Deinstitutionalisation in Hungary: a critical policy analysis

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About Hungary

Part of the “Eastern bloc”

After 1989:

→ Transition from a single-party state socialist system to a multi-party democracy

→ Transition from state planned economy to free market, neoliberal capitalism

→ Member of the European Union since 2004

Systemic changes post-1990

Much of the 1990s characterised by economic and social crises and administrative reforms.

1. Strong neoliberalisation affected disability policies (Mladenov 2016)
   - Macro level (changes in social policy, welfare 'reforms', austerity)
   - Micro level (identity construction, increasing individualism and consumerism)
2. Strengthening civil society and legislative reforms
   - By mid-1990s over 30 thousand NGOs; NGOs often become service providers (Tausz 1997, Balazs & Petri 2010)
   - Disillusionment in the civil sector, paternalism (Miszlivetz 1997)
   - Some legislative changes are achieved by DPOs
   - Legislative reforms: 1993 Education Act, 1998 Disability Act, 2008 UN CRPD

Institutions in the 1990s

- New social policy preserved institutions.
- Attempts to create alternatives to institutions: group homes.
- Activism of parents and charities driven by discontent.
- Act XXVI of 1998: small group living for people “who are capable” and “modernised and humanised” institutions for those with severe disabilities.

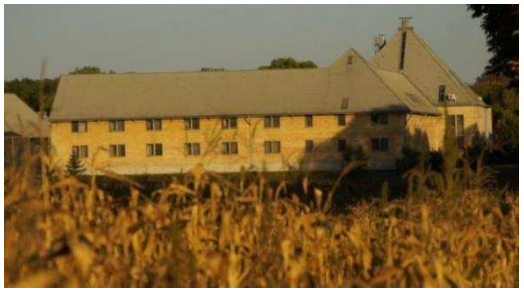


Photo credit: TASZ, Hungarian Soros Foundation

Institutions in the 2000s

- Policy dominated by the “modernisation agenda”, institutions still going strong.
- Group homes became “institutionalised”: strict regulation and size requirement (8-14 places).
- EU funding to support deinstitutionalisation and community living.
- Ratification of the UN Convention on the Rights of Persons with Disabilities.

Study aims

Key questions:

1. Are investments in deinstitutionalisation and community living in line with the EU's funding priorities (social inclusion and anti-discrimination) and the provisions of the UN CRPD in the 2007-2013 period?
2. Are the projects that received funding in line with the UN CRPD?
3. How successful actors responsible for managing EU funds in Hungary have been in terms of setting and implementing strategic objectives and allocating funding?

Methods

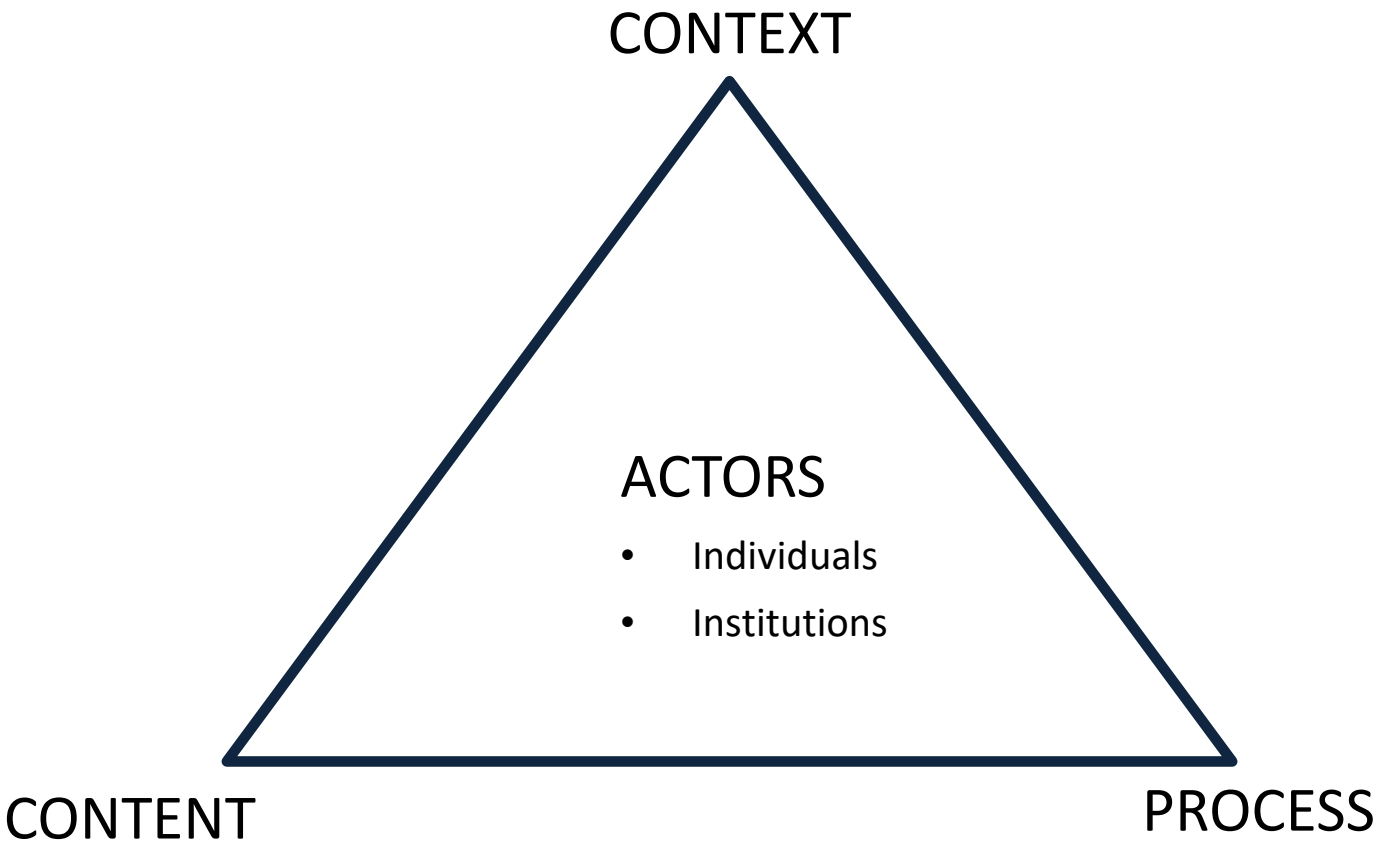
Qualitative methods

- 15 semi-structured interviews with national policy makers, DPOs, service providers, EU desk officers.
- Document analysis of EU and domestic framework.
- Photovoice (Wang & Burris 1997) in one institution (not presented here).

Analysis

- Interviews transcribed (not verbatim) and analysed thematically, alongside key (programme and policy) documents.

Analytical framework



Adapted from: Walt and Gilson 1994, p. 354

Context

- Modernisation of institutions on the policy agenda for a long time.
- Ratification of the UN CRPD (Article 19) had a clear influence on the Hungarian government's decision to start deinstitutionalisation. However, there are some important limitations of the human-rights based approach.
- EU funding (not part of a comprehensive policy reform, short-term planning).
- Wider political context: centralisation (away from local authorities), funding crisis.

UN CRPD as driver behind reforms – limitations of the human rights based approach

"The CRPD is not even law in the traditional sense, because it does not tell us what to do or how to do it." (Hungarian government expert)

"The CRPD is open to interpretations and it is difficult to say that this or that opinion is against the CRPD. We are still learning this." (EU desk officer)

"We have heard a lot about the principles [in the CRPD] but we don't know how to do it. We should work on this problem." (EU desk officer)

"General principles set out in the CRPD have come without indicators. (…) It is difficult to monitor results without indicators, because they often simply state something like 'But we respected those principles!'." (DPO representative)

Content

- Key aim is the “replacement of institutions” and a “change in attitudes” but unclear what these mean and how they could be achieved.
- Values and principles not articulated, (mis)use of examples from abroad.
- Detailed regulations (e.g. distance from public transport etc.) leave little room for local decisions. Possible implications: street-level bureaucracy.
- Uncertainty around key implementation issues (funding and sustainability) promote “conservative planning”.
- Result: large homes (8-20 places), partial closure, trans-institutionalisation.

Process

- Coordination through a national committee ('IFKKOT' in Hungarian), however this was lacking resources and a mandate to be a strong actor in the implementation process.
- Key role of "mentor network" in supporting implementation at the local level – a "black box", no leadership to ensure effective implementation, they lack power, issues of cooperation at the local level;
- Disjointed: huge delays in programme phases (due to bureaucracy and administrative requirements such as public procurement).

Actors

- European Commission: hierarchical position, relationship adversarial on the political level but close cooperation at lower levels; “soft” methods and emphasis on the involvement of civil society.
- Government agencies: competencies divided between 3 actors - no real leadership and competing interests.
- Civil society (DPOs and human rights watchdogs) played an important role before the launch of the deinstitutionalisation programme but this role was reduced during implementation.
- Other actors: institutions, mentors, service users, advocates.

Actors

Involvement of DPOs

- Involvement of DPOs and residents of institutions during implementation was scarce, tokenistic
- Monitoring of operational programmes is mandatory by DPOs – however, such monitoring is rather symbolic and ineffective ("ex-post")
- However, ad hoc DPO alliances managed to put a halt to government attempts to refurbish certain institutions
- Resources are not allocated to DPOs for monitoring or implementation.

"DPOs are important because they are the ones who usually raise concerns and suggest something – but almost always in vain, usually nothing changes." (Policy maker)

Conclusions and implications

- Policy is ‘fuzzy’ and ambiguous (see Needham 2011). Unclear if this is purposive or not, but it helps to reconcile differences between actors – broad support for “deinstitutionalisation”.
- Critical analysis has highlighted areas where changes could make major improvements to policy implementation.
- Implementation resonates with the concept of Post-socialist Disability Matrix (Mladenov 2016)
- Similarities and differences compared to other countries – more comparative research needed.

References

- Walt, G., & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health policy and planning, 9*(4), 353-370.
- Needham, C. (2011). Personalization: From Story-line to Practice. *Social policy & administration, 45*(1), 54-68.