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Social Services in Transition

ESN working paper for the seminar

Building Capacity, Improving Quality
Social Services in New Member States

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European Social Network
Social Services in Europe

ESN is the independent network for social services in Europe. Our mission is to help change the lives of the most vulnerable in society through the delivery of quality social services. We bring together the people who are key to the design and delivery of vital care and support at the local level to learn from each other and contribute their experience and expertise to building effective European and national social policy.

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In 2004 and 2007 the European Union gained 12 new members mainly from Central and Eastern Europe and encompasses today 27 countries with a total population of 495 million. The New Member States constitute a very diverse group including the three Baltic States, Visegrad Group, three South Eastern European states and two Mediterranean islands.

This paper constitutes background information for the delegates to the "Building Capacity, Improving Quality – Social Services in the New Member States" ESN seminar in Ljubljana and a draft of the forthcoming ESN paper on social services transition in the New Member States. It attempts to characterise the present social situation with its challenges and its good practice in the Central and Eastern Europe. It is unfortunately impossible in a short paper to analyse in detail all the countries in question and to bring out their special features. This analysis is thus limited to Central and Eastern European States (CEEC). It has to be noted that even though this may make some generalised comments, the CEEC are far from being a homogenous group and many detectable differences exist among its members.

The paper is divided into three parts. The first part offers an overview of the communist social policy and welfare system. This background is necessary to understand the scale and depth of social change. The second part traces the formation of social services system in the NMS and provides examples of adopted solutions. In the third and final part, some key challenges are presented.

Social policy and welfare in the past

"The old regime was characterized by three pillars: full employment and quasi-obligatory employment; broad and universalistic social insurance and a highly developed typically company-based system of services and fringe benefits"[1].

Until the fall of the Berlin Wall social policies and welfare systems in the communist states were very much the same. Allowing for some local specificity, the CEEC shared some common features.

The social system was inseparable from the political and economic structure. The ruling monopolist party was in charge of planning all spheres of public life (and private with varying success) and the dominant centralising logic can be best summarized in the "think centrally and act centrally" doctrine. Submission to the communist party-state was rewarded by subsidized housing, food, transport and free education and healthcare (although gratuities for doctors were widespread). Universal coverage was not coupled with effectiveness and good quality of service.

The state ensured employment for all capable citizens. Full employment and an egalitarian wage, pension and benefits system were stepping stones and guarantees of a "perfect society of equal comrades". It has to be noted however that the system of the hidden privileges for *nomenklatura* made some comrades were more equal than other, to paraphrase George Orwell's "Animal Farm".

[1] Esping-Andersen G., *Welfare States in Transition*, 1996, p.9

A large part of social services was provided by the state enterprises. Every citizen had the right and obligation to work for the maintenance of his/her family and the development of the communist ideology. In exchange, a good citizen-worker had access to day-care facilities for his children, various allowances and recreational services at the workplace. State trade unions and party-state cells within companies played an important role in delivery and distribution of in-cash and in-kind benefits, enjoying broad discretionary powers in this respect.

There is a number of services that had not been available for communist state populations. Generally unemployment services were deemed unnecessary – with full employment those out of work where either pensioners, young mothers, people with disabilities or "criminal elements[2]".

Another example can be long term care which was the entire responsibility of the family until 1989. The sole alternative, available only where family support was unavailable, was institutionalisation in large residential care settings[3].

Although communist ideology proclaimed the primacy of the collective over the individual, it did not support community care. Crèches, children homes, mental health institutions and all long-term care settings were run by the state (often through state enterprises). These institutions were centrally managed, usually quite monumental edifices, providing strongly medicalised care. Their personnel, dressed in white, was "administrating treatment to patients", who were objects and not subjects of any undertaken action.

The social policy and welfare system in the communist era was characterized by a highly centralised top-down approach. Central planners decided on everything from the number of places in state run institutions, personnel and diets on the basis of supposedly perfect system. Universal and standardised treatment of patients was a landmark of communist egalitarianism but did not go in unison with good quality and efficiency of services.

[2] Idleness was seen as a criminal offence.
[3] See also: Cerami A. and Ettrich F., *Social Change and New Social Risks in Central and Eastern Europe*, 2007

Social transition and formation of the post-communist welfare state

At the beginning of the 1990s the CEEC launched major structural reform. The monopoly of the communist party was broken, central planning abandoned and the private market restored. This unprecedented systemic change had in the first period a political and economic character – the population protested against party-state privilege and economic inefficiency and not against universal coverage of care. Nonetheless, the collapse of state-controlled enterprises led to the complete breakdown of the network of services provided at the workplace. According to Hungarian estimates, almost 90% of crèches disappeared after the fall of communism. At the same time, hundreds of thousands of workers suddenly found themselves jobless when the principle of full-employment was refuted in favour of policies aimed at promoting maximised productivity.

Total unemployment (in %) in selected transition countries

Country	1994	1998	2000
Bulgaria	20.2	14.4	18.7
Croatia	10	11.4	13.5
Czech Republic	4.3	7.3	8.8
Estonia	7.6	9.9	13.5
Hungary	10.7	7.8	6.6
Latvia	18.9	13.8	14.4
Lithuania	16.4	13.3	15.9
Poland	14	10.5	16.9
Slovakia	13.7	12.5	19.1
Slovenia	9	7.7	7.1

Source: Labour force survey and official estimates

The political unrest of the first years of transition was coupled with economic uncertainty and growing social inequalities. In this situation a new social paradigm had to be found. The first social legislation acts adopted by the majority of governments had a primarily proactive character and were designed to prevent social crises. Free and universal healthcare was maintained, generous benefits paid out, early retirement schemes offered to cope with rising unemployment and inflation and to compensate for the dissolution of the communist social contract. Nevertheless, these decisions were often taken ad-hoc to deal with an emerging crisis and did not constitute a coherent social policy and welfare system.

Following the first period of generosity and somehow chaotic emergency measures, the new member states of the EU had to face the challenge of growing budgetary deficit and external pressure to modernise its social assistance and social protection systems. All introduced a three pillars pension schemes as advocated by the World Bank and other international financial institutions. Health and unemployment insurance was established and private practice allowed. Flat-rate benefits were replaced by means-

tested, maternity leave shortened[4], take up of unemployment benefits made conditional and several other austerity measures set up.

Amid these socio-political changes, post-communist social services emerged. No longer ensured solely by the state or its enterprises, they were (re-)established at the community level. Local authorities took up some responsibility for providing services to their inhabitants, such as long-term care for elderly people, care for children and young people, family services etc. In many cases, this devolution of tasks was not accompanied by sufficient resources to carry them out properly. Scarce resources, inexperienced local leaders and high hopes of the local population could not guarantee success. Nevertheless, many local authorities made a visible difference to people's life and learned rapidly how to manage their limited resources in the best possible ways.

Employment services and health care services (including mental health hospitals) remained centrally managed.

Local authorities focused their attention on the groups the most disadvantaged by the regime transformation: children, some groups of women, low-skilled workers and ethnic minorities (i.e. Roma and traveller communities, Russian minority in the Baltic Republics). Numerous in-kind benefits were made available: coal, clothes and food were distributed and some community work organised. These rudimentary measures soon turned out to be insufficient and nongovernmental organisations and charities appeared on the scene. Many of them had both international experience and funds and brought the ideal of community care to the CEEC. Local NGOs and churches became important social providers too. Examples of successful cooperation between international and local non-for-profit organisations and churches can be found across Central and Eastern Europe.

CRY (Care and Relief for the Young) is working in Romania in partnership with Asociatia Centrul Vieti Noi (a Romanian NGO) and a local church to provide consistent support and help both spiritual and material to: children and young people who are living or at risk of living on the streets. In its drop-in centre and day centre it offers advice, counselling, medical aid, clothing, showers, and food to children and young people. Vocational training and rehabilitation services are also available.

Community-based services have taken various forms. Hungarian communities developed a number of basic social services for remote settlements. Local care-takers provide transport from/to school, work, hospitals etc., collect medications and distribute hot meals. In Poland, disabled people gained the possibility to contact local authority and book "an assistant" who will accompany them for 4h per day in any outdoor activity they envisage (shopping, cinema, walk, visit to a friend etc.). Bulgaria reduced the number of institutionalised children by introducing new day-care centres, rehabilitation centres and special complexes for mothers with children.

Bulgaria made a considerable progress in development of community based services for children and young people. The number grew from 40 to 122 between 2003 and 2006.[5].

[4] During the communism era, maternity leave in some countries lasted even three years.

[5] Presentation on issues of deinstitutionalisation in the Republic of Bulgaria at the closing consultations with the European Commission, Brussels, 5.09.2006

In order to help older people stay in their own homes as long as possible, Czech local authorities support the development of the early warning portable systems connected to the medical centre as well as the police.

In Czech Republic, *Zivot 90* introduced Help Line Areíon to deliver its mission "home is at home". This long distance control unit serves older, handicapped and lonely people. State of the clients is monitored for 24 hours a day and this enables them to live an independent life in their home environment.

The 2004 and the 2007 EU enlargement further strengthened the trend towards decentralised community care. Local authorities gained access to the European Social Fund and its resources help to implement innovative local projects. The Baltic Republics use the ESF funds to promote active inclusion of some vulnerable groups of society.

In Lithuania, ESF helped to introduce the programme 'Social Integration of Young Offenders' developing the social skills of teenagers set to be released from the Kaunas Centre. Providing young offenders with coping skills and trades, local authority hope to integrate them back into society and keep away from crime path. In Estonia, ESF funds covered establishment of day-care centres for young children, resulting in shorter waiting lists for nurseries and allowing mothers to return to the labour market at their discretion.

Gradually, the paradigm of community care reached also services delivered by the state. Outreach care for people with long-term mental condition has been organised in Slovenia and Poland, filling the gap between informal family care and state-run psychiatric hospitals. Open centres and clubs for people diagnosed with schizophrenia or people with mental health issues are organised by communities and social workers now work with families, helping them to care for their relatives.

The mental health institution in Dornava (Slovenia) provides children with opportunities to participate in art therapy, orthopaedic & psychological therapy, social, cultural and manual activities on a daily, weekly or permanent basis.

Employment services, although still managed by the state, were not immune to the new trends. New structures for those furthest from the labour market were set up at the local level and funded through community and European funds.

The Social Integration Centre in Wroclaw (Poland) funded by the ESF and the city council helps its users (ex-convicts, homeless people, alcoholics and long-term unemployed) to find their own way back to the mainstream society through counselling, couching, psychological support and vocational training in five professional spheres: 1) construction work; 2) gardening; 3) graphic design; 4) long-term care and 5) office work.

The transition in social services and formation of post-communist welfare state would not be possible without devoted and visionary people working at the local, regional and national level day by day. Their hard work, enthusiasm and willingness to make a difference to the most vulnerable members of society made the transformation possible.

Challenges to social services in the CEEC

Almost 20 years after the fall of the Berlin Wall, the welfare systems in the CEEC are still in transition. It is not without importance that in the initial phase of regime change virtually all efforts went towards economic turnover and democracy building. Social policy was left aside and used ad hoc to appease the population dissatisfied with the results of the transformation. Furthermore social policy was not a priority in the enlargement process. The Copenhagen criteria dealt exclusively with political and economic questions requiring that candidate countries have a functioning market economy and the capability to cope with competitive pressure and market forces within the Union. The aid provided by PHARE on the modernisation of the social security system reached only 3.6% of the total PHARE budget 1990-1998 and decreased in the next period. These reasons, combined with the lack of expertise at the local level, shrinking financial resources and strong communist legacy explain to some extent the slow rhythm of social transformation.

The unfinished character of the social transition brings about some serious challenges.

De-institutionalisation is undoubtedly one of the key issues. Heavy reliance on the institutionalisation of service users such as dependent elderly or people with mental heath condition was the dominant approach towards social policy during the communist era. Large-scale residential settings, often located in the remote areas, provided standardized care for its inhabitants and employment for local population. The policy of closure of such institutions has met some serious obstacles. It has sometimes proved to be difficult for some personnel, accustomed to the relatively secure work *intra mures*, to accept such a change. It has been feared by the local leaders as leading to dramatic increases in unemployment in the short and medium term. Lack of community-based alternatives and of support to families has further slowed down the speed of discharge.

Although the issue of de-institutionalisation (esp. of children and mentally ill) has received some attention in the last years, performance measures have focused primarily on numbers of occupied beds. Some authors suggest that – in order to comply with EU conditionality and to avoid public blaming - some new Member States opted for “forced discharges” and “prohibited admissions” policy.

In Poland, mental health hospital in Tworki reduced its capacity from 1500 to 856 beds. Meanwhile, a new psychiatric hospital of similar capacity is planned to be built in Dwornica. In 17 Serbian residential institutions for persons with cognitive and psychological disabilities 5,574 residents (average 327 per place) are accommodated, the majority of whom are displaced from their home region or city.

De-institutionalisation efforts in the field of child protection should be further supported. The number of children in residential settings – although lower than previously is still troublesome and illustrates the need for a more contemporary, community-based approach.

According to national statistical offices, in 2006 Hungary had 21,300 children in orphanages, Romania 81,233 children in care (27,188 in institutions with capacity over 100 beds) and an average size of a Bulgarian "home for medico-social care" equalled to 124 beds.

Due to political and economical change and an EU enlargement, the local authorities in the EU-10 are becoming more and more involved in the social care sector. Numerous examples of transformation of old-style institutions into smaller units and of emergence of community care are available.

Some 15 years ago, Hrastovec-Trate the largest mental health institution in Slovenia has successfully embarked on de-institutionalisation policy. Small detached units (independent and semi-independent flats, as well as group homes) were introduced and the qualification of staff constantly improved. Almost 50% of its residents enjoy today an independent form of life.

Delivery of services can be identified as another outstanding challenge. It is a complex issue, involving the question of democratic control over delivery and its proximity to users.

The move from a highly centralized and over-controlled system to a more democratic model concerned not only politics and economy but also the social sphere. The welfare system was decentralized in the new member states at the occasion of administrative reforms. Newly (re-)established local authorities were made responsible for the welfare and well-being of its citizens.

Nonetheless, the transfer of responsibilities has rarely gone hand in hand with the transfer of resources necessary to implement social policy. In addition, local authorities had to deal not only with insufficient funds but also operate in the form of legal vacuum in absence of regulations accompanying new tasks. This has inevitably led to the emergence among local policy-makers of a negative attitude towards social services, identified as expenditure pushed upon them by the central government[6].

In some countries, local authorities were opposing the de-institutionalisation of mental health residential settings, reasoning that institutional care is financed from the state budget, while the community-based alternatives will become their budgetary line.

Withdrawal of the state from the welfare support and financial instability of the local authorities contributed to the development of nongovernmental organisations active in social field. Local grass-roots organisations and the branches of some big international NGOs rapidly filled the gap, providing care services on the basis of contracts with local councils. They often respond to the needs that are unmet by public services due to financial scarcity or political reasons (e.g. to prostitutes, women after abortion, ethnic minorities or drug users).

[6] Vylitova Marketa, (De)centralisation of Social Services in the Czech Republic, March 2003, p.6

In the Baltic States, NGOs noted that special programs or separate projects for the prevention and education regarding trafficking in woman, initiated or supported by the state, did not exist in Estonia as well as in Lithuania. "Praeities Pedos" was the first in Lithuania to initiate information-preventive campaigns reaching also neighbouring countries, as majority of girls sold to the Western Europe were accommodated in Lithuania for a while and waited for forged Lithuanian passports as the latter were not well protected and are rather easily forged.

A big part of social services in the CEEC is nowadays provided by NGOs. Nevertheless, their sustainability poses a serious threat to the continuity of service provision. Dependent on the local contracts, national, foreign or European funds, NGOs cannot always guarantee to operate without interruption. This uncertainty is not particularly helpful in gaining people's confidence, especially in the region where for the last forty years all services were delivered by the state. The mistrust towards non-public service providers (in relation to all public services) continues to be expressed[7]. Additionally, it does not create the best environment for personnel development and training.

The cooperation between NGOs and local authorities occasionally encounters problems. The latter are inclined to perceive nongovernmental organisations as contracted agents, fully reliant financially and thus expected to be silently obedient. NGOs complain about the changing rules of the game and too high expectations with regards to funding provided.

Notwithstanding these complaints, it needs to be emphasized that the social services provided by municipalities are usually subject to much stricter quality controls and tend to be more transparent. Managed by the local authorities, they are accountable to the local population and thus more democratic.

In Poland old people's homes run by municipalities are controlled by the regional level (*wojewoda*). A recently uncovered case of maltreatment and abuse of residents in one of the private care home managed by Betania Foundation sheds light on the fact that the overwhelming majority of such establishments in Poland work without the necessary registration and is not required to admit social and health inspectors to their premises.

The question of **quality of care** constitutes the third challenge which needs to be addressed. It is a particularly difficult issue which cannot be tackled purely by increasing financial resources. There is still a strong legacy of the past, discernible in a medical model of care and a mechanical vision of standards.

The medical model of care typical for the communist era implied that "patient" is "sick" and in need of being "cured" by professionals. This approach gave a strong position to a carer who administered treatment and decided what was the best for the person in care. The ideal of "empowerment of users", imported from Western Europe, was met with suspicion in some professional circles where it has been argued that service users are not able to make rational decisions and define their needs and wishes. The change of language from "patients" to "users" was a first step forward; however some

[7] Sotiropoulou Vassiliki, Childcare in Post Communist Welfare States: the Case of Bulgaria, 2007, p.144

institutions did not make any further effort to deal with services users as with responsible people, capable of formulating their preferences.

In his research paper on welfare service in Bulgaria[8], V. Sotiropoulou quotes social professionals commenting on the institutions they work for: "Neither positive criticism nor civil dialogue is developed. Instead, only very military attitudes apply" and "professionals have to realize that they work for the benefit of clients and not for that of institutions".

Much attention has been devoted to the question of staff qualifications identified as the source of relatively low achievement of social services. New requirements include among others post-secondary education diploma which previously employed social workers often do not possess and – conformingly to the letter of the law – should be made redundant. However, they have an extensive hands-on experience which cannot be gained during academic, theoretical preparation. Moreover, unattractive salaries and rather low societal recognition of social work do not act as a magnet for young people to embark on such a career.

In Łódź (PL), an average salary of a social worker holding a university diploma is around 1300 PLN (less than 300 €). The minimum wage in Poland is 1126 PLN. [10.2007]

Finally, the question of standards needs to be considered. As it can be seen on the example of the social workers, standards in the Central and Eastern Europe have been understood rather narrowly. Social care personnel have to hold a given vocational or academic certification and can work a given number of hours per week. Similarly, the quality standards in care have been designed in the form of a "checklist" for institutions instead of setting targets and drawing a vision. Social services are obliged to dispose of a certain number of square meters at their premises, to work from – to, to ensure that social workers have not got more than X cases under their management and that they store them in a systematic manner.

This mechanic approach to quality does not promote innovation and improvement. Without incentives to go beyond the legal minima, social services risk stagnation. Users cannot fully influence the change as the concept of direct payment is not widespread in Central and Eastern Europe. They can rarely choose a different service and usually have to accept what is being offered. Therefore, the narrow understanding of quality standards does not lead to people's empowerment.

One of the possible explanations of this situation is the character of the still unfinished transformation. Social services have played an important role in soothing population's fears and compensating for the difficulties of the economic turnover. Identified by the elites as such an "emergency kit", social services have thus been regulated with similar precision as other "technical instruments". Without a broad strategic vision supported by appropriate resources in which all elements of the social policy and welfare system could be linked together, social services work in a disconnected way and cannot fully transform from ad-hoc measures into a proactive, empowering services.

[8] Ibid., p.147 and 151.

Conclusion

Almost twenty years after the fall of communism in the Central and Eastern Europe, the countries issuing from the ex-bloc have made a tremendous change marching from communist autocracies to fully fledged democracies and from plan to market economy. They are continuously reforming their social services and moving from a rather paternalistic and residual model toward modern empowering social assistance. This unprecedented transition has to be acknowledged and applauded. Nevertheless there are numerous issues that still wait to be properly addressed and there are challenges to be overcome so that the social transition phase can be successfully completed.