Governance, social investments and social INNovation in CARE services in the Czech Republic and Norway

FINAL REPORT

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Introduction

The objectives of the project

The main objective of the project was to explore the degree to which the strategies that are adopted by relevant actors in the two policy fields in solving the problem of care are mutually ‘compatible’ and how effective different strategies are in responding to the increasing demand for formal childcare and eldercare. The strategies of the actors who form the policies in these fields are assessed from the perspective of the households which effectively connects the above two areas, as they both help to provide appropriate care to children and the elderly and to balance work and family. The related question is how social investments and social innovations are emerging in the strategies adopted by the actors.

The following issues were investigated:

The first issue is the individual/micro-level: the needs, the preferences and the strategies adopted by the individual households in the changing broad societal context need to be explored thoroughly. In particular, we examined how the child/eldercare policy package interacts with different parts of working life to produce different structures of opportunities and constraints for families with care needs and the consequences for the strategies of the families in arranging caregiving.

The second issue is the meso- and macro-level: the preferences and strategies adopted by the actors which are involved in regulation, financing and delivery of care services and their mutual interactions-synergies will be explored. This implies quite complex interactions (coordination) among the actors involved and variety of care provisions, which may be analysed along the following dimensions:
- the dimension of service regulation, service financing and services delivery
- the role of the public, private (employers or service providers) and non-government sectors
- the state, regional, local/municipal level
- formal and informal care (families or other service providers)
- paid and unpaid care.

The third issue is how the social investment strategy by the stakeholders involved is emerging within the broader societal context (the underlying factors), like the ability of the welfare state to invest into care services or the values and objectives behind the strategies.
The fourth issue is the social innovation: are there innovative solutions (those which improve the ability of the policies to meet social needs and/or increase the capacity of the actors involved to respond to the social needs more effectively).

The two countries in focus - the Czech Republic and Norway – have different starting points which will be taken carefully into account when carrying out the in-depth investigation: one country (Norway) where care policies have a long tradition and are well developed in various forms and (so far) not affected by the crisis, and the other country (Czech Republic) where care policies are only slowly gaining priority while the needs of care are increasing. The literature on family policies predominantly concludes that Nordic countries (Norway among them) have developed the most effective policies, which facilitate most of the actual policy objectives (like work-family balance and women’s employment, gender equality, well-being and development of children, prevention of child poverty, fertility rates etc.). For this reason, family policy reforms in several countries (Germany is an excellent example) since the 1990s – especially regarding childcare policies – have been inspired by Nordic ‘women-friendly’ welfare states. Similarly, formal eldercare (both home care and residential care) is well developed in Nordic countries when compared to countries like Czech Republic (Saraceno and Keck 2011). In this book we are interested in the extent to which Norway may serve as an example for the Czech Republic.

More interestingly, at a closer look, Norway represents not only an inspiration for the developed welfare model but it is also a suitable comparative benchmark for the Czech Republic due to several similarities. Norwegian childcare policies consist of a ‘dualistic’ strategy combining dual-earner support with support for parental childcare (Ellingsæter, 2003; 2007; Leira 2002), much like the Czech Republic. Secondly, there is a proximity of ideologies behind childcare policies in both countries emphasising the psychological and pedagogical development of children, as well as the freedom of choice among care options for parents (Ellingsæter and Guldbranssen 2007). There is also a similar preference for at home provided eldercare in both countries and related consumer choice discourse although the policies for providing eldercare and long-term care diverge greatly.

Lastly, both countries experienced high employment levels for women at the beginning of the 1990s when compared to other European countries, despite the low nursery school/kindergarten enrolment rates of children under 3. However, since the late 1990s, childcare policies have gone in different directions: the fast-paced development of childcare facilities in Norway contrasts with their decline in the Czech Republic (Maegher and Szebehely 2012; Sirovátk and Tomešová Bartáková 2011). Similarly, in eldercare, the Czech Republic clearly followed a quasi-market model while Norway developed policies which provide more support to families both cash and in kind (Saraceno and Keck 2011, Ranci and Pavolini 2015). It is interesting from the above reasons to assess whether a potential change in childcare and eldercare policy options might also be introduced and sustained in the context of the Czech Republic.

The in-depth studies of the project can contribute to an understanding of how household strategies, on the one hand, and policies in childcare and eldercare, on the other, emerge in different contexts, how various actors can effectively cooperate, how they meet the needs of the households and what the options for the new effective solutions are.
The underlying theoretical approach of the book aims to effectively connect the individual level (service users’ and informal family care providers’ perspectives) with the meso- and macro-levels (the perspective of the formal service provision within the broader context of family policies and the factors behind the development of the care policies). An identical, broader theoretical frame was be used at both levels which will explain the formation of the strategies of service users and service providers: these theories will also help us analyse how individuals – be it the care providers and/or the care recipients – navigate in the set-out systems of child- and elder-care in order to meet the caring needs of families and individuals.

We are assessing the role of the structural, cultural and institutional factors in the development of care policies as well as in how households form strategies for providing care and balancing work and family life. We reflect on the interaction of these factors at the macro/meso- and micro-level. We understand the development of care policies in terms of the concepts of defamilialisation, decommodification and gender equality. Lastly, a governance perspective is employed. This helps to understand the interface among the family, market, community and state in providing care (for more explanation see Section 1).

The individual work packages of the project contributed to the main objectives as follows:

WP 1 aimed at building a platform for further research integrated into other work packages in terms of theoretical background and methodological approaches. WP 1 provided more thorough overview of: the theoretical approaches which have been used in the existing research to understand and to explain the strategies of the actors/stakeholders at the individual/micro-, meso- and macro-level and discuss how these approaches may be connected within broader theoretical perspective; the methodological approaches to the examination of the strategies of stakeholders and their interactions, employed in the existing research; the most important findings on the strategies and the interaction of the strategies of the stakeholders/actors.

WP2 summarised and compared existing knowledge (from literature, results of already existing studies and from qualitative and quantitative data sets) that describe and identify key child- and eldercare problems/gaps, existing solutions through policy design and policy change, problematic aspects of care policies and stakeholders in the Czech Republic and Norway. We identified childcare and eldercare deficits and key stakeholders as starting framework for further WPs.

WP3 explored the strategies of investors, regulators, formal providers of care and other national level stakeholders that they apply in the area of childcare and eldercare and to reveal reasoning and discourses behind these strategies in the Czech Republic and Norway.

WP4 explored the strategies of service users, be it the clients of care services themselves or the families that are to rely on these services in order to facilitate care giving. This applies to the area of childcare and eldercare aiming to reveal reasoning and discourses behind these strategies as well as innovative aspects of it, both in the Czech Republic and Norway. Equally, we examined how the child/eldercare policy package interacts with different parts of working life to produce different structures of opportunities and constraints for families with care needs.
The findings from the WPs 1-4 were compared and analysed in final WP5, also with regard to two key concepts: social investment strategy – the ability of welfare state to address the care needs via social investments; social innovation – the ability of key actors (service users, families, providers etc.) to counteract lacking policies and develop other innovative solutions and approaches in order to facilitate care giving in meeting the needs of families.

**Methods**

The individual work packages dealing with empirical material will use the following methods:

WP 1 – theoretical analysis, methodological assessment of the approaches to the topic, secondary and comparative analysis of the key findings of the relevant studies.

WP 2 – quantitative analysis of the existing data on demography, preferences/attitudes of households concerning care, quantitative/qualitative and institutional analysis of the policies and stakeholders’ roles.

WP 3 – collection of qualitative data (semi-structured) interviews on preferences and strategies of the stakeholders who regulate, finance and deliver care services, analysis.

WP 4 – collection of qualitative data (semi-structured) interviews and focus groups on preferences and strategies of the households how they use care services and innovative solutions to organise care they need, the analysis.

WP 5 – comparative analysis of the findings provided in WP 2-4.

The project is based on mixed research methods which combine qualitative and quantitative approaches. Various already existing data sources related to the research questions are exhausted: national and European databases and OECD databases, various national data, and surveys on attitudes like GGS, European Social Survey, ISSP and other national surveys related to the topic. Use of various sources such as national policy documents and data on the national policies of care enable a comprehensive institutional analysis. Next, new data have been collected as qualitative findings on the attitudes/preferences and strategies concerning care a) of the actors who regulate, finance and/or deliver care services and b) of households and individuals. These new data (presented in Sections 3 and 4) represent the key input which enable – in combination with other data collected from existing sources – a comprehensive analysis of how the strategies for providing and using care services emerge in both countries under investigation, how they are compatible and how change and innovation in policies in response to the needs of people emerge.

We explicitly aimed at the comparative research design. When carrying out the field research on the discourses and strategies of the actors who regulate and provide care to children and elderly we used similar sample sizes (14-19 different actors engaged both in childcare and eldercare in both countries, and 23-30 families who are users/and providers both of childcare and eldercare in both countries). We also employed nearly identical recruitment methods of the interviewees: various service providers were typically used as ports of entry and a snowball technique followed, aiming at the variety of the interviewees. The interview questions were based on the common
template with adaptations needed in the country contexts and also interviewing methods (combination of the individual and focus groups interviews), see Sections 3 and 4 for detail. In consequence, no significant differences regarding the above mentioned research qualities emerged.

The comparison of the two countries is based on a combination of the above data and approaches. We focus on the interaction of the discourse, preferences and strategies in care provision by families themselves and by formal service providers. This means that the first focus is on how families provide and ensure care in a certain, specific institutional frame, and second, how care providers in different sectors and at different levels (national, local) provide care, and how the discourse of the actors underpin their strategies. Lastly, we assess how the care provided corresponds to the needs and preferences of the households. These findings are interpreted within the broader institutional national contexts.
Section 1: Theoretical framework and overview of the field

Introduction

In this section we discuss a theoretical framework for understanding two issues. First, this is the role of care services in the current societal and social policy context, in relation to new social risks, work-life balance and well-being. The second issue is what the factors/drivers are that explain the recent and current developments of care services in contemporary European societies.

In approaching these issues, we integrate the theories focusing both on the micro- and meso-/macro-perspective. On the micro-perspective, these are the theories that help to understand the needs and preferences of households regarding care services, how the households provide and ensure care to children and elderly/frail family members and how they combine caring and working within the specific institutional context. In the meso-/macro-perspective, these are theories that explain how the actors involved in the field of formal care (state, public or private regional and local actors) provide care; in other words, how they meet the formal care needs of the households.

The increasing role of care services

Care can be defined as ‘the work of looking after the physical, psychological, emotional and developmental needs of one or more people’ (Standing in Kofman and Raghruran 2009) or more specifically as a range of activities and relationships that promote the physical and emotional well-being of people “who cannot or who are not inclined to perform these activities themselves” (Yates in Kofman 2012:143). The importance of care as a relationship is thus emphasised, as it is characterised by personal ties of obligation, commitment, trust and loyalty, and the process of care explored in terms of ‘loving, thinking and doing’ (Daly and Lewis 2000). Care (services) is then understood as ‘an activity and set of relationships lying at the intersection of state, market and family (and the voluntary sector) relations’ (Daly and Lewis 2000). The concept of care is thus a ‘traditionally multi-dimensional concept, which includes formal and informal care, paid and unpaid, provision in cash and in services, national and local level, state/market/community/family mix’ (ibid).

Care services represent a specific, increasingly important category of social services. Social services are understood here as ‘those services provided directly to the person and playing a preventive and socially cohesive role such as social assistance services, employment and training services, social housing, childcare and long-term care services’ (European Commission 2010: 7). The two last categories we include under the more general notion of care services, having in mind formal care services provided to children or the elderly by the state or market or non-profit sector (actors outside the family) and typically paid to the providers both from public resources and/or by the families/ recipients themselves.
The increasing role of care services in the contemporary welfare state is associated with the notion of new social risks (Bonoli 2006; Brennan et al. 2012; Esping-Andersen 1999; Hemerijck 2002; Taylor-Gooby 2004) which are understood as situations in which individuals experience welfare losses which have arisen as a result of socio-economic transformation. Reconciling work and family life represents one of these situations which require childcare work to be externalized from families, similarly as having a frail relative (elderly) require eldercare to be extended from families (Bonoli 2007; 2013). Other trends underline this need: population ageing and rising life expectancy but declining availability of informal carers due to declining family size, rising divorce rates and childlessness, and increasing female labour force participation (e.g. Colombo et al. 2011). At the same time, governments are becoming more interested in promoting the participation of women in the labour market and thus seek to close gender and family gaps in employment and income; they also expect longer working lives to remedy future labour and skill shortages (Mätzke and Ostner 2015).

Childcare and eldercare thus are becoming central policies or critical domains of contemporary social policy (Brennan et al. 2012). They also figure prominently in the social investment discourse which envisages a positive role for social policy in increasing employment and human capital etc. The role of early education and childcare in this respect has been recognised earlier (e.g. Bonoli 2013; Morel et al. 2012), but recently has also been discussed with respect to eldercare (e.g. Greve 2017; Léon et al. 2014). Earlier influential works by the Organisation for Economic Co-operation and Development (OECD 2006; 2007; 2008) introduced this approach as a new policy agenda. However, it is argued that in the Nordic countries this approach was traditional, connected from Myrdal’s times very much with the ideas of equality and universalism as well considered as an effective organisation of production and reproduction (Morel et al. 2012). In particular, work-family reconciliation policies are taken as a lynchpin of the social investment approach (Morgan 2012: 153). High quality early education and care (ECEC programmes invest in both the cognitive development of young children and the labour market skills of their mothers by enabling them to participate in paid work. Eldercare/Long-term care provides social and economic returns on investments through the combination of reduced disability in old age, improved capacity of older people to manage functional limitations and higher productivity in care delivery (European Commission 2013; Léon et al. 2014).

The social investment triad (increasing women’s and older people’s employment, promotion of gender equality, fostering child development and active ageing through quality care) is potentially promoted. Another important outcome is breaking the intergenerational transmission of poverty by ‘make-work-pay’ for low income parents and by providing developmentally enriching services to young children (Esping-Andersen 2002; Morgan 2012: 155). The EC (2013) introduced ‘investment in children’ as a key social inclusion agenda within the comprehensive Social investment package. Finally, care policies are central to the measures which can resolve the tensions between employment-focused demands and care-focused demands concerning both gender equity and women’s financial autonomy as they a) support women’s labour force participation by partly relieving them of family-linked responsibilities, b) acknowledge the value of care work by providing both time and financial compensation for care giving and c) support and incentivise men
to share care responsibilities (Saraceno and Keck 2011: 372-373). From another perspective, for left parties in the Nordic countries, publicly run care services have represented the potential to bring electoral gains in the context of growing white collar female employment and demand for services. When they are universal, they reduce class inequality, and similarly, when they are de-familialist, they reduce gender inequality in care (Meagher and Szébehely 2012).

In light of this, three dimensions of care policies appear particularly relevant: decommodification (this is independence from the market for the satisfaction of one’s own needs), defamilialisation (this is independence from family support for the satisfaction of one’s own needs), and gender equality (Saraceno and Keck 2011).

**Factors and drivers behind care services developments within the broader context of the welfare state**

Both macro/meso-level factors and micro-level factors can be classified into three main groups: structural, cultural and institutional factors. We understand the structural factors to be the broader societal, economic and political structures and processes. We understand values, beliefs, expectations and societal norms to be the cultural factors. The institutional factors are the regularised practices and policies as well as the infrastructures (and organisations) that enable them. The general assumption is that these factors interact at the macro/meso- and micro-levels (see Bonoli 2006; Kangas and Roostgaard 2007; Pierson 2001; Sirovátka 2014).

**Structural factors**

More generally, Flora and Heidenheimer (1982) explain the developments of welfare states with use of the concept ‘problem pressure’ which reflects the tension between the emerging societal problems/risks on the one hand and the political mobilisation/agency of the actors interested in solving these problems/risks on the other. The growing role of care services is due to the growing demand for them. This seems to be associated with the current socio-economic changes which put pressure on the welfare states, like transitions from industrial to service economies with their dynamic labour markets, new employment structures, an ageing society, changing family structures and, last but not least, the quiet revolution in the role of women (Esping-Andersen 2009). What matters for the ‘new welfare architecture’ is the changing structures of the ‘risks’ (see section above).

Political mobilisation represents another component of the increasing problem pressure. Traditionally, power resource theory (Korpi 1983; Huber and Stephens 2000 and others) emphasised left-party coalition domination in government as crucial for the development of welfare programmes. Jensen (2011) explains that services are, however, different from transfer programmes: they deal more with life-cycle risks associated with youth, motherhood and old age than with class risks. Since life-cycle risks affect all individuals in society almost equally, the potential pool of service users is much larger than that of transfer programs, and thus the pro-
welfare coalitions of service users/recipients and service providers also become larger. It is thus more difficult for politicians and policy makers to cut back on services, even in times of the economic slowdown, than it is in the transfer system. In this respect, gender and age are becoming more important dividing factors concerning public support to social services. However, Jensen’s assumption on the existence of a broader coalition supporting services seems to hold, as some studies show (e.g. Muuri 2010). Another argument compatible with resources theory recognises women’s political mobilisation and influence as key factors associated with the higher levels of childcare provision. Social democratic parties are considered to be interested in reorienting the welfare state towards services in order to become more attractive to women, especially in times when their traditional base (industry) is rapidly eroding because of deindustrialisation (Bonoli and Reber 2010).

Second, the increasing economic capacity of service economies also plays a role in boosting demand for services. Boorchorst and Siim (2014) explain that women-friendly policies characterised by gender equality objectives are to great extent due to state feminism emerging from women’s political participation and representation and their ability to influence the policies that are beneficial to them. ‘The service economy is driven by broadening purchasing power throughout the population’ and ‘the disappearance of cheap domestic servants and of the housewife.’ (Esping-Andersen 2009: 4). In this respect, Bonoli and Reber (2010) provide empirical arguments that wage disparities play a positive role in childcare expansion in uncoordinated economies where markets are allowed to moderate wage growth in services and where the care demands of high wage earners are met by low wage earners. In contrast, coordinated economies support much more publicly financed care: broadened purchasing power helps to broaden the tax base and public resources available. Finally, we hypothesize that an austerity climate may freeze demand for and supply of services.

Cultural factors and gender

The reactions of families and policy actors to the problem pressures are mediated through the prevailing cultural norms. The established family models, shared values, beliefs and expectations towards the roles of men and women, their part in caring and working are shaping the policies. The different patterns of preferences towards the roles of women and men are rooted in the specific gender order (Pfau-Effinger 2004). This can be seen in the patterns of family and gender roles, in the patterns of female employment and in patterns of care. The gender arrangement is gender relations in the households and labour market as well as in welfare state institutions and policies (labour law, caring policies, social services etc.) that impact on the strategies of individuals, institutions and employers. This creates the gendered environment in the labour market, where not only rationality shapes the choices of the actors but also notions of gender identities (Pfau-Effinger 2004; Hatt 1997; Rubery et al. 1999). Such processes lead to gender segregation of the female labour force that is emerging on both the labour market supply and demand side.

Corresponding to these patterns, at the meso-/macro- levels (care provision), different combinations of formal care and financial support to families (labelled as combinations of defamilialism and familialism in policies) were distinguished (Korpi 2000; Leitner 2003). Cultural
norms, especially about what proper care is (Duncan et al. 2003; Pfau-Effinger 2004), influence both household decisions on what the care should be and how it should be provided, as well as policymaker and stakeholder assumptions about how much care should be provided in order to meet the demands of the households.

Similarly, León et al. (2014) underline the role of norms when they claim that even in an atmosphere of welfare retrenchment (childcare provision seems to be protected in those environments/countries where it is expanded through educational systems as a form of welfare recalibration fuelled by social investment logic.\(^1\) In countries where ECEC still has a strong assistance component\(^2\) (such as childcare for children 0-3) however, there were cuts in public spending. In contrast, in cases of elder/long-term care, the compromise between universalism and free choice principles has shown to be inadequate in dealing with the new financial and demographic pressures.

**Institutional factors**

(Neo-)institutionalist theories are concerned with the question of ‘how institutions, understood as sets of regularized practices with a rule-like quality, structure the behaviour of political and economic actors’ (Hall 2009) or more broadly, how institutions shape agent behaviour (i.e. people, organisations, governments), see DiMaggio and Powel (1983). Second, attention is paid to explaining when and how institutions change (Hall 2009).

Historical institutionalism teaches us about the importance of the institutional legacies in policies: the policies and institutions are considered as path dependent on the institutional set up. Institutional path dependency explains to great extent the varieties of the dynamics of policies in different countries and also the varieties of policies within one country. In a period of welfare state expansion, care and other social services have been well developed in some countries because the expansion was easier (as took place in the Nordic countries), while in the welfare state retrenchment phase, new programs are hard to finance (see Anderson and Meyer 2006; Huber and Stephens 2006). More specifically, Tepe and Vanhuysse (2014), following Bonoli (2007), formulate the ‘timing hypothesis’. This hypothesis asserts that it is difficult to advance policies (like care services) responding to new social risks for countries which have either been confronted with these risks later or in times of challenges which stem from an ageing population or economic austerity, and this affects the welfare programmes (crowding out hypothesis). On the other hand, Jensen (2009a) explains that in some (Nordic) countries, well-developed policies in social services during the ‘golden age’ may persist long after the factors that caused them have been exhausted.

New institutionalism, finally, is also actor centred institutionalism (DiMaggio and Powell 1983) and discursive institutionalism (Schmidt 2008). It helps to understand the role of the actors, their ideas and discourses which precede institutional policy change by challenging the existing

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\(^1\) This means emphasis on education and development of children.

\(^2\) This means just assisting parents by taking care of children during times when parents work.
policies and practices (Mahoney and Thelen 2010). Discursive institutionalism and actor centred institutionalism may also help to reflect on mutual interactions of the families and institutions/policies as the families make the choice of the policy arrangements available to them and provide feedback to the policy makers about their care service needs (e.g. Ellingsæter and Gulbrandsen 2007).

**Work-life balance and the factors influencing care arrangements and services at the micro-level**

Work-life balance, as the equilibrium between caring and working responsibilities, involves diverse actors – in particular women as principal informal caregivers, other family members, employers, policy and decision makers as regulators of caring policies and formal care providers. The development of household patterns of combining in-family care (informal care) and care services (formal care) represents, together with work patterns, the building blocks of work-life balance.

**Structural factors**

Several developments in the society influence the needs and demands on the welfare state change. In particular, some authors argue that certain measures, such as cash for care schemes, still support the persistence of gendered roles in caring (Daly and Lewis 2000; Leira 2002; Pfau-Effinger and Geissler 2005) and underline the care provision as a key indicator in respect to work-life balance. Kröger (2011) has translated this critique into the concept of de-domestication, pointing out that defamilisation works with the notion of economic family independence, whereas dedomestication is itself based on the independence of informal care provision within the family. He measures dedomestication using an index including a time replacement rate (average hours of replacement through care services per week), availability, affordability and quality of services. His results suggest slightly different results than studies on defamilisation (Bambra 2004; 2007), with Nordic countries still in the lead (Denmark at the top) and Central European countries at the end (Austria and Hungary included as representatives).

Work-life balance is not only to be addressed at macro-level. Employers are important actors in this sense as they may help employees to reconcile these life spheres via various measures. Den Dulk (2001) differentiates the following groups of measures: flexible work arrangements, childcare arrangements, leaves and supportive arrangements. Workplace flexibility occurs in positive and negative forms (such as numeric or financial flexibility (Wilthagen 2006), time, spatial or workplace flexibility (Wallace 2003)). It has been shown that welfare states influence the forms of workplace policies. Den Dulk et al. (2012) denote that work-life balance measures in the workplace can be explained by welfare state contexts and even more by characteristics and conditions in organisations. Employers only partly make up for lacking public policies; this supports the argument of institutional accounts but mainly the argument of rational choice based decisions which consider institutional settings and conditions in the organisation as both the resource and the constraint.
Cultural factors

Marshall’s definition of social citizenship, including access to civil, political and social rights, has been contested for its notion of universal citizen being based on man and not on woman (Orloff 1993; Siim 2002). Recent feminist discussions are twofold, focusing on the value of motherhood and caring in the society and on the value of full citizenship for women (Siim 2002). The concept of universal citizenship has been recently discussed in relation to care models at micro-level.

At the micro-level, the gender culture (Pfau-Effinger 2004) impacts on preferences and ideals of care. Hakim (2003) studied preferences of women and distinguished three types of women: work-centred with a clear preference for work over family, family-centred whose priority is family and children and who do not intend to work, and adaptive women – a heterogeneous group encompassing those who want to combine both paths, to drifters and women with unplanned careers. The sizes of the groups vary across countries also due to divergent family policies. Hakim argues (2003; 2006) that men, in comparison to women, are more homogenous (assuming an orientation on work), which gives them the advantage in the patriarchal world. Although the theory provides valuable input in studying motherhood, unfortunately it does not explain how women choose among different strategies and what role the structural conditions play in this decision making (Pfau-Effinger 2004; Crompton and Lyonette 2007).

The problem of work-life balance also varies among families. Leira (2002), building on her study of motherhood (1989), distinguishes among three models of families: a model with specialised roles where the combination of work and family is ensured through a division of parental and economic provider roles; second, a model with sequential employment of mothers where women work only if there is no conflict with their caring duties, and third, a model of family with shared societal roles where both mothers and fathers are expected to share parental and breadwinning roles. Distribution of responsibilities in the family is shaped by cultural norms – the interpretation of ideal family and norms connected to good motherhood, fatherhood and childhood (Leira 2002).

Normative expectation of women to care is not necessarily in line with their personal needs and goals. Women therefore face the tensions between economic and emotional values related to care provision. The second group of tensions relate to the notion of ideal and good quality care that is informal and provided within a family based on love, obligation and commitment, compared to the formal care that does not comprise these values. Such dualisation of care is being eroded, as in reality more various forms of care occur and therefore the structure becomes more diversified (Pfau-Effinger and Geissler 2005; Anttonen and Zechner 2011). Pfau-Effinger and Geissler (2005) differentiate among several groups of caregivers based on the character of the relationship between the care-giver and care-receiver (care or paid work) and whether the care is regulated by the system or not. Care can be provided by informal carers, recognised carers who receive an income replacement benefit for care, remunerated carers who are paid a wage, organised voluntary carers, agency workers who may also do other types of work and care workers – professionals who are employed to provide care and who must have specific qualifications and adhere to quality standards. The diversity in care provision brings about the challenge of multiple agencies and
practises of care related to gender, class and ethnicity. Men get involved in caring in their older age, in the role of spouse carers, and often, especially in Nordic and Western countries, eldercare is provided by female as well as male workers of migrant origin. Thus, the picture of a principal informal female caregiver changes over time (Anntonen and Zechner 2011).

**Institutional factors**

New institutionalism also attempts to explain behaviour and action at various levels. Three schools of thought can be distinguished: historical, sociological and rational choice institutionalisms (Hall and Taylor 1996, Gorges 2001, Peters 2005). They describe differently the mechanisms through which institutions shape individual behaviour. Historical institutionalists define institutions as formal and informal procedures, norms, conventions but also routines embedded in the organisational structure of polity and policies (Hall and Taylor 1996). The view on individuals is eclectic, based on rational and cultural approaches considering people as both utility maximisers and satisficers. Institutions then provide templates for interpretation and actions for individuals. As Hall and Taylor (1996: 939) note: “Not only do institutions provide strategically-useful information, they also affect the very identities, self-images and preferences of the actors.”

According to rational choice institutionalists, the institutions are designed to help individuals overcome market failures (Gorges 2001) and exist over time only if they provide more benefits to the relevant actors than other alternatives. The behaviour of individuals is shaped by their notion of the highest utility and by their expectations on the likeliness of the behaviour of others. Institutions influence this in two ways: first, by structuring the range of alternatives, and second, by providing information or regulating the behaviour of others (Hall and Taylor 1996). A much broader understanding of institutions is common for sociological institutionalists who define them not only as rules, procedures and conventions but also symbols and moral templates. These elements function through norms of behaviour that internalise them through the process of socialisation into certain institutional roles (Hall and Taylor 1996).

Institutions may affect the behaviour of individuals through various means based on different rationalities. Clearly, it is not only legislation, rules, and institutional settings but also informal rules (Hall and Taylor 1996, Lieberman 2001, Mahoney and Thelen 2010), and other more indirect means such as values shared through powerful discourses (Bacchi 2000, Bacchi 2004).

Politicising the discussion of care provision has shifted it from the private to the public sphere, reconceptualised as entitlement of families within the discourse on equal social rights. Care is regarded as a joint venture and the responsibility of both families and the state. Similarly, the work-care reconciliation is no longer seen as the responsibility of women but also of employers and labour market organisations (Leira 2002). When referring to care as a relational good, the individual ability to manage these relationships with regard to individual well-being will always be constrained by the actual resources and governance of care.

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3 Becker (1993) explained the division of the roles within the family in a similar way.
Care burdens may impact on the quality of life of both the caregiver and the person who receives care. It is assumed that combining employment and care duties generates stress (Lilly et al. 2010), however it largely depends on the conditions under which these duties are fulfilled. Hansen et al. (2013) show that informal care of a dependent elderly family member does not have an impact on the well-being of the caregiver, be they men or women, if the elderly family member is not living in the same household. In-household caregiving adds psychological distress, surprisingly mainly to women who work part-time. As regards the care provided to a life partner, it has been shown that this type of care impacts both the cognitive and affective well-being of caregivers, however more strongly for women. This shows that care giving duties interfere to a larger extent with the personal and social activities of women (Hansen et al. 2013). However, in Nordic countries the situation is expected to be better since the provided care has mostly the character of emotional or operational care, rather than personal care that is provided predominantly by formal care providers (Hansen and Slagsvold 2013). It has been documented that combining care and work has a stronger impact on women than men, more so for those who share the household with the care recipient, as they are exposed to the care duty. Psychological well-being is possibly affected because of the care burden itself, but most probably also due to norms and notions of how the care should be provided and under what conditions.

**Linking the micro- and meso-/macro perspective of care services**

In order to explain the interplay of the macro-level and micro-level factors that shape both the strategies of households in ensuring care as well as the strategies of the actors who design and implement the policies, we begin with the distinction of three broad categories of factors which shape both the macro-level processes forming both the policy design and policy implementation by the actors involved in care policies and also the micro-level strategies of the households (see Scheme 1.1).
### Scheme 1.1 Overview of the theories on the factors shaping care policies (macro-level) and strategies of households (micro-level)

<table>
<thead>
<tr>
<th></th>
<th>Structural factors</th>
<th>Cultural factors</th>
<th>Institutional factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Micro-level</strong></td>
<td>Self-interest (problem and economic pressures, choices and gains available for the family)</td>
<td>Preference theory (combining work and family)</td>
<td>Gender divisions (homework, labour market attachment)</td>
</tr>
<tr>
<td><strong>(households – service users)</strong></td>
<td></td>
<td>Care (ideal) models</td>
<td></td>
</tr>
<tr>
<td><strong>Meso- and Macro-level</strong></td>
<td>Functional theories: New social risks + Ageing + Changing employment patterns ‘Women’s revolution’ Political factors: Power resource theory Self-interest in policies Economic factors: Policy costs and economic affluence (Austerity discourse)</td>
<td>Cultural theories (gender order, gender culture) Care cultures Intergenerational family</td>
<td>Path-dependency and critical junctures Historical, sociological, actor-centred, discursive institutionalism Policy feedback</td>
</tr>
<tr>
<td><strong>(actors: service regulators, service providers)</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Source: authors

The general assumption on why and how micro- and macro-levels interact is that in modern democracies the policies respond to the preferences and demands of the public over the long-term (at least to some extent), as democracy theory suggests.

In terms of agency and processes, the problem of caring and work-life balance that is being solved on everyday basis at the individual level, is related to three interconnected processes at the macro-level, as summarised by Leira (2002) and Esping-Andersen (2009):

- Masculinisation of female life courses, wide engagement of women in the labour market and related modernisation of motherhood;
• New forms of family formation, shifts towards collectivisation of childcare provision;
• Feminising male life-courses, familisation of fatherhoods, support to father to care for children.

These processes, however, are not mutually compatible in their extent and timing. As Leira (1998) earlier noted, these processes have not yet been successfully completed since high labour market participation of women still does not mean that gender equality in the labour market has been reached. Similarly, the development of the dual-earner model has not been yet sufficiently backed-up by the progress in the dual-carer model and unpaid work is not distributed equally. Therefore, the problem of work-life balance persists because the division of labour between key actors is not even and satisfactory for women to engage in gainful employment without constraints.

This view has largely been used by feminist scholars to analyse welfare states – supporting a strong or weak breadwinner model or a model combining features of both, this is a modified breadwinner model (Lewis and Ostner 1994). This division has been questioned for being based on the male full-time breadwinner while not explaining the other constellations. Sainbury (1996) later proposed to complement the male breadwinner model with an individual model which looks at individuals, disregarding other members in the family/household.

Fraser (1994) also formulated tripartite access to full citizenship through a universal breadwinner model based on taking men’s lives as the norm, a care parity model referring to family policies to make childcare costless, and a universal caregiver model taking women’s lives as the norm. For achieving such a situation, extensive support would be necessary. Crompton (1999) has differentiated divisions of labour varying from (1) traditional male breadwinner - female carer model, through (2) male breadwinner - female part-time carer, to (3) dual earner - state/private carer model and (4) dual earner - dual carer model. She suggests the way to a dual earner-dual carer model may lead through marketised or publicly provided care services. This model is seen by these scholars as ideal but even the Nordic welfare states with widespread provision of public care services are not getting close, since the involvement of men in care provision is not sufficient (Borchorst and Siim 2002).

Women’s strategies in reconciling work and care are affected by the above-mentioned factors – economic factors, institutional settings and cultural values (gender order). As relates to the employment of women, demand- and supply-oriented explanations may be distinguished (Daly and Klammer 2005). On the demand side, female employment is facilitated through employment in specific sectors, such as public or service sectors, or through the temporary nature of jobs. The supply side is influenced primarily by childcare policies and taxation and treatment of spousal earnings as a form of (dis)incentive for a second income in a family. Of course, the success of work-life balance efforts is visible in female employment that may feature interrupted paths, part-time work, changes in career trajectories (Rubery et al. 1999) or self-segregation into sectors where reconciliation is easier or possible at all.
In terms of the policy outcomes at the micro- and meso-/macro-levels, the welfare state typology seems to have a high relevance for understanding the ‘internal logic’ of the working of the welfare state. The typology mirrors how the policies are shaped on the macro/meso-levels as responses to the demands for the policies that are emerging at the micro-level of the households.

The classical typology by Esping-Andersen (1990) mainly focused on the old social risks and was based on the analysis of transfers and employment patterns to some extent, taking the dimension of de-commodification solely into account. Soon, feminist scholars criticised this typology as the interaction between social policies and gender relations; this criticism was neglected (Lewis 1993; Lister 2003; Orloff 2009; Sainsbury 1994). In reaction to this, the dimension of de-familisation introduced by Esping-Andersen (1999) – combined with the decommodification dimension - enables the researchers to distinguish different models of care policies. The dimension of de-familisation then has become key to incorporating the care services into the welfare state models (Esping-Andersen 2009; Javornik 2014; Jensen 2008; Jensen 2009a; Saraceno and Keck 2011; Stoy 2014) since caring services are central for making family members less dependent on family obligations.

Leitner (2003) has offered a typology which is based on the analysis of care models by distinguishing between familialising and de-familialising models. The overlap of both models is also possible and she calls this optional de-familialism; it provides both cash support for care within the family (familialism) and in-kind support/formal care (defamilialisation). Leitner also paid attention to the gender dimension by distinguishing gendered and de-gendered de-familialism. Still, some authors claim that the dimension of de-genderisation is more important (Saxonberg 2013) or emphasize feminism as underlying concept (Borschorst and Siim 2014).

Javornik (2014) and Saxonberg (2013) emphasized that childcare services have the highest explanatory power for cross-country variation in female employment. Javornik (ibid.) also explains that normative assumptions about the social organisation of care and gender roles most clearly underpin regulations on parental leave and childcare services. These assumptions constrain parents’ choices and hence their opportunities to be employed and raise children; she calls this the ‘policy conceptual logic’. Next, according to her, government initiatives can also transform gendered roles and normative parenthood ideals; she calls this the ‘policy transformative potential’. Coming from the above assumptions and with use of the analysis of legislative materials, she constructed an ‘index of de-familialism’ which measures the degree to which the state supports women’s continuous employment and promotes active fatherhood. This measure enabled her to show the striking difference between Visegrád countries (extremely low index of de-familialism levels) and other ‘post-communist’ countries like Slovenia and Lithuania (relatively high index of de-familialism levels).

Saraceno and Keck (2011: 373-374) integrate the key dimensions discussed above that distinguish the substance of care policies by focusing on the intersection of two parallel divides: the first is commodification vs decommodification and the second familialism by default/supported familialism/defamilialism. They also consider the third dimension of gender equality (rebalancing
care responsibilities in caring). They apply these three dimensions on the analysis of childcare and eldercare patterns within the broader context of family policies in the European countries and they distinguish four prevailing approaches. The first policy approach is represented as a mix between supported familialism and decommodified defamilialisation in childcare, and decommodified defamilialisation in eldercare, clearly supporting a dual breadwinner model and gender equality by rebalancing care responsibility. This is typical in Denmark, Norway and Sweden. The second approach is ambivalent concerning gender-specific expectations, strongly oriented towards supported familialism and weak decommodified defamilialisation through services, particularly for childcare. Incentives for fathers to share parental leave are weak. The Czech Republic falls into this family of countries. The third approach is represented by familialism by default where both decommodification and defamilialisation are weak, women’s independence not much supported (typical for South Europe countries and some post-communist countries). The fourth approach is characterised as internally divergent (examples are Finland, France, UK and other countries).

Léon et al. (2014: 13-14) also attempt to integrate the analytical perspectives in order to characterise the patterns of development in childcare and eldercare by referring to the paradigm of universalism ‘that aims at an equal distribution of services and/or benefits among individuals belonging to the same group’, distinguishing universalism in both the right to be cared for and the social right to care for someone else. They argue that although care services were traditionally characterised through a weak definition of rights and responsibilities, universalism has become the prevailing paradigm due to the increasing need for greater coverage and expansion in childcare and eldercare in the context of current societal and demographic changes. Nevertheless, this principle has been confronted with the challenges of diversity and autonomy on the part of care recipients, freedom of choice, with contrasting ideas of what the best way to organise care should be (public provision and funding versus more market- or family-led) as well as higher financial constraints since 2007, giving way to more ‘selective universalism’ and cross-national variations in patterns of care. This approach is compatible to large extent with the previously discussed analytical dimensions: the universalism principle seems to be constituted by a larger degree of decommodification, defamilialisation, and gender equity.

The research focuses not only on the extent and substance of the services provided but also how they are provided (Pollit and Bouckaert 2000; Daly and Lewis 2000; Ahonen et al. 2006; Jensen 2008; Sirovátka and Greve 2014; Stoy 2014). The dimension of governance in social and care services is crucial because this captures the mutual relationships and the roles of the state, market and families. Care ‘lies at the intersection of public and private (in the sense of both state/family and state/market provision’ (Daly and Lewis 2000: 282). Hence the mixed economy of care is typical, while the shape of it increasingly varies among countries. A mixed economy of care includes families and households, markets/quasi-markets, communities (third sector) and state, ‘the care diamond’ (Evers 1993). Hence the governance perspective is becoming increasingly powerful in capturing the shifts in the modes of governance which are introduced by the processes of splitting the functions of regulation, financing and service delivery, accompanied with marketization, decentralisation and recentralisation, new public management, networking and public-private partnerships (e.g. Seeleib-Kaiser 2008; Sirovátka and Greve 2014). Because of the multiple
character of care in terms of the actors involved, the issue of complexity and multi-level governance becomes a crucial aspect of care. Second, co-existence of the various modes of governance creates particularly sharp tensions during reforms, as deeply embedded institutional norms and rules are challenged by new logics of appropriate action (Newman in Vabö 2014).

Taking governance into account, the macro-level (care infrastructure and division of care services and/or benefits) and micro-level (the distribution of care – giving and receiving) may be integrated (see Scheme 1.2):

Scheme 1.2 The analytical frame of care policies

<table>
<thead>
<tr>
<th></th>
<th>Macro-level</th>
<th>Micro-level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conceptual frame</strong></td>
<td>Division of care (labour, responsibility and cost) between state, market, family and community, (formal and informal institutions)</td>
<td>Distribution of care (labour, responsibility and cost) among individuals within family and community The character of state support for caring and carers</td>
</tr>
<tr>
<td><strong>Indicators</strong></td>
<td>1 The care infrastructure (services, cash)</td>
<td>Who provides care</td>
</tr>
<tr>
<td></td>
<td>2 The distribution of provision between sectors (interaction between formal and informal institutions)</td>
<td>Who is the recipient of benefits and services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Which kind of relations exist between caregiver and receiver</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Under what economic, social and normative conditions is caring carried out</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What are the economic activity patterns of women of caring age</td>
</tr>
<tr>
<td><strong>Trajectories of change</strong></td>
<td>More/less State Market Family Community</td>
<td>An alternation in the distribution of caring activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>An alternation in the conditions under which</td>
</tr>
</tbody>
</table>
An alternation in the relations between care-giver and receiver

Daly and Lewis 2000: 287, adapted

Conclusion

Structural, cultural and institutional factors overlap when shaping the policies of childcare and eldercare. The structural factors both imply the continuous shift of the welfare states towards more emphasis on services due to the increasing need for formal care. On the other hand, cultural and institutional factors mediate the problem pressure in how and what policies emerge. This comprehensive perspective will help us to understand the development of care services in the two countries in focus. These countries vary greatly in areas such as economic level, development of the welfare state, care services in particular, institutional legacies and cultural contexts. This perspective may help us also to understand how policies and strategies of service providers (macro- and meso-levels) and service users (micro-level) interact. Lastly, we are interested in discovering the critical junctures and the path shifts/breaks in policy making which enable policymakers to respond the problem pressures more effectively. We will pay attention to the actors’ perspective (to their discourses and strategies), both at the level of households and policymakers.

The theoretical approaches presented above allow us to structure possible interpretations of care practices within work-life balance arrangements in both countries: functionalist theories emphasising structural factors, cultural theories emphasising values and norms (gender and parenthood related norms in particular), institutional theories emphasising the role of the institutions, actors and policy discourses. The limitations of each individual theory are apparent. As it is very unlikely that the individuals, as well as the other actors somehow involved in care giving, would be led only by the idea of the highest utility of their actions, it is equally short sighted to believe that care giving and provision of care is fully shaped by cultural norms or only framed by institutional settings. Our further research, unlike many other works, does not deal with the question of the highest explanatory power of one or another theoretical approach on strategies of actors involved in caregiving. Rather, the interesting question is how the strategies of caring in households as well as policies supporting formal care are shaped in the process when different factors interact. One has to bear in mind that these strategies develop in different cultural and institutional contexts, and thus their mutual compatibility or synergy emerging from such interaction is very much dependent on these contexts.
Section 2: Care policies and governance in Norway and the Czech Republic

Pavel Horák, Markéta Horáková, Marie Louise Seeberg and Jorunn Theresia Jessen

Introduction
This section is devoted to the comparison of design and governance of contemporary childcare and eldercare policies in Norway and the Czech Republic, countries that face historically similar (although not equal) structures of in-need populations. In the case of childcare, both countries are similar regarding the parental behaviour of the population, the proportion of preschool children to the total population (3-4%), most of whom grow up in two-parent households (52% in Norway, 38% in the Czech Republic in 2014), and the proportion of children with disabilities or other specific needs (under 10% of children living in at-risk-of-poverty households in Norway, and under 15% of such children in the Czech Republic) (ČSÚ 2015; Statistics Norway 2015). In case of eldercare, the populations in Norway and in the Czech Republic are ageing like in other European countries (15.9% of people are above 65 years in Norway and 17.4% in the Czech Republic in 2014) due to the long-term decline in fertility and the increasing life expectancy. This situation is expected to continue in the coming decades (more than 21% of the population is expected to be older than 65 in Norway and more than 27% in the Czech Republic in the year 2050) (Eurostat 2015).

Approaches towards care policies are different in both countries in accordance with the divergence of the welfare regimes to which they belong. Norway is a representative of the Scandinavian (social-democratic or Nordic) welfare state model, which is known for its high level of decommodification, full employment, universal benefits and high degree of benefit equality (Esping-Andersen 1990). Social protection is seen to be a crucial citizenship right in this welfare regime, which also advocates the principle of universalism as well as equal opportunities for men and women in society (Andress and Heien 1999, Leira and Ellingsæter 2006, Thorkildsen and Kavli 2009). In terms of family-linked care responsibilities, the Nordic welfare states represent the dual earner/dual carer model which resolves the tension between employment-focused and care-focused demands concerning both gender equity and women’s financial autonomy (Saraceno and Keck 2011). Moreover, the Nordic countries have often been labelled “service welfare states” due to the delivery of social care (for children and elderly) and health care services predominantly by the public sector (Greve 2007).

In contrast to Norway, it is not easy to unambiguously categorize Czech family policy and the Czech welfare regime. Indeed, social policy in the Czech Republic – like in other post-communist countries – arises from the Bismarckian tradition which was interrupted by the era of
communism and normalisation. After 1989, some analysts expected the welfare state reforms to remain minimal, others expected the development of the post-communist welfare states towards a Scandinavian-like model or a residual model with a neoliberal emphasis (Wagener 2002, Kuitto 2016). However, in current literature these regimes are increasingly classified into a specific category, often called “hybrid” (Cerami and Vanhuysse 2009, Kuitto 2016), because of the melding of features which are typical for different kinds of more mature welfare states (Szikra and Tomka 2009). Cerami (2006) suggests the emergence of the Central and Eastern European welfare regimes which combine pre-communist (Bismarckian social insurance), communist (universalism, corporatism and egalitarianism) as well as post-communist (market-based schemes) features. Moreover, some analysts show that the emerging welfare states in post-communist countries are heterogeneous as well (Kuitto 2016, Cerami and Vanhuysse 2009). As Szikra and Tomka (2009) argue, as a result of strong path-dependencies, the Central and Eastern European welfare systems have grown into more diverse and mixed structures than the ones we find in Western Europe.

**Childcare policies**

Family and childcare policy have been traditionally high on the policy agenda in the Nordic countries. **Norway** represents such countries in which an extensive support for families with children is provided through policies aiming to reconcile work and family life, to share paid and unpaid work more equally between men and women, and to provide solutions that reflect the interest of the child (Rostgaard 2014). In Norway, family policy, however, was formulated rather implicitly from its beginning, with the present model of childcare being developed gradually in a dynamic interplay of supply of and demand for childcare over the past 30-40 years (Ellingsæter and Gulbrandsen 2007). Currently, the principle of gender equality has been accentuated not only on the labour market but also in caring responsibilities accompanied by the emphasis on the parental choice and wish to maintain state neutrality (Skevik and Hatland 2008). The first is represented by the father’s quota in parental leave introduced in 1993 and extended later, while the second is posed in the cash-for-care benefits introduced in 1998. As a result, the present Norwegian childcare (welfare) model exhibits some distinctive features when compared to other Scandinavian countries, for example in the mixed governance of childcare or the much slower process of institutionalism of childcare as a legal right (Ellingsæter 2012). According to Korpi (2000), Norways has a more dualistic family policy and has been ranked high on policies that give both dual-earner support and policies that give more general family support. Rønsen and Skrede (2006) suggest labelling Norwegian policy towards family and work as “gender equality light”, while Duvander et al. (2010) propose that the dualism of Norwegian family policy presents the possibility of gender equal parenthood more as an option than as a norm.

Three measures are especially important when analysing key elements of Norwegian family and childcare policy. First, the Norwegian parental leave programme is intended to make the combination of female employment and family life more feasible not only through the mother’s rights on the labour market but also by the possibility for father’s leave. In 1993, Norway was first
to introduce a father’s quota of one month, and it was subsequently widened it to the current ten
weeks (Rostgaard 2014).

Second, Norway has very extensive formal day care facilities tied up with the “childcare
revolution” from the 2000s (Ellingsæter 2012). Some specific features are characteristic of the fast
development of childcare in Norway. Norway has supported not only the quantity of day care
services but also their quality at the same time; this was reflected in a number of policy documents
during the 2000s (Ellingsæter 2012). Similarly, in tandem with the increased efforts to achieve full
coverage, the equal financial treatment for private and public kindergartens by the state has become
the reality. Last but not least, one element of the “childcare revolution” is the mixed governance of
childcare services in which the establishment and expansion of kindergartens is a municipal
responsibility with the central government being responsible for funding and legal/regulatory
aspects, including a relatively unified standard of services (Ellingsæter 2012). Because of this
holistic approach (Ellingsæter 2012), social investment approach (Jeroslow 2014, Ellingsæter 2012)
and monitored high quality of childcare, the idea that kindergartens are good for children in their
own right is now widely shared in Norway, to the extent that one might call it hegemonic (Seeberg
2010), and this idea serves to legitimise the system. This hegemony, however, is balanced by a
persistent, if relatively mild, form of complementary gender ideology (male breadwinner/female
care provider) as represented by the Christian conservative party.

Third, the principle of free choice and state neutrality is supported by the provision of the
Norwegian childcare cash benefits which are generally available as long as state-subsidized day
care facilities are not used. The main purpose of such a benefit scheme is to give families more
flexibility with respect to their own childcare options. Its critics argued that benefits reduced
incentives for women to participate in the labour market and therefore encouraged a more
traditionally gender-differentiated family (Ellingsæter and Leira 2006), while those who are in
favour of these benefits suggest that the cash-for-care scheme would give families “real freedom of
choice” (Lappegård 2010).

In contrast, the current Czech family policy may be seen as a combination of conservative
and liberal values (Sirovátka 2004, Saxonberg and Sirovátka 2009, Plasová 2012). Together with
Slovakia, Slovenia, Hungary, and Estonia, it subscribes to an explicit familialism policy model that
supports familial childcare and reinforces gendered parenting by rewarding families with public
support to provide childcare themselves. It promotes the disproportion that exists between men
and women in labour market participation and in the division of household responsibilities and childcare
(Szelewa and Polakowski 2008, Bartáková 2009, Javorník 2014). The main responsibility for care
provision is moved to the family, and it is women who primarily interrupt their careers to care for
young children before returning back to paid (mostly full-time) employment after several years
(usually three) (Plasová 2012). The traditional gender role division persists as the cultural norm and
the main starting point for creating family policy, despite the fact that the principle of equal
opportunity is gradually permeating the discourse (‘political correctness’) as a result of EU
integration.
At least two aspects are characteristic of the “recent face” of family and childcare policy in the Czech Republic. First, there is only partial coverage of young children (especially those under 4 years), which is due to the persistently insufficient capacity of formal day care facilities. Indeed, the evolution of childcare in the Czech Republic has been particularly marked by a significant loss of childcare facilities (‘nurseries’) for the youngest age groups after 1989 and a growth trend in demand for these services by contemporary parents with children under four. To meet this demand, alternative forms of childcare by private child-minders or neighbours and newly emerging corporate kindergartens have emerged since 2007, as have new facilities for children from one to six years of age since 2014 (publicly or privately funded ‘children’s groups’) and from 4 months to 4 years of age in the form of newly scheduled ‘micro-nurseries’ to be inaugurated at the start of 2017, funded by ESF and established by municipalities in cooperation with NGOs. The emergence of public forms of these facilities is a response to the fact that private nurseries are financially unavailable to most women (Šebestová 2013) as well as the pressure on public kindergartens in many regions that must now offer places for children from two years of age who were previously in nurseries (Hašková 2010, Plasová 2011, MEYS 2014a, Školský zákon 2016).

The scheme of very long paid parental leave is the second aspect of contemporary Czech childcare. It represents the strong orientation towards supported re-familialism and only weak decommodified defamilialisation through childcare services (Saraceno and Keck 2011). Regardless of the low and flat rate of parental benefits, parental leave belongs to the schemes which have seen a relatively high development driven by the effort to move closer towards the principle of gender equality in recent years. It is now more flexible in terms of both the length of support period and the possibility for parents to combine work, home care and the use of formal childcare facilities. There is only one restriction on childcare and work options regarding the youngest children – when taking benefits, parents are only allowed to place a child under two years old into a childcare facility for only 46 hours a month. From this perspective, the relative flexibility of parental leave is the core presumption for the “intermittent” job career for parents. These options, however, depend on the labour market capacity and employment opportunities (especially part-time and flexitime) for women with small children, which are, however, limited in the Czech Republic (Plasová 2011, Plasová and Godarová 2015).

In general, the combined effect of a persistently flat parental benefit rate and a limited supply of childcare facilities for children aged 0 to 3 feeds the imbalance between the roles of women and men in Czech society. Thus, Czech childcare is based on a philosophy of family-friendly measures and conservative values that support the notion of a male breadwinner and female caregiver.

Benefits and services provided in childcare
Although the structure of the types of benefits to families with children is similar in Norway and the Czech Republic, they significantly differ in generosity and costs when the state expenditure on cash benefits for family and children has consistently been three times higher in Norway than in the
Czech Republic and almost one and half times higher than the EU 25 average in the last decade. Expenditure on child benefits in the Czech Republic are similar to Latvia or the Netherlands and the expenditure in Norway is similar to Austria or Sweden (Eurostat 2015).

Table 2.1 Cash benefits for Family/Children as percentage of the GDP in selected European countries in last decade

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Norway</td>
<td>3.1</td>
<td>3.0</td>
<td>2.8</td>
<td>2.7</td>
<td>2.8</td>
<td>2.7</td>
<td>3.2</td>
<td>3.1</td>
<td>3.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>1.4</td>
<td>1.5</td>
<td>1.3</td>
<td>1.3</td>
<td>1.6</td>
<td>1.4</td>
<td>1.4</td>
<td>1.3</td>
<td>1.2</td>
<td>1.1</td>
</tr>
<tr>
<td>EU (25 countries)</td>
<td>2.2</td>
<td>2.1</td>
<td>2.1</td>
<td>2.0</td>
<td>2.1</td>
<td>2.1</td>
<td>2.3</td>
<td>2.3</td>
<td>2.2</td>
<td>2.2</td>
</tr>
</tbody>
</table>

Source: Eurostat (2015)

The difference between Norway and the Czech Republic exists also in the design of benefits that cover the time period associated with the birth of a child and his subsequent care. These events are covered by benefits under the ‘parental leave’ legislation in Norway and under ‘maternity leave’ and ‘parental leave’ in the Czech Republic. Both systems differ in three key aspects: in the level of flexibility of possible take-up, in the generosity of coverage provided for income loss, and in the length the benefit is paid (up to two years old of a child in Norway and four years in the Czech Republic).

Norwegian parental leave can be characterized as a unitarily delivered and generously funded system where benefits are calculated from the previous income and delivered for a relatively short time period (1 year and one week at 100 percent coverage, or 1 year and 11 weeks at 80 percent coverage, compared to the previous salary) (NAV 2013). By contrast, maternity leave and parental leave in the Czech Republic are fragmented, poorly funded and delivered as a flat rate for a long period of time (maternity leave usually for 7 months at 70 percent coverage of the previous salary, and parental leave for 1 year and 12 weeks to 3 years and 7 months at ½ to 1/5 of the average monthly wage until the child reaches four years of age, with the level of benefit depending on how long the benefit is received) (MLSA, 2016). The flexibility to swap take-up between parents is much greater in Norway because the involvement of fathers in caregiving is far more common than in the Czech Republic (a ten-week maximum for the mother, a ten-week maximum for the father, and a shared maximum which equals the rest of the leave period - for 6.5 or 9 months, depending whether parents choose 100% or 80% coverage) (NAV 2013, 2015).

Whereas parents in Norway have the legal right to place all their children older than one year of age into public or private collective facilities (‘kindergartens’), parents in the Czech Republic have a right to place children usually older three years into public facilities (Školský zákon 2016). Therefore there are also other forms of public (“nurseries”) or private facilities in the Czech Republic (“children’s groups”, “micro-nurseries”, and other private facilities provided either by professionals or as part of unregulated trade) that are more or less accessible to parents with children older than one year (see in detail below in the section on accessibility of childcare services). These facilities are established by both regional offices (in the Czech Republic) and
municipalities (in both countries) as well as by national or international care-for-profit companies, churches and parishes (in both countries) and other non-commercial, private actors (in Norway).

Regulation and financing of childcare policies
The authority responsible for the regulation of childcare differs in Norway and in the Czech Republic depending on the extent and diversity of facilities offered in both countries. Norwegian childcare (“kindergartens”) is therefore managed by a single ministry (Ministry of Education and Research) that has overall responsibility for financing and regulating the quality, content and security of children’s rights to attend public and private pre-primary institutions (defined as pedagogical undertakings for children under school age/less than six years – ‘kindergartens’) (NMER 2011). In the Czech Republic, responsibility for financing and regulating the public and (in some cases also private) pre-primary institutions are in the hands of both the Ministry of Labour and Social Affairs (‘children’s groups’, ‘micro-nurseries’) and the Ministry of Education, Youth, and Sports (‘kindergartens’). Private corporations and private kindergartens that are not on the Ministry of Education’s List of Legal Entities are regulated by the Ministry of Industry and Trade (Plasová and Godarová 2015).

Whereas public kindergartens are established by the state, municipality, region or association of municipalities, private facilities are established by religious, legal persons or other legal entities. In Norway, providers of both public and private forms of kindergartens must respect the same legal framework. The responsibility for providing childcare services is held by the regional office or municipality in both countries (or trade office in case of private services in the Czech Republic) and the monitoring is performed either by the municipality (in Norway) or by the local education authority (školský úřad in the Czech Republic).

The quality of care is regulated at the national level in both countries by the enforcement of hygienic standards and standards stipulating the educational and professional level of staff. In Norway, the increasing attention directed to the quality and content of kindergartens includes a provision which has been in place since 2005 that ensures children’s rights to express themselves and to influence everyday life in the kindergarten (Lurie and Tjelflaat 2012). Specific children’s needs are reflected through advanced cooperation among actors, especially at the local level (kindergarten directors, health centres, schools, child protection services, kindergarten teams, and pedagogical/psychological service providers). On the other side, stable cooperation only takes place between city boroughs and kindergartens in the Czech Republic during periods when it is necessary to fully use the capacity of the public kindergartens (Plasová and Godarová 2015).

Financing of childcare is secured in both countries from national and supranational sources (state expenditure and grant schemes from the EU) and by individual households (individual fees payed by parents). The level of expenditure on public and private childcare services is quite high in Norway (ordinarily three times higher than in the EU, as in the case of benefits), whereas the same expenditure is at an average level in the Czech Republic (Eurostat 2015, see Table 2.2).
In the second case, some public and most private facilities in both countries use ESF sources (unfortunately, accurate statistics are not available). Finally, the costs for parents in public kindergartens are graded according to parental income in Norway and requested as unified fee for all parents in the Czech Republic (with exception of low-income families that have relief). The price for one full-time place in public kindergarten is similar in both countries: maximum of 4% of the household’s combined salary income before tax in Norway and between 3-5% of the average wage in the Czech Republic (Haug and Storø 2013; Horák Horáková and Sirovátka 2013).

In Norway, parents’ costs for private kindergarten differ only marginally from its public form: the only difference may be an added fee for meals in private kindergartens (Haug and Storø 2013). On the other side, private facilities in the Czech Republic (nurseries corporate kindergarten, babysitting etc.) are very costly, open only to wealthy parents in large cities (the cost of private nursery schools for children under three years of age are 60% of the average monthly wage compared to 44% for private kindergartens) (Horák, Horáková and Sirovátka 2013; Plasová and Godarová 2015). For this reason, a small number of parents in the Czech Republic hire nannies in the grey economy (where prices are much lower and quality is ensured by references from friends (Paloneyová et al 2013)) and other parents shy away from use of any kind of facilities and stay at home with their children.

**Accessibility and quality of childcare services**

In Norway, the same proportion of preschool children attend public and private kindergarten, whose accessibility is almost universal (98% in 2013). The same proportion of children in the Czech Republic attend public facilities, however accessibility for children younger three years is very poor (Eurostat 2015). Concretely, eight out of ten children under three years of age (80%) attended some preschool facilities in Norway in 2013 compared to two out of ten children (5%) in the Czech Republic (Eurostat 2014). The number of nursery schools and children’s groups focused on children older than one year is thus very limited in the Czech Republic (31 nursery schools to accommodate less than 1000 children in 2013) although the number of children’s groups dramatically increased in 2016 (from 100 for 1455 children in April to 400 for 5,500 children in December) (Eurostat, 2014; IHIS, 2014, 2013, MEYS 2016). At the same time, kindergarten attendance for children older than

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**Table 2.2 Expenditure on pre-primary level of education as % of GDP in the Czech Republic and Norway in 2003-2011**

<table>
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</tr>
</thead>
<tbody>
<tr>
<td>CZ</td>
<td>0.52</td>
<td>0.48</td>
<td>0.49</td>
<td>0.51</td>
<td>0.50</td>
<td>0.49</td>
<td>0.60</td>
<td>0.63</td>
<td>0.66</td>
<td>0.54</td>
</tr>
<tr>
<td>NOR</td>
<td>1.52</td>
<td>1.56</td>
<td>1.65</td>
<td>1.50</td>
<td>1.54</td>
<td>1.51</td>
<td>1.61</td>
<td>1.58</td>
<td>1.55</td>
<td>1.42</td>
</tr>
<tr>
<td>EU 28</td>
<td>0.48</td>
<td>0.48</td>
<td>0.47</td>
<td>0.50</td>
<td>0.51</td>
<td>0.52</td>
<td>0.56</td>
<td>0.56</td>
<td>0.57</td>
<td>-/a</td>
</tr>
</tbody>
</table>

Source: Eurostat (2015)

Note: a: Because the scale of ISCED was changed in 2012, Eurostat does not yet have all data from particular Member States.
three years was also higher in Norway than in the Czech Republic (96.5% versus 77% in 2013) (Eurostat 2015; MEYS 2014b) (for more details see Table 2.3).

Table 2.3 Enrolment of children by age in early childhood education in the Czech Republic and Norway in 2013

<table>
<thead>
<tr>
<th>Age</th>
<th>0 year</th>
<th>1 year</th>
<th>2 years</th>
<th>3 years</th>
<th>4 years</th>
<th>5 years</th>
<th>6 years</th>
<th>Total 3-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>CZ</td>
<td>-</td>
<td>-</td>
<td>21301</td>
<td>71550</td>
<td>101638</td>
<td>105265</td>
<td>52464</td>
<td>278453</td>
</tr>
<tr>
<td>Total population</td>
<td>108692</td>
<td>109146</td>
<td>119504</td>
<td>121413</td>
<td>122945</td>
<td>118385</td>
<td>108825</td>
<td>362743</td>
</tr>
<tr>
<td>In %</td>
<td>-</td>
<td>-</td>
<td>17.82</td>
<td>58.93</td>
<td>82.67</td>
<td>88.92</td>
<td>48.21</td>
<td>76.76</td>
</tr>
<tr>
<td>NOR</td>
<td>1894</td>
<td>42336</td>
<td>56365</td>
<td>60946</td>
<td>62981</td>
<td>62266*</td>
<td>386</td>
<td>186193</td>
</tr>
<tr>
<td>Total population</td>
<td>60530</td>
<td>61429</td>
<td>63427</td>
<td>64443</td>
<td>63386</td>
<td>61799*</td>
<td>62108</td>
<td>189628</td>
</tr>
<tr>
<td>In %</td>
<td>3.13</td>
<td>68.92</td>
<td>88.87</td>
<td>94.57</td>
<td>99.36</td>
<td>100</td>
<td>0.62</td>
<td>98.19</td>
</tr>
</tbody>
</table>

Note: *The number of enrolled children and number of children in the total population were obtained from different data sources, the disproportion between them can probably be explained by the different methodologies of data collection or by the registration of the same children in more than one kindergarten.


The absence of services for children under three years of age in the Czech Republic has prompted a large-scale media debate on the part of policymakers, legislators, and parents over how the problem should be tackled. Czech parents also often complain about the gradual closing of kindergartens during the summer holidays (and thus a need to repeatedly move children between kindergartens) (Plasová and Godarová 2015).

Norway puts strong legislative emphasis on the quality of early childhood education in public kindergartens that meet the requirements of international documents. In the Czech Republic, the quality of public childcare services is traditionally good in terms of the care provided, staff training, children’s psychosocial development, pedagogical and hygienic standards (OECD 2011). However, the quality of some private childcare facilities for children under three years of age is not controlled by law and thus is out of state control (with the exception of hygienic and qualifications standards) (Kuchařová et al 2009; Paloncyová et al 2013).

Eldercare policies

In Norway, as in other Scandinavian countries, the model of eldercare is statist, with less formal responsibility for families. Estimates suggest a 50-50 balance between state and family care, with the state being more prominent in cases of extensive needs and the family more important when the
needs are less extensive (Daatland 2015). Care work is thus shared between the public services and the families, with families mainly providing more sporadic, practical, administrative and emotional care to younger elderly by grown-up children (especially adult daughters) and the public services providing extensive care, especially intimate bodily care, a sharing model that is supported by the preferences of elderly people themselves (Kaasa and Helse-og omsorgsdepartementet 2011).

There are particular three milestones in the development of eldercare in Norway. First, there was a real expansion of institutional care facilities provided to the elderly in the 1980s in response to some of the most critical challenges that society faced at that time (the dramatic rise in the number of elderly, the lack of labour and the need for gender equality in family and working life); and their reform during 1990s and 2000s. In the first period, the “volume of nursing homes, home nursing, and domiciliary services more than doubled” (Daatland 2015: 9). Then, the volumes of nursing homes saw a decline of about 25% during 1995-2010 but this decline was nearly outweighed by a corresponding increase in assisted housing. The widespread use of home-based care (as an alternative to residential care) has mobilized family members to share the responsibility with public care providers. Some re-familialisation of care is likely to have happened. The number of people 67+ receiving unpaid care from family and friends has increased since 1985. More than half of those who regularly receive help from relatives, friends and neighbours reported that they also receive formal home care (Daatland et al 2015). Since tasks are increasingly being offloaded from the public home care services, many families feel pressed to compensate for the lack of public help (Vabø 2011).

Second, the changes in social services governance have gone hand in hand with the expansion and reform of the social services networks. In 1986, legislative changes delegated the responsibility for a wide range of services to municipalities with the aim of encouraging an integrated approach to the supply of care (decentralization reform) (Vabø 2011). In recent years, as competitive tendering and free-choice systems have been put on the agenda, a new category of private for-profit providers have entered the scene. Outsourcing, competition, legal changes and the definition of care receivers as consumers (New Public Management) have made it possible for care-for-profit actors to enter the elderly care sector. However, 90% of non-family care is still provided by government-owned and run services and most of the 10% of private providers are still non-profit (Daatland 2015).

Third, a widening of the target group and a change in orientation towards home care has been apparent in recent years. With the Municipal Health and Care Services Act of 2011, focus was shifted from the elderly as a group in need of care to all groups in special need of care in the population, regardless of age. Currently, the role of home care in Norway has changed from a preventative role stressing practical and social care for the elderly with moderate care needs towards a more medicalized role providing personal care and nursing care for the most frail, disabled and chronically ill (old and young) (Vabø 2011).

While in Norway the continuous development of the eldercare system shaped the current system over a long period of time, in the Czech Republic the reconstruction of eldercare services
was initiated after 1989. This included radical changes of the former system (new forms of services were introduced such as day-care centres or personal assistance services and fieldwork services were expanded). A more comprehensive approach to care for the elderly (as a crucial part of long-term care) was started in 2006 when the new Act on social services regulating accreditation of and contracting with service providers was adopted. Also a care allowance scheme, similar to that in Austria, was introduced (Barvíková 2011). Care for frail older people in the Czech Republic is based mainly on the informal care provided by family members and relatives with the rather modest support of the state (rather low cash subsidies given for hiring professional services or for compensating a family carer). According to Schulmann and Leichsenring (2014), the Czech Republic belongs to the cluster of transition countries in which the high provision of informal care, generally low spending with only a small (but slowly growing) share of private financing and modest cash benefits are the key elements of eldercare. Similarly, Saraceno and Keck (2011) argue that in the Czech Republic defamilialisation of care for the frail old is reduced and preference is given to supported familialism through cash-for-care payments and care leave entitlements.

There are at least three crucial points regarding recent design of eldercare implemented in the Czech Republic. First, the principle of a quasi-market, through the implementation of the care allowance since 2007, has been introduced on the assumption that people entitled to the care allowance would use it to purchase social services. In reality, informal family care is predominantly used and the care allowance does not return into the service system. As a result, in order to keep the formal social services alive, they need to be increasingly more intensively subsidised from the state budget. Data by the Czech Ministry of Labour and Social Affairs (2015) show that in December 2014, 70% of care allowance recipients were family members and only 25% were professional care providers.

Second, the national priority target for deinstitutionalization has not led in reality to greater subsidies being allocated to the development of field/home-based services. This would have prepared the ground for residential services to overtake the provision of care for older people with more intensive care needs. In reality, older people doubt that the field/home-based services are sufficient to cover their needs and prefer to apply for a place in a residential social services facility. However, the national strategy does not favour building new residential homes for older people. This gap in policies creates opportunities for alternative solutions like the emergence of quasi-services of questionable quality. According to estimations by the MLSA (2014a), these establishments form at least 14% of the homes for older people in the Czech Republic.

Third, despite the fact that policy priorities similar to those in the ‘old European’ countries were introduced on the national level, the transition to the modern conception of eldercare provision on the local and regional levels has been rather slow. The finding that implementation of the national policy target can lead to the opposite outcomes on the local level than originally intended has significant policy implications. The findings indicate that despite the existence of a developed and regulated system of provision of eldercare services, the semi-legal quasi-services (that are so low quality that even the lives of the care recipients may be threatened) may, under certain
Benefits and services provided in eldercare

Social services for the elderly in Norway are provided both by counties (responsible for hospitals that provide only medical treatment) and by specialized health care services. The key providers are municipalities, responsible for the three main care services: (social and health) home-based care, nursing home care and supported housing. While home-based care includes large-scale home care services (home help, home nursing, respite care, alarm services, meals-on-wheels, home counselling, heavy cleaning etc.), nursing home care is designed to offer both short-term stays to people needing a period of rehabilitation or respite care and long-term medical and nursing care for frail and sick older people. Supported housing has been established as an intermediate care alternative to either nursing homes or ordinary retirement flats rented or owned by (old and young) people with disabilities that will receive home help or home nursing. As mentioned above, none of the municipal care services in Norway are only provided specifically for older people. Moreover, considerable demographic, economic, and geographic differences between the municipalities have resulted in a mix of traditional residential care facilities, home-based care and intermediate solutions.

In the Czech Republic, social services and benefits for the elderly are, much like services for children, a part of the social security system and health care is provided separately from social care. The Act on Social Services from 2006 classifies three basic areas of social services provided to the elderly population in need: social counselling for specific target groups or situations of clients, social prevention services that act against social exclusion of clients and social care services, the main objective of which is to arrange for people’s basic needs that cannot be met without care and assistance by another person. As for the place of provision, three institutionalised forms of services are offered: field-based services provided in a client’s household, non-residential services visited by clients (day care centres, drop-in etc.) and residential services provided in facilities where a person lives year-round at a certain stage of his/her life (homes for the elderly or disabled persons, as well as sheltered housing for people with disabilities, mothers with children or homeless people). Within this scheme, several kinds of social services are provided (personal assistance; emergency assistance; guiding and reading services; respite care; day services centres and day care centres).

Special attention is paid to seniors with reduced self-sufficiency who require long-term care. This care is provided by two types of residential social care services (domiciliary services, homes for the elderly) and one field-based service (special regime homes). The service at these facilities is adapted to these persons’ specific needs, all of which are provided to clients for a fee.

Beside institutional care, family care, which has greater potential for reacting to the rapidly varying needs of the elderly than the care provided by formal social services, is quite widespread in the Czech Republic. Families of such clients most often provide the subsidiary care (attendance, attention to personal matters, financial assistance), or impersonal care (care of household), with a lower intensity, followed by personal care, related with body care and intimate care. The major
impulses for provision of family care include both the traditionally expected responsibility of family members to safeguard older relatives as well as the emotional closeness between family members.

Since 2012, Social care assistants, individuals eligible to provide help for the elderly in their households on a contractual basis, have become an important part of the system of eldercare. They are persons caring for his/her family member or another close person who are entitled inter alia to receive the Care Allowance. This benefit is intended to strengthen the resources and competences of persons dependent on the assistance of another person and the circle of close persons, so that every individual can select the most effective manner of having his needs provided for (Kubalčíková and Havlíková, 2016). A care allowance is graduated according to the degree of dependence, with its amount primarily derived from the usual costs connected with care. However, around 3/4 of the amount granted through this benefit does not head to formal social services providers but to informal caregivers (MLSA, 2014b). Moreover, the amount of the care allowance is not sufficient to pay for professional home care (Kubalčíková and Havlíková, 2016).

Expenditures on eldercare are – much like with childcare – about three times as high in Norway when compared to the Czech Republic and the EU average (Eurostat 2015). A significant increase of expenditure has occurred in the Czech Republic since 2007 after the Care allowance was implemented as a direct tool for financing both home care and residential care (this increase from 0.48% to 0.54% of GDP between 2007 and 2008 is evident in Eurostat data available only until 2008, but not in the newer OECD data we present in Table 2.4).

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</tr>
</thead>
<tbody>
<tr>
<td>CZ</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>0.3</td>
<td>1.0(b)</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>NOR</td>
<td>2.2</td>
<td>2.1</td>
<td>2.1</td>
<td>2.2</td>
<td>2.6</td>
<td>2.5</td>
<td>2.5</td>
<td>2.5</td>
<td>2.6</td>
<td>2.6(p)</td>
</tr>
</tbody>
</table>

Source: OECD (2016)

Note: Available data doesn’t include social expenditures on long-term care that include health-related cash benefits, other cash benefits and in-kind benefits. (b) = break in data, (p) = provisional value.

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 to such benefit by law and hence eligibility criteria vary greatly between different municipalities.

Whereas care in hospitals is free of charge to all citizens in Norway, residents in nursing homes pay a high fixed percentage (75 percent) of their basic pension and up to 85 percent of supplementary income (occupational pension, private pension, interest earnings, etc.). Still, all
residents have at least 25 percent of their basic pension as spending money. However, personal care and nursing services at home are free of charge, but municipalities are relatively free to charge people for home help (practical help such as laundry, cleaning and gardening); most municipalities have income-graded fees for home help that vary greatly (ECON, 2006).

In the Czech Republic, the separation of social and health care provision is accompanied by the separation of financing of both types of care. Simultaneously, the model of multi-resource or mix-resource financing is used. Since the social care services are fee based, care is covered by public and private sources (national, regional and local budgets on the one hand, and donations, small business activities of service provider, care allowances and personal client funds on the other hand). In the first case, the Ministry of Labour and Social Affairs distributes, in cooperation with Regional Authorities, subsidies towards the operation and development of social services delivered by other providers, the NGOs included. The subsidies are granted on a yearly basis. In the second case, a Care Allowance represents a new source of social care services funding when the number of its recipients and total expenditure increased between 2007 and 2014 (from 277,000 to 328,000 people and from 540,000 euros/14.6 billion CZK to 773,000 euros/20.9 billion CZK) (MLSA, 2015).

While the costs of domiciliary care paid in average per year/per recipient of care is not high (about half of the average monthly old age pension), institutional care is quite expensive (more than the average old age pension per month) (see MLSA, 2014c). In these cases, the service user hands over all his/her Care allowance and the remaining expenses are paid from the pension and often also by additional financial sources (by the family or from the elder’s savings). For this reason, the applicants are sometimes selected on the basis of their ability to pay for care. Eldercare provided by the family members (who use Care allowance) to people with reduced self-sufficiency is therefore a relatively widespread solution.

**Accessibility and quality of eldercare services**

In Norway, the care service sector has recipients of all ages with highly divergent needs. Moreover, the number of users of professional/formal eldercare services is about 120,000 people more than in the Czech Republic, although the population of Norway is half of the Czech population (5.1 million to 10.2 million people) (Statistics Norway 2014).

The apparent trend over the last 5 years is the increase of home nursing care and the decrease of residential care. The result is that most people in need of care in Norway used home nursing care or practical assistance (about 66%) and fewer people received services in an institution (about 16%) at the end of 2011 (Statistics Norway 2014).

It can be expected that the system of care for the elderly in Norway will be increasingly burdened by the increasing number of people with dementia: whereas today there are about 70,000 people with dementia, it is estimated that the number of people with this diagnosis could double to about 140,000 over the next 25–30 years (Skirbekk et al 2016). For this reason, a Dementia Plan
focused on care for this group of people was presented in 2007 and subsequently revised and carried out within a new four-year action programme on years 2012–2015.

In the Czech Republic, both home based and institutional care (nursing homes) are universally available based on need (and not on age or ability to pay). However, the numbers of people receiving eldercare have not increased in recent years although it is evident that the demand for care is even higher (the numbers of rejected applications for institutional care is 50% higher than the capacity of the pensioner homes - about 76,000 people in the years 2009-2013). The stagnant number of Czech homes for elderly residents in recent years is closely related to the rising dependence on intensive personal and health care, as indicated by the rising number of those who receive high care allowances. This trend causes the attractiveness of accepting such residents at the expense of unavailability of such caring facilities for needy, but still self-contained seniors. Moreover, a decline in home care services is apparent, while nearly 3% of elderly people receive institutional care and more than 6% of the elderly receive domiciliary care (MLSA 2010, 2011, 2012, 2013, 2014b).

Although a national document has existed since 2010 that focuses on quality standards for care services in Norway (“Guarantee of dignity”), it is not legally binding. Many municipalities therefore have their own quality standards, which have continued to strengthened from the time of the ‘Elderly Revolt’ in the early 1990s, and the right of frail elderly citizens to receive high quality public care has remained high on the agenda. Media-protests and efforts to mobilize a new elderly revolt occur regularly and new associations and ad-hoc organizations have been therefore added to the plethora of associations working for the elderly together with a constant quest for better service quality through attracting and retaining skilled care staff (Vabø 2011).

Moreover, half of Norway’s nursing homes were expanded, renewed and renovated and many beds in old people’s homes were upgraded with better standards (e.g. single rooms and private bathrooms and WCs) according to the single-room reform implemented thorough the Action Plan for Elderly Care (1996-1997).

In the Czech Republic, there are problems with implementing legally set quality standards. The reason lies both in the insufficient number of social workers and in their unwillingness, or in their ignorance of the importance of quality standards for the provision of care (Hubíková, Havlíková, 2011; Kubalčíková, 2009). Regarding residential care, the great majority of clients live in two of more bed rooms while about one third of them live in single rooms. The situation is changing slowly, however, and there were fewer three and more bed rooms in 2013 (MLSA 2010, 2013, 2014).

Although there is a strong emphasis on the well-being of the elderly in national documents in the Czech Republic, the elderly freedom of choice as to the utilisation of the Care allowance is confined to a limited supply of services in certain localities. Another problem is the unequal position of the elderly who use social service facilities and health care facilities because they differ in the financial resources channelled into them. Similarly, whereas social assistance provided in the
home environment is paid within the social security scheme, health and nursing care is paid within the scheme of public health care system (Bareš 2011; Holmerová 2013).

In the case of homecare, whereas family members and relatives in Norway may be supported by respite services in the form of short time placement in a nursing home (for days or weeks) according to a set schedule, or placement in a day care centre (Jessen 2014), the network of respite care is thin in the Czech Republic and flexibility of field-based services is also poor (they are not provided on a 24/7 basis). Moreover, home carers in the Czech Republic often feel lonely, without regular rest, do not pay proper attention to their health, experience sorrow and suffer from depression (Jeřábek 2013). They have limited information on both mobility aids they can use and on possibilities to withdraw benefits for household conversions. Relatives of caregivers who have left his/her paid occupation may also be at risk of poverty.

**Conclusion**

Social care policy in Norway is widely elaborated, *comprehensive and accessible* and thus it presents a suitable benchmark for the Czech Republic, both for childcare as well as for the care of frail older people. Like in the case of childcare, eldercare in Norway also represents the universal-Nordic model of care, which is distinctive for its generous, accessible and formalised nature of the system (Schulmann and Leichsenring 2014). The social services coverage of the older population (whether home-based or institutional) is high and the cash benefits are paid to the care recipients in the form of a personal budget that has to be used to purchase services under a formal contract/labour relationship. In the field of childcare, the situation is similar (extensive formal day care facilities are combined with the provision of childcare benefits based on the principle of gender equity and free choice). In this perspective, cash benefits and universal social services are intended to support the principle of individual financial autonomy for both sexes and rebalancing gender responsibilities in care giving (Saraceno and Keck 2011).

In Norway, a wide security net of benefits and child- and eldercare schemes based on the notion of equality of opportunity is provided. Values and principles of gender equality, labour market participation of both genders, and the need for a comprehensive care system are widely shared.

In contrast to the Czech Republic, care policy in Norway is *highly reactive*, i.e. it responds to the needs of the target group. The government introduces or enlarges services or provisions if there is public interest in them. The Czech social care *policy response to the needs* of the target group is rather weak and it manifests itself in relatively strong path-dependency which is strengthened by the fiscal pressures and austerity discourse. Social welfare provisions are realised only inside the financial framework set by the government. These conditions, however, limit the extension and quality improvement of the social care services to a large extent. Public budgets have often acted as a bottleneck in implementing new provisions or extending existing provisions. This is
especially true in the case of long term care, which is not considered to be a top priority (Österle 2011).

Finally, there are some specificities in the schemes of eldercare in Norway and in the Czech Republic. Norway has continuously developed a quite sophisticated universal decentralised system of eldercare, relying mainly on in-kind services, and well-coordinated health and social care provisions. There is a great emphasis put on both the rights of the users in practice and the systemic quality control of the quite high standards of care. In contrast, the Czech eldercare system may be understood as a system in flux. First reformed at the beginning of 1990s, a major reform came in 2006, and further reforms are expected. The until now, accepted solutions in principle emphasize objectives and principles like the rights of service users, individualised service in the 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 market conforming solutions (quasi-market of eldercare) 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 the accessibility of eldercare. The greatest challenge for the Czech Republic is to establish an adequate regulation system and financial frame for eldercare: this will require several improvements, underpinned with a better elaborated concept of eldercare.

Summing up, although the importance of care for the elderly is and will become more urgent in the Czech Republic due to the higher proportion of people older than 65 years, the system of care for the elderly is not, in the Czech Republic compared to Norway, as well developed. At the same time, Norway invested in developing childcare a lot more, which would, among other things, help maintain high fertility that mothers have better opportunities to combine childcare and work.
Section 3

Comparing the strategies of care investors and service providers in the Czech Republic and Norway

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Introduction

This section is the report from work package 3, “Strategies of investors, regulators, formal care providers and other national level stakeholders”. The main objective of this work package was to explore the strategies of investors, regulators, formal providers of care and other national level stakeholders in and elderly care, and thereby to reveal the reasoning and discourses behind these strategies in the Czech Republic and Norway.

We understand strategies in a wide sense, as a method or plan of any actor to achieve a particular goal, or goals, over a longer period. We did not presuppose that all the stakeholders in the care policy fields necessarily have explicit strategies, but regarded this as an empirical question. The strategies of different stakeholders may be specified according to their goals and objectives, plans for the future, and practical orientation: what do they actually do in order to achieve their goals in the near and far future? Their strategies are also likely to be embedded in the mandates, historical experiences and path dependency of each stakeholder.

Stakeholders are defined broadly as investors, regulators, formal care providers and other main stakeholders (ministries, trade unions, interest groups, municipal administration and public agencies, municipal and private care providing institutions) in accordance with the project guidelines.

Methods and data

This findings are based on interviews with stakeholders in the policy fields of childcare and elderly care. In the field of childcare, 30 research interviews were conducted whereof 14 in Norway and 16 in the Czech Republic. In the field of elderly care, 34 interviews were conducted: 15 in Norway and 19 in the Czech Republic. Due to the limited resources of the project, we decided to concentrate on stakeholders located in and around Brno (Moravian Region), and Oslo.

The selection of stakeholders was based on a combination of the following criteria: type of stakeholder, societal level, and ownership. As the public sector in both countries is organized around the principle of local or regional implementation, so that there are no public providers on the national level, we found it necessary to take account of the local and regional levels in order to include providers from the public sector. We included three types of stakeholders: governance,
interest group, and service provider. These three main types were represented on two main levels: local/regional and national, and in terms of either private or public ownership. In this way, a broad spectrum of the main stakeholders (except families, who were the focus of WP4) were represented, ensuring access to a wide range of positions and perspectives.

The interviews were recorded and transcribed for analysis through initial reading and searching for key terms while a more sophisticated analysis was performed with software for thematic coding and analytical queries.

Organization, responsibilities and cooperation

Childcare

Norway

In Norway, all respondents expressed similar, positive views on the value of cooperation, and described how cooperation was organized and how tasks and responsibilities were distributed and shared. Even presumed opponents representing different interests emerged primarily as cooperation partners, emphasizing the importance of shared goals, and of building bridges and getting to know each other outside of public debates – as their main strategies in obtaining their goals. On the borough, city, county and national levels of public administration or government, all our interviewees described cooperation through regularised and ad hoc meetings and groups, networks and conferences. These arenas all included representatives from the public sector like themselves, both vertically and horizontally, and some included researchers and politicians. The majority of our respondents were educated as kindergarten teachers. Because of the closeness in background and experiences, the level of understanding between representatives of different stakeholders was high. These respondents too underlined the value of mutual understanding and existing, well-functioning formal as well as informal arenas and networks for cooperation and negotiations.

Czech Republic

In the Czech Republic, interviewed actors at various levels of governance identified several issues. Despite the fact that formally the two-tier model was abandoned (see WP2 report on ECEC), governance still follows this split. Interviewees warned of a persistent fragmentation, where the division of care for younger and older children remains both at national and local levels where officers cooperate in terms of information exchange but real inter-connection of services cannot be observed. Despite efforts to change the age structure of target groups of various services, there is considerable resistance from officers who see the given rules as unchangeable. Also, it has been documented several times that public authorities at all levels except for city districts do not have very good overview of the actual needs of preschool children’s parents. Better cooperation would give all levels access to the experience based knowledge of city districts. Similarly, there is insufficient knowledge about the provision of services. The non-profit sector and national level regulators admit that the awareness about the provided services is quite low, both due to unmapped
unregulated trade providers and to poor cooperation among actors. External evaluation of services provided in the facilities could also help parents to select the service they are looking for.

Eldercare

Norway

Among the stakeholders at the local level of Oslo, the Centres for Development of Nursing Homes and Home Care Services are responsible for supervision activities and the counselling of care providers and municipal authorities. In addition, the Geriatric Resource Centre (07x) is a developmental centre that offers courses and training programs for health personnel and initiates projects to increase the knowledge within the dementia care services in both nursing homes and the home services.

The administration of nursing homes at municipal city level (SYE) is the largest operator of nursing homes in the country and second largest department in the municipality of Oslo. SYE has taken over the boroughs’ responsibility for running municipal nursing homes and for overseeing the private nursing homes, in total 4700 long-term spaces and 700 day-time visitors.

The home services of each borough is responsible for both home nursing and practical assistance together with various other types of supporting schemes (day care and activity programmes, cash for care, respite services etc.). Furthermore, an operative effort team is responsible for follow-up on patients with special needs for medical treatment, care and technical aids when for they are discharged from hospital or rehabilitation. In Oslo, and other big municipalities, home-care services are organized in line with the purchaser-provider model, separating responsibility for assessing and approving the granting of a contract for services from the responsibility of providing care. In fact, the responsibility has been removed from the front-line level, and transferred to a specialized purchaser unit within the local authority. Home care services and nursing homes are two different systems based on different arguments (principles) and priorities with respect to resources. At the Government level, the focus is to find the right balance for municipalities between the necessary number of nursing home beds, and organising and preparing for elderly persons to stay home in a safe environment as long as possible. Oslo has 48 nursing homes (as of 2015), of which 20 are run by the municipality through its Nursing home agency (SYE), while the rest are run by non-profit foundations or private enterprises. Official regulations are the most important restrictions guiding the operations. Oslo’s centralised Application office (booking unit) administrates all applications for nursing home beds and makes a decision, which is sent to SYE. Short-term placement is organised according to which borough and hospital sector the applicant belongs to. For long-term placement in a nursing home, the applicant may provide a wish, but there may not always be an available bed at said nursing home. The collaboration between SYE and the Oslo boroughs is important since the boroughs are responsible for ordering beds and for making decisions regarding each potential patient, and for establishing comprehensive and long-term options for patients after discharge from the hospital according to the Coordination Reform. SYE is mandated to move patients between units to avoid that boroughs order beds according to its economy. The agency also collaborates closely with each borough.
administration regarding the four Health houses, which have been established as a new type of short-term department with a stronger focus on treatment and rehabilitation after a hospital stay than what the nursing homes managed before the Cooperation reform. Further, the Health houses collaborate with the borough Home care services regarding competence and knowledge transfer for each individual patient moving back to their own home. As an alternative to care housings and nursing homes, Oslo has established care housings with 24-hour staff presence (Care+) which covers a need for safety and care among users with somatic and psychic ailments.

_Czech Republic_

Vertically, the main cooperation evident in our material is the preparation of strategic development plans. According to the Act on Social Services, the formulation of a middle-term plan of development of social services is obligatory for the Region. The Region studied applies the principle of cooperation with the municipalities with extended powers. These municipalities work out source documents in the form of separate plans for their own administrative unit, using community planning methods mostly involving providers and to a limited extent also users of the services and the public. The parties involved in the planning valued this opportunity to participate in the formulation of local and regional priorities. In 2015, the redistribution of the allocation from the national budget was transferred to Regional Authorities related to the obligation of the Region to set the basic network of social services. Interviewed providers criticised the Region for the way this was prepared, for insufficient communication with other stakeholders, and for the methodology for integration of the services in the network.

The relationships and ties are more intense in the two types of horizontal cooperation: 1) institutionalised cooperation, such as developing and maintaining ties within community planning, between providers, donors, users and other actors in the given locality; 2) informal or semi-formal ties and cooperation, which may be long-term or an ad-hoc, usually based on personal bonds and typically including cooperation between the providers and the family/client on the other hand. Similarly, there may be mutual ties or competitive relationships between local providers. Employees in municipal administrations may also cooperate with non-governmental organisations. The absence of a conception of long-term care engenders cooperation between providers of social services and actors in the health care sector. Integration and harmonisation of social and health care is one of the key themes in the provision of field-based social services. Agencies that have a registered medical service and run home care services in parallel with provision of social care may make use of multi-resource funding and cover part of the costs from their health-care budget. Field-based services also often cooperate with each other, referring the applicants whom they currently cannot accept for capacity reasons to other providers. Clients, particularly in bigger cities, may have a contract with more than one field-based agency. While one agency delivers care to this client e.g. during the working week, another one may do so on the weekends and public holidays, and possibly yet another agency takes care of meals delivery. The respondents expressed relatively negative views of the reform concerning the provision of care allowance when the competence was shifted from municipalities to local Employment Offices. The benefit provision bureaucratized and social work declined at the municipal level.
Objectives and target population: Perceptions of care needs

Childcare

Norway

In Norway, different stakeholders tended to emphasize different aspects of the generally agreed upon national objectives, depending on their positions and perspectives. Nine out of our 14 interviewees talked about the need for young children to attend kindergarten at an early age, and argued for a view of the educational pathway as a continuous process, from the second year of life and throughout school and higher education. At the same time, they stressed the need, especially with the youngest children in mind, to see kindergarten not as an institution for teaching, but rather as an institution for learning. In order to meet this need, several pointed out that the competence of kindergarten staff needs to reflect the needs of the very youngest children. Several respondents also emphasized the importance of active recruitment to kindergarten of young children in immigrant families. One respondent pointed out that now kindergarten is nearly universal in Norway, this provides a unique opportunity to approach the broad political goal of social equalization – a goal that universal schooling has not nearly reached.

Czech Republic

In the Czech Republic, the views on the objectives of policy differed according to the age of the children. As regards children under the age of 3, most respondents connected childcare objectives to work-family reconciliation, intergenerational solidarity or equal opportunities for women and men. For children aged 3+, the main objective of the policy was described as education, upbringing and preparation for school attendance, while here the reconciliation of work and family was perceived as a secondary, sometimes conflicting objective. Correspondingly, perceived target groups for childcare for the youngest children included the whole family, while target groups for 3+ childcare were perceived to be the children themselves. However, the distinction between younger and older children appears to be moving, from 3 to 2 years of age.

Eldercare

Norway

A main objective of the policy of elderly care in Norway is that older adults live their lives at home as long as possible, with those in need of care and nursing assistance receiving competent and sufficient help to prevent and avoid hospitalization. The objective of the home services is to provide sufficient medical assistance and qualitative care to the elderly recipients within the statutory framework. Care teams are expected to decide in more detail how to meet needs and report electronically whether the tasks are being accomplished within the estimated time use. Elderly who live at home will often need care, attendance, nourishment, physical therapy and medical assistance. The need for services depends on the individual’s circumstances, medical condition, housing, and
family situation. Elderly who need to be in a nursing home are those who are incapable of functioning by themselves and need more nursing care than the home services can deliver. One of the core targets of the Cooperation reform was to alleviate the pressure on the hospital sector by transferring responsibilities to the municipal level (White Paper No. 47, 2008-2009). 80 percent of the residents in nursing homes now suffer from some form of dementia, and residents’ caring and nursing needs have increased steeply in recent years. This is mainly because those with less demanding health conditions now continue to live in their own homes, in agreement with the political intentions.

**Czech Republic**

The regulators of the system of elderly care services at the national level and the providers of social services at the regional and local levels highlighted the need to tackle the life situation of those older adults who suffer from various mental and psychiatric conditions as they age. These include people with dementia and other people in need of sustained care, primarily people over the age of 85 years who form up to a third of the clients in some regions and often need special services provided either in residential facilities (so called special regime homes) or in their home environment (non-residential and field-based services, day centres). The latter has increasingly been accentuated in the Czech Republic in recent years. The providers declared the quality of care and meeting the clients’ needs to be the objectives of the service. The general goal was with few exceptions not broken down into specific goals. The target group’s perceived needs fall into three categories: routine tasks, health, and social needs. Managing routine tasks is associated with field-based or non-residential services, and typically includes assistance with hygiene, cleaning, meal preparation, and shopping. Meeting health needs is largely understood at the level of essential nursing care as guaranteed by the Ministry of Health. According to our respondents, field-based or non-residential services should not target clients unable to manage routine daily tasks. They expected growing demands on nursing services along with increasing frequency of e.g. stroke, Parkinson’s disease, or multiple sclerosis. As regards social needs, sustaining contact with the family and neighbourhood comes first in non-residential care, especially in smaller municipalities while residential care is associated with meeting the needs of those older adults whose situation requires complex care. Providers of field-based and non-residential services are subject to increased pressure from the families of older adults to secure complex care. The lacking capacity of specialised residential facilities for older adults with dementia and a growing interest in staying in one’s own home environment increase the demand for field-based and non-residential services. Finally, a growing number of older adults resort to emergency shelters for homeless people due to low incomes leading to loss of housing. In the case of reduced or lost self-sufficiency, these older adults cannot afford current social services, particularly residential services.
Policy arguments and priorities

Childcare

Norway

The private/public debate took centre stage in Norway. The debate about public and private kindergarten has several aspects, one of which is the financial aspect. Seen from a municipal perspective, the argument was that municipal legal responsibilities and the system of financing combine to leave municipalities without control of the means to fulfil their responsibilities. From the private sector, the financing problem was criticised for leaving private actors dependent on often-deficient municipal planning, leading to a lack of predictability for the private kindergartens, who get their government transfers via the municipalities. Another problem has been that private actors have been able to run their services at a lower cost than the public ones, for various reasons – a main one being that their pension expenses were lower, because they offer poorer pensions, on the average. However, from 2016 the regulations stipulate that pension expenses will not be included in the running expenses. This is expected to make it more difficult for private actors to extract extensive profit.

Czech Republic

In the Czech Republic, policy priorities are framed at the national level by the Government strategy on the equality of women and men 2014-2020. This strategy is implemented through Gender Focal Points at all ministries, the Ministry of Labour and Social Affairs being perceived as the most important actor. The strongest formulated priorities relate to the access of young children to childcare facilities and the flexibility of arrangements as an important aspect to abolish the typical model of full-time employment combined with full-time care outside family. Three recognised trends contribute to this priority: (1) ageing population and low fertility rates, (2) investment in the human capital of women (60% of university graduates) which the country cannot afford to lose due to long career breaks, and (3) investments in the human capital of children. Raising the capacities of facilities, especially for the younger group, is a priority to support the creation of child groups and micro-nurseries. Growing interest in care provision for children is recognised also through priority access to kindergartens for children aged four and three in the upcoming years (2017, resp. 2018) and making space even for younger children. The albeit controversial question of a compulsory last year in kindergarten is also a sign of more emphasis on early education. The willingness to support the creation of facilities can be detected also at regional and local levels. However, in case of Brno the engagement of local politicians does not go any further. Politicians prioritize problems that bring larger political support. Some actors also underline the impact of the unequal representation of women in politics which brings about a focus on different themes. Providers of care however recognise the sensitivity of politicians to needs of the public, especially at the lowest level of governance of the system. Various interviewed actors share the view that political discourse and priorities regarding are changing, with more support to outside the family for the youngest children, and to gender equality. National level actors recognise that is more put into wider context of employment, social inclusion, demographic changes, economic growth and equal opportunities for
women. The discourse is shifting from perceiving as a cost to seeing it as an investment in children and in the prevention of human capital losses for women with children.

**Eldercare**

**Norway**

The political arguments put forward by different stakeholders are both economic and ideological. Home services are a much cheaper solution for the authorities, as sick and frail elderly living at home averagely receive 16 hours paid home nursing assistance per month, while the patients in nursing homes get 35 hours a week on average. There is an overall agreement that recruitment of more health and social services workers must be prioritized. While the debate in media is dominated by the argument that there is a need for more nursing homes, the actors and providers we interviewed were more concerned with how to strengthen the home services. The tension between the two arguments may derive from different positions of responsibility, as well as being related to different perceptions of what is good for the individual. Since the financing of nursing homes in all likelihood will continue to be an issue, discussions about controversial user charges will probably appear. There are different views of how high the individual level of need for care and monitoring should be before triggering rights to long-term institutional care.

**Czech Republic**

The representatives of the ministry asserted that a key national priority was supporting field-based services and enabling clients to stay in their home environment. The representatives of the Region and municipalities assessed objectives and priorities in the area of elderly care as formulated for the given region or locality. Providers articulated that there is a disproportion between the formulation of priorities and their inadequate financial backing, e.g. the declared preference for field-based services which is not accompanied by increased public funding. They also expressed that there are discrepancies between the priorities in the area of fulfilling and improving the standards of quality and, on the other hand, continual under-funding of social services making it impossible to remunerate the workers adequately and hinders personnel development in terms of quantity and quality. Further, they pointed at a non-existent or unclear vision for the integration of health care with social care in field-based and residential services, with consequences for the financial sustainability of social services as well as for advancing the quality of provided care. Finally, providers called for a clearer policy in dementia care such as systematic public information campaigns also focusing on family carers. The fact that residential facilities continue to be perceived by the public as the only possible source of help for people suffering from dementia increases the pressure on residential facilities. The priorities in organisations founded and run by the Church seem to be similar to those in public facilities, with the addition of pastoral care and more emphasis on building interpersonal relations.
**Capacity and resources**

**Childcare**

**Norway**

When asked whether the needs or demands for kindergarten places were met, our interviewees generally referred to the statistics showing that there is full kindergarten coverage in Norway. Children on waiting lists in Oslo were, according to our respondents, either under the legal age of right to kindergarten, or interested only in a place in specific kindergartens, having rejected offers of places elsewhere. Children of immigrant parents are the main target group here, whether or not they form the majority of children who are not in kindergarten. When it comes to the kindergartens’ capacities, we may identify three main subtopics: staffing, ratio of pedagogical personnel, and economic resources. These are related, and it is possible to identify some dividing lines between actors emphasising the importance of increasing the ratio of pedagogical personnel and those who advocate a wider array of professions.

**Czech Republic**

In the Czech Republic, the overall extent of childcare coverage is unclear, due to shortcomings in the statistics. Respondents indicate capacity may be sufficient but unevenly distributed, and criticise public policy makers at the local level for not planning ahead in order to meet the growing demand. The system of financing is fragmented, bureaucratic, and there is a lack of predictability for providers. The systems of financing differ for child groups and other facilities providing care for children younger than 3 and kindergartens for children older than 3. Child groups have no systematic and regular financial support from national resources; therefore, different financial sources are usually combined to ensure operation of the facility. Quality requirements and market prices among are the most important considerations in balancing the prices for parents. Several bureaucratic barriers were identified by respondents, and strong criticism expressed regarding strict rules for application and management, strict evaluation of proposals and unreliability of announced calls that are usually delayed. This context makes the situation for care providers very unstable. Whereas for the registered child groups stable subsidies are not available, kindergartens are subsidised if registered. This is beneficial for public providers; however, some private providers do not register. While the financing of kindergartens for older children emerges as less unstable than that of child groups for younger children, here, too, the financing is described as insufficient and unstable, making it difficult to provide services of good quality.

**Eldercare**

**Norway**

Norway is spending more resources on elderly care than most other countries. The waiting times for elderly in need of care vary and may be longer than justifiable. However, there was agreement among our respondents that the country has reached a point where the current level of services can no longer be sustained and there is a need for innovative solutions. The staff rate in nursing homes
is already too low, in spite of changes in terms of new job categories and less unskilled workers among the staff. There is a continuing need to build and strengthen the competence of care providing staff and increasing need for competence regarding dementia.

In the home care system, many experience that their work is dictated by the ‘stopwatch’ and strictly defined timetable schedules. Several stakeholders question the home-services’ ability and capacity to account for the recipients need for security and social contact, due to the purchaser-provider model. Because resources are finite, the most urgent needs are prioritised in the home care services, and medical needs and needs related to bodily care are regarded as more urgent than other domestic and social tasks. Elderly persons with poor housing or no social networks are often regarded as having more urgent needs than people who were surrounded by family, friends and/or modern facilities. In residential care, there is a corresponding concern about meeting needs for social and emotional care when more urgent needs are prioritized within a stopwatch system.

**Czech Republic**

One of the focal themes of the current policy debate is the capacity of residential facilities. Statistics are often inaccurate, as people often submit multiple applications to several different facilities and there is no central register of applications. Although the number of residential facilities may be sufficient, there is an uneven distribution of facilities from region to region. Key priorities favour field-based services, yet there are long waiting lists for residential care.

Family members show positive involvement in care, and may convince elderly family members of the need for social services, even though services providers sometimes have to reconcile diverse expectations of individual family members. In non-residential services, eligible claimants are provided with an adequate scope of services. In some places, there is even excess capacity, and the number of clients of non-residential services is not growing. Limited and insecure funding of the whole system of home based social services consist in e.g. a multi-resource nature of funding, state subsidies paid no earlier than March of the given year, a long process to claim benefits, and insufficient funding to cover the wages of health care personnel resulting in substituting health care workers with workers in social services. The low quality of services reflects the limited number of staff and difficulties in attracting high-quality personnel at the level of two thirds of the average wage. Among the most stable workers are pre-retirement age women who might be especially vulnerable to health risks associated with work overload. Limited material and technological resources include a lack of cars for home service carers and adjustable beds available for home loan. All the interviewed providers confirm the uneven coverage of the Region with social services.

As regards residential services, the issue of funding health care in social services was raised. This can be seen as one of the adverse effects of the absence of the conception of long-term care. Health care in social services is financed from the health insurance budget, with the rules guiding the spending of this money being reviewed by the health insurance companies. The respondents also share the view that a key problem is the availability of quality and motivated staff, as this work
is not recognized in terms of social status or financial remuneration. Doubts were also voiced in the interviews whether the prospect of sufficient staff in social services can ever be realistic.

**Challenges: deficits, gaps and overlaps.**

**Childcare**

**Norway**

The participants in Norway held three areas forth as especially challenging: the working conditions for staff, staff competencies, and leadership, hereunder the organization and implementation of monitoring. A challenge that has been widely pointed out and discussed is the organization of kindergarten monitoring, in a national system where municipalities are simultaneously providers, funders, and regulators of kindergartens. Expectedly, the union representatives were the interviewees most concerned with working conditions for staff. While the participants did not report any systematic differences in salaries between public and private kindergartens, differences between municipalities could be considerable because of local salary negotiations. However, several participants emphasized that pensions are considerably better in the municipal (public) than in the private sector. The organization of time and shifts, and regulations on allocation of time to specific tasks were also part of working conditions challenges. A related aspect is the rewarding of competencies. The education of kindergarten teachers was pointed out as a challenge in two different ways. One concern was that pedagogics was, after a recent reform, no longer a separate subject but ‘mainstreamed’ or supposed to be integrated into all subjects. Another pointed to two interrelated challenges. Firstly, that the quality of the education of kindergarten teachers was uneven, with variations from one teaching institution to another; secondly, that the main problem as regards this quality deficit is a lack of training in pedagogy focusing on the youngest age group. The large scale inclusion of one- and two-year old children in kindergartens may, as some pointed out, imply a real need for new methods and approaches.

**Czech Republic**

Among the strongest challenges are a lack of systematic funding to child groups, poor awareness of the whole segment of provision due to unregulated businesses, unmapped needs of parents recognised mostly only at the lowest – city district – level. Insufficient capacity is a main challenge, especially as regards children under the age of three and children with special needs. Facilities are too few and overcrowded, and there is a lack of staff. Our interviewees described strongly embedded myths about the appropriate age to attend childcare outside the family in the form of widespread assumption, linked to the two-tier model, that only children from 3 years of age are educable. Strong cultural norms related to motherhood form a challenge in the form of a persisting norm linking the placing of children in childcare “too early” (usually younger than two or three years of age) with the notion of “bad motherhood”. A related normative challenge is the fear of a paradigm shift. Here, a tension was identified between previous efforts to keep mothers at home as care providers and the actual trend to place children in facilities. There were also challenges in terms of work-life balance: flexible work arrangements, flexible childcare facilities and incentives
for employers have not yet been sufficiently developed. Such path-dependent normative and structural challenges hinder current bottom-up initiatives, which respond to increasing pressure from parents on policy- and decision-makers to create facilities for children 1-3 years. Challenges are also identified in quality, mainly in connection to the marketization of care and the lobbying from providers on politicians, and especially concern child-to-staff ratio, available space, and general hygiene rules. Policy makers at MLSA also regard the possibility to provide childcare as an unqualified trade as a challenge. The problem of high numbers of children per staff is identified at the national and local levels, by regulators as well as by funders. The unclear set-out of parental benefit is also a challenge as it is designed as income-loss replacement but slowly turning into cash-for-care benefit. Opening a new child group is risky due to unpredictable government funding and is time-consuming due to bureaucratic procedures with many conditions to be met as well as a lack of reliable and coherent information. On the supply side, the provision of childcare is not well mapped as the unregulated provision is defined as a business activity. Communication gaps were identified between parents and kindergartens and between providers and city districts.

**Eldercare**

**Norway**

In light of the demographic challenges that are expected to hit full force in 10-15 years, there is a need for restructuring of the services and more involvement of families and volunteers. In Oslo, the new city council as of 2015 has granted 500 new jobs/positions to the home services in 2016. Nevertheless, some of the stakeholders question whether this grant is enough to develop sustainable services or a sufficient solution to solve the huge tasks ahead of them. Practically all of the new resources allocated to the sector in the past twenty years are utilized to cover the service needs of the rising number of younger user groups, due to the reform that transferred the responsibility for people with disabilities to the municipalities. The question raised is if this development reduces the services for the elderly, also because of a difference in traditions, entitlements and professional regimes within these formerly separate services. The divergence between popular expectations and demands for more nursing home places and the policy of strengthening home and field services in order to reduce the reliance on nursing homes also poses a challenge.

**Czech Republic**

Current challenges in the Czech elderly care sector are especially salient through the responses on policy arguments and priorities, and capacity and resources. Several main challenges emerge. The first is a lack of integration of health care with social care in field-based and residential services, with consequences for the financial sustainability of social services as well as for advancing the quality of provided care. Continual under-funding of social services also poses a challenge to the development of adequate staff, in terms of quality as well as numbers. The overall lack of integration also creates problems for residents in private and NGO care facilities when they need

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4 Trade licensing in the Czech Republic distinguishes between qualified and unqualified trade. For the former, appropriate education and/or training is necessary whereas the latter is accessible to anyone with no limitations.
health care, since the system of reimbursement for health care is not working towards providing such care in the residential home. The second main challenge concerns public perceptions of elderly care, especially when it comes to caring for persons suffering from dementia. Expectations are that residential care is the only possible source of help for people suffering from dementia, and this increases the pressure on residential facilities. A third challenge relates to the regulation of care services. Because use of the elderly care allowance is not subject to control, non-registered individual carers compete with costlier registered services at the expense of quality. That the regulation and auditing of allocated resources in this field are inadequate is also evident in the sporadic, rather than systematic, evaluation of the quality of social services. Finally, there is an urgent need for a more intensive funding of social care services by the state. The sector remains under-funded, leaving elderly people in need of care unable to pay for the necessary services.

**Looking back, looking ahead: plans, new solutions and strategies**

**Childcare**

**Norway**

The interviewees underlined that this sector has been through enormous changes over the past few years. A watershed that several referred to was the so-called “Kindergarten settlement” in 2003, where Parliament agreed across party lines to compromise on a number of issues in order to arrive at full coverage by 2005. As described under the topic *Organization, responsibilities and cooperation* above, the main strategy of all stakeholders was cooperation with an emphasis on relation and network platform building. Market branding tends to play only a limited role for parents, who still tend to choose kindergartens according to location more than anything else, according to our interviewees. As part of the rapid growth of the kindergarten sector, individual kindergartens have grown, and a new type of large kindergartens has appeared. While in 2002 the largest kindergarten in Norway had 111 children, in 2015 the largest kindergarten had 481 children. These kindergartens are now regarded as at least as good as more conventional, smaller facilities.

Summing up, the following areas emerged as fields where innovation is expected, on-going, or needed, with only small differences between different types and levels of stakeholders:

- The recruitment of the few children who are still not using kindergartens, with a special focus on children of immigrant parents
- The adaption to needs of the very youngest children in kindergarten, including the specialised competence of staff
- The increased size of kindergartens and kindergarten departments, creating larger and more open environments
- The continuing adjustment of the educational system as a whole to incorporate ideas and practices of learning from the ages of 0-24
- The importance of private actors in building the sector was recognised, but there were some differences e.g. in views of care for profit, of small vs large private actors, and of regulation, financing and the conditions for staff.

The new framework plan has been under way since 2013 and has been put on hold until 2017 because a revision of the Kindergarten Act is also under way, and the Ministry of Education would like to coordinate the work with these two important documents.

**Czech Republic**

In terms of suggested new solutions to challenges, clearer rules and a guarantee of quality in child groups would be welcome in order not to leave the relationship between user and provider within private law. Child groups are however perceived as a victory which ended the discussion about childcare for younger children lasting for years. Still, no legal framework is available for provision of care to children younger than 1 years of age. Therefore, micro-nurseries will be (re-)introduced as a facility for the youngest children from 6 months of age. Lack of regular financing from national level is perceived as a threat to the stability of the system.

The capacity of childcare facilities at local level is quite scarce which resulted in the introduction of electronic system for enrolment of children into kindergartens in order to make the decision-making about admission transparent.

Future plans include support to child groups as well as providing parents with legal right to childcare. Ministry of Labour and Social Affairs wants to appoint regional coordinators for child groups in order to support the creation and good-functioning of the groups. Ministry of Education Youth and Sports plans to introduce obligatory pre-school year in the kindergartens and legal right to a place to 4-year olds from 2017 and to 3-year olds from 2018. Regarding the insertion of younger cohorts in childcare institutions, pilot seminars for teachers in kindergartens about specific aspects of care for children under 3 occur at Faculties of Pedagogy.

Regional authority in South Moravian Region plans to strengthen the cooperation with towns and cities. Recently a Memorandum on cooperation in family policy has been concluded between the region and the City of Brno. This could provide a framework for future joint investments in childcare etc. Region has planned a transfer of a good practice from Austria – family friendly community audits which should help towns map the needs in the family policy fields.

Among the strongest challenges, there is a lack of systematic funding to child groups, poor awareness of the whole segment of childcare provision due to unregulated businesses, unmapped needs of parents recognised mostly only at the lowest – city district – level. Several actors would welcome better cooperation and networking in order to get better overview of the sector at local level. Even a suggestion to use the method of community planning in childcare services and involve all the relevant actors in proactive cooperation has been raised.
Eldercare

Norway

A combination of demographic change and organizational change is likely to further increase the pressure on elderly care services: the population is aging, and the Coordination reform (2012) means that home care services now target all age groups, so that “elderly care” is largely outdated as an organizational concept.

Apart from recruitment and competency plans to strengthen staff, three strategies were pointed out as especially important in addressing the expected increased pressure by turning services away from providing care to inducing self-mastering: user-empowerment, everyday rehabilitation, and welfare technology.

The municipalities already allocate more resources to home care services than to nursing homes and institutional care services. This development is due to reform efforts, professional and financial assessment in the municipalities and greater involvement by the users in designing the services. Another trend is the shift from practical assistance to health care within the home care services. The shift in emphasis means that almost exclusively the segment of the population with a need for 24-hour care is now in residential care.

Participants agree with the Dementia Plan (2015) stating the services to people with dementia must be strengthened by enhancing the knowledge and expertise in the field, increasing daytime activity programmes and creating more adapted housing.

New welfare technology may allow more people to live longer in their own homes despite reduced functionality. Planned greater implementation of welfare technology in the health and care services aims to save resources in the care services and enhance the ability of users to manage their own daily life. Attitudes towards welfare technology have changed from a focus on the monitoring of recipients to a view of technology as a source of security for users and their families. Increased construction of sheltered housing and various forms of residential care will make it possible for home care recipients to manage at a lower level of care.

The Norwegian care services model is characterised by a distribution of tasks and close cooperation between two major actors; the municipal health and care services and close family members. The future challenges also raise the question of whether other actors, private organisations and volunteers could play an active role in providing these services.

Czech Republic

Concern was voiced about insufficient financial resources and the growing bureaucratization of services. It was suggested to terminate cost-ineffective European Social Fund support for preventive and counselling services for older adults, and to extend the number of field-based facilities in smaller municipalities and the personnel capacities in all current services. Respondents suggested reducing the formalization of carers’ work, and the possibility for digitalization of reporting areas such as working with clients, activation and quality of life. The need to strengthen the capacities of
special-regime homes in response to the growing number of older adults with psychiatric diagnoses was emphasised.

Among the major deficiencies of social policy mentioned by our respondents is an absence of a housing policy responsive to the needs of older adults. What could help tackle this problem is construction of social housing that would also facilitate the use of social services, flats accessible for disabled people and wheel chairs, or developing new forms of services in the direction of sheltered housing. When it comes to the growing number of low-income pensioners, adequate low-income facilities should be provided.

**Conclusion**

Although the issues on the agenda are different in Norway and the Czech Republic, path dependency is strong in both countries. Policies are changing slowly. A multilevel governance frame is likely to represent one of the a common factors behind this slowness, as well as cultural factors and ideologies. Regarding governance issues in Norway, the long-term cultivated cooperation and consensus model plays a role in achieving solutions.
Section 4 The strategies of families and service users in the Czech Republic and Norway

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Introduction
In this section, we elaborate on how families organize care, what kind of care they provide to their children and dependent elderly members, and how they combine caregiving with other commitments in their daily lives such as paid work, family life and so on. We also address the participants’ negative and positive experiences with care services and provision, as well as their reflections on matters such as problems and deficits, solutions to such problems, and emerging and possible innovation, comparing the Czech Republic and Norway. The key issue addressed here is establishing how formal childcare and eldercare provisions meet the needs and expectations of the families and identifying potential improvements in this respect, in the context of the preferences and strategies of the families in providing care to those family members in need of care.

As explained in the WP1 report, the strategies with which families organize caregiving emerge at the micro level in the interaction of micro-level factors (such as preferences of the households and their resources – economic, human and social capital) and meso- and macro-level factors (such as the labour market situation and employment patterns, prevailing social norms and cultural patterns and institutions, including family policies). In this report, we do not aspire to analyse the role of all these factors. However, we do pay attention to the role of formal care arrangements and other relevant social policies that, as an important part of the structural and institutional factors, shape household choices and strategies.

Methods and data
The data used in this report comprises interviews with persons with care responsibilities for children or elderly family members, and with elderly persons in need of care (see below for specification). No children were interviewed.

Eldercare
This report is based on interviews with service users and family members of service users in the Czech Republic and Norway. In the Czech Republic, in constructing the sample of communication partners for the segment of eldercare, we built on the methodology used in the survey of
stakeholders (WP3) in the previous stage of the project. We applied the same territorial perspective (which is very important in the country) as in the previous survey in order to recruit participants/respondents from cities of different size and from the countryside.

We conducted three focus groups. Two of these focus groups involved family caregivers – these were family caregivers living in a city outside the Brno agglomeration in the first focus group (5 participants), and family caregivers living in a smaller municipality within the Brno agglomeration in the second focus group (5 participants). The respondents in the third focus group (5 participants) were elderly citizens – residents of a supported-living setting with in-house domiciliary care service.

The recruitment of respondents for the focus groups was significantly hindered by concerns over anonymity. Therefore, the technique of one-on-one interviews was also used during data collection. In addition to the above focus groups, 18 one-on-one interviews were conducted at this study stage, of which 8 interviews were carried out with respondents in Brno, 2 interviews with respondents living in the Brno agglomeration, 3 interviews with respondents living in the city outside the Brno agglomeration and 4 interviews with respondents living in a rural area. In total, 32 study subjects were involved at this study stage. The respondents’ characteristics are detailed in Table 1 in Appendix to the Comparative report on WP4.

In Norway, a total of 17 interviews were conducted with families of service users and service users themselves. Six of the interviews were focus group interviews (2-3 participants per interview) and the remaining 11 were individual interviews. This leaves us with material consisting of interviews with 26 participants, of which three were men and the remaining 23 participants were women. Three of the participants were service users themselves, whereas the others were all relatives of service users. The interviews were mainly carried out at the interviewees’ homes, but some were also conducted at NOVA’s offices. One interview was conducted at a café in Oslo, at the respondent’s request.

Selection and recruitment turned out to be a challenge in the eldercare part of this work package. Our conclusion was that this area may be too sensitive for a group approach, both due to the potential interviewees’ own feelings of inadequacy and possible emotional distress and an understandable reluctance to discuss one’s close family member’s needs for personal care. On top of this concern comes the individual time factor – as finding the time to be interviewed between care work and paid work is in itself almost impossible for our potential interviewees; add to that the need to agree on the time and place for the interview with several other participants with equally busy schedules.

However, we did not experience any significant issues during the individual interviews (which had been decided on as the main form of data collection). In spite of the difficulties in recruitment, most of the participants spoke freely, even when discussing emotionally challenging or sensitive themes. All questions were answered.
For an overview of the characteristics of the interview participants, see Appendix Table 2a and 2b to the Comparative report on WP4. The “typical” participant is a woman somewhere in her fifties who works part or full time and cares for her parent(s). Most of the participants cared for a family member who used public home care services, which is no surprise since a main objective in the Norwegian eldercare policy is offering home care services for as long as possible (cf. previous INNCARE reports). Some of our participants cared for family members who simultaneously used several services (e.g., home care services and day centre).

**Childcare**

As the *Czech* childcare system is substantially different for children above 3 years and under 3 years of age, our *Czech* sample consists of two parts. As Table 3 in Annex to Comparative report on WP4 shows, for 15 families in the sample, the youngest child is 0 to 2 years old and, for 14 families, the youngest is 3 to 6 years of age (for details, see Table 3 in Appendix to the Comparative report on WP4). In order to map various strategies of families with young children, we considered a variety of families in terms of the use of services (public, private, by the employer). With regard to the fact that the project focuses on work-life balance and well-being, the sample contains families where both parents, to some extent, remain in the labour market (are employed or unemployed, or, alternatively, are postgraduate students or volunteers). Due to the criterion of economic activity of both parents, university-educated parents predominate in the sample. The reason behind this can be that well-educated parents (mothers) are usually highly motivated to return to the labour market quickly after childbirth. Almost all respondents were mothers (except one father). During data collection, we found that mothers were more willing to participate in our research, whereas fathers often did not feel competent to provide interviews on the given topic and moved the interview focus to their partners (mothers). This probably mirrors the traditional division of gender roles that still remains strong in the Czech Republic (see WP2 and WP3 reports). The predominance of highly-educated mothers was probably also influenced by the use of the snowball sampling method, the problem being that some of providers of childcare service (interviewed in WP3) were not able to access their clients for interviewing.

We combined focus groups (3 focus groups with 2 respondents in each group) with individual interviews (23 individual interviews). As it turned out, we were not able to bring the participants of the focus groups together in one place at one time due to very different day schedules of the parents and their children. We then decided to employ a method of individual interviews. Data collection was conducted from June to November 2016 in the districts of Brno-City and Brno-County.

In *Norway*, two focus group interviews were conducted for INNCARE and a related project, EFFECT, with informed consent that the data would be used for both projects. In addition, further interviews were conducted as part of the related project. These interviews had been conducted earlier, and although the data is relevant to INNCARE, the current INNCARE researchers do not have access to the data, as the participants have not consented to the material being used for INNCARE. For publication purposes, this was solved by including the EFFECT researchers as co-authors and by referring to both projects. In this report, we base our descriptions on the two focus
groups mentioned above. All participants had children in full-time kindergarten education, which was the only care service they were using. All participants had also used or were using the benefit of parental leave. For characteristics of parents with young children, see Table 4 in the Appendix. All participants in this part of the study had higher education, were ethnic Norwegians, and lived with their partners/spouses. In terms of these variables, they were not representative of the population in general but rather represented a specific section of white middle class Norway.

**Care arrangements and working life**

**Eldercare**

**Czech Republic**

As regards the time allocation and content of care, 4 groups of family caregivers can be identified. The first group consists of those respondents who provide care within a relatively limited time frame (less than 20 hours a week); the scope of assistance they provide is also rather limited (typically including housekeeping, shopping, cleaning or activities such as going out, sometimes gardening in the case of elderly relatives resident in rural areas). The elderly in this group usually have substantial care needs (because of their decreased physical or mental capacity), but the family caregivers do not represent the decisive source of assistance; care is, for the most part, provided by professional carers, most typically the domiciliary care service, and often in a supported-living setting. Family caregivers in this group can be characterised as having limited potential for the provision of a more intensive level of care. This may be due either to their age or their own health issues, or to reasons of time when they also need to take care of other people (usually children or grandchildren) and/or pursue their professional lives. All the participants expressed their satisfaction with the provision of care by professional carers.

The second group consists of the participants who also devote a relatively modest time allocation to providing care to their elderly family member (below 20 hours a week), but the scope of assisting tasks is wider than in the previous group – in addition to basic tasks such as housekeeping, shopping, cleaning and going out, they handle, e.g., necessary phone calls, cooking and personal care. These elderly family members’ ability to live autonomously has not significantly declined yet. The beneficiaries of assistance are typically the carers’ parents or grandparents, and the communication and visits during which assistance is provided by these (grand)children are also understood as a way to monitor the situation or help maintain the elderly in their own homes. As regards their economic status, these family caregivers are often women on parental leave. In

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5 We use the term “kindergarten” here, well aware of its connotations to preschool programmes for 5-6 year old children in many countries. In Norway, the universal model of ECEC means that there is no distinction between “kindergarten” and “nursery” or “creche”. The term “kindergarten” is used in official documents as a literal translation of the Norwegian “barnehage”.

6 We need to be aware that this is a rather narrow group of family carers in the Czech context: they only rely on professional carers after having selected them carefully.
addition to caring for their own children, these women substitute for their parents (who have a more limited capacity for intensive contact with the elderly due to their professional commitments and workload) in securing this basic monitoring. This arrangement is therefore a form of mutual assistance within the family.

The third group involves the family caregivers who regularly assist and support the elderly in a wide range of activities (housekeeping, personal care, shopping, cooking, gardening, cleaning, handling necessary phone calls, going out and other activities), spending more than 20 hours and up to 60 hours a week on care provision. This corresponds to approximately 8 hours of care every day a week, or possibly a somewhat higher time allocation over the weekend. Given the time allocation, the provision of care basically represents a second “job”. The carers are usually offspring at around 50 years old or older (in rare cases also younger) caring for their parents. Sometimes they are grandchildren who, for a variety of reasons (e.g., a serious illness), take over the duties of their parents related to taking care of the elderly family.

In this group of family caregivers, an important aspect of care provision for the elderly family member is cooperation with field-based social services, most often with the domiciliary care service. An agreement with another person to assist the elderly in the absence of the main caregiver is also a possible strategy. The family caregivers expressed their satisfaction with this model based on a combination of informal and formal care. They see the cooperation with professional caregivers as beneficial not only for themselves but also for the elderly.

All the participants have agreed that the role of the key carer is an uphill challenge and involves serious psychological stress. There are major concerns around ensuring the needed level of coordination and provision of care in the case of illness or other emergency situations in the family. The family caregivers’ experience suggests that in the temporary absence of the key carer, the care routines are habitually sustained for some time.

The last – fourth – group is the family caregivers who basically cover the full extent of the given caring tasks for the elderly (housekeeping, personal care, shopping, cooking, gardening, cleaning, handling necessary phone calls, going out and other activities), substantially filling their time. Ensuring care for their parents (or one of the parents) or the life partner is their current priority. As regards their economic status, they are usually retired family caregivers who have time available, as well as the personal potential to manage care duties (e.g., have background in healthcare or have the organisational skills to coordinate multiple sources of assistance). They ensure care in tight cooperation with other relatives or with domiciliary care workers.

Norway

All of our participants describe taking responsibility for elderly family members that are in need of assistance and care. Occasionally the participants expressed difficulties in estimating how much time they spend on giving care to elderly family members – whether weekly or monthly – especially
since the amount of time could fluctuate periodically. The amount of time spent on care provision ranges from assistance twice a month to daily contact and assistance. Participants who care for their spouses are among those who spend most time on care provision. One retired woman in her late 70s expressed, for example, that she would characterise her care provision for her husband as a “24-hours-a-day shift”. Also, participants with elderly family members in residential care spend less time on caregiving compared with participants who have family members (such as parents) with home care services.

For participants with elderly family members who use home care services, the responsibility load is larger. Often they expressed that they had to spend a considerable amount of time on care provision, both practical and social. This could be tasks like grocery shopping and shopping for medicines and other vital items, house cleaning and light maintenance, communication and coordination with representatives of public services, paying bills, fixing broken objects, cooking and participating in visits to doctors, dentists, opticians and so on. They stated that these practical tasks were often followed by social tasks as well. Several of these participants also expressed that they spent a good deal of time and energy simply worrying about the elderly family member. Here they were typically concerned about whether the elderly person actually received the help she/he needed from the home care services, if they got the right medication and/or if they had accidentally fallen and injured themselves.

Participants who cared for an elderly person with memory issues (e.g., dementia and incipient Alzheimer’s) often worried about whether the elderly person had gone out on their own and thus may have trouble finding the way back home – a potentially dangerous scenario. Although the elderly family members in our sample used some technological innovations available from the welfare services, such as GPS and wireless alarms, to prevent such accidents from happening, the participants did not find confidence and relief in such welfare technologies and thus the concern remained.

Participants who cared for elderly persons in residential care also had some practical tasks, yet the amount of such tasks is less than for those caring for elderly family members with home care services. These participants seem to spend more time on social and emotional care, especially on visiting and spending time talking or simply being with the elderly person, either in their rooms or taking them out.

The participants who share caring responsibility with other family members seem – not surprisingly – to organize care differently from those who have sole responsibility. Sharing responsibility has the benefit that they can allocate tasks between family members, depending on what fits into other parts of their respective daily lives. Participants who had sole responsibility for elderly family members, on the other hand, often expressed a desire to have the ability to share some of the responsibility with other family members. Being alone in care provision was often described as hectic and stressful.
Childcare
Czech Republic

The building blocks of the strategy development of (paid) work and childcare reconciliation are always the needs and interests of the child. Issues frequently discussed in regards to children's needs are: whether and how long the exclusive care of the mother is needed, what the positive and negative impacts of the work activities of mothers and/or institutional day care are, how this arrangement is influenced by social discourse and norms related to motherhood, and what is or should be the roles of the father (including his parental skills and the ability to provide family with finances) and other actors of childcare. The traditional gender division of labour in which the child is almost exclusively cared for by the mother up to three years of age, i.e., the role of the woman as the carer and the man as the breadwinner, has been variously perceived in ways ranging from accepting it as something very natural, matter-of-course or given, to somewhat forced acceptance, to active efforts to make the labour division between men and women more equal as carers with the same abilities. In our sample, there was in fact only one family where both mother and father (although not on parental leave) shared the care and paid work more or less equally. To a certain extent, a family heading towards an egalitarian division of roles might face being perceived as having a non-standard or even strange strategy of reconciliation (whether this is meant positively or negatively).

Men are counted on as the primary breadwinners and the income of woman is rather perceived as supplementary (although often very important); this applies at least during the time when children are small.

The female university and college graduates in our sample are often able to find and get a job suitable for them and the childcare they prefer. If they feel that they are unable to enjoy working and caring for the child according to their expectations, they tend to (temporarily) leave the job or lower the workload, as the child's interests come first.

The majority of these women were already working during the parental leave, which they combined during their children's early years with small entrepreneurial activities or irregular work activities. This work is usually performed when the child sleeps or when the father or other family member handle care; in several cases, the female respondents used the paid services of a nanny. Nevertheless, in the earliest nursling and toddler ages of the child, some women were able to work at the direct presence of the child or take the child with them to work.

During this period, very few respondents preferred or used centre-based childcare services. The workload usually increases around the second year of the child, when the extent of many of the jobs exceeds 0.5 FTE. At this age, children gradually start to attend the day care facilities. However, at the beginning they attend several hours per week and the attendance gradually increases up to the all-day stay. The use of day care facilities depends on (geographical) availability and affordability (these facilities are usually private) and on the extent of the involvement of father and other family members (grandparents) in the care. However, some of our female respondents followed the so-
called “traditional model” in the Czech Republic, so they stayed on parental leave for three years without any paid work activities and their children started to attend kindergartens at the age of three or four.

The most distinctive feature of the (paid) work of the female respondents was flexibility, both in terms of time and location and the extent of the work. The absolute majority of women prefer part-time jobs and this applies not only in the period of parental leave (most often up to the age of two to three years of the youngest child) but also for some time after the leave. Nevertheless, in their opinion, it is difficult to find a part-time job on the labour market and the offers are often of a lower quality (lower remuneration or in reality they work full time but are paid only for the part-time job).

In several cases, being able to work from home (home office) was also a condition related to being able to work when they want/can. In this respect, problems complicating working from home are often mentioned. For example, if it is necessary to work evenings and nights, symptoms of exhaustion can make it impossible to perform a mentally demanding job (such as creative work).

In addition to the aforementioned necessary conditions jointly forming the space in which a woman can combine work and caring for small children, the partner’s work flexibility and his willingness to invest time in the care for children is also important. Significant work flexibility for the father or both parents is especially apparent in the case of families heading towards an egalitarian work-family reconciliation.

The next important work and care arrangement that appeared in our research can be called the model of one-sided reconciliation: the mother is the main person responsible for care and the father engages only when his paid job duties and motivation allow it. In some cases, the mother explicitly wants to accept the larger share of the care because she considers it natural or more suitable to the needs and interests of the child. In these cases, the father provides the care during the afternoons or evenings when he returns home and when the mother is temporarily unable to provide the care (illness, doctor's visits, a smaller share of accompaniment from/to the kindergarten or school, etc.) The involvement of the father varies in relation to his work duties but the husband's paid work is often perceived as the priority in comparison with the work activity of women.

In many cases, the essential source of help is grandparents (especially grandmothers). However, their involvement in childcare significantly varies in the sample in relation to distance from the place of the respondents' residence, the state of health of the grandparents and their willingness to participate in care. With other family members, in particular the female relatives (sisters and sisters-in-law) are engaged as the carers, sometimes only offering occasional and short-term care.

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7 This “traditional model” (three years of full-time motherhood and then full-time work) is very common in the Czech Republic. However, our research sample does not perfectly correspond with this model because we wanted to find families where both partners participate (to some extent) in the labour market.
When asking what would be, from the viewpoint of the female participants, the ideal type of work and care arrangement, we can state that the preferences reflect current individual arrangements and experience. Most often the ideal is considered to be a part-time job. The female participants whose (grand)parents are available would welcome more or at least regular involvement. Similarly, those women whose partner does not participate in the care as expected would like to transfer to him some responsibility for the care. The main argument for care provision from within the family is high confidence in the person providing the care and reliability. Two female respondents expressed a wish that the society generally (with emphasis on employers) acknowledged the care commitment of fathers and perceived the mothers with small children as an equal labour.

**Norway**

All the participants had children in full-time kindergarten and none of them used other childcare services. Such other services are, as described in previous INNCARE reports, increasingly marginal in Norway. As opening hours in full-time kindergarten are generally (but with variations within the legal definition of minimum 41 hours a week) from 07-17, most people have enough time to deliver and pick up their children before and after work. Our participants reported the general pattern of sharing this so that one partner delivers the child or children in the morning and the other picks them up in the afternoon. Most of our interviewees emphasized that they wanted the mornings to be as devoid of stress for the children as possible – the partner who was not delivering that day would normally leave the house early, be early at work, and pick up the children well before closing time. Picking up children was often described as the more stressful of these two tasks.

The time pressure varies with job flexibility, travel distances, the number and age of other children, and – not least – the access to one kindergarten for all children in the same family. All participants also described how grandparents were a more or less regular part of their childcare plans for taking children to kindergarten, picking them up, and for looking after them on evenings or weekends.

**Welfare state and care: interaction of care policies, care and work**

**Eldercare**

**Czech Republic**

In balancing family and work life alongside securing care for the elderly, and in the context of the welfare state measures and the current setup of the formal sources of assistance and support, three basic strategies, as pursued by the surveyed family caregivers, may be distinguished. The first group consists of those family caregivers who act as a secondary source of care provided to their elderly family members. The primary resource is professional carers, usually domiciliary care workers. This group typically includes elderly clients of a supported-living setting with in-house domiciliary care service who are assisted by the domiciliary care workers on a daily basis. For the most part, the
participants justify the choice of this arrangement, which combines formal and informal care, by their limited possibilities to reconcile the care for the elderly relative with employment. Other possible reasons may include personal limitations or other circumstances such as inadequate household equipment.

The family caregivers reflect the limitations of the domiciliary care service, in that it does not have the potential to ensure 24-hour care, not even for the inhabitants of these apartments in a supported living setting. Their involvement in the provision of care helps a great deal to delay the placement of their close ones in a care home for the elderly, particularly in the case of elderly relatives with severely impaired mobility or those in only the early stages of dementia. The elderly themselves – i.e., the clients of the supported-living setting with in-house domiciliary care service – have also confirmed in group discussions that the main incentive for moving was the insufficient capacity of the family to secure immediate care right at the moment of need.

The second type of strategy is represented by a broad group of family caregivers who act as the primary resource of help and support. The elderly who are being cared for still live, for the most part, in their own homes or share a household with the family caregiver. Their needs are usually covered with assistance from professional providers, with the formal care being rather complementary in this case. The scope of the formal care and the type of services used depends on a number of factors. Among them, the most decisive ones are the health conditions of the elderly, housing conditions, family circumstances and, last but not least, the nature of employment of the family caregiver.

Where health is compromised due to dementia, informal care is typically combined with a day care centre, provided it is available locally. Where self-reliance is affected due to impaired mobility and physical health of the elderly, the most common scenario is a combination of informal care and field-based services or, more specifically, the domiciliary care service delivered to the elderly client’s own home. The combination of informal care with the domiciliary care service is also common in situations where the elderly client shares a household with the family or lives in the same house. An important factor conditioning such arrangement of care is a high level of family cohesion and willingness of other family members to engage in the provision of care.

Almost all participants from this group are aware of the limits of the social services currently employed in the provision of care for their relative and are weighing their options and strategies in case their relative’s condition deteriorates. It is especially the domiciliary care service whose potential is seen as insufficient when it comes to accommodating the needs of an elderly client requiring complex care. The worsening of health does not increase pressure on the professional providers but on the family caregivers. However, the family caregivers cannot, for the most part, ensure more intensive care or widen the repertoire of services, due to the need to keep their jobs or the fact that their capacities are already being stretched to the limit. Some respondents see the offer of field-based services, including the domiciliary care service, as insufficient, not only in terms of the comprehensiveness of care but also flexibility in the partnership with the family caregivers.
The third group consists of the family caregivers who secure care without assistance from professional providers. In some cases, this arrangement comes down to the momentary condition of the elderly family member who only requires occasional or simple assistance. In other cases, it was not the respondents who opted for this strategy. Instead, they either obeyed the wish of the elderly relative who may have a hard time accepting help from strangers, or this arrangement has some consequences in terms of family relations.

Another reason why care is being secured exclusively by the family caregivers alone, without assistance from another provider, is poor orientation in the offer of professional help or possibly local unavailability of such help. This applies particularly to rural areas where such services are absent, there is a huge excess of demand, or the offer of assistance does not intersect with the needs of the family caregivers.

As regards the financing of care, most respondents had experience with the care allowance. The care allowance is appreciated and seen as a major support, essential for covering the costs of care provision, whether provided within the family or by a professional carer. Applying for the care allowance is perceived as quite a challenging and, even more so, not very clear procedure by the family caregivers. Most family caregivers are concerned or feel insecure about the financial affordability of care in case the health condition worsens and the elderly relative requires more intensive assistance. They assume that the financial support would not be sufficient, yet it would either be too complicated for them to quit their job and take over full-time care or they would not have sufficient resources available to widen the professional services hired.

What can be considered a relatively serious finding is the family caregivers' lack of familiarity with the system of social services and with other available support resources, except the aforementioned care allowance. An exception is those respondents who are well orientated with regard to the structure and offer of professional care, given their education or professional involvement in the social sector. Beneficial in this respect is an arrangement where care is shared with professional service providers who can pass necessary information on. This applies particularly to elderly people living in supported living apartments in supported housing with in-house domiciliary care service. Social workers from municipal offices, for example, were not spontaneously mentioned among sources of information by the surveyed family caregivers.

Explicit enquiries about desirable support to the family caregivers by the state were usually answered by a general appeal that the state “should provide more assistance to the caregivers”, with no concrete instruments of assistance specified.

Norway

Most of our participants cared for a family member who used home care services. More specifically, we have 14 participants who cared for elderly persons using home care services and five participants who cared for elderly persons in residential care homes while four used other services. Two of the elderly service users that we interviewed were at the time of the interview
primarily using home care services and the third used sheltered housing for the elderly (“eldrebolig”) (cf. table 2a in Annex). Often these home care services were combined with other services such as day centre, hairdressing services, physiotherapy, daytime rehabilitation services, short-term relief placements, etc.

Given that there is no legally structured, formal and extensive framework for people who care for elderly family members, it is not surprising that the participants' experiences of responsibility for an elderly person in combination with their own paid work varies a good deal. Some participants had positive experiences and described their workplace as flexible and their employers as thoughtful and understanding. Others told us they found the combination of employment and caregiving quite challenging. When it comes to care for the elderly, there appears to be no clear pattern for the attitude of employers to care obligations in the family. Rather, it is up to each employer or even each manager to make up their own informal policy or even ad hoc decisions from case to case, as nothing is formally required from them in this field.

Some participants admitted that it could periodically be stressful, but overall, they experienced the caregiving situation as manageable and found the sharing of tasks between public and private spheres sufficient. Others had the opposite experience and told us how caring for elderly family members was very burdensome in their daily life, sometimes affecting their physical and mental health as well as their social life. These participants were often of the opinion that too much of the responsibility rests on the families and that some services (like home care services) and benefits were not sufficient. Here, participants stressed how they had to coordinate their life according to the elderly family member’s needs, for instance often resulting in little or no vacations at all. Others told us that caregiving affected the quality of their mental health, which was particularly the case for those who cared for a spouse or those who had sole responsibility for their parent(s). They often described feelings of depression, anxiety, inadequacy and sometimes trouble sleeping. For some, these mental health symptoms impacted their physical health as well.

According to some participants, a solution could be to invest in more temporary relief for family members, more places in residential care or in sheltered housing, and so on.

Childcare

Czech Republic

Maternity leave and maternity allowance are predominantly perceived in a positive way, in particular with respect to the fact that the allowance is assessed based on the previous income; this is perceived (with reference to the mechanism of parental benefit calculation) as fair and the allowance itself is considered relatively generous or at least sufficient.

For some female respondents, however, an obstacle to reconciliation of work and family life is being employed under a fixed-term contract, which later expires, when the first child arrives; while caring for the child they have a part-time job and are then either completely ineligible for maternity allowance or the allowance is lower. In this way, they are in fact penalised for their work activity. The change of the birth grant, which was paid more or less universally in the past but is
now provided to low-income households only, was criticised because child-related expenses of middle-income families are also high.

As the majority of our female participants work while simultaneously receiving parental benefit, they highly appreciate the option to take parental leave up to the child's third year while working, which is perceived as a luxury (with respect to the situation 10 years ago and now). That is, to a certain extent, they perceive parental benefit as a compensation of the part of income they are unable or unwilling to receive from the labour market because of childcare commitments. The following attributes of parental benefit are also generally positively perceived: 1) flexibility of drawing the benefit (there is a single total amount and several possible time schedules/tracks); 2) possibility to change operatively monthly benefit according to current family situation; 3) possibility to take turns with the partner on parental leave or 4) using the partner's income for assessment of the parental benefit.

However, some female respondents see a certain unfairness in the fact that, if the family has another child shortly after the first one, there is pressure to draw the total amount of parental benefit for the previous child and, in fact, the family thus loses part of the parental benefit.

From the viewpoint of some female respondents, it is also disadvantageous that the possibility of choosing of parental benefit depends on the previous income and the fastest drawing option is available only to the parent with higher income. This condition significantly discriminates against the parent with low or no previous income: these parents are forced to stay outside the labour market for a long time and face all related negative consequences.

The assessment of generosity depends on the importance of parental benefit for the family budget. For the middle- and low-income households and single parents or families living from only one source of income, the benefit is modest or insufficient. The amount of benefit was also sometimes considered in relation to the costs of the services for children up to three years, which are usually private and therefore too expensive for most parents.

The recently implemented tax relief provided for the purpose of placing the child in kindergarten or a similar preschool facility is assessed as a positive change; however, some remarks of parents imply that this tax relief is too low to have more important impact on affordability of private childcare services.

The childcare services are perceived as maybe the most significant contributor to harmonisation of childcare and paid work. The crucial question of many female respondents is when the child is able to spend a part of the day without family (parents and other family members). As has been mentioned above, approximately to the child's second year, families prefer individual care in the family or the care provided by reliable nannies.

Putting a child at the age of two years into a day care facility is usually motivated (besides the work activities of the parents/mother) by the children's need to socialise and/or the need to be gradually prepared for everyday attendance of institutional childcare services, usually
kindergartens. The paramount requirement regarding day care facilities is, in the majority of cases, an individual approach to the child and small groups of children (3–5 children). Nevertheless, the majority of female respondents did not wish their children to spend too much time in institutional childcare facilities. This wish corresponds with the preference for part-time jobs also after parental leave. However, in this respect they also emphasise the individual nature of every child, where some children are already ready at the age of 18 months to stay in a group of children, which is for other children a strain even at the age of four.

Focusing firstly on the system of public childcare services (kindergartens), before anything else there were mentioned the capacity problems of kindergartens for three- to four-year-old children. In several localities (some parts of Brno but also municipalities and villages surrounding Brno), parents have to apply to several different facilities without an assurance that the child will be admitted.

However, some parents still consider the availability of the highest-quality public kindergarten to be relatively low. The quality of particular kindergarten is assessed by the parents according to recommendations and experience of other parents, the approach of the teachers to the children and also to parents (the extent and content of mutual communication) and the scope of the activities offered for children in the kindergartens (these are very diverse). Other requirements of the parents in regards to kindergartens include the possibility of children staying part time (some kindergartens responded positively and some not) and the need for longer opening hours when parents work full time. Another important factor when choosing a kindergarten is the geographical accessibility (either in relation to the place of residence or place of work) with respect to the time lost during commuting.

According to the parents' experience, the quality of public kindergartens varies a good deal, despite the unified setting and regulation. Almost all parents also pointed out that they found the children/staff ratio inadequate (too high).

All parents perceive the public kindergartens as very affordable and those who have an experience with private childcare services consider the difference between the fees enormous or incomparable. In terms of the potential of kindergartens to help to reconcile the work and family life of parents, the question of timing the return to work from parental leave was particularly significant. Parents find it difficult to really plan an exact moment to return because of the kindergartens' capacity limits for three- and four-year-old children and because of the condition of starting the attendance from the beginning of the school year: e.g., when the child is three years old in December, kindergarten attendance is in many cases possible no earlier than from September of the subsequent year. This may result in losing the job because of the expiration of the guaranteed job position.

The parents also found the discrepancy between various durations of parental leave and availability of public childcare services problematic, as this often makes impossible a personal choice of parental leave duration.
The availability of private childcare services (founded based on the Trade Law, children's groups established by employers or by other institutions, and so called forest kindergartens) seems to be good, according to the parents' assessment. Availability has especially improved during recent years but, again, there are local differences. Parents usually use these services for children up to three or four years of age. Younger children usually attend the facility only several hours or days a week, when the parents feel that the child needs a social contact and/or because of work activities of the caring parent; there is actually no other type of service available for this age group. Three- and four-year-old children attend these facilities especially when there are unavailable public childcare services or the parents perceive their quality as higher or more suitable to the needs of the child in comparison with the public kindergartens.

Although the quality of private facilities is perceived very differently, the parents who have experience with them consider the private facilities to be of a higher quality in comparison with the public ones. The main arguments are: smaller groups of children, higher degree of flexibility suitable to the parents' requirements (e.g., related to the opening hours of the facility), possibility of part-time stays and placement of children younger than three years, giving more consideration to individual needs of children (including, e.g., dietary requirements), use of more up-to-date methods of working with children and the client approach to parents. These attributes of private facilities consequently allow the parents to better balance their work schedule with childcare. On the other hand, the most salient problem is the affordability of private childcare facilities, which seems to also be low for relatively highly-qualified parents in our research.

A highly-appreciated service is the children's groups established by parents' employers; this service was available for approximately 25% of families in our research; however, the general availability of these facilities in the CR is unfortunately assessed as low by the participants of our research.

The employers' policies generally have a high potential to influence the strategies and practices of combining of work and care. According to the respondents, Czech employers are relatively conservative; speaking in general, they are not willing to offer part-time jobs and are a little bit reluctant to accept work from home and other necessary work arrangements of parents (e.g., presence of child in the workplace). For this reason, some female participants are willing to accept lower job quality in exchange for the possibility of reconciling work and care for children. An important factor seems to be the parent-friendly atmosphere in the workplace (occasional presence of children on the workplace and family-friendly-equipped offices). The approach of employers to caring needs of fathers has its own problems: such needs are often either ignored or even seen very negatively. The parents agree that an overall change in employers' approaches to parental support strongly depends on the activities and (financial) support of the state (in particular related to promotions of part-time jobs and children's groups established by employers - which the parents so far do not consider very strong or positive.

Norway
As there is so little variation in the childcare sector in Norway, most parents – including the ones we interviewed – make full-time use of kindergartens for their children and little or no use of any other services (see previous INNCARE reports). A few had been to the “open kindergartens” with their babies before starting kindergarten, but felt that these was inadequate and could not compete with “real” kindergartens.

Regarding the role of employers, there is a distinction between those who worked for the central government and others. Those who were employed in the private sector had varying experiences. The participants describe how they think the generally positive attitude to their childcare responsibilities in their workplaces is structurally embedded in society and not an individual or local workplace trait. They also thought it unproblematic to ask for a reduced position because they wanted to spend more time together as a family. Both men and women described how they would negotiate with their partners to work at home in the evenings rather than spending more time at work, and how the mornings together and the time after kindergarten before children’s bedtime were reserved for “together time” with the children.

Satisfaction with care provision, well-being, interaction of care policies and working life

Eldercare

Czech Republic

The quality of life of caregivers is shaped by a number of factors related to changes in their working life, changing conditions of their family life and household routines, and changes in their use of leisure time, as well as by the income structure and material circumstances of the household. Insecurity and distress are frequent features of the living situation of caregivers. The feelings of insecurity arise from income insecurity, lost income from employment, changes in the provision of financial benefits, as well as from insecurity over provisions in kind and housing.

Distress springs from the burdens inherent in the living situation of both the caregiver and the person being cared for. Emblematic of the situation of distress is its long-term nature that negatively impacts on the capacity of caregivers to provide care. Where care is provided in a family setting, the distress affects all family members.

Distress is associated with factors (stressors) identified as the worsening of the situation of the persons being cared for, their loss of mobility or hospitalization in healthcare facilities. As regards the caregivers, it is associated with the loss of opportunity to make long-term plans, loss of leisure time, limitations in the case of their own illness or disability, and limited opportunities for social participation.

According to the caregivers, providing care does not pay off in economic terms. It is rather the family ties and commitment to sustaining these ties that provide important incentives for
caregiving. The households’ financial strains worsen and their spending priorities need to be adjusted, as their incomes often do not suffice to cover necessary expenses.

What can be a problem are the procedures of granting various forms of benefits and the rules on the payment of the benefits. The same applies to the provision of assistive devices and aids, which is not very smooth, particularly in the event of sudden changes in the clients’ living situation. Procedural demands may be a barrier for some clients who are in need of care and potentially eligible for the benefits. The problem of insecurity is further complicated by poor awareness of the system of social care, of the instruments in use under various programmes, the possibilities to draw benefits, cooperation among different actors and the rules underlying the whole system.

Concerns also arise when the caregiver’s own health requires care. A possible solution may be for the caregiver and the client to move in together to a facility prepared for this form of caregiving; however, it took addressing the request to 26 institutions for an interviewed client to find a suitable facility of this kind. Any worsening of the caregiver’s health requiring hospitalisation also impacts on the situation of the person being cared for. This effect is twofold: care is not available, replacement for the caregiver is not easy to secure; and care does not adequately meet the needs of the client and their routines (administration of medication, hygiene, and diet and sleep habits).

The caregivers see the different forms of their social participation change and even wane. Some carers seek support from relevant support organisations, are active in community planning groups or socialize with people in a similar living situation, be it directly or indirectly. Nevertheless, the concept of leisure time virtually disappears from their lives; all their time is spent on care delivery or work and there is no time for rest.

Social care is largely delivered by family caregivers in cooperation with institutions providing social services, usually municipal or non-governmental organisations. The participants rarely use purely commercial services. Ensuring barrier-free housing is seen as important. Problems may appear in connection with planning respite care, if it is available at all. Respite care services need to be planned a long time in advance, whereas the need may arise unexpectedly. What has received criticism is lack of flexibility, time flexibility in particular, in the provision of social services. Supported-living schemes with in-house domiciliary services (which provide more privacy than care homes for the elderly) could thus help tackle the problem with respite services.

The participants also expressed dissatisfaction with a high turnover of staff in social services, which they associated with their underpayment. Staff turnover translates most markedly into the quality of provided care, since new carers lack personal knowledge of the client and often have inadequate working experience and competencies.

Some participants emphasised the necessity to correctly understand the function of the care allowance, which is to allow for purchase of social services from multiple providers. Some family caregivers shared this view, too. The form of the benefit and the application procedure appears to be
a problem, as some caregivers perceived it as humiliating, discriminatory, and based on inadequate criteria for granting a specific benefit level.

The group of participants had mixed feelings about the benefit level; the carers who cared for people with the highest degree of disability pointed out that the allowance was insufficient to cover the clients’ needs. On the other hand, other caregivers did not take up the care allowance at all, because of a very short-lasting period of care contrasting with the exacting formal requirements on granting the benefit.

In addition to the care allowance, also other forms of assistance are often needed and appreciated by the caregivers. These may concern managing the health risks (positioning beds, cushions for preventing bedsores), overcoming architectural barriers (stair gliders, ramps, carriage and load-handling devices) and supporting mobility (wheelchairs, cars). Again, what received criticism were the procedural demands of applying for various medical aids, particularly those provided and covered by the General Health Insurance Company/VZP (including maintenance, service and necessary technical aid).

Norway

Satisfaction with care provision was a recurring theme and a topic that participants were more than eager to talk about. The three participants who were elderly service users themselves expressed that they were generally satisfied with the services. They spoke of representatives of the system as competent, nice and helpful. However, this may be because the elderly participants did not have very high expectations of employees or the system in general. The elderly also expressed that they did not want to be a burden, neither to the public care system nor to their own relatives. Here they often emphasized that the main responsibility rested on themselves, that they should be able to take care of themselves and that they were satisfied as long as they got the basic assistance required for functioning normally in everyday life.

Participants who were relatives of elderly persons with need for care, on the other hand, had varying experiences with the eldercare system. How satisfied they were with the services and the eldercare system in general seems to depend largely on which services the elderly persons were using.

How satisfied our participants were with home-care services varied, but there was a good deal of dissatisfaction. Among the elements that contribute to such dissatisfaction are the careworkers and/or nurses, more specifically, their competence and their tight schedule. Some participants noted that they had some challenges in trusting careworkers or nurses who were assigned to the elderly persons’ homes, for instance because of previous experiences with wrong medication, or because the nurse or careworker had not given sufficient help or “had not done their actual job”.
Also, several participants expressed that they felt individual needs were not met because of carers’ or nurses’ tight schedule and understaffing. These participants also found it challenging that there was a high turnover in staff, making it difficult for the elderly to recognize and deal with them. Another profound element in the dissatisfaction is that several participants, who were family members of elderly persons, expressed that home-care service staff, frequently of immigrant background, often had language difficulties, thus making it quite challenging for the elderly to communicate their needs to staff and to establish a relationship with them. The elderly seemed more focused on whether the people who came to help them treated them with respect and appeared to know what they were doing, regardless of origin.

Interestingly – but not surprisingly – the participants who were satisfied with home-care services had almost the opposite experience with the services. These participants expressed that they indeed experienced the staff as competent, that the staff were at their disposal and that the turnover in staff was low. This may reflect differences in expectations, but it may just as well reflect real variations in the services, either between local services or between different types of home services.

In contrast, all of our participants caring for an elderly person living in residential care seem to, in general, be quite satisfied with this service. Participants who were family members also told us that it was a great relief to know that the elderly were satisfied with the services themselves, thus mitigating the relatives’ feelings of stress, inadequacy and worry.

Even though these participants were quite satisfied they expressed that they wished the building and its interiors had been designed more like a home and had not simply been an old, run-down “typical institution”.

Besides the above-mentioned challenges with specific care services (e.g., understaffing and rapid turnover in staff), the participants reflected on several matters that, in their opinion, were challenging with the Norwegian eldercare system.

The elderly participants expressed several times that they had a desire to get more “activated” (e.g., walking) and to have someone to socialise with. Participants who cared for an elderly person with need for assistance shared this desire for socializing and activation in both home care services and residential care. Additionally, many participants were of the opinion that access to information was quite challenging, resulting in lack of necessary knowledge about services, options and rights.

A suggested solution to the problem with accessibility and information is to have a “contact person”, and that access to information should become more “user friendly”. Participants also suggested that the cooperation between representatives of different types of services should be strengthened.

*Innovation* was not the first thing that sprang to mind for the participants. One of them knew a good deal about technological innovation in welfare, and eagerly mentioned memory diaries, and
a clock that tells you if it is morning or evening, day or night, and tells you when it is time to eat or take your medications. However, this was knowledge she had acquired through her job, and not something she found relevant for the elderly person in her own family. Another participant in the same focus group interview said that she, for one, would like to find out if her mother could have a stair glider. This would help her be able to stay in her own house even though getting up and down the stairs was getting harder for her. Two participants talked about an idea of their own, for their own future older years. They described this as a type of housing where one could live together and share some things, like a cafeteria and a common room, in order to live with an existing group of friends in a shared house. This would enable independent living in one’s own room or rooms, with access to shared space providing necessary facilities and a continued social life.

Childcare

Czech Republic

The parents in our research were generally satisfied with a longer parental leave, even though many of them simultaneously worked. The flexibility of the parental benefit scheme also definitely contributed to the parents’ satisfaction.

On the other hand, some parents pointed out the imperfections of the system that interfered with their preferred combination of work and care. There are, in particular, the following problems and deficits:

The current child-care policy design rather suits the families preferring a more traditional division of labour (where one parent almost exclusively cares for children and the other parent is the breadwinner) when their child is below three years of age, as childcare facilities are not available. Low and middle-income families (including single parents) are unable to make ends meet on the parental benefit. What is mentioned as unfair, in this context, is the impossibility to draw the maximum total amount of the parental benefit for each child. The parents also see as a problem the fact that the fastest variant of the benefit drawing is limited only to higher-income groups and that the total benefit amount can be fully drawn no earlier than when the child is two years old, which is impossible when the second child is born earlier.

The parents are fundamentally dissatisfied with the general approach of Czech employers that offer an insufficient number of part-time jobs and other family-friendly measures due to conservatism, prejudice and also insufficient state support.

In some families, the mothers are dissatisfied with a limited engagement of the fathers in daily childcare and would welcome his greater involvement. This is also determined by the overall social climate, including the above-mentioned attitude of employers.

The innovations suggested by the parents included improvements of the existing policies in cash and kind: proposals to improve the conditions for and the level of the maternity and parental benefit, and to improve availability, financial accessibility and quality of preschool facilities, access
to part-time and flexible work arrangements, and incentives for employers and for more gender-
egalitarian policies, as a reaction to the deficits mentioned above.

Norway

There was little dissatisfaction to be traced in the participants’ accounts of this care field. One man talked about the challenges of having young children who were frequently ill, and it may be that kindergartens served as arenas for the spreading of infectious diseases such as the common cold, the flu, stomach bugs and so on. At any rate, parental sick leave and often accommodating employers mean that such factors have little influence on parents’ working life in the long run. Another issue mentioned is the situation when a child was born late in the year, which meant that she had no guaranteed place, and the parents felt compelled to accept the place they were in fact given. Lastly, some of the participants in the focus group complained on the real quality of the place such as the building and facilities and the staff.

Conclusions: between family, employer, and welfare state provisions

The findings from WP4 mirror very well the differences between both countries regarding institutional features and availability of eldercare and childcare. They also provide direct lessons for the policy makers about the needs and preferences of the families caring for elderly family members, dependants and children.

When comparing both countries, we see some similarities in the assessments of carers regarding eldercare, in spite of the fact that this policy field is much better equipped with human and financial resources in Norway than in the Czech Republic and more elderly are using home-based and institutional services (in fact, the share of family and professional care is approximately equal), whereas in the Czech Republic, family/informal care is an increasingly prevailing form of care. First, in our admittedly small samples in both countries, the family carers are mainly, but not exclusively, women. Second, in both countries, caring for the elderly – in particular when care load increases – is psychologically stressful and damages the mental, and sometimes even physical, health of the carers. Third, in both countries, there are perceived shortcomings in the home-care professional services: some participants in interviews in Norway consider them insufficient (mainly in terms of the competence of the carers and nurses), while in the Czech Republic, they are clearly considered insufficient by most of the families. More specifically, they are seen as non-comprehensive, inflexible, low-quality, and often difficult to sustain financially for the family, the application procedures are perceived as complicated and information about services as not easily available. If the family is temporarily absent from their caring duties for an elderly family member for some reason, the total system of care collapses in his/her case.

In childcare, most Czech families employ the traditional model breadwinner-caregiver, typically until the child is 3 years old, which corresponds with the long parental leave (men only exceptionally take part). There is a general lack of childcare facilities for children under 3 years old, and a complicated access to part-time and flexible forms of work. Preference is not for preschool education of children under 2 years old, and instead, small groups of children are preferred in this
case. The key features of the family policy are under critique by parents: unfairness in access and entitlements to parental benefit for families with more children and/or low earnings, low level of parental benefit in families living on one wage and/or having more children, poor access to childcare services for children under 4 years old, problematic or variable quality and flexibility of services, unaffordability of private facilities, low support by employers, poor access to part-time and flexible work. However, families do manage to reconcile work and family in spite of policy deficits; to give an example, fathers help pick the children up from kindergarten. In contrast, Norwegian families use public kindergartens from an early age, and employ an egalitarian model of care in the family. Picking up children from kindergarten is typically a common task shared by both the parents. Neither availability of part-time work, nor other policies related to childcare are criticized. Consensual support of these policies is observed across society. It seems that Norway has achieved a great success with the childcare policies in terms of meeting the needs of parents. On the other hand, experience with the approach of private employers in supporting work-life balance is mixed.
Section 5: Conclusions

In this final section, we aim to summarise the findings presented in the individual sections of the book report within the theoretical frame outlined in section 1. We assess the main findings regarding the current development of childcare and eldercare policies in the Czech Republic and Norway, the discourses of the policy actors in both countries, and the strategies and views of families that are providing and ensuring care for children and elderly persons. Lastly, we discuss some possibilities for policy changes or innovations that might facilitate the combination of family care with paid employment.

Care policies compared

According to existing typologies, care service systems in Norway and in the Czech Republic belong to different types. In terms of Leitner’s typology (2003) as introduced in section 1, Norway may be described in terms of a de-gendered optional familialism model and the Czech Republic in contrast as a gendered explicit familialism model. The other typologies (see below) also find differences regarding family and care policies and promotion of gender equality in both countries.

Childcare

In Norway, universally available childcare facilities make it possible for both parents to care for their children in the family while also participating part-time or full-time in the labour market. In the Czech Republic, gender roles in families are mainly complimentary: fathers are breadwinners and mothers caregivers until their children are three years old (Szelewa and Polakowski 2008). Thus, similarly to Leitner (2003, cited above), Saraceno and Keck (2011) cluster Norway among countries which represent a mix between supported familialism and decommodified defamilialisation (see Chapter 1), while the Czech Republic is clustered among countries which represent supported familialism and weak decommodified defamilialisation.

Correspondingly, maternity leave systems differ considerably: whereas a universal and generously funded parental leave system with parental benefits computed from previous income and delivered for a short time period is in place in Norway, the maternity leave scheme and the parental scheme are separated in the Czech Republic. Here, the parental benefit – also universal – is flat rate and provided for quite a long period, although a possibility of a faster track and higher benefit level is given to parents who achieved certain limits of the employment record and earnings. Also, the flexibility to distribute parental leave periods between the two parents is much higher in Norway, where the engagement of both parents in caregiving is far more common than in the Czech Republic, where use of parental benefit by fathers remains marginal.

Also, the public financing of childcare is generous in Norway while rather modest in the Czech Republic. Regulation of childcare in Norway is more advanced than in the Czech Republic,
where some aspects are not fully covered, such as quality regulation of private facilities. There is a unified governance frame of childcare in Norway while in the Czech Republic until recently there was a split between care for children 0-3 (Ministry of Health - nurseries) and 3-schol age (Ministry of Education - kindergarten); after the Ministry of Health abandoned the responsibility for nurseries (in 2012) there has been no reliable regulation of childcare for children 0-3.

In Norway, public and private childcare facilities are highly accessible and of good quality, focusing on educational goals for preschool children of any age. In contrast, in the Czech Republic there is rather low accessibility (dramatically low in the case of children 0-3) and quality of public childcare facilities is lower due to a higher children/staff ratio. The costs for parents in Norway are similar whether the child is placed in a public or a private facility, while in the Czech Republic private facilities are several times more expensive than public facilities (see Chapter 2). This means that privately run childcare is accessible only to rich families. However, parental payments in public facilities expressed as a percentage of average income are similar in both countries.

Eldercare

Norway has continuously developed a quite complex decentralised system of eldercare relying mainly on in-kind services, which include both health and social care provisions. There is a great emphasis placed on the rights of the users in practice and quite high standards of care. Current policies emphasise the development of home care and nursing, accompanied by additional emphasis on family care, while the proportion of beds in residential care has been purposefully reduced (see Chapter 2).

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. In Norway, a major future challenge will be the capacity of services related to 24-hour care spaces in residential care. 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 are important solutions for current and future policy making.

The Czech eldercare system may be seen as a system in flux: it was reformed at the beginning of the 1990s, another major reform came in 2006 and further reforms are expected. Until now, the accepted solutions in terms of policy objectives emphasize the rights of service users, individualised service in the home environment, quality standards, and decentralisation and pluralism in service provision. Implementation of these principles, however, is slow, especially regarding the quality standards. The Czech reform of eldercare which relied explicitly on the creation of the quasi-market of eldercare may be understood as an example of market failure: while one of the objectives was to develop domiciliary care instead of residential care, this did not happen in practice. Further, health care and social care remain uncoordinated, creating gaps in service

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8 However, we note that in Norway, ‘eldercare’ is not a separate policy field: anyone in chronically poor health or disabled may apply for health and care services, regardless of age.
provision. Lastly, there are serious problems in the accessibility of eldercare. The greatest challenge for the Czech Republic is to establish an adequate regulation and financial frame for eldercare which would coordinate health and social care, home and residential care, formal and informal care, underpinned with more solid financial public support.

As regards governance, we refer to the typologies suggested by Pollitt and Bouckaert (2000) and later Ahonen et al. (2006). They distinguished ‘marketisers’ and ‘modernisers’ in social services, based on the identification of two crucial trends in the welfare state. Modernisation means putting more emphasis on social services; marketization means allowing a (quasi-) market mechanism for service provision (see section 1). Sirovátka and Greve (2014) have added the ‘regulation dimension’ which seems to be crucial in several respects, such as accessibility and quality of social service. From this perspective, Norway may be labelled as a more effectively regulated public/private mix, while the Czech Republic may be labelled as a poorly regulated marketiser.

To sum up, the eldercare model is labelled as decommodified defamilialisation in Norway and as supported familialism and weak decommodified defamilialisation in the Czech Republic (Saraceno and Keck 2011). However, our findings (see Section 2 and Section 3) document that supported familialism is also present in Norway.

**Discourses of key actors regulating and providing care: similarities and differences in Norway and Czech Republic**

**Policy objectives**

In childcare, the main difference between the two countries when it comes to objectives and target populations is the Czech distinction between younger and older children (in both countries at the age of 2-3) as having qualitatively different needs, a sharp distinction actively opposed by the key policy actors in Norway. Here, the main perception was a continuum where all children need both care and learning, with the concession from some respondents that younger children’s learning needs require specialised pedagogical training.

In addition, in the Czech Republic there is no explicit concern with immigrant or minority children, while this was one of the main concerns of several of the Norwegian key policy actors. This reflects the differences in minority demographics and rights as well as in childcare coverage in the two countries.

In eldercare, policy actors in both countries share the aim to move from an earlier emphasis on residential care to an increasing focus on home based care and field based services. The reasons are similar: as the populations age, resulting in more elderly people in need of simple and complex care services and fewer young people to provide this labour, policies shift on discursive as well as organizational levels in both countries. The policy shift appears to be stronger in Norway, in
particular concerning implementation. Although the eldercare policies are quite advanced in Norway, policy actors still recognise several challenges (see next section).

**Regulation and financing care, the resources**

The differences in capacity and resources between the two countries (Czech Republic and Norway) as explained in section 2 are reflected in the policy discourses. In the childcare sector, another difference is to be found between a hegemonic consensus on aims and objectives supporting the sector in Norway, and the absence of any corresponding consensus in the Czech Republic. Where actors in Norway unanimously subscribe to the national consensus on further developing the childcare sector, Czech actors referred to a lack of consolidated political will to do so, and pointed to a wide range of problems resulting from this lack of will. In Norway, the main policy issue, as recognised by policy actors, was the relation between the public and the private sector; the actors expressed different views on the possibility to extract profits from kindergartens, and on the fairest model for the distribution of financial resources.

This contrasts with the Czech case, where policy arguments and the priorities of policy actors centred on access to better and more flexible childcare facilities, including facilities for younger children, regardless of the public/private divide.

In the eldercare sector, policy actors in both countries favoured home based care services; however, in the Czech Republic this is not much reflected in the implementation and funding. Here, funding is considered by policy actors as insufficient in both home based and residential care. The Norwegian consensus is less evident in this sector, as there is divergence between policy objectives and policies favouring home based care and public expectations and demand by the public for more residential care. However, the policy actors were unanimous in their support of the policy and emphasized that general solutions favouring residential care were neither viable nor desirable.

This tension between a publicly dominant call for more resources to residential care facilities and official policies highlighting home and field based care services is palpable both in Norway and the Czech Republic. While arguments for the latter were predominant in discourses of the representatives from government bodies, providers, and interest groups in both countries, Czech key actors additionally described gaps between stated policies and real implementation possibilities. In Norway, although there is a high degree of consensus among policy makers on the key objectives, some issues regarding organisation and instruments of eldercare are subject to political controversies.

**Policy deficits**

In childcare, for historically embedded reasons ranging from the ideational to the material, the challenges and deficits in the two countries are very different in scale and content. Norway has followed a relatively smooth, unilineal consensus development and continues to follow the same path of developing and adjusting the kindergarten sector, while in the Czech Republic major upheavals and discrepancies are ingrained in the sector as it is today.
In eldercare, the idea that residential care is the best overall solution, especially for rising numbers of people suffering from dementia, appears to have a strong popular foothold in both countries. Policy actors in both countries, however, also pursue policies supporting the opposite view: that the generally preferred solution is home and field care. The tension resulting from the discrepancy between these two perspectives is a challenge for the relation between demand and supply in both countries. While in the Czech Republic, the overall challenges may be explained in economic terms, in Norway the most apparent lack is to be found in the access to sufficient human resources, resulting in a current and growing shortage of both staff and volunteer care providers. Several other problem issues are also recognised by policy actors in Norway: the growth of new younger user groups; more elderly in need of assistance; inadequate coordination; the lack of activities and coverage related to psycho-social needs; the financing and cost of care.

**Future developments and innovations**

The childcare sector in Norway appears to be dominated by a consolidated optimism. Most things are in place, while there is still – as always – room for improvement and adjustments and a need for flexibility in order to adapt to new needs in the target population. The needs of the youngest children were the main topical example of the latter, while the issue of private profit in this sector appeared to be the only real bone of contention. In the Czech Republic, on the other hand, political, economic, and organizational fragmentation and discontinuity hamper the development of a coherent childcare sector.

In eldercare, the two countries have in common the view of conventional residential care as unsustainable as a general solution for the future. High costs combined with passivation of residents are mentioned as the main reasons. Suggested solutions to this discrepancy are also similar: a more varied scenario of alternative and graded services, including different forms of sheltered housing. In Norway, this suggestion is supplemented by an emphasis on technological innovations as well as a general empowerment of elderly persons, whereas in the Czech Republic the emphasis is on implementing better control of actors and directing more resources to eldercare, and on finding solutions so that elderly persons can afford the care they need.

**Strategies of families in providing care in the national policy contexts**

**The strategies of families and use of care services**

In Norway, most families with children use full-time kindergarten - either public or private. As opening hours in full-time kindergarten are generally from 07-17, most people have enough time to deliver and pick up their children before and after work. Sharing this responsibility is the general strategy, so that one partner delivers, the other picks up. To some extent, grandparents were a regular part of the childcare plans of parents for taking children to kindergarten, picking them up, and for looking after them on evenings or weekends.
Within the traditional gender division of childcare in the Czech Republic, mothers almost exclusively care for the child up to three years of age. The roles of the woman as carer and of the man as the breadwinner was recognised in various ways, ranging from acceptance of this women's role as something natural, matter-of-course or given, via a somewhat forced acceptance of this role, to active efforts to make the care labour division between men and women more equal.

Until children are 2 years old, hardly any parents prefer or use centre based childcare services. Women’s labour market participation usually increases around the child’s second year, when the extent of their jobs often exceeds 0.5 full-time equivalent. At this age, children gradually start to attend day care facilities. It is difficult to find a part-time job on the Czech labour market and the offers are often of a lower quality (lower wages or, in reality, full-time work with part-time wages). In many cases, the essential source of help is grandparents - especially grandmothers.

The interviews with families have shown how adaptive Czech families have learned to be, given conditions where the institutional framework does not support combining paid work and family life. Although women carry almost all childcare obligations, they – and the highly educated in particular - try to work irregularly during parental leave while combining help from nannies and family members. Many also look for a job of lower quality and remuneration but more suitable from the perspective of work-family balance, taking children to the workplace when no other option is available. In spite of the high costs, they may bring children to private childcare facilities at least for some days a week. Typically, when children are about 2 years old, mothers will look for such an option in order to ‘socialise’ children and ‘prepare’ them for kindergarten, while this is not considered a concern for fathers. On the other hand, it is also evident how these adaptive strategies are complicated and burdensome for the families and fragile in case of any unexpected event in the family (see section 4).

In Norway, women spend more time and do more of the intimate eldercare work. Men do help nearly as often, but tend to carry out less time-consuming care work such as minor repairs, transportation etc., and provide less emotional and intimate care. For many families caring for elderly persons who use home care services, the ‘responsibility load’ is large. The practical tasks were often followed by social tasks. Informal care providers often worried about possible dangerous events, such as being lost outside of the home, that could affect the elderly. The other issue was whether the elderly received appropriate care from the formal providers. Although the elderly family members used some technological innovations available from the welfare services, the families did not find confidence and relief in such welfare technologies.

In the Czech Republic, we spoke with family caregivers who regularly assisted and supported the elderly in a wide range of activities. Taking care of the elderly in the family was almost exclusively a woman’s responsibility. For a considerable proportion of the family carers, provision of care represented a ‘second job’, since they performed care tasks for up to 60 hours per week or even more (permanently). In this group of family caregivers, an important mode of care provision for the elderly family member is cooperation with home care services. All carers in such situations described the role of the key carer as an uphill challenge involving serious psychological
stress. Also, the family caregivers’ experiences suggest that in any temporary absence of the key family carer, the care routines are not properly provided by formal carers.

**Assessment of the policies**

In Norway, there is little variation in the childcare sector. Most parents make use of full-time kindergarten for their children, and little or no use of any other services, while mostly expressing satisfaction with the childcare services. Regarding the role of employers, there was, however, a distinction between those who worked for the central government and others, since those parents who were employed in the private sector had varying experiences, sometimes experiencing less support.

In the Czech Republic, recent changes mainly regarding the flexibility of the parental benefit were appreciated. However, families faced strong and gendered barriers to balancing care and work. Such barriers were embedded in all the important arrangements. They included the following: first, regarding the parental benefit scheme, it was unfairness in access and entitlements for parental benefit for families with several children and low earnings. The levels of benefit in cases of single earning in the family and in families with more children were perceived as low. Second, regarding childcare: access to childcare services was assessed as poor for children below 4 years, the flexibility of services was problematic or of varying quality, and private childcare facilities were financially unaffordable. Third, regarding arrangements at the workplace: there were low levels of support by employers and poor access to part-time and flexible work.

In Norwegian eldercare, family carers were often of the opinion that too much of the responsibility rested on the families, and that services (like home care services) and benefits were not sufficient. Those with heavier care loads stressed how they had to plan their lives according to the elderly family member’s needs, often resulting in little or no vacations or other time to rest. Others said that caregiving affected their mental health, which was particularly the case of those who cared for a spouse or those who had sole responsibility for their parent(s). According to some family carers, a solution could be to invest in more temporary relief for family members, along with more places in residential care or in sheltered housing with in-house services.

In the Czech Republic, the family carers assessed home care services as insufficient when it came to accommodating the needs of an elderly person requiring complex care. For instance, worsening health of the main care provider in the family did not increase pressure on the professional providers, but on the other family caregivers. Some reported that accessible field-based services, including the home/domiciliary care service, were insufficient, not only in terms of the comprehensiveness of care but also in the flexibility of the partnership with the family caregivers.

Another reason why care might be extended exclusively by family caregivers, without assistance from another provider, was the lack of access to information about accessible professional help, or the possible local unavailability of such help. Applying for the care allowance was perceived as quite challenging and, more crucially, the family caregivers found the procedure to be unclear. Most family caregivers were concerned or felt insecure about the financial
affordability of care in the event that a health condition worsened and the elderly relative were to require more intensive assistance. They assumed that the financial support would not be sufficient.

**Problems envisaged by families**

Some of the participants in the Norwegian focus group were not completely satisfied with the quality of their kindergarten, having minor concerns with aspects of the building, facilities, and staff. That said, overall there was very little dissatisfaction to be traced in the families concerning childcare.

Czech families assessed the childcare policies as adapted primarily to the needs of families preferring a more traditional division of labour (caregiver-breadwinner model) during the child’s first three years. However, even in such families, low and middle-income households (including single parents) are unable to financially cover the family needs from the parental benefit. The parents are dissatisfied with the general approach of Czech employers offering an insufficient number of part-time jobs and other family-friendly measures which is caused by conservatism, prejudices and also by insufficient state support. The comparison between the two countries brings out some interesting aspects of the part-time issue. In Norway, the widespread phenomenon of part-time jobs is generally regarded as an impediment to gender equality and thus as a negative framework that employers impose on employees rather than the other way around. A negative framing is also associated with part-time work in the Czech Republic. The difference is, however, that by not facilitating part-time work Czech employers are regarded as hindering women’s (albeit part-time) participation in the labour market.

In some families, mothers are dissatisfied with the lower engagement of the father in daily care for children, an imbalance which is also upheld by the larger society, including the above-mentioned approach of employers. Not surprisingly, the innovations suggested by Czech parents included improvements in the mainstream existing policies both in cash and in kind.

In eldercare, in Norway, (dis)satisfaction with care provision was also a recurring theme. Family caregivers had varying experiences with the eldercare system. Satisfaction with home care services varied and there was dissatisfaction regarding the carers and/or nurses, primarily ascribed to their tight schedule, poor communication between different carers and departments, and understaffing, and to some extent language difficulties. On the other hand family caregivers caring for an elderly person in residential care seem to be quite satisfied with this service. To some extent, this is a relative satisfaction, where moving from inadequate home services to the more total responsibility of the nursing home was experienced as a great relief for family carers. The elderly participants expressed a desire to get more assistance/support in becoming more active (e.g. walking, getting outside the nursing home) and to have someone to socialise with. Family members also highlighted the importance of help from capable and ‘pushy’ family members for gaining access to one’s rights and in being fully satisfied with the eldercare system.

In the Czech Republic, distress springs from the burdens inherent in the living situations of both the caregiver and the person being cared for. Where care is provided in a family setting, the distress affects all family members. According to the caregivers, it is economically demanding for
them to provide care. Procedures leading to various forms of benefits and the rules on payment of the benefits are regarded as problematic. The same applies to the provision of assistive devices and aids, particularly in the event of sudden changes in the client’s living situation. In such cases, accessibility of services is a big problem: in particular residential care which is considered as the preferred option because of better quality. The problem of insecurity is further compounded by poor awareness of the system of social care, of the instruments in use under various programmes, the possibilities to draw benefits, cooperation among different actors, and the rules underlying the whole system. Concerns also arise when the caregiver’s own health deteriorates. Caregivers also report that their own social lives have been heavily impacted and reduced by their caring situations. Lack of flexibility, time flexibility in particular, in the provision of social services was heavily criticized. The respondents also expressed dissatisfaction with the high turnover of staff in social services, which translates most markedly into poor quality of provided care. Family members who cared for people with the highest degree of disability pointed out that the care allowance was insufficient to cover the clients’ needs.

The balance of carers’ strategies and the policies

The findings mirror the differences between the two countries regarding institutional features and availability of childcare and eldercare. They also provide lessons for policy makers about the needs and preferences of the families caring for their elderly and/or children.

In childcare, Norwegian families widely use publicly supported kindergarten from an early age, and practice a relatively egalitarian mode of caring within the family. Policies related to childcare are generally not criticized; rather, consensual support of them is observed across society. Norway appears to have achieved success with their childcare policies in meeting the needs of parents and children. However, views on the model of involvement of private sector employers are more mixed, and follow traditional political lines of ideological commitment.

In contrast, Czech families mostly practice the traditional model of male breadwinner-female caregiver, typically until the child is 3 years of age. Correspondingly, men are marginally engaged in caring and long parental leave, as well as in issues such as the lack of childcare facilities for children younger than 3 years, and the complicated access to part-time and flexible forms of work. Parents (mothers) prefer not to bring children into public facilities until they are at least 2 years old, and even then, small groups of children are preferred. Key features of the family policy are, however, criticised by parents. They point to unfairness in access, entitlements for the parental benefit in the case of more children (as it is not possible use the full benefit for the first child if the second child is born soon after) and/or low earnings of parents (parents with an insufficient employment record cannot get faster track and the higher level of benefit), low level of parental benefit when a family is living on one wage and/or has more children. They also criticise the problematic or variable quality and flexibility of services, and the financial unaffordability of private facilities. Lastly, they complain about low support by employers, particularly regarding poor access to part-time and flexible adjustment of working conditions.
When comparing the two countries, we see some similarities in the assessments of carers regarding eldercare. This may appear surprising, as this policy field is much better equipped with human and financial resources in Norway than in the Czech Republic, and more elderly are using home based and/or institutional services, and the share of family and professional care is approximately equal. In contrast, in the Czech Republic, family/informal care is the increasingly prevailing form of care. One main similarity is that, in both countries, family carers are predominantly women – although this tendency is much stronger in the Czech Republic. Secondly, in both countries, caring for the elderly – in particular when the care load increases – is psychologically stressful and may negatively impact the mental and sometimes the physical health of the carers. Thirdly, in both countries, there are issues with home care professional services: some of our Norwegian interviewees consider them insufficient (the time allocated, and lack of coherence in the services are the main areas of discontent), while in the Czech Republic these services are considered insufficient by most families interviewed. More specifically, our interviewees experience the home services as non-comprehensive, inflexible, of low quality, often economically unsustainable for the family, with complicated procedures of application, and lacking in information. If the family is temporarily absent from the elderly member for some reason, the total system of care collapses in his or her case.

Policies, discourses and the strategies of families

The comprehensive view on childcare and eldercare policies, related policy discourses of the key actors involved, and the interviews with care providing families document fewer discrepancies in Norway than in the Czech Republic. Alleviation of discrepancies is evidently an effect of the specific pattern of policy making in Norway. This pattern consists in the increasingly high attention paid by policy makers to the needs of families and in the principle of consensus seeking and the consensual mode of policy making. These principles lead to increased collective policy efforts aiming at the universal accessibility of services embedded in the right to services and in the reliable regulation of quality and real choice provided to the recipients/users of services. They are also translated into a cooperative approach and, especially in the field of childcare, integrated governance structures: multi-level (national, regional, local), cross-sectoral (public, private), cross-sectional (across different social policy fields) and formal-informal.

Such sensitivity of policy makers and other actors represents a strong device in breaking the path-dependency of policies, as documented in the rapid developments in childcare services in Norway after the broad political agreement on changes in the financial and legal framework for the childcare sector (The Kindergarten Agreement/Barnehageforliket) in 2003. Similarly, there has been rapid development in eldercare and important achievements have also emerged there. Still, the coverage of needs for the elderly is not optimal – partly due to the dynamic of the needs (mainly due to demographical change) which are changing faster than adjustments in policies, thus it is more demanding to meet them and requires more differential eldercare arrangements when compared to childcare. Partly, the sub-optimal results in this sector are also due to the complicated multilevel governance framework and high level of coordination needed in this field. In addition, staffing, coordination of the actors, and costs, are more challenging than in childcare. The
difference is also due to the importance of the social investment perspective in childcare in Norway, which is lacking in eldercare.

The nature of the multilevel governance frame is likely to represent one important factor which influences the policy changes and the departure from path dependency. In Norway, the long-term cultivated cooperation and consensus model plays a role in achieving faster solutions, especially in the childcare sector. The Norwegian childcare sector emerges as a well-integrated system where all actors know the game and approve of the same set of rules. Its Czech counterpart is hampered by fragmentation, distinct and partly incongruous historical legacies, and a lack of exchange of information. The other historical legacy from communist times is a historically embedded lack of trust in public childcare services for children in age 0-3 in the Czech Republic as children/staff ratio was high, pedagogical competences of staff were rather low and children quite often got sick (Saxonberg and Sirovátko 2006), which stands out as very different from the overall Norwegian trust in such kind of services. However, a certain problem in the Norwegian system may be inherent precisely in the consensus-based model, which makes it difficult for alternative views to be heard and to gain influence.

In eldercare, although the solutions are not optimal, it seems that a great part of the population considers their needs to be well taken care of in Norway, in particular when residential services are provided. In contrast, in the Czech Republic, home care services are generally assessed as insufficient and hence residential care is strongly demanded. On the other hand, also in Norway a discrepancy between views of policymakers (who emphasize home care) and the public (which demands mainly more residential care) is apparent.

The drivers of and possibilities for policy change responsive to the needs of families

One of the underlying questions behind the comparison of the Czech Republic and Norway is whether and how good practices observed in Norway might inform improvements in eldercare and childcare policies in the Czech Republic, shifting the policies to better meet the care needs of families.

The discourses, as we have analysed them, shed some light on these possibilities. In both countries, the discourses of policy actors and families (sections 3 and 4) mirror the problems and gaps in childcare and eldercare policies identified in the analysis of the systems provided in section 2. Nevertheless, important obstacles are blocking policy responses to the needs of families in the Czech Republic. In the field of childcare, strong socio-cultural/attitudinal or ideological factors sustain the policy path dependency. The general/widespread inclination towards traditional gender attitudes combined with the legacy of communism (experience of people with rather lower quality childcare for children 0-3), leads policymakers to neglect the provision of childcare facilities for children up to 3 years of age. All this consolidates the strong preference of policy makers towards ‘alternative solutions’ to public institutional childcare.

In the field of eldercare, gender attitudes also seem to play a role, but more important are contextual factors such as economic constraints, complexity of the needed regulation framework, and more demanding implementation conditions. Ideological factors were also influential, leading
to the non-critical commitment of the country to the quasi-market solution, which failed in achieving the key objectives of the reform, while several other aspects, mainly in the regulation framework were neglected.

The findings presented in this report have shown an interplay of structural, cultural and institutional factors in shaping the developments of care policies in Norway and the Czech Republic, and, similarly, also the strategies of families in ensuring care and in balancing work and family life. We have discussed this at the theoretical level in section 1.

We have identified important factors which may explain persisting differences as well as some divergence in the direction of the ongoing policy changes in the two countries as follows: First, several structural factors seem to be influential. Profound societal changes such as the demands of the knowledge economy, changes in women’s roles and their growing employment, and the ageing of the population generate a growing demand for care services in both countries. The ‘problem pressure’ emerging from the changing socioeconomic conditions (welfare and social security problems) combined with ‘political mobilisation’ were considered to be the most important drivers in welfare state development (Flora and Heidenheimer 1982). In that respect, we can observe similar societal trends regarding women’s increased participation in the workforce or the ageing of the population in both countries. However, some other factors are divergent.

First, the timing hypothesis matters. As explained in section 1, Tepe and Vanhuysse (2014) following Bonoli (2007) claim that the policies responding to new social risks (typically the policies in social services like childcare or eldercare) are difficult to advance for countries which were confronted with these risks later, in times when the challenges emerging from an ageing population and economic austerity affected the welfare programmes due to pressures on the pension and healthcare systems. This is the case of the Czech Republic as seen in the austerity discourse of the policy actors, while in Norway the care policies developed earlier.

The other important difference is the level of economic development, i.e. the higher level of purchasing power in Norway when compared with the Czech Republic and accordingly both a stronger tax base for publicly provided services and stronger purchasing power for the demand for private services in Norway. As Esping-Andersen (2009: 105) suggests, ‘unless subsidised, commercial social services are priced out of the market for most households below median income and [are] less accessible.’

There is also a deeply rooted difference regarding cultural-attitudinal factors. In particular, gender ideology and the gender order (Pfau-Effinger 2004) are different in the Czech Republic: they are less egalitarian than in Norway, and more traditionalist. This can be seen in the discourses of policy makers and families and is also mirrored in the gendered division of care work within families, in gendered labour market opportunities, as well as in gendered family, labour market and care policies.

Lastly, institutional factors and policies matter. Path-dependency in care policies is strong in the Czech Republic, blocking the faster development of care services, although the problem pressure is forcing policy actors to adopt some changes. However, there is not yet much room for paradigmatic or ‘third order change’ (Hall 1993). In welfare theory, collective ideologies and
attitudes are viewed as a product of the institutional characteristics in different countries (Korpi 2000; Esping-Andersen 1990). This assumption was confirmed by Jensen (2008: 160), who observes that from the 1970s the institutional trajectories kept welfare regimes on their existing paths: in particular the conformity of social care services to welfare regimes is due to the saliency of the underlying ideological dimensions of familisation and statism.

The ‘new politics’ of the welfare state assumes that ‘social policy institutions once in place shape welfare state politics by creating new political constituencies of welfare beneficiaries who support them and by influencing the political discourse surrounding the welfare state’ (Jordan 2013: 134-5). Thus, policy feedback effects may produce path dependency in welfare state policies.

In our cases, the path dependency produced by policy feedback means a persisting re-familisation trend in care policies in the Czech Republic, as the policies preserve the existing ‘gender cultures’ and ‘gender order’. In contrast, Ellingsæter and Guldbrandsen (2007) used a similar theoretical perspective when explaining the rapid development of childcare in Norway during the 2000s as being caused by the interactive mechanism between the demand for and supply of high quality childcare, which in turn led to rapid developments in universally accessible childcare facilities.

Correspondingly, at the micro-perspective of families we can see that they are making individual and collective care choices within specific cultural and institutional frames, similar to the carescapes (Bowlby 2012) we discussed in section 4. In the Czech Republic, the traditional gender arrangement in families, the labour market, and the welfare state is a mutually reinforcing mechanism. The policies in particular direct families towards default, restricted choices. As Hall and Taylor (1996) explain, institutions serve as templates for the interpretations and actions of people (see section 1). In spite of a high degree of adaptability of Czech families in this frame of restricted choices, their manoeuvring often offers them less satisfactory solutions in providing care, in balancing care and work, and in well-being as compared to Norway.

**Challenges and lessons for policy making**

From the discussion above, several factors emerge as working against a policy change responsive to the needs of families in the Czech Republic. From the social investment perspective, during recent years with the financial and economic crisis, austerity discourse gained strength in most European countries. This suppressed the social investment perspective which could have supported developments in childcare and eldercare policies but in reality was only marginal in the Czech Republic (Sirovátka 2016).

In Norway, like in the other Scandinavian countries, the social investment perspective seems to be more influential (Morel et al. 2012; Greve 2017). Nevertheless, there is room in the Czech Republic for increasing social investments, in particular in childcare. Such investment brings returns in children’s development, the future of society as embodied in children, labour market participation of both parents, the well-being of all family members, the prevention of poverty and social exclusion and, last but not least, new work opportunities in the service sector. We need to
note that social expenditures in the Czech Republic\textsuperscript{9} are only at the level of 19.7 percent of GDP, while the EU average is 28.7 percent and in Norway they are 26 percent. At the same time, the Czech Republic is among the countries with the lowest public finance debt in Europe.

From the social innovation perspective, which we understand mainly as attached to the responsiveness of the policies to the needs of families and their effectiveness in doing so\textsuperscript{10}, the feedback from families in the Czech Republic indicates that the most important social innovation might consist in improving mainstream policies, that is in investing and providing affordable and good quality care for families in need and improving related policies (family related benefits and labour market policies in particular). This means implementing the universalism principle in childcare by ensuring a general right to childcare services from an early age and, similarly in eldercare, providing a guarantee of accessible home and residential care to those who need it. Although some innovations like welfare technologies and new measures to coordinate formal and informal services also help meet the needs of families, these are not considered decisive improvements as seen in the findings from Norway.

For the Czech Republic, the comparison with Norway has brought several lessons. The key lesson is that several policy principles and assumptions need to be reconsidered. We will list and discuss them briefly, below.

Preconditions for policy development would be the recognition of the value of mutual understanding among policy actors within the formal and informal arenas and networks for cooperation and negotiations, as seen in Norway. Such networks also include the participation of clients and employees, leading to their empowerment. Although similar arenas and networks develop in the Czech Republic they often lack mutual understanding, suffering by public servants’ rigidity and reluctance (see sections 3 and 4).

The innovation trend in care services implies balancing universal access to care with the individualisation of care, e.g. the combination of differentiated and specialised services. Universal access includes both the right to the service and financial affordability. For example, the right to childcare for children from the age of 1 year represents a crucial step forward, as does setting rules promoting financially affordable service for all families.

Next, it is more effective in terms of universal access to services and quality when the regulations and financing frame are equal for public and private care providers. This implies similar support from public resources and similar quality standards both as required and as applied.

In childcare, a sharp age-based distinction of the needs of children regarding care and learning is not appropriate. Rather, taking a continuum of needs as the point of departure may help

\textsuperscript{9} Eurostat database, year 2014.

\textsuperscript{10} While the social investment logic/strategy emphasises education and the development of children and future societal and economic gains, the social innovation logic/strategy is concerned with how best to meet the needs of families in reconciling caring and working. Both logics/perspectives are, of course, mutually related.
meet the real needs of children, in parallel to eldercare where the establishment of appropriate individualised care packages is also optimal.

If the balance between work and family is to improve and childcare and early education is to include more 1 and 2 year olds, then the quality of education of kindergarten teachers needs great attention. Inclusion of one and two year old children as well as more children with individual educational needs, such as Roma children or children with disabilities, into pre-school programs requires new methods and approaches in care and early education. This is a relevant issue for the Czech Republic: the amendment of the Education Act from April 2016 which comes into effect in the 2016/2017 school year will ensure a place in kindergarten for 5 year olds and for children who will enrol in school the next year. In the 2017/2018 school year, places will be extended to four year olds, in 2018/2019 to 3 year olds, and in the 2020/2021 school year, kindergartens will admit 3 year olds. This is in line with population demands, however this act postpones universal provision of access to childcare for children under 3 by an additional 4 years, while children younger than 2 years old are not considered at all.

Children from immigrant or ethnic minority backgrounds should also be accorded similar inclusive attention, including their intake into early education and care, and providing qualified education as a precondition for their successful social integration. This is an overlooked policy aspect in the Czech Republic, where immigration is less prevalent but where ethnic minorities have long formed part of the population. In Norway, indigenous ethnic minorities as well as the rapidly increasing immigrant population are targeted in most policy fields; however, here, too, much work remains to be done, especially as regards newer large immigrant groups from the eastern regions of the EU.

In eldercare, it seems that in both countries, the expansion of home care services is a condition for more effective use of residential care and sustainable care costs. This, however requires the provision of good quality, integrated and individualised home care, which also includes medical care and specialised arrangements for people with more demanding needs like dementia and such. As seen in both countries, respite/temporary full time care represents an increasingly important condition for the balance between formal and informal home care.

Quasi-market solutions, where a core responsibility is given to the clients, is not the best approach. This is due to market failures like information asymmetry and insufficient resources provided to purchase the services needed. More effective subcontracting would require, for example, the involvement of public/municipal authorities, not least for effective regulation and quality control. Lack of information about accessible services is the other typical market failure identified in the Czech case.

In the future, as seen mainly in Norway, one of the most important challenges is the lack of care workforce. Here, especially in some regions, the sector already depends heavily on immigrant labour, both in the form of predominantly (but not exclusively) low-skilled immigrants who have lived in Norway for many years and in the form of skilled labour immigration. Appropriate and adequate assessment and training are key for this part of the staff population as for other staff. The salaries and work conditions in this sector are not reflected from this angle yet in the Czech
Republic. This will create great difficulties in terms of staff shortages in the near future, in particular if formal home care is expanded from its currently levels.

Similarly, it will be necessary to restructure the cooperation and involvement of families and volunteers in eldercare, especially in Norway where efforts and involvement from this sector is already present and growing. A similar need may be expected also in the Czech Republic where family involvement is extensive at present: the great challenge here is how to involve and support civil society organisations as well as how to support families better. This is also crucial for alleviating the negative consequences of caring on the work-life balance of carers and their labour market participation, as well as on the life quality of families and individuals.
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