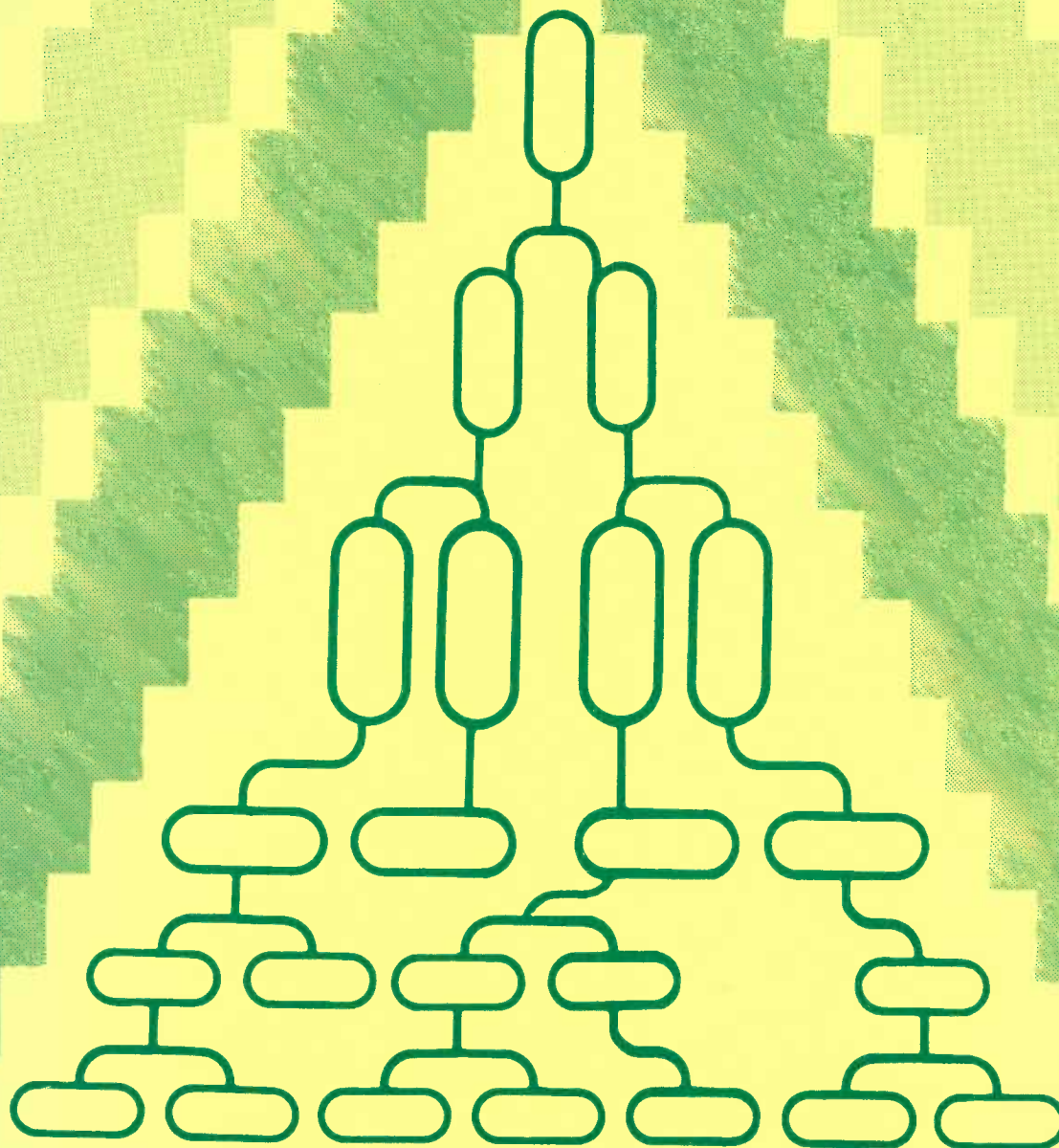


CASE STUDIES IN POPULATION POLICY:

# Hungary



UNITED  NATIONS

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Population Policy Paper No.19

C A S E S T U D I E S I N P O P U L A T I O N P O L I C Y :

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# Hungary



U N I T E D N A T I O N S

New York, 1989

## PREFACE

This publication is one in a series of country case studies being prepared by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat that focus on selected issues in the formulation, implementation and evaluation of population policies in various developing and developed countries.

The objective of the series is to present broadly comparative, issue-oriented case studies that illustrate the myriad approaches countries have pursued in implementing, formulating and evaluating their population policies. The specific issues addressed include the manner by which policies, programmes and targets aim to influence demographic variables directly or indirectly, how they have been formulated, and the extent to which they have been implemented in relation to one another and to other social, economic and political goals. Emphasis is placed on the problems encountered and the strategies undertaken to resolve the problems. It is hoped that this series will be useful to persons responsible for population programmes and policies and, in general, for the sharing of experiences among countries in the formulation, implementation and evaluation of population policies.

The population policy overview for Hungary presented on pages 1 through 6 of this publication is taken from World Population Policies, volume II, Gabon to Norway (United Nations publication, Sales No. E.89.XIII.3). The main body of the report was drafted in 1987 by Gabriella Vukovich of the Demographic Research Institute, Central Statistical Office, Budapest as a consultant to the United Nations. The views and opinions expressed are those of the consultant and do not necessarily reflect those of the United Nations. The estimates and projections presented in the population policy overview may differ from those presented in the main body of the publication, owing to demographic assessments, subsequent adjustments and differences of time reference. Special acknowledgement is due to the United Nations Population Fund for its support of project INT/84/PO8, which made possible the preparation of this publication.

To date, reports issued in the Case Studies in Population Policy series are:

MALAYSIA	(ST/ESA/SER.R/80)
KUWAIT	(ST/ESA/SER.R/82)
NIGERIA	(ST/ESA/SER.R/83)
BRAZIL	(ST/ESA/SER.R/84)
CHINA	(ST/ESA/SER.R/88)
MEXICO	(ST/ESA/SER.R/89)
UNITED REPUBLIC OF TANZANIA	(ST/ESA/SER.R/91)

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## EXPLANATORY NOTES

Symbols of United Nations documents are composed of capital letters combined with figures. Mention of such a symbol indicates a reference to a United Nations document.

Reference to "dollars" (\$) indicates United States dollars, unless otherwise stated.

The term "billion" signifies a thousand million.

Annual rates of growth or change refer to annual compound rates, unless otherwise stated.

A hyphen between years (e.g., 1984-1985) indicates the full period involved, including the beginning and end years; a slash (e.g., 1984/1985) indicates a financial year, school year or crop year.

A point (.) is used to indicate decimals.

The following symbols have been used in the tables:

Three dots (...) indicate that data are not available or are not separately reported.

A dash (--) indicates that the amount is nil or negligible.

A hyphen (-) indicates that the item is not applicable.

A minus sign (-) before a number indicates a deficit or decrease, except as indicated.

Details and percentages in tables do not necessarily add to totals because of rounding.

47 forint = \$U.S. 1 as of 1985.

POPULATION POLICY OVERVIEW

DEMOGRAPHIC INDICATORS	CURRENT PERCEPTION																					
<p><b>SIZE/AGE STRUCTURE/GROWTH</b></p> <table> <tr> <td>Population:</td> <td style="text-align: center;"><u>1985</u></td> <td style="text-align: center;"><u>2025</u></td> </tr> <tr> <td>(thousands)</td> <td style="text-align: center;">10 697</td> <td style="text-align: center;">10 598</td> </tr> <tr> <td>0-14 years (%)</td> <td style="text-align: center;">21.6</td> <td style="text-align: center;">17.8</td> </tr> <tr> <td>60+ years (%)</td> <td style="text-align: center;">18.2</td> <td style="text-align: center;">24.2</td> </tr> <tr> <td>Rate of:</td> <td style="text-align: center;"><u>1980-85</u></td> <td style="text-align: center;"><u>2020-25</u></td> </tr> <tr> <td>growth</td> <td style="text-align: center;">0.0</td> <td style="text-align: center;">-0.1</td> </tr> <tr> <td>natural increase</td> <td style="text-align: center;">-0.3</td> <td style="text-align: center;">-0.6</td> </tr> </table>	Population:	<u>1985</u>	<u>2025</u>	(thousands)	10 697	10 598	0-14 years (%)	21.6	17.8	60+ years (%)	18.2	24.2	Rate of:	<u>1980-85</u>	<u>2020-25</u>	growth	0.0	-0.1	natural increase	-0.3	-0.6	<p>Growth is perceived as <u>unsatisfactory</u> because it is <u>too low</u>. Concerns are population aging and declining population size.</p>
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#### GENERAL POLICY FRAMEWORK

Overall approach to population problems: The Government seeks to increase population growth by increasing fertility levels and improving living conditions. Population policies have as their goal a more equitable age composition of the population, decreasing the mortality rate and improving the general health of the population.

Importance of population policy in achieving development objectives: Population policy is considered an integral part of socialist socio-economic policies and is continually adjusted to reflect Hungary's demographic situation and social and economic possibilities.

#### INSTITUTIONAL FRAMEWORK

Population data systems and development planning: Censuses were published in 1960, 1970, and 1980. Vital registration is considered complete. A formal system of development planning has existed since 1956; the latest plan is the seventh five-year plan (1986-1990).

Integration of population within development planning: No single governmental agency is responsible for the formulation or co-ordination of population policies. The Unit for Long-Term Planning of the State Planning Board, established in the early 1960s, is responsible for integrating population projections into long-term development planning. The Demographic Research Institute of the Hungarian Central Statistical Office (HCSO) conducts demographic surveys and prepares population projections for planning purposes.

#### POLICIES AND MEASURES

Changes in population size and age structure: There is an official policy of intervention to increase the rate of population growth. The objective is to reduce the speed of population decline in the short run and stop it in the long run (early in the twenty-first century). By enlarging the size of generations born in the future, it is hoped that the age structure of the population will become more equitable, thus alleviating some of the undesirable consequences of population aging. The Government's policies aim at modifying the attitudes of couples and individuals concerning desired family size, since those are seen as the most crucial determinant of population growth. Most official policies regarding population growth relate to fertility. Population size and growth are also to be altered by decreasing the mortality rate of middle-aged men, which has risen since the mid-1960s. The quantitative target is to attain and maintain a level of population growth that ensures population replacement. To cope with the rapid and advanced aging process, various social policy measures have been undertaken, in such areas as pensions and health care, to improve the economic and social situation of the elderly.



Mortality and morbidity: Policy measures include a programme for the study of mortality, administered by the Central Statistical Office in conjunction with various international organizations, monitoring the health conditions of the population, programmes for the prevention of the most frequent causes of death and disease, care and treatment of chronically sick people and development of maternal and child care. Under the Health Act of 1972 all citizens are entitled to medical care at State expense. Particular attention has been given to halting the declining male life expectancy at birth by decreasing the high mortality levels of men aged 40-59 which have resulted from diseases of the circulatory system. No quantitative overall mortality targets have been established. Public information campaigns that emphasize the negative consequences of excessive alcohol consumption, smoking, poor diet and lack of exercise are being created.

Fertility and the family: So as to raise population growth and improve maternal and child health and family well-being, a policy of intervention exists to boost fertility levels. Policies aim at raising fertility in order to ensure the replacement of population, adjusting distortions in the age structure, and realizing the socialist ideal of the family. Various maternity and family benefits are designed to encourage fertility. Mothers are entitled to maternity leave with full wages for the first five months after delivery. The maternity fee, introduced in 1985, pays 75 per cent of the mother's average income after the first five months until the child reaches one and a half years of age. After that, a maternity allowance is available until the child is three years old. In addition, there is a "birth aid", a lump-sum payment given at a child's birth, and sick pay for parents to stay at home and nurse a sick child. There are also family allowances. Nurseries for children under age three and kindergarten and day-homes for children aged 6-14 are also intended to encourage childbirth. Family planning services are provided by the Government through the national health system. Contraceptives are available at all pharmacies. However, a 1984 law forbids the provision of contraceptives to women under age 18 without a medical prescription. Abortion is legal on health, eugenic, juridical, social and medical grounds during the first 12 weeks of pregnancy for single women and for married women over 35 or with three or more living children. In 1987 a decree was issued permitting sterilization for contraceptive purposes for women over age 30 with at least four children, women over age 35 with at least three children, and to all women over the age of 40.

International migration: Levels of immigration and emigration are viewed as insignificant and are not active policy concerns of the Government.

Spatial distribution/urbanization: No explicit policies have been formulated concerning spatial distribution and internal migration. However, the National Settlement System concept has several indirect aims, including the narrowing of large differentials in living conditions and income between the urban and rural populations; meeting housing requirements; reducing the amount of internal migration; and establishing functional relations between settlements suitable for long-term spatial location of productive resources.

Status of women and population: Measures such as child-care allowances and maternity benefits are aimed at facilitating the combination of motherhood with work outside the home. The Government has affirmed its commitment to improving the status of women by outlawing sex discrimination in hiring, unequal conditions for the sexes at the workplace, not hiring pregnant women, and dismissal of pregnant employees. In 1986 the minimum legal age at marriage for women was raised to 18 years in order to promote more stable marriages and lower the incidence of divorce.

Other issues: In 1984 a resolution of the Council of Ministers stated that for the period 1986-1990 special emphasis should be given to three aspects of a long-term population policy: a scientific foundation for population policy; the mutual relationship between population and socio-economic development; questions of the health, biological state and reproductive quality of the population. Based on these areas of emphasis, the Demographic Committee of the Hungarian Academy of Sciences issued a research plan in the area of population policy for 1986-1990.



The boundaries and names shown on this map do not imply official endorsement or acceptance by the United Nations.

### SELECTED SOURCES

The information contained in the overview is based on the continuous monitoring of population policies undertaken by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat, as part of its work programme.

The Government of Hungary's response to a United Nations questionnaire entitled "Fifth Population Inquiry Among Governments: monitoring of Government perceptions and policies on demographic trends and levels in relation to development as of 1982" constitutes an important source for the overview.

Except where otherwise noted, the demographic estimates and projections are based on the tenth round of global demographic assessments undertaken by the Population Division. The various demographic indicators are derived from data that were available to the United Nations generally by the end of 1985; therefore, the figures supersede those that were previously published by the United Nations.

United Nations (1987). Case Studies in Population Policy: Hungary (ST/ESA/SER.R/87).

\_\_\_\_\_. (1985). The Mexico City Conference: The Debate on the Review and Appraisal of the World Population Plan of Action.

\_\_\_\_\_. World Population Prospects: Estimates and Projections as Assessed in 1984 (Sales No. E.86.XIII.3).

United Nations Economic Commission for Europe (1985). Economic and social implications of aging in Hungary (Geneva).

World Health Organization (1985). Seventh report on the world health situation, vol. 5 (Geneva).

#### Contraceptive prevalence rate\*

United Nations. Recent Levels and Trends of Contraceptive Use as Assessed in 1987 (Sales No. E.89.XIII.4).

#### Female mean age at first marriage

United Nations. World Population Trends and Policies: 1987 Monitoring Report (Sales No. E.88.XIII.3).

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\* Contraceptive prevalence rate is for ages 15-39.

## INTRODUCTION

### A. Population concerns

The current demographic situation in Hungary can best be characterized as one of comparatively low fertility, high mortality and negative population growth. Population aging is fairly advanced even when compared to the other developed countries of Europe.

The spatial distribution of the population is generally not considered a problem, although one fifth of the population is concentrated in the capital, Budapest. Internal migration has slowed down considerably since the early 1960s, and international migration is negligible.

The economic and social implications of slow population growth and the recent onset of population decline, combined with progressive aging, are being widely discussed. The implications of population trends on economic development have until recently been assessed for the most part in the context of the influence of slow or negative growth and aging on the supply side, emphasizing the quantitative aspects of the labour force. Advanced aging, however, has also drawn attention to the demand side, and research on actual and expected changes in overall consumption and in needs in specific sectors has started.

For practical purposes the size of the labour force is taken to be the population aged 15-59 years. The size of the working age population in Hungary increased until 1980, but subsequently started to decrease as the large birth cohorts born after the First World War reached age 60 and the small birth cohorts born during the 1960s entered the working ages. According to national population projections, a further decline is expected not only in the size of the total population but also in the size of the working age population.

Female labour force participation until the early 1960s was fairly low, which meant that there was a large reserve of potential entrants into the labour force. Relatively rapid economic development and changing social conditions exhausted these reserves, and by 1980 the majority of women were economically active, even among the older persons of working age.

These are, of course, demographic and economic processes that have been experienced in many other developed countries. Their particular relevance to developmental issues in Hungary is that there seems to be a slight contradiction between its stage of population development and its stage of socio-economic development. There is usually understood to be a correspondence between the two, with slow population growth and an aged population generally associated with high levels of economic

development and high rates of population growth and a young age distribution associated with a moderate or low level of economic development; in that respect Hungary seems to be a combination of the two types. Slow population growth and recently, population decline, and a relatively advanced aging process have been experienced under conditions of moderate economic development.

These circumstances imply that although the size of the working age population and the size of the labour force increased substantially up to the early 1970s, there was no unemployment in Hungary. On the other hand, technological development is probably still not advanced enough to compensate for the decline in the size of the labour force which has recently begun. This is particularly true for unskilled and semi-skilled labour.

Progressive aging at the same time involves shifts in the age distribution of the working age population and the labour force, which implies qualitative changes in the labour force. Shifts in the age distribution of the active population are believed to be an important variable in determining output. Geographical and occupational mobility, for instance, may diminish to the extent of becoming an obstacle to structural readjustments. An older labour force is also generally considered to be more reluctant to accept technological progress. Accumulated experience, on the other hand, may be an advantage in certain occupations. There is a general trend towards increasing educational attainment among the younger generations; young entrants into the labour force are usually better qualified than older workers. The aging of the labour force and the small number of entrants imply that the qualifications of the labour force, in general, will not increase as fast as it would if the entrants were more numerous. The better qualifications of the younger generations, however, may compensate for their smaller numbers.

Besides the long-term trend in aging, there are considerable fluctuations in the sizes of the younger generations in Hungary. This is an issue of special relevance to development and planning. For instance, in 1954 there were 223,000 births, in 1962 there were 93,000 fewer births, in 1975 there were 64,000 more births than in 1962; in 1984 there were 70,000 fewer births than in 1975. Fluctuations of this magnitude mean that large birth cohorts must face serious bottle-necks in educational institutions and subsequently in the labour market, for example, while the opportunities for the small cohorts are usually far better. Planning at the macro level to satisfy the needs of large cohorts is also a major problem from an economic standpoint as investments cannot be planned to adequately meet the needs of the largest cohorts while the facilities will be under-utilized when the smallest generations pass through them.

Another widely discussed aspect of population decline and demographic aging is the social and financial burden of the growing number of pensioners. Currently, 18 per cent of the population is aged 60 years and over. Since retirement age for men is 60 years and for women 55 years, the proportion of pensioners within the total population is almost 22 per cent, and the number of pensioners is increasing. Considering the decrease in the size of the active population, the burden on the working age population is of great concern.

Providing adequate health care for the population is an issue of major importance. Under the country's current economic conditions, improving the quality of health services is difficult enough in itself, but given the usual J-shape demand for health services, decreasing after the youngest ages but rising steeply in older ages, progressive demographic aging is a factor which also makes quantitative development, in addition to qualitative improvements, necessary.

The above-mentioned issues form the basic background to current population policy considerations in Hungary.

#### B. History of population policy formulation since the Second World War

In the modern history of Hungary, three periods of population policy formulation can be distinguished since the end of the Second World War.

The first period started in 1953, when the Government announced a decree on "developing the protection of mothers and children". The decree contained several regulations concerning the medical care of pregnant women, social security benefits to families, the development of child-care institutions to improve the conditions of raising children and the living standards of families. Nevertheless, it had serious deficiencies as well. The philosophy behind the policy was that the socialist system as implemented would automatically ensure optimal population trends, and optimal population trends were implicitly considered to be synonymous with maximum population growth. On the other hand, the policy assumed that government decisions concerning practices dependent on individual decisions could be enforced through administrative measures.

These considerations provide the background for the extremely restrictive measures concerning access to abortions and contraception. Following the implementation of these measures the number of births temporarily increased. However, the public reaction resulted first in a relaxation of the restrictions, and two years later in the sanctioning of abortions on demand. Subsequently, the number of abortions increased sharply up to 1969, and the number of births decreased very rapidly up

to 1962. Economic growth during this period was substantial, and the living standards of the population improved considerably, leading to the conclusion that economic development in itself did not increase fertility, but that on the contrary, certain societal changes, such as increasing female labour force participation, resulted in fertility declines.

In the second half of the 1960s this recognition led to the formulation of a population policy on grounds totally different from the 1950s philosophy. The new policy was based on a long-term perspective of population policy; an integral part of social and economic development policy. Consequently, the demographic component was increasingly considered in societal planning, especially in long-term planning. The aims of population policy were to ensure the reproduction of the population and to moderate the uneven age distribution.

The first measure implemented under the new population policy was the maternity allowance, a fixed monthly amount to which the mother was entitled if she was economically active but chose to stay at home until the child's third birthday. One effect the measure had was to upset the pattern of lower fertility for economically active women as compared to inactive women. The fertility of active women has become the dominant determinant of overall fertility levels in Hungary.

Additional measures were implemented a few years later in 1973. Family allowances were introduced, the amount of the maternity allowance was increased and families and young couples began to receive benefits to improve their housing conditions. Oral contraceptives were made available, while the previously unrestricted access to abortions was abolished. Subsequently, abortions could be granted only for social or medical reasons.

According to a public opinion survey conducted in 1974, the measures were generally welcomed except for the restrictions concerning the granting of abortions. Many of the respondents felt that the conditions for granting abortions were too restrictive.

The general acceptance of the measures by the public was reflected in the changes in the number of abortions and number of births: there were 30,000 more births in 1974 than in 1973, while there were 67,000 fewer abortions in 1974 than in 1973. This suggests the extensive use of oral contraceptives, a situation completely different from that prevailing in the 1960s, when the dominant method of birth control was abortion.

Following the implementation of the 1973 population policy measures, a temporary increase in the number of births was observed which, however, was only partly due to the measures themselves. The controversy surrounding the impact of the 1973 population policy is discussed further on.



At present Hungary is in its third period of population policy implementation. Recent changes in population trends and the outcome of long-term demographic developments have created the current unfavourable demographic situation in Hungary. This has led to the formulation of a new long-term population policy.

The demographic situation in Hungary has become an issue of national importance. Population policy must now take into account the nation's current and future social and economic needs, but exclude any elements which may limit human rights or impose constraints or restrictions. Families are free to decide the number of children they want to have. The goal of population policy is to improve the living conditions of families so that they may achieve their desired size.

## I. THE DEMOGRAPHIC SETTING

The current demographic setting of Hungary is, to a certain extent, the consequence of long-term historical trends. The relatively delayed onset of the demographic transition has meant a delayed occurrence of all stages of the transition, while the consequences of the two World Wars, especially the low birth cohorts of the First World War, are still evident in the age pyramid of the population.

### A. Historical demographic trends

Population trends during the early nineteenth century in Hungary were characteristic of the country's slow economic development and social situation. Fertility and mortality were both high, population growth was moderate and the age distribution of the population was young.

Fertility in the period preceding the onset of the demographic transition was already considerably below natural, uncontrolled levels, but still very high. During her lifetime a woman gave birth to on average 6 to 7 children, and crude birth rates were about 50 per thousand.

Mortality was especially high in young age groups, and only about 30 per cent of live-born girls reached reproductive age. Life expectancy at birth was around 20 to 25 years, with considerable regional variations.

Both fertility and mortality showed large fluctuations around high and slowly changing values. Due to recurring epidemics (influenza, smallpox, malaria in certain regions, cholera) and famines, the number of deaths in certain periods could be four to five times higher than usual in the regions affected. Natality almost immediately followed mortality fluctuations, however, and the losses were quickly replaced.

Under the given mortality conditions the observed fertility levels were only sufficient for moderate average population growth. Net reproduction rates were around 1.1 to 1.2, and the average annual natural increase was around seven per thousand in the nineteenth century.

The period of demographic transition started in the last third of the nineteenth century when population trends changed radically. Subsequently, mortality decline was rapid and continued up to the mid-1960s. Life expectancy at birth was three times higher and crude death rates four times lower than a hundred years earlier. In 1960 the probability of dying at age 0 was six times lower, and in the age group 1-4 it was more than 10 times lower than a century before.

Gains in life expectancy, achieved primarily through the reduction of infectious and parasitic diseases, have been greater in childhood and young adulthood than in the higher ages. Endogenous factors, due in part to changing life-styles, became dominant in the cause-of-death-pattern of mortality. Consistent with the trend in life expectancies, survival probabilities have also increased, mostly at younger ages. While at the beginning of the twentieth century, the probability of both a newborn boy and a newborn girl living to age 40 was 0.50, the same probabilities in 1960 were 0.90 and 0.92, respectively. The increase in the probability of a person aged 40 surviving to age 60 has been a much smaller one: between 1900 and 1960 the probability increased from 0.69 to 0.85 for men, and from 0.71 to 0.90 for women. The increase in survival probabilities in higher ages has been even smaller. Cohort data also support the trend revealed by life table probabilities. Among members of the 1860-1869 birth cohorts, 25 per cent survived to age 60-69, whereas 44 per cent of the 1910-1919 birth cohorts survived to that age.

Together with mortality declines, fundamental changes in both the age pattern and the cause-of-death-pattern can be observed. While more than one half of all deaths before the turn of the century occurred in infancy and early childhood, 70 per cent of all deaths in 1960 occurred in ages above 60 years, as the proportion of the major causes of death affecting older adults has increased.

Mortality decline has been continuous until the 1960s, with major fluctuations observed only during the two World Wars. By the early 1960s, Hungary had become a country of low mortality.

In the course of the demographic transition, fertility also declined considerably in Hungary. The crude birth rate in 1880 was 44 per thousand, by 1960 it was only 15 per thousand. The total fertility rate dropped from 5.32 to 2.02 between 1900 and 1960, and the number of births decreased over the same period from around 260,000 to 140,000.

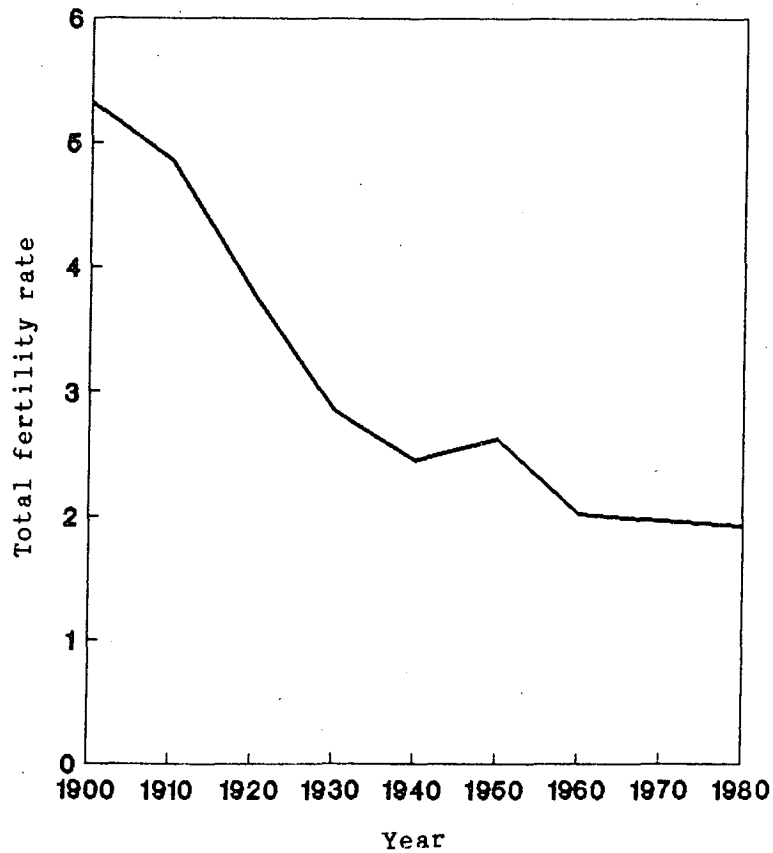
The fertility decline involved a shift in the proportion of births of different parities. The proportion of fifth and higher parity births decreased from around 50 per cent to less than 10 per cent, while the proportion of first and second parity births quadrupled within a century.

The trend of declining fertility has not been smooth, and the fluctuations have been significant. During the initial stage of the transition, in the 1870s, the decline in fertility was slower than the decline in mortality. The changes were more significant during the period 1910-1930. After the extremely low number of births during the First World War and the post-war baby boom, the fertility decline continued from a level well below the pre-war levels, and by the end of the 1930s the total fertility rate was under three children per woman. During the Depression in the early 1930s, fertility was not high enough

to guarantee simple replacement in the long run under the mortality conditions of that time. After a stagnation in the 1940s and a temporary upswing in the early 1950s, the decrease continued rapidly, and by the end of the 1950s fertility was at about the level necessary for the reproduction of the population (see figure I).

In conjunction with the fertility decline, there was a change in the pattern of the timing of births. Data on age-specific fertility show a steep decline in the number of children born to women in the higher age groups of child-bearing age. This is also reflected in the decrease in the proportion of third or higher parity children, who were and would be born at higher ages. The changed timing pattern at the same time explains the increase in the fertility of women in the youngest reproductive age groups.

Figure I. Total fertility rates, Hungary  
1900-1980



Consistent with the declining trend in fertility, the number of births also fell rapidly. The decline, however, was subject to considerable fluctuations. Extremely low numbers of children born during the four successive years of the First World War and the resulting upswing, due to delayed births, in the post-war period produced highly uneven cohort sizes, which are still apparent in the age distribution of the population. The decrease in the number of births was much less pronounced during the Second World War, and the "baby boom" which followed was also much smaller than either the one after the First World War, or the one in Western Europe in the late 1940s. Without reviewing the implementation of population policy measures in the early 1950s, which will be discussed later, it should be noted that these measures resulted in very high numbers of births, with a peak of 223,000 live births in 1954 compared with an annual average of 187,000 between 1946 and 1950. Immediately following the relaxation of legislation concerning the severe restrictions in the granting of abortions, a steady decline in the number of births began, with the number falling to 130,000 births in 1962. By the early 1960s, Hungary was among the countries with very low fertility levels.

Changes in natural growth and population size during the demographic transition suggest a difference between the two periods (see table 1). The first period, which lasted until the 1910s, was that of rapid population growth when the former balance between fertility and mortality was upset by fertility declining more slowly than mortality. The annual rate of natural increase was over 10 per thousand during that period. The population of Hungary increased from 5,011,000 in 1870 to 7,981,000 in 1915. Net reproduction rates during that period were around 1.5. Slower natural increase and considerably lower net reproduction rates were characteristic of the second period, which lasted until the mid-1960s. The significant reproductive "reserves" in the population, the large previous birth cohorts and the continuous mortality decline still resulted in a 30 per cent increase in the population between 1915 and 1960, despite declining fertility and net reproduction rates which hardly exceeded unity. According to the 1960 census, the population of Hungary was almost 10 million.

A natural concomitant of the demographic transition is the aging of the population. The age distribution of the Hungarian population has changed due to aging both at the base and the apex of the age pyramid which, in turn, is due primarily to declining fertility and secondly to declining mortality. Between 1870 and 1960 the size of the population aged 60 years and over increased from 256,000 to 1,373,000, their proportion increasing from 5 per cent to almost 14 per cent (table 2). The growth in both the number and the proportion of that group was faster in the oldest age groups and among the female population. The total number of persons aged 80 years and over was 10,000 in 1870 and more than 10 times higher by 1960. Their proportion within the total

Table 1. Population size, natural increase and average annual growth rates, Hungary, 1784-1986

Date	Population (in thousands)	Period	Change		Average annual rate of growth (per cent)
			in thousands	in per cent	
	2 681.6	1784-1787	...	...	...
31 Dec. 1869	5 011.3	1787-1869	2 329.7	86.9	0.76
31 Dec. 1880	5 329.2	1870-1880	317.9	6.3	0.56
31 Dec. 1890	6 009.4	1881-1890	680.2	12.8	1.21
31 Dec. 1900	6 854.4	1890-1900	794.4	13.2	1.25
31 Dec. 1910	7 612.1	1901-1910	757.7	11.1	1.05
31 Dec. 1920	7 986.9	1911-1920	374.8	4.9	0.48
31 Dec. 1930	8 685.1	1921-1930	698.2	8.7	0.84
31 Jan. 1941	9 316.1	1931-1941	631.0	7.3	0.70
1 Jan. 1949	9 294.8	1941-1948	-111.3	-1.2	-0.15
1 Jan. 1960	9 961.0	1949-1959	756.2	8.2	0.72
1 Jan. 1970	10 322.1	1960-1969	361.1	3.6	0.36
1 Jan. 1980	10 709.5	1970-1979	387.4	3.8	0.37
1 Jan. 1981	10 712.8	1980	3.3	0.0	0.03
1 Jan. 1982	10 710.9	1981	-1.9	-0.0	-0.02
1 Jan. 1983	10 700.2	1982	-10.8	-0.1	-0.10
1 Jan. 1984	10 678.8	1983	-21.4	-0.2	-0.20
1 Jan. 1985	10 657.4	1984	-21.4	-0.2	-0.20
1 Jan. 1986	10 640.0	1985	-17.4	-0.2	-0.16

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

Table 2. Population by broad age groups, Hungary, 1900-1986

Year	0-14 years		15-59 years		60 years and over	
	Number in thousands	Percentage total population	Number in thousands	Percentage total population	Number in thousands	Percentage total population
1900	2 391.6	34.9	3 948.7	57.6	514.1	7.5
1910	2 645.5	34.7	4 358.9	53.3	607.7	8.0
1920	2 446.3	30.6	4 820.4	60.4	720.2	9.0
1930	2 392.2	27.5	5 444.7	62.7	848.2	9.8
1941	2 420.4	26.0	5 898.2	63.3	997.4	10.7
1949	2 290.1	24.9	5 841.7	63.5	1 073.1	11.6
1960	2 529.5	25.4	6 058.9	60.8	1 372.7	13.8
1970	2 176.5	21.1	6 385.8	61.9	1 759.8	17.1
1980	2 341.2	21.8	6 538.2	61.1	1 830.1	17.1
1985	2 298.5	21.6	6 437.0	60.4	1 921.9	18.0
1986	2 278.6	21.4	6 420.5	60.3	1 940.9	18.2

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

population increased over the same period from 0.2 per cent to 1.1 per cent. The size of the female population aged 60 and over increased from 122,000 or 2.4 per cent of the total population to 783,000 or 7.9 per cent of the total population between 1870 and 1960, while the number of men aged 60 and over grew from 134,000 or 2.7 per cent to 590,000 or 5.9 per cent of the total population.

The proportion of children (population aged 0-14) within the total population fell between 1870 and 1960 from 36.7 per cent to 25.4 per cent, but due to the significant decline in infant and child mortality, the size of the population aged 0-14 increased despite the decreasing number of births, although the rate of increase in the size of this segment of the population was much slower than in the total population.

The size of the working age population (15-59 years) increased at about the same rate as the total population, thus its proportion in the total population remained virtually unchanged.

Because the fertility decline did not immediately follow the drop in mortality levels during the last decades of the nineteenth century, about 30 large cohorts started to pass through the age pyramid, the initial size of these cohorts being very similar to the previous ones, but the proportions surviving being larger due to declining mortality. The cohorts born in the first decades of the twentieth century were already of smaller initial size; thus, despite the further decline in mortality, the numbers surviving to any given age were not larger than in the previous cohorts.

The major distortion in the age distribution of the Hungarian population was due to the small birth cohorts of the First World War and, more recently, by the large cohorts born in the first half of the 1950s following the implementation of restrictive measures concerning abortions. Other events, including the Second World War and the post-war "baby boom", had much less influence on the age distribution.

The sex ratio shows an excess of females over males in the total population; this, however, is not constant over time or for the different age groups. Until the beginning of this century the proportion of the sexes was almost balanced, with only a slight female excess, which was somewhat more pronounced in the aged population than in younger segments of the population. An increasing female excess is now observed in all adult age groups, and in particular in the aged population.

#### B. Current demographic trends

Recent demographic trends have been unfavourable in Hungary. The number of marriages and the number of births have declined, while the number of deaths has increased. The general trend in developed



countries of declining family size and population aging is also observed in Hungary. In addition, there has been a very large fluctuation in birth rates, and mortality has been increasing continuously since the mid-1960s.

### 1. Marriages and divorces

While the annual number of marriages entered into has been decreasing since the mid 1950s, partly because the size of the population entering marriageable age is decreasing, marriage rates have also declined (table 3). The number of marriages per thousand unmarried males aged 15 years and over in 1980 was 29 per cent lower than in the mid-1950s and 19 per cent lower than in 1975. The decrease in the relevant female population was 29 per cent and 22 per cent, respectively. Marriage rates are declining in all age groups of never married men and women, especially since the mid-1970s. This trend is also evident for remarriages since the 1970s, despite the increase in the proportion of divorced and widowed persons within the total population. The former trend of the decreasing average age at marriage was also reversed in the mid-1970s. The balance of marriages (the difference between the number of marriages entered into and dissolved within a period) showed an excess of marriages contracted over marriages dissolved through divorce or death until 1977. The balance is increasingly negative since 1978. In 1985 the number of marriages dissolved exceeded the number of marriages contracted by 24,300. The marriage rate of around seven to eight marriages per thousand population is close to the Middle- and East-European pattern.

The number of divorces continues to increase with only slight temporal variations. In 1960 more than 16,000 marriages were dissolved through divorce. In 1983 divorces rose to more than 29,000. If current age-specific divorce rates persist, about 50 per cent of all marriages will end in divorce before the partners reach age 60. The number of divorces per thousand existing marriages increased to 10.9 in 1985, a jump of 65 per cent since 1960. The frequency of divorces was highest in the age group 20-29 years, but the increase was greatest in ages under 20 and in the age group 30-39 years. Thirty-five per cent of all divorce-terminated marriages had a duration of less than five years, the highest frequency occurring in the second and third year's of marriage. There is a continuous increase in the number of divorce-terminated marriages where the couple has one or more children.

### 2. Fertility

The basic pattern of current fertility evolved by the 1960s. The main features of the pattern are that the number of births, in the long run, is below the level necessary for simple population replacement and that the fluctuation in the number of births is, in certain periods,

Table 3. Marriage rates and marriage dissolution rates, Hungary, 1921-1985

Year	Number of marriages contracted	Number of marriages dissolved			Balance of marriages	Number of marriages dissolved		
		through death	through divorce	total		through death	through divorce	total
		Per thousand population				Per thousand marriages contracted		
1921	11.6	5.6	0.8	6.4	5.2	487.7	66.3	554.0
1930	9.0	5.2	0.6	5.8	3.2	569.1	70.5	639.6
1938	8.1	5.3	0.6	5.9	2.2	648.0	77.5	725.5
1948	10.7	4.6	1.2	5.8	4.9	429.6	113.2	542.8
1960	8.9	4.7	1.7	6.4	2.5	531.2	187.3	718.5
1970	9.3	5.6	2.2	7.8	1.5	600.5	236.4	836.9
1976	9.5	6.0	2.6	8.6	0.9	635.3	269.5	904.8
1977	9.1	6.0	2.6	8.6	0.5	663.7	280.0	943.7
1978	8.7	6.4	2.7	9.1	-0.4	740.6	307.3	1047.9
1979	8.1	6.3	2.6	8.9	-0.8	770.3	316.7	1087.0
1980	7.5	6.6	2.6	9.2	-1.7	876.7	346.0	1222.7
1981	7.2	6.5	2.6	9.1	-1.9	909.4	355.6	1265.0
1982	7.1	6.5	2.7	9.2	-2.1	918.7	378.4	1297.1
1983	7.1	6.6	2.7	9.3	-2.2	929.9	386.2	1316.1
1984	7.0	6.5	2.7	9.1	-2.1	918.5	383.1	1301.6
1985	6.9	6.4	2.8	9.2	-2.3	931.6	400.2	1331.8

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

considerable, which has a significant influence on the age distribution of the population and in particular on the variations in the size of younger generations.

As a consequence of the population policy measures implemented in 1953, which consisted in placing severe restrictions on the granting of abortions, the annual number of births between 1953 and 1955 exceeded 200,000, with a peak of 223,000 in 1954. Immediately following the relaxation of the restrictive legislation, a sharp decline in the number of births resulted; in 1962 only 130,000 children were born. A slight increase took place in the second half of the 1960s, partly due to the introduction of a maternity leave of three years with a fixed allowance during the period of leave. However, the annual number of around 150,000 births was still below the level necessary for the simple reproduction of the population in the long run.

A new set of population policy measures was implemented in 1973, consisting mainly of positive incentives and certain restrictions concerning abortions. The resulting increase in the number of births was spectacular though temporary. Between 1974 and 1976 almost 190,000 children were born annually. In fact, the demographic wave of the early 1950s was repeated in these years, however at a slightly lower level. The increase in the number of births was to a very small extent due to a real fertility increase, and to a large extent due to the size of the female population at the early child-bearing ages and to timing effects. That is, the large birth cohorts born in the period 1953-1956 entered reproductive age around 1973, when the new policy measures were implemented. The majority of children born between 1974 and 1976 were planned to be born later. The earlier timing was a result of the policy measures, though a significant decrease in the number of induced abortions is also to be noted during this period.

The number of births has been decreasing rapidly since 1977, despite the relatively slower fertility decline, primarily because the size of the female generations in early child-bearing ages has declined considerably. The number of births in 1985 was 130,000, giving a crude birth rate of 12.2.

The general decline of fertility involved a shift in the proportion of women of different ages giving birth. The majority of women complete their eventual family size within the first 8-10 years of marriage, 93 per cent of all legitimate births are within the first 10 years of marriage, and 82 per cent of all births are to women aged under 30 years. Fertility has mostly declined among women aged 30 years and over, with the decrease in the proportion of third and higher parity children. Of all births in 1985, 45 per cent were first parity births, 38 per cent second parity and 12 per cent third parity. The average parity of births during the past 15 years was 1.8 to 1.9, and this value continues to decline.

According to table 4, the current total fertility rate (1.83 in 1985) is far below replacement level fertility. This is also reflected by the net reproduction rate, which is slightly below 0.9.

In view of the fertility declines experienced up to the present and the expected additional declines, as well as increasing mortality levels which since 1981 have resulted in population declines, a set of population policy measures was formulated. The gradual implementation of these measures (which are presented in chapter II, section B began in 1985. It is difficult to evaluate the influence of these measures on fertility after such a short time, but a slight increase in 1985 in the number of births, the crude birth rate, the total fertility rate and the age-specific fertility rates (tables 4 and 5) indicate that the recent policy measures are, at least to a certain extent, effective. This is also supported by the fact that slightly more women aged over 30 gave birth to a child in 1985 than in the previous years, and the number of third parity births was also higher.

### 3. Mortality

Mortality in Hungary in the course of the twentieth century has always been higher than in most European countries, and the differences in mortality between Hungary and other developed countries seem to have widened recently.

Although the age distribution of the population is older in several European countries than in Hungary, crude death rates of 13.8 in 1984 and 13.9 in 1985 were the highest among European countries. The increase in the number of deaths and in crude death rates is due not only to the aging of the Hungarian population but also to high and increasing age-specific mortality rates, especially among males aged 30 years and over (table 6). The recent decline in male life expectancy at birth also reflects this tendency. Life expectancies are among the lowest in Europe; life expectancy at birth in 1985 was 65.6 for men and 73.6 for women (table 7).

A reversal in the trend of declining mortality started in 1965 with the onset of increases in the age-specific mortality rates for all age groups of males between 25 and 64 years (table 5). Female age-specific mortality rates declined until the early 1970s, after which time there was a slight increase in most adult age groups (table 8). The pattern of age-specific death rates for males and females is clearly observed in figures II and III. A child mortality rate of 23 per thousand for males and 18 per thousand for females in 1984 was higher than that of several developed countries.

The long-term decline of mortality, however, meant a shift in the age distribution of deaths. By 1985, 76 per cent of all deaths were in the age group 60 years and over, and 59 per cent were in the age group 70 years and over.

Table 4. Fertility and reproduction rates, Hungary, 1880-1985

Year	Live births per thousand population	Live births per thousand women aged 15-49	Total fertility rate (per woman)	Average parity	Gross reproduction rate	Net reproduction rate
1880	44.4	170	...	...	...	...
1890	41.0	163	...	...	...	...
1900	39.7	154	5.32	4.37	2.59	1.45
1910	35.1	144	4.86	...	2.37	1.40
1920	31.4	117	3.80	...	1.83	1.13
1930	25.4	88	2.85	3.12	1.39	1.01
1940	20.0	70	2.45	2.89	1.19	0.97
1950	20.9	77	2.62	2.51	1.24	1.07
1960	14.7	59	2.02	2.18	0.98	0.91
1962	12.9	53	1.79	2.15	0.87	0.81
1970	14.7	57	1.97	1.88	0.95	0.91
1973	15.0	58	1.95	1.86	0.94	0.91
1974	17.8	70	2.30	1.89	1.12	1.07
1976	17.5	70	2.26	1.84	1.10	1.06
1978	15.8	64	2.08	1.82	1.01	0.98
1979	15.0	62	2.02	1.81	0.99	0.96
1980	13.9	58	1.92	1.82	0.94	0.91
1982	12.5	52	1.78	1.83	0.87	0.84
1984	11.8	49	1.73	1.81	0.85	0.83
1985	12.2	51	1.83	1.85	0.89	0.87

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

Table 5. Birth rates by age of mother, Hungary, 1948-1985

Average of years or calendar year	Number of live births per 1000 women aged:							
	15-19	20-24	25-29	30-34	35-39	40-44	45-49	15-49
1948-1949	46.5	163.0	137.7	88.5	54.5	19.8	1.7	75.7
1959-1960	52.5	161.5	106.2	54.5	26.3	7.9	0.5	59.7
1969-1970	51.0	162.2	111.0	52.8	19.0	4.4	0.3	57.2
1979-1980	70.5	162.9	102.3	42.4	14.2	3.0	0.2	59.7
1982	58.3	149.5	95.6	38.5	12.3	2.6	0.1	52.2
1984	52.1	146.1	94.6	39.1	12.1	2.4	0.1	49.0
1985	51.5	152.5	102.9	43.0	13.6		1.4	50.9

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

Table 6. Male death rates by age, Hungary, 1920-1985

Age group	1920-1921	1930-1931	1938	1948-1949	1959-1960	1969-1970	1979-1980	1985
0	207.19	170.74	144.04	101.97	55.13	39.29	26.43	22.34
1	50.66	31.26	23.78	9.11	4.13	1.87	1.13	0.92
2	38.15	10.85	7.77	4.28	1.59	0.97	0.69	0.63
3-4	16.24	6.35	4.22	2.54	0.83	0.66	0.45	0.47
0-4	103.10	52.80	41.58	28.38	11.42	9.41	5.24	4.96
5-9	7.34	3.43	2.37	1.51	0.58	0.46	0.41	0.30
10-14	4.18	2.38	1.90	1.20	0.62	0.47	0.43	0.30
15-19	6.41	4.20	3.38	2.22	1.20	1.06	1.05	0.97
20-24	8.58	5.81	5.40	3.68	1.60	1.45	1.47	1.50
25-29	7.57	5.43	4.56	3.72	1.62	1.68	1.73	1.97
30-34	7.52	5.55	4.62	4.03	1.99	2.04	2.29	2.84
35-39	8.58	6.78	5.41	4.61	2.54	2.72	3.71	4.38
40-44	10.00	8.35	7.46	6.26	3.48	4.23	5.87	6.95
45-49	12.72	10.48	10.00	8.40	5.50	6.12	8.74	10.89
50-54	16.82	14.28	14.00	11.83	9.14	9.53	13.65	15.56
55-59	23.59	19.92	19.62	17.27	16.08	14.78	20.10	23.11
60-64	33.85	29.24	29.36	25.32	25.30	25.80	29.65	32.35
65-69	52.32	45.23	46.13	37.52	40.02	42.68	43.48	43.90
70-74	84.72	71.83	70.92	60.86	63.35	66.49	69.87	70.42
75-79	136.56	114.62	114.95	97.18	101.79	104.51	109.59	105.83
80-84	216.09	196.58	182.56	154.69	162.29	159.00	161.76	161.24
85+	278.58	292.36	271.94	257.39	271.33	269.11	260.10	259.85
Total	22.50	16.94	15.05	12.47	10.93	12.33	14.34	15.17

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

Table 7. Life expectancies by sex, Hungary, 1930-1985

$e_x^0$	1930-1931		1949		1970		1980		1985	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
$e_0^0$	48.70	51.80	59.81	63.97	66.82	72.59	65.96	73.21	65.60	73.57
$e_1^0$	58.26	59.29	65.29	68.58	68.57	73.91	66.66	73.70	66.08	73.93
$e_{20}^0$	44.77	46.09	48.71	51.85	50.42	55.48	48.34	55.13	47.62	55.32
$e_{40}^0$	29.13	30.70	31.68	34.30	32.01	36.26	30.10	35.98	29.58	36.22
$e_{60}^0$	14.50	15.38	16.33	17.68	15.69	18.69	15.08	18.82	15.12	19.15
$e_{80}^0$	4.40	4.92	5.86	6.24	5.60	6.19	5.53	6.42	5.55	6.60

Source: Government of Hungary, Central Statistical Office, Demografiai Evokonyv, 1985.



Table 8. Female death rates by age, Hungary, 1920-1985

Age group	1920-1921	1930-1931	1938	1948-1949	1959-1960	1969-1970	1979-1980	1985
0	177.31	142.38	117.88	82.44	44.65	32.07	20.58	18.27
1	47.73	29.71	22.27	8.03	3.69	1.76	0.97	0.68
2	38.66	10.53	6.59	4.03	1.45	0.78	0.52	0.47
3-4	15.54	6.25	3.85	2.39	0.69	0.54	0.31	0.39
0-4	87.72	43.82	33.94	22.72	9.22	7.69	4.11	4.00
5-9	7.27	3.62	2.16	1.33	0.40	0.31	0.24	0.23
10-14	4.83	2.61	1.97	1.09	0.33	0.28	0.24	0.19
15-19	6.92	4.81	3.58	2.04	0.59	0.41	0.43	0.40
20-24	8.13	6.05	4.72	2.94	0.79	0.53	0.51	0.49
25-29	8.24	5.94	4.33	2.86	0.99	0.67	0.68	0.70
30-34	8.17	5.64	4.23	2.97	1.28	0.95	1.04	1.20
35-39	8.44	6.25	4.80	3.29	1.84	1.45	1.62	1.86
40-44	8.95	6.83	5.83	4.01	2.72	2.27	2.74	2.87
45-49	10.80	8.42	7.66	5.60	3.85	3.59	4.21	4.41
50-54	13.90	11.67	10.38	7.83	5.93	5.82	6.33	6.64
55-59	20.04	16.42	15.58	11.63	9.41	8.43	9.63	9.93
60-64	30.33	24.76	23.72	18.17	15.82	13.95	15.63	14.79
65-69	48.92	40.88	38.63	29.81	28.07	24.90	23.86	23.36
70-74	78.87	64.62	64.57	50.44	48.98	44.78	41.98	40.70
75-79	135.49	108.73	107.31	85.30	86.92	77.91	72.89	70.20
80-84	200.61	168.15	166.63	136.19	145.96	131.31	123.30	120.09
85+	254.24	253.09	271.24	226.39	239.91	227.18	219.16	214.02
Total	20.10	15.24	13.48	10.58	9.73	10.67	12.08	12.64

Source: Government of Hungary, Central Statistical Office, Demografiai Evkonyv, 1985.

Age-specific death rate (per 1,000)

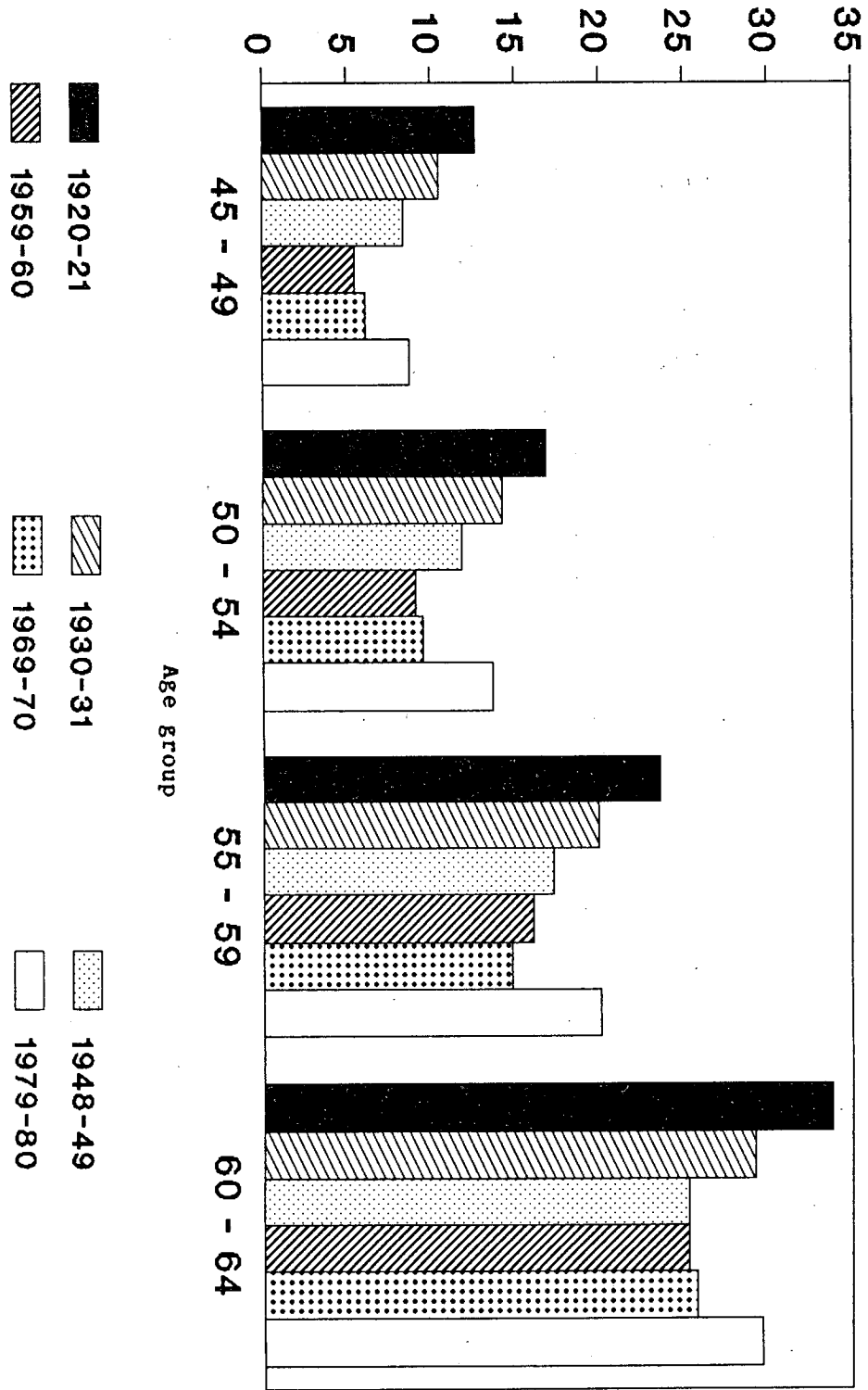
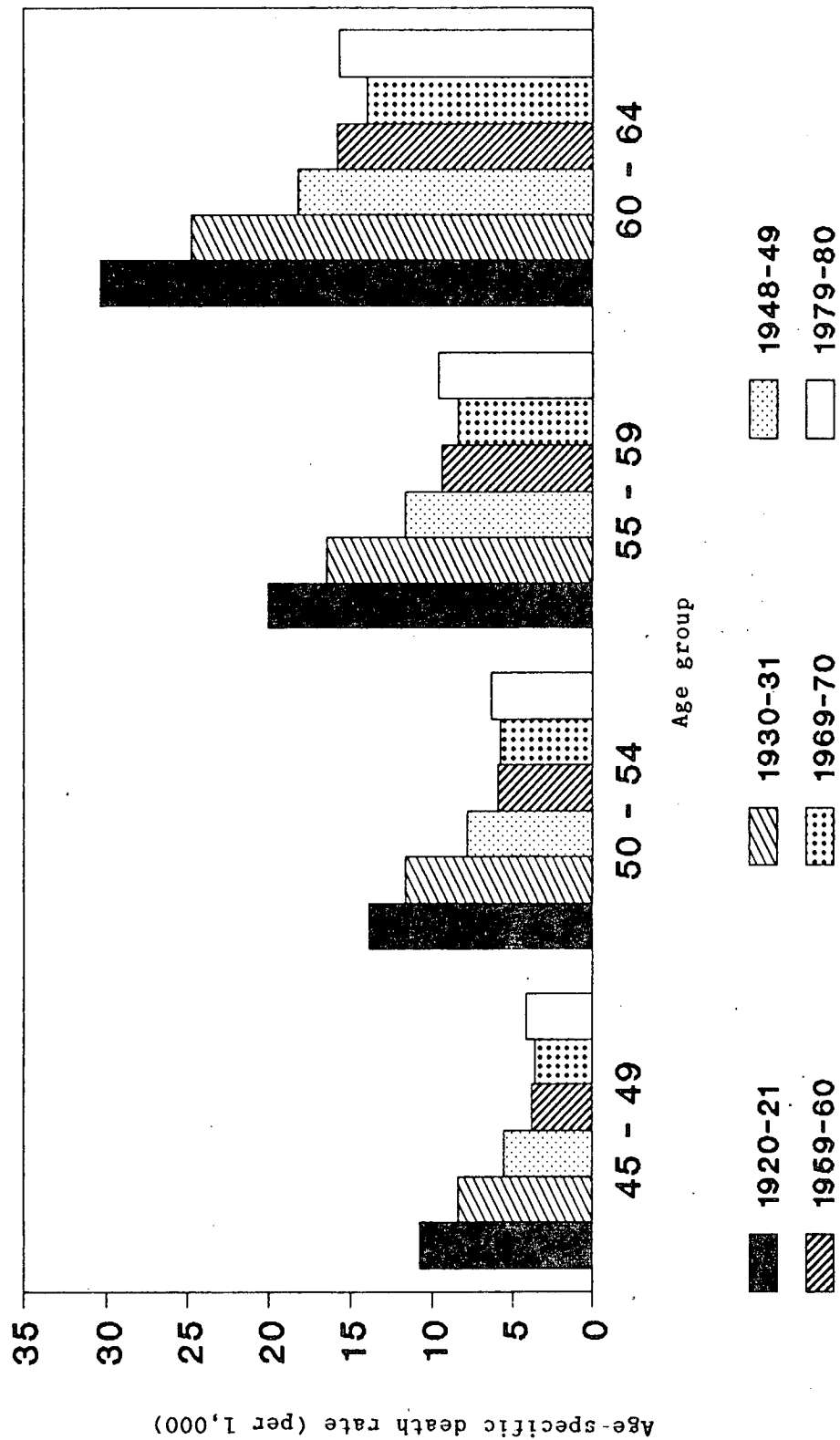


Figure II. Age-specific male death rates, 1920-1980

Figure III. Age-specific female death rates, 1920-1980



The cause-of-death-pattern has completely changed in the twentieth century. The changes are characterized by a decrease in the proportion of infectious and parasitic diseases and the increase in the proportion of cancer, cardiovascular diseases and violence among the causes of death. In the 1980s violence, mainly accidents, are the dominant cause of death for males under age 40. Over age 40 cardiovascular diseases become dominant, and they are the cause of more than one half of male deaths over age 65. Cancer becomes an important cause of death over age 30, peaking between the ages of 55 and 70. Violence is the dominant cause of death among females under age 30, although the number of deaths due to violence is fewer among women than among men. Cancer becomes the main cause after age 30 and is in second place after age 55 when cardiovascular diseases become dominant. By the early 1980s mortality in Hungary became as important a concern as the fertility decline.

#### 4. Natural increase and growth rates

Between 1960 and 1980, the population of Hungary increased by 700,000 persons, with an average annual growth rate of 0.3 per cent. Considering the magnitude of the fertility decline and mortality increase, and the low level of fertility combined with the high level of mortality, population growth during this period was almost entirely due to "reserves" in the age structure of the population. Net reproduction rates and the intrinsic rates of natural increase have indicated potential population decline for the past 25 years. Since 1981, as a result of the combined effects of low fertility, small female cohorts of reproductive age, high mortality and an older age structure, there has been an excess of deaths over births every year.

According to the most recent population census, the population of Hungary was 10,710,900 in January 1980. The decrease in the years 1981-1985 was 72,800.

#### 5. Age distribution

Due to the significant fluctuations in the number of births in the last 30 years, distortions in the age distribution are considerable. Other twentieth century demographic events, however, are also clearly visible in the age pyramid of the Hungarian population.

The most significant distortions are caused by the small birth cohorts born during the First World War and the post-war baby boom, the large birth cohorts of the early 1950s and the decline in the number of births in the late 1950s and early 1960s, the large cohorts of the early 1970s and the current decline in the number of births.

The aging process in Hungary has been fairly rapid and is relatively advanced, even among developed countries. The proportion of the population aged 60 years and over in 1980 was similar to that for France, Italy and Poland, and was considerably higher than in the countries surrounding Hungary (with the exception of Austria).

On 1 January 1986 the proportion of the population aged 60 and over was 18.2 per cent, that of the working age population (15-59 years) was 60.3 per cent, while 21.4 per cent of the total population was aged 0-14 (table 2).

The total age dependency ratio of 66 was the highest since the Second World War, although the ratio has been declining in the long run. The slight increase in recent years was due to the increase in the proportion of the aged population and to the decrease in the proportion of the population aged 15-59 years in the total population. This recent shift in the proportions was a result of the large cohorts born after the First World War who entered the 60 years and over age group, thus reducing the older working age population and increasing the size of the aged population. Another factor behind the shift in the proportion of the older working age population and the aged population within the total population was that the mortality of the population in the age groups between 40 and 60 years increased faster than the mortality of the population aged 60 years and over in recent years.

#### C. Demographic prospects to the year 2000

According to national population projections up to the year 2000, a further decline of the population is to be expected. The underlying assumptions are that after a further decline, a slight increase in fertility will be experienced in the past five years of this century, the magnitude of the increase depending upon the measures implemented to influence fertility. The mortality assumptions foresee either a further slow increase in mortality or a very moderate decrease in the last years of the century, under the general assumption that mortality trends can only be influenced with a considerable time lag. Given these assumptions and the actual age distribution of the population, a further decline in population size is inevitable up to the year 2000 and beyond. The aging process is also expected to continue, but because the small birth cohorts of the First World War will have entered the 80 years and over population just before the year 2000, the size of the oldest age group is expected to grow more slowly than that of the younger age groups of the aged population.

## II. REVIEW OF THE POPULATION POLICY SITUATION

Population policy has been incorporated into the Constitution of Hungary. The Constitution declares the equal rights of men and women, the general provisions of pregnancy and childbirth, the legal protection of maternity and children, as well as the system of institutions for mothers and children. The Constitution also declares the protection of marriage and the family. Based on constitutional provisions, more concrete regulations are provided in the Acts on marriage and the family, on the rights and obligations concerning work and employment and on social policy. The latter provides for, among other things, services and allowances for families under social policy schemes, including many pronatalist incentives. More detailed regulations are set forth in decrees of the Government and the responsible ministries and agencies.

The Government also makes more general decisions on those population policy issues which are of a more political character. In addition to defining long-term aims and the general means of achieving those aims, the Government also directs the responsible agencies in the practical execution of the decisions. The execution is partly the task of central administrative institutions (ministries or other government bodies), and partly the task of local (country or municipal) administration. The political decisions are based largely on research and expert opinion, thus demographers and other researchers have played an increasingly important role both in political decision-making concerning population policy and in population policy formulation, especially in recent years.

In view of the unfavourable demographic developments, namely, the extremely low number of births, the declining number of marriages, increasing mortality, the growing number of divorces and the declining population, the Government announced a long-term population policy in October 1984. This was followed by a supplementary decision concerning the medium-term plan of action for implementing the policy measures in the period 1985-1990.

### A. Population policy formulation

In Hungary problems related to population which are viewed as a discrepancy between the country's demographic and socio-economic development have become an important issue in formulating social and economic policy. In order to assess the complex interrelationships between demographic and societal processes, detailed data and considerable research are needed. These are provided by specialized government institutions, the institutional structure of which has been long established. The Central Statistical Office, the Central Planning Office and the Ministry of Health are governmental institutions

primarily responsible for data collection, research and analysis in the field of population processes and, more broadly, in fields associated with population and development policy. The Hungarian Academy of Sciences, a non-governmental body in charge of scientific research, is also involved in social research and therefore in population matters.

When the political decision to formulate a long-term population policy was advanced by the Hungarian Socialist Workers' Party in the early 1980s, an ad-hoc government committee acting as a working group of representatives of the responsible agencies was convened. Based on research and the expert knowledge of its members, the working group was in a position to identify the issues to be considered and to make recommendations concerning appropriate policy options. The recommended options took into account various scenarios of economic development and thus of government funds available for implementing the suggested measures.

The report of the working group was discussed by several independent bodies, such as trade unions, the National Council of Women, researchers, and so on, after which the report and the recommendations were finalized by the working group for presentation to the Government.

Central economic planning increasingly has considered social processes and the population component in the course of plan preparation; thus, the relationships between demographic and other societal processes are to a certain extent foreseen, and indirect intervention in population processes is more or less continuous. The national development strategy, as formulated in long-, medium- and short-term central socio-economic plans, is not only interrelated with population policy, but population policy is also integrated into societal planning.

Since the working group that prepared the recommendations on population policy consisted of experts representing the responsible government institutions, broader societal objectives and development planning issues were already taken into account at the initial stage of population policy formulation. When defining complex sets of mutually supportive strategies and measures to increase fertility and reduce mortality, the integration of these strategies into general development strategies was provided for.

This complex view reflects a new attitude compared to previous population policy formulation in Hungary, which was characterized by a one-sided approach concentrating on fertility and pronatalist measures. The formulation of population policy is now recognized as a complex, interdisciplinary and multi-institutional responsibility. This implies a broader view, which takes many aspects of family life, such as the stability of families, as important factors in determining fertility levels, while also recognizing mortality and morbidity to be as

important a population policy issue as is fertility. This is not to say that policies to reduce morbidity and mortality were previously non-existent, but they were more or less independent health policy concepts regarded only as relevant to population policy issues in as much as they concerned fertility control, pregnancy and child care.

The separate handling of fertility and mortality processes was understandable since during the period of continuous mortality decline until the mid-1960s, mortality had not been perceived by policy makers as having a negative impact on societal development. Since the reversal in declining mortality, however, and especially after policy makers realized that warnings concerning the imminent onset of population decline were not exaggerated, the notion of integrating a wider range of aspects of health policy into population was adopted. This coincided with the increasing attention being given to the economic and social implications of population aging, shifts in the age distribution in general and the uneven age distribution of the Hungarian population in particular. At the lower ages of the age pyramid the uneven age distribution is primarily due to fluctuations in birth numbers, induced in part by former pronatalist measures implemented in 1953 and 1974 and in part by the long-term indirect effect of those measures, namely alternatively very large and very small female cohorts reaching child-bearing age. These experiences and the demographic situation which evolved by the late 1970s and early 1980s as a result of the cumulative effect of low and declining fertility, high and increasing mortality, the fairly advanced aging process and subsequent population decline has required a novel approach to the formulation of population policy.

The general socio-economic situation at the time the Government adopted its long-term population policy, which is still in effect is of special interest.

The primary aim of the Government in the field of economic development is to promote an internationally competitive economy. This involves considerable structural changes and readjustments. Economic policy encourages internal and international competitiveness both in state-owned enterprises and on the part of small-scale private business. However, this also results in a disparity in living standards, especially in income distribution. To balance inequalities to a certain extent and to ease social constraints, various social policy measures are implemented to prevent the deterioration or raise the living standards of disadvantaged socio-economic groups. However, financing the assistance and services provided to low-income groups, primarily large families and pensioners, places a heavy burden on the national budget. Some of the measures implemented under social policy schemes fall under the traditional pronatalist population policy as well. On the other hand, economic growth has been slow in recent years and is not expected to accelerate in the near future. Thus, the resources available for allocation through social policy schemes and



population policy measures are extremely limited. There is an overlap, however, between the two types of policy, and under unfavourable economic conditions, measures implemented as pronatalist will partly act as family policy measures to narrow income inequalities. Their contribution to increasing fertility will be limited and will only be a residual effect of the incentives.

The most notable characteristics of the 1984 population policy are the aforementioned complexity in terms of both the processes to be influenced and the measures adopted, as well as the recognition that demographic events have long-term consequences, and consequently that intervention in population can only have a positive influence if it is consistent with the long-term nature of the processes.

The primary objectives of the population policy are, in view of the current and expected demographic situation, to (a) reduce the speed of population decline with the aim of checking the decline in the longer run; (b) establish the long-term goal of achieving slow population growth together with a more favourable age distribution of the population; and (c) avoid in particular the emergence of new major peaks in birth numbers. In order to accomplish these aims, an increase in fertility and a major improvement in mortality conditions were declared to be of equal importance. Consideration was also given to several factors which have been identified as influencing fertility and mortality levels. Among the indirect factors of special importance defined as an element of population policy was support for the stability of family life as a precondition for stable or increasing levels of fertility. A nation-wide programme of reducing morbidity and mortality risks was also undertaken.

The long-term view is also consistent with the need to integrate population policy into central socio-economic planning. The formal time frames of short-term (one year), medium-term (five years) and long-term (15 to 20 years) plans offer a suitable breakdown for long-term population policy and for the timing of the various measures which are not implemented simultaneously. This long-term aspect at the same time provides a certain flexibility, which is important under the prevailing difficult economic conditions, when establishing priorities for the implementation of various measures may be controversial. A long-term policy allows for the gradual implementation of various measures, depending upon the changing economic and demographic situation.

Another novel element in formulating the 1984 population policy was that more attention was given to attitudinal factors than had previously been the case. It was realized that direct and indirect financial and non-monetary inducements functioning both as pro-natalist incentives and as measures to raise the standard of health care should be important. In addition, the new policy attempts to persuade society and individuals to adopt more healthy life-styles and to consider family life as a

normal part of private life. This involves integrating preparations for family life and marriage into education programmes and intensifying information campaigns in mass communication, both in terms of informing the public on the country's demographic situation and in broadcasting programmes and publishing articles to influence public attitudes towards life-styles and harmful habits as well as family life.

The Government stressed the need to promote demographic research, especially the examination of the influence of population policy on demographic processes. Because it is planned to gradually implement the various measures and because resources are very limited, the continuous evaluation of the influence of the various measures on population trends is of special relevance. This enables more careful decision-making during the long-term implementation of the population policy when priorities must be set, taking into consideration both the changing economic conditions and the changing demographic situation. It should be noted, however, that the extensive research which had already been carried out on the country's demographic situation was taken into consideration when the 1984 policy was formulated. In the course of formulating the policy, due consideration was given to international experience as well. Particular attention was devoted to countries whose demographic situation or socio-economic circumstances were similar to those of Hungary.

In formulating the new population policy, public opinion concerning both demographic problems and population policy issues was also considered. The results of a public opinion survey on population issues carried out in 1983 indicated that although population decline and the current demographic situation did not arouse anxiety in general, indirect intervention on fertility levels was considered appropriate. That is, while most respondents either were not concerned by population problems or thought that other economic and social problems were more important, public opinion favoured the granting of financial and institutional assistance to families with children, as well as expanding the employment possibilities of mothers. The results of a longitudinal survey of marriage cohorts bore out those results in a more specific way. Many mothers in the sample who already had at least one child said that if their family's financial situation were slightly better and if offered the possibility of part-time employment or flexible working hours, they would favour having an additional child. Although fertility surveys and surveys on ideal family size have shown that completed or actual family sizes are less than either planned or ideal family size, the aforementioned results indicated a willingness to have slightly more children if the conditions of bringing up children were improved. For that reason instead of advocating the three-child family model, which was the goal of the 1973 policy, the new policy established the objective of improving the general conditions under which children are brought up, in order to enable families to come closer to fulfilling their family plans.

Another interesting point raised in both discussions by experts and in public debates, which was an important issue when formulating the 1984 policy, was the possibility of offering women a greater choice between labour force activity and staying at home for a certain period of time to care for young children. A maternity allowance of a fixed monthly amount was introduced in 1967 for mothers who were economically active but chose to stay at home to care for their child until its third birthday. Although raised several times since its introduction; the maternity allowance was far below average wages. The policy to narrow the gap between actual wages and the allowance was supported by experts and the public. A maternity fee, defined as a fixed proportion of the mother's previous income (usually 75 per cent), was introduced as part of the new population policy among the measures aiming to improve the conditions for bringing up children. Given that female labour force participation is very high in Hungary, particularly in the early child-bearing ages, measures affecting economic activity (whether providing for flexible employment, extending the possibilities of part-time employment, or permitting temporary withdrawal from the labour force) might affect a considerable number of women. Thus, labour market policies and their financial impact on the national budget had to be carefully considered. On the whole, the positive influence such measures might have on the situation of raising children and eventually on completed family size were determined to be substantial enough to justify their adoption. One of the considerations behind this decision was that if the long-term goals of population policy were to be achieved, particular attention should be concentrated on fertility in the near future, when the small female cohorts born during the 1960s would be in their child-bearing ages. It should be also noted that if such measures were to induce a slight increase in the fertility of women born during the first half of the 1950s, however slight the increase in their fertility was, the outcome in terms of absolute numbers of births might be more substantial.

#### B. Population policy implementation

High-level political decision-making on population policy issues can define the goals to be achieved in order to provide a better setting for societal development while providing the guidelines for the practical execution of population policy. The elaboration and implementation of the detailed measures require co-ordinated legislative action and organization on the part of central and local authorities.

Because the 1984 population policy comprised a complex series of interventions in terms of both the processes to be influenced and the measures to be implemented, and because of the long-term perspective adopted, additional decisions were made on the practical implementation of population policy for the period 1985-1990.

The complexity of the population policy involves the reconsideration and amending of a vast set of legislative and administrative measures and rules which are directly or indirectly related to the population policy measures.

Legislative action may occasionally take the form of amending statutes that were previously enacted by the Parliament. Amending statutes necessitates passing through all phases of parliamentary procedure. Once the amendment has been approved, entire sets of executive regulations must be implemented or previous regulations modified according to the provisions of the amended statute. Elaborating the regulations is the responsibility of the central government organs (usually ministries in charge of the various fields concerned) while implementation at the local level is the responsibility of the local administrative bodies.

In Hungary, the implementation of population policy rarely requires the convening of Parliament or the amending of statutes, as the policy measures to be implemented usually fit into the framework of existing statutes. In most cases only legal measures at lower levels of the legislative hierarchy, such as executive regulations, must be amended. The implementation of population policy measures as a sequence of progressively dependent activities nevertheless calls for co-ordinated action and co-operation between the central administration, the local administration, non-administrative social organizations and smaller communities, both in initiating legislative procedures and in the organization and control of the implementation.

When the 1984 policy was formulated, no priorities concerning the importance of any of the fields or measures were established, but the elaboration and the implementation of the various measures were not completed at the same time. The gradual implementation of co-ordinated measures was, indeed, one of the principles of the policy, to provide a certain flexibility. The reasons for this were the recognition that long-term intervention to influence population processes may require new measures if earlier measures have lost some of their effectiveness. In addition, measures might have to be extended or expanded based on the realization that long-term population policy must be modified in the light of demographic and socio-economic developments and financial possibilities.

Within the general framework of implementing the 1984 population policy, the main fields that are to be covered by new or amended regulations can be classified as follows:

- (a) Social security;
- (b) Health care;
- (c) Family life;
- (d) Housing;
- (e) Employment.

The various types of measures, however, include pro-natalist incentives as well as more indirect measures to influence the stability of families and thus fertility and to improve the system of health care in order to reduce morbidity and mortality risks.

Financial support to families is among the most widespread of the pro-natalist measures. In Hungary, such support is provided under social security. In implementing the new population policy and in accordance with the long-term nature of the concept, both immediate and gradual changes in social security provisions were introduced and will be introduced. The most important of the new social security measures was the introduction in 1985 of a maternity fee. Before that time working mothers had been entitled to a leave of four weeks at full salary prior to the birth of a child and to 20 weeks leave at full salary following a birth. The maternity fee granted a fixed proportion of the previous income (usually 75 per cent) after the first 20 weeks until the child's first birthday. This has been extended until the child reaches 18 months of age. Following the period of the maternity fee, the mother is entitled to a maternity allowance which permits the mother to stay at home and receive a fixed monthly amount until the child's third birthday. The maternity allowance was introduced in 1967, and the majority of working mothers receive it for either the full three-year period or for part of that period. Although the allowance has been raised several times since its introduction, the loss of income has been considerable for these families. By 1985 it was about 20 per cent of the average wage. With the new maternity fee, however, mothers experience only a fairly small income loss during the first 18 months after the birth of a child.

Another social security provision to which parents are entitled is sick pay for nursing a sick child. This had also been introduced previously to improve the general circumstances of raising children, but the period during which the parent may stay at home and receive sick pay has been extended. Under the new population policy it is payable until the tenth birthday of the child, and the total number of days for which the parents can receive sick pay for a child has been increased as well. Sick pay is usually 75 per cent of the parents' average income.

At the birth of a child, the mother is entitled to receive "birth aid" in the form of a one-time grant. Under the new population policy the amount has been raised and currently is equal to about 35 per cent of the average monthly income of employees.

The family benefits with the longest entitlement are the family allowances. They are very important in narrowing the gap in per capita incomes between families of different sizes. Family allowances have been increased under the new population policy, and the long-term aim is for family allowances to cover about 35 to 40 per cent of the expenses of bringing up children by the turn of century.

Improving the quality of health care is currently one of the most important population policy issues in Hungary. Extremely high morbidity and mortality rates have drawn attention to the quality of health care and to the need to eliminate harmful personal habits. To cope with these problems a nation-wide programme on reducing health risks has been announced. Because of the particular importance of this issue, it will be treated in more detail in chapter III of the present study.

The stability of family life has been recognized as a major factor in halting or reversing the decline of fertility. The most important legislative action in this respect was the modification of family law in October 1986. The statute itself regulating family relations was enacted in 1952. Although several minor modifications had been made since then, a major recodification appeared necessary because of the major changes which had taken place in socio-economic conditions during the past 30 years. Population policy issues were of major importance in public and expert debates concerning the amendment of family law. Particularly relevant was increasing the lower age limit of marriage to 18 years. A higher age limit is expected to promote more responsible decision-making, resulting in fewer divorces. Other regulations of family law which have been changed concern financial settlements and the division of property between divorcing partners. Current regulations and practices create difficult circumstances following divorce for the partner that does not receive custody of the children.

Among the measures implemented in 1985 was the creation of a network of family assistance centres. First an experimental network was organized, covering only part of the country. The centres which have been established function as institutions counselling both local authorities and families seeking advice in solving their problems. The centres also explore cases of risk, collect information on the problems of families and initiate preventive measures to solve these problems. The personnel of the centres are highly qualified and include lawyers, psychologists, teachers and sociologists, etc. The initial experiences with the experimental centres seem to be favourable, and it has been decided to extend the network of family care centres.

Housing shortages and high construction prices are still serious problems in Hungary. Especially among young couples, obtaining suitable housing is believed to be an important factor in determining family plans. Improving the housing conditions of young families and families with children was, therefore, an important population policy issue. When implementing the new population policy, various regulations concerning building loans and benefits had to be changed. The modifications included raising the upper limits of low-interest long-term building loans and increasing the social policy benefits to families with children to reduce the costs associated with home purchase

or construction. At the same time, local authorities have modified their construction plans in order to improve the housing conditions of young families and families with children.

In implementing the new population policy, recommendations concerning employment policy were formulated in order to facilitate the combining of labour force participation with household activities, parental duties and vocational aspirations.

The new population policy stresses the importance of society's general attitude towards demographic policy issues. It emphasizes that the successful implementation of population policy requires, in addition to the implementation of concrete measures, a kind of social awareness which can only be promoted if attitudes are positively influenced. To have such an impact, educational and cultural institutions and mass communications must play an increased role in providing information on population problems and population policy measures, in preparing the younger generations for family life, in promoting knowledge about psychological, health, social, biological and economic aspects of family life, and in advocating responsible family planning. These must be integrated into education programmes. Recently these issues have been given more consideration on radio and television and in the press.

#### C. Population policy evaluation

An administrative evaluation of the implementation and influence of population policy on population processes, which is the responsibility of the Central Statistical Office, the Central Planning Office and the Ministry of Health, is provided in the form of a report to the Government. Up to now, no official evaluations have been published on the new population policy. The impact of population policy is assessed mainly by scientists in various research reports.

According to the results of public opinion surveys and family planning surveys, Hungarians have reacted favourably to the new population policy. The measures which have been implemented were considered to have improved the living conditions of families and the situation of bringing up children. The introduction of the maternity fee in 1985 and its extension until the child reaches 18 months of age was especially welcomed by young couples and by those with higher education. Young inhabitants of villages indicated that the financial assistance received for building or buying houses favourably influenced them in fulfilling family plans. Married women in their early thirties mentioned that the possibility of flexible working hours and part-time employment had a positive influence on their family plans.

Among the demographic variables that population policy aims to influence, fertility is the only one which can change in such a short time following the implementation of the new population policy. Changes in nuptiality and divorce trends, as well as mortality trends, can only be expected to change over a longer period following the implementation of new policy measures.

The lowest number of births registered as yet in Hungary occurred in 1984, when there were only 125,000 births. Under current mortality conditions, about 150,000 births annually are necessary to guarantee the simple reproduction of the population. As a result of the new population policy measures, the number of births increased in 1985 to 130,000, despite the decrease in the number of married women under 30 years of age. Thus, the increase in the number of births was due to a real fertility increase. At the time that the 1973 population policy measures were implemented, a temporary increase was observed in the number of births which was due to the earlier timing of births and did not in actuality represent an increase of fertility. The new population policy seems to have avoided this effect. Moreover, the new measures appear to have acted in the opposite direction, creating more favourable circumstances for families to have an additional child which might otherwise be postponed. The objective of the population policy was to increase the fertility of women in their early thirties. This seems to have been achieved, since almost one-half of the birth increase was due to births among women aged 30-34 years. Of the total number of births, the proportion of second and third parity births also increased, while the proportion of first parity births decreased slightly.

Fertility increased in 1985, as compared to 1984, in all age groups of women of child-bearing age except in the youngest age group, where a slight decrease was observed. Preliminary data for 1986 suggest a slight decrease in the number of births as compared to 1985. Thus, the major achievement of the population policy seems to be a braking of the long-term fertility decline, without at the same time creating a large birth peak. It is also to be expected that, consistent with the intent of the long-term policy, new measures will be implemented, which again will stimulate fertility.

The declining trend in marriages continued in 1985, including a decline in remarriages. The average age at marriage was the same in 1985 as in 1984. The trend towards increasing age at marriage observed since the mid-1970s suggests that if measures to improve the well-being of families are effective in the long run, delayed marriages can be entered into, without cohort fertility being as low as the current fertility data indicate.

The increasing trend in divorces continued in 1985. The number of divorces was higher in 1985 than in 1984, and there was also an increase in both the number of divorces per 1000 population and in the number of



divorces per 1000 marriages entered into, as well as in the number of divorces per 1000 existing marriages. The negative balance of marriages has again increased slightly.

Current nuptiality trends have an important impact on fertility trends, since the majority of children (more than 90 per cent) in Hungary are born within marriage. Nuptiality trends thus may have an unfavourable influence on fertility trends.

There was a slight increase in the number of deaths in 1985 as compared to 1984. The number of deaths still exceeded the number of births, but due to the increase in the number of births, the population decline was smaller in 1985 than in 1984. (The decline was 21,400 in 1984 and 17,400 in 1985.)

### III. SPECIAL POLICY CONCERNS

Population policy in Hungary has traditionally concentrated on a single demographic variable, namely fertility. Significant increases in fertility, however, have not taken place; that is, neither completed family size nor cohort fertility have increased, although temporary upswings in birth numbers have been experienced briefly following the implementation of pro-natalist measures. These upswings, however, have had a negative influence on the age distribution, as they have resulted in large birth cohorts in certain years. Because the high birth numbers were due to timing effects, they were followed by a paucity of births. These fluctuations in some instances were so severe as to cause serious social disruptions when the large birth cohorts passed through different stages of the life cycle.

These experiences have led to the realization that more attention must be paid to properly timing the implementation of pro-natalist incentives. In 1984 and in 1985, new policy measures were implemented to influence the fertility behaviour of the small female cohorts born during the 1960s. In order to avoid major fluctuations in birth numbers, it is planned to implement the new measures on a continuous basis.

While the focus has been on the quantitative aspects of the fertility decline, the qualitative aspects of reproduction have also been investigated. The proportion of premature births and infant mortality are both very high, and congenital anomalies are relatively frequent. To lower their incidence and to ensure that future generations are born healthier and with a greater probability of surviving in good health, programmes of responsible family planning, and genetic counselling as well as medical check-ups for pregnant women have been implemented and are being extended to reach an increasing number of families.

An unusual aspect of the population decline in Hungary when compared to other developed countries that have experienced a similar decline is that it is associated not only with low and decreasing fertility but also with high and increasing mortality. By the early 1980s, increases in the number of deaths were not due primarily to progressive aging but to progressively deteriorating mortality conditions among younger and middle-age adult age groups. The average age at death began to decrease in 1982, while life expectancies began to fall long before that. These trends have called attention to mortality conditions, the underlying causes of morbidity and life-styles in general.

Extensive research is being carried out to investigate the causes of high morbidity and mortality rates. Research has taken the form of sample surveys on morbidity and on life-styles of the population in

order to study the prevalence of diseases as well as habits which may be considered harmful or damaging. The World Health Organization is carrying out an extensive ongoing research project in the counties of highest and the lowest mortality in Hungary to investigate the causes of mortality. While the results are not yet known, it is hoped that such research will permit a better understanding of the situation in Hungary.

The major causes of death in Hungary are cardiovascular diseases, which are thought to originate in modern life-styles, and cancer, some forms of which are also associated with exogenous causes that can to some extent be reduced. Accidents, injuries and poisoning are the third most common causes of death, whose incidence could also be lowered.

Increasing morbidity and mortality rates call for considerable improvements in the efficiency of the health care system. There is a need to provide health care institutions with more up-to-date diagnostic and therapeutic equipment and to decrease regional inequalities in health care infrastructure. Medical care and medical institutions are far more easily available and accessible in the capital, Budapest, and in urban settlements than in rural areas. These improvements would contribute to a decrease in mortality levels. Increasing attention, however, is also being paid to prevention and to preventive health care. This requires concerted efforts on the part of medical institutions, especially in organizing an efficient system of screening and regular follow-up examinations, to explore the incidence of various diseases at an early stage and thus improve the success of medical intervention. There has been some progress in this field, especially in tuberculosis screening and in gynecological check-ups. A large-scale screening programme for certain cardiovascular diseases for men over 30 years of age was begun in 1987.

An extended health programme which aims to improve the health status of the population is, however, beyond the possibilities, and indeed, the responsibility of the medical services.

Excessive alcohol consumption and smoking and other unhealthy habits, such as overeating and insufficient exercise, have been identified as factors that contribute to increasing the risk of mortality. To discourage such habits and encourage more healthy life-styles, a nation-wide programme to preserve and improve the health of the population will include social, medical and environmental issues. In addition, recommendations, incentives and disincentives concerning health-damaging habits are under elaboration and are expected to be announced in the near future.

#### IV. SUMMARY AND CONCLUSIONS

In summarizing population policy formulation in Hungary, it must be emphasized that the country's demographic situation is considered to be an issue of national importance. Indirect intervention into population processes to achieve a more favourable demographic situation in the future is considered to be appropriate. The legal procedures and the institutional arrangements required for formulating policies were established a long time ago. Demographic and non-demographic research, which increasingly is being taken into account when formulating population policy, led to the adoption of a long-term perspective at the time the 1984 population policy was formulated. The integration of population policy into national development strategy is undertaken by central planning which involves influencing social processes together with economic development, on the one hand, and allocating funds available for the implementation of population policy measures, on the other hand.

In summarizing population policy implementation, it should be mentioned that the continuous and gradual implementation of the various measures has been stressed, as well as the integration of various other development policies, such as those dealing with health, employment and social security, into population policy. Population policy implementation is, therefore, a continuous process requiring the co-operation of various administrative bodies and involving legislative action (amending or formulating regulations), the elaboration of recommendations concerning the manner in which institutions should operate, organizational changes (creating new organizations or changing the functions or the operating principles of existing ones), and the more indirect influencing of individual attitudes and the attitudes of society in general. In the implementation of population policy a large variety of fields are affected, ranging from social security benefits to family counselling networks. The significance or the influence of these is, of course, not similar, but the wide spectrum of measures reflects the complex approach that population policy has recently adopted.

Since the implementation of the new population policy demographic trends clearly reflect the measures which have been implemented. As it was modified only in late 1986, the effect of the new family law cannot be assessed as yet. Changes in nuptiality trends can be expected to occur with a longer time lag following legislative changes. Mortality trends are even more difficult to influence, and concrete new measures which might have a favourable influence on mortality have not been implemented yet, although a great deal of discussion has lately taken place. The issue is and will be among the most important of population policy.

On the whole, population policy seems to have attained its primary objective of reducing the speed of population decline. Achieving the long-term goal of slow population growth largely depends on whether new measures to influence fertility will be introduced shortly, as has been announced, and on whether mortality can be reduced within the next 20 years.

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GLOSSARY

Contraceptive prevalence rate: percentage currently using contraception; usually based on married or sexually active couples with women in the reproductive age.

Crude birth rate: the number of births in a year per 1,000 mid-year population.

Crude death rate: the number of deaths in a year per 1,000 mid-year population.

Dependency ratio or age dependency ratio: the ratio of the combined child population under 15 years of age and adult population 65 years and over to the population of intermediate age per 100.

Foreign-born population: persons born outside the country or area in which they were enumerated at the time of the census.

General fertility rate: the annual number of births divided by the mid-year population of women aged 15 to 49 years multiplied by 1,000.

Gross reproduction rate: a measure of the reproduction of a population expressed as an average number of daughters to be born to a cohort of women during their reproductive age, assuming no mortality and a fixed schedule of age-specific fertility rates. More specifically, it is the sum of age-specific fertility rates for the period multiplied by the proportion of the total births of girl babies.

Infant mortality rate: the probability of dying between birth and age 1 multiplied by 1,000; commonly calculated as the number of deaths of infants under one year of age in any given calendar year divided by the number of births in that year and multiplied by 1,000.

Life expectancy at birth: a life-table function to indicate the expected average number of years to be lived by a newly born baby, assuming a fixed schedule of age-specific mortality rates.

Mean age at first marriage (females): the average age at which women marry for the first time.

Median age: the age which divides the population into two groups of equal size, one of which is younger and the other is older.

Natural rate of increase: the difference between the crude birth rate and the crude death rate, expressed per 1,000 mid-year population.



Net migration: the difference between gross immigration and gross emigration.

Net migration rate: the difference between gross immigration and gross emigration per 1,000 of the mid-year population.

Net reproduction rate: a refined measure of the reproduction of population expressed as an average number of daughters that a cohort of newly born girl babies will bear during their lifetime, assuming fixed schedules of age-specific fertility and mortality rates. In other words, it is the measure of the extent to which a cohort of newly born girls will replace themselves under given schedules of age-specific fertility and mortality rates.

Rate of growth: the exponential average annual rate of population growth, expressed as a percentage.

Sex ratio: the number of men per 100 women.

Survival ratio: the probability of surviving from one age to an older one; it is often computed for five-year age groups and a five-year time period.

Total fertility rate: the sum of the age-specific fertility rates over all ages of the child-bearing period; if five-year age groups are used, the sum of the rates is multiplied by 5. This measure gives the approximate magnitude of "completed family size", that is, the total number of children an average woman will bear in her lifetime, assuming no mortality.

Urban population: population living in areas defined as urban by national authorities.