



This project is co-funded by
the European Union

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

December 2015

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INTRODUCTORY NOTE

This report has been prepared, reviewed and finalised through the research of its authors, the contributions and suggestions of the project partners, the suggestions and remarks made by the participants-members of partners' organisations at the regional seminars (Rome / Brighton / Vienna 2015) and by the Advisory Board members (AGE Platform, Eurofound). The authors wish to thank warmly all these persons for their time and contribution. The report presents the personal care and household services sector in the country at stake and in the framework of the For quality! project objectives, following the methodological grid validated by the consortium, without being exhaustive. Authors have tried to incorporate corrections and comments that were reported to them during this process. However, the content does not necessarily reflect the vision of the project partners who are not responsible for the information contained in this report.

This publication is supported by the European Union's Programme for Employment and Social Solidarity - PROGRESS (2007- 2013). This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Europe 2020 Strategy goals in these fields.

The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-28, EFTA-EEA and EU candidate and pre-candidate countries. For more information see: <http://ec.europa.eu/progress>.

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1. NATIONAL OR LOCAL REGULATION AND POLICIES

1.1. Policy backgrounds

Personal and household services (PHS) cover “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.¹.” In the Czech context, the PHS sector is spread in two separate systems:

- Non-care system: corresponds to social home care, which contains the following activities: help with the activities of daily life, help with daily hygiene, providing food or help with meal preparing, household services, and enabling contact with social surroundings².
- Care system: the Czech long-term care (LTC) corresponds to wide range of care services for dependent persons, and the system philosophy is to provide care within the family in a home environment.

The Czech workshop experts at the regional seminar in Vienna in September 2015 have specified that in a household, it is often possible for one individual to provide both types of services.

There is neither a unified legal background nor any authority responsible for the regulation of these two systems. 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 PHS³. While competences are divided in two sectors, in some cases it is not clear which sector holds the responsibility⁴.

Main legal regulations for the PHS provision and funding are⁵:

- 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

¹ European Commission, Staff Working Document on exploiting the employment potential of the personal and household services, SWD (2012) 95 final.

² Horecky J., Dignity first – priorities in reform of care services, Peer review on reform of care services, 2013.

³ OECD, Czech Republic long term care, in Help Wanted? Providing and Paying for Long-Term Care, 2011.

⁴ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

⁵ 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.

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 PHS 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. Structure and funding

The responsibility for funding is divided between the Ministry of Health (for the health care 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)⁶.

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 services⁷:

- **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

⁶ OECD, 2011.

⁷ The typology and the estimates are taken from Sowa A., 2010.

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)⁸.

The total cost of cash benefits amounts about EUR 650 million per year (about 0.6 % of the GDP), paid to about 300.000 recipients. However it is important to mention that, compared to the Western European Member States, Czech citizens may afford more hours with these amounts of benefits.

- **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.

Czech citizens also benefit from services in the case of poor health and limitations in their daily activities⁹:

- **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.

⁸ 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.

⁹ Sowa A. 2010.

- 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. Besides, the financial participation of municipalities is not systematic¹⁰.

The social home care providers are for their part funded by two main resources¹¹:

- Users' payments: either from their income (mainly retirement pensions) or from their care allowance.
- State subsidies, although there are no written rules, criteria or claims for the state granting.

Other sources of social home care funding may be founder's contributions, gifts, business activities, etc.

In terms of actors involved, the PHS 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.

One of the major concerns of the Czech experts in Vienna was to call on public authorities to reconsider the separation between social and health sector, as well as to call on the government to initiate a "trial and error" pilot project on the implementation of PHS in the Czech Republic.

2. WORK AND EMPLOYMENT QUALITY

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. OECD's estimates indicate that this represents about 200.000 full-time

¹⁰ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

¹¹ Horecky J., Peer review, 2013.

equivalent workers, about 2% of the Czech population¹². This predominant type of care in the Czech Republic is provided at 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 condition¹³.

However, most informal care providers also work: 80% of them have a full-time job¹⁴. Thus a decision upon informal care is strongly dependent on the flexibility of a caretaker's job.

Private PHS providers can be divided into two groups: non-profit and non-governmental organisations and the profit sector¹⁵.

As regards the contractual relation, according to the Labour Code of the Czech Republic, employers are obliged to ensure the equal treatment of all workers as regards their working conditions, remuneration for work, professional training, and the opportunity to be promoted or other advancement in employment. Furthermore, the Anti-Discrimination Act includes a general obligation for employers to provide equal treatment to all workers, as well as regulates the right to employment and access to employment, access to training, and to membership in trade unions¹⁶. As the current legislation guarantees equal conditions for all workers, thus including domestic workers, and creates sufficient room for balancing personal, family and work life, KZPS¹⁷ suggests that emphasis should be placed on ensuring the proper application and enforcement of current legislative framework rather than on creating new ones.

In the PHS sector, 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 persons¹⁸.

Looking at the existence of collective agreements, in the Czech Republic they take place at the sector and company level¹⁹. They are regulated by the Collective bargaining Act. In social

¹² OECD, 2011.

¹³ Eurobarometer, in Sowa A., 2010.

¹⁴ Sowa A., 2010.

¹⁵ Horecky J., 2010.

¹⁶ Koldinská K., The Policy on Gender Equality in the Czech Republic European Parliament, 2015.

¹⁷ KZPS (Confederation of Employers" and Entrepreneurs" Unions of the Czech Republic), Decent work for domestic workers, International Labour Conference, 99th Session, report, 2010.

¹⁸ Carer plus, www.carerplus.eu

¹⁹ Eurofound, Czech Republic, On wage bargaining. <http://bit.ly/1MudNHJ>

services about 200 providers have a collective agreement or are negotiating²⁰.

In the Czech Republic, the overwhelming majority of work provided in the PHS 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 Republic²¹. 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.

It is estimated that 90% of activities (none-care activities) are done in the grey economy. As it is a grey economy, there is no relevant/official data. Also, it is supposed that many of these workers receive social support from the government at the same time - their income is not official so they can be also registered at the Employment Office. The workers have basically no rights as all agreements are oral and wage is paid in cash only²².

In order to reduce undeclared work in the PHS sector, 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 offenders²³. In 2013 the country has also introduced a new system of undeclared work inspections. Furthermore, the Czech Republic envisages introducing the vouchers system, on basis of French and Belgian experiences.

Income and social protection

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 wage²⁴.

In January 2015, the Czech minimum netto wage has amounted 332€ per month²⁵, or 2€ per hour. In June 2015 the average gross wage has amounted 25.306 CZK (933€)²⁶.

²⁰ Horecky J., Project PESSIS 2 “Promoting employers’ social services organizations in social dialogue”, Country-case study: Czech Republic, UZS, 2013. <http://bit.ly/1LfYy3A>

²¹ Sowa A., 2010.

²² For quality! project, Third regional seminar Vienna, 22 September 2015.

²³ European monitoring centre on change (EMCC), Tackling undeclared work, <http://bit.ly/1UPgwyw>

²⁴ Horecky J., PESSIS 2, 2013.

²⁵ Eurostat, 2015.

²⁶ Czech Statistical Office (CZSO), <http://bit.ly/1D2AxqR>

Better conditions in remuneration are needed, particularly within the social care system²⁷.

With regard to access to social protection, 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 person²⁸.

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 calculation²⁹.

Skills development and professionalization

The PHS sector 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 will be relevant for the future. There is a need for general high quality workforce in the sector³⁰.

In terms of qualifications, Jiri Horecky portrays four professions with their qualifications requirements³¹: **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).

With regard to the training, there is no national training policy for PHS in general. In the long term, increasing shortages are to be expected within the home care services sector.

Well-being

Results of a study on 'Stress, depression and life style in the Czech Republic' conducted in

²⁷ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

²⁸ Alzheimer Europe, <http://bit.ly/1CplywF>.

²⁹ Carers plus, Being carer in Europe, Czech Republic, <http://bit.ly/1dNTSpf>

³⁰ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

³¹ Horecky J., PESSIS 2, 2013.

2015 indicate that signs of depression, burnout and stress are relatively common among the Czech workers³². 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.

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)³³. 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 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 parents³⁴.

The Czech working group experts in Vienna have that an improvement in remunerations and working conditions (in particular in care), as well as the necessity of having high qualified staff, are essential for further improving PHS in the country.

3. SERVICE QUALITY

Availability and comprehensiveness of services

The PHS 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.

³² Eurofound, European Observatory of working life, Czech Republic: new study investigates causes of stress among Czech workers, 2015, <http://bit.ly/1hjFDuR>

³³ Data in this section are taken from: Eurofound, Working time in the European Union: Czech Republic, <http://bit.ly/1KQwbeB>

³⁴ Horecky J., PESSIS 2, 2013.

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 PHS system³⁵.

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 providers³⁶.

When it comes to comprehensiveness, PHS services should be easy to access by all those who may require them³⁷. Overall, the accessibility of PHS across the country is not sufficient³⁸. Besides, some specific target groups (persons with disabilities) are specifically affiliated.

The Czech working groups experts in Vienna have underlined that important barrier to the development of PHS in the country includes low accessibility of support services (especially for target groups such as people with mental health issues or people with multiple disabilities).

Quality of regulation and of management

The quality regulation of PHS services is carried out separately within the health care and the social services systems³⁹.

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.

³⁵ Sowa A., 2010.

³⁶ Horecky J., PESSIS 2, 2013.

³⁷ AGE Platform, 2010-2012.

³⁸ For quality! project, Third regional seminar Vienna, 22 September 2015, <http://forquality.eu/>

³⁹ Sowa A., 2010.

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 rights⁴⁰. 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.

The quality of PHS is monitored according to the dimension they include:

- The quality of **health care system** is monitored by inspection of insurance companies
- The quality of **social services**: 15 quality standards are monitored by the Ministry. Since the Social services Act from 2007 the country has introduced 15 quality standards that represent the basic frame for PHS services provision⁴¹: 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.

The Czech working group experts in Vienna have stressed the importance of improving monitoring of quality of healthcare and social care, improving data collection of the sector and improve accreditation of social services which are currently controlled by local authorities.

⁴⁰ Horecky J., PESSIS 2, 2013.

⁴¹ Horecky J., PESSIS 2, 2013.

4. CONCLUSION

One of the major problems in the Czech Republic seems to be the lack of an integrated national strategy regarding PHS and as a result no common definition of PHS⁴². Although some actions have been taken to go towards a more integrated PHS 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). It would be important to build one more specific definition of PHS, as well as the more specific definition of the PHS target groups⁴³.

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 system⁴⁴. Besides, 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 system is currently focused on shifting from an institutional care system to the home care, notably thanks to the care allowance. 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 flexibility⁴⁵.

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 users⁴⁶.

The current Czech system is not sustainable in the 10-20 next years. Studies predict that, if the current policies are continued then the public financing of the Czech system will rise from 0.8% in 2014 to 1.6% of the GDP in 2060⁴⁷. 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 system⁴⁸.

⁴² Horecky J., Peer review, 2013.

⁴³ For quality! project, Third regional seminar, Vienna, 22 September 2015, <http://forquality.eu>

⁴⁴ Sowa A., 2010.

⁴⁵ Sowa A., 2010.

⁴⁶ Horecky J., PESSIS 2, 2013.

⁴⁷ 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.

⁴⁸ EUbusiness, Czech Republic: country overview, 2014. <http://bit.ly/1Wzx8fg>

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