Ad-PHS
Advancing Personal and Household Services

This project is funded by the European Union.
(Ad-PHS - VS/2018/0344)

COUNTRY REPORT

THE CZECH REPUBLIC

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October 2020

EASPD IMPROVING SERVICES IMPROVING LIVES
EFSI European Federation for Services to Individuals
UNI global union europa
EFFAT
IWAK Institut für Wirtschaft, Arbeit und Kultur Zentrum der Goethe-Universität Frankfurt am Main
diesis
EFFE EUROPEAN FEDERATION FOR FAMILY EMPLOYMENT & HOME CARE

Introduction

The Czech Republic can be characterised as a post-communist welfare regime, where a gradual transition from institutional care to home care is taking place. However, the professionalization level of PHS is rather low. According to estimates by official sources,[1] about 80 per cent of the care work is provided informally, with recipients representing about 3.4 per cent of the Czech population.[2] At present, care work at home is mainly provided in the unpaid sphere, mostly by daughters and spouses. While demographic changes combined with increasing labour mobility represent a crucial challenge under these circumstances, the availability of rather high cash benefits for dependent persons makes alternative solutions feasible.

Factors supporting the growth and development of the field of PHS

At the end of June 2019, the Czech Republic had almost 10.7 million inhabitants. Due to international migration, the population of the Czech Republic increased by 20.9 thousand people during the first six months of 2019. Migrants arriving in the Czech Republic were mostly Ukrainian nationals, followed by Slovak nationals.[3] In 2020 the population of the Czech Republic is projected to trend around 10.7 million.[4] The share of young people in the working age population is diminishing rapidly, signalling future problems. The growth of the working age population will be low in the near future, although total employment is expected to grow.[5] The challenges for the Czech Republic in the future include coping with an increasingly aging population, as well as with the increasing costs and the sustainability of the health care system.[6]

In the Czech Republic, the rate of undeclared work in the private sector was 16.9 per cent of the total gross value added (GVA), respectively 7.7 per cent of the total labour input in 2013.[7] Households figure prominently among the fields where undeclared work is performed.[8] The overwhelming majority, i.e. 80 per cent, of the work provided in the

[1] 4Quality (2015).
[2] Horecký, Jiří, written comment 20.03.2020.
[3] CZSO (2019a).
[4] Trading Economics (2020).
[5] Skills Panorama (2020).
[6] 4Quality (2015).
[7] Williams (2017).
[8] Rais (2015).

Personal Household Services (PHS) sector consists either in family care activities performed in the unpaid sphere or in undeclared work.[9]

With regards to gender equality, the employment rate for the age group 20-64 years is 66 per cent for women versus 83 per cent for men, while the total employment rate is 75 per cent. When the number of hours worked is taken into account, the full-time equivalent (FTE) employment rate is 46 per cent for women versus 65 per cent for men.[10]

In general, the Czech economy and labour market performed remarkably well in recent years, maintaining strong GDP growth and reaching the lowest unemployment rate in the EU. Additionally, unemployment is not necessarily socially stigmatised, as unemployed people may nevertheless earn an income through limited employment or undeclared work. However, this leads to an increase in persons who will not qualify for old-age pensions due to not meeting the work period requirement.

The manufacturing industry remains the backbone of the country's economy, employing more than a quarter of the workforce. Most new job opportunities will come from services, namely arts and recreation or administrative and support services. Medium-level qualifications will be required for the majority of job openings. The share of total job openings requiring low qualifications in the Czech Republic is with 3.7 per cent the smallest in the EU.[11] At the same time, the country has been unable to tackle long-term unemployment which is substantially above the OECD average and keeps rising as a share of overall unemployment. One important factor behind the high long-term unemployment rate is the high level of over-indebtedness. There are approximately 863,000 persons affected and the number is growing. Their motivation to take up formal employment is rather limited, as the disposable income remaining after compulsory deductions to the creditors of their debt is very low. For those affected, it is more lucrative to be officially unemployed and to work only in undeclared employment.[12]

Additionally, there is low demand for elementary occupation workers in the Czech Republic, which amounts to a major barrier for the employment of marginalised Roma.[13] In the PHS sector in particular, qualified labour force is most needed.[14]

Definition and development of PHS instruments

One of the major challenges facing PHS in the Czech Republic is the lack of an integrated national strategy regarding the sectors associated with it. Although some steps have been taken to develop a more integrated PHS system, its provision and funding remain shared

[9] 4Quality (2015).
[10] EIGE (2018).
[11] Skills Panorama (2020).
[12] Trlifajovà/Hurrle (2019).
[13] Worldbank (2008).
[14] 4Quality (2015).

between two sectors, health care and social services, and between three different levels of government: national, provincial and local.[15]

As stated above, the Czech PHS sector is divided into two separate systems at present. Correspondingly, access to the two sets of services is different, and different criteria, assessments and allocation procedures are used.[16] However, it is possible for one individual in a household to receive both types of services, i.e. home nursing and home care.[17]

The first system is **home nursing**, as part of the **health care** system. Home nursing is covered by the **health care insurance**, under the condition that a general practitioner (GP) has confirmed its necessity for the individual case, and it is intended to care for persons after a hospital stay or for chronically ill patients, who do not need hospitalisation, but qualified care and treatment by a professional nurse.[18] The Czech long-term care (LTC) system also belongs to this category and corresponds to a wide range of care services for dependent persons. The philosophy of the home nursing system is to provide care within the family in a home environment.

The second system consists of **home care**, which belongs to **social services**. It is targeted at individuals, who do not need medically oriented home nursing, but basic personal care, support, and help in elementary or instrumental activities of daily living. Home care includes the following activities: assistance with daily life activities, help with daily hygiene, providing food or help with meal preparation, household services, and enabling contact with social surroundings. Home care also includes caring for children older than 3 years and short-term babysitting for children under 3, in case the family is recognized as in need, e.g. in the case of chronically ill children. Home care as part of social services is usually used for elderly and persons with disabilities. There is thus a gap for long term care for children under 3 years old.

Persons, who are recognised as being in need, are entitled to one of the major instruments supporting PHS: **cash-for-care benefits,** which are granted **to dependent persons to finance full-time care**, e.g. provided by their relatives. Until 2007, these monthly care allowances were paid to the persons (or institutions) who provided assistance. Since the reform of the social services in 2006,[19] care allowances are paid to the dependent persons, who must spend them either to privately cover the home care assistance costs, or to pay for home care provided by social services, or to cover a combination of both.[20] A patient applying for care allowance must complete an examination process conducted by the Czech Social Security Administration, including an assessment of his/her health status. The patients can use this allowance according to their needs, which means that they do not necessarily work with registered professional PHS providers.

Another instrument used in the PHS sector is **in-kind provision of services**. It includes 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**

[15] 4Quality (2015).
[16] Garms-Homolová (2013).
[17] 4Quality (2015).
[18] 4Quality (2015).
[19] Czech Ministry of Labour and Social Affairs (2006).
[20] 4Quality (2015).

at home. This can include shopping, meal preparation, washing, paying bills, taking medications, etc. The service provided is determined on the basis of individual requests.[21]

Additionally, **self-employed providers** may provide PHS services, namely the care of children above 3 years, occasional short-term babysitting for children below 3 years as well as providing services for families and households such as cooking, cleaning, washing, ironing and gardening or shopping[22] under the conditions defined by the Trade Licensing Act (No. 455/1991).[23] These activities recognised as eligible by the Trade Licensing Act could be considered as a definition of PHS.[24]

Landscape of users

According to existing estimates, 80 to 90 per cent of Czechs over 65 are relatively independent. 13 per cent need support in the area of housework, 7 per cent continuous and intensive care and help, and 2 per cent long-term-care in facilities.[25] In 2004, the proportion of people needing long-term care amounted to 0.76 per cent of the entire population. In 2014, the self-reported use of home care services was 8.2 per cent in the population over 65 years.[26] In 2017, there were 353,020 individuals receiving care allowances.

Corresponding to the structure of the older population, the majority of receivers of benefits for care, i.e. 65 per cent, are women. Female clients are frequently classified into categories of low benefits.

Depending on their health status, social situation and age, patients may be eligible for a monthly allowance ranging from CZK 880 (EUR 35) for the dependent persons in the first category (slight dependency) to CZK 13,200 (EUR 525) for those in the fourth category (total dependency) as follows: CZK 880 for the category I (slight dependency); CZK 4,400 for the category II (medium-heavy dependency); CZK 8,800 for the category III (heavy dependency); and CZK 13,200 for the category IV (total dependency). The allowance might be increased to CZK 19,200 (EUR 762) if the care is provided at home.[27]

For both genders, the rate of beneficiaries is the lowest in Prague, while it is the highest in the North of the republic.[28] This is partly due to the difficult economic situation of these regions, more affected by housing issues, unemployment, and youth leaving for the cities, leaving the rest of the local population more dependent on social services.

Furthermore, as young adults tend to move further away from their families' home, it becomes increasingly difficult for them to provide informal care to their relatives. According

[21] 4Quality (2015).
[22] RILSA (2014).
[23] Czech Ministry of Industry and Trade (2020).
[24] Kotíková, Jaromíra, oral communication during the Prague seminar, 19.02.2020.
[25] 4Quality (2015).
[26] Eurostat (2020).
[27] Martišková (2020).
[28] Garms-Homolová (2013).

to a study from 2010, more than 60 per cent of Czech respondents insisted that "adult children must care for their parents with disabilities even if it means sacrificing their career" which was the highest number, along with Poland, among the EU countries.[29] Families in general find it difficult to welcome strangers in their households to take over duties which were traditionally carried out by relatives. This is exacerbated by the general lack of trust from users vis-à-vis providers.

Financing of the main instruments and associated prices

At present, the PHS system in the Czech Republic seems to be moving from institutional care to home care. However, there have been no recent policy changes which would explicitly favour one of the two models. Therefore, the institutional care system persists and continues to be supported by public resources. Nevertheless, there is a tendency to provide care for older people in their homes.[30] Within this context, the state authorities support the development of easily accessible social services at the local level (especially out-services) and provide support (care allowances) for families to insure care of their older family members.

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**. **Home nursing** (personal care and technical nursing) is financed by the **health care insurance**, if a general practitioner has confirmed the necessity.[31]

Social services 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**. Only **registered services** get a **subsidy**, one part of which is provided to the regions (kraje) that are obliged to finance services in their area of responsibility. In order to finance these services, **networks of providers** are organised at the regional level. Only providers registered in such networks may receive funding from the region, although they are not guaranteed to receive funding, which is determined on a yearly basis. There is currently a lack of coordination between the networks' budget drafted in March, and the state's adjustment of wages, conducted in December.

The amount of the subsidy is dependent on the financial plan as well as on the plan of development of the service infrastructure in the region. As a consequence, different channels are used to distribute the subsidy: Firstly, the **care providers** are **subsidised directly by the state**, secondly **by the region** (kraj), that receives funding from the state, and thirdly **by the municipality** (obec), that receives funding from the region. The clients pay for

[29] Martišková, Monika, written communication, 22.02.2020.
[30] Martišková, Monika, written communication, 22.02.2020.
[31] 4Quality (2015); Garms-Homolová (2013).

the services mainly through the use of the cash-for-care benefits. They may also apply for a form of service provision through which no co-payment may be necessary.

The Labour office is responsible for approving the entitlements for cash-for-care benefits and has to monitor if the money was spent on social services. However, the clients are relatively free in their decision of how they will spend the money and which of the social services they will use. It seems that control on the client level is not provided consequently.[32] 25 to 29 per cent[33] of the overall amount of social benefits is spent on social care provided by officially registered providers, whereas the rest is spent on informal care by relatives or not spent on care at all.[34] The total cost of cash benefits amounts to about EUR 650 million per year[35] (about 0.6 per cent of the GDP), paid to about 362,000 recipients in 2019.[36] However, it is important to mention that compared to the Western European EU Member States, Czech citizens can afford more hours of services through these benefits.[37]

Long-term care services organised by the social services sector (for home, residential and day care) are funded by **the users' co-payments**, 35 per cent of the total costs of social services, **the state budget**, 30 per cent, **local authorities**, 25 per cent, and **health insurance**, 3 per cent. According to the Social Services Act of 2006, the amount of co-payment should not exceed 85 per cent of the user's income. Besides, the financial participation of municipalities is not systematic. The **social home care providers** are for their part funded by two main resources, namely by the **users' payments** (either using their income, mainly retirement pensions, or their care allowance), and by **state subsidies** (although there are no written rules, criteria or claims for the state granting).[38]

Work arrangements

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. In the formal PHS sector the intermediation model prevails, i. e. care workers are employed by a professional provider who deploys them to the beneficiary. Additionally, there are also self-employed care providers. Both models are not very common due to the relatively high costs for the households.

According to the Ministry of Labour estimates, about 80 per cent of the care is provided informally, with recipients representing about 2 per cent of the Czech population. This predominant type of care in the Czech Republic is provided at home by relatives, mostly by the next generation, but also by spouses. Additionally, live-in care workers also perform

[32] 4Quality (2015); Garms-Homolová (2013).
[33] Oral communication during the Prague seminar, 19.02.2020.
[34] Martišková (2020).
[35] The exact amount for 2019 is CZK 31,3 billion.
[36] Data provided by Jiří Horecký 20.03.2020.
[37] 4Quality (2015).
[38] 4Quality (2015).

care work.[39] In recent years there also seems to be a trend to hire PHS workers from the Asian region.[40] Still, surveys indicate that most Czechs consider family support as the best way to provide assistance to dependent persons, especially to those in poor physical or mental condition. However, most informal care providers also work, as 80 per cent of them have a full-time job. Thus, the decision regarding informal care is strongly dependent on the flexibility of a carer's job.[41]

It is estimated that up to 90 per cent of home care activities (e.g. help with activities of daily life, food preparation or household services) are provided as family care in the unpaid sphere or, to a smaller extent, as undeclared employment. Relevant or official data is lacking.[42] Domestic workers may opt for undeclared employment if they are officially unemployed and want to keep their unemployment benefits. Nevertheless, if a person is registered as unemployed, there is the possibility of earning a small amount of money and signing a small employment contract ("agreement"), which establishes lower insurance contributions than regular employment contracts.[43]

Workers in undeclared employment relationships have no rights, as many agreements are oral, and wages are often paid in cash only.[44] Another group whose status is not regulated are the live-in care workers.[45]

Migrant workers in the PHS sector are mostly working as self-employed, because the Czech migration policy is very restrictive. Without an employment contract or registration as self-employed, migrant workers would not be granted residence permits.[46]

Landscape of intermediaries and quality management

Private PHS providers can be divided into two groups: non-profit/non-governmental organisations and the for-profit sector.[47] In the PHS sector, informal caregivers (family members, neighbours, and friends) are registered only when they are paid by means of the care allowance of the dependent person, so that the state pays for their health care insurance. Furthermore, the years spent providing care (and being excluded from the labour market) count to the compulsory years for retirement pension. Other social insurance payments, e.g. in case of illness or unemployment, are not included.

Professional providers are registered social services, such as legal entities established by regional and local authorities or private organisations, non-governmental organisations, and

[39] Horecký, Jiří, presentation during the seminar, 19.02.2020.
[40] SIMI (2019).
[41] SIMI (2019).
[42] 4Quality (2015).
[43] Martišková, Monika, written communication, 22.02.2020.
[44] SIMI (2019).
[45] Horecký, Jiří, presentation during the seminar, 19.02.2020.
[46] Martišková, Monika, written communication, 22.02.2020.
[47] SIMI (2019).

natural persons.[48] In 2017, there were 702 registered providers of social care (public organisations, NGOs or private companies) who served 100,673 clients.[49] Still less common is personal assistance for persons whose autonomy is limited because of old age, chronic diseases, or health problems. In 2008, 183 services of this kind existed, with 1,800 staff members working for 7,000 clients.[50]

Yet, there is an additional distinction to be made. As stated above, networks of providers of social services are organised at the regional level and only providers registered in such networks are eligible for funding from the region. These networks are furthermore responsible for the accreditation of providers and the quality assessment of the services provided. However, these networks do not cover all the providers of domestic work. PHS providers, legally registered as enterprises, may operate outside the networks. Additionally, groups of persons for whom limited employment contracts are attractive, such as students, retired persons or unemployed persons, may also work in the sector.

The costs involved in becoming an employer (such as social contributions, insurance, etc.) are high and thus discourage attempts at reducing undeclared work by establishing employers. The formal provision of home care was approximately up to 50 per cent more expensive than the informal care provided by an undeclared worker.[51]

The quality management of PHS services is carried out separately within the health care and the social services systems. The provision of health care services is monitored and controlled by the health insurance company concerned. The system of monitoring and control of social services "National Quality Standards of Social Services" is included into the Social services law and provided by the Ministry of Labour and Social Affairs. There are 15 standards (8 procedural, 2 personal and 5 technical). A national inspection at the ministry provides an inspection to check whether providers of social services apply the quality standards.[52] The Ministry of Labour and Social Affairs produces a Report on Social Quality Standards, focusing on quality control of social services workers and on best practices guides for training. However, the system does not provide for very much regulation. 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.[53]

Municipalities and regional governments are the principal institutions responsible for accreditations, the monitoring and control of the PHS services. The PHS provider is subject to an authorisation procedure in order to assess whether or not the provider is able to meet all the conditions prescribed by the Social Services Act, including the quality standards as well as the compliance with human rights. The authorisation procedure is overseen by the regional governments. PHS services may further be provided under the Trading licenses act,

[48] SIMI (2019).
[49] Martišková (2020).
[50] Garms-Homolová (2013).
[51] Oral communication during the Prague seminar, 19.02.2020.
[52] Horecký, Jiří, written comment, 20.03.2020.
[53] 4Quality (2015).

on the basis of licenses issued by municipalities. The control procedure is done by an inspection. If conditions are not met, the license may be withdrawn.[54]

Landscape of employees and degree of professionalisation

As mentioned above, there were 702 registered providers of social home care in 2017. The total number of employees was 10,571.[55] In the Czech Republic, the overwhelming majority of work provided in the PHS sector is informal work provided in the unpaid sphere, as 80 per cent of the care for dependent persons is provided by the family, mainly spouses, children and other relatives.[56] A study has shown that persons, who were receiving home care by an agency, still received an extra 20.84 hours of care per week by relatives. Much more care by relatives is provided to those persons, who do not use an agency or another professional caregiver at all. In the Czech Republic, children are not liable for the care of their elderly parents.[57] In 2010, about 400,000 elderly persons needed assistance in activities of daily living. With at least one person providing care to each dependent person, it was estimated that there were at least 400,000 informal providers of care, most of them family members providing care in the unpaid sphere, in the Czech Republic. These were mostly, i.e. 63 per cent, women of working age. There is no data about the employment status or source of income of the care providers.[58]

Family members are officially not entitled to a reimbursement by the care allowance, but the everyday implementation is different. Additionally, informal care giving counts towards retirement income.[59]

Furthermore, self-employed persons and workers in limited employment, who use domestic work in order to supplement their income, can be found among the domestic workers.

NGO and media reports mention the presence of Asian PHS workers.[60] No data could be found regarding their employment conditions. Most migrant workers active in PHS are nationals of the Ukraine, due to the low language barrier,[61] and nationals of Vietnam.[62]

In order to reduce undeclared work in the PHS sector, the Czech Republic introduced a law in 2004 that established the definition of illegal work, strengthened control mechanisms in the area, and introduced penalties against offenders. In 2013, the country also introduced a new system of undeclared work inspections.[63]

[54] 4Quality (2015).
[55] Martišková (2020).
[56] 4Quality (2015).
[57] Garms-Homolová (2013).
[58] 4Quality (2015).
[59] Garms-Homolová (2013)
[60] SIMI (2019).
[61] Leontiyeva (2016).
[62] Rákoczyová (2014).
[63] SIMI (2019).

Wages

The hourly wage was approximately around CZK 90 for workers officially employed by an organisation, whereas workers operating in undeclared work relationships with the family can receive an hourly wage up to CZK 150 for the same service.[64]

Collective agreements in the Czech Republic are regulated by the Collective Bargaining Act and take place at the sector and company level. In social services, about 200 providers have agreed on a collective agreement or are in the process of negotiating. Workers in social services are all bound to §109 of the Labour Code. The calculation of their remuneration is laid down in the register of social services providers, and their wage most often does not reach the average income.[65] The minimum wage amounted to CZK 13,350 (EUR 519) per month since January 2019,[66] the average gross wage was at CZK 34,105 (EUR 1,337) per month in 2019,[67] and the average gross wage in the "human health and social work activities" sector was at CZK 36,076 (EUR 1,408) per month in 2019.[68]

The "human health and social work activities" section includes the provision of health and social work activities. Activities include a wide range of activities, starting from health care provided by trained medical professionals in hospitals and other facilities, over residential care activities that still involve a degree of health care activities, to social work activities without any involvement of health care professionals.[69]

Social dialogue in the field of PHS

The main social partners involved in the social dialogue in the field of PHS are the Association of Social Care Providers of the Czech Republic (*Asociace poskytovatelů sociálních služeb České republiky*),[70] the Trade Union of Health and Social Care of the Czech Republic (*Odborový svaz zdravotnictví a sociální péče České republiky*)[71] and the Unions of Employers Association in Czech Republic (*Unie zaměstnavatelských svazů České republiky*).[72] As the unions' membership increases, they might gain access to a higher, i.e. sectoral, level collective agreement, once they can claim to represent above 80 per cent of the workers.

[64] Oral communication during the Prague seminar, 19.02.2020.
[65] SIMI (2019).
[66] Countryeconomy.com (2020).
[67] CZSO (2019b).
[68] CZSO (2019c).
[69] European Commission (2020).
[70] See: http://www.apsscr.cz
[71] See: http://www.zdravotnickeodbory.cz
[72] See: https://www.uzs.cz

This threshold has been reached for the social services sector, but not for the health care sectors.

The Czech Republic has not ratified the ILO Convention 189. This is unlikely to change due to the lack of political will in this regard.

Policy Process

In terms of actors involved, the PHS management and organisation responsibilities are divided between the Ministry of Health, the Ministry of Labour and Social Affairs, and the local governments. With 38 per cent, not-for-profit organisations represent an important share of the social services providers; their participation is enshrined in the Law Act N°108/2006.[73]

A feasibility study carried out by the Ministry of Labour and Social Affairs in 2015 identified 4 needs for an adequate development of the Czech PHS-sector: professionalisation, household protection, high quality jobs, and services and fiscal neutrality of the formal provision of PHS.[74]

There is neither a unified legal background, nor any authority responsible for the regulation of the two systems (*health care system* and *social services*). The Ministry of Health is responsible for home nursing 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 PHS. While competences are divided between the two sectors, in some cases it is not clear which sector holds the responsibility.[75] In many cases providers offer both health care and social services and receive licences from both ministries. Unfortunately, there is no data on the number of such providers.[76]

Main legal regulations for PHS provision and the funding for the health care sector, focusing on services for persons with disabilities and persons in need of long-term care, are spelled out in 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).[77]

Legal regulations for the social sector, focusing on services provided to dependent and vulnerable people, including older people, are laid down in the Law on Social Services (2006) that controls provision of home care, access to cash benefits, and different types of residential care.[78] The introduction of individual-oriented care allowances in 2006 was met with some controversy, because it generally resulted in lower budgets for established care

[73] 4Quality (2015).
[74] Kotíková, Jaromíra, presentation during the Prague seminar, 19.02.2020.
[75] 4Quality (2015).
[76] Martišková, Monika, written communication, 22.02.2020.
[77] 4Quality (2015).
[78] 4Quality (2015).

institutions and made way for informal carers. There is a sentiment of gradually increasing[79] acceptance. The government, that initiated the reform of the Social Services Act (2006) and therefore the implementation of care allowances and services in-kind, consisted of a coalition between ČSSD (Czech Social Democratic Party), KDU-ČSL (Christian and Democratic Union – Czechoslovak People's Party) and US-DE (Freedom Union – Democratic Union).[80]

Furthermore, on the basis of the Law on the Decentralisation of Public Administration (2003), regional and local governments took charge of some segments of the LTC services such as emergency units, institutions of LTC, and about half of the country's hospitals.[81]

Commonalities across countries

The Czech Republic can be described as a "post-communist European" welfare regime, which "cannot be reduced to any of Esping-Andersen's or any other well-known types of welfare states."[82] Despite major differences between their types of welfare states, the Czech Republic envisages introducing the voucher system, based on positive experiences in France and Belgium.[83]

Previous Instruments

A past instrument used in the Czech Republic for PHS development was the Occasional Occupation Pilot Project from 2003 to 2005. The pilot project was initiated in 2003 in three departments with a total number of 250,000 inhabitants and had similarities to the so-called LEA system in Belgium. While the project was very successful in 2004 and 2005, it was eventually abandoned because of decreasing unemployment rates in the Czech Republic.[84]

Promising practices

In the Czech Republic, some of the long-term care institutions are part of the health care and some are part of the social care system, which makes institutional arrangements sometimes difficult to understand. The Social Services Centre run by the City of Prague provides a large scale of services, combining the registration for social services and for

[79] Alexa/Lukáš et al. (2015).
[80] 4Quality (2015).
[81] 4Quality (2015).
[82] Fenger (2007).
[83] 4Quality (2015).
[84] Horecký (2014).

health care services, i.e. home nursing. Thus, the centre is able to cover the needs of older people, from rare and irregular home assistance and services, to daily and short-term care or residential care. With this system, the service users do not have to change the provider because of the change of their conditions and needs. This concept is rare in the Czech Republic; usually, the services are provided by regions, NGOs, and church organisations. The cities usually guarantee only social care so that service users can only choose between two or three organisations. The centre in Prague intends to tackle the lack of cohesion between health and social care for service users with complex problems. It aims to improve co-ordination and continuity between health and social care and to make better use of resources (cost reduction) by enabling older people to stay longer at home.[85]

[85] CSSP (2016).

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Alexa, Jan / Rečka, Lukáš / Votápková, Jana / van Ginneken, Ewout / Spranger, Anne / Wittenbecher, Friedrich (2015): Czech Republic. Health System review. Health Systems in Transition 17 (1). URL: http://www.euro.who.int/__data/assets/pdf_file/0005/280706/Czech-HiT.pdf (last accessed 7 February 2020).

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