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PROVISION OF SOCIAL SERVICES ON THE PLATFORM OF INTER-MUNICIPAL COOPERATION IN THE CZECH REPUBLIC: CASE STUDY²

Abstract

The main objective of this paper is to evaluate the potential of inter-municipal cooperation for the provision of social services. It seeks to answer whether inter-municipal cooperation is an appropriate form of social service provision and whether the concept of integrated care is an appropriate framework for social service provision. A qualitative research strategy is employed. It is dominated by a case study, which in part underpins the findings and opinions presented in this paper. The object of the case study research is an organization providing social services and health services in the Czech Republic in their interconnection and continuity. The analyses and findings of this paper follow the case study. In the Czech Republic, 19.1% of the total number of registered social services are provided directly by municipal contributory organizations established by them. The share of resources decided by municipalities in their independent competence from those not under direct decision-making by central authorities is 31.7%. The legal conditions for inter-municipal cooperation in the Czech Republic allow for the delegation of elements of municipal autonomy to municipal associations. The results presented in this paper show that inter-municipal cooperation is a possible and appropriate form of social service provision and that linking social services provided on the platform of inter-municipal cooperation and the concept of integrated care, specifically in the model of Integrated Community Care, is mutually beneficial and productive.

Key words: Social services, inter-municipal cooperation, voluntary association of municipalities, case study, integrated care

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1 INTRODUCTION

This paper aims to evaluate the potential of inter-municipal cooperation for the provision of social services. It seeks to answer whether inter-municipal cooperation is an appropriate form of social service provision and whether the concept of integrated care is a suitable framework for social service provision. It uses material and findings from the case study, findings and analysis outside the case study, and related expert opinions to meet the objective and answer the questions.

The object of the research carried out by the case study, on which this paper is partly based, is a voluntary association of municipalities providing social services together with health services in their interconnection and continuity in the Czech Republic. This allows the paper to focus not only on inter-municipal cooperation in the provision of social services but also on the possibilities that inter-municipal cooperation implies concerning the concept of integrated care linking health and social care.

In the first part of the paper, the position of municipalities and regions within the system of social services provision in the Czech Republic is depicted and the position of inter-municipal cooperation in it is identified. In the second part, the possibilities of inter-municipal cooperation as a form of the provision of social services in the Czech Republic are described. The third part is devoted to the case study, which in its part is the basis for the findings and opinions presented in this paper. The last part assesses the potential of interconnecting social services provided on the platform of inter-municipal cooperation and the concept of integrated care.

This paper complements and extends the case study conducted within the activities of the Centre for the Study of Longevity and Long-Term Care at the Faculty of Humanities, Charles University in Prague with the kind permission of its authors.

1 THE POSITION OF MUNICIPALITIES AND REGIONS WITHIN THE SYSTEM OF SOCIAL SERVICES PROVISION IN THE CZECH REPUBLIC

Cooperation between municipalities in the provision of social services should first be placed in the context of the position of municipalities and regions themselves within the system of social service provision in the Czech Republic. Although the topic of this paper is cooperation between municipalities in the provision of social services, without capturing the position of regions in the system of social service provision, the view needed for the subsequent work would be incomplete.

It should be noted that this paper looks at municipalities and regions within the system of social service provision in the Czech Republic only from the position of their self-governing activities, i.e. their independent competence. The exercise of state administration, which takes place in the field of social services at the level of municipalities and regions, mainly through municipal authorities of municipalities with extended competence and regional authorities, is not included here.

1.1 Legislative regulation of the position of municipalities and regions within the system of social services provision in the Czech Republic

The position of municipalities and regions within the system of social services provision in the Czech Republic is regulated mainly by four basic legal norms. In the first place, we should mention Act No. 108/2006 Coll. "On Social Services" (Act No. 108/2006 Coll.), which regulates the entire area of social services as a special law. The general conditions for municipalities in the field of social care can be found in Act No. 128/2000 Coll. "Act on Municipalities (Municipal Establishment)" (Act No. 128/2000 Coll.). In the analogous Act No. 129/2000 Coll., "Act on Regions (Regional Establishment)" (Act No. 129/2000 Coll.), which applies to regions, there is no explicit mention of social care or even social services, but these are included in the general definitions of the regions' areas of competence.

The following overview compares the position of municipalities and regions in Act No. 108/2006 Coll. "On Social Services" (Act No. 108/2006 Coll.) through its provisions. Specifically, it concerns § 94 relating to municipalities and § 95 relating to regions.

The first three functions are identical for municipalities and regions. Municipalities and counties: Identify the needs for the provision of social services to people or groups of people in their territory. Ensure the availability of information on the possibilities and methods of providing social services in their territory. Co-operate with other municipalities, regions, and social service providers in assisting people or in facilitating contact between the provider and the person.

Other functions relate to the medium-term development plan for social services. The Region prepares this in cooperation with municipalities in the territory of the Region, representatives of social service providers, and representatives of persons receiving social services, and informs municipalities in the territory of the Region about the results of the planning process. The municipality may then prepare a medium-term plan for the development of social services. It does so in cooperation with the Region, social service providers in the territory of the municipality, and with the participation of people receiving

social services.

Other provisions of § 94 and § 95 of the Act define the roles of municipalities and regions in the preparation and implementation of the medium-term plan for the development of social services in the region, in determining the network of social services in the territory of the region and monitoring and evaluating the implementation of the plans for the development of social services. It provides for cooperation of actors, information communication, and participation of stakeholders.

This comparison shows the important role of cooperation between actors in the provision of social services, which is also reflected in the statutory conditions. Cooperation between municipalities has an important position here. Its formalization, structural, functional, and procedural anchoring in Act No. 108/2006 Coll. "On Social Services" (Act No. 108/2006 Coll.) is not given, but it would be appropriate for the fulfillment of its provisions.

1.2 Municipalities and regions in the structure of the social services delivery system and their financing

Two perspectives are used to capture the position of municipalities and regions in the structure of the social services delivery system and their financing. The first one divides registered social services according to the legal form of their provider and the second one tracks the shares of individual funding sources in the total costs of social services. Table 1 shows the number of registered social services by the legal form of their provider in 2019, the last year such a summary was published (MPSV, 2019).

Table 1. Several registered social services by legal form of organization

The legal form of organization	Number of registered social services
Churches and religious societies	1 052
General benefit Societies	1 041
Associations	802
Contributory organization of region	774
The contributory organization of a municipality	762
Institute	462
Municipality	320
A limited liability company	229
Branch associations	80
Joint stock company	76
Other legal forms	77
TOTAL	5 675

Source: MPSV, 2019.

5.6% of registered social services are provided directly by municipalities. If we add those provided by municipally established contributory organizations, this is 19.1% of the total number of registered social services. If we continue and add to them the contributory organizations established by the regions, we get a share of 32.7% of the total number of registered social services. This is roughly one-third of all social services where we can find the direct influence of the independent competence of municipalities and regions.

The voluntary association of municipalities, which is the object of research of the case study presented here, falls into the category of "Other legal forms in total (with less than 50 services per legal form)" having a share of 1.3% of the total number.

A second view of the position of municipalities and regions of their share in the financing of the total cost of social services. The shares of each funding source in the total cost of social services are shown in Table 2.

Table 2. Financing of social services by source

Form of subsidy	Share of total subsidies (%)
MPSV subsidies for social services	33,7
Contribution to care	19,4
User payments	18,9
Regional contributions and subsidies	9,6
Contributions and subsidies from municipalities	7,3
Health insurance	5,0
European subsidies	2,5
TOTAL	100

Source: MPSV, 2019.

Municipalities and regions contribute 16.9 % of the financing of social services through their contributions and subsidies. Even this share can be said to be directly influenced by the autonomous competence of municipalities and regions.

From the shares shown in Table 2, we can also abstract the weight that decision-making at the level of municipalities with autonomous competence has on resources that are not under the direct decision-making of central authorities. This amounts to 31.7%.

Thus, the scope for inter-municipal cooperation in terms of financing social services is up to 7.3% of the total sources of financing social services and 35.6% of the sources that are not under the direct decision-making of central authorities.

2 INTERMUNICIPAL COOPERATION IN THE CZECH REPUBLIC

Inter-municipal cooperation is enshrined in the Czech legislation in Act No. 128/2000 Coll., "Act on Municipalities (Municipal Establishment)". In the original version in force since 2001 (Act No. 128/2000 Coll. [original wording], 2000), it was stipulated that cooperation between municipalities takes place based on a contract concluded for the performance of a specific task, based on a contract on the creation of a voluntary association of municipalities or by the establishment of legal entities under a special law by two or more municipalities. In the current wording in force since the beginning of 2025 (Act No. 128/2000 Coll. [current wording], 2024), the declaration that municipalities may cooperate in the exercise of their autonomous competencies has remained, and the specific forms of cooperation, only voluntary associations of municipalities. The possibility of forming a community of municipalities, which is a union of municipalities fulfilling the conditions set out for a community of municipalities by law, has been newly added. The association of municipalities is currently the only possible form of inter-municipal cooperation. The voluntary association of municipalities, which is the object of the case study presented here, is a union of municipalities, not a community of municipalities.

For the association of municipalities and the community of municipalities, the mentioned law (Act No. 128/2000 Coll. [current wording], 2024) specifies the conditions for their existence and activity. These conditions, however, do not prevent the transfer of processes, procedures, structures, and techniques of municipal autonomy by analogy to a union of municipalities. This is the direction in which the union of municipalities, which is the object of research of the case study presented here, is conceived and operates.

3 CASE STUDY

This paper complements and extends the case study conducted within the activities of the Centre for Longevity and Long-Term Care Studies at the Faculty of Humanities, Charles University in Prague. Two first steps are used from its workflow and then its separate analyses and findings are conducted. These, together with the above, form the basis for answering the questions in this paper and for its conclusions.

3.1 Background and purpose of the case study

The current form of provision of health care and social care shows deficiencies that lead to inadequacy of this care and to unsatisfactory meeting

of the needs of patients or clients, which are complex. There are many reasons for this, the most obvious of which are the fragmentation of health systems, the narrow specialization of health care disciplines, poor communication between specialisms and disease-to-disease rather than patient-to-client orientation, and the minimal or insufficient inclusion of aspects of patients' lives that are not directly related to the provision of health services. In many ways, this is analogous to social services.

The direct stimuli for the elaboration of the underlying case study were in particular: the phenomena of demographic aging and the transition to a society with an aging population, the development and changes in health services and social services as such, developments and changes in the provision of health and social services. The purposes of the case study are to identify appropriate tools to facilitate the provision of interconnected health and social services in long-term care at the local and community levels, to explore the phenomenon of integrated care in the provision of health and social services in long-term care, at the local and community level.

3.2 Methodology of the case study

The case study on which this paper is based uses qualitative research strategies and mostly unobtrusive methods. The case study method occupies a dominant position. Frequently used methods are content analysis of documents, interviews, observations, and expert opinions. The objects of the case study research are two organizations providing health services and social services in their interconnection and continuity in the Czech Republic for more than two decades. One of them operates in a metropolitan agglomeration, the other in a rural region. The period of detailed research is ranging from 2012 to 2023.

The case study can be characterized in terms of case study typologies as follows. According to the typology presented by Hendl (2005), two situations apply to the underlying case study: the multiple case study and the case study of organizations and institutions. In terms of the typology, which can be found in Chrastina (2019), the subject case study is a historical case study of organizations. Of the four types of case studies proposed by Yin (2018), the underlying case study is a multi-case holistic study within which the subjects under investigation will be treated as separate cases. Taking time as the dominant perspective, the subject case study is a diachronic case study or a longitudinal case study according to the typology of Thomas (2011), with it also bearing retrospective features.

If we use the concentrated typology summarizing several other typologies according to the function of the case study in research, as presented by Mareš (2015), then the case study in question bears dominantly the characteristics of an explanatory case study and a descriptive case study. Its layout will also

correspond to that of an instrumental case study, with the form of the phenomenon of integrated health and social care being investigated.

3.3 Case study workflow and follow-up steps

From the case study workflow, the first two steps were used for this paper: choosing the right tool and finding organizations to assess the suitability of the chosen tool. From the organizations selected as suitable for the case study facility, the voluntary association of municipalities was selected to represent inter-municipal cooperation for further work in this paper. The above steps from the case study workflow have been supplemented with an additional step specifically related to this paper only assessing the potential of linking social services provided on the platform of inter-municipal cooperation and the concept of integrated care.

3.3.1 Choosing the appropriate tool

To fulfill the purpose and objectives of the case study, the concept of integrated care was chosen as a suitable tool after researching possible alternatives, and the model of Integrated Community Care (Thiam et al., 2021) was chosen from its modifications and models.

The use of the concept of integrated care takes many different forms, sometimes seemingly contradictory. It is usually a set of services that are provided and coordinated between different health care providers, social care providers, or health and social care providers. These services are provided as a continuum of care and are coordinated around their central object. This object can be a single site, a single disease, a group of diseases, a group of patients, an individual patient, as well as funding arrangements or measurement and recording requirements.

Integrated care cannot be narrowly defined but should be understood as an umbrella term for a set of ideas and principles made up of many components that seek to better coordinate care according to people's needs (Goodwin, 2016).

Various taxonomies and classifications have been developed to understand the phenomenon of integrated care. They are usually examined (Armitage et al., 2009):

- type of integration (i.e., organizational, professional, cultural, technological);
- the level at which integration occurs (i.e. macro, meso, and micro);
- the process of integration (i.e. how integrated care delivery is

organized and managed);

- the scope of integration (i.e. to the whole population or a specific client group);
- the degree or intensity of integration (i.e., along a continuum that ranges from informal linkages to more managed care coordination to fully integrated teams or organizations).

Integrated care takes many forms, the most common of which are (Leutz, 1999):

- Horizontal integration. This is integrated care between health services, social services, and other care providers standing at the same hierarchical level.
- Vertical integration. This is integration across services, e.g. primary, community, hospital, and tertiary care, i.e. across hierarchical levels.
- Sectoral integration. Integrated care is implemented within a single sector.
- The whole system is integration. Integrated care focuses on the whole population and the central category is public health and the multifaceted needs of the whole population.

There are two basic general characteristics of integrated care as a concept. First, it must bring together key aspects of the design and delivery of fragmented care systems. I.e., integrate so that the parts come together to form a whole. Second, the concept must relate to the delivery of care. In this context, this means providing targeted help or treatment to those in need. Thus, integrated care is the result of integration optimizing the care in question (Goodwin, 2016). The different approaches to defining integrated care can be illustrated by at least two examples from the position of renowned international organizations, the WHO and the OECD.

The World Health Organization (WHO) defines integrated care as the management and delivery of health services so that people receive a continuum of health promotion, health protection, and disease prevention services, as well as diagnosis, treatment, long-term care, rehabilitation, and palliative care services, according to their needs, through different levels and sites of care within the health system (WHO, 2013). This is a view that includes only the health services and health perspective. Other aspects of patients' lives are either directly overlooked by this approach or included in the social determinants of health.

A second definition may be that presented by the OECD (OECD, 2015). The OECD uses the term 'integrated services' as a combination of social services

for the benefit of the users of these services and to improve the efficiency of delivery by providers. This is a very broad concept, with the context of the use of the term suggesting that social services are understood as all services related to the categories of welfare and wellbeing. Such services include, for example, housing, education, employment services, anti-poverty interventions, health-related services (not just health care or health services), etc. Significant weight is given to cost-effectiveness, benefit maximization, and economic aspects in general.

For this case study, the concept of integrated care was too broad and general. Its focus and objectives relate to more subtle relationships within health and social service delivery systems defined specifically concerning patient or service client care activities. Therefore, the Integrated Community Care (ICC) model (Thiam et al., 2021) was selected from relevant alternatives to fully meet the conditions of providing interconnected health and social services within long-term care at the local and community levels. This choice is based, among others, on the logic that can be found in the extensively conceived title of the Handbook of Integrated Care (Amelung et al., 2017). Integrated care is shown here as a polymorphic concept that is used in different disciplines, from different professional perspectives, and is associated with different goals.

The choice is also in line with the understanding of integrated care in the European region presented by the European Social Network (Montero et al., 2016).

Six dimensions form the core of the Integrated Community Care (ICC) model (Thiam et al., 2021): temporality (perception of time, temporality), local area (attachment to locality), health care, social care, proximity (territorial and relational) and integration. Each of these dimensions then has its attributes. The philosophy of this model is that health and social services are provided in each locality both territorial and temporal in a complex of social ties and relationships, interacting within the social determinants of health. Care is delivered in a holistic and integrated manner and aims to improve the physical and mental health of individuals, families, groups, and communities, the community, as well as the welfare and social capital of the community and society.

3.3.2 Finding organizations to assess the suitability of the chosen tool

To assess the suitability of the Integrated Community Care model as a tool to meet the aims, objectives, and goals of the case study, two organizations were identified. There were not enough cases that were potentially suitable for research into the phenomenon of integrated health and social care involving the provision of follow-up and long-term care at the micro-region or community level in the Czech Republic to allow the use of any type of random sampling.

Therefore, sampling was undertaken to obtain a specific type of information to maximize the usefulness of the information from each case. Of the organizations selected for this paper, the voluntary association of municipalities was then worked with (see above). Its main characteristics are:

- voluntary association of municipalities;
- operating in a rural region in the Czech Republic;
- providing health services and social services in their continuity and interdependence;
- existing for more than two decades;
- providing care for the elderly;
- providing secondary health care (specialized care);
- providing inpatient health care, a health care facility with 135 beds;
- providing outpatient healthcare;
- providing 7 types of social services;
- providing 137 residential social services;
- having a multidisciplinary team;
- having functional links with other primary and tertiary healthcare providers;
- having functional links with other social care providers;
- detailed research period from 2012 to 2023.

This association of municipalities purposefully and analogously transfers the processes, procedures, structures, and techniques of independent municipal authority to the extent possible into its constituent documents and functions. It also enables the greatest possible participation of member municipalities and their citizens in its functions and activities.

4 EVALUATIONS OF THE POTENTIAL OF CONNECTING SOCIAL SERVICES PROVIDED ON THE INTER-MUNICIPAL COOPERATION PLATFORM AND THE CONCEPT OF INTEGRATED CARE

This section describes the position of social services in the concept of integrated care, specifically in the Integrated Community Care model, and assesses the potential that the connection of social services provided on the inter-municipal cooperation platform and the concept of integrated care brings. As already mentioned, the Integrated Community Care model (Thiam et al., 2021) contains six dimensions: temporality, local area, health care, social care, proximity, and integration. Based on the attributes of the individual dimensions, the closest connection to social services can be found in the social

care dimension. The health care dimension has the least strong connection with them, but not none. This dimension understands health care as a means of achieving and maintaining health in the widest range of aspects, not only as health services. Therefore, it includes, among others, the social determinants of health, which are already influenced by social services. The attributes of the proximity dimension, in particular territorial proximity and relational proximity, are already at the very foundation of social services. The same is true for the dimension of temporality, which includes the understanding of time and its influence in all its forms that can affect human life and its quality. This includes respecting the individual perception of time by individuals, overlapping objectively flowing time, permanence, sustainability, long-term, longevity, and other concepts of aspects of time related to people's lives. The dimension of the local area, at least in the form of operating in each place and with knowledge of local conditions, is present in every provision of social services. The last dimension – integration – is an inseparable part of social services integrating much knowledge, competencies, and tools with which the complex life situations of their clients are addressed.

On the data collected within the framework of the case study described above, a step was carried out independently of this ongoing case study, following on from the two previous steps, but specifically related only to this contribution. It was an assessment of the potential for connecting social services provided on the inter-municipal cooperation platform and the concept of integrated care. This took place in two parallel sub-steps. The potential that social services can bring to successfully fulfill the individual dimensions of the Integrated Community Care model (Thiam et al., 2021) was assessed, as well as the potential contained in fulfilling these dimensions in the form of inter-municipal cooperation. The potential is understood as the degree of compliance of the attributes of the Integrated Community Care model with the attributes of social services, or rather the attributes of inter-municipal cooperation. The activities of the researched entity in the monitored period of detailed research from 2012 to 2023 were analyzed and assigned to the attributes of the Integrated Community Care model (Thiam et al., 2021). Attributes that were reflected in the reality of the operation of the subject under study in the monitored period entered the next phase of evaluation. Thus, not only the relationships and connections of theoretical concepts were examined, but their reflection in the specific situation of the object examined by the case study. Expert opinions were used in the evaluation. To evaluate the potential of social services concerning the Integrated Community Care model, the premise was used: Social services are one of the tools for the implementation of social work. Social work was monitored in its following attributes:

- empowerment and participation;

- community work;
- support for social functioning;
- critical theory, specifically legitimacy and justice in society, visibility, and the thematization of power structures that create systems of oppression;
- complexity;
- flexibility.

These attributes were then confronted with the attributes of the dimensions of the Integrated Community Care model (Thiam et al., 2021) entering this phase of evaluation. To assess the potential of inter-municipal cooperation within the Integrated Community Care model, the premise was used: Elements of the independent competence of municipalities and the participation of member municipalities and their citizens are transferred to the union of municipalities. These formed the attributes of inter-municipal cooperation. These were then related to the attributes of the dimensions of the Integrated Community Care model. The results of these assessments of the potential of social services and forms of inter-municipal cooperation in the Integrated Community Care model are presented in Table 3.

Table 3. The Potential of Social Services and Forms of inter-municipal Cooperation in the Integrated Community Care Model

Dimension of Integrated Community Care Model (ICC)	Social services	Inter-municipal cooperation
Health care	0%	0-19%
Social care	80-99%	40-59%
Integration	60-79%	60-79%
Local area	80-99%	80-99%
Proximity	80-99%	40-59%
Temporality	60-79%	40-59%

Source: own elaboration.

CONCLUSION

This contribution aims to assess the potential of inter-municipal cooperation for the provision of social services. It seeks to determine whether inter-municipal cooperation is a suitable form of social service provision and whether the concept of integrated care is a suitable framework for the provision of social services. An assessment of the position of municipalities and regions within the system of social service provision in the Czech Republic was carried out. 5.6% of registered social services are provided directly by municipalities,

including contributory organizations established by municipalities, which is 19.1% of the total number of registered social services. Approximately one-third (32.7%) of the total number of registered social services are provided within the independent competence of municipalities and regions. Municipalities and regions, with their contributions and subsidies, contribute 16.9% to the financing of social services. The share of resources decided on at the level of municipalities in their independent competence, of those not directly decided by central authorities, is 31.7%. The scope for inter-municipal cooperation in terms of financing social services is up to 7.3% of the total sources of financing social services and up to 35.6% from sources that are not under the direct decision-making of central authorities. The possibilities of inter-municipal cooperation in the Czech Republic are currently limited to only one alternative, which is a voluntary union of municipalities with the possibility of its other type in the form of a community of municipalities. The legal conditions for their existence and activity provide scope for transferring the procedures, structures, and techniques of independent competence of municipalities analogously to the union of municipalities. The results presented in this paper show that inter-municipal cooperation is a possible and appropriate form of providing social services and the connection of social services provided on the platform of inter-municipal cooperation and the concept of integrated care, specifically in the model of Integrated Community Care, are mutually beneficial and productive

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