Evaluation of health care and social public service development schemes

Final Report

Framework contract for the performance of assessments of development programmes co-financed by the Funds under the EU's Cohesion Policy, in 9 parts

Part III: Assessment of impact on labour market and social outcomes

Prepared for the Prime Minister's Office

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Executive Summary

The report summarises the results of the evaluation of the health and social public services developments implemented in the period 2014-2020 under the **TSDOP**[1] (Territorial and Settlement Development Operational Programme), the **CCHOP**[2] (Competitive Central Hungary Operational Programme) and the **HRDOP**[3] (Human Resources Development Operational Programme) schemes and makes recommendations for the development directions for the period 2021-2027. The two areas will be assessed in parallel, taking into account their development needs, in order to assess the extent to which the different relevant calls have responded to these needs and how effectively. Where possible and appropriate, we have sought to develop a common set of criteria for analysis. However, when examining specific thematic issues, the assessment of the two areas was completely separate. The evaluation analysed 23 health and 16 social calls, covering a total of 930+561, i.e. 1491 projects at a cut-off date of 07.10.2021. Since then, the number of projects has increased (+70) due to the inclusion of projects on the reserve list.

For both health and social public services, the evaluation was carried out along different thematic areas. In the area of health services development, the calls for proposals were grouped according to 1) infrastructure development of primary health care, 2) development of primary health care and public health services, 3) structural change in health care, 4) human resources development, 5) other development schemes (including medical technology, IT- development as well as projects aiming at methodological support in the field of health care).

In the field of public social services, we have grouped the calls to be examined according to 1) infrastructure development of basic social services, 2) human resources development in the social sector, 3) development of child protection services and related infrastructure and 4) other schemes related to the development of public social services.

As regards the **financial progress** of the projects, a significant part of the budget available for the two strands (83.4% for the development of health services up to October 2021 and 96.9% for the development of social services) has been committed, with absorption rates varying considerably between the schemes examined, depending on the completion date of each and on the extent to which external circumstances (e.g. pandemic, organisational restructuring, inflation, procurement difficulties) have hampered implementation. In both areas, the contracted aid covered around 68-74% of the funding needs, i.e. in both areas the need for development was greater than the resources available. The distribution of resources between the different professional areas was as follows: in the **health services area**, 23.4% of the budget was allocated to the schemes classified under other development schemes in the health sector, concentrated on two priority projects related to electronic health sector development (development of skills laboratories, development of medical infrastructure) and on projects aiming at methodological support in the field of health care system. The projects under review

[1] In Hungarian TOP.
[2] In Hungarian VEKOP.
[3] In Hungarian EFOP.

related to the structural change of the health sector accounted for 30.7% of the budget, while 22.2% of the planned budget was allocated to the development of primary health care infrastructure. The calls for proposals for the development of public health covered 17.1% of the funds and the schemes for human resources development 6.6%. The largest share of funds allocated for the development of **public social services** was devoted to the expansion of infrastructure for basic social services (41% of the budget). The development of human resources for social services is also a major area, accounting for 20% of the resources allocated to the calls examined. Other schemes related to the development of social public services (e.g. "Renewal of methodological and information systems in the social sector") account for 27% of the budget. The development of child protection services and related infrastructure received 12% of the budget.

The **timing of the use of resources** shows that the implementation of the schemes under review started in 2016, with the most intensive use of resources in 2017-2018. The **status of projects** shows that around 65% of projects in both areas have reached physical closure by October 2021, so there are still many projects in progress and many that have not yet really started. Initially, implementation was not hampered by a lack of resources, with around 60% of the contracted funding in the health sector and 85% in the social public services sector being paid in advance. However, the increase in the cost of building materials meant that applicants needed additional funding for infrastructure improvements and an extension of the project period. Up to the cut-off date of the evaluation (7 October 2021), mainly the advances paid had been used, with only a small number of other invoiced payments. In the case of health services, invoices were submitted for around 12.3% of the contracted grants, and for social services for 12.6%. 79% of the advances called on were accounted for by applicants in the health sector and 62% in the social sector.

The technical progress of the projects can be monitored by means of **indicators**. We were also able to assess the progress of the indicators up to the deadline of 7 October 2021. In some cases, it was difficult to assess the performance of the indicators because the EUPR data (data from the Database of Projects financed by European Union Funds) and the information received directly from Managing Authorities and applicants were not always consistent with each other. In general, the achievement of indicator targets is in most cases proportionate to the use of resources. In several cases, no targets are set, and thus the results achieved cannot be interpreted.

Looking at **the distribution of resources between the OPs** concerned, it can be seen that HRDOP resources played the largest role in the development of both health and social public services. In terms of the development objective of the schemes, the TSDOP is responsible for the development of primary health care infrastructure and public social services. The HRDOP covers public health development, human resources development, development linked to the structural change of the health sector and so-called other health development (IT, methodological development). While in case of social sector public services, the development of child protection services and related infrastructure, social human resources development projects and other social developments (methodological, IT) planned in the convergence regions are implemented within HRDOP. The CCHOP will implement public health, child protection and human resources development projects related to the Central Hungary region.

The health developments could draw on a number of sectoral policy documents. Overall, it can be concluded that in the case of EU-funded health development schemes in the 2014-2020 programming period, the emphasis was not on the (infrastructural) development of specialised health care, but rather on targeted programmes that will show significant progress in specific segments of the care system, such as the development and expansion of child emergency and acute psychiatric care, or preventive care.

The **structural change of the health care system** aims to strengthen primary care, develop care close to the place of residence, define the precise responsibilities of primary and specialised (including outpatient) care, create the appropriate operating conditions, transform the health care system with a preventive approach and optimise patient journey management. The change of structure is indirectly supported by the founding constructs containing methodological and impact studies (e.g. EFOP-1.8.0-VEKOP-17 Professional Methodological Development of the Health Care System and EFOP-1.8.10 Complex Health Protection and Attitude Development in the Field of Nutrition and Drug Consumption), the results of which (e.g. development of a database on dietary supplements and nutritional products, development of a database on medical aids, development of an e-cigarette database) may be of importance for the managers and participating professionals in the respective fields. However, the effectiveness of EFOP-1.8.0-VEKOP-17 has been hampered by the fact that the integration of the programmes has not always been achieved in a timely manner.

In some areas (EFOP-2.2.18-17 Complex infrastructure improvements to improve patient safety in the health care system), there was a large additional demand which could not be met, but it is noted that there is still a significant need for infrastructure improvements in the area of patient safety (e.g., improvement of hygiene systems, introduction of patient identification systems, laboratory improvements, etc.) In other areas (e.g., development of paediatric emergency and accident care (EFOP-2.2.1-VEKOP-16)), infrastructure development is lagging behind, partly due to delays in public procurement and partly due to changes in the conditions of implementation (the increase in the cost of building materials means that projects require additional resources). The beneficiary of several projects (e.g., EFOP-2.2.1-VEKOP-16, EFOP-2.2.6-VEKOP-16, structured development of the psychiatric care system) is the National Healthcare Service Center (OKFŐ), whose reorganisation in the course of the project also slowed down implementation. However, both the Development of Emergency and Accident Care for Children and the Structured Development of the Psychiatric Care System schemes are well targeted and focused.

The practice communities of physicians with a preventive and public health focus in general practice is a direction for further development in the area of structural change, based on positive professional experience. This kind of medical practice form, which provides additional services and is based on the Swiss model, could not continue to operate after the programme ended due to lack of funding. The Government Decree 53/2021 (9.2.21) provides the legal basis for the operation of practice communities for general practitioners, general paediatricians and dentists, but does not provide the funding for the additional services. Thus, in the future, it would be important to develop the financing background and the necessary infrastructure of the community medical practice form of operation providing additional services (construction of

premises enabling the provision of additional services, procurement of equipment, common IT platform), to strengthen methodological support (professional training, strengthening of community of practice management skills) and to deepen the network of cooperation with the Health Promotion Offices and the Mental Health Promotion Offices, which have been extended with a mental health promotion function.

Dissemination and promotion of complex public health screening (EFOP-1.8.1-VEKOP-15 priority project) is an important task for the structural change of the health sector. The project was already delayed before the outbreak of COVID-19, and its implementation was further hampered by the COVID-19 pandemic, some prevention modules were implemented later than planned: the oral cavity pilot screening programme with the involvement of mobile units (buses) for general screening started at the end of June 2021, mainly in disadvantaged areas), the HPV vaccination of 7th grade boys aged 12 and above was slightly delayed. A set of criteria, based on a professional consensus and in line with the WHO screening rules defined in 1968 (Wilson & Jungner) and renewed in 2014, has been established to determine which services constitute screening and which of these are recommended to be carried out, either at the level of the whole population or in the target population at risk by age. The project has achieved a coverage of 189,923 people by October 2021, which is about 26% of the planned coverage. The effectiveness of screening and the screening of the target population would be improved by a more active participation of Health Promotion Offices and of community medical practices to increase the coverage of the population. Further support for both types of organisations could help to promote population screening by mobilising the population through health status assessments in a synergistic way.

Each of the 23 health care constructs we examined reflects to some kind of **shortage or inadequacy in health care**. A prominent ambition is to increase health understanding, health awareness and promote healthy lifestyles as general objectives. It is also important to improve equal access to services (thus reducing the number of vacant practices) and to alleviate the shortage of health professionals. The implementation of human resource development programmes has been a major contributor to staff retention, with scholarships, training programmes and support for high performers being an important motivating force. At the same time, it must be seen that the European population, including our own, is ageing, an ageing trend which is placing an increasing burden on the health care system. Adequate numbers of professionals need to be available to care for the growing number of patients, but ensuring an adequate supply is a major challenge around the world, including in our country. Staffing levels in the health sector need to be adapted to human resource needs, so strengthening human resources is a priority and should be supported even if the ESF+ Regulation only allows for temporary support of up to 18 months in more developed regions from 2021. The reduction of the number of vacant practices has been addressed by several development schemes (Infrastructural development of primary health care TOP-4.1.1-15 and TOP-4.1.1-16 and TOP-6.6.1-15 and TOP-6.6.1-16) and the Comprehensive development of primary care and public health systems - Development of primary care (VEKOP-7.2.3-17 and EFOP-1.8.2-17). In several cases, the projects have progressed only up to the development of an action plan rather than the actual filling of the practice. Overall, the number of permanently unfilled practices

continued to increase between 2017 and 2020, especially in disadvantaged areas. Thus, making general practice more attractive and clarifying competence levels (i.e., redistributing medical and specialist tasks according to the level of training) remains a priority. The extension of the competence of nurses with extended responsibilities to the tasks currently performed by doctors and the exploitation of telemedicine services to reduce the burden on human resources are further opportunities for primary health care.

In terms of the **territorial coverage of grants**, the non-priority schemes included in the analysis were analysed. The benefit of the grants varied from one scheme to another, depending on whether the call explicitly stated this objective or on the willingness of applicants to apply. However, it is important to underline that, in terms of public health services, the infrastructural state of some institutions in Central Hungary or Budapest needs further improvement, so despite the overall development of the Central Hungary region and Budapest, there is still a great need for improvement, partly due to territorial constraints on access to EU development funds. In order to reduce the spatial disparities in primary health care and services to the population, it is proposed as a basic principle that, where justified, development should be targeted disproportionately, in accordance with the principle of positive discrimination, to those districts which, according to the Hungarian legal classification, are among those which are to be especially developed and. However, in the case of tenders focusing on specialised health care institutions, this can be an obstacle, as specialised health care structures are not always represented at district level. In addition to the scheduled preparation of tenders, it is important to prepare, inform and mobilise potential applicants, to increase their receptiveness and willingness to apply, especially in less developed regions and districts.

The contribution of the constructs to the improvement of health literacy and health awareness in Hungary was an important aspect of the analysis, since the health status of the Hungarian population shows a strong improving trend, but in international comparison it is still below the expected level based on the economic development of the country, and in some areas (circulatory diseases, malignant cancer mortality, diabetes, smoking, overweight) further improvements are still needed in the 2021-2027 programming period to significantly improve health indicators. In this respect, the relevant schemes we have evaluated are Comprehensive development of primary care and public health systems - development of local capacity for public health (EFI) (VEKOP-7.2.2-17 and EFOP-1.8.19-17), Comprehensive development of primary care and public health systems - development of local capacity for public health in the field of mental health (EFI-LEK) (EFOP-1. 8.20-17), Comprehensive development of the primary care and public health system - development of primary care (Community of Practice tenders) (VEKOP-7.2.3-17 and EFOP-1.8.2-17) and Complex health protection and approach development in the field of nutrition and drug consumption (Priority Methodology Project implemented by the OGYÉI, EFOP-1.8.10-VEKOP-17). The schemes identify and set as specific objectives the development of a health culture, which is essential for the promotion of healthy lifestyles, the support of related communication content and events, effective health communication, capacity building of organisations involved in local health communication. 73,515 people were reached in health promotion and disease prevention programmes (around 63% of the planned target); 66 districts where upgraded screening programmes were introduced

in deprived areas and 64 districts achieved an increase in the number of people attending screening programmes. Public health measures have an impact in the medium and even more so in the long term. Taking into account the developments of the last two programming periods, EUROSTAT data show that although life expectancy at birth in Hungary has increased by more than four years between 2000 and 2019 (from 71.9 to 76.6 years), it is still below the EU-27 average. The number of healthy life years at birth has also increased: between 2010 and 2019, it rose by 4.4 years to 60.9 years for men and by 4.2 years to 63.1 years for women (the EU average for the total population is 64.6 years).

In the context of health education, the creation of a **Skill lab network** (under the call EFOP-4.2.2-17), to create the infrastructural conditions for quality higher education, instrument and laboratory upgrades supporting practical training in accordance with the best available technological criteria are being implemented in three university skill centres and 16 county-level teaching hospitals, i.e., 19 institutions, in a total of 24 sites. The project is still ongoing, and implementation is being hampered by delays in procurement and a lack of resources due to the construction price increases in the meantime. The procurement of equipment, the related curriculum development and the established network of skill laboratories, together with the professional input of the university skill centres, have created a unique system. However, it is important to point out that there is a strong need to strengthen the human resources side. The training and further training of trainers, instructors, technical staff and further support for the work of the trainers in the simulation centres and skill labs is needed.

The implementation of development schemes has been affected in different ways by the COVID-19 pandemic. Among the schemes included in the evaluation, the COVID-19 pandemic mainly affected those that were still under implementation in 2020. In particular, those that were human-service oriented, i.e., involving face-to-face presence and personal contact, were also affected, and in many cases the completion of programmes had to be extended. While investment-focused projects, mainly involving infrastructure development, were less affected. In the context of the COVID-19 epidemic, the EFOP-1.8.0-VEKOP-17 project entitled "Professional Methodological Development of the Health Care System" is worth highlighting. Here the technical content of the call was significantly modified to reflect the epidemic and the budget was increased. Thus, the National Health Telephone and Online Information Centre is being set up, the teleradiology network and telemetry are being developed, a large number of protective equipment and devices are being installed, a pilot programme for the treatment of viral infections is being implemented, etc. Implementation of these elements is planned by 30 June 2022.

Taking into account the environmental changes, challenges and lessons learned in the 2014-2020 period, the **following key development directions for the healthcare system** are outlined for the coming 2021-2027 development period:

1. **Targeted infrastructure development**: further development of the network of skill laboratories, further renewal of the network of rural wards and care institutions in the psychiatric care system, development of forms of care that replace or shorten hospital care and their infrastructural and modern (diagnostic and therapeutic) medical technology

background. Development of specialised out-patient care facilities, improvement of internal functionality. As part of primary health care: creation of functional extension rooms in primary care surgeries. Provision of diagnostic and testing equipment, mobile screening stations to extend health promotion and public health screening nationwide and improve their effectiveness.

2. Organisational development and patient pathway management: support for organisational solutions that reduce fragmentation between levels and types of care, while improving the organisation of the national health care system, ensuring continuity of care between primary, outpatient, active and chronic inpatient specialised care. Development of mobile teams, further development of the Primary Care Community of Practice programme, further expansion of current GP community of practice activities to include dentists, pharmacists, social workers and these areas of competence. Bundled payment techniques to support the effective management of acute pathologies up to rehabilitation, on the one hand, and chronic disease management (CDM) programmes in priority population diseases, with priority given to beneficiary districts and disadvantaged counties, on the other.

3. Human resources development: in the framework of HR development, launching additional training and scholarship programmes to retain and attract staff, to increase motivation of those working in the sector, targeting shortage occupations. Human resources development programmes should be developed and implemented with EU support to create new administrative and organisational jobs in primary and specialised care, especially in disadvantaged areas. The additional human resources thus mobilised will take the administrative burden off doctors and nurses, improve the organisation of care and coordination between levels of care. This is an objective to be supported even if, according to Article 4(3)(b) of the ESF+ Regulation, only temporary support for a maximum period of 18 months is allowed for "persons who are not directly socio-economically vulnerable". In the coming years, human resources development can be targeted, following the principle of positive discrimination, so that it is mainly targeted at primary and specialised care workers providing care for the population of rural disadvantaged areas and districts. Although this is an indirect support for the disadvantaged population, it will ultimately improve the provision of care for this social group.

4. Improving the health awareness of the population in the framework of preventive action: strengthening health awareness among the population, developing curricula (education - introduction of health studies), providing healthy lifestyle advice and launching a wide range of programmes to increase primary and secondary prevention, and encouraging participation in screenings.

5. Improving patient safety and the resilience of the care system: developing and launching targeted tenders. These include, for example, upgrading patient safety equipment, internal envelopes and walkways in hospitals and, secondarily, in outpatient clinics; improving conditions for safe patient care and treatment (support for the purchase of modern hygiene and care equipment to reduce the risk of nosocomial infections, equipment for the

prevention and treatment of decubitus ulcers; improving the resilience and response capacity of health care institutions through training, the development of internal rules and protocols).

6. The development and national roll-out of telemedicine programmes should be pursued as part of the drive to modernise the care system. In order to increase the efficiency of infrastructure and software development, it is recommended to develop digital skills and knowledge not only for the population but also directly for health professionals. Development of telemedicine services and applications for better access to healthcare, in line with the National eHealth Infrastructure.

7. Improving the sustainability of projects beyond the mandatory maintenance period

Ensuring sustainability beyond the mandatory maintenance period is also very important for projects funded by EU grants. In the case of public health services, this implies that the improvements are integrated into the health care system and that the associated operating and wage costs are covered for several years after the project has been completed. This can be in the form of direct public subsidies (e.g., in the form of targeted, transitional support to the maintainer) or in the form of tendering opportunities for a transitional period until, for example, development funds become available in the new EU programming period, allowing projects to continue.

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There is no comprehensive **sector strategy in the field of social public services**, only policy and strategy documents for specific target groups (e.g., for disabled people, elderly people). The evaluation examined the basic documents of the EU development periods and the National Development 2030 National Development and Spatial Development Concept (2013). The legal background for the services targeted by the development is provided by the two basic laws of the sector, Act III of 1993 on Social Administration and Social Services and Act XXXI of 1997 on the Protection of Children and the Administration of Guardianship.

The general conclusion of our evaluation is that **EU funds** used in the field of social public services **are indispensable for the social sector, while the improvements could not be achieved at all or only to a much lesser extent with domestic budget resources.**

The structural transformation identified in the social sector is the process of deinstitutionalization, the two directions of which **concern** large residential social institutions (Sztv.) and **children's homes** (Gyvt.). The former is not covered by our evaluation, as it is the subject of a separate evaluation, while the latter is supported by the call for proposals *EFOP-2.1.1-16 Replacement of children's homes, modernisation of children's homes, creation of missing children's home capacity*, and its mirror call for proposals VEKOP-6.3.1-16 directly, and by the call for proposals *EFOP-2.2.14-17 Infrastructural and professional development of foster care networks* indirectly. The calls EFOP-2.1.1-16 and VEKOP-6.3.1-16, which support the structural adjustment that has already begun, are designed as a continuation of the TIOP schemes of the 2007-2013 period, as the last step in the process of replacing the children's homes facilities. Although we have identified difficulties and dilemmas that hinder implementation, **the schemes can be considered successful overall.** The *EFOP-2.2.14-17* call supports the infrastructural and professional development of foster care networks, thus

indirectly contributing to the replacement of institutional places by expanding and strengthening foster care places. Overall, it can be concluded that **the evaluated schemes contribute to the deinstitutionalization of children's homes**, the continuation and completion of the process and the development of the foster care network, the reinforcement of foster care places and to some extent also to increasing their capacity. **However, the replacement process was not** fully **completed** by the end of the development cycle and the expansion of the foster care network would require further development.

The schemes and calls typically address long-standing, systemic problems and gaps in the social public services sector. The calls for proposals *TOP 4.2.1* and *6.6.2* respond primarily to service and capacity gaps and inequalities in access to services by supporting the infrastructural development of basic social services. The calls *EFOP-3.8.2-16* and *VEKOP-7.5.1-16*, as flagship projects, respond to the high staff drop-out rates in the social sector, low social recognition, unmet training needs, lack of professional development opportunities and challenges in the continuous provision of services. The three calls for proposals under the evaluation area "*Development of child protection services and related infrastructure*" (calls for proposals *EFOP-1.2.7-16, EFOP-2.1.1-16, EFOP-2.2.14-17*), one call for proposals VEKOP (*VEKOP-6.3.1-16***)** and one flagship project (*EFOP-2.2.4-VEKOP-16*) reflect the different needs and gaps in the child protection system, in the provision of specialised care. The two EFOP calls in the area "*Development of other public social services"* aim at the development of institutions and services of church and civil (*EROP-1.9.8-17*) and charitable (*EROP-2.2.15-16*) organisations. Call *EFOP-2.2.3-17 addresses* the infrastructure and capacity gaps in specialised social care and family transition homes, as well as the "emptied" professional content of rehabilitation care. Call for proposals *EFOP-3.2.9-16* responds to a lack of services and a long-standing professional need by introducing and extending social assistance in nursery schools and schools. The *EFOP-1.9.4-VEKOP-16* flagship project responds to the need to continue the improvements already made to the official registers and to modernise the professional support systems by renewing the methodological and information systems of the social sector. Overall, **all the calls included in the evaluation reflect on an area of weakness.** However, it appears that **EU developments alone cannot address complex, systemic problems** and gaps. The overall poor state of the infrastructure and lack of resources of the services and institutions being developed is reflected in the high number of applications received and the high level of resources required. The success in reducing the shortfalls varies from one scheme to another, as does the extent to which resources have been concentrated and deployed in the different areas of shortfall.

Spatial disparities in social public services are manifest in several dimensions (capacity, access, accessibility, quality) and are linked to spatial-urban disparities and the spatial concentration of complex social problems. Of the calls evaluated, the TOP schemes supporting the development of infrastructure for basic social services were the main ones to reduce territorial disparities. TOP 6.6.2 targeted cities with county status with the allocations set out according to the area-specific annexes. TOP 4.2.1 was targeted at county level, with indicative resources allocated to specific districts and rural areas within the county, as specified in the area-specific annexes (in the 2015 call). The area-specific annexes mostly included as an evaluation criterion whether the development was to be implemented in a beneficiary district or municipality, a small settlement or a settlement with a lack of services (without the service developed). Infrastructural improvements have led to an increase in the quality of services, improved conditions and conditions of service provision. These are important but not sufficient

responses to territorial disparities. They cannot alleviate the complex social, economic and infrastructural problems of deprived and disadvantaged areas and (small) settlements, and overall they do little or nothing to alleviate the capacity shortages of basic services. In addition to the fact that projects were supported in six 'less developed' regions of the country, **the HRDOP calls**, due to the nature of the policy objectives, services and institutions to be developed, **largely lack a strong territorial equalising effect. A significant proportion of the projects and resources under the calls evaluated** - looking at the project municipalities included in the EUPR database - **were allocated to well-served cities with county rights.**

There have been many difficulties in assessing the **impact of the developments schemes on the quality of services**, as there is no structured data available on the professional content of services, and the monitoring systems of the operational programmes do not focus on this. Improvements in quality could therefore only be assessed indirectly, through key informant interviews, case studies and questionnaire surveys. The calls and schemes included in the evaluation all have some impact on the quality of services, but the analysis focused on the relevant calls in the **three priority evaluation areas** (development of infrastructure for basic social services, development of social human resources, development of specialised child protection services and related infrastructure) identified in the evaluation launch report (*TOP-4.2.1-15, TOP-4.2.1-16; TOP-6.6.2-15, TOP-6.6.2-16, EFOP-3.8.2-16, VEKOP-7.5.1-16, EFOP-1.2.7-16, VEKOP-6.3.1-16, EFOP-2.1.1-16, EFOP-2.2.14-17, EFOP-2.2.4-VEKOP 16*) and the call for proposals concerning **rehabilitation institutions** (*EFOP-2.2.3-17*) **and the** priority scheme for the **renewal of methodological and information systems in the social sector** (*EFOP-1.9.4-VEKOP-16*). The schemes are mostly achieving their objectives and **typically have a positive impact on the quality and/or availability and capacity of services.**

EFOP-1.9.4-VEKOP-16 supported the renewal of methodological and information systems in the social sector. The main result is that the professional materials for direct and indirect target groups and the appropriate IT support will make the work and service delivery more efficient. **Significant improvements in IT systems have been made during the cycle.** However, the shortcomings of the monitoring systems, which are not suited to assessing the quality of services, either in general or in relation to the impact of specific improvements, remain a problem.

In spring 2020, the first sector was not yet prepared for the first wave of the COVID-19 pandemic. Until the first unified management procedures for the epidemic were drawn up by the sectoral management, the service providers and maintainers were left to their own discretion to make decisions and take measures best suited to the situation, and the unexpected costs associated with this meant that they had to bear significant additional costs. **Beneficiaries of** the evaluated **TSDOP calls were not affected by the pandemic** and the related lockdown measures, **while the implementers of the HRDOP calls were affected to varying degrees and from different perspectives.** Some of the EFOP projects requested extensions beyond three months and a significant number of the face-to-face project components were kept online. In a number of cases, project activities were rescheduled, the implementation period was - extended and in several cases costs were reallocated. For the EFOP-2.2.4.-VEKOP-16 priority action, the planned renovation activities could not be carried out, partly due to the epidemic situation and partly due to unsuccessful procurement procedures, and the project had to be reworked.

Overall, it can be concluded that **the calls and schemes have met the policy objectives and orientations.** However, it is also clear that there is still much to be done in a number of areas, especially in the field of basic social services, child welfare and child protection, both in terms of infrastructure and professional conditions. Compared to the number of services and institutions, only a small number of actors have received EU development funding. Meanwhile, as domestic budget resources are barely sufficient to finance operating costs, those that have not benefited from EU projects have most likely not been able to improve and develop their services. **Further improvements in both quality and accessibility are needed, especially in areas and municipalities with a shortage of services**.

Based on the experience of the evaluation, the following areas are of particular importance for further development and expansion:

1. There is a **continued need to improve the infrastructure of basic social services.** Many development needs could not be met, and the total amount of funding is still too low compared to the number of operators and maintainers of public social services and the needs and requirements.

2. The **further development of child protection institutions and the full and careful completion of the deinstitutionalization process are essential**. The investment and refurbishment elements of the priority project for the infrastructural development of the regional child protection services, concerning real estate, have not been completed. The need for further infrastructural and professional development of the specialised services seems clear.

3. There is a great need to further expand the support activities in kindergartens and schools. Although significant improvements have been made in this area, **further expansion of the system, access to more public schools than at present, and the expansion of social assistance in kindergartens and schools would seem justified.**

4. Overall, **the further development of social public services in settlements with a shortage of services** and in **areas and settlements where socio-economic problems are concentrated and the proportion of socially deprived people is high is of** particular importance.

Based on the results of the evaluation, our further findings and recommendations are:

1. Existing monitoring systems should be improved, and outcome indicators (e.g. measures of service delivery/uptake processes and transitions, changes in well-being directly measured among service users, staff skills, or the effectiveness of preventive services) should be developed to monitor and assess changes in the quality and accessibility of services.

2. There is a need to further develop sectoral monitoring systems, using different methodological approaches (e.g. linking sectoral and development databases), so that they are also capable of monitoring changes in the quality of services, both in general and in development programmes.

3. For the **2021-2027 period, a general scheme with a longer implementation period is envisaged**, allowing a wider range of professional activities to be selected. This will allow a wide range of activities to be carried out in the same project.