ANALYSIS

LABOUR AND SOCIAL JUSTICE

SITUATION OF THOSE WORKING IN ELDERLY CARE IN THE EU AND HUNGARY

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Overall, the number of employees in elderly care can be expected to increase by a minimum of 50% by 2030 in the EU, even under unchanged conditions.

In Hungary, the average salary of someone working in elderly care is 5% lower than the overall average in the social services sector. Employees would consider a minimum wage increase of at least 50% as fair in the current situation. More than half of employees have second jobs to supplement their earnings.

The consequences of staff shortages are manifold: there is less and less time to provide individual care; increasing stress and risk of injury, rising number of patients, faster pace of work, substitutions and the division of responsibilities, and a lack of time for trade union activity.

FRIEDRICH EBERT STIFTUNG

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Content

"We really can say that every day is a challenge and a struggle an unwinnable race."
(director of an elderly care home)

EXECUTIVE SUMMARY

This study was commissioned by the Friedrich Ebert Foundation. Its purpose is to show how the accelerating trend of demographic ageing will soon necessitate reforms in the workforce policies of social service and healthcare providers. The trend is clear: ever more care recipients will have access to ever fewer carers, whether professional or informal, so unless nation states make the right decisions regarding increased capacity in a timely manner, services will become unsustainable, not only financially, but also because of a lack of caregivers.

The methodology of this study is complex. Firstly, we present the international situation and the conclusions that can be drawn from it, and secondly, we present the situation of those working in elderly care in Hungary by analyzing quantitative research data, which is supplemented by qualitative data and explanations obtained from interviews with those affected, including the effects of the COVID-19 pandemic and the lessons to be learned from it.

Approximately 6.3 million people work in the care sector across the 27 member states of the EU, making up 3.2% of the total EU workforce. Approximately 44 million people, or 12% of the adult workforce, provide informal care, which is the backbone of the system. The proportion of workers in a given country is not governed by the proportion of the population over the age of 65 who have a chronic illness that limits their daily activities, but rather on access to services, which are restricted in many member states. This has been typical of the Central European region since the change of government system in 1989–90. Despite this, the number of employees in the sector has been growing steadily, unhampered by the economic crisis. Approximately three-quarters of workers (half in Hungary) are currently employed in residential care, but this proportion will change over the longer term, and close-to-home care will employ more and more workers. Overall, the number of employees can be expected to increase by a minimum of 50% by 2030, even under unchanged conditions.

The composition of the workforce is characterized by feminization and ageing: at the member-state level, the proportion of workers over the age of 50 is 38% (43% in Hungary), but the ageing of the workforce has accelerated in recent years. Turnover is high, and labour shortages are also difficult to compare internationally, as several factors influence these two processes. In Hungary, the main cause of staff shortages is regulation (administrative constraints) and the compound problems which result, as staffing norms are now completely detached from actual care needs. The capacity freeze of 2007[1] will also contribute to growing inequalities of access.

In most member states, the wages of those working in the care of the elderly are less than 80% of the national average, and the situation is even worse in Hungary: in Hungary, according to CSO data, this proportion is 71% in the social sector. The supplementary scheme is commonplace almost everywhere in the sector. Multi-shift work is typical, but part-time employment is rare in Hungary due to low wages and the logic of shifts. Additionally, a multi-shift work schedule is attractive in Hungary because it is easier to reconcile with family responsibilities.

The intensity of the work can be measured by the caregiver–care recipient ratio, but the condition of caregivers must also be taken into account – something not usually examined in international research. Internationally, 47% of those employed in the sector work directly with care recipients for most of their working day (85% in Hungary), and the workload is typically very fast-paced and strenuous: caregivers are often unable to complete their tasks by the end of the day, and must often react quickly to unexpected situations, or interrupt unfinished tasks. The incidence of problems arising from client behaviour is alarmingly high in elderly care. Internationally, one in three workers (33%) is exposed to some form of harmful workplace behaviour (81% in Hungary). In addition, there is a significant health risk (strenuous movement, lifting), which is associated with severe musculoskeletal problems in workers. In addition, the pace of work, the behaviour of those cared for (including those suffering from dementia), the deaths of care recipients, and in many cases the behaviour of relatives, are all sources of mental and emotional strait for caregivers.

1 Government Decree 239/2006 (XI.30.) introduced the so-called managed territorial equalization system (capacity regulation) for social, child-welfare and child-protection services.

In Hungary, according to CSO data for December 2020, a total of 33,000 people work in elderly care. 43% of carers for the elderly surveyed in our questionnaire study are over 50 years of age (the average age is 49 years). This means that old-age care is the most rapidly ageing sector within the social services. Elderly care also has the lowest average level of educational attainment among the social services. It is expected that 80% of employees should have a vocational qualification, but this is typically taken to mean secondary education. Most do not plan to change jobs (due to their age or family situation – there is no quantitative data on this, but we know from interview research that many are the sole breadwinners in their families). It is predominantly younger employees who plan to change jobs, mainly due to low wages, stress, and high levels of responsibility.

Wages are low not only by international standards, but also by comparison with other sectors of the economy, and with the social services sector as a whole. According to our research, the average salary of someone working in elderly care is 5% lower than the overall average in the social services sector. The allowance system is extensive, averaging 24% of wages, and there are significant differences according to the type of maintaining institution (i.e. wages are differentiated by a factor unrelated to qualifications, neither for the position nor for the time spent at work). Employees would consider a minimum wage increase of at least 50% as fair in the current situation. More than half of employees have second jobs to supplement their earnings, typically in a field closely related to care.

The staff turnover rate is 23%, and the perceived labour shortage is higher in elderly care than in the sector as a whole – the highest rate of all is in specialist care. The situation can be characterised as one of ageing employees and a lack of younger replacements: the proportion of those approaching retirement is 19%, and 21% in basic care.

Compared to the sector as a whole, a much higher proportion of older workers believe that staffing norms should be revised, because those receiving care are given much less time than they should be. The interests of elderly care workers are less forcefully advocated than those of the sector as a whole, the primary reason for this being the extreme workload, which leaves employees with little time for anything else.

One of the lessons of our interview research was that, since central legislation and controls leave institutions with very little room for manoeuvre in terms of staffing numbers, working hours, and working conditions, regional differences are of limited significance. Instead, it is the type of maintaining institution that determines the working conditions.

Those in the 40–50-year-old age bracket are the pillars of institutional elderly care, because they typically have children and/or a family, they are obliged to work, they see little prospect of changing careers, and they have a sense of camaraderie with their colleagues. Young people switch sooner if the sector is not attractive to them (they are more educated, more mobile, and are often dismayed by the high levels of responsibility and lack of respect). Staff shortages are also common in specialist and (non-specialist) technical jobs. In the case of specialist carers, this is mainly due to two regulations. Decree 1/2000 of the SZCSM[2] sets very low staffing levels, considering the health status of care recipients (which is determined by the care needs assessment). Specialist and technical workers are interdependent, but the latter do not receive any pay bonus. The consequences of staff shortages are manifold: there is less and less time to provide individual care (and mental care is completely absent from home help); as a result, institutions feel compelled to resort to chicanery with regard to administration, resulting in more stress, a faster pace of work, increased risk of injury, a rising number of patients, substitutions and the division of responsibilities, and a lack of time for trade union activity. Managers have few tools at their disposal – such as, for instance, varying shifts, reducing care time per patient in home help, or trying to limit the number of people in serious care entering their facilities – which might otherwise help them retain their workforce.

The interview research confirmed that the financial rewards for the work are completely lacking, and these can be compensated for only to a rather limited and inconsistent degree by allowances. In addition, the fact that not everyone receives the same allowances for the same tasks (e.g. bedside allowance, health allowance) is a problem, and there are differences between maintaining institutions, which is also a source of tension for employees – especially in relation to church funding..

Marketization is a consequence of low wages combined with access problems. Since, however, few are able to pay real market prices, care can only be paid for on the black market. This problem could be alleviated if the state provided financial support to all those with care needs, which could be spent on the purchase of services if one was otherwise unable to access public benefits due to the strict access conditions.

It is important to highlight the poor physical and mental health of caregivers. Spinal and other musculoskeletal problems are common due to constant lifting, but workers do not receive up-to-date injury-prevention training The dissemination of kinesthetics training in Hungary is one important task the state could undertake. Mental health issues resulting from the strenuous pace of work can only be addressed by rethinking staffing standards, but help with grief processing and supervision would also be of great value in forestalling burnout.

The experiences of the first two waves of the Covid-19 epidemic were only briefly covered in this research, and their incorporation into the next waves was unfortunately also lacking on the part of the government.

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2 SZCSM: *Szociális és Családügyi Minisztérium*, or Ministry for Social and Family Affairs

1

DESK RESEARCH, THE SITUATION IN THE EUROPEAN UNION

1.1 LABOUR FORCE MAP

Approximately 6.3 million people work in the long-term care (LTC) sector[3] in the 27 EU member states,[4] which amounts to approximately 3.2% of the total EU workforce. Approximately 44 million people, or 12% of the adult workforce, provide informal care, which is the backbone of the system. At the same time, however, there are significant variations between countries in terms of the proportion of workers in this sector: In Greece, for instance, 0.3% of the total workforce works in LTC, while in Sweden the rate is 7.1%. Examining the comparative data between countries, it can be concluded that the proportion of workers in a given country is not governed by the proportion of the population over the age of 65 who have a chronic illness that limits their daily activities, but rather on access to services: the wider the access, the higher the proportion of workers.

The trend, or growth rate, is shown by the fact that the workforce increased from 4.7 million in 2009 to 5.6 million in 2014, then to 6.3 million in 2019 (from 2.5% of the total workforce in 2009 to 3.0% in 2014 and 3.2% in 2019). This is all the more remarkable since the overall employment rate has fallen since the 2007–2008 global financial crisis. It was in the context of the crisis that some countries, including Hungary, froze their long-term care capacities. In the EU27 as a whole, however, the number and proportion of those in the care workforce has continued to grow, increasing by about one-fifth (33.5%) over the last decade (Eurofound, 2020).

The majority of those working in the sector are employed in residential facilities providing long-term care. Data from the LFS (Labour Force Survey) show that on average in the EU27, 71% of the workforce in the sector works in old people's homes, but in Austria and Italy, for example, this figure can be as high as 75% (it is 53% in Hungary). In other countries, residential care also predominates, but in the Scandinavian countries, for instance, an increasing proportion of people work in close-to-home care – in line with the so-called deinstitutionalisation process.

The demographic composition of those working in elderly care is characterized by significant gender imbalances: According to 2019 data, 81% of those working in the sector are women. In addition, their average age is increasing: the share of workers aged 50 and over in old-age care is 37.9%, which is 4.7% higher than that of the country's workforce as a whole. The pace of ageing has likewise accelerated over the past decade. The proportion of workers over the age of 50 is higher among those providing close-to-home services than among those living in residential homes. Although the phenomenon of nurse and caregiver immigration also exists in Hungary, it is much less common than in Western European countries, where in these sectors the proportion of foreign workers with a migrant background is very high.

There is no easily comparable international data on staff turnover, but where it is measured it is typically above 10%. Measuring labour shortages is also complex: one can estimate the number of vacancies, look at waiting lists, or examine how difficult it is –how long it takes – to fill a vacancy. Labour shortages are typically affected by several factors:

3 Long-term care (LTC): according to the official definition, the sector includes long-term care for other target groups in addition to care for the elderly, but since it is mostly care for the elderly, I refer to it as the care sector, but I mean by the term care for the elderly.

4 In the following, for the sake of simplicity, I also include Great Britain in the data under the abbreviation EU27.

1. demand for services

    a. age structure, degree of limitation by age group, proportion of those with dementia,

    b. access: there are currently many unmet needs: for instance, many people in the EU have unmet needs for long-term care (Eurofound, 2020). Meeting these needs often requires more staff. In Slovakia, for example, although the number of residential nurses has recently increased significantly, the country is still struggling with labour shortages due to increased access,

    c. whether there are alternatives, range of choices within formal care, availability of informal care or residential care[5], nursing fees,

    d. what types of formal services are available: for instance, because of the popularity of close-to-home services, ever more carers are needed

2. Supply elements

    a. an aging workforce, pension policy,

    b. technology and innovation (although artificial intelligence and robotisation are less apparent in this sector, cf. EUR, 2021),

    c. capacity: how the carer-to-caregiver ratio is regulated at the member-state level,

    d. frequency of absences (older workers take more sick leave),

    e. the degree of competition for labour with other sectors,

    f. the presence of immigrants,

    g. the extent to which an adequate new workforce is being trained.

For all these reasons it is difficult to make comparisons between countries, as the causes of labour shortages are different everywhere. The number of vacancies in social services has been increasing steadily in Hungary since 2008. According to CSO data from the end of December 2020[6] there were 5,374 such vacancies nationwide, which corresponds to a deficit of 7%, of which the labour shortage in old-age care makes up 4%. (At the same time, it should be borne in mind that SZCSM Decree 1/2000[7] which sets normative staffing levels is outdated, and that nominal staffing requirements now have nothing to do with the actual number of carers needed to fulfil the needs of those they care for.) The already-cited study from Eurofound states that, overall, a minimum increase of 50% in the number of employees is to be expected by 2030 (Eurofound, 2020).

5 These are informal (trained or unskilled) carers who provide this service for a longer or shorter period of time while living in the care home.

6 Based on the public interest request of Péter Ungár, Member of Parliament, in October 2021

7 1/2000. (I. 7.) SzCsM on the professional tasks of social institutions providing personal care and the conditions of their operation

1.2 WORKING CONDITIONS

1.2.1 Wages

In 2014, the average hourly wage of those working in social services (calculated at an EU-27 average of €9.62) was lower than the average EU-27 wage across all sectors of the economy (€ 11.98). In 24 of the 27 Member States, the average hourly wage for social-service workers is at least 10% lower than the national average wage. The three exceptions are the Netherlands, Austria and Luxembourg, where average earnings in social services are more than 90% of the average wage. In more than half of member states (14), wages in social-service jobs are less than 80% of average earnings, and remain below the national average wage even after ten years of employment. A typical solution employed by many member states is a wage supplement system: e.g. shift bonuses, child allowance, overtime, sectoral bonuses, etc. However, there may also be wage differences within a particular country. For instance, where unions are strong and collective bargaining is possible, wages are also higher. Overall, wages in this sector are highest amongst healthcare graduates and therapists (Eurofound, 2020).

Overall, carers' wages in most EU countries are well below the average of gross national earnings for the economy as a whole. Only in four member states do wages reach 85% of the average (the UK, Romania, Luxembourg and Estonia) and in about three-quarters they do not even reach 65% of the average. (Those working in elderly care in Hungary are among the worst paid, with wages at 71% if the gross national average). Wages are typically higher in the public sector and in old people's homes, and in larger cities. Many are moving from the social sector to healthcare, making elderly care in the social sector a kind of career springboard. But in Austria, for instance, the wages of those working in the public sector are the same in health and social services, as in both sectors only qualification level counts. (In Hungary, those with a degree in healthcare receive a healthcare bonus).

A international, comparative trade-union study in 2019 (Kamińska et al, 2020) found the same, but also sought explanations for the pay gap. The authors found that the wage rate among social workers is not related to how much a state spends on the entire sector. The Esping-Andersen-style welfare state provides only a limited explanation: based on this, there are typically Scandinavian countries with high welfare expenditures and high wages for social workers. Germany and France, which belong to the conservative model, are good examples of extensive social security systems: welfare spending is moderate and wage levels are moderate. The countries of Central and Eastern Europe, on the other hand, are typically dominated by the neo-liberal austerity model developed during the early 1990s, and both social spending and wage levels are kept low. However, there are exceptions: Britain, for instance, has generally low level of welfare spending in accordance with its liberal model, but the wages of those working in social services are nevertheless the highest in Europe, when compared to the average wage.

1.2.2 The nature of employment and resulting difficulties

In Europe, and especially in the United Kingdom, the social service sector sees widespread use of so-called zero-hours contracts, which means that the employer is not obliged to contractually guarantee employee a minimum number of working hours (the number of hours the employee works is not specified, they merely agree to be available when necessary, but there is no minimum salary guarantee). Equally common are insufficient advanced notification, part-time employment and so-called platform work.[8] Self-employment is also widespread among residential nurses, which in many countries is also used as a means of making finances more opaque: the carer is registered as a self-employed person and their care fee is paid by the local government (as seen, for example, in Latvia). This solution only works if the payment of the care fee due to the caregiver is overseen by the state, linking the payment to the caregiver's registration. In Germany, residential care is part of the so-called mini-job system.[9] However, according to a recent court ruling, foreign carers may also be entitled to the German minimum wage.[10]

1.2.3 Working hours

Compared to other public sectors, non-standard work arrangements are much more common in elderly care, including part-time employment (primarily in home help), and multi-shift work (most commonly in residential care). In 2019, more than 40% of long-term care workers worked part-time in the EU27, compared to just 26% in the health sector. The overall part-time employment rate is 19%. (EUR, 2021a). In Hungary, part-time employment is not typical in the sector, mainly due to extremely low wages. Occupational health research indicates that atypical work schedules can lead to negative health outcomes, including higher rates of cardiovascular disease, more frequent accidents, and depression. At the same time, a 2006 study in Hungary showed that older workers value flexibility in their working arrangements: many people choose to work in this sector primarily because it is stable and predictable, yet also flexible in the (shift) work schedule that they also have a say in shaping – that is, their primary goal is to reconcile work and family life (Gyarmati, 2006).

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8 When supply and demand are linked on a web interface, the platform employs the caregiver as an agency, this type of work is most common in private teachers at home. Examples of platforms: Mindme.ie, Care.com, fermeria.hu

9 For more on this, see: https://handbookgermany.de/en/work/mini-job.html

10 https://merce.hu/2021/07/30/a-kelet-europai-idosgondozasban-dolgozok-is-jogosultak-a-nemet-minimalberre-de-igy-sem-valoszinu-hogy-meg-is-kapjak-azt/ (link in Hungarian)

1.2.4 Work intensity, stress, burnout

The intensity of work can be measured in several ways. First through the care giver–care recipient ratio, regarding which there is currently no uniform practice across member states. In terms of physical and mental wellbeing, one important question concerns what proportion of working hours should be spent dealing directly with clients, and what the consequences in terms of overwork and time-per-client are for the health status of the employees. Of those employed in the sector, Of those employed in the sector, 47% work directly with care recipients for most of their working day (85% in Hungary), which means that caregivers are often unable to complete their tasks by the end of the day, and must often react quickly to unexpected situations, or interrupt unfinished tasks. More than one-fifth of older workers (22%) spend almost all day work with clients who are difficult to manage, which is a higher figure than in healthcare (18%) and twice as high as among the workforce as a whole (11%). The incidence of problems resulting from client behaviour is alarmingly high in elderly care. One in three employees (33%) is exposed to some form of harmful workplace behaviour (either from clients or colleagues), which is twice as high as among the workforce as a whole (16%) and 8% higher than in the healthcare sector. Verbal abuse, unwanted sexual advances, physical violence, and sexual harassment are all more common in residential care than in close-to-home care (Eurofound, 2020). This may be due to the increasing number of people with dementia among those in care, but also to the wider institutional culture (a large number of institutions, caregiver overload, etc.)

In addition, those working in the sector are at higher than average risk of physical injury: the lifting and moving of care recipients is common – 40% of employees spend more than three-quarters of their working time performing such tasks (which is true of 23% of healthcare workers).

These working conditions have a negative impact on the health and wellbeing of workers, contributing to anxiety, depression, sleep and eating disorders, and emotional and physical exhaustion. A number of psychosomatic illnesses are associated with harmful social behaviours, such as headaches, fatigue, cardiovascular disease, and drug and alcohol use (Eurofound, 2015, Beer, 2016).

Overall, 37% of employees believe their work has a negative impact on their health (compared to 29% of healthcare workers and 25% of workers overall). Nearly two-fifths (38%) believe they will not be able to continue in their jobs until they are 60 years old. This proportion is higher than in healthcare (26%) and among the overall workforce (27%) (Eurofound, 2020).

1.2.5 Job satisfaction, protective factors

71% of those working in elderly care consider their work useful, but only 22% are satisfied with their working conditions (Eurofound, 2020). Stress and physical and mental overload stem primarily from inadequate organizational performance and not from individual characteristics, so in order to retain the workforce, efforts should be made to improve working conditions that pose a risk to health. Several studies have found that good management and strong professional support are key to managing stress and preventing burnout. Supervision is a useful tool for managing stress at work, but it is equally important to have adequate funding, professional autonomy, a reduction in unnecessary administration, a focus on making meetings more concentrated and efficient, clarity of job descriptions, support for employees, optimized case numbers, improved physical infrastructure and a better, safer working environment (Mack, 2012; Beer, 2016; Csesznek–Şimon, 2019).

Table 1
Incidence of Violent Behaviour Across Sectors (%)

	verbal abuse	unwanted sexual advances	threats	humiliating behaviour	physical violence	sexual harassment	harassment, bullying
elderly care	26	7	11	8	12	4	8
healthcare	18	2	6	8	5	1	9
other service sector	12	2	5	6	2	1	5
non-service sector	7	1	2	4	0	0	3
all sectors	12	2	4	6	2	1	5

Source: Eurofound, 2020, table 10

1.3 POLICY PROPOSALS FOR DECISION MAKERS

1.3.1 General suggestions

1. The interpersonal aspects of work are key to effective time management. In order to ensure high-quality care and address labour shortages, greater workforce appreciation and the targeted improvement of working conditions in the sector are vital.

2. In order to address labour shortages, measures should target part-time workers, the unemployed and economically inactive, former informal carers, workers wishing to put off retirement, and prospective young students. Men in particular should be targeted. However, for these measures to be effective, better working conditions are necessary.

3. It is becoming ever more necessary to recognize the specific physical risks faced by those working in the care sector, including the health risks associated with lifting people. The COVID-19 crisis has shown that workers also need improved training and equipment in order to work safely in a potentially infectious environment.

4. Long-term care workers are at high risk of developing mental health problems due to the great emotional burdens the work entails, and because of exposure to harmful client behaviour in the workplace. With the number of carers increasing, it is more important than ever for policy makers to address this issue.

5. Improving staff training levels can increase the quality of services and reduce physical and mental health risks. More time with staff, less administrative work, more autonomy, and increased professionalism can also contribute to improved service.

6. Physical strain and abuse: teaching kinetics, aggression management, and the widespread implementation of technological innovation can help prevent and manage these risks.

7. Contracts should be collectively negotiated across the sector.

8. Informal Residential Care – minimizing the black market: states are seeking to encourage the reported work of informal residential nurses in a variety of ways. In Cyprus, for example, care recipients are required to present to the authorities an agreement between them and the care provider – the latter can be employed by an organization or be self-employed. Some countries (for instance Belgium and Germany) have developed voucher schemes. These vouchers can only be used to purchase registered care work, and provide the carer with social security (the client receiving care registers the employee and buys a monthly voucher that includes accident insurance, pension contributions, etc.) In Austria, most of these benefits have since 2008 been formalized within employment or self-employment systems. Carers work through agencies, pay social security contributions, and are entitled to social security. Officially registered, non-black-market labour is encouraged through the state's financial contribution to the employment of caregivers in residential facilities, but it provides support only to qualified, registered workers.

9. Systematic data collection and data processing should be important elements – to help employees. In Hungary, too, several national institutions collect data, but this is not processed or incorporated at the planning stage, so there are no evidence-based practices or impact analyses.

1.3.2 International policy proposals to make the sector more attractive

Various measures could be implemented to increase the attractiveness of the sector. We can outline three key areas in which such improvements should be made. One is training and professionalizing informal carers, and offering training to the unemployed so they can act as reserve carers when needed. The second is to increase the number of carers (by drawing them from other sectors or other geographical areas) to EU levels, and the third is to retain the current workforce by improving conditions.

Concrete measures should be considered, such as the pursuit of a more diverse workforce (e.g. breaking down stereotypes about male carers, employing immigrants, and drawing labour from economic sectors which are being automatized); improving the image of the long-term care sector, e.g. through information campaigns; encouraging the professionalization of informal carers; initiatives to reduce the legal and linguistic barriers which hinder access to the profession (e.g. language training for mobile and migrant workers); and proactive recruitment from sectors with high unemployment.

Improving working conditions for carers (health and safety at work) and promoting social dialogue in the sector are also important tools for making the sector more attractive.

Therefore, in addition to recruitment, targeted and systemic efforts are needed to retain a well-trained workforce over the long term. Policy options include the following: improving working conditions and pay, in particular through enhanced social dialogue; improving work organization; retraining and further training, in particular digital and cross-sectoral skills; and enhancing health and safety at work.

2

SECONDARY ANALYSIS: ELDERLY CARE WORKERS IN HUNGARY

2.1 METHODOLOGY

In the following, I have used the data from a questionnaire survey of those working in the social sector, conducted in early 2021, for secondary analysis. The data collection, which was commissioned by the Ecopolis Foundation, was conducted in professional social-care groups, with an online questionnaire published on group Facebook pages. The total number of individuals in the clean sample was 1,280, of which 565 were selected for the present analysis (those working in home help, signal-based home help, day care, and residential facility care). The sample is representative of the sector in terms of gender, age group, region, and care specialization. In terms of education level, the methodology of data collection (online survey) means that those with only primary education are under-represented. The data is not representative in terms of type of maintaining institution.

As of 31 December 2020, according to the CSO data provided in response to the above-mentioned 2021 public-interest data request, the number of those working in the sector, subdivided by the type of care they provided, was the following: 12,932 in home help, 164 in signal-based home help, 2,588 in day care, and 17,373 in long-term residential care. Thus, the total number of individuals working in old-age care is 33,057, with a distribution of 47-53% between basic and specialist care, and 48-52% in the sample. Their distribution by type of maintaining institution is shown in Table 2. Based on this, although the sample largely corresponds to the overall workforce, it cannot be called representative.

Table 2
Distribution of Employees by Type of Maintaining Institution (31/12/2020)

type of maintaining institution	number employed by sector	proportion (%)
local government	15,425	46.7
church, ecclesiastical institution	10,942	33.1
business	2,538	7.7
national government	2,220	6.7
non-governmental organization	1,931	5.8
total	**33,057**	**100%**

Source: SCO data publication

2.2 EMPLOYEE DEMOGRAPHICS

96% of respondents were women (they make up 92% of the total social service sector) – a gender imbalance which is remarkably high by international standards. They make up 98% of those employed in home help. Looking at the data by level of educational attainment, we can observe that compared to the social service sector as a whole, the proportion of those with a tertiary education is the lowest among those working with the elderly (27%). 39% of respondents are between 41 and 50 years of age, and 43% are over 50 (the average age is 49). Thus, old-age care is among the most affected social service sectors when it comes to ageing.

Figure 1
Distribution by educational attainment in the sample

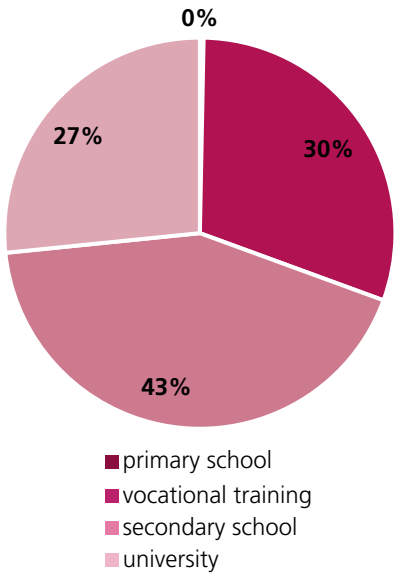


Figure 2
Age group distribution in the sample

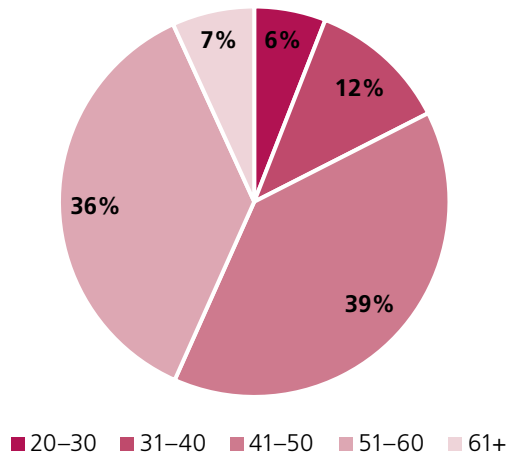


Figure 3
Maintainer of the respondent's workplace

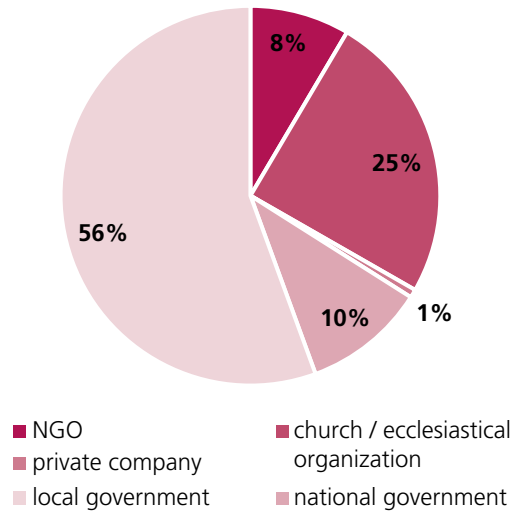


Table 3
Proportion planning to change jobs

"Do you plan to change jobs in the next 6–12 months?"	basic care (%)	specialist care (%)
yes, but within the social sector	8.4	10.7
yes, and I would rather be in the private sector	8.2	6.3
yes, I imagine my future abroad	4.7	6.8
yes, and not in social work, but I want to stay in the public sector	5.6	10.7
I do not plan to change jobs	73.1	65.4
total	**100**	**100**

Table 4
Reasons given by those planning to change jobs

reason for changing job	percentage of those planning to change jobs
low wages	78.3
my work is mentally or emotionally overwhelming	45.7
my work is too physically demanding	37.1
constant organizational uncertainty	27.4
inadequate working conditions	25.7
professional or ethical conflict	16.6
I do not receive my statutory benefits	9.7
conflict with a manager	8.0
conflict with colleagues	7.4
I do not receive my legal wage	6.3
I cannot reconcile work and family commitments	2.9

A large majority of those in the elderly-care sector are therefore women in their 40s and 50s, and have been working in their current jobs for an average of 11 years.

As for type of maintaining institution, the majority work for local governments (56%). 10% work for one of the institutions maintained by the national government, under the Directorate-General for Social Care and Child Protection (SZGYF). 25% work for a church or ecclesiastical institution and 8% work for an NGO. Only 1% work for a private company. Compared to the distribution among the workforce as a whole, those working for local governments are overrepresented in the sample, while those working for church and ecclesiastical organizations and especially for private companies are underrepresented. Those working in basic care are 10% more likely to work at a local-government-maintained institution than those working in specialist care.

Employees have been working in their jobs for an average of nearly 11 years, with the longest-serving employee having held their position for 42 years. Broken down by category, the figures are as follows: 58% of respondents have held their current job for 10 years or less, 26% for 11–20 years, and 17% for more than 21 years. (Age and loyalty are also statistically correlated: the older someone is, the longer they tend to have been in their current job.) Their current job is, on average, the fourth of their career. For 30% it is their first or second job, while it is the second or third job of 26%, and the fourth or more job of 45%.

Given the above, it should come as no surprise that more than two-thirds of respondents (69%) do not plan to change jobs in the near term. Nearly a third (32%) would like to leave their current job, but the majority of these would like to remain within the broader social service sphere (10%). It also seems that it is extremely difficult for

those working in elderly care to leave the social sector due to age discrimination and typically low educational attainment. At the same time, the correlation is significant when examined by type of care: a higher proportion of those working in long-term residential care plan to change jobs than those working in basic care (35% in long-term residential care, compared to 27% in basic care).

78% of those planning to change jobs cited low wages as their primary reason. In addition, 46% consider their work to be very mentally and emotionally stressful, and 37% find it physically exhausting. Mental and physical exhaustion is much more common among those working in the elderly care sector than in other areas of the social sector. This is in line with international research findings. At the same time, it is also worth noting that balancing work and family life is generally considered the least problematic aspect.

From the written answers, lack of appreciation and low motivation appear to be common factors:

- there are too few carers in proportion to the number and condition of those cared for,
- no appreciation for the work,
- all former benefits have ceased since the 2010 restructuring,
- employees are employed on fixed-term contracts which are not renewed, despite labour shortages.

Aside from fixed-hours work schedules, shift work is the most common scheduling arrangement. As I pointed out earlier, part-time and other atypical work schedules are very rare in elderly care in Hungary, because of the extremely low wages. Compared to the sector as a whole, even flexible start and finish times are rare in old-age care (12% of workers in the social sector as a whole have this flexibility, compared to only 6% in elderly care).

Table 5
Working time schedule

work schedule	individuals	%
commission work	3	0.4
part-time	5	0.9
full-time – with a fixed working time schedule	310	55.0
full-time – shift work	213	37.7
full-time – with flexible starting and finishing times	34	6.0
total	**565**	**100**

2.3 EARNINGS, SECOND JOBS, SUBJECTIVE WELLBEING

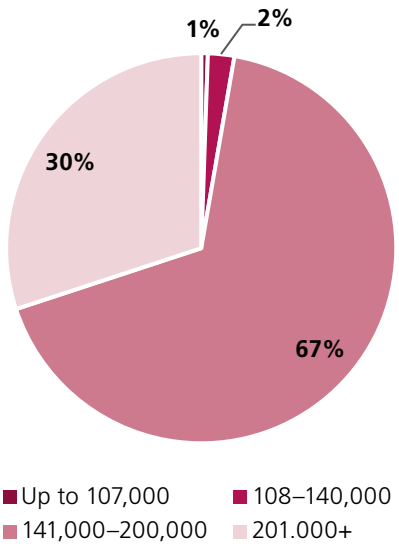
It is difficult to form a unified picture of the wage situation of those working in social services, including elderly care. The salary is based on Act XXXIII of 1992, which concerns the legal status of those in the public sector (the wages it lists have not changed since 2008), which from year to year are increasingly at the minimum-wage level (while in 2011 22% of the cells in the wage scale were at minimum-wave level, by 2021 that had risen to 85%, so the pay scale has now practically lost its original function, and there is no differentiation). In addition, three separate supplementary benefit schemes and several work supplements tied to a supplement minimum also affect actual salary levels (e.g. the social-sector consolidated allowance, the healthcare allowance, bedside allowance, and management allowance, while maintaining institutions may also provide separate allowances) (Meleg , 2021a). In a radio interview on 8 October 2021, Prime Minister Viktor Orbán announced a plan to increase wages in several sectors, including a 20% increase in wages in the social sector, which will in fact consist largely of an increase in the minimum wage. 'This increase also means that the salary scale for public-sector workers is essentially on the verge of destruction, as there are only 11 cells left which are above the minimum wage and salary requirements, and 94% of positions on the salary scale are minimum wage.' (Meleg, 2021b)

Regarding average wages in the Hungarian social sector, the disadvantageous situation of elderly care is obvious not only compared to the surrounding countries, but also to other sectors. Between 2013 and 2020, the net average wage of health care workers gradually rose to the national average, while the average for those working in education has been declining since 2016, but is still 88% of the average wage. In the social sector, however, including all allowances and supplements, wages were only 71% of the national average in 2020[11] (the CSO provides no separate statistics for elderly care).

Of those surveyed, 549 stated their income, meaning that only 16 people did not. Based on this, the mean monthly net salary, including all kinds of benefits, is HUF 198,000, while the median is slightly lower: HUF 185,000. (The difference between incomes is small, which shows the lack of differentiation.) Wages are on average HUF 10,000 below the social-sector average – the primary reason for which is to be found in lower average education levels. Overall, the net income of 70% of employees remains below HUF 200,000 per month (60% in the social service sector as a whole). 30% of employees earn over HUF 200,000, but only the heads of institutions have monthly incomes which exceed the HUF 300,000 ceiling.

11 cf. CSA, Stadat tables. 20.1.1.64. Average net earnings, without benefits, of full-time employees, by sector of the national economy

Figure 4
Distribution of net monthly wages (N=549)



We asked how much of this was made up by the wage supplement, and it comes to an average of HUF 52,000 (as compared to HUF 58,000 in the sector as a whole), which is, on average, around a quarter of the net wage (24%). One important explanatory reason for the variance between wage supplements is the type of maintainer:

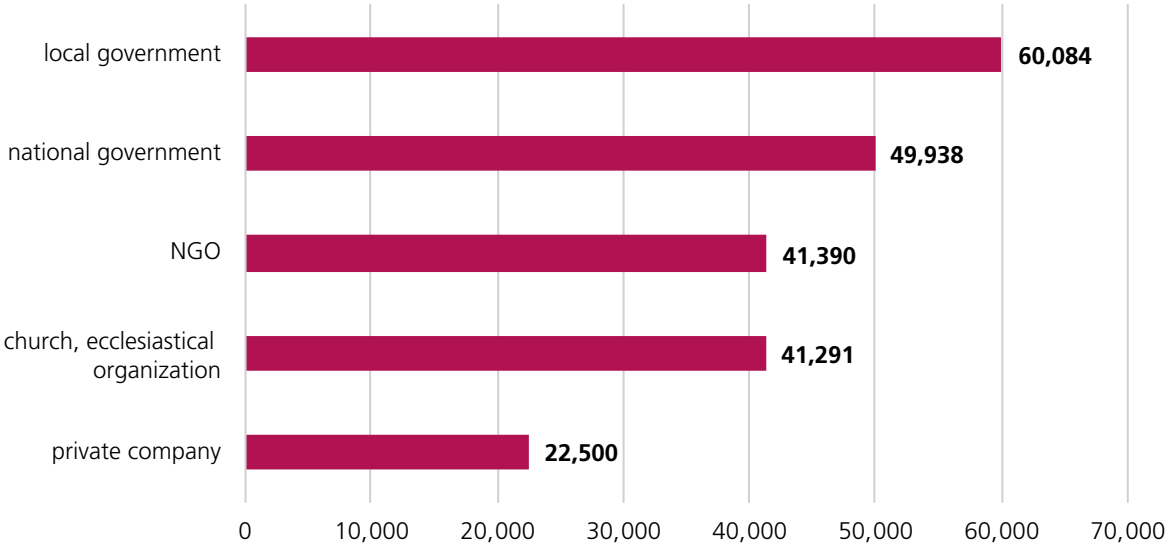
Table 6
Net average, median wage distribution by educational attainment

educational qualification level	average wage (total sector)	average wage (elderly care)
primary education	165,056	150,500
vocational training	177,082	178,173
high school graduate	185,037	183,836
university graduate	238,327	248,202
total	**207,000**	**198,352**

employees receive the highest proportion of wage supplements in the local-government sector, and the lowest working at private enterprises.[12] However, the lower level of the church wage supplement is surprising in that church maintainers currently provide the same care service for 83% higher state funding than, for instance, institutions maintained by local governments. (Running an analysis of variance, we found a significant correlation.)

Workers would consider an average wage increase of 50% higher to be fair (however, this is 6% lower than in the sector as a whole, indicating that they themselves do not value their work highly enough), but the 20% imple-

Figure 5
Amount of wage supplement by type of maintainer (HUF)



12 This is understandable for companies (especially joint ventures), as they are most discriminated against under the Budget Act (they can receive only 30% of the subsidies granted to local governments). See, for instance, 2020 XC. § 42 (1) c). A private company providing a social, child welfare and public protection service, or private companies maintaining such a service – excluding non-profit companies – and self-employed individuals shall be entitled to an aid equal to 30% of the aid referred to in points (a) and (b).

mented by the government on 1 January 2021[13] is less than half that.

Figure 6
Second job, extra work (Do You Have a Second Job?)

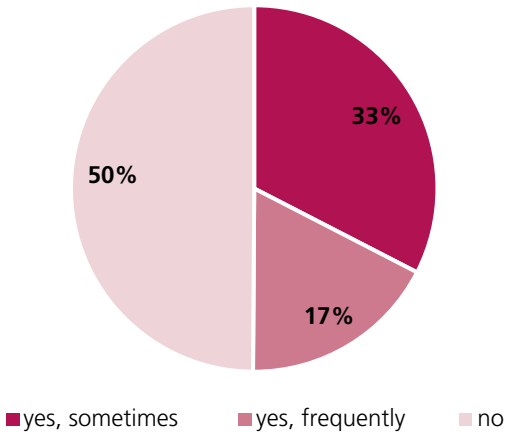


Table 7
Income from second job

Secondary income (net)	individuals	%
under HUF 10 000	30	12.8
between HUF 11–20 000	71	30.3
between HUF 21–50 000	60	25.5
more than HUF 50 000	31	18.2
rather not say	43	13.1
total	**235**	**100**

Table 8
Subjective well-being

"How do you feel about you and your household?"	Whole sector (%)	Elderly care (%)
We have no worries	4.4	2.9
We manage financially	27.5	23.3
We just get by on our monthly income	44.7	48.1
We have financial problems from month to month	21.6	23.3
We are among those in need	1.9	2.4
total	**100**	**100**

17% of respondents regularly work in a second job, and 33% do so occasionally (i.e. more than half of employees take on extra work, with differing degrees of regularity). However, 50% cannot do so (44% for the sector as a whole), and in other responses some explained why not. Typically, they already have health problems, are tired, are not allowed to split their work time, or simply cannot find suitable opportunities in their local area. Monthly net income from second jobs remains below HUF 50,000 for more than two-thirds or respondents.

Secondary activities are typically closely linked to full-time work (nursing care on weekends, healthcare assistance, observation, and temp nursing, but there are other minor, service-related jobs (cleaning, cutting hair, bathing, giving pedicures, etc.) Subjectively, however, only a quarter of respondents are satisfied with their income situation. 48% only just get by on their monthly income, while another 23% have financial problems from month to month.

2.4 PERCEIVED LABOUR SHORTAGE, STAFF TURNOVER

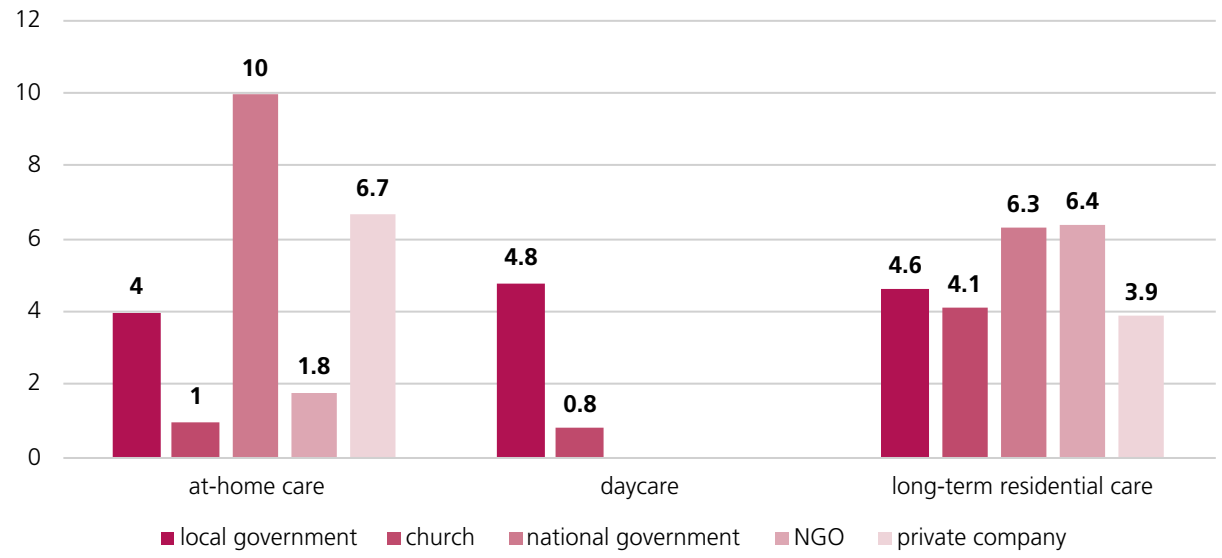
An average of 39 people work in an organizational unit. More specifically 25% of respondents work in a unit of up to 10 people, 40% in a unit of 11–25 people, 19% in a unit of 26–50 people, and 16% in an even larger organizational unit. The organizational units are thus, on average, smaller than elsewhere in the sector.

As we asked both how many people left within one year and the total number of people working in the organizational units, it was possible to calculate a staff turnover rate. According to this, on average, 23% of employees leave within one year (we do not know whether new employees took their place, so we cannot deduce from this a labour shortage, but in any case, the turnover rate is high, as the optimal level is below 10%, while 30% is critical: a quarter of employees work in an institution with a rate this high).

Labour shortages can be measured using several different metrics. One of these, with which we can partly compare the research data, is the number and proportion of listed and vacant positions (but this is only useful up to a point, as it does not show shortages of staff necessary for actual tasks, only the degree to which staffing meets a central standard). The information provided by the CSO in response to a public interest request, which has been mentioned several times, also covered this area. On this basis, it is clear that the labour shortage is most acute in at-home or close-to-home help – especially in organizations maintained by the national government. Within long-term residential care, shortages are likewise most severe among maintained by the national government and by NGOs, and at day-care facilities operated by local governments, but in general only local governments and church organizations operate such facilities. It

13 663/2021. (XII.01.) Government Decree No. XXXIII of 1992 on the Legal Status of Civil Servants 257/2000 on the implementation of the law in the social, child welfare and child protection sectors. (XII. 26.) on the amendment regarding wage increases for employees in the social sector. The law sets the reference amount for the consolidated social sector supplement from 1 January 2022.

Figure 7
Proportion of vacancies by type of care and maintaining institution (31 December 2020)



Note: based on the provided CSO data, own ed.

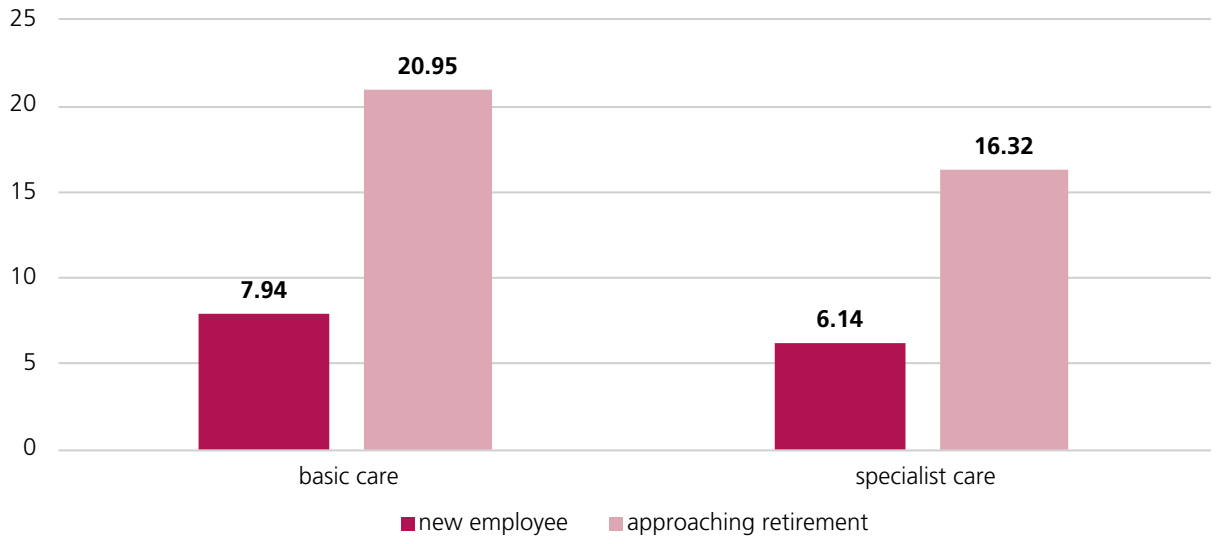
is worth noting that among all elderly care service providers, church-based organizations typically have the lowest number and proportion of vacancies.

Regarding labour shortages, we asked in the questionnaire how many additional employees they thought would be necessary to adequately fulfil the necessary tasks. Thus, we deliberately did not inquire about unfilled vacancies. Based on this, 59% of those working in elderly care perceived a labour shortage of more than 10% (compared to 68% in the sector as a whole). Within elderly care, 54% of respondents say that there is a deficit of more than 10% in basic care, while in specialist care the same figure is 65% – a significant difference.

Table 9
Labour shortage by type of maintaining institution in the sample

	0-10%	>10%
private company	25.0%	75.0%
national government	28.8%	71.2%
local government	39.0%	61.0%
NGO	39.6%	60.4%
church, ecclesiastical organization	50.7%	49.3%
total	**40.7%**	**59.3%**

Figure 8
Graduates in the Sample Close to Retirement



We did not find a significant correlation regarding types of maintaining institution, but in terms of labour shortages, the situation was perceived as worst in institutions and services maintained by private companies, followed by the services operated by the national government. It was seen as lowest in institutions maintained by churches. This data, which takes a different approach to measuring the labour shortage, is thus still in line with the data from the CSO. The relatively low labour shortage observed and actually registered among ecclesiastically maintained institutions may be due to the fact that working conditions in these institutions are generally better, and the maintaining institution more often permits the employment of extra staff in excess of normative staffing levels, as shown in our interview research in the next chapter.

Within institutions, we inquired regarding the number of employees at the beginning of their careers, and about those close to retirement. From this, as we know the total staffing numbers, we could calculate a percentage. On average, the proportion of new entrants is 7% and that of those close to retirement is 19%. The proportion of those working close to retirement among those working in elderly care is higher than in the social sector as a whole (16%). Within elderly care, the problem of staff ageing is most acute in basic care, where the proportion of those close to retirement is 21%.

In their written responses, employees were asked to explain whether there had been any reorganization since 2010 that had brought about a significant change in their work. A huge number of stories were shared – changes had taken place almost everywhere. The main topics are briefly summarized below:

– A change of maintainer is a serious problem everywhere, especially if an institution is placed under church maintenance (additional benefits are generally lost, as is the public-sector legal status and managerial status),

> 'The place was handed over to a church maintainer. They terminated our public-sector status.'

> 'Care was outsourced in 2011, and the institution I work at went local-government-maintained to church-maintained. In the last 10 years, despite the church getting more government support, I haven't seen any improvement in either working conditions or the standard of care. On the other hand, organizational problems, conflicts, high turnover, shortages of staff and money, and a bad work atmosphere have been typical during this period.'

– Reorganizations and institutional mergers for cost-cutting reasons:

> 'An institutional merger. This has led to a broader range of care recipients (e.g. care for the disabled and care for psychiatric patients combined with care for the elderly').

– Conflicts with the (usually unqualified) manager appointed by the maintainer, frequent changes of manager (in many places the appointment of managers involves local politics, with managers building contact networks, so that decisions are made over the heads of employees).

– Labour shortages and the resultant overwork (they do not replace departing colleagues with new ones, so one person ends up doing more work for less money, people take up irregular employment, social workers have to work as cleaners etc., and tasks are constantly changing. In one instance eight-hour shifts were replaced by twelve-hour shifts.

> 'Performing several jobs alone due to chronic staff shortages.'

> 'One cleaner in a social care home for 90 people. Employees, social workers and nurses also perform daily/weekly cleaning tasks, thus reducing the time available for those receiving care.'

– Deceptive practices regarding wages, and few skilled workers:

> 'I am a qualified social sector caregiver and nurse. And all my co-workers are employed as basic caregivers.[14] The lack of experienced professionals and qualified nurses. Completing the online course teaches you nothing.'

– An increased and steadily increasing administrative burden for oversight purposes only:

> 'There have been a lot of changes in the last four years, but unfortunately their impact has been totally negative. There is a lot of paperwork and documentation to complete, and this is unfortunately to the detriment of those who are cared for. There aren't many of us, just 3–4 nurses for everyone who needs care.'

– Managers are also in a difficult position:

> 'Elderly care belongs to a micro-regional association in this area, and before that each village institution had its own manager. Then all the work was put under the direction of one person, which became an awful lot, the head of the institution hardly ever wins, and gets no help – no secretary, no work car, not even a work phone. With all the administration, paperwork, invoices, etc., there is hardly any time to deal with the really important things, that is, to deal with care recipients, relatives, and co-workers. Often a manager even has to work from home at night to keep things

14 The point here is that their grade in the pay scale does not match their education.

running. When the manager retires, I have no idea what will happen, because no one else has the same levels of energy. I am afraid of what awaits us.'

'The position of administrator was abolished, so as head of the institution I was left alone to take care of everything.'

– Care recipients are also arriving in an ever more serious condition:

'We only get residents who are in a very serious, bedridden condition. Which makes our job very difficult.'

'There are more and more people in need of all-round care, so the physical and mental strain is increasing. That's why we need more nurses than the legal standard.'

2.5 THE PHYSICAL-EMOTIONAL STRAIN AND DANGER OF WORK

The working conditions of those employed in elderly care typically involve excessive paperwork and digital administration, quick responses to unexpected situations, frequent encounters with emotionally disturbing situations, and frequent physical contact with care recipients. In addition, serious physical strain due to the lifting and moving of patients is a common feature of work across the social sector. (In this regard, it is worth noting that kinetics training, which is mandatory for caregivers in many countries around the world, is completely unknown in Hungary.)

The dangers of the workplace and high stress levels are also indicated by the amount of physical and verbal abuse from care recipients. A quarter of respondents reported that such incidents happen more than once a year, and 56% said they sometimes happen – in all, 81% of those working in elderly care (the figure for the sector as a whole is 83%). Due to the condition of those receiving specialist care, such occurrences are much more common there (30%) than in basic care (19%).

The answers to the attitude questions show that, compared to the sector as a whole, those working in elderly care were more affected by the pandemic, are more tired and exhausted, and a much higher proportion consider staff numbers insufficient, given the number and condition of care recipients, than do those working in other sectors.

Figure 9
Working Conditions (In Your Work, How Often Do You Encounter…?)

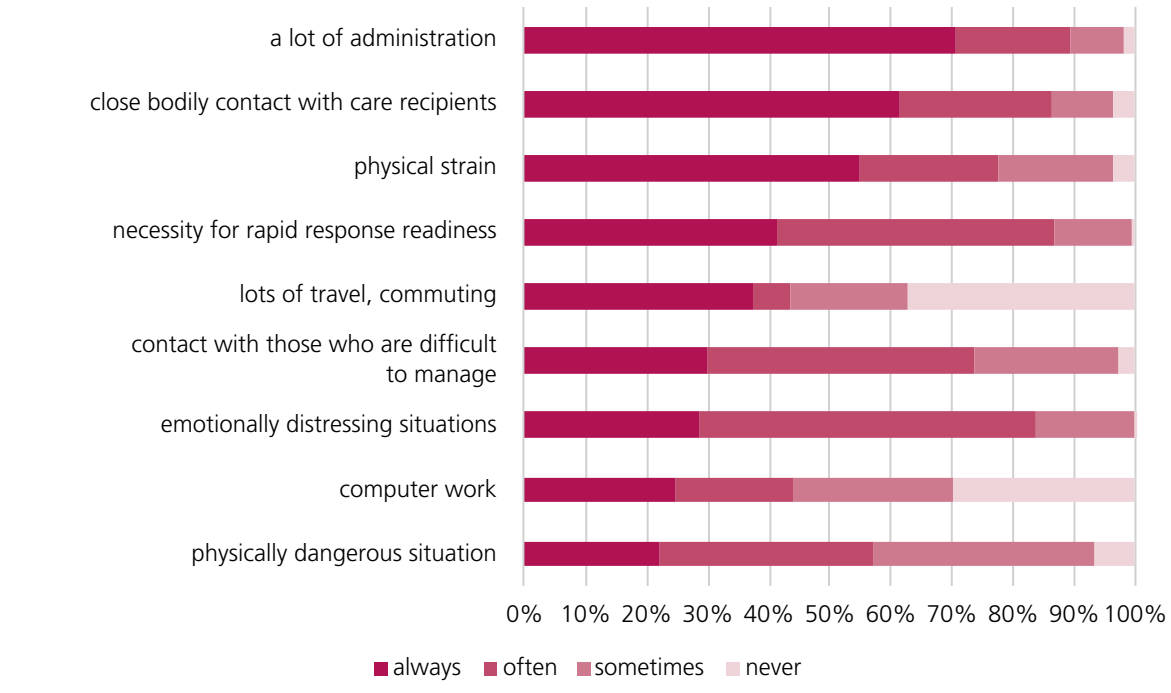


Figure 10
Have You Experienced Physical or Verbal Abuse from Clients in the Last Year?

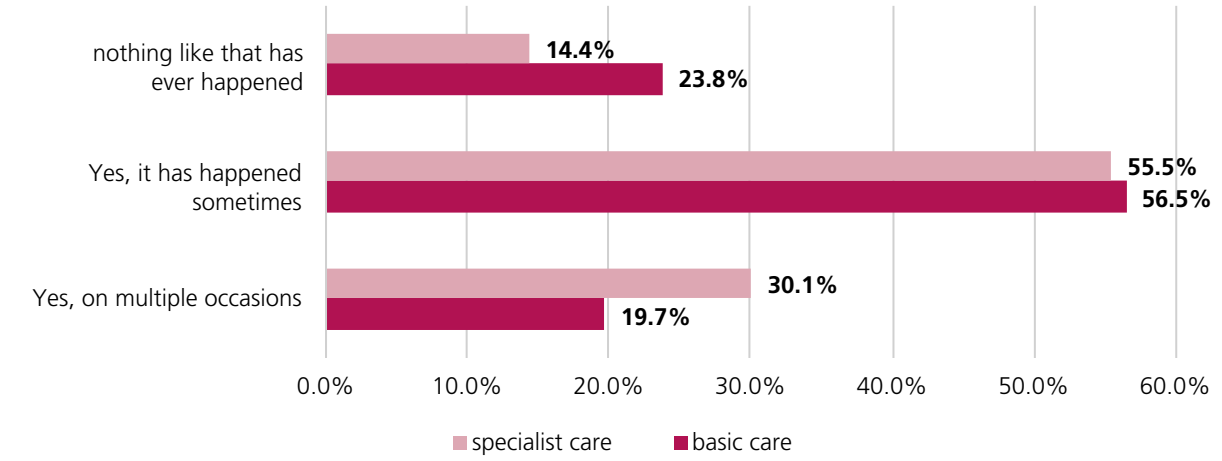
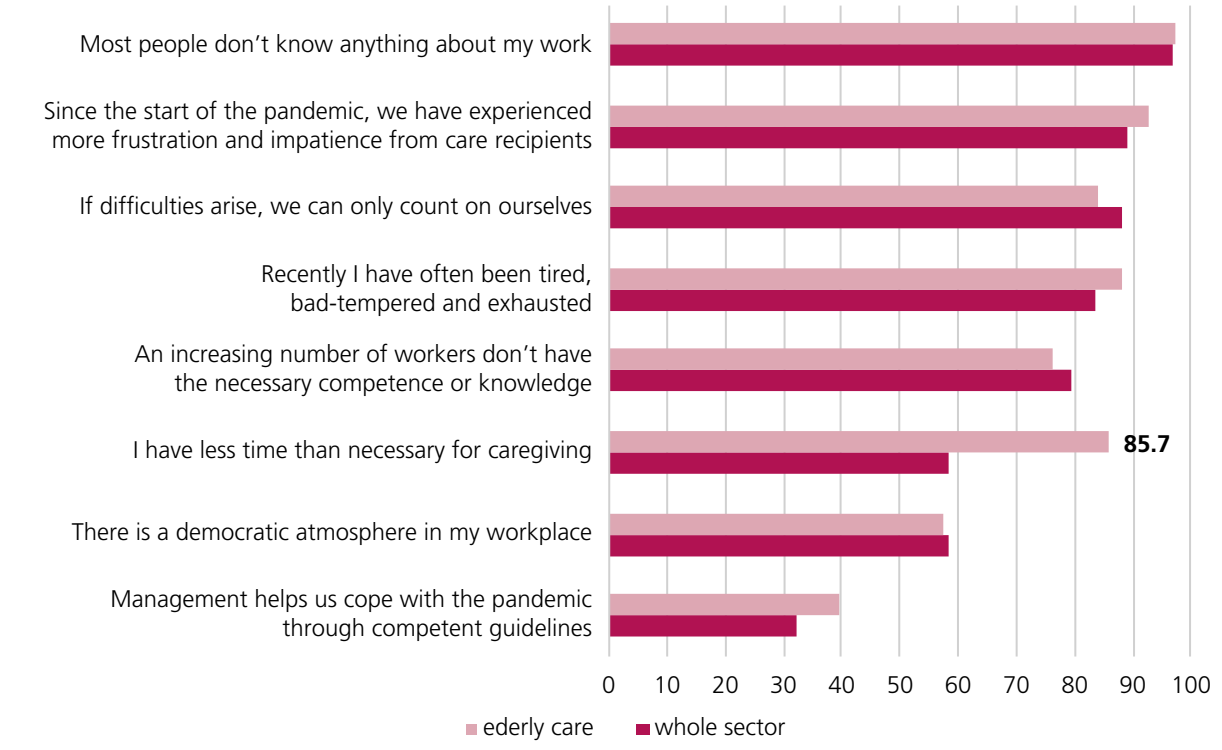


Figure 11
Answers to attitude questions (% Agreement Rate)



2.6 TRADE UNION MEMBERSHIP, ADVOCACY

88% of respondents are not members of any union. There are two main reasons for the rejection of trade unions: first, few know of any, and second, they do not see the point of joining a union in the current legal environment. Compared to the sector as a whole, a much higher proportion of elderly-care employees lack information about trade unions (10% higher). This point was also frequently raised in their written responses (they have never been contacted, they do not know about them, and there is no basic organization in their workplace. Some even said that unions had been banned in their workplace, which is a clear violation of employment rights). In addition, those who do know about unions are more dissatisfied with their performance than in the social sector as a whole (it can be assumed that those in elderly care feel as though unions are not concerned with them, but workers in some places do also express unrealistic expectations of them).

We also asked what kind of advocacy activities employees though would help their cause. The good news is that only 13% rejected all proposals, while 87% expressed willingness to get involved in some form of campaigning activity (although those in elderly care appear substantially less involved in some activities than workers in the sector as a whole). For example, 28% of the entire sector expressed a willingness to take part in demonstrations, while only 14% of those working in the elderly care said the same, while the intention to take part in strike action is much lower.

Figure 12
Reasons for turning down membership (Why Are You Not a Member of a Union? N=302, Yes %)

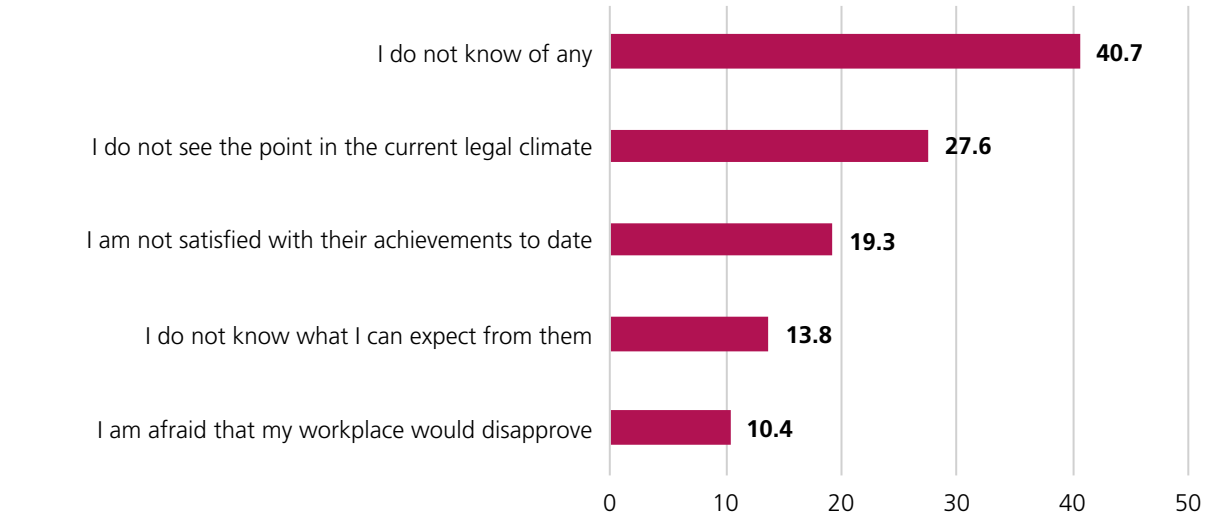
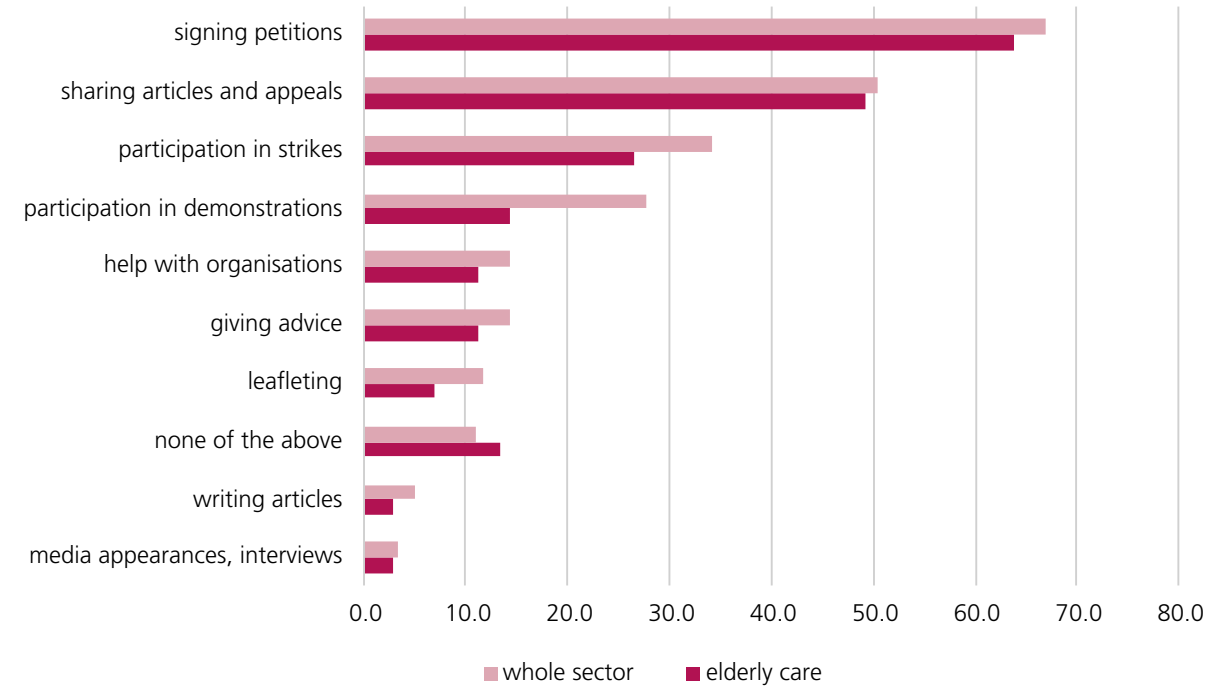


Figure 13
How would advocacy help? (Campaign Activity – % Yes)



3

RESULTS OF THE INTERVIEW RESEARCH

The main goal of our interview research was to explore the relationship between the quantitive research data, and to interpret causal relationships. Therefore, in September and October 2021, personal interviews with 17 people working in elderly care were conducted at 10 locations, according to a structured interview outline. The interviews were conducted by Ildikó Somorjai.

Recruiting interviewees was complicated by the fact that many fear retaliation from the maintaining institution if they give an interview. We could not find anyone to interview in Northern Hungary, while Western Transdanubia is overrepresented, and in terms of maintaining institutions, the smaller maintainers, i.e. non-profits and companies, are not represented at all. At the same time, as legislation and inspections leave all institutions with very little room for manoeuvre – whether in terms of staff numbers, working hours, or working conditions – regional differences are not a particularly significant factor, as we will see from the interview details.

In order to protect interviewees, we only indicate the region in which the interview was conducted, the position of the interviewee within the organization, and the type of maintaining institution (interviews were typically given by managers).

Table 10
Interviewees

region	maintainer type	care	position
Western Transdanubia	local government	basic care	manager
Western Transdanubia	local government	basic care	carer
Western Transdanubia	local government	basic care	club leader
Western Transdanubia	Municipality of Budapest	elderly care home	manager
Western Transdanubia	Municipality of Budapest	elderly care home	nurse
Western Transdanubia	church	elderly care home	manager
Central Transdanubia	local government	merged institution	institutional director
Central Transdanubia	local government	merged institution	elderly care home director
Central Transdanubia	local government	merged institution	manager of basic service centre
Central Transdanubia	church	elderly care home	manager
Central Transdanubia	church	elderly care home	carer
Central Transdanubia	local government	elderly care home	manager
Central Hungary	church	elderly care home	manager
Central Hungary	church	elderly care home	psychologist
Central Hungary	Municipality of Budapest	day-care facility	carer
Northern Great Plain	local government	elderly care home	manager
Southern Great Plain	national state government	elderly care home	group leader

3.1 STAFF IN INSTITUTIONS: COMPOSITION, STAFF SHORTAGES, FLUCTUATION

3.1.1 Composition

Regarding staff composition within institutions, the interviewees said the same thing as the survey showed: namely that the largest proportion belong to the 40–50 age group, and these are considered to be long-term, reliable employees – if they retire, there is literally no one to replace them. They are typically mothers, while men are employed almost exclusively in technical jobs.

Young people also rarely work in these institutions, and the reasons for this are varied. Some say they are less able to withstand physical and mental strain, while even the prospect of changing incontinence pads is a deterrent in itself. In addition, young people are generally more mobile and educated, and elderly care would not provide them with adequate pay, growth, or career opportunities. Levels of responsibility, on the other hand, are high, as work typically involves fulfilling healthcare-related tasks.

> 'If we calculate that a university graduate working in the social sector takes home around HUF 200,000 a month, if she has been working for many years, or perhaps 220,000 max, then she's going to take her degree and say she doesn't want to work here anymore. That's not what she studied for. Because she, too, has to take the old people to the bathroom and wash them, including wiping their bums if necessary, and do the dishes, and serve food, and clean. But she didn't study just to be a cleaner, or a dish-washer, or a basic caregiver. (…) T., for example, left because she was put together with a partner, and neither of them had healthcare training. So say an elderly person becomes unwell, and neither of the two caregivers has healthcare training. What can they do? They can call ambulance, but they have no idea what the matter is, or what to do until the ambulance arrives, because they haven't been trained.' *(Western Transdanubia, day-care manager)*

However, this can also be interpreted as a generational conflict that stems from differing expectations. For young people in the end, it is just a job, while older people tend to have a stronger sense of community with their colleagues. In several places they reported bad experiences with young people because they are quicker to claim sick leave without any notice. This can make an already tight schedule, which everyone already finds difficult to cope with, impossible to implement.

The qualification level is generally adequate everywhere, and meets legal requirements (80% qualified). Anyone hired without the appropriate qualification level must undertake training. However, institutions can no longer pay for this, so it is up to the employee to arrange it. At most a day off may be allowed, but even this causes difficulties, and is a source of conflict.

3.1.2 Staff shortages: causes, consequences, coercive solutions

Institutions are constantly struggling with staff shortages. On the supply side, reasons include low wages, difficult working conditions, lack of equipment, excessive workloads, and high levels of responsibility – I will return to these factors later. On the demand side, many heads of institutions explain staff shortages with reference to the provisions of Decree 1/2000 of the SZCSM. This regulation has been in place for more than 20 years, during which time statutory staffing levels have become completely decoupled from the number of carers required to fulfil actual care needs, while certain formerly mandatory positions have been removed. The intent of the decree's formulator was to allow institutions to hire additional workers above the statutory limit, but since these are not centralling funded, in reality only church-based maintaining institutions can afford to do so. In signal-based home help, for example, the job of coordinator is considered optional, forcing managers to look for loopholes. This means that the employee who actually performs the role of coordinator will be recruited at a lower level.

> 'I have a service for which the regulation requires me to provide two people on standby for every 40 devices, but for instance, the job of signal coordinator was removed from Decree 1/2000. Those who write the decree always cover themselves by saying it's only a minimum staffing requirement and the maintaining institution will supplement it. But the maintainer won't provide it if it's not written down. It's complete rubbish, and they know it. How can you remove the signal coordinator from the professional staff? For example, we have over 300 devices out there. This requires a full-time employee to oversee, but she can't be officially listed as a coordinator, and instead has to be classed as a caregiver, because otherwise the maintainer will say she's not in Decree 1/2000.' *(Western Transdanubia, local government institution, manager)*

The care needs assessment was introduced in 2008, according to which only those requiring over four hours of care a day can be admitted to nursing homes (this is currently defined using a points system, and someone becomes eligible for care with 40 points or more, or if he or she is diagnosed by a qualified professional as suffering from dementia, or is disabled). In practice, only those unable to care for themselves reach the 40-point threshold. As a result, those in nursing homes are now primarily elderly people who are in very poor health, bedridden, incontinent, suffering from dementia, and whose condition continues to deteriorate even after admission. However, the aforementioned government decree does not take this into account when setting staffing levels.

> 'We are constantly monitoring and following these changes in the condition of residents, but we're unable to increase staff numbers to the necessary level. (...) So the numbers have not changed, but care has become much more difficult. It would be advisable to increase the number of staff at least to the numbers available on hospital wards, or at least on wards with elderly people with a confirmed need for increased care.' *(Central Transdanubia, local government facility, managing director)*

Staff shortages are common not only among specialist caregivers, but also among technical staff. It is also important to discuss their role, because in the context of the COVID-19 pandemic, it has become clear how much institutions have come to rely on their replacement work. Due to the small number of professionals, technical workers are also often involved in caregiving (for example, porters help a night nurse who is alone on a shift if a patient falls out of bed). These workers are in an even more difficult position, in that many only receive the minimum wage, without any supplementary payments. They are trying to keep these workers on through retirement cooperatives.

> 'In a residential institution, the cleaners don't get a bedside allowance, which I think they deserve, or a hazard allowance (...) But I think you can imagine what looking after 69 people with dementia entails. My cleaning ladies do nothing but clean up excrement for most of the day. There is one cleaning lady who takes home HUF 80,000, and is raising a child alone. She cannot receive the minimum wage for skilled workers, the way the others can, because unlike them she doesn't have a skilled-labour qualification. But they all do the same job. I think it's a miracle she's still here. It's very hard to find cleaning ladies, because they can earn a lot more as domestic cleaners. We're trying to solve the shortage of cleaning ladies in our institutions by employing our more elderly cleaning ladies through a retirement cooperative. But they are 65–66 years old, so this is only a temporary solution. We can count on them for a couple of years, of course, unless they suffer an unexpected accident, a deterioration in health, or simply say they can't do it anymore.' *(Central Transdanubia, municipal home, general manager)*

The consequences of staff shortages include a lot of sick days (workers 'escape' through sick days), high staff turnover, and the fact that workers have to be able to fill several jobs at the same time (substitution is rare, and multiple roles are allowed in smaller institutions). This is why institutions count themselves lucky if they can employ someone in a management role who has healthcare as well as social care qualifications.

> 'But literally, from prescribing medicine prescriptions, I do almost everything, and it adds up to a lot. This has been reported several times, and not just to the maintainer, but to the director, because there used to always be a senior nurse and an on-site manager. Now both have been eliminated and I have to fill in for both positions. So while we're at breaking point, all we hear is 'that's the way it is' and 'you've got to learn to live with it'. That's why so many managers have left. The staff turnover rate is high.' *(Northern Great Plain, local government nursing home manager)*

The consequence of labour shortages in basic care include the fact that caregivers also work in day care centres, and vice versa. In cases where there is only one service provider for an entire sub-region, caregivers can be sent anywhere within the entire sub-region. Another consequence is daily stress, with no breaks, no lunch time, and with only minimal hours to provide home help, there is no capacity at all for mental care:

> 'More than once, a desperate relative has come to me to tell me that their mum has dementia. But it would take 3–4 hours for someone to get out to her and back. I have to tell them that we can't take her on. I simply can't afford to have a caregiver spend more than 90 minutes with a client, because then more people would not have access to care, and that would be a breach of the right to access care. There is never any discussion about increasing staff levels… There is no rest time. (...) I know there needs to be a conversation about that as well, and elderly people living alone are particularly badly provided for, but we simply don't have the staff for them.' *(Central Transdanubia, local government basic care provision, manager)*

Institutional solutions of last resort include exploiting administrative loopholes. The ubiquitous method used in home help is a 1–1.5-hour daily care statement. That is, even though they officially state that an elderly person needs help for 2-3-4 hours a day, they prepare a statement declaring that only one hour of care a day is needed, because the existing number of caregivers is no longer sufficient to provide higher care levels. In residential care homes, it is likely that managers in charge of triage will try to make sure that not only those with the most severe care needs are accepted from the waiting list, because they know that caregivers can only take on so much.

> 'We try to keep to a ratio for both bedridden patients and those with dementia. It is very important to stick to this, because otherwise it is not possible to maintain professional standards, since even as it is we can only hope to stabilize the situation.' *(Central Transdanubia, local government nursing home, manger)*

3.2 MATERIAL ESTEEM

3.2.1 Salary, supplements, fringe benefits, and their consequences

Salaries are determined by the public sector salary scale and the supplementary payment system. It is a problem that today the wage scale has essentially lost its function, since 90% of salaries are at the minimum-wage level. This means that someone at the very beginning of their career earns the same amount as a staff member who has been there for ten years. Differentiation is only possible through supplements. The social sector allowance is linked to employment and length of service (i.e. a person who has not previously worked in the public sector is not entitled to it). An additional supplement in nursing homes is the bedside supplement (HUF 24,000), an amount which has not increased since 2005, and which is not available to everyone who actually works at care recipients' bedsides – for instance, those who work in at-home care are not entitled to this supplement.

> 'The home caregiver has no shift supplement, no hazard bonus, nothing for the weather, for bicycle journeys, or anything else I could list. There is no bedside supplement, even though in at-home care are constantly at clients' bedsides. (…) You get a bedside supplement working in a nursing home, but in nursing homes there are more people, so one or two people can help you lift a heavier individual. There are lifts, and in some cases there are hospital beds with electronic controls. There's nothing like that to help you in an-home care, and you're completely on your own.' *(Western Transdanubia, basic care service centre manager)*

Another important factor the supplement provided by the maintainer, which is discretionary. For example, the Municipality of Budapest pays social care providers such a supplement, called the 'Budapest supplement', and other local governments are known to do the same (but unfortunately there is no reference data regarding how much each local government gives).

> 'I can say that our salaries aren't too bad. Not that my salary is the highest it could be – I distribute the money, the wage balance, everything. In addition to the normal allowances (shift allowance, bedside allowance, social-service supplement, etc.), we also get the 'Budapest supplement'. At first we received this on an irregular basis, but now it's regular. This is the capital's contribution to our work in the countryside.' *(Western Transdanubia, local government nursing home manager)*

Wage tension has been noted: it exists not only between at-home carers and those working in nursing homes, but also, for instance, between carers and nurses. Those with healthcare qualifications receive a special supplement, which is a significant amount by the standards of social sector pay. Many see this as unfair, as specialist care tasks are seldom needed, and the same tasks are performed by nurses and carers most of the time.

> 'Conflicts between employees generally occur because someone with a health qualification receives a healthcare supplement, but does the same job.' *(Western Transdanubia, local government nursing home manager)*

Wages in institutions maintained by ecclesiastical organizations are generally no higher, despite the current church support rate, which is 83% higher than for other types of maintainer. Only half of this difference is actually paid to the institution, which goes entirely on wages, while the rest remains with the maintainer.

> 'The fact that the church support rate is higher is not at all perceptible, because it's not received by the institution. Now it means 83% extra, but the institution only gets 50% of that 83%, while the rest stays with the maintainer.' *(Western Transdanubia, church nursing home manager)*

Fringe benefits meant something different for each location we visited, depending on the preferences of the maintainers, and the options open to them. In some places only work clothes are provided (and shoes only after one year!), while others provide a work clothes voucher for a certain amount. In still others two overalls and a pair of slip-on shoes are provided every two years. One interviewee said that at their institution 'clothes money' had also ceased, and that now at-home caregivers only get boots every two years, and two coats. In addition, some locations also provide cafeteria allowances, car use, or public transport reimbursement.

3.2.2 Black market, unofficial work

However, low wages and fringe benefits collide with a growing and unmet need for care, the direct consequence of which is the sale and **marketization** of care. This activity primarily provides income support to those working in close-to-home care, albeit on the black market (families would not be able to pay the market rate, and nor would it be worth taxing caregivers – and this is the case even in Western Transdanubia, one of the richest regions in Hungary). There are services available on the market, but in the opinion of interviewees these are largely inactive due to the lack of customers with the means to pay fees.

> 'I was having a tough time too, so the only way I was able to keep us at the level we needed to have food on the table and so on was to take on black-market work. But that meant I didn't have a Saturday or Sunday off, or even a single free night. So here I took on at-home care (work). The family couldn't change incontinence pads, couldn't do all sorts of things, and anyone who

has to be cared for in the morning and afternoon is going to have to be cared for in the evening, too. It is not officially allowed, but everyone can do it, because it doesn't require all the paperwork and organization, or tax payments.' *(Western Transdanubia, local-government-maintained institution, home caregiver)*

3.3 WORKING CONDITIONS: SCHEDULE, WORK INTENSITY, PHYSICAL ENVIRONMENT, WORK EQUIPMENT, ADMINISTRATION

Due to the nature of the tasks, multi-shift work is common in nursing homes. There are day and night shifts, both of which have their own difficulties. Day shifts are physically demanding, as patients must be bathed and have their incontinence pads changed, and the pay is lower. The night shift, meanwhile, is mentally difficult, as there are only one or two nurses on duty, and given the condition of the patients, anything can happen, so there is a heightened level of responsibility. Shifts can be four, six, or twelve hours in length. Managers try to adapt these to individual needs, because this flexibility is almost their only means of retaining their workforce. This kind of flexibility is also referred to by many as 'family-friendly', but due to the consistently high numbers on sick leave, it is very difficult to put together functioning schedules.

'For all employees who work in a nursing and care jobs here, flexible working hours are the foundation. So we have a time off wish-list. This creates tremendous difficulties in putting together the schedule, but it is one of the means of retaining this workforce, which we cannot afford to let go. We try to make allowanced for those with young children, so if someone says they can work from eight to four, we will build up their work schedule to make that happen. So in other words, we are forced to adapt.' *(Central Hungary, church nursing home manager)*

They try to provide the same 4–6–8-hour flexibility in at-home care, as many employees are single mothers with young children. For them, the single shift is an attractive aspect of this job (no night or weekend work).

The work is fast-paced and minutely subdivided. The number of caregivers per care recipient – i.e. the intensity of the work – is extremely high. In home help, there is an average of 5–6 care recipients per caregiver per day, plus travel. The number of care recipients per carer in nursing homes is also high (20-25 people), but, as has already been mentioned, it is also important to bear in mind the condition of those receiving care, and the lack of means to look after them.

'How many caregivers per care recipient? It's a disaster! There are usually three caregivers in a shift, for 50 people. Three people. In one place we have 28 incontinence pads to change, in the other 34, and everywhere there are at least ten who require complete care. (...) So those three nurses are very stretched. At night there are only two on duty, and they (the care recipients) are very sick.' *(Western Transdanubia, church institution manager)*

There are usually **no breaks**, and a pause for lunch can only be arranged in nursing homes (in some even this causes difficulties). At-home caregivers typically do not have a lunch break – they eat when they get home.

'There are no breaks… They eat when they can. In one case a colleague had her lunch interrupted four times because she was needed. It will be a wonder if it doesn't affect her nerves, or her stomach. (…) The worker has no opportunity to rest or step back, even if she is very tired. There is a task to be done. Maybe those who smoke and drink coffee get a little respite with a cigarette break, but there's nothing else.' *(Central Transdanubia, nursing home managing director)*

In some places, managers do provide a separate room (e.g. a nurses' room or library) for employees who are already very exhausted to retire to for a short time, but this is not common. Nevertheless, the introduction of such facilities is recommended elsewhere. (In another institution, because the caregiver travels to work by public transport, which is not available on weekends, she is provided with a room and a mattress, where she can sleep.)

'If an employee is very tense, or wants to step out of a situation a bit, she can go to the library room, where there is also a massage chair. If she feels like relieving some tension, she can start a program. There's also a gym with an exercise bike that can be used, but it is less popular than this retreat to the library.' *(Central Hungary, church nursing home manager)*

Infrastructure, work facilities. The buildings housing elderly care facilities are typically old, and were not originally built for this purpose (some are former stately homes with protected heritage status). Heating and lighting are usually adequate, but the rooms are small and may not be fully accessible, and there are too few of them for all necessary functions – especially now that, due to the pandemic, isolation rooms have had to be set up.

It is possible to submit renovation proposals, and it is typically church-maintained facilities that have used this option, while the condition of institutions maintained by the Directorate-General for Social Affairs and Child Protection (SZGYF), for instance, are critical (though the same is true for many institutions maintained by local governments). Many believe that maintenance of these institutions has been largely abandoned, as they are soon to be handed over to church authorities.

'… You have to understand that this building (the care facility) is over a hundred years old. There has been no painting for ten years. We have to send a report to the SZGYF every month, in which we list all the places

where windows or plumbing need replaced, or bathrooms renovated, so everything that needs work should be described. I found that in the 14–15 months I was there, the same reports went out every month but there was no change. So that's why I'm saying the worst possible institution is an SZGYF-maintained institution, especially now that the church has its eye on it, because I don't think they're going to invest money in the system. If the church needs it, it will take it as it is and then renovate it, and that's definitely what everyone expects. So extremely bad conditions, a draughty building, old, poor-quality linoleum, and falling tiles.' *(Southern Great Plain, national-government-maintained institution, middle manager)*

The situation with the equipment is the same. The furniture is old and worn out, and in many places it can only be replaced thanks to donations from relatives and others. (There is also a shortage of incontinence pads: only three are provided per care recipient per day, which is often not enough). Regarding the beds, several people who work in at-home care have said that in many places they are pushed up against the wall which causes problems, and many care recipients have sofa-beds that are too low for care activities. Adjustable beds are rare. There is also a shortage of modern hospital beds in nursing homes, and usually no lift. Even if there is, caregivers often find it cumbersome to use, and prefer to lift by hand, which in turn is physically demanding. Bathing presents many of the same problems: bathrooms are often not completely accessible, or are too small for moving patients. There are special bath beds for bedridden patients, but these are rare in institutions.

'The size of the bathroom causes problems when it comes to bathing, as two people have a hard time fitting in at once. We have a simple tub on which the seat is placed, which allows us to turn or move the resident, but there is no lifting device or anything like that. It would be great if we didn't have to bathe in bed those who could still be got out of bed, but we can't bathe them in the bathroom because they can't stand, and we can't put them onto the rotatable seat, so instead we bathe them in bed.' *(Central Transdanubia, church institution manager)*

Computer provisioning is poor – a fact confirmed by all interviewees. This is a problem mainly because there is a requirement in social services to keep daily electronic records, which is hampered not only by the KENYSZI system[15], which many criticized, but also by the condition of the machines themselves.

3.4 HEALTH CONDITION, STRESS, BURNOUT, ABUSE

As far as health is concerned, musculoskeletal problems are common among caregivers, due to the frequent lifting of patients and heavy objects. Spinal hernias, other spinal problems, varicose veins, leg and hand pain – these are all common conditions, which explains why so many people drop out of work for weeks at a time, and sometimes apply for a different job. Thus, these are all both causes and consequences of staff shortages.

'If we look at the other workers, and examine the physical strain they're under, we see that musculoskeletal problems frequently arise… It is the lifting of recumbent residents that is most difficult. But then there is also the fact that residents often have to be helped into a wheelchair because they can easily lose their balance and fall. Among the male residents, for instance, there were some individuals who could only be lifted by two people. (…) It is also a physical burden for caregivers to have to bring residents' lunches from the dining room or the kitchen, always right to the given care unit. It's a big, heavy trolley, the dishes themselves aren't necessarily light and the weight of the food is considerable… Injuries and sick leave are quite common. Several have had operations on their hands for carpel tunnel syndrome, and then they're on sick leave for a long time after the surgery. There are a lot of the same issues with spinal injuries.' *(Central Hungary, church nursing home manager)*

'Last week we buried a colleague who worked here for 25 years. He died within two months. He collapsed during a night shift, and after that events quickly accelerated. He was 61 years old. It's really affected us all. Many of us have had spine operations, spinal hernias and musculoskeletal disorders are frequent, and everyone is skinny.' *(Western Hungary, church institution manager)*

For those working in at-home care, in addition to physical exertion during care, they often also have to cycle long distances through mud and frost, in winter and in summer.

Besides physical strain, mental strain is also very significant among those working with the elderly. One reason for this is clearly the pace of work, which in turn is the result of staff shortages: slogging through tasks, or not being able to complete a work procedure without being disrupted by unexpected events.

'The psychological burdens include the exhausting pace of work. So we're constantly getting interrupted in our work and losing the plot. We can never get to the end of a work procedure. I have to read through the medication sheets for 30 patients, but I know it will take half the day, because in the meantime they call out for us, the telephone starts ringing, patients come and go, people get sick, and we call an ambulance. The number

15 KENYSZI is the so-called user registration system, from which data is sent to the Hungarian State Treasury, and this is used to check normative support spending. The system is outdated, and does not help the administration. Several explained why not (it does not follow changes in legislation, does not allow care duplication, does not indicate where the error is if there is a spelling mistake in the entry, allows self-monitoring only once a month, etc. Gathering administrative complaints would be worthy of a separate study).

of people in pain here is almost the same as in a hospital. Here, too, you get everything from fainting to vomiting blood, from feeling poorly to full heart attacks, and I won't move from the sickbed until the ambulance arrives. I oversee the work shifts, but we have to do inventory checks in the meantime – we're doing a supply check at the moment – and at such times all our attention is diverted from the patients. This has been the case for years. And then there's all the other work we're always behind on, so we're just continually slogging away, and never catch up. It's the same for nurses and caregivers. Everyone's behind, and we're constantly feeling this pressure, this burden, and the situation has only gotten worse under Covid.' *(Northern Great Plain, local government nursing home manager)*

In addition, processing the deaths of care recipients takes a very heavy mentally toll, which is another reason why many people leave the sector. In at-home help, caregivers find it very hard to deal with when they are the ones to find a deceased care recipient, with whom they have often already developed an emotional attachment (service managers try to help by not giving the caregiver a new client right away, but giving them some time to recover). It is also a real challenge for caregivers if care recipients behave aggressively, even when it is only because of their dementia, or is offensive to the caregiver, blaming them or making impossible demands of them – despite the fact that they are well aware of the effects of dementia.

According to one of our interviewees, who has a qualification in mental hygiene, the majority of caregivers show clear symptoms of burnout. However, supervision is not provided in any institution (for either managers or employees). Managers try to organize additional training, trips, team building activities, and group discussions, but they too know that these are not real solutions.

'But there is no supervision for employees either. On Friday we went on a study trip to T. We managed this thanks to a small grant from the local government, there is no separate budget for this either. You know as well as I do that the wellbeing, the extra professional things that colleagues need so as not to collapse, can only be achieved through such grants. Such things don't exist in the barebones social budget itself.' *(Western Transdanubia, head of municipal basic services)*

Two interviewees reported explicit abuse. This is either a taboo subject among carers, or else is taken to be 'natural' given the condition of those they care for. They are more willing to discuss other carers who are difficult to deal with.

'Abuse? Well, there hasn't been anything as serious as that, but sometimes dementia patients can gets more aggressive, squeezing our hands too tightly, or maybe even lashing out, but nothing more serious than that has happened, thankfully. All the same, they have to be cared for in a totally, totally different way than regular care recipients.' *(Western Hungary, nurse at a local government supported nursing home)*

3.5 TRADE UNION MEMBERSHIP, ADVOCACY

Trade unions are active in few places, and even where they are, they appear to be largely for show. This is partly because few employees join, and partly because there are no events or gatherings they can attend, given their work schedules: there is simply no time for advocacy activities. Several said they had attended demonstrations before, but had seen no results. Compared to the healthcare sector, it is as though the social sector did not even exist, which has left them very disappointed. At one point, an interviewee who was also a union representative told us how difficult it was to persuade employees to join. Those who decline union membership do so not only due to membership fees, or a lack of time or legal experience, but also under pressure from maintainers.

'But we did have a district supplement. I was a union representative, and last year, in March 2020, we fought for some extra money, as well as clothes money, in the collective contract. Uniformly, everyone received HUF 54,000 in clothes money for a year, which meant that my salary came to HUF 193,000 gross. It was very difficult in the union. Everyone complained and so on, but they simply refused to join. I represented the clubs in the district, and the day club had a total of five locations, but out of all of them, a total of six people joined as members. Our goal for the whole district was for the membership rate to reach 20% at some point, but no. And altogether the dues would have been HUF 2,110 a month per person, which isn't much money. And it bothered me that no one took me seriously as an individual, while the fact that the employers themselves are not clear about the rights of the employees is very disturbing.' *(Budapest local government elderly club carer)*

3.6 COVID EXPERIENCES

In connection with the COVID-19 pandemic, we wondered how the job had changed in general, which measures were affecting institutions and caregivers, and how all this affected the condition of those receiving care.

Government and EMMI protocols.[16] The general opinion is that the procedures were ill-thought-out, mutually contradictory, did not fit either the way institutions oper-

16 The Szocokos (support web) internet portal provides a list of all pandemic legislation and protocols relating to social work: https://tamogatoweb.hu/index.php/hirek/napi-szocokos/460-szocialis-munka-jarvany-idejen; https://tamogatoweb.hu/index.php/hirek/napi-szocokos/557-szocialis-munka-jarvany-idejen-2-0; https://tamogatoweb.hu/index.php/jogszabalyfigyelo/jogszabalyok-2021/708-koronavirus-jarvany-elleni-vedekezessel-kapcsolatos-intezkedesek (link in Hungarian)

ate or the condition of the patients (they were largely modelled on procedures for hospitals). There was no one to consult regarding clarification or interpretation and institution heads did not receive formal answers to their questions, while inspections continued to operate in the same manner.

> 'The government's management of the pandemic was dreadful. We were given conflicting instructions, and when we asked for a clarification on an issue, in order to adjust it to local conditions, no one took responsibility. I still have emails saved on my computer that I haven't received a response to. (…) In the end, we developed our own protocol to mitigate the effects of the pandemic.' *(Western Transdanubia, local government nursing home manager)*

Isolation rooms could only be set up in the already overcrowded institutions by reducing the number of residents (this was helped by a drop in admissions, and by the fact that many on the waiting list postponed moving in). Isolation is currently exclusively reserved for those who have returned from hospital, and are thus subject to a three-day quarantine. Disinfectant barriers were also difficult or impossible for homes to arrange.

Protective clothing, equipment, and disinfectants were not supplied, and had to be purchased from institutional budgets, while in some places workers disinfected rubber gloves with bleach, and initially staff were only given cloth masks, which they had to wash and iron daily. In addition, there were pointless and unenforceable protocols, such as mandating that residents wear masks even in their own rooms, all of which were checked by experts from the National Centre for Public Health (NNK).

> 'For me, absolute rock bottom came at the point when the institutions had been 'locked in' for more than two months. It was impossible to go out to public places, and everyone really was locked in their rooms. And then, suddenly, something (happened, and) there were too many face masks, or they needed to sell more, or something. Anyway, the upshot was, between 8 a.m. and 4 p.m. the residents had to wear facemasks in their own rooms. Then, when the NNK inspector came to check, I told him that we can't be there in the room all the time, so we can't check if someone with dementia is starting to suffocate! But they had to check that too.' *(Western Transdanubia, church nursing home manager)*

But the appearance of military personnel in the institutions for the stated purpose of carrying out disinfection was equally incomprehensible to institution managers.[17]

Impact on the condition of care recipients. Waiting lists were long even before the Covid pandemic, with an average two-year wait for a bed, and managers say it has grown even further, to 4–5 years. Many are putting off moving in, but nevertheless require care. Pandemic-related deaths occurred in every home where we conducted interviews.

The care recipients were mentally overwhelmed by confinement, which accelerated their deterioration. Keeping in touch over the phone is very difficult for an elderly patient with dementia.

> 'The condition of the residents, especially their mental condition, deteriorated terribly, and this was worsened by their separation from their relatives. The relatives themselves also suffered terribly from this. Trying to speak on the phone despite poor hearing and not understanding the situation also really disturbed them. In the end, relative generally called less and less often. People with severe dementia no longer recognizes their relatives, but the fact that someone is there and touches them is experienced, and is also missed. If someone is there and holds their hand, they appreciate it, but trying to have a conversation through a metal box is no use whatsoever. Eight people died, but they were very elderly, and their age really was a big contributing factor.' *(Central Transdanubia, church nursing home manager)*

Mental strains continued to arise in at-home care, but as detailed above, there was no capacity for mental health care even before the pandemic began.

Staffing problems, replacements. In addition to the controversy over the already insufficient staffing levels, finding replacements has been the biggest and most difficult problem for the institutions. Many employees dropped out of work – either because they caught the disease, because they were in a vulnerable age group, or because they could not take care of their children due to the closure of schools and kindergartens. In such circumstances, all the nursing home could do was involve all the workers – from cleaning ladies to the porters – in caregiving. All of this was exhausting, and generated constant conflicts between workers. What is more, it meant there was time for only the most necessary activities.

> 'One day 26 nurses dropped out because of Covid. And it wasn't like in the hospital where you could close a ward and redistribute patients – there was simply nowhere for them to go. We had to figure it out on site! Here, everyone from the cleaning lady to the hairdresser became a carer. Anyone whose task was not urgently essential, because residents had to be fed, had to have their incontinence pads changed, had to be bathed; everything still had to happen. It was impossible to cease care for the residents, but it left everyone completely exhausted.' *(Southern Great Plain, a national-government-maintained nursing home middle manager)*

17 https://honvedelem.hu/hirek/idosotthonokat-fertotlenitettek-a-katonak.html (link in Hungarian)

Labour law problems arose, which meant that despite all this, in some places replacement workers were not even paid substitution compensation.

> 'During Covid a lot of people didn't work, either because of kids and what have you, or because of their health. Those of us who stayed worked, but the law states that if someone is on sick leave for more than 30 days, and someone else works in their place, then that person should be paid substitution compensation. Neither I nor anyone else got anything. The conditions are not good anyway, but those of us who stayed and worked were much worse off.' *(Budapest district government, elderly care club, caregiver)*

Hospital evacuations, care for the over-70s. Due to the evacuation of hospitals ordered by the health minister in April 2020, elderly people in need of care became the responsibility of either at-home care or basic care, but caregivers were in no way prepared for this specialist care burden (either in terms of experience and training or in workload).

> '(…) It was a constant problem that the GP would tell us (the carers) to do this and that. Or that the hospital called, and said they're sending Józsi, an elderly care recipient, out of the hospital tomorrow. And the manager was constantly arguing with them, saying that the type of nursing he needed was beyond our capabilities. Because it's within the job description of a caregiver to replace stoma bags, but beyond that, what do they expect? More advanced care requires specialist training. Or they would call at two o'clock, saying tomorrow we're bringing this or that elderly person home, and they'll need 24-hour care. Well, we don't do that, and we can't organize it, especially not the very next day.' *(Budapest district government, elderly care club, caregiver)*

Government Decree 46/2020 (III.17) was promulgated on 16 March 2020, in which the government requested that persons over the age of 70 not leave their places of residence or abode. If a person over the age of 70 undertakes to do so, and informs the local government about their situation, the mayor of the local government is responsible for meeting that individual's care needs. Later, the obligation to provide care for persons in compulsory home quarantine was added to this. These tasks were to be performed by at-home carers.

Material difficulties: prohibition of second jobs, lack of substitution payments. An additional financial difficulty for caregivers was the ban on second jobs (we found in the questionnaire study that more than half of employees had another source of income before Covid), which was introduced in order to reduce the risk of infection. Despite the increased workload, the caregivers' salaries did not increase during the pandemic, so the ban on second jobs put many people in a very difficult financial situation, and some relationships and families collapsed under the strain.

> 'During Covid, the problems only intensified or became more visible. Taking a second job is impossible – it's forbidden. The employees are exhausted, and a lot of them are sick. Relationships and marriages have been ruined.' *(Western Transdanubia, church nursing home manager)*

Several also complained about the fact that the government paid them no attention even after the second wave had subsided: only very tardily, and after the mass infection in an elderly care home on Pesti Road maintained by the Municipality of Budapest, did it become apparent to them that this sector exists at all – and even then their only response was to scapegoat employees. Unlike healthcare workers, those working in elderly care received no official recognition or financial reward, though there were maintainers who felt that their work ought to be recognized, and found just the way to do it.

> 'When it was all over, I received HUF 15,360, after one year of substitution work – that was my whole reward. I said to my husband, we could buy three bottles of Unicum (a popular liqueur), and that'll be it gone. I mean really, when I saw it, I didn't know whether to laugh or cry.' *(Budapest district government, elderly care club, caregiver)*

It is hardly a surprise that several of our interviewees have since resigned.

REFERENCES

EUR (2021a): Long-term care report: trends, challenges and opportunities in an ageing society. Volume I, II.

EUR (2021b): Grubanov-Boskovic, S., Ghio, D., Goujon, A., Kalantaryan, S., Belmonte, M., Scipioni, M., Conte, A., Gómez-González, E., Gomez Gutierrez, E., Tolan, S., Martinez Plumed, F., Pesole, A., Fernandez Macias, E. and Hernandez-Orallo, J., Healthcare and long-term care workforce: demographic challenges and potential contribution of migration and digital technology, EUR 30593 EN, Publications Office of the European Union, Luxembourg, 2021, ISBN 978-92-76-30233-9 (online), 978-92-76-30232-2 (print), doi:10.2760/33427 (online),10.2760/234530 (print), JRC121698.

Eurofound (2015): Violence and harassment in European workplaces: Causes, impacts and policies, Dublin.

Eurofound (2020): Long-term care workforce: Employment and working conditions, Publications Office of the European Union, Luxembourg.

Kamińska et al (2020): Salaries of social workers in Europe, Report, Polish federation of social workers and social service employees unions

Oliver William Jack Beer (2016): Predictors of and Responses to Social Workers: A National Survey

Gyarmati, A. (2006): Idősellátásban dolgozók munkahelyi körülményei (Working conditions of elderly care workers), Kapocs, year V ed. 3.

Csesznek, C. – Şimon, M. (2019): The Profile of Social Services Workers Employed by the Local Councils and Their Perception of the Job of a Social Worker: an Exploratory Research in Braşov County Revista de Asistenţ\ Social\, anul XVIII, nr. 4/2019, pp. 23–35

Mack, J.D. (2012): Why Social Workers Remain in the Field: An Exploratory Study on the Protective Factors Associated with Social Worker Perseverance

Mel**eg, S**. (2021a): Bérek, bérpótlékok a szociális, gyermekjóléti és gyermekvédelmi ágazatban. (Wages and wage supplements in the social, child-welfare and child-protection sectors.) http://www.tamogatoweb.hu/irasaink/berek_berpotlekok_2021_02_06.pdf (letöltve: 2021. november 10.)

Meleg, S. (2021b): Béremelés (Wage increase), 2022. https://tamogatoweb.hu/beremeles-2022/ (downloaded: 10 November 2021.)

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SITUATION OF THOSE WORKING IN ELDERLY CARE IN THE EU AND HUNGARY

Contracts should be collectively negotiated across the sector.

Improving working conditions for carers (health and safety at work) and promoting social dialogue in the sector are also important tools for making the sector more attractive.

Therefore, in addition to recruitment, targeted and systemic efforts are needed to retain a well-trained workforce over the long term. Policy options include the following: improving working conditions and pay, in particular through enhanced social dialogue; improving work organization; retraining and further training; and enhancing health and safety at work.

Systematic data collection and data processing concerning employees should be important elements. In Hungary, too, several national institutions collect data, but this is not processed or incorporated at the planning stage, so there are no evidence-based practices or impact analyses.

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