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Disability Insurance Reform in Hungary: Fiscal Gains at Human Cost

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Executive Summary

- In 2012, the Hungarian government implemented a large-scale reform of the disability insurance (DI) system, aiming to reduce the number of beneficiaries and encourage their re-entry into the labor market. The reform introduced stricter eligibility criteria, reduced benefits for new claimants, and reassessed approximately 200,000 existing beneficiaries under new rules, leading in many instances to reduced or terminated benefits.
- While the reform achieved its fiscal objectives, contributing to the halving of DI recipiency rate and public spending on benefits by 2023, it caused significant hardship for the target population. Employment gains among existing beneficiaries were modest and insufficient to offset the loss of benefits. New claimants, especially those with moderate disabilities, faced declining benefit amounts and precarious employment prospects.
- A key shortcoming that impeded beneficiaries' reintegration into the labor market was the insufficient availability of support services, including rehabilitation, mentoring, and job search assistance. Interviewed experts observed that the provision of these services has further deteriorated over the past decade and emphasized the need for substantial government investment in this area. They advocate for establishing a stable, long-term state funding mechanism, potentially reallocating public revenues from employers' rehabilitation contributions to support these efforts.
- The reform's heavy reliance on negative financial incentives significantly undermined beneficiary welfare. Particularly disadvantaged were individuals whose DI status was terminated during reassessment, as they lost not only financial support but also the broader advantages associated with disability status. Beneficiaries classified as moderately disabled also faced challenges, as their benefits were capped at very low levels. Experts recommend increasing benefit amounts to guarantee a minimum standard of living.
- Serious legal and ethical concerns emerged from the irregularities in the reassessment process. In 2018, Hungary's Constitutional Court declared the practice to be in violation of the European Convention on Human Rights. The government reacted to the judgement with a two-year delay and launched a compensation campaign which, according to experts, did not provide adequate and fair reparation.
- While acknowledging the reform's objectives as progressive, interviewed experts stressed that the design and implementation of the reform was flawed in several respects, exacerbating existing social and economic inequalities. This underscores the need for a more equitable and supportive disability policy in Hungary.

Introduction

This study analyzes the large-scale reform of Hungary's disability insurance (DI) system implemented in 2012. The reform's primary objectives were to reduce the number of DI beneficiaries and incentivize their re-entry into the labor market. By the early 2000s, Hungary's DI recipiency rate had reached notably high levels in international comparisons (OECD, 2016). Despite earlier reform attempts to curb inflow rates, the system remained relatively generous prior to 2012, a situation perceived as contributing to the country's persistently low labor force participation rates.

The 2012 reform introduced significant changes across multiple dimensions. It tightened eligibility criteria, redesigned the benefit structure - resulting in lower replacement rates - and reassessed a substantial proportion of existing beneficiaries under new rules. Beneficiaries whose reassessments indicated improved work capacity faced reductions in benefits or complete terminations (Bíró et al., 2023). This aspect of the reform was particularly noteworthy, as DI reforms mandating large-scale reassessments of existing DI recipients are rare internationally.[1]

The reform carried substantial risks of exacerbating inequality. Its target population constituted a vulnerable social group, and its regional impacts were concentrated in economically disadvantaged areas with high unemployment rates. Moreover, at the time of implementation, critical rehabilitation services were only minimally available, and active labor market policies - such as training or job search assistance - were largely absent. The only notable exception was a public works program, which primarily offered low-paid, simple physical tasks.

Simultaneously, significant changes were introduced to the country's social policy framework to enhance financial incentives for transitioning from welfare dependency to employment. These measures included reductions in both the amount and duration of unemployment benefits, the abolition of early retirement schemes, and the freezing of basic social assistance benefits at a nominally low level (Scharle and Szikra, 2015). These policies severely restricted the availability of alternative forms of social support for individuals affected by the reform.

Building on this context, the present study aims to assess both the design and implementation of the 2012 DI reform in Hungary, as well as its impact on beneficiaries' employment outcomes and standards of living. Using a mixed-methods approach, the analysis combines quantitative descriptive data with qualitative insights drawn from interviews. The study offers valuable lessons from an international perspective by providing an in-depth examination of a rare policy intervention: a large-scale, restrictive

[1] The closest example is the 2004 Dutch DI reform, which reassessed a broad group of existing beneficiaries (Garcia-Mandicó et al., 2020).

reform that primarily utilized negative financial incentives within a social policy context where benefit substitution was largely unavailable.

The quantitative analysis relies primarily on an individual-level administrative panel database (Admin3), which tracks a random half of Hungary's 2003 population from 2003 to 2017.[2] This database is representative of the national adult population and offers a robust basis for analyzing the reform's longitudinal effects. To enhance this analysis, the study also incorporates aggregate publicly available data from the Hungarian Central Statistical Office (CSO) and Eurostat, which provide additional insights into trends related to the headcount, employment status, and living standards of persons with disabilities.

The qualitative part of the research is based on information from interview and focus group discussions. Twelve semi-structured expert interviews were conducted online in Hungarian language between April 2024 and August 2024. An online focus group discussion was conducted on 29 November 2024, including five experts selected from the interviewees. The group of interviewees includes researchers who have published in the topic, former and current government officials working or having worked in related fields, and employees of interest group organizations for disabled people. All interviews as well as the focus group discussion were recorded and transcribed with the consent of the participants.[3]

More closely, the discussion partners include four researchers from three independent research institutions, with expertise in economics, sociology, or special needs education. Four other interviewees previously held leadership roles in the Ministry of Human Resources and related government institutions responsible for implementing the reform; they have since moved to various, often non-governmental, roles. Oversight of the field now falls under the Ministry of the Interior.[4] Despite multiple efforts, no current staff members from the relevant department of the Ministry agreed to participate in the research. As an alternative, an interview was conducted with an employee from a different, but partially related, department. Similarly, repeated attempts to secure an interview with a representative from a local government office responsible for rehabilitation and medical assessments were unsuccessful. Additionally, three interviewees were sourced from two interest group organizations, each

[2] The Admin3 database contains data provided by the Hungarian State Treasury, the National Health Insurance Fund, the Educational Authority, the National Tax and Customs Administration, the Ministry of Economic Development and cleaned by the Databank of the HUN-REN Centre for Economic and Regional Studies. I thank the Databank for providing access and guidance in using their database. The findings, interpretations, and conclusions expressed in this work are entirely those of the author.

[3] The author is grateful to the interviewees for the engaging discussions and their valuable contribution to this research.

[4] The Ministry of Human Resources was dissolved in May 2022 and the area of disability and rehabilitation was transferred to the Ministry of the Interior.

with extensive experience as lawyer or rehabilitation service provider, including during the reform period.

The structure of the study is as follows: Section 1 describes the characteristics of the target group and the inequalities addressed by the policy. Section 2 provides an overview of the policy's fundamental aspects, including its primary objectives, legal background, funding, and broader policy context. Section 3 explores the design, coordination, and implementation details of the policy. Section 4 presents an evaluation of the policy's effectiveness in achieving its core goals combining quantitative and qualitative evidence, while Section 5 offers a final assessment and considerations for improvement.

1. The Inequalities Addressed by the Policy

The policy primarily aimed to address the country's notably low labor force participation and high welfare dependency rates in international comparison. This issue was particularly evident in the DI system. At its peak in the early 2000s, Hungary's DI recipiency rate reached 12% of the working-age population, the highest among OECD countries (Figure A1). While earlier reforms helped reduce this rate, it remained relatively high, at around 7% of the population aged 15-64 years, just prior to the 2012 reform.

The elevated DI beneficiary rate cannot be fully attributed to the comparatively poor health status of the Hungarian population. Instead, structural and policy-related factors played a more significant role, rooted in the country's transition to a market economy in the 1990s. This period of economic restructuring saw the decline of heavy industries, widespread layoffs, and a growing mismatch between the skills of the workforce and those demanded by the new economy (Vanhuysee 2004; Scharle 2008). In response, policymakers deliberately eased entry conditions of the DI scheme (as well as other early retirement schemes) to provide an escape route for the unemployed to exit the labor force.[5] Experts interviewed confirmed that the leniency of DI entry criteria during the post-transition years was a conscious decision by policymakers.

The unequal regional distribution of DI beneficiaries, with higher concentrations in economically disadvantaged rural areas, suggests a strong link between DI entry and economic factors. Figure A3 highlights substantial regional variation in the share of DI beneficiaries (both affected and unaffected by the reform) within the working-age population across counties (NUTS3), ranging from 5% in Budapest to 15% in Békés County. Notably, the top five counties with the highest rates are located in the economically challenged southern and northeastern regions of Hungary. This pattern is further

[5] Bíró and Elek (2020) provide quantitative evidence from Hungarian individual-level administrative data that job loss due to mass layoffs in the 2000s significantly increased the probability of entering the DI scheme over a five-year horizon.

illustrated in Figure A4, which maps the ratio of affected beneficiaries to the working-age population at the district level (LAU1).[6]

Several experts interviewed for this study noted a positive spatial correlation between DI recipiency rates and local unemployment rates, supporting the view that DI often served as an escape route from unemployment. This relationship is clearly depicted in Figure A5, a scatter plot showing the proportion of DI recipients targeted by the 2012 reform within the working-age population against the local unemployment rate at the district level as of December 2011.[7]

However, some interviewees cautioned that while lenient entry conditions during the 1990s and the ongoing correlation between DI recipiency and unemployment rates highlight systemic issues, they do not necessarily indicate abuse of the system by DI beneficiaries in 2012. Economic hardship is closely associated with poor health outcomes, and individuals who may have taken advantage of relaxed entry rules in the 1990s could have legitimately developed disabling health conditions over time.

Table A1 summarizes the demographic characteristics of DI beneficiaries affected by the 2012 reform (those aged 18–56 in December 2011 with less than 80% health impairment) as of 2011, based on Admin3 data. For comparison, it includes similar data for two non-disabled groups: those aged 18–56 and those aged 45–56, the latter matching the DI group more closely in average age.

The group targeted by the reform was disadvantaged in several ways compared to the broader working-age population. They were older, in poorer health, more likely to be unskilled, and often lived in remote areas with high unemployment. With an average age of 49, their two-year mortality rate in 2011 was 2.1% - over three times that of the non-disabled 45+ population. Around 40% had worked in unskilled occupations, double the rate among non-disabled individuals.[8] Their districts of residence had an average unemployment rate of 19%, compared to 16% for the non-disabled population. While the dataset lacks direct information on minority status, earlier research (Scharle, 2008) indicates that Roma individuals were overrepresented among Hungary's disabled population.

The average income of affected DI beneficiaries was significantly lower than the labor earnings of non-disabled individuals. In 2011, the average DI benefit in this group amounted to just 57% of the after-tax

[6] Hungary is composed of three NUTS1 (large regions), eight NUTS2 (regions), twenty NUTS3 (counties) and 198 LAU1 geographical entities. The most detailed geographical unit observed in the Admin3 database is LAU1, referred to as *district* (*járás* in Hungarian) in this study.

[7] The pattern is very similar if the share of DI recipients targeted by the reform in all DI recipients is plotted against the unemployment rate (not show here).

[8] Unskilled occupations are elementary occupations, corresponding to code 9 of the International Standard Classification of Occupations (ISCO). The skill level of a person is determined by her last observed occupation between 2003 and 2011. This information is missing for 42% of the disabled, 20% of the non-disabled and 15% of the non-disabled 45+ group.

earnings of the non-disabled 45+ population (or 42% when considering only employed individuals). While beneficiaries could work alongside receiving benefits (subject to an earnings limit), only a quarter did so, and even with these additional earnings, their total income reached just 69% of the average income of non-disabled 45+ individuals.

Nevertheless, for low-skilled individuals, especially the unemployed, entering the DI scheme was financially attractive (Figure A2). When combining benefits with earnings, unskilled DI recipients often earned as much as, or more than, their unskilled non-disabled peers, particularly those unemployed or working in low-paying jobs. Poor health among the unskilled workforce further increased the likelihood of entering the DI system in this group.[9]

Despite the option to work, data suggests that most DI recipients remained heavily dependent on their benefits. Those who did work typically held part-time or low-wage jobs, earning only 36% of the average wages of employed non-disabled individuals aged 45+. Survey data from 2010 shows that nearly a third of working DI beneficiaries were employed in sheltered workplaces, often in part-time roles of around four hours per day (Nagy, 2015).

It is important to note, however, that administrative data does not capture employment in the shadow economy, which may have been a significant factor in this population. Anecdotal evidence suggests that, at least in some geographical regions, many DI recipients combined their benefits with informal work. This arrangement was often viewed as beneficial, as DI status provided health insurance coverage and future pension entitlements.

2. The Basic Characteristics of the Policy

This section offers a detailed overview of the reform, examining its primary objectives, legal framework, and funding mechanisms. It also situates the reform within the broader policy context of the time, briefly highlighting the socioeconomic challenges and policy shifts that influenced its development.

2.1. Legal Background and Objectives

The legal basis for the 2012 reform was Act CXCI of 2011 “On Allowances for Persons with Disabilities and the Amendment of Certain Legislation”, which stipulated the amendment of the entire national DI system, including benefits, assessment of reduced work capacity, and rehabilitation.[10] In addition,

[9] The average unskilled person faced a twice higher mortality rate than the average skilled person in the non-disabled 45+ group. In contrast, the skilled and unskilled mortality rates were very close among the disabled.
[10] 2011. évi CXCI. törvény a megváltozott munkaképességű személyek ellátásairól és egyes törvények módosításáról.

various government decrees provide detailed rules for implementation.[11] These laws and decrees are supplemented by international commitments, particularly the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD).

The official *Justification of Act CXCI of 2011* states two objectives. Firstly, the reform aimed to foster a "lasting and effective shift in mindset", emphasizing rehabilitation and aiming to reduce dependence on state support. Secondly, the reform streamlined and simplified the system of disability-related benefits by introducing two new health insurance cash benefits: the rehabilitation allowance and the disability allowance, which replaced the earlier, more complex array of benefit types. According to the justification, the previous system was fragmented, comprising multiple benefit categories, some of which were classified as pensions and others as non-pension benefits.

The reform's increased emphasis on rehabilitation was in itself a progressive element, which closely aligned with the EU's Disability Strategy 2010-2020. This strategy aimed to empower individuals with disabilities to participate fully in society and the economy, specifically by encouraging their integration into the labor market. The EU's strategy was itself aligned with the UN CRPD, which Hungary was the first EU country to adopt in July 2007 under the former socialist government of Ferenc Gyurcsány, as noted by an interviewee.

The policy direction aligned with the political will to address Hungary's low activity rate. By 2011, only 64% of the working-age population was either employed or actively seeking work, contributing to social discontent among those in the labor force. A former ministry employee interviewed for this research identified the issue of inactivity as the primary motivation behind the DI reform, emphasizing that this goal was supported not only by the ruling political parties but also by the opposition and society at large.

Nevertheless, most interviewees identified cost-cutting on disability as the primary objective of the reform. The interviewees noted that policymakers believed that many beneficiaries were unjustifiably receiving benefits due to permissive entry rules and practices. The goal of expenditure reduction was evident in the details of Act CXCI of 2011: the newly introduced benefits and health assessment system included measures that effectively tightened eligibility criteria and significantly reduced benefit amounts, impacting not only new claimants but potentially also existing beneficiaries.

Against this background, the DI reform can be regarded largely as a reactive post-market policy to manage the financial viability of a redistributive system. However, the reform also displayed some

[11] The framework for evaluating reduced work capacity is outlined in Government Decree No. 327/2011 (XII. 29.), which specifies the procedures, criteria, and documentation required for assessing an individual's ability to work. Matters concerning the provision and implementation of rehabilitation services are addressed, among others, in Government Decree No. 117/2016 (VI. 6.).

proactive characteristics in its attempt to encourage rehabilitation and greater labor market participation.

2.2. Policy Context

The reform took place in a challenging macroeconomic environment. Hungary was severely impacted by the global financial crisis of 2007-2008, experiencing a 6.7% annual GDP decline in 2009 and persistently low growth rates until 2014. The crisis revealed structural weaknesses, including high inactivity rates and welfare spending, which contributed to fiscal imbalances. To align public debt and deficit levels with EU requirements under the Stability and Growth Pact and exit the EU's excessive deficit procedure, the newly elected government in 2010 introduced a series of austerity measures.

These measures were rolled out in 2011 as part of the Széll Kálmán Plan, a comprehensive economic reform package. At its core, the plan prioritized cost-cutting reforms across the welfare system, while promoting a shift from welfare provision to a workfare-based model. The policy changes were presented as part of an ideological shift toward creating a "work-based society" - a framework aimed at restoring the dignity of work and reducing dependence on state support.

Scharle and Szikra (2015) provide a summary of the policy changes after 2010, stating that "The government has curbed access to disability benefits and early pensions, abolished vocational early pensions, reduced the amount and duration of unemployment benefits and tightened behavioural conditions both by introducing unprecedently harsh sanctions and by extending the public works programme. This also implied reduced funding for all active labor market policies, including training."

These policy changes created strong negative financial incentives for benefit recipients to increase their labor supply in an unfavorable labor market environment. One interviewed expert described the situation of DI recipients facing benefit loss as follows: "*Those who were pushed back into the labor market had to compete with others who were also excluded from early retirement or whose unemployment benefits had been cut. While increasing labor market activity is not inherently misguided, the government relied solely on drastic financial incentives without offering any active support. Moreover, these measures were implemented during a period of already high unemployment*."

2.3. Funding

The Hungarian DI system is part of the country's social security system. Disability-related benefits, such as the rehabilitation allowance and the disability allowance payable since 2012, are therefore fully funded from the public budget. The funding institution is the National Health Insurance Fund (Nemzeti Egészségbiztosítási Alap, NEAK), which is responsible for the financing of all health-related cash benefits

and benefits in-kind. The NEAK is supervised by the Government of Hungary, currently through the Minister of the Interior, while formerly through the Minister of Human Resources.[12]

Public expenditures on disability-related benefits have steadily declined since the 2012 reform, driven by reductions in both the number of beneficiaries and the benefit amounts. As a share of Hungary's GDP, spending on DI benefits dropped from 1.2% in 2012 to 0.5% in 2023. Similarly, benefit expenditures decreased significantly as a proportion of overall healthcare spending, falling from 20% of total NEAK expenditures in 2012 to just 9% in 2023.[13]

The funding for employment rehabilitation and other supportive services, which aim to enhance employability and help labor market reintegration, has increasingly shifted to a project-based model, relying heavily on European Social Fund (ESF) resources. With the depletion of EU funds allocated to this field after the 2014-2020 funding cycle, the government has not replaced the lost funding with state resources. As a result, NGOs and other service providers, which typically deliver these services under contracts from the rehabilitation authority, are struggling to secure adequate financing for their activities. Meanwhile, the rehabilitation authority lacks the human capacity to effectively compensate for the reduced NGO involvement.

Interviews with NGO employees and employment rehabilitation experts highlight that the current ad hoc, project-based funding model poses a significant challenge. One NGO lawyer emphasized the disconnect between the sophisticated legal framework governing rehabilitation services and the absence of stable funding to deliver the extensive range of services prescribed by law. Another NGO employee, specializing in employment rehabilitation, remarked, "*Organizations like us will never be able to live from the market [...] when projects are not available, many service providers have to pause their operations.*" This interviewee also noted the need for a long-term state funding mechanism to ensure continuity of services, suggesting that public funding covering at least 40-50% of their expenses would be desirable.

3. Design, Co-ordination and Implementation of the Policy

This section examines the development and implementation of the policy. Subsection 3.1 outlines the origins and policy precedents of the reform, details its key changes, and addresses aspects of policy communication and public reception. Subsection 3.2 focuses on the main actors and institutions involved, highlighting coordination - or the lack thereof - between them. Finally, the section reviews corrective adjustments made during the implementation phase.

[12] The official website of NEAK: https://www.neak.gov.hu/oldalak/nyelvi-oldalak/english
[13] Information source of NEAK expenditures is the website of the Hungarian State Treasury. Accessed 15 November 2024.

3.1. Emergence and Design of the Policy

3.1.1. Origins of the Policy

The 2012 DI reform was not the first attempt in Hungary to reduce the size of the country's DI system. An early initiative in 1998 aimed to tighten access by eliminating the practice of automatically granting permanent disability status. Instead, individuals with temporary DI status were subject to periodic medical reassessments every few years (Scharle, 2008).

A more ambitious reform followed in 2008, which sought to shift the focus from disability to work capacity and rehabilitation. This reform introduced the complex assessment system to evaluate residual work capacity and a new temporary benefit called *rehabilitációs járadék* (rehabilitation benefit), payable for up to three years. The new benefit was designed for individuals with moderate reductions in work capacity and favorable rehabilitation prospects. Its value was set at 20% higher than the disability pension for persons with moderate disabilities. The reform also expanded employment rehabilitation services to support labor market reintegration (Vincze, 2014).

The complex assessment system introduced in 2008 was designed to emphasize skills restoration and rehabilitation potential rather than tightening entry conditions. These measures aligned with international trends in DI policies, reflecting a broader shift toward promoting rehabilitation and facilitating labor market reentry (Krekó and Scharle, 2020b; Berei, 2023).

Krekó and Scharle (2020b) provide an extensive description of changes in Hungary's DI system, documenting trends in beneficiary stock and flow rates. Their research shows that the 2008 reform successfully reduced DI inflows, combined with supportive demographic trends, resulting in a decline in beneficiaries from the peak 12% of the working-age population to below 8% by 2011. By that year, the number of DI recipients had dropped to 473,000, according to official CSO data (Figure A6).

Despite these improvements, the government elected in 2010 targeted the DI scheme as a key area for restructuring and cost-cutting. This decision was reinforced by widespread perceptions that many beneficiaries were on DI only thanks to lenient entry criteria and – in some cases – corrupt practices among medical professionals in assessment committees.[14,15] Also, an interviewed former ministry

[14] The draft of the Széll Kálmán Plan contained a sentence stating that "In Hungary, the numerous frauds and abuses surrounding the disability scheme have a very negative impact on employment." (Széll Kálmán Terv, page 18., Accessed: 18 November 2024)

[15] A former employee of the Ministry of Human Resources recounted that, before the 2012 reform, some medical professionals were found to have engaged in corrupt practices. According to the source, "*some doctors received prison sentences for interpreting regulations in a more creative manner*." These actions were reportedly motivated by compassion, as the doctors aimed to prevent individuals from being left without any income or access to social security.

employee stressed that, by 2010, both politicians and the public had lost patience with cautious social and labor market policies that had long been ineffective in tackling the problem of high inactivity.

Against this backdrop, the Orbán government initiated a large-scale DI reform in 2011, targeting both new claimants and existing beneficiaries, which reflected a dual focus on reducing inflows and increasing outflows. In Spring 2011, Minister of National Economy György Matolcsy projected savings of HUF 217 billion and 150,000 additional workers within three years. Experts at the time regarded these targets as overly ambitious, and they ultimately went unrealized.[16]

Details of the reform remained unclear until November 2011, when the draft law was finally published.[17] Until that point, stakeholders were left uninformed and uncertain, as various rumors circulated regarding the policy's details. The legislative process unfolded rapidly, with little room for consultation with affected social groups or their representatives. Draft Law T/5000 was submitted to Parliament in the second half of November 2011, enacted as Act CXCI of 2011 on 29 December 2011, and took effect on January 1, 2012.

3.1.2. Reform Details

The 2012 DI reform introduced extensive changes to the system, including modifications to benefit types and calculation of their amounts, rehabilitation services, conditions to work while on benefits, and employer incentives for hiring disabled workers. These measures are detailed in studies such as Krekó and Scharle (2020a; 2020b), Bíró et al. (2023), and contextualized internationally in Krekó, Scharle and Berei (2022).

One of the most significant changes introduced by the 2012 reform for people with disabilities was the overhaul of the benefit system. Earlier benefit types were replaced with two new categories: the disability allowance and the rehabilitation allowance.[18] Alongside these changes, a new classification system for disability categories was implemented, which determined both the type of benefit granted and the method for calculating its amount. Most changes to the benefit system resulted in stricter eligibility criteria and reduced benefit amounts.

The reform established seven categories of reduced work capacity (A, B1, B2, C1, C2, D, and E), with A representing the highest and E the lowest residual work capacity. Category A covers people with work

[16] Contemporary news articles from hvg.hu on the issue are here (May 2011) and here (October 2011). Accessed: 17 November 2024.
[17] A news article by hvg.hu from 20 November 2011 reporting on the details of the bill is here (Accessed: 17 April 2024)
[18] The rehabilitation allowance is similar to the rehabilitation benefit introduced by the 2008 reform in that it is granted for at most three years and is contingent on the beneficiary's cooperation with the rehabilitation authority.

capacity of higher than 60% who are not entitled to benefits.[19] Individuals in the moderately disabled B and C categories are entitled to benefits and considered rehabilitable based on their health status. Within these groups, assessment committees can further differentiate between those for whom rehabilitation was actively recommended (B1, C1) and those for whom it was not recommended due to non-health-related factors (B2, C2).

Beneficiaries in the B1 and C1 categories qualify for rehabilitation allowance, while those in categories B2, C2, D and E receive disability allowance. Benefit amounts were influenced by both the assigned disability category and the claimant's previous wage earnings. Moreover, these amounts were constrained by a minimum and maximum range, tied to percentages of a so-called "base amount" (*alapösszeg*).[20] In 2012, the monthly base amount was set at HUF 93,000 (EUR 320), the level of the statutory minimum wage, and has since been adjusted annually in line with the increase in old-age pensions. Because pension increases systematically lagged behind wage growth, the base amount has decreased to approximately half of the minimum wage by 2024 and is currently HUF 137,655 (ca. EUR 350) per month.

In general, the new calculation method resulted in lower benefit payments compared to the pre-reform system for individuals with similar health conditions. This is particularly pronounced for those in the moderate disability categories (B1, B2, C1), where the new rules cap the maximum benefit at 40-50% of the base amount. For more severe disabilities (C2, D, E), the benefit ceiling is set at 150% of the base amount. Due to the relative decline of the base amount compared to the minimum wage over the years since 2012, these ceilings have become increasingly binding, limiting newly granted benefits for the moderately disabled at no more than one-quarter of the prevailing minimum wage, i.e., around EUR 150 per month, in 2024.

A further significant change that often resulted in lower benefit amounts was the shift in the legal status of disability benefits. Before the reform, benefits were primarily pension-based, calculated based on an individual's entire employment history. After the reform, the newly introduced benefits became health insurance-based, with eligibility and amounts determined by contributions and earnings from more recent years only. Eligibility for the new allowances required social contributions in at least three of the past five years, while benefit amounts were calculated based on wage earnings in the 12 months

[19] Albeit, under certain conditions, employers may be eligible to tax allowances for employing them.
[20] Disability categories and rules for benefit calculations are detailed on the Government's Social Sector Portal (Szociális Ágazati Portál). Accessed: 18 November 2024.

preceding DI application.[21] These changes disadvantaged DI claimants, whose health-related labor market setbacks predated their DI applications.[22]

These adjustments affected not only new DI applicants since 2012 but potentially also existing beneficiaries at the time of the reform. As of January 2012, the benefits of current recipients were formally reclassified into one of the newly introduced allowances with unchanged amounts until reassessment. DI beneficiaries aged 56 or younger as of December 2011 and assessed under the pre-reform system as having a health impairment below 80% (totalling 196,174 persons) were required to undergo a health reassessment to maintain their benefits. They were asked to declare by March 2012 whether they wished to participate in the reassessment process. Failure to submit this declaration resulted in the termination of their benefits by May 2012. According to Vincze (2014), 186,385 individuals complied with the declaration process, of whom 466 opted out of reassessment, while 9,789 failed to submit the form altogether.

Those who chose to undergo the reassessment process had their health status evaluated, and if improvement was detected, their benefit entitlement and amount were recalculated according to the new regulations. This could result in a reduction or termination of benefits for existing recipients (Bíró et al., 2023). If no improvement in health status was found, existing beneficiaries continued to receive the same benefit amount as before the reform.

3.1.3. Employer Incentives

Reductions in benefit entitlements and amounts aligned with the policy's objective of activating more disabled individuals. To this aim, exiting employer incentives to hire disabled individuals were retained or enhanced since the 2012 reform. These incentives typically rely on financial measures that lower the relative cost of employing disabled workers compared to non-disabled workers (Krekó and Scharle, 2020a).

Central to this is the rehabilitation contribution (*rehabilitációs hozzájárulás*), a non-compliance tax imposed on employers with 25 or more employees if the proportion of disabled individuals in their workforce falls below a 5% quota. While this quota has existed for about two decades, the associated tax was relatively low until January 2010, when it was substantially increased by the socialist government to HUF 964,500 (EUR 3,500) annually per unfilled position for disabled individuals (Krekó

[21] The eligibility rule was relaxed to 7 out of the past 10 years or 10 out of the past 15 years in January 2014, to accommodate those with long employment histories but without (formal) employment in the more recent years.
[22] If there has been no wage earning in the last 12 months, the benefit amount is calculated based on the "base amount," provided that the eligibility conditions for the benefit are met.

and Telegdy, 2022). The new Fidesz government in 2010 retained this high penalty and, since 2017, linked its amount to the statutory minimum wage, ensuring regular adjustments.[23]

Internationally, while employment quotas for disabled individuals are common, Hungary's rehabilitation contribution stands out for its exceptionally high rate (Krekó and Scharle, 2020a). Krekó and Telegdy (2025) estimate that the levy amounted to about 2% of the average payroll in Hungary and was equivalent to 170% of the total labor cost of a half-time minimum wage earner. Since the quota requires disabled individuals to work at least half-time at the minimum wage, the penalty for non-compliance exceeds the variable cost of employing such a worker, creating a strong financial incentive for compliance.

Another significant incentive to promote the employment of disabled individuals is aimed at accredited workplaces that provide sheltered employment opportunities. These incentives include generous financial support, such as wage subsidies, cost reimbursements, and access to state grants. To obtain accreditation, employers must either employ at least 30 disabled workers or ensure that disabled individuals constitute at least 25% of their workforce. The reform also sought to enhance the rehabilitation role of accredited employers by distinguishing between permanent and transitional forms of employment. The latter was specifically designed for beneficiaries receiving rehabilitation allowance in order to prepare them for successful integration into the open labor market (Hungarian State Treasury, 2019).

3.1.4. Policy Communication and Public Reception

Numerous interviewees highlighted significant shortcomings in both the communication strategy and stakeholder engagement throughout the reform process. The policy was characterized by a lack of clear, professional, and transparent communication regarding its objectives, the steps required for their implementation, and the support measures designed to alleviate potential negative impacts. In the absence of adequate communication, conflicting rumors circulated in the media, fostering widespread uncertainty and fear among the affected population. Furthermore, key stakeholders had limited opportunity to provide input, as the draft law was only disclosed in November 2011, leaving a mere month for feedback before Act CXCI was enacted at the end of the year.

Although, according to interviewees formerly in government positions, the reform's planning involved several rounds of consultations across various government bodies, organizations representing disabled people were neither informed nor involved in these discussions until November 2011. While these organizations voiced numerous concerns about the draft law afterwards - including issues around

[23] Additionally, employers can lower their social contribution tax by hiring disabled individuals and various corporate tax incentives have also been introduced for smaller businesses. These financial incentives are listed on the website of the Érték vagy! portal. (Accessed on 14.11.2024.)

benefit calculation methods, unclear work conditions for benefit recipients, and the mandatory reassessment of many beneficiaries with severe impairments[24] - most of their suggestions were disregarded at the time (though some were addressed later during the reform's implementation years).

An interviewed expert also highlighted a significant issue in the reform process: the lack of a representative organization for individuals with reduced work capacity in Hungary. Unlike groups with specific disabilities, such as visual or mobility impairments, which benefit from stronger advocacy voices, the population targeted by the reform - primarily individuals receiving disability benefits due to chronic illnesses - lacks organized representation.

Public opinion on the reform was divided. Some supported the objectives of reducing welfare dependency and encouraging employment for disabled individuals, often believing that lenient entry conditions had been exploited by ineligible DI claimants. The idea that many beneficiaries are unduly benefiting from the DI scheme was further fueled by contemporary reports of criminal cases involving medical professionals accepting bribes for favorable disability assessments, as well as a politically charged narrative about so-called “fraudulent disabled” - a damaging component of the government's communication strategy, as noted by several expert interviewees.[25]

At the same time, many citizens expressed empathy for disabled individuals, recognizing them as one of society’s most vulnerable groups. With approximately 200,000 people affected by the mandatory reassessments in a country of 4 million households, many had family members or friends directly impacted by the reform.[26] The negative political narrative about widespread fraudulent claims failed to gain public support, with many interviewees noting that the broader society did not endorse the stigmatizing campaign.

3.2. Co-ordination and Implementation of the Policy

The effective implementation of the reform was hindered by a series of institutional changes at both ministerial and lower administrative levels. While some issues that arose during the implementation phase were partially addressed, the overarching policy direction remained unchanged. This section examines the specifics of the institutional framework and the corrective measures introduced to address arising challenges.

[24] A related news article from hvg.hu is here, where an expert from the National Federation of Associations of Persons with Physical Disabilities (MEOSZ) criticizes the reform for introducing burdensome reassessment processes, which they argued would be costly, lengthy, and unnecessarily taxing for both individuals and authorities. (Accessed: 17 April 2024)

[25] A related news article on criminal cases against medical professionals by index.hu from June 2011 is here. (Accessed: 19 November 2024)

[26] Two interviewees formerly working for government institutions mentioned that they themselves had close relatives affected by the reform.

3.2.1. Key Actors and Procedures

The governmental responsibilities for disability insurance and rehabilitation in Hungary have shifted among multiple ministries and institutions due to several rounds of governmental reorganization since 2010.

Initially, the Ministry of National Resources (*Nemzeti Erőforrás Minisztérium*), established in 2010 by the newly elected Orbán government, was tasked with overseeing these areas. This ministry resulted from the merger of two former ministries responsible for health care and social and employment matters. In May 2012, the ministry was rebranded as the Ministry of Human Resources (*Emberi Erőforrások Minisztériuma*, EMMI) and took on expanded responsibilities following the appointment of Zoltán Balog as minister, replacing Miklós Réthelyi. The EMMI played a pivotal role in implementing the 2012 DI reform. However, in May 2022, EMMI was dissolved, and the areas of disability and rehabilitation were transferred to the Ministry of the Interior (*Belügyminisztérium*).

At lower administrative levels, the institution serving as the rehabilitation authority also underwent substantial changes over time. The National Office for Rehabilitation and Social Affairs (*Nemzeti Rehabilitációs és Szociális Hivatal*, NRSZH), established in 2010, was designated as the central rehabilitation authority by the 2012 reform.[27] Its responsibilities included, among others, processing DI claims and conducting complex assessments. To manage these tasks regionally, specialized Rehabilitation Administrative Bodies (*Rehabilitációs Szakigazgatási Szervek*, RSZSZs) were set up in July 2012 as independent units within the county- and capital-level local government offices, operating under the professional oversight of the NRSZH. This restructuring streamlined the administration of benefit claims relative to the previous system, when three separate organizations handled this task.

Although complex assessments had been introduced by the 2008 reform, the 2012 reform enhanced their scope by incorporating occupational and social factors alongside medical evaluations.[28] Complex assessment committees, responsible for evaluating new DI claimants and existing beneficiaries subject to reassessment, are required to include at least four members: two medical experts (one serving as the committee chair), a vocational rehabilitation specialist, and a social welfare expert. The medical experts determine the claimant's classification within the seven-degree scale of reduced work capacity, and for categories B and C, additional evaluations are conducted. The occupational specialist assesses the individual's employability and prospects of rehabilitation, while the social welfare expert evaluates their social circumstances, such as family conditions and mobility. These combined evaluations form the basis

[27] Government Decree 1502/2011. (XII. 29.) on establishing the rehabilitation authority (Korm. Határozat a rehabilitációs hatóság létrehozásáról).
[28] Ministry of National Resources Decree 7/2012. (II. 14.) on detailed rules for complex certification (NEFMI rendelet a komplex minősítésre vonatkozó részletes szabályokról)

for the committee's final decision, with the chairperson holding a casting vote in case of disputes (Bodnár, 2018).

Importantly, the reform also transferred the provision of employment rehabilitation services under the umbrella of the NRSZH-RSZSZ institutional framework as of July 2012. This marked a major organizational shift in the provision of rehabilitation services, as previously, these services were administered by local Public Employment Services (PES) offices. Interviewed experts criticized this move on the grounds that NRSZH operated fewer local offices than PES, reducing accessibility for customers, while PES retained its role as the primary contact point for employers, complicating the coordination of rehabilitation efforts with job search activities.

The NRSZH-RSZSZ system has also faced a shortage of rehabilitation professionals since its inception. As Vincze (2014, p. 44) notes, RSZSZ offices employed around 100 staff members, responsible for nearly 60,000 clients - a workload that significantly strained the system's capacity.

At the end of 2016, a further restructuring took place with the dissolution of the NRSZH, transferring all its responsibilities to the employment and rehabilitation departments within local government offices. This organizational shift received mixed feedback from interviewees. Some experts regarded it positively, highlighting the increased accessibility of local government offices for clients. Conversely, a former ministerial employee raised concerns, criticizing the centralization of the duties of a formerly independent administrative body under direct government oversight.

Some interviewees suggested that repeated reorganizations of government and related institutions have adversely impacted the preservation of professional expertise in the disability field. Many professionals left their roles or exited the sector altogether, in part due to the challenges of adapting to the frequent institutional changes. This attrition likely resulted in significant losses of institutional knowledge and specialized expertise.[29]

Important actors in the field are NGOs specializing in rehabilitation services for individuals with reduced work capacity. Their collaboration with the rehabilitation authority is key, as these organizations possess the expertise necessary to offer complex, personalized rehabilitation services – albeit on a small scale. Interviewed experts highlighted significant shortcomings in this cooperation. Prior to the 2012 reform, collaboration between the PES and NGOs was described as relatively robust and promising.[30] NGOs

[29] A demonstrative example is the dissolution of FSZK (Equal Opportunities of Persons with Disabilities Non-profit Ltd), a research-focused institution with a strong emphasis on disability-related issues, in 2021. The FSZK was replaced by the Slachta Margit National Institute for Social Policy (NSZI), a supporting body under the responsible ministry, whose scope includes a much weaker focus on disability matters compared to its predecessor.

[30] By the end of 2011, the Hungarian PES had developed an accreditation toolkit for labor market services. None of this was finally implemented by the post-2012 rehabilitation authority, as it was noted with regret by an expert interviewee.

often managed entire cases, with considerable autonomy in delivering their services. Since the introduction of the NRSZH system, however, this cooperation has substantially weakened. NGOs are limited to performing narrowly defined tasks with minimal autonomy and, as funding allocations has dwindled, their mandates have further been reduced.

Further key players are accredited employers offering sheltered employment, either permanent or transitional, for DI beneficiaries. As of November 2024, there were 407 independent accredited enterprises with altogether 1669 production sites across the country.[31] The number of persons employed by accredited employers is around 30,000 and has remained stable over the years, the vast majority of whom are in permanent employment.[32] Experts highlight that such jobs are often segregated and do not match employees' qualification, offering limited opportunities for integration into the open labor market.[33] While transitional employment for rehabilitation allowance recipients is intended to include vocational rehabilitation and job search support, Krekó and Scharle (2020b) point out that subsidies for these purposes are insufficient to achieve meaningful outcomes. Furthermore, non-compliance generally goes unsanctioned.

3.2.2. Corrections during Implementation

Shortly after the reform's implementation, the dramatic impact of its measures became apparent. While some of these effects prompted the government to introduce minor policy adjustments, the core aspects of the reform process remained unchanged.

One issue that emerged over time was the insufficient administrative capacity of the rehabilitation authority to conduct the mandatory reassessment of nearly 200,000 affected beneficiaries within a reasonable timeframe. The reassessments progressed slowly, taking over four years to complete. To address this delay, the EMMI proposed an amendment to Act CXCI of 2011 in July 2015.[34] The amendment stipulated that beneficiaries within five years of reaching the statutory retirement age at the time of their scheduled reassessment would be exempted from undergoing a complex reassessment. This change spared the oldest cohorts of beneficiaries from the potential loss of benefits. A former EMMI employee characterized it as an effort to "*correct the depth of human drama*".

Due to the lack of publicly available data on the timing of individual reassessments, it is challenging to determine precisely how many people were affected by the change. However, rough estimates based on the size of the relevant age cohort within the beneficiary population (using the Admin3 database),

[31] Information source: https://kormanyhivatalok.hu/kormanyhivatalok/budapest/megye/megvaltozott-munkakepessegu-munkavallalokat-foglalkoztato (Accessed: 25 November 2024).
[32] Vincze (2014) and Érték vagy! Portal (Accessed: 25 November 2024).
[33] See also Scharle and Csillag (2016) for international experience on sheltered employment.
[34] Draft law T/5052. on the amendment of certain laws on social affairs and child protection, July 2015.

combined with the assumption that approximately 50,000 individuals remained unassessed as of July 2015 and that reassessment timing was age-neutral, suggest that around 10,000-15,000 individuals likely benefited.[35]

For disabled people, one of the most severe consequences of the reform was the reduction in the value of newly calculated benefits. This affected all new claimants as well as reassessed beneficiaries whose conditions were deemed improved compared to their pre-reform status. Moreover, stricter eligibility criteria excluded more individuals with milder health impairments (classified in category A) from the DI scheme altogether. Consequently, a growing number of individuals with reduced work capacity were compelled to increase their labor supply to compensate for the loss or insufficiency of welfare support.

Against this backdrop, to support employment among beneficiaries, policymakers gradually relaxed restrictions on working hours and earnings while on benefits. Initially, the 2012 reform capped work hours at 20 per week for rehabilitation allowance recipients and limited earnings for both disability and rehabilitation allowance recipients to 150% of the minimum wage. In May 2016, the work-hour cap was removed, likely in response to complaints from disabled interest organizations. Ultimately, in January 2021, the earnings limit was also abolished altogether.[36] Unlike the removal of the work-hour cap, the removal of the earnings limit impacted only a small subset of beneficiaries, as most were not earning at levels that made the limit binding (Bíró et al., 2023). At present, there are no restrictions on the working hours or earnings of DI beneficiaries.

The radical reform measures have led to personal tragedies among reassessed beneficiaries. Since the mandatory reassessments began in May 2012, the press has frequently reported cases of individuals whose benefits were withdrawn or significantly reduced despite no objective improvement in their health status.[37] Subjective judgment inevitably influenced the decision-making of the complex assessment committees. According to interviewed experts, committee members were likely instructed by the rehabilitation authority to adopt stricter stances if possible. And when the committees determined a health improvement, the newly restrictive benefit rules were applied.

[35] An interviewed former EMMI employee disclosed that between 2012 and 2014, approximately 40,000 reassessments were conducted annually among beneficiaries subject to the mandatory reassessment.
[36] A minor change to the law's wording eased the earnings limit from January 2014. Previously, benefit payments were suspended if a recipient's gross earnings exceeded 150% of the minimum wage for an average of three consecutive months. The amendment stipulated that benefits would be suspended only if gross earnings exceeded this threshold in all three months consecutively. This change effectively allowed for unlimited earnings in cases where the third month's earnings fell below the limit.
[37] A related news article: https://hvg.hu/gazdasag/20181129_Rokkantsagi_felulvizsgalat_Elkuldtek_fat_vagni_mert_szerintuk_annyit_javult_az_allapotom (Accessed 17 April 2024)

Some DI recipients who were adversely affected began filing appeals, leading to prolonged legal disputes. In a landmark 2018 decision, the Hungarian Constitutional Court found that Act CXCI of 2011 violated the European Convention on Human Rights by reducing benefits without evidence of actual health improvement. The Court emphasized that, in the context of reassessments, an individual's improved status cannot simply be defined by legislative percentages, which can be arbitrarily modified. Instead, it must reflect a tangible improvement in the person's physical condition.[38] Subsequently, several DI beneficiaries successfully challenged Hungary on the basis of this decision (Nagy et al., 2022).

The Constitutional Court urged the Hungarian Parliament to address its legislative breach by March 31, 2019. However, it was not until March 2021 that the Hungarian government introduced a bill, without consulting interest organizations. The bill presented disability allowance recipients, whose benefits had been reduced due to the post-2012 reassessment, with two options: they could either accept a one-time compensation of HUF 500,000 (EUR 1,350), payable by the end of March 2022, in exchange for waiving further claims, or undergo another complex reassessment to prove that their health status had not improved. If successful, they would be eligible for a higher benefit along with retroactive compensation for lost payments.[39]

The proposed compensation package faced significant criticism from interest group organizations (Nagy et al., 2022).[40] First, it was limited to a subset of former DI beneficiaries only: those who had transitioned to disability allowance after their first post-reform reassessment. Excluded from compensation were individuals reassigned to rehabilitation allowance, those who lost their benefits entirely, and the families of DI beneficiaries who had passed away since the reassessment.

Second, the compensation amount was drastically lower - by a factor of 10 to 20 - than the typical amount granted in successful court cases. Beneficiaries were thus forced to choose between an immediate but modest payment and the uncertainty of a potentially much larger, fairer compensation through reassessment. Although no information is available on how many opted for the first choice, the dire financial circumstances of these individuals and the fact that no changes were made to the complex assessment rules - which offered no guarantees of fairer outcomes - suggest that the majority likely accepted the HUF 500,000 compensation.[41]

[38] Information source: https://www.alkotmanybirosag.hu/kozlemeny/az-alkotmanybirosag-fellepett-a-rokkantsagi-ellatasra-jogosultak-vedelmeben/ (Accessed 17 April 2024)
[39] § 33/B includes the related amendment of Act CXCI of 2011.
[40] Information source: https://www.meosz.hu/blog/rokkantsagi-ellatas-500-ezer-forint-valodi-kompenzacio/
[41] A related news article: https://nepszava.hu/3148834_rokkantsagi-ellatott-felulvizsgalat-kormany-karterites (Accessed 21 November 2024)

4. Factors of Success and Failure in Policy Implementation

In what follows, the study evaluates the policy's effectiveness in achieving its objectives of labor market activation and cost savings, while also examining its role in offering social support to individuals with disabilities. The analysis begins with quantitative, descriptive evidence, which is further complemented by qualitative insights gathered through interview and focus group discussions.

4.1. Quantitative Evidence on Reform Effectiveness

This section analyzes the impact of the reform using quantitative evidence from multiple data sources. It explores the factors driving the decline of the DI scheme, both in terms of participant numbers and associated costs. The analysis then shifts to examining changes in employment, income, and living standards among individuals with disabilities over time. Lastly, it delves deeper into the specific outcomes of beneficiaries whose benefits were either terminated or reduced as a result of the reform.

4.1.1. Long-term Viability of the DI Scheme

The 2012 reform sought to improve the financial viability of Hungary's DI scheme, and by this measure, it can be deemed successful.[42] Both the rate of DI recipiency and disability-related public expenditures have significantly declined since the reform's enactment. However, it is important to recognize that a significant part of this reduction stems from favorable demographic trends, as younger cohorts exhibit better health compared to older cohorts at equivalent ages.

According to official data from the Hungarian CSO (Figure A6), the number of working-age individuals receiving disability-related benefits dropped significantly over the past 12 years, declining from 473,360 in 2011 to 244,076 in 2023. This corresponds to a reduction in the DI recipiency rate from 7% in 2011 to 4% in 2023.

The increase in the average benefit amount over the period was modest (Figure A7). By law, both disability and rehabilitation allowances are adjusted annually in line with old-age pensions, which are tied to the consumer inflation rate. As a result, the average disability allowance rose approximately in line with CPI inflation between 2011 and 2023. However, the average rehabilitation allowance experienced a significant real-term decline of 23% over the same period. This drop largely resulted from a sharp compositional shift around 2015-2016, when the three-year term for many beneficiaries placed on rehabilitation allowance after the reform ended, and newly awarded allowances were considerably smaller.

[42] Even though it did not match the ambitious expectations of the Minister of National Economy back in 2011 (Subsection 3.1.1).

As wages rose faster than consumer inflation during this period, the average amounts of both disability and rehabilitation allowances fell significantly relative to the minimum wage (Figure A7). The disability allowance dropped from 90% of the minimum wage in 2011 to 55% in 2023, while the rehabilitation allowance decreased from 66% to 29%.[43]

The particularly low level of rehabilitation allowance appears to have contributed to the declining significance of this benefit category over time. Initially, roughly 40% of DI benefit recipients were on rehabilitation allowance (Figure A6). By 2023, however, only 5.6% of beneficiaries remained on this allowance. Some interviewees suggested that the low benefit amount discourages assessment committees from assigning individuals to this category.

Collectively, these changes reduced the financing requirements related to DI benefits from 1.2% of GDP in 2012 to 0.5% of GDP in 2023, as detailed in Subsection 2.3. Additionally, the government allocated resources amounting to 0.08% of GDP to subsidize accredited employers in 2023[44], while simultaneously generating significant fiscal revenue of 0.22% of GDP from the rehabilitation contribution paid by employers that failed to meet the disability employment quota.[45] Information on public expenditure on the provision of rehabilitation services in general is not available, but according to the experts interviewed, it is not substantial.[46]

4.1.2. Employment and Income of the Disabled

As part of the reform's aim to encourage labor market participation among beneficiaries, the employment rate within the disabled population increased, albeit rather modestly. The financial situation for many disabled individuals remains challenging, resulting in high levels of material and social deprivation compared to the non-disabled population.

This subsection provides quantitative evidence using data from the Admin3 database and European Union surveys (the Labor Force Survey – LFS, and Statistics on Income and Living Conditions – SILC) to illustrate these trends. It is important to note that these data sources are not directly comparable due to

[43] Examining net replacement rates (NRR) of DI benefits across OECD countries in 2016, Berei (2023) observes that NRRs for severe disability in Hungary align closely with that of other countries, while NRRs among more moderately disabled falls below OECD average.
[44] Information source is the CSO of Hungary and Érték vagy! Portal (Accessed: 25 November 2024).
[45] Information source is the Finance Ministry of Hungary, https://kormany.hu/penzugyminiszterium/aht-jelentesek (Accessed: 25 November 2024)
[46] An interviewee revealed that only a minimal amount, HUF 236 million (ca. EUR 0.59 million), was allocated to NGO providers of rehabilitation services in 2024.

differences in data collection methods and definitions of employment and disability. Specifically, the definitions of disability vary significantly across sources.[47]

In the Admin3 database, “disabled” are individuals receiving disability-related benefits. Conversely, survey-based definitions rely on self-reported information on health status. The LFS identifies a person as disabled if they report having a chronic illness that limits their ability to work. SILC defines disability as experiencing difficulties with daily activities due to long-term health conditions or impairments, distinguishing between severe disability and a broader category that includes "some or severe" disabilities.

Using LFS data, the employment rate of working-age individuals with disabilities in Hungary increased from 18% in 2011 to approximately 25% in recent years (Figure A8). While this represents a notable improvement, it remains significantly lower than the EU average of around 50% (Eurofound, 2018; 2021) and the OECD average of 42% (OECD, 2022). Moreover, these employment gains in Hungary occurred without narrowing the disability employment gap - the disparity between employment rates of disabled and non-disabled individuals (OECD, 2022).

The disabled employment rates calculated using the Admin3 database are comparable to LFS data, with rates rising from 17% in 2011 to 24% in 2016, despite differing definitions of disability.

The LFS consistently identifies a significantly larger population of disabled individuals than the number of disability benefit recipients (e.g., in 2019, 496,000 persons versus 294,000 persons). This suggests that a considerable number of people reporting work-limiting health conditions are not enrolled in the disability benefits system in Hungary. Detailed LFS data for the period 2017-2020 further reveal that, among disabled individuals not in employment, 66% received a disability-related benefit, while an additional 20% relied on pensions or other social benefits. For the remaining 14% no income source is known.[48]

The Admin3 database facilitates a detailed examination of employment and income patterns, although only up to 2016. Figure A10 illustrates the trends in employment rates, average benefit amounts, and average total income (the sum of benefits and any wage earnings), categorized into four distinct groups of benefit recipients. The first group, “Affected,” includes beneficiaries subjected to mandatory reassessment under the 2012 reform (described in Section 1 as the primary target of the policy). The

[47] Employment definitions are more similar. The EU surveys use ILO definition of employment, according to which anyone who has worked at least one hour of gainful employment or has been absent from regular work only temporarily (sickness, leave, including maternity leave) during the reference week is considered as employed. In the administrative data, employment is defined as persons employed or self-employed with positive wage earnings observed on the 15th day of every month (Bíró et al., 2023).

[48] Information source: CSO of Hungary, https://www.ksh.hu/docs/hun/xstadat/xstadat_evkozi/e_megvamk9_16_01a.html. Accessed: 6 November 2024.

second group, "Unaffected," comprises beneficiaries exempt from reassessment due to more severe disabilities or older age. Additionally, outcomes are displayed for new beneficiaries after January 2012, separated into those receiving disability allowance and those granted rehabilitation allowance.[49]

Four key findings emerge from panels (a)-(d) of Figure A10.

a) The significant decline in the stock of beneficiaries between 2011 and 2016 was mainly driven by developments within the group unaffected by the 2012 reform. Specifically, large cohorts of older disabled individuals exited the scheme as they reached the statutory retirement age.

b) The average employment rate among beneficiaries already on DI before the reform showed only a modest increase of 2-4 percentage points between 2011 and 2016. In contrast, a substantial rise was observed among new beneficiaries receiving rehabilitation allowances, whose average employment rate reached 57% by 2016.

c) There is considerable variation in average benefit amounts across groups. Notably, the difference between the average disability allowance and the average rehabilitation allowance granted to new beneficiaries was particularly stark, with the latter being nearly half as large in 2016. Furthermore, newly granted *rehabilitation* allowances declined significantly after 2012, becoming much lower than the average benefits received by any other group by 2016.

d) Income adjusted for consumer inflation slightly increased on average across all four groups. This trend reflects the fact that groups experiencing declining benefit amounts compensated by increasing their labor supply. However, despite the rise in their employment rate, new beneficiaries on rehabilitation allowance continued to have the lowest average income among all groups.

To evaluate the living standards of working-age individuals with disabilities, including in an international comparison, SILK survey data is analyzed, focusing on the indicator of severe material and social deprivation. This measure reflects the share of individuals experiencing at least 7 out of 13 deprivation indicators, encompassing both material (e.g., inability to afford adequate heating or nutritious meals) and social aspects (e.g., being able to get together with friends/family for a drink/meal at least once a month).

[49] Note that the composition of all four groups changes over time. Compositional changes can occur due to benefit terminations (in the Affected group), retirement or death (impacting all groups but especially the Unaffected group), and due to new entries (affecting the two new beneficiary groups). Consequently, the changes in average outcomes over time, as shown in Figure A10, are influenced not only by individual trends but also by these compositional shifts.

Figure A9 illustrates levels of the deprivation indicator for Hungary and the EU-27 in 2015 and 2023 for three groups:[50] individuals with severe disabilities, a broader group with "some or severe" disabilities, and the non-disabled population.[51]

Since 2015, the rate of material and social deprivation has decreased across all three groups, both in Hungary and the EU average. This decline is likely influenced, at least in part, by broader international trends, as most EU countries saw improvements during this period. Hungary's deprivation rates for the disabled were, and remain, among the highest in the EU, surpassed only by Bulgaria and Romania. In 2023, over one-third of individuals with severe disabilities and nearly one-quarter of those with some or severe disabilities in Hungary lived in severe material and social deprivation, compared to EU averages of 21% and 14%, respectively.

Hungary also exhibits a striking disparity between the deprivation rates of disabled and non-disabled individuals. In 2023, the difference stood at 17 percentage points for the "some or severe" disability group and 27 percentage points for the severe disability group - the largest disparity among EU countries. This suggests limited welfare redistribution toward disabled individuals in Hungary compared to European standards.

4.1.3. Outcomes of Adversely Affected Reassessed Beneficiaries

This section focuses exclusively on individuals in the "affected" group - those aged 18-56 as of December 2011 with less than 80% health impairment, making them subject to mandatory reassessment. The objective is to track their employment and income trajectories over time, examining how these evolved based on the reassessment's impact on their benefit amounts. To this end, we classify individuals into three distinct groups: those whose benefits were terminated, those whose benefits were reduced, and those whose benefits remained unchanged during the reform's implementation.[52]

Specifically, the "Termination group" includes individuals who lost their DI entitlement between January 2012 and December 2015 and did not re-enter the DI system by December 2016. The "Reduction group"

[50] The indicator is reported in SILK since 2015, when it replaced the earlier indicator for severe material deprivation.

[51] Note the differences in the definition of disability between SILK and other data sources. Considering persons with "some or severe" disability in SILK, their prevalence in the Hungarian working-age population is twice higher than the disability prevalence according to LFS, and more than 3 times higher than the official share of DI benefit recipients in the working-age population. In contrast, persons with only "severe" disability in SILK form a narrower group than disabled in other data sources, corresponding to 50-60% of the number of LFS disabled and 80-90% of benefit recipients.

[52] To be clear, as reassessments are not observed in the Admin3 data, it is not possible to fully attribute all observed benefit reductions or terminations solely to the mandatory reassessments. Changes in benefit receipt may also occur independently of the reform, driven by fluctuations in an individual's health status.

comprises individuals whose annual (inflation-adjusted) DI benefit fell below its 2011 level and remained below that threshold in both 2015 and 2016. The Termination and Reduction groups consist of 7,938 and 7,418 individuals, respectively.[53] The remaining 82,607 affected DI beneficiaries as of December 2011 make up the third group, those whose benefits were not curtailed.[54]

Figure A11 depicts the trends in benefits, income, employment rates, and participation in public works from 2011 to 2016. During this period, public works emerged as Hungary's primary active labor market policy, in some years involving as much as 5% of the working-age population. This expansion was driven by a shift in Hungary's social policies from a welfare-oriented model to a workfare approach, characterized by significant cuts to cash-based benefits and the introduction of conditionality, whereby access to basic social assistance required participation in public works (e.g., Scharle and Szikra, 2015).

As shown in panels (a) and (c) of Figure A11, individuals in the Termination group had lower benefit levels and higher employment rates before the reform compared to other affected beneficiaries. This is consistent with the expectation that those with greater residual work capacity – and consequently lower pre-reform benefit levels – were more likely to lose DI eligibility during the complex reassessment process. Notably, only about one-fifth of individuals in the Termination group had exited the DI scheme by May 2012 (and did not return later), indicating that voluntary leavers were a minority.[55]

Benefit reductions were concentrated among individuals with relatively high pre-reform benefit levels. In the Reduction group, the average inflation-adjusted monthly benefit fell from HUF 62,000 in 2011 to HUF 40,000 in 2016 (EUR 222 and EUR 143 at 2011 exchange rates), representing a 35% decline in purchasing power. However, the average reduction conceals significant variation; in many cases, reassessed beneficiaries experienced losses of as much as two-thirds of their previous benefit.

Both the Termination and Reduction groups responded to benefit losses by increasing their labor supply. Between 2011 and 2016, employment in the primary labor market rose from 43% to 52% in the

[53] These numbers differ somewhat from those in Bíró et al. (2023) due to a few changes in the sample. Among others, the current analysis considers a larger age group (ages 18-56, rather than ages 30-56, in December 2011) and requires the individuals to be on DI in December 2011 only (and not the whole year 2011).
[54] The Termination and Reduction groups include the same set of persons in all years. Compositional changes due to retirement and death occur only in the third group.
[55] The low proportion of voluntary DI exits, according to Admin3 data, seems to contradict the figures presented in Vincze (2014), which reported close to 10,000 individuals who failed to submit the declaration for reassessment by March 2012. Admin3 data show that most of those whose benefits were terminated in this initial period rejoined the DI scheme within a few months or years.

Termination group and from 26% to 39% in the Reduction group. Increases in employment, however, remained modest until the end of our observation period.[56]

The fact that only half of those who lost their benefits entirely were employed in the primary labor market in 2016 underscores the significant challenges these individuals faced in finding employment. This is further evidenced by the increased participation in public works within this group, as shown in panel (d) of Figure A11.[57] When public works participation is included, the overall employment rate in the Termination group rose to 65% by 2016.[58] However, this still indicates that at least one-third of these individuals remained without a formal income source.

In terms of real income, depicted in panel (b) of Figure A11, higher wage earnings only partially compensated for the loss of benefits in the Termination and Reduction groups. Between 2011 and 2016, inflation-adjusted average after-tax income fell by 12% in the Reduction group and by 5% in the Termination group. By contrast, individuals whose benefits were not curtailed experienced a 10% increase in their average income over the same timeframe.

4.2. Insights from Qualitative Research

The interviewed experts widely agreed that the 2012 DI reform incorporated several progressive elements consistent with international best practices. These included its emphasis on the remaining work capacity and rehabilitation potential of the target group, as well as its goal of increasing employment among individuals with disabilities. Additionally, the objectives of streamlining the benefit system and achieving cost savings through more effective targeting were viewed positively by many experts.

However, according to most experts, the implementation of these objectives was, in many respects, flawed - and in some cases even harmful. The reform relied heavily on punitive financial measures, such as benefit reductions or terminations, to push the target group back into the labor market. At the same time, it failed to provide sufficient support services to facilitate the reintegration process. Alarmingly, the availability of rehabilitation services has even declined since 2012, and benefit levels - particularly the rehabilitation allowance - have fallen to amounts that are inadequate to meet even basic living standards.

[56] The small employment response is confirmed by Bíró et al. (2023), who also use the Admin3 database but focus on the narrow age group around the age cutoff of the reform in a difference-in-differences estimation framework.
[57] The period from 2011 to 2016 saw a dynamic expansion of the public works program, resulting in increasing participation rates not only among former DI beneficiaries but also across the broader unemployed population.
[58] Participation in public works was generally a last resort for individuals unable to secure other employment opportunities. These programs were widely regarded as unfavorable by society, as they involved low-prestige, predominantly physical labor and provided wages that fell below the minimum wage.

The following subsections examine the contentious aspects of the reform and shed light on the key factors behind its mixed outcomes, drawing on qualitative insights from interview and focus group discussions.

4.2.1. Anomalies Surrounding the Reassessments

The Hungarian DI reform stands out in an international context, as large-scale restrictions on benefit eligibility for *existing* DI beneficiaries are uncommon (Bíró et al., 2023). A comparable example is the 2004 reform in the Netherlands, documented by Garcia-Mandicó et al. (2020). However, the Dutch reform differed significantly from the Hungarian reform in its design: it targeted younger cohorts, was preceded by a substantial expansion of services aimed at supporting labor market reintegration, and introduced transitional cash allowances to mitigate the impact of lost benefits.

While periodic health reassessments to monitor changes in beneficiaries' health status are widely regarded as a valuable component of a well-functioning DI system, experts interviewed for this study were critical of how the mandatory reassessments were implemented during Hungary's 2012 reform. They emphasized that the process caused considerable human suffering and hardship that could - and should - have been avoided.

A significant issue was the inability to eliminate subjective judgment from the reassessment process. As demonstrated by successful court challenges, assessment committees often claimed improvements in health status without objective medical basis. Interviewees corroborated anecdotal reports of certain medical experts being notoriously more stringent, prompting beneficiaries to avoid them when possible. Furthermore, concerns were raised about potential adverse selection among medical commission members, as they were poorly compensated for their work.

Anomalies are also evident in the weak employment outcomes among beneficiaries whose benefits were reduced or terminated. As discussed in Section 4.1, employment rates in this group grew only modestly, leaving many unable to fully offset their lost benefits with labor earnings, resulting in real income losses. Interview discussions further highlighted that, for certain groups of beneficiaries, the uncertainty and anxiety surrounding the prospect of an unfavorable reassessment had adverse employment effects. In particular, some beneficiaries chose to leave their jobs or avoided taking up employment before their reassessment was completed, fearing that being employed might jeopardize their eligibility for benefits.

The weak employment outcomes of adversely affected reassessed beneficiaries mainly reflect the limited labor market prospects in this group. Many experts argued that while lenient entry conditions in the 1990s and early 2000s allowed individuals with relatively good work capacity to enter the DI scheme, it does not mean these individuals could easily reintegrate into the labor market 10 or 20 years

later. Time spent outside the workforce erodes human capital, and health conditions often worsen over time.[59] Additionally, the reform's target population was concentrated in underdeveloped, predominantly rural areas with limited job opportunities and costly commuting.

Former ministry employees admitted in interviews that no effort had been made by the Ministry to track the outcomes of beneficiaries adversely affected by the reform. However, they noted that the suddenly rising number of clients in other sectors of the social system - such as family support services and homeless care - indicated the increase in financial hardship. One interviewee recalled that in one county, a significant number of individuals who lost DI eligibility had ended up in developmental employment (*fejlesztő foglalkoztatás*), a program originally intended for a different social group - those facing persistent and severe social disadvantages.[60]

As one expert noted, "A difficult-to-manage social group emerged within the system." These individuals often have health issues (chronic illness, mental health problems, alcoholism) but do not meet the criteria for DI benefits. Typically over 50, low-skilled, and from economically disadvantaged regions, the impact of an improving labor market trend since 2016 was least evident among them. Bördős and Koltai (2020) identify this group as especially vulnerable in the labor market, requiring a complex approach beyond traditional employment services, which the Hungarian PES lacks the capacity to provide. As a result, many end up in public works, seasonal jobs, or have to rely on family support.[61]

Experts highlight that individuals whose benefits were completely withdrawn face multiple disadvantages under the policy. They lost not only their benefits but also the broader advantages associated with disability status such as health insurance coverage and pension entitlements. Meanwhile, most measures aimed at boosting labor demand for disabled workers, such as tax allowances or sheltered employment opportunities, do not apply to them. They were also excluded from the 2022 compensation campaign (along with those entitled to rehabilitation allowance), as noted in Section 3.2.2, despite their circumstances being equally shaped by potentially arbitrary reassessment decisions, just like those who did receive compensation.

Overall, most interviewed experts view the reassessment process as harsh and socially harmful. The reduction in the size of the DI scheme achieved through reassessments was relatively modest, especially

[59] The average person in the reassessed group had been on DI for 11 years at the time of the reform, according to Admin3 data.

[60] Developmental employment was formerly termed institution-based social employment (*intézményen belüli szociális foglalkoztatás*).

[61] Basic social assistance exists in Hungary but its value is clearly insufficient to cover a basic standard of living even in relatively low cost-of-living rural areas. As part of the transition to a workfare system, the Hungarian government set the monthly value of the basic social assistance (*foglalkoztatást helyettesítő támogatás*) at a very low value (HUF 22,800, about €80) in 2012 and has not increased it since. In inflation-adjusted terms, the amount decreased by 62% between 2012 and 2023.

when compared to the natural impact of demographic trends. Some experts question the justification for the reassessments, particularly in the absence of sufficient support services. They argue that the fiscal savings and labor market gains were far outweighed by the administrative costs of the process and the human suffering inflicted.

One expert further pointed out the significant legal uncertainty created by the reassessments, as they revoked long-standing benefit entitlements. The 2022 compensation campaign failed to address this issue, as it excluded a substantial portion of those adversely affected and offered limited redress even to eligible recipients. According to the interviewee, the compensation effort seemed primarily designed to prevent future lawsuits rather than to provide genuine reparations.

4.2.2. Insufficient Benefits

A recurring theme in expert discussions was the inadequacy of benefit levels. Current benefits, particularly those for individuals with moderate disabilities, fall far short of ensuring a minimal standard of living or lifting recipients out of poverty. Interviewees emphasized that this situation is not solely a result of the 2012 reform; even before the reform, average benefit levels were low.[62]

Policymakers originally intended to create a partial benefit system, where beneficiaries would supplement their benefits with wage earnings proportional to their residual work capacity. This approach has shown some success among new beneficiaries since 2012, as evidenced by a slight increase in their average total income despite declining benefit levels (Figure A10). However, the additional income from wages has merely prevented further erosion of purchasing power and has not enabled recipients to achieve a decent standard of living. Realizing this goal would require a significant increase in labor demand for disabled workers and substantial improvements in job quality.

Particularly concerning is the sharp decline in benefits awarded to new claimants with moderate disabilities (categories B1, B2, C1). As discussed in section 3.1.2, these benefits are capped at 40-50% of the base amount, which has itself diminished substantially relative to wages since 2012. The cap has therefore become increasingly restrictive, effectively limiting benefits for many new claimants to no more than one-quarter of the minimum wage, regardless of their prior employment history.

An NGO representative noted that for new claimants to achieve a decent income, they would need to meet an almost unattainable set of criteria: high earnings in the year prior to disability claim,

[62] An expert highlighted that not only are the benefit amounts low, but the financial support for acquiring essential equipment and services required for disabled individuals to establish the conditions for independent living is also severely inadequate.

classification in a severe disability category (C2 or above), and sufficient residual work capacity to maintain employment alongside benefit receipt.

Interviewees reported that assessment committees are increasingly aware of this issue and often assign claimants with moderate disabilities to more severe categories to shield them from financial hardship. However, this workaround has its drawbacks. As one expert pointed out, assigning claimants to severe disability categories unintentionally deprives them of access to rehabilitation services, which are automatically available only to recipients of the rehabilitation allowance (categories B1 and C1). While disability allowance recipients (more severe disability categories) can request such services, they are not actively encouraged to do so and rarely take advantage of them.

Persistently low benefit levels, combined with challenges in finding employment in a labor market where wages are rising faster than benefits, have widened income disparities between disabled and non-disabled populations. This dynamic has disproportionately affected disadvantaged regions and low-skilled workers, further deepening pre-existing social and economic inequalities, as noted by an expert interviewee.

4.2.3. Lack of Rehabilitation Services

One of the most significant shortcomings in the design and implementation of the reform was the inadequate provision of essential support services, including health and employment rehabilitation, mentoring, and job search assistance. Interviewed experts unanimously noted that a functional support system was absent at the time of the reform, and the situation has since deteriorated. Today, the availability of rehabilitation services is even more limited than it was during the pre-reform period and the early years of the reform.

There appears to be little political will or effort to reverse this downward trend. A former high-ranking official at EMMI attributed this failure to a form of political shortsightedness. "*Even at the ministerial level, it is extraordinarily difficult to convey the importance of rehabilitation. The chronic underdevelopment of the system is rooted in this lack of understanding*," the interviewee explained. "*Policymakers fail to grasp why benefits must be complemented by services and why nationwide systems should be built for service provision*."

Another former EMMI official suggested that the rehabilitation sector fell victim to intentional budget cuts. The interviewee recalled how, during the early 2010s, all ministry plans were required to align with the government's strict "deficit target obligation" (*hiánycéltartási kötelezettség*) imposed by the Ministry of Finance, which left little room for investment in critical support infrastructure. Even in subsequent years, when economic conditions improved, no efforts were made to allocate resources for rehabilitation services in the public budget.

The current state of rehabilitation services reveals significant gaps, as already outlined in sections 2.3 and 3.2.1. The state body responsible for providing these services lacks the capacity and expertise to deliver complex, personalized support. Independent NGOs operate on a small scale and face severe underfunding. Many have been forced to close or suspend activities over the past decade due to financial constraints. Meanwhile, accredited employers receive substantial public funding, but their role is largely limited to providing employment without offering additional services.

Experts underscored the critical importance of NGOs in delivering high-quality rehabilitation services. One interviewee noted, "*NGOs naturally provide superior services because they possess local knowledge and specialize in specific disabilities, offering expertise the state system cannot match*." However, insufficient and ad hoc funding with frequent delays, as well as weak collaboration with rehabilitation authorities hinder their operations, raising fears that their expertise may be lost over time.

In contrast, accredited employers benefit from relatively generous public funding, but their activities focus on segregated employment with limited pathways to the open labor market. Expert opinions on these employers were divided. Some criticized their reliance on low-skilled, low-paying jobs often mismatched to workers' skills, while others highlighted their value as essential opportunities for disabled individuals who lack viable alternatives in the current system.

A notable ministerial initiative aimed at offering employment together with comprehensive rehabilitation services was the Special Public Works Pilot Program, implemented in 2016-2017. Designed for DI benefit recipients, the program offered part-time, temporary employment at a special public works wage (lower than the regular public works wage) alongside a blend of employment, social, and rehabilitation services. According to Bakonyvári et al. (2020), the program showed some promising results in improving participants' motivation levels, yet it was ultimately discontinued.

An interviewee from the Ministry of the Interior attributed the program's termination to insufficient collaboration between coordinating institutions and service providers, which hindered the provision of services. Additionally, another expert recalled challenges in recruiting DI beneficiaries, citing the low social prestige of public works and fears among potential participants that their involvement might jeopardize their benefits.

The experience of the pilot program underscores the significant coordination challenges involved in establishing an effective, comprehensive rehabilitation system. As one interviewee noted, "*Complex rehabilitation requires complex coordination among ministries and state secretariats, but this simply doesn't exist. The health system is also steadily deteriorating, despite the fact that successful employment rehabilitation must be built on effective health rehabilitation. Medical, social, and employment services may exist in isolation, but they are not integrated into a cohesive system. [...] No matter where I look, there is a lack of coordination, capacity, information, and trained professionals*."

Interviewees shared stories of disabled acquaintances who, lacking centrally organized support services, managed to organize their own rehabilitation and secure employment through personal resources and networks. However, this approach is understandably out of reach for those with fewer resources, highlighting significant inequalities in access to the limited services that remain available.

4.2.4. Employer Incentivization and Attitudes Toward Disabled Workers

One of the most positively evaluated aspects of Hungary's disability policy, according to experts, is the quota system, which incentivizes employers with more than 25 employees to hire workers with disabilities by imposing a substantial noncompliance tax (the rehabilitation contribution) if the quota is unmet (see section 3.1.3). Interviewed NGO experts agree that the high tax serves as a strong motivating factor. As one employment rehabilitation specialist explained, approximately 90% of the employers they work with are primarily driven by the associated tax allowance when hiring disabled workers.

However, the quota system also has notable limitations. Krekó and Telegdy (2025) analyzed its impact and found that, despite the high tax rate, only 26% of the quotas were fulfilled - a low rate by international standards.[63] Interviewed experts also pointed out that the vast majority of newly created jobs are part-time and paid at minimum wage, merely fulfilling the minimum requirements to meet the quota.

The low fulfillment rate can be attributed to several factors. Krekó and Telegdy suggest that employers face high search costs, particularly in regions with limited disabled labor supply. Additionally, integrating disabled workers into the workplace often requires extra resources, such as mentoring or physical accommodations, costs that employers must bear largely on their own. Current policies provide limited support, although employing a rehabilitation mentor does count towards fulfilling the quota.

Finding employment as a disabled person is further complicated by employers' selective preferences. Many employers, according to interviewees, seek disabled workers who can perform their roles without requiring significant accommodations. One NGO employee noted, "*Employers are most interested in disabled workers who are otherwise 100% able to do the job - for instance, a wheelchair-bound IT specialist*." By contrast, individuals with mental illnesses or psychosocial disabilities, such as autism, face significantly lower demand.

Stigma and prejudice compound these issues. Some disabled workers are hesitant to disclose the nature of their disability to potential employers, fearing it could jeopardize their chances of being hired, as

[63] Krekó and Telegdy (2025) reference OECD data from Western European countries, where quota fulfillment rates range between 50% and 64%. By contrast, Poland, with a fulfillment rate of approximately 30%, aligns more closely with Hungary.

explained by an NGO employee. Further complicating matters is the content of complex assessment opinions, which often classify individuals as “not rehabilitable” or not recommended for rehabilitation - designations that help them avoid very low benefits but make convincing an employer to hire them more challenging.

Despite these barriers, interviewees noted a gradual improvement in societal attitudes towards disability over the past two decades. An employment rehabilitation expert rated this progress as an increase by 2 points on a 10-point scale. An expert specializing in designing company trainings on inclusive culture acknowledged the improvement but highlighted significant differences in attitudes among employer types. Large multinational companies with established diversity policies are far more advanced compared to smaller domestic firms.

Finally, the financial structure of the quota system reveals another shortcoming. Public revenues from noncompliance payments are substantial, amounting to 0.22% of GDP in 2023. Yet, since the late 2000s, these funds have lacked a designated allocation, meaning there is no guarantee they are used to support individuals with disabilities (Gyulavári and Nagy, 2019). As one interviewee lamented, “*These revenues are essentially disappearing into a bottomless pit. None of it is reinvested in employing people with disabilities*.”

5. Final Assessment and Conclusions

Largely due to lenient eligibility criteria, Hungary’s DI enrollment had reached exceptionally high levels in international comparison by the early 2000s. Attempts to tighten these conditions in the following decade were cautious and resulted in reductions in entry rates which policymakers deemed insufficient. In response, a comprehensive reform was introduced in 2012, implementing radical measures aimed not only at reducing inflows but also at increasing outflows from the system.

The stated objectives of the 2012 reform - enhancing the targeting of benefits and encouraging individuals with disabilities to work in alignment with their residual work capacity - are both important and desirable. However, as this study argues, the implementation of the reform was plagued by significant design flaws and operational deficiencies.

One of the most critical shortcomings was the striking inadequacy of rehabilitation services, a fundamental component of an effective disability support system. These services are essential to help reassessed beneficiaries and new claimants reenter the labor market and mitigate the impact of reduced and persistently low benefit levels. In the absence of a comprehensive support framework, the reform has caused considerable personal hardship, much of which could have been avoided.

To establish a functioning rehabilitation system, the government must commit significantly greater resources through a stable, long-term state funding mechanism. This is vital for retaining and developing expert knowledge, which, while sporadically available, is rapidly diminishing due to chronic funding shortages. A feasible source of funding for such a mechanism is the fiscal revenue generated from employers' rehabilitation contributions.

Low levels of benefits can be justified if individuals have access to viable wage-earning opportunities or, at least temporarily, if they receive supplementary, high-quality services aimed at enhancing employability. However, as these conditions are absent in the current system, the government should revisit its benefit calculation methods – particularly the level of the base amount and the caps applied to individuals with moderate disabilities – and adjust benefit levels to cover a minimum standard of living.

The complex reassessment of existing beneficiaries, mandated by the reform, has raised serious concerns. The process has created significant legal uncertainty and eroded public trust in policymaking. To avoid human suffering, large-scale reassessments should not have been conducted before the establishment of a functioning rehabilitation system. One interviewed expert suggested that such reassessments should have been limited to younger cohorts only, who are presumed to have better prospects in the labor market.

The reassessment process also raises ethical questions, as beneficiaries faced adverse consequences stemming from past policy mistakes. Although beneficiaries were not responsible for lenient entry conditions, they were nonetheless penalized. A former ministry official emphasized this injustice, stating: "*No one should be pushed into deep poverty because they took advantage of a situation created by the state 25 years ago. In such cases, the state unilaterally terminates the solidarity that it itself established at the time*." This injustice has yet to be adequately addressed or compensated.

These policy failures can be attributed, in part, to the rushed nature of the reform process. Insufficient time was allocated for careful policy planning that could have engaged key stakeholders and experts. However, some interviewees questioned whether the government had a genuine interest in pursuing thoughtful policy design. When asked why the area of rehabilitation has been so neglected, a former ministry employee remarked with disappointment, "*It is not important to them*." This apparent lack of prioritization is further evidenced by the limited availability of centrally provided data and the complete absence of impact assessment research, either conducted or commissioned at the central level.

This study is one of the few attempts to provide an evaluation of the 2012 reform with more than a decade of hindsight, aiming to contribute to the much-needed discourse on the topic.

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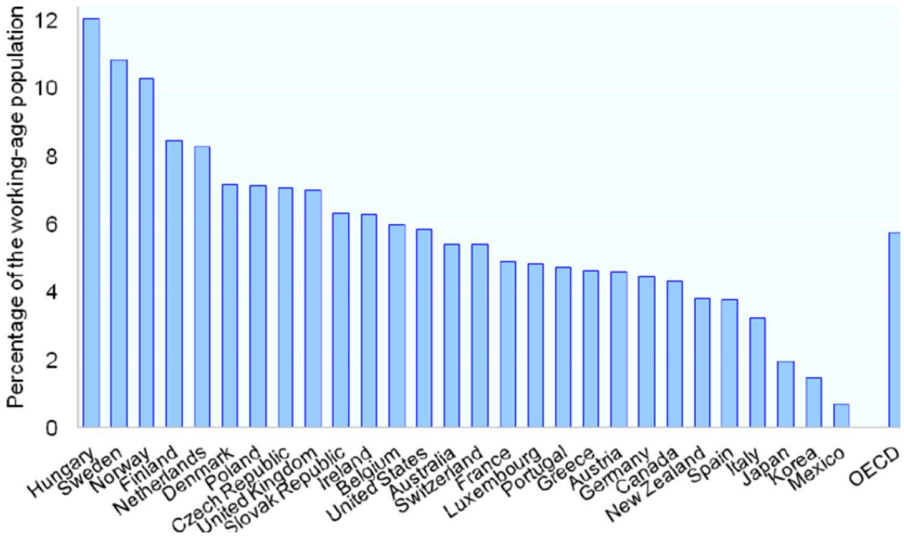
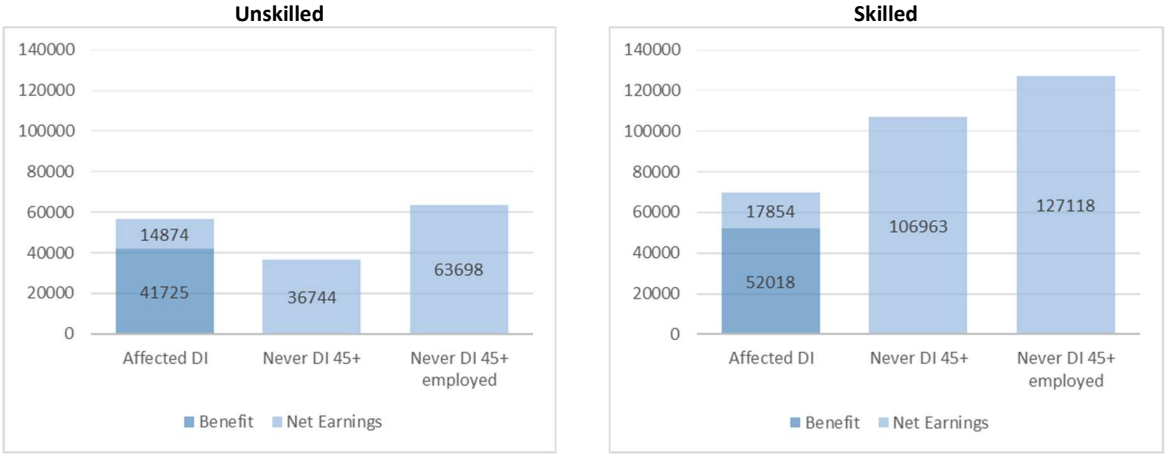
Annex

Figure A1. Share of DI recipients in the working-age population in 2001



Source: Gautier and van der Klaauw (2009)

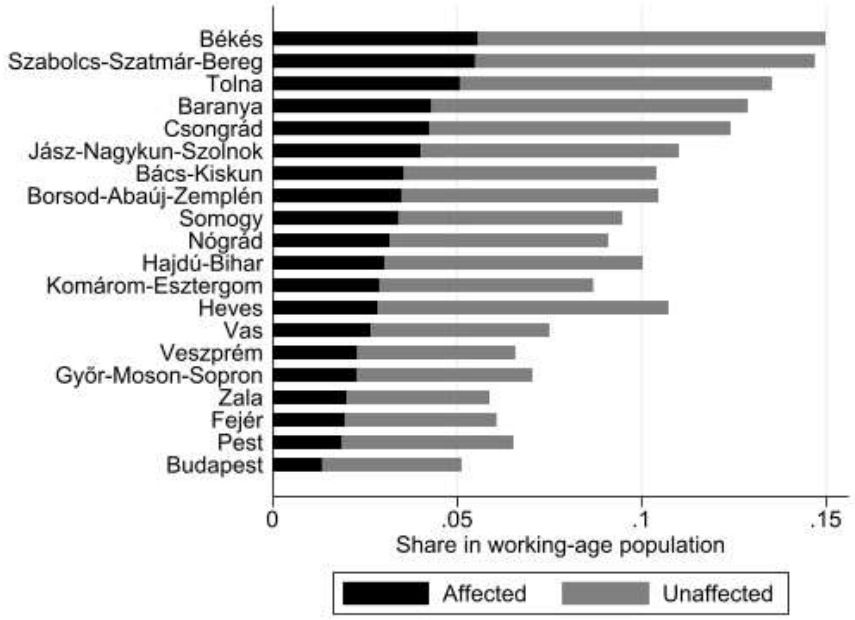
Figure A2. Income from DI benefits and labor earnings in 2011 by skill



Note: Author's calculations based on Admin3 data. Monthly benefit amount and after-tax earnings in Hungarian forints in 2011. Unskilled and skilled are determined by the last observed occupation during the period 2003-2011. The group of DI beneficiaries include only those who are affected by the 2012 reform (ages 18-56 in December 2011 and less than 80% health impairment). The group of Non-disabled 45+ include persons of ages 45-56 in December 2011 who have never been

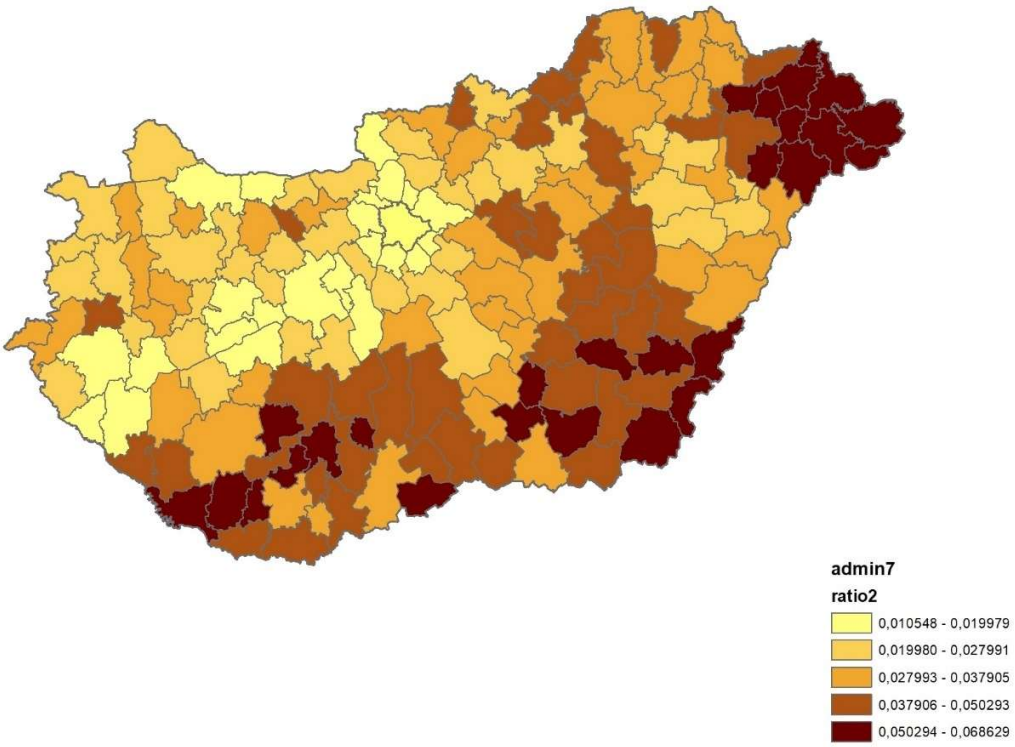
on DI before. Skill is observed for 58% of the sample of affected DI beneficiaries and for over 80% of the non-disabled samples.

Figure A3. DI recipiency rates by county in 2011 (NUTS3)



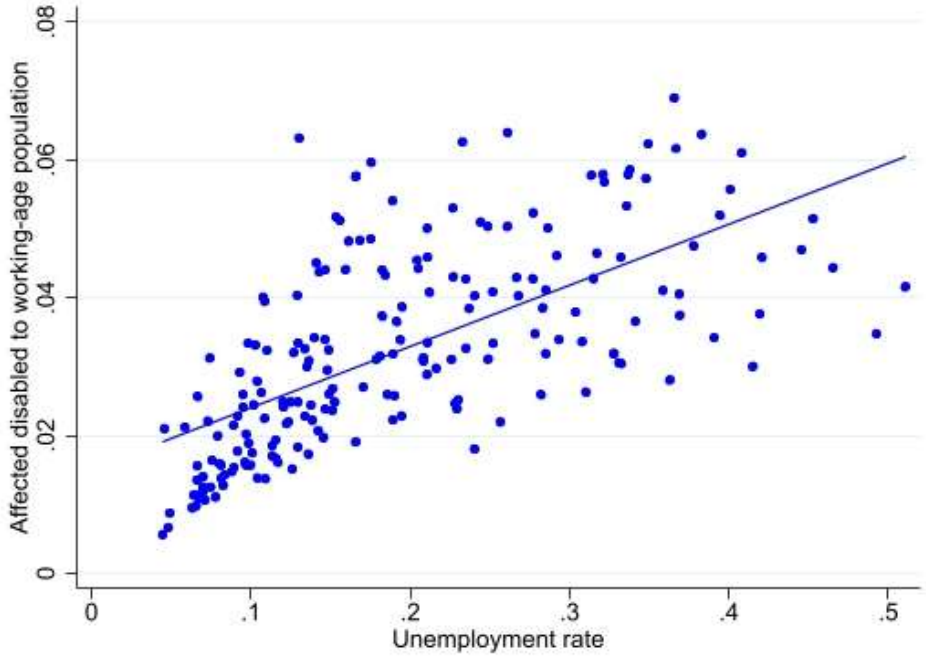
Note: Author's calculations based on Admin3 data. Share of affected and unaffected DI beneficiaries in the working-age population. Sorted by the share of the affected group.

Figure A2. Reform incidence by district (LAU1)



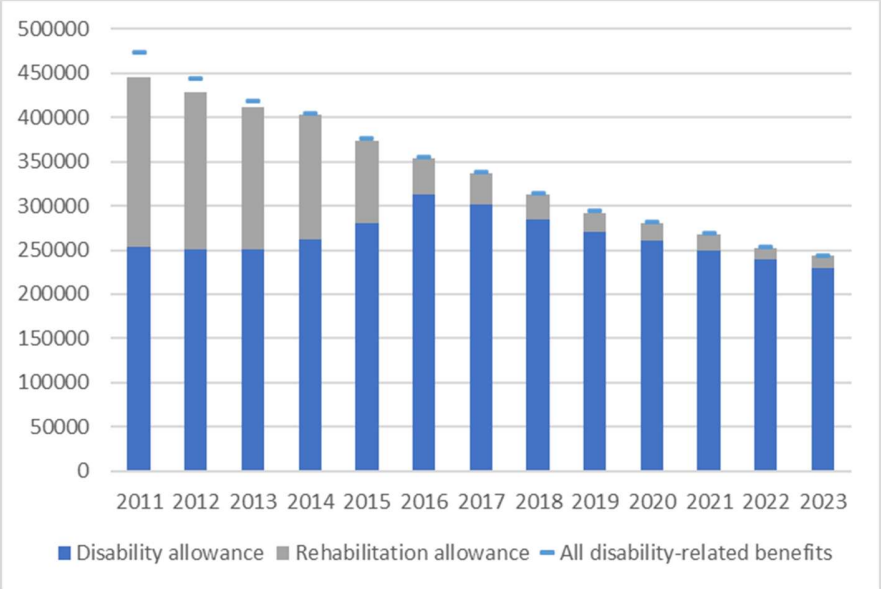
Note: Author's calculations based on Admin3 data. The colors represent various value ranges for the share of DI beneficiaries affected by the reform to the working-age population in 2011 by district of Hungary (LAU1 regional level). Visualization made by the author using the ArcGIS software. The shapefile was obtained from the OpenStreetMap project, https://data2.openstreetmap.hu/hatarok/index.php?admin=7j.

Figure A5. Reform incidence and unemployment rate by district (LAU1).



Note: Author's calculations based on Admin3 data. Share of DI recipients in the working-age population in December 2011. Unemployment rate is average of monthly rates during January-December 2011.

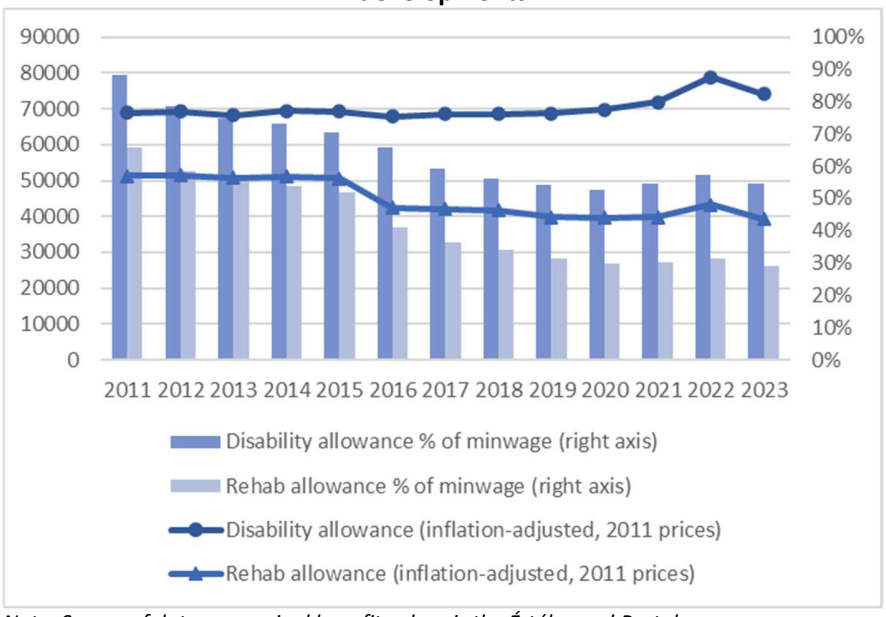
Figure A6. Number of DI benefit recipients



Note: Source of data is the Érték vagy! Portal (https://ertekvagy.hu/) and CSO of Hungary. The total number of benefit recipients exceeds the sum of disability and rehabilitation

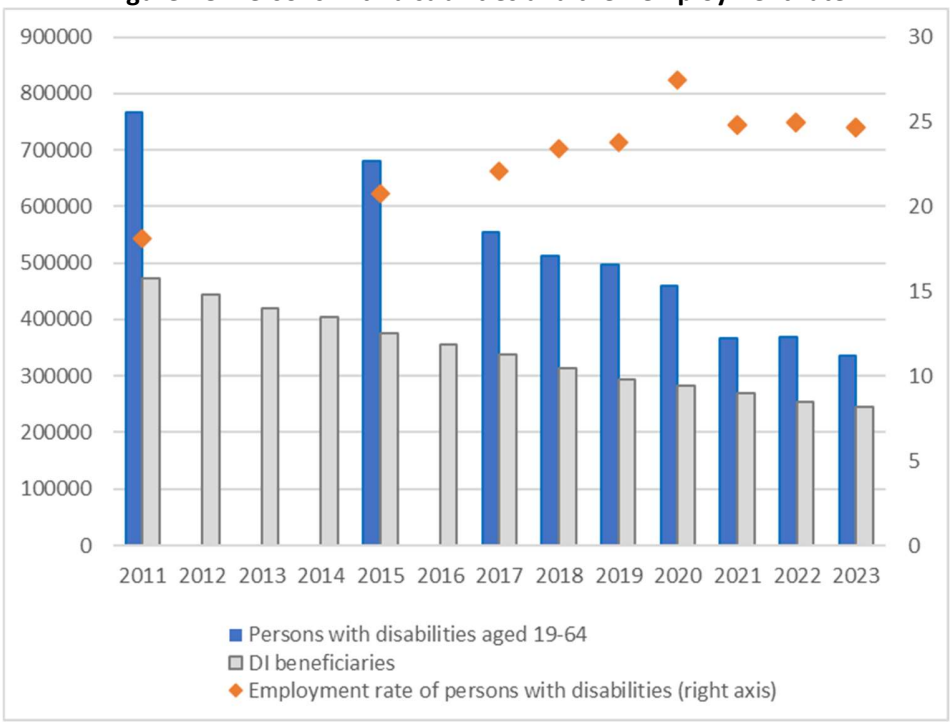
allowance recipients due to two smaller benefit types. One is the rehabilitation benefit which can be received for a maximum of three years and which has not been awarded since 2012. The other is the miners' disability benefit, received by 0.5% of all DI beneficiaries.

Figure A7. Average DI benefit amounts relative to price and wage developments



Note: Source of data on nominal benefit values is the Érték vagy! Portal (https://ertekvagy.hu/), data on CPI inflation and minimum wage is from CSO of Hungary.

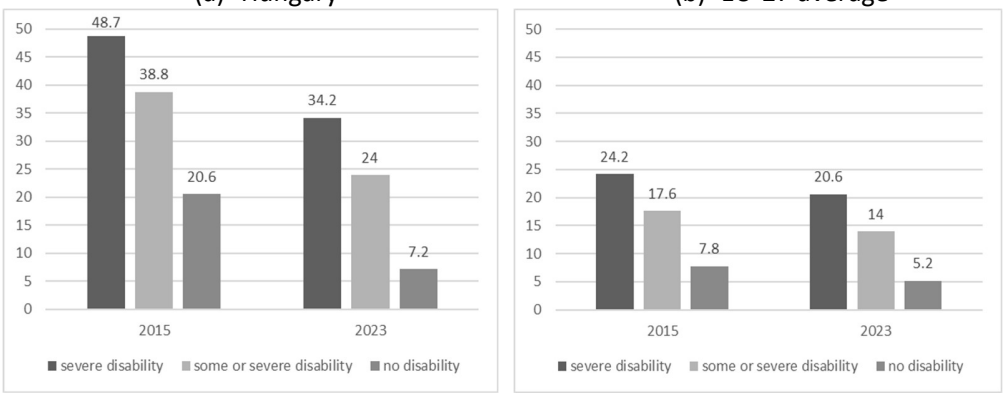
Figure A8. Persons with disabilities and their employment rate



Note: Persons with disabilities include individuals whose ability to work is limited by a chronic illness. Source: CSO of Hungary, survey data collection based on EU-LFS methodology. Surveys were conducted in the second quarters of years 2011, 2015, 2017-2020, and 2021-2023. There were changes in survey methodology in 2017 and in 2021, which limit the comparability of the surveys. Data on the number of DI beneficiaries are administrative data provided by the Hungarian State Secretary and reported by the CSO of Hungary.

Figure A9. Rates of severe material and social deprivation

(a) Hungary (b) EU-27 average

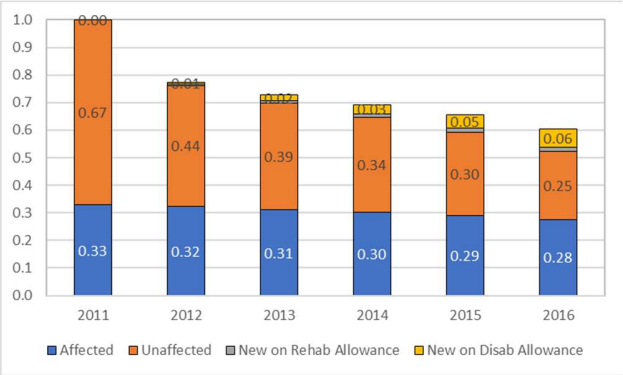


Note: EU-SILK survey data from Eurostat. Statistics refer to the working-age population of 16-64 years of age. Disability is based on a person's self-reported level of difficulty in performing everyday activities due to long-term health conditions or impairments. For someone to be considered severely materially and

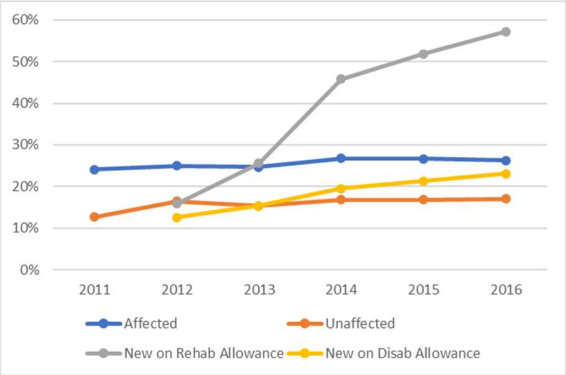
socially deprived, they must experience at least 7 out of 13 deprivation items. These items include both material (e.g. inability to afford basic goods or services, such as adequate heating or nutritious meals) and social indicators (e.g. being unable to meet friends or family, engage in leisure activities, or access the internet).

Figure A10. Employment and income of DI beneficiaries, 2012-2016

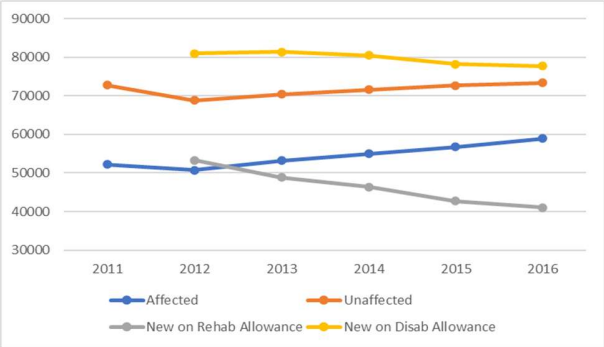
(a) Sample composition (N=1 in 2011)



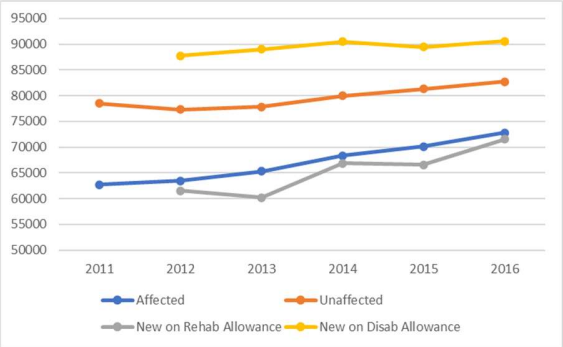
(b) Employment rate



(c) Average benefit amount (CPI-adj.)

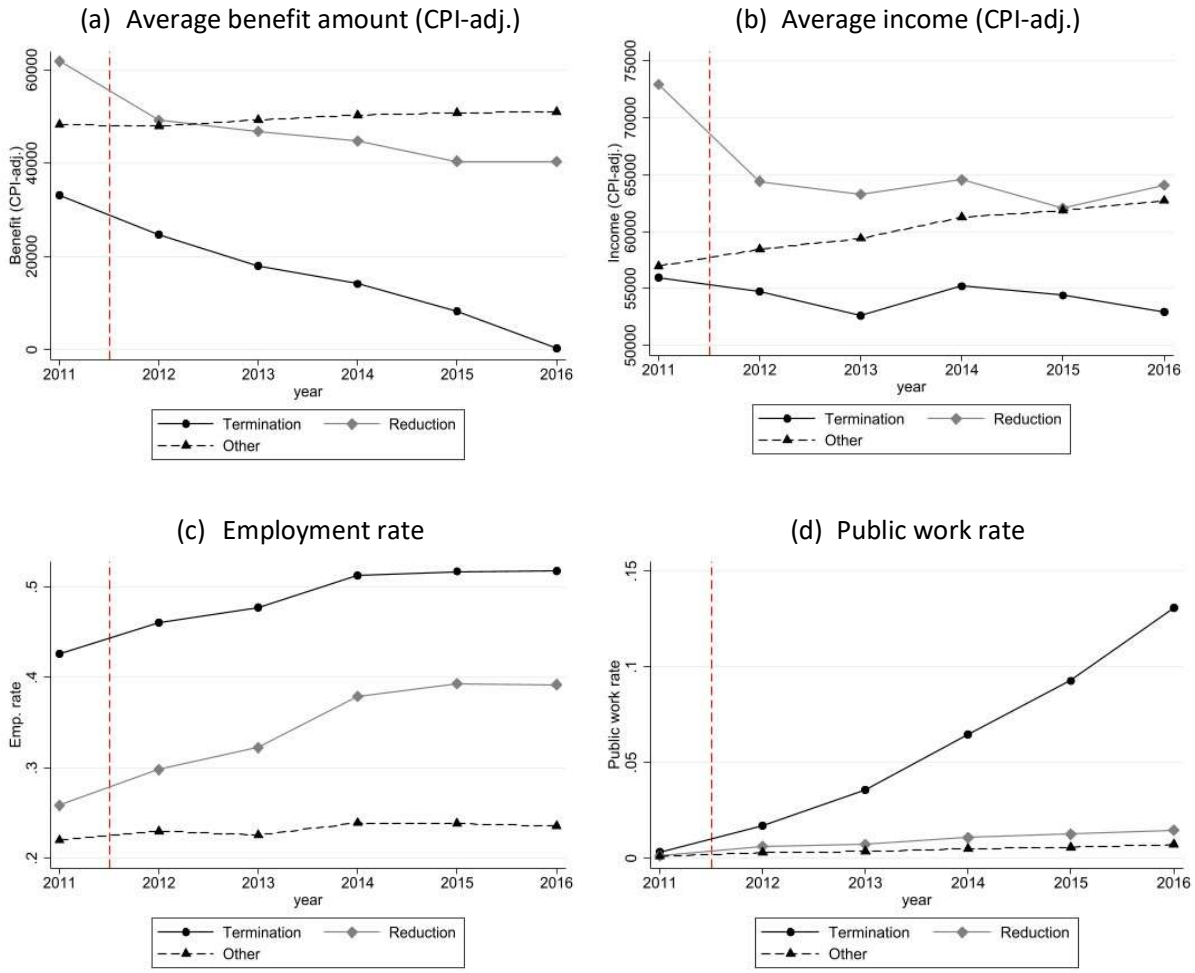


(d) Average income (CPI-adj.)



Note: Own calculations based on Admin3 database. Total income is DI benefit plus after-tax labor earnings. Benefit and income are monthly values and adjusted for consumer inflation (2012=1 price index). Values for 2012 therefore equal the unadjusted amounts.

Figure A11. Outcome trends for affected beneficiaries



Note: Own calculations based on Admin3 database. Total income is DI benefit plus after-tax labor earnings. Benefit and income are monthly values and adjusted for consumer inflation (2011=1 price index). Values for 2011 therefore equal the unadjusted amounts. Termination: individuals who lost DI entitlement between January 2012 and December 2015 and did not return to DI until December 2016. Reduction: individuals whose DI benefit reduced in inflation-adjusted terms between January 2012 and December 2016. Other: all other DI recipients affected by the reform.

Table A.1. Descriptive statistics of DI beneficiaries and the non-disabled (2011)

	Affected DI beneficiaries		Non-disabled		Non-disabled 45+	
	Mean	St.dev.	Mean	St.dev.	Mean	St.dev.
Age (Years)	49.5	6.5	36.4	10.5	50.6	3.2
Gender (0=Female, 1=Male)	0.452	0.498	0.499	0.500	0.480	0.500
Two-year mortality	0.021	0.145	0.0025	0.0498	0.0067	0.0815
Last job unskilled	0.401	0.490	0.164	0.370	0.183	0.386
Lives in Budapest	0.073	0.260	0.165	0.371	0.162	0.368
District unemployment rate	0.195	0.098	0.161	0.093	0.161	0.091
Has employment	0.240	0.427	0.584	0.493	0.720	0.449
DI benefit (HUF/month)	48,090	39,576	--	--	--	--
Net earnings (HUF/month)	10,074	23,513	63,623	83,433	83,717	89,088
Net earnings if employed	41,391	31,008	107,838	84,652	115,268	86,055
Number of persons	97,674		2,424,510		579,348	

Notes: The statistics refer to averages of monthly values during January-December 2011. The group of DI beneficiaries includes only those who are affected by the 2012 reform (ages 18-56 in December 2011 and less than 80% health impairment). The group of Non-disabled include persons of ages 18-56 in December 2011 who have never been on DI before. The group of Non-disabled 45+ is a subgroup of the Non-disabled group, with ages 45-56 in December 2011.

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