Preliminary National Report on Health Care and Long-term Care in the Czech Republic

Ministry of Labour and Social Affairs of the Czech Republic

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Health care and long-term care are assessed on the basis of three recommended principles: accessibility, quality and financial sustainability.

The term "long-term care" refers to a wide range of supportive health and social services provided 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 by another person in coping with their everyday life and daily needs. In particular, these services include assistance with self-service, personal hygiene, housework and providing links to social environment. The assistance can also involve help with such activities as shopping, seeing a doctor, paying the bills, taking medicines, etc.

Long-term care seeks to ensure that these people remain involved in a daily life as much as possible, receiving proper treatment in an adequate environment, even if their actual health condition would not enable them to do so.

Accessibility of Health Care and Long-term Care

Health Care

There are no major problems with the accessibility of health care in the Czech Republic. According to the law, all citizens must have health insurance, with the state covering insurance contributions on behalf of children, students, pensioners, the unemployed, etc. At the same time, there is enough physicians (39.2 per 10,000 inhabitants), both general practitioners and specialists (28.3 per 10,000 inhabitants) as well as doctors in hospitals (8.8 per 10,000 inhabitants). At the end of the last year, the network of institutional care facilities included 201 hospitals with 66,492 beds, the aftercare (i.e. nursing and rehabilitation medical care) being provided in hospitals (6,600 beds) and long-term care facilities (7,285 beds). The number of residential facilities is subject to only minor organizational changes, i.e. the regulation of emergency residential care results in some small facilities closing down their emergency beds, continuing on only as health care institutions of a narrow specialization. The apparent decline in the number of long-term care facilities has been caused by some of those facilities being integrated as nursing care units into other facilities, as a result of introducing a joint-financing model for emergency and nursing care.

Specialized aftercare is provided in specialist medical institutions. The Ministry of Health (hereinafter as MoH) is planning for a certain part of emergency care beds to be transformed into aftercare beds in the future.

There has been a slow, yet gradual increase in the hospice capacity, even though the number of these facilities is still not sufficient. Hospices are non-governmental facilities providing palliative care[1]. MoH creates conditions to enable the provision of palliative care to patients in terminal stages of malign diseases. MoH

[1] Palliative care is an active, life-quality oriented type of care provided to people suffering from incurable diseases in advanced or terminal stages. The primary objective is not to treat the patient or to prolong his/her life, but rather to prevent and alleviate pain and other physical or mental suffering, maintaining the patient's dignity and supporting his/her next of kin.

supports the establishment of hospices – health care facilities aimed at palliative care and chronical pain alleviation, meant for people with incurable diseases or suffering from chronical pain. Hospices work as regional centres for palliative care. As a mid-term objective, MoH strives to establish a network of hospices that would provide palliative care in all regions (Kraje) of the Czech Republic. As an alternative to the institution-based hospice care, there are home-based hospice services run by a hospice civil association "Cesta domů" ("Journey Back Home"). The aim is to enable a seriously ill person to remain in his/her home environment, spending his/her final days with his/her family and friends.

Other important providers of primary health care are home care agencies. Over the past six years, these services developed quite significantly in the Czech Republic. Currently, there are 450 agencies covering almost the whole country. Most of the agencies work 24 hours a day, thus ensuring a provision of adequate and accessible care. Home care agencies work together with general practitioners. One of the benefits of home care agencies is a provision of care in the patient's home environment. What is also positive is an intervention in the patient's family, targeted at teaching both the patient's family members and the patient him-/herself (if possible) how to be self-sufficient and independent.

Social Services

Social services provided within the framework of long-term care in the Czech Republic follow provisions of Section 73 (6) of Act No. 100/1988 Coll., on Social Security, as amended, which stipulates that these services should be provided to people who are not able to cater for their basic needs, usually because of their age or disability. Those services include institutional care or day care. Other types of social services, such as personal assistance, early intervention, contact centres or respite care, are not regulated by any statute.

Act No 100/1988 Coll. on Social Security, as amended, is outdated and does not reflect the requirements for the provision of high quality social services, entirely ignoring the fact that the aim of social services should be to support social inclusion and prevent social exclusion. Systems ensuring the quality of service provision (see below) are not regulated by the current legislation at all. This situation should be changed by the new act on social services currently under preparation.

There are huge inter-regional differences in the accessibility of social services the situation usually being better in the urban areas. People living in less populated areas find it more difficult to access long-term care, particularly services provided to the elderly, disabled or drug addicts. There is a lack of sheltered and assisted housing and other services for the mentally disabled.

Various types of social services related to long-term care are listed in Annex 2. Long-term care can be provided at home or in an institutional environment (institutional care).

<u>Home-based care</u>

In the Czech Republic, more than 80% of care for the elderly in need is provided by the family. An average length of such care is 4 to 5 years. People taking care of a close person are mostly women (64% women, 36% men), 80% of whom have a full-time job. Dependent elderly persons are typically looked after by adult children (53%), spouses (21%), relatives (10%) and friends (16%)[2]. However, as a

[2] Holmerová, I.: Eurofarmcare, National Background Report, Czech Republic 2004

result of the continuing social transformation and the changing socio-economic situation of families as well as due to high unemployment, commuting to work and housing shortage, there has been a decline of the number of families that are willing and have the capacity to take care of a dependent family member.[3] Traditionally, Czech people have required that the state plays an important role in providing social security. The "Population Policy Acceptance" research carried out in 2001 showed that citizens expect the state to be largely responsible for providing an adequate health care (79%), the second priority being a provision of the appropriate elderly care (see Table 1).[4]

People taking care of a close person or another person receive a carer´s allowance[5]. It is a social benefit awarded to carers (pursuant to Section 80 and the following of Act No 100/1988 Coll. on Social Security, as amended). On average, there are 33,146 carers receiving this benefit each month. This allowance is granted to people providing personal, full-time, and due care to a close person or another person who is fully or mostly incapacitated, or older than 80 and partially incapacitated. The carer´s allowance is also granted to a parent, grandparent or another person who, based on a decision of a competent authority, takes on the care of a child instead of his/her parents, providing a personal, full-time, due care[6] to such a child who is older than 1 year, has a long-term serious disability and is in need of special assistance, as defined by a special statute. The allowance is granted by a responsible local authority. As of 1 January 2005, the allowance amounts to 1.6 of the minimum subsistence amount necessary to provide subsistence and other basic personal needs when caring for one person, i.e. CZK 3,776, and 2.75 of the amount when caring for two or more people, i.e. CZK 6,490. An amendment to Act No 100/1988 Coll., on Social Security, is under discussion now to improve the economic situation of the carer's allowance receivers by allowing them to combine benefits with income from their economic activities.

Institution-based care

Institution-based social services in the Czech Republic are provided for by regions (Kraje) and local authorities. The Ministry of Labour and Social Affairs (hereinafter "MoLSA") recommends that institutions whose capacity exceeds 80 clients be founded by regional authorities. This type of service is governed by the current social security regulations. Other types of service are usually provided by local authorities or NGOs – a legal framework of the NGOs sector should be provided by the new act on social services.

As for the institution-based elderly care, social services are usually provided in two types of facilities: pensioners' homes and boarding houses for pensioners. Pensioners' homes should provide the elderly with a comprehensive care. Unfortunately this is not always the case as the facilities often fail to provide adequate nursing and rehabilitative care. Since 1994, there has been a continuous increase in the number of pensioners' homes and boarding houses for pensioners

[3] Bruthansová, D., Červenková, A.: Zdravotně sociální služby v kontextu nového územního uspořádání ("Health and Social Services within the Framework of New Territorial Structures"), VÚPSV, Praha 2004

[4] Vidovićová, L., Rabušic, L.: Senioři a sociální opatření v oblasti stárnutí v pohledu české veřejnosti. ("Elderly People and Ageing-related Social Measures as viewed by the Czech Public")

[5] The close person is determined according to Section 24 of Act No 155/1995 Coll. on pension insurance

[6] The obligation to provide a personal, full-time, and due care is complied with under certain conditions applying to both the carer and the person cared for. The obligation is complied with when e.g. the child attends a school or a kindergarten etc., or when a carer goes to work. In such cases, however, the care has to be provided by another adult.

(see Table 2). At the same time, there has been an increase in the number of beds in pensioners' homes, while numbers of rejected applicants have been increasing as well, as outlined in Table 2 attached in Annex 2. Pensioners´ homes are meant particularly for the elderly who, having suffered a permanent change of their health condition, require comprehensive care which is not or cannot be provided to them by their family members or through another type of social services; or for the elderly who need to stay in these facilities for other serious reasons. Waiting times for placement in a pensioners' home differ between regions from several months up to several years. The length of the period depends on the demand and the capacity available in the region as well as on the interest applicants show in a specific facility. In some cases, the client is offered a bed in another facility than he/she applied for, yet he/she decides to wait for a bed becoming available in the place he/she prefers. This applies particularly to newly built homes with modern equipment, in which pensioners show much greater interest than in the older facilities. There are no statistics for waiting times available. The options for reducing the waiting period differ from region to region. One of the options is to extend a range of alternative home-based social services (day care, home care, personal assistance etc.) that can sometimes substitute institution-based care, to extend compulsory comprehensive nursing care or modernize the current facilities, etc.

Pensioners' homes admit mostly elderly people of a rather good health. Appendix 7 to Decree No. 182/1991 Coll., implementing the Social Security Act, specifies disabilities based on which the client is admitted into or excluded from a social care institution (including pensioners' homes). If the pensioners' home does not have any nursing care unit, it cannot admit people with disabilities listed in Appendix 7 of the above Decree. Health care or nursing care provided by institutions is usually not covered from health insurance funds. It is funded by the founders of the institution.[7]

Nursing care is required not only for the elderly but also by people with physical or mental disabilities, whose number is continuously growing. In addition to that, the medical social care is required by people living on their own who suffered an injury. These people are in a particular need of community care and integrated care, i.e. rehabilitation and home-based social services.

When talking about institution-based care and the development of social care services for the elderly, one needs to take into account the growing numbers as well as the increasing average age of the old age pensioners[8]. Moreover, it is important to take notice of the current situation when day care is unavailable or denied to the elderly in need.

Social care institutions for adults are divided according to the types of disability their clients have: institutions for people with physical disabilities; for people with physical disabilities combined with other impairments; for the sensually impaired; the mentally disabled; chronic alcoholics and drug addicts; and for psychotic and psychopathic patients. It is not desirable that chronic alcoholics, drug addicts and psychotic people are permanently allocated in institutional establishments, yet it happens since there is no comprehensive rehabilitation system. Social care institutions for children and young people are divided as follows: institutions for young people with physical disabilities, for young people with physical disabilities combined

[7] Bruthansová, D., Červenková, A.: Zdravotně sociální služby v kontextu nového územního uspořádání ("Health and Social Services within the Framework of New Territorial Structures"), VÚPSV, Praha 2004

[8] At the end of 2003, there were 1,423,192 people older than 65 years living in the Czech Republic, which amounts approximately to 14% of the Czech population (source: ČSÚ)

with other impairments, and for young people with mental disabilities. The developments in the numbers of these facilities, beds and rejected applications are outlined in Table 3. The accessibility of social care to the disabled depends on a specific regional situation, the total number of beds in social care facilities and also on the proportion of the disabled or people otherwise threatened with social exclusion in the total number of inhabitants[9].

The amendment to Act No 100/1988 Coll. on Social Security, currently under discussion[10], is also going to regulate the use of restraint and coercive measures in social care institutions, such as caged beds. These measures and techniques will be allowed only in exceptional cases, when the client cannot be managed without the use of such special techniques and when there is a danger of harm to the client or others, as determined by the relevant doctor. In addition to that, the Act sets an obligation to keep a register of the use of such measures. Prevention of the use of restraints is a priority in the Czech Republic. It has to be ensured through social service quality control and the training of social care workers.

A part of the costs for staying in a social care institution is covered from the client's own resources (in institutions for young people, this cost is covered from the resources of their parents or other people in charge of the relevant child's education). The amount of payments for housing and other necessary services (cleaning, washing, and cooking) is governed by MoLSA Decree No. 82/1993 Coll., on payments for the stay in social care facilities, last amended in early 2005. Clients in social care institutions also have to cover subsistence costs[11]. Receivers of the increased incapacity benefit have to cover the costs of the incapacity-related assistance. In January 2005, the incapacity minimum subsistence amount was raised by Government Decree No. 664/2004 Coll., increasing, in effect, the benefits for partially, mostly or totally incapacitated people[12].

A general trend in social services has been a shift from the institution-based care towards the community-based care, promoting the idea of an individual care provided in a home-like environment. This trend puts emphasis on the individual approach to clients and their human rights (see the quality standards).

Social Hospitalization

Pursuant to the provisions of Section 73b of Act No 100/1988 Coll., on Social Security, as amended, social hospitalization refers to a situation when a person stays in a health care facility for other than medical reasons, e.g. for being in such a health condition which requires continuous assistance and due to which he/she cannot be released from the health care facility, unless being able to receive the required care in a social care institution, or in a day care facility. Social hospitalization is provided

[9] There are no statistics on these people, their numbers being only estimated, based on, for example, the amount of resources spent on full and partial disability benefits, social allowances, etc. In general, there are approximately 12% of people with disabilities in the population (National Plan for Promoting Equal Opportunities for People with Disabilities). A new selective periodical statistical investigation focusing on people with disabilities is currently under preparation. MoLSA is one of the active participants in this.

[10] The amendment to Act No 100/1988 Coll. on social security, as amended, has been already approved by the Czech Parliament.

[11] Subsistence costs are specified by a special regulation implementing MoLSA Decree No 83/1993 Coll., on subsistence provided in social care facilities.

[12] Partial incapacity benefit increased from CZK 464 to CZK 472 per month, the benefit for mostly incapacitated persons increased from CZK 928 to CZK 944, and the total incapacity benefit increased from CZK 1,740 to CZK 1,770. These benefits are paid out pursuant to Section 70 of Act No 100/1988 Coll., on social security. In 2004, 1.7 billion Czech crowns were paid out from the state budget to cover the increases in incapacity benefits.

when the person cannot receive the required care in a social care institution or day care facility, either due to the limited capacity or for professional reasons, even though the person complies with conditions for providing him/her with social service. Municipalities with extended powers are responsible for social hospitalization. Social hospitalization allowance is not defined as means-tested in the Appendix to the State Budget Act which specifies the part of contributions that municipalities with extended powers receive for the execution of state administration duties.

Since the social hospitalization allowance is well below the actual costs (300 CZK/day), health care facilities often do not report providing this service and do not show any interest in doing so. Social hospitalization payments are set out under MoLSA Decree No. 310/1993 Coll. on payments for social care provided in health care facilities. This payment is divided between the client (55 CZK/day) and a public administration authority (municipality with extended powers - 245 CZK/day). The contributions have not been valorized so far, even though the Decree was adopted back in 1993.

Social hospitalization is also linked to the client submitting an application for day care or for admittance to a pensioners' home, which may be rather discouraging for social service clients.[13]

MoLSA, together with the Ministry of Health and the General Health Insurance Fund, suggests the establishment of "social and health care beds" to be used in cases when the provision of social and health care services involves both the social care and health care elements. This would take care of situations where health care facilities do not report social hospitalizations since an inadequate financial compensation (300 CZK/day) is allocated to them for a "social bed". These social and health care beds will be occupied by people who need assistance with maintaining their self-sufficiency and medical nursing services. These beds will be situated both in the institution-based social care facilities and health care facilities. It is proposed that this care would be funded from several resources. Social care would be financed from the resources covering social service costs and from payments made by clients (service users), while health care would be financed by payments for medical activities and through standard medical care payments.

Quality of Health and Social Services Provided as Part of Long-term Care

The Czech health care system puts a great emphasis on introducing systemic models of a continuous enhancement of quality and safety in health care. The system is based on the following: the accreditation programme of the International Society for Quality in Health Care (ISQua) and WHO; requirements for the continuous enhancement of quality in health care services defined by WHO in the document Health 21 aimed at the European Region, approved[14] as the Long-term Plan for Improving the Health of the Czech Population – Health for All in the 21st Century; the International Convention on Human Rights and Biomedicine; the national quality promotion policy; and the strategy for promoting public service accessibility and quality.

To support the development and introduction of programmes of continuously increasing quality and safety in health care, grant programmes are announced with

[13] Bruthansová, D., Červenková, A.: Zdravotně sociální služby v kontextu nového územního uspořádání ("Health and Social Services within the Framework of New Territorial Structures"), VÚPSV, Praha 2004
[14] Government Resolution No. 1046/2002

the aim to deliver projects targeted at supporting high quality in health care. These grant projects focus on: indicators of performance and quality in health care facilities and the evaluation of health care technologies; standardization of health care; hospitals providing safe, high-quality and health-promoting services; participation of patients and their larger families in the process of health care quality enhancement; good performance and quality of health care provided at the regional level; links between health care and social care; and quality of primary care.

The Ministry of Health is a promoter of safety and quality in the Czech health care, considering it as an essential part of the health care policy of the Czech Republic. This approach is applied in two ministry councils (MoH Council for Quality in Health Care and MoH Council for the Accreditation of Health Care Facilities). Based on the principles of ISQua and WHO, a general outline of safety and quality in health care is currently drafted within the framework of a new act on health care. An optional accreditation programme with standards officially guaranteed by the state is planned. The quality assessment is supposed to have the form of national quality standards. These standards will be based on requirements for quality management, professional performance, and indicators of the quality and efficiency of health care provision, which should be also used to compare the accessibility and quality of health care in other countries.

The key tool to ensure the quality of social services (both social care and social prevention) and the accessibility of these services to all people are the National Quality Standards of Social Services. These standards are aimed, in particular, on the protection of the rights and interests of people in social disadvantage, with the aim to prevent their social exclusion or assist in their social inclusion. As mentioned above, there is no legislation regulating the quality of service provision in place at the moment (see below). The relevant legal framework will be provided only through the new act on social services. To support the implementation of quality standards, innovation-focused grant schemes have been introduced, involving the aid both from the national grant schemes as well as from Structural Funds, and the European Social Fund in particular.

The quality of social service provision is specified by a set of criteria (characteristic features and properties), which are supposed to determine how services meet the interests and needs of the two groups of actors involved – i.e. the clients and founders. Standards are defined by criteria that are very general. This is necessary so that the standards can be applied to any social service regardless of its nature, size or a legal form of the facility. This conception of standards assumes that social service providers themselves will define the important criteria in their documentation – e.g. objectives, mission, user target groups, capacity, procedures for ensuring that the users' rights are respected, means and principles of service provision, and other internal rules. This type of documentation as well as documentation on service provision (records on extraordinary events, individual plans, agreements on service provision and agreements register, etc.), are an important source of information for the assessment of the quality of services. The quality control of service provision, carried out against the social services quality standards, will be subject to social service quality inspection.

The legal framework of the quality inspection system and the social services quality standards will be provided by the new act on social services.

Financing of Social Services Provided in Long-term Health Care and Social Care

Health Care System

Ninety-two per cent of all costs in the health care system are covered from public resources (public health insurance and public budgets). The remaining 8% consist of care that has to be covered by people themselves. Hospital care is almost fully covered by public health insurance. The funding of the health care system is based on the principle of solidarity and ensures fairness as well as a general geographic accessibility and affordability of health care. Some of the EU Western countries introduced a needs-based system of resource allocation. At the moment some EU countries from Eastern Europe have started introducing this system as well, particularly when deciding on the geographic allocation of resources and services. Payments for primary care have to seek to achieve a balance between health promotion, disease prevention, treatment and rehabilitation; free choice of care providers allowed to everyone; fair pays of health care workers reflecting their performance as well as their professional qualities; responsibility to the community and provision of services reflecting the needs of the community, family and individuals; cooperation between care providers, and a demographic decision-making system. The payment system should promote efficient and flexible management aimed at continuous quality enhancement. In the primary care system there are some means of costs control at the macro level, i.e. compensations for registered patients combined with payments for specific operations. At the same time, it is necessary to supplement this system with the monitoring of the key set of indicators that will enable assessment of the structure and quality of service provision. Payments for the secondary and tertiary care can be delivered through the combined approach of prospective global budgets and monitoring the production efficiency trends to ensure long-term sustainability.

The overall costs of health care system are expected to grow due to the ageing of the population in the future. OECD predictions quantify this ageing effect as approx. 1% of GDP in the period until 2050. Therefore, this factor is not as significant as it is sometimes considered. It is the development of new technologies that is going to have a much greater impact on the growth of total costs.

Social Services

As of 1 January 2003, i.e. since the competences of responsible funding bodies were transferred from district authorities to local authorities, regional authoritites (Kraje) started to play a more significant role in long-term care financing. To run regionally founded social care facilities, regional authorities (Kraje) receive state budget funds allocated for the implementation of founding competences in social care facilities. It is within the responsibility of Kraje to allocate these funds, so they are the sole authorities deciding how they distribute the allocations. Kraje decide how much money is allocated per one bed in a particular pensioners' home or social care institution or what is the total amount allocated to social services within the region. The average amount allocated to one client of social services in the long-term care as well as the average costs depend on the type of service. For a more detailed information see Table 4.

Social care institutions and pensioners' homes founded by local authorities receive a single-purpose grant from the state budget, its amount being defined each

year by the State Budget Act. In 2005, the grant has been set to CZK 81,356 per bed per year in social care institutions providing one-week or year-long stays; CZK 43,870 in social care institutions providing daily care; and CZK 66,785 per bed per year in pensioners' homes. Long-term care social services are also funded by Kraje and local authorities from their regional and municipal budgets. Yet, this type of funding of social services is not prevalent. Table 5 outlines how funds were transferred from the state budget to the regions, local authorities and NGOs through grants in 2004.

In the past, the amounts allocated to social care facilities and payments for respective day care tasks were subject to regular adjustments, usually linked to the valorization of pensions. An average increase of payments was higher than an average increase of pensions, so there was a significant increase of payment proportions made by clients to cover costs of social services between 1995 and 2000. Table 6 shows an outline of how this percentage developed over this time in pensioners' homes. The trend was reversed at the turn of the millennium: in 2001, the proportion of average payments made towards average costs of the institutional care facilities started declining, especially due to the fact that the increase of payments for housing and subsistence in institutional care facilities was basically reflecting an average increase of old-age pensions.

The state also invests in building up new pensioners' homes. From this year on, there will be a grant, based on the relevant programme documentation, amounting up to 75% of costs allocated to the investment activities in the state budget. Last year, the average cost of beds in newly built facilities amounted approx. to CZK 1.25 million per bed (slightly less in renovated facilities), this year the amount is expected to increase, mainly due to a higher VAT on construction.

MoLSA provides a full funding from the state budget to five institutional care facilities directly administered by MoLSA.

In addition to that, social services in long-term care are funded through project grants allocated to NGOs (see The role of non-governmental non-profit organizations) and by social service clients themselves.

The Role of Non-governmental Non-profit Organizations

In 1990s, the first non-governmental non-profit organizations (hereinafter "NGOs") appeared in the system, providing completely new types of services and, most importantly, offering a new quality-based approach to the needs of service users. NGOs focus on providing social services based on out-patient rather than in-patient care. In addition to that, organizations were established which aimed at providing comprehensive social services - social service centres. Generally binding social security legislation setting out the conditions for social care provision, do not apply to the services provided by non-governmental agencies. Modern types of social services (day care centres, respite care and personal assistance) are not generally accessible throughout the Czech Republic, their development depending, inter alia, on the local situation (i.e. on local authorities). Some local authorities do not cooperate with NGOs and do not support the care provided by these organizations to the local community.[15] Some local authorities, on the other hand, provide a broad range of social services. Social services provided by local authorities are evaluated in

[15] Bruthansová, D., Červenková, A.: Zdravotně sociální služby v kontextu nového územního uspořádání ("Health and Social Services within the Framework of New Territorial Structures"), VÚPSV, Praha 2004

the study analysing municipalities, which makes it evident there are differences in the service provision.

Social services provided by NGOs are funded in a different way than services provided by regional or municipal institutional facilities (social care institutions). As mentioned above, social care institutions founded by the public administration authorities are funded from the state budget. NGOs, on the other hand, have to find their own resources to provide social services, mostly through the grant programmes of public authorities.

NGOs grants for the provision of long-term care social services are administered by regional authorities and MoLSA. Since 2005, Kraje have introduced independent grant programmes for social service provision. As for social services provided in long-term care, MoLSA administers a grant system aimed at NGO social service providers, focusing on projects delivered on the national level or in more than two regions. Among other things, the programme is aimed at supporting activities seeking integration and assistance to the elderly and disabled people. In addition to that, MoLSA administers a grant programme entitled “Programme of Support to Pilot and Innovative Projects”. This grant programme allocates grants depending on the resources available in the state budget and is aimed at MoLSA priorities as regards the development of social services. In particular, its aim is to support the introduction of new forms of social services, promoting life in a natural environment. The grant system is based on the assessment of projects presented to MoLSA by NGOs. Financial support is granted for a year and is purpose-linked.

The amount of financial support allocated as grants to NGOs service providers in the long-term care is shown in Table 7.

Pursuant to Section 14 (3) of Act No. 114/1988, Coll., on the Competences of Social Security Authorities in Czechoslovakia, as amended, NGOs are entitled to receive a financial support from municipalities and regional authorities (Kraje). This funding is provided by local authorities and Kraje in compliance with Act No. 250/ 2000 Coll., on Territorial Budget Rules, based on a contract concluded with a respective body beforehand.

Policies and Strategies in Health Care and Long-term Care

The ***National Programme of Preparation for Ageing 2003 - 2007*** (approved in Government Resolution No. 485 of 15 May 2002) is the key strategic document defining the objectives and tools in dealing with issues related to ageing population and to the elderly. The aim of this document is to support a development of the society for all age groups so that people grow older with dignity and in a safe environment, pursuing their lives as full members of the community. The programme covers a whole range of areas related to the elderly people’s lives and it should be implemented through public service policies and systems adjusting themselves to the changing age structure of the population, with the aim of promoting the development and enhancement of quality of life of the elderly in the Czech Republic. The programme concerns all age groups. The young generation is expected to acknowledge the elderly people, not discriminating against them. The middle-age generation is expected to take on the political responsibility for implementing the ageing policy and to assume personal responsibility for their own preparation for

ageing. The old generation is expected to take an active approach to their lives, getting involved in social structures. In relation to the National Programme of Preparation for Ageing, the Ministry of Health announced a grant programme entitled ***Healthy Ageing in 2004***. The programme is aimed at supporting projects delivered by municipalities and NGOs providing care to the elderly and people suffering from the old age-related diseases.

Health care and social care provided to people with disabilities is dealt with in the ***National Plan for Equalistaion of Opportunities for People with Disabilities*** (approved in Government Resolution No. 256 of 14 April 1998). Most of the tasks thereby assigned have been already achieved. The government approved the new ***medium-term Strategy for National Policy o n People with Disabilities*** (Government Resolution No. 605, 16 June 2004), based on which the new National Plan will be drafted. Following the tasks defined in the National Plan for Equalisation of Opportunities, programmes to support the social inclusion of the people with disabilities will be implemented every year. In 2004, a programme supporting civil associations and humanitarian organizations was announced. The programme is aimed at supporting projects delivered by NGOs operating on the national scale, which provide care to the disabled or chronically ill. Projects delivered in 2004 on the regional or local scale were supported through a grant programme aimed at NGOs (a programme supporting social services at the local and regional levels). In 2004, these projects were allocated CZK 43.2 million.

A ***National Plan for Support and Integration of People with Disabilities in 2006 – 2009*** is under preparation now***.*** This draft should be presented to the Czech government for approval by the end of June 2005.

Another policy document aimed at social services provided in long-term care to the disabled and elderly is the ***National Action Plan on Social Inclusion in 2004 – 2006***[16]. The document sets an objective as regards the accessibility of social services in long-term care. As for people with disabilities, the objective is as follows: "*to promote services that enable people with disabilities to live in their natural environment and, if this option is not feasible, to provide services offering them an opportunity to participate in social life and to protect their rights".* As for the elderly, the objective is to *"enable old people who are extremely at risk of social exclusion to stay in their natural environment as long as possible. Where this option is no longer feasible, they should be given an opportunity to participate in the life of society and their rights should be protected".*

Other objectives of social services are defined in the National Action Plan on Social Inclusion as follows: to finalize the transformation, decentralization and legal framework of social services; increase the quality of social services delivered at the local, regional and national levels by using the social services quality inspection system currently under preparation and by introducing the national quality standards for social services; and ensure a broad range of social services are offered, reflecting various needs. The provision of high-quality social services is closely linked to the need of educating and training social care workers. Another objective defined in the National Action Plan is promoting the system of professional life-long learning of social care workers.

The National Action Plan highlights the need for mobilizing all stakeholders to tackle poverty and social exclusion. In this respect, the Plan puts a great emphasis

[16] Government Resolution No. 730 of 21 July 2004

on supporting NGOs and their networks. Another important element is a promotion of partnerships between state authorities, Kraje, municipalities and NGOs as regards planning and implementation of social policies at the local level. Local planning of social services – also known as the community planning of social services – is a useful tool to achieve this objective.

To increase the quality of service provision, the government approved a ***Draft Policy of Life-long Learning of Social Care Workers and Human Rights Education*** in May 2003.

The Czech Republic has subscribed to the programme announced by the World Health Organization, ***Health for All in the 21st Century***. A relevant national policy document was then drafted: ***Long-term Programme for Improving the Health of the Czech Population – Health for All in the 21st Century***[17]. This policy has been drafted and implemented by the Ministry of Health. The programme includes measures to support healthy ageing (Objective 5) of the elderly who are no more self-sufficient due to disabilities or demanding social environment. The aim is to ensure an efficient coordination of health and social services, using all possible means to allow these people to live in the natural environment. The aim is also to increase by at least 50% the number of 80+ people who, living in their home environment, are in such health that enables them to maintain their self-support, self-respect and their position in the community. The social service system can influence the elderly people's quality of life in a significant way. One of the tools to achieve the objectives is a reform of social services planned in the new act on social services. Social services should enable people to lead an independent life in the natural environment of their home and community.

Objective 6 of this long-term programme, i.e. improvement of mental health, is aimed at increasing the quality of care provided to people who are mentally ill and at shifting the care from large psychiatric institutes and establishments to a more balanced combination of psychiatric hospital care and community-based services, i.e. the community care. The quality improvement should be achieved through the training of health care workers taking care of the mentally ill, teaching them how to identify risk factors. The programme is assessed on a yearly basis, the first assessment report having been presented to the government on 30 September 2004.

Stakeholders Participation in Drafting of the Report

The Preliminary National Report on Health Care and Long-term Care in the Czech Republic in 2005 has been drafted by the Ministry of Labour and Social Affairs in cooperation with the Ministry of Health. The report has been drafted in a close cooperation with experts on long-term care from various NGOs. The report has been also discussed with the Committee for Social Inclusion. This is an inter-departmental committee that participated in the drafting of the Joint Memorandum on Social Inclusion and the National Action Plan on Social Inclusion.

[17] Government Resolution No. 1046 of 30 October 2002

Annex 1 – Social Services: Typology

Social services cover social care and social prevention services. Long-term care involves the following social care services:

Day Care is provided to people whose ability is limited, particularly in terms of personal care and housework. Day care is a home-based service provided in the clients' natural social environment, in day care homes, day care facilities etc. It is the most prevalent social service. Day care includes regular personal hygiene; simple nursing activities; shopping and errands; washing and ironing; lunch delivery and cooking assistance etc. Payments per services and the services themselves are set out under the Ministry of Labour and Social Affairs Decree No. 182/1991 Coll., implementing the Social Security Act and the Act on the Competence of the Social Security Authorities in the Czech Republic.

Personal Assistance is a service provided to persons whose ability is limited, particularly in terms of personal care, public facility use, housework, contacts with the family and with the community in general. The aim is to provide personal assistance in coping with everyday activities which would otherwise be carried out by the clients themselves were it not for their disability or old age. Personal assistance is also seeking to enforce and defend the interests and rights of clients such as in their dealings with institutions. The service is provided in the client's natural environment, i.e. where the person lives, works, is educated or trained etc. Personal assistance is based on actual needs of the client. The scope of this service is determined (negotiated or set in a contract) in advance. It is not based on a list of activities. The aim is to make the client self-sufficient or to develop the client's self-sufficiency in his/her natural environment while respecting his/her own personal lifestyle. The service is usually provided by NGOs and sometimes by state-run establishments.

Respite Care involves, in particular, assistance provided to families taking care of the disabled or elderly people throughout the whole year: The aim is to help the carers while upholding the standard social opportunities for them (employment etc.). The service must include the following: assistance with self-service; hygiene; catering; housekeeping assistance; assistance with raising children; psychotherapy and socio-therapy; assistance in promoting the client's rights and interests. Respite care is either home-based or provided in specialized residential facilities offering short-term stays for up to three months.

Day Service Centres provide service to persons whose abilities are limited in some areas, such as in personal care; the use of public facilities and services; leisure time activities; gaining and keeping employment; enforcement of rights and claims; contacting the community etc. It is a combination of day care services provided in a special facility or in the client's natural environment. The aim is to activate the clients and to stabilize or reinforce their abilities and skills. Day service centres seek to reinforce the self-sufficiency and independence of clients whose capabilities are limited for some reason, allowing them to use standard public or private services (i.e. other social sources). The service is provided in special residential facilities.

Residential services in social service homes for pensioners and the disabled are provided to persons whose abilities are limited, particularly in terms of

personal care and housework and who do not live at their homes. The services include the provision of housing in special facilities to replace the clients' homes. These services are not time-limited. The aim is to assist in the development or maintenance of the current self-sufficiency of the client; help the client return back to his/her home, if possible; and assist him/her in getting back to or maintaining his/her previous lifestyle. The services are provided in special residential facilities such as pensioners' homes, boarding houses for pensioners, and social care institutions, both for adults and the young.

Sheltered Housing is a service provided to persons whose capabilities are limited, in particular in personal care and housework but whose wish is still to live on their own, in some standard home environment. Sheltered housing includes the provision of housing in a flat which becomes a home for the client while being kept by the service provider, a flat in a standard house, looking exactly like an ordinary flat and kept up just like in a normal life (shared household with the possibility of individual housekeeping). The aim is to assist the client's self-sufficiency, perhaps to return to his/her own home or to maintain or restore his/her original lifestyle. The service must provide for the following: assisted self-service; accommodation; housekeeping assistance; provision of information and contacting the community; and assistance in the enforcement of the client's rights and interests. This service is provided in special facilities resembling households.

Assisted Housing is a service provided to persons whose abilities are limited, particularly in terms of personal care and housework but who wish to live autonomously, in a standard environment. The service is based on assisted housekeeping, including the management of the household's finance, looking after the flat, and, if necessary, assisting the client with personal care. The service is provided in the client's own flat which is not kept by the service provider. It is not a time-limited service. The aim is to allow the person to stay in his/her own home environment.

Annex 2 - Tables

Table 1 - State Responsibility Rate in Elderly Care

State Responsibility Rate	%
Full Responsibility	28
Significant Responsibility	42
Some Responsibility	23
Limited Responsibility	6
No Responsibility	1

Source: PPA II – CR

Table 2 - Social Care Facilities for the Elderly

Year	Indicator	Pensioners' Homes	Boarding Houses for Pensioners
1994	Number of facilities	290	106
	Number of beds	32,798	10,159
	Number of rejected applicants	17,009	9,493
1995	Number of facilities	290	124
	Number of beds	32,305	11,549
	Number of rejected applicants	18,549	12,364
1996	Number of facilities	303	137
	Number of beds	33,779	11,969
	Number of rejected applicants	21,609	17,612
1997	Number of facilities	314	146
	Number of beds	34,436	12,593
	Number of rejected applicants	23,454	17,612
1998	Number of facilities	320*	150
	Number of beds	35,218	12,593
	Number of rejected applicants	25,431	18,443
1999	Number of facilities	333*	148
	Number of beds	35,656	12,126
	Number of rejected applicants	27,243	19,678
2000	Number of facilities	343***	148
	Number of beds	36,662	12,129
	Number of rejected applicants	28,784	20,652
2001	Number of facilities	352****	150
	Number of beds	36,612	12,432
	Number of rejected applicants	34,763	22,148
2002	Number of facilities	360****	148
	Number of beds	37,686	12,382
	Number of rejected applicants	33,222	17,601
2003	Number of facilities	378*****	144
	Number of beds	39,331	11,487
	Number of rejected applicants	50,192	25,389

* Four facilities combining the pensioners' home and boarding house are included here
*** Five facilities combining the pensioners' home and boarding house are included here
**** Six facilities combining the pensioners' home and boarding house are included here
***** Nine facilities combining the pensioners' home and boarding house are included here

Table 3 - Social Care Facilities for the Disabled

Year	Indicator	Institutions for the Disabled	
		Adults	Young People
1994	No. of facilities No. of beds No. of rejected applicants	71 5,994 1,012	174 12 487 1,335
1995	Number of facilities Number of beds No. of rejected applicants	76 6,448 817	176 12 651 1,157
1996	No. of facilities No. of beds No. of rejected applicants	75 6,402 1,535	182 12 803 785
1997	No. of facilities No. of beds No. of rejected applicants	76 6,563 1,649	181 11 906* 17,612
1998	No. of facilities No. of beds No. of rejected applicants	75 6,585 1,816	181 12 470* 741
1999	No. of facilities No. of beds No. of rejected applicants	78 6,743 2,122	185 12 468* 792
2000	No. of facilities No. of beds No. of rejected applicants	81 7,022 2,642	182 13 119* 20 652
2001	No. of facilities No. of beds No. of rejected applicants	84 7,059 2,987	184 13 116 610
2002	No. of facilities No. of beds No. of rejected applicants	88 7,065 3,241	186 13 176 400
2003	No. of facilities No. of beds No. of rejected applicants	98 7 744 3,477	173 12 056 792

* These are only residential facilities – no day-care centres are included here
Source: MoLSA

Table 4 – Average Spending per Person Compared to Average Payment Rate – Selected Service Types (2003)

	Average Spending per Resident per Month (CZK)	Average Payment per Resident per Month (CZK)	Payment Rate in Industrial Spending (%)
Pensioners' Homes	14,438	5,442	37.57
Boarding Houses for Pensioners	5,844	2,064	35.32
Soc. Care Institutions for Adults	16,480	5,401	32.51
Soc. Care Institutions for the Young	17,486	3,516	20.1

Source: MPSV

Table 5 – State Budget Transfers (Chapter 313 - MoLSA and General Cash Administration Chapter) in thousands of CZK in 2004

Subsidy	Regions	Municipalities	Providers	Total
Subsidies to regions and municipalities for performance of founding duties	4,811,282	26,113	0	**4,837,395**
Subsidies to municipalities per bed (pensioners' homes, social care institutions)	0	1,275,049	0	**1,275,049**
Subsidies to NGOs - social care providers	403,080 *)	0	918,419	**1,321,499**
Expenditure of social care institutions founded by the Ministry	0	0	343,955	**343,955**

*) These subsidies are included in the subsidies for funding the general and investment development of regional self-governing units provided from the General Cash Administration Chapter.

Source: MoLSA

Table 6 – Average Payment as Percentage of Non-Investment Expenditure of Pensioners' Homes between 1995 and 2002

	Non-investment Expenditure in Pensioners' Homes (CZK/month)	Average Payment by Person (CZK/Month)	Payment as Percentage of Non-investment Expenditure (%)
1995	7,650	2,062	26.96
1996	8,728	2,509	28.75
1997	9,258	3,436	37.11
1998	10,030	3,999	39.87
1999	10,974	4,434	40.4
2000	11,402	4,619	40.51
2001	12,728	5,030	39.52
2002	13,751	5,342	38.85

Source: MoLSA

Table 7 - Subsidies to NGOs for long-term care services in 2003

Social Service Type	**Total Subsidy - Allocated**	**Total Subsidy – Paid Out***
Shelters	141,823,400	141,823,400
Sheltered Housing	36,066,000	36,066,000
Day Service Centres	222,254,900	222,254,900
Homes and Boarding Houses	375,937,800	370,876,800
Personal Assistance	47,417,016	47,351,524
Respite Care	3,735,000	3,735,000
Assisted Housing	2,413,000	2,413,000
Day Care	83,569,400	82,928,400

* Returns are included in the subsidy paid out
Source: MoLSA