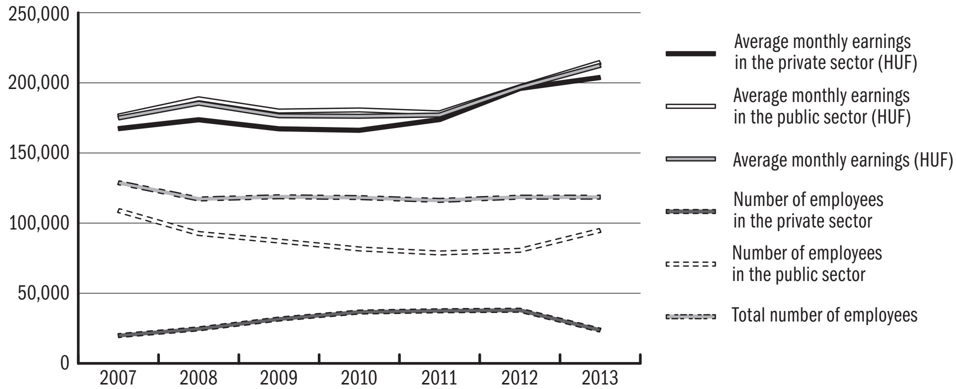
4.3 Nurses and other health care professionals

Erzsébet Berki, Éva Czethoffer & Endre Szabó

The wage demands of health care professionals have been very much in the public eye in recent years. The Association of Hungarian Residents has organized a number of actions, and regular media reports on the emigration of health care workers have spotlighted working conditions in the health care sector (for details see sub-chapter 4.2 of this issue of *In Focus*). This article explores the status and movement of health care professionals on the labour market.

Both the public (central and local governments) and the private sectors have been equally involved in health care for many years. The outcome has been a patchwork of conditions set by various employers. Some people work as public service staff while others are straightforward employees, while overtime work and a variety of special contracts including ones that legally transform health care workers into private entrepreneurs try to fill in the gaps generated by a shortage of labour. The entanglement of the private as well as central and local government sectors in this area even muddles up the statistics, but overall trends can be unearthed by using a variety of databases (*Figure 4.3.1*)

Figure 4.3.1: Number of health care workers and average earnings



Source: *Central Statistics Office Statistical Database* (KSH STADAT) Annual timelines (labour market, Tables 2.1.33., 2.1.35, and 2.1.38 and 2.1.43) and own calculations.

KSH data covering employment from 2007 to 2012 very clearly shows that employment in the public (central government) health care sector has been declining steadily while in the private sector – which includes businesses in which the government is a minority or majority owner – it has been on the rise. Overall however, the numbers have gone neither up nor down since 2008. There was one break in this picture, in 2013, when what till then had been private business entities were turned into central-budget-run institutions. That year private sector employment went down by roughly 14,000 persons, while the number of people working in the public sector increased.

At this same time, mean earnings in the private sector were slightly below the average for the public sector (the biggest difference was in 2010, when it amounted to HUF 14,000/month). For all intents and purposes, earnings stood still between 2008 and 2011, and then began to rise in 2012–2013. Data for 2013 reflects a more significant rise in average earnings in the public sector than in the private one (these numbers also reflect the earnings levels of the staff that had been moved from the private to the public sector). By that time the earnings difference between the two sectors amounted to over HUF 11,000/month to the benefit of the public sector.

Public (central and local government) health care professionals and their career paths from 2002 to 2008

There are a number of factors within the overall trend cited above that surface when exploring the career paths of health care professionals working in the public (central and local government) sector. We used data available in the databank of the Hungarian Academy of Sciences Centre for Economic and Regional Studies (MTA KRTK) to investigate this. In 2002, the sample covered half of the population between ages 15 and 74, of whom 114,089 people spent at least one month of the timeframe under investigation working in health care. This sample was made up of workers in the health care professions,[1] who constituted 4 per cent of total employees, a number that was slowly declining. During the period of the study (2002–2008) 32,809 members of the sample worked exclusively for private employers, and were therefore excluded from the sample on which the study focused. Some 81,283 people worked as public service employees or civil servants for at least a portion of the period, and were therefore included in this study. Together, they were employed for 88.5 per cent of the timeline under observation, were unemployed for 2 per cent, and were inactive for 0.65 per cent.[2] Some 8.77 per cent of the sample was not in any of the above groups. They were recipients of some sort of social transfer for 70 per cent of the months observed. Thirty-four per cent received old-age pensions, 12 per cent disability pensions or disability pensions following workplace accidents, and 16 per cent received benefits linked to small children (child-care aid/assistance/job substitution pay/support/maternity-confinement aid). The remaining 38 per cent received some other social transfer (e.g. a pension transferred through a different configuration, a family-member benefit, an allowance, or a fee for nursing a family member).

Our investigation revealed that 39,331 people or nearly half (48 per cent) of the 81,283 people in the sample quit the sector[3] during the period under exploration. A growing number of people left the public sector each year between 2002 and 2006. In 2002 the number of people from the sample who quit was

1 The selection was based on ISCO codes. 23 occupations listed with ISCO codes were included. Doctors obviously were not. Therefore, the data in the sample cannot be compared with the sectoral data of the NACE employer codes. At the same time it is obvious that most health care occupations are in the health care sector. The number of components in the sample tells us that a far larger number of people enter and leave the health care sector than reflected in the annual average data given by KSH, something also supported by the high ratio of people quitting the profession. (See below).

2 We call a person inactive if based in OEP (National Health Insurance) data the person is not insured in his/her own right or was unable to appear on the labour market. People unable to appear are (a) below the age of 18, (b) have been placed in live-in welfare/social facilities, (c) are homeless, (d) are receiving sanatorium-type care (aged 18–24), (e) pay an 11 per cent health care contribution, (f) are dependent family members or g) receive cash benefits following termination of their insurance.

3 Since a person has the option of quitting more than once, the number of quitters (40,213) is higher than the number of people leaving the sector for good. (The quitters do not include people who terminated employment and then re-established it within one month. Quitting can also mean leaving a position for another job, or leaving it and becoming inactive/unemployed.)

3,349. By 2008 the number was up to 6,541 (it peaked in 2007 when 6,950 left, meaning that the 2008 figure shows a slight decline compared to 2007).

We have reliable information on the status of roughly 75 per cent of individuals after they quit public (central or local government run) health care. Over the 2002–2008 timeframe there was a 6 per cent increase in the ratio of people who quit and found other jobs, and a 9 per cent rise in the proportion of people who remained jobless after leaving the sector (*Table 4.3.1*). About 2 per cent became inactive, and the ratio of those receiving some other miscellaneous social transfer dropped significantly (by 8 per cent). Of the group within the "other care" column 78 per cent received some sort of social transfer. Some 62 per cent of these received old age pensions while 8.52 per cent were granted some child-related benefit.

Table 4.3.1: Breakdown of people quitting public health care service in the years of the survey by their ensuing labour market status (%)

Year	Employed	Unemployed	Inactive	Other care	Total
2002	64.88	0.85	1.94	32.32	100.00
2003	66.99	0.74	2.31	29.96	100.00
2004	64.88	0.85	1.94	32.32	100.00
2005	55.47	13.14	2.19	29.20	100.00
2006	55.81	12.26	2.14	29.79	100.00
2007	68.43	12.14	2.17	17.25	100.00
2008	70.23	9.75	2.11	17.90	100.00
Total	63.02	10.03	2.06	24.89	100.00
Total, capita	25,342	4,032	830	10,009	40,213

We know the type of jobs to which 21,031 people switched. These were the people who were re-employed. Some 36 per cent remained in health care (most of them in the private sector – here we do not know how many were transferred due to the tendency of outsourcing from the public sector), 9 per cent went into social and labour market services, 14 per cent into some other service, and 5.8 per cent into a health care activity requiring a college degree. Three per cent of the latter remained public service employees or civil servants. The rest, which is about half of the people finding new jobs, chose from a wide variety of options ranging from catering to machine operation. Most of the people remaining in the health sector were general or specialist nurses and specialist assistants who found new jobs which statistically shifted them to a different economic sector, even though they actually continued working in the same occupation. A comparatively high ratio (6.7 per cent) of people who left the sector took jobs as social service nurses.

If we look at the above numbers in their entirety we have to conclude that half the people employed in public sector health care left the sector and one quarter have also quit the profession during the seven-year timeframe of the study. Since the overall number of people working in the sector showed only a slight decline, the obvious conclusion is that the sector attracted almost the same numbers of new workers as the number that departed.

The people the statistics lost

As already mentioned, we know to where 75 per cent of the people in the study went and what their status was on the labour market after they left public sector health care. Exactly 10,009 people in the sample (24.8 per cent of the quitters) left the labour market altogether (see *Table 4.3.1*).

Table 4.3.2 shows us the kind of social transfers they received, and also shows that 2,204 people received no assistance of any kind (this is equivalent to 22 per cent of all the people leaving the labour market and 5.4 per cent of all the people leaving the public health care sector).

Table 4.3.2: Social transfers received by the people who left the labour market

Social transfer	Received by (number of persons)	Breakdown (%)
Gyes (child care aid)	321	3.21
Gyed (Salary replacement for child care	109	1.09
Gyet (Support for raising children)	360	3.60
Tgyás (Maternity/confinement assistance)	63	0.63
Old-age pension	4,847	48.43
Disability pension	1,320	13.2
Disability pension (for accident victim)	12	0.12
Other pension	31	0.31
Disability support	54	0.54
Welfare-type support	166	1.66
Nursing fee (for nursing family member)	113	1.13
Care for family member	408	4.08
Benefit/assistance received, total	7,804	456.00
No data	2,204	22.02
Grand total	10,009	100.00

This sample tells us that there are really about 4,000–5,000 people for whom we have no data following their departure from public health care, and who apparently have no job and receive no social transfer of any sort. We presume that they are among the people working on the health care black market or some other black market, or that they have left the country to work elsewhere without the knowledge of the domestic authorities. We believe that although the study period has ended, the number of people disappearing from the statistical rolls has continued to rise since there were no measures prior to the salary increases of 2013 that would have reduced the number of people leaving the sector, while it became even more difficult to access social transfers.

Changes in the incomes of people leaving public sector health care

We have seen that the overall number of people in the sample leaving the sector was 39,331 (40,213 in all who quit), while the number of people who quit to do other work was 25,342. In other words, about 63 per cent of the quitters are still working (they are the ones who the health care sector could continue to employ if working conditions were satisfactory). When looking at the changes in incomes following the job changes we took the mean[4] earnings for a maximum of six months of the previous year to be the income before the job change (which led to the loss of some of the sample, because people who began working later did not have an income that fit the criteria). The post-job-change income we used was the mean salary for a maximum of six months on the new job, which did not include the salary for the first month. We had sufficient data on 16,561 people and when calculating their earnings we discounted them to the 2008 level.

Incomes for most of the job-changers – 51 per cent – went down. For 40.7 per cent incomes rose and for 8.3 per cent we were unable to make the comparison. The earnings of the individual people compared to their own specific earlier earnings yielded a 110.7 per cent combined average (standard deviation 1.35). The investigation based on income levels showed that when "before" earnings were below HUF 120,000/month the changes resulted in higher earnings, but when they had been higher, the "after" earnings declined. When earlier earnings were above HUF 160,000 the decline was over 10 per cent. The high ratio of people suffering earnings losses suggests that the majority of the people quitting public (central or local government-run) health care were unable to sustain their earnings. To be more precise, wherever they went they were faced with the same downward pressure on earning levels that were frozen somewhere in the vicinity of the minimum wage or guaranteed minimum wage for skilled workers. This was particularly true for people who abandoned health care and switched to a different skilled profession or to a job that did not require professional skills.

To double-check our calculations we also ran the numbers reflecting the earnings changes using current (non-discounted) data. Using current earnings data the earnings of 38.5 per cent of the sample went downward. However, on the whole, the average of post-job-change earnings was 20 per cent higher than pre-job-change earnings had been. This tells us that for those people whose incomes rose, they rose significantly. Losses in earnings are partially explained by movement between sectors (*Table 4.3.3*).

The number of people switching from public sector health care to the private sphere between 2002 and 2008 was 8,431 (about 1,200/year, rising slightly from one year to the next). Differences in average earnings – noting that average earnings were lower in private health care (see *Figure 4.3.1*) – were suf-

4 We used this option to prevent earnings from being distorted upwards by possible severance pay. (The severance pay is included in the earnings data of the year of job-termination, divided up into months.)

ficient to explain a portion of the decline in earnings,[5] underlining that a shift to the private sector did not automatically increase earnings.[6] Overall 2,002 people switched from jobs in public sector healthcare to social care employment. This came to nearly 300 people a year. Given that in the period under investigation, average earnings in the social care sector were lower than in health care, we feel safe in assuming that people only switched to jobs in social care if their earnings were higher or at least as high on the new job. This is why a higher percentage of people in this sub-category saw their earnings increase. People who switched from jobs in the social care to ones in health care had the best chance of increasing their earnings – true at the time of the study and just as true today. In the period under investigation 1,185 people or an average of 169/year made this switch, albeit the actual number in 2002 was only 126, rising to 187 in 2008. (For information of flows in 2012–2013, see *Erzsébet Berki* in sub-chapter 3.2 of this volume.)

Table 4.3.3: Movement between sectors, per annum

Year	From public[a] health care to private health care	From public[a] health care to social care
2002	558	137
2003	764	291
2004	1,158	333
2005	999	282
2006	1,092	268
2007	1,903	311
2008	1,957	380
Total	8,431	2,002
Available income data	7,036	1,475
Proportion of people whose earnings increased (%)	42.08	57.08
Changes in earnings (%)	107.25	117.05

[a] Central and local government-run combined.

An investigation by age shows us that this is also a factor in the decline in earnings. By using the data in the Individual Wage Survey we demonstrated that earnings for 18–44-year-olds tended on average to rise, while above the age of 45 earnings went down. This is connected with the fact that earnings in the higher income brackets tend to drop more drastically after a job change (for more on this, see *János Köllő* in Chapter 1.) It is also probable that earnings prior to a job change include a significant amount of overtime, shift bonuses, and other bonuses, which older people lose because they are no longer willing to make the effort. In other words, they halt their earlier "self-exploitation" strategy.

An investigation of post-job-change occupations shows that the people whose earnings went up the most found jobs in areas requiring a college/university degree. For instance, 81 people became family doctors, and their

5 In 2007 the government pushed forward the 13th month salary that would have been due in January 2008, by paying half of it in monthly instalments starting on 1 July. Then, at the start of 2008 it paid the remaining half of the 13th month salary for 2007, but given that the advance had been paid earlier, the move reduced everyone's monthly earnings in the public sector. Over the course of the year, a uniform HUF 15,000 was paid out twice to every public sector worker. 2008 also marked the last wage tariff increase (an average of 5 per cent). For more details see *Berki et al.* (2012). Thus, the government only offered compensation for the loss of the 13th month salary to low-income people in the public sector but not in the private one, while outsourcings continued.

6 We do not know how many of the shifts were voluntary – in other words, how many were actual job changes – and how many were the outcome of outsourcing, when a health care facility changed its profile from public to private sector and the person remained in the same job despite the sectoral shift.

earnings went up 2.4-fold. The people whose incomes rose the most steeply were among the ones who quit health care altogether. People who went into sales (121 people) saw their earnings go up 2.5-fold, while others (65 people) who took jobs in miscellaneous office occupations received a 2.8-fold jump in earnings.

In contrast, the biggest losers were people who took unskilled service industry jobs (such as driving a car, cleaning, or other unskilled work). The earnings of people working in occupations not requiring the type of degree needed in health care were more or less unchanged (1.0–1.2-fold differences) in other words, if their earnings went up as a result of the job change, it was not by much.

On the whole, it seems safe to say that the people with the greatest chance of increasing their earnings were college or university graduates who switched from the public sector to the private one and moved out of health care, unless he or she became a doctor or a dentist in the interim.

This brief analysis was intended to demonstrate that deeper-reaching changes within a segment of the labour market can be explored with the appropriate data, and that once the causes are exposed it becomes possible to seek new tools to remedy the labour market problems of a given professional area. Since quitting from health care appears to have remained at a high level over the timeframe following the conclusion of this study,[7] and while government measures taken between 2009 and 2013 (primarily the wage increases and opportunities for women to retire after 40 years of employment) have generated new flows, long timelines of data are worth analysis using similar methods, to investigate subsequent changes.

7 "According to a briefing from the ministry to our paper, and to data from the Permit-Granting and Public Administration Bureau, by 30 June 2013 some 454 people had submitted requests for certificates enabling them to work abroad from the authorities as against 542 in 2012. This year, 247 of them were doctors while last year, 342 were doctors. As far as other health care personnel with professional skills are concerned, in the first half of 2012, 300 had requested certificates enabling them to work abroad while this year the number of requests for certificates was 360. There was a significant drop in the migration of doctors and residents under the age of 35. This is probably the outcome of the Lajos Markusovszky Stipend Program offering extra money for professions in short supply, and of gradual wage increases," Népszabadság online (nol.hu) wrote on 31 August 2013 in an article on health care called "I Have No Concept Regarding the Future."

Reference

Berki, E.–Neumann, L.–Edelényi, M. and Varadovics, K. (2012): Public Sector Pay and Procurement in Hungary. National Report.