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The Growing Role of Churches in Social and Child Protection Services in Hungary

Abstract

This study examines the social and organizational dynamics of the increasing role of churches within Hungary's social and child protection service systems. The research is based on statistical data from the Social Sector Portal (SZÁP) and interviews with leaders of various religious and social organizations, highlighting the drivers and challenges of changes in provider structures. The findings indicate that major churches—primarily the Catholic, Reformed, and Lutheran denominations—play a significant role in elder care, homeless services, and the maintenance of foster care networks. Meanwhile, support for special needs groups, such as individuals with disabilities or addictions, receives less church-based involvement. Although the growth rate has slowed in recent years, the 22 percent (social care services) and 30 percent (child protection services) presence of churches has remained steady.

Overall, the study offers insights into the growth dynamics and positioning of church-affiliated institutions within Hungary's social care system. The results point out that church-based providers, despite operating within a favorable regulatory and funding environment, increasingly face internal organizational limitations that constrain further expansion. In response, state policymakers are shifting toward smaller churches and religiously affiliated organizations, leading smaller denominations to find opportunities in service areas that other providers are less willing to explore.

Keywords

Church-based Social Services, Child Protection, Specialized Care, Religious Institutions, Hungarian Social Policy, Welfare Pluralism, Post-secularization, Community Cohesion, Social and Child Protection, Religious Providers

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Introduction

The issue of church-operated social services within the discourse of secularization suggests that religious institutions do not lose their significance in modern society; instead, they adopt new roles. This perspective, combined with the theory of welfare pluralism, may strengthen the role of religious communities in fostering social cohesion and providing choices, thereby enriching the interpretation of secularization. In the American context, Putnam's work (Putnam, 2010) demonstrates that religious communities generate significant social capital, contributing to community cohesion and social solidarity—an aspect particularly relevant to church-operated social services. Castles (2004) argues that church-based activities rooted in Christian values significantly contribute to social cohesion and community strengthening, a fundamental goal of welfare pluralism. Moreover, when churches become market participants within the service system, they must also focus on the efficiency and competitiveness of service provision. This shift, according to Tomka (1996), may, in the long term, weaken authentic religious identity and generate internal conflicts within the church between mission and practical engagement.

According to post-secularization theory, religious institutions do not vanish with modernity; rather, they adapt, assume new roles, and continue to influence public life, especially in areas like social care and child protection. Jürgen Habermas (2006, 2008) suggests that in modern societies, religion may take on new public roles that enrich the communal sphere and offer alternative responses to welfare challenges. Church-operated institutions' social services, in this sense, can be viewed as a post-secular phenomenon reflecting a new balance between religion and modern society. However, this duality brings challenges for churches, as service provision often entails administrative, specialized care, and professional standards that may be difficult for some religious organizations to reconcile with their mission.

In this framework, the secular engagement of religious institutions can be seen as a survival strategy, enabling them to maintain relevance in a modern, secular society. I believe this approach can be further refined by considering historical continuity, which helps distinguish today's church social roles from perceived power strategies. Churches historically provided social

services, regardless of their congregational size. Many such institutions follow centuries-old traditions of community and social services, meaning their current involvement is more a return to historical functions than a response to declining religiosity. Historically, churches were primary providers of social services long before the advent of state systems, serving not merely as gap-fillers but as active community organizers. This role dates back to the Middle Ages in Europe, when churches established hospitals and poorhouses, suggesting that church involvement is part of a historical process connected to the origins of the welfare system.

In post-socialist countries—including Hungary—the restoration of churches' public roles over the last three decades reflects a unique development. The period following the political transition enabled churches to restore this role, with the state transferring certain social services to religious providers. In Western Europe, this prominent realignment is absent; due to the continuity of service providers, significant church organizations still operate the largest social service systems. Post-secularization thus represents not simply a resurgence of religious actors but rather an expression of historical and social interconnections between religion and modern society, developing from different regional trajectories.

José Casanova (2006) points out that certain segments of religion transcend the private sphere and become community institutions, adopting new social roles, particularly in the social sector. Casanova argues that the communal role of religious institutions affirms that religion does not necessarily lose significance through secularization; instead, it assumes new forms, such as public service provision, community-building, and social functions. This direction highlights religion's socially beneficial activities, reinforcing pluralism and community solidarity. However, in assuming these roles, churches face the ongoing challenge of balancing religious identity with state-funded responsibilities. The principle of subsidiarity, central to Catholic social teaching (where smaller communities, like churches, should act where larger communities cannot), can lead to ethical dilemmas when state funding heavily influences social service provision. In the social sector, this raises the risk of diminishing the „spirituality" of churches as they function more like secular institutions.

Peter Berger (1999) writes about the relationship between religious pluralism and secularization, arguing that in modern societies, secularization does not necessarily mean the disappearance of religion; rather, it expands religious choices and roles, enhancing ideological freedom. According to Berger, pluralism fosters freedom of choice, allowing religious institutions to participate in public service provision in new forms. In secularization theory, the maintenance of church-operated social institutions appears as a pluralistic value, offering alternatives beyond the state system. This model is not unique to Hungary but is seen in other European countries as well. Therefore, it is worth questioning the genuine options available to service users when church providers deliver services under state funding without offering additional capacity—particularly in light of waiting lists and limited care options in certain types of institutions. Church-operated services can be especially important in rural and disadvantaged areas where state capacities are limited. Decentralized, church-affiliated institutions broaden service accessibility, fostering social system inclusivity and reducing social inequalities.

The role of churches in social care and child protection is an important and often debated topic worldwide, addressing the relationship between modern welfare systems and religious

communities. In Hungary, the presence of church-operated institutions has gradually increased since the political transition, with these institutions now significantly contributing to service provision. Legislative and funding changes, along with public policy goals in recent decades, have allowed churches to establish a stable position in Hungary's social care system.

Examining the role of church-based institutions in Hungarian social policy has garnered attention over the past few decades due to their growing presence and societal impact. Szilágyi's (2019) analyses highlight that legislative changes—particularly the 1997 Vatican Concordat and the 2011 Church Act—significantly influenced the expansion of church institutions and their role in social policy.

The aim of this research is to present church-based providers and actors, their growing presence, and the transformation of provider structures within specialized care and child protection. Through this lens, the study seeks to uncover the role of church providers in social care and how the involvement of various denominations has evolved in different forms and to varying extents. Churches' social involvement stems not only from historical and cultural traditions but also from public policy goals and the regulatory environment. Another aim of the research is therefore to contribute to understanding these influences by examining the complex structure, operations, and challenges of church-operated institutions in Hungary.

Data Sources of the Research

The primary data source for this research is the Social Sector Portal (SZÁP), operated by the National Institute of Social Policy. The SZÁP database includes records of social institutions granted operating licenses by the Ministry responsible for social policy under Act III of 1993 on Social Administration and Social Services. Based on the issued licenses, the database enables the examination of provider structures and the regional distribution of institutional staff. Through SZÁP's institutional search function, I retrieved lists of institutions involved in specialized personal care and child protection services.

During the research, I categorized services by type to conduct targeted analyses on church-affiliated institutions serving various target groups. Currently, SZÁP distinguishes 22 service subtypes, which I grouped into five main categories based on target groups: homeless individuals, elderly persons, psychiatric patients, individuals with substance dependencies, and people with disabilities. By manually processing the institutional lists, I also categorized different religious providers by denomination, as SZÁP does not explicitly indicate religious affiliations.

The denominational classification was based on institution names and follows the categories established in the 2011 Act CCVI on Church Registration, creating a total of 16 denominational categories. Special attention was given to categorizing the Hungarian Maltese Charity Service, as SZÁP does not classify it as a religious provider. However, its operational structure demonstrates a close connection with the Catholic Church, and it is eligible for support reserved for recognized denominations. The differentiation between Catholic and Reformed Church organizational structures and levels also allowed for more precise analysis.

In analyzing the database, I considered the type and subtype of services, the regional location (territorial distribution), the start date of services (temporal scope), and the staffing and capacity of institutions. The reliability of the SZÁP database is primarily ensured through

state administrative inspections, as social and child protection institutions are regularly monitored. This oversight significantly enhances data accuracy, although classification ambiguities occasionally arise. For instance, the exact classification of institutions like Olajág Homes and the Human Services Center remains unclear. However, these instances are marginal and do not substantially skew the results. The classification of the Hungarian Maltese Charity Service poses a more complex issue: while its religious affiliations and access to church funding suggest its inclusion among church institutions, its association status does not necessarily fit this category, and SZÁP does not classify it as such. I decided to present its relevant data separately where applicable, given its Catholic ties and its evident alignment with the religious sphere, which closely relates to this study's focus. Another limitation of the database is that it cannot perform time-series queries and does not retain data on temporal changes. The database treats the issuance dates of licenses only as starting points, which do not always accurately reflect institutions' founding dates, as new licenses may have been issued due to legal or administrative changes. Nevertheless, I identified some correlations between licensing waves and legislative changes, providing a useful basis for analyzing the expansion strategies of religious providers.

The research interviews aimed to uncover the motivations and operational circumstances of religious providers. The interviewees included church social service experts and leaders representing the Greek Catholic, Reformed, Catholic, Lutheran, and Baptist Churches, as well as specialists from the Maltese Charity Service and other aid organizations. State administration representatives, including a former Secretary of State, a Deputy Secretary of State, and the head of a methodological center, also participated. These interviews provide supplementary information, with statistical data at the core of this analysis. In the future, I plan to explore the deeper interconnections of these qualitative findings and compare them with statistical data to gain a fuller understanding of the role of religious providers in Hungary's social care system.

The interviews conducted for this study followed a qualitative sampling method, utilizing semi-structured interviews to delve into the care management strategies of each denomination and the specificities of provider decision-making. Interviews typically lasted 1 to 1.5 hours and were conducted in person, with a dedicated question set on the expansion strategies of denominational providers. Participants were selected from decision-makers in churches with growing roles as providers, considering denominations with historical and social significance and representatives of major religious aid organizations. However, the generalizability of the results may be limited, as the sample is not representative but intentionally focused on providers with significant roles in institutional expansion. Thus, this study only shares supplemental information from the interviews related to institutional expansion aspects, which provide valuable context for analyzing SZÁP data.

Types of Providers and the Role of Churches in Specialized Social Care

Section 4 § (1) m) of Act III of 1993 (Szoctv.) identifies three types of providers for social services. However, the SZÁP database distinguishes a total of five provider types. State

providers include „the body designated by Government decree to carry out the state's provider duties, local governments, and associations of local governments." Church-based providers encompass recognized churches and internal ecclesiastical legal entities that, under Sections 9/D (5) and 9/F (1) of Act CCVI of 2011, have agreements for social, child welfare, or child protection services. For non-state providers, the law specifies private entrepreneurs, legal entities, individual companies, and certain foreign enterprises. The SZÁP database further differentiates by including separate categories for other non-state and nonprofit non-state providers. Thus, the database delineates state, municipal, church-based, other non-state, and nonprofit non-state providers.

At the time of the study, a total of 1,917 institutions held operating licenses within the field of specialized social care, with an approved capacity of 98,056 beds. Municipal providers represent the largest group, operating 504 institutions with a total of 25,812 beds. Following them are church-based providers, who manage 427 institutions with 23,813 beds, and central government providers, who operate 395 institutions with 25,425 beds. Other non-state providers operate 347 institutions with 13,410 beds, while nonprofit non-state providers manage 167 institutions with 5,339 beds. In terms of capacity, central government institutions tend to accommodate larger numbers, while nonprofit non-state providers operate smaller institutions, reflecting the differing strategies among provider types.

Church-based providers account for 22.3% of all institutions and 24.3% of all licensed beds, a proportion similar to that of municipal providers (26.3%) and central government providers (25.9%) in terms of bed capacity. These data indicate that church-based providers play a significant role in specialized social and child protection services, especially in terms of capacity, even surpassing municipal providers in the number of available beds.

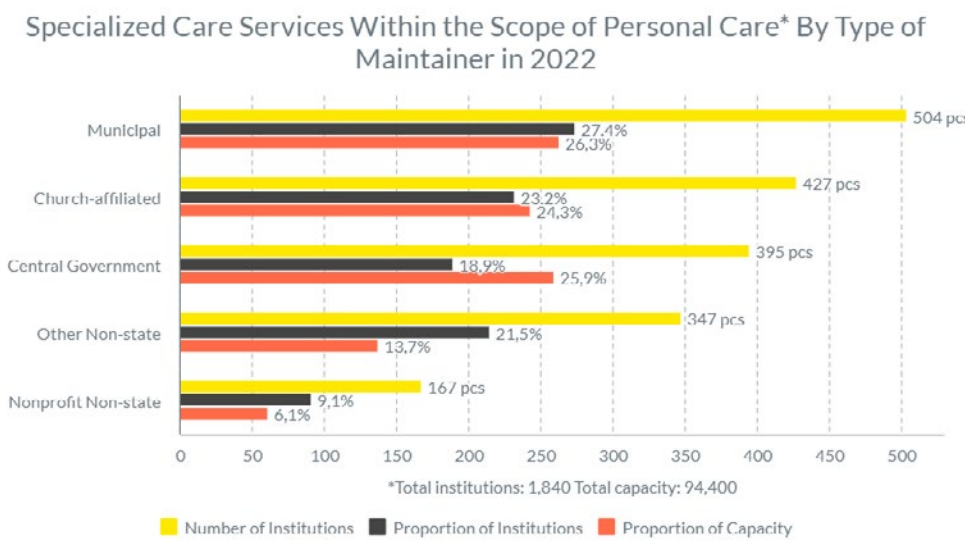


Figure 1. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

Types of Providers and Churches in Specialized Social Care

Act CXCII of 2012 significantly reshaped the structure of municipally-operated institutions by regulating the state takeover of certain specialized social and child protection institutions. As part of these changes, on January 1, 2013, 40 institutions for persons with disabilities, psychiatric patients, and individuals with substance dependencies, along with 137 child protection institutions, were transferred to state ownership. In 2014, an additional 15 integrated social and child protection institutions were handed over. This restructuring had a substantial impact on municipal sector capacity and provider structure, leading to greater centralization in the social care system. According to the 2022 SZÁP database, municipal providers operate 504 institutions, representing over one-quarter of all institutions.

Within the non-state provider category, a distinction is made between nonprofit and other non-state organizations. The nonprofit category includes nonprofit limited liability companies, while other non-state organizations are primarily composed of associations and foundations, such as the Hungarian Red Cross and the Hungarian Maltese Charity Service (MMSZ). Due to its unique status, the MMSZ plays a prominent role in the social care system: while formally registered as an association, it is eligible for church funding under an interstate agreement with the Sovereign Military Order of Malta and pursuant to Act CXL of 2010 (Article 5(1)), allowing it to receive normative and supplementary support allocated to church-operated institutions. The MMSZ operates an extensive network of institutions, with the number of institutions nearly doubling and bed capacity more than tripling since 2016; according to the SZÁP database, it currently manages 77 institutions with 4,295 beds.

When analyzing church-based providers, it is essential to consider that while the SZÁP database categorizes them under a single „church-based" label, this category actually encompasses a diverse array of legally and organizationally independent entities. Behind the seemingly homogeneous church category in statistical data are multiple denominations and organizational levels associated with various religious traditions and structures. During this research, I manually assigned each institution to denominational categories based on the Church Register specified in Act CCVI of 2011, resulting in 16 denominational subcategories. This detailed classification enables recognition of internal differences among churches, allowing for examination of the unique role and impact of each denomination. Church-based providers thus exhibit a more complex structure compared to the more unified organizational and legal frameworks of state or municipal providers. Below, I present a detailed overview of these denominational subcategories and their distribution.

Church-based providers account for 22.5% of all specialized social care institutions, with a total of 427 institutions and 23,146 beds. In terms of denominational distribution, the Reformed Church has the largest number of institutions (138) and beds (7,257), followed by the Catholic Church with 117 institutions and 6,594 beds. The Lutheran Church operates 66 institutions with 2,455 beds, and the Baptist Church participates with 33 institutions offering 1,675 beds. The diversity of church-operated institutions is reflected in the types of care provided and their geographical distribution, enabling broad support for various target groups while preserving religious and community values.

Number of Institutions and Capacity of Specialized Care Services Within the Scope of Personal Care by Denomination in 2022						
Denomination	**Number of Institutions (pcs)**	**Proportion of Institutions within Church-based Providers (%)**	**Proportion of Institutions within All Providers (%)**	**Capacity (persons)**	**Proportion of Capacity within Church-based Providers (%)**	**Proportion of Capacity within All Providers (%)**
Reformed	138	32,2%	7,2%	7257	31,4%	7,7%
Catholic	117	27,3%	6,1%	6594	28,5%	7,0%
Hungarian Maltese Charity Service	77	-	-	4295	-	-
Evangelical Lutheran	66	15,4%	3,5%	2455	10,6%	2,6%
Baptist	33	7,7%	1,7%	2204	9,5%	2,3%
Olajág Homes (Jewish)	16	3,7%	0,8%	1675	7,2%	1,8%
Greek Catholic	19	4,4%	1,0%	1052	4,5%	1,1%
Evangelical Methodist	8	1,9%	0,4%	468	2,0%	0,5%
Pentecostal	10	2,3%	0,5%	431	1,9%	0,5%
Serbian Orthodox	3	0,7%	0,2%	279	1,2%	0,3%
Jewish	5	1,2%	0,3%	245	1,1%	0,3%
Salvation Army	4	0,9%	0,2%	175	0,8%	0,2%

Adventist	3	0,7%	0,2%	92	0,4%	0,1%
Humanitarian	2	0,5%	0,1%	80	0,3%	0,1%
Nazarenes	1	0,2%	0,1%	75	0,3%	0,1%
Methodist	2	0,5%	0,1%	52	0,2%	0,1%
Constantinople Orthodox	1	0,2%	0,1%	12	0,1%	0,0%
Total	428	100,0%	22,50%	23.146	100,0%	24,5%

Table 1. Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The Hungarian Maltese Charity Service (MMSZ) has an extensive network within the field of specialized social care, with a consistent increase in the number of its institutions in recent years. While in 2016, MMSZ operated 35 institutions with a capacity of 1,138 beds, by 2022, this expanded to 71 institutions with 3,991 beds. According to the SZÁP database, MMSZ now maintains 77 institutions with a total capacity of 4,295 beds, ranking it third among denominational providers, behind the Reformed and Catholic Churches and ahead of the Lutheran providers.

All Hungarian Christian churches operate under a decentralized model, with various organizational structures. The Catholic Church is organized into dioceses, each led by a bishop with independent decision-making authority within their area, following unique strategies for organizing and maintaining social services. Dioceses, monastic orders, and Catholic organizations all function within highly regulated legal frameworks; in the „Register of Recognized Churches and Internal Church Legal Entities" of 2012, 152 internal legal entities were recorded. In contrast, Protestant churches, such as the Reformed and Lutheran Churches, appear in the register as unified recognized churches. However, this does not imply a centralized structure. Protestant churches operate under a bottom-up organizational culture, with the establishment of social services generally requiring approval and support from local presbyteries and pastors.

In the Catholic Church's social care system, various organizational units participate, each with independent legal status and decision-making authority. This organizational diversity leads to a decentralized approach to managing and maintaining services, without centralized control over different units. For instance, dioceses oversee their institutions through the Catholic Caritas network, which provides 2,271 beds across 45 institutions as separate legal entities. Monastic orders play a significant role, with female orders operating 1,312 beds in 25 institutions and male orders managing 346 beds across 7 institutions, adhering to their distinct values and organizational principles. The Catholic Charity Service, supported by the Hungarian Catholic Bishops' Conference (MKPK), operates 1,531 beds across 17 institutions, also as an independent legal entity. The Kolping movement similarly provides services aligned

with Catholic values, with 999 beds across 16 institutions. Smaller parish institutions offer 123 beds in 6 institutions, while MKPK operates a single institution with a total of 12 beds. Understanding this internal diversity is essential for comprehending the Catholic social care structure and governance, as these differences influence the organization of services and the flexibility of local decision-making.

Interviews with Protestant church providers indicate that the organizational structure reflects Protestant theological principles, granting high levels of local autonomy in social services. Within the Reformed Church, there are two main organizational units: the general Reformed provision with 5,308 beds across 100 institutions, and the nationally recognized Reformed Charity Service, which provides an additional 1,949 beds across 38 institutions. In the Lutheran Church, there appears to be even less organizational division according to the SZÁP database. However, in both Protestant churches, service organization methods emphasize autonomous, local decision-making.

Regarding types of specialized social care, church-based providers primarily focus on institutional care services, with 73% of church-operated institutions dedicated to nursing and care services. Transitional care institutions make up 12% of services, while residential homes, rehabilitation institutions, and supported housing programs cover the remaining 15%. Among all providers, church-based institutions constitute 27.1% of nursing and care services, with the remaining 56.6% provided by non-church entities. In transitional care services, church providers account for 14.4%, compared to 21.3% for non-church providers. Residential homes show a 13.4% church-operated share versus 9.2% non-church. The presence of church-based providers is thus most substantial in essential, long-term care services, where their community values and services provide a stable foundation for the target groups they serve.

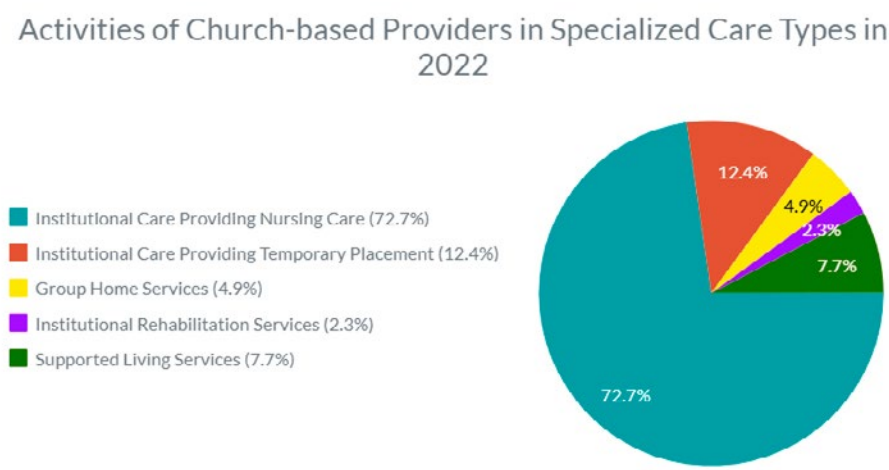


Figure 2. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

Proportion of Providers in Types of Specialized Social Care Services						
	Church-based Institution	**Proportion Within All Services**	**Proportion Within Church-based Institution**	**Non-Church-based Institution**	**Proportion Within Non-Church-based Institution**	**Total Institutions**
Institutional Care Providing Nursing	311	27,1%	72,7%	836	56,6%	1147
Institutional Care Providing Temporary Placement	53	14,4%	12,4%	315	21,3%	368
Group Home Services	21	13,4%	4,9%	136	9,2%	157
Institutional Rehabilitation Services	10	16,9%	2,3%	49	3,3%	59
Supported Living Services	33	19,1%	7,7%	140	9,5%	173
Total	428	22,5%	-	1476	77,5%	1904

Table 2. Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

Types of Providers and the Role of Churches in Child Protection Services

Section 5 § s) of Act XXXI of 1997 on Child Protection Services defines provider types for child protection services in alignment with the Social Services Act (Szoc.tv). According to the SZÁP database, a total of 1,370 operating licenses have been issued in the child protection sector, covering central governmental, non-state (including other and nonprofit), and church-based providers, with a total capacity of 28,993 beds.

Based on Act XXXI of 1997, the child protection system is organized according to provider types, creating a structure aligned with the social care system. The SZÁP database reflects the institutional composition and provider types within child protection services, illustrating the role and capacities of various provider models. The system encompasses 1,369 licensed service

providers delivering child protection services through various forms. The primary types of institutions include children's homes, external accommodations, foster care networks, and aftercare services, all aiming to provide comprehensive support to children and young people across different life situations and needs.

The extent of participation in child protection services varies by provider type. Church-based providers play a significant role, operating a total of 412 institutions, which represents a substantial part of the entire network. Church-operated institutions have a combined capacity of 20,627 beds, underscoring their considerable contribution to child protection services. In 2022, the total capacity of foster care networks was 20,069, with 19,317 of those beds managed by church-based providers.

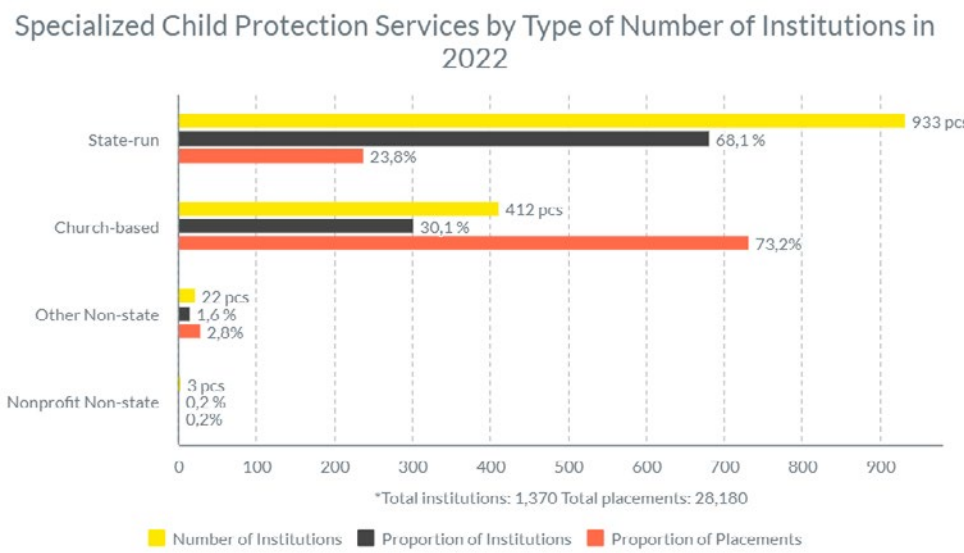


Figure 3. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The number of institutions maintained by the central government is 933, providing a total of 6,705 beds, mainly in larger facilities such as children's homes and aftercare services. The significant difference in the ratio of beds to institutions is due to the high bed capacity required for foster care networks, most of which are operated by church-based providers.

Among non-state providers, there are two categories: „other non-state" and „nonprofit non-state" providers. „Other non-state" providers maintain 22 institutions with a capacity of 797 beds, while „nonprofit non-state" providers operate only 3 institutions with a mere 51 beds, indicating substantial capacity differences among non-state providers. The Hungarian Maltese Charity Service (MMSZ) is listed separately as an „other non-state" provider, managing 3 institutions with a total of 410 beds.

In child protection services, 73% of the available beds are provided by church-operated institutions, which make up 30% of all institutions. Central government institutions provide only 24% of the beds, while non-state providers have a minimal role, collectively offering just 848 beds.

Examining the denominational distribution within church-based child protection institutions reveals the varied involvement and capacities of different denominations. The Catholic Church is the largest church provider in child protection, with 9,500 beds across 266 institutions, securing a prominent position in the sector. The Saint Ágota Child Protection Service, a national organization operated by the Catholic Church, has been managing child protection services across 9 counties since July 1, 2020. Other Catholic-affiliated institutions include those under the Diocese of Szeged-Csanád, 7 institutions managed by women's religious orders, and 2 institutions overseen by the Kolping Educational and Social Institutional Provider Organization.

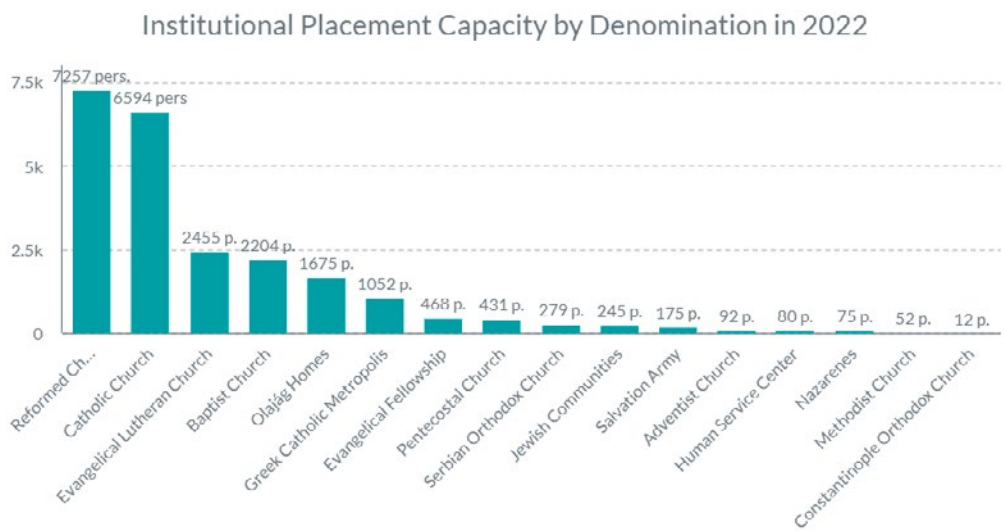


Figure 4. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

Reformed Church-based providers also play a significant role in child protection services, offering 4,318 beds across 56 institutions. The Greek Catholic Church maintains a smaller but stable presence with 79 institutions and 1,528 beds, while the Baptist Church operates 21 institutions with a total of 2,420 beds. The Lutheran Church participates with 11 institutions providing 269 beds, and the Hungarian Pentecostal Church, through the same number of institutions, offers 2,087 beds. These denominational distributions illustrate that each church contributes to the child protection system with varying capacities and roles, where community, religious values, and denominational characteristics significantly influence the structure and quality of care.

Number of Institutions and Placements in Child Protection Specialized Services by Denomination in 2022				
Denomination	**Number of Institutions (pcs)**	**Proportion of Institutions within All Institutions (%)**	**Placement Capacity (pers.)**	**Proportion of Placements within Total Capacity (%)**
Catholic Church	226	16,5	9500	33,7
Greek Catholic Church	79	5,8	1528	5,4
Reformed Church	56	4,1	4318	15,3
Baptist Church	21	1,5	2420	8,6
Evangelical Lutheran Church	11	0,8	269	1
Hungarian Pentecostal Church	11	0,8	2087	7,4
Jewish	3	0,2	47	0,2
Seventh-day Adventist Church	2	0,1	176	0,6
Faith Church	2	0,1	15	0,1
Other Church-based	1	0,1	267	0,9
Total	412	30,1	20.627	73.2

Table 3. Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The Role of Church-Based Providers in Different Types of Specialized Care

Church-based providers primarily focus on elderly care and services for homeless individuals, while they play a smaller role in the care of individuals with disabilities, psychiatric conditions, and substance dependencies. This distribution clearly reflects the social focus of church-operated institutions, while central and municipal providers ensure broader services for groups with specialized needs.

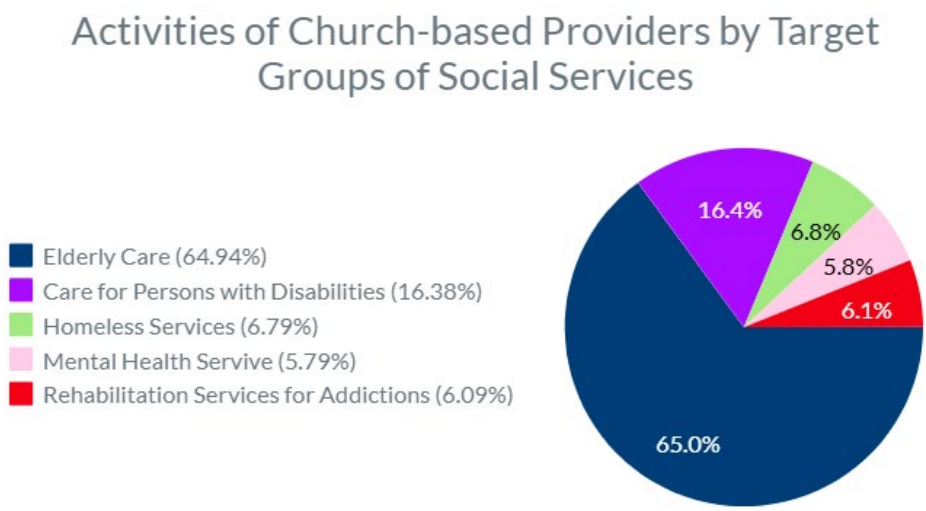


Figure 5. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The types of care provided by various providers—elderly care, care for individuals with disabilities, substance abuse treatment, and psychiatric care—define the target groups and highlight the involvement of each provider type. Based on the number and proportion of available beds, it is evident that in elderly care, central government (36.2%) and municipal providers (36.7%) participate at nearly the same rate, while church-based providers supply 29.3% of all beds for this type of care. Non-state providers play a smaller role, contributing 13.3% of beds. This distribution indicates that state-run institutions remain the primary providers of elderly care. Among church-operated institutions, the largest target group is clearly the elderly, with 65% of church institutions focused on this group. The three largest Hungarian churches—the Catholic, Reformed, and Lutheran Churches—play prominent roles, offering various care types, including nursing homes and transitional care facilities.

Among church-based providers in elderly care, the Catholic Church is the most dominant, maintaining 40% of church-run nursing homes, while the Reformed Church accounts for 25%

of these providers. Lutheran institutions represent 15% of church-based elderly care, with the remaining share divided among smaller denominations. Among these, the Baptist Church holds a 10% share, while the Pentecostal Church and other smaller denominations account for the remaining 10%.

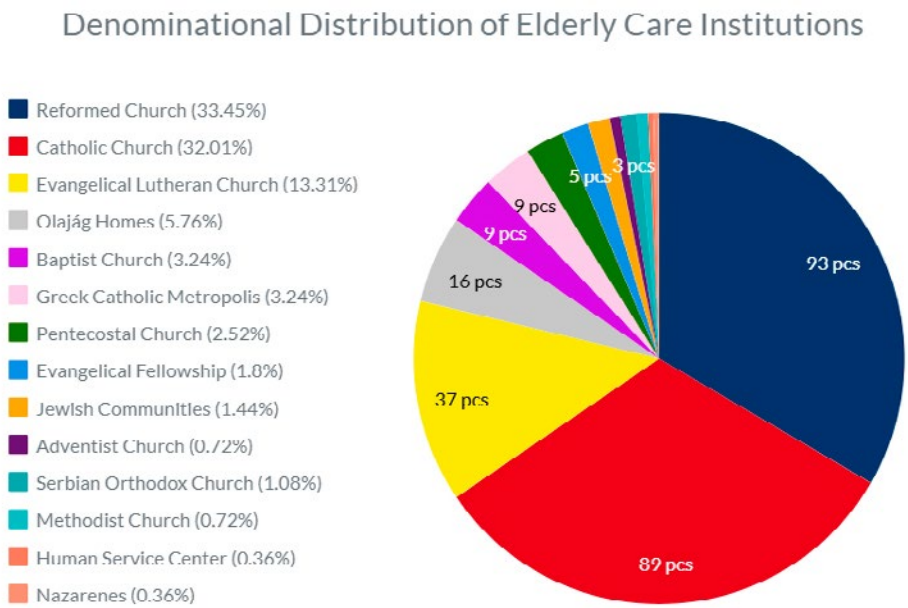


Figure 6. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The number of placements in church-based institutions has increased by 41% since 2010. This growth contributed to the total number of placements in long-term residential care for the elderly reaching 52,154 by the end of 2019. The utilization rate of these institutions is high, with only 1,868 available placements.(KSH 2019)

In the care of individuals with disabilities, municipal providers demonstrate significant dominance, accounting for 36.6% of the available beds, followed by non-state organizations with 18.2% and the central government with 16.2%. Church-based providers have a smaller presence in this care type, representing 11.8% compared to other providers. However, within church-operated care services, institutions supporting individuals with disabilities rank second, comprising 16.4% of their focus. The Catholic Church plays a notable role, operating 50% of church-based facilities for individuals with disabilities, followed by the Reformed Church, which represents 30% of church-based providers in this area. The Lutheran Church provides 12% of such care, while the remaining 8% is managed by smaller denominations, including the Baptist and Pentecostal Churches.

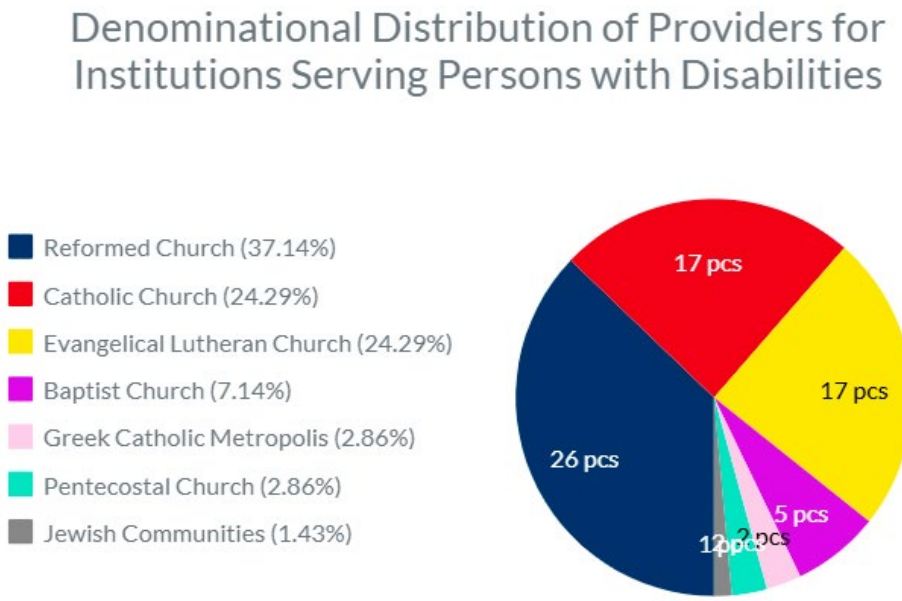
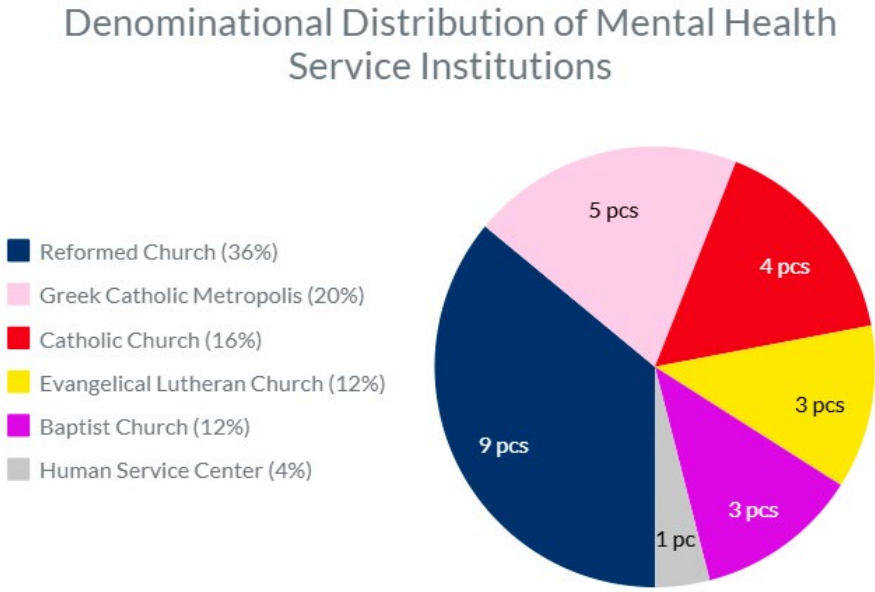


Figure 7. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

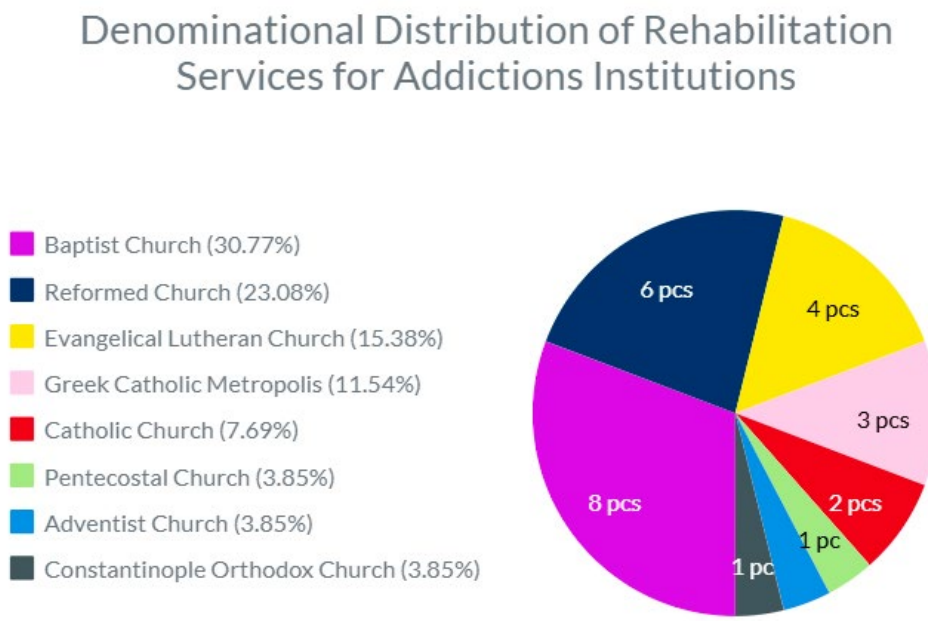
In homeless care, the central government plays a dominant role, providing 47.1% of available beds, while municipalities contribute 40.1%, and church-based providers account for 18.4% in this area. Among all church-operated institutions, homeless care ranks third, with 6.7% of church institutions offering services in this field. The distribution of church-based institutions in homeless care is particularly noteworthy. The Catholic Church maintains 35% of church-run homeless care facilities, followed by the Reformed Church with 25%. The Lutheran Church holds a 15% share, while the Baptist Church contributes 10%. The remaining 15% is provided by smaller denominations, including the Pentecostal Church and other religious communities.

In the care of psychiatric and substance abuse patients, central government providers dominate, with 54.0% of beds in psychiatric care and 61.8% in substance abuse care. Municipalities also have a strong presence, covering 53.9% of psychiatric care and 27.9% of substance abuse services. Church-based and other non-state providers have lower capacities in this segment, indicating that state and municipal structures play a central role in serving these specialized groups. Church involvement here is primarily supplementary and smaller in scale, with only 5.7% of church-operated institutions serving psychiatric patients and 6% serving individuals with substance abuse issues.

The Catholic Church holds the largest share of church-operated institutions for psychiatric patients, operating 45% of such facilities, followed by the Reformed Church with 30%. The Lutheran Church provides 10% of church-based psychiatric care, with the remaining 15% divided between the Baptist Church and smaller denominations, which generally offer complementary services in this area. In substance abuse care, the Catholic Church also leads, managing 40% of



Figures 8 and 9. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)



church-based institutions in this category, followed by the Reformed Church at 25%. The Lutheran Church holds a 10% share in substance abuse care, with the Baptist Church and smaller denominations making up the remaining 25%.

While church-based providers are actively involved across various care types, their role in serving certain target groups—such as individuals with disabilities, psychiatric, and substance abuse care—is less prominent than in elderly care or homeless services. This difference may stem partly from historical traditions and partly from differing values and mission goals among providers, which tend to prioritize support for the elderly and homeless populations. This raises the question of whether church-operated institutions align adequately with society's broader needs, particularly for complex and specialized target groups, whose care is typically dominated by state or municipal organizations.

Interviews with decision-makers from smaller churches suggest that the care types they undertake often represent their only opportunities for involvement in state-supported roles, as larger churches and state actors already cover more traditional care areas. Within this framework, smaller churches are exploring unique social roles, taking on responsibilities that other providers may avoid due to the specific expertise required and a lack of traditional foundations in those areas.

Temporal and Regional Indicators of Institutional Expansion by Church-Based Providers in Social Specialized Care

The development of church-operated institutions closely aligns with changes in the national social policy and legal environment, which unfolded in several phases. Initially, Act III of 1993 on Social Administration enabled church legal entities to take on provider roles in social services, sparking gradual growth in the 1990s. This was later reinforced through funding agreements between state and church actors.

Bernadett Szilágyi (2014) notes that, following the political transition, the regulation for church establishment was relatively flexible, with church involvement primarily supported through individual budget agreements related to the restitution of former church properties. The establishment of church-operated institutions became feasible due to Act III of 1993, which allowed church entities to maintain educational and social institutions. Later, the Vatican Agreement with the Apostolic See, followed by the Church Funding Act (Act CXXIV of 1997), brought fundamental changes for church-operated institutions. This international agreement defined the relationship between the Catholic Church and the Hungarian State, addressing the financing of public functions and creating new opportunities for church providers. Subsequently, other historical churches, such as the Reformed and Lutheran Churches, benefited from similar agreements.

The third major transformation occurred with the 2011 Church Act, which modified the range of churches eligible for funding while maintaining a multi-channel financing system. According to Szilágyi's analysis, this law established a new direction for church-operated institutions, providing long-term stability but also introducing new challenges. Changes in the number of operating licenses issued post-transition reflect that the establishment and takeover of church institutions largely adapted to new legal regulations.

During expert interviews, participants noted that sectoral difficulties, such as workforce shortages, similarly affect church-based institutions. One interviewee explained, "to address this issue, we began using our central structures to compensate for local workforce shortages." (Interviewee 12, Manuscript). The internal structures of church-based providers offer some flexibility to bridge structural and sectoral challenges and adapt to service needs. In many cases, local communities and charitable organizations participate in service provision, allowing for a division of institutional responsibilities at local, regional, or central levels.

Another interviewee highlighted regulatory incentives linked to waves of institutional transfers, which allowed for greater flexibility in resource acquisition beyond normative social service funding. They described the first wave as occurring between 2001 and 2004, during the first Fidesz government, when the Széchenyi Program provided opportunities to build new institutions with a capacity of 50 beds. Currently, the Reformed Church operates 80 institutions, 50 of which were built during this period, including elderly homes and other facilities in the Trans-Tisza region. The second wave, from 2008 to 2011, involved municipal takeovers, while the third wave, between 2015 and 2017, saw the state transfer 3,000 out of 30,000 beds, focusing on transferring existing capacities rather than establishing new institutions. (Interviewee 2, Manuscript)

The Reformed, Catholic, and Lutheran Churches played a prominent role in the dynamic expansion of social institutions, showing continuous growth from the early 2000s until 2016-17, after which a period of stagnation followed. During the same period, the Baptist Charity Service and smaller churches showed more modest growth. According to interviewees, following the expansion until 2017, churches have focused on optimizing and professionally developing existing

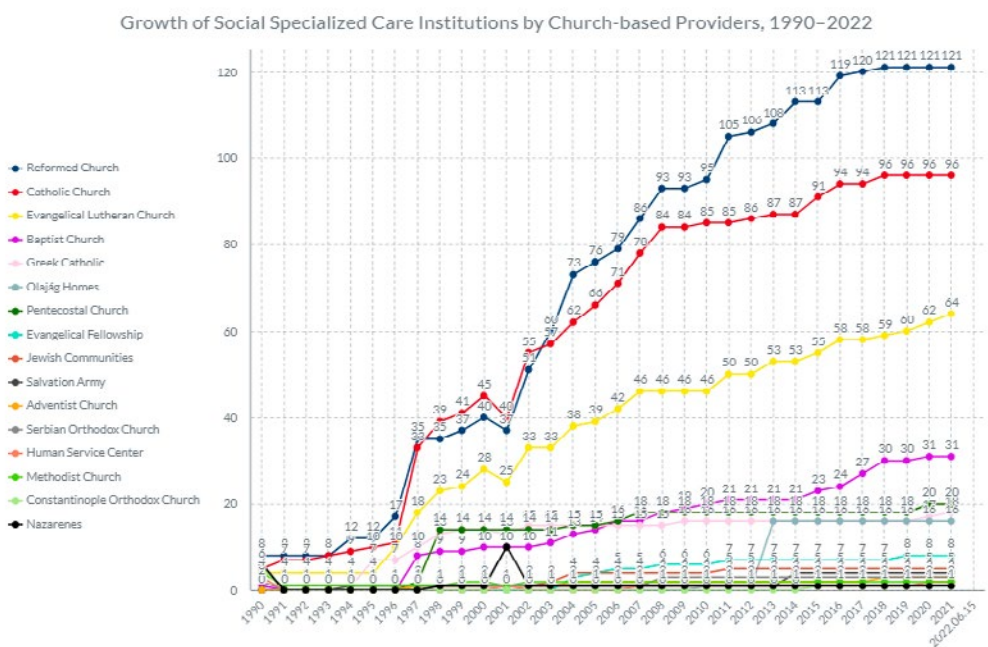


Figure 10. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

institutions. The past decade's political stability has supported predictability, yet providers now consider their organizational limits, with further expansion not being a priority. The strategic transfer of historically significant institutions—those held by churches before 1949 and important to local religious communities—has largely been completed. Church providers now also prioritize financial sustainability, mindful of potential changes in the political environment.

The government's intent to involve churches in service organization remains strong, as reflected in statements made after the 2022 elections. By 2017, when established churches were nearing their capacity limits and the number of transferred institutions began to decline, the Hungarian Maltese Charity Service (MMSZ) emerged as a new player. MMSZ operated 35 institutions with 1,138 beds in 2016, but by 2022, this had expanded to 71 institutions, largely in response to increased demand for basic services. These acquisitions were preceded by strategic decisions: "When such a request came—to possibly take over a residential institution from the state—we considered which institution in a given region would fit within our network. There might be a suitable institution, but if we don't have a Maltese institution nearby… then it's a big question. Another factor is whether there's a Maltese base, a foundation of services or a volunteer group we can rely on. For instance, if we have a well-functioning volunteer group, it would be beneficial to institutionalize it with some kind of specialized service that connects with our basic services." (Interviewee 12, Manuscript)

Church-based service organization differs from the county-based state administrative structure, resulting in a unique territorial organization. Understanding the territorial strategies of church providers requires examining the organizational units of denominations, which determine each church's territorial presence. For instance, the Catholic Church divides the country into 14 dioceses, while the Greek Catholic Church operates across three dioceses. The Lutheran Church has established three national church districts (Northern, Western, and Southern). This internal structure creates a distinctive territorial social care system that does not align with administrative boundaries, complicating county-level comparisons. The Lutheran Church demonstrates the broadest national coverage, followed by the Reformed Church.

The churches' internal, multi-level organizational structures enable services to be organized at various levels—local, regional (such as diocesan or district), and central (such as archdiocese or synod)—which can lead to parallel operational frameworks for providers. Decisions on which level a particular service type is implemented depend on care needs and local organizational capacities, offering significant flexibility for providers. Some churches are also connected to national charitable organizations, such as Catholic Caritas, which operates at the diocesan level in collaboration with the Catholic Charity Service, or the Reformed Church Aid, which operates a network of church-maintained institutions under the central direction of the Diaconal Office.

Temporal and Regional Indicators of Institutional Expansion by Church-Based Providers in Child Protection Services

Act XXVIII of 2020 has significantly strengthened the role of churches in social and child protection services. This legislation governs the transfer of licenses to church-based management, the operation of institutions with acquired licenses, and the transfer of ownership of certain state-owned properties

to churches. Based on this regulation, the MMSZ Association acquired ownership of 10 properties, the Lutheran Church received 7, and various Reformed Church parishes received 10 properties. Property ownership is critical in church financing, as highlighted in an interview with a representative from the Baptist Charity Service. Most Baptist-operated social institutions came under church management through municipal transfer; however, property ownership remained with the municipalities. This situation often leads to disputes, as the provider must cover maintenance costs for neglected properties while funding is frequently directed toward basic services and maintenance needs left unaddressed by the municipalities (Interviewee 11, Manuscript).

In child protection, there are currently 1,370 licensed institutions across five service types, with 412 operated by churches. The Catholic Church leads in church-operated child protection institutions, with 172 children's homes, 43 foster care networks, and 11 aftercare facilities with external placements. The Greek Catholic Church operates 70 children's homes and 9 foster care networks. The Reformed Church maintains 46 children's homes, 5 foster care networks, 4 aftercare homes, and 1 aftercare facility with external placements. The Baptist Church also participates in child protection services, managing 6 children's homes, 1 aftercare facility with external placement, and 14 foster care networks. Other churches are also involved in foster care networks: the Lutheran Church operates 10, the Jewish Community 3, the Pentecostal Church 11, and both the Adventist Church and the Faith Church each operate 2 foster care networks.

Child Protection Specialized Services by Denomination in 2022						
	Children's Home	**Aftercare in Child Protection Provided in External Placements**	**Foster Parent Network**	**Regional Child Protection Professional Services**	**Aftercare in Child Protection – Youth Adult's Home**	**Total**
Non-church-based	881	29	10	3	35	958
Catholic Church	172	11	43	0	0	226
Greek Catholic Metropolis	70	0	9	0	0	79
Reformed Church	46	1	5	0	4	56
Baptist Church	6	1	14	0	0	21
Evangelical Lutheran Church	0	1	10	0	0	11
Jewish Communities	0	0	3	0	0	3

Pentecostal Church	0	1	11	0	0	12
Adventist Church	0	0	2	0	0	2
Faith Church	0	0	2	0	0	2
Total Institutions	1175	44	109	3	39	1370
Total Church-based	294	15	99	0	4	412

Table 4. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

The development of child protection services follows a similar pattern to that of specialized personal care services, with particularly notable growth observed between 2010 and 2014. During this period, the Catholic Church's involvement expanded from 97 to 197 institutions, indicating a key presence in the maintenance of child protection services. A total of 5-6 churches actively participate in service organization, with the Catholic Church being especially prominent. According to the SZÁP database, church-operated child protection activities cover 9 counties, providing substantial territorial coverage for these providers.

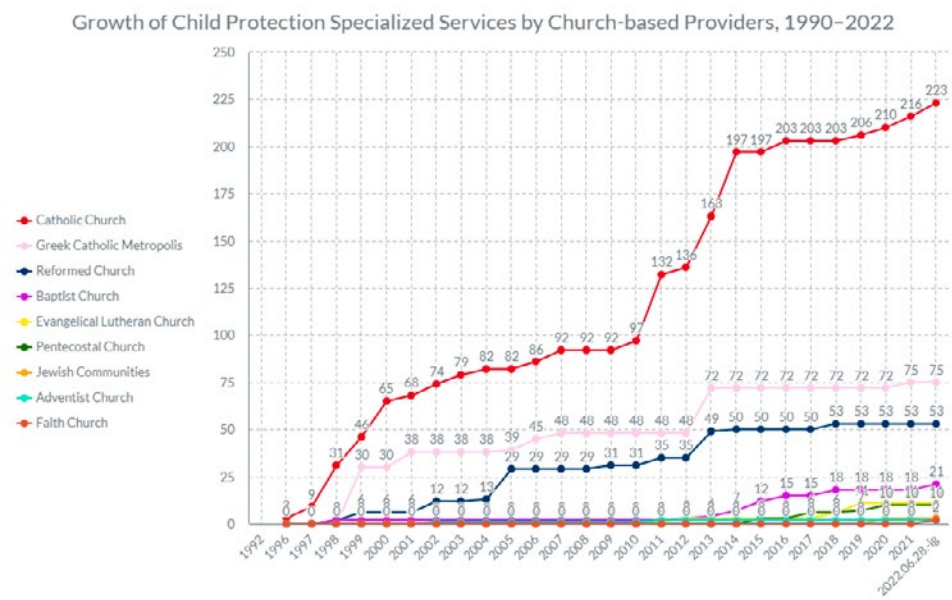


Figure 12. Source: Social Sector Portal (SZÁP) 2022, Self-Compiled (Downloaded on 2022.06.15)

This diversification has proven especially beneficial in better addressing local needs and increasing the range of social services. In social and child protection services, the expansion of church-operated institutions has also brought significant regional changes, particularly in rural areas, where they rely on local community resources and support. However, this shift doesn't always lead to greater diversity in care options, as it often involves transferring existing capacities rather than creating new ones, with church providers potentially mobilizing local community resources for service organization.

The sector's expansion has also faced challenges. Máté-Tóth – Szilágyi (2020) points out that the substantial increase in state funding and institutional takeovers by church-based providers may create new dependencies. Increasing state support may, in the long term, limit the autonomy of church institutions, as their sustainability increasingly relies on stable state funding. This dependency particularly affects larger historical churches, which, despite demonstrating flexibility in organizing internal structures and expanding their regional presence, remain closely tied to state funding policies.

The expansion of church-operated institutions has thus been shaped not only by changes in legal frameworks but also by the strength of local communities, historical traditions, and the continuous adjustments within the state support system. Over the past decades, the Catholic, Reformed, and Lutheran Churches have played a key role in social and child protection services. Although the rate of expansion appears to be slowing, government intentions to transfer responsibility to church-based providers are unlikely to change, with new methods anticipated. Ensuring stable operation, rather than further expansion, remains a priority for church providers, maintaining their significant role in Hungary's social care system.

Summary

The research confirms that church-based providers have significantly expanded their presence in social and child protection services in Hungary over recent decades. According to records from the Social Sector Portal (SZÁP), church-operated social institutions account for 22% of services, while in child protection, this share exceeds 30%, with the Catholic, Reformed, and Lutheran Churches holding the largest portions. Interviews conducted during the research also indicate that the structural flexibility of church actors and the support of local communities have played substantial roles in this growth.

The return of religion to public life does not indicate a religious revival, but rather that churches gain new legitimacy through their social functions, which are primarily grounded in their social and welfare services rather than their traditional religious authority (Rosta 2019). Religious communities are simultaneously attempting to regain social legitimacy and rebuild their institutional presence—often with the partnership (or political) support of the state (Máté-Tóth – Rosta 2022). However, extensive state funding of church institutions could create new dependencies in the long run (Máté-Tóth – Szilágyi 2020). This is especially relevant for the larger historical churches, where the sustainability of institutional autonomy may increasingly rely on the stability of state funding. Decision-makers among church providers are considering various strategies, with a key focus on the role of the local religious community and its leadership. A critical question is whether, if the current favorable funding environment changes

drastically, these institutions could secure alternative funding sources to maintain operations. The areas of care prioritized by church providers – such as elderly care and homeless services – reflect both traditional church missions and the potential for long-term stability, possibly supported by client contributions.

An imbalance may arise between societal needs and the competencies of church providers, highlighting the challenges churches face in meeting increasingly complex social care demands. The capabilities of church-based providers, their funding sources, and expertise may restrict their ability to support certain target groups.

The analysis results offer insights into the diversity of church-operated providers as a legal category, across care areas and denominational distribution. The Reformed, Catholic, and Lutheran Churches have played central roles in specialized social care, particularly in elderly care, disability care, and child protection services. While growth has slowed since 2017, maintaining stability remains a priority, ensuring the continued presence of church providers in Hungary's social care system.

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2020. évi XXVIII. törvény, az egyházak szociális és gyermekvédelmi ellátásokban betöltött szerepének megerősítéséről

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