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Current Strategy of Social Services for the Elderly in the Czech Republic: The Domiciliary Care – Opportunities and Risks

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Abstract

Due to population aging, the need for long-term care is increasing. In many European countries is now a strong stated policy preference for care in the home as opposed to institutional care and policies on the local level are bearing out this preference. The purpose of this study is to report on the position of the domiciliary care within the Czech social services for the elderly and to explore its potential to support the elderly to "age in place". In our contribution we first describe the European and national priorities in the policy of the elderly care and the system of social services for the elderly in the Czech Republic with a special respect to the domiciliary care. After that using a mix of quantitative (SHARE data) and qualitative (case study of one service) methodology, and relevant documents analysis we investigate both the current aim of the domiciliary care within the Czech social services system and its importance to the service users themselves. Above all we focus on the opportunities and threats of the domiciliary care potential for improving the quality of people's aging. The aim is to understand this issue from the viewpoint of the different actors: service users, service workers and service managers as well. The results reveal that users considered domiciliary care as the only one service which allows them to stay at home despite their worsening capacity to manage activities of daily living. They emphasized the unsubstitutable role of domiciliary care at maintaining their physical and psychical comfort. On the part of the social service workers their qualification and shared conception of the clients significantly affected the delivered service quality. Finally, the managers highlighted i.a. the problems of both insufficient geographical availability and financial sustainability of the domiciliary care delivery.

Introduction – European context

Ageing is a demographic feature of all European countries as fertility has declined and life expectancy improved. Today the countries in Europe face economic and political obstacles to finding the tax revenues necessary to support significant growth in publicly funded services and benefits for older people. The impact of ageing on health and social care expenditure arises because older people tend to need care more frequently as they develop chronic, principally cardiovascular and respiratory, disease (Blackman, Brodhurst, Convery, 2001:12). But ageing brings an increasing risk of enduring difficulties such as physical disability, depression or dementia, and of stressful life events such as loss of effective relationships. These changes affect individuals at different rates and with different patterns, and individual older people respond to them in different ways: they could have different degrees of vulnerability and different coping styles.

Concern about the future affordability of long-term care has arisen out of number of aspects

of ageing in Europe. First, the number of "older old" people - those aged 80 and over – are projected to rise even faster than the numbers of "older" people. This is significant because it is among the "older old" that long-term care needs are greatest. Second, there are concerns about rising dependency ratios. The Economic Policy Committee (EPC) estimated that by 2050 the EU-15 would move from having four people of working age for every older person to only two. Third, there are concerns that there could be a future decline in family support for older people with potential increases in demand for formal services and long-term care expenditure (Pickard at all, 2007:34).

In many European countries is now a strong stated policy preference for care in the home as opposed to institutional care and policies on the local level are (increasingly) bearing out this preference. This shift to care in the community and in the home has been slow to evolve but is now commonly and firmly promoted by policy makers and experts as well as the older person who, for the most part, have a preference for home care. In the light of population ageing, changes in family structures, an increase in women's labour market participation rates and the perceived unsuitability and high cost of institutional care, the challenge of providing adequate community care as well as care in the home has become a policy concern of great importance (Doyle, Timonen, 2007). Most countries have made decision at least in principle that, whenever possible, such care should take place in the older person's home.

Theoretical delineation of Domiciliary care service

Due to composition of the provided services, the domiciliary care has the potential to support the elderly to "age in place" as it is able to compensate lots of the old people limitations in daily living activities. According to Walker (2005) staying in well-known place is a very important aspect of the quality of life of the elderly. Halvorsrud and Kalfoss (2007) found out that all classic conceptualizations of the quality of life have among others included such domains as physical health, social relationships and support and environment. Moreover, Bowling et al. (2002) found out that the quality of area residence and the rate of social support (measured as number of areas of life with which they could ask someone for help) and social activities had strong influence on self-evaluations of quality of life among the older people.

The importance of environmental context for the quality of life has its roots in strong association of place with individual and family biographies in minds of Europeans and, therefore, the place is imbued with meaning and aspects of identity. "It is also the location where older people spend much of their time and the proportion of time spent at home rises in old age" (Walker, 2005:10).

"Domiciliary care" or "home care" has different meanings in different social service systems. A distinction can be made between medical and non-medical social care service. The focus of this text is non-medical domiciliary care (or non-medical home care).

Doyle and Timonen point out that the generic term "home care" is often used interchangeably with the term "domiciliary care" and offer a useful Cullen's typology (in Doyle and Timonen, 2007:5) that helps to define the parameters of domiciliary or home care. According to this typology, care can be broken down into four categories:

- *Practical:* for example, domestic task such as preparing a meal, cleaning the house and doing shopping;
- *Personal:* for example, washing and bathing, help with getting dressed and providing continence care;
- *Monitoring/Supervision*: for example, of persons with dementia who may be confused when using appliances or in danger of wandering;
- *Care management:* providing support through management activities such as liaising with health professionals and coordinating care services.

Person who require domiciliary care services usually have a limitation in "basic activities of daily living" (BADL) such as washing, dressing or eating, and/or in "instrumental activities of daily living" (IADL) such as shopping, cleaning, or meal preparation. Home carers typically work in a dual capacity. They deliver light domestic care (assistance with IADL) including food preparation, light housework and companionship services such as accompanying clients to medical appointments. They also provide personal care (assistance with BADL) such as helping the older person in and out of bed, assistance with dressing, prompting medication, showering, bathing, grooming, etc.

The Czech Republic – demographic development and strategy of long-term care for older people provision

Like in other European countries, the population of the Czech Republic is ageing at a similar rate. In spite of a temporary increase in fertility over the past few years, steady growth in the proportion of persons over 60, or 65, to the total number of inhabitants is apparent. As the demographic forecast (in its mean value version) implies, in the year 2050, approximately one third of the country's population may generally be expected to be older than 65. Like in other European countries, by the year 2050, the number of persons over 80 (the so-called "older-olds") will have almost quadrupled (see Table 1 for details).

Tab. 1 Demographic forecast of Czech population (mean value version)

year	Age category (both sexes)								Population Total (both sexes)
	60+		65+		70+		80+		
	abs.	*%*	*abs.*	*%*	*abs.*	*%*	*abs.*	*%*	
2009*	2 263 559	21.6	1 556 152	14.9	1 050 164	10.0	361 866	3.5	10 467 542
2020	2 823 152	26.1	2 166 389	20.1	1 483 336	13.7	457 613	4.2	10 797 484
2030	3 182 763	29.2	2 516 957	23.1	1 909 183	17.5	773 975	7.1	10 908 419
2040	3 817 445	35.1	2 913 984	26.8	2 132 872	19.6	1 013 151	9.3	10 873 660
2050	4 109 888	37.9	3 375 527	31.1	2 635 078	24.3	1 118 858	10.3	10 842 320
2060	4 093 982	38.0	3 554 579	33.0	2 895 981	26.9	1 541 411	14.3	10 776 512
2065	3 998 006	37.4	3 439 252	32.2	2 912 183	27.2	1 622 659	15.2	10 689 713

Source: Projekce obyvatelstva České republiky, 2009

* Real data

As mentioned earlier, some of the factors responsible for the ageing of the Czech population may have been a long-term decline in fertility, or, significantly, the extending life expectancy. In the year 2008, the span on longevity in newly-born men was estimated at 74 years, and that of newly-born women, at 80.1 years.

The ageing society and the growing expenditure on long-term care provision.

The demographic trends described above have significant implications for the country's expenditure[1] on social care of the aged. While in 1997, the expenditure costs amounted to CZK 123.576.000 (approx. Euros 5 million),[2] in 2006, public funds released a total of CZK 225.545 million (approx. over Euros 9 million) for the same purpose, and in 2007, the amount increased to CZK 252.990.222 (over Euros 10 million), so the expenditure costs have almost doubled during this decade.

Similarly, the ageing of the population is evident in the social services sector. Social services are provided to approximately 700,000 clients, i.e. approx. 7% of the population of the Czech Republic. According to the Czech Statistical Office records, it is the senior citizens that constitute more than half the social services clients. Social services are financed by more than one source. In 2008, the total cost of the social services system was approximately Euros 800 million, i.e. approx. 0.65 % of GDP. Clients' contributions account for 35% of thus total cost, with territorial self governing authorities contributing 25%, the state budget 30% and the funds of the public health insurance contributing 3% (usually with the concurrence of health and social care in homes for the

[1] Data produced according to Eurostat methodology for the Core system of ESSPROS (= European system of integrated Social Protection Statistics).

[2] For conversion of Czech currency amounts into Euros, the article at hand draws on the current exchange rate of Euro 1 per CZK 25.

elderly of homes for person with disability). (Social services and Care Allowance in the Czech Republic, 2009).

In 2006, 1214 residential social services in total operated in the Czech Republic, out of which 390 were homes for the elderly with 38.672 capacity on aggregate.[3] In 2008 a total of 461 of Homes for the elderly operated in the Czech Republic, these services are provided to 41,100 clients. There are employed a total of 12,600 people. In 2008, the total cost of this service amounted to Euros 299 million, of which 133 million was paid by clients (Social Service and Care Allowance in the Czech Republic, 2009). In Homes for elderly in-residence services are provided to person with reduced self-sufficiency namely due to their age, where their situation requires that they be regularly assisted by another person. This service is provided to the client for a fee.

Besides, in accordance with new legislation, since 2007, setting up a new type of residential social services, the so-called Special regime homes, has been made possible. In 2008 a total of 148 of Special regime homes operated in the Czech Republic, these services are provided to 8,200 clients. There are 4,300 employees in total. In 2008, the total cost of this service amounted to Euros 68 million, of which 26 million was paid by clients (Social Service and Care Allowance in the Czech Republic, 2009). In special regime homes, in-residence services are provided to person with reduced self-sufficiency due to their chronic illness or dependence on addictive substances, ad to persons with old-age/senile, Alzheimer's dementia and other types of dementia, with reduced self-sufficiency due to above illnesses and where their situation requires that they be regularly assisted by another person. When providing these social services, the regime of these facilities is adapted to these persons' specific needs. This service is provided to the client for a fee.

A similar growth in the number of clients can also be observed in Domiciliary service. While in 2007 this type of service was provided to approximately 98 thousand clients, in the following year, i.e. in 2008, the number amounted to 115 thousand. Although this type of service is equally available to handicapped persons, or to families with children, it is the elderly that seem to be the sole recipients of the service. In 2008, there were 594 Domiciliary services in the territory of the Czech Republic, and expenditure costs on the service provision amounted to Euros 70 million (Czech Statistical Yearbook 2008; Social Services and Care Allowance in the Czech Republic, 2009).

From the financial point of view, in-residence services in the Czech Republic can be considered rather too costly a way of help provision. For example, in 2008, the annual expenditure on the care provision per client in the Homes for the elderly amounted to Euros 7,275, and in

[3]For comparison, there were 131 in-residence services for disabled adults and 151 in-residence services for disabled young people.

Special regime homes, to Euros 8,292. In Domiciliary service, for comparison, the expenditure costs per client per year was only Euros 608. (Social services and Care Allowance in the Czech Republic, MoLSA 2009).

Strategy of long-term care for older people provision

The issues of the ageing of population, along with the increasing expenditure costs on long-term care provision, are also reflected in a number of policy documents approved by the Czech government.

Of particular interest among these is the document National Report on Strategies for Social Protection and Social Inclusion 2008-2010, and the document Quality of Life in Old Age: National Programme of Preparation for Ageing for 2008-2012. Both the texts contain principles underlying help and support provision to the elderly, with a particular focus on active ageing and active old age promotion, integration of the elderly into, and their involvement in, common daily activities within community life, and thus promoting, inter alia, the concept that older persons with care needs (recipients of long-term care) should remain living in the place which they know well, i.e., in their own homes. Two other key documents, a government resolution of 2006 *The concept of transition from residential service to different types of social service provided to user in their home environment and promoting social integration of the user into society,* and the other document, *Priorities of the development of social services for the period of 2009-2012*, contain concrete arrangements and methods leading to achieving the above mentioned goals. The pivotal issue in the field of development of long-term care for older people in the Czech Republic is strengthening the role of field-based services with the care provided in the client's own home, and the relating question of promoting cooperation between formal and informal care providers. Voiced this way, the strategic visions and the steps projected towards their realization underline the importance of Domiciliary service, which is meant to form the pillar of the whole system of social services for the elderly.

The government policy described corresponds with older persons', or their relatives', views as observed in research conducted in the past decade (comp., e.g. Veselá, 2002; Kuchařová, 2002; Kubalčíková, 2007) According to these, older persons would generally prefer to remain living in their own homes, should they become dependent on care provision due to exacerbated state of health or living conditions, and therein receiving help carried out by professional carers or their relatives. The persistent myth that their needs are virtually limited to securing the basic necessities of life is contradicted by their demands for non-material help (such as personal contact with other people, the feeling of security and help availability, etc.)

On the other hand, it is necessary to reflect the strategies which the Czech elderly use when considering their own preferences as to the suitability of the care arrangements in case of health deterioration or reduced self-sufficiency. In 2008, the utilization of accommodation capacity in Homes for the elderly amounted to 95.3 per cent in total, in some regions even 100 per cent. If the capacity is not fully utilized, as it is sometimes the case, it is generally a case of temporary situation or emergency beds. Almost every residential home has a waiting list of applicants. According to the Czech Statistical Office records, in 2008, there were in total 52,953 unsatisfied applicants for placement in an elderly people's home. In many cases, applications are submitted even though the applicants' immediate physical or living conditions do not require it – they do so to guarantee that they are secure in future if their health suddenly worsens. The placement waiting time is relatively varied, depending on the type of service and it ranges from several months up to five years. In other words, the elderly signal considerable distrust of Domiciliary service and its potential to ensure help in case of considerably reduced self-sufficiency.

With regard to the demographic development described, the government's strategy of long-term care organization and mainly to elderly people's personal goals, it is legitimate to ask: *What are the present-day risks and opportunities of Domiciliary care provision to elderly people in the Czech Republic?*

Methodology

To answer the question above, we will use data obtained by combining qualitative research methods.

According to Shawn and Gould (2001), qualitative research can be considered optimal in the area of social work or social policy if we are concerned with themes such as understanding service user and social behaviour, representing service users' voices, organizational culture and change management or understanding and evaluating complex policy initiatives. Specifically, we will use data from a large case study of a representative organization providing Domiciliary service, which was realized in the years 2009-2010 as part of a multi-year project conducted by Research Institute for Labour and Social Affairs, and focused on the impact of national social services policy on immediate practice of help provision and the social workers' attitude to clients.

A case study represents a special research concept of qualitative strategy. It can be regarded as most effective where the questions “why” and “how” are the main concern in the problem given, while we are not in control of the course of events and focus on the phenomenon within the framework of its context (Yin, 2009).The theme of research was aimed at the culture of provision of this type of social service and the attitude of social workers to clients. The theme framework set this

way enabled us to pursue a number of partial research themes, inter alia, the risks and opportunities of the present-day form of domiciliary care provision, from the perspective of the provider, workers and users.

For the research purpose, a municipality-established Domiciliary service was chosen, located in a medium-sized town with a population of 20,197, out of which, at the beginning of 2010, more than 18 per cent were aged 60 and over. The service is primarily provided to the elderly citizens of the town. At the time of research, the number of service clients totalled 475. There were 21 front-line workers, eighteen of which were social service employees and two were social workers; part of duties of a social worker involving paperwork was carried out by the head of the service,who was also engaged in management.

Data collection was carried out with the help of semi-structured interviews, which, in some cases, were conducted repeatedly. As communication partners, representatives of the local municipality, the service management, over half the front-line workers and seventeen client representatives were involved. The sample of clients was set up according to previously specified criteria: age, sex, marital status, range of service provision, degree of dependency and type of housing. Clients were interviewed in their homes, and field notes on the respondent's living conditions are included in the research findings. The data gathered were analysed with the aid of the Atlas/ti software.

The case study outputs are framed by the quantitative research findings. For studying the composition of the Czech elderly population from the viewpoint of their health, housing and social situation and with a special respect to their need of outer help and care we used the Czech sample from the second wave of the *Survey of Health, Ageing and Retirement in Europe* (SHARE). The data collection was carried out 2007 and the Czech sample included 2 827 respondents aged 50 and over.

Further information on the service-in-question practice was obtained through studying relevant documents, such as service provision regulations, house regulations in special regime homes for the elderly, data stored in the register of social services providers, leaflets for the service applicants, forms relating to service provision, agreements with clients, or worksheets and job specifications. Other sources of written information comprised conceptual municipality materials, specifically the community social service scheme.

Results

The following chapter gives a brief description of the social service system in the Czech Republic and the position of Domiciliary care in this system. On the basis of data analysis chosen

from the SHARE database, it outlines the potential need of help provision to the elderly in the Czech Republic concerning their daily activities. In this context, attention is given to ways of Domiciliary care provision, drawing namely on the parameters defined by Doyle and Timonen (2007) which were described in the previous part of the text.

The system of social services for the elderly in the Czech Republic

Formal caring of the elderly is mostly provided within the scope of social services in the Czech Republic. As such is the help and care of the elderly regulated by comparatively new Act. 108/2006 Coll. on Social Services and by the Ministry of Labour and Social Affairs Decree No. 505/2006 Coll., implementing some provisions of the Social Services Act, which came into effect in January 2007 and uniformly stipulated the conditions of the provision of social services. Through this act, basic principles concerning social services provision in the Czech Republic are defined, such as registration duty of social services providers, assessment of life situation, social services funding with elements of direct payment, care allowance stipulation, specification of qualification requirements for the employees of social services provider organizations, accessibility of informal providers to care provision, standards of quality in social services and setting out local strategies of social services development utilizing the method of community planning.

Domiciliary service as part of the system of social services for the elderly in the Czech Republic

Social services are by this Act classified into three basic areas: *Social counselling*,usually specialised for a certain target group or situation, with basic counselling being and integral component of all social services; *Social care services,* the main objective of which is to arrange for people's basic needs, which cannot be provided without another person's care and assistance. *Social prevention services*, namely serve to prevent the social exclusion of persons who are endangered by socially adverse phenomena.

Social services are also classified according to the place of their provision: *Field- based services* are provided at a person's place of residence, i.e. in his/her household, at the place where he/she works, studies, or spends his/her spare time. Examples of these types of services include domiciliary service, personal assistance or field-based programmes for endangered youth. To receive *out-patient service*, person must visit specialised facilities such as counselling facilities, day care centres for disabled people or contact centres for people at risk of becoming dependent on addictive substances. *In-residence services* are provided in facilities where a person at a certain stage of his/her life lives all year round. These are mainly homes for the elderly or homes for

disabled persons, as well as so-called protected housing for people with disabilities or asylum houses for mothers with children or homeless people.

The level of managing IADL and BADL by the elderly in the Czech Republic

From analysis of data representative of the Czech population aged 50[4] and over gathered within the scope of the European project SHARE, it is evident that the need of outer aid with daily living activities increases with age. As shown in tables 2 and 3, it is mostly activities relating to IADL that cause difficulty to the elderly, namely doing the work around the house or garden, using a map, shopping for groceries, and preparing a hot meal. Even though it is obvious that problems with BADL activities do not interfere with the percentage of the elderly as high as those in case of IADL, the importance of help with these activities cannot be belittled as the performance of these is closely related to maintaining their self-esteem and dignity, or, in some cases, even health of the persons in question.

Tab. 2 Proportion of respondents in their respective age groups who claimed to have everyday problems with the following BADL, given at percentage point rate

	Age category		
	50-64	**65-74**	**75+**
Dressing, including putting on shoes and socks	2.9	5.4	11.2
Walking across a room	0.4	1.8	6.1
Bathing or showering	1.4	3.6	13.2
Eating, such as cutting up your food	0.1	0.9	1.6
Getting in and out of bed	1.7	2.8	8.7
Using the toilet, including getting up or down	0.7	1.4	4.7

Tab. 3 Proportion of respondents in their respective age groups who claimed to have everyday problems with the following IADL, given at percentage point rate

	Age category		
	50-64	**65-74**	**75+**
Using a map to figure out how to get around in a strange place	3.9	8.7	20.3
Preparing a hot meal	0.7	2.1	10.4
Shopping for groceries	1.4	4.3	17.1
Making telephone calls	0.4	1.4	7.1
Taking medications	0.4	0.4	3.0
Doing the work around the house or garden	6.2	11.8	29.9
Managing money, such as paying bills and keeping track of expenses	0.9	1.7	7.1

[4]Representation of respective age groups in the samples was as follows: 50-64 years – 57%, 65-74 years – 25% and 75+ years – 18%.

The proportion of residents who claim to have problems with none of the activities mentioned falls dramatically with age. While as many as 88.8 per cent of respondents below 64 do not experience any permanent obstacles in performing activities related to BADL and IADL, in the oldest age group, 75+, only 57.3 per cent of persons interviewed do not encounter obstacles. Analysis outputs also reflected that the elderly in the age group 65+ claim to have some difficulty ensuring outer help with the activities described. Only 60 per cent of those who have problems with at least one of these activities, or with mobility or load transportation (e.g. a five-kilo-weight of shopping bag) claimed to have someone in their environment able to help them.

These findings show that, in the light of need declared, at present, help with managing BADL and IADL provided to the elderly by either informal or formal providers can be classified as insufficient. The possibility to solve the problem of reduced self-sufficiency by placement the person in question in a home for the elderly – without considering the permanently utilized capacity of these – is an alternative preferred not even by the elderly themselves, the signs of which can be seen from the results of SHARE analysis, where a strong attachment of the elderly to their own homes and localities can be traced (90 per cent of respondents aged 65+ had lived in their homes for at least 20 years, and in the same localities for as many as 36 years and more.)

From the demographic development trends – increasing demand for care, decreasing capacity of informal providers – it is the Domiciliary service that enables continued residence at home of older persons with care needs, regardless of their reduced strengths. In the light of the elderly people's needs described, we shall next deal with the possibilities of ensuring this type of help through Domiciliary service.

Parameters of Domiciliary service provision in the Czech Republic

In this part, we will try to reconstruct the concept and ways of Domiciliary service provision to the elderly in the Czech Republic, utilizing the sources described in Methodology. Concurrently, we will look at the parameters anticipated in this type of social service by Doyle and Timonen (2007).

1. Practical help

This parameter is relatively widely represented in Domiciliary service and explicitly defined in legislation. According to law, the term “practical help” involves food provision or help with food provision, which in practice means ensuring supply of food corresponding with the specific diet needs at old age, also delivery of hot meals, help with preparation of meals or drinks or preparation

and serving of meals and drinks. Another form of practical help is assistance given to client with the maintaining of their household, namely light housework, routine maintenance and upkeep, help with all-round or seasonal cleaning, cleaning up the house following decoration jobs, everyday shopping and running errands, heavy shopping or shopping for clothes and household equipment, washing and ironing.

The above listed assistance is also provided by the Domiciliary service examined. Interviews with the service representatives and management showed that the service has a potential to ensure this type of help in extenso to a whole spectrum of clients. Of the total number of 475 clients, almost 59 per cent demand solely the delivery of hot meals, less than 10 per cent a combination of hot meals delivery and help with house keeping and self-maintenance, and approximately 31 per cent of clients demand solely ensuring help with house keeping and self-maintenance without delivery of hot meals.

Ensuring provision of these activities is covered by the employees of the provider organization, namely the front-line workers – carers. The one exception to this arrangement is the sole preparation of meals, specifically hot midday meals, which are supplied by an external firm. The delivery itself, however, is carried out by social service workers in two cars once a day, with a special attention to keeping the delivery time around noon, including weekends.

2. Help with self-maintenance

This parameter of ensuring help through Domiciliary service is also explicitly defined in legislation. It involves activities such as assistance with serving food, dressing, transfer from bed to wheelchair, help with spatial orientation and unsupported movement. Similarly, part of Domiciliary service comprises assistance with personal hygiene, hair and nail care and continence care.

The forms of help described were also part of the official service offer of the Domiciliary service examined. In comparison with the virtual practical help in the clients' homes, however, the real range of assistance concerning self-maintenance was considerably poorer. The services of self-maintenance represent less than 17 per cent of the whole range of help provided by Domiciliary service workers. According to the head of the Domiciliary service in question, in such situations clients usually receive help from a relative or other close person, and consequently, demand for their provision by a formal provider is relatively low.

Exception to this is a group of clients who reside in the Domiciliary service home. They occupy separate housing units designed for individuals or couples. This arrangement is a form of protected housing, particularly special purpose flats at the exclusive disposal of municipality, which means that, on the one hand, the rent level of the flats is guaranteed, on the other hand, the

municipality determine the allocation of flats to applicants on the basis of their living situation assessment. The assessment criteria are not defined by a legal norm but the establisher usually determines these at their own discretion. A standard prerequisite for flat allocation is the use of Domiciliary service on the part of the applicant. In other words, the flats are designed for persons with reduced self-sufficiency, in correspondence with the national policy of development of this specific type of housing. It is necessary to point out, however, that the users of the protected housing scheme are regarded (not only from the legal point of view) as persons dwelling in their own home.

At the time of research, two houses with this type of protected housing were run in the town given. House A was inhabited by 49 elderly people. House B, with a 69 capacity, was fully utilized. It cannot be concluded, though, that the use of protected housing scheme is in any relation to a wider range of service provision concerning assistance with self-maintenance. While the residents of House A represented in this respect a sample similar to that of the elderly using other forms of housing (their own, municipal or cooperative flat or their own house), House B residents represented the target group demanding this type of housing to a larger extent than other recipients of the Domiciliary service examined. In the next part, we will present further factors which are likely to influence the clients' decision-making concerning the ways of help utilization.

Intermezzo: Funding of Domiciliary services

In connection with the two above discussed parameters of service provision, it is necessary to mention the question of funding. Considering the fact that food provision, assistance with house keeping and self-maintenance are from the point of view of the Social Services Act regarded as standard part of the Domiciliary service offer, by rule of law, maximum level prices are stipulated which the client can be charged for provision of this type of help. Most items of services are expressed at time rates, where one man-hour is calculated at CZK 85, or by a level amount per single operation such as shopping for heavy goods, at CZK 100. A main meal is charged CZK 70, its delivery CZK 20. If the client demands doing the laundry, the price is stipulated at CZK 50 per kilogram.

In addition, clients can choose the range of services with respect to their needs and financial situation. Accordingly, they make a contract agreement with the Domiciliary service. Help provision items are consistently recorded and filed by the service employees, and the service cost is charged on the basis of monthly summary and monthly settlement. It is assumed that clients may use their care allowance to cover the cost, nonetheless, the service can be used even by people who are not entitled to draw care allowance, in which case they pay for the service from their own

sources.[5]

It is also important to note that the clients' payments cover only part of the total operation costs of the Domiciliary service. To ensure the complete running of the service, further subsidy is inevitable, either from the community or municipality budgets, or on application from the local department of Ministry of Labour and Social Affairs. (Such subsidy, however, cannot be legally claimed, and at the time of provisional expenditure right or reduction in public expenditure costs, its provision is restricted). In the Domiciliary service examined, in 2009, the annual expenditure operation costs totalled CZK 5.948.000 (approx. Euros 237.920). The clients' payments comprised less than 32 per cent, the contribution from the Ministry of Labour and Social Affairs amounted to approx. 20 per cent, and the remaining 58 per cent of expenditure was covered from the municipality's own budget.

3. Monitoring/Supervision

Help provision in the form of supervision or concurrent monitoring of the client's life situation is not explicitly defined in legislation as a projected parameter of Domiciliary service in the Czech Republic. Some items of service, such as accompanying clients to medical appointments or public institutions etc., could be regarded as a kind of supervision as these are included in legislation, and the remittance is stipulated at the standard rate of CZK 85. Long-term supervision of clients with reduced self-sufficiency, for example, can be provided by Domiciliary service in the form of the so-called facultative activity. In other words, it is not part of the service by legislation, but it can be offered to clients at the establisher's discretion, in this case at the same hourly rate of CZK 85 stipulated by law.

In the Domiciliary service examined, ensuring supervision represented only 2 per cent of the total range of help provided. The head of the service mentioned, in this respect, the high expenditure costs which the ensuring of supervision demanded. As such, these have further negative impact on the establisher, i.e. municipality. There are two reasons for such high costs. In case of supervision, the worker's capacity is used by one sole client over a long period of time, whereas the stipulated hourly rate covered by client does not correspond with the real price of the job per hour. The difference between the two items stands for additional expenditure which is covered from municipality budget. The other reason for certain reluctance to provide help in the form of monitoring or supervision can be ascribed to the schedule of Domiciliary service, which operates all week, the provision of services other than food delivery is generally carried out on workdays from 7

[5]The average amount of old age pension in the Czech Republic by 31/3/2010 was CZK 10,043, the average amount of social care allowance in 2009 was approx. CZK 4,800 (www.czso.cz, www.mpsv.cz).

a.m. till 4 p.m. Expenditure costs connected with supervision beyond the schedule must be covered from the establisher's own budget.

Apart from the viewpoint described concerning covering the service costs, there are other aspects connected with supervision and monitoring, although these are more or less related to funding. As mentioned above, the problem lies in the personnel capacity, which is strongly reduced when a worker spends a fairly long time with one client. No less important is the notion of front-line workers' qualifications. In today's practice, elementary education is sufficient in the social area, at the level of a 200-hour course (at the time of research, all the workers attended and completed this course or another course of equivalent value). Work with clients with extensive care needs is therefore beyond the capacity of an ordinary social worker. In the case of systematic supervision of clients and monitoring their life situations, the practice of the Domiciliary service examined encounters the problem of insufficient number of social workers, among responsibilities of which are activities such as formulating agreement on the service aims, intervention scheme, ensuring client feedback etc. For the total of 475 clients, only two positions of social worker were set up in 2009 and the paperwork and other job content was partly carried out by the head of the service.

Although we suggested earlier in text that monitoring and supervision are not defined within a valid legal norm, and in the practice of the Domiciliary service examined this parameter is dismissed for being too costly, it is still possible to view it as at least partly implicitly present. Somewhat minimalistic attitude towards monitoring the clients' situation can be traced in the practice of food delivery. The social workers providing the delivery have to give the food to the client in person, and thus they are mutually in regular contact. In case of any extraordinary situation, if for example the client responds otherwise than usual - (s)he is not available at the time given, or if there is an apparent change in his/her health condition – the delivery person has to act in correspondence with methodology of work, i.e. call for help like in emergency and keep the social worker informed about the client's immediate state of health. The head-of-the-service's concept is creating functional ties between the client, the front-line worker and social worker. This vision, however, encounters serious problems in the form of the above mentioned capacity limits. According to front-line workers, food delivery is generally carried out under considerable pressure. They do pass the food to clients in person but they can hardly talk to them or discuss matters. The clients themselves described the practice of food delivery in a similar way. They had already got accustomed to the image of a front-line worker as of being in constant hurry, and uttering any request would therefore be viewed by many of them as inappropriate disturbance. Apart from that, there is still the aspect of the front-line worker's insufficient level of qualification. From the interviews conducted, some of them find the question of monitoring rather incomprehensible

because they generally view the clients as “mostly the same”.

As for supervision of clients with extensive care needs for physical or mental reasons, there is an apparent effort on the part of the Domiciliary service examined to respond to the demand for such service. As shown above, domiciliary service is also provided to clients residing in two homes with specific purpose housing designed for the target group of elderly people. In House B, part of the service is nonstop monitoring, which in practice means all-night presence of one of the carers. This social worker does not provide any medical service, nevertheless she is available in case of emergency and calls for help. Similarly, in the chronically ill, she monitors medication (the presence of the social worker is essential in case of severe form of diabetes in clients dependent on insulin doses even at night time). Generally speaking, most clients – residents in House B interviewed within the research, appreciated the principle of monitoring and claimed that without this service, their only alternative would be placement in the home for the elderly.

4. Care management

Like monitoring and supervision, even care management is not a codified part of Domiciliary service. As the concept of care management is beyond the framework of this type of service, it is important to note that generally, this concept is not part of Czech legislation in the area of ensuring social service. The concept of Domiciliary service provision subjected to research examination does not primarily draw on care management principles. During the research, we were able to identify certain attempts to coordinate help provision to clients One example of these attempts, primarily, is the management's effort to cooperate with a non-governmental organization, which operates in the same town and whose services are aimed at elderly people with extensive care needs and dependency on another person's help. This governmental organization has the potential to provide social help of nature similar to that of Domiciliary service, and, on top of that, in combination with home care (i.e. medical help services]. This cooperation, however, is not set up within a formal context, or as a result of negotiations at the level of official representatives of the municipality and the establisher of the non-governmental organization. Rather than that, it is a kind of “ad hoc” cooperation with the focus on seeking solutions for urgent needs of a particular client which are difficult to cover by the range of services offered by the Domiciliary service examined. An interesting piece of information was obtained from the head of the Domiciliary service in question, who participates in the process of community planning concerning social services. This process in the town given is virtually at its starting point, nevertheless the question of facilitating services to families caring for an elderly person in their home environment was discussed as one of the priorities on the agenda. The incentive for the discussion was, inter alia, the absence of a more

systematic monitoring provision by the existing organizations. In both the examples given, it is not utilization of care management, but mutual cooperation, as well as reaching certain agreement on the concept of social services, that the providers of social services to elderly people in town call for.

Within the scope of research, attention was also paid to the question of cooperation between Domiciliary service and the client's family or other close persons, which can be regarded as a significant element in the concept of care management. Like in the case of cooperation with further provider organizations, not even in this area was the cooperation with close persons as would-be informal help providers conceived systematically. In the spirit of contemporary philosophy of Social Services and Domiciliary Care Act, the representatives of Domiciliary service management repeatedly emphasized that it is the elderly person who is the client, and therefore it is necessary to reflect his/her ideas and demands when negotiating the aims and range of help. On the other hand, they appreciated the families' effort to participate in care provision and communicate with the representatives of Domiciliary service. On the contrary, the front-line workers, who have to solve a number of unforeseeable situations in everyday practice, tend to turn to family members immediately in case of a conflict, or they are forced to take decisions concerning the client's personal arrangements which they themselves consider problematic or urgent. They are likely to use this strategy especially with regard to their own protection against any prospective complaints and conflicts with the client's family, which some of them openly admitted during the interviews. The elected municipality representatives directly referred to the family as the key element in care provision to elderly people and they latently anticipated cooperation between the family and social service workers. On the other hand, they disapproved of the idea of extending the personnel capacity for financial reasons. Paradoxically, their own expectations cannot be put in practice due to the fact that, with the present-day number of social service workers (i.e. two in total), the notion of conceptual cooperation with the family is inconceivable.

Contrasting priorities of the local governance, service users and service managers

From the establisher's perspective, i.e. the municipality, it is definitely most effective to offer such activities through Domiciliary service which cover the greatest possible demand for help with the lowest possible expenditure costs. According to the representatives of municipality addressed, the indisputable priority should be given to ensuring assistance with house keeping and shopping. During the interviews with the mayor and his deputy (who is responsible for the administration of the social area), the notion of Domiciliary service was reflected as a primary form of help aimed mainly at clients with a higher level of self-sufficiency. Neither of them rejected the possibility of using the service in case of complicated life situations, nonetheless they anticipated the activity of a

functional family who would closely cooperate with Domiciliary service. To be more explicit, in such cases, the roles of Domiciliary service and the client's family, which is looked upon as the predominant element, ought to be complementary to one another. Most representatives of front-line workers – the carers – shared this opinion, although they thought that Domiciliary service had no potential to ensure help to clients with a high level of dependency on outer help. The most frequent arguments in this respect were insufficient service personnel capacity and equipment, as well as insufficient equipment in clients' households (such as lack of space for bed assistance, lack of basic bathroom equipment etc.). The front-line workers saw some perspective in massive family participation in the care. The clients themselves, interestingly, did not generally share the notion of Domiciliary service as the subject with potential to ensure help in case of their considerably reduced self-sufficiency. Their expectations in this regard were rather vague, partly due to the lack of detailed information concerning the range of services provided by Domiciliary service, and, possibly, due to their reluctance to think about the details of their prospective reduced self-sufficiency.

Slightly different perspective was observed in interviews with mid-management, namely the municipality member responsible for the area of domiciliary service and particularly the head of the service. Clearly, both of them reflected the demographic development and its considerable impact on the conditions of the service provision: with regard to the ageing of population as described above, an increased demand for social services can be expected; the extending life expectancy implies the demand for the service on part of persons with a combination of social and health problems, which calls not only for the basic satisfaction of needs but also systematic help; the process of ageing also affects the present-day clientele of Domiciliary service, and therefore today's clients may need a more demanding care in future.

Conclusion: Domiciliary service in the Czech Republic – risks or opportunities?

Viewing the present trends in ensuring long-term care, and the government policy of social service provision to the elderly in the Czech Republic through the parameters of Domiciliary service defined by Doyle and Timonen (2007), we can point out certain disproportions.

First of all, it is evident that the elderly, in connection with their reduced self-sufficiency, are expecting more from social service than ensuring basic practical help with their households, shopping or laundry. The key need in this respect is ensuring their security. Domiciliary service has the potential to cover this need on condition that it meets the parameters connected with non-material help provision, defined by Doyle and Timonen as continuous monitoring of the client's needs, supervision and application of principles of care management. The research results in the

Domiciliary service examined confirm that, at present, these parameters are not explicitly included in the concept of this type of service. Both the management and the employees of the service do not purposefully keep records of this type of demand, they only assume it implicitly and, to some extend, respond to it.

The first type of response is emphasizing the importance of the role of family, when Domiciliary service is, in the case of clients with a more extensive need of care, presented as a complementary subject of help provision. This attitude might imply some risks. The employees and management of the service, on the one hand, assume the existence of a functional family with sufficient potential to ensure the care provision to their elderly person. This assumption, however, may prove erroneous, for example in case of the family members' increased necessity to travel or move house due to a different place of work, or the necessity to solve a family member's own health handicaps (the elderly people's children may themselves be old-aged), some housing problems etc.

Another type of response is the need to transfer: clients with extended needs to another provider of social services. Also in this case we encounter a range of problems. First of all, it is important that the new provider is based in the client's locality, especially in the case of a non-governmental provider dependent on subsidies from public funds, the allocation of which is generally very uncertain. In such case, consequently, a long-term viability of the provider cannot be ensured, particularly if such cooperation is not backed by a written contract or other kind of formal agreement with municipality, as it is the case of the Domiciliary service examined.

The response in the form of protected housing practiced in House B seems to be the most conceptual of all. The clients are provided with a non-stop service involving a social worker in around-the-clock attendance. Even this arrangement, however, may bring certain risks. Primarily, the increasing number of elderly people demanding long-term care brings a problem of infeasibility to meet the demand, despite the municipality's plan to build another home with protected housing scheme, as suggested by the head of Domiciliary service. No less important is the aspect of social integration of the elderly person in need of long-term care, as this strategy practically implies, on the part of the client, the inevitability of leaving their home.

In connection with the parameters involved in the current practice of Domiciliary service provision, the elderly people's strategy of ensuring that they are provided with help in case of prospective reduced self-sufficiency is understandable. Homes for the elderly offer even such parameters which are absent from Domiciliary service, such as prospective assistance in case of considerably reduced self-sufficiency.

As the research results show, within the scope of present-day strategies in the area of social services for the elderly, we can consider as “opportunity” the start of systematic framing social

services in the town given with the use of the method of community planning. This process might bring a dual benefit. Firstly, as a starting point for building up communication between services providers, and dialogue between services providers and the elected representatives of municipality, which, in its effect, leads to setting out priorities and the concept of help, and, consequently, gives ample scope for making formal agreements on mutual co-operation both between providers and between providers and municipality as the prospective benefactor. Secondly, as a platform for the elderly – the prospective service users. The process of community planning is open to demands of prospective service users and their relatives for services which are not available in their locality, namely facilitating services. Furthermore, community planning comprises a potential platform for gathering, and providing the elderly with, more detailed information concerning the whole range of social services on offer, as well as services providers, in their locality. Thus the problem of considerably low degree of overall public familiarity with the above facts, as observed during interviews conducted with the Domiciliary service users, might be solved. Public ignorance or poor familiarity with the above details imply rather low expectations of service provision on the clients' part, which consequently creates false impression on the part of the service employees that their offer is ample.

Considering the demographic development, it is imperative that social service policy objectives, as well as those of ensuring long-term care to the elderly, are reformulated. Viewing the goal of deinstitutionalization, or transformation, of in-residence services from the perspective of the case study results concerning Domiciliary service, it is necessary to point out the risk of little potential of field-based services to ensure help to the projected number of elderly people in foreseeable future. Efforts to achieve this goal should be combined with concurrent extension of material and personnel capacity of this type of service, i.e. field-based service. Otherwise, it may be assumed that providers and, possibly, elected municipality and community representatives likewise, are likely to aim at a financially least costly solution, which means building special high capacity homes for the elderly in the form of protected housing, with waiting lists based on prior application sent well in advance. Another alternative is transferring more responsibility to the client's family, in which case it is also inevitable to support the informal providers both financially and – primarily - in the development of their skills and knowledge necessary for care provision, and offer them help in the form of systematic co-operation with formal providers.

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