Peer Review on "Germany's latest reforms of the long-term care system"

11 – 12 January 2018, Berlin, (Germany)

The Czech Long-Term Care System Ten Years after its Modernisation

Peer Country Comments Paper – Czech Republic

DG Employment, Social Affairs and Inclusion

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1 Situation in the Czech Republic relative to Germany

The Czech Republic has 10.5 million inhabitants out of which 18.3% are above 65 years old. To start with, it is necessary to point out that there was a discontinuity in the welfare policies in the Czech Republic (previously Czechoslovakia) caused by the establishment of the communist regime in the period of 1948–1989. First, in the 1990s, a new welfare system was set up with the aim to realign the policies with the European ideology. However, it has not been easy to overcome the forty-year gap. As a result, some of the developments and reforms instituted in the Western countries in the 1980s and 1990s occurred later in the Czech Republic, and the same is true for the development in the area of long-term care (LTC) policy. For example, the care allowance was introduced in 2007, the process of deinstitutionalization of care for people with disabilities has only begun in 2012, there has been no accepted formulation of a nation-wide definition of LTC so far and there still exists a division in the responsibilities for the LTC – between the social care system, on the one hand, and the health care system, on the other. Hence, LTC for older or disabled people is provided in two overlapping settings with different systems of organisation and funding: within the social care system there are residential LTC facilities and other social services (out-patient and field-based) financed from the central, regional or municipal budgets; within the health care system there are healthcare facilities for long-term inpatient care (up to 3 month), palliative care and field based nursing care (home care) financed primarily through the social health insurance. However, the majority of the LTC occurs within the social care system.

As there is no special LTC legislation in the Czech Republic, the system of social care services and the provision of care allowance are regulated by Act No. 108/2006 Coll., on Social Services. It defines the kinds of social services and the basic principles of service provision, such as registration requirements that social services providers must meet, assessment of the users' life situation, the funding of social services with an element of direct payments, care allowance rules, qualification requirements imposed on employees of social services provider organisations, standards of quality in social services, local strategies of social services development utilising the community planning method, and the basic framework for informal care provision. Unfortunately, the issues of family and informal care are dealt with to a very limited extent. These regulations set up conditions for creating the modern LTC system. They are still valid and only minor alterations have been made since 2007.

There is a variety of social care services typically providing LTC: care homes and special care homes intended for people with dementia, day- and week-care centres as a kind of respite care, field-based services like community care services and personal assistance. These services are paid for, with co-funding by clients estimated at 50 % of the costs. Lately, as a result of insufficient capacity of registered services, there has been relatively large growth in the number of non-registered for-profit care and nursing homes (as well as community care providers), that operate at the edge of the law or even beyond the law. They do not register as they usually do not fulfil the basic standards necessary for the registration, or in other cases they find the registration procedure too complicated. According to estimates, these grey market for-profit facilities form at least 14 % of the homes for older people in the Czech Republic (MoLSA, 2014). As they tend to accept the most vulnerable older people who receive the highest rate of care allowance, care for these people increasingly takes place in settings where the standards of care and care workers' qualifications are not checked, this results in low levels of quality of care, as well as in poor working conditions for care workers (Kubalčíková, Havlíková, 2016).

The Social Services Act stipulates not only the in-kind services but also a cash social security tax-based benefit – the care allowance provided to people dependent on the assistance of another person due to their age or health status. The entitlement to the allowance is subject to a medical assessment procedure. The amount of the care

allowance corresponds to the degree of "dependence on care", which is based upon an assessment of the ability to manage 10 areas of basic living needs (i.e. mobility, cognitive and sensory perception, the ability to communicate, preparing food and eating, dressing/undressing, body care, evacuation, coping with health- and therapy-related challenges, structuring everyday life and social contacts, housekeeping and self-supply). There are 4 levels of dependence (compared to 5 degrees in Germany): Grade I (slight dependence); Grade II; Grade III; Grade IV (total dependence). The amount of the care allowance differs not only according to the grade, but also depends on the age of the recipient: children with grade I receive Euro 132 per month, with grade IV Euro 528 per month; adults with grade I receive Euro 35.2 per month, with grade IV Euro 528 per month (EUR 1 = 25 CZK). In 2016, there were 345,961 people entitled to care allowance, and the coverage rate for the population over 60 is at 9.6 %. The total public expenditure on care allowance were approx. 922 million Euro. (MoLSA, 2017).

2 Assessment of the policy measure

2.1 Similarities in the policy measure

One of the LTC measures in the Czech Republic is a kind of direct payment - the care allowance. It is provided to people who are, due to their long-term unfavourable health condition, dependent on another person's assistance when dealing with basic living needs. The dependency on the care of persons entitled to the care allowance is similar to that of Germany in that it is assessed by a medical doctor of the Medical Assessment Service; the areas of assessed ability to perform the activities of daily living are more or less the same too. They are mobility, orientation, communication, self-feeding, putting on clothes and footwear, washing oneself, going to the toilet, looking after one's health, personal activities and household tasks. Additionally to Germany's approach, one of the sources for the final assessment is a home visit during which the social worker employed by the Labour Office of the Czech Republic evaluates the dependency on care in the real social environment of the person. Although the assessment procedure allows consideration of not only physical limitations, but also cognitive and psychological impairments (like in the new German assessment instrument), the empirical studies (e.g. Hubíková, 2017) shows that the Czech assessment system often fails in assessing the extent of dependency on care by people with mental disorders, in the early stages of Alzheimer's disease, or those suffering from relatively rarely occurring diseases. One of the explanations could be the low level of standardisation of the assessment tools resulting in low predictability of the assessment outcomes across the assessing doctors (Havlíková, Hubíková, 2017); another could be the definition of the subject of assessment, which is not primarily "the need of care", but "the dependency on care caused by a decline in the functional abilities of the person due to their long-term health conditions", so the assessment concentrates not on the extent and demands of care needed but rather on medical assessment of the state of health; simultaneously there is persisting tendency to stress more the physical abilities than the mental one.

The recipients may use the allowance to pay their relative/neighbour/'social care assistant' for care, or to hire a social care services provider (regardless of the form of provision – residential or community-based; as well as regardless the type of provider – public, NGOs or private for-profit), or to combine these possibilities. The care allowance statistics (MoLSA, 2011) indicate that informal care plays a crucial role in social care provision in the Czech Republic (72 % of care allowance recipients spent the allowance solely on informal care in 2010, and 9.5 % used combined care that was delivered by informal and formal caregivers).

Although there is not large support for family caregivers in the field of supporting social services as discussed below, there are some policy measures improving their

situation, similar to that of Germany. For example, the state covers the contributions to social (pension) and health insurance for family caregivers who are caring for a family member with the II level of care allowance or higher, provided they are living with them in a shared household. Moreover, in 2017, a long-term care leave was introduced in the Czech Republic – after acute hospitalization, which results in long-term need of care, a family member who is an employee may ask their employer for up to 90 days of leave. During the leave, the person is entitled to a benefit in the amount of 60 % of their monthly wage, which is paid from the health insurance scheme.

Similar to Germany, there is a system of quality assurance of social care services. Social care providers have a duty to apply for registration with the regional authorities. If the applicant proves that their staff has appropriate qualifications to provide these social services, with respect to national quality standards for the provision of social services, and, where residential care is concerned, that the facility meets the required sanitary and construction norms, the regional authorities have the duty to issue a license to the applicant. Furthermore, the residents of the care homes and special care homes have the right to be provided with activation services (e.g. brain training, music therapy, handiwork). However, as mentioned above, there is a growing field of "grey" providers of social care services which operate beyond these regulations.

2.2 Differences in the policy measure

In comparison to Germany, there is not a legal or at least nation-wide agreed definition of long-term-care in the Czech Republic; a kind of "Long-term Care Act" is missing as well. As a consequence, first, the Czech LTC system is like a patchwork made from more or less isolated social care pieces and health care pieces. Secondly, the lack of a shared definition of LTC makes it difficult to set up long-term priorities and elaborated measures to reach the planned goals (e.g. the goal of deinstitutionalization in the field of LTC for people with mental disorder/illness lacked appropriate coordination: the long-term patients of the psychiatric hospital were first released home and only after that the out-patient centres for psychiatric care as well as community based social care services intended for these people started to be developed; another example is the hospice care – a kind of palliative care – there are many years of discussions whether it should belong to health care system or the social care system which means persistent financial insecurity for providers of these services); this is because neither part – social or health – share the same perspective on this issue. Consequently, there is not one system of LTC in the Czech Republic because there is LTC provided, regulated and financed (through taxes and co-payments by service users) within the social care system; in parallel, there is also LTC provided, regulated and financed (through compulsory health insurance) within the health care system.

In the Czech Republic, the "long-term care need", which is the unavoidable condition for care allowance entitlement, is stipulated as a health condition causing the need for care that lasts or it is likely to last at least one year (compared to 6 months in Germany). In individual cases of sudden necessity of intensive care, this sometimes causes difficulties in ensuring the care to the needed extent because of the lack of sufficient personal/family financial resources necessary to pay for care or to live on in the case of interruption of employment.

The support by counselling or care management to the people in need of care and their family members when they are arranging for care has not been recognized as substantive by the majority of the Czech public authorities yet. Not only are these people not entitled to such support (compared to Germany's case), but such counselling/advisory services are very rare. The relevant public bodies that could provide such counselling, above all the local authorities as well as the local branches of the Labour Office of the Czech Republic (see above), share the opinion that people

in need of care and their family members are fully competent to organize the care themselves. Moreover, such a specialized advisory service is not stipulated by the Social Services Act. In line with this, the family care-givers are not recognised as a unique target group of any kind of social service in the Czech Republic and if any support should be available, it is provided by NGOs/church on project basis or self-help groups. Generally, the burden of care management lies on the person in need of care and their family members, if they are available. Furthermore, any consultancy assistance or other measures to enhance and assure the quality of care provided at home by family/informal care-givers has not been introduced yet.

The strengthening of care at home under the heading of deinstitutionalization has been declared as a national policy priority since 2006 in the Czech Republic. However, in the field of LTC, the national priority for deinstitutionalization has not led to greater subsidies being allocated to the development of community-based services. This would have prepared the ground for field-based services to overtake the provision of care for older people with more intensive care needs. Only recently some of the community care providers have extended their services beyond providing predominantly meals-on-wheels or helping with the household to time-consuming accompanying and monitoring services. At the same time, some of the providers have also recently started to provide their services in the late afternoon hours and during weekends. As a result, people with extended care needs living in their homes need to combine several community care providers and home care for nursing tasks. Older people thus distrust the field-based services (since 2009, the number of home care users has a decreasing tendency, MoISA 2017); simultaneously, they lack appropriate information about the services available as well as they lack abilities to coordinate a series of different providers. As a result, they prefer to apply for a place in care homes, although the majority of older people wish to stay at home as long as it is possible. However, the national strategy has not favoured the building of new residential homes for older people. Currently, there is unsatisfied demand for placement in care homes that is almost twice as high as the actual capacity; demand for placement in special care homes is equal to its capacity. This gap has thus created opportunities for "innovative" solutions that in the Czech case have taken form in the emergence of the above-mentioned quasi-services of questionable quality.

3 Assessment of the success factors and transferability

3.1 Assessment of the success factors

One success factor of Germany's LTC system is that it has been developed systematically over more than 20 years. Therefore, the latest reforms implemented through their three so-called "Long-term Care Strengthening Acts" aim at improving its weak points and reinforcing its strengths. Moreover, the reforms were prepared over many years of discussions with and consideration by experts and scientists, which increases the likelihood that the reforms will meet the needs of the system and its users adequately.

To make such continual development possible, it is vital to adopt a common view on the issue of LTC, one that is shared by the majority of the relevant stakeholders. Thus, the other successful factor compared to the Czech case is the approval of the appropriate legislation.

Furthermore, the integration of social and health care within the framework of the LTC system contributes to the effectiveness and long-term sustainability of the system. The coordination of the provision of LTC services, as well as regulating the structure and the capacity of the services, is easier than under the circumstances of scattered responsibilities and regulations across several ministries and diverse legislation. Simultaneously, as the needs of people in need of long-term care are usually both social and nursing care, the integrated system seems to be more accessible for these

people and their relatives in terms of their being able to understand their rights and duties, their orientation in the services offered, and the benefits available.

Recognition of the necessity to support the family care-givers and the home-based services seems to be reasonable and natural if we take into account the fact that approximately 70 % of all LTC insurance beneficiaries in Germany are receiving care at home, most of them by informal family care-givers. However, the Czech case, where the rate is almost exactly the same, shows that such a policy is not self-evident at all. Nevertheless, it has already been acknowledged that without the informal care-givers, the system of long-term care would collapse.

Finally, an important factor of the German system is the elaborated model of the financial sustainability of the system in the future and the employment of the LTC insurance scheme that not only allows the relatively quick reaction to the expected rising costs of the system, but also cultivates public opinion regarding the issues of LTC.

3.2 Assessment of the transferability

Although the adoption of the LTC Act, which would overcome the persistent split between social and health care in the Czech Republic, would enhance the quality and effectiveness of the Czech LTC system, attempts to enforce such legislation have been unsuccessful so far (the LTC Act was formulated already in 2010, however was abolished; in 2016, at least an amendment to Social Services Act dealing with LTC at the social-health boundary was formulated but was not put on the agenda of the government so far). Simultaneously, there is no evidence to show that the situation could change in the near future. Therefore, it can be assumed that the potential for transfer would be higher in cases where measures are possible to implement within the current legislation, or would require only minor legislative changes.

From this point of view, there are at least two measures that would contribute to the Czech LTC system. The first one consists of strengthening the ability of doctors of the Medical Assessment Service to assess the claimants with mental or psychological disorders correctly. To fulfil this goal, it would be necessary to provide them with a comprehensive methodological guide and appropriate training.

The second area is the support of family/informal caregivers. As mentioned above, advice services and care management could be carried out by the municipal social workers, alternatively by the social workers of the Labour Office. There have already been some pilot projects of such services. Nevertheless, their nation-wide expansion has not occurred yet. In addition to the advisory services and assistance with care management, the assurance of the quality of informal care would be of predominant importance. Introducing measures such as on-site training of care skills for family members, regular visits of a community nurse at the home of the care recipient, and the development of respite care would also prevent cases of serious neglect of care regarding the person in need of care, as well as the risk of burnout, social isolation, health deterioration, etc. related to the family carers.

4 Questions to the host country in the Peer Review

- Regarding the new assessment instrument, how is it assured that the doctors and nurses of the Medical Service of the Health Insurance Funds would use it in the same way? Was there any training in using the new assessment tool?
- As the assessment of individual care needs is carried out by doctors and nurses, is there any rule as to what kinds of applications for the assessment process the doctors and nurses must undergo?

- What is the first experience with the newly established advisory service for people in need of care and their families? Is there already any evidence about its usage rate and evaluations by its users?
- How is the care management at the regional or municipal level organized/provided where the new advisory centres are not available (e.g. Saxony)?
- In general, what is the spatial and financial availability of the community-based social care services, on the one hand, and of the care homes, on the other?

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Annex 1 Summary table

Situation in the peer country relative to the host country
• In the Czech Republic, there still exists a division in the responsibilities for the LTC – between the social care system and the health care system. • There is no special LTC legislation in the Czech Republic, the system of social care services and the provision of care allowance are regulated by Act No. 108/2006 Coll., on Social Services. • The care allowance is a tax-based in-cash benefit for people in need of care to enable them to buy social care services or to "hire" a family/informal carer. • There is a variety of social care services typically providing LTC: care homes and special care homes intended for people with dementia, day- and week-care centres as a kind of respite care, community-based services like home care services and personal assistance. • Lately, there has been relatively large growth in the number of non-registered for-profit care and nursing homes (as well as community care providers), as a result of insufficient capacity of registered services.
Assessment of the policy measure
• There is no system in the Czech Republic similar to LTCI in Germany; both the care allowance and funding of social care services are tax-based, additionally, the LTC care provided within health care system is covered by the health insurance. • A similar feature in the Czech Republic is that the dependency on the care of persons entitled to the care allowance is assessed by a medical doctor of the Medical Assessment Service; the areas of assessed ability to perform the activities of daily living are more or less the same too. • The subject of assessment is not primarily "the need of care" as for Germany, but "the dependency on care caused by a decline in the functional abilities of the person due to their long-term health conditions", which favours medical perspective within the assessment procedure. • The support by counselling or care management to the people in need of care and their family members when they are arranging for care has not been recognized as vital in the Czech environment yet. • Policy measures improving situation of family carers, similar to that of Germany: the state covers the contributions to social (pension) and health insurance for family caregivers who are caring for a family member with the II level of care allowance or higher, provided they are living with them in a shared household; in 2017, a long-term care leave was introduced.
Assessment of success factors and transferability
• One success factor of Germany's LTC system is that it has been developed systematically over more than 20 years and the reforms were prepared over many years of discussions with and consideration by experts and scientists. • The integration of social and health care within the framework of the LTC system contributes to the effectiveness and long-term sustainability of the system. • Recognition of the necessity to support the family care-givers and the home-based services seems to be reasonable and natural if we take into account the fact that approximately 70 % of all LTC insurance beneficiaries in Germany are receiving care at home, most of them by informal family care-givers.

- Strengthening the ability of doctors of the Medical Assessment Service to assess the claimants with mental or psychological disorders correctly is one of the crucial prerequisites of functional LTC system.
- The support of family/informal caregivers by easily accessible advice services and care management could be carried out by the Czech municipal social workers, alternatively by the social workers of the Labour Office.

Questions to the host country in the Peer Review

- Regarding the new assessment instrument, how is it assured that the doctors and nurses of the Medical Service of the Health Insurance Funds would use it in the same way? Was there any training in using the new assessment tool?
- As the assessment of individual care needs is carried out by doctors and nurses, is there any rule as to what kinds of applications for the assessment process the doctors and nurses must undergo?
- What is the first experience with the newly established advisory service for people in need of care and their families? Is there already any evidence about its usage rate and evaluations by its users?
- How is the care management at the regional or municipal level organized/provided where the new advisory centres are not available (e.g. in Saxony)?
- In general, what is the spatial and financial availability of the community-based social care services, on the one hand, and of the care homes, on the other?

Annex 2 Example of relevant practice

Name of the practice:	Long-term care leave
Year of implementation:	Since 2018 onwards
Coordinating authority:	Ministry of Labour and Social Affairs, CZ
Objectives:	The measure is designed as a coverage period that follows after the release from the hospital, e.g. after a serious injury or illness. For a family member, long-term care leave shall include the possibility of drawing up to 90 calendar days of leave with replacement income in the amount of 60 % of the daily assessment base. During this time, in some cases, the person who needs care recovers, in other cases the family must decide how to organise the care. Long-term care leave shall provide space for it, so that the family could prepare for such an alternative and, for example, ask for a care allowance. The new benefit will be provided to employees or self-employed persons that cannot work because of caring for a person who requires it in a home environment. At the time of the provision of long-term care leave workers shall not be given notice. This scheme supports care-givers not only itself, but also the strengthening of intergenerational ties within the family.
Main activities:	Amendment to act 187/2006 Coll., on sickness insurance, as amended, and other related laws are introduced, this dose was 8. February 2017 has been approved by the Czech Government.
Results so far:	There are any so far.

Name of the practice:	Pečuj doma (Take care at home)
Year of implementation:	October 2016 – September 2019
Coordinating authority:	Diaconia of the Evangelical Church of Czech Brethren
Objectives:	„Take care at home "is a three-year project, financed from the resources of the ESF. Its goal is to offer family care-givers from the whole Czech Republic support in the form of sharing information, guidance, training and support activities to strengthen their knowledge, skills and competence, because the role of informal care-givers in long-term care is indispensable. For more information see www.pecujdoma.cz .
Main activities:	- School of care-giving: this section at www.pecujdoma.cz contains online accessible articles on caring and nursing, practical tutorials

	needed to care, but also texts to further self-education, learning series, videos, manuals, lectures; - Online counselling service for informal caregivers; - Online and printed periodical newspapers "Take care at home"; - Organizing of self-help groups; - Training courses for family caregivers; participation is free of charge.
Results so far:	The results of this project are not available yet. However, it is expected that they will be similar or even better as the outcomes of preceding project "We help to take care at home" (2013 – 2015). Within this project over 150 training courses with over 2000 participants took place, 6 practical guides were published, 25 instructional videos were recorded, and hundreds of questions from family carers were answered.

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