ESPN Thematic Report on work-life balance measures for persons of working age with dependent relatives

Czech Republic

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Robert Jahoda, Ivan Malý, Tomáš Sirovátka,
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European Social Policy Network (ESPN)

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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Summary / Highlights

The Czech Republic adheres to the traditional model, where long-term care (LTC) is largely considered a “family affair” and where family members and friends provide most care. This is not just the case for less-intensive assistance: more than 30% of those who are involved in care provision spend more than 20 hours a week providing care (ÚZIS/IHIS, 2012). Women make up more than two-thirds of the family assistants.

Our report suggests that for many people in the country a work-life balance is not easy to achieve – or in any event, there are few measures to promote it. The Czech social and health system neither values nor lightens the role of informal care providers. Existing measures of support are not sufficient (MPSV/MLSA, 2015a).

Excessive demand for inpatient services clearly suggests that there is an imbalance. Czech families may rather prefer less involvement with LTC. It is not clear whether this is mainly due to a lack of support services; to the low well-being of carers (mostly women), who are often forced simultaneously to deal with care and some kind of parallel economic activity; or purely to low family income, where the household has to make ends meet on just one income.

There is no proper carer’s leave scheme, direct cash benefits are limited, and the supply of support services varies quite considerably across regions. The quality of informal care is of serious concern, due to a lack of information about good practice, education and training.

Carers face many shortcomings in current LTC policy. There is no integrated LTC system, either in terms of legal environment or financing. There is an inadequate supply of field social and health services that target dependent persons, and this also applies to public services for carers.

It is quite difficult to assess the effectiveness of existing work-life balance measures for working-age people with dependent relatives. Detailed and specific data are not available, and the whole issue remains considerably under-researched.

Based on the scarce indications available, we claim that the way in which the arrangements regarding care and carers function and interact has negative repercussions, mainly in terms of the employment of carers. However, this is not a policy concern in the country, since the lion’s share of care for the elderly and for disabled persons relies on informal family care, and the system would collapse if family members did not provide care when necessary.

Although there are some protective elements within the social protection system, designed to compensate for care-induced periods of inactivity, the overall effect on the well-being of carers is thought to be rather negative, although the risk of poverty is largely prevented. On the other hand, the key positive factor is that dependent persons get outpatient care of a quality that they would not otherwise be able to receive.

It may be worth paying greater attention to the issue of the employment effects of informal care, as well as to the well-being of carers and dependent persons. There is a need for reform to integrate social care and healthcare into one system, and to enable a rather substantial development of professional home care. Lastly, measures that would support part-time work for specified reasons, such as care obligations, should be introduced – e.g. special care leave and special benefits/allowances for carers.

1 Description of main features of work-life balance measures for working-age people with dependent relatives

1.1 Overall description of long-term care regime

Long-term care (LTC) in the Czech Republic has developed in a fragmented fashion, with responsibility split between the healthcare and the social care sector. This is combined with vertical fragmentation, with responsibility divided between different institutional tiers: the state, regions and municipalities. The governance of LTC, as well as of palliative, health and social care, remains an issue, mainly in terms of integrating the health and social aspects. There are great differences in the cost of care for clients. While the clients pay for a major part of social care, care in healthcare facilities is covered from public health insurance. This discrepancy often leads to the hospitalisation of people who rather need social care.

Social care providers are either registered or unregistered. If registered, they have to follow the price regulations set by the Ministry of Labour and Social Affairs (MLSA),[1] if they are to be eligible for public subsidies. Unregistered providers of social services (e.g. private residential homes for senior citizens) are free to set their own pricing policy; however, they have to cover all costs from the payments made by the recipients of their services.

The introduction in 2006 of personal care allowance (cash benefits) for people in need of long-term care represents a major reform step in the area of social services. The criteria for granting a specific allowance level are specified in the law on social services.[2] They are based on the recipient's mobility, ability to manage daily activities, etc.

The Czech Republic adheres to the traditional model, where LTC is largely considered a "family affair", and family members and friends provide most care. Internal MLSA data estimated this share at between roughly 52% and 75% (depending on the degree of dependence of the service user) in 2010 (MPSV/MLSA, 2013). This is not just the case for less-intensive assistance: more than 30% of carers spend more than 20 hours a week providing care (ÚZIS/IHIS, 2012).[3] Women make up more than two-thirds of the family assistants. In older age groups, the proportion of men is higher.

Multi-source funding is a key concept of the current social services funding scheme. Client fees represent the main source; others include the MLSA's subsidies and grants flowing into regional governments' budgets. Health insurance funds are another important resource – they partly cover the cost of health services linked with social services.

1.2 Description of carers' leaves

In the Czech system, there is basically no real guaranteed leave available to carers that is related to care for dependent relatives. Employers are obliged to excuse an employee's absence from work only if care is being provided to a sick child under 10; in the case of any other family member, absence can only be excused in the case of serious illness, documented by a doctor's certificate. The duration is formally unlimited, but cash benefits are paid for up to nine calendar days in each individual case[4] (OECD, 2015). The payment is basically sick pay, but it involves a rather complicated calculation – a parent on an average salary receives CZK 464/EUR 17.20 per day. This provision does not apply to the care of dependent relatives, in the sense of the topic under review.

[1] Resolution No. 505/2006 Coll. of the Ministry of Labour and Social Affairs, at www.mpsv.cz/cs/7334

[2] Act No. 108/2006 Coll., at http://www.mpsv.cz/files/clanky/7372/108_2006_Sb.pdf The Act also recognised a broader scope of types of social care services.

[3] Colombo et al. (2011) speak of "intensive" care because of such workload.

[4] Sixteen calendar days for single parents caring for at least one child under compulsory school age.

The Labour Code[5] sets the right of an employee to ask the employer to reduce his/her workload or to move to other working arrangements if he/she should need to take care of a long-term dependent person with Level 2 dependency on others (i.e. medium dependency), as well as with Level 3 and Level 4 dependency (heavy and full dependency, respectively). The employer is obliged to accept the request, unless there are serious operational problems. In real life, most employers have little difficulty in not complying with this obligation. However, a recent study (PPM Factum, 2013) suggests that the majority of employed women aged 45–65 who care for dependent relatives received a helpful response from their employers, at least in "serious" cases. On the other hand, the detailed findings suggest a lack of opportunity for employed women to benefit from a reduced workload and/or other working arrangements (e.g. flexible working schedule), especially those women in full-time work. The Ministry of Labour and Social Affairs is considering the introduction of a legal entitlement to care leave of 3–6 months, accompanied by care-related benefit (see below).

1.3 Description of carers' cash benefits

There are no special direct benefits provided to informal carers – the Ministry of Labour and Social Affairs is only now considering the possibility of introducing some kind of benefit (MPSV/MLSA 2015b; interview with the Minister of Labour and Social Affairs on Czech TV, 13 February 2016): this could be provided for the duration of care leave in an amount similar to sickness benefit.

What is relevant for carers of dependent persons are financial benefits in the form of tax relief. These include a wastable tax credit that can be claimed by a taxpayer whose spouse's annual income does not exceed CZK 68,000 (EUR 2,473). However, this credit is not targeted exclusively at taxpayers with dependent family members. The value of the yearly tax credit is the same as the basic taxpayer credit – CZK 24,840 (EUR 903), which is the reason why only taxpayers with income above 81% AW can fully benefit from the measure. If the spouse of the taxpayer holds a disability certificate (ZTP/P), the credit doubles. Currently, there is no evidence of the extent to which this credit is being used. However, using a household tax-benefits simulation model,[6] we can prove that in 2014 the full advantage of this credit was available to only 31% of men and 17% of women on the highest salaries.

Another significant measure is child tax credit. In 2014, child tax credit amounted to CZK 13,404 per each child per year (approx. EUR 41 a month). Since 2015, the amounts of the child tax credit have been differentiated according to the number of children (a higher amount for the second child and for any subsequent children). Since the tax credit can take the form of negative income tax, it is the main redistributive measure targeting families with children. This is especially true of families with a disabled child, since the value of the tax credit doubles if the child holds a disability certificate (ZTP/P). For details on tax credits see OECD (2016, pp. 229).

There are also other tax reliefs relevant to families that care for dependent members. For example, a person with a disability certificate (ZTP/P) is exempt from property tax on home ownership. There are other exemptions, too: from administrative and local charges, as well as from radio and television fees.

As was noted above, the personal care allowance is a cash benefit provided directly to those being cared for. There are four levels of care allowance, according to the recipient's degree of dependency on support and age (for details see Table 1). The highest level of dependency entitles the recipient to care allowance of around half the average salary and slightly above the average pension. Care allowance is not means tested. The number of recipients increased from 260,000 in 2007 to almost 332,000 in 2014. In total,

[5] Act No. 262/2006 Coll. § 241 (2).

[6] Our own simulation; based on ČSÚ/CZSO (2014) data on wage differentiation.

expenditure reached CZK 21.1 billion/EUR 780 million in 2015 (compared to CZK 20.4 billion/EUR 750 million in 2014 (MPSV/ MLSA, 2015b).

Table 1: Personal care allowance, 2014

Category	Monthly benefit 2014–15 CZK / EUR		Average number of recipients (2014) (thousands)			Total cost (million CZK / million EUR)
		Age		Age	Total	Total
	<18	18+	<18	18+		
Level 1 (mild dependence)	3,000/111	800/30	11.3	96.8	108.1	1,413/52.3
Level 2 (medium dependence)	6,000/222	4,000/148	6.6	101.8	108.4	5,330/197.2
Level 3 (heavy dependence)	9,000/333	8,000/296	4.8	67.6	72.4	6,894/255.0
Level 4 (full dependence)	12,000/444	12,000/444	4.9	37.8	42.7	5,930/219.3
Other costs						835/30.9
TOTAL			27.6	304.0	331.6	20,402/754.5

Source: MPSV/MLSA (2015c).

A large part of care allowance is retained by the recipients and is not used to purchase formal services. This means that it at least partially serves to reimburse the costs of informal care provided by relatives and/or friends, and represents some sort of income/benefit for carers.

Table 2: Care allowance utilisation (number of people; figures for December 2014)

Age	Under 18 years				18+ years				Total	
Level of dependence	1	2	3	4	1	2	3	4	Number	%
Care allowance utilisation – provision of social care										
Natural person (individual)	11,369	6,758	4,731	4,282	73,693	75,698	46,555	20,246	243,332	69
Registered social service provider	51	110	184	654	20,104	25,081	22,579	18,656	87,419	25
Unregistered social service provider	24	37	35	14	108	125	181	145	669	0.2
Not specified	194	107	77	101	7,280	6,321	3,163	1,301	18,544	5
Total number of care allowance recipients	11,638	7,012	5,027	5,051	101,185	107,225	72,478	40,348	**349,964**	100

Source: MPSV/MLSA 2015: database/registers on care allowance recipients (Oknouze/Okslužby); preliminary data.

Specific allowances are guaranteed for persons with a disability (Act No. 329/2011 Coll.). They include mobility allowance (*příspěvek na mobilitu*) and special-aid allowance (*příspěvek na zvláštní pomůcku*). Spending in 2015 was CZK 1,929 million/EUR 71.3 million – about the same as in 2014.

There is no specific allowance paid directly to carers. However, some direct support for carers does exist within health insurance. The state pays health insurance premiums, through the state budget, on behalf of persons who are dependent on assistance from others at Level 2 (medium), Level 3 (heavy) and Level 4 (full) dependency, and on behalf of those caring for these persons, including persons caring for children younger than 10 who are dependent on assistance from others at Level 1 (mild) dependency.

1.4 Description of carers' benefits in-kind

A recent "round table" organised by the MLSA in December 2015 addressed issues of informal care in the Czech Republic (MPSV/MLSA, 2015b). The participants clearly indicated the need to increase not only carer's leave and cash benefits, but also in-kind benefits, professional services and support for informal carers. The Czech Republic is one of those countries with a less-developed supply of field social services that is inadequate for the needs of either carers or dependent people. Most public services often include just food delivery. Respite support (provision of a short break from caring duties), psychological support and counselling for carers were explicitly mentioned by the organisations representing dependent people in this respect (ibid.).

Tomášková (2015) published a survey mapping the utilisation of health and social services available to those who care for a dependent person. She looked at six key services: 1) health services provided at home, 2) respite support, 3) personal assistance, 4) day-care centres/ambulatory services centres, 5) domiciliary care service, and 6) early care for children up to the age of 7. Her findings suggest a large shortfall in unmet needs – with the exception of early care, the number of responses "I do not use it, but I would like to" and "I use it, but I wish I could use it more" exceeded the response "I use it in a sufficient volume" in each category. The cost of services and a lack of information represent two main barriers to higher utilisation.

To assess the need for the above-mentioned services for carers, it is helpful to know the capacity of social services available to dependent persons, including residential capacity. We can use official data from the MLSA's Yearbook (MPSV/MLSA, 2015c) although this limits the scope to registered providers only. Even so, it can provide sufficient insight into this issue.

There are more than 3,000 *registered* social services providers in the country. Not all of them are relevant to the care of dependent persons (e.g. shelters, independent housing support, interpretation services, etc.). Table 3 presents the number of specific registered providers. The network of providers seems to be reasonably dense – compared, for instance, to inpatient health facilities (hospitals, facilities for long-term health care and aftercare). Detailed regional data (MPSV/MLSA, 2015c; Průša, 2011) suggest several serious regional discrepancies.

Table 3: Number of registered LTC providers

Type of social care	2009	2015	Index	Available beds
Ambulatory services centres (*centra denních služeb*)	107	88	0.82	
Day-care centres (*denní stacionáře*)	274	281	1.03	
Homes for people with disabilities (*domovy pro osoby se zdravotním postižením*)	232	209	0.90	12,926
Homes for the elderly (*domovy seniorů*)	485	513	1.06	37,327
Special-regime homes (*domovy se zvláštním režimem*)	179	302	1.69	14,354
Sheltered housing (*chráněné bydlení*)	153	209	1.37	3,214
Respite services (*odlehčovací služby*)	264	297	1.13	
Personal assistance (*osobní asistence*)	219	222	1.01	
Domiciliary care services (*pečovatelská služba*)	816	735	0.90	
Guiding and reading services (*průvodcovské a předčitatelské služby*)	41	20	0.49	
Early care (children up to 7)	45	47	1.04	
Week-care centres (*týdenní stacionáře*)	81	58	0.72	845

Source: MPSV/MLSA (2015c).

As regards in-kind benefits, two groups of carers enjoy a special position in Czech legislation,[7] since disabled people with severe mobility and/or orientation problems have a specific status: (1) persons who care for and accompany a disabled person belonging to the higher dependency categories (ZTP or ZTP/P card holders) and (2) parents of disabled children.

Most benefits ensure disabled people and their carers cheaper and easier mobility. They consist of the free use of motorways (i.e. no need to pay for a sticker), exemption from administrative fees, exemption from certain traffic rules (e.g. exemption from obeying “No Entry” restrictions), and parking-charge exemptions. There is a complex set of discounts – entrance fees at cultural and sporting events, discounted or free travel tickets, etc.

[7] Act No. 329/2011 Coll.

2 Analysis of the effectiveness of work-life balance measures for working-age people with dependent relatives

2.1 Assessment of individual measures

There is an implicit expectation among current policy makers that recipients should decide themselves on the most suitable way of obtaining social services, and that the recipients' decisions will shape the network of formal providers of social services in a desirable way. However, almost 50% of the recipients entitled to these allowances do not use them to purchase services from any registered provider. The recipients retain nearly two-thirds of all care allowances (MPSV/MLSA, 2015d: 19).

The availability and quality of long-term care are not satisfactory. There is still a rather large volume of unsuccessful applicants for residential social services (Table 4). In some sense, we can use this indicator to assess the demand for measures supporting informal carers (families).

Table 4: Number of clients and unsuccessful applicants for specific types of institutional care, 2014

Service (A)	Number of clients (B)	Number of unsuccessful applicants (C)	Ratio C/B
Week-care centres	750	159	0.21
Special-regime homes	13,668	18,530	**1.36**
Homes for people with disabilities	12,500	2,522	0.20
Sheltered housing	2,979	1,972	0.66
Homes for the elderly	35,882	63,390	**1.77**
Day-care centres	N/A	163	N/A
Respite centres	10,658	N/A	N/A
Personal assistance	7,835	N/A	N/A
Domiciliary care services	109,962	N/A	N/A

Source: MPSV/MLSA (2015b).

The excessive demand for some services (elderly homes) stems partly from an inadequate supply of ambulatory and field services. Healthy and more or less independent pensioners sometimes apply "just in case". An elite Czech gerontologist, Professor Holmerová, comments: "It is really pointless to send self-sufficient and independent people to retirement homes. In reality, though, there are very often very sick people in the homes. [They have to remain here] … with no medical assistance. The physician does not see them all year long. Ten per cent of retirement homes' clients did not see a physician all year! … These are alarming numbers … There is a lack of day-care providers, field services and community assistance in the country" (Kňazovický, 2015). More than 18,000 pending applications are reported from special-regime homes, typically intended for clients with mental health issues (Table 4). For the sake of accuracy, it has to be mentioned that these statistics include multiple applications by one applicant to several institutions, and the real need is therefore slightly lower (Holub and Němec, 2014).

Nevertheless, some estimates indicate (Daňková et al., 2011) that there are roughly 400,000 persons with a self-reported need of intensive long-term care (of whom 60% are women), and this number is only going to increase.

2.1.1 Carers' leave

There is no special, guaranteed leave for persons caring for dependent persons in the Czech Republic.

2.1.2 Carers' cash benefits

Coverage and take-up of care allowance

As we have already shown, there are about 330,000 recipients of care allowance in the country, of whom about 115,000 are at Level 3 and Level 4 dependency (in need of intensive care). The recipients can use the allowance for any kind of care: institutional, professional home care, informal care by relatives, etc. Estimates suggest that between 50% and 70% receive only informal care (MPSV/MLSA, 2013; 2015d; Průša, 2013). At the same time, accessibility of institutional care is not satisfactory (Table 4).

All of this indicates a strong pressure for the provision of informal care, with care allowance being the main source of compensation for informal carers. Data on non-take-up are not available; however, one may assume that some better-off families do not apply, especially if the degree of dependency is lower (Level 1 or 2).

Employment effects

The impact of care obligations on the employment of carers is difficult to assess, due to lack of suitable data. Nevertheless, a general conclusion can be drawn from the various sources of data that the family is the main provider of care for dependent persons in the Czech Republic, if their degree of dependency requires daily intensive care. At the same time, arrangements facilitating care, such as professional home-care services, care leave and/or part-time working arrangements, are rarely available. This implies, quite reliably, a negative impact on the employment of carers in such cases. Saraceno and Keck (2011: 385–387) note that the Czech Republic is one of those countries that provide only scant long-term support through care services for the elderly; on the other hand, the elderly are offered cash subsidies. They thus combine a weakly de-commodified supported familialism with a weakly de-commodified defamilisation.

The EC and SPC report (2014) states (based on Průša, 2013) that:

> more than two thirds of recipients [of care allowance] don't use any social services provided by registered providers, slightly less than 20% of them use residential social services, slightly less than 10% use home services and less than 5% use ambulatory social services. The three fifth of recipients who don't use residential social services use the care allowance for coverage of costs of drugs that are not covered or are only partially covered by the public health insurance scheme. Only a limited share of recipients use their care allowance for the purpose of informal care (e.g. only 10% use it for paying an informal personal carer).
>
> In the Czech Republic, more than 80% of care for the elderly in need is provided by the family ... The persons providing informal long-term care are mostly women. The dependent elderly persons are looked after by adult children (around 50%) and spouses (around 20%), by other relatives (10%) or by friends (around 15%). The average daily time of care depends on the level of dependency. It is about 6.5 hours for the first level, around 10 hours for the second level, around 16 hours for the third level and finally around 18 hours a day for the fourth level.

Considering these findings and the fact that, in 2014, 331,000 care allowances were provided (MPSV/MLSA, 2015c), of which 43,000 were for Level 4 (full) dependency and 73,000 for Level 3 (heavy) dependency, this would mean that about 116,000 people

were in need of quite intensive care. If provided by family members fully engaged as carers this would be about 2% of the labour force. However, we may assume that the share of the level 3 and 4 care allowance recipients who are clients of residential care or professional home care might be higher than implied by the average estimates above.

A Eurofound survey document has found that about 7% of respondents in the Czech Republic report caring for an elderly or disabled person several days a week; 4% report daily care.

Table 5: Q 36c How often are you involved in caring for your elderly or disabled relatives? in per cent

	Every day	Several days a week	Once or twice a week	Less often	Never
Women	4.5	3	5.2	14.4	72.9
Men	3.8	3.6	5.1	12.1	75.4

Source: Eurofound 2012, in ESPN TR 2 2016.

This is, in fact, less than the EU average. However, we note that Southern European and post-communist countries drag the average up disproportionately.

We also note that in the Czech Republic, the share of inactive persons who do not seek employment on account of their care duties is among the highest in the EU (in fact, only the UK is higher).

Table 6: Main reason for not seeking employment: looking after children or incapacitated adults (inactive persons 15–64), per cent

	2006	2011	2014	EU 2011
All	14.3	15.7	16.7	9.6
Males	0.4	0.4	0.2	1.2
Females	22.4	24.4	25.8	15.0

Source: Eurostat Labour Force Survey.

Assuming about 1.8 million inactive persons in the country in the age category 15–64 (ČSÚ/CZSO, 2015), that would represent more than 300,000 people, almost exclusively women – although the prevailing reason would be care for children.

With the help of a special Labour Force Survey module from 2010, we can still identify nearly 110,000 inactive persons who care for adults in need of care.

Table 7: Persons (15–64) regularly taking care of a) relatives/friends aged 15 and over in need of care, and b) children up to age 14 and relatives/friends aged 15 or over in need of care

	All persons	Employed persons	Unemployed persons	Inactive persons
a) caring for adults (in thousands)	**350.4**	**237.1**	**14.8**	**98.5**
Males	138.3	104.0	6.7	27.6
Females	212.1	133.1	8.1	70.9
b) caring for children and adults (in thousands)	**32.7**	**19.7**	**2.7**	**10.4**
Males	11.5	9.6	0.7	1.2
Females	21.3	10.2	2.0	9.1

Source: Eurostat Labour Force Survey 2010 – special module on work-family balance.

Altogether there are more than 380,000 people caring for adults, of whom women account for 233,000. This figure is about 50,000 higher than the number of recipients of care allowance. The number of care allowance recipients at Level 3 and Level 4 dependency roughly corresponds to those who are inactive, which confirms our hypothesis that when there is need of full-day care, almost without exception carers have to leave the labour market.

It is possible that a great proportion of these carers prefer their carer status. This may be due to several reasons: there may be few labour market opportunities, or they may prefer to provide care in person, in order to ensure an adequate level of care for their relatives. Nevertheless, in 2010 nearly 30,100 people (more than two-thirds of them women, i.e. 22,900) reported that they either did not work or else worked part time (only 3,500 in this latter case) for care-related reasons.

Table 8: Main care-related reasons for not working or working part time (persons 15–64 years), in thousands

	No care services available	Care services too expensive	Care services of insufficient quality	Other reasons linked to the lack of suitable care services
All	**6.3**	**9.4**	**2.7**	**11.7**
Males	1.5	2.7	0.5	2.5
Females	4.8	6.7	2.2	9.2

Source: Eurostat Labour Force Survey 2010 – special module on work-family balance.

Generally, part-time work is not widely available in the Czech Republic, and neither is professional home care: only 317,000 (out of 5.06 million employed persons) work part time in the country (i.e. 6.3% of employed people), with women working part time more often (231,000, 10.5% of working women) than men (86,000, 3% of working men).[8]

Strong disincentives for carers to undertake part-time work are apparent from the simulations presented below.

Overall effects on well-being of the carer and the person being cared for

In the Czech Republic, the effects of the care allowance (which is the only measure available to carers) on the well-being of the carer and the dependent person have not been evaluated.

The effect on the overall quality of life of carers may be assumed to be rather negative because of the huge gaps in LTC provision, the non-existence of care leave, and the lack of available part-time work. However, this is not on the policy agenda, since involvement of informal/family carers is the main option for closing the gap between the need for care and the care available.

On the other hand, it seems that the social system protects carers against poverty risks, although they face a drop in living standards due to the need to leave their job. If a person cares for his/her family member or another close person who is dependent on the assistance of others (i.e. care allowance has been granted), either independently or with the assistance of social services, such a person is granted the following additional components of social protection:

- Care allowance is not included in the carer's income for the purposes of the benefits system (income/means testing) or for tax purposes.

[8] Data from the Czech Statistical Office, III Q 2015.

- In the case of the chief carer, the period of care is usually considered as a substitute period when calculating the pension amount; and health insurance is covered by the state.

Although there are no data on the poverty risk among carers and dependent persons receiving care, the above measures should guarantee that the households of carers and persons dependent on care are lifted above the legal poverty threshold.

Similarly, they find themselves above the 60% median-income threshold (EU poverty line), as the following simulation clearly documents.

Here, model simulation is employed to present the well-being and work incentives of families with dependants. The models present an insight into the financial situation of three different households (A, B and C) for three scenarios (1, 2 and 3) that reflect the "typical cycle" of care for dependent family members. These are the following:

- Scenario 1 assumes that there is no dependent person in the household and thus no entitlement to personal care allowance.
- In Scenario 2, one person becomes dependent and is eligible for personal care allowance. At the same time, another person in the household withdraws from economic activity and cares for the dependent person.
- In Scenario 3, the household buys care services for the dependent member. The family member who withdrew from economic activity in Scenario 2 returns to the labour market on a part-time basis.

In the text below, we simulate household income for the three scenarios, compare it to the value of the median income for the selected type of household, and calculate employment incentives. Basic model assumptions are listed in Table 1 of the Annex.

In the case of all the selected families, we take into account income from economic activity, all relevant social income and tax credits. In particular, we simulate the housing allowance, child allowance, material need benefits, child tax benefit and the tax credit for a low-income partner.

The results for Household A are shown in Table 2 of the Annex. In Scenario 1, income from the labour market ensures a sufficient net household income, which exceeds several times 60% of median income (income threshold for the at-risk-of-poverty measure). When the first person becomes dependent (Scenario 2), he/she is entitled to a disability pension and personal care allowance. Since the second person withdraws from the labour market and provides care for the first person, there is a sharp decrease in household income. It still exceeds 60% of median income. When the caregiver decides to return to the labour market and part-time employment (Scenario 3), the family has to purchase care services for the dependent person. As a consequence, it may experience a further drop in household income. Since the effective tax rate on labour income (taking into account all taxes, loss of benefits eligibility, and the cost of care services) reaches prohibitive values, labour incentives are relatively low. One can object that the caregiver may return to the labour market even when the effective tax rates exceed 100% (this corresponds to the situation when return to the labour market does not result in an increase in the household's net income or when it even results in income decline). This may be valid in a situation when the purchased care services for dependents secure better-quality care or bring better psychological well-being in the household. It is obvious that the issue of labour market return cannot be reduced solely to the dimension of the financial situation.

Households B and C show similar results to the previous case for Household A. In the case of Household B, the income in Scenario 2 does not change much, due to the fact that the first family member continues to work at the average wage. Incentives to labour market return are even lower in this family model than was the case in the previous example.

In Scenario 2 of Household C, a dependent grandmother becomes a household member and a second adult relative withdraws from the labour market to take care of her. Even though the household income may increase in nominal terms, it remains unchanged in real terms, or even decreases (due to the growth in family size). Financial incentives to return to the labour market are still very low. Taking into account the influence of other factors, a return to the labour market is plausible.

These three examples show that providing home care for a dependent member will not cause the household to fall into income poverty. At the same time, however, they also confirm that the financial incentives to labour market re-entry are very unfavourable. In such a case, there is no growth in household income. In the situation of return to part-time work, one can even expect a drop in family income.

2.1.3 Carers' benefits in kind

The support available to carers is insufficient. Even the official proposal of the National Strategy for Social Services Development for 2016–25 states that the Czech social and health system neither values nor lightens the role of informal care providers. Carers have to face many obstacles. There is an inadequate supply of field social and health services that target dependent persons, and this also applies to public services for carers (MPSV/MLSA, 2015a). Carers can use a growing number of various support services from non-governmental organisations, and they frequently create their own self-help associations. However, the situation is a long way from being satisfactorily coordinated, in the sense of what we find in, for example, Colombo et al. (2011). The supply of support services varies considerably across regions, with some services – such as psychological counselling – by and large missing. The quality of informal care is of serious concern due to a lack of information about good practice, education and training. Data about this segment are not easily available.

2.2 Assessment of overall package of measures and interactions between measures

The interaction of the arrangements regarding care and carers yields negative effects, mainly in terms of the employment of carers. However, this is not a policy concern in the country, since the lion's share of care for the elderly and for disabled persons relies on informal family care, and the system would collapse if family members did not provide care when necessary.

A need for more intensive care pushes family members out of the labour market because of a lack of professional and quality home care, and because of long waiting lists for institutional care. Part-time work is a less commonly available option, while inactivity is the option most readily available; the loss of earnings in the households of carers and dependent persons is partly covered by care allowance provided to the dependent persons. There is no special benefit provided directly to the carers, and nor are there any special measures for family carers to help them re-enter the labour market – while generally, labour market policies in the Czech Republic, such as counselling, training and job creation, are below EU standards.

Although there are some protective elements within the social protection system, designed to compensate for care-induced periods of inactivity, the overall effect on the well-being of carers is thought to be rather negative. On the other hand, the key positive factor is that the dependent persons get outpatient care of a quality that they would not otherwise be able to receive.

2.3 Policy recommendations

The care allowance introduced in 2006 did not accelerate the development of formal, especially community-based, social services. Holub and Němec (2014) note that the expert community and stakeholders linked to the providers of formalised services have raised the issue of effectiveness and quality. Recipients retain nearly three-quarters of all

care allowances, instead of spending them on purchasing professional social services. Expert opinion would like to see care allowance differentiated according to whether or not formal social services are used, and according to the type of services purchased.

The policy measure most needed is more effective support for professional home care. This could have positive impacts both on the accessibility and financial sustainability of the care services. The authors strongly incline to recommend the right/entitlement for the (professional) care services to be stipulated in legislation, accompanied by a greater variety of care allowances, depending on the degree of dependency and the kind of care provided (professional or informal). These allowances would be better provided in the form of vouchers than in cash.

The system of care, as it is currently constituted, is not sustainable in the long term and requires reform to integrate social care and healthcare into one system and to allow for a rather substantial development of professional home care. These measures could benefit informal carers. It is not so easy to make recommendations, since such integration would probably have a considerable impact on expenditure: similar plans were already considered by the government in 2011; however, the financial limits represented an obvious barrier. Possibly, in the currently improving economic situation, such plans might be reconsidered.

Measures should be introduced to help support part-time work for specified reasons, such as care obligations – e.g. special care leave and special benefits/allowances for carers. This issue is currently being considered by the government (see above) and this should lead to the adoption of concrete measures. The MLSA has already introduced a proposal into public debate (in December 2015), mentioning its intention of establishing a legal right to paid carer's leave of 3–6 months (MPSV/MLSA, 2015b). The authors would appreciate such a step, although it cannot solve the most critical issues of long-term intensive care (mainly for older adults or disabled children).

Finally, greater attention should be paid to the issue of the employment effects of informal care, as well as to the well-being of carers and dependent persons. An assessment is also needed of the economic efficiency and quality of informal care, while taking into consideration the negative employment effects.

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Annex

Table 1: Model assumption (monthly, in CZK; CZK 10,000 is equal to EUR 364)

		Household A	Household B	Household C
Scenario 1	Household members	2 Adults	2 Adults + 1 Child	2 A + 1 Ch (+ 1 grandma)
	labour income of the first family member	100% AW (average wage)		
	labour income of the second family member	40, 50, 67, 100, 150% AW		
Scenario 2	disability pension	CZK 10,000		
	old-age pension			CZK 9,000
	personal care allowance	CZK 8,000	CZK 9,000	CZK 8,000
Scenario 3	part-time equivalent of the person returning to the labour market	67%	50%	75%
	cost of the care services	CZK 10,000	CZK 9,000	CZK 10,000

Source: own calculations.

Table 2: Simulation of financial well-being and work incentives for three selected model households

Labour income of the second member (in % of average wage)	Scenario 1		Scenario 2		Scenario 3		
	net income (monthly, in CZK)	income to median income	change in net income (in CZK)	income to median income	change in net income (in CZK)	income to median income	average effective tax rate
	"1"	"1" / M	"1" - "2"	"2" / M	"3" - "2"	"3" / M	AETR
	Household A: married-couple household where the man becomes dependent						
40%	30,184	122%	-8,596	87%	-5,514	65%	177%
50%	32,045	129%	-10,457	87%	-4,393	69%	149%
67%	35,145	142%	-13,557	87%	-2,524	77%	121%
100%	41,346	167%	-19,758	87%	2,432	97%	86%
150%	50,648	205%	-29,060	87%	10,442	129%	61%
	Household B: two-parent family with a child who becomes dependent						
40%	31,301	105%	4,342	120%	-5,636	101%	204%
50%	33,162	112%	2,481	120%	-6,244	99%	193%
67%	36,262	122%	-619	120%	-4,726	104%	153%
100%	42,463	143%	-6,820	120%	-1,364	115%	110%
150%	51,765	174%	-16,122	120%	3,286	131%	84%
	Household C: two-parent family with a child. A dependent grandmother becomes a family member in Scenarios 2 and 3.						
40%	31,301	105%	9,559	108%	-4,585	96%	157%
50%	33,162	112%	7,699	108%	-3,059	100%	130%
67%	36,262	122%	4,598	108%	-699	106%	105%
100%	42,463	143%	-1,603	108%	3,952	118%	80%
150%	51,765	174%	-10,905	108%	10,928	136%	64%

Source: own calculations.