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EUROPEAN SOCIAL CHARTER

17th National Report on the implementation of the European Social Charter

submitted by

THE GOVERNMENT OF HUNGARY

Articles 3, 11, 12, 13 and14

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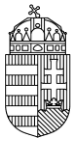

Ministry of Human Capacities

National Report

Seventeenth Report

on the implementation of the commitments undertaken in the Revised European Social Charter

Submitted by:
The Government of Hungary

covering the period from 1 January 2016 to 31 December 2019

Budapest, 2020

Pursuant to Article C of Part IV of the Revised European Social Charter (hereinafter: Charter), the implementation of the commitments undertaken in the Charter falls under the same control as those undertaken in the European Social Charter. Pursuant to the reporting procedure set out in Article 21 of Part IV of the European Social Charter, the reporting obligation covers the adopted articles of the European Social Charter. Based on the decision of the Committee of Ministers of the Council of Europe No. CM(2014)26 adopted at its 1196th meeting held on 2 April 2014, the 2020 National Report covers the topic entitled "Helath, social security, social protection".

This Report concerns the implementation of the following Articles of the Revised European Social Charter, ratified and approved by Hungary, for the reporting period set out in the table:

Provision	**The title of the article**
Paragraph (1) of Article 3	1 January 2016 – 31 December 2019
Paragraph (2) of Article 3	1 January 2016 – 31 December 2019
Paragraph (3) of Article 3	1 January 2016 – 31 December 2019
Paragraph (4) of Article 3	1 January 2016 – 31 December 2019
Paragraph (1) of Article 11	1 January 2016 – 31 December 2019
Paragraph (2) of Article 11	1 January 2016 – 31 December 2019
Paragraph (3) of Article 11	1 January 2016 – 31 December 2019
Paragraph (1) of Article 12	1 January 2016 – 31 December 2019
Paragraph (1) of Article 13	1 January 2016 – 31 December 2019
Paragraph (2) of Article 13	1 January 2016 – 31 December 2019
Paragraph (3) of Article 13	1 January 2016 – 31 December 2019
Paragraph (4) of Article 13	1 January 2016 – 31 December 2019
Paragraph (1) of Article 14	1 January 2016 – 31 December 2019
Paragraph (2) of Article 14	1 January 2016 – 31 December 2019

The implementation of the above articles was last reported by the Government of Hungary in its 12th National Report for the period 1 January 2012 to 31 December 2015.

This National Report was prepared on the basis of the questionnaire approved by the Committee of Ministers of the Council of Europe on 26 March 2008, and with a view to the above-mentioned decision adopted on 2 April 2014. The report incorporates the answers of the Government to the specific questions and statements raised by the European Committee of Social Rights (hereinafter: ECSR) in its Conclusions published in 2016 on the report concerning the provisions falling within the thematic group "Helath, social security, social protection".

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

LIST OF REFERENCED LEGAL REGULATIONS AND REGULATORY INSTRUMENTS PERTAINING TO PUBLIC LAW ORGANISATIONS

- Fundamental Law of Hungary
- Act IV of 1991 on Job Assistance and Unemployment Benefits
- Act XI of 1991 on health authority and administrative activities
- Act LXVI of 1992 on Keeping Records on the Personal Data and Addresses of Citizens
- Act LXXIX of 1992 on the Protection of Foetal Life
- Act III of 1993 on Social Administration and Social Services
- Act XCIII of 1993 on Labour Safety
- Act CXVII of 1995 on Personal Income Tax
- Act LXXV of 1996 on Labour Inspections
- Act CXVI of 1996 on Nuclear Energy
- Act XXXI of 1997 on the Protection of Children and Guardianship Administration
- Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services[1]
- Act LXXXIII of 1997 on Mandatory Health Insurance Contribution
- Act CLIV of 1997 on Health Care
- Act LXXXIV of 1998 on Family Support
- Act XXV of 2000 on Chemical Safety
- Act LI of 2000 on the Promulgation of Convention No. 81 on Labour Inspections in Industry and Trade, Approved at the 30th session of the International Labour Conference in 1947
- Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunities
- Act XXXIV of 2004 on Small and Medium-sized Enterprises and the Support Provided to Such Enterprises
- Act LXXXVIII of 2005 on Public Interest Volunteer Activities
- Act I of 2007 on the Entry and Residence of Persons with the Right of Free Movement and Residence
- Act II of 2007 on the Admission and Right of Residence of Third-Country Nationals
- Act LXXXV of 2007 on Asylum
- Act CVI of 2007 on Sate Assets
- Act XLVII of 2009 on the Penal Register, on the Register of Judgments Delivered by the Courts of Member States of the European Union Against Hungarian Nationals, and on the Register of Biometric Data Related to Criminal Prosecution and Law Enforcement
- Act LXXV of 2010 on Simplified Employment
- Act CIII of 2011 on Public Health Product Tax
- Act CXII of 2011 on the Right of Informational Self-Determination and on Freedom of Information

[1] Repealed by: Act CXXII of 2019 on Entitlements to Social Security Benefits and on Funding These Services as of 1 July 2020

- Act CXC of 2011 on the National Public Education
- Act CXCI of 2011 on the Amendment of Certain Laws on Benefits to People with Reduced Working Capacities
- Act CXCIX of 2011 on Public Service Officials
- Act CCIV of 2011 on National Higher Education
- Act I of 2012 on the Labour Code
- Act C of 2012 on the Criminal Code
- Act V of 2013 on the Civil Code
- Act CCXL of 2013 on the Detailed Rules of Execution of Punishments, Measures, Certain Coercive Measures and the Custodial Arrest for Offences
- Act XLII of 2015 on the Service Status of the Official Staff of Law Enforcement Agencies
- Act C of 2015 on the Central Budgetary of Hungary for 2016
- Act XXXIII of 2016 on the Public Project Evaluation Legal Relationship and the Amendment of Certain Related Acts
- Act XC of 2016 on the Central Budgetary of Hungary for 2017
- Act I of 2017 on the Code of Administrative Court Procedure
- Act XX of 2017 on the Amendment of Certain Acts Relating to Strengthening the Procedure Conducted in Border Surveillance Areas
- Act L of 2017 on Amendments of Certain Acts Relating to the Entry into Force of the Act on General Public Administration Procedures and the Act on the Code of Administrative Court Procedure
- Act LII of 2018 on Social Contribution Tax
- Act CXXII of 2019 on Entitlements to Social Security Benefits and on Funding These Services
- Act XII of 2020 on the Containment of Coronavirus[2]
- Act LVIII of 2020 on the Transitional Rules and Epidemiological Preparedness related to the Cessation of the State of Danger
- Government Decree 217/1997 (1 December) on the implementation of Act LXXXIII of 1997 on Mandatory Health Insurance Contribution
- Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund
- Government Decree 113/2007 (24 May) on the Implementation of Act I of 2007 on the Entry and Residence of Persons with the Right of Free Movement and Residence
- Government Decree 114/2007 (24 May) on the Implementation of Act II of 2007 on the Admission and Right of Residence of Third-Country Nationals
- Government Decree 301/2007 (9 November) on the implementation of Act LXXX of 2007 on Asylum
- Government Decree 118/2011 (11 July) on the Nuclear Safety Requirements for Nuclear Facilities and the Procedures of the Hungarian Atomic Energy Authority
- Government Decree 190/2011 (19 September) on Physical Protection during the Application of Nuclear Energy and the Relating Licensing, Reporting and Control System
- Government Decree 273/2011 (20 December) on the Detailed Rules of the Amount of Occupational Safety Fines and the Method of Imposing Them

[2] Repealed by: Act LVII of 2020 on the Termination of the State of Danger as of 18 June 2020

– Government Dedcree 327/2011 (29 December) on the Basic Rules of Care For the Persons with Changed Working Capacity

– Government Decree 373/2011 (31 December) on the Designation of Organisations Performing Occupational Safety and Health Authority Tasks

– Government Decree No 110/2012 (4 June) on the Issuance, Introduction and Implementation of the National Core Curriculum

– Government Decree 320/2014 (13 December) on the Designation of the Public Employment Agency and the Health and Safety and Labour Authority and the Performance of the Public Authority and Other Tasks of Those Bodies;

– Government Decree 105/2015 (23 April) on the Classification of Beneficiary Local Governments and the Conditions of Classification

– Government Decree 487/2015 (30 December) on Protection against Ionising Radiation and the Relating Licensing, Reporting and Control System

– Government Decree 489/2015 (30 December) on Monitoring Radiation Conditions Relevant for Public Exposure of Natural and Artificial Origin and on the Scope of Quantities Obligatory to be Measured

– Government Decree 385/2016 (2 December) on the Performance of Public Health Tasks by the Budapest and County Government Offices and District (Budapest District) Offices and on the Designation of the Health Public Administration Body

– Government Decree 166/2018 (17 September) on the Radiation Protection Authority Tasks in the Defence Sector

– Government Decree 47/2020 (18 March) on Immediate Measures Necessary for Alleviating the Effects of the Coronavirus Pandemic on National Economy[3]

– Government Decree 61/2020. (23 March) on the detailed rules on taxes relating to Government Decree 47/2020 (18 March) on Immediate Measures Necessary for Alleviating the Effects of the Coronavirus Pandemic on National Economy and on Certain New Measures[4]

– Government Decree 85/2020 (5 April) on Certain Home Affairs and Public Administration Rules Applicable during the State of Danger[5]

– Government Decree 88/2020 (5 April) on Certain Measures Relating to Social and Child Protection Services during the State of Danger and the Order of Operation of Social Services during the State of Danger[6]

– Government Decree 140/2020 (21 April) on Tax Facilities Necessary to Mitigate the Economic Impact of the Coronavirus Pandemic within the framework of the Economic Relief Action Plan[7]

– Government Decree 168/2020 (30 April) on Protective Measures[8]

– Decree of the Minister of Agriculture and Food 15/1989 (8 October) MÉM on the Issuance of Forestry Safety Regulation

[3] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

[4] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

[5] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

[6] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

[7] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

[8] Repealed by: Government Decree 282/2020 (17 June) on the Termination of the State of Danger announced on 11 March 2020, as of 18 June 2020

– Decree of the Minister of Labour 5/1993 (26 December) MüM on the Implementation of Certain Provisions of Act XCIII of 1993 on Health and Safety
– Decree of the Minister of Welfare 9/1993 (2 April) NM on Certain Issues of Social Security Financing of Health Care Services
– Decree of the Minister of Welfare 27/1996 (28 August) NM on the Reporting and Investigation of Occupational Diseases and Cases of Increased or High Exposure
– Decree of the Minister of Welfare 51/1997 (18 December) NM on Health Services for the Prevention and Early Detection of Diseases Available under Compulsory Health Insurance and the Certification of Attendance of Screening
– Decree of the Minister of Labour 2/1998 (16 January) MüM on the Safety and Health Protection Signs Applied at Workplaces
– Decree of the Minister of Health 25/1998 (27 December) EüM on the Minimum Safety and Health Requirements of Manual Movement of Heavy Items Involving Primary Risks of Back Injuries
– Decree of the Minister of Welfare 33/1998 (24 June) NM on the Medical Examination of and Opinion on Fitness for a Job or a Profession and Personal Hygiene
– Decree of the Minister of Economy 47/1999 (4 August) GM on the Issuance of the Safety Code for Lifting Machines
– Decree of the Minister of Health 50/1999 (3 November) EüM on the Minimum Safety and Health Requirements for Work with Display Screen Equipment
– Decree of the Minister of Health 61/1999 (1 December) EüM on the Protection of Health of Employees Exposed to Impacts of Biological Factors
– Decree of the Minister of Health 65/1999 (22 December) EüM on the Minimum Safety and Health Requirements of the Use of Individual Protective Devices used by Employees at the Workplace;
– Decree of the Minister of Health 4/2000 (25 February) EüM on Family Practitioner, Family Paediatrician and Dentist Services
– Joint Decree of the Minister of Health and Minister of Social and Family Affairs 25/2000 (30 September) (EüM-SZCSM) on the Chemical Safety of Workplaces:[9]
– Decree of the Minister of Health 26/2000 (30 September) EüM on the Protection from Carcinogenic Substances used at Workplaces and on the Prevention of Health Damage caused by Them
– Decree of the Minister for Environment 15/2001 (6 June) on Radioactive Discharges to the Atmosphere and into Waters during the Use of Nuclear Energy and on Monitoring of the Discharge
– Decree of the Minister of Agriculture and Rural Development 16/2001. (3 March) FVM on the Issuance of the Agricultural Safety Regulation
– Joint Decree of the Minister of Social and Family Affairs and the Minister of Health 3/2002 (8 February) SzCsM-EüM on the Minimum Level of HSE Requirements at Workplaces
– Joint Decree of the Minister of Social and Family Affairs and Minister of Health 4/2002 (20 February) SZCSM-EüM on the Minimum Labour Safety Requirements at Construction Sites and during Construction Processes
– Decree of the Minister of Employment and Labour 11/2003 (12 September) FMM on the Publication of the Safety Regulation for Industrial Alpinist Activities

[9] Repealed by: Decree of the Minister of Innovation and Technology 5/2020 (6 February) (ITM) on the Protection of the Health and Safety of Workers from the Risks Related to Chemical Pathological Factors as of 6 February 2020

– Decree of the Minister of Employment and Labour 14/2004 (19 April) FMM on the Minimum Level of Safety and Health Requirements for the Use of Work Equipment[10]

– Decree of the Minister of Employment and Labour 24/2005 (23 March) FVM on the Safety Regulation for Slaughtering and Processing Animals

– Decree of the Minister of Health 66/2005 (22 December) EüM on the Minimum Safety and Health Requirements Concerning Workers' exposure to Noise;

– Decree of the Minister of Health 12/2006 (23 March) EüM on the Protection of Workers Exposed to Asbestos-Related Risks

– Decree of the Minister for Environmental Protection and Water Management 24/2007 (3 July) KvVM on the Issuance of the Water Safety Regulation

– Decree of the Minister of Defence 1/2009 (30 January) HM on the Special Working Safety Requirements and Procedural Rules Applicable to the Hungarian Defence Forces and Armed National Defence Services

– Decree of the Minister of Health 20/2009 (18 June) EüM on the Prevention of Health Care-Associated Infections and on the Minimum Conditions of These Activities

– Joint Decree of the Ministers of Justice and Law Enforcement, the Minister of Local Governments and the Minister of Postal Services and Communications 57/2009 (30 October) IRM-ÖM-PTNM on Health, Psychological and Physical Aptitude of Members of the Career Personnel of Certain Law Enforcement Agencies, on Health Aptitude of Civil Servants and Public Officials, on Establishment of Inability for Service and Earning, and on Basic Health Care Provision

– Decree of the Minister for Local Governments 15/2010 (12 May) ÖM on the Applicability of Fire Protection Technology Related to Firefighting and Technical Rescue Activities

– Decree of the Minister of Health 22/2010 (7 May) EüM on the Minimum Health and Safety Requirements Regarding the Exposure of the Workers to Artificial Optical Radiation

– Decree of the Minister of Defence 13/2011 (20 October) HM on the Notification, Investigation and Registration of Accidents and Incidents in the Defence Sector

– Decree of the Minister of Interior 70/2011 (30 December) BM on the Rules of Occupational Safety and Health and the Performance of Occupational Health Activities of Law Enforcement Agencies under the Control of the Minister of Interior

– Decree of the Minister of Human Capacities 20/2012 (31 August) EMMI on the Operation of Educational and Training Institutions and the Names of Public Education Institutions

– Decree of the Minister of Human Capacities 8/2013 (30 January) EMMI on the Common Requirements for Teacher Training and Training and Output Requirements for each Training Programme

– Decree of the Minister of Human Capacities 71/2013 (20 November) EMMI on the Highest Permissible Amount of Trans Fatty Acids in Food Products, the Conditions and Official Control of the Distribution of Food Products Containing Trans Fatty Acids, and the Rules Relating to Monitoring the Population's Intake of Trans Fatty Acids

[10] Repealed by: Decree of the Minister for National Economy 10/2016 (5 April) (NGM) on the Minimum Level of Safety and Health Requirements for the Use of Work Equipment from 5 May 2016

– Decree of the Minister of Justice 8/2014. (12 December) IM on the Health Care of Convicts and other Prisoners in Penitentiary Institutions
– Decree of the Minister of Justice 16/2014 (19 December) IM on the Detailed Rules of Confinement Replacing Prison Sentence, Confinement, Pre-trial Detention and Disciplinary Fines
– Decree of the Minister of Defence 10/2015 (30 July) on Health, Mental and Physical Fitness for Military Service and Review Procedures
– Decree of the Minister of Human Capacities 49/2015 (6 November) EMMI on the Public Health Requirements for Matrices and Facilities Posing a Risk of Legionella Infection
– Decree of the Minister for National Economy 10/2016 (5 April) NGM on the Minimum Level of Safety and Health Requirements for the Use of Work Equipment
– Decree of the Minister of Human Capacities 18/2016 (5 August) EMMI on the Amendment of the Decree of the Minister of Human Capacities 8/2013 (30 January) EMMI on the Common Requirements for Teacher Training and Training and Output Requirements for each Training Programme
– Decree of the Minister of Human Capacities 33/2016 (29 November) EMMI on the Minimum Health and Safety Requirements for the Exposure of Workers to the Risks Arising from Physical Factors
– Decree of the Minister of Interior 54/2016 (22 December) BM on Law Enforcement Health Benefits Applicable to Bodies Performing Law Enforcement Activities Under the Control of the Minister of Interior
– Decree of the Minister of Defence 15/2018 (27 September) HM on the Application of the Act on Nuclear Energy in the Armed Forces
– Decree of the Minister of Human Capacities 16/2019 (30 July) EMMI on the Professional Supervision of Healthcare Providers
– Decree of the Minister of Innovation and Technology 5/2020 ITM (6 February) ITM on the Protection of the Health and Safety of Workers from the Risks Related to Chemical Pathological Factors
– Parliament Resolution 80/2013 (16 October) OGY on the National Anti-Drug Strategy for 2013-2020
– Government Resolution 1289/2016 (13 June) on Vaccine Purchases for 2017-2019
– Government Resolution 1581/2016 (25 November) on the National Occupational Health and Safety Policy
– Government Resolution 1621/2016 (11 November) on the Restatement of Appropriations from the Reserve for Extraordinary Government Measures, on the Use of the Remaining 2015 Budget Balances and on the Transfer of Appropriations Between and within Certain Chapters, and Amending Certain Government Resolutions[11]
– Government Resolution 1277/2018 (15 June) Amending Government Resolution 1289/2016 (13 June) on Vaccine Purchases for 2017-2019 and on the Current Tasks relating to Vaccination
– Government Resolution 1722/2018 (18 December) on National Health Programmes and Special Policy Programmes for 2019-2022 Related to them

[11] Repealed by: Act C od 2015 on the Central Budget of Hungary for 2016 as of 31 December 2019

– Government Resolution 1768/2018 (21 December) on Raising the Amount of Home Care Allowance for Children and the Amount of Care Allowance for 2020– 2022 Years

– Government Resolution 1114/2019. (13 March) on the Adoption of the National Radon Action Plan

– Government Resolution 1404/2019. (5 July) Laying Down the Foundation of the Long-term Programme for "Converging Settlements"

– Order of the Minister of Defence 126/2011 (25 November) on the Order of Health and Safety Activities

– Order of the National Police Headquarters 30/2008 (OT 16.) (ORFK) on Measures to be Taken to Prevent Damage to Health Caused by Heat to Police Personnel, Customers in Police Buildings and Persons Subject to Police Proceedings when Ordering a Heat Alert

– Order of the National Police Headquarters 28/2014 (1 August) (ORFK) on the Uniform Implementation of Individual (Personalized) Risk Assessment of the Work Environment of the Police Staff

– Order of the National Headquarters of the Prison Service 1/2016 (15 April) (BVOP) on the Code of Organisation and Operation of the National Headquarters of the Prison Service

– Order of the National Police Headquarters 12/2018 (4 May) on the Vaccination Policy of the Police

– Order of the National Headquarters of the Prison Service 20/2019 (19 December) (BVOP) on Wages, Scholarships, Cash Compensation for Occupational Therapy and Contributions to Maintenance Costs for Prisoners in 2020

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ARTICLE 3 - THE RIGHT TO SAFE AND HEALTHY WORKING CONDITIONS

In order to ensure the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and employees' 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) THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF REFORMS

The European Committee of Social Rights (ECSR) requested information on policy-making processes and practical solutions that are aimed at detecting new and increasing situations that threaten health and safety at work. It also asked for information on the outcome of these procedures and possible future reforms.

The national response to coronavirus is led by the government and is supported by the so- called Operative Corps, jointly led by the Interior Minister and the Minister of Human Capacities, with representatives of relevant organizations, such as the national chief medical officer of the National Public Health Center. The measures of the government are mostly announced in regular, daily press conferences of the Operative Corps except those with strategic importance communicated directly by the Prime Minister.

With regard to the situation in Italy, on the 11th of March the Government declared State of Emergency, which allowed to introduce quick and extraordinary measures. On the 30th of March, the Parliament − with the adoption of Act 2020. of XII. on the Protection Against the Coronavirus (hereinafter referred as to: Authorisation Act) − approved the State of Emergency until it is withdrawn.

On 26 May 2020, the Government submitted a legislative proposal to the Parliament to end the state of State of Emergency and to withdraw the Authorisation Act. On the same day, the Government submitted another proposal to the Parliament on the temporary rules in relation to ending the state of danger. The latter document aims to entitle the Government, on the proposal of the National Chief Public Health Officer, to declare a health crisis situation in case an epidemiological danger or other unforeseeable event that jeopardises the operation of healthcare providers would justify this. The decree of the Government on proclaiming a health crisis situation could establish special rules in relation to healthcare services. In such a crisis, the Government would be entitled to impose restrictions on the operation of any institution or facility and on the organisation of events that would contribute to spreading the disease.

The specific measures to contain the coronavirus epidemic are described in the section dedicated to Article 11 (3).

In its 2017 conclusions, the ECSR requests information on policies that address psycho-social risks that may lead to work-related stress, aggression, violence and harassment. Occupational health and safety regulations should cover the management of stress, aggression and violence at work, with particular attention to atypical working conditions.

1. Rules applicable to employees

The amendment of Act XCIII of 1993 on Labour Safety (hereinafter: Labour Safety Act), which came into force on 1 January 2008, introduced the employer's task of dealing with psycho-social risk factors in the statutory regulation of occupational safety and health, while also defining the concept of this factor.

According to the statutory provision, a psycho-social risk means the effects to which an employee can be exposed at work (conflicts, organization of work, work schedule, uncertainty of employment etc.), that have an influence in connection with his or her reactions to such effects, or in consequence of which stress, occupational accidents may occur, and psychosomatic symptoms (relating to or involving both the mind and body) may develop [Section 87 1/H of the Labour Safety Act].

Section 54 (1) (d) of the Labour Safety Act stipulates that the human factor shall be taken into consideration when setting up the workplace and 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 of such, and to the scheduling of the work time, and to avoid any psycho-social stress that may result from work.

Due to the stress of alertness, the information load and the significant emotional impact - dealing with people, unexpected situations, the sight of injuries that are incompatible with life, communication with aggressive people - employees may be exposed to increased psychological stress. The effects of increased mental strain can endanger the employee's physical integrity and health, and can also increase the likelihood of traffic accidents and minor injuries. Disorders caused by psycho-social risks may include: changes in physical condition, illnesses such as high blood pressure, neck, shoulder and back pain, various forms of sleep disorders, obesity, chronic fatigue, as well as psychiatric symptoms, illnesses - depression, excessive sensitivity, symptoms of burnout -, behavioural and conduct disorders: forgetfulness, impaired concentration, various abuses (alcohol, cigarettes, drug use).

The essential content of the regulations on the consideration of psycho-social risks is that the employer should make every effort to avoid lasting effects that cause harmful stress. This risk prevention and management activity always requires individual consideration of the employers, during which the work situation (activity, work environment) must be taken into account, together with the employee's individual abilities with regard to stress tolerance. Psycho-social risks are rarely unique, so similar solutions can be applied in different sectors and in different businesses. Stress-related risk assessment is based on the same principles and procedures as for other workplace risks - identifying hazards, deciding on the action needed, communicating the results of the assessment, and reviewing it at adequate intervals. An essential condition for success is that the employer should involve employees and their representatives in the process. In order to fulfil this employer's task, the occupational health service must be used both during medical examinations of job suitability and during the inspection of workplaces and work processes.

In the context of a risk assessment, the employer must therefore identify all the circumstances which place a psychological burden on employees and take measures to reduce the impact of psycho-social pathogens to the lowest level, indicating the time limit and the person responsible. Adverse stress-inducing long-term effects should be avoided in all possible ways. These effects also include harassment at the workplace. In order to perform the employer's task, the occupational health service must be used and the person entitled to perform occupational health and safety activities must be involved.

The Labour Safety Act does not specify employee rights related to psycho-social risks, but it regulates the employee's entitlement in general.

Government agencies acting in the powers of the occupational safety and health authority examine the psycho-social pathogens affecting employees, the psychological stress at the workplace, and monitor the fulfilment of the employer's obligations. The occupational safety and health authority checks whether the risk assessment covers psycho-social pathogens and psychological stresses, and whether the employer and the persons/professionals involved in the risk assessment are aware of the complexity of these pathogens. During the inspections, the government officials also examine who is involved in the risk assessment, whether the employer has taken measures to eliminate or reduce the identified psycho-social risks based on the assessment, and whether specific responsibilities and deadlines are defined in the action plan. If the authority finds that the employer does not have a risk assessment, or that the risk assessment does not cover psycho-social pathogens, or that the specialists required by the Labour Safety Act do not participate in its preparation, or it does not include an action plan indicating the deadline and responsible persons, it issues an administrative decision obliging the employer to rectify the deficiencies.

The inspection should also examine the frequency with which the employer sends employees exposed to psychological strain and psycho-social pathogens for a medical examination of their suitability for work. The need for medical examinations is regulated in Section 6 e) and f) and Annexes 5 and 6 of the *Decree of the Minister of Welfare 33/1998 (24 June) NM on the Medical Examination of and Opinion on Fitness for a Job or a Profession and Personal Hygiene*. Based on the employer's failure to do so the authority is entitled to take action. The government official verifies the fulfilment of the obligations prescribed in the decision issued by the occupational safety and health authority during a follow-up inspection.

2. Rules applicable to civil servants

In connection with the enforcement of the right to safe and healthy working conditions, *Act CXCIX of 2011 on Public Service Officials* (hereinafter: Public Service Act) stipulates that the public administration body is obliged to employ the official in accordance with the terms of their appointment and the laws and public service regulations, and to ensure healthy and safe working conditions for them. The employer also ensures the requirements for healthy and safe work. Prior to taking up employment and at regular intervals during the employment relationship, the employer is obliged to arrange for a free examination of the official's suitability for the job [Section 75(1) and (4) of the Public Service Act.] In addition, the official is obliged to appear at the required place and time, in a condition capable of work, to perform the job in person, and to behave in such a way that does not endanger the health and physical integrity, or disturb the work of others, or cause material damage or misjudgement [Section 76(1) of the Public Service Act].

3. Rules applicable to members of the professional staff of law enforcement agencies

In Hungary, the right to safe work of the members of staff of law enforcement agencies (the body performing general police tasks, the body performing internal crime prevention and detection tasks, the anti-terrorism body, the immigration police, the professional disaster management body, the penitentiary organization, the Parliamentary Guard, the civil national security services, the National Tax and Customs Administration) is guaranteed by *Act XLII of 2015 on the Service Status of the Official Staff of Law Enforcement Agencies (*hereinafter: Official Service Act*)* and the related implementation decrees.

Within the framework of the rules of service of the Official Service Act, the supervisor exercising the employer rights is obliged to specify the duties of the professional staff member in the job description, to employ them according to the rules of employment and other legal acts, to ensure for them the conditions of healthy and safe service and to inform them about its requirements [Section 101 (1) a) of the Official Service Act].

Pursuant to Section 102 (1) and (4) of the Official Service Act, a member of the professional staff is obliged to appear in the prescribed place of the performance of the service and at the required time in a condition suitable for the service and to maintain that condition throughout the service, to perform their duties, and to be available for this purpose. They are obliged to co-operate with co-workers, to perform the work and to behave in such a way that, unless it is inevitably involved by the performance of the task, it does not endanger the health and physical integrity of or cause material damage to others. They are also obliged to meet the health, mental and physical fitness requirements and to undergo surveys, screenings and examinations necessary to control them, and to follow the prescribed medical instructions in order to protect their health and to recover from illnesses.

The Official Service Act provides for compliance with the requirements of health, mental and physical fitness necessary for joining the staff and for the maintenance of the legal relationship, as well as the for procedure applied in the event of changed work capacity. It determines the rights and benefits (e.g., extra leave, recreation) of the member of the staff that are necessary for the prevention of health impairment and the preservation of physical endurance. It also provides for measures relating to possible illness or health impairment (e.g., medical treatment, reassignment, sick leave, sick pay, absence pay), specifies the increasingly risky service positions exposed to the risk of infection from high hazards, such as high frequency and ionising radiation, poisoning or the presence of biological pathogens, service positions in underground installations, under artificial and climatic conditions, as well as the special provisions relating thereto.

The psychological aptitude test, which takes place at the time of recruitment and at regular intervals, should include an examination of personality, mental balance, abilities and skills, deviations, and career motivation.

4. Rules applicable to members of the professional staff of bodies performing defence tasks

According to Section 9(4) of the Labour Safety Act, the minister in charge of defence "*shall have powers to establish - in due consideration of the provisions of this Act and where deemed justified under extraordinary circumstances - special requirements and procedural*

rules with respect to work performed within the framework of service relationships, public service relationships, government service relationships, political service relationships, commissioner's relationships, civil service relationships, legal relationship of army civilian personnel or in employment-related relationships - including if performed under extraordinary working conditions - at defence organizations, public education institutions - other than military organisations - maintained and supervised by the minister in charge of defence, at external work locations or construction sites under temporary deployment on land controlled and managed by the ministry of the minister in charge of defence for reasons of national defence, at business associations where ownership rights are exercised by the minister in charge of defence, and at business associations defined in Section 3(2) c) of Act CVI of 2007 on State Assets, concerning occupational safety and health."

Based on the authorization granted by law, the occupational safety activities of the defence organisations, the different requirements and procedural rules are regulated by the following Decrees and Orders of the Ministry of Defence:

1. *Decree of the Minister of Defence 1/2009 (30 January) HM on the Special Working Safety Requirements and Procedural Rules Applicable to the Hungarian Defence Forces (hereinafter: HDF) and Armed National Defence Services*;
2. *Decree of the Minister of Defence 13/2011 (20 October) HM on the Notification, Investigation and Registration of Accidents and Incidents in the Defence Sector*
3. *Order of the Minister of Defence 126/2011 (25 November) HM on the Order of Health and Safety Activities*

In connection with the reorganization of tasks and responsibilities affecting the HDF on 1 January 2019, the amendment of the *Decree of the Minister of Defence 1/2009 (30 January) HM on the Special Working Safety Requirements and Procedural Rules Applicable to the Hungarian Defence Forces and Armed National Defence Services* is being amended and the HM Order *126/2011 (25 November) (HM) on the Order of Health and Safety Activities* is currently being repealed.

Following the amendment of the law, the senior management body of the HDF will ensure the enforcement of the requirements of healthy and safe implementation of activities related to the application, training, preparation, operation and maintenance of military organizations by issuing internal regulations and conducting regular inspections in order to enforce military professional requirements.

5. Occupational safety and health regulations for the employment of prisoners

Pursuant to Section 220 (1) of *Act CCXL of 2013 on the Detailed Rules of Execution of Punishments, Measures, Certain Coercive Measures and the Custodial Arrest for Offences* (hereinafter: Penitentiary Act) while employing prisoners, the employer is obliged to ensure conditions that do not endanger health and safely of work, to provide the information and guidance necessary for work, to provide the required training, to establish a work schedule appropriate to the nature of the work and the composition of convicts and other prisoners participating in the work, to pay remuneration for the work performed.

The employer classifies the work processes and the jobs into risk categories from the point of view of occupational safety. The employer is obliged to comply with the occupational safety

regulations applicable to those categories. Before or after employment, the detainee participates in a medical examination for suitability for work, as required by law. Prisoners are given a job description for the tasks they perform. The employed prisoners receive fire, work and accident prevention training, as well as information on environmental regulations.

An employed prisoner is entitled to remuneration, accident care and medical services in the event of an occupational accident, and paid leave for regular work. *Order of the National Headquarters of the Prison Service 20/2019 (19 December) (BVOP) on Wages, Scholarships, Cash Compensation for Occupational Therapy and Contributions to Maintenance Costs for Prisoners in 2020* provides for the wages and salaries of prisoners in 2020, the scholarship for occupational therapy employment and the contribution to the maintenance cost, in accordance with Section 133 (3), Section 181, Section 258 and Section 270 (3) of the Penitentiary Act and Section 118 of the *Decree of the Minister of Justice 16/2014 (19 December) IM on the Detailed Rules of Confinement Replacing Prison Sentence, Confinement, Pre-trial Detention and Disciplinary Fines.*

2) MEASURES TAKEN FOR THE IMPLEMENTATION OF THE LEGISLATION

The following specific actions have been taken in response to the above requests for information of the ECSR

1. Measures affecting employee

In addition to work organisation, education, proper management, clear definition of roles and responsibilities, as well as support (e.g., social support) and encouragement of employees, health promotion activities relating to occupational health, conflict management, stress management trainings, educational materials also play an important role in prevention.

The guide, constantly available on the official website of the professional management organization of the occupational safety and health authority (the Occupational Safety and Health Department of the Ministry of Innovation and Technology), helps employers to prepare a psychosocial risk assessment properly. The website also contains a guide to psycho- social risks. The government officials performing occupational safety and health inspections usually bring the attention of employers to these information materials.

There is currently no legislation specifically on psychoterror at work (mobbing). Nevertheless, Act I of 2012 on the Labour Code (hereinafter: Labour Code) prohibits discrimination and prescribes norms for the establishment of an employment relationship as well as the right to appropriate working conditions. The Labour Code also provides for the right to an individual legal remedy.

In Hungary, Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunities (hereinafter: Equal Treatment Act) provides for harassment at the workplace and in connection with work. The Equal Treatment Act defines the concepts of equal treatment and direct and indirect discrimination and lists the social groups that are considered to be particularly vulnerable.

The Equal Treatment Act incorporated and specifically named the concept of harassment in accordance with international case law. According to the law, direct negative discrimination, indirect negative discrimination, harassment, unlawful segregation, retaliation and any orders

issued for those mean a violation of the principle of equal treatment. [Section 7 (1) of the Equal Treatment Act]

Harassment is a conduct of sexual or other nature violating human dignity related to the relevant person's characteristics with the purpose or effect of creating an intimidating, hostile, degrading, humiliating or offensive environment around the particular person. [Section 10 (1) of the Equal Treatment Act] Harassment can be identified in the context of all protected groups (only if a protected feature can be detected). These facts can be examined in all areas covered by the law, including employment, the world of goods and services, education, and legal relationships relating to health and social security.

The Equal Treatment Authority (hereinafter referred to by the Hungarian abbreviation as EBH) is the body responsible for enforcing the requirement of equal treatment under the Equal Treatment Act. The EBH investigates (upon request or ex officio) whether the requirement of equal treatment has been infringed and may bring an action under the public interest right to protect the rights of individuals and groups whose rights have been violated. It is important to note that in the event of a complaint, the EBH conducts its proceedings in the framework of an administrative procedure, a claim for damages cannot be enforced before the authority. The greatest number of grievances in employment are reported to the EBH when employers violate their employees' right to human dignity in a way that violates the Equal Treatment Act.

It is important to emphasize that despite the fact that the aggrieved conduct is always exhibited by a natural person, the authority does not act directly against them, so it does not prosecute them, but the body or undertaking that is obliged to comply with the requirement of equal treatment. Accordingly, the perpetrator of the harassment, the active perpetrator, and the body responsible for their conduct commit the infringement by default, i.e., by failing to provide adequate protection or effective assistance to the complainant's problem. Incidentally, the Labour Code also places a responsibility for this in employment, when it stipulates the provision of a healthy and safe working environment as an obligation of the employer [Section 51 (4) of the Labour Code].

In order to keep the public informed, the EBH regularly publishes its reports, proposals and detailed information on its operation on its website, and also addresses the type of gender discrimination in the "Harassment during employment" section of its annual reports. In addition, EBH Administrative and Legal Department has published a study relevant on the topic in a series of factsheets entitled EBH Booklets under the title: Prevention of harassment at work and forms of enforcement.

As harassment is a common and extremely harmful phenomenon in the labour market and in other areas of life, the Advisory Committee on Equal Treatment Authority has issued a position statement on the concept of harassment and sexual harassment, with the aim of helping to bring such disputes to justice and ensuring professional resolution of disputes.

In addition to the above, in terms of personal rights, Act V. of 2013 on the Civil Code (hereinafter: Civil Code) states that everyone is obliged to respect human dignity and the personal rights arising from it. Anyone whose personal rights have been violated, including those who have been harassed at work, can also go to court for remedy pursuant to the Civil Code.

2. Rules applicable to members of the professional staff of law enforcement agencies

In order to create a healthy work environment, the Police operates a system of occupational safety and health supervision, which, in cooperation with the health services, contributes to the establishment of a health-friendly and safe working environment through its wide-ranging professional activities, in particular:

- by conducting official and non-official on-site inspections of the adequacy of the working environment;
- by performing a work environment risk assessment;
- by providing the necessary personal protective equipment;
- by providing job-related vaccinations [*regulated in the Order of the National Police Headquarters 2/2018 (4 May) on the Vaccination Policy of the Police*];
- by supplying winter and summer protective drinks [*regulated in the Order of the National Police Headquarters 30/2008 (OT 16) ORFK on Measures to be Taken to Prevent Damage to Health Caused by Heat to Police Personnel, Customers in Police Buildings and Persons Subject to Police Proceedings when Ordering a Heat Alert]*.

Given that certain personal conditions need to be defined in order to eliminate unfitness for professional recruitment and maintenance of a legal relationship in the Police, incoming employees will undergo a prior medical and psychological aptitude test. After being admitted to a law enforcement agency, the necessary medical and psychological aptitude tests must be performed periodically in the manner assigned to the given position or job, and, when necessary, immediately, in order to prevent and recognize occupational diseases. The order and regulation of preliminary and periodic examinations is included in the *Joint Decree of the Ministers of Justice and Law Enforcement, the Minister of Local Governments and the Minister of Postal Services and Communications 57/2009 (30 October) IRM-ÖM-PTNM on Health, Psychological and Physical Aptitude of Members of the Career Personnel of Certain Law Enforcement Agencies, on Health Aptitude of Civil Servants and Public Officials, on Establishment of Inability for Service and Earning, and on Basic Health Care Provision* (hereinafter: Joint IRM-ÖM-PTNM Decree).

The Department of Psychology, which provides primary care at the Police, provides psychological services that are available to all police departments in addition to aptitude tests. The service is available free of charge at any time on the employee's request or on the advice of a primary care physician for the purpose of coping with stress at work, mental care and counselling.

The *Order of the National Police Headquarters 28/2014 (1 August) (ORFK) on the Uniform Implementation of Individual (Personalized) Risk Assessment of the Work Environment of the Police Staff* aims to comply with the requirement of the risk assessment, based on which the occupational safety and health department fulfils the obligation of risk assessment and risk management of employers. For the assessment of psychological and psycho-social risks, only an individual, i.e., individualized, risk assessment is available within the Police, in which the employee can indicate the possible psycho-social pathogens relating to their position based on their own judgment. If the risk assessment shows an unacceptable level of risk, a risk mitigation measure will be applied.

3. Measures affecting the Penitentiary staff

In the Joint IRM-ÖM-PTNM Decree the activity aimed at screening psychosocial risks appears at the psychological aptitude tests, taking into account a specific set of criteria. The psychological aptitude test, which takes place at the time of recruitment and at regular intervals, should include an examination of personality, mental balance, abilities and skills, deviations, and career motivation. Psychological fitness is assessed by the psychologist performing the examination on the basis of personality tests, intelligence tests, paper-based and instrumental attention tests and complex assessment of exploration and, if justified by the subject's mental condition, additional tests. The system of psychic aptitude testing and, in case of a disorder, therapy, is a guarantee that workplace stress, aggression, predisposition to it, as well as the development of violence and harassment symptoms can be prevented or detected.

Within the scope of determining medical fitness, similarly to mental aptitude tests, the staff is obliged to take part in screening tests from time to time, and to present the results to the primary care physician. The organization provides premises to perform some of the screening tests at the local medical centre (e.g., lung screening, blood sampling, ophthalmic examination, dental examination).

In order to help professional staff meet the annual physical fitness requirements and to help law enforcement staff lead a healthy lifestyle, the employer provides a two-hour weekly working time allowance to support sports opportunities.

The occupational safety management activity is performed by the chief occupational safety inspector who is a member of staff of the National Headquarters of the Prison Service, Technical and Supplies Department with a degree in occupational safety engineering, in accordance with the Order of the National Headquarters of the Prison Service 1/2016 (15 April) BVOP on the Code of Organisation and Operation of the National Headquarters of the Prison Service. In the course of their activities, the Chief Occupational Safety Inspector provides appropriate professional assistance to the occupational safety inspectors of penitentiary institutions. They provide ongoing contact information for occupational safety inspectors and staff on occupational safety issues.

If a member of staff has a psychological difficulty or problem, the penitentiary organisation arranges for care by a psychologist. If there is a suspicion of a psychiatric illness discovered by a psychologist, the detecting psychologist will contact the primary care physician, who will refer the patient for psychiatric care if necessary.

4. Measures concerning the staff of the professional disaster management body

During their health and psychological activities, the professional disaster management body applies the provisions of *Joint Decree of the Ministers of Justice and Law Enforcement and of Local Governments and of Postal Services and Communications 57/2009 (X. 30.) IRM-ÖM-PTNM on Health, Psychological and Physical Aptitude of Members of the Career Personnel of Certain Law Enforcement Agencies, on Health Aptitude of Civil Servants and Public Officials, on Establishment of Inability for Service and Earning, and on Basic Health Care Provision* (hereinafter: Decree). According to the Decree, in order to be recruited to the professional staff, to maintain a legal relationship and to determine suitability, the organization has expectations regarding the health, psychological and physical abilities of the

staff. Applicants for admission to the organization undergo a preliminary medical, psychological and physical aptitude test. After being hired, compliance with the requirements and criteria set for the given position or job is checked during the periodic aptitude tests.

Basic health and psychological care of the professional disaster management body is provided with national coverage and in the context of regional care. Currently, nine Health, Psychology and Occupational Safety Centers provide the staff with directly available medical and psychological assistance. Existing co-operation with the police allows the use of the primary health and psychological services of the police body in acute cases. Medical and psychological support helps the staff and provides opportunities for mental care or psychological counseling. The health sector of the professional disaster management body pays special attention to health preservation.

The professional management of occupational safety and health is uniform throughout the country, and its observance is constantly monitored by the occupational safety inspectors of the central and regional bodies.

The public health and epidemiology tasks are performed in a nationally uniform system by the county health protection commissioners under the direction of the Chief Inspector of Public Health and Epidemiology of the Ministry of the Interior's National Directorate General for Disaster Management.

5. Measures concerning alien police staff

The help of a psychologist is constantly available to the staff of the National Directorate-General for Aliens Policing (hereinafter referred to by the Hungarian abbreviation as OIF) as necessary. Simultaneously with the transformation of the OIF into a law enforcement agency, since 1 July 2019, a specialist psychologist of the National Police Headquarters has been inspecting officers every 1-2 years, depending on their positions, as part of a mandatory psychological occupational health examination to identify psychosocial risks. In recent years, OIF staff have received training on workplace conflict management and how to strengthen cultured treatment of clients. In 2017, anti-burnout and stress management training was held in 19 groups in 6 locations for 133 people, and articles on stress management were regularly published on the OIF's internal network.

In order to support exercise as a form of health preservation, a gym was set up in the OIF area and a covered bicycle storage shed was erected for those who came to work by bicycle. In addition, free sports facilities are available for the staff at the sports complex.

In addition to the above, the ECSR requested information on the implementation of the National Occupational Health and Safety Policy 2016-2022, adopted in accordance with the European Union Strategy for Occupational Health and Safety 2014-2020 and the Global Plan of Action of the World Health Organization.

The Government approved the National Occupational Health and Safety Policy (hereinafter referred to by the Hungarian abbreviation as MNP) in Government Resolution 1581/2016 (25 October) with the aim of effectively contributing to the improvement of working conditions, to the preservation of the working capacity of employees, to the increase of healthy life years, and at the same time to the increase of Hungary's competitiveness. The MNP defines the priorities of domestic occupational safety and health for 2016-2022, in accordance with the

current strategy of the European Union for occupational safety and health for 2014-2020. The MNP sets out five main tasks, within which it also defines a number of additional tasks.

In order to successfully implement the tasks, set out in the MNP, the following progress has been made:

1. Developing the competitiveness of enterprises

One of the key objectives of the MNP is to enable small and medium-sized enterprises to apply effective and real risk prevention measures as much as possible. To achieve this, the following tasks have been identified:

➢ Supporting introduction of free online tools to be used to carry out occupational safety and health tasks

- With the help of an EU project ("Improvement of occupational health and safety"), sector-specific (retail, hospitality, health, construction, transport, etc.) electronic occupational safety and health methods have been developed that promote the development of and support occupational safety and health activities.

  Within the project, 3 applications were accepted with the aim of developing an online risk assessment tool for psychosocial risks. Sector(s) concerned: mining and quarrying, textile, leather, clothing, leather goods, footwear manufacturing, rubber and plastics; and land, pipeline, water and air transport.

  Further 4 applications were accepted to set up an online “signalling system" to assess the hazards and conduct screening tests. Sector(s) concerned: computer, electronics, optical product manufacturing; manufacture of electrical equipment; building industry; wholesale; and education. The project also developed a methodological guide and electronic application proposals to support employers' risk assessment in the construction industry.

  The following online risk assessment tool has been developed for the transport sector: On land, water, in the air - online occupational safety risk assessment for road haulage drivers, vehicle maintainers, ship captains, sailors, pilots, air traffic controllers, train drivers, traffic controllers.

- There was also a professional event for digitalisation and online communication entitled "Digital Welfare Forum - State Control and Digitization": The state is the largest data owner, managing information to the extent that it requires the use of the most advanced technical, technological and organisational solutions possible.

➢ Encouraging the development of an effective occupational safety and health management system

The promotion and support of the introduction of the Occupational Health and Safety Management System (MEBIR) was declared as early as in the year of the announcement of the MNP. The following organisations took advantage of this opportunity:

- Mining, Energy and Industrial Workers' Union,
- Iron Trade Union Confederation as well as the

- Hungarian National Federation of Consumer Co-operative Societies and Trade Associations

➢ **Communication of good practices and promotion of adoption**

In the field of improving the competitiveness of enterprises, the presentation of good practices and the encouragement of their exchange should be supported. Sharing the results of occupational safety and health developments of enterprises helps smaller, more inexperienced or start-up businesses to improve their own working conditions.
For such purposes, the following events were held in 2017-2019:

- Conference of the "Healthy Workplaces for All Ages" campaign
- Opening conference of the campaign "Focus on agriculture - work safety is No.1"
- Construma Trade Fair Academy of Occupational Safety on "Focus on Construction",
- 23rd National Forum of occupational safety representatives
- 6th National Forum of Occupational Safety Professionals
- Forum of Occupational Safety Representatives in the Electricity Industry
- Conference on Good Practices in the Handling of Hazardous Substances. At the conference related to the two-year campaign "Healthy Workplaces Manage Dangerous Substances" organised by the EU Occupational Health and Safety Administration (EU-OSHA) the winners of the Good Practice Award in Hungary and their applications were presented.
- The "Energy of Safety" event was designed to present the good practice of the large company to suppliers and other small businesses.
- Bilbao held the closing event of the EU-OSHA campaign "Healthy Workplaces Manage Dangerous Substances", where the Good Practice Awards were distributed and presented.

In the mining and quarrying, computer, electronics, optical product manufacturing and electrical equipment manufacturing sectors a publication has been compiled with good examples of occupational safety and health risks and solutions.

➢ **Developing a concept for accident insurance within the scope of social security**

The aim of establishing the accident insurance branch of social security is a good employer incentive system for the improvement of working conditions, owing to which working conditions can be improved, the number of accidents at work and occupational diseases can be reduced, and the competitiveness of enterprises can increase. The implementation of the tender of the EU project GINOP-5.3.7-VEKOP-17 ("Development of legal employment") is currently in progress in which one of the key elements is the preparation of the concept for the development of the accident insurance branch of social insurance.

2. Maintaining the working capacity of employees

➢ The methods developed to reduce absence at work due to psychosocial risks should ultimately lead to a reduction in the number of accidents at work and occupational

diseases. The following sector-specific summaries of psycho-social risks have been published:

Training

- Workplace stress and burnout. Are you also affected? - Workplace stress survey for those working in education

Manufacture of electrical equipment

- Methodological guide for risk assessment of sector-specific workplace psychological stress
- Psychological stress in the workplace - the possibilities of stress management

Water supply, wastewater collection, treatment, waste management

- What you should know about psycho-social factors of the workplace

➢ The ongoing implementation of the programme Encouraging Research on Assessing the Origin of Locomotor Diseases and Cancer Diseases of Occupational Origin is supported by the GINOP-5.3.7-VEKOP-17 priority project.

➢ The following sector-specific summaries have been published for the implementation of the programme item Encouraging and Supporting the Development of new Ergonomic Methods:

Manufacture of computer, electronic and optical products
Ergonomics in the workplace

Manufacture of electrical equipment
Ergonomics in the workplace

3. Occupational health and safety training and education

➢ The task of the "Development of a system (and database) of compulsory in-service training for occupational health and safety professionals" described in paragraphs 3.1 and 5.4 of the National Occupational Health and Safety Policy is aimed at the registration of occupational safety and health professionals and the continuous maintenance and development of their knowledge. The consultation with the National Occupational Safety and Health Committee has started, and the authorization to carry out the task has been published in the Labour Safety Act. The technical specification has been completed, and a government decree containing the regulation is currently being prepared.

➢ The aim of the task of expanding the knowledge about occupational safety and chemical safety at workplaces in education is to form a prevention-conscious approach. According to the task, the basic materials of occupational safety training and education should be developed by sector and also by profession within each sector.

Related events:

- 7th International Congress of the Federation of Occupational Health Nurses within the European Union, FOHNEU Presentation of the EU-OSHA campaign "Healthy Workplaces Manage Dangerous Substances"

- Participation in the Safety Week programme series.
The aim of the programme series is to develop students' safety-conscious behaviour. The opening of the national programme series was held at the University of Public Service The subsequent road show event awaits members of the 9-14 age group in each county, where thousands can meet with the parties of broad collaboration.

- Closing conference of the biennial campaign "Healthy Workplaces Manage Dangerous Substances". The event focused on the achievement of the objectives of the two-year campaign, the experience of occupational safety inspections, the investigation of reported occupational diseases, current EU regulations, company experience in the regulation of hazardous substances and laboratory testing tools for prevention.

- Congress of the Hungarian Chemical Industry Association
The aim of the event is to review the occupational safety situation in the chemical industry and to present the expected amendments to the domestic and EU occupational safety legislation.

- Safety Week thematic programme week - organized by the National Accident Prevention Committee of the National Police Headquarters and the Association of Hungarian Insurers. The road show addressed members of the 9-14 age group in all counties, where thousands could meet with the parties of broad collaboration.

➢ In order to reduce the occupational risks for employees belonging to vulnerable groups and those involved in atypical forms of employment, knowledge must be compiled and disseminated to targeted employers. The implementation of this objective is planned within the framework of the GINOP-5.3.7-VEKOP-17 priority project.

4. Information, communication

The ministry controlled by the minister responsible for the employment (hereinafter: Ministry) provides regular, relevant and professional information to interested parties, primarily small and medium-sized enterprises (hereinafter: SMEs) and representatives of micro-enterprises, by operating a public information system on occupational safety and health.

The Ministry's Occupational Safety Department participated in the in the preparation of the Hungarian language versions of the information materials of the campaign (campaign guide, NAPO film[12]) of the EU-OSHA 2016-2017 annual "Healthy Workplace for All Ages!" campaign and in the distribution of the materials during EU-OSHA events.

The "Cooperation for the Safety of Workplaces" partnership programme, aimed at recognising and cooperating with companies that voluntarily comply with the law, was

[12] https://www.napofilm.net/hu

officially announced at the occupational safety conference held at the Budapest University of Technology and Economics.

The issued publications included the following:

- Notice of the Ministry's Occupational Safety Department on the dangers of bee and wasp stings.
- Information of the Ministry's Occupational Safety Department about the updated interpretation of construction machine operator licences. Occupational health and safety consulting with the physical participation of 2-2 consultants at the "I. National Chamber of Agriculture and Economy Field Days" event organised by the National Chamber of Agriculture.
- A guide and leaflet related to the "Focus on Agriculture - Work Safety is No.1" campaign has been published.
- Publication of the Ministry's Occupational Safety Department information on employment of students in the summer.
- Publication of a call by the Ministry's Occupational Safety Department on the dangers of heat waves.
- Launch of a "Forum of Occupational Safety Representatives" on the website of the occupational safety and health authority.
- Publication of the notice of the Ministry's Occupational Safety Department on the dangers of must fermentation.
- Notice of the Ministry's Occupational Safety Department for asbestos-contaminated industrial abrasives (EUROGRIT).
- Holding the “Safe Work in the Field” occupational safety roadshow in agriculture organised by the National Chamber of Agriculture at various venues across the country.
- Reports on the development of accidents at work (quarterly).
- Reports on the experience of the inspections of the occupational safety and health authority (quarterly).
- European Commission guide to noise and vibration reduction.
- Information on occupational safety issues related to employment of students in the summer.
- Notice concerning the dangers of working in the heat - Particularly important preventive measures during a third-degree heat alarm.
- European Commission Guide: Protecting Occupational Health and Safety of Workers in Agriculture, Livestock Farming, Horticulture and Forestry.
- The focus is on the construction industry - work safety first - a flyer, and campaign guide.
- General occupational safety and health guide for those working in the construction sector.
- European Commission guide on health and safety risks to health workers at work.
- Notice about the dangers of must fermentation.
- Health and safety at work affects everyone - EU-OSHA factsheet.
- Managing nanomaterials in the workplace- EU-OSHA factsheet.
- Informative occupational health and safety publications for upper classes of primary schools

- Information in English on basic occupational health and safety for foreign employees employed in Hungary.
- Information on instructive accidents at work.
- Notice about the dangers of working in the cold.
- Information on Regulation (EU) 2016/425 of the European Parliament and of the Council.
- Information for employers on the regulations on the supply of protective clothing (personal protective equipment) and work wear.

The staff of the Ministry's Occupational Safety Department organised or participated as speakers in various events in many settlements of the country e.g.,

- Participation and giving presentations in an Open Day organised by government offices.
- Current issues in zoonosis; The scientific meeting described the current situation of animal-to-human infectious diseases (e.g., West Nile fever, tick-borne encephalitis, Lyme disease, anthrax).
- National Association of Hungarian Vehicle Parts Manufacturers Occupational Safety Conference: Occupational safety and technical development, new challenges, innovative solutions
- 25th National Forum of Occupational Safety Representatives
- Occupational safety and fire protection conference. Current issues and changes in occupational safety and health

Issued publications, brochures, guides, teaching aids by sector:

Healthcare

- Handbook for those working in the social sector and for employers
- Handbook for those working in the health sector and for employers
- Occupational safety knowledge for those working in the social sector
- Occupational safety knowledge for those working in the healthcare sector

Building industry

- Directions of occupational health and safety and the occupational health system transformation

In the education sector

- Checklist before the bell rings for the lessons - For accident-free and safe classroom work

Rubber industry

- General rules of conduct and most important occupational safety standards
- Occupational health brochure - in the rubber industry

Manufacture of computer, electronic and optical products

- Sector-specific training material for occupational safety representatives
- General occupational safety information booklet
- Sector-specific training syllabus
- What to do in case of an accident or malaise
- Occupational health examinations

Manufacture of electrical equipment

– Sector-specific training material for occupational safety representatives
– Training material for occupational safety representatives in the electrical equipment manufacturing sector
– Summary table of the minimum occupational safety and health requirements applicable to companies during operation

Steel manufacture:

– Support material for the training of occupational safety representative
  - Work at height
  - Material handling in the workplace
  - Individual protective equipment
  - Ionising radiation and electromagnetic fields
  - Risk assessment
  - Investigation of accidents at work
  - Occupational health tasks and their implementation
  - Requirements for workplaces and work equipment
  - Occupational safety foundations

Retail

– Accidents at work - occupational accident, or the most important information for employees
– Work safely in retail
– Occupational health effects of observing the rules of working time and rest time
– The price of the work, or is the employee's health affordable?

Agriculture

– Risks for agricultural forestry workers

Water supply, wastewater collection, treatment, waste management

- What you should know about working in extreme climatic conditions
- What you should know about biological risk factors in the workplace
– Man is the most valuable asset, keep that in mind
– Use personal protective equipment
– Occupational safety syllabus in the water supply, sewerage, treatment sector
– Occupational safety questions - answers

Chemical safety information leaflets for students were also produced during the above-mentioned "Safety Week" thematic programme week summarising, in addition to general occupational safety knowledge, basic knowledge of chemical safety and the hazards of using chemicals in various professions.

The following information has been published on the website of the Ministry's Occupational Safety Department:

– What you need to know about chemical safety at workplace! - information for upper classes of primary school students;
– Occurrence of hazardous substances in certain professions - information for students of upper classes of primary schools;
– Substitution of hazardous substances in the workplace - EU-OSHA factsheet;

– Information on the closing conference of the "Healthy Workplaces Managing Hazardous Substances" campaign - EU-OSHA information.

5. Research and development on occupational safety

A comprehensive evaluation of all domestic legislation on occupational health and safety, applying 24 directives, is currently underway. The aim of simplifying existing legislation is to implement international occupational health and safety standards in Hungary and to create coherence.

In accordance with Directive 89/391/EEC, the Ministry of Innovation and Technology is continuously conducting a comprehensive evaluation of the legislation on health and safety at work.

The Labour Safety Act and the ministerial decrees on occupational safety and health are based on a number of ILO conventions and recommendations and incorporate the provisions of Directive 89/391 / EEC and the individual directives.

On 13 May 2016, the European Commission took the first step in reducing the occurrence of cancer of occupational origin by preparing a first package of legislative proposals amending Directive 2004/37/EC on the protection of employees from the risks related to exposure to carcinogens or mutagens at work.

Directive 2017/2398/EC of the European Parliament and of the Council amending Directive 2004/37/EC (Carcinogens package 1, hereinafter: 2017/2398 Directive) was adopted on 12 December 2017.

On 16 January 2019, Directive (EU) 2019/130 of the European Parliament and of the Council amending Directive 2004/37/EC on the protection of employees from the risks related to exposure to carcinogens or mutagens at work (hereinafter: 2019/130 Directive) was promulgated.

During the transposition of Directive 2017/2398 and Directive 2019/130:

– In order to comply with the legal acts of the European Union, Joint EüM- SZCSM Decree 25/2000 (30 September) on the Chemical Safety of Workplaces was repealed and was replaced by the *Decree of the Minister of Innovation and Technology 5/2020 (6 February) ITM on the Protection of the Health and Safety of Workers from the Risks Related to Chemical Pathological Factors*

– the EüM Decree 26/2000 (30 September) on Protection against Carcinogenic Substances used at Workplaces and on Prevention of Health Impairment caused by them (hereinafter referred to by the Hungarian abbreviation as EüM Decree 26/2000) was amended.

Several researches and studies on occupational safety have been prepared on the topic.
The following publications have been prepared.

- Research Report - Health Sector Specification
- Summary of research results in the computer, electronics, optical products manufacturing sector
- A research study in the electrical equipment manufacturing sector
- Assessing the risks of railway work

- Impact of global warming on the health status of forest and agricultural employees
- Occupational safety in agriculture - a sector-specific study
- Research report in the water supply, wastewater collection, treatment, waste management and decontamination sectors

The GINOP-5.3.7-VEKOP-17 priority project supports priority research and studies too:

- Investigation and analysis of the direct and indirect health effects of climate change (e.g. sunstroke, heat stroke, heat depletion, increased occurrence of zoonoses) and the risk of additional deaths due to heat waves depending on meteorological data;
- Study on occupational health and safety challenges related to the increase in the average age of employees;
- Occupational health and safety aspects of atypical forms of employment in Hungary;
- Research to assess the occupational origin of occupational musculoskeletal diseases;
- Study on the possibilities of reducing the administrative burden on employers and simplifying the legal regulation of health and safety, forecasting the effects of the measures;
- Assessment of the real situation of cancers of occupational origin in Hungary, exploring the causes, developing procedures for recognising the occupational origin of cancers;
- Options of introducing OiRA (online risk assessment system) in Hungary;
- Reducing occupational risks for employees in the vulnerable group, and the definition and development of working conditions for employees with disabilities and persons with a reduced ability to work, taking into account the disability and remaining working abilities, exploration of workplace equipment, work assistive technologies, technical aids for employees with reduced ability to work, technical and organisational solutions to help transport and orientation of employees with disabilities at work;

In addition, in order to strengthen the professional and operational conditions of the integrated occupational safety and health authority, 17 textbooks were prepared for the professional training of government officials as well as the up-to-date education of new entrants.

In addition to the above, the Government of Hungary also participated in meetings related to occupational health and safety research and development, and also participated in organising them;

- The meeting of the leaders of the V4 countries responsible for health and safety management in order to develop international co-operation took place on 4 June 2019, in Kosice, after Budapest. The heads of delegation from the four countries shared their experiences on prevention and ways to promote health and safety.
- Based on the invitation of the Ministry of Labour, Employment, Veteran and Social Policy of the Republic of Serbia, the secretary of state of the ministry responsible for employment policy discussed the issues of state management of health and safety and tripartism with the officials of the Hungarian National Occupational Safety and Health Committee.

- Regarding occupational safety and health research and development, Government and national and local interest representation bodies have professional co-operation in the following areas:
  - The quarterly meetings of the National Occupational Safety and Health Committee
  - Event of the National Occupational Safety and Health Congress, titled as 'Occupational safety situation'
  - Opening event of a two-year national information campaign to protect workers in the construction sector, co-organised with the National Federation of Hungarian Building Contractors
  - Event titled as 'Requirements for the application of standards and the experience of the occupational safety and health authority'

It is also worth mentioning that the Government of Hungary participates in the Senior Labour Inspectors Committee (SLIC). Within this, it contributes to the work of the SLIC CHEMEX working group and the MACHEX working group.

The ECSR requested information, supported by statistics on the coronavirus pandemic, on the measures put in place to protect frontline workers, including guidance and training on the management of the pandemic and the provision of protective equipment.

1. Measures related to professional health care workers

In order to address the increased threat to professional health care workers, the Operative Body in charge of the coronavirus pandemic control issued an order on 26 March 2020 to train doctors and nurses at the appropriate level. In accordance with the instructions three educational programmes were developed within the framework of B-learning (mixed-type distance learning). The programmes have been made up of theoretical and practical elements.

A significant chapter of the curriculum is protection against coronavirus infection (hand hygiene, protection of the respiratory system, use of personal protective equipment, patient isolation, organisation of patient paths, cleaning and waste management).

The distance learning framework for the acquisition of the theoretical elements of the trainings is available on the platform of the National Healthcare Services Center[13]. The interface can also be accessed by registration and mobile phone application.

The syllabus was provided by the National Public Health Centre, the University of Debrecen, the University of Pécs and Semmelweis University. The acquisition of the theoretical curriculum ended with the completion of an electronic test, the successful performance of which was a condition to start practical preparations. The practical training was organised in the intensive care units of inpatient institutions (doctors, nurses), in the skill laboratories of higher education institutions (students attending higher education) and in the demonstration rooms of vocational health training institutions (volunteers).

26,046 users were registered, of whom 5,751 are now enrolled in the in-service training of physicians, 17,640 in the in-service training/programme for nurses and health care graduates, and 2,513 are enrolled in the volunteer nursing programme. The practical training has been or

[13] https://tavoktatas.aeek.hu

will be carried out with the involvement of 227 instructors in 48 locations for doctors, 359 instructors in 62 locations for nurses/students and 60 instructors in 24 locations for volunteers.

2. Measures related to workers in the social sector

The Ministry of Human Capacities (hereinafter referred to by the Hungarian abbreviation as EMMI) has been working continuously to provide the necessary resources everywhere as soon as possible to protect staff members and those cared for. Based on the decision of the Operative Body, the social institutions received protective equipment for epidemiological control from the central budget on a weekly basis through the Directorate-General for Social Affairs and Child Protection. In the first round, distribution started in all residential social institutions (maintained by the state, municipalities, churches and NGOs) providing care for the elderly, and then it continued in all social institutions providing specialised care received protective equipment on an ongoing basis, regardless of the maintainer.

In total, by 20 November 2020

- 52,794,780 surgical masks,
- 15,391,200 rubber gloves,
- 160 thousand litters of hand sanitiser,
- 160 thousand litters of surface sanitiser,
- 69,190 isolation cloaks,
- 84,640 FFP2/3 masks,
- 910 polycarbonate face shields with forehead straps, and
- 51,200 quick tests

were provided in the social field.

With regard to the pandemic situation, the Minister of Human Capacities has issued guidelines on primary social and child welfare services, specialised social services and child protection services and correctional facilities to assist service personnel in their emergency procedures to be followed in the State of Danger. Each of the recommendations concerning the protection of employees' health sets out practical examples to prevent social and child protection workers from becoming infected with the coronavirus.

Examples are regulations promoting the use of hygiene etiquettes, for the protection of employees, the recommendations for the use of protective equipment and supplies, continuous health monitoring of employees and those cared for, drawing attention to credible reference points on the situation of the pandemic, in the case of basic services, care through info-communication means, formulation of rules for the isolation of those cared for as needed.

3. Measures applicable to members of the staff of law enforcement agencies

A package of measures related to the management of the coronavirus pandemic was issued on 20 March 2020. It contains the most important care and protection rules, information on general and personal hygiene, and general rules on the use of protective equipment.

In order to reduce the risk of the pandemic affecting both the police staff and the persons subject to the measure, the Police continuously monitored the legislation in force in connection with the health State of Danger, the website of the National Public Health Centre (hereinafter referred to by the Hungarian abbreviation as NNK), the koronavirus.gov.hu

website, and rules of procedure and professional materials issued by the Minister of Human Capacities and the National Chief Medical Officer.

To replenish the protective equipment, the request for protective equipment for the police staff was sent to the Ministry of Interior on 13 March 2020. The statement included stocks sufficient for 15 days in the current pandemic situation and 6 months in the event of a mass cases. To ensure the continuous provision of protective equipment, the police agencies also took measures to replenish stocks in their own competence. Police agencies monitored the amount and availability of protective equipment and hygiene equipment (FFP2/FFP3 respirator, surgical nasal-mouth masks, protective clothing, goggles, rubber gloves, anhydrous hand sanitizer gel, hand sanitizer soap, surface disinfectant). The Police took the necessary measures to replenish the protective equipment. In this context, on the basis of the available data, it took measures to procure the following protective equipment:

- mouth masks, surgical masks - rubber, binding 6 483 910 peaces;
- textil mouth masks 233 000 peaces;
- FFP2 masks 140 481 peaces;
- FFP3 masks 3 442 peaces;
- examination gloves 11 871 055 peaces;
- disposable overalls 48 498 peaces;
- disposable lab coats 2 560 peaces;
- hand sanitizer fluid, solution, concentrate 62 933 l;
- Hand sanitizer gel, foam 8 202 l;
- surface sanitizer fluid, solution, concentrate 58 287 l;
- surface sanitizer gel, foam, spreadable material 2 804 l;
- face protection plexiglass 3 762 peaces;
- protective goggles 6 316 peaces.

Occupational safety and health professionals continuously monitored compliance with hygiene regulations for the protection of the health of police staff, along with the availability of hygienic equipment and protective equipment.

Information of the staff on the coronavirus and prevention was continuous in all police agencies on an ongoing, professional basis. In addition to the Rules of Procedure, the Police's internal website contains professional materials related to the coronavirus, epidemiologically important precautionary measures, correct hand washing/hand sanitising techniques, personal hygiene, psychological professional materials, and rules of procedure issued by the Minister of Human Capacities and the National Chief Medical Officer are also available.

A measure was taken to reorganise primary health and psychological care, which, in addition to providing care for the staff, contributes to mitigating the risk of infection by reducing physical contact. In the case of primary health care and psychological care of law enforcement and defence agencies, in addition to ensuring the full health and psychological primary care of the staff, doctor-patient and psychologist-patient meetings were minimised. For such purposes, where possible, care is provided through distance consultation; also, the options offered by the digital world are exploited (e.g., e-prescription). Patients with coronavirus symptoms and other patients are treated separately (separate ward, appointment in a banded time frame). Periodic aptitude tests, vehicle aptitude tests have been suspended, and only

emergency dental care has been provided. Constant mental hygiene care is provided for staff members. A standby service has been set up in both the medical and psychological fields.

In order to preserve the psychological stability of the police staff, measures have been taken to carry out the psychological activity to be carried out in the pandemic situation and to ensure the continuous provision of psychological care. Specialist psychologists created educational materials for the staff, which were sent directly to the agencies and are also available on the MyPolice platform.

Extraordinary events during the State of Danger were constantly reported by the primary care psychologists to the head of the Department of Psychology, the necessary interventions took place, primary care psychologists provided the crisis intervention to those affected.

Occupational safety and health and public health inspections are constant in police facilities and service areas, which also covers the supply, feeding and placement of protective equipment and sanitisers for the staff.

Separate rules of procedure were drawn up for each field (border policing, public order, criminal technology, etc.) in accordance with the tasks to be performed by the particular field and the risk involved in their implementation.

Professional materials and briefings were regularly forwarded to the police agencies (recommendations of the World Health Organisation, recommendations, briefings, rules of procedure, manuals of the Minister of Human Capacities and the National Chief Medical Officer, possibilities of redeeming the e-prescription, etc.).

The epidemiological authority was consulted several times on the protective equipment needed for the staff, on the possibilities of sampling patients showing symptoms of respiratory infection and suspected cases, and on the possibilities of disinfection.

In connection with the epidemic caused by the coronavirus, a new task was to reorganise the primary care of law enforcement and defence personnel, to perform aptitude tests and curative activities without any personal meeting. It became necessary to establish a closer relationship with the individual professional fields in order to make well-based decisions about the range of protective equipment required for the staff, thus ensuring health protection with sound and economical asset management.

For the future, the priority is to preserve the health of the staff and to maintain their ability for the service. Consequently, the health area, similarly to the practice before, will continue to monitor the NNK website, as well as the koronavirus.gov.hu website, the professional pages in order to follow the latest guidelines and situation assessments.

4. Measures affecting penitentiary staff and detainees

For controlling the human coronavirus pandemic, on 7 March 2020 a central operative body with national competence was established within the penitentiary organisation, which carried out tasks related to the relevant management activities, co-operation with partner organisations and the operation of the penitentiary organisation.

In order to facilitate the analytical and evaluation activities of the staff, a central database was also set up to meet the information needs of all the professional fields concerned. Members delegated to the staff regularly analysed the daily upload of data by the penitentiary institutions. In order to conduct regular analytical work, a weekly standby service was organised, which ensured the continuous availability of the staff. The staff held 124 meetings since its establishment, which served to set regular terms of reference, develop new rules of procedure, and made reference on the specialised areas involved.

On the basis of the guidelines of the centrally issued Action Plans and protocols, local bodies were set up for the law enforcement agencies, as well as contact persons were appointed, in order to solve the local analytical and evaluation activities and the problems arising at the local level who, primarily, liaise with the territorially competent public health departments of government offices and co-law enforcement agencies, territorially competent civil health institutions, and local governments.

The operative body assigned tasks regularly in order to ensure that the norms and rules of procedure issued by the Government of Hungary and the NNK were enforced out of turn in the penitentiary bodies, as well as to eliminate the shortcomings identified during the analyses and to introduce new special rules of procedure. As of 7 March 2020, the head of the operative body, their deputy, and the specialised areas of the penitentiary organisation have set tasks in 398 cases, according to their competence, and Action Plans and a pandemic plan have been issued 13 times.

In view of the coronavirus epidemic, the following measures have been taken concerning staff and prisoners:

- organization and implementation of epidemiological screening of personnel and detainees;
- regular screening of healthcare workers;
- review of the notification system, implementation of notification tests;
- issuing and implementing procedures related to disinfectants and air disinfection;
- preparation and implementation of epidemiological measures for kitchens;
- enhancing the electronic contact opportunities of detainees;
- establishment and operation of Call Centers;
- preparation of emergency plans
- examining the possibility of working from home, developing and implementing its rules;
- reviewing the regulations related to the work of the present staff, taking related measures;
- standardization of COVID reports and issuance of related measures;
- establishment of a central COVID service for the detailed and continuous evaluation and analysis of epidemiological data;
- establishment and operation of the COVID and POSTCOVID departments;
- planning and implementation of measures related to the epidemiological outbrakes;
- development and implementation of procedures for recovered personnel and detainees;
- carrying out tasks related to the epidemic closure and its decommissioning;
- ensuring the transport of the infected persons;

- elaboration and implementation of the procedure for release and reintegration detention, with special regard to the pre-release sampling procedure;
- development of procedures for the scheduled provision of vaccination
- since the beginning of the epidemic, the penitentiary has paid special attention to the regular screening of health workers. PCR tests are performed in inpatient care institutions, while the penitentiary institutes are providing antigen rapid tests in the context of primary health care.

In addition to the above, in order to compensate for the restrictions imposed on prisoners in view of the coronavirus epidemic - restrictions on visits and temporary institutional leave - measures and compensations were introduced that facilitate communication between prisoners and their relatives. As part of this, electronic contact opportunities were made more widely available and free telephone calls were provided to detainees.

In order to prevent the coronavirus pandemic and to eliminate its consequences, the penitentiary business associations provided the state-owned health and law enforcement agencies and the Kiskunhalas Mobile Epidemic Hospital with the production and delivery of furniture and textile products not manufactured previously or manufactured but not in the current quantities.

28 678 textile mouth masks, 744 841 medical face masks, 61 671 FFP2 masks, 64 272 protective garments, 224 non-contact thermometers, 3,576,111 rubber gloves were distributed to prison staff, and 86 325 textiles were distributed to detainees. from the stock procured by the implementing body by 12 December 2020.

The operative body will continue to operate in the future, the analysis and assessment activities will continue, it will monitor international practices, and it will provide guidance and professional support to law enforcement agencies.

As a result of the vigorous preventive action, by 12 December 2020, 421 detainees in prisons had been infected with the coronavirus, 339 of whom had already recovered. In terms of personnel, the test of 1 103 people was positive, around 543 people have already recovered. The necessary epidemiological measures have been implemented in these cases.

Sections 236-245 of Chapter “80. Different Application of the Provisions of the Penitentiary Act” of Act LVIII of 2020 on the Transitional Rules and Epidemiological Preparedness related to the Cessation of the State of Danger contain a series of measures, which are justified according to the specialisation areas of the penitentiary organisation, taking into account the closed community, in order to prevent possible epidemic diseases.

Thus, it introduces, inter alia, the following provisions in order to increase the protection of probation officers and penitentiary probation officers:

"200. § *(1) The probation officer may also communicate with the persons required to cooperate via other electronic means if, due to an epidemiological measure or other reasons related to a health crisis, personal contact is impeded. When using a telecommunications device, it is not necessary to record the discussion.*

(2) In the course of the contact pursuant to paragraph 1, the probation officer shall verify the identity of the person concerned by reconciling his or her personal data and/or in such other way as to establish the identity of the person concerned.

(3) If, in the course of the contact pursuant to in paragraph 1, there is a reasonable doubt as to the identity of the person concerned, the voluntary nature of his or her participation or the absence of influence, such contact shall not be continued.

237. § *(10) If, in the context of preparation for release, taking into account the epidemiological measure or other reasons related to the health crisis situation, the measure requiring personal contact is impeded, the penitentiary or the penitentiary probation officer may fulfils it via telephone or other electronic means.*

241. § *(1) If contact with and information to the probationer and the monitoring of the probationer's conduct, studies, behaviour and lifestyle at work or at the place of residencethroughpersonal contact are impeded by an epidemiological measure or other reasons related to the health crisis, the supervisor or the probation officer may fulfil it via telephone or other electronic means.*

(2) Subject to an epidemiological measure or other reasons related to the health crisis, during the probationary period may also contact with the probation officer or the penitentiary probation officer via telephone or other electronic means if personal contact is impeded."

In addition to the above, the law also contains measures to reduce the number of personal contacts, such as the conduct of judicial enforcement proceedings:

"236. § *(6) In criminal enforcement proceedings, if justified by the epidemiological measure or other reasons related to the health crisis, or on the basis of the order of the President of the Tribunal, ensuring the presence of participants during the trial may be ensured via electronic communications network or other means of a device capable of transmitting electronic images and sound, provided that if the convicted person or other detainee is detained, his presence must be ensured primarily by the use of a means of telecommunication."*

5. Measures applicable to members of the staff of disaster management

In 2020, public health and epidemiological measures were introduced at the professional disaster management agency in order to prevent and reduce the effects of the coronavirus pandemic, based on the recommendations of the Government and the NNK. The Director General of the National Directorate General for Disaster Management of the Ministry of Inferior issued an Action Plan for the implementation of tasks related to the coronavirus pandemic, as well as a Procedural and Action Plan for the coronavirus pandemic.

By increasing the preventive activity, the organisation ensured the preservation of the health of the staff members, it was prepared to treat the development of possible epidemic foci and

to prevent the spread of the infection. In view of the State of Danger, continuous documented training of the entire staff and increased monitoring of compliance with public health and epidemiological measures were ordered across the country. There are uniform rules of procedure for the use of hand and surface sanitisers in buildings, when working outdoors and when using official vehicles, and workplace meals were served in pre-packed form. The human health specialised area participated in the assessment of the amount of personal protective equipment and sanitisers needed to prevent the pandemic, and co-ordinated the tasks related to the delivery of hand and surface sanitisers to regional bodies.

In view of the emergency situation, the National Directorate General for Disaster Management of the Ministry of Inferior carried out the following procurements in order to comply with the public health and epidemiological measures:

- Medical masks 20 000 pieces
- Textilmasks: 235 pieces
- Rubber gloves: 70 400 pieces
- Thermometers: 44 pieces
- Hand and surface disinfectant: 5 533 l

At the professional disaster management body, the basic health and psychological care was reorganized in accordance with the measures of the National Center for Public Health and the Chief Law Enforcement Officer, in order to provide the necessary services to the full staff and in compliance with epidemiological regulations. In order to reduce the spread of the infection, the degree of physical contact during personal doctor-patient contacts was minimized, and telephone consultation came to the fore during medical and psychological care. Colleagues showing symptoms were examined separately using appropriate protective equipment. Despite the suspension of the periodic aptitude tests, the examinations required for the recruitment procedures and the career- aptitude tests were continuous. The development of the epidemic was continuously monitored by public health, occupational safety, psychology, and epidemiological experts.

Following the lifting of the State of Danger, the above Action Plans were amended to maintain the preventive measures required by the instructions of the Chief Medical Officer and the NNK, as well as the epidemiological measures required by the epidemiological preparedness regulations.

6. Measures applicable to the alien police staff

To protect employees, including frontline workers, an OIF employee whose close relative travelled abroad in March 2020 was required to undergo two weeks of home quarantine. Following the declaration of the State of Danger, a travel ban was imposed in a government decree. In view of the declared State of Danger, absences paid (exemption from service) for long-term illness, chronic illness and pregnant staff members were granted. In order to protect the staff members during the pandemic, in some departments of the OIF, staff members working in one office could take turns taking 2 weeks' leaves, thus reducing the number of people in one airspace at a time. In addition, in justified cases employees raising several children were allowed to work in home office in justified cases.

The staff was immediately informed about the nature of the virus, how it spread, and what to do to help prevent it, such as the process of washing hands properly and wearing the mask correctly. The buildings were disinfected and sanitising hand cleaners were provided and have

been provided on an ongoing basis. Masks and rubber gloves were constantly made available to employees who came into personal contact with customers during the State of Danger, in addition, glass walls were set up in the customer service areas to prevent the virus from spreading. In order to avoid mass customers' turnover, it was only possible to show up at the customer services at a time booked in advance.

Thanks to the above measures, to the best of their knowledge, no one in the OIF staff has contracted the coronavirus.

7. Measures applicable to immigrants and asylum seekers

In connection with the coronavirus pandemic, **in view of the measures taken by the aliens policing specialised area**, both for third-country nationals residing in Hungary and for persons with the right of free movement and residence, were able to submit an application electronically using the EnterHungary system, the electronic interface for initiating alien policing measures, due to the settlement of their right of residence during the State of Danger. For those individuals who were not able to leave the territory of our country not due to their own fault, pursuant to Section 30 (1) c) of *Act II of 2007 on the Admission and Right of Residence of Third-Country Nationals* (hereinafter referred to as RRTN Act), the aliens policing law made it possible to issue a certificate entitling to temporary residence.

Section 6 of *Government Decree 85/2020 (5 April) on Certain Home Affairs and Public Administration Rules Applicable during the State of Danger* provided for the period of validity of documents expiring during the State of Danger. The validity of residence permits as well as residence permit and immigration permit documents issued on the basis *of Act I of 2007 on the Entry and Residence of Persons with the Right of Free Movement and Residence* (FRMA Act) and the RRTN Act - with the exception of short-stay entry visas and residence permit documents - was automatically extended until the 45th day after the end of the State of Danger.

With regard to a State of Danger, in general, health emergency plans were made in accordance with the United Nations Health Regulations (detection of the disease, segregation at the border). With regard to the health situation of unauthorised persons in view of the State of Danger, the OIF has no information on the introduction of unusual rules of procedure.

With a view to the measures taken by the asylum bodies in connection with the pandemic, the entry of asylum seekers into transit zones has been suspended. In the transit zones, visits among sectors were suspended and personal protective equipment was provided to persons placed in the individual institution as needed.

In order to reduce the virus risk, container separators were installed in the containers of the transit zones (Röszke and Tompa). Legal representatives or other persons (interpreters) may stay only separated from asylum seekers inside the separated container.

There was no infection in the institutions maintained by the OIF either.
In order to deal with the virus outbreak, the OIF has acquired the necessary measures as follows:

- cleaning with disinfectant, aquisition of disinfectant products: HUF 66.5 million
- aquisition of personal walls HUF 9.2 million
- body temperature meters HUF 1.1 million

- personal protective equipments
  (masks, gloves, disposable clothing) HUF 10.4 million

8. Measures concerning the protection of "frontline workers" during the second surge of coronavirus

From 20 November, 2020 persons employed in health care institutions, health care professionals as well as other persons working in health care, persons undergoing residency training, persons performing education and training in education, training and vocational training institutions, and persons working in social institutions and nurseries have the opportunity to regular sampling on a voluntary basis for antigen rapid testing within a publicly funded framework.

In order to ensure the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and employee' organisations:

2. to issue safety and health regulations

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF,REASONS FOR AND EXTENT OF THE REFORMS

During the reporting period, the following significant changes were made in sectoral legislation:

1. As of 1 January 2018, Section 51 (3) of Act I of 2012 on the Labour Code (hereinafter: Labour Code)

entered into force, and states the following:

"Employees shall be employed for work of such nature which is not considered harmful with a view to their physical condition or development. The employer is obliged to amend the working conditions and working hours accordingly, taking into account the provisions of Section 6, in view of the change in the employee's state of health."

As of 1 January 2018, Section 60 (1) of the Labour Code entered into force and states the following:

"An employee shall be offered a job fitting for her state of health if considered unable to work in her original position according to a medical opinion from the time her pregnancy is diagnosed until her child reaches one year of age [if the conditions of employment in her job cannot be changed in accordance with Section 51 (3)] The pregnant worker shall be discharged from work duty if no position appropriate for her medical condition is available."

Article 5 of Directive 92/85/EEC[14] on the introduction of measures to encourage improvements in the safety and health at work of pregnant employees and employees who have recently given birth or are breastfeeding provides for measures in the field of health and safety at work. Accordingly, the Directive imposes an obligation on employers in order to avoid exposing pregnant and breastfeeding employees to occupational risks. The amending legislation adopted in 2017 changed the Labour Code accordingly, under which the employer is obliged to change working conditions and/or working hours before transferring employees to another job. An employee with reduced ability to work may be offered a job that differs from their condition only after that and in the event that it is not possible to objectively change the working conditions. According to the amendment, if it is not possible to employ an employee in accordance with their state of health, they should be exempted from work.

[14] Council Directive 92/85/EEC of 19 October 1992 on the introduction of measures to encourage improvements in the safety and health at work of pregnant workers and employees who have recently given birth or are breastfeeding (tenth individual Directive within the meaning of Article 16 (1) of Directive 89/391/EEC)

2. Act XCIII of 1993 on Labour Safety (hereinafter Labour Safety Act)

In 2016, a major amendment to the Labour Safety Act was implemented, with which the legislator responded to the increase in the number of accidents at work, taking steps to curb the trend. With the amendment, the investigation of all accidents at work was included in the scope of activities requiring professional qualifications, and it became mandatory to involve doctors providing basic occupational safety and health services in the investigation of serious accidents at work.

The amendment to the Labour Safety Act, which entered into force on 8 July 2016, again made it possible to sanction breaches of occupational safety obligations by natural persons (primarily employees). With the introduction of the institution of administrative fines, it is no longer only on the basis of the objective responsibility of the employer that violations of occupational safety rules named in the law can be assessed, which encourages employees to work in a prevention conscious manner.

Pursuant to the 2016 amendment of Section 70/A of the Labour Safety Act, the range of employers obliged to elect a representative has significantly expanded by reducing the number of employees required for the compulsory organisation of the election of an occupational safety representative from 50 to 20, and the regulation is no longer valid only for employees covered by the Labour Code. As a result, the obligation to hold the election of an occupational safety representative applies to more than 99% of small and medium-sized enterprises (most employers employ less than 50 people), as well as hazardous sectors employing significant numbers of staff, such as healthcare. As a result of all this, the number of occupational safety representative in Hungary has doubled.

3. Major changes in legislation at decree level

- The EüM Decree 26/2000 was amended for the purpose of approximation to Directive 2014/27/EU of the European Parliament and of the Council of 26 February 2014 amending Council Directives 92/58/EEC, 92/85/EEC, 94/33/EC, 98/24/EC and Directive 2004/37/EC of the European Parliament and of the Council, in order to align them to Regulation (EC) No 1272/2008 on classification, labelling and packaging of substances and mixtures.

- Commission Directive (EU) 2017/164 of 31 January 2017 establishing a fourth list of indicative occupational exposure limit values pursuant to Council Directive 98/24/EC, and amending Commission Directives 91/322/EEC, 2000/39/EC and 2009/161/EU amended the limit values for hazardous substances in the air at work, with a view to which, and in relation to the amendment of Directive 2014/27/EU, the *Joint Decree of the Minister of Health and the Minister of Social and Family Affairs 25/2000 (30 September) EüM-SzCsM on the Chemical Safety of Workplaces* (hereinafter referred to by the Hungarian abbreviation as EüM-SzCsM Joint Decree) was amended.

- The *Decree of the Minister of National Economy 10/2016 (5 April) NGM on the Minimum Level of Safety and Health Requirements for the Use of Work Equipment* appeared as new legislation, replacing the *Decree of the Minister of Employment and Labour 14/2004 (19 April) FMM* on the same subject. The structure of the

decree is in line with Directive 2009/104/EC of the European Parliament and of the Council of 16 September 2009.

2) RESPONSES GIVEN TO THE QUESTIONS OF THE ECSR RELATING TO THIS PARAGRAPH

The ECSR also emphasised under this paragraph that occupational health and safety regulations should cover the management of stress, aggression and violence at work, with particular reference to atypical working conditions. Our previous report did not include the requested information.

The above-mentioned regulations and measures for the elimination of psychological stress and psycho-social risks also apply to employees employed in the framework of organised work. The above also applies to the control of the employer's obligations.

Organised work pursuant to the Labour Safety Act: in an employment relationship - excluding work in the household of a natural person in the framework of a simplified employment - in the employment of public employment, government service, political service, commissioner, public service, civil servant, in the service of defence staff, in the service of law enforcement administration, in the service of a judge, in the service of judicial staff, in the service of the prosecutor's office, in the framework of direct participation based on membership in an employment relationship, in a social co-operative, in the framework of personal participation in a school co-operative and a public interest pension co-operative on the basis of an external service membership agreement, in vocational education in a vocational training institution or in a dual training place, student training, work as a convicted person or other detainee, public interest work in infringement proceedings, and work in the public interest in criminal matters, working for defence organisations, public educational institutions not classified as military organisations under the maintenance of the Minister responsible for defence, work in an area of the Ministry managed by the Minister responsible for defence, temporary workplaces serving temporary interests, temporary construction workplaces, business associations, in which the right of ownership is exercised by the Minister responsible for defence, and work performed for business associations pursuant to Section 3 (2) (c) of Act CVI of 2007 on State Assets, work in a service relationship at law enforcement agencies, the Parliamentary Guard, municipal fire brigades, and voluntary work in the public interest under the Act LXXXVIII. of 2005 on Public Interest Volunteer Activities and social work organised (initiated, directed or approved) by the employer.

The ECSR also requested information on the minimum health and safety requirements for the exposure of employees to the risks arising from physical agents (electromagnetic fields) [20th specific Directive within the meaning of Article 16 (1) of Directive 89/391/EEC] and transposing into national law Directive 2013/35/EU of the European Parliament and of the Council repealing Directive 2004/40/EC.

1. General occupational safety regulations

The Ministry of Human Capacities was responsible for transposing the directive based on the authorisation of Section 15 (9) b) of Act XI of 1991 on health authority and administrative activities. The Directive was transposed into national law by the *Decree of the Minister of Human Capacities 33/2016 (29 November) EMMI on the Minimum Health and Safety Requirements for the Exposure of Workers to the Risks Arising from Physical Factors*, which is a legal act on the tasks and powers of the public health authority.

Pursuant to Section 86 (1) of the Labour Safety Act, the occupational safety and health authority does not extend to the inspection of regulations related to electric and magnetic fields.

2. Special sectoral occupational safety and health regulations

The general rules related to the preservation of health prescribed in the framework of some special employment relationships and the preliminary medical fitness examination were presented in the previous chapter. The requirements for the prevention of the consequences of exposure to harmful effects for the individual sectors are set out below.

3. Rules relating to the professional staff of law enforcement agencies

Within the scope of determining medical fitness, similarly to mental aptitude tests, the staff is obliged to take part in screening tests from time to time, and to present the results to the primary care physician. The organization provides premises to perform some of the screening tests at the local medical centre (e.g., lung screening, blood sampling, ophthalmic examination, dental examination).

Section 257 of Act XLII of 2015 on the Service Status of the Official Staff of Law Enforcement Agencies provides for the mechanism of assessment and re-evaluation of occupational diseases, cases of fatal occupational diseases, classification of accidents and illnesses related to service obligations. The detailed rules for the investigation of occupational diseases and cases of increased exposure are contained in Section 28/A of *Decree of the Minister of the Interior 70/2011 (30 December) BM on the Rules of Occupational Safety and Health and the Performance of Occupational Health Activities of Law Enforcement Agencies under the Control of the Minister of Interior. (XII. HM*

The Decree defines the infectious diseases in respect of which, in order to avoid the risk of a biological pathogen endangering the health and safety of a member of the professional staff or certain groups in connection with their duties or certain duties, in particular during their service abroad, ordering compulsory vaccination is justified. On the recommendation of the chief medical officer responsible for the performance of the law enforcement agency's health duties, compulsory vaccination shall be prescribed by the national commander or the national director-general.

During the medical fitness examination, biological and environmental monitoring must be performed in justified cases on the basis of the *Decree of the Minister of Welfare 33/1998 (24 June) NM on the Medical Examination of and Opinion on Fitness for a Job or a Profession and Personal Hygiene (*hereinafter referred to by the Hungarian abbreviation as NM Decree), which helps in prevention and detection.

The transposition of the minimum requirements for exposure to electromagnetic fields with regard to the Police is implemented as follows:

The Decree of the Minister of Human Capacities 33/2016 (29 November) EMMI on the Minimum Health and Safety Requirements for the Exposure of Workers to the Risks Arising from Physical Factors required the review of the risk assessment of non-ionising radiation for

the Police occupational safety and health inspectors and, if necessary, established the obligation to take action to eliminate deficiencies.

4. Rules relating to the professional staff of the Penitentiary

The chemical risk assessment was performed by the law enforcement agencies in accordance with *Act XXV of 2000 on Chemical Safety,* and the biological risk assessment was conducted by the law enforcement agencies as defined in the *Decree of the Minister of Health 61/1999 (1 December) EüM on the Protection of Health of Employees Exposed to Impacts of Biological Factors.*

In the fields of activity of the penitentiary agencies, the occupational safety equipment of the employees is provided in the appropriate quantity and quality, partly in accordance with collective and partly in accordance with individual protection. The list of jobs required for using personal protective equipment and the list of protective equipment against hazards and harms are contained in the annexes to the occupational safety regulations and risk assessments.

Frequency of repetitive occupational safety training:

a) once a year for white-collar employees,
b) quarterly for employees of production and maintenance plants,
c) monthly for detainees.

5. Rules relating to the professional staff of disaster management

With regard to employees, professional disaster management bodies pay special attention to compliance with the provisions of legislation and the regulatory instruments of public law agencies. They provide for the necessary conditions for the performance of the basic tasks of the organisation, including the provision of personal protective equipment and safe workplaces. Therefore, tens of thousands of protective equipment were purchased between 2016 and 2019, as well as several real property and barracks investments and renovations took place.

At the central and regional agencies, there are chief labour inspectors and supervisors, and at the local organisations, health and safety representatives are responsible for the lawful and professional implementation of occupational safety and health activities. They develop the personal protective equipment allowance system for each job, analyse and evaluate the law enforcement agency's occupational safety and health situation, activities, the development of accidents, their causes, and propose the measures needed. They monitor and comment on the observance of occupational safety and health regulations during the preparation and handover of investments and renovations covered by the Public Procurement Act. They regularly review the practice of reporting, recording and investigating accidents at work. They participate in the regularisation procedures of the equipment that is newly procured at the professional disaster management agency, and form an opinion on the work equipment procured centrally before commissioning them in occupational safety and health use.

6. Rules relating to the professional staff of aliens policing

The National Directorate-General for Aliens Policing (hereinafter referred to by the Hungarian abbreviation as OIF) provides regular, weekly occupational medical consultations

to its staff, during which any illness can be immediately screened. In the case of occupational diseases detected during the annual compulsory occupational health screening examinations, the employee concerned may be assigned to a different service position corresponding to their changed state of health.

Annually, fire and occupational safety training is provided to the staff, and smoke and fire alarm equipment are also inspected regularly. The occupational safety and health regulations are constantly available to employees on the intranet, knowledge of which is also required by appointment orders. The same occupational safety and health rules apply to the work of students employed by the OIF as part of internship.

They also requested information on domestic measures related to the risk of exposure to benzene.

As regards benzene as a carcinogen, the EüM-SzCsM Joint Decree, the EüM Decree and the NM Decree must be applied together to take safety and health protection measures (e.g., limit values allowed in the air of workplaces for tests required for biological monitoring).

Regulation (EC) No 1907/2006 of the European Parliament and of the Council concerning the Registration, Evaluation, Authorisation and Restriction of Chemicals (REACH), and Regulation (EC) No 1272/2008 of the European Parliament and of the Council on classification, labelling and packaging of substances and mixtures, amending and repealing Directives 67/548/EEC and 1999/45/EC, and amending Regulation (EC) No 1907/2006 (hereinafter CLP Regulation) are directly applicable in all Member States of the EU, thus also in Hungary. Manufacturers, importers and downstream users of chemical substances required by the above-mentioned legislation must also comply with the regulations in Hungary. The regulation also covers employers in other industries (e.g. construction industry, plastics industry, etc.) if they manufacture, import or use a substance classified as a hazardous/carcinogen substance under the Regulation in the course of their activities.

Section 2 (1) of Act XXV of 2000 on Chemical Safety (hereinafter referred to as Chemical Safety Act) states that the REACH and the CLP Regulation is applicable together with this Act. Furthermore, the Chemical Safety Act has been amended in accordance with the legal acts of the EU, e.g., through the classification and clarification of terms, in compliance with the provisions of the REACH and CLP Regulation.

In the interest of occupational safety and health, employers shall observe the following general requirement, whereby sources of hazard shall be replaced with non-hazardous or less hazardous sources. [Section 54 (1) f) of the Labour Safety Act].

With respect to the fact that benzene is a carcinogen, the EüM decree stipulates the employer's obligations regarding the substitution of these substances when using benzene or benzene-containing substances. The use of a carcinogen may only be introduced if it cannot be replaced by an identical, non-carcinogenic or less potent carcinogen for technical reasons [Section 5 (10) of the EüM Decree]. The employer shall justify in writing to the occupational safety and health authority the choice of the carcinogen as defined in Annex 3 of the EüM Decree, stating whether there is a non-carcinogenic or less potent carcinogenic substance, mixture or process identical for the targeted use. If there is non-carcinogenic or less severely carcinogenic substance, the employer must also indicate why they were not used and why the carcinogens were not substituted with them. Depending on the result of the risk assessment,

the employer is compelled to prescribe risk management (measure). The effectiveness of risk management should be examined in the next risk assessment [Section 5 (1) of the EüM Decree].

Sections 4-17 of the EüM Decree regulate in detail the technical and occupational health and safety measures, which are population and individual risk mitigation, prevention and exposure reduction measures. The purpose of the Decree is to promote the protection of employees against carcinogenic substances, including occupational health impairment caused by benzene and tumours by reducing the risks to minimum.

With regard to the substitution of carcinogens, Section 2 (6) f) of Joint Decree of the Minister of Social and Family Affairs and the Minister of Health 3/2002 (8 February) SzCsM-EüM on the Minimum Level of HSE Requirements at Workplaces (hereinafter referred to by the Hungarian abbreviation as SzCsM-EüM Decree) also sets out the procedure to be followed. Under this provision, the employer must ensure that "Chemicals that have been proven to be carcinogenic to humans" (Category 1 substances), "Chemicals that are likely to be carcinogenic to humans" (Category 2A substances) as well as mixtures with a content of more than 1% of the above should be selected for technological purposes only if they cannot be replaced by other, less hazardous substances.

The following technical and occupational health and safety measures provide effective protection for workers handling benzene and substances containing benzene: use of a closed system, automated or equivalent procedure (e.g., manipulator, robotics), the obligation to comply with the limit value, the provision of air-conditioning procedures (local and general ventilation), limiting the volume of carcinogen substances in the workplace, keeping the number of employees as low as possible to do the job, job aptitude test, biological exposure impact examination, etc.

The EüM Decree and the EüM-SzCsM Joint Decree contain provisions to prevent the release of benzene vapours in the air of the workplace.

The EüM Decree states the following:

- The carcinogen substance(s) may be manufactured and used (if scientifically and technically possible) in a closed system, by automated or other equivalent process (e.g., manipulator, robotics).

- If it is technically not possible to apply the closed system or the technological processes detailed in paragraph (1), the employer ensures that all (daily, weekly, annual) exposure of the employee is at the lowest possible level according to scientific and technical standards, and in the case of substances with limit values, the carcinogenic contamination of the workplace may not exceed the limit values pursuant to Section 5 (2) and (3).

- Local or general ventilation should be provided by ventilation procedures to ensure that the materials produced, used, produced as intermediates, by-products and pollutants do not pollute the working environment, the air in the room and the equipment, as well as the air inside and outside the building. The applied air technology solutions must not impose any risk to the employees of other workplaces. [Section 6 (1)-(3) of the EüM Decree]

Pursuant to Annex 1 of the SzCsM-EüM Decree, the value of the maximum permitted concentration of benzene in workplace air is: 3 mg/m^3.

The employer shall arrange for the work hygiene examinations relating to the pathogens of the workplace regulated with permitted values. The occupational safety and health authority is eligible to order the performance of occupational health and safety inspections. [Section 84 (1) n) of the Labour Safety Act].

Measurement tests may only be performed by a laboratory accredited by the National Accreditation Authority in this field and for the determination of the chemicals to be measured, or successfully participating in a national or international proficiency test in writing.

When using carcinogens (benzene and substances containing benzene), the employer is compelled to take personal protective measures and provide personal protective equipment, if the exposure to the carcinogen cannot be reduced to a tolerable level by collective protection measures and procedures - 1:105 risk - or in the case of substances subject to limit values, below the limit value. [Section 7 (4) of the EüM Decree].

The Decree of the Minister of Health 65/1999 (22 December) EüM on the Minimum Safety and Health Requirements of the Use of Individual Protective Devices used by Employees at the Workplace compels the employer to provide protective devices that protect against the risks of the working environment in such a way that it does not cause additional danger itself, meets the working conditions, ergonomic requirements and the employee's state of health, fits its wearer after adjustment.

Employees who may come into contact with liquid benzene or some material containing liquid benzene must be provided with appropriate personal protective equipment to prevent absorption through the skin.

The employer is obliged to provide occupational health and safety services to all its employees [Section 58 (1) of the Labour Safety Act]. The occupational health and safety service carries out the job aptitude tests specified in the NM Decree as part of the basic service and initiates the necessary specialist medical examinations.

Under the provisions of the NM Decree, employees exposed to benzene must undergo a pre-employment medical aptitude test before being employed and, every six months, a periodic occupational medical aptitude test must be performed, under which they are compelled to undergo a biological monitoring examination.

An extraordinary job aptitude test must be performed at the employee

- if the health condition of the employee has changed and, as a result, he is unlikely to be suitable for performing his job in a healthy and safe manner,
- in the event of an acute occupational disease, increased exposure, sickness or illness of the employee, which is presumably due to reasons emerging at the workplace or after 30 days of incapacity for work;
- if the employee suffers an exposure during an unforeseen event; and
- if the employee's work is suspended for more than 6 months for reasons other than health.

Under the amendment to the NM Decree effective from 1 January 2013, at the initiative of the activity or the employer, a final examination shall be carried out at the end of the employment relationship, if it takes place after four years of exposure to benzene.

The employment of women and minors (persons under the age of 18) is regulated by Sections 8, 10 and 10/A of the NM Decree and its Annexes 8, 9 and 9/A.

Section 10/A (3) provides for the employment of students:
(3) The employment of a student necessary for the acquisition of the profession, under working conditions involving a risk of health impairment, shall not exceed the period necessary for the acquisition of the profession.

It is forbidden to employ a pregnant woman under the exposure of carcinogens (benzene and substances containing benzene), and minors can be employed under exposure to carcinogens (benzene and benzene-containing substances) only with personal protective equipment and only for the time and to the extent necessary for practical training [Section 6 (2) of the EüM Decree].

Biological monitoring with sufficient frequency is of paramount importance for exposure to hazardous substances, such as benzene, in order to prevent and detect occupational diseases and cases of increased exposure in a timely manner. The concentration of biological exposure indicators measured in certain biological samples (blood, urine) characterises the dose of the chemical having reached the employee's body, the employee's actual exposure. Biological monitoring and work environment monitoring (measuring and assessing the concentration of a chemical in the air of the workplace) complement each other and cannot be substituted.

In Hungary, it is obligatory to use biological monitoring for more than 20 different hazardous substances with occupational exposure limit values permitted in the air of the workplace, which has a long history. Its statutory application was mandatory in Hungary as early as in 1981.

The permissible limit values for biological exposure and effect indicators to be tested in the case of occupational chemical exposure in urine is contained in Annex 2 of the SzCsM-EüM Decree. The figure below shows the permissible biological exposure indicators for benzene:

			Allowed treshold			
Chemical	Biological exposure (impact) indicator	Date of sampling	mg/g kreatinin	micromol/mmol creatinine (rounded value)	mg/l	µmol/l
Benzene	t,t- muconic acid	After shift	1,5	1,2		

Source: SzCsM-EüM Decree; Annex 2.

The number of occupational exposure cases reported to the benzene occupational safety and health authority in Hungary between 2016 and 2019 was as follows:

Year	2016	2017	2018	2019
Number of reported occupational cases of encreased exposure to Benzene	9	12	12	5

Source: Occupational Hygiene and Occupational Health Body

Activities with benzene as a carcinogen and changes must be reported to the labour authority, for which the occupational safety and health authority keeps records, and checks the reports regularly.

Pursuant to Section 18 (1) of the EüM Decree 26/2000, by 10 January each year the employer notifies the occupational safety and health authority of the activities carried out with the carcinogen (benzene), the substances, mixtures or processes used in performing the activity, as well as the identity of the exposed employees and any change in the carcinogens used.

Data for the reporting of activities with occupational carcinogens between 2015 and 2019 are shown in the figure below, also including data for benzene.

Name	**2016**	**2017**	**2018**	**2019**
Number of employers reported activity with carcinogens	1 379	1 655	1 614	1 541
Number of employers reported "changes"	491	536	583	644
Number of employees exposed to carcinogens based on the reports of the current year (person)	22 150	22 024	22 188	24 609
Number of occupational safety inspections at employers made reports during the current year	214	190	212	228

Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

Based on the experience of the inspections, most common and the most serious deficiencies are revealed by the occupational safety and health authority in those employers where the employer does not comply with the obligation to report the activity with a carcinogenic substance; thus, unlike the previous practice, the authority no longer strives primarily to control the notifiers, but to detect unannounced activity.

For employers reporting carcinogenic activity, it is generally appropriate to keep employer records, provide written information to employees, regulate biological monitoring, and perform tests on employees exposed to carcinogens.

It still happens that the procedure for job aptitude tests is regulated in writing by the employer, but did not specifically define the direction and frequency of biological monitoring examinations required per job. It is a frequent shortcoming that the employer does not mark workplaces where employees may be exposed to carcinogens.

Employers prioritise the substitution of carcinogens, including benzene, for the purpose of complying with the requirements of the EüM Decree. Prohibitions on the use of benzene and products containing benzene are contained paragraph 5 of Annex XVII of the REACH regulation:

5. Benzene CAS number: 71-43-2 EINECS No: 200-753-7	1. Not permitted in toys or parts of toys as placed on the market where the concentration of benzene in the free state is in excess of 5 mg/kg (0.0005%) of the weight of the toy or part of toy. 2. Toys or part of toys not complying with the requirements of paragraph 1 cannot be placed on the market. 3. They cannot be placed on the market or used: — as material, — as a component of other materials or in a mixture, when the concentration is 0.1 percentage by weight or greater. 4. However, paragraph 3 shall not apply to: a) motor fuels which are covered by Directive 98/70/EC; b) substances and preparations for use in industrial processes not allowing for the emission of benzene in quantities in excess of those laid down in existing legislation.

With regard to the use of carcinogenic fuels and the management of risks in their trade, it should be noted that paragraph 5 of Annex XVII of the REACH regulation exempts petrol from the restriction despite its benzene content exceeding 0.1 weight percentage. However, due to the carcinogenic properties of motor gasoline, in order to protect the health of the petrol station operating employees, the relevant provisions of the EüM Decree compel the employer to comply with the obligation to notify carcinogens, benzene exposure of the air of the workplace every two years and to conduct annual (or more frequently) biological monitoring tests, as well as to take preventive measures (storage and washing of clean and dirty clothing, etc.).

The benzene exposure cannot be terminated due to certain technology features (oil processing, research laboratories, fuel consumption, etc.). The experience reflects favourable tendencies. In relation to paints and surface treatment substances, certain economic sectors (vehicle industry and metal surface treatment) switched to water-based chemical substances and organic solvents not containing any benzene.

Materials containing asbestos fibres used before 1 January 2015 may continue to be used pursuant to our national law. The ECSR is interested in whether Hungary plans to compile an inventory of all equipment and buildings in use that contain asbestos fibres. Respectively, as the subject also concerns Article 11, the ECSR requests that we present our measures to neutralise the risk of exposure to asbestos.

The Decree of the Minister of Health 12/2006 (23 March) EüM on the Protection of Workers Exposed to Asbestos-Related Risks serves the purpose of complying with the provisions of Article 7, Indent Two of Council Directive 87/216/EEC on the prevention and reduction of environmental pollution by asbestos and Directive 2009/148/EC of the European Parliament and of the Council on the protection of employees from the risks related to exposure to asbestos at work.

In our previous report, we presented all the requirements for reducing the risk to employees from working with asbestos or an asbestos-containing material, product, or activity with an asbestos-containing product.

The legal requirements did not change during the reporting period.

The figure below shows the number of asbestos removal activities and the number of employees affected reported to the occupational safety and health authority during the reporting period, and the proportion of incomplete reports per year.

Name	**2016**	**2017**	**2018**	**2019**
Number of reported asbestos demolition activities	2.28	251	221	245
Number of employees affected by the reported activities	unknown	1 276	978	1 340
Rate of incomplete reports	23,6%	15%	4,5%	11,8%

Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

The notifications are examined on site by the occupational safety and health authority and, if necessary, measures are taken to ensure compliance with legal requirements and thus to protect the health of employees.

It was typical that smaller asbestos removal (demolition of slate roof) works were often performed without prior notice, thus endangering not only the employees but also the wider environment. Personal protective equipment, which is of paramount importance for excluding asbestos exposure, has not always been provided to employees.

For employers engaged specifically in asbestos removal, the personal protective equipment provided was adequate, as they specialised in this activity and had encountered official health and safety inspections several times in demolition work areas. Employers specialising in asbestos removal prepare the demolition plan in a time and comply with the provisions thereof. They pay attention to the selection of personal protective equipment with adequate protection, its intended use during demolition, as well as the method of hazardous waste is stored and transported.

However, in work areas where the presence of asbestos is not clearly recognisable, in most cases the possible presence of asbestos is not investigated during demolition work.

The public health authority and the National Public Health Centre (hereinafter referred to by the Hungarian abbreviation as NNK) have competence in relation to the exposure of the environment to asbestos.

The ECSR requests confirmation that the protection of employees against exposure to ionising radiation is ensured at least up to the limit values indicated in the ICRP recommendations.

Pursuant to Section 86 (1) of the Labour Safety Act, the public authority of the occupational safety and health authority does not extend to the control of the radiation health regulations specified in a separate legislation.

The 2007 Recommendations of the International Commission on Radiological Protection (ICRP Publication No. 103, 2007) have been integrated into Council Directive 2013/59/Euratom laying down basic safety standards for protection against the dangers arising from exposure to ionising radiation, and repealing Directives 89/618/Euratom,

90/641/Euratom, 96/29/Euratom, 97/43/Euratom and 2003/122/Euratom (hereinafter: Directive). These provisions of the Directive have been transposed into the Hungarian national law [Governmental decree no. 487/2015. (XII. 30.) on the protection against ionizing radiation and the corresponding licensing, reporting (notification) and inspection system] which is therefore in full compliance with the ICRP recommendations.

The regulations on the defence sector, renewed in 2018 (Government Decree 166/2018 (17 September) on the tasks of the radiation protection authority in the defence sector, and Decree of the Minister of Defence 15/2018 (27 September) on the military application of the Act on Nuclear Energy) contain references to civil rules (including the rules of Government Decree 487/2015 (30 December) on the protection against ionising radiation and the corresponding licensing, reporting (notification) and inspection system) with regard to limit values, and do not formulate any other regulation in this respect.

The ECSR stated that since the occupational health regulations do not cover domestic employee and the self-employed, Hungary does not comply with Article 3 (2). In addition, the ECSR requests information on the occupational health regulations applicable to special employment conditions (simplified employment, employment in public service, civil servants, government officials, court services, judicial service, prosecutors, student's internship, work by convicts and detainees, etc.).

In Hungary, in the case of organised work in accordance with the Labour Safety Act, the objective task of employers (economic organisations) is to implement labour safety [occupational health (hygiene and health at work)] requirements.

Occupational health and safety legislation must be applied in a comprehensive manner to those employed in the context of organised work, regardless of the organisational or ownership form. According to the Labour Safety Act, an employer is a person or organisation who employs an employee in the framework of organised work. Thus, if the private entrepreneur employs an employee, the scope of the Labour Safety Act also extends to these employees. In the case of private entrepreneur, the application of occupational safety regulations is a legal obligation for the protection of those within the scope of the activity.

The Labour Safety Act defines the responsibilities, rights and obligations of the state, employers and employees, which apply equally to special employment conditions (simplified employment, employment in public service, civil servants, government officials, court services, judicial service, prosecutors, student's internship, work by convicts and detainees, etc.).

Organised work according to the Labour Safety Act: work performed in the employment of public employment, government service, political service, commissioner, public service, civil servant, in the service of a judge, in the service of judicial employees, in the service of a prosecutor's office, in the course of student internship, work performed as a convict or other detainee in the public interest during the infringement proceedings as well as work in the public interest imposed in a criminal case.

The scope of occupational safety regulations (Labour Safety Act and ministerial decrees on occupational safety) for compliance with European Union legal acts also extends to all domestic employees employed in the framework of organised work, with the exception of simplified employment in the household of the natural person's employer. Inspections in

private dwellings are hampered by the fact that the occupational safety and health authority does not currently have a record of which private individual and under which contract it employs a domestic employee, and the option of inspections in private dwellings is very limited in terms of respect for privacy.

In the case of employment in the framework of organised work, the main occupational safety tasks of employers are:

- implementation of various conditions of work that do not endanger health and are safe (related to installation, commissioning, material conditions, work processes, technology, materials, personal factors, etc.);
- ensuring and maintaining requirements for safe and secure work (risk assessment, organisation of first aid and medical emergency care, rescue, fire and disaster protection, occupational safety training, provision of personal protective equipment, employment of occupational safety professionals, provision of basic occupational health services, performing information - consultation - cooperation tasks, performing occupational hygiene tests, etc.);
- compliance with regulations (notification, investigation, registration, measures, etc.) on accidents at work and occupational diseases (including cases of increased exposure).

Employers are free to determine the method of implementation of their occupational safety tasks, within the framework of legislation and standards.

As we wrote above, instead of the previous number of 50 employees, the employer has to organise the election of an occupational safety representative from 20 employees. Instead of limiting the previous employment relationship, the personal scope already covers all forms of employment (e.g., public employment, government service, state service, public service, civil servant, service of a judge, service of judicial employees, prosecution service).

The Labour Safety Act and other relevant Hungarian legislation comply with the provisions of the Framework Directive 89/391/EEC and the individual directives.

There are several other rules (regulations, standards) related to the three levels of occupational health and safety regulation (laws, government decrees, sectoral legislation).

Students pursuant to Section 1 (f) of the NM Decree: all persons receiving vocational training, vocational secondary school training, vocational school and special vocational school, as well as other vocational training and retraining. Section 87 (8) of the Labour Safety Act stipulates that it qualifies as an employer providing practical education within the framework of vocational training. Accordingly, the employer must provide students with safe working conditions that do not endanger their health as part of their practical training.

The following requirements must also be observed during the employment of students in the framework of their internships:

Under working conditions which involve a risk of health impairment, the employment of the student necessary for the acquisition of the profession may not exceed the period necessary for the acquisition of the profession [Section 10/A (3) of the NM Decree]. This principle is also followed by the EüM Decree, according to which a juvenile may be employed with a

carcinogen only in the case of the use of personal protective equipment and only for the time and to the extent necessary for practical training [Section 6 (2) of the EüM Decree].

In the case of the employment of students, the regulations for the employment of juveniles must also be taken into account:

- The Labour Code and the legislation on the occupational health and safety contain special provisions for juveniles. The Labour Code has introduced a ban in some cases, night work and extraordinary working hours cannot be ordered for a young employee [Section 114 (1) of the Labour Code]. Under the Labour Code, a young employee is an employee under the age of eighteen [Section 294 (1) a) of the Labour Code].

- The main rules concerning the occupational safety of juveniles are defined by the Labour Safety Act and ministerial decrees on occupational safety. In addition to the general regulations of the Labour Safety Act, the list of burdens potentially harmful to health, requiring a prohibition or permissible under conditions in the case of employment of juveniles belonging to the vulnerable group of employees is contained in Annex 8 of the NM Decree.

- The NM Decree also specifies in detail the working conditions (active substances, processes and work operations) where a separate risk assessment performed in the framework of the aptitude test is required in the case of employment of juveniles [Annex 9 of NM Decree]. Risk assessment is necessary to determine the conditions of employment and preventive measures.

Special rules for occupational safety:

- Pursuant to Decree of the Minister of Agriculture and Food 15/1989 (8 October) on the Issuance of Forestry Safety Regulation, students under the age of 18 participating in practical education organised in vocational training may be employed in logging with hand tools or multi-purpose machines only under constant professional supervision and up to 4x1 hours per week [Section 3.1.12. of MÉM Decree 15/1989 (8 October)].

- According to the Decree of the Minister of Agriculture and Rural Development 16/2001 (3 March) (FVM) on the Agricultural Safety Regulations, a juvenile under the age of 18 cannot be employed on a livestock farm [Section 4.1.1.d) of FVM Decree 16/2001 (March 3)]

- Pursuant to the Decree of the Minister of Agriculture and Rural Development 24/2005 (23 March) (FVM) on the Safety Regulation for Slaughtering and Processing Animals, a person under the age of 18 may not be employed as an employee during the slaughter of animals, the production of meat products or the handling of meat equipment [Section 3 (2) d) of the FVM Decree 24/2005 (23 March)].

- According to the Decree of the Minister of Agriculture and Rural Development 11/2003 (12 September) (FMM) on the Publication of the Safety Regulation for Industrial Alpinist Activities only persons over the age of 18 may perform industrial alpine engineering activities. The employee must have a suitable qualification based on a

preliminary and periodic medical examination of the job or professional aptitude. [Section 9 of FMM Decree 11/2003 (12 September)]. An industrial alpinist trainee may be a person who has reached the age of 16 but is under the age of 18 [Section 2 8c of FMM Decree 11/2003 (12 September)]. The employee must have a suitable qualification based on a preliminary and periodic medical examination of the job or professional aptitude. [Section 9 of FMM Decree 11/2003 (12 September)].

Additional legal, standard prohibitions or restrictions for the protection of young people:

- Lifting machines may only be operated or driven by a person who has reached the age of 18 in the framework of organised work [Section 5.1 of the Decree of the Minister of Economy 47/1999 (4 August) (GM) on the Issuance of the Safety Code for Lifting Machines

- Industrial diving work may only be performed by employees over the age of 18 [Section 2.07 of Annex 2.04 of Decree of the Minister for Environmental Protection and Water Management 24/2007 (3 July) (KvVM) on the Issuance of the Water Safety Regulation.]

- Only persons over the age of 18 may be assigned to work on boarding hazardous equipment [according to standard MSZ-09-57.0033:1990].

The following requirements must also be observed during the employment of students in the framework of their internships:

Under working conditions which involve a risk of health impairment, the employment of the student necessary for the acquisition of the profession may not exceed the period necessary for the acquisition of the profession [Section 10/A (3) of the NM Decree]. This principle is also followed by the EüM Decree 26/2000, pursuant to Section 6 (2) of which a juvenile may be employed with a carcinogen only in the case of the use of personal protective equipment and only for the time and to the extent necessary for practical training.

In order to ensure the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and employees' organisations:

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

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF, REASONS FOR AND EXTENT OF THE REFORMS

During the period under review, the legal provisions related to the implementation of the article did not change.

2) RESPONSES GIVEN TO THE QUESTIONS OF THE ECSR RELATING TO THIS PARAGRAPH

- ***In its conclusions of 2017, the ECSR requested information on the domestic concept of occupational diseases, mechanisms for recognising, evaluating and re-evaluating occupational diseases, cases of fatal occupational diseases, the most common occupational diseases, measures for eliminating inadequacies in the recognition and treatment of occupational diseases.***

- ***It also requested information on the structure of the labour inspection system and the resources available for labour inspection, including human resources, in an annex to the call for the report. Data are also requested on the number of labour inspections performed, the proportion of employees covered by inspections and the number of occupational safety and health infringements. An answer is expected to the question of whether the power of the occupational safety and health authority covers all sectors of the economy and whether inspections can be performed at all workplaces, including accommodation. If an occupational safety and health authority's powers of inspection do not extend to a workplace, this must be stated in the report.***

1. Description of the system of labour inspection and occupational safety

Pursuant to the appointment of Government Decree 320/2014 (13 December) on the Designation of the Public Employment Agency and the Health and Safety and Labour Authority and the Performance of the Public Authority and Other Tasks of Those Bodies, the tasks of the occupational safety and health authority were performed by the Minister responsible for employment policy and for the period from 1 January 2016 to 31 December 2016, by the capital and county government office, and from 1 January 2017 by the district (capital district) office of the capital and county government office.

The Minister responsible for employment policy, who headed the Ministry of National Economy until 18 May 2018 and then renamed the Ministry of Finance from 19 May 2018) provided the professional management of the activities of the government office as an occupational safety and health authority.

Changes in the average number of occupational safety inspectors* in 2016 - 2019:

Year	Average number of supervisors (person)
2016.	102,34
2017.	95,01
2018.	97,63
2019.	89,04

* Average number of supervisors: a theoretical ratio for the correct measurement of the performance of supervisors. For each performance objective and evaluation, the standards calculated for this unit are determined by the professional managing minister. The ratio also takes into account the absences of supervisors (illness, leave, vacant status, training, blood donation, etc.).
Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

Data on employment protection inspections
2016-2019

Year	Number of ispected emplyers	Number of employers affected by irregularity	Rate of irregular employers (%)	Number of employees affected by visit (based on the visit sheets)	Number of inspected employees affected by irregularities	Number of employees affected by serious irregularities	Rate of employees affected by irregularities and serious irregularities
2016	15 459	12 231	79.1	281 486	186 022	53 322	28.7
2017	14 605	11 272	77.2	269 103	173 683	50 467	29.1
2018	14 298	10 407	72.8	309 319	207 965	51 540	24.8
2019	12 784	9 468	74.1	188 337	125 058	36 359	29.1

Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

Occupational safety measures
2016 -2019

Year	All measures	All priority measures	All measures on occupational safety	Number of priority measures on occupational safety	All measures on occupational health	Number of priority measures on occupational health	All measures on occupational safety	Number of priority measures on occupational protection
2016	75 555	33 462	21 145	11 292	9 926	1 682	44 484	20 494
2017	69 353	33 373	20 110	11 611	9 475	1 910	39 768	19 852
2018	73 822	43 628	25 403	19 345	8 245	1 860	40 174	22 423
2019	69 906	42 904	25 729	19 994	6 852	1 584	37 325	21 326

Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

The scope of the occupational safety regulation for compliance with the legal acts of the European Union (Act XCIII of 1993 on Labour Safety [hereinafter: Labour Safety Act] and its implementing decrees) covers all work performed within the framework of organised work. In the case of organised work, the Labour Safety Act does not differentiate with regard to the fulfilment of occupational safety requirements on the basis of the organisational or ownership forms of individual enterprises.

2. Regulation of occupational diseases

In Hungary, the Decree of the Minister of Welfare 27/1996 (28 August) NM on the Reporting and Investigation of Occupational Diseases and Cases of Increased or High Exposure (for the purposes of this section, hereinafter: NM Decree 27/1996 (28 August)) defines the concept of occupational disease, according to which the following are considered occupational diseases: acute and chronic health impairment occurring during work, during the exercise of an occupation, and chronic health impairment developing after the exercise of an occupation, which is related to work, occupation, can be traced back to physical, chemical, biological, psycho-social and ergonomic pathogens occurring during the work, work process, or which is a consequence of the employee's use of more or less than optimal. The NM Decree 27/1996 (28 August) serves to comply with Recommendation 2003/670/EC on the European Schedule of Occupational Diseases.

The European schedule of occupational diseases was included in 2007 in NM Decree 27/1996 (28 August), replacing the schedule in force until then. However, during the transfer, the Hungarian legislator kept certain categories of the previous Hungarian schedule, opened it up and expanded it with some diseases not included in the European schedule. The structure of the Hungarian schedule is characterised by categorisation according to pathogen groups, the differentiated occupational disease groups are as follows:

A. Chemical pathogens
B. Physical pathogens
C. Biological pathogens
D. Non-optimal use, psycho-social, ergonomic pathogens

Occupational disease groups based on pathogenic factors typically specify pathogens (e.g., specify the chemical that caused the disease), with few exceptions where the conditions are named (e.g., miners' nystagmus, shoulder bursitis). The names follow the names of the diseases listed in the European schedule. An important exception is certain diseases classified in group D of the Hungarian schedule (Non-optimal use, psycho-social, ergonomic pathogens), which are not included in the European schedule, and the category itself is as well not included. Some diseases that can only be found in the Hungarian schedule: Diseases of the lumbar spine caused by load movement of the disc; Diseases of bones, joints, muscles, tendons caused by excessive or unilateral exercise. Another important difference, already mentioned above, from the European schedule is that each group of pathogens in the Hungarian schedule contains at least one category (e.g., other diseases caused by occupational biological pathogenic factors) that can be used in cases where the causal factor of the disease is not specifically included in the schedule of pathogenic factors. This feature of the Hungarian schedule of notifiable occupational diseases makes the schedule open and suitable for notifying and recognising any illness that is related to the occupation.

If it is suspected that the occupation of the employee played a role in the development of an illness, then according to NM Decree 27/1996 (28 August), the detecting physician must report the suspicion of an occupational disease to the occupational safety and health authority of the county government office responsible for the place of work. A physician notifying under an NM Decree 27/1996 (28 August) may be any physician practicing medical practice who has diagnosed or suspects an occupational disease.

The investigation is performed by the occupational safety and health authority, which includes, in addition to the employer and the notified employee, the occupational health service physician, the occupational safety representative and medical doctor government official of the ministry controlled by the minister responsible for employment policy.

The investigated reports together with the investigation documentation are forwarded by the occupational safety and health authorities to the occupational hygiene and occupational health agency (Department of Occupational Hygiene and Occupational Health of the NNK, before 1 October 2018, Directorate of Occupational Hygiene and Occupational Health of the National Institute of Public Health) in order to assess the completeness and professional validity of the application.

Subsequently, the fact of an occupational disease must be assessed by an agency with competence and jurisdiction for the payment of sickness benefits pursuant to Government Decree 217/1997 (1 December) on the implementation of Act LXXXIII of 1997 on the Benefits of Compulsory Health Insurance.

Benefits to be determined in the case of occupational diseases (compensation) are granted in a social security decision at the end of the procedure on the fact of the occupational disease.

In the case that the employee concerned complains about the failure to investigate an occupational disease, they may apply to the territorially competent occupational safety and health authority electronically or by other means on the notification form provided in the Annex to the Labour Safety Act. The occupational safety and health authority shall refer a person with the suspicion of an occupational disease or who complains about the failure to investigate it, to a physician who is entitled to report it or, to the occupational hygiene and occupational health agency. If the suspected occupational disease of the employee concerned has not been reported, the employee may also apply to the territorially competent occupational safety and health authority.

Special rules for the professional personnel of the Hungarian Armed Forces:

The screening of the psycho-social risks of the entire personnel of the Hungarian Defence Forces is performed during aptitude and targeted screening tests. During the performance of the actual service, or in case of an individual personal request or a proposal of the supervisor, the psychological service provides assistance with its own tools. Psychological training in stress management, coping with stress, temper management, emotional control development, aggression detection and treatment is currently partly implemented in preparation for external service, as a particularly important area in this respect, through which a relatively large number of staff can be reached.

With regard to the management of stress, aggression and violence at work stress and stress management are included in the topics of the trainings during the mission preparations. Topics specifically related to the treatment of aggression and violence are currently not

included in these programmes. The mission's command staff will receive an interactive session on temper management and behaviour in crisis situations. In other cases, such a session is conducted upon express targeted request. The planning and organisation of such training sessions affecting the entire staff of military organisations is performed by issuing central training directives and under the authority of the unit commanders.

Within the framework of the Health Preservation Premium Programme, cardiac stress screening tests (Vicardio) are performed at the organisational level on the basis of a preliminary request, based on the results of which recommendations are made to the competent commander or the health care staff for certain forms of stress management. Stress and everyday workplace conflict management are implemented within the framework of trainings among the staff of the Hungarian Defence Forces.

Within the Hungarian Defence Forces, the suspected occupational disease is reported to the Administrative Department of the Ministry of Defence (hereinafter referred to by the Hungarian abbreviation as HM HF) by the detecting physician. With regard to Hungarian Defence Forces, the investigation and registration of occupational diseases is carried out by HM HF.

- ***In its 2017 conclusions, the ECSR requested information on the list of occupational diseases, their number of events, the number of recognised and reported occupational diseases during the reporting period, broken down by employment sectors and years.***

- ***It also requested statistics on rates of employment-related deaths, injuries and illnesses, including suicide, other forms of self-harm, post-traumatic stress disorder and burnout. In addition, epidemiological studies were requested on the long-term health consequences of new high-risk jobs (e.g., bicycle courier services; athletes; workplaces involving special forms of contact with customers or the use of potentially harmful substances, alcohol and drugs; new forms of high-yield, high- stress trade; army; law enforcement; etc.). They also request data on victims of harassment and malfunction at work.***

Information on harassment at work is described in paragraph 2 of the chapter dealing with Article 3 of this Report.

Suspected cases of occupational disease reported to the occupational safety and health authority:

Investigated from the aspects of the sectors of the national economy, **in 2016**, 39.4% of suspected cases of occupational diseases were received from the manufacturing sector. The second largest number of reports, i.e., 22.9% of the total reports was received from the human health and social care. These were mainly due to the large number of cases of mass infections such as calicivirus, rotavirus, scabies or Hepatitis A. 20.9% of the reported cases were received from the mining sector. These cases are typically diseases that result from the exposures affected to former miners decades ago but have now developed or been diagnosed.

In 2017, most suspected cases of occupational disease (30.9% of all reported cases) were also received from the manufacturing sector. 27.7% of the reports were received from the human

health and social services sector, which resulted from the reporting of some mass infections. Mining employees reporting is 25.9% of cases.

In 2018, the majority of cases of suspected occupational diseases continued to come from the manufacturing (28.5% of all cases) and human health and social care (28% of all cases) sectors. Mining employees reports made up 25% of cases. Based on the experience of recent years, the number of these latter reports is gradually decreasing.

The trend for manufacturing did not change **in 2019** either - 38.8% of all reported cases were received from here. Reporting of employees in the mining sector accounted for 24.6% of cases. 21.8% of notifications were received from the field of human health and social care.

The figure below shows the number of suspected occupational diseases reported to the occupational safety and health authority during the reporting period according to pathogens:

Development of reported cases of suspected occupational diseases according to pathological factors					
2016. January 1. – 2019. December 31.					
	Chemical pathological factors (person)	**Phisical pathological factors (person)**	**Biological pathological factors (person)**	**Not optimal use, psicho-social, ergonomical factors (person)**	**reported cases altogether**
2016	**116**	**48**	**158**	**62 (+4)***	**384 (+4) ***
2017	**81**	**29**	**128**	**43**	**281**
2018	**69**	**27**	**59**	**45**	**200**
2019	**80**	**40**	**54**	**37**	**211**
Total	**346**	**144**	**399**	**187**	**1 076 (+4) ***

*One single employee was reported due to multiple pathological factors simultaneously

Source: Occupational Protection Department of the ministry controlled by the minister responsible for employment policy

During the reporting period, based on the examination of pathogens, it can be stated that the most suspected occupational diseases were reported due to biological pathogens, 36.9% of all cases. This is followed by reports of chemical pathogens, which account for 32.0% of all cases, and reports of non-optimal use, as well as reports of psycho-social and ergonomic factors, which account for 17.3% of all cases. Reporting due to a physical pathogen is 13.3% of all cases.

Accepted and registered occupational diseases:

The number of registered occupational diseases investigated by the occupational safety and health authority and found to be professionally substantiated by the occupational health agency was 245 in 2016, 230 in 2017, 175 in 2018 and 148 in 2019.

Fatal and mass occupational diseases:

In 2016, there were 2 fatal occupational diseases. In one case, the employee was employed in a pest control job without a medical gas manager qualification, and in the other case, the employee was engaged in forestry activities. In both cases, the fatal outcome was the result of

excessive occupational heat exposure, at the time of their occurrence a third-degree of heat alarm was in force. Both employees suffered from severe, chronic underlying diseases that could have significantly increased the risk of developing heat stroke.

Mass, i.e. at the same time, at the same workplace, occupational disease affecting at least 5 employees was registered in 6 cases in 2016. In total, 67 employees became ill in the mass cases.

In 2017, 1 registered fatal occupational disease occurred. A female employee developed mesothelioma following inhalation of asbestos dust as a result of exposure during cutting machine operations.

In 2018, there were 2 fatal occupational diseases. In the first case, 1 (male) employee engaged in mining activities; the operator of the solid mining machine has been reported with a disease caused by ionising radiation. In the other case, 1 (male) employee was employed in a pipe fitting job, with a diagnosis of lung cancer caused by inhalation of asbestos dust.

In 2019, there was 1 fatal occupational disease. 1 (male) employee who died due to an occupational disease was employed as a mining machine operator in a uranium ore mine and was reported to be suffering from ionising radiation.

The ECSR requests information on the measures aimed at labour inspection of small and medium-sized enterprises with regard to this paragraph.

Occupational protection, i.e. occupational health and safety protects the rights of employees to health and safety, while the protection of employees' other guarantee rights relating to pay, rest, leave and employment is represented by labour regulations. The two parts altogether are considered by the European practice as the labour inspection systems.

The tasks and objectives to be implemented of the ‘labour inspection system’ (provisions on safety, health, employment of children and juveniles, working time, wages and related matters) are set out by ILO Convention No. 81, which has also been ratified by Hungary (promulgated by Act LI of 81 of 2000 on the Promulgation of Convention No. 81 on Labour Inspections in Industry and Trade, Approved at the 30th session of the International Labour Conference in 1947).

With the accession of Hungary to the European Union, Act XXXIV of 2004 on Small and Medium-sized Enterprises and the Support Provided to Such Enterprises (hereinafter SME Act) entered into force in accordance with the non-mandatory EU legislation (with Commission Recommendations 96/280/EC concerning the definition of small and medium- sized enterprises and 2003/361/EC concerning the definition of micro, small and medium- sized enterprises) The act serves to support the development of small and medium-sized enterprises (hereinafter: SMEs) by joining the process of the single European market. The classification of enterprises is based on the number of employees (0-1 persons, 2-9 persons, 10-49 persons, 50-249 persons) and net sales (or balance sheet total), which is not exactly the same as the EU classification (according to the number of employees: under 10 persons, 10- 49 persons, 50-249 persons).

Occupational health and safety is defined in the Hungarian legal system as a fundamental human right, for which employees in SMEs must be provided with working conditions that do

not endanger their safety or health,, and that ensure the prevention of accidents at work and occupational diseases in order to maintain and develop their ability to work.

The state facilitates and monitors the implementation of occupational health and safety regulations as part of official activities. In the practical implementation of this, the SME occupational safety and health authority conducts inspections to enforce compliance with the legal requirements applicable to the employer. In the case of organised work, the Labour Safety Act does not differentiate between the organisational or ownership forms of individual enterprises with regard to the fulfilment of occupational safety requirements.

Competent control authorities:

- the government employment agency; the Minister responsible for employment policy pursuant to Government Decree 320/2014 (13 December) on the Designation of the Public Employment Agency and the Health and Safety and Labour Authority and the Performance of the Public Authority and Other Tasks of Those Bodies;
- government offices acting under the authority of the occupational safety and health authority

The area of competence of the government office for occupational health and safety is divided into the county level.
The Minister responsible for employment policy is responsible for the professional management of the activities of government offices acting within the competence of the occupational safety and health authority.

In order to eliminate the deficiencies revealed during the inspection of SMEs, the occupational safety and health authority is entitled to apply the measures and liability specified in the Labour Safety Act and in separate legislation:

– Oblige the employer to eliminate the identified deficiencies within a specified period of time.
– An employee who has been employed in serious violation of occupational health and safety regulations should be banned from doing the objected work.
– In the case of a danger to the health and physical integrity of the employee, order the suspension of the use of the dangerous activity or work equipment until the danger is eliminated.
– The occupational safety and health authority shall impose an administrative fine on a natural person who, in the course of organised work:
  - violates the rules for the healthy and safe performance of work and its control or tolerates the non-implementation of these rules in its competence;
  - fails to fulfil the obligation to register, investigate, record and report in connection with an accident at work in time, or provides false information or conceals the real cause of the accident, prevents its exploration;
  - fails to fulfil the obligation to provide information related to the occupational disease or case, or prevents the investigation of the occupational disease; or
  - as the employer's representative, prevents the occupational safety and health representative from exercising their rights provided for in the occupational health rule, takes adverse action against the occupational safety representative due to the exercise of their rights.
– The occupational safety and health authority shall impose occupational safety fines against the employers failing to fulfil the requirements on occupational safety and

occupational health, and thereby seriously endangering the life, physical integrity or health of employees.

Based on the analysis and evaluation of data from supervisions and inspections on accidents at work and health impairment, the occupational safety and health authority plans, organises and conducts targeted inspections and action inspections each year. Within the framework of these, the occupational safety agencies of the capital and county government offices throughout the country examine the areas designated for inspection according to uniform criteria determined by the professional manager. Targeted inspections and action audits are prepared by the professional manager and the data received are analysed, and summary reports based on the experience of the audits are published on their website, so that they are available to SMEs at any time.

A strong government effort is to review the rules for employers and simplify regulations, reducing administrative burdens. In the spirit of this, the SME Act was amended and supplemented, and for this purpose Government Decree 273/2011 (20 December) on the Detailed Rules of the Amount of Occupational Safety Fines and the Method of Imposing Them was also promulgated.

The occupational safety and health authority will issue a warning instead of imposing a fine if an infringement detected at an SME for the first time (provided that there is no imminent threat to human life, physical integrity or health, damage to the environment or a violation of the protection of juveniles). In case of a breach of occupational safety and health standards by SMEs, the amount of the occupational safety fine may be reduced by 20% and calculated on the basis of methodological guidance (with regard to the employment of health and safety professionals, the selection of occupational safety representatives, risk assessment, etc.) as well as the amount of the fine is reduced to 0.8 times it.

The 2011 amendment of the Labour Safety Act already took into account the reduction of administrative burdens for SMEs by requiring employers to perform risk assessment, risk management and the definition of preventive measures, unless otherwise provided by law, before and after the start of the activity, where appropriate, but at least every 3 years (as opposed to the previous annual review).

In our opinion, the cessation of certain notifications (e.g., the use of occupational health services) has reduced the administrative burden, the new regulation of occupational safety fines also provides significant financial relief, and the advice of the occupational safety and health authority provides professional assistance to SMEs.

One of the key objectives of the National Occupational Health and Safety Policy announced by the Government of Hungary by Government Resolution 1581/2016 (25 October) is to enable SMEs to apply effective and real risk prevention measures as much as possible. The tasks defined in order to achieve this are described in Section 1.

The professional management body of the occupational safety and health authority has published on its official website a general guide for performing a risk assessment at workplace. The guides primarily help SMEs to become familiar with the risk assessment system, to apply the relevant legislation correctly and to practice preparing and to perform risk assessments.

The legal background for the interest conciliation at the national level is also provided for SMEs. The national interests conciliation related to healthy and safe work is performed by the Occupational Safety Committee, which consists of representatives of employees, employers' interest representation organisations and the Government, and operates in accordance with its own rules of procedure. At the employer level, occupational safety representatives, occupational safety committees and parity occupational safety agencies are the forum for consultation. The Labour Safety Act manages co-operation with employees and their representatives, and provides consultation as a priority.

According to the Hungarian regulations, employees are entitled to choose an occupational safety representative(s) from among themselves to represent their rights and interests related to health and safety work. As a result of the amendment of the Labour Safety Act, the number of employers wherein an occupational safety representative is needed to be elected doubled, thus strengthening the occupational health and safety enforcement capacity of those working there. An election of an occupational safety representative must be held at employers with at least twenty employees. The election of an occupational safety representative can be held even if the number of employees is less than twenty.

The employee, the occupational safety representative and the employer must cooperate, in particular, with regard to the necessary information. The occupational safety representative (in the case of three representatives, a committee) has a number of rights, so they are entitled to be convinced of the following:

- on the safe condition of workplaces, work equipment and personal protective equipment,
- on the implementation of preventive measures,
- on the preparation and preparedness of employees for their healthy and safe work.

The occupational safety representative has the right to participate in the investigation of accidents at work and may also contribute to the investigation of the circumstances of an occupational disease. The occupational safety representative may, in justified cases, turn to the competent occupational health and safety authority and, by prior agreement with the employer, have recourse to an expert and have discussions with the occupational safety and health authority.

During occupational health and safety inspections, the acting government official inspects the holding of the election of an occupational safety representative for all employers with at least twenty employees. During the occupational health and safety inspections, the government official specifically requests the employer to ensure the participation of the occupational safety representative.

The regulation on the interest representation of occupational safety at work includes the further training of occupational safety representative as an obligation of the employer. The provisions of the Labour Code apply to the employment protection of occupational safety representatives.

The labour authority conducts labour inspections of SMEs in order to enforce compliance with the employer's legal requirements and to enforce the fundamental rights of employees.

Accordingly, in the case of working for an SME, the labour authority also examines the following:

- the order of employment relations, in particular a written employment contract and unregistered employment or artificial contract, compliance with the legislation on temporary agency work and the regularity of employment of third-country nationals,
- compliance with legislation on the financial security and livelihood of employees, concerning the level and protection of wages,
- the exercise of employees' right to rest,
- compliance with legislation on working time and the recording of data relating thereto.

In order to eliminate the deficiencies revealed during the inspection of SMEs, the labour authority is entitled to apply the measures and liability specified in Act LXXV of 1996 on Labour Inspections (hereinafter: Labour Inspections Act.) and in a separate legal act:

- prohibits further employment if, due to the seriousness of certain infringements, it cannot be maintained and the damage cannot be remedied within a short period of time,
- orders the employer to terminate the infringement within a specified period,
- obliges the employer to pay into the central budget due to a violation of the rules on permitting the employment of a third-country national in Hungary,
- imposes a labour fine,
- establishes the existence of an employment relationship from the date of entry into employment and obliges the employer to comply with the rules governing the employment relationship,
- prohibits the employer from continuing their activities if they do not have the permit and registration required by the legislation on employment,
- in the event of a violation of the age conditions related to the legal personality of the employee, a signal is made to the child welfare service due to the vulnerability of the child,
- in order to prevent further infringement, it shall establish the infringement of the employer.

Pursuant to Section 12/A (1) of the SME Act, the labour authority issued a decision containing a warning replacing a labour fine by 31 December 2017.

Weaker sanctions to support small and medium-sized enterprises due to the economic crisis have not necessarily deterred employers from infringements who are increasingly finding themselves economically. The majority were already aware that even in the most serious cases they did not have to reckon with a fine and there were no other adverse consequences of their first infringement, but unregistered employment could achieve significant cost reductions by ‘saving’ taxes and contributions payable.

With regard to this experience, it proved necessary to change the previous legal consequences in case of violation of the minimum employment rule (failure to notify), so from 2018 this irregularity will result in labour fines for SMEs in the first case.

In order to ensure the right to safe and healthy working conditions, the Parties undertake, in consultation with employers' and employees' organisations:
4. to promote the progressive development of occupational health services for all employees with essentially preventive and advisory functions.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF, REASONS FOR AND EXTENT OF THE REFORMS

During the period under review, the legal provisions related to the implementation of the article did not change.

2) RESPONSES GIVEN TO THE QUESTIONS OF THE ECSR RELATING TO THIS PARAGRAPH

The ECSR requests information on access to occupational health services for seasonal employees, temporary employees, private entrepreneurs and domestic employees, and on the measures taken to ensure that small and medium-sized enterprises comply with the standards.

As stated above, occupational health and safety regulations cover all forms of organised work, including seasonal work.

Act XCIII of 1993 on Labour Safety (hereinafter: Labour Safety Act) regulates the free of charge nature of medical examinations for the affected employees [Section 2 (2) of the Labour Safety Act]. The basic service performs a written documented examination of working conditions and the harmful effects of work on the basis of the service contract, and contributes to the creation of a healthy working environment, prevention of health damage. Furthermore, without prejudice to the responsibility of employers it shall participate in the development of working conditions in compliance with health requirements and in the prevention of health impairment, and also in performing the tasks prescribed by specific other legislation, recognised as specialised occupational health activities.

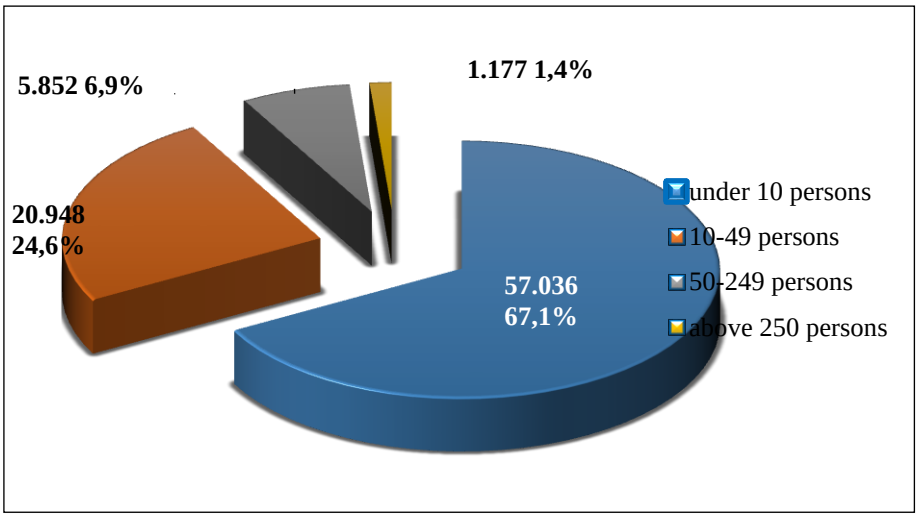
The provision of occupational health care is examined at all times during inspections by the occupational safety and health authority.

Considering that the employer also finances occupational health care for those working in organised work, the private entrepreneurs can also use the nationally covered occupational health service, so the opportunity is also provided for them. For those who are not employed, full occupational health care is available for a fee, and certain examinations can be used at the expense of social security at regional specialist care places and at the national care level. Those not employed typically do not receive occupational health services.

The figures below show the number of enterprises and the distribution by headcount category (micro, small, medium, large enterprises) provided by the basic occupational health services during the reporting period. The data were provided by the occupational hygiene and occupational health agency (before 1 October 2018, the Directorate of Occupational Hygiene and Occupational Health of the National Institute of Public Health, from 2018 the Department of Occupational Hygiene and Occupational Health of the National Public Health Centre) for the report on the occupational safety situation in the national economy.

Number of enterprises supplied **in 2016**: 89 792

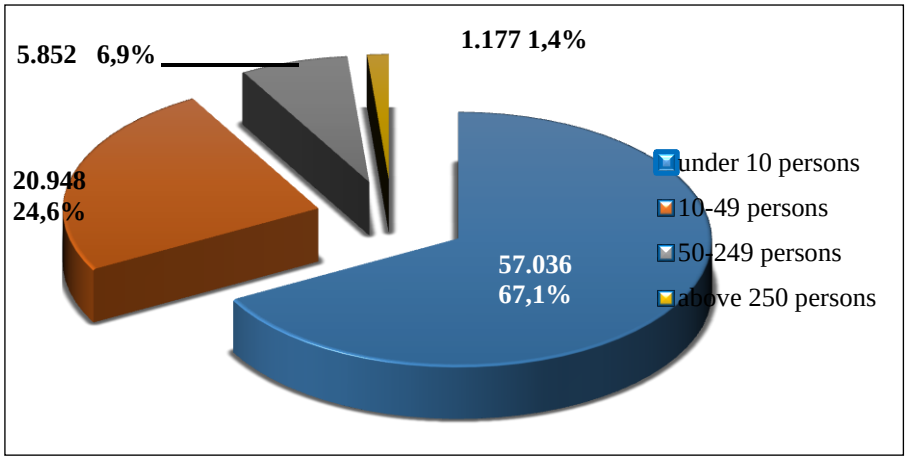
Distribution of the enterprises by number of employees



Source: Directorate of Occupational Hygiene and Occupational Health of the National Institute of Public Health

Number of enterprises supplied **in 2017**: 85 013

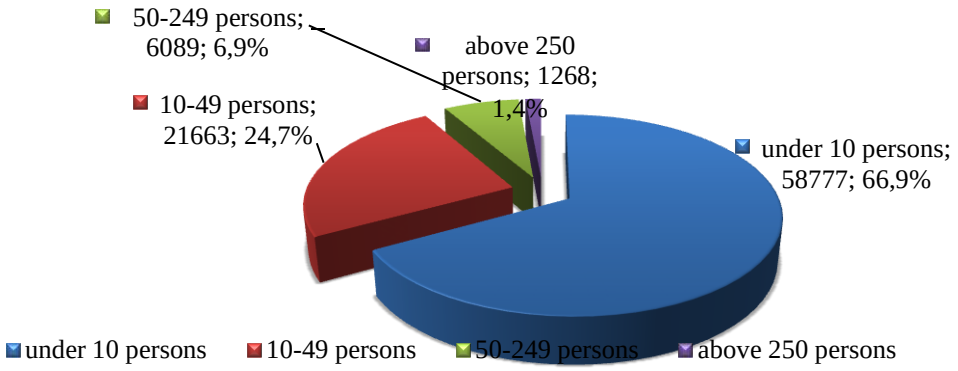
Distribution of the enterprises by number of employees



Source: Directorate of Occupational Hygiene and Occupational Health of the National Institute of Public Health

Number of enterprises supplied **in 2018**: 87 797

Distribution of the enterprises by number of employees



Source: Directorate of Occupational Hygiene and Occupational Health of the National Institute of Public Health

Relevant information, methodological materials, statistics, regulations and professional materials, guides on good practice in healthy and safe work, which are available to SMEs free of charge and on an ongoing basis, are regularly published on the website of the national organisation for occupational safety. The free telephone information service is also often called by SME representatives and employees, to receive information on occupational health care and occupational aptitude tests. They will also be informed if requested in writing.

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

In its conclusions of 2017, the ECSR requested statistical data:

- ***life expectancy in relation to certain areas of the country and different social groups (countryside, cities, ethnic groups and minorities, long-term homeless or unemployed, etc.);***
- ***which highlight existing differences (between certain areas of the community; between specific occupations or jobs; proximity to active or decommissioned industrial or heavily polluted areas or mines); and***
- ***in relation to infectious diseases specific to each age group (e.g., cancer) or blood-borne infectious diseases (e.g., new HIV or Hepatitis C infections among drug addicts and those serving prison sentences).***

In addition, data was requested on sexual, gynaecological and reproductive health services available in Hungary, as well as on the number and rate of early (child or juvenile) pregnancies, maternal and child mortality, and policies to address the problems listed above (early death, prevention of infectious diseases).

The implemented improvements are presented under this Section, the related statistical data are presented under Section 4) of this chapter.

1. Development of health care for the period 2016-2019

The Government of Hungary is committed to further improving the health situation in the country; one of the most important objectives is to continuously improve the health status of the Hungarian population, therefore it manages the development of primary care as a priority. In addition to prevention, an important government goal is to improve patients' chances of recovery.

- **Development of family practitioner care:**

The appropriation for family practitioner care in the Health Insurance Fund has developed as follows in recent years.

(data in million HUF)											
Title	**2010**	**2011***	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020****
practice financing (fix price, territorial allowance, "card money")	69 092.0	73 257.7	71 846.8	80 320.2	86 308.4	96 345.8	106 385.8	112 230.6	119 918.3	121 556.5	121 492.0
ad hoc care	567.0	652.0	612.6	625.6	597.2	552.9	512.9	498.6	500.1	512.6	649.3
indicator system									4 799.8	7 299.1	7 300.0

Summary	69 659.0	73 909.7	72 459.4	80 945.8	86 905.6	96 898.7	106 898.7	112 729.2	125 218.2	129 368.2	129 441.3

* with performance fee for 13 months
** planned payment
Source: National Health Insurance Fund

The planned payment in 2020 exceeds the payments in 2010 by almost HUF 60 billion, which means a 76% increase in the field of family practitioner care during the examined 10 years.

Changes in 2016:

In 2016, the second phase of the program related to the renewal of the family practitioner care system of the Government of Hungary began. As part of this, the HUF 130 000 monthly remuneration of family practitioner services with territorial care obligations doubled to HUF 260 000. The implementation of the measure required the involvement of HUF 10 billion in additional funds on an annual basis. In addition, the overhead support fee for family practitioner providers has also increased.

As part of the second phase of the project, tenders were issued on the basis of the provisions of Section 18/A (1) and (2) of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund in connection with the purchase of the right of establishment and the practice right of family practitioner. The total amount available was HUF 750 million. The applications are presented in detail under the following Section.

In total, 112 applications were received by the National Health Insurance Fund during the year (hereinafter referred to by the Hungarian abbreviation as OEP): 35 applications for establishment and 77 applications for practice right. Out of 112 applications, 103 received a winning qualification. Out of the 103 winning applicants, the support and funding contract was finally concluded with 96 family practitioners. In total, HUF 642.3 million support amount was paid.

From August 2016, retroactively from January 2016, the basic fee for dental services and specialist practice was also increased. The fee increase was implemented by raising the age group score on which the basic fee is based, which changed to HUF 53.2 per month. Based on this, the remuneration of dental service providers increased by 7.9%. This required the involvement of HUF 2.0 billion in additional funds.

Due to the amendment of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund, the remuneration of health visitors was also increased. The service providers were entitled to the increase from the August 2016 payment, similarly to dentists, until January 2016 retrospectively. Retrospective fee increases for the months of January-August 2016 were disbursed in a lump sum in August 2016. Compared to the 2015 funding data, the increase in funding in September 2016 reflected an average surplus of HUF 29.9 thousand in the monthly funding of health visitor services, while the monthly funding in the case of school health visitor services accounted an average increase of HUF 47.5 thousand.

The amendment to the government decree obliged health care providers contracted with OEP to use funding increases to increase benefits for nurses. From January to December 2016, the providers contracted for the cervical screening of health visitors remunerated HUF 3,304,000 in total based on 1,652 cases.

Changes in 2017:

The third phase of the renewal of the family practitioner care system started in 2017, in the framework of which the overhead support fee for family practitioner service providers was further increased from June 2017. The HUF 260 000 monthly remuneration of family practitioner services with a territorial care obligation increased by HUF 130 000, so they receive HUF 390 000 monthly remuneration on this title. The implementation of the measure required the involvement of HUF 5.8 billion in additional funds on an annual basis.

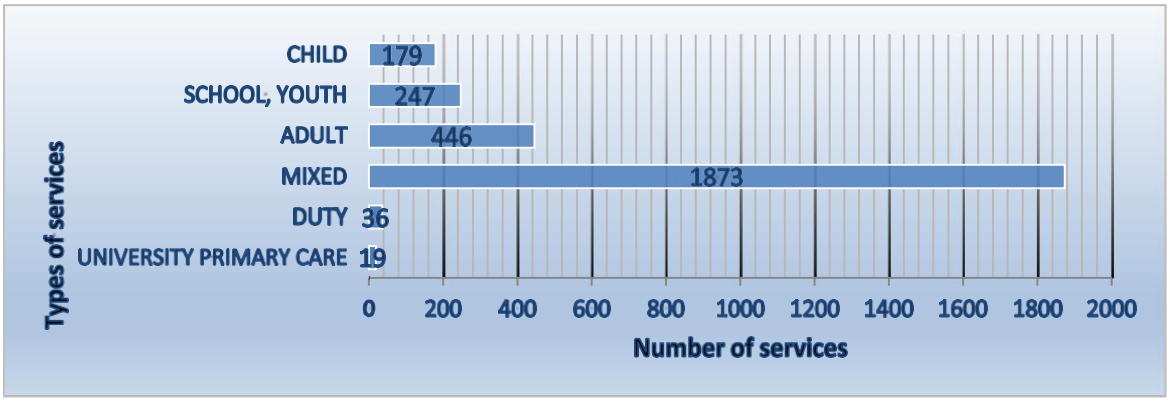
Applications for the purchase of the right of establishment and the practice right as a family practitioner continued. Similar applications have been launched for dentists. The total available amount was HUF 1,250 million, which increased by an additional HUF 1 000 million.

In total, 162 applications were received by the National Health Insurance Fund Manager (the successor body of the OEP, hereinafter referred to by the Hungarian abbreviation as NEAK): 55 applications for the establishment of a family practitioner, 41 applications for the establishment of a dentist, 66 applications for the purchase of practice right of family practitioner. Out of the 162 applications, 152 were awarded. Out of the 152 winning applicants, 111 family practitioners and 37 dentists were finally signed support and funding contracts. In total, HUF 2 335.3 million in support was paid, of which HUF 1 408.1 million was paid to family practitioners and HUF 927.2 million to dentists.

Benefits for heaqlth visitors have also increased: From November 2017, all health visitor service providers will be entitled to an additional supplement of HUF 33,000 per service for full-time services. If the service is part-time, it is entitled to a proportionate share of the specified amount. The amendment states that the health visitor supplementary allowance should be used to pay the health visitors' wages.

A one-time additional fee has also been introduced for dentists: The dental service provider operating the dental service providing primary care, regardless of the form of operation, is entitled to remuneration in the amount of HUF 3 million per service in December 2017. The HUF 3 million remuneration is paid for services operating at 30 hours of office time per week, and for services operating at lower office times (similar to the additional monthly allowance for health visitors), a time-proportionate fee is set. In total, 2 800 operators of primary dental care services received the above form of remuneration, in total, HUF 7.6 billion was paid.

From January to December 2017, the providers contracted for the cervical screening of health visitors remunerated HUF 9 055 000 in total based on 4 529 cases.



Source: National Health Insurance Fund of Hungary

Changes in 2018:

From March 2018, the overhead support fee for family practitioners increased again, and the increase of the previous year was also equalised. The HUF 390 000 monthly remuneration of family practitioner services with a territorial care obligation increased again by HUF 130 000, so the family practitioners concerned now receive HUF 520 000 monthly remuneration. The implementation of the measure required the involvement of HUF 8.3 billion additional funds on an annual basis. Bringing the increase in the overhead support fee implemented in June 2017 to the level required an additional HUF 4.2 billion in 2018.

Applications for the purchase of the right of establishment and the practice right as a family practitioner and dentist continued. The total available amount was now HUF 1 250 million, which increased by another HUF 500 million.

In total, 131 applications were received by NEAK during the year: 37 applications for the establishment of a family practitioner, 37 applications for the establishment of a dentist, 57 applications for the purchase of practice right of family practitioner. Out of the 131 applications, 125 were awarded. Out of the 125 winning applicants, 88 family practitioners and 33 dentists were finally signed support and funding contracts. In total, HUF 1 726.8 million in support was paid, of which HUF 992.9 million was paid to family practitioners and HUF 733.9 million to dentists.

Overhead support for dentists has also been introduced: pursuant to Section 23 (13) of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund, from 1 March 2018, dental service providers operating a dental service providing primary care became entitled to a monthly overhead support of HUF 130 000 per service. remuneration is paid for services operating of 30 hours of office time per week, services operating at a lower office time are entitled to a reduced proportionate overhead support. Based on this, the average monthly revenue of primary dental care services increased by 13.0%. This required the involvement of HUF 3.3 billion in additional funds.

The score of dental interventions in the framework of dental care has also been increased: in Annex 12 of Decree of the Minister of Welfare 9/1993 (2 April) NM on Certain Issues of Social Security Financing of Health Care Services the scores of dental interventions marked ‘TB’ and ‘TE’ that can be reported by specialist care and university care have increased. The settlement based on the increased score value had to be applied from the settlement of the performances in January 2018, the retrospective adjustment amounts will be paid within the framework of the August 2018 transfer. Based on this, the average monthly revenue of specialist dental services increased by 15.2%. This required the involvement of HUF 0.8 billion in additional funds.

In 2018, the HUF 33 000 supplementary allowance for health visitors, introduced from November 2017, was paid to all service providers providing health visitors services for full-time services throughout the year. If the service is part-time, it is entitled to a proportionate share of the specified amount. The amendment states that the health visitors’ supplementary allowance should be used to pay the health visitors’ wages.

Changes in 2019:

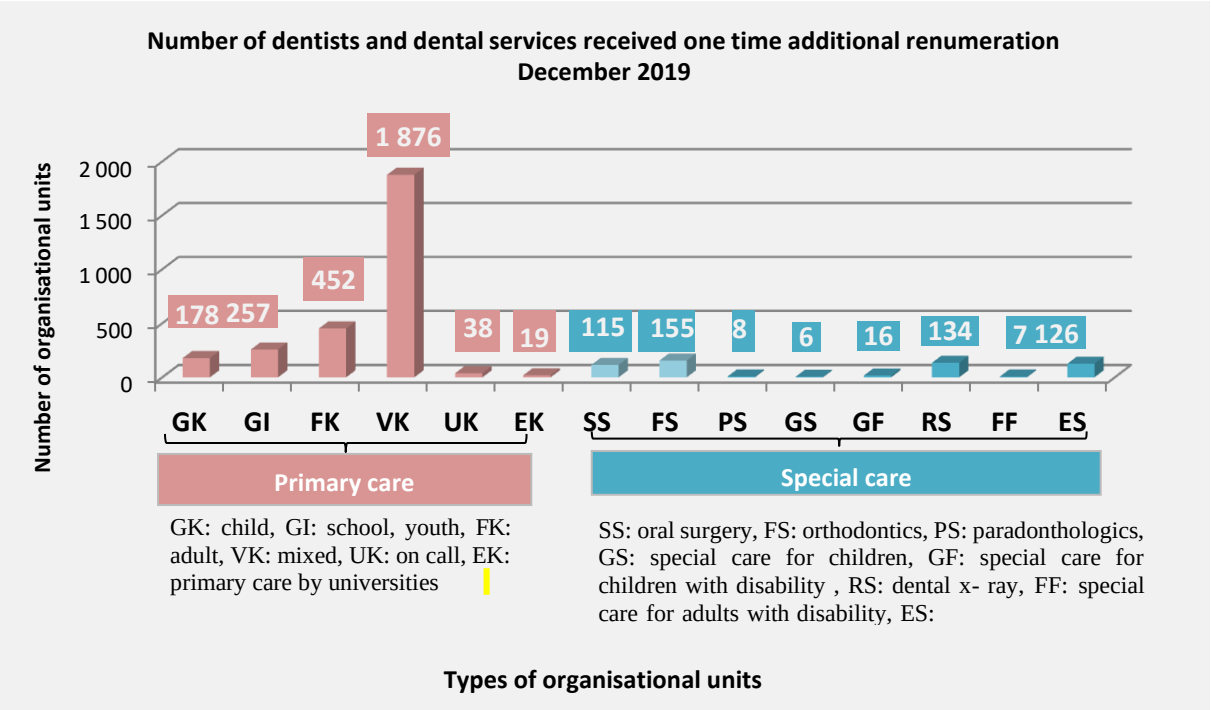
Bringing the increase in the overhead support fee implemented in March 2018 to the level required an additional HUF 1.65 billion in 2019.

There was also an increase in the remuneration of the family practitioner indicator system. The previous annual remuneration budget of HUF 4.8 billion increased by more than 50%, so in 2019 HUF 7.3 billion (more than HUF 600 million per month) is available to remunerate the results achieved in the indicator system. Thus, HUF 2.5 billion more payments will be made for professional and quality work in practice. The increased amount of remuneration was first paid in March 2019, together with the adjustment amounts for January and February.

In the case of the applications for the right of establishment of a family practitioner and a dentist and for the purchase of the practice right as a family practitioner, the total available amount is HUF 1 250 million, which increased by an additional HUF 500 million.

In total, 145 applications were received by NEAK during the year: 36 applications for the establishment of a family practitioner, 30 applications for the establishment of a dentist, 79 applications for the purchase of practice right of family practitioner. Out of the 145 applications, 139 were awarded. Out of the 139 winning applicants, 108 family practitioners and 28 dentists were able to sign support and funding contracts. In total, HUF 1 731.9 million in support was paid, of which HUF 1 083.8 million was paid to family practitioners and HUF 648.1 million to dentists.

In addition, the public-funded primary and specialist dental care providers and specialist practices operated for 30 hours again received a one-time additional remuneration of HUF 1.5 million in December 2019. In case of a lower office time, they are entitled to a reduced proportionate fee. The coverage of the one-time supplementary remuneration was HUF 4 459.5 million, from which 3 388 organisational units of 2 291 primary care and specialist care providers received the one-time supplementary support.



Source: National Health Insurance Fund of Hungary

- **Applications to promote the development of family practitioner care**

Pursuant to the provisions of Section 18/A (1) and (2) of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund, the NEAK issued an application to support the establishment of physicians who are filling family practitioner and dental district positions that have been vacant for at least 12 months and to support the purchase of the practice right as a family practitioner.

The OEP/NEAK first announced the application for the establishment of a family practitioner in 2014, and in 2015 the purchase of the practice right as a family practitioner. In 2017, dentists were already able to submit a settlement application. The applications prove to be successful from year to year, the interest in them is uninterrupted among family practitioners and dentists, so their announcement has been continuous ever since.

Applications may be submitted by a physician who is entitled to perform family practitioner/dental activities on the basis of the personal conditions specified in Decree of the Minister of Health 4/2000 (25 February) (EüM) on Family Practitioner, Family Paediatrician and Dentist Services and has undertaken to provide independent medical practice in the relevant family practitioner/dental service for at least 6 or 4 years, respectively, in the form of operation agreed with the competent local authority, but in each case with personal assistance.

The eligible support amounts were as follows:

In the case of application for establishment of family practitioners and dentists:
-in the case of filling a service, which was vacant for at least 12 months: HUF 12 000 000
-in the case of filling a service, which was vacant for at least 24 months: HUF 14 000 000
-in the case of filling a service, which was vacant for at least 36 months: HUF 16 000 000
-in the case of filling a service, which was vacant for at least 48 months: HUF 18 000 000
-in the case of filling a service, which was vacant for at least 60 months: HUF 20 000 000

In the case of an application for practice right as a family practitioner purchase:
- maximum: HUF 4 000 000

Only vacant family practitioner and dental service positions could be applied for, where the population to be cared for exceeds:

1. in the case of family practitioner service
   - in the case of adult and mixed districts: 1 000 people,
   - in the case of a children district: 500 people

2. in case of dental service
   - in the case of adult and mixed districts: 1 800 people,
   - in the case of a children district: 1 600 people.

Applications for support for practice right purchasing could only be submitted in respect of family practitioner positions where the population to be cared for exceeded:
- 800 people in the case of adult and mixed districts:

- 300 children in the case of a children district.

In the case of the applications for practice right purchased by a family practitioner, another important condition was that the applicant physician should not have had a practice right within the two years preceding the announcement of the application.

Between 2014 and 2019, in total, 212 family practitioner services and 98 dental service positions were filled, as well as 293 family practitioner practice rights were purchased by the winners, so that the family practitioner care of nearly 820 000 residents will be guaranteed for years to come. In the case of dental services, the applications will result in the dental care of 374 thousand residents for a minimum of 6 years, who have not had an 'own dentist' for many years before.

Year	Number of successful candidates in the establishment tender		Number of successful candidates in the establishment tender who concluded a grant agreement.		Amount paid to successful candidates in the establishment tender (million HUF)		Number of successful candidates in the practice right tender	Number of successful candidates in the practice right tender who concluded a grant agreement.	Amount paid to successful candidates in the practice right tender (million HUF)
	GP	Dentist	GP	Dentist	GP	Dentist	GP	GP	GP
2014	41	-	38	-	412.8				
2015	26	-	25	-	290.3		45	39	181.3
2016	32	-	27	-	282.4		71	69	359.9
2017	53	39	52	37	1 096.6	927.2	60	59	311.5
2018	36	35	35	33	719.8	733.9	54	53	273.1
2019	36	29	35	28	707.8	648.1	74	73	376.0
All	**224**	**103**	**212**	**98**	**3 509.7**	**2 309.2**	**304**	**293**	**1 501.8**

Source: National Health Insurance Fund of Hungary

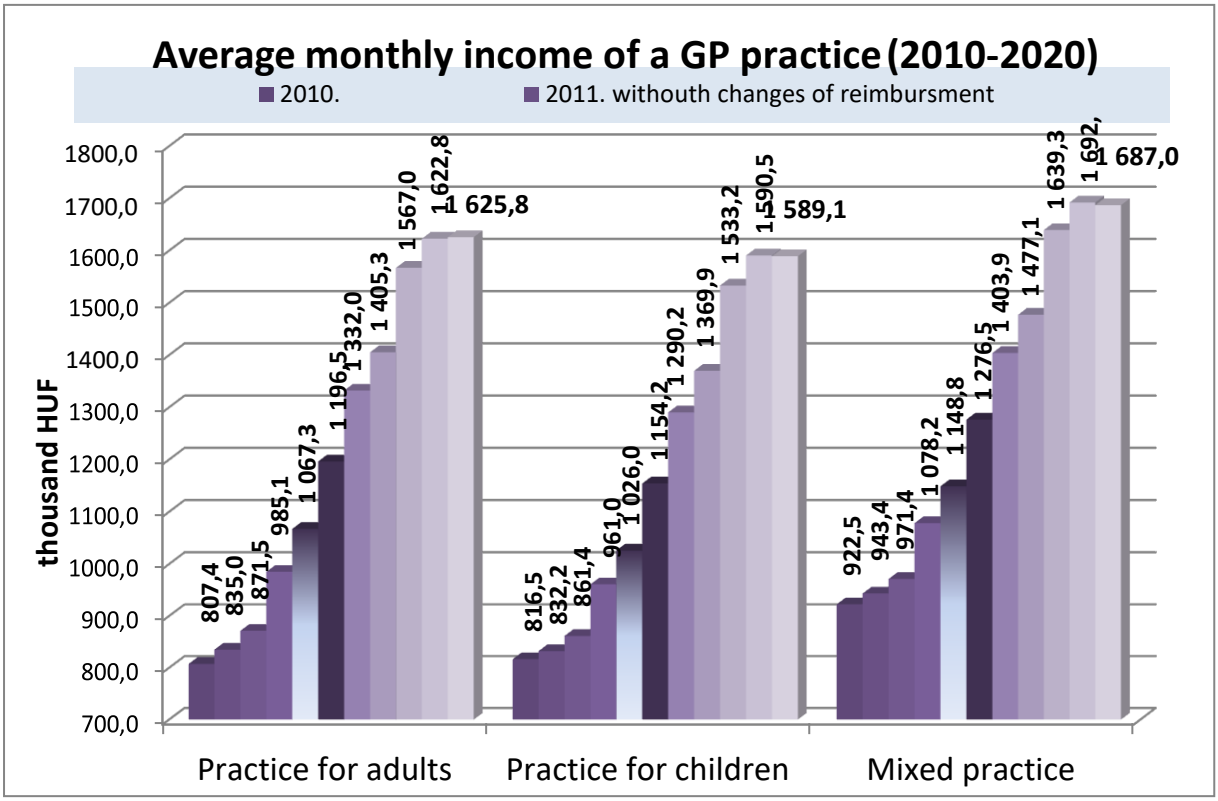
- **Development of the family practitioner duty service**

Payments for family practitioner duty care in recent years have been as follows in the Health Insurance Fund.

Year	Payments (Million HUF)
2010	9 613.5
2011	9 589.4
2012	9 578.2
2013	10 100.7
2014	10 137.7
2015	10 145.7
2016	10 146.2
2017	10 151.7
2018	10 156.7
2019	10 168.8

2020*	10 106.2
* planned payment	

Source: National Health Insurance Fund



Source: National Health Insurance Fund

- **Development of dental care**

The appropriation for dental care in recent years within the Health Insurance Fund is as follows:

Title/Year (Million HUF)	**2010**	**2011***	**2012**	**2013**	**2014**	**2015**	**2016**	**2017****	**2018**	**2019****	***2020******
Dental care	**22 644.3**	**23 469.6**	**22 447.0**	**24 446.7**	**26.241,8**	**25 946.7**	**27 946.8**	**35 546.1**	**32 070.1**	**37 354.3**	***42 494.1***
Support of undertakings performing primary care	200.6	380.6	3 736.5	3 619.0	1 663.0	51.3	43.2	35.4	30.5	26.6	*55.0*
Settlement support	-							2 250.0	1 768.9	1 731.9	*1 250.0*
- of witch to be used for dental care								927.2	733.9	648.1	
Comment: ** with 13 months of performance fee* *** With a one-time additional fee (2017: Appropriation no.: 27.946,8 + 7.599,3) (2019: Appropriation no: 32.894,8+4-459,5)* **** Planned*											

Source: National Health Insurance Fund

The payment in 2019 was HUF 14.7 billion higher than the actual payments in 2010, which represents an increase of 64.9%.

Changes in 2018:
Call for applications for establishment: Pursuant to the provisions of Section 18/A of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund, on 31 January 2018, NEAK issued an application to support the establishment of family practitioners and dentists who are filling family practitioner and dental districts that have been vacant for at least 12 months thus ensuring continuous family practitioner and dental care for the population living there in order to provide primary care (family practitioner and dental care) at a higher standard and quality. An application could be submitted continuously, no later than 15 October 2018.

Changes in 2019:
Call for applications for establishment: Pursuant to the provisions of Section 18/A of Government Decree 43/1999 (3 March) on the Detailed Rules of Financing Healthcare Services from the Health Insurance Fund, on 12 February 2019, NEAK issued an application to support the establishment of family practitioners and dentists who are filling family practitioner and dental districts that have been vacant for at least 12 months thus ensuring continuous family practitioner and dental care for the population living there in order to provide primary care (family practitioner and dental care) at a higher standard and quality. An application could be submitted continuously, no later than 15 October 2019. In total, HUF 1
711.9 million was paid in 2019 to support the establishment of family practitioners and dentists, which includes, in addition to the net support amounts paid to the winning applicants, the tax and contribution charges payable thereafter. In total, 28 dentists were signed a support contract. NEAK paid HUF 648.1 million to the winning dental applicants.

Development of the amounts paid for the renewal of the asset support system between 2016 and 2019:
The additional source of total primary care was HUF 9.6 billion, of which HUF 2.8 billion was paid to dental service providers. (Asset-property support and asset acquisition support in the period 2011-2014, asset-property support in 2015-2018)

Number of services providing primary dental care in the beneficiary settlement by county (based on contract data for December 2019):
In April 2015, Government Decree 240/2006 (30 November) on the Register For Social-Economically and Infrastructurally Backward Regions, with Unemployment Considerably above the National Average was replaced by Government Decree 105/2015 (23 April) on the Classification of Beneficiary Local Governments and the Conditions of Classification, Annex 2 of which contains the list of beneficiary settlements.

In the settlements defined in the government decree, in total, 590 dental services providing dental primary care at national level. The performance of tasks in the beneficiary settlements provides HUF 100 000 in additional revenue per service.

The number of dental services providing primary care in distavantaged settlements:

- in Baranya county, 49 services;
- in Bács-Kiskun county, 36 services;
- in Békés county 27 services;
- in Borsod-Abaúj-Zemplén county, 94 services;
- in Csongrád-Csanád county, 17 services;

- in Fejér county, 5 services;
- in Győr-Moson-Sopron county, 1 service;
- in Hajdú-Bihar county, 48 services;
- in Heves county, 34 services;
- in Komárom-Esztergom county, 1 service;
- in Nógrád county, 29 services;
- in Pest county, 4 services;
- in Somogy county, 45 services,
- in Szabolcs-Szatmár-Bereg county, 85 services;
- in Jász-Nagykun-Szolnok county, 31 services;
- in Tolna county, 22 services;
- in Vas county, 15 services;
- in Veszprém county, 14 services and
- in Zala county, 40 services

provided primary dental care in December 2019.[15]

- **Development of health visiors care and school health care**

The appropriation for health visitor, maternity, child and youth protection benefits in recent years has been as follows in the Health Insurance Fund.

(data in Million HUF)

Year	School health care	Nurse care	Mother-, child- and infant-protection	**Nurse care, mother-, child- and youth-protection altogether*:**
2010	1 856.0	15 439.8	451.5	17 747.3
2011	1 856.0	15 433.6	458.7	17 748.3
2012	1 899.4	15 688.7	460.6	18 048.7
2013	2 217.1	17 786.5	476.3	20 479.9
2014	2 241.6	19 526.9	486.4	22 254.9
2015	2 217.1	19 525.8	487.5	22 230.4
2016	2 317.1	21 532.8	482.7	24 332.6
2017	2 317.1	21 873.1	481.2	24 671.4
2018	2 317.1	24 009.8	483.4	26 810.3
2019	2 617.1	23 538.3	478.6	26 634.0
planned appropriations for 2020	2 317.1	24 009.8	483.4	26 810.3

** Payments without Moving Specialist Services (Mozgó Szakorvosi Szolgáltatások; MSZSZ)*
Source: National Health Insurance Fund

[15] Source: National Health Insurance Fund

Changes in 2016:
The amended appropriation increased the budget for school health care by HUF 100 million and the budget for health visitor care by HUF 2 000 million. With these increases, payments in 2016 were 37.1% higher than in 2010.

From 1 January 2016, full-time school health care services became free of charge: the increase took place retroactively, so in August 2016 the difference in fees calculated for the first 8 months of the year was paid, and then providers receive increased funding from the September transfer. The floating HUF/score fee for full-time medical services increased from an average of HUF 321 to HUF 342.

Changes in 2017:
In 2017, the funding fee for health visitor care increased due to the introduction of health visitor supplement for health visitor services, which was allocated by NEAK for the first time at the November 2017 payment. With this increase, the amount that can be spent health visitor care has increased by 39% compared to the 2010 budget.

Changes in 2018:
In 2018, the financing of health visitor care increased significantly due to the full-year payment of the health visitor supplement (HUF 33 000) introduced in November 2017. If the service is part-time, it is entitled to a proportionate share of the specified amount. The amendment states that the health visitors' supplementary allowance should be used to pay the health visitors' wages.

Changes in 2019:
In November 2019, the appropriation planned for the screening of cervical cancer for health visitors was almost entirely (in the amount of HUF 476 million) reallocated to application payments for dental and family practitioner care.

In order to ensure the continuous operation, HUF 300.0 million was paid to the school health care services financed in primary care from the balance of the 2019 balance, taking into account that part-time and full-time service providers would also receive a one-time remuneration in school health care. The remainder will result in more than a month of additional funding to recognise prevention and curative actions.

2) MEASURES TO IMPLEMENT LEGISLATION

The ECSR requests that, as before, we provide information on the health reforms introduced in our next report. They ask for information on the implementation of the reforms presented in our previous report, their impact on health care costs, their results in reducing avoidable deaths, and how these reforms relate to society's health demands. In its conclusions of 2017, the ECSR highlights the following reforms:

- ***oncological developments;***
- ***a ban on smoking in enclosed public places;***
- ***conducting cervical cancer screening by health visitors;***
- ***conducting colon screening in three counties;***
- ***vaccination of 12 and 13-year-old girls against Human papilloma virus.***

1. Specific health developments, projects (2016-2019)

In 2018-2020, the Government provided a central budget of HUF 10 billion for the further development and system-wide dissemination of family-friendly maternity benefits.

As part of this, full infertility testing has become free for both men and women. The Government provides HUF 4.4 billion annually for the inclusion of new studies in public funding. The state also takes over the purchase price of medicines undertaken in infertility treatment, for which it spends HUF 1.6 billion a year from the budget.

At the end of 2019, the Government provided in total HUF 36.608 billion fund for the following tasks related to facilitating the change of institutional structure, rationalising care and recognising the achievements provided by institutions:

- increased the financing of outpatient care by HUF 15.7 billion,
- provided an additional HUF 17.7 billion in inpatient care to those institutions that provided care to patients beyond their funding,
- the Government provided HUF 3.15 billion to inpatient specialist care institutions based on the fee for molecular diagnostic testing performed above the performance volume limit.
- In traumatology care, on an annual basis, care can be provided to patients from HUF 19.7 billion surplus nationwide, while
- vascular surgery care will receive HUF 2.5 billion in additional funding.

Projects implemented during the reporting period, achieved results:
In 2019, more than HUF 1.25 billion was available for the purchase of practice right as a family practitioner and for the establishment of a family practitioner and dentist. Until now, as a result of the applications, 675 000 residents have been provided with family practitioner care and 274 000 residents with dental care.

In 2019, an application programme was launched to encourage the development and prevention of primary care, entitled "*With three generations in health*", for which the Government has provided HUF 11 billion so far: family practitioners providing care for adults and/or children, as well as associations of local governments operating such practices, could apply for a non-refundable subsidy of HUF 50-80 million.

The main goals of the application are:

- prevention of childhood obesity and smoking,
- increasing public participation in organised targeted public health screening,
- timely detection and effective care of cardiovascular diseases; and
- mental health support.

In the first round of the program, budget support of about HUF 6 billion was provided to 79 group practices, and investigations and advice were provided in more than 130 000 cases.

In the second round of the programme, 64 group practices won support. Out of the available HUF 5 billion, on average HUF 74 million per group practice is allocated for more efficient performance of public health tasks and prevention. With this mode of care, a new approach is emerging and disease prevention and health promotion are already becoming more accessible to 1.2 million people.

In the framework of the national dissemination of kindergarten and school prevention

programmes supporting the prevention of smoking addiction, the acquisition of kindergarten and school equipment for smoking prevention programmes in connection with the EMMI Focal Point for Tobacco Control's kindergarten and school prevention programme[16] in the second half of 2018, as well as their nationwide distribution with the participation of county government offices, involving kindergartens and schools and updating the online interface of megelozes.cikiacigi.hu. Tools to assist more effective performing prevention programmes in kindergartens and schools aim to further reduce the proportion of young people who smoke and are exposed to second-hand smoke.

From 2019, educational institutions belonging to the area of government offices will be able to rent both machines and demonstration dummies, which have also been handed over, free of charge. The puppets illustrate the diseases caused by smoking on life-sized parts of the body, which, with their tales and playful content, target the youngest age group. Kindergartens can also request the tools available to them free of charge via the http://megelozes.cikiacigi.hu/ website.

In the framework of Hungarian Village Programme, HUF 13 billion was provided specifically for the development of family practitioners in small settlements, of which:

- 190 physician's consultation rooms can be built or renewed, with HUF 4 billion total value (*sub-programme entitled Physician's Consultation Room*),
- There is an opportunity to purchase medical devices in 783 small settlements, with HUF 2 billion total value (*sub-programme entitled Medical Devices*),
- HUF 5 billion is available for the construction of service flats (*sub-programme entitled Medical Service Flats*), and
- HUF 2 billion is available for the development of an IT program package supporting primary care activities (*sub-programme entitled Medical Care Assistance Pilot Programme*).

Hospitals and physician's consultation rooms were renewed across the country and the largest hospital development programme in the history of Budapest was launched. In recent years, the Government has implemented more than HUF 500 billion in development in the convergence regions

<u>The following have been reconstructed since 2010:</u>

- 91 rural hospitals,
- 54 outpatient care centres,
- 107 ambulance stations

<u>created:</u>

- 23 new outpatient care centres,
- 34 new ambulance stations

By the end of April 2019, the National Ambulance Service already had 793 newly acquired vehicles, bringing the average age of ambulances to 5.51 years.

Within the framework of the Healthy Budapest Programme, the Government will implement health improvements in the amount of more than HUF 700 billion between 2017-2026, affecting the capital and the Central Hungarian region. As part of this, 4 central hospitals will be established in the capital, and development will be performed in total, 24 more hospitals and 32 specialist consultation rooms.

[16] Source: http://www.dohanyzasvisszaszoritasa.hu/megelozes_es_leszokas_segites.html

Approximately HUF 42 billion was available for the Healthy Budapest Programme in the 2019 budget.

As a result of the developments, about 36 000 CT scans are performed in Budapest every month. With the involvement of national budget resources, further health improvements were implemented within the framework of the Modern Cities Programme (affected cities: Érd, Székesfehérvár, Tatabánya, Salgótarján, Győr) in the total amount of HUF 30.44 billion.

Improvements in quality and patient safety:

Improving the safety and quality of patient care, increasing the transparency and efficiency of the operation of health care providers is an increasingly important expectation of the advanced health care system.

In the field of health, it is a guarantee of sustainable development, recognition and continuous improvement of individual value and social interest. The fulfilment of health goals can be achieved if the central role and systematic operation of health care is given priority in the social division of labour, in line with economic development, social justice and environmental protection.

Measures and developments implemented since 2010:

- The Government has transferred most of the indebted health care facilities into state maintenance, which has guaranteed a more efficient, long-term safe operation.
- In 2011, the Health Quality Development and Patient Safety Strategy (MIBES) was completed.
- The Hungarian Health Care Standards - MEES 1.0 handbook, published in 2006, was an important milestone in the development of healthcare quality. A network of auditors with a medical degree in MEES certification has been established. The institutions have set up their quality management system together with the ISO standard or independently.
- In addition, the preparation and revision of professional guidelines and the introduction of a clinical audit programme took place continuously.

Measures and developments implemented in 2019:

- The renewal of the specialist supervision system has been implemented, according to the Decree of the Minister of Human Capacities 16/2019 (30 July) EMMI on the Professional Supervision of Healthcare Providers, the activities of the supervising chief physicians cover the operation of the entire health care system. In order to provide professional care to patients, they examine patient complaints, the process of patient care, and the results of the operation of a given practice or institution.
- The handbook of the renewed Hungarian Health Care Standards (MEES 2.0) has been published[17], which contributes to further improving the health status of the population, patient satisfaction, confidence in health and social care, and the satisfaction of health professionals through awareness of the quality approach.
- In 2019, the development of 29 professional guidelines started. The application of the professional recommendations specified in the mandatory health professional guidelines serves the safe care of patients, the utilisation of the latest knowledge of science, and the enforcement of patients' rights.

[17] Egészségügyi Közlöny (Health Gazette), Volume LXIX, Issue 17

2. Public health, epidemiology, vaccinations

The vaccination system is an extremely important element of the epidemiological safety of Hungary. The aim of the National Immunisation Programme is to ensure the protection of the population, especially children, by using vaccines against preventable serious infectious diseases and their complications.

The Government of Hungary treats the Hungarian, age-related, mandatory vaccination schedule and the achievements in the field of preventable diseases as a national value, which have achieved outstanding results worldwide, and considers the costs spent as a state investment in the health of the next generation. In international comparison, there is no other country in the European Union that, like Hungary, provides vaccinations for children and the population in such a wide range of infectious diseases and in a mandatory system, financed by the state. In Hungary, a compulsory vaccination system against the most common and serious childhood diseases have been developed under the given climatic conditions, as a result of which, these diseases were managed to eradicate in the vaccinated population.

Vaccines against paediatric diseases including the compulsory vaccination schedule are generally considered to be a more cost-effective solution in the long run than the costs of treating infectious diseases and their complications in the event of non-vaccination, in particular, taking into account the significant mortality rate from each infectious disease.

<u>The main features of the age-related compulsory vaccination schedule are as follows:</u>

- the vaccine is provided free of charge by the state to the population,
- in line with international recommendations (e.g., World Health Organisation's recommendations)
- the vaccines used are of high quality, effective and safe,
- vaccinations are given at the optimal age,
- full equality of opportunity is ensured,
- has a stable legal background under state responsibility.

In Hungary, compulsory vaccination against pathogens caused tuberculosis, diphtheria, pertussis, tetanus, epidemic polio, measles, rubella, mumps, Haemophilus influenza type b infection, *Pneumococcus* and Hepatitis B virus are currently available in Hungary. Vaccination against the human papilloma virus (HPV), which causes cervical cancer, is a vaccine compulsory to offer for adolescent girls (and boys from 2020).

In 2014-2019, the following objectives were achieved as a new element concerning the compulsory vaccination system:

1. The <u>pneumococcal vaccine</u> has been included in age-related, free-of-charge vaccinations since September 2014. Vaccinations are given at 2 and 4 months of age and 1 year of age. Severe complicated (invasive) pneumococcal infection is more common in patients younger than two years and in elderly chronic patients. Mortality is also higher in these age groups.

The most effective way to fight invasive pneumococcal disease is to integrate vaccination with age-related voluntary or compulsory ongoing vaccinations. In this case, there is the best chance of achieving a high vaccination rate for infants and young children. At high vaccination rates above 70%, population-level protection develops, and the number of

bacterial carriers among infants and young children is minimised, thus vaccinated individuals also indirectly protect non-vaccinated people living in their environment from infection.

2. In order to reduce the risk of cervical cancer and further strengthen the vaccination system, the Government introduced voluntary vaccination of adolescent girls against HPV from the 2014/15 academic year, which is a vaccine compulsory to offer free of charge. Since the nationwide introduction of voluntary vaccination against HPV, the vaccination rate for girls in the 7th grade in this age group has reached 81%.

3. Starting in the 2018/2019 academic year, the state will provide the HPV vaccine against 9 strains of the virus, which provides the highest level of protection currently available, for school campaigns, which will reduce the risk of cervical cancer and prevent about 90% of genital warts.

4. The Hungarian population is committed to vaccinations and considers them as value. This is evidenced by the fact that among the European countries that have introduced HPV vaccination campaigns, according to the European Centre for Disease Prevention and Control, the Hungarian figures show an outstanding result. Only Portugal and the United Kingdom can present a similarly good rate across Europe that have introduced HPV vaccination campaigns.

5. Internationally outstanding results with HPV vaccination contribute to the goals set in the National Cancer Control Programme.

6. As HPV can also cause certain types of cancer in men, and men and women can transmit the virus to each other, a decision was made to extend the free HPV vaccine to boys in 2020.

7. From 1 January 2017, the previous increased 70% support for Meningococcus type C vaccination for young children aged 0-2 years has been changed to 100% support, i.e., the vaccination is available as a vaccine compulsory to offer, and is available free of charge to families concerned. Vaccination is recommended at the discretion of the family practitioner, paediatrician or infant paediatrician specialist. Based on the prescription they issue, the parent can acquire the vaccine at the pharmacy with 100% support.

8. As the latest element of the mandatory age-related vaccination system, vaccination against varicella was introduced in 2019. Most cases of varicella occur in preschool- school age, but at this age the disease is relatively mild and patients recover well. More severe, complicated cases are more likely to occur in adults.

In Hungary, varicella accounts for nearly 50% of reported infectious diseases. In countries where varicella vaccination has been included in the vaccination schedule and a high level of vaccination rate has been achieved, the incidence of varicella not only in vaccinated but also in other age groups (adults, infants) has decreased significantly.

Hungary has been able to present very good results in the implementation of compulsory vaccinations for decades. The National Public Health Centre (hereinafter referred to by the Hungarian abbreviation as: NNK), Department of Hospital Hygiene and Epidemiology Supervision prepares a report on the number of age-related compulsory vaccinations

performed and the rate of vaccinations. According to the data of 2019, the vaccination rate of compulsory age-related vaccinations in our country is 99.6-99.9%.

In Government Resolution 1277/2018 (15 June), the Government decided to test measles for health care employees and, on the basis of screening, to provide vaccination against measles to susceptible persons.

On 13 December 2018, the Hungarian Hepatitis Commission was established. In 2016, the World Health Organisation (hereinafter: WHO) adopted the 1st Global Strategy on Viral Hepatitis. The strategy aims to eliminate infections caused by hepatitis viruses (HCV and HBV infections) by 2030. According to the strategy, the best way is to divide the national elimination targets into smaller, population-based targets, where that target can be reached more quickly ('micro-elimination'). One group of individuals at high risk for HCV, not or not systematically tested, is health employees, and the National Hepatitis Action Plan under development also proposes risk group-based screening, starting with health employees.

Measures and developments implemented in the field of public health and epidemiology since 2016:

In 2015/2016, Hungary conducted a self-assessment survey using the Equal Opportunities Assessment Form developed under the Protocol on Water and Health, with the aim of collecting data on the population without potable water supply and sanitation services and identifying disadvantaged or groups at risk in this respect. The main finding is that despite high service coverage, access to potable water continues to be a challenge for socially and economically disadvantaged groups and in farm areas distant from public supply.

In 2015, Decree of the Minister of Human Capacities 49/2015 (6 November) EMMI on the Public Health Requirements for Matrices and Facilities Posing a Risk of Legionella Infection entered into force. The measures set out in the regulation can reduce the risk of the occurrence, multiplication and spread of legionella and the diseases they cause in various facilities, such as health and social care institutions, commercial accommodation and public baths.

In order to further reduce and prevent the number of healthcare-associated infections, the Government has adopted a complex package of measures, for the implementation of which Decree of the Minister of Health 20/2009 (18 June) EüM on the Prevention of Health Care-Associated Infections and on the Minimum Conditions of These Activities was amended, the new provisions entered into force on 1 October 2018.

Measures and developments implemented in 2019:

Under the supervision of the EMMI, a potable water lead survey project is in progress in the NNK to identify the areas most at risk and to estimate the number of facilities concerned. The results are available from 30 September 2020.[18]

In Government Resolution 1114/2019 (13 March) on the Adoption of the National Radon Action Plan, in order to protect the health of the population and in accordance with the provisions of Council Directive 2013/59/EURATOM (hereinafter: Directive), the

[18] https://efop180.antsz.hu/csapviz-olomtartalom-kockazati-terkep.html

Government adopted the National Radon Action Plan established by EMMI in order to reduce exposure from natural sources in the long term.

Mandatory hepatitis C screening of healthcare employees will be implemented by amending the published epidemiological decree; and measles screening of healthcare employees and vaccination of susceptible individuals. HCV screening of healthcare employees began in 2019, for which HUF 400 million was available in the budget.

In order to further reduce and prevent the number of healthcare-associated infections, a complex package of measures was established, for the implementation of which Decree of the Minister of Health 20/2009 (18 June) EüM on the Prevention of Health Care-Associated Infections and on the Minimum Conditions of These Activities was amended, and the new provisions entered into force on 1 October 2018. One of the elements of the package is that service providers should be introduced to prevent the four most common healthcare- associated infections (healthcare-associated pneumonia, vascular catheter-related and other bloodstream infections, surgical wound infections, urinary catheter-related infections), guided by methodological letters from the national chief medical officer.

Rules for the professional staff of the Hungarian Defence Forces:
The International Vaccination Department, as an organisational component of Hungarian Defence Forces, Health Centre, Directorate of Defence Health, Institute of Occupational Health and Public Health plans, organises and implements the immunisation tasks of the personnel of foreign missions and emergency services arising from the international obligations undertaken by the Government of Hungary with the participation of the Hungarian Defence Forces, as well as the non-military contract staff entering for basic training.

The scope of the mandatory immunisation of the staff of the contingent participating in peace support and crisis response operations was determined taking into account the Hungarian vaccination schedule established by the National Public Health Centre based on national and international experience and the current public health and epidemiological situation in the foreign operation area. Based on these, diphtheria, tetanus, pertussis, typhoid, hepatitis A and B, meningococcal encephalitis, polio, rubella, measles, mumps, tick-borne encephalitis, cholera, rabies, malaria, yellow fever, Japanese encephalitis are prevented. Immunisation was performed on the total number of personnel of foreign missions (100%).

The immunisation of the contract staff without military qualifications entering the HDF staff is performed in accordance with the epidemiological situation in Hungary. 100% of the entering staff will receive diphtheria, tetanus, pertussis, meningococcal encephalitis, rubella, measles and mumps vaccines as a primary vaccine, which will be supplemented seasonally with influenza vaccines.

The main task of the Institute is to monitor the influenza vaccination of the Hungarian Defence Forces staff according to the measure on the tasks to be performed during the influenza season. The vaccination coverage of the personnel at the Hungarian Defence Forces level is 69%.

3. Measures related to the development of the screening system

In Hungary, a targeted (hereinafter: organised) screening system for public health purposes has been set up to involve as many target populations as are at risk on the basis of age [as set out in Annex 3 to NM Decree 51/1997 (18 December): *breast screening every two years for women aged 45-65 (mammography)*; *cervical screening* every 3 years after a single negative screening of *women aged 25-65* (cytology)].

As part of the expansion of the scope of organised screening, the nationwide extension of organised colon and rectal screening started in 2018, and from 2014 a pilot examination of low-dose multi-slice CT (LDCT) lung cancer screening (HUNCHEST Programme) is started coordinated by the National Korányi Institute of Pulmonology. For each type of screening, the goal is to achieve a participation rate of at least 70% according to the international recommendation.

Organised breast screening:

More than 2 300 women die and nearly 8 300 new cases are diagnosed each year as a result of malignant breast cancer. Since the launch of organised breast screening in 2002, more than 11 000 malignant tumours have been discovered. Each year, the number of women between the ages of 45 and 65 who are eligible for organised breast screening is 550 000 (they receive a screening notice (letter of invitation) stating the exact time and place of screening). The experience of the last 18 years is that, based on the letter of invitation, an average of 230-250 000 people (approx. 45-50%) appear on the screening test every year. If the participation rate of at least 70%, according to the international recommendation, is reached, 370-380 000 target persons per year will be screened.

As a result of recent developments, the organised breast screening task is provided by 39 Complex Mammography Centres and 11 Mammography Screening Stations with nationwide coverage, suitable for both mammographic screening and clinical patient follow-up, with the capacity to examine the entire population at risk. All screening centres and screening stations have digital mammography devices. Equal access is facilitated by buses with mammographs in the ‘We take the tests in place’ programme (detailed description: see below).

Organised cervical screening:

In Hungary, more than 400 women die every year due to cervical cancer. Each year, 700 000 women aged 25-65 are eligible for organised cervical screening. According to the National Health Insurance Fund Manager, screening is around 60%. Annually, the proportion of those screened among women in the vulnerable age group is approx. 40 000 people, and the number of people who took part in a diagnostic test in the spirit of the oncological vigilance is about 380 000 people. In order to achieve the 70% participation rate according to the international recommendation, the goal is to have 490 000 to 500 000 target people appear in an organised screening test per year.

Within the framework of the ‘We bring you the tests’ programme, as a service close to home, equal access to cervical screening is also facilitated by 10 health-promoting examination buses. In their screening schedule, the municipalities identified in the long-term programme of ‘Catching-up Settlements’ are given priority.

Organised targeted colon and rectal screening:

Within the European Union, Hungary has the highest mortality from colon and rectal cancer. As a result of colon and rectal cancer, more than 5 000 people die every year and nearly 11 000 new diseases are registered in Hungary.

After several years of testing, a biannual colon and rectal screening of men and women aged 50-70 (2 500 000 people, 1 250 000 people to be invited annually) based on a faecal blood test, was launched in 2018 in a nationwide extension. Recommended method is two-step: (1) immunochemical detection of hidden blood in the faecal, (2) complete, qualitative colonoscopy to determine the source of bleeding in the case of a faecal blood test with a non- negative result. It aims to detect and remove the preventive condition of early colon cancer in these medium-risk individuals, and to detect and treat early-stage tumours that have already developed.

The goal is to achieve a participation rate of at least 70% according to the international recommendation (850-900 000 target persons per year). Based on the pilots conducted so far, the proportion of those who were screened with a non-negative faecal blood test result and referred for colonoscopic examination was 6-10%.

Low-radiation multi-slice CT scan of lung cancer:

Today, lung cancer is still one of the least curable malignant tumours. The five-year survival rate is 12 to 15 percent in even the most developed countries. The only cure for real healing is radical resection surgery in the early stages, surgical removal of the tumour. The condition for this is that as many lung cancer cases as possible should be detected at an early stage.

Based on the results of international screening pilot programmes in recent years, it has been professionally accepted that lung cancer screening with low-dose CT (LDCT) screening reduces mortality. Comparing the results of various international scientific studies (e.g., American Institute for Cancer Research, European NELSON clinical examination) published so far, a European expert recommendation issued in 2017 urges the European Commission and Member States to develop a low-dose lung cancer screening (LDCT) programme with well-defined risk groups.

From 2014, the National Korányi Institute of Pulmonology, simultaneously with Western European countries, has been conducting pilot tests with low-dose multi-slice CT (LDCT) (HUNCHEST programme) covering a target group at risk for lung cancer (55-75 years, those with an anamnesis of ≥30 package years). Based on the experience of pilot testing, a nationwide extension of LDCT screening is planned for 2022. Supporting smoking cessation is an essential part of the programme.

'We bring the tests to you' programme:

The 'We bring the tests to you' programme aims to achieve the participation rate in the organised screening tests according to the international recommendation, within the framework of which, as a service close to home, 10 health promotion buses and 9 screening buses from 2020, equipped with modern mammographs support equal access. Their screening schedule also names the settlements defined in the long-term programme of 'Converging Settlements'.

In 2019:

- Of the 300 settlements named in the Government Resolution 1404/2019 (5 July) on Laying Down the Foundation of the Long-term Programme for 'Converging Settlements', 2 329 people were examined in 31 settlements
- out of 50 settlements named within the framework of economic recovery, 609 people were surveyed in 9 settlements,
- in the framework of other programmes, in addition to the above, joining the programmes of Government Offices, health promotion offices, foundations performing health promotion activities, involving in total 7 705 people were involved in 88 locations.

Participation in the general health assessment, cardiology and gynaecology examination was uniformly ensured in all settlements, in addition, those entitled to it received the colon screening unit package. Further examinations were provided depending on the free capacity of the local/county health care provider in a contractual relationship with the NNK (angiological, dermatological, otolaryngological examinations, and dietary counselling).

The general condition assessment follows general and cardiological registration, and was attended by almost all patients. The assessment includes blood glucose and cholesterol determination, blood pressure measurement, body mass index (BMI) calculation, abdominal circumference measurement, body composition analysis, ECG and ankle-arm index examination, and completing a cardiological risk assessment questionnaire that includes lifestyle and family history. The results of the listed examinations and the questionnaire determine who should perform a cardiological examination.

The provision of an additional patient pathway was resolved through the cooperating local/county health care providers, and all family practitioner were informed (requesting mobilisation and follow-up) when and where the examinations would be available in the settlement they cared.

Health Promotion Offices:

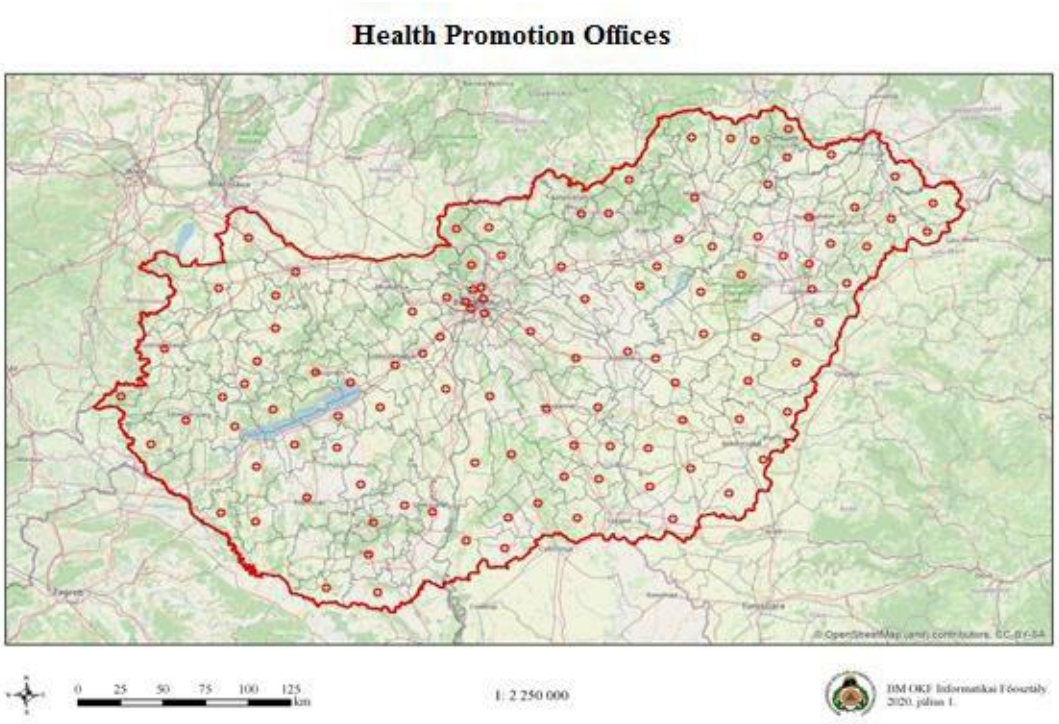
There is a Health Promotion Office in 112 districts in Hungary (hereinafter referred to by the Hungarian abbreviation as: EFI). Their basic goal is to support the reduction of cardiovascular and cancer diseases, to reduce early and avoidable death, to improve the lifestyle that determines health, and to improve the habits and attitudes that affect health behaviour. As a result of the developments of the two programming periods, an efficient organisational network was created in accordance with the requirements necessary for health promotion, enforcing a flexible, modern approach in partnership cooperation.

At the district level, EFIs support and strengthen primary care in the provision of prevention services close to home, providing primarily community-based, group health promotion services not only for those who are healthy, but also for those who already have a known disease (e.g., exercise programmes, patient clubs, etc.), and, in accordance with local needs, help to improve the health behaviour of the population through individual counselling and take an active part in mobilising the population for organised public health screenings.

The target group of their activities extends from pregnant women to families with small children, schoolchildren and young people, active adults, as well as the elderly, providing

them with individualised lifestyle counselling and community programmes to help them make health choices. As a result, it is also easier to reach the part of the population who have not been motivated to participate in health promoting programmes or have not received the messages formulated in the national public health communication.

In order to expand the network of EFIs and extend it to all districts, out of the HUF 5.4 billion budget in the 2014-2020 planning cycle, 12 of the 53 newly established EFIs were established in the KMR (Central Hungary) region, half of which were established in Budapest districts, which have already been expanded with the Mental Health Centre (hereinafter referred to by the Hungarian abbreviation as: LEK) function, 38 of the previously established EFIs have integrated the LEK function into their activities.



Source: Ministry of Human Capacities

The ECSR requests information on the development of measures to reduce obesity, in particular with regard to the tax surplus on unhealthy foods and measures for healthy public catering.

Measures to reduce obesity:

- **Nutritional health measures**

The Public Health Product Tax (NETA):

– The creation of Act CIII of 2011 on the Public Health Product Tax was part of the Government's complex package of public health measures. The tax, introduced in September 2011, has set as its primary goal the reduction of the consumption of food that is not useful for public health. Foods subject to the tax are pre-packaged products with a high sugar, salt and certain caffeine content that pose a health risk and are not essential foods. (soft drinks, energy drinks, sugared preparations, salty snacks, flavoured beers and other

alcoholic beverages).

– In September 2018, the Ministry of Human Capacities submitted the Public Health Product Tax to the European Commission for consideration as a good practice. The review was based on a pre-established set of criteria and the introduction of the tax was included in the European Commission's good practice database.

Trans fatty acid regulation:

The measures focused mainly on maintaining the measures taken earlier.

– According to scientific data, a 2 percent increase in trans fatty acid consumption increases the risk of cardiovascular disease by 23 percent.19 The Decree of the Minister of Human Capacities 71/2013 (20 November) EMMI on the Highest Permissible Amount of Trans Fatty Acids in Food Products, the Conditions and Official Control of the Distribution of Food Products Containing Trans Fatty Acids, and the Rules Relating to Monitoring the Population's Intake of Trans Fatty Acids regulates the maximum levels of trans fatty acids in foods, the conditions for the marketing and official control of foods containing trans fatty acids, and the rules for monitoring the intake of trans fatty acids by the population. The decree entered into force on 18 February 2014. The essence of the provision is that it is prohibited to place on the market a food in the fat content of which the proportion of trans fatty acids exceeds two per cent. The Decree also requires that the manufacturer's register include the trans fatty acid content of food ingredients, in particular oils, fats and fat emulsions, which the manufacturer uses or applies as an ingredient in the production of food.

– According to the Decree, the National Food Chain Safety Authority (NÉBIH) performs TFA measurement checks and transfers the data to the National Institute of Pharmacy and Nutrition (hereinafter referred to by the Hungarian abbreviation as: OGYÉI). OGYÉI develops a database from the measurement data, assesses the trans fatty acid intake of the population, monitors changes in the fatty acid composition of foods sold to the population, and performs laboratory tests.

– Between 2010 and 2016, the TFA content of in total 1 586 products was determined (including confectionery, fine bakery products, sweet biscuits and Neapolitans, chocolates and coated products, and vegetable fats).

– Based on the results of the 2016 impact assessment, the regulation has achieved its objective. Thanks to uniform regulation, the number of foods with a high trans fatty acid content has been drastically reduced, and in parallel, the TFA intake of the population.

– In September 2018, the Ministry of Human Capacities presented the decree to the European Commission as a good practice. Following the Commission's review of the common criteria, the decree has been entered into the European Commission's good practice database

Decree on healthier public catering:

According to the results of Hungarian nutritional studies, nutritional risk factors (e.g., high intake of salt, saturated fatty acids, energy, and decreased consumption of vegetables and fruits) appear already in childhood, therefore it became necessary to make the food given in public catering healthy. The Decree of the Minister of Human Capacities 37/2014 (30 June) on Nutritional Health Prescriptions Relating to Public Catering, applicable from 1 September 2015, serves to achieve this goal.

[19] source: http://www.nature.com/ejcn/journal/v63/n2s/pdf/1602973a.pdf

The decree contains the minimum personal and material conditions for public catering, the definition of the concepts concerning the area, the values of the permitted daily energy and salt intake by age group, the raw material release guide, the regulations for the use of certain food ingredients, and the principles of menu planning. In addition, the decree stipulates that the provision of a diet is mandatory in all cases certified by a specialist.

With the transformation of public catering, the food given in the public catering became healthier (the amount of milk and dairy products given in the public catering, the amount of vegetables and fruits increased, the content of salt and saturated fatty acids in the food decreased, the amount of polyunsaturated fatty acids increased, as the proportion of whole grain products among pastries and pasta has also increased, as well as energy and nutrients intake is ensured according to the needs of each age group), thus promoting the healthy physical and mental development of our children and the healthy nutrition of those who use public catering services.

The transformation of public catering will lead to a significant reduction in overall mortality, mortality from cardiovascular disease and cancer in the long term, as well as an increase in life expectancy and the number of years spent in health.

In order to examine compliance with the provisions of the decree, OGYÉI conducted a survey in 2017 entitled National School Canteen Panorama, following the methodology of previous surveys. According to the survey, a significant number of institutions are able to comply with the regulation, but there are still challenging provisions. Favourable changes during the study:

- Public caterers introduced new foods that fit a healthy nutrition, using new ingredients that most of the children liked.
- According to school questionnaires, there was a significant increase in the proportion of primary schools in which fresh vegetables and fruit were provided once a day (2% in 2013, 17% in 2017) and several times a day (45% in 2013, 65% in 2017) for children.
- The proportion of kitchens using traditional high-fat frying technology has decreased.
- The number of menus that did not contain the information required by the regulation at all has decreased.
- There has been an increase in the number of schools which can satisfy the need for dietary meals.
- The Childhood Obesity Surveillance Initiative (COSI), launched by the Office of the WHO European Region in 2007, was performed in nearly 40 member states of the European Region, to which Hungary joined in 2010. In Hungary, starting from the 2016/2017 academic year, COSI takes place as part of the annual school health screenings, with the participation of school health visitors and coordinated by OGYÉI. The national representative survey included 5 332 children aged 6-8 years. According to the data obtained, in Hungary more than 20% of children aged 6-8 (boys 20.5%, girls 21.9%) are overweight or obese.

Compared to the values of 2010, a stagnation can be observed in the combined ratio of overweight and obesity, i.e., the growth typical of the whole world has stopped in Hungary for the time being. The government's public health measures, especially nutritional health measures, taken in recent years have a significant role to play in achieving this favourable result.

- **Measures to promote physical activity**

European School Sports Day:

The Hungarian School Sports Day is an initiative launched by the Hungarian School Sport Federation (hereinafter referred to by the Hungarian abbreviation as: MDSZ) in 2006, the essence of which is to thematise the activities of Hungarian schools at least one day a year, processing topics such as volunteering, grassroots sports, social inclusion or health-enhancing physical activity (HEPA). In 2017, due to the success of the ESSD, the National Assembly declared the last Friday of September every year to be the Hungarian School Sports Day. The recognition of the programme is shown by the fact that the Hungarian example has found followers all over Europe, and with the help of the ERASMUS+ sports sub-programme in 2019 the European School Sport Day®, based on the Hungarian Student Sports Day, was organised in 44 countries on 4 continents under the coordination of the Hungarian School Sport Federation. In the framework of this, 3 million children took part in 2019, recommended for schools registering for the pan-European initiative, in a programme of at least 120 minutes, making it the largest and most important series of events of the European Week of Sport.

Implementation of the programme in 2018

The purpose of the programme

Programmes related to the school promoting physical activity - attitude formation in the framework of the European School Sports Day - Hungary 2018.

Implementation of the programme

As in previous years, MDSZ implemented three flagship events in Hungary to raise awareness of the initiative and the importance of regular physical activity. The events were also attended by national and European politicians, athletes and examples. Special festival-like events based on grassroots spirit were held.

Results

A 50% increase has been achieved compared to previous years, so their strategic programme related to the use of the support (preparation, regional workshop series, development of a new remuneration system, organisation of flagship events and conducting active promotion and communication campaign) proved to be extremely successful.

With the series of events held on 28 September 2018, as in previous years, MDSZ joined again the European Sport Week #BeActive initiative launched by the European Commission, whose series of events, like the last two years, was the event with the largest number of participants in 2018 as well. In the framework of the European School Sports Day - Hungary, 1 200 schools registered for the event in 2018 and 913 school reports were received. In 2018, the European School Sport Day® programme, based on the Hungarian initiative, was implemented with the participation of 29 countries, 3 continents and 2.5 million children.

Implementation of the programme in 2019

The purpose of the programme

Programmes related to the school promoting physical activity - attitude formation in the framework of the European School Sports Day - Hungary 2019.

Implementation of the programme

A call published in 2017 by the three Commissioners concerned of the European Commission, the Tartu Call for a healthy lifestlye, raises awareness of healthy nutrition and food at a systemic level in terms of maintaining health, in addition to emphasizing the importance of physical activity. Thus, a lifestyle that is poor in physical activity is not the only cause of the development of morbid obesity and related lifestyle diseases. Regular physical activity, an active lifestyle and a healthy nutrition, including food safety, can work together to overcome these problems. [20]

MDSZ has implemented three flagship events in Hungary to raise awareness of the initiative and the importance of regular physical activity and healthy nutrition (water and fruit consumption). The events were also attended by national and European politicians, athletes and examples.

Results

With the series of events held on 27 September 2019, as in previous years, MDSZ joined again the European Sport Week #BeActive initiative launched by the European Commission, whose series of events, like the last two years, was the event with the largest number of participants in 2019 as well. In the framework of the European School Sports Day - Hungary, 1 306 schools registered for the event in 2019 and 1 100 school reports were received. With this, an 8% increase in the number of registered schools and a 20.5% increase in the number of schools that also report has been achieved compared to last year. In 2019, the European School Sport Day® programme, based on the Hungarian initiative, was implemented with the participation of 44 countries, 4 continents and 3 million children.

The ECSR also requested information on access to mental health care, rates of mental disorders, and recovery measures.

Data on access to mental health care, rates of mental disorders, and recovery measures.

The current health priorities of the Government include the implementation of the five National Health Programmes, on which the Government decided by adopting *Government Resolution 1722/2018 (18 December) on National Health Programmes and Special Policy Programmes for 2019-2022 Related to them.*

As part of this, the National Mental Health Programme aims to develop health services for mental disorders, to reorganise Hungarian psychiatric and social care, and to establish a progressive and coordinated care organisation based on the principle of subsidiarity.

[20] Source: https://ec.europa.eu/sport/sites/sport/files/ewos-tartu-call_en.pdf

Regarding the rate of *mental disorders,* statements from public funded data are attached according to the following methodology:

The data reported on the incidence of mental illness refers to the number of people for whom a disease (in code range F or code F32, F33) was reported by providers in their specialist or family practitioner reports sent to NEAK in the year under review was coded even once according to the BNO 10 code system.

Data available to the Hungarian Central Statistical Office on the care of psychiatric patients:

Care for psychiatric patients						
Year	Care for adult psychiatric patients			Child and youth psychiatric care		
	Number of care institutions	patient-traffic (thousand persons)	Number of new patients taken care of (person)	Number of care institutions	patient-traffic (thousand persons)	Number of new patients taken care of (person)
2016	137	1 025	14 192	24	82	4 355
2017	134	1 011	12 038	22	76	4 253
2018	134	964	11 135	21	83	4 071
2019	138	954	11 247	23	89	4 311

Source: Ministry of Human Capacities-Hungarian Central Statistical Office

Special rules for members of the professional staff of the Hungarian Defence Forces:
Pursuant to *Decree of the Minister of Defence no. 10/2015 (30 July) HM on Health, Mental and Physical Fitness for Military Service and Review Procedures* (hereinafter: Decree no. 10/2015), soldiers must comply with the parameters of the physique recommendations specified in the Decree no. 10/2015. In case they have different indicators, the participation in the Solders Physique Programme (hereinafter referred to by the Hungarian abbreviation as: HTP) should be offered to.

Following the entry into force of the regulation in 2015, HTP started its actual operation on 6 January 2016. Amendments to the legal background of the decree are currently in progress, and participation in the HTP is planned to be mandatory in the future in the event that the solder does not meet the specified physical requirements.

In total 847 instrumental tests were performed at HTP from 2016 to 6 March 2020. There is an increasing trend in the number of tests each year, which will increase further after the amendment of the Decree no. 10/2015 (due to mandatory participation).

Mental health care is currently provided in 11 garrisons in national area and on the United Balkans Battlefield with a team psychologist. The psychological staff of the Hungarian Defence Forces perform its activities with personal case management, a telephone helpline and, if necessary, an online (Skype) interface for both national and foreign service. Individual case management is conducted on the topic of family and parenting problems, life management problems, mourning processing, mood disorders, stress-induced problems, anxiety, eating disorders, sleep disorders, support for those in crisis, temper problems and psychosomatic disorders, addictions. Almost 2 600 people are cared for annually in particularly problematic cases. With psychoeducational processes, the Service reaches approximately 1 500 people. During mission preparations and re-integrations, an additional

approx. 2 000 people meet professionals. The Hungarian Defence Forces has no information on the number of cases belonging to the BNO and thus to medical diagnostic competence.

3) RESPONSE TO OTHER QUESTIONS OF THE ECSR

In addition to the above questions, the ECSR requested information on trends in the length of waiting lists and average waiting times. Changes to waiting lists are detailed in this Section. The related statistical data are presented in Section 4).

As of 1 July 2012, NEAK will operate the National Institutional Waiting List Registration System, operating on the online interface, for registering the waiting and booking list of planned surgeries designated by law.

There are two types of registration lists to be kept within the waiting list:

- a waiting list where the order of care is to be followed when making appointments and where a care date before the next available care date can only be designated in severe cases requiring more urgent care than the others, except for a 7- day organisational tolerance period.
- booking list, where, at the request of the patient, the planned date of care exceeds the earliest possible date of care by at least 14 days.

Significant government measures have been taken to reduce waiting lists, waiting times; as a system, starting from 2015, HUF 5 billion is available in the programme for post-financing every year, and in addition, funds were also available periodically at the end of the year. The allocation of additional resources was based on modelling to the providers most unfavourable indicators, as well as to all providers who also undertook to car patients from other providers for redirection, in order to reduce waiting times and equalise and improve access.

Providing additional resources for the longest waiting patients, providers with the longest waiting times:

Date	Goal	Additional resources
end of 2010	shortening of waiting lists for elective haemodynamic interventions and open heart surgeries, as well as traumatological and orthopedic prosthetic surgeries	2.748 Billion HUF
end of 2013	care for the 1 300 patients from the longest time on the waiting list	786.5 Billion HUF
August 2014	shortening of waiting lists and patient admission lists	431.8 Million HUF
end of 2014	care for patients on the waiting lists before 2013	1.004 Billion HUF
2015	shortening of waiting lists and other policy goals	5 Billion HUF
2016	shortening of waiting lists and other policy goals	5 Billion HUF
2017	shortening of waiting lists and other policy goals	5 Billion HUF
2018	shortening of waiting lists and other policy goals	5 Billion HUF
end of 2018	at the expense of the pre-financed cash balance	1 Billion HUF

2019	shortening of waiting lists and other policy goals	5 Billion HUF
2020	shortening of waiting lists and other policy goals (under implementation)	5 Billion HUF
Total		**35.9703 Billion** HUF

Source: National Health Insurance Fund

Legislative changes:

As of 1 July 2016, the following 4 waiting lists were removed from the list of mandatory waiting lists based on professional consultation, taking into account that the actual waiting time at the national level did not reach 60 days (e.g., in 2015, it was established between 5-32 days)

8	Intervention, exploration due to gallstones
9	Intervention, laparoscopy due to gallstones
11	Abdominal and groin hernia surgery with implantation
12	Hernia surgeries (abdominal, groin, navel and femoral hernia) without implantation

Source: National Health Insurance Fund

A problem was that the planned waiting times were significantly longer than the actual waiting times; in order to strengthen the credibility of the planning, a new type of audit was introduced from April 2019 to improve sequence and schedule. The development of the actual waiting times clearly indicates the positive results: the value of the actual waiting time has significantly decreased in all priority waiting lists, such as by 33.8% for cataracts, by 13.7% for knee prostheses and by 24.2% for hip prostheses.

Pursuant to OECD data, the actual waiting time in Hungary in 2019 is close to the value of the countries with the most favourable value.

The ECSR also requested information on how the share of out-of-pocket payments (gratuity, etc.) in the use of health care has changed compared to the previous reporting period, and what measures have been taken to reduce out-of-pocket payments.

We do not have any data on gratuity.

4) RELEVANT DATA, STATISTICS

In its conclusions of 2017, the ECSR requested statistical data in addition to the above:

- ***life expectancy in relation to certain areas of the country and different social groups (countryside, cities, ethnic groups and minorities, long-term homeless or unemployed, etc.);***
- ***which highlight existing differences (between certain areas of the community; between specific occupations or jobs; proximity to active or decommissioned industrial or heavily polluted areas or mines); and***
- ***in relation to certain age-specific diseases (e.g., cancer) or blood-borne infectious diseases (e.g., new HIV or Hepatitis C infections among drug addicts and those serving prison sentences).***

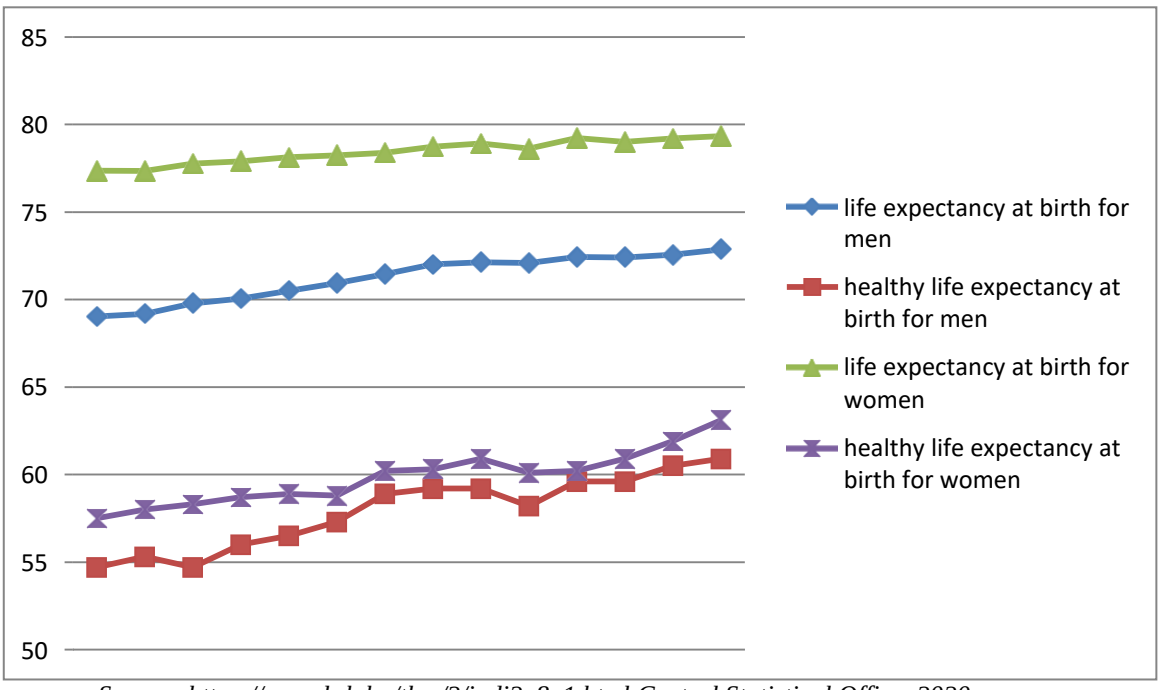
These data are shown under this section. We do not have data on the distribution of life

expectancy by ethnicity and occupation. Information on the proportion of infectious diseases among intravenous drug users is provided in the section on Article 11 (4).

1. Statistics supporting the result of public health reforms

The main indicators of the health status of the Hungarian population have been continuously improving since 2010 (however, there are still significant lags compared to the averages of the EU Member States:

- **Life expectancy at birth:** In 2019, life expectancy at birth was 76.16 years for the entire population, an increase of nearly 2 years compared to 2010. Based on gender breakdowns, the value of life expectancy at birth increased by more than 2 years for men and by more than 1 year for women between 2010 and 2019.
- **Healthy life expectancy at birth:** In 2010, the healthy life expectancy at birth for men was 56.5 years, an increase of 4.4 years by 2019, to 60.9 years. For women, the rate of increase was 4.2 years (2010: 58.9 years, 2019: 63.1 years), i.e., there was a positive trend for both genders in this respect.
- **Infant Mortality:** The infant mortality rate per 1 000 live births decreased from 5.3 to 3.8, or 28% between 2010 and 2019. The improvement was particularly significant in the Northern Great Plain region, where the infant mortality rate decreased by more than half, by 56%, between 2010 and 2018. There was also a significant improvement in the Western Transdanubia region, where a 44% reduction was achieved.
- **Total mortality and specific mortality rates:** in the analysis of standardised mortality rates, there has been a decrease since 2011 in both total mortality and mortality from the disease groups highlighted in the table on page 101. The indicators obtained by gender breakdown of the data also indicate this trend: the total mortality decreased by 4% for women and by 9% for men between 2011 and 2018. The most significant decrease was in mortality from cerebrovascular disease: it decreased by 25% for men and by 27% for women.



Source: https://www.ksh.hu/thm/2/indi2_8_1.html Central Statistical Office, 2020

Development of infant mortality in Hungary between 2005-2019 in regional breakdown

Infant mortality rate per thousand live birth	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
	6.2	**5.7**	**5.9**	**5.6**	**5.1**	**5.3**	**4.9**	**4.9**	**5.1**	**4.6**	**4.2**	**4.0**	**3.6**	**3.4**	**3.8**
By regions															
Budapest	4.5	5.1	4.5	4.7	3.3	3.8	3.5	2.9	3.6	3.7	3.4	3.1	2.2	2.7	2.4
Pest	4.4	5.0	5.4	5.3	3.8	5.1	3.7	3.4	3.6	4.0	3.3	3.1	3.2	2.4	3.1
Central Hungary	**4.5**	**5.1**	**4.9**	**4.9**	**3.5**	**4.3**	**3.6**	**3.1**	**3.6**	**3.8**	**3.4**	**3.1**	**2.7**	**2.6**	**2.7**
Central Transdanubia	6.2	5.4	6.4	5.3	4.4	4.5	4.8	6.0	5.3	4.4	5.2	3.2	2.1	2.3	2.8
Western Transdanubia	6.0	4.9	5.4	4.4	5.4	5.4	4.1	6.5	4.3	5.4	3.3	3.4	4.4	3.8	3.0
Southern Transdanubia	4.6	5.4	6.5	4.6	5.0	6.0	4.5	6.3	7.2	5.6	4.7	5.1	3.3	4.3	3.7
Transdanubia	**5.6**	**5.3**	**6.1**	**4.8**	**4.9**	**5.3**	**4.5**	**6.3**	**5.6**	**5.1**	**4.4**	**3.8**	**3.2**	**3.4**	**3.1**
Northern Hungary	7.5	9.0	9.5	8.8	8.1	5.5	7.7	7.1	9.1	5.3	4.5	4.7	4.7	5.7	5.4
Northern Great Plain	6.8	5.3	5.2	4.6	5.6	7.2	5.2	4.7	4.9	4.5	5.0	4.8	4.2	3.2	5.3
Southern Great Plain	9.2	5.2	5.2	6.9	6.1	5.2	6.3	4.2	4.1	4.8	4.3	4.5	4.9	3.2	3.8
Great Plain and Northern Hungary	**7.7**	**6.5**	**6.5**	**6.5**	**6.5**	**6.1**	**6.3**	**5.3**	**6.0**	**4,8**	**4.7**	**4.7**	**4.5**	**4.0**	**4.9**

Source: https://www.ksh.hu/thm/2/indi2_8_1.html, Central Statistical Office, 2020.

Ratio of crude and standardized mortality by sex (2018) compared to EU28 countries in time[21]

	Crude mortality, 2018		Standardised mortality, 2018			
	Number of cases, 2018	**Total cases in %.**	**Number of cases per 100 000**	**Compared to the EU28 (2016)**	**Changes, compared to year 2011**	**Value changes compared to EU28 since 2011**
FEMALES						
Total mortality	**67 029**	**100%**	**1179**	**144%**	**-4%**	**-2%**
Circulatory System Diseases	**36 156**	**54%**	**636**	**210%**	**-7%**	**8%**
Ischemic heart disease	17 435	26%	307	354%	-11%	26%
Cerebrovascular disease	6 416	10%	112	154%	-25%	-17%
Cancers	**1 5297**	**23%**	**267**	**128%**	**-2%**	**-4%**
Lung	3 375	5%	59	184%	5%	-3%
Breast	2 127	3%	37	113%	-7%	-6%
Colorectum	2 198	3%	38	165%	-6%	0%
Pancreas	1 082	2%	19	126%	-11%	-25%
Ovary	716	1%	13	120%	-9%	-3%
Cervix	408	1%	7	193%	-5%	8%
MALES						
Total mortality	**64 016**	**100%**	**1833**	**147%**	**-9%**	**-10%**
Circulatory System Diseases	**28 539**	**45%**	**888**	**208%**	**-11%**	**-8%**
Ischemic heart disease	1 4667	23%	460	283%	-14%	-6%
Cerebrovascular disease	4 851	8%	150	172%	-27%	-30%
Cancers	**17 953**	**28%**	**468**	**131%**	**-7%**	**-8%**
Lung	5 341	8%	131	159%	-16%	-13%
Colorectum	2 836	4%	77	191%	-11%	-13%
Prostate	1 314	2%	42	106%	-5%	0%
Pancreas	1 071	2%	27	137%	-12%	-23%

Source: National Health Institute, 2019

[21] 10% or better improvement: green color, 10% or worse deterioration: red color

- **Frequency of risk behaviours:**

➢ The positive effect of the measures taken to curb ***smoking*** seems to be confirmed by the 2009, 2014 and 2020 research results of ELEF, with the statistical data indicating a decrease in both the frequency of smoking and the degree of exposure to second-hand smoke. With regard to the adult population, the proportion of regular smokers in Hungary has shown a slight declining trend among middle-aged men over the past 15 years. According to the Hungarian results of the European Health Interview Survey (EHIS) conducted since 2009, the proportion of the currently active smokers decreased by 4% by 2020 compared to the 2009 results. According to the survey, currently 27.1% of the adult population smokes, compared to 31.4% in 2009.

➢ Based on the results of the Hungarian youth surveys, it can be stated that there is a clear decreasing trend in the ***smoking and e-cigarette use frequencies of young people****:* By 2020, the proportion of non-smokers increased and the proportion of occasional and daily smokers decreased, together with the monthly prevalence of e-cigarette use. According to data of the HBSC surveys, the proportion of teenagers who smoke daily decreased from 16.8% to 10.6% between 2010 and 2018.

➢ ***Alcohol consumption*** in Hungary was responsible for a total of 8 400 deaths in 2016, which is equivalent to the loss of 187 344 years of life, with the data also showing a steadily declining trend for the period after 2010.

➢ According to the results of the HBSC research (2017/2018), the value of almost all types of ***drug use*** among 16-year-old students increased until 2005 at a variable rate and extent. The earlier trend was clearly reversed after the 2009/2010 survey: the lifetime prevalence value of the legal drug types examined has steadily declined since compared to the 2011 results: Their proportion decreased from 13.6% to 9.8% by 2018.

Smoking prevelance (%) among the Hungarian men and women older than 15 years of age based on its annual data surveys of the Hungarian Central Statistical Office ELEF between 2009 and 2019.

Smoking habits	ELEF 2009			ELEF 2014			ELEF 2019		
	Men	Women	All	Men	Women	All	Men	Women	All
Rate of current non-smokers (%) (%)	63.8	74	68.6	66.5	77.8	72.5	69.6	75.9	72.9
Rate of current smokers (%)	36.2	26	31.4	33.5	22.2	27.5	30.4	24.1	27.1
Rate of dailz smokers (%)	31.9	21.7	26.2	31.6	20.8	25.8	27.7	22.2	24.8
Rate of occational smokers (%)	4.3	4.3	4.4	1.9	1.5	1.7	2.7	2.0	2.3
Rate of persons quit smoking (%)	22.4	13.6	17.7	22.1	15.3	18.5	22.1	14.3	18.0

Rate of persons never smoked (%)	39.3	57.2	**48.8**	44.4	62.4	**53.9**	47.5	61.6	**54.9**

Source: https://www.ksh.hu/thm/2/indi2_8_2.html , Hungarian Central Statistical Office, 2020.

- **Frequency of lifestyle risks:**

➢ ***Physical activity*** in the case of children is close to the EU average, but for adults it is still a risk factor requiring public health interventions. Based on the fitness tests for school-age children introduced since the 2014/15 academic year (NETFIT), the differences compared to the overall health zone ratios range from
+6.0 to -0.1% compared to the 2017/18 academic year. The greatest improvement was seen in the torso lift test (+6.0%) and the paced push-up test (+4.8%) (other measurement areas showing a positive tendency: endurance, curl-up test, standing long jump test).

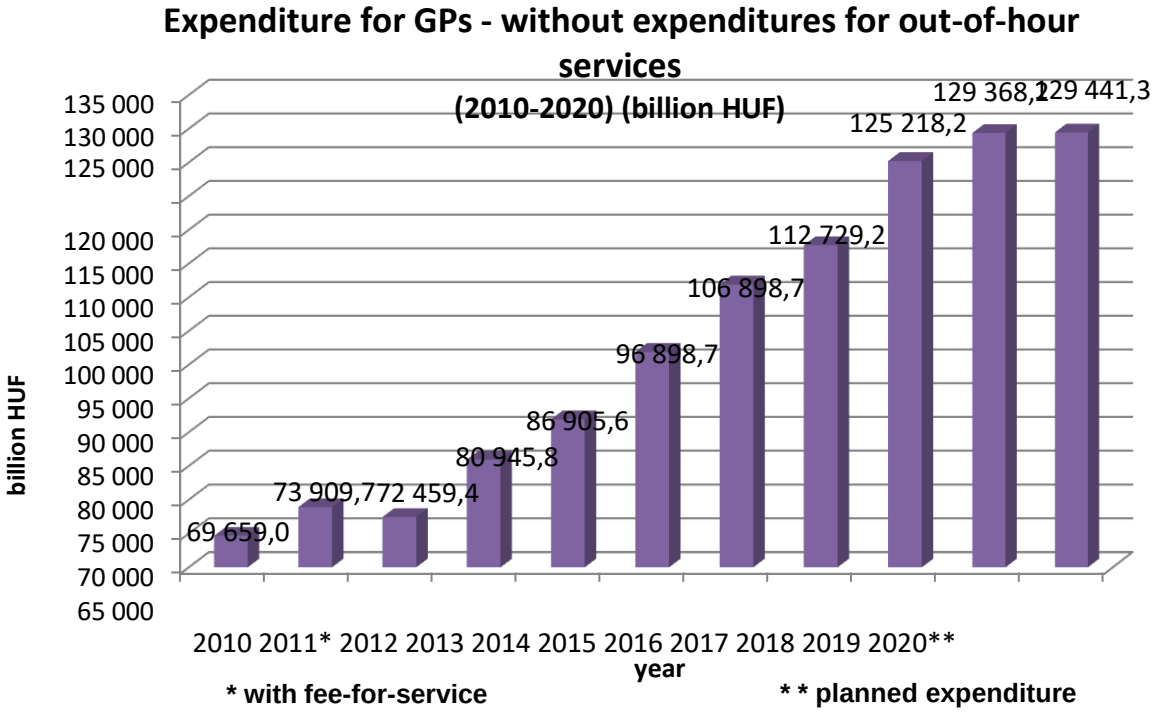
➢ ***Vegetable and fruit consumption*** plays an indispensable role in a healthy diet (in Hungary, half of the deaths can be traced back to a poor diet). The annual per capita consumption of fruit by households has been steadily rising since 2010 in all Hungarian regions, which is a favourable tendency.

Amount of fruits per capita consumed in households (kg)

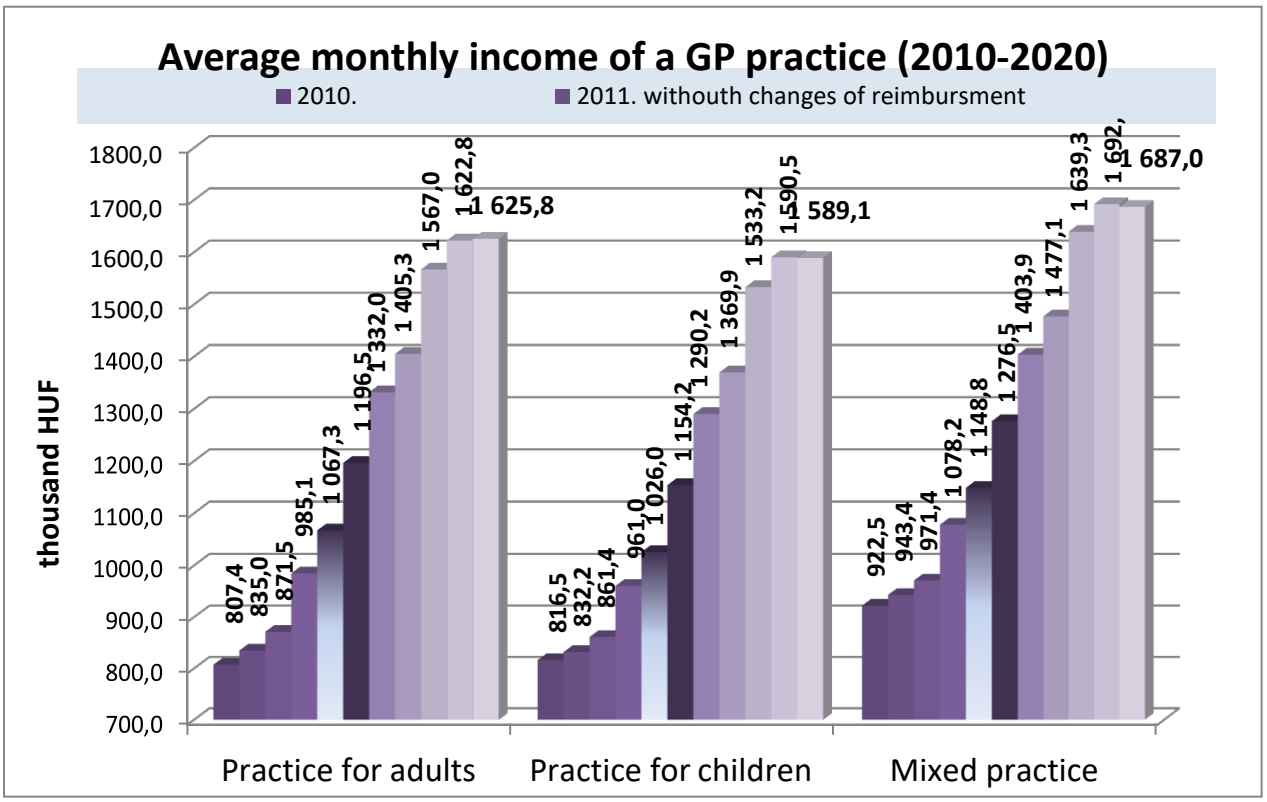
Annual amount of fruit consumed per household per capita , kg	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	48.4	**45.1**	**44.6**	**44.9**	**42.0**	**42.2**	**37.8**	**39.9**	**38.7**	**40.2**	**38.8**	**45.8**	**44.7**	**48.8**	**51.9**
By regions															
Budapest	…	…	…	…	…	…	42.2	42.8	43.1	39.3	41.6	52.1	49.8	53.0	58.0
Pest	…	…	…	…	…	…	…	…	…	…	….	…	…	38.9	41.5
Central Hungary	47.5	44.5	42.3	45.4	44.3	38.7	42.2	41.8	39.0	38.3	36.5	45.0	43.8	47.0	51.0
Central Transdanubia	45.7	43.0	45.8	46.1	37.4	42.8	33.0	41.1	39.3	47.1	39.4	53.0	53.8	47.6	56.1
Western Transdanubia	43.5	45.7	41.4	41.7	38.0	36.8	32.0	35.4	35.7	39.4	38.2	38.2	37.2	35.8	34.5
Southern Transdanubia	42.7	42.9	47.1	48.6	41.1	43.9	39.3	42.6	39.9	55.7	45.4	45.5	52.9	52.8	55.6
Transdanubia	44.0	43.8	44.8	45.4	38.8	41.2	34.6	39.7	38.3	47.2	40.8	45.8	48.0	45.2	48.7
Northern Hungary	40.3	41.5	39.1	39.1	39.3	38.3	34.1	35.3	37.6	31.9	36.1	47.1	41.7	42.1	42.2
Northern Great Plain	57.0	45.4	43.6	42.5	42.7	43.3	34.8	34.5	35.3	33.2	39.1	45.2	41.4	55.5	57.4
Southern Hungary	58.1	52.2	55.1	50.9	46.2	55.0	42.5	46.4	43.7	43.9	41.5	47.3	45.9	60.0	64.4
Great Plain and Northern Hungary	52.3	46.4	46.0	44.2	42.8	45.6	37.1	38.6	38.8	36.3	39.0	46.4	43.0	53.0	55.2

Source: https://www.ksh.hu/thm/2/indi2_8_2.html , Hungarian Central Statistical Office, 2020.

2. Financing of General Practitioners care

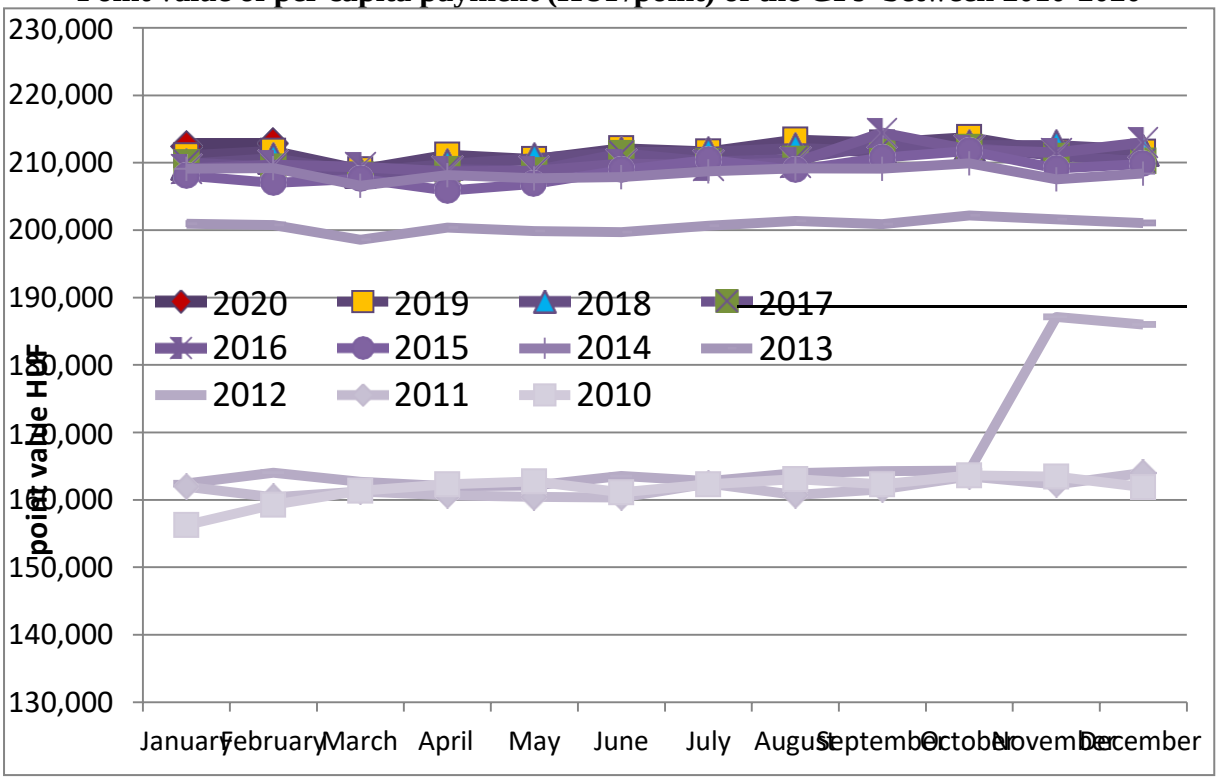


Source: National Health Insurance Fund



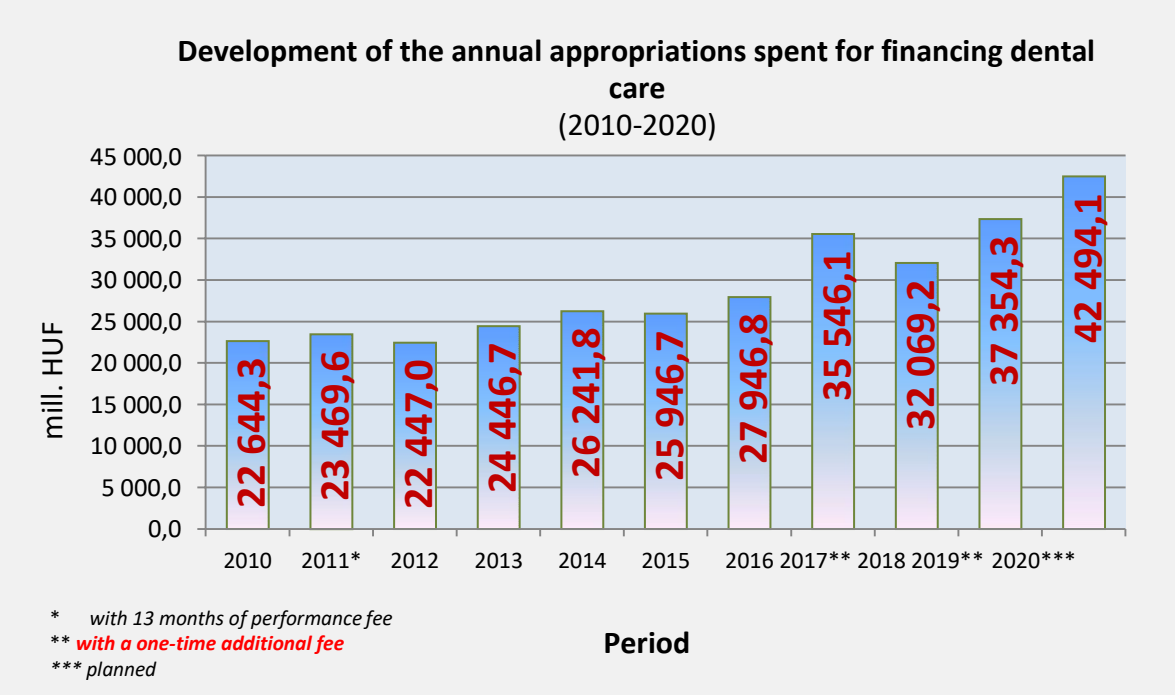
Source: National Health Insurance Fund

Point value of per capita payment (HUF/point) of the GPs' between 2010-2020



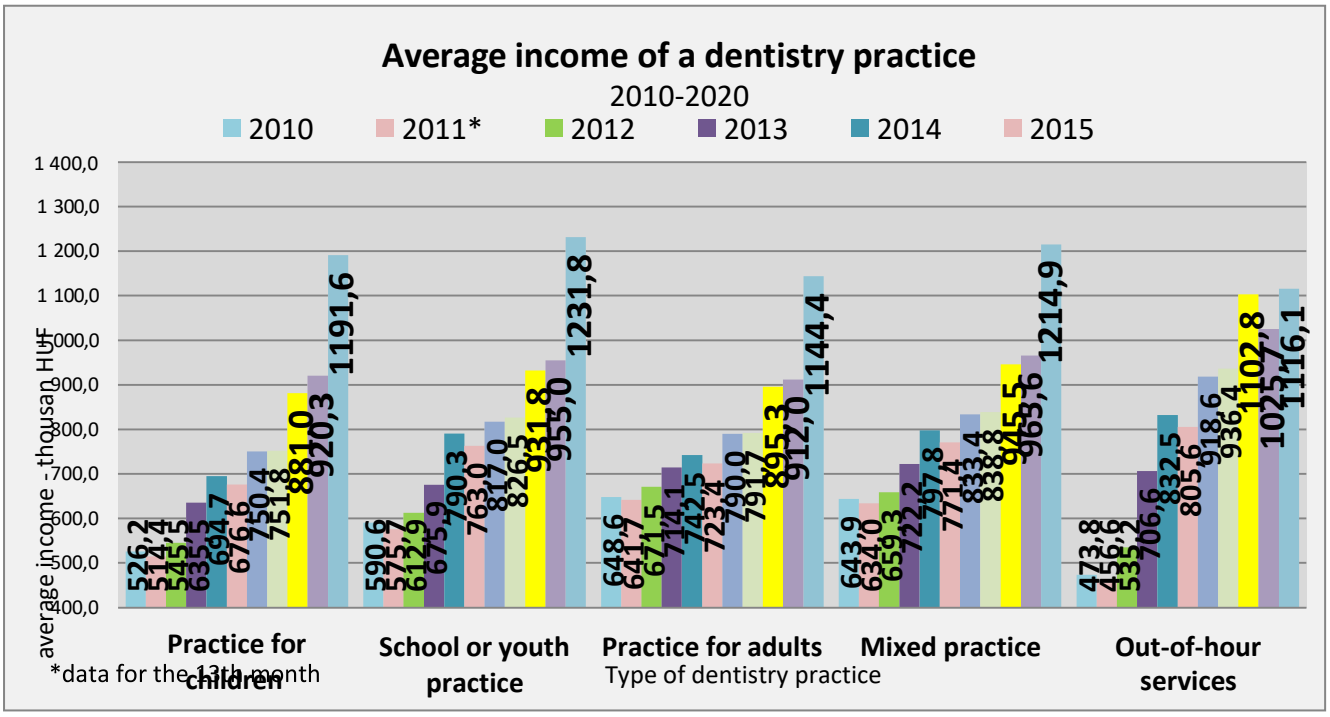
Source: National Health Insurance Fund

3. Financing of dental care

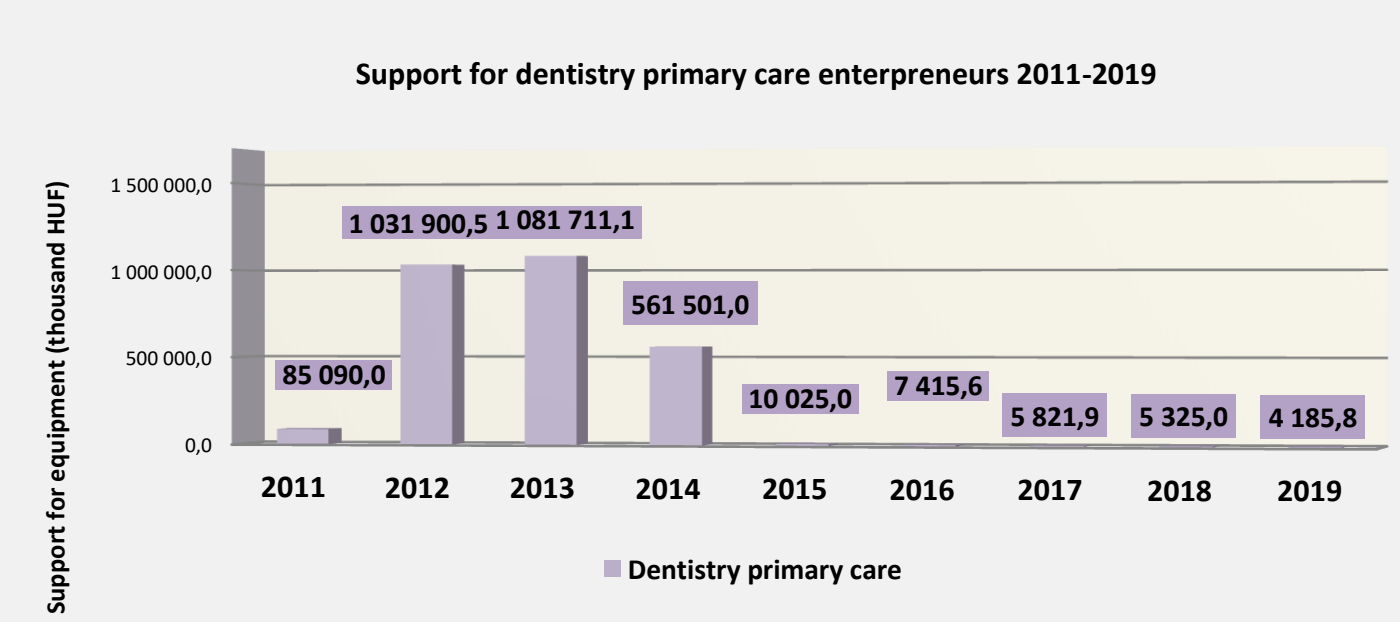


Source: National Health Insurance Fund

The development of the average revenues of dental practices in 2010-2019 by level of care and type of organizational units is shown in the following figures.

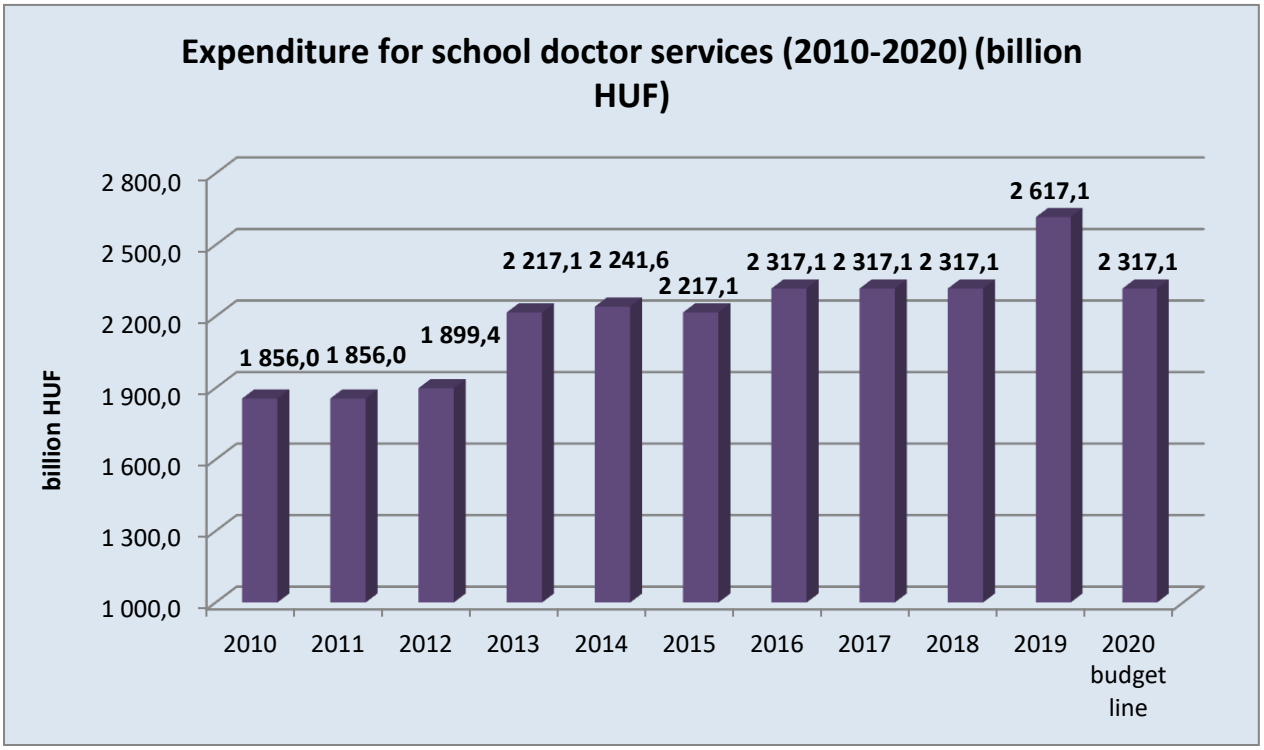


Source: National Health Insurance Fund

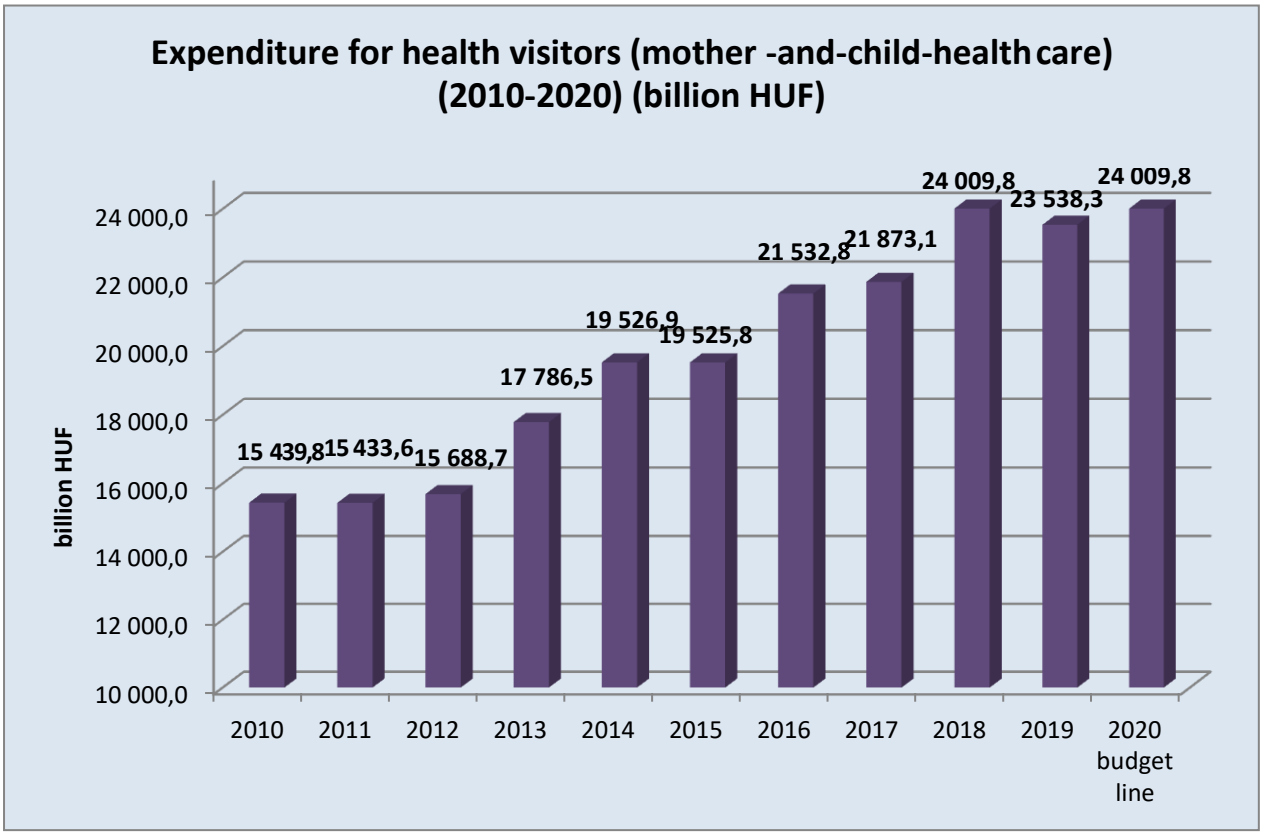


Source: National Health Insurance Fund

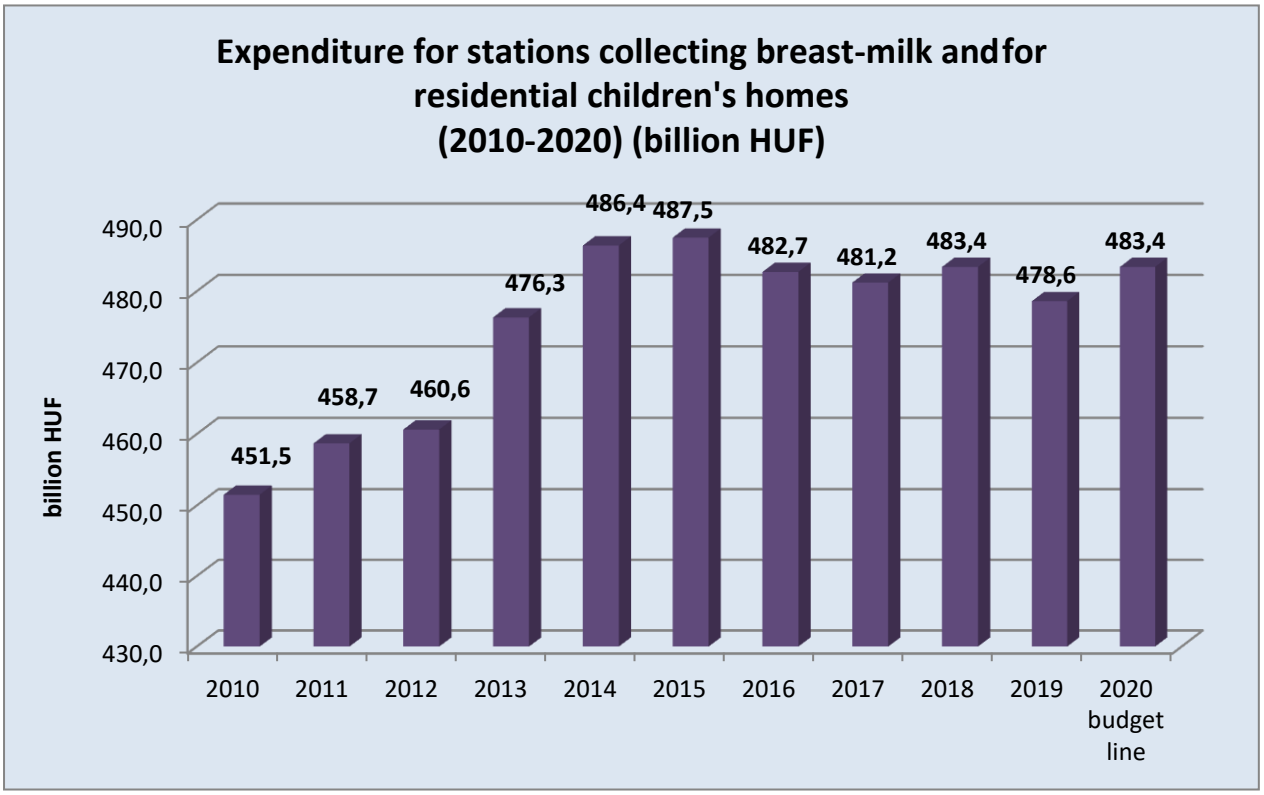
4. Financing of school doctor and health visitor service



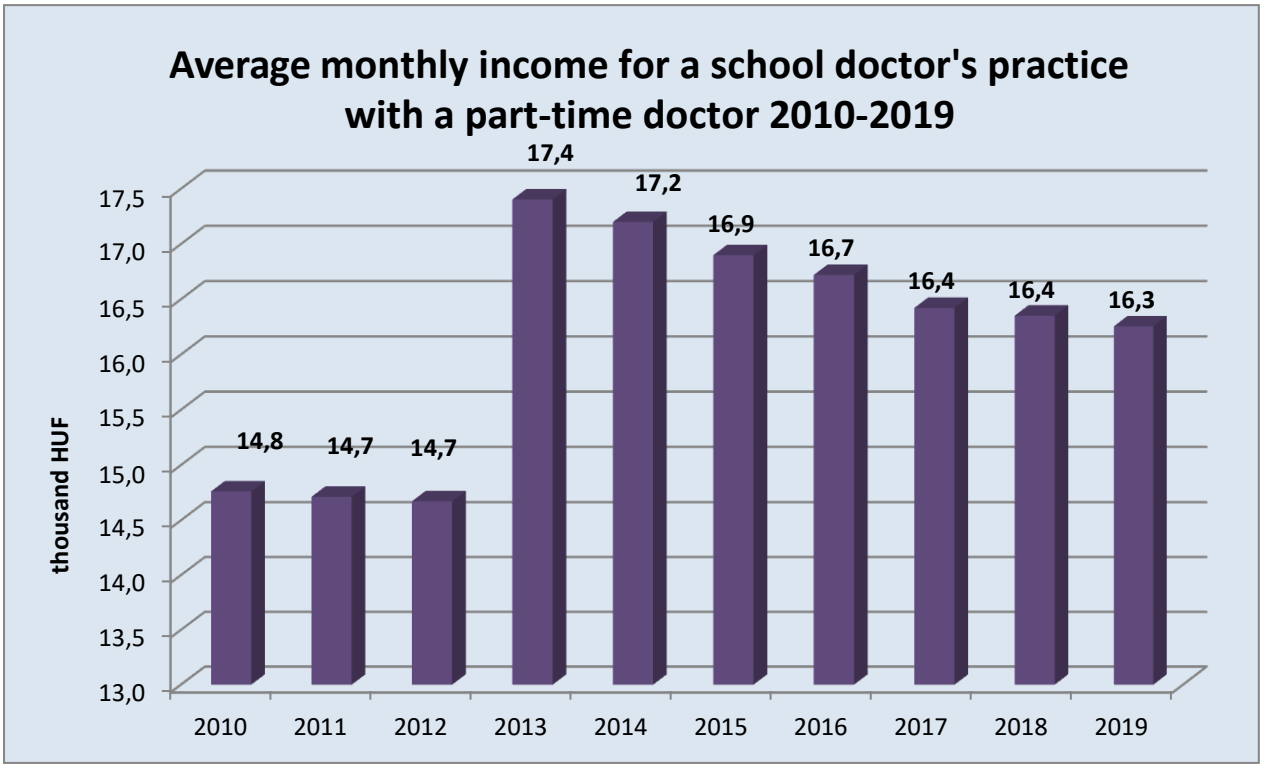
Source: National Health Insurance Fund



Source: National Health Insurance Fund

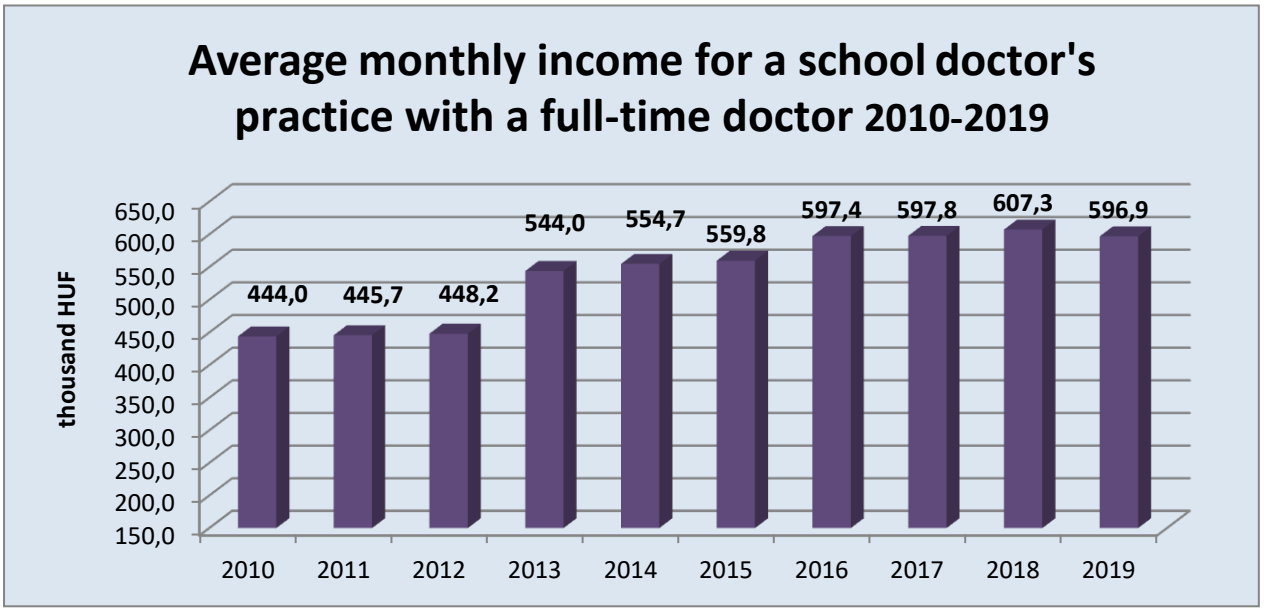


Source: National Health Insurance Fund

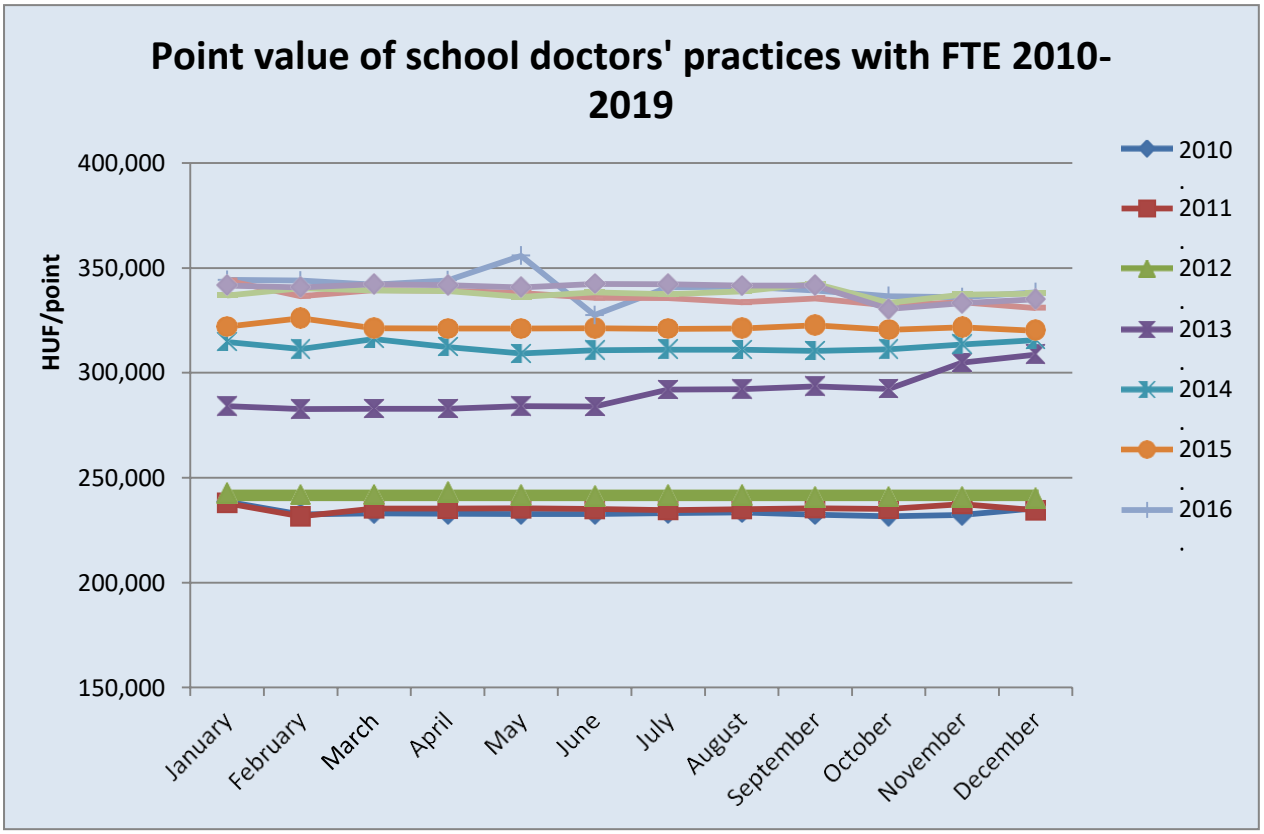


Source: National Health Insurance Fund

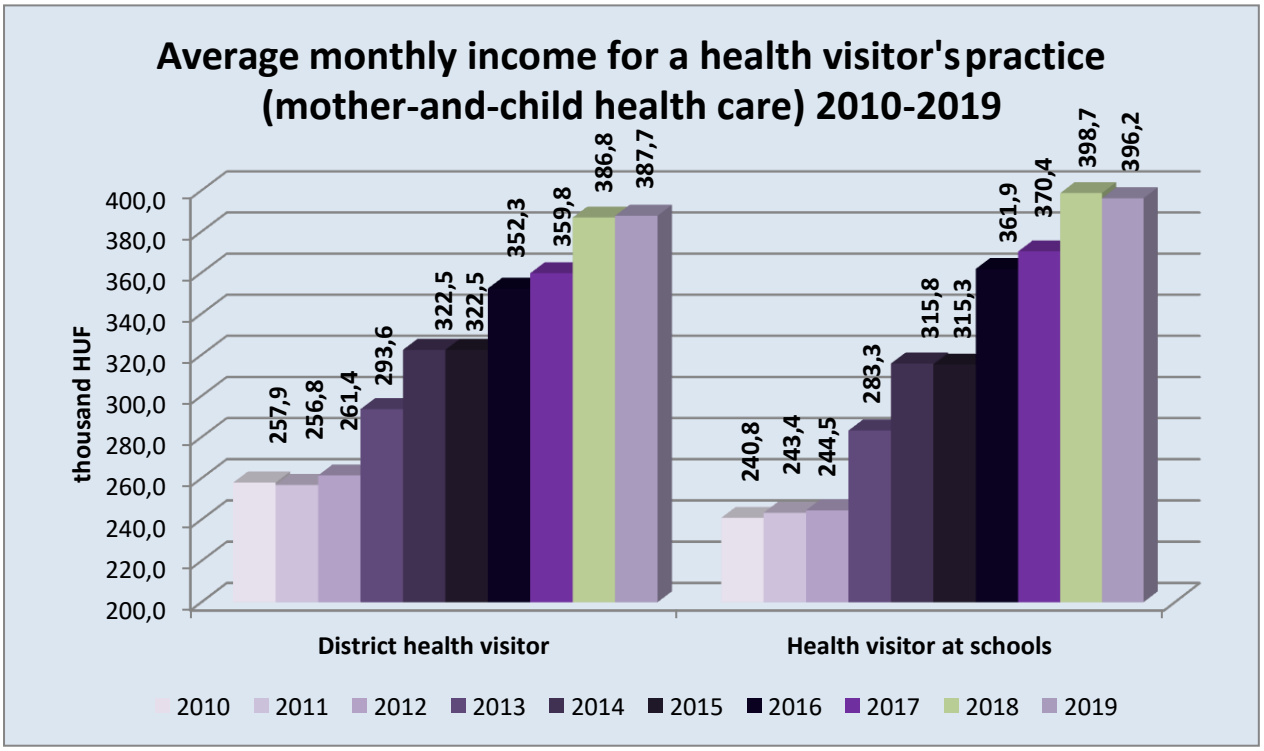
The decrease in the average revenues of part-time services is caused by the decrease in the number of caregivers, the point-HUF value of the normative financing has not changed since 2013.



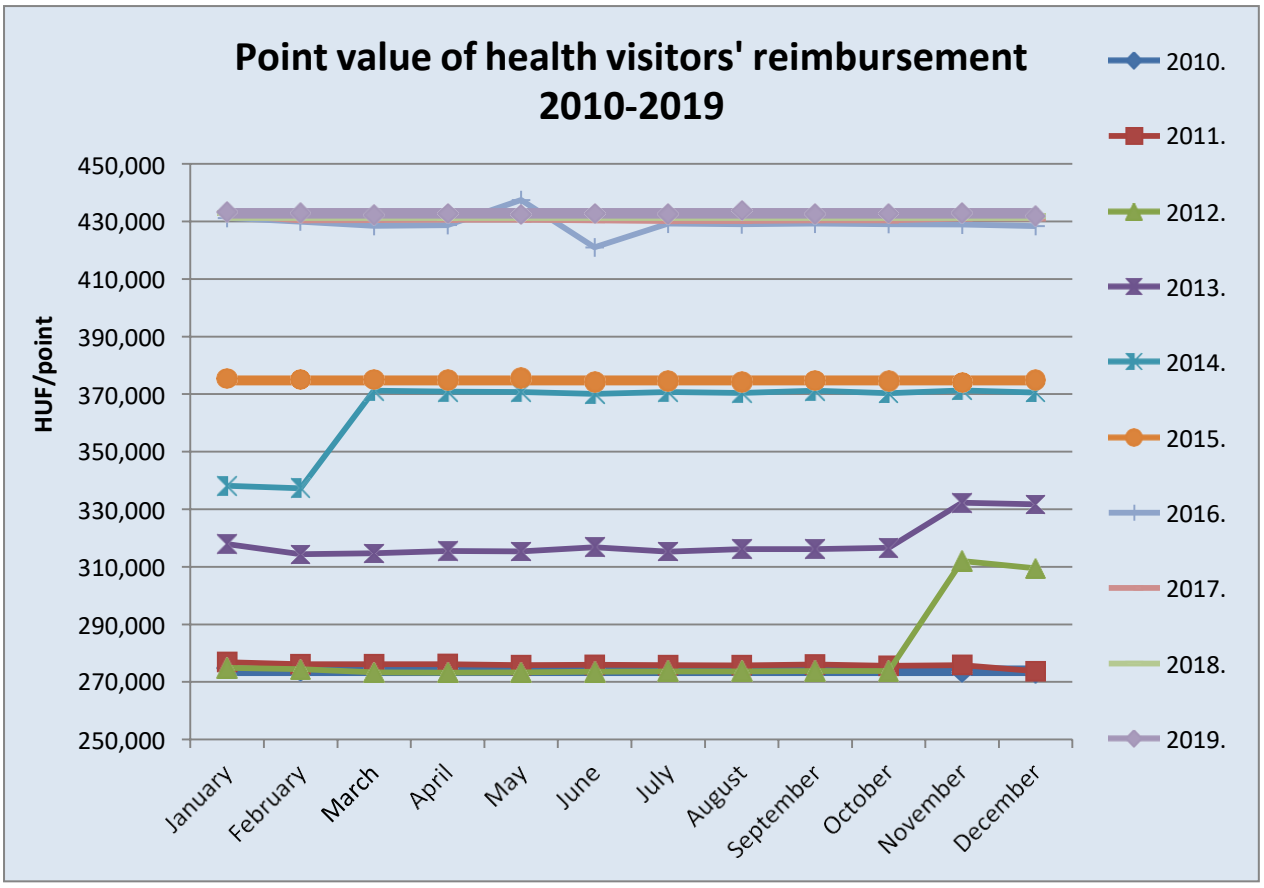
Source: National Health Insurance Fund



Source: National Health Insurance Fund

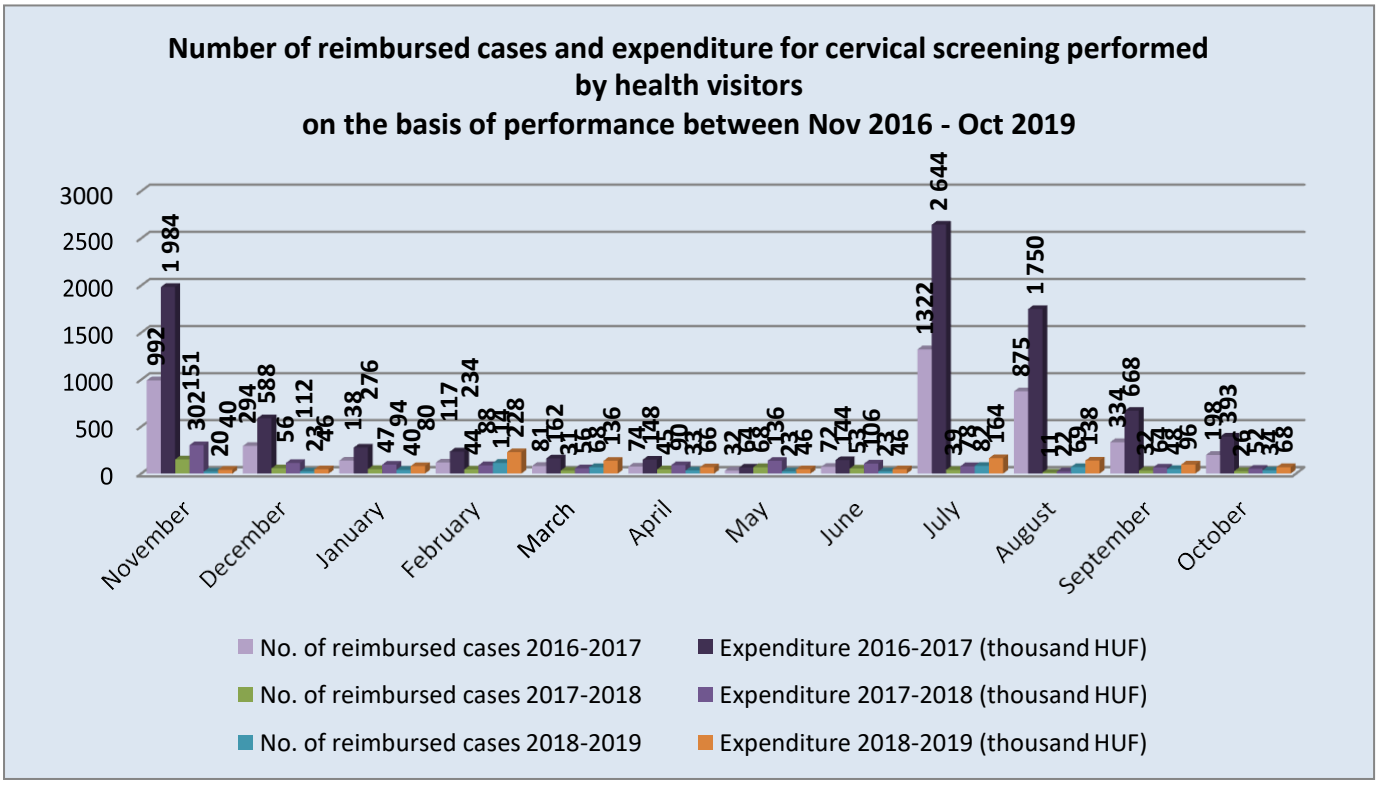


Source: National Health Insurance Fund



Source: National Health Insurance Fund

The data on cervical screenings done by health visitors is shown on the following diagram:



Source: National Health Insurance Fund

5. Data on waiting lists 2016 - 2019

Development of case numbers on the following waiting lists (31 December 2015 = 100%)			
Period	**Patients waiting**	**Rate of patients waiting**	**Number of registrants altogether on the record day**
31 December 2015	34 281	100.00	100.00
31 December 2016	27 959	81 56	79 23
31 December 2017	28 082	81 92	78 95
31 December 2018	28 245	82 39	77 76
31 December 2019	19 511	56 91	72 54

Source: National Health Insurance Fund

Development of the case numbers of mandatory waiting lists per years (number of patients waiting)				
	2016	**2017**	**2018**	**2019**
Gray cataract surgeries	10 269	11 849	11 588	8 052
Knee prosthesis implantation	6 060	5 859	5 928	5 194
Hip prosthesis implantation	5 725	4 923	5 139	3 255
Coronaria interventions	2 400	2 132	2 358	795
Spinal stabilization surgeries, surgeries on spinal deformity	683	683	690	696
Tonsillectomy	1 081	856	752	514

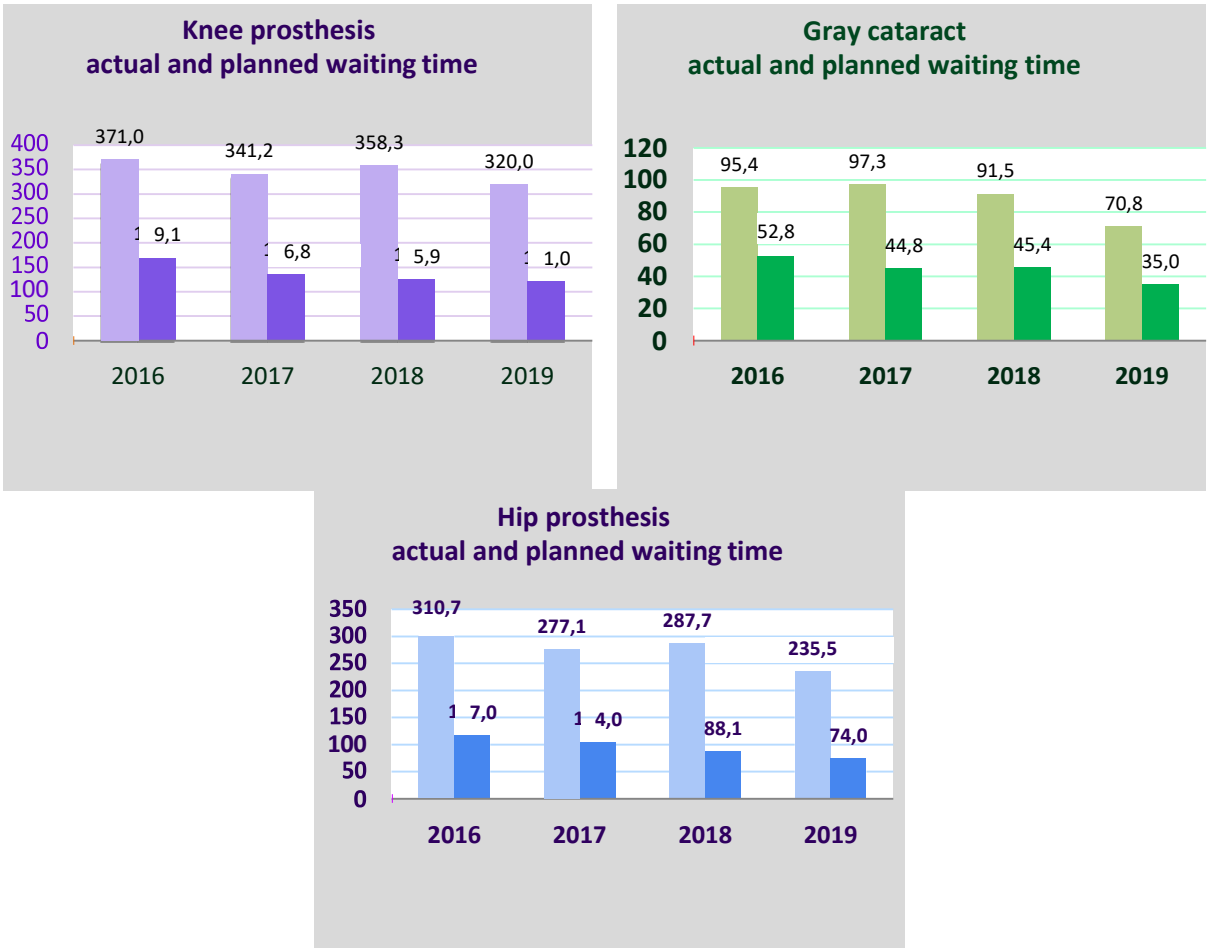
Electrophysiological examination of the heart, large and radiofrequency ablations	568	711	773	337
Gynecological surgeries in non-malignant processes	519	353	378	249
Surgery for benign prostatic hyperplasia II. (Transurethralis prostatic surgeries)	231	311	296	176
Paranasal sinuses, proc. mastoid surgeries	157	118	113	102
Surgery for benign prostatic hyperplasia I. (Prostatectomia)	140	159	105	66
Spinal surgeries of significant extent	46	41	48	47
Spinal hernia surgeries	80	87	77	28
Total	**27 959**	**28 082**	**28 245**	**19 511**

Source: National Health Insurance Fund

Planned and actual waiting time on the mandatory waiting list based on the number of cases treated in the current year (day)						
	2016		**2017**		**2018**	
	planned	**actual**	**planned**	**actual**	**planned**	**actual**
Gray cataract surgeries	95	53	97	45	91	45
Tonsillectomy	53	20	47	21	46	19
Paranasal sinuses, proc. mastoid surgeries	48	16	37	17	42	15
Spinal stabilization surgeries, surgeries on spinal deformity	399	37	320	38	325	41
Spinal hernia surgeries	56	7	54	8	38	8
Surgery for benign prostatic hyperplasia I. (Prostatectomia)	37	14	79	15	34	15
Surgery for benign prostatic hyperplasia II. (Transurethralis prostatic surgeries)	41	14	50	16	35	16

Gynecological surgeries in non-malignant processes	33	10	29	9	40	8
Knee prosthesis implantation	371	169	341	137	358	126
Hip prosthesis implantation	311	117	277	104	288	88
Coronaria interventions	57	18	50	17	56	17
Electrophysiological examination of the heart, large and radiofrequency ablations	210	27	211	31	219	35
Spinal surgeries of significant extent	392	51	410	84	358	87

Source: National Health Insurance Fund



Disclaimer: lighter columns: planned waiting times; darker columns: actual waiting times (in days)
Source: National Health Insurance Fund

International comparison of data on waiting lists:

According to the latest data published by the OECD on 1 July 2020, the position of the Hungarian situation in 2019 on the priority waiting lists developed as follows: The lower value in parentheses in the table shows the average value calculated from the actual waiting time of the cases registered in the queue without prior reservation.

Gray cataract	Actual waiting time	Year of data provision
Lithuania	14	2019
Hungary	**40.6 (35.0*)**	**2019**
Netherland	52.4	2019
Italy	56	2019
Denmark	60	2018
Sweden	75	2019
New Zealand	78.9	2018
United Kingdom	84.6	2018
Spain	100.6	2019
Finland	104.5	2018
Chile	105	2019
Israel	132	2015
Portugal	133.3	2018
Austria	138	2018
Norway	156	2018
Estonia	272	2019
Poland	366	2018

Source: http://www.oecd.org/els/health-systems/health-data.htm

Hip prosthesis	Actual waiting time	Year of data provision
Denmark	45	2018
Netherland	57.6	2019
Lithuania	75	2019
Italy	83	2019
New Zealand	87.5	2018
Sweden	92	2019
Hungary	**92.3 (74.0*)**	**2019**
Israel	95	2015
Finland	95.4	2018
United Kingdom	120.4	2018
Portugal	139.4	2018
Norway	141	2018
Spain	146.7	2019
Austria	163	2018
Estonia	320.2	2019
Poland	373	2018
Chile	487	2019

Source: http://www.oecd.org/els/health-systems/health-data.htm

Knee prosthesis	Actual waiting time	Year of data provision
Denmark	53.6	2018
Netherland	63.1	2019
Italy	78	2019
New Zealand	94.9	2018
Finland	115.8	2018
Lithuania	120	2019
United Kingdom	129.7	2018
Sweden	131	2019
Israel	133	2015
Hungary	**134,5 (121,0*)**	**2019**
Norway	168	2018
Spain	190.6	2019
Austria	207	2018
Portugal	215	2018
Poland	482	2018
Estonia	634.2	2019
Chile	794	2019

Source: http://www.oecd.org/els/health-systems/health-data.htm

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. improve health and promote individual responsibility in healthcare by providing counselling and education opportunities;

1) RESPONSES GIVEN TO THE QUESTIONS OF THE ECSR RELATING TO THIS PARAGRAPH

The ECSR requests the confirmation of whether the following areas are part of the health preservation related education of schools:

- ***prevention of smoking and drug use;***
- ***sexual and reproductive education, in particular sexually transmitted diseases and AIDS;***
- ***road safety; and***
- ***healthy eating.***

They asked us to show how the above topics are integrated into the curriculum.

1. Health preservation related education in curricula

Hungarian public education has three levels in terms of input content regulators. This is represented by state (National Core Curriculum and framework curricula) and institutional level curricula (local curriculum). The National Core Curriculum and framework curricula determine the mandatory content of public education. The former is a comprehensive document that aims to provide a comprehensive but non-detailed definition of cultural tool knowledge (i.e. knowledge above or between subjects). Its task is to outline the content framework of the terms and phenomena that will be included in the framework curricula that determine the content of each subject according to the given grades. These contextual frameworks provide an opportunity to develop a framework curriculum and then teach a specific topic. Therefore, certain terms may not have described in the above regulators.

Government Decree 110/2012 (4 June) on the Issuance, Introduction and Implementation of the National Core Curriculum (hereinafter referred to by the Hungarian abbreviation as: NAT), amended in 2020, the requirements of the framework curricula prepared on the basis thereof, and textbooks developed from central sources in recent years and smart books were examined to see if they included knowledge on the following topics:

- smoking and drug prevention,
- sexual and reproductive education, in particular sexually transmitted diseases and AIDS,
- road safety,
- healthy eating.

Among the central content regulators, the overall educational goals of the NAT include the education of students physical and mental health. Already at this level, it is stated that pedagogues encourage students to have a need for proper nutrition, exercise, and the application of stress management methods. The task of the school, in cooperation with the family, is to prepare students for independence, disease prevention, as well as compliance with the rules of transport, physical hygiene, recognition of dangerous conditions and

materials, and the handling of unexpected situations. Pedagogues motivate and help students prevent the development of habits that lead to harmful addictions.

1.1 The topic of **smoking and drug use prevention** appears at the NAT, the framework curricula and textbook levels alike, generally in the biology and chemistry curricula for grades 7-8 and 9-10.

In biology, smoking appears as a risk factor for the development of cardiovascular and cancerous diseases in topics related to individual organs and organ systems, life processes (respiration, circulation, regulation) and health prevention. Furthermore, the effects of drugs are also discussed when presenting the mechanism of addiction. At the same time, the emphasis on participating in regular screening tests as part of prevention will play an important role. The framework curriculum for grades 7-8 deals with the general chemistry of substances, drugs, and the concept of addiction and prevention under 'everyday chemistry'. Chemistry in grade 9-10 also deals with the above: the active ingredients of the most commonly used substances (spirits, tobacco products, coffee, energy drinks, drugs, doping agents), and the dangers of their use. The content also appears at textbook level.

1.2 Comprehensive content providing a conceptual framework for **sexual and reproductive education, in particular sexually transmitted diseases and AIDS**, is included in several places in the NAT, partly in key areas of competence and partly (mainly) in the description of the learning objectives and outcomes of 7th-8th and 9th-10th grade biology. For example: *"It also assesses the importance of human sexuality in relation to relationships and conscious family planning, taking into account the student's knowledge of biology."* These describe the topics of immunity, the culture of sexual behaviour, health awareness, the functioning of viruses, infections and screenings, along which specific knowledge and awareness-raising activities on AIDS and HIV are included in the biological framework curricula. Textbooks based on the framework curricula also contain knowledge about HIV and AIDS. The development of preventive health education is a fundamental goal of teaching the subject of biology.

1.3 Road safety already appears in the subject curricula of lower grades, in the technics and planning subject of grades 1–4, in the curriculum of natural history in grades 3–4, after which the relevant knowledge and the physics background of modern means of transport and the safe use of the devices is taught in higher grade physics. The topic of first aid taught as part of the biology subject has received more emphasis in the NAT of 2020 than before; practice- based acquisition of knowledge about the methods of caring for injuries of different origins will be essential for the rising generations.

1.4 The topic of **healthy eating** appears in the subject of biology in grades 7-8, with the study of the digestive system and digestive and physiological processes, after which the topic is expanded upon in grades 9-10. Physical and mental health education is promoted by proper nutrition and learning the chemical bases of harmful addictions while studying the subject of chemistry, already in primary school. Students should be familiar with the most important components of our foods and their properties, as well as the nutrients of the most important foods found in the household, in addition to dealing with the most important food additive groups. The subject of physical education also deals with the principles of sports nutrition, as well as good eating habits, and children can learn about food preparation procedures during the technics and planning classes.

- **Comprehensive health promotion in schools**

Pursuant to the Decree of the Minister of Human Capacities 20/2012 (31 August) EMMI on the Operation of Public Education Institutions and on the Use of Names of Public Education Institutions, the use of comprehensive health promotion programmes (hereinafter referred to by the Hungarian abbreviation as: TIE) has been introduced in educational institutions. TIE is a summary name for school activities that promote the preservation and development of health, effective disease prevention, health-conscious behaviour, and a health-based approach. TIE is a requirement in public education legislation, but is also supported by a number of other relevant legislation.

Within the TIE, emphasis is placed on the development of physical and mental health (including the development of health-conscious behaviour, awareness of the criteria of healthy eating, education aimed at a harmonious family life, sex education), the prevention of addictions, the prevention of violence and abuse to which students are exposed, and the knowledge of safe traffic rules, which closely relate to the topic.

With the regulation of comprehensive school health promotion in 2012[22], all children attending school participate in health promotion activities, taking into account the biological, social and age characteristics of the children and students. Its regulation states that the implementation of the TIE must be planned in a coordinated, traceable, measurable and evaluable manner. Stress and conflict management, problem-solving development, and primary prevention of aggression, abuse, and addiction are also an integral part of these programmes. The comprehensive health promotion programme can be implemented by public educational institutions with the involvement of their own internal resources or through external specialists and organisations with a ministerial recommendation.

Comprehensive school health promotion means the regular performance of the following four basic health promotion tasks, with all students, involving the entire faculty and staff, school healthcare service professionals, parents and the school environment, with professional supervision and assistance:

- ***Implementing a healthy diet*** (preferably by linking local production to local consumption);
- ***Daily physical education*** for all students to the meet health promotion criteria, and other physical activities that support it;
- Promoting the transformation of children into mature individuals, i.e. ***development of their mental health***, through person-centred pedagogical methods and the effective application of the arts in personality development (singing, dancing, drawing, storytelling, national games and traditional games, crafts, etc.);
- ***Promoting the acquisition of a wide range of health knowledge at skill level*** (including accident prevention and first aid; personal hygiene; prevention of the use of substances leading to the development of addiction, and prevention of violence and abuse to which students are exposed): a detailed list of topics is included in the Annex.

In order to assist the pedagogues in their day-to-day TIE work, the Minister of Human Capacities jointly prepared the TIE Recommendation, which was sent to all school principals on 19 April 2016 by the Educational Authority.

[22] *Decree of the Minister of Human Capacities 20/2012 (31 August) EMMI on the Operation of Public Education Institutions and on the Use of Names of Public Education Institutions.*

In order for a school to be effective in the day-to-day execution of the TIE, it is essential that, in accordance with the regulation, it plans its overall health promotion tasks in a coordinated, traceable, measurable and evaluable manner as part of a local pedagogical programme. This programme should be prepared by the teaching staff with the assistance of the school healthcare service.

Effective school health promotion means meeting the following requirements:

1. Affects all major health risk factors (unhealthy eating, mobility impairment, mental health deficiencies, health education deficiencies).
2. Constantly and regularly present in the daily life of the school.
3. Participation of all students of the school conducting health promotion.
4. Involvement of the entire faculty (while all non-teaching staff of the school also assist). The main helper for pedagogues is the school healthcare service.
5. Involvement of parents and suitable institutions and civil societies operating in the vicinity of the school.

On 25 September 2019, the WHO organised a workshop in cooperation with the Minister of Human Capacities, the aim of which was to establish and launch the Hungarian Public Health Partnership. The participants from public health and related industries agreed that only complex, i.e. wide-ranging participatory interventions at national, regional and local levels that affect both health behaviours and living conditions can improve the health of the population. It was also found that the participants unanimously support and participate in the implementation of the project jointly proposed by the WHO and the Minister of Human Capacities, the topic of which is the implementation of a complex public health development project to improve children's health, which would indirectly promote the renewal of Hungarian public health. The implementation of the 2-year project started at the end of 2019 from HUF 100 million in funding.

- **Professional programmes assisting in the achieving of goals set out in comprehensive health promotion programmes in schools:**

DADA, ELLEN-SZER:

Safety education school programmes of the police, which develop various competencies, develop self-worth and build self-esteem, which also include drug prevention topics. Emphasis is placed on education aimed at a safe life, strengthening of self-empowerment, and the development of decision-making and the ability to say no. Their goal is for children to recognise dangers at all times, to be able to distinguish between positive and negative influences. The basic premise of the programmes is to increase the safety of young people against the most serious deviances, crime and substance use. The classes are held by police staff. With the help of interactive lesson plans containing exercises, situational games and constructive pedagogical tools, each lesson plan can be covered in groups with the active participation of everyone.

School Health Promotion Programmes:

The responsibility of the National Public Health Centre (hereinafter referred to by the Hungarian abbreviation as : NNK) is to perform the tasks related to the recommendation of health promotion programmes in educational institutions pursuant to Section 128 (7) of the Decree of the Minister of Human Capacities 20/2012 (31 August) EMMI on the Operation of Educational and Training Institutions and the Names of Public Education Institutions The

NNK is the professional and administrative executor of the programme recommendations. The recommendation system means the evaluation of health promotion programmes that can be implemented at educational institutions on the basis of pre-defined professional requirements. It aims to raise and standardise the professional quality, efficiency and reliability of the programmes at national level. Currently, 35 organisations with professional recommendations support the health promotion tasks of public educational institutions.

School police programme:

The school police programme was launched in September 2008 with the express purpose of promoting the safe and accident-free transportation of children, expanding their transportation knowledge, and identifying and eliminating other factors that endanger the safety of children. The school police perform public safety, crime prevention, traffic education and accident prevention tasks. In the 2019/2020 academic year, 2 963 public education institutions joined the School Police Programme, with 2 209 school police officers assisting the implementation of the programme. The school police held 12 003 prevention sessions for 308 316 students. In September, in connection with the start of the academic year, at the start and end of the school day, the school police provided a demonstrative police presence in 1 259 locations.

Buda Area Health Programme:

The Buda Area Health Programme is a national and international model programme implemented by the National Korányi Pulmonology Institute (hereinafter referred to by the Hungarian abbreviation as: OKPI) and the Buda Area Municipal Association (hereinafter referred to by the Hungarian abbreviation as: BÖT) in cooperation with the Ministry of Human Capacities, other professional institutions, partners and the WHO. The programme was launched in January 2019 with a funding of HUF 98.8 million.[23]

The aim of the programme is to improve the health of the population of BÖT and to ensure a longer, healthier life: to promote a healthy lifestyle in all ages; improve the health of children, young people and their families; to prevent and detect circulatory, respiratory and locomotor diseases early; to conduct public health screenings for cancerous diseases; to reduce chronic disease mortality rates; to promote mental health and well-being.

Activities implemented under the programme:

- Development of a group practice: acquisition of equipment
- Promotion of outdoor exercise: Pure Soul Story Trail
- Lung cancer screening with a low-dose CT realised by OKPI
- Health development programmes of Biatorbágy EFI
- Authentic data on the health of the inhabitants of the settlement, for targeted and effective intervention
    - on smoking habits: as part of a minimum intervention in family practitioner practices
    - on the health behaviours of the adult population in the community of practice: as part of the 'Three Generations for Health' programme
    - on the health status and health behaviours of school-age children: as part of a school health survey

[23] 20/22/28 - HUF 17 million from the appropriation titled 'Tasks related to the National Public Health Strategy', WHO BCA: HUF 2.8 million, within the framework of the 'Three Generations for Health' tender: HUF 79 million

- Complex improvement of children's health: promoting the effective implementation of comprehensive school health promotion
    - mental health support; addiction prevention (assertive communication development training for pedagogues; multiplier training; school thematic week on smoking prevention; supervision and focus group discussion; peer support)
    - promoting healthy body weight (encouraging the regular joyful physical activity of children through the intensive involvement of sports associations in settlements; sports competitions; OGYÉI Canteen programme; healthy body weight promotion for obese children; 'BÖTMove' programme)

2. The emergence of health preservation in pedagogue training

The basic function of pedagogue training is to ensure the personal conditions of public education, in which the client itself continuous to be the public education: with the goals and institutional system of pedagogy, education and vocational training. The aim of teacher training is to prepare the candidates for the simultaneous education of children with different skills, abilities, social backgrounds and ethnic backgrounds.

The contribution of pedagogues trained in accordance with the requirements set by the NAT is becoming more and more important in shaping the knowledge and competencies of highly qualified professionals needed in the labour market of an increasingly globalised world, but especially in the shaping of society.

The 2016-2020 curriculum requirements related to health preservation and the role of gender are included in the definitions of the development areas, as well as educational goals and areas of the NAT issued in 2012.

- **Public education curriculum expectations**

The development areas and educational goals of the NAT include the requirement of physical and mental health education and family life education.

- **Education for physical and mental health**

Education for a healthy lifestyle helps in living a joyful life in a healthy physical and mental condition. The NAT requires pedagogues to encourage students to eat properly, exercise, and use stress management techniques. They should be able to preserve their mental balance, regulate their social behaviour, and manage conflicts. The task of the school, in cooperation with the family, is to prepare students for independence, disease prevention, as well as compliance with the rules of transport, physical hygiene, recognition of dangerous conditions and materials, and the handling of unexpected situations. Pedagogues motivate and help students prevent the development of habits that lead to harmful addictions.

- **Education for family life**

According to the NAT, the family is of paramount importance in shaping the moral sense, loving relationships, self-awareness, and physical and mental health of children and young

people. Changes in the more immediate and wider environment, rearrangements in the order of values, disturbances in the operation of some families necessitate the inclusion of family life education in public education. Therefore, public educational institutions have a special task to convey harmonious family examples and to appreciate family communities. Preparing for family life helps children and young people to form responsible relationships, and provides them with knowledge on how to deal with conflicts in their family lives. The school should also address sexual culture issues.

- **Basic curriculum requirement for human and nature education**

The content requirements of the NAT divided into subjects prescribe the appearance of the requirement of education for a health-conscious lifestyle, primarily in the case of subjects belonging to the field of human and nature education.

It is a basic principle that the conscious preservation of health, the responsible and sustainable shaping of the natural, technical and built environment is inconceivable without the application of scientific research and its results. The relationship to science and technology culture is determined by attitudes, therefore they are essential for understanding the natural and technical environment around us, which is a prerequisite for a sensible, health-conscious lifestyle and sustainable farming.

With regard to this topic, the demonstration of health preservation options should be a priority in grades 7-8. In grades 1-12, the development of healthy eating habits, the presentation of qualitative and quantitative aspects, the knowledge of the characteristics and physiological role of the main nutrients of foods, and the use of data and recommendations for healthy eating follow each other. The topic also includes: assessing the impact of nutrients on health; understanding the harmful effects of smoking, alcohol and drug use; recognition of the relationship between the state of the environment and human health, the need for healthy living conditions; recognising the preventive importance of regular health and screening, self- testing, vaccinations, hygiene, skin care and a healthy lifestyle; and understanding the correlation between health and homeostasis, the state of the immune system, and the development of diseases.

- **Reproduction, ontogeny, sexuality**

The topic focuses on the discussion of processes influencing pregnancy, childbirth, breastfeeding and human fertility, and familiarisation with methods suitable for avoiding harmful effects. It presents the main stages of human ontogeny, their comparison, secondary gender characteristics, physical and mental differences. The topic also includes: a comparison of the most characteristic physical and psychological manifestations of the postnatal developmental stages; analysis of the psychological background of behavioural changes and crises; knowledge of the stages of the whole human life before and after birth, insight into its values; recognising personal responsibility for sexuality, presenting arguments for adherence to basic moral and health rules; and an argument for conscious family planning, a responsible lifestyle for the pregnant mother.

The above requirements appear primarily in the requirements of biology and natural history.

In informatics, the effect of IT tools on health will also be introduced. Creating a healthy work environment.

The requirement of the subject of lifestyle and practice reflects the validation of conclusions derived from the analysis of accidents, injury analyses, adverse health effects and other hazards. The methods and means of prevention, knowledge and practice of the possibilities of assistance. Identification and analysis of adverse health effects related to one's own activities and of those in the vicinity.

The NAT presents the following topics in relation to Family and the household:

- Family
- The scene of family life is the family home
- Family tasks, division of labour
- A safe home, home accident prevention, first aid
- Healthy lifestyle: eating, dressing, bathing, exercising
- Water and energy saving, selective waste collection, recycling
- Caring for plants and animals in and around the apartment and house

Topics presented in relation to Material culture, technologies and production:

- Practical order, cleanliness and saving during work
- Properties of objects, materials, tools and technologies that can be learned through observations and experiences

Topics presented in relation to Health Science:

- The concept of health
- Dimensions of health
- Factors of a healthy lifestyle
- Physical health conditions
- Hygiene: environmental hygiene; personal hygiene at home, in school, in physical education and in sports
- Healthy lifestyle, risk factors, primary prevention
- Healthy eating, the impact of food quality on the functioning of the body
- Food safety
- The role of exercise in the preservation of health at school age
- Classification of diseases: the most common groups of diseases occurring at school age and among young people, their early symptoms
- The relationship between physical and mental health
- Harmful dependencies, addictions
- Addiction recognition and the crucial steps to be taken
- Health science of sports
- Relaxation and health protection
- Sex education
- First aid and resuscitation

Topics presented in relation to Life Skills:

- Skills aimed at the practical knowledge of the social and artificial (technical) environment and the development of the provision of the knowledge necessary for the handling of everyday life

- Family, household, material culture
- The concept of minority and disadvantage, minority groups in Hungary and their lifestyle characteristics
- Health opportunities for minorities and the disadvantaged
- Family as the most important small group
- Changes in the family
- Family socialisation, gender role socialisation
- Stages of family life
- Risk factors in the family
- Way of life and lifestyle definitions
- Factors determining a healthy lifestyle

Topics presented in the special field of Nutrition:

- Physiology and biochemistry of nutrition
- Utilisation of nutrients
- Nutrient demand and energy turnover
- Grouping of nutrients
- Properties and composition of foodstuffs
- Purpose, significance and basic principles of food preservation
- Preserved products
- Foodstuffs of plant origin: cereals, mill products, pasta products, bakery products, sweeteners, confectionery products, fruit and vegetable products
- Knowledge of food of animal origin: meat and meat products, edible fats, milk and milk products, eggs
- Knowledge of luxury goods
- Principles of healthy eating
- Diet

Topics presented in relation to Bioethics:

- Origin of life, artificial insemination, methods of reducing fertility, contraception
- Abortion
- Bioethical aspects of genetic engineering and biotechnology research
- Genetically modified animals and plants (preservation of health, healthy eating, impact on the environment)

The topic presented in relation to the structure and functioning of the animal and human body: Reproduction and reproductive organs.

- **Content and output requirements for pedagogue training and teacher training that meet the requirements of the public education curriculum**

➢ **Elementary school teacher training:**

The Decree of the Minister of Human Capacities 18/2016 (5 August) EMMI on the Learning Outcomes of HE Vocational Trainings, BA and MA Programmes and on the Modification of the Decree of the Ministry of Human Capacities 8/2013 (30 January) EMMI on the Common Requirements of Initial Teacher Education and the Learning Outcomes of Each Initial

Teacher Education Programme provides for the requirements for the general training of elementary school teachers.

The aim of the training is to train elementary school teachers who, in accordance with the changing social needs and the goals of primary school education, are able to develop the personalities of the students in a complex way, and to fulfil the full role of an elementary school teacher. They must be prepared to perform the education tasks of all fields of education in the first four grades of primary school and of one chosen field of study in the first six grades, while in the case of nationality specialisation, the education tasks of all fields of education in the first four grades of primary school and of the national mother tongue in the first six grades.

The elementary school teacher is familiar with the theoretical background and practical application of school activities and pedagogical procedures aimed at the full health promotion of children aged 6-12. They know the theoretical background of the special posture correction that creates and maintains a biomechanically correct posture as well as its correct practical application. In relation thereto, they are able to shape the methods and agenda of school education in such a way that it achieves the full health development of children aged 6-12. They correctly apply the special posture correction practice material that creates and maintains a biomechanically correct posture.

- **Teacher training:**

Decree of the Ministry of Human Capacities 8/2013 (30 January) EMMI on the Common Requirements of Initial Teacher Education and the Learning Outcomes of Each Initial Teacher Education Programme provides for the content and output requirements for teacher training in general for all teachers and for subject specific teacher trainings.

<u>According to the general requirements of teacher development:</u>
The professional (scientific, artistic) training includes the basic knowledge of the development areas and attitudes of the NAT, as well as the interpretation of the content and approach of education, as well as the interpretation of literacy, knowledge and learning, and knowledge building. Furthermore, the connections and interactions of the knowledge of the discipline(s) corresponding to the subject according to the NAT-based framework curricula, fields of education, epistemological bases of artistic fields, peculiarities of learning of its history, internal structure and terminology with other subjects, sciences and fields of education, the knowledge of the scope of knowledge defined in the content regulation of public education and vocational training, the peculiarities of the knowledge conveyed by the subject related to the given teacher qualification, the possibilities of general and specific skills development inherent in it.

Teacher training is expected as a general part of the competence requirement to be acquired in the field of the development of the student's personality and the enforcement of individual treatment on the conditions of teacher knowledge, skills and abilities that can be acquired in teacher education, so that the graduate/qualified teacher has a basic knowledge of child rearing, nurturing of talent and health promotion.

<u>Part of the biology teacher training and output requirements</u>:
The aim of the training is school education, as well as the training of teachers capable of teaching biology, health science subjects, preparing and organising natural science exercises,

performing the pedagogical tasks of the school and performing pedagogical research, planning and development tasks in the grades of vocational secondary school leading to the acquisition of a vocational school teaching and education qualification and in adult education, which teachers are able to integrate their professional and pedagogical and psychological knowledge in the possession of the competencies acquired during the training, are suitable for planning, organising and directing the teaching and learning process of biology and health science for the formation and development of the students' environmentally and health- conscious education, skills, abilities, healthy lifestyle and scientific approach, as well as for continuing their studies in doctoral training.

Physical education teacher training and output requirements:

The aim of the training is school education, as well as the training of teachers capable of teaching subjects related to physiotherapy and health promotion and performing pedagogical research, planning and development tasks in the grades providing preparation for the acquisition of a vocational school teaching and education qualification and in adult education, who possess the knowledge of physiotherapists, health developers, health education, mental health, prevention and rehabilitation based on the complex concept of health, and are able to apply as a model and mediate a healthy lifestyle and health culture in the institutions of the public education system. They are qualified to the rehabilitate children receiving physiotherapy together with their psychological changes, for the organisation, management and conduct of professional classes, as well as for the continuation of their studies in doctoral training. The basic goal is to develop an approach that encourages a healthy lifestyle and the development of physical fitness, and to follow responsible behaviour that pays attention to the harmonious balance of people and their environment.

Part of the physiotherapy and health promotion teacher training and output requirements:

- to convey a physiological and health-promoting approach to all actors in the school, to form attitudes towards a healthy lifestyle in and out of class;
- to prepare school health promotion projects, to initiate physiotherapy and health promotion programmes in the natural environment around the school;
- for the special health promotion of disadvantaged students according to the modern approach to health promotion and physiotherapy;
- physiotherapy and health promotion activities for parents (thematic parenting meetings on drug prevention, sex education, healthy lifestyles and lifestyle management, health-preserving exercise programmes, individual therapeutic consultations), involvement of parents in school health promotion (health day, family day, outing);
- to implement first aid routines (wound care, care for the injured, use of resuscitation techniques in school and in other environments).

Health science and health protection in detail: a modern approach to health. Individual and social factors of health. Possible syntaxes of health promotion: workplace, school, settlement. Scopes and methods of health promotion. The role of health promotion in the way of life. Definition of health psychology, factors that help and hinder its development. Perceptions of health in everyday life. The relationship between health and personality. Stimulus, response, and transactionalist approaches to stress. Coping with stress. Health psychological aspects of the prevention of eating disorders and addictive consumption, especially smoking.

Part of the technics, lifestyle and practical teacher training and output requirements:

Understanding and applying the rules of healthy living, initiative to transform the environment, entrepreneurial competence, knowledge and application of the rules of transport, establishing the experience of creation, conscious application of modelling).

Healthcare teacher training and output requirements:
The aim of the training is the training of teachers capable of teaching theoretical and theoretically demanding professional subjects in school-based and non-school-based vocational secondary school and vocational grammar school education, as well as in vocational trainings specified in the National Qualifications Register, capable of performing the pedagogical tasks of the school, performing pedagogical research, planning and development tasks in healthcare vocational education, and performing healthcare-oriented education and training tasks in adult education in the grades providing preparation for the acquisition of a vocational school teaching and education qualification, as well as their preparation for the continuation of their studies in doctoral training.

During general educational, training, health education and mental health tasks the healthcare teacher is able to recognise, among other things, the negative effects arising from health-damaging environmental and lifestyle (drug user, alcoholic) or poor social situations, is capable of learning about individual and social norms and practices of health preservation and restoration, the planning, elaboration, development and application of prevention programmes in vocational training and, in order to improve the quality of life, to recommend problem-solving, modern life models and lifestyles appropriate to the changed health status with the most effective methods and tools; and during the healthcare vocational training, of the development of professional identification, career socialisation and attitude formation.

- **Higher education trainings**

Higher education reflects the discipline of health preservation and health development in higher education courses that provide specialist care in the fields of healthcare services, social services and even sports science, but the development of a positive attitude towards health and health development is also a common expectation in other training areas.

- **Pedagogue further training programmes**

Crime prevention at schools (competence development and methodological training):
The aim of in-service training is to prepare educators for crime prevention classes and to develop their competencies related to crime prevention in a constructive way, with the help of pedagogical methodology and experiential learning. The participants will be able to apply the age-appropriate thematic processing and methodology of the crime prevention short films. In addition to learning about crime prevention topics, they also receive information on basic legal and criminological knowledge. The educator becomes motivated to use methods that involve children in the learning process, to assist to the development and consolidation of steps leading to individual and group problem solving, and to give confidence to the students by the experiences of the tasks (there is no bad solution, we learn from everything) and knowledge passed on to prevent becoming a victim or perpetrator.

From bullying to crime - Held captive by abuse, aggression, deviance and self- destruction:
Its aim: to train participating pedagogues to

- get to know the psychological factors underlying deviant development, as well as family, sociological and socio-psychological factors,
- get to know the reasons behind each deviance,
- be able to identify intervention points and their own limits of competence in the cases concerned,
- expand their pedagogical tools for dealing with deviant, aggressive or abusive children/adolescents.

Mental Health Basic Training for Pedagogues (MAP):
Its aim: The overall aim is to establish a mental health approach for participants and thereby expand the mental health resources of their place of work.

Specific objectives: participants should know the basic values and approach of mental health and be able to apply it effectively in their daily work. They should be able to handle and solve pedagogical problems with a good mental health approach. Develop the personal and professional skills needed to deal with problems. Their professional identity and professional self-image should become more refined and conscious. They should be able to self-reflect on the forms of work experienced and become more open to professional collaborations in their professional role. They should be aware of the limits of their own 'helper' tasks and responsibilities.

Mental health approach and techniques in shaping the personality of pedagogues and validating competencies:
Its aim: Providing mental health knowledge and expanding the existing knowledge that shape the participants' attitudes and personalities. The programme helps the pedagogue, with sufficient professional self-awareness, to observe and deal with the problems of the child and their family, as well as the difficulties of life management, within the limits of their competence. The course also aims to provide participants with skills in conflict management and case management, as well as in the maintaining of their own mental health.

ENABLE programme:
Further training organised for pedagogues, which is a sensitisation programme designed primarily for secondary school students. Its aims are to adequately address and reduce harassment and aggressive manifestations online and offline, within and outside of the school environment. ENABLE's professional programme is generally based on classroom sessions held by trained pedagogues and school psychologists. The institutions can choose from two modules: both modules consist of 10 lessons, it is recommended to use the framework of the homeroom teacher classes. One of the modules is the SEL module, in which the sessions generally focus on recognising and understanding your own and others' emotions. This can be supplemented with a peer support programme. The other module is the anti-bullying module, in which the sessions are specifically relate to abuse.

The ECSR also requests updated information on available health screening tests. The conclusions specifically mention breast cancer, ovarian, prostate, and colon screening, as well as neonatal screening. The information requested is specified in the previous paragraph.

We provided the data on breast and colon cancer screenings at the measures taken in connection with health promotion, in paragraph 1 (2) of the chapter dealing with Article 11 (1).

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. prevent, as far as possible, epidemic, infectious and other diseases and accidents.

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF,REASONS FOR AND EXTENT OF THE REFORMS

In its annex to this request for a report, the ECSR requests information on measures taken against exposure to air, water and other environmental pollutants, including pollution, emissions, leakages or discharges from active or closed (but not fully decommissioned) industrial sites, slow outflows into the neighbouring environment, nuclear facilities and mines. They also request us to present the measures aimed at tackling health impairment

They also request the presentation of awareness-raising activities relating to general and local environmental pollution, in particular for students and university students.

1. Changes related to waste management

Although packaging waste is not considered to be an environmentally relevant waste in our view, generation and recovery were included in the previous report, therefore the data for the last closed year (2018) reported to Eurostat are provided below:

Rate of generation and recycling of packaging wastes in 2018 (tons)

Material	Generated	Recycled	All use (recycling, energetic- and other use)	Recovery rate	Recycling rate	EU-goals			
						recovery 2012	recycle 2012	recovery 2025	recycle 2030
Glass	141 785	50 069	50 069	35.3%	35 .3%	60%		70%	75%
Plastic	340 621	101 598	192 641	29.8%	56 .6%	22.5%		50%	55%
Paper and carton	522 827	352 766	404 349	67.5%	77 .3%	60%		75%	85%
Aluminium	27 924	n.a.	n.a.	n.a.	n.a.			50%	60%
Steel	60 007	n.a.	n.a.	n.a.	n.a.			70%	80%
All metals	87 931	62 629	62 629	71.2%	71 .2%	50%			
Wood	257 213	62 896	64 875	24.5%	25 .2%	15%		25%	30%
Other	2 078	28	28	1.3%	1 .3%				
TOTAL	1 352 455	629 986	774 591	46.6%	57 .3%	55%	60%	65%	70%

Source: Ministry of Innovation and Technology

2. Radiation protection measures

The control of radioactive effluents to prevent radiation exposure to the public via atmospheric or aquatic pathways is regulated by Decree 15/2001. (VI. 6.) KöM of the Minister for Environment on radioactive discharges to the atmosphere and into waters during the use of atomic energy and on monitoring of the discharge (hereinafter referred to as:

Decree). The Baranya County Government Office is the national competent inspectorate to verify the fulfilment of requirements related to release limits and other environmental radiological requirements contained in regulations applicable to nuclear facilities and radioactive waste disposal sites.

The Decree stipulates that specific users of atomic energy (special facilities, e.g. nuclear installations, uranium mines) shall derive the annual limits of radioactive effluent discharge from the dose constraint for the public approved by the competent authority for radiation safety of the public (Hungarian Atomic Energy Authority; HAEA). Specific users of atomic energy should also develop a regulation for discharge monitoring and environmental monitoring. This regulation and the annual limits shall be licensed by the competent authority for radiological environmental protection (the Baranya County Government Office). Other users of atomic energy (such as hospitals, laboratories) should abide by the general rules prescribed in the Decree.

Additionally, the discharge control of radioactive materials and the safety measures to avoid unintended releases and to protect the public in case of accident shall be included in the license application submitted to HAEA. The safety requirements for the design and operation of nuclear facilities and the minimal content of the license application are detailed in Government Decree 118/2011 (VII. 11.) on the Nuclear Safety Requirements of Nuclear Facilities and on Related Regulatory Activities.

The discharge control and environmental monitoring data shall be reported to the Baranya County Government Office as well as to HAEA. The discharge control actions on-site are supervised by HAEA as well.

Developments in the area of radiation protection:

Pursuant to Government Decree No. 385/2016. (XII. 2.) on defining the public health care tasks of the Capital Government Office and County Government Offices as well as territorial offices, and designating the state health care administration organisation, the official tasks related to patients' radiation protection and monitoring of the radiation hygiene of the public are carried out by the public health departments of the 6 county government offices as regional radiohygiene authorities.

The professional management of the radiohygiene authorities is performed by the National Public Health Centre, Department for Radiobiology and Radiohygiene (hereinafter referred to as: NPHC DRR). NPHC DRR performs professional-methodological, scientific research, training, further training, registration, coordination, expertise activities that support official decision-making in various fields, and the National Radiohygiene Stand-by Service (hereinafter: NRSS) and the National Personal Dosimetry Service (hereinafter referred to as: NPDS) operates within the framework of NPHC DRR as well.

As of 1 January 2016, Government Decree 487/2015 (XII. 30.) on the protection against ionizing radiation and the corresponding licensing, reporting (notification) and inspection system transferred official control of workplace radiation protection and radiation protection of the public from the public health departments of the government offices to HAEA. The registration of workplace units using ionising radiation and their categorisation according to work areas and areas of application were performed in accordance with the national radiation protection regulation, Government Decree 487/2015 (XII. 30.).

From the areas of application, the medical X-ray diagnostics are still dominant in respect of the number of units, the number of employees, and the public exposure of artificial origin. The majority of licensed activities are related to medical use of atomic energy, including generators (medical, dental and veterinary units using X-ray equipment) and radioactive materials (open and sealed sources) as well. 51% of licensed, registered radioactive sources and approximately 93% of licensed, registered generators are used for medical purposes. Since 2016, the competence of the HAEA is also extended to regulatory supervision of particular activities related to radiation protection, e.g. the issuance to permit radiation protection expert activity, the approval of radiation protection training programmes. HAEA also operates a duty service to receiving notifications on incidents or accidents from licensees.

Type of license issued by the HAEA	**Number of licenses issued**			
	2016	**2017**	**2018**	**2019**
application of radioactive material	94	93	93	101
operation of generators	631	658	651	806
operation of equipment containing radioactive material	13	22	28	25
non-located radiation hazardous activity, including maintenance & servicing of generators and other equipment	16	16	7	21
distribution of generators („type license")	40	70	49	25
distribution of radioactive material	-	-	5	1
exemption of certain types of generators	26	34	33	34
program of radiation protection trainings	9	29	27	10
radiation protection expert (RPE) activity	38	23	45	27

Occupational exposure

NPHC DRR operates the central accredited dosimetry laboratory (NPDS) to monitor the workers exposed to external X-ray and gamma radiation by providing and evaluating authorized personal thermoluminescent dosimeters (TLDs) in bi-monthly frequency. The variation of number of monitored workers, their workplaces and investigations initiated by the monitoring results are summarized in the table below. It is important to note that in 2019, there was only one worker, whose radiation burden (50 mSv effective dose) exceeded the annual dose limits, employed in the field of the industrial X-ray radiography.

	2016	**2017**	**2018**	**2019**
number of workers monitored by authorized TLDs	16 744	16 743	15 736	15 554
number of evaluations of authorized TLDs	94 165	94 792	88 558	86 598
investigations triggered by monitoring results exceeding 6 mSv Hp(10):	7	4	6	9
investigations triggered by monitoring results lying between 2	22	27	47	47

and 6 mSv Hp(10):				
extraordinary events identified promptly, which caused radiation burden of workers	5	0	7	6

The table below shows variation of the number of workplaces, where radiation workers supplied by authorized personal dosimeters, and the distribution of these radiation workers among the different sectors:

number of workplaces applying workers monitored by authorized TLDs	1 101	1 078	1 088	1 116
distribution of workers monitored by authorized TLDs health sector: NPP: industry: education: R&D+others:	 51 % 26% 9% 9% 5%	 51% 26% 8% 9% 6%	 57% 14% 9% 10% 9%	 55% 12 % 9% 11% 13%
foreign nationality workers employed via dosimetric certificate	41	80	17	42

The following table shows the number of workers exposed to high level indoor radon and number of evaluations of their occupational doses.

number of workers exposed to high level indoor radon	46	47	39	39
number of evaluations of doses arising from high level indoor radon	313	359	314	264

National Environmental Radiological Monitoring System – NERMS

Government Decree 489/2015 (XII.30) on monitoring radiation conditions relevant for public exposure of natural and artificial origin and on the scope of quantities obligatory to be measured[24] describes the legal background and principles of operation of the National Environmental Radiation Monitoring System (hereinafter referred to as: NERMS), and defines the structure of the monitoring systems and networks as well as the monitoring and reporting requirements (also provides for the radiation monitoring of the human food chain.)

[24] The decree is in accordance with *2000/473/Euratom Commission recommendation of 8 June 2000 on the application of Article 36 of the Euratom Treaty concerning the monitoring of the levels of radioactivity in the environment for the purpose of assessing the exposure of the population as a whole*.)

In Hungary, the NERMS is responsible for the coordination of the environmental radioactivity monitoring (air, soil, plants, surface and underground water) which is carried out by several organisations according to their specific responsibilities described in the Act CXIV of 1996 on Atomic Energy.

In line with Government Decree 489/2015, the national environmental monitoring shall be organised by the NERMS Steering Committee in which ministries and other organisations are represented. The Steering Committee operates under the coordination of the HAEA. The NERMS Steering Committee (chaired by the HAEA) requires radiation monitoring networks belonging to NERMS members to perform the annual environmental sampling and measuring programme.

The NERMS Information Centre (operated by the HAEA) collects and processes the measurement data from the individual monitoring networks, and prepares annual reports based upon these data. The evaluation of the environmental effects in the environment of special facilities (nuclear power plants, training and research reactors, nuclear waste management facilities, etc.) is also obligatory. The authorities should draw up specific regional monitoring arrangements.

Since 2016, the NERMS incorporates the former Joint Environmental Radiological Monitoring System of the Ministry of Human Capacities and the agrarian and environmental protection sector of the Ministry of Rural Development, having competence to perform harmonised measurements and checks within the 30 km radius of the nuclear power plant.

Protection of nuclear and other radioactive materials

Since 2011, when the Government Decree 190/2011 (IX. 19.) on physical protection requirements for various applications of atomic energy and the corresponding system of licensing, reporting and inspection came into force, the HAEA carries out all physical protection-authorisations and inspection procedures, with the help of the Police as a co-authority.

All operations related to radioactive material are subject to a licence according to Government decree 487/2015. (XII. 30.). The current regulations are in compliance of the regulations explained in our previous Report.

In its conclusions of 2017, the ECSR emphasises that as Hungary is not rich in raw materials and energy sources, waste management is considered a particularly important area. Updated information on the relevant policies, the implementation of relevant legislation and any new developments are requested. Data are also requested on the levels of air pollution, drinking water pollution and food toxicity levels.

The circular economy adopted by the European Union and its amendments to the Directive are being transposed into Hungarian law. Hungary's goal is to transition to a circular economy. The circular economy has been a priority area in the European Union since 2014, and then from 2015. As a result of lengthy negotiations, a package of directives to be mandatorily transposed by the Member States entered into force in the summer of 2018. In 2020, together with the transposition, the Government created a waste management strategy and a new national waste management plan in order to reform and strengthen waste management.

1) OTHER QUESTIONS OF THE ECSR

The ECSR requests information on the implementation of measures related to the national conducting, financing and coordination of public-private vaccine research.

As this is an ongoing programme of high national importance, we are unable to provide publicly available information at this stage of the process.

The ECSR also requests that we evaluate the measures implemented in connection with the coronavirus epidemic to reduce the spread of the virus (testing and monitoring, distance and isolation, provision of medical masks and disinfectants etc.) and for the treatment of those infected (adequate number of beds, intensive care units and equipment, expanding medical staff while ensuring healthy and safe work). It also requests the presentation of the measures, which have been taken or are planned to be taken as a result of the evaluation.

1. Restrictive measures imposed by the Government of Hungary

From 8 March:

- Prohibition of the visiting of nursing and social institutions.

From 12 March:

- Closure of higher education institutions, launch of online distance learning.
- Prohibition of indoor events with more than 100 people and outdoor events with more than 500 people.
- Prohibition of all events, restriction of opening hours of restaurants and other shops until 15:00.
- The Government strongly requested people in vulnerable age groups to remain at home. It also promised that the task of caring for people in need would be carried out by the local governments.

From 15 March:

The mayor of local government where the institution provides nursery care or the the kindergarten is located − in the capital, the mayor of the district of Budapest − could order extraordinary break to the institutions provide nursery or kindergarten care.

From 18 March:

- Introduction of out-of-classroom digital education in schools. Based on the needs of the parents, in justified cases, the territorially competent school district centre and the territorially competent vocational training centre organised small group day care for children and students on working days.
- Closure of the country borders to passenger traffic and introduction of the obligation for Hungarian citizens entering the territory of Hungary to undergo a medical examination and, depending on the results, subjecting them to various types of quarantine measures. The decision made it possible to maintain a humanitarian corridor for the passage of foreigners through Hungary.

From 28 March, the Government announced more stringent measures due to the increase of diagnosed infections to over 300:

- A curfew was put into place, people could only leave their homes to work and to obtain the basic necessities. They were required to keep a distance of 1.5 metres in public spaces.
- Persons over the age of 65 were only allowed to visit grocery stores, pharmacies, medical aid stores, and markets between 9:00 and noon, while others were not allowed to visit these places during that period.
- The restaurants were closed to the public and could only serve customers through takeaway or home delivery services.

From 27 April:

- The obligation of people to cover their mouth and nose (wearing a mask, shawl or scarf) when shopping or using public transport.
- Persons showing symptoms were asked to call their family practitioner or the Emergency Medical Service instead of visiting healthcare facilities in person.

From 30 April:

- In light of the health emergency, the mayors were obliged to maintain a duty during the extraordinary break in nurseries and kindergartens for children who were not suffering from infectious diseases and whose parents or guardians requested it due to working or other reason.
- For the period of the the health emergency, every employers had the opportunity to organize day care for the children (from 20 weeks to 14 years of age) of persons engaging in gainful employment for them.

According to the government decree published on 4 May, the closures were relaxed in the countryside (with the exception of Budapest and Pest county), but the rules on social distancing remained in force. Restaurants were allowed to reopen and serve customers in their garden and outdoor areas. Measures relating to the relaxation of the lockdown rules came into force in the capital and Pest county on 18 May, but the 1.5 metre distance still had to be maintained and the obligation to wear a mask remained in force when shopping and using public transport [Government Decree 168/2020 (30 April) on Protective Measures].

From 25 of May, the nurseries, mini nurseries, family and workplace nurseries outside Budapest returned to the usual order. The duty was ceased. From June 2, this was applied to the institutions in Budapest providing nursery care.

On 29 May, restaurants were allowed to serve their customers indoors. Outdoor events were allowed in compliance with epidemiological rules. On 15 June, the Government authorised the reopening of cultural institutions such as libraries, museums, cinemas and theatres.

2. Measures taken to prevent a new wave of the coronavirus epidemic

On 15 July 2020, the Government of Hungary again imposed travel restrictions to prevent the emergence of a new wave of the coronavirus epidemic. The individual countries were classified as ‘red’, ‘yellow’ and ‘green’ based on the severity of the coronavirus epidemic in their country.

The Government of Hungary regularly reviews the classification of each country and adjusts it according to changes in their position with regard to the coronavirus. Freight and carriage

are exempt from the restriction, but may only pass through an officially designated corridor. In their case, health checks will be performed as needed.

In view of the State of Danger ordered by the National Assembly, vocational training institutions largely switched to digital education again from 11 November 2020. The emergency rules applicable to vocational training are laid down in a specific ministerial decision. The call of the Deputy Secretary of State for Vocational Training provides detailed guidelines for the organization of vocational trainings. During this extraordinary situation, the Basic System for Public Education Registration and Study (Köznevelési Regisztrációs és Tanulmányi Alaprendszer; KRÉTA) provides support for home learning, communication with students and parents, as well as online educational processes.

3. Measures for ensuring the necessary physical infrastructure

In addition to importing necessary medical devices mainly from China and Turkey, the production of face masks has started in Hungary which has been designed primarily for the purposes of health care workers.

The government has started to expand hospital capacities both for the isolation of suspected cases and the treatment of COVID-19 patients. In the beginning of March, one of the buildings of a Budapest hospital was repurposed for the isolation of suspected COVID-19 cases. One hospital from the private sector also offered its capacity. A temporary (container) hospital was built in the countryside, and a 330 bed-capacity temporary facility has been established in Budapest. Military installations had also been set up on the yards of hospitals to provide place for the screening of patients prior entering the hospital building.

On 29th March, hospital commanders were appointed to the inpatient care institutions to ensure the availability of the stocks and protective equipment necessary for the maintenance of smooth medical activities and to guarantee the security of supplies and equipment. Furthermore, they can relieve hospital staff from the duties of various statistical data services. Hospital commanders are not allowed to state opinions, make recommendations or adopt decisions on medical issues. Hospital directors are obliged to comply with the instructions of hospital commanders in two areas: issues regarding the security of assets and compliance with disease control regulations.

From the 29th of April the competence of hospital commanders extended not only to hospitals but also to nursing homes with at least 200 beds.

4. Measures for ensuring the necessary workforce capacity

Essential workers (e.g. healthcare professionals) were not allowed to leave the country anymore.

The EMM(I started recruiting volunteer health workers between age 18-49 (e.g. students, health professionals from the private sector) as the health workers above 65 had to be relocated to positions where they could not meet a coronavirus patient.

The operating licence of health workers were automatically prolonged and certain training requirements were allowed to finish via distance learning. Health care workers were able to travel free on regional public transport.

Several services were launched to provide psychological support to frontline health and social workers (Call for Help lines 0-24).

Health workers received a one-time bonus of HUF 500 000 gross.

5. Measures for ensuring effective health care

Most of the hospitals nationwide were deferring elective procedures, including surgeries and examinations, and only performed emergency procedures and interventions, which were necessary to avoid the deterioration of the patients' health status.

GPs do health check by phone and use a short checklist to decide whether it is a suspected coronavirus case or not. If it is, the GPs notify the National Emergency Ambulance Service and ask to take a sample for laboratory testing. If a suspected case of a new coronavirus infection is identified, the patient is isolated immediately. Specifically, new coronavirus patients with severe conditions should be transported to one of the two priority hospitals.

As a result of the coronavirus pandemic, the issue of telemedicine has become a priority, which has expanded the permissible scope of the doctor-patient relationship to allow physicians to conduct remote consultations with patients. The use of already implemented eHealth technologies was encouraged: diagnostic test results and other medical documents can be downloaded from the National eHealth Cloud, which also manages the ePrescriptions.

6. Government IT developments and measures related to the coronavirus

The Ministry of Interior continuously ensures the smooth operation of infrastructure, systems, IT services and applications that are critical for the functioning of the state. Therefore, instructions were issued to the background institutions operating the IT systems to establish safe working opportunities on the one hand, and rapid response units on the other, capable of performing the necessary interventions immediately anywhere in the country to maintain the continuous operation of the systems. As the workload of the administrative system transitioning to the digital channel increased in the recent period, immediate infrastructure expansions were implemented.

The Ministry of Interior implemented electronic administrative developments that not only provide a solution in the context of the coronavirus epidemic, but also provide the conditions for convenient, simple and fast, as well as safe, administration for public employees and citizens. In the situation created by the coronavirus, the digital competence of citizens has made an enormous leap forward, they have become more open to electronic administration methods, which is also supported by the explosive increase in the number of online cases. Developments will, in the long run, fundamentally change the way citizens and agencies work together: people have realised that administration is no longer tied to a specific place and time thanks to electronic solutions.

Koronavirus.gov.hu:
The website provides the public with authentic and up-to-date information on official measures, preventive steps and actions to be taken in the event of a complaint.

Home Quarantine System:
The mobile application, which supports home quarantine control, works by identifying the person obligated to quarantine based on a facial image and its comparison with the central database, as well as by controlling the coordinates of the residence GPS coordinates.

NOVA Mobile System:
Nowadays, police operations are aided by solutions based on artificial intelligence. New developments in the automated NOVA mobile application integrated into police systems support police administrative tasks during on-site controlling of quarantined persons and border crossings. The processes are accelerated and costs are significantly reduced. The NOVA scene investigation system supports the inspections of crime scene investigators and the preparation of reports with intelligent voice recognition and automated reports.

- Between 14 March and 29 May 2020 1 367 658 measures were recorded
- Between 14 March and 29 May 2020 816 577 border crossings were documented
- Between 14 March and 29 May 2020 44 202 quarantines were recorded
- Between 9 April and 29 May 2020 289 420 quarantine controls were performed
- Between 9 April and 29 May 2020 20 522 State of Danger measures were recorded

NOVA Vote application:
An electronic voting application operating on mobiles, which documents the votes of the boards of directors and decision-making bodies of business associations with the help of electronic identification and signature in an authentic manner.

VirusRadar app:
To support the fight against the coronavirus epidemic, the Government of Hungary has developed and deployed a mobile phone contact search application called VirusRadar. The app, which can be downloaded and used by the public on a voluntary basis, records close contacts between people using the app by bluetooth technology built into phones, so that in the event of a person later confirmed to be infected, competent epidemiologists can more effectively trace their past contacts.

Personal eID:
There are numerous situations in life where it is necessary to remotely sign an authentic document, only a few examples of these are urgent declarations, contracts or official announcements. This demand has been further strengthened in the recent period by the State of Danger caused by the epidemic. A solution for this is the e-ID, the e-signature function of which allows you to conveniently manage official matters even from home, with the help of a card reader.

There were 4 886 828 valid e-ID cards with chips in circulation on 30 November 2020, of which about 150 000 already contain valid digital signature certificates, and their number is constantly growing. The use of the e-ID and digital certificates can be further promoted by the new development of the Ministry of Interior: with the help of the new mobile application, electronic documents will soon be authenticated without a card reader, with the NFC function of suitable mobile phones.

ePrescription:
Given the coronavirus epidemic risk, the conditions for redeeming ePrescriptions have been significantly simplified. Generally, after a telephone consultation, the doctors recorded in the IT system the ePrescriptions essential for redeeming the medication and the patient or their relative was able to redeem them in the pharmacy after providing the social security number of the relevant person and proving their identity. Medical aids most commonly redeemed in pharmacies have also become available on ePrescriptions and can be redeemed in pharmacies.

During the State of Danger, the proportion of ePrescriptions issued by doctors for all prescriptions increased from 70% to 90%. The use of ePrescriptions is not expected to decline after the epidemic.

Telemedicine:
In order to effectively deal with the emergency, the ePrescription module of the Electronic Health Cooperation Service Space (hereinafter referred to by the Hungarian abbreviation as: EESZT) has made it possible for patients to avoid having to physically see their family practitioner for the prescription of the medicines necessary for their treatment.

Healthcare institution management system:
In order to eliminate the anomalies in the management of healthcare institutions, the unification and integration of management systems into a central cloud is being performed in close cooperation with the co-ministries, similarly to the already proven municipal ASP system.

Municipal ASP system:
In mid-March, the ASP Centre officially informed the local governments about the possibility of work at home, the ordering of which may be decided by the municipalities in their own competence. Full electronic administration is essentially provided in the Municipal ASP system. An intelligent online form is available for virtually all relevant (130 types of) municipal cases, of which municipalities can publish the forms relevant to their case on the E- Government Portal within their own competence. In the case of free text submissions, the e- paper service is available to customers, and the electronic payment option also become available on the portal immediately prior to the announcement of the State of Danger.

Residential notifications: 1818 government customer service line:
The 1818 national telephone customer service line also manage the coronavirus information line, which performs a wide range of information activities in connection with the State of Danger.

In order to perform the radically increased tasks professionally, significant development goals have been formulated, based on which the introduction of a chat based on video technology and a robot based on artificial intelligence is in progress.

- Compared to the same period in 2019, the number of the total incoming calls increased by 66.86% between March and May 2020.
- In the period between 13 March and 31 May 2020:
  - incoming calls: 161 154 calls
  - average talk time: 4 min 15 sec
  - incoming e-mails: 54 162 e-mails

7. Financing of pandemic control

Adequate funding for health was important to manage the excess demands on the health system.

Until 31th of March, HUF 225 billion has been spent on the procurement of protective supplies, preparations and the construction of an epidemic hospital.

On the 4th of April, by reallocating certain budgeted items, the government established a so-called Pandemic Protection Fund with the framework amount of HUF 663 billion. The fund will cover several items, including the cost of the medical equipment and the one-time bonus for health workers.

Hungary's budget of the year 2021. is built on the Health Assurance and Epidemiological Fund, and on the Economy Protection Fund. The Health Assurance and Anti-Epidemic Fund includes circa 3 000 billion forints (EUR 8.719 billion) in resources for protecting against the epidemic and assuring the functioning of the healthcare system. 138 billion forints (EUR 401 million) in additional funding is being made available for the financing of treatment and prevention services, which will also assure a pay increase for healthcare workers and health visitors.

The ECSR also requests a general overview of the healthcare of prisoners and those otherwise restricted in their free movement, in particular prisons (who is responsible for operation; to which ministry does the responsible person/body report to; other human resources (subordinate levels); practical solutions, medical screening on arrival; access to specialised medical care; infection prevention; mental health care; conditions for community-based care if necessary; etc.)

Pursuant to Act CCXL of 2013 on the Detailed Rules of Execution of Punishments, Measures, Certain Coercive Measures and the Custodial Arrest for Offences, the healthcare of convicts shall be ensured during the execution of imprisonment in accordance with the applicable healthcare, social security and health insurance legislation and the mandatory professional procedures. The Decree of the Minister of Justice 8/2014 (12 December) IM on the Health Care of Convicts and other Prisoners in Penitentiary Institutions also regulates the provision of healthcare, medicine and medical aids to prisoners, and activities related to the protection of mothers and children in the case of women prisoners, and public health and epidemiological activities.

The primary curative and preventive care of the prisoners is provided by a doctor present in all the institutions of the prison service, who meets the basic care conditions of the law and national defence.

During the execution of sentences and measures, the curative and preventive care of the convicted person according to their state of health is provided primarily by the prison institution and the Prison Health Centre (hereinafter referred to by the Hungarian abbreviation as : BVEK) and its sites (District Tököl National Prison Area F and the Chronic Aftercare Unit of the Algyő-Nagyfa Facility of the Szeged Prison [hereinafter referred to by the Hungarian abbreviation as: KUR]) and by the Forensic Psychiatric and Mental Institution (hereinafter referred to by the Hungarian abbreviation as: IMEI). The convicted person is obliged to use this care service. Based on the expertise of the BVEK or the IMEI, prisoners

with a reduced ability to work or in need of long-term care who need permanent medical supervision can be accommodated at the KUR.

If it is not possible for the convicted person to receive adequate medical care (emergency care, outpatient or inpatient specialist care) within the prison service, the prison healthcare body shall ensure that the convicted person receives medical care in the nearest and territorially competent healthcare institution providing the appropriate and mandatory medical care. The prison service has cooperation agreements with the above institutions for the provision of continuous and safe healthcare.

With the exception of cases of an urgent nature or in certain specified cases, the prison doctor examines the prisoner no later than 72 hours after admission, records their medical history, general health, physical status and assesses their ability to work. At the time of admission, the prisoner is also examined from a public health and epidemiological point of view by a health professional, who questions them of their illnesses and their regularly taken medicines. On the recommendation of a doctor, a prisoner whose state of health justifies it, but who does not require hospital inpatient care, shall be placed in the medical unit of the prison.

The prisoners in prisons shall have a lung screening test within 15 days of admission, and once a year thereafter, on the anniversary of the date of their admission. The prison service provides prisoners with the opportunity to participate in organised screening for public health purposes.

In addition, information is requested on community-based mental health care and the reorganisation of large care centres into community-based centres. Statistics are requested on crisis measures introduced in connection with the mental health assessment of vulnerable people, including those affected by poverty and social exclusion, and the unemployed (especially the long-term unemployed). Information is also requested on the measures taken to provide psychological assistance to those in need in view of the situation created by the coronavirus.

The organisational system of mental health care did not change during the reporting period. An exception to this is the child protection area, where the establishment of family and child welfare centres has made the transformation of children's mental health care community- based. Family and child welfare centres are described in more detail in paragraph (3) 1, titled ‘Measures in the field of social services and primary child welfare services’, of the chapter on Article 13 (1).

Measures taken in connection with the coronavirus in vulnerable professions (healthcare, social affairs, law enforcement, prison service, immigration) and in relation to the mental health assessment and treatment of immigrants, asylum seekers and prisoners are covered in the chapter on Article 3.

Information is also requested on the prison healthcare system for convicts who have a mental health problem and, according to experts, do not belong to the prison system in this regard, or who would probably not have become a criminal if they had received adequate care.

The prison service maintains an independent psychiatric institution (Forensic Psychiatric and Mental Institution) within the organisation for offenders for whom the court has ordered

involuntary medical treatment due to a lack of accountability for the abnormal state of mind at the time of committing crime. In their case, the court does not apply a custodial sentence, so their legal position is not the same as that of convicts. Pursuant to the measures implemented by the proceeding court, the Forensic Psychiatric and Mental Institution ensures the forensic psychiatric examinations of these prisoners during criminal proceedings.

The ECSR requests data on drug-related deaths and infectious diseases among intravenous drug users within the community and among prisoners. They request the presentation of the Hungarian policy that includes government responses to drug use and related problems (diversion; education; public health harm reduction approaches, including the use of drugs registered for WHO-registered opioid addiction treatments), in particular the enforcement of the WHO criteria of 'availability, accessibility, acceptability and adequate quality' (WHO 3AQ), the respecting of informed consent, and the avoidance of forced consent (in which case refusal to participate in the withdrawal course would result in a custodial sentence) and consent based on insufficient, inaccurate or misleading information.

Based on the 2019 Annual Report (2018 data) prepared by the National Focal Point for the EMCDDA, the following information is available on the given topic:

1. Trends in drug-related deaths until 2018

Drug-related deaths prior to the release of new psychoactive substances in 2010 were typically linked to opiate use, including heroin use. The annual variance in the number of deaths was mainly due to the change in the purity of street heroin. In parallel with the drastic decline in heroin availability in 2010, the number of deaths associated with the drug has also declined. Between 2010 and 2015, there were several methadone-related cases, but this decreased to one case per year.

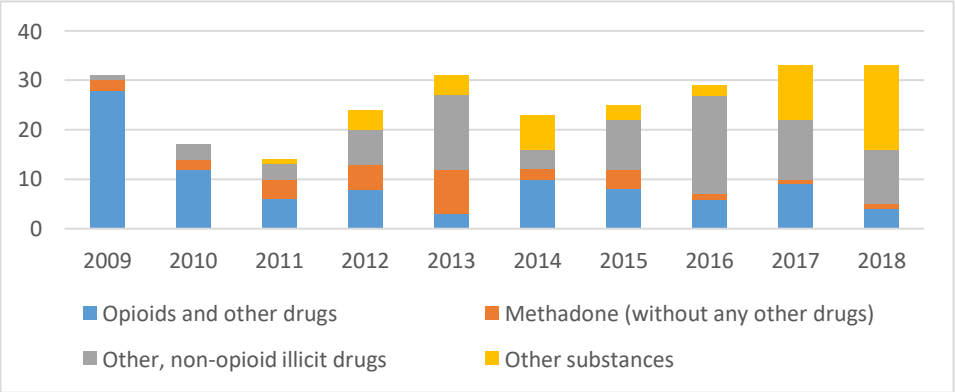
Although the trends can be interpreted to a limited extent due to the low number of cases (20-30 cases per year), the decrease in the age of the deceased and the increase in the number of deaths among women cannot be justified in the domestic data.

Since 2012, the use of new psychoactive substances has also been demonstrated in the samples obtained from the deceased. Initially, mephedrone, later MDPV, pentedrone, and 4- MEC also played a role in several deaths. Several deaths were occasionally linked to the emergence of certain particularly dangerous new psychoactive substances: Consumption of 5- API in 2012 and 4.4′-dimethylaminorex (4.4'-DMAR) in 2013 led to the deaths of several people. In 2014, there were no particularly dangerous new psychoactive substances that would have killed more people, typically α-PVP and synthetic cannabinoids were detectable. In 2015, in addition to pentedron and α-PVP, α-PHP appeared in several samples, while synthetic cannabinoids were not detected. Since 2016, ethylhexedrone has been the most detected NSAID, with 4-Cl-PVP being the second most common cathinone. A synthetic cannabinoid is often identified in samples of the deceased, typically 5F-MDMB-PINACA, secondarily AB-FUBINACA.

The lethal role of new psychoactive substances cannot be clearly defined due to polydrug use and limited pharmacological knowledge. Intravenous drug use and polydrug use were characteristic of drug use patterns in the deceased, benzodiazepines were often detected in biological samples, and in many cases alcohol also played a role.

Overall, the declining trend explained by the decline in heroin was offset by an increase in the number of deaths associated with new psychoactive substances in 2012 and 2013. In 2014, there was a slight increase in the number of deaths associated with opiates, primarily heroin. After 2016, the number of deaths associated with other non-opiate drugs (including new psychoactive substances regulated as psychotropic substances) increased. After 2017, new non-narcotic psychoactive substances became dominant in deaths, which is explained by the stable presence of ethylhexedrone in poisonings.

Breakdown of direct drug-related deaths between 2009-2018 (persons)



Source: Hungarian Reitox National Focal Point 2019

Overall, the shift in drug structure did not cause a change in the number of deaths in 2015, but there was an increase in 2016 and 2017, and stagnation in 2018, with a slow change in the composition of drugs detectable in drug-related deaths.

We do not have detailed statistics on emergency, clinical toxicology care. However, anecdotal information also mentions a high number of healthcare cases related to the use of synthetic cannabinoids in 2016 and 2017.

2. Infectious diseases among intravenous drug users - Main infectious diseases related to drug use - HIV, HBV, HCV

Reported cases:
One of the HIV-infected and AIDS patients in the known risk group belonged to the intravenous drug user risk group (verbal communication Dudás 2019).

HIV/HBV/HCV prevalence among intravenous drug users:
In the 2018 national HIV/HCV biobehavioural study conducted in collaboration with the National Focal Point and the National Public Health Centre[25] (Tarján et al. 2019), 332 (75.5%) of the 440 samples were male and 108 (24.5%) were female. Of the three age groups (<25, 25-34, 34<), those over 34 years of age accounted for 47% of the study participants, those between 25-34 years of age accounted for 33%, and those under 25 years of age accounted for the smallest group (20%).

[25] HIV/HCV screening from a biological sample (saliva, blood) and a questionnaire examination related to the associated substance use pattern and risk behaviours.

HIV:
Based on the 2018 national HIV/HBV/HCV prevalence study, one man from the 439[26] test subjects (0.2%) was HIV-positive. The man was over 34 years old and had also injected in the past four weeks. During the survey, he declared himself HIV negative.

HBV:
HBV was not tested in the 2018 study. Based on the 2015 national HIV/HBV/HCV prevalence study, hepatitis B surface antigen was detected in 13 of the 596 test subjects (2.2%). Of the 13 individuals, 12 were also infected with HCV.

HCV:
The HCV tests showed antibodies to the hepatitis C virus in 191 test subjects (44%)[27]. The HCV infection in men was significantly higher than in women (men: 47% and women: 34%). The HCV prevalence values in men aged between 25-34 years of age and in men older than 34 years of age exceeded the average prevalence value. In addition, it is important to mention that HCV prevalence was 40% among young men under 25 years of age.[28]

Drug policy and main harm reduction objectives:
The National Anti-Drug Strategy, which entered into force in 2013, emphasises the importance of harm reduction activities in music and dance venues in the Health Promotion and Drug Prevention chapter: i.e. involving entertainment venues in the safer entertainment of young people, creating safe entertainment conditions by training the staff of entertainment venues, providing support services at the entertainment venues and consistent monitoring of related requirements.

The chapter titled 'Treatment, care, recovery' of the Strategy emphasises that harm reduction programmes are also part of the treatment chain operating on the basis of a recovery-centred approach, signifying the first stage thereof. In connection with the operation of the services, it sets out the following objectives: to find secret drug users, which also provides an opportunity for their treatment; reducing the spread of infectious diseases and the risk of crime; and the prevention of deaths resulting from an overdose. At the same time, the Strategy emphasises the importance of integrating harm reduction programmes into recovery-focused complex programmes and working closely with medical and rehabilitation institutions. In Hungary, the Act on Social Administration and Social Services regulates the operating conditions and service types of low-threshold services.

Diversion:
Act C of 2012 on the Criminal Code (hereinafter: 'Criminal Code') also regulates the cases and conditions of diversion from criminal proceedings [Section 180 of the Criminal Code], in accordance with the system of dogmatics of Hungarian criminal law, as grounds on which criminal offences may be extinguished. According to the wording of the Act, person who cultivates, produces, acquires or keeps a small quantity of drugs for his personal use or consumes drugs shall not be liable to punishment if he or she "presents a document before a first instance conclusive decision is adopted as confirmation that he/she received continuous medical treatment for drug addiction or other treatment for drug use or he/she attended another preventive-informative service for a period of at least six months". 'Diversion' can also take place at the prosecution and court phases of criminal proceedings. A person is

[26] From the entire sample (440 people), the HIV rapid test result for 1 person was missing.
[27] From the entire sample (440 people), the HCV rapid test result for 1 person was missing.
[28] Source: Tarján et al. 2019

deprived of the possibility of diversion if they have participated in diversion or have been held criminally liable for drug trafficking or drug possession within the two years preceding the committing of the offence. There is no possibility for diversion in the case of acts related to new psychoactive substances.

In 2018, 62 service providers out of 76 reporting treatment units, excluding prison treatment units, reported the admission of a new psychoactive drug-using patients to outpatient care. 91.8% (4 325 people) of all patients (4 709 people) started treatment with a specialised outpatient provider, low-threshold provider, or general mental health provider. Of the 4 325 people, 3 489 people (80.7%) entered treatment for diversion, including 2 452 people (56.7%) for prevention and awareness-raising services. A further 114 patients received care as a prisoner in a prison institution as part of an intervention provided by an external service provider. All 114 patients started treatment within the framework of a diversion.

In 2017, 67 service providers out of 86 reporting treatment units, excluding prison treatment units, reported the admission of a new psychoactive drug-using patients to outpatient care. 90.7% (4 365 people) of all patients (4 813 people) started treatment with a specialised outpatient provider, low-threshold provider, or general mental health provider. Of the 4 365 people, 3 173 people (72.7%) entered treatment for diversion, including 2 042 people (46.8%) for prevention and awareness-raising services. In 2017, 146 prisoners began treatment (134 men, 6 women, 6 genders unknown) for a drug problem. Of the prisoners, 134 were treated as part of a diversion and 12 were treated independently of a diversion.

In 2016, 62 service providers out of 78 reporting treatment units, excluding prison treatment units, reported the admission of a new psychoactive drug-using patients to outpatient care. 88.2% (3 616 people) of all patients (4 098 people) started treatment with a specialised outpatient provider, low-threshold provider, or general mental health provider. Within the framework of outpatient care, 2 510 people entered treatment due to diversion (excluding those treated in prisons). In 2016, 128 prisoners began treatment for a drug problem, all as part of a diversion.

Replacement therapies:
In terms of treatment options, a special treatment programme available to opioid users is opiate replacement treatment. Within the framework of which, methadone and a buprenorphine/naloxone combination are the available medicines. In 2015, 669 people participated in opiate replacement therapy in Hungary, while in 2018, a total of 650 people participated in it.

3. Special rules for members of the professional staff of the Hungarian Armed Forces

The main directions of drug prevention activities performed within the organisational framework of the Hungarian Defence Forces are set out in the currently effective Parliament Resolution 80/2013 (16 October) OGY on the National Anti-Drug Strategy 2013-2020, and the guidelines contained in the draft theoretical and practical approaches to the national drug strategy and the action programme for its implementation.

From a professional point of view, of the practical objectives included in the three areas of intervention of the National Anti-Drug Strategy, the drug prevention activities of the Hungarian Defence Forces concerning primary and secondary prevention are related, within

the area of Health Development and Drug Prevention (V.), to the scope of activities of the Occupational scene (V.2.1.8.). The Hungarian Defence Forces place a great emphasis on prevention. The dangers of the use of drugs and other harmful substances are presented to the staff in the form of cognitive knowledge transfer, informative publications and visual illustration. Within the framework of the Health Preservation Programme of the Hungarian Defence Forces, the aim of which is to establish and develop the health-conscious behaviour of the staff in accordance with the priorities defined in the National Public Health Programme, the risks of legal and illegal substance use are treated as a priority topic.

Article 12
Right to social security

In order to ensure the effective exercise of the right to social security, the Parties undertake to:

1. establish or maintain a social security system;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF,REASONS FOR AND EXTENT OF THE REFORMS

1. Amendments affecting Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services (hereinafter: former Social Security Act) and the amendments concerning the social contribution tax replacing the social security contribution payable by the employer from 2012:

- **2016**

Law enforcement and defence health impairment allowance and wage supplement:
As part of the law enforcement and defence career model, implemented from 1 January 2017, the Government has introduced the law enforcement and defence health impairment allowance and wage supplement. The law enforcement and defence health impairment allowance and the wage supplement are considered wages by the Act CXVII of 1995 on Personal Income Tax, therefore, as part of the consolidated tax base, they qualify as taxable income. The recipients of the law enforcement or defence health impairment allowance are entitled to healthcare services, with the health service contribution paid by the state, given that the recipients of the allowance become members of the national risk community. In addition, the deduction of pension contributions from the allowance is compulsory, so the period of payment of the allowance is taken into account as active service when determining the pension.

Public project evaluation legal relationship:
The public project evaluation legal relationship was established by Act XXXIII of 2016 on the Public Project Evaluation Legal Relationship and the Amendment of Certain Related Acts, which entered into force on 6 May 2016. On the basis of the public project evaluation legal relationship the pursuit of gainful activity takes place domestically, and therefore, from 16 June 2016, an insurance obligation arises from it [Section 5 (1) k) of theformer Social Security Act]. Remuneration received based on the public project evaluation legal relationship is thus subject to a 10% pension contribution and an 8.5% health insurance and labour market contribution. The payer is required to pay a 27% social contribution tax on the remuneration.

From 26 July 2018, a person in a state project appraisal relationship is insured only if his or her contribution income from this activity, which forms the contribution base for the current month, reaches thirty percent of the minimum wage or one-thirtieth of it for calendar days.

- **2017**

Increase in the amount of health service contribution:
From 1 January 2017, the monthly amount of the health service contribution increased from HUF 7 050 to HUF 7 110 [Section 19 (4) of the former Social Security Act]. Any person who qualifies as a resident who is not insured and is not entitled to healthcare on other grounds (e.g.: minor, socially deprived, retired, receiving child care allowance) [Section 39 (2) of the former Social Security Act], as well as private entrepreneurs engaged in auxiliary activities and business partnerships on behalf of any business partner who is engaged in auxiliary activities [Section 19 (4) of the former Social Security Act], are obliged to pay a health service contribution.

By paying the contribution, the private individual becomes entitled to receive healthcare services (e.g., family practitioner care).

Changes in the rate of social contribution tax
The rate of social contribution tax levied on employers was reduced from 27% to 22% from 1 January 2017, to 19.5% from 1 january 2018 and to 17.5% from 1 July 2019.

- **2018**

Increasing the amount of health service contribution
In view of the increase in the consumer price index, the amount of the health service contribution increases from 1 January 2018, therefore in 2018 the amount of this contribution was HUF 7 320 per month, amounting to HUF 244 per day. Thus, a Hungarian resident who is not insured and is not entitled to health care services on other grounds (e.g.: minor, receiving child care allowance, socially deprived) must pay a monthly health care contribution of HUF 7 320, amounting to HUF 244 per day [Section 19 (4) of the Old Tbj.].

In addition to the above, private entrepreneurs engaged in auxiliary activities, and business partnerships, on behalf of any business partner who is engaged in auxiliary activities, are obliged to pay health care contributions.

The amount of the health care contribution paid by the central budget per person for those belonging to the national risk community does not change (HUF 7 320 per month) [Section 26 (5) of the former Social Security Act].

- **2019**

Exemption of the employment of retired employees from public charges:
From 1 January 2019, an employee who receives a pension in their own right and is employed in accordance with Act I of 2012 on the Labour Code (hereinafter: Labour Code) is exempt from paying the 10% pension contribution and the 4% health insurance contribution in kind. Therefore, only personal income tax is payable on wages. At the same time, the employer is exempted from the social contribution tax they are liable to pay in respect of their employment, which is 19.5%. Furthermore, in view of this employment relationship, there is no obligation to pay a vocational training contribution. With this measure, the employment of a person receiving a pension in their own right will be free of public charges, with the exception of personal income tax. [Pursuant to Sections 5 and 25 of the former Social Security Act, and the new Act LII of 2018 on Social Contribution Tax]

At the same time, it is worth drawing attention to the fact that in the absence of payment of contributions, these persons are not entitled to accident benefits, i.e. they cannot claim accident health services, accident sick pay or accident allowance. [Section 15 of the former Social Security Act]. Furthermore, it should be mentioned that while an entrepreneur engaged in auxiliary activities is exempted from paying the health care contribution, if they were employed for 36 hours a week, this favourable rule will no longer apply to a pensioner employed under the Labour Code, taking into consideration the fact that non-contributory legal relationships should not be taken into account in the application of favourable rules [Section 37/A of the former Social Security Act].

Increasing the amount of health service contribution:
In view of the increase in the consumer price index, the amount of the health service contribution increases from 1 January 2019, therefore in 2019 the amount of this contribution was HUF 7 500 per month, amounting to HUF 250 per day. Thus, a Hungarian resident who is not insured and is not entitled to health care services on other grounds (e.g.: minor, receiving child care allowance, socially deprived) must pay a monthly health care contribution of HUF 7 500, amounting to HUF 250 per day [Section 19 (4) of the former Social Security Act].

The amount of the health care contribution paid by the central budget per person for those belonging to the national risk community does not change (HUF 7 320 per month) [Section 26 (5) of the former Social Security Act].

Reduction of the pension contribution payable under the agreement:
From 1 January 2019, the pension contribution payable in the case of an agreement for the purpose of acquiring pensionable active service and pensionable income and for the purpose of acquiring only active service has been reduced from 34% to 24%. This is due to the fact that the rate of social contribution tax is currently constantly decreasing in the case of the rate previously including the pension contribution to be paid by the private entrepreneur and the employer, so it is justified to reduce the rate of the pension contribution payable under the agreement. [Section 34 (1) - (5) of the former Social Security Act]

Reduction of the social contribution tax rate:

From 1 July 2019, the social contribution tax was reduced by 17.5%.

adoption of a new Social Security Act
On 11 December 2019, the Parliament passed Act CXXII of 2019 on Entitlements to Social Security Benefits and on Funding These Services (hereinafter: new Social Security Act), which re-regulated, without significant changes, the bases of social security and the obligation to pay contributions. The new regulation entered into force on 1 July 2020.

2 Tax and contribution related measures adopted due to the coronavirus epidemic

o First half of 2020

The purpose of Government Decree 61/2020 (23 March) on the Detailed Rules on Taxes Relating to Government Decree 47/2020 (18 March) on Immediate Measures Necessary for

Alleviating the Effects of the Coronavirus Pandemic on National Economy and on Certain New Measures (hereinafter: Decree) was to exempt all economically affected employers in the beneficiary sectors from all public charges of employers and for the employees to pay less individual contributions during the transitional period affected by the coronavirus. For employees employed in the beneficiary sectors under the Regulation (e.g.: taxi passenger transport; hospitality; creative, arts, entertainment, sports, leisure activities; travel agency, tour operator), instead of the general rules (10% pension contribution and 8.5% health insurance and labour market contribution payment obligation), only a 4% health insurance contribution in kind must be paid for the income on which the contribution is based, but it must be paid only up to a total of HUF 7 710. Private entrepreneurs and business partnerships pursuant to the Old Tbj. and the new Social Security Act may also apply this favourable contribution provision instead of the general contribution rules applicable to them. These favourable contribution rules could only be applied to the contribution obligations for March, April, May and June 2020. As a guarantee rule, it was included in the provisions that this favourable contribution payment does not affect the right of insured persons to social security and labour market benefits and the amount of benefits. A payer belonging to the beneficiary sectors is exempt from paying social contribution tax with regard to the employment of a natural person under an employment relationship. This exemption also applies to private entrepreneurs and business partnerships according to the former and new Social Security Act. The social contribution tax exemption was applicable only to the tax liability for March, April, May and June 2020.

Section 20 of Government Decree 140/2020 (21 April) on Tax Facilities Necessary to Mitigate the Economic Impact of the Coronavirus Pandemic within the framework of the Economic Relief Action Plan (hereinafter: Government Decree 140/2020) stipulated that during the period of the State of Danger an employee on unpaid leave due to an emergency is entitled to healthcare. In this case, from 1 May 2020, until the 12th day of the month following the reference month, the employer determined, declared and paid the health service contribution for the employee. Furthermore, at the request of the employer, the National Tax and Customs Administration allowed the amount of the health service contribution determined and declared as above to be paid by the employer until the 60th day after the end of the State of Danger [Section 20 of Government Decree 140/2020].

3. Changes implemented by Act CXXII of 2019 on the Eligibility for and Funding of Social Security Benefits

- **2020**

Entry into force of the new Social Security Act from 1 July 2020:
The new Social Security Act, which replaced the former Social Security Act− and also the Government Decree 195/1997 (5 November) on the Implementation of Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Serviceswhich implementing it − entered into force on 1 July 2020.

Introduction of social security contributions:
From 1 July 2020, the 10% pension contribution and the 8.5% health insurance and labour market contribution, further subdivided into 4% in-kind health insurance, 3% cash health insurance and 1.5% labour market contributions, was replaced by a single social security contribution of 18.5%. This step brings about a significant reduction in tax administration, as it makes it considerably easier to file a monthly tax and contribution declaration for insured

persons and to pay the contribution. Furthermore, this increases the amount of the family tax benefit, as it can be claimed up to 18.5% instead of the previous 17% (the benefit could not be claimed from the labour market contribution).

In addition to the contribution rate of 18.5%, only the 10% pension contribution rate remains from the previous regulation, which is levied on certain benefits (e.g.: care allowance, childcare benefit), so that the duration (as an active period) and the vaue (for determining the value of the pension) of these benefits can be taken into account when determining the retirement benefit. In addition, there is a 10% pension contribution payment obligation for those who are employed by the church, for recipients of job-seekers' allowance and for members of business partnerships in an employment relationship.

Exemption of working pensioners from all forms of contributions:
From 1 January 2019, employees who are pensioners in their own right will not be required to pay an individual contribution (the 10% pension contribution and 4% health insurance contribution in kind have been abolished), and the employer will not be liable to pay social contribution tax. From 1 July 2020, no contribution obligation will arise in the case of other gainful activities, which otherwise result in the obligation to pay contributions, if it is performed by a retired person (e.g.: in the case of civil servants, private entrepreneurs and business partnerships, in connection with an employment relationship). Accordingly, pensioners in their own rights performing gainful activities are not entitled to accident benefits (e.g.: accident sick pay) and pension increases.

Introduction of a minimum contribution base for employment:
In the case of employed insured persons, the contribution shall continue to be paid on the income actually acquired, forming part of the tax base of independent and non-autonomous activities included in the consolidated tax base under Act CXVII of 1995 on Personal Income Tax, with the change that the contribution base may not be less than 30% of the minimum wage. Accordingly, the social contribution tax base has also been determined, i.e. in such cases the social contribution tax must also be paid after at least 30% of the minimum wage. However, the rule on the minimum contribution base does not apply if the insured person receives a statutory benefit (e.g.: care allowance, child care allowance, child-care assistance). Furthermore, in the case of legal relationships arising and ending during the month, as well as if the employee received sick pay or accident sick pay in the given month, the minimum contribution base must be applied proportionally [Section 27 (2)-(3) of the new Social Security Ac].

Reduction and standardisation of the contribution base for insured private entrepreneurs and business partners:
The minimum, increased, contribution base paid by private entrepreneurs and business partners (if the flat-rate income or the entrepreneurial exemption does not reach this amount) is uniformly the minimum wage from 1 July 2020. Until 30 June 2020, private entrepreneurs and business partners had to pay pension contributions after at least 100% of the minimum wage, and health insurance and labour market contributions after at least 150% of the minimum wage. The obligation to pay social contribution tax does not change in their case, it still has to be paid after 112.5% of the minimum wage.

Changes affecting certain special legal relationships and incomes:
In the case of other employment relationships for remuneration [Section 6 (1) f) of the new Social Security Ac], the uniform contribution obligation of 18.5% is levied on the income

forming the contribution base from this gainful activity. This is an increase of 1.5% in the contribution burden, but at the same time, it results in an entitlement to labour market benefits.

In the case of primary producers, this group of insured persons is also burdened by the uniform contribution rate of 18.5%, which results in a 1.5% increase in the contribution burden and entitlement to labour market benefits, however, in order to avoid an increase in the burden, the amount of the contribution base was set at a lower rate (instead of the minimum wage, at 92% of the minimum wage). Smallholders also pay social security contributions (instead of the previous 14% contribution payment obligation), but the amount of the contribution base was set at a lower rate (15% of the previous year's income instead of 20% of the previous year's income).

2) ANSWERS TO THE QUESTIONS OF THE ECSR

The ECSR previously considered insufficient:

- ***the minimum old-age pension,***
- ***the pre-retirement job-seekers' allowance, and***
- ***in some cases, the rehabilitation and disability benefits***

therefore, has found the non-compliance of Hungary with this paragraph. It also points out that the payment period for the unemployment benefit, which ranges from 36 to 90 days, is too short compared to the required contribution period.

1. Level of care for people with changed working capacity

The transformation of health-based benefits on 1 January 2012 was aimed at creating a uniform, transparent and cost-effective system that would strengthen employability. The main goal of the transformation was to ensure that anyone who is able to earn a living for themselves and their families from gainful activities rather than receiving cash benefits, should do so. Therefore, with the transformation of cash benefits, the system of occupational rehabilitation services and benefits also changed.

According to the previous regulation, the minimum and maximum amount of benefits had to be determined on the basis of the 2012 minimum wage, therefore the value of the minimum and maximum benefits continuously decreased compared to the benefits established in 2012.

In order to create the value resistance of the minimum and maximum amounts, the amendment sets their projection base, the basic amount in a fixed amount (HUF 94 500, i.e. the amount of the projection base on 1 January 2016, increased by the pension increase of HUF 93 000 in 2016 [1.6%]), and provides that the basic amount is to increase in line with the increase in pensions.

In compliance with the rules of raising old-age pensions, disability and rehabilitation benefits, increase by the same proportion as the pension increase, in line with the basic amount taken into account when calculating the amount of benefits, thus helping to maintain the value of the benefits.

2. Level of pre-retirement job-seekers' allowance

According to the position of the Hungarian Government, the support of registered job-seekers can be managed dynamically, primarily by supporting employment or by involving them in active labour market instruments. As a result, the extension of the period of payment of the unemployment benefit is not on the agenda. In contrast, new constructs based on active labour market policy solutions are constantly emerging. These include the job protection wage subsidy for the protection of jobs in the first period of the closure due to the coronavirus, available from 16 April 2020, and the job-creating wage subsidy available from 18 May, after the reopening.[29]

3. Minimum old-age pension

The amount of the minimum old-age pension did not change during the period under review. At the same time, due to the low amount of the Hungarian pension, it is very rarely necessary to apply it when determining old-age pensions. This is mainly due to the fact that even with the minimally required 20 years of service at the minimum wage level, a starting pension higher than the minimum pension can be established.

The data on the establishment of the minimum pension also support this: in the 23 years from 1997 to 2019, a total of 24 190 people were set the minimum pension amount as a starting pension. At the beginning of the period, until 2003, the frequency was 1 273 and 2 835 per year, then until 2013, the number of people set the minimum pension amount varied between 200 and 500 per year, and starting from 2014, with the exception of 2016 (287 people), the number of people set the minimum pension amount remained below 200. Adjusting the above figure with mortality losses, we find that since 1997 there might currently be approximately 17 470 people living on the minimum old-age pension, which is less than 1% of the total headcount (hovering around 0.6%).

Only the initial amount of the minimum old-age pension remains unchanged, in the years following the establishment the amount increases in accordance with the current pension increases. Thus, for example, between 2002 and 2020, the amount of the minimum pension increased 2.33 times (from HUF 20 100 per month to HUF 46 980 per month) with interim increases, and between 2008 and 2020, the pension established in 2008 (HUF 28 500/month) increased to HUF 41 837, with is equivalent to a 47% increase.

According to the indicators presented above, the performance of the Hungarian pension system can be said to be good in international comparison. Tt is in line with the EU averages or better, and its low frequency does not justify its changing for the time being.

Social security pensions are based primarily on the principle of insurance, and this is also reflected in the fact that the amount of the pension must replace the claim on which the insured person paid pension contributions during the period of active employment and reflect the length of the contribution period. Insurance performance accordingly expresses the extent to which and for how long the insured has contributed to the maintenance of the pension system. At the same time, in addition to the strict insurance principle, the system also contains

[29] https://nfsz.munka.hu/

elements of solidarity, but these elements may prevail in addition to the priority of the insurance principle. Solidarity elements are for example:

- the length of service scale, which requires a short period of service to be taken into account at a higher rate, so that those who have been able to achieve a shorter period of service in a fragmented career receive a higher rate of average earnings as a pension,
- degressivity results in an internal redeployment from higher earners of contributors to those with lower insurance performance,
- an additional solidarity element is that recipients of long-term income replacement benefits should not take into account the amount of the benefit when calculating the pension base, but earnings should be averaged (irrespective of the amount of the benefit), or the minimum wage should be taken into account, whichever results in the higher pension.

Experience has shown that the minimum old-age pension is rarely applied in practice when setting pensions, and those receiving low pensions do not form a homogeneous group. Low pensions can arise for several reasons. For example, if:

- the applicant's length of service was short and/or they had low earnings (for example, worked part-time);
- the applicant is only entitled to a partial pension (certified 15 to 20 years of service);
- the applicant has acquired pension rights in several states, therefore they are only entitled to a part of their pension under the Hungarian pension scheme, because, for example, they have only completed one or two years of service in Hungary; these can be extremely low amounts (for example, up to a few hundred forints).

In the Hungarian pension scheme, the social elements prevail in addition to the priority of the insurance principle. In addition, for people with a low pension, there is currently the possibility, examining their individual circumstances, of an exceptional pension increase on equitable grounds and the payment of a one-off benefit. This can be determined at the request of the pensioner. The amount of the equitable pension increase is not just temporary assistance, because it is included in the amount of the pension. The January increase of the following year and, if justified, the November pension supplement increase this already increased amount.

According to general assessments and based on the indicators presented below (pp. 165-167, the performance of the Hungarian pension system can be said to be good in international comparison, it is in line with the EU averages or slightly more favourable, and the low frequency of pension minimums does not justify the change.

In addition, it requests information on whether the pre-retirement job-seekers' allowance, like the unemployment benefit, has a maximum payment period.

The pre-retirement job-seekers' allowance can be paid until the time when old-age pension entitlement is obtained or until the entitlement to benefits for persons with reduced ability to work is acquired, therefore, there is no maximum payment period set for a specific period of time.

3) RELEVANT DATA, STATISTICS

The ECSR requested information on the percentage of recipients of healthcare, maternity and unemployment benefits, pensions and occupational healthcare in relation to the total active population. It also requested information on the minimum amount of sick pay, wages during sick leave and any other related benefits.

1. Proportion of healthcare recipients

Given that the concept of the active population has not been defined, we have attached the number of persons who have visited family practitioners or specialist care providers in the publicly funded care system in a given year, broken down by age group.

YEAR	USERS' SOCIAL SECURITY IDENTIFIER	ALL SOCIAL SECURITY IDENTIFIERS, whose holders had entitlement for at least one day in a year
2016	8 942 339	10 046 642
2017	8 891 941	10 016 060
2018	8 843 782	9 991 320
2019	8 804 532	9 953 739

Source: National Health Insurance Fund

YEAR	AGE GROUP	USERS' SOCIAL SECURITY IDENTIFIER	ALL SOCIAL SECURITY IDENTIFIERS, whose holders had entitlement for at least one day in a year
2016	0 - 4	447 457	465 255
2016	5 - 9	458 707	476 183
2016	10 - 14	465 909	486 811
2016	15 - 19	464 337	495 643
2016	20 - 24	486 270	578 358
2016	25 - 29	513 430	628 987
2016	30 - 34	512 907	637 451
2016	35 - 39	638 264	787 216
2016	40 - 44	703 583	857 338
2016	45 - 49	622 247	739 832
2016	50 - 54	527 544	607 407
2016	55 - 59	569 625	634 159
2016	60 - 64	685 953	745 324
2016	65 - 69	569 498	606 730
2016	70 - 74	446 026	466 968
2016	75 - 79	346 069	359 543
2016	80 +	449 201	473 437
2016	Not	35 312	

	classifiable		
2017	0 - 4	449 324	468 520
2017	5 - 9	451 727	469 543
2017	10 - 14	465 496	487 676
2017	15 - 19	459 542	489 849
2017	20 - 24	465 172	562 462
2017	25 - 29	507 021	624 815
2017	30 - 34	503 278	630 043
2017	35 - 39	601 125	742 807
2017	40 - 44	718 599	879 714
2017	45 - 49	625 464	745 398
2017	50 - 54	546 595	631 670
2017	55 - 59	546 687	610 465
2017	60 - 64	678 819	737 126
2017	65 - 69	574 298	612 849
2017	70 - 74	452 387	474 075
2017	75 - 79	357 378	370 976
2017	80 +	453 801	478 072
2017	Not classifiable	35 228	
2018	0 - 4	451 057	471 376
2018	5 - 9	442 156	460 617
2018	10 - 14	469 002	492 395
2018	15 - 19	455 370	487 468
2018	20 - 24	447 915	547 654
2018	25 - 29	500 627	620 063
2018	30 - 34	501 416	630 023
2018	35 - 39	565 410	702 868
2018	40 - 44	725 255	891 121
2018	45 - 49	623 638	748 424
2018	50 - 54	567 718	659 370
2018	55 - 59	531 288	595 345
2018	60 - 64	652 676	709 469
2018	65 - 69	589 568	629 790
2018	70 - 74	463 803	486 139
2018	75 - 79	364 202	378 057
2018	80 +	456 831	481 141
2018	Not classifiable	35 850	
2019	0 - 4	450 760	467 199
2019	5 - 9	439 379	458 113
2019	10 - 14	469 208	493 879
2019	15 - 19	453 985	487 247
2019	20 - 24	427 846	529 745
2019	25 - 29	494 591	613 282

2019	30 - 34	501 146	629 859
2019	35 - 39	535 911	668 185
2019	40 - 44	701 718	865 600
2019	45 - 49	646 731	777 073
2019	50 - 54	589 176	685 310
2019	55 - 59	521 803	586 166
2019	60 - 64	610 571	663 932
2019	65 - 69	616 307	657 245
2019	70 - 74	470 355	493 175
2019	75 - 79	377 370	391 742
2019	80 +	460 506	485 987
2019	Not classifiable	37 169	

Source: National Health Insurance Fund

2. Proportion of recipients of pension-type benefits

The percentage of pension recipients in relation to the total number of the active population (people aged 20-64) in 2019 was 34%. There was no significant change in the number of old-age pensioners in the period under review (for demographic reasons, a more dynamic increase in the number of pensioners is expected, but the increase in the age limit until 2022 is currently delaying this). The number of people receiving a widow's pension as a main benefit and survivor's benefits show a decreasing trend in the period under review. The number of insured persons developed in a balanced manner.

A similar picture emerges from the data on the relative median income of those over 65 years of age. The median income of the elderly is roughly equivalent to that of the active age. Between 2016 and 2018, this indicator is 5-7 percentage points higher than the EU average and, although declining, in 2019 it remained around the EU average.

Number of insured people, thousand persons

Name	2016	2017	2018	2019
Average number of insured persons**	4 217.0	4 240.9	4 226.6	...

** average daily headcount

Source: Hungarian State Treasury, pension sector

A few importand data on pensions*, thousand persons

Name	**2016**	**2017**	**2018**	**2019**
Monthly average number of old-age pensioners	2017 9	2024 6	2035 6	2034 1
Number of new pension findings on the recipients' own rights	103.9	76. 6	82.3	115.3
Number of persons receive widow's pensions as main benefit	81.5	75.2	69.0	63.0
Number of persons receive widow's pensions as	650.7	647.7	644.8	639.6

additional benefit				
Number of persons receive orphan's pensions	67.0	63.8	60.3	57.2

Source: Hungarian State Treasury, pension sector

According to the data of the Hungarian Central Statistical Office of Hungary, at the beginning of 2019, the pension payer disbursed a pension or some other benefit to more than a quarter of the population, and every fifth person within the total population receives an old-age pension.

The number of old-age pensioners did not change significantly compared to previous years, their share in the population was around 21%. 62% of recipients of pensions and other benefits were women, with a higher proportion than men among most types of benefits, standing out particularly in the case of widows' pensions received as the main benefit (94%).

Almost the entire elderly population, and 8% of those under 64, received benefits. At the beginning of 2019, there were 2 million people of retirement age, i.e. people aged 64 and older, living in Hungary, 92% of whom received an old-age pension, and another 5% received an old-age widow's pension, disability or other benefits.

The average age of women at the time of their retirement (61.2 years) was almost 3 years lower than that of men (63.8 years). Thus, women retire at an average age of 61 and men at 64.

The earning capacity of the Hungarian old-age pension is considered high. In January 2019, after the pension increase, the 2.6 million beneficiaries received an average of HUF 122 614 in total benefits (the total amount of basic and supplementary benefits). Within this, old-age pensioners received an average of HUF 134 947 per month. The old-age pension amounted to 59% of the average net earnings in January.

The coverage of the system is also favourable, which is also indicated by the fact that the eligible age group has received a very low proportion of old-age benefits − which replaces or supplements the low level pensions − in recent years (6 958 in 2016, 6 596 in 2017 and 6 757 in 2018).

According to the available data for the comparison of the earning capacity of old-age pensions at European level (this aggregate replacement rate is the quotient of the median individual gross pension of the 65-74 age group and the median gross earnings of the 50-59 age group), the Hungarian rate decreased from 67% in 2016 to 64%, in 2018 to 59%, and then in 2019 to 55%, but even so it was above the EU average, and in 2019, around the average. (Source: Pensions and other benefits, 2019 Hungarian Central Statistical Office).

A similar picture emerges from the data on the relative median income of those over 65 years of age. The median income of the elderly is roughly the same as that of the active age, between 2016 and 2018 this indicator is 5-7 percentage points higher than the EU average, but in 2019 it was also around the EU average.

Relative median income* above 65 years of age between 2016 and 2019

Years	EU-average	HU	Men	Women
2019	**0,90****	**0.90**		

2018	**0.91**	**0.97**	**1.03**	**0.92**
2017	**0.93**	**0.98**	**1.04**	**0.96**
2016	**0.93**	**1.01**	**1.05**	**0.98**

** The relative median income of those over 65 compares the equivalent median income of those over 65 with the median equivalent of those under 65.*

***https://ec.europa.eu/eurostat/databrowser/view/ilc_pnp2/default/table?lang=en*
Source: EU-SILC survey;

Data on income poverty among pensioners are also favourable compared to the EU averages. Although it has shown a deteriorating trend in recent years, the Hungarian indicator, according to the latest data, is still much more favourable than the EU average:

Income poverty of pensioners: Comparison of averages in the EU and Hugary between 2016 and 2019

	EU-average	**HU**	**Men**	**Women**
2016	**14.6**	**9.1**	**7.9**	**9.8**
2017	**14.6**	**10.0**	**7.7**	**11.3**
2018	**14.4**	**10.9**	**7.9**	**12.6**
2019	**15.0**	**14.3**	**14.8**	**14.0**

Source: Eurostat

Article 13
Right to social and healthcare assistance

In order to ensure the effective exercise of the right to social and healthcare assistance, the Parties undertake to:

1. provide adequate assistance for any person who does not have adequate resources and who is unable to provide such resources on their own or from other sources, including under a social security scheme, i.e. in the event of illness, receives the care that their condition requires;

1) PRESENTATION OF THE GENERAL LEGAL FRAMEWORK, THE NATURE OF,REASONS FOR AND EXTENT OF THE REFORMS

The ECSR requested information on all legal reforms implemented in the social and healthcare sector during the reporting period.

1. Measures implemented in the field of social inclusion

Sure Start Children's Centre:
The aim of the Sure Start Children's Centre (Biztos Kezdet Gyerekház) is to ensure the healthy development of disadvantaged or multiple disadvantaged children, including Roma, to compensate for their developmental delays, and to strengthen the parenting competencies of their parents. The service is used jointly by the parent and the child who has not reached kindergarten age. The development of the Children's Centres based on the English Sure Start programme started in 2003 with Hungarian model test, and then accelerated between 2007-2013, in the EU programming period. On 31 December 2013, altogether 58 Children's Centres were operated[30], mainly in the most disadvantaged micro-regions, as well as in villages and settlements densely populated by Roma.

Important progress was made in 2013 when the Children's Centres established within the framework of EU projects were incorporated into Act XXXI of 1997 on the Protection of Children and Guardianship Administration (hereinafter: Child Protection Act). The Sure Start Children's Centre, as an element of the child welfare primary care, fills a gap in the child protection system,focusing on the 0-3 year olds not reached by institutional care and their families . As of 31 December 2019, 110 Sure Start Children's Centres were operating from domestic resources[31], and 45 were operating without government support. Additionally, in the period between 2014 and 2020, 82 new children's centres started operating with EU co-financing.

'Tanoda':
The goal and task system of the 'Tanoda' type after school institutions represents different priorities compared to the goal and task system of the schools and seeks to provide additional services. The 'tanoda' not only undertakes educational tasks, but also considers its activities related to socialisation, career building, cultural mediation, community development, recreational activity organisation, and social support to be equally important. 'Tanoda'

[30] Source: Hungarian Central Statistical Office OSAP 1775

[31] Source: Hungarian Central Statistical Office OSAP 1775

institutions have been operating with EU funding since 2004, but as a result of lengthy preparatory work, they were integrated into the Child Protection Act in 2019. Their main task is to operate a prevention service for children who receive regular child protection benefits or are disadvantaged, multiple disadvantaged or in exceptional cases young adults, which can be used on a voluntary basis, helping social inclusion and taking into account the whole of personality development. As of 31 December 2019, there were 191 'tanoda' institutions operating nationwide[32].

Complex settlement programmes:
One of the goals of complex settlement programmes with a long history (currently EFOP- 1.6.2-16, EFOP-2.4.1-16, VEKOP-7.1.4-16) is, among other things (e.g.: to increase the level of education of the persons involved, as well as to improve their employability and employment and housing conditions) to improve access to, and coordination of, human services (mainly social, community development, education and health services) for people living in segregated living environments, and to increase the kindergarten rate of children living in settlement-type environments. Connecting the human and infrastructural developments is a fundamental goal during the implementation. The local municipalities were also involved to the implementation of the programmes. With constant social work, the complex settlement programmes were realized in 97 settlements. The social urban rehabilitation programmes were realized similarly to the complex settlement programmes, which, in addition to the improvement of housing conditions and additional interventions, such as public space developments, public works, with the maintenance of social work, implemented developments adapted to local needs, such as community development, employment support, health promotion and crime prevention programmes..

The 'Emerging Settlements' programme is a long-term programme approved by Government Resolution 1404/2019 (5 July) to help the 300 most disadvantaged settlements in the country. A special prime ministerial committee has been set up to implement the programme. The involvement of settlements takes place in stages. The programme launched with the involvement of charities in 31 settlements in 2019, and in 36 settlements in 2020. The overall goal of the programme is to improve the social and infrastructural provision of the settlements and to bring about positive, forward-looking changes in the lives of the people and communities living there with the widest possible set of tools and a child centric approach, from conception to employment.

An important element of several of the above-mentioned programmes (e.g.: complex settlement programmes, the 'Emerging Settlements' programme) is presence-based (or 'settlement-type') social work.

2. Measures affecting members of the professional staff of the Hungarian Armed Forces

The Hungarian Armed Forces operates a welfare support system to support its staff, supporting a wide range of soldiers with cash and in-kind benefits. In addition to its normative support (start-up contribution, educational allowance), depending on the person's needs, it provides applicants with assistance, a salary advance, support for starting a family, and operates a bereavement care system.

32 Source: Hungarian Central Statistical Office OSAP 1775

Its support system is multi-level, with the commanders of the organisations, the commander of the Hungarian Armed Forces and the Minister of Defence (through the Secretary of State for Administrative Affairs) both having the financial resources to help those in difficulty. The Social Policy Public Foundation of the Hungarian Defence Forces was also established to provide financial support to personnel, helping those in its care: active and retired soldiers, as well as the widows and orphans of the deceased. The range of benefits in kind is also wide-ranging: housing and other accommodation services, and services that improve the quality of life are available, promoting the social and mental well-being of soldiers. The basis for assessing applications for social benefits is the degree of need, the amount of per capita income and the extraordinary circumstances that can be demonstrated in the reasoning of the application.

In terms of equal opportunities, the employment position of disadvantaged groups of workers in military organisations is constantly monitored. In order to improve it, and with the primary intention to draw the attention of both commanders and personnel to the importance of equal opportunities in the workplace, the institutional background for ensuring equal opportunities has been developed in all organisations (equal opportunities plans). In order to respect the principle of equal treatment and to promote equal opportunities, military organisations have sought to prevent any discrimination that would have resulted in a person or group being treated less favourably because of their actual or perceived status, characteristics or attributes. Equal opportunities for promotion and progression were provided for all employees in compliance with the regulations and requirements, taking into account the time spent by the employees in training, in the given job, and in a particular rank. The main criteria for advancement in a position are professional knowledge and qualifications.

In recent years, the possibility of introducing and applying a range of benefits has been on the agenda, focusing in particular on the difficulties arising in relation to the alignment of remuneration, other benefits, working conditions, health prevention, family and occupation. The situation of employees with children and military families is treated as a priority category. With regard to the granting of leave, in the case of employees raising children under the age of 14, the organisations take into account the breaks of educational institutions, reconciling the interests of employers and employees. Extraordinary leave is provided for employees who request it in connection with family events (childbirth, funeral, etc.). The situation of those absent due to long-term missions and their left behind family members is emphasised. In order to take care of them, the Hungarian Armed Forces operates a family support system integrated into the mission system of the human service personnel of military organisations.

3. Measures in the field of social services and primary child welfare services

Modification of certain rules relating to subsidised housing:

The most important change is that the legislation defines the service elements to be provided in the framework of subsidised housing, in addition to housing services, case management and other social inclusion services. Each service element to be provided to the user is selected on the basis of the results of a complex needs assessment. The new rule lists nine service elements, supervision, catering, care, skills development, counselling, pedagogical assistance, special education assistance, transportation and household or household supplementing assistance, which cover broad groups of possible activities. The service elements to be provided must also be included in the agreement with the user.

The amendment, entering into force on 1 January 2019, also allows the child of a dependent person, who is unable to care for their child, to move to subsidised housing with them. In this case, the child is considered to be in care, and a complex needs assessment must be performed. The provider is entitled receive state support for such a child.

In the case of foster children, section 75 of Act III of 1993 on Social Administration and Social Services (hereinafter: Social Administration Act) lists subsidised housing as a form of home care. The Child Protection Act has been amended accordingly from 1 January 2020.

Integration of family support and child welfare services, establishment of services and centres for family and child welfare:

Since 1 January 2016, **child welfare services and family support** can only be operated within a single service provider. The aim of the measure is to create a system that better serves the protection of children and the interests of families, in which the family and the child are treated with a holistic approach. The background for the transformation was provided by the elimination of the parallelism and professional unification of family assistance and child welfare services, as well as the expansion of the accessibility of family support, with the service becoming available in all settlements. As a result of the transformation, a significant improvement can be observed regarding the services provided to persons and families in need of assistance due to social or mental health problems or other crisis situations, the promotion of the child's physical and mental health, as well as and his/her family upbringing, the prevention and elimination of child endangerment, the territorial coverage of services aimed at returning children removed from their families, and the access to the services.

A significant change is that all local governments (in the capital, all district governments) operating independent or joint offices are obliged to operate **family and child welfare services**, with the area of care covering the population of the settlements belonging to the joint local government office, i.e. all Hungarian settlements. As of 31 December 2019, there were 709 family and child welfare services in operation due to the joint performance of tasks[33].

With the establishment of **family and child welfare centres**, an actor in the local service system was created, that sees the entire district-level public care system, monitors the situation of children and families living in the districts and the activities of the institutional actors providing services to children and families in the district. The district seat settlement, the district self-government in Budapest and the town with county rights are obliged to operate a family and child welfare centre regardless of the population.

The government has modified the operation of the child werfare centres. An important goal of the transformation was to separate the services based to voluntary use, social work and tasks related to official measures. The main task of the centres was to perform the duties related to the official measures within the framework of child protective care, to liaise with the child protective services, as well as to provide special services and counselling, such as psychological counselling, legal advice, standby duty and contact duty, that are not made available by the services. On 31 December 2019, 202 family and child welfare centres has been operated.

[33] Source: Hungarian Central Statistical Office OSAP 1696

Both the service and the services provided by the centre are available free of charge. The specific rules on benefits are provided in this report, in the chapter on Article 14 (1).

Strengthening the endangerment detection and alert system:

The child protection alert system is one of the cornerstones of our preventive child protection services, it is of paramount importance in enforcing children's rights. It has a prominent role in promoting the upbringing of children in their biological family, and in the detection of problems as early as possible. One of the most important roles of the interprofessional network, which covers the whole country and all fields working with children, is to detect the problems of children and young people as soon as possible and to take the necessary measures to organise the services and care most suited to the child's needs.

Due to the above, it became justified to develop a multi-level alert system in line with the redesigned family support and child welfare service, as well as to strengthen the child protection detection and alert system with a legal background and methodological guidelines, which resulted in the strengthening of the provisions relating to the performance of mandatory alert system tasks.

In parallel with the transformation of the family and child welfare service, the child protection detection and alert system was strengthened and the alert system of the former family support and child welfare service was integrated in 2016 at legislative level.

Key points in the strengthening of the child protection alert system:

- Redefining the tasks and competencies for the organisation and operation of the alert system (local, district, county and national level)
- Regulation of sanctions.
- Unification, simplification and extension of the documentation of the child protection alert system.
- Training and further training of the participating professionals, support of local professional workshops.

The child endangerment detection and alert system was modified to have four levels.

Introduction of social assistance in kindergartens and schools:

Kindergarten and school social assistance activities were introduced nationwide on 1 September 2018, and it became a mandatory task for the local government of all district seats to ensure these services. For every 1 000 children registered in a public education institution, the required 1 kindergarten and school social worker must be employed. With the introduction of the new service, nearly 1 500 new jobs were created to strengthen primary child welfare care. Kindergarten and school social workers perform their duties in kindergartens, schools and dormitories. The Government provides HUF 5.6 billion annually from the central budget for this. The daily presence and activities of the social worker focus on prevention, helping prevent the development of endangerment, the development of competences, mediation in the resolution of conflicts between the child and the parent, the child and the teacher, and the parent and the teacher, and the building and maintenance of contact with partner institutions.

Temporary homes for families - external accommodation:

From 1 January 2018, the temporary home for families can provide care for families who are capable of living independently with support, in external accommodations. External

accommodations firstly provide affordable housing for families, and secondly, social work for families. Families can currently stay in the temporary family home for 12 months, which can be extended by 6 months if needed. Families can stay in the external accommodation for 3 years, including time spent in the temporary family homes.

Measures relating to persons with a reduced ability to work:

Pursuant to Act CXCI of 2011 on the Amendment of Certain Laws on Benefits to People with Reduced Working Capacities (hereinafter referred to by the Hungarian abbreviation as: Mmtv.), the duration of rehabilitation benefits is a maximum of 36 months. The period of entitlement to rehabilitation benefits expiring during the State of Danger was extended until the first day of the second month following the State of Danger.

A review of benefits depending on the state of health, personality status or disability was not performed during the State of Danger in order to reduce the number of personal meetings and the burden on the doctors and experts performing the examinations, and no documents were sent for reviews, therefore care, benefits and exemptions were not terminated.

The transitional rules relating to the support of employers of persons with a reduced ability to work and disabilities.

- In view of the declared State of Danger, in order to ensure the employment of persons with a reduced ability to work and disabilities, transitional provisions were made to facilitate the use of the support in the case of sheltered employment (employment with accredited employers and developing employment).
- During the epidemic situation, the above measures managed to retain the jobs of approximately 36 000 persons with a reduced ability to work and disabilities.

2) IMPLEMENTATION OF EACH MEASURE

The ECSR requested the provision of relevant statistics and other important information, such as: evidence of an adequate level of social assistance (social benefits are able to meet the basic needs of those in need and are not below the poverty line). Information is requested on basic and supplementary benefits and on the level of the poverty line (50% of the median equalised income, calculated on the basis of the at-risk-of-poverty threshold published by Eurostat).

1. Changes in the regulation of social and child protection benefits in cash and in kind during the reporting period

The benefits that can be provided under the Social Administration Act can be grouped as follows:

- Income replacement benefits,
- Expenditure compensating benefits,
- Crisis benefits.

Income replacement benefits, as the last link in the social welfare system, provide subsistence support to people without other incomes. This group of benefits includes the following support:

- Care for persons of active age (employment replacement allowance and health impairment and childcare allowance[34])
- Old-age benefit,
- Care allowance
- Home care allowance for children (introduced: from 1 January 2019).

Expenditure compensation benefits contribute to the socially recognised, regular expenses of persons in need. This group includes the following benefits:

- Public healthcare,
- Entitlement to healthcare.

Crisis benefits, ad hoc support for the management of emerging crisis situations:

- Local government support (introduced: from 1 March 2015)

2. Benefits provided under the Social Administration Act

• Care for persons of active age

Care for persons of active age is support for people of working age, who are disadvantaged in the labour market, and their families. A person who has reached the age of 18 but has not reached the retirement age is considered to be of active age.

Care for persons of active age can be determined for the person of active age,

a) who has lost at least 67% of their ability to work, who has suffered at least 50% health impairment, or whose state of health does not exceed 50% according to the complex qualification of the rehabilitation authority, or

b) who receives a personal benefit for the blind, or

c) who receives a disability allowance [the persons referred to in paragraphs *a)* to *c)* hereinafter jointly referred to as: 'person with impaired health'], or

d) in respect of whom the period for payment of unemployment allowance, unemployment benefit, job-seekers' allowance, or self-employed benefit [hereinafter jointly referred to as: 'job-seekers' support'] has expired, or

e) in respect of whom the payment of job-seekers' support was terminated due to the pursuit of gainful employment before the expiry of the payment period, and following the gainful employment they are not entitled to job-seekers' support under the Act IV of 1991 on Job Assistance and Unemployment Benefits (hereinafter referred by the Hungarian abbreviation as: Flt.), or

f) who has cooperated with the public employment body or the rehabilitation authority for at least one year during the two years preceding the application for care for persons of active age, or

[34] Regular social assistance was withdrawn from the care system on 28 February 2015, and its was replaced by the health impairment and childcare allowance (for details, see the description of care for persons of active age).

g) in respect of whom the home care allowance for children, care allowance, childcare benefit according to the Act LXXXIV of 1998 on Family Support (hereinafter: Family Support Act), regular social allowance, miners' health impairment allowance, transitional allowance, rehabilitation allowance, disability pension, accident disability pension, benefits for persons with a reduced ability to work, the payment of the temporary widow's pension or the payment of the widow's pension ceased for a reason specified in Section 52 (3) of the Tny., and immediately prior to the submission of the application they cooperated with the public employment body for at least three months,

provided that their and their family's livelihood cannot be ensured by any other means and that they are not gainfully employed (excluding public employment, employment pursuant to the Act LXXV of 2010 on Simplified Employment, and household work).

For the purpose of determining entitlement to care for persons of active age, livelihood is not guaranteed if the family's monthly income per unit of consumption does not exceed 90% of the current minimum amount of the old-age pension and it has no assets exceeding the threshold specified in the Social Administration Act.

The persons, who entitled to care for persons of active age, can receive two types of cash benefits, employment replacement allowance or health impairment and childcare allowance:

Employment replacement allowance:

Employment replacement allowance is a benefit provided to employable persons of active age. The person receiving the benefit is obliged to cooperate with the public employment body. Entitlement to benefits shall cease if the person concerned has not been employed for at least 30 days in a year.

The employment replacement allowance is a fixed amount (HUF 22 800).

Health impairment and childcare allowance:

Health impairment and childcare allowance can be established for a non-employable person of active age, who:

- has a health impairment, or
- is raising a child under the age of 14, whose day-time institutional care is not provided.

The health impairment and childcare allowance supplements the family income up to the family income limit, but may not exceed 90% of the amount of the net public employment wage (HUF 48 795 in 2016). The amount of the family income limit is equal to the sum of the ratios belonging to the consumption units of the family multiplied by 92% of the current minimum amount of the old-age pension.

Only one person in a family is entitled to care for persons of active age at a time, unless one family member is entitled to employment replacement allowance and the other family member is entitled to health impairment and childcare allowance. The combined amount of the two benefits may not exceed 90% of the net public employment wage.

From 1 January 2018, the amount of the family income limit for healthcare and childcare allowance is equal to the sum of the ratios belonging to the consumption units of the family

multiplied by 95% of the current minimum amount of the old-age pension. The increase in the multiplier resulted in an average increase of 3% in the amount of benefits.

- **Old-age benefit**

Old-age benefit is an allowance for elderly people without a means of subsistence. The conditions for entitlement to the old-age benefit and the amount of the benefit vary according to the life situation and age of the beneficiary.

The old-age benefit can be determined for persons who have **reached the retirement age** applicable to them, if the following conditions are met:

a) if the applicant is **not independent and under the age of 75**, they are entitled to the benefit if, after aggregating their own income and the income of their spouse or partner, their monthly per capita income does not exceed 80% of the current minimum amount of the old-age pension (HUF 22 800 in 2016; currently: HUF 26 350),

b) if the applicant is **independent and under the age of 75**, they are entitled to the benefit if their monthly income does not exceed 95% of the current minimum amount of the old-age pension (HUF 27 075 in 2016; currently: HUF 30 995),

c) if the applicant is **independent and has reached the age of 75**, they are entitled to the benefit if their monthly income does not exceed 130% of the current minimum amount of the old-age pension (HUF 37 075 in 2016; currently: 41 840).

Old-age benefit amount for **non-earners**

a) if the applicant is not independent (i.e. living with a spouse or partner), then 80% of the current minimum amount of the old-age pension (HUF 22 800),
b) if the applicant is independent but has not yet reached the age of 75, 95% of the current minimum amount of the old-age pension (HUF 27 075),
c) if the applicant is independent and has reached the age of 75, 130% of the current minimum amount of the old-age pension (HUF 37 075);

For entitled persons with an income, the amount of the benefit is the difference between the above amount and the monthly income of the entitled person. If the amount of the benefit does not reach one thousand forints in the case of an allowance paid to an entitled person with an income, a benefit of at least one thousand forints must still be established for the entitled person. The payment of the old-age benefit is not subject to a time limit.

From 1 January 2017 and 1 January 2018, in order to strengthen the social security of the elderly, the amount of the old-age benefit increased by an average of 5% respectively in the two years. In 2018, in addition to the increase in the number of recipients of the benefit, the amount of the benefit also increased, as its rate increased in line with the rate of pension increase (after inflation). From 1 January 2019, the income limit for old-age benefits and the amount of benefits increased in line with the rate of the annual pension increase (2.7%).

- **Care allowance**

The care allowance is a financial contribution provided to an adult relative who is caring for a person in need of long-term care at home.

On 1 January 2016, the Social Administration Act regulated three forms of care allowance:

I. A **basic care allowance** is available to people who are caring for a severely disabled or chronically ill relative under the age of 18 who needs long-term care. The amount of the care allowance in this case is the basic amount specified in the Act C of 2015 on the Central Budgetary of Hungary for 2016 (hereinafter: Budget Act) (HUF 29,500).

II. An **increased care allowance amount** can be provided to family members who care for severely disabled relatives who require an increased level of care, the amount of which is 150% of the basic amount established in the Budget Act (HUF 44 250).

III. A close relative is entitled to a **special care allowance** if the person cared for: has reached the age of 18 and the rehabilitation authority determines during the complex qualification that the health impairment of the person with a reduced ability to work is significant and they are unable to care for themselves or only with assistance, or they have not reached the age of 18 but are studying and a higher amount of family allowance is paid due to their condition, and at the same time the specialist certifying the condition entitling them to a higher amount of family allowance certifies that they require long-term care due to their illness or disability. The special care allowance is 180% of the basic care allowance (HUF 53 100).

The monthly amount of the care allowance is the difference between the amount of the care allowance and the monthly amount of other regular cash benefit paid to the entitled person in the case of a recipient receiving another regular cash benefit. If the difference does not reach one thousand forints, a care allowance of one thousand forints must be established for the entitled person.

The duration of the payment of the care allowance entitles to service time. The person receiving the care allowance is obliged to pay a pension contribution and a private pension fund membership fee after the benefit. The payment of the care allowance is not subject to a time limit.

From 1 January 2017, the basic amount of the care allowance according to the Act XC of 2016 on the Central Budgetary of Hungary for 2017 increased by 5%. Thus, the amount of the basic care allowance increased from HUF 29 500 to HUF 31 000 per month, the increased care allowance amount increased from HUF 44 250 to HUF 46 500, while the amount of the special care allowance increased from HUF 53 100 to HUF 55 800.

From 1 January 2018, the basic amount of the care allowance increased to HUF 32 600 due to a further 5% increase in the basic amount of the care allowance. At the same time, the amount of the increased care allowance increased from HUF 46 500 to HUF 48 900, and the amount of the special care allowance increased from HUF 55 800 to HUF 58 680.

From 1 January 2019, the duration of the care allowance counts as an advance insurance period for entitlement to benefits for persons with a reduced ability to work. A three-month benefit is disbursed if loss of entitlement to the benefit is not attributable to the carer (institutional placement of the person being cared for, cessation of incapacity for self- sufficiency or death of the person being cared for).

From 1 January 2019, the basic amount of the care allowance increased by another 15%, therefore the basic amount of the care allowance increased to HUF 37 490 per month. At the same time, the amount of the increased care allowance increased to HUF 56 400 and the amount of the special care allowance increased to HUF 67 485. By 2022, this will be followed by a further 5% increase respectively.

- **Home care allowance for children**

As of 1 January 2019, a benefit titled 'home care allowance for children' (hereinafter referred to by the Hungarian abbreviation: GYOD) **for caregivers of children unable to provide for themselves was introduced.**[35]

A biological or adoptive parent is eligible for GYOD if they care for

a) their biological or adopted child who is unable to support themselves due to a severe disability, or

b) their child who is unable to support themselves due to their long-term illness.

Eligibility can be established regardless of the age of the child, only the parent-child relationship is relevant. As a general rule, only the biological parent and the adoptive parent can receive the benefit. Other relatives may become entitled to the benefit in the event of the death of the parent, or if the parent is unable to continue to care for their child due to their state of health, or if the parent's right of parental custody is suspended or terminated by a court. In this case, an additional condition is the previously established GYOD entitlement of the parent.

The condition for entitlement to GYOD is the inability of the cared-for child to be self-sufficient, as determined by a person with expertise in accordance with the conditions specified by law during the procedure.

In addition to the payment of the benefit, in the case of working at home for up to 4 hours a day, it is possible to pursue gainful employment without a time limit.

The monthly amount of the home care allowance for children in 2019 was gross HUF 100 00. If the parent takes care of several children who are unable to support themselves, they must be paid one and a half times the amount of the care allowance.

The amount of the GYOD is the difference between the monthly amount of the GYOD and the gross amount of other regular monthly cash benefits paid to the entitled person in the case of an entitled person receiving other regular cash benefits. If the difference does not reach one thousand forints, a benefit in the amount of one thousand forints must be established for the entitled person. Exception rule (regular cash benefits that can be paid in full together with GYOD):

– the parent is entitled to the GYOD in full if they do not receive other benefits that can be paid for children (e.g.: childcare benefit, childcare allowance) with regard to the cared-for child,

[35] Those entitled to GYOD were selected from the list of those entitled to care allowance on 31 December 2018, on the basis of the parent-child relationship, in such a way that the actual examination of the conditions for entitlement to benefits took place only from the second half of 2019.

– the parent is entitled to the GYOD in full if they receive a child-raising benefit (hereinafter referred to by the Hungarian abbreviation: GYET) for the upbringing of three or more minor children.

The duration of the payment of the home care allowance for children entitles to service time. A person receiving a home care allowance for children is required to pay a pension contribution and a private pension fund membership fee after the benefit. The payment of the home care allowance for children is not subject to a time limit.

The duration of the GYOD payment can be recognised as an advance insurance period in respect of benefits for persons with a reduced ability to work. A person receiving a home care allowance for children is entitled to healthcare.

In 2018, the Government decided on the amount of the home care allowance for children and the amount of care allowance for 2020–2022 years.[36]

- **Public medical care**

Public medical care is a contribution provided to a socially deprived person in order to reduce their expenses related to the maintenance and restoration of their state of health. A person with a public medical care certificate, as specified in separate legislation, is entitled, free of charge, to

a) outpatient medicines, including those for special dietary needs, up to the limit of their medication allowance,
b) certain medical devices, including prosthetic and orthodontic devices, and their repair and hire, as defined in separate legislation, and
c) medical services available for medical rehabilitation, included in social security benefits.

The Social Administration Act contained two types of entitlement to public medical care on 1 January 2016:

i. The following persons are entitled to public medical care **on subjective right**, regardless of their income situation and regular monthly pharmaceutical expenditure:
   - a minor in temporary care or in foster care;
   - a person with a disability entitled to care for persons of active age;
   - a military veteran care or national care recipient receiving cash benefits;
   - the recipient of central social assistance;
   - the recipient of disability benefits;
   - who is a recipient of a disability benefit and whose state of health does not exceed 30% according to the complex qualification of the rehabilitation authority;
   - who is a recipient of a disability benefit and on 31 December 2011 was entitled to a disability or accident disability benefit belonging to group I. or II.;
   - who is a recipient of an old-age pension and on 31 December 2011 was entitled to a disability or accident disability benefit belonging to group I. or II.;
   - who is a recipient of an old-age pension and received a disability benefit on the day before their entitlement to a pension and on 31 December 2011 they were

[36] Government Resolution 1768/2018 (21 December) on Raising the Amount of Home Care Allowance for Children and the Amount of Care Allowance for 2020–2022 Years

classified as having a group I. or II. disability, or received benefits as a new entrant taking into consideration their health status of up to 30%;

- who receives a higher amount of family allowance or after whom their parent or carer receives a higher amount of family allowance.

ii. A person is also entitled to public medical care on a **normative basis** if the payable allowance for the monthly regular medical care recognised by the health insurance body exceeds 10% of the current minimum amount of the old-age pension, provided that the monthly per capita income in their family does not reach the current minimum amount of the old-age pension, or 150% thereof in the case of a person living alone.

The medication allowance consists of

a) an individual medication allowance to support regular medication needs, and
b) an ad hoc allowance to support the need for medication due to an acute illness.

The amount of the individual medication allowance is the regular monthly medication cost of the entitled person, but at most HUF 12 000 per month[37]. The annual amount of the ad hoc allowance is HUF 6 000. If no individual medication allowance is established for the person entitled to public medical care, the medication allowance is the same as the ad hoc allowance.

From 1 January 2018, the income threshold for **normative public medical care** increased by 5%. This means that the minimum per capita income for persons living in a family may not exceed 105% (HUF 29 925) of the old-age pension, while for persons living independently, the minimum per capita income may not exceed 155% (HUF 44 175) of the old-age pension. The number of recipients of public medical care has increased due to the raising of the income limit, as more people can be granted entitlement to the benefits.

As of 1 January 2019, the central social assistance was removed from the **subjective public medical care** titles, considering that no benefit is being provided to any person under this title any more.

- **Eligibility for health care services**

Persons who do not have an insurance relationship or are not eligible to health care services on other grounds may become entitled to them based on their social needs.

In order to use the health care services, the district office determines the social need of a person whose family has a monthly income per person of 120% of the current minimum old age pension (HUF 34 200 in 2016), who lives alone and their income does not exceed 150% of the current minimum old age pension (HUF 42 750 in 2016) and their family has no assets.

The district office issues an official certificate proving the social needs, which is effective for 1 year from the submission of the application. If the eligibility conditions are met, the certificate can be reissued.

[37] The maximum monthly amount of the individual mediation allowance and the amount of the ad hoc allowance are determined by the act on the annual central budget.

In possession of the certificate, the person in social need is entitled to health care services based on Section 16 (1) item o) of Act LXXX of 1997 on the Eligibility for Social Security Benefits and Private Pensions and the Funding for These Services.

- **Local government support**

After 1 March 2015, the local governments were given the opportunity to develop a care system that better responds to local needs, as they can determine the types and system of conditions of benefits falling within their competence.

The name of the benefits provided by local governments under the Social Administration Act is uniformly **local government support**. In the framework of this support, local governments can provide support for life situations that they consider eligible and regulated by their decrees. It is entirely within the discretion of the local government to decide the purposes of and conditions to be fulfilled for its municipal support, as well as the amount of support. The only obligation imposed by the Social Administration Act is that the Board of Representatives of the local government must provide **extraordinary local government support** to persons in an extraordinary life situation endangering their livelihood and persons with temporary or permanent livelihood problems.

Extraordinary local government support should be provided primarily to those who are unable to support themselves or their families in any other way, or need financial assistance due to occasional additional expenses, in particular for illness, death, to mitigate elementary damage, to keep the child of a pregnant woman in crisis, schooling, to prepare the receiving of a child, to contact with the foster child's family, expenses in relation to facilitate the return of the child to the family, or disadvantaged situation of the child.

In addition, the Social Administration Act lists the range of benefits to be provided within the framework of local government support only as examples:

In particular, support may be provided in the framework of local government support

a) to cover regular housing-related expenses,
b) for a person caring for a chronically ill relative who has reached the age of 18,
c) to cover the cost of medicines,
d) for persons accumulating arrears related to housing expenses.

In the decree of the local government, the amount of the monthly local government benefit must be regulated in such a way that it may not exceed the current minimum old-age pension, not including the allowance granted for debt management purposes.

- **Other local government support**

The Board of Representatives of the local government may supplement the cash benefits within its competence and may establish other financial supports for the socially deprived, in the manner and under the conditions specified in its decree.

3. Benefits under the Child Protection Act

The purpose of the Child Protection Act is to determine the basic rules according to which the state, the local governments and natural and legal persons providing child protection services,

as well as other organisations without legal personality should assist in enforcing the rights and interests of children provided by law, to fulfil their parental obligations and to ensure the prevention and elimination of vulnerability of children, the replacement of missing parental care and the social integration of young adults no longer eligible for child protection care.

Based on the Child Protection Act, the following cash and benefits in kind may be provided.

- **Regular child protection allowance**

The purpose of determining entitlement to regular child protection allowance is to certify that the child is entitled to receive the following on the basis of their social situation

- normative allowance of child catering,
- in-kind support in the form of vouchers for the purchase of special ready-to-eat food, school supplies and clothes twice a year (in August and in November),
- other benefits specified in a separate legal regulation (textbook support, tuition support, etc.).

The purpose of the regular child protection allowance is to enable the family in need to care for the child at home, in accordance with children's rights. The allowance − according to the regulations in fore in 2016 − could be granted to a child in whose family providing care the monthly income per capita did not exceed 130% of the current minimum old age pension.

In some cases, considering the special situation of the family, the income limit entitling to benefits was higher, 140% of the current minimum old age pension. Such cases of special consideration include when:

a) the child is being cared for by a single parent or other legal representative, or
b) the child is chronically ill or severely disabled, or
c) the child has reached the age of majority
   - is studying according to the full-time education schedule and has not yet reached the age of 23, or
   - is studying full-time at a higher education institution and has not yet reached the age of 25.

An additional condition for eligibility to benefits is that the value of the property per capita (usable property, vehicle and property rights) in the family caring for the child during the inspection of the financial situation does not exceed

a) calculated separately: twenty times the minimum old age pension, or
b) calculated together: seventy times the minimum old age pension.

The property items, in which the parent or other legal representative obliged to provide care habitually lives, the property right to the property inhabited by them, and the motor vehicle kept for the disabled person, do not qualify as property, so they do not have to be taken into account during property inspection.

From 1 January 2017, the amount of in-kind support provided twice a year under the regular child protection allowance has been differentiated and increased. The amount of support increased from HUF 5 800 to HUF 6 500 in the case of disadvantaged, increasingly disadvantaged children entitled to regular child protection allowance, while in the case of children entitled to allowance but not classified as disadvantaged or increasingly

disadvantaged, the amount increased from HUF 5 800 to HUF 6 000. From 1 January 2018, the eligibility income limit for the regular child protection allowance has been increased again, from 130-140% to 135-145% of the minimum old age pension.

Due to the withdrawal of the voucher, which can also be used for the purchase of ready-to-eat food, school supplies and clothing, from 17 July 2019 the benefit related to the allowance, provided twice a year, has been provided as a cash benefit.

- **Child support advance**

Child support may be advanced by the state if the court has legally established the child support, but the obligor does not fulfil its obligation to pay and court recovery is temporarily impossible. An additional condition for the advance is that the person caring for the child is unable to provide the necessary child care, i.e., the average monthly income per capita in the family caring for the child is less than twice the minimum old age pension.

The guardianship office advances the amount determined by the court in its decision ordering the payment of child support, paying the basic amount when the support is defined as a percentage, provided that the amount of the advance child support cannot exceed 50% of the minimum old age pension per child. The guardianship office may set an amount lower than this amount, if the child can be supported in part by the caring parent. In this case, too, the amount advanced may not be less than 10% of the minimum old age pension.

The advance child support is paid from the date of submission of the application until the foreseeable existence of the underlying reason, but for a maximum of three years. In justified cases, the disbursement of the advance may be re-ordered once for a further period of up to three years.

If the conditions are met, the child support advance can be established even after the child has reached the age of majority, and the child support already established can continue to be paid as long as they are studying according to the full-time secondary education schedule, but only up to the age of twenty.

In the course of the advance payment, in order to protect the rights of the child, the state acts as a ‘responsible party in the background’, essentially instead of the obligor, during a transitional period. The amount advanced by the state must be reimburse by the obligor to the state.

- **Home building support**

The purpose of the home building support is to facilitate the access of a young adult who has left temporary or permanent care (foster parent, children's home) to accomodation and to establish long-term housing. The application for support can be submitted after the young adult has reached the age of majority.

A young adult is eligible for a home building support, who

a) continued education in a place of care for at least three years, which ceased when they reached the age of majority, and

b) the value of their cash, deposit for insurance or other purposes, or real estate property does not exceed sixty times the minimum old age pension when they reach the age of majority.

The support can be used in part or in full for the purchase or construction of a building plot, a flat suitable for habitual residence, a family house, a homestead, to make it habitable, to renovate or expand a property or part of a property, to pay rent, to renovate a municipal rental apartment, to purchase of tenant status, to participate in a state-subsidised housing programme, and to repay a loan for the establishment of a home in a lump-sum to a credit institution. In justified cases, the home building support may also be used for a one-off contribution payable to a residential social institution falling within the scope of Social Administration Act providing adequate care for a chronically ill or disabled young adult.

The amount of the home building support shall be determined on the basis of the years spent in continuous education and the combined value of the cash and real estate assets of the beneficiary in such a way as to reach the following amount on its own, for beneficiaries without any assets, and with the assets for beneficiaries with assets:

a) forty times the minimum old age pension for care lasting less than four years,
b) fifty times the minimum old age pension for care lasting more than four years,
c) sixty times the minimum old age pension for care lasting more than five years.

The applicant can submit a claim for home building support after reaching the age of majority, but no later than until the age of 30. This is a statutory limitation deadline.

From 1 May 2016, the amount of home improvement support increased by an average of 12%:

Duration of care	**Amount of support before 1 May 2016** (in the case of recipients without own assets)	**Amount of support before 1 May 2016** (in the case of recipients without own assets)
shorter than 4 years	1 140 000 Ft	**1 339 500 Ft**
longer than 4 yeras but does not exceed 5 years	1 425 000 Ft	**1 624 500 Ft**
longer than 5 years	1 710 000 Ft	**1 909 500 Ft**

Source: Ministry of Human Capacities

- **Other local government support**

The Board of Representatives of the local government may supplement the benefits within its competence and may establish other financial support in the manner and under the conditions specified in its decree, taking into account the needs of the child and the young adult.

4. System of benefits for persons with reduced ability to work

Pursuant to Mmtv., those are entitled to benefit of reduced ability to work:

- whose health status is not more than 60% based on a complex assessment,
- who was insured for at least 3 years within five years prior to the submission of the application, or for at least 7 years within ten years or 1 year within 15 years from 1 January 2014,
- who does not engage in paid employment and does not receive any other regular cash benefits.

As a result of a complex assessment those entitled to cash benefits may receive the following two benefits, depending on the rehabilitation recommendation.

Rehabilitation benefit: rehabilitation services provided to persons recommended for employment, rehabilitation and cash benefits provided to compensate for lost income, which can be established for the period of occupational rehabilitation, or for a maximum period of three years. Its purpose is to support the restoration of employability by providing rehabilitation services on the one hand and cash benefits on the other. Its amount depends on the degree of health retained and the average monthly income earned before. As of 1 January 2016, recipients of rehabilitation benefit were allowed to work for 20 hours a week in addition to the benefit.

The degree of health maintained	Extent of rehabilitation care /minimal and maximal amount (HUF/person/month) on 1 January 2016
health status between 50-60% percent	ability to work can be restored with rehabilitation 35% of the monthly average income minimal amount: 30% of the minimum wage (HUF 27 900) maximal amount: 40% of the minimum wage (HUF 37 200)
health status between 30-50%	person needs long-term employment rehabilitation 45% of the monthly average income minimal amount: 40% of the minimum wage (HUF 37 200) maximal amount: 50% of the minimum wage (HUF 46 500)

Source: Ministry of Human Capacities

Disability benefit: the income substituting benefit for persons not recommended for employment or rehabilitation, which may be disbursed without any limitation in time, as long as the eligibility conditions prevail. Its amount depends on the degree of health retained and the average monthly income earned before. Recipients of the benefit, may pursue a paid activity but, according to the status at 1 January 2016, the 3-month average of the resulting income may not exceed one and a half times the monthly amount of the current minimum wage.

The degree of health maintained	Extent of disability benefits /minimal and maximal amount (HUF/person/month) on January 1. 2016
health status between50-60%	can be rehabilitated based on his/her health status, but cannot be employed due to his/her other criteria defined by specific legislation, employment rehabilitation not recommended 40% of the monthly average income minimal amount: 30% of the minimum wage (HUF 27 900) maximal amount: 45% of the minimum wage (HUF 41 850)
health status between 30-50%	needs long-term rehabilitation based on his/her health status, but cannot be employed due to his/her other criteria defined by specific legislation, employment rehabilitation not recommended 60% of the monthly average income minimal amount: 45% of the minimum wage (HUF 41 850) maximal amount: 150% of the minimum wage (HUF 139

	000)
health status is 30%	a disabled worker who can only be employed with ongoing support 65% of the monthly average income minimal amount: 50% of the minimum wage (HUF 46 500) maximal amount: 150% of the minimum wage (HUF 139 500)
health status is not more than 30%	significant health damage, partly or fully incapable to self-sufficiency 70% of the monthly average income minimal amount: 55% of the minimum wage (HUF 51 150) maximal amount: 150% of the minimum wage (HUF 139 500)

Source: Ministry of Human Capacities

Changes in 2016:

The modification of Mmtv., which entered into force on 1 May 2016, formulated provisions aimed at increasing the employment opportunities of people with reduced ability to work, strengthening their social security and reducing bureaucracy based on the four years of operational experience of the system.

The most important modifications are as follows:

- **Harmonisation of the rehabilitation benefits and the paid activity limit for disability benefits**

In terms of working in addition to benefits, there was previously an incomelimit for those receiving disability benefits, while there was a time limit for those receiving rehabilitation benefits. Disability benefit must be cancelled/terminated if the eligible person is pursuing a paid activity and their income exceeds 150% of the minimum wage for three consecutive months. In addition to rehabilitation cash benefits, it was previously possible to work for up to 20 hours a week. In the case of paid employment for more than this number of hours, the payment of benefits must be suspended. This provision did not provide sufficient incentives for benefit recipients to take up full-time work in the open market. According to the amendment to the law, there is no working time limit for paid employment for recipients of rehabilitation benefits, but the benefit must be terminated if the eligible person's income exceeds 150% of the minimum wage for three consecutive months.

- **Establishing a differentiated system of sanctions for breach of the cooperation obligation**

According to the modification, if recipients of rehabilitation benefits breach the cooperation obligation for the first time, the rehabilitation benefits will not be terminated but suspended for 3 months.

- **Creating the value preservation of the minimum and maximum amount of benefits, amending the rules on the amount of benefits for persons having no income**

According to the previous regulation, the minimum and maximum amount of benefits had to be determined on the basis of the 2012 minimum wage, therefore the value of the minimum and maximum benefits continuously decreased compared to the benefits established in 2012. In order to create the value resistance of the minimum and maximum amounts, the

amendment sets their projection base, the basic amount in a fixed amount (HUF 94 500, i.e. the amount of the projection base on 1 January 2016, increased by the pension increase of HUF 93 000 in 2016 (1.6%)), and provides that the basic amount is to increase in line with the increase in pensions. For those who do not have a cash health insurance contribution base to be taken into account in determining the benefit, the amount of the benefit will be the same as the minimum amount of the benefit category applicable to the beneficiary instead of the amount calculated on the basis of the minimum wage.

Changes in 2017:

From 1 January 2017, the amount of disability and rehabilitation benefits and the projection base used to determine the minimum and maximum amounts of benefits increased by 1.6% in line with the rate of old age pension increase.

Customers who can be rehabilitated on the basis of their health condition, but cannot be employed due to other circumstances specified in a separate legal act, whose occupational rehabilitation is not recommended (B2 rating) and those requiring permanent rehabilitation based on their state of health, but not employable due to other circumstances specified in a separate legal act, and not recommended for vocational rehabilitation (C2 rating), are also entitled to a rehabilitation card, which provides a social contribution tax credit to the employer of employees with a reduced ability to work. So far, this allowance has only been available to those who have been classified as suitable for rehabilitation (categories B1, C1).

Changes in 2018:

From 1 January 2018, the amount of disability and rehabilitation benefits and the projection base used to determine the minimum and maximum amounts of benefits increased by 3% in line with the rate of the old age pension increase.

- **Introduction of the option of equity in benefits for persons with a reduced ability to work**

The modification effective from 1 January 2018 established a system of exceptional disability benefits based on a uniform basis, which provides benefits to people with severe health problems who have been unable to obtain the necessary insurance period due to long-term illness or other justifiable reasons, but have at least half of the required insurance period. Exceptional disability benefits may be granted to persons whose health status is maximum 50% and cannot be rehabilitated, who have at least half of the insurance period specified by law, do not perform any paid activity and do not receive regular cash benefits. The monthly amount of the benefit is 65% of the minimum amount of the classification category governing the eligible person.

Changes in 2019

- **extension of the periods which may be included in the period of insurance required for the determination of benefits for persons with a reduced ability to work**

In many cases, people receiving care allowance may move away from the labour market for a longer period of time, so they cannot and could not obtain the insurance period for the benefits of persons with a reduced ability to work. In many cases, this has led to persons with a reduced ability to work receiving care not being able to obtain eligibility to benefits. Recognising the social usefulness of caring for a relative, from 1 January 2019, the period of payment of the care allowance and the home care allowance for children is already included in the insurance period required for determining the benefits of persons with a reduced ability to work.

From 1 January 2019, the amount of disability and rehabilitation benefits and the projection base used to determine the minimum and maximum amount of benefits increased by 2.7% in the same way as the old age pension increase.

5. Data on the amount of each benefit and the relevant thresholds

Monthly average amount of benefits provided on a monthly basis

Name of benefits	Annual monthly average amount of benefits (HUF)			
	2016	**2017**	**2018**	**2019**
Disability and childcare allowance	26 164	26 893	28 016	28 217
Aid to replace employment	22 874	22 868	23 039	23 049
Old age allowance	26 870	28 664	29 251	30 174
Care allowance	37 931	40 385	42 923	50 279
Home care allowance for children				95 453
Public healthcare*	5 509	5 570	5 698	5 753
Advances of child support**	9 219	8 770	9 313	n.a.

** Average monthly drug limits, source: National Health Fund/National Health Insurance Fund*
***Source: Ministry of Human Capacities*
Source: Hungarian Central Statistical Office Social Statistical Yearbook 2018./STADAT

2. 2. Values of ad-hoc benefits

2.2. a) Annual average amount per case

Name of benefit	Annual average amount per case (HUF)			
	2016	**2017**	**2018**	**2019**
Settlement support (amount per case)	6 145	6 859	6 956	7 465

** A The settlement support was created at the time of the change in the social welfare system on 1 March 2015 (detailed in the previous Report) by "merging" several previous benefits, so the comparability of the data with previous years is limited.*
Source: Hungarian Central Statistical Office Social Statistical Yearbook 2018./STADAT

2.2. b) Annual average amount per capita

Name of the benefit	Average annual income per one person (HUF)			
	2016	**2017**	**2018**	**2019**
Settlement support*	24 057	23 606	23 080	22 168
Home creation support **	777 160	843 488	829 192	n.a.

** The settlement support was created at the time of the change in the social welfare system on 1 March 2015 (detailed in the previous Report) by "merging" several previous benefits, so the comparability of the data with previous years is limited.*
***Source: Ministry of Human Capacities*
Source: Hungarian Central Statistical Office Social Statistical Yearbook 2018./STADAT

3. Poverty threshold, minimum wage, old-age pension minimum amount (2016-2019)

		2016	2017	2018	2019
Poverty threshold /year[38]	One-person households	932 162	1 006 249	1 119 752	1 263 114
	households with 2 adults amd 2 children	1 957 541	2 113 122	2 351 479	n.a.
Minimum wage	gross	111 000 HUF/month	127 500 HUF/month	138 000 HUF /month	149 000 HUF /month
	net (without children)	73 815 HUF/month	84 788 HUF/month	91 770 HUF/month	99 085 HUF/month
Old-age pension minimum amount		28 500 HUF			

Source: Hungarian Central Statistical Office STADAT

Amounts of rehabilitation and disability benefits as of December 31, 2019

The degree of health maintained	Amount of the rehabilitation benefits/minimum and maximum amounts (HUF/person/month)
health condition between 50-60% (qualification B1)	restorable with occupational rehabilitation 35% of the monthly annual income minimal amount: 30% of the basic amount* (HUF 30 470) maximal amount: 40% of the basic amount (HUF 40 625)
health condition between 30-50% (classification C1)	prequires long-term rehabilitation 45% of the monthly annual income minimal amount: 40% of the basic amount (HUF 40 625) maximal amount: 50% of the basic amount (HUF 50 780)
health condition between 50-60% (classification B2)	can be rehabilitated based on her/his health status, but cannot be employed due to her/his other criteria defined by specific legislation, employment rehabilitation not recommended a 40% of the monthly annual income minimal amount: 30% of the basic amount (HUF 30 470) maximal amount: 45% of the basic amount (HUF 45 705)
health condition between 30-50% (classification C2)	needs long-term rehabilitation based on his/her health status, but cannot be employed due to his/her other criteria defined by specific legislation, employment rehabilitation not recommended 60% of the monthly annual income minimal amount: 45% of the basic amount (HUF 45 705) maximal amount: 150% of the basic amount (HUF 152 340)
health condition is 30% (classification D)	a disabled worker who can only be employed with ongoing support 65% of the monthly acerage income minimal amount 50% of the basic amount (HUF 50 780) maximal amount: 150% of the basic amount (HUF 152.340)
maximum 30% health condition (classification E)	significant health damage, partly or fully incapable to self-sufficiency 70% of the monthly acerage income minimal amount: 55% of the basic amount (HUF 55 860)

[38] Threshold set at 60% of median income.

	maximal amount: 150% of the basic amount (HUF 152 340)

**The amount defined in Section 8/A of Government Decree 327/2011. (29 December) on the Basic Rules of Care For the Persons with Changed Working Capacity. From 31 December 2019: HUF 104 405.*
Source: Ministry of Human Capacities

Main data on benefits for the disabled

	2016.	2017.	2018.	2019.
Average number of persons receiving benefits*	**413 193**	**392 153**	**367 862**	**346 348**
Expenditure on care (Mrd. HUF)	**307.3****	**298.8****	**286.6****	**286.7*****

** In addition to disability and rehabilitation benefits, it also includes the number of recipients of disability benefits and health workers' benefits for miners.*
*** the amount of expenditure adopted in the final accounts act for the given year*
**** the amount of the appropriation adopted in the central budget for the year in question*
Source: data from the payers

The ECSR requests information on special measures to ensure access to social and health services for those in need during pandemics such as coronavirus. They also request information on the extent and differences in health and social assistance provided to persons without a place of residence or settlement status compared to normal benefits.

The answer is contained in the previous paragraph.

2) RESPONSES GIVEN TO THE QUESTIONS OF THE ECSR RELATING TO THIS PARAGRAPH

In its 2017 conclusions, the ECSR requests information whether non-Hungarian citizens who wish to receive the benefits stated in the Social Administration Act need to live in Hungary for a certain period of time before they become entitled to them.

The right to receive social benefits is related to the submission of an asylum application or the acquisition of status by Act LXXX of 2007 on Asylum (hereinafter: the Asylum Act). According to the Asilum Act and its implementing decree, Government Decree 301/2007 (XI. 9.) on the implementation of Act LXXX of 2007 on Asylum (hereinafter: Implementation Decree), there is no period of stay requirements for the use of benefits based on social need for either asylum seekers or beneficiaries of international protection (refugee, protected, asylum seeker, admitted). The lack of income and financial resources does not in any way lead to the withdrawal or suspension of basic needs for asylum seekers and beneficiaries of international protection. The legal regulations clearly provide for this [Section 5 (1) a)-d), Section 10 (1), Section 10 (3) a) -b), Section 17 (1)-(2), Section 22 (1) a)-c), Section 25/C of the Asylum Act].

Persons with refugee and protected status have the same rights as Hungarian citizens. Accordingly, refugees and beneficiaries of international protection are entitled to the same benefits and subsidies of a social nature under the same conditions as Hungarian citizens based on their social need. Although it is not part of this report, it can also be said that they do not need a work permit to work in Hungary similarly to Hungarian citizens, they are free to work in Hungary and are entitled to active employment policy instruments under the same conditions. Pursuant to the Act CXC of 2011 on the National Public Education, children are

entitled to participate in the education of public educational institutions from the time of submitting the application for recognition, and are obliged to attend school from the submission of the application for recognition. There was no change either in this area during the reporting period.

The National Directorate-General for Alienc Policing (hereinafter referred by the Hungarian abbreviation as: OIF) continuously monitors the special care needs (minority, illness, injury, mental problems, etc.) during the procedure and takes the necessary measures in view of the applicant's particular situation. These measures can be extremely diverse due to the diversity of vulnerabilities and the nature of special needs. The most common measures include the provision of the necessary health care (on-site, hospital, medicines, psychiatric care, etc.), the personalised provision of in-kind benefits (special meals, residential areas for the persons with moving disability, appropriate clothing, etc.) and extraordinary administration for unaccompanied minors with the assignment of a guardian.

The OIF ensures the identification of asylum seekers with special needs and takes the necessary measures for both official administrators and social workers through internal regulators and regular training.

In connection with Article 13 of the Charter, the report also covers the provisions of the Asylum Act the Implementation Decree, pertaining to the health care of applicants without any social security relationship, applicants for the recognition of social needs, refugees, sheltered, protected and admitted persons which determine the scope of health care available to socially deprived persons without any social security relationship.

Pursuant to Sections 26-28 of the Implementation Decree, if a person applying for recognition is not in a social security relationship, in the case of an illness, they are entitled, free of charge, to primary health care according to a separate legal regulation, examinations and medical treatment within the scope of family practitioner services, examinations, treatment, medication and bandages used in outpatient care, inpatient care in an emergency, and medical treatment prescribed by a doctor, including surgical interventions, and the medical materials and medical devices used in the course of the treatment. They are also entitled to the necessary examinations and treatment after outpatient care or inpatient treatment until they recover from the disease or their condition stabilises, non-substitutable medicinal products and a medical devices necessary for the administration of a medicinal product, which are not among the medicinal products which may be prescribed free of charge for ‘persons entitled to public health care’ under the special legislation or with 90% or 100% social insurance support under ‘legal provisions on health’, other medical aids prescribed by the doctor and their repair, emergency dental care and dental treatment, as well as maternity care and obstetric care, and intervention to terminate a pregnancy under the conditions specified in the Act LXXIX of 1992 on the Protection of Foetal Life, as well as compulsory vaccinations connected to age. In addition, the OIF finances the costs of medical examinations carried out and compulsory vaccinations ordered by the public health administration during the asylum procedure.

From 1 June 2016, the Implementation Decree specifies separately the entitlement to primary health care, which, in addition to family practitioner care, may be used by the applicant for recognition as part of the care provided by the local government of the accommodation. The family practitioner care of persons applying for recognition placed in a receiving institution will continue to be provided at the reception centre or in asylum detention in accordance with

the regulations of the previous period. Pursuant to Section 34 of the Implementation Decree, if the care is necessary in view of their individual situation and on the basis of a specialist opinion, in addition to the provisions laid down in Sections 26-27 of the Implementation Decree, persons in need of special treatment are entitled free of charge to the use of health services justified by their health status, rehabilitation, psychological and clinical psychological care, as well as psychotherapeutic treatment. There was no change in this area during the reporting period.

As a result of the amendment of the Asylum Act and the Implementation Decree, from 1 June 2016, in the case of socially deprived refugees and protected persons who are not in a social security relationship, the period of entitlement to primary health care and health care under special legislation is 6 months. Based on the needs of refugees and protected persons, if they are not in a social security relationship, they are entitled to primary health care and health care according to special legislation for 6 months from recognition pursuant to Section 29/A of the Asylum Act [Section 32 (1)-(1a) of the Asylum Act].

Pursuant to Section 44 (1) of the Implementation Decree effective as of 1 June 2016, if the refugee or the protected person is not in a social security relationship, they are entitled to health care for 6 months from the finalisation of the final recognition decision in accordance with the rules applicable to those seeking recognition. If an admitted person is not in a social security relationship, they are entitled to family practitioner care free of charge in the event of an illness, as well as to benefits specified in Section 142 (2) and (3) e) and i) of Act CLIV of 1997 on Health Care [Section 44 (3) of the Implementation Decree]. The admitted persons are entitled to the compulsory vaccination provided for in the separate legislation [Section 44 (4) of the Implementation Decree].

Detailed rules for claiming cash and in-kind benefits:

From 1 January 2016, the personal scope of Social Administration Act extends to the following persons living in Hungary:

a) Hungarian citizens,
b) immigrants and settlers,
c) stateless persons,
d) persons recognised as refugees by the Hungarian authorities.

In view of the above, immigrants and settlers, stateless persons or persons recognised as refugees or protected persons by the Hungarian authorities may receive benefits in cash and in kind if they live in Hungary.

With regard to **extraordinary local government support,** the scope of Social Administration Act also extends to citizens of the countries ratifying the European Social Charter who are legally residing in the territory of Hungary.

The scope of the act extends to persons with the right of free movement and residence if, at the time of claiming the benefit, they exercise their right of free movement and residence for more than three months in the territory of Hungary and have a registered residence specified in the Act LXVI of 1992 on Keeping Records on the Personal Data and Addresses of Citizens.

With regard to the old age pension, the scope of the Act covers:

- persons belonging to the group of entitled persons defined in the EU regulations on the coordination of social security systems and their implementation if, at the time of

claiming the benefit, they exercise their right of free movement and residence for more than three months in the territory of Hungary and have a registered residence specified in the Act LXVI of 1992 on Keeping Records on the Personal Data and Addresses of Citizens.

- third-country citizens holding a permit issued for the purpose of employment and residence requiring a high level of qualification (EU Blue Card), provided that they have a registered place of residence or stay registered in accordance with the Act LXVI of 1992 on Keeping Records on the Personal Data and Addresses of Citizens, and third-country citizens holding a consolidated permit and legally residing in the territory of Hungary.

From 1 January 2018, with regard to the old age pension, the Social Administration Act also covers third-country citizens holding a residence permit covered by Directive (EU) No. 2016/801 of the European Parliament and of the Council of 11 May 2016 on the conditions for the entry and residence of a third-country citizen for the purposes of research, study, traineeship, voluntary service, student exchange programmes or educational projects, and au pair activities. In addition to the above, the scope of Child Protection Act covers

a) children, young adults of Hungarian citizenship residing in the territory of Hungary and, unless otherwise provided by an international treaty, children, young adults with a settled, immigrant and admitted status as well as recognised as refugees, protected or stateless persons by the Hungarian authorities and their parents;
b) persons with the right of free movement and residence if, at the time of claiming the benefit, they exercise their right of free movement and residence for more than three months in the territory of Hungary and have a registered residence specified in the Act LXVI of 1992 on Keeping Records on the Personal Data and Addresses of Citizens;
c) foreign children aged less than eighteen who have applied for asylum and entered the territory of Hungary unaccompanied by an adult responsible for their supervision by law or custom, or who have remained unaccompanied after entry, until they are placed under supervision by an adult responsible for them provided that the minor age of person concerned has been established by the OIF.

Therefore, benefits that can be paid under the Child Protection Act can also be provided to non-Hungarian citizens referred to above.

The ECSR emphasises that State Parties may not deprive foreigners residing in their territory of the right to housing on the sole ground that the persons concerned have no income, thus excluding them from the rights under the respective paragraph. The ECSR is interested in whether such a situation exists in Hungary. The ECSR recalls that foreigners with a disorderly status must have a legally recognised right to basic needs (food, clothing, shelter) to cope with possible urgent and serious emergency circumstances. Suspension of this right is not permitted. The ECSR is interested in whether the legal system and practice of Hungary grants the mentioned right.

Within the scope of entitlement to a residence permit, Section 13 (1) of Act II of 2007 on the Admission and Right of Residence of Third-Country Nationals (hereinafter: RRTN Act) defines the basic conditions of stay of third-country nationals for more than ninety days within one hundred and eighty days. A third-country citizen may reside in the territory of Hungary for such a period who, beside fulfilling other conditions:

- has accommodation or a place of residence in the territory of Hungary;

- has sufficient means of subsistence and financial resources to cover their accommodation costs for the duration of the intended stay and for the return to their country of origin or transit to a third country,
- has full healthcare insurance or sufficient financial resources for healthcare services;
- is not considered to be a threat to public order, public security or public health, or to the national security of Hungary.

Section 13 (2) of the RRTN Act allows the OIF to authorise the entry and stay of third- country nationals in the event of non-compliance with the requirements set out in paragraph (1), only on humanitarian grounds, on grounds of national interest or because of international obligations.

In relation to the conditions of entry and stay, Section 29 of Government Decree 114/2007 (24 May) issued on the implementation of the RRTN Act (hereinafter: Implementation Decree of the RRTN Act) contains further detailed rules regarding the purpose of stay, accommodation in Hungary, subsistence, entitlement to health care, and the conditions necessary for further or return travel. Thus, the requirement of accommodation is considered satisfied if the third-country national is the owner of a residential property registered in the real estate register as a detached house or a residential suite, or if entitled to use such property under any title; and if the size of the living space per person residing in the property is at least 6 sqm [Section 29 (3) and (3a) of Implementation Decree of the RRTN Act]. In cases deserving special equity, the regional directorate may accept the housing of third-country nationals even in absence of the housing conditions. [Section 29 (3) b) of the Implementation Decree of the RRTN Act].

With regard to living in Hungary, a third-country national shall be construed to have sufficient resources to cover their subsistence for residence for a period of longer than three months if their income or assets or their family members' income or assets is sufficient to cover their living expenses, including accommodation, return travel, and if necessary, health care. The Implementation Decree of the RRTN Act determines with illustrative examples the supporting documents with which the subsistence can be justified (e.g., by a certificate from a credit institution; a document certifying the existence of booked and paid accommodation and benefits; a document certifying the existence of a property in Hungary which is the basis of subsistence; proof of income from legal and paid activity in Hungary; a certificate of regular income from abroad; the declaration of maintenance of the family member with the right of residence specified in the territory of Hungary, and with the document certifying the maintenance capacity of the person undertaking the maintenance). At the same time, the customer's subsistence can be supported in other credible ways, so subsistence cannot be justified solely by legal salary or income [Section 29 (5) and (6) of the Implementation Decree of the RRTN Act].

The condition laid down for the health insurance is fulfilled by a third-country national who

a) is for the entire duration of their stay in Hungary, in accordance with the specified act on the social security benefits,
   - is insured, or
   - has acquired access to Hungarian health insurance services by virtue of an agreement, or financing for services similar to what is provided to Hungarian residents is ensured under international convention or agreement; or
   - is entitled to receive medical services only;

b) is entitled to health care services under the scope of a private accident and health insurance plan outside the compulsory social security system;
c) by virtue of international convention or agreement the applicant is entitled to health care services similar to those provided to Hungarian residents or
d) is able to cover the costs of health care services as verified by the documentary evidence on their subsistence.
[Section 29 (7) of Implementation Decree of the RRTN Act]

It should be emphasised that the OIF, as an authority responsible for immigrational issues, decides on applications for a residence permit under the conditions indicated above, acting in its discretion, after assessing all the circumstances and evidence individually and on a consolidated basis.

In addition to the above it needs to be stressed that, pursuant to Section 29(1) of the RRTN Act, in the absence of the requirements for a residence permit specified in this Act the following persons shall be granted a residence permit on humanitarian grounds:

- the person recognized by Hungary as a stateless person or an adopted person;
- who applied to the immigration authority for asylum, or who applied to the immigration authority for any subsidiary form of protection or temporary protection;
- any third-country national who was born in the territory of Hungary and has been later removed from the custody of his/her guardian responsible for him/her according to Hungarian law, and also unaccompanied minors;
- who has cooperated with the authorities in a crime investigation;
- third-country nationals who have been subjected to particularly exploitative working conditions, or to third-country national minors who were employed illegally without a valid residence permit or other authorization for stay.

Within the scope of entitlement to a residence permit, if the other legal conditions are met, a third-country national may be granted a temporary residence permit, a national residence permit or an EC residence permit if they have residence and subsistence in Hungary, who is considered to be insured for the full range of health care service or can cover the costs of their health care services and against whom there is no ground for exclusion specified in this Act [Section 33 (1) of the RRTN Act].

Section 95 (1) of Implementation Decree of the RRTN Act defines the range of documents intended to support living in Hungary with illustrative examples, even in the case of types of residence permit. Even in case of a residence permit, the authority shall make its decision in its discretion, after assessing all the circumstances and evidence individually and in its entirety, indicating the criteria for consideration.

The OIF may withdraw the residence permit, a national permanent residence permit or immigration permit if the circumstances based on which they were issued have changed to an extent that the criteria for authorization is no longer satisfied, and if a period of five years has not elapsed from the date of issue of the permit [Section 37 (1) a) of the RRTN Act].

Pursuant to Section 105 (1) of the Implementation Decree of the RRTN Act, the circumstances of granting residence permit referred to in 37 (1) (a) of the RRTN Act have changed significantly if the settled third-country national is unable to ensure the subsistence of accommodation for themselves and the dependent relatives or if, despite their ability to

work, they need regular social care and support, or a member of the family undertaking their maintenance or housing does not fulfil this obligation.

As mentioned above, a residence permit, a national residence permit or an immigration permit may only be revoked if the indicated time limit is maintained, subject to an examination of the conditions detailed in Section 105 (1) of the Implementation Decree of the RRTN Act. The OIF has a broad scope of discretion also in this area.

Those EEA citizens are entitled to stay for more than ninety days within one hundred and eighty days:

- whose purpose of residence is to pursue paid activity;
- who has sufficient resources for themselves and their family members for the entire duration of the stay so that their stay does not constitute an unreasonable burden on the Hungarian social security system, and is entitled to use health insurance services within the framework of an insurance legal relationship as specified in a separate legal act, or provides for their coverage in accordance with the provisions of legal acts; or
- who has been admitted to a public educational institution, vocational training institution or higher education institution for the purpose of pursuing studies and has sufficient resources for themselves and their family members for the entire duration of the stay so that their stay does not constitute an unreasonable burden on the Hungarian social security system, and is entitled to use health insurance services within the framework of an insurance legal relationship as specified in a separate legal act, or provides for their coverage in accordance with the provisions of legal acts;

The criterion of sufficient resources is laid down in Section 21 (1)-(3) of Government Decree 113/2007 (24 May) on the Implementation of Act I of 2007 on the Entry and Residence of Persons with the Right of Free Movement and Residence:

"21 (1) Sufficient resources shall mean if the per capita monthly income in the applicant's household reaches at least the current minimum old-age social security pension. A person shall be considered to lack sufficient resources if drawing:

a) social welfare for the elderly under Subsection (1) of Section 32/B of Act III of 1993 on Social Administration and Social Welfare Benefits (hereinafter referred to as: SAA),

b) benefits provided to persons of active age under Section 33,

c) attendance allowance under 43/B of the SAA,

for any period of more than three months.

(2) If the per capita monthly income in the applicant's household is below the prevailing minimum old-age social security pension, the competent authority shall check the applicant's income and financial position to determine as to whether the applicant has sufficient resources for him/herself and his/her family members not to become a burden on the social assistance system of Hungary during their period of residence.

(3) If the purpose of residence is to pursue studies, the competent authority shall determine the availability of sufficient resources without the examination referred to in Subsection (2), if the applicant provides a statement declaring to have sufficient resources for him/herself and

his/her family members not to become a burden on the social assistance system of Hungary during their period of residence."

Pursuant to Sections 27-29/A and 32 (2)-(3) of the Asylum Act, asylum seekers and foreigners granted international protection legally residing in Hungary, if they are socially depraved, are entitled to the caretypes specified in the Asylum Act and the Implementing Regulation. It is necessary to emphasise that foreigners who illegally arrive in Hungary and apply for asylum receive the same benefits as those who are legally here. They receive food, accommodation, health care, legal assistance and education free of charge in the host institutions designated for them (in the case of asylum detention, in the asylum reception centre). Interpretation is also provided to them free of charge by the OIF.

In addition to the above, they can also use the support of social organisations and international organisations (Cordelia Foundation, IOM, Baptist Charity Service, etc.). Pursuant to Section 26 (3)-(4) of the Asylum Act, only persons who have adequate financial resources are obliged to reimburse the cost of their benefits.

In addition to the above, extraordinary settlement support, meals and accommodation can also be provided to citizens of the countries that strengthen the European Social Charter legally residing in Hungary, if their absence would endanger their lives and physical integrity.

The ECSR calls for confirmation that those engaged in paid activity can also receive care for persons of active age if they meet the conditions, i.e. their income is lower than 90% of the minimum old-age pension.

Care for persons of active age is support for people of working age, who are disadvantaged in the labour market, and their families. There are two types:

1. health impairment and childcare allowance,
2. employment replacement allowance.

According to Section 33 (1) of the Social Administration Act, care for persons of active age is a benefit provided to persons of active age, who are disadvantaged in the labour market, and their families. The district office determines the entitlement to care for persons of active age for an active age person

a) who has lost at least 67% of their ability to work, who has suffered at least 50% health impairment, or whose state of health does not exceed 50% according to the complex qualification of the rehabilitation authority, or

b) who receives a personal benefit for the blind, or

c) who receives a disability allowance [the persons referred to in paragraphs a) to c) hereinafter jointly referred to as: 'person with impaired health'], or

d) in respect of whom the period for payment of unemployment allowance, unemployment benefit, job-seekers' allowance, or self-employed benefit (hereinafter jointly referred to as: 'job-seekers' support') has expired, or

e) in respect of whom the payment of job-seekers' support was terminated due to the pursuit of gainful employment before the expiry of the payment period, and following the gainful employment they are not entitled to job-seekers' support under the Flt., or

f) who has cooperated with the public employment body or the rehabilitation authority for at least one year during the two years preceding the application for care for persons of active age, or

g) g) in respect of whom the care allowance, the benefit pursuant to the Family Support Act, regular social allowance, miners' health impairment allowance, transitional allowance, rehabilitation allowance, disability pension, accident disability pension, benefits for persons with a reduced ability to work, the payment of the temporary widow's pension or the payment of the widow's pension ceased for a reason specified in Section 52 (3) of the Tny., and immediately prior to the submission of the application they cooperated with the public employment body or the rehabilitation authority for at least three months,

provided that their and their family's livelihood cannot be ensured by any other means and that they are not gainfully employed.

Pursuant to the above regulation, in the case of continuing gainful employment, the care for persons of active age according to the Social Administration Act cannot be provided.

The ECSR emphasises that care for persons of active age must be discontinued if the person, who is also entitled to employment replacement allowance:

- ***rejects the job offered by the employment authority;***
- ***unlawfully terminates their public employment relationship;***
- ***the employer terminates their public employment relationship with immediate effect;***
- ***is deleted from the database of job seekers due to lack of cooperation; or***
- ***does not register as a job seeker until the deadline specified in the decision to disburse the benefit.***

The ECSR requests information on whether, in such cases, the benefits are withdrawn completely, depriving the affected person of their means of subsistence.

Entitlement for employment replacement allowance is reviewed annually. Further payment of the allowance is possible only if the annual review finds that the eligibility conditions continue to be met, and if − for at least 30 days during the year preceding the date of the review, prvided that his/her entitlement to the employment replacement allowance existed during this time − the entitled person:

- participated in public employment,
- engaged in gainful employment,
- participated in a labour market programme,
- participated in training according to the Flt. and announced for a period of at least six months,
- continues to participate in such training, or
- within the framework of their membership in the business partnership, they were directly involved in the joint production of the business partnership.

In some cases, the job may be re-established within thirty-six months of termination without prior cooperation with the public employment service, provided that the conditions for entitlement are otherwise met and the termination of the benefit is not for 'sanctioning' reasons.

The provision of employment replacement allowance is subject to an obligation of cooperation, and in the case of non-compliance the entitlement the allowance is terminated.

The ECSR is also interested in whether the local government housing maintenance allowance is mandatorily disbursed to everyone who meets the criteria, or is it at the discretion of the disbursing authority?

The benefits provided by the local government are provided under the conditions set out in their local government decrees. Local governments are free to determine the types of benefits they provide and the conditions under which they are provided. If the decree grants discretionary powers to the competent person, the provision of benefits cannot be considered mandatory.

The ECSR also stated that the amount of social assistance paid to people without resources is insufficient in Hungary, as it does not reach the poverty line. Therefore, Hungary does not comply with Article 13 (1).

The Government places great emphasis on ensuring that everyone who can be employed earns a living from work instead of assistance, as work provides the primary means for getting out of poverty. Therefore, the Government has taken several measures in recent years to create jobs and ensure full employment.

The return of people with a disadvantage to the active labour market is facilitated by the system of public employment organised by the state, the objective of which is for employable people excluded from the labour market to earn their and their family's living from working rather than from receiving assistance (from the HUF 22 800 employment replacement allowance), strengthening the principle of self-sufficiency.

The net public employment wage in 2019 in the case of a childless person employed for 8 hours is HUF 54 217, this amount increases in the case of persons raising a child due to the family discount. In the case of parents raising three or more children, the net public employment wage in the case of 8 hours of public employment is HUF 80 307. However, in addition to providing an opportunity to return to the labour market, public employment also makes it easier for the person concerned to make a living due to the wage amount.

In addition, a number of measures have been taken in recent years to strengthen the social security of families in need of assistance living in difficult financial conditions. In order to strengthen the social security of the elderly, the old-age pension has increased by an average of 5% since 1 January 2017. From 1 January 2018, in addition to increasing the income limit of the benefit by a further 5%, the amount of the allowance also increased in line with the rate of pension increase (in line with inflation). From 1 January 2019, the income limit of the benefit and the amount of the benefit increased in line with the rate of the annual pension increase (2.7%).

Among the additional social benefits available to persons without income, public medical care should be highlighted, which is an income supplementing benefit provided by district offices to reduce the costs of maintaining and restoring health.

The entitled persons specified by law are entitled to public medical care on subjective right (a person with impaired health entitled to care for persons of active age; person receiving disability benefits with their state of health not exceeding 30% according to the complex qualification of the rehabilitation authority; persons entitled to higher family allowance, etc.).

A person is entitled to normative public medical care if the payable allowance for regular medical care exceeded 10% of the old-age pension amount in 2016 and the monthly per capita income in the family does not reach 100% of the old-age pension amount, or 150% for those loving alone.

The income limit for benefits increased by 5% from 1 January 2018. This means that in the case of a family member, the per capita income may not exceed a minimum of 105% (HUF 29 925) of the old-age pension, while in the case of an applicant living alone, the per capita income may not exceed 155% (HUF 44 175). The number of recipients of public medical care has increased due to the raising of the income limit, as more people can be granted entitlement to the benefits.

It is an in-kind benefit, which can be used with a public medical care certificate. The amount of medical care consists of an individual medication allowance (HUF 1 000-12 000) depending on the monthly medication needs, and an ad hoc allowance. The latter provides support for acute illnesses (HUF 6 000 once a year). In addition, public medical care is used for the free use of medical aids and medical services.

As a result of the measures implemented so far, based on the latest data of the Hungarian Central Statistical Office for 2018 according to the EU methodology (but also considering the previous years), the Hungarian poverty data show a continuous and significant improvement.

In order to ensure the effective exercise of the right to social and healthcare assistance, the Parties undertake to:

2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;

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

The ECSR requests information on whether Hungary applies its legal provisions with regard to the exercising of political or social rights, which establish the principle of equality and prohibit discrimination in such a way that they prevent discrimination on the basis of social or medical assistance.

In Hungary, by organising basic social services, the state and local governments support socially deprived people to maintain their independent living in their own homes and living environments, as well as to solve their problems arising from their health, mental state or other reasons. Family assistance provided by family and child welfare services for persons in need of assistance due to social or mental health problems or other crisis situations, and services provided for families to prevent the causes of such a situation, to end a crisis situation and to maintain life skills, which are mandatory tasks for all local governments and are services available everywhere to those in need. Family support should include social, life and mental health counselling and the provision of access to cash, in-kind and social services for people in financial difficulties.

Both the service and the services provided by the centre are available free of charge. The specific rules on benefits are provided in this report, in the chapter on Article 14 (1).

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) RESPONSES GIVEN TO THE QUESTIONS OF ECSR

The ECSR requested information on wether those in need can receive free assistance and counseling and whether the geographical distribution of these services and institutions is appropriate. Updated information on the legal and practical background to this is also requested.

The requested information can be found in the section on the article 12 (2) of this Report, under the paragraph dealing with the measures implemented on the area of social inclusion.

ARTICLE 14
Entitlement to social welfare services

With a view to ensuring the effective exercise of the right of entitlement to 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) THE GENERAL LEGAL FRAMEWORK, THE NATURE, CAUSES AND SCOPE OF REFORMS

The ECSR requested updated information on the overall operation of the system of social service providers, the activities they perform, including public and private institutions and other organisations.

In the 2017 conclusions of the European Commission of Social Rights, the question arose in connection with Article 14 (2) as to what preventive and reparative monitoring system Hungary should use to control the quality of services and to ensure the rights of users and respect for human dignity and fundamental freedoms, in particular to ensure the requirement of equal opportunities and equal access. In connection with this issue, the Hungarian Government provides the following information on the regulatory system of Act CXXV of 2003 on Equal Treatment and the Promotion of Equal Opportunities (hereinafter: Equal Treatment Act) and on the means of redress of a person who has had their rights violated.

The provisions of Article XV (2) of the Fundamental Law of Hungary are specified in the Equal Treatment Act, therefore, it determines the personal and material scope of the requirement of equal treatment. The Equal Treatment Act defines in detail conduct that violates the requirement of equal treatment (direct or indirect discrimination, harassment, unlawful segregation, retaliation), as well as the concepts of direct and indirect discrimination, thus ensuring the coherence of the anti-discrimination legislation, with the provison that the rules on the requirement of equal treatment stipulated in other legislations shall be interpreted in accordance with the provisions of this Act. Accordingly, the content of the requirement of equal treatment may not be determined by a separate legal act differently from that provided for by this Act, but it is possible for separate legislation to determine the scope of the obligation of equal treatment more extensively than the law, and to impose a specific sanction for violation of the principle of equal treatment with regard to the legal relationships governed by the relevant sectoral legislation.

In order to enforce the provisions of the Equal Treatment Act, the law established the Equal Treatment Authority (hereinafter referred to by the Hungarian abbreviation as: EBH), which is independent within the meaning of Section 33 (3) of the Equal Treatment Act, is subordinate to the law only, cannot be instructed within its scope, and performs its task independently from other bodies, without any interference. Furthermore, the task of the authority can only be determined by law.

Opportunities for claim enforcement of an injured person are set out in Chapter 2 of the Equal Treatment Act and in separate legislation. It is left to the injured party to choose whether to apply to the EBH or to initiate other legal proceedings (e.g.: litigation for the enforcement of privacy rights, employment lawsuits, public service lawsuits, as well as consumer protection, employment, or infringement authority proceedings). An EBH investigation of an infringement of the principle of equal treatment may be initiated ex officio or upon request in the cases specified in the Equal Treatment Act. Pursuant to Section 14 (1) a) of the Equal Treatment Act, EBH adopts a decision on the basis of the investigation. Where the authority has established the infringement of the principle of equal treatment, it may order the cessation of the infringement; prohibit future practising of the unlawful conduct; order the public disclosure of its final decision in the public interest, except for the public information of the offender in the public interest, in a manner unsuitable for identification; impose a fine or impose a legal penalty specified in separate legislation.

There is no appeal against the decision of the EBH, however a judicial review of the decision can be initiated. The appeal against the decision of the EBH was terminated before 1 January 2018 by Section 17/B (1) of the Equal Treatment Act, the provisions of which were repealed by Act L of 2017 on the Amendment of Certain Laws Relating to the Entry into Force of the Act on General Public Administration Proceedings and the Act on the Code of Administrative Litigation, considering, pursuant to the general rules of Act CL of 2016 on General Public Administration Proceedings, that there is no option for appeal in the proceedings of the EBH. This is also highlighted in the reasoning provided for the amendment. Pursuant to Section 33 (2) a) of the Equal Treatment Act, EBH adopts a decision on the basis of the investigation. Under Section 13 (3) of Act I of 2017 on the Code of Administrative Litigation, the Budapest-Capital Regional Court has exclusive jurisdiction in such cases.

1. The basic system of social and child welfare benefits providing personal care

Social benefits providing personal care are regulated by Act III of 1993 on Social Administration and Social Services (hereinafter: Social Administration Act), and primary child welfare benefits are regulated by XXXI of 1997 on the Protection of Children and Guardianship (hereinafter: Child Protection Act).

2. Forms of social services

Personal care includes basic social services and specialised care. Basic services and specialised care should be provided for the elderly, disabled persons, the homeless and people with psychiatric and addiction issues.

Basic social services help socially deprived people to maintain independent living in their own homes and living environments and to solve problems arising from their health, mental state or other reasons.

The ***basic social services*** are the following:

- village caretaker and farm caretaker service,
- catering,
- home assistance,
- family support,
- home assistance with a signalling system,

- community care,
- support service,
- street social work,
- day care.

If, due to their age, health status and social situation, persons in need can no longer be cared for in the framework of basic services, they must be cared for in a form of specialised care appropriate to their condition and situation.

The ***specialised care services*** are the following:

- Institutions providing long-term accommodation:
  - institution providing nursing and care,
  - rehabilitation institution,
  - residential home,
- institution providing temporary accommodation,
- subsidised housing.

3. Primary child welfare benefit

Primary child welfare care should contribute to the child's physical, intellectual, emotional and moral development, well-being, family upbringing, prevention and elimination of vulnerability, and prevention of the removal of the child from the family, exploring the disadvantage and multiple disadvantage of the child and to overcome it by reducing the socialisation disadvantage of the child.

The ***primary child welfare benefits*** are the following:

- child welfare service (family and child welfare service, family and child welfare centre),
- day care for children (nursery care, daycare alternative daycare),
- children's empowerment services,
- temporary care of children (temporary home for families, temporary home for children, surrogate parent),

<u>Measures taken in the field of day care for children:</u>
As of January 1, 2017, a new nursery system provides day care for children in two institutional (nursery, mini nursery) and two service forms (family nursery, occupational nursery). By making the nursery care system more flexible, help will be given to families in which both parents work or where the working parent raises a child under 3 years of age alone. The goal is to provide day care for children for these families locally, or at least in one of the surrounding settlements. By June 30, 2022, nurseries fo at least 70 000 children should be available. As of May 31, 2020, as a result of the improvements, 51 458 nursery care places are already available[39], compared to approximately 32 000 in 2010. The establishment of the nursery also has an impact on the population retention and growth of the settlement. The development of nurseries also has an impact on employment, both directly and indirectly, on the one hand by creating new jobs in the new institution and on the other hand by enabling mothers with young children to return to the labor market. Nursery care also contributes to the foundation of children's socialization, helping them to integrate into the kindergarten

[39] Source: Hungarian Centra Statistical Office OSAP no. 1203.

environment by getting children to know the basic rules of behaving with their peers already in the nursery.

4. Task performance method

Social services and primary child welfare benefit can be provided by any maintainer if the conditions prescribed by law are met, if the service provider or institution maintained by them is registered in the register of service providers.

With regard to the basic services, the Social Administration Act imposes an obligation on local governments to perform tasks as follows.

The **local government** is obliged to provide, ***regardless of the population***:

- family assistance if it runs a mayor's office or the seat of the joint local government office is in the settlement,
- catering,
- home assistance.

Depending on the population, the local government is obliged to provide the following:

- day care for the elderly above three thousand people,
- day care for the elderly, disabled persons, the homeless and people with psychiatric and addiction issues above ten thousand people,
- in addition to all day care, temporary care for the elderly, night shelter and temporary accommodation for the homeless above thirty thousand people.

The **district self-governments in Budapest** are obliged to provide the social services listed above, taking into account the task performance obligation of Budapest Municipality.

The **Budapest Municipality** is obliged to organise and maintain the following:

- homes for the elderly, homes for the homeless, rehabilitation facilities for the homeless,
- in the capital, unless otherwise agreed with the district self-government, the night shelter and temporary accommodation for the homeless.

The **town with county right** is obliged in its own territory to organise and maintain the following:

- basic service tasks,
- homes for the elderly,
- a night shelter, temporary accommodation for the homeless and, if justified by the needs of the population, a home for the homeless and a rehabilitation facility for the homeless.

With the exception of the care for the homeless, the State is responsible for the provision of social residential care, and the maintainer tasks of the state are performed by the Directorate-General for Social Affairs and Child Protection.

A **Directorate-General for Social Affairs and Child Protection** is obliged to ensure the following:

- specialised benefits in the territory of the county, with the obligation to provide the benefits that the town with county right is not obliged to organise, also covering the territory of the town with county right,
- specialised care in the capital for disabled people and for people with psychiatric and addiction issues,
- temporary residential care for disabled people, and people with psychiatric and addiction issues in settlements with a permanent population of more than thirty thousand,
- subsidised housing in the territory of the county, and
- development employment.

The Child Protection Act imposes a task performance obligation on local governments as follows.

The local government ensures primary child welfare services that provide personal care, with the exception of children's empowerment services.

The local government operating the mayor's office, the local government according to the seat of the joint local government office, and the district self-government in Budapest is obliged to operate the following ***regardless of the population***

- child welfare service.

The local government and the district self-government in Budapest is obliged to operate the following ***depending on the population***

- Nursery above ten thousand people, with the same obligation for less than ten thousand people if the children younger than 3 years of age living in the settlement exceeds 40, or ademand arises for at least 5 young children for the use of care,
- a temporary home for children in addition to the nursery above twenty thousand people,
- in addition to the above, temporary homes for families above thirty thousand people.

The **district seat, the district self-government in Budapest and the town with county rights** is obliged to operate the following ***regardless of the population***

- child welfare centre

In addition to the state and local governments, social and child welfare services **on a voluntary basis can also be provided by**

- **church and**
- **civil maintainers.**

The performance of the tasks of these actors may take place on the basis of a service contract concluded with the state or the local government, by which the task is taken over from the obligor, but it may also be performed without the conclusion thereof.

The legal basis of the Hungarian regulation on child welfare, child protection and guardianship is the Child Protection Act, which, in addition to its implementing regulations, regulates the operation of the institutional system intended to prevent, avoid and manage the child's vulnerability and the tasks arising from it.

Pursuant to Section 39 (1)-(2) of the Child Protection Act, a child welfare service is a special personal social service that protects the interests of the child and serves to promote the child's physical and mental health and family upbringing by using the methods and tools of social work, the prevention of the child's vulnerability, the elimination of the developed vulnerability, and the return of a child removed from their family. The task of the child welfare service is, among others, to provide information on children's rights and support for the child's development, to facilitate access to support, to help with the child's physical and mental health and family development, and the arranging of counselling and access to family planning, psychology, education, health, mental health and the addiction prevention services.

In Hungary, a child may be removed from their family and placed with foster parents or into children's home only if their endangerment has not been eliminated despite assistance within the framework of primary child welfare and there is no parent living independently, relative or third party who would undertake or be a suitable option for bringing up the child. In such a case, the child must be provided with full care and, regardless of the place of care, a child protection guardian who provides legal representation. This can happen based on a decision of the guardianship authority. The guardianship authority must perform a wide range of evidentiary steps, including the interviewing of the parents and obtaining the opinion of the child, as well as the views of professionals (paediatrician, health visitor, kindergarten, school, social worker) who know the child and the family. Parents can initiate proceeding before the court against the decision of the guardianship authority.

According to the Child Protection Act, a child who is separated from their family, especially a child under the age of 12, must, as a general rule, be placed with foster parents in order to develop properly. All children placed into care by the guardianship authority, with foster parents or in a children’s home are under the guardianship of a child protection guardian who promotes and monitors the proper care and upbringing of these minors, ensures their enrolment in school, access to necessary health care, etc. The guardianship authority reviews at regular intervals prescribed by the Child Protection Act the need to maintain the care, the possibility of caring for the child at home, or, in the absence thereof, the possibility of proceeding with adoption.

Priority is given to the provision of foster care, which came into force on 1 January 2014, according to which a child under the age of 12 must be placed with foster parents and not in an institution, unless the child has a long-term illness, severe disability or, due to the need to accommodate a large number of siblings together or for other reasons, the best interests of the child are better served by institutional placement. As a result of the measure, the ratio of foster care placement to institutional placement is constantly increasing. The role of church maintainers in the provision of child protection specialised care, especially in the field of foster care, is becoming increasingly important.

2) IMPLEMENTATION OF CERTAIN MEASURES

On 31 December 2019, in the institutional system of child protection specialised care:

- 49 foster care networks and 508 children's and residential home sites with operating licences. Of the foster care networks, 21 are maintained by the state, 24 by a church or a foundation and 4 by non-governmental organisations, and of the children’s and residential home sites, 439 are maintained by the state, 67 by a church or a foundation and 2 by non-governmental organisations;

- there are in total 28 121 places, of which 16 091 maintained by the state, 11 386 by a church or a foundation and 644 by non-governmental organisations. Within this, the total number of places in foster care networks is 19 620, of which 8 437 are maintained by the state, 10 543 by a church or a foundation and 604 by non-governmental organisations.

In addition, the ECSR requested a demonstration of the practical application of the reforms described in the previous report, such as:

- ***the 2012 reform of the Child Protection Act of the alert system and the protection of the notifying person or organisation;***
- ***the introduction of the foster parent legal relationship in 2014;***
- ***the obligation to provide care for unaccompanied minors by professional child protection institutions introduced on 1 May 2011, including the two institutions set up for this purpose and the 2015 reform of the institutions' temporary admission capacity;***
- ***the introduction in 2013 of subsidised housing as basic support for people with disabilities, psychiatric disorders and addictions.***

1. Measures as a result of the 2012 reform of the Child Protection Act

In order to comply with the Convention against Sexual Exploitation and Sexual Abuse of 25 October 2007 in Lanzarote, the Child Protection Act introduced provisions for the enforcement of children's rights as of 15 March 2014, which also serve to improve the operation of the alert system and the protection of the notifiers.

According to the amendment, the child welfare service provider and the guardianship authority must treat a report of child abuse, neglect or other serious danger in a closed manner without a separate request. Closed data management can ensure the more efficient operation of the alert system and the protection of the body or person alerting against a person suspected of abusing or threatening to abuse the child. The law stipulates mandatory closed data processing in order to report acts committed against the child as early as possible and to take effective action against the endangerment of the child.

Practical experience has shown that many times there is no indication of child abuse or neglect due to fear of family retaliation. The change introduced supports the prevention of child abuse and its detection as soon as possible, and thus the taking of immediate measures for the protection of the child.

In accordance with the amendment to the act, in order to facilitate its practical application, the regulation was also published in the implementing rules related to the Child Protection Act, and a guide was drawn up for the operating bodies to make the operation of the detection and alert system uniform and predictable.

Based on the implementing rules, it has become clear that the child welfare service provider and the guardianship office ex officio take care of the closed processing of the data came from the institutions or persons which alerted the child abuse or neglect, or initiated procedure because of this. Based on this, the guardianship office rejects the client's request for access to the part of the document containing the data to be kept closed, from which a conclusion can be drawn about the identity of the alerting or procedure initiating institution or person.

The child welfare service provider also does not provide the person affected by the alert with insight into the part of the document containing the data to be treated in a closed manner, from which a conclusion can be drawn about the identity of the alerting or procedure initiating institution or person. The child welfare service provider shall not indicate the alerting body or person on the data sheet completed by it in the case of data to be handled in a closed manner. In this case, the child welfare service provider shall attach the closed data to the guardianship office or the body acting to eliminate the child endangerment in a separate envelope.

At the same time, the closed processing of data does not affect the cooperation obligation of professionals and the proper clarification of the facts. It is not the individual members of the alert system who have to act individually against the subjects of the proceedings. Instead, the child welfare service provider and, if necessary, the guardianship office take steps to eliminate the endangerment of the child.

In addition, it is a guarantee requirement of the Child Protection Act that child protection professionals act on the basis of uniform principles and methodologies in child abuse cases and in cases of child sexual abuse.

To indicate abuse within the family or against a child, it is recommended to use a separate alert form suitable for the processing of closed data separately. The professional regulatory documents published by the Ministry of Human Capacities focus on the processes of support work, the operation of the alert system, especially the recognition and treatment of child abuse, and provide guidance in these areas.

As of 1 January 2018, with the amendment of the Child Protection Act, the investigation and management of child abuse cases in institutions providing child protection care and correctional facilities are based on the institutional, maintenance and sectoral methodology approved by the Minister responsible for child and youth protection and published on the Ministry's website. [Section 11 (1b) of the Child Protection Act].

In order to meet the legal requirement, a professional regulatory material entitled *"Institutional, Maintenance and Sectoral Methodology for Investigation and Management of Child and Young Adult Abuse in Childcare Institutions, Foster Care Networks and Correctional Institutions"* (hereinafter: 'Methodology'). The provisions of the Methodology are mandatory from 1 July 2018 in all child protection specialised care institutions and correctional institutions, regardless of the form of care and the maintainer. The introduction and application of the Methodology provides an opportunity for institutions specialised in child protection care and correctional institutions to act in the same way and with binding force in all child abuse cases. From the application of the Methodology, the Government expects that the latency of abuse cases will decrease, and the knowledge of the results of the conducted studies will improve the prevention capacity and tools of care providers.

Since 1 January 2018, the Child Protection Act also stipulates that the person exercising the right of appointment and assignment shall request a professional opinion from the previous employer of the person affected by the assignment or appointment and from the persons and bodies performing legal protection duties at the previous employer in connection with the performance of the professional duties of the person concerned and termination of employment. In the case of re-appointment, the person exercising the employer's rights is informed about the professional opinion of the representative of children's rights, the child

protection guardians, the opinion of the advocacy forum, the board of educators, and the results of government, ombudsman and prosecutorial inquiries concerning the institution [Section 15 (9a) of the Child Protection Act].

Also from 1 January 2018, pursuant to the amendment to the Child Protection Act, a person applying to be a foster parent is obliged, in the context of a foster parent aptitude test, to declare whether they have previously had a foster parent, professional foster parent or foster parent employment relationship with another operator. On the basis of this declaration, the operator requests a professional opinion of the previous operator on the foster parent regarding the performance of the foster parent's professional tasks and the termination of their legal relationship in order to determine the suitability of the foster parent [Section 66/B (8) of the Child Protection Act]. The purpose of this amendment was to make the historical information and circumstances related to the previous legal relationship, its cancellation and termination available to the potential new employer, thus reducing the risks (dangers) related to the information that can be withheld in order to increase the protection of children.

At the end of 2018, it was decided that from 1 January 2019 the tasks of the regional child protection services would include the service based on the Barnahus model aiding those examining and treating neglected and abused children, in particular sexually abused children and, at the request of an official body, the interviewing of the affected children [Section 61 (2) of the Child Protection Act]. Its objective is to protect child victims of sexual abuse from the re-traumatising effects of multiple interrogations during evidentiary and criminal proceedings, as well as other severely traumatic factors during the proceedings (e.g.: confronting the abuser, frustration caused by non-child-friendly interrogation, frustration caused by incompetent interrogation). The main objective of the model is that the child abuse procedure should not be dominated by the aspects of proof and criminal law, but by the consideration of the best interests of the child. The new service is also available to children living in families and children in child protective care upon official request. In Hungary, the Barnahus Department has been operating in the building of the Vas County Child Protection Centre, Primary School and Regional Child Protection Service since 2016. In the coming years, our objective is to ensure the national coverage of this service, for this purpose developments have started in Budapest, Debrecen, Gyula and Miskolc from individual subsidies from central budget sources.

In view of the seriousness/weight of the offence of sexual abuse committed against a person under the age of 18 and the seriousness of the offence against sexual morality and in order to protect children, it was appropriate to prohibit the perpetrator of such offences from engaging in any occupation or other activity with definitive effect, in the framework of which they perform the upbringing, supervision, care, medical treatment of persons younger than 18 years of age, or have another relationship of power or influence with such a person. The restriction came into force on 1 December 2017 by amending Act C of 2012 on the Criminal Code (hereinafter: Criminal Code) [Section 52 (3) of the Criminal Code].

A permanent prohibition of occupation also strengthens the intention to deter, as well as the protection of vulnerable or incapacitated children. The law also excludes the possibility that offenders who commit a crime of this gravity to the detriment of minors may later come into direct contact with of persons younger than 18 years of age again as a result of their occupation.

Endangering a minor includes behaviours that endanger the minor's physical, intellectual, moral, or emotional development. Prohibition of occupation also became mandatory in the case of this crime, but in view of the smaller weight of the crime, it was justified that the compulsory application of the prohibition of occupation could be waived in cases worthy of special consideration, at the discretion of the court [Section 52 (4) of the Criminal Code].

From 1 January 2019, the range of grounds for exclusion from employment was also extended, and the period of prohibition of occupation was tightened in the child protection system in order to protect those who deal with persons younger than 18 years of age but have previously committed crimes. After the amendment, in the event of a final determination of criminal liability, persons with a criminal record may not be employed for a period specified by the employer who educates, supervises, cares for or treats a person under the age of 18, which periods the amendment corresponds to the maximum registration times permitted by Act XLVII of 2009 on the Penal Register, on the Register of Judgments Delivered by the Courts of Member States of the European Union Against Hungarian Nationals, and on the Register of Biometric Data Related to Criminal Prosecution and Law Enforcement (even if the offender was not excluded from employment). The provisions of the Child Protection Act on the prohibition of the employment of persons who have committed certain criminal offences in the child protection system have been extended to include the indication of the criminal offence of abuse in the proceedings of a person performing a public function [Section 10/A (1) of the Child Protection Act].

The measure to increase the protection of the interests of children is also an amendment to the Child Protection Act that came into force on 1 January 2020, according to which the licensing body for the official registration of social, child welfare and child protection service providers, institutions and networks and the official control of these service providers, institutions and networks against the person employed or intended to be employed under the child protection system may request data from the criminal record for this purpose.

2. Introduction of the foster parent legal relationship in 2014

Pursuant to Government Decree 513/2013 (29 December) on Questions of the Employment Status of Foster Parents, which entered into force at the same time as the introduction of the foster parent employment relationship, the legal relationship of a person in a foster parent or professional foster parent relationship on 31 December 2013 was transformed into a foster parent employment relationship by operation of law, of which the operator had to inform the foster parent by 10 January 2014. The foster parent had to conclude a framework agreement with the operator on the employment relationship by 30 June 2014, however, they received the remuneration for their activities as of 1 January 2014 on the basis of the regulations on the foster parent employment relationship.

At the same time, the child protection guardianship was introduced from 1 January 2014, during which the temporary or long-term foster status of all minors placed in child protection care was reviewed in 2014 and if the child's child protection professional care was still justified, their status was changed to fostered status with the assignment of a child protection guardian. Foster parents who had previously been appointed as guardians were already ex officio exempted from the full performance of their legal representative duties during the course of their employment relationship.

It is also true for all age groups of those placed in child protection care, including young adults in aftercare, that the proportion of those placed with foster parents has increased since 2010. Since the adoption of foster care as a general rule, on 1 January 2014, the proportion of foster care for children under the age of 12 and children with special needs has also increased. While in 2010 58.83%, in 2019 68.77% of children, including 84.77% of children under 12 years of age, were placed with foster parents.

From 1 January 2020, foster parents may become entitled to a childcare allowance in respect of a foster child under the age of 2.

3. Care for unaccompanied minors by professional child protection institutions

The care of unaccompanied minors has been the responsibility of the child protection special care system pursuant to Section 48 (2) of Act LXXX of 2007 on Asylum and Section 4 (1) (c) of the Child Protection Act from 1 May 2011. Unaccompanied minors were placed in the reception centre of the asylum authority before 1 May 2011. Subsequently, all unaccompanied minors were placed in the childcare special care system by a decision of the asylum authority on temporary placement, regardless of their age and the purpose for which they came to Hungary, or the circumstances under which they became unsupervised in Hungary, and regardless of the fact of declaring a mass crisis caused by immigration.

Unaccompanied minors placed temporarily were received by the Károlyi István Children's Centre (hereinafter referred to by the Hungarian abbreviation as: KIGYK), a child protection specialised care institution maintained by the Directorate-General for Social Affairs and Child Protection (hereinafter referred to by the Hungarian abbreviation as: SZGYF), and the Szeged Children's Home for Unaccompanied Minors, and until 31 March 2016 by the Hódmezővásárhely Children's Home of the Szent Ágota Child Protection Service Provider maintained by the Szeged-Csanád Diocese. The placement of children who remained in Hungary for a long time, were granted refugee and protected status and, as a result, were placed in foster care by the guardianship authority, and the placement of young adults receiving aftercare care and international protection after reaching major age, received care by KIGYK Unaccompanied Minors' Children's Home and Aftercare Home and External Accommodation, and Orphanages and Aftercare Homes in the capital, also maintained by SZGYF, provided care in the first half of the reporting period. In the second half of the reporting period, young adults who received long-term stay in Hungary, refugee, protected status, and aftercare after receiving adult care and receiving international protection, were typically placed in the KIGYK Unaccompanied Minors' Children's Home and in residential aftercare homes and external residential places.

Unaccompanied minors placed in the KIGYK Unaccompanied Minors' Children's Home, aftercare homes and external residential homes, young adults receiving international protection and aftercare received full care in the same way as children and young adults of Hungarian citizenship receiving child protection specialist care. Child protection guardians were also assigned to unaccompanied minors (the same way as children of Hungarian nationality receiving child protection care).

Following the adoption by the Government of the report *'On the care of migrant children in Hungary',* recognising the special care needs of unaccompanied minors, in the light of the implementation experience gained in the care of unaccompanied minors, the regulation of the

specific professional tasks of an orphanage and temporary accommodation for unaccompanied minors (i.e., placed on a temporary basis) only entered into force in October 2015, with particular reference to information and interpretation in foreign languages, and to provide accommodation and services in accordance with religious and cultural customs. In addition, professional staffing standards for unaccompanied minors and temporary reception places not recognised as refugees have been laid down, which regulate the use of health visitors in addition to the general staffing standards for children's homes.

The temporary accommodation can operate in connection with a children's home for unaccompanied minors in addition to being entered in the register of service providers in a simplified procedure, it can even be operated in a building, part of a building or a structure not subject to a building permit (mobile home, residential container, tent) belonging to the children's home, if it is justified by the emerging need for care.

The Minister responsible for child and youth protection designated about 250 temporary shelters that can be operated only in the event of a crisis caused by mass immigration declared by the government, which can be included in the care within a short period of time if justified.

In practice, it can be said that placement in a temporary reception place has not actually taken place, but the relevant regulations are still in force.

4. The introduction of supported housing as a basic support for people with disabilities, psychiatric disorders and addictions

Subsidized housing, introduced by the amendment of the Social Administration Act that entered into force in 2013, creates appropriate conditions for persons with disabilities, psychiatric patients and addicts to receive housing and social services appropriate to their age, health and self-sufficiency.

The system of service elements for subsidised housing was introduced on 1 January 2017. These service elements should be provided in addition to housing services, case management and other services to facilitate participation in social life. Each service element to be provided to the user is selected on the basis of the results of a complex needs assessment. Nine service elements - supervision, meals, care, skills development, counselling, pedagogical assistance, special education assistance, transportation and household or household supplementing assistance - are listed by the law and cover a broad range of possible activities. It is worth providing the service elements through the basic services in the residential environment, so the basic services that can be provided for each service element are also defined in the law.

As of 1 January 2019, the conditions for the provision of care for minors in subsidised housing were confirmed by another amendment to the Social Administration Act, which also defined the mandatory service elements. In the framework of subsidised housing, from 2019 the elements of supervision and catering services for minors must be provided in all cases, on the condition that supervision can only be provided in a personal presence.

As of 31 December 2019, there were 1 119 licensed beds were available for disabled persons, 451 beds and 301 for patients with addictions in the form of subsidised housing for psychiatric patients. In 2019, twelve times as many disabled persons used subsidised housing

as in 2014(in 2014: 85 persons; in 2019: 1 038 persons), and this rate is six times higher (for psychiatric patients (in 2014: 68 persons; in 2019: 434 persons).[40]

3) RESPONSES GIVEN TO THE ADDITIONAL QUESTIONS OF ECSR

The ECSR requests information on how and to what extent each social service functioned during the coronavirus crisis and what possible measures have been taken in relation to similar crises in the future.

Due to the coronavirus pandemic in Hungary, between 11 March and 18 June 2020, an extraordinary legal order, the 'State of Danger' was in force.

During the State of Danger, the operating and service provision of day care institutions changed. Services provided in the day care facility building were suspended, but social workers continued to provide services to support the recipients' independent living (e.g., food delivery, shopping assistance, medicine purchase on prescription). Thus, during the State of Danger period, the operation of day care institutions did not cease, the activity was modified in order to prevent the spread of the epidemic, so that the maintenance of independent living is supported by assistance and infocommunication contacts in the user's living environment.

In the institutions providing specialised social care, with the exception of night shelters, temporary accommodation and external accommodation for the homeless, a ban on visits and leaving institutions and an admission stop has been introduced. The institutions could only be left in particularly justified cases, for example, in order to work, use health care services, and in the case of disabled persons, psychiatric patients and addicts during the daily sessions ensured by the service provider.

A ban on visits and leaving institutions was in place in child protection specialised care institution (foster parent networks, childcare home) until 18 May 2020. The National Chief Medical Officer set out the exceptions to leaving the institution (e.g., work, use of health care services, participation in daily leisure activities organised by a child protection institution) in her decision. At the same time, there was no admission stop in child protection specialised care institution, and both foster parent networks and childcare homes received new children into care. Admission of a new child was not conditional on a negative coronavirus test result. With regard to the pandemic situation, the Minister of Human Capacities has issued guidelines on primary social and child welfare services, specialised social services, child protection services and correctional facilities to assist service personnel in their emergency procedures to be followed in the State of Danger. Each of the recommendations concerning the protection of employees' health sets out practical examples to prevent social and child protection workers from becoming infected with the coronavirus.

Government Decree 88/2020 (5 April) on Certain Measures Relating to Social and Child Protection Services during the State of Danger and the Order of Operation of Social Services during the State of Danger contained temporary measures regarding social services, strengthening primary services and improving the situation of those concerned, in order to ensure the avoidance of personal contact and to protect the health of those living in social and child protection institutions. These are the following:

- in the case of using the primary services, the administration was simplified

[40] Source Hungarian Central Statistical Office OSAP no. 2257

- the examination of the eligibility for care did not have to be performed
- the signature of the recipient certifying the daily use had to be disregarded
- the validity of previous expert opinions and proposals is extended
- the number of admitted recipients, the number of places and the task index could be exceeded (in case of a supply contract)
- the maintainers are entitled to the support provided in the act on the central budget for the persons they cared according to the Government regulation
- in order to ensure the continuous operation of social and child protection service providers and institutions, employees who were exempted from work could be redirected, etc.

The National Chief Medical Officer lifted the ban on leaving the institution and visiting all social institutions operating in Hungary by its Resolution No. 13305-59/2020/EÜIG of 18 June 2020.

From 7 September 2020, in all social institutions providing specialised care in Hungary a ban was again imposed on leaving the institution and visiting by a decision of the National Chief Medical Officer. Exemption from the ban on visit can only be granted if someone wishes to say goodbye to a dying relative. The ban on leaving the institution does not apply to night shelters and temporary accommodation for the homeless persons. Institutions may be left only in justified cases, such as work or health care, or with the permission of the head of the institution, in particularly justified cases, or for leisure purposes organised in institutions providing care for the disabled persons, psychiatric and addicted patients. It still does not mean leaving the institution if someone is in the garden or area of the institution, so it is not subject to the restriction either.

A new recipient can only be admitted in possession of 2 negative COVD-19 tests taken before admission. This provision does not apply to night shelters for the homeless persons. A homeless person with symptoms of COVD-19 should always be taken to a health care facility.

With regard to child protection specialised care institutions, neither a ban on leaving the institution nor a visit ban was imposed in the autumn of 2020, during the second wave of the coronavirus epidemic. Foster parent networks and childcare home receive children who have been newly taken out of their families by an official measure. Negative coronavirus test results are not currently a condition for admission to a new child.

The ECSR emphasises that Hungary does not provide the same treatment as Hungarian citizens to citizens of other State Parties residing in Hungary with regard to access to social services, thus Hungary does not comply with Article 14 (1).

Social services providing personal care are regulated by the Social Administration Act, the scope of which extends to the following persons living in Hungary:
a) Hungarian citizens
b) immigrants and settlers,
c) stateless persons,
d) persons recognised as refugees or protected persons by the Hungarian authorities

The local government, regardless of its jurisdiction and competence, is obliged to provide extraordinary settlement support, meals and accommodation to those in need, if the absence of this endangers the life and physical integrity of the person in need. Citizens of countries

ratifying the European Social Charter who are legally resident in Hungary are also entitled to the listed benefits.

In addition to the above, the scope of the Act extends to any persons with the right of free movement and residence under the Act I. of 2007 on the Entry and Residence of Persons with the Right of Free Movement and Residence if they exercise their right of free movement and residence for more than three months at the time of claiming benefits, and has a registered place of residence in accordance with the Act on the Registration of Personal Data and Addresses of Citizens.

Information also requested on the legal provisions ensuring the protection of personal data when using social services.

The rules of data processing are set out in Section 18-24/B of the Social Administration Act

Pursuant to Section 20/C of the Social Administration Act, the Central Electronic Register of Service Recipients (hereinafter referred to by the Hungarian abbreviation as: KENYSZI) operated in order to control the financing is the TAJ-based (social security number) central register of the data of the recipients. Pursuant to Section 21 of the Social Administration Act, data from the institutions' own recipient register and KENYSZI can only be provided to the body entitled to request data, i.e., to the directorates of the Hungarian State Treasury and to the bodies licensing the operation. Section 22 of the Social Administration Act ensures that those to whom the registers specified in the Social Administration Act contain data can exercise their rights provided by the data protection rules, such as access, rectification, erasure, as well as the information necessary for the exercise of rights.

Pursuant to Section 25/L (1) a) of Act CXII of 2011 on the Right of Informational Self-Determination and on Freedom of Information (hereinafter referred to by the Hungarian abbreviation as: Info tv.), a data protection officer shall be appointed in all cases where the data processing is performed by public authorities or other bodies performing public tasks. Organisations performing social tasks comply with this item, so in their case the appointment of a data protection officer is necessary, in addition, they are obliged to create data protection regulations pursuant to Section 25/A (3) of the Info tv. in order to enforce the fundamental rights of those concerned.

With a view to ensuring the effective exercise of the right of entitlement to 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) THE GENERAL LEGAL FRAMEWORK, THE NATURE,CAUSES AND SCOPE OF REFORMS

The ECSR requested information on the requirements to be met in order for an organisation to be registered as a social service provider. It also asked Hungary to present the practical operation of the funding system for non-state social service providers. It is also wishes to know which social services are provided by non-profit organisations.

Social services may be provided by any maintainer if the conditions prescribed by law are met, if the social service provider or social institution (registered office, site) maintained by them is entered in the register of service providers by a final decision. Thus, a social service can be provided in possession of an entry in the register of service providers. In order to be registered, the material, personal and professional conditions prescribed by law must be met. The licensing body is the county government office.

Act III of 1993 on Social Administration and Social Services (hereinafter: Social Administration Act) prescribes the obligation of local governments to perform tasks with regard to the basic services. With regard to the provision of social residential care services, with the exception of the care of the homeless, which is also a mandatory task of the local government, this task performance obligation falls on the state. In addition, on a voluntary basis, a social service can also be provided by a church and civil maintainer. The performance of the tasks of these actors may take place on the basis of a service contract concluded with the state or the local government, by which the task is taken over from the obligor, but it may also be performed without the conclusion thereof.

Regarding the number of providers of basic social services, the following ratio of maintainers can be established (in 2019):

Pirimary social care	
Local governments	48.2%
Churches	44.0%
Non-governmental organisations	7.4%
State	0,4%

Source: Ministry of Human Capacities

In the case of social housing benefits, the ratio in 2019 is as follows:

Special social care	
State	29.5%
Local governments	27.4%
Non-governmental organisations	18.0%
Churches	25.1%

Source: Ministry of Human Capacities

The condition for entitlement to the support provided in the act on the central budgetary is the inclusion of the service, the number of persons cared for, the number of places, the task index in the funding system in compliance with the law, which takes into account the territorial coverage of the social services. In some cases, the service is automatically eligible for funding, without inclusion (e.g.: subsidised housing, service provided by a local government or association, etc.).

The conditions for including the service differ depending on the type of maintainer:

1. Local Government or association as maintainer

In this case, inclusion is not a condition for eligibility for the support provided for in the act on the central budgetary and relating to the service (hereinafter: 'budget support'). The maintainer must indicate in their e-request to the territorially competent government office the intention to establish or expand the service, inclusion is not required.

2. Non-state maintainer

a) The service must be included, regardless of the available capacity, as part of an admission procedure if:

- they have been awarded a tender for the establishment and expansion of the service,
- they wish to re-distribute the number of persons cared for among their own licensees.

b) In the framework of a capacity tender: until 15 January each year, applications may be submitted for the number of persons cared for listed in the notice published on the website of the Ministry of Human Capacities by the Minister responsible for social affairs and pensions (hereinafter: 'Minister'). Evaluation takes place in the order in which the applications are received. There is currently no notice listed.

c) Independent Ministerial decision: in the framework of a fairness assessment, the Minister decides on the application (without the consent of the Minister responsible for public finances, with continuous assessment throughout the year) if, in the context of a change of maintainer or transfer of persons cared for between maintainers, the non-state maintainer wishes to take over the service (from a local government, association, non-state or church maintainer).

d) Joint Ministerial decision: in the framework of a fairness assessment, the Minister decides on the application (with the consent of the Minister responsible for public finances, once or twice a year) if the non-state maintainer requests the establishment or expansion of the service and none of the above applies to them.

3. Church maintainer

a) The service must be included, regardless of the available capacity, as part of an admission procedure if:

- they have been awarded a tender for the establishment and expansion of the service,
- they wish to re-distribute the persons cared for among their own licensees,

- they have entered into a service contract with a local government or association for the provision of the service (up to the number of persons cared for included in the contract, in the care service area of the local government),
- they want to take over the service from another, also church maintainer, by changing the maintainer or transferring the number of persons cared for between maintainers.

b) In the framework of a capacity tender: until 15 January each year, applications may be submitted for the number of persons cared for listed in the notice published on the website of the Ministry of Human Capacities by the Minister. Evaluation takes place in the order in which the applications are received. There is currently no notice listed.

c) Joint Ministerial decision: the Minister decides on the application within the framework of a fairness assessment (with the consent of the Minister responsible for public finances, once or twice a year)

- if the church maintainer requests the establishment or extension of the service and none of the above applies to them,
- if the church maintainer wishes to take over the service in the context of a change of maintainer or transfer of persons cared for between maintainers, and this entails additional budget expenditure (takeover from a local government, association, non-state maintainer).

According to the regulations of the Child Protection Act, foster care and orphanage care can be provided by a state, church and civil maintainer if the conditions prescribed by law are met, and if the child protection institution and foster care network maintained by it is registered in the service provider register (has an operating licence). Regardless of the type of maintainer, the same legal requirement regarding the professional content of the care to be provided is regulated on the basis of the Decree of the Minister of Welfare 15/1998 (30 April) NM on the Professional Tasks and Operating Conditions of Child Welfare and Child Protection Institutions and their Staff Providing Personal Care (in accordance with Government Decree 369/2013 (24 October) on the Official Registration and Control of Social, Child welfare and Child Protection Service Providers, Institutions and Networks). Inclusion in the statutory funding system is not a condition for maintaining foster care and orphanage care benefits. The maintainer providing these benefits is automatically, without inclusion, eligible for funding from the central budget as defined in the relevant legislation.

As of 31 December 2019, there were a total of 28 121 places in the child protection specialised care system[41], of which 644 were maintained by non-profit (civil) organisations. Within this, the total number of places in foster care networks was 19 620, of which 604 were maintained by non-governmental organisations and of the 8 501 places of children and family homes 40 were maintained by a non-governmental organisation. Of the 49 foster care networks 4, and of the 508 sites of children and family homes 2 were maintained by non- governmental organisations. Non-profit institution maintainers receive support for the performance of their tasks under the title specified in the act on the central budgetary.

The ECSR also requests information on the preventive and reparative supervision system used by Hungary to control the quality of services and to ensure the rights of users and

[41] Source: Hungarian Central Statistical Office OSAP 1208

respect for human dignity and fundamental freedoms, in particular to ensure the requirement of equal opportunities and equal access.

Under the social sector rules, service recipients and children can lodge a complaint with the head of the institution, turn to the mandatory interest protection and advocacy forum in residential social and home providing child protection institutions, and contact the social care rights representative and the child rights representative to assist them in the exercising of their rights.

Pursuant to the Social Administration Act, the social care rights representative assists the recipients of institutional accommodation providing basic and specialised care and persons cared for in the exercise of their rights. Their role is essential because it helps and supports citizens in using social services to be fully aware of their rights, helps them to formulate a complaint, guides them through the handling of complaints, and interprets and evaluates the response to them. Their activity is so wide ranging that they can judge the adequacy of the professional activity of the given service in the interests of the persons cared for, reveal professional errors violating the interests and rights of the service recipients, initiate action with the social service provider's manager, maintainer and licensing and control authorities.

According to the Child Protection Act, the performance of the duties of a child rights representative are determined by the Child Protection Act and its implementing regulations. The child rights representative protects the rights of children receiving child protection care, as defined in the Child Protection Act, and assists the child in learning about and enforcing their rights. They pay special attention to the protection of special (under 3 years of age and/or with a long-term illness or disability) and/or special needs (with severe psychiatric symptoms, severe dissocial symptoms, using a psychoactive substance) children, as well as children with dual needs in child protection specialised care. In this context, the child rights representative

- assists the child in formulating their complaint, and may initiate an investigation into it;
- helps the child to receive care appropriate to their situation;
- participates in the case discussion of the child welfare service and the planning meeting of the territorial child protection service, as well as in the placement meetings of the guardianship offices;
- acts at the request of the child's parent (or other legal representative), the child or young adult, and the child self-government, as well as at the request of the advocacy forum;
- represents the child in the upbringing supervision proceedings on the basis of the secondment of the guardianship office;
- has the right to make a recommendation to the guardianship office, to impose a child protection administrative fine, and to hold a conciliation meeting between those involved in the infringement (with the involvement of experts if necessary);
- is entitled to make a proposal to the maintainer or operator for the further training of the infringing person.

As a member of the child protection detection and alert system, the representative of children’s rights is obliged to follow the alert procedure if a child is danger or is being abused.

The objective of the Integrated Rights Protection Service, which employs social care rights and child rights representatives, is to draw society's attention to the rights of persons cared for, to reduce information asymmetries among those living in society, and to sensitise the population. The organisation is committed to protecting the rights of service recipients and supports initiatives that promote the more effective enforcement of the rights of persons cared for.

Legal protection is also provided by the procedure of the Commissioner for Citizens' Rights and the person of the carer and the child protection guardian (deputy child protection guardian).

2) ANSWERS TO OTHER QUESTIONS OF THE ECSR

The ECSR requested information on the practice of social services involving users ('co-production'): implementation of the promotion of 'co-production' in the field of law, budget and multilevel decision-making; the structure and practical implementation of such services; 'Co-production' is a service, in which service providers work with their users on certain principles, such as equality, diversity, accessibility and reciprocity.

In subsidised housing, service providers work with users along the lines of certain principles. Subsidised housing creates the right conditions for people with disabilities, psychiatric and addiction issues to receive housing and social services appropriate to their age, state of health and ability to support themselves. Instead of receiving residential care in a ready-made 'package', subsidies housing uses a flexible combination of different forms of housing services and assistance services, the locations of which are also separated from each other. By separating places of stay throughout the day from the place of residence, we strengthen and encourage independent participation in local community life. The service is based on a complex needs assessment of the users, which enables care to be tailored as much as possible to individual needs, and also includes the mapping of the individual's desires and volition.

In Hungary, subsidised housing can be created not only through institutional replacement, but also through the construction of new apartment and the renovation of existing apartments. Approximately half of the places were created not as a result of the closure of large capacity institutions, but as a result of the renovation of one or two apartments scattered throughout the country. The current legal regulation on subsidies housing, as well as its professional recommendations, meet the criteria of community-based services and take into account not only the needs of the user but also their individual volition.