

Care Triangle or Care Diamond? The Case of Childcare and Eldercare in Serbia

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Overall changes in political, social and economic spheres in Serbia, along with ongoing demographic processes, have affected various policies and all aspects of people's lives, including system(s) of care. While care became an important analytical concept and category of social policy analysis internationally, it has not been systematically applied in the analysis of the Serbian welfare state. Incorporation of care in welfare state analysis is much needed as its organisation in the national context reveals a lot about the nature of the welfare state, changes in its socio-institutional arrangements and, most importantly, the effects of provision. This article thus aims to outline the evolution of childcare and eldercare policies in Serbia over the last decade, employing the concept of the care diamond developed by Shahra Razavi, which allows examining the "architecture" through which the care is provided: families/households, markets, the state and the voluntary sector. By analysing the prevalent care policy "architecture" for children and the elderly in Serbia and the roles of different sectors in that respect, as well as by identifying similarities and differences in the provision of childcare and eldercare in the national context, the article exposes developments and current state in childcare and eldercare provision in Serbia. The analysis indicates the profound role of the informal sphere in both care systems in Serbia, childcare and eldercare. Some differences between the two care domains could also be noted. These relate to the configuration of welfare sectors involved in care provision, revealing the modified shape of the care diamond in the case of childcare. That is, while all four sectors are involved in providing care in the case of eldercare forming an eldercare diamond, this is not the case with childcare. In the latter case, the voluntary, nonprofit sector does not exist as a care provider in Serbia, with childcare "architecture" having a shape of a care triangle. In light of this evidence, the role of families and the voluntary, nonprofit sector should be taken into account in future planning and funding of policies as well as in their implementation.

Key words: care, childcare, eldercare, care diamond, policy, provision, Serbia.

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INTRODUCTION

Care tended to be dominantly limited to the private, that is, the domestic sphere and considered the intrinsically female domain of activity leading some authors to frame it as “women’s compulsory altruism” (Javornik 2014: 240). This informality is somewhat paradoxical as care has been of ultimate significance for the survival of society. However, principles underlying care, such as love, affection, connections, reciprocity and responsibility etc. (Lynch, 2014), made it spontaneously a self-sustainable work. It was not until the end of the 1960s and the beginning of the 1970s that the second-wave feminists labelled care as work and started reconstructing and debating it to conclude that community care and care by families equal care given by women (Ungerson, 1999; Pascall, 1997).

Ageing populations, along with the emigration of younger family members and increased female employment rates (as well as their consequences), resulted in a care deficit. These trends urged policy makers to react to the heightened need for support of both those in need of care and those providing care in family and community (Lynch, 2014). An awareness of the need to design, implement and manage better-suited and more responsive care policies, being understood as “public policies that allocate resources to recognising, reducing and redistributing unpaid care in the form of money, services and time” (ILO, 2018: 113), has been raised. Therefore, constellations of stakeholders involved in the production, organisation and delivery of welfare in modern societies have changed. Traditional welfare configuration, the so-called welfare triangle (Esping-Andersen, 2002) that mainly rested on the provision of three key sectors – the state, the market and the family/household – has been challenged by adding another sector – the voluntary one (that is, nonprofit) – to this mix,

thus turning the welfare triangle into the welfare diamond (Evers et al., 1994; Jenson and Saint-Martin, 2003).

This shifting of responsibilities for social welfare highlights the care provision from families, that is, an informal sector on the one hand and from the public (that is, state) sector on the other hand, but also takes into account the roles of the private and voluntary sectors in the care provision. The coordination of competencies and activities of the four sectors has thus become one of the most important demands of the care diamond developed by Razavi. Used as a metaphor for mixed sources of care provision, the care diamond evaluates how care responsibilities are shared across four different welfare sectors (families, the state, the market and the voluntary sector) and how the care needs of particular groups of dependents (e.g., children and the elderly) are provided for within these four domains (Razavi, 2007).

While care became an important analytical concept and category of social policy analysis internationally, it has not been systematically applied in the analysis of the Serbian welfare state. Serbian welfare regime has been transforming from an exclusive reliance on the public sector that was the norm during socialism towards embracing market-oriented values as of the beginning of the transition from the socialist to capitalist order as from the 1990s. Despite the dominance of the public stakeholders in the provision of care in all domains of social policy nowadays, many important trends could be observed, calling into question the position of the state and the effectiveness of its engagement in the care provision. In Serbia, the role of the state sector is somewhat specific. Changes in its role have had significant implications for new configurations of welfare provision and governance. On the one hand, it is declining, as evidenced by the withdrawal

of the state sector from the provision and financing of many care services for both children and the elderly. On the other hand, the state has been entering into partnerships with other sectors to provide care, but the effects are sometimes controversial. For example, controversies have become frequent when subcontracting institutional care for the elderly and children to the private sector (Perišić, 2016a). However, informality has always had a substantial role in the national welfare state, not only in terms of caring responsibilities, but also in other aspects of welfare provision.

In this article, we analyse the transformation of childcare and eldercare policy in Serbia in the last ten years to demonstrate the similarities and differences in the policy approaches and review the distribution of care burden between different stakeholders in care provision. The research question addressed is twofold: First, whether the evolution of childcare and eldercare policies in Serbia has followed different development trajectories? Second, what is the configuration of the institutional arrangements that are involved in the provision of care? The article proceeds as follows. Section 1 provides the theoretical background by presenting the concepts of welfare mix and the care diamond. Section 2 outlines regulations and institutional arrangements of childcare and eldercare in Serbia. The design and implementation of childcare and eldercare, relying on the concept of the care diamond, is discussed in Section 3. The conclusion, presented in Section 4, brings final remarks and recommendations.

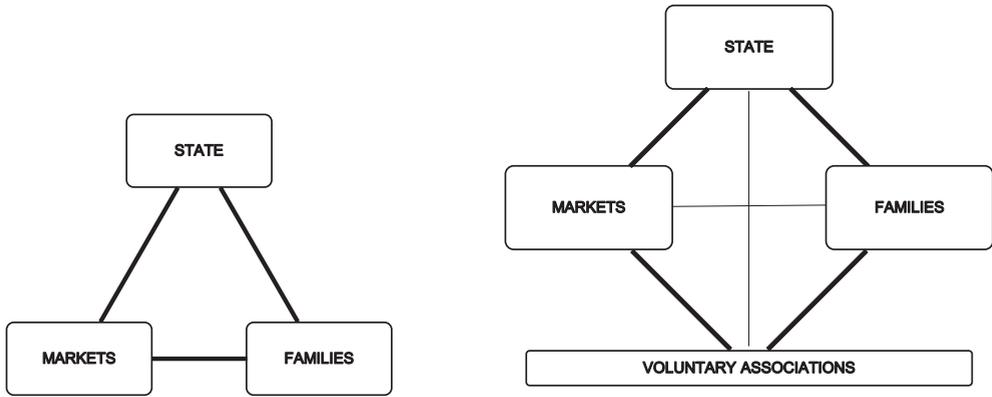
THEORETICAL FRAMEWORK – WELFARE MIX AND CARE DIAMOND

The concept of a welfare mix, also called welfare pluralism, is a perspective that originated in the 1980s and 1990s, highlighting that, in parallel to the state,

other institutions are involved in welfare provision. According to Spicker (2013: 198), this concept “leads to one of the most important categories in the contemporary study of social policy, which is the distribution of welfare services through a range of social mechanisms beyond the state itself”. Stating that “the welfare mix constitutes the centre of gravity of welfare regimes”, Powell and Barrientos (2004: 86–87) defined the concept as “the articulation of the market, the state, and the family in welfare production”.

As an important dimension of well-being, care became a widespread category of welfare state analysis because of the way it “connects the micro and macro dimensions of our lives and embeds personal practices within the context of social structures and social relations” (Yeats, 2005: 227). It can also be understood in terms of “the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out” (Daly and Lewis, 2000: 285). In order to label a diverse range of public policies and institutional arrangements in providing care, the welfare regimes literature has been using various terms to illustrate the roles of the sectors and classify care regimes. Many see society’s total welfare as a result of inputs from three sectors – the state, the market, and the family as in Esping-Andersen’s welfare triangle (Esping-Andersen, 2002), while others (Evers et al., 1994; Jenson and Saint-Martin, 2003) add a fourth sector, the voluntary, turning the triangle into welfare/care diamond (Figure 1) (Evers et al., 1994; Jenson and Saint-Martin, 2003; Razavi, 2007). All these conceptualisations have in common the emphasis on “decentralisation, institutional plurality and shared responsibility for welfare” (Mažeikienė et al., 2014: 643).

Figure 1:
Welfare triangle vs Welfare diamond



Source: Andersen, 2012.

The care diamond, proposed by Razavi, is used to describe and compare the patterns of care provision in different national contexts and in a more detailed manner. Intending to distance from welfare regimes and care regimes (having in mind their deficiencies *per se*), Razavi (2007: 21) wrote: “we could think of the ‘care diamond’ as the architecture through which care is provided, especially for those with intense care needs such as young children, the frail elderly, the chronically ill and people with physical and mental disabilities”. She describes the “care diamond” as an institutional architecture through which care is provided – including four sectors: family/household, the state, the market and the nonprofit sector – and the distribution of care labour, costs and responsibilities among them (Razavi, 2007).

Aiming to reconstruct the problem of high labour content in care work and offer a solution for it, Razavi considered the functions and roles of each of the welfare sectors involved: the informal, private, public, and voluntary ones. She demonstrated that the informal welfare sector (family and/or household) provides a large proportion of care, which is unpaid even in more developed economies. She also showed that

informal care is by far more frequently a contribution of women than men and that care labelled as unpaid actually incurs a cost for caregivers. Caregiving women are attributed direct and indirect costs: they have monetary and non-monetary costs for caregiving and they confront lost opportunities for employment and reduced wages (due to care obligations) (Razavi, 2007). Caregivers also report experiencing some degree of social isolation, anxiety, depression and loss of self-esteem (Kluzer, Redeker and Centeno, 2010). On the other hand, caring is, as a rule, connected with stronger ties between caregiver and care receiver, that is, family members. She claims that societies have the most prominent economic benefits from the informal care (Razavi, 2007), which they frequently tend to underestimate (Spicker, 2013). Lynch (2014: 15) also pointed out that “in the future the family may not be the mainstay of meeting the needs of older people”, bringing severe challenges and concerns for other sectors involved in the care provision, but most importantly for care receivers.

Razavi (2007: 12) sees the private market as striving to “keep wages down (or to increase the hours of work for the same

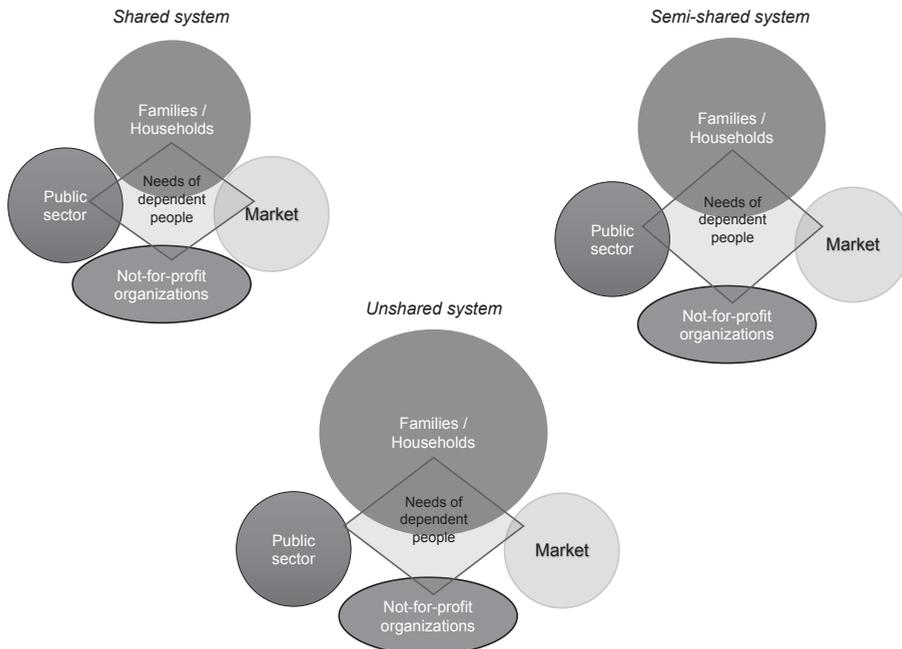
wage) by using ‘docile’ labour”. Care workers who are most frequently employed by the private sector are underprivileged women, that is, those with rural, immigrant, ethnic minority and marginalised backgrounds. The status of the caring profession is low, including the salaries (Razavi, 2007), and training opportunities are rare (Kluzer, Redeker and Centeno, 2010).

Razavi argues that the state has qualitatively different roles compared to the other three sectors. It is a decision-maker regarding the responsibilities that should be assumed by the other three sets of institutions (Razavi, 2007: 20). Along with deciding on policy design and regulating and setting priorities in the field, the state also guarantees the policy implementation (Perišić, 2016b), but it also attempts to withdraw from the direct provision and funding of care work due to high costs. Therefore,

there is political pressure for privatisation (Razavi, 2007). Rationing of the process of care provision, described by Spicker (2013: 285) as “balancing supply and demand outside the mechanism of the market” through denial (restricting access and eligibility rules), filtering, imposing costs on users, delay, and limiting care quality is also seen.

Finally, the voluntary sector frequently absorbs the labour costs “by frontline care workers who may, for a variety of reasons, perform the work for less pay (than in the market sector) or even for no pay at all” (Razavi, 2007: 14–15). They rely on the altruistic motivation of their staff, which is, however, frequently not stable (Salamon, 1995). Voluntary sector organisations have donations for their work and form versatile partnerships (Deakin, 1999), but their capacities can be overstretched (Spicker, 2013).

Figure 2:
Shared, semi-shared and non-shared systems of eldercare



Source: Rogero-Garcia, 2012.

As a useful heuristic mechanism, the concept of the care diamond can help to classify countries regarding the distribution of care provided across different sectors and the roles each of the actors has in delivering and funding care services. The boundaries between different institutional arrangements and sectors are not precise or static. This can be illustrated by three types of eldercare systems identified by Jesus Rogero-Garcia: shared, semi-shared and non-shared systems. An informal sector plays a fundamental role in all three systems, but the engagement of other sectors makes a difference among them. In the shared systems, the participation of the public and the private sectors is depicted as important, and the needs of dependents are widely covered, even though not totally. In semi-shared systems, formal care is scarce, but the private sector has a slightly more important position than the public sector, while dependents' needs are scarcely covered. In non-shared systems, the sectors other than family are almost non-existent (Rogero-Garcia, 2012). While the diamond represents the needs of the dependent people, the circles around the diamond represent different sectors of care provision (Figure 2). The size and the presence of the circle in the diamond represent two main characteristics of the sectors involved in care provision. The size of the circle indicates the capacity that these actors have in each society, and their presence (absence) in the diamond represents the sector's contribution in meeting the needs of dependents (Rogero-Garcia, 2012).

Employing this theoretical background and the concept of the care diamond in the analysis of childcare and eldercare in Serbia can be useful for at least two reasons. First, it helps to identify differences in the division of responsibilities in care provision, depending on the care domain concerned.

Second, it enables to explore mutual relation between different sectors (potentially overlapping), including gaps in organising, financing and providing care.

REGULATIONS AND INSTITUTIONAL ARRANGEMENTS OF CHILDCARE AND ELDERCARE IN SERBIA

Generally, care-related interventions in a broader sense can be classified into three groups, differentiating those dealing with: time (e.g., paid care leaves), financial resources (e.g., cash benefits) and services (e.g., early childhood education and care services, residential care for the elderly) (Daly, 2001). Following this categorisation, in the next section, regulations and institutional arrangements in childcare and eldercare in Serbia are presented, with the particular emphasis being put on services and paid care leaves. A more detailed analysis of the differences and similarities between these two systems of care, especially regarding care-related services, follows.

Childcare – Early childhood education and care and parenting leaves

Early childhood education and care

The early childhood education and care (ECEC) system in Serbia is primarily regulated by the Law on Foundations of Education System and the Law on Preschool Education and accompanying by-laws. Representing public activity of immediate societal interest (Article 2, *Zakon o predškolskom vaspitanju i obrazovanju*, 2010, 2017, 2018, 2019), ECEC services form an integral part of the educational system. ECEC refers to the education of preschool-aged children, that is, children from six months to the beginning of primary school¹. ECEC

¹ The Law on Foundations of Education System (Article 18, *Zakon o osnovama sistema obrazovanja i vaspitanja*) prescribes that every child who is at least six and a half and at most seven and a half years old by the beginning of the school year should be enrolled in the first grade of primary school.

facilities in Serbia are organised at three levels, based on the age of children: (1) nurseries – children aged 6 months to 3 years, (2) kindergartens – children aged 3 to 5.5 years; and (3) preparatory preschool programmes (PPP) – for all children aged 5.5 to 6.5 years. While aiming to support early child development as its primary function, they also enable parents to engage in the labour market or (re)enter the education process.

In the last decade, driven by a strong commitment to EU integration and organisational and financial support from the OECD, UNICEF, and other international organisations, Serbia has started with reforms aiming to respond to the growing demand for a better and more equitable education system. This period was marked by the attempt “to encourage ‘evolutionary changes’ to address existing problems, including insufficient development of the network of preschool facilities and insufficient coverage of children, especially from vulnerable groups” (Stojanovic, Kovacevic, Bogavac, 2018: 10). Actually, the reform process began with a significant improvement of the strategic and legal framework, primarily with the adoption of the Law on Preschool Education in March 2010² (and its subsequent amendments) and the Strategy for the Development of Education in Serbia by 2020. In addition to the general goal of harmonising the ECEC system in Serbia with the ones in EU member states, the Law has made one crucial step forward

in advocating equal rights and access to ECEC for every child by giving priority to children from vulnerable social groups (e.g., Roma children, children with disabilities...). The Strategy aimed to increase the number of children participating in ECEC programmes and ensure almost universal ECEC coverage of children aged 3-5 years. Despite the well-documented positive effects of ECEC programmes³ and a favourable strategic framework, Serbia still has one of the lowest rates of children’s participation in ECEC compared to EU member states (UNICEF, 2018).

This is clearly seen in the next section, assessing the development of the ECEC system in Serbia based on three main indicators: 1) availability (e.g., ECEC enrollment rates); 2) accessibility (e.g., a right of a child to ECEC and enrollment criteria) and 3) affordability (e.g., costs of ECEC services, parent’s participation in ECEC costs). The selection of indicators was underpinned by the Proposal for key principles of a quality framework for early childhood education and care (EC, 2014). By identifying the main elements of ECEC provision, this document listed five main aspects of quality in early childhood education and care – access, workforce, curriculum, evaluation/monitoring and governance/funding – that should contribute to improving accessibility and quality of ECEC programmes, as well as to providing children with the best possible start in life (EC, 2014).

² Adoption of this document is important since this was the first Law on Preschool Education after the ECEC system became the part of the education system in 2003. Until 2003, the ECEC system was the responsibility of three ministries – the Ministry of Social Affairs, the Ministry of Education and the Ministry of Health. Since 2003, with the normative unification of the activities of the ECEC system within competence of the Ministry of Education, greater efficiency and improvement of the work of preschool facilities has been provided. Together with the introduction of a compulsory preparatory pre-school programme in 2006/2007, a process of significant reforms in the field of ECEC has begun.

³ UNICEF study shows that ECEC plays a crucial role in child’s development. Not only does it improve health and educational achievements of children, but it also contributes to long-term labour productivity, prosperity and competitiveness of national economies. It has been proven to be particularly useful for the children from vulnerable social groups, as they have a significantly higher return rate on investment in ECEC (UNICEF, 2012; UNICEF, 2018).

Availability of ECEC

Compared to high enrollment rates in other educational levels (primary, secondary, higher education) and PPP, enrollment rates in nurseries and kindergartens are considerably lower, indicating that ECEC is the weakest part of the educational system in Serbia. In 2019, ECEC enrollment rate was about 50% (24% for nursery programmes and 76% for kindergarten programmes), while the PPP enrollment rate was almost universal, reaching 97.4% of children (RZS, 2020a). Emerging data for the pedagogical year 2020/21 show a nearly similar trend – enrollment rate of children aged 0-3 (nursery programme) is 23.4%, and the enrollment rate of children aged 3 to primary school age is 76.6%. High enrollment rates in compulsory PPP (96.4%) were also reported, with half of the children enrolled in the PPP attending a full-day programme (55%) and 45% of them a part-time (that is, 4-hours) programme (RZS, 2021a). The function of the PPP is to equalise children's initial position before entering obligatory primary school, that is, providing all children at the beginning of the educational process with equal opportunities and conditions and alleviating socio-cultural differences among them. Hence, PPP represents a link between ECEC and primary education.

Although the number of private ECEC facilities has almost doubled since 2016 (from 172 in 2016 to 304 in 2019) and the considerable rise in the number of ECEC units (both public and private, from 2,144 in 2016 to 2,208 in 2019) has been made, the ECEC capacities are still insufficient. The Statistical Office of the Republic of Serbia analysis (RZS, 2021b) indicates an increase in the number of children attending ECEC in Serbia in the last decade – the number of children attending different ECEC programmes increased by 17% (from 184,900 in 2011 to 216,570 children in 2020). In

the same period, the number of children aged 6 months to 3 years attending ECEC increased by 72%, and a more modest increase (7%) was reported within the older age group, children aged 3 to mandatory school age (RZS, 2021b). This analysis also shows that the number of children in private ECEC units is almost 8 times higher in 2020 compared to 2011 (from 3,244 in 2011 to 25,085 children in 2020), while the increase in the number of children in public ECEC units in this period was almost insignificant (from 181,656 in 2011 to 191,485 children in 2020) (RZS, 2021b). This overall growth can be primarily attributed to increased enrollment rates in private ECEC facilities, which can be explained by the introduction of an incentive measure in the field of public-private partnership – the inclusion of private ECEC facilities in the ECEC subsidies system in certain municipalities/cities. However, despite the growth in ECEC enrollment rates in the last decade, attendance levels remain below average in most EU countries (UNICEF, 2018).

UNICEF (2020) study shows that the ECEC system in Serbia is characterised by an uneven access and geographical distribution of ECEC, especially when it comes to the most vulnerable children. Access to ECEC is significantly lower for children from rural areas and from households at risk of poverty, children with disabilities and Roma children. Compared to the least developed municipalities, twice as many children are enrolled in ECEC in the most developed municipalities (RZS, 2020a). Also, children from vulnerable groups are the least involved in ECEC, especially when the programmes are not mandatory. For example, in the age group 3 to 5, only 7.4% of Roma children, 10% of children from the poorest households and 45.9% of children from rural areas attend ECEC. In addition, 24% of Roma children do not participate in compulsory PPP (UNICEF, 2020).

Accessibility of ECEC

Legal entitlement to ECEC has never been introduced in Serbia. Attendance in nurseries and kindergartens is optional, and it is a matter of parents' decision. ECEC facilities define the enrollment procedure, which has to be approved by their founder, and parents are free to choose any ECEC unit regardless of their place of residence. Priority enrollment in a public ECEC facility is given to children from vulnerable social groups, to children of employed parents or parents who are full-time students and to the third or any subsequent child in the family.

All children are required to attend only a half-day (that is, 4-hours) preparatory preschool programme (PPP) in the year before entering primary school. Namely, at the beginning of the pedagogical year 2006/2007, Serbia introduced a compulsory (PPP) for all children aged 5.5 to 6.5 years. PPP is mainly organised in ECEC facilities, and it can be organised in primary schools only if ECEC units are overcrowded. Parents are responsible for the enrollment of their children, and PPP is free of charge if it is implemented in facilities founded by the state or local authorities. Under the same conditions, verified private preschool facilities can also implement a PPP.

The organisation of ECEC follows different modalities. Activities in nurseries and kindergartens usually have a form of full-day (9-12 hours per day) or half-day programmes (up to 6 hours per day), while a compulsory PPP lasts 4 hours per day and could be extended according to parents' needs and working time. Concerning children enrolled in nursery or kindergarten programmes, less than 4% of enrolled children are in programmes that last less than 6 hours per day (RZS – Devinfo, 2020), which indicates that the ECEC programmes mainly have a caring function.

Affordability of ECEC

ECEC system is predominantly organized and financed at the local level. Therefore, the funding model for public facilities is decentralised, and most of the funding comes from local self-governments. The financing is regulated by the Law on Foundations of Education System and the Law on Preschool Education and it includes a three-level model for funding: republic level, local level and the users' (that is, parents') participation. Until 2017, local self-governments had an obligation to finance 80% of the economic price of the ECEC programme per child and parents financed the remaining 20%. In 2017 the provision defining local self-governments' share in the financing of ECEC services was relaxed, prescribing the share of "up to 80%" and actually giving the possibility for local self-governments to reduce their share in the financing of ECEC services. Hence, having in mind that ECEC services are mostly used by the children from higher socio-economic groups as well as the fact that the current network of preschool facilities is not adequate in terms of geographical coverage and physical capacity (UNICEF, 2012), a strengthened local governments' autonomy in financing ECEC services could additionally intensify inequalities and put less developed municipalities in an unfair position. The implementation of compulsory PPP in public facilities is entirely financed by the state, that is, from the state budget. However, in the case of private facilities not included in the public subsidies system, total funding comes from end-users, that is, the child's parents.

Children without parental care, children with disabilities and those living in financially disadvantaged families are exempted from paying ECEC fees. That is, for children without parental care, children with disabilities and children receiving state benefits, the parents' fee of 20%

(or more) is covered from the state budget (Ministry of Labour, Employment, Veteran and Social Affairs), and for children living in financially disadvantaged families by local self-governments according to their criteria (Zakon o finansijskoj podršci porodica sa decom, 2018). Data for 2019 show that parents' ECEC fees were high – 59% of parents covered the total price of the ECEC programme, 20% of them paid a reduced price, and 21% of them did not pay for ECEC services (RZS – Devinfo, 2020).

Parenting leaves

Unlike the ECEC system, which has not experienced major changes regarding its institutional setting in the last decade, the design of leave policies in Serbia has been subject to significant remodelling in the same period. Reform of the legal framework regulating this field has had considerable implications on the institutional characteristics of leave policies, especially regarding eligibility criteria and the level of leave benefits.

In Serbia, since 2001 parenting leaves have been divided into 3.9 months of maternity and 8.2 months of childcare leave (see Pantelić, 2021)⁴. In order to ensure the health of the mother and child during the pregnancy, maternity leave represents the right of every employed woman (Zakon o radu, 2018) and covers the period immedi-

ately before and after childbirth⁵. As maternity leave, the supplemental childcare leave is defined as the primary right of the mother that can be fully transferred to the father with her consent. It starts straightway after the end of maternity leave and lasts until the expiration of 365 days from the day maternity leave had started. Pronatalist objectives can be found in the design of parenting leave scheme, as in the case of a third and every subsequent child the parents have a right to a prolonged leave, that is, they are entitled to childcare leave in total duration of 20.2 months. Despite the legal basis allowing fathers to use the leave, childcare leave is the right that is mainly exercised by women in Serbia, which further contributes to the traditional gendered division of work and care responsibilities. Regardless of the possibility of fathers to exercise the right to parental leave, in society in which the patriarchal model of the father as the breadwinner is dominant, this possibility is rarely used (Stanojević, 2018). The percentage of fathers exercising the right on childcare leave is almost insignificant since the data for 2013 showed that less than 1% of fathers were exercising the right on childcare leave (Perišić, 2016b). Although there is no official information on take-up rates, according to the latest available data from the Ministry of Labour, Employment, Veteran and Social Affairs, in 2019, only 328 fathers exercised their

⁴ In comparative leave policy literature the term 'parenting leaves' is used as a common term for all three types of leave – 'maternity leave', 'paternity leave' and 'parental leave'. While maternity leave is primarily the mother's right, aiming to protect the health of the mother and newborn child during and immediately after childbirth, the paternity leave is granted to fathers only, enabling them to spend time with their partner, new child and older children. Parental leave is the right of both parents, either as a family right that parents use by their agreement or as an individual right, transferable or non-transferable from one parent to another. In Serbia, the distinction between these types of leave is blurred by the possibility that part of maternity leave, so called supplemental 'child care leave', can be transferred to the father, making it seem like a variant of parental leave, but this should be treated as transferable maternity leave, since the father's use of leave derives from the mother's entitlement and her agreement to transfer part of that entitlement (Kosłowski et al., 2021).

⁵ Maternity leave can start 45 days at the earliest, but imperatively 28 days prior to childbirth and it lasts for three months after childbirth.

right to various parenting leaves: 14 fathers have used the right to maternity benefit, 213 fathers have used childcare benefit, while 101 fathers have used leave for special care of a child^{6,7}.

Although Serbia has a rather generous maternity/childcare leave scheme regarding leave duration, generosity is quite restricted when it comes to eligibility criteria for the full amount of employment-based leave benefits and the level of leave benefits in general. The latest reform in the field, which was marked by the amendments to the Law on Financial Support to Families with Children in 2018, has affected self-employed parents and those in precarious employment. Even though the right to maternity/childcare leave has been extended to parents in non-statutory work, farmers and owners of agricultural farmsteads, the full amount of maternity/childcare benefit is granted to persons who have been employed or self-employed for 18 months continuously before the leave. That is, the level of leave benefits is calculated by dividing the gross base of earnings in the previous 18 months (24 months in the case of farmers and owners of agricultural farmsteads) by 1.5. Besides, with the same reform, an upper ceiling on leave benefits was reduced and can reach a maximum of three average monthly incomes in Serbia. In reality, these new provisions and their implementation might be potentially detrimental for the parents in insecure employment, that is, those who have been employed or self-employed less than 18 months before the leave. The level of their leave benefits can be extremely low, which could affect the overall well-being of parents and children.

Eldercare – leaves, services and cash transfers

Care leaves

Paid leave to support an older family member with care needs is defined as the right of an informal caregiver who is in employment. As of 2014, the duration of paid leave has been shortened from 7 to 5 working days in a year (Zakon o radu, 2009, 2013, 2014, 2017, 2018). The care leave benefit is not exclusively related to an older family member, but a family member in general, and it does not prescribe explicitly care needs, but a severe disease of a family member (Zakon o radu, 2009, 2013, 2014, 2017, 2018). It is calculated based on the average earnings in the 12 months before the leave started (Zakon o radu, 2018). There are no data on the use of care leave due to caring obligations towards older family members. Therefore, estimations cannot be made on their frequency and take-up.

The design of care leave for those in employment is rather traditional. It does not consider the challenges families face, which are typically longer than five days per year. The challenges for caregivers come from underdeveloped public care services and unaffordable private care services. At the same time, family members rarely have an option of relying on any other sector when it comes to eldercare provision and the care system is heavily based on informality (Kolin, 2011; Perišić, Satarić, 2021). In such circumstances, the family member with a lower salary typically shortens their working hours to provide care (Babović, Veličković, Stefanović, Todorović, Vračević, 2018). In Serbia, these are frequently women as they

⁶ Official data about the number of fathers exercising their right to various parenting leaves are not publicly available, but there are media reports, such as <https://poslovi.infostud.com/vesti/SAMO-RETKI-328-oceva-u-Srbiji-tokom-2019.-bilo-na-porodiljskom-bolovanju/54507>

⁷ After the expiration of maternity and supplemental childcare leave, one of the parents of a child in need of special care due to a serious degree of developmental difficulties has the right not to work or work part-time (half of the full working hours) until the child turns five years (referred to as 'leave for special care of a child').

are earning lower salaries⁸. Besides, flexible working arrangements are rather limited. When present, they are in the sphere of precarious employment, connected with low salaries and security (Perišić, Tanasijević, 2018). Women are also overrepresented in flexible working arrangements (RZS, 2020c). Interestingly, but unsurprisingly, the Labour Force Survey has been continuously reporting that more than 80% of women stated that the reason for their part-time employment is a need to take care of a child or a frail adult family member⁹ (RZS, 2020b; RZS, 2020c). The active labour market measures are extremely modest in Serbia, and they also do not provide any incentives for (re)entering the labour market for persons with care responsibilities.

Many non-governmental organisations advocating for the rights of the elderly and their caregivers have been arguing in favour of introducing the right that would clearly acknowledge and name the caring obligations of employed family members towards their older family members. Specific family-friendly working arrangements due to the care of an older family member are non-existent. On top of this, initiatives to support and empower employees to take family-friendly working arrangements are absent from the policy agenda. Concerns about the balance of the needs of employed caregivers on the one hand and employers on the other hand are also not appropriately taken into account, with the employer's interests dominating the interests of employees and their dependents (Bradaš, 2018).

Eldercare services

Eldercare services are organised within the field of social assistance and in two forms: residential services and in-home care services. Eldercare services have been subjected to reforms since 2004, with a view to decentralising eldercare and developing diversified services for the elderly. The last reform (in 2011) continued on the same path and acknowledged the pluralism of eldercare providers. That is, it enabled voluntary and private service providers to organise, deliver and provide care, along with the public sector (Zakon o socijalnoj zaštiti, 2011), limiting the involvement of the voluntary and private sectors to services that are demanded, but cannot be provided by the public sector "at the appropriate level" (Zakon o socijalnoj zaštiti, 2011). However, such prohibitions regarding the involvement of voluntary and private sectors do not relate to residential and in-home eldercare services, that is, the pluralism of providers is nourished in the legislation and in the field. The establishment of integrated social-health care residential services is foreseen by the legislative framework (Zakon o socijalnoj zaštiti, 2011), but these were not implemented in Serbia yet. Licensing of service providers is prescribed as a means of providing quality standards.

Residential care is provided in about 40 public and 100 private facilities accommodating approximately 6,700 and 3,000 persons over 65 years, respectively¹⁰ (Vlada Republike Srbije, 2018). Therefore, the residential care coverage rate is less than 0.8% of the population older than 65 years

⁸ In Serbia, gender pay gap accounted for 10.1 and 11.6 in private and state sectors respectively in 2020 (RZS, 2020c).

⁹ The data cannot be segregated based on care needs in relation to a child and/or older family member.

¹⁰ Data on the number of private residential facilities are extremely unreliable and depend on the source (Vlada Republike Srbije, 2018; RZSZ, 2018). Despite the differences in the sources, two additional reasons are on the scene. Their number is changeable, since many of them have been prohibited to work rather frequently. Also, many are not registered as residential care facilities, but work in the grey zone.

in Serbia, which is comparatively very low (Vlada Republike Srbije, 2018). Longitudinal data show that in the last ten years, there have been no significant changes in the residential care coverage rates (RZSZ, 2020). Additionally, there are substantial regional differences regarding the availability of residential care. Some local communities do not have public residential services for the elderly, in which case an elderly person has to move to another local community.

Demand for private residential care resulted from waiting lists for public residential care and the urgent need for accommodation due to the health condition of ageing care receivers. Therefore, residential care is most frequently provided to those with specific functional and health problems and rarely presents an option for an independent life in old-age. Private residential care is provided on an individually funded basis, and prices are market-driven. The subcontracting with the public sector has been on the scene since 2018, when about 20% of the total number of private homes in Serbia signed framework agreements with the ministry in charge of the social assistance sector¹¹. That is, the Ministry started subcontracting part of the private residential care providers and co-funding the costs of care. While in subcontracted private facilities all care receivers have to contribute towards care costs, public residential care can be free of charge, depending on means-testing, besides being paid partially or in full by a beneficiary. Despite the licensing procedure, both public and private residential care has been confronting serious challenges regarding the quality of care provided. Regular reports on the topic are absent, however, Ombudsperson reports indicate that the care is sporadically of low

quality and that there are different kinds of misuse of care receivers (Zaštitnik građana Republike Srbije, 2017). On the one hand, the prohibition of employment in the public welfare sector, including public residential care for the elderly, has effectively contributed to the extremely high workload of employees caring about the elderly and thus decreased the quality level of services. On the other hand, private residential care for the elderly is frequently labelled as the one that determines high and ultimately unjustified costs of care for their beneficiaries.

The voluntary sector is absent from the provision of residential care services, with the important exception of providing palliative care. A voluntary sector organization leads the only hospice in Serbia – “BelHospice” – and their services are free of charge (Bogićević, 2020). Due to rather limited capacities of the hospice and insufficient capacities in public hospitals for palliative care, it is clear that families primarily have the responsibility of taking care of their dying older family members in their own homes. Problems also arise from the fact that the majority of the elderly in Serbia live in old-age households, that is households without members below 65 years of age. Women are more affected, since they live longer¹².

The general population of the elderly frequently reports that they can live in their houses, with certain support (Satarić and Perišić, 2017). In-home support care service is the right of those who are not able to take care of themselves and who do not have any family members to provide care to them. It comprises of indirect care activities provided for by home-help, which is called in Serbia ‘geronto-housewives’ (Perišić, 2021). It is the most developed eldercare service,

¹¹ Official data about the number of contracted private homes for the elderly are not available, and there are media reports, such as <https://www.novosti.rs/vesti/naslovna/drustvo/aktuelno.290.html:793694-SUBVENCIONISANI-SMESTAJ-ZA-NAJSTARIJE-Drzava-za-dom-doplacuje-do-40000-dinara>

¹² In 2019 life expectancy for women and men was 78.3 and 73.1 years of life respectively (RZS, 2020c).

but its coverage is still inadequate. It covers only 1.24% of people over 65, that is, there are about 15,000 service users. In-home care has been developing at a stable pace since 2012 and 84% of local communities offer it. The service intensity is not equal throughout the country – only in less than half of local communities, the service is provided during the whole year, covering 57% of users (Matković and Stranjaković, 2020). For a slightly more than half of the users (55%), these services are provided by public providers. However, the public sector's provision share decreased compared to 2012 when the public sector covered 74% of care receivers. Contrary to that, the voluntary sector's role has increased – the percentage of service users covered by their services grew from 26% in 2015 to 34% in 2018. Also, it was for the first time in 2015 that private sector providers started offering their services, currently covering 9% of all care users (Matković and Stranjaković, 2020: 53). The majority of service users are from the urban area, but the difference is not huge – 52.5% of users are from the urban areas, and the rest are from the rural ones. A noticeable difference is observed regarding gender – 71% of care receivers are women (Matković and Stranjaković, 2020).

Foster care for the elderly is an option which is provided for by the law in the form of accommodation into another family. It is envisaged with a view to enable the elderly to “maintain or increase the quality of life” (article 48, Zakon o socijalnoj zaštiti, 2011). There is anecdotal evidence on its extremely rare usage in the national context (Kolin, 2011), but the available data cannot be segregated based on the age of users.

Care related cash benefits

Benefits related to eldercare are different types of allowances for the support provided by caregivers. Two such allowances can be exercised in the social assistance

system and one in the old-age and disability insurance system. Eligibility criteria are dependent on the medical situation of an applicant and not on their capacity for functioning. The right to allowances in the social assistance system can be exercised regardless of the previous employment status. In contrast, the right to allowance in the old-age and disability insurance system is dependent on the retirement status. The social assistance system acknowledges the right to an allowance in a regular and in an increased amount, depending on the level of incapacity (Vlada Republike Srbije, 2018). The allowance amount in the old-age and disability system is defined at a unique, flat-rate level. More precisely, the lower level of allowance in the social assistance system amounted to approximately half of the minimum wage, while the higher level of allowance in the social assistance system amounted to 1.4 minimum wage. The allowance in the old-age and disability system amounted to $\frac{3}{4}$ of the minimum wage. Despite the Government's claims on the adequacy of amounts (Vlada Republike Srbije, 2018), significant efforts from the elderly themselves and their family members are still needed to cover care needs.

The number of the elderly receiving allowances from the social assistance system is rather low. In 2019, 5,632 and 13,751 elderly exercised the right to an allowance in a regular and in an increased amount, respectively. In the last five years, the number of the elderly receiving an allowance in a regular amount decreased by 17.2 percentage points, while the number of the elderly receiving an allowance in an increased amount increased by 7.5 percentage points (RZSZ, 2020). At the same time, the number of beneficiaries of an allowance in the old-age and disability system is high, both when compared with the number of beneficiaries in the social assistance system and when compared with the estimated number of those in need of long-term care

(there are estimations that around 80,000 of the elderly is in need of long-term care) (Crveni krst Srbije, 2020). Namely, it increased from 74,795 in 2010 to 79,949 in 2019 (RFPIO, 2020).

CHILDCARE AND ELDERCARE THROUGH THE PERSPECTIVE OF THE CARE DIAMOND

In this section we use the perspective of the care diamond to map and analyse the responsibilities of care sectors in childcare and eldercare in Serbia. In doing so, we compare and contrast the care provided by the two sectors – childcare and eldercare.

There are certain similarities between childcare and eldercare policies in Serbia. The fact that the public sphere in Serbia is still quite patriarchal has consequences on what is happening within the private, that is, informal domain (Stanojević, 2018). This kind of patriarchy contributes to certain expectations regarding the role of men and women in the family and society, leading to the conceptualisation of care as a gendered phenomenon, both in the case of childcare and eldercare. As the primary caregivers, women carry the bulk of the care burden of the elderly and children (RZS, 2020c). This is especially a challenge for older women, who seem to take on increased levels of care as they grow older (Perišić, Satarić, 2021).

The informal sphere has always had its profound role in the care system in Serbia, even during socialism. Even though the socialist paradigm was to ‘free’ women from their caring obligations by transferring care towards the public stakeholders (e.g. through the investment in care infrastructure), the informality was rather strong. Besides, the transition saw the intensification of patriarchal norms which were pushing women back into informality very strongly. In combination with budgetary cuts, which were reducing the costs for public care arrangements, the reality was that the women

took on once again many caring obligations, either in their homes or for low salaries out of their homes (Nikolić Ristanović, 2008; Blagojević, 1998). The reversal of this trend cannot be clearly observed even today since it was potentiated again by the global financial and economic crisis of 2008 and currently the COVID-19 crisis.

There are differences between these two domains of care regarding the architecture through which it is provided. As the previous analysis showed, in spite of explicit pronatalist objectives that sought women’s redomestication, the underlying principle for design and institutional setting of childcare policies in Serbia has been reconciliation of family life and work responsibilities and overall child development. Nevertheless, the state’s efforts in implementing these objectives have been modest. Institutional support and organisation of childcare is still underdeveloped and does not respond to actual children’s and parent’s needs adequately. The current ECEC system is not sensitive and reactive enough, especially towards children from vulnerable social groups. A better access to quality ECEC services requires a more equity-oriented approach. Institutional design of parenting leaves, although generous regarding leave duration and benefits’ levels for some groups of parents, does not contain explicit entitlements aimed at father and thus contributes to the maintenance of gender-based inequalities and a traditional division of work and care responsibilities within the family.

Due to its cultural and institutional heritage, Serbia is a country where “socialisation” of childcare burden within entire society has historical significance, but also this process has never been fully completed, so an important part of caring activities is still being performed within the family and the informal networks (Stanojević, 2018). An illustration of the architecture through which childcare is provided in Serbia is

presented in Figure 3. As it is clearly seen from the illustration, the care diamond has the shape of the care triangle in the case of childcare. The voluntary, nonprofit sector as a care service provider is non-existent in the childcare diamond¹³. The responsibility for childcare provision has been traditionally distributed between the state and the family, while in the last few years, the role of the market in meeting the care needs of children has been expanding. Namely, institutional childcare services are arranged into the public and private sector. Whether these are public or private facilities, the establishment procedure is entirely under the state's control, while the admission procedure, placement and costs are determined by the facilities themselves and they have to be approved by their founder (state or other private entities). In terms of the scope and quality of services as well as prices, private facilities are free to decide for themselves, and they are mostly market-driven. Another important feature concerning the private sphere of childcare provision is the existence of childminders, who are beyond any control, underdeveloped and unregulated. As the analysis shows, there are some

interdependent relationships between the state and the market regarding the childcare provision, especially when public childcare facilities are overcrowded.

Due to traditional family ties and the organisation of family life, the family has always represented a "safety net" in providing care to children. Although there has been a paradigmatic shift in the public discourse emphasising that the responsibility for the care and socialisation of the child is no longer just on the family, but on the whole society, family members such as grandparents still have significant roles in providing childcare. Grandmothers are the most common caregivers (Dragišić Labaš, 2016), especially when the network of public childcare institutions is underdeveloped or the institutional childcare is unaffordable for the parents.

Finally, taking into account the capacity and contribution of each of these three sectors (public, family and private) in childcare provision, it can be seen that the state and the family somehow have shared responsibility for providing childcare, while the role of the market is growing, but it is more modest compared to the state and family.

Figure 3:
Childcare diamond

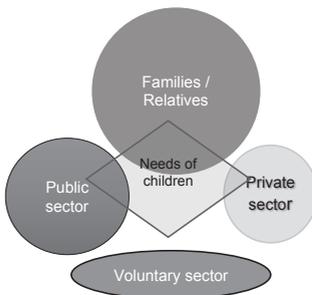
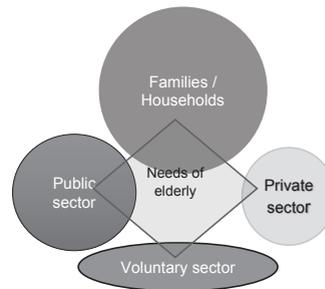


Figure 4:
Eldercare diamond



Source: Authors' own figures.

¹³ Actually, there are certain civil society organizations that provide support to early child development and education by taking part in the reform of preschool education programmes and infrastructure improvement in the domain of childcare, but they are not direct service providers.

Figure 4 illustrates the shape of the care diamond for eldercare in Serbia. Eldercare is pre-dominantly provided for by families, with an extremely low percentage of care provided by other sectors. Still, the care provided by the public sector precedes the one provided by the private sector. Unlike in childcare, the voluntary sector care also has its role in eldercare, similar to the one provided for by the private sector. Unsurprisingly, reasons for the inclusion of private and voluntary sectors vary substantially, and subsequently, so does the modality of their engagement. In eldercare, on the one hand, family care is provided in the form of spousal care and on the other hand in the form of daughters' or sons' care (more rarely) for their ageing parent(s). Frequently, a daughter/son is not in a position to directly meet the care needs of their parents, either due to geographical distance, family or professional burden, and caregivers out of the family are engaged to support the elderly in their homes (Satarić, Perišić, 2017). Their engagement still leaves certain gaps in the care for an elderly family member.

The public and political discourses on the care needs of the elderly underestimates their capacities for independent living with certain in-home support. The elderly have strengths and resources, and they are frequently caregivers. It would be helpful to acknowledge these two-sided interactions and to move away from the public discourse of care needs which seems to emphasise the lack of capacities of the elderly and neglects their contributions.

Public competencies in eldercare are within the domains of policy designing and regulating, funding, and direct service provision. Accessibility and availability of public services is not adequate, and many needs of the elderly are not met, either entirely or in an adequate way. Monitoring of the service quality has been under the radar; that is, the implementation mechanisms are not fully in place. Subcontracting with the pri-

vate sector has been a recent development to meet the increased care needs of the elderly. When there is a subcontracting relationship, private residential facilities have to follow the procedure prescribed for the public residential capacities. However, it does not seem that partnership with the public sector always pushes the private stakeholders to modify their market-driven logic, as it could be expected from their involvement in the partnership relations. There are also concerns that sometimes there is a clientelistic approach from the public sector to the private one, when it comes to deciding on partnerships.

However, the role of the private sector in the area of residential services has been present for a long period, as a reply to the demand of families. Only recently, the private sector started to develop other services for the elderly. Their profit-oriented activities enable a certain number of the elderly to meet their care needs, but the number is negligible. The rules prescribe the scope of their activities quite strictly, but the major concern comes from the implementation problems. Besides, the quality of care seems to require stricter monitoring.

Voluntary sector organisations have been providing care to the elderly, which is the first difference compared to childcare, where there are no such organisations. Their activities date back to socialism; however, in that period, they were frequently thought of as the state's voluntary organisations and not the truly civil society organisations. After the beginning of the transition, the voluntary sector's involvement was in connection with the actual inability of the state sector to react to profound social challenges, regarding insufficient public resources (financial, legal, human etc.). Moreover, their involvement in eldercare today is exclusive when it comes to hospice care. It is also important from the point of view of the elderly having needs, which could not be met by the public sector, due to some specificities

(most importantly for the elderly living with different forms of dementia, etc.).

CONCLUDING REMARKS AND RECOMMENDATIONS

By debating the current state of the care diamond in childcare and eldercare, some key features regarding the prevalent care policy design and the “architecture” through which the care is provided have been revealed.

Besides the families, that is the informal sphere, which represent a significant ‘safety net’ and the most significant stakeholder in meeting care needs of children and the elderly, traditional welfare configuration – resting on sharing responsibilities for social welfare between the state, market and family/household – has been identified in the case of childcare. In this regard, the childcare diamond has the shape of a care triangle, within which the family and the state have a shared responsibility for providing childcare. At the same time, the role of the market is fast-growing, but still modest compared to the state and family. However, since institutional childcare services are arranged into public and private sectors, some interdependent relationship between the state and the market regarding the childcare services’ provision is evident. Furthermore, recently adopted incentive measures in the field of public-private partnership, that is the inclusion of private ECEC facilities in the public subsidies system, led us to the conclusion that in the future it can be expected that the provision of institutional childcare will be more equally distributed between the public (state) and the private (market) sector. While it is possible to predict with some certainty the future trajectories of the development of these three providers (state, market and family) in childcare provision, it is not easy to identify the potential role the voluntary sector could have as a direct childcare service provider.

The striking absence of many relevant data in the field of eldercare has important shortcomings in analysing the eldercare diamond. First, it disables us to make many exact claims about the care diamond and the eldercare system. While it is clear that the informality is by far the strongest factor in eldercare, it is difficult to “measure” the impact and scope of other sectors. Because the public one has wider coverage than the private one, we would argue that eldercare in the national context should still be classified as a shared, and not a semi-shared system. However, its heading under the label of the shared system should be taken cautiously, since many characteristics of the shared systems are actually absent. The most critical is a questionable orientation of the eldercare system towards enabling dependents and their caregivers to live independent lives. Also, the care provided by the public sector is conditional in many respects and rather tiny when compared to the informal sector. For example, the provision of eldercare services of the public sector has been declining as a result of the need to reduce budgetary costs. For that reason, it could be argued that eldercare has characteristics of the semi-shared system. Still, without more comprehensive data, only approximations can be given that the eldercare is between the shared and semi-shared systems.

The role of the public sector has been rather traditional in childcare and eldercare with low, if any, modernisation impulses. One of the reasons are budgetary constraints, that is, austerity measures. However, it does not seem that societal debates around the need to change care patterns are on the agenda of decision makers.

Designs and forms of childcare and eldercare should also be considered from the perspective of their intersections. Families are dominantly in charge of the care for both children and the elderly. Families are burdened with care, sometimes even simultaneously: they care for both children and

the elderly. The public policies should fully acknowledge such engagement of families and make plans for their empowerment to perform their care work. The empowerment strategies should range from supporting families to care to developing supportive and complementary public, private and voluntary services for care. Furthermore, the roles of families should be duly taken into account in state planning, funding and implementing the policies. An emphasis on de-institutionalisation brings more responsibilities for the family, which should be taken into account properly. Gender neutral caring policies should also be scrutinised. It is clear that there is a strong gender inequality, both in the formal and informal sectors of childcare and eldercare. Women take the bulk of care and this should be acknowledged in the policies regulating care, but also care related areas (such as employment, education, training), since gender-neutral policies are discriminatory towards caregiving women. At the same time, care and care-related costs families are having are underestimated by the state. As already mentioned, data about childcare and eldercare are strikingly absent, which lowers the visibility of main challenges, effectively disables their understanding and analysis, and particularly the creation of evidence-based interventions and policies.

The creation of robust and available databases about different aspects of childcare and eldercare is of utmost importance for policy-makers and researchers in the field. Some important aspects that should be documented and researched further relate to all sectors included in care provision. The engagement of the informal sector, that is, the family, should be scrutinised from the point of view of female and male participation in care work, division of care responsibilities between the genders, incentives for work-care balance, but also the factual ability of

family members to provide care, either due to their age, disability, migration, etc. Forms of trans-national care should be scrutinised too – the impact of emigration of younger family members and their ties to their elderly parents, but also the care grandparents are providing to their geographically distant grandchildren. The care obligations should be analysed from the point of view of their economic cost, constraints they are imposing on societal life of caregivers and emotional burden. The declining role of the public sector should also be approached in terms of the position of vulnerable children and the elderly, and jeopardised solidarity in society. Communitarization of national care policies, that is, the harmonization with the *acquis communautaire*, could present an incentive for the modernisation of the public sector in the field of care. Still, it should be analysed whether the prospective policy transfer is designed and implemented equitably so that care receivers are entitled to accessible and decent care. The effects of the private sector engagement should be researched from the point of accessibility, affordability and quality of care, while the innovation in the voluntary sector activities regarding care should be researched and disseminated.

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Sažetak

TROKUT SOCIJALNE SKRBI ILI ČETVEROKUT SOCIJALNE SKRBI? SLUČAJ SKRBI ZA DJECU I STARIJE OSOBE U SRBIJI

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Sveukupne promjene u političkoj, socijalnoj i ekonomskoj sferi u Srbiji, zajedno s kontinuiranim demografskim procesima, utjecali su na razne politike i sve aspekte života ljudi, uključujući sustav(e) skrbi. Iako je skrb postala važan analitički koncept i kategorija analiza socijalne politike u međunarodnom kontekstu, ona još nije sustavno primijenjena u analizi srpske socijalne države. Uvrštenje skrbi u analizu socijalne države nužno je potrebno jer njezina organizacija u nacionalnom kontekstu otkriva mnogo o prirodi socijalne države, promjenama u socio-institucionalnom uređenju i, što je najvažnije, učincima pružanja skrbi. Rad nastoji izložiti evoluciju politike skrbi za djecu i skrbi za starije u Srbiji tijekom posljednjeg desetljeća, koristeći koncept četverokuta socijalne skrbi koji je razvila Shahra Razavi, a koji omogućuje analizu "arhitekture" unutar koje se socijalna skrb pruža: obitelji/kućanstva, tržišta, država i dobrovoljni sektor. Analizom prevladavajuće "arhitekture" politike skrbi za djecu i starije osobe u Srbiji i uloge različitih sektora u tom pogledu, kao i identifikacijom sličnosti i razlika u pružanju skrbi za djecu i za starije osobe u nacionalnom kontekstu, rad prikazuje razvoj i sadašnje stanje u pružanju skrbi za djecu i starije osobe u Srbiji. Analiza ukazuje na bitnu ulogu neformalne sfere u oba sustava skrbi u Srbiji, skrbi za djecu i skrbi za starije osobe. Isto tako, mogu se uočiti neke razlike između dviju domena skrbi. One se odnose na konfiguraciju sektora socijalne skrbi uključenog u pružanje skrbi i otkrivaju modificirani oblik četverokuta socijalne skrbi u slučaju skrbi za djecu. Drugim riječima, iako su sva četiri sektora uključena u pružanje skrbi za starije osobe tvoreći četverokut socijalne skrbi, to nije slučaj u pogledu skrbi za djecu. U potonjem slučaju dobrovoljni, neprofitni sektor ne postoji kao pružatelj skrbi u Srbiji, te "arhitektura" ima oblik trokuta socijalne skrbi. U kontekstu ovih dokaza, uloga obitelji i dobrovoljnog, neprofitnog sektora trebala bi se uzeti u obzir u budućem planiranju i financiranju politika, kao i u njihovoj primjeni.

Ključne riječi: skrb, skrb za djecu, skrb za starije osobe, četverokut socijalne skrbi, politika, pružanje, Srbija.