

The structural components of the situation of nurses in Hungary

I VINGENDER^{1*}, N SZALÓCZY² and M PÁLVÖLGYI¹

¹Faculty of Health Sciences, Department of Social Sciences, Semmelweis University, Budapest, Hungary

²Faculty of Health Sciences, Doctoral School of Pathological Sciences, Semmelweis University, Budapest, Hungary

(Received: December 12, 2017; revised manuscript received: March 5, 2018; accepted: July 25, 2018)

Purpose: The purpose of the research is to assess the socioeconomic and sociocultural status of Hungarian nurses. **Materials and methods:** In the research team working at the Department of Social Sciences, the Faculty of Health Sciences, Semmelweis University, by 2015, the idea surfaced that it would be worthwhile to perform a complex socioeconomic and sociocultural study of this social group. We managed to have a sample representative of educational attainment and residence ($N = 682$). The survey was conducted with a structured questionnaire of 119 questions, 1,195 items, which was filled out in every county by nurses working in three areas: inpatient care, outpatient care, and general practitioner's office. **Results:** The analysed data indicate that nurses are recruited from the lower social strata. This background has a definitive impact on their future careers, both in an existential and in a cultural way. Nurses have persistently arrived from the same background in the past decades (Pearson's R sig = .244), and have attained the same qualifications (Pearson's R sig = .204). There is a remarkably significant disparity between the perceived real social situation and the desired social situation, which, on the one hand, explains the genesis and nature of social discontent, and on the other hand indicates the difficulties of solving the problem. Only 3.8% of nurses assess their own social prestige similar to that of the doctors'. **Conclusions:** The social position of the nurses shows multidimensional and multileveled status inconsistency. First and foremost, we can find a relatively low ascribed and an adequately low achieved social position. This is coupled with a social self-image that, alluding to different (mainly work-related) factors, holds a significantly higher social status as desired and acceptable.

Keywords: social strata, socioeconomic status, social position of nurses, social prestige, educational attainment, hierarchy

INTRODUCTION

In contemporary Hungarian society, the role, competencies, social status, and opportunities of nurses have become the forefront of public and academic discourse. The complex socioeconomic status (SES) of nurses is not only relevant to the theoretical point of view of social sciences, but also in light of pragmatic social management questions: can the healthcare system remain functioning, will the quantitative and qualitative reproduction of the Hungarian society be ensured, will the development of the society remain sustainable, and can the basic rights to health care and the preservation or restoration of health be granted?

Since 1990's, the research of the structure of the Hungarian society has declined. Apart from a few examples [1] nowadays, the main question is not what kind of integral social system is formed of the separate social groups, but rather what kind of groups are formed in the society at all, and what the specific indicative features are of these groups. This paradigm shift has several reasons from the fragmentation of academic and everyday interests to ideas envisioning the end of society as such [1–3].

All these have severe consequences, not only do we barely (if at all) know the social structure surrounding us and

providing the framework for our personal lives, but there is also an increased probability that social groups or persons have inadequate assessment and interpretation about the situation, position, and status features of their own and those of others. The subjective experience of one's social position in many respects has excluded the social positioning and the designation of social relations generated by objective social factors and indicators [4].

Sociological theories and empirical experience on stratification traditionally have a double orientation on social structure and stratification [5, 6]. Not striving for an exact and scientifically unquestionable definition of structure and stratification, in the analysis below, we have set out from the understanding that the former means the segmented relation system of society, its sociocultural embeddedness, its values, and operational mechanism, whereas the latter is the hierarchical order generated essentially by the particular and measurable social inequalities.

* Corresponding author: István Vingender; Faculty of Health Sciences, Department of Social Sciences, Semmelweis University, Vas utca 17, Budapest H-1088, Hungary; E-mail: vingenderi@se-etk.hu

In the research team working at the Department of Social Sciences, the Faculty of Health Sciences, Semmelweis University, by 2015, the idea surfaced that it would be worthwhile to perform a complex socioeconomic and sociocultural study of Hungarian nurses. The reasons for the study, therefore, also outline the necessary and possible frameworks in complex and multidimensional ways. Simultaneously, the lack of previous studies and the methodological problems have made the constructionist planning of the research difficult. In this field of study, the usual methodological–technical and procedural groundings turn into academic problems. The following factors are predominant in this transformation:

1. A basic theoretical question arises concerning which social structural concept can define the social status of nurses.
2. In the postmodern society, the structural relations have, in many respects, weakened and thus have become irrelevant. Social status has become undefinable in many aspects. The complex social structure models that strive to outline social inequalities consistently (“L-model” [7] or “double triangle model” [8]) can be suitable for creating a global model of the whole society, but they are less useful in assessing the exact social situation of a specific person or social group. Instead of or at least besides these models, there are constructions of the network society [9], which emphasise the new social arrangements organising the structure in the wake of technological development, as well as how a social group can thrive implementing the acquired [10] social capital, and what kind of conditions they can attain with all this for the assertion of their interests.
3. Social prestige is a central factor in the social position. Of course, what sort of prestige generated by the social position has to be sharply separated from the question of how prestige influences social status [11]. In addition, there are other questions that cannot be overlooked, namely what kind of global (i.e., similar to other countries, regions, and civilisational models) constructions construes social prestige and thus to what extent it can be typical of a given country’s culture or of the occupational group of a given country [12]. A basic question arises about how the social prestige of nurses – as a component of their SES – contributes to the genesis of their actual position. The other relevant issue is how the social identity of this professional group can be defined by the social factors of their professional and individual life. Accordingly, the social ethos is a very central topic of the research.
4. The social environment in which people actually live their lives is an increasingly important component of the social position [13]. The milieu-dependent life of people takes first place in the field of available recourses, especially existential and cultural goods; second, in the conditions manifesting at the meeting point of work and leisure; and third, in the field of communal relationships, which is in an exceptionally peculiar environment, namely in the world of health-care institutions; or rather, it takes place in this world and in the private life that – in many respects – is dissolved in it; it is a question how all this is manifested in the social position.
5. Defining the subjects of the study, the target population, and creating a sample are an academic problem in itself. On the level of common sense, the entity we call “nurse” is simple to define, but hardly so on the level of academic approach and interpretation. The activity of nurses is manifold, strongly dislocated, and highly differentiated in its content. It is fundamentally important to ask: on what basis and with what kind of outcome can the social construction of nursing activity and nurses be made, and also: why do we have this conceptual and systematic disintegration. Does this phenomenon reflect the deprived position of nurses in the professional order [14] or the lack of academic interest in the field?
6. The exploration of the situation and the SES of nurses are possible, at the very least, in the following cognitive and factual forms: the real, objective situation parameters of nurses accounted for by empirical facts; the subjective–relative and subjective–factual status of nurses (in this paper, only these ones are analysed); the expected and desired way of life of nurses; the image of nurses in the non-professional society – its prescriptive and descriptive segments; and the organisational ideologies concerning the situation of nurses in the professional field, the institutional system of health care. The emerging divergences and causal patterns can enrich the academic explorations in this field.

Hypotheses

In this study, we only disclose those hypotheses that provided a background for the analyses offered below.

1. Nurses come from the lower middle class (nowadays rather the declassed lower middle class). Low educational level, strata-specific family socialisation, loss of prestige, declassing, sometimes pauperisation, desperation, indifference, hopelessness, apathy – these are the foci of the socioemotional aura. These circumstances are usually attributed to the occupation, but the relationship actually works the other way around: nurses otherwise arrive to the low-prestige profession from this social situation.
2. The basic intellectual aura of nurses is an everyday thinking with all its paradoxes. The all-encompassing collective consciousness of the professional order does not surface in their way of thinking. The here and the now provide the main dimensions of everyday experiences, the daily routine and manual work give the framework of life activities. Their self-knowledge is weak, their self-image is negative. Their educational and cultural resources are (inherently) rather limited, and their work prevents them from broadening the possibilities. The inconsistencies of their everyday thinking have an effect on the consistency of their whole life and existence. Their abilities and responsibilities serve the benefit of the patients but not themselves and each other.

3. Around them, there is a significantly more integrated and higher prestige social group (the medical professionals), who are the ones to define the culture of healthcare organisations. In the world of health care, the “dominant coalition” is formed by doctors and by professionals with lower qualifications (including some nurses). Consequently, the highly educated nurses feel marginalised, excluded, and foreign.

MATERIALS AND METHODS

With the efficient help (for which we are grateful) of the Department of Migration and Human Resources Methodology of the National Healthcare Service Center of Hungary, we managed to have a sample representative of educational attainment and residence ($N = 682$). The survey was conducted with a structured questionnaire of 119 questions, 1,195 items, which was filled out in every county by nurses working in three areas: inpatient care, outpatient care, and general practitioner’s office. The data were recorded by the administrators and undergraduate assistants at the department, and was processed using SPSS 24.0 software.

RESULTS

Social status can be divided into two basic components: the ascribed and the achieved positions [15]. In this case, we need to examine both of these regarding the social position of nurses: what kind of social background and sociocultural environment they come from, and how they can utilise the received resources, i.e., what kind of social position they can achieve (what is the received sociocultural capital enough for and what is it compatible with; Figure 1).

With regard to the educational attainment of the fathers, the background conditions of nurses are rather bleak. More than three quarter of them were born to fathers with vocational training without secondary final examination or even lower level of educational attainment, and barely more than 5% of nurses come from families with college- or university-educated fathers, which show that nurses’ social background is low; we can speak about not more than lower

middle-class or rather about lower-class origin. We get an absolutely similar picture when examining the educational attainment of the mothers: in Hungary, homogamy is very strong in this field.

Several research studies and social theories are based on research having shown that the educational level of the father has a strong effect on the educational career of the child (Blau-Duncan status [11] attainment model), and consequently, their whole social status. This can be found in the case of nurses as well (Figure 2).

The vast majority of nurses attain secondary-level qualification at most, only about one tenth attaining college or university degree. As a one-step intergenerational mobility, the doubling of those with higher education as compared to the generation of fathers could be deemed significant but in the past 20–30 years, there has been a structural transformation and shift of paradigm in higher education, and if we take these changes into consideration, the educational attainment pattern of nurses should be understood as a continuation of the fathers’ educational attainment level.

Obviously, a social group consisting of about 60,000 people is not homogenous in either its background or its educational attainment indicators. On the contrary, one would expect to see several internal factors and conditions segmenting this structure: first of all, one related to age. However, the data do not support these expectations. Despite the social-cultural changes and the adjustments and structural changes in the educational system, nurses have persistently arrived from the same background in the past decades, (Pearson’s R sig = .244) and have attained the same qualifications (Pearson’s R sig = .204). There are not less nurses with college or university degrees among those above 50 than among the young, most probably due to correspondence (part-time) trainings.

In our research, we can only observe the subjective attributes of social position, namely how nurses themselves see their own situation, where they place themselves in the unequal system of the society – i.e., how they assess their prestige. In this study, we do not understand prestige as a general social appreciation but rather its sociological deconstruction: we have assessed the self-image of nurses along the following dimensions: the attainable income, the knowledge level required for the occupation, power, and social

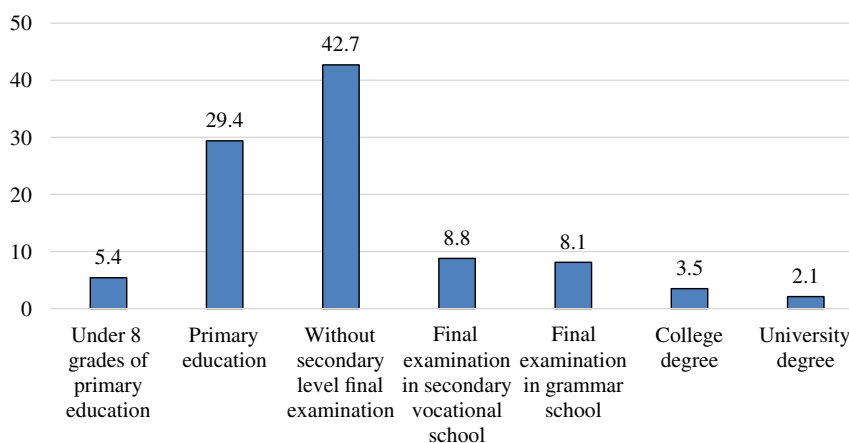


Figure 1. Educational attainment of fathers

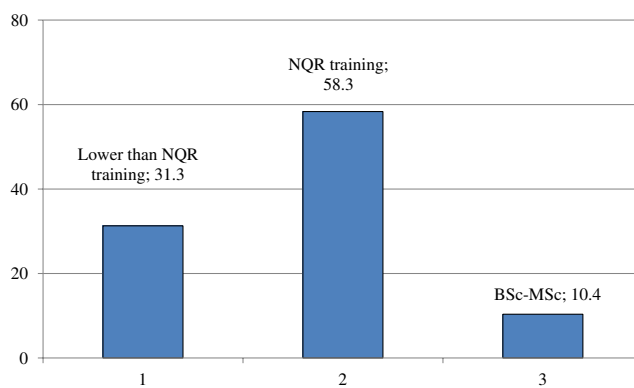


Figure 2. Educational attainment of nurses. NQR: national qualifications register

usefulness. On a scale of 100 where 1 indicated the occupation with the highest prestige and 100 indicated the one with lowest, nurses generally ranked themselves in the middle rank (Table 1).

Nurses have a very similar self-image across the different components of prestige; in all items, they find themselves around 50, i.e., in the middle rank, with available income being the only indicator where self-assessment falls below average. However, the diversion from the mean is not significant with this component either. They see themselves in the worst position concerning the income possibilities and in the best concerning the usefulness of their work. The difference between the two marginal indicators is 20% of the whole scale, which shows that nurses consider their own social prestige rather homogenous, their status consistent, and structurally void of tension. This consistency can be detected in the dispersion of opinions as well: we can see an even more uniform self-image in this respect, as their self-image is very similarly differentiated across the prestige indicators. However, this is not true to the most common

value related to the position in the prestige hierarchy. Besides the general homogenous assessment, the position concerning their income shows a very different picture; according to the most common opinion, nurses are in the worst position in this respect in the society, in other words, most of the nurses think they are the ones who earn the least in the society.

Within the ranks of nurses, the discontent with social appreciation does not follow the typical model of the Hungarian society. In case of subjective–relative deprivation, the given social groups usually view the strata at one or two hierarchical levels above them as referential points, they compare their own status to them, and that is what they consider an expected (and attainable) social position. On the contrary, in the case of nurses, we can observe a significant distance between the perceived real social position and the one expected and deemed fair (Table 2).

The majority of the nurses would like to belong to the top 20% in the social hierarchy, which is what they would consider a fair and just social position. If social stratification

Table 1. What is the position of nurses in the social prestige hierarchy scale of 100?

Prestige indicator	Mean	Dispersion	Mode
Quantity and quality of knowledge required by the occupation (healing and care-taking)	46.05	30.693	50
Attained educational level	43.51	30.332	50
Usefulness of their healing and care-taking work	42.24	31.385	50
Attainable income	60.54	32.954	100
Available career routes	53.32	32.076	50
Acquired power at the work place (influence, impact of utterances, authority to instruct, etc.)	50.81	32.072	50
Ability to assert interests	55.32	33.788	50

Table 2. What is the expected position of nurses in the social prestige hierarchy scale of 100?

Prestige indicator	Mean	Dispersion	Mode
Quantity and quality of knowledge required by the occupation (healing and care-taking)	13.59	20.774	4
Attained educational level	14.21	21.320	4
Usefulness of their healing and care-taking work	12.42	21.306	5
Attainable income	15.60	23.318	4
Available career routes	15.32	20.970	4
Acquired power at the work place (influence, impact of utterances, authority to instruct, etc.)	15.83	21.315	4
Ability to assert interests	13.59	20.774	4

is segmented to deciles, then nurses would rank themselves in the second highest decile across all prestige parameters. The expected social situation is just as homogenous as the perceived one, as no significant status inconsistency can be detected in the normative self-image. Only the expected level of appreciation of the usefulness of their work differs a little from the other indicators; therefore, in this respect, nurses would like to belong to the elite.

On the whole, there is a remarkably significant disparity between the perceived real social situation and the desired social situation, which, on the one hand, explains the genesis and nature of social discontent, and, on the other hand, indicates the difficulties of solving the problem. Simultaneously, we conclude that nurses cannot reach the desired social position exactly because of their social conditions (or deficiency of them).

How one sees oneself as related to the others, where one places oneself in the system of inequalities, is a relevant attribute of the social position. We have examined the subjective ranking of nurses with regard to doctors and other occupational strata. Of course, nurses realise that society attributes different prestige to them and the medical profession (Table 3).

Nurses see the reasons as manifold, manifested in virtually all the prestige indicators. Among the factors that are leading the higher prestige of doctors, they consider characteristics of the healthcare system and the institutional circumstances as the most important, and view the occupational ethos and indicators of background as the least significant. All these demonstrate that they view the inequalities in prestige less as a social determinant and more as the functional result of the healthcare system and provision. And this illustrates rather an inequality understood as a dysfunction of the operation of the healthcare system, not an interpretation where these inequalities would be an organic structural and functional part of the social inequality system. Another data underlining this conclusion is whether the nurses see any chance for absolving these inequalities: 2.6% of them thinks that the differences will cease to exist in 10 years, and 12.8% thinks it may happen in over 10 years. However, the vast majority of them (84%) are pessimistic in this respect; they deem it necessary that the prestige of the two occupational groups be levelled, but they think it will

never happen. A mere 0.6% of nurses think that there is no need for this levelling.

This image is formed in their thinking despite the fact that they definitely rank themselves among the other occupational groups of the lower middle class (shop assistants, nursery school teachers, administrators, and unskilled and semi-skilled factory workers), and in terms of prestige they do not feel close to the intellectuals (engineers, accountants, economists, actors, and journalists). Only 3.8% of nurses assess their own social prestige similar to that of the doctors'.

DISCUSSION

The analysed data indicate that nurses are recruited from the lower social strata. This background has a definitive impact on their future careers, both in an existential and in a cultural way, and since in this feature, the whole occupational group is rather homogenous, it predestines the whole group's social position. We not only discuss those stratum-components that are constituted from the social conditions of the specific people, but of all those group conditions as well, which make up the level and components of a social position transcending from and independent of the specific persons involved: the collective consciousness, the strategies of interest assertion, the models of lifestyle, the values attached to work, the recruitment of their leaders and representatives, the life strategies, etc.

From the latter, the strategies of learning and training stand out in their significance. Nurses predominantly attain secondary-level education, the number of nurses with higher educational degree is very low, and even among those having a degree, very few have master's degree. (the weaker professional occupational group construction of a bachelor's degree as opposed to that of a master's is known from several studies) [16]. The background supported by the attained level of education closes the nurses' paths to the lifestyle of the intellectuals, and within it to the culture of the intellectuals, to the realisation of mobility strategies. A degree in higher education also cannot provide nurses with the conditions necessary for a higher social status due to the changes in the quality and social activity of higher education.

Table 3. Why do you think people attribute higher prestige to doctors than to nurses?

	Mean	Dispersion	Mode
Their educational attainment is higher	6.17	1.233	7
Their professional knowledge is higher	6.11	1.190	4
They have a managerial-authoritative role	5.67	1.492	7
They have higher competencies in healing	5.56	1.567	7
Their income is higher	5.42	1.819	7
They assume a role in the elite	5.25	1.802	7
The usefulness of their work is higher	5.25	1.661	7
They have a strong ability to assert their interests	5.13	1.781	7
They have more responsibility	4.94	1.789	7
They work more independently	4.65	1.720	7
They are more well-informed and well-read	4.64	1.796	4
The leaders of health care policies are doctors	4.54	1.976	7

Note. 1 = not significant factor; 7 = very significant factor.

Nurses rank themselves with regard to prestige to the middle class, and within it to the lower middle class, which is presumably (although it does need further analysis) more or less accurate, it reflects an exact and realistic self-image. They would expect, though, to belong to the higher classes due to all of their status attributes, but particularly as a consequence of the social usefulness of their work. The discrepancy between the actual social position and the one deemed ideal could be a major factor in their discontent, but at least one of the factors prompting it. Underlying this discrepancy, we may see the general attributes of everyday thinking (as understood by Alfred Schütz [17]). The lack of scientifically based and constructed worldviews is obviously the outcome of the characteristics of the background and education analysed above.

As a consequence, nurses do not identify with the social stratum of the intellectuals, they perceive a significant distance between them and themselves, they much rather identify themselves as workers, maybe as employees of the service sector. Their social existence, their thinking, and ultimately their situation are fundamentally defined by the milieu they take on and feel belonging to themselves. They primarily see personal fates and institutional constructs as the cause of their social position; they do not realise or accept the social determinants. Such an experience of injustice does not urge one to change; nurses are content with articulating against their point of view and fighting against the presumed social injustice. Their social position, however, allows only specific, local, and short-term tactical advancement (one of these is emigration), but this line of thinking does not generate long-term mobility strategies.

CONCLUSIONS

The social position of nurses shows multidimensional and multileveled status inconsistency. First and foremost, we can see a relatively low ascribed and an adequately low achieved social position. This is coupled with a social self-image that, alluding to different (mainly work-related) factors, holds a significantly higher social status as desired and acceptable. In these aspirations and ideals, the positions of doctors are the reference points, while nurses do not rank themselves among the intellectuals; they identify a lot more readily with middle-rank employees. It is a fundamental question what this diversion can be attributed to and how the related public policies can be managed. We are convinced, and will show in a later study, that the reasons can be found in the most important channel of mobility in Hungary, namely the educational system, and also in the genesis of the present status of the nurses' society. The social conditions related to the present status do not allow for the exploitation (conversion) of the attained and attainable knowledge capital for existential, empowerment, and interest assertion interventions.

Acknowledgements: This research was supported by the Department of Migration and Human Resources Methodology of the National Healthcare Service Center of Hungary [Egészségügyi Nyilvántartási és Képzés Központ Migrációs

és Humánerőforrás Módszertani Főosztálya], providing us with exact sociodemographic statistical data about Hungarian nurses. The authors would like to thank the President of the Institute, Hanna Páva Ph.D and Head of Department, Mr. Zsolt Béltéki for their help.

Authors' contribution: IV, NS, and MP designed the study and wrote the manuscript. IV and MP performed the statistical analyses. NS realised the evaluation of data.

Ethical approval: This paper is conducted in accordance with the Declaration of Helsinki and according to requirements of all applicable local and international standards. It was accepted by National Scientific and Ethical Committee, Medical Research Council of Hungary (11425-2/2016/EKU).

Conflict of Interest/Funding: The authors declare no conflict of interest and no financial support received for this study.

REFERENCES

1. Bukodi E, Altorjai S, Tallér A. A társadalmi rétegződés aspektusai [Aspects of Social Stratification]. Budapest: KSH Népeségtudományi Kutató Intézet; 2005.
2. Ferge Z. Struktúra és szegénység [Structure and poverty]. In: Kovách I, ed. Társadalmi metszetek érdekek és hatalmi viszonyok, individualizáció [Social Segments, Interests and Power Connections, Individualization]. Budapest: Napvilág Kiadó; 2006. p. 479–500.
3. Beck U. Túl renden és osztályon? – Társadalmi egyenlőtlenségek, társadalmi individualizációs folyamatok és az új társadalmi alakulatok, identitások keletkezése [Over the orders and classes. Formation of social inequalities, social processes of individualization and new social figures, identities]. In: Angelusz R, ed. A társadalmi rétegződés komponensei. Válogatott tanulmányok [Components of Social Stratification. Selected Studies]. Budapest: Új Mandátum; 1997. p. 418–68.
4. Kingsley D, Moore WE. A rétegződés néhány elve [Some principles of stratification]. In: Angelusz R, ed. A társadalmi rétegződés komponensei. Válogatott tanulmányok [Components of Social Stratification. Selected Studies]. Budapest: Új Mandátum; 1997. p. 10–23.
5. Blau PM. Approaches to the Study of Social Structure. New York: Free Press; 1975.
6. Kolosi T. Tagolt társadalom [Structured Society]. Budapest: Gondolat; 1987.
7. Kolosi T. A terhes babapiskóta [The Pregnant Ladyfinger]. Budapest: Osiris Kiadó; 2000.
8. Szelényi I. Harmadik út? Polgárosodás a vidéki Magyarországon [The Third Way? The Procedure of Becoming Citizen in the Rural Hungary]. Budapest: Akadémiai Kiadó; 1992.
9. Castells M. The network society: from knowledge to policy. In: Manuel C, Cardoso G, eds. The Network Society: From Knowledge to Policy. Washington, DC: The Johns Hopkins Center for Transatlantic Research Relations; 2006. p. 3–21.
10. Parkin F. Strategies of social closure in class formation. In: Parkin F, ed. The Social Analysis of Class Structure. London: Tavistock Publications; 1974. p. 1–18.

11. Blau PM, Duncan OD. *The American Occupational Structure*. New York: John Wiley & Sons; 1967.
12. Treiman D. *Occupational Prestige in Comparative Perspective*. New York: Academic Press; 1977.
13. Hradil S. Társadalmi rétegződés és társadalmi változás [Social stratification and social changes]. In: Andorka R, Hradil S, Peschar J, eds. *Társadalmi rétegződés [Social Stratification]*. Budapest: Aula; 1995.
14. Weber M. *Gazdaság és társadalom. A megértő szociológia alapvonalai 1 [Economy and Society. The Basic Line of the Understanding Sociology 1]*. Budapest: Közgazdasági és Jogi Könyvkiadó; 1987.
15. Linton R. *The Study of Man*. New York: Appleton Century Crofts; 1936.
16. Becker G. *Human Capital. A Theoretical and Empirical Analysis with Special Reference to Education*. Chicago: University of Chicago Press; 1975.
17. Csepeli Gy. Alfred Schütz és a tudásszociológia [Alfred Schütz and the sociology of knowledge]. In: Csepeli Gy, Papp Zs, Pokol B, eds. *Modern polgári társadalomelméletek [Modern Civil Society Theories]*. Budapest: Gondolat; 1987. p. 11–50.