Just Welfare?:
Social Services Reform in Bosnia-Herzegovina, Croatia and Serbia

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ABSTRACT
Social services reform in countries in transition is driven by three broad principles, sometimes described as the '3Ds' of reform, namely deinstitutionalization (the move away from an over-reliance on long-term care in residential institutions towards more humane and cost effective community-based services); diversification (the promotion of a renewed welfare mix of state and non-state providers including NGOs and the private sector); and decentralization (the transfer of rights, duties and responsibilities as close as possible to local populations).

Based on evidence of actual and proposed reforms in Bosnia-Herzegovina, Croatia and Serbia, the paper suggests that the three principles have tended to be treated separately rather than as inter-linked. Hence, reforms have often been blocked, or had unintended consequences, as a result of an excessive legalism, and a lack of concern with equity, economies of scale, incentives for new providers, safeguards regarding standards, and creative ways of overcoming resistance to change. In addition, external assistance efforts have often been uncoordinated and contradictory.

The paper argues that more emphasis needs to be placed on the development and implementation of a meso-level planning framework to reorder existing services and establish alternative, community based and family-centred services. In this way, the reform process would be led by clusters of municipalities based on assessments of the supply of and demand for services.

Key words: social services, deinstitutionalization, systems approach, equity

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1. SOCIAL SERVICES REFORM IN TRANSITION: SYSTEMATISING RIGHTS

The reform of social protection policies in post-Communist countries in transition in Central and Eastern Europe has proved to be one of the biggest challenges for policy makers, professionals and politicians in the last fifteen years (cf. *inter alia* Ringold, 1999; Deacon, 2000; Stubbs, 2001a). Within this, most attention has been paid to poverty alleviation and the importance of tailoring social assistance payments to need and respecting fiscal envelopes (Krumm, Milanović and Walton, 1994). Existing well-developed systems, based on the principles of equity and solidarity, have had to be re-designed, sometimes painfully, to fit into new kinds of political economies. Nevertheless, a broad consensus exists on the importance of poverty alleviation such that the questions become more or less technical ones of the best ways to reach agreed goals.

Until recently, the reform of social services and, in particular, the over-reliance on institutional care for those at risk, was not a major priority outside of a small number of countries, notably Romania and Bulgaria, where the numbers in institutional care were so high, and the nature of that care so intolerable, that there was massive internal and external pressure for change (cf. Sotiropoulos, Neantu and Stoyanova, 2003). Crucially, in terms of the legacy of social services, formal commitments to social justice and to human rights were less well developed than medicalised models of individual and family deficiencies, dysfunctionalities and abnormalities, under the influence of a 'defectology' approach (UNICEF, 1997; Carter, 2005; 43). In this context, passive or compliant service users were meant to fit into existing services, often in remote locations, with long-term protection, in its most paternalistic sense, the only identifiable plan. A shift towards respecting the human rights of clients depends, then, in a way quite unlike poverty alleviation, on fundamental systemic changes including changes in the commitments, attitudes and behaviour of service providers (Bošnjak, 2005).

Recently, the reform of social services has risen up the policy agenda, for a number of reasons. Firstly, a broad agenda of governance reform, in which public services seek to work for the benefit of citizens, has had 'spill over' effects in the realm of social services, too. Secondly, key international actors such as the World Bank and UNICEF, have found common ground in arguing for deinstitutionalization based on the fact that institutional care is both an infringement of human rights and, on the whole, more costly than community-based alternatives (UNICEF 2003 a, 2003b, and 2003c). Thirdly, a number of non-governmental

organisations both international and domestic have sought a greater role as providers of mainly alternative, community-based, non-institutionalised, services. Fourthly, the process of accession to the European Union has highlighted issues of long-term care and the importance of decentralisation of services in terms of local social planning processes and, again, improved citizen choice.

Thus far, the so-called '3Ds' of social services reform: deinstitutionalisation, diversification and decentralisation have tended to be treated separately rather than as inter-linked. There is a need for a clarification of each of the terms themselves; a modeling of their relationships to each other, and to other terms, within a systems framework and, above all, for greater clarity of purpose and assessment of institutional capacity to carry out holistic reforms, than has been hitherto attempted. Externally-funded and -driven projects, technical assistance and capacity building, themselves sometimes contribute to a fragmented, inconsistent, badly sequenced, and short-term reform agenda. In addition, existing domestic institutions, whose dominant modes of operation are, themselves, obstacles to reform are either tasked with leading the reform or are ignored completely in a rush to construct new 'pro-reform' agencies which often have little legitimacy and, in reality, even less power. In this context, stakeholder resistance needs to be seen as a systems feature, requiring attention, rather than an aberration to be ignored or ridden roughshod over.

The concept of 'deinstitutionalisation' refers to a process of systemic change in which there is a significant and irreversible shift in the balance of care for vulnerable or 'at risk' groups, such as children deprived of parental care, young people in conflict with the law, people with disabilities, people with mental health problems, and older people, away from full-time placement in residential institutions and towards community- and family-based alternatives. The results of such a process should be a reduction in rates of institutional care and in length of time in care. From a rights-based, client-centred, perspective, institutional care should be a 'last resort', only used for those who really need it and, wherever possible, should be a transitional rather than a permanent form of care. The emphasis is thus placed on support to the client's family to prevent family separation or facilitate family reintegration, or placement in a substitute family. A notion of 'deinstitutionalisation' as "the complete replacement of institutions by services in the community" (Mansell, 2005; 26), demanded by some social movements in Western Europe and the United States for mental health survivors and people with learning disabilities, can produce resistance conjuring up images of rapid closure of all

institutional care services without ensuring that appropriate alternatives are in place. The term transformation of institutions is therefore used to refer to institutions' potential to develop new services, reduce the scale of their operations, and either to provide higher quality services or to close following a process of planning alternative care for clients and retraining and redeployment of staff. Hence, institutional care is no longer the sole nor the main type of service but rather one amongst many types of service resources within a 'continuum of care'.

The 'diversification' of service provision, sometimes also referred to as 'deetatisation' (cf. Puljiz, 2005), is another key principle which, whilst having echoes in trends in developed countries, takes on a specific meaning in the context of post-communist societies with a legacy of a near monopoly of service provision by state agencies. The aim of diversification is to create a welfare mix in which the state retains its regulatory competence but facilitates service provision, on a level playing field, by state and not-state actors including both not-for-profit and for-profit organizations, and creating legitimate channels for the participation of citizens groups in shaping policies and for clients' participation in decisions affecting their lives (Matković, 2006). In some welfare mix models, 'welfare' is produced by the actions of, and inter-actions between public agencies in the state, non-governmental, community-based and voluntary organizations in civil society, private agencies in the market, and families and other household forms (Powell and Barrientos, 2004; Gough 2001). Newer approaches stress the importance of 'quality' of services without any *a priori* assumptions of the relative merits or comparative advantages of public or private services *per se*, advocating ever more complex partnerships between traditionally separate sectors (cf. Beck et al (eds.), 2001. The role of quality control, long-term contracting, and financial subsidies remain important, however, if new welfare mixes are not to produce new kinds of inequalities, a recommodification of welfare, and an 'individualisation of the social' (Puljiz, 2005; Ferge, 1997) in which clients become more or less consumers in the welfare market place.

'Decentralisation', most succinctly defined as the transfer of authority, rights, duties and responsibilities as close as possible to local populations, is also rather more complex than first appears. It can encompass a shift in fiscal and administrative responsibilities to lower levels of government ('devolution'); to local units of central government ('deconcentration'); and/or to semi-autonomous agencies ('delegation'). In a sense, the outcome of decentralisation needs to be in keeping with the principle of 'subsidiarity', emphasized within the European Union, which suggests that decentralization should be to the lowest level of government capable of

performing functions efficiently and effectively. Of course, different tasks or functions can be held at different levels or, indeed, be shared, so that all political arrangements in contemporary societies exhibit tendencies towards 'multi-level governance' in which "supranational, national, regional and local governments are enmeshed in territorially overarching policy networks" (Marks, 1993; 402-3), necessitating 'continuous negotiations' (ibid; 392). Matković (2006) refers to the use of 'asymmetrical decentralization' or the transfer of certain functions to some regions or local governments not all, which can be appropriate when local governments significantly differ according to economic strength, number of inhabitants, cultural specificities and/or administrative capacity.

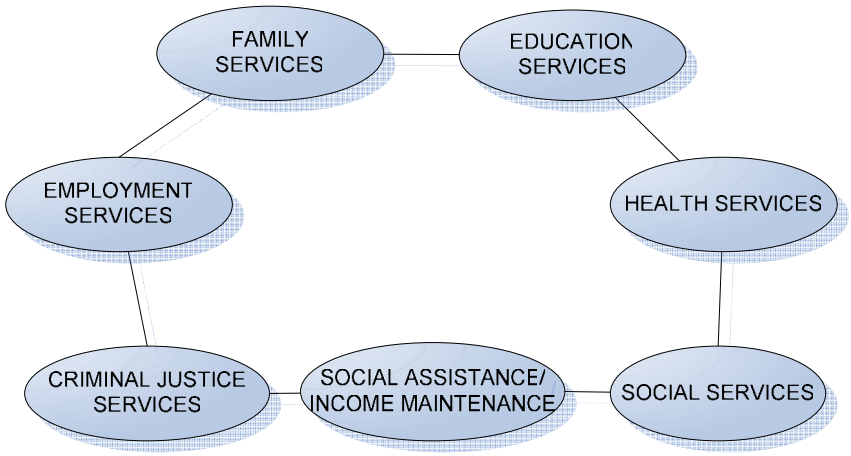
Local and regional social planning, perhaps best defined as an inclusive process, involving all local stakeholders, which maps needs and resources; sets plans for the local solution of local social problems; commissions specific services; and regularly reviews results, is crucial here. It usually involves "the establishment of an agreed planning mechanism which seeks to mobilise existing resources, stimulate new initiatives, and ensure a network of services to meet agreed outcomes and targets" (Stubbs and Warwick, 2003; 9). It is a crucial part of ensuring that decentralised services are in line with local needs and attain a level of allocative efficiency. Decentralisation is not a magical panacea and, indeed, can be disastrous in the absence of safeguards to ensure that local elites do not capture resources for their own purposes and, even more importantly, if adequate long-term predictable systems of transfer payments and equalisation formulae are not in place to counter the rise of geographical inequalities. It may, indeed, be a product of political expediency in terms of shifting responsibility for unpopular structural adjustments to other levels of government, and resolving fiscal crises and decreasing deficits at the central level (Matković, 2006). Above all, there is a need to ensure good governance of services and to improve relationships between the national and sub-national units of government (cf. Tendler, 1997). Unless associated with shifts in policy priorities, decentralisation could, indeed, result in an increase in rates of institutional care, as each sub-unit maintains, or even builds anew, its own residential care facilities.

In order to promote change, there is a need for a Whole Systems Approach (WSA), increasingly influential in health care reforms (cf. Hirsch et al, 2005). Essentially, such an approach maps and analyses interdependent elements of a complex system in order to deliver benefits to the whole system. Any change in a part of a system impacts on other parts of that

system and, in the case of social services, changes in statutory services impact on other services and on a range of non-statutory providers. The approach is particularly suited to issues of deinstitutionalization since it seeks to reorganise services to ensure that the service user is at the centre of the system and that the user's experience defines the effectiveness of a system. This is a process of moving , more or less gradually and smoothly, from a fragmented system where the user is outside the system, through a more co-operative system in which the user is increasingly central, to a goal of a fully integrated, user-centred system in which "a mixture of different people, professions, services and buildings … have … service users as their underlying concern and deliver a range of services in a variety of settings to provide the right care, in the right place, at the right time." (Health and Social Care Change Agent Team, n.d.; 1). This can only be achieved by analysing, systematically, the factors which impede and impel whole systems working, sometimes referred to as 'systems' regulators', and the impact of changes in one system on adjacent systems.

In thinking about deinstitutionalisation, it is possible to examine systems at four, inter-connected levels. One is the 'supra' level, in which the social services system is related in a complex way to, at least, six other systems or policy regimes. The complexities of the inter-relationships at the supra-system level are beyond the scope of this paper although it is important to recognise that social services, as a relatively minor and somewhat marginal sub-system, is often forced to respond to wider changes in other systems.

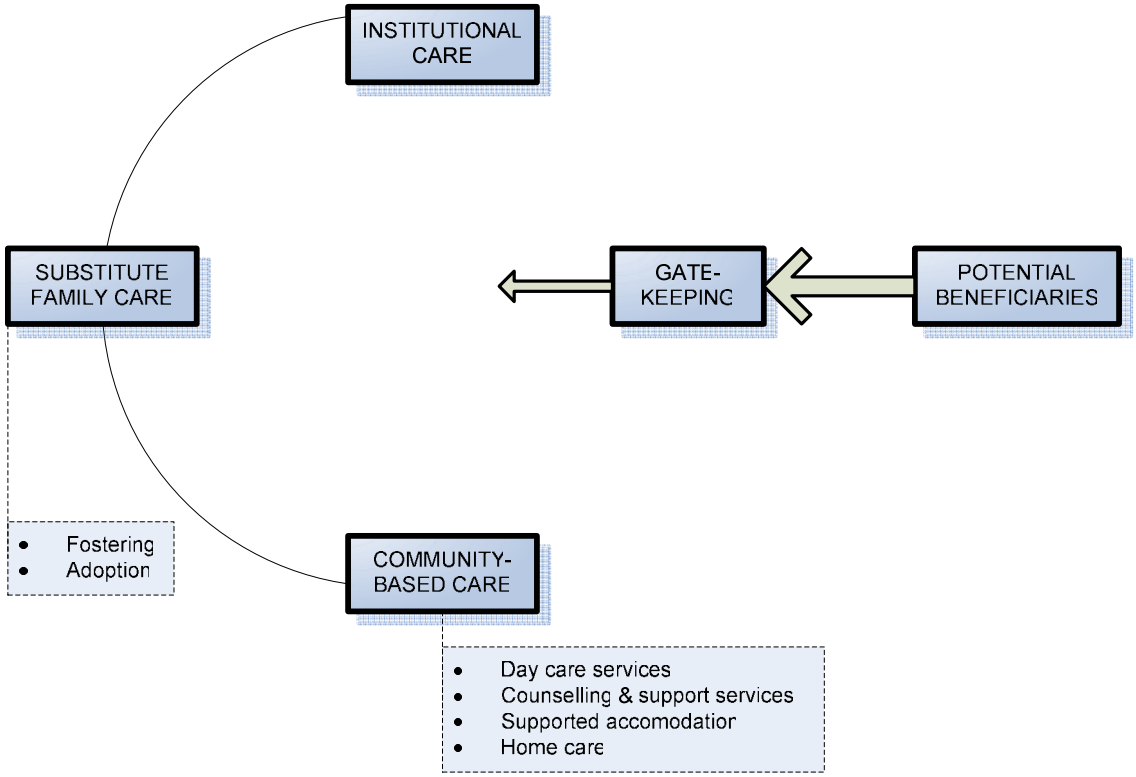
Figure 1: Social services at the 'Supra'-system level



The second level is that of social services as a system in itself. At this 'macro' level, two broad features are crucial. The first is the overall demand for services, in terms of the number

of users in the system. The second is the diversity of types of care and the relative weight of institutional and non-institutional forms of care. The two dimensions are illustrated in the diagram below. Crucially, a process of deinstitutionalisation works along both dimensions. On the first dimension, attempts can be made to reduce the overall number of users in the system, through 'gatekeeping', the reduction of access, and 'reintegration' in terms of expediting exit. On the second dimension, attempts can be made to reduce numbers in institutional care through increasing numbers in non-institutional care and through expanding the range and type of non-institutional services. In terms of system regulators, there is a need to address the inter-linkages between laws and administrative procedures, financial flows, and professional practices and discretionary decision-making. Many reform efforts assume a more straightforward approach in which legislative change is seen as, either, sufficient *per se*, or as having inevitable effects in terms of financing and professional practice. In our view, these need to be addressed simultaneously. In addition, decentralisation and diversification, whilst appearing to add complexity can, in fact, free up a 'locked in' system and promote news kinds of services and, crucially, new financial flows. As we shall note below, the 'scale' of intervention is crucial and, in some cases, sub-national, regional or zonal scales may be the most optimal, representing the third, or 'meso' level to which we return in section three of this paper.

Figure 2: De-institutionalisation at the 'Macro' level



The fourth level of intervention is in terms of a single institution which is, itself, a complex sub-system. At the 'micro' level, change in one institution can facilitate learning and demonstrate effects which can be 'scaled up' to other levels. Here the focus is on care planning for each resident, a re-training and re-deployment plan for all staff, and a clear mission statement for the institution. Inevitably, working on a single institution depends on linkages in terms of financial source for transition costs of deinstitutionalization and in terms of collaboration of statutory services at the local level. There are, however, significant risks in an exclusive focus on the 'micro' level in terms of generating demand for institutional care elsewhere in the system.

In the next section, these issues are described for three countries, Bosnia-Herzegovina, Croatia, and Serbia. In each case, the gap between 'macro' and 'micro' level reform initiatives seems rather large.

2. SOCIAL SERVICES REFORM IN BOSNIA-HERZEGOVINA, CROATIA AND SERBIA

With the recent independence of Montenegro and, notwithstanding continued uncertainty over the future status of Kosovo, there are now six successor states of the former Yugoslavia. In this paper, we focus on the three largest, representing quite significant differences in terms of national wealth and human development, levels of poverty and social exclusion, nature of the state, and prospects for EU membership. All three inherited, and have more or less maintained, a system of social policy, in which services are dominated by statutory Centres for Social Work (CSWs) and a range of institutional care facilities. In terms of key economic and social indicators, the following Table, deriving from a paper by Matković (2005), provides a broad comparison.

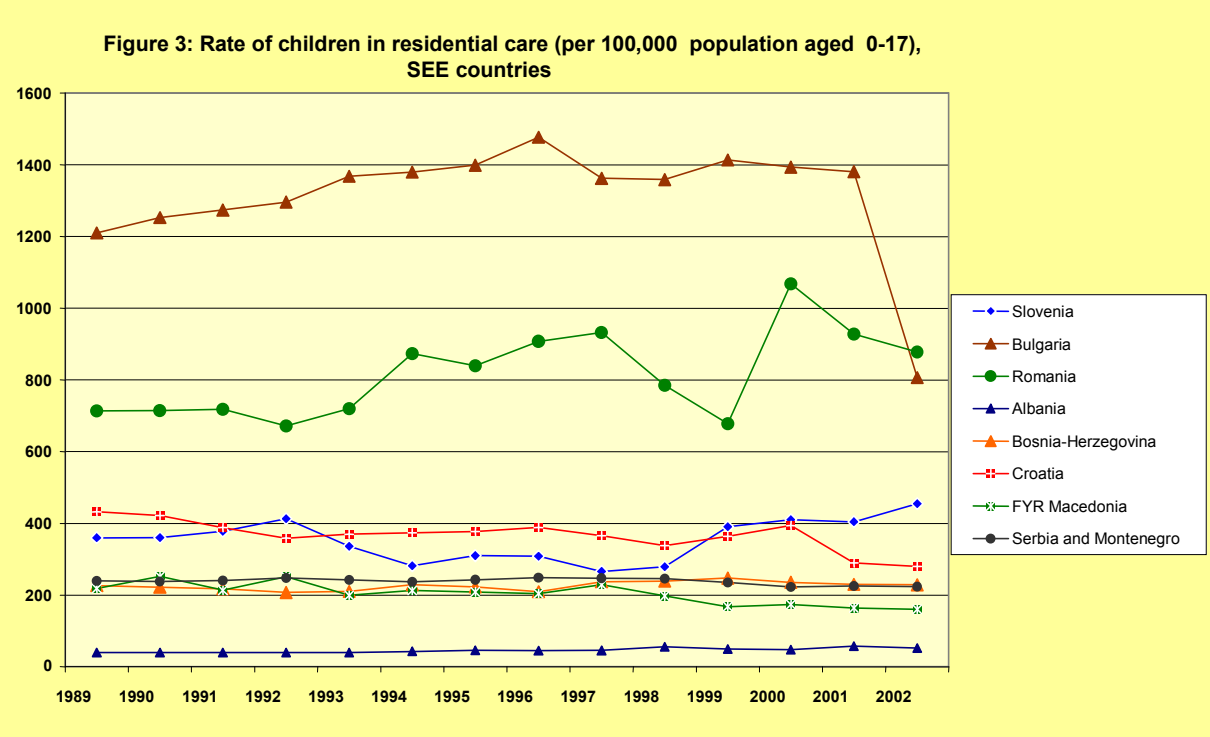
TABLE 1 Key Economic and Social Indicators

COUNTRY	Pop	GNI per capita	HDI	POVERTY RATES			Gini Coefft	LFS Unemp
				Absolute	Extreme	Relative		
Bosnia-Herzegovina	3.9 m	$2050	0.781	19.5%	0	16.7%	0.27	16.4%
Croatia	4.4 m	$6820	0.830	8.4%	0	17.2%	0.36	14.3%
Serbia*	8.1 m	$2700	0.772	10.6%	2.4%	20.2%	0.30	15.2%

Source: Matković (2005) with updates where available from
http://www.worldbank.org/data/countrydata/countrydata.html

In terms of institutional care, the UNICEF TransMONEE database is the most useful for comparative purposes although it provides figures only for children and young people. It is reliant on state statistical office reporting and contains many gaps. In addition, a recent study has suggested that it under-states the true figures significantly and that, often, significant year on year falls are a result of changed methodologies (Carter, 2005). The graph below, for the countries of South Eastern Europe, uses TransMONEE figures expressed as a rate per 100,000 children aged 0-17 years, combined with Carter's estimates for years where no figures are available. It is noteworthy that, whist in Bosnia-Herzegovina and Serbia, insufficient information is available to judge the accuracy of the figures, Carter estimates that true numbers of children in residential care in Croatia is some 30% above the official figure (Carter, 2005; 85)†. This suggests that, in fact, the rate remains higher in Croatia than in Bosnia-Herzegovina or Serbia but that this is lower than in Slovenia and significantly lower than in Bulgaria or Romania. We now address each country in turn in terms of its specificities.

* Population and GNI figures are for Serbia and Montenegro
† The methodology used is based on a multiplier derived from those countries with known levels of exclusion of children from official figures.



Source: Carter, 2005; 22.

2.1 Bosnia-Herzegovina

1. Administrative Context

Bosnia-Herzegovina is a case of an extremely complex administrative environment for social policy, in large part a product of the constitutional General Framework or Dayton agreement, which gave most authority to the two entities of the Federation of Bosnia-Herzegovina and Republika Srspka and to the District of Brčko (cf. Stubbs, 2001b). Social work services are the responsibility of municipalities who also contribute payments to residential care facilities which are administered and primarily financed by the entity in RS and by cantons (the regional tier of Government) in FBiH. In reality, the situation is much more complex with a number of institutions having no clear legal status and others reliant on municipal contributions and donations for their survival. Cross-entity transfer payments remain controversial and under-developed. There are 101 CSWs in BiH, 40 Social and Child Welfare Offices, 2 Cantonal CSWs and a Sub-Department for Social Welfare in Brčko District. These services employ 534 professional and 622 administrative and other staff (Maglajlić and Rašidagić, 2006). In FBiH, the cantons also pass laws and finance child benefits and foster care. In RS, a draft Law envisages all social protection functions to be at the entity level. A Children's Fund exists in RS which finances child benefits and there are plans for a similar

fund in FBiH. Spending on social protection in different cantons and municipalities varies enormously (cf. IBHI, 2006). The recent introduction of VAT and the channelling of revenues to the state level are meant to stimulate new state-based social programmes, although many political obstacles continue to make this difficult.

2. Nature and Problems of Institutional Care

Problems of transition and of economic problems have been compounded by war so that a rise in demand for services, including a significant rise in the numbers of children without one or both parents, has been accompanied by a lack of resources. There is a chronic lack of accurate and timely statistical data to facilitate service planning. Levels of institutionalisation are a product of the survival of pre-war institutions, along with the renovation of damaged facilities, and the opening of new facilities, often funded, in whole or in part, by development aid grants from foreign donors. Rates of institutional care for children are higher in FBiH than in RS, although the latter has a much higher proportion of children in conflict with the law in institutional care compared to children without parental care or with disabilities (the ratio is 3: 1 in RS compared to 1:10 in FBiH). Foster care rates remain low and have actually fallen in parts of FBiH, although both Tuzla and Sarajevo cantons have increased rates. Only 3% of all those fostered have a disability (Save the Children, 2006).

3. Implemented and Proposed Reforms

Reforms in social welfare have been very piecemeal, with a large number of externally funded short-term 'pilot projects' seeking to introduce a variety of innovations usually at the level of individual municipalities and/or institutions (cf. IBHI, 2006). Whilst certainly exposing professionals to a range of new ideas and approaches, the models introduced were, quite often, at odds with one another and have had contradictory and, at times, perverse effects. New institutions have been built which militate against system transformation and drain system resources. External grants have also promoted a somewhat artificial growth in NGOs as service providers but, again, this has been short-term and somewhat parallel to the existing system. There is almost no transparent funding for NGOs from any level of government. Macro-level social welfare reform, led by the World Bank, has tended to focus on fiscal constraints and on governance reforms but, even here, reform has been very slow and incremental, not least in the face of resistance to cutting very high benefits to war veterans and their families.

A number of projects seeking to link pilots with macro-level reforms have produced some blueprints for system reform but action has been limited. UNICEF and Save the Children have been active in developing a strategic focus on child protection as have a number of organisations in the field of disability. There have been significant innovations in 'islands of excellence', notably in Tuzla canton where, over a long period, International NGOs have supported the Cantonal Government in developing more coherent service planning. Generally, however, the production of studies and policy recommendations has rarely been translated into changes on the ground. Within the Medium-term Development Strategy for BiH, which grew out of the Poverty Reduction Strategy work, there is a focus on social protection at the state and entity levels but this is often marginalised in the context of more pressing priorities and the need for structural reforms.

4. Stakeholders

Capacity to steer reforms from the central level is limited by the political and fiscal implications of the Dayton agreement. In both entities, social protection questions are "a marginalised part of marginalised Ministries" (Stubbs, 2001b). External agencies have some leverage but this is often project-specific and promotes contradictory and instrumental approaches. There is a lack of intellectual debate on social policy issues and social welfare professionals are also rather weak and tend to focus on existential concerns or to resist change. Crucially, service users have not been encouraged to participate in reforms, outside of small-scale initiatives. Numerous ad hoc multi-stakeholder groups are formed around certain projects but these rarely have a wider impact.

5. Assessment

Confusing administrative and fiscal responsibilities combined with projectisation militates against any coherent reforms. The existence of cantons as a regional tier in FBiH has had little impact on an improved planning of services, with the exception of Tuzla Canton, and there is no such administrative tier in RS. There are few, if any, financial incentive effects for de-institutionalisation. Experiments in social planning have been concentrated at the municipal level so that these have tended not to focus on institutional care (cf. Maglajlić and Stubbs, 2006).

2.2 Croatia

1. Administrative Context

Centres for Social Work are deconcentrated units of central Government. They no longer correspond to municipalities in the context of a massive growth in the number of municipalities since independence (there are now some 555 local government units including 427 municipalities, and 128 towns or cities and some 80 CSWs and 24 branch offices, largely corresponding to pre-war municipal boundaries). Residential care facilities are mixed, with most still state-owned and financed. However, homes for older people are now owned and run by the regional tier of government, namely the 21 Counties. In addition, private homes have grown in number and importance in the last ten years. Larger towns and cities have their own social protection programmes, sometimes granting additional assistance to social assistance beneficiaries.

2. Nature of Problems of Institutional Care

There has been limited progress in reducing numbers in institutional care. With regard to children, the largest falls occurred in the early 1990s, largely as a result of the war, as children were transferred to other Republics. At the end of 2004, 1,073 children were in state-run homes for children without parental care, 124 of whom were 3 years old or younger. There has been some, geographically uneven, success in promoting fostering as an alternative to institutional care. Many problems remain, however, in terms of the size of some residential care facilities, and the distance away from centres of population. In addition, new residential facilities have emerged in the 1990s, run by NGOs. Statistics, whilst more accurate than those in Bosnia-Herzegovina, are still confusing regarding the definition of institutional care between health and social welfare services. Croatia has 17 state-owned homes for physically and mentally disabled children and adults with a total of 3,052 residents at the end of 2004, ranging in size from 17 to 463. Perhaps most worrying, a significant proportion of residents are aged 0 - 8 (a total of 257) or between 9 and 15 (a total of 569). Indeed, in these homes, notwithstanding deinstitutionalisation efforts, which have concentrated on one of the largest institutions where there have been a number of problems regarding hygienic standards, there appears to have been an increase in numbers since 2001 when there were 2,867 residents. There are 46 county-run homes for older people, accommodating 10,168 people at the end of 2004. The largest rise has been in private and voluntary sector homes for this population with a rise from 10 homes in 2000 to 57 in 2004, accommodating some 2,314 persons.

3. Implemented and Proposed Reforms

Reforms were largely piecemeal until the election of a coalition Government in January 2000 and the beginnings of a strong political push for reforms and for EU membership (cf. Stubbs and Zrinščak, 2005). Social protection reform, including the reform of social services, was a priority of the Ministry of Labour and Social Welfare, with an overview document produced by a leading social policy academic and the, then, Assistant Minister (Puljiz and Žganec, 2001), committed to deinstitutionalisation of services. This was followed by the commissioning of a policy study on deinstitutionalisation in 2001 which proposed a rather 'radical' deinstitutionalisation scenario. Parts of the report were reported on in the press prior to its completion, provoking something of a backlash from trades unions representing residential staff and, subsequently, the full report was not released and, indeed, upon the change of Government in 2003, essentially marginalised (cf. Bratković, 2006; 213). Under a World Bank and DFID project, a number of teams worked on blueprints for reforms, including social services (cf. Stubbs and Zrinščak, 2006). Work on a subsequent loan to promote reform was delayed as a result of the change of Government. The new Ministry of Health and Social Welfare emphasised the importance of renovating existing institutions over and above deinstitutionalisation. In July 2005, a €46.7 m Social Welfare Development Project was agreed by the Government and the World Bank, including a €31 m. loan and a €1.5m. Swedish Government SIDA grant. The cost of upgrading existing facilities is envisaged to be €34 m, whereas €5.3m is envisaged for a new model of social services to be introduced in three 'pilot' counties. Part of this includes a transitional fund to finance 'Innovation and Learning' to promote alternative social services models. The SIDA grant promotes technical assistance designed to secure a 10% reduction in referrals to residential institutions in pilot areas and an unspecified degree of deinstitutionalisation. This, together with considerable delay and uncertainty regarding a number of single institution plans for deinstitutionalisation, suggests a rather limited and very long-term process in operation.

The Ministry does provide funding to a number of NGO initiatives in the field of community-based care and, in particular, supported housing. In addition, one of the priorities of the National Foundation for Civil Society, administering state grants to NGOs as well EU CARDS funding, is the promotion of community-based social services although, again, these tend to be short-term and geographically uneven. Some larger cities have also worked on funding community-based services as outreach services from existing residential facilities. However, local social planning remains limited by the lack of decentralisation of functions

and by the sheer number of local authorities. Counties, themselves somewhat over-politicised entities, lack the capacity to steer social welfare reforms.

4. Stakeholders

Social policy responsibilities in Croatia are now divided between three Ministries and, in addition, there is a degree of 'captured' social policy, particularly in terms of war veterans, pensioners and, to an extent, demographically-motivated family policies. Fiscal concerns dominate both in terms of the locked in financing of existing and new institutional facilities and the greater concern with social assistance benefits. Residential care workers, numbering some 8,852 at the end of 2004 (Jurčević, 2005; 349) are mainly unionised and well organised. Neither they nor field social workers represent a strong interest group for deinstitutionalisation. There are a small number of leading NGOs and academics, often with international links and support, who are advocates of de-institutionalisation but their influence remains limited. Service users also have little influence although, at times, the argument that it is the parents of children with disabilities who oppose change is made. Importantly, the main print and broadcast media has tended, either, to be largely positive regarding coverage of institutional care or has failed to connect investigation of particular 'scandals' with wider systemic analysis.

5. Assessment

There is some greater coherence to reform in Croatia than in Bosnia-Herzegovina. Deinstitutionalisation practices exist, policy recommendations have been made and, to a degree, macro-level commitments are in place. However, in the absence of a strong 'driver for change' (Stubbs and Zrinščak, 2006) and with other social policy issues receiving greater priority, the likelihood of substantial change in the short- or medium-term is limited. Crucially, debates on decentralisation are stalled and there is more welfare parallelism (ibid.) than partnerships both in terms of the role of different levels of government and in terms of the involvement of NGOs as alternative service providers.

2.3 Serbia

1. Administrative Context

Serbia has 132 Centres for Social Work and 167 municipalities, one third of which has less than 20,000 inhabitants. There are also 25 Districts which represent a new regional tier of Government. Centres for Social Work are primarily owned and financed by the central

Government but municipalities fund exceptional social benefits and the running costs of CSWs. Residential care facilities are mainly central government owned and run. Social Welfare was the responsibility of a Ministry of Social Affairs from January 2001, and is now the responsibility of a sector in the Ministry of Labour, Employment and Social Affairs. In a way not unlike Croatia, a largely decentralised system became highly centralised in 1991.

2. Nature of Problems of Institutional Care

Serbia's social welfare system, like that of Bosnia-Herzegovina, has faced increased demand and reduced funding. Legacies of high levels of institutional care have not yet been effectively countered. There are some 1,200 children without parental care or with disabilities in institutional care, a large proportion of whom are some distance away from their original place of residence. Children with disabilities, placed in one of five large, remote, residential centres, are particularly vulnerable, tending to send their whole life in institutional care. A recent Social Welfare Strategy Document notes the problems in this regard:

> These institutions are characterised by a large number of beneficiaries (from 300 to 650), children and adults aged from 4 to 50, even older, which exceeds the number prescribed by norms and standards. The facilities are in poor condition, the staff structure prescribed by norms is inadequate, and care-takers are insufficiently trained for the application of contemporary work methods. All of this raises issues regarding respect of beneficiaries' rights. (Government of Serbia, 2006; 7).

There are 17 institutions for persons with mental and physical disabilities and mental health problems, accommodating 5,574 beneficiaries. There are some 7,800 people in homes for the elderly. There are few non-state residential care facilities. NGOs do receive support from external donors and, more recently, from the Social Innovation Fund (see below) but, as in the other two countries, funding tends to be short-term and not integrated into wider social planning. Provision is very geographically uneven.

3. Implemented and Proposed Reforms

Reforms only began in earnest with the establishment of a new Government in January 2001 following the overthrow of the Milošević regime in October 2000. The re-organised Ministry of Social Affairs, under the dynamic leadership of Gordana Matković, whilst emphasising poverty reduction as its main priority, also developed a strategic focus on social services reform, including deinstitutionalisation. One part of a project on 'The Reform of Social Protection', beginning in March 2001 focused on «family-centred support and protection of

children, the elderly, disabled people and people with special needs» (Government of Serbia Ministry of Social Affairs, 2002; 1). A number of ad hoc working groups, consisting of academics, policy-makers and practitioners, were established focusssing on reform processes (social welfare services; transformation of institutions; information systems) and target groups (the elderly; Roma; disability; and victims of violence and abuse). From May 2001 until March 2002, the Ministry organised a series of consultative conferences throughout the country. Later, the working groups were re-organised and tasked with outlining a strategic reform agenda, through inter-linked reform projects.

Crucially, the Government established a Social Innovation Fund, operational since 2003, as a transitory mechanism providing competitive funding and management support to reform-oriented social services projects at the local level. SIF is designed to promote the development of a coherent and sustainable range of community-based, alternative, social services implemented through partnerships between a plurality of service providers, in order to ensure that local level innovations inform central level reforms (cf. SIF, 2004). The overall funding for SIF for the period 2003-2009 is some 12.3 million euros. Total EU support of 4.9 million euros is supplemented with the funds from the Government of Serbia of approximately 2 million euros for local projects for the period 2003 -2006 and an anticipated 1.4 million euros for the period 2007-2008. The Government of Norway provided 3 million euros for the period 2003-2004 and 2006-2009, while DFID has provided 1 million euros for the period 2006-2009 (Arandarenko and Golicin, 2006). A demand-driven mechanism for distribution of central funds, previously reserved for existing umbrella organisations for persons with disabilities, was established by the Ministry in 2002as a Fund for Financing Organizations for Persons with Disabilities. Like SIF, the Fund has developed transparent criteria and procedures for financial and technical support for local level services for persons with disabilities.

Serbia's Poverty Reduction Strategy Paper, approved in October 2003, also emphasises «more efficient social protection» as one of its seven key strategic priorities. Within this, the section on 'the reform of social services' (Government of Serbia, 2003; 126) is committed to a coherent national level reform. The parameters of this have now been set out in a recent 'Social Welfare Development Strategy' document which, for the first time, explicitly links a territorial appraoch to social welfare with the issue of deinstitutionalisation.

Whilst there has been, and continues to be, donor support for core social protection reform, including SIF and the Social Welfare strategy, a number of 'pilot projects' in particular municipalities have had limited results, distorting priororites and mitigating against macro-level planning. In addition, donors have tended to emphasise one client group above others, also resulting in infficiencies.

4. Stakeholders

The Social Welfare Strategy document has a section on ‘Stakeholders in Social Welfare Reform’, perhaps indicative of a greater commitment to stakeholder consultation and to co-ordination than elsewhere. Nevertheless, the Government itself and the Ministry have only very recently begun to prioritise social services themes and still, sometimes, speak and act with rather divergent voices. One useful consequence of externally funded projects has been the stimulation of the main body representing local authorities to take a keener interest in social welfare reform. In addition, Serbia has a number of informed experts working on reforms in ad hoc groups. NGOs tend to be more focused on their own projects and, still, as elsewhere, service users are relatively absent from reform debates, although the recent SIF beneficiary assessment, conducted by the Centre for Liberal Democratic Studies, introduced the practice of including service users in the assessment of service quality and relevance. Media, not listed as a key stakeholder in the strategy, have largely been supportive of existing institutions.

5. Assessment

Considerable progress in terms of strategic thinking and planning has been made in Serbia in a little over five years. The reforms are far more locally owned and driven than is the case, certainly, in Bosnia-Herzegovina. Nevertheless, real resource constraints combine with somewhat overlapping and contradictory project based pilot reform efforts and a proliferation of expert-led working groups. The new strategic focus will receive the support of the Governments of the UK and Norway but the task remains to create a critical momentum for combining decentralisation, diversification and deinstitutionalisation.

3. CONCLUSIONS: THE CASE FOR MESO-LEVEL PLANNING

Notwithstanding differences which relate to politico-administrative context, levels of resources, and the nature and extent of external development agency involvement, there are a

number of striking similarities in the broad pictures emerging from the country descriptions, certainly in terms of the barriers to root and branch reform. Firstly, social services reforms, themselves quite marginalised, have largely been implemented without sufficient attention to either governance arrangements nor to fiscal flows. When these have created obstacles, a resistance to tackle such 'big issues' has tended to predominate. Reforms have tended to be single issue focused, with a series of short-term, crisis-oriented solutions rarely forming a coherent whole. There have been inevitable tensions between keeping the system going ('business as usual') and a need for fundamental reforms and the creation of new systems or sub-systems. The conceptual steering of the reforms has, in fact, often been rather too intellectual with connections to practice left rather vague. In any case, a number of consultative or steering groups, with overlapping memberships, have tended to work sporadically and too much initiative has been taken by 'consultants' of one kind or another. Crucially, the balance between directive authority and consultation has been rather problematic, with an emphasis on technical and expert-driven legal changes and facilitator-led consultative processes which have neither analysed nor attempted to lock in key stakeholders to the reforms. Issues of mistrust between stakeholders have rarely been addressed systematically. The problem of overlapping and confused mandates has been compounded by the creation of new agencies and reform bodies.

Above and beyond this, however, two key problems have been detailed above. The first is that of 'scale': stated simply, reforms have worked at both too large and too small a scale, with a failure to work at the meso-level and a chronic failure to connect micro-level pilots with macro-level paroles. Secondly, diversification of services has been rather half-hearted, simply adding on new providers funded erratically, unevenly and, almost always, in a highly short-term, projectised, way.

Ongoing deinstitutionalisation efforts in all three countries have concentrated on small-scale interventions at the level of institutions and not on a multi-level systemic approach to reduce entries and accelerate exit from institutions. Some institutions have closed and others have improved, but these measures have had little impact on overall service outcomes. Sometimes, alternative services have developed with no systematic assessment of which groups of clients need these services to prevent their reception into care or facilitate family and community reintegration. Lessons learnt so far do not support the continuation of deinstitutionalisation efforts on the level of a single institution unless as a part of a national or regional plan which

addresses changes in institutional admission policies, draws up quantitative targets for the transfer of groups such as children and persons with disabilities into alternative care, provides clear guidance on priority groups for placement in alternative care, and assures financial flows in favour of services which are currently lacking.

Nothing short of a new institutional framework is needed which coordinates the supply of services and entitlements at local and regional levels, plans and adjusts it to local priorities and involves potential and actual beneficiaries and the public at large in the design, monitoring and evaluation of the system and its outcomes. A new 'zonal' approach to social services is needed in which existing regional structures, or groups of municipalities, large enough to ensure a match of supply and demand, deliver a planned approach to meeting needs and ensure a more appropriate balance between community-based and institutional forms of care.

In Bosnia-Herzegovina, the recent Strategic Directives for the Social Protection of Children Without Parental Care is a step forward, based on consultations with staff in CSWs and in residential institutions, and has the support of the respective entity Ministries. It envisages further work on alternative services and deinstitutionalisation within Regional Action Groups in Cantons in FBiH, in the District of Brčko, and through Inter-Municipal Bodies to be formed in accordance with the Constitution of Republika Srpska. In comparison with Croatia and Serbia, BiH residential institutions tend to be smaller and their integration in a regional network of services could be developed with less need for drastic downsizing or complete closure.

In Croatia, counties are legally established regional intermediary structures which already function as political and administrative actors in aspects of social policy and social protection. It remains to be seen whether the three pilot counties in the Social Welfare development project will be able to establish an optimal model of social services which forms the basis for the Ministry to introduce regional networks of services. Ambitious goals of reducing the ratio of children and other beneficiaries in institutional as opposed to alternative care will have to be based on a regional planning methodology, involving all three levels of Government including the municipalities.

The recognition of a need for regional planning in social welfare is a recent phenomenon in Serbia, where regions as intermediary levels of government do not yet function, but local planning, mainly introduced through donor-driven projects, has proved to be an insufficient tool for introducing and/or rationalising services, especially in smaller municipalities. Lessons learnt from ongoing efforts in deinstitutionalization suggest that the most significant impact in terms of transformation of large residential institutions into centres of alternative services can occur only in the larger municipalities or by basing new services in clusters of smaller municipalities. Initial efforts are being made to stimulate inter-municipal planning initiatives through SIF and other projects. Attention is being paid, within this, to assuring quality of services through outreach to municipalities lacking human resource capacity. Inter-municipal planning needs to operate on the principle of creating economies of scale for services which would otherwise be unsustainable.

Hence, notwithstanding evidence of regional inequalities in many of the countries of the region (cf. UNDP, 2006; Jovičić and Arandarenko, 2006), and the need for new forms of equalization payments and, above all, for a system of agreed minimum standards to be in place, it does appear that meso-level planning is now on the agenda. In our view, this is a necessary, although perhaps not sufficient, precondition for ensuring that social services reform achieves principles of social justice and human rights, and acts as a model for a new scale of reform of social and public administration.

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