

AGEING

JUDIT MONOSTORI – GABRIELLA GRESITS

MAIN FINDINGS

- » Demographic ageing, that is, the increase in the proportion of older generations, is one of the most significant socio-demographic phenomena in the developed regions of the world. Regardless of the type of indicator considered, we can witness an ever more dynamic change, which will continue in the coming decades, according to population projections. In Hungary, the proportion of individuals aged 65 years and over increased from 13% to 19% between 1990 and 2017, and according to predictions will reach 29% by 2070.
- » Over the past decades, the internal age structure of the elderly has also changed. Most notably, the number and proportion of the very old – that is, individuals aged 80 and over – has increased. Whereas in 1990 they numbered 260,000, in 2016 there were 412,000 individuals from this age group.
- » Due to the different mortality rates for men and women, the proportion of women is higher among the elderly. Furthermore, the older a given age group, the more disproportionate this feature becomes: while 57% of those aged 65–69 are women, this increases to 73% among individuals aged 85 and over.
- » In recent decades, not only has life expectancy at birth increased, but so too has life expectancy at age 65, which means that old age has become longer. In 2000, life expectancy at 65 was 12.5 years for men and 16.2 years for women. In 2016, 65-year-old men could expect to live for an average of 14.4 years and women for an average of 18.2 years.
- » The increase in life expectancy means that the minimum age limit for old age has also risen for a variety of reasons. Quite apart from scientific evidence, the population is also well aware of this: whereas in 2001, the adult population on average considered 65.3 years to be the beginning of old age, in 2016 the figure had risen to 68.3 years.
- » In 2016, healthy life expectancy at 65 was 6.7 years for men and 6.4 years for women. Since women can expect to live longer than men with no significant difference in healthy life expectancy, women are likely to have a longer period of illnesses.
- » In 2016, 31% of those individuals aged 65 and over who lived in a private household lived there alone. The proportion of one-person households is higher among women than among men, and the proportion increases with age.

- » Among single-person households, the proportion of divorced individuals is steadily increasing, which means that the fragility of partnerships also plays an important role in the fact that a large number of elderly people live alone: in 1990, 17% of men aged 65 years and over were divorced, but by 2016 this figure was 27%; among women, the indicator rose from 9% to 16% during the same period.
- » According to the microcensus of 2016, approximately 43% of elderly people were living in two-person households with their partner. This set-up is more common among men than among women across all age groups.
- » Keeping contact with their children who live in a separate household is vitally important to the elderly, and especially to those living alone. With regard to this, it can be stated that the family connections of women are somewhat stronger than those of men: over a fifth of women are in daily contact with their child/children who are living separately from them; among men, the figure is only 5%.
- » One important task for elderly individuals can be caring for their grandchildren. In 2016, three-quarters of the generation aged 55–79 had at least one grandchild. Over two-thirds of grandparents – with approximately equal proportions of men and women – helped with taking care of and looking after their grandchildren.
- » The health status and subjective assessment of the health of elderly Hungarians are worse than in Europe generally: 18% of those aged 65 and over consider their health to be poor, and 10% think of it as very poor. Generally, a higher proportion of women than men report poor health.
- » The incidence of mental illness is of vital importance in relation to subjective and objective health. The probability of major depression is highest among individuals aged 80 and over (24%), and a further 19% have symptoms of depression. Among individuals aged 65 and over, women are more likely than men to have such problems. Partnerships are important, as they go some way to prevent depression: the proportion of major depressive symptoms is lowest (5%) among those living in a partnership. In relation to educational level, the occurrence of depressive symptoms is highest among individuals with at most eight years of primary education (12%); the figure is lowest among those with a university degree (2%).
- » Different age groups of the Hungarian adult population have different views on various aspects of elderly care. Those aged 34 and under disagree most with statements about the responsibility of grown-up children for their elderly parents. A higher proportion of women than of men agree with such statements.
- » As they get older, individuals aged 55–69 consider living with their children in case of dependency to be the least preferable solution (5%). While 30% of them would consider moving into a nursing home offering proper care to be a possibility, 61% would like to remain in their own home.

INTRODUCTION

Ageing is a natural part of human life; however, there are significant individual differences with regard to the nature of this period, and how one lives through old age. Important questions include when old age begins; what events and changes indicate the beginning of this period; how long the stage of old age lasts; and what kind of changes old age brings to one's life. At the same time, ageing can also be interpreted at the social level, when investigating the age structure of a society and the effects that a given age structure have on various aspects of social sustainability. It is well known that many countries around the world, including those of Europe, have ageing societies. This means that the proportion of older generations is increasing, while the proportion of children and middle-aged generations is decreasing. This is one of the biggest challenges facing today's societies, since the increasing proportion of old-age individuals reshapes the redistribution of resources between generations and has a significant impact on certain social institutions (e.g. pension funds, the healthcare system). In this chapter, the different aspects of individual and social – or demographic – ageing will be discussed.

INDICATORS OF SOCIAL AGEING

Demographic ageing is a well-documented phenomenon, both at a European level and domestically. In Hungary, the proportion of individuals aged 65 and over was 13% in 1990, 15% in 2001 and 17% in 2011. According to the most recent figures – from 2017 – the proportion of this age group has increased to 19%. According to the predictions of Eurostat, this indicator will increase even more significantly, and by 2070 it might reach 29%.

One of the most important social aspects of the changing age structure is the effect it has

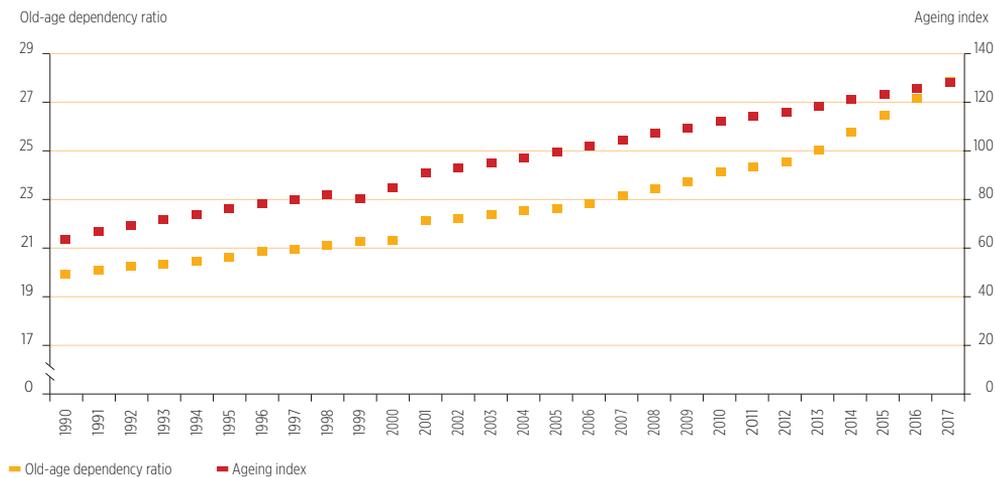
on the sustainability of social institutions: i.e. how dependency rates will change and how many active individuals will have to 'provide for' inactive people. The decreasing number of active individuals results in a shrinking labour force potential, which leads to difficulties in sustaining state supply systems.

The *old-age dependency ratio*^G indicates how many old-age individuals (aged 65 years and over) are supported by 100 active people (aged 15–64). In Hungary, this indicator increased from 20 to 28 (per 100 active people) between 1990 and 2017 (*Figure 1*). According to the latest Eurostat calculations, by 2070 the figure will rise to 52, meaning that for approximately every two active individuals there will be one aged 65 and over. The proportion of children in relation to the elderly is expressed by the so-called *ageing index*^G, which shows the number of old-age individuals per 100 children (aged 0–14 years). Between 1990 and 2017, this indicator increased from 65 to 129 (*Figure 1*).

The Hungarian old-age dependency ratio is lower than that of the European Union average, and only a few countries have values lower than Hungary. These include Central and Eastern European countries (Poland, Romania, Slovakia) and Ireland. While in the case of the former, this indicator is low because of poor mortality rates, in the case of Ireland it is because of a more favourable fertility rate.

Besides traditional indicators of social ageing based on age (usually 65 years), there are other indicators that seek to illustrate ageing and describe its social challenges and burdens, considering other factors or taking a different approach to age. The main consideration behind these indicators is the fact that it is not only the proportion of old-age individuals within a given society that changes, but also the phenomenon of ageing itself. Today people are present on the formal labour market for longer than they were a few decades ago, since in many countries the retirement age has been raised. Changes in lifestyle, a decline in

Figure 1: Old-age dependency ratio and ageing index in Hungary, 1990–2017



Source: HCSO, Demographic Yearbooks.

the proportion of those doing heavy physical work, developments in medical science and the use of new technologies in health care all mean that *healthy life expectancy*^G is on the increase. This goes to suggest that the beginning of old age should be set later than it has been in the past.

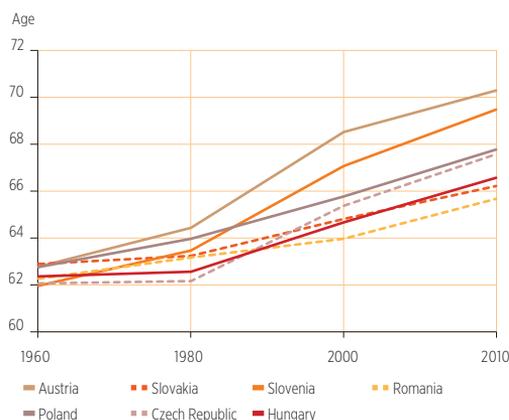
One approach that takes account of the changing features of old age considers using the increasing life expectancy as the basis for defining the onset of old age. It determines old age as the last phase of one’s life, with a clearly defined timeframe. According to Sanderson and Scherbov (2007), this period lasts 15 years: that is, the age limit for the start of old age is the point when one can expect to live for another 15 years. Based on this approach, the age limit for old age is continuously increasing in all European countries, with significant regional variation even between neighbouring countries. According to Hungarian figures, the age limit for old age was 62.6 years in 1980, 64.7 years in 2000 and 66.6 years in 2010. Of the neighbouring countries, only Romania has a

lower value. In 2010, the age limit for old age in Austria, for example, was 70.3 years and in Slovenia it was 69.5 (Figure 2).

According to the definition based on a fixed age limit and the definition that takes account of life expectancy, we can calculate differences in long-term developments in the old-age dependency ratio. Compared to indicators based on a fixed (i.e. predetermined age limit), indicators that take life expectancy into consideration only show a moderate increase in dependency ratios.

Alongside indicators that consider life expectancy, indicators that look at the social burdens of demographic ageing in relation to performance of the labour market are also becoming more widely used. One such indicator is the economic old-age dependency ratio, which shows the number of inactive individuals aged 65+ per 100 active persons (aged 20–64). In 2016, this indicator was 40.6 in Hungary. This was somewhat lower than the European average, but higher than in several neighbouring countries (e.g. Czech Republic, Slovakia, Austria).

Figure 2: Threshold of old age, taking into account of life expectancy, 1960–2010



Source: IIASA (2015)

Note: The diagram is based on Sanderson and Scherbov's approach: that is, the age limit for the start of old age is the point when one can expect to live for another 15 years.

CHANGING THRESHOLD FOR OLD AGE FROM THE PERSPECTIVE OF THE POPULATION

The increase in the age limit for old age is not only observed by researchers interested in ageing, but is also felt by the wider population. The findings of the survey entitled *Turning Points of the Life-course* reveal that the adult population defines old age as commencing three years later than it did 15 years ago. In 2016, the population aged 24–75 suggested an average of 68.3 years for the onset of old age. Typically, women suggested higher values. The older a respondent, the higher the threshold for old age that he or she suggested. The indicator also increases with level of education (Table 1).

Table 1: Threshold of old age according to the population aged 24–75, 2001, 2008, 2016

	(average values, age)		
Social characteristics	2001	2008	2016
Population aged 24–75	65.3	66.4	68.3
Sex			
Men	64.6	65.5	67.3
Women	65.9	67.1	69.1
Age group			
24–29	64.6	64.9	65.8
30–39	65.4	65.4	67.2
40–49	64.7	66.3	68.3
50–59	65.0	66.2	68.4
60–69	66.0	67.6	69.3
70–75	67.2	68.7	70.1
Educational level			
At most 8 years of primary education	64.5	65.5	67.2
Vocational education	64.3	65.6	67.7
School leaving certificate	66.3	67.0	68.5
Tertiary degree/diploma	67.4	67.8	69.4

Source: HCSO HDRI Turning Points of the Life-course survey, 2001, 2008, 2016; authors' calculations.

Table 2: What determines old age? – Proportion of responses among the population aged 24–75, 2001, 2016

	Proportion of responses (%)	
Properties	2001	2016
Is over the age of 65	36.1	37.6
Suffers from health problems	49.8	48.6
Is unable to provide for one's own self, is dependent on others	61.2	58.7
Mental capacities are deteriorating	51.6	55.0
Is a pensioner	22.1	23.7
Cannot easily adapt to change	35.0	39.5
Cannot solve problems	29.3	29.6
Has grandchildren	7.5	8.0

Source: HCSO HDRI Turning Points of the Life-course survey, 2001, 2008, 2016; authors' calculations.

Old age is most often associated by the population with deteriorating health, dependency on others and diminishing mental capacity. Less than a quarter of the population views retirement as an important feature of old age, while grandparenthood is associated with old age to an even lesser degree. The significance of factors determining old age according to respondents showed surprising stability over time. The proportion of the most important features of old age according to respondents was almost the same 15 years ago as in the most recent (2016) survey (Table 2).

AGE STRUCTURE OF THE OLD-AGE POPULATION

In recent decades, not only has the proportion of individuals aged 65 and over increased, but also the age structure of the elderly has changed. Both the number and the proportion of the very old – that is, individuals over the age of 80 – have increased. Whereas in 1990, some 260,000 persons belonged to this category, by 2016 the figure was already 412,000 (Table 3). The rise in the number of those aged 80 and over is vitally important: their state of health means that they are the people most in need of support from their families, the civil sphere and the state. This explains why certain international organizations have started in recent decades to calculate the dependency ratio not only of individuals aged 65 and over, but also of persons aged over 80. With regard to this indicator, predictions about population number and its structure show a much sharper rise than the dependency ratio for those aged 65 and over: between 2016 and 2060, the proportion of the younger age

groups of elderly individuals is set to double, while the dependency ratio of those aged 80 and over is likely to increase by almost 3.5 times in Hungary.

Figure 3: Number of individuals in various elderly age groups, 1990, 2001, 2011, 2016



Source: HCSO, Microcensus 2016. Part 3: Demographic data, 2017.

Due to the difference in the mortality of men and women, women are over-represented among elderly age groups – and the older the age group, the higher the proportion of women. With regard to those aged 85 and over, there are almost three times as many women as men (Table 3). As a consequence, when discussing the issue of those most in need of support, we can refer primarily to women.

Table 3: Proportion of sexes among various elderly age groups, 2016

Age group	Men	Women	Total (%)
65–69	42.9	57.1	100.0
70–74	40.1	59.9	100.0
75–79	34.6	65.4	100.0
80–84	32.2	67.8	100.0
85+	27.1	72.9	100.0

Source: HCSO, Microcensus 2016. Part 3: Demographic data, 2017.

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY OF THE ELDERLY POPULATION

Ageing is a natural part of life; however, not everybody lives to be old, and there are further differences as to how many years one can expect to live once one reaches the threshold of old age.

Table 4: Life expectancy at age 65, 1990–2016

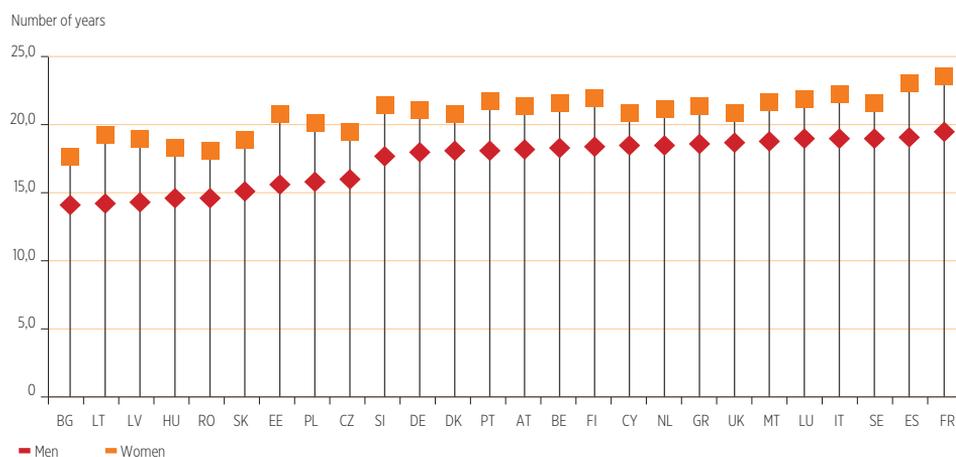
Years	Men	Women	Difference between men and women (year)
1990	12.0	15.3	3.3
2000	12.5	16.2	3.7
2010	13.8	17.6	3.8
2011	13.9	17.7	3.8
2012	14.1	17.7	3.6
2013	14.3	17.9	3.6
2014	14.4	18.0	3.6
2015	14.2	17.8	3.6
2016	14.4	18.2	3.8

Source: HCSO calculations.

With regard to the past two or three decades, positive changes have taken place not only in relation to life expectancy at birth, but also in life expectancy at age 65. Between 1990 and 2016, the life expectancy of men at age 65 increased from 12 years to 14.4 years, and among women from 15.3 years to 18.2 years. Ever since the early 2000s, women can expect to live for an average of 3.6–3.8 years longer than men. Therefore, the difference between the two sexes has not changed significantly (Table 4).

Despite these positive trends, life expectancy in Hungary is still worse than elsewhere in Europe: only in Latvia, Bulgaria and Lithuania can men aged 65 expect to live for a shorter time than Hungarian men; meanwhile only in Bulgaria and Romania is female life expectancy at 65 lower than in Hungary. Among Europeans, Swedish, French, Spanish, British and Italian men can expect to live the longest at the age of 65, together with French, Spanish, Swedish, Italian and Finnish women (Figure 4).

Figure 4: Life expectancy at age 65 in European countries, 2015



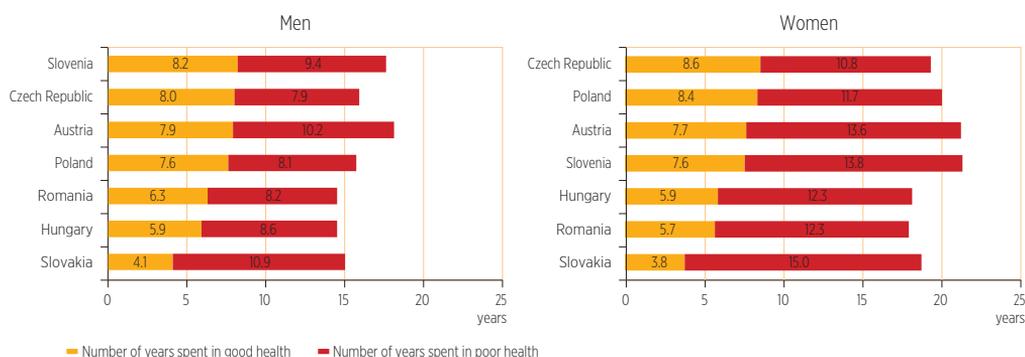
Source: HCSO, Demographic Yearbook 2016.

There is not a single country in Europe where life expectancy at age 65 is higher for men than for women. However, there are significant differences in terms of how many years less men can expect to live. Generally, differences are bigger in Central and Eastern European countries, especially in, for example, the Baltic countries and Poland. Elsewhere – for example, in the majority of Southern European countries, Sweden and the United Kingdom – the difference between the sexes is small.

Besides changes in life expectancy, the number of years we live in good health is also important – not only for the individual,

but also on a social level. Does increasing life expectancy result in an increasing number of healthy years? In order to answer this question, the so-called healthy life expectancy indicator was introduced. This divides life expectancy into two parts: one spent in good health and the other spent in poor health. In relation to the number of years one can expect to spend in good health, there is a much smaller difference between the sexes than in the case of life expectancy. This means that while women live longer than men, they can also expect to spend a longer period in poor health (*Figure 5*).

Figure 5: Life expectancy at 65, according to the number of years spent in good and poor health, 2015



Source: Eurostat

FAMILY EMBEDDEDNESS OF THE ELDERLY

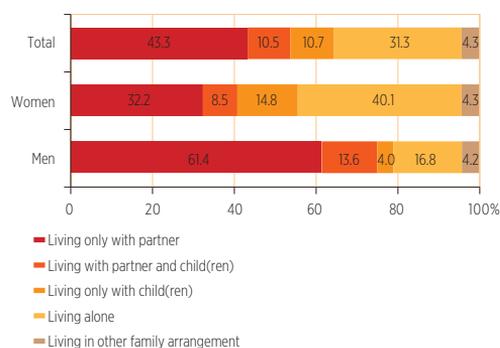
The rising proportion of the elderly and the increased duration of old age pose challenges not only for the various social institutions, but also for families. The important questions are how the potential of the elderly can be utilized; how they can help younger generations; and how those in need can be supported by their families. In light of this, we define ‘family’ more broadly as a cohabiting community, although the family structure in which elderly people live their lives is also very important. Numerous studies have clearly revealed that

elderly individuals who live alone are more vulnerable than their counterparts who live in a family: a higher proportion of them face serious financial problems and more of them end up in a nursing home. According to the 2016 microcensus, over 30% of those individuals aged 65 and over who live in a private household live alone (*Figure 6*). The proportion of women who live alone is higher, and this increases with age.

If we look at the period since 1990, we can see that the proportion of elderly people living in a single-person household has been increasing, and an ever-rising proportion of them are divorced. This means that the

fragility of relationships plays an important role in the spread of single-person households. In 1990, 17% of single men aged 65 years and over were divorced; by 2016 the figure was 27%. During the same period, the indicator for women rose from 9% to 16%.

Figure 6: Distribution of the population aged 65 and over, according to household structure, 2016



Source: HCSO, Microcensus 2016; authors' calculations

The largest group of persons living in private households features individuals living with their spouse/partner. According to the findings of the 2016 microcensus, 43% of elderly people were living in such an arrangement. Across all elderly age groups, the figure is higher for men than for women: the difference is already apparent for people in their sixties, and becomes even more significant for older age groups: according to the figures of the 2011 census, three times more men than women in their eighties lived with their spouse/partner. Among those aged 80–84, for example, 65% of men but only 20% of women lived in such an arrangement. This is mainly a result of the difference in mortality between men and women, but is also because women in a relationship tend to be 4–5 years younger than their male partner; thus, even if men lived as long as their partners, the proportion of women living in a relationship would still be lower.

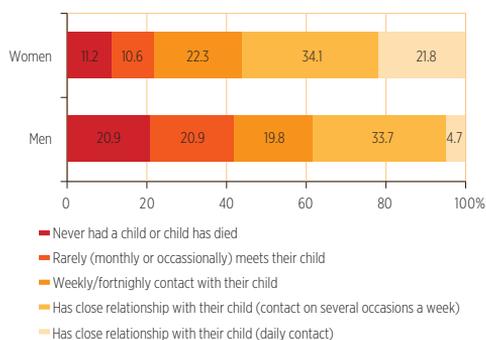
The proportion of elderly people living with their grown-up children is still high: 18%

of men and 23% of women. This includes households where children have not yet left home, but also those where the children have returned.

Embeddedness of the elderly is not solely described by who they live with, but also by whether they have children, grandchildren or siblings living outside their household; what kind of relationship they have; and to what extent they can rely on each other. International surveys have shown that such ties are just as important as the relationship between family members living together/cohabiting relatives. Although it may be the case that nowadays the proportion of elderly individuals living as grandparents in a multi-generational household is lower, they can still have a strong relationship with their children, grandchildren or even siblings. The embeddedness of elderly people is better described by investigating the family connections of persons living either together or separately, as opposed to simply looking at household arrangements. According to the findings of the Turning Points of the Life-course survey, in 2016 10% of the population aged 65–90 did not have a single living biological child; 6% were living with their single biological child; 70% of individuals only had children living away from them; and 14% had some biological children living with them and others living apart from them. The older somebody is, the more likely it is that they do not have biological children. This is probably because their children will themselves have reached an age when the mortality rate increases significantly: i.e. as a person's age increases, so does the likelihood that (some of) their children will have died. Furthermore, the older the given age group being investigated, the lower the proportion of those whose children live separately from them. This might partly be due to the fact that the oldest are the most vulnerable, and in some cases they again set up house with their children; thus, once separated children again become cohabiting children.

Keeping contact with children already living separately is crucial, especially for elderly people who live alone. In this regard, it can be stated that women living alone are somewhat better embedded: over a fifth of them have daily contact with their child(ren) living apart from them; the figure for men is only 5%. The proportion of individuals who either never had children or have already lost them is higher among men: 11% of women and 21% of men belong to this category (Figure 7).

Figure 7: Relationship of elderly individuals living alone with their children, 2016

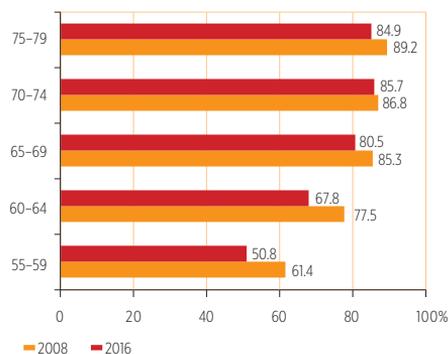


Source: HCSO HDRI Turning Points of the Life-course survey, wave 5; authors' calculations

For the elderly, maintaining contact with their siblings is just as important as keeping in contact with their children, since they can also provide familial support. Almost two-thirds of individuals aged 65 and over have living siblings; of that group, approximately half have one sibling and half have two or more. However, very few have a close relationship with their siblings: 44% of respondents meet their sibling(s) on only a few occasions annually, and only 16% meet at least one sibling several times a week. Women have somewhat closer connections with their siblings: while only 41% of women meet up with their sibling(s) on only a few occasions each year, the same applies to 48% of men.

Besides relationships with children and siblings not necessarily based on cohabitation, the third strong connection could be the relationship with grandchildren. The role of grandparents and the participation of older generations in child care are influenced by processes affecting children, parents and grandparents. With regard to (grand)children, the availability of institutional day-care opportunities is a significant factor, as is which of their needs remain unfulfilled, in spite of parental and institutional involvement. In connection with parents, labour market tendencies, part-time job opportunities and flexibility all influence the fulfilment of childcare responsibilities. As for grandparents, for them to be able to participate in child care, they need to have free time and to be in good enough health.

Figure 8: Proportion of individuals aged 55–79 who have grandchildren, 2008, 2016



Source: HCSO HDRI Turning Points of the Life-course survey, waves 3 and 5, 2008, 2016; authors' calculations.

However, the involvement of older generations in child care depends primarily on what proportion of them become grandparents and at what stage in their lives. Obviously, low fertility, an increasing proportion of childless young individuals and postponed childbearing all result in a greater proportion of individuals who

never become grandparents – or only later in life. There is little relevant information, although a comparison of data from 2008 and 2016 shows that even over such a short space of time, the probability of becoming a grandparent declined: in 2008, 61% of those aged 55–59 had a grandchild; in 2016 the figure was only 51%. With regard to those aged 60–64, the figures were 78% and 70%, respectively (*Figure 8*).

Table 5: Proportion of individuals aged 55–79 participating in child care and supervision, 2016

Social characteristics	Participants' ratio (%)
Total	69.2
Sex	
Men	67.7
Women	70.1
Age group	
55–59	75.5
60–64	76.0
65–69	71.0
70–74	57.4
75–79	46.7
The age of the youngest grandchild	
0–3 year	81.0
4–6 year	80.3
7–18 year	63.2
population aged 14 and over	30.6
Health status: health problem affecting the performance of daily tasks	
Non-qualified	72.0
There is	62.2
Educational level	
At most 8 years of primary education	58.9
Vocational education	68.0
School leaving certificate	74.8
Tertiary degree/diploma	79.4

Source: HCSO HDRI Turning Points of the Life-course survey, wave 5; authors' calculations.

Note: Only involvement in looking after children in separate households was taken into consideration.

In 2016, over two-thirds of grandparents aged 55–79 took part in caring for and

looking after their grandchildren, with approximately the same proportion of grandfathers and grandmothers. The involvement of grandparents decreases with age. This obviously has to do with their grandchildren growing up and becoming independent, but the form of support also changes: while 76% of those aged 55–59 and 57% of those aged 70–74 took part in child care and supervision, the same can be said of only 47% of those aged 75–79. Looking after grandchildren also depends on health, and the data also suggest that differences according to level of education are significant (*Table 5*).

HEALTH STATUS OF THE ELDERLY

Old age is usually accompanied by deteriorating health, although the nature and speed of deterioration show significant differences. These differences are apparent between men and women, according to level of education; but they are also influenced by whether elderly individuals live alone or can share their everyday challenges in a multi-person household. Therefore, the health of the elderly population is affected by numerous social and lifestyle-related factors. Analysing the health of the elderly is possible using population surveys. The data from the European Health Interview Survey (EHIS) 2014, conducted by the Hungarian Central Statistical Office (HCSO) for the European Union, allow us to gain a general picture of the health status of the elderly.

How respondents answer the question of how they feel about their general health (on a scale of 1–5) provides an indication of subjective health status, which can also indicate certain factual health problems. In 2014, 18% of individuals aged 65 and over considered their health poor, and 10% very poor. The proportion of those who regard

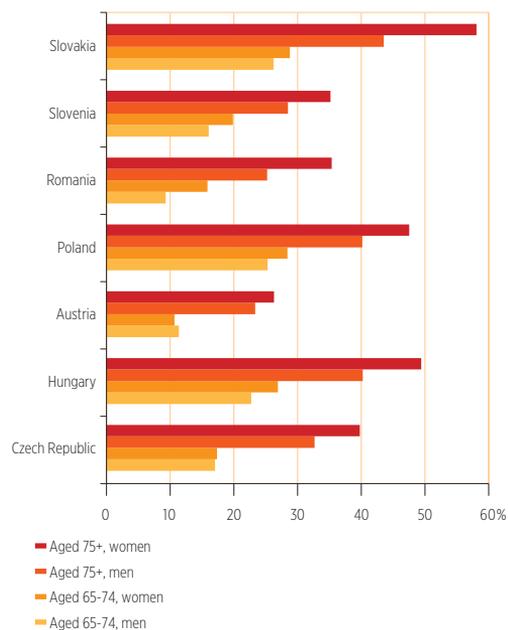
their health as poor or very poor increases with age: only 22% of those under 74, rising to 30% of those over 75 and 40% of those over 85. Regardless of age, more women than men consider their health to be poor – and consequently visit their doctor more frequently. Of those aged at least 65, 30% of women and 25% of men consider their health to be inadequate (i.e. poor or very poor). There is a clear tendency among those aged 65 and over for individuals with a lower educational level to be dissatisfied more often with their health. While 43% of those with primary education consider their health to be poor/very poor, the figures for other categories are: 26% of those who have completed secondary education without any qualifications; 19% of those with school-leaving qualifications; and 15% of those with a degree/diploma. In case of individuals with a low level of education, a low evaluation of their health stems from a number of disadvantages that affect them not only in old age, but throughout their lives.

Among the countries of the region, the proportion of those who feel that their health is poor/very poor is highest in Slovakia and lowest in Austria. Elderly Hungarians are closest to their Polish counterparts in this respect.

There are several reasons for poor subjective health: 80% of individuals aged at least 65 reported chronic, long-term disease (of at least six months' duration). The proportion of those dying with Alzheimer's disease and dementia has also risen sharply in Hungary because of numerous factors (e.g. ageing population, better diagnostic methods, lack of efficient treatment). In the 2000s, Alzheimer's disease was the 33rd most common disease in the population; by 2014 it was ranked 8th. Chronic diseases like hypertension, diabetes and musculoskeletal problems also have an important effect on the well-being of the elderly. Some 39% of elderly individuals reported severe musculoskeletal issues or sensory deprivation and 35% less

severe problems. The most serious such health problems were musculoskeletal conditions that affect movement and prevent individuals from completing household tasks: while 11% of individuals aged 65–69 experience difficulty with household chores, the figure rises to 21% of those aged 70–74 and soars to 62% of those aged at least 85; the proportion of those who do not even tackle such household tasks is highest (11%) among the latter age group. The proportion of individuals doing light chores is far better in all age groups: 34% of the oldest age group experience problems while doing such tasks, and 12% do not even attempt them. The proportion of those reporting severe sensory limitations that affected their everyday lives was lower: more individuals had impaired hearing than impaired vision. In relation to this problem, 21% of those aged over 65 reported moderate and 11% serious limitations in terms of providing for themselves.

Figure 9: Poor or very poor subjective health status, 2016



Source: Eurostat, 2016

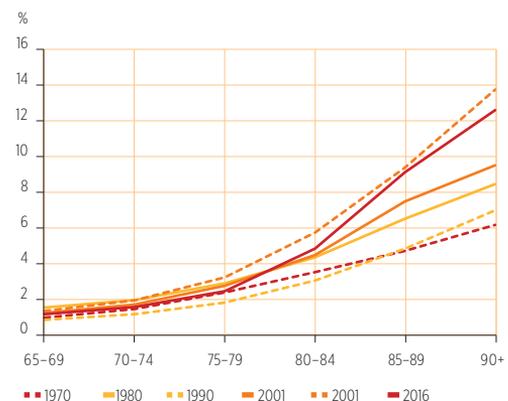
With regard to subjective and objective health, mental problems are of vital importance. The EHIS 2014 contained several questions related to depression. These were designed to identify major depression, but symptoms of minor – less serious – depression could also be detected. A comparison of age groups reveals that the probability of depression is highest among those aged at least 80 (24%), with 6% of men and 9% of women aged over 65 also affected. Analysis of household arrangements shows that relationships are effective in preventing depression: the proportion of individuals with major depressive symptoms is lowest (5%) among those living with a partner. Meanwhile, the proportion is 9% among individuals living in a single-person household and is highest (15%) among those living with their child but without a partner. The latter cases are most probably a result of necessary cohabitation following the death of the partner, and are also affected by other negative factors (e.g. mutual financial dependency). If we take level of education into consideration, the proportion of individuals with major depressive symptoms is highest (12%) among those with at most eight years of primary education and is lowest (2%) among those with a tertiary degree/diploma. The presence of depressive symptoms shows a similar pattern: 10% of men and 13% of women aged over 65 are affected. Among individuals living in a single-person household, 15% show depressive symptoms; only in more complex, unconventional cohabitation arrangements is the figure higher (20%).

ELDERLY CARE

The nature of old age and the problems that arise can be varied. Just as older generations take a share in looking after their grandchildren, so – when they themselves

become dependent on others – they rely primarily on the support of their family; this can take several forms. Furthermore, aside from the family, the social care system also supports them. From the various institutional options open to the elderly, residential homes provide care for those individuals with the most serious problems. In Hungary, the proportion of individuals living in such homes is relatively low in European terms; this can be attributed to many factors: low capacity, quality problems, and a certain reluctance on the part of the elderly people themselves and their families. Nevertheless, the proportion of individuals who live in nursing homes has shown an upward trend since the 1970s. The only drop in the proportion of elderly people living in nursing homes occurred in 1990, as a consequence of problems with regulations at the time of the change of regime (*Figure 10*).

Figure 10: Proportion of elderly people living in a nursing home, by age group, 1970–2016



Source: Monostori (2017) for data from 1970 to 2011; HCSO microcensus 2016; authors' calculations.

Care of the elderly – and the quality of such care – depends on the family values of a given society, general features of the relationship between generations, state policies and the responsibilities undertaken by the state. Various indicators can be used

to compare the elderly care practices of ageing societies. One possible approach is that taken by Saraceno and Keck (2010), who investigated the specific patterns of institutionally regulated downward (toward children) and upward (toward the old) intergenerational obligations with regard to care and financial support, and identified specific country profiles and clusters of countries in Europe. Based on these dimensions, the countries of Northern Europe prefer the so-called 'de-familization' model, where elderly care services are widely available, but the family can still decide to organize elderly care themselves, after considering the available options. 'Supported familialism' is typical of countries where state elderly care is not well developed, but the state provides enough support to families for them to care for the elderly. The familialist system, however, is one in which institutional elderly care is underdeveloped and families receive little support in caring for the elderly. This is the category to which Hungary belongs.

In Hungary, families play a highly significant role in elderly care. It is difficult to draw up an accurate picture of family-provided elderly care through surveys, since not only do the elderly have a variety of needs and demands, but also the families provide different responses to those requirements. Also, elderly individuals living in institutions and homes are often excluded from surveys, and so information on this group is even scarcer. Analysis of family-based support, however, reveals that it tends to be based on lineage (the relationship between parent and child or grandparent and grandchild), while 'collateral relatives' – such as siblings – are less likely to be involved. Elderly care is mainly provided by women: a higher proportion of female offspring look after their elderly parents (Dykstra 2009), while

men whose elderly parents need care are most often supported by their partner. If we consider the responses to the question of how children feel about responsibility towards their elderly parents, then, according to the findings of the first wave of the Turning Points of the Life-course survey, Hungarians seem to have a similar opinion to that of the Germans and the French (Herlofson et al. 2011). The question aimed at determining the extent to which respondents agreed with the statement that it is the responsibility of children to look after their elderly parents in need. Of the countries involved, the people of Georgia, Russia and Romania showed a higher degree of responsibility, while those in Norway and the Netherlands agreed least with the statement. Hungary was somewhere in the middle.

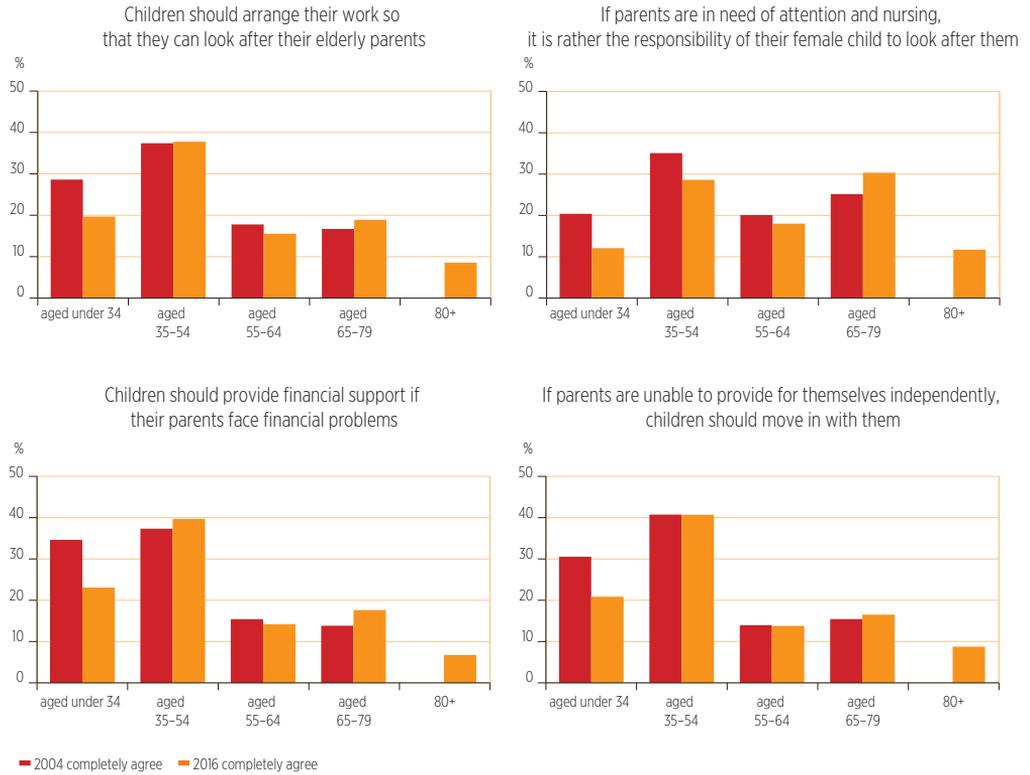
The 2004–2005 and 2016 waves of the Turning Points of the Life-course survey also aimed at determining the various forms of involvement in elderly care desired by respondents. Questions included whether it is the responsibility of children to provide financial support for their parents; whether they should manage their work so that they can look after their parents; whether it is the responsibility of female children to look after their parents; and whether children should move in with their elderly parents in need. We analysed the opinion of respondents from various age groups at one given time. From 2004 to 2016, responses to the above questions show remarkable consistency among both men and women, similar to the difference in opinion between the sexes. With regard to the findings of 2016, the difference in opinion between men and women is most obvious in relation to whether it is the responsibility of female children to look after their parents: women feel it is their duty, with 29% of them agreeing or strongly agreeing with the statement; meanwhile only

23% of men felt the same way. While 36% of men disagreed strongly with this statement, only 32% of women did so. With regard to all the other questions, 4–5% more women agreed with each statement than did men. The answers reveal that the youngest age group (those under 34) is even less likely to identify with traditional forms of elderly care. Moreover, in this age group there has been a significant decline (of approximately 10%) since 2004 in those agreeing with each and every statement. In the case of individuals aged 55–64, the decrease is more modest in relation to their agreement with the statements, and their willingness to move in with their parents barely changed over the intervening 12 years. The attitude of this age group is all the more interesting, because this is the stage of life when they are most likely to encounter the problems facing their elderly parents. By contrast, those aged below 34 are voicing an opinion about a problem that will only surface at a later stage in their lives. The proportion of those aged 64–79 who agreed with the statements increased. This is worthy of note, since they find themselves dependent on their children, while some of them also have old parents with care needs; thus, they are articulating their opinion about their own responsibility. Analysis of the opinions of individuals over the age of 80 is only possible using data from 2016, because in 2004–2005 the oldest respondents had not yet reached that age. The oldest individuals, as beneficiaries of support from their children, were even less likely than the youngest age group to agree that it is the responsibility of children to look after their parents. It seems that the opinions

of the middle-aged generation (35–54) are the most consistent on all questions, with only their attitude about the responsibility of female children towards their parents showing a decline (*Figure 11*).

In light of all this, it can generally be stated that Hungarian families try to support their loved ones in being able to stay in their familiar environment for as long as possible. However, there comes a point in the lives of many elderly individuals when they are no longer safe in their familiar living space. As has already been discussed, responses to the questions show that the generations affected do not feel it is the responsibility of children to move in with their elderly parents in case of need. Rejection of this option raises the question of what alternatives the ageing generation (55–69) would find acceptable. According to the findings of the Turning Points of the Life-course survey of 2001, 71% of this generation felt that when they reached that stage in their lives when they could only provide for themselves with difficulty, they would wish to find a solution that allowed them to stay in their own home. Only 10% thought they would be willing to move in with a family member, and only 18% wanted to go into a home that provided professional support. Responses to the same question in 2016 among individuals aged 55–69 were somewhat different. Only 5% of respondents from this age group wanted to move in with another family member, while 30% would consider going into a home that provides professional care. The majority – some 61% – still said they would rather stay in their own home, even in case of dependency.

Figure 11: Attitudes about mutual support between generations, 2004, 2016



Source: HCSO HDRI Turning Points of the Life-course survey, waves 2 and 5; authors' calculations.

Note: At the time of wave 2 of the Turning Points of the Life-course survey, the oldest respondent was aged 78.

ELDERLY CARE ABROAD AND MIGRANT CARE WORKERS¹

With the rise in life expectancy, the number of elderly people with care needs is increasing in Hungary and other European countries. In many countries, long-term care consists of a combination of state-provided services (i.e. formal care) and informal care. This combination can vary, as can the demand for caring (Ilinca et al. 2015).

The advantage of home care (often provided by migrant care workers) over formal, institutional care is that those in need can stay in their own homes, and do not have to leave their familiar environment. In recent decades, several studies have investigated the migration of care workers in various regions of the world. They clearly show that the phenomenon is a global one. Whereas in the 1970s, Filipino women were the best-known international performers of care work and domestic work (Parreñas 2001), nowadays Hungarians have also joined the network of care workers working in richer countries.

The number of Hungarian care workers is steadily increasing in Austria, one of the most popular destinations for Hungarian labour migrants.² Although there are historical and structural reasons for the close labour market ties between Hungary and Austria, so far as the employment of care workers

is concerned, it is worth mentioning the legal framework introduced by Austria in 2007, as it enables foreign care workers to start working in the country easily and legally by acquiring a self-employment licence (Österle and Bauer 2012). Furthermore, since 1993 the Austrian state has provided a cash care allowance benefit (*Pflegegeld*) according to the level of need of the patient. This allowance can be used freely by the recipient, and most commonly it goes to employ cheap foreign labour.

The rotating shifts – usually fortnightly – are typically undertaken by women. Another important demographic characteristic of the Central and Eastern European care workers generally is that they usually commence this work when they are quite old (Rostgaard et al. 2011). This is partly due to the intimate, confidential nature of the work, but also because the mainly elderly patients prefer it. The age distribution of commuting elderly care workers is also important, because this form of migration creates transnational relations that affect not only the individual, but also their families and households. It is not unusual for migrant care worker women to leave their sick/incapacitated husbands or to pay for a nurse to look after their mothers. Thus, undertaking better-paid work abroad involves significant sacrifice by the care workers.

¹ This section was written by Dóra Gábrriel.

² Although the exact number of Hungarians employed abroad in elderly home care is as yet unknown, qualitative research has been conducted on the topic (Váradi et al. 2017; Turai 2017; Gábrriel 2019).

GLOSSARY

Ageing index: The ratio of individuals aged 65 and over to individuals aged 14 and younger.

Healthy life expectancy: Life expectancy is divided into two parts, depending on the number of years spent in good or in poor health. This indicator allows not only the length of one's life, but also the quality of life to be expressed.

Old-age dependency ratio: The ratio of individuals aged 65 and over to individuals aged 15–64.

Subjective health status: Evaluation of health status based on self-assessment, which closely correlates with several objective, quantifiable health-status indicators.

REFERENCES

- Dykstra, P. (2009): Intergenerational relationships in ageing societies: United Nations Economic Commission for Europe Working Group on Ageing. ECE/WG. 1/2009/3.
- Gábel, D. (2019): A Magyarországról Ausztriába irányuló idősgondozói migráció. Egy kvalitatív kutatás eredményei a dél-barányai térségből induló idősgondozói migráció mechanizmusáról. [Migration of care workers from Hungary to Austria: Results of a qualitative research on the mechanisms of care workers' migration from Southern Baranya county.] Kutatási jelentések 101. HCSO Hungarian Demographic Research Institute, Budapest.
- Herlofson, K., Hagestad, G., Slagsvold, B. and Sørensen, A.-M. (2011): Intergenerational family responsibility and solidarity in Europe. Multilinks deliverable 4.3. *Norwegian Social Research* (NOV A), April.
- IIASA (2015): The characteristics approach to population aging: New measures (Version 2, December 2015). International Institute for Applied Systems Analysis. <http://www.iiasa.ac.at/web/home/research/researchPrograms/WorldPopulation/Reaging/Indicators.html>
- Ilinca, S., Leichsenring, K. and Rodrigues, R. (2015): From care in homes to care at home: European experiences with (de) institutionalisation in long-term care. European Centre, Policy Brief, December.
- Monostori, J. (2017): Stabilitás és változás az idősek háztartásszerkezetében [Stability and change in elderly household structure.] *Demográfia*, 60(1): 105–39.
- Österle, A. and Bauer, G. (2012): Home care in Austria: The interplay of family orientation, cash-for-care and migrant care. *Health and Social Care in the Community*, 20(3): 1–9.
- Parreñas, S.R. (2001): *Servants of Globalization: Women, Migration and Domestic Work*. Stanford University Press, Stanford, CA.
- Rostgaard, T., Chiatti, C. and Lamura, G. (2011): Tensions related to care migration: The south-north divide of long term care. In B. Pfau-Effinger and T. Rostgaard (eds): *Care Between Work and Welfare in European Societies*. Palgrave Macmillan, Basingstoke: 129–154.
- Sanderson, W.C. and Scherbov, S. (2007): A new perspective on population ageing. *Demographic Research*, 16(2): 27–58.
- Saraceno, C. and Keck, W. (2010): Can we identify intergenerational policy regimes in Europe? *European Societies*, 12(5): 675–696.
- Turai, T. (2017): Beilleszkedés és kiilleszkedés, otthon és otthontalanság. A társadalmi beágyazottság újraszerveződése a kelet- és közép-európai házi ápolók migráns életútjában. [Integration and separation, home and homelessness. Restructuring of social embeddedness of Central and Eastern European live-in care workers' migrant life course.] *Socio.hu*, 2017(3): 1–24.
- Várad, M.M., Durst, J., Fehér, K., Németh, K. and Virág, T. (2017): Kényszerű mobilitás: migrációs utak hátrányos helyzetű vidéki terekben. [Coercive mobility: Migration routes in disadvantaged rural areas.] *Socio.hu*, 2017(3): 25–46.