

LIVING CONDITIONS, QUALITY OF LIFE

Quality of life has received increasing attention in recent decades, reflecting the realisation that economic development alone does not necessarily improve living conditions. In welfare states, it is increasingly recognised that physical and mental health and the improvement of human living conditions should be at the heart of development.

Quality of life is a complex concept and is closely related to the dimensions of social stratification, economic conditions and a number of geographical and demographic characteristics. Physical and mental health, access to services, safety, consumption opportunities and pleasant surroundings are all key aspects of quality of life. There are two sides to quality of life: the objective

and subjective sides. The first entails statistically measurable characteristics, while the second pertains to people's satisfaction with their health status and socio-economic situation.

Quality of life is shaped by several factors: the social, economic and political environment; the institutional system and its functioning; and the knowledge, skills and opportunities of individuals. Satisfaction with life is primarily determined by an individual's personality, goals, values, guiding principles and ability to adapt. Therefore, people may assess differently the same health and living conditions or financial situation.

The various elements of quality of life in Hungary have undergone changes in recent decades. In some

cases, the changes have been positive (e.g. life prospects, some characteristics of consumption and environmental quality have improved), while in others they have been negative (e.g. air pollution from transport has increased, some features of the health status have deteriorated).

The initial focus of the chapter is on the human side of living conditions and quality of life. This is followed by an examination of the positive and negative impacts of the environment on people's well-being in Hungary. The analysis is further divided into two parts: housing conditions (the living environment) and the settlements where people live their daily lives.

HUMAN SIDE OF LIVING CONDITIONS AND QUALITY OF LIFE

Viktor Pál, Annamária Uzzoli, Lajos Boros, Szabolcs Fabula, András Trócsányi, Gábor Nagy, Gábor Pirisi, Tamás Kovalcsik

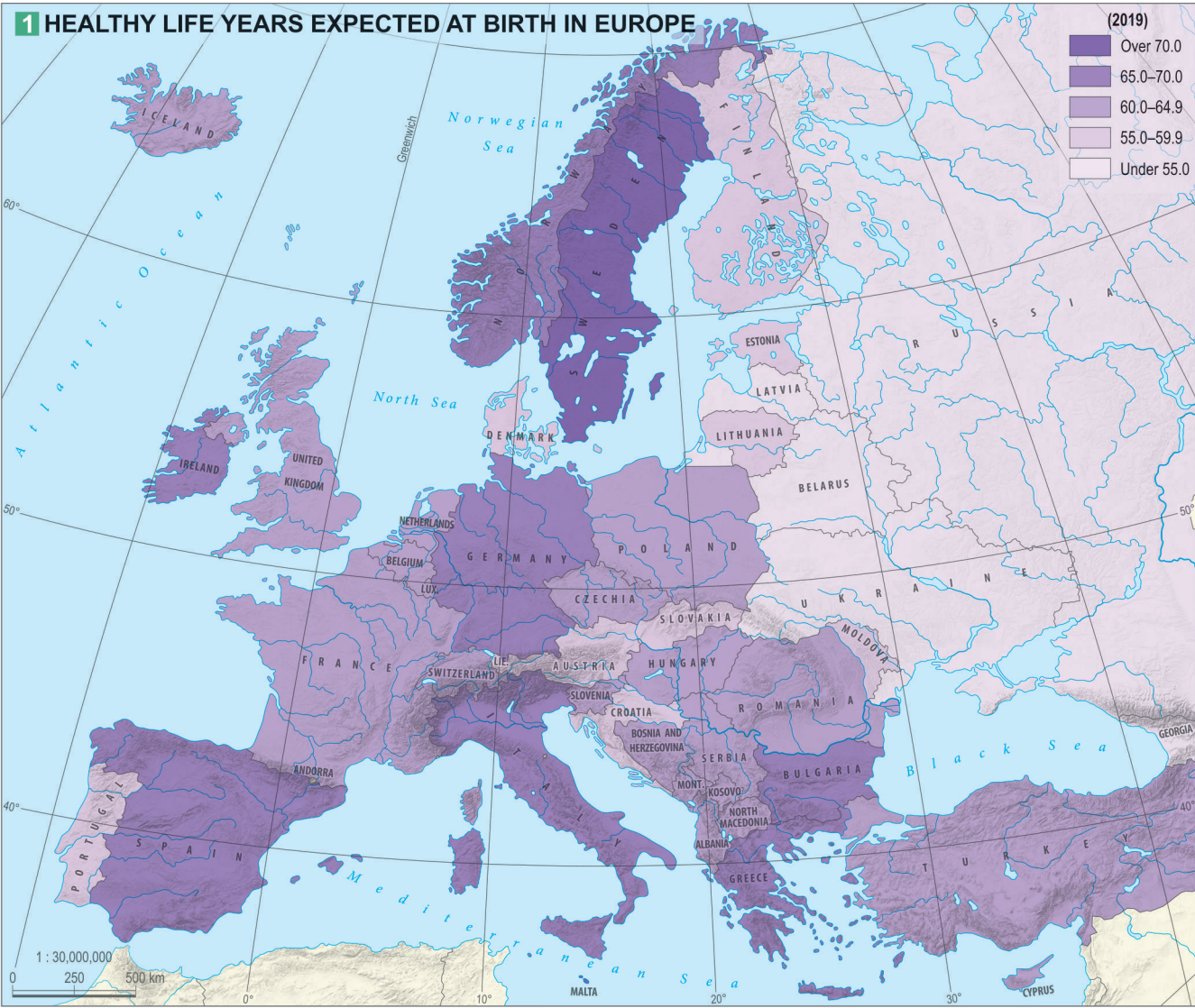
Health and quality of life

Health conditions of the population

In times past, health was regarded merely as the absence of disease or disability. In 1946, however, the World Health Organisation (WHO) defined health as a state of full physical, psychological and social well-being. The general health of the population has traditionally been measured by looking at deaths (mortality) and illnesses (morbidity). However, according to the WHO, knowledge of such factors as well-being, risks and hazards, health culture and human health-related behaviour (health behaviour) is also required for this task.

Changes in the state of health of the population occurred in various phases throughout history – these are known as the epidemiological eras. In the first of these, pandemic diseases (e.g. plague) caused most deaths. In the second, infectious diseases (e.g. TB) concentrated in smaller areas were the determining causes of death. In the third, infections were suppressed, but mortality from non-infectious diseases (mainly cardiovascular disease and cancer) became significant. Such diseases are associated with lifestyle (e.g. harmful addictions, unhealthy diets, sedentary lifestyles) and with environmental factors: for instance, the negative impacts of industrialisation and modernisation (e.g. air pollution, stress) have intensified. The fourth era is a period of delayed non-communicable diseases, during which the same diseases lead to the most deaths but at a much later age. Today, the population of each country in the world can be placed in one of the epidemiological eras. The most advanced economies and societies are currently in the fourth era.

Hungary – like the rest of East Central Europe – followed the trends of economically developed and moderately developed countries until the 1960s, at which time the country entered the third epidemio-



logical era. During the 1960s, however, the health of the population began to deteriorate. By the 1980s, Hungary was experiencing an epidemiological crisis which reached its lowest point in 1993. By then, the entire adult population had been affected by the deterioration of life prospects, with mortality rates among middle-aged Hungarian men being particularly unfavourable. Subsequently, however, life prospects began to improve, reflecting changes in lifestyle, living conditions and health behaviour, as well as

advances in medicine and the use of new types of therapies. Although Hungary and the surrounding countries have now entered the fourth epidemiological era, they are still at the beginning of it. Indeed, the health of the inhabitants of these countries continues to lag behind in relation to their economic development. Despite improvements, the rate of premature death (i.e. before the age of 60) is still high compared to the European level. Thus, the health of the general population is unfavourable in compari-

2 HEALTHY LIFE YEARS EXPECTED AT BIRTH (MALES AND FEMALES, 2018)		
	Males	Females
Central Hungary	63.0	63.2
Central Transdanubia	60.4	61.3
Western Transdanubia	61.4	67.1
Southern Transdanubia	57.0	58.7
Northern Hungary	56.8	57.4
Northern Alföld	57.8	58.7
Southern Alföld	61.1	61.6
Hungary	60.1	61.4

son with the European average. Notwithstanding the increase observed in recent decades, average life expectancy at birth remains low [16](#) and is very unequal both spatially and in terms of gender [18](#).

Diseases that rarely end in death but impair the quality of life are also relevant to people's health and well-being. Since only a small part of the disease data can be statistically evaluated an indicator of the number of healthy years in people's lives (the healthy years of life) is often used. According to calculations by Eurostat, on average the inhabitants of some Northern European countries, as well as Malta, can expect the most disease-free years of life. According to this indicator, conditions in Hungary are slightly more favourable than those in the neighbouring countries [XII.1.1](#), which is the opposite of what is observed in the field of life prospects [17](#) [19](#). In this context, a relevant factor is health culture, because the indicator can only be calculated on the basis of diseases detected, and in Hungary there are quite a few unrecognised diseases. However, regional differences within the country are clearly visible: the inhabitants of the economically dynamic region of

Central Hungary can expect the greatest number of healthy years, while those living in Northern Hungary and in Southern Transdanubia, which are economically underdeveloped and have many social problems, have the smallest number of healthy years. For men, the difference between the best and worst values is 6.2 years; the gap is even greater for women: 9.7 years [XII.1.2](#).

The standardised mortality ratio (SMR, [23](#) [25](#)) is also suitable for measuring regional differences in health status, as it eliminates the distorting effect of different age structures. A more detailed geographical breakdown shows that districts with the worst health conditions have the highest rates. In 126 districts SMR is higher than the national average. Regional differences are considerable: the least favourable rate occurs in the multiply disadvantaged district of Edelény (134.2%), while the most favourable occurs in District II of Budapest (65.7%) [XII.1.3](#). Such differences are indicative of the impact of socio-economic and cultural factors on health.

The two most common causes of death are circulatory diseases and cancer [23](#) [25](#). Although this is true in all districts, the relative importance of these diseases varies. For example, mortality from circulatory diseases is concentrated in the southern part of Békés County and in the eastern part of Csongrád-Csanád County. In the western areas of the latter, cancer represents a higher proportion. Since the two leading causes of death account for the majority of all deaths, the proportion of people dying from diseases of the digestive and respiratory systems is similar in most districts [XII.1.3](#).

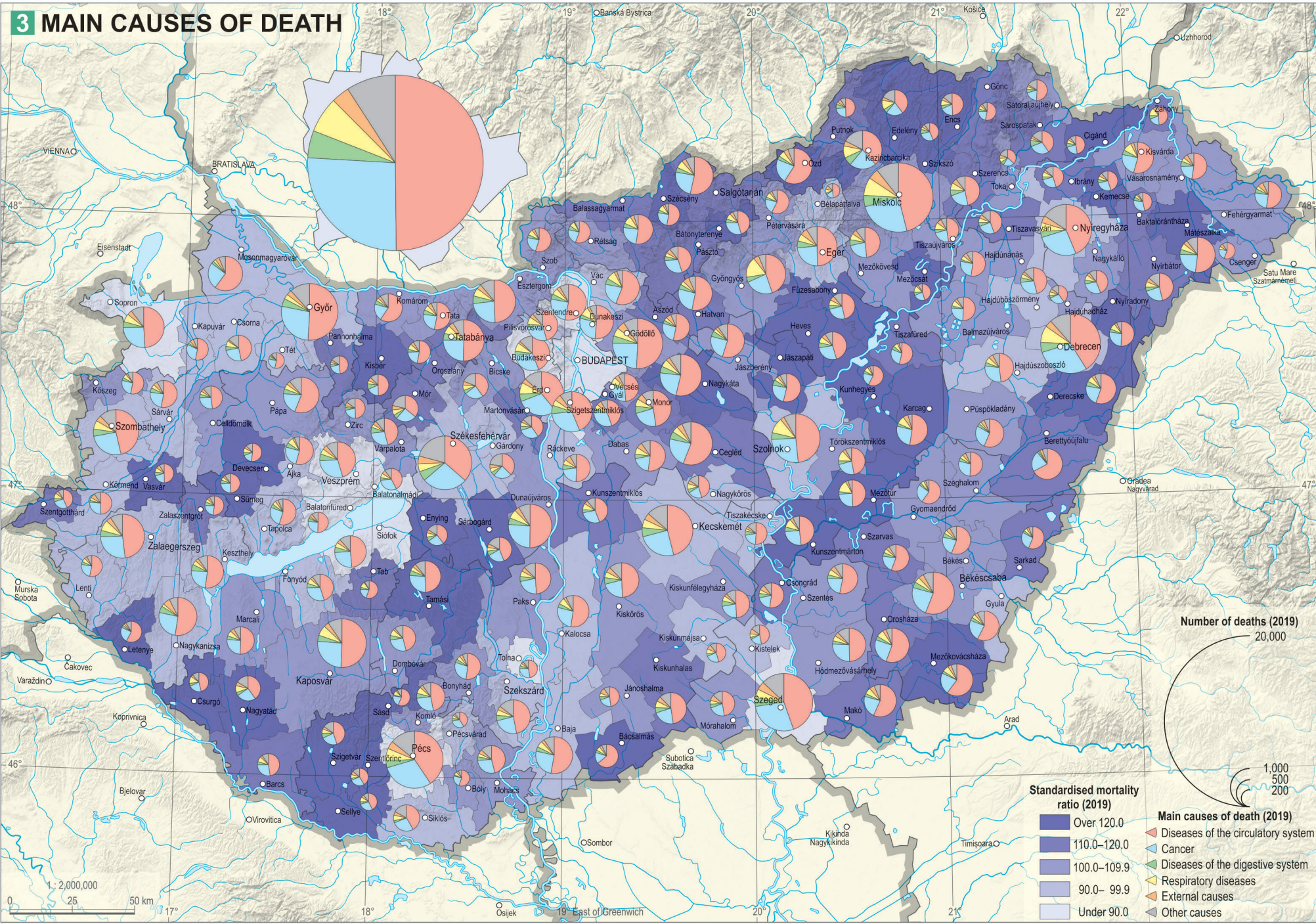
The spatial distribution of known diseases based on the patient's place of residence only partially co-

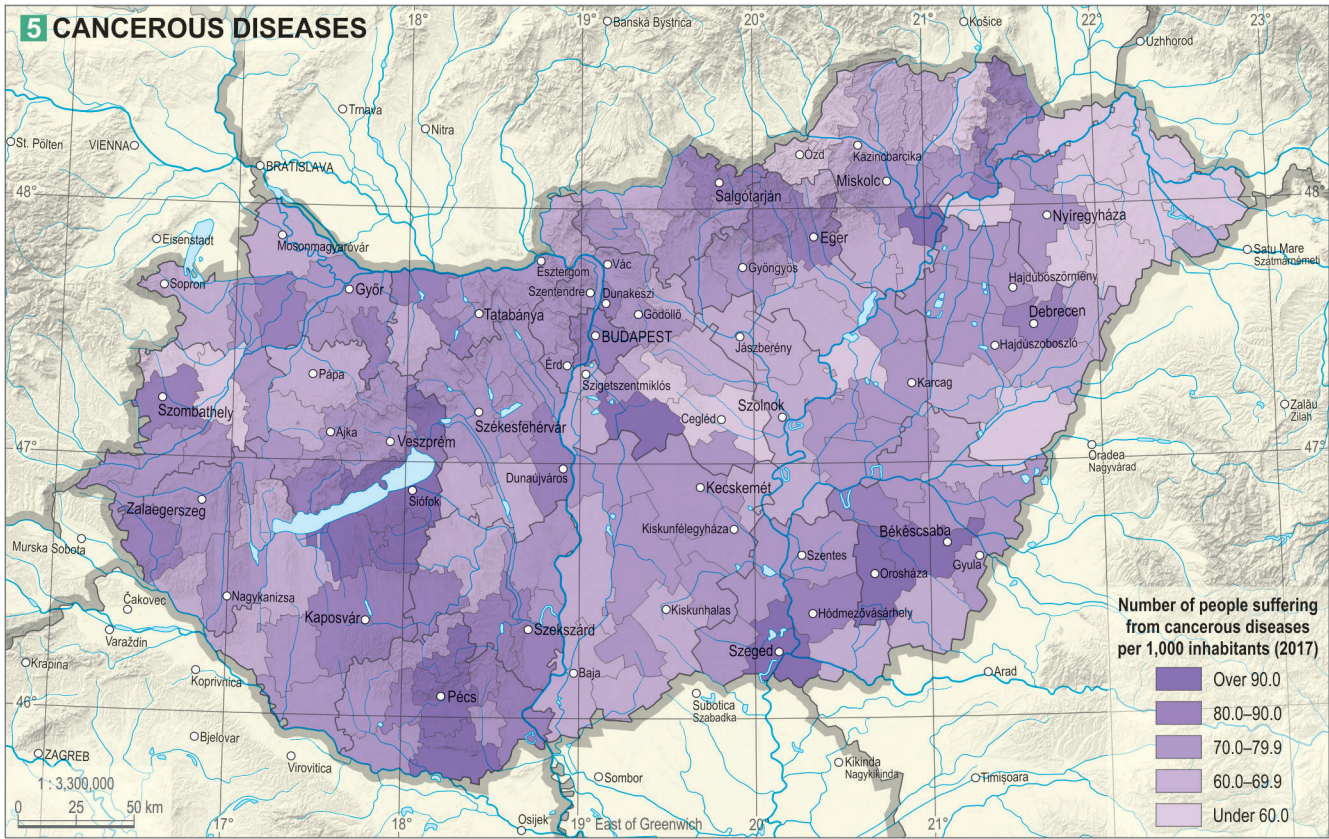
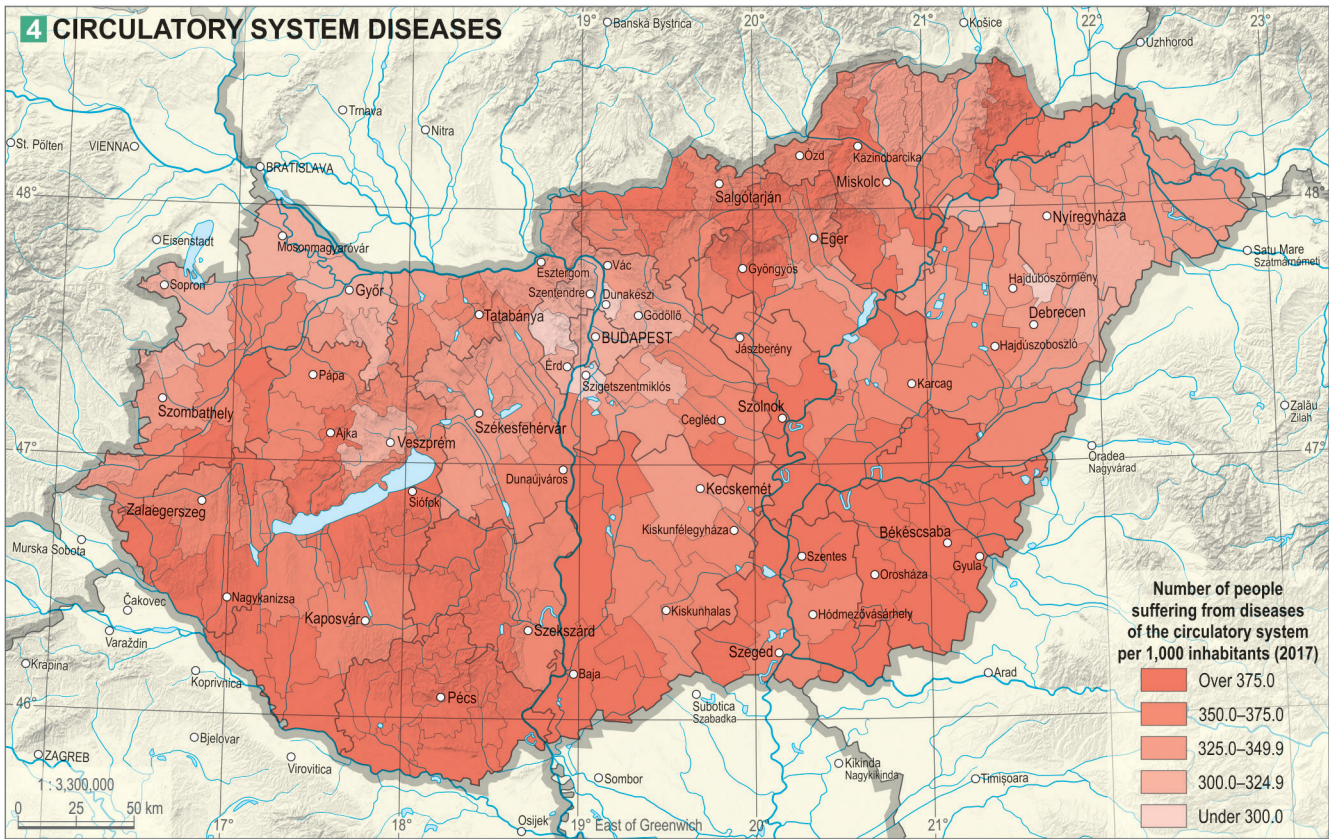
incides with the spatial distribution of causes of death. For instance, although fewer people suffer from *diseases of the circulatory system* in and around Budapest and in Western Transdanubia, the data on causes of death do not reflect this [XII.1.4](#). Similarly, the relatively favourable data in this field in the peripheral areas of Hungary can be explained by a more youthful age structure [VI.1.8](#), as diseases of the circulatory system occur less frequently at a younger age. A similar effect can be seen in the case of recorded cancer cases: they are less common in those areas of northeastern Hungary and Southern Transdanubia that are inhabited by a large proportion of Roma people. In contrast, such diseases are overrepresented in some of the former or current industrial areas (e.g. the Salgótarján and Tatabánya areas) [XII.1.5](#). Since the above observations can be explained only partly by the age structure, it is essential to look at other reasons for the spatial distribution of unfavourable health and to examine the role of the various health risks.

Health risks – lifestyle, health behaviour

The health of the population is influenced by individual and environmental factors. *Biological characteristics* are important among the individual factors. Elderly people (aged 65+ years) and women in Hungary tend to judge their health less favourably and therefore feel hindered in their daily activities.

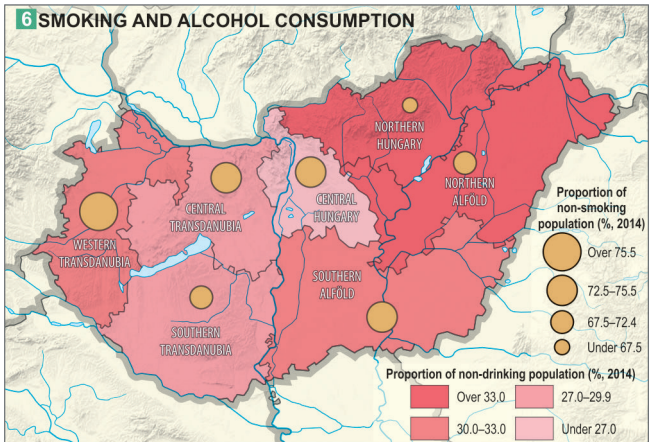
Perhaps even more important than the biological characteristics is the second *group of factors related to individual lifestyles*. Alcohol consumption in Hungary is significant but spatially unequal: consumption is highest in Budapest and Pest County and lowest in the Northern Alföld and in Northern Hungary





XII.1.6. Overweight and obesity – associated with a poor diet and a lack of physical activity – are also major problems (more so than the European average). The frequency of fruit and vegetable consumption is higher among women, people with higher levels of education and income, and people living in urban areas **XII.1.7.** Lifestyle risk factors show a slow improvement at society level, but there remain significant inequalities.

The third group of factors is associated with the *socio-economic situation of the individual (household)*. Groups in a less favourable situation tend to have worse health outcomes **VI.7.20.** For example, mortality figures for people living in the outer and inner peripheral areas (near the northern and eastern border and in rural areas of Southern Transdanubia



and the Central Tisza Region) **VI.7.7.** **VI.7.8.** **VI.7.9.** are worse than in the central regions **XII.1.3.** The degree of health-related quality of life impairment is also lower in the economically more developed regions **XII.1.8.** **XII.1.9.** Thus, the polarisation of Hungarian society is also reflected in health risks: the disadvantages of poorer people and those with lower educational attainment are significant in terms

7 HEALTH BEHAVIOUR AND RISK FACTORS (2014)					
Region	Consuming vegetables and fruits daily	Appropriate physical activity	Normal weight	Non smokers	Consuming no alcohol
	Proportion (%)				
Central Hungary	68.6	13.3	47.0	73.6	24.5
Central Transdanubia	67.2	13.4	43.2	75.3	28.4
Western Transdanubia	63.2	9.3	43.3	79.2	30.4
Southern Transdanubia	70.6	12.7	42.1	70.7	29.5
Northern Hungary	66.1	12.7	38.8	63.5	33.3
Northern Alföld	63.0	11.6	37.7	70.1	36.3
Southern Alföld	67.9	12.0	41.4	74.6	32.8
Settlement type					
Capital	72.7	15.6	47.1	76.1	23.5
Town with county rights	65.8	14.7	41.2	78.2	27.2
Other town	69.1	12.6	42.1	69.8	31.9
Village	61.4	8.4	41.8	69.4	33.2
Hungary	66.9	12.4	42.7	72.5	29.8

Based on the self-declaration of the surveyed population.



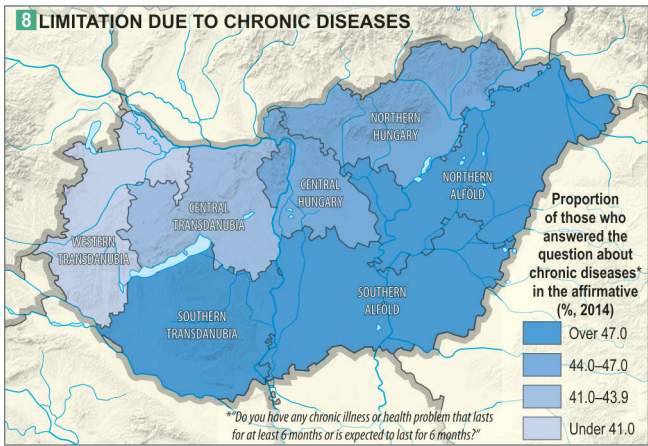
1 A renovated local health centre in the Southern Alföld

of health, and the lag of this social class begins already in the younger age groups (people aged 35–44).

The fourth group of factors, which involves *access to healthcare*, has improved on average in recent years **I.**, although there has been a deterioration among the poorest people. The main reason for this latter development is that although public health services are free as little as two thirds of all health expenditure comes from state resources. Indeed, public health expenditure per capita is significantly below both the EU average and the average in the neighbouring countries, excluding Romania. For this reason, the proportion of out-of-pocket expenditure (direct payments made by households to providers) is high (twice the EU average). Nevertheless, the majority of the population is satisfied with the quality of healthcare. The proportion of people who report not receiving adequate care is small, despite long waiting lists, a shortage of specialists and many long-term unfilled GP practices **XII.2.2.8.**

Less data is available regarding the fifth group of factors (*the impact of environmental conditions on health*). In 2013, air quality was excellent in just one in three settlements but the level of air pollution was high only in Budapest and in some areas of northern Transdanubia. Noteworthy, the proportion of people who heat their homes with solid fuels, thus increasing the risk of indoor air pollution, is higher among those with lower income levels.

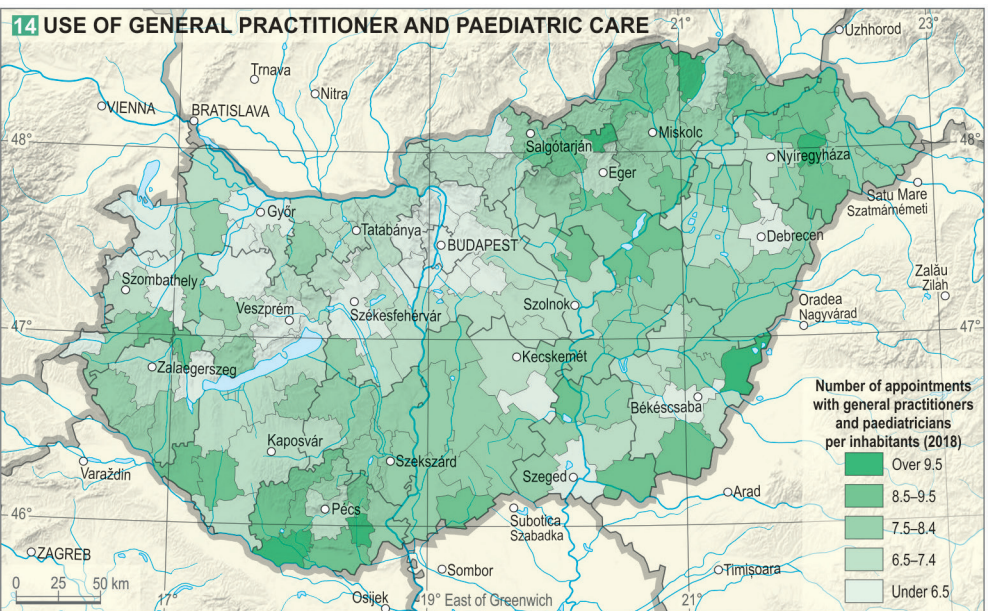
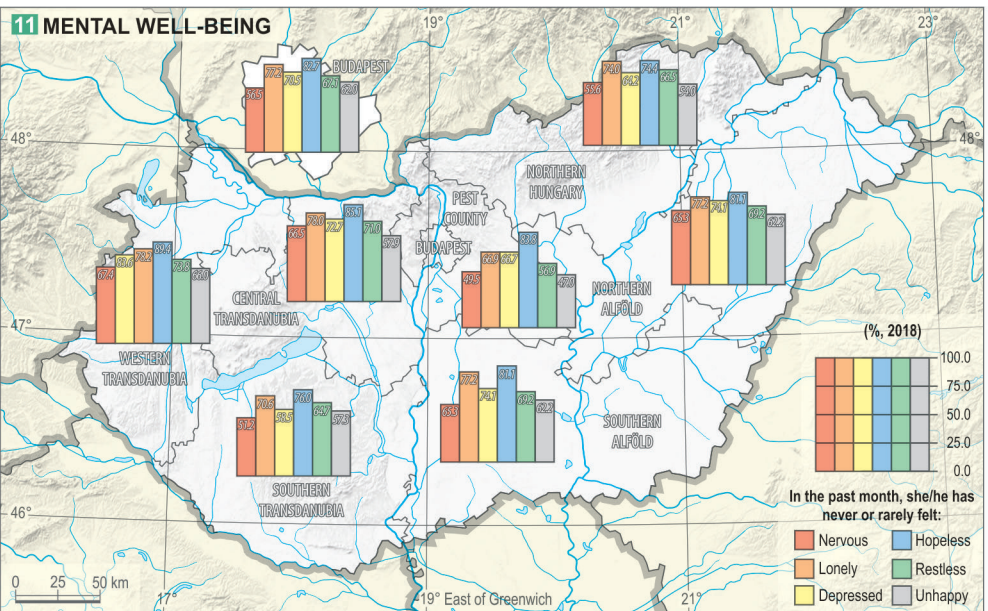
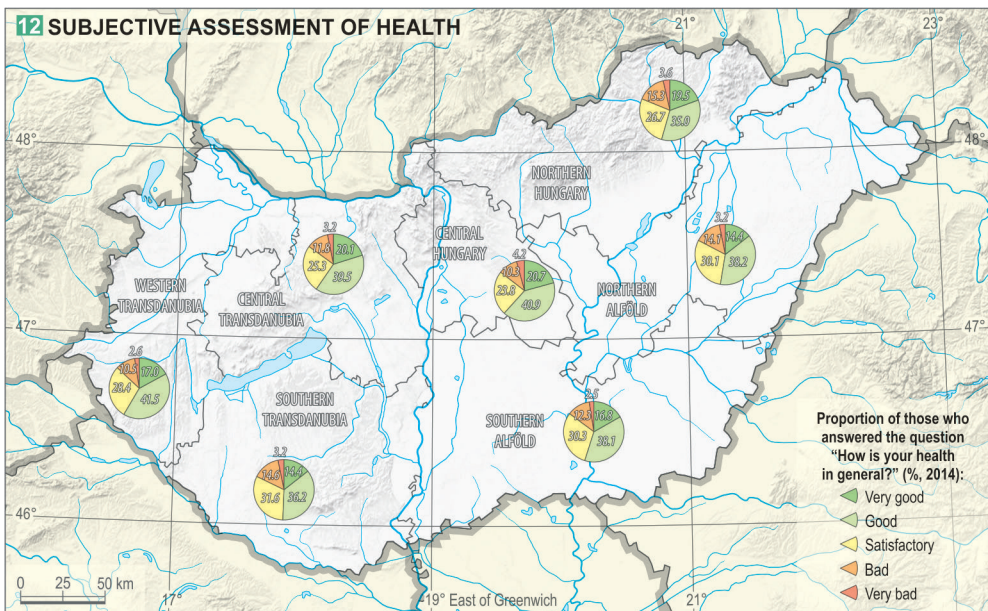
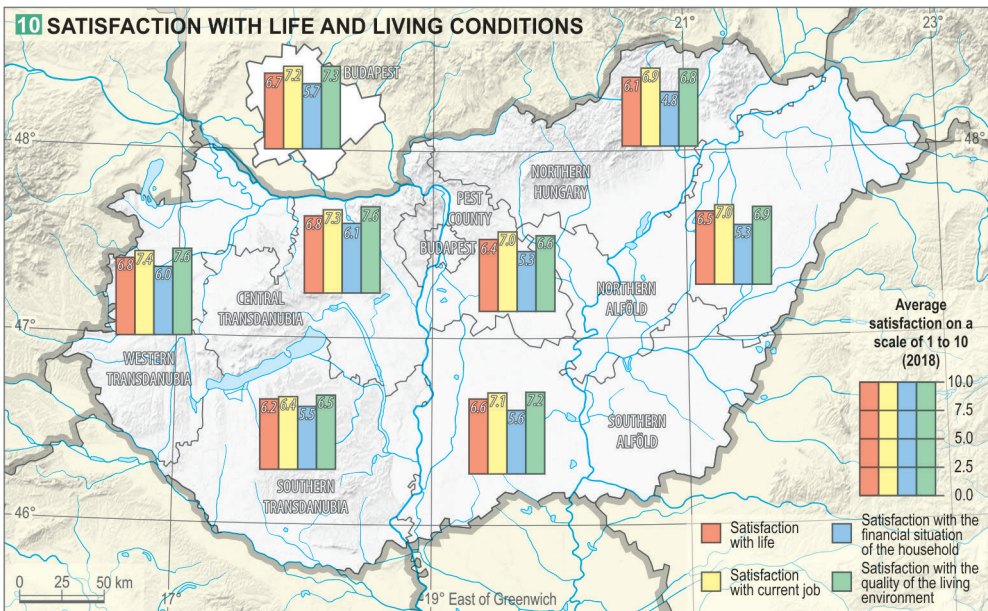
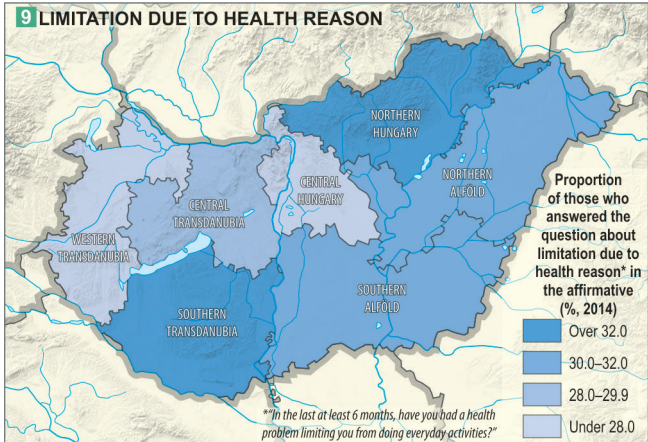
In the future, Hungary must reduce spatial health inequalities **XII.1.9.** and strengthen public health awareness **2.** In particular, it is desirable to increase health literacy, which includes access to health information and the ability to understand, evaluate and apply knowledge. The aim should be to help individuals to better navigate the domains of healthcare, disease prevention and health promotion, thus contributing to the improvement of objective and subjective health status.



Health culture – subjective well-being and use of the healthcare system

Health culture is a set of community objectives and instruments for the preservation, restoration and development of health, together with the related individual and community health behaviour. It includes the way of life of the population and all activities aimed at acquiring health-related knowledge.

Subjective well-being and the use of the healthcare system are essential elements in the development of health culture, providing a wide range of information on health literacy and ultimately the quality of life of the population. Self-assessment of health status (i.e. how individuals perceive their own



health) may not be the same as their actual – objectively measured – health status. Subjective health depends on an individual's educational attainment, occupation, income, and place of residence.

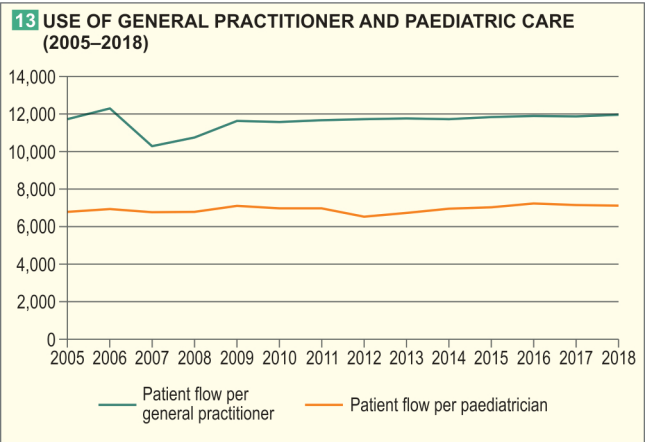
It is generally true that people who are socially and economically disadvantaged or who live in small settlements and peripheral areas judge their own health less favourably than those whose status in these fields is higher **XII.1.10.** The results of the European Health Interview Survey in 2014 indicated that people are more likely to rate their own health as good or very good in areas with higher educational attainment and household incomes and relatively low levels of unemployment, poverty and social exclusion **VI.7.2.** Perceived health has an impact on overall well-being, which is also at the heart of the WHO health definition. Here, one of the key factors is *satisfaction with life and living conditions* **XII.1.10.** The results of a survey conducted by the Hungarian Central Statistical Office (KSH) on the standard of living of Hungarian households show that in regions with better social and economic conditions, the population is more satisfied with life, work, household income and the quality of the residential environment. The situation in Central Hungary is special: in that region, there is a significant difference between the optimism of Budapest residents regarding their situation and the pessimism of the inhabitants of Pest County. Moreover, there are also substantial differences between the various parts of Pest County: the higher income level of people living in settlements within the Budapest agglomeration **VI.7.16.** is matched by a better opinion of their living conditions, while social and economic disadvantages in the southeastern part of the county are combined with a less favourable view of living conditions.

Mental well-being can affect the subjective assessment of health and the perceived satisfaction with life **XII.1.11.** Negative feelings (e.g. anxiety, loneli-



2 Locals playing sports or relaxing in a refurbished park in Szeged

ness and unhappiness) are more likely to be experienced in areas where perceived health is worse and where people are less satisfied with life and their living conditions. In this regard, the north-south division of Transdanubia is striking: there are more people in the tiny villages of Southern Transdanubia (e.g. Ormánság) who consider their mental well-being to be unfavourable. This is also related to the fact that the health and social situation of people living in the peripheral parts of Somogy and Baranya counties is particularly unfavourable. As they age, people experience declining health and become less satisfied with their health. This process is associated with the deterioration of their mental well-being.



The *subjective assessment of health* is an important source of information for the healthcare system. Use of healthcare services is influenced both by individual needs and by the availability and accessibility of health services and the propensity of people to use them [XII. 1. 12.](#), [XII. 2. 2. 9.](#), [XII. 2. 2. 11.](#). People's willingness to use health services depends on their educational attainment: a higher level of education means less frequent use of primary healthcare and more frequent use of specialist care.

The number of *patient visits* in primary healthcare is high, partly because municipalities are obliged to operate general practitioner and paediatric care. In tiny villages and areas remote from county centres, general practitioner care is often the only local health service available. Patient flow per general practitioner and paediatrician largely stagnated between 2005 and 2017 [XII. 1. 13.](#). (The temporary decrease in patient flow in 2007 was mainly the result of the visit fee that was payable by the public between February 2007 and March 2008.) The number of appointments with general practitioners and paediatricians was highest in Southern Transdanubia and Northern Hungary, where the health status of the population is worse than the national average [XII. 1. 14.](#). In more favourable and economically developed areas, and in major cities and county centres, patients are less likely to see a general practitioner or paediatrician. There is a two-fold difference between the lowest number of appointments and the highest number of appointments (Encs and Sellye) Evidently, the inhabitants of the worst-off areas see their doctors the most often.

Hospital care is the highest level of the healthcare system and its use is particularly affected by the

health status of the population. As objective indicators of health decline [XII. 1. 4.](#), [XII. 1. 5.](#), so the flow of hospital patients increases. However, the use of hospital care depends not only on an individual's state of health but also on the general health culture: for example, where it is common for patients not to seek medical attention on time, it is more likely that their advanced disease must be treated in hospital. The *use of inpatient hospital care* differs within Hungary [XII. 1. 15.](#). In Southern Transdanubia and in the eastern part of Northern Hungary, people living in areas far from hospitals, mainly along the border, are more likely to be hospitalised. In the northeastern and southwestern parts of Hungary and along the eastern border, where health conditions are poorer, people are more likely to turn to their general practitioner or paediatrician, and hospital care is more frequently used.

The rather unfavourable state of people's health in Hungary, which lags behind the European average [XII. 1. 1.](#), and the regional differences [XII. 1. 4.](#) can be connected with the regional distribution of health risks [XII. 1. 9.](#), perceived health [XII. 1. 12.](#) and the use of the healthcare system [XII. 1. 15.](#). Due to their spatial coincidence, the unfavourable situation of the counties of Baranya, Borsod-Abaúj-Zemplén, Nógrád, Somogy and Szabolcs-Szatmár-Bereg can be considered a long-term issue on the basis of the state of health of the population.

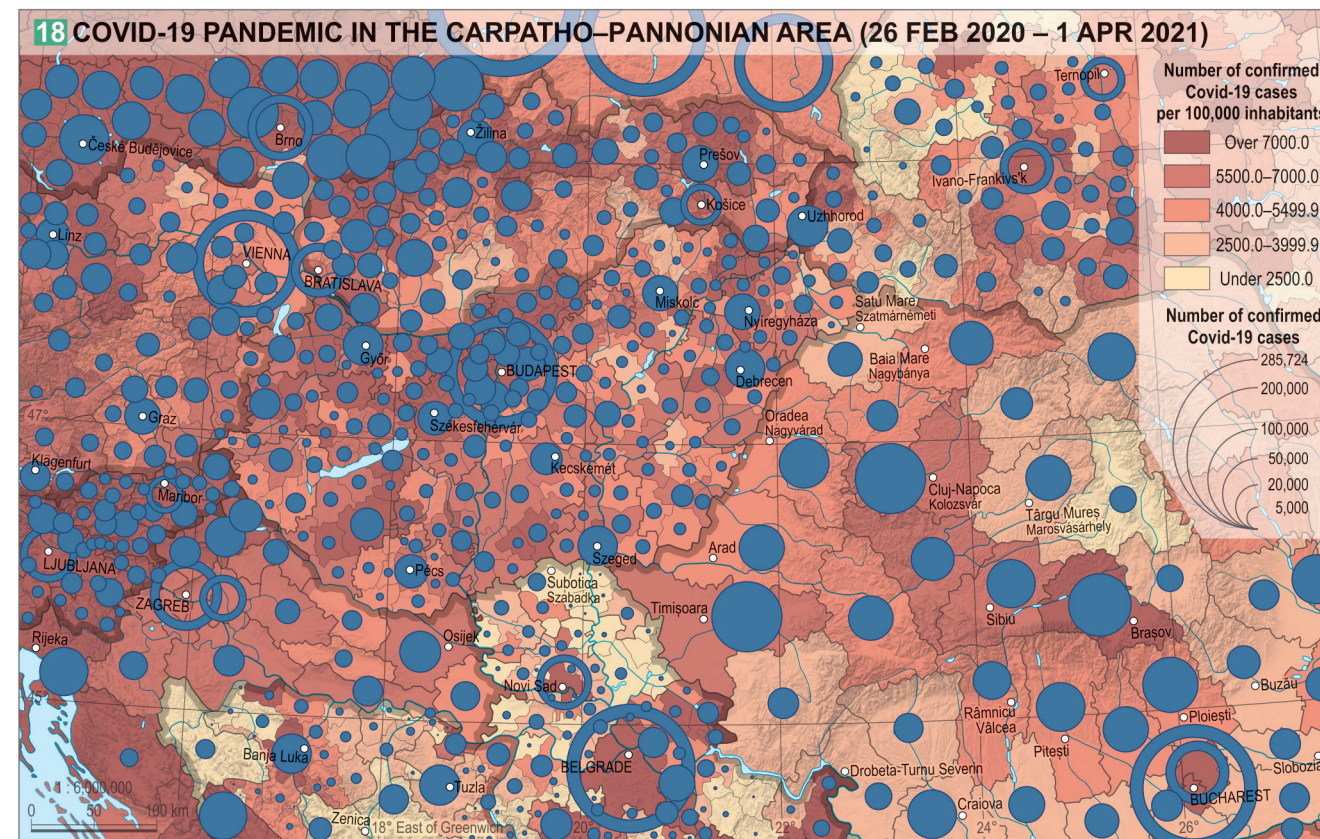
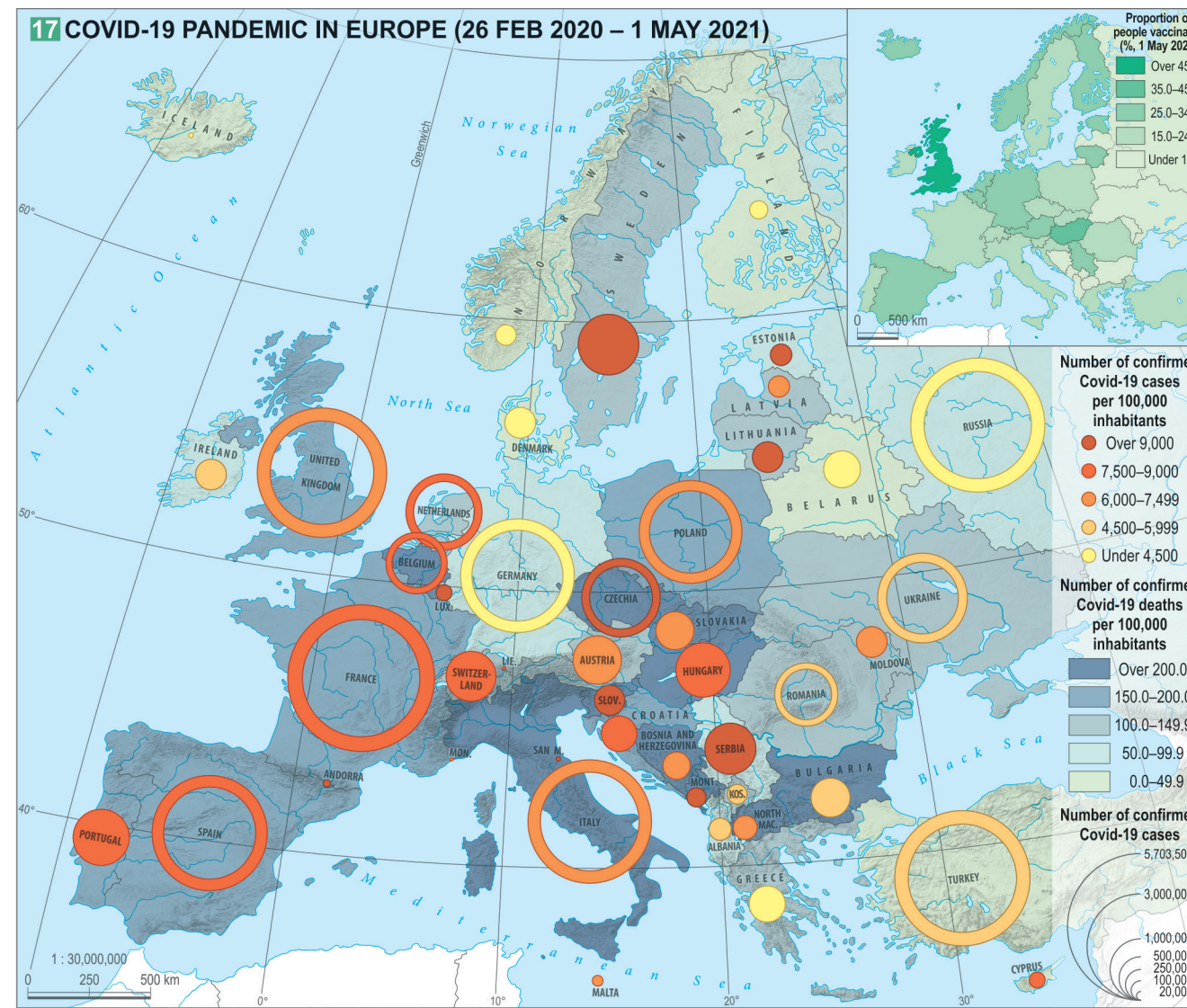
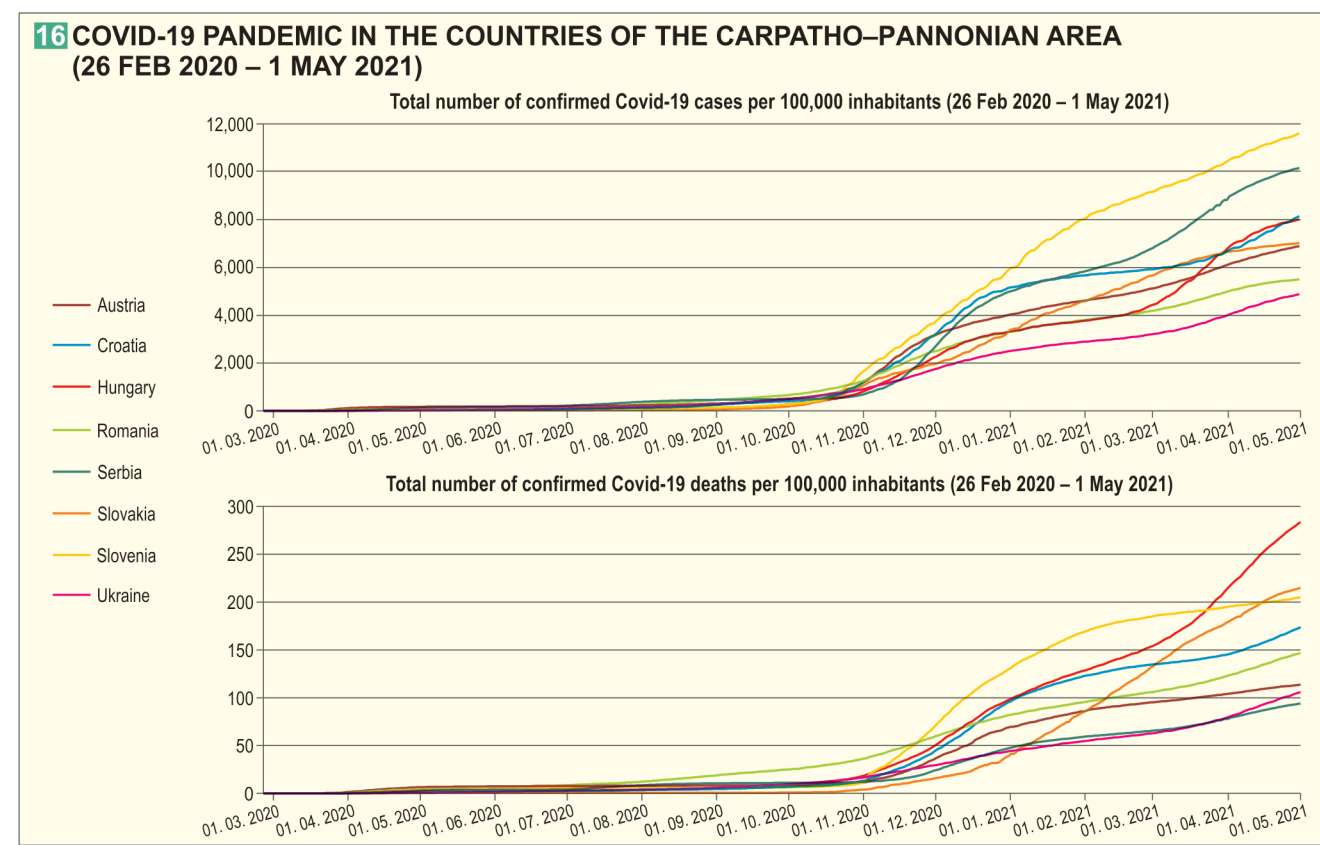
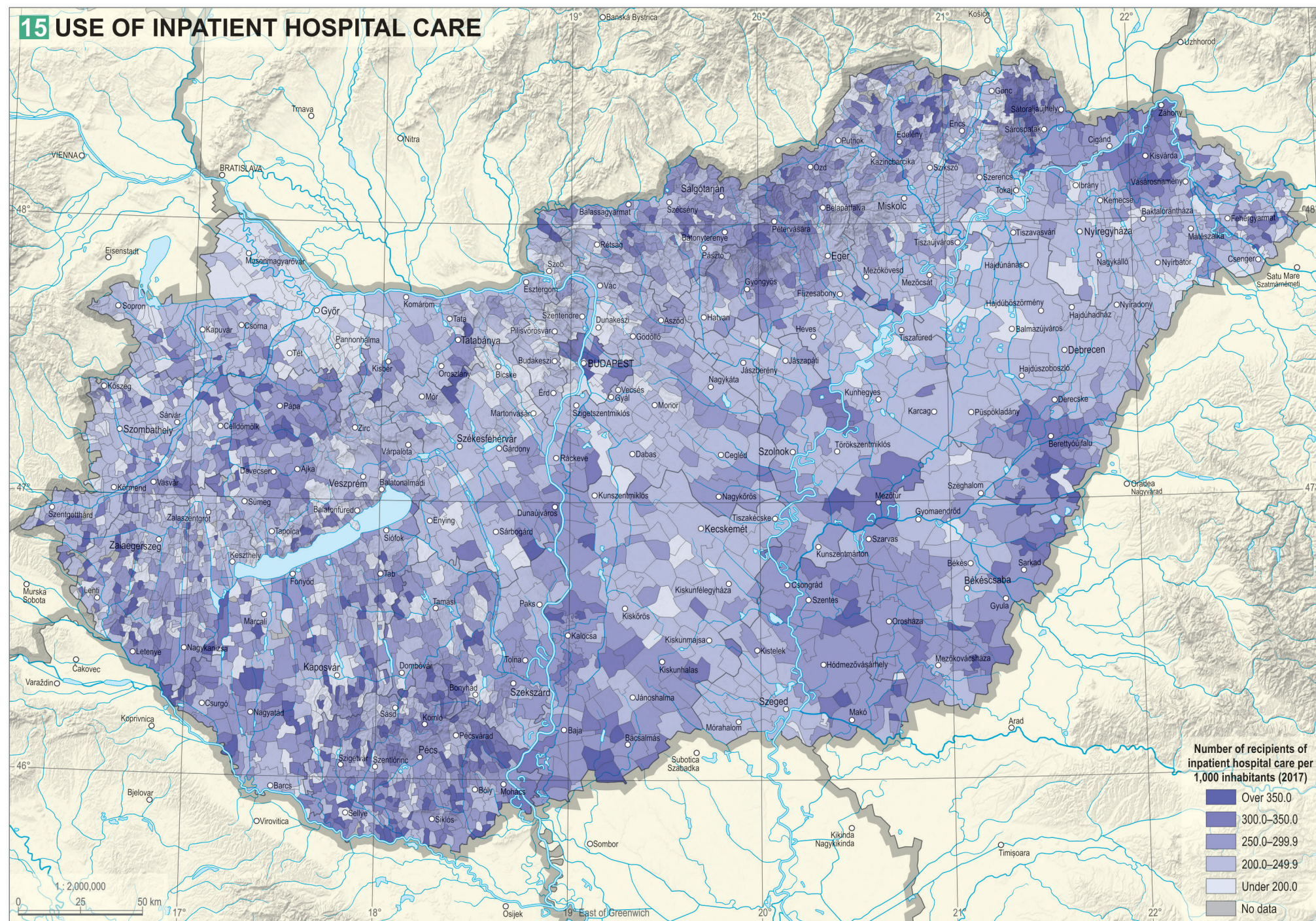
Covid-19 pandemic

As the epidemic caused by the new coronavirus (SARS-CoV-2) emerged in late autumn 2019 and became global in 2020, the importance of infectious diseases for health and quality of life increased.

The WHO declared the mass spread of Covid-19 a pandemic on 11 March 2020. The first cases in Hungary were recorded on 4 March. With a view to slowing the spread of the pandemic, the Parliament adopted the Emergency Powers Act in March. Experience has shown that the virus is most dangerous for the elderly and chronically ill, as they are more likely to have a severe course of infection, to be hospitalised due to complications and to die of the disease.

The Covid-19 hit Hungary until the spring of 2021 in three waves. During the first wave (spring 2020), most infections occurred in Budapest and in Pest County, as well as in institutional focal points (hospitals, nursing homes). In late August 2020 (the beginning of the second wave), new cases were more related to community spread, with the development of chains of infection in several counties concurrently. At that time and unlike during the first wave, the pandemic spread primarily among young people and later reached the older age groups. New infections per day, active cases and the number of deceased were higher than they had been in the spring [XII. 1. 16.](#). In the second and third wave the pandemic situation in Hungary resembled that in the surrounding countries, with an increase in the number of cases also leading to an increase in the number of deaths [XII. 1. 17.](#), [XII. 1. 18.](#). In November 2020, the Parliament reinstated the Emergency Powers Act.

The pandemic has had a significant impact on the economy and on quality of life, and it has transformed daily life to an extraordinary extent. A decline in certain economic sectors and an increase in unemployment have been observed. Innovative community habits (e.g. online shopping) have be-



come more widespread in response to the curfews. At the same time, access to some services has been restricted (e.g. shopping time slots, postponed medical interventions). As the pandemic is ongoing (at the time of compilation of this volume), no final conclusions can be drawn about the long-term effects on human health, the economy and society.

Income, consumption and quality of life

Sources of spending – income, state benefits

Regional differences in income and the changes over time have been presented in Chapter VI. Here, we focus on the sources of income that are particularly important for people who are in the worst situation: the various *forms of benefits*. In their case, the regulatory background is of prime importance (i.e. who can obtain them, from what source, under what conditions and how much).

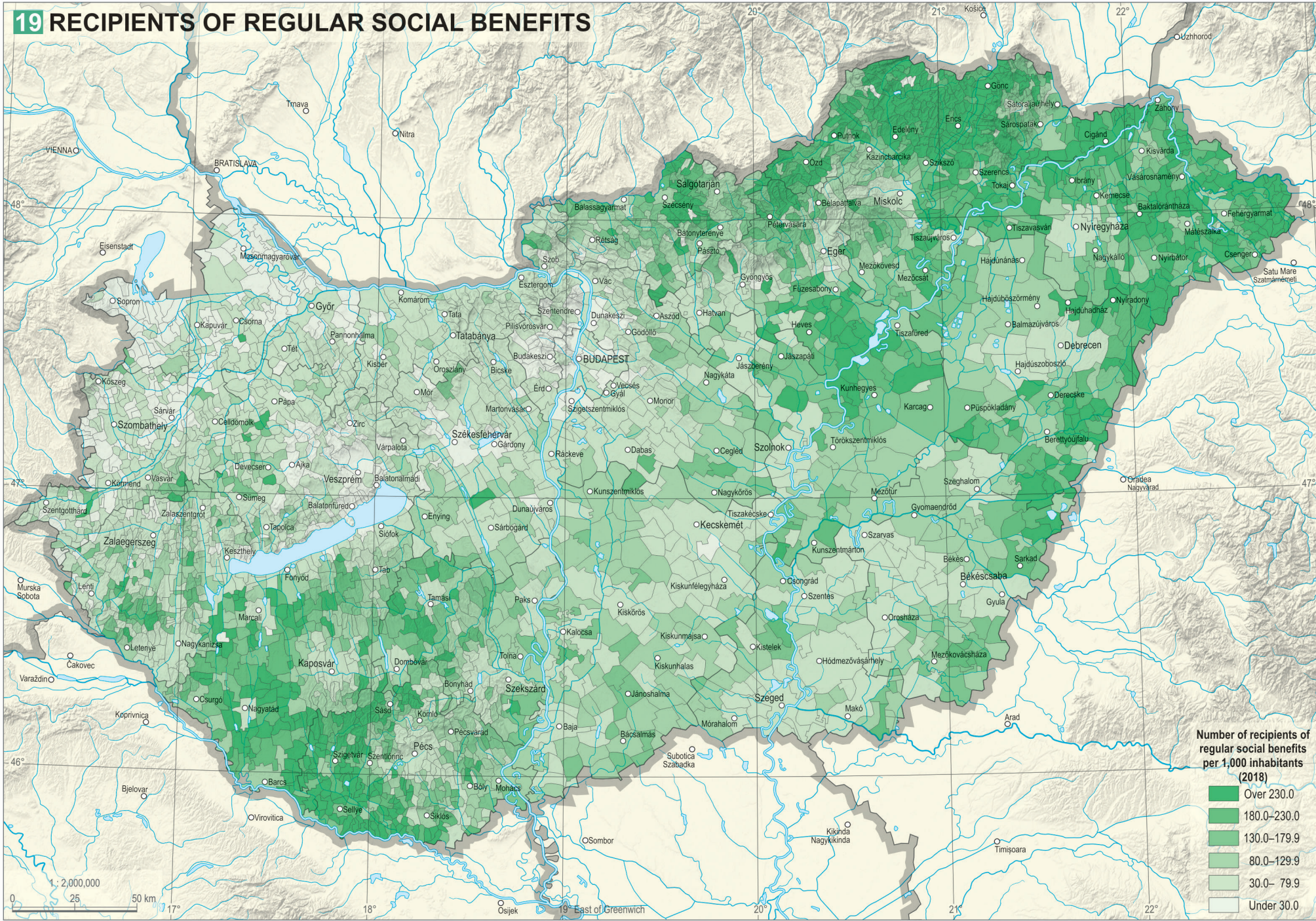
Since 2012, the maximum amount of regular social benefits has been reduced in order to ensure that earnings from jobs or public works schemes are higher than the benefits. The last major change was in 2015, when several forms of benefit ceased to exist and were replaced by the municipal allowance. In this way, the amount of money that each municipality was able to use for this purpose became more valuable (i.e. in settlements with lower tax revenue, the level of benefits per capita decreased) [XII. 1. 20.](#) On the basis of the number of people supported, the spatial structure of benefits is similar to the income conditions presented: in small towns and villages with a lower level of average income and a high proportion of public workers, there is also a high proportion of people receiving benefits [VI. 7. 10.](#), [VI. 7. 16.](#), [XII. 1. 19.](#)

The regional distribution of the *recipients of disability benefits* is also linked to the spatiality of the various indicators relating to development and social care. This shows a strong concentration of financial impoverishment and social problems, which in turn re-create disadvantage. This is substantiated by the fact that the share of social income (pensions, social benefits, sickness benefits, family allowances and unemployment benefits) is higher in the less-favoured regions [XII. 1. 21.](#). The number of people receiving regular childcare benefits, however, has decreased as a result of the increase in average income in recent years. While the eligibility threshold has not changed, the average income of the families concerned has increased slightly, and this has often been enough to raise them above the eligibility threshold. Thus, the financial situation and quality of life of these families have in many cases deteriorated.

In terms of quality of life, the satisfaction of people and their assessment of their situation are important. The data on *subjective income expectations* (i.e. how much money people think is necessary to make ends meet) show that the expectations of people living in Budapest and in Pest County are higher. There are two main reasons for this: first, incomes and the actual cost of living (e.g. housing); second, the social environment and people's own experiences of life strongly shape expectations. It can be observed that as the situation of a person improves, so an ever greater amount of money is needed to maintain that standard of living [XII. 1. 22.](#)

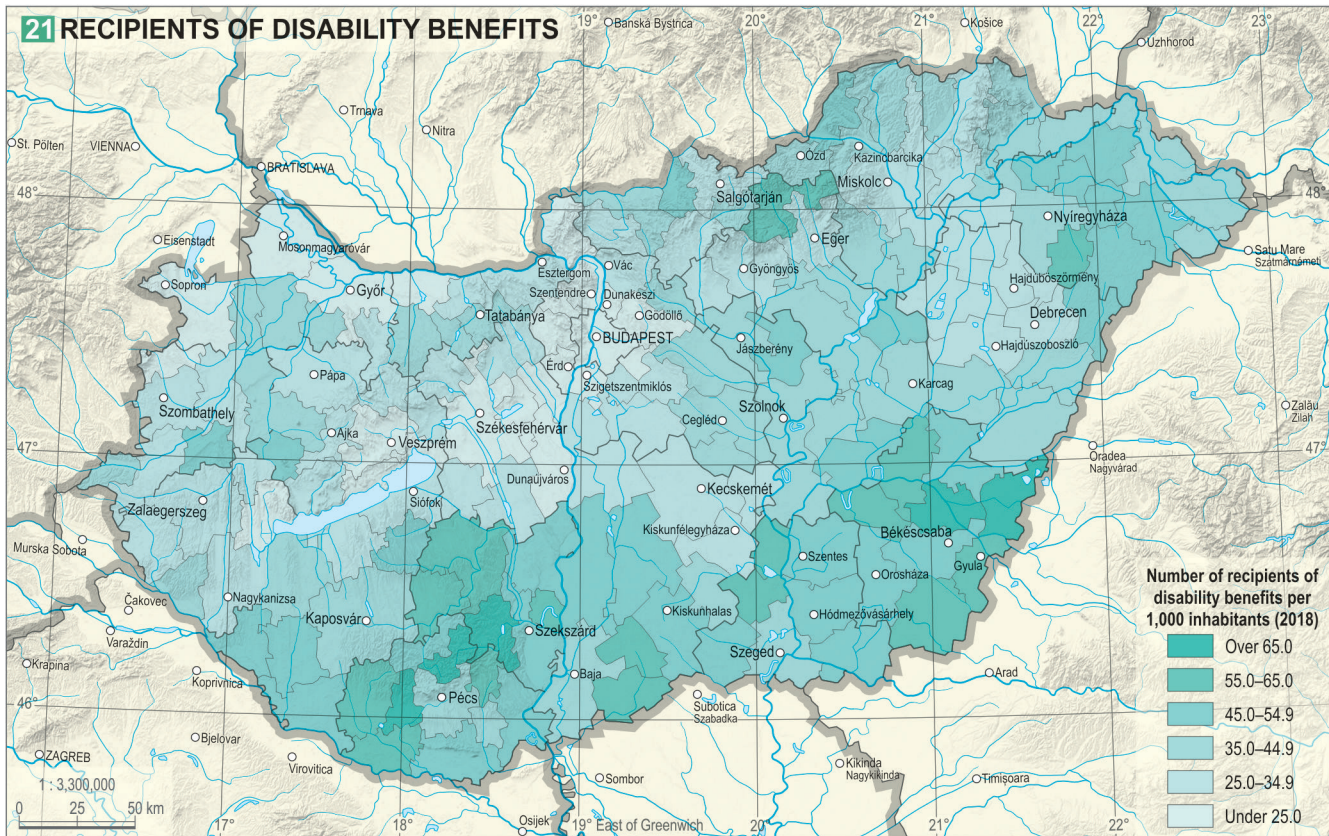
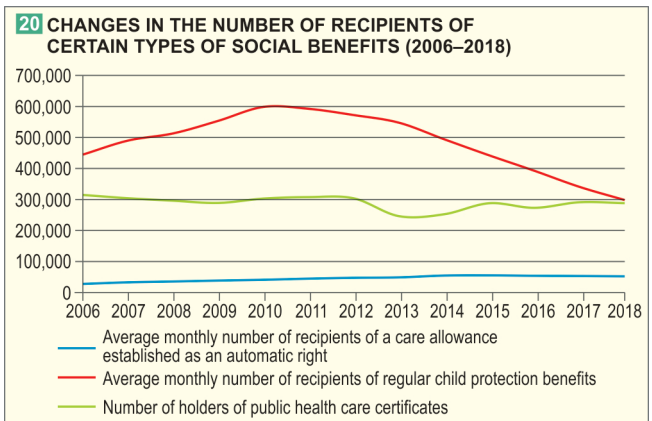
Household expenditure and consumption

The financial conditions of daily life are influenced not only by income but also by expenditure and

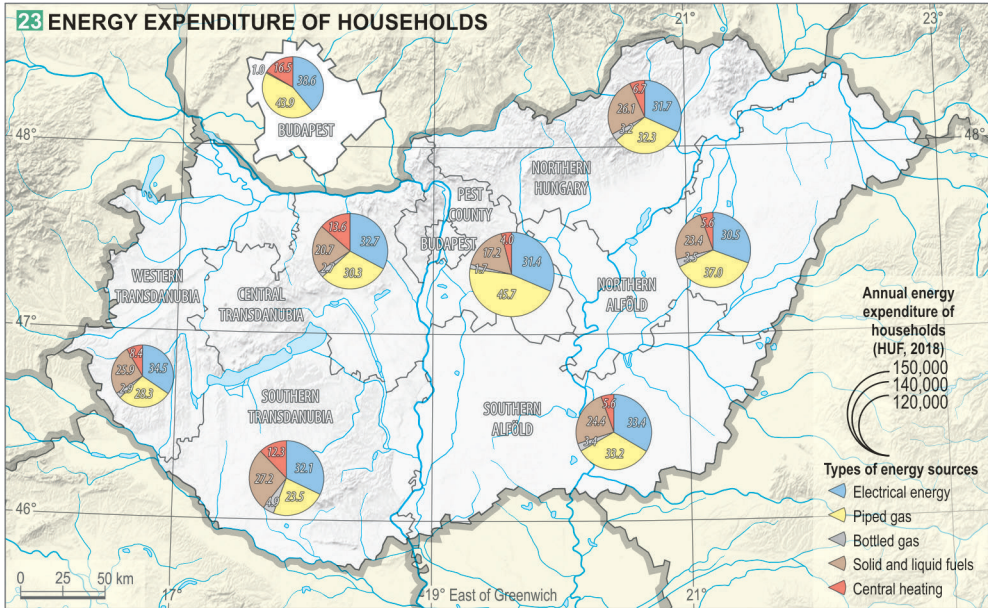
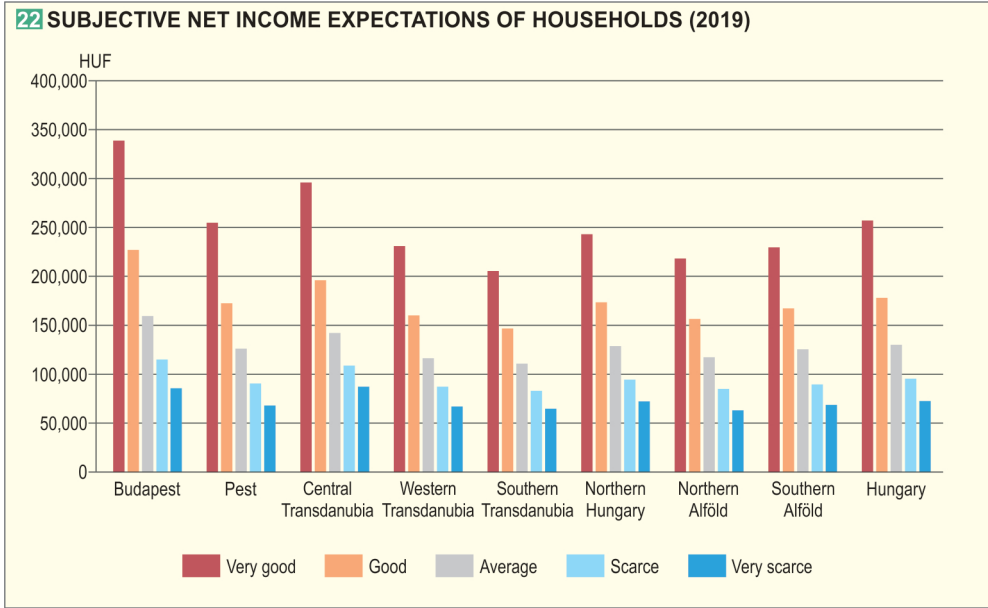


the associated consumption. These in turn reflect the stratification of society, since the same income is used differently by people belonging to different social groups.

According to a KSH survey, in 2018 the average household spent nearly a quarter of its income on food and non-alcoholic beverages and nearly 20% on housing and household energy. In contrast, very little (0.9% of household income) was spent on education. Compared to 2010, the proportions changed only slightly. The consumption potential of cities, towns and villages is also influenced by the spatiality of supply: where are the shops, do they exist at all [XII. 2. 2. 14.](#) ? These inequalities are not reduced substantially by online retail either. Between 2010 and 2018, the largest increase in consumption occurred in Central Transdanubia. Those in the top income quintile spent 3.6 times more than those in the bottom quintile. Poorer members of society can only make limited consumer choices, as they have little money left after basic living expenses have been paid. *Energy expenditure* and its composition are important indicators of well-being but entail



Household expenditure and consumption are also indicated by ownership of consumer durable goods. In the 1990s, the quantity and composition of *consumer goods owned by the population* changed significantly compared to the period before the collapse of communism, when there were shortages of such goods. The changes strengthened consumer society in Hungary [3](#). According to a KSH survey, communication devices accounted for the highest proportion of consumer durable goods in 2018. For example, on average, there were just under two mobile phones per household, but 91% of households also had smartphones. Economically less developed



[3](#) A typical urban shopping centre: Corvin Plaza in Budapest

regions are less behind in the supply of consumer goods that are important in everyday life, but entertainment and computer devices are clearly higher in proportion in households in Pest County, Budapest and Western Transdanubia [XII. 1. 24.](#)

As many as 68% of households own a car. The spatiality of this indicator is partly related to economic development, whereby Hungary is one of the European countries with a moderate level of car ownership. The number of cars per thousand inhabitants (the motorisation rate) is higher in the economically more developed countries. The same is true in the more developed regions of the Carpathian Basin (e.g. near the major cities). Regardless of the level of economic development, some areas exhibit a high degree of motorisation due to the specifics of the urban network or the lack of public transport means. Within Europe, for example, the degree of motorisation is higher than average in the agrarian regions

of Poland and southern Italy. In Hungary, while the motorisation rate is higher in Budapest and the more developed, western part of the country, the Danube–Tisza Midland also exhibits a relatively high rate [XII. 1. 25.](#), owing to the high proportion of people living on the outskirts [9](#) and to hidden incomes.

Literacy, consumption of culture

A somewhat enigmatic feature of quality of life is literacy, which is usually measured in part by the educational level, which is closely related to such other dimensions as higher education [VI. 1. 5. 5.](#) The shortest path to a higher education degree is still grammar school and vocational grammar school. In addition to higher educational attainment, language skills are becoming increasingly important. Foreign language speakers are more open, their opportunities are multiplied, their cultural needs and opportunities are more diverse, they are more adaptable, and they can attain a higher quality of life. One of the least measurable components of literacy is (the level of) cultural demand, which ranges from literary preferences to musical literacy and theatre visits. The frequency of participation in cultural events is a further element in this component [4](#).

The number of people choosing grammar school and vocational grammar school in a given age group will also reflect the accessibility of the institution and the need to change social status [XII. 1. 26.](#) In the last two or three decades, there have been increases in the proportions of secondary school graduates

and higher education graduates [VI. 5. 3.](#) The steady increase in the average number of school grades completed [VI. 5. 6.](#) is evidence of this trend. However, efforts to address regional inequalities have been rather unsuccessful, although polarisation has decreased. Together with shrinking school age groups, competition has appeared on the supply side: many schools seek to specialise and to attract students from further afield. Traditions, economic factors and accessibility influence the formation of the spatial structure [XII. 2. 2. 13.](#)

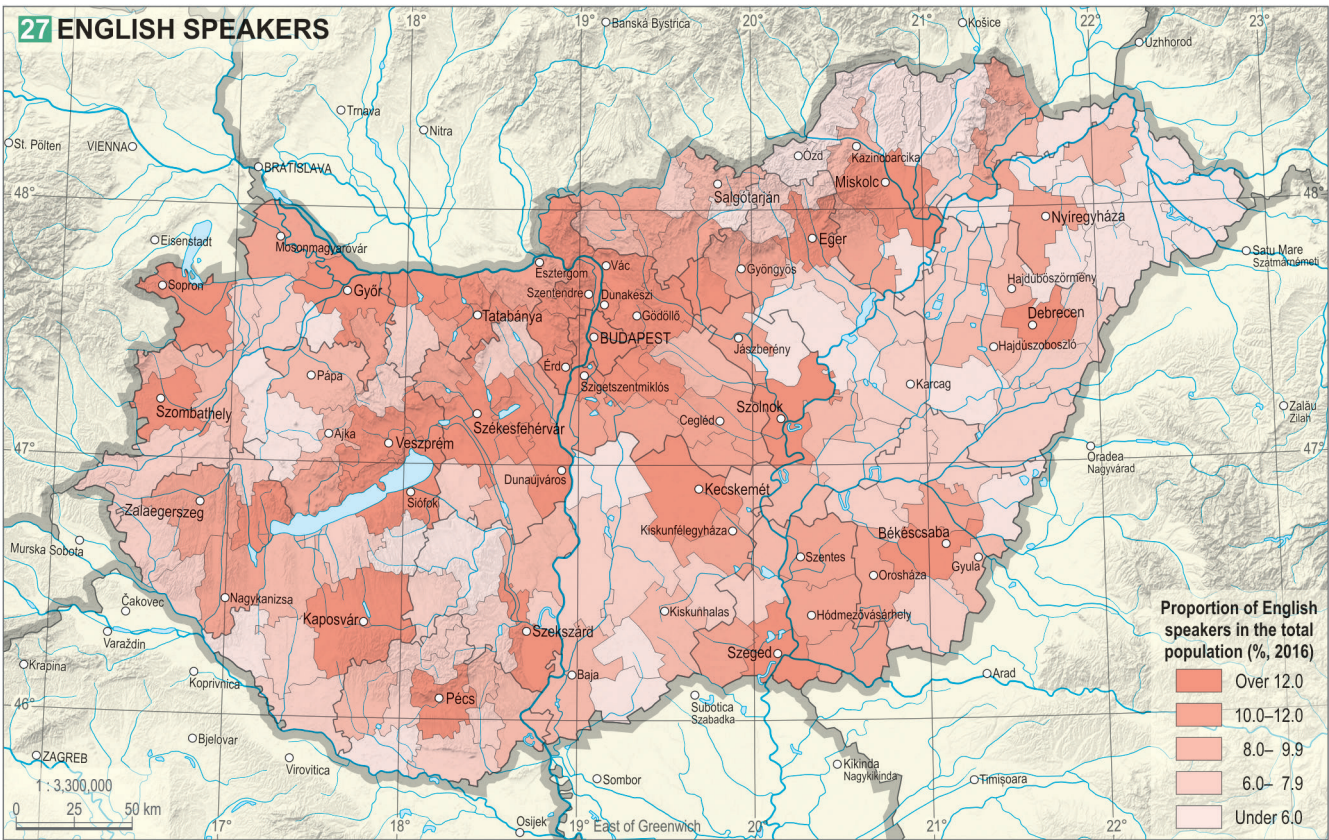
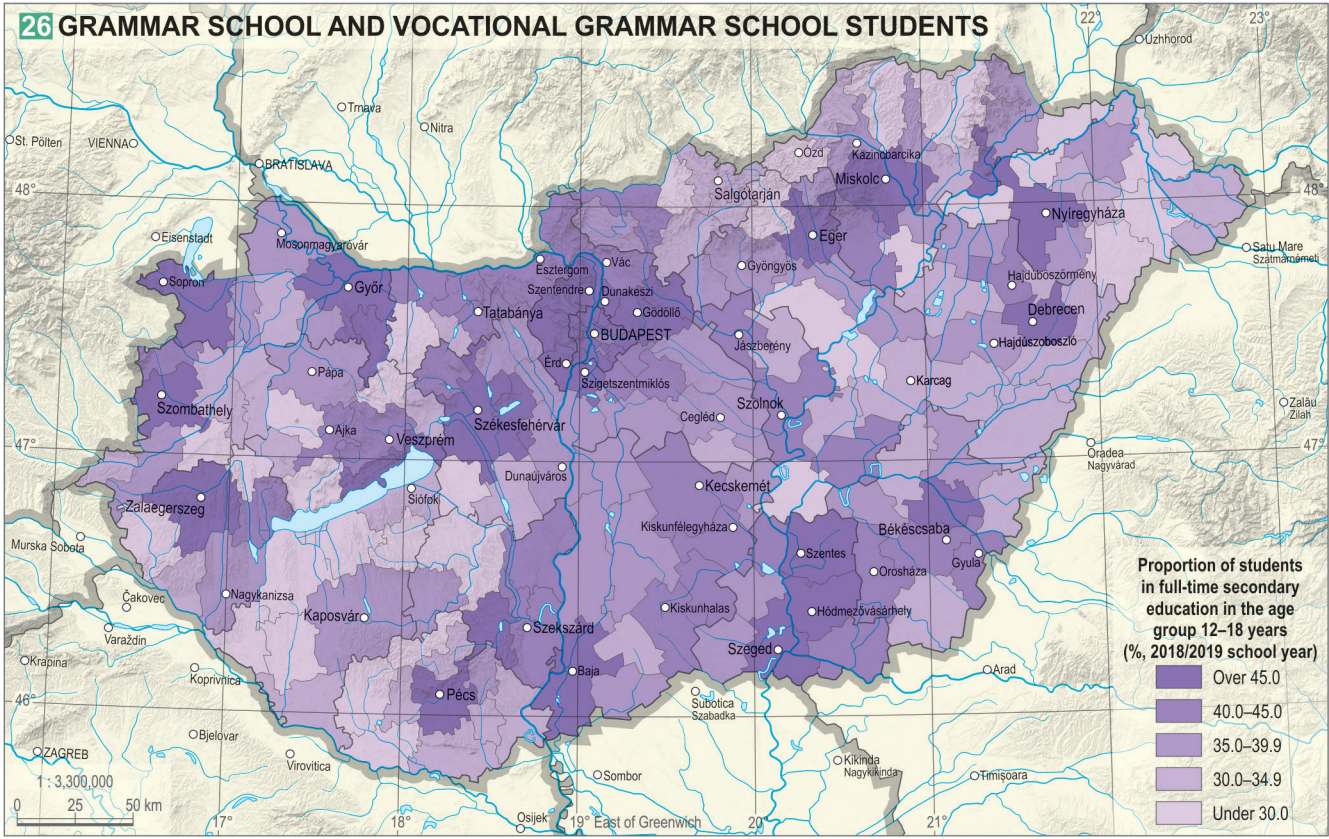
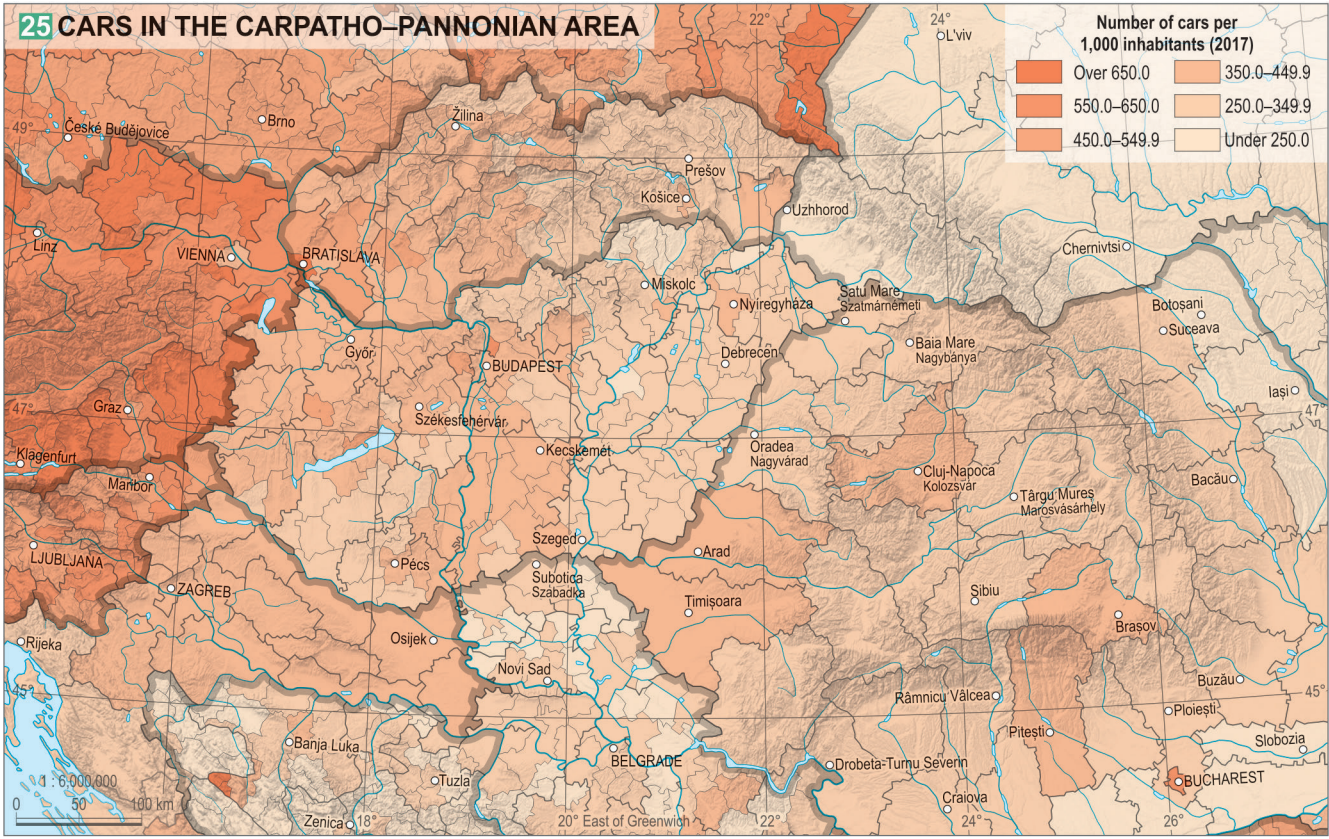
Language skills in Hungary are somewhat weaker in an international comparison. English has become preeminent in Hungary, displacing German, French and Russian, the latter of which had been compulsory in schools for many decades. In 2011, English was spoken by more people in the country than the three other languages combined. Only on the western border and in ethnic German areas has German retained its status. In terms of language skills, Budapest is the clear frontrunner, but its agglomeration



[4](#) An outdoor classical music concert in Pécs

24 SUPPLY OF HOUSEHOLDS WITH CONSUMER DURABLE GOODS (2018)

	Small household appliances					Entertainment electronic devices				Computer appliances		Telephone			Other		
	Refrigerator and freezer	Microwave oven	Dishwasher	Automatic and semi-automatic washing machine	Washing machine with tumble dryer	Colour television		Digital camera	Home movie system	Personal computer	Laptop	Mobile phone		Landline telephone	Air conditioning	Sophisticated alarm system	Own car
						Total	plasma, LCD, LED television					Total	Smart-phone				
	Appliances per 100 households (pieces)																
Budapest	79	89	30	89	2	146	100	36	7	47	81	193	97	66	21	14	57
Pest County	69	96	32	89	4	174	102	38	9	55	68	219	83	48	10	9	79
Central Transdanubia	74	92	21	88	6	161	97	29	7	51	54	203	123	55	7	3	73
Western Transdanubia	70	97	27	87	7	172	102	38	7	43	62	210	86	56	6	5	88
Southern Transdanubia	72	92	20	87	2	167	93	29	7	44	52	197	86	53	10	4	65
Northern Hungary	67	91	15	79	4	174	94	22	6	37	51	189	83	50	4	3	61
Northern Alföld	62	91	18	82	4	163	75	21	6	40	45	200	71	43	9	3	60
Southern Alföld	54	89	19	88	2	158	89	24	6	45	49	191	96	32	11	2	68
Hungary	68	92	23	86	4	163	94	29	7	45	59	199	91	51	11	6	68



also stands out. These areas are closely followed by the regional centres and the language teaching centres [XII.1.27.](#) The spatial structure of foreign language knowledge in Hungary is closely related to education, settlement size and access to educational infrastructure [XII.2.2.13.](#)

Literacy is also linked to the barely definable concept of culture consumption, which can possibly be measured by examining and quantifying *participation in cultural events* [XII.1.28.](#) Settlements with the highest level of culture consumption tend to have small populations and to host major festivals (e.g. Ka-



5 Book launch

polcs with the Valley of Arts, Tornabarakony with its folk art festival). Here, there is an ambivalent effect on local quality of life: on the one hand, the cultural events have a positive impact on the local economy; on the other hand, increasing attendance rates can have negative social and environmental impacts, which may impair quality of life.

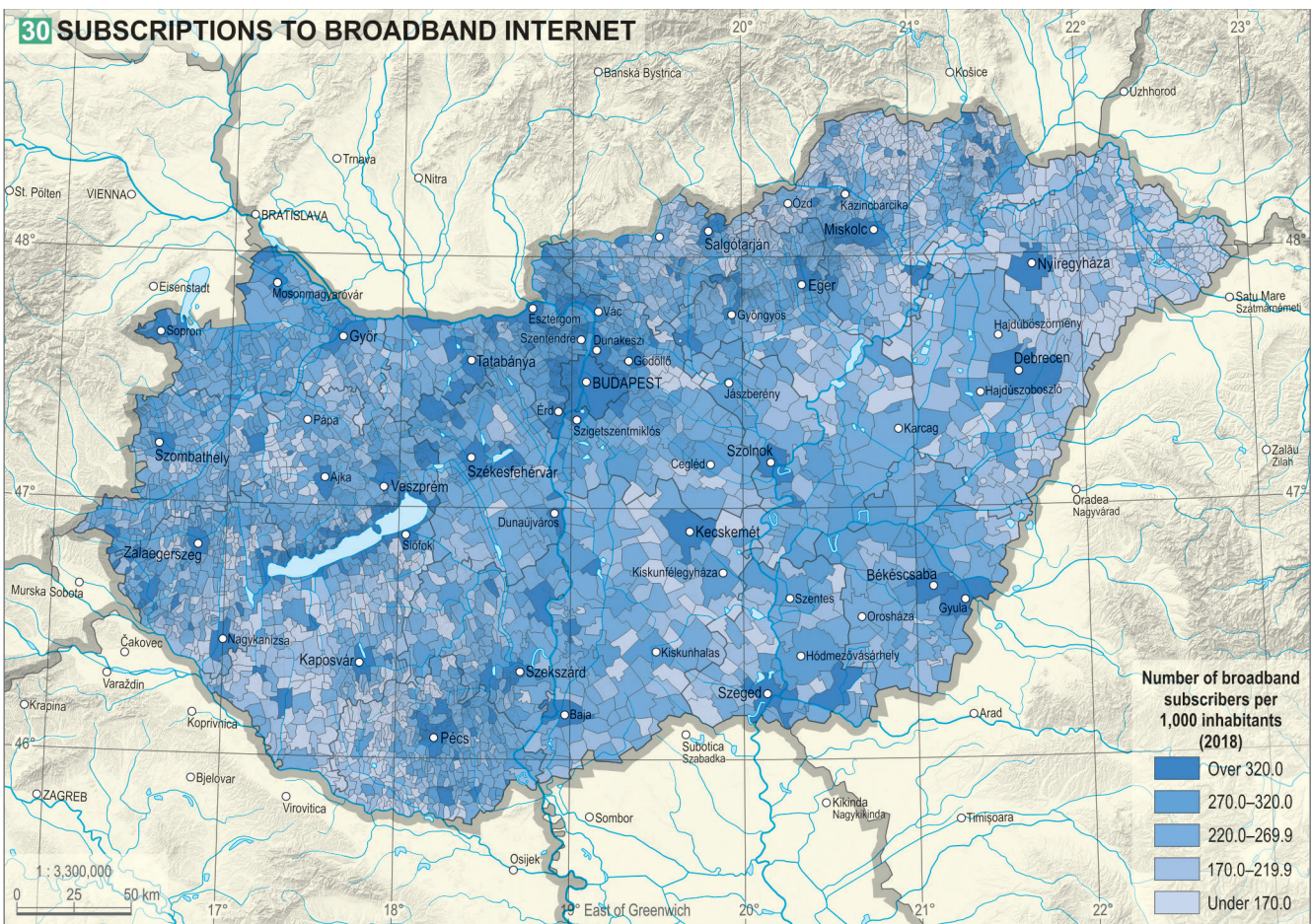
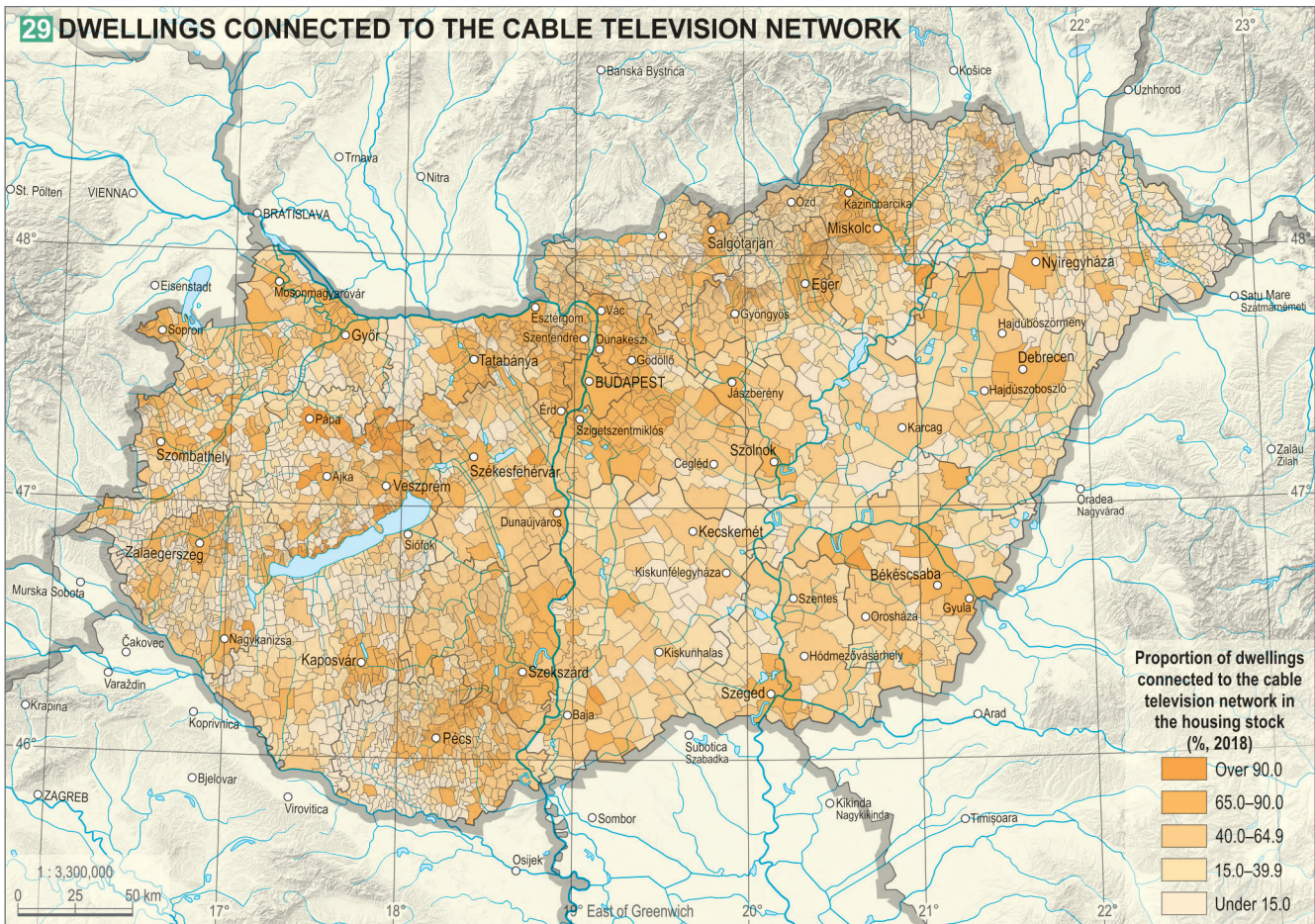
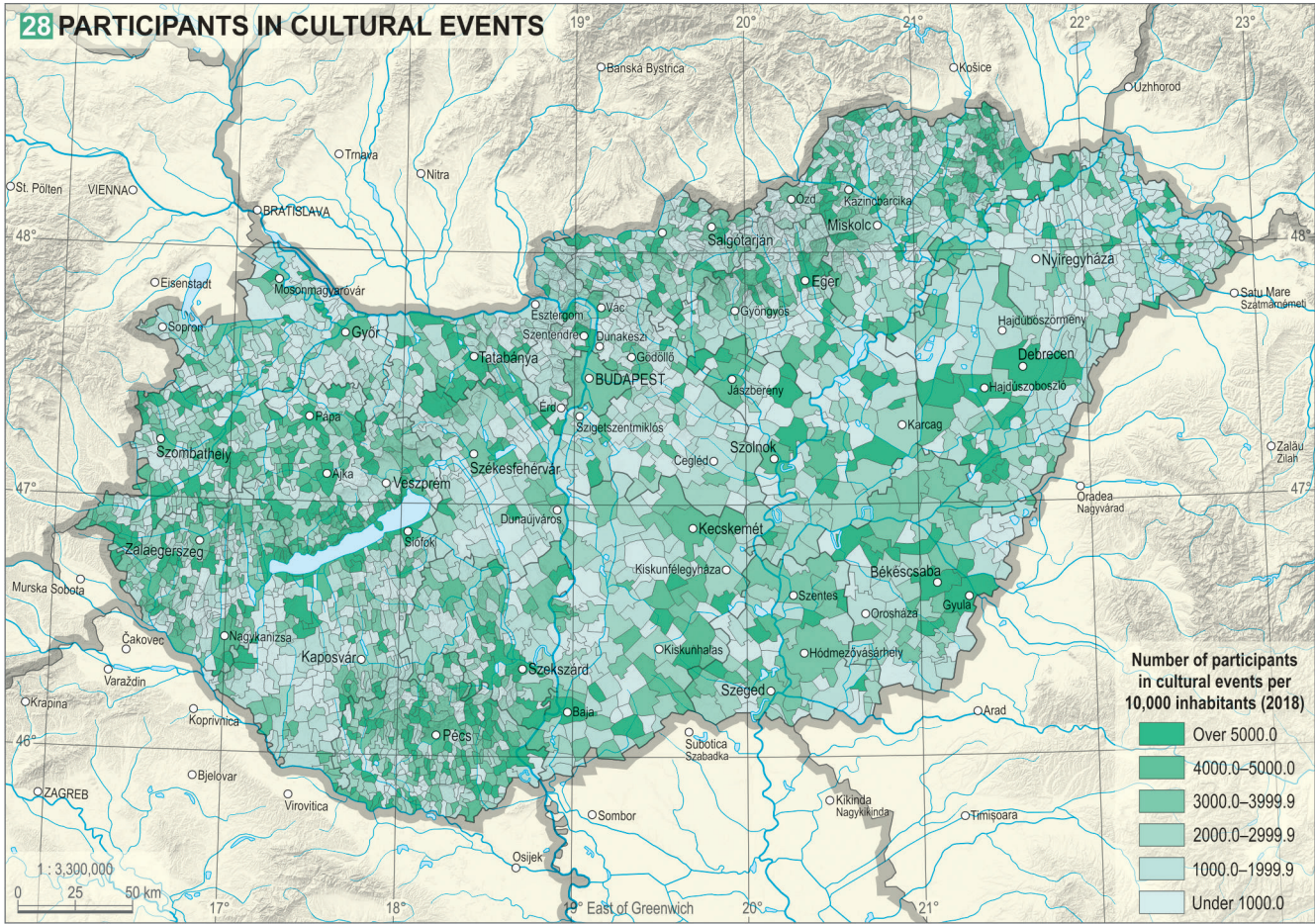
A consistently high level of culture consumption is most evident in Hungary's major cities [5](#). Here, such consumption may again be associated with the level of education, a higher proportion of people of high social status and a broader range of events. The well-known tourist destinations (e.g. Óriszentpéter, Bük and Hollókő), the centres of wine regions (e.g. Tokaj and Neszmély) and the shores of Lake Balaton likewise have outstanding values. Culture consumption is also a feature of those regions that have sizeable ethnic minority populations. This applies in particular to the ethnic German regions in the counties of Baranya and Tolna (e.g. Pécsvárad, Ófalu and Óbánya).

Our digital world – access, use and well-being

The digital world is of growing importance in the 21st century. Access to ICT networks and to the necessary devices is an increasingly important aspect of an individual's quality of life. Moreover, people need to be equipped to use such devices and pay for them (digital well-being). Many claim that humanity has entered the era of the 'information society', in which the most important resource is the ever broadening range of systematisable and analysable information [6](#).

Internet access of sufficient quality and the existence of services linked to it are becoming a basic need in the European Union. Nevertheless, service providers are not in a position to provide everyone with high-quality internet access, and this is true both in Hungary and in the rest of the European Union. Network coverage is not yet complete, and replacing older technologies is time consuming and capital intensive. However, a universal aim in the European Union is to ensure that everyone has access to a network connection guaranteeing download speeds of at least 30 megabits per second (Mbps) and to provide a network connection of at least 100 Mbps to at least 50% of subscribers. In Hungary, nearly 75% of subscribers had an internet connection guaranteeing download speeds of at least 30 Mbps in spring 2020. The average speed of the internet in Hungary is also high in a global comparison: this reflects the advantages enjoyed by 'late arrivals', whereby in Hungary modern technology could be used in the first place and there was no need to accommodate or eliminate an outdated network.

The existence of a network, however, does not nec-



6 Online education using mobile devices at a university

essarily mean usage, as this will depend on a number of social factors. According to surveys, people in their late 60s have fewer digital skills in Hungary: still, more than half of them can be considered regular internet users, but in the case of those in their 70s, this is less than 25-30%. Even in the most advanced and active societies, a small percentage of people – the so-called 'digital illiterates' – remain. Such people are unable or unwilling to use any information communication tools or channels. They leave no digital footprint (all the data generated by the online activities of users). Failing to acquire at least basic user skills at the right age [VI.5.4.](#) [VI.5.6.](#) is mainly related to the family background [VI.7.17.](#) and the impact of the school system. Furthermore, financial reasons [VI.7.14.](#) [VI.7.16.](#) may also mean that the acquired skills were not practiced because the right tools could not be purchased. Such people can only find employment in an ever-shrinking part of the labour market and get mostly low-prestige, low-paid jobs [VI.7.10.](#)

At the beginning of the digital age (1990s), most users in Hungary were men, but by the first decade of the 2000s the differences between the two sexes in this field had disappeared. However, education remains a dividing line: those who are considered functionally illiterate (a fifth to a sixth of each age group) can only use digital tools at a basic level; this group takes advantage of only a few of the services available. The relationship between income level and digital activity is similar [VI.5.7.](#) [XII.1.20.](#): only 70% of the lowest income decile (the poorest one million people) are considered digitally active, compared with at least 90% of the decile above.

Digital activity and provision in Budapest and its surroundings stands out in most indicators; it is 1.5 times the national average. Outside Budapest, differences between the country's various regions are moderate, especially compared to other social and economic indicators. Differences are greater in the settlement hierarchy, especially when a comparison is made between Budapest and small villages, with the differences being three- to fivefold in some cases. The relationship between knowledge of English and the level of digital activity is clear [XII.1.27.](#)

Broadly, the same spatial structure is shown by the proportion of broadband subscribers and dwellings connected to the cable television network [XII.1.29.](#) [XII.1.30.](#) Regional differences in the development of landline and mobile networks and in the use of devices have decreased considerably. This is important because reliable, fast internet access can make many tasks in life easier (e.g. purchases and the payment of bills and taxes). The Covid-19 pandemic in 2020 and 2021 has brought about significant changes in digital everyday life (e.g. working from home, online education, watching movies, listening to music and ordering food), and most of these changes may become a permanent part of our lives.

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Revised by

Ferenc Probáld, Gábor Gercsák

English translation by

Richard William McIntosh

English translation revised by

Andrew Gane, Gábor Gercsák, Ferenc Probáld

Cover design

Geographical Institute, RCAES, Ildikó Kuti – Civertan Bt.

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Ildikó Kuti – Civertan Bt.

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SOCIETY

Authors

PÉTER BAJMÓCY
LAJOS BÁLINT
PÁL BELUSZKY
LAJOS BOROS
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†BÁLINT CSATÁRI
ZOLTÁN DÖVÉNYI
TAMÁS EGEDY
SZABOLCS FABULA
TAMÁS FARAGÓ
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GÉZA TÓTH
PÁL PÉTER TÓTH
ANDRÁS TRÓCSÁNYI
ANNAMÁRIA UZZOLI
ANDRÁS WÉBER

Authors of maps and figures

NORBERT AGÁRDI
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PÉTER BAJMÓCY
LAJOS BÁLINT
DÁNIEL BALIZS
ANDRÁS BALOGH
OLGA BARANYAI
ZSOMBOR BARTOS-ELEKES
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†ANDRÁS BOGNÁR
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KÁROLY KOCSIS
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SÁNDOR SZÜCS
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†ÁRPÁD E. VARGA
GÁBOR LÁSZLÓ VASÁRUS
ANDRÁS WÉBER
JERNEJ ZUPANČIČ

Chief cartographers

FANNI KOCSÓ
ANIKÓ KOVÁCS
GÁSPÁR MEZEI
ZSOMBOR NEMERKÉNYI

Contributors to cartography

NORBERT AGÁRDI
LAJOS BÁLINT
ZSOMBOR BARTOS-ELEKES
ZSOLT BOTTLIK
GÁBOR DEMETER
RENÁTA SZABÓ

Technical staff

MARGIT LACZKÓ
ÁRPÁD MAGYAR