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Tomáš Sirovátka,
Jana Válková (eds.)

UNDERSTANDING CARE POLICIES IN CHANGING TIMES:

EXPERIENCES AND LESSONS FROM THE CZECH REPUBLIC AND NORWAY

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Table of Contents

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Schemes and tables

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Introduction

Tomáš Sirovátka and Jana Válková

Due to societal and economic developments during the two last decades, issues such as increased female labour market participation, the ageing of society, changes in family structures and changing preferences of people, the issues of work-family balance and accessibility of good quality care services for children, the elderly and other groups with care needs have become increasingly important across Europe, especially with respect to the well-being of both those who provide and those who receive care.

In this context, both childcare (early childhood education and care/ECEC) and eldercare are becoming the central issues in welfare state efforts. A growing body of studies have examined the ability of the welfare states to respond to the challenge of the need for care (European Commission 2010; OECD 2006, 2012). During the 1990s and after 2000, several scholars have recognised the need for a 'new welfare state architecture', a 'female friendly welfare state' (e.g. Esping-Andersen 1999, 2009), and a 'social investment state' (Giddens 1998; Taylor-Gooby 2004, 2008; Morel et al. 2012), and others have already noticed the trend of increasing investments in services helping families to meet their care duties (Jensen 2008, 2009).

The development and continuity of care services (children, elderly) in the longer-term perspective has in many countries been blocked by factors such as the financial capacity of the welfare state, the cultural patterns and preferences reflective of the so called 'gender order' (Pfau-Effinger 2004) and path dependency in policy making (Pierson 2005), which in some countries includes the communist legacy (Saxonberg and Sirovátka 2006). On the top of that, and as a consequence of the ageing of society, there is an increase in direct expenditure on pensions and healthcare in most countries which may outpace the expenditure on care services.

Another issue is the changing governance context in care services. Many studies have followed and recognised the trends in social services during the 1990s and 2000s towards a public-private mix or quasi-mar-

kets in service provision and a split of the governance functions of regulation, financing and service delivery, accompanied with de-centralisation and re-centralisation trends, marketization, New Public Management methods implemented in public services, and networking/partnership (e.g. Dingeldey and Rothgang 2009; Léon 2014; Matzke and Ostner 2010; Pavolini and Ranci 2008; Ranci and Pavolini 2015; Sirovátka and Greve 2014; Seeleib-Kaiser 2008; van Berkel et al. 2011).

Due to the participation of many actors in the field of care services and the complexity of the relationships among them, service users face the difficulty of being well-oriented and well-informed. The other important questions that emerge are how compatible the strategies of various actors involved in this field can be, and to what extent it is possible to implement effective and efficient solutions that meet the needs for care services in the population. The variety of actors involved and the complexity of the relationships among them creates room for a variety of possible solutions which may entail, for instance, co-ordination of policies at the national, regional, local levels, cooperation among public, private, non-government sectors, combinations of the formal and informal/family care and of various policy tools like direct service provision, benefits tied to the purchase of care, regulations to guarantee quality standards, as well as more involvement of care recipients and care providers in decision making.

Lastly, the related issue of whether being in paid labour exacerbates or alleviates caregiver distress is still an open and under-researched issue. Academic discourse usually assumes that paid work adds stress to caregivers (e.g. Lilly et al. 2010), but so far there is little scientific evidence for this claim. Little is also known about whether part-time work has the same effects as full-time work.

Although the research on care policies has investigated many aspects of this issue (e.g. needs and preferences of the families in securing care for children or the elderly, financing, quality standards etc.), less attention has been paid to a more integrative approach which would examine the mutual compatibility of the strategies of the various stakeholders in providing care, and how they correspond to the preferences and strategies of households, including the impacts on their working lives. This perspective, however, is increasingly important since the public-private mix of actors involved in regulation, financing and provision of care and the

variety in households' living situations, preferences and strategies imply varieties of the solutions and open space for innovation.

The main objective of this book is 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 care services. The book is focused on two areas of social services: 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. In addition, the book examines how being pulled between work and care giving interact to affect well-being and how families manoeuvre when affected by this squeeze affect – importantly in terms of gendered strategies.

The two chosen countries – 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 Guldbransen 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; Sirovátka 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 may be interesting 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 in this book 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 will 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 Chapter 1).

The book 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 like Generations and Gender Survey (GGS) and some 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 Chapters 3, 4, 5 and 6) 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 Chapters 3, 4, 5 and 6

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.

The content of the book is as follows: in Chapter 1 we assess the theoretical approaches that have been used in previous research in order to understand and to explain the strategies of the actors at the individual/micro-level: in balancing work and family. Similarly, we examine the approaches which explain the factors behind the care policies at the meso- and macro-level. We also explain what key findings these theoretical approaches and emerging empirical studies have brought in the two categories of care: childcare and eldercare.

In Chapter 2, the authors explain the origins and key characteristics of childcare and eldercare services in the Czech Republic and Norway and compare them from the above-outlined analytical perspectives. The historical legacy of and recent developments in the care policies are also compared.

In Chapter 3 (Czech Republic) and Chapter 4 (Norway), the strategies of funders, regulators, formal providers of care and other national level actors in the area of childcare and eldercare are explored and explained, and the reasoning and discourse behind these strategies in the Czech Republic and Norway are revealed.

These chapters highlight:

- how funders, regulators, formal care providers and other national level stakeholders perceive key child- and eldercare problems and deficits
- the capacity of funders, regulators, formal care providers and other national level actors to act in the context of other stakeholders' agency/strategies

- preferred, real and successful strategies of funders, regulators, formal care providers and other national level actors.

The discussion of the findings attempts to shed light on the current and future development of care services in the two countries, with possible generalisations for other countries.

The main objective of Chapters 5 (Czech Republic) and 6 (Norway) is to explore strategies of service users. The chapter aims to reveal how service users (and their families) perceive key child- and eldercare problems and deficits, to explain the strategies families make use of when faced with different policy packages, to identify new innovative solutions to facilitate and provide both child- and eldercare. The consequences for work-family balance is assessed.

In Chapter 7, the authors analyse how the time squeeze between childcare and eldercare impacts the well-being of the care givers in both countries, taking into account the variety of family compositions and labour market involvements. The chapter looks into the impact of care burdens on various outcome variables indicating well-being. The comparison of child- and elder-care burdens and well-being is interpreted in the context of different policy frameworks.

In the concluding chapter, two different care models (universal and residual) and their dynamics in recent years are compared in the two countries in focus. The three more general questions/aspects are assessed based on this two-country, in-depth, comparative investigation.

Firstly, what are the recent policy developments (what types of policy changes are emerging) and is there any convergence in policies? Secondly, how are the preferences and strategies of key actors in delivering care policies mutually compatible, considering the multilevel governance context and the plurality of actors at different policy levels? How do they influence policy practices and the path of policy change? How do the policies and practices meet the needs of households for child and eldercare? Thirdly, what are the impacts of the policies on the effectiveness of combining family and work by individuals and families and the impacts on individual well-being? In addition, we discuss what the drivers/factors are behind the policy change, and what the role of ideas and policy discourses is here. An in-depth study of two country cases is suitable to respond to such questions.

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CHAPTER 1

Understanding care services in changing times

Tomáš Sirovátka and Jana Válková

Introduction

In this chapter we provide a theoretical framework for understanding two issues central to this book. 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.

In the following section, we focus first on the increasing role of care services in the welfare state architecture and the reasons for their growing significance. Then we deal with the theories which explain the developments in care service provision and the strategies of care service providers in providing services. Further, we elaborate on the theories which explain the strategies of families in ensuring care, within the context of their work-life balance strategies. Lastly, we link the macro/meso and micro perspectives in order to provide a valuable framework for the analysis presented in the following chapters.

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 Raghuran 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 Szebehely 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

In this section we address the factors/drivers of the development of social services, care services in particular, because the review of the theoretical approaches to their assessment and key findings on these factors could help to understand the recent trajectories of care services developments in both the Czech Republic and Norway.

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) 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 sup-

porting 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.

Culture is likely to influence the change imposed by the structural factors. For example, van Hooren and Becker (2012) explain how the changing culture of care in the Netherlands has shaped the divergent development of eldercare and childcare since the 1980s. While before the 1980s eldercare was fast developed as a universal policy in line with the expectations of more independent lives of the elderly from their children, in times of austerity and liberalisation, the trends towards containing expenditure while expanding the scope of formal care provided took place at the same time in order to meet the demands in the long-term. On the other hand, expenditures on childcare grew fast in this time, perceived as supportive to female employment and economic growth, in contrast to 'costly eldercare.'

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) how-

[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.

ever, 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). This is the case of the Continental and Anglo-American countries and post-communist Czech Republic as well. 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.

Coming from the path dependency hypothesis, one may assume that once social services are developed to a certain level, the economic and social systems become 'service dependent' since the patterns of family life

and employment in strategies of households and other actors adopted to the opportunities provided (typical reverse causality problem, see Bonoli and Reber 2010).

Some theories also show how institutional path dependency may be relevant due to the specific policy-field institutional traditions or due to the political system rigidities. For example, Jensen (2009b) has documented that the developments of childcare policies in recent years have been much faster in countries with a readiness-for-school-curriculum tradition[3] like the UK, Belgium, France, and the Netherlands than in countries with social-pedagogical-curriculum tradition[4] like Austria, Germany, Sweden, and Norway, especially in the context of the growing emphasis on the social investment approach.[5]

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 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 deci-

[3] This tradition is concerned with educational cognitive goals with emphasis on maths, languages, and literacy skills; teachers are typically even engaged in early education and care.

[4] This tradition puts emphasis on the overall development of children, including social competences and children's well-being. Special pedagogical staff for early education and care is mostly engaged.

[5] We may rank the Czech Republic rather among the first groups of countries. Although pedagogical staff in pre-school education/kindergarten have a different (and lower) degree of education, the substance of their training is very similar to primary education.

sion makers as regulators of caring policies and formal care providers. Reconciliation is understood as a relationship (Donati in Rossi 2006) that requires greater transformation due to higher participation of women in the labour markets (e.g. Esping-Andersen 2009; Leira 2002). Such relational goods are based on multiple subsidiary strategies and create an action system. The goal of the relationship is to make work subsidiary to family; the processes are regulated by rules for societal governance and supported by appropriate resources building on individual potential to manage these relationships well and allowing for individual well-being (Donati in Rossi 2006). Much like the formation of social (care) services policies (macro-level, meso-level), individual reconciliation strategies (micro-level) are influenced by structural, cultural and institutional factors. 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 de-domestication 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) dif-

ferentiates 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

The notion of gender equality is connected with citizenship since it refers to and builds on values related to justice, political participation, power and rights as such (Siim 2002). 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). This is of particular importance when discussing cultural factors impacting the work-life balance since men, masculine life trajectories and the involvement of men in the public sphere are considered the norm. 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 (Leira 1998), 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).

In addition, gender order, as argued by Jakobsen (2005), impacts on life modes of individuals. She defines a life mode as *'structurally positioned social practises through which people gain the means of existence and human existence itself'* (ibid.: 113) and distinguishes between typically male and female life modes. Among masculine life modes, there are the worker life mode, the career life mode and the independent life mode (typical of entrepreneurs). These are complemented respectively by the housewife life mode, the back-up woman life mode in which women work but where their partner's career is primary, and the assistance life mode in which women work to support the activities of men (e.g. in family company). The study works with the notion of complementarity among partners where spouses are each other's means of reaching their life goals (if no other support is available e.g. through the welfare state and when opportunity costs of caring for the partners increase).

Care is a complex concept which encompasses diverse aspects – emotional, personal, social and economic – and which generates various doubts and tensions for care-givers and care-receivers (Anttonen and Zechner 2011). First, the 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 strate-*

gically-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 then 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.[6] 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, 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.

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

[6] Becker (1993) explained the division of the roles within the family in a similar way.

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)**

	Structural factors	Cultural factors	Institutional factors
Micro-level (households service users)	Self-interest (problem and economic pressures, choices and gains available for the family)	Preference theory (combining work and family) Care (ideal) models	Gender divisions (homework, labour market attachment)
Meso- and Macro-level (actors: service regulators, service providers)	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)	Cultural theories (gender order, gender culture) Care cultures Intergenerational family	Path-dependency and critical junctures Historical, sociological, actor-centred, discursive institutionalism Policy feedback

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.

Scheme 1.2 Male breadwinner vs. individual model

Dimension	Male breadwinner model	Individual model
Family ideology	Celebration of marriage Strict division of labour Husband=earner Wife=carer	No preferred family form Shared roles Father=earner/carer Mother=earner/carer
Entitlement	Differentiated among spouses	Uniform
Basis of entitlement	Breadwinner	Citizenship or residence
Recipient of benefits	Head of household	Individual
Unit of benefit	Household or family	Individual
Unit of contributions	Household	Individual
Taxation	Joint taxation, deduction for dependants	Separate taxation, equal tax relief
Employment and wage policies	Priority to men	Aimed at both sexes
Sphere of care	Primarily private	Strong state involvement
Caring work	Unpaid	Paid component

Source: Sainsbury 1996

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 typol-

ogy 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).

Jensen (2008), for example, used a hierarchical cluster analysis of the expenditure on transfers and services[7] and showed that the worlds of transfers and services are different: the world of social transfers is guided by the principle of decommodification, the world of social services is guided by the principle of defamilisation. Second, two different types of services were distinguished by the degree to which the ideological conflicts over defamilisation and state involvement were salient during the formative years of the Golden Age of welfare state expansion: these two types are health care versus social care services. Defamilisation and ideological conflicts over this dimension as well as over de-genderisation are argued to be of special importance for care services.

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 as-

[7] Social services were defined here as social protection expenditures in all fields in kind, in contrast to cash transfers.

sumptions 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 Bouckhaert 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 1.3):

Scheme 1.3 The analytical frame of care policies

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

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CHAPTER 2

Care policies and governance in Norway and the Czech Republic

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Introduction

This chapter 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 percent), most of whom grow up in two-parent households (52 percent in Norway, 38 percent in the Czech Republic in 2014), and the proportion of children with disabilities or other specific needs (under 10 percent of children living in at-risk-of-poverty households in Norway, and under 15 percent 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 percent of people are above 65 years in Norway and 17.4 percent 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 percent of the population is expected to be older than 65 in Norway and more than 27 percent in the Czech Republic in the year 2050) (Eurostat 2015).

The data above also show some demographic differences between the two countries. Especially, both the higher proportion of children living in two-parent households and increasing dynamics in demographic ageing (which is greater due to low fertility rate in the long-term) are apparent in the Czech Republic. The proportion of the population aged 65+ is therefore higher in the Czech Republic than in Norway; this means the care for the elderly is and will become more urgent in the Czech Republic alone.

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 European welfare systems

have grown into more diverse and mixed structures than the ones we find in Western Europe.

In the following text we first focus on childcare policy and subsequently on eldercare policy. The comparisons of both policies in Norway and the Czech Republic begin with a summary of crucial theoretical assumptions on welfare regimes as well as the current characteristics of care policies in both countries. Then we analyse key characteristics of the two policy systems in terms of policy design (benefits and services provided and conditions of its offer) and their governance (financing and regulation of policies, accessibility and quality of particular policy measures). To cover these areas of comparison – in which we explore similarities and differences of both systems – we use a wide range of quantitative and qualitative data obtained for the last decade: national and international statistics, legislation, research studies, professional literature, and newspaper articles.

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), Norway 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; Javornik 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**

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Norway	3.1	3.0	2.8	2.7	2.8	2.7	3.2	3.1	3.1	3.0
Czech Republic	1.4	1.5	1.3	1.3	1.6	1.4	1.4	1.3	1.2	1.1
EU (25 countries)	2.2	2.1	2.1	2.0	2.1	2.1	2.3	2.3	2.2	2.2

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 percent or 80 percent 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 ('chil-

dren'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). These monies cover very high quality services in both countries (public and private kindergartens in Norway and public kindergartens and other private facilities

listed in the register of the Ministry of Education, Youth, and Sports in the Czech Republic).

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

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
CZ	0.52	0.48	0.49	0.51	0.50	0.49	0.60	0.63	0.66	0.54
NOR	1.52	1.56	1.65	1.50	1.54	1.51	1.61	1.58	1.55	1.42
EU 28	0.48	0.48	0.47	0.50	0.51	0.52	0.56	0.56	0.57	- / a

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.

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 percent of the household's combined salary income before tax in Norway and between 3–5 percent of the average wage in the Czech Republic (Haug and Storø 2013; Horák et al. 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 percent of the average monthly wage compared to 44 percent for private kindergartens) (Horák et al. 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 (Paloncyová 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 percent 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 percent) attended some preschool facilities in Norway in 2013 compared to two out of ten children (5 percent) 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 three years was also higher in Norway than in the Czech Republic (96.5 percent versus 77 percent 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**

Age	0 year	1 year	2 years	3 years	4 years	5 years	6 years	Total 3–5
CZ	-	-	21,301	71,550	101,638	105,265	52,464	278,453
Total population	108,692	109,146	119,504	121,413	122,945	118,385	108,825	362,743
In percent	-	-	17.82	58.93	82.67	88.92	48.21	76.76
NOR	1,894	42,336	56,365	60,946	62,981	62,266*	386	186,193
Total population	60,530	61,429	63,427	64,443	63,386	61,799*	62,108	189,628
In percent	3.13	68.92	88.87	94.57	99.36	100	0.62	98.19

* 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.
Source: Statistic Norway (2015), CSO (2015)

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).

Both countries also differ in their strategies for dealing with children with special needs (particularly speech disorders, visual impairment, hearing impairment, and mental disability) or who are disadvantaged (especially the children of single mothers, unemployed parents, and immigrants in Norway, and Roma children in the Czech Republic). While in Norway the vast majority of special needs children attend preschool facilities alongside healthy children (except those with visual impairments), in the Czech Republic, these children are sent to special facilities. Norwegian kindergartens are a success story and, for the majority of children, kindergarten is a good place to be.

A closer look at the working conditions and the qualifications of staff in public childcare facilities – who represent the general framework for ensuring the quality of services – shows that the quality is good in both countries, although the number of pupils per teacher is higher in the Czech Republic (12.9) than in Norway (3.7) (data for the 2013/2014 school year) (Eurostat 2015; MEYS 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 percent 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 eldercare sector. However, 90 percent of non-family care is still provided by government-owned and run services and most of the 10 percent 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. This, together with a range of reforms affecting the disabled and other groups, means that services formerly thought of as targeting the elderly are increasingly being used by younger people (Gautun et al.2014; Helse-og omsorgsdepartementet 2013). 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 prefer-

ence 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 percent of care allowance recipients were family members and only 25 percent 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 percent 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 conditions, effectively attract the attention of older people in need of regular care as well as that of their families.

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).

Regulation and financing of eldercare

The responsibility for health and social care provision in Norway is shared between the central government, the counties and the municipalities. At the central level, the government retains overall responsibility for health

care, including regulation, monitoring and providing substantial block grant funding to the local governments (municipalities). In the area of health policy, the Norwegian Directorate of Health, a subordinate agency of the Norwegian Ministry of Health and Care Services, is the regulatory and implementing authority responsible for improving the health of the entire nation through integrated and targeted activities across services, sectors and administrative levels.

At the county level, the overall responsibility for supervision and monitoring of health services is the Norwegian Board of Health (NBH) together with 19 County Medical Officers (CMOs). All public care services are also regulated by quality regulation ('*Kvalitetsforskriften*'), which lays out some general descriptions of quality aspects of clients and which obliges municipalities to have plans and written procedures detailing how they intend to implement them. All long-term care providers must also implement internal controls; this means that the way in which most procedures should be performed by nursing home staff is specifically defined.

At the local level, care service provision is controlled by the Norwegian central government through legislation, regulations, judicial decisions, monitoring and substantial block grant funding. The most important laws include The Municipal Health Service Act (1982) and The Social Service Act (1991) that require municipalities to provide 'essential medical services' to all inhabitants in the first case and 'essential practical help' for inhabitants who are not able to care for themselves in the second case.

In the Czech Republic, two key laws regulate the Czech social care system: the Act on Social Services that, since 2006, has defined both the kinds of social services and the basic principles of service provision, and the Decree of the Ministry of Labour and Social Affairs that implemented some provisions of the Social Services Act in the same year. There are several types of actors in the domain of Social and care services: the Ministry of Labour and Social Affairs (MLSA), regions and municipalities, non-profit organizations, advocate groups of users (f.e. Czech National Disability Council) and volunteers.

The MLSA is responsible especially for setting long-term social policy priorities, preparing long-term systematic measures, legal regulation and quality enhancement of all social service provision. Municipalities and regions formulate two or three-year plans for the development of social services that are in accordance with national social policy priorities. They

assess people's real needs, secure the resources necessary to satisfy these needs and provide social services. At the same time, regional authorities distribute public resources from the state budget and take part in controlling quality standards. Non-profit organisations provide a wide array of services while playing the role of innovators, associations or pressure groups.

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 percent to 0.54 percent 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).

Table 2.4 Expenditures on long-term health care as percentage of GDP

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
CZ	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	1.0 (b)	1.0
NOR	2.2	2.1	2.1	2.2	2.6	2.5	2.5	2.5	2.6	2.6 (p)

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 Norway, municipal long-term care operating costs increased in the years 1998–2011 and totalled nearly 9.5 billion euros in 2011, while two out of three NOK were spent on services to the elderly (Statistics Norway 2013). These expenses were about 3 percent of GDP and the largest single municipal cost (over 25 percent of all municipal expenses). The largest share of the increase, 41 percent, consists of care services to people under the age of 67 while those over 67 saw an increase of 16 percent in the same period. At the same time, the trend to spend more money on home-based services has been visible since 2013 (48.6 percent compared to 46 percent) (Ramm 2013).

In-kind services are very much dominant in Norway, while cash for care plays a marginal role in eldercare. 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 percent) and fewer people received services in an institution (about 16 percent) at the end of 2011 (Statistics Norway 2014). In this context, the current government is in favour of strengthening the quality and accessibility of care services in contradiction to the goal of the Social Democratic party, which lost the 2013 elections and which set the goal of full nursing home coverage (defined in 2002 as a capacity of 250 beds per 1000 persons over the age of 80 years). Whereas some municipalities have chosen to focus on nursing homes and institutional operations, other municipalities emphasise home care services, daytime activity programmes and residential care homes (Statistics Norway 2014).

Table 2.5 Nursing and care services in Norway – key figures

	2013	2012–2013	2009–2013
	Users of care services	Percentage change	
Total	271,406	0.0	1.9
Users of home help only	40,991	-2.7	-9.5
Users of home nursing only	75,011	2.3	12.8
Users of both home help and home nursing	63,856	1.0	1.9
Residents in institutions, short term stay	9,082	-8.3	-5.4
Residents in institutions, long term stay	33,968	-0.1	-2.4
Other home-based services	48,498	-0.8	2.0

Source: 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 percent 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. Moroever, a decline in home care services is apparent, while nearly 3 percent of elderly people receive institutional care and more than 6 percent of the elderly receive domiciliary care (MLSA 2010, 2011, 2012, 2013, 2014b).

Table 2.6 **Social care services for the older people in numbers in the Czech Republic**

Type of social service		Year					
		2008	2009	2010	2011	2012	2013
Domiciliary care service	Number of clients	115,000	114,364	113,307	113,490	112,805	108,493
Home for the elderly	Number of facilities	461	453	466	471	480	491
	Number of clients	35,945	35,640	36,183	37,616	36,197	36,598
Special regime home	Number of facilities	148	165	176	189	210	228
	Number of clients	7,016	7,908	8,526	9,727	10,296	11,560

Sources: MLSA (2009, 2010, 2011, 2012, 2013, 2014b)

Moreover, there is the tendency for accumulation of social services in larger municipalities to the detriment of suburban and rural areas which is apparent in the accessibility of certain types of services (especially field-based services, non-residential services and emergency call service that are practically inaccessible in any larger municipality with the exception of the capital city of Prague) (Havlíková and Kubalčíková 2014; Bareš 2010). Another problem is a low awareness of the social care services system (arrangement, providing, financing) and low availability (insufficient information) of care in their residential area (Matoušek 2007; Jeřábek 2013).

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). Connected with this, the Norwegian State Housing Bank supports scheme that stipulates the idea that all nursing homes and residential care homes must be built as small, adapted units, whether they are organised as small wards or as shared flats with several residents. This is in reaction to actual data which shows that 80 percent of nursing home patients today suffer from dementia (Skirbekk et al. 2016).

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 and 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 in which the model of valence rather than position politics prevails. The result is no deep division between political parties or population categories when it comes to ends. Values and principles of gender equality, labour market participation of both genders, and the need for a comprehensive care system are widely shared. Although the general compliance with the need to support families is their key function, some differences across the right-left political spectrum in Norway is evident. Recently, for example, at least two measures raised public and political debate about the direction of Norwegian childcare policy: the non-transferable father's quota in parental leave and cash-for-care benefits. This has been articulated as a debate about principles of active fatherhood, real gender equality and free choice (Rostgaard 2014). While the parties on the left political axis favour gender equality and service provision, parties on the centre-right often support more traditional family forms and are thus more in favour of the cash transfers and the promotion of parental choice (Leira 2006; Rostgaard 2014; Skevik and Hatland 2008). Norwegian political party programmes are more consistent in the question of family support and the impact of politics on the design, and implementation of childcare policy in Norway is in fact much stronger than in the Czech Republic. As some analyses have shown, in the Czech Republic, a left-right division in relation to institutional care persists (even at the beginning of the 1990s, the family policy of the leftist parties was more conservative than that of the right wing) (Plasová 2011; Válková et al. 2015).

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 rapid development of childcare services in the 2000s (the so

called 'toddler invasion', Ellingsæter 2012), accompanied by the strong emphasis on their increasing quality, is a good example of such policy reactivity. Although enrolment rates of children below 3 years in nursery schools and kindergartens were relatively similar (similarly low) in both countries, only in Norway has it started to grow very rapidly towards a universal arrangement. This is now reflected both in day care that is institutionalised as a social right for children 1–5 years and that the great majority of children in this age group (90 percent) are enrolled in childcare services (Ellingsæter 2012).

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. This is particularly evident in the lack of childcare facilities (Hašková 2007; Hašková and Saxonberg 2014) as well as in the weak pluralisation of service provision in eldercare (Österle 2011). Although the effort to bring the system of social care closer to that of western countries[1], in the Czech Republic (like in other Central and South European countries) in the past few years, 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

[1] In some respects, the current Czech government may be presented as more attentive to the needs of users and more flexible in terms of financing schemes. It brings, for example, new themes to the discussion about flexible and parent-friendly childcare policy, some of which are now in the process of approval and enactment (introduction of fathers' postnatal childcare, more flexible parental leave with the possibility of using childcare facilities (without restriction for parents of children under 2 years) or leave for family caregivers for three to six months).

of care. Despite the significant rise in the proportion of elderly people in the population, the largest growth has occurred in services provided to people under 67 years old. 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.

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CHAPTER 3

Providing care services: strategies of key actors in childcare and eldercare in the Czech Republic

Jana Válková and Kateřina Kubalčíková

Introduction

In this chapter, we summarise the findings regarding objectives, needs and existing solutions in child- and eldercare in views of care funders, regulators, formal care providers and other national level stakeholders. We are interested in various aspects of governance in care services and the analysis is conducted along the lines of perceived challenges in regulation, service delivery and financing (Sirovátka and Greve 2014). Given the multilevel character of care services governance, the chapter aims to explore the compatibility of various actors' views and their capacity to act and cooperate within the existing policy context.

From the perspective of discursive institutionalism (Bachii 2000, 2004; Pierson 2000, 2001), the discourse of policy makers, regulators, funders and care service providers not only shapes the policies but also the needs, related norms and strategies of families with care responsibilities. At the same time, contesting theoretical accounts related to cultural norms regarding care provision and gender arrangements (Pfau-Effinger 2005; Pfau-Effinger and Rostgaard 2011) are seen to influence the perspective of the key policy actors (for further information see Chapter 1). Since care provision is strongly gendered in the Czech Republic, we will pay attention to the extent to which the gender aspects of care provision and the related social norms are recognised in the discourses of the key actors.

Further, several changes were introduced in both of these policy fields (see Chapter 2). The different views of actors across the governance levels may help shed light on the substance of these policy changes and developments, in particular to help distinguish between the path-dependency and policy feedback approaches. Whereas the former explains policy developments as both long-term self-sustaining and self-undermining processes, the latter argues that the changes are resultants of both exogenous and endogenous forces (Jakobs and Weaver 2015).

Method and data

This chapter is based solely on interviews with policy makers (regulators), funders and providers in the childcare and eldercare services fields.

In the Czech context, the main actors in childcare policy governance are found at the national level (government) and at the local level. Regional level actors serve as funders and regulators, whereas the burden of childcare provision lies on municipalities (children aged 3 to 6) and on a variety of actors (children aged 0 to 3) who establish child groups.

Despite the fact that the two-tier model was formally abandoned, the governance unfortunately still follows this split. Therefore, the stakeholders selected for interviews included regulators, funders and providers from the care field for children aged 0 to 3 and 3 to 6. Altogether, 15 stakeholders were interviewed, of which 3 act solely as regulators, 3 represented regulatory and, to some extent, funding authorities, and 3 represented funders from regional and local levels. The remaining 6 respondents were care providers – 3 for younger children (0 to 3), of which there was 1 private provider, and 3 for older children (3 to 6), of which there was also 1 private provider. Data collection was conducted from October to December 2015 in Prague (national level stakeholders) and Brno (regional and local level stakeholders).

The selection of a research sample of communication partners in the area of eldercare was motivated by the fact that the role of Regional Authorities has been considerably strengthened in the current system of social services. Regional Authorities guarantee the basic network of social services in their administrative districts, including funding (see Chapter 2). Considering the assumed scale of the survey, it was desirable that the sample should be consistent in terms of regional policy in particular. The region selected for the survey belongs among the largest regions in the Czech Republic, with a high population density, a greater proportion of ageing population and a relatively proportionate representation of urban and rural populations. Regulators are represented by employees of the Ministry of Labour and Social Affairs (MLSA) in charge of the social services agenda and social work development. Representatives of the Regional Authority and municipalities also find themselves in the position of regulators (as co-funding authorities they participate in the decision making about the shape of the basic network of services) – both these

authorities also have the role of founders, as both the Regional Authority and municipalities directly found social services, particularly residential facilities. The sample included 9 providers of whom 3 can also partly be regarded as regulators – these providers are active in the Association of Social Services Providers, which represents the interests of services providers e.g. in negotiations with the MLSA. Another criterion applied in sampling was spatial distribution; providers from across the territory of the selected region were included in the sample. Yet another aspect considered was the legal form of the provider, i.e. both services run by NGOs and publicly run services are represented in the sample. An important viewpoint was also the form of service provision; the sample covers both residential and field-based services.

Objectives, target populations and perceptions of care needs

Childcare

The objectives of childcare policy differ in the views of interviewed stakeholders according to the age of the child (younger than 3, older than 3). For children aged 3+, the main objectives of the policy are education, up-bringing and their preparation for school attendance, and the reconciliation between work and family is perceived only as a secondary objective. The needs of parents to combine their work and family lives is seen by some public kindergartens as a complicating factor, e.g. in relation to the need to place the child in kindergarten at the earliest possible age or in relation to the facility's opening hours. Kindergartens operate within the legislative and methodical framework set up at the national level but the conceptual, methodical and controlling functions, as well as the capacity of these institutions, are implemented at the local level of cities and/or city districts.

As regards the younger age group of children (below 3), most of the actors connected the objectives to work-care reconciliation or equal opportunities for women and men, although they still principally referred to mothers as caregivers. The educational and developmental objectives seem compatible with and equally important to the objectives of facilitating work-life balance. The employers who run child groups especially

underscore the function of these facilities with regard to earlier return of parents, mostly mothers, to work.

The perception of who the target population is differs according to the role of the interviewed actors in the system. National and regional level stakeholders (regulators) see the entire family, its wellbeing and good functioning, as the target. The target population shrinks in the view of the care providers, especially when these are employers who offer childcare uniquely for the children of their employees.

As already mentioned, the fragmentation of childcare leads to the perception of two target groups of children – younger and older preschool children – but the bordering age of 3 seems to be slowly shifting to 2. There are several reasons for this: (1) demand for childcare of children aged 2+ in relation to the duration of parental leave (which is flexible and the shortest alternative is up to the child's 2nd year); (2) demographic changes associated with the end of the baby-boom caused an increase in childcare capacities which may now be available even to younger children; and (3) a change in political priorities due to the change of government.[1]

Many actors are however restrained regarding greater kindergarten attendance by two-year-old children. Childcare providers are afraid that conditions for service provision in kindergartens would need to change significantly to allow more two-year-olds to attend. The problematic aspects are perceived in lowering the number of children per class; this seems unrealistic due to the still insufficient capacity mainly in large cities, and abandoning of age-mixed classes, as needs of children aged 2 and 7 substantially differ. As a legacy, there is still a very strong perception that children under 3 should be cared for by nurses whereas older children should be in the hands of teachers. Despite the formal access to kindergartens, the 2-year-olds will most likely only supplement the primary target population. This might be currently caused by the shortage of capacities in these institutions as well as by the mental barriers of the actors involved, including both providers and regulators.

Caring needs are perceived differently and also align with the age of the child. Whereas the public kindergartens refer to the needs of children

[1] After the right-wing government in the years 2006 to 2009 and 2010 to 2013 (each of these followed by interim expert governments in 2009–2010 and 2013), the coalition of Social democrats, Christian democrats and the centrist party ANO was established in 2014. The MLSA is led by Social democrats.

and their development, private providers and actors in care services for children aged below 3 also reflect the needs of parents to combine their work and family life. There are also parents who would like to place their child in kindergarten while on parental leave with another child in order to relieve them from the caring burden. This is often perceived as an illegitimate requirement, and these needs are often not satisfied. Public kindergartens recognise the needs of parents that relate to the child and his/her wellbeing in the facility. The most important needs identified were in the areas of participation and trust.

Parents generally need to place children below 3 in childcare facilities in order to maintain professional contact. However, they face barriers in the form of insufficient capacity in childcare facilities and strong cultural norms. The MLSA has implemented a micro-nursery project to partially help abolish these norms:

> *"We also need to set up the norm. Because if you look at the media reaction to micro-nurseries, mothers with high education and demanding professions… Simply, it is terribly normative. And we, by saying that putting children into a nursery from 6 months of age is all right, may cause the shift."*
>
> (Funder and regulator, national level)

Financial accessibility of childcare services also plays a role for parents, especially for the more costly child groups and private nurseries and kindergartens. Workplace care providers also indicate the parental need for physical proximity with their child and time saved on commuting.

Eldercare

The main target group, as viewed by all the respondents, are older adults in higher-age cohorts who face increasing dependency on help from others with increasing age (which is often perceived as being the same as health problems). The respondents date the onset of problems and of the need for social care to the age of 70–75 years. The core part of the at-risk population, as seen by the respondents, are older adults at the age of 75+, and the target group are older adults at the age of 75+ with advanced health problems. A specific category of care recipients are also

older adults suffering from dementia. On the other hand, it must be noted that most respondents do not primarily associate the definition of the target group with age, but rather with the nature of difficulties faced by the applicants for the service. The providers very often derive the extent of need from the level of the care allowance (see Chapter 2) granted to individual clients.

As regards the perception of the target group's needs, these can be divided into three categories: managing routine tasks, health and social needs. Managing routine tasks is associated particularly with provision of field-based or non-residential services, and typically includes assistance with hygiene, cleaning, meal preparation and shopping. This is common to all the providers. Meeting the health needs is largely understood at the level of essential nursing care, however that is not a regular part of social services (it is guaranteed by the Ministry of Health as part of medical care). The view was voiced that the demands placed on nursing services would grow in connection with increasing incidence of diseases of civilisation, such as stroke, Parkinson's disease or multiple sclerosis, which now also affect younger age cohorts. As regards social needs, maintaining contact with the family and neighbourhood comes first in non-residential care, especially in smaller municipalities. Residential care is associated with meeting the needs of those older adults whose situation requires complex care (with very low levels of self-sufficiency). Nevertheless, the providers of field-based and non-residential services are also the subject of increased pressure to secure complex care. This pressure comes from older adults themselves, or rather from their families, and causes the nature of the services to change from simple tasks (shopping, cleaning) to more complex client care. It is also the lack of capacity of specialised residential facilities for older adults with dementia, as well as a growing interest in staying in one's own home environment, that increase the clients' (or their families') specific demand for field-based and non-residential support.

> *"The clients of field-based services are usually between 65 and 85 years old, but 30 percent of these clients and most residential clients are over 85 years old."*
>
> (Provider, municipal elderly house)

"The goal of our service is to provide services to all needy persons, often to older adults with mental or psychiatric problems. However, there has been a clear trend recently from simple services towards a growing number of clients in need of permanent care."

(Provider, NGO field-based service)

The respondents from both the Regional Authority and municipalities, whose jobs also involve developing strategic documents, also draw attention to a growing target group of older adults who become clients of emergency homeless shelters as a result of their low incomes; this is usually associated with loss of housing. In the case of reduced or lost self-sufficiency, these older adults cannot access current social services, particularly residential services, for financial reasons.

Policy arguments and priorities

Childcare

Policy priorities for the years 2014 to 2020 are framed at the national level by the governmental strategy towards the equality of women and men in the Czech Republic. This strategy is pushed forward and gets implemented through Gender Focal Points at all Ministries and it is intended to promote gender equality values in specific sectoral agendas through established working groups. The Ministry of Labour and Social Affairs, due to its agenda focussed on employment and family policy, is perceived as the most important actor. Their strongest formulated priorities relate to access of young children to childcare facilities outside of the family. This access should be available in relation to 3 recognised trends: (1) the ageing of the population and low fertility rates in the Czech Republic, (2) investment in the human capital of women (women compose 60 percent of university graduates), which the country cannot afford to lose due to long career breaks, and (3) investments in the human capital of children. However, the MLSA also recognises the deeply embedded social norms about the appropriate age to attend childcare facilities and finds these norms very hard to dispel. Such strong cultural framing is seen as a barrier to stronger pressure from parents on policy/decision-makers

and blocks any bottom-up initiatives. The MLSA also sees the flexibility of childcare arrangements as an important aspect to abolish the typical model of full-time employment combined with full-time care outside of the family.

Challenges are also identified in the area of quality, mainly in connection to the marketization of care, child-to-staff ratio and general hygienic rules ensuring quality of care. Policy makers at the MLSA find an additional challenge in the fact that childcare can be provided as unqualified trade.[2] In their views, decision-makers, unlike the MLSA, put the value of the free market above the regulation of quality standards. Quality of care is regulated from the national level by norms regarding hygienic standards, standards on educational and professional achievements of staff, requirements to submit developmental and education plans, etc. The standards compliance process is similar for public kindergartens, child groups, and private for-profit and non-profit institutions. The institutions with a long tradition, such as public kindergartens, apply the norms without any problems, and the newer type of care in private facilities requires more support. Therefore the role of the regulator has also grown from being strictly regulatory to also providing support.

The demographic developments of the last decade have placed extreme pressure on childcare facility capacities. According to one interviewed quality regulator, the representatives of local authorities lobbied at the national level for exceptions from hygienic rules in terms of number of children per staff member[3] and the number of square meters per child in order to place as many children as possible into the existing facilities during the baby boom. Such a solution meant that kindergartens were, especially in large cities, overcrowded and the municipalities were not obliged to open new facilities. This softening of the rules is perceived negatively by the quality and hygiene regulators and the directors of public kindergartens, and they have slowly begun to revert to the previous standards.

[2] 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.

[3] The initial limit for one class in kindergarten was 24 children but many facilities obtained exceptional right to enrol 28 children in class with no further requirements on raising the number of employees or enlarging the premises.

Raising the capacities of childcare facilities (especially for the younger group) is a priority of the MLSA. It has started a grant scheme from ESF to support the creation of child groups and micro-nurseries. The aim is to provide more options for parents with the youngest children. Micro-nurseries are being tested in a pilot project in the largest cities, which can then be more widely introduced. At least until the end of the programming period, in the views of the national level actors, the financial resources are allocated and should be immune to political changes and shifts in priorities. The constant criticism of very long parental leave and the enduring pressure to raise capacities in childcare facilities from the European Commission are now finally being relieved due to changes in political priorities within the existing government, which focuses also on collective care. Growing interest in care provision for children is recognised also by the Ministry of Education, Youth and Sports (MEYS) which amended the School Code in 2016. Obligatory preschool attendance is being introduced for children aged 5 and older beginning in September 2017. Children aged 4, 3 and 2 are granted priority access to kindergartens from September 2017, 2018 and 2020 respectively. The MEYS also indicates more emphasis on preschool education in line with European trends and making European Funds available to kindergartens. The topic of an obligatory last year in the kindergarten, despite being recognised as disputable, is also a sign of more emphasis on early education. The willingness to support the creation of childcare facilities can be detected also at regional and local levels[4] through funding schemes and other necessary provisions (renting premises, etc.).

Across all policy-making levels, the role of politicians is recognised as crucial not only for the power to formulate priorities and introduce positive changes but also for the strength of political discourse and impact on the general public. Various interviewed actors share the view that political discourse and priorities regarding childcare are changing over time, with more support for care outside of the family for the youngest and towards gender equality.

[4] The region involved in this research has made funding available through financial schemes for child groups and other non-registered childcare services, such as forest kindergartens. This grant scheme for child groups was open even earlier than the funding scheme at the national level.

Eldercare

From the viewpoint of the representatives of the MLSA, the policy of social services for older adults represents an important segment. The representatives of the ministry affirm support to field-based services in the Czech Republic and enabling the clients to stay in their home environment to be key priorities.

The representatives of the Region have recent experience with developing the minimum regional network of social services, and the municipal representatives are involved in the planning of social services at the local level as part of their job. These actors are better suited to assess the objectives and priorities formulated at the national level in the area of eldercare, and they also state that some of these priorities have been met in practice. As an example, extension of non-residential services to a 24-hour service can be mentioned, as well as the foundation of a municipally supported living environment with in-house domiciliary care service. On the other hand, they have also experienced barriers which hinder the practical implementation of these priorities and measures. For the most part, these are political decisions that are often guided by different goals than those set in the strategic documents. In addition, there is also a lack of adequate tools to translate general objectives into the reality of provided care. The representative from the Regional Authority also mentioned the systematic evaluation of the quality of social services among the priorities, and pointed out that the current model is insufficient and inadequate and collides with the legal obligation of the Region to condition the granting/suspending of registration on the quality of the given service.

As regards the providers, two groups of respondents can be distinguished. The first group consists of those respondents who view the policy priorities in social services from the perspective of their immediate impact on the practice of assistance provision, since it is their role as heads of these services to guarantee the service. They regard the formulated policy priorities and related measures as decisions that have either a favourable or unfavourable impact on the practice. These are usually the heads of services with more limited professional experience, or heads of those services that are part of a broader organisational unit, where the upper management take care of negotiating the terms of service provi-

sion and funding. These head of services themselves consider the existing model of social services financing and governance to be very complicated and prefer to be concerned with care provision and contact with the users.

> *"I'm not so familiar with funding, we have someone who takes care of this … she did tell me what the formula was."*
>
> (Provider, municipal field-based service)

The second group consists of respondents who have been working in social services for a long time, or who are actively involved in strategic planning as members of various advisory panels (the MLSA, Czech Alzheimer Society, and the Association of Social Services Providers). These respondents are able to reflect a broader context of practical work, as well as to evaluate the success/failure of implementation and the effectiveness of the implemented tools of care policy formulated at the national level into the practice. In discussing the definition of the priorities of eldercare services policy, this group of respondents primarily articulated the following topics: 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; b) discrepancies between the priorities in the area of quality improvement and fulfilling the standards of quality on the one hand, and, on the other hand, continued under-funding of social services that makes it impossible to adequately remunerate the workers and which hinders personnel development both in terms of quantity and quality; c) non-existent or unclear vision for the integration of health care with social care – both in field-based services, and in residential services – with marked consequences for financial sustainability of social services, as well as for advancing the quality of provided care; d) non-existent or unclear conception in the area of care for older adults suffering from dementia, particularly in terms of preventive measures, such as, for example, systematic public information campaigns which also target the family carers. All of this increases the pressure on residential facilities, which continue to be perceived by the public as the only possible source of help for people suffering from dementia.

"There's no prevention, no information campaigns … I think that a great many people with health impairments can really be able to make it at home in their old age, with the help of the home care service. A great many older people whom the family puts away simply because they do not know what the person needs. Let someone take care of him. But it would only take better organisation. The mother needs medication, needs this and needs to take a bath once a week. This can be managed with support of the field-based service. But even this, this problem is resolved by many by placing the person in some home."

(Provider/regulator, private elderly house)

Capacity and resources

Childcare

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.[5] Child groups run by employers are more financially accessible due to company contributions or grants. The quality requirements affect the price. As one child group care provider states, registering a service as a child group makes it financially unsustainable without public funding:

"In the non-profit sector, the capacity is quite large, but at the moment you start to run it officially [as a registered child group]*, you hit the limits… For example, the child group can ideally function only with payments from parents in case you are self-employed and you run it in the premises where you live, which you have at your disposal and you don't have to pay for it. As soon as you have employees, you pay social*

[5] A private non-profit provider estimated the monthly operational costs for care at 9,500 CZK (i.e. 352 EUR) per child at the lowest (without investment or overhead costs) which makes the services without any subsidies (national grants, regional level grants, employer contributions) very costly for parents. The median income in the 3rd quarter of 2015 reached 22,531 CZK according to the Czech Statistical Office; the cited costs therefore represent 42 percent of the median income. Monthly payments for childcare in municipal child groups in Brno is income-tested and the maximum payment is 6,000 CZK (i.e. 222 EUR).

and health insurance, you need to pay rent, the bills, you have an organisation that has overhead costs… suddenly it doesn't make ends meet. Suddenly, it doesn't work without subsidies."

(Representative of a child group in an NGO)

Whereas stable yearly subsidies are not available for the registered child groups, kindergartens are subsidised if they are registered at MEYS. The MLSA tries to compensate for the lack of regular state subsidies to child groups through the ESF scheme. Within the framework of a systemic project at the national level, the grant scheme has a total allocation of 8 billion CZK (i.e. 296 million EUR) until 2020, with the current call making 1 billion CZK available. Representatives of the MLSA are aware that the conditions for the use of funding should not be as complicated and bureaucratic as they have been in the past. However, one rule is set in the call – the providers can receive up to 100 percent of the operational costs if the attendance of the facility is 75 percent. The representative from the MLSA admits that this is problematic and suggests covering the differences with payments from parents. Bureaucratic barriers were also identified by the providers, and strong criticism was mainly related to strict rules for application and management of ESF funded projects, strict evaluation of proposal budgets and the unpredictability of the timing of the calls for proposals, which are usually delayed in the Czech Republic. This context makes the situation for care providers very unstable.

Funding from grant schemes does not guarantee sustainability of services, and this is also seen as very problematic by service providers and local level actors. Discontinued support due to the unclear schedule of calls also means the child groups will operate in a very precarious environment, with constant insecurity about funding for the upcoming year. Grant funding also creates a burden on the organisations in administrative and operational terms:

"The grant system such as it is set up here forces the organisations to constantly create new services in order to get further funding. This is the biggest weakness of the grant system. Organisations never know in advance if the services might be long-term. The opinion changes, the new call opens and they [the organisation] *are still preparing new applications which uselessly fragmentise the activities of the organisation and some-*

times the organisations perform activities which are not so necessary at the expense of those which would be more important in their view."

(Funder, local level)

Some actors suggest introducing the same system of financing child groups as is in place for kindergartens, if childcare for youngest children is seen as a priority. The representative from the MLSA sees a potential for the top-down policy solution to consequently generate a critical mass of demand: *'And mainly, the rule of demand and supply works there. If you are offering something in a big quantity, people will get used to it and then it is difficult to take it back.'* This can lead to more systematic support achieved though pressures from parents once the capacities in child groups are created but jeopardised by financial instability.

Public and private kindergartens that are registered in the school register and are supported through state subsidies[6] have quite stable financing (per child). National funding is regulated at the regional level, where the money is redistributed to the facilities based on more criteria than the number of children and this is perceived negatively.

Private providers suffer from financial instability every September when enrolled children get places in public facilities and their capacity is not fully used. They consider it to be a great success when parents decide to keep their child in private kindergarten, as the difference in payments is so high.

The capacity of remaining services is insufficient for both the younger and the older group of children. The places in child groups are very scarce, which is a problem recognised across levels and actors. 300 child groups with 3,913 available places were registered as of April 2017 (MLSA 2017a) and the capacities should still increase with the use of ESF grants.[7]

The situation might be different among the private childcare providers that are not registered as child groups. The actor from a private nursery in-

[6] The kindergartens can also apply for funding for renewal of the premises, which they often do. Newly, the applications for innovation in methods of work may be prepared for Operational Programme Research, Development and Education.

[7] The MLSA received an unexpectedly high number of applications in an open call to support the creation and operation of child groups. Within 2 days, a total of 300 applications were submitted for a total amount of 900 million CZK, which is triple the amount of the call allocation (MLSA 2017b).

dicates sufficient capacities are available at facilities run as businesses with no quality regulation. Representatives from the MLSA consider mapping these non-registered services in the private sector to be a challenge.

Some actors indicate the sufficient capacity in kindergartens, except for in areas with new housing developments where sufficient social infrastructure is missing. As an actor from the national level says, the capacity is satisfactory for the number of children at the county level but disproportions may occur at the municipal level – small towns meet the needs better than large cities. The statistics about refused applications to kindergartens however does not provide reliable and concise information due to multiple applications for one child. Some actors think the capacities will be sufficient in the future due to the weakening baby-boom, but during its peak they were scarce.[8] Public policy makers at the local level respond slowly and weakly to the local needs for childcare despite knowing the demographic developments. Limited capacities in kindergartens lead to priority selection of older children, leaving the families with the smallest children in an irresolvable situation.

Eldercare

One of the focal themes of the current policy debate in social services for older adults is both the real and the seemingly insufficient capacity of residential facilities. The viewpoint of the MLSA experts is that the number of residential facilities is sufficient at present. What they rather see as an obstacle is an uneven distribution of the facilities – while in some regions, it is not possible to make a full use of the available capacities, others regions face excess demand for residential services. As the MLSA representative highlighted, the statistics are often inaccurate. There are more submitted applications than there are potential clients – the applicants often submit multiple applications to several different facilities and there is no central register of these applications. Some applicants also submit their application a long time in advance and when they are offered a place they refuse. However, their application remains in the register.

[8] In Brno, the capacities have been very short in recent years which caused pressure from parents, therefore a new and transparent electronic kindergarten application system was introduced.

"If we have a look at the figures, statistical yearbooks, we'll see some insane figure, thousands applicants for a residential home. But we have to remember that this figure is biased, as the applicants apply to five facilities at the same time."

(Regulator, national level)

The MLSA officials referred to a representative survey in the interviews which showed that half the respondents would care for an older family member in the home environment. The other half of the respondents stated insufficient income compensation for the carer as the main reason behind their reluctance to care for a family member; they would prefer to use the help of non-residential and field-based services at the same time. Only a third of the respondents explicitly stated that their priority was placement of the older family member in a residential care home. In this respect, the MLSA official notes that home care for older adults with fourth-degree disability is more expensive than residential services because this care regime requires a 24-hour availability of the carer. The regional representative shares the same viewpoint on the definition of key priorities, favouring support for field-based services.

"The Region indeed sees support for field-based social services for older people as its priority; so that older people could stay in their home environment for as long as possible. Only where the family has used all care possibilities and is no longer able to manage care despite field-based service support, so only then comes the time for the residential social service."

(Regulator/funder, regional level)

As regards the availability of resources and current capacities, the regional experts mention: limited and insecure funding of the whole system of social services in the Czech Republic; the quality of services reflecting the limited number of staff (predominantly women in their higher age), and the difficulties in attracting high-quality personnel willing to perform a physically and mentally demanding job with a 'desperately low wage' at the level of two thirds of the average wage in the economy. Material and technological resources are perceived as limited, e.g. a low number of cars (for delivery services in rural areas) and adjustable beds available

for home loan. Basically, all the interviewed providers of social services confirm the uneven coverage of the Region with social services. The unavailability of residential services also often results from the unavailability of field-based services in rural areas. The heads of the field-based service mention that care is typically provided to the older people in villages within 10–15km from the city where the service is located. Villages that are more remote (some up to 30 km away) are not covered by the service at all. The workers providing care in rural areas use the train as the means of transport, which makes service provision very demanding in terms of organisation and time. One of the key reasons why field-based services are not available in rural areas is also the method of payment for travel costs incurred by the carer. The clients cannot be charged the full cost. On the other hand, though, the providers were not given a guarantee that they would be reimbursed for these costs in the form of public subsidies.

As regards residential services, all the providers – regardless of their legal form (e.g. private, NGO, municipal) – thematise the problem of funding health care in social services. 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 health insurance company regulates the reimbursement levels. In addition, the insurance company puts pressure on physicians for them not to prescribe medication under the public insurance and reimbursement scheme. And the MLSA's standpoint is that this must be done solely by a trained healthcare professional."*
>
> (Provider/regulator, NGO elderly house)

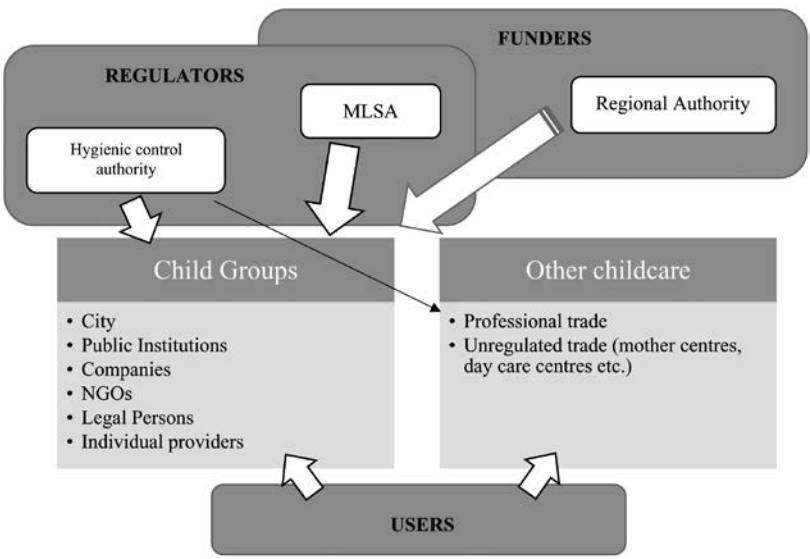
> *"The combination of social and health care in residential services, there definitely is a problem with reimbursing care and, really, the health care … This means that the client… cannot stay when the health condition worsens and is transferred to a long-term care facility, to a hospital… even though health care could have been delivered directly in the residential home."*
>
> (Regulator/funder, municipality)

Organization and responsibility, cooperation and compatibility of strategies

Childcare

Day care for children between the ages of 0 to 3 can be provided in child groups, micro-nurseries, kindergartens, private facilities provided as professional trade and private facilities provided as unregulated trade (see Scheme 3.1).

Scheme 3.1 Actors in childcare for younger children (0 to 3)



Source: authors

The cooperation of actors is not strongly inter-connected. In the case of public actors, this is also due to a sensitivity to the priorities of the current political representation. This can be documented in the field of financing – both the MLSA and the regional authority provide funding for child groups, yet both from different budgetary sources (MLSA from ESF, the region from its own budget), but also under different

conditions and in differing schedules. The priorities of actors differ. Whereas the MLSA has only recently, with political change, become pro-active in resolving the problem of childcare for the youngest, the selected Regional Authority pays great attention to childcare on a long-term basis. The local authority remains disconnected from regional priorities, although it should be one of the most important actors in care service provision.

The MLSA closely cooperated with the Hygienic authority when preparing the new regulation on child groups. The communication was found to be quite lengthy, especially regarding the conditions for providers. As for the creation of the child groups, the MLSA counts on the willingness and motivation of a wide range of actors to establish new groups. Evidence at the company level indicates lengthy procedures, from the decision to establish the group to the actual launch of the service. They also report information gaps or discrepancies between instructions received from various actors. The representative of a private nursery also misses more assistance and help from the public administration.

Another challenging issue occurs with the private providers who function as unregulated trades or sometimes in the grey economy (typically baby-sitters). They are neither obliged nor motivated to communicate and cooperate with the municipality, hygienic station or other actors. This segment of care provision is not only unregulated but also unmapped in terms of capacities, prices, age of children, provided quality etc.

In preschool education, the municipalities are the most important actors. This is recognised also by the MEYS who identifies the role of municipalities in terms of predicting the demand for childcare and creating the necessary capacities *('where there is an interest, the systems function well')* However, local level actors are responsible for care provision but are not expected to intervene in setting the conditions; this, together with financing, is the role of MEYS. Regarding the capacities, the key decision lies with the city districts who are the founders of kindergartens. At the city level, the pressures on kindergarten directors to maximally fill the available capacity is recognised, as they want to relieve the pressure on parents of preschool children. MEYS communicates mainly with the regional level actors, which is perceived as limiting by the local level actor who indicates some potential information loss if the communication is not direct.

Eldercare

The stakeholders cooperate both on the vertical and the horizontal level. The vertical level is represented by the above-mentioned preparation of the 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. In 2015, the financial agenda, that is the competence to redistribute the allocation from the national budget, was transferred to Regional Authorities. This is related to the obligation of the Region to set the basic network of social services. In the course of the interviews, many providers criticised the Region for the way in which this basic network had been prepared, and for its insufficient communication with other stakeholders, and, lastly, for the nature of the methodology for integration of the services in the network.

The relationships and ties are more intense at the horizontal level. They can be divided into two groups. The first one represents institutionalised cooperation, such as e.g. developing and maintaining ties between providers, donors, users and other actors in the given locality. The second group are informal (or semi-formal) ties and cooperation, which can have a more long-term form or can be an ad-hoc solution to a certain situation. It is usually based on personal bonds. Most typically, this group includes cooperation between the providers and the family and the client's close ones. Similarly, there may be mutual ties between local providers, not only in terms of jointly addressing the client's needs; some providers also cooperate on exchange training programmes for their staff. There may also be competitive relationships between the providers, because they compete within a single, usually local, market.

Considering the above-mentioned absence of a conception of long-term care, the relationships and ties between providers of social services and various other actors that, in terms of administrative structure, fall under the health care sector, represent a very unique form of cooperation. This group covers actors such as health insurance companies, hospitals, general practitioners and specialised health care professionals, medical officers etc. Healthcare professionals are often among the first ones to inform clients about providers of social services.

Integration and harmonisation of social and health care is one of the key themes in the provision of field-based social services.[9] The interviews with some providers of field-based services suggest that those agencies that have a registered medical service and run home care services in parallel with provision of social care find themselves in the better position. They can benefit from the possibility to make use of multi-resource funding and to cover part of the costs from their health-care budget. The possibility to provide medical home care is limited and is conditional on a contract being signed with a health insurance company.

> *"We can also run home care. So it is either paid for by the health insurance company, well, we only have a contract with the General Health Insurance Company, we also have the nurses and we can provide nursing and medical home care."*
>
> (Provider, municipal field-based service)

> *"The Act on Public Health Insurance still includes the contractual obligation of health insurance companies. That is, when a residential service is applicable, the company must sign the contract. This is our advantage, for example in comparison with home care agencies that have to compete for public procurement contracts. Residential services have an advantage here."*
>
> (Provider/regulator, NGO elderly house)

Field-based services also often cooperate together, with the aim to refer the applicants whom they currently cannot accept for capacity reasons to other providers. It is not exceptional that clients, particularly in bigger cities, have a contract with more than one field-based agency, because of the capacity of these agencies. While one agency is able to deliver care to

[9] In practice, the institutions of providing health and social care are not interconnected and health care is provided separately from social care. The same separation applies to the financing of both types of care. This is demonstrated in provision of care to the elderly in their natural (home) environment as well as in provision of residential care. The existing arrangement in practice brings forth a dual provision of residential care, with homes for the elderly and special regime homes classified as social services, whereas long-stay hospitals are classified as health-care facilities. These three facilities in principle look after similar types of clients. Yet in the social service facility, the financial resources for health care are reduced.

a particular client only during the working week, another one is able to cover the weekends and public holidays, and possibly even another party takes care of meal delivery.

Remaining challenges: summing up the views of actors

Both child- and eldercare fields suffer from fragmentation in policy making. Whereas for the care services for children the two-tier model remains with the decoupling line drawn along the age of child (Hašková 2010), in eldercare the divide lies between social and health care services. Better integration within the services for children and the elderly is perceived as beneficial but still faces many institutional barriers. Further, field-based services for the elderly, notably domiciliary services aimed at providing more complex care with a lower amount of practical help and a greater focus on more complicated and complex needs as recognised in other countries (cf. Yandle at al. 2012) should be prioritised.

Gaps in the work-family balance framework are persistent and suitable policy solutions for the reconciliation of work and care duties have not yet been sufficiently developed, yet the protection of parents is still better than that of caregivers for elderly family members. However, according to policy makers from the national level, this is also underpinned by the remaining strong preference for full-time employment and full-time care both from the side of employers as well as care providing institutions, whereas the evidence from the micro-level suggests a preference for combining both duties (cf. Chapter 5, Lutherová et al. 2017).

Both policy fields to a certain extent suffer from bureaucratisation and implementation deficits as noted by both service providers and actors at the national level, e.g. the inclusion of children younger than three in kindergartens would require changes in management, equipment, staff professional background and organisation of activities, and this is perceived as a barrier.

One problematic aspect of policy planning in the Czech Republic is the lack of reliable and relevant data. Both in child- and eldercare, the statistics provide information on the number of refused/pending applications for kindergartens and elderly homes which is biased, as every family may submit an unlimited number of applications.

The supply side is also not very well mapped due to the sector of unregulated childcare and eldercare provision run as a business activity. It is precisely the unavailability of suitable services and the high costs associated with the services for clients with a higher degree of dependency and for children younger than three that, according to the representatives of the providers, gave rise to illegal organisations. These providers do not offer any guarantee of quality, and the care they provide, especially for the elderly, may even be health-threatening. This problem of the care provision 'black market' concerns the residential facilities as well field-based services delivered by non-registered individual carers who thus create competition for the registered field-based services that are more costly. The lack of capacity in public facilities then forces the families with caregiving burdens to compromise on the quality of service or on their own labour market involvement for becoming full-time caregivers.

Therefore, it remains necessary, in the views of eldercare professionals, to extend the number of field-based services, especially in smaller municipalities as well as extend the personnel capacities in all current services (that is both residential and field-based, including development of non-residential services), and further, to extend the special in-residential facilities to provide care for the growing number of clients with special needs (like a psychiatric diagnosis, dementia) or clients with various combinations of disabilities. This appears to be a discrepancy between the strategy of MLSA and the needs formulated by field professionals. With the growing number of low-income pensioners, the need for adequate low-income facilities will grow. As regards the care for children younger than three, the need for facilities is mainly recognised at the national level and partially at the regional level, however the local level remains reluctant to address the lack of capacity for this age group. For the older children, in the discourse of the interviewed policy makers across the governance levels, the remaining capacities appear sufficient. The literature (cf. Kuchařová 2010; Lutherová et al. 2017) suggest an opposite trend based on the experiences of families which is in line with the view of the quality regulation authorities and the care providers themselves.

The fragmented policy framework also translates into the system of funding. In childcare, a comprehensive system for schooling institutions is in place for kindergartens, whereas child groups have no guaranteed

regular support per child from the state budget and depend on funding from ESF, which brings about instability and bureaucratic burden. There is no consensus across the governance levels that children below three are a target group worth social investments. With the recent changes, however, some capacities will be created and made available. In eldercare, the system of funding delimits the outreach of as yet independently living elderly, especially those from remote areas, and the divide between health and social care impacts on financing the services in elderly homes.

In addition to insufficient financial resources and the bureaucratization of work, the respondents from municipal authorities mention an absence of a housing policy responsive to the needs of older adults among the major deficiencies of social policy. What could help tackle the problem is the construction of social housing in municipalities 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.

Conclusion

In childcare, key actors recognise the strong normative underpinning of how long children should be taken care of by their parents and what the ideal age to attend a childcare facility is; e.g. actors from the educational field perceive only children above three as educable and the well-being of the child is at the centre of their attention. However, across the governance levels (except for the MLSA), the parents (specifically the mothers) and their needs to reconcile caregiving and work are not seen as a priority. Some actors (regional and local level) even expressed their fears connected to new policy measures (such as child groups) as they can cause a paradigm shift towards more children placed in institutional childcare. These actors favour the existing model of care for children under the age of three within family.

Similarly in eldercare, family caregivers are perceived by policy makers (notably at the local and partly at the regional level) and by professional care providers as actors of care provision and not as secondary clients, e.g. a person or persons who have a central role in the life of the primary client (older people) and whose welfare is an important but

secondary objective. The welfare of primary and secondary clients are however often bound up with each other (O'Sullivan 2011).

Family caregivers stay outside the decision-making processes, e.g. when priorities for development of care services are being formulated at the local (childcare and eldercare) and regional (eldercare) levels. Their needs are overlooked and measures allowing them to combine caring for a child or a dependent elderly relative and work are not available. The labour of love encompasses multiple agents and related needs and tensions (Anttonen and Zechner 2011) which the existing care systems in the Czech Republic are not able to address, as the gender equality perspective is undermined in policy making.

The findings also suggest differences in approach to eldercare across the governance levels (cf. Chon 2013). Whereas the national level strategies and regulations emphasise the needs of family caregivers, such needs are revised at regional and local levels with reference to insufficient material, human and financial resources, and the needs of family caregivers are not included in the portfolio of available services and support from professional caregivers. Family caregivers are perceived by regional and local actors as those who drain the available financial means through the caregiver's allowance. Alternatively, in the situation in which a professional caregiving organisation has limited financial means, family caregivers are seen as a suitable complementary source of help. However, the elements of cooperation and partnership (cf. Tanner and Harris 2008) between formal and informal care are missing. The system of governance does not allow for penetrability of strategies formulated at the national level down to the local level and further to all relevant end-users of the services.

The eldercare system suffers from poor permeability of the legitimacy aspects of caregivers needs from the national level where strategies are being formulated to regional and local levels. Despite the existing strategies and instruments in place, such as planning of social services at the regional level, the demand for residential and home-based services remains unmet. In childcare the situation of parents is largely affected by the fragmentation between the policy fields – care and education – underpinned strongly by the cultural values about the specific age line until which the child should be provided only with motherly care (Hašková 2010) which are reproduced by some actors, mainly the regulators and funders from regional and local levels.

On the example of childcare, we observe that the existing gender contract and largely shared cultural values about the organisation and provision of childcare in the Czech society (Hašková 2010; Hašková et al. 2013; Sirovátka and Bartáková 2008) contributed to the refamilialistic trend of Czech childcare policy (Saxonberg and Sirovátka 2006) which remained persistent until recently (for more details on developments of policies see Chapter 2). Therefore, the childcare policy had a path-dependent long-term undermining character which reoriented the care towards the family, notably the mothers. Only in recent years, have new significant changes in the form of flexibilisation of parental leave, regulation of child groups and related measures providing funding (see above) been introduced. Such changes are not the resultants of external drivers (such as macro-economic, geopolitical and structural shocks), but rather seem to be endogenous, driven by the need for policy change due to several systemic and legislative gaps. Among these, the legal regulation of nurseries was abandoned and institutions providing care for children aged below three remained pending in a legal vacuum with no applicable legal regulation. Further, the parental leave has become more flexible and can be taken up also in the shorter alternative until the 2nd child's year, however, the necessary capacities in childcare facilities were missing. The new political representation took the opportunity to resolve such pending policy gaps and has developed some further measures to tackle the problems in childcare (as discussed in Chapter 2 and this chapter). After many years of an unchanged framework, a new policy direction towards building capacities for children below three was introduced as a top-down policy change.

In eldercare, the policy change is driven by the growing and ageing elderly population and the related pressures for the care needs (Saraceno and Keck 2011) which are exogenous factors. The introduction of the cash-for-care scheme classifies the Czech Republic as a country which combines weakly decommodified supported familialism with weakly decommodified defamilisation that allows compensation for care provided by a family member or a professional caregiver, although but the available amount is very low (ibid.). This still requires co-funding and the engagement of family members in care if the care needs of the frail elderly family member become extensive.

To summarise, the findings reveal that both policy fields suffer from similar challenges in terms of capacity, financing and the lack of reliable

data regarding the care needs. The gender perspective is not strongly present in key actor discourses, and it is weaker still in eldercare than in childcare, where the gendered division of care and work duties is recognised, especially in care for younger children. In the discourse of both policy fields, however, neither the end-users of services nor the caregivers are considered to be agents and/or partners in the policy making processes. In certain aspects, the local level, where the real burden of providing care remains, is also overlooked. Both policy fields remain quite fragmented, with poor ability to translate national level policy into sustainable solutions which would satisfy the actual needs of end-users at the local level.

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CHAPTER 4

Providing care services: strategies of key actors and emerging policy change in Norway

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Introduction

In Norway, key actors in eldercare and key actors in childcare do not as a rule coordinate their work across the two care fields. On the contrary, each of the two fields appears to be anchored in sets of policy history that do not, at any recent point in time, converge. Yet they are both part of the same political and social development. Family care strategies and public care regimes are mutually constituted, so that changes in the one will necessarily lead to changes in the other. Comparing the two care fields within one country is especially useful in bringing out the characteristics of each field. In the present chapter, we shall look into some of the implications of the dynamics between family care and public care regimes on the macro level, with emphasis on gender equality both on the labour market and in the family as an explicit and undisputed political goal. In so doing, we build on Daly (2002), especially on her discussion about the implications of care provision for society and on her typology for provision of care. The former draws attention to the implications for gender and ethnic equity. The latter facilitates a comparison of two policy fields that, in spite of being contemporaneous parts of the same welfare state, are organized and understood very differently.

Approaching care as a social good through systems theory

Our approach in this chapter is informed by recent complexity and systems theory, especially as informed by critical realism (Bakewell et al. 2012; Danermark et al. 2002; Iosifides 2011; Seeberg 2011; Walby 2007). In this approach, any social system – here, the eldercare system and the childcare system – can be distinguished from its environment by internal feedback mechanisms, yet as interacting dynamically with its environ-

ment, which in turn consists of other systems. The boundaries of a care system will be changeable, but identifiable, at any point in time through the observation and analyses of feedback mechanisms versus external processes. For our purposes here, this perspective makes visible each care field, or care system, as historically, discursively and materially distinct yet dynamically interlinked with developments in other care systems and in the wider society.

With Mary Daly (2002), we regard care as a good for social policy, while defining care as 'the activities and relations involved in caring for the ill, elderly and dependent young'. Rather than referring to simple practical arrangements, care is a complex concept with significant moral and emotional aspects. This makes providing care and developing care policies especially precarious, as any choices between different types and combinations of types of care will have political and social implications. In other words, and as we shall see, navigating between available choices is a challenging task for policy makers and providers alike. Available choices are described by Daly through the identification of four main types of care policy measures summarized as benefits, employment-related provisions, services, and market incentives (Daly 2002: 255).

Equality and diversity

As laconically summarized in the White Paper *Future Care* (Helse- og omsorgsdepartementet 2013), which focuses on the eldercare sector, 'Men account for only 10 percent of the person-hours within the sector. It appears that gender equality has come further within family care than within the public health and care services.' In fact, both eldercare and childcare are dominated by a feminine workforce. While the sectors could not have expanded without the extensive inclusion of women in the paid workforce, it has been noted that the shift from unpaid work in the family to paid care work has not necessarily changed more fundamental issues of gender equality such as the presumption that women are naturally better carers than men. The workforce has in later years gradually also become more ethnically diverse. In the process, a tendency towards masculinization is also present, in that men from immigrant backgrounds are more likely to work in this sector than men born and bred in Norway (Seeberg 2012).

Methods and samples

In the pages to follow, we present our findings from interviews with key actors in both care policy fields and explore their practices, plans, and reflections in light of the role of each care field in the gender equal welfare state. In the field of childcare, we conducted 14 research interviews and in the elderly care field, 15 interviews. The selected actors varied along a combination of the following criteria: type of stakeholder, societal level, and ownership, and 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. With one exception, the interviewees had their workplaces in or around Oslo. For those working on the national level[1], this is less significant, but for the local and regional representatives[2], this means that their viewpoints are not representative of the country as a whole. Although not technically representative in any statistical sense of the word, a broad spectrum of the main actors was thus represented, ensuring access to a wide range of positions and perspectives.

To recruit the participants, individual representatives of selected key stakeholder institutions were contacted by email with summarised information about INNCARE project and an interview request. Some of the contacted persons had already been involved in INNCARE through the workshop organised as part of WP2 and were thus familiar with the research and topics. Some agreed to take part, while others helped us find another person who was better positioned to participate on behalf of their organization.

The findings

In order to capture the dilemmas and choices faced by the different actors in the two fields, the analysis below first describes the organizational aspects of their tasks before moving on to their aims, arguments and

[1] 10 in the childcare sector, 4 in the eldercare sector

[2] 4 in the childcare sector, 11 in the eldercare sector

priorities. We then show how they regard issues of capacity and resources in order to provide a background for their views on challenges in their policy fields, and possible solutions to these challenges.

Organization, responsibilities and cooperation

Differences between the two systems were evident. For instance, all our respondents in the childcare field 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. Although our interviewees held different perspectives depending on their current and previous positions in the sector, their common pedagogical outlook was deeply ingrained in their statements and in their understanding of the needs of children. This became especially clear through the interviews with childcare respondents from other professional and educational backgrounds, where alternative views on several issues came up. However, these respondents also underlined the value of mutual understanding and the existing, well-functioning formal as well as informal arenas and networks for cooperation and negotiations. Only one respondent, at the borough level, voiced some opposition to the prevalent views and pointed to several areas where, according to this respondent, there was a discrepancy between reality and political agreement. However, this respondent underlined that if the political and higher administrative levels wanted to know about this, they would need to ask, as it was not the position of a borough employee to take any initiative

in this direction. The unity in the childcare system also pertained to the tendency within this system to develop from a patchwork of different services into one, universal service – kindergarten.[3]

In elderly care, the picture was very different. Where our childcare respondents unanimously described cooperation and coordination, in elderly care the emphasis tended towards difference and disjunction. At the government level, the focus was on providing a framework for the right balance for municipalities between providing the necessary number of nursing home beds on the one hand, and organising and preparing for elderly persons to stay home in a safe environment as long as possible on the other hand. In contrast to the childcare sector, the predominant tendency in eldercare was a branching out from an earlier emphasis on universal residential care into many highly different and specialized services.

The SYE (Sykehjemsetaten), the largest operator of nursing homes in the country and the second largest department in the municipality of Oslo, was in charge of nursing home administration.. Official regulations were the most important restrictions guiding their operations. In 2015, Oslo had 48 nursing homes, of which 20 were run by the municipality through its central nursing home agency, SYE; the rest were run by non-profit foundations or private enterprises. SYE had recently taken over the boroughs' responsibility for running publicly owned nursing homes and for overseeing the private nursing homes, in total 4,700 long-term places and 700 users of day-time services.

The home services of each borough were responsible for both home nursing and practical assistance together with various other types of supporting schemes such as day care and activity programmes, cash for care, respite services and many others. Furthermore, an operative effort team was responsible for follow-up on patients with special needs for medical treatment, care and technical aids when they were discharged from hospital or rehabilitation. Among the stakeholders at the local level of Oslo, the Centres for Development of Nursing Homes and Home Care Services were responsible for supervising activities and for the counselling of care

[3] We use the term 'kindergarten' here, well aware of its connotations in many countries to pre-school programmes for 5–6 year old children. 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 from the Norwegian 'barnehage'.

providers and municipal authorities. In addition, the Geriatric Resource Centre (recently reorganized into the Centre for Professional Development and Research) was a developmental centre that offered courses and training programs for health personnel and initiated projects to increase the knowledge within dementia care services in both nursing homes and the home services.

In Oslo, and other big municipalities, home-care services were organized in line with the purchaser-provider model, separating the 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 were two different systems based on different principles and priorities with respect to resources. Oslo's centralised Application office (booking unit) administers all applications for nursing home beds and makes a decision, which is sent to SYE. Short-term placement was organised according to which borough and hospital sector the applicant belonged to. For long-term placement in a nursing home, the applicant could state a preference, but there might not always be an available bed at the preferred nursing home.

The collaboration between SYE and the Oslo boroughs was important since the boroughs were 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 was mandated to move patients between units to avoid that boroughs order beds according to its economy. The agency also collaborated closely with each borough administration regarding the four Health houses, which were established as a new type of short-term ward with a stronger focus on treatment and rehabilitation after a hospital stay than the nursing homes were able to provide before the Cooperation reform. Further, the Health houses collaborated 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 housing and nursing homes, Oslo has established care housing with 24-hour staff presence (Care+) which covers the need for safety and care among users with somatic and psychic ailments.

Although such considerable efforts were made to coordinate and cooperate within eldercare, this was a sprawling sector. The range of services with similar names and overlapping characteristics, frequent renaming and reorganizations of tasks, services, and responsibilities, and individually adapted service packages for users of all ages meant that it was not possible to maintain a coordinated overview of the sector. In this, it differed strongly from the childcare sector with its strong universal kindergarten model and secondary individual considerations.

The Norwegian childcare, or kindergarten, sector emerges as a well-integrated, almost organic and harmonised horizontal system where all actors know the game and approve of the same set of rules. Paradoxically, however, a problem in the childcare system may be inherent in the same successful, consensus-based model, which may make it difficult for alternative views to be heard and to gain influence. In the elderly care sector, most of our material describes a vertically organized system with many different forms of actors at different levels even within the municipality, who only to a limited extent cooperated horizontally.

Objectives and target population: Perceptions of care needs

In childcare, 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, they pointed out that the competence of kindergarten staff needed to a larger extent to reflect the needs of the very youngest children. Several respondents also emphasized the importance of active recruitment of young children in immigrant families to kindergarten. With an immigrant population[4] of 13 percent, near universal coverage and the capacity to include all

[4] Persons born abroad and persons born in Norway both of whose parents were born abroad.

children aged 1–5, the few children who were not in kindergarten raised some concern, and it was generally assumed that these were mostly of immigrant background. One respondent further pointed out that since kindergarten was nearly universal in Norway, this provided a unique opportunity to approach the broad political goal of social equalization – a goal that universal schooling had not nearly reached.

A main objective of the elderly care policy in Norway was 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. This was also the expressed policy of Oslo municipality: all city boroughs were obliged to provide adequate services, including non-residential and field based services, home nursing care and day care centres. One of the core targets of the Cooperation Reform had been to alleviate the pressure of elderly patients in need of care rather than medical treatment on the hospital sector by transferring responsibilities to the municipal level (Helse- og omsorgsdepartementet 2009). Eighty 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. As our participants confirmed, this was mainly because those with less demanding health conditions now continued to live in their own homes, in agreement with the political intentions. The objective of the home services was to provide sufficient medical assistance and qualitative care to the elderly recipients within the statutory framework. Care teams were expected to decide in more detail how to meet needs and report electronically whether the tasks were being accomplished within the estimated time frame. As elderly people who live at home often need care, attendance, nourishment, physical therapy and medical assistance, the need for services depended on individual circumstances, medical condition, housing, and family situation. Those in most need of care were aged 80 or over, yet needs cannot simply be defined by age: at 70, one person might be in as much need of care as another at 90. In the two city-boroughs in our sample, a larger proportion of the service users than city average were single persons living alone, often with lifestyle diseases, addictions, or psychiatric problems. Several also lived in small apartments/homes that were not suitable when they needed technical equipment. Elderly who needed to be in a nursing home were those who were incapable of functioning by themselves and needed more nursing care than the home services are able to deliver.

In both care fields, any sharp distinction of needs based on age was rejected. In childcare, 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 elderly care, more elderly people in need of simple and complex care services and fewer young people to provide this labour had led to a policy shift on the discursive as well as on the economic and organizational levels, from the earlier emphasis on residential care to a current view of home care services as the most viable option.

Policy arguments and priorities

The private/public debate was currently one of the few fields of political contention in the kindergarten sector in this country. The debate about public versus private kindergartens has several aspects, one of which was financial. 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 was that private actors were able to run their services at a lower cost than the public ones, for various reasons – a main one being that their pension expenses to former employees were lower, because they offer poorer employee pensions, on the average.[5] One consequence of this may be the greater stability of staff and children in private kindergartens than in the municipal ones; more money is also spent on noticeable elements such as meals and technology, making municipal kindergartens appear less attractive to the public at large. However, since 2016, the regulations have stipulated that pension expenses would not be included in the operational expenses. This was expected to make it more difficult for private actors to extract extensive profit. All our childcare sector interviewees talked about this. Other debates, such as the line of responsibility between the family and

[5] The rules for retirement pensions in the public and private sectors are different. Comparing them is extremely complex (e.g. Fredriksen 2013).

the care sector, and parents' right to choose or not choose a kindergarten for their children were only briefly touched upon in a few interviews.

In the eldercare sector, the political arguments put forward by different stakeholders were both economic and ideological. Home services were a much cheaper solution for the authorities, as sick and frail elderly living at home receive 16 hours paid home nursing assistance per month on average, while patients in nursing homes get 35 hours a week on average. There was an overall agreement that recruitment of more health and social services workers must be prioritized. Immigrant men and women constitute an important labour pool and a growing part of the labour force in this sector.

While the debate in the media was dominated by the argument that there was a need for more nursing homes, the actors and providers we interviewed were more concerned with strengthening the home services. The tension between the two arguments may derive from different positions of responsibility, as well as being related to different, value-laden perceptions of what was 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 were different views of how high the individual level of need for care and monitoring should be before triggering rights to long-term institutional care.

As regards childcare, the main policy issue derived from the interviews was the relation between the public and the private sector, and interviewees expressed different views on the possibility to extract profits from kindergartens, and on the fairest model for the distribution of financial resources. In the elderly care sector, the tension between a publicly dominant call for more resources to residential care facilities and official policies highlighting home and field based care services was palpable. Arguments for the latter were predominant in our interviews with representatives from government bodies, providers, and interest groups.

Capacity and resources

When asked whether the needs or demands for kindergarten places were met, our interviewees generally referred to the statistics showing that there was full kindergarten coverage in Norway. A representative for the private kindergartens pointed out that in some municipalities, there was

a real or potential overcapacity, so that municipalities were less eager to establish new kindergartens. On the municipal level in Oslo, respondents suggested an overcapacity of 400–500 kindergarten places that were not being used at the time of the interview, an estimate based on detailed overviews of available places in each borough. Children on waiting lists in Oslo were, according to our respondents, either under the legal age of right to kindergarten, or their parents were interested only in a place in specific kindergartens, having rejected offers of places elsewhere. Another respondent in Oslo held a different view, and a view more in concordance with the overall agreement that there were some children who should have been in kindergarten who were not there, who did not attend kindergarten because their parents had not applied for them to do so. Children of immigrant parents were the main target group here, whether or not they actually did form the majority of children who were not in kindergarten. Since the issue of capacity in the sense of supply and demand of kindergarten places was marginal at this stage in Norway, most of our interviewees understood this part of the interview as a question about kindergartens' capacities to meet the needs of children. At the national level, none of the stakeholders expressed any concern about their own capacity to fulfil their responsibilities. At the local level, such concerns were expressed more widely, also outside the immediate capacity of kindergartens themselves, and the respondents conceded that they had a good deal of tasks and a very limited number of people. However, they claimed to be able to meet most deadlines and fulfil their obligations, mainly through strict prioritization. When it comes to the kindergartens' capacities, we may identify three main subtopics: staffing, ratio of pedagogical personnel, and economic resources. These were related, and it was possible to identify some dividing lines between actors emphasising the importance of increasing the ratio of pedagogical personnel and those who advocate for a wider array of professions.

Norway spends 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 was a need for innovative solutions. The staff rate in nursing homes was already too low, in spite of changes in terms of new job categories and less unskilled workers among the staff.

There was a continuing need to build and strengthen the competence of care providing staff and an increasing need for competence regarding dementia. In the home care system, many felt that their work was too rigidly dictated by strictly defined and fragmented time schedules. Several stakeholders questioned the home-services' ability and capacity to take into account recipients' need for security and social contact, due to the purchaser-provider model. Because resources were finite, the most urgent needs were prioritised in the home care services, and medical needs and needs related to bodily care were regarded as more urgent than other domestic and social tasks. Elderly persons with poor housing or no social networks were often regarded as having more urgent needs than people who were surrounded by family, friends and/or modern facilities. In residential care, there was a corresponding concern about meeting needs for social and emotional care when more urgent needs were prioritized within a stopwatch system.

Challenges: deficits, gaps and overlaps

The participants in the childcare sector held three areas forth as especially challenging: the working conditions for staff, staff competencies, and leadership, hereunder the organization and implementation of monitoring. A widely pointed out and discussed challenge was the organization of kindergarten monitoring in a national system where municipalities were simultaneously providers, funders, and regulators of kindergartens. Our participants pointed out that the challenge was generally greatest in smaller municipalities, where one office or in some cases one person may have several conflicting spheres of responsibility. From the point of view of private providers, municipal systems for monitoring vary greatly, and may suffer from a lack of impartiality, competence and recognizable structure.

As expected, 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 were considerably better in the municipal (public) sector 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 was the rewarding of competencies. As today's law only specifies the competency requirements for kindergarten teachers, other competencies were not necessarily remunerated. Different forms and levels of competence were linked to different levels of social status and prestige, and to the appeal of different positions.

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 was a lack of training in pedagogy focusing on the youngest age group. The recent 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. A particular challenge was posed by the legal requirement for children's active participation, as laid down in the Convention for the Rights of the Child and thereby in Norwegian law: How do you get one-year olds to participate in a democratic sense?

In eldercare, in light of the demographic challenges that were expected to hit full force in 10–15 years, our participants all expressed the need for restructuring of the services and more involvement of families and volunteers. In Oslo, the new city council as of 2015 granted 500 new jobs/positions to the home services in 2016. Nevertheless, some of the stakeholders questioned whether this grant was enough to develop sustainable services or a sufficient solution to solve the huge tasks ahead of them. Together with a competitive labour market, the shortage of care workers will present major challenges to the care sector. The growth of new and younger user groups with the need for extensive assistance of in-home nursing care and user-driven personal assistance was also an important part of the picture. Practically all of the new resources allocated to the sector in the past twenty years were 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 was if this development reduces the services for the elderly, also because of a difference in traditions, entitlements and pro-

fessional 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. Populist framing of a place in a nursing home as a right raised widespread expectations, difficult to meet for municipalities as the main providers within actually decided policies prioritizing home care services.

Our participants were well aware of the policy documents in their fields of work, and in eldercare several interviewees referred to the Official Norwegian Report *Innovation in the care services* (Hagen 2011) and the subsequent White Paper *Future Care* (Helse- og omsorgsdepartementet 2013). Here, the challenges in the (elder)care sector are summed up as follows:

- the increase in new younger user groups;
- more elderly in need of assistance;
- the shortage of volunteer care providers;
- the shortage of health and social services personnel;
- the lack of coordination and medical follow-up;
- the lack of activities and coverage related to psycho-social needs;
- the internationalisation of the market for personnel, service providers, patients and users.

Our participants agreed on these challenges, but emphasis on the various points differed slightly between participants.

When it comes to childcare, Norway has in recent years followed a relatively smooth, unilineal consensus development and continues to follow the same path of developing and adjusting the kindergarten sector. Although there are challenges related to small child pedagogics and staff competence, the overall agreement on the importance of continuing the development of the kindergarten sector provided a strong basis for constructive discussions. The idea that residential elderly care was the best solution overall, especially for the rising numbers of people suffering from dementia, appears to have a strong popular foothold, while extant policies supported the opposite view, namely that the generally preferred solution was home and field care. The tension resulting from the discrepancy between these two perspectives was a challenge for the

relation between demand and supply. The most apparent lack was to be found in the access to sufficient human resources, resulting in a current and growing shortage of staff.

Looking back, looking ahead

The interviewees underlined that the childcare sector had been through enormous changes over the preceding 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. Other strategies included lobbying. Shifting alliances from issue to issue also formed part of the picture, and should be understood as part of the platform building, where different parts of one's network could be mobilised as allies in different constellations, depending on common interest in individual questions. Large private providers may strategically prioritize investing in symbolic innovations highlighting aspects and elements present in all or most kindergartens. The effect of such innovative use of symbols may to some extent be understood as market branding, rather than as solutions to existing problems. However, market branding plays 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 kindergarten has appeared. While in 2002 the largest kindergarten in Norway had 111 children, in 2015 the largest kindergarten had 481 children. This kindergarten was located in Oslo (Bråten et al. 2015). Our participants agreed that these kindergartens had gone through a rough reception, where parents were sceptical of leaving their children in what the media had called 'child factories'. However, these kindergartens became regarded as at least as good as more conventional, smaller facilities.

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

- the recruitment of the few children who were 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, from kindergarten to university, to incorporate ideas and practices of learning from the ages of 0–24 years;
- 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.

Several of our interviewees were waiting in anticipation for the expected new framework plan for kindergartens. Would it amend the gaps, meet the challenges they saw as particularly important, in ways they wanted? 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 was also under way, and the Ministry of Education would like to coordinate the work with these two important documents. As part of the work with the new framework plan, a new White Paper was also under way.

A combination of demographic change and organizational change was likely to further increase the pressure on elderly care services: the population was aging, and the Coordination reform (Helse- og omsorgsdepartementet 2009), effective since 2012, meant that home care services now targeted all age groups, so that 'elderly care' was outdated as an organizational concept. According to the government's competency and recruitment plan, the Competency Development programme 2015 (Helse- og omsorgsdepartmentet 2015a), 300 million NOK was spent annually to increase staffing and enhance the level of competencies in the municipal health and care services. 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 was due to reform efforts, professional and financial assessment in the municipalities and greater involvement by the users in designing the services. Another trend was 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 was now in residential care.

All informants emphasized the importance of further creating safe home environments, but differed somewhat on how to achieve this. Some argued that the future challenges should be met by reprioritisation, giving priority to medical needs, antisepsis and nutrition over domestic and/or social tasks. However, when it came to dementia, our participants agreed with the Dementia Plan 2020 (Helse- og omsorgsdepartementet 2015b), stating the services to people with dementia must be strengthened by enhancing knowledge and expertise in the field, increasing daytime activity programmes and creating more adapted housing. This applied to home care as well as residential care, and it was pointed out that home services to people with dementia currently fulfilled these goals to a larger extent than residential care, where current challenges especially regarded assistance in physical and other activity such as going for walks, attending cultural events and so on.

New welfare technology may allow more people to live longer in their own homes despite reduced functionality. Planned greater implementation of welfare technology in health and care services aimed to save resources in the care services and enhance the ability of users to manage their own daily life. Attitudes towards welfare technology had 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 would make it possible for home care recipients to manage at a lower level of care. The Norwegian care services model was characterised by a distribution of tasks and close cooperation between two major actors: the municipal health and care services and close family members. Future challenges also raised the question of whether other actors, private organisations and volunteers could play an active role in providing these services.

The childcare sector in Norway appeared to be dominated by a consolidated optimism. Most things were in place, while there was 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 constituted the main example of such new needs, while the issue of private profit in this sector appeared to be the only real bone of contention. In elderly care, conventional residential care was regarded as unsustainable as a general solution for the future. High costs combined with passivation of residents were mentioned as the main reasons. Suggested solutions to this were a more varied scenario of alternative and graded services, including different forms of sheltered housing. This suggestion was supplemented by an emphasis on technological innovations as well as a general empowerment of elderly persons.

Concluding remarks

The relation between the state and the family in the two care fields in Norway may be summarized visually as follows:

Table 4.1 Comparative overview

	Childcare	**Eldercare**
State	Less formal responsibility Universalized system Parental leave: Gender equality Kindergarten: Education (care)	More formal responsibility Particularized system Home care services (independence, mastering) Residential care services (dependence)
Family	More formal responsibility Both parents Care (education)	Less formal responsibility Any relative, mostly spouses/children Bridging the gaps: coordination and care

Source: authors

As the table illustrates, the two care systems are constituted and enacted in separate discursive and organisational fields and show very different characteristics. This contrast reflects an important difference between caring for children and caring for the elderly: although all children are different, they are only at the starting point of their development into

the vastly different older persons they will one day be (Helse- og omsorgsdepartementet 2009). Thus, the needs of individual children are more similar than those of individual elderly persons, making it easier to provide one universal service with individual adaptations for children. In addition, the two care fields have been constituted as separate policy fields, with few common actors and little attempt at regarding them as parts of a whole, hindering any potentially beneficial mutual interchange of experience based knowledge between the two fields. A final difference which may contribute to explaining the contrast between the two policy fields was the strong professional identity in the childcare field versus a multiplicity of professions involved in forming the elderly care field.

As the table indicates, the ideological emphasis on gender equality is prevalent in the childcare sector, while this is not an explicit topic in the eldercare sector. Because both parents are important as parts of the labour force while both are also legally responsible for childcare, the gender equality implications of childcare are very clear. In eldercare, this connection is less visible and accordingly not an explicit part of the discourse and policies. In Chapter 6, we shall take a closer look at what this means in practice, for families and individuals providing and receiving care.

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CHAPTER 5

Balancing acts: Family care strategies and policy frameworks in the Czech Republic

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Introduction

As is deeply discussed in Chapter 1, childcare and/or eldercare stand at the intersection of the state, the market and the family (Daly and Lewis 2000). From the micro-perspective, it is then important how families/caregivers cope with care requirements in a contemporary society characterized by an aging population together with increased life expectancy, growing labour market participation of women (as traditional caregivers), enforcement of gender equality and welfare state changes (permanent austerity trends, expansion of the service sector) (e.g. Esping-Andersen 2009; Blome et al. 2009). Thus, we firstly explore how families organize care, what kind of care they provide to their children and dependent elderly members, how the responsibilities and tasks are shared, and how they combine caregiving with other commitments in their daily lives such as paid work and family life. The question of care arrangements, work-family balance and expectations of family caregivers is relatively open in expert and public debates in the case of the childcare field (e.g. Křížková and Vohlídalová 2009); however, the study of care provided by families to older adults is a recent focus in the Czech Republic (e.g. Jeřábek 2013; Havlíková 2012). In our data, we found several models in child- as well as in eldercare arrangements which we introduce below.

Since the regime of the welfare state significantly affects the practices and strategies of caregivers (e.g. Saraceno and Keck 2011; Esping-Andersen 2009; Pfau-Effinger 2004; Leitner 2003), we further focus on the role of child- and eldercare policies in the strategies and practices of families in providing care for their dependent members. In subchapter 4, we pay attention to the participants' negative and positive experiences with care services and provision, as well as their discursive reflections on matters such as problems and deficiencies, solutions to such problems, and emerging and possible innovation. The main aim is to identify how

childcare and eldercare provisions (formal care arrangements and other relevant social policies) meet the needs and expectations of the families and what the appropriate improvements in this respect may be.

Method and data

This chapter is based on interviews with persons with care responsibilities for children and elderly family members.

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. The first group of communication partners (15) were families with the youngest child between the ages of 0 and 2 years and the second group (14) had children between ages 3 and 6. In order to map various strategies of families, the variability of families regarding use of services (public, private, by the employer) was considered. With regard to the fact that the project focuses on work-life balance and well-being, the sample contains families in which both parents to some extent remain in the labour market (employed or unemployed, or alternatively post-graduate students or volunteers). Families that use neither public nor private services were included, as their way of reconciling care and work might particularly contain elements of innovation. During the process of data collection we found that mothers were more willing to participate in our research and fathers often did not feel competent to give interviews on the given topic and they shifted the interview to their partners (mothers). This fact, together with the criterion of economic activity of both parents (highly educated mothers are usually more motivated to return to the labour market soon after childbirth) and with the use of the snowball sampling method, led to the predominance of university-educated mothers in the sample. This sample composition limits possible generalization of acquired findings to a certain extent, however, it does enable us to explore less typical work-childcare practices as well.

In constructing the sample of communication partners for the segment of eldercare, we applied above all the territorial perspective in order to get participants/respondents from cities of different sizes and from the countryside. The first group were family caregivers living in a city outside the county town agglomeration, the second were caregivers living in a smaller

municipality within the county town agglomeration, next were caregivers living in a county town and the last group were people living in a rural area. Both female and male caregivers were in the sample (daughters, sons, husbands, granddaughters, daughters-in-law). In regard to the project focus, almost all respondents participated in the labour market (full-time and part-time employees, self-employed) and family caregivers with education at all levels were involved. Family caregivers in our sample provide different kinds and scopes of assistance depending on the self-sufficiency level of the elderly person and the extent of professional provider involvement.

The communication partners – family caregivers for both samples – were contacted through service providers and they were also recruited by applying the snowball sampling method. The data collection techniques of both focus group samples were combined with one-on-one interviews. As the project focuses on a comparison of Czech and Norwegian childcare and eldercare policies, the interview guide as well as the main topics of the interview were designed in cooperation with Norwegian partners. Similarly, the techniques of data collection were discussed, but also with respect to national specifics such as availability of family care givers in rural area, willingness to participation in the focus group and the possibility to approach the family caregivers through the professional care providers.

Care arrangements and working life

This part is focused on real work and care arrangements of respondents as well as some expressed expectations of family caregivers concerning the work-life balance.

Childcare

The foundation stones of strategy development for (paid) work and childcare reconciliation are always the needs and interests of the child. Subsequently, it depends on the availability of family-friendly work regimes that the labour market is able to provide for mothers but also for fathers. Simultaneously with this issue, the way to divide the care for children between the mother and father or the availability and preference of other sources of care are dealt with.

Speaking of child needs, frequently discussed issues are: whether and until when is a mother's exclusive care needed, what are the positive and negative impacts of the work activities of mothers and/or institutional day care, how is this arrangement influenced by social discourse and norms related to motherhood, what is or what should be the role of the father in the care (including his parental skills and ability to provide the family with finances) and other actors of childcare. Traditional gender divisions of labour, comprised almost exclusively of a mother's care for a child up to three years of age (i.e. the role of the woman as the carer and the man as the breadwinner), are perceived and accepted in various ways. Some female respondents accept it as something very natural or more suitable to the needs and interests of the child. Other mothers feel that they are somewhat forced to the role of primary caregiver and some of them actively try 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 (*model of egalitarian work and childcare reconciliation* or *dual earner – dual carer model*, Crompton 1999*)*. Another four families also make an effort to balance care more equally between mother and father, however they have not been able to achieve this balance as of yet. To a certain extent, a family heading towards the egalitarian division of roles can face being perceived as having a non-standard or even strange strategy of work and care reconciliation (sometimes meant positively and sometimes negatively).

The second type of work and care arrangement which appeared in our research can be called *the model of 'one-sided work and childcare reconciliation' on the part of the mother* (c.f. *modified breadwinner model* in Lewis and Ostner 1994). In this model, the mother is the main person responsible for ensuring care and the father engages only when his paid job duties allow and when he feels somehow motivated to provide care. In this scenario, the father provides care during the afternoons or evenings when he returns home and when the mother is temporarily unable to provide care (illness, accompaniment to the doctor, a smaller share of the accompaniment from/to the kindergarten or school etc.) The involvement of the father varies in relation to his work duties but often the paid work of the male partner is perceived as the priority in comparison with the work activity of women. Hence, work activities of these women

depend on how successful they are in arranging external care (childcare services, nannies or other family members).

> *"I am the person primarily responsible for finding the solution for how we do it. And sometimes I don't like it but I have the feeling that it is my responsibility what will happen with the children. And if my husband finds the time then he somehow participates. But I just feel that the difference is in the fact that I am the one who has to resolve it, discuss with him when he is able to and if not then what's another way to solve it. But I would say that when they are ill, at that moment I have the larger share of the responsibility."*
>
> (university-educated woman, 2 children 4 and 5 years old)

In some cases the father participates in the care only minimally or not at all and focuses only on the role of breadwinner. The woman's income (if there is any) is perceived rather as a supplementary (although often very important); this applies at least during the time when the children are small.

The female university and college graduates in our sample are often able to find and get a job which is suitable for them and which accompanies the childcare to the extent they prefer. If they feel that they are unable to live up to the expectations of both providing care and enjoying it, as well as working, then they tend to leave the job (temporarily) or to reduce their workload, as the child's interests come first.

The majority of these women have already been working during their parental leave. They have combined childcare with small entrepreneurial activities or irregular work activities during their child's early age. This work is usually performed when the child sleeps or when the father or other family member can provide care; in several cases, the female respondents used the paid service of a nanny. Nevertheless, in the earliest nursing and toddler ages of the child, some women were able to work in the direct presence of the child or they took the child with them to the work.

During this period, almost none of the respondents prefer nor use centre-based childcare services. Workload usually increases around the second year of the child, when many of their jobs exceed 0.5 fill-time equivalent/FTE. At this age, children gradually start to attend day care

facilities. However, at the beginning, they attend several hours per week and the attendance gradually increases up to an 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 the 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,[1] 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 to 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, according to their responses, 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 perform full-time work but they are paid a part-time salary).

In several cases there was also the condition to be able to work from home (home-office); this relates to the requirement to be able to work when they want/can. In this respect, problems complicating the ability to work from home are often mentioned. For example, if it is necessary to work during evenings and nights, symptoms of exhaustion might occur that make it impossible to perform mentally demanding work (such as creative work).

In addition to the aforementioned necessary conditions which jointly form the space allowing the woman to combine work and care for small children there is also a requirement for the partner's work flexibility and his willingness to invest time in the care of children. The requirement of significant work flexibility of the father or both parents is especially apparent in the case of families heading towards the model of egalitarian work and childcare reconciliation.

[1] This 'traditional model' (three years of full-time motherhood and then full-time work) is very common in the Czech Republic (e.g. Javornik 2014; Křížková et al. 2007). However, our research sample does not correspond with this model because we wanted to find families where both partners participate (to some extent) in the labour market (see also subchapter 2 Method and data above).

In many cases, grandparents are the essential source of help (especially grandmothers). However, their involvement in childcare significantly varies in the sample according to the distance from the place of the respondents' residence and also according to the state of health of the grandparents and their willingness to participate in the care. The help of the grandparents is often limited by their own economic activity (then it depends whether their paid work is compatible with the care) and also by their pastime activities and plans which do not necessarily have to correspond with the care of grandchildren. Other family members, female relatives in particular (sisters and sisters-in-law), are also engaged as carers, but this is sometimes only random and short-term care.

The described practices of the combination of work and family life are, however, often very fragile and the parents make a considerable effort to be able to organise everything that is necessary every day. Often, it is impossible for the parents (and other actors in the care) to agree on a long-term valid model (this is especially the case for parents working in flexible work modes). When there is an unexpected situation, such as the illness of a child or unplanned work activities or the immediate unavailability of regular care, the balance collapses.

From the viewpoint of the female participants, the preferred or ideal type of work and care arrangement reflects the form of the current individual arrangements and experience. Most often the ideal is considered to be a part-time job. The female participants whose parents cannot meet their childcare needs would welcome greater or at least regular involvement of the grandparents in the care. Similarly, those women whose partners do not participate in the care as much as the women would like them to, would like to transfer a part of responsibility for the care to them. The main argument for these decisions is that the women have confidence in the person providing the care and feel that they are reliable. Two female respondents expressed the wish that society generally (with an emphasis on employers) acknowledge the care commitment of fathers and perceive the mothers with small children as equal labour (cf. the concept of gender culture by Pfau-Effinger 2004). Another idea of optimal care arrangement relates to childcare services (cf. the importance of childcare services for parents' choices and opportunities to be employed in Esping-Andersen 2009; Javornik 2014; Leitner 2003 etc.); this reflects some problems in the whole system including the lack of more affordable private childcare

services, the general availability of public services for children up to three years of age or company kindergartens (in more detail below).

Eldercare

Although families have always provided care to older adults, the conditions have changed in regard to demographic transformations in the last two decades. In the past, caring for the elderly within the family was the norm, but care was rare, since most people did not live to old age, and the period of decline at the end of life was commonly short. Now life expectancy is longer and most people live to ages when it is likely that they will require ongoing care. As a result, older people need more care than ever before and for longer periods of time (Szinovacz and Davey 2008). In the light of these changes, the resilience of families is remarkable. Despite the fractures in family life caused by many different problems, family are tied to their elders and remain the main source of care, even in countries with well-developed public support programs (Shea at al. 2003 The family caregivers represent an important part of the current Czech care policy. Although their relevance has increased in connection with the ageing population, especially in case of caregivers at a productive age, public debate has only recently begun on the opportunities to leave/return to labour market flexible.

In our sample, four 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) and the scope of assistance they provide is also rather limited (typically housekeeping, shopping, cleaning, going out). 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 people disposing of a limited opportunity 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 their need to pursue their professional lives. They thus choose to delegate basic care provision

to professional carers. The second group consists of the respondents who also allocate a relatively modest amount of time 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 the basic tasks mentioned above, they take care of e.g. handling necessary phone calls, cooking and personal care. These elderly family members' ability to live autonomously has not significantly declined yet and the family caregivers provide, for the most part, occasional or one-off help to satisfy a variety of their needs. The beneficiaries of assistance are typically the carers' parents or grandparents, and the communication and visits during which assistance is provided by the children and grandchildren are also understood as instruments of ongoing monitoring of the situation, or sometimes these efforts are intended to help maintain the elderly in their own homes. As regards their economic status, these family caregivers are often granddaughters – women on parental leave. In addition to caring for their children, they take care of their grandparents. Mostly, they 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 of the grandparents. 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 a week, and up to 60 hours a week, on the care provision. This corresponds to approximately 8 hours of care every day of the week, with possibly more time allocated 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 caring for their parents. For the respondents in this group, the need to balance family and work life is most pressing. Their choice of strategies is determined by several factors. It is, in the first place, the nature of their working activities; that is whether they are employees working fixed hours or self-employed persons whose profession gives them more leeway in managing their daily schedules. The latter is seen as a huge advantage in the given situation, based on the assumption that contractual employment would not enable them to ensure the same extent of care. Another factor that appears to be decisive is the possibility

of sharing care with other members of the family. These are usually the carer's partner or children, but the respondents also reported agreements amongst siblings on joint or shared care for their parents. 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 respondents in this group of family caregivers confirmed that sharing care with other members of the family and with professional caregivers requires close coordination in practice. It is most often the family caregivers that become the key carers. A more long-term absence of the key carer, resulting for instance from increased workload or from a change of employment associated with a change in working hours, would necessitate the rethinking of the shared care model.

The fourth group are the family caregivers who basically secure the full extent of the caring tasks for the elderly, with a substantial time allocation. Ensuring care for their parents (or one of the parents) or their 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 the 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. The economically active man with an employment contract who combines his duties at work with care for his parents – both with decreased self-sufficiency – was unable to balance the care with his work commitments in his original job, yet for a long time was unable to find an employer willing to agree on mutually acceptable terms. In consideration of his family circumstances, he resigned from his original profession and started working night shifts in a local bakery.

> *"This is exactly where I had terrible problems, I mean finding a job. This came up, that the bakery opened up here. Well, it sure is a challenge. I'm telling you that I'm on my last legs on Fridays."*
>
> (man, 61 years, high-school)

The situation in this group of caregivers is made more complicated, firstly, by a poor offer of field-based services available locally. In the experience of the respondents, this is usually offset by various forms of neighbourly assistance. Secondly, the lack of information on the part of the respondent himself in terms of other local sources of help also plays a role to some extent.

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

Childcare

In the following subchapters we focus mainly on the key problems and deficiencies of childcare policies (including state as well as employer policies) and preferred and/or suggested changes in the perspective of families and their needs.

Services and benefits – (dis)satisfaction, key problems and deficiencies, ideal care policies

The 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 which is perceived (with reference to the mechanism of parental benefit calculation) as fair and the allowance itself is considered to be relatively generous or at least sufficient. Some female respondents, however, perceive it as an obstacle to work and family life reconciliation. Especially in the case when families are planning a second (or another) child and women have had a fixed term contract before the first childbirth. If, after their fixed term employment has expired, these women hold a part-time job while on parental leave, they are either ineligible for the maternity allowance (relates to second child) or the amount of the allowance is reduced. Thus they are in fact penalised for their work activity. Also, the change of the birth grant, which was paid more or less universally in the past but now is provided to low-income households only, was criticised because the child-related expenses of middle-income families are also high.

As the majority of female participants in the sample work while simultaneously receiving their parental benefit**,** they greatly appreciate

the possibility to take the parental leave up to the child's third year while working (for details on parental leave and benefits see Chapter 2). That is, to a certain extent, they perceive the parental benefit as compensation for part of income which they are unable or unwilling to receive from the labour market because of their childcare commitments. Also, the following attributes of the parental benefit are generally perceived in a positive way: 1) flexibility of drawing the benefit (there is a single total amount and several possible time-schedules/tracks); 2) possibility to operatively change the monthly benefit according to the current family situation; 3) possibility to take turns with the partner on parental leave or 4) using the partner's income in the assessment of the parental benefit.

However, some female respondents see a certain unfairness in the fact that when the family has another child shortly after the first one there is a time restriction to draw the total amount of parental benefit for the previous child and, in fact, the family loses a part of the parental benefit. From the viewpoint of some female respondents, it is also disadvantageous when the possibility of choosing a parental benefit depends on the previous income and the fastest drawing option is available only to parents with a higher income. This condition significantly discriminates against parents with low or no previous income and these parents are forced to remain outside the labour market for a long time and face all of the related negative consequences.

The assessment of the generosity depends on the importance of the 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 the 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 of parents in the sample.

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

The childcare services are perceived as maybe the most significant arrangement of the childcare and work reconciliation. The crucial question

of many female respondents is at what age is the child able to spend a part of the day without their family (parents and other family members). As was mentioned above, up to approximately the second year of the child's life, the families prefer individual care in the family or care provided by reliable nannies.

Putting the child at the age of 2 into a day-care facility is usually motivated (besides the work activities of the parents/mother) by the child's need to socialise and/or by the need to be gradually prepared for everyday attendance of kindergartens. The paramount requirement regarding the character of the care in day-care facilities is in the majority of cases the individual approach to the child and small groups of children (3–5 children). Nevertheless, the majority of female respondents did not want their children to spend too much time in the institutional childcare facilities. This wish corresponds with the preferences for part-time jobs after parental leave. However, in this respect they also emphasise the individual nature of every child; while some children are ready for stay in the group of children already at the age of 18 months, which is for other children a strain even at the age of four.

Discussing the system of public childcare services (kindergartens), respondents first mentioned the capacity problems for 3 to 4 year old children. In several localities (some parts of Brno but also municipalities surrounding Brno), parents have to apply to several different facilities without any assurance that the child will be admitted. In other localities, parents provide evidence that the availability has improved in recent years. However, some parents still consider the availability of the highest-quality public kindergartens to be relatively low. The quality of a particular kindergarten is assessed by the parents according to recommendations and the experiences of other parents, according to the approach of the teachers to the children and also to parents (the extent and content of mutual communication) and according to the offer and scope of the activities for children in the kindergartens (these are very diverse). Further, the parents require the possibility of part-time attendance of children (some kindergartens responded positively and some do not) or the need for longer opening hours in the case that parents work full time. Another important factor when choosing a kindergarten is geographical accessibility (either in relation to the place of residence or the place of work), with respect to the time lost commuting.

According to the parents' experience, the quality of public kindergartens varies despite the unified setting and regulation (see also Chapter 2). Almost all parents also pointed out that they found the children/staff ratio inadequate.

Concerning the kindergarten fee, all respondents perceive public kindergartens as very affordable and those who have had experiences with private childcare services consider the difference between the fees enormous or incomparable. In terms of the potential of kindergartens to help to reconcile work and family life, the question of when to return to work after parental leave was discussed in particular. Firstly, it is difficult to really plan an exact moment for the return because of the kindergartens' capacity limits for three and four year old children. The condition of starting the attendance from the beginning of school year is also problematic (e.g. the child is three years old in December but kindergarten attendance is in many cases possible no earlier than September of the subsequent year). This may result in a parent losing a job because of the expiration of the guaranteed job position (see also Chapter 2). Secondly, the parents also found the discrepancy between various durations of parental leave and availability of public childcare services problematic, as this often makes it impossible for them to decide on the length of their leave based on their own preferences. Thirdly, the fixed opening hours of kindergartens are not usually compatible with the work schedule of parents (including the time needed for commuting and the closure of kindergartens during holidays).

The availability of private childcare services (founded based on the Trade Law, children groups established by employers or other subjects and forest kindergartens) seems to be good according to the parents' assessment. The availability has improved, especially 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 attend the facility only several hours or days a week, when the parents feel that the child needs social contact and/or because of the work activities of the caring parent. 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 the individual needs of children (including e.g. dietary requirements), using more up-to-date methods to work with children and the client approach to parents. These attributes of private facilities consequently allow the parents to better balance their work schedules with the care for the child. On the other hand, the most salient problem is the cost of private childcare facilities, which seems to be too expensive even for the relatively high-qualified parents in our research.

> "*When one converts the salary into net figures, the result is that one works more or less to earn only enough for a childcare service. Of course, it has its benefits but it's not very encouraging.*"
>
> (university-educated woman, 2 children 4 and 8 years old)

Employers' approaches and policies

The employers' policies generally have a high potential to influence the strategies and practices of combining of work and care (e.g. den Dulk et al. 2010; Křížková et al. 2007). In spite of the fact that the majority of our respondents are able to arrange suitable family-friendly working conditions (e.g. part-time job, company children groups are available to 25 percent of families in the sample), they perceive it as something exceptional or non-standard. According to the respondents, Czech employers are relatively conservative and, speaking in general, they are not willing to offer part-time jobs and are a little bit reluctant to accept the work from home and other necessary work arrangements of parents. From this reason, some female participants are willing to accept a lower quality of job in exchange for the possibility to reconcile work and care for children. The children's groups established by parents' employers are also greatly appreciated. However, the general availability of these facilities in the CR is assessed by the respondents of our research (with regret) as being low. A parent-friendly atmosphere in the workplace (occasional presence of children on the workplace and family-friendly equipped offices) seems to be an important factor.

The approach of employers towards the caring needs of fathers (often either ignoring such needs or even very negative) is a story on its own. The parents agreed that a change in the overall employer approach to the support of parents strongly depends on the activities and (financial) support of the state (in particular related to promoting part-time jobs and children's groups established by employers), which the parents so far do not consider very strong or positive.

Innovations and suggested changes in care policies

The innovations suggested by parents in the sample included improvements to the existing in-cash and in-kind policies. The most important changes focus on the accessibility and affordability of childcare services for children up to 3 years of age, private childcare services supported by public budgets through direct financial subsidies (similar to public ones) and/or through new cash-for-care benefits for parents. Concerning public childcare services, there is a need to increase quality in terms of the number of children per worker, communication with parents, and the flexibility of opening hours. Company children's groups are also probably a solution to the affordability problem of private childcare facilities (usually, the employers partially subsidize their operation) and allow the parent to save the time needed to accompany the child to the facility, as these children's groups are often located directly at the place of the parent's work.

Suggested changes to the parental benefit should 1) allow parents to draw the whole sum of the parental benefit for each child, irrespective of the presence of other children in the family; 2) prevent economic discrimination against mothers who have another child and who work during their first parental leave (resulting in lower earnings and reducing the amount of their parental benefit) and 3) shorten the minimum period for drawing the parental benefit to one year.

Key suggestions also focus on family-friendly as well as gender-egalitarian policies of employers. Parents in the sample find it necessary to have access to part-time and other family-friendly flexible work, and this is dependent mainly on the will of employers. Nevertheless, the role of the state and its incentives to employers is also emphasized.

Eldercare

The demographic changes mentioned above are increasingly becoming a subject of public debate. The coupling of falling birth rates with rising life expectancy is significant for economically development countries. These trends pose new challenges for social policy. From a social policy point of view, the key problem is to find a sustainable balance between contributions and benefits as well as to adapt public policy to the structural changes in the family; some of these include compatibility between family and employment, reduction of family caregivers poverty as well as an expansion of the service sector (Blome et al. 2009).

Services and benefits – (dis)satisfaction, key problems and deficiencies, ideal care policies

As regards the financing of care, most respondents in our sample had experience with the care allowance (see Chapter 2). The care allowance is appreciated and seen as 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. An exception, in this respect, are the respondents who are professionally involved with the social sector and are familiar with the agenda. The family caregivers presented a variety of opinions on the costliness of the provided care, in dependence on the financial situation of the elderly relative (the level of pension), as well as the financial circumstances of the family, and, most of all, on whether the granted level of the care allowance corresponded with the real extent of needs that had to be accommodated through assistance.

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 will not be sufficient, yet it would either be 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.

"It can be done and, this is silly but I'll say it like it is. When there's money available, then it can be done. When grandma has the fourth degree of some support, then we can have the domiciliary care service, we can have the neighbour. I think that if there wasn't the financial support from the state, it would be a real problem."

(woman, 39 years, university-educated)

On the whole, the provision of care seems to be a factor that deepens economic insecurities faced by the households. According to the caregivers in our sample, it does not pay economically to provide care. It is the family ties and commitment to sustaining these ties that provide important incentives for caregiving. The households' financial strains worsen, and they have to adjust their spending priorities, as the household incomes often do not suffice to cover necessary expenses. Some of family caregivers compensate for their earnings-related insecurity by self-employment, which, however, involves insecurities of a different kind, linked to the shape of the economy.

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, while the need may arise unexpectedly, for example when another family member is taken sick and the caregivers find themselves in difficulty with time management, where the solution was a supported living setting with in-house domiciliary care service and intensified assistance from professional caregivers. Lack of flexibility, time flexibility in particular, in the provision of social services has received criticism.

In addition to the care allowance, also other forms of assistance are largely appreciated by the caregivers. These may concern managing health risks (positioning beds, cushions for preventing bedsores), overcoming architectural barriers (stair lifts, ramps, carriage and load-handling devices) and supporting mobility (wheelchairs, cars). Again, the procedural demands of applying for various medical aids, particularly those provided and covered by the General Health Insurance Company[2], including maintenance, service and necessary technical exams have received criticism.

[2] This is the largest health insurance company in Czech Republic providing private and public medical plans. Almost 6 million clients are covered by this health insurance company. The expenditure is 160 billion CZK per year.

Employers' approach and policies

In respect to 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 in our sample.

The first type of strategy consists of those family caregivers who act as a secondary source of care provision for their elderly relatives. The primary resources are 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 respondents justify the choice of this arrangement combining 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. On the other hand, the family caregivers reflect on the limitations of the domiciliary care service, in that it does not have the potential to secure 24/7 (permanent) care, not even for the inhabitants of these apartments in the supported living setting. Their involvement in the provision of care helps a great deal in delaying the need to place their loved 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 second type of strategy is represented by a broad group of family caregivers who act as the primary resource for 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, however this formal care is rather complementary in this case. The scope of the formal care and the type of services used depend on a number of factors. Among them, the most decisive ones are the health condition 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, family care is typically combined with a day-care centre, provided it is available locally. Where self-reliance is affected due to impaired mobility and the physical ability of the elderly, the most common scenario is a combination of family care and field-based

services or, more specifically, the domiciliary care service delivered to the elderly client's own home. An important factor conditioning such an arrangement of care is a high level of family cohesion and willingness of other family members to engage in the provision of care. However, this strategy appears to be challenging both in terms of other activities of the family caregivers (hobbies, social life, health prevention), but mainly in terms of balancing care and work commitments, especially in the case of those family members who have the role of the key family caregiver. Almost all the respondents 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. The family caregivers ponder over the possibility of placing their elderly relative in a care home and some of them have confirmed that they have enquired about the availability of this type of service in their surroundings.

The third type of strategy consists of the family caregivers who secure care without the 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 is poor orientation in the offer of professional help or possibly the lack of local availability of such help. This applies particularly to rural areas where such services are absent, or where there is a huge excess of demand, or where the offer of assistance does not intersect with the needs of the family caregivers.

> *"I approached the charity and was told they didn't have any capacity, so they put me on a waiting list. And the lady said that the Red Cross was also full. That's about it, no more possibilities there in the village. In a city like this there are more organisations that deal with it, but not in the village."*
>
> (woman, 47 years, high school)

In these cases, it is extremely difficult for the family caregivers to harmonize caregiving with professional commitments and, much like the situation for the previous group, applying for a care home is the first strategy considered when their relative's health deteriorates.

Innovations and suggested/preferred changes in care policies

What can be considered a relatively serious finding is the low familiarity of the family caregivers with the system of social services and with other available support resources, mostly including the above-mentioned care allowance. The respondents who are well orientated (or better oriented) with regard to the structure and offer of professional care are an exception, given their education or professional involvement in the social sector. An arrangement where care is shared with professional service providers who can pass on necessary information is beneficial in this respect. This applies particularly to elderly people living in supported housing with in-house domiciliary care services. Social workers from municipal offices, for example, were not spontaneously mentioned among sources of information by the surveyed family caregivers. The respondents did not prove familiar with the planned changes to the national policy either, such as e.g. the carer's leave currently under consideration. Some of the respondents were not even aware of the indexation of the care allowance. 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.

Conclusion

Concerning the families with children, we can conclude that Czech childcare policy predominantly supports the traditional model breadwinner-caregiver, typically until the child is 3 years old (with a marginal or lower level of the engagement of men in caring compared to women, long parental leave, lack of childcare facilities for children younger than 3 or even 4 year old, and complicated access to part-time and flexible forms of work). Generally, the parents in our research are rather satisfied with longer parental leave, even though many of them simultaneously work.

In such cases, their work activity is rather voluntary and the parents have a larger manoeuvring space to fulfil their needs and the needs of the child (e.g. if they do not find a job which would adjust to them they reduce or postpone their work activity but at the same time, they have a guaranteed income in the form of parental benefit). Also the flexibility of drawing the parental benefit definitely contributes to greater parental satisfaction, as it allows them to adjust the income and duration of parental leave to a changing individual family situation. But on the other hand, some parents point out the imperfections of the system, which restricts them from their preferred combination of work and care. Most of the parents criticize the unfairness in access and entitlement to the parental benefit in the case of more children and/or the low earnings of parents. Families living on one wage and/or who have more children perceive the level of the parental benefit to be rather low. Mainly parents heading toward a more equal division of care and paid work emphasize poor access to childcare services/facilities for children under 3 years as one of the most important deficiencies in the childcare system. However, it is not preferred to bring children into collective facilities until they are at least 1.5 or 2 years old. Further, they preferred small groups of children and part-time attendance. The problematic or variable quality and flexibility of childcare services and the financial unaffordability of private facilities are also criticized. The most of parents are fundamentally dissatisfied with the general approach of Czech employers who offer an insufficiently small number of part-time jobs and other family-friendly measures (including family-friendly company culture or the team and work place atmosphere etc.), which is, in their opinion, caused by conservatism, prejudices and also by insufficient state support. The majority of our female respondents have been working or worked for an employer with a relatively forthcoming approach but, based on their experience, they consider it to be 'luck' rather than a general trend in employer policies.

Care of the elderly is a still-evolving part of life. The focus on context helped us understand, support and learn from the ways that families meet the challenges involved. As we could recognize, families are willing to take care of their older relatives but they have limited resources and abilities to provide care, especially as the disability of the older person becomes more severe. The interviews with family caregivers suggest that the question of reconciling family and professional life is largely seen as

secondary when the need for care first arises. If close family members face a situation in which they require regular assistance, the family commits themselves to meeting this need. It is only when the elderly relative's self-sufficiency worsens and dependence on assistance by another person deepens that the family caregivers feel the pressure and that the need arises to reconcile their role as caregiver with their professional careers. There may be different reasons for this – caregivers with higher education may be concerned about their career slowing down or about their business declining; caregivers in localities with higher unemployment rates or caregivers approaching the pensionable age may be faced with the risk of losing their job; or their job requires that they must be at work at fixed hours. The solution is often found in combining informal care with professional assistance in the form of social services. The level of intensity of such cooperation is determined by a number of factors, for example the financial affordability of professional assistance, that is, whether the elderly client has been granted the care allowance at a level corresponding to his or her condition, and whether the elderly client and the family possess other financial resources. Family caregivers sometimes gave explicit, but mostly implicit, accounts of the limited opportunity for field-based services to provide comprehensive assistance and support to elderly clients with a wider spectrum of needs. Those family caregivers for whom field-based or outpatient services are not available find themselves in the most complicated situation and under the greatest pressure. In these cases, accommodating the elderly relative's needs requires either intensive involvement of other family members, or changing a job to allow for regular day care, switching to part-time hours at work, giving up one's job, or a combination of all of the above. Where these measures fail or where coordination of care among family caregivers and professional providers fails, the usual strategy is to secure a place in a residential facility.

The interviews with family caregivers in our sample have revealed that we need to have appropriate support and services available to meet family caregivers' as well as older people's needs and a more thoughtful conception of collaboration between family caregivers and professional care providers that helps people balance the care and their personal lives, including their labour market participation.

When comparing the childcare and eldercare systems, we can see some similarities. In both fields, family/informal care is the prevalent

form of care. Nevertheless, almost all families expect and need the help of the welfare state in some aspects. Support from the caring policies is often lacking, not only in terms of financial and/or (professional) services, but also in terms of relevant and reliable information. The standard paid work requirements are often not very compatible with more demanding caring commitments, since flexible work arrangements and other care-friendly measures are not generally available. This causes either a double-burden on caregivers or the necessity to change work/profession or a temporary leave from the labour market. This concerns mainly women, as they are usually the prime caregivers (maybe more often in childcare than in eldercare). Thus, the need to share the care responsibilities of the prime caregiver (with other family members and/or other actors in caring policies) is obvious. Our findings about the work-family balance issue also indicate that parents of small children express more expectations toward employers' care-friendly approach in comparison to those who care for the elderly, who do not criticize employers directly in interviews. It is possible to offer the explanation that the topic of reconciling work and eldercare is not often publicly discussed, in contrast to the childcare field. However, this can be caused also by the specific composition of our research sample.

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CHAPTER 6

Balancing acts: Policy frameworks and family care strategies in Norway

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Introduction

What is the practical and emotional reality of combining paid work and care in a highly developed universal welfare state with high levels of employment of women and strong institutional and ideological support for the dual earner–dual carer model? In this chapter we explore this question using Norway as a case, and drawing on qualitative interviews with both parents of young children and adults who have care responsibilities for older family members or relatives.

In Norway, both children and elderly persons are entitled to substantial care services. Yet combining paid work and care while ensuring the quality of care provided and quality of life for those cared for as well as for the carers is not without challenges. Solutions rely on adaptations of paid work, welfare services, and care as well as on the micromanagement of separate, overlapping, and sometimes incompatible demands on time, space, and effort in everyday life.

Seen from within the family, caring for a young child and caring for an elderly spouse or parent are in no way identical tasks and fields of responsibility yet they do have some aspects in common. In this chapter, we direct attention to the strategies, experiences and reflections of individual people using available care services combined with family based care for children or elderly family members. The comparison of the two different care fields allows us to discuss families' practices and reflections in light of existing care policies and to highlight unmet needs, paradoxes, and tensions.

In order to compare the practices pertaining to these two quite different fields, we will apply the caringscapes/carescapes approach proposed by McKie et al. (2000, 2002), developed for studying caring practices in context. This enables us to investigate and compare family care strategies

systematically between the two care fields in question, and to indicate how differences and similarities are embedded in policy frameworks with specific histories and rationalities.

The co-development and interlinkages of gender equality policies, family policies and labour market policies are important in understanding the current work–family configuration in Norway (Bjørnholt 2012; 2014). Reconciliation of work and care in Norway is facilitated by the availability of paid work due to low unemployment and the relatively short working hours. Formal working hours are 40 hours per week; due to collective agreements, most Norwegian employees work 37.5 hours. As regards care for children, in addition to paid parental leave, working parents are also eligible to entitlements in the workplace such as part-time work and fully compensated leave to care for sick children. When it comes to workplace adaptations and eldercare, a fragmented and little used range of small measures reflects that families have no universalised rights corresponding to those in the childcare field.

The caringscapes/carescape approach: Caring and working in time and space

The concept of caringscapes was first launched by McKie et al. (2000, 2002). It has been elaborated further by the original authors and co-authors (Bowlby et al. 2010; Bowlby 2012) and has also been adapted across a wide diversity of fields as a tool for exploring 'the time–space links between the processes producing policies and services and those affecting individual behaviours' (Bowlby 2012: 2101).

The caringscape metaphor encourages the study of care as 'social processes in both time and space' (Bowlby 2012: 2114). Caringscapes can be thought of as the shifting and changing multi-dimensional terrain that comprises people's vision of caring possibilities and obligations: routes that are influenced by everyday scheduling, combining caring work with paid work and the paid work of carers (McKie et al. 2002). People create routes through a 'caringscape', which changes and evolves as they move through their lifecourse.

While the early caringscapes approach focused on how individuals organise their caring activities in time and space, the carescape concept,

added later, draws attention to the 'external' context or structure, in terms of the resources and services that shape the individual caringscape 'terrain' (Bowlby et al. 2010:151). The carescape of a particular society encompasses the level of services as well as prevailing political and social ideas about care. The approach underlines the importance of viewing concrete care policies in their wider historical and cultural context, as well as viewing care practices as imbued with memories, anticipations and speculations, policy and service dimensions, and political and social ideas about care.

We will employ the caringscapes/carescapes approach as a sensitizing concept that facilitates looking at people's practices and strategies of combining paid work and care, related to the institutional and employer support available in the two care fields, and how people navigate emotionally and morally in their practical adaptations.

Childcare: changes in services and entitlements

Norway provides strong institutional support for the dual earner–dual carer model for parents of young children. This support was strengthened in a series of reforms during the 1990–2000s, including successive extensions of parental leave and the paternal quota in particular, and expansions in the kindergarten sector. Today parents are entitled to 49 weeks of fully compensated parental leave of which both parents are entitled to a 10-week non-transferable quota. The policy package for working parents supports a particular model of 'serial' organization of early childcare (first mother, then father and then formal child-care, see Stefansen and Farstad 2010).

The normalisation of institutional childcare for children below three years is of recent origin (Stefansen and Skogen 2010). Throughout the 1980s and 1990s, Norway lagged behind the other Scandinavian countries with a substantial 'childcare gap' (Ellingsæter and Gulbrandsen 2007). The closing of the childcare gap was a result of the historic parliamentary agreement in 2003 that secured several reforms, including a low maximum price, and a substantial expansion of places and facilities and an ensuing legal right to kindergarten[1] from age one from 2009. As a re-

[1] We use the term 'kindergarten' in this book, well aware of its connotations in many

sult, the care arrangement for young children in Norway changed rapidly from informal to institutionalised care. In 2014, 80 percent of children aged 1–2 years and 97 percent of children aged 3–5 years attended formal childcare (SSB 2015). Maternal employment followed suit: mothers return earlier to paid work after birth and an increasing percentage of mothers work full time (Rønsen and Kitterød 2012).

The dual earner–dual carer model also enjoys strong ideological support. It draws on a conglomerate of interlinked ideas including the importance of paid work for women's autonomy and the value of and need for a father's involvement in early childcare for several reasons (child development, fathers' emotional well-being, gender equality in the family and vis-a-vis employers (see Haas and Rostgaard 2011; Eydal and Rostgaard 2016; Rege and Solli 2013). It is also supported by cultural ideas of a good childhood and a competent child that thrives in and benefits from formal childcare from an early age (Kjørholt and Qvortrup 2011; Seeland 2011).

Eldercare: changes in services and entitlements

Public eldercare services may be regarded as a major innovation in terms of the strong growth of municipal homecare and institutional care services in the 1970s. The expansion of these services was a response to some of the most crucial challenges that society faced at the time: the dramatic rise in the number of elderly and the need for gender equality in the family and working life. From around 1970, the main building blocks of the current system were in place, with a subsequent expansion in 1970–1985. In this period, the 'volume of nursing homes, home nursing, and domiciliary services more than doubled' (Daatland 2015: 9). Nursing homes saw a decline of about 25 percent between 1995 and 2010; this decline was nearly outweighed by a corresponding increase in assisted housing. Notably, there has also been a de facto decline in home services, from 58 percent of the 80+ population receiving such services in 1995 to 50 percent in 2009 (Daatland 2015).

countries to pre-school programmes for 5–6 year old children. In Norway, the universal model of ECEC means that there is no distinction between 'kindergarten' and 'nursery' or 'crèche'. The term 'kindergarten' is used in official documents as a literal translation from the Norwegian 'barnehage' that encompasses all age groups 0–6 years.

With the Decentralisation Reform in 1986, legislative changes delegated the responsibility for a wide range of services to the municipalities. The aim was to offer people a health care arrangement where medical treatment, rehabilitation and care were woven together in a cohesive continuum. After this reform, municipalities had to pay more attention to cost control, and policies stressed awareness of local problems, flexibility, proximity, and user participation (Vabø 2011). Accordingly, home services, which were previously divided into two segments—home help and home nursing—became more or less integrated. Thus, it was argued that the role of home care had changed from a preventive role stressing practical and social care for elderly with moderate care needs towards a more medicalized role providing personal care and nursing care for the most frail, disabled and chronically ill among both old and young people (Vabø 2009).

As argued by Gautun and Bratt (2016), there is a structural problem in eldercare as institutional care has been considerably reduced while home care services have not only not been increased accordingly, but have also effectively been reduced (cf. also Daatland 2015 cited above). This creates a gap between the care needs of elderly persons living in their own homes and the capacity of the home services. Family members and daughters of elderly people in particular feel obliged to try to bridge this gap, in spite of having no legal duty to do so. Øien (2016) has shown that, contrary to the general policy argument, better access to home care services leads to *more* frequent use of hospitalization: more home care implies medicalisation of ailments otherwise understood as normal aspects of aging. While the main policy argument that we have encountered in INNCARE for strengthening homecare services is that more homecare leads to a lower need for residential care, the two arguments are related. Both are rooted in the perceived need to strengthen homecare services because of the growing proportion of elderly persons, where the continued operation of residential care at today's rate is unsustainable in terms of cost and labour.

Methods and samples

For the analysis of care practices related to young children below school age, we draw on interviews conducted both as part of the INNCARE

study (2 interviews, 6 participants) and the EFFECT study[2] (7 interviews, 17 participants). The two studies used the same strategy for accessing participants and the same interview methodology and interview template and we treat these interviews as one sample for the purposes of this chapter. In total, the sample consists of 23 participants, 10 women and 13 men. Participants were recruited primarily from three types of work places: academic institutions, service institutions, or health care institutions. This gives some variation in the sample in terms of work flexibility, with academics enjoying a higher degree of freedom in terms of work presence and work content compared to the rest of the sample. The participants were interviewed in groups of 2–5. The interviews were semi-structured and revolved around childcare policies, employer support, concrete childcare arrangements, and participants' ideas about work-life balance. The reader should keep in mind that our presented findings are not necessarily generalizable, but—as with all qualitative research—focus on the content of the interview material engendered by the researchers and the interviewees together and thus—in this case—on the meaning of policies and practices for the interviewees.

In the eldercare field, 17 interviews were conducted (6 group interviews and 11 individual) with 26 participants (3 men, 23 women). Three of the participants were elderly service users themselves, two using home care services and the third in sheltered housing for the elderly. The other interviewees were all close family or relatives of service users. Nine participants worked full time, four worked part time, eight had retired, one was unemployed and one was self-employed. Most participants were aged 50–60 and cared for parents or, in two cases, parents-in-law. Four participants cared for their spouses. 14 cared for a family member who used home care services, often combined with other services such as day centres, hairdressing services, physiotherapy, daytime rehabilitation services, short-term relief placements, etc. Five cared for family members

[2] The *EFFECT study: Enhancing the effectiveness of work–life balance initiatives use* was carried out in cooperation between Norwegian Social Research at Oslo and Akershus University College (Oslo, Norway), Policy and Social Research AS (Oslo, Norway), and the Department of Health and Work Psychology at the Nofer Institute of Occupational Medicine (Łódź, Poland). It was funded by the Polish–Norwegian Research Programme under the Norway Grants funding scheme. Grant number EOG78. The project is described in more detail in Bjørnholt and Stefansen (2017), Bjørnholt et al. (forthcoming) and Bjørnholt and Stefansen (forthcoming).

who were in residential care. The interviews were semi-structured and covered the main topics of type of service used, balance between daily life and caregiving, experiences with public services, and reflections on challenges, innovation, and solutions. Difficulties in recruiting participants resulting in a delay were eventually resolved through engaging a company specialising in surveys, interviews and focus group research. This company maintains large databases of contact information for persons who have consented to take part in their various projects and who are remunerated with gift cards.

The findings

To capture the lived realities of care responsibilities for children and old persons respectively the analysis below describes 1) family care strategies, 2) the perceived level of support from the welfare system and employers and 3) the emotional aspects of care arrangements.

Care strategies

Childcare

Bjørnholt and Stefansen (forthcoming) describe how couples with young children in Norway embrace the family policy measures offered them by the welfare state. Parents generally arranged their lives in concordance with the thinking that supports this policy package—they used the parental leave and the father's quota and enrolled the child in kindergarten after the leave. There was some variation related to the level of adjustment parents made in their work arrangement when the child started in kindergarten. In Bjørnholt and Stefansen (forthcoming), this variation is described as spanning from a neo-traditional arrangement (the mother adjusting slightly more than the father) to a gender reversed pattern (the father adjusting slightly more than the mother). A third prominent arrangement was the gender symmetrical arrangement, where both (or none) of the parents adjusted working hours or commitment after the child started in kindergarten. It is important to note that this pattern was based on snapshot pictures of work–family adaptations. We found that arrangements also changed

over time, and that they were the subject of reflection, renegotiation and open to possible changes in the future (cf. Bjørnholt et al., forthcoming; Bjørnholt and Stefansen, forthcoming).

The two 'family portraits' below, analysed in greater detail in Bjørnholt and Stefansen (forthcoming), represent the most common arrangements, the neo-traditional arrangement and the gender symmetrical arrangement.

> *The neo-traditional arrangement: At the time of the interview, Camilla and her husband Dag both worked full-time and their son had a full-time place in kindergarten. For them, as for the rest of the sample, having the child in kindergarten from age one was perceived as a natural thing to do. Due to work–family stress, Camilla had previously reduced her working hours as a researcher (to 80 percent) for a short period. This did not work out as planned, as she felt that she worked full-time but for lesser pay. They now managed because she split her working day into segments and worked weekends and evenings, while Dag made only moderate adjustments, such as taking turns working late and going home early to pick the child up from kindergarten.*

This arrangement is sometimes referred to gender 'equality light' (Skrede 2004), referring to the idea of gender equality as relating to exactly 50/50 equal sharing. What is more important here is the combination of a taken-for-granted gendered responsibility for adapting paid work to caring responsibilities—hence 'neo-traditional'—and the strong naturalisation of a particular work and care script—the dual earner–dual carer model, that Camilla and Dag's arrangement illustrates. This is even more pronounced in the case of Marcus and Nina described below.

> *The gender symmetrical model: Marcus and Nina succeeded in pursuing dual careers and sharing childcare and household responsibilities equally. They were both very absorbed in their jobs and also had a high mutual tolerance for working during evenings and weekends. A fulfilling working life for both parents was seen as non-negotiable for both. Formal childcare — kindergarten — after parental leave was also perceived as a self-evident part of the care arrangement.*

In conclusion, and particularly related to the academic group of parents, the dual earner–dual carer model seems to be taken for granted as a new normative order for family life: Parents' everyday adaptations are to a large degree directed towards combining paid work and care within the available structures. A few families however relied on regular informal support of grandparents or other family members. On the general level, the parents expressed that they lived 'normal' family lives and more or less the life they wanted.

Eldercare

For our participants, the amount of time spent on care provision ranged from daily contact and assistance to assistance twice a month. Most of our participants constantly adapted to the changing needs of the older person. Participants who had elderly family members in residential care spent less time on caregiving compared with participants whose elderly family members received home care services. For participants who cared for and lived together with their spouses, the geographical and emotional distances were negligible and one retired woman in her late 70s typically characterised caring for her husband as a '24 hour a day shift'. Several of the participants caring for a family member receiving home care services stated that they spoke on the phone at least once daily, and assessed the changing need continuously based on these phone conversations. Others had established weekly or more frequent visits, often at weekends, as a basic routine with added assistance or contact as needed. One woman reported that she had earlier visited her mother daily after work, but experienced ill health herself due to exhaustion and had to limit her visits to once or twice a week. Although she shared the responsibility with other family members, she still felt guilty that she could not manage to be with her mother more frequently.

Participants described their caregiving as both 'practical' (e.g. house cleaning, grocery shopping) and 'social' (e.g. visits, walks). Emotional care in the form of talking, or just 'being there', was an important part of the 'social' category, and one might sum up the two forms of care as 'doing' and 'being'. Types of help and care depended on the specific and changing needs of the elderly person, what type of welfare services the elderly persons received, and whether the participants had sole responsibility for care giving or if they shared responsibility with other family members.

For participants with elderly family members who used home care services, a bigger part of the total 'responsibility load' fell on the family, and most had to spend time on both practical and social care. Participants whose elderly family members were in residential care also had some practical tasks such as shopping or preparing special food, yet the amount of such tasks was smaller for this group. These participants spent more time on social or emotional tasks, especially on visiting and spending time talking with or being with the elderly person, either in their rooms or taking them outside. Some of these participants had experience with both home care services and residential care and a few of them described the transition from home care services to residential care as a positive one, even as a great relief. This was for instance the case for a woman in her mid-40s, who at the time of the interview had her mother in a residential care home:

> *"Now the situation is quite different. Now she doesn't need help, because she lives in a residential home and gets everything there. So, no; it's more the social stuff that I help out with. Well, I mean, of course I buy something if she [for example] needs clothes, but otherwise I now use most of the time on being present, visiting her there and taking her to the theatre and stuff like that. I would say that I normally visit her every Saturday and Sunday."*

While some participants shared the care responsibility for the elderly person with other family members, some reported having sole responsibility. Participants who shared responsibility with other family members organized care accordingly. Sharing responsibility gave the benefit of allocating tasks and problem solving between family members, depending on their respective roles and abilities and other parts of their daily lives. Participants who had sole responsibility for elderly family members often expressed that they wished they could have shared some of the responsibility with other family members. Being alone in care provision was described as hectic and stressful, leaving them with all of the responsibility and many tasks every week:

> *"I'm the only child left here [nearby]. And that's something that really makes an impact [on my life] (…) I have to do the shopping, I have to*

do all these little things. And of course, I do it happily, but I wish I could sometimes just go there, sit and talk for two hours, not 'you have to pay the bills' 'you have to do this and that'. So I'm the only one that helps out and does everything for her."

Some participants told us that they did have family members who might have helped out with care provision, but they chose to not involve them so as not to burden them with a responsibility they felt was mainly their own.

Family members who had no arrangements of sharing the responsibility with others and whose elderly dependants received home care services struggled to cope with demands from other parts of daily life. Individual strategies to cope varied, but the most typical response was to reduce that which was not defined as a responsibility to others, e.g. time to relax, exercise, go on holidays, or socialise with friends. Several noted with resignation that this priority was detrimental to one's own health, while they clearly saw no other available strategy. As we shall see below, only rarely did they rely on employers to adapt their work situation.

Perceptions of institutional and employer support

Childcare

The parents generally took the institutional support system offered them by the welfare state for granted. This applied both to the parental leave system including the father's quota and to formal childcare—kindergarten. Parents did not voice any concern that such measures could suffer cutbacks for instance during times of crisis. Some talked about how the system in Norway was generous compared to systems in other countries, stating for instance that the Norwegian parental leave scheme was the 'longest in the world'.[3] Some also compared the system today with the system available earlier when the parental leave was three months: 'You get spoiled, sort of, by having what we have.'

[3] Although Norway has a generous parental leave, it is far from the longest. In terms of combined length of leave and level of compensation, it is surpassed by five other countries, among them the Czech Republic (OECD 2015).

Very few parents were critical of the system offered them. One exception was participants who had a partner who was not eligible for parental leave, for instance because he or she was self-employed or a student. Further, some were unable to make use of entitlements due to a mismatch with other major life course events, such as transition from studies or temporary jobs to ordinary work, like Per:

> *"I was about to take paternity leave with the youngest one, but then I got a job in the newspaper, so then…Fulltime. Up till then, I only worked part-time and temporary. So, then we thought, here we are assured of income, so then it just turned out that way."*

Landing the new job was particularly pertinent, as Per's wife was not eligible for any paid leave, illustrating the structural limitation in access to paid parental leave due to the fact that it is derived from paid work. A few also talked about other aspects of inflexibility in the system, for instance that the father's quota could not be transferred to the mother or that they ideally would have wanted a longer leave for the mother or a longer parental leave period, for instance because returning to work early could interfere with breastfeeding.

Apart from concerns of the length and flexibility of parental leave, criticism also related to minor problems such as filling out complicated forms and understanding the somewhat complicated rules around the father's quota in the parental leave scheme: 'The first time I was on paternity leave. This thing about sharing the days and that. I did not understand it at all.' While being a rather minor problem, the complicated system also takes a lot of time for some. Brage, for instance, suggested that he and his partner had used approximately one week of the parental leave to talk to the welfare services about their rights and what to expect.

The general picture, however, was one of a system that accommodated most parents' needs. A few parents offered very positive evaluations of the system, such as Marcus: 'For people who are employed it is an incredibly flexible system. I don't know how you can design a more flexible system.'

Among the academics in the sample, employer support seemed also to be taken for granted. Several of the participants who worked in research institutes or at a university referred to their employer and type of work as generally flexible—such as Knut:

"And one of us picks them up quite early then, compared to many others, which is possible because we both have employers who are very flexible with office times, to put it like that."

He also found employer flexibility to be high in the private sector, referring to his friends and acquaintances working outside of academia: 'Even in the competitive part of the private sector it seems fine to organise, reorganise your days so that it is possible to stay at home one day a week for instance.'

His own employer had also been very helpful in arranging all the practicalities around his paternity leave. He had some trouble with forms but the employer relieved him of the responsibility: 'They said that, no, we will fix that. This is no problem, just go on leave, relax, we will fix all of it.' Brage had similar experiences. His boss summoned him to a meeting to discuss if there was anything he needed after the child was born, for instance to leave earlier in the afternoon. Related to minor and practical issues, parents in service and care work had the same experiences of the employer being very helpful.

Employer flexibility could not be taken for granted among non-academics. Gunhild, who worked in a shift based service organisation, explained how the principle of seniority in shift allocation could be problematic: 'You have to have worked here a few years to get the shifts that corresponds with the life you have at home.' At the same time, she offered that it was no problem to leave work to pick up a sick child from kindergarten. She had also had positive experiences with her employer in returning to work after parental leave and during her pregnancies.

Eldercare

There is no integrated, universal and extensive framework for people who care for elderly family members corresponding to the institutionalised childcare system. Cash benefits are limited and little known and none of our interviewees reported using or having tried to apply for such benefits. The range of more widely available services targeting elderly in need of care includes a large number of specific services such as transportation, respite services, dentistry, foot therapy or day care centres, that each require separate applications. As families are not legally required to care for their elderly, employers are not formally required to

facilitate or adapt to the needs of employees who are caring for elderly persons.

In sum, family members providing care for elderly persons cannot take anything for granted as regards institutionalised support for their experienced caring responsibilities. It was not surprising, therefore, that how the participants experienced combining paid work with having responsibility for an elderly person in need of care varied a good deal. Participants were asked whether provision of care to elderly family members affected their lives and whether they were of the opinion that there was a balanced relationship between public and private task sharing. Some participants admitted that it could periodically be stressful, but that they overall experienced the care giving situation as manageable and that the task sharing between public and private was satisfactory, in line with e.g. Hansen and Slagsvold (2015).

Some participants had positive experiences and described their workplace as flexible and of their employers as thoughtful and understanding. Several expressed that they would not like their caring responsibilities to affect their working life and careers, and preferred reducing their own leisure time rather than talking to their employers about what they experienced as a private problem. In doing so, they were protecting their own career and position in the workplace as well as the privacy of their elderly family members. Both these and some participants who had tried to appeal to their employers found the combination of employment and caregiving challenging. Two of the participants who worked part time at the time of the interview had negative experiences with previous employers, for one of them resulting in a situation where she had to use up her own days of vacation or annual leave for providing care to her father. When the other participant who was employed part time was asked whether her employer was flexible in respect to her situation of caring for a sick father, she responded:

> *"No, not at all. So I'm kind of relieved that I got sick, because then I 'got a kick in the pants' and got myself out of the workplace that I'd been in for 19 years. I really liked the job, but that was a management with zero empathy when something happened in [an employee's] life. I had to schedule all meetings with the municipality [care services] for lunch-time, in the early morning or after work. I had to switch shifts,*

and I couldn't say anything to my boss, because they didn't show any understanding and you keep thinking 'oh, what if I lose my job because it's too much', you know? And my mom could call me and say 'You have to come now, dad is going crazy!'"

When it comes to care for the elderly, then, 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.

The emotional aspect of caring and care arrangements

Childcare

Parents of young children conveyed a general level of satisfaction with the system and their employers' support. There is subsequently no major crisis relating to childcare.

Nevertheless, and as described in Bjørnholt and Stefansen (forthcoming), parents also voiced worries and ambiguities related to combining paid work and care and related to kindergarten facilities. These ambiguities were often subdued and muted, invoking feelings of strain and emotional stress rather than open critique of the systems and institutions in question.

Expressions of strain and ambivalence followed classed and gendered patterns. The shift workers predominantly discussed the organisation of childcare and paid work in practical terms, often relying on a naturalised neo-traditional model. They also talked about the child's need for postponing entry into kindergarten, using arguments of the child's need for a safe space and the mother-child bond, in line with the classed models of parenting that Stefansen and Farstad (2010) identified in a previous study.

Among the academics, both men and women expressed worries that can be seen as related to small deviations from the ideal of sharing (exactly) equally. Above we described the couple Camilla and Dag who practiced a neo-traditional arrangement, with the mother doing slightly more adjusting than the father. Still, Camilla expressed ambiguity. Camilla's reflections below illustrate the multiple, entangled emotional struggles involved:

"I tried, I reduced to 80 percent last semester. I did it for a few months. Because I felt very, I felt exactly that I was not really, that I did not really work 100 percent and that I was so guilty all the time, so I thought I try it somehow. So … (laughs) but it was such a discussion at home where, where my partner really, he did not understand. As I said, we have somewhat different attitudes (…), he has not, I do not think he has as much conscience like me for those things. However, it worked very badly because, (…) that semester I worked, I think I worked more than 100 percent because it was so incredibly busy then (…). I think I worked 100 percent then for 80 percent wages."

Camilla's explicit reference to 'being a woman and not a man' reducing work hours, is a strong indication of the cultural shift that has taken place, towards a full-time worker norm for mothers, at least among highly educated Norwegian academics. On the other hand, Camilla seems to think it would not have been shameful for a man to work part-time. Working part time does not seem to be an option for men however. Fredrik—also an academic—described his colleagues puzzled reactions when he had voiced the idea of reducing his working hours to 80 percent because of the stress of combining work and care:

"Then everyone I spoke to thought it was a bit like 'Huh !? Really, somehow?' I ended up not doing it then, just in reality worked less, instead of going down in percent. However, there were real reactions to it."

Fredrik resolved his work–family conflict by choosing to work less without reducing his formal working hours, expressing no conflict of conscience for doing so.

Among the men who took a larger responsibility than their partner for adapting paid work to care (practicing a gender reversed model), a few expressed ambiguities. This was often done in a joking manner: Erik who took a larger responsibility for everyday adaptations of his work to their caring responsibilities was not fully comfortable with this adaptation, as expressed (with a smile) in the following quote: 'I sometimes have to remind her that I have a job, too.'

Another area of ambivalence related to kindergarten. On one hand, kindergarten was taken for granted as part of work–family arrangements,

and most expressed overall satisfaction with the kindergarten: *'So, all in all, we are pretty much satisfied with the kindergarten. I'd give them—let's say, a four-plus out of six, over all.'*

Informants voiced several concerns regarding the quality of kindergarten and the amount of time children spent in institutional care. Berit looked back at the first kindergarten facility the family was offered, where she found both the building, the playground and the staff to be of low quality:

> *"When we had been there to look at it, I went outside and had a good cry. (...) And I thought: 'she can't be there'. And then she got a place in another one, luckily, and had a great time there."*

Across the sample, worries related to the time spent in kindergarten followed a gendered pattern, with mothers worrying more than fathers, as illustrated in the quote below:

> Christian: *"At least among us there is one [partner] who feels more... I mean, when I'm at work then I'm at work, and then I know when I'll get to kindergarten, but I think [partner] feels more and thinks a lot more that [our daughter] is small and goes to kindergarten, and if it goes well. She probably worries a little more than I do."*

While such worries were gendered, men, too, could express stress. However, parents did not seem to see any alternatives to sending the children to kindergarten. Either dissatisfaction with kindergarten was contained as feelings of emotional distress, or they chose exit strategies, moving their child to another facility. Stefansen and Bjørnholt (forthcoming) discuss in greater detail Norwegian parents' restricted sense of agency related to work-family arrangements.

Eldercare

Satisfaction with care provision was a recurring theme. The elderly service users themselves were generally satisfied with the services, while the relatives of elderly persons with need for care, on the other hand, had varying experiences. How satisfied they were with the services and the eldercare system in general seems to depend on which services the

elderly persons were using. We will focus on satisfaction with home care services and residential care.

Most of our participants had elderly family members who were using home care services. Satisfaction with the services varied; there was a good deal of dissatisfaction. Among the elements that contributed to dissatisfaction were the competencies and tight schedules of care workers and nurses, experiences with wrong medication, or insufficient or off-target help. Some also doubted their formal competence, suggesting that some of the carers were way too young and professionally inexperienced.

Several participants expressed that they felt individual needs were not met, as there was a high staff turnover, making it difficult to recognise and deal with the staff, and further, home care service staff, frequently of immigrant background, often had language difficulties. However, 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 or language fluency.

All of our participants caring for an elderly person in residential care seemed to be quite satisfied with this service. As mentioned previously, many of them described the transition from home care services to residential homes as positive, as being relieved of a burden. Having an elderly family member moved from their own house to residential care eased the carer's everyday life, leaving them with confidence that the staff could care for and assist the elderly with daily tasks. Family members also saw it as a great relief that the elderly were satisfied with the services themselves, thus mitigating the relatives' feelings of stress, inadequacy and worry. Nevertheless, even among those who were satisfied with the nursing homes, some had complaints, such as the technical-structural standard of the residential home, that the building was old, worn, not 'cosy', and a 'typical institution', and that staff was too pressed for time.

Beside the challenges with specific care services, participants reflected on challenges in the Norwegian eldercare system. For the elderly as well as carers, a major issue was the feeling of loneliness, a desire to for assistance in becoming more physically active (e.g. walking) and to have someone to socialise with. This was particularly the case for users of home care services. The wide scope of experiences with home care services reflects the fragmentation of this field, much less standardised and rights-based

and with much more extensive local and individual variation than in the childcare field.

Several carers also highlighted that as a relative, one had to be 'pushy' and unswerving in order to succeed in the complex eldercare field. Additionally, many participants found access to information quite challenging, resulting in a lack of necessary knowledge about services, options and rights. Several had opinions on possible improvement, such as the appointment of a 'contact person', more 'user friendly' technical systems, and better cooperation between different service providers.

Some participants also emphasized that the eldercare field's major issues should be seen in light of demands of efficiency and budgeting. A man in his 50s said:

> *"But I feel that…the municipality is always saving money, and that is also the case in the rest of society, in kindergarten and hospitals and other care services. They always want to save money, everything is measured in money, efficiency, and that's not in the patients' or the users' best interest."*

The elderly persons interviewed had little use for innovations in the form e.g. of computers. One had a tablet, provided by the municipal services, and stated that all she could do with it was to turn it on to see what to expect for dinner, and turn it off. She had not received any training on how to use it for anything else, and had no particular inclination to do so. Another explained that she could no longer use a mobile phone because her fingers were too stiff, and she had never used a computer. The third could not think of anything at all she could want except perhaps more of the services and care she already did receive.

The family members of elderly people in need of care had more to say about this, but innovation was not the first thing that sprang to mind. One of them knew a good deal about technological innovation in welfare, adding that she may have come across this information at work. She was less sure if any of these things would help her mother in her daily life. Another participant said that she would like to find out if her mother could have a stair glider.

Two participants talked about an idea of their own, for their own future older years. This entailed a type of housing where one could live together and share some things like a cafeteria and a common room.

The advantage would be being able to lead an independent life with easy access to old and dear friends, while at the same time sharing and having easy access to the needed care services.

According to the informants, caring for elderly family members could be very burdensome, sometimes affecting their physical and mental health and social life. This finding is consistent with other studies (e.g. Pinquart and Sörensen 2003; Verbakel 2014). Many participants were of the opinion that too much responsibility rests on the families, and that home care services and accessible benefits were not sufficient. The carers had to adjust their lives according to the elderly family member's needs, often resulting in little or no vacations or other time to relax.

For some, caregiving negatively affected their mental health. This was particularly the case for those who cared for a spouse or those who had sole responsibility for their parent(s). They described feelings of depression, anxiety, inadequacy and sometimes difficulties with sleeping. For some, these mental health symptoms impacted their physical health as well. A woman in her mid-50s, who cared for her mother with a dementia diagnosis, felt stressed most of the time. Although she generally had a very good relationship with her mother, all the caregiving sometimes affected her mood negatively:

> *"I get it all the time, and in the end I become so furious and then I let it…I don't hit her or anything like that, but sometimes I 'bite back' and say 'I can't take any more now, just shut up!'. So, it's rage and …"*

Several participants spent a good deal of time and energy worrying about the elderly family member. Here they were typically concerned about whether the elderly actually received what they needed from the home care services, if they got the right medication and/or if they had accidentally fallen and injured themselves. For participants who cared for an elderly person with memory issues (e.g. dementia and incipient Alzheimer's), they often worried about whether the elderly person had gone out on their own and thus might have trouble finding the way back home. 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 accidents from happening, the participants did not find relief in such welfare technologies. Even though the

amount of time spent on worrying about the elder does not manifest itself as 'physical time' spent on care, participants with such concerns described the time preoccupied with worrying as sometimes overwhelming.

For those who experienced the relationship between public and private task sharing as unbalanced, a recurring statement was that the public care system should take more responsibility, investing in more temporary relief for family members, more places in residential care or in sheltered housing, and so on. Such expectations and preferences are in line with studies that show how Norwegian attitudes to eldercare build on the premise that eldercare is a public responsibility, while childcare is more of a family responsibility (e.g. Daatland et al. 2012).

Concluding remarks

From the analysis of practices, support systems and the emotional aspects of caring for children and the elderly, we can discern two distinct contextual configurations or carescapes (Bowlby et al. 2010). In the following, we will reflect on differences between the two, which are important in understanding families' strategies and scope of manoeuvre related to childcare and eldercare.

For childcare, there is a standardised cultural script related to responsibilities and timing of transitions, which is supported by an extensive and integrated policy package, covering the time from birth to school-entry. This script draws on three different fields of policy-making and knowledge production; family and gender equality policies, labour market policies, and childhood policies, all of which are supported by ideas of what constitutes a good and proper family life, the value of paid work, the nature of employee-employer relations, and the discourse on involved fatherhood. These are all elements contributing to the dual earner–dual carer as a hegemonic ideal, fitting well with the emphasis of formal childcare (kindergarten) and early education for children's development and a good childhood. In conclusion, childcare in Norway takes place in the context of strong and coherent institutional and ideological support, prescribing a rather fixed trajectory with little need for improvisation. It is easy to access and the package offered satisfies demand. However, despite the eradication of the previous care gap, and despite the general accept-

ance and normalisation of the current model, in the everyday manoeuvring of combining care and paid work by using the institutional support available—at the level of the individual caringscape, to use Bowlby's (2010) metaphor—tension and ambivalence is also part of the picture.

Caring for the elderly, in contrast, takes place in a weaker and more fragmented policy context. Caring for the elderly is not embedded in different policy-frameworks regarded as contributing to a higher aim, like gender equality or the best development of the next generation. There are few entitlements available for carers, and while employers and workplaces are important in facilitating parents' caring, for people caring for elderly family members or relatives, there is no institutional preparedness in working life to facilitate the combination of paid work and care. There is, furthermore, less ideological consensus regarding what constitutes a good life for the elderly and the importance of this for other causes and for society as a whole. In addition, there are legal and relational differences between the two fields when it comes to the carer and the cared for. Unlike children, the elderly are independent subjects of their own, free to accept or reject the help offered. The carer will lack formal authority to act unless the elderly person is put under guardianship—a rare occurrence. Further, caring for an elderly parent will differ from caring for a spouse. While child-care is deeply intertwined with gender equality endeavours, caring for an elderly spouse is gendered due to demographics. Due to general age differences in marriage, women more often tend to care for an elderly spouse. When women become fragile, they are often widowed and must rely on public services, children or others. For adult children caring for an elderly parent, there are also gender differences: Berge et al. (2014) found that elderly who had daughters received less public assistance than elderly who had only sons. Compared to child-care, caring for elderly relatives relies more on improvisation and ad hoc measures. This is due to the lack of a coherent, universal and ideologically underpinned ready-made package of entitlements and ideologies in the field of eldercare, the lack of universally available structures of support for carers, as well as the diversity and complexity of the field and of the relations involved.

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CHAPTER 7

Work-family squeeze in Norway and the Czech Republic: On the prevalence and consequences of care and work combinations in two different contexts

Thomas Hansen and Jana Válková

Introduction

Population ageing profoundly changes the balance between generations in developed countries. Governments are responding with policies to promote active ageing (e.g. later retirement) and intergenerational solidarity (i.e. family care) (Daatland et al. 2010; Huber et al. 2009). However, these goals may be hard to reconcile for people in midlife who have to balance work and family obligations to parents or children. The plight of midlife caregivers confronted with multiple role responsibilities raises concerns over their psychological well-being.

In the academic discourse it is typically assumed that paid work adds stress to caregivers; that the combination of paid work and caregiving is a 'double burden' that harms health and well-being (Allen et al. 2000; Lilly et al. 2010). If true, this would also entail societal costs—for example, in terms of decreasing productivity and increasing work absence, disability, and health-care services. Whether being in paid labour exacerbates or alleviates caregiver distress is still an open and under-researched issue, however. For many caregivers work may offer much needed respite from the stresses at home, as well as important financial resources. More research is thus needed to better understand the psychological consequences of caregiving in the context of employment status.

Importantly, also, research should address the fact that the work-family nexus is structured by gender. Although growing female employment has challenged traditional gender roles, care for children and other family still is mostly understood as the responsibility of women, even in the egalitarian Scandinavian countries (Hansen and Slagsvold 2012). Many women are thus caught between contrasting ideals of a successful career woman and a caring and devoted mother. Female caregivers also may

experience more opportunity costs than male caregivers. Several studies show, for example, a motherhood penalty in terms of lower pay (Kahn et al. 2014; Gafni and Siniver 2015) and occupation status (Abendroth at el. 2014). Similarly, there is cross-country evidence that care commitments for frail elderly are negatively associated with women's labour market participation (Viitanen 2010). Importantly, however, such opportunity effects might be moderated by public policies. In Norway, for example, providing care for adult family members generally does not seem to reduce earning, work hours, or the probability of being employed (Kotsadam 2012). Such effects are only detectable for those involved in intensive caregiving (at least 20 times a month) (ibid.). This likely reflects that employee rights are more generous in Norway than in most other countries (Chung and Tijdens 2013), which may make it less burdensome to combine work and care. Even though there are no special arrangements to facilitate workers in their caring for a frail partner or parent, employee rights and arrangements that apply to all employees can make it easier to manage such a squeeze (Gautun and Hagen 2010). Similarly, it has been shown that with higher expenditures on public childcare, the need to compromise on employment is lower and women as primary caregivers may keep their occupational status whereas a cash-for-care scheme leads employers to discriminate against women due to lower stability and the expected lower productivity of the female labour force (Abendroth et al. 2014).

The fact that work-family impacts vary by both institutional and cultural context suggests the need for more comparative research. Comparative research is still sparse, however, and the available literature is largely based on the U.S. and other English-speaking countries (Goni-Legaz and Ollo-Lopez 2016). Caregiver distress and work-family conflict may be lower in countries where public support for care-intensive recipients is generous and readily available. The present article explores the implications of the squeeze between care (childcare and personal care to an adult) and work on psychological well-being in different policy contexts, comparatively with reference to Norway and the Czech Republic. These countries provide strong contrasts and make for an interesting comparison of effects of the childcare/eldercare burden combined with work on individual psychological wellbeing. We also explore whether part-time work has the same effects as full-time work. Regarding eldercare, we fo-

cus specifically on personal care, which, compared to practical and emotional support, is more intimate and comprehensive, and may impose greater individual costs (Borg and Hallberg 2006).

The well-being consequences of caregiving

Childrearing

Thomas Hansen (2012), in his article 'Parenthood and happiness: a review of folk theories versus empirical evidence', reviews research findings on the effect of having children on well-being in different countries. He shows that most cross-sectional and longitudinal evidence suggests that people without children are as happy as or even happier than are parents. These findings reflect the strains of caring for young children and the costs for marital and financial well-being, and restrictions on employment and leisure activities. Not surprisingly, the emotional impact of dependent children is more negative for the social categories that generally experience the most burdens and challenges of having children: women, singles, lower socioeconomic strata, and people residing in societies with less pro-natalist policies, especially when these characteristics are combined.

Effects vary in predictable ways according to levels of state-based supports to young families, and gender equality in work and domestic roles. Of the OECD countries, the Nordic countries have the most extensive and the U.S. the least extensive support to young families (such as available and affordable day-care, flexible work schedules, job leave security, cash benefits, and paid parental leave) (Gornick and Meyers 2008; Ray et al. 2009; Save the Children 2010; UN 2009). Because family-friendly policies are designed to facilitate dual-earner families and father involvement in childcare (Crompton and Lyonette 2006), men assume a larger share of childcare and domestic work in the Nordic countries than in other Western countries (Geist 2005; Hook 2006; Smith and Williams 2007).

Country differences in the emotional impact of parenthood suggest that culture and policy may shape the balance of rewards and costs associated with parenting. In the Nordic countries, the effects of having children are either neutral or slightly positive (Hansen 2012). Also, and

in contrast to much of the literature, Nordic studies find no vulnerability associated with raising children in unpartnered or low socioeconomic groups. Having dependent children are, globally, associated with substantial detriments in financial satisfaction and marital satisfaction, also in longitudinal data (in the U.S.) (Angeles 2009), but not in the Nordic countries (Hansen et al. 2009; Savolainen et al. 2001).

Care for adult family members

A voluminous multidisciplinary literature exists on the association between family caregiving and psychological outcomes (for a useful review, see Pinquart and Sörensen 2011). Two meta-studies of 228 (mostly U.S.) papers examine the relationships between caregiving and well-being (Pinquart and Sörensen 2003a, 2003b). The studies show that caregiving is related to a reduced subjective well-being and more depression and psychological distress. Moreover, caregiving typically has a more adverse emotional impact on women, perhaps because women provide more care in general and more personal care especially (ibid.).

Again, adverse effects seem to be weaker in stronger welfare states. Norwegian data suggests that the effects of providing regular personal care are quite small unless the caregiver shares a household with the care recipient. Providing regular personal care to a partner is associated with adverse effects across psychological outcomes (life satisfaction, depression, and loneliness) both cross-sectionally and longitudinally, and for men and women alike (Hansen and Slagsvold 2013). Providing such care to a live-in parent has the same adverse effects, but only among women. Providing regular personal care to an out-of-household parent is largely unrelated to well-being (Hansen et al. 2013).

Blending the caregiving role and the employment role

Different theoretical perspectives offer conflicting views on whether being in paid work is beneficial or harmful to caregivers' well-being. The role strain hypothesis (Goode 1960) and role conflict theory (Biddle 1986) argue that the conflicting expectations and demands that accompany different roles may lead to poorer physical and mental health. In-

deed, employed caregivers report a number of ways in which caregiving responsibilities have negative impacts on their work, such as time lost from work, decreased productivity, missed career opportunities, unpaid leaves of absence, early retirement, and decreased lifetime earnings (Edlund 2007). Similarly, in a Norwegian study of working parental caregivers aged 45–66, 57 percent reported problems in combining employment and care for older parents during the previous year, with 20 percent absent from work for a period for this reason (Gautun and Hagen 2010). The most frequently reported effects of care obligations on their work were irregular attendance at work, poor concentration, and being prevented from participating actively in social and career-promoting activities. In a Canadian survey, virtually all employed caregivers state that the need to balance work and eldercare has negatively affected their mental health—causing worries, anxiety, stress, and depressive symptoms. One in four also report that the demands placed on them by the two roles mean that they have little time for themselves. Almost three-quarters of the employed caregivers note that their working role has caused them challenges at home—for example, that their family and home life has suffered from a lack of time and/or energy (Duxbury et al. 2009). Women have been found to be more likely than men to experience conflict between work and family care responsibilities (Fredriksen and Scharlach 1999). This difference may be a result of the unequal division of family responsibilities and sex role expectations and socialization (ibid.).

By contrast, role accumulation (Sieber 1974) or social roles theory (Thoits 1983) argue that being involved in multiple roles can be beneficial to subjective well-being. These perspectives argue that juggling work and caregiving roles may be beneficial because of positive spillover effects between roles. For example, adding the worker role may be beneficial because it provides financial resources, social support, and increased self-esteem and a sense of competence, which may enhance well-being in the caregiver role (Barnett and Hyde 2001). Conversely, satisfying or rewarding aspects of the caregiver role, such as an increased sense of mastery or self-esteem, could help to offset the effects of stress at work. Furthermore, if strain is experienced in one role, this may be alleviated by success in another, or one role may offer respite from more stressful roles. For example, work may provide caregivers with respite from stress at home.

Supportive evidence for the role-enhancement perspective comes from emerging literature indicating that employment can be beneficial to the well-being of informal caregivers. U.S. data show that employed caregivers tend to experience less caregiver strain and better mental health and well-being than their non-employed counterparts (Coughlin 2010). The level of work involvement may also matter. In a U.S. study of 118 employed women, greater time in work was found to buffer women from the negative effects of caregiving stress: greater caregiver stress was associated with poorer physical health, greater depression, and less positive affect among women with a low number of working hours (< 27 hours/week) and not among women with a high number of working hours (> 45 hours/week) (Martire et al. 1997).

The role of cultural norms and institutional frameworks: The cases of Norway and the Czech Republic

The prevalence and implications of various work-family role configurations may vary between countries because of differences in demography and cultural (gender roles) and institutional framework (workers' right, health care systems). Perhaps the perceived stress of a role or a role combination lies not in the role obligations themselves, but in the extent to which they are expected (normative) or supported (institutionally) (Daatland et al. 2010).

We expect a lower level of conflict between work and family demands in regimes in which the state provides the means for combining these two competing activities. More specifically, arrangements such as childcare services, paid leave with job protection after childbirth, extended and flexible parental leave schemes, and flexible working hours may increase reconciliation of work and domestic life (OECD 2011). Weak family-oriented policies and the lack of institutional arrangements designed to reduce conflicts are likely to increase the sense of imbalance, especially among full-time working mothers. The perceived conflict may also be higher when the children are young, since care arrangements for children are not well developed in these settings, especially for very young children, but also for children of school age.

Norway

The Nordic countries are characterized by universal and relatively comprehensive public care services (Hvinden 2010). In the Scandinavian countries, a variety of reconciliation policies can be found that facilitate the combination of participation in paid employment with private life, including high-quality publicly funded and universal care services for children, and parental rights, such as generously paid parental leave. Welfare supports extend to family supports, and the Nordic states all rank high as far as support for the 'dual-earner' family model is concerned, with good provision of public day-care services and eldercare, as well as paid parental leave and caring entitlements (Korpi 2000).

Furthermore, intensive caregiving by family members is largely voluntary and generally combined with assistance from public care services. Caregivers may thus feel that support is available should they feel overwhelmed. Also, it is mainly practical help and emotional support that is informally provided. Personal care (e.g., help with dressing, bathing, eating) is usually the responsibility of the public services in Norway.

In addition, employee rights are more generous in Norway than in most other countries (Chung and Tijdens 2013), which may make it less burdensome to combine work and care. Even though there are no special arrangements to facilitate workers in their caring for a frail partner or parent, employee rights and arrangements that apply to all employees can make it easier to manage such a squeeze (Gautun and Hagen 2010). For example, the Nordic countries have relatively flexible work arrangements in terms of working hours.

In the Nordic states, state support for dual-earner families has been accompanied by efforts to encourage men to undertake a greater share of domestic work, particularly in respect to childcare. Service provision in eldercare also facilitates employment in Norway – 80–90 percent of 35–45 year olds who provide care for an older family member are in paid work (Daatland et al. 2010). The best overall work–life balance is reported by Scandinavian men and women (Lunau et al. 2014).

The Czech Republic

The Czech Republic has a high employment level of women compared to

many other European countries, however, the policy support in caregiving in both child- and eldercare is not extensive. In the nineties during the transition period, most of the childcare facilities for children under age 3 were shut down (Kuchařová 2010) and the parental leave was extended to three, and later to four years. Childcare policy took a refamilising direction which encouraged childcare in families (Saxonberg and Sirovátka 2006) provided however usually by mother as only around 2 percent of men engage in full-time childcare and take up the parental benefit (Nešporová 2005, 2015). Later, making the rules for parental benefit entitlement more flexible with regards to combination of full-time day care with work did not prove to be a critical policy juncture and the activity rates of women with young children still remained low. This has been underpinned both by the complete lack of places in nurseries as well as minimal employer willingness to allow for flexible work arrangements suitable for work-care reconciliation. Poor accessibility of such workplaces is combined with the fact that e.g. part-time work means a significant fall in income. For these reasons the part-time employment rate of women aged 25 to 49 is more than three times lower in the Czech Republic than it is in Norway[1] (Eurostat database 2016). With regards to childcare policy field, the Czech Republic is considered to be explicitly familialistic and most childcare, especially for children below 3, is provided by the family (Szelewa and Polakowski 2008; Javornik 2014).

Eldercare policy solutions do not alleviate the care burden and related tensions between formal and informal care (Pfau-Effinger and Rostgaard 2011) from women either. The reforms in long-term care led to the introduction of a cash-for-care benefit provided to the frail elderly. Such a residual system is typical for the lack of capacities in institutional care, the fragmentation of the care provision (for further information see earlier chapters) and the marketization of home-based services (Ranci and Pavolini 2015).

Both countries have different systems with regard to defamilisation/decommodification of care. Norway allows for choice in childcare – i.e. care in family (supported familialism) and use of childcare institutions (defamilisation of care), and strongly supports defamilisation in eldercare. The

[1] Similarly overall part-time employment for the age group 25 to 54 is much lower in the Czech Republic than in Norway, i.e. in 2015 it was 4.4 percent in the Czech Republic and 19.6 percent in Norway (Eurostat database 2016).

Czech Republic favours childcare for children under 2 to be ensured by the family and allows for choice in eldercare; institutions are available (but capacity is insufficient) and there is a cash-for-care scheme (however, a not very generous one). According to Saraceno and Keck (2011), Norway is considered to be a country with strong defamilisation and weak supported familialism, whereas it is the opposite in the Czech Republic. Such different policy settings may have different impacts on the wellbeing of caregiving persons due to different availability of choice, generosity of support and accessibility of care providing institutions, be it for children or the frail elderly.

Methods

Data

We use data from the Generations and Gender Survey (GGS) (Vikat 2007). The survey forms part of the Generations and Gender Programme (GGP). The GGP is a system of national GGS surveys and contextual databases based on 19 countries. The GGP aims to improve the understanding of demographic and social developments and the factors that influence these developments. We use data from Norway and the Czech Republic and restrict our analysis to the ages 25–64 (n=18,077). These countries represent different types of welfare regimes (Eikemo et al. 2008) with more generous provisions in Norway than in the Czech Republic. Data were collected in 2007 and 2008, and with response rates of 61 percent and 49 percent, respectively (Fokkema et al. 2014).

Dependent variables

Depression is a mental health construct that refers to lowered mood, loss of interest, self-deprecation, and hopelessness (Bowling 2005). It can be conceived as a general measure of psychological distress or negative affect (Mirowsky and Ross 2003). Caregiving may increase psychological distress because it generates more daily problems, stress, and worries. Caregiving may deplete energy and vitality; yet many caregivers report that caregiving promotes feelings of fulfilment and pride (Toljamo et al. 2012).

Depressive symptoms are measured by a seven-item version of the 20-

item Center for Epidemiologic Studies Depression (CES-D) scale (Radloff 1977). It was designed to identify depressive symptoms in the general population and is currently the most widely used instrument to measure depressive symptoms and to estimate prevalence rates in population surveys (Shafer 2006). The CES-D has consistently shown to be reliable and valid in different populations, with adequate internal consistency and construct validity (McDowell 2006). The measurement equivalence of an eight-item version of this scale has been shown among seniors from different European countries (Missinne et al. 2014).

The seven-item scale encompasses the following items: I felt that I could not shake off the blues even with help from my family or friends; I felt depressed; I thought my life had been a failure; I felt fearful; I felt lonely; I had crying spells; I felt sad. Respondents were asked to report how often they had felt like this during the past week: (0) seldom or never, (1) sometimes, (2) often, or (3) most or all of the time. A mean score index (0–21) was created (α = .88–.92, pooled α = .89) in which higher scores indicate higher levels of depressive symptoms. Missing values are deleted list wise.

Loneliness is defined as an unwelcome feeling of lack or loss of companionship, support, and intimacy (Bowling 2005). Caregivers may be susceptible to loneliness because they are restricted from pursuing social activities, or because they actively withdraw from social contact in response to the care recipient's situation (Toljamo et al. 2012).

Loneliness is measured by the six-item version of the de Jong-Gierveld Loneliness Scale (de Jong-Gierveld and Van Tilburg 2006, 2010). The reliability, validity, and structural characteristics of the scale are of high quality, and the instrument has proven cross-national equivalence, thus allowing for intercultural comparison (Van Tilburg and De Leeuw 1991; de Jong-Gierveld and Van Tilburg 2010). For example, the scale has been tested for seven GGP countries (France, Germany, the Netherlands, Russia, Bulgaria, Georgia, and Japan) and was found to be reliable and valid for each of the countries under investigation (De Jong Gierveld and Van Tilburg 2010).

The scale encompasses three positively formulated items (There are plenty of people that I can lean on in case of trouble; There are many people that I can count on completely; There are enough people that I feel close to) and three negatively formulated items (I experience a general sense of emptiness; I miss having people around; Often, I feel rejected). None of the items refer directly to loneliness. The items have three re-

sponse categories: 'no' (0), 'more or less' (1), and 'yes' (2). After reversing positively formulated items, a simple additive score index (0–12) was created (α = .75, range .62–.79 across countries) in which higher scores indicate higher levels of loneliness.

Independent variables

Child caregivers are individuals that have a child (including step-child) in their household who is aged 0–9 years and/or have a chronic health problem (any age). 'Chronic health problem' is measured by the variable 'Is any member of your household limited in his/her ability to undertake normal everyday activities, because of a physical or mental health problem or a disability'.

Adult caregiving (provision of personal care) is measured by the question: 'Have you during the past year given regular help with personal care to someone you do/do not live with. Help with, for example, eating, getting out of bed, dressing, or using the bathroom.' We focus on those who have provided care to a partner, parent, or parent-in-law.

Partnership status, employment status, and *work intensity* ('Is this full-time or part-time work?') are based on self-reported measures. *Age* and *educational level* are self-reported in the Czech sample, and obtained from public registers in the Norwegian GGS. We also wished to control for *health*, as some people may choose not to work or may be prevented from working because of their health. We indicate health by a measure of being limited in the ability to carry out normal everyday activities because of a physical or mental health problem or a disability (no/yes). We could not to use self-rated health (1–5) because of high (65 percent) missing data in the Czech sample.

Analytic strategy

All multivariate analyses use ordinary least squares (OLS) regressions. To increase analytical power, we have merged (i) part-time work and non-employment among men, because very few male caregivers work part-time (see Table 7.1). Analyses are run separately for Norway and the Czech Republic and for men and women. We control for age, education, health problems, and partnership status (single vs. cohabiting/married).

Results

Table 7.1 describes the sample of caregivers and non-caregivers on sociodemographic variables and health. In the Czech sample, 17.5 percent of men and 22.4 percent of women care for a minor or ill child. These percentages are 32.0 and 32.5, respectively, in the Norwegian sample. In the Czech sample, 2.6 percent of men and 4.7 percent of women provide regular personal care to a partner or parent, a little less than in the Norwegian sample (3.9 and 5.8 percent). Few individuals care for both child and adult; 8 men and 7 women in the Czech sample, and 58 men and 63 women in the Norwegian sample (not shown). Child caregivers are younger than other respondents and thus tend to be in better health and more often are employed and partnered than adult caregivers.

Analyses presented in Table 7.2 explore the effect of child caregiving, employment, and their interactions on loneliness and depressive symptoms. Being employed full time relates to greater well-being rather uniformly in all analyses. Part-time employment, only explored for women, seems to have either the same effects (Norway) or somewhat smaller effects (Czech Republic) as full-time employment. Child caregiving relates to somewhat more loneliness and depressive symptoms among Norwegian men, and to more loneliness among Norwegian women, but shows no significant association with loneliness and depressive symptoms among Czech men and women.

Figure 7.1 Effect of childcare by employment status on loneliness. Norwegian men

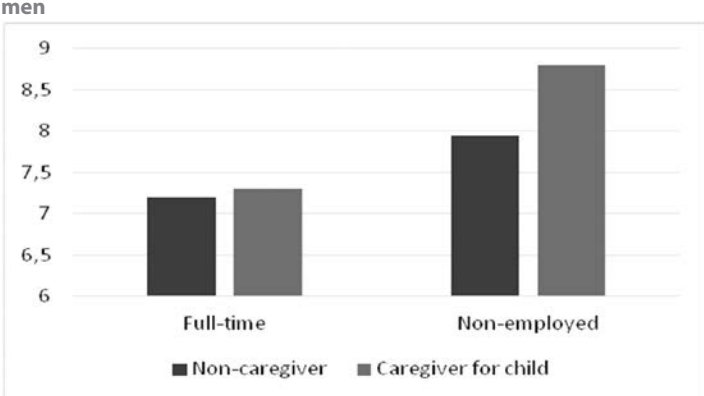


Table 7.1 Sociodemographic characteristics of individuals aged 25–64, by country, gender and caregiver (CG) status. Proportions (percent) or means (SD)

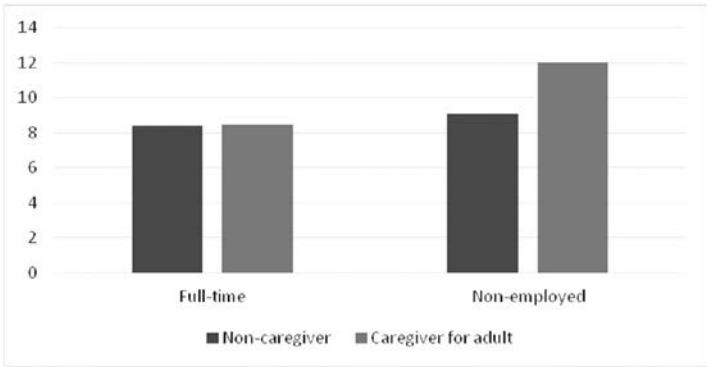
	Czech Republic								Norway							
	Men				Women				Men				Women			
	CG for children	CG for adult	Non-CG	Total	CG for children	CG for adult	Non-CG	Total	CG for children	CG for adult	Non-CG	Total	CG for children	CG for adult	Non-CG	Total
Age	35.4	46.7	45.0	43.4	33.4	50.5	46.5	43.8	39.1	47.7	47.1	44.7	36.9	49.4	47.8	44.5
Education (1–3)	2.06	1.98	2.02	2.03	1.98	1.88	1.96	1.96	2.24	2.14	2.16	2.28	2.38	2.16	2.24	2.03
Partnered (in percent)	97.9	68.6	58.2	65.2	80.1	71.6	60.0	64.9	93.0	88.6	64.8	74.4	86.1	80.9	66.4	73.4
Employed (in percent)																
Full-time	86.3	65.1	70.7	73.3	54.6	50.3	59.0	57.6	91.2	81.0	78.4	82.4	52.4	47.0	56.4	54.6
Part-time	1.5	3.5	2.8	2.6	8.1	5.9	5.1	5.8	2.8	1.9	4.4	3.8	30.6	30.7	21.9	25.2
Not working	12.2	31.4	26.5	24.2	37.2	43.8	35.9	36.6	6.0	17.1	17.2	13.8	17.0	22.3	21.7	20.2
Health problem (in percent)	6.5	23.0	13.1	12.3	6.4	21.2	15.4	13.6	8.2	20.3	14.0	12.4	13.8	30.9	20.4	18.8
N (in percent)	583 (17.5)	85 (2.6)	2681 (80.3)	3337 (100)	811 (22.4)	167 (4.7)	2654 (73.3)	3619 (100)	1740 (32.0)	210 (3.9)	3548 (65.3)	5431 (100)	1849 (32.5)	331 (5.8)	3583 (63.0)	5690 (100)

Table 7.2 Multiple regression of indicators of well-being on caregiver status and interaction terms with controls for sociodemographic background variables. Age 25–64. Unstandardized regression coefficients.

	Loneliness (0–12)				Depression (0–21)			
	Czech Republic		Norway		Czech Republic		Norway	
	Men	Women	Men	Women	Men	Women	Men	Women
Employment status[a]								
Full time	-0.64 **	-0.49 **	-0.45 **	-0.46 **	-0.75 **	-0.74 **	-0.65 **	-0.66 **
Part-time		-0.32		-0.45 **		-0.40		-0.66 **
Caregiver status[b]								
Childcare	0.10	-0.21 †	0.26 **	0.17 *	-0.13	-0.24	0.26 *	0.19
Interactions[c]								
Childcare x full-time	-0.46	-0.14	-0.54 *	0.09	0.23	-0.16	-2.33 **	0.00
Childcare x part-time		0.58		-0.02		0.85		-0.19

* $p < .05$, ** $p < .01$. Parameters not presented in the table (e.g., standardized coefficients, SE) are available upon request from the authors. Reference categories are [a] not in paid work, [b] non-caregiver. Control for age, education, partner, and health limitation. Presented main effects of caregiver status and employment status are calculated before including interaction terms in the model.

Figure 7.2 Effect of childcare by employment status on depression. Norwegian men



The relationships between childcare and well-being are unaffected by employment status, except among Norwegian men, where the effects of childcare are significantly stronger among those who are non-employed than among those who work full-time (Figure 7.1 and Figure 7.2). Furthermore, effects of childcare are similar (not significantly different) for women who work full time as for women who work part time (tests not shown).

Figure 7.3 Effect of personal care by employment status on loneliness. Czech men

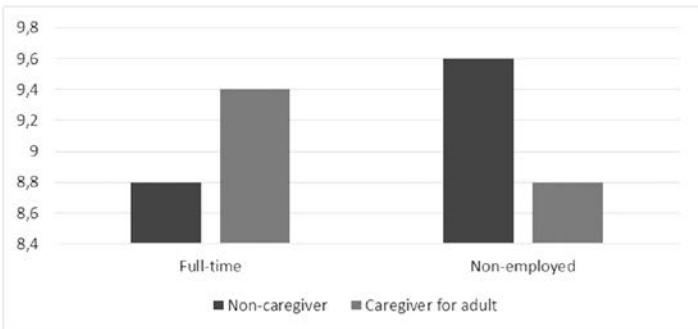


Table 7.3 Multiple regression of indicators of well-being on caregiver status and interaction terms with controls for sociodemographic background variables. Age 25–64. Unstandardized regression coefficients.

	Loneliness (0–12)				Depression (0–21)			
	Czech Republic		Norway		Czech Republic		Norway	
	Men	Women	Men	Women	Men	Women	Men	Women
Employment status[a]								
Full time	-0.52 **	-0.46 **	-0.45 **	-0.50 **	-0.74 **	-0.74 **	-0.39 *	-0.71 **
Part-time		-0.53 *		-0.39 **		-0.70 *		-0.60 **
Caregiver status[b]								
Adult care	0.13†	0.15 †	0.16	0.15 †	0.22 †	0.39 *	0.12	0.43 *
Interactions[c]								
Adult care x full-time	1.52 *	0.16	-0.51	0.07	0.97 *	0.47	0.28	-0.26
Adult care x part-time		-0.36		0.41		0.26		-0.07

† p < .10, * p < .05, ** p < .01. Parameters not presented in the table (e.g., standardized coefficients, SE) are available upon request from the authors. Reference categories are a not in paid work, b non-caregiver. Control for age, education, partner, and health limitation. Presented main effects of caregiver status and employment status are calculated before including interaction terms in the model.

Figure 7.4 Effect of personal care by employment status on depression. Czech men

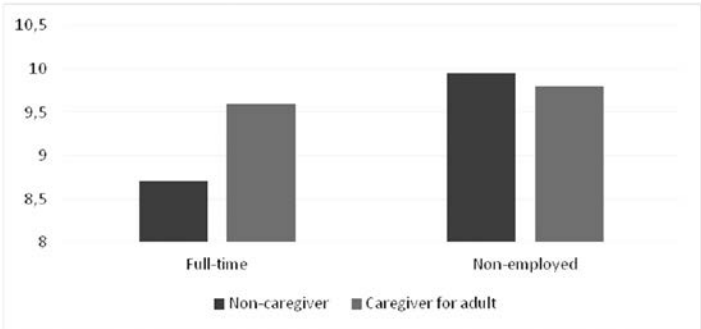


Table 7.3 presents the results of analyses of caregiving (for a partner or parent) and employment status. Caregiving is weakly and inconsistently related to loneliness and depressive symptoms. Yet in most subgroups (by country and gender), caregiving relates to lower well-being. Furthermore, no interaction term between caregiving and employment status is significant, except among Czech men, where associations between caregiving and loneliness and depressive symptoms are significantly more positive among the full-time employed than the non-employed ($p < .05$).

Discussion

Although the consequences of combining work and caregiving are an increasing concern to researchers and policymakers, little research has examined how work and caregiving interact to affect well-being, especially in a cross-country comparative context. This study explores the effect of childcare and regular personal care to a partner or parent on two aspects of well-being (loneliness and depressive symptoms) by employment status in Norway and the Czech Republic. We use nationally representative data of individuals aged 25–64. Among women, we compare three employment groups: not in paid work, part-time, and full-time. Among men, because few men work part-time, we merge the not employed and the part-time employed and compare them with the full-time employed.

Findings show that childcare is unrelated to these aspects of well-being in the Czech Republic. In Norway, however, childcare relates to increased loneliness and depressive symptoms. This country difference is somewhat surprising given greater gender equality and stronger institutional support of parenthood in Norway. The psychological effects associated with caring for young children can be tied to the stress and burdens of raising children, especially under difficult social or financial circumstances, for example for single parents (Hansen 2012).

Furthermore, the interaction analyses reveal that childcare generally has uniform effects according to employment status. The exception is among Norwegian men, where the adverse effects of childcare are significantly stronger among the non-employed than those who work full-time. The same trend is evident, albeit non-significant, among Czech men. The lack of significance may relate to low number of respondents in some analyses and thereof resulting weaker power of findings. These findings can be interpreted to indicate that is it stressful to care for young children, but that employment may offer a beneficial respite or distraction from the responsibilities at home. Another interpretation draws on traditional gender roles and the assumption that the man is supposed to be 'the strong one' who takes care of the family. Accordingly, his unemployment, because it threatens or interferes with traditional gender roles, may be more harmful to couples' well-being than her unemployment (which may reinforce gender roles), and especially so in families with young children.

Providing personal care to a partner or parent relates, albeit weakly and inconsistently, to more loneliness and depressive symptoms. The fact that these associations are relatively weak (and sometimes non-significant) is surprising because it runs counter to anecdotal and empirical evidence about the burdens of providing personal care. One interpretation is that caregivers go through a phase of great stress but adjust to the caregiver role and to the care recipient's situation over time. A great deal of literature attests to the human capacity to accommodate to adverse life conditions and events (see Hansen 2010, for a review). However, weak or nonsignificant associations conflict with a large body of (mainly US) literature that links caregiving to substantial psychological distress. This contrast highlights the role of social policies and care systems in shaping the impact of caregiving on well-being. The Czech and especially the

Nordic care regimes, more often than the US, may take responsibility for the most challenging care tasks and the family usually only plays a complimentary role. That said, there may be large heterogeneities in the effects that is not captured here, and caregiving may have more substantial emotional effects in strata with higher caregiving intensity and/or with lower socioeconomic status or with caregiver health problems (Hansen and Slagsvold 2013; Hansen et al. 2013).

It should be acknowledged that, even though providing personal care demonstrates low-moderate effects on global measures of well-being, it may strongly affect more specific aspects of well-being with differences due to employment status. Indeed, a large amount of literature shows that it is quite common for working caregivers to report work absenteeism and decreased productivity due to caregiving duties, and that the need to balance work and eldercare has caused them worries, anxiety, and stress (Duxbury et al. 2009; Edlund 2007; Gautun and Hagen 2010).

Furthermore, with one exception, no interaction term between caregiving and employment status is significant. The only exception is among Czech men, where positive associations between caregiving and loneliness and depressive symptoms are more strongly evident among those who work full time ($p < .05$). Poor cultural and institutional support for male caregivers who are working may explain this experienced squeeze. The general lack of interaction effects for the combination of caregiving and employment roles may suggest that it is not a major problem for people's well-being to combine employment with providing personal care–perhaps the most challenging aspect of aged care–to a partner or parent. However, the findings may also reflect that there is great variation in these interaction effects: for some caregivers work may represent respite, for others it may represent a burden.

Although there may be little to indicate that the current nature and level of parental caregiving in Norway and the Czech Republic has strong harmful consequences for well-being, a reduction in formal care and a stronger reliance on informal care may create more caregiver distress. In the future, because of increasing need for informal care and growing female employment, more adult children are expected to combine family caregiving with paid work. There is concern that this development may affect population mental health, as paid labor may be an additional burden to many caregivers (OECD 2011).

Any comparison of the predictions of role conflict theory versus role enhancement theory obviously depends on the type of roles in question and the level of involvement in those roles. The current study indicates that the combination of high work involvement and intensive caregiving has few implications for well-being. Working caregivers do not seem to experience a 'squeeze' that decreases global well-being. The results thus support the predictions of role enhancement theory over those of role conflict theory.

However, this conclusion comes with several caveats. First, the cross-sectional design does not allow conclusions about causal effects. Full-time employed caregivers may fare better due to role enhancement, but at the same time it can be a selection effect whereby the 'happiest' caregivers stay in full-time jobs. Second, interpretive caution is warranted because of the limited sample of carers. If the magnitude of a population effect is low to medium, then the effect may not be detectable in small samples due to large random sampling errors (Rosenthal 1991). Third, as mentioned, we cannot rule out the possibility that full-time working caregivers have care recipients with lighter care needs or more often share the care responsibilities with family members or the public services than other caregivers. Fourth, the lack of interactions may also reflect the heterogeneity of the implications of combining care and work. For some caregivers, work may offer respite, for others it may create stress. Average effects may thus mask large variation across individuals.

The results may also be specific to the Nordic and Czech contexts. The strain of working caregivers may be lower than in other countries (e.g. the US) because a wide range of supports are available to and affordable for overwhelmed caregivers; the most care-intensive recipients are usually taken care of by the state; and due to more worker-friendly conditions (Chung and Tijdens 2013; Gallie 2003). The results should nonetheless be of interest to researchers and decision makers in this field because they may shed light on the moderating role of different welfare and long-term care regimes on the psychological effects of caregiving.

A different possible caveat is that caregivers who work full-time have less impaired care recipients, provide less care, are less often mainly or solely responsible for ensuring care, or receive more paid or public assistance with caregiving.

In conclusion, while lay-person and scholar perspectives alike tend to depict the combination of paid work and caregiving responsibility as

a 'double burden', we find little empirical support for this claim. Overall, the findings suggest that, at least in the two countries, combining employment with providing personal care to a family member is not a major problem for people's well-being.

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CHAPTER 8

Conclusions

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In this final chapter, we aim to interpret the findings presented in the individual chapters of the book within the theoretical frame outlined in Chapter 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 Chapter 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-school 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.[1] 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 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.

[1] 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.

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 Chapter 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 Chapter 2 and Chapter 4) 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 Chapter 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 Chapter 5).

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 res-

idential 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 predom-

inantly 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.

Work-family squeeze in Norway and the Czech Republic: quantitative evidence on the impact on well-being

A question related to caregiving is whether employment provides respite or adds stress to caregivers. Based on cross-sectional data from the Generations and Gender Survey, the response to the question was provided in Chapter 7. According to our findings, childcare is unrelated to the specific indications of well-being like depression and feelings of loneliness in the Czech Republic, yet relates to decreased well-being in women in Norway. Next, childcare has uniform effects according to employment status. Among men, and especially in Norway, childcare has significantly stronger adverse effects on well-being for those who are unemployed than those who work full-time.

Providing personal care to a partner or parent is associated with lower well-being, albeit weakly and inconsistently. The effects of caring for a frail or older adult vary according to employment status only among Czech men, where caregiving has more negative psychological effects for those who work full-time. Psychological distress in this group may be tied to a lack of adequate institutional support.

In Chapter 7, the strain hypothesis/conflict role theory and the contradicting role accumulation/social role theory were introduced as a way

to understand the impact of caregiving on the well-being of the carers. Overall, the findings presented in Chapter 7 suggest that in the two countries, combining employment with providing personal care to a family member is not a major problem for people's well-being, except for some specific subgroups of people like (unemployed) men in Norway in the case of childcare and full-time employed men in the Czech Republic in the case of eldercare. This means that conflict role theory does not hold, while role accumulation theory seems to be more plausible. However, some aspects need to be considered: it is for example possible that caregivers who work full-time have less impaired care recipients, provide less care, are less often the main or sole responsible persons for ensuring care, or they receive more paid or public assistance with caregiving. In addition, there might be specific subsamples of caring family members who are affected more by their care obligations and others who are affected much less. It was not possible to distinguish one group from the other due to the small size of the samples; further research is needed.

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 Sirovátka 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 policymak-

ers (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 of 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 (Chapters 3–6) mirror the problems and gaps in childcare and eldercare policies identified in the analysis of the systems provided in Chapter 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 book 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 Chapter 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 Chapter 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 Chapter 6. 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 Chapter 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[2] 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[3], 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 im-

[2] Eurostat database, year 2014.

[3] 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.

proving 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 Chapters 3 and 5).

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 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 effec-

tive 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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Index

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UNDERSTANDING CARE POLICIES IN CHANGING TIMES:
Experiences and lessons from the Czech Republic and Norway

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The main objective of this book is to explore the mutual compatibility of the strategies adopted by the relevant actors in the policy fields of child- and eldercare and to determine how effective different strategies are in responding to the increasing demands for care services.

The book focuses on two areas of social services: childcare and eldercare. The strategies of the actors who form the policies in these fields are assessed from the perspective of the households and this effectively connects the above two areas of policy making, as they both help to balance work and family (care giving). In addition, the book examines how being pulled between work and care giving interact to affect well-being and how families manoeuvre when affected by this squeeze affect – most importantly in terms of gendered strategies.

The two chosen countries – the Czech Republic and Norway – have different starting points which are taken carefully into account when carrying out the in-depth investigation. In Norway, care policies have a long tradition, are well developed in various forms and well accessible, not affected by crisis.

In the Czech Republic, care policies are only slowly gaining priority while the care needs are increasing. This in-depth study can contribute to the understanding of how strategies and policies in child- and eldercare emerge in different contexts, how various actors can effectively cooperate and what the options for new effective solutions are.

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