Social Policy Issues

ISSN: 1640-1808
E-ISSN: 2719-7328

1/2025 vol. 68

Problemy Polityki Społecznej

Faculty of Political Science
and International Studies
University of Warsaw

Published thanks to the support of the University of Warsaw under the Excellence Initiative – Research University programme and the Faculty of Social Science and International Studies

ISSN 1640-1808
e-ISSN 2719-7328

PUBLISHING PARTNER
Scholar Publishing House Ltd.
ul. Obożna 1, 00-340 Warsaw, Poland
phone: + (48) 22 692 41 18; e-mail: info@scholar.com.pl
www.scholar.com.pl

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The reference version of the journal is the online version

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Problemy Polityki Społecznej. Social Policy Issues 2025, 68(1): 1–26
https://doi.org/10.31971/pps/196564

Submitted: 2023-12-05/Accepted: 2024-11-27

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Migration and healthcare professionals in the public sector in Kosovo

Abstract

This study examines the migration of healthcare professionals in Kosovo, emphasising trends and motivations following the EU and Switzerland's visa liberalisation in January 2024. A survey of 50 specialist doctors and 50 nurses from the University

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Clinical Center of Kosovo and General Hospitals reveals a high intent to emigrate, particularly, among nurses (72%) compared to doctors (34%). Key drivers include inadequate salaries, poor working conditions, limited health insurance, career stagnation, and personal well-being. Younger professionals (18–30) show the highest inclination to migrate, with male nurses displaying stronger emigration tendencies. Social influences affect migration intentions, with 82% of nurses and 58% of doctors citing family encouragement. Preferred destinations like Germany and Switzerland offer supportive healthcare systems and competitive compensation. The study contextualises these findings within brain drain theory, push-pull theory, and world systems theory, highlighting systemic deficiencies in Kosovo's healthcare sector. Policy reforms are needed to enhance financial incentives, working conditions, and career growth opportunities to retain healthcare talent as well as mitigate brain drain.

Keywords: migration, Kosovo, doctors, nurses

1. Introduction

The migration of healthcare professionals, commonly known as the "brain drain", poses a significant challenge to Kosovo's healthcare sector. Brain drain refers to the movement of health personnel seeking better living standards, higher salaries, access to advanced technology, and stable political conditions (Dodani & LaPorte, 2005). This study investigates the trends and factors influencing healthcare professionals' migration intentions in Kosovo, with a particular focus on the University Clinical Center of Kosovo and general hospitals in Kosovo. Employing a mixed-methods approach, the research includes a survey of 50 specialist doctors and 50 nurses in public healthcare facilities to identify the main drivers behind migration tendencies, encompassing demographic factors and systemic challenges in Kosovo's healthcare infrastructure.

The study is based on three theoretical frameworks: brain drain theory, push-pull theory, and world systems theory. The brain drain theory highlights the effects of skilled emigration on Kosovo's healthcare system, where limited resources drive qualified workers abroad (Docquier & Rapoport, 2012). The push-pull theory analyses internal "push" factors, such as low salaries and poor working conditions, against external "pull" factors, including better job opportunities abroad (Lee, 1966). World systems theory contextualises Kosovo's migration trends within global economic disparities, illustrating the impact of inequalities between core and peripheral economies on labour migration (Wallerstein, 1974).

Findings indicate that younger healthcare professionals, particularly, male doctors aged 18–30, are more inclined to migrate than their older counterparts. Financial constraints, including low salaries and poor working conditions, are the primary push factors, while family well-being and recent visa liberalisation with the EU and Switzerland further contribute to migration intentions. This study highlights systemic challenges driving healthcare professionals abroad and offers insights for targeted policies to enhance retention in Kosovo's healthcare sector.

2. Theoretical background

Understanding the migration of healthcare professionals from Kosovo necessitates a comprehensive theoretical framework that addresses the multifaceted drivers and consequences of this phenomenon. This chapter integrates key migration theories, including the brain drain theory, world systems theory, and push-pull theory to analyse the factors influencing healthcare workers' emigration. These theories elucidate the complex interplay of economic, social, and professional networks prompting healthcare professionals to seek opportunities abroad, while also highlighting the systemic challenges in Kosovo's healthcare sector.

2.1. Migration theories in the context of healthcare professional emigration

The brain drain theory offers insights into the emigration of skilled healthcare professionals from Kosovo. It asserts that skilled individuals from less developed countries (LDCs) migrate to more developed countries (MDCs) in search of better opportunities, such as higher salaries, access to advanced technology, and improved living standards (Docquier & Rapoport, 2012; Ferrie & Hatton, 2013). Dodani and LaPorte (2005) characterise brain drain as the migration of health personnel seeking enhanced living conditions, professional growth, and political stability. The exodus of skilled professionals from Kosovo results in a shortage of qualified personnel, adversely affecting healthcare delivery and overall public health.

The world systems theory frames global migration within core-periphery dynamics (Wallerstein, 1974). Core countries with robust economies attract skilled labour from peripheral nations like Kosovo, which experience economic instability and limited resources. This theory emphasises the economic disparities driving healthcare worker migration from Kosovo to developed countries. Despite recent wage increases, the persistent pay gap between Kosovo and EU nations remains a significant pull factor for healthcare professionals.

The push-pull theory provides a dual framework for understanding migration by identifying factors that compel individuals to leave their home country (push factors) and those that attract them to a new destination (pull factors) (Lee, 1966; Brettell & Hollifield, 2000). For Kosovo's healthcare workers, push factors include inadequate salaries, insufficient health insurance, and limited professional development opportunities, as highlighted by survey respondents. Conversely, pull factors encompass the prospect of higher wages, advanced medical training, and enhanced living conditions in developed healthcare systems.

2.2. Global trends and migration in Kosovo's public healthcare system

The migration of healthcare workers is shaped by both global and local dynamics. Over the past two decades, migration has increasingly appealed to medical specialists, students, and recent graduates (Bunduchi et al., 2024). Developed nations face a rising demand for healthcare professionals, which often goes unmet in less developed

regions. The WHO (2016) predicts a global shortage of 18 million healthcare workers by 2030, particularly in low- and middle-income countries, posing threats to global health security as these nations lose essential personnel (IFMSA, 2021). This outflow limits access to vital services, including public healthcare (FEPS, 2024).

Young professionals are more likely to migrate due to poor working conditions and limited career opportunities in their homelands, often pursuing education or employment abroad (Bunduchi et al., 2024). Countries frequently struggle to attract and retain youth in health professions (WHO, 2023), with less developed nations primarily contributing to healthcare migration to developed countries (Vujicic et al., 2004). Nurses, in particular, seek better opportunities, higher incomes, and family support abroad (Hughes, 2022).

Eurostat data indicates that from 2008 to 2018, 529,647 Kosovans emigrated, compared to 318,271 from Bosnia, 258,020 from North Macedonia, and 36,089 from Montenegro. Albania led with 1,249,706 emigrants during this period (UNDP, 2020). Within the Western Balkans, emigration rates are highest in Albania (28%), followed by Kosovo (22%) and Bosnia and Herzegovina (20%). This trend suggests a sustained propensity for migration from Kosovo until per capita incomes align with those in the EU (Government of Kosovo, 2024).

OECD survey results emphasise "higher salaries" as a critical migration motivator, with 79% of respondents considering this factor highly important (OECD, 2022). The substantial salary disparities between Western European and Western Balkan countries, coupled with limited professional opportunities, contribute to emigration from the region (Pranghe et al., 2020). Between 2012 and 2014, around 1,700 physicians under 30 migrated for work from Serbia, North Macedonia, Albania, and Kosovo (Lazarevik, 2016). Recent years have seen a surge in healthcare worker emigration from the Western Balkans, driven by superior salaries and career opportunities abroad (Omic & Handeland, 2021). In 2018, average salaries in health and social work sectors in Western Balkan countries were two to three times lower than those in the EU (BPRG, 2020). Germany, Slovenia, Austria, Switzerland, Croatia, Denmark, and Italy have emerged as primary destinations for health professionals from the region, especially in the last five years. Germany notably attracted over 18,000 healthcare workers from the Western Balkans between 2015 and 2020, accounting for nearly 20% of foreign-trained professionals migrating to Germany in this period, with 37% from Bosnia and Herzegovina, 28% from Serbia, and 13% each from Albania and Kosovo (Mara, 2023).

These global migration trends have profound implications for Kosovo. Stakeholder interviews reveal that emigration significantly affects skilled workers, particularly, in healthcare (UNDP, 2020). Despite efforts to enhance working conditions and salaries, Kosovo struggles to retain healthcare professionals, who are increasingly lured by better career prospects, salaries, and working environments in developed countries.

2.3. Migration dynamics and challenges in Kosovo's healthcare sector

Kosovo's emigration, whether regular or irregular, stems from push factors such as youth unemployment, high corruption levels in the public sector, as well as inadequate

healthcare and education policies (BPRG, 2020). Kosovo is among the top five origin countries with the highest emigration rates in the world; however, accurate estimates of Kosovars abroad are challenging due to data limitations (IBRD, 2024). However, data from the Kosovo Agency of Statistics (KAS) indicate that approximately 41,553 individuals emigrated from Kosovo in 2022, including legal and illegal migrants (KAS, 2023). The emigration rate for Kosovo is about 31%, placing it among the top five countries globally with populations exceeding one million (IBRD, 2024). The most recent data from the World Bank's Life in Transition Survey (LITS IV) conducted in 2022–2023 reveal that over 15% of individuals intend to migrate abroad within the next year, double the rate of those considering internal migration.

Despite improvements in migration management, there is still a need for enhanced data collection, analysis, and staff training. Kosovo's institutional structure and legal framework largely align with EU standards (European Commission, 2024). The healthcare sector has experienced significant impacts due to the emigration of skilled doctors, nurses, and health technicians. A few years ago, the Federation of Kosovo Health Syndicates reported that around 400 medical doctors emigrated, with approximately 73% of medical students expressing intentions to leave (UNDP, 2020). Kosovo currently has a higher number of nursing graduates than available job positions which is about 4,000 nursing students graduate from private institutions, along with 350 from public systems each year (IBRD, 2024). The Government Authority for Monitoring Migration Movements in Kosovo noted that first-time residence permits issued to Kosovar citizens for employment in EU member states decreased to 8,802 in 2022 from 16,785 in 2019. Approximately two-thirds of Kosovar citizens with valid first-time residence permits in the EU and Schengen countries reside in Germany, Slovenia, and Croatia (GAMMM, 2023). Currently, 9,416 Kosovars are employed in Germany's healthcare sector (GAP, 2024a).

Migration within Kosovo has shown steady movement over the years, despite recent decisions by the European Union (EU, 2023) and Switzerland (Der Bundesrat, 2023) to lift visa requirements for Kosovo citizens. Since January 1, 2024, holders of Kosovo passports enjoy visa-free travel to the EU (European Commission, 2024). Although there were expectations of significant departures from Kosovo following visa liberalisation, there is still no verified data on how many Kosovo citizens have emigrated in 2024. According to the European Commission (2024), there has been an increase in emigration from Kosovo, primarily for economic reasons. However, a study by Rexhepi and Murtezaj (2024) concludes that visa liberalisation has not significantly impacted the domestic market, and Kosovo has not experienced a substantial outflow of citizens since January 1. Considering current indicators of Kosovo's economic development, public sentiment, and the unique aspects of the local labour market, a large-scale labour migration from Kosovo is not expected to occur (Rexhepi & Murtezaj, 2024), even in the future, as a result of lessening EU visa restrictions.

Visa liberalisation expected in January 2024 may further influence migration dynamics, likely increasing emigration rates due to high demand for healthcare professionals in EU countries. Migration within Kosovo have demonstrated continuous upward movement over the years, and a new wave of migration is anticipated to commence in 2024. According to the UNDP (2024), here are worries that visa

liberalisation could exacerbate the brain drain, particularly among young and educated individuals, undermining efforts to build a more dynamic and competitive economy. Recent decisions by the European Union (EU, 2023) and Switzerland (Der Bundesrat, 2023) to lift visa requirements for Kosovo citizens mark significant milestones for Kosovo and its citizens. Commencing January 1, 2024, Kosovo citizens are expected to enjoy unrestricted travel within the European Union's Schengen area and Switzerland. The migration trends and factors affecting the doctors and nurses within the University Clinical Center of Kosovo and general hospitals in Kosovo are comprehensively understood through a survey conducted with 50 specialist doctors and 50 nurses, and the findings are presented in the results. Kosovo contends with a notably low number of doctors and nurses per capita compared to the EU average, a shortfall primarily exacerbated by their migration to other countries, notably Germany.

The interplay of social dynamics, economic conditions, and personal aspirations continues to propel healthcare workers towards migration. Research from the GAP Institute indicates that 27.9% of the population plans to emigrate from Kosovo within the first quarter of 2024. This emerging trend following visa liberalisation reflects demographic shifts, particularly, among younger populations. In 2023, Eurostat reported 3,045 asylum applications from Kosovo nationals in the EU27, a slight decrease from 3,185 in 2022 (European Commission, 2024).

Data suggest that the majority of potential emigrants are young individuals motivated by the prospect of higher wages and better working conditions abroad. Notably, 33.4% of prospective emigrants are under 24, indicating a substantial youth presence among those contemplating emigration (GAP, 2024a). The inclination to migrate is particularly evident in key economic sectors, with 7.1% of respondents in human health activities and social work expressing intentions to leave Kosovo.

The emigration of healthcare professionals has escalated into a pressing issue with significant repercussions for Kosovo's healthcare system. This chapter establishes a theoretical foundation for understanding the migration trends and their implications for the country's healthcare sector, emphasising the need for policies aimed at retaining skilled workers and enhancing the overall healthcare environment.

3. Methodology and Data

3.1. Study Overview

This study investigates the migration patterns of healthcare professionals in Kosovo's public health sector, emphasising the factors driving these movements. It focuses particularly on the University Clinical Center of Kosovo, which represents the tertiary level, and the general hospitals, which represent the secondary level of the healthcare system, as defined by Law No. 04/L-125 on Health (OG-RKS, 2013)[2].

[2] As defined by Law No. 04/L-125 on Health, the public healthcare sector in Kosovo is organised into three levels: primary, secondary, and tertiary. The primary level includes the main family medicine centres with their constituent units, as defined by sub-legal acts issued by the Ministry. The secondary level comprises general and specialised hospitals, specialised poly-

Given Kosovo's status as a peripheral economy, established migration theories – brain drain theory, push-pull theory, and world systems theory – are employed to interpret how economic, professional, and social dynamics influence migration decisions. The study combines a literature review, statistical analysis, and targeted surveys to address the research question:

RQ: *What are the trends and factors influencing the migration of healthcare professionals in the University Clinical Center of Kosovo and general hospitals in Kosovo?*

3.2. Literature review

This study leverages core migration theories to examine the factors influencing healthcare professional migration in Kosovo. The brain drain theory elucidates how limited resources and career advancement opportunities compel professionals to seek better conditions abroad. The push-pull theory distinguishes between push factors, such as insufficient compensation and poor working conditions, and pull factors, including competitive salaries as well as improved environments abroad. The world systems theory situates these patterns within a global economic framework, highlighting disparities between Kosovo's economy and more stable, opportunity-rich nations. This theoretical framework also informs survey design and analysis, linking migration patterns to specific economic and professional factors while contextualising them within broader systemic inequalities.

3.3. Analysis of secondary data

This study complements the theoretical exploration with an analysis of statistical data obtained from the Kosovo Agency of Statistics, the Ministry of Health, and the State Treasury. The data includes employment figures, salary levels, and other economic indicators specific to healthcare professionals in Kosovo's public health sector, with a particular focus on the University Clinical Center of Kosovo and general hospitals in Kosovo.

3.4. Survey with healthcare professionals

To gain direct insights into the factors influencing healthcare professionals' migration decisions, two surveys were conducted among 100 respondents – 50 specialist

clinics and clinics, dental clinics, mental health centres with community integration houses, blood transfusion centres, centres for physical and climatic rehabilitation, sports medicine centres, occupational medicine centres, regional public health centres, and centres for the rehabilitation of hearing and speech. The tertiary level includes the University Clinical Center of Kosovo, the University Dental Clinical Center, the National Institute of Public Health, and the national centres for occupational medicine, sports medicine, blood transfusion, and telemedicine (OG-RKS, 2013).

doctors and 50 nurses – working in public healthcare institutions, including the University Clinical Center of Kosovo (UCCK) and general hospitals in Kosovo. Each survey contained 10 identical questions aimed at exploring areas such as professional motivations, economic considerations, working conditions, and external factors influencing migration.

Anonymity and data privacy: in adherence to ethical standards, the survey was designed to ensure participant anonymity. No personal information, such as names or identification numbers, was collected, allowing respondents to express their views freely and honestly regarding their motivations and challenges without concern for personal identification.

Survey structure and data collection: the online survey, administered via Google Forms and processed in Excel, focused on core areas influencing healthcare professionals' migration intentions, including primary factors like low salaries, limited career progression, and challenging working conditions, as well as pull factors such as improved opportunities abroad. It examined migration trends over the past decade, the influence of family and colleagues on migration decisions, and reasons for staying in Kosovo, aiming to understand the motivations and challenges that impact professionals' choices regarding migration.

Data processing and analysis: data collected from these thematic areas was analysed in Excel to identify patterns and trends. The qualitative and quantitative responses were synthesised to capture the motivations and potential factors that could influence healthcare professionals to stay or consider migration. This mixed-methods approach ensures a balanced perspective on the broader and nuanced influences affecting migration trends within Kosovo's healthcare sector.

3.5. Survey sample

Sample selection and justification: the study strategically selected a sample of 50 specialist doctors and 50 nurses to represent Kosovo's public healthcare workforce, particularly, within the University Clinical Service of Kosovo (UCCK) and general hospitals in Kosovo, which employ around 3,302 healthcare professionals, including 729 specialist doctors and 1,893 nurses. This choice reflects the structure of Kosovo's healthcare sector, focusing on its largest professional groups. Although the sample represents only 3.03% of the total workforce, it effectively captures diverse insights and challenges faced by these professionals, supporting the study's goal of understanding migration motivations and informing targeted policies for retention in the sector.

Survey sample distribution: in the survey of specialist doctors among the 50 respondents, 22 were from the University Clinical Center of Kosovo (UCCK), with 4 from the general hospitals of Peja, Ferizaj, Vushtrri, Mitrovica, Gjakova, Prizren, and Gjilan respectively. Similarly, in the survey of nurses among the 50 respondents, 22 were from UCCK, and four from the general hospitals of Prizren, Mitrovica, Gjakova, Gjilan, Peja, Ferizaj, and Vushtrri. The survey ensured a balanced representation by including healthcare professionals from various specialties.

Among the 50 specialist doctors surveyed, five were paediatricians. Four doctors represented the departments of anesthesiology, neonatology, pulmonology, radiology, and gynecology and obstetrics. Additionally, three doctors each were cardiothoracic surgeons, otolaryngologists, urologists, and emergency medicine doctors. Internal medicine had two respondents. Other departments, such as pediatric dentistry, neurology, microbiology, dentistry, oncology, orthopedics, and gastroenterology, had one respondent each, while epidemiology and ophthalmology had two respondents each.

The group of the 50 nurses surveyedhad the following representation: five nurses were from both cardiology and emergency medicine. Four nurses were from gastroenterology, gynecology, paediatrics, and radiology. There were also two nurses from neonatology, otolaryngology, endocrinology, abdominal surgery, vascular surgery, neurosurgery, and pulmonology. Additionally, orthopedics, psychiatry, urology, infectious diseases, thoracic surgery, ophthalmology, and dentistry each had one representative.

4. Results, emigration of healthcare professionals from Kosovo

This chapter presents the findings from the survey conducted among healthcare professionals in Kosovo, specifically 50 specialist doctors and 50 nurses working at the University Clinical Center of Kosovo (UCCK) and general hospitals. The administrative and survey-related details, including the distribution of the sample, specialty coverage, and data collection methods, have been comprehensively outlined in part 3 of this article. This section focuses on analysing the responses to understand migration intentions, demographic factors, and the key motivations influencing healthcare professionals' decisions.

4.1. Migration intentions

The survey findings reveal significant differences in migration intentions between specialist doctors and nurses in Kosovo, highlighting their varying professional and personal motivations. Among the 50 specialist doctors surveyed, 34% expressed intentions to migrate, while 66% indicated a preference to stay in Kosovo. In contrast, the data for nurses show a much higher propensity for migration, with 72% considering emigration compared to only 28% who plan to remain in Kosovo. These results suggest that nurses exhibit a stronger inclination to migrate than doctors, likely due to disparities in working conditions, career advancement opportunities, and economic incentives that are more pronounced in nursing roles.

As illustrated in Figure 1, migration trends are notably high among healthcare professionals, particularly nurses. A significant majority of nurses (72%) expressed a willingness to emigrate, while a much smaller percentage of doctors (34%) also considered migration. This underscores the urgent need for targeted interventions to address the root causes driving healthcare professionals to seek opportunities abroad.

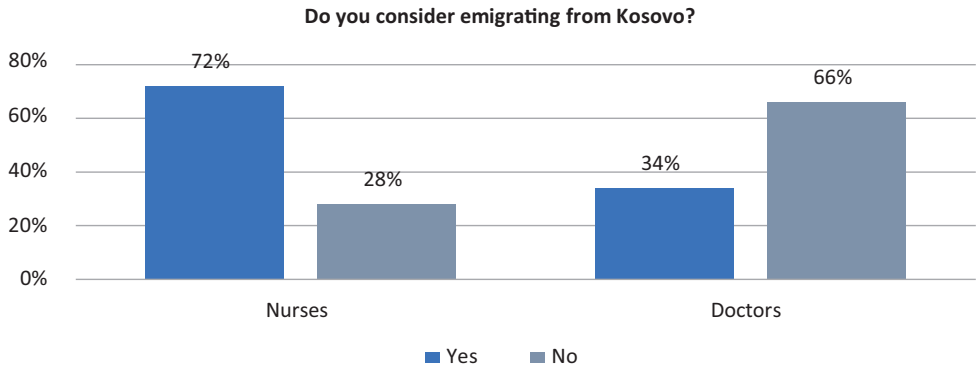

Figure 1. Emigration tendencies among doctors and nurses in Kosovo

Based on the data regarding migration tendencies among doctors and nurses, of the 50 surveyed doctors, in the University Clinical Center of Kosovo (UCCK), seven doctors indicated that they are considering emigration ("YES"), while 15 responded that they are not considering emigration ("NO"). In the general hospital of Peja, two doctors said "YES", and another two said "NO". Similarly, in the general hospital of Ferizaj, two doctors expressed that they are considering emigration, while 2 others said they are not. In the general hospital of Vushtrri, two doctors answered affirmatively, and two negatively. Additionally, in the general hospital of Prizren, Mitrovica, Gjakova, and Gjilan, each had one doctor with a "YES" answer to emigration and three responding "NO".

For nurses, out of the 50 respondents, 18 nurses at UCCK indicated that they were considering emigration, while four responded that they were not thinking about it. In the general hospital of Prizren, three nurses answered affirmaively and one negatively. In the general hospital of Mitrovica, one nurse was for emigration, while three were against it. For the general hospitals of Gjakova and Gjilan, two nurses in each hospital indicated a "YES" answer and two responded with a "NO". Additionally, in the general hospitals of Peja, Ferizaj, and Vushtrri, each had three nurses in favour of migration intentions and one against.

While based on the data regarding migration tendencies among doctors and nurses across various units, in the pediatrics department, two doctors indicated that they were considering migration, while three responded that they were not thinking about it. In the anesthesiology department, there was an equal split, with two doctors responding affirmatively and negatively. In neonatology and pulmonology, one doctor stated "YES" and three stated "NO" in each unit. In radiology, as well as in gynecology and obstetrics, two doctors were in favour of emigration and other two were against it. For cardiothoracic surgery, one doctor responded affirmatively, while two responded negatively. Similarly, in otolaryngology and urology, there was one doctor in favour and two against it in each department. In emergency medicine, one doctor considered migration while two did not. Internal medicine had a balanced response with one doctor for and one against. In paediatric dentistry, neurology, microbiology, and dentistry, there was one doctor in each department with a negative response, without any positives, while in ophthalmology and epidemiology there was one doctor

responding "YES" and one responding "NO. Finally, in oncology, orthopedics, and gastroenterology departments there was one doctor answering "NO" in the survey, with no "YES" responses.

For nurses, in the cardiology department, three nurses indicated that they were considering migration, while two responded they were not thinking about it. In gastroenterology, gynecology, paediatrics, and radiology, three nurses said "YES" and one said "NO" in each department. Both neonatology and otolaryngology had two nurses considering migration, no negative responses were recorded. Emergency medicine showed the highest tendency for migration, with four nurses in favour of migration and one against it. In the anesthesiology and intensive care units, one nurse responded affirmatively, while two negatively. In the endocrinology, abdominal surgery, and vascular surgery departments one nurse said "YES" and one said "NO" in each unit. In neurosurgery and pulmonology, the situation was the same. Lastly, in orthopedics, psychiatry, urology, infectious diseases, thoracic surgery, ophthalmology, and dentistry one nurse responded affirmatively in each department.

To provide a comprehensive view of the migration dynamics within Kosovo's healthcare sector, the survey also examined historical migration patterns by asking respondents about the number of colleagues who had emigrated over the past decade. Responses from nurses indicate that 26% were aware of 1–5 such people, while 40% reported knowing 5–10 colleagues who had left Kosovo. Furthermore, 26% mentioned over 20 colleagues who had emigrated, suggesting a high level of migration awareness among nurses. Notably, none of the nurses knew more than 50 or 100 colleagues who had emigrated, while 8% stated they were unaware of anyone who had emigrated in the past decade. In comparison, doctors' responses reveal that 22% were aware of 1–5 colleagues who had migrated, while 36% knew of 5–10 such cases. Additionally, 18% indicated they knew more than 20 colleagues who had emigrated. A smaller portion of doctors reported larger numbers: 12% stated they knew over 50 people who had migrated, and 4% reported knowing over 100 colleagues. In contrast, 8% of doctors said that they did not know any colleagues who had left the country in the past decade.

Moreover, the survey investigated the encouragement from family and colleagues regarding emigration. Among nurses, 82% (41 respondents) reported that their family and colleagues encouraged them to emigrate, whereas only 58% (29 respondents) of doctors indicated similar encouragement. This disparity suggests that social influences significantly shape the migration intentions of healthcare professionals in Kosovo, particularly, among nurses.

In terms of preferred countries for emigration, responses differed slightly between the two groups; however, both doctors and nurses showed a strong preference for Germany and Switzerland as top destinations. Among the 50 doctor respondents, 18 selected Germany as their desired destination, while nine preferred Switzerland. Three doctors pointed to the United Kingdom and Sweden as potential migration locations, with Denmark and Italy being selected by two doctors. Additionally, one doctor expressed interest in the Netherlands, and another indicated a general preference for "anywhere outside Kosovo". Six doctors expressed interest in migrating to the United States, whereas four doctors stated they were not inclined to emigrating and preferred to stay in Kosovo.

Among the 50 nurse respondents, 23 indicated Germany as their preferred destination, while seven chose Switzerland. Three nurses selected Sweden, and one – the United States as their desired destination. Additionally, two nurses expressed a non-specific preference for "anywhere outside Kosovo", and 14 nurses stated that they had no interest in emigrating, preferring to remain in Kosovo instead.

These findings highlight the ongoing brain drain issue within Kosovo's healthcare sector, particularly, among nurses who reported higher numbers of emigrating colleagues compared to doctors. This trend underscores the systemic challenges faced by healthcare professionals in Kosovo, including inadequate economic opportunities and limited professional development prospects.

4.2. Age-specific trends in migration intentions

The population of Kosovo is relatively young, with 47.3% under 25 years old. In 2021, only 8% of Kosovo's population was over 65 years of age – compared to 19% in the EU-27 (Government of Kosovo, 2024). Continued high levels of labour emigration, especially of young talents, pose a severe development challenge for the region. (OEDC, 2022). Youth (aged 15–24) also constitute an important share of the migrant population. The emigration of the youth is a persistent trend in recent times: analysis of WB6 labour force survey data covering the period 2015–2019 shows that emigration tends to be most pronounced among the younger cohorts (Leitner, 2021). The analysis of the survey data from this research reveals distinct age-specific trends in migration intentions among healthcare professionals in Kosovo. Respondents were asked, "Are you considering emigrating from Kosovo?" with responses analysed across different age groups for both doctors and nurses (Figure 2).

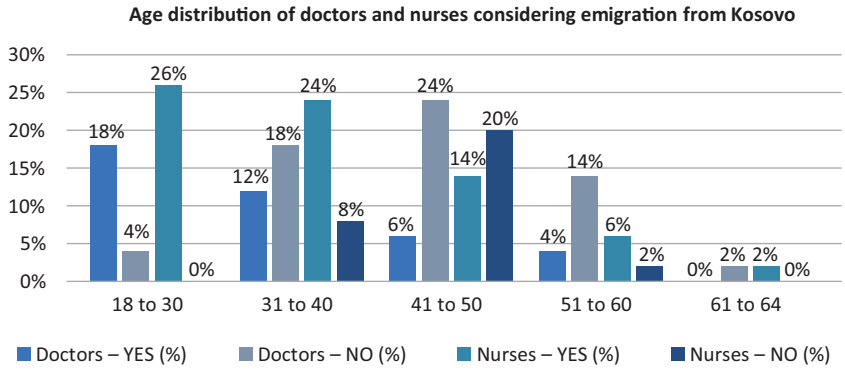

Figure 2. Age distribution of doctors and nurses considering emigration from Kosovo

The findings indicate that younger healthcare professionals, particularly, those aged from 18 to 30, are the most likely to express intentions to migrate. Among doctors, this age group shows the highest inclination to emigrate, which aligns with the push-pull theory. Younger doctors may be driven by the "pull" of opportunities abroad,

including better training, career advancement, and higher salaries, as well as the "push" of economic challenges and limited professional development opportunities within Kosovo. The trend diminishes as age increases, with older doctors, especially those nearing retirement age (61 to 64 years), showing significantly less interest in emigration. This pattern suggests that as doctors progress in their careers, the potential risks and uncertainties associated with migration might outweigh the perceived benefits.

For nurses, a similar pattern emerges. The survey results show that nurses between the ages of 18 and 30 are the most inclined to consider migration, with 13 out of the 36 respondents who answered affirmatively. The desire to emigrate decreases as age advances, with only one respondent from the age group of 61 to 64 years indicating an interest in leaving the country. Nurses in the 31 to 40 age group also show a relatively high inclination to emigrate, with 12 respondents expressing this intention. This distribution underscores that younger nurses are driven more by economic and professional development factors, as suggested by the brain drain theory, which posits that younger, skilled professionals are more likely to seek opportunities abroad when local conditions are inadequate.

The data also highlight that, among older age groups, particularly, those between 41 and 50 years, there is a greater tendency to stay. This could be attributed to established careers, familial responsibilities, or the perception that migration may not yield long-term benefits as these professionals are further along in their professional journey. These findings align with the theoretical framework, showing that migration intentions are heavily influenced by age, career stage, and perceived professional growth prospects.

In summary, the age-specific trends observed in this study provide critical insights into the migration dynamics of Kosovo's healthcare sector. Younger healthcare professionals, who are at the beginning or early stages of their careers, are more inclined to migrate due to economic and professional factors, while older ones are less likely to leave as they approach career stability and retirement. These findings highlight the need for targeted policy interventions to retain young talents, emphasising improvements in salary, working conditions, and professional development opportunities.

4.3. Gender of doctors and nurses considering migration

The migration patterns of healthcare professionals in Kosovo reflect complex gender dynamics similar to what is observed globally. Gender norms significantly influence the educational fields that boys and girls pursue, with boys tending to gravitate towards engineering, while girls often favour education and healthcare. Professions traditionally chosen by women are typically linked to the public sector and lower-paid occupations (AGE, 2020).

According to the Agency for Gender Equality in Kosovo, despite the improvements in girls' educational participation, their employment prospects remain adversely affected by lower education rates compared to men among the working-age population (AGE, 2020). Specifically, over two-thirds of girls (62.8%) attending vocational schools are enrolled in fields such as business, administration, law, health, and welfare, whereas over 43% of boys are enrolled in engineering, manufacturing, and construction.

Notably, 75% of women students express a preference for studying in the health sector, with a strong inclination towards public employment (AGE, 2020).

In 2022, the labour force participation rate for the population aged 15–64 in Kosovo was 38.6%–55.5% for men compared to only 22% for women – highlighting a significant gender gap that remains below the EU-27 average of 74.5% for the same age group (Government of Kosovo, 2024). Low participation rates, particularly, among women and young people aged 15–24 (19.4%), underscore the systemic challenges in the labour market.

Survey data reveal significant gender-specific trends in the migration intentions of healthcare professionals in Kosovo. These findings are crucial for understanding how gender influences emigration trends and for developing gender-sensitive policies to address these challenges effectively.

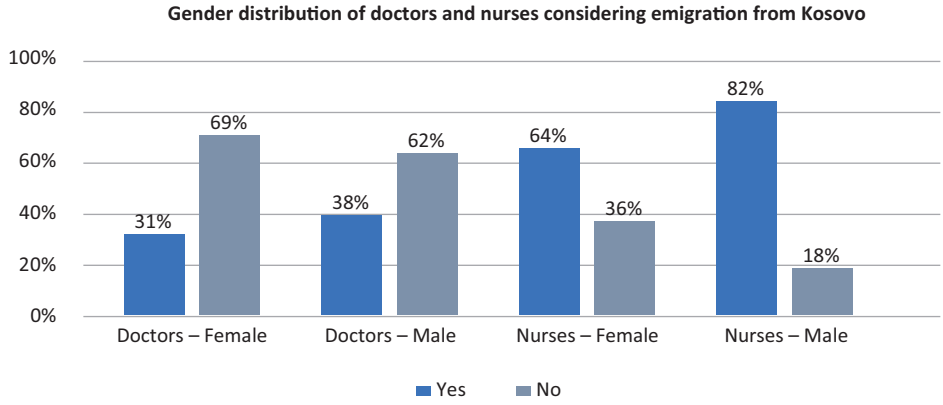

Figure 3. Gender distribution of doctors and nurses considering emigration from Kosovo

Among doctors, male respondents exhibit a higher tendency to migrate than their female counterparts. Out of 21 male doctors surveyed, 38% expressed intentions to emigrate, while 62% indicated a preference to remain in Kosovo. This trend suggests that male doctors may be more motivated by factors such as career advancement opportunities and economic incentives abroad, which serve as stronger "pull" factors for migration.

Conversely, the majority of female doctors, comprising 69%, opted to stay in Kosovo, with only 31% considering migration. This preference may reflect a greater emphasis on stability, family considerations, or the challenges associated with practicing in a new environment. These findings align with theoretical perspectives that highlight the differing motivations for migration based on gender, where professional and personal factors interact in distinct ways for men and women.

The patterns among nurses differ markedly, with both genders showing a strong inclination toward migration. Among the 39 female nurses surveyed, 64% expressed a desire to emigrate, while 36% intended to remain in the country. This pronounced interest in migration among female nurses suggests a high level of economic and professional dissatisfaction, driving many to seek opportunities abroad despite potential personal and family obligations.

For male nurses, the trend is even more striking; 82% expressed intentions to migrate, compared to just 18% who preferred to stay. This indicates that male nurses may be particularly affected by challenging economic and professional conditions, prompting a significant majority to seek work opportunities outside Kosovo. This trend emphasises the urgent need for targeted interventions to improve working conditions and provide better incentives for this demographic to remain.

These gender-specific findings underscore the importance of recognising gender as a critical factor when addressing the migration of healthcare professionals. The data suggest that while male doctors and nurses are more likely to migrate due to economic and professional reasons, female healthcare professionals – especially doctors – tend to prioritise other considerations. Consequently, tailored policy measures are necessary to address the specific needs and motivations of each gender, focusing on improving economic conditions, enhancing professional development opportunities, and supporting work-life balance, particularly for female healthcare professionals.

4.4. Factors influencing emigration

Emigration among healthcare professionals is influenced by a complex interplay of personal and professional factors. According to Hansen (2003), migration is not driven by a single factor but rather by a combination of interacting and synergistic influences, including social, demographic, economic, climatic, and biological factors. The survey results, as illustrated in Figure 4, provide an in-depth analysis of the primary motivations behind the emigration of healthcare professionals from Kosovo's University Clinical Center (UCCK) and general hospitals. The findings reveal a multifaceted set of motivations and challenges faced by these professionals. The key factors influencing the migration of doctors and nurses are nearly identical, with only differences in the realm of priority among them but the underlying reasons remain consistent. The main factors identified in the survey results are categorised into six groups: low salary, poor working conditions, lack of health insurance, limited education and professional development opportunities, family and personal well-being, and respondents indicating that they have no desire to emigrate.

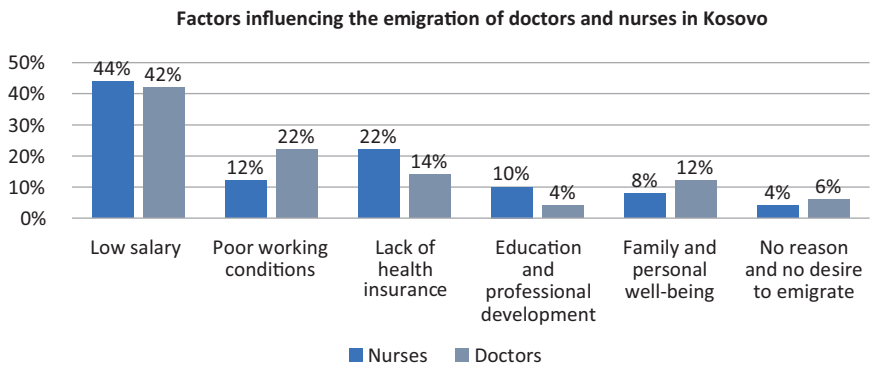

Figure 4. Factors influencing the emigration of doctors and nurses from UCCK and general hospitals in Kosovo

Survey results indicate that economic factors, particularly low salaries, are the most significant drivers of emigration among healthcare professionals in Kosovo, with 42% of doctors and 44% of nurses citing it as their primary motivation.

According to the results, out of 50 respondents from both groups, 42% of doctors and 44% of nurses mention salary as a factor that leads them to consider migration. For poor working conditions, 22% of doctors and 12% of nurses have responded and mentioned it as a reason. Regarding the lack of health insurance, for 14% of doctors and 22% of nurses it is a factor for considering migration. For 4% of doctors and 10% of nurses education and professional development are important factors in these terms. Personal well-being and family reasons are of value for 12% of doctors and 8% of nurses mention regarding migration. Additionally, 6% of doctors and 4% of nurses state they have no specific reason and do not wish to emigrate.

The findings of surveys conducted with specialist doctors and nurses also align with the results of the surveys (OECD, 2022), which indicate that higher salaries are a significant motivator for migration among respondents from the Western Balkans. Furthermore, a 2019 research on the likely effect of visa liberalisation on migration patterns in Kosovo confirms that the key determinant for emigration is the level of income, i.e., the main push factor is the wage differential between the Kosovo labour market and the wage levels offered in the EU-27 countries. Another aspect likely to influence migration patterns is the extensive network of Kosovo workers living abroad, which represent another strong pull factor, especially for destinations such as Germany, Switzerland, and Austria (Government of Kosovo, 2024).

4.5. Salary as a motivating factor for the migration of healthcare professionals

Significant salary disparities exist between Western European and Western Balkan countries, which, coupled with a lack of professional opportunities, contribute to a rising trend of emigration from the Western Balkans (Pranghe et al., 2020). Between 2012 and 2014, approximately 1,700 physicians, primarily under the age of 30, from Serbia, Macedonia, Albania, and Kosovo left to work abroad (Lazarevik, 2016). The emigration of healthcare workers from the Western Balkans has been steadily increasing in recent years, driven by factors such as higher salaries and better career prospects abroad (Omic & Handeland, 2021). In 2018, average salaries in the health and social work sector in Western Balkan countries were two to three times lower than those in the EU countries (BPRG, 2020a).

In Germany, doctors earn an average monthly salary ranging from 4,500 to 6,500 euro, while nurses receive an average salary of around 3,000 euro, and the salary for nurses is around 3,902 euro (WHO, 2016; BPRG, 2020a; Tushe, 2024). The stark contrast in salary levels between Kosovo and Germany serves as a significant push factor for healthcare professionals, as the comparatively low wages in Kosovo highlight the allure of higher earning potential abroad, effectively making Germany an attractive destination for those seeking improved economic stability and career advancement. Despite these legislative efforts, the salary levels in Kosovo's healthcare system still fall short, as well as compared to neighbouring countries. For instance, in Serbia,

specialist doctors earn around 1,800 euro, while in North Macedonia, they earn approximately 1,600 euro. In Albania, the average salary for nurses in 2020 was 420 euro, while in Montenegro, the salary for medical specialists and dental specialists in 2023 was 2,065.83 euro, and the salary for secondary healthcare personnel was 776.34 euro (BPRG, 2020; OECD, 2022; MZ-MNG, 2023; Tushe, 2024).

Survey results from this study(as shown in Figure 4), highlight that one of the primary driving factors for specialist doctors and nurses emigration to other countries are the low wages in Kosovo. Specifically, 44% of respondents in the nurses' group cited low wages as the key reason for migration, while 42% of respondents in the doctors' group identified low wages as the primary driver. This indicates that salary concerns are a shared issue among both professional groups, although it impacts nurses slightly more. Additionally, OECD survey results show that respondents from the Western Balkan Six countries consider "higher salaries" as a significant motive for migration. Out of a list of 13 potential reasons, 79% of respondents ranked higher salaries as either very important or important (OECD, 2022)[3].

4.6. Evolution of salary structures for doctors and nurses in Kosovo: policies and implications

Salaries for healthcare staff in Kosovo have undergone changes during the period from 2011 to 2021. Base salaries and other financial benefits have been regulated up to 2023 through the Sectoral Collective Agreement signed by the Ministry of Health and the Federation of Healthcare Unions of Kosovo on May 28, 2011[4], as well as the Sectoral Collective Agreement also signed by the Ministry of Health and the Federation of Healthcare Unions of Kosovo on June 11, 2018. Based on the Sectoral Collective Agreement of 2011, the monthly base salary for a specialist doctor was 509 euro or a coefficient of 8.4, while nurses with a coefficient of 5.4[5] had a salary of 326.30 euro, and nurses with a coefficient of 4.8[6] had a salary of 292.80 euro. Based on the Sectoral Collective Agreement in 2018, the monthly base salary for a specialist doctor was 660 euro (coefficient 8.4), and the salary for nurses with a coefficient of 5.4 was 430 euro, whereas nurses with a coefficient of 4.8 it was 380 euro. According to both agreements, it was envisaged that the employee's salary would increase by 0.5% of the base salary for each full year of work experience. Meanwhile, in Law No. 06/l-111 on public sector salaries, approved on March 1, 2019, the coefficient for a specialist doctor was 5, where

[3] Between June 2021 and January 2022, the OECD conducted a survey among respondents from the Western Balkan Six with current and past migration experience. Respondents were asked about their main reasons to move to another country. From a list of 13 potential reasons, 79% of respondents ranked higher salaries as either very important or important.

[4] The 2011 Sectoral Collective Agreement was obtained by the author Fatime Lumi Qehaja from the Ministry of Health and Hospital Services and University Clinics of Kosovo through a request for access to public documents sent via email.

[5] Coefficient 5.4 Nurses with a Bachelor's degree (HUCSK, 2019).

[6] Coefficient 4.8 Nurses with a High School Diploma (HUCSK, 2019).

the monetary value of one coefficient was 239 euro. This implies that the monthly base salary of a specialist doctor was envisaged to be 1,195 euro. Meanwhile, the coefficient for all third-level healthcare intermediaries was 2.25, and this would result in a projected monthly base salary of 537.75 euro for nurses[7]. In 2020, the Union of Nurses, Midwives, and Other Healthcare Professionals, in an appeal submitted to the Constitutional Court, considered the increase of the coefficient from 2.25 to 3.2 for all healthcare intermediaries of utmost importance to prevent nurses from leaving Kosovo, given the significant number of applications they had made for work visas in EU countries (Constitutional Court, 2020). As of 2023, the salaries of healthcare professionals in Kosovo's public health sector are regulated by Law no. 08/l-196 on salaries in the public sector, which came into effect on January 5, 2023. Based on data provided by the State Treasury at the Ministry of Finance in Kosovo[8], in 2022, before the implementation of the Salary Law (OG-RKS, 2023a), the base salary for specialist doctors at the national level was 659.77 euro, while the base salary for nurses was 425.34 euro.

The coefficients for doctors and nurses, as well as for all public sector employees, are determined based on the Law on Salaries in the Public Sector (OG-RKS, 2023a). According to this law, the coefficient for doctors at all levels, including the secondary level (including ggeneral hospitals) and the tertiary level (including the University Clinical Center of Kosovo – UCCK), is 12. For nurses, the coefficient at the secondary level (including general hospitals) is 5.5, while at the tertiary level (including UCCK), it is 5.6. The value of the coefficient varies according to the State Budget Law, which is approved each year. In 2023, the coefficient value was 105 euro (OG-RKS, 2022), while in 2024, it increased to 110 euro (OG-RKS, 2023a).

Based on this assessment, in 2023, the monthly gross salary for doctors was 1,260 euro. For nurses, the gross salary was 577.50 euro per month at the secondary level (including general hospitals) and 588 euro per month at the tertiary level (including UCCK). In 2024, the gross salary for doctors at all levels increased to 1,320 euro. For nurses, the gross salary at the secondary level (including general hospitals) rose to 605 euro per month, while at the tertiary level (including UCCK), it increased to 616 euro per month.

The trend of salary increases is expected to continue in Kosovo in 2025, particularly benefitting healthcare professionals such as doctors and nurses working in the University Clinical Center of Kosovo (UCCK) and general hospitals. On October 30, 2024, the Government of Kosovo approved the draft budget for 2025, allocating 916.5 million euro for public sector salaries, including a planned salary increase. Starting in January 2025, salaries will rise by 55 euro for all public sector employees, including doctors and nurses. From July 2025, the increase will double to 110 euro per employee (Government of Kosovo, 2024).

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[7] This law was not implemented because on July 9, 2020, the Constitutional Court made a decision regarding the constitutionality of Law no. 06/L-111 on Salaries in the Public Sector and suspended its enforcement (ConstitutionalCourt-RKS, 2020).

[8] The data on the salaries of specialist doctors and nurses were obtained by the author Fatime Lumi Qehaja from the State Treasury at the Ministry of Finance and Transfers in Kosovo through a request for access to public documents sent via email.

However, despite the trends towards stabilisation and improvement, salaries in the public healthcare sector in Kosovo continue to pose challenges and problems for Kosovo institutions. Although Law no. 08/196 on salaries in the public sector came into force on January 5, 2023, it continues to be contested. This is because on April 7, 2023, the Ombudsman in Kosovo sent a request for the assessment of the constitutionality of Law no. 08/196 on Public Sector Salaries, which request does not include any specific demands for healthcare staff (KOI, 2023). On January 23, 2024, the Constitutional Court of the Republic of Kosovo issued its ruling regarding the assessment of the constitutionality of Law no. 08/L196 on public sector salaries (Constitutional Court, 2024). The Court declared it partially invalid, stating that for officials whose salaries have been reduced by the new law, the ruling of the Constitutional Court restores their previous salary until it becomes equivalent to the existing salary. Officials employed after the entry into force of this law will receive a higher salary, similar to their colleagues who were employed before the enactment of the Law on Salaries in the Public Sector, based on the principle of "equal pay for equal work". Furthermore, regarding the adjustment of the work experience bonus from 5% to 0.25%, the Constitutional Court found this reduction to be in violation of the Constitution; thus, the Assembly was ordered to make the necessary amendments within six months, with the ruling's effect extending from its effective date. The Constitutional Court has stipulated that this ruling will come into force on February 1, 2024, and will produce legal effects from that date. However, the Constitutional Court determined that the salary lists submitted by the Ministry of Internal Affairs indicate that the base salary of public employees in the healthcare system has increased (Constitutional Court, 2024).

This is the second time that the Public Sector Salaries Law has been contested by different sectors and ended up in the Constitutional Court. The first time, on July 9, 2020, the Constitutional Court made a decision regarding the constitutionality of Law no. 06/L-111 on Salaries in the Public Sector and suspended its enforcement (Constitutional Court, 2020). However, the law has already started to be implemented in public institutions, including the healthcare staff in the University Clinical Center of Kosovo.

5. Discussion and conclusions

This study sheds light on the complex dynamics driving the migration of healthcare professionals from Kosovo's public health sector, with a particular focus on the University Clinical Center of Kosovo and general hospitals in Kosovo. It identifies several key trends and factors influencing this phenomenon, with salary disparities emerging as a significant motivating factor. However, both economic and social factors collectively play a crucial role in healthcare professionals' decisions to migrate abroad. According to a study published in *The Lancet*, the global health workforce crisis is driven by economic opportunities, safety, and career development, with these being the central motivators for migration (Abubakar et al., 2018). Similarly, the *International Journal for Equity in Health* emphasises that economic factors, such as salary, living

standards, and professional satisfaction, significantly contribute to healthcare professionals' migration decisions (Siyam & Dal Poz, 2014). The World Health Organization (WHO) also identifies economic factors, such as salaries and working conditions, as major drivers of healthcare workforce migration (WHO, 2020).

The data from this study suggest a clear trend of healthcare professionals seeking employment opportunities abroad, largely motivated by significant wage and working condition gaps between Kosovo and other countries. This trend is most pronounced among younger professionals and those working in critical care units, who often feel that their potential is underutilised within the local system. Existing literature supports the finding that migration is driven by factors such as professional aspirations, economic opportunities, and dissatisfaction with working conditions. For example, *The Lancet* discusses how the migration of doctors and nurses impacts healthcare quality in source countries and highlights strategies for retaining healthcare professionals. The article also notes that young healthcare workers, particularly nurses and junior doctors, are more likely to migrate due to limited professional advancement opportunities at home (Abubakar et al., 2018). Additionally, the World Bank has conducted studies on the economic consequences of healthcare workforce migration for both source and destination countries, highlighting that while migration can bring financial benefits through remittances, it can also deplete healthcare systems in countries losing skilled workers, thus reducing access to essential healthcare services (World Bank, 2021). Similarly, the *International Journal for Equity in Health* discusses how receiving countries benefit from the influx of healthcare professionals while acknowledging the challenges it poses for the healthcare workforce and service delivery in source countries (Siyam & Dal Poz, 2014).

5.1. Gender dynamics in healthcare migration

Demographic analysis in this study reveals that while both genders are affected by migration, younger females, particularly in nursing and medical specialties, are more likely to seek opportunities abroad. The *Global Health Workforce Alliance* (GHWA & WHO, 2014) report emphasises that young female nurses are increasingly mobile, driven by economic and professional motivations (GHWA & WHO, 2014).

The *Journal of Nursing Management* explores the specific challenges faced by young female nurses in low- and middle-income countries (LMICs), noting that migration is seen as a means to secure better wages and working conditions. Studies in this journal suggest that young women in nursing are particularly motivated to migrate due to limited opportunities for specialisation and advancement in their home countries, as well as the potential for improved work-life balance in high-income regions (Kingma, 2018). The OECD's report on health worker migration and gender notes that young female healthcare professionals, especially in nursing and medical specialties, are more likely to seek opportunities abroad. The report attributes this trend to economic disparities and the appeal of higher-income countries, where women in healthcare professions may receive more equitable pay and advancement opportunities. Furthermore, high-income countries often provide better policies for maternity leave

and family support, making them more attractive to young female professionals (OECD, 2020; 2021). This indicates a potential gender dynamic in migration patterns, with younger professionals seeking better work-life balance and career advancement opportunities.

5.2. Social networks and migration

In addition to economic factors, this study highlights the role of social networks in healthcare professionals' decision-making processes regarding migration. Many reported feeling encouraged by their families and colleagues to emigrate. According to the *International Journal of Human Resources for Health*, social networks play a significant role in shaping migration decisions, with healthcare workers who feel supported by family and friends being more likely to follow through with plans to work abroad. Families often see migration as an opportunity for economic improvement, while colleagues may endorse the decision, having made similar choices themselves or due to shared workplace challenges (Humphries et al., 2019). Similarly, the WHO report emphasises that social encouragement is a key motivator for healthcare professionals deciding to migrate, especially among younger workers. Families often support the move due to the potential financial benefits, while colleagues may offer encouragement by sharing their own positive experiences of working abroad. This support can help alleviate concerns about adjusting to new environments and professional cultures (WHO, 2020).

5.3. Policy implications and recommendations

The findings of this study have important implications for policymakers in Kosovo. To mitigate the outflow of healthcare professionals, it is crucial to address the root causes of dissatisfaction within the domestic healthcare system. Key strategies should focus on increasing investment in healthcare infrastructure, improving salary structures, and fostering a more supportive environment for professional growth. Literature emphasises the importance of policies aimed at retaining younger healthcare workers, particularly those newly trained, in order to prevent migration (Siyam & Dal Poz, 2014). The *International Labour Organization* (ILO) recommends creating a more attractive work environment in source countries as a strategy to counter this migration trend (ILO, 2021). Similarly, the OECD calls for policies that ensure more attractive working conditions and competitive salaries to curb the migration of young healthcare professionals (OECD, 2020; 2021).

In addition, retention strategies should focus on enhancing job satisfaction and improving workplace culture. Initiatives such as mentorship programmes, continuing education, and mental health support could significantly improve the working environment for healthcare professionals. Encouraging family and community support for those who choose to remain in Kosovo could also play an important role in reducing migration rates.

5.4. Future research directions

This study opens avenues for further research, particularly on understanding the long-term effects of healthcare migration on the quality of care in Kosovo. Future studies could examine the experiences of healthcare professionals who have migrated, as well as those who have remained, to provide a more comprehensive understanding of the implications for the healthcare sector. Investigating the impact of migration on both patient outcomes and healthcare system performance in Kosovo could help inform more effective retention strategies.

5.5. Summary

In conclusion, the migration of healthcare professionals from Kosovo is driven by a complex interplay of economic factors, demographic trends, and social influences. The *Global Health Workforce Alliance* (GHWA & WHO) and *The Lancet* both highlight that financial incentives and career advancement are strong motivators for young healthcare professionals early in their careers, as they often view relocation as beneficial for their long-term professional growth (GHWA & WHO, 2014; Abubakar et al., 2018). According to the results of the study, this migration trend is particularly pronounced among younger workers, especially nurses, who view migration as a strategic career move offering both financial benefits and opportunities to develop their skills in more advanced healthcare systems. Addressing this issue requires comprehensive policy solutions focused on improving working conditions, increasing salaries, and providing career growth opportunities in Kosovo. A holistic approach to policymaking is essential to retain skilled healthcare professionals and strengthen the healthcare system in Kosovo.

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Problemy Polityki Społecznej. Social Policy Issues 2025, 68(1): 1–20
https://doi.org/10.31971/pps/190120

Submitted: 2024-02-13/Accepted: 2024-06-16

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Financial transfers from parents to adult children and the invisible role of state policy in Poland

Abstract

In this article, we explore the role of financial transfers from parents to adult children in Poland, highlighting their significance in areas such as education, housing, and family formation. Our aim is to bring attention to the complex interplay between family support and state policy in shaping the lives of young adults in Poland. We investigate how both the older generations providing the transfers and the younger generations receiving them perceive state public policies during the transition

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to adulthood. Our analysis is based on empirical data from in-depth family interviews with individuals aged 24–40 and their parents, as well as from 12 Focus Group Interviews (FGIs) with representatives of both generations. Additionally, we use data from the 8th round of the SHARE survey to provide a broader context of intergenerational transfers. Our findings suggest that while state policies are generally seen as transparent and rarely influence the decision to support the younger generation, the scale and purposes of these financial transfers are inherently linked to deficiencies in state policies. This indicates an implicit reliance on family resources to fill the gaps left by public policy, which may exacerbate inequalities between families with different financial capabilities.

Keywords: qualitative research, public policy, households, intergenerational transfers, SHARE

Introduction

One of the key moments in the lives of many families is when adult children gain independence and form a new household. Often this process begins with young people moving out of the family home, while the symbolic stages of such a transition are relocating to another city for study or work, formalising a relationship with a partner, or having children (Buchmann & Kriesi, 2011). Usually, the transition to adulthood is linked to the situation of young adults in the labour market. A factor delaying the whole process is unemployment or job insecurity (Unt et al., 2021) which also makes it difficult to move out of the family home (Gousia et al., 2020). The transition to adulthood is often supported by various types of transfers from older generations to younger ones, with parents offering both financial and non-financial support (Kohli, 1999; Albertini et al., 2018; Szydlik, 2016). These financial transfers allow young people to consume more than their current income and are consistent with the life-cycle hypothesis (Deaton, 2005). Supporting newly formed households, or young people more broadly, is also important from a state policy perspective, particularly in the context of population policy and efforts to increase fertility rates. The possibility of establishing a new household is, alongside a stable financial situation, one of the key factors encouraging people to have children. On the other hand, having children is inhibited by the housing problems experienced by younger generations.

In this article, we examine the role of financial transfers from parents to adult children in Poland. We discuss the importance of financial transfers in areas such as education, housing, and family formation. Our aim is to bring attention to the complex interplay between family support and state policy in shaping the lives of young adults in Poland. We analyse the extent to which both the older generations making the transfers and the younger generations who are the recipients recognise the public policy of the state during the key stages in the transition of young people to adulthood.

Our analysis focuses on the practices and justifications of financial transfers from parents to their adult children, using empirical data from qualitative in-depth family interviews conducted in 2019–2021 with people aged 24–40 and their parents. In addition, we analyse data from 12 focus group interviews with representatives of the

young generation and parents' generation, which revealed social expectations and cultural norms regarding intergenerational transfers of money and wealth in Poland. To show the broader context of intergenerational transfers, we use data from the 8th round of the SHARE survey conducted in 2019/2020.

In analysing the qualitative data, we were less interested in the scale of the transfers and more in the rationale behind them and the impact on relationships within the family and the new household's choice of living strategies. We focused especially on how these transfers affected key life and financial decisions, including milestones related to work, housing and starting a family (cf. Sawulski, 2019). In examining the impact of family transfers on breakthrough events, we also looked for how social policy affected the life course of research participants. "This is because social policy is one of the factors influencing the social construction of the course of life. It is the source of the norms and rules that define them and determines the extent of the availability of different life models for people belonging to particular social categories (e.g., men and women) and groups (e.g., socio-professional groups)" (Szatur-Jaworska et al., 2021, p. 57). Combining these two perspectives, we were interested in whether and how the family tries to go beyond what is available without family support, from the first attempts to move out of the family home and become independent, to issues related to raising the next generation, i.e., children of adult children.

We argue that for most families, state policy appears transparent, meaning that it rarely features in considerations of supporting the younger generation and is rarely the main justification for a transfer. However, in practice, both the scale and the purposes of transfers are directly related to state policy deficits, ranging from housing policy, and education policy to social and early childcare services. In other words, state policies, while in the minds of respondents usually not directly influencing the willingness to provide support and financial transfers, are in fact important in terms of their scale and direction. The practices and justifications for financial transfers also reflect the perceptions of the role of the state and public institutions in the everyday lives of Polish households.

State of the art

Comparative research on intergenerational transfers in Europe shows that downward transfers, from parents to adult children, are significantly more frequent and intense than upward transfers: from adult children to parents (Kohli, 1999; Albertini et al., 2018). While the scale and direction of these transfers depend on the dynamics of individual families, at the macro level, they are influenced by socio-demographic changes that affect the structure and conditions of households.

From a demographic perspective, the increasing role of downward transfers has been influenced by both increasing life expectancy and declining fertility rates (Seltzer & Bianchi, 2013). Due to longer life expectancy inheritances are received later in life, which means that in the process of children transitioning to adulthood and establishing their own household *inter vivos* transfers become especially significant. Referring to the classic opposition between the quantity and quality of children (Becker & Lewis,

1973), fewer children in a family also means the possibility of larger transfers, and perceiving the children as investments in human capital, particularly, in their education and extra-curricular activities to increase their future employability (Bandelj & Spiegel, 2023).

These investments, moreover, are not only optional, but increasingly necessary, given the transformations that the process of entering adulthood has undergone in recent years. Changes in the education system, labour and housing market are making the transition into adulthood take longer and become a joint venture between parents and children, where the important part of the smooth transition is financial assistance from parents (Swartz et al., 2011). The analyses particularly address this issue in the context of the housing market and the decreasing availability of housing for young adults entering adulthood in European countries (Albertini et al., 2018; Mulder & Lauster 2010; Mulder & Smits, 2013; Druta & Ronald, 2016, 2018; Lennartz & Helbrecht, 2018; Lux et al., 2018), also in Poland (Olcoń-Kubicka & Halawa, 2018; Halawa & Olcoń-Kubicka, 2019).

Research shows that parents with more resources finance their adult children to a greater extent (Szydlik, 2016; Fritzell & Lennartsson, 2005). At the same time, middle-class parents use financial tools in the long term to help their children achieve autonomy (Zaloom, 2019) and at least the same social status as their parents (Albertini & Radl, 2012). This shows that financial transfers are factors for increasing social inequality. Children from poorer families entering adulthood have a much smaller chance in the competitive labour or housing market than peers from wealthier homes equipped with additional skills and being able to finance higher rental or property costs to a greater extent. This can result in a shift from education to a precarious labour market and the need to take any job, even low-quality jobs, to support themselves, which negatively affects their well-being (Unt et al., 2021).

Other studies based on longitudinal research focus on parents' main motivations for transferring (Swartz et al., 2011), and explore the nature of transfers, the social and cultural norms that govern them, and the relationship between parents and their adult children, using survey data, vignettes, and in-depth interviews in the analysis (Rowlingson et al., 2017), revealing situations that parents believe merit support ("deserving cases") (Finch & Mason, 1993), and the ambivalence surrounding the transfer and receipt of money in the parent-adult child relationship (Heath & Calvert, 2013). The growing importance of parents' financial presence in the lives of their adult children is depicted in the literature pointing out to different situations where parental support is mobilised with parents acting as "scaffolding" or "safety nets" (Swartz et al., 2011), while many aspirations of middle-class young people can only be realised because parents act as "oxygen tanks" (Weiss, 2019).

Thus, in the social dimension, which is the focus of the article, the importance of parental financial support lies in the fact that it allows young households to bridge the gap between the actual costs of living in a large city, class-shaped aspirations, and the financial capabilities of young people. At the same time, wealth transfers allow parents to make attempts at social mobility in a multigenerational plan, by mobilising resources to "set" the next generation higher in social stratification. These actions, including the justification of their amount on the part of the donors and the reactions

of the recipients, must of course be considered in the context of the existing economic situation, labour conditions, and social policy programmes.

Comparative studies of European countries show that there is some variation in the forms and intensity of parental support, and the context of welfare state support matters.

> Parents in southern European countries with low levels of public family expenditures predominantly support their adult children by providing living space, whereas parents in northern European countries with more generous welfare states give direct financial support. Differences in country-specific transfer patterns can theoretically and empirically be traced back to welfare state support in general and national housing regimes and markets in particular (Isengard et al., 2018, 178).

This research situated Poland closer to southern European countries suggesting that downward financial transfers play a more limited role in Poland compared to established capitalist economies, and a relatively more important role is played by parental in-kind support, including time, and support in housing. Data from the 6th wave (2015) of the SHARE survey shows that 30% of parents aged 50 and older in Poland support their children, primarily by providing housing and, to a lesser extent, through direct monetary transfers (Isengard et al., 2018). Similar frequencies were identified also in SHARE data collected in the survey in the years 2019/2020, which we discuss later in this paper. The results from the studies suggest also that the generosity of the welfare state could influence both frequency and intensity of private support within families. Analyses based on SHARE data show that the more public assistance was available, the more frequent but less intense was the financial and non-financial support by parents to their adult children (Brandt & Deitl, 2013). That is in line with the findings of Albertini (2016) and Albertini et al. (2007), in which they observed that the likelihood of the exchange of support between family generations decreases from the North of Europe (Scandinavian countries) to the South and the intensity of support follows "an opposite North-South gradient".

Referring to the division proposed by Saraceno and Keck (2010) instead of the conventional North and South, one can distinguish three types of policy frameworks that favour, or limit, intergenerational transfers due to the organisation of family care. From familialism by default, where the lack of institutional support forces transfers and support within the family, through an intermediate form such as supported familialism to de-familialisation, "when individualization of social rights […] reduces family responsibilities and dependencies" (Saraceno & Keck, 2010, 676). Regardless of the regulation and formal assessment of welfare regimes from the perspective of the family, the level of trust in public institutions and the stability of existing arrangements are also important. Indeed, households are guided by "familial pragmatism" (Pustułka & Sikorska, 2023), mixing the private and public dimensions and making choices that are as rational as possible, from their perspective, seeking primarily to maximise the benefits to their own family.

However, this support is insufficient in many cases, and the complex and multidimensional process of entering adulthood can be delayed. Hence the demand

raised in the literature for "building in Polish social policy (public policies) an approach that could be described as a policy of the process of entering adulthood (transition to adulthood regime)" (Grotowska-Leder & Dziedziczak-Foltyn, 2021, 2; see also: Grotowska-Leder & Kudlińska, 2018). The goal of such a policy would be to level the playing field on the one hand, and to minimise the risk that the process is unduly prolonged on the other. At the same time, it seems that the empty space left by the missing public programmes has been, at least in part, privatised and taken over by market-oriented solutions (Pawłowski, 2020; Sawulski, 2019).

Poland is often underrepresented in research on intergenerational transfers in Europe. In this text, we address this gap by providing new qualitative evidence on the practices and justifications of financial transfers from parents to their adult children. We also explore the complex interactions between family support and state policy in shaping the lives of young people in Poland.

Data and methodology

The analyses presented below are divided into two sections: the first using data collected through family interviews and FGIs, and the second based on SHARE (*Survey of Health, Ageing and Retirement in Europe*) data. By juxtaposing the data from wave 8 of SHARE carried out in years 2019/2020 and interviews conducted with 24 families mostly at the same time, we show both the scale of transfers and the meaning attributed to them. Therefore, we indirectly examine whether there is evidence of familial pragmatism within family transfers and to what extent they are influenced by, or in contrast to, existing family policy solutions.

The family interviews were conducted in related households of young Warsaw residents (24–40) and their parents. Data includes interviews with 72 individuals (36 adult children and 36 parents) from 24 families preceded by a pilot based on interviews with 16 parents of young adults from Warsaw and Radom which were also included in the analysis. While all adult children lived in Warsaw and had higher education, the category of parents included residents of Warsaw and smaller towns in the Mazowieckie, Świętokrzyskie and Warmińsko-Mazurskie voivodeships with varying levels of education and material situation. Parents and their adult children were interviewed separately, and the meetings focused on intergenerational transfer practices and the moral justifications for them in each specific family, told from a biographical perspective. The interviews took place mainly in the participants' homes and lasted between 1.5 and 2.5 hours.

The family interviews were supplemented by 12 focus group interviews (FGIs) with 95 representatives of the young generation and the parents' generation conducted in six locations Kraków, Gdańsk, Wrocław, Bielsko-Biała, Gdynia, and Wałbrzych. The FGI research focused on exploring social expectations and cultural norms regarding intergenerational transfers of money and wealth in Poland. All interviews were recorded, transcribed, and then coded in the qualitative analysis software MaxQDA.

Regarding the quantitative analysis based on SHARE data, the sample was based on population aged 50+ so all the estimations refer to people in this age group from

27 countries surveyed in the SHARE wave carried out in the years 2019/2020. There are two main questions to estimate what percentage of people aged 50+ pass on funds to their descendants. The wording of the first question is the following:

> *Now, please think about the last twelve months. Not counting any shared housing or shared food, have you [or your husband/wife/partner] given any financial or material gift or support to any person inside or outside this household amounting to 250 euro or more? By financial gift we mean giving money, or covering specific types of costs such as those for medical care or insurance, schooling, down payment for a home. Do not include loans or donations to charities.*

The amount of 250 euro was adjusted according to the purchasing power in different countries[2]. In the second question, the value of the financial gift is equal to 5,000 euro or more (adjusted according to the purchasing power[3]) and respondents answered the following question:

> *Not counting any large gift we may have already talked about/Since our last interview in […], have you or your husband/wife/partner ever gave a gift of money, goods, or property worth more than 5,000 euro? Not including any gifts you have already mentioned.*

The context of intergenerational transfers in Poland

The purpose of the quantitative analyses was to show the broader context of parent-to-child transfers and their scale. The results for Poland are presented in line with results for other countries for comparison. About 27% of respondents aged 50+ surveyed in SHARE declared that they gave some financial or material gift or support amounting to 250 euro or more and 5% that they gave 5,000 euro or more. Differences among countries are significant. For smaller gifts, the frequency is less than 10% for Latvia, Spain, or Bulgaria to over 40% in Austria, Denmark, or Luxembourg.

Among those who received financial support respondents mention their own children first and then grandchildren. In the case of a donation of 5,000 euro or more in many countries children are usually the main recipients of such transfers, i.e., over 80%. Valuable gifts for grandchildren were relatively more popular in Austria (10%), Hungary (13%), and Romania (20%), whereas in Poland it was 4%.

Generally, among all donors from 56 to 98% listed own children in the group of main recipients of transfers. In the case of smaller gifts worth 250 euro or more, children were mentioned by 55 to 84% of respondents.

Analysis of the sample of those who give, shows that some characteristics are correlated with higher frequencies of giving money. As far as marital status is concerned, divorced people are most likely to give financial gifts, followed by married

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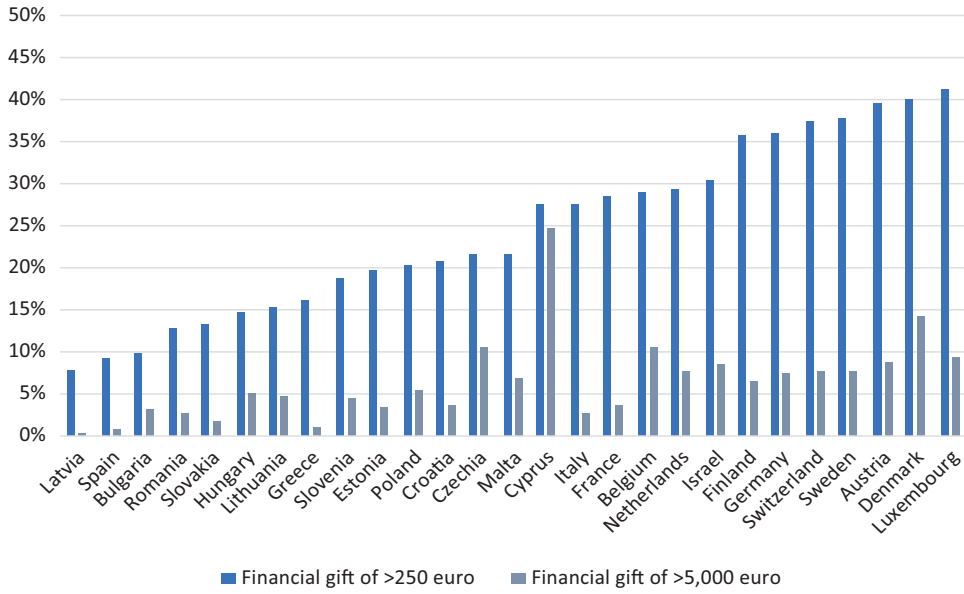
[2] In Poland 600 zlotys.

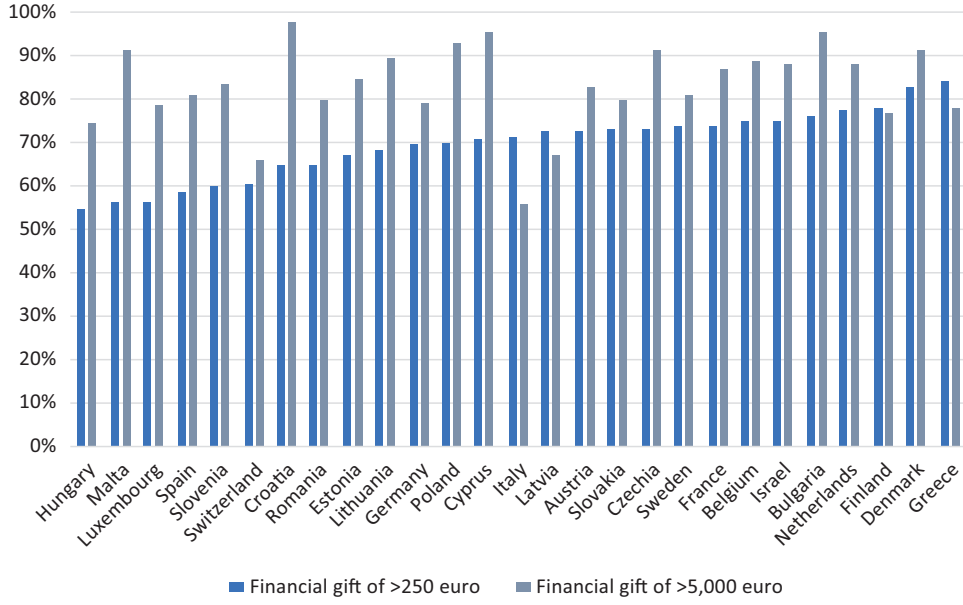
[3] In Poland 12,000 zlotys.

Figure 1. Frequencies of financial gifts by countries participating in SHARE



Source: Own calculation based on SHARE wave 8 individual data

Figure 2. Share of own children in the group of mail recipients of financial transfers



Source: Own calculation based on SHARE wave 8 individual data

people and then widowed. Those never married declared giving financial gifts to anyone very seldom. The pattern is similar in various countries.

Frequencies by gender vary among countries. In some, women were more likely to declare giving financial gifts, while in others it was men. There were also differences when it came to who was more likely to give smaller and larger amounts. In Poland, in both cases, it was women who were more likely to declare financial gifts.

Better education is another characteristic linked to a higher probability of financial support, mainly in the case of amounts equal to and exceeding 5,000 euro. One of the explanations can be correlation between education and financial situation (income) in the population 50+ in Europe.

Quantitative analyses based on SHARE data provided important context for understanding the broader landscape of intergenerational transfers in Poland, highlighting the scale and frequency of these transfers compared to other countries. They revealed that Poland does not significantly differ from other central and eastern European countries, with financial transfers being generally less commonly compared to wealthier western European nations. However, significant monetary transfers from older to younger individuals are primarily directed toward their own children and occasionally grandchildren, albeit usually in smaller amounts.

Intergenerational transfers from households' perspective

Building on insights gained from quantitative analyses, our qualitative research delves into the nuances of intergenerational transfers in Poland. Through in-depth family interviews and focus group discussions, we outline the underlying motivations and social expectations that shape the dynamics of these financial transfers, as well as perceptions of the role of public policy in young people's transition to adulthood.

Our interviewees, both parents and young adults, when asked what parents should provide for their children entering adulthood, most often pointed to ensuring that they get an adequate education and cover its related expenses. Family transfers provide a more comfortable study environment for those moving out of the family home to another city, and sometimes are even the main condition that enables a young person to study:

> *I come from a small town, and in fact, I think that if it weren't for this financial help from my parents, it would be really hard for me to live here in general, to start studying, because actually it would be hard for me to pay rent and have money for daily upkeep, and therefore, I think that this start, even more so in relation to people moving to a city with better prospects, requires such financial help from parents* (33-year-old woman, FGI Kraków).

> *Well, usually parents pay for some apartments, send children to study, to Wrocław, because it's such a cost even somewhere there, a friend's daughter, they rented an apartment for the three of them, she had to give 2 thousand each, yes? Well, because it's a 3-room apartment, but for that a room with a kitchen like that, they paid 2,000 each there, well, and so when you go to college, where to get the money from? If your*

parents don't help you […]. So, in general, financial help from parents is such a good start (27-year-old woman, FGI Wałbrzych).

While pursuing higher education by children was one of the key aspirations of parents, worthy of financial support, some interlocutors claimed that it was about providing an education that allows for life and career stability. For instance, financing of specialised training or courses, allowing the acquisition of competencies needed in the labour market.

To offer at least some qualifications, funded by parents. Because a TIR driver's license is not a small cost, it costs 11–12,000 zlotys, well, a high-school graduate cannot take it out of pocket, nor take a loan. Neither will they earn such money too quickly, and yet, when they can gain a license in a month… And then they would earn 8–9,000 per month. So, it pays itself off very quickly (25-year-old man FGI, Walbrzych).

Parental financial support also has a significant impact on further career development, and sometimes parents even finance the path chosen later in their professional life. Ewa, an interviewee from Radom, a mother of two adult sons, used financial transfers to "motivate" her older son to return from emigration in Ireland. She felt that the physical work he did there was not up to his education, professional competence, and aspirations. With the money he received from her, he was able to purchase the proper equipment and machinery needed to run a construction company in Warsaw. Ewa continued to support him financially in the company on several occasions by sporadically "lending" him money, without expecting repayment. Moreover, she assisted her second son in establishing an architectural studio, primarily, through her own labour and providing space in her apartment to operate the business.

The second key dimension when young adults require financial support from their parents is housing. Due to political and economic conditions, a significant proportion (85%) of households in Poland is own housing, a consequence of the privatisation of housing stock in the early 1990s. This ownership rate is higher compared to many other European countries. However, the growing gap between real estate prices in large cities and wages makes it increasingly difficult for young adults starting out in the labour market to buy an apartment and the rental housing market is not affordable everywhere. Research participants, both parents and young people, recognise these difficulties related to the possibility of buying an apartment out of a salaried job and acknowledge the fact that financial assistance from parents is becoming a significant factor in facilitating home ownership. More affluent parents mobilise property resources, such as apartments and houses previously received by inheritance or as gifts from their own parents. To facilitate their children becoming home owners, parents utilise various strategies such as leveraging properties they previously purchased, selling land, or tapping into accumulated savings to acquire new properties. Parents are often present in the process of their children taking out mortgages by contributing to down payment or fully financing their own contribution. The housing donation is usually the most financially significant transfer that passes from parents to children in *inter vivos* transfers.

At the same time, the research participants notice the real estate market and the changes taking place in it. They see large institutions, often of foreign origin, appear on this market, which are interested in buying apartments in bulk for investment purposes counting on an increase in real estate prices in the future. In this context, providing housing for the younger generation becomes even more urgent. Those parents who have the financial capacity, enter the real estate market to buy an apartment to be gifted to an adult child in the future.

> **Young woman***: Because I'm just afraid of what will happen in the future. Once we don't start putting away, even what this government is giving, well, I don't know what will happen. Because we will need to give her something to start, I don't know, an apartment or whatever. We already have to think about what she will have in the future, because if we don't think about it now, we don't know what it will be at all.*
> **Researcher***: So, what do you think… Would you like to provide a good starting point for your daughter in some way?*
> **Young woman***: Yes.*
> **Researcher***: But you mean to buy her an apartment or to contribute?*
> **Young woman***: No, the whole apartment, because she would have to have some other resources. And I don't want to think what will happen, what the prices will be in a dozen years. As there are already such crazy prices. That it's all being bought up by foreigners* (32-year-old woman, IDI Warsaw).

Providing home ownership for one's children is the issue where one most often sees the need for support from the state. Mostly, because it is often beyond the capacity of parents who do not have the resources to support their children financially.

> *It would be nice that for those young people who have cool plans, who make personal progress, that the state would just be able to offer housing in an attractive way, I don't say for free, but according to the capabilities of this young person, without the support of parents* (mother of two adult sons, IDI Radom).

> *Not every family can afford to help. Let's not fool ourselves. So that's the first rule. But the state should, well, see, facilitate this start in life. Especially since one is working, paying some kind of taxes, so they should have it made easier. I don't know in what way, whether more housing for the young, for example* (mother of five adult children, family interview, Siedlce).

In addition to willingness to provide the adult child with an adequate education, ensuring that the young person has competencies and skills useful in the labour market, and contributing to resolving the housing issue, another area where parental assistance to adult children becomes significant is the arrival of a new generation, grandchildren. With the arrival of small children in a young household, monetary transfers from the parents' household are mobilised once again. Financial support for a young family with a child is another case, after housing, that deserves parental support. But also, this is the case in which the need for institutional solutions is recognised. The

importance of reproduction in the family can be seen in the case of Regina, a mother who, together with her husband, financially supported their children who had an infertility problem and financed medical treatments at a private infertility clinic to a large extent.

Further transfers take place during pregnancy, when the young buy new items for the newborn, and the grandparents-to-be reimburse the cost of some baby items. Both youngsters and parents indicated that traditionally the purchase of a stroller belongs to the grandparents, which is a financial relief to the youngsters' household budget and is received with gratitude.

Grandparents are present in their children's financial lives through covering expenses related to their grandchildren. It is not always the case of giving cash in hand, but rather covering expenses incurred. Grandparents insist on covering the cost of certain purchases, in which case the cash flow has a specific purpose, like buying clothes or appliances. Refunding expenses related to the purchase of children's goods, financing extracurricular activities at the kindergarten, such as English classes or dance lessons, opening a bank account for the grandchildren and regularly depositing amounts there for the future help make significant contributions to the young household's budget. Knowing that grandparents are having their backs, allows to reduce anxieties about having and bringing up children and to make confident decisions related to financing their various activities.

> *I think we generally wondered whether to let her [his daughter] go [to English classes] as we had an offer from this language school, and our mother-in-law offered to dispel these doubts of ours "well, listen, I'll pay for these", so one can approach such expenses more freely* (30-year-old man, family interview, Warsaw).

Parents and grandparents also provide support by co-financing care in private educational institutions when their adult children experience difficulties with access to public nurseries or kindergartens. In some cases, they facilitate the "exit" from the public institution and suggest the possibility of attending a private one.

> *I can also say from a mother's perspective, because I kind of want to go back to work in January or February. And for example, I can say, about the availability of nurseries. It's a dramatic situation and they are so damn expensive. I won't get into a public institution, because my husband and I both work, we are a normal family. And privately it's 2,000 zloty, every month and you have to somehow make this money. […] I have to do something with the baby as I want to go back to work, but on the other hand, if I don't go back to work, the mortgage has to be paid off. It's just that it's not a one-time, very big expense, but it's every month. For 2.5 years you have to pay for private care, to make sure your child is taken care of. If you don't have grandparents here, well it's a dramatic situation, unfortunately* (30-year-old woman, FGI Gdańsk).

> **Young woman:** *My mother contributed so my son could go to a private kindergarten. Well, I didn't ask for it either, but she knew that if she didn't contribute, I would send him to a public one, so…*

Researcher: *And what would have happened if he had gone [to the public one]?*
Young woman: *I don't know, probably nothing would have happened, but… I mean, it was actually a good choice, where I insisted that he would not go to the public one, like all children, although I was very happy with the kindergarten, so I have to admit that she succeeded, but it was on the principle that here she controlled my life, that is, she sort of put her own way. At that time I also didn't think selfishly only about myself, that I would stand up to her and do my own way, but more also about the child, that maybe it would be for the best if he went to this kindergarten, so I accepted that money* (34-year-old woman, FGI Kraków).

The transfers for the benefit of grandchildren and their educational needs, discussed above, indicate a vertical direction downward in financial flows. The assumption is to support the next generation, with no expectation of reciprocity of upward transfer. This lack of expectation, or even reluctance to accept help from an adult child often took the form of strong declarations among participants. In these statements, the scenario of accepting help from a child in the form of an upward transfer would indicate a failure in life. It would be a signal that parents were unable to take care of themselves. Participants stressed that it was easier to make a transfer for a child when the current financial situation based on a steady income from a professional job still allowed for it. One interviewee indicated that he felt at peace after making the transfer. If he had decided to transfer at a later age, such as in retirement, it would have meant worsening of his material conditions. By making the transfer earlier, one can still plan for his old age and future financial situation allowing for independence from his family. This independence was something extremely important to interviewees. Some of them have already started planning for their old age wanting to have money set aside for care, some are striving for such a situation, like the FGI participant:

I wouldn't want to burden my daughter, if I manage to live to the old age, that I'm going to be some kind of old woman and she's going to have to always come over there every day and take care of me. I certainly wouldn't want that. I would like to be financially secure enough that I would already be very old and infirm, well I don't know that maybe I would find a home where they will take care of me there, there are such homes for seniors (mother of an adult daughter, FGI Walbrzych).

Sometimes children are also aware of such plans made by their parents who have assured them that the financial assistance they would give them does not involve the expectation of reciprocating the transfer at a later age or requiring them to take care of their aging parents.

My mother is putting money aside to pay for a retirement home for herself, and preferably the premium one. So that she doesn't have that feeling that I have to take care of her, just because she contributed and there's no such thinking: I gave, I expect. She absolutely wants to be in her old age totally, so to speak, independent of us, she doesn't want to be such a crutch, and that's why she saves money and she says she

wants to go to a retirement home, so she expects absolutely no gratitude, that I will take her under my roof and take care of her (33-year-old woman, FGI Kraków).

Often, however, the need to accept help from children, whether financial or caregiving, is a subject that respondents are unwilling to acknowledge. The time horizon plays a role here: these are either still active on the labour market or have only recently retired, and the vision of old age linked to physical incapacity is still too far on the horizon to seriously consider it, much less talk about it with their own children. While they note that other people may have expectations of various kinds of support from their adult children, they themselves stress that they would not want to direct such expectations to their own children.

I think in our society people mostly expect (support from their children in the older age). Well there is even a saying that the reason why one has children is to be given a glass of water, which is nonsense. That's not why one has children but there is a pattern in most that one imposes this care on children in some indisposition in the old age. That one hands over these houses for care, it's sort of a standard, and I think that a parent should manage just this property of theirs, if they have it, in such a way that they are able to hire a nurse, a nursing home and everything else that is related to infirmity possibly in old age. And not to give the child the role of caregiver, from a young age, from childhood (mother of an adult son, FGI Gdynia).

It should be emphasised once again that we are presenting here the declarations of parents who would not like to see transfers of goods within the family as a transaction, where they buy attention and care for money, material goods, or time. It does not mean that they would not want "spontaneous" attention and interest from the younger generation, and the denial of the "exchange" nature of the transfer shows that the rule of reciprocity in the exchange of gifts does play a role after all, and cannot simply be passed over in silence, but must be verbalised to negate it. The interviewees underlined the desire to live as independent a life as possible in the old age. What is important here is that this vision does not include the state and public institutions, such as on-site day support and long-term care but the belief that this independence will have to be bought on the market. Which is probably related to the low assessment of current support for the elderly. This assumption, although not verified in the interviews, is so legitimate that the interviewees expressed rather negative views of the state and public institutions.

While looking for general opinions on the role of social policy, also referred to by respondents as the role of the state, we observed that in most interviews this subject was rather invisible and did not appear spontaneously. The topic of the role of the state in the transition to adulthood was frequently discussed in the context of housing, as the purchase of a home is one of most significant costs in life. The role of state also appeared in the interviews when respondents made comparisons between economic circumstances in the lives of present young generations and the circumstances experienced by the generation of parents in the past. In that context, the experience of living under the socialist regime was sometimes mentioned in a positive way by both older and younger generations.

The Polish state should participate in the development of this young person, should somehow give these "baits". But in what way? I don't know. […] a young person's bond with the homeland will not be established when this homeland does not help her or him. I remember those years with fondness, because the state helped me. I always sensed some kind of debt to this homeland. Because I started this family, here the state helped me. It gave me an apartment, a job. We were able to live peacefully and, as it were, also develop this family in some way. And now, I don't know how the state could help. It just seems to me that these days it is these young people, even my daughter's generation, who are left to themselves (mother of two adult daughters, IDI, Radom).

Because the state used to partially provide, maybe it wasn't some rarity, but in a certain way, if you were enrolled in a housing cooperative, if you were in the Party and so on, the state built some housing and made it available. Someone applying for a three-room apartment would get a studio and so on, but after 30 years they would buy it back for a 1 zloty and have it. They are the lucky ones actually, and we just had to earn it and we envy them a little… (36-year-old man, IDI Warsaw).

Sentiment towards the socialist era is at the same time combined with criticism of current support, albeit of a rather generalised nature, without indicating what exactly this support would look like, but rather criticising the current one as insufficient.

And I think that no start is given by our state and our government to such youth and such a silly talk: he is supposed to become independent. He would like to become independent, but how? Should I make my child pack his bags and throw him out on the street and manage on his own? I just can't do something like that (mother of an adult son, FGI, Bielsko-Biała).

Our findings indicate that while intergenerational financial support is crucial to young people's entry into adulthood, there is a significant lack of visibility and recognition of state policies in these areas. Participants often did not spontaneously mention the role of the state in their discussions of financial transfers and support, suggesting a disconnect between public policy and individual expectations. However, when asked to do so, many respondents expressed a critical view of current state support, emphasising its inadequacy in meeting the needs of young adults, particularly in housing and educational expenses. This indicates an implicit reliance on family resources to fill the gaps left by public policy, which may exacerbate inequalities between families with different financial capabilities.

Conclusion

The analyses presented in this paper point out to the potential increase in inequality among younger generations. This unequal start into adult life related to unequal resources, or to the lack of access to financial parental support and safety nets contributes

to increasing challenges to be experienced by the younger generation. One of these challenges, if not the most significant, would be rising housing costs most likely. Our findings support the arguments made by researchers who point out to the "privatisation" of particular areas of life (see: Pawłowski, 2020), also taking into account those areas that are of key importance for the independence of the young generation. Most of the interviewees did not spontaneously see the role of the state and public institutions in the process of transition to adulthood or accepted the situation that services provided in education or childcare support require financing from private family funds. Public policy towards the young ones was rarely mentioned, and even those interviewees who referred not only to the experiences from the socialist era but also to most recent public transfers, such as the 500+ programme, or public subsidies for the purchase of an apartment made it clear that the public support was insufficient. In other words, financial transfers from parents to their adult children are taken for granted and to some extent can result from the weakness of public policy. On the other hand, as the results of the SHARE survey have shown, in some countries where public policies support young people's entry into adulthood, the frequency of financial support for adult children is the same as in Poland or even higher. That suggests that other reasons found in the literature can play the role, e.g., helping children achieve autonomy quicker and achieve the same or higher social status than previous generations.

Due to the limitations of the empirical material, we are unable to give a clear answer as to the main reasons for recognising that the family is the main, and usually the only one, responsible for the younger generation's independence, and sometimes even – as evidenced by statements about the need for children to attend non-public childcare and educational institutions – to guarantee quality care and education. This sense of obligation may also create additional constraints when planning more children, as the costs related to bringing up children to the moment when they reach adulthood do not end there, and the need for parental support of adult children continues after they move out from a family home. For instance, if one has three children, assisting each of them to achieve home ownership might be financially challenging. However, the SHARE data presented in the article shows that the scale of these transfers against the background of European countries is not large and close to the average. Much more and more frequent transfers are made by residents of the richest countries, such as Luxembourg, Denmark, Austria, Sweden, and Switzerland, which is probably due to the lack of comparable financial resources of the Polish households.

In defining the meanings of such wealth transfers from parents to children, one can point to two interconnected perspectives: long-term and short-term. Looking at parental financial support in the short term, it consists of allowing young households to meet certain life needs and fulfill aspirations more quickly. For instance, in the case of young people going to study in another city, it allows to bridge the gap between the actual cost of living in a large city, class-shaped aspirations and young people's financial capabilities. The same is true of support in the organisation and financing the wedding or more broadly, the decision to formalise a relationship, to have offspring, or the temporary withdrawal or return to the labour market. At the same time, such support is associated with the participation of parents, or even a network of family-connected households, in key life decisions of young people, such as housing strategies (Olcoń-

Kubicka & Halawa, 2018; Halawa & Olcoń-Kubicka, 2019). Such a support network provides, on the one hand, comfort and peace of mind and a kind of "safety cushion" in the event of life setbacks.

In this article, we have outlined how the macro perspective of public policy in supporting the younger generation is perceived from the micro perspective of the household. This transparency, or invisibility of policy programmes in the accounts of the interviewees carries significant political implications, especially when combined with the fragility of the broadly defined Polish middle class (Karwacki et al., 2023). Along with the struggle to maintain the status quo, there seems to be some disenchantment with the support of public institutions, as manifested, for example, in the continued withdrawal from the public education system.

One of the most important findings in the context of state public policy in young people's transition into adulthood is that respondents are unlikely to expect the state to provide equity. Instead, they are more interested in complementary transfers, i.e., the possibility of complementing private transfers with state action. In this way, the role of family transfers would be maintained in the form of facilitating social mobility, where family support could be more targeted and specialised. From the perspective of the state and, more broadly, public policymakers, there is a need to decide and clearly communicate to society whether and how the state should support young people's transition into adulthood. These topics often appear in the Polish media discourse on specific problems, e.g., housing, fertility rate, or the adaptation of education to the needs of the labour market. What is lacking, however, is a clear message to what extent the state is (co-)responsible for young people's transition into adulthood. A possible next step is the appropriate implementation of proposed public programmes that can reinforce, or redress inequalities caused by family transfers.

Finally, our findings and conclusions may provide a starting point for future research on intergenerational transfers within families in Poland. In addition to public policy developments, demographic changes and the evolution of the family network may also play a role in the frequency and "directions" of such transfers in the future. Trends in demographic change in Europe are leading to a "new demography of Europe" as a result of increasing life expectancy, low fertility rates and changing household structures in many countries (Kotowska & Jóźwiak, 2012). It may be interesting to investigate whether the observed changes in household structures – divorce, single parenthood, second partnerships, stepchildren, etc. – affect transfers from older to younger generations.

Funding

This text was financed by National Science Centre, Poland (NCN) under the OPUS grant "Intergenerational transactions: relational work and moral frames in transfers of wealth from parents to their adult children" (DEC-2018/29/B/HS6/02072), and by Intercollegiate Rectoral Grant of the Warsaw School of Economics "Intergenerational Transfers, Family Relationships and Public Policy in the Context of Old Age and Disability".

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Problemy Polityki Społecznej. Social Policy Issues 2025, 68(1): 1–23
https://doi.org/10.31971/pps/193178

Submitted: 2024-03-18/Accepted: 2024-09-10

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Social policy with the citizen at the centre. The Centre for Social Services as a new Polish institution and an example of service-based modernisation of social policy

Abstract

The article presents the reform of the Polish social welfare system consisting of the introduction of a new institution – the Centres for Social Services (Pl. Centra Usług Społecznych, CUS). From 2020 Polish municipalities have the statutory option to: transform social assistance centres previously operating in each municipality into CUSs or create CUSs as a new institution based on the partnership of several municipalities. CUSs have become a kind of laboratory of changes, expressing a new formula for the operation of local social policy institutions. This new format of a local institution fits into contemporary trends in European social policy of mature welfare

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states (with a fundamental focus on the production, coordination and provision of tailor-made social services available locally). The article considers the presentation of reform processes in the social policy system by moving from protecting citizens in social crises to investing in the form of dedicated social services for the well-being of all citizens in local communities. CUSs are the subject of reflection on reform in modern welfare states: with exposure of potential and added value but also risks and resistance to change. The analyses and conclusions use data collected during a monitoring study focused on the experience of CUS operation including data found in municipality documents and CUS reports, data obtained from moderated group discussions conducted with CUS managers and specialists, and desk research. The Polish experiences analysed in the article can inspire other reformers in countries where similar reforms are planned.

Keywords: social services, Centres for Social Services, social welfare system, post-communist countries, the rhetoric of reaction

1. Introduction – investment in social services' development as a social policy response to contemporary civilisational challenge

The development of social services is a nationwide trend and the new paradigm in social policies implemented in mature welfare states in response to the new challenges (Evers et al., 2011). This development means a change in the welfare infrastructure towards a three-pillar structure. The first pillar is the regulated labour market created as a result of the many years of civilising labour relations after the industrial revolution. The second pillar, so to speak encapsulating the first, has become the social security system. From this system, the key task of which are social transfers, the third pillar of the welfare infrastructure is gradually emerging – the system of public social services. The well-being of citizens in (post)modern societies increasingly depends on a universal access to effectively organised (one stop shop model – Lundberg, 2018), comprising tailor-made (personalised) service packages, appropriate to needs and of adequate quality, provided by professionals representing various helping professions (Rymsza, 2021). The growing demand for social services has to be seen as a civilisational challenge, linked to the extension of human life, changes in lifestyles and family functioning patterns. Such a well-developed service component – integrated, complex social services operating on a local level – reshapes welfare state into a new format: social investment welfare state (Morel et. al., 2012).

In the second decade of the 21st century an investment in social services became one of the UE social policy priorities. Especially the EU6 programming documents indicate the need to invest in the social sphere, and the priority for the 2021–2027 period is the development of comprehensive local systems of social services provided to the general population (Integrated Care and Support, 2021). Poland as the UE member state includes this priority in the programming documents[2]. Providing access

[2] The most important is the Strategy for Social Services Development adopted in 2022.

to social services to all members of municipalities is precisely the mission of Centres for Social Services (Pl. Centra Usług Społecznych, CUS) – the newly created entities responsible for social policy issues at the local level.

The subject of the analyses in this article is the process (formally initiated in 2020) of reforming social welfare system in Poland through the implementation of regulations of the 2019 Act on delivering social services by a social services centre (hereinafter the CUS Act 2019)[3]. The new regulations created an opportunity (not an obligation) for local governments to establish social service centres (CUSs). The paper presents the concept of CUS and the most important findings on their functioning during the first phase of operation (2020–2022). The analyses are based on the data collected under the monitoring research conducted by the Expert Team of the Council for Social Affairs functioning within the National Development Council (NDC Expert Team). The text concludes with a presentation of potential risks and dilemmas faced by the CUS reform. The presentation of resistance to CUS dissemination is framed by the Albert O. Hirschman's (1991) concept of reactionary rhetoric.

2. Objectives for the reform and the concept of CUSs

The social welfare system that has been operating in Poland during last 30 years and it is a product of transformation. Its key element is the network of social assistance centres (SACs) established in 1990 to mitigate the social side-effects of the first stage of transformation – the rapid introduction of market mechanisms into the economy (Golinowska, 2013, 19). The SACs located in all municipalities performed a classic safety net function, addressing assistance of different kind (mainly cash benefits but also in kind benefits, social services and social work) to "reform failures", persons and families finding it difficult to find their way in the post-market transition, ending up in long-term unemployment, falling into poverty and social marginalisation[4]. The safety net of SACs guaranteed a minimum of security and thus significantly limited social costs of economic transformation (Rymsza, 2014, 141–143). On the other hand, the selectivity of support and orientation mainly on delivering cash benefits resulted in severe stigmatisation of support recipients as social welfare beneficiaries were thought of as unable to cope with life. Another side effect was bureaucratisation of social workers operating in SACs more as providers of administrative procedures in aim to select individuals and families with income below the defined poverty thresholds as beneficiaries of cash transfers than professional frontline helpers specialising in social work (Rymsza, 2013).

After the key stage of political changes and Poland's accession to the EU in 2004, the model of social welfare became a dysfunctional one that did not meet changing social expectations and did not face new challenges. Especially SACs required changes and the redefinition of formula for action. While social welfare system was limited to

[3] Journal of Laws. 2019, item 1818.

[4] The creation of safety nets was a feature of the social policy of the Central Eastern European countries in the 1990s (Standing, 1996).

respond to the needs of the poorest, research by sociologists revealed the unmet needs of other social categories (e.g., the middle class – Karwacki et al., 2023), first of all, demanding an open access to social services based on the universal and not the selective (mean-tested) formula. Citizens who are not traditional clients of the social welfare system define the access to social services as the consumption of increased prosperity. So that social services are supposed to be delivered without the risk of stigmatisation. Due to a number of conditions, irrespective of the expert discussions regularly triggered, for many years the authorities did not decide on a general reform of the social welfare system, but only made amendments within the existing institutional order. A way to brake the impossibility and meet new expectations is the reform related to the transformation of SACs into CUSs.

The CUS concept was developed as part of the work of the National Development Council, an expert body under the President of the Republic of Poland[5]. In the Chancellery of the President of the Republic of Poland, on the basis of the prepared assumptions, a draft law was created, which was then sent to the Sejm by President Andrzej Duda in November, 2018 as a presidential legislative initiative. In 2019, the law was, with the support of the government, passed by consensus by the Sejm and approved (also consensually) by the Senate, and its provisions came into force on January 1, 2020.

The adoption in the CUS Act 2019 the principle of optionality in the creation of centres is based on the concept of progressive system change, where the target solution is reached in three steps, taking into account (1) the years 2020–2022 which period is called pilot phase (experience of the first group of CUSs), (2) the years 2023–2025 as the innovation scaling phase (the second, broader group of CUSs, also created optionally using the experience of the first group) and (3) starting in 2026 the suspected wider dissemination of CUSs as a systemic solution (phase three). In addition, an important programme assumption was the construction of the CUS Act 2019 as regulations leaving space for the use of local know-how in organising the process of service provision and the cooperation of service providers.

By the end of December 2022, 51 such centres were established in Poland, with their launch hampered in that time due to the coronavirus pandemic. These centres were named in public discourse as the "pilot group". A wider number of municipalities established CUSs or are on a way to establish CUSs in the second phase, of progressive social change, starting from January, 2023. Social policy programming documents guarantee these municipalities an access to the European Social Fund Plus resources to cover the cost of CUS implementation[6].

Formatted by the provisions of the CUS Act 2019, the model of the new institution complies with the social policy priorities of the European Union such as (i) animating

[5] The initial conceptual material of the NDC Social Policy and Family Section was published in: Rymsza, 2021, 365–375.

[6] The SSC Act 2019 gives each municipality the option to establish SSC in two modes: either by transforming a SAC centre that was previously operating, or by establishing a joint inter-municipal SSC. During the years 2020–2022 only the first option was implemented.

the creation of a local offer of social services, (ii) coordinating the processes of providing citizens with tailor-made services and (iii) developing of community organising are three main tasks assigned to the CUS.

Social service centres face tasks consistent with the priorities expressed in institutional reforms and practices present in other EU countries:

- to contribute to the development, integration, and expansion of **the availability of social services** (see: Grossi & Reichard, 2016; Wollmann, 2018; Wollmann & Marcou, 2010);
- **to consolidate local government initiatives** aimed at integrating and coordinating social services as an expression of the practice of territorial self-government at the municipal level (see: Bauer & Markmann, 2016; Fuentes, 2020; Giubboni et al., 2017);
- to use local know-how in **organising cross-sectoral cooperation** involving local service providers (see: Grewiński, 2009; Kendall, 2005; Urmanaviciene et al., 2021);
- **to extend the provision of social assistance beyond poorer individuals and families** or those socially marginalised – an offer to resident-citizens who demonstrate needs for social services in the life cycle of individuals and families (Inglot, 2019; Siza, 2017; Stankowska et al., 2023);
- **to be an expression of social investment policy**, using infrastructure co-created by local service providers from the public, civic and private sectors (Hemerjick et al., 2023; Vanhercke et al, 2022; Van Vliet et al., 2021);
- to contribute to **strengthening NGOs** and social enterprises (Kitzman, 2015; Wevers et al., 2020);
- to be a place for **the development of social work methodologies** based on both individualised case-work management approach and community work with a bonding profile, using an approach referred to as community organising (Bunger, 2010; Christens & Speer 2015; Knox et al., 2022);
- to contribute to the development of **collaboration between different helping professions** (O'Daniel & Rosenstein, 2010; Reeves et al., 2017).

In the CUS model, social services enhance citizens' quality of life and general well-being when easily accessible. Therefore, such services must not be an element of the market game (which limits the universality of access) but of a well-organised public system whose infrastructure is located close to people – in municipalities (Rymsza, 2021). At the same time, an important element of well-being is access to services on the basis of citizenship rights, i.e., without acquiring the status of a social assistance beneficiary (Gagacka, 2022). This was to be ensured by the transformation of SACs into CUSs whose offer of services is addressed to all residents – members of local territorial communities.

In the CUS model of service-oriented support, frontline workers play a leading role, representing various helping professions such as social work, psychotherapy, occupational therapy, family assistance, community work, specialist care, socio-cultural animation, and other. However, an important complement to the services provided by professionals is the development of self-help services provided by commune residents to other residents based on volunteering, self-help and

neighbourhood initiatives. Activating this potential is the task of the local community organisers (LCOs) employed in the CUSs (Bąbska & Skrzypczak, 2021).

The local service system based on CUS, in order to provide comprehensive and at the same time "tailor-made" support, is based on the activity of many local service providers, and its management must skilfully combine elements of fair competition with cooperation. In Poland, competition rules are regulated, but institutional incentives for cooperation are lacking. Strengthening the aspect of cooperation is precisely assumed by the CUS model (Waszak & Wejcman, 2021). The CUS "one-stop shop" model is used to manage service provision. Access to a package of services is possible by contacting one specialist – the coordinator of individual social service plans (ISSPs). The services included in the ISSP, however, are provided by specialists employed by various entities co-creating the local service system, coordinated by the CUS (Kaźmierczak & Karwacki, 2021). The more local co-operators there are in the system, the greater the possibilities to provide comprehensive services and at the same time ones tailored to the individual needs of specific residents.

3. The normative aspect of the CUS model

Dariusz Zalewski (2021, 14) points out that "the idea of creating Centres for Social Services is not only about the dissemination of social services in local communities but also about the transformation of the social welfare institution itself". It is a transformation that strengthens local government territorial communities. The pro-self-government character is in the very construction of the Act, based on the pursuit "that the provisions of the Act, apart from the necessary technical adjustments, do not violate in any way either the existing system of municipal self-government, in particular, the sphere of its tasks, or the statutory regulations on various social services" (Kaźmierczak, 2021, 16).

The CUSs' dissemination strategy based on optional decisions made by local authorities and building network of local service delivers based on cross-sectoral cooperation and voluntary involvement of civic sector organisations, social co-operatives, and social enterprises has to be seen as a processual innovation, contrary to the top-down approach dominant in Poland in implementing social policy reforms. In the works on the dissemination of the centres, the expert knowledge in the field of public policy programming was applied, taking into account the latest trends and directions in public policies, such as the empowerment approach, the concept of investment social policy or the governance mode in public management.

The normative basis for the delivery of social services by the CUS incorporates three main values: the state's subsidiarity, the subjectivity of residents, and the cohesion of territorial collectivities, which are broken down into seven programmatically linked guiding principles in the CUS Act 2019 (cf. Box 1).

Box 1. Rules for the implementation of social services by social service centres

Article 14 (1) In carrying out its tasks, the Centre:
1) offers specific social services to all eligible persons (universality principle);
2) takes into account the welfare of persons using social services, in particular, the need to respect their sense of subjectivity and safety (subjectivity principle);
3) maintains quality standards of social services (quality principle);
4) aims to provide social services that meet the needs of the local community to the fullest extent possible, taking into account the different phases of life and the situation of families (principle of comprehensiveness);
5) cooperates with public administration bodies, non-governmental organisations, and entities […], as well as natural and legal persons (cooperation principle);
6) taking into consideration the needs of the local government community, undertakes activities aimed at extending the offer of social services, using the potential of entities providing social services in the area of the Centre's operation (subsidiarity principle);
7) strives to strengthen social bonds and to integrate and develop the local government community (principle of strengthening social bonds).

Source: The CUS Act 2019, Art. 14.

The axiological backbone of the system of local social services coordinated by CUS legitimises and reinforces the idea of self-governance of municipalities as territorial communities in four ways.

- The principle of subsidiarity mentioned in the Act signifies the orientation of CUS towards building a service offer based on network connections with local service providers (Waszak & Wejcman, 2021). The logic of subsidiarity here draws a sequence in the delivery of services first by establishing cooperation with the existing service providers, and taking own action is the second step two when local service providers are scarce.
- Aiming to respond to the needs of residents by their own efforts fosters the diagnosis of both the needs themselves and the service potential of local actors (Bazun et al., 2021), which implies the activation of endogenous development factors.
- Community organising fosters the activation of non-professional social support potential (volunteering, neighbourly help, self-help), strengthening the community cohesion (Bąbska & Skrzypczak, 2021).
- The community is reinforced by the pursuit to agree on forms of support with the residents. It is difficult for the community to be empowered when its members are defined as dependant clients receivers of public social services.

4. Activity of social service centres – an analysis

By the beginning of February 2025, 108 CUSs were established in Poland[7]. CUSs are currently operating in municipalities in 15 out of 16 voivodeships (excluding Łódzkie Voivodeship), namely:

- sixteen CUSs in Kujawsko-Pomorskie (CUS Aleksandrów Kujawski, CUS Brodnica, CUS Chełmno, CUS Fabianki, CUS Golub-Dobrzyń, LUS Lisewo, CUS Lubanie, CUS Lubicz, CUS Mrocza, CUS Płużnica, CUS Rogowo, CUS Sępólno Krajeńskie, CUS Solec Kujawski, CUS Toruń, CUS Więcbork, CUS Włocławek[8]),
- fourteen CUSs in Wielkopolskie (CUS Czarnków, CUS Dopiewo, CUS Jarocin, CUS Kramsk, CUS Krotoszyn, CUS Pleszew, CUS Pniewy, CUS Rawicz, CUS Rokietnica, CUS Rychwał, CUS Swarzędz, CUS Szydłowo, CUS Śrem, CUS Trzcianka),
- thirteen CUSs in Mazowieckie (CUS Czarnia, CUS Grabów and Pilicą, CUS Kozienice, CUS Milanówek, CUS Mława, CUS Mszczonów, CUS Słupno, CUS Sochaczew, CUS Wiązowna, CUS Wieniawa, CUS Zbuczyn, CUS Żabia Wola, CUS Żyrardów),
- twelve CUSs in Zachodniopomorskie, (CUS Będzino, CUS Goleniów, CUS Karlino, CUS Kołobrzeg, CUS Koszalin, CUS Łobez, CUS Mielno, CUS Pełczyce, CUS POlanów, CUS Police, CUS Resko, CUS Świdwin),
- eight CUSs in Pomorskie (CUS Cewice, CUS Chmielno, CUS Czarna Dąbrówka, CUS Czersk, CUS Krynica Morska, CUS Pruszcz Gdański, CUS Skarszewy, CUS Słupsk[9]), in Śląskie (Bojszowy CUS, Czeladź CUS, Goleszów CUS, Łaziska Górne CUS, Mikołów CUS, Radzionków CUYS, Ruda Śląska CUS, Woźniki CUS) and in Świętokrzyskie (CUS Górno, CUS Ługów, CUS Mniów, CUS Ostrowiec Świętokrzyski, CUS Połaniec, CUS Starachowice, CUS Stopnica, CUS Zagańsk),
- five CUSs in Dolnośląskie(Głogów CUS, Jedlina-Zdrój CUS, Pieszyce CUS, Prusice CUS, Żmigród CUS), in Lubelskie (CUS Bełżyce, CUS Łuków, CUS Opole Lubelskie, CUS Świdnik, CUS Wojcieszków), and in Małopolskie (CUS Alwernia, CUS Klucze, CUS Myślenice, CUS Skawina, CUS Tarnów),
- four CUSs in Podkarpackie (CUS Adamówka, CUS Bukowsko, CUS Dębica, CUS Tryńcza) and in Warmińsko-Mazurskie (CUS Elbląg, CUS Górowo Iłowieckie, CUS Kurzętnik, CUS Srokowo),
- three CUSs in Lubuskie (CUS Międzyrzecz, CUS Szczaniec, CUS Zielona Góra),
- two in Podlaskie (CUS Łapy, CUS Stawiski),
- one CUS in Opolskie (CUS Gogolin).

Numerous municipalities are preparing to set up social service centres in the following years. The centres to be established will be able to benefit from ESF+

[7] See the table with information of these 108 CUSs in justification of the Presidential legislative initiative changing the CUS 2019 Act sent to Sejm on 14th of March, 2025 (https://www.prezydent.pl/prawo/wniesione-do-sejmu/inicjatywa-ustawodawcza-prezydenta-w-sprawie-cus,98757).

[8] CUS operates in the rural municipality Włocławek located around city Włocławek.

[9] Actually CUS operates in the new created gmina Redzikowo, earlier a part of the Słupsk (rural) municipality.

support, as agreed with the European Commission by the Polish government and the voivodeship authorities[10].

The municipalities that established CUSs between 2020 and 2023 can be divided into three categories/types of settlement. There are 24 urban municipalities, 45 rural municipalities, and 39 municipalities of an urban-rural and rural-urban character. The territorial distribution of the pilot CUSs is diverse, which is conducive to further dissemination of CUSs across the country as part of the second phase of the progressive system change.

The activity of the 49 of 51 social service centres[11] that were established between January 2020 and January 2025 was included in the analytical and research monitoring of the NDC Expert Team[12] (Rymsza & Karwacki, 2023). The authors of the article led this team and decided on the scope of research activities undertaken. The monitoring carried out in the period of May 2022–March 2023 consisted of four types of analytical and research work:

1) analysis of the data submitted in the reporting system by social service centres to the Ministry of Family and Social Policy;
2) analysis of the documents produced in the municipalities that launched the centres, including above all the Strategies for the potential and needs of local communities in the field of social services and the Municipal programmes of social services;
3) analysis of 14 moderated group discussions (MGD) conducted by the NDC Expert Team with the participation of professionals working in social service centres: directors of CUS, social service organisers (SSOs), LCOs, ISSP coordinators (ISSPCs), social assistance organisers, and experts.
4) a review of publications on CUS that appeared in the Polish scientific literature after the CUS 2019 Act came into force (desk research).

The concept of the monitoring study was carefully thought out and the methodology designed to take into account the various aspects of the centres' operation and the numerous available data sources (both in-situ and triggered data), and to perform the analysis using the triangulation method. At the same time, an effort was made to limit the risk of overinterpretation accompanying the study of start-up entities. In particular:

- For the quantitative analyses, reporting data provided by CUSs to the Ministry from three consecutive reporting periods were included: as at December 31, 2021, March 31, 2022 and December 31, 2022. The centres were established successively. The comparison of the activities of all centres on the basis of data from one reporting period would be subject to the error of "comparing the incomparable" as it is difficult to draw analogies between the activities of an entity that has just been

[10] Expresis verbis provisions on supporting the creation of SSC from ESF+ funds were included in 15 of the 16 voivodeship programming documents (with the exception of the programme for the Mazowieckie voivodeship).

[11] Two CUSs were established at the end of that period and did not prepared reporting data that might be included in the empirical basis for the analysis.

[12] Research and analytical work under the CUS monitoring process was undertaken by Dobroniega Głębocka, Arkadiusz Karwacki (co-leader), Izabela Krasiejko, Barbara Kromolicka Marek Rymsza (co-leader), with the assistance of Grażyna Ancyparowicz, Anna Dudzik, Marek Kośny, and Ewa Leś.

established and one that has been operating for two years. Therefore, we have developed a typology of centres based on their maturity, distinguishing: (i) centres in the start-up phase, (ii) centres in the process of being established, and (iii) established centres that met a total of five maturity criteria in operation. In-depth analyses of service activities were narrowed down to this group of centres only.

- In the case of qualitative research, we did not use classic focus group interviews, but their "soft" version – moderated group discussions (MGD). In MGD, more freedom is left for the "self-directed" statements of the interviewees and, at the same time, there is an emphasis on ensuring a maximum sense of safety. The latter was served by the organisation of separate discussions for particular groups of CUS managers and professionals: directors, SSOs, LCOs, and ISSPCs. The comfort environment of MGDs was widely perceived by participants as an opportunity to exchange experiences and share both successes and problems. This allowed the NDC Expert Team to gather information not only about the activated potential of CUS but also on the implementation difficulties related to the "resistance" phenomenon.
- We also ensured a high saturation of the research sample: a total of 86 interviewees participated in the 12 MGDs conducted: 30 CUS directors, 10 SSOs, 23 LCOs, 23 ISSPCs. They represented more than one third of professionals and managers employed in the centres during the research period.
- The MDGs with CUS specialists were complemented by some additional discussions with various CUS stakeholders (officials at the central and regional level, experts, representatives of the community of social workers of SACs that have not transformed into CUSs). We treated the knowledge gained in this way as contextual knowledge to better understand and more accurately analyse MGD.
- Analysis of key local documents: "Diagnoses of the potential and needs of the local community in the field of social services" (potential and needs diagnoses – PNDs) and local Social Services Programmes (SSPs) we supplemented with the analysis of documents related to obtaining support in the implementation of the grant programme (41 out of 56 centres were concerned). This allowed us to analyse the dynamics of the process of intentionally induced social change taking into account the impact of what was called "project culture".

The conducted monitoring studies have confirmed the great potential of CUS for the development and coordination of local social service systems. Below, we indicate the most important benefits that, in the light of our own research findings, the establishment of CUS brings to municipalities.

Firstly, an important change in the programming of local social policy is brought about by conducting PND, in accordance with the provisions of the CUS Act 2019. Carrying out this diagnosis results in the development of SSP (cf. Table 1), which constitutes the municipality's service offer that responds to the so-far unmet needs of residents. Significantly, the SSP is distinguished from other local public policy programming documents by taking into account both the demand side (demand for social services) and the supply side (potential of local service providers). This allows for a socially relevant and, at the same time, economically efficient formatting of the service offer by CUSs. Previously strategic documents focused either on the demand

side (municipal strategies for solving social problems) or on the supply side (municipal development strategies). The second characteristic feature of PND is the extensive use of participatory diagnostic methods and techniques (e.g., individual and group interviews with key actors from local institutions and residents, world cafe method, participant observation).

Table 1. Diagnoses of the potential and needs of the local community and Social Services Programmes in 49 municipalities that established CUSs in the period 2020–2022

	Status as of March 31, 2022 ready / in preparation	**Status as of March 31, 2022 accepted**	**Status as of August 31, 2022 ready / in preparation**	**Status as of August 31, 2022 accepted**	**Status as of December 31, 2022 ready / in preparation**	**Status as of December 31, 2022 accepted**
CUS under analysis	48	48	49	49	49	49
PND	46	44	48	47	49	47
SSP	38	36	45	39	49	46

Source: Own calculations based on CUS reporting data at the disposal of the Ministry of Family and Social Policy.

The implementation of the standard of the development of SSP based on the PND means that municipalities with CUS apply a three-phased sequence of measures within local social policy:

(1) diagnosis of the potential and needs of the local community → (2) adoption of the Social Services Programme → (3) provision of new social services available to residents

This is an important step towards practising evidence-based local social policy.

Secondly, the broader targeting of service support – to residents in general and not only to social assistance clients – creates a new image of CUS in relation to the established image of the SAC in local communities. The new image fosters a broader interest in the CUS service offer from residents. The surveyed CUS managers and specialists (Rymsza & Karwacki, 2023, 77–147[13]) have repeatedly unanimously indicated that the CUS offer is used by numerous residents who "steered clear of the CUS", not wanting to become social assistance beneficiaries. It can be seen that CUS meet the social expectations characterising the post-transition period, according to which social services should no longer be an element of social protection for the vulnerable but a manifestation of social well-being provided to the general public by the welfare state.

[13] Chapters 5–8 of the Report by Rymsza, Karwacki, Krasiejko, and Kromolicka consecutively.

A good illustration of the demand for social services provided on a universal basis is the dynamic development of *specialist counselling services* in the CUS, especially psychological, therapeutic, family, pro-health, and vocational. The interest of residents in the use of specialist counselling is due to the safe formula of this support, which does not imply and does not activate mechanisms of social control, characteristic of assistance practices carried out within the SAC and, more broadly, social welfare institutions. The advantage of counselling is also that it does not activate the mechanisms of self-labelling, which means entering into the role of the dependent person. Indeed, counselling support is seen as a way of activating one's own coping potential in difficult situations.

The residents' demand for universal services is also indicated by the popular *mobile services* organisation, especially in CUS operating in rural areas with a widely dispersed population, i.e., assistance practices provided to residents at their place of residence, without the need to attend a specific facility (Rymsza & Karwacki, 2023, 59–64). Examples include service buses transporting specialists with specialised equipment to individual villages in the municipality or the provision of counselling services "in the field" using local facilities, such as village community centres. Mobile services are complemented by door-to-door transport services, which take residents with reduced mobility due to disability, illness or age, to and from places where the required services are provided.

While organising the offer of services available to the general public, the centres do not only target individual categories of residents based on specific needs. They also took into account the situation and needs of families, especially families with young children, people with disabilities and seniors in need of care. The service offer by CUS became an element of *local social policy towards families* exceeding "sectoral" measures (Krasiejko, 2021). Pro-family support includes, among others, support in fulfilling family roles (clubs for mothers with young children operating in the form of self-help groups) and assistance support addressed to dependent persons and their home carers (provision of rehabilitation equipment, personal assistance for persons with disabilities, respite care – Rymsza & Karwacki, 2023, 59–64). The activation of services aimed at families promotes the already-mentioned image change of CUS.

Thirdly, CUSs *promote cooperation with local partners from the three sectors (welfare mix)*, including NGOs and social enterprises providing social services (Rymsza & Karwacki, 2023, 94–105[14]). Municipalities with a well-developed civic sector infrastructure use local know-how in terms of intersectoral cooperation, and the novelty brought by CUS is related to crossing sectoral barriers in service delivery by associating elements of social support with cultural, educational, and healthcare activities. Where NGOs are lacking, efforts are made to animate them and include them in service and support activities. The ministerial grant competition played an important role here: the requirement to benefit from ESF support was to allocate a minimum of 30% of the ESF funds obtained for services to commissioning these services to civil sector entities.

The experience of the pilot group of CUS indicates that the condition for the development of local social services is not only the *diversification* of service providers

[14] Excerpt from Chapter 6 of the Report by Karwacki.

but also *of sources of financing services* as the basis for the financial stability of CUS in the long term using all four available resources: (1) the state budget, (2) EU funds, (3) the budget of the local community, as well as (4) co-payments from residents paid directly when using services (Rymsza & Karwacki, 2023, 90–93[15]). The CUS Act 2019 stipulates that the conditions for the provision of social services by the CUS that go beyond the municipality's statutory tasks are determined by local law – in the Social Services Programme. Local authorities may charge for the use of CUS services, subject to the statutory requirement that the services are not provided on a commercial (for profit) basis. Local authorities actively use this option, with the calculation of fees being in line with the EU formula for services of general interest as free of charge or for a fee under conditions that do not constitute a barrier to access. This formula is generally understood and accepted by residents.

Fourthly, *community work is developing* rapidly in CUS. The key here is the involvement of LCOs. At the end of December 2022, LCOs were working in 47 of the 49 reporting CUS. There were 51 in total, as five centres had two community work specialists each[16]. An important aspect of LCOs is to activate the potential of the local government community in terms of neighbourhood support, volunteering and self-help (Rymsza & Karwacki, 2023, 132–147[17]), which complement the CUS service offer implemented by helping professionals. Yet an important factor for change is also the openness of the personnel of CUS professionals to cooperation with LCOs, which was confirmed by MDGs with directors of CUS, SSOs and ISSPCs (Rymsza & Karwacki, 2023, 77–131[18]). Research has shown that LCOs, by being carriers of a new approach both in the community and in CUS itself, are gaining the status of "double-rooted" innovators, thus ensuring that community work methodology is permanently embedded in municipalities.

Fifthly, the monitoring research confirmed the *viability of the 'one-stop-shop' concept* of access in CUS to a package of services provided by different local service providers. The tool for making this concept a reality is the ISSP introduced by the CUS Act 2019. Their creation using the new service offer is handled by the ISSPCs.

For methodological reasons, our analysis of the development of the ISSP work method was limited to the group of solidly established centres. We described the developmental trajectory of the centres as moving from the start-up phase (type C), through the acquisition phase (type B) to reaching the solidification-in-operation phase (type A) (cf. Table 2). Centres meeting the following five criteria are considered to be solidly established: 1) functioning for at least 9 months, 2) preparation of a PND, 3) adoption by the municipality of the SSP defining new social services, 4) employment of new specialists in the CUS (SSO, LCO, ISSPC), 5) implementation of new social services, confirmed by structured CUS reporting. In short, reaching the stage of solidification in CUS activities is a state in which the centre's activities are focused on implementing the service assigned to it by the CUS Act 2019, rather than

[15] Excerpt from Chapter 5 of the Report by Rymsza.
[16] The statutory requirement is employing one LCO in the centre.
[17] Chapter 8 of the Report by Kromolicka.
[18] Chapters 5–7 of the Report by Rymsza, Karwacki, and Krasiejko consecutively.

preparing to run them. Only then, as we have stated, do CUSs implement the ISSP method in a structured manner.

Table 2. Categorisation of CUS by phase of implementation in programme activities The "solidification" process of social service centres

Status as of	Centres solidified in operation (type A)	Centres in acquisition (type B)	Centres in the start-up phase (type C)	In total
March 31, 2022	24	16	8	48
August 31, 2022	32	16	1	49
December 31, 2022	42	7	0	49

Source: Rymsza & Karwacki, 2023: chapter 4 by Rymsza, table, p. 35.

Table 2 illustrates the development dynamics of CUS in 2022. While at the end of March 2022, half of the CUSs had reached the solidification stage in their operation (24 out of 48 reporting), five months later approximately two-thirds of the centres (32 out of 49), while at the end of 2022 – four-fifths (41 out of 49), i.e., the vast majority.

The research confirmed the growing *potential of service support using ISSP* as a professional helping practice. At the end of 2022, 41 solidified centres employed 85 ISSPCs (an average of two per centre) who had prepared a total of 10,048 ISSP (an average of 118 ISSP per coordinator). The 10,000 completed ISSP placements are a sufficient basis for starting the work of methodically transforming the professional experience of ISSPCs into new professional helping practices.

Last but not least, *asset-based development approach* is practised in different ways in the centres. The asset-based methodology (c.f. Green et al., 2006) exists in CUS activities on three levels. At the casework level, this methodology can be found in widely developed specialist consulting services. Counselling, by its very nature, aims to mobilise the own strengths of those receiving support. At the community organising level, asset-based approach is realised by activating residents in voluntary, self-help and neighbourhood support activities. At the level of CUS management of the local service system, the work on resources is triggered by a participatory PND. The diagnosis makes it possible to take stock of and integrate the service resources at disposal. A side-effect of the fragmentation of the social services system characterising Poland, consisting in their dispersion in various mutually "invisible" support subsystems (Rymsza, 2013, 348–355), is the only partial utilisation of the resources held: premises infrastructure and specialist personnel. Coordination activities within CUSs make it possible to use these resources more effectively. This is a kind of bonus for the implementation of modern social service management.

Social service centres passed the test as coordinators of the ad hoc relief action aimed at war refugees from Ukraine. Organising the relief action, assuming not to locate them in closed camps but relocating them efficiently and providing them with comprehensive service support, led to the rapid appearance of refugees in a significant

part of the towns where CUSs operated. The centres proved to be *efficient coordinators of the community absorption of refugees*, activating and streamlining the cooperation of various local organisations (Rymsza & Karwacki, 2023, 73–76).

5. Reactionary rhetoric towards CUS – reformist dilemmas

57 new social service centres of the "second weave" have been appearing in Poland since January 2023 and large number of next municipalities have already decided to transform their previously functioning SACs into CUSs, creatively adapting to the regulation of the CUS Act 2019[19]. Analysts find it challenging to look at the conditions that may determine to what extend CUSs will become widespread in Poland, meeting expectations and responding to the needs of citizens. Therefore, this is a question about analysing the risks of the process of disseminating CUS's.

Given the expected subsequent decisions of Polish municipalities to establish CUSs, it is important to note that the decision-making process takes place under conditions of trying to take into account multiple values embodied by members of different social groups with their own interests (Lindblom 1959, 82). And this is why substantive arguments and empirical evidence form comparative studies and monitoring research do not collect all important arguments (Frieske, 1990, 101–102). Public decisions are the results of the multidimensional influences, adaptation to the combinations of values, interests, factors, and determinants.

Thus, analyses of the potential for CUS dissemination (and decisions made in specific local government units) should also take into account several determinants beyond the characteristics of this new institution and the concept of its operation. Among the crucial aspects in triggering the change in the institutional order, we recognise the availability of financial resources to implement innovations but also the quality of human capital including key agents of change and decision-makers. Here, it is essential to provide information relevant to the dilemmas, doubts, and knowledge needs of those on whom decisions to establish CUSs ultimately depend (Rogers & Shoemaker, 1971). It is where we encounter resistance to change, questions, doubts, and discussed potential problems that may be caused by reform efforts.

In the course of analysing the discourse around CUSs, we were able to identify numerous risks, concerns, and problems related to the process of dissemination of this new institution (concerning the creation of further entities, the sustainability of processes in those already functioning, the implementation of tasks in accordance with the defined functions of CUSs). The perspective proposed by Albert O. Hirschman (1991) is considered a useful theoretical framework for structuring this resistance to change. This proposal refers to Thomas H. Marshall's (1950) reflections analysing the emergence of European welfare states as a process of realising civil (18th century), political (19th century), and social (20th century) rights successively. While Marshall

[19] Justification of the Presidential legislative initiative changing the CUS 2019 Act sent to Sejm on 14th of March, 2025 (https://www.prezydent.pl/prawo/wniesione-do-sejmu/inicjatywa-ustawodawcza-prezydenta-w-sprawie-cus,98757) .

displayed optimism, Hirschman exposes ideological reactions to successive stages of development and reconstructs three main ways of criticising the social solutions introduced, undermining their sustainability. These are: the perversity thesis of counter-effectiveness (Hirschman, 1991, 11–42) assuming that undertakings intended to improve particular spheres of collective life cause the problems they were intended to prevent. The unintended effects of reforms are central to this. The second is the futility thesis (Hirschman, 1991, 43–80), indicating that attempts at social transformation will ultimately prove futile and will fail. The third is the jeopardy (contradiction) thesis (Hirschman, 1991, 81–132), according to which the costs of change may prove greater than the benefits.

Hirshman's analysis of more than 200 years of social reforms was widely received. to illustrate resistance to specific reforms in public debate (the sustainability debate – Holden, 2010) or in academia (the dispute over business ethics – Brink, 2009). Of course, "reactivity" can be reduced to disputes between right and left or conservatives and progressives (Sunstein, 2023). Scholars bring in the cyclical nature of reactionary resistance; the rhetorical strategies of reactionism are repeated and reconstructed over time (Schargel, 2022). And it does not need to be a specific strategy based on a particular socio-political ideology. Richard Shorten (2015), in an attempt to fill in the gaps in Hirshman's proposal, points out that reaction should not be equated with the political right in a broad sense. It is more of a tool to capture and abstract the "rhetorical repertoire" of responses to the proposal to trigger a particular change. In public debate, it can be a set of arguments to challenge proposed reforms (Chater & Loewenstein, 2023), and it is often done without strong evidence support (and therefore as loose speculation) appropriate to those seeking immediate insights and absolute certainty (Sunstein, 2023). This is also how we treat the "reactionary rhetoric" – as a tool to structure arguments critical of the proposed reform in the Polish social welfare system related to the establishment of CUSs. It is a perspective that does not expose political divisions but structures institutional resistance in a solidified system in local environments, where the real power is held by representatives of groupings located on different sides of the political scene. Reactionary rhetoric thus becomes a tool for organising the voices collected by us throughout the study and rooted in their structure of interests, but also (and perhaps above all) for identifying weaknesses (gaps, risks, mistakes) in the first stage of implementing CUS as a new institutional formula.

The arguments questioning the creation of CUS in Poland can be assigned to the three reconstructed by Hirschman (see Table 3). It must be stressed that positive opinions and expressions of benevolent interest in the future of progressive systemic change[20] predominate in the literature. However, we focused on the critical voices, treating them as a "counterweight" to the activated elements of CUS potential already described above. Knowledge of the critical arguments, concerns, and reservations is essential. Only by being aware of the real and possible unintended effects and side-effects, as well as the strength of defence mechanisms against change, can rational

[20] An analysis of publications in the Polish-language scientific literature on SSC, cf. Rymsza & Karwacki, 2023, 148–153 (Chapter 9 by Karwacki).

adjustments to reforms be prepared. Such adjustments are, moreover, envisaged in the concept of progressive systemic change related to the dissemination of CUS. These voices, arguments, and problems presented in the Table 3 are of a different nature due to the fact that they are formulated by different actors. Ultimately, however, they constitute the "matter of resistance" and a set of reform risks.

Table 3. Reactionary rhetoric towards the dissemination and operation of CUSs

Ineffectiveness due to:	**Counter-effectiveness in form of:**	**Internal contradictions in form of:**
too few municipalities choosing to establish a CUS (the change induced by the optional formula will prove marginal on a national scale)	widening inequalities between municipalities (in some, the offer of services for many groups of citizens will be developed, in others, there will be a shortage of access to services)	shortage of resources to cover social risks while incurring expenditures on universal access services (risk of losing sight of the problems of people in the most difficult social situation)
lack of knowledge of decision-makers about the investment character of social services (the perspective of the budget burden and shortage of funds is decisive)	raising citizens' expectations regarding the locally available support offer in the absence of a guarantee of the institution's survival and maintaining the scope of this offer	re-arrangement of the local hierarchy of institutions and dominance of CUSs (shortage of resources for the functioning of other entities)
lack of deadline of the target system solution and belief in the temporariness of the new institution	tensions generated in CUS teams (as tension between the team involved in the transfer of services and those staff who carry out established social assistance tasks)	lack of potential to respond to the identified needs (conclusions from the diagnosis do not translate into the services offered)
insufficiency of elements beyond the current scope of activity of the social assistance system institutions	employee burnout due to understaffing and extensive scope of responsibilities	pressure to co-operate from the institution's beneficiary who do not have the capacity to use the services effectively
lack of resources (service provider, services) to establish CUS	taking on too many tasks with a threat to the coherence of the institutions' activities (an attempt to respond to subsequent needs of citizens from various systems, e.g. health, social assistance, culture, and sport).	weakening of responsibility on the part of the state and local government (where the offer of services is not followed by activities that increase the potential of citizens to reach for services and come into contact with the institution)
failure of third sector organisations and social enterprises to build their service offer	involvement of the new institution in political conflicts (in the event of recognition of a new institution in relation to the authority that established it)	

lack of financial resources adequate to the scale of the institution's challenge for professional actions	inducing inequalities between local third sector organisations (in connection with contracts for the provision of services coordinated and commissioned by CUS)	
problems in accessing professional personnel (shortage of professional staff, inability to replace staff with more qualified ones)	stimulating the disclosure of the needs and aspirations of specific groups without a final response to them (e.g. thanks to regular and in-depth diagnosis, with restrictions in access to services in the context of the scale of demand for a specific service)	
problems in creating CUS as an institution free of the "stigma" of a SAC (consistent association of CUS as SAC by citizens)		
infrastructure deficiencies (in the context of working conditions, also as a denial of institutional modernisation processes)		
weakness in the process of distributing knowledge about CUS and its good practices		

6. Conclusions

The process of popularising CUS as a new institution focused on local provision of social services to citizens encounters many dilemmas, potential threats, and real problems. Regardless of the basis on which the idea of the reform is based and the needs and premises behind the initiative and the final shape of the legal provisions shaping the new institution, the above arguments should be taken into account and, consequently, through specific solutions, promotional activities or development conditions, they create the potential to disseminate, adaptation to achieve efficiency in response to citizens' needs. It becomes crucial to take into account emerging criticism in the consistent improvement of the change model by strengthening the conditions necessary for the effective implementation, mitigating side effects and preventing the deepening of problems that were supposed to be solved but also precisely communicating and responding to reported problems. This increases the chances of socialising decisions, reduces uncertainty around changes and gives the new institution a chance to have a real impact on local needs (adequacy, adaptation, coherence).

Nevertheless, the analysis of the activities of the first CUS group in 2020–2022 shows the potential of the CUS model in the development and coordination of local social service systems. The activation of this potential is facilitated by the framework provisions of the CUS Act 2019, which leave space for the use of proven practices and solutions that co-create local know-how in the provision of social services and inter-institutional and inter-sectoral cooperation, "directing" them towards the path of progressive systemic changes. However, numerous municipalities preparing to establish CUS are the surest confirmation at the level of social practice of the potential of the model of development and integration of local social service systems using CUS.

The monitoring study of the activity of social service centres to date allows us to identify some important findings related to the challenges of reform in the field of social policy. We mainly mean:

– The realisation through social practice of the needs/challenges postulated by researchers for the consolidation and coordination of local systems of social policy implementation as networks of inter-institutional links. These networks of interaction function on the basis of action strategies (this is the form the Social Services Programme takes), based on up-to-date diagnoses of the needs of citizens and potentials of the local community. Thus, we have examples of the occurrence of processes of networking of local inter-institutional relations and investment rationality by basing actions in the diagnosis (cf. Błędowski & Kubicki, 2014).
– Confirmed by subsequent investment activities, there is a growing local awareness of the necessity of developing a social policy based on social services. Municipalities where CUSs operate indicate that there is no single formula for this institution, but what they have in common is to give a primordial role to social services, treated as investments and not just costs. The experience of operating social service centres shows the potential in organising access to a wide range of social services provided in a "one-stop-shop" formula with simultaneous personalisation of service support. The day-to-day functioning of these institutions provides material reflecting the challenges, barriers and opportunities of implementing local social policy based on social services (cf. Grewiński, 2021).
– Legitimisation through practical local action of policies in line with the empowerment model of activation, which we have advocated in our other studies (Rymsza & Karwacki, 2017; Karwacki & Rymsza, 2023). What we mean by this is to include in the practice of social service centres such assumptions as comprehensive understanding of the needs of citizens (comprehensive strengthening of the social roles performed, going beyond the experience of the social crisis), development of the idea of governance (also by involving the voice of citizens in the constructed strategies of action of institutions, active inclusion of social organisations in the processes of organising support), decentralisation and co-production of social services, building local social partnership and making the idea of case management more practical, development of community work and organising the local community (with emphasis on the role of volunteering), personalisation of support or orientation towards the effectiveness of the assistance provided.
– Exploring the potentials of community organising practices and community service as a policy expression for citizens and taking into account citizens' potential for

self-help activities expressed through civic engagement. One of the key possibilities of a social service centre is the activity of community organisers.

– It is natural for resistance, opposition and doubts to emerge against triggered change in institutional systems that have had the opportunity to become entrenched in a particular operating model. This is a motivation to rethink ways of diagnosing critical arguments and doubts, forms of responding to these voices in order to create conditions for innovation to spread.

The next few years and the continued activity of social service centres will undoubtedly provide further arguments and evidence concerning the potentials and barriers to the development of social policy based on personalised social service provision dedicated to citizens and, at the same time, the modernisation of local social policy systems with the citizen (their needs and aspirations) located at the centre of interest and activity of local institutions.

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Problemy Polityki Społecznej. Social Policy Issues 2025, 68(1): 1–18
https://doi.org/10.31971/pps/200745

Submitted: 2024-07-25/Accepted: 2025-02-02

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How to close down a care home in 24 hours: privatisation, fragmentation, and ambiguous quality regulation in senior long-term care in the Czech Republic

Abstract

Long-term care in the Czech Republic is characterised by workforce and service shortages; care homes often do not have a good reputation and are considered a last resort. What high-quality care should look like and how it can be ensured is controversial in this context. This paper studies these questions using the example of a small, private care home for Czech as well as German seniors that had been shut down abruptly, with residents being moved to nearby institutions in less than 24 hours. Drawing on an in-depth analysis of the Czech long-term care regime as well as newspaper articles and interviews with different actors on the closure, the paper analyses the definition,

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implementation, and assurance of care quality. It shows how responsibilities for defining, providing, and controlling care services are divided between various public and private actors and how quality is understood as something to be implemented via standards and their control. We argue that the fragmentation of the Czech care system and its ambiguous quality regulations create a landscape that is difficult to navigate and, ultimately, resulted in a situation where seniors were moved around – as one relative put it – "like furniture".

Keywords: long-term care, ambiguous quality regulations, privatisation, fragmentation, care home closure

Introduction

In the spring of 2023, a small private residential care facility located in the Czech–German border region catering to local clients as well as a few seniors from Germany was closed down by the authorities[2]. The case received media attention because the home was closed and the 24 residents, who were mostly in need of a high level of care, were moved to nearby care institutions all within one day, with the last occupants being relocated after midnight. How the closure was conducted was criticised in various ways. Relatives, care workers, and employees of the regional authority in charge of re-organising the residents' care complained they had only been informed of the closure on that same day. Relatives and care workers expressed concern that what they perceived as a brutal handling of the situation negatively affected the seniors' health conditions. Employees of the regional authority and the care workers accused one other of not collaborating during the relocation. An intermediary who had established contact between the German clients and the home complained that she had not been treated as a legitimate contact person by the authorities despite having valid service contracts with the residents.

Irrespective of the extent to which the problem definitions and criticisms are substantiated in detail, they are interesting insofar as they point to different underlying definitions of what constitutes high quality in institutional care and how it should be ensured. High quality is a declared goal and a crucial aspect of long-term care policies (e.g., European Commission, 2022). However, what high quality exactly denotes is not clear. Even more difficult is the question of how it can be implemented and controlled. This article understands care quality as a complex and multidimensional endeavour shaped by the coming together of a variety of actors, including relevant authorities at different levels, public and private care providers, care workers, people in need of care, their relatives, interest groups, and others. All these actors have their own interests, responsibilities, and potentially contradicting ideas about what good care should look like. Furthermore, care is embedded in societal norms and values as well as national and supranational institutions, laws, and regulations (Williams, 2018).

[2] We would like to thank August Österle, Kristine Krause, Mariusz Sapieha, and Hanna Horváth as well as the editor of the journal and the anonymous reviewers for their thoughtful comments on earlier versions of this paper.

More than a year after the closure of the care home, the heated debates about the abrupt closure have subsided but the question remains as to how a long-term care facility with 24 residents, most of them requiring a high level of care, could have been closed in less than 24 hours and given such different explanations. The article takes the care home closure and the discourses around it as the starting point for an in-depth analysis of the Czech system of senior long-term care. It shows how the system is slowly opening up to private providers, how responsibilities for offering and controlling institutional care services are divided between different government bodies, and how quality is defined. We argue that the fragmentation of the Czech long-term care regime and its ambiguous quality regulations create a landscape that is difficult to navigate, and, ultimately, have resulted in a situation where seniors were moved around "like furniture", as one relative put it.

The paper first gives an overview of the current literature on long-term care regulation and care home closures and introduces the concept of care regimes. It then describes our data and empirical approach. The main section presents the case of the care home closure and shows how it relates to the specificities of the Czech long-term care regime. The conclusion summarises our findings.

Quality regulations, care home closures, and care regimes

Quality is a central aspect of long-term care regimes, defined here as "a judgement about the goodness of both technical care and the management of the interpersonal exchanges between client and practitioner" (Donabedian in Guo & McGee, 2012, 125–126). According to Guo and McGee (2012, 126), there are five domains that should be measured in order to establish the overall quality of care: consumer and employee satisfaction, workforce stability, clinical outcomes, and regulatory performance. Regulations play an important role in that regard. Regulations can be defined as "the intentional intervention in the activities of a target population, where the intervention is typically direct – involving binding standard-setting, monitoring, and sanctioning – and exercised by public-sector actors on the economic activities of private-sector actors" (Koop & Lodge, 2017, 21). The quality of care is then determined based on pre-defined standards and criteria, and measured by compliance with the regulations. In a 2023 published review of determinants of regulatory compliance in health and social services, Dunbar and colleagues found that structural characteristics such as smaller size, higher nurse staffing levels, lower staff turnover, and the facility's geographic location were positively associated with regulatory compliance. On the other hand, high staff turnover was cited as one of the strongest reasons for poor compliance with quality regulations (Dunbar et al., 2023, 23).

Compliance with regulations is closely related to the question of how to control quality in inspection processes. Vincent Mor (2014) distinguishes two basic modes of quality control. While adversarial approaches are characterised by a legalistic character and strict interpretations of standards from which inspectors, who are understood as opposing parties to providers, are not supposed to deviate, in consensual approaches inspectors seek to convince providers to adhere to regulations by offering information and consulting them (Mor, 2014).

As Choiniere et al. (2016) show in their study of inspection processes in six different countries, ownership type is one of the most important structural quality indicators and closely linked to characteristics of the respective regulatory and inspection system. Countries with a high level of for-profit providers in long-term care tend to have the most standardised and complex regulatory systems as well as deterrence-based audit systems, comparable to Mor's (2014) adversarial inspection type. On the other hand, countries with a high proportion of public providers tend to have less strict and less standardised regulatory systems as well as a stronger tendency towards a compliance, or in Mor's (2014) terminology, a consensual inspection approach. The authors relate this to the fact that for-profit long-term care facilities are more often associated with low quality of care expressed in lower staffing levels, higher fluctuation of staff, and worse physical condition of the clients, as shown in many studies (Choiniere et al., 2016; Comondore et al., 2009; McGregor & Ronald, 2011; McGregor et al., 2006). A recent study from England confirms these connections and shows that almost all closures ordered by the authorities due to quality deficiencies affected for-profit care homes (Bach-Mortensen et al., 2024). Therefore, strict quality regulation is seen as critically important in contexts with high shares of for-profit providers. In cases where compliance with care regulations is insufficient, closing a home serves as a last resort for securing quality in institutional long-term care.

In the last years, three comprehensive review articles on care home closures have been published that provide a detailed overview of the current state of research in this field (Douglass et al., 2024; Iqbal et al., 2023; Weaver et al., 2020). Findings stem almost exclusively from the UK or US context (with single exceptions referring to Canada, Ireland, and Sweden). The long-term care systems in both countries are characterised by a dominance of private for-profit organisations in the provision of residential care (Choiniere et al., 2016; Douglass et al., 2024, 472). To our knowledge, there is no literature (in English, Czech, or German) on care home closures from Central-Eastern Europe. Institutional care services in this area are less developed and public entities are still the most important providers although private providers have expanded significantly over the last two decades (Eurofound, 2017), as can also be seen in the Czech Republic (see below on marketisation and privatisation processes in the Czech long-term care system).

Literature on care home closures consists largely of studies that examine planned closures following providers' business decisions (e.g., due to lack of profitability because of low demand and occupancy, insufficient public funding, high standards and associated investments, intense competition; or staffing problems, especially regarding qualified nurses); a few papers also mention closures based on negative inspection outcomes or following emergencies such as a fire, without, however, going into detail about what difference it makes in terms of the process and the outcomes. Most studies follow a clinical approach and examine the outcomes of closures using quantitative health indicators to measure residents' well-being and mortality risk. A few also include interviews with seniors, relatives, managers, or public employees responsible for carrying out inspections or relocating seniors.

Findings suggest that a closure comes "with inevitable distress during the closure but, if done well, with scope for improved outcomes for some people in the longer

term" (Glasby et al., 2019, 79). A reasonable notice period and comprehensive, ongoing, as well as timely communication are cited as decisive factors for a decent closure process, also including seniors, relatives, and care workers as much as possible in the decision-making process, for instance by taking residents' wishes regarding their new care home into account. The studies conclude that feelings of loss, anger, and disempowerment cannot be completely avoided but they can be limited through forward-looking planning and respecting seniors' individual pace. Regarding protocols for closures, research shows that in most of the studied contexts, no recommendations or guidelines exist. It results in differing approaches, whereby lessons learned are not shared (Douglass et al., 2024; Iqbal et al., 2023; Weaver et al., 2020).

In analysing the closure of a small care home as an outcome of how long-term care services are organised in the Czech Republic, the article draws on the concept of care regimes. "'Regime' does not only refer to policies and regulation but, importantly, to conditions, cultures, practices, and legacies, and to major forms of social relations of power and inequality inherent in care […] and also to the forms of mobilization and contestation that each regime in each country provokes" (Williams, 2018, 552). Regimes cut across scales and include, for example, local care practices and relationships; subnational, national, and supranational laws and regulations; transnational inequalities; regional histories; social norms and discourses; institutional arrangements and the like (Williams, 2018). Analysing the care home closure through the lens of care regimes enables us to focus on the interplay of actors and developments at different levels and the contradictions and fractures that arise from them and play a crucial role in the studied case. To understand especially the tensions, we find it fruitful to follow Sciortino's (2004, 32–33) notion of a regime as not being "the outcome of consistent planning" but rather "a mix of implicit conceptual frames, generations of turf wars among bureaucracies and waves after waves of 'quick fix' to emergencies, triggered by changing political constellations of actors. The notion of a […] regime allows room for gaps, ambiguities, and outright strains: the life of a regime is the result of continuous repair work through practices". Precisely these gaps, ambiguities, and the different actors' interpretations and implementations of care quality are crucial for understanding the presented case, as the text will show. Before analysing the case of the care home closure, we will describe our base of data and methods.

Research background and methods

This paper is part of the ERC-funded research project "ReloCare"[3]. The project studies the relocation of seniors from German-speaking to Central-Eastern European countries, such as the Czech Republic, Poland, Slovakia, and Hungary, where care is more affordable. It understands the phenomenon as an expression of the trans-nationalisation and marketisation of care in Europe and as symptomatic of the

[3] "Relocating Care Within Europe. Moving the elderly to places where care is more affordable," led by Kristine Krause, University of Amsterdam (ERC Grant No. 949200; duration: 2021–2025), www.relocatingcare.org.

transformation of Central-Eastern European care regimes. In 2022 and 2023, ReloCare team members interviewed important stakeholders, such as care home owners and managers, brokering agencies, regional authorities, local politicians, care workers, care home residents, and their families, and spent several months of fieldwork in numerous care homes engaging in participant observations and informal conversations[4].

In the Czech Republic, we identified nine care homes catering to approximately 300–400 German-speaking clients. All care homes are located in close proximity (up to 30 km) to the German border, in the regions previously known as "Sudetenland" that had been inhabited by German-speaking populations until the Second World War. Matouš Jelínek, as a Czech native speaker, conducted 10 interviews with care home owners and managers and eight interviews with representatives of the Ministry of Labor and Social Affairs (cs. *Ministerstvo práce a sociálních věcí (MPSV)*), regional offices (cs. *krajský úřad*), and of departments for social affairs of different Czech regions[5] and municipalities (cs. *sociální odbor kraje*). Veronika Prieler, a German native speaker, conducted three interviews with intermediaries who connect clients from German-speaking countries and Czech care homes. During the time of our fieldwork, one of the care homes was suddenly shut down, which caused a shock in the field and triggered fear, uncertainty, and speculation among our interlocutors.

The closure of the care home and underlying developments in the Czech long-term care regime thus became one of the dominant topics of our research. Although our interviews originally had not been focused on long-term care quality or the Czech care system as such, quality definitions, inspection processes, and broader trends in the Czech care regime had been mentioned in each interview and gradually became the focus of our attention and one of the dominant interview topics. When the abovementioned care home was shut down in the spring of 2023, we decided to meticulously reconstruct the whole story based on the various material and information we could gather. To understand the case, we conducted an in-depth analysis of relevant laws, regulations, policy documents, and academic literature on senior long-term care in the Czech Republic. Information on the care home closure stems from newspaper articles as well as interviews with the owner of the facility, an intermediary who had recruited German-speaking seniors; representatives of the regional office that carried out the closure of the facility; and a representative of the MPSV. All newspaper articles and interviews have been closely read and critically discussed among the authors to examine how the care home closure was explained, who was ascribed which responsibilities, and which broader developments were referred to. We supplemented this with information from other interviews with municipal and regional departments of social affairs as well as care home managers. Putting together this diverse material

[4] Ethical clearance was obtained by the ethical boards of the ERC and the Amsterdam Institute for Social Science Research.

[5] Regions (cs. *kraje*) represent the second highest administrative unit after the national level in the Czech Republic. Every region has an elected regional assembly and a regional governor. Regions themselves own and run care homes, and their departments of social affairs select and organise long-term care facilities within the region in the social service network (cs. *síť sociálních lužeb kraje*) to ensure care for the residents of the region.

allowed us to reconstruct the closure through the narratives and perspectives of the various actors involved and to relate it to broader developments within the Czech care regime.

The care home closure and how it relates to the Czech long-term care regime

Running a private care home in a transforming care regime

Seven years ago, an individual entrepreneur opened a care home for just over 20 residents in a small Czech town not far from the border with Germany. The home's owner and administrator, a trained cook, had already owned the property for several years and had run a private guesthouse before turning it into a care home. Together with his wife and without any previous experience in long-term care, he entered this sector. In the beginning, the majority of the clients were German, recruited by a transnationally operating intermediary who linked seniors in need of care and their relatives from Germany, Switzerland, and Austria with care facilities in the Czech Republic, Slovakia, and Hungary. The website and the name of the care home were also partly in German. Over time and fuelled, among other things, by empty beds attributable to COVID-19-related deaths, the care home's primary focus on the German-speaking market shifted towards a mixed clientele. At the time of the closure, 18 Czech and six German seniors lived there.

To understand the emergence and existence of a care home catering to local as well as foreign seniors, we take a closer look at the Czech care landscape and recent developments therein. Long-term care for seniors in the Czech Republic is mainly provided by family members. The share of seniors who receive formal care services is comparatively small (Souralová & Šlesingerová, 2017). As in other Central-Eastern European countries, care homes are perceived by many as an option only should no other alternative exist. At the same time, there are considerable shortages in professional care services. Waiting periods of a year or longer for a place in a care facility are not uncommon. These gaps are linked to labour shortages caused by poor working conditions, including low salaries and low social recognition (Uhde & Maříková, 2019), and out-migration of care workers to Germany and Austria, especially in the border regions (Uhde & Ezzeddine, 2020).

Over the last two decades, the Czech care landscape has been shaped by an emphasis on decentralisation and pluralisation of providers, expressed in an (albeit slow) increase in private for-profit providers. Starting in the 1990s, long-term care shifted from being the responsibility of the nation-state and provided by central government-run institutions to the responsibility of regional and municipal authorities (Souralová & Šlesingerová, 2017). This development was in line with similar trends visible in many Western European care regimes in the 1990s (Kubalčíková & Havlíková, 2016). However, "a lack of experience in local social care governance and budgetary constraints have for many years constrained the modernization, coordination, and extension of services" (Barvíková & Österle, 2013, 247). The scarcity of resources mirrored the low attention that long-term care at that time had in social policymaking.

Only from the mid-2000s on did this start to change, with the adoption of the 2006 Social Services Act (*Zákon o sociálních službách, 2006*) as a major reform step (Souralová & Šlesingerová, 2017).

Consistent with the neoliberal, marketised idea that a broader diversity of providers and more competition would foster higher quality, the care sector has been opened to private providers, many operating on a non-profit basis but also including an increasing number of individual entrepreneurs as well as bigger companies that see care as a business opportunity, sometimes operating transnationally (Farris & Marchetti, 2017; KPMG, 2022). Over the years, the number of for-profit providers increased slowly but steadily. While in 2008, only 3% of senior care providers were private for-profit companies (Sowa, 2010, 11), their share rose to 9% in 2019 (KPMG, 2022, 107), which is mainly due to the strong increase in numbers in recent years. In the residential care sector, their number doubled from 69 in 2014 to 137 in 2019. As noticeable as this increase is, we should not lose sight of the fact that the largest proportion of residents by far (72% in 2019) still live in a care home run by a region or municipality (KPMG, 2022, 109).

The care home studied herein is an example of these new private market actors that entered the care landscape in recent years. Like other care facilities in Poland, Slovakia, Hungary, and the Czech Republic, the care home targeted local as well as foreign clients. Based on transnational inequalities and especially on differences in labour costs, these homes offer care at around a third the cost of similar institutions in countries like Germany. People in need of care benefit from the possibility of transferring their pension and care-related entitlements from one EU member state to another (Ezzeddine & Krause, 2022; Großmann & Schweppe, 2020). The facilities are located in relative proximity to the German or Austrian border, and often EU funds are used to renovate buildings. Intermediaries play an important role in this new trend. They not only connect families with care needs to care homes but offer a broad range of services to seniors and their relatives as well as to the care homes and contribute to spreading the idea of catering to foreign seniors among care entrepreneurs (Prieler, 2024).

The role of private for-profit care entrepreneurs in the Czech care landscape, especially if they (also) cater to foreign seniors, is ambiguous: In accordance with neoliberal argumentation, private care where the client may pay for extra services is seen as a high-quality option. On the other hand, private care is perceived as a bigger risk for low quality and even care negligence as it is suspected that profitability is prioritised over the quality of care, as expressed for instance by the representative of MPSV. Mistrust of private providers gets stronger when foreign clientele is involved, as the business logic of such an arrangement seems to be more obvious than in cases where private providers offer their services to Czech citizens. In the interviews, care homes that (also) address foreign seniors were associated with lower quality of care and higher staff turnover, a connection which is also addressed in the international literature, as shown above (Choiniere, 2016; Comondore et al., 2009; Dunbar et al., 2023; McGregor & Ronald, 2011; McGregor et al., 2006).

Mistrust of private providers might have been fuelled further by the emergence of unregistered homes about a decade ago. Czech regions had reported a growing number

of unregistered facilities that offered services similar to those in registered care facilities, but without being registered as social services providers and thus without the need to adhere to quality standards or employ qualified staff. This "grey market" consisted of over 70 providers, representing 7% of all registered care homes in 2015 (KPMG, 2022; Kubalčíková & Havlíková, 2016). Although the ministry took action against this illegal sector and decreased the numbers considerably, this development could still impact the Czech long-term care regime in that it influenced the general perception of private providers.

Contested inspection outcomes and ambiguous quality definitions

Already a year after the care home's opening, the regional office pointed out staffing problems, which were subsequently confirmed by an inspection. In the different sources, it was discussed controversially what kind of personnel was missing exactly and how persistent the shortage was – and inspection results were not made public. The newspaper articles emphasise that there was not enough medical staff to ensure clients were adequately taken care of around the clock. The owner of the facility confirmed that there had been staff shortages but highlighted that this had not been a long-term problem since he had been able to improve the situation quickly. He also emphasised that the reported problems that ultimately led to the closure of the home were merely administrative. Furthermore, he rejected the complaint that medical staff shortages meant that clients were not cared for around the clock and stressed that although a general nurse was lacking, a practical nurse had been present. He also admitted that no social worker had been present in the home for several months due to maternity leave. However, according to him, this had not caused problems since the departed social worker instructed her non-social worker successor remotely, a practice which had worked out well and yielded no objections.

Interestingly, explanations other than the staffing problems were also mentioned in the news and interviews. The facility owner, for instance, speculated about a competitor's interest and political reasons related to the fact that the care home also catered to foreign seniors. The owner of another care home as well as the regional politician responsible for carrying out the closure expressed suspicion of care negligence. The latter also added that even though the license withdrawal had been based on personnel problems, proper medical care alone was no longer enough. High-quality care also encompassed social activation programmes and the like. The care home's management, care workers, and former residents countered the allegations by underscoring high client satisfaction, thereby bringing in another quality dimension and implicitly criticising the approach of assessing quality based on formal requirements. The intermediary who had brokered the German seniors also stressed that clients had been highly satisfied, which she saw substantiated in the positive feedback from relatives who, in her experience, are the best quality indicators since they are often even more critical of the delivered care than the seniors themselves. In the inspection process, however, it ultimately came down to the presence or absence of a nursing care professional.

Staffing issues are not a surprise given the sector's labour shortages in the Czech Republic. According to estimates by experts, over three thousand additional care workers and other care professionals were needed in Czech long-term care in 2023, a three-fold increase over the past two decades (Horecký & Průša, 2023). In addition to social workers, there is also a shortage of thousands of nurses, especially general nurses with university education who are authorised under Czech law to perform a wider range of tasks than practical nurses with only a high school education (Tóthová & Sedláková, 2008). The lack of care and medical staff is even higher in the border regions with Germany and Austria, where many care workers out-migrate to work in care facilities or as live-in care workers on the other side of the border for salaries two to three times higher (Uhde & Ezzeddine, 2020) – this is where the analysed care home was located. While the conditions are advantageous for attracting German seniors, they are the opposite when recruiting personnel in the chronically understaffed Czech care sector.

To understand the competing problem definitions and why even the question of staff shortages cannot be answered easily, a closer look at how quality and quality inspections are conceptualised in the Czech care regime is needed.

The Czech Republic, like other countries, does not address long-term care as a distinctive social policy area. Instead, it is part of the healthcare and the social care sector, and senior care services are not only provided in care homes but also in specialised hospital departments. Although the services may be very similar, the former are regulated, funded, and controlled by MPSV and the latter by the Ministry of Health (Souralová & Šlesingerová, 2017). The horizontal fragmentation and lack of coordination results in tensions between the systems which also affect the care provision in care homes. For instance, the emphasis on people's dignity and free choice in the social care regulations tends to conflict with health care's emphasis on safety (MPSV, 2015). Strict regulations regarding the "medical" tasks of care workers restrict holistic care provision (Uhde & Maříková, 2019). The aforementioned reference to the fact that high-quality care is more than correctly performed medical tasks can be interpreted as an expression of the tension between the two areas.

When it comes to the definition of care quality, the 2006 Social Services Act is crucial. Besides defining registration requirements for providers, it also includes paragraphs on the quality of care provisioning, although formulated vaguely. Terms such as "proper oversight" or "appropriate risk", which serve as legally binding obligations for providers, are not specified exactly. Service providers as well as regional governments, municipalities, and inspectors therefore need to interpret them, which opens room for different understandings (MPSV, 2015, 54). This became evident in the interviews with regional authorities responsible for registering care facilities. Several interviewees first stressed that they only acted according to the law. However, when explaining how they understand the requirements stated in the law, they indicated that other regions may have different interpretations of the same requirements.

Besides public authorities, providers also face the problem of ambiguous formulations, as can be seen, for instance, in the "Legal Cookbook of the Social Worker" (cs. *Právní kuchařka sociálního pracovníka)* issued by the Association of Social Service Providers (Matiaško & Hofschneiderová, 2015). Among other things,

the authors discuss the question of whether a nurse must be present in care homes for seniors during the night shift. Based on their understanding of the term "health care", the authors conclude that "proper oversight" of a client would require the presence of a nurse only in cases where the absence of a nurse would pose an "inappropriate risk" to a particular client. This risk in turn is to be assessed and documented in the "risk management plan" of the respective client established by the provider. What is noticeable about this interpretation is that it is introduced and framed very cautiously, using phrases such as "it seems to us" or "we presume". Although the interpretation is based on jurisprudence, it remains only one of several possible interpretations of the legal terms and requirements.

In addition to the Social Services Act, quality is further specified in the MPSV Decree No. 505/2006, which introduced what is called standards of quality in social services (cs. *Standardy kvality sociálních služeb*). The role of the standards is twofold: First, they are supposed to serve as a guideline for providers as regards what high-quality services should look like and, therefore, what the state expects of providers. Secondly, they are used as an evaluation tool in the assessment of service and facility quality in domains such as personnel standards, client negotiations, goals, and means of service provision, or complaints (MPSV, 2008). Each of the 15 standards consists of three to five "criteria" that specify what quality means in the respective dimension.

From the time of their implementation onward, experts such as sociologists, social workers, social services managers, and state representatives criticised the standards as failing in both intended functions (Horecký, 2008; Kocman & Paleček, 2013). As the main problem, Kocman and Paleček (2013) identify the standards' formalistic nature. They are formulated in general and abstract terms and prescribe what is to be done but do not specify what good implementation looks like. For instance, standard number 3, "Negotiation with the applicant in social service"[6] states the following:

a. [The social service] provider has written down internal rules, according to which they inform an applicant in a comprehensible manner about the options and conditions of social service provision; the provider acts in line with those rules.
b. The provider negotiates with a person interested in social service the requirements, expectations, and personal goals that are possible to realise through social service according to their abilities and skills.
c. The provider has written down the internal rules of proceedings on how to refuse the applicant for reasons defined by law; the provider acts in line with those rules.

What exactly the negotiations between a provider and an interested party should look like remains an open question, leaving room for different interpretations. This confirms Choiniere and colleagues' (2016) findings that countries with a high proportion of publicly owned long-term care facilities tend to have less strict and less standardised regulatory systems.

Consequently, the quality of the provided services is often reduced to the existence and quality of the written procedures (Kocman & Paleček, 2013). Properly completed forms, well-made individual plans, and the like are understood as an expression of good care. Accordingly, the focus of the actual control of the standards' implementation

[6] www.mpsv.cz, authors' translations.

is on how care practices are translated into documents (MPSV, 2015). Quality control is carried out as an inspection of the documentation and written procedures and not of the actual care practices or outcome indicators. Considering that more than half of the standards' criteria focus on the documentation of rules and procedures, this focus is not surprising. Care home managers in our research described their experience with a typical inspection process in the following way: usually, inspectors ask for a room in the care home where they are not disturbed and then check specific parts of the documentation. The time that the inspectors spend outside this room during a three-day visit to observe the everyday life of the care home can be counted in minutes; they are interested only in the documentation. Thus, the main emphasis lays on the prerequisites for quality, whereas indicators regarding client satisfaction and quality of life are missing (Malý, 2018, 12). Nevertheless, despite widespread criticism of the standards' formulation, the excessive paperwork linked to these, the vague and outdated requirements regarding the documentation itself, and the standards-based inspection process, the only outcome of the discussions was a shift of inspections from regional to central responsibility (see below). Neither the formulation of the standards nor the approach of the inspections have changed.

During an inspection, the potentially different interpretations of the legal framework and their documentation come together. Given that the authority's understanding is ultimately decisive, the provider's interpretation may be wrong. Therefore, providers are in a difficult situation of having to anticipate the interpretations of different authorities and may even be confronted with contradictory requirements from various government bodies. As the inspection process is neither consistent nor fully transparent and the outcomes are not publicly accessible (Malý, 2018, 12), its results cannot serve as a guideline for the management of care homes. This mode of quality control corresponds to what Mor (2014, 17) defines as an adversarial approach.

Apparently, in the present case, the care home manager and the inspectors interpreted the requirements differently. This relates, as explained, to the ambiguous legal definitions, where terms such as "proper oversight", so relevant in this case, are not specified exactly. According to the interpretation from the "legal cookbook" quoted above, a practical nurse was enough to fulfil the requirements. However, the inspectors, whose interpretation was decisive in the end, had interpreted the legal obligations differently. As the standards contain few concrete requirements regarding hands-on care but rather focus on formal requirements and the documentation of processes, quality assessments can more easily document administrative issues than problems in nursing and social care. Another recent care home closure in the country substantiates this: in that case, there were reports of care negligence, but the actual closure was justified solely due to administrative reasons.

Vertical fragmentations and a care home closure within 24 hours

The care home's management appealed the negative inspection result, which, according to the media, they had successfully done before. This time, however, the ministry rejected the appeal. According to the interviews, the ministry's decision was

communicated to the care home and the regional social department in charge of reorganising the care for the seniors only on the day the provider's license revocation came into force. The care home was expected to close in less than 24 hours and have all clients moved to other institutions by midnight that day. Organised by employees of the regional office, 12 Czech residents were relocated to a care home run by the region where the care home was located, six Czech clients were moved to a care home run by a neighbouring region and the six German-speaking seniors were moved to a private care home with a mixed clientele of local and foreign clients and some German-speaking care workers. Relatives of the seniors were also informed of the relocation only on that day, as angry blog posts under one newspaper article show and as highlighted by the intermediary who was interviewed.

How could it have happened that the care home was closed so abruptly and in a way that was in discord with the recommendations of a good liquidation as summarised above? The answer lies in the vertical fragmentation of the care regime. As in many other countries, responsibilities for long-term care in the Czech Republic are divided between national, regional, and local governing bodies. While MPSV sets the general agenda for the development of social services, the regions are responsible for the implementation and actual planning of service provision. Municipalities are obliged to make background information available for the planning and to develop municipal plans for social services development (Kubalčíková & Havlíková, 2016).

Vertical fragmentation is further complicated by the general division of responsibilities between different governing bodies in the Czech public administration. In order to de-centralise state power and disperse it into the regional and municipal level, between 2000 and 2003, the Czech Republic adopted a "so-called fused model of territorial administration in which the state administration tasks and activities are carried out by the self-governmental bodies (i.e., co-governmental tasks)" (Dostál & Hampl, 2007, 10). The so-called regional offices (cs. *krajský úřad*) are thus an administrative unit of the regional government as well as the state and exercise delegated state powers determined by law (Čmejrek, 2022; MVČR, 2004) – including the registration of social services.

All public and private organisations and companies interested in providing social services are obliged to register with the regional office. To do so, they need to prove that they fulfil the requirements regarding the qualification of staff as well as construction and sanitary norms (Kubalčíková & Havlíková, 2016). The registration process, therefore, can be understood as the first step in quality control, one typical for institutional long-term care in many European welfare regimes (Spasova et al., 2018, 28). Providers are also obliged to regularly report changes in staff and clients to the regional office. Therefore, in the case of the closed care home, the regional office must have had an overview of the number and composition of the care home's staff, which eventually became a problem.

While granting registration as well as control of compliance with registration conditions and requirements is the responsibility of the regional office, quality inspections are a centralised task, carried out by inspection offices reporting directly to the ministry, with each inspection office responsible for two regions. Controlling care quality had once been the responsibility of the regional offices. However, this was

changed in 2012 in order to cut the supposedly overly strong links between regions, regional offices, and providers and ensure the impartiality of the process. Since then, the administrative division of controlling tasks has been rather complicated. Regional offices are authorised only to control compliance with the registration requirements, but they are not eligible for inspecting the care quality. However, when MPSV decides on the withdrawal of registration based on the outcome of the inspection, the regional office is the body exercising state power in this matter. It resulted in a situation where the regional office learnt about the ministry's decision to revoke the registration of a particular care service only at the very last moment – the day the care facility was supposed to be closed down. Although this seems to be a very unlikely coincidence, it meant that the regional office had no time to prepare for the closure in advance.

Because of their responsibility for social service provision in their territory, the regional office was in charge of finding new places for the residents. Given that everything had to happen rapidly, each region took care of "their" senior citizens. Regarding the six foreign seniors, the German language skills of the staff in the new care home were the decisive criterion. User choice, autonomy, and free negotiation between consumer and provider as to the scope of the service provision were just as secondary as the private contracts between the seniors and the brokerage agency, which could itself be viewed as a perfect expression of the marketised conception of care.

Given the time pressure, it is understandable. Meanwhile, the timetable apparently stemmed from passing on information at the very last moment. Fragmented responsibilities and poor coordination between various actors led to the closure being carried out in a way that those involved described as "at the expense of the seniors", in whose interests everyone claimed to be acting, while at the same time, blaming other parties for their "inhumane" and "brutal" approach. The voices of the seniors were left seemingly unheard. The presented case thus represents a counterexample of what current studies submit as good practice when closing a care home, which includes having early, honest, and ongoing communication between all involved parties; taking the perspectives, wishes, and needs of seniors, relatives, and care workers into account; and granting them as much say as possible in the relocation (Douglass et al., 2023; Iqbal et al., 2023).

Roughly half a year after the deregistration and closure of the care home, a nearby social service provider re-opened a care home in the same building. The heated debates about the abrupt closure subsided again, but the question remains as to how a long-term care facility with 24 residents, most of them requiring a high level of care, could have been closed in less than 24 hours. In a context of labour shortages and mistrust towards for-profit providers, different public and private actors, each with their responsibilities, room for manoeuvre, and "implicit conceptual frames" (Sciortino, 2004, 32), came together in the complex endeavour of providing high-quality care. Amidst the inspection and ensuing closure of the care home, competing interpretations of the legal requirements and different understandings of how to ensure good institutional care collided.

Conclusion

In this article, we presented the case of the closure of a small private residential care facility located in the Czech Republic catering to Czech and German seniors. The facility was closed down by the authorities within 24 hours, which attracted a lot of media attention. As we have argued, the case can be understood as the result of a care regime that is characterised by: (1) its vertical fragmentation, where responsibilities are divided between national, regional, and local governing bodies, which is further complicated by the general division of responsibilities between different governing bodies in the Czech public administration; (2) marketisation policies that emphasise a diversity of providers and contractual relationships between clients and providers in the delivery of services; (3) ambiguous quality regulations and legal definitions that create a landscape that is difficult to navigate for authorities as well as care providers.

The presented case highlights severe gaps in the Czech long-term care regime regarding care home closures. There is no functional procedure for carrying out the closure of a long-term care facility, which is mainly due to the fragmentation of the system. Different parts of the inspection process are carried out by different governmental bodies, and the decision to withdraw registration is communicated without prior notice by one governmental body to another responsible for carrying out the closure. The way the presented situation was handled resembles the procedure in other long-term care regimes in emergency situations such as floods, fires, or other natural disasters that require immediate closure and relocation of the clients. Paradoxically, however, in this case, the closure within one day was not the result of an emergency, but created a state of emergency for all parties involved. The abrupt closure is furthermore related to the increasing marketisation of care, which is one of the results of the post-socialist transformation of the Czech long-term care regime that is slowly opening up to private for-profit care providers. Their position in the care landscape is more ambiguous than that of public care providers, who have closer connections to the public authorities and are, therefore, considered more trustworthy partners. Private, profit-oriented providers, on the other hand, are more vulnerable when it comes to controlling quality in the inspection processes.

The analysed case took place in a specific geographical area at a specific point in time, with a specific constellation of actors and particular regulations. Simultaneously, elements typical of many long-term care regimes in Central-Eastern Europe and beyond came into play, such as the division of responsibilities between national, regional, and local governments and between different welfare branches; labour shortages due to the undervaluation of care work and poor working conditions; the intersection of familial, marketised, and publicly organised care; ambiguous regulations and difficulties in reforming the established system even if it is widely criticised. This paper thus can contribute to a better understanding of care home closures also beyond the Czech context and to preventing a situation where residents are moved around "like furniture".

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