HUNGARY

Privatization targets few remaining public services

Practically all areas of social policy have been affected by the transition from a socialist to a capitalist economy and by the neoliberal policies dictated by the international financial institutions. Wide-scale privatization has resulted in foreign ownership of two thirds of industry, and today even the handful of public services still provided by the state are being privatized under the official slogan of 'necessary reforms'.

ATTAC Hungary
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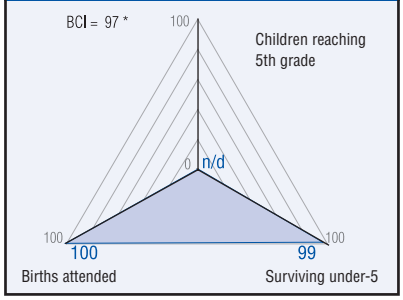
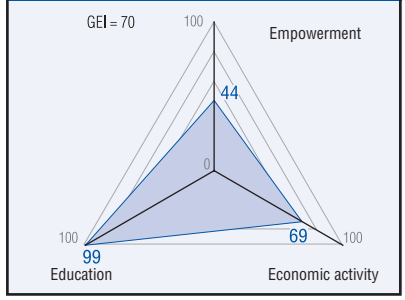
Basic Capabilities Index (BCI)



Gender Equity Index (GEI)



After the collapse of the socialist system, the transformation to a capitalist economy had severe social impacts. In the early years of the transition, up until the mid-1990s, GDP fell by about 20%, accompanied by a drastic decline in real wages and a dramatic increase in unemployment and poverty. The country's GDP eventually reached its 1989 level in 1999, while real wages only recovered their pre-transition level in 2002. The number of jobs sunk from 5 million to 3.8 million. The loss of jobs and growing unemployment have become the main factors causing poverty. With growing inequalities, about 60% of the population of 10 million have been adversely affected. The sectors hardest hit by the difficulties include unskilled workers, the population living in small settlements, families with children, and the Roma people (who made up about 7% of the total population in 2006).

Based on UNDP's definition of poverty – namely the proportion of those living on a daily income of less than USD 4.3 in terms of purchasing power parity (PPP) – 11% of the population was poor in 1991. During the subsequent economic recession the poverty rate steadily increased and reached its peak (18%) in 1996, then began to decrease consistently. By the end of the 1990s this figure had fallen to 6%. The relative poverty rate (the proportion of those living on less than 60% of the median income) increased from 11% in 1991 to 13% in 1995, and in 2004, 13.9% of the population could be considered poor in accordance with this standard. However, when measured on the basis of another definition of poverty –the proportion of those living on less than half of the average consumption level of the EU-15[1] – 73% of Hungarians are poor.

Practically all areas of social policy have been affected by the transition and the neoliberal policies dictated by the international financial institutions in accordance with the Washington Consensus, in other words, the strengthening of individual responsibility and the weakening of public responsibility. Meanwhile, labour rights have been weakened and joblessness has increased, so that labour security has been strongly undermined.

In accordance with the Lisbon Strategy, the EU's open method of coordination (OMC) on social protection and social inclusion is based on the fight against poverty and social exclusion, and includes the establishment of adequate and sustainable pension and health care systems. As part of the OMC, a standardized Hungarian National Strategy Report (HNSR) was prepared in 2006 by the Committee Against Social Exclusion for the period 2006-2008. The HNSR was drawn up in parallel with the elaboration of measures to implement the new government's comprehensive package of reforms, aiming at:

- Restoring macroeconomic balance.
- Implementing a reform process encompassing the entire operation of the state, including social services (public health, pension system, education, social policy, etc.)
- Elaborating and implementing a comprehensive development policy.

The HNSR was submitted to the European Commission in autumn 2006 together with the Convergence Programme, the New Hungary Development Plan and the Revised National Lisbon Action Programme.

The official slogan of 'necessary reforms'

Privatization had already begun in the early 1980s. In 'socialist' Hungary, a dual economy emerged, consisting of the first economy, which covered the state sector, and the second economy, covering all private initiatives and contributing close to one quarter of the aggregate household income in 1988. Some of these private initiatives were legalized and even encouraged by the 'socialist' state.

Another stage of privatization, starting in 1988, was the so-called 'spontaneous privatization', which meant the uncontrolled process of the transfer of state-owned property into private hands. The main players in this process were managers with connections in the state machinery, and it primarily involved the establishment of joint ventures with Western partners. Spontaneous privatization came to an end in early 1990 because the government realized that managers were an important source of capital and a legal framework for management buyouts was set up. Beginning in early 1993, it was also possible for employees to obtain shares in large state-owned companies, although the shares made available represented only 10% to 15% of total ownership. Privatization was led centrally and proceeded at a fairly brisk pace until 1994.

In the mid-1990s, the Hungarian privatization policy was aimed at the fiscal potential of privatization and therefore favoured direct sales of state-owned companies to foreign strategic investors. Some of the largest privatization deals in the Central and Eastern European region were struck, including the sale of gas distribution companies, electricity distributors and power stations. As a result of this policy, the flow of foreign direct investment into the country since 1990 has exceeded EUR 62 billion (USD 84.3 billion), which is now the highest in the region in per capita terms. The share of foreign capital (mostly transnational corporations) in industrial ownership is two thirds.

By the end of the 1990s, the privatization process had been practically completed, and only a small

1 The 15 members of the European Union before the 2004 enlargement.

* One of the BCI components was imputed based on data from countries of a similar level.

number of public services (e.g. health care, transport, postal services, education) remained in state hands. But even these public services are now being privatized under the official slogan of 'necessary reforms'.

Pensions shift from social security to private investment focus

Since 1998 the mandatory public pension system has consisted of two 'pillars'. The first is the social security pension system, operating on a 'pay as you go' basis and financed from contributions paid by the employer and the employee. The second pillar comprises market-based private pension funds.[2] Individuals starting out in the work force are obliged to participate in the mixed system (i.e. in both pillars) and a considerable part of their individual pension contribution (8% of 8.5%) goes to the private pension fund they select. The mixed system currently covers over 60% of the whole insured population. Private pension funds will begin to administer their services as of 2013, and will not comprise a 'typical' pension payment system until 2020, which leaves the social security pension system as an exclusive or predominant player for decades to come.

The retirement age is now 62 years for men and 60 years for women. However, various forms of early retirement exist and are often used, which means the average effective retirement age is significantly lower. The amount of pension received under the social security pension system depends on the pre-retirement average monthly salary and the number of years of employment. In the second pillar it will depend on the contribution paid, plus yields, minus the costs of the fund chosen by the insurance holder. In 2006 the minimum pension was about EUR 100 per month (USD 136).

In addition to providing an income for the elderly, pensions comprise a significant source of income for a large number of households and thus have an impact on the standard of living of the economically active population as well.

Public health: structural problems, misguided reforms

The financing of health care is based on two pillars. Maintenance costs are borne by the clinic and hospital owners (primarily local governments), while operating costs are covered by the National Health Insurance Fund (NHIF). The NHIF is partially funded through compulsory payroll contributions from both employers and employees, combined with transfers from the central budget. In addition, private expenditures are estimated to represent between 20% and 30% of health expenditures today.

The current health care system faces serious structural problems. Health services do not rely on potential prevention and screening systems from either an organizational or a professional point of view, and the capacity of rehabilitation centres is insufficient as well. Structural problems are made more severe by overlaps existing between certain services (e.g. health and social system), and the lack of advanced communications, which further obstructs the efficient operation of the health service system.

Under the slogan of 'reforms', the ruling social-liberal government is closing down hospitals, leading to a significant decrease in the number of hospital beds. Another objective of this 'reform policy' is to open the way for private health insurance companies.

Increased joblessness, decreased protection

During the socialist era, the country followed the principle of 'full employment'. Today, its labour market is characterized by a low employment rate (56.9% in 2005, although the rate of unregistered employment is estimated to be around 15% to 20%); a moderate – yet growing – rate of unemployment (7.5% in 2006); and a rather high rate of inactivity (38.6% in 2005).

The employment rate is especially low among individuals with low skills, members of disadvantaged groups, young people and the elderly. The unemployment rate among people with no elementary education was 35.3%, and among those with an elementary education it was 13.6%, while for the population aged 15 to 24 it was 19.1% in 2006.

Since the beginning of the systemic change, the unemployment rate has been consistently lower for women than for men, although the decline in activity has been greater among women, contributing largely to the decreasing total participation. One of the main reasons for this is that women faced with the difficulty of finding a job were more inclined to choose early retirement schemes as a preferred way of withdrawing from the labour market: several hundred thousand took early retirement or simply became housewives. The fact that the retirement age was lower under the socialist planned economy (55 years for women, 60 years for men) contributed to the widespread use of these schemes. The gender gap is greatest in the activity rate of the 55-59 age group, where it stands at 45.9% for men and only 16.6% for women.

The Roma population is faced with the most disadvantaged situation. They were among the first to become unemployed in the late 1980s, and most have been unable to re-enter the labour market, where they face serious discrimination. Although they make up only 7% of the country's population, they represent between 25% and 30% of the registered unemployed. In 2003, only 29% of Roma men and 15% of Roma women aged 15 to 59 had jobs.

In the meantime, social insurance in times of unemployment has become increasingly limited. Tighter eligibility conditions for unemployment benefits were first introduced in 1992, and the entitlement period was cut initially from two years to 18 months, and later to one year. The ratio of benefit to last wage was also reduced. In 2000 the entitlement period for unemployment benefits was further reduced to only nine months, and since 1 November 2005, unemployment benefits have been replaced by a 'job-search benefit'.

Social protection

Social protection expenditure constitutes over one fifth of the GDP. In 2003, over one third of welfare spending went to financing old age pensions, while old age, survivors and disability pensions combined accounted for 50% of social protection expenditure (10.5% of GDP). A further 30% of expenditure was allocated to health care, while family/children's benefits represent almost 3% of GDP.

Hungary operates a sophisticated family benefit system in which various forms of benefits may be universal, tied to the payment of contributions, or income-dependent. Benefits include, among others, family allowance, family tax benefits, pregnancy confinement benefits and child-care allowance. The reduction of child poverty has been a social expenditure priority since 2006.

According to a survey taken in 2005, on average 52% of the total annual income of households derives from work and 43% is some kind of welfare transfer. The largest welfare contribution to household income – approximately one fourth – comes from old age pensions, including all pension-like benefits. The second largest item (5%) is family benefits (maternity and child-related benefits together), while disability pensions represent a similar share (4%). More than half of the population receives payment compensation for electricity and gas expenditures. The disbursement of social assistance is basically the responsibility of local governments. ■

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2 There is also a 'third pillar' of fully voluntary contributions to private mutual funds.