European Network of Economic Policy Research Institutes

ANCIEN

Assessing Needs of Care in European Nations

THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN THE CZECH REPUBLIC

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ENEPRI RESEARCH REPORT NO. 72
CONTRIBUTION TO WP 1 OF THE ANCIEN PROJECT

MAY 2010

ENEPRI Research Reports present the findings and conclusions of research undertaken in the context of research projects carried out by a consortium of ENEPRI member institutes. This report was produced by the ANCIEN project, which focuses on the future of long-term care for the elderly in Europe. Funding for the project is received from the European Commission under the 7th Framework Programme (FP7 Health-2007-3.2.2, Grant no. 223483). See back page for more information on ANCIEN. The views expressed are attributable only to the authors in a personal capacity and not to any institution with which they are associated.

This report is also published as CASE Network Studies and Analyses No 415, by the Center for Social and Economic Research – CASE, Warsaw, 2010.

ISBN 978-94-6138-014-2
Available for free downloading from the CEPS website (www.ceps.eu) and ANCIEN website (http://www.ancien-longtermcare.eu/node/27)

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1. The system of LTC in the Czech Republic

1.1 Overview (summary) of the system

The system of long-term care (LTC) in the Czech Republic, as in other countries of Central and Eastern Europe, is not considered as a specific sector of the social security system. Rather, services are provided within the medical and social sectors, and are not regulated by a unified legal arrangement administered by one central and/or regional institution. They cover a wide range of supportive health and social services provided to people who are not self-sufficient. The latter category includes not only the elderly, but individuals who need assistance for reasons other than age, such as long-term illness, physical and mental disabilities and to persons in vulnerable groups (such as drug users, or people in mental crisis).

Despite the fact that LTC is not grouped under a separate sector, an operational definition of LTC can be found in the document of the Ministry of Labour and Social Affairs – the Preliminary National Report on Health and Long-term Care in the Czech Republic. LTC is referred to as

> (…) a wide range of health and social activities to people who are no more self-sufficient – either because of their age, disability or for any other serious reason – and thus require constant assistance with self-service, personal hygiene, housework and providing links to social environment" (MoLSA 2005).

The philosophy of the LTC system is to provide care within the family in a natural, home environment. The principles behind the design of LTC are expressed as "accessibility", "quality", and "fiscal tenacity" and express EU policy in the field (Potůček et al. 2006). This attitude is also underlined in the National Programme of Preparation for Ageing 2008-2012, which is the most important strategic document expressing the direction of LTC policy.

Family care is supported by the state in the form of home care and home nursing care. As a result, the LTC system is targeted towards the social activation of the elderly and disabled people. Nowadays, it is estimated that approximately 80% of care for elderly people in need is provided by the family, mostly by children, but also spouses (MoLSA 2005). Informal care within the family is estimated to last 4 to 5 years on average. The results of the Eurobarometer survey show that the Czech population believes that support by the family is the best way to provide assistance to elderly people who need it due to poor physical or mental health. Sixty six per cent of the survey respondents indicated that the elderly should be provided with help by a family member who either lives in the same household or visits the person in need and provides care on a regular basis (European Commission, 2007).

Another important aspect of LTC provision is institutional care, which is partly provided within the health care system (in hospital departments or aftercare, rehabilitation and LTC departments) and partly within the social services system (in pensioner homes).

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It should be underlined that while some steps towards integrating care have been taken, the provision and funding of LTC is still separated into two sectors: health care, which comes under the supervision of the Ministry of Health (MoH), and social services, which is supervised by the Ministry of Labour and Social Affairs (MoLSA). The most important legal regulations with respect to the provision and funding of LTC services, either institutional or home-based, include:

- In the health sector:
  - The General Health Insurance Act (1991, last amendment 1997), the Act on the General Health Insurance Funds (1992) and the Act on Departmental, Professional, Corporate, and Other Health Insurance Funds (1992) introducing health insurance for health services, including aftercare and LTC provided within the health sector,
  - The Law on Private Health Care Facilities (1992) that sets out regulations for the existence of hospitals, out-patient, LTC and home health care services,
- In the social sector:
  - The Law on Social Services (2006) that regulates the provision of home care, access to cash benefits for individuals with limitations in activities of daily living (ADL) and different types of residential care, including care for seniors. The new regulations were introduced in January 2007, while the provision of social services was previously regulated by the law of 1988. The new legal regulations anchored in law the services that had been in practice since 2001 (Potůček et al., 2006).

Additionally, the responsibilities of regional and local governments with respect to LTC are regulated by the law on the decentralization of public administration which was introduced in 2003. According to the law, regional and local governments are responsible for the ownership of emergency units, institutions of LTC and approximately half of hospitals (Bryndová et al., 2009).

1.2 Assessment of needs

Czech citizens have a right to services in the case of poor health and limitations in their daily activities. The right is guaranteed by the state and available in the health care system, as well as in the social services system.

Health care services are available for all citizens and eligibility is based on their health insurance coverage. The provision of care is conditional on the need and severity of the illness, as assessed by the medical doctor. Medical services include long-term institutional services for the severely ill who need constant medical supervision and treatment as well as home health services, which are recommended and supervised by a primary care doctor.

Eligibility for social services is based on citizenship, while the need for social services is assessed by a social worker. This holds for institutional care provided in pensioners' homes and daily and weekly care centres as well as for home-based services. The only exception is cash benefits, which are provided to individuals with limitations in ADL (activities of daily living) that have been confirmed by a medical doctor's examination. The care allowance is granted to any person who is not self-sufficient and is dependent on the assistance of another person in the area of personal care and basic social activities. Specifically, eligibility criteria for cash allowances for an individual in need of personal care (often family care) are based on the concept of the limitation in ADL. The Social Services Act of March 14th 2006 (Act No 108/2006 Coll. on Social Services) links the admittance of a benefit and benefit level with the level of dependency, which is a result of limitations in ADL. Four levels of dependency are distinguished:

- (1) light dependency on assistance in ADL performance - not being able to perform 12 activities from the list of 36 for adults over 18 years of age, and not being able to perform 5 activities of daily living for children below 18 years of age,
- (2) medium dependency on assistance in ADL performance – not being able to perform 18 activities from the list of 36 for adults over 18 years of age, and not being able to perform 10 activities of daily living for children below 18 years of age,
- (3) heavy dependency on assistance in ADL performance – not being able to perform 24 activities from the list of 36 for adults over 18 years of age, and not being able to perform 15 activities of daily living for children below 18 years of age,
- (4) very heavy dependency on assistance in ADL performance – not being able to perform 30 activities from the list of 36 for adults over 19 years of age, and not being able to perform 20 activities of daily living for children below 18 years of age.

In order to be eligible for cash assistance, the person in need should submit an application for a care allowance, which includes all the compulsory information (i.e. personal data, information on the care provider, and the manner in which allowance should be paid). The degree of dependency is assessed by a social worker, together with a social investigation into the social environment of the applicant. This is later confirmed by the employment office's medical doctor. Finally, a municipal authority decides if the applicant should be granted a care allowance (MoLSA, 2009). It should be noted that before the introduction of the new legal regulations in 2007, the benefit in cash, called the social welfare allowance, was provided to persons taking care of the dependent in need (typically a family member) (Act no. 100/1988 Coll. on Social Security as amended).

1.3 Available LTC services

LTC services are provided within two parts of the social security system: the health care system and the social services system. The first one concentrates on the LTC services for the disabled and long-term sick and the second one concentrates on services provided to dependent and vulnerable people, among whom are also the elderly.

The health care system provides **institutional LTC facilities** in the form of **aftercare** in hospital departments and specialized medical institutions (aftercare covers nursing and rehabilitation services) and in **LTC facilities** (so-called LTC homes – LDN) which are located near the public hospitals or managed by private institutions. Still, expensive hospital services were believed to be overused by clients with LTC illnesses, in response to which per diem fees were introduced in 2008 (of 2.40 euro). The goal of the policy was to move LTC patients from hospitals to LTC institutions that typically provide nursing and rehabilitation to disabled people and to individuals with serious long-term illnesses.

Table 1. Organisation of institutional and home-based care

Type of social security system	Institutional care settings	Home based care	
		In cash	In kind
Health care system	Aftercare (rehabilitation and nursing) in the hospital departments' LTC homes (LDN)	--	Home nursing care
Social services	Pensioners' homes Day/week care centres	Benefits in cash to the individual in need of assistance due to reduced self-sufficiency	Personal assistance and community care at home (meals, shopping, washing, etc.).

Source: Own compilation.

Another form of residential services, managed within the social system, is **pensioner homes**, which provide care to the elderly who have suffered a permanent change in their health condition, require comprehensive care, and cannot be self-sufficient. This type of care is intended for individuals whose capabilities are limited, particularly in the areas of personal and household care and for whom home care, either formal (home-based) or informal, cannot be provided or is not sufficient. Still, the health status of the pensioners admitted to pensioners' homes is relatively better than patients in the LTC homes. The services in pensioners' homes are not restricted in time.

In addition to residential care in pensioner homes, the system of social services includes **daily and weekly care centres**. This type of care is also intended for individuals with limited capabilities in the area of personal and household care and who cannot live without assistance on a daily basis. The Ministry of Labour and Social Affairs plans to develop and promote this type of institutional care.

Home-based care is provided by nursing staff in the health care system and in cooperation with the primary care doctor, as well as within the system of social services covering services in kind and cash benefits.

Services in-kind include personal assistance and community care to individuals whose capabilities are limited due to age, disability or chronic illness. Personal assistance is provided to the clients of social services in their home environments and includes shopping, meal preparation, washing, paying bills, taking medicines, etc. The service is provided without a time limitation and depends upon individual request. Community care services are a very similar field-based type of care, though they are provided within a given timeframe.

Benefits in cash are granted to individuals who are provided with personal, full-time care by a person close to them, typically a family member. As mentioned above, prior to 2007, benefits were provided to the persons who provided assistance. After the social services reform of 2006, the individual in need became the one who receives the allowance. Despite the fact that the benefit is not targeted towards the elderly, 67% of recipients of benefits in cash are aged 65+ (Wija, 2008) while 57% constitute older seniors (75+) (MoLSA, 2009). The allowance takes the form of a personal budget benefit and can be used to cover the costs of arranging assistance for the dependent, to pay for care provided within social services, or to pay costs incurred by the caretaker. It is also possible that all the costs are combined at the individual level. A care allowance is not treated as income for tax purposes or other social benefit system purposes.

Overall, it is estimated that the total cost of care allowances is approximately 650 million euro annually (i.e. 0.5 % of the GDP) (MoLSA, 2009).

1.4 Management and organisation

Residential LTC homes are within the competencies of hospitals, their managers, regional and local governments and finally the Ministry of Health. The Ministry of Health, together with the health insurance institutions, is responsible for control over the quality of services as well as long-term policy in the sector.

The organisation of the system of social services, both institutional and home care, lies within the responsibility of the Ministry of Labour and Social Affairs, however the services themselves are provided at the local level. With respect to social services, the Ministry of Labour and Social Affairs is responsible for policy decisions, budgetary negotiations, monitoring and control of system performance, introduction of the information system and data collection. Additionally, the Ministry of Labour and Social Affairs manages five specialized social care institutions, however these are not targeted assistance for elderly people, but the long-term ill, people with intellectual disabilities, physically disabled people and children. Regional and local governments play a major role in the organisation and provision of cash benefits and social services. They are responsible for the process of needs assessment, monitoring and control, and provision of services or contracting out social services to service providers.

Table 2. Division of responsibilities between the ministries and local self-governments

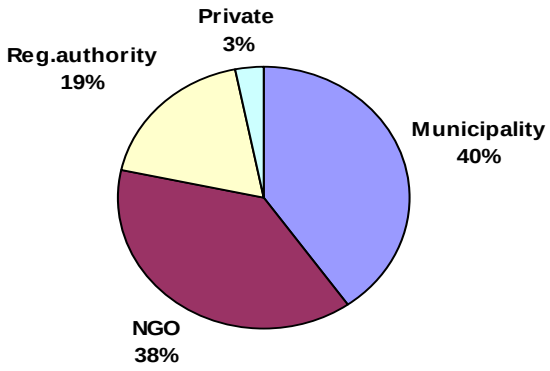
Ministry of Health and Ministry of Labour and Social Affairs	**Regional and local self-governments**
Legislative initiative and policy disposal	Assessment of needs
Assurance of funding (in case of the LDN homes, funding is provided by the health insurance)	Contracting and providing services
License, accreditation, quality standards	Monitoring and control

Source: Own compilation

Important providers of social services are non-governmental and non-profit organisations (see figure, below), which sign service contracts with local governments on the one hand and social service clients on the other hand. The participation of the non-profit sector in the provision of services is anchored in the new law (Act No 108/2006 Coll. on Social Services). Still, problems related to the operation of NGOs in the field of social services are reported with respect to funding procedures. Services provided by NGOs are contracted and funded on an annual basis, which means that NGOs are obliged to compete for contracts every year. Moreover, delays in transfers of contracted funds have been reported (Holmerová, 2004).

The quality of services is supervised from within the health care system and social services systems separately. Provision of health care services reimbursed from the health insurance fund is monitored and controlled by the respective health insurance company. Hospitals and LTC homes also receive accreditation from the Ministry of Health stating that they fulfill quality standards.

Figure 1. Providers of social services



Source: Wija, 2008.

The system of monitoring and control of social services (National Quality Standards of Social Services), although incorporated into the social services law and supported by the Ministry of Labour and Social Affairs, is not highly regulated. The provision of high quality social services can be monitored by the MoLSA, regional governments, municipalities and labour offices, as stated in the Social Services Act of 2006. The Ministry of Labour and Social Affairs has indeed proposed social care quality standards, but they are rather general recommendations for social care providers; they should be much more specific. This remains a rather vague procedure, however. According to the ministerial standards, the main institutions responsible for the monitoring and control are municipalities and regional governments as they are legally responsible for the creation of a system of social care services and assuring funding (Holmerová, 2004). MoLSA has also prepared a Report on Social Quality Standards, concentrating on two core activities: training quality control officers in the field of social services, and training guides in best practices (Potůček et al., 2006). It also provides examples of good practices that can serve as benchmarks in the provision of high quality social services.

Still, the media often provide examples of the under provision of care and claim there is a need for stricter regulation with respect to quality control in the entire LTC system.

1.5 Integration of LTC

Within the LTC system

From the clients' perspective, the level of integration of LTC services was low before the introduction of the Social Services Act of 2006 (Bryndová et al., 2009). Before 2007, as eligibility criteria and financing procedures for institutional and home-based care were different, there were no benefits to which clients of both systems could be entitled simultaneously. The reform introduced the possibility of combining the financing of both systems, i.e. giving a cash allowance to the client for the use of services he/she could choose independently. The allowance could thus be used for the provision of medical or rehabilitative services or long-term institutional care. At the same time, home care agencies, which typically employ nurses, can enter into a contract for the provision of home health services with health insurance funds. As a result, comprehensive home care for some medical services (rehabilitation, nursing) are

provided in the home environment and at pensioner homes, although the system suffers from a lack of adequately trained staff.

Between the health care and social services sector

As mentioned in the summary above, the health care and social services systems are not combined. This is apparent when looking at the administration and funding of LTC services: part of the system comes under the competencies and management of the Ministry of Health and part under the competencies and management of the Ministry of Labour and Social affairs. The problem is especially apparent for institutional care, monitoring and control of the system as well as planning and LTC strategy. Each of the ministries develops different measures for long-term policy. Additionally, professional societies (i.e. the Gerontology Centre) have their own LTC policy proposals. A discussion between the different stakeholders in the LTC sector is therefore a must.

Another problem is that of data collection on LTC. Since the system is not integrated if data are collected, they are also dispersed. Integrated financial data on the LTC system are available only in the structure of the National Health Accounts. Public data on the volume of services cover social services, especially pensioner homes, while other types of data are difficult to gather.

2. Funding

There are two types of funding, for LTC homes (LDN) and social services (which includes pensioner homes).

Medical services provided in hospitals and LTC homes for individuals with advanced illnesses (LDN) are financed from the health insurance funds. Until 2008, when co-payments for medical services in outpatient and hospital care were introduced, any type of out-of-pocket payment for services was illegal.

The LTC services organised by the social services sector are funded from general taxes, and further administered from the social budgets of regions and municipalities, client contributions, territorial self-governing authorities and the funds from the public health insurance. Regions, after receiving state contributions for social services, decide autonomously on the allocation of resources, which typically includes decisions on the allocation of costs per bed in residential care and total costs of home-based social services. Still, the main sources of funding are client contributions (35% of the total costs of social services), followed by the state budget (30% of total costs), and local authorities (25%). Health insurance only plays a minor role (3%) (MoLSA, 2009). Clients of social services are obliged to contribute to the costs of the service in the form of co-payment. The co-payment ceiling for home care services was set by the Social Services Act of 2006, which states that the amount of co-payment should not exceed 85% of an individual's income. Specific costs of services are decided in the contract with the service provider. This regulation holds for home care as well as residential and day care.

3. Demand and supply

3.1 The need for LTC (including demographic characteristics)

Evaluations carried out the Ministry of Labour and Social Affairs, the Ministry of Health or the Czech Statistical Office do not specify the need for LTC. However, the case for assessing the needs of the elderly has been made by policy-makers, which resulted in the establishment of the Governmental Council for Older Persons and Population Ageing, in 2006. The objective of the Council is to recognize the needs of an ageing population and prepare an adequate policy

response to ageing. The Council consists of 28 representatives of the ministries, health insurance companies, NGOs, social partners and experts.

Current estimates of the potential need are based either on survey data or demographic data and projection.

Results of the Eurobarometer survey indicated that approximately 24% of the Czech population reported being severely limited in the activities they normally perform within the six-month period preceding the survey. They attributed these limitations to either poor physical or mental health (European Commission, 2007).

Another estimation of the potential need for LTC is possible due to demographic data and projections. In 2007, elderly people above 65 years of age constituted 14.4% of the total population. Naturally, the proportion of elderly in the population was significantly higher for women than for men (17.10% compared to 11.6%), which reflects the demographic composition of elderly cohorts and mortality. It is foreseen that the proportion of elderly people in the total population will more than double in 50 years time, while the share of the very old (80+) will increase more than threefold.

Table 3. Projections of selected demographic indicators, 2008-2060

	2007/ 2008	**2010**	**2020**	**2030**	**2040**	**2050**	**2060**
Life expectancy at age 65, males	14.7	15.0	16.2	17.4	18.6	19.7	20.8
Life expectancy at age 65, females	18.1	18.3	19.5	20.7	21.9	23.0	24.1
Population 65+ as a share of the total population	14.4	15.4	20.2	22.9	26.3	30.9	33.4
Population 80+ as a share of the total population	3.3	3.8	4.1	6.6	8.4	9.3	13.4
Old age dependency ratio	20.0	22.0	31.0	36.0	43.0	55.0	61.0

Source: European Commission, 2009 Ageing report.

The old age dependency ratio[1], which is a significant indicator of demographic pressures reflecting the future possibilities of financing of pensions and LTC, was 22.2% in 2007. According to Eurostat estimations, it is predicted to increase to 35.7% by 2030. By 2060, the indicator of the elderly to the labour market active population is projected to be higher than 60%.

3.2 The role of informal and formal care in the LTC system (including the role of cash allowances)

Overall, the system of LTC is targeted to community-based services. Like other countries in the region, the provision of family care is very high. According to Ministry of Labour and Social Affairs estimates, approximately 80% of care is provided at home by the spouse or children of a person in need. Also, both the reform of 2006 and the National Programme of Preparation for Ageing 2008-2012 promote community-based care, which implies supporting active ageing on the one hand and informal family care on the other. Home care and cash allowances are viewed as a crucial means of supporting family care.

[1] Which is estimated as a ratio of elderly (65+) to the labour market active population (20-64 years of age).

3.3 Demand and supply of informal care

According to the results of the Eurofamcare project,[2] there is no systematic research on the demand and supply of informal care for elderly and chronically ill people in the Czech Republic (Holmerová, 2004). It is estimated that approximately 80% of care is provided by the family, mainly spouses, children and other relatives. This translates into approximately 100,000 elderly people who need assistance in basic activities of daily living and 300,000 elderly people who are unable to perform functional daily living activities. Assuming that every elderly person is provided with help by at least one person means that there are about 400-500,000 informal care providers in the Czech Republic. These are mostly women (63%) of working age, most of whom (80%) also have a regular full-time job. There is no research that allows us to state the source of income of care providers; it should also be assumed that the type and level of income depends on the severity of need for assistance in daily living. However, caretakers are eligible for the caretaker's allowance, which, since the reform of 2006, was transformed into a benefit provided to the elderly person in need (with limited ADL).

Results of the Eurobarometer survey confirm that informal care is perceived as the most important type of care. 36% of respondents asked about the type of care they thought would be the best option for elderly people indicated that dependent elderly people should live with one of their children, while only 13% claimed that the elderly should be taken care of at an LTC institution (European Commission, 2007).

3.4 Demand and supply of formal care

3.4.1 Introduction

The demand for LTC depends on demographic pressures (which, as stated above, are predicted to grow in the coming decades), labour market activity, and the possibilities of combining care provision and traditions in a given country. On the other hand, the supply of formal care is strongly dependent on political objectives and funding opportunities.

3.4.2 Institutional care

Residential care, suit it is provided in the health and social sectors separately, is also presented separately based on the statistical data of the health sector and the Ministry of Labour and Social Affairs.

Table 4. LTC homes (LDN) 1996 – 2008

Items	**1996**	**1998**	**2000**	**2002**	**2004**	**2006**	**2008**
LTC homes	71	74	75	80	73	74	70
Beds	6151	5996	6713	7438	7272	7462	7194
Physicians (FTE)	212	207	229	265	282	329	375
Professionally qualified paramedical workers (FTE)	1681	1700	1918	2242	2978	2098	2010

Source: Czech Health Statistics Yearbooks, 1996 – 2008.

[2] See: http://www.uke.de/extern/eurofamcare/

The number of LTC institutions for severely ill people has been stable over the last decade, reaching a peak of 80 institutions throught the country in 2002, dropping to 70 in 2008. Despite stabilisation in the number of facilities, the number of beds grew by 16%. Additionally, the number of staff working at LTC homes increased by 77% for doctors and 20% for paramedical employees.

The number of residential homes for pensioners within the social services system is much higher. According to the Czech Statistical Office, at the end of 2006 there were 390 pensioner homes, with an average occupancy rate of 97.1%[3]. It should be noted however, that in 2005, the Ministry of Labour and Social Affairs already pointed out that the number of facilities was insufficient and that waiting times for pensioner homes differed between regions from several months to several years (MoLSA, 2005). Studies have also found that the supply of care is unequal between urban and rural areas, and access to care is easier in urban settings (Potůček, 2006). The data from the Ministry of Labour and Social Affairs gives a good picture of the scale of the problem – in 2003 there were 378 pensioner homes with 39,331 beds while 50,192 applications were rejected (MoLSA, 2005). Another problem mentioned by the Ministry of Labour and Social Affairs was the quality of services, especially the lack of adequate nursing and rehabilitation services and the need to modernize outdated facilities. Developing daily and weekly care centres has been identified as a measure to cope with such problems.

Despite the fact that the number of full-time elderly homes has been increasing over the last decade, it is still highly insufficient and results in long waiting lists. Also the demand for institutional care for people who do not have long-term illnesses and are not in terminal condition is increasing much faster than the number of beds in the pensioner homes. In 2003, the number of individuals whose applications for a place in retirement homes were rejected was 128% of the number of available beds.

Table 5. Pensioner homes facilities 1996- 2006

Pensioners' homes	**1996**	**1998**	**2000**	**2002**	**2004**	**2006**
Number of facilities	303	320*	343**	360***	376	390
Number of beds	33779	35218	36662	37686	37867	38672
Number of rejected applicants	21609	25431	28784	33222	-	-

* 4 facilities combining the pensioner home and boarding home are included.
** 5 facilities combining the pensioner home and boarding home are included.
*** 6 facilities combining the pensioner home and boarding home are included.
Source: MoLSA 2005, Czech Statistical Yearbooks 2005, 2007.

3.4.3 Home care

There are two types of care provided to the elderly in need in the home environment: home care and home nursing care. Home care includes personal assistance services and community care in daily activities, such as dressing, washing, shopping, transport or meals-on-wheels. Home nursing care, which is an integrated form of home health and assistance provided in the home, was introduced in the Czech Republic in the 1990s. (Rokosová, Havá, 2005). It is an element of outpatient care and takes the form of nursing or rehabilitation[4] provided with the consultancy

[3] See http://www.czso.cz/csu/2007edicniplan.nsf/engt/FE003FE442/$File/0001072414.xls

[4] Typical activities provided by home care agencies include taking blood, measuring blood pressure, and assistance in taking medicines.

and cooperation of a primary care doctor. Both types of care are typically integrated in one provider institution as they are provided by the home care agencies, the number of which increased throughout the 1990s (from 27 in 1991 to 484 in 1998). Typically the staff of the home care and home nursing care are nurses and volunteers (Potůček at el., 2006). Most of the home care agencies are private or non-profit organisations (Holmerová, 2004). It is estimated that 58% of home care agencies also provide care during nights and weekends, 22% during weekends and 20% in the afternoons. Still, some problems are reported with respect to cooperation with general practitioners. Another problem is caused by the unequal regional distribution of home health care agencies (Wija, 2008).

Table 6. Basic home care statistics 2000 – 2007

Items		**2000**	**2004**	**2005**	**2006**	**2007***
Persons who received home care services		113 528	109 475	112 927	105 088	95 520
Home care service workers		4 793	4 355	4 265	4 106	4 491
including	Professional nurses	4 139	3 700	3 585	3 511	3 810
	Others	654	655	680	595	681
Home care service volunteers		967	652	556	450	304

*Preliminary
Source: Czech Statistical Yearbook, 2008.

It is estimated that a total of 7,000 clients received personal care from the social services centres in 2008 at the total cost of 15 million euro (out of which 3 million were paid by the clients). Further, approximately 115,000 clients received community care in 2008 at a total cost of 70 million euro (out of which 16 million were paid by the clients) (MoLSA, 2009). The data cover not only elderly, but the whole population of care recipients; however, it is estimated that the elderly constitute about 75% of the home care recipients' population.

3.4.4 Semi-institutional care

Semi-institutional care is provided at daily and weekly care homes, which were legally approved as part of social services with the Social Services Act of 2006, although they already existed as boarding homes for the elderly. Daily and weekly centres for elderly people operate only in a few communities, so their number is considered to be insufficient. They provide day care or care during the week, which mainly consists of the provision of meals and involving the elderly in specific programmes to encourage social participation. According to the Social Security Act, daily and weekly care centres should also provide care when the person who typically takes care of the elderly person is away for several days. Overall, these centres are thought to be an important source of support for informal care providers, though they are criticized for not always being able to provide adequate care or a sufficient number of activities. In recent years, several additional centres for individuals with dementia were opened, offering assistance and in some cases also transport.

Typically, the centres are open for more than eight hours a day. Nevertheless, the supply of part-time care is insufficient. Although the number of day care centres increased by 16% between 1995 and 2003, the number of rejected applicants more than doubled. In fact, the number of rejected applicants was more than twice the number of available beds in the day care centres in 2003 (Table 7).

Table 7. Boarding homes for pensioners 1995-2003

Boarding homes for pensioners	1995	1997	1999	2001	2003
Number of facilities	124	146	148	150	144
Number of beds	11549	12593	12126	12432	11487
Number of rejected applicants	12364	17612	19678	22148	25389

Source: MoLSA, 2005.

The latest data (2008) show that the services at the day care centres were provided to 36,000 clients, while a further 1,300 clients used the services of weekly care centres. The cost of the services was 26.5 million euro for the day care centres and 9.3 million euro for the weekly care centres. Client contributions were 3.5 million and 2.2 million, respectively (MoLSA, 2009).

4. Long-term care policy

4.1 Policy goals

The LTC system in the Czech Republic is heading towards shifting from an institutional care system to ageing in a home-like environment. The policy thus puts pressure on the development of easily accessible social services at the local level, especially non-residential services and provides incentives and support (care allowance) for families to take care of their elderly relatives. The strategy is in line with the fact that most of the care for the elderly is provided at home. However, most informal care providers work (according to the MoLSA, 80% of them have a full-time job). Thus a decision upon informal care is strongly dependent on the flexibility of a caretaker's job. Some survey research shows that Czechs expect the state to provide appropriate care for the elderly – the second priority of the population, after the provision of adequate health care.

The long-term policy of the Czech government towards ageing and, partially, LTC is reflected in the National Programme of Preparation for Ageing 2008-2012. It was prepared and approved by the government in January 2008 and is monitored by the Governmental Council for Older Persons and Population Ageing. Strategic priorities set up in the document include the promotion of active ageing in a friendly community environment, improving the health of older persons, improving available social services, supporting family and caretakers, supporting the social inclusion of the elderly and protecting their human rights (Wija, 2008).

4.2 Integration policy

At the moment, no administrative integration policy between facilities located in the health care system and home care is foreseen either by the Ministry of Labour and Social Affairs or by the Ministry of Health. However, some policy proposals made by professional organisations, such as the Geriatric society, concentrate on the creation of an integrated system of institutional care for the elderly and long-term ill, covering appropriate nursing and rehabilitation. At the central administration level, integration is assured by the introduction of the Governmental Council for the Elderly. The Council was created in order to enable discussion on the issues related to assuring care for the increasing numbers of elderly among all the stakeholders (Ministry of Labour and Social Affairs, Ministry of Health, NGOs, other social organisations and professional associations).

4.3 Recent reforms and the current debate

The last reform of the social system, which included LTC services, was conducted in 2006 and took social services into consideration. The need for reform was pronounced by experts who found the previous legal regulations of 1988 inadequate for the changing social situation. Nevertheless, most of the services to assist the elderly that are provided in the new social services system were also provided before the reform. These include personal and nursing services, pensioner homes, and day care centres (previously also called boarding houses for pensioners). The reform introduced a care allowance to the individual in need while previously it was provided to the care provider. The social services system also strongly encourages the involvement of non-governmental organisations in the provision of services. The problems that the system faces currently and that are the subject of public debate (also in the media) include:

- lack of legal definition of the LTC, regulation of types of services,
- lack of adequate quality control by the ministries, regional governments, local governments and health insurance funds, especially of privately run LTC facilities,
- low levels of LTC funding,
- insufficient number of qualified staff, especially nurses,
- low salaries of nurses, rehabilitants and other qualified staff,
- waiting times for LTC homes (estimated to be up to 1 month) and pensioner homes (up to several years).

LTC goals identified by the Ministry of Labour and Social Affairs include the reduction of chronic diseases and other factors that impact functional health status; the increased availability of rehabilitative services and community health care; more support for social mobility and social participation of the elderly; deinstitutionalisation of social services and improved integration of health care and social services (Wija, 2008).

4.4 Critical appraisal of the LTC system

Although the importance of the LTC system is growing, which is reflected in the lively public discussion on the provision of services and the problems that the system faces, it is still fragmented on the side of the health care system and social security. The most important problem seems to be the lack of an integrated national strategy of LTC and, as a result no common definition of LTC. The structure of the institutional arrangement is not transparent, with some of the LTC institutions located in the health care system and some in social services. The pressure on home-based care, which is often expressed in the documents of the Ministry of Labour and Social Affairs, will not be successful without appropriate labour market measures such as employment flexibility, especially when most of the informal care-givers are active members of the labour market who work full-time.

References

Bryndová L., Pavloková K., Roubal T., Rokosová M., Gaskins M., Czech Republic: Health System Review, WHO Health Systems in Transition, Vol. 11 No 1 2009.

Czech Statistical Office, *Demographic Yearbook of the Czech Republic 2007*, (http://www.czso.cz/csu/2008edicniplan.nsf/engpubl/4019-08-2007).

Czech Statistical Office, *Czech Health Statistics Yearbooks 1996-2008*, (http://www.uzis.cz/download.php?ctg=10&search_name=Czech%20health%20statistics%20yearbook&region=100&mnu_id=5300).

European Commission, (2007) Health and long-term care in the European Union, Special Eurobarometer 283/Wave 67.3 – TNS Opinion & Social, December (http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf).

European Commission, (2009) Ageing Report, Economic and budgetary projections for the EU-27 Member States (2008-2060), Statistical Annex, European Economy 2/2009, (http://ec.europa.eu/economy_finance/publications/publication14994_en.pdf).

Holmerová I., *Eurofamcare National Background Report for the Czech Republic*, (2004) (http://www.uke.de/extern/eurofamcare/documents/nabares/nabare_czech_rc1_a4.pdf).

Ministry of Labour and Social Affairs, *Preliminary National Report on Health Care and Long-Term Care in the Czech Republic*, (2005) (http://www.mpsv.cz/files/clanky/1343/report_health_care.pdf).

Ministry of Labour and Social Affairs, Social Services, (http://www.mpsv.cz/en/1613).

Ministry of Labour and Social Affairs, Social Services and Care Allowance, Ministerial Conference on Social Services, Social Services – an Instrument for Labour Mobilisation and Bolstering of Social Cohesion, Prague 22-23 April 2009, (http://www.mpsv.cz/files/clanky/7163/Social_Services_and_Care_Allowance.pdf).

Potůček M., Hanušová P., Kopecká P., (2009) *Study on Social and Health Services of General Interest in the Czech Republic*, Prague, October.

Rokosová M., Havá P. (2005) *Health Care Systems in Transition (HIT), Czech Republic 2005*, (http://www.euro.who.int/Document/E86823.pdf).

Social Services Act of March 14th 2006, No 108/2006.

Wija P., (2008) *Ageing Policy in the Czech Republic*, presentation of the Ministry of Labour and Social Affairs, CEFRES, December 18.

About the Center for Social and Economic Research – CASE

We are an independent non-profit economic and public policy research institution founded on the idea that evidence-based policy making is vital to the economic welfare of societies. Established in 1991 in Warsaw, CASE scholars and researchers assisted policy-makers during the early years of transition, before turning their attention to the challenges inherent in the European Union enlargement process and then EU key policy challenges in the globalized world. While remaining focused on our five core thematic areas of: (1) European Neighbourhood Policy, enlargement, trade and economic integration, (2) labour markets, human capital and social policy, (3) innovation, competitiveness and entrepreneurship, (4) reforms, growth and poverty reduction in developing and transition countries, (5) macroeconomics and public finance, we want to contribute to new debates facing Europe, including the economic impact of climate change mitigation policies and the economics of energy policy. In addition to consolidating our position in the European research market, we are also broadening our geographic horizons by going beyond our traditional countries of interests, i.e., the Western Balkans and the Commonwealth of Independent States. Starting in 2006, we became active in the Middle East and Africa, where we hope to strengthen our presence by competing for technical assistance projects. Networking and communications activities remain central to our organisational development. As CASE entered its eighteenth year of existence in 2008, we want to build on our relationships with our own internal network, associated organisations, and membership in international and external networks, partnerships and alliances to make our research and expertise available and have a growing impact in the European policy debate. Reaching out to an increasing number of international experts is another of our priorities.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).