

Quality and cost-effectiveness in long-term care and dependency prevention



COUNTRY REPORT

Czech Republic: Emerging policy developments in long-term care

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Introduction

The goal of this country report is to provide an overview of the key emerging policy developments in long-term care quality and cost-effectiveness across four themes: dependency prevention, informal care support, use of information and new technologies, and coordination of long-term care. The report is based on a review of published articles and books, a review of policy documents, especially governmental strategic documents and plans, information from grey literature, information provided on the internet websites of the Ministry of Health, the National Institute of Public Health, and the Ministry of Labour and Social Affairs, and expert opinions. The authors would like to thank reviewers of the report: Hana Geissler from Further Education Fund and Markéta Vanclová from the Institute for Social Policy and Research for their comments on the content of the report.

Outline of the long-term care system

The philosophy of care for older and dependent people in the Czech Republic should be—according to the main policy documents—driven by the principles of ‘equity’, ‘accessibility’, ‘quality’, and ‘fiscal tenacity’ (Potůček et al. 2006). However, there is no integrated long-term care (LTC) system, and not all of these goals have been reached. Traditionally, informal care constitutes a major part of care provided to older and dependent people. It is estimated that roughly 52% to 75% of care is provided by relatives, at home (Jahoda et al. 2016).

Formal LTC in the Czech Republic is based on a two-tiered system of regulation, funding, and services provision—separate for the health sector and for the social services sector (Sowa 2010; Jahoda et al. 2016). The major regulations covering LTC issues include (Sowa 2010): the Public Health Insurance Act (48/1997)¹, which introduced health insurance for health services, including after-care

and LTC provided within the health sector; the Health Services Act (372/2011)², which defined the types and conditions for the provision of health care services (acute and after-care, LTC, and home health care, among others); the Decree on the Requirements for Minimum Staffing of Health Services (99/2012)³ and the Decree on the Activities of Health Workers and Other Professionals (55/2011)⁴; the Social Services Act (108/2006)⁵, which regulates the provision of home care⁶, residential care, including care for seniors and other types of social services, and access to cash benefits for individuals with limitations in activities of daily living (ADL); and the Decree on the Implementation of the Social Services Act (505/2006), which specifies the process of health assessment, ‘obligatory’ and ‘facultative’ tasks in and maximum prices for individual services, qualification requirements for workers in social services, and quality standards and their assessment.⁷

The major reform in the field of LTC was the introduction of the Social Services Act in January 2007. The regulation identifies dependency as a social risk (Łuczak 2015), and when it occurs a care allowance (a cash non-contributory benefit) is granted. The introduction of the new benefit—the care allowance—has been the most significant change in the social services system since the 1990s.⁸ Besides the introduction of the care

² Act no. 372/2011 Sb., on Health Services. www.zakonyprolidi.cz/cs/2011-372

³ Decree no. 99/2012 Coll., on Requirements for Minimum Staffing of Health Services. www.zakonyprolidi.cz/cs/2012-99

⁴ Decree no. 55/2011 Coll., on the Activities of Health Workers and Other Professionals. www.zakonyprolidi.cz/cs/2011-55

⁵ Act no. 108/2006 Coll., on Social Services. www.zakonyprolidi.cz/cs/2006-108

⁶ The term ‘home care’ (‘domácí péče’) is often used to refer to home health care (‘home care agencies’) paid from public health insurance. Such is prescribed by general practitioners and hospital physicians during the discharge of a patient. Increasingly, palliative care is provided by home care agencies.

⁷ Decree no. 505/2006 Coll., on the Implementation of the Act on Social Services. www.zakonyprolidi.cz/cs/2006-505

⁸ Before 2007, there was no allowance aimed specifically at social services and formal LTC users.

¹ Act no. 48/1997, on Public Health Insurance. www.zakonyprolidi.cz/cs/1997-48

allowance, the act formulated quality and professional standards in social services (Klimentová & Thelenová 2014).

The care allowance is a non-contributory benefit provided exclusively on the basis of care need, irrespective of the previous or current economic activity, income, or property of the recipient or informal carer.⁹ The new allowance replaced two previous benefits: the 'increase of pension due to helplessness' and 'an allowance for the carer of a relative or other person'.^{10,11} Most of the recipients of the care allowance are people aged 80 and older, who comprise 43% of all recipients. In 2015, two-thirds of the people who received the care allowance were people in the first or second degree of dependency (65%), while people with the highest (fourth) degree comprised only 13% of all recipients (MoLSA 2016a).¹²

Benefit level depends on an assessment of health status and functional ability conducted by the Medical Assessment Service and a social worker's assessment of health and social situation during the

visit to the client's home (Hirose & Czepulis-Rutkowska 2016). The assessment doctor makes a decision based on reports from general practitioners, specialists, and a social worker employed by the Labour Office. They can also visit a claimant at home, though this rarely happens in practice. If a claimant disagrees with the decision, they can appeal to the Ministry of Labour and Social Affairs.¹³

There has been growing criticism regarding the length of the assessment and the administration process for care allowance applications. The time between making an application and the decision of the employment office on entitlement and the level of care allowance can last from months to a half year or even longer. Cases of claimants who die before they receive a decision are reported. In such cases the allowance is received by the informal (family) carer in a lump sum retroactively. One of the reasons for the lengthy administrative process is a shortage of assessment doctors, with many long-term unfilled positions for these with the Czech Social Security Administration.¹⁴ Due to the long-term shortages of assessment doctors, there is ongoing discussion on delegating some assessment competencies to other professions, such as general practitioners, ergotherapists, or a new profession of assessment assistants.¹⁵

⁹ Since January 2012, an increase of the care allowance for people with a low income was introduced as partial compensation for changes to the law on state social support. This change brought a new aspect of income to the care allowance. Care allowance is not a means-tested benefit. According to some experts, this change was not well considered and systematic, as income protection should belong to different parts of social system (Kepková 2016).

¹⁰ The 'helplessness benefit' for pensioners, including survival pensioners aged 70 years and older, was regulated by §70 of the Act no. 100/1988 Coll., on Social Security. Pensions could be increased by 20%, 40%, or 75% depending on the care need assessed by medical doctors (Koldinská 2016). The benefit was financed from the state budget;

¹¹ The 'allowance for carer of relative or other person' was regulated by §7 of the Act no. 482/1991 Coll., on social neediness. It could be provided to full-time carers for a close relative who was 'severely or totally helpless' or older than 80 years. The allowance was awarded also to a non-relative under the condition that they lived in the same household with the person being cared for. It is not clear whether the Ministry realised that the transformation of two benefits into a new single allowance would result in carers having no entitlement to direct financial support (Koldinská 2016).

¹² Data source: MoLSA 2016c (own calculations).

¹³ If a claimant appeals to the Ministry of Labour and Social Affairs (through the regional Labour Office) the assessment commission of the ministry invites him/her to participate in the commission meeting. If a claimant does not succeed in their appeal, he/she can turn to the ombudsman (Public Defender of Rights) or Administrative Court.

¹⁴ This specialisation is unpopular among medical doctors because as it entails administration tasks with no patient contact, and lower salaries in comparison to doctors in hospitals and private practice. The average age of the assessment doctors is high and many of them are pensioners.

¹⁵ Another large implementation deficit of the assessment process is that people with psychiatric diagnosis who do not require direct care but have decreased self-sufficiency in instrumental activities (i.e. the ability to live independently in the home and society) fall through the assessment criteria and are assessed at the lowest degree of dependency and respective level of allowance.

The benefit is designed as an individual budget for buying formal care services or covering informal care costs. Before the introduction of the new law, the number of beneficiaries was estimated at 170,000, with total expenditures per year at CZK 8 billion¹⁶ (Barvíková & Österle 2013). However, the actual take-up of the benefit was much higher and resulted in a rapid increase in social expenditures. Between 2007 and 2015, the number of beneficiaries increased by 30% to 337,000.¹⁷ According to the latest available data, there were 349,200 beneficiaries in February 2017 (MoLSA 2017c). One year after the introduction of the Act, expenses increased by 25 percentage points (pp), from CZK 14.6 billion in 2007 to CZK 18.3 billion in 2008. Between 2007 and 2016, expenditures on the care allowance increased by half, from CZK 14.6 to CZK 21.2 billion (MoLSA 2016a). Annual costs are expected to reach CZK 23.8 billion in 2017 (MoLSA 2017c).

Since August 2016, the amount of the care allowance was raised by 10%. This was the first time in ten years (since 2007) that the allowance increased for all recipients.¹⁸ Consequently, between February 2016 and 2017, monthly costs increased from CZK 1.8 to CZK 2.0 billion by 14% (MoLSA 2017c). The largest annual increases recorded were 25pp between 2007 and 2008, and 9pp between 2015 and 2016 (MoLSA 2017c).

The amount of the care allowance currently (as of April 2017) stands at CZK 880 per calendar month for persons aged 18 and above with a first degree of dependency (moderate dependency), CZK 4,400 in the case of a second degree of dependency (medium dependency), CZK 8,800 in the case of a third degree of dependency (severe dependency),

and CZK 13,200 in the case of a fourth degree of dependency (total dependency) (MoLSA 2017b).¹⁹ Originally, in 2007, the care allowance for adults with a first degree of dependency amounted to CZK 2,000 for those aged 18 and above and CZK 3,000 for those under the age of 18. In 2011, the amount of the care allowance for recipients aged 18 and above with a first degree of care dependency was cut by 60% to CZK 800 as part of austerity measures²⁰ (Hirose & Czepulis-Rutkowska 2016). Nevertheless, the allowance for recipients aged 18 and under with the first degree of dependency remained at the same level of CZK 3,000 per month. The difference in the amount of the care allowance for people aged under and above 18 thus ‘dramatically increased’ (Kepková 2016).

There is continuing discussion on the efficiency of financing and the role of the care allowance in the social services system. The allowance was intended to empower people in need of LTC, who become ‘brokers’ between the state and providers, to choose the type and level of care they prefer. The allowance increased their ‘purchasing power’ to make social services and care more affordable. However, although the introduction of the new benefit led to an increase in ‘LTC expenditures’, the new resources are used mostly to pay for informal care, and the introduction of the care allowance did not lead to the development of new alternative services for older people. The dependence of service providers on public subsidies and the price regulation of direct payments for board and accommodation is a source of inefficiency in the social services system (Průša 2013).

Private sector provision of social services (including

¹⁶ €1 = CZK 26.56 (7 April 2017)

¹⁷ The number of recipients increased from 260,000 to 337,000.

¹⁸ Since 1 August 2009, the amount of the care allowance for the fourth degree was increased from CZK 11,000 to CZK 12,000 for both people above and under the age of 18. Since January 2012, the care allowance was increased from CZK 5,000 to CZK 6,000 for people aged 18 and under with a second degree of ‘dependency on care’ (Kepková 2016).

¹⁹ Updated information on the care allowance can be found on the Information Portal of the Ministry of Labour and Social Affairs (in Czech only) (MoLSA 2017b).

²⁰ Besides reducing the state budget deficit, another argument for lowering the care allowance for the first degree was that the amount of CZK 800 corresponds to the need of services. The recipients of the beneficiaries for the first and second degrees of dependency, who are mostly older people, largely used ‘domiciliary services’ such as home help, meals on wheels, and help with cleaning and shopping, among others (Kepková 2016).

home and residential LTC facilities) has been developing. This care is paid for fully out-of-pocket. There is no monitoring of the number and quality of services provided in the private sector. However, providers who are not authorised by the regional authority cannot receive subsidies from regional or local governments (city councils).²¹ According to the Social Services Act, the recipients of care allowances can use the benefit only for the purpose of buying registered social services²² or paying for informal care. Although the public sector should continue to play a central role in ensuring essential care for all, according to a recent International Labour Organization (ILO) report (Hirose & Czepulis-Rutkowska 2016), there are certain areas (such as food delivery and domestic help) where private providers could work efficiently under proper regulations and quality controls.

In recent years, there have been an increasing number of unregistered private providers, especially homes for seniors, that do not meet quality standards and illegal under the Social Services Act. According to data from the regional authorities, there were 72 unregistered providers in March 2015, which accounted for about 7% of the total number of registered 'homes for seniors' and 'homes with special regime' (aimed especially for people with dementia).

The uncontrolled rise of unregistered services was partly caused by the failing market for formal LTC services, which was not able to generate services of legal quality in a sufficient quantity and at an

affordable price. This trend led to an inquiry by the Public Defender of Rights (ombudsman)²³ who questioned the quality of care in unregistered facilities (Veřejný ochránce práv 2015).²⁴ The Ministry of Labour and Social Affairs increased the maximum fine of CZK 250,000 to CZK 1 million for the provision of unregistered social services (MoLSA 2014). The purpose of the amendment was to prevent the risk of poor care and abuse of users. Further measures have been considered to take control of this trend, such as increasing fines and the powers of authorities to close down such facilities.

Registered providers participate in the community planning of social services in cooperation with representatives of commissioners (local or regional authorities) and users (the 'triad principle'). According to the Social Services Act, all 14 regions are obliged to prepare a 'medium-term plan for social services development' for a period of three years in cooperation with the municipalities in their territory. Although it is not obligatory, a majority of the municipalities prepare plans, especially the larger ones with special administrative competencies. There are 205 municipalities with these 'extended powers'.

The users of residential social services often require medical care, which is provided according to health care legislation (MoLSA 2015a). The health system mainly provides nursing care, rehabilitation, palliative care, and psychiatric care, among others. In the social sector, home care, residential care, and semi-residential care are provided to older people. Home care services cover a range of tasks related to self-maintenance and are often complemented by medical (nursing) home care (Pfeiferová et al. 2013).

²¹ Some providers argue that they have unequal access to the public subsidies provided by regional and local authorities, which are, at the same time, the commissioners and 'owners' ('allowance organisations') of the service providers. Four in five (82%) service providers, of a total of 78,500, were founded by either regions (46%), municipalities (27%), or church organisations (9%). Regional and local governments are the founders of nearly three-quarters of all social service providers (MoLSA 2016c). There might be a conflict of interest in the provision of subsidies to providers (Průša 2013).

²² The authorisation allowed for the improved mapping of social services and the establishment of the public register of services (<http://iregistr.mpsv.cz>). The Act also set up the qualifications and further education requirements for social workers (MoLSA 2015a).

²³ The Public Defender of Rights protects people against the conduct of authorities and other institutions if the conduct is against the law or does not correspond to the principles of a democratic legal state and the principles of good administration, or the authorities are inactive. More information is available (in English) at www.ochrance.cz/en/.

²⁴ A summary report from the visits to accommodation facilities providing care without authorisation is available at <http://bit.ly/2nM4xG7>.

Residential care is provided in care homes (homes for seniors, among others), and semi-residential care in day care centres. Municipalities, regional authorities, and non-governmental organizations (NGOs) play a key role in the provision of these services. All service providers financed from public sources must be authorised by one of the 14 regions ('kraje').²⁵ Previously, subsidies were provided by the Ministry of Labour and Social Affairs. Since 2015, this competence has been transferred to the regions. The system of social services is financed from the general budget. The regions, together with the city councils, provide subsidies to providers. The regions are obliged to prepare strategic plans in cooperation with other stakeholders ('community planning').²⁶

In the current system, people with similar health statuses may receive care in either health or social care institutions ('institutions for the long-term ill' or care homes); however, these institutions are funded differently (MoLSA 2015a). Funding and payment conditions differ for both providers and users. Care provided in health care facilities is fully covered by health insurance, while care in homes for seniors is financed from several sources (the state budget, regional or municipal budgets, and direct payments from users with care allowances or old-age or disability pensions). Stays ('placements') in care homes thus require significantly higher direct payments than stays in hospitals or nursing homes ('institutions for the long-term ill').²⁷ Receiving LTC in a health care facility for as long as possible is thus,

for a person in need of care and his/her family, much more efficient than the residential care provided by social services. However, it is also much more expensive for public health insurance companies and public budgets to pay for LTC in health care facilities (MoLSA 2015a). Moreover, as confirmed by several case studies, when a person in a care home is transferred to a hospital for a health intervention, they often return in a significantly worse health condition (e.g. with pressure sores, malnutrition, and decreased mobility, among others) (MoLSA 2015a).

The Health Services Act defines long-term inpatient care as care that is provided to patients whose health condition cannot be significantly improved and whose condition requires complex nursing care (Wija 2015). There is an evident disproportion between the provision and financing of health and nursing care in inpatient health care facilities and in residential social services. Health facilities providing social services receive on average about 3.5 times more funding per patient in nursing and rehabilitation care than in homes for seniors (MoLSA 2015a). It was estimated that health insurance companies cover only one-fifth of the real costs of nursing and rehabilitation care provided in residential services, despite the fact that the health care is prescribed by medical doctors and provided by health workers employed by the care homes (Průša 2010).

The financing of medical procedures based on the performed health tasks as compared to flat-rate payments per day/patient is significantly lower than the actual cost of nursing care. Reporting on performed health tasks and subsequent communication with health insurance companies represents a significant administrative burden for social services (MoLSA 2015a). There is also the well-known problem of providing medication to users in care homes. If a user is not capable of taking pills him/herself and, at the same time, has no relatives who could assist him/her, the provider of social services is not allowed to dispense the pills. Home health care providers that are authorised to provide medicines in care homes, on the other hand, are not paid for this health task (MoLSA

²⁵ There are 14 regions and regional authorities in the Czech Republic, including Prague, which is at the same time a region and municipality.

²⁶ However, there is no obligation to plan services across sectors or to cooperate with health departments at the regional level. There are no guidelines on preparing plans including other public services financed or provided by state, region, or city councils.

²⁷ 'Léčebny dlouhodobě nemocných'. Other main providers of LTC are 'after-care hospitals' ('nemocnice následné péče'). However, after-care and LTC are provided through various services within the health care sector. More important than the name of the health care facility is the structure of the beds classified as after-care or LTC, among others, with different rates per day and per bed paid by health insurance companies.

2015a). There is thus continuing controversy between public health insurances and social care providers over the competencies of care homes and the financing for health care provided in care homes.

From an institutional perspective, the competencies for LTC at the national level are divided between the Ministry of Health and the Ministry of Labour and Social Affairs, and at the regional and local level, between regions, municipalities, health insurance companies, and families themselves (MoLSA 2015a). Institutional fragmentation, however, leads to considerable inequalities in the availability and quality of the care provided to clients with similar needs in health and social services. Moreover, there is no coordinated continuous transition between the provision of health and social care (MoLSA 2015a). The different development of health and social services controlled by two different ministries and systems of funding was identified as a key threat to ensuring seamless, efficient, and sustainable LTC (MoLSA Deloitte 2015). If no significant change occurs, the inefficient use of public resources can be expected to continue, and, consequently, the situation and health of users will gradually deteriorate (MoLSA 2015a).

Health care providers can register their provision of social services in their health facilities in line with the Social Services Act (no. 108/2006 Coll.). However, this legal provision is aimed at providing social services in the health care sector rather than integrating health and social care, which is what is needed (MoLSA 2015a). Moreover, hospitals, nursing homes, and psychiatric hospitals do not take the option to register as social services providers and continue to prolong hospitalization of people with complex interconnected health and social needs, even though this is unnecessary and costly for public insurance (MoLSA 2015a).

Main policy directions in long-term care

The main policy discussion with respect to long-term care, informal care and ageing issues in the Czech Republic is conducted in the field of ageing

and social services policies. The main strategic policy document for social services is the National Strategy of Development of Social Services 2016–2025 (MoLSA 2015a). The strategy was adopted by the government in March 2016.²⁸

The implementation Action Plan 2017–2018 was adopted in February 2017²⁹ (MoLSA 2017a). The strategy sets targets not only for informal care, but also for other issues connected to LTC, including among others the deinstitutionalization of social services, the cooperation of health and social services, and the work of social workers and social care workers in social services. The other key policy documents are strategies on ageing.

Policymakers first addressed issues related to population ageing in the early 2000s when the Ministry of Labour and Social Affairs prepared and published the first *National Programme of Preparation for Ageing 2003–2007*, which was further developed in the *National Programme of Preparation for Ageing 2007–2012* (MoLSA 2007).³⁰ In 2012, the third programme, the *National Plan for Positive Ageing for the period 2013–2017*, was adopted (and later amended in 2014) (MoLSA 2014). At present, the *National Strategy of the Preparation for Ageing 2018–2022* (MoLSA 2017d) is being prepared and should be submitted to the government by the end of 2017. The new strategy 2018–2022 proposes to establish LTC insurance as part of a public health insurance (or social insurance, LTC), similar to Germany and other European countries.³¹

The main goals of the current plan (2013–2017) are supporting active ageing, ensuring the human rights

²⁸ The Strategy was approved by Resolution no. 245 on 21 March 2016 (Národní strategie rozvoje sociálních služeb na období 2016–2025) (MoLSA 2015). www.mpsv.cz/cs/29623

²⁹ The Action Plan ('Akční plán rozvoje sociálních služeb na období let 2017 a 2018') was approved by Resolution no. 135 on 20 February 2017. www.mpsv.cz/cs/29620

³⁰ Available at <http://www.mpsv.cz/en/4539>

³¹ However, the discussion about new type of insurance on LTC has not progressed far and the issue has received little public attention to date.

of older people, strengthening national, regional, and local ageing policies, increasing access to lifelong learning and participation in the labour market, and promoting housing and public space which is designed to enable participation and inclusion in communities.

Among the key priorities listed in the plan is promoting healthy ageing and LTC services for older people and people with disabilities. The plan points to the need for:

- further developing affordable, high quality, and personalised LTC services and support adapted to the individual preferences of users;
- increasing the availability of services for people with dementia and other neurodegenerative diseases;
- interlacing social, health, and other services provided at home and supporting geriatric care and services, including timely and accessible health assessment;
- preparing the new act on social workers as a highly qualified independent profession; and
- supporting families in the provision of care and stimulating the use of assistive technologies enabling independent living, education, and participation in communities.

Activities within the programme are financed from national and international subsidies, including European Structural Funds (especially the European Social Fund – ESF), the Norwegian Fund, and the Programme of Swiss–Czech Cooperation.

It is worth noting that the plan envisages preparing several new bills, such as a bill on integrated LTC and a bill on social workers. These objectives are very ambitious given that the current system has been criticized for a lack of cooperation between the social and health sector, a lack of social workers and low support for informal carers, and the fact that the new interdepartmental bill on LTC has already been discussed, submitted, and rejected two years previously.

In 2010, the Ministry of Labour and Social Affairs set up an expert commission aimed at preparing new LTC regulations that would integrate existing services in the health and social system into a comprehensive network of services. The commission included representatives of the Ministry of Health and the Ministry of Labour and Social Affairs, insurance companies, and regional and local governments. The new system was supposed to be transparent, and integrated, and provide efficient care of good quality based on an interdisciplinary health assessment. An analytical report and a ‘white book’ on the key principles of LTC were published (Holmerová et al. 2010).³² The report defined LTC services across the social and health sectors, the goals of the LTC system, target groups, the role of informal carers, and an analysis of the costs related to the planned measures and reforms. In 2011, conferences³³ and meetings on the new system were organised and an extensive analysis of the key aspects of the LTC system was conducted. The analysis was commissioned by the Ministry of Labour and Social Affairs and financed from the ESF (MoLSA 2011).³⁴ However, after two years, work on the new regulation was abandoned, as the Government Legislative Council³⁵ rejected the draft of the legislative intention on LTC as redundant and recommended that the required changes be implemented through amendments to the existing social and health legislation (Wija & Holmerová 2016).

³² Holmerová et al. (2010). The Discussion Paper on the starting points for long-term care in the Czech Republic, Ministry of Labour and Social Affairs, Prague, 2010.

³³ One of the conferences is described in the Social Services Journal (časopis Sociální služby) issued by the Association of Social Services Providers. www.mpsv.cz/cs/10980

³⁴ The analysis has been realised mostly by experts from the Institute for Health Statistics (ÚZIS), the Ministry of Health, and external experts. All thematic analyses on specific issues are available on the website of the Ministry of Labour and Social Affairs at www.mpsv.cz/nahled/cs/10763

³⁵ The Council is an advisory body to the government on legislative issues. The Council is responsible for the quality of new legislative proposals. More information is available at <http://bit.ly/2oQ1iQg>

The main steering body of ‘ageing policy’ in the Czech Republic is the Government Council for Older Persons and Population Ageing.³⁶ The Council was established in 2006 at the Ministry of Labour and Social Affairs. The council is an interdepartmental body consisting of 24 members. It includes representatives of several ministries³⁷ (Ministry of Health, Ministry of Regional Development (housing), Ministry of Education, and Ministry of the Interior), representatives of the Association of Social Services Providers, employers and employees (‘social partners’), health insurance companies, representatives of regions, NGOs, seniors’ organizations, academia, and the Czech Statistical Office. The Council established four working groups on priority themes, which include the improvement of health and social services for older people and housing and residential social services (Křížová et al. 2010).

The chair of the council is the Minister of Labour and Social Affairs, according to the statute, and the role of the council secretariat is performed by the Ageing Policy Unit³⁸ of the Ministry. The unit administers (among others) two subsidy programmes aimed at the implementation of the plans and policies on ageing: the subsidy programme for local authorities and municipalities established in 2015³⁹ and the subsidy programme for seniors’ organizations established in 2012.⁴⁰

Another emerging policy issue is the shortage of health and social care workers in both sectors,

especially nurses and direct care workers. Their job is very demanding while salaries are very low. Residential, ambulant and home social services have difficulty filling vacancies. There is a considerable staff turnover and workers often prefer employment in supermarkets or factories where low-qualified work is better paid.

The challenge has become urgent during recent years. In reaction to the decreased supply of nurses, the government has proposed to lower the qualification criteria and shorten the education period for nurses to bring more workers into hospitals and LTC services. The legislative proposal to change the education system, called 4+1,⁴¹ has been approved by the government and house of representatives (lower chamber of Parliament), despite protests by nurses who claimed that tertiary education is necessary to ensure quality of care. The organizations representing nurses argued that the main reasons for the current shortage are low salaries⁴² and overburdened staff in health and social care services, especially in hospitals. The issue of care worker shortages also shed more light on support for informal carers and ‘sharing’ care between formal and informal carers.

The shortage of workers is also discussed in the context of an ageing and shrinking workforce, with a focus on specific professions (i.e. general practitioners and nurses, among others), and in connection with the outflow of nurses and carers to neighbouring (mostly German-speaking) countries and to other Western higher-income countries. The migration of doctors and nurses is frequently used

³⁶ The Council is a permanent advisory body to the Government of the Czech Republic on issues related to ageing and older persons. More information is available at www.mpsv.cz/en/4538

³⁷ The list of members of the Council is available at www.mpsv.cz/cs/2866

³⁸ The unit deals specifically with ‘ageing issues’ and is part of the Department for Family and Ageing Policy of the Ministry of Labour and Social Affairs. The organisational structure of the Ministry is available at www.mpsv.cz/cs/1856

³⁹ The programme aims to support local authorities in ageing policies. Available at www.mpsv.cz/cs/27262

⁴⁰ The programme aims to support seniors’ organisations ‘beneficiary public activities’. More information is available at www.mpsv.cz/cs/12600

⁴¹ The 4+1 system aims to change the education system for the qualification of nurses, to require only four years of study at a secondary school for practical nurses (formerly health assistants) and a further one year of study at higher professional schools (HPS) for general nurses. Graduates receive non-academic degrees (an associate degree, ‘specialist with diploma’, DiS). Currently, an associate degree can be awarded only after three years’ study. At present, nurses qualify through bachelors and masters university or college programmes. More information is available at www.osetrovatelstvi.info/info/co-znamena-system-41

⁴² There are significant differences in the salaries of nurses employed in public and private hospitals as well as between nurses working in social or health LTC facilities.

as an argument in the debate on increasing salaries. The providers and the government seek to attract workers from foreign countries, especially from Ukraine, Slovakia and other post-Soviet countries. The ILO points out that an increasing number of care workers migrating from Central and Eastern European (CEE) countries will further restrict the potential supply of carers in these countries (Hirose & Czepulis-Rutkowska 2016). The Ministry of Labour and Social Affairs anticipates in the social services strategy that the pool of potential informal carers may decrease in line with the increasing proportion of older people (MoLSA 2015a). The ILO argues that there is lack of formal LTC services in the Czech Republic and other CEE countries, both residential and home, and that the availability of formal care services needs to be extended in the CEE region (Hirose & Czepulis-Rutkowska 2016).

According to the ILO, LTC systems in post-socialist countries are still influenced by an orientation towards the institutional care of the past (Hirose & Czepulis-Rutkowska 2016). There were about 53,000 residential care places in 2015,⁴³ which corresponds to about 16% of care allowance beneficiaries and to more than two-thirds (68%) of the total capacity of residential social services, including asylums, sheltered housing, or hostels for homeless people.⁴⁴ About 10% of care home residents do not receive a care allowance, implying that their self-care capacity is not decreased and that they would be able to live at home. Despite the increase in residential care places, the number of people asking for placement in homes for older people is about two times higher than the total capacity.⁴⁵ The seniors' houses providing rented

barrier-free apartments (board and accommodation) with domiciliary care ('houses with domiciliary care') have been removed from the Social Services Act and ceased to be a specific type of social service, according to the Act. At present, houses for seniors with domiciliary care fall under the competency of the Ministry for Regional Development, which is responsible for housing policy in the Czech Republic. The municipalities (city councils) – specifically, their 'Social Commissions' – decide on the eligibility criteria and allocation of the barrier-free rental flats in the houses to the claimants. The houses are usually owned by the municipalities. They allocate the flats based on the current health condition of the claimant and the level of urgency.⁴⁶ Disagreement over the amendment of the Social Services Act (108/2006 Coll.), which removed senior housing from the system of social services, led, *inter alia*, to the establishment of the Association of Boarding-Houses for Seniors at the end of 2014. The NGO argues that there are growing problems in residential social care for older people, and especially a lack of accommodation for people who need round-the-clock supervision and support.⁴⁷ It is clear that adequate housing for seniors plays a key role in lowering the demand for residential LTC, group housing, and assisted living facilities.

The main goal of the Social Services Act is to support independent living in the 'natural environment' (ordinary housing integrated in the community), to support social inclusion and prevent social exclusion. However, this did not happen for many older people, as the amount of residential services has increased substantially over the past few years, while home-based services for older people have been stagnating. There are also

⁴³ There are nearly 13,000 beds (places) in homes for persons with disabilities. In total, there were more than 1,500 residential facilities providing social services with a capacity of 78,502 places (beds) and 73,415 users in 2015 (MoLSA 2016a).

⁴⁴ Calculated from data of the Ministry of Labour and Social Affairs (MoLSA 2016a).

⁴⁵ However, the data cannot be viewed as demand for institutional care. Some people ask for 'placement' in care home several years in advance, making several applications to different residential homes. The homes for seniors are considered by some people as 'senior housing'. The boundaries between small

rental apartments, assisted living homes, and nursing homes are blurred and more information would be needed to prevent unnecessary 'institutionalization', unmet expectations, or wrong consumer housing market decisions.

⁴⁶ The eligibility criteria are set by the local municipality (city council) and can differ between municipalities.

⁴⁷ Source: Association of Social Services Providers of the Czech Republic (APPS ČR). More information about the association is available at www.appscr.cz/vize-appscr.html

economic and financial barriers to the higher uptake of home services, both for people in need of care as well as providers and commissioners (payers).⁴⁸

Generally, if more intensive daily care needs to be provided at home, for example by a personal assistant or nurse, it is more costly for users than residential care. More intensive home care services are less widely available than residential services and they need to be provided together with some level of informal support. Furthermore, there are no economic incentives either for the providers or for the users to seek the preferable home-based and community-oriented services instead of residential care.

A review of 73 studies of deinstitutionalization and community living carried out in the mid- 1990s showed that community-based services appeared to be the best option offering better outcomes in terms of quality of life for people with disabilities than institutions (European Commission 2009).⁴⁹ It seems there is minimal support for the deinstitutionalization of LTC and housing for older people compared to people with disabilities.⁵⁰

What is important is that community-based services are better not only for users, but also for professionals working with people in need of LTC (European Commission 2009). The dignity and quality of life of both the people receiving and

providing formal or informal care should be the most important criteria for a sustainable model of LTC.

Irrespective of the lack of community LTC services, home care is the preferred option for most people and the recipients of the care allowance in the Czech Republic. According to the Czech NGO ‘Cesta domů’ (‘Homecoming’),⁵¹ more than three-quarters of health professionals believe that it is possible to provide good care at home until the end of life, given that there is a specialised mobile hospice team, including a medical doctor, available (Cesta domů 2011). Four out of five people (78%) wish to die at home. Only one in eight respondents believed they would not provide care for their closest relatives at home until the end of life (Cesta domů 2011). Older people aged 80 and above with worsened health are more attached to their homes compared to people aged 70-80 and wish to stay at home until the end of life. If the respondent or their family member owns where they live, 95% of them wish to stay. If they are not owners of their housing, only 84% express their wish to stay in their current housing (Vidovičová et al. 2012).

Dependency prevention policy

The population of the Czech Republic is ageing rapidly. The proportion of the population aged 65-79 was slightly above the European Union (EU-28) average (13.9% compared to 13.4%) in 2015. The proportion of the oldest old (80+) in the population accounted for 4.0% in 2015 and was below the EU-28 average of 5.4%. Given the low birth rates and increase in longevity, the share of older people (65+) in the Czech population is foreseen to increase to 28.6% by 2060. At the same time, the proportion of the oldest old is foreseen to almost triple (11.4%) in the next 45 years. According to the population forecast, demographic ageing in the Czech Republic will be accelerated by the transition of the cohorts born in the 1940s and 1950s over the next decades and will be faster than in other European countries

⁴⁸ The commissioners responsible for the availability of social services are mostly regional and local governments. Only 1% of the total capacity of residential, semi-residential, or day-care social services has been provided by facilities founded and commissioned by the state in 2015, 838 out of 78,502 places or beds (MoLSA 2016c).

⁴⁹ The Report of the Ad Hoc Expert Group on Transition from Institutional to Community-based Care (European Commission 2009). Available at www.trass.cz/archive_2015/files/8-document3.pdf

⁵⁰ Although organizations of people with disabilities call for deinstitutionalization and it is supported through European funds, people with disabilities are still institutionalized. The Czech Republic was among the first signatories of the UN Convention on the Rights of Persons with Disabilities (CRPD) and its Optional Protocol, on 30 March 2007. The process of ratification of the Convention, but not the Optional Protocol, was completed in 2009. The Convention entered into force on 28 October 2009.

⁵¹ ‘Cesta domů’ is an NGO advocating the provision of palliative care at home.

(Burcin & Kučera 2010).⁵² An increasing number of the oldest-old seniors with a higher risk of frailty and disability will lead to a rising demand for both formal and informal LTC (Wija 2015).

Between 1990 and 2000, life expectancy increased rapidly, especially for men: by 4.1 years compared to 2.9 for women. The increase continued in the next decade but at a slower pace, 2.7 years for men and 2.3 for women (Wija 2015). More than half of the population aged 65+ suffers from chronic conditions. The major health problems of the older population include cardiovascular system diseases (especially hypertension), arthritis, chronic headaches, and allergies. Diabetes is becoming an important health problem, with a prevalence in the total population above the Organisation for Economic Cooperation and Development (OECD) average (8% compared to 6.9%, in 2013) (OECD 2014). The main behavioural risk factors of ill health, functional impairments, and dependency are high alcohol consumption, high tobacco use, and obesity.

The main document shaping public health activities is the Public Health Act (258/2000).⁵³ Its aims include health protection and the promotion of healthy living for the Czech population. Older people became a specific target of public health policy in 2004, when a grant programme entitled the Healthy Ageing Project was launched. However, the age-specific focus was abandoned after only three years (Křížová et al. 2007). At the time of writing, public health policy towards older people is shaped by two main documents: the *Health 2020 – National Strategy for Health Protection, Promotion, and Disease Prevention* and the *National Plan for Positive Ageing for the Period 2013–2017*. The first sets the overall policy directions in health promotion and prevention, including for older people. The second, prepared during a process of social consultations coordinated by the Ministry of Labour

and Social Affairs, points to healthy ageing as one of the policy targets. Dependency prevention in older age is understood as undertaking activities promoting a healthy lifestyle and preventing diseases, and is perceived as a prerequisite for longer life, active ageing, and a high quality of life in its later stages.

Although the policy points to the need for integrating dependency prevention in social services practice and integrating medical and social services provided to older and dependent people, typically, social services are not directly linked to health promotion programmes or prevention activities. However, while provided by medical or care professionals, they can be combined with advice and support regarding a healthy lifestyle and recommendations for activities suitable for seniors and dependent people. The scope of such activities has not, however, been recognised.

Health promotion and dependency prevention activities are often implemented by non-governmental institutions operating at the community level, in cooperation with services providers and residential care facilities. These projects typically gain financial support from the National Institute of Public Health, Ministry of Health, local governments, ESF, and other, often international, sources. Examples of dependency prevention programmes implemented include the activities of Gerontocentrum (GEMA – the centre for health support) located in Prague. Their projects include organising dancing therapy for seniors living in residential care homes (aimed at improving their quality of life, strengthening their physical capacities, supporting their mental health, and preventing cognitive decline),⁵⁴ organising memory training for seniors living in the community,⁵⁵ and providing information on different aspects of life in older age, peer support, and health education, among others.

⁵² Population Development Forecast of the Czech Republic for 2008–2070 (Prognóza populačního vývoje České republiky, 2008–2070). Available at www.mpsv.cz/cs/8838

⁵³ Act no. 258/2000 Coll., on Protection of Public Health. Available at www.zakonyprolidi.cz/cs/2000-258

⁵⁴ www.starnout-je-normalni.cz/index.php/gema/25-uvodniky/75-taneni-pro-senior-y-2016

⁵⁵ www.starnout-je-normalni.cz/index.php/gema/25-uvodniky/74-anglicky-jazyk-zai-2016

Informal care support

Informal care plays an important role in the sustainability of LTC (Börsch-Supan et al. 2013). It is often the only alternative for older people living in rural areas due to the unavailability of adequate professional care. The issue of informal care has been gaining importance on the policy agenda together with raising awareness of the inadequacy of formal LTC services and the rapidly increasing demand for care.

Support for informal care is considered an integral part of the LTC system and the key policy direction for ensuring the availability and sustainability of LTC (MoLSA 2015a). Another reason for the increased policy interest in support of informal care is a shift towards community services and an emphasis on the deinstitutionalization of LTC services (MoLSA 2015a). The demand for home care solutions and for support of 'ageing in place' is growing, and informal care is seen as an important source of support for independent living and the process of deinstitutionalization (Geissler 2016). The strategic support of formal community services and of informal carers can also curb the increasing demand for institutional care. Civic society organizations and academia play crucial role in increasing the awareness of family care-related issues and the needs of informal carers through advocating for better conditions for carers and informing the public policy agenda.⁵⁶

There is growing emphasis on support of informal carers in social services and on improving the availability of respite services and counselling, and the coordination and management of care (Průša 2016). Informal carers consider respite services the

most helpful way of supporting carers and would like to have better access to respite care in communities (Geissler 2015). However, respite services are often unavailable in the Czech Republic. Among the reasons for the low availability of respite care, according to the providers, are the irregular use of respite services and economic uncertainty in planning. For example, if respite care beds are occupied for only six months a year or irregularly, the service is not financially self-sufficient. It is also difficult for providers to plan for the provision of respite care (Geissler 2015). Another big barrier to respite care is financial affordability for caring families. They are often (especially if they have to give up work to provide care, despite the care allowance) poor and cannot afford respite care. There is not enough awareness of the availability of respite services among caring families. The insufficient supply of this service is caused not only by lack of supply but also by low demand (Geissler 2015).

There were more than 349,000 care allowance recipients requiring some level of support and care in February 2017 (MoLSA 2017c). More than three-quarters of them receive informal care or informal care combined with social services. It has been estimated that there are about 250,000 informal carers in the Czech Republic who provide informal care to a close relative.

According to a sociological survey (Jeřábek et al. 2013), there are about 120,000 'caring families' providing some level of support in the Czech Republic and about 80,000 family carers, who provide care on a daily basis. The main motivation for family carers is to accompany and care for close relatives until the end of life. Carers also express concerns about the quality and safety of institutional care (Jeřábek et al. 2013).

About 18% of men and 28% women (23% in total) provide regular support and care to a frail older family member (Klímová Chaloupková 2013). Women provide more intensive care in terms of time consumption than men: 42% of women and 25% of men provided care for more than 72 hours per week.

⁵⁶ Among the most visible examples are the Diaconia of Evangelical Church of Czech Brethren (ECCB) project 'Care at home' ('Pečuj doma') providing services, training courses, and a helpline for informal carers; 'Cesta domů' ('the Homecoming'), which advocates palliative care provided at home; the NGO 'Life 90' ('Život 90'), which provides home and remote emergency support to seniors and their families; and the Czech Alzheimer Society, which provides counselling, education courses, peer social support groups, and dementia cafés.

Women also leave their jobs and are unemployed due to caring for another person more often than men. Men also more frequently mention lack of time among the barriers to care: 17% compared to 10% of women (Geissler 2016). About 31% of people believe they would provide care to their parents or grandparents in a situation of dependency on care, while 35% prefer the provision of formal home care services and 25% opt for residential care in a care home.

Only 9% of respondents would use day care services such as respite care or day care, among others (MoLSA Deloitte 2015). A lack of information and the high costs of formal LTC services, especially for those in need of daily, more intensive care provided at home, are among the key barriers for carers to access and benefit from professional help (Geissler 2015). The maximum price for social services is set by law, and should not thus be unreasonably high. At the same time, providers of social services are often struggling to survive economically. The problem is thus rather the ratio between the cost of the services and the low disposable income of the target groups to which they are assigned.

The other obstacle to providing informal care is fear of a negative impact of caring on the care recipient due to lack of knowledge or skills. The barriers to providing informal care thus are not only 'objective', but also 'subjective'. However, the objective factors such as excessive burden on the family, lack of finances, etc. are significant and it would not be right to ignore them (Geissler 2015).

To support the financial stability and availability of social services, the government approved several amendments of the Social Services Act in March 2017, one of which moved the financing of social services into mandatory spending.

The government also proposed to increase the amount of the care allowance for people with the fourth degree of 'dependency on care' ('total dependency') who receive informal care in their homes from the current 13,200 CZK to 19,200 CZK.

The aim of the amendment was to increase support for informal carers and to encourage the provision of informal care in the natural environment, at home. However, the amendment has not been approved by the Parliament. This was the first time since the introduction of the care allowance in 2006 (the act came into force in 2007), that informal carers and care at home have been specifically encouraged and preferred in the system of social services and given priority as compared to other forms of care. Informal carers were also, for the first time, explicitly included among the recipients of social services. However, the Czech formal LTC system, especially for seniors, still does not adequately support home and community care and remains biased towards residential care (Hirose & Czepulis-Rutkowska 2016).

Expert discussion about the impact of the care allowance on the social services system has been ongoing since the adoption of the Social Services Act in 2006. It was expected then that the allowance would encourage the development of new services, especially community and home-based services, and increase the flow of money into formal social services, thus improving their financial situation. However, the majority of recipients do not receive professional, formal services, but instead use the allowance to pay for informal care.

Some experts proposed to introduce an in-kind care allowance (paid with vouchers) (Průša 2013). According to the ILO, a proposal to replace cash benefits with service vouchers was being discussed both in the Czech Republic and in Poland. (Hirose & Czepulis-Rutkowska 2016). The authors argue that there are limited options for incentivising the recipients of the care allowance to spend it on formal care services while assuring their freedom of choice (Hirose & Czepulis-Rutkowska 2016). This debate lasted for several years in both Poland and the Czech Republic; however, as it did not gain broader support, it was dropped.

Nevertheless, intensive daily care provided by formal long-term services at home is often more costly for older or disabled people than payments for residential care. The care allowance is not

enough to pay for all the necessary services provided at home. Families prefer to put the money into the common budget than use the allowance towards professional help, when it would only pay for part of the necessary help and not enough hours for the caregiver to remain in paid employment. For example, care provided by a ‘personal assistant’ is not affordable for many people. This also explains why people receiving the care allowance turned their backs on the formal care system and why the majority of care allowance beneficiaries and their families prefer using it for informal care – under such conditions it is rational choice to keep the care allowance in the family. It can thus be considered a legitimate option (Bareš et al. 2012).

Although the care allowance is used largely for family care, it is not designed to compensate for carers’ loss of income. The person entitled to a care allowance is the person in need of care, not family caregivers. There is no direct entitlement for the informal carer to receive a care allowance, and Czech social legislation includes no other financial benefit designated for family carers (Koldinska 2016). However, the care allowance recipient is obliged to state who will provide care – the social service provider or the names of family carers. In the case that the care is provided by family members, the allowance is perceived as a reward. Some experts suggest that informal carers could be supported more directly by the introduction of a new direct financial benefit⁵⁷, which could be provided in combination with either a reduced care allowance or with the full amount of the allowance (Koldinska 2016). There are also indirect financial benefits in the form of tax reliefs. However, such tax credits (for example, the spouse tax credit or the child tax credit) are not aimed specifically or exclusively at informal

carers of family members (Jahoda et al. 2016).

Informal carers can receive unemployment or sickness benefits while being paid using a care allowance, as it is not considered income according to the social system and the benefit is not means-tested (Průša 2013). Conversely, an unemployed person receiving assistance in material needs (‘living allowance’) and providing informal care to a person with a second to fourth degree of ‘dependency’ receives a higher amount of the ‘living allowance’.⁵⁸

The benefits for carers may continue to be financed by tax revenues or by new insurance on LTC. The possibility of introducing a new law on informal care could be also considered (Koldinska 2016).

Informal care has recently been highlighted in several policy documents:

- the *National Family Policy* (MoLSA 2016b)
- the *National Strategy for the Development of Social Services 2016–2025* (MoLSA 2015a)⁵⁹
- the draft of the *National Strategy of Preparation for Ageing 2018–2022* (MoLSA 2017d)⁶⁰

The *National Family Policy*⁶¹ was prepared by the Expert Commission on Family Policy, which was established in 2015,⁶² ten years after the adoption of the previous family policy in October 2005.⁶³ The

⁵⁸ The amount of the ‘living allowance’ is derived from the amount of the ‘existence minimum’ and ‘subsistence minimum’. The existence minimum is lower than the subsistence minimum and cannot be applied to some vulnerable groups, such as seniors or family carers. The System of Assistance in Material Need is regulated by Act no. 111/2006 Coll. See MoLSA 2017e for more information on the Czech system of assistance in material need (in English).

⁵⁹ Approved on 21 March 2016.

⁶⁰ According to Resolution no. 218 on 30 March 2015, the Minister of Labour and Social Affairs shall submit to the government the new ‘comprehensive framework strategy on ageing’ by 31 December 2017.

⁶¹ The draft of the family policy (version of November 2016) is available online: <http://bit.ly/2oFKJ9D>

⁶² The commission was established by the Minister of Labour and Social Affairs, who also chairs the commission. More information is available at www.mpsv.cz/cs/21022

⁵⁷ Care allowance replaced an allowance for the carer of relative or other person. This strengthened the autonomy and rights of care-dependent people, but at the same time significantly weakened the position of family carers. They have lost direct financial appreciation from public sources and at the same time a demeaning debate whether it is legitimate to use the care allowance for the needs of the caregiver instead of paying for social services was opened. However, the issue of financial reimbursement of family carers has been gaining attention.

consultation process on the new family policy included roundtables of interested experts, institutions, NGOs, and other stakeholders, who discussed its key priorities and measures. However, the government postponed approval of the new family policy due to coalition controversies over the definition of family and some of the proposed measures. Eventually, the policy has been approved by the Government, despite the opposition of Christian Democrats.⁶⁴

The new family policy deals with the issue of informal care in relation to work-life balance, labour market participation, and gender equality. It places an emphasis on improving the income situation and availability of respite services to informal carers (MoLSA 2016b). It underlines the role of informal carers in the LTC system and the impact of family care on the caregiver (MoLSA 2016b).

Although the National Family Policy has not been adopted as of the writing of this report (April 2017), the process of preparing the document has led to the proposal and approval of legislative measures formulated by the Expert Commission in support of informal and family carers. A carer's leave and a new contributory cash benefit – 'long-term nursing allowance' – paid from sickness insurance have already been approved by the Parliament in September 2017. An insured person will be entitled to carer's leave and the new long-term nursing allowance if they need to care for a close person who has been hospitalised due to a worsened health condition or accident. An employee's care leave is dependent of the agreement of the employer, a condition which was added to the proposal during the approval process at the request

of one of the coalition parties.⁶⁵

The National Family Policy contains the following measures in support of informal carers (MoLSA 2016b):

- Introduction of a 'carer's leave'. According to the proposed amendment of the Act on Sickness Insurance, a person who cares for a relative(s) discharged from the hospital can draw up to 60% of their salary for a period of up to three months.
- Preparation of a comprehensive longer-term policy in support of carers, including improving income protection and their position in the labour market. Support for carers through social services and education and training is to be included in the proposed policy on informal carers.
- Introduction of a pilot programme of 'household help services', to be carried out by authorised providers. The measure is expected to decrease the 'grey economy' and stimulate local employment in the care sector. The proposal is based on the easily transferable system of vouchers used in Belgium (MoLSA 2016b). The rationale behind this proposal is to allow families to spend more time together.
- Drafting of a bill on 'adaptation to demographic changes' with the aim of streamlining ageing-related policies and coordinate them better.
- Introduction of a new subsidy programme with the allocation of billions of Czech crowns per year to support municipalities in the construction and renovation of buildings in order to offer small rental apartments to families with young children and seniors.

⁶³ The Family Policy of 2005 was complemented by the Action Plan for the Period of 2006–2009.

⁶⁴ The Christian Democrats did not approve of the definition of family in the new policy, which includes among families single parents, two partners without children, and gay or lesbian partners, among others. The Christian Democrats preferred a tax deduction before increasing child care allowances and did not agree with some proposed measures, for example, abolishing the condition of partner approval in assisted reproduction.

⁶⁵ The measure was originally proposed as a right of the employee, but the approved version envisages that the employer would have to agree with the leave. Working culture in the Czech Republic is not very family-friendly, and sceptics predict that in practice the implementation of the measure will be negatively affected by the reluctance of employers to support it. Moreover, there is risk that due to the nearness of general elections, the proposal will not be passed by the current Parliament and new Government and Chamber of Deputies may drop the bill.

Another policy document dealing with the issue of informal care is the *National Strategy for the Development of Social Services 2016–2025* (MoLSA 2015a). The strategy considers unpaid informal care to be an ‘exceptionally important part of the LTC system’, estimating that there are up to 300,000 informal carers, and recognises the low level of support available for them in the Czech Republic (MoLSA 2015a). According to the document, there is a lack of cooperation between formal and informal carers and flexible working conditions are not offered to carers.

Care allowance recipients comprise 3% of the total population, while only a quarter (26%) of them uses a registered social service, which amounted to 83,000 people in 2011.⁶⁶

The strategy sets a goal to increase and coordinate support for informal carers by public services. One option to support of carers is to introduce a position of ‘support coordinator’, a social worker or community nurse whose main task is to help people with a reduced self-care capacity and carers to obtain the appropriate help and support (services, benefits and aids, among others) by providing them with advice, counselling, and guidance.⁶⁷ They should provide support to people in need of care or to carers at the beginning of care provision or in a time of crisis or acute problems with health or otherwise, connect different providers, and mediate communication between the carer and relevant services and authorities, among others. Another objective of the strategy is to increase support for informal carers at the regional and local levels and to integrate the views of informal carers into strategic regional documents (MoLSA 2015a).

The *Action Plan on the Development of Social Services 2017–2018* sets the following measures in

support of informal carers (MoLSA 2017a):

- To improve support of carers at the local level through social workers and labour offices.⁶⁸ The aim of the measure is to support carers by increasing the availability of social workers in the communities. The social workers should provide counselling to carers, prevent social exclusion and isolation, and prevent the overburden of informal carers.
- To increase the number of social workers employed by municipalities which have been cooperating with the Ministry of Labour and Social Affairs on the project aimed at supporting social work at the local level. The Ministry expects that the measure will increase the number of social workers employed by the municipalities by about 45,000. The costs of their education and remuneration will be paid by the Ministry for a period of two years;
- To develop a sustainable subsidy programme or other method of financing of social workers that will ensure sufficient numbers of social workers in the municipalities and labour offices; and
- To specify and expand the competencies of municipal authorities in the provision of social services and social work and to provide guidance to municipalities in this area. The measure is expected to increase the local availability of social work.

The *National Strategy of Preparation for Ageing 2018–2022* (MoLSA 2017d),⁶⁹ to be approved by the government by the end of 2017, includes, as compared to previous years, a chapter specifically addressing the issue of informal care which sets out a goal to ‘ensure adequate comprehensive support

⁶⁶ Latest available data.

⁶⁷ It is obvious that better coordination of care and individual counselling at the local level in the Czech Republic is lacking. The discussion of both positions, the competencies performed and the possible way of financing again confirms the existing lack of coordination and agreement between health and social sectors and departmentalism in long-term care policy.

⁶⁸ Social workers employed by labour offices must visit every claimant of a care allowance in their homes or at the hospital to determine their capacity level for self-care and their social situation.

⁶⁹ According to Resolution no. 218 of 30 March 2015, the Minister of Labour and Social Affairs shall submit to the government the new ‘comprehensive framework strategy on ageing’ by 31 December 2017.

for informal carers'. The strategy proposes the following measures in support of informal carers:

- To create a subsidy programme for informal carers to support the availability of medical aids, education and training courses, and other kinds of help for carers;
- To improve the availability and quality of informal LTC in the Czech Republic by supporting counselling focused on family carers, free training programmes, respite care services (in residential, day care, and home care services), and other forms of assistance; and
- To create quality short courses, e-learning, and other new tools that will strengthen cooperation between informal carers and professionals.

According to the *National Programme of Preparation for Ageing 2007–2012* (MoLSA 2007), education and support for informal carers is one of the most effective investments within LTC and the care of seniors in general, increasing their productivity and improving the outcomes of care leading to decreased spending on health and the social system and a lower incidence of health complications. Therefore, family members taking care of seniors should be offered maximum support in the form of education, psychological counselling, and facilitation services, including the necessary financial support, taking into account their situation in the labour market.

Information systems and use of new technologies

The issue of information and communications technology (ICT) has become an essential topic in the health and LTC policy debate. The use of ICT-based services and solutions has become synonymous with innovation. It is often presented as a panacea for all ills. Awareness of ICT possibilities has been increasing in both the private and public sectors, as well as in academia (research sector) and NGOs (providers of services). The use of ICT in the health and social sectors has gained increased

relevance and attention in relation to EU initiatives and programmes: for example, Horizon 2020, which highlights personalised care, e-health, and e-care, among others; the ESF, which has a focus on social innovations, efficiency, and e-inclusion; and the Ambient Assisted Living (AAL) programme.

The following benefits of ICT in the social and health sectors can be identified:

- increasing the safety of patients by avoiding duplications, omissions and polypharmacy, among others
- reducing the length of hospitalization, frequency of outpatient visits, and readmissions to hospital
- lowering the administrative burden for health and care workers
- compensating for the shortage of workers in health and LTC
- sharing information within and between the health and social sectors and between agencies and professionals (at the micro, meso, and macro levels)
- increasing economic efficiency and effectiveness in the health and social sectors
- improving integration between social and health services, including the integration of care and housing ('smart housing')
- supporting the safety of older people and people with disabilities living at home as well as in institutions
- improving the availability of information to the public, providers, and policymakers and increasing the availability of evidence and data for planning and evaluation
- increasing transparency in the social and health sectors (open data, interdepartmental and multi-sectoral platforms, public control, and the availability of data for policy-oriented research)
- empowering patients and promoting a person-centred approach
- supporting horizontal and vertical cooperation –

specifically, cooperation between different levels of government (national, regional, and local) and between social, health, housing, education, transport, and other sectors

- improving social support and social contacts to prevent the social exclusion of carers and people in need of LTC.

The main policy documents dealing with the use of ICT in LTC are the *National Plan for Positive Ageing for the period 2013–2017* (MoLSA 2014)⁷⁰ and the *National Strategy of Preparation for Ageing 2018–2022* (MoLSA 2017d).⁷¹ Both documents consider the potential of ICT for improving the quality of life of seniors and their inclusion in society an important theme and priority. The issue of ICT in relation to ageing policy includes the development and support of assistive technologies, increasing digital skills, and the use of ICT in the health and social sectors. These issues have been discussed for almost ten years by the Government Council on Ageing and Seniors, which was established in 2006. Shortly after the installation of the council, the Working Group on Assisted Living and ICT was established.⁷² In 2010, the government approved the recommendation of the council to support the development of assistive technologies,⁷³ and in 2014, the Ministry of Labour and Social Affairs organised an expert meeting⁷⁴ on the integration of

ICT and assisted living into the National Plan on Ageing (MoLSA 2014).

The *National Plan for Positive Ageing 2013–2017* (MoLSA 2014)⁷⁵ sets as one of its priorities to increase the use of ICT in the social and health sectors and to increase the digital skills of older people. As of 2016, about 1.6 million people in the Czech Republic aged 16 or over had never used the internet, mostly people aged 65 and over, people with an elementary education, and unemployed people (CZSO 2017). In this year, 6.7 million inhabitants over 16 years (76.5% of the population) did use the internet, which represents an increase by 36 percentage points compared to 2006. According to the plan, ICT can partially compensate for the increasing pressure on public finances due to the increasing demand in health and social care (MoLSA 2014). The plan is a cross-sectional document setting the priorities for ageing-related policies. It has been monitored and updated approximately every two years during the implementation period.⁷⁶

Assistive technologies can improve the quality of life and independence of older people and help them to remain active at work or in the community. They can also provide substantial help to family carers and support seniors when they wish to remain at home despite a decreased self-care capacity and a reasonable level of risk (MoLSA 2014).

The plan sets the strategic objective of developing a range of health and social services to meet different needs and specific life situations. One of the goals is to ‘support the development of ICT-based services and assisted living services for older people in the Czech Republic’.

To meet these goals, the plan for the period of 2013–2017 set the following measures related to the use of ICT:

⁷⁰ More information about the plan, activities, and the situation in the Czech Republic can be found in the bilingual publication *Ageing Policy in the Czech Republic 2015* (Vidovičová & Khýrová 2015).

⁷¹ According to Resolution no. 218 on 30 March 2015, the Minister of Labour and Social Affairs shall submit the new ‘comprehensive framework strategy on ageing’ to the government by 31 December 2017.

⁷² The working groups consist of the members of the council as well as external experts. The working groups’ topics and focus has been changing in line with the policy priorities and interests of the members. Information on the focus of the working groups is available at www.mpsv.cz/cs/2867

⁷³ Resolution no. 536 on 12 July 2010 on the Government Council for Seniors and Ageing, the recommendation to adopt measures encouraging the development and implementation of technology and services for assisted living for seniors. Available at www.mpsv.cz/files/clanky/9218/uv100712_0536.pdf

⁷⁴ Presentations are available at www.mpsv.cz/cs/19592

⁷⁵ Updated version of December 2014.

⁷⁶ The reports on the implementation of the national plans on ageing are available at www.mpsv.cz/cs/2857

- to propose a plan of development of sustainable and efficient assisted living services for older people
- to implement Government Resolution no. 769 of 2011, on the council recommendation to adopt and implement the Policy of Assisted Living Technologies and Services for Seniors
- to adopt technical and organizational standards in ICT in the area of assistive technologies
- to encourage participation in international programmes supporting the development of assistive technologies for older people in cooperation with the government, academia, and the private sector, and to evaluate the progress made on an annual basis
- to seek the possibility for the Czech Republic to participate in the EU 'Active and Assisted Living Joint Programme – AAL 2', including considering co-financing from the Czech Government (MoLSA 2014).

However, not all these targets were achieved between 2013 and 2017. Although the Czech Republic has been considering joining the AAL programme since at least 2010, with discussions and continuous support from NGOs and experts⁷⁷, it is among the few EU countries that have yet to join.⁷⁸ This can be considered an important barrier to ICT and AAL development in the Czech Republic.

⁷⁷ The NGO Life 90 ('Život 90') has been steadily advocating for the AAL and assistive technologies, together with the Department of Cybernetics of the Faculty of Electrical Engineering at the Czech Technical University in Prague, which is a prominent research institution in the field of ICT and assistive technologies. Assistant Professor Lenka Lhotská, Ph.D has been involved in the projects coordinated by the Ministry of Labour and Social Affairs to integrate ICT technologies in support of older persons and introduce new technologies into the Czech Republic. More information on the Department of Cybernetics is available at <https://cyber.felk.cvut.cz>

⁷⁸ Currently, there are 24 countries involved in the programme, including Canada, the United Kingdom, Norway, Israel, and Romania. Among the countries that accessed the EU in 2004, Slovakia and the Baltic countries are also not members of the EU AAL programme. Available at www.aal-europe.eu/our-projects.

The National Strategy of Preparation for Ageing 2018–2022 (draft) (MoLSA 2017d)⁷⁹ repeats the target to join the AAL programme, specifically under the objective 'to expand the use of assistive technologies in support of independent living for older people'. It proposes 'to discuss the possibility of involvement of the Czech Republic in the 'Active and Assisted Living Joint Programme – AAL 2' and its co-financing'. Alternatively, the government should 'seek to engage in another similar programme under Horizon 2020'. The strategy also specifies the term of AAL and the activities and services included in the definition and concept of AAL.

The strategy also sets out to 'ensure coordination of steps promoting the use of assistive living technologies in practice' and 'motivate health insurance companies to support assistive technologies'.

Another specific objective in the strategy is 'to eliminate barriers to the use of modern digital technologies among older people' specifically by 'supporting counselling through public subsidies aimed directly at increasing the use of digital technologies by older people'.

Between 2010 and 2015, the Ministry of Labour and Social Affairs realised a large project on 'processes in social services' financed from the ESF.⁸⁰ One of the activities included the analysis of assistive technologies.⁸¹ The activity refers to the concept of assistive technologies and inclusion services (ATIS). The goal was to assess the situation in the development and use of assistive technologies and to set up mechanisms for their use. One of the tasks of the project was to investigate the costs and prices of social services using assistive technologies (e.g. 'emergency care' – remote voice control) and

⁷⁹ To be approved by the end of 2017.

⁸⁰ Information about the 'Support of processes in social services' project and its activities and outputs is available at www.podporaprocessu.cz/projekt/aktivita-projektu

⁸¹ More information about the activity on assistive technology can be accessed at www.podporaprocessu.cz/aktivita13

to quantify the economic benefits and potential contribution of assistive technologies to the efficiency of informal care and social services, including a comparison with selected EU countries. The results were published in a report (MoLSA 2015b) that discusses the reasons for the low uptake⁸² of ‘emergency care’ (remote home support) in the Czech Republic. Emergency care (audio-visual distant support) was selected for economic analysis as ‘the only social service currently using assistive technologies to a large extent’ (MoLSA 2015b). The authors proposed in the analysis to introduce a new lump-sum contribution of CZK300–500 for people with the second and higher degree of dependency, or receiving a disability pension, to reduce the initial financial barrier for the uptake of the service.

In November 2016, the government approved the National Strategy for eHealth 2016–2020 (MH 2016)⁸³ and established a special website for e-health (www.nsez.cz). The strategy reacts to the uncoordinated digitalization of the health care system, and the digitalization of all sectors of society (MH 2016). The vision of the strategy is that e-health can substantially contribute to improving the accessibility and quality of health care across society and can support the greater involvement of citizens in health care, increasing their engagement in the care of their own health, and reorienting the health system towards the citizen (MH 2016). The strategy is expected to bring better cooperation between the social and health sectors and shorten administrative and assessment processes for all the contributory and non-contributory benefits provided on the basis of health or disability assessment (MH 2016).

⁸² Only 2,185 people used the service in 2015, according to the Statistical Yearbook of the Ministry of Labour and Social Affairs for 2015 (MoLSA 2016c).

⁸³ National Strategy for e-Health of the Czech Republic 2016–2020 was approved by Resolution no. 1054 on 28 November 2016. The Resolution asks the Minister of Health to submit the follow-up action plan by 31 March 2017 and to submit information on the implementation of strategic goals regularly on the 30 June every year, starting from 2017.

The Action Plan on Digitalization of Health System (MH 2015b)⁸⁴, one of the 13 plans (no. 11), has been adopted in the framework of Health 2020 – the National Strategy for Protection and Promotion of Health and Disease Prevention (MH 2014).⁸⁵ The plan is considered to be the first stage of the National Strategy for e-Health (MH 2016). It classifies the benefits of e-health by individual target groups or stakeholders, such as professionals, patients, and insurance companies, among others. Concerning patients, it should ensure easy and equal access to health services. Among the four strategic goals are ‘increasing the efficiency of the health system’ and ‘improving the quality and accessibility of health services’. Regarding families and patients, the plan should improve access and cooperation with health professionals and social service workers and minimise distress due to duplicated examinations (MH 2016). The overall objective of the plan is the development of support in the provision of health care services through the use of information technologies, which will lead to the increased availability, quality, safety, and efficiency of health care (MH 2016). Among the outputs of e-health should be comprehensive, transparent, and credible public information sources, for example, a portal administered by the Ministry of Health. It will, as a consequence, lead to a reduction in health risks and promote effective practices in the care of the chronically ill (MH 2016).

Generally, there is increasing pressure for ICT solutions and digitalization in the health and social sectors from both patients and providers (public and private), workers, and the general public (potential and future patients, clients, or relatives of people with long-term conditions or disabilities/frailty). The growing demand and support for digitalization comes from the broader tendency and pressure on implementing an e-government strategy, pressure

⁸⁴ The Action Plan on Digitalisation of the Health System is one of the action plans adopted in the framework of Health 2020 – National Strategy for the Protection and Promotion of Health and Disease Prevention. All action plans are available at <http://bit.ly/1YizOOj>

⁸⁵ Adopted by Resolution No. 23 on 8 January 2014).

on the effective use of public and private finances, and demand for a more friendly, timely, and responsive health care system. Generally, both the public (patients and clients) and providers of services are in favour of the digitalization of health and social services, given that digitalization is linked to easier and quicker access to services, saving of time, decreasing unnecessary tasks, and better comfort.

The issues of e-health, e-care, and assistive technologies are dealt with in the Czech Republic in the broader context of European and global trends. There is growing demand for more friendly, transparent, and accessible health and LTC services. However, due to the complexity of ICT and the variety of stakeholders, the gap between the potential and the practice of ICT use may increase. Moreover, ‘multi-speed’ digitalization may drive disparities within and between social and health services and their quality. Given the political instability and challenges in LTC, especially the scarcity of technicians and financial resources on one side, and the growing demand on the other side, a comprehensive and coordinated policy towards using the untapped potential of ICT in LTC remains a challenge.

Coordination of long-term care services

The issue of cooperation between health and social services is one of the key challenges in the Czech Republic’s long-term system (Kalvach et al. 2011; Holmerová et al. 2014). As mentioned, the Czech Republic has no single LTC scheme. There are two separate pieces of legislation on social and health services⁸⁶ with different personnel and quality standards and quality monitoring, and different processes of planning, financing, statistics, competencies of regional and local authorities, and working conditions. The disparities in the health and social systems lead to disconnections between the two systems and barriers for the continuity,

availability, and efficiency of care and services for older people with chronic conditions and LTC needs, especially for people with disabilities and geriatric frailty (Kalvach et al. 2011; Holmerová et al. 2014). According to the ILO, a coherent strategy for institutionalising and coordinating all types of providers of formal LTC services is required in the Czech Republic (Hirose & Czepulis-Rutkowska 2016).

The challenge of inter-sectoral cooperation has become more urgent with the increasing demand and expenditures on LTC. Several interdepartmental commissions have been established in last two decades to propose a better integration of LTC services. Currently, there are commissions on LTC both at the Ministry of Labour and Social Affairs and at the Ministry of Health. They have different tasks, structures, and goals, and are dealing mostly with issues in the health or social sector. To date, no interdepartmental policy document setting key principles and definitions and dealing with the integration and coordination of LTC across the two sectors has been approved. There are only departmental policy documents with different targets and perspectives on integrated LTC, and different opinions on the role of health or social services. The departmentalism and ‘departmental approach’ to financing and the provision of LTC has been criticised by experts for creating inefficiency and gaps in care provision (Kalvach et al. 2011; Holmerová et al. 2014).

The major challenges in the coordination of the LTC are as follows:

- Lack of coordination between the two sectors, meaning:
 - lack of transition procedure from health to social care
 - financial barriers (sectoral budgets)
- Preferences for specific (mostly health) LTC created by:
 - different eligibility criteria in both systems
 - different quality standards (or even their lack

⁸⁶ The Social Services Act and the Health Services Act (see list of legislation).

- in the social system) leading to poorer and non-monitored quality in social services
- different personnel requirements and working conditions (remuneration) between the public and private sectors
- different systems of financing
- uneven geographical distribution (supply) of care and disparities between urban and rural areas and inner peripheries and cores of regions
- lack of transparent data on quality of care, measures of effectiveness of care, and societal costs of LTC.

As a result the whole system is not very user-friendly. People in need of support and care come in contact with a large number of staff from different services and institutions, support is incomplete and unclear, searching for information is time consuming, different professionals make home visits, and dependent persons have to attend various services.

At present, the Act on Social Services does not define the term ‘long-term care’ and has only minimum provisions regarding cooperation between social and health services. Health care facilities are required to report to municipalities that a patient in need of social care services is to be discharged. Municipalities are also obliged to inform the health care provider when they have no capacity available to provide social care services. The municipalities are not obliged to plan social services; however, most of the 205 municipalities ‘with extended powers’ prepare their development plans for social services in cooperation with providers and representatives of users.

One of the major interdepartmental issues is the financing of health care provided in care homes. Care homes for seniors and people with disabilities provide nursing and rehabilitative care and employ health workers (nurses, physiotherapists, health assistants, and orderlies, among others), but find it difficult to reach agreements on health care financing with health insurance companies. Health

care provided to the clients in care homes is not fully covered by health insurance companies because of different systems of financing health care in residential services (care homes) and in health institutions for long-term patients (Průša 2013).

Municipalities should play a key role in ensuring integrated care for older people (Kalvach et al. 2014). There has been a process of devolution of social services in the Czech Republic with responsibilities for financing social services providers shifted to the regional authorities. There is high number of municipalities with small populations, limited personnel and limited financial capacity to deal with the issues of social services and formal LTC. The municipalities have a responsibility for social care and the regional governments and, especially, insurance companies have a responsibility for the availability of health care services (home health care, LTC facilities, and primary care, among others). Another source of challenges to the coordination of LTC is the division of competencies between labour offices, which are responsible for care allowances and for visiting claimants at home or in hospital to assess their level of needs for care, and the municipalities, which are responsible for the planning and delivery of services, social work, the monitoring of service needs, and communicating with health care facilities.

District or community nurses could play a key role in coordination (Kalvach et al. 2014). Their role would be to coordinate services and to support planning, monitoring, coordination of services, and sharing information among agencies and professionals. However, although there are qualified district nurses in the Czech Republic, no piece of legislation requires employing them. Municipalities, public health agencies, and providers are not obliged to employ community nurses, as compared to specializations such as physiotherapists, ergotherapists, nurses, or nutritionists, whose number per number of patients is stipulated by health legislation, depending on the hospital unit and target groups of patients.

Nevertheless, introducing the position of district nurses in the LTC system would improve the results of care and increase its efficiency. There is no specialized position dealing with both social and health needs defined or regulated by legislation.⁸⁷ According to international experience (for example, the UK), district nurses can lower the risk of institutionalization and reduce the costs and risks related to the hospital readmissions of frail seniors.

The introduction of either ‘community social and health workers’ or ‘coordinators of care and support’ for carers and people in need of LTC has been considered in the Czech Republic. They would provide timely help and support, counselling, and facilitate care coordination at the local level. An ongoing discussion of the possible tasks, competencies and financing of such health and social workers confirms the existing departmentalism and sectoral barriers to LTC between the Ministry of Labour and Social Affairs and the Ministry of Health.

A recent amendment of the Social Services Act was approved by the government in March 2017. It brought about some important changes in social services, which concern increasing the financial stability of social services, increasing the care allowance for the fourth degree of disability, and the introduction of a new service of palliative care into the social services system.⁸⁸

Among the specific provisions of the amendment were:

- The amount of the care allowance for the fourth degree of disability (‘total dependency on care’) has been increased for people receiving informal care at home from the current 13,200 CZK to 19,200 CZK. The aim of the measure was to support care provided by informal carers at home and in the community. For people who receive residential care, the amount of the allowance remains the same (13,200 CZK).
- To protect human rights and the freedoms of users, new duties of providers were introduced. In the event of a serious wrongdoing identified during the inspection of social services, the Ministry of Labour and Social Affairs will be entitled to close the facility.
- Establishing a minimum allocation of funds for subsidies for social services in order to increase the certainty of financing in the social services system and its stabilization.
- Introducing a new type of social services for the terminally ill, which will be provided in hospices as well as in the context of palliative care.
- Specifying the competencies of public authorities in the provision of social services, especially the activities of qualified social workers.

The Action Plan on Improving the Quality, Accessibility, and Effectiveness of After-care, Long-term Care, and Home Care (MH 2015a)

This is one of the 13 Action Plans adopted by the government in August 2015⁸⁹ as part of the implementation of the Health 2020 Strategy (MH 2014). The proposed measures are expected to be discussed further with the relevant stakeholders.

The action plan aims to address the following priorities (MH 2015a):

- continuous improvement of the quality of after-

⁸⁷ Although there are fields of study and study programmes called ‘social-health worker’ in different types of schools, and ‘health-social faculties’ at several universities, these professions and qualifications are not regulated by law. In practice, social workers are employed in health care facilities and, conversely, different health workers are employed by the providers of social services.

⁸⁸ Although there are about 16 hospices in the Czech Republic, until the amendments to the social and health services legislation, the hospices were not regulated by health legislation. Nevertheless, they were financed from health insurance and from social services budgets. The amendments made the facilities ‘official’ or ‘legal’. Resources provided to hospices are much higher than the budgets of care homes.

⁸⁹ The plans were adopted on 20 August 2015 by Resolution no. 671. Support for the action plans was also expressed by the Chamber of Deputies Committee on Health at its 23rd meeting held on 2 September 2015. The 13 action plans can be found on the Ministry of Health website at <http://bit.ly/2nOXFb5l>

care, LTC, and home care

- improving the availability of care in line with demographic developments
- increasing the efficiency of after-care, LTC, and home care services.

The plan speaks of 'post-acute care' as an umbrella term for 'after-care, LTC, and home care' (MH 2015a). It identifies the key problems of post-acute care as:

- disparities in levels of expertise in post-acute care
- demand for services exceeding the capacities of social and health services
- inadequate staffing and equipment
- inadequate investments in post-acute care with respect to needs
- a lack of incentives to improve quality and efficiency
- inadequate system of data collection and a lack of adequate indicators to measure the quality, impact and efficiency of care
- inadequate system of quality control and efficiency monitoring of specific post-acute care services.

According to the action plan, there is no joint agreement between the Ministry of Health and the Ministry of Labour and Social Affairs to ensure the provision and coordination of services between the health and social sectors. Similarly, there is no consensus on the definition of LTC between the Ministry of Health and the Ministry of Labour and Social Affairs (MH 2015a).

Furthermore, the action plan stipulates that it is necessary to increase the prestige of post-acute care and to improve its financing as compared to acute care (MH 2015a). Among the priorities for cooperation between the social and health sectors are personnel standards for long-term health and social care and adequate standards of health care in care homes (residential social services), where many

clients need skilled nursing and medical care similar to the care provided in health care facilities (MH 2015a).

The action plan also points out the following weaknesses in post-acute care:

- absence of a national policy on after-care, LTC, and home care
- inconsistent statistics and data collection methodology
- inadequate staffing, particularly a shortage of geriatricians due to the lack of education in post-acute care generally
- absence of a system of incentives for providers to improve quality of care
- system of financing significantly reduces the possibility of incentive programmes for employees
- inadequate technical and material equipment in post-acute care
- a lack of awareness about post-acute care among professionals and the public
- a lack of awareness about the scale of the challenge (i.e. future problems)
- insufficient cooperation with social services
- work overload and the subsequent loss of interest and 'burnout' of medical and non-medical workers.

[The National Strategy for the Development of Social Services 2016–2025](#)

The vision of the strategy is a 'flexible network of social services that helps address the needs of persons in adverse social situations which is financed in a transparent, effective, and fair way' (MoLSA 2015a). The global aim of the strategy is to develop a sustainable system of accessible social services and a system of support for informal carers in difficult social situations (MoLSA 2015a).

In 2017, the *Action Plan for the Strategy of Development of Social Services 2017–2018* was

approved (MoLSA 2017a). The plan includes the following measures related to LTC and to the coordination of and cooperation between social and health services:

- introduce a flat-rate payment for health care provided in residential services (care homes)
- introduce palliative and hospice care in the system of social services and health services (this measure has already been approved by the government in March 2017)
- define comprehensive rehabilitation services and draft legislation on comprehensive rehabilitation and its financing
- continue to cooperate with the Ministry of Health on the preparation of reforms of psychiatric care and prepare guidelines for the establishment of Centres for Mental Health.

The action plan includes the strategic goal 'Ensuring transition from the institutional model of care for people with disabilities to support provided in their natural environment'. The plan focuses on the deinstitutionalization of services for people with disabilities and will be financed from the ESF. It consists of the following activities:

- defining the basic concepts of community services in law
- creating a plan to support the transition from institutional to community care and support (i.e. the transformation of residential social services)
- supporting the regions, municipalities, and providers of social services in the process of the development and establishment of community-based services and in reducing the capacity of institutional (residential) social services ('homes for people with disabilities')
- providing guiding support in creating or modifying services to support persons with disabilities living at home
- preparing financial support from EU funds for deinstitutionalization and the prevention of institutionalization.

The National Strategy of Preparation for Ageing 2018–2022 (draft)⁹⁰ set the goal of creating a functioning system of long-term health and social care, including palliative care, which will provide seniors with quality, coordinated, and comprehensive health and social care (MoLSA 2017d).

To reach this goal, the strategy set out the following measures and objectives (MoLSA 2017d):

- to establish LTC insurance as a part of public health insurance, or within social insurance, according to the German model and based on experiences from other European countries
- to prepare a bill addressing the issue of LTC based on the outputs of the interdepartmental working group on the "Social and Health Interface";
- to ensure the sufficient supply of workers who will be able to meet the increasing demand for LTC, especially among the increasing numbers of people aged 80 and over; and
- to improve the coordination and integration of LTC services and to monitor access to LTC services.

Summary

The Social Services Act, adopted in 2006, introduced a new benefit into the social system, the care allowance, as well as other major social services reforms. Although very necessary, as shown by the number of care allowance recipients, the allowance did not lead to the development of a community-oriented model of services for older people. Formal care services are often unavailable, while the number of care allowance beneficiaries is rapidly increasing. Providers of social services are often struggling to survive economically.

The quality of the formal LTC system has substantially improved in recent years with investments in the life-long education of workers

⁹⁰ To be approved by the end of 2017.

and other initiatives. Residential capacities in social services have increased; however, the availability of health care and health staff in facilities such as homes for seniors remains a challenge (Wija 2015).

The present LTC system, split between the health and social systems, is perceived as inadequate and inefficient. Attempts to adopt new legislation dealing with integrated LTC have to date been unsuccessful, and consensus on the definition and role of key stakeholders has not been achieved. There are problems and tensions between the health and social systems when patients move from one system to the other. There are different financial conditions and direct payments in health and social care facilities for people with similar complex needs who require integrated health and social care, provided by a qualified and interdisciplinary team. Policymakers and experts are discussing the possible shape of an integrated LTC system. Even though work on new regulations has been undertaken over the last two years, results remain vague. Both ministries are addressing issues of 'long-term care' in their own departmental strategies without a shared vision and consensus on the key principles of an integrated LTC system. The inability of the fragmented system to provide seamless, continuous, and personalised tailored care leads to costly and uncoordinated services with unnecessary (re)hospitalizations, 'social hospitalizations', avoidable institutionalization, and decreasing access of social services users to qualified health and nursing care. It also has negative impact on the quality of life and health of people with chronic conditions, frailty, and complex care needs.

It is paradoxical that an integrative approach is emerging at the level of policy, while at the level of providers, health and social care remain separated. Attempts for a more precise definition of health and social care, including where one ends and the other begins, have proven, in practice, to be unrealistic and ineffective due to the large range of specific individual needs, and new measures should thus point to a different direction (MoLSA 2015a). Due to the nature and scope of LTC, which goes beyond a

system of social services or a health system, it is necessary that the solution involves both the Ministry of Labour and Social Affairs and the Ministry of Health, and includes representatives of health insurance companies and other stakeholders (MoLSA 2015a).

Older people with a decreased self-care capacity often have no other alternative than informal care without adequate support for informal carers, or institutional care. Support for informal carers has become the policy priority during recent years, and their role in LTC has been increasingly recognized. The new National Family Policy introduced several measures in support of carers. While there has been an increase in both the capacity and quality of residential care during the last decade, the current model of financing did not support the development of community services. It seems there is no will from the key stakeholders or political support to shift services for seniors to the community and towards more integrated care. It is evident that the number of people with complex health and social needs is only going to increase. The Czech Republic should concentrate on a comprehensive reform of the LTC system and respond to the increasing demand for integrated services provided in communities.

New technologies, if well coordinated, could become essential instruments for increasing the safety and availability of care at home, allowing older people to remain in their own environment with some level of formal or informal care and support. Nevertheless, the strategic shift towards community care and the integration of services would require strong political will and leadership to overcome the current stereotypes and barriers. The key stakeholders, especially the two departments responsible for the fragmented parts of the system, should thus agree on the key definitions and principles and adopt a joint strategy prepared with the cooperation of both departments. Without fulfilling these preconditions, the current challenges are unlikely to be met in the near future, while the demand for formal professional services will continue to increase.

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