ESPN Thematic Report on Challenges in long-term care

Czech Republic

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European Social Policy Network (ESPN)

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Summary

The transformation of the Czech system of social services towards adequate access to services, deinstitutionalisation, sustainability and quality assurance has not been completed. In part, this is directly associated with issues surrounding long-term care (LTC) provision. The split between the health and social parts of it causes operational difficulties and inequalities, and sometimes raises concerns about the quality of care.

The Czech Republic belongs to the traditional model, where LTC is largely considered a 'family affair', although there is no explicit legal or even constitutional obligation to care. Family members and friends provide most care. Institutional governance of LTC is a vertically fragmented, plural system, with competencies distributed between different institutional tiers: the state, the regions and municipalities. Significant regional differences in capacities – and consequently access to care – can be identified.

Multi-source funding is a key concept of the funding scheme. Clients' fees represent the main funding resource for social services – they account for nearly half of total costs. Other sources consist of the Ministry of Labour and Social Affairs (MLSA) subsidies and grants flowing into regional governments' budgets. Health insurance funds are by far the most important resource for long-term health services – they cover almost all the costs. In 2015, total LTC expenditure was CZK 61.0 billion/EUR 2.39 billion (1.4% of GDP). A major reform step in the area of social services was accomplished in 2007. The new law on social services[1] not only recognised a much broader range of social care services and institutions than before, but has also handed over a substantial share of public funds to the recipients of social services, in the form of care allowance. The allowance is scaled into four levels, according to the recipient's degree of dependency on support. There was an implicit expectation that the recipients would decide for themselves on the most suitable way of acquiring social services and that their decisions would positively shape the network of formal providers of social services. These expectations have not been met fully.

By introducing a new caregiver's allowance in 2017, the government has demonstrated its awareness of the importance of informal care. It tries to improve the financial situation of family members who provide care for their dependent relatives, and it strengthens their position in the labour market.

Demographic forecasts clearly suggest an increase in demand and need for care in future years. Between 2008 and 2067, the number of older seniors (aged 75 and over) will approximately treble, rising from 0.69 million to 2.02 million. Besides the financial sustainability of a system that relies significantly on public budgets, there are also concerns about the availability of human resources. The fact that the jobs are mostly poorly paid and demanding is the reason why the LTC system is already suffering a workforce shortage.

The system faces several serious challenges. Access to some residential services is clearly inadequate. But the situation in the segment of non-resident, community-based or home care services is not satisfactory either. In some regions, there is an absence of support services for families caring for their members. The quality of care is difficult to assess – systematic monitoring is not conducted and the quality assurance system is far from perfect.

Our policy recommendations deal mainly with areas of informal carer support, financial benefits for the most dependent persons, measures of financial stabilisation, quality assurance, and linking the social and health parts of LTC.

[1] Act No. 108/2006 Coll., see at www.mpsv.cz/cs/7334

1 Description of the main features of the country's long-term care system(s)

The Czech Republic belongs to the traditional model, where LTC is largely considered a 'family affair' and family members and friends provide most care. In 2010, internal MLSA data estimated this share at between roughly 52% and 75%, depending on the degree of dependence of the service user (MPSV/MLSA, 2013a).

The development of long-term care (LTC) has been carried out in a fragmented fashion in the Czech Republic, with responsibility strictly divided between the health care sector and the social care sector. This is combined with vertical fragmentation, with competencies split between different institutional tiers: the state, regions and municipalities. This has had an impact not only on funding, but also on the provision of long-term care. There are great differences in the costs of care for clients. While the clients pay for a major part of social care, the care in health care facilities is covered by public health insurance. This discrepancy often leads to the hospitalisation of people who rather need social care. On the other hand, the clients of some homes for the elderly may suffer from a lack of adequate medical or nursing care. The National Programme of Action on Ageing claimed:

'One of the biggest challenges in the field of LTC is integration of health and social services. The multiplicity of providers and financial resources hinders the achievement of continuity and comprehensiveness of care. The division of competences and funding into several systems and providers increases the risk of fragmentation and insufficient coordination of services, poor transparency of the system for clients as well as providers, low flexibility of services and unclear responsibility for achieving the goal and results of care provided' (MPSV/MLSA, 2008).

Under the public health insurance system, as introduced in 1993, providers of health care services and social services had to be mutually distinct entities. Residential social care providers' entitlement to provide distinct health care (mainly nursing care) covered by the public insurance scheme was re-established in 2006. However, the governance of long-term care, as well as palliative, health and social care, remains an issue, mainly in terms of integrating the health and social aspects (for instance, social workers caring for their clients in elderly care homes or even hospices are not allowed to look at the medical records of their clients). Progress here has been marginal. Both the Ministry of Health (MoH) and the MLSA have declared their intention of working on conceptual documents. Numerous strategic documents have actually been issued. Nevertheless, the desired level of change has not yet been achieved. No 'well-performing system of LTC ensuring access to quality, coordinated, complex and interlinked health and social services for the elderly' has been established (MPSV/MLSA, 2013b: 41).

A major reform step in the area of social services was accomplished in 2007. The new law on social services[2] not only recognised a much broader range of social care services and institutions than before, but also handed over a substantial share of public funds to the recipients of social services, in the form of care allowance. The allowance is scaled into four levels, according to the recipient's degree of dependency on support. The degree of dependency is determined according to the number of basic living needs that cannot be met without everyday help from another person (out of a total number of 10 activities). The highest level of dependency entitles the recipient to a care allowance amount which is approximately equivalent to half the average salary or a slightly above-average pension in the country. The number of recipients of the care allowance increased from 260,000 in 2007 to almost 350,000 in 2016. In total, it accounted for CZK 23.0 billion/EUR 900 million in 2016 (compared to CZK 21.1 billion/EUR 780 million in 2015) (ČSU/CZSO, 2017). From 1 August 2016, this allowance was raised by 10% (see Table 1). The relevant legislation requires recipients to use the allowance exclusively for care. Labour offices are allowed to undertake checks on how the allowance is used.

[2] Act No. 108/2006 Coll., see at www.mpsv.cz/cs/7334

There was an implicit expectation that recipients would decide for themselves on the most suitable way of acquiring social services, and that their decisions would positively shape the network of formal providers of social services. 'These expectations have not been met fully' (Holub and Němec, 2014: 38). The care allowance has not accelerated 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 raise the issue of effectiveness and quality. Almost 50% of the recipients entitled to these allowances do not use them to purchase services from any registered provider. This means that the allowance serves (at least partially) to reimburse the costs of informal care provided by relatives or friends, and represents some sort of income/benefit for the carers.

Table 1: Personal care allowance, from 1 August 2016

Category	Number of basic living needs that cannot be met	Monthly benefit CZK/EUR	
		Age	
		<18	18+
Level 1 (slight dependence)	3-4	3,300/122	880/33
Level 2 (medium dependence)	5-6	6,600/244	4,400/163
Level 3 (heavy dependence)	7-8	9,900/366	8,800/326
Level 4 (full dependence)	9-10	13,200/488	13,200/488

Source: MPSV/MLSA (2016a).

Multi-source funding is a key concept of the current social services funding scheme. Clients' fees represent the main resource – they account for nearly half of total costs (NCPTSS/NCSSTS, 2013). Other sources consist of the MLSA's subsidies and grants flowing into regional governments' budgets. As regards health services, health insurance funds are by far the most important resource – they cover almost all the costs.

In 2015, official LTC expenditure[3] was CZK 61.0 billion/EUR 2.39 billion (for recent developments, see Table 2). From 2010 to 2015, the share of LTC expenditure in total health care expenditure varied between 15% and 18%, which is relatively close to the EU average (15% in 2014), according to the ČSU/CZSO (2017).

Table 2: Expenditure on LTC by type of care, 2010-2014 (billion CZK) and 2015 billion CZK/EUR)

Type of care	2010	2011	2012	2013	2014	2015
Long-term health care	35.8	37.0	37.0	38.6	44.0	42.4/1.66
Inpatient	29.8	30.8	30.9	31.9	37.1	34.8
Outpatient	1.5	1.5	1.4	1.5	1.6	1.7
Home care	4.5	4.8	4.8	5.2	5.3	5.9
Long-term social care	17.0	16.0	15.9	17.2	18.1	18.6/0.73
Social services[4]	1.4	1.4	1.4	1.6	1.8	1.8
Cash benefits	15.6	14.6	14.5	15.7	16.3	16.8
Total sum	52.8	53.0	53.0	55.8	62.1	61.0/2.39

Source: Data from ČSU/CZSO (2017b).

[3] The CZSO adopted the new System of Health Accounts (SHA) 2011 methodology. The item of long-term social care was included and the expenditures on long-term health care were extended by expenditures on selected social services, such as daily and weekly care centres, sheltered housing, nursing services, etc.

[4] Data on expenditure on social services are available only from the state budget, not from the direct household expenditure. Almost half of the expenditure on long-term care in social services was invested in sheltered housing.

Concerning cash benefits, as well as the above-mentioned care allowance there are also specific allowances guaranteed for persons with disabilities (see Act No. 329/2011 Coll.). They include mobility allowance (*příspěvek na mobilitu*) and special-aid allowance (*příspěvek na zvláštní pomůcku*).[5] Expenditure on these reached CZK 1,993 million/ EUR 78.3 million in 2016 – about 3% higher than in 2014 (MPSV/MLSA, 2017).

There is no specific allowance paid directly to carers yet (this will change from June 2018, when a new long-term caregiver's allowance will be introduced – see section 2). However, some direct support for carers already exists within health insurance. The state pays health insurance premiums, through the state budget, on behalf of those 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 people, including persons caring for children younger than 10 years who are dependent on assistance from others at level 1 (mild) dependency.

According to the 2015 National Strategy for Social Services Development, just 15% of individuals in need of LTC are clients of institutional care in health care or social care facilities. Most long-term care is provided as informal care by persons close to those in need of care (MPSV/MLSA, 2015a). More than 30% of those who are involved in care provision spend more than 20 hours a week providing quite intensive care (ÚZIS/IHIS, 2012). Women make up more than two thirds of the family assistants. In older age groups, the proportion of men is higher.

The National Centre for Social Services Transformation Support conducted quite a complex analysis of social services for the MLSA (NCPTSS/NCSSTS, 2013). Using data from the Register of Social Services Providers,[6] it suggests that residential services account for nearly half, and home care services for two fifths of total services. Less than a third of care is provided in the form of day services (see Table 3). The analysis pointed out distinctive regional differences in capacities, utilisation and other features.

Table 3: Social services from the register by form of provision (1 March 2012)

Form of provision	Number of services	%
Home care	919	28
Day care	487	15
Residential	1,457	44
Ambulatory and home care	421	13
Other	47	1
Total	3,331	

Source: NCPTSS/NCSSTS (2013).

Notwithstanding the importance of informal carers[7] (mostly family members and friends), LTC is also a significant segment of the labour market. The trade unions estimate that there are overall roughly 100,000 employees in the social services sector (Chválová,

[5] **Mobility allowance** is designated for disabled persons who use paid transportation repeatedly during the month. The amount of the benefit is CZK 400/EUR 16 per month. A person who has severe disability for longer than 1 year is entitled to **a special-aid allowance** to purchase the needed special aid (device), e.g. fitting a motor vehicle for disabled, construction works related to fitting a household, access to a house or apartment (stairway platform) and other arrangements. The amount of the allowance reflects the overall social and property conditions of the applicant.

[6] It should be noted that, in reality, there are also a number of private unregistered providers of services (mainly residential services for elderly people) who, in contravention of the law (Act No. 108/2006 Coll.), actually provide social services under the guise of 'providing services for families and households' – which is considered a 'licence-free business' (allowed by Regulation No. 278/2008 Coll.). The poor quality of care provided by some unregistered services has raised a strong concern recently. For more details, see the ombudsman's web page at https://www.ochrance.cz/ochrana-osob-omezenych-na-svobode/neregistrovane-socialni-sluzby/

[7] Official MLSA sources estimate that there are 250,000 informal carers (MPSV/MLSA, 2015a).

2017). Official MLSA statistics that cover public-sector employment report nearly 45,000 employees, including 24,000 social workers and 5,000 nurses (MPSV/MLSA, 2017).

There are currently almost 1.1 million disabled people in the country, representing 10.2% of the total population. The highest proportion – 42.1% – is recorded in the uppermost age category (75+). The average self-sufficiency rate is 0.69 (in the case of women it is 0.66). Two fifths of disabled people report full self-sufficiency and almost one third require assistance only for a few hours a day (ČSU/CZSO, 2013).

Between 2008 and 2067, the number of older seniors (aged 75 and over) will approximately treble, rising from 0.69 million to 2.02 million. However, the most significant changes in both the short and the long term almost certainly face the oldest ones – those who are aged 85 and over. At the end of 2008, there were approximately 136,000 people aged 85 and over in the Czech Republic. That figure will top half a million probably by 2037. About 913,000 of the oldest seniors are expected to live in the country around 2070. In relative terms, that is a 570% increase since 2008 (Burcin and Kučera, 2010).

2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

2.1 An assessment of the challenges in LTC

2.1.1 Access and adequacy challenge

Current statistics suggest a relatively stable situation in terms of the number of registered LTC service providers (see Appendix 1). However, the supply is often considered inadequate. This is mainly true of social and health services for the dependent elderly, both residential and field based. For example, the number of beds in residential long-term care facilities (per 1,000 population) increased from 6.3 in 2000 to 7.0 in 2015. But using a more relevant measure (per 1,000 population aged 65 years and over) gives us a different perspective – a decrease from 45.9 to 39.2 (OECD, 2016). The population is growing older faster than the country's LTC capacities are evolving. MPSV/MLSA (2016b) and Průša (2011) draw attention also to certain serious regional discrepancies.

The number of persons using some kind of residential social services increased from 72,738 in 2015 to 75,212 in 2016. However, there is still a backlog of unresolved applications for residential social services (Holub and Němec, 2014). In 2016, there were 37,247 beds in homes for the elderly and almost 67,000 open applications (MPSV/MLSA, 2017). More than 21,000 unresolved applications were also reported for special regime homes – facilities serving mainly persons with dementia or psychiatric illnesses – compared to the total capacity of 17,784 beds in 2016 (ibid.).[8]

There are similar issues with community outreach and home-care social services. These are perhaps even more urgent, given the amount of care provided by informal carers, family members or friends. An eminent Czech gerontologist, Prof. Holmerová, comments: 'There is a lack of day care providers, field services and community assistance in the country' (Kňazovický, 2015). A round-table discussion organised by the MLSA in December 2015 addressed these issues (MPSV/MLSA, 2015c). The participants indicated the need to increase not only carers' leave and cash benefits, but also in-kind benefits, professional services and support for informal carers. The Czech Republic belongs among those countries with a less-developed supply of field social services, which does not meet the needs either of carers or of 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 representatives of dependent people's organisations 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. Her findings suggest a large gap of unmet needs – with the exception of early care. The cost of services and a lack of information represent two main barriers to greater utilisation. The amount of care allowance for heavy dependency (CZK 8,800 monthly) would cover approximately 2.5 hours of care per day.[9]

In the future, there will be a dynamic increase in demand and need for services.

2.1.2 Quality challenge

Compliance with the quality standards is checked on a sample basis both by inspectors from the Ministry of Labour and Social Affairs and by regional authorities, but the quality of services remains an issue. The most alarming situation concerns unregistered providers – in 2015, the ombudsman expressed deep concern after inspections in several unregistered private retirement homes where even elementary services were missing; only an unprofessional level of care was delivered, and the living conditions were undignified

[8] 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.

[9] We use here the price of CZK 120 per hour. The price can vary significantly.

(Ombudsman, 2015). However, quality is considered an issue even in the service segment that is regulated.

Current standards of quality focus on processes within the institutions and on personal capacities, or we might say on 'quality prerequisites. However, the user has been lost from sight: the focus of social services on improving the user's quality of life is missing (MPSV/MLSA, 2015b).

The inspection system suffers from a lack of qualified inspectors and the way of assessing the fulfilment of quality standards is neither uniform nor fully transparent – for more details see NCPTSS/NCSSTS (2012) and Kocman and Paleček (2013).

The findings of inspections are not reflected in any public reports and there is no monitoring indicator of quality of service. This is in striking contrast to the number of data and indicators dealing with funding, capacities and utilisation of services (see part 3).

The unfinished process of deinstitutionalisation and transformation represents a specific issue. According to the National Strategy for Social Services Development, it leads to a continuing trend of reliance on the provision of care in residential types of facilities and to an overall reduction in the competences of people living in their home environment (MPSV/MLSA, 2015b).

Quality (as well as access) could increasingly be an issue in the near future due to shortfalls in the labour force. The Ministry of Labour and Social Affairs assesses the remuneration of employees in social services as 'very unsatisfactory and long left unaddressed' (MPSV/MLSA, 2015a). The trade unions speak about 'the eve of a personnel crisis' (Chválová, 2017). Although wages and salaries in the care sector have increased since 2014, they are still below the average gross wage, which amounted to CZK 27,589/EUR 1,084 in 2016. On the contrary, the average pay of the 55% of social workers who are engaged on a salaried basis is CZK 21,065/EUR 828 – which is 23% lower than the general average wage. Employees remunerated on a wage basis (non-profit and church organisations) were even worse off, to the tune of about CZK 1,000/EUR 39 (ibid.).

Matters are even more striking when we take into account the qualification level required for social workers: at least a higher vocational education is necessary. Even a lower-skilled position of 'worker in social services' requires specific training to be passed. Lifelong learning is compulsory by law for social workers.

Unfortunately, looking at the measures available to support informal (mainly family) carers in providing good-quality services, we can see a difference. 'Basic information on the adequate way of service provision, training of carers and psychological consultancy or care are missing' (MSPV/MLSA, 2017: 27).

2.1.3 Employment challenge

The inadequate provision of formal care, which hinders mainly female labour market participation,[10] is frequently mentioned in all strategic documents, reports and surveys (e.g. MPSV/MLSA, 2015a; 2015b; Klímová Chaloupková, 2013). However, the impact of a potential increase in capacities is clearly difficult to measure. Using Eurostat data on the inactive population not seeking employment, we can see a slightly higher share of inactive females reporting family/caring responsibilities as a reason in the Czech Republic than in the 'traditional' EU countries with presumably better service infrastructure (9.0% and 7.6% of inactive population in 2016, respectively). Provided this is the only cause for deviation from the average, we could estimate the potential impact at the level of tens of thousands of women.

The government has recently improved the position of family members providing long-term care for their relatives. It will introduce a new sickness insurance allowance from 1

[10] But not necessarily only female. According to Klímová Chaloupková (2013), two fifths of carers are male in the Czech Republic.

June 2018. This new direct cash benefit is called 'long-term caregiver's allowance' (*dlouhodobé ošetřovné*). The carer, whether employed or self-employed, will be compensated for the loss of earned income from work that had to be interrupted, at the same rate as in the case of short-term care, i.e. 60% of the daily assessment base, during the period when he/she provides care for a family member (maximum 90 days). The employee cannot be dismissed and, after the care responsibilities end, is guaranteed to return to the same job under the new regulation in the Labour Code.

2.1.4 Financial sustainability challenge

The National Strategy for Social Services Development in 2016-2025 states that, with respect to demographic development and the growing demand from users, the current system of financing social services is not sustainable.[11] If the current model of funding and legislative regulation of social services remained, it would be very difficult to support people with reduced self-sufficiency in their independent lives (MPSV/MLSA, 2015b). The strategy properly identifies several causes for such assessment, quoting mainly lack of reliable data on social services funding, which makes any relevant comparison and summation impossible (ibid.). No relevant efficiency assessment can be done.

Subsidies from public budgets represent an essential source of funding mainly for not-for-profit providers. These subsidies are paid under a grant system, on a 1-year basis, and providers can never be sure if their project will succeed the following year. Long-term planning, personnel policy, innovations and investment are all unlikely under this scheme, and of course the position of clients is not secure. The current strategy, as an official document confirmed by cabinet (Cabinet Decree No. 245/2016), even demands the introduction of mandatory subsidies from the central government budget. This would create a revolutionary precedent in the system of public finance, and it would be surprising if any government actually conducted such a policy change. The introduction of some kind of medium-term contracts seems a more realistic option.

2.2 How the recent/planned reforms address the challenges outlined

Given the very limited space in this thematic report, we cannot cover more than a couple of aspects. After all, the current National Strategy for Social Services Development in 2016-2025 consists of 233 pages! It provides a very competent insight and a relevant list of strategic goals, as well as proposed measures and possible scenarios. The analytical part tries to rely on evidence. Although the strategy may sometimes lack more sophisticated analytical methods, it serves very well as a useful tool for learning more about the current situation and possible future of the system of LTC. We can largely agree with the assessment of recent and planned reforms presented there.

According to the Ministry, the personal care allowance scheme should be revised in order to improve the access of disabled persons to good-quality care. As we mentioned in the ESPN Country Profile, Stage 1 – 2014-2015, a large part of the care allowance is retained by the recipients and not used to purchase services. There is, indeed, some potential to improve the efficiency of the funding of care by redesigning the allowance. At the moment, it is rather difficult to foresee which changes are going to be adopted. Different stakeholders declare different preferences and interests. For instance, the Czech National Disability Council (NRZP) strongly opposes the idea of reducing the allowance for those who do not use it for service purchase and who keep it in the family (which provides necessary care instead of professional services).

As we mentioned above, recent policy involves an essential failure. Integrating the health and social aspects of LTC has been failing for many years and complicating provision of LTC. This is a real issue, mainly in palliative care, follow-up health services and social care for disabled people. Despite earlier expectations, the announced draft bill addressing cross-

[11] The same is true of the health part of LTC.

cutting issues in social and health services, mainly 'integrated long-term care', has not so far been released.[12]

2.3 Policy recommendations to improve access to and the adequacy, quality and sustainability of the LTC system(s)

1. Extend the currently approved 3-month period of caregiver's allowance to 6 months, in order to support informal care providers and increase their job protection.
2. Reduce the tax burden on labour in the case of part-time jobs, in order to make them more attractive to both employers and potential employees.
3. Provide versatile support for the extensive development of affordable services for households (e.g. tax relief, subsidies).
4. Continue to increase the amount of care allowance for the highest levels of dependency.
5. Introduce a (German-style) mandatory long-term care insurance as a predictable source of finance for the long-term care system; or, if this proves too radical a change, develop a social-service insurance in order to introduce more stability to the funding of services. That stability is inevitable for the development of a supply of much-needed community-based or home-care services supporting both dependent clients and their carers.
6. Amend the current set of standards with some indicators addressing the impact of the services provided – clients' well-being, satisfaction and/or self-sufficiency.
7. Increase the number of inspectors and unify the methodology of quality standards assessment.
8. Plug a legal vacuum regarding the position of unregistered and illegal social services providers, in order to increase the dignity and safety of the elderly.
9. Allow flexible and timely communication between health and social care personnel in residential facilities (requires changes in law).
10. Introduce the principle of medium-term contracting, in order to allow providers to plan and invest properly, and to provide clients with a higher level of security.

3 Analysis of the indicators available in the country to measure long-term care

There is a large volume of statistical data on the capacities, expenditure, access to, utilisation, benefits and employment related to LTC available in the Czech Republic. It is impossible to list all of them within the space available. We briefly discuss the main issues related to available data, and subsequently we provide a selection of possibly the most relevant indicators in Table 4.

It is apparent that data on access and adequacy, as well as sustainability (resources, costs), are prevalent. There are no publicly available indicators on the quality of services and their outcomes. We believe that rather than an underestimation of the concept of quality itself, this is a consequence of the traditional bureaucratic governance amplified by technical and ethical difficulties related to measuring quality in social services.

There are two essential limitations for any scholar who explores the available data on LTC in the Czech Republic:

[12] According to the vice-minister, Jentsche Stocklová, the draft bill has been ready and awaiting both ministers' (MoH and MLSA) approval prior to public release since April 2016 (Zdravotnický deník, 2016).

1) Most statistics do not treat LTC as a specific area that consists of social and health care. The MLSA's statistical yearbook, as the most relevant data source, covers LTC services as part of a broader system of social services dealing with other target groups, and does not include services provided at health facilities. Aggregate numbers of staff, wages and expenditure are either difficult or impossible to relate to LTC only.

2) As was noted at the beginning of this thematic report, institutional governance of LTC is a vertically fragmented, plural system, with competencies split between different institutional tiers: the state, regions and municipalities. Non-state facilities provide a significant share of services. Information, such as wage level, qualification structure and total revenue, may not be available for the whole sector. The Czech Statistical Office's (CZSO) indicator 'Total LTC Expenditures' can serve as a good example here. It is a much appreciated and relatively new indicator that puts together both health and social services, based on the SHA 2011 methodology. However, it does not include households' out-of-pocket payments for social services, and so it basically reflects only public expenditure.

As noted above, the number of unresolved applications – a key indicator of access to care – is hard to interpret. These statistics include multiple applications by one applicant to several institutions. An indicator reflecting the number of persons is greatly needed.

Table 4: Selected indicators available at the national level

Area	Name of the indicator in Czech	English translation	Precise definition	Source/website address	Years available	Frequency	Note
Access and adequacy	Počet uživatelů (klientů) soc. služeb	Number of users (clients) of social services	Field and community outreach social services for elderly and disabled people	MLSA (Yearbook, chapter 5) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by region, age and sex
	Evidovaný počet neuspokojených žadatelů	Recorded number of unsatisfied applicants	Field and community outreach social services for elderly and disabled people	MLSA (Yearbook, chapter 5) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by region
	Počet služeb a jejich kapacita	Number and capacity of social services	20 social services defined in §34 Act No. 108/2006 Coll. (both residential and outpatient)	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	Including beds where relevant
	Počet uživatelů (klientů) pobytových soc. služeb	Number of users (clients) of residential social services	11 services, Number of clients admitted and clients discharged	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down according to the level of client's mobility
	Počet uživatelů (klientů) soc. služeb	Number of users (clients) of social services	20 social services defined in §34 Act No. 108/2006 Coll. (both residential and outpatient)	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by region, age and sex
	Počet neuspokojených žádostí	Number of unresolved applications	20 social services defined in §34 Act No. 108/2006 Coll. (both residential and outpatient)	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by region
Quality							We are NOT aware of any regular publicly accessible indicator

Area	Name of the indicator in Czech	English translation	Precise definition	Source/website address	Years available	Frequency	Note
Sustainability	Výdaje na sociální službu	Social service expenditures	Field and community outreach social services for elderly and disabled	MLSA (Yearbook, chapter 5) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by region
	Kapacita a ekonomické ukazatele v soc. službách	Capacity and economic indicators in social services	Number, capacity (beds), revenues, expenditures	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	Broken down by founder
	Personální zabezpečení soc. služby – počet osob k 31.12.	Staff numbers in a social service – number of persons as of 31 Dec.	16 specific positions, 20 services	MLSA (Yearbook, chapter 6) https://www.mpsv.cz/cs/3869	N/A	Yearly	
	Zaměstnanci a prostředky na platy	Employees and salaries budget	Social services in the public sector	MLSA (Yearbook, chapter 7) https://www.mpsv.cz/cs/3869	N/A	Yearly	Quite detailed
	Vývoj výdajů a počtu příspěvků na péči	Year-on-year index of expenditure and the number of care allowances	Average monthly number of paid allowances	MLSA (Yearbook, chapter 14) https://www.mpsv.cz/cs/3869	N/A	Yearly	
	Vývoj výdajů a počtu příspěvků na mobilitu	Year-on-year index of expenditure and the number of mobility allowances	Average monthly number of paid allowances	MLSA (Yearbook, chapter 14) https://www.mpsv.cz/cs/3869	N/A	Yearly	
	Vývoj výdajů a počtu příspěvků na zvláštní pomůcky	Year-on-year index of expenditure and the number of special-aid allowances	Average monthly number of paid allowances	MLSA (Yearbook, chapter 14) https://www.mpsv.cz/cs/3869	N/A	Yearly	
	Výdaje na příspěvek na péči	Care allowance expenditures		CZSO – selected data on social insurance, chapter 4 https://www.czso.cz/csu/czso/socialni-zabezpeceni-cs	2007	Yearly	Comprehensive coverage, more detailed than in the

Area	Name of the indicator in Czech	English translation	Precise definition	Source/website address	Years available	Frequency	Note
							MLSA Yearbook
	Výdaje na dlouhodobou péči	LTC expenditures		CZSO – Výsledky zdravotnických účtů ČR [Health accounts results], chapter 3.3 https://www.czso.cz/csu/czso/vysledky-zdravotnickych-uctu-cr-2016	2010	Yearly	
Impact of caring responsibilities on employment	Počet neformálních poskytovatelů péče	Number of informal carers		Estimates based on Survey of Income and Living Conditions (SILC), ISSP Family and Health 2012 Survey, and data from care allowance applications			

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Appendix 1

Number of registered LTC providers

Type of social care	2009	2015	Available beds	2016	Available beds
Day care centres/centra denních služeb	107	88		82	
Day stationary facilities/ denní stacionáře	274	281		269	
Homes for people with disabilities/domovy pro osoby se zdravotním postižením	232	209	12 926	209	12402
Homes for the elderly/domcovy seniorů	485	513	37 327	514	37247
Special-regime homes/ domovy se zvláštním režimem	179	302	14 354	307	17784
Sheltered housing/chráněné bydlení	153	209	3 214	205	3898
Respite services/odlehčovací služby	264	297		302	
Personal assistance/osobní asistence	219	222		229	
Domiciliary care services/pečovatelská služba	816	735		721	
Guiding and reading services/průvodcovské a předčitatelské služby	41	20		16	
Early care (children up to 7 years)	45	47		49	
Week-care centres /týdenní stacionáře	81	58	845	57	779

Source: MPSV/MLSA (2016b; 2017).