Fact Sheet

Hungary

FINANCING OF CARE SERVICES FOR PERSONS WITH DISABILITIES

Written by Gabor Petri

Coordination and Editing by Policy Impact Lab

EASPD

IMPROVING SERVICES
IMPROVING LIVES

This publication has been produced with the financial support from the European Union Programme for Employment and Social Innovation "EaSI" (2014-2020). This publication reflects the view only of the author and the Commission cannot be held responsible for any use which may be made of the information contained therein.

Contents

Executive Summary

In Hungary, there is an estimated 35,000 to 40,000 persons with disabilities (PWDs) who receive at least one type of social service – this accounts to only about 10-15% of all PWDs in the country.[1] Community-based social services still reach only a small share of those PWDs who would be potential clients, and many social services (including those covered in this report) often offer services that are not based on the real needs of PWDs. Still over 30,000 PWDs live in residential institutions, many of them in homes for the elderly.[2]

Financing social services for PWDs is done in a complex system based on flat rates, largely including elements of reserved market scheme, and additional funding facilities covering some wage supplements of social care personnel working in licensed services. The core legislation and also the source of information for providers for calculating funding for services is Hungary's annual Budget Act, and its Appendices (Appendix 2 and Appendix 8) – these contain both flat rates per services and other necessary information, such as 'multipliers' specific to service types.

The Hungarian social care sector is highly diverse, where four types of service providers are present, in the order of their share of the sector: municipalities; churches; state-bodies; and other non-state entities (mostly NGOs).[3] The rules regulating funding for all service providers are largely the same, with one notable exception: churches and other faith based organisations receive additional annual funding from the state, based on the Vatican Concordat (1997), an international agreement between Hungary and The Holy See. The share of for-profit providers in the social care sector for PWDs is insignificant, probably due to limited state funding available for them.

Funding amounts – including for the same type of services – vary between types of providers. All providers – with the exception of state-run services – receive less state-funding for their services than the actual costs they incur. Church-run services (due to the Vatican Concordat) and municipality-run services (due to municipalities' additional income from other sources) enjoy a better level of funding, while NGOs are widely seen as getting the least satisfactory funding for their services. In fact, most NGOs-run services for PWDs find it extremely hard to raise sufficient income for their services. The funding mechanisms of state-run services for PWDs lack transparency.

In Hungary, the chiefly reserved market-like funding mechanisms of services for PWDs do not incentivise providers to improve the quality of services, in fact, most licensing, auditing and monitoring practices are focussed only on bureaucratic issues.[4] Currently, both users and service providers report that the prerequisite for funding is only formal licensing and the tri-annual approval of client numbers, and funding is given largely regardless of the quality of services.

Funding amounts for social services for PWDs cover only a part of the annual costs necessary to run a legally licensed service. EU funds also contribute to the income of some service providers, however, these funds rather aim at infrastructural investments or other projects, and do not contribute to the running costs of services. Most service users also pay a service fee, however, the amount paid per client is limited by law.

Current funding mechanisms and funding amounts affect most providers adversely that run their services with a projected annual deficit, especially in the NGO-sector. Limited funding for services for PWDs appears to be a strong barrier to the availability of services, and also to opening new or extending existing services. The quality of services is further impacted by the generally poor salaries of social care professionals – although wages have been somewhat rising recently, many service providers report to be struggling with staff turnover and staff shortages, especially among skilled workers.

Working conditions are reported to be generally poor across the social care sector, partly due to limited funding. Residential instituions, especially those run by the state are probably the most likely to be featuring sometimes extremely poor material (building, equipment etc.) conditions. Due to staff shortages, overwork and

1 Kozma et al., 2019
2 Central Statistical Office, 2019
3 Czibere & Mester, 2020
4 See for example: Bugarszki, 2010 and Halász et al., 2013.

fatique of personnel is also reported across sectors. Among service providers, churches and municipalities are often able to provide better working conditions, for example they may refurbish physical infrastructure or purchase better equipment, while state-run services are more likely to offer somewhat poorer conditions.

During the COVID-19 pandemic, many residential services found it difficult to provide protective equipment to staff and residents. Many service users also struggled to receive statutory services, for example due to staff shortages or safety measures at service providers.

Main Findings

- ★ The main funding model in Hungary is a ‚reserved market' one where the state only allows certain providers (after licensing and the approval of client numbers) to enter the market. Clients also pay a service fee that contributes to providers' revenue.
- ★ Social services for PWDs are generally underfunded in Hungary, particularly those run by NGOs.
- ★ Lack of funding is a strong barrier to the availability of services. Only a fraction of PWDs access community-based services and existing services often do not respond to their real needs.
- ★ Funding mechanisms are not related to quality assurance measures, because the auditing and monitoring of services focusses mostly on administrative issues.
- ★ Working conditions are reported to be poor across the sector, particularly in residential institutions.
- ★ Despite some increase in the salaries of social care professionals in recent years, turnover appears to be a serious problem at many services, and there are regular reports about staff shortages.
- ★ Current funding mechanisms are not drivers of reforms to continue the establishment of community-based services for PWDs.

Introduction

In Hungary, social services for persons with disabilities (PWDs) have developed following the medical model of disability, bearing strong characteristics of a state-socialist heritage. Under state-socialism, disability was defined as a medical and individual problem where services for PWDs were almost exclusively segregated (e.g. residential institutions, sheltered workshops)[5]. After the democratic changes in the 1990s, due to new legislation also lobbied for by disability advocacy groups[6], the modernisation of existing and the introduction of new services types aimed at strengthening community-based services. Modernisation efforts of the 1990s and early 2000s were only partially successful[7], criticised by policy experts as well as disabled people's organisations.

Despite the ratification of the UN Convention on the Rights of Persons with Disabilities (CRPD) by the Hungarian state in 2007 and some government efforts to implement it[8], social services for PWDs have been stagnating. For example, the number of disabled people using community-bases social services remained low throughout the 2010s, excluding most PWDs who wish to use community-based services[9].

Today, social services for PWDs are regulated by, among others, the Social Act (3/1993), and two Social Ministry Decrees (1/2000 and 9/1999) about the duties of social services, and the eligibility for receiving services, respectively. Other relevant laws regulate service fees (29/1993 Government decree); the financing of social and child protection services run by churches and other non-state service providers (489/2013 Government decree); and the licensing and auditing of social services (321/2009 Government decree). In most aspects, the Social Ministry ('Ministry of Human Capacities') is the main regulator of the social care sector, however, in the context of financing of services, more general laws and authorities take a large part in regulating and monitoring

5 See for example Mladenov, T. (2017). Postsocialist disability matrix. *Scandinavian Journal of Disability Research*, *19*(2), 104-117.

6 See for example Turnpenny, Á. (2019). People with intellectual disabilities in the European semi-periphery: the case of Hungary. In. Walmsley, J. & Jarrett, S. (Eds.) *Intellectual Disability in the Twentieth Century: Transnational Perspectives on People, Policy, and Practice*. Bristol: Policy Press, 113-129.

7 Bugarszki Zsolt (2004*): A szociális szolgáltatások újjászületése Magyarországon*. Esély, 2004/4. 100—110.

8 For example, the Hungarian government launched a deinstitutionalisation programme in 2012, aiming to move out thousands of residents of long-term care residential institutions to the community.

9 Kozma, Á., Petri, G., & Bernat, A. (2020). Kiszolgáltatottság és stagnálás: fogyatékos emberek társadalmi helyzete a 2010-es években. In. Kolosi, T., Szelényi, I. & Tóth, I. Gy. (eds.) *Társadalmi Riport 2020*, 434-449. Budapest: TÁRKI.

service provision. For example, flat rates for financing social services are set out in Hungary's annual Budget Act (in 2020: the 71/2019 Act), and in its Appendices, mostly in Appendix No. 2 (on supporting municipalities) and Appendix No. 8 (on subsidies for social and child protection services) – these are highly relevant for social services for PWDs. Several authorities outside the social care administration are also responsible for monitoring social services for PWDs[10]: both the Hungarian State Treasury and the State Audit Office of Hungary can perform financial audit duties inspecting either service provider organisations or actual social services.

In Hungary, the annual budget for social care services was an estimated 186 billion HUF[11] in 2019 (approx. 512 million EUR), accounting for 0,7%[12] of Hungary's national budget. Social services reach around 600 thousand people annually[13]. The Hungarian social services sector is rather fragmented where a range of service subsectors and several different service providers are present. These include[14]:

- ★ municipalities and alliances of municipalities: 72,5% of all service users of basic social services, and 28% of clients of specialised social services;
- ★ churches and faith-based organisations: 15,3% of clients in basic social care and 20,4% of service users in specialised social care;
- ★ the Hungarian state (i.e. central government bodies as service providers): 0,7% of clients in basic social care and 30,7% in specialised social services;
- ★ non-governmental organisations (NGOs, including foundations, assocations, and non-profit enterprises): 11,6% of service users in basic social care, and 20,9% is specialised social services;
- ★ the share of for-profit providers in services for PWDs is insignificant: only 6 clients were in day care services run by for-profits in 2018, and in the same year there were no PWDs in long term residential care or respite care services of for-profits.[15]

By the end of the 2020, state-run services received approximately 21%, municipalities 38%, churches and faith-based organisations 30%, and civil society actors 11% of the total sum of state funding allocated to social services.[16] In the field of services for PWDs, only a very small number of private enterprises are present in the market (see below).

Funding of social services is provided through a highly complex system, whereby a blend of *reserved market schemes* on the one hand, and *flat rate unit costs* (usually based on client numbers per unit, i.e. days or hours) on the other are used to allocate money to service providers. Providers also charge clients a service fee, however, there are legally set limits as to how this fee calculated, based on clients' income – the monthly fee usually cannot exceed 80% of a service-user's monthly income. Clients without a minimum level of income cannot be charged a service fee, with the difference in cost expected to be covered by the providers themselves. Anecdotal evidence suggests some users have limited access to some services if unable to pay the fee. Service fees contribute significantly to the income of service providers, however the share of service fees in the revenue of service providers varies across sub-sectors.

All social service providers (incl. municipalities, churches, NGOs etc.), except state-run services are obliged to apply for client numbers and receive a license from state authorities. Licenses are issued only to those services

10 The former Special Social Issue Authority (NRSZH), responsible for several administrative duties, was dismantled and merged with other authorities in the end of 2016.

11 Calculation provided by government expert participant. Disaggregated financial data for disability services is not available. The total annual state budget for social services for PWDs, 'psychiatric patients', and 'people with addiction' was an estimated 53,6 billion HUF (approx. 154,8 million EUR) in 2019.

12 Estimated by Czibere & Mester, 2020

13 Goldmann et al., 2016 – includes all social service users, including PWDs. Estimation of annual budget is kindly provided by a government expert participant.

14 Data from Czibere & Mester, 2020. 'Basic social services' (*'szociális alapellátás'*) is a term specified in law, it includes day care for PWDs. 'Specialised social services' (*'szociális szakellátás'*) include supported housing, long term residential care, and respite care.

15 Central Statistical Office, 2019.

16 Estimated by Czibere & Mester, 2020

that fulfil criteria set out in laws such as the 1/2000 Social Ministry decree. Licensed providers then need to acquire an official approval of their planned client numbers. Client numbers are approved jointly by the Ministry of Human Resources ('social ministry') and the Ministry of Finance – client numbers can only be applied for and approved tri-annually. This system aims to ensure that the Hungarian state can control the budget allocated to services, but also gives opportunity to adjust services to local or regional specificities, such as certain demographic or economic characteristics of a region. In reality, according to interviewees, the approval of client numbers is reported to be lacking transparency (e.g. insufficient explanation given when an approval is rejected). Furthermore, approved numbers do not reflect the local demand in many regions – while providers can provide services for fewer clients than they have got approval for[17], they cannot exceed the maximum number of approved client number.

Notably, municipalities above a legally defined number of inhabitants are mandated by law to run certain social services – for example municipalities above 10,000 inhabitants must run day care centres for PwDs[18]. However, not all municipalities run services they are mandated to run.[19]

The calculation and allocation of funds for social services for PWDs is set up in a highly complex and regularly changing system (see Table 1). Most interviewees – although they had substantial (i.e. several years of) experience in the social sector – claimed that the funding system is nearly impossible to be fully understood even for social care professionals, due to its complexity, and its ever-changing nature. The amount of funding one service receives from the state depends on factors such as:

- ★ The **type of service** one provider delivers, e.g. day care differs from long-term residential care etc.
- ★ The **client group20**, e.g. funding of day care for PWDs differs from day care for elderly people; long-term residential care for PWDs or people with psychiatric conditions is different from long-term care for elderly people etc.
- ★ The **type of service provider**. In Hungary, funding levels for social services are different in the case of state body providers; churches; municipalities; and other non-state entities. Thus, service delivery in a small group home for PWDs, run by an NGO is financed differently from a group home with the same client group, run by a church.
- ★ **Needs assessment of clients** may also play a role in some social services, however, in services for PWDs flat rate funding is rarely differentiated based on clients' support needs.
- ★ **State-level legislative changes, including national strategies,** such as new laws or new service types established as part of national-level government strategies. One prime example is the social service 'supported housing' (see further details later), that was established after the Hungarian government launched its deinstitutionalisation reform in the early 2010s.[21]

17 Services get their funding based on actual client numbers and not based on the approved number. Actual client numbers are reported by providers regularly through a state-run online database. For example, if a service provider has an approved number for 30 clients in day care for PWDs, they cannot legally exceed that number at any one time until they get an approval for higher number.

18 There are no similar obligations for municipalities for other kinds of social services covered in this report.

19 Bugarszki, 2010

20 In day care, supported housing, long-term residential care and respite care, statutory financial mechanisms do not differentiate between disability groups (such as learning disability, physical disability etc.). However, non-state residential care providers can annually apply for a grant provided for those delivering services to autistic people. The amount allocated through this grant is a small part of services' annual budget. See more info at: https://www.nfszk.hu/palyazatok/palyazati-felhivasok/aut2021.

21 Several interviewees claimed that other factors play a minimal role in determining financing levels and funding instruments: for example, lobby by disabled people's organisations or trade unions of social care workers is usually reported to be often ineffective.

TABLE 1 | Financing social services run by different service providers

Service Provider	Financing mechanism	Relevant law	Note
Municipalities	Flat rates are fixed in the Budget Act.[22] Alliances of municipalities get extra subsidies tied to services.	Appendix No. 2 and No. 8 of the Budget Act	Municipalities may also get state aid, earmarked or not earmarked to services.
State body	Sum included in the total running costs of the relevant state body	Budget Act, budget line relevant to state body	Sum is not based on the number of clients but on 'budgetary traditions'.
Churches	Similarly to municipalities, funding is allocated by the state, based on the flat rates set for municipalities in the Budget Act. Additional funding and subsidies given per the Vatican Concordat.	Budget Act and Final Accounts Act, Vatican Concordat	Additional funds may also be allocated to churches in relation to social services.
Non-state actors	NGOs: similarly to municipalities, the same flat rates are used, provided from the state budget. For-profit providers get 30% of the flat rate for municipalities.	Appendix No. 2 and No. 8 of the Budget Act	Some annual grants are made available to aid NGOs running services for PWDs.

There was a general agreement among all interviewees – regardless of the sub-sector they worked in – that funding schemes in Hungary have no positive impact on the quality of services. In fact, some experts claimed that effects are to the contrary, for example in the words of an expert: *'the problem is that there are no guidelines and rules to ensure better service quality – these days you just need to fill in all the papers and will get the money for running the service. So it is not even that the money is missing, because there are better places with less money and terrible services with a rather good budget'23.* Several interviewees also noted that once a social service is licensed by authorities, providers are not motivated through funding or other mechanisms to maintain high quality services, because '*they will get the money anyway*'.

Funding social services run by municipalities

Until the early 2010s, municipalities were responsible for running most social services in Hungary, including nearly all residential and community-based services for PWDs. Major changes were introduced by the government in the early 2010s when most residential institutions formerly run by municipalities have been overtaken and centralised under one state-owned body. Thus, since 2012, many services (mostly 'specialised social services' i.e. residential services) have been overtaken by the state, and there are also reports about municipality-owned social services overtaken by churches.

Funding social services run by municipalities is done in a variety of ways, depending on client groups, kinds of service etc. Among social services for PWDs, municipalities are funded mostly through flat rates or through earmarked funding specific to services. Actual sums are detailed each year in the Budget Act and its appendices – flat rates for municipalities are also the basis for funding for all social services in the country, except state-run services.

Although the main funding source for municipalities is the flat rate (or in certain service types) earmarked funding detailed in the Budget Act, municipalities may allocate additional funds to their social services from their own income (such as local taxes or other income). According to interviewees, *'those municipalities that want and can afford'* often do complement state-funding from their own budget. Indeed, municipalities may be able to renovate service buildings, buy equipment for services or '*give somewhat better salaries*' than other providers such as state-owned services or NGOs. Some municipalities

22 For several other social service sub-sectors, not covered in this study (e.g. elderly homes, shelters for homeless people etc.), municipalities receive funds based on other type of agreements.

23 Also noted by Bugarszki, 2010 and Halász et al., 2013

also get one-off state aid from the national budget – these contributions are not always earmarked to social or community services but, according to interviewees, some municipalities do use these to help running social services for PWDs. Thus, most participants agreed that municipality-run social services for PWDs are able improve the quality of services if local bodies are willing to commit and have resources to allocate extra funding to services.

Funding social services run by state bodies

Following the 2012 centralisation of most social services previously run by municipalities[24], today the majority of state-owned services for disabled people are run by the Directorate-General for Social Affairs and Child Protection ('SZGYF'). The organisation runs mostly long term-care facilities (residential institutions) at 147 locations across the country, delivering social services to around 20,000 PWDs[25] (incl. persons with psychosocial disabilities). State-run social services are financed through direct funding of their responsible body – the amount is not calculated through the same system as funding for other providers, but – according to participants – based on 'funding traditions', i.e. how much money the given organisation (SZGYF) has been allocated before.

One participant noted that although the centralisation of such a big number of services would have been an excellent opportunity to improve the transparency of services nationwide (e.g. financial transparency, service quality etc.), today much of the data about state-run services are difficult to acquire, and the independent monitoring of social services owned by SZGYF is virtually non-existent.[26] Several interviewees – including those working for state-run bodies – agreed that most state-run social services are badly underfunded. Two experts stated that services are so centralised at SZGYF that – quoting a somewhat sarcastic statement – '*directors [of state-run institutions] cannot even buy a toilet roll without getting formal approval from the top level*'. Several participants also observed the overall poor conditions for workforce in social services of SZGYF. For example, according to an interviewee, staff '*cannot even hope for a collective agreement'* and ' *[staff's] situation in SZGYF services in some regions is absolutely hopeless'* due to bad working conditions, and serious shortcomings of health and safety measures for staff as well as residents/service users.

Several interviewees stated that current funding mechanisms of state-run services do not require or indeed support managers to attempt to improve the quality of services. Experts claimed auditing visits within SZGYF focus mostly on administrative issues or bureaucratic responsibilities, leaving issues related to service quality or 'quality of life' of clients aside. Quoting one expert: '*It is all about counting lightbulbs and looking at numbers, paperwork, red tape…, no one is looking at the clients or service quality when they check on those places. They see only numbers.'*

Funding church-run social services

Churches' share of the Hungarian social care services sector has been increasing.[27] Churches ran only 3,3% of 'basic social services' (incl. day care and homes assistance etc.) in 2008, and their share increased to 15,3% by 2018. A similar rise has been documented in 'specialised social services' (incl. long-term care and respite care), where churches' share of the market rose from 13% in 2008 to 20,4% by 2018.[28]

In Hungary, besides the flat rate-based funding, social services run *by churches* or *faith-based organisations* also receive an annual subsidy based on the Concordat between the Republic of Hungary and the Holy See – often

24 The centralisation of social services in the early 2010s happened parallel with the nationwide centralisation of other public services like — formerly municipality-run — schools. Objectives and motives behind the Hungarian government's massive centralistion efforts have been disputed (see for example: Horváth, 2016 and Semjén et al., 2018).

25 Data from 2014. Source: www.szgyf.gov.hu.

26 Another interviewee noted: '*They would never let us in officially, the gates are shut! Institution directors need to ask the central office even about speaking to a journalist, let alone letting in someone to monitor services'*. Other participants also claimed that directors of state-run services are often afraid of repercussions, therefore they try to avoid taking even the smallest decisions about issues they think controversial.

27 See for example: Havasi, V. (2017) or media reports such as: https://magyarnemzet.hu/belfold/erosodik-az-egyhazak-szerepe-a-szocialis-agazatban-8412339/

28 Czibere, K. & Mester, D. (2020). A magyar szociális szolgáltatások és főbb jellemzőik 1993 és 2018 között. In. Kolosi, T., Szelényi, I. & Tóth, I. Gy. (eds.) Társadalmi Riport 2020, 434-449. Budapest: TÁRKI.

called 'the Vatican Concordat'[29] (1997). The Concordat set out rules about the financing of services provided by churhces. The rules of the Vatican Concordat have been extended to other churches beyond the Catholic Church, including the Hungarian Calvinist Church, the Hungarian Lutheran Church, the Hungarian Greek Catholic Church, the Hungarian Jewish Congregation, and several smaller denominations. In short, the Vatican concordat guarantees that church-run social services receive an annual subsidy for their social services on top of the flat rate that is guaranteed for other non-state actors such as NGOs. The annual subsidy for churches must reflect on the actual costs of services run by state-owned providers (see below).

Thus, funding of churches (and other faith-based organisations enjoying a status equal with churches covered by the Vatican Concordat, such as the Charity of the Order of Malta), have a somewhat privileged status in the social care sector: they receive subsidies beyond the flat rates for services, guaranteed in the appendices of the Budget Act. Based on the Vatican Concordat, their funding is calculated based on two elements: first, the flat rate costs set out for municipalities in the Budget Act, and second, extra subsidies given based on the amount of the *actual running costs* of social services based on each year's Final Accounts Act.[30] Extra subsidies are allocated to churches based on the total amount of money that *all state-owned and municipality-run services* spent in the previous year. Importantly, the calculation is based on *all social services* (incl. day care, residential care, home assistance, shelters, street social work etc.) and not matched in a kind-to-kind manner[31]. Between 2010 and 2018, the annual amount of the extra subsidy for church-run services varied between 72-98% of the flat rate set in the Budget Act. Many interviewees noted that increased funding usually means that church-run social services for PWDs can improve their service quality as well.[32] However, experts also stated that not all church-run services are of better quality, regardless of their better funding.

It is reported that in recent years, the trend of churches taking over services has accelerated. There is anecdotal evidence that a host of previously state- or municipality-run services (including social services, schools and child protection services) are being taken over by churches across the country. This, broader trend is also reflected in the disability sector where several participants noted that residential institutions, group homes and other services are being taken over by churches in many geographic areas.

Funding other non-state social services

Non-state services, similarly to all other service providers, work under a reserved market funding mechanism, with their funding allocated based on flat rates set out in the Budget Act. In this regard, their funding is not at all different from other providers. However, it was agreed among interviewees that most non-state providers (chiefly NGOs) are far the most disadvantaged financially, among service providers. For historical reasons, NGOs, including disabled people's organisations (DPOs) and organisations of parents of persons with intellectual disabilities or autistic people have been playing an important role in the sector: they have been drivers of progressive policy changes[33] and are also providers of services. For example, NGOs run many long-term care small group homes for PWDs, reaching over 1,200 clients (2018)[34].

Several interviewees noted – in line with NGO and DPO statements – that underfunding seriously jeopardises the sustainability and availability of NGO-run services. In most sub-sectors, state funding for NGOs only accounts for less than 50% of costs necessary for running licensed social services. Thus, non-state providers need to raise funds from other sources, with varying levels of success.

One obvious potential funding source is service fees paid by clients, however, most interviewees noted this

29 See http://www.concordatwatch.eu/hungary--s848

30 The difference between the flat rate (per Budget Act) and the actual running costs (per Finanal Accounts Act) reflects on the real funding levels of social services in Hungary: the state-provided flat rate does not cover all the costs services meet.

31 According to one interviewee (an expert of the government), a kind-to-kind calculation would result in a lower subsidy for churches, because services have distintly different costs and flat rate/total costs ratio.

32 See also Havasi, 2017.

33 See for example: Balázs & Petri, 2010.

34 Central Statistical Office, 2018. NGOs also run other social services for PWDs, not covered in this report.

source of income is rather limited for two reasons. First, the maximum amount of service fees is set by law (e.g. 80% of a client's income in residential care), second, most PWDs (or their families, who in some cases can and do complement fees) have low income. Civil society organisations also often try to raise funds from private or corporate donations, however interviewees claimed these contribute to only a very small part (under 5-10%) of all costs, and they also noted that income from these sources is erratic, making it impossible to rely on them when making annual financial plans for services. Many NGOs also apply for grants by the Hungarian state or other entities, however, these can rarely be used for running costs of services. Many interviewees noted the important role of EU-funds in the social care sector, however, EU grants cannot be used to cover regular running costs of services – thus, their role is more present in innovation-driven projects or infrastructural investments.

Over the 2010s, NGOs repeatedly published lobby documents detailing difficulties about their funding and how funding rules adversely impact the availability and sustainability of services[35]. Despite lobby efforts, the system of financing NGO-run social services for PWDs has remained unchanged, leaving many NGOs struggling to remain open, despite demand for services by their local communities. Consequently, interviewees claimed that some NGOs – in their efforts to keep services open – are seeking agreements to see their social services overtaken by churches.

Funding for-profit service providers

For-profit providers remain insignificant across social services for PWDs, mostly because they can only be funded up to a legally set 30% of the flat rates regulated annually in the Budget Act. Existing for-profit social care providers – mostly running services for elderly people – work under the same 'reserved market' mechanism as all other providers. Another limiting factor for enterprises wishing to open social services is the legally set limitation on clients' service fees. These rules prevent potential enterprises from being able to generate enough revenue for social services.

Salaries of staff in socal services for PWDs

Following lobby by trade unions, repeated media reports about staff[36] shortages, and an inquiry report in 2012 by the Ombudsman[37] about the bad working conditions and low salaries in the social care sector, wages of staff in social services have somewhat improved in recent years. Today, a 'wage supplement' dedicated especially for staff in social services complements wages – this supplementary funding is available and allocated to licensed services. According to interviewees, however, in many social services there are still staff shortages due to bad working conditions and uncompetitive wages. Several interviewees claimed that many social services – especially residential institutions – struggle to recruit skilled social care workers, thus need to rely to '*work with whoever they can get to work for them'*.

Many interviewees also noted that the salaries of personell are calculated through a highly complex system where several 'supplements' and 'allowances' complement the basic salary set by the law.[38] Among others, there are allowances for extra hours worked; weekend hours; night shifts; worked hours during public holidays etc. It is reported by trade unions that sometimes providers fail to inform their staff about their rights for all available allowances. Some service providers, mostly churches and some municipalities, are seen to be able to provide better working conditions including better wages for staff – for example, some church-run services provide benefits such as living allowance, contribution to housing costs of staff etc.

35 For example: MEOSZ, 2017; Céhálózat, 2016.

36 Notably, the overwhelming majority of staff in social care are women. A recent report found that, in social care and child protection services in Hungary, 91% of full time professional staff are women. (Czibere & Mester, 2020).

37 The report, published in 2013 by the Ombudsman, found that working conditions in social services are deteriorating, and the ‚*income and life circumstances of social care constantly worsening.*' See more at https://www.ajbh.hu/documents/10180/111959/Jelent%C3%A9s+a+szoci%C3%A1lis+gondoz%C3%B3k+b%C3%A9rez%C3%A9s%C3%A9r%C5%91l/560ea56b-9328-4d92-aa37-4f88b25634ae?version=1.0

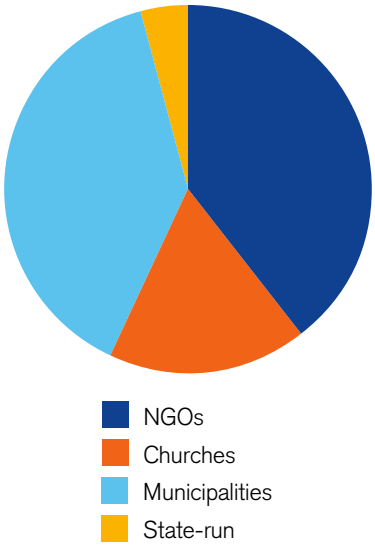
38 See for example: https://szmdsz.blog.hu/

Day Care for PWDs

Day care is a specific kind of social service, based on the Social Act. Based on clients numbers, day care for PWDs is the third most common service for PWDs in Hungary, after long term care (see later) and 'support services' (not covered in this report)[39]. Day care centres organise day-time activities for clients, and also provide meals. Day care services can be found in cities with over 50,000 inhabitants, and in nearly all settlements with 10,000 to 50,000 inhabitants (KSH, 2016).[40] Day care centres are seldom available in small towns and villages. The number of clients in day care centres for persons with disabilities was 7,613 in 296 centres in 2018[41]. Both the number of clients and the number of centres have been rising since the 2000s.

Most day care centres for PWDs are run by NGOs (including associations, foundations and non-profit enterprises), and municipalities (or alliances of municipalities). Churches only account for less than fifth of services nationwide. The role of state-owned services has been insignificant in the sector (Chart 1.). In 2018, there were 239 people on waiting lists to join day care centres for PWDs[42] –interviewees stated that demand for day care varies greatly between regions.

CHART 1 | Day Care Services in 2018 (N=7962)[43]



Funding of day care is based on flat rates set annually in the Budget Act and its appendices. The flat rate for 2020 was 689.000 HUF/person/year (approx. 1,900 EUR). Besides state-funding, services also charge service fees, these contribute to about 20-30% of total costs at NGOs. (Data was unavailable at church-run and municipality-run services.) According to the Central Statistical Office, in 2018, around 54% of users of day care services for PWDs also paid a service fee. Many municipalities provide services free of charge for clients, only charging for costs of meals (around few hundred Forints/1-2 EUR per day). The maximum of service fee in day care, set by law, is 15% of client's monthly income, if the service includes meals the maximum is 30% of client's income.

According to NGOs' analyses, the funding allocated to NGO-run day care services for PWDs constitute less than 50% of costs of service-running (including all costs necessary for licensed services, like staff costs, taxes, rental fees, utility bills etc.).[44] DPOs also noted that licensed service client numbers are often stagnant, in the words of an expert: '*if you got a license for a day care centre for say, 10 people five years ago, no matter how many others want to join, you will find it difficult to get a license for more clients. Even if you wanted more clients, you can't.*' This shows that the tri-annual application and official approval for client numbers does not always reflect on local needs.

Another issue featured in interviews was the lack of ackonwledgment of clients' care needs: the same funding is allocated for people with low support needs and those with higher, e.g. 24-hour care needs. Thus, current funding in the case of day care services may act as a gatekeeper, keeping many potential clients, especially those with higher support needs outside services, because providers, already short of resources, are motivated to 'fill up' services with clients with lower support needs (if they can).

39 Kozma et al., 2020.

40 Municipalities with over 10,000 inhabitants are obliged to organise day care services, but only 71% of these municipalities run centres.

41 Central Statistical Office, 2019

42 Kovács-Angel, 2019

43 Central Statistical Office (KSH), 2019. The number excludes day care services for 'psychiatric patients'.

44 For instance MEOSZ, 2017; Céhálózat, 2016 etc.

One interviewee working for a provider also stated that demand for day care services has been changing in recent years: people with low support needs are now more likely to find sheltered employment in some regions, and may leave day care services – at the same time more people with higher support needs are reported to apply for services.

Box 1 | Flat rates in residential social services

Calculation of flat rates in most residential social services is done through a rather complicated system, based on a sum set each year in Appendix 8. of Hungary's annual national Budget Act, for social care *'staff members' acknowledged average* [annual] *salary*' – this sum in 2020 was 3.858.040 HUF (approx. 10,700 EUR). Services receive funding for *one* '*average salary'* per *four* service users. Importantly, the Budget Act also sets out ***multipliers*** as to how this annual flat rate should be calculated in different services, as follows:

- ★ the multiplier in PWDs' long term residential care homes is 1,3;
- ★ in group homes for PWDs 1,5;
- ★ and in supported living services 1,19 to 1,50 (see explanation below); and in respite care/ temporary homes for PWDs 0,96.

Besides funding through this system, all licensed services are also eligible to receive a so-called 'wage supplement for staff in social care'.

Independent/Supported Living

Supported housing' ['támogatott lakhatás'] as a legally defined service was first introduced following legislative changes in 2013, after the Hungarian government declared its commitment to deinstitutionalisation in 2011[45]. The stated aim of supported housing is to help PWDs to live independently. Notably, this type of social service has a markedly different definition in Hungary than in many other countries in Europe.[46]

Supported housing can be provided to PWDs but also to psychiatric patients and those with drug or alcohol addiction. The service fee in these services can be up to 80% of the resident's monthly income. Since its establishment in 2013, the number of clients in supported housing services has been rising, from 220 clients in 2014 to 1,626 clients in 2018.[47] Thus, compared to the number of PWDs in residential institutions, supported housing services still account for only a small share of the market. There were only 116 people on waiting lists[48] for 'supported housing' in 2018[49]. Supported housing services are often run by large residential institutions (most of them owned by the state-run SZGYF), as well churches and non-governmental organisations. Data is not available about the share of different providers. According to interviewees, lack of data and monitoring/ transparency at state-run services makes it difficult to assess the quality and indeed the appropriateness of these services, to clients' needs.

Service providers can receive differentiated funding for clients in supported housing settings. Three different levels of clients' needs are recognised, based on individual needs assessments – each of these levels are matched with different levels of funding (see also Box 1.):

45 See for example: https://fszk.hu/szakmai-tevekenysegek/intezmenyi-ferohely-kivaltas/

46 Internationally, the term 'supported living' usually refers to living arrangements for a small number of people who receive social support independently from housing services. 'Supported living' in Hungary can be provided in houses and flats for up to twelve residents, but also in 'living centres' – units of residential institutions - for up to 50 people, and in most cases the same organisation is responsible for housing services and social support. For an academic analysis of differences see Kondor, 2018.

47 KSH, 2019

48 Experts report that authorities are not obliged to run and publish waiting lists. Thus available waiting lists do not reflect the real demand for social services – it is likely that the actual number of people waiting for services is much higher.

49 Kovács-Angel, 2019

- ★ Clients with 'normal' support needs is supported housing receive 119% of the flat rate;
- ★ Clients with 'high' support needs in supported housing receive 143% of the flat rate;
- ★ Clients with 'increased' support needs in supported housing get 150% of the flat rate set annually in Appendix 8. of the Budget Act.

A small number of supported housing services can be found in every geographical region but data is not available about their availability on local levels. Some interviewees claimed that, supported housing services often attempt to 'fill up' all beds with people with lower support needs, because the legally required minimum number of support workers low – for clients with high support needs extra personell need to be recruited which would not be covered by the available flat rate funding. Non-state providers claimed the flat rate funding only covers around 35-40% of all annual costs related to running of a supported housing service; service fees account for around 35% of costs. Due to better funding, the share of state-funding is higher, and the share of service fees is lower (around 30%) at church-run services. Working conditions for staff are usually fair in supported housing, mostly because these are new services in relatively new or refurbished buildings or flats.

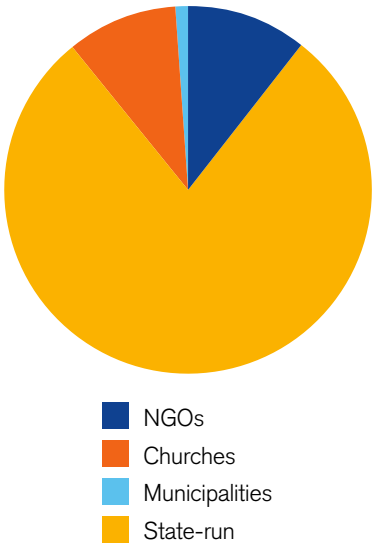
Notably, supported housing services in Hungary were heavily criticised be the UN Committee on the Rights of Persons with Disabilities in their 2019 inquiry report.[50] Among other issues, the UN CRPD inquiry report found that supported housing services in Hungary remain institutional in their nature, they are under the control of service managers, restrictions are in place on the private life of clients, and many clients do not get individualised support.[51] It is likely that current funding levels described above contribute to the shortcomings of supported housing services noted by the UN CRPD inquiry report.

Long Term Institutional Care

Hungary features a very strong sub-sector, with around 39,000 persons with disabilities who still live in residential institutions[52] including in residential institutions for persons with disabilities or social care homes for elderly people (KSH, 2015). The Hungarian government launched a deinstitutionalisation programme in 2011, that included a mid-term strategy aiming to move out 10,000 PWDs from residential institutions to the community. Consequent deinstitutionalisation programmes have relied on European Union Structural Funds.

Most residential institutions for PWDs (incl. persons with psychosocial disabilities, categorised ‚psychiatric patients' in social care), are run by the state through its directorate-general ‚SZGYF' (Chart 2.). NGOs (incl. non-profit enterprises, foundations, public foundations, and associations) run settings for 2,431 people and churches provide services for 2,200 clients, and. Municipalities' share with 213 clients is insignificant. In 2018, there were 1,766 people on waiting lists to residential care services for PWDs.[53]

CHART 2 | Clients in residential institutions in 2018 (N=22 761)[54]



50 See https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25799&LangID=E

51 See Art. 66 to Art. 70 of the UN CRPD Unquiry report. Report available at: http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2fPPRiCAqhKb7yhsmg8z0DXeL2x2%2fDmZ9jKJskcOPORsTebSnOJ4Cd0WGYL2TRl9Mj9TFm8%2b6vdTpXIiWRi4jazyDcI1TkNMlxua0imYcblMrwFj9gXpUkX%2bH%2bv

52 Halmos, 2019

53 Kovács-Angel, 2019

54 KSH, 2019

Funding long-term institutional care is calculated through the already mentioned flat rate-system (see Box 1.). In 2020, flat rate for long term residential institutions, including small group homes was 130% of the flat rate set out in the Budget Act: 3.858.040 HUF * 1,30 = 5.015.452 HUF (approx. 13.948 EUR) per four service users per year. State-run institutions, however, receive funding directly from ‚SZGYF' where the annual budget of institutions is related to client numbers but, according to interviewees, the calculation is mostly based on funding traditions, i.e. the budget of the previous year. The lack of transparency of budgetary matters of state-run institutions is represented by the fact that none of the interviewees (incl. those working at state bodies) were able to tell how the budget of state-run services is actually calculated. Remarkably, flat rates only cover about 25-30% of all costs at NGO-run services, and service fees paid by clients contribute to around 35% of all income. The rest of the annual budget comes from other sources such as grants, donations or one-time fees by clients who newly join residential services.

Conditions in state-run institutions were seen '*often miserable'* and '*sometimes medieval'* by interviewees, with anecodtes about care workers and their family members decorating/repainting wards themselves or staff members bringing their own used refrigerators to the institution for lack of purchase of a new one by the responsible state body. Many institution buildings are in a decayed state, and even though there are some refurbishments funded by SZGYF, directors of services often have little influence on how investments are planned and executed. This results in highly bureacratised projects where the final outcome (such as new furniture for clients or a renovated corridor) may not be appropriate to clients' or indeed staff' needs. Thus, working conditions in institutions were described by all interviewees 'usually horrible' with some exceptions – most interviewees claimed church-run and NGO-run services are more likely to be better than those run by the state. All interviewees talked about 'very long' working hours in institutions, and staff shortages are also reported due to many social care personell leaving to work elsewhere.

Respite care

Respite care services are somewhat insignificant in the social care sector for PWDs, with a small number of services and service users. Respite services are referred to as 'temporary homes for disabled people'. Temporary homes are residential social services in the form of temporary accommodation for those PWDs whose personal circumstances such as family background, personal problems or other issues do not allow them to stay in their own or their families' home. Service users in temporary homes also pay a service fee. The total nationwide capacity in such temporary homes is relatively small: 265 beds (2018)[55]. According to media reports, there were 42 people on waiting lists in 2018[56]. Data is not available about the share of different service providers (churches, municipalities etc.) of this sub-sector.

Several interviewees claimed that nearly all such temporary home beds are found within long-term residential institutions. In fact, both DPO representatives and providers claim that respite care services are closely related to long-term residential care. Quoting one interviewee: *'for the most part, temporary homes are a way to get into a long term residential care institution, because you can extend clients' stay in temporary homes as many times as you want – and then they just put them into long-term care'*.

Funding of 'temporary homes' is allocated based on flat rates set in the annual Budget Act. (see Box 1.) . In 2020, the flat rate was 3.858.040 HUF * 0.97 = 3.742.298 HUF (approx. 10.47 EUR) per four service users per year (plus wage supplements allocated for social care sector workers).

55 There were 226 service users in 2018. (Central Statistical Office, 2019)

56 Kovács-Angel, 2019

Interviews

- ★ Tibor Migács, Senior Trade Union Official, Interview on 10th of December, 2020
- ★ Anna Kazinczi, DPO representative at *ÉFOÉSZ* Central Hungary Regional Public Benefit Association, Interview on 11th of December, 2020
- ★ Katalin Monostori, NGO Service Provider and Senior Expert at the Equal Opportunities Foundation, Interview on 10th of December, 2020
- ★ Erzsébet Szekeres, NGO Service Provider and Senior Expert at the Equal Opportunities Foundation, Interview on 10th of December, 2020
- ★ Barbara Hajdú, NGO Service Provider and Senior Expert at the Equal Opportunities Foundation, Interview on 10th of December, 2020
- ★ Anonymous Ministry Expert and Regulator, Interview on 27th of November, 2020 Anonymous Senior Social Policy Expert at the State Body, Interview on 3rd of December, 2020
- ★ Anonymous Director of State-run Long Term Care Institution and Provider, Interview on 4th of December, 2020
- ★ Anonymous Director of Church-run Long-Term Care Institution & Supported Housing and Provider, Interview on 11th of December, 2020
- ★ Anonymous Director of a Church-run Social Service and Provider, Interview on 11th of December, 2020

References

Relevant laws:

1993. évi III. tv. a szociális igazgatásról és szociális ellátásokról

1997. évi CXXIV. tv. az egyházak hitéleti és közcélú tevékenységének anyagi feltételeiről

1999. évi LXX. tv. a Magyar Köztársaság és az Apostoli Szentszék között a Katolikus Egyház magyarországi közszolgálati és hitéleti tevékenységének finanszírozásáról, valamint néhány vagyoni természetű kérdésről 1997. június 20-án, Vatikánvárosban aláírt megállapodás kihirdetéséről [the Vatican Concordat]

191/2008. (VII.30.) Korm. rendelet a támogató szolgáltatás és a közösségi ellátások finanszírozásának rendjéről

226/2006. (XI. 20.) Korm. rendelet a szociális, gyermekjóléti és gyermekvédelmi szolgáltatók, intézmények ágazati azonosítójáról és országos nyilvántartásáról

29/1993. (II. 17.) Korm. rendelet a személyes gondoskodást nyújtó szociális ellátások térítési díjáról

489/2013. (XII. 18.) Korm. rendelet az egyházi és nem állami fenntartású szociális, gyermekjóléti és gyermekvédelmi szolgáltatók, intézmények és hálózatok állami támogatásáról

321/2009. (XII.29.) Korm. rendelet a szociális szolgáltatók és intézmények működésének engedélyezéséről és ellenőrzéséről

1/2000. (I. 7.) SzCsM rendelet a személyes gondoskodást nyújtó szociális intézmények szakmai feladatairól és működésük feltételeiről

9/1999. (XI. 24.) SzCsM rendelet a személyes gondoskodást nyújtó szociális ellátások igénybevételéről

Literature:

Balázs, Zs., & Petri, G. (2010). Az autizmussal élőket segítő magyarországi civil ellátórendszer kialakulása./ Organisations helping people with autism in Hungary and their role in the development of policies and services. *Budapest: SCOLAR*, 36-77. Available at: https://www.researchgate.net/publication/338886522_Az_autizmussal_eloket_segito_magyarorszagi_civil_ellatorendszer_kialakulasa

Bernát, A., Simonovits, B., Kozma, Á., & Kopasz, M. (2017). Értelmi fogyatékossággal élő felnőttek életminősége intézetben, lakóotthonban és magánháztartásban. *Esély folyóirat*, *28*(5), 31-66.

Bugarszki Zs. (2004*): A szociális szolgáltatások újjászületése Magyarországon*. Esély, 2004/4. 100–110.

Bugarszki, Zs. (2010) A jelenleg Magyarországon a „szociális" szektorban használt tervezési eszköztár áttekintése, kritikai értékelése. TÁMOP 5.4.1. keretében a Magyar Addiktológiai Társaság megbízásából. Downloaded from http://www.mat.org.hu/dok/pdf/00114.pdf

Céhálózat (2016). *Az állami normatív támogatás alakulása*. Downloaded from http://www.cehalozat.hu/sites/default/files/osszehasonlitas2015.pdf

Central Statistical Office ('KSH') (2019). Yearbook of Social Statistics. Budapest: KSH.

Czibere, K. & Mester, D. (2020). A magyar szociális szolgáltatások és főbb jellemzőik 1993 és 2018 között. In. Kolosi, T., Szelényi, I. & Tóth, I. Gy. (eds.) *Társadalmi Riport 2020*, 434-449. Budapest: TÁRKI.

Goldmann R., Gyetvai G., & Mester D. (2016): A szociális ellátórendszer jellegzetességei, korprofilja és területi megoszlása. Megjelent: Kolosi T.—Tóth I. Gy. (Eds.): Társadalmi Riport 2016. Tárki, Budapest. Available at: http://old.tarki.hu/hu/publications/SR/2016/17goldmann.pdf

Greskovits, B. & Scharle, Á. (2019). A szociális alapszolgáltatások bővítésének lehetséges költségei. Budapest: BUDAPEST INTÉZET.

Halász, A., Kőműves, Zs., Nagy E., & Reszkető, E. (2013). *Szociális alapszolgáltatások és gyermekjólléti alapellátások finanszírozása.* Budapest: Budapest Institute. [Authors' copy]

Halmos, Sz. (2019). *Támogatott életvitel és támogatott döntéshozatal – a CRPD 12. és 19. cikkének konzisztens végrehajtásának lehetőségei Magyarországon*. Pázmány Law Working Papers, Pázmány Catholic University, Budapest. Available at http://plwp.eu/files/2019-03Halmos.pdf

Havasi, V. (2017) A történelmi egyházak társadalmi szerepvállalása — szociális ellátás és gyermekvédelem. In. Szabó-Tóth, K. & Várhelyi, K. (eds.) *Történelmi egyházak — modern társadalom.* Budapest: L'Harmattan.

Horváth, T. M. (2016). From municipalisation to centralism: Changes to local public service delivery in Hungary. In *Public and Social Services in Europe* (pp. 185-199). London: Palgrave Macmillan.

Kiss, J., & Mihály, M. (2019). *Social enterprises and their ecosystems in Europe*. Updated country report: Hungary. Luxembourg: European Commission.

Kondor, Zs. (2018). Közösségi lakhatás-e Magyarországon a támogatott lakhatás? PhD Dissertation. Available at: https://edit.elte.hu/xmlui/handle/10831/42350

Kovács-Angel, M. (2019) Mélyponton a szociális ellátás: 34 ezer rászoruló a várólistán. 24.hu. Available at https://24.hu/fn/gazdasag/2019/01/08/szocialis-varolista-rekord/

Kozma, Á., Petri, G., & Bernat, A. (2020). Kiszolgáltatottság és stagnálás: fogyatékos emberek társadalmi helyzete a 2010-es években. In. Kolosi, T., Szelényi, I. & Tóth, I. Gy. (eds.) *Társadalmi Riport 2020*, 434-449. Budapest: TÁRKI. Available at: https://www.tarki.hu/sites/default/files/2020-10/381_403_Kozma_Petri_Bernat_Online.pdf

MEOSZ (2017). Előterjesztés – Intézményi normativa. Downloaded from: http://www.meosz.hu/wp-content/uploads/2019/02/1.-sz-melleklet-eloterjesztes-intezmenyi-normativa2017.pdf

Mladenov, T. (2017). Postsocialist disability matrix. *Scandinavian Journal of Disability Research*, *19*(2), 104-117. doi.org/10.1080/15017419.2016.1202860

Semjén, A., Le, M., & Hermann, Z. (2018). The Goals and Consequences of the Centralization of Public Education in Hungary. *Acta Educationis Generalis*, *8*(3), 9-34.

Turnpenny, Á. (2019). People with intellectual disabilities in the European semi-periphery: the case of Hungary. In. Walmsley, J. & Jarrett, S. (Eds.) *Intellectual Disability in the Twentieth Century: Transnational Perspectives on People, Policy, and Practice*. Bristol: Policy Press, 113-129.

United Nations Committee ont he Rights of Persons with Disabilities (2020). *Inquiry concerning Hungary under article 6 of the Optional Protocol to the Convention – Report from the Committee.* Downloaded from https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeCategoryID=7

EASPD is the European Association of Service providers for Persons with Disabilities. We are a European not-for-profit organisation representing over 17,000 social services and disability organisations across Europe. The main objective of EASPD is to promote equal opportunities for people with disabilities through effective and high-quality service systems.

EASPD

IMPROVING SERVICES
IMPROVING LIVES

European Association of Service providers for Persons with Disabilities
Handelstraat 72 Rue du Commerce, B-1040 Brussels
+32 2 233 77 20 | info@easpd.eu | www.easpd.eu

Follow our work on

Easpd Brussels

@EASPD_Brussels

EASPD