WP2

Care provision in the Czech Republic and Norway

(Extended summary)

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To build on in further research, WP2 summarises and compares existing knowledge (from literature, results of already existing studies and from qualitative and quantitative data sets) regarding child- and eldercare policies, involved stakeholders and policy developments in the Czech Republic and Norway. We also aim to reflect on how and to what extent the caring needs are being met by child- and elder-care policies in these countries.

The main WP2 objectives were defined as follows:

- Identification and description of the population/households with caring needs in the Czech Republic and Norway (social and demographic characteristics of families and individuals with caring needs, attitudes of families and individuals towards the different forms of care, demands for childcare and eldercare).
- Identification and description of existing caring policies and delivery of different forms of childcare and eldercare in the Czech Republic and Norway (arrangements, providers, financing, regulation, policy changes)
- Identification of child- and eldercare deficits and key stakeholders in the Czech Republic and Norway in post-crisis era.

In order to achieve these goals, four background reports were delivered - two national reports in area of childcare and two national reports for eldercare Based on them two comparative reports were drafted: the comparative report on child care in Norway and in the Czech Republic and the comparative report on elder care in Norway and in the Czech Republic which represent the deliverables of the WP 2 and create integral parts of this report.

In both reports, the countries were compared along the following four themes: identification of population in need of care, analysis of the child/elder care systems (its philosophy, history of development, and key milestones), governance of the systems (regulation, financing, service delivery, employment in social services), outcomes/responsiveness to the needs of care (coverage/accessibility, financial accessibility, quality, well-being of service users, well-being of service providers, work-family balance, and specific other issues.

Beyond the analysis of child/elder care systems, we have focussed on the analysis of discourses led by various stakeholders involved in child/elder care and the public. There are two reasons for this concern: first, both areas are typical multilevel governance systems, where the pluralism of the actors involved plays a role, this means that their understandings of the problems and compatibility of these understandings are important for the policy making in terms of policy objectives and policy instruments. Second, from the perspective of policy change, we reflect on the assumptions of the discursive institutionalism according to which the policy change is preceded by discursive change.

Our main focus when comparing the outcomes of both care policies is on work-family balance as an important component impacting both on caregivers' and care users' well-being as these concepts are central to this study and the whole project.

PART I

Comparison of Childcare Systems: similarities and differences between the Czech Republic and Norway

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Existing literature, research studies and statistical data show childcare systems in the Czech Republic and Norway are similar only in two subjects, in others they vary. Similarity can be found in ***the structure of population*** in need of childcare on the one hand (although the number of children aged under five years is double in the Czech Republic than in Norway), and in low level of use of childcare services offered by ***nannies or childminders*** in au-pair system on the other hand.

In the first case, almost equal is the portion of families with dependent children and preschool children, although the number of children aged bellow five years is double in the Czech Republic (690,000) than in Norway (376,000) (Eurostat 2015). The model of two-parent households with children still prevails in both countries over the model of single-parent households (52% of all households in Norway and 38% in the Czech Republic were families with children with married parents) and at the same time, only small portion of households were lone-parent families with children (4% in the Czech Republic and 11% in Norway). Moreover, many households of single mothers with children and households of low-educated parents or cohabiting partners with low income have problems to cover the costs of care. On the other side, only rarely they are facing at-risk-of-poverty families (under 10% in Norway and under 15% in the Czech Republic) and children with disabilities or other children with specific needs due to their migrant background in Norway or Roma origin in in the Czech Republic (ČSÚ 2015; Statistics Norway 2015a).

In the second case, although for nannies or childminders (as well as for other private facilities) does not exist official statistics, available studies show only rich families can use au-pairs in both countries. In this context, some Czech parents often hire nannies within the grey economy, because prices are much lower than prices charged by official au-pair agencies, and the quality is ensured by references from friends (Paloncyová et al 2013). In Norway, parents' costs for private kindergartens are only marginally different and the maximum prices are the same for

private and public kindergartens (the only difference may be an added fee for meals in private kindergartens).

Despite the structural similarities of the population in need of childcare, the ***governmental strategies*** for solving it significantly differ according to the type of the institutionalized form of welfare state. Whereas Norway belongs to countries that represent family policy model that combines supported familialism and de-familialisation (optional de-familialisation by Leitner 2003) where parents can choose to care for their children in the family and also have the opportunity participate part-time or full-time in labour market due to existing jobs and childcare facilities, the Czech Republic represents explicit familialistic family policy model where gender roles in families are often separated, fathers are breadwinners and mothers caregivers until their children are three years old (cf. Szelewa and Polakowski 2008; Saraceno and Keck 2011). This extreme divergence of both countries lies in the access to childcare, especially for the youngest children, and in the lengthy provision of parental benefit in the Czech Republic and moderate length in Norway.

Different types of welfare state correspond to the different approach in financial compensation to parents on ***maternity and parental leave*** in both countries. While the unitarily delivered and generously founded system of maternity leave counted from the previous income and delivered for short time period exist in Norway (49 weeks at 100 percent coverage, or 59 weeks at 80 percent coverage compared to the previous salary), in the Czech Republic, there is a fragmented and poorly funded maternity and especially parental leave delivered as flat-rate for long time (parental leave for 28 weeks at 70 percent coverage compared to the previous salary, and subsequently maternity leave until four years of children´s age at from about ½ until 1/5 of the average monthly wage coverage according to the selected duration of benefits).

Also the flexibility to swap take-up between parents of the child is much higher in Norway where engagement of father in caregiving is far more usual than in the Czech Republic where take-up of parental benefit by father remains very low. In other words, the systems of leaves and benefits differ in several aspects: (1) in the level of flexibility of possible take-up, (2) in the generosity – the coverage of income loss, and most importantly in (3) length of provision of benefit which is maximum 2 years in Norway and twice as many in the Czech Republic. Consequences for female employment in the exposed life period are substantial.

From the kind of ***collective facilities*** perspective, childcare in Norway represents unified system in which parents have a legal right to place their child from one year of age into public or private

collective facilities (“kindergartens”) at the same time (an individual, legal right to a place in kindergarten was introduced and put into effect in 2009). In the Czech Republic, parents can place their three years old children and older into a public or private collective facilities (“kindergartens”), however, the legal right for the placement into public kindergartens is only for 5-years old children. Whereas children from age 3 attend kindergartens in dependence on its capacity which is insufficient in some localities and for children under three years of age exist only private facilities in big cities (“nurseries”, “minischools”) that are very expensive and of limited extent.

The founder of these facilities is mostly regional office (only in the Czech Republic) and municipality (in both countries) in case of public kindergartens, national or international care-for-profit company, church or parish (in both countries) as well as other non-commercial, private actors (in Norway). Whereas corporate kindergartens in Norway are historical legacy from the times when public kindergartens were not available, these facilities newly run in the Czech Republic as the result of an effort of employers to reconcile work and employment of their employees since last few years.

Financing of childcare is well developed in Norway (usually three times higher than in EU) and underdeveloped for the youngest children and on average level in comparison to EU standards in case of older children in the Czech Republic (when taking both provisions as facilities and benefits into account). Whereas spending on care for pre-primary educated children (i.e. those older three years until the compulsory school age) was slightly below the EU average in the Czech Republic in 2011 and almost triple in Norway in 2012 (0.54 % of GDP in the Czech Republic, 0.57 % of GDP in EU, and 1,42% of GDP in Norway), public facilities for children younger 3 years are not subsidised in the Czech Republic (Eurostat 2015).

Costs for parents in public kindergartens show that whereas kindergarten and after school care facilities have either maximum price that grade according to parental income in Norway, the amount paid for this services is only symbolic in the Czech Republic. The maximum price for kindergarten in Norway is NOK 27,980 or approx. 3,000 euros per year. This is the price paid by most double income families. The average income for couples with at least one child under the age of six is NOK 700,000 or 75,000 euros a year. This means that the maximum price for one full time place (41 hours) in kindergarten in this case is 4% of the household's combined salary income before tax. Similarly, Czech parents pay between 3-5% of average wage in the economy (Horák, Horáková and Sirovátka 2013). On the contrary, private facilities (nurseries corporate kindergarten, babysitting etc.) are costly in the Czech Republic and can be afforded

only by wealthy parents in larger cities (private nurseries for children under three years of age are more expensive than private kindergartens: 60% compared to 44% of average monthly wage in the economy - Plasová and Godarová 2015; Horák, Horáková and Sirovátka 2013). For this reason, parents often hire nannies within the grey economy, because prices are much lower and the quality is ensured by references from friends (Paloncyová et al 2013). In Norway, parents' costs for private kindergartens are only marginally different and the maximum prices are the same for private and public kindergartens. The only difference may be an added fee for meals in private kindergartens.

Regulation of childcare in Norway is more advanced than in the Czech Republic where many aspects of family policy are not covered (de-discrimination of women with young children in the labour market, non-existence of quality regulation of private facilities). In Norway, the Ministry of Education and Research has the overall responsibility for financing and regulation of quality, content and ensuring children´s rights of public and private pre-primary institutions (defined as pedagogical undertakings for children under school age/less than six years – "kindergartens"). In the Czech Republic, responsibility for financing and regulation of public and (in some cases also private) pre-primary institutions are both in the hands of the Ministry of Labour and Social Affairs ("Social group" for children older one year) and the Ministry of Education, Youth and Sports ("kindergartens" for children older three years and younger six years). Moreover, responsibility for functioning of private kindergartens that are not registered in a List of school legal entities (školský rejstřík) is in hands of the Ministry of Industry and Trade. The state therefore doesn´t ensure the quality of these (private) devices and offer no subsidies from the state budget.

While the legislative trends are identical in both countries in emphasis on children's rights (it is in form of a proposal for legislative changes in the Czech Republic, and in the Act in "national curriculum" in Norway), the control of public facilities (in Norway also private facilities) is not performed by the municipality (as in Norway), but by local education authority (školský úřad) in the Czech Republic.

There is high ***accessibility*** and good ***quality*** of delivered public and private childcare facilities focused on educational goals for preschool children of any age in Norway. On the other side, low accessibility and average quality of delivered public childcare facilities due to higher child-to-staff ratio is typical in the Czech Republic. The costs for parents in Norway are similar whether the child is placed in public or private facility. The situation is opposite in the Czech Republic where private care providers ask several times more the payment in public facility

which is even more than the highest parental benefit level. Such type of care is accessible only to the richest families. However, the payments in public facilities expressed as percentage of average income are similar in both countries.

Specifically, participation rate of children under three years of age was almost full in preschool facilities in Norway and very low in the Czech Republic in 2013 (80 % compared to 5%) (Eurostat 2014). Simultaneously, kindergarten attendance for older children was high in both countries in the same year (96,5% in Norway and 77% in the Czech Republic) (Eurostat 2015; MŠMT 2014b). Available data show entitlement to place a one-year old child into kindergarten used almost 70 % of parents in Norway. Although kindergarten in the Czech Republic are designed for children aged three years and older, 18% of two-year children attended it in 2013 because there have been limited opportunities to place children into nurseries that almost doesn´t exist (46 nurseries run in 2011 in the Czech Republic for less than one thousand of children) (ÚZIS 2012). Whereas half of Norwegian children attend a public kindergarten and half attend a private kindergarten (both kind of providers must follow the same legal framework and maximum cost of parents is the same), almost all Czech children (98%) visit public facilities (Eurostat 2015).

From the qualification of staff and working conditions point of view, both Norway and the Czech Republic have good reputation especially in the first of these areas. Especially Norway has a strong legislative emphasis on quality of early childhood education in public kindergartens that meet requirements of international documents. However, although the quality of public childcare services is traditionally at a good level in terms of care provided, staff training, psycho-social development of children, pedagogical and hygienic standards in the Czech Republic, the quality of some private childcare facilities for children under three years of age is not legislatively checked (with exception of hygienic and qualifications standards) and is therefore different (Kuchařová et al 2009; Paloncyová et al 2013).

Successful ***inclusion of children with special needs*** (disabled children with some exception of deaf cases) and needs due to their migrant origin into usual childcare facilities is apparent in Norway, contrarily to less successful inclusion of Roma children into usual childcare facilities in the Czech Republic together with rising number of special classes for disabled children placed outside mainstream childcare facilities. Against children with special needs take governments of both countries different strategies, notwithstanding parents of disabled children are entitled to special benefits in both countries. While the vast majority of children with special needs attend pre-school facilities together with healthy children in Norway (with the exception

of children with visual impairments), these children attend special facilities in the Czech Republic. Norwegian kindergartens are a success story and for the majority of children kindergarten is a good place to be.

However, some research indicates that children with special needs could be even better included and met, and that especially children with behavioural difficulties might benefit through better adapted and more competent care (Brenna, 2010). Czech experts in this context highlight need for special educational approach for these children. From this reason, children with special educational needs (speech disorders, visual impairment, hearing and mentally disability especially) have possibility to use special kindergartens: 2% of all preschool pupils (7,987 from 367,603 children) had special needs in school year 2014/2015 while half of them were handicapped (MŠMT 2015). In this context, the issue of childcare quality is quite important in both countries, similarly as educational objectives, with the aim to help disadvantaged children to break the cycle of disadvantage (in Norway these are especially children of single mothers, unemployed parents and immigrants, in the Czech Republic mostly Roma children).

Discourses of policy makers and ordinary citizens reflect the ***stage of development (and path dependency) as well as the problems (the challenges)*** in both countries. In particular, two contextual issues are important for the difference in discourses: first, it is almost full accessibility of child care in Norway but poor accessibility of childcare for children below 3 years and some problems with accessibility of childcare for older children in the Czech Republic (mentioned above). Second, it is almost full support of the public for gender equality in Norway but still prevailing traditional understanding of the gender roles in the Czech Republic.

In this context, the women´s employment that could be supported on the labour market, in families and by the state is virtually closely linked to the concept of "equality" in Norway and with the "inequality" in the Czech Republic. This issue is associated with three aspects of 'equality' successfully reached in Norway: (1) equality of job quality and associated rights when comparing part-time jobs to full time jobs and equality in access to full time jobs (2) institutionalised support to gender equality in the labour market and enforcement of it, (3) strong public childcare provision, and (4) equality of spouses in sharing childcare tasks. On the contrary, the lack of part-time jobs, limited work career opportunities for women, lack for childcare facilities especially for children bellow 3 years, limited support of most men in Czech families. Many women with young children can´ work for several reasons in the Czech Republic: lack of childcare facilities for children younger three years and limited accessibility

of facilities for older children in some localities; fathers´ and employers´ expectations that women with young children should/would stay at home, extremely low availability of part-time jobs for women with young children. In this context, more educated women often complain of limited job growth (even in educational, health and social sectors where the incidence of men is marginal) and lower wages of women than men working in the same job (f.e. Maříková 2003; Dudová et al 2006; Křížková andVohlídalová 2009; Plasová and Válková 2009; Bartáková 2009). Moreover, mostly dilatory attitude of government to solute these problem is apparent in the Czech Republic. Work-life balance is therefore perceived as women´s problem in the Czech Republic where the assumption of the gendered division of household tasks still prevails. This preference for traditional gender roles indicated in public discourse and attitudes also mean that any significant change will need to be promoted top-down or would need actions at all levels to help erode such cultural norm.

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PART II

Comparison of Elder-care Systems: similarities and differences between the Czech Republic and Norway

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Like in other European countries, the ***population*** in Norway and in the Czech Republic is ageing despite temporary increase in fertility over the past few years.This growth was more rapid in the Czech Republic than in Norway during past twelwe years and in 2014 there were 17.4% of people above 65 years in the Czech Republic and 15.9% in Norway. As the demographic forecast implies, in the year 2050, more than 27% in the Czech Republic and 21% of the population in Norway may be expected to be older than 65 and share of opulation over 80 years will be about 8% in both countries, more than twice more than in 2015. Norway is one of the European countries that will experience the least dramatic changes in the age composition of the population. This is partly because Norway has already undergone such changes and partly because Norway has a higher birth rate.

Some of the factors responsible for the ageing of population in both of our countries may have been a long-term decline in fertility, or, significantly, the extending life expectancy. The current life expectancy of newly-born continues to grow – between 2004 and 2013 the increase was remarkable mainly in case of men in both Norway and the Czech Republic and in the Czech Republic also in case of women (by more than 2 percentage points). Still, it is by about five years lower in the Czech Republic when compared to Norway in case of men and by 2.5 years lower in case of women.

How much and what kind of care is needed, varies a good deal, and the ***need for care*** changes and increases with age. Although great majority of elderly until 80 years of age do not need care/help, it is clear that majority of the elderly above 80 years is in need of help. ***Philosophy of the systems*** in both countries are different. In Norway, the issues of the ageing population, along with the future challenges are reflected in a number of policy documents. Of particular importance are the Report to the Storting White Paper No.29 (2012-2013) about ‘Future Care’, and the documents Report to the Storting White Paper No.7 ‘An innovative and sustainable

Norway', National Report No. 25 'Long term care- Future challenges, Care Plan 2015,' and National Report NOU 2011 'Innovation in the Care Services'.

The White Paper (2012-13) seeks to create a basis for further development of professional activities in the field, both for those with the greatest need for care and relief from their conditions and for those who will require daily assistance throughout their entire lives. It is also designed to provide safeguards to ensure that Norway can continue to focus on the community-based solutions it has developed over time through innovation and renewal. The Care Plan 2015 emphasise that the services offered must have a more active profile that encourages greater user influence, user skill mastery and active participation by the individuals, their families and social networks. The policy documents emphasize the values and principles as central to the care services like: equal access to care, afffording people the opportunity to live a meaningful life, in spite of illness and reduced functionality, to create a strong welfare society in cooperation with the citizentry, based on faith in the people's capacity to assume responsibility and participate actively in the community at large, to strengthen the ability of individuals to take care of themselves and others so that all the caregiving tasks need not be entrusted to professional practitioners by active participation. Gender equality and non-discrimination comprise fundamental values in the efforts related to health and care services.

In the Czech Republic, the issues of ageing of population, along with the increasing expenditure costs on social services providing, are reflected in a number of policy documents. Of particular importance among these are the document *National Report on Strategies for Social Protection and Social Inclusion 2008-2010*, and the document *Quality of Life in Old Age: National Program of Preparation for Ageing for 2008-2012*. Both the texts contain principles underlying help and support provision to the elderly, with a particular focus on active ageing and active old age promotion, integration of the elderly into, and their involvement in, common daily activities within community life, and thus promoting, inter alia, the concept that older persons with care needs (recipients of long-term care) should remain living in the place which they know well, i.e., in their own homes. Two other key documents, a government resolution of 2006 *The Concept of transition from residential service to different types of social service provided to user in their home environment and promoting social integration of the user into society*, and the other document, *Priorities of the development of social services for the period of 2009-2012*, contain concrete arrangements and methods leading to achieving the above mentioned goals. Recently, *The National Action Plan to Support Positive Ageing for the Period of 2013-2017* has been formulated and approved by Czech government in March 2015. The policy

priorities in care for the fragile older people stated here are in line with the previous strategic documents. Consequently, the Czech Ministry of Labour and Social Affairs responsible for elder care emphasised as a key goal of the reforms in elder care services protection of human rights of the elderly – right to respect, to dignified treatment and life conditions in any environment, right to live in dignity and to participation in the society.

Regarding the ***regulation of the system,*** in Norway, *The Municipal Health Service Act (1982)* requires municipalities to provide 'essential medical services' to all inhabitants. *The Social Service Act (1991)* requires municipalities to provide 'essential practical help' for inhabitants who are not able to care for themselves. The home based care, involving nursing care and personal care and practical assistance, as well as the nursing homes (institutional care), are available on a universal basis dependent on need and not on age or ability to pay. The overall responsibility for supervision and monitoring of health services in Norway is the Norwegian Board of Health together with 19 County Medical Officers (CMOs). The Norwegian Board of Health co-ordinates supervision activities carried out by CMOs in each county.

The National Health Plan for Norway (2007-2010) state that services of high quality should reach out to everyone regardless of their financial situation. All public care services in Norway are regulated by a quality regulation ("*Kvalitetsforskriften*") which provides some general descriptions of vital quality aspects. The Norwegian Directorate of Health is a regulatory authority and an implementing authority in areas of health policy. The Directorate of Health is a subordinate agency of the Norwegian Ministry of Health and Care Services, responsible for improving the health of the entire nation through integrated and targeted activities across services, sectors and administrative levels.

The municipalities are increasingly influenced by central government through judicial acts, funding, instructions, guidelines and accountability arrangements. The nursing home operates under constitutional law, human rights law, formal law, regulation, and guidelines. Among the formal laws are patients' rights law, municipal health service law, and health care staff law. Regulations include medical records regulation, quality regulations, and regulations for nursing homes and long-term residential care. Many other guidelines, regulations, and laws are in place, and the procedures followed by the nursing home are required to stay up to date with these.

Social services in the Czech Republic are the part of social security system. Since 2007, the social services system in the Czech Republic has been regulated by Act No. 108/2006 Coll., on

Social Services, and by the Decree of the Ministry of Labour and Social Affairs No. 505/2006 Coll., implementing some provisions of the Social Services Act.

The Act from 2006 has profoundly changed the system of social services in the Czech Republic. It defines the kinds of social services and the basic principles of service provision, such as the duty to obtain a licence for social services provision, the funding of social services with an element of direct payment, care allowance rules, qualification requirements imposed on employees of social services provider agencies, standards of quality in social services, local strategies of social services development utilising the community planning method, and basic framework for informal care provision.

Within this scheme, in the Czech Republic can be provided several kind of social services for the eledrly, such as *personal assistance; emergency assistance; guiding and reading services; respite care; day services centres and day care centre*. The long-term care of older people is more often provided by two types of residential social care services *Homes for the elderly* (in homes for the elderly, in-residence services are provided to person with reduced self-sufficiency), *Special regime homes* (in special regime homes, in-residence services are provided to person with reduced self-sufficiency due to their chronic illness or dependence on addictive substances, ad to persons with old-age/senile, Alzheimer's dementia and other types of dementia) and one of field-based service *Domiciliary service* (it is a field-based or out-patient based provided to persons with reduced self-sufficiency due to their age, chronic illness or disability).

The provision of social services is based on a contractual principle by the Social Services Act the contract must be concluded in writing. The character of the contract is that of a private-law contract and is governed by the provisions of the Civil Code.

In Norway, municipal long-term care operating ***costs*** were 83 billion NOK or nearly 9.5 billion euros, and two out of three NOK were spent on services to the elderly. Compared to 1998, a smaller share of the expenses was spent on elderly in 2011, both in general hospitals and in long-term care (https://www.ssb.no/en/helse/artikler-og-publikasjoner/eldres-bruk-av-helse-og-omsorgstjenester). The expenses in 2011 were about 3% of GNP and were over 25% of all municipal expenses - the largest single municipal cost. There has been an estimated increase in these expenses of 32% in the years 1998-20011. The largest share of the increase, 41%, consists in care services to people under the age of 67 while those over 67 have seen an increase of 16% in the same period (Ramm, 2013).

In-kind services are very much dominant in Norway, while cash for care plays a marginal role in elderly care. Norwegian municipalities are obliged to offer care salary for family members as a substitute for home care services. However, nobody is entitled of such benefit by law and hence eligibility criteria vary greatly between different municipalities. The figures show that in 2009 48 % of total nursing and care expenses were used to finance institutional services, while 46.5 per cent of the expenses were used on home-based services. In 2013, the figures reversed in example a higher percentage of the expenses was used on home-based services (48.6 per cent) compared to institutional services (46 per cent).

In the Czech Republic the model of multi-resources or mix-resources ***financing*** was implemented. Since the social care services are for a fee, the care providing is covered by A) public sources: (1) national budget – resources distributed by *Ministry of Labour and Social Affairs* (MoLSA) and Regional Authority; (2) regional budget – lie within Regional Authority; (3) local budget - lie within Municipal Authority; B) private sources: (1) donations; (2) small business of service provider; (3) care allowance; (4) personal sources of the clients. The Ministry of Labour and Social Affairs distributes in cooperation with Regional Authorities subsidies (from the national budget) towards the operation and development of social services delivered by other providers, the NGOs including.

A care allowance is intended to strengthen the competences of persons dependent on the assistance of another person and the circle of close persons. A care allowance is graduated according to the degree of dependence, with its amount primarily derived from the usual costs connected with care. The Care Allowance, introduced in 2007, was projected as a new source of founding of social care services, however this plan hasn´t been fulfilled. Annually, around 3/4 of the amount granted through the Care Allowance is not heading to the formal social services providers, as the older people use it predominantly for paying to informal caregivers (MoLSA, 2010). The number of the recipients increased between 2007 and 2014 from 277 to 328 thousand people and expenditure from 14.6 bln CZK to 20.9 bln CZK (Source: MoLSA, 2015 (Oknouze/Okslužby, AIS SoS). From 328 thousand recipients of care allowance, 133 thousand were in age over 80 years,86 thousand in age 65-80 years and the rest (109 thousand, this is about one third) below 65 years of age.

In the Czech Republic, health care is provided separately from social care. The same separation applies to the financing of both types of care. The existing arrangement in practice brings forth a dual provision of residential care, with homes for the elderly and special regime homes are classified as social service, whereas long-stay hospitals are classified as health-care facility.

These three facilities in principle look after similar type of the clients. Yet in the social service facility, the financial resources for health care are reduced.

The ***responsibility for health and social care provision*** in Norway is shared between three levels of government: Central government, the counties and municipalities. Central government retains overall responsibility for health care, including the task of regulation, monitoring and substantial block grant funding to the local governments (municipalities). The counties are responsible for hospitals and specialized health care services. Norway has 19 counties; the largest of them is Oslo and Akershus (surroundings). Hospitals only provide medical treatment. The municipalities are responsible for the following three main care services: home based care (social and health), nursing home care, supported housing.

In the Czech Republic, there are several types of actors in the domain of Social and care services. These are above all the Ministry of Labour and Social Affairs, Regions and Municipalities, and Non-profit organizations. Furthermore, there are several pressure groups of users (among the most influential ones is the Czech National Disability Council) and volunteers. The MoLSA is responsible for the preparation of long-term systematic measures and relevant legal regulations, the setting of long-term social policy priorities, as well as for quality enhancement. The role of *municipalities and regions* are partly similar. They seek to establish suitable conditions for the development of social services, particularly by assessing people's real needs and securing the resources necessary to satisfy these needs, besides setting up organisations to provide social services. *Non-governmental, non-profit organisations* and individuals provide a wide spectrum of services as crucially important party. They often play the role of innovators and sometimes form associations or pressure groups to influence the policy of the MoLSA. Since 2012, *Social care assistants* have become an important part of the structure; these are individuals eligible to provide help for the elderly in their households on the contractual basis. If a person *cares for his/her family member or another close person* who is dependent on the assistance of others than is guaranteed some kind of social protection under the Act of Social Services.

Regarding ***coverage and physical accessibility of care,*** in Norway at the end of 2011, more than 268 000 people had received care services in one form or another. Of these, about 43 500 people received services in an institution and some 177 000 were recipients of in- home nursing care and/or practical assistance. Today there are about 70 000 people with dementia in Norway, and it is estimated that some 250 000 people – both patients and their close family members – are affected by the disease. About 10 000 people per year are diagnosed with dementia. Since

the number of elderly over 75 years old, especially those over 80 years, will increase in the coming decades, the number of people with dementia in Norway could double to about 140 000 over the next 25–30 years.

A Dementia Plan was presented in 2007 to strengthen services to people with dementia through three main measures: enhancing knowledge about and expertise on dementia, increasing daytime activity programmes, and creating more adapted housing. In 2011, the Dementia Plan was revised with a new four-year action programme (2012–2015). The number of users of professional/formal elder care services is about 120 thousand people higher compared to the Czech Republic although the population of Norway is half of the Czech population (5.1 million to 10.2 million people). In fact from 771 thousand people older than 67 years, more than 30% receive some formal care service (own computations). The apparent trend in recent 5 years is the increase of home nursing care and decrease of residential care.

In the Czech Republic, the numbers of people receiving elder care are not increasing in recent years: slight increase of clients of homes for the elderly is observed and more rapid increase of the clients of homes with special regime but decline of domiciliary/home care services. In total, nearly 3% of elderly people receive institutional care while above 6% of elderly receive domiciliary care in the Czech Republic. On the other hand it is an evident that demand for care is even higher. The numbers of the rejected applications for institutional care is by 50% higher than the capacity of the pensioners' homes. Stably, during 2009-2013 this number was about 76 thousand people (MoLSA 2010, 2011, 2012, 2013, 2014).

In Norway, according to The Action Plan for Elderly Care (1996- 1997) a single-room reform was implemented, in order to improve the ***quality of services***, and half of Norway's nursing home spaces were either newly constructed or fully modernised. Nursing homes have therefore been expanded, renewed and renovated, both in terms of the buildings and to some extent with regard to the expertise needed to per- form the tasks that the sector is now dealing with. According to the authorities' plans for the sector, there is a priority for nursing homes and home-based services compared to old people's homes. Many beds in old people's homes and nursing homes are upgraded with better standards, in example single rooms and private bathroom and WC. In 2013, 4 out of 5 beds in nursing homes were in such rooms. Although many municipalities have quality standards for their care services, no national standard exists.

In the Czech Republic, in spite of legally set quality standards the problem is in their implementation. The ability/capability of service providers concerning quality standards

implementation into the practice of formal social service providing is limited by insufficient human resources, low number of social workers involved, qualification of the staff for work with the quality standards as well as poor understanding of the quality standards importance for the provision of care (Hubíková, Havlíková, 2011; Kubalčíková, 2009). Regarding residential care, in the Czech Republic, data show that in pensioner´s homes, two or more bed rooms number is approximately the same as the number of single rooms what means that great majority of the clients are living in two of more bed rooms while about one third of them is living in single rooms.

In Norway, as already documented in the part on regulation of elder care and quality of elder care, there is a strong emphasis on ***wellbeing of the elderly*** and their participation in co-determination of the service provided not only in legislation and policy document but also in practice. Some specific indications are monitored in Norway to assess and effort to increase wellbeing of the elderly. For example it is indicated that the physician's time use in nursing homes has increased by 7 per cent from 2012 to 2013, and by 35 per cent since 2009. In 2013, physicians provided services close to half an hour per resident per week. The physiotherapists' time use in nursing homes has also increased since 2012, and amounts to 23 minutes per week per resident in 2013.

Well-being of the elderly/rights of the elderly are officially declared in a number of nation-wide documents as well as in the *Charter of Fundamental Rights and Freedoms* which forms a part of the Czech Republic constitution, and expressed in Act No. 108/2006 Coll. on Social Services. It emphasises the option of choosing the form of care provided, i.e. field-based, non-residential or in-residential care as well as choosing between several types of care which may be provided on the basis of the previous decision. A discussion has been held about the wide range of risks that is being addressed while maintaining and enforcing the above mentioned rights. Another problem is the unequal position of the elderly - clients of social services (primarily in special regime homes) and the elderly who are provided with basically identical scope of aid in long-stay hospitals which are established within the health care scheme (Bareš 2011, Holmerová 2013).

Wellbeing of the caregivers is differently addressed in both studied countries. In Norway, in the home care services, care provision is often based on a complementary mix of private (family) and public care (Daatland & Herlofson, 2003). It is normally expected that formal care providers assume responsibility for "hands on care" such as cleaning, personal care and nursing care whereas family members expected to secure that elderly family members live a meaningful

life (Daatland et al., 2009). Family members and relatives may be supported by respite services in sense of short time placement in a nursing- home (for days or weeks) according to a set schedule, or placement in a day care-center. Availability of residential respite for care-givers varies between municipalities and depends on the municipalities' capacity and vacancies. Respite services are rarely offered to adults who provide extensive care for their parents when not living together in the same household (Jessen 2014).

There is no systematic support and training of home caregivers in the Czech Republic. They are not recognised as a specific target group deserving any support (Hubíková 2012). If the caregiver has to leave his/her paid occupation, the family is at risk of poverty. The situation of the home caregivers is even worsened by a thin network of respite care and poor flexibility of field-based services, which are not provided on a 24/7 basis. The current analyses (Jeřábek, 2013) suggest that the home carers provide their service without regular rest, do not pay proper attention to their health, experience sorrow and suffer from depression. They feel lonely in their role of caregiver. The need for continuous care considerably increases in persons aged 81+. While in Norway formal and family care may be effectively combined as well as working and caring, this is much more difficult in the Czech Republic. The group of caregivers predominantly consists of old age pensioners (i.e. usually the partners, spouses and/or children at retirement age). When the care is provided by people at pre-retirement age, they have option to apply for early pension.

Summing-up, Norway has continuously developed quite sophisticated universal decentralised system of elder care relying mainly on in-kind services, well-coordinated health and social care provisions. There is a great emphasis put on the rights of the users in practice and systemic quality control of quite high standards of care. Current trend is development of home care and nursing, accompanied with some more emphasis on informal family care while some restrictions took place regarding nursing homes. In discourse, although there is a consensus in key objectives some issues regarding organisation and instruments of elder care are subject of political controversions.

The following challenges in elder care have been identified and recognised in current development and future challenges are described in several documents (*Meld.St.29 (2012-2013) Report to the storting, Care Plan 2015 and in Official Norwegian Report 2011:11 Innovation in the Care Services*):

- the growth of new younger user groups;

- more elderly in need of assistance;
- shortage of volunteer care providers;
- shortage of health and social services personnel;
- the lack of coordination and medical follow-up;
- the lack of activities and coverage related to psycho-social needs;
- the financing and cost of care.

Despite the significant rise in the proportion of elderly among the population, the largest growth has occurred in the services provided to people under 67 years old. A major challenge in the future will be to expand the capacity of all services related to 24-hour care spaces in nursing homes and residential care homes so that Norway does not lag behind when the need for care services and personnel will increase dramatically in 10–15 years. Better adaptation of people's own homes, the use of welfare technology, daytime activity programmes, an expansion of assisted living residences and greater focus on home care services and rehabilitation may be alternative solutions to postpone the need for, 24-hour care spaces. The average cost of a 24-hour care space in a nursing home comes to almost NOK 1 million per year. It will be an innovation task for the municipalities to test out whether using such a large sum in a different way can result in other, better solutions for individuals.

The Czech elder care system may be understood as a system in flux, which has been reformed at the beginning of 1990s, a major reform came in 2006, further reforms are expected. The until now accepted solutions in principle emphasize objectives and principles like rights of service users, individualised service in home environment, quality standards, decentralisation and pluralism in service provision. Implementation of these principles, however, represents a problem, the quality standards in particular. The Czech reform which relied explicitly on the market conforming solution (quasi-market of elder care) may be understood as a typical market failure example. Paradoxically, while one of the key objectives was to develop domiciliary care in contrast to residential care, this did not happen. Health care and social care remains uncoordinated, which creates great big holes in service provision. In general, there are serious problems in accessibility of elder care. The greatest challenge for the Czech Republic is to establish an adequate regulation and financial frame for elder care: this will require several improvements, underpinned with better elaborated concept of elder care.

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