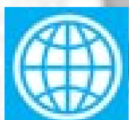
UNICEF Innocenti Research Centre

CHANGING MINDS, POLICIES AND LIVES

IMPROVING PROTECTION OF CHILDREN IN EASTERN EUROPE AND CENTRAL ASIA

REDIRECTING RESOURCES TO COMMUNITY-BASED SERVICES



CHANGING MINDS, POLICIES AND LIVES

Improving Protection of Children in Eastern Europe and Central Asia

Redirecting Resources to Community-Based Services

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

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A girl sits with her parents on a bench outside their home in Tbilisi, Georgia. UNICEF/C-116/13/Steve Maines

Foreword

After more than a decade of coping with transition challenges in Eastern Europe and Central Asia, the need for the reform of family and child welfare systems has been widely acknowledged. The mindset is changing, policies are increasingly embracing new directions, reform efforts are underway, but the lives of hundreds of thousands of poor families with children have yet to improve. Every year a large number of children are still at risk of being separated from their families and being placed in institutional care. This problem was first highlighted by the MONEE Project based at the UNICEF Innocenti Research Centre in 1997 in the Report "Children at Risk in Central and Eastern Europe: Perils and Promises". The MONEE Project has been monitoring the well being of children and families in the Region since 1989 and provides fundamental data that supports family policy formulation to safeguard children's rights in transition. However, knowledge, capacities, resources and practices in the countries of the Region are still inadequate to bring about the much-needed system changes.

Through "Changing Minds, Policies and Lives", UNICEF and the World Bank have teamed up in an effort to increase the understanding of the essential challenges of the system changes, and to propose strategies to advance the reform of child and family services. The results of the joint work are the concept papers and corresponding tools that suggest how to change three important system regulators, decision making, standards and financing.

We hope that these three toolkits will be useful instruments for policy makers, practitioners and for child rights advocates wishing to make the difference in the lives of families and children at risk in the region.

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Introduction

"CHANGING MINDS, POLICIES AND LIVES"

In response to the challenge of family and child welfare system reform in the transition countries of Central and Eastern Europe and Commonwealth of Independent States, the World Bank and UNICEF teamed up in the project "Changing Minds, Policies and Lives". The purpose of this joint initiative was to develop knowledge and tools for family and child welfare policy makers and practitioners in the region. The products of the joint work are published in this three-volume publication, each containing concept papers and tools addressing essential components of the system reform, namely decision making processes: "gatekeeping", redirecting resources into preventive and family-based services, and standards of care.

REGIONAL CONTEXT

The countries of Central and Eastern Europe and the Commonwealth of Independent States have undergone extensive economic and social change in the last decade. Family and child welfare has been recognised as one of many areas in need of reform. The public child-care systems in former socialist countries relied extensively on the institutionalization of vulnerable children, including children with disabilities and deprived of parental care at the expense of preventive assistance and support to the families at risk. As a consequence of the economic transition, social transformation and political instability the number of families at risk has increased, thus increasing the demand for public care. Across the region, roughly 1,5 million children are in public care (UNICEF, 2001). Governments in the region spend up to one per cent of their GDP in sustaining the institutional care for vulnerable individuals including children (World Bank). Worldwide experiences indicate that institutionalization is more expensive and less beneficial per client than more inclusive approaches designed to support individuals within the families. Institutional care shortfalls in enabling harmonious development of the child including her/his full inclusion in society.

There is a growing understanding and willingness among child welfare policy makers in the region to establish alternatives to institutionalization and in a number of countries the child welfare systems are undergoing reform. However, these encouraging initiatives are scattered across the region, not framed within coherent policy and characterised by:

- discrepancy between policies to reduce placement in residential care and the existing practice
- lack of coherent reform framework – fragmented coordination, piecemeal and isolated innovative initiatives
- deficient information management systems lacking data on referral patterns, profiles of needs for particular groups, service availability and no contact with local decision making, policy and practice
- absence of a systematic care plan for each child in public care endorsed in law, policy and practice
- public monopoly on financing of services resulting in a supply driven care system in spite of governance and fiscal decentralization
- deficient regulatory framework to enable decentralization of service provision within defined care standards
- little incentive to tailor the response on clients' needs
- budget structure that favours residential care, does not encourage mixed options, offers few choices to clients and limits the range of available care options
- lack of information on true costs of care as full financial costs of public care are not calculated.

The reform challenges have revealed the need to build a knowledge base and tools to assess and analyse the family and child welfare situation from the perspective of the system's outcomes; to inform the design of the reform towards effective family and child centred outcomes and to guide management of the reform.

PURPOSE

To support and facilitate the ongoing reform processes in the region, UNICEF and the World Bank decided to team up in the 'Changing Minds, Policies and Lives' initiative. As the winner of the World Bank Development Market Place Programme the project was awarded a grant and was officially launched at a Regional Conference on Children Deprived of Parental Care: 'Rights and Realities' in Budapest, Hungary, October 2000.

The project addresses two important strategic concerns of both organisations. For the World Bank it is about the support to child and family welfare system change as one of the cornerstones of social protection strategy in Eastern Europe and Central Asia (ECA). For UNICEF it is about promotion, fulfilment and protection of the human rights of children.

"Changing Minds, Policies and Lives" aims to achieve major policy and practice change by contributing to a permanent shift from extensive reliance on state institutions towards provision of family and community based care for vulnerable individuals, especially children at risk and those deprived of parental care. The initiative focuses on supporting the design of a comprehensive national strategy grounded in concerns for both human rights and cost-effectiveness. This innovative approach:

- promotes the reform of public care systems for children in a way to prevent institutionalization by supporting families and by establishing family based care alternatives
- provides tools, which in interaction with ongoing reform efforts, help generating knowledge for further support rather than to offer the blue print for reform
- brings together policy makers, families, communities and NGOs in an effort to raise awareness and mobilise the change agents.

The project strategy focused on developing knowledge and tools for the reform of three essential system regulators: *finances*, to redirect resources to community-based services; *standards*, to ensure family-centred outcomes; and *decision-making processes* to reshape the gatekeeping system. The main outputs of the project are three technical instruments, toolkits. Each toolkit contains an analytical framework, templates and checklist for the reform of regulators and examples of good models for reference.

THE TOOLKITS

Gatekeeping

The analytical framework defines the gate-keeping as the system of decision making that guides effective and efficient targeting of services. Such a system is based on the following principles:

- the best interests of the child
- proper safeguards for clients' rights
- fair and clear criteria of entitlement to services in all user groups
- transparent decision-making, verification and control mechanisms
- efficient use of scarce resources
- monitoring, evaluation and review of the decision-making process based on the quality of outcome for the client
- fair and consistent service allocation
- individual child service plan based on review of the child and family situation.

The gate-keeping is designed to be operational not only at the point of referral but at all stages of service provision. The conditions for effective gatekeeping include an agency responsible for coordinating the assessment of the child situation, a range of services in the community to provide support to children and their families, and an information system to monitor and review the outcomes and provide feedback on operation of the system as a whole.

The toolkit contains elements relevant for reform at local and national levels. The templates and check lists for multidisciplinary planning; development of local management information systems; individual needs assessment and corresponding decision making for services are examples of instruments to support the local level processes. The set of tools envisaged to support the national level processes include guidance for development of an efficient coordination mechanism, revision of the legal framework, and establishment of national monitoring and information systems including performance indicators.

The gatekeeping toolkit combines and builds upon some interesting regional initiatives, such as the establishment of national coordination agency in Romania and Bulgaria, the community based services in support of children and their families in Russia and on improvement of information systems in Hungary and Latvia.

Redirecting resources

The objective of this toolkit is to guide redirection of resources to community-based services by changing financing flows towards support to families at risk and family-based care alternatives. The toolkit promotes orientation towards the purchaser-provider model and in this context proposes the following pillars for the reform:

- establishment of a purchaser with clear incentives to serve clients, not the provider
- changes in financing procedures to allow output oriented financing to providers
- development of tools for the agreement between the purchaser and the provider (contracts, rules on pricing, tendering)
- reform of the existing providers.

The proposed framework for the reform of child and family welfare system financing suggests that the purchaser should be guided by client's needs and the most efficient ways to meet them. In this manner the purchaser acts as the gatekeeper and therefore should have the power and resources for decision-making. The new financing system should place all the public funds for social care into the hands of the purchaser

and acknowledge output based reimbursement. All private and public providers should be subject to licensing. Contracts should be developed to specify what should be achieved at what costs and included in tenders. The conditions for the transformation of existing providers include changes in the legal status of existing public institutions, regulation to allow them to participate in a tender, incentives to reduce available residential care and expand community care, and opening of the space to the non-governmental sector.

The toolkit contains templates, checklists and guidance for assessment of current financial flows, planning of changes, including development of purchaser-provider models and budgeting for new structures, and needs assessment to determine future demand.

STANDARDS

Standards are understood as accepted or approved criteria to measure and monitor the management, provision and quality of services and their outcomes. The aim of the toolkit is to support the assessment of current standards and to guide development of new criteria for service provision and performance outcomes. Appropriately defined standards of care are realistic, reliable, valid, clear and measurable and will ensure the family-centred outcomes.

The proposed framework for setting standards adopts the rights of the child as the guiding principle and promotes the need to minimise the reliance on residential childcare, and points to the importance of a case management approach and support structures for quality outcomes.

The toolkit includes a combination of statements on good practice with concrete and observable sets of indicators which describe what the 'standard good practice' means in terms of outcomes for the child, for care practice, for management action, for structures and inputs.

To date only Hungary and Slovenia have systematically modernised childcare standards. Other efforts in the region that are more in initial stages include changes in legislation and pilot projects on quality care standards in Romania, 'environmental' child care standards in Bulgaria, mechanisms for monitoring of care in Lithuania and Latvia.

The process of standards development will be participatory to ensure that standards are owned by the stakeholders, shared and understood by the staff, and developed with the participation of children and their parents.

WHAT IS NEXT?

Testing of the toolkits in Bulgaria, Romania and Latvia has helped to ensure that the toolkits systematically address important challenges in the child welfare system reform. However, for the proposed strategies to become useful tools in the hands of regional policy makers, the toolkits need to be used in a real context of reform and adjusted to the country context.

To that end, UNICEF and the World Bank are planning to organise dissemination seminars for the countries that are committed to the child welfare system reform and have expressed interest in using and adjusting the toolkits.

In addition, the concept papers and the toolkits will be posted on the UNICEF and World Bank web sites for the widest possible use.

Judita Reichenberg, UNICEF
Aleksandra Posarac, World Bank

Redirecting Resources to Community-Based Services

A CONCEPT PAPER[1]

Louise Fox and Ragnar Gotestam

June, 2003

[1]This report has been prepared as part of a joint UNICEF-World Bank project, *Changing Minds, Policies and Lives* (CMPL), a programme designed to support national programmes reduce the institutionalization of vulnerable individuals in Eastern and Central Europe and Central Asia. For information on this regional project, see http:// www.worldbank.org/childrenandyouth. The authors are grateful for the extensive comments of Gaspar Fajth, Judith Harwin, Loraine Hawkins and project team members. Comments to the authors are welcome at lfox@worldbank.org or ragnar.gotestam@chello.se.

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Executive summary

One of the legacies of the command economy in Central and Eastern Europe and the former Soviet Union has been a system of social protection for vulnerable individuals which focuses on institutional care. It is well-known that removing a child or an adult from their family and community is more expensive per client served than more inclusive approaches designed to support individuals in their own families and communities. Institutional approaches tend to produce worse outcomes than community-based approaches for most individuals.

Countries seeking to change the model of social protection services have faced a number of constraints. Financing new programmes means redirecting resources away from institutions. If countries want to develop the supply of new programmes, how can they do so in an affordable manner? How should they change the financing flows to support a menu of new options, better tailored to the needs of individuals and without putting the burden of financing on those who are vulnerable?

This paper provides a framework to help countries re-orient their financing systems for social care, so that they can implement a change programme for the social care system. The ultimate objective is for countries to use more family-based and inclusive care programmes, and use institutional care as a last resort, thus supporting families to care for their vulnerable members rather than place them in residential care. Family-based and inclusive care are generally more effective in meeting social needs and are, at least on a unit cost basis, less expensive.

Changing the financing system will not automatically reduce institutionalization. Other components of a reform programme include quality of provision such as standards and accreditation, training, information to clients, monitoring, etc., and those which improve the gatekeeping and needs assessment process, including rigorous outcome and impact evaluation. The effectiveness of the financing framework in doing its job is partly determined by the effectiveness of these other policy reforms.[2] This paper reviews key concepts in social care financing, before going on to apply them to the problem of changing social care models in ECA countries.

Social care financing concepts

What are social care services? Social care services are services supplied to vulnerable individuals and families to help them out of poverty and exclusion, and to live a fuller and more satisfying life. Vulnerable individuals are usually considered to be disabled, frail elderly, people at risk of abuse or deprivation of basic needs, or children deprived of parental care or mistreated in their family. Social care services are a support for everyday life and should be a complement to services provided by families, and other public services (health care, education, housing, employment assistance and training, justice, etc.). A broad range of services may be provided. Institutional care is only one possible product, and it should only be used when strictly necessary.

What is the public sector role? Families usually do not have the financial resources to buy these services or to provide them directly. They often need professional advice on choosing the service package (as with health care). In principal, social care services are privately insurable. However, there are major problems in developing an insurance market in this sector, including the classic insurance problems of adverse selection and moral hazard. Vulnerability tends to be correlated with poverty, so the demand is greatest among those least able to afford insurance, implying that some public subsidy is needed. It has been observed that as national income increases, the demand for public finance for these services increases. Public finance is seen as the best substitute for inefficient and ineffective private insurance markets.

Public finance for social care services immediately creates problems of rationing. The public sector has to ration the financing available, prioritizing needs and resources so that public financing is directed to ensuring access to services for those with the greatest need, and to those services that produce the best outcomes. If a good rationing system is not in place, those most in need are likely to find themselves without services. Rationing requires technical knowledge and training to perform the needs assessment and service matching, and often the assistance of a social worker or

[2] For Concept Papers on gatekeeping and developing standards, see Bilson and Gotestam (2003) and Harwin and Bilson (2003).

other trained specialist is needed to select the service and monitor the result. In the case of children, especially children deprived of parental care, social care almost always requires someone to act on the child's behalf. This person is called an *agent* and acts on behalf of the individual or family in need (*the principal*). The agent acts as one of the gatekeepers to the system, rationing care.

The public sector plays a major role in organizing the supply of services. This is done by either directly supplying the service; contracting out the supply of the service to a monopolist private or NGO supplier according to service standards; and/or by setting standards for service provision by a competitive private sector.

What is the role of the financing framework? The financing framework has a critical role in regulating the supply and demand for social care services. A good financing framework:

- ensures that demand, as determined by the gatekeeper and the agent or individual, is financed so that care is rationed properly, so that those most in need receive access to services which have the high benefits
- provides incentives so that the providers supply high-quality services efficiently.

Thus, one of the key tasks of the financing system is to try to align the incentives of the system. The financing framework is one of the key public policy tools to ensure access, cost-effectiveness and quality in the social services. Put into a comprehensive framework of reform that also contains an effective gatekeeping function and standards for care, an improved financing framework has the potential to improve the social care and service system.

What kinds of financing frameworks are used for social care? Three models can be considered – two extremes and a middle ground.

- **Pure private system**. This occurs when there is no public involvement in the financing of social care services (which usually means to public provision either). Complete private finance and provision results in an under-consumption of social services as well as lower outcomes because those most in need would not be able to afford the services, and households and individuals in many cases do not have the information to match services with needs, or they may have a conflict of interest (e.g. a child in need of protection from domestic violence).
- **Public provision and finance**. The purely public solution – public finance and provision – is the simplest way to ensure that services are provided to populations in need. Available resources are allocated not among people in need, but among providers. There is no balancing of supply with need or demand, there is just supply, without choice. The input determines the output and the outcome. There may be an oversupply or undersupply of services relative to demand. Quality problems may also arise since the public sector tends to face problems in sanctioning itself for poor quality, and there are usually limited channels for community and client participation in quality assurance. In its most extreme form, the pure public model substitutes the public sector for the family.
- **Purchaser-provider**. This model attempts to duplicate the roles of the consumer and the supplier in the free market system, but without the market failures. The public sector retains the financing role, but public sector finance is provided in a more competitive environment, with more voice for the consumer. The public roles above are divided into two different functions: the purchaser, who finances and purchases care; and the provider, who operates the service delivery units. The purchaser will act as *gatekeeper or rationer* of public funds, determining eligibility, and, in the case of more specialized services, as the *agent for the principal* (the vulnerable individual). The purchaser may be any qualified official with responsibility for this task (teacher, social worker, a child protection officer, a court, etc.). Basically, the role of the purchaser is to act as an agent for the financier and the client, to ensure that funds are used to obtain the best outcome for the client. While the provider could be a public agency, in OECD countries, the provider is more likely to be a private[3] or NGO provider contracted by the public authority, an approach adopted to bring increased client responsiveness and efficiency. In transition countries, public providers are more likely in the initial stages as the private sector is underdeveloped. The private sector will grow over time.

What are the keys to success for a purchaser-provider system? Experience in OECD and developing countries has shown that purchaser provider systems can contribute to higher client satisfaction and cost-efficiency in service delivery if the following are in place.

- The price the purchaser faces reflects the opportunity cost (true price) of supplying the service, rather than a subsidized or distorted price.
- The purchaser is responsible for the financial consequences of proscribing a service for the client, and is the budget holder for social care services for the population in the catchment area.
- Private providers are allowed to enter the market and compete for public funds under appropriate licensing arrangements, with transparent standards and effective quality monitoring arrangements.
- Purchasers assure market stability and avoid over

[3] Here we use the term 'private' to mean any non-publicly owned supplier. This includes, for example, foster care or guardianship (a self-employed private provider of parenting services), private tutors, a private care giver, a private transportation company or an NGO such as a charitable foundation or a self-help association.

capacity through multi-year sector planning, block contracts, and multi-year contracts. Market exit also has to be managed to ensure continuity of care.

What problems have emerged with purchaser-provider systems? While recognized as an improvement, these models have not solved all the problems of equitable and efficient social service provision. The job of the purchaser is complex, including both gatekeeping and acting on behalf of individuals and families. The purchaser is also balancing access and quality. Clear legislative intent on how to handle these conflicting interests is helpful, as well as a strong role for client monitoring. Problems have emerged in the contracting side. Public sector suppliers find it difficult to respond to the new incentives, and seek subsidies or ways around the competitive process. Price setting - a negotiation - is not simple since cases are often not standard. Setting prices and writing contracts requires a full-cost accounting system on the provider side, as well as good accounting and case management on the purchaser side. As a result, introducing a purchaser can increase the management and administrative workload. Finally, it may take some efforts by government to develop the market to avoid the situation of only one bidder.

What occurs with political and fiscal decentralization? The purchaser-provider framework is well suited to a decentralized government structure, if the roles are assigned properly, and financing flows support the purchaser-provider incentive structure.

- The purchasing level needs adequate financing, and full control of the budget.
- Roles which have large economies of scale, such as quality monitoring and facilities planning and management, should be placed on a high level of government (normally the national level).

How to set eligibility criteria and budgets for care? Once the institutional set-up is in place, public financing policy has to resolve the questions of how much financing should be provided, and to which services should it be allocated? This is the authorizing legal framework which guides the purchaser. A number of criteria are used in different countries, and each has its drawbacks.

How much public finance should be in place, and should the allocation differ among households? There are strong arguments for providing less than 100 per cent public finance for care, especially for upper-income households, as it reduces over-usage and allows more families to be reached. This approach will not work, however, in the face of catastrophic costs or poorly functioning families unwilling to pay, and when prevention is needed. The total cost to the household (including the time of household members) needs to be considered in setting fees and proposing care plans.

How to chose the essential service basket? In principle, the policy framework should encourage the most cost-effective care to be selected. This is a two-dimensional process. Professional judgments and best practice identify the care package that is likely to produce best outcomes. But making choices among needs is by necessity a political decision. It can be facilitated by needs mapping and good outcome monitoring. The legacy from the Soviet era was to provide care for vulnerable citizens in residential institutions. Today, most transition countries still use this approach. Spurred in part by increased poverty and vulnerability during the transition, the rate of institutionalization has grown in almost all countries. Use of community care is growing as well, as countries, mostly with foreign assistance, implement projects aimed at replacing residential care - or parts of it - with community-based non-residential alternatives. Unit costs for residential care appear to be 3–4 times as much, indicating a vast misuse of funds in the current system.

The incentives for the use of residential care are clear. The public monopoly provider model is the dominant one in ECA, even after political and fiscal decentralization. As a result, the system is supply-driven. Municipalities consider referral to state paid residential care as free facilities. Needs assessments are rarely performed – clients are simply assigned to care on the basis of *ad hoc* priorities (usually by well-meaning local officials). Residential institutions are financed on an input budget. Often, countries do not know the true cost of care since financial statistics do not show the full financial cost. There is no purchasing function, little care planning, and weak outcome monitoring.

Implementing a better framework

Improvement in social care requires changes in the financing framework (complemented by changes in the systems for gatekeeping and standards). This does not mean reducing the public's responsibility for vulnerable citizens. Four main changes have to be made.

- **Purchasing**: a purchasing organization should be set up with the following tasks: to assess people's needs and to find the appropriate care and service for them; work out a care plan; manage the budget for the care it purchases, rationing care according to policy guidelines; monitor outcomes; and follow the care market, knowing best practice.
- **Budget reforms**: a new budgeting system needs to be established which places all the public funds for social care in the hands of the purchaser, and allows for output-based reimbursements. It should also provide adequate funds for the purchasing function.
- **Market-making reforms**: prices to providers have to be based on full opportunity costs, which are explicit and transparent. Public and private providers (current and potential) should submit to licensing. Contracts between purchasers and providers need to

be developed which regulate what should be achieved at what cost. These contract forms should be included in tender documents.

- **Provider market reforms**: the legal status of existing public institutions, as well as the ownership, may have to be changed to allow them to participate in a tender (and possibly lose). The number of places in residential care will need to contract, and the community care places need to expand. The provider sector needs to be made open to NGOs.

How should the transition be handled? Making the transition to a new financing system will be demanding for all stakeholders. A number of transition problems emerge. Countries seeking to change the financing structure to a purchaser-provider model need to develop a sound project plan. The plan needs to be based on:

(a) an analysis of the current situation, which maps out the economic roles in the current system, the costs and who pays
(b) a proposed institutional structure for the new system, specifying new roles, responsibilities, accountabilities and financial flows, and an analysis of incentives
(c) needs assessment, projecting possible future demand scenarios with a change in practices towards more community and family-centred care
(d) costing of demand scenarios
(e) a proposed new financial flow structure (in currency) given (b) and (d)
(f) a facilities management plan
(g) activity plan for project implementation.

Changing the financial rules of the game will not automatically ensure better use of public and private resources for better outcomes. Much more is needed. These issues are not dealt with here, but need to be part of the overall reform strategy.

What will the transition cost? The analysis described above should help to answer this question. The type of reform program discussed here is not likely to be expenditure-reducing, because new investments will be needed to develop new services, and because the increased availability of community-based services will reveal unmet needs, increasing demand for those services. An atmosphere of fiscal crisis is probably counterproductive for this type of reform. It is difficult to reach agreement among stakeholders on new roles and responsibilities as budgets are being cut. It is better to develop the reform plan in line with available financing. Public demand for social care rises with national income (all other variables being constant) so it is reasonable to expect that as income rises, social care will absorb a constant or growing share of expenditures. Reform is, therefore, important, as it makes it possible to serve more clients with better quality care and reduce the harm done by residential care.

Is this much change possible? In most countries, staff and managers are already busy, and the demands of this type of reform are considerable. However, most managers and political leaderships work for change once they understand that better methods and tools exist. Frequent international contacts have fostered this awareness and develop a motivation. Many features of the new financing structure are in fact already in place or underway. Nevertheless, a reform of this type is a medium term one, and as with any change project, the time frame has to be realistic, and coordinated with the ability of the system to change. It must also be put into a larger framework including gatekeeping functions and appropriate standards for care delivery.

Introduction

One of the legacies of the command economy in Central and Eastern Europe and the former Soviet Union (Europe and Central Asia or ECA region) is a social protection system for vulnerable individuals which focuses heavily on institutional care. Universal social protection was provided to families in the form of guaranteed jobs and old-age pensions, as well as child allowances and benefits in kind such as housing, education, and health care. If an individual needed help beyond this level of universal support, an institutional placement was offered where available. Families, in turn were encouraged to use institutional care, instead of trying to keep the family member in the community and participating in school, work, or leisure, alongside others.

Research indicates that this approach of removing a child or adult from their family or community is more expensive per client served than more inclusive approaches designed to support individuals within their families and communities (Tobis, 2000). Countries attempting to move away from this model of social care services face a number of constraints. In particular, there is the problem of how to finance new services given that individuals or their families are not normally able to do so. How can countries change the financing flows to support a menu of new options, better tailored to the needs of individuals and without placing the burden of financing on vulnerable members of society themselves?

Reform of the social protection system in formerly planned economies is taking place against the backdrop of social and economic changes, including fiscal and political decentralization. In theory, decentralization offers a good context for reform, as it can provide communities with the resources and responsibilities to ensure that quality services are available to meet needs. In practice, it has been a challenge, since implementation has not always had this effect. Facilities – rather than resources – are often decentralized, and a market for services does not exist. Local governments end up using institutions rather than empowering families to resolve problems using a variety of approaches and tools. The more financial resources that flow into institutions, the less will be available for providing other services or serving more people. This cycle needs to be broken in order to meet community needs.

The objective of this paper is to provide a framework to help countries re-orient their financing systems for social care in such a way as to facilitate a programme of reform. The ultimate goal is for countries to move away from institutional care towards more family-based and inclusive care programs which are generally more effective in meeting social needs and which are, at least on a unit-cost basis, less expensive.

This paper examines the theory and practice of redirecting financing flows away from institutions to support reform of social care systems. Taking the age-old advice to "follow the money", Section I reviews what a good financing policy should do by examining the need for services, the demand for services, and the supply of services. It should be noted that a public role is needed because those in need often cannot afford to purchase their own services. In addition, clients need quality assurance and specialized help to identify which services will suit them best.

Turning to ways in which the institutional structure of public financing can use incentives to help balance these three concepts - with a high overlap so that what is supplied meets the needs which are accepted by the community as appropriate for public finance – we suggest that countries do this by separating the purchase (selection and financing) of care services from their provision, and recommend that this institutional approach be used to develop an appropriate role for the private sector.

Section II examines the situation in specific countries and asks what are the needs for social protection services, what kind of care is currently supplied in selected countries in the ECA region, what it costs, and who pays for it. Using the yardstick set out in Section I to evaluate how well the financing framework allocating resources works relative to needs and demands we find that input-based financing is still the main source of financing in most countries, hampering the desired shift in service and product mix.

Sections III and IV examine the policy measures necessary for countries to change the financing mix, and to identify any problems involved in realizing this transition.

Reforming the financing system is a necessary, but not sufficient, condition to achieving better social care services. A system-wide change programme is needed. Other components of a change programme would include reforms to ensure quality of provision such as

standards and accreditation, training, client information, monitoring, etc., and those which improve the gatekeeping and needs assessment process, including rigorous outcome and impact evaluation. The effectiveness of the financing framework is partly determined by the effectiveness of these other policy tools.[4]

A system-wide change effort will not be an easy task. Nonetheless, international contacts have led policymakers and system managers to become more aware of other practices, and this has fostered new attitudes and an enthusiasm for change which will be an asset in the future.

[4]See Bilson and Harwin (2003) and Bilson and Gotestam (2003).

I What should a social care service financing framework do?

Social care services are supplied to vulnerable individuals and families to help them move out of poverty and exclusion towards a fuller and more satisfying life. Vulnerable individuals are usually classified as:

- children (minors) and adults with serious disabilities (temporary or permanent), including the frail elderly
- children (minors) or adults at risk of abuse or deprivation of basic needs
- children (minors) deprived of parental care (usually due to parental absence, illness including disabling addiction, or death), or at risk of deprivation of parental care.

Social care services are a support for day-to-day life and complement support provided by families. They should also complement other social services (health care, education, housing, employment assistance and training, etc.), and support other public services (justice, etc.). Indeed, encounters with other services often trigger the needs assessment of the client and referral to care services. The objective of social care services may be prevention of human rights abuses, the maintenance of well-being, or the correction of a specific problem.

In some cases, social care services replace other social services. This is especially true of residential care. As a general rule, replacement of other services by care in a specialized institution is more expensive and generates poorer outcomes in terms of inclusion, functionality, and general well-being.

The families of vulnerable groups are also at risk, primarily because the individual risk factors include, or are correlated with, poverty, and because such factors can lead to emotional and social stress in the family.[5] This in turn affects the family's ability to support its members and social services should help reduce levels of family stress and support the individual.

Identifying the public sector role in social care service provision

Needs and demand. Historically, families have been the primary source of most social care services. For example, children often helped in bringing up their siblings, and adults took care of a family member unable to work, or a child. Extended family networks helped sub-family units in crisis by providing transfers in cash or kind, or with emotional support. Religious groups and charities often provided help, and better-off families would hire services (e.g. a care-taker for someone with mobility problems or a teacher for home schooling for a child with special needs).

As the workplace has increasingly moved outside the home, formal labour force participation has increased, extended family networks have begun to fragment and the opportunity cost of family labour in caring for members in need has grown. In addition, developments in expertise and technology stimulated the emergence of new, professional, and often higher-cost services. Families often do not have the financial resources to purchase these services, and may need professional advice on the choice of a service package (e.g. health care).

In principal, social care services are privately insurable and in countries with a well developed private insurance sector some risks are insured for upper-income segments of the population (e.g. long-term nursing care for the elderly). However, there are major problems in developing an insurance market in this sector.[6] First, vulnerability tends to be correlated with poverty, so that demand is greatest among those least able to afford insurance. Without enforced risk pooling, there is a serious adverse selection[7] problem which would make premiums unaffordable.[8] Moral hazard problems (increased consumption of services despite insurance)[9] are also a problem. Yet social care services are vital for families and society in general, since soci-

[5]See, for example, UNICEF (1997) on poverty and vulnerability among children at risk, and Elwan (1999) for a discussion of the links between disability and poverty.

[6]Barr, 2001, develops this argument more fully. See, in particular, Ch. 3.

[7]Adverse selection occurs when risks are identifiable in advance, and the highest-risk group purchase insurance. This results in a very high price for the product, making insurance unaffordable. The solution is to force everyone (or most people) to buy the product, so that the price is lower and the risk is spread. Mandatory car insurance is an example of this type of risk pooling.

[8]See, for example, Aarts and De Jong (1999) for a discussion of which private costs associated with disability are insurable, when, and by whom. Birth-related disabilities are particularly difficult to insure, since insurance is rarely purchased voluntarily in advance of the risk. Moreover, people are unlikely to purchase insurance for low-probability, high-cost events.

[9]Moral hazard is common in personal services. In health care, e.g. if clinic attendance is free, people attend more often, even when a visit is not strictly necessary, but because they are lonely or unsure. Co-payments (charging a small fee) are the standard remedy, but these can cause access problems. Overconsumption of medicine when it is free is another common moral hazard. Counseling services are also subject to this problem, and their use needs to be strictly limited.

ety wants to protect and support the vulnerable. As national income increases, the demand for the public financing of these services rises (Barr, 2001; Lindert, 1996). Public financing is perceived as the best substitute for inefficient and ineffective private markets.

Public financing for social care services creates problems of rationing. The demand of households for free or subsidized services can be considered virtually unlimited, whereas financing is not (public or private). The public sector has to ration available financing, prioritizing needs and resources so that public financing targets access to services for those in greatest need, and for services that produce the best outcomes. If a good rationing system is not in place, those most in need are likely to find themselves without services.

A broad range of services may be provided. Institutional care is only one of a range of possible products, and should be used sparingly. More family-friendly services include day programmes, temporary shelters, counseling and family support, transport services, prostheses, special health or education services or training, etc. It is generally more cost-effective to prevent a problem than to correct it, although the boundary between preventive and corrective services is permeable.[10] The cost of these services varies, as does the quality, depending on how production is organized and what technology and methods are used.

Rationing services and matching them to clients is not a simple matter. It usually requires technical expertise and training to perform needs assessment and service matching. In some cases, the family can select and purchase the service and be responsible for monitoring the results, so that the role of government is limited to assisting with financing based on a needs assessment (assessing eligibility). In other cases, the assistance of a social worker or trained specialist is needed to select the service and monitor the results. In the case of children, especially those deprived of parental care, social care almost always requires someone to act on the child's behalf. This person is the *agent* for the individual or family in need (the principal), and acts as one of the gatekeepers to the system, rationing care.[11] All participants in the system need the specialized knowledge of the agent. However, most of the system management problems occur around the conflicting interests of the principal and the financier, as intermediated through the agent.

Supply. Because of the difficulty in ensuring an adequate supply of quality services, in most countries the public sector plays a major role in organizing the supply of services. This is done by supplying the service directly; contracting out the supply of the service to a monopolist, private or NGO supplier according to service standards; and/or by setting standards for service provision by a competitive private sector (usually, but not exclusively, non-profit). The public sector also helps families to monitor results, and conducts research on techniques and approaches, to encourage the development and supply of new and cost-effective models.

Thus, there are three distinct aspects of social care service delivery which have to be balanced:

- the needs of households and vulnerable individuals for assistance/support (the needs of the principal)
- the identification of appropriate and affordable interventions and prioritizing funding to families and individuals for interventions given the costs and effectiveness (demand, often involving an agent acting on behalf of the principal and a gatekeeper working on behalf of the financier according to norms and laws)
- the efficient supply of high-quality services (providers).

The role of the financing framework is to balance these three aspects. A good financing framework does this by:

- ensuring that demand, as determined by the gatekeeper and agent or individual, is financed so that care is rationed properly, according to agreed criteria and that those most in need receive access to services with high benefits, and
- providing incentives so that the providers supply high-quality services efficiently.

Thus, one of the key tasks of the financing system is to align the incentives of system participants so that the interests of individuals and society are served efficiently. These interests often differ (see Table 1).

The financing framework is therefore one of the key public policy tools to ensure access, cost-effectiveness and quality in the social services. These are the assessment criteria for any framework. The most effective way to do this is to provide a separate channel for the interests of each of the three parties involved, so that they can be balanced. Especially important is the voice of the client, since they tend to have the least power in the system yet are most important in solving the problem. Inclusive problem resolution is difficult unless the client agrees with, or at least understands, the solution. Other complementary tools to achieve this balance include ensuring quality of provision such as standards and accreditation, training, information to clients, monitoring, etc., and those to improve gatekeeping and needs assessment, including rigorous outcome and impact evaluation. The effectiveness of the financing framework is partly determined by the effectiveness of these other policy tools.

Financing models

Organizing a financing framework which supports efficient and effective social care provision is primarily a question of institutional structures. If a key role or

[10]For example, effective parenting classes for young mothers and families can be considered both preventive and corrective.
[11]See Harwin and Bilson (2003).

Table 1 Needs, demand and supply

	Needs (client)	Demand (financier)	Supply (provider)
Who observes?	Point of entry person: health worker, teacher, police, social worker, day nursery staff, family. Client can self-identify	Office responsible for supporting families to cope or, if needed, referring individuals to care (gatekeeper and agent)	Everyone in the market
How is it determined?	Revealed by client through needs assessment (review of situation and communication with the individual or family at risk)	Revealed by public and private financiers through budget allocations - the total envelope available to spend on meeting needs - and the priority or rationing plan used by the gatekeeper (set in legal norms)	Quantity and quality of services supplied by providers
How is it measured and evaluated?	Outcome measurement: the result for the individual	Budgets and care plan procedures	Output measurement—the quality-adjusted quantity of services relative to price
Policy tools	Outreach, targeting	Legislation sets eligibility thresholds, targets, and financing responsibilities; budget sets total financing	Cost accounting, quality monitoring (standards)

responsibility of an institution is unmet, or mixed up with another, so that there is a conflict of interest, fewer people will be served, they will be served less well, and resources are likely to be wasted. Below we discuss several ways this can occur in conventional financing models.

The pure private model – market failure. This occurs when there is no public involvement in the provision and purchase of social care services. In the absence of public-sector involvement, there will be no agent for the principal and no gatekeeper so that households will either provide the services themselves (family care) or purchase services from providers in the same way as they would purchase a car or a restaurant meal.[12] This was the case in most countries 100 years ago, and still applies in many of the world's poorest nations today. In this case plenty of channels exist for information on demand to providers, and competition can produce a variety of services if households have the money to purchase them, but there would be few channels of information on needs, since those in need may not have the funds to channel money into demands. As noted, this approach would result in an under-consumption of social services as well as lower outcomes because those most in need would be unable to afford the services, and because households and individuals often do not have the information to match services with needs, or there is a conflict of interest (e.g. a child in need of protection from domestic violence). Because of a thin market, there could also be an under-supply of services. If there is no quality regulation (e.g. certification of providers), high-cost, high-quality providers may not enter the market since they would have to compete with low-quality but cheaper services. Economists refer to this as 'market failure'. In a market economy, the public sector should try to remedy this failure with public resources to increase consumption, and with regulation to improve quality.

The public provision and finance model – public failure. In the centrally planned economy, the financing framework is very simple. The government finances a supply of services and these services are rationed to the population in need by an agent/gatekeeper. Available resources are allocated not among those in need, but among providers. The problem with this approach is that since the agent works for the supplier, there is no independent channel for information about needs or demands. There is no balancing of supply with need or demand, there is just supply, without choice. The input determines both output and outcome. There may be and oversupply or undersupply or services relative to demand, but this is unknown, since there is no independent voice for demand. There are only needs and

[12]This is a slight simplification. Even in a pure market system, an agent may still be needed to develop a care plan and make recommendations on services. However, the supplier would probably include this in the package, thus biasing results toward the services provided. In the case of private insurance, a gatekeeper would automatically be present to control for moral hazard.

services. The incentives are mostly on the side of the providers. Quality problems may also arise since it is difficult for the public sector to sanction itself for poor quality, and there are usually limited channels for community and client participation in quality assurance, through choice and independent feedback. In its most extreme form, the pure public model substitutes the public sector for the family.

The purely public solution is, however, the simplest way to ensure that services are provided to populations in need. All market economies have used this approach at some point to ensure social sector service supply meets demand, including health, education and social care services but now it has come under increasing criticism (see Torres and Mathur, 1995; OECD, 1997; Preker, Harding, Girishankar, 1999, and the references therein). In addition to the problems cited, it may not produce the best services most efficiently, since the monopolist faces no pressure from competitors. Public service 'culture' is often not client-oriented and the resulting dissatisfaction with public-sector provision is referred to as 'public-sector failure'. Countries are looking for a way out of the double bind of public monopoly/public-sector failure and no public financing or provision/private market failure.

Purchaser-provider models. The result of this search has been the evolution of the 'purchaser-provider' model which attempts to duplicate the roles of the consumer and the supplier in the free market system, but without market failures. It starts by recognizing that market failures on the demand side, i.e. inadequate financing and information in families, can be corrected through public financing, agency, and quality monitoring. In the simplest case the public sector may still be responsible for the same roles as in the simple model of public provision. However, these roles are separated into two different functions: the purchaser, who finances and purchases care; and the provider, who operates the service delivery units. The job of the purchaser is to act as gatekeeper or rationer of public funds, determining eligibility, and in the case of more specialized services, to act as the agent for the principal (the vulnerable individual). The purchaser uses public financing (or a mix of public and private financing) to purchase services from suppliers for individuals. The purchaser may be any qualified official with responsibility for this task (teacher, social worker, child protection officer, court, etc.) Basically, the role of the purchaser is to act as agent for the financier and the client, and so as to ensure that funds are used to obtain the best outcome for the client. This implies seeking the highest value for money, and ensuring as much access as the financial envelope affords. The purchaser-provider approach is also know as "money follows the client" (as opposed to the money following the supplier) approach.

While the provider may be a public agency, in OECD countries the provider is more likely to be a private or NGO provider[13] contracted by the public authority – an approach adopted to generate increased client responsiveness and efficiency.[14] One of the strengths of the purchaser-provider model is that it allows a market for providers to emerge, gaining benefits from competition. In a full purchaser-provider system, multiple private providers supply care to clients, allowing client need to be fully expressed within the financing framework. The public sector role is to provide and ration financing (i.e. to universally insure the population).

The public sector still maintains the role of quality assurance. This role is exercised both through standard setting and licensing, and through monitoring standards and outcomes. Client groups can carry out tasks to assist in monitoring, as can self-regulating organizations such as professional bodies. The public sector can also educate clients as consumers, in some cases reducing the role of the purchaser to needs assessment and channeling finance, whilst the client selects and evaluates the provider.[15]

Purchaser-provider models have a number of advantages. First, they allow a clearer transmission of demand signals to the provider, which can improve supply-side efficiency. Second, they allow the separation of needs assessment and financing from provision, thus giving voice and power to this process, independent of the problem of service provision. Third, they confer an explicit role to the care management process, allowing the quality of this function to improve. Finally, they allow the emergence of competition and a market in the service supply sector, which should in turn improve quality. They allow the public sector to concentrate on what are clearly monopoly public functions, i.e. quality regulation and insuring risk in the face of an insurance market failure, and allow the private sector to produce services for individuals (within the constraint of quality regulation, see Bilson and Gotestam, 2003).

Making the market work

Pricing and budgeting are the keys to effective purchasing. This means, first and foremost, that the pricing structure faced by the purchaser must reflect the oppor-

[13]In this paper, the term 'private' encompasses any non-publicly owned supplier. This includes, for example, foster care or guardianship (a self-employed private provider of parenting services), private tutors, private care-givers, private transport companies, and NGOs such as charitable foundations or self-help associations.

[14] If the private supplier is still the only provider, contracting out still lacks the feature of consumer choice.

[15]The 'voucher' or insurance model, with client choice, works best in cases where the diagnosis of the problem is relatively straightforward and the outcome is easily observed, e.g. mobility services or home care for the elderly or disabled. Where the outcome is more difficult to observe or the supplier can induce increased demand, a more extensive involvement of the purchaser is needed, raising more principal-agent problems.

tunity cost[16] of supplying services. The price paid by the purchaser to the supplier must be fair – at least the average cost of supplying the service over the medium term, including maintaining capital, service improvements, etc. If the price is below this cost, the supplier will go out of business or service levels will decline.[17]

The second key is that 'who decides, pays', that is, the purchasing organization is responsible for the financial consequences of demanding a service for the client. The purchaser must therefore control the whole public (or privately insured) social care budget for a given population, and be accountable for all access issues, as well as the cost-effectiveness of service decisions.

The third key is that the budget must flow through a 'single pipe' to the purchaser, i.e. all available funding to the purchaser must come through one channel. In other words, the social worker purchasing services should not be biased by whether funding is derived from one budget rather than another. No funding can flow to the providers directly as this would inhibit price signals and prevent the purchaser from seeking the most cost-effective solution. Financial resources flowing directly to a provider usually result in a subsidy to a provider, distorting the price structure. User fees or co-payments must also be consistent across substitutable services.[18]

With these rules in place, the purchaser (e.g. social worker) can theoretically obtain the most cost-effective client allocation among all possible services, and use the budget to meet the highest priority needs. If, however, market or budget segmentation exists, these optimizations will not occur.

While recognized as an improvement, purchaser-provider approaches have not solved all the problems of public service provision, and have created new ones. First, there is still the issue of needs assessment and allocation inherent in the principle/agent problem. If someone, other than the person in need, makes the decisions on service purchase (i.e. the client or the principal), what mechanisms are in place to ensure that the client's needs are met as far as possible given limited financing? In other words, how can we ensure that the agent (with their own interests) acts correctly with respect to the principal in a complex situation? One way to limit this problem is to reduce the role of the agent to a minimum whilst empowering that of client as much as possible. A market for providers in a range of standardized services can reduce the danger of misallocation by the purchaser, especially if the choice of provider for standardized services is left to clients. Empowering clients also helps ensure better outcomes, since the client is included in decisions regarding treatment. The danger is, however, that full public financing combined with a weak agency may increase moral hazard (i.e. raise the cost).

Allowing choice is not always possible, e.g. in the case of children, or where there is a conflict of interests in the household. In some cases, assessment of needs and results is difficult, and clients may make short-term, convenience choices, or choices with no long-term benefits. Effective outcome monitoring is needed to track the results of case management decisions.[19] It is important that the agency in charge of monitoring is not the purchaser. Consumer/family roles in monitoring especially through advocacy organizations, can act as a safeguard to balance the purchaser's power.

The second issue is how to ensure that the purchaser rations care effectively, using limited funding. In other words, to ensure that the policy intent of legislation is followed with respect to those most in need and most at risk. The purchaser implicitly balances access and quality within a fixed budget, often in a non-transparent manner. This issue is best addressed through community-level monitoring and feedback. At the national level, community demographics compared with service utilization can also provide information on how well the purchasing function is performed.

Problems emerge with respect to the provider market. When purchaser-provider models are in place, provision is usually in the hands of the public sector. Public sector agencies are not always able or willing to respond flexibly to new demands. Private providers may enter the market, but if the public sector does not shrink in response there will be an oversupply in the public sector which will push up unit costs and/or lead to deficits in agency budgets. This is because empty places have to be paid for and the provider will add the cost to the bed-day price. Faced with these deficits, purchasers are under pressure to use public services rather than private ones. Experience shows that public sector providers can use political power to undermine competition or downsizing. Thus, exit and transition strategies must be carefully formulated in advance to ensure continuity of care.

Market stability is also a key issue. Investment is required by private or public providers to develop care programs. Providers will only undertake this investment if they are assured of a client base. Clients also need continuity, especially in the case of long-term care. Some countries have developed a range of methods to resolve this problem, including multi-year contracts, block con-

[16]Resources are never free. Opportunity cost is the cost of the alternate use. It may not be monetary, and may not be observed in the market, but it always exists. For example, public buildings used to supply residential services could also be used as schools, police stations, or sold and the money used to help poor children.

[17]This does that mean that the supplier should obtain whatever price they propose, but that the prices the purchaser faces should not be subsidized (by the public sector, for example, in the form of free capital, or by the private sector in the form of underpricing).

[18]For example, if the budget pays 100 per cent of service cost for a public provider, but only 75 per cent for a private provider, the purchaser's decision is distorted. Likewise, if the family has to pay 10 per cent of the cost of home care, but pays nothing for institutional care, the family may push the purchaser to choose residential care.

[19]For a discussion of outcome monitoring see Bilson and Gotestam 2003. It is particularly difficult in the case of social care services, since it is usually not directly observed, but is instead inferred from individual behaviour.

tracts, etc. (see Box 2 for the Stockholm example).

Price-setting, which is usually a negotiation between purchasers and providers, can also be problematic. For the supplier, the price must be equal to the long-run average cost in order to maintain assets and remain in business. Analyzing this requires full-cost accounting. The purchaser seeks the lowest price possible in order to maximize value. Price stability is needed in both markets for the necessary investments to take place. Prices are usually set for an 'average' case, whereas individuals differ, and it is not easy to predict needs which vary enormously together with the costs to meet these needs. A care facility that only caters to clients with limited needs will have lower expenditure (and therefore lower prices) than a care facility that caters to demanding cases needing constant care and staff expertise. In a growing market it is easier to find care options for the mildly disabled than for the severely disabled, e.g. a mildly disabled client is able to participate in their own care and contribute to their rehabilitation, which eases the burden on staff and cost to the provider.

Thus, there is a limit to the concept of cost-effective purchasing. Best practice experiences indicate that services do not rehabilitate clients directly, but instead provide the supportive conditions that help clients rehabilitate themselves.

It should be noted that purchaser-provider models are more expensive administratively than public monopoly models, especially in the case of multiple providers. This does not necessarily raise the total cost of social care services, thus reducing access as some of these costs will be offset by gains in efficiency stemming from competition. In the U.K., the introduction of competition in the 1990s resulted in increased productivity and lower costs, especially when public entities were subject to competition.[20] Some of the additional costs observed with the introduction of purchasing are for functions which need to be performed to increase the value of care (improve outcomes), such as better needs and agency assessment on the part of the public financier, and better quality regulation. Often the budget of a public system in the case of a public monopoly does not reflect the full cost of the system (e.g. capital charges and maintenance). However, it should be recognized that inserting a purchaser-provider model into a situation of continued monopoly will generate limited efficiency gains compared with the benefits of competition on the provider side.

To summarize, vulnerable individuals need social care services, and societies wish to supply them with these services at affordable prices. The role of governments is to ensure that such services are available to those who need them at the required quality level. This means governments must:

- finance some or all of the costs for some or all of the client groups
- decide who should receive what services with limited public funding, based on good tools for needs assessment, careful evaluation of results for clients, and targeting policies to ensure value for money in terms of social goals such as preventing deprivation or human rights violations and fostering inclusion
- monitor quality for services provided (public and private).

Governments can do this through direct service provision. However, to encourage a more efficient, flexible, and diverse provider network, governments in OECD countries have been introducing purchaser/provider financing models.

[20] Fölster (1993).

Box 1 Contracting out residential care for children in Iceland

In the early 1990s, the government of Iceland was concerned about the cost of residential care for children in state-owned and operated facilities. Costs had been rising without a comparable increase in services or quality. As part of the government's Competitive Tendering Initiative, in 1993 it was decided to experiment with contracting out management services for a new residential care home. After much debate on qualifications and standards, a tender was launched. Potential contractors were ranked according to qualifications, and a contract was signed with the leading candidate following negotiations.

The experiment was judged a success, and as a result, in 1995, a purchasing agency was created - the National Child Protection Agency. Today, most residential treatment homes for children have been, or are being, contracted out. Whenever possible, former management is invited to make a tender in order to preserve expertise and contribute to stability of service. Contracts are usually for two years with an extension clause.

A recent evaluation highlighted the following benefits of the new system:

- contracting out has added flexibility to the system, making it more client responsive
- unit costs have declined 20%, government overhead costs have also declined, and budget overruns have been eliminated
- quality standards are higher owing to the requirement for the buyer to define requirements and expectations and the separation of service from supervision.

Source: OECD, 1997

Box 2 Purchasing and providing social care for adolescents and children in Stockholm

The approach taken by the municipality of Stockholm (population 750,000) to ensure availability of social care services for adolescents and children at risk is an example of how the purchaser-provider spilt works in practice.

Until 1970 most care provision was in the hands of public authorities: the City of Stockholm, the County and the State. The forms of care were private foster homes and public institutions, with foster homes representing the larger part of care provision. In the late 1970s and early 1980s private entrepreneurs started to provide care and services for children (and adults). Most new care developed out of foster homes that expanded and became small institutions and group homes. This was the start of a market for care provision, which expanded slowly and peaked in 1992, when it started to balance demand better. Alongside the private providers, there are still some municipal residential care centres operating, mainly for short-term care and/or to prepare for foster home referrals.

Stockholm is divided into 18 districts. The Social Assistance Office (SAO) in each district has its own social services budget, allocated according to criteria such as social and economic needs. Each SAO is in charge of assessing needs and translating them into demands for service in order to purchase care and pay for the care costs. Care providers are private, and some of them are NGOs. There are also some municipal residential care facilities that are handled by an Administrative Agency (Stockholm HVB) that provides care for children, both to the City of Stockholm and to some 20–30 other municipalities in the region.[24]

Due to economies of scale (saving money and concentrating skills in one office), Stockholm concentrates some of the purchasing functions in a central office which acts as a broker for the districts. The Bureau for Placement, a part of the Social Assistance Administration negotiates contracts with the care providers. To procure care, the broker announces a tender and receives around 85 bids among which less than half results in contracts. There are two types of contracts:

- long-term contracts (1–3 years) for frequently used services (about 35 allocated per year, based on demand forecasts). These specify a price and quantity to be purchased over the year.
- short-term contracts, for infrequently used services, which are paid for as demand arises. The broker advises the SAO concerning placements at these care facilities.

The long-term contracts help ensure a stable supply of services, as they lower the provider's risk thus reducing costs. They also ensure that care is available throughout the city so that clients do not have to travel far from their families. The short-term contracts provide flexibility.

The advantages of this system are:

- competence and capacity is concentrated with a single agent (broker)
- the broker can act as a strong negotiator to keep costs at a reasonable level. This is helpful for small districts and municipalities
- the broker has good control over the supply in advance, and can avoid *ad hoc* and panic-driven decisions in single client cases
- the broker's experience with providers will help in avoiding mistakes with other providers in the future
- the skills in the broker office are helpful for both providers and purchasers; they can rely on support and good advice. (Providers that are likely to provide sub-standard services can be avoided.)
- the stable staffing of the broker's office can to some extent compensate for high staff turnover and lack of continuity on district level; the broker remains in close contact with the district social worker
- the risk of an expensive long-term contract is shared among districts
- economies of scale achieved, lowering unit cost of care (which cannot be achieved in a small district)

The disadvantages of this system are:

- some districts may think that a broker office constitutes "centralism" and try to set up their own care organizations (they are free to do so, but few do)
- care market capacity is not built up at the district level but is handled by the broker, although the district social worker is encouraged and expected to stay in touch with their clients during placement
- it raises the price of care slightly since the fees pay a part of the costs for the broker office; however, the extra cost is compensated for by the city's lower unit cost for care.

The system also put an end to the "over planning" common in the old system where districts had a tendency to over-estimate their needs for institutional resources as long as others paid the placements.

Thus small municipalities should preferably purchase care on a day-to-day basis for single clients, unless they can pool their resources and establish a broker to deal with the issue. However, purchasing care in this flexible way (day-to-day) does not mean that a market-orientated system is out of reach as a provider can sell its services to more than one municipality. The disadvantage is that a small municipality is unlikely to build good capacity in purchasing if such purchases are rare, e.g. who is likely to undergo by-pass surgery at a small hospital that rarely carries out this kind of surgery?

An evaluation of this system was prepared in 1993–94. The results were positive.[25] Overall, unit costs were lower for an acceptable level of quality. However, the implementation of the purchaser-provider system coincided with several other management changes and budget cuts in Stockholm city and county. As a result, it is difficult to distinguish between the effects of the different measures.

[24] The only state-owned institutions today are for compulsory care of adult drug addicts, alcohol abusers and young delinquents. This represents a minor proportion of those in care (350 adults and 600–700 young delinquents). Some state or county owned institutions provide care for the severely handicapped.

[25] The evaluation was conducted by the National Board of Health and Welfare in Sweden and was published in the Report Series Active Follow Up 93/94, by Karin Mossler. The study targeted the privatization effects in Stockholm municipality and county administration in general.

Decentralization

Although 'government' and 'public' have been considered a unitary entity, in all but the smallest countries in the world there are multiple levels of government. Political and fiscal decentralization has been an important trend in the last 30 years with multiple goals primarily clustered around ensuring a greater voice for and participation by the community. This is believed to produce better public service through more transparency and accountability, as well as flexibility to adjust to changing service needs.

In theory, the purchaser-provider model is well suited to a decentralized framework. This is because local governments are often even less effective as monopoly suppliers of services than national ones. In the case of some services, there may be economies in the provision of care services beyond the catchment area of the local government. Local governments may lack the long-term financing necessary to invest in care provision but be effective purchasers since they can identify the needs of their populations, prioritize them and purchase care for them, *assuming that local governments have an adequate financing base, either from own revenues or central government transfers.* Once again, the key role of the financing framework emerges. For a small municipality, getting rid of the burden of managing an institution means that it can concentrate on its role as a good purchaser.

The obstacles to implementing a purchaser-provider system for social care start with the lack of resources for purchasing at the local level. This can occur for several reasons:

- local governments have been allocated too many functions relative to their share of total public resources (their overall pot of resources is too small)
- some local governments have a higher number of vulnerable individuals than others but with fewer resources (the risk pool is too small and/or mechanisms for horizontal equity are not in place)
- local governments do not allocate sufficient funding to meet social care needs.[21]

Solutions to these problems require central government intervention. The first two can be addressed with increased untargeted transfers to local governments, whereas the last requires national standards or norms to ensure that a minimum standard of social care services is available nationwide. It may also require earmarked transfers to some local governments.

A second reason why decentralization does not lead to the purchaser-provider model is that local governments are not able or allowed to optimize their social care purchasing (i.e. a set of providers and a payment mechanism does not emerge). There are several reasons for this.

- *Local ownership of facilities.* In some countries, the sort of decentralization implemented was a decentralization of facilities rather than functions. This meant, for example, that a local government received a large care home instead of revenues. Central government transfers may be tied to the operation of this home and until the local government can rid itself of such a dinosaur (by selling or transferring it to an NGO, partial or total closure) the government is the monopoly supplier of care and there is nothing to purchase.
- *No payment system.* A functioning system of payments between purchasers and providers is necessary. During the first years of decentralization (when many suppliers were still government-owned) this may not be in place.
- *Skill shortages.* Local governments may lack the skills to purchase care effectively and to monitor outcomes.

These problems can be mitigated through actions by central government or an association of local governments (see Box 2 for the Stockholm example of local government pooling of resources). For example, as a service to purchasers and clients, one national agency can be entrusted with standard setting and quality monitoring. A national agency can also provide methodological support to gatekeepers and providers, and support research and training on best practice. The national government can support an intergovernmental payment system, with heavy sanctions for non-payers. The restructuring of the provider sector can be assisted by national governments, through master planning processes and one-off subsidies to help restructure or close down institutions.

One problem which cannot be resolved is when municipalities are too small to manage low-probability/high-cost social risks. This can occur when the main employer in a town shuts down, causing extensive social problems with no public revenue to address the situation, or with a group of very small municipalities. In this case, decentralization of social care competences is not practical without some consolidation of government units of development in the regional government structure.

In sum, political and fiscal decentralization can provide support for the development of an improved financing framework. But for this to occur, partnership and support from central government are usually necessary to ensure the transformation of monopoly suppliers into providers in a properly regulated quasi-market.

How much care should be financed by the public sector, and for whom? How should the budget be spent?

As discussed above, public sector financing effectively combines two roles:

[21] This statement begs the question of "how much social care is enough and who decides?" This is beyond the scope of this paper. For a discussion of the question in the OECD context see Lindert (1996).

- selection of care (the expert or the agent function), and
- public subsidy to help reduce the costs of care for families.

It should be noted that although the first role is needed, this does not mean the second one may not be equally necessary. Where care is relatively inexpensive, families may pay the cost themselves, with the public role limited to the agency function and quality monitoring. However, care is often expensive for families (residential care is prohibitively expensive), so that public subsidies end up being put in place to reduce costs.

Ideally, the selection of care by the agent and the decision on the amount of subsidy should be separate decisions. The agent makes a 'technocratic' recommendation, based on the latest evidence of what programme best meets a client's needs. In reality, this is not the case. Limited budgets, the difficulty of determining service effectiveness and the political and social context all tend to lump the decisions together, so that the purchaser makes both decisions simultaneously. This means that payment for care always enters into the decision on how much care and what type should be provided.

The question remains of how much subsidy should be in place, and to whom it should be allocated. The mere existence of a need does not justify 100 per cent public sector financing. Resources, especially public ones, are always limited and face competing priorities, equally important for well-being (i.e. education, health care, roads, etc.). Taxes cost money to collect, and the higher they are, the more evasion there is, and thus the higher the cost to the economy of collecting taxes and providing public services. Needs, on the other hand, are infinite. As a result, the funds available to the purchaser are always too limited. Choices among needs and interventions are a daily problem in setting and implementing social policy where rationing is a reality.

Choosing among households. In considering how to ration funds, most economists argue that public subsidies should not go to those who could pay for care themselves (the targeting or equity approach). A corollary to this argument is the recommendation to require some contribution to service cost from almost everyone (a co-payment). Co-payments are supposed to provide a signal to purchasers about the client's valuation of services, and reduce the increase in consumption which always occurs when something is free. This economic argument calls for directing subsidies to the poor to avoid wasting resources, and some form of user fees.[22]

The problems in applying this approach start with the difficulty of measuring ability to pay. How, for example, can we compare rural with urban, and children's needs with adults needs? Poverty can be transitory, with those in need of social care services in transitory poverty. Forcing them to pay could reduce their ability to climb out of poverty, but once out of poverty, it is hard to enforce a contribution. Secondly, some problems such as a temporarily or permanently disabled family member, the onset of HIV/AIDS, etc. are catastrophic in nature. This means that expenditure is high at a given point in time (or over time), and having to pay for services out of pocket would push the non-poor into poverty. From this perspective, public subsidies are a form of insurance in an insurance market failure. Everyone pays taxes and everyone is insured. There should be no discrimination among individuals with respect to access.[23] It should be noted that this approach does not resolve the rationing problem but simply adds another dimension and may reduce the size of the service package.

In assessing ability to pay, it is important to examine the total cost of the service to the household. Even if the service is free, it may imply travel time and the time of other household members. If these costs are not considered, a service that is 'free' may end up being expensive, and therefore under-used. For example, once a client has been referred to residential care the economic responsibilities of their family and breadwinner are 'taken over' by the residential institution. Thus, residential care appears to replace, rather than complement, family care. Non-residential care involves clients' families to a larger extent. Open care requires a family or someone who can take the child to the premises where the open care is provided. For example, half-way care facilities cannot function properly unless there is someone to attend to the other half and to assist the client between their visits to the half-way house.

If the care approach is exclusive (as in most residential institutions) most costs remain with the care-giver. But if care is inclusive (to encourage clients to return to family and society) the cost of payment will depend on the participation of and contribution from that part of society. Care cannot be inclusive unless there is someone outside the institution to care, show concern and compassion. Usually, these costs are not significant and most families are prepared to sacrifice a little of their own comfort and economy to help a child or elderly parent. In some cases it is likely that the government will have to assist the family with benefits to allow the desired participation in the care process.

Finally, there is a difference between willingness to pay and ability to pay. Some services are too important to society (e.g. child protection) to be left entirely up to the family's willingness to pay even a part of the cost and so require public financing. In some cases, public financing may be combined with legal requirements for the household to pay part of the cost.

Choosing among services: the essential service basket. Some argue that subsidies should be provided according to type of service, i.e. those with the greatest

[22]The rules for requiring co-payments should be specified in advance and not decided *ad hoc* by the purchaser.

[23]This approach is referred to as the "solidarity principle".

Table 2 'Objective' criteria for allocating funds among families and programmes

Criteria	Who benefits?
Equity: finance care for the poorest, others pay on a sliding scale	This criterion appears objective until the question of how to define poverty and available resources is faced (including resources at the time of a catastrophe). In practice, this criterion tends to favour whichever group is considered 'in need' (the poor, minority groups, women, age groups, etc.).
Solidarity: equal and universal for those in need	This criterion usually results in an assured basic package, but may result in underfunding of services to the poorest due to budget constraints, while substituting the family in some cases.
Catastrophic cost: financing care where costs are too high for a family to bear (the social insurance approach)	This criterion favours severe problems over smaller, more manageable ones. It does not favour prevention, which may mean that small problems develop into larger ones.
Cost effectiveness: financing care that has the biggest impact on a client's life	This criterion appears objective, but in fact favours those with the least severe problems, since these are easier and the service has a much higher chance of success. It also favours prevention. It should be noted that "effectiveness" is very difficult to measure, and is not the same as success. Cost-effectiveness should be applied to treatments which provide similar outcomes, but not to rationing funds between treatments with different outcomes.

impact on the most people for the smallest amount of money. Which services constitute 'basic rights'? For example, effective prevention lowers the overall cost of social care services, and should thus be subsidized. The argument for public subsidy is greatest in the case of preventive services which are difficult to target: these services can be consumed by a number of households at the same time with the benefits spread across the population in terms of lower overall social care costs for the same result. The problem with this approach is that separating out prevention, cure and maintenance is complex in social care. It also implies the sort of thorny value judgments and choices – the need of a child with a mild disability against that of an elderly home-bound person – that most societies are not prepared to face.

In practice, countries use combinations of the criteria in Table 2, depending on social tradition, degree of homogeneity, income level, etc. The mix of criteria will be reflected in the financing rules which apply to the purchaser. Current ideas on good practice (recognizing the political and social arena in which these choices are made) include the following:

- *Mapping needs.* Purchasers should prepare a community needs map and try to identify those at highest risk. They should consult with the community to determine local priorities. Purchases should be partly planned in advance. Planning should try to define a basic package that best suits the community's needs and available financing.
- *Price-conscious care planning.* Financing should include low-cost day services and high-cost residential interventions to avoid the low-cost ones being rejected by households with limited means in favour of subsidized high-cost ones. For a given problem, purchasers should use the lower-cost ones as much as possible and the higher-cost ones as little as possible. This tends to favour day-care services, which on average tend to have better outcomes.
- *User fees.* Wherever possible, a contribution should be sought from the household. This will save money *and* provide information on the client's perception of effectiveness, e.g. the elderly will choose home care three times a week instead of once a week if care is free. But if the client pays a fee per visit, then three times a week care will only be selected where really necessary. Equally, co-payments for homecare should not be higher than for residential care. If they are, the family may exert pressure for residential care. User fees should be similar for substitutable services, i.e. for services addressing the same problem. Purchasers should consider total costs to the household of service options, and include them in evaluating the household contribution.
- *Choice.* Provide choice to client, with prices which reflect the opportunity cost. Options with a higher cost will only be chosen when the benefits are perceived to be higher.
- *Information.* Allocating financing to monitoring and evaluation. This should include analyzing household costs and perceptions of value. It should also include educating clients and the community about needs, options and choices in order to reduce the information gap between the community and the purchaser.

In sum, OECD countries have more or less abandoned the idea that the public authorities should finance social assistance services *and* provide (produce and deliver) services through their own organizations. We can witness a shift towards a system where public authorities (state, counties, municipalities) are responsible for financing and purchasing whilst the provision (production and delivery) of services is entrusted to others. In the provision sector, monopolistic public provision of social care services is unlikely to produce the best results for society or the client. Some kinds of market provision offer much better options in terms of quality. However, even in areas where there are no private suppliers ready and able to provide services, the public authorities have made a division between the purchaser and the provider's role but kept them both within the framework of the public authority. Development of a purchaser-provider financing framework is critical to establishing this market, and ensuring access.

However, the purchaser role is complex, serves multiple interests and is subject to a number of political, social and economic pressures.

The rationing of funds among service products and clients is the result of the interplay of these interests through the institution of the purchaser.

Information transmission is the key to making the system work. The easiest information to transmit is the cost of service, which comes through price signals. The market helps transmit information about production efficiency. However, as each client is different and therefore services are not standardized, the information in a price signal is less than would be expected in another type of service industry.

Needs and outcome signals are more complex. Demand, that is, what society is willing to pay with private and public funds, emerges through a political and technical process. Services which are free will always find more needs than services that incur costs for the client. However, clients understand quality, and will, given the opportunity, supply the purchaser/financier with information on perceived quality and effectiveness.

Fiscal and political decentralization may make balancing these interests more difficult, but may also provide the political opportunity to introduce a purchaser-provider model.

Table 3 Allocation of functions in Stockholm

Purchaser (district)	Purchaser-Broker (central)	Providers
• Assesses and prioritizes needs, makes a care plan, and secures client agreement and family support • Rations financing • Reviews service recommendation from broker, accepts them or sends them back for further work • Pays for care • Reviews outcomes on client level, provides feedback to broker • The ultimate responsibility for a client always rests with the purchaser	(1) *Contracting* • Agree (make contracts on annual basis) with providers • Agree (set a day price) with providers • Manage administration and accounts (2) *Matching* (prescribing) • Match client to best care option and make a proposal to the district (3) *Quality monitoring* • Assess and monitor quality (on aggregated level) • Present outcome, costs and propose new contracts to the political board as well as termination of contracts no longer needed • Keep informed about demand and supply and take initiatives to encourage provision of care that is needed	• Must produce the quantity and quality of care at the agreed price • Must submit to audits and monitoring indicators, including statistics giving costs, client numbers, outcomes etc. • Are responsible for their own training, development and other measures making them competitive and able to produce good quality care and services[26]

[26] Care provision is also monitored by the County Administration Board (a regional state function) and the National Board of Health and Welfare (a central state function).

II Overview of social care provision in the ECA region

Summary of social care situation

The legacy from the Soviet era was to provide care for vulnerable citizens in residential institutions. Today, most transition countries still use this approach, although projects designed to replace residential care – or parts of it – with community-based non-residential alternatives are being developed. This overview is based on the experience gathered from a number of care-related projects in the region. Anecdotal data has been collected from countries in the region to exemplify the current structures of care and services, how and by whom it is managed, its costs and financing. It should be noted that the data are not comparable due to differences in reporting techniques as well as the time period the figures refer to. This chapter will focus mainly on the situation of children.

Deteriorating economic conditions and the far-reaching economic and political changes undergone in the 1990s in ECA caused a major increase in poverty and vulnerability in the region. Between 1988 and 1998, absolute poverty rates increased by an unprecedented amount from 2 per cent of the population to 21 per cent (World Bank, 2000). By 1997, real incomes were 30–60 per cent of their recorded 1990 levels. Unemployment and poverty, especially among families with children, rose to levels not seen before in these countries. The transition brought all kinds of deprivation, from actual hunger to the disruption of previous norms and expectations of the social structure. Social protection needs increased along with poverty. However, most governments cut back cash and in-kind social supports in the face of major fiscal crises (partly caused by the downturn). Overall, the negative impact of the early years of the transition on people's lives, especially those of children, was unprecedented (UNICEF, 1997; 2000; World Bank, 2000).

Growing use of residential care. A common response to this poverty crisis in the region has been a major increase in the number of children in residential care - a trend that shows no sign of abating. Some of the countries place around 1 per cent of their children in infant homes, while most countries show lower figures. These figures are high compared to Western Europe, both as a total number of children brought up outside their birth family and as the number in residential care. The figure for Sweden is 0.5 per cent of all children in out-of-family placements and the majority of these children are placed in foster homes.

Official data confirm that the number of children directed into care institutions increases each year and that only a small proportion have been placed in alternative care. This trend continues despite that fact that countries are instituting changes in cash-benefit systems to help families keep disabled children at home and that the share of funds allocated to non-residential care appears to be increasing.

The elderly, mentally and physically disabled and children are the three large client groups. Children are either orphans, non-orphans deprived of parental care or children with social problems (e.g. children not deprived of parental care but at risk for other reasons due to their own behaviour and/or parental maltreatment). Poverty plays a role insofar as some institutionalized clients would not be in institutions if they were not poor or lacked someone to care for them.[27] The term "social beds" indicates when residential care is used for clients who would not be in care if they could be provided for in other ways.

Table 4

Children in infant homes (per 100,000 population aged 0–3) 1998 and the increase in the rate of children institutionalized in the period 1989–97 (%)[28]

Country	1989	1998	1989–1997 (% change)
Czech Republic	533,0	571,7	3
Slovakia	191,7		44
Hungary	504,6	378,9	- 25
Bulgaria	873,8	1299,6	46
Romania		836,4	56
Estonia	149,9		115
Latvia	528,2	996,5	72
Lithuania	275,6	324,1	16
Belarus	169,4	325,6	75
Moldova	183,5	285,8	31
Russia	208,3	365,0	64
Armenia	13,2	23,4	68
Azerbaijan	35,5	27,0	-20
Georgia	75,7	79,9	-25
Kazakhstan	122,4	267,3	78

[27] Tobis, 2000.
[28] *Source:* MONEE project database.

Growing alternative care. Ambitious work is being carried out in the region to develop community-based care (see Box 3). These alternatives are designed to help with housing and to provide counseling and support to families and vulnerable people. Community-based care is less expensive and more cost-effective than residential care. This is because in many cases alternative care can postpone or prohibit a referral to residential care. It also helps clients cope after leaving residential care and takes account of each client's ability to function which in turn has an impact on demand for staffing.

Alternative forms of care are mainly used for the self-sufficient elderly with the support of home-helpers, and sometimes for the disabled. Home-helpers are available and fairly easily trained in many countries in the region, but home care is not as professionalized as in Western countries. Guardianship and foster homes for children appear to be on the increase. Figures from Lithuania for 2001 indicate that alternative care for children covers 51 per cent of the total number of children in care. However, there are differences between countries. Some have come far in appointing guardians for children some of whom would otherwise have been placed in residential care, while other countries report less non-residential alternatives for children although it is a policy goal to give priority to services at home and other forms of non-residential care.[29] The financing forms are partly decisive for how this care develops insofar as any form of care that is subsidized or even paid out of the state budget, appears to expand.

Spending on care. If we examine spending on residential and non-residential care for two countries in the ECA region, Latvia and Lithuania, the following picture emerges.

Unit costs of residential care account for 165–209 per cent of per capita GDP whereas unit costs of non-residential care amounts to 51–55 per cent of GDP per capita.

The difference between the cost of residential and non-residential care is striking. One must, however, take into account that different methods used to calculate the figures may over-emphasize this difference. Furthermore, the large number of guardianships reported distorts the comparison since payments to guardians are low. However, guardianship must be considered as community-based care because it allows the child to remain in a family and is private. Other sources of information confirm that the costs for new forms of alternative care services are lower than those for residential care.

Financing framework: roles and responsibilities. These are mostly monopoly, even after decentralization. Public authorities on different levels (state, regions/counties or municipalities) generally provide care. The NGO (non-governmental organization) share of provision is still on a very small scale even if figures show that this is slowly increasing. Private entrepreneurs in care provision are still unusual.

The financial implication of the monopoly system is that care provision is not geared by client needs, but is supply-driven. The fact that only a certain kind of care is available is decisive for how client needs are deter-

Box 3 Examples of family-focused care currently operating in transition economies

- Day centres for support, counseling and service for the elderly, risk families and the disabled
- 'Meals on wheals' - practical help with meals delivered to the door
- Local services to families with disabled children or social problems
- Help for children who have experienced violence or been deprived of parental care
- Crisis centres for individuals/families in crisis
- Guardianship for children instead of referrals to institutions
- Half-way houses and service-apartments in the interface between residential care and an independent life in society
- Home help and advanced home help
- Support for ex-prisoners to find employment and housing and to reintegrate into society
- Centres for battered woman and their children, short-term overnight facilities
- Group homes; small institutions providing care and services to a specific client group
- Adoption and foster care
- Night shelters for the homeless for short-term placements
- Rehabilitation training for the physically disabled, assistance with handicap devices and equipment
- Open programmes and outreach activities for families at risk
- Counseling centres

Table 5 Average costs per year and client for residential and non-residential care

Client group	Residential care	Non-residential care
Elderly	3700 USD	1200 USD
Disabled	4340 USD	*
Children	4880 USD	1300 USD

* Data not available (few disabled placed in non-residential care)
Source: Ministry of Labour and Social Protection, Lithuania, 2000 and Ministry of Welfare, Latvia, 2000

[29] Foster-home is usually intended for short-term placements while guardianship is a long-term alternative care form.

Box 4 Pitfalls of decentralization during economic decline: lessons from Romania

In 1997, Romania transferred responsibility for child protection to local governments, and in 1998 accelerated the decentralization process by transferring resources, responsibilities and accountability for many social and community services to local governments. In principle, the decentralization was designed to encourage local innovation and initiative, including the development of more community-based social care services. By 2000, local governments provided over 50 per cent of the total government funding for social services (a larger share in social assistance in community services and a smaller share in other sectors such as health).

Unfortunately, the reform became effective in the middle of a fiscal crisis. Between 1996 and 1999, GDP fell by 13 per cent and local government revenues fell even more. In 1998, local revenues were 25 per cent below the 1996 level, and in 1999, 20 per cent below. This revenue crisis, combined with what was at times an *ad hoc* distribution of functions and ownership, a lack of support for already weak local administrative capacity, and constantly changing policies on revenue transfers, resulted in an almost chaotic situation in social assistance in 1999–2000. Local governments were unable to cover the costs of the institutions they suddenly owned, and in some areas, conditions deteriorated sharply. In other cases, governments cut back on cash benefits, which simply caused poor families with children to increase their demand for institutional care. Fragmentation of social assistance policy, monitoring and oversight responsibilities across the national government reduced the scope for national leadership and support during this process. Local governments viewed decentralization not as an opportunity, but as the national government passing the problem down the line.

In some localities, the reforms had the desired effect of inducing system change. Some localities were able to cope by working with NGOs and outside assistance to rationalize and cut back on institutional care, and to integrate the NGO sector effectively into the service network, providing more choice.

Romania has worked hard to address these problems and in late 1999, the government intervened with emergency aid. The Law on Social Assistance consolidated national functions and reduced overlapping roles and responsibilities, enhancing accountabilities. As of 2001, local councils are required to fund residential care on a per capita, rather than an input, basis, improving incentives for reform. Romania's experience illustrates the importance of a strategic approach to reform from the outset, as well as the difficulty in implementing a reform at a time of declining revenues.

Source: World Bank (2001); UNICEF (2000)

mined. Funding is not allocated among those in need, but among providers. The social worker (agent) has more loyalty to the supplier (the monopoly) than to the client and the referring authority (municipality) has little incentive to make adequate need assessment to find out what helps an individual best. If needs assessments are not performed, or are poorly performed, no information feeds back to the supplier (institution) on what needs must be met and how to do this.

The process of political and fiscal decentralization has not changed the picture a great deal. Where institutions have been decentralized, funding often remains centralized. Some alternative care, such as guardianship, is handled by the state, whilst most alternative care provision rests with the municipalities. In a long-term perspective, funding for alternative care has to be reallocated so that if institutions are transferred to the local level, the funding should follow automatically.

Table 6 illustrates the most common division of tasks and responsibilities between state, counties and municipalities. The state often funds care and services of a more category-based type (the severely disabled, blind and similar groups), and also manages the care and owns the facilities. In most cases local government is responsible for non-residential care, with a few exceptions; the elderly in residential care are often the

Table 6 Distribution of financing responsibilities by target group

Target group	Residential care	Funding	Alternative care	Funding
Children	Residential institutions	Mostly the state, but sometimes on the municipality budget	Foster homes, guardians, group homes, open activities	Mostly the municipal budget, but for guardians, state budget, NGOs
Elderly	Homes for elderly	Mostly municipalities but also the state	Home care, open activities	Mostly municipalities, NGOs
Disabled	Residential institutions	Mostly state	Open activities	Mostly municipalities, NGOs

responsibility of local government and the state sometimes funds guardianship, making an attempt to cut back on referrals of children to residential care.

Input budgeting. The provider is usually financed by an input budget in such a way that the provider is paid regardless of what is produced, e.g. financing is not clearly related to the number of clients in care, duration of care, or outcomes of care. The estimated costs for a projected number of clients are allocated beforehand. Outcomes are not tracked or systematically analyzed which means that prices related to care outcomes are unusual. In most cases the authority responsible for care and services is the owner of the care facility. Funding is allocated directly from the state treasury, through an agency, out of local resources, including equalization fund revenues, or a combination of these three. In some cases municipalities in a region contribute to funding according to their size and the demand for service facilities.

Weak or non-existent purchasers. The system does not make a clear distinction between purchasers and providers. The pure form where a single clearly identified purchaser carries out needs assessment, acts as gatekeeper, refers clients to care, and pays the fees, and a single equally clearly defined provider who manages care, and is paid by fees, is not very common in the region. The following combinations of ownership, management, financing and power to decide on referrals can be found.

Since many institutions assume the conflicting roles of ownership, management and provision, financing, and client referral, they have a strong decisional influence on which clients to accept and discharge. This does not provide an incentive to produce good outcomes and be cost-effective. Purchaser-provider systems have been implemented throughout the region, but either lack the two key features that make them work adequately – the right to decide, and obligation to pay – or have more roles than they should. If the purchaser making the decision to refer a client to care does not finance that care they cannot ensure that the need, as determined by the gatekeeper, is financed according to budget constraint and therefore that care is properly rationed.

Little outcome monitoring. There is no systematic tracking of care outcomes and there is little awareness of the importance of the relationship between costs and outcomes. The absence of appropriate monitoring pushes economic considerations (who pays) into the foreground and makes these considerations more decisive for the choice of care than client's needs. This also makes the follow-up on results unimportant. If the purchaser does not strive to find the care that best meets clients needs, why bother to find out if those needs have been met? And if this important element of evaluating outcomes of care is not in place, the development of best practice is hampered. There is little feedback to institutions about what care is effective, and without that information it is difficult for institutions to change and adapt to clients needs and develop best practices.

Prioritization. There is little information on how prioritization is made. For example, state financing of guardians has supported an expansion of this form of alternative care, but there is incomplete information on the day-to-day prioritization to ensure that the most needy are targeted and that care producing the best outcomes at the most reasonable price is used. In general, two factors appear to be important for setting priorities. One is supply; if there is a place vacant, a client is likely to be referred to it. The second is financing; care that the referring authority does not have to pay for appears to be prioritized. Anecdotal evidence from Moldova and Armenia indicates that poor people, especially children, end up in institutional care. Where the resources are, children will follow.

Financial statistics. Financial statistics do not generally indicate the true costs of care (alternative or residential) since capital and maintenance costs may be financed separately. These costs, which are easy to forecast and cal-

Owner	Manager	Financier	Referring clients	Combinations
x	x	x	x	1. Usually a state or municipality owned institution that decides which clients to serve. This type is predominant in the region.
		x	x	2. A municipality that purchases care from a provider (state or other), makes decisions to refer clients, and pay the fees. This is a clear *purchaser*, but rather unusual in the region.
x	x			3. A provider that owns and manages an institution and sells its services and is financed by the fees. This is a *provider*, also rare in the region.
			x	4. A municipality that refers clients to care that is paid by others, in most cases the state (or region). This form is common in the region.

culate in the normal budget, are often covered by the funding authority in a separate budget. Decentralization has led to multiple pipe financing, usually all financing for state institutions is derived from the state budget, all costs for municipal institutions are covered by municipal funding, and financing is not transferable between the two. The part of the care costs paid by the client is usually a relatively small portion of the full costs. Most alternative care is provided free of charge. For residential care, in most cases a pensioner pays the care facility from their pension and the sum varies from almost the whole pension to smaller amounts. As a share of the total cost of residential care, the client contribution is insignificant, but the fact that some services are free of charge is likely to increase demand.

Conclusions

Faced with a massive increase in poverty and social dislocation, countries responded by increasing their use of institutional care. This is comprehensible given the inability of the present system for care and service delivery to promote the necessary range of alternative care options or to attain specific targets, e.g. the concepts for a good financial framework outlined in Section I cannot be fully applied. It constitutes, however, an unfortunate waste of resources. The balance between the needs of vulnerable people, what the gatekeeper (social assistance office) finds most helpful for the client within the current budget constraint, and a supply of care at good quality and in appropriate quantity, is difficult to realize in the current system.

- Care and service provision are supply-driven, needs are not properly assessed and there are weak incentives to focus client needs. Costs, i.e. who pays, appear to have too much impact on the choice of care, and awareness that needs must be converted to demands, rationed and prioritized is low.
- Incentives to use alternative care are not sufficiently attractive, and many municipalities prefer to use the residential care available at little or no cost to their budget in order to save funds for other needs. The purchasers do not generally pay fees, thus lacking one of the more important functions of an efficient purchaser. However, if financial incentives are in place – as for guardians – it appears to change referral patterns for the better.
- Countries are caught in a vicious circle insofar as the greater amount of money that goes to residential care, the greater the fiscal burden and the more difficult it is to find other, less expensive and more qualitative solutions to peoples' needs. The input budget system does not encourage competition, it limits the care mix and allows client and purchasers little choice, thus hampering the improvement of the effective supply of care.
- NGOs appear to stay outside the policy loop and are setting the terms and conditions for their own work. The monitoring of NGOs is not systematic although the result of NGO work often becomes known through their own public relation activities. However, there appear to be productive and open channels between public authorities and NGOs and their contribution to social work is important.

Box 5 Why is the number of children in care growing in Latvia?

Latvia overall has experienced a 72 per cent increase in residential care in the period 1989–1999. However, the distribution has not been even nationwide. This is not surprising, as Latvia is a fiscally very decentralized country, and since 1995 the responsibility (ownership and operation) for most care facilities rests with local governments, in some cases with regional governments, and in some cases with municipalities. The government's intent was to transfer homes to the municipalities from the regions in order to encourage the developmment of a market but this did not always occur. It should be noted that not all municipalities own a home even when the regions did give up control, as Latvia has over 400 municipalities. Municipalities are supposed to pay an output-based fee when they place a new client in another local government's facility (mutual payment system). This payment system has been slow to develop.

In 2001, the Latvian Ministry of Social Welfare commissioned a study on why, in some areas, residential care is growing faster while others are meeting new needs with community care. The results were striking.

- Municipalities which have an institution tend to keep the institution full, partly in order to maintain employment. The rate of institutionalization is growing in these regions.
- Municipalities which do not have an institution have adopted one of two strategies: some are building new institutions; others are developing more community care.
- Community care grows faster in regions where the mutual payment system works well.
- All localities cited lack of funds as the main constraint to the development of more community care. However, many see community care as an addition to the service basket, not a substitution.

Latvia's experience demonstrates the difficulty of achieving results through a simple fiscal decentralization. A broader strategy is necessary, including a nationwide strategy for facilities consolidation and training program to develop the purchaser and gatekeeping functions. Improvements in standards are also necessary. Latvia's current strategy involves all of these activities.

Source: Ministry of Welfare, Latvia, 2000

III Implementing a better framework

Improvement in social care services, and hence in the life choices, opportunities, and welfare of vulnerable groups, requires changes in the financing framework as part of an overall reform. Such a change does not mean a shift from public financing to private financing, e.g. placing the burden of costs on the vulnerable families themselves rather than on public authorities. The public's responsibility for vulnerable citizens remains but should take place within a more effective financing framework.

In reviewing the main aspects of the current system in need of reform we address several key issues. First, purchasers need to be established, with clear responsibility and incentives to serve the client, not the provider. Second, budgeting and financing procedures need to be changed to allow output-oriented financing of providers. Third, tools for agreements between purchasers and providers must be developed, including contracts, rules on pricing, and tendering. Fourth, existing providers need to be reformed, and new entrants facilitated.

Establishing a purchaser

The table below presents a simplified example of the tasks for the purchases currently in place in the region, and the desired mix of functions that a purchaser should have in order to be effective. A purchasing organization should be established to assess people's needs and find the most appropriate care and service for them. This organization should also manage the budget for the care it purchases. Purchases cannot be made without knowing what to buy, and how much it costs. Therefore the purchaser organization must be informed about the care market, costs, and match client needs with the best care option available, be it residential or alternative.

The purchaser's decisions to refer a client to care should be driven by a profound understanding of two things – what a client needs, and how these needs can best be met. Establishing needs is done in a need assessment procedure in which the social worker, the client, the client's family or/and other significant individuals take part. However, needs are not the same as demands and assessment of needs is a professional procedure of converting client needs into appropriate and affordable interventions. (The drug addict may express a need for drugs, but the public sector is willing to finance something quite different, i.e. treatment to 'get off' drugs.) The need assessment should lead to a care plan which identifies the client's weaknesses but also their own capacity to contribute to a good care outcome. The purpose of care is not to 'over-treat' but to help the client with what they cannot manage on their own.

In pursuing the best option for meeting the client's needs, the purchaser should aim at a solution without moving the client out of their family and natural environment, e.g. it is better to support a family to care for a child, to help family members to keep an elderly parent at home, or to provide home-help etc. Referrals to residential or alternative care should always be the last option.

One function of a good purchaser is to act as a gatekeeper to ensure that the client is referred to care only when necessary, that the right form of care is used, and that there is a care plan with clear targets for outcomes and re-entry into society. The gatekeeper must have

Owner	Current system	Proposed system
Purchaser	Meets client and assesses needs Matches needs with supply Refers client to best available care Suggests areas where new supply needed	Meets client and assesses needs Transfers needs into demands Rations care Works out a care plan with clear targets Refers client to best possible care Pays for the care (fees) Follows up outcomes
Provider	Takes in client Works according to concept for supplier Obtains finance on input budget	Takes in client and works according to care plan Reports back to purchaser Finances the care establishment on incoming fees

	Current system	Proposed system
Financing	Public authorities usually finance care at the institutions they run from their own budgets	The public authority (purchaser) that refers a client to care (municipality) is responsible for the financing or some or all of the costs
	Most financing is according to an input-based budget system	The budget system is based on what a provider produces, e.g. per outputs, per capita, per bed and day etc.; global ceilings are set to avoid over-runs and to guide rationing decisions.

the power to make the (correct) need-driven decisions about care and, above all, have the money to pay for care purchased.

Reforming budgets

The current input-based budget system is a legacy of the old command economy and does not promote the correct sort of behaviour and performance among care providers. Input budgets do not focus sufficiently on the results of care. The new financing system has two basic elements: where the referrer pays the (publicly-financed) fees for client care (the single pipe); and where fees are related to the output produced. When all costs for care and services are related to its value, i.e. to what is being produced, this is referred to as an output-based payment system. This system gives the purchaser an incentive to buy the best care at the best price. The simplest form of output-based budgeting is a capitation system, where the same payment is made per client. More complex forms include fee for services, according to standardized diagnoses or outcomes.

New budgeting procedures may include guidelines on the amount to be spent for a certain type of client in order to avoid cost runaway (see contracting, below). These guidelines assist purchasers in designing affordable care plans, and clarify expectations from the client side on what services are available.

Output-based budgets may imply that some revenues have to be taken away from one level of government and allocated to another (the purchasing level). If governments stop paying for care and municipalities take over financing responsibilities, governments must hand over funding to municipalities. This is likely to occur over time. Section IV provides models of how to organize a safe retreat of budgets away from residential care whilst freeing funds for community-based care.

Making a marketplace: prices, tendering, contracting

Purchasing and budget reforms need to be complemented by the development of tools to regulate the purchaser-provider financial relationship. The first tool is an agreement on the cost of care supply. An economically sound institution should cover all its costs by revenues received from the provision (production and sale) of care and services. This includes not only recurrent costs but also capital costs. A part of the revenues should be set aside for future costs for maintenance, purchases of equipment, vehicles etc. to ensure that the institution is sustainable.

A market system, and the purchaser–provider system means that prices for care and service provision are not set beforehand. Bidding for services and making contracts with providers will result in a price structure that is affordable for the purchaser and sufficient for the provider to survive. All purchasers must have an idea of what constitutes a fair price for a care product and project the costs for the purchases needed.

	Current system	Proposed system
Prices	(Implicit) prices set on input norms but not to cover all costs Revenues added over time from different sources Real costs unclear	Explicit prices reflecting true costs Transparency and accountability
Tender and contracting	Providers assigned through various budget systems No clear contracts exist New providers are discriminated against and are not encouraged to be a part of care provision	A care assignment is regulated by a contract between purchaser and provider Contracts regulate what should be achieved and for what costs Call for tenders allows new providers to participate in care and service production
Market	No real market exists	A marked set up on which resourceful professionals, public, NGOs and private providers, compete to deliver best possible care for lowest possible costs

	Current system	Proposed system
Licensing	Rules and regulations set the condition for care provision; the few private and NGO providers are not usually covered by these rules	Providers (public, NGO or privately managed) can be licensed if they meet required standards Providers are monitored and corrected for non-compliance with license Licenses can be revoked

A tender procedure (where a purchaser identifies and mobilizes new providers) does not normally stipulate prices beforehand. A purchasing organization issues a call for bids in a document specifying type of care, quality requirements, and quantity. The tender document also discusses how the contract will be made (over what period, etc.). The winning bid is the one that offers the best quality at the most reasonable price.

There are basically two types of purchaser-provider contracts. The first is a contract for an individual client and regulates what results the care period is expected to generate, the fees and what they include, conditions for payment, time in care, division of responsibilities between the open social assistance office and the care-giver (issues such as contact with the family, after-care activities, follow-up, etc.), and a number of similar items. The goals for the client's care or service should be based on the care plan. The second type of contract is more appropriate for a purchaser who needs to purchase large amounts of care of the same kind. In this case the purchaser can agree with a provider to use a fixed number of places for a fixed period or time (a year or more) and agree on a fee. The contract should include roughly the same items as the individual contract, but will need to be more general. It is not recommended to make contracts for extended periods of time as there is a risk that the provider reverts to "business as usual" if not repeatedly subject to competition. It may be helpful for the purchaser if a national agency or ministry (or the project work group) formulate a standard contract as guidance (Bilson and Gotestam, 2003).

Licensing

Licensing sets the ground rules for who takes part in the tender. Once standards are in place the parties concerned (purchaser, providers, clients, relatives, social workers etc.) have a fairly good idea about what to expect from a certain care-giver/provider. Standards for similar care facilities should be the same regardless of who runs a placement – the public authorities, NGOs or private providers. Minimum standards express the lowest threshold whereas standards of excellence raise standards above this minimum level. This gives the provider a competitive advantage. This is an important element in the market structure. Standards are also good guidance for how to train staff and management and they set the rules for monitoring.

Most Western European countries have different types of licensing system in place to safeguard qualitative care provision and to avoid sub-standard care. Thus, any provider able to meet the demands in standards may be licensed. Licenses can either be issued by a public authority or a licensing agency operating on behalf of such a public body. Issuing a license will always include an obligation to cancel the license if a care-giver no longer meets the license requirements.

Reforming the providers

If countries adapt the principle of setting up contracts (individual or group) between the purchaser and provider, it should include the current residential institutions, or rather, those that will remain and continue to provide care and services. This change raises a number of issues. The first is the legal status of a public institution. It may be difficult for a public institution that has always received its revenues from an input-based government budget to find itself subject to competition on a care market and face the risk of losing its revenues due to poor performance. It is critical for success that all institutions are in the market and face

	Current system	Proposed system
Provision of residential care	Public sector provides care and services for disabled, elderly, orphans and children deprived of parental care	Some categorical residential care remains within the public sector but the provision of care and services is opened up for private providers and NGOs
Provision of alternative care	Public authorities (mostly municipalities) are responsible for community-based care; some NGOs and private providers are now starting to provide alternative care; the state is active in guardianship and some foster home care	Public authorities continue to provide and develop alternative care, opening it up for greater provision from NGOs and private entrepreneurs

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competition. Any sort of guarantee for public institutions would conflict with the very core of a competitive market since private providers will not obtain similar guarantees. This issue will have to be faced clearly. One option is to have competition among public institutions first, to facilitate a consolidation and accustom institutions and their owners to the new system.

A market for care and service provision will not occur spontaneously. It has to be stimulated and supported at the outset and barriers to change must be removed. In Western countries market provision has emerged in different ways. For example, a group of home helpers take over a part of a service in a community, change their status from public entity to private firm and sell their services to their former employer; a foster home expands its activities, takes in more children and becomes a small group-home for children; well trained social workers set up a family counseling unit, selling services to the municipality or the family courts; a day nursery is privatized and taken over by its staff. These are a few examples of the transition from public to private provision. The new private providers usually offer their services to the public authority concerned and a formal agreement or contract is set up. But it can also be a top-down exercise where senior management decide to privatize some public units.

There will be a need to support the private and NGO sector to take on the challenge to develop community-based care. Experiences from other countries in the region bear witness to the need to support community-based care provision from the governmental level, once the type of care to support is known. A plan for this has to be developed, including (i) mapping of provision of all care, (ii) assessing the need of care, (iii) projection of future demand of care, (iv) working out an idea about a future service/care basket. Such a plan would give government (county, large municipality) a fairly good understanding of a future service mix, which in turn, is a condition for deciding what care and services to keep operative and what new care and services are needed.

Standards (and to some extent gatekeeping) will have an impact on how a government (or county/municipality) shapes the care and service structure. A basic element in any standard is to stipulate what an institution is meant for, what it should do, how it can help clients and what type of clients. Once these two elements are in place an idea about the new service mix (from the purchasing and budgeting reforms), and standards for quality in the service mix, will help a government to focus support to the new providers on the essentials. That is, a government that does not know what it needs, how much and what quality, will be little help to a growing market of providers; it will not know what new initiatives to promote and support and it will not know what the obstacles are for private and NGO provision.

How a service is valued has an impact on supply and demand. With growing consciousness about quality and outcomes, purchasers will demand services that produce a good outcome and meet the targets set out in care plans and referral agreements (contracts) between purchaser and provider. At the same time, the institution that fails to deliver what has been agreed will lose confidence and become less attractive on the care market. The demand for these services will decrease. This will provide an incentive for the provider to perform well, which in turn benefits the clients, the economy and the development of quality in care provision.[30] Finally, it is important to repeat that a market for care and services must protect itself from low quality provision that may even be harmful for clients.

Concerns have been voiced that competition on lowest price will impair the quality of care. If this occurs, it can be remedied. First, one must assume that managers and staff want to be successful and there is no reason why this should change as a result of the transition from one system to another. Second, licensing, standards for care, and monitoring will safeguard sufficiently good quality. Third, a purchaser is unlikely to buy bad quality products since low-quality care does not generate sustainable results, but instead leads to a recurrent need for care, which in turn, increases costs. A competent purchaser will make the right choice the first time.

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[30]Some data suggests that highly specialized institutions are less likely to be competitive and survive on a privatized care market compared to multi-purpose centers that are flexible and can adapt to changes in demand

IV How to handle the transition

Making the transition to a new system of financing will be demanding for all stakeholders. A number of transition problems emerge. Countries seeking to change the financing structure to a purchaser-provider model need to develop a sound project plan based on:

a) an analysis of the current situation, which maps out the economic roles in the current system, costs and who pays
b) a proposed institutional structure for a new system, specifying new roles, responsibilities, accountabilities and financial flows, and an analysis of the incentives
c) a needs assessment, projecting possible future demand scenarios with a change in practices towards more community and family-centered care;
d) a costing of the demand scenarios
e) a proposed new financial flow structure (in money) given (b) and (d)
f) a facilities management plan
g) an activity plan for project implementation.

In this section we discuss the concepts involved in preparing such a project. The Toolkit will involve developing the tools for the analysis.

Changing the financial rules of the game will not automatically ensure better use of public and private resources generating better outcomes. Much more is needed. For example, all the work of setting up a purchaser and developing contracts will pay few dividends if reforms are not made in gatekeeping, including developing better assessment and care planning tools. Likewise, contracts with providers should make reference to standards, which must be observed by contractors. Training programs are needed to ensure that staff are able to deliver the quality promised in the standard. A monitoring system needs to be in place to protect clients. These issues are not dealt with here, but should be part of the overall reform strategy.[31]

Social care reform strategies are often undertaken in the context of the need to reduce public expenditure. However, the type of reform program discussed here is not likely to reduce expenditure, because new investments will be needed to develop new services and because the increased availability of community-based services will reveal unmet needs and an increasing demand for such services. Indeed, an atmosphere of fiscal crisis is probably counter-productive for this type of reform. It is difficult to reach agreement among stakeholders on new roles and responsibilities as budgets are being cut. It is better to develop the reform plan in line with available financing. Public demand for social care rises with national income (all other variables being constant) so it is reasonable to expect that as income rises, social care will absorb a constant or growing share of expenditures. Reform is, therefore, important, as it enables providers to serve more clients with better quality care and reduce the harm done by residential care.

Analyzing the current system

A reform plan starts with an analysis of current expenditures and assets. This includes total expenditures, unit-costs, and a matrix for sources and uses of funding. All costs must be considered, including opportunity costs of capital. The reform team needs to work with the current providers to prepare this data. Worksheets can be developed to collect data, which is then aggregated across the country (or regions). A rough assessment of the balance sheet (valuation) for each provider can also be developed.

The reform team also needs to assess utilization by target group based on the demographics of clients, rates of treatment by demographic group and geographical area, etc. For example, what percentage of children in each age group are clients, and for what type of service? Why did they enter the institutional system? This can be analyzed by region, income group, ethnic group or any other important determinant of socio-economic status.

Developing the new institutional structure

The next step is to map the current and new institutional structure, using the functions map in Section III. Starting with the purchaser one must ask which purchaser functions are currently being carried out and which are missing. Given current and proposed political and fiscal decentralization, what level of government could assume this responsibility? It may help to develop options and consider how radical a change from current practice this would imply for each option. It is also important to consider the number of clients to be served in each purchasing unit, based initially on the analysis of rates of utilization, and the

[31] See Harwin and Bilson, 2003; Bilson and Gotestam, 2003; and UNICEF 2000 and 2001 for discussion of comprehensive reform issues.

Table 7	Measuring total costs – an example	
A. Recurrent municipal costs per year	**residential care**	**non-residential care**
Wages, excluding tax		
Tax		
Office, administration, other consumable materials		
Premises		
Maintenance of premises		
Utilities (electricity, heating)		
Car use, car maintenance, travel		
Catering		
Miscellaneous		
Other recurrent costs		
Total		
B. Capital costs	**residential care**	**non-residential care**
Building		
Office hardware and audio equipment		
Furniture		
Special equipment (medical, training etc.)		
Kitchen equipment		
Cars		
Interest (breakdown on x years)		
Other capital costs		
Total		
C. Indirect costs	**residential care**	**non-residential care**
Social Assistance Office (SAO) for need assessment, care planning and referral of clients.		
SOA costs for having contact with client during care		
SOA costs for follow-up on client outcome		
SAO costs for preparing and maintaining post-care arrangements		
SAO costs for keeping contact with family during placement of client		
Opportunity costs (clients return to work, support family and pay taxes)		

number of transactions with different levels of government a change would involve. Too many transactions can be expensive. In the case of too many small municipalities, one proposal could be to force them to work together as in the Stockholm example. Finally, there is the question of which functions are best performed nationally. For example, should the national government formulate a model contract?

This analysis should also consider the current ownership of the provider structure. If the intention is to close or consolidate facilities, are the owners prepared to undertake such a change? If the owners are small local governments, such a change may not be possible. This would imply a further step in the reform – transferring ownership.

Needs assessment, costing and projection of financial flows

One of the first questions the Ministry of Finance asks about any reform is – what will it cost? As the purpose of the financing reform is to shift clients and money toward more higher value uses (e.g. community care), projection of future costs should not be based on current utilization patterns, but new ones. This is not easy to do, as it will partly depend on how quickly the provider sector can respond. One approach is to make a simple projection of the numbers in each key risk group over a ten-year period. Then, with utilization coefficients for a country which has no tradition of institutional care, a project utilization pattern can be developed. Looking at this pattern, what kind of change in facilities does this involve? Is such a change possible? Some adjustment of the projections may need to take place, based on the distance between current utilization and desired utilization to reflect an appropriate speed of adjustment. A trend then needs to be projected between the current utilization and the future utilization to obtain annual demand estimates.

Annual budgets can be formulated for this new pattern using existing unit costs (based on full capital costs), and the demand forecast. This initial assessment

will not include the costs of restructuring, however, and this will need to be calculated later. As a result, the cost estimate at this stage will be an under-estimate of probable costs.

The final step in the cost projection is to map the annual budget forecasts into financial flows from the purchasers to the provider, by type of facility and ownership. This will indicate winners and losers. It will allow some idea of resource re-allocation needs so that purchasers have the funds to purchase. It may also reveal which facilities will be in deficit, providing a basis for the next stage of the operation.

Facilities development and management plan

The next step is to use the projections to develop a facilities master plan. It is not necessary to map all the new community-based options to be developed. Many of these will be developed in the community, based on community needs. Often the facilities will be multi-purpose centres, serving more than one type of client. For example, family counseling and open family programs can be combined with foster care and guardian support, and needs assessment. NGOs may be contracted to develop the services within the centre.

The main purpose of the master plan is to target existing residential facilities for bed reduction or closure. It is critical that a plan be developed to restructure institutions at an early stage in the project. Unoccupied beds cost money and as purchasers will buy fewer residential care beds, the institution will have to charge more for full beds in order to cover costs. This will push up costs in the system overall. The facility master plan should be discussed with the owners and managers of the facility so that all stakeholders agree with the plan. Implementation should include staff and management training, and a plan for handling redundant staff. It is likely that the plan will reveal a need to cut back on residential care and to develop new community-based care.

When Western European countries implemented the purchaser-provider system in the mid-1990s, some managers submitted their own public entities (care facilities) to competition as a technique to distinguish the best from those producing sub-standard outcomes. Allowing public entities to compete is one way to cut back and the process has revealed that many public entities were over budgeted. Another way is to assess the entities to see which of them provides good quality at the best price, and to simply close down or restructure the others.

Developing a project plan

With all these analyses in hand, the project team is ready to develop a project plan including the following key elements:

1. Preparation of the legislative framework for the new financing framework:
   - new rules on fiscal transfers to ensure that adequate funding goes to the purchasers, and that funding can go to providers on an outcome basis
   - removal of obstacles for NGO and private providers
   - pilot projects and experiments
   - enshrining the new roles and competences in legislation, including the power of the central authority to monitor all providers.
2. Training plan for the new functions and accountabilities for all public officials, as well as for NGO and potential private providers (especially important at an early stage for purchasers/gatekeepers), for example:
   - everyone needs training in standards and licensing procedures
   - purchasers need training in care planning, using new tools
   - purchasers and financial authorities need training in output budgeting and contracting
   - providers need support
   - on demand support is also helpful.
3. Develop an adequate financial management system for purchasers and providers. This is probably a separate project. Providers and purchasers can be required to buy a national system (but financing for this investment will be needed).
4. Develop a model contract for purchasers and test it.
5. Consider how to assist community care providers to develop new services (investment financing, training, etc.). Consult with NGOs, as they could provide some support and financing.
6. Formulate a sequenced activity plan, including plan for piloting purchasing arrangements (either *de facto* or real), specifying indicators of success.
7. A key sub-project will be the implementation of the facilities management plan. Funding for this will be required in advance.

Concluding note

This paper has reviewed the concept of a financing framework for social care and its role in a pluralistic, decentralized political system and market economy. We have discussed the approaches used by OECD countries to modify institutional roles in order to improve incentives for quality, client service, and efficiency. OECD countries dissatisfied with a purely public system yet aware of the risk of failure inherent in an unfunded and unregulated private system, have adopted forms of the purchaser-provider system pioneered in health. This model has been judged a success. Two country case studies discussed how systems work in practice in Western Europe.

Despite widespread recognition of the harmful

impact of public residential care on children, use of this service continues to grow in the ECA. The legacy of the old service model partly explains the trend, but the lack of financing reforms is a contributing factor. In most countries local-level fiscal incentives focus on using institutions when children are in need instead of shoring up families. Countries such as Romania have made strenuous efforts to implement reforms in the financing system, but such efforts have at times been hampered by a lack of an overall strategy, causing even more stress in the system. We have outlined the building blocks for a more comprehensive approach. As with any change project, the time frame must be realistic, and coordinated with the ability of the system to change.

Money is an effective lever for changing the minds (and eventually policies and lives) of vulnerable people. Few people will spend their money on something considered worthless, and most like the idea that good performance is rewarded. Yet, these simple and fundamental features which guide our private life are not in place in the overall system. We think that a thorough appreciation of these fundamental points will constitute the driving forces for change. In most countries staff and managers are already busy, and the demands of this type of reform are serious. Most managers and political leaderships work for change once they understand that better methods and tools exist. Frequent international contacts have fostered this awareness and develop motivation. Many of the features in the new financing structure are in fact already in place or underway.

References

Aarts, L. and De Jong, Ph. (1999) "Disability Insurance in a Multi-Pillar Framework". Paper Prepared for the World Bank Conference: New Ideas About Old Age Security, Washington, D.C. September 14–15, 1999. http://www.worldbank.org/knowledge/chiefecon/conferen/papers/dismulti.htm

Barr, N. (2001) *The Welfare State as Piggy Bank: information, risk, uncertainty, and the role of the state.* Oxford: Oxford University Press.

Bilson, A. and Gotestam, R. (2003) *Improving Standards For Child Protection: A Concept Paper.* Florence: UNICEF IRC-World Bank.

Bilson, A. and Harwin, J. (2003) *Gatekeeping Services for Vulnerable Children and Families: A Concept Paper.* Florence: UNICEF IRC-World Bank.

Elwan, A. (1999) *Poverty and Disability: A Survey of the Literature.* Social Protection Discussion Paper No. 9932. Washington D.C.: World Bank.

Fölster, St. (1993) *Report from Industrins Utredningsinstitut,* Sweden: Research Institute of Industrial Economics.

Lindert, P.H. (1996) "What Limits Social Spending?" *Explorations in Economic History* 33(1): 1–34.

Ministry of Labour and Social Protection, Lithuania (2000) *Annual Social Report.*

Ministry of Welfare, Latvia (2000) *Annual Social Report.*

OECD (1997) "Best Practice Guidelines for Contracting Out Government Services". Summary available on line at http://www.oecd.org/puma/budget/budpubs.htm. See also Iceland case study in full text.

Preker, A., Harding, A. and Girishankar, N. (1999). "The Economics of Private Participation in Health Care: New Insights from Institutional Economics." Paper submitted to the International Social Security Association.

Tobis, D. (2000) "Moving from Residential Institutions to Community Based Social Services in Central and Eastern Europe and the Former Soviet Union", Washington D.C.: World Bank.

Torres, G. and Mathur, S. (1995) "The Third Wave of Privatization: Privatization of Social Sectors in Developing Countries", Private Sector Development Department Discussion Paper, Washington D.C.: World Bank.

UNICEF (1997) *Children at Risk in Central and Eastern Europe: Perils and Promises.* Regional Monitoring Report 4. Florence, Italy: UNICEF-ICDC.

UNICEF (2000) *Children Deprived of Parental Care: Rights and Realities.* Regional Office for CEE/CIS and the Baltic States: Occasional Papers No. 1. Geneva: UNICEF.

UNICEF (2001) *A Decade of Transition.* Regional Monitoring Report 8. Florence, Italy: UNICEF-ICDC.

World Bank (2000) "Making the Transition Work for Everyone: Poverty and Inequality in Europe and Central Asia". Washington D.C.: World Bank.

World Bank (2001) "Romania: Local Service Delivery Study", June 14.

Redirecting Resources to Community-Based Services

A Toolkit

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June, 2003[1]

[1]This paper has been prepared as part of a joint UNICEF-World Bank project, *Changing Minds, Policies and Lives*, a programme designed to support national programmes to reduce the institutionalization of vulnerable individuals in Eastern and Central Europe and Central Asia. For information on this regional project, see http://www.worldbank.org/childrenandyouth. The authors are grateful for the extensive comments of Gaspar Fajth, Judith Harwin, Loraine Hawkins and members of the project team. Comments to the authors are welcome at lfox@worldbank.org or ragnar.gotestam@chello.se.

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Introduction

This Toolkit is based on the Concept Paper *Redirecting Resources to Community-Based Services* and provides methodological support to implement a reform of the system financing social care. This reform should result in less use of institutions for children and more use of family and community-based care. Together with reforms in the quality assurance system (standards and outcomes), and gatekeeping, the financing framework is one of the main public policy tools to ensure access, cost-effectiveness, and quality in publicly and privately supplied social care services. By regulating the supply and demand for social care services, the financing framework can help countries to affordably support their commitments under the UN Convention on the Rights of the Child.

Social care in transition economies is often financed on an input basis, and public financing is limited to public providers. These are usually large institutions which do a poor job of providing care. As a result, systems are supply-driven: countries do not know the true cost of care, care planning is weak, budgets are tight, and vulnerable individuals are often underserved. More could be achieved with the same resources if financing were shifted away from institutions. A better use of resources requires reform in:

- **Purchasing**, to separate the process of needs assessment and care planning from the supply of care.
- **Budgeting systems**, to allow purchasing to take place, facilitate output-based re-imbursement of providers, and to develop contracting models. This reform should create a "single pipe" of child welfare funds to the purchaser.
- **Provider status**, to allow providers the autonomy to compete and receive funds based on output-based contracts; planning for the closure or restructuring of public facilities is also required.
- **Service regulation systems**, including standardization of interventions so that prices can be set and output-based contracts agreed; licensing procedures and other quality assurances systems must be in place.

Implementing this type of reform is generally a multi-year process and requires complementary reforms in the standards and monitoring system, and the gatekeeping system.[2]

The reform process

The reform process has three steps: assessment, design and implementation.

Assessment of the institutional set-up and mapping the financing flows. What type of care is available, how is it financed, and by whom (public or private)? What does care cost? Who is placing the children where and why? What are the consequences? What roles do public and private actors play? How do budgetary incentives affect this?

Design of the reform requires:

- Definition of a new institutional structure to separate needs assessment and demand management from supply, and reforming regulations to create or modify these institutions.
- Mapping new financing flows, new demand patterns (not determined by supply), and costing alternative transition paths; this may be tried on a pilot basis according to new regulations.
- Mapping changes in roles, responsibilities and accountabilities for key stakeholders (including clients) and consultation on these proposals.
- Developing a plan to reduce the number of institutional beds and increase the supply of community services (a facilities plan).

Implementation of the reform requires:

- Developing tools and regulations to support the market, usually on a pilot basis and then nationwide.
- Training, monitoring and evaluation.

The toolkit supports this reform process with:

Templates for assessment phase. Templates are forms or models developed to facilitate countries to collect, aggregate and analyze data. Separate spreadsheets are provided to analyze: financing, reimbursements to providers, referral patterns, providers' incomes, providers' costs, indirect costs, clients, organizations and volumes and projections.

Checklists to help design and implement the reform. Checklists are a series of questions and advice to consider, including best practice examples.

The checklists cover the following topics: financing and budget reforms, setting up the purchaser organization, opening up to new providers and creating a functioning market, handling the tendering process, formulation of the contract, and facility planning and management.

[2] For a complete guide to implementation see Concept Papers and Toolkits on "Standards" and "Gatekeeping" in the *Changing Minds, Policies and Lives* project.

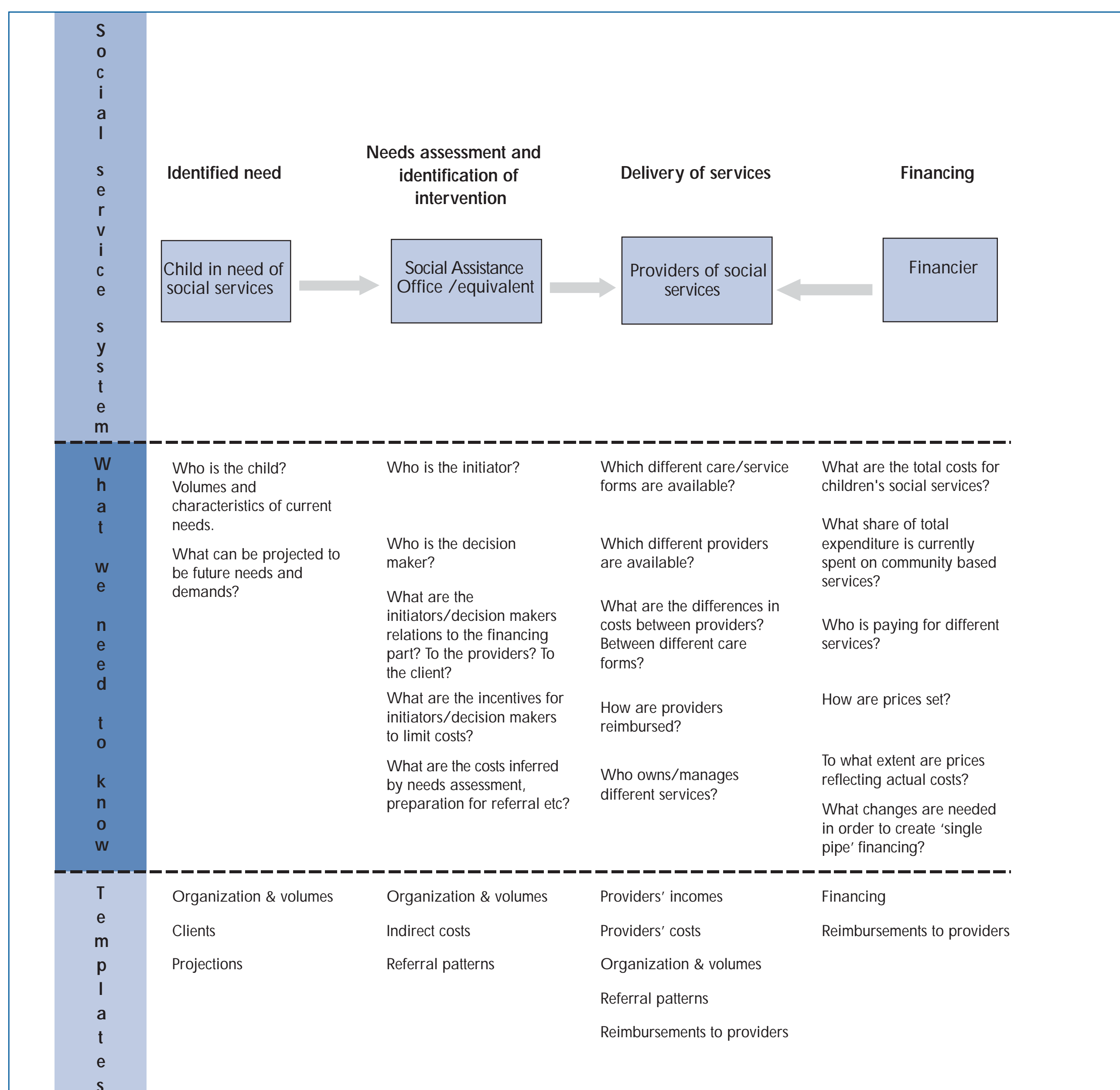
Introduction to templates

The templates are created for describing and analyzing the current situation in the participating countries concerning, for instance, financial systems and institutional structures. The basic facts and analyses of the current state will function as the basis for development of the social care system. Having done this, the participants can start working to develop new systems and institutional structures for their respective countries.

The information collected in the templates should fulfill several purposes:

- provide a common understanding of the current situation in participating countries
- serve as basis and support for taking decisions on future systems by projecting possible future demand and supply scenarios
- result in a valid basis for comparisons and future assessments.

Overview of the templates



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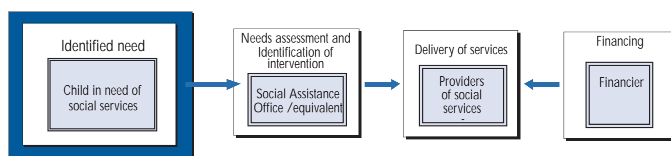
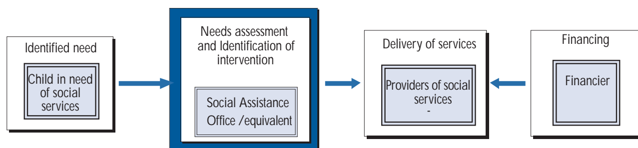
Overview - aggregated data (selected key data from the different templates)

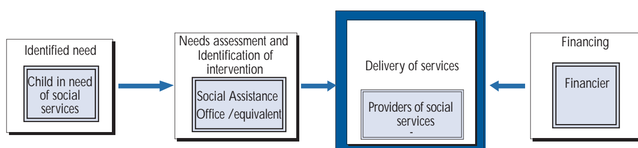


	a) Children deprived of parental care (voluntary or mandatory)	b) Disabled children	c) Maltreated children	d) Other category:	TOTAL
Number of clients/users in different categories	0	0	0	0	0
Residential care	0	0	0	0	0
Community based care	0	0	0	0	0
TOTAL					
Projected numbers of clients/users:					
Projected rate of affected population in 5 years	0	0	0	0	0
Projected rate of affected population in 10 years	0	0	0	0	0



Estimated costs for referring clients:	**Time spent (person days at SAO/eq + other actors)**	Total costs
to residential care	0	#DIV/0!
to community based care	0	#DIV/0!

From case management system; average case costs for referring clients:	
to residential care	0
to community based care	0



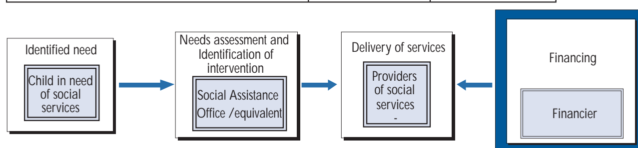
Number of facilities/establishments owned or managed:	State	Municipality	NGOs	Other private	TOTAL
Residential services	0	0	0	0	0

Average number of cases in care	State	Municipality	NGOs	Other private	TOTAL
Residential services	0	0	0	0	0
Community based services	0	0	0	0	0

Costs for different providers (actual costs previous year)	State	Municipality	NGOs	Other private	TOTAL
Residential services	0	0	0	0	0
Community based services	0	0	0	0	0

Cost per case (total costs/average number of cases)	State	Municipality	NGOs	Other private	TOTAL
Residential services	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Community based services	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Basis for reimbursing providers	Residential services	Community based services
Percentage of providers that are financed by input budgets	0	0
Percentage of providers that are financed by selling services/output based reimbursements	0	0



Total expenditure for social services for children	State	Region/country	Municipality	TOTAL
Amount	0	0	0	0
Share	#DIV/0!	#DIV/0!	#DIV/0!	

Amount of expenditures from financiers divided on different care/services	State	Region/country	Municipality	TOTAL
Residential care	0	0	0	0
Community based care	0	0	0	0

Amount of expenditures from financiers divided on different providers	State	Region/country	Municipality	TOTAL
State provider	0	0	0	0
Region/country provider	0	0	0	0
Municipality provider	0	0	0	0
NGO provider	0	0	0	0
Other private provider	0	0	0	0

How to fill in the templates

- Each template has an instruction to help fill in the data. The instructions contain several definitions and specific explanations of what is requested.
- If data is not easily accessible or available, we suggest using as realistic estimations as possible, preferably based on an average from a selection of data.
- If data cannot be estimated in a reliable way, we suggest leaving the field blank.
- To guarantee that aggregated data in the templates will function as a valid basis for projections and simulations of a new system, we suggest trying to obtain the most reliable data.
- The template worksheets are linked together to present aggregated key data on national level (see worksheet "Aggregated data"). If some data needs to be collected at regional or local levels, please transfer the summed figures to the original worksheet. Templates forwarded to other levels can be copied into separate worksheets and distributed electronically, or they can be printed out as forms to fill in.
- Some fields in the templates contain formulas and should not be filled in. The last worksheet "Aggregated data" is linked to cells in the other worksheets and should not be filled in.
- At the bottom of every template there is a table for filling in date, respondent and the respondent's organization.

Template 1: Financing - Instructions

Purpose of template	To analyze the total costs for children's social services on a national level and to map the flow of resources directed to social services for children
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Total expenditure for social services for children (previous year in national currency). Specify for each level (state, region, municipal, other organizations) the total costs of social services for children. Own revenues (from taxation and non-earmarked transfers from other bodies) if costs for services are funded by own revenues or non-earmarked transfers from other bodies for each financing body. Transfers from state budget from one level to another Transfers from regional budget from one level to another Transfers from municipal budget from one level to another On what basis are funds transferred? e.g. catchment area, average costs for clients etc. What is the money earmarked for? Fill in all kinds, if there is earmarked funding. (Extend the lines if needed.) Transfers from neighbouring regions/municipalities for social services. Reimbursements for providing services to clients from other regions/municipalities. Contributions from international organizations e.g. UNICEF, World Bank. Contributions from national/regional organizations e.g. organizations established in the country or specific regions. Contributions from private actors companies, private persons etc.
Units	Total costs, stated in the national currency.
Notes	1) If data not available, please leave field blank. 2) If field for any essential data collection is missing, please add this.

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Toolkit a

Financing of children's social services

What are the total costs for children's social services?

		Financing body				TOTAL
		State	Region/county	Municipality	Other organizations	
How much?	Total expenditure for social services for children (previous year in national currency)					
How?	Sources of revenues	Total amount	Total amount	Total amount	Total amount	
	Own revenues (from taxation and non-earmarked transfers from other bodies)					
	Transfers from state budget					
	On what basis is the money transferred?					
	What is the money earmarked for?					
	Transfers from regional budget					
	On what basis is the money transferred?					
	What is the money earmarked for?					
	Transfers from municipal budget					
	On what basis is the money transferred?					
	What is the money earmarked for?					
	Transfers from neighbouring regions/municipalities for social services					
	Contributions from international organizations					
	Contributions from national/regional organizations					
	Contributions from private sources					
	Other:…………………………… …………………………………					
	TOTAL					

Date:

Respondent:

Organization:

Template 2: Reimbursements to providers - Instructions

Purpose of template	**To map the flows between financing actors and producing bodies** At the top, horizontal level, is the *financing* body On the left side, vertical level, are the *producing* bodies, divided into the two main types of care forms, residential and community-based care.
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Transfers to households Reimbursements to households from each financing body, i.e. social allowances and benefits for children. Reimbursements divided among different providers If reimbursements are not divided by type of care forms, fill in the total amount for all providers in one field. If not divided among providers, fill in "Total reimbursements to providers". Total reimbursements to providers. This sum indicates the total amount of reimbursements to each producer of social services.[3] TOTAL EXPENDITURE This sum indicates the total amount of reimbursements to each producer of social services *plus* the amount of reimbursements to households.
Units	Total costs, stated in the national currency.
Notes	[1)] If data not available, please leave field blank. [2)] If field for any essential data collection is missing, please add this. [3)] The right hand column adds the total amount of reimbursements from state, regional, municipal levels and other organizations to each producer. This column also gives the percentage of reimbursements for each producer, compared to the total amount of reimbursements to providers, household transfers excluded.

Toolkit a

Reimbursements to providers

What share of total expenditure is currently spent on community-based services?

Who is paying for different services? Which different care/service forms are available?

Expenditures on social services for children (previous year in national currency)	Financing body					
	State	Region/county	Municipality	Other organizations	TOTAL	Percentage
Transfers to households						
State residential						
State community-based						
Regional residential						
Regional community-based						
Municipality residential						
Municipality community-based						
NGOs Residential						
NGOs Community-based						
Other private residential						
Other private community-based						
Total reimbursements to providers						
TOTAL AMOUNT EXPENDITURES						

Date:

Respondent:

Organization:

Template 3: Referral patterns - Instructions

Purpose of template	**To map the referral patterns to see both who is referring clients to care and who is the financier**
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Who is the referrer (decision-maker)? State all actors authorized to decide which care form the client should be referred to. N.B. This is not necessarily the same person/organization that identifies clients' needs. There may be more than one referrer for every care form. Main type of clients If the stated referrer generally handles specific categories of clients, please note this. Use the same definitions as in "Client Template". If the referrer handles all kinds of categories, leave blank. Who is the financier? Fill in the name of the financing body that pays for the services determined by the referrer, e.g. state, municipality, insurance fund etc.

Owner	Care form	Who is the referrer (decision-maker)?	Main types of client	Who is the financier?
State	**Residential**	Example: Social assistance officer Example: Children's court	Mentally disabled children Maltreated children	State State
	Community based			
	Combination of the above			

Notes

[1] If data not available, please leave field blank.

[2] If field for any essential data collection is missing, please add this

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Who is referring clients to the specific service forms?

Who is the initiator?
Who is the decision maker?
What are the initiators/decision makers relations to the financing part? To the providers? To the client?
What are the incentives for initiators/decision makers to limit costs?

Owner	Care form	Who is the referrer (decision-maker)?	Main type of clients	Who is the financier?
State	Residential			
	Community-based			
	Combination of above			
Municipality	Residential			
	Community-based			
	Combination of above			
NGOs	Residential			
	Community-based			
	Combination of above			
Private	Residential			
	Community-based			
	Combination of above			

Date:

Respondent:

Organization:

Template 4: Providers' incomes - Instructions

Purpose of template	**To identify how providers are reimbursed**
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Percentage of providers financed by input budgets Providers reimbursed by appropriations. Percentage of providers financed by selling services/output-based reimbursements. Relevant for NGOs and private actors; also municipal/regional providers who sell their services to neighbouring municipalities/regions. Percentage of providers with a combination of financing via input budget and output-based reimbursements. Give percentage of providers reimbursed with a combination of financing via input budget and sale of services. Total revenues for providers. Fill in the total amount of revenues each providing body receives, divided by the two main types of care forms. Amount/Source (horizontal level, under "specify revenues on a yearly basis"). Give total amount in the national currency and specify the source of revenues: state, region, municipality, other. Input budget based on capitation (size of catchment area). If the budget is set according to capitation; i.e. the number of inhabitants in a specific area to be served by the providers' services; "Catchment area", specify how and the amount. Input budget based on size of institution/service provision. If the budget is set according to e.g. number of beds, personnel, square feet, or actual number of clients/year, capacity to provide clients etc. Specify how and the amount. Input budget based on demand for service facilities. If the budget is set according to the clients' demand for services. Specify how and the amount. Specific budget for capital costs. If specific financing for capital costs is given aside from the ordinary budget, specify how and the amount. Specific budget for maintenance of buildings etc. If specific financing for maintenance of buildings etc. is given separately from the ordinary budget, specify how and the amount. Specific budget for investments. If specific financing for investments is given separately from the ordinary budget, specify how and the amount. Output-based user fees. Fill in the amount of user fees, i.e. transfers to households directed to providers, as a fee for receiving social service.

(continued)	4. Providers' incomes
	Output-based per bed and day. If money is allocated to providers based on the actual number of used beds/year or number of days for each client/year. Output-based per other type of unit (visits, hours of counseling etc.). If money is allocated to providers based on any other type of unit, specify the type(s) of unit(s) Output-based according to type of diagnosis. If a system for reimbursing providers is calculated for specific diagnoses. Contributions. Specify the amount of contributions from any private or organizational actors (not state, region or municipality.) Describe the process of receiving reimbursements. Specify actors and stages of the decision-making process; procedure of adjusting budget to actual costs, other circumstances. How often are the transactions carried out for the various types of reimbursements? State average periods for money transactions.
Units	Specify costs in the national currency.
Notes	[1] If data not available, please leave field blank. [2] If field for any essential data collection is missing, please add this.

Main form of incomes for different providers' services

How are providers reimbursed? How are prices set? To what extent are prices reflecting actual costs?

Type and amount of financing	State		Municipal		NGOs		Other private	
	Residential	Community	Residential	Community	Residential	Community	Residential	Community
Percentage of providers that are financed by input budgets								
Percentage of providers that are financed by selling services /output-based reimbursements								
Percentage of providers with a combination of financing via input budget and selling services /output-based reimbursements								
Total revenues for the providers (amount)								

Specify the revenues on a yearly basis	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source
Input budget based on;																
Capitation (size of catchment area)																
Size of institution/service provision																
Demand for service facilities																
Other:...................................																
Other:...................................																
Specific budget for																
Capital costs																
Maintenance																
Investments																
Other...................................																
Other...................................																
Output based reimbursement	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source	Amount	Source
User fees																
per bed and day																
per other type of unit (visits, hours of counseling)																
according to type of diagnosis																
combinations of the above																
Other:...................................																
Other:...................................																
Contributions																
From																
From																

Receiving reimbursements								
Describe the process of receiving reimbursements (procedure of adjusting budget to actual costs, other circumstances)								
How often are the transactions being done for the various types of reimbursements?								
In advance?								
For what period of time?								
Contract periods?								

Date:

Respondent:

Organization:

Template 5: Providers' costs - Instructions

Purpose of template	**To compare cost structures for different types of providers and services**

Definitions / descriptions of data collection[2]

Data to be collected:[1]
Description:

Full costs (actual, not budget).
Specify last year's outcome for the cost items below.

Recurrent costs per year

Wages for managing/administrative/auxiliary personnel excluding social contributions.
Wages for this type of personnel excluding tax and/or social contributions.

Wages for personnel delivering care, excluding social contributions.
Wages for this type of personnel, excluding tax and/or social contributions.

Social contributions.
Tax and/or social contributions costs.

Consumable materials.
All consumable material, e.g. linen, sanitary articles, clothing, etc. Specify in as much detail as possible what costs are covered by this budget item.

Premises.
Rent for facilities, buildings etc.

Maintenance of premises.
Specify costs for cleaning, other costs for minor maintenance.

Utilities.
Costs for electricity, heating, gas etc.

Car use, car maintenance, travel.
State the costs for petrol, cleaning, travel taxes (if any).

Catering.
All costs for catering, food or cooking, including kitchen utensils and other expendable items.

Interest.
Yearly costs for existing loans.

Miscellaneous.
If other recurrent costs exist but are not given above, please specify them.

Other recurrent costs.
Specify these costs both with amount and purpose.

Capital costs (average cost/year, based on previous 3 years)
To allow comparisons between different providers the average costs for investments on a yearly basis must be estimated.
N.B. Capital costs in forms of depreciation already listed under "Recurrent costs", should not be restated here.

Buildings.
Take actual capital costs for the previous three years and divide this sum by 3.

(continued)	5. Providers' costs
	Office hardware and audio equipment. Take actual capital costs for the previous three years and divide this sum by 3. Furniture. Take actual capital costs for the previous three years and divide this sum by 3. Special equipment; medical, training. Give all costs for rehabilitation equipment, handicap aids etc. Use actual capital costs for the previous three years and divide this sum by 3. Kitchen equipment (depreciation). Specify costs for "white goods" (refrigerator, freezer, stove, oven, kitchen appliances etc.). Use actual capital costs for the previous three years and divide this sum by 3. Cars (depreciation). Take actual capital costs for the previous three years and divide this sum by 3. Other capital costs. Specify these costs with amount and purpose.
Units	Specify costs in the national currency. All costs are to be given per year.
Notes	[1] If data not available, please leave field blank. [2] If field for any essential data collection is missing, please add this.

Costs for Providers

What are the differences in costs between providers? Between different care forms?

To what extent are prices reflecting actual costs?

	State		Municipal		NGOs		Other private	
Full costs (actual, not budget)	Residential	Community based	Residential	Community based	Residential	Community based	Residential	Community based
A. Recurrent costs per year								
Wages for managing/administrative/ auxiliary personnel excluding social contributions								
Wages for personnel delivering care excluding social contributions								
Social contributions								
Consumable materials								
Premises								
Maintenance of premises								
Utilities (electricity, heating)								
Car use, car maintenance, travel								
Catering								
Interests								
Miscellaneous								
Other recurrent costs:								
....								
....								
....								
TOTAL								
B. Capital costs (average cost/year, based on previous 3 years)								
Buildings								
Office hardware and audio equipment								
Furniture								
Special equipment; medical, training etc								
Kitchen equipment								
Cars								
Other capital costs:								
....								
TOTAL								

Date:

Respondent:

Organization:

Template 6: Indirect costs (purchasers' costs) - Instructions

Purpose of template	**To identify all purchasers' costs for supporting and having contact with clients in different service forms** (i.e. costs for services not included in reimbursements to providers)
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Number of Social Assistance Offices (SAO)/equivalent (eq). State the total number of offices in the catchment area. Number of employees in SAO/eq. Give the number of person days per year. TOTAL costs for SAO/eq. Give the total costs for the SAOs in the catchment area. Cost per person day. Divide the total costs by the number of personnel. If possible, estimate time spent in relation to children's social services; *To approximate costs for purchasing functions of children's social services, try to estimate time spent on different activities. If possible, divide referrals by residential and community-based services.* Time spent on need assessment, care planning and referral of clients, contacts with client during care, follow-up on client outcomes, preparing and maintaining aftercare arrangements, keeping contact with family during placement of client, other activities related to children's social services. Give estimated number of person days per year. Case Management System. Referral of clients to residential services. If Case Management System is used, estimate the average costs for referring clients (cases) to residential services. Referral of clients to community-based services. If Case Management System is used, estimate the average costs for referring clients (cases) to community-based services.
Units	Specify costs in the national currency.
Notes	1) If data not available, please leave field blank. 2) If field for any essential data collection is missing, please add this.

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Indirect costs (purchasers costs)

What is the cost inferred by needs assessment, preparation for referral etc?

Social Assistance Offices/equivalent	
Number of Social Assistance Offices (SAO/equivalent)	
Number of employees in SAO/eq. (person days/year)	
TOTAL costs for SAO/eq.	
Cost per person day	

If possible, estimate time spent in relation to children's social services				
Type of activity	Social Assistance Offices/equivalent		Other: (e.g. courts, children's rights associations, police)	
	Residential	Community based	Residential	Community based
Time spent on need assessment, care planning and referral of clients (person days/year)				
Time spent on having contact with client during care (person days/year)				
Time spent on following up on client outcomes (person days/year)				
Time spent on preparing and maintaining after care arrangements (person days/year)				
Time spent on keeping contact with family during placement of client (person days/year)				
Time spent on other activities related to children's social services (person days/year)				
SUM (person days/year)				

Or from Case Management System; specify average case costs for	
Referral of clients to residential services	
Referral of clients to community-based services	

Date:

Respondent:

Organization:

Template 7: Clients - Instructions	
Purpose of template	**To map service forms with client structure**
Definitions / descriptions of data collection[2]	**Data to be collected:**[1] **Description:** Primary reason for needing social care. State the number of children that are utilizing some sort of social care. Classify them by their main reason for needing social care. Children deprived of parental care (voluntary or mandatory). If parents are either dead or absent for parental care. Disabled children. Give the total number of disabled children. If possible, specify in the fields below. Physically disabled children. If available data do not support this sub-category, please leave this field blank. Mentally disabled children. If available data do not support this sub-category, please leave this field blank. Maltreated children. If parents are considered unsuitable for parenthood. Age 0-3 Age 4-12 Age 13-18 If other age intervals are used in your country, please change the given intervals.
Units	Specify costs in the national currency.
Notes	1) If data not available, please leave field blank. 2) If field for any essential data collection is missing, please add this.

Categories of clients/users in different services

Who is the child? - Volumes and characteristics of current needs.

Volumes (number of children, 2001)		State		Municipal		NGOs		Other private		TOTAL	
		Residential	Community based	Residential	Community based	Residential	Community based	Residential	Community based	Residential	Community based
Primary reason for needing social care	a) Children deprived of parental care (voluntary or mandatory)										
	Age 0-3										
	Age 4-12										
	Age 13-18										
	b) Disabled children										
	Age 0-3										
	Age 4-12										
	Age 13-18										
	of that, physically disabled children (if possible)										
	Age 0-3										
	Age 4-12										
	Age 13-18										
	of that, mentally disabled children (if possible)										
	Age 0-3										
	Age 4-12										
	Age 13-18										
	c) Maltreated children										
	Age 0-3										
	Age 4-12										
	Age 13-18										
	d) Other										
	Age 0-3										
	Age 4-12										
	Age 13-18										
										SUM:	

Date:

Respondent:

Organization:

Template 8: Organization and volumes - Instructions

Purpose of template	**To view the total number of establishments, classified by type of provider, and number of clients and length of care in the various service forms**

Definitions / descriptions of data collection

Data to be collected:
Description:

A) Number of facilities/establishments owned and/or managed (horizontal level)
Fill in the number of establishments for each level; national, regional and municipal.

Residential services
24-hour measures directed to a child outside the home. If possible divide into relevant categories. Use your country's categories of existing services. Examples of residential services are given below.

1. Social care centres for orphans
Institutions for children who are orphans or deprived of parental care (voluntary or mandatory)

2. Specialized social care centres
Institutions for mentally and/or physically disabled children

3. Children's asylums
Institutions to take in orphans, disabled children or children deprived of parental care temporarily.

4. Other
If any other form of residential care is used, please state the aim of the service and the total number of establishments.

Community-based services
24-hour or other measures directed to the child in the home or in a home-like environment. Use your country's categories of existing services. Examples of community-based services are given below.

5. Foster homes
Families having a child/a number of children living with them in their home, offering a more permanent solution for the child.

6. Temporary shelters
Smaller care units (households, group homes etc.) offering temporary shelter for orphans, disabled children or children deprived of parental care.

7. Guardians
Private persons temporarily supporting a child, in the case of momentary deprivation of parental care.

8. Group homes
Smaller units of care provision, where mentally or physically disabled children are offered care in a homelike environment.

9. Home care
Help to nurse a mentally or physically disabled child at home as an alternative to an out-of-home institutional placement.

(continued) 8. Organization and volumes

10. Day programmes
Programmes to stimulate disabled children physically and socially. The service is a complement/relief for the family members, and takes place outside the home where the child still lives.

11. Parent training
Supporting parents or expectant parents to cope with practical issues of parenthood.

12. Counseling/family support
Supporting families to cope with parenthood, conflicts in the family due to abuse, assault etc., and the roles of family members, by counseling.

13. In-home assistance
Allows families to keep a disabled child at home by providing medical or counseling assistance. The service is a complement/relief for family members.

14. Transport services
Transport services from the child's home to various activities; day programs, counseling sessions, any other open activity, family visits etc.

15. Help with housing
Certain types of handling for living in the home with a disabled child.

16. Other open activities
If any other activities are used, please state the aim for the activity and the total number of activities provided.

B) Average number of cases in care and average length of time in care (horizontal level)
Fill in the average number of cases in care for each care form.

C) Number of children on waiting list/equivalent, i.e. unsatisfied demands (horizontal level)
Fill in the number of unsatisfied demands for each care form.

D) Number of vacancies in providers' services, e.g. beds, counseling hours (horizontal level)
Fill in the number of vacancies for each care form. Specify the unit according to available data.

Organization and Volumes (Social care service provision for children)

Which different providers are available?
Who owns/manages different services?
Which different care/service forms are available?

A) Number of facilities/establishments owned and/or managed

		State		Municipality		NGOs		Other private	
		Owned	Managed	Owned	Managed	Owned	Managed	Owned	Managed
Residential services	Social care centres for orphans								
	Specialized social care centres								
	Children's asylums								
	Other								
Community based services	Foster homes								
	Temporary shelters								
	Guardians								
	Group homes								
	Home care								
	Day programmes								
	Parent training								
	Counseling/family support								
	In-home assistance								
	Transport services								
	Help with housing								
	Other open activity - - - - - - - - - - - - - - - - - -								

B) Average number of cases in care and average length of time in care

		Average number	Average length	Average number	Average length	Average number	Average length	Average number	Average length
Residential services	Social care centres for orphans								
	Specialized social care centres								
	Children's asylums								
	Other.....................								
	Foster homes								
Community based services	Temporary shelters								
	Guardians								
	Group homes								
	Home care								
	Day programmes								
	Parent training								
	Counseling/family support								
	In-home assistance								
	Transport services								
	Help with housing								
	Other open activity - - - - - - - - - - - - - - - - - -								

C) Number of children on waiting list/equivalent (i.e. unsatisfied demands)

		Volume	Volume	Volume	Volume
Residential services	Social care centres for orphans				
	Specialized social care centres				
	Children's asylums				
	Other.....................				
	Foster homes				
Community based services	Temporary shelters				
	Guardians				
	Group homes				
	Home care				
	Day programmes				
	Parent training				
	Counseling/family support				
	In-home assistance				
	Transport services				
	Help with housing				
	Other open activity - - - - - - - - - - - - - - - - - -				

D) Number of vacancies in providers' services (e.g. beds, counseling hours)

		Volume	Volume	Volume	Volume
Residential services	Social care centres for orphans				
	Specialized social care centres				
	Children's asylums				
	Other.....................				
Community based services	Foster homes				
	Temporary shelters				
	Guardians				
	Group homes				
	Home care				
	Day programs				
	Parent training				
	Counseling/family support				
	In-home assistance				
	Transport services				
	Help with housing				
	Other open activity - - - - - - - - - - - - - - - - - -				

Date:
Respondent:
Organization:

Template 9: Projections - Instructions

Purpose of template	**To estimate the need for service until 2010, projected on a changing supply structure and changing incentives.** **N.B. This template only suggests data to be considered in this calculation. You should use the indicators and methods normally used to make projections in your country.**

Definitions / descriptions of data collection[2]

Data to be collected:
Description:[1]

A) Demographic projection

For calculation of projections, fill in relevant figures for your future population in this template. Use the demographic projections that are officially reported in your country.

Items currently listed in table A are examples of commonly used categories for projections of future needs and can easily be replaced with the established items from your country. Feel free to adjust the template to your needs.

To take part in projections done by the World Bank for different countries go to: http://devdata.worldbank.org/hnpstats/DPselection.asp

B) Transform demographic forecasts into projection of population in different categories of children
Extrapolate the current needs in different categories of children in need of social services according to the projected demographics in A)

Current rate of affected population (horizontal level)
Share of the population in the age-group that fits the description (e.g. disabled)

Percentage that receive services (horizontal level)
Percentage of affected population that receives social services

Projected rate of affected population in 5 years/10 years (horizontal level)
If the share of the population in the age-group that fits the description (e.g. disabled) can be projected to change, i.e. because of new reporting systems, state the new rate in these columns

Percentage that will receive services (horizontal level)
If the percentage of the affected population that receives social services can be projected to change, i.e. because of new service supply, state the new percentage in these columns

a) Children deprived of parental care (voluntary or mandatory)
If parents are either dead or absent for parental care.

b) Disabled children
Give the total number of disabled children. If possible, specify in the fields below.

Physically disabled children
If available data do not support this sub-category, please leave this field blank.

Mentally disabled children
If available data do not support this sub-category, please leave this field blank.

c) Maltreated children
If parents are considered unsuitable for parenthood.

d-f) Other important categories
If you consider other risk-groups to be important for projecting needs for social services, state them here.

Age 0-3
Age 4-12
Age 13-18
If other age intervals are used in your country, please change the given intervals

C) Project future volumes in different kind of services/facilities taking into account the effects of a social reform.
Use the projected utilization rates from table B) to also stipulate the distribution among different service forms.

A reform involving the creation of alternative, community-based services ultimately leads to an increased demand for services. To project this increased demand, adjust your estimations with respect to data from already reformed countries.

Residential services
24-hour measures directed to a child outside the home. If possible divide by relevant categories.

Community-based services
24-hour or other measures directed to the child in the home or in a home-like environment. If possible divide by relevant categories.

Volumes
Number of children receiving services

Units	Number or rate in population Number or rate of children in different services
Source of information	National projections
Notes	[1] If data not available, please leave field blank. [2] If field for any essential data collection is missing, please add this.

Projections of future needs and volumes

What can be projected to be future needs and demands?

A) Demographic projection			
Start out from the demographic projections that are officially reported in your country. If you find it useful for further calculation you can fill in the relevant figures for your future population in this template.			
	TOTAL Population		
Suggested variables (replace them with the established items from your country)	Current	In 5 years	In 10 years
Age groups			
Interval 0-x			
Interval x-xx			
Interval xx-xx			
Interval xx-xx			
Number of households in different income groups			
x-y			
y-			
w-			
Benefit receivers			
One parent families			
Divorce rate			
Number of children under custody of persons of retirement age			
Other important factors:			
x			
y			
z			

B) Transform demographic forecast into projection of population in different categories of children in need of social services						
Volumes (rate)						
	Current rate of affected population	Utilization: percentage that get services	Projected rate of affected population in 5 years	Utilization: percentage that will get services	Projected rate of affected population in 10 years	Utilization: percentage that will get services
a) Children deprived of parental care (voluntary or mandatory)						
Age 0-3						
Age 4-12						
Age 13-18						
b) Disabled children						
Age 0-3						
Age 4-12						
Age 13-18						
of that physically disabled children (if possible)						
Age 0-3						
Age 4-12						
Age 13-18						
of that mentally disabled children (if possible)						
Age 0-3						
Age 4-12						
Age 13-18						
c) Maltreated children						
Age 0-3						
Age 4-12						
Age 13-18						
d) Other important category						
Age 0-3						
Age 4-12						
Age 13-18						
e) Other important category						
Age 0-3						
Age 4-12						
Age 13-18						
f) Other important category						
Age 0-3						
Age 4-12						
Age 13-18						

C) Project future volumes in different kind of services/facilities taking into account the effects of a social reform. Examples of utilization in other countries can be of help for estimating volume changes in your country.				
Volumes	Residential services		Community based services:	
	Actual 2001	Projection 2011	Actual 2001	Projection 2011
a) Children deprived of parental care (voluntary or mandatory)				
Age 0-3				
Age 4-12				
Age 13-18				
b) Disabled children				
Age 0-3				
Age 4-12				
Age 13-18				
of that physically disabled children (if possible)				
Age 0-3				
Age 4-12				
Age 13-18				
of that mentally disabled children (if possible)				
Age 0-3				
Age 4-12				
Age 13-18				
c) Maltreated children				
Age 0-3				
Age 4-12				
Age 13-18				
d) Other important category				
Age 0-3				
Age 4-12				
Age 13-18				
e) Other important category				
Age 0-3				
Age 4-12				
Age 13-18				
f) Other important category				
Age 0-3				
Age 4-12				
Age 13-18				

Example to help estimate future demands in different services

Number of children (0-20 years old) in social services per 1000 inhabitants within this age group, in Sweden

Total number	Residential care		Family home care		Non-institutional measures	
	number	% of services	number	% of services	number	% of services
18,3	1,5	8,2%	4,5	24,6%	12,3	67,2%

Swedish definitions of different care and service forms for children

24 hour measures; Residential and Family Home care

Foster home
Foster home placement at relatives
Emergency/short-term home
Children and young people´s homes
Care home or hostel run by private persons
Special supervisory homes
Other form of placement

Non-institutional care measures

Structured non-institutional care programmes
Personal support
Contact person/family
Contact person and treatment
Companion service
Relief service
Short term supervision

Costs for care, 24 hour measures, in Sweden

		Residential care	Family home care	
USD		299	68	

Checklists

Introduction

Design of the reform

Checklists are suggestions to help reforming countries design and implement reforms

Checklist	Purpose
1. Financing and budget reforms	Covers items to consider when creating budgeting and financing procedures, that place all public funds for social care in the hands of the purchaser and allow for output-based reimbursement to providers.
2. Setting up the purchaser organization	Lists the advantages of a purchaser-provider system and the functions and tasks of a purchaser organization and points out key competences.
3. Opening up to new providers and creating a functioning market	Gives advice on what to consider legally and financially to create a functioning market, and how to create incentives for new providers.
4. Handling the tendering process	Presents examples of the steps involved in a good tendering process and what items to include in an invitation to tender.
5. Formulation of contract	Regards the final step in the administration of the tendering process; the agreement and formulation of contract. Lists headings and items to be included in a contract concerning social services. Example of contract is attached.
6. Facility planning and management	Gives advice on how to formulate a strategic planning process for restructuring publicly-owned facilities and what items to consider in order to reduce the supply of institutions.
7. Terms of reference for technical assistance and training	Provides an outline of terms of reference if external assistance is going to be procured.

CHECKLIST 1
FINANCING AND BUDGET REFORMS

This checklist concerns items to consider when creating budgeting and financing procedures placing all public funds for social care in the hands of the purchaser and allowing for output-based reimbursement to providers.

Changing the reimbursement of providers to an output-based system

This system means that the purchaser allocates the budget to a facility based on actual usage by the clients for whom the purchaser is responsible. The simplest form of output-based budgeting is a capitation system where the same payment is made per client. More complex forms include fee for services, according to standardized diagnoses or outcomes.

Changing the systems for reimbursing providers requires a number of measures and considerations on how to set prices, how to handle the tendering process and how to work out contracts with providers. (*See checklists 4 and 5 on the latter issues.*)

PRINCIPLES FOR SETTING PRICES

- Prices must always reflect true costs; therefore, accounting systems as well as methods to ensure accuracy in calculating costs must be developed.
- The provider's costs for supplying care should be covered by the revenues from selling services, including recurrent costs and capital costs; subsequently, transparent and accountable systems must be worked out in order to define real costs and to monitor them.
- To avoid over-production (and to ensure quality) ceilings must be set to limit, for instance, the number of clients to be served.

HANDLING THE TRANSITION TO A NEW REIMBURSEMENT SYSTEM

To manage the transition to a new financing system, residential institutions and the municipalities should be given support to:

- develop a plan for the transition process
- phase-in changes and assess impact
- redesign the provision of care
- help staff and management explore new options
- restructure the institutions.

FINANCING THE TRANSITION

In order to manage the bulk of the transition from one system to another, the state may set aside a sum to help institutions over the financial hardships that may occur between ending the input-based financing system and starting the output-based financing system. (There may be a month or so during which very little funding is directed to a care facility). This transition-linked problem, albeit not permanent, has to be dealt with.

Changing the money flow

Another key principle in the reform is that the public authority (purchaser) that refers a client to care is responsible for financing. Output-based budgets may imply that some revenues are taken away from one level of government and allocated to another (the purchasing level). Local governments can be effective purchasers since they have a better chance of identifying the needs of their populations, prioritizing them and purchasing the appropriate care. This assumes that local governments have an adequate financing base, either from own revenues or central government transfers.

The money should go from budget to purchaser instead of from budget to provider in order to create the right incentives for the purchaser to find the most cost-effective alternatives. If funding flows to providers directly, this impedes clear price signals and prevents the purchaser from seeking the most cost-effective solution. The desired change is to create incentives for the purchaser to find options that are less expensive and higher quality than residential care. In this way they will be able to provide better services to more clients than before or to reduce the resources needed for social services.

HANDLING THE TRANSITION TO A NEW BUDGET SYSTEM

In order to achieve the change there must be incentives to change the structure of financing. This means the current financier (often a ministry) hands over its funds to the purchaser (an independent agency and/or another level of government). There must be incentives for the purchaser to take over not only the funds, but also full responsibility for their use in the provision of care.

When this reform is combined with more decentralization, national government and local governments must agree on the reform, preferably regulated in a long-term contract where the conditions for the reallocation are carefully settled.

To manage the transition to a new, decentralized, financing system, the state and the municipalities should:

- develop a mutually agreed plan for the reforms to take place
- ensure a suitable time schedule for the reforms, should the budget transfer take place gradually or over a shorter period of time?
- find measurements to assess impact
- create prerequisites and facilitate the funding of initial investments needed to establish new community-based services.

The technique for reallocating funds from a national or ministerial budget to a purchaser budget must be worked out depending on the prevailing conditions in each country. We present two models that could be

considered or used to formulate a model that fits with the national regulatory framework and local conditions. These models are worked out for a transfer from the national ministry budget to the budget of a local government purchasing agency. However, the same issues arise if the purchaser is a national level one.

Technique	Description	Advantages
"Stock–Flow"	■ A date is set for the change of financing ■ Ministry* budget pays for all referrals before this date (stock), and municipalities pay for all new referrals after the date (flow). ■ The savings on state budget due to fewer clients in care are transferred to municipalities, so they can start paying for the new referrals, or spend the new allocation on alternative care. ■ The Ministry continues to pay for the stock until the turnover has made the stock vanish. (The shift of financing from state to municipality will depend on the turnover time for clients).	The model can be speeded up in order to see the outcomes of the project in a short-term perspective.
Gradual transfer "Envelope-model"	■ Ministry* financing decreases over a period of time, while the municipality financing increases correspondingly. State 100 % → State 0 % Municipality 0 % → Municipality 100 %	Stable and predictable method; institutions and municipalities can foresee the future costs.

** This is also applicable to any reallocation to municipalities from other financing bodies.*

a Toolkit

CHECKLIST 2
SETTING UP THE PURCHASER ORGANIZATION

Separating the purchasing function from the provision of care and services

The main objective for separating the purchaser from the provider is to create a more effective and purposive social service market by:

- splitting up and developing the distinctive roles of the *financier* whose task is to purchase the best care/services at the lowest price and the *provider* whose task is to produce the best care/services at the lowest price
- creating a channel for the expression of specific demands for service and quality
- obtaining a more transparent and clear view of the financial flows between types of services, client groups and needs
- creating incentives for public providers to increase productivity and limit costs
- using performance-based reimbursements to providers to encourage them to produce qualitative care at reasonable costs
- strengthening freedom of choice by stimulating new providers to enter the social service market.

The functions of the purchaser organization should be to:

Assess needs and refer clients

- Provide general objectives and guidelines for the service. Translate these general concepts into policies, hands-on guidelines and routines easily accessible to individuals.
- Gather information and expertise on the populations' current and future needs.
- Prioritize, plan and ration the public funds according to needs and available services. Ensure that funds are used to obtain best outcomes for clients. Supply the information and knowledge that individual social workers need to make well founded decisions on client referral. This comprises information on available alternatives and their respective costs, quality and expected outcomes.
- Ensure that the actual control over the money is delegated to those staff members that make the decisions on referrals.
- Be clear about the social workers' new tasks by supplying information to create reliable foundations for the purchasing process:
  - assess the needs of "typical" clients
  - help stimulate new care and service forms that respond to the identified needs
  - match clients with available services
  - formulate plans that clearly state the objectives for expected outcomes
  - follow up the results at a client level.
- Supply training and coaching to individuals.
- Examine and if needed reconsider existing criteria for prioritizing client needs.
- Set firm criteria for needs assessment and prioritizing.
- Communicate available services to the population.
- Guide the market so that as demand for institutional care decreases, an appropriate supply response results. (*See Checklist 6 "Facility planning and management"*)

Set prices and control costs

- Ensure that the new financing model controls total costs for social services. Develop better models and systems to monitor and analyze the provider's outcomes and costs and to thus pressure providers to limit costs (and enhance quality). Stress the early development of outcome measures supported by computerized information systems (*see Standards Toolkit*).
- Enable providers to develop more cost efficient operations by focusing, for instance, on outcomes rather than contents in the agreements (allowing them to use new and better working methods) and by using relatively long contract periods (allowing providers to reap the gains of their investment).
- Develop price-setting methods to ensure that prices are 'right', i.e. that they reflect actual costs for obtaining a given result.
- Set rates and determine the framework for user fees.
- Change the supply by seeking alternative care/service forms that fills client needs at lower costs. Promote the development of new providers.
- Prevent increased supply of new services from generating increased demands, i.e. demands that do not fully correspond to actual client needs; this kind of "supply-induced demand" results in higher costs for social services.
- Examine possibilities of introducing user fees to limit the demand for certain services where this is appropriate.

Handle the purchasing process

- Ensure that the terms of the agreement/contract with providers set a ceiling for production volumes so that the incentives for providers are linked to the objective of the purchaser. If needed, limit the existing ceiling.
- Specify demands and conclude contracts with providers.
- Gather information on available providers.
- Consider options for limiting administrative costs linked to the activities in the purchasing process (tendering, writing contracts, reimbursement, monitoring, evaluating etc.).
- Develop systems and methods to reimburse providers.
- Organize/facilitate cooperation between providers, where needed, to ensure clients' needs.
- Ensure there is competence and capacity in the pur-

chasing organization to analyze needs and ensure effectiveness in the purchasing process.

- Concentrate purchaser resources, e.g. in the region or at another relevant organizational level ("broker") instead of having small municipalities organizing their own purchasing function; concentration can be carried out for the whole or parts of the purchaser's mission.
- Supplement the providing organization with competence on a consulting basis, e.g. from the government, municipal/regional organizations or others.
- Supply training for the employees in the purchasing organization.
- Ensure that the purchasing role is not limited to handling technical contract issues but contributes to the development of more effective care and service processes.
- Ensure that profound competence in social services and knowledge of the prerequisites for the operations are represented in the purchasing organization, in addition to legal and economic skills.
- Prevent competition between providers from raising barriers to meeting clients needs or applying their freedom of choice by fragmenting the service market (many providers delivering only limited services makes it difficult for more complex needs to be handled adequately).
- Find a functioning distribution of responsibility between different providers. This may mean combining different providers to create a functioning chain of care sequences and encouraging cooperation between providers.
- Ensure that care plans express what outcomes the purchaser expects from the provider and that these criteria are included in the contracts.
- Monitor, review and evaluate the provision of social services; content, quality and cost effectiveness.

Key competence requirements for individuals in the purchasing organization

In *social care:*

- to make assessment of client needs
- to determine the best form of service/care that can meet those needs
- to make care plans.

In *social services management:*

- to develop principles for reimbursement
- to determine policies and frameworks for price-setting
- to carry out cost-benefit analyses
- to monitor, follow-up and value outcomes.

In *legal and financial issues:*

- to handle the tendering process
- to negotiate and write contracts.

CHECKLIST 3
OPENING UP TO NEW PROVIDERS AND CREATING A FUNCTIONING MARKET

Allowing new providers to enter the market should generate the following positive results:

- facilitate the development of new care forms and new methods
- create a market where public providers, in order to compete with new actors, are forced to increase productivity, limit costs and improve the quality of the service
- strengthening the populations' freedom of choice by stimulating new providers to enter the social service market.

Opening up to new providers presupposes the creation of a functioning market for social services. The transition towards such a market involves dealing with a number of issues:

- how to encourage and *support the establishment of new providers* and new services both within and outside the public sector
- how to create and *secure competition neutrality* between public and other providers
- how to *handle the surplus capacity among public providers* that is derived from new providers entering the market and delivering services formerly offered by public institutions, often in a monopoly-like situation
- how to *prevent the introduction of market forces from discriminating against clients* and ensure that the availability and quality of services are equally good for clients with complex or severe needs.

In the following we address each of these issues in terms of items to consider while planning and executing the transition.

Supporting the establishment of new providers

Establishment

Are the necessary prerequisites in place in order for new providers to set up services? In some cases providers may meet legal obstacles that need to be addressed first. The regulatory framework may need to be revised in order to avoid discrimination against new non-public market actors. Are there legal rights for private providers to establish services in the social care field? How are potential providers identified, e.g. staff at an institution with an interest in taking over the management of a small part of a service, new market entrants, NGOs and others. How can they be encouraged, how can the authorities set the conditions for a take-over?

Consider what other difficulties non-public providers may meet in setting up a facility and suggest ways to eliminate these. For instance, is there a risk that features of corruption/nepotism in the current system may interfere with opening up for new providers? How can municipalities deal with such obstacles?

Incentives

What guarantees can an authority give a new provider in order to create good incentives? Authorities cannot favour new providers in any way that is anti-competitive, but a local authority can declare its interest and policy to purchase care and services on an open market and in conditions of full competition. They can make agreements on using the services offered by new providers, express good will to use a new facility etc. on certain neutral conditions (in such a way that anti-competitive behaviour is avoided).

To make an establishment more attractive to purchasers the duration and scope of contracts must be reasonably satisfying. In some cases purchasing guarantees may be a solution.

Funding

Do non-public providers have difficulties in receiving public funding? Can this be altered by law or policy adjustments?

Support

New providers may be discouraged from setting up by high costs at the start-up phase. Examine ways for the purchaser to compensate for this. Such compensation must not conflict with the rules of competition neutrality, but may consist of loans, letting out a facility, lengths of contracts, support in management and training for staff etc.

Ensuring that new providers are part in the information flow and have access to information on best practice and good working methods. The municipality could set up a 'help desk' to assist first-time new providers.

Lack of competent staff can be an obstacle for new providers starting up. How can a lack of competence be met and what role can the authorities play in supporting the development of needed skills?

Lack of management knowledge is another obstacle for new actors in starting their own businesses and the authorities may want to consider providing support/training in basic management skills.

Monitoring All care providers should be subject to the same type of monitoring and licensing. Is the government legally entitled to monitor private providers?

Offer competition-neutral contributions to public and non-public providers in the form of staff training, management support etc.

Create and secure competition neutrality

Political issues Political considerations of regional/local development, budget constraints and labour market policies can have a constraining effect on the development of non-public providers. This can lead to discrimination towards these actors in the tendering process. The redundancy that arises among public providers discourages local politicians from inviting other actors into the service sector.

One alternative to the preservation of the current system is for the municipality to support redundant personnel in career transition programmes or in the form of help to start a private business etc.

To minimize the risk of having to pay rent for facilities/premises not in use, municipalities should be allowed to sell or let any premises they own for other purposes.

Information A prerequisite for non-public providers to be invited to tender is that the purchaser organizations have information on newly established services in the area. The national government (e.g. the agency which handles licensing) may perform the task of gathering and updating information on all service providers and make this available to purchasers (e.g. in an on-line catalogue).

Handle the transition capacity among public providers

Surplus capacity Scaling back on residential care will lead to an oversupply of facilities/premises etc. no longer in use; how such facilities can be handled (see Checklist 6 "Facility planning and management").

Quality of services There may be a risk of public providers becoming "second-class provision", due to the fact that the most skilled staff may be encouraged to start their own business or will be attracted to work for new providing employers. Public employers may have difficulties in developing new ideas regarding work management for historical and traditional reasons.

Introduce quality-monitoring systems where these are not in place.

Encourage and support public providers in managing change, input of methodological progress, dissemination of best practice etc.

Allow public providers to keep the financial gains they have achieved, to encourage them to find new, more effective ways of running a social service facility.
(*See Concept Paper and Toolkit "Standards" for more on quality issues.*)

Avoid discrimination among clients

Costly clients Some clients are more demanding than others; demanding clients are usually more expensive to care for. Prices must reflect the real costs and therefore vary according to the costs for providing care and services. A provider should not refuse or neglect demanding clients because they are less profitable. Strategies must be created to handle this, e.g. a purchaser may pay a higher price if the provider agrees to accept all clients.

Prices and contracts Prices must reflect the actual costs for the various types of clients, costly and less-costly. What price instruments can be used to set a fair price on different clients?

Contracts should reflect tender conditions on client mix.

CHECKLIST 4
HANDLING THE TENDERING PROCESS

In this checklist we present examples of good tendering process and a list of items to include in an invitation to tender. Countries which contract out public services usually have public procurement legislation that stipulates the framework for tendering and contracting activities. Here we give advice and make recommendations to consider in the process, in addition to the specific legal conditions which apply.

To make the process and result credible there are some principals that always should be valid for the government when considering a tendering process:

- ensure *competition neutrality* – ensure all possible providing actors are given the same prerequisites for entering the process
- ensure *transparency* in the tendering procedure, once the decision is taken; all bidders should receive the basis for accepting the winning bid/s; information on how to adjudicate the decision should also be provided.

Steps in the administration of a tendering process

The tendering process can be divided into three stages:

1. formulation of the written tender material – invitation to tender
2. qualification process and evaluation of tenders
3. agreement and formulation of contract.

In the following we give a brief description of the different steps to be considered in each stage.

1. Formulation of the written tender material and invitation to tender

Well-prepared tendering material simplifies the process both for the government purchaser and for contractors and creates the prerequisites for the evaluation, decision and formulation of the final contract. The material should:

- give objective and comprehensive information on the conditions for the contract
- contain all demands that the purchaser will have on the contractor. The demands should be as distinct and measurable as possible in order for the contractor to make realistic calculations
- focus on the qualitative demands of operations when listing the criteria for evaluating tenders
- not limit contractors' operations to the extent that this impedes their chances of rationalizing operations with maintained or increased quality.

2. Invitation to tender, qualification process and evaluation of tenders

The tendering process sets high demands on the purchasing organization. All legal regulations must be followed, and neutrality in the competition must be guaranteed. The evaluation of received tenders should be carried out in two steps. First, there is an examination of the contractors' fulfillment of the general qualification demands that are stated in the invitation to tender. This is a prerequisite for the contractor to be considered.

The *qualification phase* may, depending on legal regulations, include for instance the following elements:

- formal examination; taxes, insurance, registration etc.
- evaluation of contractors' structural prerequisites, financial position, management competence, access to human resources etc.
- evaluation of contractors' process prerequisites; methods, approach, internal organization, working, management and employee education, routines for quality assurance and documentation etc.
- control of contractors ability and experiences via contacts with former principals/employers.

The evaluation phase then continues for those contractors that have qualified. The steps of the evaluation phase depends on the criteria listed in the request for tenders, but in the field of social services the evaluation would normally include quality, prices and other terms of business.

The *evaluation phase* can then include these elements:

- examination of quality on basis of the description in the tender of how the contractor will carry out the assignment. This evaluation is done from the criteria previously listed in the request for tender
- evaluation of quality after a verbal presentation from the contractor
- evaluation of prices and other terms of business in relation to the quality assessment above
- in some cases a renewed evaluation takes place after negotiation with contractors.

3. Agreement and formulation of contract

After possible negotiations the contractor should be selected. The contract is then a confirmation of the agreement between the purchaser and the contractor. The contract should be as closely linked to the tender request as possible. For advice on the structure and contents of a contract, see Checklist 5.

Content – invitation to tender

1. Background information

Purchaser information; unit, address and contact person during the tendering process.

2. Information on the service to be purchased

Specify the contents of service to be purchased and state, for example:

a) number and types of clients to be offered services
b) expected quality outcome of provided services
c) length of contract for services

3. General orientation

a) practical information
b) location of the service, description of the facilities, e.g. the size of the rooms and the equipment every patient is entitled to
c) general regulations for the service
   - the entrepreneur will not handle any authority decisions
   - every patient should have an individual care plan provided by the entrepreneur
   - a service manager must be appointed, in charge and responsible for all services
   - medical and technical equipment is to be provided by the entrepreneur
   - all patients must have valid insurance
   - all services to be supervised by public authorities.

4. Purchasing regulations

a) competition neutrality; specify how this is achieved
b) legal basis for purchasing services, refer to specific laws
c) the time limit for the tendering process
d) define how the estimation of each tender will be performed.

5. Standards for performing services

a) prerequisites; any contractor must have knowledge of how to perform services
b) commitment according to the public authorities' demands and legal regulations
c) contents of the service; each patient's needs should be satisfied regarding:
   - maintaining and improving health
   - technical and medical resources
   - food
   - housing and maintenance of housing
   - valid insurance
   - periodic revisions of care plans in case of changed need
   - cooperation between service personnel and patient's relatives, other authorities.
d) information, documentation and revision; the public authorities must have access to all documentation to be able to revise the services.
e) personnel adjusted to the needs of the patients and employed according to legal regulations
f) limitations of services, if any
g) evaluations and follow-up performed by the public authorities:
   - periodic quality measurements where the patients, relatives and personnel are asked about the services. The results will be compared with all relevant documentation and the contents of the contract.

(See Concept Paper and Toolkit on Standards for further help)

6. Commercial regulations

a) contact person during the contract period
b) length of contract and when the service will be repurchased
c) responsibility for damages and insurance
d) economy - annual reimbursements from the purchasing unit to the provider, based on number of patients and service provided. Regulations on what might lower the reimbursements; absence for a longer period, termination of services, death etc.
e) changes of contract, amendments, cancellations, legal trials, *force majeur*, the legal ranking of documents for the purchase.

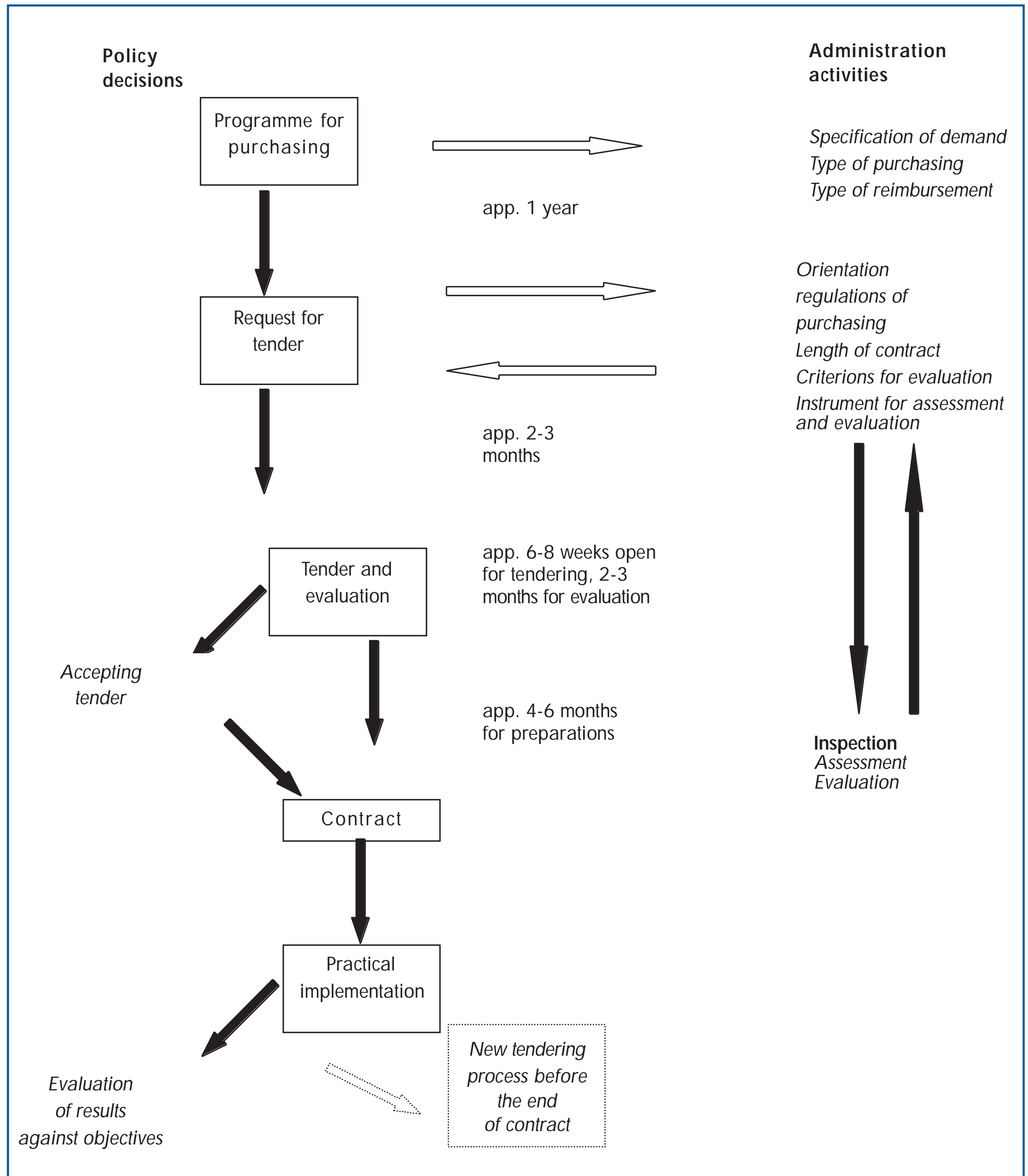
7. Quality measures for the patient

a) freedom of choice within reasonable limits
b) continuous services
c) integrity
d) security and safety
e) access to an active life.

(See Concept Paper and Toolkit on Standards for further help)

The complete tendering process: phases and time estimations

The diagram below illustrates the steps in the tendering process, from the point where the politicians decide to start purchasing services to the point where a contractor performs the operations. The time estimations given should be taken as indicators for a standard process but may vary considerably depending on the prevailing prerequisites.



a Toolkit

CHECKLIST 5
FORMULATION OF CONTRACT

This checklist focuses on the final step in the administration of the tendering process - the agreement and formulation of contract. The purpose of the contract is to make clear what the parties have agreed on. The process of formulating the contract is facilitated if the invitation to tender gives comprehensive directions concerning the items that will be included in the contract. The contract then primarily summarizes and documents the contents of the invitation to tender and the accepted tender and includes cross-references to these documents.

Especially when the purchasing concerns a large public service that will be operated by an entrepreneur for several years, the contract also serves as an instrument of legal control. The contract is a way for the purchaser to ensure that the provider fulfils their obligations. It should also ensure that the individual client receives a well-defined level of quality in the services.

The contract must be formulated on the basis of the specific circumstances in every procurement situation, but there are some items that must always be considered in the contract formulation process. Below we list headings and items that should be included in a contract for, for instance, a group home for children. An example, a contract for "Family Day Care Home Provider Services", is included as a separate supplement (page 84).

Contract – example of contents

1. **Parties to contract.** Contact persons for both parties during the contract period, address and other contact information. The service manager responsible for all services must be named.
2. **Term of agreement.** The contract is valid from X/X-200X until X/X-200X
3. **Extent of contract, main contract and other valid documents.** Contract; Tender; Request for tender. Appendix 1 - price list for how the provider is reimbursed. Appendix 2 - instructions on how evaluations and follow-up on quality of services to be performed by the public authorities. Appendix 3 - example of care plan.
4. **Information on the service to be provided by entrepreneur.**
   a) maximum number of clients to be offered services will be *x* children
   b) various types of clients to be offered services will be age *x*, have syndromes such as *x*, *y*, *z*
   c) clients will have an individual care plan (see Appendix 3)
   d) content of service; each client's needs (stated in individual client care plan) should be satisfied regarding:
   - maintaining and improving health
   - technical and medical resources
   - food
   - housing and maintenance of housing
   - periodic revisions of care plans in case of changed need
   - cooperation between service personnel, patient's relatives, other authorities
   - expected quality outcome of services (see Appendix for quality measurement).

5. General regulations for the service

a) location of the service to be performed and description of the facilities (size of rooms and equipment that every patient is entitled to)
b) requirements according to public authorities' demands and regulations, e. g. Law *x*, Regulation *x*, etc.
c) required documentation from the provider, such as; revisions, contains care plans
d) personnel, adjusted to needs of patients, employed according to legal regulations
e) limitations of the services (if any)

6. Commercial regulations

a) the provider is responsible for damages and insurance to property, personnel and clients
b) changes of contract, amendments, cancellation, legal trials, *force majeur*, legal ranking of documents for the purchase.

APPENDIX 1

Forms for reimbursement

Annual reimbursements from the purchasing unit to the provider based on number of patients and service provided according to the individual care plan.

Client category	Amount of money per time period
A – Children from age 0-2	X
B – Children from age 3-6	X + Y
C – Children from age 7-X…	
D – Children from age 0-2 with mental/physical handicap	
E – Children…	

Quality-based reimbursements; 25 per cent of the total amount of reimbursement to the provider will be disbursed only if and when the service provided reaches agreed quality standards, measured as per Appendix 2.

Adjusted forms for reimbursement

The adjustment of the reimbursement can be carried out quarterly.

Regulations that will lower the reimbursements	Reduction amount per client/time period
Absence of clients for a longer period	
Termination of services	
Non-fulfilling quality measurements	
Death of client	
Miscellaneous	

Regulations that will increase the reimbursements	Extended amount per client/time period
New clients	
Extended/revised contents of a client's individual care plan; changed nutrition, medical equipment, counseling support	
Individual additional costs (give example)	
Miscellaneous	

APPENDIX 2

Quality measures for the service

The patient should expect:
a) freedom of choice within reasonable limits (e.g. change provider of services due to personal circumstances)
b) continuous services
c) integrity
d) security and safety
e) access to an active life.

APPENDIX 3

Example of care plan

Supplement: Contract for Family Day Care Home Provider Services for the Columbiana County Head Start Program, (see page 34).

CHECKLIST 6
FACILITY PLANNING AND MANAGEMENT

When projections of future demand for social services have been carried out the process of planning for the reform can takes place. The redirection of resources from residential to community-based services requires, among other things, a plan for restructuring publicly-owned facilities. The reduction of the supply of institutions will not occur spontaneously but must be supported by a strategic planning process.

This is also an economic issue. If the reduction in the use of institutional care frees up resources which can be earmarked for the construction of alternative services, the recurrent and capital costs linked to buildings and equipment must be reduced as rapidly as possible.

The decisions that have to be made include:

- What institutions are targets for reduction or closure? Over what period of time should the reduction take place? Draw up a facilities plan.
- What should be done with the facilities/premises no longer needed for supplying social services?
- If facilities are maintained, should the responsibility for their operation be contracted out? How should the costs for buildings and equipment be handled if other actors (private, NGOs) take over responsibility for the operations?
- If buildings are kept for the same or other services, can they be used more efficiently? Partial closure?

Facility plan

A facility plan is a strategic tool where the process of handling (in this case mainly reducing) facilities is outlined. The items in a facility plan should include the following:

- a list of owned and/or managed facilities
- a list of owned equipment
- data on acquisition costs for the different buildings/equipment
- depreciation plans for the different buildings/equipment
- data on rental contracts
- plans and costs for maintenance
- schedule for closing institutions/part of institutions
- plan for alternative use/disposal of facilities
- calculations on economic effects of restructuring, cash flow etc.

What should be considered if facilities are no longer needed for supplying social services?

The costs must be reduced or eliminated as rapidly as possible in order for the savings to be used for the transition to community-based services. Even if parts of the services remain, the government should consider disposing of parts of them, e.g. a section, floor or wing of a building can be closed. Possible options include:

- selling the building/part of the building on the private market
- use of facilities by other public operations and the costs transferred to other entities
- demolition.

What should be considered if facilities are contracted out?

If the contractor takes over the facilities in connection with taking over responsibility for operations, government must consider how to handle the costs for buildings and equipment.

- Should the contractor be encouraged to buy the facilities?
- Should the contractor rent/lease the facilities? How should rental terms be fixed?

If the provider is supposed to take over the facilities, that prerequisite must be included in the invitation to tender. The terms of the agreement on facilities must then also be included in the contract between purchaser and provider.

What should be considered if facilities are maintained as social service facilities?

Even if the government decides to keep the facilities, the costs for running, maintaining and financing can be reduced.

- Can the current facilities be used more efficiently? Consider when and how they are used. Can different operations use the same buildings? Can new operations be performed in old premises?
- Is the size right? Consider whether areas could be reduced thus making space free.
- Are the functions right? Is current equipment adjusted to prevailing needs?
- Are the costs right? Costs for localities = Area * (Running + Maintenance + Capital costs). Consider whether, for instance, the maintenance can be operated in a more efficient or less costly way. Try to raise cost-awareness among managers within different services.

CHECKLIST 7
TERMS OF REFERENCE FOR TECHNICAL ASSISTANCE AND TRAINING

This checklist deals with additional technical assistance (TA) and any training a country may need in using the toolkits through the three phases of assessment, projection and design of reform and reform implementation. It also provides a sample Terms of Reference (ToR) for procuring TA.

TA can be obtained from different sources. Consultants can be hired to help initiate the assessment, or the toolkit work can be incorporated into other governmental or donor-financed projects.

The CMPL project is path-dependent and the way a country chooses to proceed in the project will depend on where it stands and how far it has come in making reform. Subsequently, the need for training and TA will vary. The sample ToR can be used by a country, adjusted to fit its need and specific conditions. This means that the activities listed in the ToR are a menu with examples from which a country can choose what is relevant and applicable. Not all countries will need TA on all the activities listed, but the list can provide ideas on how to work out the ToR and procure TA.

Sample terms of reference for technical assistance and training

Background

Excessive reliance on institutional care has a number of causes, including the legacy from the Soviet period, lack of expertise on community-based, family-centered approaches, and a lack of ability to assess needs, etc. One of the main obstacles to change is the system which pays for residential care. In most countries, funding for this care goes directly to the institution on an input basis. This is a major obstacle to changing the care model as it fails to provide incentives to allocate money to the most cost-effective interventions and, as a policy, it fails to encourage respect for the rights of the vulnerable individual in making decisions about care.

Changing Minds, Policies and Lives is a joint World Bank/UNICEF project to sustain reform by focusing (i) quality assurance and standards, (ii) effective systems for gatekeeping entries to care and (iii) the setting up new institutions and structures to finance care and services to move resources out of institutional care into community-based care. The project has formulated a Concept Paper and Toolkit for 'Redirecting Resources to Community-Based Care'. The Toolkit consists of (i) templates to assess the current situation in the provision of care and services, and (ii) templates and checklists to project what is needed to apply the concepts and design and implement the reform.

The government has decided to use the toolkits in its strategy to reform the provision of care and services and develop a new financial structure in social services.

Objectives

The objective for the consultancy is to provide TA and training to assist the working group through the three stages in the reform process based on the toolkits:

- assessment of the institutional set up and mapping the financial flows
- design of reform
- implementation of reform.

Activities

1. Preparation and assessment

- prepare for participation in the project and guidance on the concepts, assess how they are applicable in the country, support prioritization and progression and assist in formulating a strategy
- help assessing the institutional set-up and mapping the financing flows: type of care available, how and by whom it is financed, costs for care, referral patterns, consequences for children
- assist in mapping the roles of public and private actors and the incentives in the budget system
- assist in data collection and help in selecting relevant and informative data, analyze it and draw conclusions.

2. Designing the reform

- assist in setting up pilots to test the toolkits on a small scale
- assist in analyzing the possible impact of application of one or several concepts based on the Concept Paper
- assist in designing reform by choosing the best mix of activities and processes to implement these activities, draft an activity plan
- help defining a new institutional structure to separate needs assessment and demand management from supply, and reforming regulations to create or modify these institutions; setting up of the purchaser-provider system
- help mapping new financing flows, new demand patterns (not determined by supply), and costing out alternative transition paths
- assist in mapping the changes in roles, responsibilities and accountabilities for key stakeholders and consultation on these proposals
- help develop a plan to reduce the number of institutional beds and increase the supply of community services; a facilities plan
- assist in monitoring the toolkit work and help formulate indicators.

3. Implementing reform

- assist in implementation of reform including development of tools and regulations to support market,

usually on pilot basis first and nationwide later, and assist in formulating training programs, monitoring mechanisms and evaluation strategies
- assist in handling the tendering process
- assist in working out standardized contracts between purchaser and provider
- assist in finding links between the toolkits and other projects that could benefit from using the toolkits and help coordinate these
- assist through the implementation phase, keep track of progress and milestones.

Outputs

- workshop to introduce the concepts and toolkits to initiate the assessment
- TA during the assessment phase
- training for staff involved in the assessment
- workshop to analyze the outcomes and findings during the assessment phase and outlining a plan of activities and timetable for the next two years
- TA in designing reform and applying lessons learned during the assessment phase
- training and TA for setting up the monitoring function, working out indicators to assess progress in reform
- training of staff in tendering and contracting process
- workshop on linking the toolkits to other projects that help boost the reform work
- follow-up workshop to assess progress
- deliver reports on the steps in reform process.

Reports

The consultant should sum up each step in a written report that goes to all concerned stakeholders; e.g. government and ministries concerned, municipalities, regions, NGOs, private providers, and others. The report should include an assessment of status of project work, deviations and necessary corrections and proposals for next steps. Intermediate progress reports should also be defined.

Requirements

University education with a higher degree in economics, business or public administration, experience in the field of social care services policy and expenditure analysis, experience in international work, good knowledge of cost calculation and projections, ability to organize conferences and fluency in English.

SAMPLE CONTRACT

Contract for Family Day Care Home Provider Services for the Columbiana County Head Start Program, p. 1 of 4

This contract is made and entered into on ____________________ between the Community Action Agency of Columbiana County, Inc, Head Start Program, [CAA Head Start Program], and ________________________, a Columbiana County Department of Human Services certified Type B Home Day Care Provider, located at ____________________, and whose phone number is 330- ______ - ____________ -All Head Start Family Day Care Home services will be provided in the certified permanent residence of the Provider as listed above.

1. Contract Period:

A] The effective date of this contract is ________________ and the end date of the contract is ______________ . This contract is subject to termination prior to that date as described in Item 3, p. 1.

2. Service Population:

A] The Provider agrees to provide Head Start/Family Day Care Home services, as described in Attachment A, [attached and by reference made a part of this contract], for a minimum of 1 child and a maximum of 6 children of Parents or Guardians who are eligible for Head Start.

3. Termination of Contract:

A] The Provider understands and agrees that this Contract may be terminated by the CAA Head Start Program or by the provider for cause or convenience with a minimum advance written notice of 15 calendar days. The Provider's contract with the CAA Head Start Program is contingent upon the Provider's performance while under contract to the CAA Head Start Program. Termination or revocation of the contract for cause will result in summary termination of the contract with the CAA Head Start Program.

B] The CAA Head Start Program may terminate this contract for any of the following reasons or any other reason the CAA Head Start Program deems necessary, based on the best interests of the Head Start eligible children:

1. failure to comply with any CAA Head Start Program Performance Standard [Attachment B]
2. failure to maintain appropriate insurance coverage [see Item 6]
3. failure to maintain program or family information in a completely confidential manner
4. failure to comply with any terms of this contract
5. refusal to allow access to the home to consumer families or CAA Head Start Program staff
6. discovery of any history of child abuse or neglect, whether substantiated or indicated
7. falsification or misrepresentation of any information
8. mistreatment of any child in the Provider's care
9. loss or reduction in state or federal funds necessary to operate the Head Start Program
10. failure to maintain a drug free workplace as required by Federal Law.

4. Independent Contractor:

A] The Provider understands that he is not an employee of the CAA Head Start Program but a self-employed contracted service provider for Head Start and is not covered by CAA Head Start Program personnel policies and employee benefits. Providers who offer Head Start/Family Day Care Home services through this agreement are responsible for payment of any local, state or federal tax obligations on income earned through this Contract as well as for other requirements of self-employment which include but are not limited to: reporting of income to the IRS, payment of Social Security taxes, purchase of liability insurance, establishment of a retirement plan and any other self-employment benefits, if desired.