

Ageing and Care for the Elderly in Hungary

General Survey and Problems

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- The burden of social care in Hungary is constantly increasing. The over-65 age demographic now numbers 1.8 million people, around 1.3 million of whom live with some form of disability. However, care close to the home (home help) is accessible to just 7% of those in this category. Only 3% of elderly people are able to take advantage of specialist care in a nursing home, while those on the ever-lengthening waiting lists already number more than half of those already in care institutions. No new places in state-funded nursing care accommodation have been created in the last eight years.
- All municipal governments are obliged to provide certain basic social services (catering, home help). Their capacities, however, are unevenly distributed: In some areas as many as 80% of elderly inhabitants are guaranteed care services, while in others the figure is only a few percent. The system is characterised by a lack of available information: only about one third of elderly people are actually aware of what they are entitled to.
- The Hungarian state currently only spends about 0.4% of GDP on care for the elderly, with a minimal year-on-year increase. Financing is provided through a kind of planned economy: the funds specified in the budgetary law are not earmarked for any actual expenses related to care provision.
- The care deficit, meanwhile, continues to grow. The number of professional carers is declining, as wages in the social sector are the lowest in the entire national economy, which means that since 2010 the number of unfilled job vacancies has steadily increased. The average age of professional carer is around fifty, meaning that a large proportion will shortly retire, and more and more positions are filled by unskilled labour.
- The number of family carers stands at around 400,000–500,000, of whom a total of only around 20,000 receive the legally mandated private care stipend. Many are unaware that they are entitled to this financial support. The number of family carers is low by European standards, and a variety of factors contribute to their continued decline: an ever-increasing number of elderly people do not have living children, and even if they do, those children have often moved abroad. The number of divorcees, meanwhile, continues to rise.
- The consequences are already apparent: if the state does not reassess its role in the care crisis, an ever-greater number of vulnerable elderly people will be left without professional care, or indeed any form of assistance whatsoever.

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1. Introduction

The social and political problems caused by the ageing demographic profile of welfare states are multifaceted. Among other issues, they call into question the sustainability of social security and the pension system, and raises issues around quality of life in old age and long-term care¹. All these issues also intersect, however, with the politics of employment and equal opportunities, since home care work is largely carried out by middle-aged women. Work in the social sector is generally considered a low prestige occupation, and is among the worst paid. In addition, private carers often find it difficult to balance the obligations of work and care.

Elderly care policy can be broadly defined as a specialist policy domain dealing with the needs, social role and quality of life of the elderly (aged 65+). It is also based on the idea of a social consensus between the generations. The goals of the elderly care policies of the state must be to ensure that all necessary assistance and resources are available to the elderly, and to their formal and informal carers, to ensure that need is equalled by capacity. This, however, is not presently the case: In many capitalist societies we see both an ageing population and a continual depletion of care capacity for the elderly. Fraser calls this process a 'crisis of care.' (Fraser, 2016).

In the following study I try to show that the rapid increase in care requirements, driven by demographic change, are beyond the capacity of either the state or the family to meet. Since Hungary joined the EU, its elderly care policy has been characterised by a neoliberal approach which primarily aims to minimise expenditure. This is reflected in the stagnation of both care funding and the number of carers, as well as in underpaid staff in the nursing and care sector and the rapid increase in the number of patients per caregiver. Only a quarter of those in the 65+ age group

are able to avail themselves of any kind of social care. With limited access to state-funded care, we might expect that families – and in particular women – would shoulder the care burden, but the data does not support this. Low remuneration for carers and the lack of relief services, as well as changing social attitudes and women's own career goals, mean that ever fewer are willing to take on care roles, particularly in intensive care. For these reasons, the number of caregivers for the elderly is extremely low in Hungary in comparison with other EU states: just 8-10% of the adult population. We may consequently assume that the number of elderly people with unmet care needs is high. This in turn means that care becomes more and more of a commodity: the market response to this lack of capacity is the establishment of quasi-legal or illegal solutions which often rely on forced labour and further increase inequality.

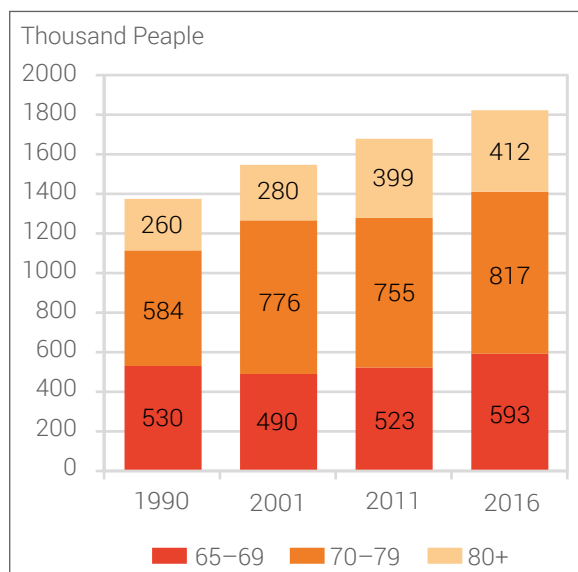
2. Growing Need

Between 1990 and 2017 the number of those aged 65 and older in Hungary increased from 13% to 19% (presently 1.8 million people) and according to predictions it is set to reach 29% (2.7 million people) by 2070. An examination of the internal dynamics of this age group shows that both the number and relative proportion of those aged 80 and above – the very elderly – is increasing rapidly. While this group numbered just 260,000 in 1990, according to the Hungarian Central Statistical Office (HSCO) there were 412,000 by 2016 (figure 1).

The difference between the sexes is significant: 57% of those aged between 65 and 69, and 73% of those aged 85 and above, are women. For men at age 65, average future life expectancy rose from 12 to 14.4 years between 1990 and 2016, while among women it rose from 15.3 to 18.2 years. In the years since 2000, women have lived an average of 3.6 – 3.8 years longer than men.

¹ In the international professional literature, long term care (LTC) refers to all forms of financial support and services supplied under the rubric of personal care, which assist the elderly in maintaining their everyday standard of living (whether short or long term, formal or informal, health-care or social support).

Figure 1: Changes in numbers in elderly age groups



Source: Monostori-Gresits (2018) 132. o. figure 3

At the same time, life expectancy does not equate to years spent in good health, so the statistics also examine the average future expectancy of years in good health from age 65. According to HSCO data, men who were 65 in 2016 could expect 6.7 further years of good health, while among women the figure was 6.4 years (Monostori-Gresits, 2018). These figures, and those of the WHO, are in contrast to the latest data from EUROSTAT, which uses a different methodology², and according to which women in Hungary live in good health for an average of 60.2 years, while the same figure among men is 59.5 years (EUROSTAT, 2019).

From a care perspective, one of the most deprived groups are elderly people living alone. According to data from a 2016 microcensus, 31% of those aged 65 and above lived alone (554,000 people). 11% of women and 21% of men aged 65 and above had no living children who could care for them in time of need, and these figures worsen as age increases. The preponderance of women is significant: 40% of women over 65 live alone,

but just 17% of men. Living alone, however, is not only a result of bereavement: the rate of divorce is also increasing. While in 1990 the proportion of divorcees among elderly men living alone stood at 17%, and that among women 9%, those figures had increased to 27% and 16% respectively by 2016 (Monostori-Gresits, 2018). This is an important tendency, as among the very elderly the caregiving role of a spouse is especially valuable (the very elderly generally no longer care for their parents, but for their spouse (cf. Huber et al, 2009).

The most complete picture of the nation's health is provided in data from the 2014 EHIS or European Health Interview Survey, according to which 18% of those aged 65 and older judged their health condition to be bad, and 10% very bad. The older a respondent was, the worse they were likely to consider their health: among those between 65 and 74, 22% judged their health to be either bad or very bad, but this rose to 30% among those over 75, and 40% among those over 85. Among all age groups, women give a more negative judgement of their health than do men. 80% of those over 65 reported themselves as having a chronic illness. Among the elderly, 39% reported a serious, health-affecting motor or sensory impairment, and 35% reported a chronic but non-serious impairment. (The proportion of elderly people living with some form of impairment is thus 74% in total, or approximately 1.3 million people). The most serious problems in this category of illnesses are motor impairments which limit the ability to walk, thus also impairing the ability to manage a household. While among those aged 65 to 69, 11% reported experiencing difficulties in doing the housework, this rose to 21% of those aged 70-74, and 62% of those aged over 85 (Monostori-Gresits, 2018).

Mental health issues are also common among the very elderly. The likelihood of severe depression is highest among those aged over 80 (24%), and a further 19% show symptoms of depression. The increase in care needs is also closely

² According to the WHO (European Health Information Gateway) the expected number of healthy life years at birth in 2015 in Hungary was 79.1 years for women and 72.3 years for men. The EUROSTAT estimate is based on respondents' self-evaluation of their health, which many health-care professionals consider more reliable than the more clinical criteria of the WHO estimations. Considering that among those over 65, 80% suffer from a chronic illness, we may agree that the EUROSTAT data clearly appears more reliable.

linked to the rise in the number of elderly people affected by dementia. Dementia is a collection of symptoms and a category of illness, and in this latter sense belongs among mental-behavioural disorders as an organic and symptomatic mental illness which is most commonly caused (in 60-70% of cases) by Alzheimer's disease. Dementia is divided into three categories according to its severity: mild, moderate and severe. The relative prevalence within Hungary can be deduced on the basis of international surveys. In Europe, 6% of those over 60 suffer from some form of dementia (in those over 90 the figure is around 30%). According to WHO data, in 2017 around 10 million people in European countries suffered from dementia, and this figure is expected to double by 2030.³ Estimates suggest that between 200 and 250 thousand Hungarians have some form of dementia (Érsek et al. 2010, 176). The final stage of dementia entails very high care requirements (24-hour supervision) and costs which are a struggle for either the family or the state care system to bear.

The economic sustainability of the care system is shown by the population maintenance rate,

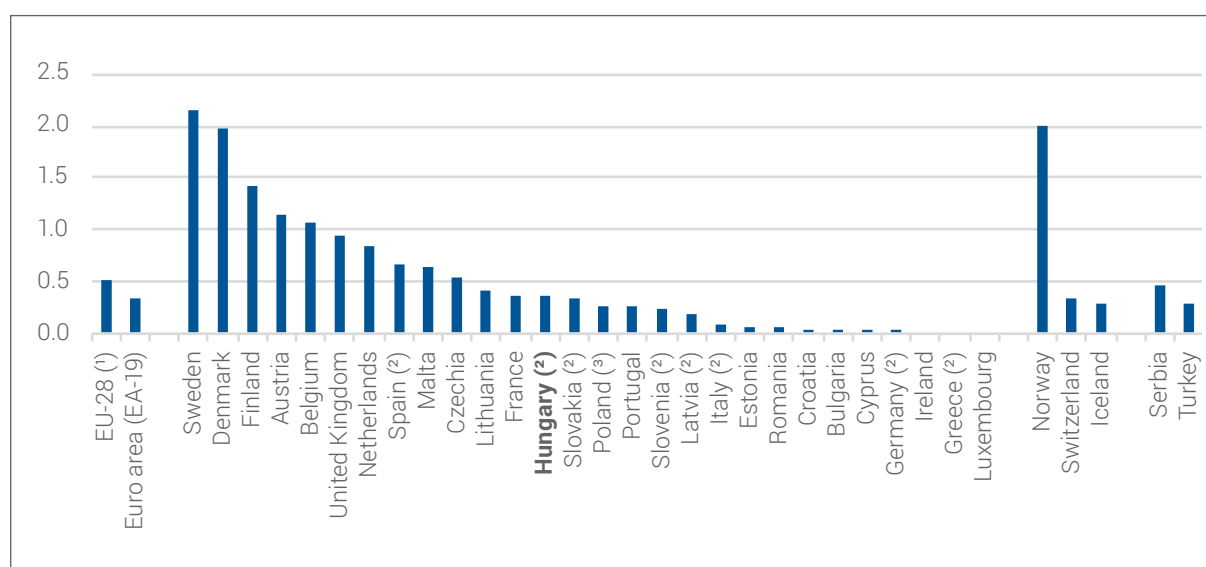
which gives the number of those aged 65 and over per 100 working-age people in the country. Between 1990 and 2017 this figure grew from 20 to 28, and by 2070 it is expected to reach 52, thus for every two active people there will be one elderly person. According to EUROSTAT's calculations, in 2015 the 28 Member States of the EU spent an average 0.5% of their GDP on care for the elderly, with Sweden and Denmark paying the most at about 2%. Spending about 0.4%, Hungary is below the EU average⁴ (by way of comparison, in 2015 Hungary spent 3% of GDP on supporting families with children).

3. Accessibility and financing of social care for the elderly

3.1. Types of social care for the elderly

The social care system (state-managed institutions, financial allowances, services, rights, number of accommodation spaces, opening hours etc.) is regulated by Act III of the 1993 law on social care (Social Law or Szt). This law provides for financial support, including a care allowance

Figure 2: State expenditure on care for the elderly as a percentage of GDP



Source: EUROSTAT

³ <https://www.who.int/news-room/fact-sheets/detail/dementia>

⁴ https://ec.europa.eu/eurostat/statistics-explained/index.php/Social_protection_statistics#Analysis_of_the_structure_of_social_protection_expenditure

for family carers, but this is discussed in more detail in a later chapter on informal care. Within the sphere of personal care, this Social Law differentiates between basic social services and specialist care. The provision of basic social services is generally a mandatory duty of the local government, which is financed from the central budget. Beyond this, local governments may voluntarily maintain any other form of specialised social care. Other non-state institutions (NGOs, churches, business associations etc.) may also maintain social services, but are obliged to first obtain an operating licence. Thus, these organisations are also included on the national register of operating licenses (MÚKENG) (regardless of whether or not they receive state subsidies.) Services provided within the domain of personal care are covered by a separate decree (29/1993. (II. 17.) Gov. Decree) which stipulates that certain defined collective costs (institutional or personal costs, which in the case of retirement homes may also include entrance fees) must be reimbursed to the carer.

Among those services covered in the Social Law I will focus here on those dealing with care of the elderly. Among basic social services, those affecting the elderly include the village and rural caretaking service, catering, home help (including on-call home help) and daytime care. Specialist care comprises nursing provisions, including that provided by residential care homes, as well as institutions ensuring the availability of temporary accommodation (nursing homes for the elderly). In two places I add 'for the elderly' but not for those services provided in the Social Law, as these cover the whole gamut of social service provision.

3.1.1 Basic social services

Village and rural caretaking service. The goal of the village and rural caretaking service is to minimise the disadvantages, in terms of service provision, which stem from living in either a small village, an outlying location or a rural environment, as well as to provide services meeting certain basic needs, and to ensure access to basic public ser-

vices. Their obligations are not precisely defined, and in many settlements the village caretaker, in addition to making deliveries, also provides home help assistance.

Catering. Within the framework of social catering, the local authority is obligated to provide at least one hot meal per day to socially deprived persons who are unable, either alone or through their dependents, to provide for themselves on either a long-term or short-term basis, particularly, for instance, because of their advanced age.

Home help. All municipal authorities are likewise obliged to ensure home help for socially deprived persons who require help in maintaining their independence. This care service is available after means-testing, which determines whether the applicant is eligible for social support or personal care. (If, on the basis of this means test, it is determined that the applicant is ineligible, home help can still be obtained if the recipient pays the service cost.) The framework of social help also includes an obligation to help with cleaning, to participate in household activities, and to help avoid and prevent possible accidents or emergencies. Personal care includes an obligation to ensure the completion of all nursing and care tasks.

It does not fall under the scope of the Social Law, but home help provision is similar in its aims to *specialist home nursing*, an elderly care initiative launched in Hungary at the end of 1996, which was publicly financed through the National Health Insurance Fund (OEP) as a public health service. Its goal was to transfer hospital nursing activities to the patient's home, along with other achievable forms of specialist care and therapy. Specialist home nursing takes place in the patient's home or place or residence, at the request of the patient's consultant physician, and is conducted by a qualified specialist nurse.

On-call home help. On-call home help is a home help duty which the state delegates to a designated body (presently the Hungarian Directorate-General for Social Affairs and Child Protection⁵)

5 This public body maintains specialist child protection institutions, including residential care for children with learning difficulties.

as a taskforce to help socially deprived persons who, while maintaining independent lives, need help in dealing with crises which may arise (for instance accidents, fainting fits, break-ins). This service is available 365 days a year, 24 hours a day. In the event of a call, the dispatch centre must ensure that the on-call carer reaches the location as quickly as possible, that action is taken immediately to resolve the problem, and, if necessary, that other health or social services are informed. The service is available chiefly to those aged 65 and above, and/or to the severely disabled.

Daytime care (elderly club). Daytime care must be provided by all municipalities of over 3000 inhabitants to disadvantaged elderly people who require help in maintaining their independent lives and social connections. The services provided vary, but can include organising free-time activities, consulting, life-coaching, help with official administration, group organising etc.

3.1.2 Specialist care

A nursing and care institution (residential care home) serves to provide accommodation and care for people who are incapable of looking after themselves, or are capable only with continual assistance. These institutions must provide at least three meals a day, as well as mental care and a defined level of healthcare provision. In addition, they must ensure adequate living quarters and, if necessary, provide clothing and other textiles. An elderly care home provides care for people with a given degree of required assistance, but cannot offer the treatment provided by a specialist care facility for the permanently bedridden. Anyone reaching the age of retirement is entitled to reside in one. A new category – in fact a post-hoc sanctioning of the current situation – was introduced into the Social Law in 2016: specialist care centres (residential care homes which also offer professional nursing) after it became clear that the majority of those in elderly care homes actually required specialist nursing care.

Institutions providing temporary accommodation (elderly care homes) provide full-time care for a

temporary period of up to one year. This class of institutions includes care centres for the elderly which, among other tasks, ensure care for elderly patients who, because of illness or for some other reason, are temporarily unable to take care of themselves. Municipalities with a population of over 30,000 are obliged to provide such a service. As just one third or so of those in such centres actually require only temporary care (usually, for instance, after discharge from hospital) and the other two thirds are merely waiting for an available space in a residential care home, a 2017 amendment to the Social Law stipulated that from 2023 temporary care homes should be transformed into residential care homes.

At this point we must also draw attention to one other service which, though not strictly falling under the rubric of social care, ensures long-term housing for the elderly (lease until death). These are so-called retirement homes, and their establishment and operation are governed by the same legal rules which cover normal residential buildings. Retirement homes are operated either by local municipalities or free-market service providers, and are designed for elderly people who are capable of looking after themselves. Aside from a reception desk, 24-hour supervision and cleaning they offer no additional services, and so do not provide nursing care (but may, on request, subcontract social service providers to carry out social care functions). In many instances these institutions operate at a loss, and so municipalities have recently begun transforming retirement homes into residential care homes in order to access support funding. In other instances they operate illegally on a free-market basis (Sarkadi, 2008) so there is no public register showing the number of available places or of the number of residents, nor of the services they provide.

3.2. Financing social services

We have observed in the above that the basic social services which the local municipality is obliged to provide include ensuring vulnerable residents receive hot meals, as well as home help. In addition, municipalities with more than 3,000

residents must provide daytime care, and those with over 30,000 must provide an elderly care home. This means that the obligation depends only on total population, but there is no link to the actual number of residents who require these services. In addition to the municipal government, the central government is also involved in carrying out these public duties, as are a number of non-governmental organisations (e.g. churches, business societies and non-profit organisations).

The central budget helps finance local government care obligations, and supplies social and institutional funds, as well as providing ring-fenced financial support for certain tasks. At the same time, state support is not universal, as the known operating expenses are linked to the so-called 'anticipated revenue', which depends on total local government revenue. (That is, state support drops with increased municipal revenue, in a ratio determined by a municipality's so-called tax-strength capacity.)⁶ Poorer municipalities may also request special support to fund the provision of their care obligations, and may levy a fee upon care recipients, to a degree, in a manner and by a method of calculation specified in the Social Law (a separate decree regulates whom the municipalities may levy this fee upon.)

Table 1: Fees

service	fee
village and rural caretaking service	none
catering	max 30% of income
home help	max 25% of income
daytime care	max 15% of income
temporary accommodation	max 60% of income
residential care home	80% of revenue + admission contribution determined by provider

Source:

The role of state guarantor is performed by the Directorate General for Social Affairs and Child Protection, which was set up in 2012 as a consequence of centralisation efforts. It took over from local governments the running of specialist childcare institutions, as well as several other residential institutions (177 institutions in total). Financing is provided through the annual state budget act, and amounts to approximately 13 billion forints annually, which supports around 50,000 care recipients and 2,300 employees nationwide (Mohácsi, 2015).

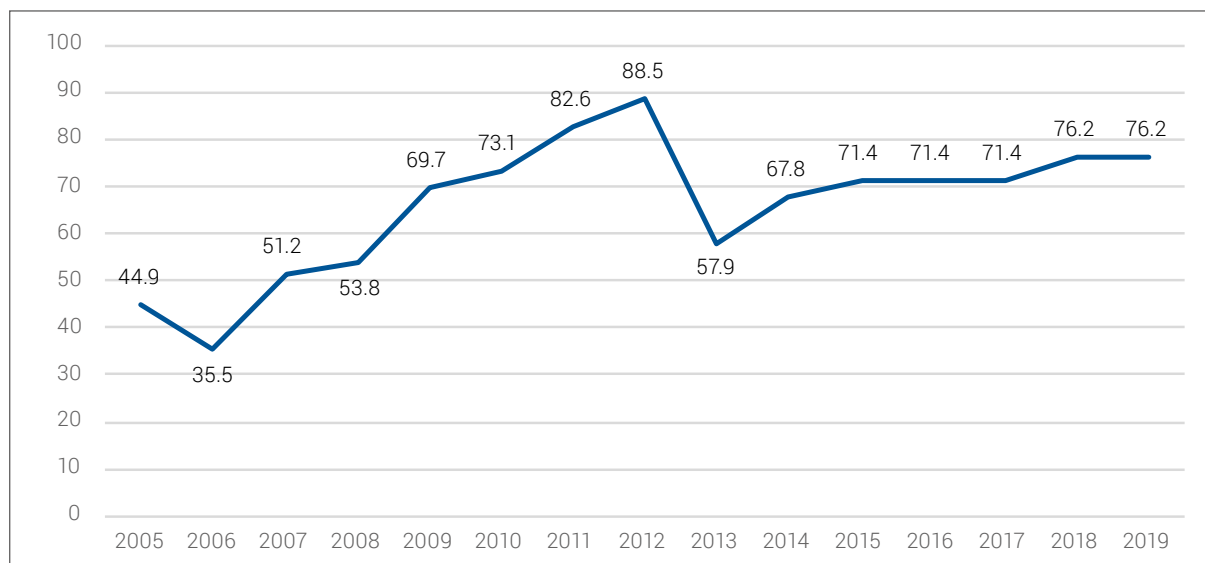
Among non-governmental organisations, special attention should be paid to the role of churches as social care providers, since the institutions they maintain not only receive support from local governments, but are also given a share of the so-called 'supplementary church support fund.'⁷ This presently amounts to 76.2%, which is a cause of significant tension with other care providers. This support increased dramatically beginning in 2007, though it did drop significantly in 2013.

Until 2013, budgetary support was provided on a normative basis, that is it was based on specific costs, and tied to the number of care recipients. In 2013, however, a process of centralisation among caregivers was begun (the official explanation was that this was a consequence of debt consolidation, and an effort to prevent further indebtedness) which has led to the state taking more tasks out of the hands of municipal governments (e.g. primary education, child protection, residential care, and among basic social services the on-call home help system). An attempt was then made to link support for the remaining tasks to specific task-related indicators (number of available places, care days, care hours etc.). The essence of task-based financing is that the state ensures ringfenced financial support for certain local tasks, to a degree which decreases proportionally with the tax-strength capacity of the municipality. In effect, this type of financing results in a form of planned economy (Bordás, 2017). At

⁶ Tax strength capacity is calculated on the basis of per-capita income from business tax.

⁷ According to the Act CXXIV of 1997 on the Financial Conditions of Religions and Public Purpose Activity of Churches, churches receive a supplementary fund.

Figure 3: Normative change in additional church support



Source: Regulation governing the implementation of the annual state budgetary laws

present it has only been possible to implement this system among long-term residential institutions (here the operating costs and wages are currently paid by the state, which reduces the fees paid by residents) while other services are still funded through ringfenced state support. In addition, the Social Law also includes something called ‘capacity regulation’, which means that whenever a specialist care provider, or any care provider not linked to the municipal government, wished to increase care capacity or adopt new care recipients into the existing financing system, this can only be done with special ministerial permission and under strict conditions.

The funding cost chart (expenditure per person) (chart 2) established on the basis of the annual state budget, clearly shows that since 2011 there has been no increase in catering expenditure. Support for home help actually decreased in 2013, before the financial restructuring which took place in 2017. Village and rural caretaking saw a substantial increase in funding in 2015. The last, minimal increase in daytime care occurred in 2013, while care costs for dementia patients increased by around 100,000 forints (though even this does not cover the staffing costs of care). In

the case of residential care for the elderly, since 2013 this has been funded through task-based financing, so the figures from the budgetary law show only the total budgetary support provided – this total indicates a slight year-on-year growth.

The preferential financial support for church-based care providers, the centralisation of care and the introduction of task-based financing and capacity regulation, all mean that local municipalities are progressively less motivated to maintain either basic social or specialised care facilities. In long-term residential care for the elderly and home help provision, the number of care recipients provided for by churches is only slightly less than those provided for by local municipalities (table 3). In a response to a 2019 opposition interpolation, however, it transpired that the state is continually transferring residential care places to church ownership: “Over the past several years the maintenance of 3087 residential care facilities has passed from the Directorate-General for Social Affairs and Child Protection to church control, affecting 25 locations.”⁸ Compared to 2014, data from sectoral statistics indicate that 2240 places in residential care homes have been transferred to church control.

8 K / 4135 doc. 1. Bence Rétvári’s response to Lajos Korózs’s interpolation

Table 2: change in budgetary support (in Hungarian Forints)

Service	2011	2013	2015	2017	2018	2019
Social catering (per person)	55,360	55,360	55,360	55,360	55,360	55,360
Home help (per person)	166,080	145,000	145,000	Help: 25000 care: 210,000	Help: 25000 care: 210,000	Help: 25000 care: 210,000
Village/rural caretaking (service)	2000,000	2000,000	2000,000	2000,000	2000,000	2000,000
Elderly daytime care (per person)	85,580	109,000	109,000	109,000	109,000	109,000
Dementia daytime care (per person)	405,600	500,000	500,000	500,000	500,000	500,000
Residential elderly care (per person)	635,650	20.9bn	22.3bn	22.3bn	23.6bn	24.8bn
Residential dementia care (per person)	710,650					

Source: Budgetary Laws (own compilation)

Note: Table only shows those years in which a change took place. All figures are in Hungarian forints, and unless stated otherwise show cost per person.

Table 3: number of places / care recipients according to care provider, 2019

Service	Municipal	Church	State	Non-state non-profit	Non-state other	Total
Village caretaking service	16,370	11	0	1	7	16,389
Rural caretaking service	5,405	1,034	0	208	427	7,074
Home help	62,609	50,800	132	4,107	4,326	121,974
On-call home help	17,856	1,478	1,215	835	455	21,839
Daytime care	32,824	4,599	40	950	723	39,136
Temporary care facility	1,430	232	30	580	710	2,982
Residential care home	20,077	15,212	8,141	4,203	7,577	55,210

Source: Sectoral administrative data (MŰKENG) (own compilation)

Table 4: number of sites

Service	Number of sites	Number of places / recipients
Catering	2,198	176,407
Village caretaking service	981	16,389
Rural caretaking service	452	7,074
Home help	1,333	121,974
On-call home help	204	21,839
Daytime care	1,113	39,136
Residential care home	865	55,210
Temporary care facility	178	2,982
Total	7,324	441,011

Source: Sectoral administrative data (MŰKENG, 2019) and for catering TEIR, 2017. (own compilation)

Note: There may be overlaps in terms of service recipients.

3.3. Data on care recipients, and inequalities in service accessibility.

Nationwide, 7324 municipalities offer some form of care service for the elderly. Only 7% of those within the eligible age group, however, are able to take advantage of home help provisions, and only 3% can make use of residential care facilities.

The problem, however, is only partly down to a lack of capacity. What exacerbates this lack is the unequal territorial distribution of services, characterised both by mismatches between need and availability in certain areas, and by inequalities in service provision even where facilities do exist. Both regulation and funding ignore the disadvantages of an urban-oriented policy plan: statutory regulations, for instance, based on population (and not on the number of those requiring services, which is often higher than the national average in smaller communities as a result of their ageing populations). Such regulations do not, therefore, guarantee equality of access to services.

In 2015, home help was available in 91% of municipalities, and a catering service was available in just 86%, despite the fact that all municipalities are obliged to provide such a service. Many

municipalities are only able to provide these two services as a so-called 'subsidiary municipality,' in a system whereby carers travel out from a nearby 'managing' municipality. This is the basis upon which, nationally, one third of municipalities provide home help and half provide a catering service (the figures for small settlements are 11% and 37% respectively). Elderly clubs are provided by 41% of municipalities, but only a third of those with under 1000 inhabitants, though it is true that in their case this is not an obligation. (Bácskay, 2017). But even where services are available, capacity does not match need. *"For instance, based on the number of recipients of one of the most widely used services in home help, there are districts in which the number of available places in retirement homes amounts to some 85 per 100 inhabitants over 65, while in other districts not a single place exists. Accordingly, the data of utilisation shows some marked extremes. The proportion of elderly people provided for varies from 1% to 80% in those settlements where any care provision exists at all ... In the social care system, care recipients – to put it bluntly – merely 'fill the place at their disposal' in a system where the space for manoeuvre is at time determined more by professional politics, the governing bodies of service providers, civil and church organisations and state organs charged with distributing funds among available places."*

(Goldmann-Mester-Gyetvai, 2016, 375-376) A further problem is lack of information. In places, for instance, where no service is provided, there is also no information about the rights elderly people have to such provisions (Kostyál, 2009).

There is very little socio-economic data available on care recipients: generally only the age and sex distribution are known. In institutions which provide nursing care, the proportion of those aged over 60 is 77.3%. The proportion of those receiving home help who are over 60 is 94.6%, among those receiving daytime care it is 58.4% and among those receiving home catering it is 86.5%. The majority of those who receive home help provision and social catering, and who are looked after in care and nursing institutions, are elderly women (Goldmann-Mester-Gyetvai, 2016). By European standards, the proportion of those living in institutions in Hungary is rather low, but since the 1970s the numbers have steadily increased (between 1993 and 2017 the figures almost doubled, rising from 30,155 to 55,770).

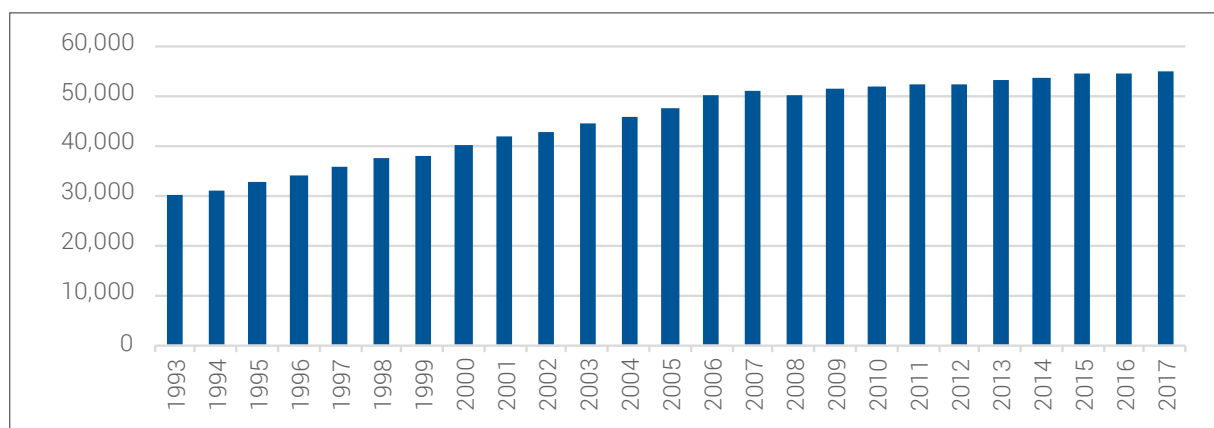
As we have seen, 3% of the population aged 65+ live in long-term residential institutions under the scope of the social law. As age increases the probability of admission rises: among the very elderly (80+) more than 10% live in such institutions, the majority of them women. Of elderly

people living in an institution, 47% or around 30,000 people have a chronic illness. 28% of the elderly living in an institution suffer from some form of disability, while this is true of only 10% of those living relatively independently in retirement homes. Those living in institutions primarily suffer impaired mobility, along with mental disability or reduced mental function.

As a result of the introduction of needs testing in 2007, those admitted to nursing homes are increasingly only those who are in the greatest need. Even in 2011, the proportion of those in residential nursing homes aged over 75 was 63%. Among those elderly persons in care, 53% belonged to the 3rd highest category of care need. Loss of vision and hearing are frequent, as is impairment to spatial or temporal orientation. Behavioural problems and difficulty with independent eating or dressing mean that the need for nursing care is almost constant (Czibere et al, 2011).

Particular reference must here be made to the number of those with dementia, who have the most pronounced care needs: according to sectoral data from the central administration from January 2017, 2421 people in elderly day-care institutions⁹ and 12,361 people in full-time residential institutions suffer from severe forms of

Figure 4: Number of people in temporary or residential elderly care facilities



Source: STADAT, 2.5.17. Residents in long- and short-term residential social institutions (1993–)

⁹ Municipalities with more than 10,000 inhabitants are obliged to provide daytime care for people with dementia. This care is effective on multiple fronts, since as a place for developing hobbies and occupations it slows down the progress of the disease, and also relieves the burden on family caregivers.

dementia. In other words, 23% of those in nursing homes suffer from dementia. (by comparison, in most European countries this figure is already over 50%, comp. *Dementia in Europe Yearbook 2017*). This is only a fraction (around 6%) of the total number of people, around 200,000, affected by dementia, though both the number and proportion of those in care is increasing dramatically (Gyarmati, 2012).

Both the lack of capacity in elderly care and the poor, uncoordinated nature of the care system are best illustrated by the waiting lists: The number of those waiting for a place is rapidly increasing. Data on these waiting lists are published monthly on the social sector portal of the Hungarian Directorate-General for Social Affairs and Child Protection. According to the earliest available data, from 01/06/2016, 16,853 people were waiting for a place in a nursing home, and by 05/02/2019 this had risen to 24,824. (These figures are in reality higher, and estimates suggest that the real figure is presently around 35,000, since many have not registered on account of the long waiting lists.) In 2016 there were 40 people waiting for every 100 occupied places in residential care homes, while 76 were waiting for every 100 occupied places in temporary care homes. Calculating from the raw data, it would appear that the figure for residential care homes is now 45, while for temporary care homes it is now 74. The average wait is

Table 5: waiting list numbers, 05/02/2019

Services	Waiting list number
Home help	679
On-call home help	524
Daytime care	147
Temporary care	2199
Residential care home	24,842

Source: http://szocialisportal.hu/documents/10181/202037/Varakozoi_jelentes_2019_februar.pdf/45040c1d-3703-2620-c8b9-cc50f2229982

around two years, and around half of applications are withdrawn before this waiting period is over. In half of these instances it is due to the death of the applicant. For this reason it is particularly difficult to explain why, during the last eight years of centralised state operation of care facilities, no new places have been created.¹⁰

3.4. Cooperation with the healthcare sector

Cooperation with the healthcare sector seems justified from the perspective of the care system's sustainability, and also because social and healthcare problems are so often intertwined, meaning that physical healing should take place in conjunction with social work and social policy interventions. There are also overlaps between the two systems in terms of their clientele, particularly in the case of elderly psychiatric care, but despite all this there is no actual cooperation at either the systemic or individual professional levels. The principles underlying their financing and care systems are also completely different. After the fall of the Iron Curtain in 1989, several conceptual ideas for cooperation were put forward. For instance, in 2003 the idea of introducing a so-called nursing insurance system was floated, which would have functioned similarly to the social insurance system in covering the long-term costs of nursing and care, and was based on foreign models (Győri-Mózer, 2006, 19. o.)

Another concept, this time from 2005, was the Integrated Social and Healthcare System, or ISZER, the principle aim of which was funding the care of over 65s whose independent capabilities were impaired for health or social reasons, and which would have adopted a largely preventative support strategy. It would have begun by assessing the recipient's condition and needs, then functioned on the basis of a tailor-made care program. Care providers would have been pooled together in a consortium, and the system would have been assembled from the following elements: a Social

¹⁰ <http://www.parlament.hu/irom41/04135/04135-0001.pdf> In the response given by Bence Rétvári to the interpellation of Lajos Korózs in January 2019, it transpires that over the past eight years 54 new places have been created, but that these are all reserved for the care of either those with disabilities or those suffering from addiction (as part of the redemption strategy).

and Healthcare Needs Assessment Institute to deal with primary care, general practitioners, professional home nursing, home-based social care, acute healthcare provision, hospitals, drop-in clinics, professional care (chronic care) nursing institutions, care homes, daytime centres for the elderly, signalling systems, geriatric/gerontological centres, institutions providing residential care, social homes, retirement homes, apartment buildings, housing estates and case management (Falus-Juhász, 2005).

At a national level, ISZER was never introduced, though in some areas, for instance in the city of Győr, municipal governments have succeeded in integrating health and social care into a single system. In Győr the Unified Health and Social Institution for Local Care Services (EESZI) has a professional responsibility to provide basic and specialist social services to locals and people resident within the city's jurisdictional limits. Seven care centres, thirteen clubs for the elderly and a temporary care home ensure care provision, while home help and specialist home nursing are provided through a single unified system. Special apartment buildings have been established for the elderly, in which nursing services, catering and the formation of clubs can all be conducted, and at exceedingly affordable prices. Development plans also included more social housing designed expressly for the elderly (Social Innovation Foundation, 2009).

In March of 2016 a new ministerial concept appeared, a reform proposal by then State Secretary for Healthcare, Zoltán Ónodi-Szűcs, the goal of which was the eradication of duplications within health and social care provision. With an aim to this, roughly a third of beds (10,000) currently allocated to the chronically ill would have been transferred to specialist social care. The plan was to establish specialist care homes on the sites of existing hospitals, where elderly people in need of healthcare and specialist nursing could have been tended to in a nursing home setting. This bed transfer would also have led to a total saving of approximately three billion forints. In addition, the idea of nursing insurance was once more raised, again with a view to securing

long-term financing (Fülöp, 2016). Ultimately this proposal was not adopted (the health service proved unwilling to give up either the beds or the attendant funding) and all that ultimately resulted was that in 2016 the concept of the specialist nursing home was introduced into the Social Law as a new form of specialist care, though no such homes have actually been physically constructed yet.

3.5. Policy changes in elderly care from 1989 to 2018.

The III. Law 'On social administration and social care' adopted in 1993 by the Antall government, aimed to resolve the contradictions between legal obligations in terms of social care arising out of constitutional and/or international arrangements and their actual domestic provision. In addition, the large-scale social changes which took place in the 1990s warranted the drafting of a new law. The transition to a market economy, the increase in income inequality and the attendant rise in poverty all necessitated the development of a new system of distribution, and the establishment of an independent, modern social care system. The closure or privatisation of large, inefficient, state-owned enterprises, and the huge round of lay-offs which resulted, meant that the number of actively employed persons fell by 1.1 million in the period from 1989 to 1992. The new law defined the scope of measures, provisions and obligations governing the establishment of an independent, structurally unified social policy, and focusing primarily on financial support. The new law both strengthened and expanded social rights in Hungary, introducing forms of relief and care which aimed principally to alleviate the situation of those impoverished social groups who found themselves in an increasingly perilous position, and sought to provide them with some level of social security (Hodosán, 2003).

Looking back at the most important legislative changes introduced by the post-1989 governments in terms of elderly care and in part also carers, we can specify several processes. In terms of professions, professional development or even

the possibility of such development, we cannot really speak of alignment with Western European trends. Professional issues are not covered in the legislation, and the authorities took no account of this perspective when it came to evaluating care. The role of so-called methodological institutions (which are responsible for updating professional standards) is negligible. The EU goal is to develop specialist care at home, preferring home care for the elderly and a recognition of the status of home carers over expensive institutional care. Although the Social Law obliges all municipal governments to provide catering and home help, over the past twenty-five years this has not become a form of basic social security available to all those in need of it. All that is available to informal carers is the possibility of a very modest care allowance (which only a fraction of those looking after an elderly relative at home can avail themselves of) but even at a theoretical level, no background services have been proposed to help caregiving families. Nor is there any client protection system, and the lack of any policy coordination between care policy and employment policy is detrimental. In terms of institutional care, the nurse/guardian approach has not been superseded, and aside from financial reasons, the explanations for this should be sought in professional training and a lack of knowledge (Szabó, 2011).

Since Hungary joined the EU, the financing of social care has been determined through a neoliberal economic policy represented by the OECD and the World Bank, the primary aim of which is to reduce state redistribution and dismantle welfare subsystems, arguing that social care prevents the effective functioning of the market, and thus inhibits economic growth. In terms of financing social care, both the specific amounts and the means of calculation (tied first to the number of inhabitants, then the number of care recipients, and most recently to task indicators) have been subject to rather hectic change, but the goal in all instances has been to keep expenditure at a fixed level, or at times even to reduce it. Since 1989 there have been only two years in which funding increased: 2003 and 2005, which was when the

greatest funding increases were seen in all sectors. Since 2005, however, there have only been a few specific funding increases (home help, catering, daytime care for the elderly). In terms of specialist care (residential care, temporary accommodation) the level of expenditure has dropped significantly since 2005 (Mester, 2010). Characteristic of the survival of neoliberal economic policy is the way the goals and principles laid out in the SZOLID project of 2003¹¹ reappeared in 2016 as the National Social Policy Concept.

As a result of the centralisation of care providers initiated in 2013, as well as the introduction of task-based financing and capacity regulation, the institutional system has finally lost the ability to respond effectively to local needs. The 2018 amendment to the care needs test, for instance, shows clearly that departmental decision makers are seeing an increase in need as a result of the freezing of the number of places in residential care facilities, but for the time being this is to be addressed by extending the time available for home help (in other words, by adding another burden to the basic care provider, though the number of care recipients assigned to one carer is already unmanageable). The perspective of the state budget office was practically the only perspective represented in the amendments to the Social Law, and funding is not to be adjusted to real costs. There has been no attempt to ensure the long-term sustainability of the sector, but rather a professionally based strategy which ignores future demographic and social changes. The profile of the minister responsible for social care is very low (it is telling that the minister responsible for social care is not personally able to approve new care capacities in the Social Law; the approval of the finance minister is also required).

The Social Law of 1993 established a decentralised service system based around local municipal governments. At the same time, the disadvantages of decentralisation were already apparent from the start: the provision of social services depended heavily upon the capabilities of the local government, which resulted in sig-

11 The goal of the project was to renovate the social care system and Social Law, cf. Györi-Mózer (2006).

nificant inequalities. Legislators tried to remedy this by heaping more and more tasks upon local governments (though without funding, since they could not estimate the costs) and encouraging integration and the pooling of targets and resources, as well as by increasing supervision (one by one, new central registries were created, the main purpose of which was to help in financial supervision). By 2011 this had led to the indebtedness of local governments. The government, however, did not address this problem by increasing funding to match real costs, but by depriving municipalities of their public responsibilities (centralisation). In addition to all this, financing is not provided in a sector-neutral manner: churches can offer the same services at considerably cheaper rates than municipalities due to the lighter conditions for operation that apply for them, and because they have better opportunities to apply for grants. Therefore it is hardly surprising that the transfer of residential care facilities to church maintenance has begun. As a result of these processes, the burden on families continues to grow: the state has already made it clear, by raising the maintenance charge in the Fundamental Law, that it does not view caregiving family members as partners in addressing the care crisis (indeed, they may be punished if they fail to pay the fee on behalf of their elderly dependents). As a result of all this, local governments are unable to articulate local needs, and care recipients are lost in the struggle for resources between care providers, while illegal solutions continue to proliferate.

4. Caregivers

4.1. Professional caregivers

According to data from HCSO OSAP¹² no. 2023 of December 31st 2013, there were 92,102 people employed in the sector's various institutions. The largest category of work (39,000 or 42% of the total) was in specialist social care, followed by basic social care (29,000, or 31%). The number of care recipients per caregiver was highest

in basic social care, where on average one caregiver provided for 13 care recipients. 80% of jobs are classed as professional occupations. Of the 60,000 full time, professional employees working in the social sector, 91% are women, which by international standards is very high (cf. WICARE project, 2015). The age composition of those working in the sector has shifted markedly towards more elderly employees: Around a third of those in full time work are over fifty, while only 7.5% are under the age of thirty. By examining the evolution of the nation's demographic profile we can predict that within a few years the demand for social workers will increase sharply, as the large number of retirees have to be filled by young newcomers. A large majority of those in the sector, around two thirds, left formal education after secondary school. The proportion of university graduates stands at around 25%, while those with only primary-school education represent around 13% of the total. The proportion of graduates in basic and specialist social care is lowest (20%) Goldmann, 2014).

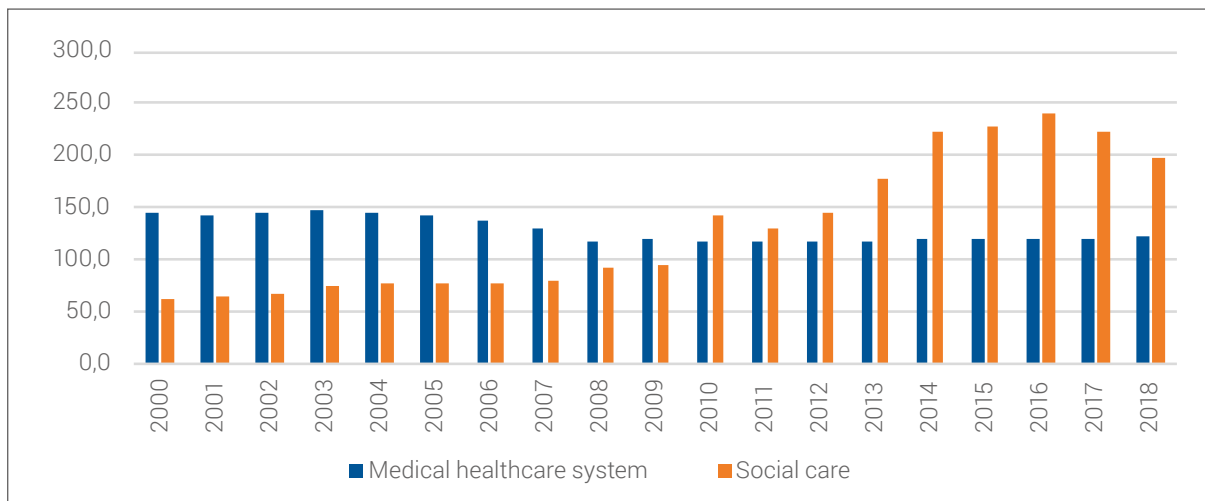
The social status of social workers is very low (this is shown by the number of women in this sector, the low rates of pay, and the high proportion of community service workers in certain areas of work. The number and needs of care recipients, however, continues to grow, as does the number of cases per worker (for instance, a home help caregiver in 1995 received an average of 3.6 care recipients, compared to 8.4 in 2015, cf. Social Statistical Yearbook, table 2016.8.2.)

According to data from the HCSO, since 2010 the number of employees in the social sphere has exceeded the number of employees in healthcare (with continuous growth, which was only interrupted in 2017). While in 2010 there were 143,400 people working in the social sector, this had risen to 198,600 by 2018.

At the same time, according to the HSCO, the number of vacant (unfilled) positions has also been growing continuously since 2010, with 3605 unfilled vacancies registered in 2017.

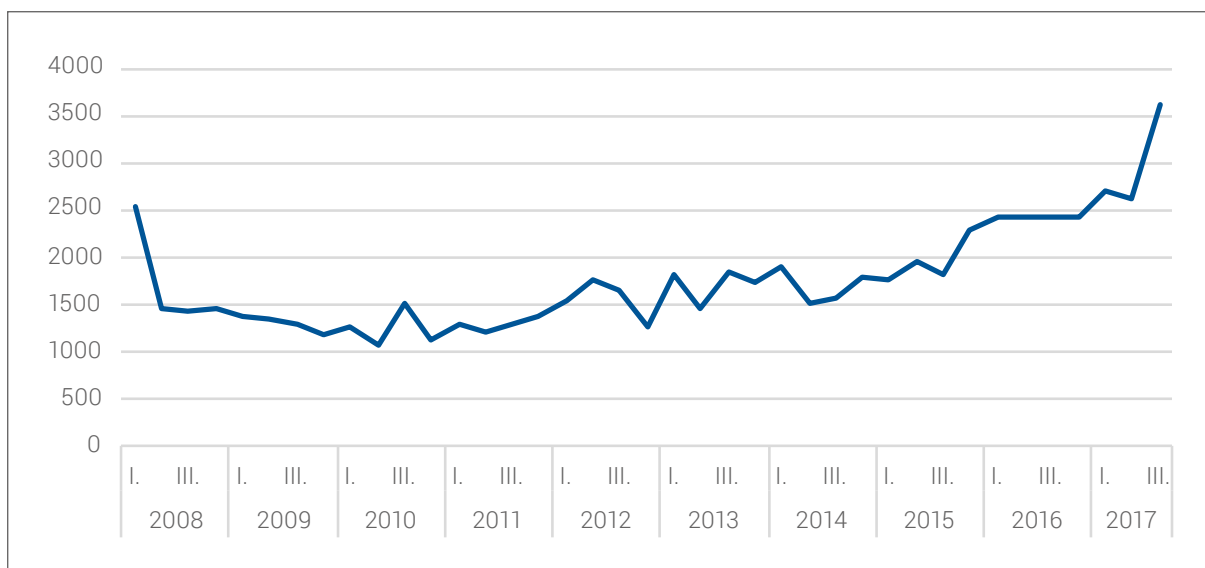
12 OSAP: Országos Statisztikai Adatgyűjtési Program or National Statistical Data-Collection Program

Figure 5: Number of persons employed



Source: HSCO STADAT tables: 2.1.38. Number of people in employment, including community service employees

Figure 6: Number of unfilled job vacancies in the social sphere



Source: HSCO, 2009.sz. OSAP, own data compilation

We may be permitted to ask what the reason behind this continual growth in both the number of employees and the number of unfilled job vacancies (which is the best indicator of a labour shortage) might be? The best indication probably lies in the use of community service labour, but as the HSCO does not disclose either the wages of workers or the number of community service personnel as a separate group from professional personnel, so it is impossible to even estimate the degree to which this distorts the true picture.

The attractions of a career in social work are slight, on account of overwork, stress and a lack of adequate monetary compensation. According to those who work in the sector, it constantly struggles against a dearth of professionally qualified staff, and large numbers of workers quit the profession. The shortage of professionals is accentuated by a steep drop since 2005, and even more so since 2009, in the number of those pursuing higher vocational qualifications in social work. This figure is now very low indeed. While in

2005 more than 7300 began studying social work and social education studies, this had dropped to 1300 by 2014/2015 (Balogh et al, 2015).

According to the HSCO's data on wages, the average net monthly wage earned in social work was 101,000 forints (this data, however, is misleading, as it is calculated together with the earnings of those in community service, which significantly lowers the average. At the same time, we can say that in the entire national economy, it is social workers who bring home the lowest monthly wages).

In 2013, a report from the Commissioner for Fundamental Rights found discrimination against social workers with regard to wages, as they received lower pay for the same work (elderly care, nursing) as those working in healthcare. Since 2008, social workers' unions have been demanding pay rises. As a result of this pressure, in December 2013 the state secretary responsible for this sector announced that the government planned to introduce a so-called Social Sector Career Plan model to regulate the wage situation in this sphere. The first step was the social sector bonus, which sought to provide raises of 5 – 11%, or 6,000 – 17,000 forints per month. A wage supplement was also established on 1st July 2015¹³, which provided an average gross monthly wage supplement of HUF 16,000 for 66,418 people. In

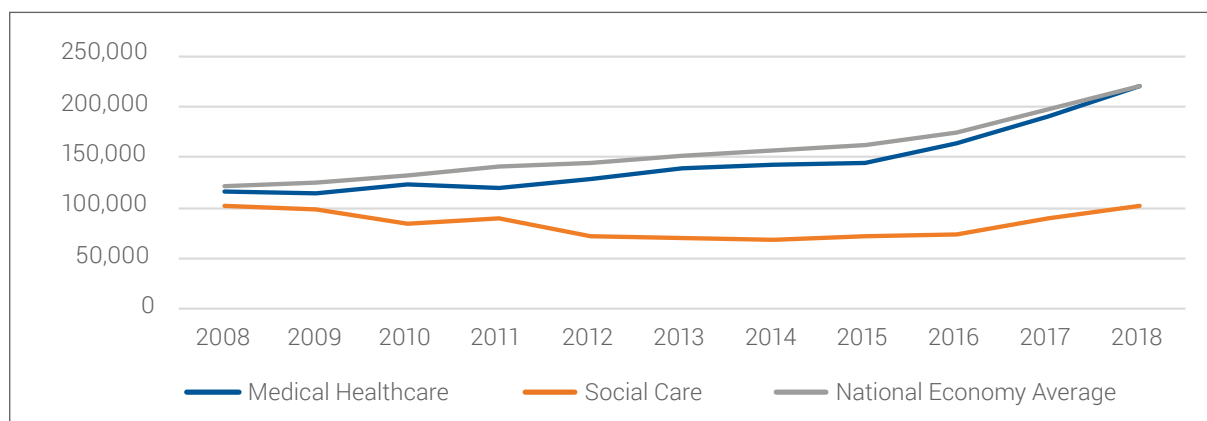
connection with this supplementary allowance payment, caregivers – in a manner similar to the bonus payment – are entitled to budget support (Máté, 2016). The EMMI has been planning to introduce the Social Sector Career Plan, but so far there has been no government support.

4.2. Informal caregivers: family caregivers

An HSCO report published in 2011, entitled 'Employment and Family Bonds', which analyses data from a separate survey of the labour market, established that 5.6% of the population aged 15-64 regularly cared for a person older than 14 limited by either illness or disability.

Similarly to all other tasks conducted within the household, the involvement of women is greater than that of men, though the difference here is far less stark than in the case of, for instance, childcare. According to the data, 4.4% of men and 6.7% of women cared for a family member in need. This type of care activity is characteristically performed by those in middle age or older, including 8.9% of those aged 45-64, and 10.4% of women in that age category. The majority of those in this age group are presumably caring for a parent, though with increasing age it becomes ever more likely that a spouse will require care. 15.3% of those involved in non-child-related care

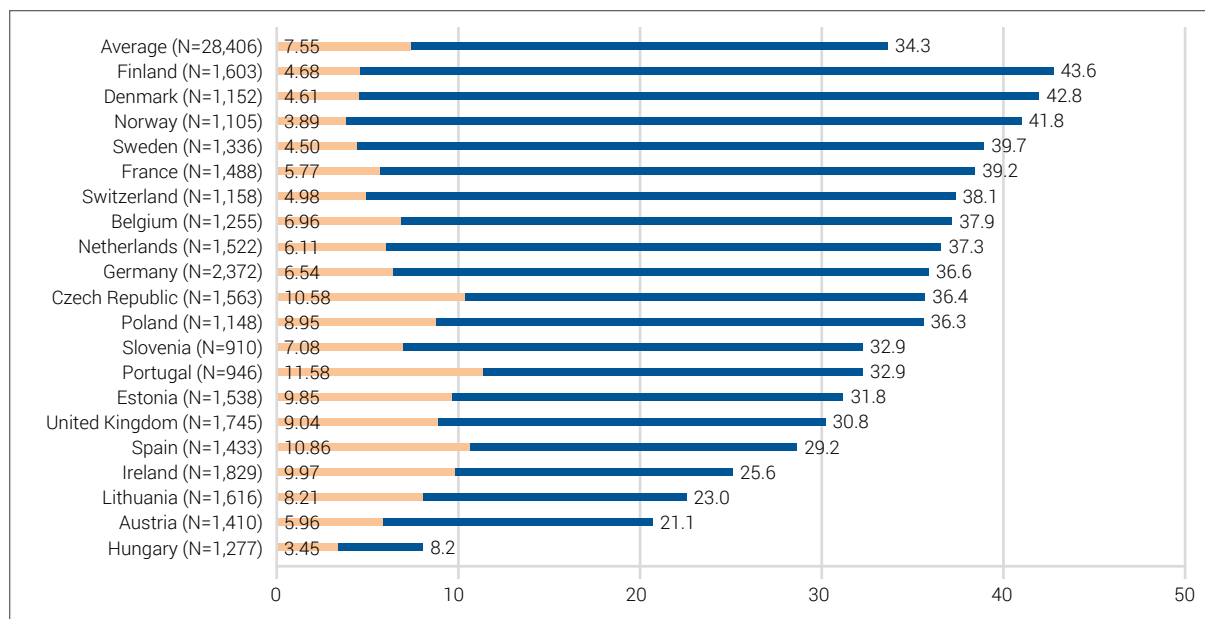
Figure 7: Average monthly net pay in national economy



Forrás: HCSO, STADAT 2.1.46. Average net monthly earnings of full-time employees in the national economy

13 165, 166/2015. Government Regulation

Figure 8: Proportion of informal (family) caregivers within populations, ESS. 2014.



Source: Informal care in Europe: findings from the European Social Survey (2014) special module on the social determinants of health Ellen Verbakel¹, Stian Tammlagsrønning², Lizzy Winstone³, Erlend L. Fjær², Terje A. Eikemo

activities (8.2% of men, 19.8% of women) reported that these activities limited them in terms of employment (typically they were unable to take on work as a result of care obligations, though this group also includes those who took early retirement for these reasons, or who were only able to work part-time). However, at the time of the survey only 11% of carers aged 15-64 indicated that they had received any kind of nursing stipend. More recent, large-scale data was supplied by Round 7 of the European Social Survey, from 2014 (22 countries, 28,000 samples). According to this data, an average of 34% of the adult population of the EU cares for an elderly dependent at home, with the figure for Hungary the lowest at 8.2%. (Intensive carers, i.e. those who provide care at least 11 hours a week, number just 3.4%). Among informal carers, religious, economically inactive women aged 50-59 are overrepresented. They judge their mental and physical condition to be much worse than the average for the entire population.

Two important links are worth highlighting: firstly, the higher the proportion of people in care in a country, the lower the proportion of intensive caregivers, and vice versa. Secondly, there is a corre-

lation between the type of welfare state and the amount of care activity provided by the family: several studies on informal care and the welfare state (e.g. Visser et al., 2018) support the validity of the so-called crowding-in hypothesis. According to this analysis, the larger the participation of the state (for instance through increased financing, more care home places, and other relief efforts which recognise and honour the work of family caregivers) the greater the degree to which families will become involved in care provision. In such cases the burden is shared, which results in much higher voluntary involvement. It follows from this, however, that a consequence of state withdrawal is not an increase in the proportion of family caregivers, but rather a decline: only those who have no other option accept the burdens of caregiving (cf. Gyarmati, 2016).

Role expectations and attitudes towards the care of the elderly are currently undergoing a generational shift: According to our 'Turning Points of Life' study series, different age groups have differing opinions on the subject. Those aged under 34 are least likely to agree that adult children have a responsibility to care for their elderly parents. This represented a 10% drop by 2018 over the

2016 figures. A gender difference does exist, but it is not especially significant: women are somewhat more likely to agree (29%) than men (23%). A segmentation of the opinions of the elderly shows that 5% would like to move in with their children, 30% would like professional care in an old person's home, and 61% would like to remain in their own homes (Monostori-Gresits, 2018).

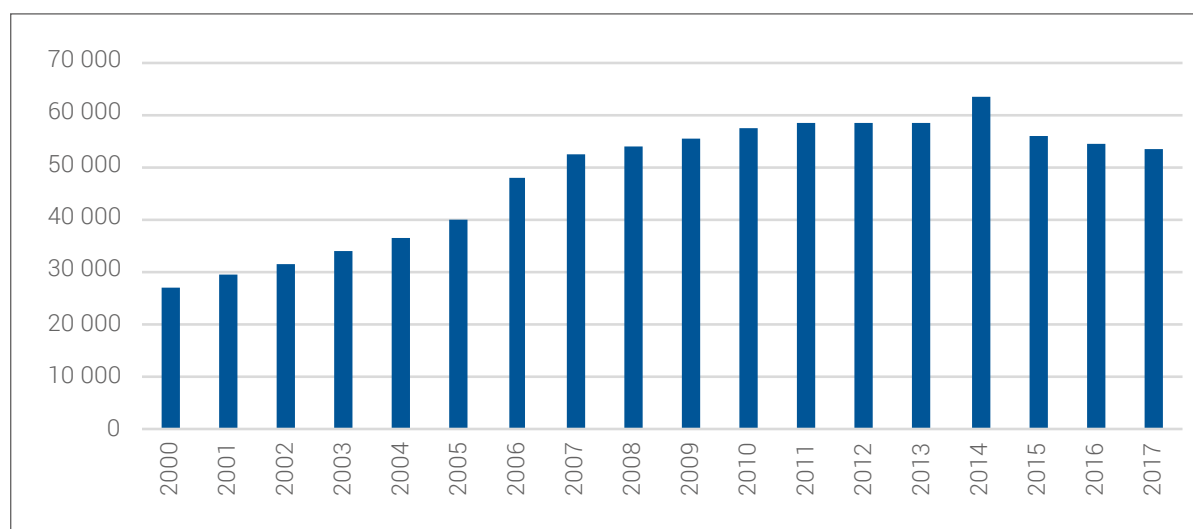
4.2.1 Nursing stipend

For the care of the severely disabled or chronically ill in the home, the financial sum provided for in the Social Law is the nursing stipend. This nursing stipend is based upon a subjective right, and is divided into three classes: basic (for the severely disabled, regardless of age, or for chronically ill persons under the age of 18), raised (for dependents requiring increased care) and enhanced (the rehabilitation authority has classified the care recipient as category E, meaning they receive a higher total family supplement). After a 15% increase in 2019, the basic care stipend stands at 37,490ft, raised at 56,398ft and enhanced at 67,482ft (these are gross figures, from which social security costs are deducted). In addition, until March 2015 the Equitable Nursing care Stipend also existed as a form of financial support. Those who were not entitled to a care sti-

pend on the basis of subjective right (for instance because they were caring for someone who was not a close relative in a legal sense) could apply for this Equitable Nursing Care Stipend from the municipal government. Figure 9 shows the numbers of those availing themselves of this stipend: in 2017 nursing stipends were extended to 53,000 people. The reason for the decline after 2014 is that the number of those receiving the Equitable Nursing Care Stipend were removed from the statistics.

In 2015, TÁRKI conducted a representative sample study on the social situation of family caregivers receiving the nursing stipend. As this research is quite unique, being the only one which provides a credible picture of the situation of informal caregivers in Hungary, we shall discuss it here in some detail. In its conclusion, the study established that 52% received a basic stipend, 28% received the raised stipend, and 21% received the enhanced stipend. It also found significant differences in terms of geographical distribution: Budapest shows the lowest number of those receiving support, with just 10,000 people, while the more economically disadvantaged regions of Eastern Hungary, Northern Hungary and the Northern and Southern Great Plains regions saw the highest proportion of nursing care stipend recipients. 74% of recipients are women (the more intensive

Figure 9: Number of recipients of nursing care stipend



Source: HCSO, STADAT tables, 2.5.13. Supplemental income social assistance (2000–)

the care needs, the more likely it is to be done by women). They are typically between 40 and 50 years of age, 40% of them live in a village or small town, and their education level is similar to that of the general population.

Half of caregivers live in households in which there is no economically active member, and 36% live in households with one economically active member. Three quarters had been in paid work before claiming the stipend, with the majority of them working in full-time employment. At the time of the survey, 17% were still carrying out paid work. Those who did not work justified this by the condition of the care recipient. Among the economically inactive, 55% would be willing to take up work if they did not have to provide care. 79% of those wanted to work full time, and 10% part time. Their financial situation can be characterised by the fact that their income per unit of consumption places 70% of them in the lowest two-fifths of the Hungarian population in terms of income.

In terms of care recipients, we know that 19% of them are minors, and 51% are aged 60 or older. Two thirds of cases are parent child relationships, and they typically provide care for around a decade (47%). 70% of care recipients are restricted in their movement, 62% are chronically ill, 42% have dementia. Their nursing needs typically require 6-9 hours of care per day, and half of care recipients require 24-hour supervision. For 37% and 49% of caregivers respectively, providing care is either physically burdensome or very physically burdensome. They generally have very little information about basic or institutional care services (support services, home help, specialist home care) – only about 20-30% are aware that this support exists. Most consider the nursing care stipend unjustly low, and this causes many to worry about their own pensions. One of the most important results of this research was that it refuted the stereotype of decision-makers in this sector, who generally consider the nurs-

ing stipend a form of social refuge. After all, as we have seen from the data, the majority were in paid employment before they became informal carers, and would continue to work if they had the opportunity (Tátrai, 2015).

Non-governmental organisations succeeded in securing a significant increase in the nursing care stipend, as well as recognition of home care activity as a working relationship, but this success was only partial. From 01/01/2019 a new form of care stipend was introduced into the Social Law (1993. III. tv. Szt.): the GYOD or Home Childcare Stipend, the total amount of which is fixed in the annual budget for 2019 at 100,000ft gross. This care supplement is only available for caregivers in a parent-child relationship, which means that many are left out (according to MEOSZ data, only 18,000 people were able to move from January into this new care system, but another review is pending¹⁴). Those caring for elderly parents must still make do on the nursing stipend provided for in subjective law.

4.3. Work-Care Coordination

In Hungary, according to HCSO statistics from 2012, 30,550 people over 50 years of age had given up work as a result of family and care obligations. 26,100 of these (74%) were women (HCSO, 2013, table 7). This is not simply a problem in terms of increased poverty at the individual family level, it also negatively affects the entire economy. It contributes to the existing labour shortage, and goes against the employment objectives of the Europe 2020 strategy. According to this strategy, the employment rate of those aged 20-64 should be increased from 69% to at least 75%, in particular by encouraging more women and older working-age people to enter paid employment. In Hungary, the coordination of work and care is only “assisted” by the possibility of two years of unpaid leave.¹⁵

¹⁴ MEOSZ (Hungarian National Association for the Mobility Impaired), Nursing stipend, open letter. http://www.meosz.hu/wp-content/uploads/2019/02/Apolasi-dij-nyilt-level_2019.02.04.1.pdf downloaded: 14/02/2019.

¹⁵ Mt. 61. 131 § (1) “An employee is entitled to up to thirty days leave for the purpose of nursing a dependent relative, and to a maximum of two years of unpaid leave.”

The International Labour Organisation (ILO) addressed the problem of family care, and in Convention no. 156 from 1981¹⁶ it proposed protection for family carers against the threat of employment termination. Hungary has never ratified this convention, and protection against employment termination remains partial.

In April 2019 the European Parliament voted on a directive concerning “the establishment of work-life balance for workers and carers,” which must be incorporated into the legislation of Member States within three years. This initiative, however, is largely symbolic, and may be viewed only as a first step.

The directive was proposed in 2017, and was predicated on the inadequacy of policies covering the coordination of work and private life. “The legal framework currently in force at the EU and Member State level contains only a few provisions concerning the equal participation of men and women in the provision of care (...)” For this reason, a so-called carers’ leave provision was proposed. This would entail a subjective legal entitlement of five days per year, with remuneration equal at least to that provided during sick leave.¹⁷

5. Main Problems, Findings

As regards the scale of the need, the 2016 micro-census reported that there were 1.8 million people over the age of 65 living in Hungary. Of these, 1.3 million (or 74%) live with some form of physical limitation. Among these, those in greatest need were those over the age of 80, who numbered around 412,000 in 2016. Dementia affects around 250,000 elderly people in Hungary. In terms of social services, there exist both basic and specialist social services. The situation is worst as regards care homes for the elderly: altogether, only 3% of the elderly can avail themselves of this service. Only 6% of those with dementia move into elderly care homes, though

they already make up 23% of total care home residents. According to official statistics, for every 100 occupied places in care homes there are 45 people on waiting lists, but estimates suggest that the true figure is even higher: For every 100 places, there are actually around 60 waiting for a place. The waiting period is long, averaging around two years, and during this period the family must somehow manage to provide care.

The provision of basic services (catering, home help) has been obligatory upon all municipal governments since 1993. Still, only 80-90% of municipalities actually provide these services, meaning that in many districts these services are not locally available. Besides this, the unequal distribution of capacity is also a problem: in some areas as many as 80% of the elderly are provided with care, while in others this figure might be just a few percent. A characteristic problem is the lack of information: only around a third of elderly people are actually aware of what they are entitled to.

The Hungarian state currently spends just 0.4% of total GDP on care for the elderly. This figure shows only a minimal year-on-year increase. The reason for this is that since Hungary’s accession to the EU, elderly care policies have been dominated by a neoliberal economic policy perspective. Funding takes place through a form of planned economy: in the annual budget, financing is not linked to the actual costs of care work. Capacity size is essentially frozen, meaning that it is impossible to create new full-time residential care places, and only the existing basic care provisions are funded by the central government. Since 2013, local municipalities have been subjected to a form of financial guardianship, which has obliged them to hand institutions they had previously maintained over to centralised state control. The significantly more favourable terms granted to church-based care providers, who receive 76% more state funding for the work they do or the places they provide in care facilities, are a particular source of tension.

¹⁶ https://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO:12100:P12100_INSTRUMENT_ID:312301:NO

¹⁷ https://eur-lex.europa.eu/procedure/EN/2017_85

There are a number of signs which show that the care deficit is growing ever wider. One is the declining number of professional caregivers, who currently number around 60,000 in the entire social care system. Wages in the social care sector are the lowest in the entire national economy, and since 2010 the number of unfilled vacancies in the sector has been continually increasing. There are currently more than 3600 vacant positions, while large-scale emigration exacerbates the problem, and more and more positions are filled by unskilled community service workers. The average age of a professional caregiver is around 50 years old, meaning that many will soon retire, while the numbers of those studying social care in higher vocational training has plummeted since 2009. The estimated number of those caring for an adult family member currently stands at between 400,000 and 600,000, but of these only around 20,000 receive the nursing care stipend to which they are entitled in subjective law. Many do not even know that they are entitled to benefits. The available benefits are, in any case, humiliatingly meagre: a maximum of 67,000ft, while the GYOD introduced in 2019 does not cover them.

They are characterised by income poverty, and though many would like to, they cannot enter paid employment on account of their care commitments. The age of family caregivers is on average around 45, but their health is severely affected by the intensive care they provide. As there are no relief services provided for them, care entails social isolation, increased poverty, and mental and physical problems. Several factors have led to the decline in the number of family caregivers: an increasing number of elderly people do not have living children, and even when they do, many have moved, either abroad or to another region. The rate of divorce among the elderly age group has been increasing, and social attitudes are also changing: ever fewer middle-aged adults feel a moral obligation to look after their elderly parents, and elderly people themselves do not seem to expect it of their children.

The consequences are obvious: if the state does not reassess its own role in the care crisis, an ever-increasing number of deprived elderly people will be left without care, or indeed any kind of support whatsoever.

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