4QUALITY

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Quality of jobs and services in the Personal care and Household Services sector in the Czech Republic

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CONTENTS

1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy and legal backgrounds

The Czech long-term care (LTC) covers a wide range of health and social services provided to dependent people[1], and the system philosophy is to provide care within the family in a home environment.

There is neither a unified LTC legal background nor any authority responsible for the LTC regulation. The Ministry of Health is responsible for home health-care and care provided in health institutions, the Ministry of Labour and Social Affairs is responsible for social services, and municipalities/regions are responsible for the planning of social services and for the availability of social personal and household services (PHS)[2]. Main legal regulations for the LTC services provision and funding are[3]:

- In the health sector (focused on services for disabled and long-term ill people): the general health insurance Act (1991, amended in 1997), the Act on the general health insurance funds (1992), the Act on departmental, professional, corporate, and other health insurance funds (1992), and the Law on private health care facilities (1992);
- In the social sector (focused on services provided to dependant and vulnerable people, including the older people: the Law on Social Services (2006) that controls provision of home care, access to cash benefits and different types of residential care;
- Next to these regulations, and on basis of the Law on the decentralisation of public administration from 2003, regional and local governments are also in charge of some segments of the LTC: emergency units, institutions of LTC and about half of hospitals.

In order to move its LTC system from an institutional care to the home care provision, the Czech policy supports the development of PHS services at local level, as well as allocates the care allowance, thus giving its dependent citizens the freedom of choice.

1.2. Structural framework, funding and actors involved

The responsibility for funding of LTC is divided between the Ministry of Health (for the health care

[1] Long-term care corresponds to a diversity of personal and household services (PHS) for dependent persons. In the present report, PHS are defined as services covering "a broad range of activities that contribute to well-being at home of families and individuals: child care, long term care for the elderly and for persons with disabilities, cleaning, remedial classes, home repairs, gardening, ICT support, etc." Source: European Commission, Staff Working Document on exploiting the employment potential of the personal and household services, SWD (2012) 95 final.

[2] OECD, Czech Republic long term care, in Help Wanted? Providing and Paying for Long-Term Care, 2011.

[3] Sowa A., The system of long-term care in the Czech Republic, ENEPRI research report n°72/2010, and CASE Network Studies & Analyses N°415/2010.

sector) and the Ministry of Labour and Social Affairs (for social services). More specifically:

- Health services costs in the health and social sectors are covered by health insurance funds;
- Social services - those under the responsibility of the Ministry of Labour - are financed by a mix of general taxes, regional budgets and individual contributions (notably from the cash benefits/care allowances)[4].

Home-based care is delivered through the health care system (nursing staff) and through the system of social services, which consists of cash benefits and of in-kind services[5]:

- **Cash benefit** is granted to dependent persons to finance the full-time care provided by their relatives. Until 2007, these monthly care allowances were paid to the persons who provided assistance. Since the social services reform of 2006, cash benefits are paid to dependent persons, who must spend it either to cover the home care assistance costs, or to pay for care provided within social services, or to combine these costs. These benefits are granted to dependent persons on the basis of four levels of dependency on care. The amount is set on the basis of assessment of the person's health and social situation, and it varies from EUR 32 for the dependent persons in the first category (slight dependency) to EUR 471 for those in the fourth category (total dependency):

  - CZK 800 for the category I (light dependence),

  - CZK 4.000 for the category II (medium-heavy dependence),

  - CZK 8.000 for the category III (heavy dependence),

  - CZK 12,000 for the category IV (total dependence)[6].

  The total cost of cash benefits amounts about 650 million € per year (about 0.6 % of the GDP), paid to about 300.000 recipients.

- **Services in-kind** include personal assistance and home care for persons that are dependent as a result of their age, disability or chronic illness. Personal assistance is provided to the clients of social services at home, without time limitation. This can include shopping, meal preparation, washing, paying bills, taking medications, etc. The service provided is determined on the basis of individual requests.

[4] OECD, 2011.

[5] The typology and the estimates are taken from Sowa A., 2010.

[6] Amounts of care allowance for persons over 18 years old. For persons up to 18 years old, the amounts are respectively CZK 3.000, CZK 6.000, CZK 9.000 and CZK 12.000.

Czech citizens also benefit from services in the case of poor health and limitations in their daily activities[7]:

- **Health care services** are prescribed by the doctor, on the basis of the need and severity of the illness: long-term institutional services for ill persons who need continuous medical supervision and treatment, as well as home health services supervised by a doctor;
- The need for **social services** (institutional care in centres, care in daily and weekly care centres and/or home-based services) is assessed by a social worker.

From a funding perspective, the Czech LTC has two types of funding:

- Medical services provided in the hospitals and LTC homes are financed from the health insurance funds. The system of users' co-payments has been introduced in 2008.
- The LTC services organised by the social services sector (for home, residential and day care) are funded as follows: users' co-payments (35% of the total costs of social services), the state budget (30%), local authorities (25%) and health insurance (3%). According to the Social Services Act of 2006, the amount of co-payment should not exceed 85% of the user's income.

In terms of actors involved, the LTC management and organisation responsibilities are divided between the two Ministries and the local self-governments. Not-for-profit organisations represent an important share of the social services providers (38%) and their participation is enshrined in the law Act N°108/2006.

2. WORK AND EMPLOYMENT QUALITY

2.1. Career and employment security

2.1.1. Employment status

While healthcare services are provided by home care agencies contractually linked to health insurers, social services are provided either by informal carers and/or by professional providers.

According to the Ministry of Labour estimates, about 80% of care to the dependent persons is provided informally. OCED's estimates indicate that this represents about 200.000 full-time equivalent workers, about 2% of the Czech population[8]. This predominant type of care in the Czech Republic is provided at

[7] Sowa A. 2010.

[8] OECD, 2011.

home by the relatives, mostly by children, but also spouses. Besides, surveys indicate that most Czechs consider the family support as the best way to provide assistance to dependent persons, especially to those in poor physical or mental condition[9].

However, most informal care providers also work: 80% of them have a full-time job[10]. Thus a decision upon informal care is strongly dependent on the flexibility of a caretaker's job.

Contractual relation between employer and employee

Informal caregivers (family members, neighbours, and friends) are registered only when they get a care allowance from the dependent person so that the state pays their social and health insurance. Professional providers are registered social services: legal entities established by regional and local authorities or private organisations, non-governmental organisations and natural persons[11].

Existence of a collective agreement

Collective agreements in the Czech Republic take place at the sector and company level[12]. They are regulated by the Collective bargaining Act. In social services about 200 providers have a collective agreement or are negotiating[13].

More information is kindly requested from participants.

Nature of employer

No data gathered at this stage. More information is kindly requested from participants.

Temporary contracts

No data gathered at this stage. More information is kindly requested from participants.

[9] Eurobarometer, in Sowa A., 2010.

[10] Sowa A., 2010.

[11] Carer plus, www.carerplus.eu

[12] Eurofound, Czech Republic, On wage bargaining. http://bit.ly/1MudNHJ

[13] Horecky J., Project PESSIS 2 "Promoting employers'social services organizations in social dialogue", Country-case study: Czech Republic, UZS, 2013. http://bit.ly/1LfYy3A

Regularisation of undeclared work

In the Czech Republic, the overwhelming majority of work provided in the LTC sector is the informal work: 80% of care for the dependent persons is provided by the family, mainly spouses, children and other relatives. In 2010, about 400.000 older persons needed assistance in activities of daily living; as at least one person provides care to each dependent person, it was estimated that there are at least 400.000 informal care providers in the Czech Republic[14]. These are mostly women (63%) of working age, most of whom (80%) have a regular full-time job. There is no data about the source of income of the care providers.

In 2004 the country has introduced the Law that establishes the definition of the illegal work, strengthens control mechanisms in the area, as well as introduces penalties against offenders[15]. In 2013 the country has also introduced a new system of undeclared work inspections.

Migrant work (figures)

No data gathered at this stage. More information is requested from participants.

2.1.2. Income and wages

Workers in the social services are all bound to the §109 of Labour Act or wage. Their way of remuneration can be found in the register of social services providers, and their wage most often does not reach the average wage[16].

Minimum wages

In January 2015, the Czech minimum netto wage has amounted 332€ per month[17], or 2€ per hour.

In June 2015 the average gross wage has amounted 25.306 CZK (933€)[18].

[14] Sowa A., 2010.

[15] European monitoring centre on change (EMCC), Tackling undeclared work, http://bit.ly/1UPgwyp

[16] Horecky J., 2013.

[17] Eurostat, 2015.

[18] Czech Statistical Office (CZSO), http://bit.ly/1D2AxqR

Median wages

No data gathered at this stage. Information is requested from participants.

2.1.3. Social protection

Access to social protection, retirement

With regard to carers in paid employment, the Act on Sickness Insurance (1956) entitles family carers to special leave to care for a sick relative. These workers are entitled to allowance of 69% of the average wage for the first 9 days of their own sickness. It is required that the worker resides in the same household as the dependent person[19].

Since the reform from 2006, carers receive care allowance from dependent persons. The state pays health and social insurance contributions for persons who are registered as informal carers. Periods of caring are taken into account for the purposes of old-age pension calculation[20].

More information is kindly requested from participants.

2.1.4. Workers' rights

Rights to collective bargaining

No data gathered at this stage. More information is kindly requested from participants.

Non discrimination

No data gathered at this stage. More information is kindly requested from participants.

2.2. Skills development and professionalization

The home-based care in the Czech Republic is a sector with increasing demands for quality and skills. Shifting care from institutions to people's homes and the use of new technologies influence the skills that

[19] Alzheimer Europe, http://bit.ly/1CplywF.

[20] Carers plus, Being carer in Europe, Czech Republic, http://bit.ly/1dNTSpf

will be relevant for the future.

2.2.1. Qualification

Jiri Horecky portrays four professions with their qualifications requirements: **nurses** (compulsory university degree), **social workers and ergotherapists** (secondary upper school and higher education in the field, combined with 200 hours expert course), **workers in the basic social care provision** (basic education combined with 150 hours expert course), and **management/technical staff** (qualification requirements given by special laws)[21].

2.2.2. Training

There is no national training policy for personal and household services in general.

More information is kindly requested from participants.

2.2.3. Career development

No data gathered at this stage. More information is requested from participants.

2.2.4. Recruitment and staff shortages

In the long term, increasing shortages are to be expected within the home care services sector.

More information is kindly requested from participants.

2.3. Health and well-being

No data gathered at this stage. More information is kindly requested from participants.

[21] Horecky J., 2013.

2.3.1. Work organisation

No data gathered at this stage. More information is kindly requested from participants.

2.3.2. Risk exposure and health problems

Sick leaves

No data gathered at this stage. More information is kindly requested from participants.

Stress-related work

No data gathered at this stage. More information is kindly requested from participants.

Harshness of work

Results of a study on 'Stress, depression and life style in the Czech Republic' conducted in 2015 indicate that signs of depression, burnout and stress are relatively common among the Czech workers[22]. It is notably the case in the PHS sector, and there are reasons to consider work in the private care sector as the precarious one.

Little data was found on the harshness of work. More information is kindly requested from participants.

2.4. Work/Life balance

Working time and work schedules

The average number of hours worked per week in the Czech Republic is estimated from 40.5 hours (Eurostat) to 41.7 hours (the Czech statistical office CZSO)[23]. Full-time workers work on average 42.7 hours weekly and part-time workers 20.5 hours weekly. Self-employed workers work on average 9 hours more than employees per week and men almost 4 hours more than women per week. The only group that

[22] Eurofound, European Observatory of working life, Czech Republic: new study investigates causes of stress among Czech workers, 2015, http://bit.ly/1hjFDuR

[23] Data in this section are taken from: Eurofound, Working time in the European Union: Czech Republic, http://bit.ly/1KQwbeB

comes close to the legal limit of hours actually worked (40 hours) is women employees. 7.9% of workers work more than 50 hours a week.

Furthermore, the practice of multiple job holding is widespread and usually perceived as an additional source of income. In 1993 5.2% of employees had more than one job; in 2001, it was 2.5% and about 2.1% in 2006. Two-thirds of additional jobs are taken by male workers.

As most of the informal PHS workers already work full-time, they face the problem of availability, in order to be able to provide home care for their older persons.

There is no working time limit defined by the legislation for the PHS workers. Irregular working hours (night and weekend shifts) are especially problematic for workers who are single parents[24].

Little data was found about the situation of PHS workers for this section. More information is kindly requested from participants.

3. SERVICE QUALITY

3.1. Availability of services

The LTC system in the Czech Republic is oriented towards shifting from an institutional care system to the home care. In this regard, the state authorities support the development of easily accessible social services at local level (especially out-services) and provide support (care allowances) for families to insure care of their older persons.

The current network of PHS services is not sufficient across the country. Czech media regularly bring testimonies on the insufficient care provision across the country, as well as on a need for stricter rules with respect to quality control in the entire LTC system[25].

Among 14 Czech regions, the accessibility and availability of PHS services is low and insufficient in the regions with lower population density. In parallel, regions with higher population density have more competing PHS providers[26].

Little data was found on the availability of PHS from a user perspective. More information is kindly requested from participants.

[24] Horecky J., 2013.

[25] Sowa A., 2010.

[26] Horecky J., 2013.

3.2. Affordability

The principle of universal access to services for dependent people in need of care and assistance is stated by AGE Platform: they should be provided either free of charge or at a price which is affordable to individual[27].

No data gathered at this stage. More information is kindly requested from participants.

3.3. Comprehensiveness of services

As stated by AGE Platform, services for dependent people in need of care should be easy to access by all those who may require them[28].

No data gathered at this stage. More information is kindly requested from participants.

3.4. Quality of regulation

The quality regulation of PHS services is carried out separately within the health care and the social services systems[29].

Provision of health care services is monitored and controlled by the health insurance company concerned. The Ministry of health issues accreditations for hospitals and LTC homes, stating that they fulfil quality standards.

The system of monitoring and control of social services "National Quality Standards of Social Services" is included into the Social services law and supported by the Ministry of Labour and Social Affairs. Yet, the system is not very much regulated. The provision of high quality social services can be monitored by the Ministry, regional governments, municipalities and labour offices, as stated in the Social Services Act of 2006. Although the Ministry has offered a set of social care quality standards, they are rather general recommendations for social care providers.

[27] AGE Platform, WeDo quality principles, 2010-2012.

[28] AGE Platform, 2010-2012.

[29] Sowa A., 2010.

3.5. Quality of management and organisational level

Municipalities and regional governments are the principal institutions responsible for accreditations, the monitoring and control of the PHS services.

PHS services may be provided on basis of licences issued by regional governments. The PHS provider is subject to an authorisation procedure in order to assess whether or not the provider is able to meeting all the conditions prescribed by the Social services Act, including the quality standards as well as the compliance with human rights[30]. The control procedure is done by an inspection. If conditions are not met, then the license can be withdrawn.

At the state level, the Ministry of labour and social affairs produces a Report on Social Quality Standards, focusing on quality control of social services workers, and on training best practices guides.

Since the Social services Act from 2077 the country has introduced 15 quality standards that represent the basic frame for PHS services provision[31]: 8 "process standards" on quality level and users' life, 2 "personal standards" on the conditions of employees (development, education), and 5 standards on operational activities (information, accessibility, quality measurements,..). With the introduction of these standards, the role of the user changed from being an object to being a subject of the care and influencing the quality of the provided care.

Little data was found regarding this section. More information is kindly requested from participants.

[30] Horecky J., 2013.

[31] Horecky J., 2013.

4. CONCLUSION

80% of work provided for the dependent persons in the Czech LTC sector is the informal work, by the family, mainly spouses, children and other relatives.

The state LTC system is focused on shifting from an institutional care system to the home care, notably thanks to the care allowance provided to informal workers, to insure home care of their older persons. To achieve this strategy, it nevertheless also needs to be complemented by labour market measures for the informal PHS workers who already work full-time, such as employment flexibility[32].

The introduction of the quality standards by the social services act from 2007 has played a positive role by putting an emphasis on rights and dignity of users[33].

The challenges of the Czech Republic in the future notably include coping with an increasingly aging population, as well as with the increasing costs and the sustainability of the health care system[34]. If the current policies are continued, then studies predict that the public financing of LTC will rise from 0.8% in 2014 to 1.6% of the GDP in 2060[35].

Although some actions have been taken to go towards a more integrated LTC system, its provision and funding remains shared between two sectors (health care and social services) and between different levels of government (national, provincial and local).

Recent researches suggest that the care provision is not sufficient across the country, as well as that there is a need for stricter rules with respect to quality control in the entire LTC system[36].

[32] Sowa A., 2010.

[33] Horecky J., 2013.

[34] EUbusiness, Czech Republic: country overview, 2014. http://bit.ly/1Wzx8fg

[35] Lipsky M., Hervertova V., Long-term care – the problem of sustainable financing, Peer review on financing of long-term care, Ljubljana 18-19 November 2014.

[36] Sowa A., 2010.

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