'Grey' marketisation in institutional elderly care: a conceptualisation

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Abstract

In many countries, an increasing role of a public responsibility for long-term care (LTC) has been generally coupled with a rise of formal markets for provision of care. The expansion of market(s) in social services might also be understood more broadly, as it may also constitute an increasing role in the informal and/or illegal market. While the issue of grey marketisation has been widely studied with regard to domiciliary care, the topic of the expansion of grey markets in institutional LTC (mostly in residential care facilities) remains understudied in care regime literature.

The article will attempt to answer the following research questions:
i) How to conceptualise and to approach grey marketisation in institutional care?
ii) What are the main drivers of grey marketisation in institutional elderly care?
iii) How can LTC policy contribute to the expansion of grey markets in the field of institutional elderly care?

The analytical framework of this paper is built on the general assumption that grey marketisation in institutional care should be considered as a (unintended) consequence of the state policy towards LTC. In this paper I argue that specific elements of the design of care regime could be regarded both as demand-side and supply-side drivers of the expansion of grey markets in institutional LTC.

This paper attempts to demonstrate that a specific context of the emergence of a grey market in two countries form Central and Eastern Europe (the Czech Republic and Poland) is a process that could be called 'deferred deinstitutionalisation'. Despite official framing of policy towards dependent people which aims at increasing the role of care in the community, the real development of services for the dependent elderly – especially for those with most severe needs who cannot rely on informal care, has been taken place in residential care. Hence, the important role of residential sector facilities – coupled with crucial processes that have taken place *within* this sector, most notably marketisation – has given rise to the creation of an illegal market for residential care facilities.

1. Introduction

In many countries, an increasing role of a public responsibility for long-term care (LTC) has been generally coupled with a rise of formal markets for provision of care (Gingrich 2011). The expansion of market(s) in social services might also be understood more broadly, as it may also constitute an increasing role in the informal and/or illegal market. The issue of grey marketisation (Kubalčíková et. al 2017) of LTC has been widely studied with regard to domiciliary care: past research has shown that the specific regulations of Cash-for-Care (CfC) schemes have fostered the utilisation of home care provided by undocumented immigrants (Da Roit 2007). For example, the Italian case shows that the central role of the cash benefit for LTC favours the growth of a vast and socially accepted grey market of private care migrant workers (Costa 2013; Da Roit & Sabatinelli 2013). Other countries that have adopted CfC as the main pillar of their LTC system have tried to address the prevalence of grey markets in LTC. For example, Austria has introduced a legal framework which regulates the previous grey market of home care provided by migrants (Österle & Bauer 2016).

Grey market in the institutional elderly care sector could be defined as the provision of services by entities that have not been authorised by the state public administration. These entities may claim that they provide services – even in compliance with tax and labour regulations - which do not belong to social services (i.e. hotel accommodation) However, in practice they circumvent the rules concerning provision of institutional care.

The topic of the expansion of grey markets in institutional care (mostly in residential care facilities) remains understudied in care regime literature mostly due to the paucity of reliable data. In practice, researchers who want to explore this issue are immediately confronted with *de facto* an insuperable problem of measurement: it is impossible to make accurate estimates of the scale and dynamics of grey markets. In other words, the dependent variable seems to be hopelessly vague and one could hardly expect that there will be any substantial progress in this regard. Nevertheless, social policy researchers should not abandon their attempts to understand various determinants of this phenomenon, because the expansion of unregistered services in institutional care may undermine the quality of services for dependent elderly and potentially lead to increased risk of abusive situations towards dependent people.

In order to find a way out of the data-driven problem related to the estimation of a scale of the issue, researchers could view the problem of grey markets expanding in institutional

elderly care through the lens of coherent theoretical frameworks such as 'care regimes'. This strategy – which is applied in this article – might help to make sense of the scant evidences of those problems by framing them in a more general picture of the welfare state and care arrangements and, in consequence, might facilitate the exploration of factors that constitute the drivers of the expansion of 'grey' markets in institutional LTC. The aim of the paper is to conceptualise the major dimensions related to the emergence of grey markets in institutional care. Such conceptualisation might not only help to make sense of the related observations derived from various sources, but also lead to operationalisations of this phenomena in the nearest future.

In this paper I argue that specific elements of the institutional design of care regime could be regarded both as demand-side and supply-side drivers of the expansion of grey markets in institutional LTC. I define care regime as 'a way in which the financing and provision of care are organized in a given society' (Simonazzi 2009). Nevertheless, I also include a broader perspective on the care regime that takes into account crucial dimensions – including the aspects of migration and employment and – that directly influence how elderly care is organised and financed with regard to roles taken by the state, market and families.

The analytical framework of this paper is built on the general assumption that grey marketisation in institutional care should be considered as a (unintended) consequence of the state policy towards LTC. A similar approach has been applied in the recent article on the issue of unlicensed care homes [UCH] in the USA, which has so far been one of the notable examples of studies on this topic. In the aforementioned article, the Authors state stated that 'policy changes, new licensure requirements for residential care facilities, and changes in residential care markets have altered the context in which UCHs operate, potentially increasing the demand for and prevalence of UCHs' (Lapote et. al. 2018). As the higher reliance on market forces in elder care has been a central element in the construction of policies towards LTC in Europe (Burau et. al. 2017), grey markets in institutional care for the frail elderly could also be regarded, to a great extent, as politically constructed, even if they are not explicitly included in the policy agenda. Thus, the main hypothesis of the paper could be formulated as follows: the crucial determinants of grey markets could be found when delving into the processes of formal marketisation of care services in a given country. Therefore, in order to shed some light

on the causes and dynamics of the expansion of 'grey' markets, it is necessary to depart from the (politically influenced) expansion of formal markets in institutional care.

This paper is of theoretical nature; it constitutes an empirical analysis aiming to illustrate the major concepts discussed in the text. The article uses the macro-comparative approach (although comparative research design is still under preparation) which focuses on the institutional settings of care systems, care policies and care practices.

The article will attempt to answer the following research questions:

i) How to conceptualise and to approach grey marketisation in institutional care?
ii) What are the main drivers of grey marketisation in institutional elderly care?
iii) How can LTC policy contribute to the expansion of grey markets in the field of institutional elderly care?

We could expect that the relevance of grey markets in institutional care would be especially high in countries where LTC systems are not well developed, but – at the same time – social services underwent rapid and possibly also *ad-hoc* marketisation. The countries from Central and Eastern Europe fit this picture very well and, consequently, two of them have been selected to empirically illustrate the analysis. The cases in the article have been narrowed down to the Czech Republic and Poland: countries which have had relatively similar starting points for the LTC reform, but have experienced significantly different LTC outcomes (Łuczak 2018). One of the main differences between these two countries lies in the fact that in the Czech Republic, unlike in Poland, there exists a relatively generous non-earmarked cash-for-care scheme that could be regarded, in line with the current literature (e.g. Burau et. al. 2017), as one of the demand-side drivers of ongoing (grey) marketisation in LTC.

Also, this paper attempts to demonstrate that a specific context of the emergence of a grey market in these two countries is a process that could be called 'deferred deinstitutionalisation': despite official framing of policy towards dependent people which aims at increasing the role of care in the community, the real development of services for the dependent elderly – especially for those with most severe needs who cannot rely on informal care, has been taken place in residential care. Hence, the important role of residential sector facilities – coupled with crucial processes that have taken place *within* this sector, most

notably marketisation – has given rise to the creation of an illegal market for residential care services.

2. Marketisation of LTC policies and the issue of grey market

Anneli Anttonen and Gabrielle Meagher (2013) indicate that the marketisation of social services involves two possible dimensions: (1) the usage of market practices and logics (such as competition) in organising services and (2) the involvement of private, particularly for-profit, companies. At first glance, it seems that the second dimension could be of utmost importance for explaining grey marketisation, especially when an attempt is made to view the *outcomes* of this phenomena, i.e. the proliferation of for-profit unregistered facilities that constitute a growing share of all providers within a given society. Nevertheless, the first dimension may become essential when the *causes* of grey marketisation are to be explored. Therefore, from this perspective, the growth of a grey market could be seen as an unintended consequence of political decisions aiming at the expansion of the market and its logics into the provision or financing of social services.

Certainly, there are various ways to introduce market solutions into the welfare state (Barr 2012). Thus, it is possible to identify different shades of possible marketisation within residential care facilities (see Scenario 1 depicted below).

Scenario 1: State regulation (i.e. quality standards concerning residential care services)

1a) public provision + public financing
1b) public or private provision + public financing
1c) public provision + private financing
1d) private provision + private financing
1e) private provision+ private financing + partial public financing (i.e. non-earmarked care allowance)

The implementation of market forces in a pure 'public' scenario *1a* could be based on the implementation of managerial practices within provision of the public sector, whereas in scenario *1b* marketisation may be related to the competition between public and private

providers for public financing, including the application of publicly paid vouchers. It should be noted that in practice, different shades of greyness can be observed, even in 'the least privatised' scenarios 1a/1b. Such practices could illustrate the fact that state regulations do not catch up with evolving care practices. For example, a state regulation can be missing with regard to certain activities performed by certain people within the care system, such as in the case of unregulated care providers in countries like Canada (Afzal et. al 2018) or the UK (The Cavendish Review). This aspect is crucial because such providers deliver care directly and/or perform activities that used to be performed by health professionals whose status is regulated by a specific legislation and who have higher and more appropriate formal qualifications.

Concerning the higher reliance on private provision (scenarios 1b, 1d, 1e), Müller (2018) argued that future research should pay closer attention to differences between residential providers from the perspective of ownership (non-profit vs. for-profit) rather than commonalities between them. In this context, the complex issue of quality at micro level (i.e. lower/higher quality in non-profit/for-profit facilities) has been discussed extensively in the literature (Hjelmar et. al. 2018; Barron and West 2017; Winblad, P. Blomqvist, A. Karlsso 2017). Nevertheless, so far comparisons between the quality of services provided by public and private elderly care institutions have yielded no conclusive results, mostly due to different policy contexts and general difficulties in measuring quality in residential care settings.

The expansion of private for-profit residential facilities can also be explored at a care regime level. In this vein, Müller (2018) stated that constantly increasing the share of for-profit providers in the German care market exerts higher pressure for strengthening the position of the market and, at the same time, lessens regulations within the LTC system. Armstrong et al. (2016) concluded that the rise of for-profit chains of residential care in Canada poses a considerable challenge to various aspects of old-age security with regard to physical access, financial access, quality and finally, employment of care workers. Also, the ongoing process of privatisation of public nursing in the US has brought about concern about class inequalities in access to services, according to which 'non-profit providers serve healthier, more educated, and affluent consumers and for-profit homes provide substandard quality to everyone else' (Amirkhanyan 2008). Assuming that the expansion of the private formal for-profit market in residential elderly care brings about challenges indicated above, we can therefore argue that the emergence of a parallel 'grey' for-profit market can cause much more knotty problems.

Firstly, a risk of abuse of the elderly in unregistered institutions is higher than in institutions that are holders of a state-issued licence, because caregivers who work in the former can have lower training and can receive inadequate supervision; there may also be lower consequences of abuse for workers (Schiamberg et. al. 2011) and an overall lower patient safety culture (Gartshore et. al. 2017). Secondly, the utilisation of institutions in a grey market might be highly correlated with a social class of the elderly, because the costs of accommodation and staff in institutions offered on the regular market are high and facilities that operate in the grey market could charge lower prices for lower quality (Lapore et. al. 2017).

In a similar vein, grey marketisation could be regarded in the two following scenarios. Poland could be viewed as an example of scenario 2a, whereas the Czech Republic fits to scenario 2b.

Scenario 2: Outside state regulation

2a) Private provision + private financing

2b) private provision + private financing + partial financing from public (through cash-for-care)

3. How to approach grey marketisation in residential care (in the CEE context)?

We can distinguish at least three different analytical approaches that could shed light on the causes of grey marketisation in institutional elderly care. Each approach might be a building block for formulating different hypotheses. Ideally, in order to account for the development of grey markets, we should probably take into account a combination of these perspectives. However, it would require the implementation of complex research designs that bridge various research traditions, because each of the approach stems from different epistemological premises. These approaches are:

1) *Functionalism*: 'problem pressures' which eventually lead to grey marketisation are inherent to the field of LTC and its political and economic environment;

2) *Specific institutional configuration*: care regime as the main driver; here, we tend to focus on the supply perspective of the development of grey markets;

3) *Strategies and choices* of dependent people and their families including their (socially-constructed) preferences; here, we tend to focus on the (individual) demand perspective of the development of grey markets.

Functionalism

This perspective focuses on the inherent complexity of the issue: the development of grey markets is determined by various 'failures' within different elements of the social system (such as the state or the market). More specifically, it tends to emphasise that different actors – either public or private – have major difficulties concerning competent 'management' in the realm of social services for the elderly people. For example, because defining the quality criteria of services in institutional settings is an extremely challenging task for every government, public authorities might fail to introduce or implement effective legislation that would protect the market from emerging a 'grey zone'. Another important issue that could be raised in this context is a general quality of legislation with regard to social care, i.e. including the lack of legal loopholes that may increase the scale of the grey zone in a given society. State 'failures' could be related to weak law enforcement on meeting the requirements of providing services after authorisation, which can manifest itself by the lack of effective control mechanisms (such as inspections). This could be a consequence of the state's limited administrative capacity, which could be further strengthened by the important role of a 'grey' economy in a society.

Economic literature emphasises that the market for institutional care, mostly nursing care, is plagued with information problems, as there is a wide asymmetry between the providers and the users (and their families and even insurers providing LTC insurance) with regard to the quality of services provided (Norton 2016). Consequently, users could make 'bad' choices – i.e. choosing an unregistered provider – simply because they cannot asses the quality of services and – in addition – do not have firm preferences. Dependent people could have problems in altering 'bad' choices easily due to specific transaction (sunk) costs, as moving to another care facility is often costly (including valuing time as a cost). The state can respond to this market failure by providing information to potential patients which might be based on pooling collective experience (as in Nursing Home Compare in the USA).

Specific institutional configuration

Gaps in public provision. To begin with, concerning the role of the state - at the most general level - it could be argued that the expansion of a 'grey' market could be a response to limited public involvement in care provision. Strategies of dependent elderly and their families must also be framed with a general supply of services provided at the local regular market, because the 'grey' market may be a substitute for the small availability of institutions that are run in accordance with the law. According to this line of argument, a grey market might fill the gap with regard to the availability of support for the dependent elderly provided by the state. The process of the filling gap by the 'grey' market might also take place when there are geographical differences with regard to public provision of services (i.e. lower availability in rural areas/less urbanised areas). Also, the entitlement criteria to services provided by the state might favour certain groups of the elderly (i.e. poor; living alone without access to family support; with severe health conditions) at the expense of other groups of people (i.e. those living together with families) who, having more difficult access to public services, are being 'crowded into' the grey market. Finally, the low supply of places in residential care coupled with a high demand for services (due to luck of public investments in new facilities) might be an important driver that prevents providers from delivering services of better quality. Consequently, taking an economic perspective, when demand for (affordable, thus preferably subsidised) residential care substantially exceeds the supply, then the pressure for 'suboptimal' solutions – such as an unregulated market that offers lower prices – grows. On the other hand, regulation of the quality of provided services might be extremely difficult to meet for providers and thus they decide to take a risk and enter the grey zone. From the perspective of non-public (for-profit) providers, the crucial aspect of social care is the relatively smaller capital intensity of formal care, therefore small organisations can enter the market relatively easily (Glennerster 2009, p. 85). However, providing residential care requires substantial inputs from the very beginning of doing business activity in this filed. Those inputs are generally costly and might be even more expensive due to quality assurance and safety investments necessary in accordance to the state's regulations (i.e. adjustments of buildings that are necessary to the meet needs of disabled people or sanitary requirements).

Regulation of the care market. Finally, the state can contract out the provision of services to private providers and thus may create a market for elderly care in which the providers with diverse ownership structure compete for public financing (i.e. through vouchers or cash-for-care benefits). In theory, the mechanism of competition between providers would operate well when there would be no distortion that would affect the providers' bargaining power. In practice, the state can influence the position of selected providers, mostly those who belong to a public sector, by additional financing (i.e. through subsidies) that may in effect undermine the relative position of non-state actors. Obviously, while the actual consequences of such activity depends on its scale, such 'unequal' treatment of the state might prevent private providers (especially those who have small capital resources) from participating in the regular market and incentivise them to take a risk of providing their business on 'their own rules' by entering the grey zone. The state can also set maximum prices for the provision of particular services on the market that may have, from the perspective of private providers, similar effect to the subsidies discussed above. State regulations concerning maximum prices on the formal market, in combination with other factors including input costs, may also heavily impact the packages of services offered by providers. Consequently, providers might be more willing to deliver less-costly services at the expense of more intensive (personal) support, thereby lowering the availability of support offered on a formal market.

The workforce in the LTC sector remains a key challenge in most countries. One of the crucial aspects is this regard is decreasing the availability of informal care (especially in 'traditional' societies), as even a slight decline of 'caring potential' of families may rapidly increase the demand for formal care (Glennerster 2009, p. 84), thereby bringing the issue of recruiting higher number of workers in LTC to the fore. Hence, often the immigration of LTC workers has been regarded as a solution: thus, in many OECD countries, LTC workforce consists of a large share of foreign-born people (OECD 2011, p. 174). However, geographical proximity and high cross-border earning differences leads to an unbalanced situation within OECD, as immigration inflowing from the less affluent countries creates 'care drains' in these societies which has crucial consequences for both informal and formal care. These gaps of workface lead to a lowered quality of formal care, a general tendency to concentrate workforce in institutional care rather than home care and possibly also the emergence of an unregistered care market. The most important drivers of the high representation of migrant workers

providing care to the dependent elderly in many European countries were low salaries and overall poor job quality in the social care sector (Hooren 2012).

The strategies of the dependent elderly and their families should not be taken as given, because in practice they are limited and conditioned by the institutional framework of the care regime (Da Roit 2010). Clearly, one of the most frequently studied strategies aimed at coping with a deficit of comprehensive support in social care is the utilisation services provided within the healthcare sector. Such strategies might be more prevalent in countries where public healthcare systems are leaned towards hospital care, which can manifest itself by a high availability of hospital beds in a given country. In fact institutional care organised in the healthcare sectors in Poland and the Czech Republic is to some degree a 'substitute' for social services (Łuczak 2018) and the utilisation of those services could be regarded as rational, especially because healthcare facilities in these countries are generally less costly for individuals compared to social care sector facilities. In a similar vein, dependent people and their families may 'opt for' unregistered care facilities, because they are more available and/or less costly than formal care providers. In other words, the strategy of the dependent elderly and/or their families would be to minimise the costs of services/accommodation provided in institutional care by, *inter alia*, searching for less expensive offers of unregistered providers which might charge lower prices – possibly due to lower quality – than registered providers. This can lead to specific selection amongst the grey market, as lower-income people might be overrepresented among potential users. Therefore, the expansion of the grey market in residential care raises serious distributive challenges (Lepore et. al. 2017)

Cost-minimising strategies could be complemented with (and even probably, to some extent, substituted by) other strategies that may be a result of 'valuing' other aspects of 'grey' providers such as higher flexibility of arrangements (i.e. lack of administrative procedures prior to submitting an application to publicly-run institutions) and the general distrust towards 'public' institutions which might be driven by negative experiences with the public sector etc. Moreover, it seems that the public opinion may constitute a crucial factor with regard to the emerging grey market substitutes. Consequently, a predominant *perception* of poor quality (i.e. due to old, unrenovated buildings of institutional care settings or due to the fact that such facilities are too large and tend to provide services to various group of vulnerable people at

the same time) of publicly provided services within a given society facilitates the expansion of a private (grey) market.

While it is not controversial that the institutional care facilities of the 'grey' market may compete with residential facilities on the regular market (see below), one could also ask to what extent the 'grey' market in institutional care substitutes for the lack of formal support (of good quality) provided at home and/or in the neighbourhood. As approaching this question would be very difficult in practice, what researches could do is look at potential contextual variables that may be important in this regard. One of them is the quality of places where dependent people live, including also the issue of availability of space for additional persons (i.e. caregiver, possibly migrant care worker). Therefore, inadequate housing conditions which hinder 'ageing in place' might be a crucial factor for searching for relatively less costly substitutes, such as unregistered care providers. Another important contextual variable in this regard is support towards informal caregivers. This might be especially important in societies on a 'familistic' approach towards care for dependent people, because inadequate support of caregivers might lead to a growing interest cheaper alternatives, such as services offered on the grey market.

Finally, as indicated in the previous section (and exemplified below using the example of the Czech Republic), non-earmarked generous cash-for-care programmes, especially when there are no incentives for using formal services, might create favourable conditions for the expansion of grey markets.

4. Grey markets in residential elderly care in Poland and the Czech Republic: a short overview

The issue of unregistered care facilities has attracted the public attention in both countries mostly due to revelations concerning scandalous ill-treatment of the elderly in such institutions. As shown in the previous research (i.e. Lloyd et. al. 2014.), media scandals concerning residential care facilities contribute to inclusion of this issue into state policy agenda. Consequently, grey markets of residential care in both countries have been subjected to inspections by respective public institutions, including public audit institutions and/or public advocates, in the last few years.

The occasional monitoring of support for the older people in Poland conducted by the Supreme Audit Office in 2016 has provided interesting insights into the issue of unregistered care providers (NIK 2016). The report revealed that this problem existed in every province (*voivodeship*). According to the report, the problem could not be efficiently solved, because public administration was responsible for only, monitoring and inspections registered facilities; there was no easy access to providers who did not have authorizations. The report describes strategies adopted by managers of unregistered facilities who often pretended that they were involved in solely hotel activities that were open to disabled people or elderly people. Other providers, in order to disregard rules of authorization, registered two separate formal business activities (thereby splitting them): one related to care services and another one to accommodation services. The Supreme Audit office concluded that unregulated providers operated in buildings that had not been adjusted to needs of the frail elderly people. In 2016 the Ombudsman in Poland called the Prime Minister for creating a system that would facilitate inspections undertaken by local government administration representatives (*wojewoda*) of private facilities regardless of a name of entity and their declared function. In response, the Ministry of Family, Labour and Social Policy confirmed that the problem of mistreatment and elder abuse was serious in such entities and it requires changes in the legislation including introducing higher fines for providing services without authorization[1] (a draft of legislation still under preparation at the time of writing). According to the press statement issued by the Ministry of Family, Labor and Social Policy at the beginning of 2019, the number of unregistered care providers had been growing: there were 105 unregistered facilities in 2017; while this 'official estimate' increased to in 128 facilities in the next year[2].

According to varies estimates, there are between 70[3] and 80 (Lukasová 2015) unregistered care facilities in the Czech Republic. To best knowledge of the author of this paper, the most comprehensive source of information on unregistered residential care providers in the Czech

[1] See http://www.rynekseniora.pl/rynek_opieki/105/rafalska_zbudujemy_nowy_model_kontroli_i_ograniczymy_dzialalnosc_nielegalnych_domow_opieki,7394.html *(accessed 30 May 2019)*

[2] See *http://www.rynekseniora.pl/rynek_opieki/105/wiceszef_mrpips_wzrosla_liczba_nielegalnych_domow_opieki,10588.html (accessed 30 May 2019)*

[3] See https://socialnipolitika.eu/2018/11/zamestnavatele-nesouhlasi-se-zvysenim-prispevku-pouze-pri-peci-doma-povazuji-to-za-diskriminaci/ *(accessed 30 May 2019)*

Republic is the report by the Public Defender of Rights (the Ombudsman). This report is based on the results of detailed controls of nine unregistered facilities. According to the report, ill-treatment of the elderly has been detected in all controlled entities. The main results of this text are as follows (Public Defender of Rights 2015):

- care tasks, including nursing care, were provided by unskilled workers. Also, care was provided in a random and rather intuitive and amateurish way;
- buildings of the facilities were not adjusted to needs of people with impaired mobility and with dementia
- restrictions of the freedom of movement of residents were a common practice;
- clients had to hand over all their income to the facility, this practices violated the rules of registered social services according to which each user should retain minimum 15% of his/her income;
- families and other interested parties (such as health providers and even staff) often did not know that the facility that provided services is not registered. Moreover, according to the Ombudsman, some state authorities even tolerated provision outside formal rules due to 'ignorance' or underestimation of risk related to provision of services outside formal rules.

5. An empirical illustration: a grey markets in residential care as side-effects of LTC policy? (not completed; in progress)

To begin with, the crucial component of the LTC system in the Czech Republic – as mentioned above – is arelatively generous (for those with high needs) cash-benefit for dependent people. The political justifications for introducing a cash-for-care scheme in this country resembled those previously used in Western European countries (Ungerson, 2004), as this scheme was framed as the extension of the "free choice" of dependent people to determine the way care benefits could be used. The argument concerning the empowerment of service users through the increase in "choice" carried a lot of weight with the political process since the welfare system that was inherited from the pre-transition period was largely perceived as paternalistic (Večerník, 2008, p. 500). Data shown in Table 1 clearly indicate that there is a growing

utilization of residential care services among beneficiaries of the highest levels of care allowance alongside with a persistently high share of dependent people who opt for 'non-registered providers'. The latter category means that beneficiaries could transfer the cash allowance to a 'close person', but in practice the benefit could be (as the report by the Ombudsman has shown) also used to pay for provided services by unregistered providers.

Table 1. Utilization of the care allowance in the Czech Republic (share of beneficiaries in each level of dependency in %)

	Level I		**Level II**		**Level III**		**Level IV**	
	informal	residential	informal	residential	informal	residential	informal	residential
2007	79.3	10.8	78.2	15.2	80.1	15.2	68.5	26.6
2011	74.5	9.7	70.4	16.2	65.4	24.2	52.4	38.0
2017	80.8	9.0	76.6	14.9	67.1	26.1	50.7	43.5

Source: computed from (Průša, Víšek & Jahoda, 2013, p. 28) and from (Horecky & Prusa 2019). Level I is the lowest dependency, whereas level IV is the highest dependency)

Concerning demand for institutional care (which is to a great extent boosted by cash benefit) in this country, one could also emphasize that there has been persistently high number of people with 'unmet needs' with regard to access to formal residential care. For example, according to data given by Ministry of Labour and Social Affairs, the ratio of numbers of those who unsuccessfully applied for services provided by registered homes for seniors to those who used these facilities in Central Bohemian Region (the largest region in the Czech Republic) in 2017 was 173%, while in a less urbanized Liberec Region this ratio was 106%. It is argued that a big share of the elderly in the Czech Republic anticipate problems with receiving the support from the formal providers and apply for institutional care far in advance expressing lack of confidence in the ability of domiciliary care services to meet their needs (Kubalčíková & Havlíková 2011). Additionally, one of the consequences of introduction of cash-for-care scheme was rapid increase of prices charged by domiciliary care agencies for their services, thereby making that residential care might be more viable option for dependent people (also given the fact that many agencies do not offer comprehensive support and tend to provide such services as *meals-on-wheels* (Kubalčíková et. al. 2017)). The high demand for residential care has led to political decisions concerning redesigning cash-benefit in a way that – as it is believed by the government – would support the role of informal caregivers. Since 2019 the amount of cash benefits granted to people with two highest levels of dependency has been increased by 45 per on the condition that they will not opt for residential care, leaving users of residential care with unchanged amounts. As the utilization of cash-for-care is not monitored when a dependent person uses it

informally, the substantial increase of cash-benefit might – as indicated by the representatives of social services providers[4] - may further accelerate development of grey markets of residential care.

The common feature of social care services in both countries is that development of new care infrastructure in residential care in the has been taking place mostly in a private sector. The rapid expansion of for-profit residential care facilities in the last few years has been accompanied with a general stagnation with regard to publicly-run institutions. In the Czech Republic the number of regional and municipal facilities (i.e. the same kind of institutions as presented in Table 2) between 2011 and 2016 increased only by less than 4 per cent, whereas the number of beds available at these institutions decreased by more than 8 percent. As shown in the previous research (Łuczak 2018), the introduction of CfC in the Czech Republic services brought about the increase of number of beds in institutions for people with special needs (*Domovy se zvláštním režimem*) such as Alzheimer's disease: between 2007 and 2016 the number of beds in such units increased by four times due to ongoing process of establishment of new units of this kind (mostly run by non-public entitirs). However, in the same period, the number of available beds in homes for seniors (*Domovy pro seniory*)—the most common residential social care facilities—decreased by 10%, whereas the number of such residential units increased by 10% which indicates some qualitative changes in this domain mostly due to the role of private sector (i.e., newly open homes for seniors tend to be smaller; one-bed rooms are becoming more common, etc.).

Table 2. Number of registered private for-profit residential social care facilities

	Year	Number of residential care facilities	Number of beds
CZR	2011	55	2309
	2016	195	10158
PL	2011	145	4170
	2016*	368	12224

Note: for CZR we include only Domovy pro seniory and Domovy se zvláštním režimem run by *Ostatn*i (private person, excluding i.e. church organizations)

Note: * data for Mazowieckie woivodiship for 2015; data for PL include all for-profit institutions that provide 24/7 care

The standards of services for registered private residential care in Poland have been obviously stipulated by the law, but generally they are lower than in public institutions due to less restrictive requirements concerning employment regulations and staff qualifications. Thus,

[4] See https://socialnipolitika.eu/2018/11/zamestnavatele-nesouhlasi-se-zvysenim-prispevku-pouze-pri-peci-doma-povazuji-to-za-diskriminaci/

prices for private providers are competitive comparing to prices for residential care in a public sector. These facilities offer also more flexible practices (i.e. without following administrative procedures) that might be adjusted to needs of dependent people and/or their families, such as stays for short-stays (that is generally not possible in a public system). In Poland eligibility rules to social care services are not based, like in the Czech Republic, solely on criterion of needs, but a family situation of a claimant is also taken into account (as care services in Poland are intended to predominantly substitute for the lack of access to informal family care).

Based on aggregate administrative data on domiciliary care services in Poland (own calculation on data derived from ministry reports) it can be argued that the number of people who were granted a social services is steadily growing, but at the same time total number of services delivered is more or less stable – which means that the granted support is becoming less intensive in terms of average time/tasks devoted to one beneficiary. Although introduction of fees for accommodation in residential care services provided by municipalities in 2004 (including participation of costs from families) led to decrease of waiting times for these institution, there are also other 'alternatives' in public residential system that steadily increasing availability of nursing homes provided in the healthcare sector. In sum, in Poland, similarly to Czech Republic, we can conclude that dependent people are 'pushed' into residential settings, thereby increasing the potential of unregistered providers.

6. Discussion (in progress)

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