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The Czech pathway to home-based elder care model.

Discussion of gender consequences.

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Stream: 4. Gender Equity and Social Policy

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In our presentation we address the development of eldercare in the Czech Republic from the second half of the 20th century until the present time because the development in this area has not yet been sufficiently covered in terms of:

- its institutional and non-institutional development, together with discourses of care, and
- the gender dimension of this development.

Work done on the topic after 1989 usually deals only with the current situation of the elderly and the development after 1989 at most (Veselá 2001 and 2003, Kuchařová 2002; Vidovičová and Rabušic 2003). These studies focus on the quality of life (Kopecká 2002; Lux 2002; Kuchařová 2002, Svobodová 2006), demographical aspects of aging (Rychtaříková 2006, Rychtaříková and Kuchařová 2008), the impact of social policy on the elderly (Haberlová 2003; Bareš 2006) and the impact of aging on social policy (Kučera 2002; Potůček 1999 and 2007) etc.

Because of this, we focus in this study on the historical roots of eldercare and chart the development of the organisation of eldercare during communism¹ and in the following period. We are interested in to what extent the social-policy practice of the current welfare state is influenced by the recent past (the social policy during socialism), to what extent and how it differs from it and what its intent / goal is. Finally, we ask what the impact is on gender equality, which is an issue that is often neglected in studies of this type, not only in the Czech Republic but also abroad, as Lewis (2007: 271) underlies. The issue of gender inequalities has not occupied a prominent place in academic literature on policy trends. Not enough attention is paid to the need of care over the life course and to the care work that is provided mainly by women in both the formal and informal sectors. Development of the institutional (formal) as well as informal setups of childcare from a gender perspective has been mapped in the Czech Republic to a greater extent than eldercare (Saxonberg and Sirovátka 2006, Hašková 2007, Kuchařová and Haberlová 2008).

Therefore, we ask these very concrete questions:

- (1) Could Czech families and the elderly choose among different types of care in the past and can they in the present? Or, is the right to provide care within the family equated with the family's obligation to care for its dependent members? Consequently, it is necessary to ask
- (2) what this means for the Czech families – mainly women – in the context of the persistent traditional division of work and in the context of the imbalance between work and family.

Thus, our paper concentrates on analyzing the development of the eldercare system and on discussing its gender consequences. While finding answers to these central questions, we will

¹ In the paper we use the terms communism and post-communism, keeping in mind that these are not 'scientific terms'. We use these terms to denote the period of state socialism and the subsequent period of transformation because they are used in the natural language both in Czech and English and are understandable for the wider public.

also try to identify critical moments or junctures on the path to the current eldercare model in the Czech Republic. More precisely, we will consider the most important reforms implemented before communists came to power, during the communist regime and in the post-communist era, in order to contribute to explaining the current model of eldercare and its gender consequences in the Czech Republic.

Our paper is divided into several sections. First, we address the theoretical starting points of our analysis where we build on the concept of path dependency. Nevertheless, we enrich the approach of historical institutionalism of which this concept is an integral part, with a sociological perspective (sociological institutionalism). This allows us to expand our research focus to 'everyday' practices as well as the value and normative background of these practices. Then we chart the development of eldercare in the period of communism (part 2) and post-communism (part 3); we chart the main trends in the development and major turning points. In conclusion we discuss the course of elder care development and its junctures during communism and post-communism in the Czech Republic in relation to gender equalities in elder care.

THEORETICAL STARTING POINTS FOR AN ANALYSIS OF ELDERCARE

In our analysis of eldercare in the Czech Republic we build on the concept of path dependency, a key concept of historical institutionalism (for more see e.g. Pierson 1996; Mahoney 2000; Thelen 1999). The starting premise of this approach is that history matters. In other words, this means that it is indispensable to understand present action in the context of past actions. From the perspective of a course of action (how a certain 'social system' develops) two basic approaches can be identified: one is an evolutionistic one, stressing stability, continuity of development² and operating with the term 'transformation'. The second is an approach that emphasizes possible discontinuities in development, social change and possibly progress.

We have chosen the concept of path dependency because it makes it possible to capture the development of institutions (their institutional settings) – in our case the institution of eldercare – both in the direction of (path) institutional stability or rather continuity, to be concrete, in the direction of links, interconnections of social policy measures (when existing institutional practices are reinforced and consolidated), and in the direction of 'change' where 'formative moments' or critical junctures appear (when core principles are changed) (cf. Cerami and Vanhuyse 2009: 4).

Nevertheless, we are aware that the just outlined scheme is a basic one, one that has been elaborated by many authors striving to capture in greater detail potential course of development, including potential 'subtler' mechanisms in processes of system change or transformation. For example, Thelen (2004) considers two mechanisms of institutional transformation: *institutional layering*, in which certain elements of an institution are partially renegotiated while leaving other elements in place, and *institutional conversion*, in which existing institutions are redirected to fulfil new purposes (Thelen 2004). Later Ebbinghaus (2005), Hall and Thelen (2009) outline 'path-stabilization' (in terms of marginal adaptations to environmental changes without core principles being changed). Ebbinghaus (2005) further differentiates between 'path-departure', i.e., gradual adaptation through partial renewal of institutional arrangements and limited redirection of core principles, and 'path-breaking' or 'path-cessation', i.e., an intervention that ends the self-reinforcement of an established institution and may result in the formation of a new one. However, as Cerami and Vanhuyse (2009: 4) caution, the creation of a new path can also occur through new forms of

² Some theoreticians of historical institutionalism (cf., for example Pierson 1996) state in this connection that even small choices about institutional arrangements can have great impact at the later date.

'recombinant transformation' that result in the formation of unique institutional hybrids (post-communist welfare pathways).

Even though these follow-up concepts are undoubtedly inspirational, in our analysis we will also follow other schemes and 'logics' to explain the potential development of eldercare in the Czech Republic after the Second World War. We believe that a strictly historical approach to institutional development cannot adequately account for the interplay between institutions and attitudes. We will therefore combine the historical institutional approach with a sociological institutional approach and a gender perspective.

The patterns of institutional development do not only include the formal aspects of institutional functioning (laws, rule sets and institutional interaction) but also the informal ones (the way things are generally done) because seemingly neutral institutional processes and practices are, in fact, embedded in hidden norms and values privileging certain groups and their interests over others (Kenny 2007: 95). Therefore, we consider it important to unveil both directions of development, 'layering' and 'breaking points', as well as the background of this development which is interlaced with people's everyday practices, value and normative frameworks of their action.

Apart from people's everyday practices, norms and values are also 'reflected' in discourses, in 'cultural goods' which 'present....the world to us in a specific perspective and organize our experience in well-arranged general schemes' (Marada 2003: 17). Because the rules of discourse dictate what can and what cannot be said, they delimit (or better restrict) the scope of further action (Kress 1985 in Philips 1998: 850-851); therefore, researchers' attention (not only ours) should also concentrate on this aspect in analyzing the development of social policy systems.

Focus on the above-mentioned levels will make it possible to follow, in our analysis, the mutual interlinks between the socio-historical context, discourses of care and social policy measures in eldercare in terms of their institutional setup, together with people's real behaviour in this area.

In terms of the direction of social policies, we can distinguish between the process of familiarisation and de-familiarisation. Familialistic policies in general represent such arrangements which make it possible but also demand that family members' needs be satisfied within the family. This, in other words, means reinforcement of an individual's dependence on the family in terms of care needs. De-familiarisation then does not involve only reduction in family's responsibility for care but also reduction in an individual's dependence on the family when he or she needs care (cf. McLaughlin and Glendinning 1994: 64; Leitner 2003: 358). From the perspective of "strong and weak expressions within both kinds of family policies", Leitner further distinguishes four potential, i.e., ideal types of welfare state policies in the area of care, namely: explicit familialism, implicit familialism, optional familialism and de-familialism.³

The concept of familization and re-familization is an alternative to the just outlined tendencies in the welfare state and its policies. According to Saxonberg and Sirovátka (2006: 200),

³ *De-familialism* representing a combination of strong de-familialization and weak familialization, means that care for dependent family members is ensured through the State or market provision of care services. In this model, family carers are (partly) unburdened but the family's right to care is not honoured. In the 'optional familialism' model there is also a strong tendency toward de-familialization but it is combined with strong familialization: in this model there is both state support for care facilities as well as the option to provide care in the family (there is the 'the right to time to care'). 'Implicit familialism' is the very opposite of just said. In this model there is no support from the State for formal institutional care, nor for family care. The family performs the care work because there is no alternative to this. 'Explicit familialism' supporting strong familialization with weak de-familialization is typical of its strong support for the family in its caring roles and missing alternatives to family care. A lack of state and private facilities together with support for family care reinforces care functions of the family (for more see Leitner 2003: 358-359).

familization policies are general policies that a regime pursues, while re-familisation connotes a direction. “It implies that a country that once has carried out policies which to some extent have deviated from familization policies has now moved back toward policies that encourage increased familization.” (ibid) It is this tendency that is mentioned in the case of childcare in the period of state socialism in the countries of CEE where the care policy development has been systematically studied for some time. Let us now explore the development of policies and practices of eldercare using the example of the Czech Republic.

1. Eldercare in the period of democratic Czechoslovakia: the interwar-period

The 1918-1938 interwar period can be characterised as a period of widely defined participation in eldercare with family and community care predominating. In the period of the First Republic care for elderly, dependent people with family members was ensured primarily in the family (Kotous et al. 2003: 60). The elderly without a family or with a “non-functioning” family were secured through the so-called ‘poor care’ (provided they met the criteria)⁴ which included the operation of facilities for the elderly (poor asylums, infirmary asylums and homes for seniors). Poor care was provided as an extreme solution to a situation where a poor (aged) person was not supported from other sources. Responsibility of the entities involved in this type of care was formulated as a gradient with a clear prioritisation of the family (Matoušek 2007: 23).

The public welfare system⁵ was supplemented with voluntary social care provided by non-state entities (various private associations, foundations, charities and organisations and institutions operated by churches) (Kotous 2003: 62). In this period eldercare was based on the principle of solidarity, period definition of social justice, the principle of subsidiarity (primary responsibility of a person for his or her life, followed by the family, charities, municipalities and then finally the State) and a widely defined participation of various entities in social care.

2. Eldercare after the Second World War and in the period of state socialism

Wider historical context

Until the Second World War Czechoslovakia was a democratic and one of the most developed countries in Europe (Kubat 1963), including citizen social security (Kotous 2001: 19). After the communist coup in 1948 the democratic political system was replaced with a totalitarian regime, and market economy was transformed into state-controlled economy. After 1948 the country witnessed substantial changes in its social security. The insurance system was abandoned, and new rules were adopted along the Soviet mould. Individual responsibility for care was replaced under socialism with State responsibility which stemmed from the concept of redistribution of financial and other social resources. Thus, the social insurance system was transformed into a social security system. The Czechoslovak system followed the Soviet model even if Soviet legislation developed in totally different conditions, was affected by Stalinism, by forcible collectivisation and a difficult period of industrialization (Tröster et al. 2008).

The new political regime introduced a new concept of relations between the ‘sexes’ – with the proclamation of ‘equality of the sexes’ which was to be achieved through ‘women’s

⁴ The applicant had to have a domicile in a municipality in the country’s territory, had to be incapable of sustaining himself or herself through his/her own labour, must not have had a legal entitlement to provision against other persons (such as alimony claims) (Kotous et al. 2003: 62).

⁵ The quality of public care depended on the financial possibilities of individual municipalities; nevertheless, counties or lands guaranteed these types of care. This type of facilities could have been funded from multiple sources: in addition to municipal, county and land sources also from state or private sources.

emancipation'. The officially declared ideal of the 1950s was an 'emancipated socialist' woman independent of the patriarchal family model (where the man was the sole breadwinner and a head of the household). This ideal should have been achieved through women's inclusion in the paid labour force as well as through transferring domestic work, childcare and eldercare outside the family. While the first of these goals was implemented⁶, the second was fulfilled only partially, as will become shortly obvious.

Conditions and changes in social policy between 1945 and the end of the 1950s: growing importance of the State

The social policy measures introduced after the 1948 coup partially built upon changes that occurred after the Second World War. The Košice Governmental Programme from the end of April 1945 declared changes in social policy in terms of expanding citizens' social rights, which included, apart from the social protection against unemployment and poverty, other important social rights such as the right to education, healthcare and security in old age etc. It was already this document that set the State in the post-war period as the main guarantor of social protection for those, especially, who cannot work (children, students, the infirm, the elderly). Nevertheless, the expansion of social protection and citizen security between 1945 and 1948 occurred in the conditions of plurality democracy where democratic principles precluded a more serious restriction on citizen sovereignty.

The period of 1948-1953⁷ is classified as a period of social system transformation (cf. Kalinová 1998: 130) because the whole system of norms, institutions and mechanisms of functioning in social policy changed.

The Act on National Insurance No. 99/1948 Coll., built on the Košice Governmental Programme and had the ambition to cover all social risks for the widest range of the population and ensure protection after social events with negative impact on a person's life. The universalistic intention of the previous programme of social security and social protection for all citizens was embodied in concrete measures.⁸ Nevertheless the existing corporatist model of insurance funding was changed into a 'universal' model where insurance was paid by the insured, employers and the State.

In 1951 the Ministry of Labour and Social Affairs was cancelled with the justification that in socialism there are no social problems (ibid.). Their existence (such as unemployment, poverty etc.) were only linked to capitalism.⁹ At the beginning of the 1950s the public discourse of 'social policy' disappeared to come back as late as in the 1970s after certain social problems (including the issue of eldercare) had been 'admitted' in the 1960s.

⁶ In 1948 women made up approximately 36 % of the total number of the employed; by 1985 the percentage peaked at a value 10 percentage points higher (cf. Čermáková 2000: 85).

⁷ The period after 1948 cannot be defined as a period of welfare state as the concept is linked to plurality democracies, decentralisation of State power and market economy, and not a single of these conditions was met at that time (cf. Žižková 2004, Kotous et al. 2003: 51).

⁸ It planned on providing security to employees as well as the self-employed in cases of work accidents, loss of the breadwinner and in old age (Kalinová 1998: 133).

⁹ Some former functions of the Ministry were transferred to other bodies, for example, the newly formed Ministry of Labour Forces (governmental decree no. 74/1951 Sb.) and the State Social Security Authority which covered old age and disability pensions, old people's homes etc.

3. Eldercare between 1948 and 1989

After 1948 the right of domicile and thus the care for the disadvantaged, including senior citizens in need, was transferred from municipalities to the State, which resulted in the centralisation of this type of care. Act No. 55/1956 Coll., on Social Security, had not effect on this fact although made it possible for both state “entities”/organisations but also the non-state ones such as voluntary organisations, churches and religious societies etc. to establish institutional care for the disabled, including the elderly. During the entire period of socialism the State played a central role in the organisation of eldercare because state and party bodies and institutions defined the directions of this type of care, distributed money for eldercare expenditures through the state budget to the defined areas of care according to party defined priorities, methodically governed this area, initiated research studies about the elderly etc.

Eldercare under socialism was understood widely: “... contemporary society must organise all-embracing social services for senior citizens such as services in the area of housing, food sustenance, help with domestic chores, extension of labour activity and satisfaction of cultural needs and needs of social life.” (Tomeš 1968: 234).¹⁰

Discourses of eldercare in the period of socialism

After the communist coup, and mainly in the 1950s, the family was seen as a ‘reactionary force’ and cause of all ills of modern societies, as a ‘destabilizer’ of the new regime (Marušiak 1964, Máchová 1970; Ferge 1978; Sokolowska 1978). In the vein of the critique of the bourgeois family, the idea of women’s emancipation was promoted top down and was to be achieved through women’s participation in gainful employment and their liberation from the performance of domestic chores, including care for dependent family members including the elderly. In this context, during the first decade of the new state emphasis in eldercare was placed on the provision of formal institutionalised care organised by the State.

While the 1950s operated with the *discourse of outside-family institutional care* for dependent family members, the 1960s introduced rhetoric of eldercare (and childcare –cf. Hašková and Uhde 2009) in which the family had a role to play. The family started to be seen as a ‘potential ally’ that could also play an important role in the stabilization of the recently introduced political regime (Ferge 1978, Sokolowska 1978).

In terms of eldercare the 1960s brought rhetoric where the family gained ‘its place’. The Act on the Family No. 94/1963 Coll., defined mutual alimony duties between parents and children,¹¹ which created the possibility for the State to ‘extricate’ itself from the provision of free services and direct financial subsidies to all (!) senior dependent citizens. Another legal norm (Act on the Social Security No. 101/1964 Coll.) defines the sequences of responsibilities in the life of a citizen which goes along the line from the citizen through the family to the State. The State ‘retains’ space for the provision of services and care to the ‘socially needy’ who are not able to ensure their basic living needs with their own effort or with the help of their close relatives but the discourses which considers the State as the main and most important subject of care for dependent family members (except for small children and the elderly) was gradually replaced with a *discourses* which places *the State in the position of a ‘substitute’*.

¹⁰ Apart from direct monetary benefits (such as one-off or repeated allowances for heating, housing etc.), various financial benefits were provided in the form of subsidized prices of some basic services for the population (such as discounts for transport, culture, housing, sustenance subsidy etc.) and specific services (such as care services, old people’s homes, long-term infirmary asylums and similar facilities).

¹¹ However, old people felt financially dependent on their children and in a research study from the beginning of the 1970s they, among other things, demanded that the alimony duty of adult children toward their parents be lifted (Kaufman and Schimmerlingová 1971: 132).

The State substitutes the family:

- in certain specific life situations: in the case of the elderly it enters the scene only when a person does not have a family or when close family members cannot, do not want to or are not able to provide care (which can be considered as a discourse of a 'family care deficit'),
- in a certain period / phase of life when specialised healthcare is acute – in the case of the elderly 'only when' the family does not manage specialised care ('medical discourse' of care).

The 1960s are a period which rhetorically postulated the 'sequence' of care from the family to the State, and 'attributed' to the family its specific place and function in eldercare.

In the 1970s the pressure on resolving the issue of 'aging' intensified, and the issue became a 'national' topic in relation to the 'aging of the population' and the economic problems which socialism started to show. In 1977 the "Principles of Care of Society for Elderly Citizens" were adopted through a resolution of the government of the Czechoslovak Socialist Republic which outlined a direction for developing eldercare in terms of the greatest possible 'supply' ('variability and richness') in order to delay as much as possible the necessity of institutional care for completely dependent people. In relation to the UN World Assembly on Aging and Eldercare Development the government adopted resolution No. 156/1983 titled "Main Directions of Development of Care for Old People in the Czechoslovak Socialist Republic until 1990". It appealed to 'the preparation for active senescence' and built on the idea developed in the 1970s that old people should, as long as possible, stay in their habitual domestic environment (Schimmerlingová and Novotná 1992: 14).

As some researchers, however, cautioned (Schimmerlingová and Novotná 1992: 14), "...the model of active senescence pushed out the real notion of an old person who gradually loses the ability to fulfil his or her daily tasks... and in the end relies on the help of others." It started to be reflected that the insufficient capacity of facilities and funds for their establishment and operation in the future would result in many old people staying in the care of their families or care services although they would need permanent institutional care (ibid.).

The discourse cautioning about problems related to eldercare in families, especially the 'sandwich' situation of the generation of caring children, was a reaction to the actual burden on caring families in the 1980s (Rendlová 1982: 633).

a) Development of institutional eldercare during socialism

The 1950s are (for the time being) a 'white space' on the map of eldercare because in the past nothing was officially published about it and today there are not many sources from which this period can be 'reconstructed'. Officially declared and published data on eldercare started to appear as late as 1960. Eldercare by the State was gradually divided into several segments: institutional care which was divided into social institutional care, field work and treatment-preventative care including permanent (long-term) institutional care, and family care. Eldercare fell predominantly within the remit of the Ministry of Social Affairs and partially also Healthcare.

Period publications from the years of state socialism mention the trend of the growing number of places in institutional social care facilities for the elderly, both homes for seniors and other forms of institutional care. Homes for seniors were among the oldest and most used form.¹² The number of homes for seniors increase from 308 with 29,000 places in 1960 to 322 homes for seniors with 42,000 places by 1985 (cf. Nový and Víšek 1988: 84).

¹² Old people's homes were intended for citizens who, after a permanent change in their health situation, demanded permanent care unless their health situation required treatment and nursing in an in-patient healthcare facility.

If we link the information about the number of places in homes for seniors to the number of people in the relevant age category (see Graph 3 in Appendix)¹³, we can see that during the entire period of state socialism:

- In the age category of 65 year olds and older the potential uptake of this form of care remains at approximately the same level (i.e., theoretically/hypothetically at the level of 3-4%) – in the age category of octogenarians and older this form of care was relatively the most available theoretically or hypothetically in the first half of the 1960s (when institutional care could have been provided to over 20 % of people of this age cohort provided that no other age category had used it) and since then we can see a stable decline in this purely theoretical ratio.

The data just stated, nevertheless, prove that it was increasingly less possible to provide this form of institutional care (in homes for seniors) to those in most need, i.e., ‘overmature’ people. Care for ‘overmature’ people was only partially ensured by the long-term infirmary asylums intended for ‘exceptional solutions’ of adverse health or social situations of an old person (cf. Nový and Víšek 1988: 71 et seq.). Nevertheless, the insufficiency of beds in long-term infirmary asylums was then perceived as one of the most serious problems of eldercare and care for the chronically ill in the then society. In 1984 the need for beds in long-term infirmary asylums was covered only to 65 % (ibid.).¹⁴

Since the end of the 1960s we can see development of ‘alternative’ forms of institutional social care. After 1969, when the first assisted living facilities were established¹⁵, we can see their gradual expansion.¹⁶ Furthermore, there were houses for pensioners¹⁷ intended for people with the highest degree of independence; there was a great interest in these among ‘clients’. The number of applicants for this form of care increased from 700 in 1970 to 3,000 in 1985 (Nový and Víšek 1988: 86).

There continued to be a great interest in homes for seniors. Their number, however, did not match the applications¹⁸ even though these facilities, unlike the new forms of institutional care, were often situated in completely unsuitable buildings. As late as 1987 it is stated that of 94 % of monitored buildings housing homes for seniors, almost 10 % dated to before 1700, 34 % dated to 1701-1900, and less than 25 % were built between 1901 and 1945, less than 9 % between 1946 and 1960 and only 23 % were located in buildings from the period 1961 to 1984. A large part of homes for seniors were not purpose-built buildings but buildings (often insufficiently) modified for the purposes of institutional care. As the author of the analysis stated (Wolfová 1987: 268): “From the age of the buildings, together with the large number of applicants for homes for seniors, we can glean deficiencies which appear in the accommodation of inhabitants of these facilities.” These included especially the large number of people in one room, small percentage of floor space per ‘client’, lack of hygienic facilities etc.

¹³ Because the data structure for institutional and home care clients has not been taken by age cohort but aggregately (these are aggregated data), we calculate the potential percentage of the uptake of the given care on the assumption that it was used only by the given age cohort and no other .

¹⁴ In 1984 there were 84 sanatoriums in the entire Czechoslovak Socialist Republic, with 7,552 places. (Nový and Víšek 1988: 86).

¹⁵ Assisted living facilities were defined as apartment-like dwellings where old people lived in their apartments furnished with their own furniture and other equipment. Assisted living facilities were part of the housing stock of municipalities; they were governed by the National Committee of the municipality; apartments were distributed by the Department of Housing Management after consultation and position provided by OSVZ ONV (Kasalová et al. 1988: 10-11).

¹⁶ In 1970 there were 17 in the entire Czechoslovak Socialist Republic with 329 apartments; in 1985 there were 331 with 12,733 apartments (Nový and Víšek 1988: 62).

¹⁷ In 1975 there were 7 houses for pensioners with 1,200 places; in 1985 there were 49 with 5,900 places (ibid.).

¹⁸ Which is why people submitted applications to old people’s homes or assisted living facilities in a great time advance (‘preventatively’) in order to ensure a place for themselves timely (Kasalová et al. 1988).

These deficiencies illustrate the dehumanization of the environment in which many old people at that time lived if they were placed in this type of institutional care. Together with a lack of caring staff this dehumanization of the physical environment could in many places interlace with dehumanization of care – not very ‘forthcoming’ and ‘sufficiently friendly’ attitude toward the elderly. At the end of the 1980s the highest mortality of the elderly was recorded 3 to 8 weeks after a person’s arrival in an old people’s home (Schimmerlingová and Novotná: 1992: 14). Nevertheless, it was only after 1989 that the opinion appeared that most homes for seniors were ‘dying factories’, and dying in not very dignified conditions at that (Haškovcová 1990; Kasalová and Schimmerlingová 1991).

Old women predominated among applicants and residents of old people’s home during the entire period of socialism (Kasalová 1991: 8). According to a survey carried out at the end of the 1980s homes for seniors residents most often had only sons (49 % of cases). This fact was explained in terms of the period gender conservatism, traditionally understood masculinity, femininity and gender roles, namely: men’s ‘poorer caring talent’, ‘instinctive struggle of women for the integrity of their families’ which allegedly took the form of their attempt to isolate the man from his friends and wider family and, last but not least, the fact that sons as men ‘are more oriented toward their job’ and thus ‘need to have their parents definitively cared for in a full-day care facility’. (Kasalová et al. 1988: 16)

Another form of care provided by the State was *field care service* which built on the tradition of the First Republic.¹⁹ After the transformation of this care after 1948 and again in 1952 when nursing and healthcare services of the Czechoslovak Red Cross were transferred to the department of healthcare²⁰ and when it started to exclusively focus on lone dependent people, the need increased for care services for less dependent though not necessarily lone people. In the end, in 1959, the caring service was subordinated to the methodical leadership of the State Social Security Authority, and was incorporated into the social departments within the National Committees. In 1960 the caring service was provided by county offices or municipalities²¹ to 1,871 recipients and as many as 1,895 carers were registered (!) (Splítková 1979). Still, at the end of the 1960s Tomeš (1968: 235) stated that this service was so far insufficiently developed due to a lack of labour force and was performed predominantly by voluntary carers.²² Since 1966 this care gradually professionalised although there was a parallel structure of voluntary carers especially in the Czechoslovak Red Cross (see Graph 2 in Appendix).

It is clear from the Graph 1 Coverage of population 65+ and 80+ by home care services 1966-2008 that the caring service could have been theoretically/hypothetically used relatively significantly by octogenarians and older people, which in practice could have meant that it was actually used by this age cohort. In this end, this could have meant the fulfilment of the demand that the care for old dependent people be transferred to their home environment.

¹⁹ This care dates back to 1920 when the Czechoslovak Red Cross operated services which made it possible for old people to stay in their home environment as long as possible (help with maintaining personal hygiene, domestic cleanliness, facilitation of cooking, ensuring food sustenance, ensuring shopping etc.). In 1948 the Czechoslovak Red Cross and various religious groups were appointed to organise nursing and healthcare services. In 1950 it was only the Czechoslovak Red Cross that received this appointment. (Splítková 1979)

²⁰ As an organisational unit of the then formed National Health Institutes (ústav národního zdraví, OÚNZ).

²¹ This care was provided upon a doctor’s recommendation; National Committee bodies made a decision whether the service would be provided or not. It was most often provided in cooperation with the voluntary organisation of the Red Cross (Tomeš 1968).

²² The voluntary carers could be remunerated for their work by the National Committees.

In the 1980s the caring service came to be used increasingly more compared to the past; there was far greater demand than could be satisfied.²³ This service, however, often substituted for another needed form of care. According to a survey, of 100 people to whom it was provided, 11.5 % needed to be placed in an assisted living home, 15.4 % in an old people's home and 7.7 % in long-term infirmary asylum (Nový and Víšek 1988: 60).

Nevertheless, the interest of old people in the caring service attests to the fact that a portion of the elderly realised their need of professional help in a certain phase of their lives. Most old people (76 % of respondents over 65) would, however, rely on the help of members of their family if their health condition deteriorated (Research into the Life and Needs of Old People). Under socialism family was both 'the desired carer' and 'the necessary carer'. The actual lack of institutional care facilities, the poor quality of homes for seniors together with a lack of the caring services did not create much space for people's free choice of adequate service; on the contrary, this lack created pressure on the actual provision of care within the family (especially by one's own children).

b) Development of non-institutional care (family care) during socialism

Although eldercare in families was ignored and was not thematised by the State in the 1950s, in reality it had to be provided because (among other reasons) apart from the institutional care in the 1950s and the first half of the 1960s 'home care' for the elderly was underdeveloped on the part of the State (see above).

A survey of old people over 70 living in urban areas at the beginning of the 1970s revealed that 70 % of people with a limited ability to take care of themselves received care in their family²⁴ – from their partner (or more precisely female partner), from children or other relatives (Kaufman and Schimmerlingová 1971 : 67). Later research from the 1980s, which also addressed the gender dimension of caring, confirmed that this care was provided predominantly by women – both wives caring for their dependent husbands, and daughters caring for their dependent parents (Schimmerlingová 1980; Kasalová et al. 1988). There was a significant deficit of care provided by sons because the dominant gender conservatism did not demand their involvement in care provision; on the contrary, it produces the 'discourse of understanding' of their life situation referring to the fact that they were the main breadwinners. At the same time, they were seen in this discourse as the 'weak sex' unable to assert themselves in the decision-making in the family (Možný 1990) who 'for peace in the family' – in an effort to avoid conflicts with their partners – chose not to care for their parents (see above). Both these discourses were accompanied with the discourse of 'men's incompetence' in terms of care provision. Men were perceived as incompetent or not very competent carers with a reference to their 'nature'.

Although many old people expected help from their family (see above), in old people's applications for institutional care the reason stating the family's inability to ensure care was not uncommon. According to a research "The Living Situation of Senior Citizens" from the 1980s this reason hid various aspects (of this 'inability') (cf. Kasalová et al. 1988: 16-17):

- the aspect of independence: when old people do not want to burden their children or other relatives (which is attested to by the growing autonomy between ancestors and offspring and illustrates the growing individualism in families),

²³ As many as 20 % of respondents (in an age group of 65+) from urban areas in the Czech Socialist Republic declared an interest in this service in a "Research into the Life and Needs of Old People" from the beginning of the 1980s (compared to 3% at the beginning of the 1970s).

²⁴ According to the same source, 78-86 % of the elderly living in households declared that they were capable of caring for themselves.

- the economic aspect: when old people's children work and do not receive an adequate compensation for care (which proves the understanding of care as economically 'unattractive' or 'deficit' activity)
- the health aspect: when the health condition of children is so adverse that it does not make it possible for them to provide care to their parents (which underlies the problematic nature of family eldercare in aging society)
- the social aspect: when care is problematic due to disagreements in the family as to the nature of this care (which shows that the family is not necessarily the place of 'solidarity', 'cohesion', 'self-effacing caring love' as the ideology of the 'family hearth' presupposed)
- the spatial aspect: when children live far away from their parents (which again attests to the growing autonomy between children and parents and a change in the lifestyle of families of children taking the form, among other things, of 'neo-location' of the procreation family).

While in the 1950s family eldercare was overlooked by the State, in the following decade it started to be claimed as a 'matter-of-course activity' and in the end (in the 1970s) it started to be perceived at the State level as 'caring work'. In the second half of the 1970s a facultative benefit was introduced, titled *financial contribution to care for a close person*. This benefit brought not only financial but also social appreciation of family care. The goal of the benefit was to:

- either mitigate the adverse income situation of family members who cared for an old person in the family but could not be remunerated within the caring service (i.e., it was intended for non-working children of retirement age providing care to their old parents or 'housewives' etc.),
- or ensure the basic needs of a citizen who stepped out of work in order to care for a close person.

Although we did not manage to find out to what extent and by whom this option was taken up, reactions to it suggest that it was not necessarily used widely: firstly, because it was a facultative benefit, secondly it was a 'low' benefit which, because it did not reach the salary level, was 'unattractive' in view of the necessity of having two incomes per family in the conditions of full employment²⁵ (Kasalová and Schimmerlingová 1991: 21-22).

In the 1970s and especially in the 1980s the State continued to strive to 'help' families and facilitate eldercare by introducing facilities which made it possible to combine home care with care in a collective facility – such as elderly day care centres etc. (Rendlová 1982: 634). Nevertheless, this form of care just appeared and was underdeveloped during socialism.

The actual burden on caring families in the conditions of full employment, the lack of institutional care facilities, insufficient financial compensation for care, and the growing pressure on the inclusion of the family in care, produced on the part of the care/caring (?) generation of the 1980s a discourse warning about the real problems in caring families. It builds on the 'sandwich situation' of caring women who, in consequence of providing care to their elderly parents and dependent children, face conflictual life situation producing increased stress in families of this type etc. (cf. Rendlová 1982: 633). Along the lines of women's emancipation explanations appeared that "the contemporary woman fully counts on her labour inclusion which often satisfies her more than care for dependent family members, which she could entrust to facilities built for this purpose (parallel of nurseries and homes for seniors)." (Kasalová and Schimmerlingová 1991: 21-22) Additionally, psychological demands of family care and its financial disadvantages were also acknowledged (ibid.).

A portion of the female population – especially younger women, women with higher education and qualifications – especially in the urban areas were not willing to provide care to

²⁵ We must not forget that socialism introduced the dual-breadwinner model where both incomes from gainful activity were necessary in order to ensure a family's living standard (Čermáková 1997, Maříková 2000).

their parents at the end of the 1980s 'at all cost' and found State-provided care (caring service, homes for seniors etc.) to be acceptable. And this fact cannot be changed, not even by a slogan popular under socialism that 'homes for seniors are revenge for nurseries' morally condemning collective care for dependent family members instead of providing family care.

4. Eldercare After 1989

After the Velvet Revolution in 1989 and transition to a democratic system the need for a complex revision of the social security system became obvious. Potůček characterised the development in the 1990s as follows: "As in other Central and Eastern European (CEE) countries, the economic transformation of the country was characterized by a drop in Gross Domestic Product, and double-figure inflation rates, at the beginning of the 1990s. This was followed by a moderate GDP increase in the mid-1990s and inflation rates in single figures. Privatization and restructuring of the economy has continued, followed by a sharp increase in direct foreign investment since 1999. The high unemployment rate has become the persistent feature of the development after 1997." (2004: 258) Despite the good level of security in some areas (e.g. security of families with children), the system suffered from a number of serious problems, particularly in the pension system. Primarily, the system was extremely financially demanding, complicated and was not suited for the new political, social and economic conditions (see e.g., Potůček 1999, 2004, 2007). After the revolution the government pursued an approach that combined socio-liberal and social-democratic philosophies. The '*Scenario of Social Reform*', developed and adopted by the government, became the fundamental conceptual document for reforming the social sector (Potůček 2004; see e.g., Potůček and Radičová 1998; Cerami 2009 etc.). A plan to create a universal and unified system of social welfare was adopted which would offer universal compulsory pension insurance (complemented by voluntary supplementary pension insurance for individuals or groups) (ibid). This system was accompanied by means-tested state social assistance which was available for pensioners exposed to poverty risk. The social system concentrated more on benefits preventing or at least mitigating the direct impact of the economic transformation (Sirovátka 2000) than on the development of social services (Průša 2007). The adoption of new legislation on social services was continually delayed; although as early as in 1995 a bill of law on social assistance was presented by the government, it aroused massive critique and discussion among experts (especially among social services providers) and the discussion of the bill was suspended (Průša 2007). Concerning elder care services, during the 1990s and at the beginning of 21st century the welfare system continued to strengthen home-based elder care (Kubalčíková 2005; Národní program.. 2003-2007; and Národní program... 2008-2012), as was also the case in other CEE countries (see Theobald, Kern 2009). We could observe pressures on de-institutionalisation, de-centralisation, pluralisation (of providers and financing) and (partly²⁶) professionalisation of social services. These pressures were accompanied with another pressure on a more independent and autonomous role of persons receiving care (compare to Kubalčíková 2005; Průša 2007; Koldinská 2007) and higher personal responsibility for one's own welfare (see Národní program... 2008 - 2012). The most important change was the adoption of the Social Services Act (No. 108/2006 Coll.) in force as of 1.1.2007 which tried to implement all these principles and which changed mainly the structure of social services, conditions under which they were provided and the system of financing.

²⁶ On the one hand, the pressure on quality of care pushed social services to either hire qualified workers/professional carers or educate already employed staff (see Act No. 108/2006 Coll., for sections concerning who can work in social services, quality standards). On the other hand, there was the expectation that families (informal providers) will take care of their close relatives without having any specialisation.

The family has come to play an increasingly important role in elderly care. Older people believe that their children are capable of and willing to take care of them in case they need it (Holmerová 2004). On the other hand, some segments of Czech society express the expectation that also State/society should assume some caring responsibility (see Svobodová 2006; Veselá 2002; Vidovicova, Rabušic, Mazáčová 2003). Furthermore, dependent seniors also prefer their independence (Holmerová 2004). In consequence, seniors have become accustomed to the fact that they can look for help outside their families and state institutions, though confidence in the family is more prevalent (ibid.). Nonetheless, formal institutional care services are still used most frequently when other possibilities are missing or have failed (e.g. Průša 2007; Svobodová 2006). The 2008-2012 Czech National Action Plan on Ageing (Národní program...2008-2012) describes the role of family as follows: “care is provided to elder people especially by the family, partners and children. We cannot expect, in the upcoming years, that the family will cease to play a key role in this area.” (Národní program...2008-2012: 43). Nevertheless, the document also presumes that family policy should create support measures to facilitate the caring function of informal providers and protect them (ibid.). Furthermore, the document says that care work provided by informal carers as well as professional care workers should be appreciated and respected in society. According to the gender aspects of caring, National Plan says that “support for caregivers must be gender sensitive and equitable” because the “most informal carers are older women” (Národní program... 2008-2012: 44) but further do not offer how the gender equality would be explicitly achieved. The National Plan only suggests that the state and employers should provide such conditions which facilitate reconciling work and care to enable carers to stay in the labour market what protect/secure incomes and living standards of carers (what for example including: flexible working arrangements but also flexible home care services helping families in caring tasks). Thus, we can deduce that official caring policies expect that carers/women will take care of elderly and at the same time they will participate in the formal labour market. When we take a look on the each single task which should fulfill mentioned principals/goals, we do not find any which support also men to take a part on this care work.

a) Development of residential care services and home care services

The main type of residential care services after 1989 were *retirement homes*²⁷, together with *houses for pensioners*²⁸ which were an alternative to the traditional retirement homes until 2006. The Social Services Act no longer distinguishes between retirement homes and houses for pensioners, and recognizes only the category ‘*homes for seniors*’. In homes for seniors (according to Section 49 of the Act) residential care services are provided to persons with reduced self-sufficiency, in particular because of their age and because their situation requires

²⁷ Retirement homes were intended primarily for seniors who reached the retirement age and who needed permanent and comprehensive care, and this kind of care could not be provided in their home environment with the help of family or other services. However, retirement homes did not take care of people in need of comprehensive medical treatment. Besides services provided in houses for pensioners (see below), retirement homes provided services such as: (limited or basic) health care, rehabilitation, if necessary personal care, cultural program and festivities. Uptake of these services was usually mandatory for residents, and they did not reflect the actual and specific needs of residents (Nešporová, Svobodová, Vidovičová 2008).

²⁸ This kind of service was intended for people who reached the retirement age and for people with a higher level of self-sufficiency (compared to the retirement homes). These facilities did not provide comprehensive health care and residents were able to lead relatively independent lives in appropriate conditions. There were provided with: accommodation and basic utilities and services (such as heating, electricity, water, quarterly cleaning, painting etc.). Other services were paid and clients could choose from the particular range of services offered by each house. It could be, for example, the provision of meals, regular cleaning, laundry and ironing, shopping, accompaniment on medical visits, help with administrative or business affairs, etc. (Nešporová, Svobodová, Vidovičová 2008).

regular assistance from another person. Even if the total number of places in residential care services constantly increased (see Table 1 in Appendix), the coverage of target populations 80+ slowly decreased (Graph 3 in Appendix). A possible explanation of this trend can lie in the fact that the ratio of population 80+ to the population 65+ escalated from 23.8 % in 1989 to almost 30 % in 2007 (ČSÚ 2007)²⁹. At the same time, the number of rejected applicants for institutional care in retirement homes dramatically grew between 1989 and 2008 (see Graph 4 in Appendix), and the wait period for many residential homes is very long (several years) (Holmerová 2004). The increased number of rejected applicants could document a lack of capacities in the homes for seniors. However, some scholars (Průša 2008; Holmerová 2004) point out that this indicator cannot be used in this way because seniors are aware of the long waiting lists; therefore, they often apply for a place in a residential home when they do not yet require the care of a residential home. Then, it is not so surprising that there are people among inhabitants of residential houses who do not need the care but entered the residential home according to the waiting list earlier than was necessary (Holmerová 2004) and on the other hand, seniors in need of residential care wait for a very long time (e.g. Veselá 2003). Besides the existence or non-existence of residential services, it is also important to know to what extent residential services are financially affordable for seniors. The maximum fee for publicly funded homes is given by the implementation rules of the social security legislation. We can see in Table 2 (in Appendix) that the expenditures per place increased constantly since 1999³⁰ and the share of residents' contribution toward non-investment expenditures decreased slightly between 1999 and 2006 when the share started going up, also because of new legislation (for an explanation see below). However, for real affordability of services it is more important to observe the ratio between residents' contribution and an average pension. The ratio of the contribution to an average pension was 76.9 % in 1999, 77.4 % in 2006 and then the contribution escalated to 101.6 % in 2007 and 109.7 % in 2008 (see Table 2 in Appendix). This was a consequence of a new financing model introduced in 2006. Since 2007 institutional care services (as well as home care) have been financed mainly by seniors themselves, with the so-called care allowance³¹ or with the residents' own income/pensions (see Act No. 109/2006). This is to strengthen the autonomy of seniors in terms of deciding which kinds of care they need (see e.g. Průša 2008; Kubalčíková 2005; Nešporová, Svobodová, Vidovičová 2008). The rest of the costs are covered by contributions of social services providers, subsidies from public budgets and various other sources (e.g. donations, sponsorship, own secondary economic activity, etc.) (see Act No. 109/2006). Nevertheless, an evaluation of the new model has shown that 34 % of residents in homes for seniors are not eligible for care allowance (see Průša 2008). The monthly fees are much higher than before 2007 and this could severely limit its affordability for seniors (compare to Nešporová, Svobodová, Vidovičová 2008) and especially for women whose average pension is constantly lower³². On the other hand, approximately 75 % of care allowance receivers do not bring the

²⁹ For comparison in 1920 the ratio of population 80+ to population 65+ was only 11.1% (ČSÚ 2007).

³⁰ Older data are not available.

³¹ Care allowance is part of the social assistance scheme. A person entitled to this allowance and its recipient is one who needs care. Acts of personal care are understood to mean mainly daily acts which pertain to arranging for or receiving food, personal hygiene, dressing and movement (Act No. 108/2006 Coll.).

Levels of care allowance (ibid.):

- a) CZK 2,000, in the case of light dependence,
- b) CZK 4,000, in the case of medium-heavy dependence,
- c) CZK 8,000, in the case of heavy dependence,
- d) CZK 11,000, in the case of total dependence.

³² In 2008 the average pension of men was CZK 10,715 and the average pension of women was CZK 8,784 (ČSÚ 2009).

money back to the area of social services (Průša 2008)³³. This fact can lead to existential problems of social services providers. New legislative provisions may improve the situation which will come into force on 1 January 2011 and which govern the payment of the care allowance for the elderly with the first level of self-insufficiency (MPSV 2010a). According to this new legislation, beneficiaries will get one half of the benefit in cash (CZK 1,000) and one half in-kind (CZK 1,000) (ibid.). Thus, recipients will be pushed to use registered social services. Furthermore, this scheme should aim to enforce the equal opportunity of public (including non-governmental organisations) and private providers of social services. Data on the development of various social care providers since 1989 are not available but during the 1990s we could observe extensive expansion of NGOs in the area of social services (Nešporová, Svobodová, Vidovičová 2008, Holmerová 2004). However, between the 1990s and 2006 (more precisely before Act No. 109/2006 Coll.) this sector suffered on account of the insufficient legislative framework governing the conditions under which they could operate in the area of social services. According to an analysis of the Ministry of Labour and Social Affairs we can see that in the area of our interest NGOs play quite an important role (see Table 3 in Appendix). However, analyses of grant procedures in 2007 showed that the principle of equal conditions for all providers was also breached because the level of coverage of their claims differed significantly according to their legal form (Průša 2008). Financial resources were allocated in favour of organizations established by regions (their claims were satisfied to 82.8 %) whereas private organisations reported the lowest levels of claims being met (their claims were satisfied only to 2.7 %) (ibid.).

Home care service has become an increasingly popular and widespread type of care provided to the elderly and severely disabled persons who lose full self-sufficiency and who are unable to obtain the necessary help in their family. The main objective is to enhance the clients' abilities and enable them to lead an independent life at home, to maintain contacts with their social environment and to postpone the need for institutionalisation (e.g., Nešporová, Svobodová, Vidovičová 2008 etc.). Before 2006 home care services could be provided either on a residential basis (in special assisted living facilities) or on non-residential basis. However, special assisted living facilities were not social service facilities; the flats in these facilities were rented like standard flats with rental contracts. Seniors in need lived together in one building but in their own flats and there was a home-helper continuously present there (for the whole working time/working days). Since 2007 these houses officially disappeared because they did not become part of the official structure of social services.³⁴

The popularity of the caring services is a result of the contemporary preference of care provided in the home environment for as long as possible, both by the national elderly care policy (see quotation from National plan... above) as well as by seniors themselves (Veselá 2002). The standard offer of home help services has not changed compared to previous decades³⁵. The model of home care service financing is currently similar to the residential social care service; recipients of home care service pay part of the costs by themselves either with their pensions or with the care allowance which depends on the level of their self-sufficiency. In comparison to the previous era, seniors today cannot be exempted from paying the fee for the reason of lacking financial resources. In such a situation the care allowance

³³ According to the data of the Ministry of Labour and Social Affairs, only 27.7 % of care allowance receivers indicate their intention to use at least one registered social service (MPSV 2010a).

³⁴ Information about what happened with these facilities is not available. They probably changed their legal status to homes for seniors or just in-the-field home care services.

³⁵ Home helpers offer services such as: assistance in dealing with common tasks of care for oneself (e.g., assistance with dressing, help to move to the wheel-chair or to bed), help with personal hygiene (e.g., bathing, washing hair, hair trimming, shaving), provision of food (e.g., lunch delivery, food preparation), helping to ensure the functioning of the household (e.g., cleaning, laundry, ironing, shopping) and help with maintaining social contacts (e.g., supporting and accompaniment service) (Act No. 108/2006 Coll.).

should cover at least part of the costs. After 1989 the number of recipients increased very quickly until 2003 (as Graph 5 in Appendix shows). In 2004 the number of recipients started to decrease, and we can offer only a hypothetical explanation that this happened as a result of a change in the organisation of the public sector and tendencies to decrease the expenditures on home care services (see Průša 2007). Indeed, in 2007 the number started to increase again. Anyway, in the era of ageing society, we have to see not only the overall number of recipients, but what is more important for availability of the service is the potential possibility for older people to use such service. The coverage of the target population can bring at least part of such information. Graph 1 (in Appendix) shows that currently approximately 30 % to 40 % of seniors in the age of 80+ could use this service but in the category of 65+ it is only around 10%.

According to the already mentioned analysis of grant procedures, we can say that home care services received only 31 % of the claimed financial resources in 2007 (Průša 2008). This lack of financial resources could be covered by the care allowance but around 82 % of recipients of home care services are not entitled to this benefit. However, home care service seems to be financially affordable to seniors (compare to Nešporová, Svobodová, Vidovičová 2008) – the ratio of an average receiver's contribution to an average pension was only 4.1% in 2007 (for comparison in 1991 it was 0.4% (MPSV 2008, own calculation)). On average, home care service is provided to 7.09 % of seniors up to the age of 65 (Průša 2008b). Some authors point out that the geographical availability of home care service greatly differs by region/districts (the lowest availability in the population of 65+ is in the Liberec region and the highest availability is in the Central Bohemia region) (Průša 2008a) and by the size of the municipality as big cities or villages do not have enough (mainly financial) resources to provide home care service even in the close localities and small ones are not willing to participate in the quite high expenditures related to providing home care services (Veselá 2003). Furthermore, Veselá (2003) shows in her research that a large distance of senior's residence from the headquarters of the home care service as well as a solitary request for home care in a given municipality are one of the most frequent reasons for refusing the service by a home care provider. Unfortunately, we cannot find more detailed statistics which could show the structure and extent of particular services. For example, do clients receive just lunch or also other services like hygienic care, cleaning and ironing or do home helpers accompany seniors to see the doctor? With regard to research by Veselá (2003), some of the most missing services include day-long care and simple health care; these services are especially wanting if a senior becomes dependent to a degree of requiring residential care but has to wait to enter. On the other hand, since 2006, when the range of social services was expanded, seniors can use other services like personal assistance³⁶ or a day care centre and a week care centre³⁷.

The condition that changed dramatically was the number and structure of home care workers. Although the number of recipients of home care services almost constantly increased since 1989, the number of home helpers showed decreasing tendencies. Between 1989 and 2007 one half of home helpers disappeared from this service (ČSÚ Statistical Yearbooks...; in 1989 there were 8,107 home-helpers and in 2007 only 4,114 workers – see Graph 2 in

³⁶ Personal assistance is intended “for people whose capabilities are limited because of disabilities, age or illness for example in the area of personal care, use of public places, household care, contact with family and wider society. The service is provided in the environment where an individual lives, works, etc. Personal assistance services include reading, interpreting and guiding services. The client contributes to funding the service.” (MPSV 2010b).

³⁷ Day care centres and week care centres are intended “for people whose capabilities are limited, particularly in the area of personal care and household care and who cannot live at home on a daily basis without someone else's assistance. Providing temporary housing may be part of the service. The client contributes to funding the service” (MPSV 2010b).

Appendix). When we take a look at Graph 2 (in Appendix), it is obvious that this fall is mostly made up by volunteers.

During most of the communist period volunteers were quite a large part of home care workers but this trend started to change in 1989 when the number of volunteers dropped. Since 1989 almost 95 % of volunteers left social services or maybe their working status changed to the employment status because the number of professional care workers slowly increased. As a result, the ratio between home helpers and recipients rapidly and negatively changed for service receivers. While at the beginning of the 1990s one home helper took care of approximately 8 clients, in 2002 (when the curve culminated) this ratio was 1 home helper per 29 clients (see Graph 6 in Appendix). Today, the trend seems to have become more client-friendly and there are fewer clients per home helper (in 2007 it was 23.9 clients per home helper).

In our opinion, the contemporary arrangement of formal institutional care definitely strengthens the home-based care model. Availability of residential care is increasingly financially demanding and applicants cannot be sure that they will receive care allowance as an additional source for covering the increasing costs/fees of residential social services. On the other hand, some recipients of the care allowance do not transfer the benefit back to the social services system and take the allowance as a means of increasing their living standard; this practice can strongly limit further development of (mainly) residential social services as well as (partly) home-care services. This could prove fatal for residential social services in conjunction with the general pressure on cutting back public spending. Home care services would be an ideal model of providing the necessary care (with respect to the wish of seniors to stay at home as long as possible and also to the official position of policy-makers) but the number of home-care workers has been continuously decreasing and the ratio between receivers and providers of home care service has been adverse for the receivers and the quality of care alike. Other problems include: geographically differentiated availability of home-care and the real extent of care. The remaining question is who will take care of seniors who cannot or do not want to use formal institutional care arrangements? The logical answer is that family members have to provide this lacking care. We can say that all the above-mentioned trends shift elderly care policies toward the familialistic (re-familialistic) regime of the welfare state. In order to make a decision which of the different types of familialism according to the Leitner's (2003) typology is in play, we have to explore the extent of support for these informal carers, which is main aim of subsequent section.

b) Development of support for families caring for their dependent seniors

Between 1989 and 2006 support for informal carers was provided through a care allowance paid to the caregiver or through a pension supplement in case of a person's lowered level of self-sufficiency (Niederle 1996, Hacaperková, Niederle 2000). The *care allowance* was provided from the social assistance scheme (ibid.). Until 1995 the amount of the benefit was defined directly by the law; between 1996 and 2006 the amount was derived from the multiples of the living minimum: a) a caregiver taking care for one person received 1.6 multiple of the appropriate living minimum; b) a caregiver providing care for 2 and more persons received 2.75 multiples of the appropriate living minimum (Niederle 1996). Shortly before the so-called Velvet Revolution, in 1988, the care allowance started to reflect the number of people to whom care was provided. When care was provided to 2 and more persons, the care allowance was higher. In 1991 the care allowance was changed from being a facultative benefit to being a universal benefit; to calculate the benefit, it was ascertained who had the alimentary obligation toward the caregivers (Act No. 482/1991 Coll.). During one year (in 1993) the care allowance could be awarded only if the property of a person receiving care was not sufficient to cover the services (Niederle 1996). This rule was abolished already in

1993 (with effect from 1994) due to the protests of the public; furthermore, means-testing of the person receiving care was excluded from the calculation formula (ibid.). However, the income of care allowance recipient was still means-tested. Since 1997 the amount of the benefit derived from the difference between the recipient's income and 1.6 multiple of living minimum. If a caregiver was entitled to some kind of a pension (widow's, widower's or disability pension), he/she could not receive this allowance (until 2005 when the parallel payments of widow's / widower's pension and care allowance was allowed (MPSV 2005a)). In order to qualify for the care allowance, it was also important that the care be provided duly, all day, and be personal (Section 80 of Act on Social Security No. 100/1988 Coll.). Before 2000 the condition of all-day, personal and due care was not satisfied if a person receiving care used some social service facilities or if the care was provided by someone else instead of the care allowance recipient (Hacaperková, Niederle 2000). Thus, this arrangement almost made participation in the labour market impossible (perhaps with the exception of some kind of home-work). There were problems mainly if a senior needed short hospitalisation (see Hacaperková, Niederle 2000). Since 2002 care allowance recipients were allowed to have income from paid work but the net income must not have exceeded 1,5 multiple of the living minimum (Act No. 100/1988 Coll., as amended). The allowance level increased over time and the last significant change came shortly before its definitive abolition. In 2005 the care allowance was approximately 37 % of current average net income if a caregiver took care for one person and more than 63% when care was provided to 2 disabled persons (ČSÚ 2009, own calculation).

Supplement to the pension in case of lowered level of self-sufficiency was part of the social insurance scheme and the entitled person was a pensioner with a lowered level of self-sufficiency (Niederle 1996). The main aim of this benefit was to help to cover the costs of social services which a senior could not provide by himself or herself. The supplement was derived from the level of insufficiency (higher level of self-insufficiency meant higher level of supplement) and the amount of the supplement was tied to the living minimum as well as the care allowance. The main problem was that this supplement was often understood only as a supplement to the classic pension and not as an allowance to cover the needed services (Niederle 1996).

We can conclude for the period 1989-2006 that support was divided among persons who needed care and persons who received care. The way the care allowance was set up indicated that this benefit was not meant as an award for taking care (or a substitute for a wage from paid work). The main purpose of the care allowance was not even to cover all the living costs of the caregivers but only to contribute to them (see Niederle 1996). Furthermore, since 2000 we can see increasing tendencies to expect caregivers to participate in the labour market in order for them to improve their financial situation; this tendency culminated with the last change of the legislative framework in 2007 when the provision of the care allowance changed dramatically.

We have already mentioned that in 2006 a new Act on Social Services was passed, which abolished both the care allowance for caregivers and the pension supplement in the event of a lowered level of self-sufficiency for seniors. Currently, the new care allowance can be provided to a person in need of care and he/she can quite autonomously decide what kind of care she/he wants to use to cover his/her need. Beside the already mentioned problems with the new care allowance in the institutional form of care (see above), we can also identify some limitation or burdens in the informal care, with consequences for informal caregivers. According to an analysis of the provision of social services carried by the Ministry of Labour and Social Affairs in 2010, we can see that almost 53 % of care allowance applicants write in their forms that the so-called close person will be the only caregiver (or in 9.5 % a combination of one registered social service and an individual person) (MPSV 2010a). In

such a case, the care allowance recipient should pay this close person for the care provided using the care allowance, according to the Act. The State relies on an informal and non-complicated settlement of care financing between the elderly and their relatives. However, can we really expect that mothers or fathers will pay their children for caring activities? We should rather expect no, mainly because the traditional Czech society agrees with the opinion that children are responsible for their elderly and/or disabled parents (see Svobodová 2006; Veselá 2002 etc.). Another reason to doubt this presumption could stem from the fact (which has been confirmed by research studies) that seniors usually perceive this type of benefit more as a supplement increasing their living standard than as a special benefit with a specified 'caring purpose' (see above, Průša 2008, Niederle 1996). So, in comparison to the past, the legislation/the State do not provide even a low level of financial security for informal carers. We can say that caregivers are not limited in the participation in the labour market but in this case, the right equated the necessity. At the same time, for children of seniors 60+ (66 % of daughters and 77 % of sons) the limitation or risk of losing their paid work could be the most important reason for giving up providing personal care for their dependent parents (Veselá 2002). Among other reasons or insecurities leading children to ensure elderly care through formal care services is the insecurity related to providing competent and professional care and the time-consuming nature of care (ibid.). On other hand, for facilitating care at home by informal providers, policy-makers also introduce variations of the so-called supportive services as day and week care centres for elderly, respite care centres, social counselling etc. (see MPSV 2010b). The question is if they are sufficiently available in all regions of the Czech Republic, an issue that has not been yet explored. However, the overall number of these facilities seems to be quite low and strongly differentiated across the regions³⁸. This tendency could in effect worsen the well-known phenomenon of the double burden affecting caregivers, more precisely women (similar to childcare and the gendered division of domestic work – see below).

We will now concentrate in greater detail on the gender perspective of elderly care provided on the informal basis in order to explore who is affected more seriously with the above-mentioned problems and how they could be interconnected with the broader context of the role of men and women in society. Although we do not have new valid data on the structure of caregivers, we can assume that the structure and behaviour of caregivers could not have changed much in since the beginning of the 21st century. Before 2007 more than 80 % of care for dependent seniors in the Czech Republic was provided by the family (MPSV 2005b). This corresponds with the preferences of 80 % of children who want to provide needed care in their home environment (Veselá 2002, compare to Nešporová, Svobodová, Vidovičová 2008). More than 50 % of them would like to provide care by themselves with the help of their siblings (ibid). 27 % of children (more daughters (57 %) than sons (42 %)) would ensure care for their parents through home care service or similar services (ibid). On the other hand, 38 % of Czech men and women think that elderly care should be shared by the family and the State equally (Nešporová, Svobodová, Vidovičová 2008). The average length of this type of care provided by family members was from 4 to 5 years (Holmerová 2004). Those who do most of the care work are predominantly women (64 % women compared to 36 % men), 80 % of whom are at the same time employed (Svobodová 2006). Přidalová (2006) adds that employed and unemployed women almost do not differ in terms of providing care for their dependent parents. The difference is that employed women use formal services more

³⁸ **Respite care services** – in 2008 there were overall 1520 beds which were used by 7098 clients; the highest number of the beds had Prague (517 beds) and the lowest number of beds were in regions of Plzen (4 beds) or Olomouc (6 beds) (MPSV 2010).

Week care centres – there are 968 beds but only 915 clients; in Central Bohemia region there were 233 beds but in Karlovarsky region only 15 beds in 2008 (MPSV 2010).

and include other relatives in ensuring at least part of care. Care for dependent elderly is often ensured by children (53 %), spouses (21 %), other relatives (10 %) and friends (16 %) (Holmerová 2004). Thus, this means that the consequences of care arrangements or policies concern mainly women and partly men, as Přidalová (2006) pointed out. The traditionally perceived role of women as caregivers is so strongly internalised that it lives its own life almost irrespective of individual variations in attitudes, access to employment or time availability (Přidalová 2006). Women and men do not differ in the perception of commitment toward their elder parents and strongly agree with the moral norm that adult children should take care of their parents (Veselá 2002; Přidalová, 2006; Nešporová, Svobodová, Vidovičová 2008 etc.). However, some authors point out that the injunction to care is experienced differently by men and women (Sevenhuisen 1998 and Tronto 1993 quoted by Lewis 2007). Lewis adds that “women’s reputation as carers is often important to them, because caring for one’s children or one’s elderly parents is often felt to be a duty” (2007: 280). According to stereotypes concerning the male and female role, men and women can have different ideas about the way care should be provided. Men more often than women plan to use formal services (including residential services) as a substitute for their direct care (Přidalová 2006, Veselá 2002). Surprisingly, the Czech research Family Work Division 2001 (Dělba práce v domácnosti 2001) came to the conclusion that elderly care is shared equally by men and women in 50% of families. Přidalová (2006), however, objects that, according to research findings (Přidalová 2006 quotes: Horowitz 1985, Montgomery, Kamo 1989; Matthews 1995; Gerstel, Gallagher 2001) women and men do not differ in the participation in the so-called ‘male’ or ‘neutral’ work (like transport to the doctor, home maintenance, garden, administration of finances etc.) but men participate less in the so-called ‘female’ work (like personal care, hygiene or cooking) (compare to Kuchařová et al. 2006).

Thus, what is the message of such a policy to informal carers – mostly women – within families? We can summarise that the current policy presumes that families will take the main part of care for their dependent elders for as long as possible. At the same time they also presume that caregivers will participate in the labour market because the financial support for caregivers appears to be less secure. Consequently, carer support increasingly shifts toward services provided in the home environment, which allows these family carers to have gainful employment; however, these services are unlikely to be available and affordable to all families across all the Czech regions. In terms of the different varieties of familialism, we can say that care policies tend to the optional familialism - mainly in the perspective of seniors (they can autonomously decide whether they prefer to receive care in their home environment - by family or by home care services - or in residential care; intention of policy-makers to develop the services/facilities for informal caregivers). However, the freedom of choice can be limited in some families or situations (formal care services seem to be available/affordable only for selected groups; financial security of informal caregivers is not guaranteed).

CONCLUSION

Evaluating developments and shifts in the eldercare system during communism and post-communism is not a 'clear-cut' and unproblematic matter. There is also necessary to distinguish between the intention with which individual institutions were established and their subsequent actual functions and development, and last but not least, their impact/influence on everyday practices (actions-practices) of ordinary people.

The eldercare system was set up newly at the beginning of socialism, differently compared to the period before the Second World War. Instead of family care and 'domicile community' it introduced the primary responsibility of the State for eldercare in an effort to lift the burden of caring activities from the family, or better working women (at least in its intention) so that they could concentrate on working in the public sector of the national economy.

The principle of eldercare provision shifted from 'exclusivity/exceptionality' to universalism (the system was conceptualised for 'everyone') and unification (i.e., moreover 'for everyone equally'). This was to ensure provision of care and social security in old age without special social benefits or conversely disadvantages for any class or group of the population.

The first period after the 1948 coup can be classified as a period of de-familialisation or a phase of de-familialism in eldercare because care was to be shifted from the family to the State. However, the actual lack of places in institutional care facilities and the totally insufficient coverage of non-residential care services by the State at that time did not actually reduce the caring role of the family although it was rhetorically overlooked and neglected.

The 1960s brought a 'family turn' both on the discursive level and in the institutional setup. Mutual alimentary duty between children and parents was instituted, and children became obligated to provide care to their parents. This shift could be interpreted as a suggestion of re-familialisation, which further intensified in the 1970s when a facultative monetary benefit was introduced (close person care allowance). However, the introduction of this measure did not bring a 'turning point' - 'juncture' in the provision of eldercare in the sense that families would start to provide more care to seniors, which was something that the discourse appealing to the elderly to stay in their home environment for as long as possible counted on to a certain extent. The 1960s together with the 1970s, however, introduced implicit familialism. Although State-provided care was affordable for people/families, there continued to be a lack of capacities in these facilities together and the alternatives supported families in caring were missing or insufficient. In effect, this 'forced' families to provide primary care for elderly citizens.

The intentions embedded in the state measures in eldercare, however, did not always meet the attitudes of the population and did not always take the same 'direction'. In the 1960s criticisms started to be voiced by lay public and partially also by experts who cautioned about the shortcomings in institutional form of eldercare, in the 1980s the problem of sandwich generation is addressed in expert discourse. This discourse makes clear that care was not 'attractive' for the younger and more educated generations of women and turned into 'unwillingness' on their part to provide care at all cost. We can say that socialism created a mental space in some segments of the population to shift care from the family to formal care institutions. Actually, however, due to the continued lack of care facilities and professional care services provided in the home environment, there was not much space for people to make free choices. Thus, in many cases, the family may have been a wanted and desired carer for old people but it was certainly a 'necessary' carer due to a lack of other alternatives.

When studying the gender dimension of eldercare, women predominated both among care recipients and providers. Although socialism flaunted the idea of the equality of the sexes, it was unable to eliminate the gendered nature of care for dependent family members, did not place any demands on men to provide care and did not create proactively any measures to

reduce gender inequality in care provision. On the contrary, by neglecting this issue and postulating care as being women's nature and as unnatural for men and men unable to care, it reproduced and reinforced the stereotype of women's caring. During the entire period of socialism women were a reservoir of cheap labour force: whether it was initially completely unpaid care in women's own families (wives, daughters or daughters in law) or unpaid or only symbolically remunerated voluntary care 'for people from around / from the neighbourhood' and last but not least professional care which was not paid much even back then. In eldercare socialism not only prolonged and reinforced the gendered nature of care but due to the double burden placed on women it increased gender inequality in society as a result of care for dependent family members.

After the 1989 Velvet Revolution the tendency to increase family's responsibility for providing care to its dependent members continued and was reinforced. Building on discourses about aging population and appropriate, dignified provision of quality eldercare, Czech society reached consensus in terms of the principles of this care where stress is placed on de-institutionalisation, de-centralisation, professionalisation and pluralisation of care providers together with strengthening the autonomy of seniors in making decisions about the desired types of care.

Although the total capacity of institutional facilities and caring services gradually increased, the number of seniors in need also grew, especially in the age category 80+. Thus, the actual possibility to place seniors in these residential care facilities fell down. Caring service which is a very popular means of ensuring care in the home environment is taking on more and more clients but due to the systematic reduction in the available work force, the ratio of clients to caring service staff has dramatically worsened. This, among other things, can result in worsening quality or range of services provided.

Insufficiencies in eldercare should thus be covered by the family which is explicitly stated to be primarily responsible for eldercare. Care in residential facilities should come only when the old person's self-sufficiency is greatly aggravated.

Compared to the past, the way of supporting families ensuring caring duties radically changed. First, at the beginning of the 1990s the nature of until then facultative care allowance changed into a universal benefit. Compared to the previous regime, this increased carers' chances of receiving this benefit for providing eldercare. Nevertheless, the benefit continued to only contribute to covering carers' basic living needs and was not made 'financially equal' to paid work.

Since 2006, in relation to the implementation of a new model of social service financing, the care allowance setup changed significantly. The care allowance is no longer paid out to the person providing care but person receiving care who can autonomously decide which type of care they will receive / 'buy'. Apart from the unquestionably positive effect of this change on the role of seniors (expansion of their choices) in the given system, this step has serious impact on those who provide care. Most seniors (53 %) choose their family as the only care provider and care is thus usually provided by a daughter or daughter-in-law and thus the money is not returned to the formal system of social services.

Furthermore, the state reduced the volume of funds that are allocated directly to care providers arguing that additional financing will be gotten from clients according to their will through the above-mentioned care allowance. The seniors' behaviour just outlined is thus likely to contribute to endangering the development of professional services, which will further limit their quality as well as their general affordability. The average service fee for institutional care has increased significantly since 2007 to reach more than 100 % of the average pension, which endangers service users who are not entitled to the care allowance or receive a reduced amount of the allowance.

As for informal care providers, we believe that their financial security in relation to eldercare may be hugely reduced, as it is fairly 'risky' to presume that seniors will pay their children/daughters/daughters-in-law for care, especially when many seniors see the care allowance more as a contribution to their pension than a means to pay for care in the event of their self-insufficiency and also because they do not have to be (very) willing to pay for care provided by their children/daughters because in line with the tradition they take it for granted. It is this presumption which has to be verified through empirical research.

The change in the allowance recipient has also meant that potential extra earnings of the carer on the formal labour market are no longer restricted (formerly, if carers were to maintain their entitlement to the care allowance, they were allowed to earn up to 1.5 multiple of the living minimum). However, in this case the right is more of a necessity, especially due to the growing pressure on all adult family members to ensure means to cover their current and future subsistence through paid work. However, this trend does not seem to be in contradiction with the intentions of policy makers who in relation to eldercare in the family stress the necessity to ensure such conditions for carers that will make it possible for them to combine paid work and care. The problem, however, is that for example flexible work regimes that help to facilitate the combination of these two spheres are generally of poorer quality and thus are also wages. This further aggravates gender inequalities during the entire life cycle of carers: women/carers may thus first accept poorer quality work in order to combine work and childcare, somewhat later to combine work and care for their parents, which is later reflected in their lower pensions and in the end in their poorer ability to ensure proper eldercare for themselves.

Instead of benefits, the State is trying to offer support services for primary carers (understand female carers) to facilitate the combination of work and care but those are not available to all. This approach, however, has, in our opinion, the potential of significantly worsening the double burden on women far more efficiently than the previous regime. Although the attitudes of policy-makers show that they are aware of the continued gender inequalities in eldercare, they do not offer any measures to support directly men in their inclusion in care. Women's attitudes to care commitments show a permanent and quite strong intensity and it is a question how their reactions will develop to these often contradictory pressures.

Development of eldercare institutions thus suggests that the family is becoming a more wanted, more necessary and more expected source of primary eldercare in a situation when care-givers' support is for many reasons becoming inadequate. If we were to briefly summarise the development of eldercare in the Czech Republic since the Second World War, it went from a phase of de-familialization through implicit and explicit familialism to the current optional familialism, and we can identify several junctures in this development.

In the period of communism the juncture lies the change of the system itself, including a change in the way the social policy system was set up (which changed to social security system). Stress was placed on universalism and unification (along the line: "for everyone to everyone equally") with paternalist State being the main care guarantor and organiser. Another juncture or rather 'juncture period' came with the 1960s and its family turn when family was re-defined as the co-care-giver / co-provider of care and along with these changes other changes occurred as well (i.e., development of home care, introduction of a facultative benefit for caring for a close person). Nevertheless, the impact of these measures did not come through as an 'impetuous' change / 'drastic' turn; it did not result in a dramatic/significant decrease in the number of institutional care clients or in an increase in family care. Rather, it involved a gradual decrease and gradual increase in the given segment respectively. After 1989 the change in the care system was linked again to the wider social change where the basic principles of the system were re-defined. The emphasis is still on home care where family plays a key role; at the same time, stress is put on seniors being able

to choose a concrete type of care they want. The main juncture is represented by the adoption of the 2006 Act on Social Services which reinforced/stabilised as a core principle, the primary responsibility of the family for caring for dependent family members and personal responsibility of each person for their own welfare. The introduction of the care allowance in the Act makes it theoretically possible for people to choose but due to the great financial costs of quality institutional care this type of care has actually become unaffordable for many senior citizens. Likewise, in the case of care services not all needed services can be delivered to clients in some locations. Seniors thus still depend on either direct provision of care by their children or financially subsidising residential institutional care.

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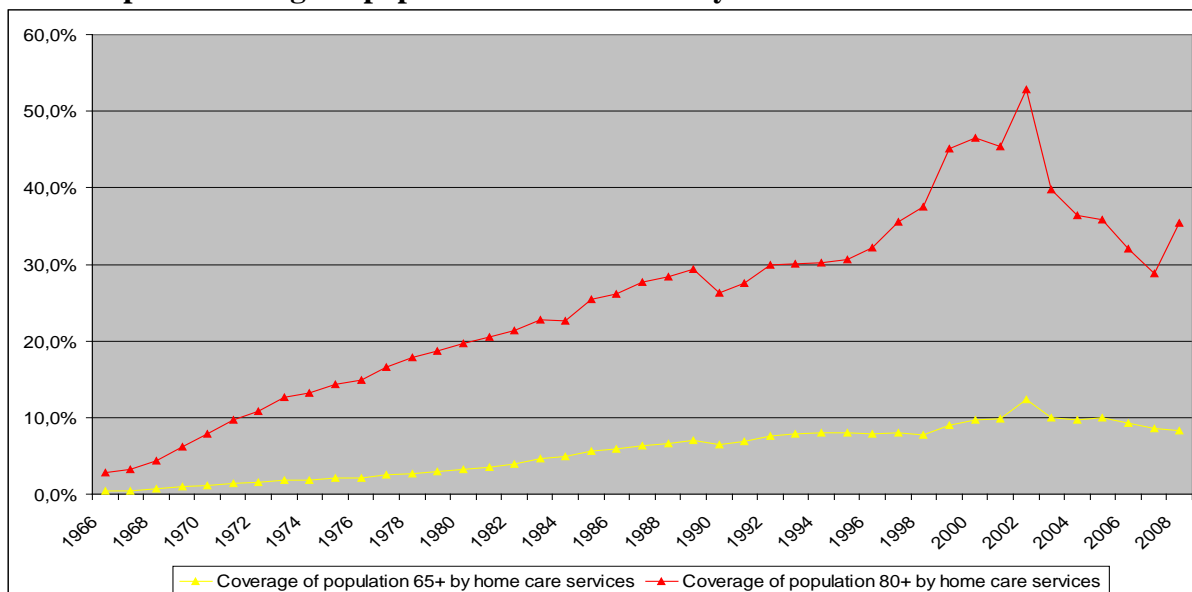
Act ČNR č.482/1991 Coll., on Social Needs

Act No. 108/2006 Coll., on Social Services

All legislative sources are available from <http://aplikace.mvcr.cz/archiv2008/sbirka/>

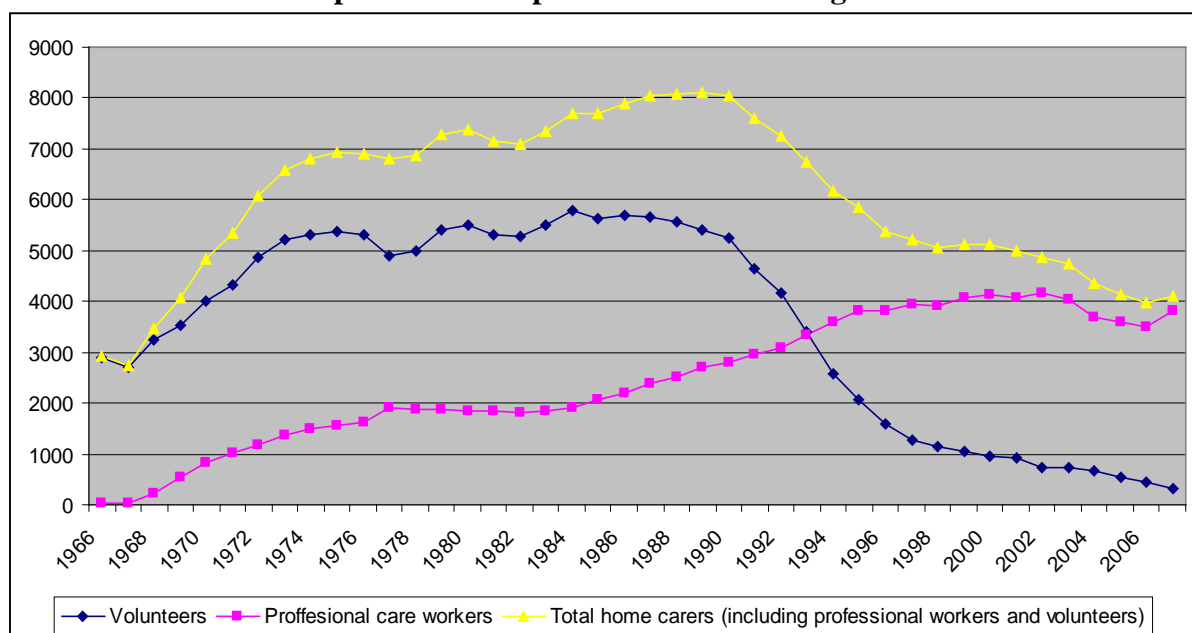
APPENDIX

Graph 1 Coverage of population 65+ and 80+ by home care services 1966–2008



Sources: Historická statistická ročenka ČSSR, 1985; ČSÚ 2007, ČSÚ 2008.

Graph 2 Home helpers and their working status



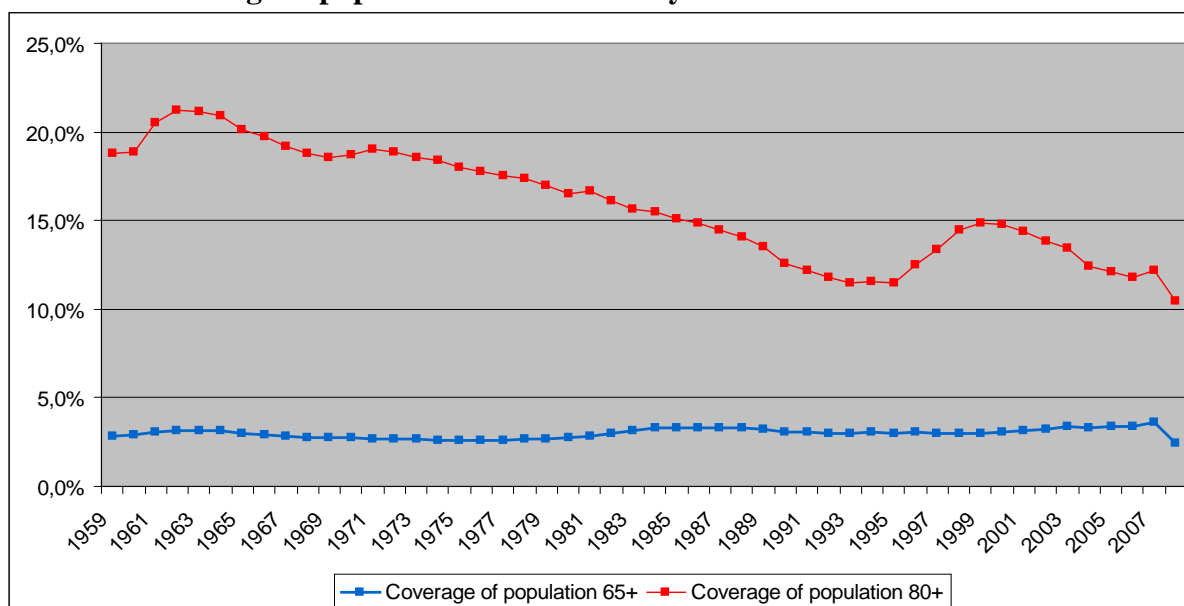
Source: Historická statistická ročenka ČSSR, ČSÚ Statistical Yearbooks ČSSR, CSFR, CR (1986 – 2008), own calculation.

Table 1 Numbers of places in retirement homes and houses for pensioners

	Places in retirement homes	Places in houses for pensioners
1989	33,449	5,622
1990	32,110	5,432
1991	31,915	5,903
1992	31,669	6,130
1993	31,719	7,291
1994	32,798	10,159
1995	32,305	11,549
1996	33,779	11,969
1997	34,248	12,547
1998	34,931	12,593
1999	35,182	12,131
2000	36,163	12,129
2001	36,230	12,432
2002	37,258	12,370
2003	38,196	11,487
2004	37,319	11,894
2005	38,023	11,701
2006	38,672	11,428
	Places in homes for seniors	
2007	41,618	
2008	37,854	

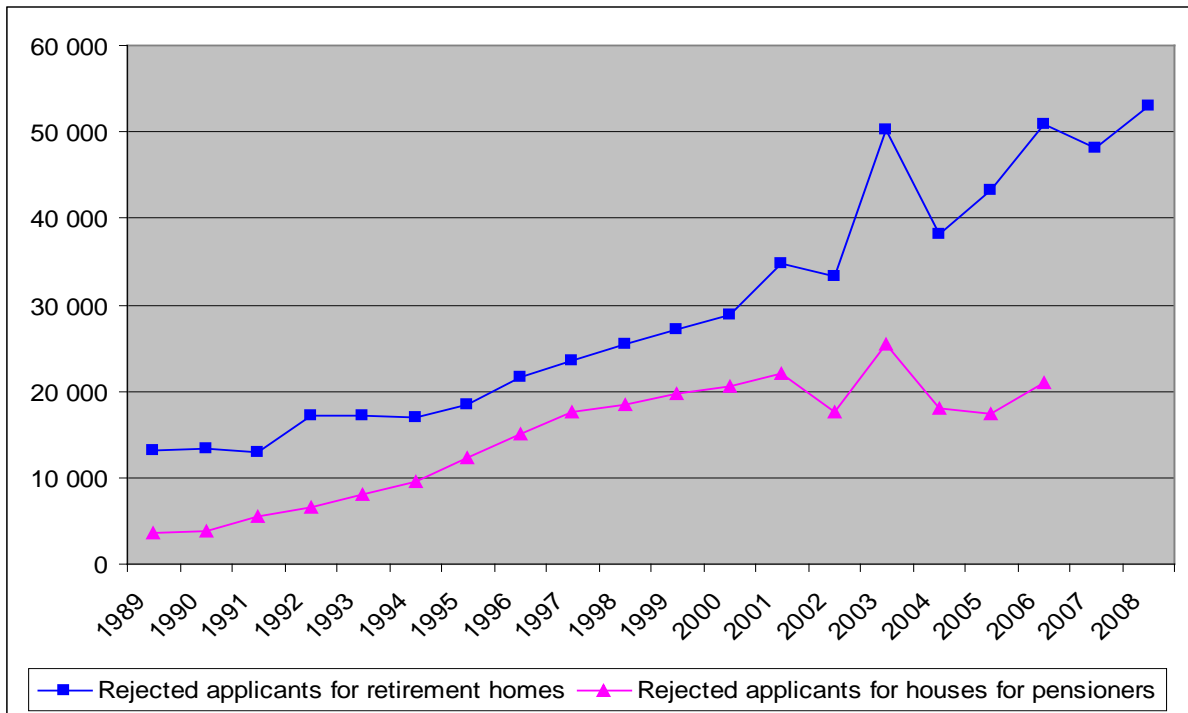
Source: MPSV 2008

Graf 3 Coverage of population 65+ and 80+ by residential care services 1959-2008



Sources: Historická statistická ročenka ČSSR, 1985; ČSÚ 2007, ČSÚ 2008.

Graf 4 Rejected applicants for residential care services



Source: ČSÚ 2009.

Table 2 Costs of Social Services and Residents' Contributions

Year	Retirement homes ¹⁾			Houses for pensioners ¹⁾			Relation of residents' contribution and average income ²⁾		Relation of residents' contribution and average pension ²⁾	
	Average non-investment expenditures per 1 place a year (CZK)	Average contribution of a resident per year (CZK)	Share of residents' contribution on non-investment expenditure □ per 1 place	Average non-investment expenditures per 1 place a year (CZK)	Average contribution of a resident per year (CZK)	Share of residents' contribution on non-investment expenditure □ per 1 place	Average income - net	Share of average residents' contribution on average income	Average pension	Share of average residents' contribution on average pension
1999	131,693	52,831	40.12 %	44,893	17,193	38.30 %	120,396	43.88 %	68,688	76.91 %
2000	136,823	55,427	40.51 %	45,782	17,531	38.36 %	163,368	33.93 %	71,544	77.47 %
2001	152,738	60,362	39.52 %	50,533	19,388	38.37 %	177,516	34.00 %	76,224	79.19 %
2002	165,013	64,103	38.85 %	55,769	20,960	37.58 %	190,392	33.67 %	81,960	78.21 %
2003	172,979	66,209	38.28 %	70,124	27,567	39.31 %	203,004	32.61 %	84,852	78.03 %
2004	176,350	66,212	37.55 %	70,543	26,148	37.07 %	216,492	30.58 %	87,072	76.04 %
2005	202,473	72,044	35.58 %	74,212	28,120	37.89 %	227,904	31.61 %	92,736	77.69 %
2006	207,024	75,928	36.68 %	74,107	27,891	37.64 %	242,628	31.29 %	98,076	77.42 %
	Homes for seniors									
2007	213,996	106,452	49.74 %				260,328	40.89 %	104,832	101.55 %
2008	237,000	123,000	51.90 %				282,504	43.54 %	112,164	109.66 %

Source: MPSV 2008, own calculation.

1) The distinction between retirement homes and houses for pensioners was abolished with Act No. 108/2006 Coll., on Social Services. Nowadays both types are called homes for seniors.

2) Relation to residents' contribution in retirement homes only.

Table 3 Providers of selected social services by legal status
(in 2009)

Type of social service	NGO	Business enterprises	Individual/natural person	Municipality	Contributory organisation	Other
Homes for seniors	21.0%	2.9%	0.8%	1.0%	74.2%	0.0%
Home care services	34.5%	2.5%	3.7%	37.2%	22.1%	0.9%

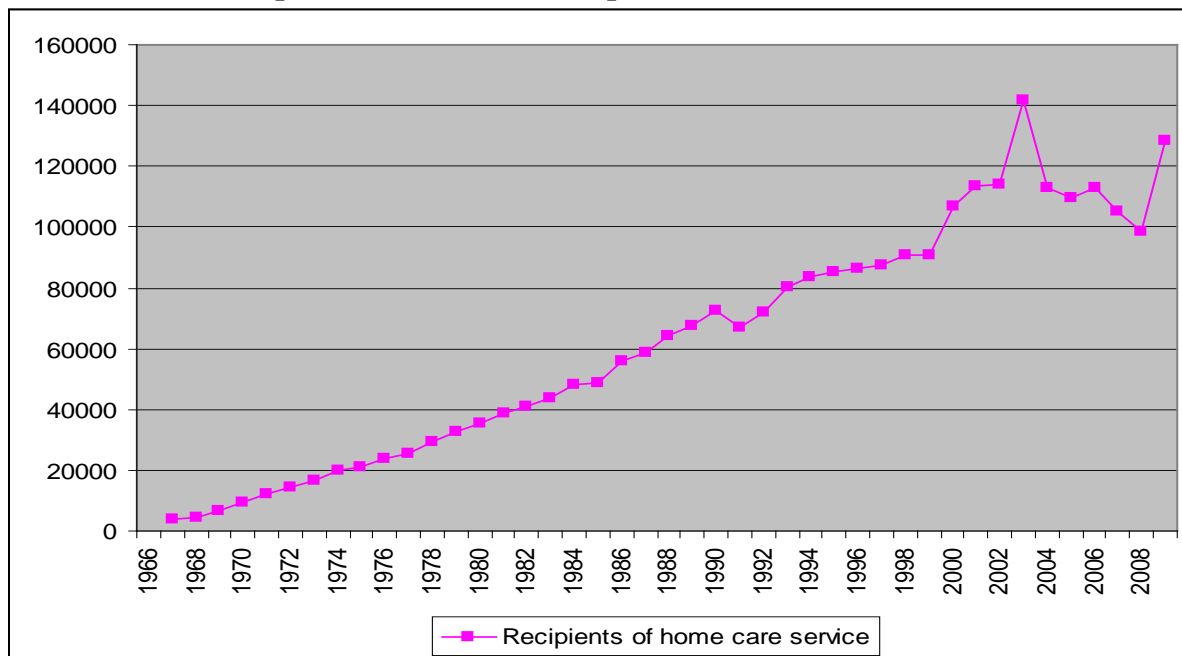
Source: Ministry of Labour and Social Affairs 2010a, own calculation.

Contributory organizations – in particular contributory organizations established by cities/municipalities

Municipality – services are provided directly by an organizational unit of a municipality without it having its own legal status.

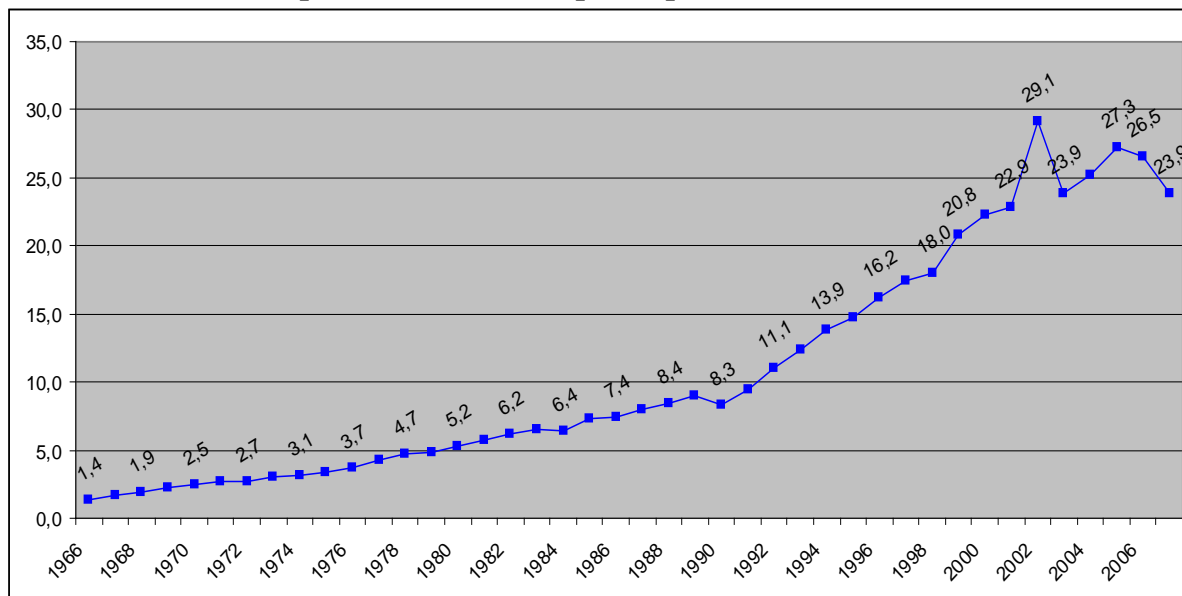
Others – e.g., organisational units of the State

Graph 5 The number of recipients of home care services



Sources: Historická statistická ročenka ČSSR. Federální statistický úřad. Nakladatelství SNTL a ALFA. + Statistické ročenky ČSSR, ČSFR a ČR. Obyvatelstvo podle pětiletých věkových skupin v letech 1920 - 2007 (stav k 1. 7.) (ČSÚ), Demografická ročenka ČR 2008

Graph 6 Number of recipients per home care worker



Source: Historická statistická ročenka ČSSR, ČSÚ Statistical Yearbooks ČSSR, CSFR, CR (1986 – 2008), own calculation