

11. The de-institutionalisation of care for older people in the Czech Republic and Slovakia: national strategies and local outcomes

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INTRODUCTION

In this chapter we address changes occurring in the public provision of long-term care (henceforth LTC) for older people in the Czech Republic and Slovakia, with particular attention to the process of ‘de-institutionalisation’, on the basis of two case studies developed in the course of the COST Action IS1102 *SO.S. COHESION – Social services, welfare states and places*. These two countries shared a common trajectory – under the Soviet rule – up to 1989, which may explain a number of similar problems they are facing in the domain of social services. This is especially true in the case of care for older people, a service historically organised in residential structures, the financial viability of which has come under severe strain because of demographic changes and austerity measures.

In the Czech case, changes in the provision of such services started in 2006 when the notion of de-institutionalisation entered Czech social policy at the national level and the first – and still only valid – Social services act was approved. In Slovakia, the first act on social services was adopted in 2008, introducing decentralisation, de-institutionalisation and diversification of services.

In what follows, we address the following questions:

1. How has the concept of de-institutionalisation influenced the Czech and Slovak national strategies, legislation and organisation of social services for older people?
2. What has been the actual ‘response’ of the regional and local authorities, as well as the providers of care services for older people, to the new national policy strategies and regulation in this area?

To answer these questions, we first review the national policy strategies that followed the new Social service acts in both countries and the interplay between national strategies and regulation, on the one hand, and the regional and municipal provision of care services for older people, on the other. Subsequently we critically assess two case studies: (1) the organisation of domiciliary services for older people in the municipality of Blansko in the South Moravian region of the Czech Republic; (2) the innovative solutions implemented for the delivery of domiciliary care services to older people in the municipality of Kalná nad Hronom in the Nitra region of Slovakia. We focus on domiciliary care as a way to assess the current de-institutionalisation process, also because this form of care takes a central role as a 'substitute' for outdated or too expensive residential care. Through these two case studies we seek to highlight the ambivalent nature of the de-institutionalisation agenda: the Blansko case is somewhat representative of an ambiguous de-institutionalisation process trapped between policy discourse and socioeconomic reality, while the Kalná nad Hronom case is rather an outlier and represents a more optimistic example of how de-institutionalisation can be creatively implemented. The above case studies may also be seen as different outcomes of the implementation of national strategies: in the Czech Republic the stronger role of the established system of social services plays a regulative role, whereas in Slovakia there is room for innovative projects of de-institutionalisation.

The chapter is structured in five parts. In the next section the conceptual framework guiding the analysis of the case studies is briefly presented. Subsequently, the changes in national social policy of the last ten years are described in the two countries, with a focus on de-institutionalisation discourses and strategies. In the third and fourth sections the two municipal case studies are detailed. Finally, some concluding remarks are drawn.

1. THE ANALYTICAL APPROACH

In this section we briefly review the literature about welfare state models and 'transition' countries, de-institutionalisation strategies and the emerging vertical and horizontal division of responsibility in the provision of care services.

'Transition' Countries

Current differences in, and the potential future direction of, the organisation of social services may be explained by the welfare state type under which an individual state can be categorised (Rothgang and Engelke,

2009). However, in the case of Central European countries it is complicated to classify systems of social services in general, and for older people in particular. Early works by welfare model theorists (Esping-Andersen, 1990) did not include Central European countries among the liberal, conservative or social democratic models, which led to a subsequent discussion on whether post-Communist countries should be categorised into one of the established welfare models, constitute a separate welfare model – in the case of the Visegrad countries mainly resembling the conservative welfare state (Fenger, 2007) – or be regarded as a hybrid model – as argued by Hacker (2009). In what concerns LTC more specifically, based on the features of their demand for care and their provision of formal and informal care, researchers have classified these new EU members as a separate, hybrid model ‘in transition’ towards other established models (Lamura et al., 2007). Taking into account the fact that Rodrigues and Nies (2013) suggested that not only the Central European but all European LTC systems are currently in a transitional state, we regard LTC systems of the Czech Republic and Slovakia as ‘transition’ models and analyse their de-institutionalisation process within this analytical framework.

De-institutionalisation and Care of Older People

Institutional care came under attack following the mental illness reform movement of the 1960s and 1970s and the disability movement (for independent living) of the 1980s. The main argument was that the situation of residents living in institutions, including LTC institutions such as nursing homes or mental health hospitals was humiliating (Shen and Snowden, 2014). This line of reasoning was strengthened by the cost-saving agenda of neo-liberal, economically conservative politicians promoting individualised and often privatised care (Chesters, 2005).

Since the mid-1990s, several reforms have been undertaken in the field of care for older people in almost every welfare state, promoting community and domiciliary care services instead of institutional LTC (Pavolini and Ranci, 2008). These reforms have first and foremost been undertaken by governments seeking socially and economically sustainable solutions to create high-quality LTC for a higher number of older people without raising costs (OECD, 2013). This goal was reinforced by the outbreak of the financial crisis in 2008.

Whether for ethical, political or economic reasons, de-institutionalisation currently refers to a process through which institutional care is either reduced and replaced by community and home-based (or domiciliary) care arrangements or is radically reorganised. Thus, de-institutionalisation may not only refer to the notion that traditional institutions are closed down,

but also to the concept that large institutions are replaced with smaller, home-like residences (Anttonen and Karsio, 2016).

Albeit a generalised strategy, de-institutionalisation is a highly context-bound phenomenon: the transition from institutional care to domiciliary or community care in Europe is implemented in rather different ways in different countries (Anttonen and Karsio, 2016). In the case of the Czech Republic and Slovakia, de-institutionalisation started later than in other European welfare states, as part of a radical transformation from one social services model to another. Although the end point of the transformation is still not visible, the beginning is clear: it was the denial of the old Soviet-style welfare model consisting of the state as a dominant service provider and an overall change from state monopolism to plurality, from direct control to market relations and from paternalism to self-governance (CAP Kubalčíková and Havlíková, 2013; CAP Kováčová et al., 2014). In this framework, policy-makers and experts now in both countries promote a shift to care in the community and at home.

The ‘Vertical’ Division of Authority and the New ‘Horizontal’ Welfare Mix

As part of the Soviet bloc, Czechoslovakia adopted the Soviet-style, paternalistic model of social protection, with a centralised, state-run system that did not allow for private providers but tolerated (informal) residential care. After 1989, state paternalism was gradually replaced with more flexible and decentralised mechanisms, based on the following new principles: administrative decentralisation, new forms of social services provision and new ways of funding social services (Koldinská and Tomeš, 2004).

In 1990, social services were transferred from the central state to municipalities, also giving responsibilities to newly formed non-state actors, such as churches and NGOs (Mansfeldová et al., 2004). After the split of Czechoslovakia into two countries in 1993, social service providers and social workers – supported by the emerging non-profit, non-governmental sector striving to provide modern social services – started to discuss the parameters of a new conception of social services provision in both countries: in the Czech Republic the overall reform of the social services system culminated in the 2006 adoption of the Act on social services (*Zákon o sociálních službách*) (CAP Havlíková and Kubalčíková, 2014), while in Slovakia substantial changes in social service provision (including decentralisation of competences and funding in the care system for older people) were brought about by the 2008 Act on social services (*Zákon o sociálnych službách*) (CAP Kováčová et al., 2014).

If we apply the ‘vertical division of authority’ concept laid out by Martinelli (Chapter 1, in this volume), the general re-scaling of authority

Table 11.1 The 'vertical division of authority' in the field of care for older people in the Czech Republic and Slovakia

Level and function	Central state		Region		Municipality	
	CZ	SK	CZ	SK	CZ	SK
Regulation	X	X				
Funding	X	X		X	X	X
Organisation/planning			X	X	X	X
Monitoring		X	X			
Provision				X	X	X

Source: Authors' compilation.

that took place in the Czech Republic and Slovakia in the last twenty years looks as summarised in Table 11.1.

In both countries, a decentralisation of planning responsibilities occurred and regional and local actors became jointly responsible with the relevant ministries in the area of social services: in accordance with national social policy priorities, regions and municipalities must now elaborate plans for the development of social services and also take part in the funding of social services. But the most important change is that municipalities and regions must now provide social services by establishing suitable conditions for the development of such services and securing the resources necessary to satisfy people's needs, in addition to setting up organisations to provide social services (CAP Havlíková and Kubalčíková, 2014).

Parallel to the vertical 're-scaling' of authority, a new 'horizontal' mix of service providers (see Martinelli, Chapter 1, as well as Leibetseder et al., in this volume) is also being established in place of state monopolism. In the Czech Republic, regional governments and municipalities still provide the majority of social care services for older people (87 per cent), but non-governmental organisations and churches now account for around 10 per cent, while the share of the for-profit sector is around 3 per cent (Pfeiferová et al., 2013). In Slovakia, a slightly lower share of LTC services is provided by public bodies (75 per cent), while the share of private non-profit providers is higher (23 per cent) and for-profit providers remain at 2 per cent (CAP Kovačová et al., 2014).

In conclusion, the current state of care services for older people in the Czech Republic and Slovakia is a consequence of different restructuring processes, the roots of which are found in the early decentralisation process of the 1990s (Kazepov, 2010) and the changes in the division of responsibility among territorial levels. Subsequently, a new horizontal mix

of service providers also developed through reforms advocating pluralism of supply and 'ageing in place', especially with the accession to the EU in 2004. As will be stressed in the next section, the current system of care for older people is thus characterised, in both countries, by a mix of continuity and new principles, such as decentralisation, pluralisation and privatisation, which is subject to growing financial pressures (Österle, 2011; Barvíková and Österle, 2013).

2. NATIONAL STRATEGIES FOR THE CARE OF OLDER PEOPLE IN THE CZECH AND SLOVAK REPUBLICS

The growing concerns over the ageing of the population, along with the increasing costs of providing social services, are reflected in a number of recent policy documents approved by both the Czech and the Slovak governments.

In the case of the Czech Republic, of particular importance are the 'National report on strategies for social protection and social inclusion 2008–10' (*Národní akční plan sociálního začleňování 2008–2010*) and the 'Quality of life in old age: National programme of preparation for ageing 2008–12' (*Kvalita života ve stáří: Národní program přípravy na stárnutí*), which focus on active ageing, integration and involvement of older people in daily activities within the community, promoting the idea that older persons with care needs should remain living in their own homes ('ageing in place'). Two other key documents, 'The concept of transition from residential service to different types of social service provided to users in their home environment and promoting social integration of the user into society' (*Koncepce podpory transformace pobytových služeb v jiné typy sociálních služeb, poskytovaných v přirozené komunitě uživatele a podporující sociální začlenění uživatele do společnosti*) of 2006 and the 'Priorities of the development of social services for the period 2009–12' (*Priority rozvoje sociálních služeb pro období let 2009–2012*), contain concrete suggestions and methods for achieving these goals. The recent 'National action plan to support positive ageing for the period 2013–17' (*Národní akční plán podporující pozitivní stárnutí pro období let 2013 až 2017*) confirms the strategies of the previous documents.

A key issue highlighted in these documents is the lack of an integrated conception of LTC. There is still poor or non-existing interdepartmental cooperation between the Ministry of labour and social affairs and the Ministry of health, and health care is provided separately from social care. The same separation applies to the financing of both types of care.

In the case of Slovakia, the orientation and organisation of social services began to change after the adoption of the Act on social services in 2008. Subsequently, two documents were approved in 2011: the 'Strategy of de-institutionalisation of social services and substitute care in the Slovak Republic' (*Stratégia deinštitucionalizácie systému sociálnych služieb a náhradnej starostlivosti v Slovenskej republike*) and the 'National action plan of transition from institutional to community-based care in the system of social services for the period 2012–15' (*Národný akčný plán prechodu z inštitucionálnej na komunitnú starostlivosť v systéme sociálnych služieb na roky 2012–2015*).

The reforms recommended in these documents aimed at improving the quality of care services, creating sustainable financing mechanisms, and increasing social inclusion. All social services were to be exclusively financed from regional and local budgets. In what concerned the division of responsibilities between the two sub-national tiers of government, municipalities were in charge of providing services for senior citizens and legally obliged to provide both domiciliary care and institutional care to those in need, whereas self-governing regions were obliged to provide institutional care. In both cases, however, community-based social services were to be preferred.

Thus, in both the Czech Republic and Slovakia, as in many other European countries, there is now a strong explicit policy preference for de-institutionalisation, i.e. for domiciliary care as opposed to institutional care. This national preference is supposed to be increasingly adopted at the local level (Carrera et al., 2013).

3. THE CASE OF BLANSKO IN THE SOUTH MORAVIAN REGION OF THE CZECH REPUBLIC

The South Moravian region, with its 1.17 million inhabitants, is the fourth largest of the 14 regions of the Czech Republic. The region has seven districts and 21 municipalities with extended competences. It is one of the three regions with the oldest population in the Czech Republic. In 2014, 231 228 people aged over 65 lived in this region and it is expected that at least 16 per cent of the region's population will be over 80 in 2060, which means that the proportion of persons aged 80+ will have almost quadrupled compared to 2010. This proportion is projected to be greater in the region than in the Czech Republic as a whole and the EU-28, which implies that the demand for care and social care services in the region will increase dramatically.

De-institutionalisation in Regional and Local Care Strategies for Older People

The regional strategic documents on social services development approved by the South Moravia region for the periods 2006–09, 2010–13 and 2014–20¹ and their priorities concerning social care for older people are fully in line with national goals. They all state that the region should support non-residential (daycare centres, short-term care centres) and domiciliary services (i.e. provided at the person's place of residence). However, the strategic documents for the first two periods did not specify any indicators for measuring the fulfilment of these goals, nor the allocation of funding from the regional budget, thereby betraying that although de-institutionalisation was officially a priority, political support for its implementation was lacking. In fact, no substantive measures were established. In 2014, 13 100 people used domiciliary services in the region, compared to 5643 users in residential facilities for older people, but there were as many as 17 725 unmet applications for the latter service (MoLSA, 2014a).

The magnitude of the demand for places in residential care facilities was acknowledged in the last regional strategic document (although in many cases older people submit an application for residential services as a back-up plan in the event of future loss of self-sufficiency). The objective to further develop domiciliary care services and respite care was thus stressed again, but this time indicators were introduced to measure achievements.

Care for Older People in the Municipality of Blansko

Against this background, a qualitative case study carried out in 2009–10 on a domiciliary care service agency established by the Municipality of Blansko² helps to shed light on the gap between policy strategies and actual implementation (Kubalčíková and Havlíková, 2015). Blansko is a medium-sized town in South Moravia with a population of 20 103. Here, the desirability of promoting ageing-in-place was as apparent at the municipal as at the regional level, but with a similarly limited impact in terms of the actual development of municipal care services. From 2008 to 2012, the main priorities of the Blansko municipality, as specified in its strategic plans³ were: first, to preserve the 2008 level of domiciliary care delivery; second, to increase the number of beds in residential care (using funding from the regional and state budgets) given the great demand for this type of service; and, third, to sustain leisure and cultural activities for older people. The 'Third community plan' for social services of Blansko for the period 2013–16 seemed to underscore the change in attitude observed

at the regional level. However, the municipal plan presumed that the proposed changes concerning domiciliary care service would not require additional funding, which gives rise to doubts about the possibility of successful implementation.

The findings from the case study of domiciliary care services in Blansko, complemented by updated administrative data, indicate that the present approach to these services in the Czech Republic is rather problematic for de-institutionalisation. There are two main reasons: first, the need for a greater involvement of social workers in the provision of domiciliary care has not been recognised yet; second, domiciliary services still largely consist of the provision of 'practical' assistance, especially meals-on-wheels.

At the time of the survey (2009), the number of users in Blansko was 475, cared for by 21 frontline workers (of whom 18 were care workers and only two were actual social workers). Although the ratio of social workers to users has slightly improved over time (to approximately 154 users per social worker in 2013), their very limited number does not allow either individualised social work or care management. The type of assistance provided by the domiciliary care agency predominantly involved the delivery of meals. This became even more pronounced over time, as this service came to represent 78 per cent of interactions with users in 2013, compared to 56 per cent in 2009, to the detriment of other kinds of assistance. Although this model of domiciliary care service runs counter to trends in other countries, which involves eliminating practical help in favour of providing more personal care (Yeandle et al., 2012), the head of the service in Blansko advocated that the delivery of meals was very popular among users.

In contrast, the domiciliary care service agency only rarely provided assistance in the form of long-term supervision or monitoring of the users' health condition and life situation. In 2009, this type of support represented only 5.5 per cent and in 2013 it had shrunk to 2.5 per cent of the total range of services, despite the fact that users perceived this kind of assistance as most important and stated that without it their only alternative would be residential care.

A Preliminary Assessment

Evidence from the qualitative case study points to four main explanations for the above trends in the implementation of domiciliary care services in Blansko.

First, only tasks falling under the categories of 'practical help' and 'personal care' were prescribed as compulsory by the national Act on social services, whereas medical care (nursing) is not part of social services

provision. Therefore, domiciliary services cannot offer comprehensive care. Second, monitoring is voluntary and care management is not codified. Both are too expensive, as explicitly stated by the head of the service in Blansko; in the case of supervision, the worker's attention is devoted to a sole user for a significant period of time and the hourly fee provided by the user, as stipulated by the Social services act, does not cover the real cost of the service per hour. Third, although the provision of intensive domiciliary care is promoted in the strategic document, it has not become a real priority for the Blansko municipality. Since the municipality covers the majority of the domiciliary care budget, it also has a marked influence on the conception of domiciliary care itself. Moreover, budget constraints do not allow the domiciliary care agency to take on older people who need more intensive care. Fourth, and most importantly, the municipal implementation of the national priority of de-institutionalisation was not supported by appropriate financial transfers from the national or regional government. Although state contributions towards the funding of domiciliary care have risen over time, the direct allocation of these funds towards more intensive care is still missing.

In conclusion, domiciliary care service agencies have continued to focus on the provision of practical help with little or no care service. And yet, given their reduced self-sufficiency, older people expect more from social services than just ensuring basic practical help with household tasks, shopping or laundry. Moreover, since social care and health care are provided by different Czech agencies, these services can only be integrated within residential facilities, where the provision of complex social and health care is guaranteed by law. The current situation can, thus, be described as a major gap in care services, producing a significant degree of discomfort for older people and their families.⁴

The Development of a 'Grey' Private Market

A major fallout of the above situation is the rise of a 'grey' market of institutional care. The narrow conception and limited availability of domiciliary care, coupled with the shortage of places in registered homes for older people, have created the conditions for the growth of non-registered private institutions that accept the vulnerable older people with the highest level of care allowance.

According to the experts' comments,⁵ these 'quasi-services' for older people are primarily housing facilities, without legal registration for providing care service. Care for the residents is provided with the help of so-called 'care assistants', whom the recipients of care allowance may hire instead of relying on their own relatives. These assistants do not need to

have any training in caring or nursing and they do not even have the status of employees (CAP Kubalčíková and Havlíková, 2013; MoLSA, 2014b).

As these quasi-service structures are not registered, there are no official statistics about the number of users they serve. The experts' guess was that in the South Moravian region alone tens of these facilities existed and in the Czech Republic as a whole these facilities may constitute at least 14 per cent of all homes for older people (MoLSA, 2014b). It can be assumed that this 'grey' marketisation is likely to have a greater negative impact on the quality of provided care in the Czech Republic than 'regulated' marketisation in Germany (Bode et al., 2011), Great Britain (Ferguson and Woodward, 2009) or the United States (Harrington, 2013). At the same time, even if such facilities were surveyed, there are no instruments for evaluating the quality of the care provided and the working conditions of care workers (MoLSA, 2014b).

4. THE CASE OF KALNÁ NAD HRONOM IN SLOVAKIA

The Slovak Republic had 5.4 million inhabitants in 2012, of which 13.1 per cent were aged 65+. The old age population is relatively smaller in Slovakia than in Western European countries, but forecasts put the number of people aged 65+ at around 33 per cent by 2060 (and people 80+ around 12 per cent), indicating that Slovakia will have one of the highest economic dependency ratios in the EU (CAP Kováčová et al., 2014). This implies a huge rise in the demand for care services and a projected increase of 237 per cent in public spending in LTC by 2060, just to keep up the present level of service (Österle, 2011).

This service level is already comparatively low, since roughly 4 per cent of older people (65+) receive social care services (Rodrigues and Nies, 2013). Residential care institutions include homes for older people and specialised homes providing care services according to type of disability. They typically accommodate large numbers and provide social services over the whole year. In 2012, Slovakia had 271 homes for older people, with a total capacity of 13922 places (50 beds per facility on average), whereas about 34000 people aged 65+ were cared for by family members eligible for care allowance (which is possible in the case of severe disabilities since 2009) and only 7085 caregivers were employed by municipalities for domiciliary care services as of 2010 (CAP Kováčová et al., 2014).

The Health and Care Component of Domiciliary Services

In Slovakia, as in many other countries, domiciliary care services are subdivided into two main components: (1) health care services such as home nursing care; and (2) social care services. After a failed legislative attempt to integrate these two kinds of services, a strict division still exists in terms of financing: health care services are covered by health insurance, while social care services are financed through municipalities and self-governing regions (from general taxation) for roughly two-thirds and user co-payments for the remaining one third (Radvanský and Páleník, 2010).

Domiciliary or home nursing care is provided by 162 agencies (*Agentúra Domácej Ošetrovateľskej Starostlivosti*, hereafter ADOSs) that are free of charge after the insurance companies have assessed the individual level of disability and found the user eligible (Ležovič et al., 2007). ADOSs are part of the primary health care system and do not generally provide any home assistance in non-medical tasks, such as help with shopping, cooking or cleaning. In order to get the latter services, an older person has the choice of resorting to: (1) informal care provided by a relative; (2) paying for a private service provider (which is usually too expensive for an average retired person); or (3) applying for social care provision to the municipality responsible for providing social care (except for people with disabilities for whom the regional government is responsible).

Since it is financed at the regional and local level, the eligibility for social services provided in a home environment is assessed with a more complex procedure than health services: while disability or unfavourable health status is assessed by a medical examiner, the individual needs, family background and living conditions are assessed by a social worker employed by the municipality or regional government, based on national guidelines (Radvanský and Páleník, 2010).

Partly due to the division between medical and social care provision, the domiciliary care system in Slovakia faces several challenges. Among these are: (a) some eligible people do not receive adequate care since municipalities and other providers are not sanctioned for non-provision; (b) the assessment procedure for municipal domiciliary care may be ineffective due to regulatory overlaps and redundancy (Bode et al., 2011); (c) there are insufficient financial resources since they are mostly spent on residential care (Ležovič et al., 2007); (d) access to social services strongly varies according to local and regional policies (Genet et al., 2012); (e) funding regulations of private providers are so complicated that they can be viewed as an obstacle to competition between private and public service providers (Brichtová and Repková, 2009).

An Innovative Solution for the Integration of Services: The Case of Kalná nad Hronom

The local case study examined in Slovakia concerns the very innovative domiciliary service agency established in the Municipality of Kalná nad Hronom, a small town of 2082 inhabitants, located in the Nitra region.⁶ Here, the municipality attempted to overcome the abovementioned national shortcomings through a new type of service provider, an NGO called Help Centre Kalná, established specially for this purpose in 2014. The aim of the NGO – financed at the local level – was to provide older people in need with integrated social and medical care, without going through the established multiple eligibility determination procedures.

The main support for this new kind of service provision came from the mayor, who wanted to ensure that older people could get comprehensive quality services at their homes. In addition to already existing social care services, since June 2014 Help Centre Kalná has started to offer an extended service, called ‘family assistance’. This service can be provided to those older persons in the Kalná municipality who are not entitled to the official domiciliary care services but still need some assistance with routine household, personal and social activities. ‘Family assistance’ includes activities such as support in shopping, carrying out medical-related activities (visits to doctors or pharmacy), assistance in daily activities (farmyard, animal feeding or housekeeping), facilitating social contacts with peers, supervision in the absence of family members, assistance in contacts with authorities (social insurance, health insurance, post office), and visits to other older people in hospitals.

The pool of users is small in scale: there were 11 users at the beginning of the agency’s activities (June 2014), which more than doubled (27) in 2015, showing a successful mutual trust-building process and underlined by the fact that one more family assistant was employed with the help of a grant from the European Social Fund. At least seven volunteers, including students and mothers on maternity leave, were continuously supporting the agency’s work in service provision and monitoring. The funding has allowed the assistance to be provided in very favourable financial terms for users (in comparison to private providers): the single use of a service is charged at EUR 1 per hour, while the repeated use of a service is charged at EUR 0.50 per hour.

Another type of service offered by Help Centre Kalná since November 2014 is integrated nursing care, usually not provided at the local level, which is targeted at older people who fit the eligibility criteria determined by the current national legislation (which defines the minimum degree of dependence). It is not financed through public funds, social or health

insurance, but paid by the user (or his/her relatives), with a contribution from the municipality. The current rate is EUR 0.29 per hour, in exchange for which older people receive some practical medical assistance (such as administering of medicines, blood pressure checks, insulin injections, etc.), but also standard care services (such as help with hygiene, clothing, eating and drinking) and support in household chores (cleaning, tidying, or fixing problems with running water or heating) and social activities (driving services or support in administrative matters).

Thus, the nursing services provided by the Help Centre Kalná try to bridge the need between the nursing care provided by the health insurance system after eligibility determination and the less formal social care services. The aim is to support relatives who cannot undertake the role of informal carers and/or have an older person in the family who might be in a situation requiring care, but who is not currently eligible for state provision. With this initiative, not only were the current institutional boundaries between health and social care provision made less sharp, but also formal care gained an officially recognised role of complement to informal social care provision. In order to provide monitoring, municipal employees and volunteers in Kalná visit the older persons in their households and check their condition, listen to their wishes and needs, and provide them with information about care possibilities that would fit their individual needs. The future plan of Help centre Kalná is to provide the whole portfolio of services from basic care to rehabilitation.

The initial infrastructural and human resources investments needed for the implementation of these services at the Help centre Kalná were partly financed by the Slovak government, through a project run by the SOCIA foundation, which allowed the purchase of vehicles and the re-training of social workers. As mentioned, the project extension was also financed through the European social fund.

Replicability of the Kalná Experience

A positive restructuring of the current institutional care model of Slovakia could be envisaged if domiciliary service provisions similar to our case study were implemented in more places across the country. The Kalná experience, however, has certain specificities that explain its success but also make it difficult to replicate.

First and foremost, the municipality has a proactive leadership strongly supporting the centre's management in fulfilling their innovative ideas, while building on existing legislative opportunities. As seen in Table 11.1, certain responsibilities are divided among local, regional and national levels, which can serve as both opportunity and hindrance in implementing

new types of service provision for older people. In Kalná's case the local political, administrative and professional decision-makers could work in harmony to get the family assistance and nursing care service functioning.

Funding was also a crucial factor, because the new ideas would not become a reality without adequate financial resources. The Kalná municipality is in a better position than many of its counterparts (particularly in Eastern Slovakia) due to a steady flow of local taxes (partly stemming from the nearby nuclear plant contributing to the local budget through land leases and business taxes) but the success in finding, applying for, and effectively using 'out-of-the-box' funding opportunities such as EU or national funds is also a sign of an effective political and administrative management and an efficient interplay between them.

In sum, the replicability of such a novel de-institutionalised experience, through effective domiciliary care services for older people, is largely dependent upon the presence of proactive and motivated leaders in the municipality and a stable financing flow. However, this is not the case in the majority of Slovak municipalities. In order to make 'outliers' such as Kalná more replicable around the country, legislative changes would be needed to ensure a steady flow of financial resources to every municipality and balance out the territorial differences in tax bases. The strict division in financing of health and social care services should also be re-thought since a large part of LTC officially belongs to health care services which can only be financed at a central level. Some practical assistance to municipalities in finding the necessary funding resources (e.g. state or EU tenders) should also be considered.

5. CONCLUDING REMARKS

During the first decade of the millennium the concept of de-institutionalisation significantly influenced legislation in both the Czech Republic and Slovakia. It was introduced in the context of an ongoing administrative restructuring process based on the principles of decentralisation, pluralisation and privatisation, whereby many competences in the domain of social care for older people were transferred to lower administrative levels and to non-governmental organisations. While implicit re-scaling was prevalent in the 1990s, when the adaptation of social assistance legislation resulted in changes of the relative weight of specific LTC policies, since the accession to the EU in 2004 all national-level strategies in this area have put 'ageing in place' at the forefront, leading to a more explicit form of vertical re-scaling and horizontal re-mixing through various de-institutionalisation reform packages.

However, despite discourses and legislation, there are still relevant organisational challenges in both countries, which prevent the actual implementation of de-institutionalisation. In the first place, there still is a strict division between health care and social care provision in both countries, resulting in the fact that nursing care is not part of social services provision (in the Czech Republic) or can only be provided after cumbersome administrative procedures for eligibility determination (in Slovakia). The social care services provided to older people are then generally limited to the most elementary (practical) assistance, a fact which is also a side-effect of the vertical reorganisation of competences. Secondly, there is significant fragmentation among the various levels of government regarding funding, leading to financial means that are often insufficient at the local level. Fragmentation and legal uncertainty also result in neglecting the proper monitoring of social services provided within the framework of the new systems. Therefore, the actual outcome of the re-organisation of care provisions based on the new regulations and strategies embracing de-institutionalisation might result in an inadequate level of service provision, consisting only of practical assistance in the best cases, which runs in parallel with the decreasing number of official opportunities for institutionalised care. Moreover, since social care services are now more dependent on local funding, the services provided to older people can vary significantly among different regions and communities within regions.

In terms of policy discourse, regions and municipalities do embrace de-institutionalisation (reflected in regional and municipal strategic documents), which often translates into restrictions to the development of residential services. But, in practice, regional and local policies do not support domiciliary social services, since the financial resources that are no longer allocated to residential services are not invested in the qualitative and quantitative development of domiciliary services. Thus, despite the fact that policy priorities similar to those existing in 'older' European countries were introduced at the national level in the Czech Republic and Slovakia, the transition to a 'new' conception of care for older people has been rather slow at the local and regional level, while the lack of political will to provide the necessary funding to expand service provision indicates a convergence with the Mediterranean welfare model, rather than the Continental or Nordic ones.

In conclusion, an official de-institutionalisation strategy was adopted in both countries – including the legislative and financial decentralisation of state responsibilities to regional and local governments – as a possible solution for a rapidly ageing population and as a modernisation strategy. However, this shift was implemented without guaranteeing adequate financial resources, while at the same time the demand for care in shrinking

and understaffed residential facilities – as witnessed by the steady migration of nurses to the neighbouring Germany and Austria to provide care as personal assistants in private households – kept growing.

This has led to two ‘spontaneous’ but very distinct ‘responses’ that are well illustrated by our case studies: in one case (Blansko in the Moravia region of the Czech Republic) the development of a significant number of new private for-profit ‘grey’ residential structures, of questionable quality and with no legal accreditation, thereby with no guarantee of safeguarding the rights of older people; in the other case (Kalná in the Nitra region of Slovakia) a re-defined and innovative domiciliary care centre, in the form of an NGO supported by the municipality, which was able to overcome national legislative shortcomings.

However, while the Czech case exemplifies a rather widespread response, the Slovak one exhibits rather special features. Although the lack of funding at the local level made the emergence of market forces visible in both countries, it is still unclear whether innovative solutions such as the Help Centre of Kalná can diffuse to remedy the problems faced by other municipalities in the public provision of care for older people. Moreover, the fact that implementation of a national policy principle can lead to the exact opposite outcome than originally intended at the local level has significant policy implications. Sufficient funding and real support from policy-makers at all levels of government, as well as a prompt response to reduce the unintended impacts of the policy reforms seem thus to be vital for a successful implementation of the de-institutionalisation strategy in both countries.

NOTES

1. ‘South Moravian region development strategy 2006–2009’; ‘South Moravian region development programme 2010–13’; and ‘Strategy for the South Moravian region 2020’.
2. Evidence was gathered in 2009–10 through semi-structured interviews with representatives of the Blansko municipality, the agency’s management staff, over half of its front-line workers (11) and 17 representatives of users. Furthermore, in 2013, a Panel of experts was organised in the context of the COST Action IS1102, to update information on the case study.
3. The ‘First’, ‘Second’ and ‘Third community plans for social services of the Blansko Municipality’ covering the periods of 2008–09, 2010–12, and 2013–16.
4. This has long been subject to debate by the Panel of experts established in 2013.
5. Panel of experts established in 2013; see note 4.
6. The functioning and relevance of this novel help centre was assessed in 2014–15 through semi-structured interviews with the local stakeholders (municipal leaders, social workers and users).

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