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p. p. 306, SI-1001 Ljubljana, Slovenija
Tel.: +386 (0)1 4706 485; Fax +386 (0)1 4257 802
E-naslov / E-mail: dd-th@zrc-sazu.si
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SEEKING CARE IN THE NEIGHBORING COUNTRY: AN INSTITUTIONAL ANALYSIS OF TRANSNATIONAL CARE FOR OLDER PEOPLE BETWEEN SLOVENIA AND CROATIA

Majda Hrženjak[I]

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ABSTRACT

Seeking Care in the Neighboring Country: An Institutional Analysis of Transnational Care for Older People Between Slovenia and Croatia

Using the concepts of care gap, transnationalization of care, and retirement migration—and based on interviews with stakeholders and an institutional analysis of care provision for older people in Slovenia and Croatia—the article examines retirement care migration between the two countries. It shows that the marketization of care in Croatia matches the care gap in public provision in Slovenia, which establishes "precarious hybrid transnational care." Older people use two strategies—citizenship rights and the market—to access cheaper residential care across the border, though of lower quality than in Slovenia. The study shows that transnational care can arise out of specific national institutional configurations of care.

KEYWORDS: care for older people, care gap, transnationalization of care, retirement migration, hybrid transnational care

IZVLEČEK

Iskanje oskrbe v sosednji državi: institucionalna analiza transnacionalne oskrbe starejših ljudi med Slovenijo in Hrvaško

Avtorica prispevka s pomočjo konceptov skrbstvene vrzeli, transnacionalizacije oskrbe in upokojenske migracije ter na podlagi intervjujev z deležniki in institucionalne analize oskrbe v Sloveniji in na Hrvaškem predstavi skrbstvene mobilnosti iz Slovenije na Hrvaško. Pokaže, da marketizacija oskrbe na Hrvaškem dopolnjuje skrbstveno vrzel v javnih storitvah v Sloveniji, s čimer prihaja do »prekarne hibridne transnacionalne oskrbe«. Starejši ljudje uporabljajo dve strategiji – pravice iz naslova državljanstva in trg – za dostopanje do cenejše institucionalne oskrbe onkraj meje, čeprav je ta slabše kakovosti kot v Sloveniji. Avtorica pokaže, da lahko transnacionalizacija oskrbe izhaja iz specifične institucionalne konfiguracije oskrbe na nacionalni ravni.

KLJUČNE BESEDE: oskrba starejših ljudi, skrbstvena vrzel, transnacionalizacija oskrbe, upokojenska migracija, hibridna transnacionalna oskrba

[I] PhD in sociology; Peace Institute, Ljubljana; majda.hrzenjak@mirovni-institut.si; ORCID https://orcid.org/0000-0003-1809-5450

INTRODUCTION

> "I was paying €1,080 a month all year round in a residential care in Brežice and €570 a month in Croatia," said a Brežice resident whose mother is in Bregana: "My mother has a farmer's pension of €200. You can write down the reason we send parents to Croatia." In the seven counties along the border with Slovenia, there are 169 residential care facilities, which can take up to 20 care receivers each and are classified by the Croatian state as out-of-institutional care, and hundreds of Slovenians are living in them. (Zore, 2018)

A series of articles has been appearing continuously since 2014 in the Slovenian media reporting on Slovenian citizens seeking old-age care in Croatia. Cross-border care can be seen from a wider perspective as a symptom of the care gap faced by countries in the Global North because of the aging populations and the neoliberal economization of care costs. The challenges of the care gap cross national borders. People experience them in many ways: as a high cost of care that exceeds the available income of older people, insufficient coverage of public services, and inequalities in access to services; care workers shortages; overburdened family members when care is delivered at home; the alignment of care with institutional rationales instead of focus on individuals' needs (Bettio & Verashchagina, 2010; Spasova et al., 2018).

The transnationalization of care as the outsourcing of the labor, time, and cost of care to poorer countries is becoming an important strategy that countries, families, and individuals use to face old-age care gaps. Concerning the lack of staff, one of the most common responses of the states has been to facilitate the migration of caregivers from low-income countries. Germany, for instance, is implementing the Triple Win program, i.e., the systematic recruitment of care workers from peripheral European countries by setting up nursing schools and providing elaborate integration programs (Mosuela, 2020). Through its public care homes, the Norwegian welfare state acts as a global employer, collaborating with a nursing college in Latvia and brokering recruitment agencies (Widding Isaksen, 2012). Slovenia also tries to compensate for the shortfall of care workers by recruiting care workers from "third countries" through the activation of migrant networks and bilateral employment agreements (Hrženjak & Breznik, 2023). Families increasingly rely on privately paid caregivers who often work irregularly within a circular migration pattern and provide 24/7 care in older people's households. In the European Union, these are mostly migrant care workers from Eastern European countries (Aulenbacher et al., 2024). A series of important concepts, such as "global care chain" (Hochschild, 2000), the "international division of reproductive labor" (Parreňas Salazar, 2001), the "global nursing care chain" (Yeates, 2009), and "circular care migration" (Triandafyllidou & Marchetti, 2013), have been developed at the intersections of migration, gender, and care research to articulate this transnational division of care, in which class and race play out within gender hierarchies.

The research on care labor migration has left the impression that traveling care workers are the mobile ones, while care receivers are perceived as sedentary, as "belonging," and as those who are recruiting "strangers" into their homes and services (Widding Isaksen & Näre, 2019). However, in contrast to the strategy of "moving care work in," another more recent cross-border care migration strategy refers to establishing residential care in other countries, catering to specific national groups of people in need of care. This is the strategy of "moving care work out," whereby older people and their care needs are shifted to other countries. These developments have been observed as older people from Germany, Switzerland, and Japan migrating to residential care established in Southeast Asia (mainly Thailand) and Eastern Europe (mainly Poland and Slovakia) (Toyota & Xiang, 2012; Horn et al., 2015; Schwiter et al., 2020; Großmann & Schweppe, 2020). This strategy reverses the directionality of care migration, in what Hochschild (2000) has termed the global care chain, by sending older people needing care to countries where care is less expensive (Schwiter et al., 2020). So far, the migration of older people who pursue affordable care has only been given scant research attention.

Both strategies of coping with the care gap call attention to the transnational dimension in understanding changes in care for older people. Here, transnationalization is understood in terms of people having professional and private ties to institutions and individuals in various countries simultaneously. In contrast to understanding migration as a unidirectional and permanent movement of people, the analysis from a transnational perspective highlights migration as an unfinished multidirectional process, circular back-and-forth movements, daily commuting, and maintaining cross-border ties and obligations (Amelina & Lutz, 2019, p. 35). While methodological nationalism (Anderson, 2019) cannot be entirely abandoned, a critical distance from it is necessary even when analyzing nation-state-bounded policies and institutions such as the welfare state. It enables the understanding of social structures, relations, identities, and practices that stretch across national terrains and redirects analytical focus to the diverse and complex ways in which socio-institutional formations and practices are materially connected across distant and proximate territories. Focusing on care from a transnationalization perspective reveals how social organization, institutions, relations, and welfare practices are being stretched and structured across national borders (Yeates, 2011, pp. 1116–1117).

The transnationalization of care for older people between Slovenia and Croatia is intense and takes place in both directions, especially in places along the Slovenian–Croatian border. As of 2018, Croatian citizens no longer need work permits and enjoy the labor rights of European Union citizens in the Slovenian labor market. Although Croatia faces a major staff shortage in care, many of the country's care workers commute daily to work in Slovenia (Bađun, 2024). Due to the proximity of the border, the linguistic affinity, and the higher salaries resulting from the economic differences between the two countries, they choose to work in Slovenia and reside in Croatia. The media also regularly report the emigration of older people from

Slovenia to Croatia for residential care due to lower prices and shorter waiting lists, especially in Croatian family residential care facilities, representing a specific deregulated, market-based, low-cost form of residential care for older people. Indeed, the phenomenon sits at the intersection of migration and mobility, as it involves both a change of residence driven by care needs and more fluid, temporary, cross-border movements characteristic of mobility. Dwelling in a residential care facility in Croatia is related to transnational life as it demands frequent cross-border traveling for family visits, sustaining social networks, and medical care (Hrženjak, 2019).

In this article, we analyze the nationally and internationally under-researched aspect of the transnationalization of care, i.e., the migration of older people from Slovenia to Croatia for more affordable care. The study focuses on the institutional configuration that drives older people's cross-border mobility and the marketization of care. We aim to contribute to a better understanding of how the co-effect of two neighboring national welfare states, which in past decades have been caught up in transitional neoliberal reorganization, results in the transnationalization of care for older people.

First, we outline how the migration of older people for care has been discussed in an international research framework on retirement migration. We then present the methods used to collect the empirical evidence and outline how older people migrate for care in Slovenia. The analysis is intended to provide an institutional analysis that enables an understanding of the structural factors driving the transnationalization of older people between Slovenia and Croatia. Therefore, in the following, we provide an institutional analysis of the Slovenian and Croatian care systems, focusing on identifying the push and pull factors and their interaction that drive this migration between these neighboring countries.

RETIREMENT MIGRATION

The migration of older people for care is mainly discussed in studies on international retirement migration (IRM) emerging since the 1990s at the intersection of demography, sociology, geography, anthropology, and gerontology (Williams et al., 1997; King et al., 1998). Although IRM is a relatively small-scale phenomenon, its conceptual relevance is significant as it relates to broader societal changes such as aging populations, globalization, hypermobility, and individualization. The presumed declining reliance on personal networks of family and enhanced opportunities for bridging physical distances have made IRM a viable option in the changing imagination of old age in late modernity (Savaş et al., 2023). IRM has been reflected as a multifaceted topic. One strand of studies comes from transnational family research. It explores the mobility of older people seasonally visiting or permanently joining their emigrated kin, often children, to provide intergenerational support or receive care and support themselves (Baldassar, 2007). Studies of return migration discuss

the experiences of migrants who move to their countries of origin after retirement. One of the issues they face is the portability of their social protection rights across borders (Levitt et al., 2023, pp. 144–146).

A dominant topic in the IRM research is amenity-led or lifestyle migration, which has been debated as something between tourism and migration (Janoschka & Haas, 2013; Bender et al., 2014). Interest in this form of retirement migration centers on how relatively affluent older people navigate and negotiate their identities, aspirations, and social positions through mobility, thereby challenging traditional binaries between tourism and migration and illuminating the interplay between agency and structural conditions in migration processes (Benson & O'Reilly, 2009; O'Reilly & Benson, 2016). This type of IRM is generally related to the movement of older people from high-income to low-income countries with better climatic conditions and lower cost of living. It is fueled by a motive to raise the quality of life in pension by leisurely lifestyle, pleasurable activities, new interests, and protecting health (Levitt et al., 2023, pp. 135–136). It involves the relatively wealthy and well-educated retirees, sometimes referred to as "privileged migrants" or "long-stay tourists" (Croucher, 2012), who typically integrate into communities with co-ethnics coming from similar national and linguistic backgrounds and interact with the local population to a limited extent (Gavanas, 2017). By moving from richer to poorer countries, they capitalize on their superior purchasing power while maintaining ongoing ties with the home nation (Yeates, 2011).

Recently, Iorio (2020, pp. 198–200) has observed the entrance of new actors in IRM, e.g., Italian pensioners in precarious economic situations relocating to Bulgaria, the poorest country of the European Union, as an emerging destination. Moving to Bulgaria, where the cost of living is lower compared to Italy, enables the Italian pensioners to recoup a living standard that is no longer possible at home after the 2008 economic crisis, its reduction in public spending, and the rising cost of living. This phenomenon has been well documented in earlier studies on British retirees in Spain and Italy (King & Patterson, 1998; O'Reilly, 2000). Recent trends, however, suggest a reconfiguration of the European periphery, with Eastern and Southeastern Europe increasingly emerging as attractive retirement destinations. The free movement inside the European Union with entitlements to residence, work and health services for European Union citizens, and the difference in the cost of living between the East and West, makes "Eastern periphery" interesting and affordable for Western retirees facing financial constraints in their home countries.

Some countries purposefully put in place policies to attract migrant retirees because governments see them as potentially profitable. Moreover, Yeates (2011, pp. 1117) argues that poorer countries compete for a larger share of expanding international markets for wealthy retirees. In Bulgaria, Iorio (2020, pp. 199–200) found various internet sites promoting the country as a retirement destination for Italians, including web agencies assisting pensioners in finding a property to rent or purchase and in the administrative requirements related to relocation. Many

countries in Southeast Asia (for example, Malaysia, Thailand, and the Philippines), in Latin America (for example, Costa Rica, Panama, Ecuador, and Mexico), and in Europe (Portugal, Malta) have established government programs to promote IRM by facilitating visas or residence permits, and by offering tax benefits to foreign older people who settle in the country. Toyota & Xiang (2012, pp. 710–712) conceptualized these developments as "the transnational retirement industry," which refers to business operations that are related to the international relocation of foreign retirees and has been led by three sectors: tourism, real estate, and care provision. They found out that the retirement industry in Asia has been endorsed and promoted by states as part of their national development strategies. IRM is welcomed, marketed, and brokered because it is believed to create lucrative opportunities for the retail, tourism, and healthcare sectors.

An emerging strand of studies points to a new type of IRM that concerns retirees needing care who seek an alternative to the precarious and expensive old-age care options in their home countries. It can be described as retirement care migration, and it refers to older people who need care, many of whom are frail or suffer from forms of dementia. Their care needs are complex, extensive, and expensive, and they can no longer arrange their care for themselves. Family members often decide to place them in a care home abroad (Schwiter et al., 2020). This type of IRM has been observed in older people from Germany and Switzerland who emigrated to live in residential care in Eastern Europe and Southeast Asia (Bender et al., 2020). Certain places, such as Thailand, are especially attractive for the affordable, intensive, and high-quality care they provide. Many care facilities in Thailand cater specifically to German-speaking countries and are marketed as built to "German or Swiss norms" (Schwiter et al., 2020). They offer individualized, 24-hour, one-to-one care arrangements, with an individual team of three caregivers available around the clock, with a high emphasis on care according to individual medical, social, and emotional needs, at prices that are generally much lower than in Germany and Switzerland (Bender & Schweppe, 2019).

Ormond & Toyota (2016) discussed the economic precariousness of retirees in combination with their growing care needs as a push factor for IRM. They argue that outsourcing care services toward peripheral areas is essentially driven by a decrease in the purchasing power of pensions within the national territory and is, therefore, a result of the restrictions imposed by the national welfare systems in the global North. Similarly, Toyota & Xiang (2012, pp. 712) point out that the cost of social and medical care is a common motivator for retirement care migration of Japanese retirees across socioeconomic status who relocate to Southeast Asia. The aging population in Japan creates a demand for intensive long-term care, which puts financial strains on the state and the families. Japan also faces a severe shortage of care labor. Japanese retirement care migration indicates the complex relationship between the national and the transnational. While the nation-bound welfare model seems unsustainable due to the aging demographic and economic stagnation, state

welfare—through its well-established national pension scheme, which provides retirees with relatively stable consumption capacity—is a precondition for developing the international retirement industry. The recruitment agencies in Malaysia, Thailand, and the Philippines systematically target countries with well-developed pension schemes. With the development of old-age care markets comes the redirection of purchasing power and other forms of economic activity, as well as substantial relocations of social and healthcare costs to the destination country (Yeates, 2011).

Although lower cost of care seems to be the primary motivation for retirement care migration, studies show that it is not the only one. The appeal of care facilities designed for retirement migrants in peripheral countries also stems from a good staffing situation, including high staff ratios and qualified staff. Accordingly, the facilities promote high-quality care, paying special attention to individualized, flexible, and professional care in a familial atmosphere. Integrated care concepts are implemented that, in addition to good medical care, also include the social and emotional components (Bender et al., 2014). These care markets seem to systematically appropriate the Western ideals of "good care" and address the structural constraints and weaknesses faced in the Global North, such as the lack of time and staff, institutional logic of care, high prices, etc. However, available, affordable, and extensive care is provided due to lower wages and lower cost of living in the periphery, while the poverty-driven provision of emotional labor counters emotional and intimate limitations. These high-end facilities are often beyond the reach of local older people who are offered scarce old-age services, if any (Schwiter et al., 2020; Levitt et al., 2023).

METHODS

Retirement care mobility from Slovenia to Croatia has yet to gain recognition in research and policy debates. Since the phenomenon has not yet been researched, our approach was exploratory. Our empirical evidence is based on individual interviews conducted in 2023 and 2024 in several small towns in the border region of both countries in question (for reasons of anonymity, we do not disclose the towns). We conducted interviews with a range of diverse actors to illuminate the phenomenon from multiple perspectives—state, social work, professional expertise, care home management, and care workers with experience on both sides of the border. We aimed to capture a broad spectrum of views, encompassing policy and systemic aspects, procedural issues, and concrete experiences. Due to the diversity of the interviewees, each possessing distinct knowledge about the phenomenon, we employed semi-structured interviews, tailoring the interview guides to each participant. The thematic scope of the interviews included the institutional arrangements of care for older people in both countries, the scale and types of care mobilities, specific procedures of relocation and placement, daily care routines, cost of care, cooperation with families, and the role of the border in structuring care practices.

In Slovenia, individual semi-structured interviews were conducted with three care home managers and a social worker in a hospital; two nurses daily commuting from Croatia for work in care homes in Slovenia, both with experiences in care homes in Croatia; a representative of the Association of Social Institutions of Slovenia, and a policymaker at the Ministry of Labor, Family, Social Affairs and Equal Opportunities (MDDSZEM). In Croatia, we interviewed an expert on the care system for older people, who also runs a placement agency, and a manager of a private residential care facility close to the Slovenian border, who has long-term experience with the placement of older people from Slovenia. Interviews lasted between 30 and 65 minutes and were recorded and transcribed upon the interviewees' informed and signed consent and thematically analyzed. The institutional analysis was informed by both primary data from interviews and secondary sources, including our own previous research, existing academic literature, and national and international studies.

AN OUTLINE OF THE RETIREMENT CARE MOBILITY FROM SLOVENIA TO CROATIA

The interviewed expert from Croatia said there are many Slovenian citizens in Croatian residential care, especially near the border, and there is a particularly high demand for care for people with dementia. Although the facilities are advertised on local radio stations, this is unnecessary because of high demand. The residential care facility in Croatia where we interviewed the manager has a capacity of 50 residents, 14 of whom are Slovenian citizens. According to the director, residents come not only from the border regions but also from the interior of Slovenia, including Ljubljana.

Media coverage frames this care mobility as a critique of the Slovenian care system, citing high prices and long waiting lists. In contrast, Croatian residential care is portrayed as significantly more affordable—costing about half as much as Slovenia—and immediately available (Držaj, 2017; Zore, 2018; Čeh, 2019). The media also highlights positive aspects of Croatian residential care, such as a sense of homeliness, community, and family. The small size of Croatian residential care facilities and the involvement of users in everyday activities such as working in the kitchen, in the fields, in the vineyards, and participating in the preparation of meals are said to contribute to this (Kramberger, 2016; Srpčič, 2018).

However, our interviews conducted on both sides of the border reveal a different picture, highlighting inadequate treatment of residents, unsuitable spatial arrangements for users with reduced mobility, and insufficient medical care. They point out that accommodation in Croatia is substandard and that "Residential care in Croatia cannot compare with services in Slovenia" (MDDSZEM). Users from Slovenia keep their family doctor in Slovenia, where they undergo medical check-ups and receive medications, as Croatian residential care does not include health care services. Residential care managers on the Slovenian side pointed out, "Users who need more

complex medical care return to Slovenia from Croatian facilities." In emergencies, they can be treated in Croatian hospitals using the European Health Insurance Card (EHIC) and supplement payment. Transport to Slovenia by ambulance is very expensive because the EHIC does not cover cross-border transport. The Slovenian social worker from the hospital told us, "Croatian residential care facilities discharge a person whose health deteriorates seriously, put them in a car, and send them to Slovenia. We often admit people from Croatia with extremely deteriorated health conditions." One residential care manager said that they had admitted users from Croatia: "One lady, I remember, was immobile and was on the second floor in a house without a lift; basically, the standard is quite unsuitable for care. We received two ladies in poor condition, with wounds." The director of a Croatian residential care facility reflected critically on the situation in Croatia:

> You have quite a lot of family residential care facilities that take up to 20 users, which unfortunately don't have the conditions; they don't have the staff. Even though it was a nice idea for the family to be involved in this business, you as a family cannot take care of twenty old and helpless people. You must have a nurse because these people need medical care.

Rather than assessing the extent or quality of care mobility of older people from Slovenia to Croatia, our analysis aims to use institutional analysis for a clearer understanding of these dynamics and to reveal the interplay of the push and pull factors that sustain this form of transnational care.

INSTITUTIONAL ANALYSIS OF CARE FOR OLDER PEOPLE IN SLOVENIA AND CROATIA AND THEIR CO-EFFECT

In Slovenia, the population aged 65+ was 21.4% in 2023. Besides family care, the central pillar of care is the public/private network of residential care, which provides placement for 4.8% of older people (Skupnost socialnih zavodov Slovenije, 2022). Residential care facilities offer integrated services, including access to family doctors on-site, physical and occupational therapy, and various social activities. They strive to engage with their local communities through cultural events, intergenerational cooperation, and the promotion of voluntary work (Mali, 2008).

In the 1990s, a mixed economy of services was introduced, and the number of private residential care facilities has increased rapidly since then. They are included in the public network and are subject to the same quality standards as public residential care but charge up to 30% higher prices to recoup their investment (Hrženjak, 2019).

The cost of residential care is individualized as only 30% of funding comes from the public health care budget. In comparison, 70% is paid by the users and their families, who are legally bound to co-payment. Because of a high poverty rate among

older people, in particular women (Leskošek, 2019), working and middle-class families often cannot afford to pay for residential care. The municipality subsidizes costs for users if they have no relatives or those they do have cannot pay; however, these subsidies are later recovered from the inheritance. This further complicates the situation as older people and their families do not opt for a subsidy to avoid losing property (Hrženjak, 2019).

While the state promotes aging in place, it offers little support for its implementation. Public home care services are 50% subsidized, but they remain underdeveloped. Only 1.8% of older people receive home care services on an average of 3.5 hours per week (Kovač & Petrič, 2023). Due to insufficient capacity, waiting lists exist for both residential care and home care services. Furthermore, low wages and high workloads contribute to high turnover rates and staff shortages, so providers are often forced to decline new users (Skupnost socialnih zavodov Slovenije, 2024).

In such a situation, family members, primarily women, are pushed into providing most of the care. However, a dual-breadwinner full-time employment regime places Slovenia among the countries with high labor intensity put on women, which makes family care unsustainable. The Long-Term Care Act, prepared by successive governments since 2002 and finally adopted in 2023, exemplified the long-standing political marginalization of senior care and the deflection of responsibility for population ageing onto families. Inadequate policies create a huge care gap. While the informal care market is booming, another strategy is to place older people in residential care in Croatia, which is also observed in the Social Inspection report:

> In inspections in 2016–2020, providers of residential care for older people in the public network, social work centers, as well as providers who provided the service without the appropriate legal basis, reported that relatives of older persons, instead of placing them in residential care in the vicinity, placed them with individuals in the immediate vicinity or with families and providers of similar activities in Croatia and Hungary. They are often seriously ill persons or persons with dementia placed in this way by their relatives. The relatives justify their actions on the grounds that they are unable or unskilled to care for such a relative, that the public network providers are too expensive, and that they have already submitted applications for admission, but the public network placements are full.
>
> In 2016–2019, relatives also expressed their dissatisfaction and distrust in exercising the right to the care allowance and the right to exemption from payment for social care services. This was due to their poor financial and property situation and concerns with the municipality's right to register a lien on the property in the Land Register in the case that the municipality covers part of the costs of care and later makes a claim against the beneficiaries to recover these funds (Socialna inšpekcija, 2021, p. 21).

The Ombudsman's press release (Varuh človekovih pravic RS, 2018) suggests that this transnationalization of care is systemic: "It often occurs that relatives of applicants for accommodation, residential care facilities, and social work centers in extreme need are looking for a solution in accommodation in residential care for older people outside Slovenia, most often in Croatia. They also send older people there who can no longer pay the care fees."

In Croatia, 22% of the population is older than 65 years. Care relies heavily on informal family care provided by women. Home care services are only available in a few bigger cities and are afforded by about 0.5% of older people (OECD, 2023). Like Slovenia, Croatia is facing a significant shortage of care workers. The number of formally employed workers in long-term care reaches only 1.7 per 100 people aged 65+, compared to 3.8 for the EU-27 (Bađun, 2024).

Less than 3% of older people receive residential care compared to an OECD average of 4% (OECD, 2023). Residential care is divided into state-run or public facilities and private or market-run facilities. Six hundred eighty-one providers provided residential care in 2023. Only three were state-run, 54 were established by local authorities, and 624 were privately run (Gradonačelnik.Hr, 2023). The government only subsidizes placement in public residential care, but subsidies are given under non-transparent criteria and are not means-tested. This causes extremely long waiting lists in public residential care due to limited capacities (Bađun, 2024). In transition, the state has left the creation of new residential care facilities entirely to private market initiatives. To obtain a license to operate, private residential care facilities, which can provide care for 20 to 50 users, have to meet the minimum conditions for the provision of social services, while the providers themselves set the price according to market conditions (Manojlović, 2020). The state does not subsidize placement in private residential care; the user has to pay the full price, which is two or three times higher than public residential care. The expert on the system of care for older people who also runs a placement agency in Croatia said in our interview:

> In public residential care in Zagreb, a single room costs €490 because it is subsidized. The waiting period for placement is between 10 to 15 years. In a new private residential care in Labin, the price is between €1,200 and €1,800, depending on the level of care. Prices for private residential care vary by region. The most expensive are in Zagreb, Split, and Istria. The rural areas, Slavonia and Croatian Zagorje, are the cheapest.

Croatia has one of the highest rates of older people living below the poverty threshold among the European Union countries, amounting to 31% (Klempić Bogadi & Podgorelec, 2024), so most older people cannot afford private residential care. The manager of a private residential care facility in Croatia said in our interview that mainly returning migrants and old people whose children have emigrated abroad and are financially supporting their parents can pay: "We have many pensioners who don't

have a Croatian pension but have an Austrian, German, Swedish, Slovenian pension that they can use to pay for private residential care. Or their children work abroad."

The state addressed the problem of care for older people with low pensions by deregulating residential care. As Manojlović (2020, p. 110) demonstrates in her study of the Croatian system of care for older people, in 2003, the state authorized the operation of family residential care homes (Croat. *obiteljski domovi*), which are officially classified as non-institutional forms of care intended to resemble home care, but are not subject to state control. Family residential care is organized in purpose-built apartment houses and can accommodate between 5 and 20 users. The homeowner or a family member with at least a secondary vocational education can provide care. Other people may also be employed, and non-employed family members may participate in care. The facility must have a maximum of 3-bed rooms with a minimum of 4 square meters per person, heating, ventilation, and daylight, and include a food preparation and serving area (Manojlović, 2020, p. 111). The number of family residential care facilities has been increasing steadily since 2003. In 2024, there were 404, and they provided more than 6,000 placements (about 20% of all existing placements in Croatia) and employed about 2,000 persons (Udruga obiteljskih domova, 2024). Family residential care facilities are most common in small towns and rural areas, where just a few years ago, the cheapest accommodation cost as little as €150–250 (Manojlović, 2020, p. 117). Our interviews indicate that today, the average price of family residential care ranges between €400 and €600, and between €600 and €800 in better-equipped facilities. Due to high demand, the increasing number of immobile users, and rising labor costs, prices in family residential care are expected to increase rapidly. The deregulation of family residential care, combined with the absence of state oversight and care standards, allows for flexibility in pricing based on the local environment and demand.

Croatia has thus privatized residential care, leaving it to the market. By issuing work permits, two types of private residential care facilities have emerged: the slightly regulated, larger, and more expensive facilities for the wealthy and the highly deregulated, family residential care facilities for the poor. This confirms the indications from the interviews that care in family residential facilities can be precarious compared to care provided in both public and market-based facilities in Croatia, and even more so when compared to standards in residential care in Slovenia. Family residential care facilities are typically understaffed; care is de-professionalized, unsupervised, and lacks medical services. It is limited primarily to basic monitoring and accommodation in private houses, which are often not adapted to the needs of older people.

As a rule, eligibility for a nation-state's social protection requires membership (i.e., citizenship) and residence within its territories (i.e., territoriality) (Levitt et al., 2023, p. 9). The deregulation of private residential care and its placement on the market outside the public service network is thus central to the transnationalization of care. Slovenian citizens cannot be placed in public residential care facilities

in Croatia; however, they can access private facilities, which operate not according to the logic of citizenship and territoriality but according to the logic of the market and the user's purchasing power. As we learned from the interviews, older people cared for in private residential facilities in Croatia retain their permanent residence in Slovenia, which is a prerequisite for continuing to receive health and social protection benefits. In Croatia, they declare temporary residence at the residential care facility where they receive social care services. In this arrangement, they continue to access health and social benefits in Slovenia based on the logic of citizenship and territoriality while purchasing social care in Croatia according to the logic of the market and their purchasing power. In doing so, they are generating a precarious and hybrid model of transnational care (Levitt et al. 2023, p. 4). Such care is hybrid because it uses two different logics of the access to services, i.e., citizenship and the market; it is transnational because it takes place in two countries and requires regular back-and-forth movements; and it is precarious because it is driven by necessity, and the standards of care in Croatia—particularly in family residential care—are lower than those in Slovenia (UN Women Training Centre, 2014).

Croatia, which is "solving" the care gap in its own country through the privatization and deregulation of care, has thus inadvertently, as a by-product, produced "solutions" to the care gap in its neighboring country. As Toyota and Xiang (2012) argue, transnational care is not necessarily a consequence of globalization but can emerge by chance because of the co-effect of specific institutional configurations of two or more countries. However, this institutional configuration is changing in both countries. In Slovenia, the Long-Term Care Act, intended to provide for a larger share of co-financing of care and a larger extent and diversity of public services, will fully enter into force in 2026. In Croatia, numerous reports of poor performance, maladministration and neglect have led to the decision to abolish family residential care by 2026. It will be interesting to see how these changes will affect the transnationalization of care between the two countries.

CONCLUSION

Using the concepts of care gap, the transnationalization of care, and retirement migration, and based on individual interviews with stakeholders and institutional analysis, we explored retirement care migration from Slovenia to Croatia. It is driven by geographical, language, and social proximity, which is typical of a border region. However, as the institutional analysis in both countries clearly showed, it is also driven by the co-effect of the specific institutional configuration of the two neighboring countries.

Existing research on retirement care migration highlights the motivation to find more affordable care and a better quality of care than the one available in the home country. In comparison to high costs of care, understaffing and time-pressured

working conditions, a lack of focus on older people's needs, and a dearth of individual care in services in home countries, residential care in the Global South offers high-quality, professional, holistic, and individualized care arrangements (Bender et al., 2014; Bender et al., 2018; Schwiter et al., 2020). This reflects the global inequalities because it means that average pensioners in one country can become high-power consumers in another, which is a significant driving force behind the retirement care industry. Cheaper and better quality care results from wage differentials and the lower cost of living in the destination countries. The non-affordable Western ideals of old-age care in the country of origin are shifted to lower-wage countries, thus "solving" cost burdens in rich countries by exploiting global economic inequalities. These migratory dynamics emanate from both relatively wealthier retirees and those in precarious economic situations but still having greater consumer power than locals.

Our study of retirement care migration from Slovenia to Croatia, in the specific context of the two post-transition countries on the periphery of the European Union, both facing rapid population aging and neoliberal restructuring of the welfare state, shows a different picture. Institutional analysis shows that retirement care migration from Slovenia to Croatia is fueled by the scarcity of public services, the high poverty rate in old age, and individualization of care costs, which particularly burden families in weak socioeconomic situations. The class aspect is accentuated on the European margins. The privatization and deregulation of care in Croatia have produced family residential care—a unique combination of market-based residential and informal family care. As the most affordable option, it fills the care gap for poor older Croatians who are excluded from subsidized public residential care services due to limited availability and priced out of private residential care options due to the high cost. Slovenian citizens use both types of Croatian private residential care according to their purchasing power. However, both types, particularly family residential care, provide services to significantly lower standards than Slovenian residential care regarding the qualifications and number of staff, the quality and adaptability of accommodation, health care, supervision, etc. Although retirees from Switzerland or Germany, even if from weaker economic groups, receive better-quality care for a significantly lower price in Thailand than at home (Bender et al., 2014; Bender et al., 2018; Schwiter et al., 2020), Slovenian citizens, including those from the middle class, receive significantly worse care in Croatia than at home for only a slightly lower price. Therefore, paraphrasing a concept of hybrid transnational protection (Levitt et al., 2023, p. 4), we have called the retirement care migration from Slovenia to Croatia a precarious hybrid transnational care because, as transnational care recipients, the care users partly receive old-age care in their source country according to the logic of citizenship, and partly in the country of destination in the form of services according to the logic of the market, and their purchasing power. However, this care does not align with the standards of their home country. It insufficiently addresses their health needs and is often the outcome of constrained decision-making shaped by the care gap in Slovenia.

Although the transnational extension of welfare is necessary in times of global migration, the case of retirement migration from Slovenia to Croatia shows that it can be problematic if its drivers are the neoliberal economization of welfare: the downsizing of the role of the state in providing care, privatization, and deregulation. In this scenario, individuals are no longer viewed as citizens entitled to equal rights but as consumers purchasing services in the global market. The market transforms into an increasingly important source of social welfare and reaches out to international users, too. However, the market as a source of care is highly stratified and precarious since it depends on individuals' purchasing power. The state, which in this vein maintains the public cost of care at a low rate, withdraws from regulating the services so that the market functions more efficiently and profitably. The transnationalization of care appears as the "solution" because it allows for the outsourcing of care labor either by its extraction from (in care workers migration) or by its externalization to (in retirement care migration) the women from poorer countries, whose care labor is cheaper.

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POVZETEK

ISKANJE OSKRBE V SOSEDNJI DRŽAVI: INSTITUCIONALNA ANALIZA TRANSNACIONALNE OSKRBE STAREJŠIH LJUDI MED SLOVENIJO IN HRVAŠKO

Majda Hrženjak

Upokojenska migracija je relativno novo raziskovalno področje, ki obravnava tudi emigracijo starejših ljudi, ki iščejo cenejšo in bolj kakovostno oskrbo, kot jim je dostopna v državi izvora. Avtorica z uporabo konceptov skrbstvene vrzeli, transnacionalizacije oskrbe in upokojenske migracije analizira skrbstveno mobilnost starejših ljudi iz Slovenije na Hrvaško v specifičnem kontekstu dveh sosednjih posttranzicijskih držav na obrobju Evropske unije, ki se soočata s staranjem prebivalstva in neoliberalizacijo države blaginje. K tovrstni mobilnosti prispeva geografska, jezikovna in socialna bližina, značilna za obmejno regijo. Empirični podatki, pridobljeni s polstrukturiranimi intervjuji z deležniki in institucionalno analizo, pa kažejo, da jo spodbuja tudi součinkovanje specifične konfiguracije institucionalnih vrzeli v oskrbi starejših ljudi med obema državama. V Sloveniji se skrbstvena vrzel kaže v visokih in individualiziranih stroških oskrbe, v revščini upokojenih ter v pomanjkanju javnih storitev in njihovi kadrovski podhranjenosti. Na drugi strani je Hrvaška privatizacijo in deregulacijo oskrbe slednjo prepustila trgu in sprožila nastanek dveh tipov zasebne domske oskrbe: delno regulirane, večje in dražje domove za premožne ter družinske domove, ki jih umešča v neinstitucionalno oskrbo in jih država zato ne nadzoruje. Družinski domovi so kot najcenejša oblika oskrbe dostopni revnim. Državljani Slovenije uporabljajo oba tipa zasebnih domov na Hrvaškem glede na svojo kupno moč. Vendar oba tipa domov, zlasti pa družinski domovi, izvajata oskrbo po bistveno nižjih standardih kot veljajo v Sloveniji, in sicer tako z vidika usposobljenosti in števila osebja kot z vidika kakovosti in prilagojenosti namestitve, dostopnosti zdravstvene oskrbe, različnih aktivnosti, nadzora ipd. Tako se vzpostavlja oblika oskrbe, ki jo avtorica opredeli kot »prekarna hibridna transnacionalna oskrba«. Starejši ljudje, ki zaradi oskrbe migrirajo iz Slovenije na Hrvaško, v državi izvora še naprej prejemajo zdravstvene storitve in socialne prejemke po logiki državljanstva, na Hrvaškem pa kupujejo institucionalno oskrbo po logiki trga in svoje kupne moči. Taka oskrba je hibridna, ker uporablja dve različni logiki dostopa do storitev – državljanstvo in trg; je transnacionalna, ker poteka v dveh državah in terja redno prestopanje državne meje; in je prekarna, ker so standardi oskrbe na Hrvaškem slabši kot v Sloveniji, ker ne izpolnjujejo v zadostni meri potreb uporabnic_kov in ker je izbira tovrstne pogosto prisilna, torej rezultat skrbstvene vrzeli v Sloveniji.

Hrvaška, ki z deregulacijo in privatizacijo oskrbe »rešuje« skrbstveno vrzel v svoji državi, je tako nenamerno, kot stranski produkt, proizvedla »rešitve« tudi za skrbstveno vrzel v sosednji državi. Študija pokaže, da transnacionalizacija oskrbe ni nujno posledica procesov globalizacije, temveč lahko do nje pride naključno, kot posledica součinkovanja med specifičnima institucionalnima konfiguracijama oskrbe med dvema državama.

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MIGRACIJE IN RAZVOJ NA GORSKIH OBMEJNIH OBMOČJIH ŠVICE IN SLOVENIJE (18.–20. STOLETJE) / MIGRATION AND DEVELOPMENT IN THE MOUNTAIN BORDERLANDS OF SWITZERLAND AND SLOVENIA (18TH–20TH CENTURY)

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POTOMKE, POTOMCI SLOVENSKIH IZSELJENK, IZSELJENCEV TER OHRANJANJE SLOVENSKEGA JEZIKA IN KULTURE V BOSNI IN HERCEGOVINI / DESCENDANTS OF SLOVENIAN EMIGRANTS AND THE PRESERVATION OF THE SLOVENIAN LANGUAGE AND CULTURE IN BOSNIA AND HERZEGOVINA

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