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Neoliberalization of Familialism by Default: The Case of Local Organization of Elder Care in Poland

Abstract

This chapter examines diverse local care loops within a single country, explaining how local contexts affect the implementation of elder care policies from the perspective of two Polish towns. Poland has a family-by-default care regime based on the informal and unpaid provision of care by family members. Only modest amounts of public in-home and institutional care are available. In recent years care provision has been the subject of both cuts in spending and marketisation, while care work continues to undergo precaritization in neoliberalism. Given that no large-scale de-familialisation of care for older adults has taken place in Poland, the current situation is best described in terms of a neoliberalisation of the family-by-default model.

We present empirical cases of care provision from our ethnography of elder care in two mid-sized Polish towns. Our comparative study shows how local care loops can successfully mobilize local actors under favourable conditions. However, central cuts have increased the financial burdens under which local public care institutions and families operate. By resisting caring obligations, these actors have contributed to the creation of care loopholes that may leave low- or no-income people without care. Such care loopholes are often filled by 'hybrid' third-sector organisations that encompass both social needs- and care provision rather than focusing on a single function.

Keywords

elder care, local care regime, private maternalism, care loopholes, hybrid institutions, Poland


KOŃSKIE
KLUCZBORK

Introduction

The provision of care is a contentious issue in welfare states, both at the general level of policy and at the level of local implementation. The provision of care often involves multiple actors and forms of care coming together in a care arrangement (Radziwinowiczówna et al. 2018). Care arrangements do not exist in a void: they are very much embedded in local contexts, including space, and require care loops, understood in terms of daily routines and micro-mobilities, in order to operate (Isaksen and Näre 2019). Care policies can help sustain care loops; alternatively, they may fail to support or even hinder the existing efforts of families and other actors. This chapter offers the case of Poland, whose elder care regime can be characterised in terms of 'familialism by default', meaning that families typically take responsibility for the bulk of care provided to older people, with such care being provided informally and with little support from the state (Saraceno and Keck 2010, cf. Gábriel in this volume). In the twenty-first century, central government reforms have defunded statutory elder care provision in the spirit of neoliberalism, contributing to further re-traditionalization in this area (Isaksen and Näre 2019). Such reforms have led to a reduction in state-provided care; by placing increased care obligations upon female family members, they can be interpreted in terms of the continuation or reinforcement of private maternalism (Glass and Fodor 2007).

The subject of this chapter is the local-level implementation of neoliberal elder-care policies. The neoliberalisation of a care regime has several components. It primarily entails and stems from cuts to funding for care services. But beyond austerity measures, neoliberalisation in this context also means reorganising care so that care receivers are required to contribute more to obtain the same services as before, to the point at which service provision becomes commodified (Isaksen and Näre 2019). Market institutions and logics become more prominent in the provision of care (Sahraoui 2019), and care workplaces change, rendering care jobs more precarious (Sahraoui 2019). A deterioration in the working conditions experienced by care workers is a frequent by-product of the implementation of new reforms (see Kordasiewicz and Sadura 2017).

Different care regimes within different models of welfare state provide different starting points for neoliberalisation. Where the care regime in question is familialism by default, the results are alarming. Such is the case in Central and Eastern Europe, where a robust elder care system has never been built. Statutory support is already scarce in this context, because the familialism by default model is based on *informal* family care (Pfau-Effinger 2012). Budget

cuts, commodification and marketization exacerbate an existing care deficit, even where they are promoted as flexible solutions (cf. Gábriel this volume).

Understanding the neoliberalisation of familialism-by-default and the re-traditionalisation of care requires a comprehensive analysis encompassing both public, private and third-sector organisations and the families of care receivers. Moreover, in the context of the expansion of private maternalism, an analysis of the relationship between public institutions and the family is crucial. As we explain below, families have responded in various ways, ranging from compliance to resistance, to being made both practically and financially responsible for elder care.

We aim to explain how neoliberal policies are implemented at a local level. The (often fragmentary) regulations and guidelines that make up a given care regime are devised at state level. But actual responses to the phenomenon of ageing arise at the level of local communities. Ageing happens locally: people get old in villages, towns, districts or residential areas. Local care loops emerge, drawing upon resources from local care regimes. As people age, it is locally available resources that they rely upon in the first instance. Aging adults schedule an appointment with the local GP, have their blood pressure taken by a community nurse or are looked after by a social-welfare carer. Similarly, state regulations in the realm of care are enacted at community level. For this reason, it is crucial to explain both how the Polish care regime undergoes neoliberalisation at a local level and how local actors negotiate such processes.

In the next section we introduce the Polish care regime and the changes it has undergone as a result of the neoliberalisation of elder care services. In the third section we outline our ethnographic research. In the fourth section we describe the local care regimes in the two local communities that are the subject of our ethnography. We open that section by illustrating how care provision involves different (sometimes numerous) actors providing care in differing degrees of intensity. In this section we propose, as a complement to the idea of care loops, the concept of care *loopholes*: that is, instances in which there are no or scarce local public, private or third-sector institutions that provide care at a local level. In the context of our research, an example of a care loophole would be the more remote and depopulated villages of Poland, which often lack social services. We conclude with additional remarks about care loopholes and the steps that may need to be taken to prevent more of them being created. The severe consequences of local care loopholes are mitigated by 'hybrid' institutions which provide social-needs services to local people aged 50 and over and which also engage their members

as voluntary care providers. Despite civil society's attempts to step up, effective care provision for an aging society will not be possible without better financing for elder care in Poland.

The expansion of private maternalism

While analysts do not agree on where Poland and other post-state-socialist countries sit in relation to the various typologies of the welfare state (Arts and Gellisen 2010), a shared legacy in such states is the centralisation that prevailed pre-1989. Elder care regimes in contemporary Central and Eastern Europe differ significantly, however. Different states diverge in their welfare paths—especially around the importance accorded to institutional care and levels of investment. When countries that invest less in the welfare system (such as Poland or Romania) are compared with countries with a better developed care infrastructure and more funding (such as Slovenia and Latvia) clear differences emerge (Bettio and Verashchagina 2010, for Slovenia see also Hrženjak, this volume).

As for our case country, elder care in the People's Republic of Poland was limited in scope, since 'long-term care is a latecomer in welfare state development' (Österle 2010). Between 1944 and 1989 the Polish elder care system lagged behind other areas of the welfare state. It was also highly centralised, which was typical of the way public services were managed under socialism. During the post-socialist transition period, statutory elder care provision were decentralised through the delegation of competencies and responsibilities to borough (*gmina*) and county (*powiat*) level (Piątek 2001).

Responsibility for Social Welfare Centres (SWC) and their care services was delegated to boroughs (the lowest level of administrative unit in Poland). Later, responsibility for the organization of Senior Citizens' Councils, as well as for supporting NGOs active in the area of welfare and the organization of Elderly Day Care Centres, was also delegated to boroughs. Counties, in turn, were put in charge of managing County Family Support Centres as well as Nursing and Therapeutic Establishments. Both boroughs and counties may be charged with setting up and managing Public Care Homes (PCHs) (for the full list see Augustyn et al. 2010, p. 61).

In 2016 there were 226 Elderly Day Care Centres in Poland, providing services to 19,278 people (Szatur-Jaworska, 2016, p. 90). Long-term care infrastructure is not evenly spread across the territory of the country. In 2013, 80 out of 314 counties in Poland had no PCH (Grabusińska 2013). At the end of 2015, there were 227 PCHs for older adults in Poland, with 5080 residents (Ministry of Family, Labour and Social Policy 2016, p. 40). Where there

is no local PCH, individuals who qualify for such care are guaranteed a place in a PCH located in a nearby county.

In spite of this decentralisation, the governance of elder care in Poland accords with the model of 'legal governance', which favours implementation through regulations and aims at compliance with laws as an end goal, rather than at the development, increased efficiency or self-organization aimed at by other modes of governance (Howlett 2011). In this model, power is exercised in a top-down manner (Zybała 2013). Consequently, local governments act under different social and demographic conditions, but within a uniform legal framework. For this reason, it is important to understand how different local care regimes implement the state care regime.

In the Polish care regime there is little outsourcing of care beyond the family (Bettio and Verashchagina 2010). Only 0.9% of people aged 65 and over and 1.6% of those aged 80 and over (OECD 2019) live in care homes. Publicly provided care services are marginal (Perek-Białas and Racław 2014): among people aged 65 and over with care needs, 93.5% received care from family members, 9.3% from informal non-kin networks (e.g. friends and neighbours), 4% from social welfare carers, and 4% from other people, including paid carers (Błędowski 2012). This care regime minimizes public spending—only 0.5% of Polish GDP was spent on institutional and in-home care combined in 2016, compared to an EU average of 1.6% (Kerschbaumer et al. 2019). Between 2010 and 2013 the level of public spending in Poland was estimated at around 0.8% of GDP (European Commission 2015). There has therefore been a net drop in spending despite a growing pool of aging adults (Fihel and Okólski 2019). However, neoliberalisation in this area has not only taken the form of austerity measures. It has also seen changes to the mechanisms through which care is financed.

In 2004, a neoliberal reform took place in the shape of changes to the way in which the main type of residential care institution in Poland, the Public Care Home, was funded. As a result of this change, it was no longer state-government subsidies but rather regional budgets that co-financed care in PCH, along with 70% of the care-receiver's monthly income. Strict income thresholds were put in place, meaning that funding would only be provided for people from very low-income backgrounds. Polish boroughs subsidise residential care for only 8% of people in PCHs: those who meet the measly income threshold of €116 per month per family member (CSO 2020). At the same time, our own research has shown the challenges the poorest people (including those without a pension) face in accessing PCHs (Radziwinowiczówna and Kordasiewicz 2018). Boroughs may be reluctant to place such individuals in a PCH, where they would have to subsidize 100% of the costs of their stay. The 2004 reform inevitably led

to a significant decline in intake into Public Care Homes. The number of residents decreased from 13,000 to 10,000, while the number of such institutions fell from 169 to 143 between 2003 and 2008 despite an ageing population (Augustyn et al. 2010, 98). There followed (on one hand) an increase in the burden placed on families and (on the other) an increase in the marketization of care, given that private care homes are often more affordable than their public counterparts.

Older people and their families are now expected to bear the costs of care themselves. Given that Poland has never seen the large-scale de-familialisation of elder care, the current state of affairs represents a neoliberalisation of familialism by default—i.e. a care regime in which family members are responsible for arranging help for dependent family members (Glass and Fodor 2007)—rather than the 're-familialisation' of care (Hantrais 2004), as observed in Scandinavia, France, the Netherlands and elsewhere (Zigante 2018).

The neoliberalisation of familialism by default also involves changes in public policy which, while not directly related to care, increase the burden of caregiving placed on women. We therefore conceptualise such changes in terms of the expansion of private maternalism. 2017 saw the restoration of a previously abandoned differential in the legal retirement ages of women and men. These now stand at 60 and 65, respectively, whereas for the preceding five years the retirement age had been set at 67 for both men and women. This recent change, introduced by the conservative Law and Justice government, has increased the pool of potential carers available to provide care for grandchildren, ageing spouses, older parents and in-laws. The retirement age for women was lowered significantly as conservative policy-makers sought to take advantage of the gendered pattern, prevalent across Central and Eastern Europe, which sees informal care work performed predominantly by women (cf. Souralová, this volume).

Ethnography of care

The findings presented in this paper come from a research project entitled 'Unfinished migration transition and ageing population in Poland: Asynchronous population changes and the transformation of formal and informal care institutions'[i] (Mig/Ageing). This four-year multidisciplinary research project studied the effects of accelerated population ageing and international migration in Poland.

Between 2014 and 2015 we conducted ethnographic research in two Polish towns. We selected Kluczbork in Opolskie Province and Końskie in Świętokrzyskie Province (see Map 1) as our research sites. As both towns serve as the administrative centres of their respective counties, our research provided insight into all of the major actors involved in care at a local

level. In Poland it is the county (*powiat*) that is responsible for stationary forms of care (e.g., selected PCHs), while the borough (*gmina*), or in this case the town-as-borough, oversees in-home care provision (e.g. care services provided by local SWC). The small size of the two towns selected (both have approximately 20,000 inhabitants) was designed to facilitate comprehensive analysis of the provision of elder care at a local level.

[Fig. 3.2 here]

We chose Kluczbork and Końskie from among the 191 Polish towns which had between 10,000 and 40,000 inhabitants. We made our choice on the basis of two demographic criteria: a high rate of population ageing and high levels of international migration. We identified towns where the rise in the Old Age Dependency Ratio (OADR) was among the highest in Poland between two census periods (OADR 2011/2002). Kluczbork recorded one of the fastest growing rates in terms of the percentage of older adults: from 18% (2002) to 26% (2014). In Końskie people over 60 make up 27.6% of the population. 3.6% of population is aged 80 or more. According to population statistics, the OADR was 28.9% in 2014, comparted to a Polish average of 21.4%. During the second step of the research site-selection process, we chose from the list of rapidly aging towns those which had experienced intensive international out migration (our Mig/Ageing project researched not only regional but also transnational care arrangements).

Although Kluczbork and Końskie are characterized by similar dynamics in terms of ageing, they differ markedly in other respects. Końskie is famous for its cast-iron industry, which underwent privatisation during the post-1989 economic transformation. This was a painful experience for Końskie: employees with longer professional experience were expected to apply for a pre-retirement allowance or to retire, while others were laid off on a mass scale. Some foundry workers retired early and left the job market while still in their forties. Kluczbork is wealthier than Końskie (Jaźwińska, Kiełkowska, Kloc-Nowak, Kordasiewicz, Radziwinowiczówna, 2016); this economic advantage is in part a result of the town's history, which includes a longer tradition of migration to Germany (Radziwinowiczówna et al. 2018).

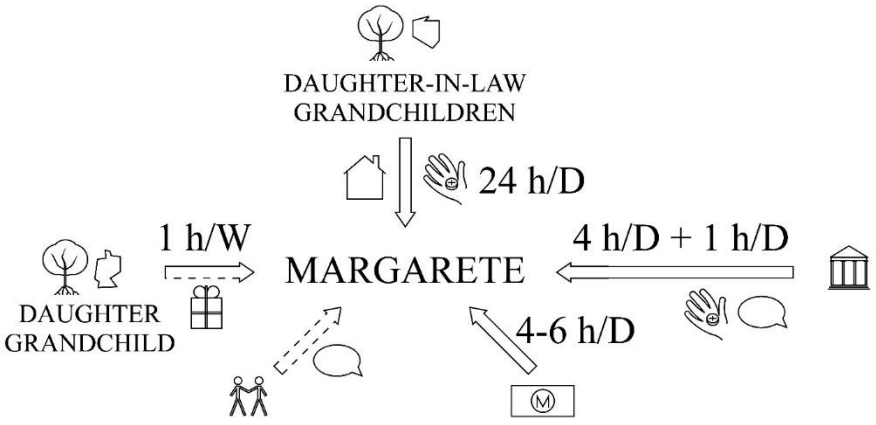
During three study visits to each town in 2014 and 2015[ii], we carried out ethnographies of organizations and institutions providing services for older adults. In each town we contacted 34 representatives of 11 institutions and subsequently carried out in-depth, semi-structured interviews, asking participants about the scope of activities of their organizations. Our ethnographies also consisted of non-participant observation within these institutions and participant observation across some of the activities they provided for older clients (e.g. bike trips and carnival parties). We also conversed with elderly service users (introductions were

facilitated by managers), recording such conversations in our fieldnotes. We conducted 76 interviews with individuals receiving elder care in Kluczbork and Końskie, both in domestic and institutional settings. All of the interviews were recorded, with prior consent having been obtained from interviewees. The recordings were transcribed and the transcripts coded using a code tree reflecting the *ethnomorality* of care scheme (Radziwinowiczówna et al. 2018), which included three basic branches: care beliefs, care intentions and care arrangements. Further along in our analysis, we used visual tools, such as code networks, to map care beliefs, intentions and arrangements at multiple scales and identify patterns and differences between the two studied localities. In writing-up we anonymised all research participants and changed some details to preclude their identification. For a comprehensive description of our research design see Chapter 3 in Radziwinowiczówna et al. 2018.

Local care regimes in the two towns

To illustrate how local care regimes translate into care arrangements—including care loops—we offer two empirical cases of the care arrangements that have been made for two frail and highly dependent older women. Elsewhere we have characterised these two case studies in terms of 'dense networks of care': that is, a care arrangement that involves various and multiple actors providing round-the-clock or nearly-round-the-clock care (Radziwinowiczówna et al. 2018). As we explain, in the absence of adequate publicly provided solutions, frail individuals and their families engage other actors in their care loops. Given that the implementation of the Polish care regime differs in Kluczbork and Końskie, the resulting care arrangements also differ.

Case study A: Margarete in Kluczbork



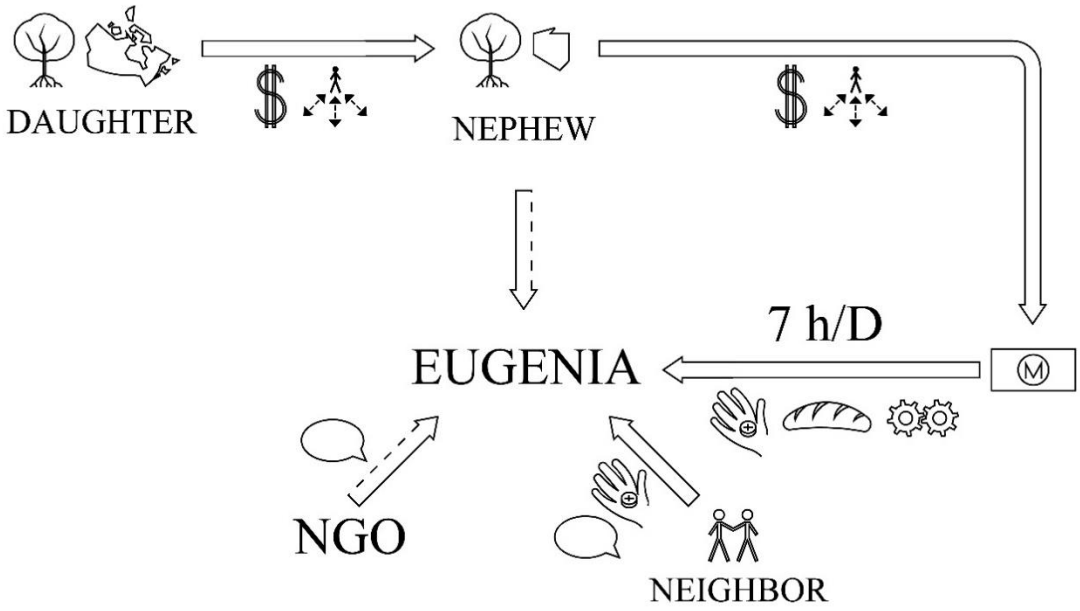
Margarete is an 82-year-old widow living in a village in the borough of Kluczbork. She is severely disabled but has chosen to remain at home, where she and her family believe she will get better support. One of Margarete's daughters lives in Germany. Margarete lives with her deceased son's nuclear family, which comprises her daughter-in-law and grandchildren. After experiencing serious health problems, Margarete underwent intensive physical therapy in hospital for several weeks. She is now back at home, where she is largely bed based. Her dense network of care allows round-the-clock care in her own home. On weekdays, she receives four hours of statutory in-home care daily. This is the maximum number of hours per day provided by the SWC. Since this is not enough to furnish the care she requires, Margarete's family pays for four to six hours a day of additional private care. Both care workers are women. A social welfare carer is responsible for daily hygiene (bathing) and dressing, as well as cleaning the bathroom and Margarete's bedroom, while a privately paid care worker is responsible for lighting the old-fashioned kitchen stove, cooking for Margarete and the rest of the family, daily hygiene and keeping Margarete company. During afternoons and at weekends, Margarete is looked after by her daughter-in-law and granddaughters. She also receives one hour of physiotherapy daily (from the SWC) and visits from a community nurse. Margarete's care loop therefore involves the mobility of numerous individuals who travel between Kluczbork and her village. In terms of care at a distance and additional emotional care, Margarete receives phone calls from her granddaughters, who are based in Germany, and is visited twice a year by her migrant daughter. Her neighbour pops in occasionally to keeps her company. Margarete's nephew looks after her farm animals and helps with grocery shopping.

This dense network of care is based on local and transnational care loops that involve both family and non-family actors. It is made possible thanks to public support and private resources available to the family. Its shape is conditioned by the local care regime. The modest number of in-home care hours provided by the SWC has compelled the family to hire a private care worker in order to keep Margarete at home. Before taking up her current care job, the same privately hired care worker worked by SWC as a flexible 'carer-neighbour'. Such roles are casual and temporary, with no prospect of a permanent contract. The carer subsequently took up a more stable, privately arranged post supporting Margarete, although according to her this pays worse than the SWC arrangement.

Hiring neighbours as SWC carers has been an important step towards meeting care needs in rural areas of the borough of Kluczbork, a place where care loopholes are most likely to emerge than in many other areas. The villages around Kluczbork have a long history of migration to Germany and this drives the need for care for the ageing parents of migrants. It

has been local custom for migrant children to engage a female neighbour to look after parents. The SWC copied this solution, creating an 'on-call' job with a casual contract—tantamount to a care 'gig'—which does not pay well enough to sustain the person doing it. Though 'flexible' and well-targeted at the needs of elderly people in rural areas, such solutions to local care deficits threaten to rendering care work more precarious and low-paid than ever. This dimension of the neoliberalisation of public services shifts the local care regime in the direction of private maternalism and the precarisation of care work, building upon both local-community ties and the exploitability of women in rural areas.

Case study B: Eugenia in Końskie



Eugenia (aged 75), who suffers from advanced Alzheimer's disease, lives by herself in a house in Końskie. She has a dense network of care, consisting of neighbours, relatives and a privately paid carer. Despite her Alzheimer's disease, Eugenia refuses to move to a care home. In order for such a move to take place, her children would need to have her declared lacking in capacity. Eugenia has two children— both are international migrants who do not return to Poland. Her daughter has lived in Canada for at least ten years now and has not visited Poland since she migrated. The family lost contact with Eugenia's son after his departure abroad. Eugenia's nephew was 'nominated' to look after Eugenia by her daughter, who sends him money for this purpose. The nephew stokes the heating stove in Eugenia's house and looks after her pet, but has delegated personal care to professional care workers.

Previously, Eugenia was supported by two social welfare carers from the SWC, but the quality of this care was very low. The nephew consequently recruited Lucyna, Eugenia's current, private care worker. (Lucyna, a 67-year-old pensioner and Końskie native, used to work as a carer for disabled people in Warsaw, but returned to Końskie to care for her own mother). Lucyna works longer hours than the SWC carers. She visits Eugenia first thing in the morning, returning both during the day and at night to prepare her for sleep. Lucyna moves repeatedly between her own house and Eugenia's home in the course of a given day. Badly paid by Eugenia's family (about 1.6 EUR per hour), Lucyna, a religious Catholic, continues caring for Eugenia out of compassion and mercy. Eugenia's neighbour, who did not have any social ties to the family before Eugenia developed advanced Alzheimer's disease, also supports the elderly lady. In doing so she is guided by religious values. In this dense care network there is also a community nurse, who carries out medical tests once a month, and a GP, who prescribes medicines and diapers. Additionally, Eugenia receives material support (clothing, shoes, food) from the Catholic Charismatic Renewal Community, of which Lucyna and the neighbour are active members. The actors involved in this dense network of care understand that Eugenia requires 24-hour institutional care as a result of her advanced dementia, and that ageing at home presents a risk to her life. She has on occasion been discovered sleeping underdressed, hypothermic and covered in faeces.

Despite the efforts of her carers, Eugenia has a patchy and inadequate care network. Her migrant child provides insufficient financial support and there is a history of inadequate statutory in-home care provision. Currently, Eugenia's care arrangement involves very little statutory input. Her situation can be characterised in terms of a care loophole. The care that Eugenia needs to keep her alive has resulted in a non-formalised arrangement bordering on exploitation for Lucyna. This is one outcome of a private maternalism that paints women as carers-by-default, especially if they already have a history of caring for others. The case of Margarete, on the other hand, illustrates an effective care arrangement. It is emblematic for Kluczbork, a more affluent town with more care providers and better public services, relatively speaking.

Local care regimes compared

Despite their differences, it is possible to say that in both towns publicly-provided elder care reaches few people. In the county of Kluczbork (data for the borough is not available) as few as 2.9% pensioners were cared for by social welfare carers in 2015. In the county of Końskie the figure was 3.8 % (Bank of Local Data 2016). These very low figures are likely shaped by

especially low levels of publicly provided elder care in rural parts of both counties (Krzyszkowski 2011), where care loopholes often emerge as a result of limited access to social services.

In the two towns the most important care entities include: a SWC; a Public Care Home catering for people with physical disabilities (in Kluczbork only); a Nursing and Therapeutic Establishment (in Końskie only—Kluczbork's nearest Nursing and Therapeutic Establishment is 14 kilometres away); and hospices. Neither Końskie nor Kluczbork has a private care home, with the nearest being located approximately 15 kilometres from each town. The costs of care in a private care home are borne by the care receiver and their family: in Poland the state does not make a contribution to the costs of care in private care homes. However, monthly fees for private care homes may be lower than the 100% PCH fee charged to individuals not eligible for the borough support. Both towns also have organizations whose function combines social-needs support and care. These include branches of Caritas, the Section for Pensioners and Disabled Persons within the Teachers' Union and other non-governmental organizations (NGOs).

In both towns in-home care services are provided by the Care Services Department of the local SWC. Social welfare carers offer personal and emotional care to their clients; their role also includes cooking, cleaning, shopping and bill payment (where necessary and possible within the time allocated to a given household). The amount of time a social welfare carer spends in the home of a person requiring care varies depending both upon on the client's degree of independence and their ability to pay. At the time of research fees varied from 0 Złoty to 14.70 Złoty (€3.30EUR) per hour. Hiring a privately paid carer like Lucyna may be more affordable for individuals with higher pensions, especially given that such employment is rarely formalized.

In 2014, 16 carers cared for 96 people in Kluczbork, while in Końskie 25 carers cared for 70 clients. In Kluczbork, the declared demand for the services of district carers was bigger than in Końskie and exceeded the financial resources of the SWC. In 2015, Kluczbork SWC was able to increase its number of clients from 96 to 115. This change happened at the cost of carers' working conditions and care time. Social welfare carers often believe their clients do not receive enough care. One carer told us that where previously she took care of 3 or 4 people a day, that number had now gone up to 7. This meant that she could only spend a maximum of 50 minutes with each client. Only ten minutes was allocated for social welfare carers' travel between clients. In Kluczbork social welfare carers frequently travel by SWC bicycle as no

public transportation is available. Social welfare carers, who are exclusively low-income women, often do not have a driver's license or own a car. Travel between their clients' homes takes time and can be particularly challenging in bad weather. The care loops traversed by social welfare carers in Kluczbork involve a lot of movement around town, as well as to and to and from villages in the borough. In Końskie, by contrast, carers spent more hours with each client and did not have to travel between more than three households per day.

In both towns carers employed in the local SWC provide care between 7:30am and 3:30pm on weekdays only. A few carers from the local SWC in Kluczbork earn extra income by doing overtime, including weekend work in the houses of their SWC clients. This patchwork of care allows individuals reliant on social welfare carers to be helped in the morning and before going to sleep. In Końskie, however managers have prohibited such work after carers were accused of stealing clients' property.

SWC carers can be an important source of support, However, and as illustrated by the cases of Eugenia and Margarete, this depends significantly on the health condition of the care receiver and the availability of other actors. In Margarete's case, the social welfare carer's contribution to a dense care network helped consolidate an effective care arrangement. But as Eugenia's case demonstrates, SWC carers alone are not a sufficient source of support for individuals with more significant care needs. Private not-for profit (friends, neighbours) carers and NGOs play an important role in both dense networks of care, mobilising to counteract care loopholes.

The role of NGOs in filling local care loopholes

One consequence of the neoliberalisation of local care regimes has been that a number of NGOs have stepped in to support individuals who find themselves with no or inadequate support. Local authorities are often unaware of the caregiving potential of those groups, which serves to counteract the effects of neoliberalising reforms. Often religious in profile and founded on the Christian notion of charity (Caritas), they reach out to frail people who cannot count on family support and/or cannot afford to pay for private care. In both towns, most institutions for older people focus either on care or social needs. By contrast, 'hybrid' organizations (such as the two NGOs described) combine social-needs provision and care in an organic fashion. In both towns, there are local branches of Caritas as well as local branches of the Section of Pensioners and Disabled Persons of the Teachers' Union. In Końskie the Catholic Charismatic Renewal Community (which forms part of Eugenia's dense care network) and the Rosary

Prayer Group play a similar role. In Kluczbork, the secular Voluntary Service 50+ Association fulfils a like function.

Local branches of Caritas provide care to disabled people by taking on tasks that might otherwise be performed by social welfare carers. A branch of Caritas in one parish in Końskie dedicates part of its function to assistance for older adults living by themselves. The help provided includes both material support and nursing care. Where care loopholes appear, Caritas steps in. In Kluczbork, the services offered by Caritas to the physically disabled reach 80 people. The care offered by Caritas is more professional in character than that offered by other NGOs and involves the delegation of public services by local authorities and the National Healthcare Fund. The Kluczbork branch of Caritas runs a centre offering nursing care, a physiotherapy unit, a canteen, and occupational therapy workshops.

In an effort to address the problem of care loopholes in Końskie, other Catholic organizations have become involved in providing care for the physically disabled. These include the Rosary Prayer Groups and the local Catholic Charismatic Renewal Community. The latter organisation, of which the two women who care for Eugenia are members, brings together people aged 20 to 70. It also offers informal financial support to members experiencing hardship.

Another hybrid institution in Końskie is the Section of Pensioners and Disabled Persons of the Teachers' Union, A few of this group's female members are active as 'outreach' officers: this means they volunteer to take care of around 15 frail union members, all of whom are retired teachers. The relationship between 'outreach' officers and care-receivers hinges on professional solidarity and the shared experience of working as school teachers and carrying out union activism. The hybrid character of the Section evidences the care-giving potential of organizations based not on family ties, but on professional bonds: the union serves as a kind of modern guild, not only representing group interests but also facilitating a network of mutual support.

The Voluntary Service 50+ Association (VS50+) was established in 2014 in Kluczbork as a joint initiative of the deputy mayor and the director of a local hospice. The purpose behind its creation was to formalize the volunteer work that was already being undertaken by people over 50. In April 2015 VS50+ had 17 active volunteers, offering support to between 10 and 20 people. Most support recipients were aged 80-90, lived by themselves and had physical disabilities. Volunteers visited them both in their homes and in public care facilities. VS50+ volunteer caregivers benefitted from specialist training and liability insurance. In Końskie,

local authorities have not tapped into the local care potential of older people through the creation of a formalized volunteer scheme.

Such hybrid institutions in Końskie and Kluczbork rely on an unspoken (and unwritten) agreement between care givers and care receivers. The work of older volunteers is based on the principle of delayed reciprocity: a volunteer makes a 'gift of time' to someone who may not be able to return the favour. This non-instant and indirect form of exchange functions through the expectation of a 'counter-gift', to be given in the future by another person (i.e. when today's volunteers come to need support themselves). However, organizations combining care and social-needs support would be more effective if they were intergenerational, as they would then generate not only caregiving potential but also solidarity that might lead to longer term and more sustainable solutions.

Conclusions

The care loopholes that emerge in Końskie and rural areas of Kluczbork are a consequence of a systemic lack of state-level solutions. The neoliberalisation of the family-by-default care regime has led in many instances to unsustainable care arrangements at a local level. In practice, both families and local public institutions frequently resist accepting the care obligations that are thrust upon them. Economically excluded individuals may experience systemic inequalities in access to local care actors, including those managed by local state agencies, which remain constrained by their annual budget.

In both towns care actors reach out to a limited number of older adults. This hypothesis is based on a simple simulation for Kluczbork. In another research project, conducted in 2014 in one Polish province, 8% of people aged 50-79 declared themselves to be in need of help in their everyday life from family and friends. 6% also felt they needed support from neighbours and strangers (Kalski and Damboń-Kandziara 2014, p. 34). Extrapolating this distribution onto the population of Kluczbork, we find that there might be as many as 1000 people in need of support in their daily life, and additionally a large proportion of people aged 80 or over. Yet in 2015, local SWC carers provided care services to 115 people, while the local PCH accommodated only 15 people from the town.

Instead of reaching out to more people, public care institutions are cutting the number of hours available to clients and delegating the costs of whatever care is available to older people and their families. This has facilitated the growing role of private care homes, which are funded exclusively by individuals and their families. Public care institutions are also rendering the labour conditions of social welfare carers more precarious, making it harder for

care loops to be completed. In the context of a rapidly ageing Poland, the neoliberalisation of the family-by-default model of elder care has inevitably led to a growing number of people being left with no sustainable care arrangements.

Alternative solutions, both commercial or non-profit in nature, arise to fill care loopholes. Marketised solutions are often unaffordable for older adults who cannot count on family members to pay for care. NGOs rely partly on the services of volunteers; alternatively, they may fulfil public functions where they are contracted to do. But they alone cannot meet the care needs of the severely disabled. Local NGOs offering seniors both social-needs support and care could become a model for the development of other organizations to address the needs of an aging population; their work often goes unrecognised by local authorities,

However, the development of innovative hybrid institutions is no substitute for well-funded and inclusive public elder care. More money needs to be invested in cost-intensive provision and responsibility for this cannot be placed on the shoulders of the families of care receivers. It may be possible to achieve a higher standard of elder care for the mass of the population, but this will require a significant increase in financing at a local level. The introduction of a universal right to long-term care would oblige the sector to provide elder care to all who need it.

Other researchers have highlighted how diversity can arise within a single national care regime as a result of differences in the prevailing logics of neoliberalism in elder care as compared to childcare (see Hrženjak 2019, writing about Slovenia). We have shown how internal diversity can also exist in the context of a single national elder care regime. The way in which national care policies are implemented and adapted at a local level, and their supplementation by local innovations in care practice (whether well conceived or not), defines the diverse quality of elder care within a given national care regime.

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Endnotes

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