Eszter Kováts

The Effect of Covid-19 on Women in Hungary

A Short Analysis of Social, Economic and Policy Changes

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About this publication

Eszter Kováts maps the gendered social effects of the pandemic in Hungary with a focus on labour market situation, care work and violence against women, in the context of government measures to contain the virus. The gender bias of the Hungarian government's lockdown measures has manifested itself in a failure to pay proper attention to female-dominated sectors and the lack of help with work–life balance in relation to caring for children or the elderly. However, in the second, fourth and fifth waves the government postponed to the latest possible moment or even decided against school closures precisely to avoid overburdening families and to enable parents to keep their jobs. In line with global trends, reported cases of domestic violence and demand for related services increased during the lockdown in Hungary, too. As feminist organizations have repeatedly stressed, violence did not so much increase, as escalate in intensity.

About the author

Eszter Kováts holds a PhD in political science. Between 2012 and 2019 she worked at the Budapest office of the Friedrich-Ebert-Stiftung, where she was responsible for the foundation's East-Central European gender programme.

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1. INTRODUCTION

To begin with some background data, as of 10 May 2022, the number of people:[1]

- who had been vaccinated once was 6,407,918 (65.7 per cent of Hungary's 9.7 million population);
- who had been vaccinated twice was 6,194,102 (63.5 per cent);[2]
- who had been vaccinated three times stood at 4,162,198 (42.7 per cent);
- who had died was: 46,343 (the second worst proportion per 1 million population in the EEA + UK);[3] and
- the number of PCR tests was 11,394,556 (1,185,122 tests per 1 million population).[4]

A 2020 study in Nature, analysing over 3 million Covid-19 cases from 46 countries states that the virus is more dangerous for men than women, for reasons inherent in the differences between male and female bodies (such as testosterone hormonal levels influencing immune reactions) (Peckham et al. 2020). While there is no significant difference between men's and women's chance of contracting the virus, almost three times (2.84) more men than women were transferred to hospital intensive care, and 1.39 times more men than women died of Covid-19. Hungary was not covered in this study, and no official data are available on the distribution of men and women in statistics on the seriousness of the infection or of so-called "long Covid-19" or, for example, the occupations of infected people. There are only general sex-disaggregated data about deaths caused by the virus infection. According to one Hungarian article from March 2021 the then total of 20,500 deaths comprised 10,000 women and 10,500 men, so with only slightly more deaths among men (Haiman 2021). The Nature article also says that in the case of people with diabetes or high blood pressure there are no significant sex differences in relation to the proportion of deaths. In Hungary these two diseases or conditions are prevalent among both sexes, which may explain the similarity of the proportions (ibid.).

This aim of the present article is to map the gendered social effects to date of the Covid-19 pandemic in Hungary, with a focus on labour market situation, care work and violence against women, including in relation to government measures to contain the virus.

Generally it is fair to say that the gender perspective was not taken into account, neither by the Fidesz-KDNP government, nor the opposition parties, when it comes to the measures implemented. However, the government's reluctance in the second wave of the pandemic (autumn 2020), and the fourth and fifth waves (autumn/winter 2021–2022) to impose lockdowns was partly related to its desire to help families by keeping kindergartens and primary schools open (thus limiting the burden of care and enhancing the ability to hold a job). Also, some opposition MPs insisted on improving working conditions and pay in the social incl. elderly care sector, albeit without talking explicitly about the gender perspective.

2. CHANGES IN THE LABOUR MARKET AND WOMEN

In line with transnational trends, after the outbreak of the pandemic and the measures adopted to contain it the labour market experienced severe consequences in Hungary, especially in tourism, hospitality and personal services. Furthermore, employees in certain sectors were more exposed to the virus than others, such as retail, education, social services like elder care and, obviously, health care, in all of which women are overrepresented among the employees.

In contrast to many other countries, the Hungarian Parliament did not adopt meaningful measures to help the hardest hit sectors. In fact, one of the first measures it announced was a flexibilisation of the Labour Code for the benefit of employers (supposedly on the grounds that this would help them to maintain jobs). Also, there was little financial support for those affected by the rapid increase in unemployment. Hungary's unemployment insurance period is the shortest in the EU: the citizens can access it for only three months, based on the ideology of a "work-based society". The government refused to increase the period during the pandemic, not even temporarily, despite the fact that people lost their jobs because of lockdown and other measures.

As for the situation of women on the labour market, at least three aspects need to be mentioned in the context of the pandemic: the female employment rate, the situation of the female-dominated sectors, and transnational care migration. First, according to IPSOS data, already at the beginning of the crisis, 7 per cent of the Hungarian working population had lost their jobs by March 2020.[5] The situation was worse among women, among whom the figure was 13 per cent. Thus, the first estimates suggested that, unlike the 2008/2009 economic crisis, this time it was women who were losing their jobs first in Hungary. EIGE counted for the second quarter of 2020, based on Eurostat data, that around 4 per cent of men and 5.5 per cent of women had lost their jobs (EIGE 2021b: 9). Köllő (2020) estimated slightly worse figures for the same period, albeit with a similar gender gap (5.3 per cent loss for men, 6.3 per cent for women). This was partly due to the sectors they were mainly employed in, such as

1 https://koronavirus.gov.hu/; https://ourworldindata.org/covid-vaccinations?country=HUN

2 At the beginning of the vaccination process, women were more likely to refuse them, but in the fourth wave, while there was a slight gender difference (12 per cent of men and 14 per cent of women were reluctant to be vaccinated), it was not statistically significant (Ligeti et al. 2022: 37). In terms of rationale, however, men and women gave significantly different explanations of their refusal to accept the vaccine: women referred more often to the dangers of side-effects or some other health reason, while men tended more to doubt the efficacy of the vaccine against the pandemic or even the danger of the virus itself (ibid.: 39).

3 Data from 8 May 2022, https://www.statista.com/statistics/1111779/coronavirus-death-rate-europe-by-country/

4 https://www.worldometers.info/coronavirus/#countries

5 Two other polls confirmed these data, measuring 7 and 6 per cent, respectively (Tóth/Hudácskó 2020: 560561).

tourism and hospitality, which were hardest hit by the crisis, and partly the increased care burden following the closure of schools and kindergartens, making it impossible for many to engage in both paid work and (increasing) unpaid care work. The gender inactivity rate gap in Hungary rose above the EU average: in summer 2020 it was above 15 percentage points (EIGE 2021b: 13–14; OH 2021: 1).

Second, women are overrepresented in the social services jobs that were now in the frontline of the crisis: education (where from one day to another teachers had to move to online teaching), social care (including institutional elderly care, which was, as in other countries, a hotbed of the virus) and, obviously, the health care system. All three are heavily feminised sectors, and as they came under pressure it became abundantly clear who was doing these jobs, under what conditions, and with what recognition. In all three sectors, infrastructure is in a terrible state, staff are underpaid, and institutionalized dialogue with the government was abandoned years ago. All this explains the huge lack of personnel in these areas, as many leave the profession or emigrate to western Europe. From 1 March 2021 employees of the health care system had to sign a new contract, which changed their status from public servant to a specific type. The new law pursued various goals, such as banning gratuities or under-the-table paymentse and regulating the activities of health care workers who are employed in both the private health care system and use public infrastructure for their private practice. Those who did not sign the new contract lost their employment in the state health care system. The law received a lot of criticism from medical interest groups for the lack of consultation and for inducing new requirements and insecurities in the midst of the pandemic. Another controversial measure was introduced, aimed at decreasing the (increasing) labour shortage in the health care system, namely a temporary ban on health care workers quitting their job. This was in force between 19 November 2021 and 31 May 2022. To halt the fourth wave of the pandemic employers were given the right to make the first and second vaccinations mandatory and to send home unvaccinated employees on unpaid leave. Furthermore, if these employees did not accept the vaccine within one year, they could be fired. The law was criticized not only for making vaccination de facto mandatory, but also for outsourcing responsibility for it (the decision to impose it and bearing the consequences). Many schools made it mandatory for their teachers to be vaccinated, which further aggravated the existing labour shortage in education. Unrelated to the pandemic, in spring 2022 unusually large teacher protests took place all over the country after the Parliament took away teachers' right to strike. As for the social sector, elderly care in particular suffered a lot during the pandemic, affecting both the old people being cared for because of the lack of protection (institutional elderly care homes were hotbeds of the pandemic) and the ban on receiving visits from their relatives, and also their carers, again because of the lack of protection, but also the low pay and inhumane working conditions. And if that wasn't enough, they didn't receive the one-off state support of HUF 500,000 (then around 1,500 euros) that health care workers received in 2020 as compensation for their enormous workload and the risks the were exposed to during the pandemic. The pandemic and the government measures thus took a particular toll on these three sectors, in which women are overrepresented.

Third, the pandemic exposed western European societies' reliance on eastern European labour, not only in the case of seasonal workers, whose plight has made international headlines (for example, in Germany, Italy and the United Kingdom), but also in care work. Those who can afford to outsource parts of this work rely on lower-class and migrant women. It is through this "care drain" that higher female labour market participation has been achieved in the core countries of the EU. While emigration is still the better option for many eastern European health care and social care workers, their departure leaves a huge care deficit in their home countries. Despite trade unions' concerted efforts – in the sending and the receiving countries – to combat this trend, wages can be kept low and working hours long in western Europe as long as migrant women are ready to do the job under such conditions (which are still better than in their home countries). The pandemic, which led to the closure of borders, has severely disrupted supply chains, also in health care and elderly care, leaving western European countries facing an acute care deficit. In Germany, for instance, according to various estimates, by Easter 2020, 200,000–300,000 elderly people (cared for in nursery homes or within the framework of live-in arrangements) had been left without professional care.

While this article series is nationally oriented – that is, it takes independent and sovereign nation states as units – the various phenomena brought to light by the pandemic at the EU and international levels need to be addressed to obtain a full picture of national responses. This is best exemplified by the care burden and solutions to it, both before the pandemic and since its outbreak.

Experts have been drawing attention to western Europe's care crisis for many years, pointing to the need to find sustainable and dignified solutions for caregivers and people requiring care alike. Such solutions include better care infrastructure, adequate remuneration, regulated working hours and contractual protection. This applies both to those working in public long-term care facilities and to live-in carers who work in, for example, German households. For years, many European countries have been displacing care work from the public to the private sphere. Often on the pretext of "upholding civil liberties" governments have been shirking their responsibilities in both west and east. Families are left to sort out their own care situations. Those who can afford it hire a carer from East-Central Europe or, say, the Philippines, often without labour contracts and with exploitative working hours. Czech sociologist Zuzana Uhde calls this "distorted emancipation", in the sense that women's emancipation in the core countries (rich countries in the EU) is enabled by migrant carers. In other words, a German woman can go out to do paid work or enjoy free time because her Polish domestic employee takes care – often illegally – of her father suffering from dementia.

Besides the inequalities between individual EU countries the EU level must be discussed, too. The EU gender equality strat-

Table 1
Poverty and material deprivation in Hungary in 2019 and 2020 (by sex)

	Proportion of poor (relative income poverty, OECD median60) **MEN**	**Proportion of poor** (relative income poverty, OECD median60) **WOMEN**	**Proportion of people affected by serious material deprivation MEN**	**Proportion of people affected by serious material deprivation WOMEN**
2019	12.4 %	12.1 %	7.8 %	8.1 %
2020	12.3 %	13.1 %	8.1 %	8.5 %

Source: Hungarian Central Statistical Office.

egy 2020–2025, in line with the EU's neoliberal gender equality approach, treats care work as a burden on labour market participation (Zacharenko/Elomäki 2022). This is why expanding childcare institutions has been recommended. However, the working conditions and pay in these sectors remain unaddressed, and women are encouraged to take up professions in more lucrative sectors (Kováts/Zacharenko 2020), ignoring the vital importance of the sector. The European Care Strategy currently in preparation, however, seems to be a step in the right direction.

To conclude, care migration in Europe exhibits intersectional, gender and regional inequalities. Not only are women overrepresented in this form of exploitation but gender inequality here is embedded in and largely structured by intra-EU inequalities, similar to those in agriculture and the meat processing industry. A truly intersectional analysis should not merely look at those who are affected, and from which societal groups, but also address – at the same time as gender inequalities – other intra-EU inequalities, rooted in the EU's very economic structure.

According to a survey conducted in April–May 2020 (thus in the first wave of the pandemic) 18 per cent of Hungarians reported a significant decrease in income following the imposition of restrictions: most affected was the age group 40–59 years of age (26 per cent), and least affected those over 60 years of age (9 per cent). There was a slight gender difference, to the detriment of men (19 vs 17 per cent) (Tóth-Hudácskó 2020: 557–558).

According to the latest available Eurostat data, the gender pay gap decreased in Hungary from 2019 to 2020, from 18.2 per cent to 17.2 per cent.[6]

The Hungarian Central Statistical Office collects data on poverty and deprivation; the latest data available, segregated by sex, are from 2020.[7] They reveal a slight decrease in poverty for men, and a 1 percentage point increase for women in the first dimension; in the second, deprivation, there was a slight increase for both sexes (0.3 and 0.4 per cent, respectively).

As for the social effects of the crisis: As described by many analysts (for example, Szombati 2020), class bias was very pronounced in state interventions in Hungary. The Labour Code was flexibilized; the sectors affected by the lockdowns, including SMEs, received – except for loan repayment suspensions – little or no state compensation; and what state help was available was channelled mainly towards the companies of oligarchs loyal to the government.

The gender bias of the lockdown measures manifests itself in the lack of acknowledgement of the female-dominated sectors and the failure to cushion the work–life balance aspects of the restrictions for couples with children or elderly people to care for. In the second and the fourth/fifth waves, however, the government postponed to the last minute or even decided against school closures precisely to avoid overburdening families and enabling them to keep their jobs.
Another rarely discussed aspect are the mental health effects of the lockdown restrictions and the requirement of "social distancing". According to a survey from the first wave, 16 per cent of Hungarians experienced increased feelings of being locked-in depression or anxiety, with a very strong gender difference: 11 per cent of men and 20 per cent of women reported this increase, and even more so among the elderly (Tóth/Hudacskó 2020: 562). This could be explained at least partially by the increased care burden (Fodor et al. 2020a, 2020b), which for obvious reasons affected single mothers most severely. Women's organisations repeatedly emphasised the situation of these women, numbering several hundred thousand (for example, NANE et al. 2021).

3. COVID-19 AND CARE

When Prime Minister Orbán announced the closure of schools and child-care facilities and a switch to online learning on 13 March 2020, over one million Hungarian couples with small children and several hundred thousand single parents were confronted with a huge challenge: besides procuring the necessary technical equipment (which was scarcely possible for many in a country in which more than half of all

6 https://ec.europa.eu/eurostat/databrowser/view/sdg_05_20/default/table?lang=en

7 https://statinfo.ksh.hu/Statinfo/haViewer.jsp

households only have enough savings to survive for two or three months), child care had to be organized. Not only did kindergartens close, but grandparents and private paid caregivers could also not be counted on.

In mid-April 2020, sociologists Éva Fodor, Anikó Gregor, Júlia Koltai and I carried out research into the patterns of the division of care labour during the first wave of the Covid-19 pandemic among internet-using Hungarians with at least a secondary school education (Fodor et al. 2020a). What we found in this higher-status segment was that, indeed, external help for such parents had collapsed: by two-thirds in the case of grandparents, by half with regard to other family members, and by four-fifths in the case of paid help (in comparison to pre-Covid-19 levels).

In our study we found that approximately half of the women and one-third of the men were working from home at the time of the research; those who with a university degree did this twice as much as those with only a secondary education. Working from a home office, which is always praised as the ultimate solution to the work–life balance for women with small children, turned out to be more difficult during the pandemic: 24-hour home care and assistance with home-schooling require a higher level of multi-tasking. While in our research both men and women reported that men had stepped in to help with care work more than before (including household chores and care for elderly relatives), women were still five times more likely than men to report that it would help if their partner took on a higher share of household chores and child care. Two out of 10 men reported tensions between their paid work and family care duties; the figure for women was four out of 10.

The existing infrastructure for care for the elderly and the chronically ill outside the home was also not prepared for the increased burden of the pandemic. Couples therefore found themselves with the extra task of looking after otherwise healthy grandparents (who could previously have been relied on for assistance but who now needed to be cared for, for example, for shopping).[8] Caring for the elderly who were already in need of assistance also became more difficult. One-third of the 1.8 million people aged 65 and over need assistance on a daily basis in their everyday activities in Hungary, but just tens of thousands reside in eldercare homes. (The waiting time to access the very few available places is two to three years). Also, municipal-level assistance structures were under immense pressure, especially because carers visiting the elderly could spread the virus themselves; the few families who could afford private, so-called live-in care have had to give that up, given the increased risks of transmission. Families therefore have been able to rely less on external help in caring for the elderly.

In fact, the study I conducted with Anikó Gregor in 2017 clearly shows that the tension between paid work and (unpaid) care duties was a major difficulty for Hungarian women even before the pandemic (Gregor/Kováts 2019). Measures to contain the spread of the virus thus exacerbated an already difficult situation. This is partly because of the care infrastructure, which was already underfunded and understaffed before the pandemic, and partly due to the new situation, thanks to the closure of schools and kindergartens and the even more pressing need to care for the elderly and chronically ill.

Telework, which used to be seen as a panacea for mothers' employment, has now shown a more ambiguous picture: on one hand it indeed helped a certain, white-collar "teleworkable" segment of the labour market to keep working and jobs despite the lockdown. "Workers able to telework during the COVID-19 crisis have been more likely to remain in employment and to work the same or similar working hours as before the crisis and have been less likely to suffer a decline in income" (EIGE 2021: 26). On the other hand, it exposed various problems:[9] (I) the rampant class inequalities: who has access to this option of caring for one's own health; whose work is essential to enable the (upper-)middle classes to work from home (production of technical devices, retail, food delivery and other essential work); (II) the extreme difficulties parents in paid work face when kindergartens and schools are closed at the same time; and (III) more generally, how it makes it more difficult to draw boundaries between a paid job and free or family time; and (iv) it increased the inequalities between men and women (women shouldering the larger share of the increased care burden), but also between women with and those without children.

Besides the smaller scale survey in April 2020, we conducted another study with Fodor, Gregor and Koltai in May 2020 (Fodor et al. 2020b, 2020c, 2020d), consisting in a representative computer assisted telephone interviewing, to map among other inequalities gender inequalities. We focussed, for example, on how families cope with the increased care burden, and how the pandemic affected the gendered division of these childcare duties. "We found that on average, in relative terms, men have increased their contributions at roughly the same rate (by 35 per cent) as women. But given that women had been doing a lot more childcare work before the pandemic, in absolute terms, women's contributions grew significantly more than men's and the gap between men and women has increased in absolute working hour terms. This was particularly so among a specific group of women: middle class, highly educated city-dwellers. Our data suggest that in Hungary the pandemic increased gender inequality the most among the highest educated" (Fodor et al. 2020c: 1) (see Table 2).

As for demographic trends: within 9–11 months of the beginning of the pandemic there was a 10 per cent decrease in births compared with the numbers from one year previously,

8 According to a survey conducted during the first wave of the pandemic, 49 per cent of those over 65 years of age received such help from relatives or other acquaintances (Tóth-Hudacskó 2020: 556).

9 "Although telework can offer workers unprecedented temporal (time) and spatial (location) flexibility, greater autonomy, an improved work–life balance and reduced commuting times, it can also lead to longer working hours, increased intensity of work, higher stress levels, blurred boundaries between work and private life and a greater sense of isolation and loneliness, which, in turn, may adversely affect workers' mental health and well-being" (EIGE 2021: 26).

Table 2
Weekly average hours spent on childcare (by sex)

	MEN	WOMEN
Mean hours per week spent on childcare before lockdown	19.3	32.4
Mean hours per week spent on childcare during lockdown	26.1	43.8

Note: For the significance of changes, as well as other data see: Fodor et al. 2020c: 8f.

but after that it went back to the average, or even increased. In more detail, only the first three months of the pandemic brought a decrease in conception; in summer 2020 it was even 10 per cent more than average. In spring 2021 there was again a big decrease in conceptions (Szabó-Morvai 2022).

Interestingly, while Hungary had an above-average (and above the necessary) proportion of caesareans among births before the pandemic (49 per cent of all births) this share has decreased significantly during the pandemic. This might be explained by the fact that medical interventions were minimized during the pandemic, so that hospitals may have performed caesareans in this period only in necessary cases (Szabó-Morvai 2022: 48–49).

The number of abortions has been continuously decreasing since 1990, this trend hasn't changed during the pandemic: it has been decreasing at the same pace (ibid.: 50).

4. COVID-19 AND VIOLENCE AGAINST WOMEN

The EIGE study on intimate partner violence in EU member states between March and September 2020 also conducted interviews with service providers, with one organization completing the questionnaire from Hungary (EIGE 2021a). I quote the scarce Covid-19-related data from this study and from empirical research on the helpline statistics of the biggest feminist service provider, NANE, in the second wave of the pandemic, from November 2020 to January 2021 (László forthcoming). Unrelated to the pandemic I also quote from Hungarian government sources (Hungarian government: 9th CEDAW report, and information material of the Hungarian Parliament: Országgyűlés Hivatala 2020).

In line with global trends, reported cases of domestic violence and demand for related services have increased during the lockdown in Hungary, too (EIGE 2021a: 16, 22, László 2022). In March 2020 alone, the official state helpline reported a doubling in the number of women asking for help.[10] As feminist organizations have repeatedly stressed, violence now was not increasing, but rather escalating in intensity. Women in households in which less severe forms of control and coercion were being exercised by the male partner prior to the pandemic were now facing a deterioration of the situation. Their isolation (often a tool of abusers) was now much easier, while frustration at being stuck at home and perhaps facing financial stress enhanced the likelihood of violence being committed. It is even more difficult to seek help outside the household (for example, a place in one of the very few shelters for domestic abuse victims) for those whose lives are in danger.

According to estimates from 2015, approximately 260,000 women are affected by intimate partner violence, although the latency must be very significant (OH 2020). As for the available places explicitly for victims of violence against women in 2020, according to official data, there are 20 crisis centres (with maximum stays of eight weeks), eight secret shelters (with maximum stays of six months) and two preliminary shelters, for a total of 320 affected women (OH 2020: 3), which is utterly inadequate. Against this backdrop the increase in violence against women during the pandemic could not be handled by the available infrastructure, although both the official violence against women hotlines, as well as those run by feminist NGOs reported an increase in the number of calls (László forthcoming). A striking new feature of the pandemic – related to the decrease in personal contacts – was the threefold increase in reported online violence, from 27 to 73 per cent (ibid). Also economic violence has increased: prior to the pandemic 66 per cent of callers reported this type of violence against women, while in the period under study it rose to 88 per cent (ibid). This might be related to the increased care burden and the loss of employment, hence the increase in economic pressure potential by the perpetrators.
In light of this, it was even more cause for worry when, in May 2020 the Hungarian Parliament –to the initiative of the junior coalition partner, the Christian Democratic KDNP – adopted a resolution not to ratify the Istanbul Convention, the Council of Europe Convention on preventing and combating violence against women. Their purported argument was that the convention would spread "destructive gender ideology" and "speed up immigration". While the Convention would indeed introduce the term "gender" into the legal system (which, in case of progressive legislation, could open the door to more radical, queer-understandings) (Kováts 2020c) and indeed urges signatory countries to take in refugees on the basis of gender-based violence, feminist scholars and activists have repeatedly pointed out that while the Hungarian government has the means to establish the necessary infra-

10 https://infostart.hu/belfold/2020/04/02/duplajara-nott-a-bantalmazas-miatt-segitseget-kerok-szama

structure to help the victims of domestic violence and to prevent further such cases even without ratifying the Convention, it seems reluctant to do so.

(which, in case of a very progressive legislation, could open the door to more radical, queer understandings) (Kováts 2020c)

5. CONCLUSIONS

The pandemic exposed many structural flaws and further exacerbated various inequalities in national contexts, entangled with transnational interdependencies. Previous policy papers on Covid-19 and gender and the EIGE analyses contain many useful policy recommendations on child care, health care and so on. What is missing is the transnational aspect (discussed in this paper under Point 2). However, the European Care Strategy currently in preparation seems to be a step in the right direction, including for the regulation of live-in care work. Both national trade unions should perhaps engage in more bilateral cooperation (for example, with Austrian or German trade unions) to improve the situation of migrant workers and to lobby for changes that decrease regional inequalities. The EU level could also take more responsibility, although the issue of competence would always arise. In Hungary the gender-specific effects have not been discussed by the united left-liberal opposition, although the disastrous situation in health care and education have been on their agenda for years. More generally, gender questions are discussed only to a very limited extent (sexism, female political representation, and most recently the government's anti-LGBT propaganda). Few individual MPs are working on elderly care issues and the pay situation and working conditions in the social sector, and those who do tactically refrain from framing them as gender questions.

We need to shed critical light on class relationships and regional disparities in Europe, as well as the responsibilities of the countries of the core. We must expose those structures that are at the origin of the disastrous state of health care and elderly care systems at the periphery of the EU. This includes distortions and conditionalities that are embedded in the very architecture of the EU and work in favour of richer countries. This directly or indirectly impacts the room for manoeuvre of national governments seeking to restructure their fiscal policies, including labour market and health care policies (Kováts 2020a). It goes without saying that, even with these limits, national governments have had some leeway in the Covid-19 pandemic, but limitations do need to be taken into account and we should not blame the governments of poorer EU countries entirely for their inadequate measures.

Whether carried out by men or women, care work – done as profession or by relatives – must be recognized as an essential prerequisite for the functioning of the economy, for the reproduction of the workforce and for human existence in general, in times of pandemic and beyond.

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EUROPA

The Effect of Covid-19 on Women in Hungary – A Short Analysis of Social, Economic and Policy Changes

- In the context of the pandemic, at least three aspects of women's labour market situation should be mentioned: the female employment rate (women have lost their jobs disproportionately more than men, especially in sectors such as tourism and hospitality); women's overrepresentation in the sectors hardest hit by the virus and the lockdown measures, namely health care, education and the social sector; and how the circumstances of women involved in transnational care migration have become more visible and have deteriorated during the pandemic.

- The gender bias of the Hungarian government's lockdown measures has manifested itself in the failure to pay proper attention to female-dominated sectors and the lack of help with work–life balance in relation to caring for children or the elderly. However, in the second, fourth and fifth waves the government postponed to the latest possible moment or even decided against school closures precisely to avoid overburdening families and to enable parents to keep their jobs.

- As for the increased care burden, a study in 2020 found, that found that "on average, in relative terms, men have increased their contributions at roughly the same rate (by 35 percent) as women. But given that women had been doing a lot more childcare work before the pandemic, in absolute terms, women's contributions grew significantly more than men's and the gap between men and women has increased in absolute work hour terms. This was particularly so among a specific group of women: middle class, highly educated city-dwellers. Our data suggest that in Hungary the pandemic increased gender inequality the most among the highest educated." (Fodor et al. 2020c: 1)

- In line with global trends, reported cases of domestic violence and demand for related services increased during the lockdown in Hungary, too. As feminist organizations have repeatedly stressed, violence did not so much increase, as escalate in intensity. Women in households in which less severe forms of control and coercion were being exercised by the male partner prior to the pandemic now faced a deterioration of their situation.

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