Social Inclusion
2026 • Volume 14 • Article 12029
https://doi.org/10.17645/si.12029

cogitatio

ARTICLE

Open Access Journal

Skill Construction and Challenges of Professionalization in the Hungarian Home Care Market

Noémi Katona [1,2] **and Dóra Gábriel** [1,3]

[1] ELTE Centre for Social Sciences, Hungary
[2] Corvinus University of Budapest, Hungary
[3] ELTE Centre for Economic and Regional Studies, Hungary

Correspondence: Noémi Katona (katona.noemi@tk.elte.hu / noemi.katona@uni-corvinus.hu)

Submitted: 29 January 2026 **Accepted:** 26 May 2026 **Published:** 13 July 2026

Issue: This article is part of the issue "Transnational Organization of Labour, Mobility, and Senior Care in Central and Eastern Europe" edited by Ewa Palenga-Möllenbeck (Goethe University Frankfurt), Dora Gabriel (ELTE Centre for Social Sciences / ELTE Centre for Economic and Regional Studies), Olena Fedyuk (CEU Democracy Institute), and Kristine Krause (University of Amsterdam), fully open access at https://doi.org/10.17645/si.i533

Abstract

Precarious working conditions, low pay, and limited access to labor and social rights characterize market-based home care globally. Alongside growing concerns about the exploitation of carers, calls for the professionalization of the sector have also intensified. However, qualifications and training in market-based care services remain only loosely regulated. Drawing on Ortiga et al.'s (2021) concept of skill regimes and the literature on skills and professionalism in care, this article examines how a segmented informal care market shapes the construction of skills considered necessary for providing good care, and to what extent training initiatives support professionalization. The analysis is based on qualitative interviews with care workers, family members, intermediaries, and training providers, as well as ethnographic fieldwork conducted through online and in-person training programs. The findings show that the strong underregulation of the home care market has hindered the emergence of widely accepted professional standards, while similarly underregulated training programs often fail to support professional competency development and instead undermine the value of formal qualifications. The Hungarian case thus illustrates how a loosely regulated skill regime can contribute to both deprofessionalization and market segmentation.

Keywords

care marketization; home-based care; professionalization of care; skills regime; tacit knowledge

1. Introduction

Demographic aging and the increasing care needs of older people are among the major challenges that European societies face today. In most countries, older people typically prioritize home care over residential care (Bartha & Zentai, 2020). However, since states are not keeping up with the growing demand for home care services, care for older people is both familiarized and commodified in many European countries. In recent decades, market-based home care has become an essential pillar of long-term care in most European countries.

Although the home care market constitutes a crucial component of care systems, it is typically undervalued in most countries, marked by precarious working conditions, low remuneration, and limited or absent access to social and labor rights (Aulenbacher et al., 2021, 2024; Palenga-Möllenbeck, 2022). These challenges have intensified debates around service quality and the professionalization of care work. However, training and qualification requirements associated with market-based home care remain weakly regulated in many contexts (Fiebig-Spindler, 2026; Wojczewski et al., 2023). Consequently, the meaning and implementation of professionalization in home care require further investigation.

Care has historically been framed as a "natural" feminine attribute rather than recognized as skilled and professional labor. Feminist scholars have long criticized the systematic undervaluation of care and other forms of reproductive labor (Lutz, 2011), drawing attention to the persistent lack of social, economic, and institutional recognition attached to this work. Recognizing care as professional labor has become increasingly important in international policy frameworks, including several ILO conventions, which provide an important basis for strengthening labor rights and improving working conditions in the care sector. Nonetheless, the meaning of professionalism in care for older people remains highly contested. Debates continue over what kinds of knowledge, competences, and emotional capacities constitute professional care work, and to what extent care skills can or should be standardized. In the scholarly literature, there are numerous approaches to the professionalization of care for older people. These address working conditions, regulations, standards, and remuneration, but also, very importantly, the required skills, competencies, behaviors, and practices of care workers. The state, through regulation and policy, plays a central role in shaping and institutionalizing professional care. This relates to what Ortiga et al. (2021) conceptualize as an "elderly care skills regime comprising a loose configuration of policies, programmes and institutions that govern what constitutes appropriate skills for elderly care and who can be suitably equipped to perform such tasks" (p. 437). While Ortiga et al. primarily examine skills regimes at the intersection of care and migration regimes, they also provide a feasible framework for studying how skills are governed and constructed in a national context, allowing us to examine processes of (de)professionalization.

This article examines the Hungarian skills regime in the home care market for older people. Thereby, it pays attention to how professionalism is constructed in the narratives of various stakeholders within the sector and to which kinds of skills are emphasized. Additionally, the article investigates market-based training programs for home care workers, focusing on their assessment by different stakeholders. Specifically, the study explores: (a) which skills and knowledge are constructed in the narratives of care workers, family members, and intermediaries when talking about "good care"; (b) what kind of qualifications matter, and how much; and (c) what skills does market-based training aim to develop, and how far do these contribute to the professionalization of care services. The analysis draws on qualitative data from interviews with care

workers, family members, intermediaries, and training providers, as well as ethnographic fieldwork involving participation in both online and in-person training sessions.

In the investigated Hungarian case marketization of home care remains largely informal, underregulated, and highly segmented. In this context, a parallel market of training and "skilling" has emerged, shaped primarily by private actors with minimal state oversight. The article argues that this has important consequences for both the quality of care and the construction of professionalism in home care. By linking stakeholders' narratives on skills to the structure and segmentation of the care market, the analysis highlights how care provision operates in an open market where even intermediation is frequently organized through social media, without meaningful institutional regulation or oversight. In doing so, the article applies and further develops the concept of skill regimes by studying and connecting regulation, the training system, market segmentation, and narratives on skills in care, including professionalization and personalization trends and the discourse on care quality.

2. Knowledge, Skills, and Professionalism in the Home Care Sector

Professionalization in care for older people has been approached differently in the international literature. What skills and knowledge are necessary to provide professional care, and whether they can be measured and standardized, have been widely debated and analyzed. Many scholars draw on Polanyi's (1966) concept of tacit knowledge as a central element of professional care for older adults, understood as subjective, embodied knowledge that cannot be fully articulated verbally. Based on participant observation in care units in Sweden, Börjesson et al. (2014) studied the importance of "silent knowledge," or tacit knowledge, in the everyday work of care workers and highlighted the gap between this tacit, experience-based knowledge and the state policies' rather theoretical approach to knowledge in care. Similarly, Gottfried (2022) criticized the US care system for failing to recognize tacit knowledge in care for older people adequately and argued that this is an essential factor in the low wages and undervaluation of care. Reinders (2010) also criticized the aim of standardization and quantification, as well as methods of quality assessment that rely on objectively measurable "indicators," and sharply contrasted these with the crucial element of tacit knowledge in care, which also entails the know-how involved in building a personal relationship with care recipients. Kontos and Naglie (2009) also elaborate on tacit knowledge in care, highlighting the socio-cultural significance of embodied selfhood.

While some studies seek to define the core characteristics of professionalism in care, often contrasting tacit with rather fact-based knowledge, others offer more nuanced analyses of how professionalism is socially and institutionally constructed across different contexts and by various actors. Gazzaroli et al. (2020) examined how care workers in Italy construct their professional identities and demonstrated that the professional profile of home care workers remains poorly defined. Their findings show that carers' narratives about their skills and expertise are often vague and fragmented. While "hard" care skills were more frequently emphasized, these often overlapped with competencies found in other professions, whereas relational and "soft" skills tended to remain implicit and taken for granted.

The distinct skills and values involved in professional care—including both measurable, standardized hard skills and the soft skills required for relational, embodied, and emotional labor—have been widely discussed

in policymaking and policy analysis within the UK context as well. Hussein and Kispeter (2025) focus on care policies and their effects in the UK, and contrast "professionalization" to "personalization":

> Personalisation prioritises coproduction between care practitioners and those receiving support, aiming to empower individuals by granting them greater control over their care. In contrast, professionalisation focuses on the expertise of care workers, as reflected in formal qualifications and training, which may inadvertently prioritise professional credentials over care's relational and value-driven aspects. (Hussein & Kispeter, 2025, p. 10)

Hussein and Kispeter (2025) provide a detailed comparative analysis of policy approaches across the four nations of the UK, examining how the agendas of professionalization and personalization intersect and sometimes conflict. Hayes et al. (2019) also analyze how these policy aims are implemented across the same four nations and the skills they require. In addition to medical knowledge and "values of care," they also list communication, digital, employability, and body-work skills. However, in the UK context, where care services have been increasingly outsourced to the market for several decades, Hemmings et al. (2022) highlight the diversity and complexity of care provision systems, showing that different groups of care workers rely on distinct skill sets. All in all, the UK context shows a complex and rather regulated home care market, in which local governments shape local markets in different ways, promoting the efficient operation of market services to meet care needs (Needham et al., 2023).

Marketization is a crucial trend in the development of care regimes and, consequently, strongly shapes the skills regime and how skills in care work are constructed. In Germany, while national legal regulations define carers' qualifications in the public sector, the authorities responsible for setting and enforcing such standards in the home care market are far less clearly defined (Grenz & von Kutzleben, 2024). This regulatory ambiguity results in weak oversight of qualifications and, consequently, low levels of formal training among live-in carers. In Austria, for example, live-in care workers do not require any formal training to be able to work (Wojczewski et al., 2023), and there are no legally defined qualifications for live-in carers in Germany either (Fiebig-Spindler, 2026). The lack of regulation has a crucial effect on how skills are defined in care work. Giordano (2021) compares professionalization in private and public care in Belgium and argues that, while formal qualifications are more important in public care, market actors focus more on emotional labor, soft skills, and vocation when interpreting professionalization. The discourse of market actors (i.e., brokering agencies) that highlight soft skills can result in the work of migrant carers being naturalized, essentialized, and even perceived as nationally embedded characteristics rather than learned professional competences (Palenga-Möllenbeck, 2022). Social hierarchies and gendered and ethnicized expectations also play a fundamental role in the training of care workers and in the constructed subjectivities of "good carers" (Prieler, 2021).

Overall, the international literature highlights the tension between efforts to "professionalize" care work through standardization and the emphasis on measurable "hard skills" (e.g., medical knowledge), and approaches that foreground the "personal" dimensions of care, including emotional, intimate, and relational labor, also associated with tacit knowledge. Combining these two dimensions poses significant challenges both at the policy level and in everyday care practices. In our analysis, we contribute to this debate by examining how different actors narrate and understand skills associated with care work. This discourse and the lack of policies reflecting these aims are also crucial elements of the Hungarian skills regime that connects regulation, discourses, and working conditions in the home care market.

3. The Hungarian Care Regime and Its Implications for the Home Care Market

Since 2010, the Orbán regime in Hungary has restructured welfare politics in line with the broader political-economic model of illiberalism (Szikra & Öktem, 2023). While childcare was a prominent and well-funded issue under the Orbán regime (Fodor, 2022), care for older people was largely silenced in political discourse and severely underfunded (Katona & Gábriel, 2026). While the conditions of education and health care frequently feature in public discourse, issues related to social care, particularly care for older people, receive comparatively little attention. The increasing gap in care for older people resulting from labor shortages and the limited capacities of residential and home care services is striking, given the evidence. The social care sector in Hungary ranks among the lowest-paid fields, with particularly acute challenges in long-term care for older adults (Gyarmati, 2019, 2022; Meleg, 2025). Working conditions in the formal long-term-care sector are deplorable: Wages for care workers often fall below the already modest averages across the social services. This is especially problematic since the actual work of home carers requires more competencies than before, due to rising care needs. In terms of care activities performed by care workers over recent decades, while in the 1990s, social care involved shopping and cleaning, by the early 2020s, home-based care workers considered medical knowledge, symptom identification, and proper techniques for moving bedridden patients to be fundamental professional competencies (Vida, 2021). As care needs evolve, care workers must acquire new competencies and knowledge; however, they are not adequately compensated for these increased demands.

Due to the limited capacity of public care services, there is an increasing demand for market-based services, especially home care. Many workers in the formal social and health care sectors move to the market sector due to the difficult working conditions described above. However, the home care market is largely underregulated and informal. The Long-Term Care Strategy released in 2020 by the Ministry of Human Capacities (Emberi Erőforrások Minisztériuma, 2020) has been sharply criticized for lacking both a critical approach to the real problems and a clarification of the responsibilities of the actors involved in care, in particular the state (Gyarmati et al., 2021). While the Strategy fails to mention the existence of market-based home care, the more recent long-term-care strategy of 2024 also omits the informal market from the report (Belügyminisztérium, 2024). The employment of care workers is irregular due to the lack of a formalized home care market; however, the document's silence on the care market implies that the state has no intention of regulating the current situation.

As a result, the Hungarian home care market is strongly informal. Gábriel and Katona (2024) have analyzed the structure of the home care market, showing that different types of intermediaries provide various levels of protection and quality assurance to care workers and families. At the bottom are informal networks and social media-based online platforms, where carers and families connect directly with almost no formal regulation, contracts, or social protection, while at the top are agencies that provide formal employment for carers, which are very rare. In contrast to the trends of marketization in care known in Western European countries, characterized by the formalization of home care and large and powerful agencies (Aulenbacher et al., 2021), or more recent trends of the emergence of care platforms (Bonifacio & Pais, 2025), in Hungary informality prevails, and instead of the development of care platforms, social media groups unassociated with regulations are prevalent. All in all, due to the lack of regulation regarding who can provide home care services in the market (especially through social media), an extremely diverse pool of people advertise themselves on these sites.

This has crucial consequences for the lack of regulation of skills. While professional standards are regulated in public care provision, policy documents do not specify standards of practice or the required skills for market-based home care workers. This trend impedes effective regulation of the sector, leading to the absence of professional standards and oversight and, consequently, a decline in the overall quality of care (Katona & Gábriel, 2026). Crucial transformations in the training of care workers also contribute to this picture. The most significant changes include the decline of secondary schools specialized in medical and social care since the 2000s, and the accelerated spread of online training, especially since the Covid-19 pandemic in 2020. While institutions that provide such training should be officially licensed, the certificates of completion issued after these courses merely confirm that a person has participated and do not constitute officially recognized professional qualifications. They are issued directly by the training provider and do not require corresponding state-issued qualifications; therefore, there is weak state oversight of what is taught and how on these training courses.

The article will examine how relevant actors construct and negotiate discourses around care skills, and how participants evaluate the role and importance of training and formal qualifications.

4. Methodology

This study is part of a larger qualitative research project on the marketization of home care in Hungary, which has been underway since 2022. The current article builds on (a) semi-structured interviews with care workers, family members, intermediaries, and trainers; and (b) ethnographic research conducted during two training sessions.

4.1. Data Collection and Sample

The current article primarily relies on semi-structured interviews with care workers, family members of care recipients, and intermediaries, including companies that organize training sessions (Table 1). Interviews were conducted between 2022 and 2025, online or in person, in Budapest. Participants were recruited via official

Table 1. Interviewed stakeholders.

Stakeholder	No. interviews	Description
Intermediaries and training companies	8	Five formal intermediaries, including matchmaking companies (one providing training to their carers), one informal intermediary who uses her informal network to connect families and care workers, and two training companies that also offered matchmaking services.
Care workers, including social media group administrators	10	This sample also includes three social media group administrators, two of whom were qualified nurses with several years of experience working in hospitals; the third administrator was a qualified social carer. Of the other carers, three were qualified social carers, one was a qualified nurse, one had completed short-term training at a faith-based organization, and two had no training at all. Only one carer in the sample was male.
Family members	10	Family members were recruited through social media groups. The sample includes children, husbands, and grandchildren of (former) care recipients.

websites (in the case of matchmaking and training companies) and via social media groups focusing on home care services for older people. Preliminary mapping was also conducted during our research; we identified that Facebook is an increasingly important site for mediation in home care. The online mapping was conducted in 2025, and over 30 Facebook groups were identified (public and private) with over 1,000 members (ranging between ca. 1,000 and ca. 30,000) focusing on care for older people in Hungary, without any regional focus within the country. The names of most groups contained the words *gondozó* (carer) and *ápoló* (nurse). The groups were mainly founded in the 2020s, with some in the 2010s. We posted a call for research participation several times across seven Facebook groups where both family members and care workers are present. Additionally, we contacted the administrators of these Facebook groups directly to gather their perspectives and experiences. Throughout the article, we refer to carers who have completed a state-recognized professional qualification in nursing or social care as "qualified nurses" or "qualified carers."

Interviews explored experiences of home care work and mediation, focusing particularly on working conditions; perceptions of care skills and perceptions of qualifications. Agencies were asked about their own training requirements and programs, and social media group administrators were asked about their experiences as administrators. Training companies were specifically asked about the training content and the skills they taught.

The second component of the data collection effort consisted of participant observation conducted in 2025 at two different training providers. Given the limited empirical scope of the observations (only two training programs were attended), the aim was not to provide a comprehensive overview of existing training courses, but rather to illustrate and complement the narratives identified in the interviews. The two sites were selected to capture different forms of training provision: one in-person, and one online. The in-person training was chosen based on earlier interviews that identified the provider as a well-known actor in the field, while the online training was selected following an online mapping of available courses conducted in early 2025. This was conducted using the Google search engine, with combinations of the following keywords: "care," "caregiving," "senior care," "training," "training course," "education," and "online course." From the available training programs, we included only market-based ones for which participants paid a fee that were organized by a for-profit company. We distinguished two categories: (a) adult education platforms that include care training among many other courses, and (b) the websites of companies exclusively providing care courses, or closely related training. Finally, we interviewed a representative from a company in the first category and selected a training session from the second category to observe and gain insights from both types.

The on-site training course lasted five days and took place at a Budapest-based company with a strong reputation and high-quality instruction, as reported to us beforehand. Besides providing training, the company also engages in matchmaking activities. This on-site course was completed by author Dóra Gábriel. The second training program was completed by author Noémi Katona. This involved a 220-hour online course, which corresponded to the most common length of training identified during the desk research, and specialized exclusively in care-related training programs, such as babysitting and elderly care. During the participant observation, we collected ethnographic notes and documented observations. In both cases, we revealed our dual motivation—personal and academic—and clearly communicated the research purpose of our participation to the training organizer and fellow students. A research information and consent form outlining the study's objectives was shared with each company in advance.

4.2. Limitations, Potential Bias, and Positionality

As the research described in this article examined only two training programs and draws on a limited number of interviews, it cannot provide representative data or a comprehensive picture of the level and types of training across the Hungarian home care market; nonetheless, it offers important insights. Indeed, precisely because the home care sector is underregulated, there is a lack of reliable data on the level and types of training received by home carers. Another limitation of this study is that most interviews were conducted in the capital. Further research is needed in smaller municipalities, where the availability of home-based care provision may differ. Since participants were recruited through Facebook groups, the sample consisted of individuals who voluntarily chose to respond and share their experiences. This likely introduced a bias toward more engaged and dedicated carers and family members, while less committed or unreliable carers, frequently mentioned by interviewees, were probably underrepresented. Throughout the research process, we explicitly presented ourselves as researchers and clarified the study's academic purpose to all participants. We had no prior personal or professional relationships with the individuals or organizations involved in the research, which helped us maintain an independent position during data collection and analysis.

4.3. Data Analysis

All interviews were audio-recorded and transcribed verbatim using Alrite software, after which the transcripts were reviewed and corrected by the authors. Afterward, inductive thematic analysis following Braun and Clarke (2006) was applied to the interview material using MAXQDA software. The analysis focused on participants' narratives of skills, care practices, carers' duties, and the assessment of formal qualifications. Thematic analysis enabled the identification and interpretation of recurring patterns and meanings across participants' accounts. Interviewing different stakeholder groups also enabled reflection on the diverse positions from which this discourse was constructed. Ethnographic notes and the educational materials from the training sessions that were attended were also analyzed using the same methodology.

4.4. Research Ethics

At the beginning of the research project, in 2022, all methods that were applied were approved by the ethics committee of ELTE Centre for Social Sciences. For both online and offline interviews, participants were provided with information about the study's objectives, and all interviewees subsequently signed a consent form outlining their rights and data management procedures. They were informed that they could withdraw their consent, or decline to answer specific questions. Participants also agreed to the use of interview excerpts once any sensitive data had been anonymized. Throughout the article, we use acronyms to refer to our respondents: CW for care worker, FM for family member, MC for matchmaking company, SMA for social media administrator, TC for training company.

5. Personalization Versus Professionalization in the Home Care Market

In our empirical fieldwork, we encountered a wide range of narratives about what constitutes good care in market-based home care for older adults. In the following sections, we will analyze how interviewees perceive the role of hard skills (e.g., medical knowledge) and soft skills (e.g., empathy and tacit knowledge), depending on their background; and how far these narratives support aims of professionalization versus

personalization. Subsequently, we will examine how different stakeholders evaluate the role of qualifications and, finally, analyze the skills that the observed training programs were designed to develop.

As discussed previously, personalization and professionalization are described in the literature as two distinct, often conflicting trends and aims. While personalization focuses on the relational aspect of care and the needs and control of the care recipient, professionalization "includes initiatives such as registration and professional regulation, compulsory training, continuous professional development, career progression, and minimum employment standards" (Hussein & Kispeter, 2025, p. 5). Both approaches appeared in the interview narratives; however, nearly all stakeholders emphasized the central importance of personal relationships in care, while narratives resembling professionalization were considerably less frequent.

It was primarily qualified nurses who articulated that fact-based knowledge, training, and continuous professional development are necessary to provide care:

> But this profession is one [for which] you must keep learning all the time….You always learn something, because there are new techniques, new things, healthcare is developing….And the problem here is that experience is not necessarily good experience—the way you do it might not actually be right. (CW08)

The quoted care worker specifically questioned the legitimacy of relying solely on personal, on-the-job experience when this is not supported by formal training in care work. A representative of a training company expressed a very similar opinion, emphasizing the importance of formal qualifications and professional training in care work. She stressed that experience gained in a family setting does not in itself qualify a person to be a professional caregiver:

> It's not certain that someone who has cared for their own mother is suitable to be a professional caregiver….Through our training, we aim to ensure that caregivers can perform their job safely and competently. (TC02)

These narratives construct professionalism on the basis of the possession of fact-based knowledge and qualifications, and acknowledge tacit knowledge and experience only if acquired in professional training settings. However, as mentioned, these accounts were relatively rare. A matchmaking company explicitly mentioned that the introduction of compulsory training would not work: "If I told a carer, 'Fine, but before you come work for me you have to complete some training,' they might immediately run away. And that is not in my interest" (MC05). A family member stated explicitly that they do not consider care to be a profession that requires extensive training:

> If someone decides that they want to be a carer, I don't think they need very much. You don't need to be a nurse or a very qualified person, but a two-week training course, I think…would be good. (FM02)

Instead, most narratives highlighted the relational aspects of care and framed these as the most important elements of their work. "So, I have to get under their skin [to know them intimately], because if I don't, it doesn't work" (CW05), as a care worker noted. Family members, carers, and intermediaries all emphasized the role of "sympathy" in the care relationship. As one carer, a trained nurse, noted:

> But I think the most important thing in the world is to find a common tone [have a harmonious relationship]. If a caregiver cannot find the right way to communicate with the person they care for, and vice versa, then there is nothing to talk about—in that case, they should leave. So, the first impression and mutual sympathy are extremely important. (CW09)

When discussing what good care means, beyond the relational aspects, interviewees highlighted various skills and types of knowledge, including empathy and psychological skills. A qualified nurse also addressed the importance of psychological knowledge, but immediately referred to qualification and fact-based knowledge:

> A good caregiver is someone who has empathy, who truly sees the patient in their vulnerable situation, who has proper qualifications, and who knows that it matters how you move the patient, how you speak to them, or what you give them to eat. (CW08)

In her narrative, the ability to "see the patient" was therefore also linked to formal qualifications. When discussing psychological knowledge and skills, many stakeholders referred to care recipients living with dementia, which appeared to be highly prevalent among care users. In these cases, references to empathy often reflected the need to understand the specific characteristics of the disease and to respond to them appropriately. Thus, while the literature often distinguishes communication skills and medical knowledge (Hayes et al., 2019), some interviewees described these as closely intertwined in caring for people living with dementia.

In other narratives, empathy and soft skills were more closely associated with personal qualities and attitudes than with acquired psychological knowledge. This was especially common among carers without training:

> This cannot be learned. It simply cannot be learned. A person is either born with it [or not]—it's their life purpose, their calling. (CW09)

The quoted carer expressed an essentialized view that personality and natural skills in care work are superior to both factual and tacit knowledge and qualifications. According to this approach, the relevance of formal qualifications and fact-based knowledge must be questioned. This position was in line with the narratives of family members, who seldom considered professional qualifications essential in caring relations. Family members tended to prioritize dedication and personal traits, such as mutual sympathy and compatibility, and the significance of formal training did not emerge in their narratives:

> She [a carer] became absolutely dear to our hearts—she kept praying constantly for my mother-in-law. She could have listened to the radio, watched TV,…whatever, but instead, she chose to sit there and pray. (FM03)

All in all, the importance of trust and care in personal relationships prevailed in the narratives. It was also considered consequential whether carers could be replaced by others: "It cannot be that my mother sees a different face here every day" (FM04). In some cases, this was the reason families decided to purchase a market-based service instead of relying on the public home care they had received, as in their view private providers were better able to ensure continuity of carers, whereas frequent staff turnover in public home care was beyond their control. All matchmaking companies explained that when they select an eligible carer for a

family, they consider not only the skills required for the tasks but also the personalities of the carer and the care recipient: "We always try to work in a way that is adapted to the patient's needs" (MC08).

While the literature on personalization mainly emphasizes the needs and autonomy of care recipients (Hussein & Kispeter, 2025), which is the prevailing narrative of market actors (Giordano, 2021), the narratives in our sample show that care workers also considered it important for their own job satisfaction to be able to choose whom they care for, based on personal compatibility with the care recipient and their family: "I would say it also matters what kind of home you enter and whom you let into your home. It works both ways" (CW06).

6. Contested Professional Standards in a Segmented Market

Besides dedication, reliability and trustworthiness were among the most frequently emphasized qualities across all stakeholder narratives. These can be understood as forms of "employability skills" (Hayes et al., 2019), referring to the ability to perform care work responsibly. Social media group administrators, who possessed a broader overview of this segment of the home care market, mostly complained about the low professional standards they had encountered from many other carers, and described cases of neglect or maltreatment:

> Yes, there were cases—and more than one—involving incorrect medication practices, alcoholism, taking sedatives, not showing up for work, and abandoning the patient. (SMA02)

These narratives pointed not only to a lack of medical knowledge but also to problematic attitudes toward both the work and the care recipients, including inappropriate communication. Administrators had even experienced instances of illiteracy that prevented carers from writing down basic information about patients in their own language: "I have even met a carer who could not write her own name" (MC04). In other cases, a lack of basic knowledge of hygiene-related issues was complained about.

Thus, many care workers and administrators of social media groups reported a continuous decline in the quality of care and often quoted a saying about the home care market: "You get what you pay for." By this, they meant the poor quality of work produced by colleagues who lack the skills, training, and knowledge to provide decent care work. Overall, the interviews reveal a segmented market, with significant differences in the quality of care.

While this narrative was represented by qualified carers working in Budapest, one of our informants working in the countryside, a qualified nurse, complained about families' lack of recognition of carers' qualifications and professionalism:

> The problem is that families don't really pay attention to it. So, if they like you as a person, they will accept you. So, they don't really care what your qualifications are….They don't have time to care about what is really good for that old person. (CW02)

In her view, families' ignorance and lack of attention to older people's well-being lead to low expectations and a generally lower quality of care. She claimed that even skilled professional carers (or nurses) cannot earn significantly more in the home-based care sector than unskilled workers. This divergent perspective, which

contrasts with accounts from other professional nurses, may indicate regional heterogeneity in the home care market.

The poor care quality was also reported in other segments of the market mediated by agencies. A matchmaking company owner explained that the problem of inadequate knowledge and skills is not new, even among formally qualified carers:

> There was a period [about 10–15 years ago] when I would only consider hiring a social care worker after checking where they had obtained their qualification. Some of them…who came in were absolutely dreadful. And yet, they had the official qualification. (MC07)

Social media administrators and qualified nurses were especially critical of online training and its use in providing care, and several interviewees claimed that it was "worth nothing":

> I would ban it, especially the online version. They [course attendants] have no practical experience, no qualifications, no knowledge—nothing. They don't even know the most basic things. (SMA02)

Some matchmaking companies are dedicated to providing high-quality care services and, to ensure quality, regularly organize training sessions for care workers. The company we interviewed aimed to ensure high-quality care by providing regular, mandatory training for its workers. They found this particularly important because, in their view, the official qualification may not accurately reflect the carer's professionalism: "The CV is unnecessary. In most cases, there is no professional background behind it" (MC03). This narrative reinforces the lack of trust in formal qualifications.

Although some companies claim to be dedicated to providing high-quality services, neither training nor matchmaking companies take responsibility for the work of carers, as their services are performed informally, without contracts between the company and the care recipient or the carer. Some family members also expressed the view that intermediaries should determine which care recipients require a qualified carer to prevent dangerous situations arising from unprofessional work by unqualified carers, such as medication-related errors: "I think that the intermediaries should be aware of who has what skills in this area….I think that whoever is the intermediary should be aware of exactly what the tasks are" (FM01).

However, some family members reported mixed or negative experiences with matchmaking companies and therefore returned to using social media groups. Interviewees recruited through these groups explained that, although they would prefer greater quality assurance from intermediaries, they could not afford the additional costs. These financial constraints—closely linked to the lack of state support—also limit the profitability of matchmaking services in Hungary (see also Gábriel & Katona, 2024). Therefore, social media sites, offering almost no quality assurance, have become key platforms for connecting the demand and supply sides of home care, linking family members with care workers (Palenga-Möllenbeck et al., 2026). The social media administrators we interviewed appeared motivated to contribute to quality assurance within the sector by voluntarily dedicating one to two hours of unpaid work daily to managing and moderating these groups:

> Well, this takes about two hours out of my life every day. So in the morning I go through the group, during the day I just briefly check in, and then usually I spend another hour on it in the evening. (SMA03)

Despite efforts to exclude carers and family members who fail to communicate or act in a dignified manner with each other and the care recipients or do not respect the assumed basic standards of care relationships, the absence of effective regulation and the limited demand for professionalism from either side have contributed to a decline in the overall quality of care services.

7. Market-Based On-Site and Online Training

Given the expanding market for short-term courses on home care and dementia care, we were curious whether the growing number of training opportunities might signal a process of professionalization, or whether they complicate the picture of skill construction in care. In the following section, we highlight our impressions after attending an online and an on-site training course.

The on-site training event took place over five days in a central district of Budapest. Each day, one or two trainers conducted the sessions, representing a diverse range of professional backgrounds. Among them were a pastoral carer, a nurse, a paramedic, a marketing expert, and a Catholic priest. One of the most significant contributions of the on-site course was its interactivity, allowing participants to ask the trainers questions. Questions and discussions addressed care workers' rights and working conditions, but communication skills and psychological knowledge (e.g., how to handle people living with dementia), and self-marketing skills were also addressed.

The training company's philosophy of good care emphasizes, first of all, humility and the vocation of care workers. As the head of the company said during a training session: "One must be humble toward the profession." However, the training focused more directly on everyday tasks and emerging issues related to caregiving. One of the most practical parts of the training was first-aid education. In addition, discussions about the identification and treatment of illnesses showed that the training placed strong emphasis on the transfer of fact-based, medical knowledge. Interestingly, the participants' questions tended to focus on everyday practical concerns, such as the proper protocol in specific situations or what would happen if the caregiver became ill.

Additionally, considerable attention was also paid to the company's internal regulations. The trainers emphasized the policy associated with their matchmaking activity. Matchmaking had to take place exclusively through them, as part of quality assurance. The exam consisted of open-ended questions to be answered at home and delivered on paper to the company. The questions covered the whole curriculum and were relevant to daily care work activities. After passing the exam, participants could receive a job offer from the company if they were seeking employment. Practical placement in a care home was missing from the curriculum, although it had been part of the program in earlier years.

The online course was advertised as a 220-hour training program and highlighted that this duration would be stated on the certificate, which was common practice for companies offering online training. However, in fact, the course material could be completed within a few days, and the final exam—consisting exclusively of multiple-choice questions—required only minimal effort to pass. There were no real-time sessions, lecturers, or experts to discuss the topics with, but the educational material was available online, and students were supposed to study on their own. In fact, it was more of a self-study course, without having the opportunity to ask questions about either factual material or everyday dilemmas. The video materials, which were strongly

advertised as an advantage of the training, were home-made-style videos in which (possibly) an employee of the training company sat at her computer and read the training material.

The training material was highly uneven in its terminology, relevance, and overall quality, combining very different levels of knowledge and skills. It began with basic household tasks, such as using a coffee machine, but later shifted abruptly to sections on diseases and gerontology written in highly medicalized language. These clinical sections appeared to have been copied from websites or medical textbooks and were often difficult to understand without formal medical training. The material also contained repeated passages and inconsistencies, suggesting that it had not been specifically adapted to the needs of home care workers. Although communication and general employability skills were addressed, the lack of practical training meant that tacit knowledge and concrete communication practices were largely absent from the curriculum.

All in all, despite their differences, participants received very similar certificates at the end of the two training programs. The on-site training—despite the short duration—did deliver an idea of what good care means, focusing primarily on humility, as the preferred attitude in care, and on the relational aspects of the latter, while also providing practical information relevant to everyday care tasks. By contrast, the online training addressed the relational aspects of care much less, instead providing guidance, or "fact-based knowledge," about everyday household duties, but also medical knowledge. Still, the overall low quality of the online training raised concerns about the adequacy of knowledge transfer and the company's credibility. This type of training not only misleads participants but also contributes to the broader devaluation of caregiving as a profession.

8. Discussion and Conclusion

This article has examined the construction of skills in the Hungarian home care market, situating the findings within broader debates on the marketization of care. Drawing on the conceptualization of Ortiga et al. (2021), who argue that the skills regime is governed, negotiated, and unevenly recognized through policies, markets, and discourses, the analysis demonstrated that the underregulation of the market and the explicit familialization of care for older adults have contributed to the absence of clear professional standards, leaving both training provision and quality assurance largely in the hands of market and informal actors. Additionally, the chronic underfunding of care for older people and the limited state support available to families have created a highly segmented market in which social media has become a dominant—and free—means of connecting families and care workers. As a result, these arrangements operate without quality assurance or the capacity to establish professional standards.

Based on Giordano's (2021) findings, a formal diploma or care-related training does not necessarily confer an advantage in the care market or lead to more professionalized work. Our empirical findings confirm this insight by revealing that notions of good care and professionalism are highly fragmented. A striking difference in how interviewees constructed skills lay in the extent to which they addressed the specific needs of the patients that had to be covered. Even though the personalization of care services (Hussein & Kispeter, 2025) was favored by all interviewees, intermediaries and qualified carers provided a more nuanced understanding of patients' needs and who should care for them, while carers without training and family members did not reflect on these specificities.

The aims of professionalization, focusing on qualification and fact-based knowledge, were much less present, while soft skills and tacit knowledge were seen as more important (Giordano, 2021). Additionally, most families valued personality and vocation. This divergence reflects the weak institutionalization of care work and the persistence of cultural understandings of care as women's "natural" disposition rather than as a skilled profession. This difference also reflects how the home care market operates. In cases when formal or informal intermediaries were involved, they could provide more personalized service, reflecting actual care needs. However, the segment of the home care market organized through social media groups provided the lowest level of quality assurance for care recipients and their families (Gábriel & Katona, 2024), as reflected in how carers' skills were evaluated. In the absence of intermediaries, families themselves had to decide what qualifications and skills were necessary and choose among available carers. Respondents to advertisements ranged from experienced nurses to individuals with no prior care experience, requiring families to invest considerable time and effort into assessing both competencies and costs. At the same time, many families were already overwhelmed and financially constrained, as the costs of home care often stretched the limits of affordability.

Short-term market-based training initiatives—which have prevailed in recent years—do not compensate for this trend. Instead of fostering the accumulation of professional skills and fact-based or tacit knowledge, short-term, often unregulated courses risk degrading the meaning of such qualifications, eroding rather than strengthening the idea that care work is a profession. The proliferation of such programs, together with the informal and underregulated operation of matchmaking services, perpetuates unequal access to quality care and market segmentation by quality, and further hinders market-wide quality assurance.

From a broader perspective, Hungary's home care system exemplifies a skills regime in which an informal home care market prevails, and the state outsources skill formation and quality assurance to private actors with insufficient oversight. This arrangement not only undermines the prospects for the professionalization of care work but also jeopardizes the long-term sustainability and quality of care for older people.

Acknowledgments

We thank the reviewers and editors for their feedback and comments. We are also grateful to our informants for sharing their insights with us. We would like to thank our colleagues in the CareOrg team for their feedback, support, and the collaborative work we have shared over the past years.

Funding

The project Researching the Transnational Organization of Senior Care, Labour and Mobility in Central and Eastern Europe (CareOrg, 2023–2026; https://careorg.eu) is funded by the Volkswagen Foundation (VolkswagenStiftung).

Conflict of Interests

The authors declare no conflicts of interests. In this article, editorial decisions were undertaken by Ulf R. Hedetoft (University of Copenhagen).

Data Availability

Due to the nature of the research, data sharing is not applicable to this article.

LLMs Disclosure

Grammarly was used solely for language editing (grammar, spelling, and style) and did not influence the scientific content, analysis, interpretation, or conclusions of the manuscript.

References

Aulenbacher, B., Lutz, H., Palenga-Möllenbeck, E., & Schwiter, K. (2024). Introduction—Senior home care for sale: Agency-brokered transnational live-in care in Europe. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 1–20). Sage.

Aulenbacher, B., Lutz, H., & Schwiter, K. (2021). *Gute Sorge ohne gute Arbeit? Live-in-Care in Deutschland, Österreich und der Schweiz* (1st ed.). Beltz Juventa.

Bartha, A., & Zentai, V. (2020). Long-term care and gender equality: Fuzzy-set ideal types of care regimes in Europe. *Social Inclusion*, *8*(4), 92–102. https://doi.org/10.17645/si.v8i4.2956

Belügyminisztérium. (2024). *Tartós Ápolás-Gondozásra Vonatkozó Stratégia 2030*.

Bonifacio, F., & Pais, I. (2025). *How platformisation is shaping the future of domestic work. A mapping of home care and cleaning platforms in six EU countries* (Working Paper 2025.08). European Trade Union Institute. https://www.etui.org/sites/default/files/2025-07/How%20platformisation%20is%20shaping%20the%20future%20of%20domestic%20work_2025.pdf

Börjesson, U., Bengtsson, S., & Cedersund, E. (2014). "You have to have a certain feeling for this work": Exploring tacit knowledge in elder care. *Sage Open*, *4*(2). https://doi.org/10.1177/2158244014534829

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Emberi Erőforrások Minisztériuma. (2020). *Tartós Ápolás-Gondozásra Vonatkozó Stratégia 2030*. https://cdn.kormany.hu/uploads/document/c/c6/c68/c68381aafe390e0744e99b10df3a98b3bd67ce67.pdf

Fiebig-Spindler, R. (2026). Selling care skills? The multiple meanings of training for polish live-in care workers in Germany. *Social Inclusion*, *14*, Article 11909. https://doi.org/10.17645/si.11909

Fodor, E. (2022). *The gender regime of anti-liberal Hungary*. Springer. https://doi.org/10.1007/978-3-030-85312-9

Gábriel, D., & Katona, N. (2024). Diversification of the senior home care market in Hungary: Informality and the operation of intermediaries. In B. Aulenbacher, H. Lutz, E. Palenga-Möllenbeck, & K. Schwiter (Eds.), *Home care for sale: The transnational brokering of senior care in Europe* (pp. 64–78). Sage.

Gazzaroli, D., D'Angelo, C., & Corvino, C. (2020). Home-care workers' representations of their role and competences: A diaphanous profession. *Frontiers in Psychology*, *11*, Article 581399. https://doi.org/10.3389/fpsyg.2020.581399

Giordano, C. (2021). The professionalisation of domiciliary care for the elderly: A comparison between public and private care service providers in Belgium. *International Journal of Sociology and Social Policy*, *41*(9/10), 1072–1088. https://doi.org/10.1108/IJSSP-06-2020-0226

Gottfried, H. (2022). Tacit knowledge in low-status eldercare work. *AMA Journal of Ethics*, *24*(9), E883–E889. https://doi.org/10.1001/amajethics.2022.883

Grenz, A., & von Kutzleben, M. (2024). Conceptualisations of good care and conflicts in live-in migrant care arrangements for people with dementia—Perspectives of family caregivers in Germany. *BMC Geriatrics*, *24*(1), Article 702. https://doi.org/10.1186/s12877-024-05283-9

Gyarmati, A. (2019). *Ageing and care for the elderly in Hungary. General survey and problems*. Friedrich-Ebert-Stiftung.

Gyarmati, A. (2022). *Situation of those working in elderly care in the EU and Hungary*. Friedrich-Ebert-Stiftung.

Gyarmati, A., Katona, N., Somorjai, I., Staller, J., & Szokoli, E. (2021). *Tartós Ápolás-Gondozás Stratégia 2021–2027*. Friedrich-Ebert-Stiftung Budapest.

Hayes, L., Johnson, E., & Tarrant, A. (2019). *Professionalisation at work in adult social care: Report to the All-Party Parliamentary Group on Adult Social Care*. GMB Union.

Hemmings, N., Oung, C., & Schlepper, L. (2022). *New horizons: What can England learn from the professionalisation of care workers in other countries?* Nuffield Trust. https://www.nuffieldtrust.org.uk/research/new-horizons-what-can-england-learn-from-the-professionalisation-of-care-workers-in-other-countries

Hussein, S., & Kispeter, E. (2025). *Policy drivers of social care workforce change: United Kingdom insights, impacts, and future directions*. Centre for Care. https://centreforcare.ac.uk/wp-content/uploads/2025/09/SH-EK-Policy-brief-May-2025-FINAL.pdf

Katona, N., & Gábriel, D. (2026). The quiet collapse: Authoritarian neoliberalism and the crisis of care of older people in Hungary. *Economy and Society*, *55*(2), 301–323. https://doi.org/10.1080/03085147.2026.2632445

Kontos, P. C., & Naglie, G. (2009). Tacit knowledge of caring and embodied selfhood. *Sociology of Health & Illness*, *31*(5), 688–704. https://doi.org/10.1111/j.1467-9566.2009.01158.x

Lutz, H. (2011). *The new maids: Transnational women and the care economy*. Palgrave Macmillan.

Meleg, S. (2025). Mi a gondoskodáspolitika? Megújítási vagy ideológia vezérelt kiszorítási kísérlet? *Párbeszéd: Szociális Munka Folyóirat*, *12*(1). https://doi.org/10.29376/parbeszed.2025.12/1/9

Needham, C., Allen, K., Burn, E., Hall, K., Mangan, C., Al-Janabi, H., Tahir, W., Carr, S., Glasby, J., Henwood, M., & McKay, S. (2023). How do you shape a market? Explaining local state practices in adult social care. *Journal of Social Policy*, *52*(3), 640–660. https://doi.org/10.1017/S0047279421000805

Ortiga, Y. Y., Wee, K., & Yeoh, B. S. A. (2021). Connecting care chains and care diamonds: The elderly care skills regime in Singapore. *Global Networks*, *21*(2), 434–454. https://doi.org/10.1111/glob.12281

Palenga-Möllenbeck, E. (2022). Making migrants' input invisible: Intersections of privilege and otherness from a multilevel perspective. *Social Inclusion*, *10*(1), 184–193. https://doi.org/10.17645/si.v10i1.4789

Palenga-Möllenbeck, E., Kyliushyk, I., & Fiebig-Spindler, R. (2026). The invisible hand of care: A typology of brokerage actors in migrant care labour. *Social Inclusion*, *14*, Article 11953. https://doi.org/10.17645/si.11953

Polanyi, M. (1966). *The tacit dimension*. Doubleday & Company.

Prieler, V. (2021). 'The good live-in care worker': Subject formation and ethnicisation in Austrian live-in care. *Sociológia – Slovak Sociological Review*, *53*(5), 483–501. https://doi.org/10.31577/sociologia.2021.53.5.18

Reinders, H. (2010). The importance of tacit knowledge in practices of care. *Journal of Intellectual Disability Research*, *54*(s1), 28–37. https://doi.org/10.1111/j.1365-2788.2009.01235.x

Szikra, D., & Öktem, K. G. (2023). An illiberal welfare state emerging? Welfare efforts and trajectories under democratic backsliding in Hungary and Turkey. *Journal of European Social Policy*, *33*(2), 201–215. https://doi.org/10.1177/09589287221141365

Vida, A. (2021). A professzionális gondoskodás konstrukciója és válsága az idősellátásban dolgozók perspektívájából. *Socio.Hu*, *11*(4), 69–84. https://doi.org/10.18030/socio.hu.2021.3.69

Wojczewski, S., Ernst, A., Bagheri, R., & Adler, V. (2023). *MigraCare—Weiterbildungsbedarf bei 24-Stunden-Betreuer*innen in Österreich*: *Ergebnisse einer Online-Umfrage**. Ludwig Boltzmann Gesellschaft – Open Innovation in Science Center. https://ois.lbg.ac.at/wp-content/uploads/sites/24/2024/03/MigraCare-Umfrage-Endbericht-0.2.pdf

About the Authors

Noémi Katona (PhD) is a sociologist and research fellow at the ELTE Centre for Social Sciences, Hungary, and an assistant professor at the Corvinus University of Budapest. Her main research interests are gender, migration, care work, and sexual labor.

Dóra Gábriel (PhD) is a sociologist and research fellow at the ELTE Centre for Economic and Regional Studies, Hungary, and at the ELTE Centre for Social Sciences, Hungary. Her main research interests are care marketization, the communitization of care, and international retirement migration.