Structure of the Personal Social Services in Hungary[1]

Prof. Dr. István Hoffman
Eötvös Loránd University (Budapest, Hungary), Faculty of Law, Department of Administrative Law
Marie Curie-Skłodowska University (Lublin, Poland), Faculty of Law and Administration, Department of Public International Law
hoffman.istvan@ajk.elte.hu
i.hoffman@poczta.umcs.lublin.pl

ABSTRACT
The article reviews the changes of the service provision system, especially the structure of the Hungarian social care. Firstly, theoretical and international backgrounds of the topic are shown. Secondly, the article presents the transformation of the Hungarian social care in the last decades. Here, a tendency of concentration and centralisation can be observed. Thirdly, the mixed nature of the Hungarian municipal social care system is analysed, which system have been strongly centralised in the last five years. The effects of the centralisation are analysed as well, the article shows, that the changes of the funding have the most significant impact on the spatial structure of the service provision.
Key words: social care, municipal social care, funding, centralisation, concentration, spatial structure

1. Introduction: hypothesis and research method

In Hungary, the system of the social care has changed radically in the last decade. The system was originally based on a strong, but fragmented municipal system. The main goal of the transformation of the system in the last decade has been firstly to maintain the grassroots model of the Hungarian social care. Secondly the reforms have tried to solve the problem of economies of scale. This article will examine the regulatory methods and the related budgetary support system applied for this aim. Thus, the primary method of the research is jurisprudential, but the effects of the regulation and the practical outcome of the new support system will also be analysed.

Firstly, the article will review the main models of the social care. This comparative review is very useful, because different administrative systems and paradigms have different concepts on spatial structure of these services. After a short comparative review, the jurisprudential and budgetary analysis will then show the transformation of the social care system and the paradigm-shift of these services after 2011/12. Finally, the effects and impacts of the partly centralised model will be examined by this article.

2. Social care and local governments

The role of the municipalities is significant in the welfare states in the field of personal social services. However the social care is partly or fully based on these local entities several models have been evolved.[2]

The models can be characterised by different methods, because these systems are impacted by the welfare model of the given country, by the municipal model and by the spatial structure, as well.[3]

The characterisation of these models of my chapter is based mainly on *the role of the municipalities* and on the *spatial structure of the service provision.* Thus *decentralised and centralised models* can be distuingished.

2.1. Decentralised model

The decentralised model is based on the main service provision role of the *municipalities.* In this model the local governments are mainly responsible for the social care services, the agencies of the central government have just limited tasks.

Two main types of the decentralised model can be distinguished: the first one is the local community centred model which is based on the prominent role of the 1st tier municipalities and the regional centred model in which the most important services are organised and provided by the regional (2nd tier government). The inter-municipal cooperations are mainly correctional they are very important in the community centred model.

[1] This article is based on the investigations of the research project „Restricting the legal capacity of adults in Hungary" No. OTKA FK 132513 (leader of the project: Prof. Dr István Hoffman) supported by the research grant of the Hungarian National Research, Development and Innovation Office.

[2] Lőrincz, L. *A közigazgatás alapintézményei.* Budapest : HVG-Orac, 2005. Pp. 191–194.

[3] Hoffman, I. A személyes jellegű szociális szolgáltatások igazgatása // In: Horváth, T. M. and Bartha, I. (eds): *Közszolgáltatások megszervezése és politikái. Merre tartanak?* Budapest and Pécs : Dialóg Campus, 2016. Pp. 330–332.

2.1.1. Local community centred model

The social care is primarily organised by the local (1st tier) municipalities in the countries of the *local community centred.* These local social services are mainly basic social care services (e.g. home care, catering). In this model the role of the regional (2nd tier) municipalities are just additional, those services are organised by the regional (2nd tier) municipalities which cannot be provided by the local communities (especially several special, residential, in-patient social care services).

Although this type of the service provision is based on the dominant role of the local (1st tier) municipalities, two subtypes were resulted by the different spatial and municipal system of the given countries.

Large, concentrated municipalities with broad service provision responsibilities: the Nordic model * The *Nordic (Scandinavian) countries* can be classified as examples of the local community based model. In *Sweden* the Social Services Act (SFS 2001: 453) makes clear that *only* the 1st tier local governments are responsible for the provision of the social services.[4] *Finland* developed a model similar to the Swedish one.[5]

Denmark and Norway have a mixed model because the communities (1st tier municipalities) are responsible for the basic social care but and the majority of the residential (in-patient) social care services but the regional (2nd tier) municipalities have relevant competences because the residential services of children protection and the alcohol and drug addicts are provided by these municipalities.

Community centred model with the additional responsibilities of the regional municipalities and the inter-municipal cooperations * The majority of the European countries follow this model therefore countries with different municipal and welfare model belongs to this. In these states — having regard to their mainly Bismarckian (Continental) welfare model — the social services provided by the municipalities are typically means-tested and these services have a complementary role.

Some countries with *Latin (French) local government type* can be classified into this model as well, for example *Italy* and *Belgium.* In *Italy* the settlement-level municipalities *(comune)* are primarily responsible for the provision of the social services including elderly care, child and youth protection and helping people with disability. The regional municipalities *(regione)* have a regulatory and coordinating role in the field of these services. Because of the wide range of municipal tasks the Italian public law developed legal institutions for the general correction of the economy of scale problems. These legal institutions are the typically — exceptionally compulsory — inter-municipal associations. These tendencies were strengthened by the reform of the *legge Delrio* (2014)[6] by which the establishment of the different type service provision inter-municipal associations have been encouraged.[7]

In *Belgium* the community governments are primarily responsible for the provision of the social care. The municipal social services are organised by the public centres for social welfare *(openbare centra voor maatschapelijk welzijn / centres publics d'aide sociale)*, regardless of the region to which the municipalities belong.[8] The centres are professionally independent from the municipalities, but their budgets are approved by the local councils[9]. Although the number of the Belgian local municipalities *(gemeente / commune)* was significantly reduced during the 1970s, the inter-municipal associations have been institutionalised by the Belgian administrative law for the correction of disparity in size between the settlements. The Belgian regions, which can be considered as member states of a federation, are responsible for the higher-cost services.[10]

In *Slovakia* the local municipalities are responsible for the non-residential (basic) social care and the regional municipalities, the districts *(kraj)* are responsible for the residential social services and for the services of child protection.[11] The *Czech Republic* has chosen a similar model. *Poland* has a special

---

[4] Strönholm, S. *An introduction to Swedish law.* Stockholm : Norstedts, 1981. P. 93; Thakur, S. et al. *Sweden's welfare state. Can the bumblebee keep flying?* Washington D. C. : International Monetary Found, 2003. P. 8.

[5] Niemelä, H., Salminen, K. *Social security in Finland.* Helsinki : Finnish Centre for Pensions, 2006. Pp. 17–18.

[6] Legge Delrio — Italian law dated April 7, 2014 No. 56 as amended by Laws dated June 23, 2014 No. 89 and August 11, 2014 No. 114, which reorganized the local government system and amended the powers of local administrations. — Approx ed.

[7] Vandelli, L. *Città metropolitane, province, unioni, e fusioni di communi. La legge Delrio, 7 aprile 2014, n. 56 commentata comma per comma.* Santarcangelo di Romagna : Maggioli, 2014. Pp. 125–145.

[8] Bocken, H., de Bondt, W *Introduction to Belgian law.* Kluwer Law International, 2001. P. 70.

[9] Aerts, Y., Siegmund, H. *Kommunalpolitik in Europa //* in Belgium, In Wehling, H. G. (ed.). Berlin, Stuttgart and Köln : Verlag V. Kohlhammer, 1994. P. 110.

[10] Supra note 7. Pp. 70–71.

[11] Nižňanský, V. *Verejná správá na Slovensku*. Bratislava : Government of Slovakia, 2005. P. 56; Malikova, L. Regionalization of Governance: Testing the Capacity Reform // In: Baldersheim, H. and Batora, J. (eds.): *The*

position among the Visegrád countries considering its larger area and arger population[12]. The Polish local government system is a three-tier system. The 1st tier municipalities (communities — *gminy*) are responsible for the non-residential social and child protection services. The provision of the expensive residential services belongs to the competences of the 2nd tier municipalities, to the districts *(powiaty)*. The Voivodships as 3rd tier municipalities do not have any competences in the field of social services. The inter-municipal associations do not have significant role in the Polish municipal system because of the concentration of the municipalities.[13]

2.1.2. Regional municipality centred model

The social care system of the *United Kingdom* can be characterised as a regional municipality centred one. The — professionally independent — local social authorities of the county councils and unitary councils are responsible for the provision of the social services.[14] The reforms encouraged by the New Public Management in the 1980s and 1990s altered the role of the local governments significantly: they became organizers instead of being providers.[15] The private sector has played an increasingly important role in the change. The *competitive compulsory tendering (CCT)* was introduced by the selection of social care provider. As the result of the reforms the local governments became the "managers" of the services instead of their former providers.[16] This model has not been transformed significantly by the reforms of the Labour Party Government of the Millennium.[17]

2.2. Centralised model

Primarily, *Germany* can considered as one of the example of the centralised model. Article 3 of 12th Book on personal social assistance of the Social Code *(Sozialgesetzbuch — SGB)* states that personal social assistance is provided by the designated municipal bodies and the designated administrative bodies above the local tier. As principle the local administrative bodies responsible for the social care are the German *Landkreise* (the county-like districts of Germany[18], and the unitary councils *(kreisfreie Städte)* — if the provincial social law *(Landessozialrecht)* does not make an exception[19]. The provinces *(Länder)* can designate the bodies responsible for regional *(überörtlich)* services. The provinces (*Bundesländer)* are empowered by the Article 99 of the 12th Book of SGB to design the local municipalities *(Gemeinde)* and the– typically obligatory — inter-municipal associations *(Gemeindeverbände)* to provide several, basic personal social services. The 12th Book of SGB determines that — if a provincial acts did not have other regulation — the administrative level above the German counties (*Kreise)* (the so called *überörtlich* level) is responsible for the care for disabled and blind people, for nursing and care services and for the statutory defined social services in the event of crises.[20] Thus the provinces, the Member States of the German federation have the most important role in the field of personal social services.[21]

Bavaria has chosen a specific solution, which — as the largest German province — has developed not a two, but a three-tier local government system: the seven districts *(Bezirke)* are self-government units.[22] Social care (assistance) tasks have been shared between the under intermediate level counties

Governance of Small States in Turbulent Times: The Exemplary Cases of Norway and Slovakia. Opladen : Barbara Budrich Publishers, 2012. P. 210.

[12] The Visegrad Four, or V4, is a cultural and political union of four Central European countries — the Czech Republic, Hungary, Poland and Slovakia. — Approx. ed.

[13] Wollmann, H., Lankina, T. Local Government in Poland and Hungary: from post-communist reforms towards EU-accession // In Baldersheim H. et al. (eds.), *Local Democracy in Post-Communist Europe*. Opladen : Leske + Budrich, 2003. P. 106.

[14] Arden, A., Manning, J., Collins, S. *Local Government Constitutional and Administrative Law.* London : Sweet & Maxwell, 1999. Pp. 103–104.

[15] Jones, B., Thompson, K. Administrative Law in the United Kingdom // In Seerden, R. and Stroink, F. (eds.), *Administrative Law of the European Union, Its Member States and the United States. A Comparative Analysis.* Antwerpen — Groningen : Intersentia, 2007. P. 232.

[16] Wilson, D., Game, C. *Local Government in the United Kingdom.* Basingstoke & New York : Palgrave Macmillan, 2011. Pp. 135–136.

[17] Healy, J. The Care of Elder People: Australia and the United Kingdom // *Social Policy and Administration. 2002. Vol.* 36. Issue 1, pp. 6–8. DOI: 10.1111/1467-9515.00266

[18] Steiner, U. *Besonderes Verwaltungsrecht.* Heidelberg : C. F. Müller, 2006. Pp. 147–148.

[19] Waltermann, R. *Sozialrecht.* Heidelberg : C. F. Müller, 2009. P. 129.

[20] Eichenhofer, E. *Sozialrecht*. Tübingen : Mohr Siebeck, 2007. P. 298.

[21] Baron v. Maydell, B., Ruland, F., Becker, F. *Sozialrechtshandbuch*. Baden-Baden : Nomos, 2008. P. 408

[22] Reiners, M. *Verwaltungsstrukturreformen in den deutschen Bundesländern. Radikale Reformen auf der Ebene der Staatlichen Mittelinstanz*. Wiesbaden : VS Verlag für Sozialwissenschaften, 2008. P. 154.

(Kreis) and unitary councils *(kreisfreie Städte)* and the upper intermediate level district *(Bezirke)* municipalities.

It is shown by the short international outlook, that the local level has very important role in the field of the provision of personal social services. Even the local municipalities of the countries of the centralised model could have responsibilities in this field. It is clear, that the spatial structure of these welfare services is deeply impacted by the spatial structure of the given country, especially the spatial structure of the municipalities.

After the review of the main models of the spatial structure of the personal social services, the Hungarian system will be review, but firstly the frameworks of the Hungarian system will be analysed.

3. Social care in Hungary

This part of my chapter is based on a jurisprudential analysis. Firstly, I would like to review the framework of the Hungarian social care system, especially the changes and the role of the municipalities in the Hungarian public service provision system. After that I would like to review shortly the changes of the social care services and Hungary and finally, I would like to show shortly the reform of the personal social service system. This analysis could show the main factors of the recent spatial structure system.

3.1. Hungary: a country with a fragmented municipal system

Hungary has a fragmented spatial structure. The majority of the Hungarian municipalities had less than 1,000 inhabitants in 2010 (see Table 1).

Table 1

Population of the Hungarian municipalities (1990-2010)

Year	0–499	500–999	1,000–1,999	2,000–4,999	5,000–9,999	10,000–19,999	20,000–49,999	50,000–99,999	100,000–	All
	Inhabitants									
1990	965	709	646	479	130	80	40	12	9	3,070
2000	1,033	688	657	483	138	76	39	12	9	3,135
2010	1,086	672	635	482	133	83	41	11	9	3,152

Source: Szigeti[23], 2013, p. 282

Therefore the provision of local public services — included the personal social services — in Hungary has been based on this condition, and the (inter-communal) cooperation has a significant role.

3.1.1. Personal social services before 1945

In the 19th century when the modern Hungarian public administration evolved the personal services have only limited significance. Only the framework of the services for poor and the children protection were established. This fragmented and residual system was based on the communities which have a limited self-governance under the supervision of the county municipalities[24].

3.1.2. Social services of the Soviet-type administration

After the World War II a Soviet administrative system evolved in Hungary. The administration radically changed after 1950. The self-governance of the communities, towns and counties was terminated and the former intercommunal associations were liquidated[25], as well. Social administration was a void territory of the Hungarian public administration. Firstly, the social benefits were "taboos" in the Soviet type system, because it was an axiom of the Communist regime that poverty was liquidated by the Socialism. The personal social services and the social insurance remained public administration tasks[26]. This model changed after the reforms of 1968, the significance of the personal social services increased.

[23] Szigeti, E. A közigazgatás területi változásai // In. Horváth, T. M. (ed.): *Kilengések. Közszolgáltatási változások.* Budapest and Pécs : Dialóg Campus, 2010. P. 282.

[24] Hoffman, I. *Önkormányzati közszolgáltatások szervezése és igazgatása.* Budapest : ELTE Eötvös Kiadó, 2009. Pp. 89–90.

[25] Ibid. Pp. 105–109.

[26] Krémer, B. *Bevezetés a szociálpolitikába.* Budapes : Napvilág, 2009. P. 126.

Although merging communities was an important element of the public service provision reforms, the intercommunal associations were reborn. A dual system evolved: the local councils (1st tier) were responsible for the basic social care and the county councils (2nd tier) were responsible for the residential (in-patient) social care. The main element of this system were the large institutions by which primarily residential social care was provided. During the 1980s the frameworks of the social administration were stabilised.

3.1.3. Democratic Transition and the reborn of the social administration system

In 1990 a new, local government system was established by the Amendment of the Constitution and by the Act LXV of 1990 on the Local Self-Governments (hereinafter: Ötv). This system was a two-tier, but local-level centred system. The first tier was the local (community) level. According to the Ötv villages, large villages, towns, county towns and Budapest as the capital city were considered as local-level governments (municipalities). The second tier was the county level. The county local governments had an intermediate service-provider role, but the county-level service delivery could largely be overtaken by the municipalities. The local-centred nature of the Hungarian local government system was strengthened by the system of voluntary inter-municipal associations.[27].

In 1993 the Act III of 1993 on the Social Administration and on the Social Benefit was passed. The municipal social benefits and the personal social services has been regulated by this act. A new, local level centred model have been evolved. The local municipalities — the communities and the towns — were responsible for the basic social services and the counties and the towns with the status of the counties were responsible for the residential social care. The local municipalities could take over the provision of the residential social care. The main provider was the local level and the counties — as regional municipalities — had practically supplementary tasks: the residential social care was provided by them if the local municipalities could not organise the provision of these services.[28]

3.1.4. Institutionalisation and dysfunctional phenomena

Although the act on social administration and benefits was passed in 1993 the institutionalisation of the new service system required years. As I have mentioned earlier, the personal social service provision was based on the great institutions before 1990.[29] Thus the system of the local basic services evolved in several steps.

Practically, the period of the institutionalisation of these services ended to the Millennium, therefore after 2000 the dysfunctional phenomena of the new system could be analysed. These dysfunctions were related to the general dysfunctions of the new municipal system. After 1990 a local tier centred, and fragmented local government system evolved in Hungary in which model the major responsibilities belonged to the communities and towns. This fragmented spatial structure was strengthened by democratic changes, as a counterpart to former Communist times: where compulsory inter-municipal associations (the above presented common village councils) treated size inefficiency problems. This compulsory form was unpopular among Hungarian municipalities; therefore, it disappeared with the democratic changes, giving opportunity to a disintegration tendency in the transition period.[30]

This fragmentation and the related size inefficiency problem was tried to be solved by inter-municipal cooperation which was based on voluntary cooperation. The new types of associations could not stop the disintegration because of their purely voluntary nature and the poor financial support provided by the central budget. Therefore, the number of service provider associations was only 120 in 1992. The joined municipal administrations decreased in these years: the number of common municipal clerks was 529 in 1991, 499 in 1994, and only 260 administrative inter-municipal associations were established until 1994[31]. The lack of intercommunal cooperation, the fragmented spatial structure, and the weak, subsidiary intermediate level public service provider role of the county local governments resulted in significant service delivery dysfunctions. The local self-governments — especially the small villages which were the majority of the Hungarian municipalities — were not able to perform a significant part of the municipal tasks. In 2005 the most basic social services — social catering and social home care — was

[27] Verebélyi, I. (ed.) *Az önkormányzati rendszer magyarázata*. Budapest : KJK-Kerszöv, 1999. Pp. 30-36

[28] Velkey, G. Központi állam és a helyi önkormányzatok, In: Ferge, Zs. (ed.): *Magyar társadalom- és szociálpolitika 1990–2015.* Budapest : Osiris, 2017. Pp. 128–133.

[29] Ibid. Pp. 126–128.

[30] Hoffman, I. *Önkormányzati közszolgáltatások szervezése és igazgatása.* Budapest : ELTE Eötvös Kiadó, 2009. Pp. 130-132.

[31] Hoffman, I. A helyi önkormányzatok társulási rendszerének főbb vonásai // *Új Magyar Közigazgatás. 2011. Vol.* 4 (1), Pp. 30-31.

not performed by 725 municipalities, by almost a quarter of the municipalities in Hungary.[32] The municipal social services were mandatory municipal tasks; therefore they should be performed and the performance has been supported by the central budget. The share of the central grants was just limited, in 2006 50,4% of the municipal social expenditures on basic social services were financed by the central grants[33]. The small communities which have only limited own revenues could just hardly perform their tasks.

Although there were service deficiencies in the field of basic social services, the residential social care was relatively well organised as a heritage of the former service provision system. The service deficiencies in basic care resulted a dysfunctional phenomenon: people who required basic care were provided by residential care because the basic social care was not available for them[34]. Another problematic element was the so called 'care need' test: this test was performed practically by the institutions, by the providers, therefore it was not an independent one and the remedies against the decisions were limited.[35]

Therefore a consensus evolved at the Millennium among the Hungarian experts: reforms are required.

3.2. The reforms of the social care

3.2.1. The first step: new forms of municipal cooperation (2005-2007)

The first step of the reforms was related to the municipal reforms. Firstly, at the end of the 1990s the institutions of the various inter-municipal associations were regulated, and new, additional state subsidies were introduced to accelerate the formation of voluntary inter-municipal associations after 1997.[36] As a result of these changes, the number of inter-municipal associations radically increased (see Table 2).

Table 2

Number of the inter-municipal associations responsible for public service provision between 1992 and 2005

Year	Number of the inter-municipal associations responsible for public service provision
1992	120
1994	116
1997	489
1998	748
1999	880
2003	1,274
2005	1,586

Source: Belügyminisztérium, 2005: 205[37]

In 2004, the legislator introduced a new type of inter-municipal association — the multi-purpose micro-regional association — based on the French inter-municipal association form 'SIVOM'. The central government significantly supported service delivery through associations: in 2004, the share of the special subsidies for them was 1.19% of the whole central government subsidies for local governments, and in 2011 it already reached 2.91%.[38]

---

[32] Rácz, K. Szociális feladatellátás a kistelepüléseken és a többcélú kistérségi társulásokban // In: Kovács, K. & Somlyódyné Pfeil, E. (eds.): *Függőben. Közszolgáétatás-szervezés a kistelepülések világában.* Budapest : KSZK ROP 3.1.1. Programigazgatóság, 2008. P. 191.

[33] Ibid. P. 189.

[34] Krémer, B., Hoffman, I. Amit a SZOLID Projekt mutat. Dilemmák és nehézségek a szociális ellátások, szolgáltatások és az igazgatási reformelképzelések terén, 2005. *Esély* 16 (3), P. 35.

[35] Ibid. Pp. 50–51.; Rozsnyai, F. K. Current Tendencies of Judicial Review as Reflected in the New Hungarian Code of Administrative Court Procedure // *Central European Public Administration Review. 2019. Vol.* 17 No. 1. Pp. 9–10.

[36] Balázs, I. 'L'intercommunalité en Hongrie' // in Steckel-Assouère, M. C. (ed.), *Regards croisés sur les mutations de l'intercommunalité*. Paris : L'Harmattan, 2014. P. 428.

[37] Belügyminisztérium: *A helyi önkormányzati rendszer tizenöt éve. 1990–2005. 15 év a magyar demokrácia szolgálatában*. Budapest : BM Duna Palota és Kiadó, 2005.

[38] Hoffman, I. A helyi önkormányzatok társulási rendszerének főbb vonásai // *Új Magyar Közigazgatás. 2011. Vol.* 4 (1). P. 31.

3.2.2. Partial reforms of the personal social services

In 2007 a partial social service reform was passed by the Hungarian Parliament. The reform act amended the act on social administration and benefits. The decentralised, local level centred model remained but the partial reform tried to solve several problematic elements of the service delivery system. The funding of the services has been partly transformed: the share of the central funding in the field of the basic social services was increased, which resulted the fast increase of the recipients of the basic social services. For example, in 2007 45 989 persons were performed by social home care but 48 120 persons were performed in 2008 and 63 392 persons were performed in 2009 (KSH, 2017[39]). The service delivery tasks of the inter-municipal associations were encouraged by the funding reform, as well. The share of the grant for the joint service provision was increased.

The care need test was amended as well. A new model was established: the care need test was performed by an independent commission which was organised by the chief public servants of the town municipalities (by the town clerks — *jegyző).* The detailed conditions of the test were regulated by a ministerial decree and this regulation tried to objectivise the test.[40]

3.2.3. The effects of the constitutional and municipal reforms. The age of centralisation after 2011

The former municipal regulation was changed radically, the former decentralized model has been transformed by the new Constitution — the Fundamental Law of Hungary — and by the new Municipal Code — the Act CLXXXIX of 2011 on the Local Self-Governments of Hungary (hereinafter Mötv). The local service performance role of the municipalities has been weakened, and the scope of the tasks has become narrower. The legislator is allowed to reduce the local government tasks by the new regulation. Due to this remodelling, the concentration of the municipal local services has partially lost its significance. The regulation on voluntary tasks has been changed, as well. A simple model has been chosen by the central government to reduce the fragmentation of the public service system: the most problematic service provisions were centralized and now they are performed by the local agencies of the central governments. The local government tasks have been significantly reduced, which is reflected by the size of the local government expenditure: before the reforms, in 2010 the total local government expenditure was 12.8% of the GDP, while in 2016 it was 8.1% only (see Table 3).

Table 3

Local government total expenditure in Hungary (in % of the GDP) 2002–2015

Year	2002	2006	2010	2011	2012	2013	2014	2015
Local government total expenditure (in % of the GDP)	12.9%	13.0%	12.8%	11.6%	9.4%	7.6%	7.9%	8.1%

Source: Eurostat, 2016[41]

The main tasks of the education, inpatient care, residential social care and residential child protection are performed by the agencies of the central government[42].[43] The county municipalities lost their tasks in the field of social services (included the services of children protection). Although the basic social services are provided by the local level municipalities and several residential care in the field of

[39] Központi Statisztikai Hivatal (2017): *Éves társadalomstatisztikai adatok 2000–2016* [Electronic resource]. URL: http://www.ksh.hu/docs/hun/xstadat/xstadat_eves/i_fsi002b.html?down=644 (date of access: 17.06.2017) (KSH, 2017).

[40] Rácz, K. Szociális feladatellátás a kistelepüléseken és a többcélú kistérségi társulásokban // In: Kovács, K. & Somlyódyné Pfeil, E. (eds.): *Függőben. Közszolgáétatás-szervezés a kistelepülések világában.* Budapest : KSZK ROP 3.1.1. Programigazgatóság, 2008. Pp. 193-194.

[41] Eurostat (2016): *Total Government Expenditures* [Electronic resource]. URL: http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do;jsessionid=9ea7d07e30dcd247b519937c4d909261df02fe3369b7.e34MbxeSahmMa40LbNiMbxaMchmTe0?tab=table&plugin=1&pcode=tec00023&language=en (date of access: 17.06.2017).

[42] Fazekas, J Central administration // In Patyi, A. & Rixer, Á. (eds.): *Hungarian Public Administration and Administrative Law.* Passau : Schenk Verlag, 2014. Pp. 298–301.

[43] The main tasks of the education, inpatient care, residential social care and residential child protection are performed by these agencies. The maintenance of the state-run schools belongs to the responsibilities of the Klebelsberg Maintainer Center which is a central agency with district and county level bodies. The residential social care and children protection institutes are maintained by the county agencies of the Directorate General of the Social and Children Protection. The inpatient health care institutions are maintained by the National Healthcare Service Center. Thus the local governments are mainly responsible for the settlement operation, for the maintenance of the kindergartens, for basic social care, for basic services of child protection, and for cultural services (Balázs & Hoffman 2017: 12-13).

elderly care can be performed by these communities, the majority of the provision of residential care was nationalized. The majority of the providers of residential social care and the children protection institutes are maintained by the county agencies of the Directorate General of the Social and Children Protection which is an agency of the Ministry of Human Capacities.[44]

The transformation of the role of the central administration can be observed by the change of total expenditure of the budgetary chapter — practically the sectors — directed by the Ministry of Human (formerly National) Capacities (see Table 4).

Table 4

Total expenditures (in million HUF) of the budgetary chapter directed by the Ministry of Human Capacities

Year	Total expenditures (in million HUF) of the budgetary chapter directed by the Ministry of Human (formerly National) Resources
2011	1,535,370.6
2012	1,949,650.5
2013	2,700,363.9
2014	2,895,624.8
2015	3,049,902.2
2016	3,011,947.7

Source: Act CLXIX of 2010 on the budget of the Republic of Hungary, Act CLXXXVIII of 2011, Act CCIV of 2012, Act CCXXX of 2013, Act C of 2014 and Act C of 2016 on the central budget of Hungary

Inflation rate was 3.9% in 2011, 5.7% in 2012, 1.7% in 2013, and -0.9% in 2014 based on the data of the Hungarian Central Statistical Office.

Although the central budget support of the municipalities has been reduced the in 2012 the funding of the basic social care was increased, especially the funding of the social home care. The funding of the municipal social services was strengthened by the new municipal finance model which was based on the actual expenses.

3.2.3. Reform of the last years

The last reform of the Hungarian municipal social system was in 2015. The reform was focused primarily on the social benefits. In the new model the central budget support of the municipal social cash benefits was strongly reduced, several municipal cash benefits were nationalised. The most important transformation of the reforms was the amendment of the financing of the social benefits and services. In the new model primarily these benefits and services are financed mainly by the local business tax. The state aid is only a supplementary source for funding these services. The basic services are practically real municipal services, and the central government has only a compensative role.

The regulation on the social services in Hungary changed significantly in the last decade. The changes were connected to the municipal and public service reforms. Although the majority of the residential social care was nationalised the social services have remained the most important municipal services.

These changes impacted the spatial structure of the Hungarian social service system, as well. In the next point I would like to review this impact.

4. Spatial structure of the personal social services in Hungary

4.1. Hypothesis

As I have earlier mentioned, the reforms in the last decade tried to solve the economy of scale problem of the Hungarian personal social services, which were based on the fragmentation of the Hungarian municipal system. The provision of the high cost services, the personal services was nationalised.

Secondly, the new provision of the basic services was encouraged by the new financing methods, especially in the rural areas. The service provision of the smaller municipalities has been supported

[44] Fazekas, J., Fazekas, M., Hoffman, I., Rozsnyai, K., Szalai, É. *Közigazgatási jog. Álatalános rész I.* Budapest : ELTE Eötvös Kiadó, 2015. Pp. 269–270.

by the increased finance, by the support of the inter-municipal cooperation and by the new block grant.

Thus two hypotheses could be formulated. *First hypothesis* is that the accessibility to the social service has been improved by the new financial mechanism. The *second hypothesis* is based on the strong nationalisation of the residential care. The spatial structure of the residential social services has been primarily impacted by the nationalisation.

4.2. Analysis and findings

To examine these hypotheses, I analysed the number of the recipients and the share of recipients of two basic social services (social meal and social home care). As I have mentioned earlier, they were not provided by almost the quarter of the Hungarian communities in 2005. If we look at the number of the recipients of social catering it could be observed that the share of the recipients has been increased significantly between 2008 and 2011 when the funding reforms occurred. The share of the recipients decreased modestly after 2012 when the central budget support decreased, and the municipal own revenues were preferred. Similar changes occurred in the number and share of the recipients of the social home care (see Table 5, 6 and Figure 1).

If we look at the regional data, it could be observed that the number and the share of the recipients increased more in all regions but the most significant growth can be observed in those regions where the spatial structure is not very fragmented and the medium-sized villages (with 2 000 to 4 000 inhabitants) are dominant.[45] Thus primarily the access to these services has been strengthened. The modest decrease of the recipients shows that the service provision is sensible to the decrease of the central budget support.

Table 5

Recipients of social catering in Hungary (in share of the population, in %)

Recipients of social catering in Hungary (in share of the population, in %)								
NUTS 2 region / Year	Central Hungary	Central Transdanubia	Western Transdanubia	Southern Transdanubia	Northern Hungary	Northern Great Plain	Southern Great Plain	Hungary
2008	0,59	0,9	1,20	1,43	1,66	1,38	1,13	1,08
2011	0,72	1,35	1,57	1,98	2,15	2,18	2,03	1,55
2012	0,79	1,34	1,51	1,93	2,28	2,53	2,28	1,67
2015	0,63	1,31	1,49	1,89	2,41	2,89	2,76	1,73

Source: KSH, 2017

Table 6

Number of recipients of social home care in NUTS-2 regions of Hungary

Number of recipients of social home care in NUTS-2 regions of Hungary				
Regions / Year	2008	2011	2012	2015
Central Hungary	6683	7548	9914	7753
Central Transdanubia	4144	6426	9260	10397
Western Transdanubia	4897	7598	8525	8485
Southern Transdanubia	6779	9508	10753	10600
Northern Hungary	7490	12252	19312	16568
Northern Great Plain	8746	23716	45537	38657
Southern Great Plain	9181	17893	21980	25921

Source: KSH, 2017

[45] Szabó, P., Farkas, M. Different types of regions in Central and Eastern Europe based on spatial structure analysis // In: Černěnko, T., Sekelský, L. & Szitásiová, V. (eds.): *5th Winter Seminar of Regional Science.* Bratislava : Society for Regional Science and Policy, 2015. Pp. 8–10.

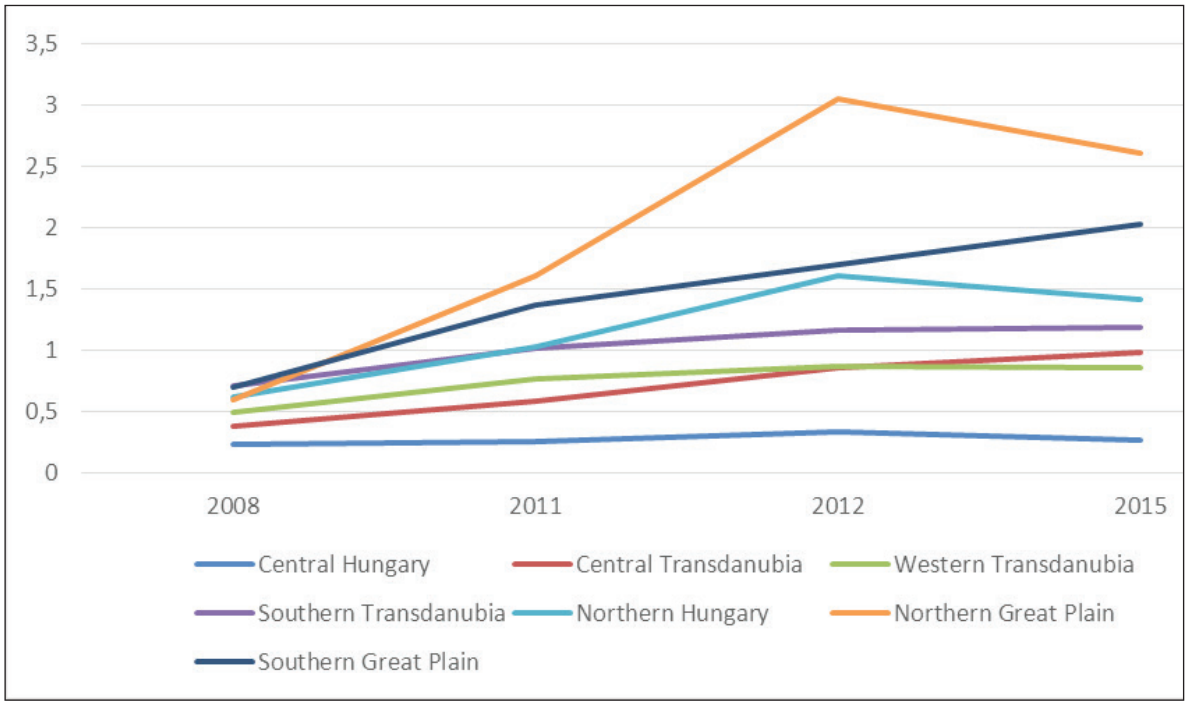

Figure 1. Social home care — share of recipients (in %)

Source: KSH, 2017

The *hypothesis 2* has been certified by the statistical data: the service provision is services is very sensitive to the financing, especially to the central budget supports. Thus, the spatial structure of the services became more balanced after the reforms in 2008. The system was impacted by the municipal reform limitedly, especially the preference of the own revenues has had modest effect on the structure of the basic services.

If we look at *the residential social care* only a modest change can be observed. Although the service system became moderately balanced, the regional differences partially decreased, but practically the whole system has not been transformed (see Table 7 and Figure 2).

Table 7

Number of recipients of residential social care

Number of recipients of the residential social care				
NUTS — 2 regions / Year	**2008**	**2011**	**2012**	**2015**
Central Hungary	20640	21417	21847	22630
Central Transdanubia	8833	9607	9770	9836
Western Transdanubia	9304	9477	9721	9630
Southern Transdanubia	9201	9818	9853	9858
Northern Hungary	10239	10904	11111	10797
Northern Great Plain	14786	13542	13692	14077
Southern Great Plain	13441	14121	14106	14152

Source: KSH, 2017

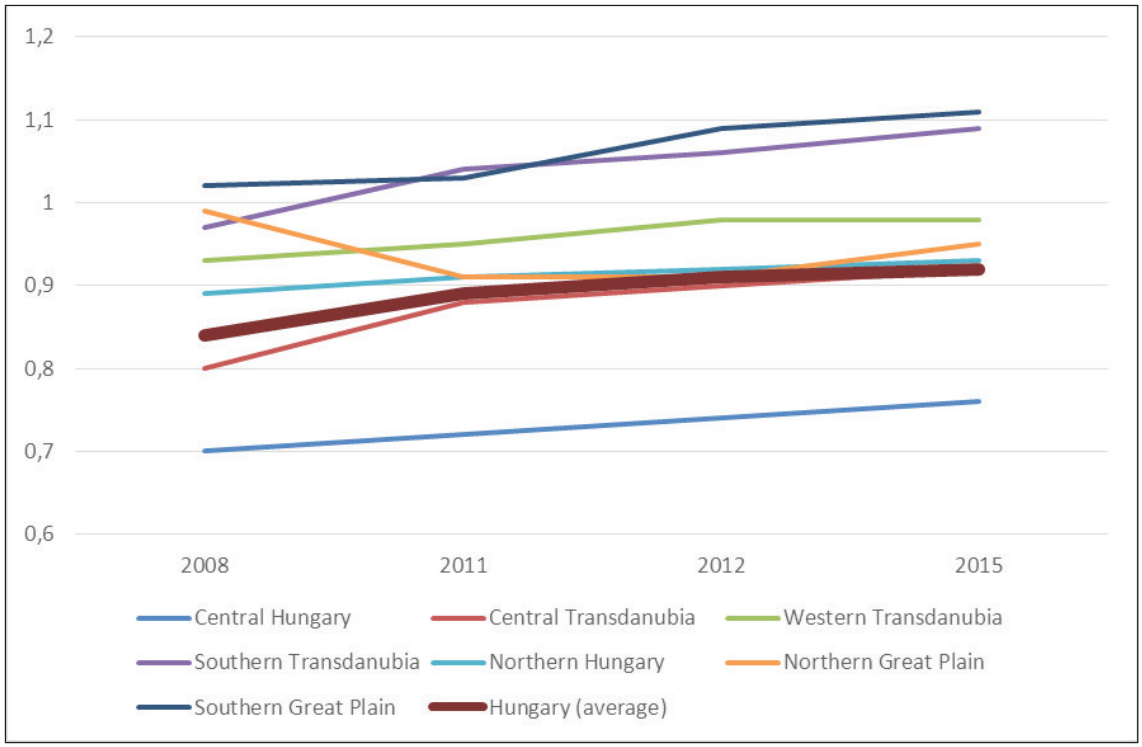

Figure 2. Share of the recipients of residential social care (in % of the population)

Source: KSH, 2017

The *hypothesis 1* has been just partially certified: the nationalisation had just a modest impact on the residential social care system. It can be observed that the service provision is strongly impacted by the transformation of the financing then the transformation of the organisation and management of these services.

5. Conclusions

If we look at the structure of the Hungarian personal social services, it could be stated that the community (1st tier municipality) centred system has remained however the majority of residential care service providers were nationalised after 2012. The main actors in the system are the local municipalities. The role of the municipal own revenues increased in the funding of the social care because of the reforms after 2015.

Although the reason of the nationalisation of the residential care was to balance the unequal and fragmented service provision system, this transformation impacted only moderately the system of social services. This effect was far more limited that it was expected by the experts. Although the system became a bit more balanced the former inequalities and the fragmentation have remained.

If we look at the Hungarian reforms it could be observed that the most effective reforms are the reforms on the funding the organisational reforms have just limited effect and impact.

References / Литература

1. Arden, A., Manning, J., Collins, S. *Local Government Constitutional and Administrative Law.* London : Sweet & Maxwell, 1999.
2. Aerts, Y., Siegmund, H. *Kommunalpolitik in Europa // in* Belgium, In Wehling, H. G. (ed.). Berlin, Stuttgart and Köln : Verlag V. Kohlhammer, 1994. Pp. 102–114.
3. Balázs, I. 'L'intercommunalité en Hongrie' // in Steckel-Assouère, M. C. (ed.), *Regards croisés sur les mutations de l'intercommunalité*. Paris : L'Harmattan, 2014. Pp. 425–435.
4. Balázs, I., Hoffman, I. Can (Re)Centralization Be a Modern Governance in Rural Areas? // *Transylvanian Review of Administrative Sciences. 2017.* Issue No. 50 E/February. Pp. 5-20. DOI: 10.24193/tras.2017.0001

5. Baron v. Maydell, B., Ruland, F., Becker, F. *Sozialrechtshandbuch*. Baden-Baden : Nomos, 2008.
6. Bocken, H., de Bondt, W *Introduction to Belgian law.* Kluwer Law International, 2001.
7. Eichenhofer, E. *Sozialrecht*. Tübingen : Mohr Siebeck, 2007.
8. Fazekas, J Central administration // In Patyi, A. & Rixer, Á. (eds.): *Hungarian Public Administration and Administrative Law.* Passau : Schenk Verlag, 2014. Pp. 287–303 .
9. Fazekas, J., Fazekas, M., Hoffman, I., Rozsnyai, K., Szalai, É. *Közigazgatási jog. Általános rész I.* Budapest : ELTE Eötvös Kiadó, 2015.
10. Healy, J. The Care of Elder People: Australia and the United Kingdom // *Social Policy and Administration. 2002. Vol.* 36. Issue 1, pp. 1–19., DOI: 10.1111/1467-9515.00266
11. Hoffman, I. *Önkormányzati közszolgáltatások szervezése és igazgatása.* Budapest : ELTE Eötvös Kiadó, 2009.
12. Hoffman, I. A helyi önkormányzatok társulási rendszerének főbb vonásai // *Új Magyar Közigazgatás. 2011. Vol.* 4 (1), pp. 24–34.
13. Hoffman, I. A személyes jellegű szociális szolgáltatások igazgatása // In: Horváth, T. M. and Bartha, I. (eds): *Közszolgáltatások megszervezése és politikái. Merre tartanak?* Budapest and Pécs : Dialóg Campus, 2016. Pp. 329–342.
14. Jones, B., Thompson, K. Administrative Law in the United Kingdom // In Seerden, R. and Stroink, F. (eds.), *Administrative Law of the European Union, Its Member States and the United States. A Comparative Analysis.* Antwerpen — Groningen : Intersentia, 2007. Pp. 199–258.
15. Krémer, B. *Bevezetés a szociálpolitikába.* Budapest : Napvilág, 2009.
16. Krémer, B., Hoffman, I. Amit a SZOLID Projekt mutat. Dilemmák és nehézségek a szociális ellátások, szolgáltatások és az igazgatási reformelképzelések terén, 2005. Esély 16 (3), pp. 29–63.
17. Lőrincz, L. *A közigazgatás alapintézményei.* Budapest : HVG-Orac, 2005.
18. Malikova, L. Regionalization of Governance: Testing the Capacity Reform // In: Baldersheim, H. and Batora, J. (eds.): *The Governance of Small States in Turbulent Times: The Exemplary Cases of Norway and Slovakia.* Opladen : Barbara Budrich Publishers, 2012. Pp. 208–228.
19. Niemelä, H., Salminen, K. *Social security in Finland.* Helsinki : Finnish Centre for Pensions, 2006.
20. Nižňanský, V. *Verejná správá na Slovensku*. Bratislava : Government of Slovakia, 2005.
21. Rácz, K. Szociális feladatellátás a kistelepüléseken és a többcélú kistérségi társulásokban // In: Kovács, K. & Somlyódyné Pfeil, E. (eds.): *Függőben. Közszolgáétatás-szervezés a kistelepülések világában.* Budapest : KSZK ROP 3.1.1. Programigazgatóság, 2008. Pp. 183–209.
22. Reiners, M. *Verwaltungsstrukturreformen in den deutschen Bundesländern. Radikale Reformen auf der Ebene der Staatlichen Mittelinstanz*. Wiesbaden : VS Verlag für Sozialwissenschaften, 2008.
23. Rozsnyai, F. K. Current Tendencies of Judicial Review as Reflected in the New Hungarian Code of Administrative Court Procedure // *Central European Public Administration Review. 2019. Vol.* 17. No. 1. Pp. 7–23.
24. Steiner, U. *Besonderes Verwaltungsrecht.* Heidelberg : C. F. Müller, 2006.
25. Strönholm, S. *An introduction to Swedish law.* Stockholm : Norstedts, 1981.
26. Szabó, P., Farkas, M. Different types of regions in Central and Eastern Europe based on spatial structure analysis // In: Černěnko, T., Sekelský, L. & Szitásiová, V. (eds.): *5th Winter Seminar of Regional Science.* Bratislava : Society for Regional Science and Policy, 2015. Pp. 1–13.
27. Szigeti, E. A közigazgatás területi változásai // In. Horváth, T. M. (ed.): Kilengések. Közszolgáltatási változások. Budapest and Pécs : Dialóg Campus, 2010. Pp. 269–290.
28. Thakur, S et al. *Sweden's welfare state. Can the bumblebee keep flying?* Washington D. C. : International Monetary Found, 2003.
29. Vandelli, L. *Città metropolitane, province, unioni, e fusioni di communi. La legge Delrio, 7 aprile 2014, n. 56 commentata comma per comma.* Santarcangelo di Romagna : Maggioli, 2014.
30. Velkey, G. Központi állam és a helyi önkormányzatok, In: Ferge, Zs. (ed.): *Magyar társadalom- és szociálpolitika 1990–2015.* Budapest : Osiris, 2017. Pp. 125–160.
31. Verebélyi, I. (ed.) *Az önkormányzati rendszer magyarázata*. Budapest : KJK-Kerszöv, 1999.
32. Waltermann, R. *Sozialrecht.* Heidelberg : C. F. Müller, 2009.
33. Wilson, D., Game, C. *Local Government in the United Kingdom.* Basingstoke & New York : Palgrave Macmillan, 2011.
34. Wollmann, H., Lankina, T. Local Government in Poland and Hungary: from post-communist reforms towards EU-accession // In Baldersheim H. et al. (eds.), *Local Democracy in Post-Communist Europe*. Opladen : Leske + Budrich, 2003. Pp. 91–122.