontja szerinti körben,

b) a támogatás érvényesítésével kapcsolatos feladatainak teljesítése céljából a szolgáltatónak, illetőleg a támogatás forrásául szolgáló előirányzat kezelésével kapcsolatos, külön jogszabályban meghatározott közreműködői feladatokat ellátó szervezetnek a (2) bekezdés *a)–b),* valamint *d)* és *f)* pontja szerinti körben,

c) a külön jogszabály szerinti értesítési kötelezettségének ellátása céljából a támogatásra jogosult személy közös képviselőjének a (2) bekezdés *f)* pontja szerinti körben

adatot szolgáltat.

(5) A kincstár a (2) bekezdés szerinti adatokat, továbbá a (4) bekezdésben meghatározott szerv, illetve személy az átadott adatokat a külön jogszabály szerinti jogosultsági időszak végétől számított öt évig tartja nyilván.

(6) A kincstár a nyilvántartásban kezelt adatokat személyes azonosító adatok nélkül statisztikai célra felhasználhatja, illetőleg azokból statisztikai célra adatot szolgáltathat.

1997. évi XXXI. a gyermekek védelméről és a gyámügyi igazgatásról

A törvény hatálya

4. § (1) A törvény hatálya kiterjed

a) a (2) és (3) bekezdésben foglalt eltéréssel a Magyar Köztársaság területén tartózkodó magyar állampolgárságú, valamint – ha nemzetközi szerződés másként nem rendelkezik – a letelepedett, bevándorolt, illetve befogadott jogállású, továbbá a magyar hatóságok által menekültként, oltalmazottként, illetve hontalanként elismert gyermekre, fiatal felnőttre és szüleire;

b) a szabad mozgás és tartózkodás jogával rendelkező személyek beutazásáról és tartózkodásáról szóló törvény (a továbbiakban: Szmtv.) szerint a szabad mozgás és tartózkodás jogával rendelkező személyre, amennyiben az ellátás igénylésének időpontjában az Szmtv.-ben meghatározottak szerint a szabad mozgás és a három hónapot meghaladó tartózkodási jogát a Magyar Köztársaság területén gyakorolja, és a polgárok személyi adatainak és lakcímének nyilvántartásáról szóló törvény szerint bejelentett lakóhellyel rendelkezik;

c) a menedékjogról szóló törvény szerint, arra a tizennyolcadik életévét be nem töltött menedékjogi kérelmet benyújtó külföldi gyermekre, aki jogszabály vagy szokás alapján felügyeletéért felelős nagykorú személy kísérete nélkül lépett a Magyar Köztársaság területére, vagy a belépést követően maradt felügyelet nélkül, mindaddig amíg ilyen személy felügyelete alá kerül – feltéve, hogy az illető gyermek kiskorúságát a menekültügyi hatóság megállapította.

(2) A törvény hatálya a rendkívüli gyermekvédelmi támogatás tekintetében az (1) bekezdésben foglaltakon túlmenően kiterjed az Európai Szociális Kartát megerősítő országok állampolgárainak a Magyar Köztársaság területén jogszerűen tartózkodó gyermekeire is.

(3) E törvény szerint kell eljárni az (1) és (2) bekezdésben meghatározott személyeken kívül a Magyar Köztársaság területén tartózkodó nem magyar állampolgárságú gyermek védelmében is, ha az ideiglenes hatályú elhelyezésnek, a nevelési felügyelet elrendelésének vagy az eseti gondnok kirendelésének az elmulasztása a gyermek veszélyeztetettségével vagy elháríthatatlan kárral járna. A Magyar Köztársaság területén a szabad mozgás és tartózkodás jogával rendelkező és szokásos tartózkodási helyet létesítő gyermek védelmét szolgáló eljárás során e törvény rendelkezéseit kell alkalmazni, feltéve, hogy a házassági ügyekben és a szülői felelősségre vonatkozó eljárásokban a joghatóságról, valamint a határozatok elismeréséről és végrehajtásáról, illetve az 1347/2000/EK rendelet hatályon kívül helyezéséről szóló 2201/2003/EK tanácsi rendelet vagy nemzetközi szerződés eltérően nem rendelkezik.

(4) A Magyar Köztársaság területén kívül tartózkodó magyar állampolgárságú gyermek és fiatal felnőtt, valamint szülei gyámügyében e törvényt akkor kell alkalmazni, ha nemzetközi szerződés vagy más jogszabály szerint a személyes joguk az irányadó.

Értelmező rendelkezések

5. § E törvény alkalmazásában

a) gyermek: a Magyar Köztársaság Polgári Törvénykönyvéről szóló 1959. évi IV. törvény (a továbbiakban: Ptk.) 12. §-a szerinti kiskorú,

b) fiatalkorú: az a személy, aki a szabálysértés vagy a bűncselekmény elkövetésekor 14. évét betöltötte, de 18. évét még nem,

c) fiatal felnőtt: az a nagykorú személy, aki a 24. évét nem töltötte be,

d) a gyermek hozzátartozói: a vér szerinti és az örökbe fogadó szülők (a továbbiakban együtt: szülő), a szülő házastársa, a szülő testvére, a nagyszülő, a nagyszülő házastársa, a nagyszülő testvére, a dédszülő, a testvér, a testvér házastársa, a saját gyermek,

e) a gyermek közeli hozzátartozói: ha e törvény másképp nem rendelkezik, a szülő, a szülő házastársa, a szülő testvére, a nagyszülő, testvér, a saját gyermek,

f) a gyermek tartására köteles személy: a házasságról, a családról és a gyámságról szóló 1952. évi IV. törvény (a továbbiakban: Csjt.) 61. §-a (4) bekezdésében és 62. §-a (1) bekezdésében, a Csjt. 69/A. §-ában, valamint a 69/D. § (2) bekezdésében meghatározott személy,

g) gyermekjóléti és gyermekvédelmi szolgáltató tevékenység: a gyermekjóléti alapellátás, illetve a gyermekvédelmi szakellátás keretében – működési engedéllyel – végzett tevékenység, függetlenül a feladatellátás e törvényben nevesített formájától és módjától; a szolgáltató tevékenység célja a gyermekjólétnek, azaz a gyermek testi, értelmi, érzelmi és erkölcsi fejlődésének, személyi, vagyoni és egyéb jogainak biztosítása,

h) gyermeki jogok: a Magyar Köztársaság Alkotmányában, a Gyermek jogairól szóló, New Yorkban, 1989. november 20-án kelt Egyezmény kihirdetéséről szóló 1991. évi LXIV. törvényben és más törvényekben megfogalmazott, a gyermeket megillető jogok összessége,

i) ellátás: jogszabályban meghatározott pénzbeli, természetbeni, illetve személyes gondoskodást nyújtó alapellátás és szakellátás,

j) természetbeni ellátás: olyan támogatás, amellyel a gyermeket alapvető szükségleteinek kielégítésében az állam (önkormányzat) anyagi javak biztosításával, szolgáltatások kifizetésével és nyújtásával segíti,

k) gyámhatóság: a települési önkormányzat jegyzője és a gyámhivatal,

l) gyámügy: a jogszabály által a gyámhatóság feladat- és hatáskörébe utalt ügyek köre,

m) gyermekvédelmi gondoskodás: az e törvényben meghatározottak szerint elrendelt hatósági intézkedésen alapuló ellátás és védelem,

n) veszélyeztetettség: olyan – a gyermek vagy más személy által tanúsított – magatartás, mulasztás vagy körülmény következtében kialakult állapot, amely a gyermek testi, értelmi, érzelmi vagy erkölcsi fejlődését gátolja vagy akadályozza,

o) várandós anya válsághelyzete: olyan családi, környezeti, szociális, társadalmi helyzet vagy ezek következtében kialakult állapot, amely a várandós anya testi vagy lelki megrendülését, társadalmi ellehetetlenülését okozza, és ezáltal veszélyezteti a gyermek egészséges megszületését,

p) tartós betegség: azon kórforma, amely a külön jogszabályban meghatározott magasabb összegű családi pótlékra jogosít,

q) fogyatékos gyermek, fiatal felnőtt:

qa) a gyermekvédelmi pénzbeli és természetbeni ellátások tekintetében a külön jogszabályban meghatározott magasabb összegű családi pótlékra jogosító fogyatékosságban szenvedő gyermek, fiatal felnőtt,

qb) a személyes gondoskodás keretébe tartozó gyermekjóléti alapellátások és gyermekvédelmi szakellátások, valamint a gyermekétkeztetés normatív kedvezménye tekintetében a közoktatásról szóló 1993. évi LXXIX. törvény (a továbbiakban: Kt.) 121. §-a (1) bekezdésének 29. *a)* pontjában foglaltaknak megfelelő gyermek, fiatal felnőtt,

r) jövedelem: a szociális igazgatásról és szociális ellátásokról szóló 1993. évi III. törvény (a továbbiakban: Szt.) 4. §-a (1) bekezdésének *a)* pontjában meghatározattak,

s) fenntartó:

sa) a központi költségvetési szerv, a helyi önkormányzat, a helyi önkormányzatok társulásairól és együttműködéséről szóló 1997. évi CXXXV. törvény 8. §-a, 9. §-a, illetve 16. §-a szerinti intézményi társulás, a települési önkormányzatok többcélú kistérségi társulása, a

települési kisebbségi önkormányzat és a területi kisebbségi önkormányzat (a továbbiakban együtt: állami fenntartó),

sb) a lelkiismereti és vallásszabadságról, valamint az egyházakról szóló 1990. évi IV. törvény (a továbbiakban: Ltv.) szerinti, magyarországi székhelyű egyház, az egyházaknak az Ltv. 14. §-a szerinti magyarországi székhelyű szövetsége, illetve az Ltv. 13. §-ának (2)–(3) bekezdése szerinti magyarországi székhelyű egyházi jogi személy, amennyiben az egyház a Kormánnyal a gyermekjóléti, gyermekvédelmi vagy a szociális feladatok ellátására is kiterjedő megállapodást kötött, ideértve a Magyar Köztársaság és az Apostoli Szentszék között a Katolikus Egyház magyarországi közszolgálati és hitéleti tevékenységének finanszírozásáról, valamint néhány vagyoni természetű kérdésről 1997. június 20-án, Vatikánvárosban aláírt Megállapodás alapján a Magyar Katolikus Egyházat is (a továbbiakban együtt: egyházi fenntartó); nem minősül egyházi fenntartónak az a jogi személy, amely más típusú szervezetként jogalanyisággal rendelkezik, így különösen a társadalmi szervezet, annak alapszabályban jogi személlyé nyilvánított szervezeti egysége, az alapítvány, annak alapító okiratban jogi személlyé nyilvánított szervezeti egysége, a gazdasági társaság és a közhasznú társaság,

sc) az egyéni vállalkozó,

sd) az *sa)–sb)* alpontokban nem említett, magyarországi székhelyű jogi személy, jogi személyiség nélküli gazdasági társaság és egyéni cég,

se) az Európai Gazdasági Térségről szóló megállapodásban részes valamely államban (a továbbiakban: EGT-állam), valamint – ha az Európai Közösséggel és tagállamaival létrejött nemzetközi szerződés alapján az adott állam szolgáltatói a letelepedés szabadsága tekintetében az EGT-államok szolgáltatóival azonos jogállást élveznek – az EGT-államoktól eltérő más államban honos vállalkozás belföldön bejegyzett fióktelepe [az sc)–se) pontokban foglaltak a továbbiakban együtt: nem állami fenntartó],

ha az e törvényben és más jogszabályban meghatározott feltételek szerint, működési engedély alapján gondoskodik a gyermekjóléti és gyermekvédelmi szolgáltató tevékenység biztosításához szükséges feltételekről. Ha jogszabály másképp nem rendelkezik, az egyházi fenntartóra a nem állami fenntartóra vonatkozó rendelkezéseket kell megfelelően alkalmazni.

t) személyazonosító adat: az érintett személy természetes személyazonosító adatai, neme, állampolgársága, bevándorolt, letelepedett, oltalmazott vagy menekült jogállása, lakó- és tartózkodási helye,

u) intézmény: az e törvényben meghatározott gyermekjóléti és gyermekvédelmi szolgáltató tevékenységet végző szervezet vagy annak szakmailag önálló szervezeti egysége, amely a rá vonatkozó külön jogszabályban foglaltak alapján jön létre, legalább három főt foglalkoztat teljes munkaidőben, és tevékenysége működési engedélyköteles. Ha e törvény másképp nem rendelkezik, az intézmény fogalmát kell megfelelően alkalmazni a helyettes szülői, illetve nevelőszülői hálózatra is,

v) működtető: az a természetes személy, jogi személy, illetve ezek jogi személyiség nélküli szervezete, aki, illetve amely a fenntartó által biztosított működési feltételek között a gyermekjóléti és gyermekvédelmi szolgáltató tevékenységet szervezi,

x) államilag támogatott lakás-előtakarékossági programban való részvétel: a lakástakarékpénztárakról szóló 1996. évi CXIII. törvény szerinti lakás-előtakarékossági szerződés megkötése és teljesítése,

y) családi pótlék: a családok támogatásáról szóló 1998. évi LXXXIV. törvény (a továbbiakban: Cst.) 5. §-ának *a)* pontja szerinti nevelési ellátás és iskoláztatási támogatás,

z) rendszeres jövedelem: a legalább három egymást követő hónapban keletkezett jövedelem.

IV. Fejezet

Pénzbeli és természetbeni ellátások

18. § (1) A jogosult gyermek számára

a) a települési (fővárosi kerületi, a továbbiakban együtt: települési) önkormányzat jegyzője az e törvényben meghatározott feltételek szerint rendszeres gyermekvédelmi kedvezményre való jogosultságot,

b) a települési önkormányzat képviselő-testülete az e törvényben, illetve az önkormányzat rendeletében meghatározott feltételek szerint rendkívüli gyermekvédelmi támogatást

állapít meg.

(2) A települési önkormányzat képviselő-testülete a hatáskörébe tartozó ellátást kiegészítheti, valamint a rendeletében meghatározott módon és feltételek szerint a gyermek és fiatal felnőtt rászorultságára tekintettel más pénzbeli támogatásokat is megállapíthat.

(3) E törvény szerint a gyámhivatal a gyermek gondozó szülőjének vagy más törvényes képviselőjének a gyermektartásdíjat megelőlegezi, a jogosult fiatal felnőttnek otthonteremtési támogatást állapít meg, és ezen pénzbeli ellátások folyósításáról rendelkezik.

(4) Az (1) bekezdésben meghatározott pénzbeli és természetbeni ellátások megállapítását nevelési-oktatási intézmény, gyámhatóság, továbbá más családvédelemmel foglalkozó intézmény, illetve természetes személy vagy a gyermekek érdekeinek védelmét ellátó társadalmi szervezet kezdeményezheti.

(5) A települési önkormányzat képviselő-testületének döntése alapján a rendkívüli gyermekvédelmi támogatás természetbeni ellátás formájában is nyújtható, különösen a védelembe vett gyermekek számára.

(6) Természetbeni ellátás különösen az általános iskolás gyermekek tankönyv- és tanszerellátásának támogatása, a tandíj, egészségügyi szolgáltatásért fizetendő térítési díj, illetve egyéb ellátás kifizetésének átvállalása.

18/A. § (1) A pénzbeli és természetbeni ellátás iránti kérelmet az a 18. § (1) vagy (3) bekezdése szerinti szerv bírálja el, amelynek illetékességi területén a kérelmező lakcíme van. Ha a kérelmezőnek több lakcíme van, az illetékességet az a lakóhely vagy tartózkodási hely alapozza meg, ahol életvitelszerűen lakik.

(2) A lakcím megállapítása szempontjából a személyiadat- és lakcímnyilvántartás adatai irányadóak.

Rendszeres gyermekvédelmi kedvezmény

19. § (1) A rendszeres gyermekvédelmi kedvezményre való jogosultság megállapításának célja annak igazolása, hogy a gyermek szociális helyzete alapján jogosult

a) a 148. § (5) bekezdésének *a)* és *b)* pontjában meghatározott gyermekétkeztetés normatív kedvezményének,

b) a 20/A. §-ban meghatározott pénzbeli támogatásnak,

c) a külön jogszabályban meghatározott egyéb kedvezményeknek

az igénybevételére.

(2) A települési önkormányzat jegyzője megállapítja a gyermek rendszeres gyermekvédelmi kedvezményre való jogosultságát, amennyiben a gyermeket gondozó családban az egy főre jutó havi jövedelem összege nem haladja meg

a) az öregségi nyugdíj mindenkori legkisebb összegének (a továbbiakban: az öregségi nyugdíj legkisebb összege) a 140%-át,

aa) ha a gyermeket egyedülálló szülő, illetve más törvényes képviselő gondozza, vagy

ab) ha a gyermek tartósan beteg, illetve súlyosan fogyatékos, vagy

ac) ha a nagykorúvá vált gyermek megfelel a 20. § (3) vagy (4) bekezdésében foglalt feltételeknek;

b) az öregségi nyugdíj legkisebb összegének 130%-át az *a)* pont alá nem tartozó esetben,

feltéve, hogy a vagyoni helyzet vizsgálata során az egy főre jutó vagyon értéke nem haladja meg külön-külön vagy együttesen a (7) bekezdésben meghatározott értéket.

(3) Az egy főre jutó jövedelem megállapításánál a 131. § (2) bekezdését kell alkalmazni. Ettől eltérni akkor lehet, ha a jövedelmi viszonyokban igazolható ok miatt tartós romlás vélelmezhető.

(4) A (2) bekezdésben meghatározott összeg számításánál – a kérelem benyújtásának időpontjában – közös háztartásban élő közeli hozzátartozóként (gondozó családként) kell figyelembe venni

a) a szülőt, a szülő házastársát vagy élettársát,

b) a 20 évesnél fiatalabb, önálló keresettel nem rendelkező gyermeket,

c) a 23 évesnél fiatalabb, önálló keresettel nem rendelkező, a nappali oktatás munkarendje szerint tanulmányokat folytató gyermeket,

d) a 25 évesnél fiatalabb, önálló keresettel nem rendelkező, felsőoktatási intézmény nappali tagozatán tanulmányokat folytató gyermeket,

e) korhatárra való tekintet nélkül a tartósan beteg, illetőleg a fogyatékos gyermeket,

f) az *a)–e)* pontokba nem tartozó, a Csjt. alapján a szülő vagy házastársa által eltartott rokont.

(5)

(6) A vagyoni helyzet vizsgálata kiterjed a (4) bekezdésben meghatározott közös háztartásban élő közeli hozzátartozók vagyonára.

(7) Vagyon alatt azt a hasznosítható ingatlant, járművet, továbbá vagyoni értékű jogot kell érteni, amelynek egy főre jutó értéke a gyermeket gondozó családban

a) külön-külön számítva az öregségi nyugdíj legkisebb összegének húszszorosát, vagy

b) együtt számítva az öregségi nyugdíj legkisebb összegének hetvenszeresét

meghaladja, azzal, hogy nem minősül vagyonnak az az ingatlan, amelyben a szülő vagy a tartásra köteles más törvényes képviselő életvitelszerűen lakik, az a vagyoni értékű jog, amely az általuk lakott ingatlanon áll fenn, továbbá a mozgáskorlátozottságra vagy tartós betegségre tekintettel fenntartott gépjármű.

(8) A települési önkormányzat jegyzője a rendszeres gyermekvédelmi kedvezményre való jogosultság megállapítására irányuló kérelmet elutasítja, ha a (4) bekezdésben megjelölt személyek együttesen vagy külön-külön a (7) bekezdésben meghatározott értékű vagyonnal rendelkeznek.

(9) Nem állapítható meg rendszeres gyermekvédelmi kedvezményre való jogosultság, illetőleg a megállapított jogosultságot meg kell szüntetni, ha a gyermek tartózkodási joga megszűnt vagy tartózkodási jogának gyakorlásával felhagyott.

20. § (1) A rendszeres gyermekvédelmi kedvezményre való jogosultság megállapítását a szülő vagy más törvényes képviselő, illetve a nagykorú jogosult a lakcíme szerint illetékes települési önkormányzat polgármesteri hivatalánál terjeszti elő.

(2) A feltételek fennállása esetén a települési önkormányzat jegyzője 1 év időtartamra megállapítja a gyermek rendszeres gyermekvédelmi kedvezményre való jogosultságát.

(3) Az egyéb jogosultsági feltételek fennállása esetén nagykorúvá válása után is jogosult a gyermek a rendszeres gyermekvédelmi kedvezményre, ha

a) nappali oktatás munkarendje szerint tanulmányokat folytat és 23. életévét még nem töltötte be, vagy

b) felsőfokú oktatási intézmény nappali tagozatán tanul és a 25. életévét még nem töltötte be.

(4) Házasságkötés esetén a rendszeres gyermekvédelmi kedvezményre való jogosultságot meg kell szüntetni, ha a jogosult házasságkötése szerinti új családban az egy főre jutó havi jövedelem összege, illetve vagyon értéke meghaladja a 19. §-ban meghatározott jövedelemhatárt, illetve vagyon értékét.

20/A. § (1) A települési önkormányzat jegyzője annak a gyermeknek, fiatal felnőttnek, akinek rendszeres gyermekvédelmi kedvezményre való jogosultsága

a) a tárgyév augusztus 1-jén fennáll, a tárgyév augusztus hónapjában,

b) a tárgyév november 1-jén fennáll, a tárgyév november hónapjában

pénzbeli támogatást folyósít.

(2) Az (1) bekezdés szerinti pénzbeli támogatás esetenkénti összege 2006. évben gyermekenként 5000 forint. A 2006. évet követően a pénzbeli támogatás összegének emeléséről az Országgyűlés a költségvetésről szóló törvény elfogadásával egyidejűleg dönt.

Kiegészítő gyermekvédelmi támogatás

20/B. § (1) Kiegészítő gyermekvédelmi támogatásra az a rendszeres gyermekvédelmi kedvezményben részesülő gyermek gyámjául rendelt hozzátartozó jogosult, aki

a) a gyermek tartására köteles, és

b) nyugellátásban, vagy baleseti nyugellátásban, vagy nyugdíjszerű rendszeres szociális pénzellátásban, vagy időskorúak járadékában részesül.

(2) A kiegészítő gyermekvédelmi támogatásra való jogosultságot a gyám lakcíme szerint illetékes települési önkormányzat jegyzője – határozatlan időre – állapítja meg.

(3) A kiegészítő gyermekvédelmi támogatás havi összege – gyermekenként – az öregségi nyugdíj mindenkori legkisebb összegének 22 százaléka.

(4) A települési önkormányzat jegyzője annak a gyámul kirendelt hozzátartozónak, akinek kiegészítő gyermekvédelmi támogatásra való jogosultsága

a) a tárgyév augusztus 1-jén fennáll, a tárgyév augusztus hónapjában – az augusztus hónapra járó kiegészítő gyermekvédelmi támogatás összege mellett –,

b) a tárgyév november 1-jén fennáll, a tárgyév november hónapjában – a november hónapra járó kiegészítő gyermekvédelmi támogatás összege mellett –

pótlékot folyósít.

(5) A (4) bekezdés szerinti pótlék esetenkénti összege 2006. évben gyermekenként 7500 forint. A 2006. évet követően a pótlék összegének emeléséről az Országgyűlés a költségvetésről szóló törvény elfogadásával egyidejűleg dönt.

(6) Ha a kiegészítő gyermekvédelmi támogatást jogerősen megállapították, az a kérelem benyújtásától esedékes azzal, hogy ha a kérelmet

a) a tárgyhónap tizenötödikéig nyújtották be, a támogatás teljes összegét,

b) a tárgyhónap tizenötödikét követően nyújtották be, a támogatás ötven százalékát

kell kifizetni.

(7) A kiegészítő gyermekvédelmi támogatásra való jogosultság feltételeit – az (1) bekezdésben meghatározottak alapulvételével – a települési önkormányzat jegyzője évente legalább egyszer felülvizsgálja. Ha a kiegészítő gyermekvédelmi támogatásra való jogosultság megszűnik, az a jogosultság megszűnésének hónapjáig esedékes azzal, hogy ha a megszűnés

a) a tárgyhónap tizenötödikéig következik be, a támogatás ötven százalékát,

b) a tárgyhónap tizenötödikét követően következik be, a támogatás teljes összegét

kell kifizetni.

Óvodáztatási támogatás

20/C. § (1) A települési önkormányzat jegyzője annak a rendszeres gyermekvédelmi kedvezményben részesülő gyermeknek a szülője részére, aki a három-, illetve négyéves gyermekét beíratta az óvodába, továbbá gondoskodik gyermeke rendszeres óvodába járatásáról, és akinek rendszeres gyermekvédelmi kedvezményre való jogosultsága fennáll

a) a gyermek óvodai beíratását követően első alkalommal, ha a gyermek óvodai beíratása

aa) a naptári év első felében történik és a gyermek óvodai nevelésben való részvétele óta legalább két hónap eltelt, a beíratás évének június hónapjában,

ab) a naptári év első felében történik, de júniusig nem telt el két hónap, a beíratás évének december hónapjában,

ac) a naptári év második felében történik és a gyermek óvodai nevelésben való részvétele óta legalább két hónap eltelt, a beíratás évének december hónapjában,

ad) a naptári év második felében történik, de a beíratás évében decemberig nem telt el két hónap, a következő év június hónapjában [a továbbiakban az *aa)–ad)* pont alattiak együtt: első alkalom],

b) a gyermek beíratását követően második és további alkalommal az óvodai nevelési jogviszony fennállásáig

ba) a tárgyév június hónapjában,

bb) a tárgyév december hónapjában,

pénzbeli támogatást folyósít.

(2) Az (1) bekezdés szerinti pénzbeli támogatás folyósításának további feltétele, hogy a gyermek felett a szülői felügyeleti jogot gyakorló szülő, illetve ha mindkét szülő gyakorolja a szülői felügyeleti jogot, mindkét szülő a jegyzői eljárásban önkéntes nyilatkozatot tegyen arról, hogy gyermekének hároméves koráig legfeljebb az iskola nyolcadik évfolyamán folytatott tanulmányait fejezte be sikeresen.

(3) Az (1) bekezdés szerinti pénzbeli támogatás összege a 2009. évben gyermekenként első alkalommal húszezer forint, ezt követőn esetenként és gyermekenként tízezer forint. A 2009. évet követően az összeg emeléséről az Országgyűlés a költségvetésről szóló törvény elfogadásával egyidejűleg dönt.

(4) A helyi önkormányzat rendeletben előírhatja, hogy az első alkalommal folyósításra kerülő pénzbeli támogatás helyett a szülőnek gyermeke részére természetbeni támogatás nyújtható. A természetbeni támogatást a gyermek beíratását követő legfeljebb huszonegy napon belül kell a szülő rendelkezésére bocsátani.

Rendkívüli gyermekvédelmi támogatás

21. § (1) A települési önkormányzat képviselő-testülete a gyermeket a rendeletében meghatározott mértékű rendkívüli gyermekvédelmi támogatásban részesíti (a továbbiakban: rendkívüli támogatás), ha a gyermeket gondozó család időszakosan létfenntartási gondokkal küzd, vagy létfenntartást veszélyeztető rendkívüli élethelyzetbe került.

(2) Elsősorban azokat a gyermekeket, illetve családokat kell alkalmanként rendkívüli támogatásban részesíteni, akiknek az ellátásáról más módon nem lehet gondoskodni, illetve az alkalmanként jelentkező többletkiadások – különösen a válsághelyzetben lévő várandós anya gyermekének megtartása, a gyermek fogadásának előkészítéséhez kapcsolódó kiadások, a nevelésbe vett gyermek családjával való kapcsolattartásának, illetve a gyermek családba való visszakerülésének elősegítése, betegség vagy iskoláztatás – miatt anyagi segítségre szorulnak.

(3) A rendkívüli támogatás iránti kérelmet a szülő vagy más törvényes képviselő a lakcíme szerint illetékes települési önkormányzat polgármesteri hivatalánál vagy az önkormányzat rendeletében meghatározott szervnél terjeszti elő.

Gyermektartásdíj megelőlegezése

22. § (1) A gyermektartásdíj megelőlegezésének akkor van helye, ha

a) a bíróság a tartásdíjat jogerős határozatában már megállapította vagy van olyan külföldi bíróság, vagy más hatóság által hozott jogerős határozat, amelyet a Magyarországon élő gyermek javára nemzetközi szerződés vagy viszonosság alapján kell végrehajtani, és

b) a gyermektartásdíj összegének behajtása átmenetileg lehetetlen, továbbá

c) a gyermeket gondozó szülő vagy más törvényes képviselő nem képes a gyermek részére a szükséges tartást nyújtani,

feltéve, hogy a gyermeket gondozó családban az egy főre jutó havi átlagjövedelem nem éri el az öregségi nyugdíj legkisebb összegének kétszeresét.

(2) Az egy főre jutó jövedelem megállapításánál a 131. § (2) bekezdését kell alkalmazni.

(3) A gyámhivatal a gyermektartásdíj behajthatatlanságát a gyermektartásdíj fizetésére kötelezett személy rendszeres jövedelmére, illetve egyéb vagyonára vezetett eredménytelen végrehajtást követően állapítja meg. Az eredménytelen végrehajtást, illetve a végrehajtás szünetelését kimondó foglalási jegyzőkönyv hat hónapnál régebbi nem lehet.

(4) Az (1) bekezdésben meghatározott összeg számításánál a kérelem benyújtása időpontjában közös háztartásban élő közeli hozzátartozóként kell figyelembe venni a 19. § (4) bekezdésében meghatározott személyeket.

(5) Nincs helye a gyermektartásdíj megelőlegezésének, ha a kötelezett

a) lakóhelye olyan államban van, ahol a tartásdíj nemzetközi szerződés vagy viszonosság alapján nem érvényesíthető, vagy

b) külföldi tartózkodási helye ismeretlen, vagy

c)

d) a jogosulttal közös háztartásban él, vagy

e)

(6) Nincs helye továbbá a gyermektartásdíj megelőlegezésének

a) részösszegű megfizetés vagy részösszegű behajthatóság esetén, ha ennek mértéke a bíróság által megállapított gyermektartásdíj alapösszegének ötven százalékát meghaladja, vagy

b) lejárt gyermektartásdíj esetén.

(7) A feltételek fennállása esetén a gyermektartásdíj megelőlegezése a gyermek nagykorúvá válása után is megállapítható, illetve a már megállapított gyermektartásdíj továbbfolyósítható

addig az időpontig, ameddig a középfokú nappali oktatás munkarendje szerinti tanulmányokat folytat, de legfeljebb huszadik évének betöltéséig.

23. § (1) A gyámhivatal a bíróság által a tartásdíj megfizetésére kötelező határozatában megállapított összeget, százalékos marasztalás esetében az alapösszeget előlegezi meg.

(2) A gyámhivatal az (1) bekezdésben meghatározott összegnél alacsonyabb összeget akkor állapíthat meg, ha a gyermek tartását a gondozó szülő részben biztosítani tudja. A megelőlegezett összeg ebben az esetben sem lehet kevesebb a bíróság által megállapított összeg 50%-ánál.

(3) A gyámhivatal a gyermektartásdíj megelőlegezését elrendelő határozatát a fellebbezésre tekintet nélkül végrehajthatóvá nyilváníthatja.

(4) A gyámhivatal határozata alapján a – székhelye szerinti – települési önkormányzat jegyzője a gyermektartásdíj megelőlegezését a központi költségvetés terhére biztosítja.

24. § (1) Ha a gyermektartásdíj megelőlegezését jogerősen megállapítják, az a kérelem benyújtásától esedékes. A folyósítás időtartama a kérelem benyújtásának napjától az alapul szolgáló ok előrelátható fennállásáig, legfeljebb azonban három évig tart. A feltételek fennállása esetén – függetlenül az adók módjára történő behajtás eredményétől – ugyanazon gyermekre tekintettel, egy alkalommal, legfeljebb további három évre a megelőlegezés továbbfolyósítható, illetve ismételten elrendelhető.

(2) Ha a gyermektartásdíj megelőlegezését jogerősen elrendelték, az a kérelem benyújtásától esedékes, azzal, hogy ha a kérelmet

a) a tárgyhónap 15-éig nyújtották be, a gyermektartásdíj megelőlegezését elrendelő jogerős határozatban megállapított teljes összeget,

b) a tárgyhónap 15-ét követően nyújtották be, a gyermektartásdíj megelőlegezését elrendelő jogerős határozatban megállapított összeg 50%-át

kell kifizetni.

(3) A gyámhivatal hivatalból vagy a külön jogszabályban meghatározott szervek és személyek értesítése alapján a gyermektartásdíj folyósítását – legfeljebb hat hónapra – felfüggeszti, ha

a) a kérelmezőnek a 22. § (1) bekezdésében meghatározott körülményeiben változás állt be,

b) a kötelezett rendszeres jövedelmére, illetve az egyéb vagyonára vezetett végrehajtás eredménnyel jár,

c) a kötelezett a kérelmező részére közvetlenül fizet tartásdíjat,

d) a gyermek ideiglenes hatályú elhelyezését rendelték el.

(4) A gyámhivatal a felfüggesztést követő vizsgálat eredményeképpen, ha a felfüggesztés időtartama alatt a jogosult nem részesült gyermektartásdíjban – a felfüggesztés lejárta után – elrendeli a gyermektartásdíj további folyósítását és a felfüggesztés időtartamára esedékes megelőlegezett gyermektartásdíj utólagos, egy összegben történő kifizetését vagy a megelőlegezést megszünteti.

(5) A gyámhivatal a gyermektartásdíj megelőlegezését megszünteti, ha

a) a gyermek – a gyámhivatal, illetve a bíróság végrehajtható határozata alapján – a külön élő másik szülő vagy más személy gondozásába kerül,

b) a gyermek nagykorúvá vált, és nappali oktatás munkarendje szerint tanulmányokat nem folytat,

c) a gyermeket a gyámhivatal átmeneti vagy tartós nevelésbe vette,

d) a kötelezett meghalt.

(6)

(7) Ha a gyermektartásdíj megelőlegezésére való jogosultság megszűnik, az a jogosultság megszűnésének hónapjáig esedékes azzal, hogy ha a megszűnés

a) a tárgyhónap 15-éig következik be, a gyermektartásdíj megelőlegezését elrendelő jogerős határozatban megállapított összeg 50%-át,

b) a tárgyhónap 15-ét követően következik be, a gyermektartásdíj megelőlegezését elrendelő jogerős határozatban megállapított teljes összeget

kell kifizetni.

(8) A megelőlegezett gyermektartásdíjat a kötelezett a Polgári Törvénykönyvben meghatározott kamattal az államnak megtéríti. A megelőlegezett gyermektartásdíjnak meg nem térült összegét adók módjára kell behajtani az adózás rendjéről szóló törvény rendelkezései szerint.

(9) A megelőlegezett gyermektartásdíj behajtása során a hátralékra a települési önkormányzat jegyzője adóügyi hatáskörében indokolt esetben méltányosságból részletfizetést vagy kamatelengedést engedélyezhet. A települési önkormányzat jegyzője adóügyi hatáskörében a hátralék teljes összegét akkor engedheti el, ha a kötelezett gyermeke a reá tekintettel megelőlegezett gyermektartásdíjat hagyatéki teherként megörökli.

Otthonteremtési támogatás

25. § (1) Az otthonteremtési támogatás célja, hogy az átmeneti vagy tartós nevelésből kikerült fiatal felnőtt lakáshoz jutását, tartós lakhatása megoldását elősegítse.

(2) Otthonteremtési támogatásra jogosult az a fiatal felnőtt, akinek

a) legalább hároméves időtartamú folyamatos – gondozási helyén töltött – nevelésbe vétele a nagykorúvá válásával szűnt meg, és

b) készpénzének, biztosításra vagy más célból lekötött betétjének, vagy ingatlan vagyonának értéke a nagykorúvá válásakor nem haladja meg az öregségi nyugdíj legkisebb összegének hatvanszorosát, azzal, hogy az öregségi nyugdíj legkisebb összegeként az otthonteremtési támogatás megállapítása időpontjában érvényes öregségi nyugdíj legkisebb összegét kell figyelembe venni.

(3) A készpénz vagyonba a fiatal felnőtt árvaellátásából és keresményéből származó megtakarítást nem lehet beszámítani. A nevelésbe vétel időtartamába az ideiglenes hatályú elhelyezés időtartamát is be kell számítani, feltéve, ha a gyermeket ideiglenesen nevelőszülőnél vagy gyermekotthonban helyezték el.

(4) Akkor is jogosult a fiatal felnőtt a támogatásra, ha a három évnél rövidebb időtartamú nevelésbe vételére a 80. § (1) bekezdésének *a)–c)* pontjában meghatározott okból került sor.

(5) A támogatás felhasználható részben vagy egészben a fiatal felnőtt tulajdonába kerülő építési telek, életvitelszerű lakhatásra alkalmas lakás, családi ház, tanya vásárlására, illetve építésére, lakhatóvá tételére, tulajdon vagy tulajdonrész szerzéssel járó felújítására vagy bővítésére, bérlakás bérleti díjának kifizetésére, önkormányzati bérlakásának felújítására, bérlői jogviszony megvásárlására, államilag támogatott lakásprogramban vagy lakás-előtakarékossági programban való részvételre, valamint otthonteremtést elősegítő hitelintézeti kölcsön egyösszegű törlesztésére. Indokolt esetben az otthonteremtési támogatás felhasználható a tartósan beteg vagy fogyatékos fiatal felnőtt megfelelő ellátását biztosító, az Szt. hatálya alá tartozó bentlakásos szociális intézménybe fizetendő egyszeri hozzájárulásra is.

(6) Az otthonteremtési támogatás iránti kérelemben nyilatkozni kell a (2)–(4) bekezdésben meghatározott feltételekről, valamint arról, hogy a fiatal felnőtt az otthonteremtési támogatás felhasználása során az utógondozójával együttműködik.

(7) A gyámhivatal az otthonteremtési támogatás iránti kérelem megérkezését követő naptól számított tizenöt napon belül az utógondozás vagy utógondozói ellátás alatt nem álló fiatal felnőtt részére a lakcím szerinti területi gyermekvédelmi szakszolgálat utógondozóját rendeli ki. Az otthonteremtési támogatás céljának megvalósulásához az utógondozó a támogatással való elszámolásig segítséget nyújt.

26. § (1) Az otthonteremtési támogatás mértékét a folyamatos nevelésben eltöltött évek és a jogosult készpénz és ingatlan vagyonának együttes értéke alapján úgy kell megállapítani, hogy a vagyonnal nem rendelkező jogosult esetén érje el, a vagyonnal rendelkező jogosult esetén pedig a vagyonnal együtt érje el

a) a négy évnél rövidebb időtartamú nevelésbe vételnél az otthonteremtési támogatás megállapítása idején érvényes öregségi nyugdíj legkisebb összegének negyvenszeresét,

b) a négy évet meghaladó időtartamú nevelésbe vételnél az otthonteremtési támogatás megállapítása idején érvényes öregségi nyugdíj legkisebb összegének ötvenszeresét,

c) az öt évet meghaladó időtartamú nevelésbe vételnél az otthonteremtési támogatás megállapítása idején érvényes öregségi nyugdíj legkisebb összegének hatvanszorosát.

(2) Ha a fiatal felnőtt az otthonteremtési támogatást bérlakás bérleti díjának kifizetésére vagy államilag támogatott lakás-előtakarékossági programban való részvételre használja fel, a gyámhivatal az otthonteremtési támogatás összegének részletekben történő kifizetéséről dönthet.

(3) A fiatal felnőtt az otthonteremtési támogatás gyámhivatal által elfogadott célra történő felhasználásáról legkésőbb a támogatás megállapításától számított egy éven belül okmányokkal igazoltan elszámol, kivéve, ha az otthonteremtési támogatást bérlakás bérleti díjának kifizetésére vagy államilag támogatott lakás-előtakarékossági programban való részvételre használja fel. Ebben az esetben az otthonteremtési támogatás felhasználásáról az utolsó részlet kiegyenlítését követő hónap utolsó napjáig számol el.

(4) A gyámhivatal határozata alapján a – székhelye szerinti – települési önkormányzat jegyzője az otthonteremtési támogatást a központi költségvetés terhére biztosítja.

(5) A gyámhivatal jogosult 5 évi időtartamra elidegenítési tilalmat bejegyeztetni a magyar állam javára az ingatlan-nyilvántartásba, az otthonteremtési támogatással megszerzett ingatlanra.

(6) Az otthonteremtési támogatásra jogosult fiatal felnőtt kérelmére, körülményeinek lényeges változása esetén a gyámhivatal az általa bejegyeztetett elidegenítési tilalmat feloldhatja, illetve a lejárat előtt hozzájárulhat az államilag támogatott lakás-előtakarékossági programba befektetett otthonteremtési támogatás összegének a 25. § (5) bekezdése szerinti célra való felhasználásához. A gyámhivatal az (5) bekezdésben meghatározott elidegenítési tilalmat bejegyezteti a korábbi – az otthonteremtési támogatás felhasználásával a fiatal felnőtt tulajdonába került – ingatlan felhasználásával megszerzett újabb ingatlanra, legfeljebb az előzőleg előírt elidegenítési tilalom időtartamának lejártáig.

(7) Az (5)–(6) bekezdésben meghatározott elidegenítési tilalomból eredő valamennyi polgári jogi jogviszonyban a Magyar Államot a kincstár képviseli.

27. § (1) A gyámhivatal a gyermeket nagykorúságának elérése előtt 6 hónappal írásban tájékoztatja az otthonteremtési támogatás lehetőségéről.

(2) Az otthonteremtési támogatás iránti igényt a kérelmező a nagykorúvá válást követően, de legkésőbb a 30. évének betöltéséig nyújthatja be. E határidő elmulasztása jogvesztő.

289/2007. (X. 31.) Korm. rendelet a lakossági vezetékes gázfogyasztás és távhőfelhasználás szociális támogatásáról

A Kormány a szociális igazgatásról és szociális ellátásokról szóló 1993. évi III. törvény 132. §-a (1) bekezdésének *t)* pontjában kapott felhatalmazás alapján, az Alkotmány 35. §-a (1) bekezdésének *b)* pontjában meghatározott feladatkörében eljárva a következőket rendeli el:

1. § E rendelet alkalmazásában

a) háztartás: az egy lakásban együtt lakó, ott bejelentett lakóhellyel vagy tartózkodási hellyel rendelkező személyek közössége;

b) jövedelem: az elismert költségekkel és a befizetési kötelezettséggel csökkentett

ba) a személyi jövedelemadóról szóló törvény szerint meghatározott, belföldről vagy külföldről származó – megszerzett – vagyoni érték (bevétel), ideértve a jövedelemként figyelembe nem vett bevételt és az adómentes jövedelmet is,

bb) az a bevétel, amely után az egyszerűsített vállalkozói adóról, illetve az egyszerűsített közteherviselési hozzájárulásról szóló törvény szerint adót, illetve hozzájárulást kell fizetni.

Elismert költségnek minősül a személyi jövedelemadóról szóló törvényben elismert költség, valamint a fizetett tartásdíj. Ha a magánszemély az egyszerűsített vállalkozói adó vagy egyszerűsített közteherviselési hozzájárulás alapjául szolgáló bevételt szerez, a bevétel csökkenthető a személyi jövedelemadóról szóló törvény szerint elismert költségnek minősülő igazolt kiadásokkal, ennek hiányában a bevétel 40%-ával. Ha a mezőgazdasági őstermelő adóévi őstermelésből származó bevétele nem több a kistermelés értékhatáránál (illetve ha részére támogatást folyósítottak, annak a folyósított támogatással növelt összegénél), akkor a bevétel csökkenthető az igazolt költségekkel, továbbá a bevétel 40%-ának megfelelő összeggel, vagy a bevétel 85%-ának, illetőleg állattenyésztés esetén 94%-ának megfelelő összeggel.

Befizetési kötelezettségnek minősül a személyi jövedelemadó, az egyszerűsített vállalkozási adó, a magánszemélyt terhelő egyszerűsített közteherviselési hozzájárulás, egészségbiztosítási hozzájárulás és járulék, egészségügyi szolgáltatási járulék, nyugdíjjárulék, nyugdíjbiztosítási járulék, magán-nyugdíjpénztári tagdíj és munkavállalói járulék.

Nem minősül jövedelemnek

1. a temetési segély, az alkalmanként adott átmeneti segély, a lakásfenntartási támogatás, az adósságcsökkentési támogatás,

2. a rendkívüli gyermekvédelmi támogatás, a gyermekek védelméről és a gyámügyi igazgatásról szóló 1997. évi XXXI. törvény (a továbbiakban: Gyvt.) 20/A. §-a szerinti pénzbeli támogatás, a Gyvt. 20/B. §-ának (4)–(5) bekezdése szerinti pótlék, a nevelőszülők számára fizetett nevelési díj és külön ellátmány,

3. az anyasági támogatás,

4. a tizenharmadik havi nyugdíj és a szépkorúak jubileumi juttatása,

5. a személyes gondoskodásért fizetendő személyi térítési díj megállapítása kivételével a súlyos mozgáskorlátozott személyek pénzbeli közlekedési kedvezményei, a vakok személyi járadéka és a fogyatékossági támogatás,

6. a fogadó szervezet által az önkéntesnek külön törvény alapján biztosított juttatás,

7. annak az alkalmi munkavállalói könyvvel történő foglalkoztatásnak a havi ellenértéke, amely a teljes munkaidőben foglalkoztatott munkavállaló külön jogszabály szerinti kötelező legkisebb munkabérének (minimálbér) 50%-át nem haladja meg,

8. a házi segítségnyújtás keretében társadalmi gondozásért kapott tiszteletdíj,

9. az energiafelhasználáshoz nyújtott támogatás;

c) havi jövedelem:

ca) havi rendszerességgel járó – nem vállalkozásból, illetve őstermelői tevékenységből (a továbbiakban együtt: vállalkozás) származó – jövedelem esetén a kérelem benyújtását megelőző hónapban megszerzett jövedelem,

cb) nem havi rendszerességgel szerzett, illetve vállalkozásból származó jövedelem esetén a kérelem benyújtását közvetlenül megelőző tizenkét hónapban szerzett jövedelem egyhavi átlaga, azzal, hogy a vállalkozásból származó jövedelem számításánál azon hónapok esetében, amelyek adóbevallással már lezárt időszakra esnek, a jövedelmet a bevallott éves jövedelemnek e hónapokkal arányos összegében kell beszámítani;

d) nagycsaládos háztartás: az a háztartás, amelyben

da) a családok támogatásáról szóló 1998. évi LXXXIV. törvény (a továbbiakban: Cst.) 11. §-a (1) bekezdésének *e)* vagy *f)* pontjában,

db) nevelőszülőként, hivatásos nevelőszülőként a háztartás legalább három tagja után a Cst. 11. §-a (1) bekezdésének *j)* pontjában

meghatározott összegű családi pótlékban részesülő személy él;

e) gyermek:

ea) a húszévesnél fiatalabb, önálló keresettel nem rendelkező,

eb) a huszonhárom évesnél fiatalabb, önálló keresettel nem rendelkező, nappali oktatás munkarendje szerint tanulmányokat folytató,

ec) a huszonöt évesnél fiatalabb, önálló keresettel nem rendelkező, felsőoktatási intézmény nappali tagozatán tanulmányokat folytató, továbbá

ed) korhatárra való tekintet nélkül a tartósan beteg, az autista, illetve a testi, érzékszervi, értelmi vagy beszédfogyatékos

vér szerinti, örökbe fogadott, illetve nevelt gyermek;

f) háztartási cél: a távhőnek, továbbá a földgáz alapú hőnek (a továbbiakban együtt: távhő), illetve a vezetéken szolgáltatott földgáznak, a vezetéken szolgáltatott propán- és bután gáznak, valamint ezek elegyének (a továbbiakban együtt: gáz) főzés, sütés, vízmelegítés, fűtés, hűtés, valamint használati melegvíz céljára történő felhasználása;

g) társasház:

ga) a társasházakról szóló 2003. évi CXXXIII. törvény alapján társasháznak minősülő épületingatlan,

gb) a *h)* pont *hb)* alpontjában foglaltak szerint szolgáltatónak nem minősülő lakásszövetkezet,

gc) azon egyéb lakóépület, amely műszakilag, illetőleg az ingatlan-nyilvántartásban megosztva legalább két önálló lakást tartalmaz, továbbá

gd) azon önálló ingatlan, amely műszakilag elkülönült lakást tartalmaz. Műszakilag önállónak kell tekinteni a lakást, ha az a lakás használatbavételi engedélyéből egyértelműen kiderül;

h) szolgáltató: a lakosság energiafelhasználásának szociális támogatásáról szóló 231/2006. (XI. 22.) Korm. rendelet (a továbbiakban: R.), illetőleg az e rendelet alapján nyújtott támogatás érvényesítésére és elszámolására a Szociális és Munkaügyi Minisztériummal (a továbbiakban: minisztérium) megállapodást kötött

ha) gázszolgáltató, gázkereskedő, távhőszolgáltató, valamint a távhőszolgáltatásról szóló 2005. évi XVIII. törvény hatálya alá nem tartozó központi hőellátó rendszert üzemben tartó gazdálkodó szervezet (a továbbiakban: hőtermelő), továbbá

hb) azon lakásszövetkezet vagy ingatlankezelő gazdasági társaság, amely a fogyasztóknak közvetlenül hőt szolgáltat és erről számlát bocsát ki;

i) fogyasztó: az a természetes személy,

ia) aki a szolgáltatóval vagy annak megbízottjával gázfogyasztásra, illetve távhőfelhasználásra – háztartási (lakossági) árszabással – szolgáltatási szerződést kötött,

ib) akinek nevében a társasház, illetve annak közös képviselője a szolgáltatóval – háztartási (lakossági) árszabással – szerződést kötött, és a szolgáltatás díjának megfizetésére a társasház vagy a szolgáltató felé kötelezett;

j) fogyasztási hely:

ja) a gázfogyasztó által részben vagy egészben lakás céljára használt ingatlan, ahol a fogyasztói berendezés(ek), továbbá gázmérőhely van(nak), vagy

jb) a távhőszolgáltatás igénybevételének helye, vagy

jc) a szolgáltatás díját díjszétosztás nélkül fizető társasházi fogyasztói közösségek esetében az a közös tulajdonú helyiség, ahol a társasház fogyasztói berendezése, továbbá a gázmérőhely van;

k) fogyasztási időszak: a számlán feltüntetett hőmennyiség felhasználásának időszaka;

l) jogosultsági időszak: a 2009. január 1-je és 2011. augusztus 31-e közötti időszak;

m) elszámolási időszak: havonta elszámolási céllal végzett fogyasztás-megállapítás (leolvasás) esetén a 2008. december 31-én vagy azt közvetlenül megelőzően történő leolvasástól a 2011. augusztus 31-én történő vagy az azt követő első leolvasás közötti időszak; évente egyszer végzett elszámolási célú fogyasztás-megállapítás (leolvasás) esetén az évente elvégzett leolvasási időpontok közötti időszak;

n) fogyasztási jelleggörbe: az éves gázfogyasztás naptári hónapokra eső részének százalékos arányát tartalmazó adatsor;

o) közös képviselő: a társasház szolgáltató felé történő képviseletével a társasház szervezeti-működési szabályzatában, alapszabályában, illetve megállapodás alapján feljogosított személy vagy szervezet.

2. § (1) E rendelet alapján a jogosultsági időszakban energiafelhasználási támogatásra (a továbbiakban: támogatás) jogosult a gáz-, illetve a távhőszolgáltatást háztartási célra igénybe vevő fogyasztó, feltéve, hogy háztartásában az egy fogyasztási egységre jutó havi jövedelem nem haladja meg az öregségi nyugdíj kérelem benyújtása időpontjában érvényes legkisebb összegének (a továbbiakban: nyugdíjminimum) három és félszeresét. Az egy fogyasztási egységre jutó havi jövedelem megegyezik a háztartás összjövedelmének és a fogyasztási egységek összegének hányadosával.

(2) Az (1) bekezdés alkalmazásában fogyasztási egységen a háztartás tagjainak a háztartáson belüli fogyasztási szerkezetet kifejező arányszámát kell érteni. Az arányszámok a következők:

a) a háztartás első nagykorú tagjának arányszáma 1,0,

b) a háztartás második nagykorú tagjának arányszáma 0,9,

c) a háztartás minden további nagykorú tagjának arányszáma 0,8,

d) a háztartás első és második kiskorú tagjának arányszáma személyenként 0,8,

e) a háztartás minden további kiskorú tagjának arányszáma tagonként 0,7.

(3) Ha a háztartás

a) (2) bekezdés *a)–c)* pontja szerinti tagja magasabb összegű családi pótlékban vagy fogyatékossági támogatásban részesül, vagy

b) (2) bekezdés *d)–e)* pontja szerinti tagjára tekintettel magasabb összegű családi pótlékot folyósítanak,

a rá tekintettel figyelembe vett arányszám 0,2-del növekszik.

(4) Ha a háztartásban gyermekét egyedülállóként nevelő szülő – ideértve a gyámot, a nevelőszülőt és a hivatásos nevelőszülőt – él, a rá tekintettel figyelembe vett arányszám 0,2-del növekszik. Egyedülállónak kell tekinteni azt a személyt, aki hajadon, nőtlen, özvegy, elvált vagy házastársától külön él, és nincs élettársa.

(5) Nem jogosult támogatásra a fogyasztó a szabálytalanul vételezett gázfogyasztására vagy távhőfelhasználására tekintettel.

(6) A támogatás csak a lakás céljára használt ingatlan tekintetében – háztartási (lakossági) árszabással – igénybe vett gázfogyasztásra, illetve távhőfelhasználásra jár. A társasház nem lakás céljára szolgáló közös helyiségeinek fűtésére támogatás nem vehető igénybe.

(7) A fogyasztó, valamint háztartásának tagja egyidejűleg csak egy lakóingatlan tekintetében jogosult támogatásra, de azonos lakóingatlan esetében a támogatás fogyasztási helyenként igénybe vehető. A fogyasztó, illetve a háztartásának tagja a támogatásra való jogosultság megállapításánál – kivéve, ha a fogyasztó támogatásra való jogosultsága a (8)–(9) bekezdésben foglalt okból szűnik meg – a jogosultsági időszakban csak egyszer vehető figyelembe.

(8) A támogatásra való jogosultság

a) a szolgáltatási szerződés, vagy

b) a gázszolgáltatást közös mérővel igénybevevő, illetve a szolgáltatás díját díjszétosztás nélkül fizető társasház esetén a gáz- vagy távhőszolgáltatás igénybevétele

megszűnésének napján megszűnik, kivéve, ha a szolgáltatási szerződés a 2/A. §-ban foglaltak szerinti szolgáltató-váltás miatt kerül felmondásra.

(9) A fogyasztó – írásban, a Magyar Államkincstár 4. § (1) bekezdése szerint illetékes területi szervénél (a továbbiakban: Igazgatóság) – a támogatásról lemondó nyilatkozatot tehet. A támogatásról való lemondás esetén a támogatásra való jogosultság a lemondó nyilatkozat megtételét követő hónap első napjától szűnik meg.

(10) Amennyiben a fogyasztó a jogosultsági időszakban támogatásban részesült, vagy háztartásának tagja a támogatásra való jogosultság megállapítása során figyelembevételre került, az azonos jogosultsági időszakra benyújtott új igény esetén igazolni kell – a szolgáltató erre vonatkozóan kiadott igazolásának csatolásával – a támogatás megszűnésének tényét.

(11) Amennyiben a támogatásra való jogosultság lemondó nyilatkozattal szűnt meg, ugyanazon jogosultsági időszakra támogatást csak akkor lehet megállapítani, ha a támogatásról lemondott fogyasztó vagy háztartása – a támogatás megállapításánál figyelembe vett – tagjának lakcíme megváltozott.

2/A. § (1) A támogatásra való jogosultság nem szűnik meg, ha a fogyasztó, illetve a szolgáltatás díját díjszétosztás nélkül fizető társasház esetén a közös képviselő a korábbi szolgáltatóval kötött szolgáltatási szerződésének felmondását követően ugyanazon fogyasztási helyre másik szolgáltatóval szerződést köt (a továbbiakban: szolgáltató-váltás).

(2) Gázszolgáltatás igénybevétele körében bekövetkezett szolgáltató-váltás esetén a korábbi szolgáltató a fogyasztóval történő elszámolás keretében kibocsátott végszámlához igazolást állít ki a fogyasztó által a szolgáltatás megszűnésének időpontjáig felhasznált azon hőmennyiségről, amelyre a jogosultsági időszakban támogatást érvényesített.

(3) A szolgáltatót váltó fogyasztónak az új szolgáltatóval háztartási (lakossági) árszabással gázfogyasztásra, illetve távhőfelhasználásra kötött, érvényes szerződésének másolatát – a szerződésben a szolgáltatás igénybevételének kezdő időpontjaként rögzített időponttól számított 15 napon belül – a fogyasztó, illetve a közös képviselő megküldi az Igazgatóságnak. A szerződés másolatához gázfogyasztás esetén csatolni kell a korábbi szolgáltató (2) bekezdés szerinti igazolását.

(4) Amennyiben a fogyasztó, illetve a közös képviselő a (3) bekezdésben meghatározott határidőn belül az új szolgáltatóval kötött szerződés másolatát megküldi az Igazgatóságnak, a fogyasztót a támogatás folyamatosan megilleti.

(5) Az új szolgáltatóval kötött szerződés megküldésére a (3) bekezdésben meghatározott határidő elmulasztása esetén a fogyasztót a támogatás a szerződés megküldése hónapjának utolsó napjáig, de legkésőbb a jogosultsági időszak végéig nem illeti meg.

(6) Gázszolgáltatás igénybevétele körében bekövetkezett szolgáltató-váltás esetén az Igazgatóság a fogyasztó támogatásának az új szolgáltatónál történő érvényesítéséről rendelkező határozatban meghatározza azt a hőmennyiséget is, amelyre a jogosultsági időszakban még támogatás érvényesíthető. Az Igazgatóság a támogatás érvényesítésére

határozatában feljogosított új szolgáltatót a 6. § (1) bekezdésében foglaltak megfelelő alkalmazásával értesíti.

3. § (1) A gázfogyasztás esetében a támogatás fajlagos bruttó összege

a) 0,771 Ft/MJ, ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem nem haladja meg a nyugdíjminimum kétszeresét;

b) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum kétszeresét, de nem haladja meg annak két és félszeresét,

ba) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 0,556 Ft/MJ,

bb) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 0,278 Ft/MJ;

c) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum két és félszeresét, de nem haladja meg annak háromszorosát,

ca) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 0,238 Ft/MJ,

cb) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 0 Ft/MJ;

d) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum háromszorosát, de nem haladja meg annak három és félszeresét,

da) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 0,018 Ft/MJ,

db) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 0 Ft/MJ.

(2) A távhőfelhasználás esetében a támogatás fajlagos bruttó összege

a) 1767 Ft/GJ, ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem nem haladja meg a nyugdíjminimum kétszeresét;

b) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum kétszeresét, de nem haladja meg annak két és félszeresét,

ba) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 1377 Ft/GJ,

bb) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 688,5 Ft/GJ;

c) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum két és félszeresét, de nem haladja meg annak háromszorosát,

ca) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 783 Ft/GJ,

cb) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 0 Ft/GJ;

d) ha a háztartásban az egy fogyasztási egységre jutó havi jövedelem meghaladja a nyugdíjminimum háromszorosát, de nem haladja meg annak három és félszeresét,

da) a jogosultsági időszak 2010. április 30-áig terjedő részidőszaka vonatkozásában 399 Ft/GJ,

db) a jogosultsági időszak 2010. május 1-jétől 2011. augusztus 31-éig terjedő részidőszaka vonatkozásában 0 Ft/GJ.

(3) Gázfogyasztás esetén a támogatás

a) a jogosultsági időszak 2009. január 1-jétől 2009. december 31-éig terjedő részidőszakában legfeljebb 68 000 MJ, nagycsaládos háztartás esetében legfeljebb 136 000 MJ,

b) a jogosultsági időszak 2010. január 1-jétől 2010. december 31-éig terjedő részidőszakában legfeljebb 68 000 MJ, nagycsaládos háztartás esetében legfeljebb 136 000 MJ

c) a jogosultsági időszak 2011. január 1-jétől 2011. augusztus 31-éig terjedő részidőszakában legfeljebb 47 600 MJ, nagycsaládos háztartás esetében legfeljebb 95 200 MJ

hőmennyiségre jár.

(4) Távhőfelhasználás esetén, amennyiben a (2) bekezdés szerinti fajlagos bruttó összeg a hőmennyiség egységárát meghaladja, úgy a támogatás a hőmennyiség egységárával egyezik meg.

(5) A jogosultat a jogosultsági időszakban megillető támogatás összege az (1)–(2) bekezdés szerinti fajlagos bruttó összeg, valamint a jogosultsági időszakban a jogosultság kezdő időpontjától – a (3) bekezdés szerinti felső határra figyelemmel – felhasznált hőmennyiség szorzata.

(6) A fogyasztó által a jogosultsági időszakban felhasznált hőmennyiséget – a (7) és (8) bekezdésekben foglaltak kivételével – a szolgáltató havonta vagy az elszámolási időszak végén a fogyasztási helyen mért adatok alapján állapítja meg.

(7) Amennyiben a hőtermelő hiteles mérés nélkül szolgáltat hőt a fogyasztónak, az érvényesítendő támogatás alapja a hőszolgáltatás átlagos hatásfokának, valamint a tárgyidőszakban a hőtermelő által felhasznált földgáz hőmennyiségének szorzata. A hőszolgáltatás – a kazánházból kiadott hőmennyiség és az ahhoz felhasznált földgáz hőtartalmának arányát meghatározó – átlagos hatásfokát a Magyar Államkincstár központi szerve állapítja meg.

(8) Az önálló gázmérővel nem mért, csak főzési célra szolgáló gázfogyasztás esetében a támogatás alapja a számlázott hőmennyiség.

(9) Közös mérővel rendelkező társasházi lakás esetén az elszámolási időszak végén a közös mérőn mért fogyasztás fogyasztónkénti megosztását a szolgáltató

a) a szolgáltatás díját díjszétosztás nélkül fizető társasház esetén a közös képviselő 4. § (5) bekezdése szerinti nyilatkozata alapján,

b) a távhőszolgáltatás díját közvetlen számlázás alapján fizető fogyasztók esetén a közös képviselő szerződésben foglalt nyilatkozata alapján, vagy ennek hiányában az épületben lévő épületrészek légtérfogat-arányának megfelelően

végzi el.

(10) Az elszámolási időszakra megállapított fogyasztásból a támogatás alapját képező, jogosultsági időszakra eső fogyasztást a 8. § (4)–(6) bekezdésében foglaltak szerint kell megállapítani.