Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for Hungary

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Summary of Main Findings

- Civil organisations, foundations and associations dealing with the elderly play an important role in representing interests in the area of care. JOINT, Red Cross, the Hungarian Maltese Charity Service, etc. provide professional, integrated social and health care and also voluntary medical and health service (e.g. ambulance service) for the elderly. They negotiate with institutions at macro and micro level (ministries, local authorities), contact with other civil organisations and the market sphere, and combine practice and scientific theory in its methodology centre.
- An important body is the Council on Affairs of the Elderly. Its members include leaders of Budapest and national pensioners' associations, doctors, and experts dealing with social insurance, demography, gerontology and geriatrics. The task of the body is the general protection of interests of the elderly (pension increases, etc.). Recently it has placed great emphasis on developing new models, e.g. geriatric departments and their integration within hospitals, an examining model promoting safe living at home for the elderly, and it has recommended that these be launched.
- The Act on Local Government of 1990 made health care a basic mandatory task of local authorities. In social care according to the Hungarian law adult children and relatives had maintenance obligations (including care, financial obligations) towards their elderly or disabled parents for a long time. The Act on Social Welfare (1993) made the services the task of formal care. Services providing personal care (help at home) for the socially needy and / or those unable to care for themselves were made the mandatory task of the local authorities. Financial help for the elderly is also primarily the task of the local authorities.
- In Hungary a new welfare regime has been taking shape. Besides the formal service providers, a large number of foundations also appeared as service providers. The Act on Social Welfare also makes it possible for non-state bodies to carry out public tasks; foundations and associations belonging to the voluntary sector can also receive the capitation for providing such services. A few private service providers also appeared but their presence is negligible.
- At the same time, informal actors – families, relatives, neighbours – continue to play an important role as service providers.
- It is the intention of policy makers at macro and micro level (local authorities) to strengthen the formal services together with the interest protection organisations representing the elderly (pensioners' clubs, Council on Elderly Affairs), to develop new types of services, to integrate them into the existing services, to identify the financial implications at macro level and whether they should be financed by the health or social

sphere, and to find out how far they can count on the help of the civil organisations as service providers. The family appears to a lesser extent as service provider: the problem is rather to find ways to ease the burden on the family through formal services.

Introduction – An Overview on Family Care

- In 2001 the number of persons over 60 years was 2,079,000, representing 20.4 % of the total population. Of this total 3.2 % were in residential homes for the elderly (only data in this breakdown are available in the official statistics). 0.6 % of those over 60 received exclusively home help from professionals. Meals on wheels were provided for 1.9 % of persons over 60 years having limited mobility (Információs Évkönyv, 2003). At the same time there is a very great demand for care but it is still left largely to families to solve the problem. However the majority of older people live in households either alone or with an older person. The share of households where older people can rely on the help of the younger generation is steadily decreasing although the majority of older people have several children and grandchildren. 86 % of those over 60 have a living child and the great majority can count on them in case of sickness (Lakatos, 2000).
- Hungarian society has very strong traditions of family solidarity and family help. The strength of family solidarity has remained unchanged over the past 15 years too. In case of trouble, sickness (nursing) it has been found that the majority of older persons would still turn to a family member.
- The role of the public sector in care provision is much smaller. The reason for this is to be sought in the phenomenon found in Eastern and Central Europe where the law made solidarity between generations within the same family compulsory. The maintenance obligation was for many years a “relationship of obligation that the law attaches ipso jura to certain family relationships, placing an obligation on one person to provide for the essential needs (maintenance in the broad sense) of another person who is in need”. (CDSC, 2001) (In Hungary the Family Act, 1952, 1986) obliged family members (not only the children) to provide for the elderly financially too. It was in the mid-1970s that the state first entered care (home help called social home help) at the experimental level. The Act on Social Welfare of 1993 (and its numerous amendments) made many forms of care part of the basic services that have to be provided by the local authorities, but at the same time in certain cases made it possible for families to receive a fee for providing care.
- Private care is not typical in Hungary because the low incomes of the elderly do not allow them to buy market services. This is particularly true in advanced old age when the income consists almost exclusively of the pension and pensioners pay as much as half or more of their pension for medicines. If we consider in addition the ‘gratitude money’ they are expected to pay for health care (to the doctor, nurses), private care is practically out of the question for the elderly. (In 1998 in households of persons over 60 years living alone per capita spending on health was divided as follows: medicines 56.7 %, medical aids 9.2 %, health services

4.9 %, gratitude money 7.1 %, personal toilet articles 16 %, personal toilet services 6 %, durable personal toilet articles 0.1 % (Keszthelyiné Rédei M, 2001). Despite this there are a small percentage of cases where an elderly person receives care and nursing from more than one actor: the local authority, civil organisation, a church organisation, market actor (in most cases the latter is paid for by a family member).

- The big, strong civil organisations have a large presence in care for the elderly, not only with their volunteers but also with their innovative model experiments. Experiences show that the civil organisations succeed in linking their innovative services to the public sphere, thus making them part of the normal services. Besides their traditional care for the elderly, the churches have their own foundations and so are linked to the civil sphere in two ways.
- Neighbours are a big source of help for the elderly. Not counting other help (handling official affairs, housework, financial help), one seventh of the elderly can also count on their neighbours for nursing (Lakatos, 2000).
- 30-50 % of people in the 70-79 year age group (data are available in this age breakdown), and the majority of elderly people of 80 years of age and beyond face difficulties and need serious help in day to day activities in their homes.
- The overwhelming majority of older persons wish to grow old in their own homes. At the same time the family is unable to cope with the problems arising with long-term care. The transition to a market economy has not brought the spread of part-time work but rather, is resulting in practice in people working longer than 8 hours a day (even though the legislation provides specific safeguards). The family model of two earners working full time continues to be typical. Despite the dynamic development of recent years, for which the Act on Social Welfare of 1993 created the possibility, many types of services are lacking from the network of services or are not sufficiently widespread. There are regional differences, for example in home nursing, chronic internal departments, hospital geriatric departments, residential institutions and hospices. The focus of debate is the possibility of integrating forms of social and health services, assisting living at home for the elderly, and the need to give them the possibility of choice between a residential home and remaining in their own homes. The primary goal is to expand the quantity and quality of formal services and thereby ease the burden on families (Kardos, Szabó, Széman & Talyigás, 2002). Support given by families and neighbours will not cease in the future either. There are a number of reasons for this: Hungarian pensioners are in a much worse state of health then their fellows in Western countries (Orosz, 2001; Mollenkopf et al., 2003; Széman, Harsányi, 2003), their financial situation does not allow for the majority to buy services, so in certain life situations they are obliged to rely on the care of the public sector and / or the

professional help given free of charge by civil organisations or volunteers, and on the support of the informal sphere (Széman, Harsányi, 2000; Széman, Harsányi, 2003).

- All this suggests that when examining family care under Hungarian conditions, the problem of care needs to be placed in a wider context than care and nursing in the strictest sense. This context includes handling official affairs, financial help, mental help, carrying out household tasks and repairs, and also nursing. It is not by chance that both statistical data and surveys dealing with the family connections of the elderly approach the subject in these terms.

1 Profile of family carers of older people

Approaches to a maintenance obligation principle have evolved as a result both of changes in the family and of the development of welfare and support systems. In general, in states which have legislation prescribing a maintenance, assistance between close relatives comes before public support. Support from public funds comes only after the person's descendants have been means-tested (CDCS, 2001). Based on the Family Act (1952) this was the case for many years in Hungary. An elderly person could not seek financial help from the state if the family members were not poor according to criteria set by the state. Descendents were obliged to cover the cost of health (including hospital and residential home) and social care of their older relatives. In addition to the law, peasant culture which played a very important role up to the Second World War also strengthened ties between family members. This and the law together reinforced the attitude of Hungarian society that took the help of family members for granted.

Hungarian society is strongly child-oriented; it is taken for granted that the parent gives and the child receives. Parents give throughout their entire lives, to the limit of their possibilities and often beyond. Indeed, they often feel it their obligation to support their children even when they are adults (Havasi, 2000). The elderly person could also count on help from the family in case of problems, housework, health and personal care, night-time care, help with administrative formalities (Lakatos, 2000; CDCS, 2001). There has been no change over the decades in the significance of the family in Hungarian society, the only change is the help received from the different actors, from the genders (Utasi, 2002).

1.1 Number of carers

In 2001 the number of persons over 60 years was 2,079,000, representing 20.4 % of the total population. Of this total 3.2 % were in residential homes for the elderly. 0.6 % of those over 60 received exclusively home help from professionals. Meals on wheels were provided for 1.9 % of persons over 60 years having limited mobility. This means that slightly more than 2 % of the elderly received help in their homes (Információs Évkönyv, 2003). At the same time there is a very great demand for care but it is still left largely to families to solve the problem. 30-50 % of people in the 70-79 years age group, and the majority of elderly people of 80 years of age and beyond face difficulties and need serious help in day-to-day activities in their homes. This problem is further aggravated by the fact that the majority of elderly people live in households either alone or with an elderly person. The share of households where older persons can rely on the help of the younger generation is steadily decreasing although the majority of older people have several children and grandchildren. 86 % of those over 60 have a living child. Among those with

grandchildren, 14 % have six or more, increasing the number of potential carers within the family. In the case of sickness and nursing, 87.6 % of older persons can count on them, 84.6 % could find help with household tasks, 87.6 % in official affairs and 72.9 % of older persons could count on their children for financial help. One in seven can count on their neighbours for nursing in case of need (Lakatos, 2000). Hungarian society has very strong traditions of family solidarity and family help. We know from representative surveys dealing with family connections in 1986 and 2001 that the strength of family solidarity was unchanged in Hungarian society over these 15 years. Naturally, in the great majority of cases this represents unpaid help. In case of trouble or sickness (nursing) the majority of interviewees would turn to a family member. With the decline in the number of persons living with a marital or cohabiting partner, this means principally children. The whole range of kinship relations are important for the individual, but with advancing age these diminish. While the average value (the number of helpers on whom they can count) for persons in their twenties and thirties is 5.3-5.4, for persons in their sixties it is only 3.7 and declines to 2.6 for those over seventy. In other words, the number of potential family carers steadily declines for older persons (Utasi, 2002).

Together with the large number of persons providing free help arising from the nature of family relations, in 2001 the number of paid family carers receiving the so-called nursing fee was low (applications for the nursing fee can be made to the local authority on the basis of the expert opinion of the family doctor), only 29,378 (Információs Évkönyv, 2003). In reality, the number receiving the nursing fee to care for older persons is less than this (there are no separate statistics), since the fee is awarded not only for care of the elderly (see definition of 2.1.2).

For this reason older persons struggling to cope with various problems (here too, the statistics apply only to persons over 60 years) can rely to a great extent on the informal network: above all on the help of neighbours and friends. 34.4 % of those interviewed can count on neighbours and 19.2 % on friends. One seventh of the elderly can count on the help of neighbours in the case of sickness, 17.3 % in household tasks, 34.4 % in official affairs, and 5.1 % would also receive financial help from their neighbours. The help that could be expected from neighbours in nursing was the strongest in small towns: 16.5 %. 8 % of the elderly look to friends for help in nursing. Their role is greater in Budapest and other cities, where one tenth of those interviewed count on them in case of trouble.

Only 4.5 % of older persons can count on institutional help from the local authority in case of illness and nursing; this proportion was highest in Budapest (8.2 %) and the lowest in villages (3.3 %).

1.2 Age of carers

We have no representative data on the age of carers. Our figures are available for parent, child and grandchild in breakdown for the older age groups. In 1996 12.1 % of persons over 60 years lived together with a grandchild (Lakatos, 2000), which could mean the potential help of a younger person, but we do not know whether the grandchildren actually gave help or whether the elder persons needed help (see 1.8 and 1.9.). We know from case studies (Széman, 2004a) that those over 50 carry an especially heavy burden of caring.

1.3 Gender of carers

There has been no comprehensive research on the gender of family carers providing care or nursing for older persons. In the past families generally counted on the help of their sons and daughters. In recent times there has been an increase in the role of families counting on sons as carers. This is a consequence of the fact that boys marry later, many of them are still living in their parents' household in their thirties and so parents count on them in the case of minor illness. While a representative survey in 1986 found that 10.8 % of families counted on their daughters and 4.4 % of sons, in 2001 the figures were 11.3 % for daughters and 8.7 % for sons. This represents a considerable increase in help from sons within families (Utasi, 2002). The help given by brothers to families declined somewhat between 1986 and 2001 (from 2.4 % to 1.5 %), while over the same period there was a slight increase in help given by sisters (from 3.5 % to 4.1 %) (Utasi, 2002).

An investigation conducted in a county seat and a large village as part of an international research project, (Mollenkopf et al., 2003; Széman, Harsányi, 2003) found that, apart from members of the household, the child was the most important person for the elderly. One third of the interviewees mentioned their daughter and another third their son. Because of their earlier withdrawal from the labour market, more women than men are potential carers (see 1.10).

Other soursec also show that spouse, daughters, sons are the most important helpers of elderly people (CDCS, 2001).

The professional carers for the elderly employed in nursing and care jobs by local authorities, foundations, etc., regardless of whether they are trained or untrained, are exclusively women (with the exception of one or two young men on civil service in place of military service).

1.4 Income of carers

The prestige of those employed as carers is very low and they are paid the minimum wage or around that level, representing an income below the average wage. This fact has been a sensitive point for decades both in basic social services and in the care activities of the health services. In view of this nega-

tive social attitude it is not surprising that the sum of the nursing fee, intended in principle to serve as an incentive for family care, is very small and in reality does not recognise care as an important activity.

1.5 Hours of caring and caring tasks, caring for more than one person

Research projects classified the tasks of family carer into four main types: help provided in handling official affairs, help with household tasks, nursing, financial help. As already indicated above, in a difficult life situation over 80 % of older persons can count on the help of relatives in official affairs, household tasks and nursing. Fewer can count on financial help; this is because the financial circumstances of the carers do not allow them to give more substantial financial support (e.g. they have school-age children, earn only the minimum wage, must pay instalments on loans, are unemployed, etc.).

We have no data on the hours of caring in the case of family carers, but this obviously depends on the type of care.

The main problem is the insuffient co-ordination between health and welfare services. The home help which is a basic social service, financed from the government budget cannot provide home care (although the majority of helpers's have a nursing qualification). In contrast, home nursing as part of the health services is financed by health insurance and is not allowed to give "social-welfare" care / help. In many cases elderly people do not receive a complex care.

Despite the increased demands for care, there has been a decline in the number of persons employed in social caring (home help) jobs in the public sector: in 1993 there were 12,203 carers. By 2001 their number had fallen by 43 % of the previous level. This decline is the result of a structural change. Earlier in the basic services (home help, meals on wheels, clubs for the elderly) a) the carers could be trained or untrained persons employed full time, b) or persons undertaking work in the care structure for a token fee c) or entirely volunteers. In practice, the carers in groups b) and c) carried out minor tasks that could also be performed by a family member or neighbour in case of need. By the mid-nineties these carers receiving a token fee and the unpaid volunteers left the local authority (public) sphere and entered the civil sector because they had more confidence in it and they felt that they could be more active there. The vacuum left by their departure was partly filled by increasing the number of trained carers employed. Between 1993 and 2001 the proportion of trained persons rose by one third (from 2,525 to 3,384).

Despite the professionalisation, the lack of volunteers and the lack of provisions for safe living at home, together with the ageing of society resulted in an increase in the number of older persons per carer (from 4 to 5; Információs Évkönyv, 2003).

1.6 Level of education and / or Profession / Employment of family carer

No data, we have information only on the trained carers, most of whom are nurses while the managers must have higher qualifications (Social Workers College, university).

1.7 Generation of carer, Relationship of carer to OP

With the great increase in the number of people living alone there has been a decline in the possibility for the elderly to receive help from those most directly available, family members living with them. This was somewhat counterbalanced by the fact that between 1986 and 2001 family generations lived at a similar distance from each other, and were able to bring help within a relatively short time. In the case of families with a still living mother the average time it took to reach each other was a maximum of 60 minutes in 1986 in 76.3 % of cases and in 78.5 % of cases in 2001. In the case of generations with a still living mother, in 1986 22.4 % of those interviewed lived in the same apartment as the mother and in 2001 18.2 %. Despite the decline, the potential help from another generation was considerable, and the relatively short distance also points to the importance of family help (Utasi, 2002).

Daughters, sons are very important helpers of elderly people (CDCS, 2001; Mollenkopf et al., 2003).

1.8 Residence patterns (household structure, proximity to older person needing care, kinds of housing etc.)

The residence patterns of national statistical data also show large numbers of potential family carers. Among older persons who have a living child, 24.8 % live in the same apartment with the child, 65.8 % live in the same settlement, 48.8 % live in another settlement (more than one answer could be given). In the case of grandchildren, the figures were: 12.1 % live together with a grandchild, 68.0 % live in the same settlement, 54.9 % in another settlement. If living together can be regarded as a very strong precondition for care-giving, in the second half of the 90s over one third of Hungarians over the age of 60 lived together with a direct descendant, that is, with a potential carer (Lakatos, 2000). In households where elderly and young persons lived together, the following figures are obtained: 19.8 % of those aged 60-69 years, 39.3 % of the 70-79 years, and 57.5 % of those 80-89 years old lived together with a younger relative. 8 % of all households aged 60-69 years, 8.1 % of those aged 70-79 years, and 18.8 % of households over the age of 80 lived together with a person who was a member of the family (Lakatos, 2000). The linear rise in co-existence with age is obviously due to the deteriorated health status of the older persons and their need for care. An artifical kinship (in villages teen-age

people had taken a very close friendship and since that time they considered each other as close family members) and neighbours also play an important part in care, mainly in rural areas (Utasi, 2002) where they are regarded as quasi family members, playing a role equivalent to the family or acting as a substitute for the family (Széman, Harsányi, 2003; Mollenkopf et al., 2003). Consequently, they can be regarded as a kind of family carer. They live very close to the older person, in the same building or within 100 metres (Széman, Harsányi, 2003).

1.9 Working and caring

In Hungary the pension age has been very low for decades: 55 years for women and 60 for men. The transition from a centrally planned economy to a market economy following the systemic change led to a very high level of unemployment in the early 90s with many people escaping into retirement. The flight through this channel was further intensified by the measure raising the retirement age (to a uniform 62 years) (see 5.1). The former 55 years retirement age for women was raised to 62 years in steps of one year every second year, while certain age cohorts still had the possibility of choice. As a result there was a very sharp decline in the activity rate for woman aged 55-59 years, and it almost disappeared in the 60-64 years cohort (see 1.10.). These young older women became potential reserve resources of the society on whom children, grandchildren and the older age groups alike could count in case of problems or the need for nursing. They also represented a very important source of volunteers for civil society.

1.10 General employment rates by age

In Hungary there is very little part-time employment and this situation has remained largely unchanged for years. The proportion of those employed part-time was 3.3 % in 1997, 3.5 % in 1999 and 3.2 % in 2000, which is one fifth of the OECD average (15.3 %) (ESZCSM, 2004). The reason for this is that firms do not willingly employ part-time workers because of the complicated taxation system and the high wage-related contributions. Workers, for their part, need the earnings from full-time work for a livelihood (In practice firms demand more than 8 hours of work – contrary to the legislation in force.)

Examining the employment of manpower by age groups it is striking that the proportions of men and women aged 45-50 years are largely the same, but in the five years higher age group the proportion of women is already lower (because of earlier retirement), then in the 55-59 years cohort there are less than half as many women in employment as men.

Taking into account the distribution by sector, it is also important to note that the social prestige of jobs in health and education is low. These care areas are poorly paid, not valued by society and are predominated by women.

Table 1: Number and proportion of persons in employment from the population aged 15-74 years according to the nature of employment, by gender in 1992, 1995 and 2001

Gender	Total persons	Employees	Co-operative members	Members of companies	Entrepreneurs	Helping family members
				%		
1992						
Women	1,864.5	83.6	3.8	5.3	5.5	1.8
Men	2,161.2	76.1	7.1	7.4	8.7	0.7
1995						
Women	1,629.2	87.1	1.6	3.1	6.6	1.6
Men	1,993.6	78.3	2.9	5.9	12.2	0.7
2001						
Women	1,728.9	89.8	0.6	2.0	6.6	1.0
Men	2,115.6	82.4	1.0	4.0	12.2	0.4

Source: Központi Statisztikai Hivatal, 2003

Table 2: Activity of the population aged 15-64 years by age groups and gender, 2001 (%)

Age group	Women	Men	Total
40-44	78.8	84.0	81.3
45-49	75.7	79.9	77.7
50-54	64.9	71.6	68.2
55-59	23.9	53.4	37.5
60-64	5.7	13.6	9.1

Source: Központi Statisztikai Hivatal, 2003

Table 3: Proportion of persons in employment from the population aged 15-74 years, by economic branch, 2001 (%)

Economic sector	Women	Men
Agriculture	3.5	8.4
Mining	0.1	0.5
Processing industry	23.0	26.2
Electricity industry	1.1	2.8
Construction industry	1.2	11.8
Commerce	16.1	12.7
Accommodation service	4.1	3.4
Transport, warehousing	4.9	10.6
Financial activity	3.2	1.1
Real estate	5.7	5.7
Public administration, social insurance	7.7	7.4
Education	13.9	3.3
Health, social services	10.4	2.6
Other services	5.1	3.5
Total	**100**	**100**

Table 4: Proportion of registered unemployed by gender

Year	Proportion		Number
	Women	Men	
1992	41.2	58.8	663,027
1995	42.5	57.5	495,893
2001	44.9	55.1	342,773

Source: Központi Statisztikai Hivatal, 2003

1.11 Positive and negative aspects of care-giving

Although violence against elderly persons is discussed in the media, by politicians and the public there are no representative data available. Before 1990 the practice of contracts for support (see 5.7.4) gave opportunities for abuse against the elderly. Today one of the greatest problems is robbery of the elderly. One or more persons visit an often frail elderly person on some pretext. They often say they are carrying out a research project or are authorised by the local authority, police and after gaining entrance to the apartment in this way they take valuables or, in worse cases, attack the older person. Another recent problem is that elderly fear the housing mafia who trick older persons into signing a paper selling their apartment.

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand

Because of the difficulty of selling apartments (e.g. in regions with a high unemployment rate) internal migration is very limited.

1.13 Other relevant data or information

See contracts of support: 5.7.4.

2 Care policies for family carers and the older person needing care

To understand care of elderly people and policy for family carers it is important to know that the Hungarian system comprises a social care unit and a health care unit which operate independently of each other. On the one hand both forms of care carry out certain nursing tasks. In social care, which operates under the name of home help, four hours of “lower level” health care are allowed. In contrast, home care concentrates specifically on home nursing. It is a basic problem that the money paid by the employee and the employer to the National Health Insurance Fund (see below) becomes invisible, it is absorbed by the Health Insurance Fund and none of it goes to the care existing at the social level. Although in practice the health and social spheres together provide health care for the elderly, that is, there are two channels of care, the Health Fund reimburses for only one channel. There is no separate nursing insurance.

Social care as understood both by society and the state comprises handling official affairs, help in kind, financial help and ad hoc nursing. The earlier state expectations towards the family set down the obligation of family members to support family members in need. This has changed The Act on Social Welfare of 1993 the following services were listed as basic mandatory services (provided by local authorities):

- home help, meals,
- family help

and at the level of specialised care

- day-time services,
- respite care,
- rehabilitation,
- residential homes providing nursing and care (these were previously known as social homes, although they also provided nursing),
- as well as numerous financial and other care elements placing the emphasis on the responsibility of the state or local authority, thereby directly or indirectly helping families, including families with elderly members. Financing is from the government allocated to local authorities on the basis of capitation. In practice these sums are not sufficient to cover the costs of the compulsory basic services. The wealthier local authorities make up the difference from their own resources, e.g. from local taxes (see 2.1.3).

The Act on Social Welfare also introduced the “nursing fee for family carer”. Applications may be made for payment of the fee for nursing a person over the

age of 18; the decision on the application is made by the assembly of the local authority and the fee is also financed by the local authority.

As mentioned, the Act on Social Welfare also made it possible for non-state actors undertaking to provide public services of a care-nursing type to receive the same financing as the local authority.

The carers of the civil organisations are either in employment or volunteers who give care free of charge. The civil organisations not only carry out basic or specialised service tasks on the same or higher standard than the local authorities, they have also initiated numerous model programs that they have developed independently.

Actual home nursing was first introduced in 1994 at model level – besides the hospitals and health care institutions – and later integrated to the Health Fund. The share of health care in Social Security is as follows.

In 2003

a) employers made the following contributions to social insurance:

- Pension Insurance Fund 18 %
- Health Insurance Fund 11 %
- In addition they paid a health contribution of 3,450 HUF (approx. 14 EURO) per / capita for their employees
- 3 % to an unemployment fund, this was increased to 4 % in 2004

b) Employees' contribution to social insurance:

- 8.5 % pension insurance (of which 7.5 % went to the compulsory funded system; since 1998 the three-pillar pension system has been in force)
- 4 % to health insurance (this % was unchanged in 2004)

The changed system solved many problems, but as shown below there are many gaps and areas that are not functioning adequately. New ideas and models have been put forward between 1994 and 2002 to rectify these.

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent older people

Both official policy and the civil organisations in their ideas regarding services give priority to models launched in the recent past stress living at home for as long as possible. At the same time, politicians, decision-makers and the heads of civil organisations consider it important to stress that the possibility of choice must be ensured for the elderly and for this reason the quality of residential homes must also be improved. In Hungary the state sector counts heavily in care for the elderly on the civil sector, on foundations, associations, the

churches, on their inherent reserves and a quasi kinship role. Co-operation between the state and the civil sector in the area of welfare services is not new, its traditions reach back to before the Second World War (Széman, Harsányi, 2000). The market, such as paid home help receives little attention and recognition.

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

The Act on Social Welfare of 1993 changed the direction prevailing for decades that the elderly person could turn to the state only in case of social (and health) neediness. The Act also made it possible for other actors besides the local authorities (public sector) to participate in care, in particular the non-governmental organisations, but also market actors. Thirdly, with the introduction of the nursing fee, the macro level recognised the role of families in caring for their sick, elderly and disabled family members, even if the sum paid for care is less than the income from work. In the first years of the transformation the Act thus created the legal frame for a multi-actor care structure, in which the local authority has the main task and where NGOs, market actors and families play a supplementary role. However, financing remains a practical problem for the local authorities of small settlements where the capitation received is not sufficient for them to carry out the tasks set out in the Act. As a result of such problems the role of civil organisations has increased. Informal actors, such as neighbours, are also important in small settlements (Széman, Harsányi, 2003).

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

Disabled person: someone who is significantly limited in the use of or does not possess abilities of the senses, particularly sight, hearing, mobility and intellectual capacities, or who is significantly limited in communication and consequently suffers a lasting disadvantage in social life. Disabled persons are equal members of society and the local community, therefore the conditions enabling them to participate actively in social life must be created in the manner set out by the Act. The state provides for respect of the rights to which they are entitled and for compensation of their disadvantages (Act XXVI of 1998). The Act made no distinction by age groups and the intention of the legislators was principally to assist persons of active age or minors. For a long while neither society nor the legislators considered the mobility, hearing, sight and other health problems accompanying old age to be part of dependency and did not deal with the problems. From 2002 the emphasis shifted to the WHO approach which concentrates not on the deficit but on the possibilities and limitations of

participation in society. In 2003 a proposal was made for a service-providing model (Széman, 2004a), which took the disabilities of the elderly into account.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

According to Hungarian law adult children have had financial obligations towards their elderly or disabled parents for a long time. Nowadays services providing personal care for the socially needy and / or those unable to care for themselves were made the mandatory task of the local authorities. Financial help for the elderly is also primarily the task of the local authorities:

An *allowance for the elderly* is paid to persons over the age of 62 years (or who have reached the retirement and) if the per capita monthly income (their own and that of spouse or partner) does not exceed 80 % of the minimum old-age pension.

Public provision of medicines: this is of great importance in care for the needy elderly because it means free medicines. It may be requested for socially needy persons on an automatic or normative basis or on the merits of the case, to preserve or restore the state of health. Persons entitled automatically include the disabled, persons receiving the higher family allowance, persons receiving regular social aid. Persons entitled on a normative basis: the local authority's notary awards the certificate for public provision of medicines to persons whose regular monthly expenditure on medicines exceeds 10 % of the minimum pension, if the per capita income in the family does not exceed the minimum old-age pension. The representative body of the local authority can also award the certificate on the basis of the merits of the case to persons who are socially needy and whose expenditures on medicines are so high that their livelihood is endangered. Despite the increases, the majority of pensioners receive a pension equivalent to the average pension. For years this has been around the subsistence minimum. Because of the constant and drastic increases in the prices of medicines and the rising costs of housing overhead, paying for medicines is a serious problem for the elderly (see also 7.1.1.6).

Housing maintenance support: this is paid by the local authority to families or individuals (including many elderly persons), where a) the cost of housing maintenance reaches or exceeds 35 % of the total monthly household income, b) the monthly cost of heating the home reaches or exceeds 20 % of the total monthly household income.

Temporary aid: the representative body of the local authority can give persons facing temporary or lasting livelihood problems ad hoc or monthly aid. This can affect elderly persons receiving the minimum pension or close to the minimum.

The various entitlements clearly show the responsibility, which basically lies in the public sector and in the micro-environment of the elderly.

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

All local authorities must take the Social Welfare Act into consideration, but the representative body of the local authority decides within its own competence on awarding nursing fees on the merits of the case.

Nursing fee: see 2.2 and 2.2.1.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)

In the demographic sense the population 60 years and above is considered as old. The statistics are available in this distribution (60X). After the systemic change there was a change in the definition of the elderly. As a result of the large-scale retirement before normal retirement age the definition of older person changed in both the view held by society and the language used by public administration (Családpolitikai kisszótár, 2000) and in sociological analyses, becoming synonymous with pensioner.

2.2 Currently existing national policies

2.2.1 Family carers?

The spread of respite care houses is an important element in help for family carers. The increased demand for this type of care and also for advice shows that the service is really a help for families. Both the general principle, the orientation and the action were correct. The situation regarding the nursing fee is different. In principle the support for family carers was a very important step. The biggest problem in this connection is that if the family carer was previously a member of the labour market, the sum of the nursing fee does not make up for the lost earnings and so does not provide sufficient incentive. The period of nursing fee for family member is regarded as time spent in employment, the person receiving a nursing fee pays a pension contribution from it. In theory the nursing fee attaches greater value to family carers in recognising this work as work done on the labour market. However, entitlement to the nursing fee ceases if the person being cared for spends more than two months in a health or educational institution, if the state of the person deteriorates to such an extent that the carer is no longer able to care for the elderly person and he or she is admitted to an institution. This raises a serious problem for the carer, as indicated below.

In 1993, when the Social Welfare Act came into force 17 684 applied for this form of care. In 2001 the number of persons being cared for in this form was only one and a half times the number of 9 years previously (Információs Évkönyv, 2003). The reason is obvious: the sum of the nursing fee is very low,

equivalent to 60 % of the minimum old-age pension less than one third of the minimum wage (Hungarian Central Statistical Office, 2002). This means that even persons earning the minimum wage hesitate over whether to leave the labour market to care for a family member. At the same time, it is doubtful whether a person who has been caring for a family member is capable of returning later to the labour market, especially if that person falls in the category of ageing manpower around the age of 50 whom firms no longer willingly employ. The small number of persons applying for the nursing fee also indicates that this element of care is not functioning properly because it does not provide sufficient financial incentive for carers. There is not expected to be any substantial increase in the sum in the foreseeable future.

2.2.2 Disabled and / or dependent older people in need of care / support?

It has already been noted that under the provisions of the Act on Social Welfare the local authorities are obliged to meet the financial and care needs of the elderly (*allowance for the elderly, public provision of medicines, housing maintenance support, meals, home help)*. Social insurance enters the picture only in the case of home care / nursing and only for acute problems, temporarily. The district nurse and the general practitionar are available for long-term needs (see point 4). Greater local authority and state help is now available for the elderly than previously. However, they are still unable to meet the needs of older dependent people.

In a model program in 2003 in a large town (Debrecen) and in a district of Budapest in a survey conducted among persons aged > 75 years we examined three types of recipients of care: persons receiving only home help; persons receiving home help combined with an alarm bell system and those cared for by some family member receiving a nursing fee. Besides the social care (home help), half of the recipients also received health care from the district nurse and one third from a doctor as well. In addition to the considerable professional, formal help (from the local authority, state social services and health services), 40 % of those receiving home help also received care from a family member, 12 % from a neighbour and 2 % from a friend. These data show that informal connections continue to play an important role in the lives of more than half of the dependent elderly persons living at home when their health deteriorates or care problems arise: this involves principally the family (but also neighbourghs). Two-thirds of the persons interviewed indicated an average of 2 persons providing nursing and care, while 8 % indicated four persons (Széman, 2004a).

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

The period on nursing fee is regarded as time spent at work, on the labour market. Thus in principle it is an incentive for family members to provide help in the form of nursing (see 2.2.1).

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

Local or regional policies for family carers of dependent or older people are based on nation-wide regulations. However, observations show that non-governmental organisations can improve conditions of carers and caring persons at the same time, e.g. by introducing quasi-caring family (see 3.1.2 or 3.1.1).

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

Local and regional differences exist in general. The smaller local authorities are partly or wholly unable to provide the compulsory basic services set out in the Social Welfare Act since the capitation received is not sufficient to cover the costs. This is the case mainly in smaller settlements where there are strong ties to family members and neighbours (who are included in the network of kinship relations in such settlements, placing them in the quasi category and so they too can be regarded as family carers) (see also 1.8). It must be stressed once again that beside professional help, a very big role is played by informal help, family carers and neighbours, even in large or the very largest settlements (see 2 and 2.1.1).

3 Services for family carers

In order to understand the existing services, in addition to the health services (4.1.1) we need to have a clear picture of the aims and tasks of the Hungarian family helping service.

Help and support provided for the family is complex and independent of the age of family members. It is also complex in structure, comprising services, care and financial supports. To understand this structure, we need to know the complex system of family help and the state help given to families as a whole.

Services – institutional help

The family help service is a basic service that must be provided by local authorities under the provisions of Act III of 1993, Section 64. The tasks of family help:

- to identify general social and mental hygiene problems occurring in the family, to signal the causes of crisis situations to the competent authority or body providing the service,
- to provide information,
- to promote the participation of the health services, the care centres, child welfare service, civil organisations and churches in prevention,
- to give information on social, family support and social insurance services,
- to give social, mental hygiene and lifestyle advice,
- to listen to the family's complaints and remedy them as far as possible,
- to help individuals handle official affairs and child welfare affairs,
- to promote and encourage civil initiatives of a caring nature,
- to take various initiatives towards the local authority,
- to launch new social services,
- to provide certain services set out in the Act for certain socially needy groups,
- to carry out the given activity on the basis of a care plan for the individual or family through personal contact.

Financial benefits include the following family support forms:

Child-raising benefit	Family allowance Schooling support	Paid through the employer or, where the person is unemployed, by the Regional State Budget and Public Administration Information Service (TÁKISZ)
Child care support	Child care aid	Paid through the employer or, where the person is unemployed, by the Regional State Budget and Public Administration Information Service (TÁKISZ); in other cases by the National Health Fund
	Child-raising support*	Paid through the locally competent branch of the National Health Fund
Maternity support		National Health Fund
Nursing fee**	Paid for the care of chronically ill persons over the age of 18	Can be awarded on the merits of the case; decision is made by the representative body of the local authority

* Act LXXXIV of 1998, Section 34
** Act on Social Welfare of 1993, Section 40

It can be seen from the above that help for families is more comprehensive and is not limited to help for family members caring for an older person. It must identify problems and signal them to the authorities who solve them from public funds, but it is also the task of the family helper to maintain contact with the civil organisations and churches, to co-operate with them in the prevention and handling of problems. And this is an area where it is difficult to say who finances and how. The civil sphere has a strong presence also in care for the elderly and family help. The financing – also in care for the elderly – can be through public funding, if a civil organisation takes over provision of a public task, e.g. it undertakes to provide home help in place of the local authority and enters into a contract with it. Financing may also be directly, through the macro level, if it undertakes to provide e.g. residential institutional care. It may be financed from the civil organisation's own revenues or from donations made for the creation of such a service. Lastly, the civil organisation may finance a service created for the elderly simultaneously through all three channels.

In Hungary the civil organisations play a very big role in welfare policy. We know of over 70,000 registered civil organisations. Their financing differs from the western practice, e.g. from that in Germany. Among the three main sources of the civil (voluntary) sector in Hungary state support is still low (26.2 %), own revenues are high (52.7 %) and private support is also quite substantial (21.1 %). (In Germany the corresponding proportions are 42.5 %, 21.8 % and 36.2 % (Salamon, Sokolowski & List, 2003). Around 13 % of all

non-profit organisations in Hungary are active in the health and social welfare field. Among the biggest, national organisations are the Hungarian Red Cross and the Hungarian Maltese Charity Service. The latter plays a leading role in easing social and health problems, not only providing a high standard service free of charge but it has also introduced many innovations. One of the areas to which it gives priority (besides children and the homeless) is care for the elderly where it has not only created new care models but has also set up a methodological centre supervising many elements of care for the elderly by the local authorities, with the approval of the Ministry of Social Welfare and Family Affairs. In their experience a crisis situation often arises in the family if an elderly member falls sick and the family members are unable to leave their jobs. At such times, apart from giving advice they help the family to place the elderly person in residential and / or hospital care, nursing the elderly person, providing mental care and creating quasi family contacts for them. In general, initiatives of NGOs can improve the quality of care and the situation of family carers, sometimes even create quasi family carers (see 3.1.2; appendix 7.2).

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public funding	No public funding	
Needs assessment (formal – standardised assessment of the caring situation)			X	yes			yes	
Counselling and Advice (e.g. in filling in forms for help			X	yes			yes	
Self-help support groups		X					yes	
“Granny-sitting”							yes	
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X					yes	
Weekend breaks		yes					yes	
Respite care services		X					yes	yes
Monetary transfers								
Management of crises			X	yes			yes	
Integrated planning of care for elderly and families (in hospital or at home)*			X	yes			yes	
Special services for family carers of different ethnic groups								
Other**			X			yes	yes	

* The role of NGOs in integrated planning is very important (JOINT / Jewish, Social Innovation Foundation / SZIA, Hungarian Red Cross, Hungarian Maltese Charity Service, etc.).

** *Other:* An important activity of the Maltese Charity Service is to help elderly people, families and family carers in kind, with food, clothing, medicines and medical and technical aids to help independent living. The latter are especially important because such aids are very expensive. Family members caring for an elderly person receive free of charge from the Maltese Service such aids as bath lifts, beds on wheels, wheelchairs, etc. The civil organisations – particularly the large ones (Hungarian Maltese Charity Service, Hungarian Red Cross) – give very substantial help of this kind to both the elderly and family members caring for them. Without this help fewer people would be able to remain at home.

Remark: The Hungarian Maltese Charity Service takes over numerous public tasks from the state and local authorities and consequently state sources also appear in its budget. But the organisation also receives substantial support from citizens in the form of regular, voluntary work and donations from the general public. Donations in cash and kind from the market sphere are also important.

3.1 Examples

3.1.1 Good practices

In order to solve the problem arising from the separation of health and social care outlined in points 1.5 and 2, in 1992 the state authorised the Budapest Centre of the Hungarian Maltese Charity Service to establish a secondary school where students receive a qualification both as social workers and assistant nurses and so, after leaving school are able to do work in both areas (Széman, Harsányi, 2000). In 1994 the organisation launched the model of an alarm bell system which has been introduced throughout the country by 2004. In this way, together with home help this alarm bell system has greatly contributed to safe living at home for the elderly and has taken a burden from the shoulders of families.

3.1.2 Innovative practices

- Introduction of geriatric care in a Budapest hospital
- Social-health service and alarm bell system
- ISZER (Integrated Social and Health System)
- Development of a methodological geriatric model
- Elderly-friendly housing program helping elderly persons to continue living safely at home

Introduction of geriatric care in a Budapest hospital integrated into the work of the other hospital departments and playing a role in rehabilitation. It faces the problem of higher financing required because of the longer nursing time needed by elderly patients and the greater human resources required (Gabányi, 2004).

Social-health service and alarm bell system: With this model the Budapest Centre of the Hungarian Maltese Charity Service not only linked a two year health and social training but also created jobs for disadvantaged young girls and boys living in poor family circumstances with emotional and family deprivation. After finishing their studies the young people took jobs in care for the elderly where, besides carrying out care and nursing tasks they also functioned as quasi grandchildren. After a while they regarded the paid work as a family task and the elderly persons treated them as grandchildren (elderly women baked cakes for them, etc.). With this the organisation introduced several innovations simultaneously: a) it linked health and social training, b) it created jobs for disadvantaged young girls and boys of poor family circumstances with emotional and family deprivation and c) at the same time gave both the young people and the elderly a "family" background, a quasi family; d) it combined all this with a new kind of high technology, the alarm bell system. It developed a technology for this that took Hungarian characteristics into account, in particular the fact that many elderly people do not have a phone. They carried out social, health and technological innovation simultaneously. In disseminating the model throughout the country they developed a number of sub-models taking into account the characteristics of the given region, settlement and housing structure and since it was aimed principally at the poorest strata – the service was provided free of charge – with this care type the organisation found what can be considered a path out of the poverty trap. As a by-product of the model "informal helping sub-types" arose in many settlements, e.g. alarm units were made by neighbours connecting an elderly person to their home.

ISZER (Integrated Social and Health System), principally for persons over 65 years. Its aim is to promote independent living by reducing the defencelessness of the elderly and the numbers requiring long-term institutional care. It is a personalised service and care programme with the participation of general practitioners, home nursing and home social care. The elements of the system also include the hospital, day hospital, the various specialised (chronic care) institutions and residential homes (Falus, 2004).

Development of a methodological geriatric model: The development of a methodological geriatric model in Budapest which presents the theory and practice of geriatrics in harmony with EU recommendations in the training and further training of doctors dealing with the elderly, nurses and public health specialists. Creation of geriatric advisory units, outpatient units where the results of tests explore the hidden problems of the elderly. Creation of a new outpatient form.

Elderly-friendly housing program helps safe living at home for elderly people by altering the apartments of elderly persons with loss of functions to ensure greater accessibility. It is vitally important to prevent falls. An investigation conducted prior to the alteration in a country town and a district of Budapest found that around half of the elderly persons living at home and in need of care

have falls and around one fifth of the falls are caused by unsuitable conditions in the apartment (Széman 2004a). Numerous apartments have already been altered. It was much more difficult to introduce the service among persons cared for by someone being paid a “nursing fee for a family member” because of the resistance of family members. The family members did not want to accept any kind of help. There may be a number of reasons for this. They may be afraid that the elderly person will gain greater autonomy and so become less dependent on them, they may also lose their small income. They fear that the appearance of the state and the civil organisation will in some way endanger their inheritance. They are afraid of exposing the elderly person to the increasingly widespread abuse and robbery.

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

The basic health services are the task of local governments. Up to 1992 entitlement to health services was automatic for all citizens. Since 1992 health care operates on the basis of social insurance. The Health and Pension Insurance Funds were set up in 1993. The Health Fund reimburses the costs of treatment and certain expenditures of medicines for the insurees. Thus in principle the basic function of the Health Insurance Fund is to finance the services belonging within the scope of health insurance (for those entitled to the compulsory insurance). In practice many factors impede this. The role played by local authorities in health care is a) to elaborate a local health policy aimed at improving the health status of the population, b) to assess the needs, c) to act as owner of the health institutions.

In the present health care system citizens receive health care from general practitioners where – with the exception of urgent cases - they go with appointments to avoid waiting. Problems requiring specialist treatment are handled in the outpatient service, hospitals and special clinics.

As far as social care services are concerned as discussed in 2.1.3 according to the Act on Social Welfare of 1993 local authorities have basic mandatory tasks. As already mentioned, these tasks can also be carried out by NGOs (or the private sphere). Local authorities are required by law to provide for the population's needs. All local authorities receive a capitation for this from the general government budget. Although in principle this sum should cover all costs, in general it is sufficient for around only 80 %. This is why civil organisations operating and providing services in the social welfare (and health) areas are very important for the local authorities (in the form of contracting out or agreement). After an initial period of jealousy, the majority of local authorities regard their activity as outstanding or good. For all these reasons they are extremely important actors in welfare policy and also play a determining role in shaping policy on the elderly and caring family persons. Through their volunteers or workers employed at low cost the NGOs are able to provide the same standard or even much higher standard of services than the local authorities, making service provision cheaper for the local authorities (Széman, Harsányi, 2000). Moreover, 90 % of the employees of NGOs are trained compared to 60–70 % for the public sector.

The problems between the social and health sector have been mentioned already under point 2.

4.1.1 Health services

Despite the positive factors such as the high standard of primary care, the Hungarian health services are marked by a great number of negative elements and health care is inaccessible for certain social strata (unregistered unemployed, homeless, that is, the very poor). Others enjoy the high standard of care provided by some private hospitals and clinics set up since the systemic change.

The fundamental problem of the health services is that none of the governments since the systemic change has had a political incentive to reform the health system.

Another major problem is the practice of “gratitude money”. It is characteristic of the anomalous nature of the system that in the early 90s two contradictory regulations were simultaneously in force. One made it *illegal* for doctors to accept gratitude money, on the grounds of the medical oath and medical ethics. At the same time the Act on Taxation, because of the commonly known scale of this invisible income, made it *compulsory* for doctors and health workers to list gratitude money on their tax returns and pay taxes accordingly. In 1996 doctors had to declare the gratitude money received. According to a survey conducted in late 1999 among the public and doctors, close to two-thirds of the doctors agreed with the statement that “gratitude money is reassuring because the patient buys extra attention in this way”. Among the general public, 54 % approved of the institution of gratitude money (Bognár, Gál, Kornai, 1999). Gratitude money is most widespread (paid in 80–90 % of cases) in cardiac surgery, gynaecology and obstetrics, appendicitis operations and for staff on night duty. But the great majority of people also give gratitude money to the pediatrist, the general practitioner and the masseur. It is also widespread in routine gynaecological treatment, for injections, physiotherapy and radiation therapy. The doctor can expect gratitude money for measuring blood pressure. It is least present (8 %) in the case of x-ray examinations (Bognár, Gál, Kornai, 1999, p. 13). The volume of gratitude money paid can only be estimated. By the most conservative estimates the public spends a sum equivalent to 10 % of the annual state budget for the health services, the great majority (88 %) of which goes into the pockets of doctors and to a lesser extent of nurses and assistants. Patients, including the elderly, consider that they have to pay gratitude money if they want proper treatment. It is an indication of how widespread the practice is that some doctors request the gratitude money in advance. The most recent scandal over gratitude money arose when a website posted the names of doctors and the amounts of gratitude money they asked for in advance. This launched an avalanche on the issue in Hungary. Case studies show that for a week of hospital treatment an elderly person “should” spend one eighth of his / her pension on gratitude money (Széman, 2004b). Gratitude money is a legacy from the socialist system. “The citizen – both as doctor and patient – does not know what was withheld from him and why (he has no insight into the financing” (Losonczi, 1998). The phenomenon of gratitude

money can also be interpreted as the emergence of individual interests within institutions (Orosz, 2001).

4.1.1.1 Primary health care

- Community and homecare teams

The number of general practitioners rose steadily between 1990 and 2002. In 1990 there were 1,769 inhabitants per general practitioner and pediatrician, in 2002 this figure was 1,512.9. In primary health care the number of doctors per capita in Hungary is high: by 1999 the number of doctors per 100,000 inhabitants increased from 369 in 1990 to 464 (1.26-fold) and over this period the proportion of doctors with specialist qualification grew to 82.7 % from 75.1 %. In the general practitioner service the number of home visits also rose substantially, from 3 869 in 1990 to 5,574 in 2000 (HCSO, 2002). However, behind the fine figures there are nevertheless problems in the case of the elderly. The problem is the big regional inequalities. Doctors are concentrated in the cities, and the smaller villages with an aged population are left without services. In the best of cases the elderly are visited only by a district nurse. This situation reflects the health state of the population. While in Budapest where, besides the special clinics and national institutions there are more than 50 hospitals the life expectancy at birth for males was the highest in the country in 2002 at 70.1 years (in case of women 77.7 years), in settlements with a population of less than 1000 inhabitants it was only 66.2 years (in case of women 76.2 years). The other problem for the elderly is the existence of gratitude money mentioned in point 4.1 which imposes a great strain on their low pensions. (The majority of persons over the age of 60 years have one or more chronic diseases; only one quarter of those over 70 say that they have no chronic health problem; these figures imply medical treatment.) (ESZCSM, 2004)

- Other home care health services?

Dentistry: there is no home dental care service in Hungary. This is all the greater problem since the number of visits to dental offices fell by half between 1990 and 1999 (from 9 142 to 4 426), due mainly to the high cost of dental treatment. The range of treatments covered by health insurance has been restricted (HCSO, 2000).

Home care: (by a nurse) reimbursed by the health insurance. At first on model level in 1994. This service is available by prescription of the family doctor if necessary. Nursing care delivered in the person's home for a certain period (usually 14 days which can be extended in case of need). In practice home care is frequently given within the frame of home help because the majority of all the trained carers in the home help service are nurses. This is forbidden according to the rules because health and social care are strictly separated. At present in practice "social carers" also give health care, for a number of reasons: a) it is required by the state of the elderly person, b) the carer has health

training (many of them have years of hospital experience, including in internal medicine or surgery departments), c) the carer develops an emotional attachment to the elderly person (Széman, 1999). For this reason the carers falsify the records, entering only "social" activities (e.g. cooking lunch, shopping, bathing) and not mentioning the dressing of a leg ulcer or giving an injection. The nurses working in home nursing that comes under social insurance face the same problem: they falsify too, entering only health care tasks in the records although in practice a carer showing empathy towards the elderly person also carries out social tasks that belong in the scope of home help (such as bathing) (see 2.1.3). A non-profit organisation (the Maltese Service) has developed an integrated care model. The ISZER (Integrated Social and Health System) also attempts to solve the problem of uniform treatment (see point 3 and also 4.3).

4.1.1.2 Acute hospital and Tertiary care

The number of hospital beds declined steadily, from 104,686 in 1990 to 80,220 in 2001 (HCSO, 2002). This had a negative effect on the elderly sick too, because in the absence of a sufficient number of residential homes (see 4.1.2.1) earlier elderly persons had been kept mainly in the internal medicine departments of hospitals. The cuts eliminated mainly these beds. On the whole the number of active hospital beds declined drastically. In 1990 there were 98.3 beds per 10,000 inhabitants and in 2002 only 79.2 (ESZCSM, 2004).

Table 5: Hospital beds

	1990	1999	2000	2001
Active hospital beds of which	105,097	83,992	83,430	80,220
Internal medicine	19,218	15,563	15,513	14,734 (76.6 % of the 1990 level)
Surgery / traumatology	13,508	12,107	11,999	10,834 (80.2 % of the 1990 level)

Source: HCSO, 2002

We have no exact figures on the number of geriatric beds, but there are estimates of the possibilities available for the elderly. In Budapest, where the health services are the best, there are more than 50 hospitals, not counting the clinics. A few of these are of a special type (e.g. children's hospitals, infectious diseases, traumatology, etc.). However, on the whole only one fourth of the Budapest hospitals have chronic internal medicine departments, which is in practice a form of long-term care, in addition to the acute internal medicine departments. Around half of these departments have possibilities for rehabilitation. One hospital also has a hospice service. There are also chronic internal

medicine departments in hospitals of large towns and county seats. The problem is that as a whole there are not sufficient rehabilitation or residential health services (discussed in 4.1.2.1) for the elderly. This is why, in addition to the ISZER established in one of the hospitals, the second model already presented in which a Geriatric Centre has been operating in a Budapest hospital since 2003 is also important. The Centre has been accepted by the other departments of the hospital but the present in-patient financing is inadequate for its operation since geriatric care requires more human resources.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

In 2001 2 % of all hospital beds were in church, foundation and private hands. There are no figures on the percentage of elderly persons among their patients. The majority of geriatric beds remain in the public sector, but the civil sphere has also began to deal with this problem (HCSO, 2002). There are charity homes operated by different denominations (e.g. MAZSIHIS / Jewish charity organisation, Catholic homes, etc.), where the elderly and sick are nursed and cared for. There are also a few privately owned residential homes providing nursing and care; they are very expensive and not on the highest standard, but they represent less than 1 % of all homes.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

There is a big demand for hospice care but there are hardly any hospices. They can be found only in a few big towns and in Budapest, mainly through NGO service providers and mostly for cancer patients. A hospice service has been operating for a few years in one of the hospitals. The latest development is that in 2003 a complex geriatric model was launched in the Central MÁV (Railways) Hospital, incorporating a geriatric hospice. An investigation is now being made into the sustainability of the model (see 3.2).

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

In most hospitals there is a shortage of nurses due to the very low wages and the high fluctuation. For this reason, if a person wishes to be certain that a sick family member is receiving proper care, he or she also nurses the patient (e.g. bringing the bedpan), obtains more costly and efficacious medicines not refunded by social insurance after consulting with the doctor, and – after consultation with the dietician and nurses – provides the elderly patient with better quality food than that served in the hospital. The family provides the patient with most hygiene and toilet needs, including even toilet paper. Society and families feel this kind of nursing to be a great burden; they consider that such material and nursing tasks should be part of the official health services for which they pay a social insurance contribution. For this reason the aim is to develop models which ease the burden of informal care. Hospitals often dis-

charge patients without suitable rehabilitation and, at the same time, discharge patients early because of the high costs per hospital bed.

The volunteers of NGOs take part in in-patient health care in the areas of mental hygiene, providing proper care for the sick (informally making up for the lack of nurses), preventing ill effects of hospitalisation and preparing patients for rehabilitation.

4.1.2 Social services

Although there are regional inequalities in social services too, the situation is not as bad as in health care and in many cases evens out the shortcomings in health care through the basic services (e.g. the fact that the great majority of home helpers have health training). In 2001 8.9 % of the population over 60 lived in small, ageing settlements with less than 1,000 inhabitants (where it is difficult to organise health care and medical services). At the same time, 22.9 % of all recipients of home help lived in such settlements (that is, at least they were visited by a person giving home help). 12.6 % of all persons receiving meals also lived in such ageing settlements. 16 % of the recipients lived in Budapest while 19.6 % of persons over 60 years lived in that city (Információs Évkönyv, 2003). The indicators are quite good also for the clubs for the elderly which provide prevention and are one of the specialised services. 16.9 % of all these institutions are found in settlements with less than 1,000 inhabitants and only 8.4 % in Budapest. The situation is much worse in the case of residential homes providing respite care intended to alleviate the burden on families. Only 3 % of those using these institutions are from villages (with an insignificant proportion from very small villages), while 82.3 % are from towns and 14.4 % from Budapest. It can be seen that this form of care is flourishing and helps older persons living in towns and their family members, while it is hardly available at all for older persons in villages (see 4.2.2.2). There are regional inequalities also in the case of residential homes. However the real problem is the substantial differences in quality. The Act on Social Welfare also allows “normal” and higher standard care. The former can mean homes with several beds per room and poor infrastructure. The homes set up earlier (during socialism) in old buildings, such as mansions, barracks, mills, etc. are unable to create the modern infrastructural facilities prescribed in the Act on Social Welfare, e.g. square metres per resident, number of bathrooms, toilets, etc. and they do not have the funds needed for alterations. At the same time, homes newly established by NGOs and a few newly built public institutions already fully meet these conditions.

4.1.2.1 Residential care (long-term, respite)

Temporary care home for the elderly: Institutions available temporarily for older persons unable to care for themselves during illness or for some other reason, e.g. the carer family is away on holidays, during winter independent

living poses a risk in the home of the older person. Between 2000 and 2001 the number of places offering respite care for the elderly increased by 14 % (Információs Évkönyv, 2002). Older persons request respite care more often in winter because they, especially those living in the country, are afraid of falls (going to the outdoor toilet, shovelling snow, icy streets, etc.). Families and family members caring for older persons tend to request respite care in summer when they are on holidays. The spread of the institution helps ease the burden on families for a while. At the same time, this service is least available to persons living in small settlements, and for this reason informal connections and neighbours acting as quasi family play a greater role here.

Residential care: Besides local authorities, residential homes may be maintained by churches, legal entities, foundations, non-profit companies, social organisations, and business enterprises (see 4.1.2.1.3). The number of places rose steadily between 1993 and 2001. In 1993 28,742 persons lived in such institutions, in 2001 this figure was 41 % higher. Even with this substantial growth there is a great volume of demands that cannot be met. In 2000 11,767 persons were on the waiting list for places, and 53 % had been waiting for more than a year. The consequence: a number died because the families (together with the local authorities, civil organisations and neighbours) were unable to provide long-term care in the form of nursing. The home nursing funded by health insurance is not sufficient for rehabilitation or the care of the chronically ill elderly (already discussed in 4.1.1.1).

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes)

No data available. Data available only for persons over 60 years. 1.9 % of the population over 60 years live in residential homes for the elderly (Információs Évkönyv, 2003).

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

Home for the elderly: provide nursing and care for persons over retirement age, that is for older persons (this is the official definition, discussed in 2.1.5) whose state of health requires regular treatment in a therapeutical institute. In institutions providing nursing and care, including homes for the elderly, and in rehabilitation institutions the fee charged may not exceed 80 % of the income of the recipient of care.

Institutions maintained by foundations, churches, private businesses may also set other criteria, e.g. age. Investigations show that as long as there are places available in a new residential home, younger older persons, e.g. persons aged 60-65 years, are also admitted. The new homes built by foundations and churches are of a high standard (in contrast to rooms for 4-16 persons in the state homes they have rooms with 1-2 beds and apartments) and provide good services. As a result the mortality rate here has dropped and the institu-

tions' "turnover speed" has been reduced. As a consequence they have been forced to raise the age for entry (e.g. to 70 or 75 years) and also the sum to be paid on entry.

If institutions not operated by the state do not wish to receive the state per capita funding they are free to set an entry charge usually amounting to several million HUF (or the transfer of an apartment they are able to sell), as well as a monthly fee for the care.

4.1.2.1.3 Public / private / NGO status

According to the data for all long-term residential homes (including psychiatric institutions, shelters for the homeless, homes for the handicapped and other institutions), the maintaining bodies were as follows: 63 % local authorities, 14 % churches, 19 % foundations or associations (this means that the civil sphere maintained one third of the institutions), 2 % individuals, 1 % central budget, and the remaining less than 1 % other (e.g. private).

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

Not as a rule.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Community care is regulated by the Act on Social Welfare, as mentioned earlier (4.1; 2.1.3); see also the following subpoints.

4.1.2.2.1 Home-help

Home help is one of the basic mandatory social services provided by the local authority to care for people, usually older persons, unable to care for themselves (Tudnivalók a szociális ellátásról, 2000). The local authority may contract out the task to a civil organisation or market actor under an agreement or contract.

4.1.2.2.2 Personal care

See 4.1.2.2.1.

4.1.2.2.3 Meals service

Meals are one of the basic social services provided by the local authority, ensuring at least one hot meal a day for socially needy persons who are unable to provide this for themselves or whose carers are permanently or temporarily unable to do so. The local authority must also provide meals for applicants who are unable to provide for meals in any other way because of their age or

state of health (Act III of 1993, Section 62). This service operates well (see 4.1.2*)*.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Laundry and shopping are the tasks of home help, but the civil organisations also play a big role in meeting demands.

Transport except escorting to the doctor (home help) is not a basic or special task of the local authorities. The absence of such a service is a serious problem for older persons and their family members, e.g. if the older person has to go to hospital, for a medical examination, wishes to go to the cemetery or to church. They often have to wait hours for the private ambulance and the alternative ambulance service is expensive. Transport for older or handicapped people is provided by NGOs. Older persons can also count to a great extent on the help of family and neighbours.

4.1.2.2.5 Community care centres

Their task is to organise home help and the meal service. In addition to this activity and to identifying problems, the centres inform the elderly, households of the elderly and their family members of the services to which they are entitled. Consequently this type of service plays an important role in the lives of older persons and the family members supporting them.

4.1.2.2.6 Day care ("protective" care)

Club for the elderly, protective care: within the frame of specialised services the local authority provides elderly persons who are partly able to care for themselves with day care, one to three meals a day, the possibility to bathe and with activities. The number of clubs for the elderly remained practically unchanged between 1993 and 2001 (around 3000), in other words the local authorities carried out this special task (Információs Évkönyv, 2003). (See also 4.2.) The clubs for the elderly, the first element in special services, serve the purpose of prevention and the indicators are good. 16.9 % of the clubs operate in settlements with less than 1000 inhabitants and 8.4 % in Budapest while the villages are in practice not covered by respite homes, the second element in special services.

4.1.2.3 Other social care services

The family help centres have a counselling role (see point 3). NGOs also play such a role. In addition, to the help in kind NGOs also provide aids to assist independent living, e.g. providing families caring for older persons with bath lifts, beds on wheels, wheelchairs, etc. They install alarm bells in the homes of older persons. Such help provided by the civil organisations, particularly by the bigger ones (Hungarian Maltese Charity Service, Hungarian Red Cross) is very important for both older persons and family carers. Without such help

fewer older persons would be able to continue living at home. See also point 3; 3.1.1 and 3.1.2.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

Since the introduction of the Act on Social Welfare the standard of basic services has been rising steadily, despite the problems mentioned. The heads of the care centres – these centres comprise the basic services, home help, family help, meals and the first two elements of special care (preventive care in the form of clubs for the elderly, and respite care) – had to undergo regular further training and only persons with higher qualifications could be heads of such centres. In many cases they nursed the older person together with the informal sphere – family, civil organisations. The new model elaborated in this way greatly improved the standard of the service and helped family members nursing the older person (see below). Qualitative development can also be observed in the case of residential homes, especially in the wake of investigations by the ombudsman and as a result of further training for the staff, but the standard of care depended to a large extent on the maintaining body, the age of the institution and the attitude of its head.

4.2.1 Who manages and supervises home care services?

Home help is maintained and supervised by the care centres of the local authorities.

Linking home help and the alarm system: supervised throughout the country by the Methodology Centre of the Hungarian Maltese Charity service. The reason: they have elaborated many highly successful new care models that have since been introduced on the national level (e.g. see 3.2), and for this reason the Ministry of Social and Family Affairs endowed the Centre with this right of supervision.

Home care is supervised by the Health Insurance Fund.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls

Control must be carried out in the social institutions by the public administration offices on the basis of the relevant regulations: Act LX of 1990 on Local Authorities, Act III of 1993 on Social Welfare amended numerous times, Government Regulation No. 169 / 1999 (XI. 24.) korm., Regulation No 9 / 1999 SZCSM of the Ministry of Social and Family Affairs, Government Regulation

No. 188 / 1999 (XII.16) korm., Regulation No. 1 / 2000 (I.7.) SZCSM, and Regulation No. 6 / 2000 (VII.6) SZCSM of the Ministry of Social and Family Affairs. The methodology centre(s) entrust their own or outside experts to carry out the controls. In 2001 the Budapest Public Administration Office had controls carried out in 90 social institutions by the experts of two non-state institutions (Foundation for Social Innovation, Hungarian Association of Social Directors) (Gáthy, 2002).

In case of home help (care) and the alarm system all institutions participating in the alarm system are under regular control carried out by the methodology centre of the Maltese Service. The Centre considers it important not only to carry out checks, but also to shape attitudes through training. This is given in the form of basic training at two levels.

The *first level* of training in the form of a few hours of conversation is for the heads of the local service system, including those in charge of social welfare, the heads of the local authority, the fire brigade, the hospital, the police, civil organisations and the local press.

The *second level*, the training of care-givers, is longer. It consists of 10 hours of training over two days divided into four modules:

- presentation of the technical system, parallel with the division of responsibility arising in care for the elderly,
- general care-giving, how to provide care during the day and at night,
- mental hygiene, with the emphasis on the mental and health problems of the elderly and how to deal with them,
- health care, medical module, with the emphasis on chronic illnesses rather than on emergency care.

These two steps are followed by regularly monthly after-training where they consult with care-givers, discuss problems that arise and protect them from burn-out.

In smaller settlements the lack of professional carers and family carers is made up for by carers receiving a token fee. See also 4.2.1.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

In the public sector professional workers in home help generally have a certificate from a 3-year health training school or in the case of heads (e.g. social workers), a diploma from a 4-year health college. A minority have no formal qualifications.

Students studying for two years in the integrated care specialised secondary school of the Maltese Service receive a certificate entitling them to work as assistant nurses and in social care.

The short training course (10 hours) held by the Maltese Service does not give participants a certificate. However, this type of training is important in shaping attitudes and in raising the standard of care.

Many other civil organisations and a few local authorities have held training courses for workers in social care and health care and for lay persons in the micro environment of the elderly, with the participation of the public and civil spheres. These courses generally lasted 1-3 days and did not give a certificate either, but were important in shaping attitudes. Training held for the micro environment, involving the micro environment in care is especially important in small settlements where family members cannot be reached easily. The quality is ensured with regular supervision.

4.2.4 Is training compulsory?

Not in the public sector. However, the heads of institutions strive to participate in as many training courses as possible. In addition, relevant qualifications or further training are required for certain jobs. Participation in training on quality assurance is especially important.

In the case of local authorities operating the alarm system, supervision is carried out by the Maltese Service. Their methodology centre prescribes compulsory training. All paid carers must undergo training. In the case of carers receiving a token fee this is achieved by only paying their monthly fee if they first participate in a consultation to discuss problems.

4.2.5 Are there problems in the recruitment and retention of care workers?

The income and prestige of workers in both social care and health care are very low. There is a shortage of suitable carers (see also. 1.4). There has been a decline in the public sector in the number of carers receiving a token fee and of volunteer carers. The public sphere is struggling to cope with a shortage of labour. At the same time, some of those who previously worked for a token fee or were volunteers in the public sector have appeared in the civil organisations where they also do nursing-helping-caring work (discussed already in 1.5).

Recruitment is not really a problem for the Maltese service either despite the high fluctuation (the girl carers marry, have children) because their own school training nurses-social workers ensures a continuous supply of recruits (see 4.3).

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels)

The regulations strictly separate health and social care in the state sector even though the state of older persons often calls for complex care. For this reason, both social and health carers (home help) falsify the records entering only “social” or only health activities (e.g. cooking lunch, ironing, bathing; or only nursing) (see 4.1.1.1).

Integrated care (home help, and home care) as already mentioned, is given by the biggest non-profit organisation (the Maltese Charity Service). They link health and social care, provide technical help, enable safe living at home, identify problems and give information, carry out prevention and rehabilitation activity, create quasi families, involve the micro environment in helping the elderly, etc. At the same time they also carry out very strict quality control and supervision.

They elaborated an integrated service. It is provided for elderly persons who meet the following criteria: a) there is nobody in the vicinity who could help in a critical situation (family member, neighbour), b) socially needy (following the definition of local governments), c) a health / mental state enabling use of the alarm bell, d) the recipient of care must allow the civil organisation to enter the apartment.

The ISZER, at present at model level, also aims to achieve such integrated care (see 3.2).

4.3.1 Are family carers' opinions actively sought by health and social care professionals usually?

No.

5 The Cost – Benefits of Caring

The GDP for the country? (Will be obtained from OECD and others centrally)

5.1 What percentage of public spending is given to pensions, social welfare and health?

Table 6: Financial and social incomes as a percentage of GDP

Year	Pensions*	Family support benefits	Unemployment benefit	Sick pay and other sickness benefits	Aids, scholarship, other	Total
1989	9.2	4.0	0.0	1.3	0.6	15.0
1995	10.4	2.6	1.1	1.0	1.0	16.2
2000	9.3	1.7	0.6	0.8	0.9	13.3
2001**	10.1	2.6	0.6	0.9	0.7	14.4

* Pensions and pension-like benefits. Source: ESZCSM, 2004
** KSH put pensions, retirement provisions at 9.5 % of GDP (HCSO, 2003, p. 92).

Following the systemic change in 1990 early retirement became a general withdrawal from the labour market, resulting in a higher share of pensions within GDP by 1995. Following decades of full employment, high unemployment was registered in the early 1990s and the costs of this also appeared in GDP. At the same time the rules for sick pay were made stricter and the proportion of family supports was also smaller. Despite all this, the share of financial social incomes within GDP rose compared to 1989. In the second half of the 1990s the channels of early retirement were restricted or closed. As a result spending on pensions declined within GDP. By 2000 the share of pensions within the GDP was 9.3 %. (With new channels of early retirements later on the number of pensioners increased.)

Table 7: Social incomes in kind as a percentage of GDP

Year	Education	Health	Culture, sport, holidays	Social welfare services	Other	Total
1989	4.4	3.3	1.8	..	0.6	10.1
1995	4.8	5.5	1.3	0.8	1.2	13.6
2000	4.1	4.9	1.0	0.8	0.6	11.4
2001	4.7	5.0	1.1	0.9	0.8	13.4

Source*:* ESZCSM, 2004, 21

The situation of Hungarian health care has deteriorated steadily in recent years. In 1992 per capita spending on health amounted to 54 % of the OECD average, in 1998 this figure was only 39 % (Orosz, 2001). Various calculations

are available for the share of health expenditures within GDP. In 1994 they were 8.3 %, then fell to 6.8 % in 1998 / 99 (Orosz, 2001) and to 5.0 % (in 2001) (ESZCSM, 2004).

Taking 1991 as base year, there was a strong erosion of welfare expenditures: expenditure on health care fell to 85 %, social insurance, welfare and social services to 79 % in 1999?) (Ministry of Finance, 2000).

The real value of current health expenditures in 1999 was 5 % higher than the level of 1991.This resulted in the substantial 77 % growth in the real value of private expenditures (between 1991 and 1999) (Orosz, 2001).

Table 8: Health expenditure in 1991-2000 (in billions of HUF at current prices

	1991	1998	1999	2000
Current expenditure	145.6	526.6	588.0	642.0
Budget	14.0	57.6	72.0	75.0
Health insurance	131.6	469.1	516.0	567.0
of which:				
Therapy-prevention	96.1	301.1	393.3	373.0
Pharmaceuticals-medical aids	34.1	155.1	160.1	176.0
Pharmaceuticals	31.4	135.5	139.5	153.0
Medical aids	2.7	19.6	20.6	23.0
Current private expenditure	19.6	121.3	146.9	-
of which:				
Pharmaceuticals	7.7	54.4	58.0	-
Other	11.8	66.9	88.9	-
Total current expenditure	165.1	647.9	734.9	
Investments	15.0	40.7	36.8	36.3
Total public expenditure (a+c)	160.6	567.3	624.8	678.3
Total expenditure	180.2	688.6	771.7	

Source: Orosz, 2001

5.2 How much - private and public - is spent on long term care (LTC)?

There is no data available on private expenditure on residential care and the chronic internal medicine departments of hospitals are not available. We do have information on the following:

Local authorities (and civil organisations) carrying out tasks in the manner defined in the Act on Social Welfare are entitled to a specific contribution for persons living in residential institutions (whether long-term or temporary and

short-term). This applies to homes for the elderly, refuges for the homeless, nursing and care homes including rehabilitation institutions, as well as institutions for the temporary accommodation of the elderly, psychiatric patients and addicts and disabled persons). The residents also pay a fee which may not exceed 80 % of their income (see also 4.1.2.1.2).

Only 2 % of persons in long-term care (in residential homes) were not obliged to pay a fee. Among those who were required to pay, in 2001 for 11.5 % the fee was paid by another person, in the great majority of cases a family member (Információs Évkönyv, 2003, p. 298-299). In short-term care close to one third did not have to pay a fee. In LTC the cost of care is covered entirely by someone else (relatives) in one tenth of case.

5.3 Are there additional costs to users associated with using any public health and social services?

Health care for insured people is basically free because it is reimbursed by the Health Fund. (Health care is a problem for groups at social risk who do not have a social insurance card (e.g. the homeless). In practice in addition to the reimbursement patients are expected to pay gratitude money already discussed in 4.1; 4.1.1. Furthermore, patients very often have to wait for a visit to a specialist. If they choose to have private treatment (doctor) it is very expensive. In this situation not only the elderly but also their family carers have extra expenses.

In addition reimbursement of costs of medicines is limited and changes from year to year. The reimbursement applies only to certain types of medicines. The certificate for the public provision of medicines issued to the needy is valid only for a specified list of medicines. However, the elderly generally have not one but several illnesses which require medicines not covered or only partly covered by Health Insurance. A survey conducted in 2003 found that older persons receiving home help or cared for by a family member who received a nursing fee took an average of 7.5 medicines (Széman, 2004a).

5.4 What is the estimated public / private mix in health and social care?

The presence of private actors operating in the social sphere is relatively easy to understand, and this has already been mentioned in connection with social services and the residential homes and respite care homes operated by NGOs and private persons.

Demonstrating or estimating the public / private mix in health care is extremely complicated and the mix is constantly changing. In the wake of the changes that occurred in the first half of the 1990s, complex connections arose between the public and the private sectors in the sphere of health care too.

- Health care businesses spread in primary care, to a growing extent in outpatient care and to a lesser extent in inpatient care, as well as through the privatisation of (the right to operate) general practionars practices.
- Privatisation of the pharmacies has been concluded.
- Pharmaceutical factories and factories manufacturing health equipment have been privatised.
- Many-sided connections have been formed among hospitals and private businesses (in part by contracting out the auxiliary activities of hospitals).

The operation of health care has been formed not only by privatisation within the health services; it has been influenced to a much greater extent by the privatisation in the environment of health care, above all by the privatisation of the pharmaceutical factories and the enterprises manufacturing health equipment. As a consequence there are now complex connections between the public and private sectors.

Constellation of Private / public Mix

Private financing Budget-financed institutions Gratitude money	Private financing Businesses
Public financing Budget-financed institutions	Public financing Businesses

The above figure shows the types of financing and service provision by the public and private sectors.

- Public financing + budget-financed institutions
- Public financing + private service providers (businesses, self-employed entrepreneurs, non-profit organisations)
- Private financing + budget-financed institutions
- Gratitude money + budget-financed institutions
- Private financing (household, enterprise, non-profit organisations) + private service providers (businesses, self-employed entrepreneurs, non-profit organisations)

The Government regulation of 1989 opened the possibility for private businesses to operate in the health care and social sector. The privatisation shows many differing characteristics in the various areas of health care. One of the essential differences is whether the given process was encouraged principally by health policy (governmental) decisions or by entrepreneurs (market relations). In the latter case as well, two different types can be distinguished: in one case the services of private business are purchased by health insurance,

while in the other case they are purchased by the public (or the employers), that is, the private service provision goes together with private financing. The private sector in health care is very heterogeneous: it includes general practitioners financed by health insurance, a few (not full-time) doctors employed by private clinics and paid entirely from the fees paid by patients, the occupational health services financed by the employers, the diagnostic laboratories living on orders from hospitals operated by local authorities, the auxiliary services of hospitals (laundry, cleaning, maintenance, etc.). The practice of hiring in contract form doctors previously employed as public servants in branches where there was a shortage of manpower became increasingly widespread in the 1990s (a special form of settling the income problem). The regulations in force allow local authorities to carry out the transformation of hospitals and clinics in their ownership into institutions operating in the economic form of their choice, to contract out their management, to contract out different activities or even – with certain restrictions – to sell the hospital (Orosz, 2001).

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

In 2001 the operating costs of long-term and temporary care institutions was 65,528,481,000 HUF (Approx: 255,290,600 EURO). The monthly operating costs per resident were 73,458 HUF. In 2001 the average monthly fee paid per resident was 20,233 HUF. This was equivalent to one third of the net average earnings or half the minimum wage (Információs Évkönyv, 2003; ESZCSM, 2004; Tudnivalók a szociális ellátásokról).

The average monthly fee in respite care was 6,990 HUF, equivalent to one ninth of the average earnings and one sixth of the minimum wages.

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

Within the budget of the Republic of Hungary for 2003 the local authorities receive a capitation for providing the *basic services* (home help, meals, family help, special tasks such as day care, child welfare service). The problem, as already mentioned, is that the sum provided is generally only sufficient for 80 % of the costs. The local authorities must make up for the shortfall from their own resources (from local taxes such as the resort tax). The larger local authorities are able to solve this problem, but the smaller ones are not.

As already mentioned home care / nursing is financed by the Health Insurance (see 2).

The specific cost of care in homes providing nursing and care, institutions for the homeless and for rehabilitation is 725,000 HUF per person (2,958 EURO).

The state contribution to maintenance is available to local authorities (or NGOs, church institutions) providing the care in the manner set out in the Act on Social Welfare.

It should again be emphasised that in Hungary NGOs play an important role in social welfare and health services and can count on three main sources of income: state support, their own revenues, private donations; their own revenues amount to twice the state support and the private support is also substantial (Salamon, Wojciech, Sokolowski & List, 2003). On the one hand citizens can donate any sum, without limitation, to any non-profit organisation and receive tax relief at the end of the year. On the other, since 1996 individuals can donate 1 % of their personal income tax to the non-profit organisation of their choice. Since 1998 they can also donate another 1 % to any church of their choice (a total of twice 1 %). (These donations are not compulsory.) All this has strengthened the non-profit sector. The 1 % donations are redistributed through the Taxation Office, that is, the state.

5.7 Funding of family carers

Nursing fee: in case of social neediness, applications can be made to the local authority. See also 2.1.1.

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

	Attendance allowance	Carers´ allowance	Care leave
Restrictions		Yes[1]	
Who is paid?		The family carer	
Taxable		A pension contribution must be paid for the fee.	
Who pays?		Local government	
Pension credits		Regarded as time spent in employment	
Levels of payment / month		For a child under 18, the nursing fee may not be less than the minimum old-age pension. For persons over 18 the sum may not be less than 60 % of the minimum old-age pension.	
Number of recipients in 2002*		29,378	

*Source: Információs Évkönyv, 2003

5.7.2 Is there any information on the take up of benefits or services?

No.

5.7.3 Are there tax benefits and allowances for family carers?

No.

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

Inheritance earlier played a very important role in caregiving because of the housing shortage in Hungary. However, this affected mainly not only family members but lay caregivers. Anyone could sign a so-called maintenance contract with an older person in which they undertook to care for the older person

[1] Payment of the nursing fee is terminated if the person (elderly person, child) is cared for for more than two months in a health or educational institution. Entitlement to the nursing fee ceases if the family carer undertakes paid work for more than 4 hours a day.
A medical opinion stating that the person to be nursed is unable to care for himself must be attached to the application for the nursing fee.

in case of sickness (meals, nursing, etc.), and in return they would inherit the older person's apartment. This regulation gave rise to many abuses before the systemic change (1990). There were cases of supporters locking them in, starving them, etc. The law therefore introduced a waiting period of 6 months for maintenance contracts. If the older person died within this period the contract became void.

A more refined and modern form of the maintenance contract giving greater security is now popular among elderly persons with property. This is a contract e.g. signed with a lawyer's office to whom they sell their apartment. A certain, agreed part of the purchase price is paid immediately and, in addition, they receive a monthly allowance for the rest of their lives. This is a suitable solution for older persons who own an apartment in good condition and of high value because the lawyer's office also undertakes to transfer them to health institutions in case of need.

Others sign a maintenance agreement with a neighbour they trust, ensuring nursing and care.

5.7.5 Carers' or Users' contribution to elderly care costs (check list of services and costs to user)

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X[2]					
Specialist doctor	X					
Psychologist	X					
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)	[3]					
Day hospital	[4]					
Home care for terminal patients	No					
Rehabilitation at home	[5]					
Nursing care at home (Day / Night)	[6]					
Laboratory tests or other diagnostic tests at home						
Telemedicine for monitoring						
Other, specify						

[2] General practicioner, specialist doctor and acute hospital care are free or wholly reimbursed for persons with a social insurance card (but in the case of elderly homeless persons, for example, this is a problem).

[3] A model is now being created for long-term medical care (gerontology), but the financing conditions still have to be clarified.

[4] A model is now being created.

[5] Provided mainly by NGOs (mainly the large ones), free of charge, or by a few private careers (insignificant in proportion).

[6] Provided by the Health Insurance Fund for persons with social insurance card.

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		Yes[7]				
Temporary admission into residential care / old people's home in order to relieve the family carer		Yes[8]				
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		Yes[9]				
Laundry service		Yes[10]				
Special transport services	Yes[11]					
Hairdresser at home	Yes[12]					
Meals at home		[13]				
Chiropodist / Podologist						
Telerescue / Tele-alarm (connection with the central first-aid station)	Yes[14]					
Care aids	Yes[15]					
Home modifications	Yes[16]					
Company for the elderly	Yes					
Social worker	Yes[17]					
Day care (public or private) in community center or old people's home		Yes[18]				

[7] A monthly fee amounting to no more than 80% of the income is charged. In some cases care is free of charge because the income is so low; this is means-tested. This can be in a state institution, there are also institutions operated by NGOs and churches. The institution itself sets the poverty live and decides how many residents to accept free of charge.

[8] A monthly fee amounting to no more than 60% of the income is charged.

[9] In houses for pensioners. Residents have self-contained units but health care is provided and there are common rooms. The monthly fee amounts to no more than 50% of the income.

[10] The charge may not exceed 20% of the income of the recipient of this social care (provided by home help).

[11] Provided only by NGOs.

[12] Provided only by a few NGOs at home, in residential homes this service is available.

[13] If the older person receives meals and home help, the combined charge may not exceed 30% of the income.

[14] Started as a model in 1994. Now part of the public service, controlled by the Methodology Centre of an NGO.

[15] Distributed mainly by NGOs (free of charge) and partly by the state.

[16] Started as a model in 2003. Financed by the Ministry of Social and Family Affairs.

[17] In family help centres, care centres (but not principally for the elderly).

[18] Charge for clubs for the elderly may not exceed 30% of income.

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Night care (public or private) at home or old people's home		Yes[19]				
Private cohabitant assistant ("paid carer")						
Daily private home care for hygiene and personal care			Yes			
Social home care for help and cleaning services / "Home help"		Yes				
Social home care for hygiene and personal care		Yes				
Telephone service offered by associations for the elderly (friend-phone, etc.)						
Counselling and advice services for the elderly	Yes[20]					
Social recreational centre						
Other, specify						

[19] Mainly by family members and by some NGOs.
[20] Provided within the home help and family help services, also provided free of charge by NGOs.

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring	Yes					
Telephone service offered by associations for family members	Yes					
Internet Services						
Support or self-help groups for family members	Yes					
Counselling services for family carers	Yes					
Regular relief home service (supervision of the elderly for a few hours a day during the week)						
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)		Yes				
Assessment of the needs	Yes[21]					
Monetary transfers						
Management of crises	Yes[22]					
Integrated planning of care for the elderly and families at home or in hospital	Yes[23]					
Services for family carers of different ethnic groups						
Other, specify						

[21] By public sector and NGOs.
[22] In family help centres, but not principally for the elderly.
[23] Experimental models by family help centres and NGOs (see point 3).

6 Current trends and future perspectives

In writing the Hungarian NABARE report it should be stressed that the newly acceded EU country can be characterised since 1990 by the transformational welfare model. This means that Hungary is undergoing an extremely rapid but not yet completed process of social, economic, political and social political transformation. As a result basic shifts are constantly occurring, even compared to what has been written and sent in the Report.

One important aspect is that the Government has accepted the gradual introduction of nursing insurance following the German model. In essence this is intended not to replace health insurance but to solve the problem of the border area of care which involved both the social and the health spheres. It is planned to introduce a 1 % health insurance contribution to cover the costs, to be supplemented by various other sources.

Parallel with this, there are plans to make changes in the nursing fee: not only family members would be entitled to the nursing fee, but nursing of persons requiring constant supervision could be undertaken in the status of full-time employment.

A separate specialist qualifying examination in geriatrics was introduced in 2000. At present 90 persons have this qualification. (www.ezustkor.hu:kormanyzat)

Other changes in the regulations will be: with the introduction of the new Act, health service providers can also provide social care, as a universal entitlement (which will has an essential impact on social and health services discussed in point 4). The intention is to ease the conditions from both the legal and professional viewpoints:

- Making it possible to transfer patients directly from an active department to a department providing nursing;
- The National Medical Officer Service issues permits for operating social services to health care institutions;
- A social institution may also obtain a permit to introduce additional health services, for example, it can launch special local services 1-2 hours a week for patients with limited mobility.
- A medical office can be opened in a room of a home for the aged;
- Geriatric care as an independent branch of medicine with a separate code number will figure among the minimum conditions;
- In inpatient departments, the rules will be set not for the number of beds but for the simultaneous care of 15 patients;

- The authorisation process will be quicker in places where geriatrics appears as an independent unit, but hospitals may also apply for a permit for all branches of medicine simultaneously but this will take longer;
- The progressive classification of departments with the present conditions will also be announced. Complaints are anticipated in this connection. These are to be forwarded to the professional colleges, because this system of conditions has been drawn up on the available data.

In the case of the social institutions no special permit is required for the basic health care, but this will depend on the functions of the given institution. The same incentive system should be provided for them as in health care. The minimum conditions for the other professions will also be published this year, together with the professional protocols. Geriatric nursing will also be included here:

- Also in connection with the Act on Institutions, the creation of a professional supervisory system will begin;
- This will also be elaborated for geriatrics, probably within 1-2 years.

All this mean the expansion of formal support services and the development of quality, the development of complex, integrated and missing services with the participation of local authorities and civil organisations. Creating wide access to services at present existing at model level.

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

The most important policy and practice debates are on improving the financial situation and the quality of life of older persons (pensioners) Better state of health and sufficient help and care for older people are especially important issues. To this end the Ministry of Health, Social and Family Affairs recently launched a number of models already discussed under point 3 (housing alterations to adapt them to the deteriorated health status of older persons; a complex geriatric hospital model intended in part to ease the burden on families; development of an integrated social and health system taking into account case management; creation of a geriatric-rehabilitation unit and its smooth operation together with acute departments).

There are no comprehensive, representative surveys on the phenomenon of abuse of older people. However, it is a phenomenon appearing with increasing frequency, confirmed not only by reports in the mass media but also by by-products of research dealing with the elderly. E.g. people interviewing the elderly have reported cases where the elderly person has been visited by someone presenting false identification and claiming to be a policeman or a repre-

sentative of the local authority, and who then took money from them on the most unbelievable pretexts. For example, that there were counterfeit banknotes in the pension they had just received and the counterfeit money must be seized. In other cases the older person was immobilised (they threw a sheet over her) while they robbed the apartment.

Since the problem of abuse arose as a phenomenon accompanying scientific surveys, it is important to pay attention to it and develop elements to protect the elderly. At the same time the matter must be treated flexibly, adapting to the latest tricks used by the abusers.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

The present trend in services available for the elderly shows a shift in the direction of formal support, and the development of new types of services. It is not likely that the nursing fee for family members will be increased to a level that would make it an attractive alternative to the labour market. The aim is therefore to integrate new forms of formal support into the existing services, to determine what financial implications these would have at macro level and whether they should be funded by the health or the social sphere. Another question is the extent to which the help of civil organisations can be counted on in developing the new services, and how the family can be involved in creating the model. Experiences so far have been that it was in many cases the family (the informal support) that places obstacles in the way of the model, even though a wider spectrum of formal services for the elderly would be important for them. In cases the older person mistrusts even relatives. At the same time, the latest studies show that where such trust is missing or family help is not available to the elderly person for some other reason, another actor of the informal sphere in the neighbourhood can act as a substitute (see 6.4).

6.3 What is the role played by carer groups / organisations, "pressure groups"?

The civil organisations with activities related to the elderly, particularly the big foundations and associations play an important role in the protection of interests in the area of care. E.g. the Hungarian Maltese Charity Service besides the integrated social and health care already mentioned, it provides a voluntary medical and health (e.g. ambulance, doctors) service for the elderly. Their doctors provide care on a high level which is based on regular voluntary work (they do not accept ‘gratitude money’). The organisation develops new service models and monitors the effect of the changes on the recipients of the new services. It negotiates with institutions at macro and micro level (ministries,

local authorities), it has contacts with other civil organisations and the market sphere, and combines practice and scientific theory in its methodology centre.

A very important body is the Council on Affairs of the Elderly already mentioned as well. Its members include leaders of Budapest and national pensioners' associations, doctors, and experts dealing with social insurance, demography, gerontology and geriatrics. The task of the body is the general protection of interests of the elderly (pension increases, etc.).

6.4 Are there any tensions between carers' interests and those of older people?

There are no representative data in this connection either, but as earlier indicated it was found when developing the elderly-friendly housing model (designed to make homes obstacle-free for the elderly) that it was family members receiving a nursing fee who most strongly opposed the formal help, in this way coming into conflict with the interest of the target group, the elderly.

6.5 State of research and future research needs (neglected issues and innovations)

The results of models already introduced need to be studied. Secondary analysis of earlier research in which we examined in some way the social and family connections of the elderly (Mollenkopf et al., 2003; Széman 2004a).

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

This aspect has already been discussed in point 3 (alarm bell, elderly-friendly environment) (see 3.1. 1 and 3.1.2).

6.7 Comments and recommendations from the authors

Taking Hungarian reality into consideration we can expect the expansion and qualitative development of formal support services with the participation of local authorities and the civil sector. (The civil organisations maintain institutions and in this sense they are formal carers.) The aim: for the elderly to be able to preserve their dignity and independence as long as possible with the help of these services. The overwhelming majority of older persons wish to grow old in their own homes. Besides home care / nursing(health care) and social help, there is a need for the integration of hospital geriatric departments into normal hospital departments as this is important for rehabilitation. There is also a lack of hospice care, including in the area of gerontology. Another task to be solved: when, under what circumstances, in what financing is it possible and necessary to integrate forms of social and health care services. In Hungary the

expansion of formal services represents help not only for the elderly but indirectly also for their families. The family model with two full-time earners continues to be the standard. The transition to a market economy does not favour the spread of part-time work, indeed, in practice people in employment are now typically working longer than 8 hours (even if this is contrary to the labour legislation). Despite this, support from family and neighbours will not disappear in the future either. There are a number of reasons for this: Hungarian older persons are in a much worse state of health than their western counterparts (Orosz, 2001; Mollenkopf et al., 2003; Széman, Harsányi, 2003). The financial situation of the elderly will not improve substantially in the near future and it is doubtful whether the health services will be able to cope with the present problems. This means that in certain situations – financial problems, need for care, nursing – the elderly are obliged to rely on other sources for support, principally the family and the informal sphere. The models described serve only to solve certain problems given priority. However, they do not solve such questions as handling official affairs, queuing in public offices, and handling the increased administrative demands made by the changing economic and social life.

All this suggests that when examining family care under Hungarian conditions, the problem of care needs to be placed in a wider context than care and nursing in the strictest sense. This context includes handling official affairs, financial help, mental help, carrying out household tasks and repairs, and also nursing. It is not by chance that both statistical data and surveys dealing with the family connections of the elderly approach the subject in these terms.

Family care can only be really developed in Hungary if care is interpreted in this wider sense, if the elements that have long existed are developed and integrated with new ones. In addition to elaborating models it is important to count on the initiatives of the civil organisations because these organisations are much more flexible than the public sector (state, local government), they develop effective forms of interest protection, have methodology centres, are able to lobby through their network of connections, and disseminate tested models throughout the country (as happened, for example, in the case of the alarm system).

7 Appendix to the National Background Report for Hungary

7.1 Socio-demographic data

Due to the low fertility rate for the past several decades and the improving life chances in old age, the proportion of older persons within the population is growing and will continue to grow in the future; the percentage of persons aged 65 and over will grow compared to that of persons aged 15-64 years raising serious economic and social problems (Népesedéspolitikai Kormányprogram koncepciójához, 2004).

7.1.1 Profile of the elderly population-past trends and future projections

At present there are about as many elderly as children in Hungary, in terms of age groups 60+ and 0-19. By 2050, it is projected that there will be at least 80 % more elderly than children. The new phenomenon of a shrinking labour force poses new challenges for society. The share of those of working age is expected to decrease below 50 %, while their number will fall to the level of before World War One, only 4 million.

In Hungary challenges of population ageing are strongly connected with challenges of the population decline. Population size has already decreased by 600 000 since 1981. The decline is expected to continue.

In 1980 only 13-14 % of the elderly were 80 years or older, but in 1996 this figure approached 19 %, almost one in five elderly persons reached the age of 80 years (Kapitány, 2000).

Population decline and ageing are in strong relationship in Hungary. It is a fundamental economic and social issue that ageing alters the burden of dependency ratio. In Hungary, old age dependency ratio almost doubled in the 20th century and it will double again during the next 50 years. Life expectancy at birth for males will increase from 62.8 years to 76.5 years and for females from 76.6 years to 82.6 years. The fastest growing age group in Hungary are the oldest old persons, those aged 85 years and older. This group will grow 34-fold in size by 2050 according to the projection database of the Hungarian Central Statistical Office (Hablicsek, 2004).

Besides biological ageing, another problem is social ageing. Close to one third of the population receives pensions or pension-type benefits. This substantially adds to the expenditure on pensions, social services for the elderly and involves health and economic problems.

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years

Table 9: Average life expectancy at birth and at selected ages in 2000

Ages	Male	Female
At birth	67.1	75.6
At age 40	29.6	37.2
At age 50	21.8	28.3
At age 60	15.3	20.0
At age 65	15.3-9.9*	20.0-12.6*
At age 65 in 2002**	13.0**	16.8**

Source: EUROSTAT yearbook – edition 2001, Statistical Pocketbook of Hungary, 2001
*There are no figures available for life expectancy at 65 years, the table contains life expectancy at 60 and 70 years.
**Source: Demográfiai Évkönyv 2002, 2003

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

The % of 65-74 year-olds within the population is almost identical, the presence of the elderly becomes lower from 75 years, but according to forecasts this will change substantially by 2050 (see 7.1.1).

Table 10: Population 65 years and over by age groups (in %) and gender in 2001*

Age groups	Total population N=10,198,000 (%)	Male	Female
65-69	490,000 (4.8)	202,000	286,000
70-74	437,000 (4.2)	169,000	269,000
75-79	339,000 (3.3)	119,000	220,000
80-84	154,000 (1.5)	50,000	105,000
85-89	89,000 (0.9)	26,000	63,000
≥ 90	36,000 (0.4)	10,000	26,000
Total	1,545,000 (15.1)	576,000	969,000

Source: Statistical Pocketbook of Hungary, 2001
*February

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Since women have a higher life expectancy than men, women make up the majority of elderly persons. This difference increases with age. In 1996 83.7 % of women over 80 were widows, while for men this proportion was only 43.6 (Kapitány, G. 2000).

Table 11: Marital status of the population 65 years and older by gender and age group (Based on the 1996 microcensus.)

Marital status	Age and Gender					
	65-69		70-79		≥ 80	
	Men	Women	Men	Women	Men	Women
Single	3.5	3.2	3.3	4.2	2.7	2.9
Married	78.9	45.1	72.2	28.4	52.3	8.0
Widow	12.0	44.9	21.3	62.9	43.6	83.7
Divorced	5.7	6.8	3.2	4.6	1.3	2.6

Source: KSH, 2000

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups

After an increase in the 1980s, the number and percentage of households with middle-aged and older members began to decline in the 1990s. Two- and three-generation households living together with an older person also declined in number.

Table 12: Age composition of households (in thousands) 1980-1996

Year	Only older persons	Young and old	Middle-aged and old	Young, middle-aged and old	Other house-holds	Total
	persons living in the household					
1980	661.2	80.4	322.1	186.0	2,369.7	3,719.3
1990	820.5	71.7	344.5	221.8	2,531.2	3,889.5
1996	932.1	55.6	303.0	194.6	2,384.1	3,869.5
	%					
1980	17.8	2.2	8.7	7.7	63.7	100.0
1990	21.1	1.8	8.9	5.7	62.5	100.0
1996	24.1	1.4	7.8	5.0	61.6	100.0

Source: Szűcs, 2000

Table 13: Older persons living alone by age group, 1980-1996*

Age group	1980	1990	1996	1980	1990	1996
	000 persons			%		
60-64	54.4	103.6	105.5	14.8	21.5	18.0
65-69	101.2	121.1	133.6	27.5	21.5	22.9
70-74	93.7	74.0	141.8	25.5	15.3	24.3
75-79	68.6	100.1	93.0	18.7	20.7	15.9
≥ 80	49.7	83.9	110.5	13.5	17.4	18.9
Total	367.5	482.5	584.5	100.0	100.0	100.0

Source: Szűcs, 2000

On the whole, the age composition of older persons living alone shifted to the age group > 80.

7.1.1.5 Urban / rural distribution by age (if available and / or relevant)

Table 14: Age composition of the population by settlement type and size, 1996

Settlement type, size group	Population (000 persons)	0-14	15-59	≥ 60
		As a percentage of annual population		
Budapest (capital)	1,900.7	14.9	63.5	21.6
> 50 000 county seat / city	1, 886.5	17.9	65.0	17.1
20 000-49 999 county seat / city	1,186.6	18.2	64.1	17.7
10 000-19 000 persons				
town	904.1	19.2	63.5	17.3
village	151.0	18.2	65.4	16.4
5 000-9 999	960.8	19.9	61.5	18.7
2 000-4 999	1,491.0	19.1	61.2	19.7
1 000-1 999	1,008.0	18.8	60.8	20.4
< 1 000 village	709.4	18.2	59.5	22.2
Total	**10,198.2**			
From this				
Budapest	1,900.7	14.7	63.5	21.6
County seats	1,803.9	18.0	64.9	17.1
Other towns	2,705.3	18.7	63.5	17.8
Villages	3,788.2	18.8	60.7	20.5

Source: Kapitány. G., 2000. 31.

Two settlement types in Hungary show a higher proportion of ageing. In Budapest the proportion of elderly persons, who live mainly in the inner districts, was 21.6 %; many of the younger generations have moved to the agglomeration providing a healthier way of life.

There is also a high proportion of elderly persons in villages with less than 2000 inhabitants, and even more in those with less than 1000 inhabitants (20.4 % and 22.4 %), since the younger generations have migrated to the towns in search of jobs.

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care

More than 60 % of all persons stating that they have a chronic illness live in households with a head over 60 years old. High blood pressure and cardiovascular diseases are especially prevalent.

The statistics record the following disabilities by disability groups.

Table 15: Characteristic disability problems of the older age group compared to younger age groups (2004)

Nature of disability	Total	0-14	15-29	30-59	≥ 60
Physically disabled	251,560	4,664	9,327	104,804	132,765
Sight-impaired	83,040	3,503	8,266	26,610	44,610
Mentally handicapped	56,963	10,550	15,940	21,644	8,829
Deaf	44,679	1,562	2,665	11,108	29,344
Other hearing / speech impairment	16,186	1,934	2,293	6,626	5,333
Other	124,578	6,590	8,307	71,939	37,742
Total	577,006	28,803	46,798	242,731	258,623

Source: ESZCSM, 2004

Data on the physical activity of the population over 70 give a more detailed picture of the care needs of the elderly.

Table 16: Physical activity of persons over 70 years, by gender and age groups

Physical activity	Total			Men			Women		
	To-gether	70-79	≥ 80	To-gether	70-79	80x	To-gether	70-79	≥ 80
A) Bathing									
Not a problem	51.1	56.5	31.4	57.8	62.2	37.5	47.4	53.2	28.9
Some difficulty	30.6	28.9	36.6	26.2	24.1	35.6	33.0	31.8	37.8
Great difficulty	11.5	10.0	17.0	8.5	7.9	11.3.1	113.1	11.2	19.3
B) Dressing									
Not a problem	58.9	64.2	29.7	64.8	69.0	45.4	55.7	61.4	37.4
Some difficulty	28.2	25.5	38.0	223.6	20.9	35.9	30.8	28.3	38.8
Great difficulty	8.7	7.4	13.6	7.0	6.3	10.3	9.7	8.0	15.0
C) Getting out of bed, Standing up from chair									
Not a problem	59.8	64.6	42.3	66.2	70.2	47.6	56.3	61.3	40.1
Some difficulty	27.9	25.5	36.5	23.4	21.0	34.9	30.4	28.2	27.2
Great difficulty	8.7	7.3	13.8	6.6	5.9	9.7	9.9	8.1	15.4
D) Moving around inside the home									
Not a problem	72.1	76.6	55.6	77.6	80.6	63.9	69.1	74.3	52.2
Some difficulty	18.4	16.2	26.5	13.2	12.1	17.9	21.3	18.7	30.0
Great difficulty	6.0	4.5	11.6	5.8	4.3	12.7	6.2	4.6	11.2
E) Use of WC									
Not a problem	69.1	74.4	49.7	73.3	77.5	53.5	66.8	72.6	48.1
Some difficulty	21.0	18.0	31.9	18.6	15.2	34.9	22.3	19.7	30.7
Great difficulty	6.6	5.3	11.5	4.6	4.4	5.2	7.7	5.7	14.1

Source: Lakatos, 2000

Households with a head 70 years or older spend more than 20,000 HUF a month on health needs. This is equivalent to half the average per capita income of persons of this age (Kardos, Szabó, Széman & Talyigás, 2002; ESZCSM, 2002). The percentage of those regularly taking medicines within all pensioners is 74.5 %, within disability pensioners around 80.5 % compared to 19.1 % for active earners and 24.4 % for the unemployed. In view of the poor health state of the elderly, the high spending on health needs and the low income of the elderly, it is not surprising that researchers found a link between physical activity and income.

Table 17: Persons 70 years and older by mobility and income, 1998

Unable to	Income situation of the elderly by deciles									
	1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th
Walk 2 km	44.7	55.2	58.1	51.7	52.6	50.6	46.9	41.2	40.4	32.5
Climb 10 steps	51.5	51.4	56.0	57.9	55.2	52.8	48.7	44.3	40.6	30.5
Stand for 2 hours	39.7	50.0	46.9	46.6	43.5	41.0	40.4	34.7	33.4	29.2
Sit for 2 hours	20.7	18.5	23.4	21.0	22.7	21.2	21.8	17.1	17.0	15.1
Squat, kneel	51.2	73.8	73.8	67.1	66.8	65.8	62.4	57.7	55.6	49.8
Reach above head	22.5	13.3	19.7	20.0	16.1	17.7	17.3	15.0	12.3	10.8
Stretch out arm	14.4	9.9	12.9	10.9	11.3	9.3	12.0	8.7	9.2	8.2
Grip with hand	9.9	11.6	12.5	15.7	12.5	14.1	12.9	10.2	9.9	10.1
Lift 10-12 kg	68.6	71.4	75.0	68.9	71.0	64.9	63.0	64.7	64.0	50.5
Lift 5-6 kg	55.3	47.8	53.4	38.9	47.1	44.9	43.6	39.8	38.3	35.2

Source: Lakatos, 2000

Table 18: Physical activity of persons 70 years and older by income deciles

Physical activity	Income situation of the elderly by deciles									
Has difficulty	**1st**	**2nd**	**3rd**	**4th**	**5th**	**6th**	**7th**	**8th**	**9th**	**10th**
Bathing	37.4	44.8	54.3	49.6	46.7	43.5	45.5	39.4	34.2	30.9
Dressing	40.8	42.9	52.5	47.4	41.8	40.7	37.8	30.4	30.3	27.2
Getting out of bed, standing up from chair	47.6	39.6	50.0	42.3	42.9	42.7	37.6	31.4	28.5	26.4
Moving around inside the home	34.1	31.1	36.5	27.1	28.9	29.9	24.8	18.8	19.4	17.0
Leaving the home	28.2	40.4	37.9	42.6	39.6	36.3	37.5	34.7	28.7	29.0
Using WC	32.4	37.4	46.6	36.9	31.7	32.4	27.8	21.2	21.3	16.1
Cooking	34.4	17.6	30.0	22.8	24.7	24.3	23.2	19.1	18.8	14.3
Ironing	27.3	33.7	37.0	34.8	37.4	31.2	35.2	34.0	29.8	28.8
Handling affairs	30.1	36.7	34.1	33.6	37.8	33.8	35.9	36.8	31.3	31.0
Heavy housework	36.1	57.7	58.1	50.6	53.8	46.1	47.9	49.2	44.3	38.4
Lighter housework	37.8	37.5	48.7	45.2	42.1	41.1	39.6	36.1	29.1	23.7

Source: Lakatos, 2000

The better a person's financial situation, the greater the chance that the physical state is satisfactory (the deviations are less for some activities). But the data indicate that attending to basic needs is a problem for substantial masses of elderly persons. They need help. Those with low income, chronic illness and more limited family connections are especially at risk. At such a high level of risk, the exclusive development of residential institutions cannot be a solution. Other solutions are needed (7.2.).

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups

Data surveys of the income of the elderly have been made mainly by the Central Statistical Office (KSH) and therefore apply to the elderly in the demographic sense, that is, the population 60 years and older; there are no figures in more detailed breakdown. Other figures appear in investigations on persons regarded as socially elderly, that is, pensioners (but these also include younger pensioners under 60 years).

Table 19: Main income inequality indicators among the elderly based on the 1998 household budget survey*

Indicator	Elderly
Proportion of persons with average incomes in highest and lowest deciles, percentage	2.8
Robin-Hood index	11.0
Gini index	0.1561

Source: Havasi, 2000

*In the household budget survey on which the analysis is based households with very low and very high incomes are underrepresented because both the very poor and those in the highest income decile refused to answer; consequently the data are slightly distorted.

A Robin-Hood index, which has a value of 11 %, shows that the only 11 % of the income of elderly persons living above the average would have to be regrouped to the benefit of those living below the average to achieve full income equality among the elderly. While they differ greatly in wealth, the income situation of the elderly generation is much more homogeneous than that of the younger generations. However, it must be added that the elderly are better protected than the younger age groups (e.g. the unemployed) because of the regular pension which gives security, even if it enables a livelihood on only a low level.

Table 20: Support received from a person outside the household in households of elderly persons with the lowest and highest incomes

Nature of the support	Lowest income decile households	Highest income decile households	Elderly households together
Regular monthly financial help	0.6	7.0	2.8
Regular monthly help in kind	24.6	18.3	21.6
Occasional financial help	5.6	5.1	8.8
Occasional help in kind	69.2	69.6	66.8

Source: Havasi, 2000

Regular or occasional financial help was received by 12 % of households of the elderly in the highest income decile, while those in the lowest decile received practically only help in kind. The wealthier elderly have a higher level of schooling, are better informed, and their children are also better off and they are able to request occasional help from them.

It is worth noting that the percentage of occasional help in kind, e.g. nursing is the same in both the lowest and highest income deciles, indicating the strength of family-kinship and neighbourhood ties already discussed.

The connection between the objective income based on per capita income and the subjective income situation according to the opinion of households was also examined for income quintiles.

Table 21: Opinion of the elderly on their own income situation by their per capita actual income group

Opinion	income quintiles				Elderly together
	1st	2nd	3rd and 4th	5th	
Very poor	12.7	20.9	57.5	8.9	100.0
Relatively poor	6.3	15.6	60.8	17.4	100.0
Average income	3.3	9.4	53.9	33.3	100.0
Well off	5.3	12.8	56.3	25.6	100.0

Source: Havasi, 2000

The investigation of subjective and objective income found that those elderly persons who considered themselves to be well off were highly likely to be well off in reality on the basis of their income. Around one tenth (12.7 %) of those who regarded themselves as very poor were in fact in the lowest 20 % income group of the population. At the same time, close to one third of households which can be regarded as poor on the basis of income do not consider themselves to be poor.

The KSH survey also examined how households of the elderly and of other age groups judge their own income situation.

Table 22: How people judge their household income level

People's judgement of income level	Households			Whole country
	Elderly only	Not only elderly	Together	
Very poor	9.3	8.7	9.1	8.8
Relatively poor	42.3	35.6	40.1	32.7
Average income level	46.6	52.3	48.5	54.7
Relatively well off	1.7	3.3	2.2	3.7
Very well off	0.1	0.1	0.1	0.1

Source: Havasi, 2000

Compared to the end of the active life stage, the income of the elderly steadily declines with advancing age so they have to use up their earlier reserves to maintain their standard of living or accept a more modest standard. Both options strengthen the feeling of poverty. At the same time, analysts emphasise that poverty cannot be restricted to income poverty, but is much more com-

plex, including also the material and non-material background ensuring lasting security. In the case of elderly persons living together with younger people the households are better equipped (see 7.1.1.10), consequently they live more comfortably even if not at a higher level of income. The following stood out among the factors leading to a negative subjective judgement of the income situation.

Subjective judgement of the income situation is greatly influenced by illness and poor housing (and the lowest income quintile).

Table 23: Main characteristics of low income households with elderly heads by the subjective judgement of their income situation

Characteristics of household	Those in lowest income quintile				Total
	Very poor	Poor	Not poor	Together	
% of households of same type where:	100.0	100.0	100.0	100.0	100.0
There is a chronically ill person	36.7	32.1	16.2	27.9	16.9
Their financial situation has deteriorated in the past year	89.9	91.8	52.1	78.5	73.7
The building is dilapidated	66.6	16.9	6.2	24.2	22.5
Only elderly members	35.0	35.6	41.2	37.3	3.4
Young and older members	29.3	39.9	30.8	10.3	1.4
Young, middle-aged and older members	9.9	55.6	34.5	19.2	5.5

Source: Havasi, 2000

The incidence of chronically ill persons among the elderly and even more among low-income elderly persons is higher than the national average. More than one quarter of low-income elderly households have a chronically ill member. This proportion increases with advancing age. With the poor state of the Hungarian health services, the available income goes not for the family's livelihood but to cover additional expenditures arising from the illness (increasing costs of medicines, gratitude money, etc.). To continue his or her way of life and preserve the quality of life the sick person needs something more and different. This concept known in studies of poverty as capability and calculation of the subsistence minimum must be taken into account even if what can be regarded as the minimal needs of the elderly person are covered (Havasi, 2000).

If we examine the situation of those regarded as elderly from the viewpoint of social policy, that is, pensioners (this concept includes young pensioners over the age of 50 years), we obtain the following picture.

A comparison of pensions and pension-type benefits with the subsistence minimum shows that the two values are close to each other. The average pension exceeded by 10 % the subsistence minimum calculated by the Central Statistical Office (KSH) (in 2000 in one-member pensioner households this was 29,566 HUF. In January 2000 close to one third of pensioners above retirement age (above 55 for women and 60 for men before the pension reform, after it a uniform 62 years to be reached in gradual steps) lived on less than this sum (Kardos, Szabó, Széman & Talyigás, 2002).

Despite the pension increases since then, around one third of pensioners continue to live around the subsistence minimum.

7.1.1.8 % > 65 year-olds in different ethnic groups (if available / relevant)

In Hungary the Gypsies (Roma) constitute a large ethnic group. Because it is against the law to ask questions about ethnic identity in the census, figures concerning the Gypsies are only estimates. It is estimated, for example, that they represent 5-6 % of the population. The Gypsies are far from homogeneous. A large group strongly aspire to assimilate and although many of them live in Gypsy colonies and have a Gypsy culture they regard themselves as Hungarian. Other groups of Gypsies cling to their traditions. In general it can be said that they have a lower level of schooling, are in a worse position on the labour market and their health status is also poor. Social benefits make up the larger part of the livelihood of Gypsy women (30.6 % are on child-care aid, 1.7 % receive unemployment benefits, 11.6 % receive other types of aid, 11.6 % are dependants). Only 16.1 % are pensioners. The proportion of pensioners is not higher among the men (16.4 %). (12.1 % receive aid, 5.8 % unemployment benefits, 2.6 % are on child-care aid, 7.4 % live from casual work, 7.8 % in some other way, 12.1 % are dependent but not students). The proportion of persons in employment is somewhat higher among the men.) But 60.5 % of the men and 73.4 % of the women do not have regular paid work (The largest numbers are employed in Budapest.) (ESZCSM, 2004). The average life expectancy of Gypsies is much lower than that of the Hungarian population, as a result their presence on the older elderly population is not typical.

7.1.1.9 % Home ownership (urban / rural areas) by age group

In Hungary at the time of the systemic change housing was privatised. People were able to buy the apartments they had previously rented from the local council. This radically transformed the housing situation. By 1994 87 % of the

apartments in country areas and 65 % in Budapest were privately owned (Hegedűs, Tosics, 2001). The trend continued in the 1990s.

Table 24: The elderly (> 60 years and older) by age composition of their households and legal status of housing occupation

Legal status of housing occupation	All	Only elderly	Young	Middle-aged and elderly	Young and middle-aged
		persons living together			
Owner or relative of owner	92.2	91.4	87.0	93.6	95.1
Tenant, co-tenant or relative	7.0	7.5	12.2	6.1	4.7
Subtenant	0.1	0.1	0.1	0.0	0.0
Other	0.7	1.0	0.8	0.3	0.1
Total	100.0	100.0	100.0	100.0	100.0

Source: Szűcs, 2000

This extensive privatisation of apartments was linked to many factors. 1) People were given a possibility to acquire property, something which was almost forbidden during socialism, 2) it was considered as a type of capital (investment) which would increase in value in the future, 3) the tenants of apartments were able to buy them very cheaply, 4) many people bought apartments with the compensation coupons they had received, gaining access to them at very low prices, 5) ownership of the apartment was important for older persons as something their descendants could inherit, since very few people had been able to accumulate money or bank deposits during the years of socialism. In country areas most people live in family houses while in towns privately-owned apartments are most common. This explains how people could obtain a rented apartment relatively cheaply, but since then housing prices have risen at an accelerating pace. It became especially important for the elderly person (or a family member) to be the main owner of the home. There are a number of reasons for this: the apartment is an asset that can be inherited by the child or grandchild of the elderly person. Home ownership is also very important for elderly persons because in this way elderly people can enter into a contract with someone who will provide care and support in return for inheriting the apartment / house.

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

The great majority of elderly persons have been living for decades in the same old buildings which are now obsolete and their apartments are poorly equipped. (This applies even more to those living alone.)

Table 25: The equipment of apartments / homes with only elderly residents* (1996)

Mains water	80.7 %
Hot water supply	76.6 %
Bathroom	78.4 %
Mains gas	58.5 %
Sewerage	41.8 %

Source: Kovács, 2000
*There are no national data of this nature on phones. A survey conducted in 2000 in a county seat and a village among 600 persons 55-74 years and > 75 years found that 75 % have wireline phones (Széman, Harsányi, 2003; Mollenkopf et al., 2003).

There are no data on lifts. The findings of a survey of persons over 75 years covering this aspect too will be available later.

Regarding the size of the apartment, three-quarters lived in a one-room or two-room apartment, while this figure was only 50 % for the whole population. Elderly people lived in a larger apartment in cases where two or three generations lived together. The elderly lived in the smallest apartments in Budapest (one out of four elderly persons lived in a one-room apartment). There was a much higher proportion of apartments / houses with several rooms in the villages (Kovács, 2000). (During the years of socialism it was easier to build family houses in villages with the help of relatives and neighbours and “artifical kinship”.)

A comparison of the equipment of homes showed that the households of Hungarian older people have less basic amenities, especially in the case of rural areas, whether compared to western rural areas or the urban Hungarian area (Széman, Harsányi, 2003). The homes of the elderly also have fewer durable consumer goods than the population as a whole.

Table 26: Incidence of durable consumer goods in households of the elderly compared to the national average

	Households with heads aged			nationally
	60-64	65-69	≥ 70	
Colour TV	85.1	83.0	76.4	86.5
Black and white TV	23.6	23.8	27.6	20.5
Automatic washing machine	37.3	32.6	23.5	48.7
Old model washing machine	63.3	62.7	68.9	50.3
Refrigerator	86.2	87.8	87.3	82.9
Freezer	64.3	63.2	44.5	57.2
Microwave oven	28.8	23.9	13.5	36.6
Sewing machine	49.3	50.8	42.9	41.7
Car	29.5	23.7	11.5	35.4

Source: Havasi, 2000

Table 27: Number of selected durable consumer goods per 100 households in households of the elderly and nationally in the lowest and highest income deciles

	Households of elderly only		Households of not only elderly		Total		Nationally
	1st decile	10th decile	1st decile	10th decile	1st decile	10th decile	
Black and white TV	46	15	34	23	35	12	21
Colour TV	62	102	74	118	67	110	95
Automatic washing machine	10	56	19	75	20	71	49
Freezer	47	65	56	92	35	67	60
Microwave oven	6	35	11	64	10	61	37
Video	0	21	37	62	24	62	44
Parabola antenna	5	17	6	31	7	20	17
PC	0	2	3	10	1	20	9
Car	11	41	22	71	8	58	36

Source: Havasi, 2000

7.2 Examples of good or innovative practices in support services

Because of the extremely rapid ageing process, the deteriorating demographic indicators (leading to a decline in the available family and informal help too), the poor health status of the elderly, their limited mobility and physical activity due to bad housing conditions, the development and expansion of services for the elderly is of great importance. Priority is being given to ealth and social welfare services which enable independent living and safe living at home, which directly or indirectly also ease the burden on the family. The first such models were launched in 1994. Since then other new models have been elaborated. In 2002 a further four model experiments were launched and are still running.

- In 1994 the model of home care was launched to ease nursing of elderly people living at home. It is financed by the Health Fund. Since then the model has become part of the health system. This insures on the one hand a longer period of living alone at home. On the other hand the separation of the health and social care has created new problems.
- In 1994 the model of an alarm bell system was launched and has since become a model in both towns and villages. The very poorest elderly were also taken into account in developing the model. Technical solutions were developed that could be used by the lowest income elderly without a telephone and in cases even without electricity. The criteria for inclusion in the model were low income and poor health status. By 2004 the former model had become part of the national service system. It was included in the Act on Social Welfare and so the local authorities are able to include it in the basic services. The methodological supervision is provided by the Budapest Centre of the Hungarian Maltese Charity Service (Széman, 2002).
- ISZER (Integrated Social and Health System), principally for persons over 65 years. Its aim: To reduce the defencelessness of the elderly and the numbers requiring long-term institutional care by assisting independent living. It is an individual care program drawn up with the participation of general practitioners, the home nursing service and social home care. The elements of the system also include the hospital, the day hospital and institutions at various level providing specialised care, as well as residential homes (Falus, 2004).
- Development of a geriatric methodology model in Budapest which presents the theory and practice of geriatrics in harmony with EU recommendations in the training and further training of doctors dealing with the elderly, nurses and public health specialists. Creation of geriatric advisory units, outpatient units where the results of tests explore the hidden problems of the elderly. Creation of a new outpatient form.

- The elderly-friendly housing program helps safe living at home for elderly people by altering the apartments of elderly persons with loss of functions to ensure greater accessibility (Széman, 2004a).

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