Services for Supporting
Family Carers of Elderly People in Europe:
Characteristics, Coverage and Usage

EUROFAMCARE

National Background Report for the Czech Republic

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Content

Summary of Main Findings

- Organisations of seniors play an important role in the Czech Republic. The most visible and the most important are Svaz důchodců České republiky (The Union of Retired People of the Czech Republic) and Život 90 (Life 90). These organisations run various activities for seniors, i.e. meetings, lectures, leisure activities (trips, theatre), senior telephone etc. They also act on behalf of seniors and protect their interests. They lobby on the local, regional and central level for important issues, i.e. drug prices and reimbursement for drugs by the general health insurance (Svaz důchodců). Život 90 also offers different types of services, i.e. short term stays at the respite centres, home alarm systems etc. Apart from these organisations, there are, unfortunately, only few organisations representing family caregivers.
- One of them is the Czech Alzheimer Society, which was founded in 1997. This organisation has about 30 contact and information points in all regions of the Czech Republic. It aims at improving the situation of the people with dementia and their family caregivers. It also lobbies for their interests and rights. As a successful example of this activity, let us consider the reimbursement for cholinesterase inhibitors (symptomatic drugs of Alzheimer's disease), which was achieved after a massive media campaign and after the reference of the Czech ombudsman. In addition, the Czech Alzheimer's Society provides forms of support oriented at family caregivers, organizes self-support groups of carers, counselling for carers, as well as, respite care at home.
- Very important in this field is also the activity of Česká katolická charita and Diakonie of Reformed Churches (Evangelic and Hussite), which organize social services for older people in all regions of the Czech Republic and thus help their carers, and non profit nongovernmental organisations (Czech Red Cross, Remedium, Senior etc). Czech Helsinki Committee deals with human rights and in the last few years the organisation also focuses on issues concerning seniors, especially those living in institutions.
- The responsibility for provision, organisation and supervision of services for older people needing care in the Czech Republic is assumed by two departments, Ministry of Health and Ministry of Labour and Social Affairs. The lack of communication between these two departments, inadequate interface of services, poor continuity of health and social services, lack of coordination of strategies, are all generally considered to be the main problem of the policy and care for older people, with important and fatal consequences in practice.
- The contemporary system of health and social care in the Czech Republic was preceded by the socialist one. The latter has developed during the years of communist regime in the Czech Republic (1948 – 1989). During

that period, both, health care and social care, were organised, supervised and funded by the state. After the political change in 1989 both systems underwent a special kind of development, which can be described in the following way.

- Health care system has been significantly decentralised and privatised. Most general practices, specialist out-patient departments as well as home care agencies are run by private companies or individuals. Health care is reimbursed by the general health care insurance and, according to the law and the constitution, it is free. However, there are some co-payments. These co-payments concern especially drugs which are not reimbursed and drugs, which are only partially reimbursed. It is also possible to pay for so called “nadstandard” (better care than standard care), but these co-payments are acceptable only for non-medical services (in hospital the so called hotel services). The reason is that the health care is explicitly free and cannot be paid for. Obviously, this system is opened to shadow economy.
- The problem of abundance of acute hospital beds, the lack of beds for rehabilitation and the long-term care has been discussed for many years. There were already several political declarations made by Ministry of Health stressing the need to transform acute hospital beds into the “chronic” ones, long-term care beds and rehabilitation beds. Unfortunately, due to the still absent conception of a health care system, which would be officially accepted, new hospitals and hospital departments are still being constructed. The main problem of care for old and chronically ill people is not only the absence of geriatric departments in most hospitals, but also the lack of capacities for rehabilitation and continuing care. Older people are often transferred home in an unstable condition, too sick to be cared for at home. Very often these people need long-term care and rehabilitation, but capacities for this type of care are not available. Some chronic and rehabilitation beds are blocked by patients whose state of health has been stabilised and who need residential social care. These patients wait there for admission to residential homes because of the long waiting lists for this type of homes. The absence of institutions oriented at long-term nursing care for those who need this kind of care is considered to be a very serious problem. The separation of health and social care systems and the legislative of both departments do not enable (institutional) care for those who are chronically sick and demand skilled nursing care (thus contraindicated for residential social care) and their condition is chronic (thus not indicated for health care). Significant improvement of this situation could be brought about by a new legislative proposal dealing with health and social (integrated) care. This proposal is being prepared by the Ministry of Health.
- System of social care, on the other hand, has not been decentralised and a certain degree of deetatisation was achieved together with the state

administrative reform in 2002 / 2003. Privatisation of social services is minimal. Legislation of the social services is still predominantly based on laws accepted during the socialist era, some of which underwent many changes and became unclear. Social services are listed in the law but the responsibility for their organisation and the way of their funding are not determined. The official system of social care consists of residential care and home help. In the last few years there has the Ministry of Labour and Social Affairs made several attempts to define social care more precisely and separate it from the health care (attempting to avoid "substitution" of health care by social services). Skilled nursing personnel have been considered unnecessary in residential institutions of social type, despite the fact that residential homes provide service for dependent and sick older people.

- After 1989 non-profit non-governmental organisations (NGOs) have developed many innovative types of care and services and have filled in many gaps present in the existing social care. The system of funding of NGOs is different. Whereas residential homes which were originally owned by the state get regular funding from the state budget, NGOs have to raise their own funds and they have to apply for a grant from the state budget. Grants are distributed through the process of public competition controlled by Ministry of Labour and Social Affairs (and by Ministry of Health). Applications have to be submitted each year.
- The major differences between the systems of health care and social care are following.

  According to the law and constitution, citizens of the Czech Republic have a right to receive free health care based on the general health care insurance. In many cases (especially in case of old and dependent people, who are chronically ill) this right is not fully and sufficiently respected, which causes many problems to both, patients and to family caregivers.

  According to the law, the citizens of the Czech Republic do not have a right to receive social care. Social care providers (with an exception of state run institutions) may exist (and may be funded from) but have no right to be funded neither from the state budget nor from any of the other public budgets. Despite this situation there is a surprisingly consistent system of social services whose quality, however, differs depending on the type of the community and region.
- Policy makers only seldom focus on caregivers' issues. Despite that there are some important policy materials on ageing and handicap, i.e. National Plan on Ageing (Národní plán přípravy na stárnutí.2000) and National Plan on Equal Opportunities for People with Handicap (Národní plán pro vyrovnávání příležitostí pro občany se zdravotním postižením.2000), that include measures, which are friendly to caregivers. Whereas activities and programmes based on the National Plan on Equal Opportunities for People

with Handicap are funded by the grant system of Ministry of Health, there is no system of funding to support the implementation of the National Plan on Ageing.

- Conclusions: Family is the main care provider and approximately 80 % of care is provided at home.
- There is no systematic research on caring in the family. Nevertheless, it can be estimated that approximately 100 000 seniors need assistance with basal activities of daily living, about 300 000 seniors need assistance with instrumental activities of daily living. Most of them are cared for at home. Provided that the care is performed by one or more individuals, it can be assumed that there are cca 400- 500 000 family caregivers in the Czech Republic. Apart from the statistic on the allowance for care for a dependent relative or another person, there are no other official data concerning care in the family.
- Conditions for caring in families are not satisfactory. The allowance for care for a relative or another person is generally considered to be small. There is only a small number of respite care opportunities and even home help, which is the most common type of home assistance, is not available in all communities and for all seniors in need.
- The main obstacle in care provision is probably the gap between health and social care.
- Absence of a modern and sufficient law on social care causes severe problems in care provision and funding. The system of social care is, therefore, unequal and, sometimes, insufficient.
- Better interface of health and social care is a necessary condition for improving the situation of family caregivers. Legislative and political conditions enabling social care provision on one hand and support of caregivers on the other are necessary and important.

Introduction – An Overview on Family Care

Demographic situation in the Czech Republic may be characterised as a transition from a socialist model of social behaviour (with high and early marriage rate, relatively high natality rate, low average age of mothers at childbirth, but also with a high abortion rate and a low life expectancy) to the West European model that has developed in the most advanced countries since the late sixties. In the Czech Republic these changes have taken place with a delay. They emerged as a result of a social and political transformation following the year of 1989. The changes in reproductive behaviour can be seen in the way marriages and childbirth is being postponed while marriage and natality rates are decreasing. Since 1994 the number of deaths exceeds the number of births, which results in a natural decrease of population (167 thousands=1,6 %). This decrease had been earlier compensated by positive migration balance which diminished as well and became negative in 2001.

The Czech Republic had 10 203 269 inhabitants as of 31.12.2002. In 2002 the proportion of children aged 0-14 years represented 15,6 % of the population and exceeded the proportion of people over 65 years that constituted 13,9 %. There were 89 persons over 65 years per 100 children 0-14 years old. The age preference index slightly increased from 87 in 2001. The life expectancy in 2002 at the time of birth is 72,1 for men and 78,5 for women. From the territorial viewpoint the oldest age structure can be seen in Prague-City region and also in other large cities (low natality and mortality rates in urban regions). Relatively young age structure can be seen in border regions (Karlovarský region, Ústecký region). That is related to the intrastate migration in the 20th century (post-war migration and labour migration).

The group of potential caregivers (45-55 years old) is quite numerous, because these people were born soon after the war, the biggest group being women of 55 years. This relatively favourable situation is going to change over the next 20 years, because this cohort will get old and will need care. A less numerous cohort of women now being 30-45 years old will become of age to be considered potential caregivers. (Zdravotnická ročenka 2002.2003)

The number of inhabitants of the Czech Republic will not change with immigration in the medium term perspective. In the long-term perspective the number of inhabitants will steadily decrease and even more intensive immigration will not change this trend. The most important and the most decisive factor of this kind of unfortunate demographic development is the low natality rate caused by low fertility. In the near future these factors will be augmented by two facts. It is the lower number of potential mothers and also increased mortality rate as a result of ageing demographic structure. When the great cohort of people born in 4th decade of the last century proceeds to the retirement age the process of ageing of population will still accelerate.

The age structure of the population of the Czech Republic is undergoing a transformation into an extremely regressive type of age structure, which will strongly determine further trends of demographic development. The number of people over 75 years of age will increase more rapidly than the total number of older people. Number of the oldest ones will thus multiple many times. (Burcin B, Kučera T. 2003)

In the community, more than 80 % of care of older people, dependent on the help of others, is provided by a family. The average time period of this type of care is 4-5 years. Women in the productive age are the most frequent caregivers. 80 % of women of that age are employed. The care of old dependent seniors is thus most frequently provided by adult children (53 %), spouse (21 %), relatives (10 %) and friends (16 %). Women provide care in 64 % men in 36 %. (Zavázalová H et al. 2001)

Dependency of the old person on others increases with the worsening of his / her somatic and mental condition. The need for care which must be provided by family, health professionals and social care is increasing. This process has its objective and subjective issues and concerns of all participants.

Study carried out in 2001 brought the following information. There are good relationships between generations and the members of all generations meet often to help each other. In contrast with these good relationships there is a clearly discernible preference for a separate dwelling of nuclear families. Generations live very close to each other due to limited intrastate mobility of inhabitants and this way of life appears to be feasible. Housing of three generations living together or of adult individuals living together with some of their parents is not frequent and generally not considered to be feasible.

The family is the central institution in providing emotional and practical support for older people. Also mutual help and support among members of different generations is considered to be a custom. This mutual assistance has developed during the past centuries and the cultural and political changes in the second half of the 20th century brought about new forms of aid. Older people believe that their children are capable of and willing to take care of them in case they need it. On the other hand, they are not actually willing to accept this kind of care and they prefer their independence. As a consequence, seniors get accustomed to the fact that they can look for help outside their families and state institutions, though confidence in the family is more prevalent. The level of confidence in nongovernmental organisations is approaching that of state organisations. Financial support is mostly expected from the state or state institutions.

About 20 % of people older than 60 years have serious health problems and about 10 % needs (and uses) domiciliary services. These numbers increase with age, the need for services increases more quickly as there are probably “non-medical” reasons for the use of services. As the willingness of the institutions to provide care for the older members of the community does not guaran-

tee the ability to do so, the support of caring families is quite necessary. Providers of health and social care should be more motivated to offer family caregivers help, support, information and also training of necessary skills. (Kuchařová V, Rabušic L, Ehrenbergerová L. 2002).

Good relationships between generations detected in answers to the questionnaire do not necessarily depict the real behaviour of family members. Separate housing which is preferred by seniors is convenient for time to time help and assistance but could present an obstacle in case there is a need for long-term care. Most people are convinced that seniors should live in separate households but not far so that adult children could provide necessary assistance. Only 11-12 % persons consider living of both generations in one household to be convenient. 14 % of seniors and 5 % of all population prefer separate housing of older people despite the risk that adult children would not be able to take care of old parents. Seniors are anxious about being dependent on their children.

The state has taken over too many responsibilities in the past and families got accustomed to rely on this type of assistance. Therefore, adult children often do not have enough responsibility to take care of older parents and, in addition, seniors are willing to “release” their children from providing care for them. The ability of the adult generation to provide assistance and support for their ageing parents depend on general conditions in the extensive family, way of housing etc. Common housing of two generations with parents living with their young adult children is more frequent than the case of families living together with their ageing parents.

The fact that ageing parents provide their adult children with assistance and support is a well known peculiarity of Czech society. Similar situation occurs with the assistance of adult children to their parents. This type of care is combined with more specialized and skilled activities and families are not always able to provide this service at a desirable level. (Kuchařová V, Rabušic L, Ehrenbergerová L. 2002)

Regarding other institutions, adult children and the state are generally considered to be the most important sources of assistance. Other relatives, friends, neighbors but also community / local authorities receive less confidence and so they are less able or willing to provide care. Older people are considered to be more reliable concerning the help with young children than are younger individuals but seniors do not want to be dependent on their children’s assistance and they prefer to live alone in the same way as the younger generation. The proximity of older persons’ households and their adult children seems to be adequate. In case of impaired self-sufficiency seniors prefer living in institutions to common housing with their adult children. 67 % of interwieved seniors older than 60 years consider institutions to be a better solution and a better guarantee of care than living at home or in a sheltered home with home help.

Table 1: What kind of assistance is expected by people over 60 years in their old age?

In case I need assistance:	definitely yes	rather yes	rather no	definitely no
Children will provide assistance	33	41	13	13
Relatives will provide assistance	4	23	38	35
Neighbours and friends will provide assistance	2	27	39	32
Municipality (local authority) will provide assistance	3	21	40	36
The state will provide assistance	5	26	35	34
Charitative organisation will help me	3	23	36	38

Source: Kuchařová V, Rabušic L, Ehrenbergerová L. 2002

In case of disability or dependence on the help of others, generally, older people seem to prefer living in institutions to housing at home or in sheltered home with home help (67 %). When they are asked individually what they would prefer in case of disability and dependence under optimal conditions, the preference of institutionalization in not so high.

Health care in the Czech Republic is provided on the basis of general health care insurance and it is free. Health care providers are organisations founded and administrated by the state (Ministry of Health), regions (Regional Office), communities and municipalities, private organisations and individuals, non-profit organisations and churches (Diakonie, Charita). The care provided by these institutions is reimbursed by health insurance companies according to contracts. Conditions of the contracts with health insurance companies are stipulated in General Health Care Insurance Act (Zákon 48 o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů. 1997), which generally speaks about compliance with personal standards, technical standards and a success in public competition organised by health care department of the Regional Council**.** Important influence on the final decision has insurance companies. Health care is provided in the in-patient institutions (hospitals and other health care institutions) and out-patient ones (out-patient departments of hospitals, practices of general practitioners, specialists etc.) General practitioners, their nurses and nurses of home care agencies visit patients in their households.

Social services, located mainly in big institutions and institutions with social diagnostic function, are provided, organised and funded by the state (Ministry of Labour and Social Affairs) and regions (Regional Office). Some services (home help, sheltered houses, other smaller institutions) are organised and funded by communities and municipalities. There is a limited co-payment paid by a client for these social services. (Vyhláška 182 kterou se provádí zákon osociálním zabezpečení a zákon České národní rady o působnosti orgánů

České republiky v socilním zabezpečení. 1991). Act on Social Security (Zákon 100 o sociálním zabezpečení. 1988) and other legal standards enable institutions to organise and provide social services. However, this (as well as any other) act does not determine which institution guarantees both organisation and funding of social services. The practical result of this situation is the absence of some social services in smaller and more remote communities.

Many non-governmental organisations started their activity in the last decade of the 20th century including Diakonie and Charita founded by churches. These NGOs have developed many modern types and forms of social services which were not available before and which are very innovative and useful. System of funding of NGOs by the state and regional budget (annual grant system) does not facilitate development of modern types of social services (including day care units, respite care, personal assistance etc.) whereas the state and regional system of funding of huge social institutions (residential homes etc.) may seem sometimes abundant (i.e. from the architectural point of view). Modern types and forms of social services are not generally available and their development depends also on the attitude of the local community. Some communities support NGOs and the care provided by them. Some communities do not cooperate with NGOs though NGOs provide care for the members of the community. This situation is slowly getting better due to the renaissance of a civil society after many years of totalitarian system.

The legislative of social department does not determine what are the responsibilities of state, regions or communities to secure social services for its citizens. On the contrary, citizens of the Czech Republic have, according to the constitution and laws dealing with health care, right to receive free health care on the basis of general health insurance.

General practitioners for adults (most of them private) provide care for all adults including seniors and they visit patients in their households. The care of a general practitioner is reimbursed by health care insurance per capita (capitation) according to age groups. In the Czech Republic home care is provided by nurses mostly organized in home care agencies. Most of these agencies are private, some of them are non-profit (Charita, Diakonie, Czech Red Cross etc.). Some of them employ also physiotherapists, others provide a certain amount of home help offered as a paid service according to the needs and choices of clients. Specialized medical care is provided by private specialists or physicians working in out-patient departments of a hospital. There is a free access to dermatologists and psychiatrists. To visit other medical specialists the patient should be referred by the general practitioner. Hospitals in the Czech Republic are owned by the state (i.e. teaching hospitals and psychiatric hospitals), regions, municipalities, by private companies, and very few are owned by NGOs. The care provided by hospitals is reimbursed by the general health insurance and it is free. Rehabilitation care, long-term care, aftercare and long-term nursing care are provided by various types of health care facilities. The care is funded (for many years) by the general health insurance and

it is free. There are 6 hospices with 171 beds (Zdravotnická ročenka 2002.2003). These facilities are relatively new; all of them were established only after the political transformation in 1989 by nongovernmental organisations often with the help of church and the support of Ministry of Health and Ministry of Labour and Social Affairs.

Accessibility of "acute" health and medical care is generally good, though regions differ in quality and availability of some services. Difficulties arise in situations when an older person needs rehabilitation and long-term care. Unfortunately, these patients are often labelled as "casus socialis", dismissed and sent home in an unstable state or transferred to long-term care hospital. Due to the small number of such institutions in some regions (i.e. Prague) some patients are transferred to long-term care hospitals in other regions, far from their homes and families. General Health Insurance Company with other health insurance companies check long-term care hospitals in order to reduce "social" stays of patients, which result from situations such as waiting for a placement in a residential home, incapacity of family to provide care, short-term respite stays etc. In addition, there is a limited offer of chronic care services on commercial basis especially in Prague and other cities. Those services are scarcely used as they are very expensive for most family caregivers.

Caring families generally cannot rely too much on informal services such as the help of volunteers, neighbours, friends, church etc. This type of custom of a civil society was impaired by the totalitarian socialistic political system and system of social security, where the state limited civil and church activities and as a "compensation" offered to provide care for "overaged" and "invalid" people, mostly in remote and huge institutions.

Estimated needs for care in > 65 year olds based on disability levels (local or national data)

Older people have more health problems. Some studies investigated numbers of people with frequently or seriously impaired health conditions.

Table 2: Subjective feeling of health status (%; N 871)

Subjective feeling	men	women	60-64	65-69	70-74	75+
Healthy	8	8	14	9	1	4
Few health problems	47	43	50	49	43	24
Frequent health problems	28	29	22	27	35	41
Long-term or more serious health problems	17	20	14	15	21	31

Source: Kuchařová V, Rabušic L, Ehrenbergerová L.2002

Numbers of people with a handicap are listed in a chapter dealing with socio-demographic data. In the age group 60-74 years about 80 % people suffer from chronic disease, in the age group over 70 years it is already 87 %. The morbidity of women is higher than the morbidity of men. The most frequent

health problems are: pain, insomnia, instability, dyspnoea, frailty. The most frequent chronic diseases suffered by seniors are: cardiovascular diseases, diseases of musculoskeletal system, endocrine and metabolic diseases (diabetes mellitus), respiratory and gastrointestinal diseases, sensory impairment, mental disorders, incontinence and trauma. The number of handicapped people in the Czech Republic is approximately 12 % of total population, older people represent two thirds of this number. More than 40 % seniors (over 65 years of age) live with some kind of disability. 25 % of them are not able to deal with instrumental activities of daily living, such as activities involved in keeping their household and, therefore, need assistance.

Table 3: Geriatric risk factors – seniors 60 years old and older (%; N 871)

Risk factor	% in people 60+
Age: 80 years and over	12,4
Loneliness	32,7
Lack of social contacts	1,8
Widowhood of women over 75	15,2
Bad health conditions	11,1
No children	16
Dependency	7,1
Dependent life partner	1,3

(Source: Zavázalová H et al.2001)

Table 4: Cummulation of risk factors - seniors 60 years old and older (%; N 871)

Number of risk factors	men	women	total
1 risk factor	27,3	34,7	31,8
2 risk factors	11,7	20,9	17,3
3 risk factors	2,6	6,5	4,9
4 risk factors	1	2,6	1,9
5 risk factors		0,6	0,4

(Source: Zavázalová H et al.2001)

Table 5: Morbidity of persons 60 old and older (%)

	men	women	total
Without sickness	4,0	1,8	2,7
Some health problems in the last year	6,6	8,2	7,5
Frequent health problems (more than 3) in the last year	1,8	1,4	1,6
Stabilised chronic condition (remission more than 1 year)	9,1	9,9	9,6
Uncomplicated chronic condition	52,6	54,5	53,7
Complicated chronic condition	25,9	24,2	24,9
Total (%)	100	100	100
N	870	1259	2129

Source:Zavázalová H et al.2001

Table 6: Locomotion of persons 60 years old and older (%)

	men	women	total
Ambulant, walking outside without problems	66,1	57,1	60,8
Walks with assistance	30,9	37,1	34,5
Does not leave house	2,4	4,8	3,9
Bedridden	0,6	1	0,8
Total	100	100	100
N	871	1261	2132

Source: Zavázalová H et al.2001

The problem of chronically ill and disabled seniors is not a topic to be frequently discussed. Media including the public ones do not inform us very often about these issues. However, there is an intensive public discussion at the moment on the transformation of health care system. The main issue is the necessity to reduce acute care hospitals, departments and beds and transform them to chronic care ones. This idea is consensually accepted by both, professionals and the general public. On the other hand, whenever it becomes obvious that the transformation should be implemented in one specific ("our") hospital, many, often intensive, protests arise. Most of the antagonists of the transformation from acute to chronic care are usually local health care professionals, who often consider chronic care to be less qualified and attractive. Information campaign explaining the advantages of the transformation to general public is considered to be an important contribution to the process of transformation generally and also locally.

At present, the Ministry of Labour and Social Affairs together with a team of social care professionals is preparing a new act on social care. Unfortunately, there is a minimal public discussion on this topic going on at the moment.

Organisations of the handicapped have tried to inform the public about the unequal conditions of family caregivers and institutions. In case that handicapped people live in a social institution (e.g. residential home), the state contributes significantly to their care. In case handicapped people live at home, the caring family takes the responsibility both for the care and for its funding. This situation may be considered as an institutional support of non-caring families and a penalization of the caring ones.

The information about the poor quality of care in some social institutions has appeared in media only in the last few months and years. Even though this information is insufficient, it can be considered a start of a more intensive public discussion on the situation of the disabled and chronically sick people.

Caregivers are neither heroes nor examples to be followed, at least not in the media picture. On the contrary, people occupying important social and political positions very often place their parents and relatives in health care institutions (long-term care hospitals and psychiatric hospitals) and do not contribute to their care.

It is very difficult to identify the country's specific issues without thorough international comparison. Yet there are some issues that can be considered to be relatively specific for the Czech Republic. Free long-term health care is one of them.

The gap between health and social system, the lack of communication between the two departments, poor coordination of the legislative process and also practical obstacles in providing care are often discussed. In addition, the legislative dealing with social care does not guarantee good conditions both for social care providers and for their clients. On the other hand, the fact that despite these obstacles the system of social care is continuously improving is a certainly positive factor. It is mainly thanks to the initiative and creativity of health and social care providers as well as representatives of NGOs and municipalities.

1 Profile of family carers of older people

1.1 Number of caregivers

There are no data on the number of caregivers in the Czech Republic. It can be estimated that about 100 000 older persons need assistance with basal activities of daily living and about 300 000 older persons need assistance with instrumental activities of daily living. Taking into the account that care is provided by one or more individuals the total number of caregivers in the Czech Republic can be estimated as 400 000 -500 000 people.

1.2 Age of caregivers

There is no research which could give information on this item.

1.3 Gender of caregivers

Women in the productive age are the most frequent caregivers. 80 % of women of this age are emloyed. (Zavázalová et al. 2001)

1.4 Income of caregivers

There is no research which could give information on this item.

1.5 Hours of caring and caring tasks, caring for more than one person

Several research studies of selected forms of assistance offered to older persons have been done in the last few years. (Kuchařová V, Rabušic L, Ehrenbergerová L. 2002)

Table 7: Selected forms of assistance of children to their older parents (%)

	anytime	sometimes	rarely	not at all
Consultations	41	31	17	11
Help in a household	17	27	26	30
Help with a more demanding household work	27	30	22	21
Financial support	5	10	27	58
Intensive financial support	3	6	18	72
Shopping, transport to doctor etc	17	20	22	41
Personal care, personal hygiene	3	5	10	82
Other	2	3	4	91

Source: Kuchařová V, Rabušic L, Ehrenbergerová L.2002

1.6 Level of education and / or Profession / Employment position of family carer.

There is no research which could give information on this item.

1.7 The generation of carer. The relationship of carer to OP

Care for dependent seniors is most frequently provided by children (53 %), spouse (21 %), friends (16 %) and relatives (10 %). Out of the whole group of caregivers it is 64 % of women who provide care and 36 % of men. (Zavázalová et al. 2001)

1.8 Residence patterns (household structure, kind of access to older person needing care, kind of housing etc.)

Several studies have been made on the representative sample of population. Their goal was to research residence patterns of seniors. A study conducted by Kuchařová V, Rabušic L and Ehrenbergerová L proved that seniors live most frequently in their own households.

Table 8: Housing of seniors over 60 (%)

Men or women live:	single		married		divorced		widowed	
	men	women	men	women	men	women	men	women
Alone	71	66	1	3	73	64	78	80
With a partner	27	25	86	90	21	8	8	1
With a partner and single children			10	5	3		2	
Alone with single children					3	19	6	7
Alone in a married children's household	3		1	1		6	6	4
With a partner in children's household				1				
With relatives		6						3
Other possibility		3	2			3		5

Source: Kuchařová V, Rabušic L, Ehrenbergerová L. 2002

1.9 Working and caring

There is no research which could give information on this item.

1.10 General employment rates by age (part time / full time / self-employed) for general population

Numbers of employed persons in 2002 are listed in the following tables.

Table 9: Number of employed and unemployed by age (thousands)

age	total	employed	unemployed
40 - 44	643,8	568,8	34,3
45 - 49	768,4	673,4	40,8
50 - 54	800,8	655,2	42,9
55 - 59	700,7	389,2	16,2
60 - 64	502,4	100,8	4,2
65+	1 416,30	54,2	2,2

Source: Czech Statistical Office. 2004

Table 10: Employed and unemployed women by age (thousands)

age	women	employed women	unemployed women
40 - 44	318,4	271	19,4
45 - 49	384,8	329,4	22,6
50 - 54	406	317,9	24,6
55 - 59	363,2	131,1	6
60 - 64	268,5	32,4	2,4
65+	869,2	19,3	0,9

Source: Czech Statistical Office. 2004

Table 11: Second job holders (thousands)

age	total	females
35 – 44	37,1	14,1
45 – 54	34,1	13,4
55 – 64	14,1	3,8
65+	1,4	0,1

Source: Czech Statistical Office. 2004

1.11 Positive and negative aspects of care-giving

There are only few data. Some outcomes of the studies made show extensive burden of family caregivers and also conditions that can improve the ability of carers to continue the care.

Table 12: How people feel in their care-giving situation

carer's feeling	all „yes" answers	frequently and very frequently
Carer is mentally exhausted	70 %	28 %
Carer is physically exhausted	69 %	23 %
Carer has health problems	68 %	19 %
Exhaustion from permanent 24 h care	65 %	29 %
Lack of finance	60 %	23 %

Source: Veselá J. 2003

Table 13: Conditions encouraging families to care for dependent elders

condition	yes in %
Possibility of respite care in LTC hospital or other health institution	29
Possibility to lend aids for care of dependent persons	21
Possibility of respite care in a social institution	17
Possibility of temporary paid stay in hospital (social hospitalisation)	17
Counselling	8
Personal assistance for seniors	6

Source: Veselá J. 2003

1.12 Profile of migrant care and domestic workers (legal and illegal). Trends in supply and demand.

Immigration is a relatively new phenomenon in the Czech society and it became common only after the political change of 1989. Illegal workers come most often from countries of the former Soviet Union. They work legally and also illegally in less qualified professions. There are no data on illegal workers who can be also involved as aids in households or in the care for seniors.

1.13 Other relevant data or information

no information provided

2 Care policies for family carers and the seniors needing care.

2.1 Introduction: Family ethics and expectations – the national framework of policies and practices for family care of dependent seniors.

The present situation of family care in the Czech Republic is a result of various factors. Some of them have been relatively specific for the Czech Republic as well as for the post communist region in general. Big families underwent a process of disintegration into smaller nuclear families in the same way as in other European countries and this process resulted in isolation of seniors in municipal agglomerations, in particular. Since the end of the 2nd World War till the political transformation of 1989 the Czechoslovakia has been a part of a region of Soviet influence. The communist putsch of 1948 started the period of socialist political system.

Socialist state declared that it would take over the care for all people who need it. As a consequence, confiscated castles and mansions, often in remote and isolated areas, were adapted for residential homes and social institutions.

In addition, the health care system was organised by state and funded by the state budget, therefore, several social problems were managed by health care, too. Despite the fact that the quality of care in these institutions and hospitals was not of a good quality, many people were satisfied with the idea that the state would take care of the disabled on behalf of the citizens themselves. They got accustomed to the fact that the state would take over the care for seniors as well. This belief was supported by the massive communistic propaganda. This idea still persists among the Czech people. Even though the majority of care is provided by families (like in other countries), many of the family caregivers feel that the care for seniors should not be their responsibility, on the contrary, the state should be the one responsible.

After the change of political situation in 1989 health care system was decentralised and many health care institutions were privatized.

There have been only minimal changes in the social care system during that time. However, some important innovations and development of modern services were brought about with the activities of the non-profit nongovernmental organisations (NGOs).

This situation has made the essential problem in the care for dependent older persons (the gap between health and social care) even more evident. It became clear that the health care system as well as the system of social care focused mainly on the specific problems of its own department. While the health care system deals primarily with the problems of acute care and tends

to consider the chronic conditions as “social” and not appropriate for the health care, social care aims only at providing social care and avoids medicalisation.

In both sectors the problem of the chronically sick and dependent older people (as well as other groups of people in similar condition) was marginalized. They are considered to be “too sick” and thus contraindicated for placement in residential homes but, on the other hand, they are too “long-term” and “social” and “unperspective” for health care. Despite the fact that both health care and social care departments are not too willing to provide care for chronically sick, dependent seniors, both of them actually provide it and the chronically sick and dependent seniors represent a very important number of patients and clients of the institutions in question. Unfortunately, this long-running situation causes many problems especially to the family caregivers and the patients themselves, whenever coordination of health and social care is necessary, which is very often.

As an example, let us consider the situation of long-term care giving for a chronically ill and dependent senior when the family needs respite stay. The patient is not indicated to stay in hospital, because his / her state is stabilised. In long-term care hospitals there are often long waiting lists and what’s more the patient is also not indicated to stay there, as the true cause of admission is “social” and not “medical”. Residential homes may offer placement for temporary stays (respite care) but the number of places is very limited and again, as there are long waiting lists for placement in residential homes, it is very difficult to find a place. This situation is characteristic especially of Prague and some other cities.

2.1.1 What are the expectations and ideology about family care? Is this changing? How far are intergenerational support and reciprocity important? Do minority groups have different ideologies?

In the Czech Republic only few studies dealing with family care have been conducted. Nevertheless, it is quite obvious that family care remains the most important source of care for seniors who need the care. In terms of expectations and ideology of care there are also very few data. Discussion on old age issues is not frequent neither among the general public nor in the media. Media often depict older people as victims of crimes or as pensioners who will consume even more public resources with the ageing of population. Serious and honest discussion on all issues concerning ageing and family care has not yet started. Similarly, politicians do not see the improvement of the situation of seniors, dependent persons and their caregivers as a priority and, therefore, they do not include these issues into their political programme, with some merely declarative exceptions.

Some studies showed that the general public, including the seniors themselves, is very insufficiently informed on care issues. (Veselá J. 2001)

Some studies even investigated the views of seniors and their families and tried to detect the care provision (in case of chronic condition and dependency) preferred by these people (Veselá J. 2002). The place most often chosen for the care provision is not surprising. Living in one's own apartment is preferred by 55,2 % of seniors, boarding house for retired people is preferred by 12,7 %, sheltered house by 13,4 %, residential home by 5,8 % and 12,9 % are undecided. Some studies have found even higher rate of preference of seniors to stay at home.

Table 14: What place to live in your old age would you individually prefer given that it depends only on your preference (not on situation in your family, finance etc)?

place to live	Now	In worse health
In my apartment	85	25
In the apartment or house of my children	5	14
With close relatives	0	2
In a sheltered house	3	27
In a boarding house for retired persons	2	17
In a residential home	1	10
Other or undecided	4	5

Source: Veselá J. 2002

The actual behaviour of seniors, however, may differ from the results mentioned above. There are long waiting lists for social institutions. This situation is caused by the following facts. Many residential houses have a very long waiting period (years). Therefore, seniors often apply for a place in residential home in a situation, when they do not need the care of a residential home. They are aware of the fact that in case their health gets worse and they need the care, they may wait for a very long time. Then it is not so surprising that among inhabitants of residential houses are people who do not need the care but they entered the residential home according to the waiting list earlier than it was necessary.

Table 15: Reasons of stay in a residential home

reason	%
Family was not able to provide care	44,5
Senior was invited according to the waiting list (before the care of that type was needed)	10,2
Senior needs home help and can live at home but community services are not available	8,7
Family wanted to get the apartment of an old person	7,9
Family did not want to take care	6,2
Senior was perceived as an obstacle by another family member	5,1
Senior entered an institution to avoid abuse from family	2,7
Senior entered an institution to avoid abuse from an apartment owner	2,7
Other reasons	13,1

Source: Veselá J. 2003

In the study on how the adult children view the situation of their parents-seniors (Veselá J.2002), the majority of adult children consider the care for older parents to be their obligation. However, there are some conditions that may prevent them from providing care. Even though there is a general opinion among the general public that even a dependent older person feels better at home than in a institution, only a very small number of respondents admit that the majority of care for dependent seniors should be provided by a family. Adult children of seniors were asked how they would provide care for their older parents in case they become dependent (Veselá J.2001). About 80 % of children answered that they would provide care for their parents at home. More than half of respondents (57 % of daughters and 42 % of sons) answered that they would provide care at home with the help of other family members, 27 % of children would organise the care at home with the assistance of professional home help or another organisation providing care. About 14 % respondents (in case of a mother) and 18 % respondents (in case of a father) would prefer institutional care for their parents. Sheltered houses are considered to be the most appropriate and residential houses the least appropriate type of institution. Factors preventing potential family caregivers from care at home are: a limited capability to pursue career and occupation (34 %), feeling that the skilled and demanding care is beyond their reach (33 %), excessive time load (20 %), necessity to move the parent to their apartment (16 %), mental and somatic distress resulting from care (15 %) etc.

2.1.2 Are there any legal or public institutional definitions of dependency – physical and mental? Are these age-related? Are there legal entitlements to benefits for caring?

Dependency is defined in several legal standards. Because of the complexity of the social system, the dependency is defined for each purpose and situation in a different way.

Dependency is defined in the act 100 On Social Security for the purpose of allowance in case of dependency, age 80 years is mentioned as one of the criteria (Zákon 100 o sociálním zabezpečení. 1988).

Another legal definition of dependency has been given for the purpose of provision of technical aids and household adaptations for the handicapped. Health conditions listed in legal standards (Vyhláška 182 kterou se provádí zákon o sociálním zabezpečení a zákon České národní rady o působnosti orgánů.1991) entitle the handicapped to receive reimbursement for household adaptations and compensation aids. Listed health conditions apply, preliminarily, to a physical and mental handicap of younger people and do not apply to multimorbidity of old age (e.g. people with dementia are not eligible according to this standard).

Act 100 On Social Security (Zákon 100 o sociálním zabezpečení.1988) also stipulates the right for provision of exceptional social care benefits and allowances (household adaptation, purchase or maintenance of means of transport, allowance for public transport) to severely handicapped persons. Assessment of health status for the purpose of getting extra benefits and allowances according to the Act 100 On Social Security is provided by physicians of District Social Security Administration and Assessment Commissions of Ministry of Labour and Social Affairs, according to the Act 582 On Organisation and Administration of Social Security (Zákon 582 o organizaci a provádění sociálního zabezpečení. 1991).

Citizens who are entitled to receive exceptional benefits and allowances for handicapped of 1st grade are those who are not able to stand on their feet for a long time (e.g. impairment of one lower extremity), who have impaired function of one upper extremity, ischemic disease and impaired function of lower extremity and seizures with unconsciousness at least several times in month.

Citizens who are entitled to exceptional benefits and allowances for handicapped of 2nd grade are those who are neither able to stand on their feet for a long time nor to walk, for example after amputation of both legs, plegia of both lower extremities, states after spinal operations or implantations of hip or knee endoprothesis with significantly impaired function of lower extremities. People with sensory impairment limiting orientation (practical or total surdity) and chronic internal diseases and impairments limiting locomotion are also eligible.

Citizens who are entitled to exceptional benefits and allowances for handicapped of 3rd grade are those with the most severe impairment, e.g. those with

anatomic or functional loss of both lower extremities, permanent or long term multiorgan failure severely limiting locomotion or orientation, in severe mental impairment (imbecility and idiocy), total or practical amaurosis (in all ages) and surdity of children.

All the health conditions mentioned above apply, preliminarily, to physical and mental handicap of younger people and do not apply to multimorbidity of old age (e.g. people with dementia are often not regarded eligible according to this standard) which causes many complications to older people and their families.

2.1.3 Who is legally responsible for providing, financing and managing care for older people in need of help in daily living (physical care, financial support, psycho-social support or similar)?

Citizens of the Czech Republic have a right for free health care based on general health insurance according to the law and constitution of the Czech Republic. Even though there are some limitations regarding health care provision and some inequities which are described further, generally, the health care is accessible to all including dependent older people. Problems dealing with health care provision are discussed in the chapter on health and social care. Regional health authorities (Health Department of the Regional Office), health insurance companies and health care providers are legally responsible for providing, financing and managing health care.

Act 100 On Social Security (Zákon 100 o sociálním zabezpečení.1988) determines that it is the state who provides assistance, such as social benefits or other allowances, to people whose income is not sufficient, to citizens who need assistance due to the age or health status or to those who, without the assistance of society, are not able to overcome the difficulties of their living conditions. Act 114 On the Field of Activity of Social Security Institutions (Zákon 114 o působnosti orgánů v sociálním zabezpečení.1988) determines generally that communities and District (Regional) Offices organize and provide social care for citizens and, in cooperation with other institutions and organisations, detect people in need of social care (Veselá J.2001).

2.1.4 Is there any relevant case law on the rights and obligations of family carers?

Rights and obligations of family carers are not legally defined.

2.1.5 What is the national legal definition of old age, which confers rights (e.g. pensions, benefits, etc.)?

Retirement age for men was 60 years and 57 for women (56 for women with one child, 55 for women with two children, 54 for women with three and more children). (Zákon 155 o důchodovém pojištění. 1995). Since 2007 the retirement age for men will be 62 and 61 for women (60 for women with one child,

59 for women with two children, 58 for women with three and four children and 57 for women with five and more children).

Age 80+ is legally considered to be a factor contributing to the reduction of self-sufficiency.

2.2 Currently existing national policies

2.2.1 Family carers?

There is no official strategy or action plan dealing with family caregivers. The support of family caregivers and the care in home environment are included in several issues of the National plan on Ageing (Národní program přípravy na stárnutí na období let 2003-2007, schválený usnesením vlády ČR ze dne 15. května 2002 č. 485. 2002). The aim of this plan is to improve the climate in the society and to create better conditions for solving problems concerning ageing of society, to change the attitudes towards ageing on all levels and to create a society for people of all ages.

The chapter on social environment stipulates for the fact that it is necessary to support and create conditions for life of older persons in their natural environment, simply, to support care in the family. It is also necessary to support activities of organisations and help the realisation of the project of counselling for seniors and the support for caring families (responsible: 12 ministries including Ministry of Labour and Social Affairs).

The National plan on Ageing further stipulates:

- To conceive “A statement on the family situation in the Czech Republic” and to propose a plan of state policy concerning the family (including seniors) as well as to find a solution of problems reappearing in various fields and social situations.
- To support the development of assistance to seniors in their original environment, to announce pilot projects of extramural (noninstitutional) social services for older seniors (responsible: Ministry of Labour and Social Affairs).
- To develop a system of integrated home service as a necessary condition to enable older people to remain home. This system should be included in a new conception of health and social care.

Apart from these proposals National Plan on Ageing also claims that it is necessary to provide conditions for provision of flexible services for older people in the community. The continuity of the administrative reform in the Czech Republic and the improvement of the coordination of health and social care are, therefore, essential. In addition, it is necessary to create a comprehensive system of social services that would respect rights and individual needs of older

people, minimize the risk of social exclusion and enable seniors to stay at home as long as possible. These changes would support their self-sufficiency and dignity of life. The family caregivers should also be helped by this system. The legal conditions to achieve the goal mentioned above should be determined before 2007 – a responsibility taken by the Ministry of Labour and Social Affairs.

2.2.2 Disabled and / or dependent older people in need of care / support?

National Committee for People with Disability was established on May 5, 1991, according to the resolution 151 of the Government of the Czech Republic. National Committee for People with Disability elaborated the National Plan of Help for People with Disability, which was adopted by the Government of Czech Republic on June 29, 1992. After the reconstruction of the National Committee for People with Disability (December 2,1992), this committee revised the National plan of Help for People with Disability and elaborated National Plan of Measures to Reduce the Negative Impact of Disability. The latter was adopted by the Government on September 8, 1993. National Plan on Equal Opportunities for People with Disability was adopted by the Government on April 14, 1998. (Národní plán vyrovnávání příležitostí pro občany se zdravotním postižením, schválený usnesením vlády ČR č. 256 ze dne 14. dubna 1998. 2000). The aim of this plan is to provide available and accessible health care for people with severe disability. It attempts to secure better coordination of health care, rehabilitation and complex assessment of the level of impairment and handicap. The construction of centres for chronic and acute illnesses (hospices, spinal centres etc.) should also continue. This programme is subsidized by 15 millions CZK per year by grants provided by the Ministry of Health. Another goal of the plan is to promote the development and construction of counselling and information centres offering technical aids, their provision and adaptation according to individual needs. These centres should be constructed in cooperation with NGOs of people with disability, rehabilitation centres and other non-profit organisations. This programme is subsidized by 10 million CZK per year by the grants of the Ministry of Health.

The grant system of the Ministry of Health has helped to develop several new models of care, many of which are very helpful also to older persons with disability and to their caregivers.

Personal assistance and family care should, according to this plan, become a realistic alternative to the institutional care. The plan also determines the responsibility of the Ministry of Labour and Social Affaires in the following way:

To include conditions for the provision of personal assistance and care provided by the family in the law On Social Care by January 1, 2003. This goal has not been reached.

To elaborate an innovative system of funding of social services that would raise social and economic participation of eligible individuals, concerning the choice of services based on individual needs, in particular. Funding of services should be oriented at eligible persons. System should maximize the efficiency of services for users and provide such an offer of services that would react to the needs of an eligible person and his / her choice. The system should support independent living in home environment as far as it is the choice of a person with disability. This goal has not been reached.

Ministry of Labour and Social Affairs must organize and fund the training of personal assistants for people with severe disability. It must help to develop and improve the quality of a comprehensive system of home care and help to coordinate this type of care with other social services. Respite care should be included in the law On Social Care by January 1, 2003 (this goal has not been reached). The development of respite care should be subsidized by the grants of Ministry of Labour and Social Affairs, which is 20 million CZK each year (by January 1, 2003). This goal has been achieved only partially.

In addition, communities and municipalities should improve and help to develop the system of home care and home help. Ministry of Labour and Social Affair should transform institutions for disabled people into more modern forms of care. All persons with disability should have the right to choose freely between the personal assistance, care in the family, care in the community, sheltered living, care in an institution or another form of social care and service. Ministry of Labour and Social Affairs should also prepare legislative that would help the reduction of institutional care capacities and their replacement by other forms of social care by January 1, 2003. This goal has not been achieved.

Construction of sheltered houses should be supported by the Ministry of Local Development.

2.2.3 Working carers: Are there any measures to support employed family carers (rights to leave, rights to job sharing, part time work, etc)?

Act On Sickness Insurance (Zákon 54 o nemocenském pojištění zaměstnanců.1956) determines the right to receive paid allowance for care for a sick family member. The allowance for care for a sick family member belongs to a man or a woman who cannot work, because he or she has to take care of a sick family member in case that the health status of the sick family member demands such care. Persons eligible for such allowance are those who live in the same household with the sick person. The allowance (69 % of average wage) is provided in the first nine days of the sickness and may be provided only once for one diagnosis.

There are no other measures of support as far as employed family caregivers are concerned.

2.3 Are there local or regional policies, or different legal frameworks for carers and dependent older people?

State administration has been changed during the public administration reform. Instead of the previous 50 districts, there have been 14 regions including the city of Prague since 2003. The execution of the state administration was also delegated to 184 municipalities (municipality with authorised municipal authority). New regions have started to design their strategy of health and social care. 767 of social institutions (including 183 residential homes and 40 boarding houses for elderly with 24 000 inhabitants), 160 social institutions for physically and mentally disabled individuals and 23 home help agencies were controlled by the district offices before the public administration reform. Ministry of Labour and Social Affairs recommended that institutions with 80 inhabitants and more should be under the control of Regional Office, especially those that are situated in smaller communities.

2.4 Are there differences between local authority areas in policy and / or provision for family carers and / or older people?

There are differences among local authority areas both in policy and in the provision of care. We have sent a questionnaire investigating care provision for older people to all local councils of municipalities with authorised municipal authority. (Holmerová I, Janečková H, Rokosová M, Stolín M. 2004). According to the preliminary results, it is evident, that the authorities of municipalities with authorised municipal authority organise social services in various ways. Some of them sent information concerning all territory of the delegated state administration, some of them released information only on services in the municipality itself. For there is no legal standard determining obligations of communities and municipalities as far as social services are concerned. Some communities and municipalities provide a whole spectrum of social services, some of them provide no services at all. According to the study on municipalities (Veselá J.2003) it is evident that there are differences in the care provision.

Table 16: Evaluation of social services in the municipality

Answers of local authorities of municipalities with devolved authority (%)	Negative evaluation (4,5)	Service is not available (6)	positive evaluation (1,2,3)
Capacity of residential homes	43	18	39
Capacity of sheltered homes	39	12	49
Care aids	20	49	31
Number of home help services for seniors	19	10	71
Counselling and advice	11	69	20
Number of day-care centres	8	74	18
Numbers of temporary stay services	8	64	18
Amount and quality of home help services provided by a community	2	30	68
Amount and quality of home help services provided by a home care agency	5	50	45
Amount and quality of home help services provided by a district authority	5	52	43
Amount and quality of home help services provided by a other institutions	4	78	18
Amount and quality of home help services provided by church	2	57	41
Amount and quality of home help services provided by private organisations or individuals	3	62	35

Evaluation 1 = excellent; 2 = very good; 3 = good; 4 = not convenient; 5 = bad
Source: Veselá J. 2003

3 Services for family carers

Services for family carers	Availability			Statutory	Public, Non statutory	Voluntary		Private
	Not	Partially	Totally			Public fund-ing	No public funding	
Needs assessment (formal – standard-ised assessment of the caring situation)		X[1]						
Counselling and Advice (e.g. in filling in forms for help		X[2]		x	x	X		
Self-help support groups		X[3]				X		
"Granny-sitting"		X[4]				X		
Practical training in caring, protecting their own physical and mental health, relaxation etc.		X[5]					x	
Weekend breaks	X							
Respite care services		X[6]				X		X
Monetary transfers				X[7]				
Management of crises	X							
Integrated planning of care for elderly and families (in hospital or at home)		X[8]						
Special services for family carers of dif-ferent ethnic groups	X							
Other								

1 "Needs assessment" is rare. It is performed in some geriatric institutions and also by some edu-cated and skilled social workers in hospitals or in offices.
2 Counselling and advice depends also on local conditions. In some municipalities there are skilled social workers who provide counselling and ad-vice. Several organisations (Union of Retired Per-sons, Czech Alzheimer Society and others) also provide counselling and advice.
3 Self-support groups are organized by the Czech Alzheimer Society.
4 " Granny-sitting" is provided by the Czech Alzheimer Society (respite care programme) and it is funded by grants of Ministry of Labour and Social Affairs.
5 Several forms of training of caregivers are also available but not frequent. However, there are some home care agencies, such as Diakonie and Charita, which closely cooperate with caregivers.
6 Respite care may be provided as a temporary stay in an institution, "granny-sitting" or a day stay in a day care centre. All these forms of care are available only in some municipalities.
7 described in chapter on allowances
8 see x[1]

3.1 Examples

3.1.1 Good practices

It is necessary to stress that there are municipalities that coordinate and support services for their citizens, prepare information materials where also caregivers can easily find out about alternative and, at the same time, available services. Good examples of “caring municipalities” can be found in i.e. Chrudim, Litoměřice, Ústí nad Orlicí, Nasavrky, Litomyšl etc.

Some hospitals restructured their LTC departments into modern geriatric centres providing also caregivers with support (Geriatrické centrum Nemocnice Pardubice).

Home services provided by NGOs such as Diakonie, Charita, Czech Red Cross as well as some municipalities include both health and social care and therefore bridge the gap between health and social care.

Many residential houses transformed their “institutional” attitude into that of a modern organisation opened to a local community, providing modern services and care.

3.1.2 Innovative practices

The Czech Alzheimer Society has 30 contact and information points located in every region of the Czech Republic. Caregivers of people with dementia can get there information and advice on dementia as well as information brochures and leaflets. In addition, the Czech Alzheimer Society started a new project, the so-called “granny sitting”, which provides family caregivers with respite. All information is also available on the web pages of the Society.

Day care units and modern departments for people with dementia have been opened in some institutions and hospitals.

Hospice movement which started in the last decade of the past century supports family caregivers in their care and also after bereavement.

Some institutions were designed primarily as opened, integrated (health and social) and community based (Centre of Gerontology, Prague 8, Sue Ryder House, Prague 4 etc.)

4 Supporting family carers through health and social services for older people

4.1 Health and Social Care Services

The system of care for seniors in the Czech Republic has existed for centuries and its level and quality used to be very good especially in the late 19th and at the beginning of 20th century. It was in Prague where one of the first geriatric university departments was established. Masaryk homes in Krč (Prague) represented a modern health and social care institution at that time.

This situation has changed during the 2nd World War and the following period of communist regime (1948-1989). Nearly all property was expropriated as a base of all economic activities, including health and social care facilities. A system of socialist health and social care provision was established.

Health care was controlled by the Ministry of Health, which supervised Regional Institutes of National Health including the regional and teaching hospitals. Regional Institutes of National Health controlled District Institutes of National Health including the district and other smaller hospitals and clinics with out-patient departments of specialists, general practitioners, health centres with general practices, gynaecologists, stomatologists and paediatricians. The National Plan of Care for the Aged and Chronically Sick (1982) was accepted by the government and geriatrics became an independent medical specialty. The aim of the National plan of Care for the Aged was to establish 0,5 of a "geriatric nurse" in each general practice. In 1989 there was 0,4 of a geriatric nurse in each general practice (300-400 older people) who provided prevention and care for seniors and visited them in their households. The concept of geriatrics was accepted and long-term care hospitals were declared to be a clinical base of geriatrics.

The system of health care was directly controlled by the state and, therefore, naturally, health care institutions (especially long-term care hospitals) played an important role also in the social care provision.

The system of social care was also directly controlled by the state (Ministry of Social Affairs). Districts organised their District Institutes of Social Care. These institutes provided home help and, together with communities, the care in sheltered houses, especially since the 1980s. Social care institutions including residential homes were also controlled by the state. These institutions were often situated in expropriated buildings of mansions and castles, very often in remote, isolated places. People with disabilities and dependent seniors were thus segregated from the "normal" population. The segregation and isolation of the disabled and seniors was a very peculiar feature to the socialistic social care system. Moreover, people with disabilities were considered and called "invalid" and older people "overaged". Both of the terms very much reflected

the attitude towards these people at that time. After political changes in 1989 both systems of health and social care have changed.

Health care system was soon decentralised and deetatised (Zákon 160 o péči v nestátních zdravotnických zařízeních. 1992) and many services were privatised. Important health insurance acts were accepted in 1991 and 1992 and the system of general health insurance was established. Citizens of the Czech Republic have a right to receive free health care based on health care insurance. This right is stipulated by the constitution and the law.

System of social care had not undergone any substantial change before the reform of the state administration. After this reform, which took place in 2003, the control of social institutions passed from state and district authorities to regions and local authorities. Also, since the beginning of the 1990's many innovative practices in social care were introduced by NGOs. However, the citizens of the Czech Republic have no right to get social care. The legislation dealing with social care enables to organise social care but it neither determines the duty to provide it nor the way of its funding. The law on social care defines only possibilities of organizing these services.

4.1.1 Health services

Health care costs of the General Health Insurance Company based on the type of health establishments (2002) are: total health care per 1 insured person 13 845 CZK, out-patient care 2 909 CZK (incl. GP 664 CZK, Home care 71 CZK, rehabilitation 112 CZK, diagnostic 434 CZK, special out-patient care 867 CZK). In-patient care 6 903 CZK (including hospitals 6 038 CZK, LTC and nursing 385 CZK). Prescribed medicaments 2 929 CZK. Prescribed medical aids 397 CZK.

The trend of public expenditure on health services per 1 inhabitant is following: 8 000 CZK in 1994, 15 000 CZK in 2002. Direct personal expenditure per 1 inhabitant: 801 CZK in 1996, 1 417 CZK in 2002.Total expenditure per 1 inhabitant: 10 728 CZK in 1996, 16 520 in 2002. Proportion of total expenditure on health services in GDP (%): 1996: 7,06, 2002: 7,00. The indicator of the total expenditure on health expressed as percentage of the gross domestic product (GDP) calculated for the Czech Republic is in the lower third among OECD countries. According to OECD sources the average ratio of the expenditure on health to the GDP in 2001 was 8,4. In the Czech Republic it was 6,8 % in the same year (comparable with, e.g., Hungary). The comparison of these values should be considered as only general information because of possible differences in methodology in different countries. Also in the Czech Republic the GDP value was recently revised by Czech Statistical Office, as of 24.10.2003, his revision diminished the indicated ratio from the earlier value of 7,3 % (Zdravotnická ročenka České republiky 2002.2003)

Table 17: Average health care costs of the General Health Insurance Company per I insured person based on age

age groups	men	women	total
55-59	20 404	14 540	18 935
60-64	23 838	19 912	21 718
65-69	29 363	24 161	26 401
70-74	34 552	28 451	30 895
75-70	37 635	31 567	33 698
80-84	39 144	34 800	36 180
85+	29 759	35 290	33 684

Source: Zdravotnická ročenka České repulbiky 2001. 2002

4.1.1.1 Primary health care

- Primary health care is a type of care which includes general practitioner for adults, general practitioner for children and adolescents, stomatologist and gynaecologist and home nursing care.
- The number of general practitioners for adults registered by the end of 2002 was 5 186. There were 1650 inhabitants older than 14 years per one physician's contract. (Zdravotnická ročenka 2002.2003). General practitioners for adults provide care for all adults including seniors and they visit patients in their households. The care of a general practitioner is reimbursed by health care insurance per capita (capitation) according to age groups.
- This system of reimbursement creates a situation where insured individuals who have no health problems and do not need care are more feasible to general practitioners than those who are sick and need the care, drugs and aids. Therefore, this system often brings problems both to patients and to caregivers. When a family decides to take care of their dependent senior-relative and the old person has to move to the household of the family, it is sometimes very difficult to find a new general practitioner. The reason is basically that the old person is dependent, needs to be cared for at home and needs more drugs, aids, medical and nursing care. Despite the fact that all those items are regulated by health insurance companies, the more dependent and severely sick patients the general practitioner has in his / her practice, the more likely he / she is to lose the benefits paid by the insurance company or face other regulations. Moreover, families sometimes do not find a general practitioner with an office close to their household. Long distance between a patient and his / her general practitioner causes further problems for the caring family when they need prescription of drugs or aids. It is also a limiting factor that prevents the patient to visit the doctor and vice versa. Under these conditions general practitioner often prescribe drugs without an

examination of the old person. When the examination is necessary due to the worse condition of the patient, sometimes only medical emergency is accessible.

- The reimbursement including bonification of care of general practitioners by health insurance companies is provided only on condition that the practitioner will keep to the limits of prescription and so called induced care, e.g. prescription of drugs and aids including incontinence aids and home nursing care. However, the cost of a stay in hospital or in a long term care facility is not included in this regulation system. As a paradox, it might be more convenient for a general practitioner to send the patient to hospital than to arrange home care at a patient's household. Many home care agencies are able and willing to provide nursing care on weekends and at nights. Unfortunately, as this care is too "expensive" when considering the general practitioner's budget, its prescription is limited. We may summarize that the system of reimbursement of the care of general practitioner supports hospitalisation and prevents from providing care in the home environment.
- General practitioner should visit patients in their homes in all cases when it is necessary. Funding of this service is included in per capita reimbursement for care. Therefore, general practitioners are not motivated to provide this care. The quality of care depends on local conditions and on the general practitioner himself / herself. There are many general practitioners who visit their patients regularly and whenever it is necessary they visit also their sick and dependent old patients. Unfortunately, there are also some general practitioners who take care only of the drug prescription without visiting and examining their patients regularly.
- In the Czech Republic home care is provided by 1879 nurses mostly organised in home care agencies. Most of these agencies are private, some of them are non-profit (Charita, Diakonie, Czech Red Cross etc.). Some of them employ also physiotherapists, others provide a certain amount of home help offered as a paid service according to the needs and choices of clients. Nurses of home care take blood and other biological material samples, they usually measure blood pressure and blood glucose at bed side. According to a recent research on the field of home care, 41,5 % of all agencies provide both home care and home help, 56,7 % provide only home nursing care (Misconiová B, Průša L, Vostrovská H. 2003). According to the research, 58 % of agencies work also on nights and during weekends, 21,7 % during weekends and 20,3 % on afternoons. This research has also detected difficulties in cooperation with general practitioners (who are eligible to issue home care prescription for their patients) and also with other physicians (i.e. a physician of a hospital department may prescribe home care for 2 weeks following the dismission). In addition, all of the limitation by health insurance companies mentioned above were confirmed by the research.

- Other health services are seldom provided. Home visits of stomatologists are exceptional and visits for podiatric care are organized and paid by the families.
- Specialised medical care is provided by specialists. There is a free access to dermatologists and psychiatrists. To visit other medical specialists the patient should be referred by the general practitioner. However, many patients visit specialists without the general practitioner's reference. Home visits by the specialists are not reimbursed by general health insurance with exception of those by psychiatrists. Several rehabilitation aids can be prescribed only by specialists such as traumatologists, orthopaedists or rehabilitation specialists. Also, some prescription of drugs can be issued only by specialists such as psychiatrists, internists, neurologists or geriatricians. This situation causes many problems to patients and also to their family caregivers. In real life it means that several important and necessary rehabilitation and care aids cannot be prescribed neither by the physician of the geriatric department nor by the general practitioner. Family caregivers have to look for a specialist who is entitled to prescribe the aid. Sometimes the office of such a specialist is far both from the hospital and from the patient's home. To receive aid which needs to be prescribed by the specialist it is necessary to undergo an often exhaustive transport to a specialist. Most frequently, family caregivers get the medical report from the general practitioner or from the hospital physician, visit the specialist by themselves and get the aid prescribed without the examination of the patient by the specialist. Sometimes they even buy the aid themselves (without prescription) and in the most regrettable cases they resign and provide the care without it.
- Dealing with this very problem, it might be useful to explain why there are only cca 15 geriatric outpatient practices. Until 2003 geriatricians were not entitled to prescribe some of the important drugs including antiosteoporotic drugs (prescribed only by internists), several antidepressants, neuroleptics and cholinesterase inhibitors (prescribed only by neurologists and psychiatrists). They were neither entitled to prescribe home care nor some of the important care and rehabilitation aids. This situation was so unfavourable that most of the physicians who specialised in geriatrics worked not as geriatricians but used their original specialisations to label themselves (most often as general practitioners and internists). This situation has slightly improved since the beginning of 2004. Geriatricians are now entitled to prescribe all of the most necessary drugs, mentioned above. The number of physicians in out-patient care is: internal medicine including sub branches 2 383, geriatrics 15, neurology 695, psychiatry 606, orthopaedics 527, prosthetics 9, and urology 271. Total number of physicians in the Czech republic is 43 824, which includes 12 % general practitioners, 16 % stomatologists, 6 % surgeons, 10 % internists, 0,7 % geriatricians.

4.1.1.2 Acute hospital and Tertiary care

- Hospitals in the Czech republic are owned by the state (i.e. teaching hospitals and psychiatric hospitals), regions, municipalities, by private companies, and very few are owned by NGOs. The care provided by hospitals is reimbursed by the general health insurance and it is free. Due to the way in which the hospital care is being reimbursed (historical budgets on fee for service basis) and due to the decreasing payments for a patient, in particular (the longer the patient stays, the lower is the payment), hospitals limit the duration of a patient's stay in acute departments. Therefore, old multimorbid, dependent, geriatric patients with potentially chronic conditions (stroke) are very often perceived as a problem for many hospital departments as the average time of their stay tends to be longer than that of younger patients. Simply, they are not welcome. Numbers of places (beds) in acute curative care are: internal medicine including sub branches 13 967, geriatrics 611, neurology 3 620, psychiatry 11 218, surgery 10 470, orthopaedics 3 003, urology 1 747, aftercare and nursing care 12 461. There has been discussion in the last ten years on the transformation of beds in hospitals, reduction of the number of acute beds and the increase of the number of rehabilitation, continuing care and nursing care beds.
- Geriatric departments are relatively rare and the number of beds is very small compared to other medical departments. Some geriatric departments act more as aftercare departments than as departments of acute care. Only few hospitals run modern acute geriatric departments (Hradec Králové, Pardubice, Zlín). Geriatric departments of university hospitals (clinics) are in Prague, Hradec Králové and Brno. Geriatric Clinic in Prague provides aftercare and geriatric assessment, the Clinic of Geriatric, Internal Medicine and General Medicine can be found in the University Hospital Brno and in Hradec Králové the Clinic of Gerontology and Metabolism. Modern geriatric rehabilitation units are in Zlín, Pardubice, Liberec, Kladno, Prague, Ostrava etc. However, statistically, organisationally and financially (reimbursement by the health care insurance) they are considered to be (and also funded as) the other long-term care hospitals whose care is more like the care provided by a nursing home.
- Total number of hospital beds in Czech Republic is 64 761, including: institutes for long-term patients (long-term care hospitals) 7 438 beds (average duration of stay 71days), institutes for tuberculosis and respiratory diseases 1 097 beds (average duration of stay 38 days), psychiatric institutes for adults 9 677 beds (average duration of stay 80 days), other special institutes for adults 1 629 beds (average duration of stay 20 days). (Zdravotnická ročenka 2002.2003).
- Out of the 9 677 psychiatric beds for adults, there are 1715 gerontopsychiatric beds. According to the information released by the

Office of Health Information and Statistics in 2001, the length of stay is very long. 421 patients stay in gerontopsychiatric departments more than 1 year and 203 stay more than 5 years.

4.1.1.3 Are there long-term health care facilities (includes public and private clinics)?

Rehabilitation care, long-term care, aftercare and long-term nursing care are provided by various types of health care facilities. The care is funded (for many years) by the general health insurance and it is free. The Health Care Insurance Act does not allow any co-payments for health care (Zákon 48 o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů. 1997). This also means that patients, who stay for a long time or even life-long in a chronic health care institute, have at their disposal their full income (pension) even if this pension increases because of the dependence allowance. The patient and / or his family do not pay anything even for those long-term stays, which last more than a year, because those stays are covered by health care insurance including the costs of the stay itself, meals, drugs, incontinence or other aids. Families who do not want to or who are not able to take care of their patients feel comfortable when all the costs of the long-term stay are covered by the health insurance. Very often these families get most of the patient's pension (including the allowance for dependence), when they visit their relative in the health care institution. In case the patient is unable to decide about his / her legal and financial issues, hospital has to save his / her finance and after his / her death they become a part of an inheritance. As a result, health insurance companies sometimes limit the length of stay up to 3 months in their individual contracts with facilities. Some families which are not able or willing to take care of the patient at home successfully bypass this 3 months limit (imposed by health insurance companies) by moving their patients from one facility to another (and from one insurance company to another).

In long-term institutions health insurance covers only standard care. Quality of the standard care is sometimes not acceptable for the families. In some institutions, i.e. psychiatric hospitals or old long-term care hospitals, there are still rooms for many patients. However it is very difficult to find better care even when the family wants to provide a co-payment. Several hospitals provide so called "nadstandard", which is a service better than the standard one. However, this service applies rather to the equipment of the patient room etc. (single room with TV, fax, internet, refrigerator etc.) than to the health care itself, because the co-payment cannot be provided for health care, which is free according to the law (Zákon 48 o veřejném zdravotním pojištění a o změně a doplnění některých souvisejících zákonů. 1997). This system is not very feasible especially regarding long-term care. There is an immense difference between various institutions: some of them are very good, some of them are very poor. Unfortunately, this situation creates an opportunity for few "entrepre-

neurs", who provide bad quality care on a private basis (the care is only moderately better than in the state psychiatric hospitals). This type of care is paid for by both, the families and some insurance companies. Especially in the case of people with dementia it is difficult to find a good solution, as gerontopsychiatric departments are for many families quite unacceptable and in many regions there is no other option.

It is also necessary to mention the so called social hospitalisation defined as "further stay in the health care establishment". Theoretically, this type of stay is also possible, but it is not carried out in practice, as the payment (offered by district authority) is substantially lower than the real costs of even less expensive facilities.

4.1.1.4 Are there hospice / palliative / terminal care facilities?

There are 6 hospices with 171 beds and with the average stay of 33 days (Zdravotnická ročenka 2002.2003). These facilities are relatively new, all of them were established only after the political transformation in 1989 by non-governmental organisations often with the help of church and the support of Ministry of Health and Ministry of Labour and Social Affairs. All hospices are modern, patient and caregiver-friendly facilities with good quality care. Hospices closely cooperate with families and carers, provide them with information and support. Some of them organise also home hospice care. Even though hospices provide care especially to terminally ill patients with oncology diagnoses, sometimes, when the hospice does not operate at full capacity, they admit also patients in terminal phase of dementia etc. or other patients who need the hospice care.

4.1.1.5 Are family carers expected to play an active role in any form of in-patient health care?

The communication between health care professionals and patients and carers is probably sometimes still stigmatized by the long lasting paternalistic socialist system of health care that had taken over all care and responsibility for the patient along with the majority of decisions. Family caregivers still often do not feel themselves to be partners of health care professionals, and often they are not, in fact, considered to be partners by the health care team. Modern health care facilities, especially those established after the transformation of the political situation (hospices, centres of gerontology), put more stress on better communication with patients and family carers. Especially in hospices family members can stay with their relative for some time and support him / her.

Hospitals provide all services for patients including the so called hotel services (catering, laundry etc.) and they also provide clothes especially in case of emergency.

Despite this situation, it is necessary to state that the medical part of health care is generally considered to be of good quality. Most complaints of patients and family carers refer to the nursing care and to the behaviour of care personnel. In hospitals and other health care facilities the nursing care is sometimes considered to be inadequate due to the lack of nursing and auxiliary personnel. The most frequent complaint concerns insufficient nutrition (meals do not have appropriate temperature and consistence, are brought away sooner than patient is able to eat them, sometimes are unnecessarily minced and mixed). Family caregivers sometimes try to compensate these problems, attend frequently their patient-relative in the hospital or other health care facility and help with the provision of the nursing and auxiliary care. Both hospital and long-term care facility often do not contact neither the general practitioner nor home care service, and the carer is thus expected to inform the general practitioner and to do the necessary logistic concerning nursing and rehabilitation aids before the patient can be dismissed home.

4.1.2 Social services

The analysis of the contemporary legislative regarding social security states clearly that the citizens of the Czech Republic have a right to receive allowances which are defined by the social security acts (Zákon 100 o sociálním zabezpečení. 1988., Zákon 114 o působnosti orgánů České socialistické republiky v sociálním zabezpečení. 1988., Zákon 582 o organizaci a provádění sociálního zabezpečení. 1991). However, none of these acts nor any other acts guarantee the citizens of the Czech Republic the right to receive social services and also they do not determine who is responsible for provision and funding of these social services.

4.1.2.1 Residential care (long-term, respite)

Residential care is provided in several types of institutions. Institutions for the physically and / or mentally handicapped provide care for people with various types of physical or mental impairment, including people of old age. Residential homes and boarding houses for pensioners provide care for people of retirement age who need care and support.

The establishments of social care consist of 74 499 beds in total including 54 261 beds for adults. This number includes 35 795 beds in residential homes (pensioners homes), 11 195 beds in boarding homes for pensioners, 418 beds in establishments which are combinations of both, residential and boarding homes, 493 beds in institutions for physically handicapped adults, 466 beds in institutions for physically and mentally handicapped adults, 133 beds in institutions for adults with multiple anomalities, 245 beds in institutions for adults with sense organs defects, 4 809 beds in institutions for mentally disabled adults, 160 beds in institutions for alcoholics and drug addicts, 547

beds in institutions for chronical psychotics and psychopaths. (Zdravotnická ročenka ČR 2002.2003)

4.1.2.1.1 Basic data on % of > 65s in residential care by age group and type of residential care (sheltered housing, residential homes).

According to research performed in 2002 there was following age structure of inhabitants of residential homes.

Table 18: Age of residents in residential houses

age groups	residents in residential houses
up to 60	6,60 %
60-64	4,30 %
65-69	6,90 %
70-74	11,00 %
75-79	17,60 %
80-84	21,10 %
85-89	17,40 %
90-94	12,10 %
95+	3,00 %

Source: Veselá J. 2003

4.1.2.1.2 Criteria for admission (degree of dependency, income etc.)

Criteria for admission to a residential home or a boarding home for pensioners are: achievement of the retirement age and submission of the application for placement. These criteria are stipulated by the Social Security Act and related standards (Zákon 100 o sociálním zabezpečení. 1988., Vyhláška 182 kterou se provádí zákon o sociálním zabezpečení a Zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991). Criteria for admission to the residential home are not further specified, both, people in good mental and somatic health as well as people with disabilities may, therefore, apply for admission to the residential home. It is necessary to consider that the Social Security Act was accepted in 1988, just before the downfall of the communist government. The regulation 182, too, was accepted in 1991, very soon after the political change. The philosophy of both of these legal standards dates back to the socialistic ideology, where the state declared to take care of the “invalid” and “overaged”. As a consequence, also those who do not need any care can be admitted into residential homes. The only necessary condition for the admission to a residential home is the achievement of retirement age which is low in the Czech Republic if we compare it to retirement age in other European countries. As a paradox, there is a list of contraindications for admission to the residential home, which includes many of the health conditions, which appear quite frequently. This list may not be respected in case that the residential house has a nursing department. The nurs-

ing department, however, is only mentioned in the regulation 182 On Social Security (Vyhláška 182 kterou se provádí zákon osociálním zabezpečení a zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991) but no nursing care or nursing care departments are defined by the law. On the contrary, Ministry of Health, Department of Nursing, defines nursing as a skilled health care activity. Ministry of Labour and Social Affairs seems to agree in principle with this statement, however it declares that social institutions should provide social care and not health care. Nurses are, therefore, not included into the list of personnel of residential houses. It is clear that these legislative ambiguities cause many problems in practice. As a consequence, the practice differs in various regions, communities and municipalities. While some residential homes admit seniors with a disability after thorough health and social assessment and consideration, some others admit healthy and self-sufficient seniors. Several residential homes admit people with dementia but not those with Alzheimer's disease. Despite the chaotic situation majority of people who get to be admitted to residential homes do need this type of care.

Sheltered houses (or houses with home help) are usually established by the community of a municipality. The amount of care which is provided in these houses differs and depends on local conditions. There are sheltered houses with continuous care and there are those where the staff is not present at evenings, nights and on weekends Admission criteria to get a place in a sheltered house depend on local conditions and local authorities. Construction of sheltered houses is subsidized by the grant system of the Ministry of Local Development. About 26 000 inhabitants live in sheltered homes (Veselá J. 2001)

4.1.2.1.3 Public / private / NGO status.

Residential homes and boarding houses for pensioners are social institutions originally established and controlled by the state. Since the state administration reform they have been controlled by regional authority or community. The Act 100 On Social Security claims that social institutions should provide both social and health care, while the health care laws state that the health care can be provided exclusively by a registered health care facility.

Residential homes mostly provide services for seniors with a disability, who need care and / or supervision whereas inhabitants of boarding homes for pensioners live independently and use only certain type of home help. Institutions for the mentally or physically handicapped provide care for people with disability.

All these institutions are funded by the following sources: allowance per inhabitant (60 000 CZK per year) sponsored by the state budget and by the payment of inhabitants themselves. Institutions and organisations which help to establish and control these institutions contribute also to their funding from their own sources. Payments of inhabitants of residential homes are limited in the resi-

dential homes, which are controlled by state, regions and communities. According to the law, the residents of these residential homes have a right to have at least 600 CZK monthly (as a rest from their pension after payment for stay) for their personal expenses (i.e. co-payments of drugs etc.). This rule does not apply to residential homes established by private persons and organisations, as well as NGOs.

All of the residential homes and boarding homes for pensioners were originally established and controlled by the state. Since the state administration reform they have been controlled by regions and communities. The latter alternative presents a serious problem when a big residential home is located in a small community and the total budget of the residential home is substantially bigger than that of the local community. Many inhabitants of that residential home come from other communities and those communities have not a duty to contribute to the residential home budget. Responsibility for the residential home, therefore, finally depends on the community where the residential home is situated.

Besides all these “social” institutions there are other facilities that are established by communities and municipalities and which are not included in the statistic of social institutions. Boarding homes or houses for seniors are the most frequent types of facilities established by communities. Their construction is supported by Ministry of Local Development. Seniors purchase or hire apartments for reduced prices in a boarding house, where they may receive some home help services, also for lower prices.

Day and week centres for seniors exist only in few communities. They provide day care or the care during the week, while families provide care at nights and / or during the weekends. These centres play an important role in supporting carers. Some communities, especially in bigger municipalities, establish houses of nursing care. According to the legislative, the nursing care is considered to be skilled health care, however, these houses of nursing care are considered to be “social nursing care” facilities, which cause many further problems in the care provision (medical supervision etc.). Health insurance companies consider these nursing care houses to be “social” institutions and they do not reimburse the nursing care provided by them. Therefore some facilities of this type cooperate with (or establish their own) home care agency, that provides nursing care which is reimbursed from the health care insurance.

NGOs including churches have established many innovative types of social care. Only few social services are provided by private persons or companies. Residential care in residential homes established by the organisations mentioned above may be covered completely by the resident. However NGOs raise funds to reduce this payment to a level usual in residential homes run by state or community. This type of fund raising is usually difficult, as both state and regions have to be addressed. Every year NGOs have to submit applications and projects to continue in the care they have been providing for many

years. Administrative errors (i.e. late submission of the application, non-compliance with all formal requirements of the project application) may cause absence of funding. Even when the application is successful, the administrative evaluation of grants is so prolonged, that the necessary funds arrive regularly with substantial delay. Before the state administration reform Ministry of Health and Ministry of Labour and Social Affairs provided NGOs with grants covering up to 70 % of total expenses for social services provision. After the state administration reform the state provides only 50 % of the costs of social services for seniors on the local level. Regions might be eligible for the rest of funding. As the state urges the organisations to account separately for the whole project including the share of the state and regions ask the organisations to account for their grant separately as well, it is very difficult to manage funding and accounting of NGOs which provide social care. Moreover the application forms differ from each other and, therefore, the fundraisers of NGOs have to fill in several completely different forms to raise funds for a single project of social care.

In 2001 31 % of social service was provided by the state, 48 % by communities and 21 % by “other” institutions (Veselá J.2001). This situation has changed, however, with the state administration reform.

4.1.2.1.4 Does residential care involve the participation of carers or work with carers?

The participation of carers varies depending on the different types of institutions. Even in institutions of one type one can find great differences concerning the participation of carers. Generally, sheltered houses are constructed by communities and they are very often situated in the centre of the community or not far from it. They are often smaller than residential homes and are usually not viewed as an “institution” by the general public. Seniors live here close to their original environment and their relatives with whom they keep in contact. Family carers continue to provide care also when the older person lives in a sheltered home. The sheltered home provides better environment for help and the carers have also the support from formal services. In addition, seniors can move to their new, smaller but complete, apartments in sheltered homes with their furniture etc.

The situation in residential homes seems to be quite different. While in sheltered houses seniors purchase or hire their own apartment, the stay in a residential home is considered to be a “placement” in an institution. Even when people live in a boarding house for pensioners (which might be a part of a residential home) they can be moved to the nursing department of a residential home etc.

Some of the residential homes are modern and seniors live in single rooms with bath / shower and toilet. However, other residential homes have only double, triple or bigger rooms sometimes even without bath / shower and / or

toilet. Some of these residential homes still look more like a hospital than like a home environment in which seniors would like to spend the rest of their lives. Some residential homes are huge institutions with more than 100 inhabitants. Many of these are situated in remote areas, some of them are situated in castles and mansions. Several cities established residential homes not only far from the centre of the city but even far from the city itself. For example, some residential homes established by Prague municipality for seniors living in this city are more than 100 km from Prague. As a result, seniors are isolated and carers (often seniors too) are not able to keep in touch with them. This kind of isolation of the "overaged" and "invalid" in huge, isolated institutions seems to be a result of the previous socialistic philosophy of social care. It is necessary to admit, however, that the management and staff of these residential homes may provide good care and activities for their inhabitants, trying to compensate the isolation. The care in these residential houses may be good. Unfortunately, there are also residential homes whose isolation goes hand in hand with a bad quality of care.

4.1.2.2 Community care services (statutory coverage and whether aimed primarily at older people living alone or including support to family carers)

Community care services are oriented primarily at older people who need assistance. They help seniors to live in their home environment when they are not able to take care or their household by themselves and / or when they need other care and assistance.

4.1.2.2.1 Home-help

Home help (pečovatelská služba) is the most common service for older people in their home environment. It is meant for people who are not able to deal with the activities of daily living by themselves or with the help of the family. Home help used to be organised by the district authorities, communities, NGOs etc. After the reform of the state administration, it is provided mostly by the municipalities and NGOs etc. (Zákon 100 o sociálním zabezpečení. 1988.,Zákon 114 o působnosti orgánů České socialistické republiky v sociálním zabezpečení. 1988, Vyhláška 182 kterou se provádí zákon o sociálním zabezpečení a zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991)

Home help is one of the relatively well-defined services in the legislative. It includes household work (cleaning, shopping etc.), laundry and meals on wheels usually provided by communities or by NGOs in cooperation with communities. Other home help services defined by the law are not usually provided. As in the case of all other social care services, home help provision is also stressed by the law but there is no legislative determination who is responsible for its provision and funding. Therefore, some communities do not provide home help and in case there is no other home help provider in the community the home

help is simply not available. According to the data of Ministry of Labour and Social Affairs on community services in 1999 (Veselá J. 2001) 107 000 clients made use of home help. 26 % of them lived in sheltered houses, 37 % received meals on wheels, 24 % visited personal hygiene centres, 13 % used laundry services and 0,6 % visited day centres for seniors.

Besides the home help defined as a social service (charged with a regulated price), there are several private providers who provide services as economic activity. Paid services are also provided by some home care agencies.

A research done on social care provision in municipalities with devoted authority showed that home help covers the whole area of the community (including small localities) only in 31 % of the communities. The author of the research investigated reasons for obstacles preventing the home help provision and / or reasons why the home help in not provided in some areas (Veselá J.2003). The conclusion is that home help is not provided on the whole area of the community because of these factors: The locality is too remote (30 %). There is no contract between the community and the home help provider (26 %). Only few potential clients are in that area (24 %). The same author inquired communities about the most frequently demanded services that are not provided by home help: supervision 6-22 hours (46 %), night service 22-6 hours (15 %), personal assistance (8 %), health care (7 %), home help during weekends (6 %), respite care at home (6 %), transport to a physician (2 %), hairdressers and podiatric care (2 %).

Provision of care for seniors covering the whole territory of the municipality should be the responsibility of the authority of municipality with devoted authority. Municipality authorities were inquired about the measures that should be taken in case that seniors need home help and this type of help is not available in the locality where they live (Veselá J.2003). The most frequent answers are the following. 1. The family should provide all necessary care. 2. We recommend admission to a residential home. 3. We recommend admission to a long-term care hospital and we are looking for a permanent stay. 4. We try to find a place in a sheltered home. 5. We solve the situation temporarily with the help of neighbours and friends and we look for a permanent stay. 6. We recommend admission to a social bed in hospital and we look for a permanent stay. The same author (Veselá J. 2003) also inquired municipalities with devoted authority about the factors which may exclude older person from receiving home help. The author points out that among these factors are problems which come very often along with the old age. For example, sensory impairment, incontinence, need of nursing care, dementia and immobility may exclude 11-48 % persons from getting home help. This alarming situation might be explained by both, material and financial problems of home help providers, as it is the clients with the problems mentioned above who need the most complex care (night services, long term supervision etc.).

Table 19: Factors which may exclude older person from receiving home help

Factor	% of answers "definitely not"
Older person lives in an apartment of lower category (no bathroom, local heating etc.)	94
No elevator	93
Insufficient equipment (no refrigerator etc.)	93
Neglected and dirty apartment	76
Solitary client of home help in a locality	65
Remote from the home help provider	54
Sensory deficit, impaired communication	89
Incontinence	81
Need of nursing care	64
Alzheimer's disease	63
Dementia	57
Immobility	52
Alcohol addiction	36
Infectious condition, infectious skin disease	32
Drug addiction	31
Veneric disease	23
Other infectious or parasitary condition that might be a source of infection	22
Psychosis or other psychic disease that might threat him / herself or others	20

Source: Veselá J. 2003

4.1.2.2.2 Personal care

Personal care in home environment is generally considered to be a nursing task and this service is included in home nursing care provided by nurses. Home nursing care must be prescribed by a general practitioner and this prescription is supervised (and limited) by health insurance companies. In municipalities with more sophisticated systems of home help the personal care is provided by home help workers. Personal assistance (permanent assistance in all situations when it is necessary) is provided to severely disabled people (quadriplegics etc.) The personal assistance has not yet been included in the social care legislative. Its provision, therefore, depends on local conditions and especially on NGOs, which have to raise funds for its provision. In many municipalities home help providers provide their clients also with personal hygiene service in personal hygiene centres.

4.1.2.2.3 Meals service

Meals service is the most frequent service provided by home help providers for older people and other people who need this type of service. Several communities organise also public catering for older people. Some of them provide meals for older people in dining rooms of schools etc.

4.1.2.2.4 Other home care services (transport, laundry, shopping etc.)

Laundry and shopping services are also frequently provided by home help providers. The law determines the maximum price for these services. In localities where the home help is not provided, older people and others who need these services have to purchase them for unregulated market prices. The transport of sick people to a health facility, between health facilities and from the health facility to a patient's home is provided by health transport service. It is free on the basis of general health insurance. This transport must be prescribed by a physician. There are also several social care facilities that provide transport services, e.g. some day care centres etc.

4.1.2.2.5 Community care centres

Day and week centres for older people are rare. The few existing centres provide day care or care during the week while families provide care at nights and / or during the weekends. Where available, these centres play an important role in the support of carers.

Some communities, especially of bigger municipalities, establish houses of nursing care. Though nursing care is, according to the legislative, considered to be a skilled health care, the houses of nursing care are considered to be "social nursing care" facilities, which cause many further problems in terms of the care provision (medical supervision etc.) Health insurance companies consider these facilities to be "social" institutions and they do not reimburse for the nursing care provided by them. Therefore some facilities of this type cooperate with (or establish their own) home care agencies, which provide nursing care reimbursed by the health care insurance.

4.1.2.2.6 Day care ("protective" care)

Community care and day care centres exist only in some communities usually run by home help providers. Seniors attend these centres, have their meals and participate in programmes. Often these day centres do not provide transport and they do not offer adequate care and enough activities. In addition, they are open only for few hours daily. Their attendance is, therefore, relatively small.

In the last few years several day care units for people with dementia started their activity. These day care units provide both supervision, care as well as activities oriented at patients with dementia. Some of them also take care of the transport of the patients. They are open usually for more than 8 hours a

day. This type of a day care centre is very appreciated by family carers of people with dementia.

4.1.2.3 Other social care services

Counselling and information services, respite care and other modern forms of social care also exist in the Czech Republic but their provision is not based on the social care legislation. Their provision depends on the creativity of individuals, municipalities and NGOs, in particular, they provide many types of services that are both modern and necessary. This very trend started soon after the political transformation of 1989 and the variety and amount of these services has been rising since. The social services provided by NGOs are partially funded by the state budget by the way of the grant system of the Ministry of Labour and Social Affairs and the Ministry of Health. In the previous years NGOs were entitled to apply for funding of 70 % of social care provision by the state. For the remaining 30 % they had to raise funds themselves. After the state administration reform of 2003 they are entitled to apply for funding of 50 % social care provision by the state and the remaining 50 % must be raised from regional and other sources. This system may bring more problems to social care providers and even more to older people and their caregivers themselves.

Physically handicapped people and also people with a sensory impairment are entitled to ask for technical aids and also home adaptations according to the Social Security Acts and Regulations (Zákon 100 o sociálním zabezpečení. 1988.Zákon 114 o působnosti orgánů České socialistické republiky v sociálním zabezpečení. 1988. Vyhláška 182 kterou se provádí zákon osociálním zabezpečení a zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991.) These acts include the list of chronic conditions which entitle individuals to the benefits mentioned above. All of these laws and regulations respect the needs of physically handicapped people and people with sensory impairment but they do not apply to several chronic conditions (i.e. dementia) and multimorbidity of the old age. Therefore, some physicians do not consider these people eligible for these benefits mentioned. Many caring families are also not adequately informed.

4.2 Quality of formal care services and its impact on family caregivers: systems of evaluation and supervision, implementation and modelling of both home and other support care services

Health care services reimbursed by the health care insurance are controlled by health insurance companies that require compliance with personal and technical standards and supervise the adequacy of the health care provision. Home care is indicated and prescribed by a general practitioner who should control its quality.

Social care services are controlled by the authorities which establish them and which contribute to their funding (municipality, NGO, private person or company etc.).

4.2.1 Who manages and supervises home care services?

Home care health services are managed by private individuals or organisations, by NGOs or by other health care providers. Home care services are reimbursed by the health care insurance based on the contract with health insurance companies. A condition necessary for entering into the contract is a registration by the Health Department of Regional Council, successful participation in public competition and a compliance with personal and technical standards for the home care. Home care providers are controlled by health insurance companies.

Home help services are managed and supervised by municipalities, private individuals / companies and NGOs.

4.2.2 Is there a regular quality control of these services and a legal basis for this quality control? Who is authorized to run these quality controls?

There is a difference between health and social care.

For health care facilities, technical and personal standards, the system of registration and public competition in order to achieve a contract with a health insurance company, as well as the control system of health insurance companies are all defined. Ministry of Health prepares system of accreditation of hospitals.

There is no regular control system of quality regarding social services including social home help services for older people. As a result, some home help providers have their own standards of quality. Ministry of Labour and Social Affairs has elaborated social care standards of quality. However, these standards are rather general recommendations on how to implement the system of quality improvement in social care. Based on these general principles social care providers should establish their own standards of quality. Some providers (Diakonie, Czech Alzheimer Society), for example, create quality standards for those types of care they are concerned with. However, there are several social care providers, private individuals and companies as well as institutions run by the state which do not implement any quality improvement programme at all. Regions and municipalities may, however, control social services which receive funding from them.

4.2.3 Is there any professional certification for professional (home and residential) care workers? Average length of training?

There is no system of certification for professional workers in social care. Even managers of services and directors of residential homes do not need to meet any qualification criteria.

The system of qualification and continual education of physicians is supervised by the Czech Medical Chamber. The Czech Association of Nurses introduced the system of registration but the registration has not become compulsory yet.

Nevertheless there are several high schools and universities that prepare health and social professionals for work in the field of the integrated health and social care.

4.2.4 Is training compulsory?

Czech Association of Nurses introduced the system of registration and continual education of nurses. This system is, however, not compulsory for nurses.

There is no official system of training for personnel in the social care trade including managers of residential homes etc. However, many social care providers organise training for their professional care workers. The situation again varies depending on the different types of providers and institutions.

4.2.5 Are there problems in the recruitment and retention of care workers?

Regional differences, as far as the problem of recruitment and retention of care workers is concerned, depend on the level of unemployment of a region. But even in regions with a high unemployment rate there may be vacancies in social care. The level of income received by caring professionals is so low that many people prefer to stay rather unemployed than to work with older people.

4.3 Case management and integrated care (integration of health and social care at both the sectoral and professional levels).

The integration of health and social care at sectoral and professional levels are probably the most important issue in terms of the care provision for older people. Insufficient and ineffective communication between the Ministry of Labour and Social Affairs and the Ministry of Health might have created the situation where the contemporary state of health and social legislative does not reflect the actual situation, demographic changes and needs of many older, chronically sick and dependent individuals and their families.

According to the view of the Czech Society of Gerontology and Geriatrics, this situation has not improved in the last years. The Absence of necessary laws, strategies, concepts and the poor coordination of activities of both ministries

cause great problems both, for health and social care providers, as well as for older people and caregivers, in particular.

As it is not feasible to explain this complicated situation of health and social care in the Czech Republic it might be more comprehensible to identify a model situation of patients needing integration of health and social care, i.e. the situation of patients with dementia.

Dementia is a very frequent condition detected in older people. In addition, it can be also considered to be a typical example of a patient who needs both, health and social care, as well as, the integration of both.

A patient with dementia has a right to receive free health care. General practitioners should visit such patients at home and prescribe necessary drugs, incontinence aids. He should also prescribe the home nursing care in case the patient is at home. The problem seems to be that some drugs and care aids can be prescribed only by a specialist. Similarly, a general practitioner prescribes home nursing care only in the case of a patient needing skilled nursing care including personal care and rehabilitation, for general practitioners are limited in home nursing care prescription by health insurance companies. Night and weekend visits are prescribed in a very limited amount and to very few patients due to the limitations by health insurance companies. When the patient needs expensive drugs, incontinence aids as well as frequent home nursing care visits, he / she burdens the budget of a general practitioner. That appears to be the reason why the general practitioner more often than it is necessary refers such a patient to a hospital. In some situations (i.e. when moving the patient to live with adult children who would provide care) it is also difficult to find general practitioner for a patient who needs complex care.

As was already mentioned the law includes no legal right for the social care provision and, therefore, the provision of social care depends on local conditions. There may be no social services provided in case the patient and the carer live in a municipality where no social services are available (i.e. smaller communities in remote areas). Most of the municipalities, however, provide at least some social services and some of them offer also greater variety of social services including those for people with dementia and their carers (day care unit, respite care etc.).

A family may apply for a dependency allowance for their relative-patient. Patients with partial dependency are entitled to dependency allowance which is added to their pension: 20 % of life minimum in case of partial dependency, 40 % in major dependency and 57 % in total dependency (Zákon 100 o sociálním zabezpečení. 1988). According to another regulation, some older people should be able to profit also from the benefits of other handicapped and dependent individuals (Vyhláška 182 kterou se provádí zákon osociálním zabezpečení a zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991). However, regulation 182 which defines eligible conditions for the extra benefits and allowances for handicapped apply

more to the physical and mental handicap of younger people than to the conditions of old age, such as dementia and multimorbidity. Even people with severe dementia who need permanent supervision and care are not assessed as eligible to these extra benefits and allowances for the handicapped.

When a family member decides to quit his / her employment and to take care of a dependent old person he / she is entitled to an allowance for care for a relative or another person, provided that he / she lives in the same household. (Zákon 100 o sociálním zabezpečení. 1988) He / she also must provide the care personally, permanently and properly. According to the law, the patient might be cared for by another person or an institution for up to 6 hours daily. The law does not, however, determine funding of this type of care. The allowance for care for a relative or another person is provided (1,6 of life minimum for 1 person and 2,75 of life minimum for 2 or more individuals) on condition that the possible income of eligible person will not be more than 1,5 of life minimum. These conditions are very inconvenient for family carers. On the other hand, in regions with high unemployment, some unemployed may solve their social situation by means of this allowance.

When the family caregiver of an older person is not willing or able to provide care at home, admission to an institution may be necessary. In case the patient stays in a long-term health care institution (a long term care hospital or a psychiatric hospital) for a long time, the care is free. Patients with stable chronic conditions are not sometimes assessed, as indicated to stay in health care facility. In the last few weeks the General Health Insurance Company has organized an extensive control in long-term care hospitals in order to reduce the stays “on account of social reasons”.

Dementia is considered to be a contraindication for admission to a residential home. Only residential homes with a nursing department for patients with dementia are entitled to admit these patients. Nursing is considered to be a health care and it should be provided only by health care institutions, not by social institutions including residential homes. Despite these obstacles residential homes usually provide care for the chronically sick and disabled, including people with dementia. Since they are social care institutions and not health care institutions, they are not supposed to employ health care personnel. Therefore, nurses who work in these institutions were renamed and they are called “workers in direct care”. As they are not registered as health care institutions, residential homes should not provide health care including skilled nursing care. Medical care for the patients in residential homes is provided by general practitioners and their care is reimbursed by health care companies on the per capita basis. This type of funding of medical care in residential homes is disadvantageous because the population in residential houses is more likely to be incapacitated and thus demanding more care than average population of the same age cohort living at home. The question of nursing care in residential homes has not been solved yet. In practice, the nursing care is provided by health care professional (renamed but skilled) in a social care institution (not

registered for health care provision) and it is not reimbursed by health companies. Many suggestions how to solve or improve this situation has failed due to the lack of political will to change the legislative conditions. The last initiative of Intersectoral Commission on Health and Social Institutional Care which defined an integrated stay (health and social stay) in an institution should bring substantial improvement.

4.3.1 Are family carers ' opinions actively sought by health and social care professionals usually?

It depends on local conditions. In some facilities there is a good communication between family carers and health professionals. Professionals in such facilities are interested in the opinions of family carers. Poor communication is often caused by the lack of professionalism of a professional caregiver or the lack of interest of a family member.

5 The Cost – Benefits of Caring

5.1 What percentage of public spending is given to pensions, social welfare and health?

The system of health care financing in the Czech Republic relies first of all on resources collected in the general health insurance. About 82 % of all expenses on health care were covered by health insurance companies. Supplementary resources are provided by the state budget, covering about 10 %, and private direct payments by the population provide the remaining 8 %. In 2002 there were 9 health insurance companies operating in the Czech Republic. The largest is General Health Insurance Company with 7 million clients which represents 70 % of all insured persons in the Czech Republic. This number decreased by 200 000 from the preceding year, mostly by transfer of clients to other health insurance companies. In 2002, General Health Insurance Company expended 50 % of the basic health insurance fund on institutional health care, 21,1 % on out-patient care and 21,2 on prescription medicaments. Besides General Health Insurance Company there were 8 other employees' insurance companies. The total revenue of health insurance in 2002 was 136,3 thousand million CZK, by 2,8 % more than in 2001, but its expenses increased by 4,8 % and the balance was negative, -1,2 thousand million CZK. (Zdravotnická ročenka České republiky 2002. 2003)

The trend of public expenditure on health services per 1 inhabitant is following: 8 000 CZK in 1994, 15 000 CZK in 2002. Direct personal expenditure per 1 inhabitant: 801 CZK in 1996, 1 417 CZK in 2002.Total expenditure per 1 inhabitant: 10 728 CZK in 1996, 16 520 in 2002. Proportion of total expenditure on health services in GDP (%): 1996: 7,06, 2002: 7,00.

Table 20: Trend of public expenditure on health services

	1996	1997	1998	1999	2000	2001	2002
total in mill CZK	102 400	109 033	119 267	123 453	129 626	145 096	154 066
proportion of public expenditure in GDP (%)	6,53	6,49	6,49	6,49	6,04	6,25	6,4

Source: Czech Statistical Office. 2004

The indicator of the total expenditure on health expressed as percentage of the gross domestic product (GDP) calculated for the Czech Republic in the lower third among OECD countries. According to OECD sources the average ratio of the expenditure on health to the GDP in 2001 was 8,4. In the Czech Republic it was 6,8 % in the same year (comparable with, e.g., Hungary). The comparison of these values should be considered as only general information because of possible differences in methodology in different countries. Also in

the Czech Republic the GDP value was recently revised by Czech Statistical Office, as of 24.10.2003, his revision diminished the indicated ratio from the earlier value of 7,3 % (Zdravotnická ročenka České republiky 2002.2003)

Expenditures on social services in 2002 were: Care for seniors with reduced capacity to work, and severely handicapped persons 3 548 725 thousand CZK, community care service 705 090 thousand CZK, institutional social care 7 283 962 thousand CZK. Pension insurance benefits (pensions) in 2002 were 210 440 million CZK to (to 3,227 millions of pensioners) according to Czech Statistical Office.

Table 21: Trends of public expenditures on pensions an social welfare (mill CZK)

	1999	2000	2001	2002
Sickness insurance benefits	19 287	27 205	29 585	32 609
Social welfare benefits	31 328	31 855	31 942	33 700
Old age pension insurance benefits	173 014	181 921	195 814	210 440
Other pension insurance benefits	47 461	49 014	52 784	57 169

Source: Czech Statistical Office. 2004

5.2 How much - private and public - is spent on long term care (LTC)?

General Health Insurance Company provided data on health care costs by type of health establishment (Zdravotnická ročenka České republiky 2002. 2003). From the total amount of 97 548 million CZK spent on health care by General Health Insurance Company there were 2 385 million CZK spent on care in long term care hospitals and 436 on aftercare in hospitals. This amount represents 2,0 % of total health care costs of General Health Insurance Company in 2002. Co-payments of clients are not legal and therefore not included in official data.

5.3 Are there additional costs to users associated with using any public health and social services?

For people who are insured, health care is free on the basis of general health insurance. Co-payments are received but not legally. Social care is paid by the client, but these payments are regulated by the regulation of Ministry of Labour and Social Affairs (Vyhláška 182 kterou se provádí zákon osociálním zabezpečení a zákon České národní rady o působnosti orgánů České republiky v sociálním zabezpečení. 1991). Due to the absence of some services families must purchase them at unregistered market prices which are usually high.

Table 22: Participation of clients in health and social care CZK per person and year

	1999	2000	2001	2002
Health care - direct payments	11 523	12 296	13 665	14 361
Social care - payments for stays in institutions		3 081	3 403	3 708

Source: Czech Statistical Office. 2004

Table 23: Expenses for person and year in CZK

Type of health care	1999	2000	2001	2002
Prescribed drugs	164	208	271	286
OTC drugs	455	468	516	559
Other health products	27	27	27	27
Orthopaedic and therapeutic aids	176	207	229	231
Out-patient medical care	63	60	58	60
Out-patient stomatological care	152	147	157	169
Other out-patient care	23	29	31	22
Institutional care including balneal care	60	46	43	62

Source: Czech Statistical Office. 2004

5.4 What is the estimated public / private mix in health and social care?

It is difficult to estimate the public / private mix in health and social care. Czech Health Statistics 2002 says that a total of 25 288 health establishments were private, ¾ of this total were independent offices of general practitioners and of specialists. A marked enhancement of the non-state sector occurs after January 1st, 2003, when health establishments formerly under district administration (state founded) have been transferred to the competence of regions. About ¼ of out-patient physicians work in ambulatory parts of hospitals, almost ¾ in independent out-patient establishments (mostly private offices). The network of establishments for in-patient care included 201 hospitals, 168 other acute care hospitals and 22 after-care hospitals, 169 specialised therapeutic institutes and 68 balneal care institutes. 25 % of in-patient bed care (measured by bed capacity) is privatised (11 % of hospital capacity, over 13 % of specialised therapeutic institutes and 79 % of balneal care capacity).

Table 24: Expenditures on social care institutions - by founder

Founding organisation	2000	2001	2002
Salvation Army	59	49	75
Cz.Hussite Church	6	7	7
Cz.Catholic Charity	187	184	173
Cz.Evangelic Church	89	93	98
Cz.Red Cross	8	7	9
Private person	15	17	15
Other church	125	149	136
Regional Office		135	220
Town office	609	747	804
Municipal office	1 594	1 766	2 120
Municipal Office Prague	1 022	1 057	1 140
Ministry of Labour and Social Aff.	560	303	336
Society of citizens	91	151	168
Local authority	55	60	67
District Office	5 963	6 661	7 064
Other	70	81	56
Other church organisations	96	164	215
SOS children villages	13	16	15
Health care organisation	19	20	22
Total	**10 582**	**11 667**	**12 740**

Source: Czech Statistical Office. 2004

5.5 What are the minimum, maximum and average costs of using residential care, in relation to average wages?

According to the Act 100 On Social Security, residential care founded by the state or municipalities is funded by the budget of the founder, by the state budget (in case of institutions originally founded by the state) and the payment of the resident. According to the law, the client has a right to have pocket money of approximately 600 CZK after he / she has paid for the stay. This rule included in Social Security Act does not apply to residential care founded by NGOs and private persons or companies. According to the Ministry of Labour and Social Affairs (Bílá kniha v sociálních službách, konzultační dokument. 2002), co-payments for care provided by NGOs are not higher than those paid in institutions run by state or municipality. Residential care provided on commercial basis is rare and there are no data on it. Average pension in 2002: men 7 776 CZK, women 6 435 CZK, total 7 021 CZK in 2002. Average wage was 16 362 in 2002, 17 445 CZK in 2003 (Czech Statistical Office.2004).

5.6 To what extent is the funding of care for older people undertaken by the public sector (state, local authorities)? Is it funded through taxation or / and social contributions?

The structure of social care funding in 1999 is following: communities 18,8 %, district authorities 14,6 %, clients 29,3 %, state 33,6 %, NGOs 3,4 %. In 2000: communities 16,5 %, district authorities 17,6 %, clients 29,1 %, state 33,1 %, NGOs 3,7 %. (Průša L. 2002)

5.7 Funding of family carers

5.7.1 Are family carers given any benefits (cash, pension credits / rights, allowances etc.) for their care? Are these means tested?

	Attendance allowance	Carers´ allowance	Care leave
Restrictions		Yes	
Who is paid?		Caregiver of a relative or a person in a common household	
Taxable		No	
Who pays?		State	
Pension credits		Yes when care is provided to a relative.	
Levels of payment / month		3 700 CZK	
Number of recipients in 2002		24 330	

5.7.2 Is there any information on the take up of benefits or services?

Table 25: The way in which seniors are informed about social allowances

Type of allowance	Allowance was granted	Is aware of conditions how to get allowance	Knows that allowance exists	Does not know
For housing	4,9	16,7	51,2	27,2
For heating	2,9	11,9	48,1	37,1
For rent	1,9	11,2	48,6	38,2
For care of relative	2,5	13,6	50,0	33,9
For recreation	5,0	9,0	37,6	48,4
For heating oil	0,3	2,9	23,5	73,3
For installation of telephone	3,0	5,5	25,8	65,6
For operation of telephone	3,6	5,9	23,9	66,6
For public catering	2,6	9,4	31,5	56,5

Source: Veselá J. 2001

Table 26: The way in which seniors are informed about social services

Type of services	Informed		
	well	partially	not
Home help	27,3	49,9	22,9
Personal assistance	8,5	28,5	63
Respite care	5,9	28,8	65,3
Public catering	18,2	37,4	44,3
Pensioners clubs	10,9	32,8	56,3
Social care institutions	8,5	36,9	54,7
Sheltered houses	15,4	42,7	41,9
Boarding houses for retired persons	12,7	38,3	48,9

Source: Veselá J. 2001

5.7.3 Are there tax benefits and allowances for family carers?

There are no tax benefits for family caregivers.

When a family member provides care for a dependent relative or another older person, he / she is entitled to receive an allowance for care for the relative or another person living in a common household (Zákon 100 o sociálním zabezpečení. 1988). However, he / she must provide the care personally, permanently and properly. According to the law, it is possible for the patient to be cared for by another person or an institution up to 6 hours daily. However, the law does not determine funding of such care. The allowance for care for a rela-

tive or another person is provided (1,6 of life minimum for care of 1 person and 2,75 life minimum for care of 2 or more persons) on the condition that the possible income of eligible person will be not more than 1,5 of life minimum (life minimum -2 320 CZK). These conditions are very inconvenient for family carers. On the other hand, in regions with high unemployment, some unemployed may solve their social situation by means of this allowance.

Social workers of municipalities were asked about the measures that could positively influence the ability and / or willingness of family members to provide care to a dependent family member. 57,3 % of them suggested higher allowance (Veselá J.2001). The allowance for care for a relative or another person was received in 24 332 cases of seniors (Veselá J. 2003).

5.7.4 Does inheritance or transfers of property play a role in caregiving situation? If yes, how?

Not legally.

5.7.5 Carers' or Users' contribution to elderly care costs

a. Medical, nursing and rehabilitation services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
General practitioner	X					
Specialist doctor	X					
Psychologist (1)	X	X	X			
Acute Hospital	X					
Long-term medical residential care (for terminal patients, rehabilitation, RSA, etc.)	X					
Day hospital						
Home care for terminal patients	X					X
Rehabilitation at home	X					
Nursing care at home (Day / Night)	X					
Laboratory tests or other diagnostic tests at home	X					
Telemedicine for monitoring						
Other, specify						

b. Social-care services	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Permanent admission into residential care / old people's home		X				
Temporary admission into residential care / old people's home in order to relieve the family carer		X				
Protected accommodation / sheltered housing (house-hotel, apartments with common facilities, etc.)		X				
Laundry service		X				
Special transport services (2)	X	X	X			
Hairdresser at home			X			
Meals at home		X				
Chiropodist / Podologist			X			
Telerescue / Tele-alarm (connection with the central first-aid station) (3)	X	X	X			
Care aids (4)	X	X	X			
Home modifications (5)	X	X	X			
Company for the elderly (3)		X	X			
Social worker	X					
Day care (public or private) in community center or old people's home (3)		X				
Night care (public or private) at home or old people's home						
Private cohabitant assistant ("paid carer")			X			
Daily private home care for hygiene and personal care (6)	X	X	X			
Social home care for help and cleaning services / "Home help"		X				
Social home care for hygiene and personal care (6)	X	X				
Telephone service offered by associations for the elderly (friend-phone, etc.)	X					
Counseling and advice services for the elderly	X					
Social recreational centre						
Other, specify						

c. Special services for family carers	General access:			Access based on:		
				Means-tested		
	Free at point of use / wholly reimbursed	Partly privately paid / partly reimbursed	Completely privately paid	Partly reimbursed	wholly reimbursed	Based on severity
Training courses on caring						
Telephone service offered by associations for family members	X					
Internet Services	X					
Support or self-help groups for family members	X					
Counseling services for family carers	X					
Regular relief home service (supervision of the elderly for a few hours a day during the week) (3)		X	X			
Temporary relief home service (substitution of the family carer for brief periods of time, for example, a week)						
Assessment of the needs (3)	X					
Monetary transfers						
Management of crises						
Integrated planning of care for the elderly and families at home or in hospital (3)	X					
Services for family carers of different ethnic groups						
Other, specify						

Comments

(1) reimbursed from general health insurance on condition that psychologist has a contract with health insurance company

(2) transport of patients (from, to an between health care facilities) is reimbursed from general health care insurance, other transport services are rare, they are organized mostly by NGOs

(3) rare

(4) some care aids may be prescribed by physician and they are totally or partially reimbursed from the general health insurance

(5) some home modifications may be reimbursed according to the law, however this is not often used by caregivers of older people

(6) when prescribed by physician and provided by home nursing care agency it is reimbursed from the general health insurance, when provided by a “social care provider” it is partially reimbursed

6 Current trends and future perspectives

6.1 What are the major policy and practice issues debated on family care of the elderly in your country from the carers' point of view? Are older people and / or carer abuse among these issues?

The discussion on family care for old people is almost non-existent in the Czech Republic. Media mostly present old people as the people who are abused. They often show criminal cases and scandals concerning seniors and hesitate to introduce the discussion on age related issues (with an exception of pensions). In the last month organisations of the handicapped started a discussion on family versus institutional care of handicapped people. They pointed out that the system of institutional care is preferred to that of family care, as institutions are financed by the state while family care has received very little support so far. When browsing on internet and looking for a family care with the help of the most frequently used browsers (seznam, centrum etc.) only few citations are available, most of them concerning the family care of children. The links to learn about the care issues regarding older people are: www.alzheimer.cz, www.gerontologie.cz, www.gerontocentrum.cz (pages of the Czech Alzheimer Society). There is also a web page for caregivers: www.pecujici.cz.

Ministry of Labour and Social Affairs has been elaborating a new act on social care since early 90´s. The last version is being prepared by experts of the ministry together with social care organisations and institutions. Unfortunately, there is almost no public discussion on this legal standard and the preliminary version of the social care act is not available for public discussion.

In case that the social care act will be accepted in a satisfactory version, it will substantially improve the situation of many older persons and their family caregivers. As far as we are informed, representatives of caregivers' organisations (Czech Alzheimer Society) were not invited to the discussion on this legislative standard. Family caregivers, i.e. from the Czech Alzheimer Society, feel that the society pays no attention to their problems.

6.2 Do you expect there to be any changing trends in services to support family carers, e.g. more state or more family support, more services or more cash?

Despite the difficulties described above, there is a stable development of social services, especially of the services provided by communities and NGOs, which respect the needs of family caregivers. The social care act should also bring improvement of the situation of family caregivers. Municipalities should

play more active role (and some of them already do) in the planning of social services for their citizens and in the care management and provision.

6.3 What is the role played by carer groups / organisations, "pressure groups"?

Family caregivers have practically no organisations of their own unlike the handicapped. The Czech Alzheimer Society can be considered as one of the exceptions, which brings together family caregivers of people suffering from dementia with health and social care professionals. This society was founded in 1997 and its activities are described in the corresponding chapter. Following the media and information campaign in 2000-2001 the Czech Alzheimer Society successfully promoted the reimbursement for cholinesterase inhibitors by the general health insurance. These drugs were not reimbursed and families had to bear all costs of care and cure while the antiobesitic drugs were for certain patients reimbursed. The Czech Alzheimer Society has 30 contact and information points in all regions and regularly informs on caregivers issues.

6.4 Are there any tensions between carers' interests and those of older people?

There are not many seniors' and caregivers' organisations in the Czech Republic. We do not perceive any conflicts of interests. The regular consultations of the Czech Alzheimer Society with organisations of seniors can serve as an example and there is the opinion that it is necessary to improve the situation in family care is quite common.

6.5 State of research and future research needs (neglected issues and innovations)

The Czech Grant Agency supports scientific projects of research in the Czech Republic. Applied research projects are supported by internal grant agencies of Ministry of Labour and Social Affairs and of Ministry of Health. The activity of Grant Agency of Ministry of Health is subdivided into sub programmes and commissions, out of which commission 06 (neurology, psychiatry, social medicine) and 13 (public health) may be eligible for caregivers' issues. We have not found a research project dealing with caregivers' issues, however, there were few research projects on health and social care coordination and geriatric care which mentioned also caregivers' issues. Grant Agency of the Ministry of Labour and Social Affairs started its activity last year, submitted proposals are being evaluated. Research Institute of Labour and Social Affairs has conducted few research projects dealing with caregivers' issues. It is necessary, however, to call for more research on family care in the Czech Republic.

6.6 New technologies – are there developments which can help in the care of older people and support family carers?

The producers of new technologies are not really interested in the field of care for older people and family care. There are some home alarm systems operated by Zivot 90 and the Centre of Gerontology. Czech Alzheimer Society has created a database of services which can be viewed on internet at www.gerontologie.cz.

6.7 Comments and recommendations from the authors

Despite all the changes of family structure family care is still the most important part of care concerning older dependent people. Its importance will increase with the ageing of the Czech population. Support for family caregivers is necessary to help the family to provide care as long as possible and of the best quality. Studies prove that even simple forms of support and help offered to family caregivers may, for example, substantially postpone institutionalisation of people with dementia.

A very little attention is paid to the care in the family and caregivers' issues. As the demographic trends are quite evident and, within a few decades, the Czech population will become one of the oldest countries of Europe it is essential to reorganise the system of care provision for older people. The support for caring families and the care in home environment must be an integral part of a new system. Family care must be considered a valuable contributor to a healthy society.

7 Appendix to the National Background Report for Czech Republic

7.1 Socio-demographic data

7.1.1 Profile of the elderly population-past trends and future projection

Table 27: Life expectancy at birth

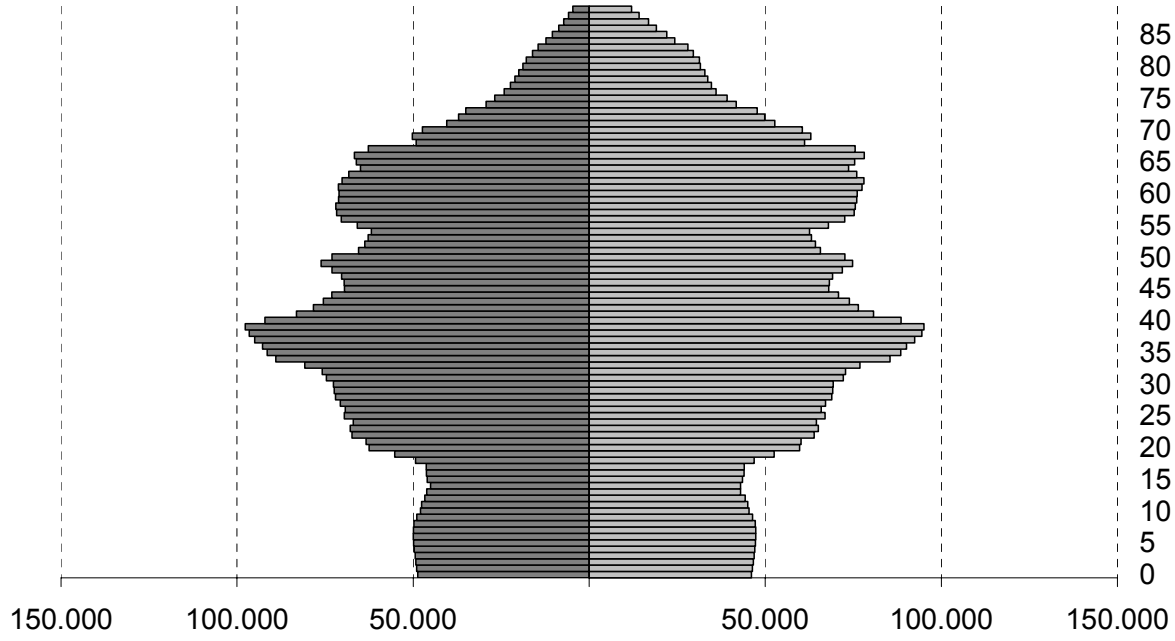
Year	Men	Women
1991	68,2	75,7
1992	68,5	76
1993	69,3	76,4
1994	69,6	76,6
1995	69,9	76,8
1996	70,4	77,2
1997	70,5	77,6
1998	71,1	78
1999	71,5	78,1
2000	71,8	78,2
2001	72	78,3
2002	72	78,5

Source: Burcin B, Kučera T. 2003

Table 28: Age structure 1993

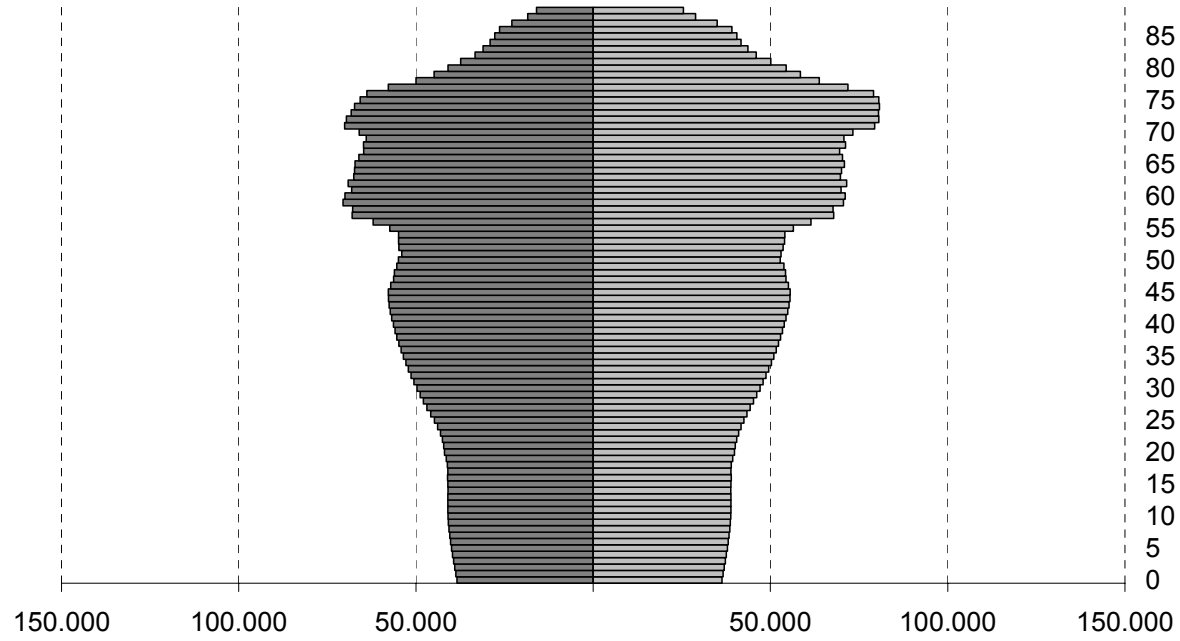
Source: Czech Statistical Office.2004

Table 29: Age structure 2013



Source: Czech Statistical Office.2004

Table 30: Age structure 2050



Source: Czech Statistical Office.2004

7.1.1.1 Life expectancy at birth (male / female) and at age 65 years.

Table 31: Life expectancy in 2002

	Men	Women
at birth	72,1	78,5
at age 50 years	25,0	30,1
at age 65 years	13,9	17,2

Source: Czech Statistical Office. 2004

7.1.1.2 % of > 65 year-olds in total population by 5 or 10 year age groups

Table 32: Seniors 65 years and older

Age group	Total		Men		Women	
	number	%	number	%	number	%
65-69	413 708	4,1	182 867	3,7	230 841	4,4
70-74	404 994	4	165 908	3,3	239 086	4,6
75-79	322 056	3,2	116 285	2,3	205 771	3,9
80-84	179 025	1,8	57 452	1,2	121 573	2,3
85-89	65 344	0,6	18 192	0,4	47 152	0,9
90-94	28 784	0,3	6 932	0,1	21 852	0,4
95+	4 051	0	785	0	3	0,1

Source: Czech Statistical Office. 2004

7.1.1.3 Marital status of > 65 year-olds (by gender and age group)

Table 33: Age structure of inhabitants of Czech Republic - age, gender, marital status - 31.12.2001

Age	Men				Women			
	single	married	divorced	widowed	single	married	divorced	widowed
66	1 419	30 631	2 661	2 607	1 061	25 949	4 300	15 154
67	1 341	30 406	2 617	2 817	1 085	25 254	4 284	16 675
68	1 286	30 358	2 392	3 158	1 098	24 411	4 065	18 070
69	1 340	30 336	2 365	3 520	1 146	24 127	4 301	20 311
70	1 228	29 299	2 085	3 887	1 235	22 701	4 165	21 839
71	1 137	28 416	1 972	4 141	1 184	21 241	4 124	24 222
72	1 120	25 748	1 754	4 389	1 199	18 616	3 757	24 034
73	1 006	24 039	1 645	4 414	1 287	17 037	3 720	25 134
74	920	21 662	1 373	4 522	1 320	14 919	3 390	25 455
75	866	20 105	1 262	4 752	1 319	13 531	3 275	26 593
76	871	18 230	1 057	4 844	1 325	11 590	3 081	26 877
77	768	16 369	1 016	4 831	1 351	10 204	3 039	27 665
78	764	15 063	901	4 976	1 311	8 529	2 753	28 054
79	642	12 983	799	4 807	1 292	7 014	2 493	27 012
80	508	11 301	614	4 705	1 133	5 442	2 120	25 606
81	396	8 611	481	4 076	845	3 789	1 611	22 193
82	280	5 888	331	3 207	724	2 454	1 142	16 478
83	168	2 915	178	1 639	388	1 121	613	8 883
84	114	2 429	154	1 637	377	845	478	8 195
85	128	2 270	124	1 589	337	754	453	8 099
86	132	2 295	137	1 919	399	661	574	9 529
87	145	2 483	123	2 399	482	797	657	11 301
88	110	1 807	119	2 057	398	567	439	9 655
89	92	1 394	79	1 695	371	424	335	7 844
90	65	852	55	1 350	305	276	278	6 104
91	46	598	29	996	220	144	219	4 758
92	24	420	13	801	165	130	139	3 547
93	25	206	12	560	107	81	85	2 420
94	12	110	6	349	80	57	50	1 694
95	9	66	7	215	63	38	43	1 099
96	8	30	3	140	63	2	28	628
97	10	15	-	70	37	10	7	377
98	2	5	-	45	26	5	2	217
99	2	8	-	22	11	1	6	146
100 +	7	3	1	13	20	-	4	158

Source: Czech Statistical Office. 2004

7.1.1.4 Living alone and co-residence of > 65 year-olds by gender and 5-year age groups.

Table 34: Number of retired persons living alone

age	men	women
65 - 69	19 591	85 187
70+	61 625	325 126

Source: Czech Statistical Office. 2004
Data from research on residential patterns are in 1.8.

7.1.1.5 Urban / rural distribution by age

no information provided

7.1.1.6 Disability rates amongst > 65 year-olds. Estimates of dependency and needs for care.

Disability is not officially recorded in the Czech Republic. One can obtain some information from the numbers of diseases and allowances statistically detected.

- Notified cases of **malignant neoplasms** in 2001 are: 28 783 men (17 001 men of 65 years and older) 29 484 women (16 126 women of 65 years and older), 58 267 people of 65 years and older.
- **Diabetics under treatment** (based on the type of treatment) are: 667 135 in total, 240 022 on diet only, 287 415 on peroral antidiabetic drugs, 102 297 on insulin therapy, 37 401 on combined therapy.
- Mental diseases registered in out-patient care: **Organic mental disorders** (F00-F09): 16 887 men, 25 885 women, 42 772 total. **Schizophrenia** (F20-F29): 17 399 men, 22 711 women, 40 110 total. **Affective disorders** (F30-F39): 22 510 men, 54 077 women, 76 587 total.
- **Invalidity and partial invalidity** paid benefits: 536 169 total.
- **Total invalidity** paid benefits: 180 508 men, 189 753 women, 370 261 total.
- **Partial invalidity** paid benefits: 92 394 men, 73 514 women, 165 908 total.

(Source: Zdravotnická ročenka ČR 2002)

7.1.1.7 Income distribution for top and bottom deciles i.e. % aged > 65 years in top 20 % of income, or % > 65s in top 20 %, and the same for poorest 20 % income groups.

Research made on a representative group of Czechs (Kuchařová V, Rabušic L, Ehrenbergerová L.2002) proved that individual incomes of people over 60 years greatly differ. The differences are very like those in productive age. They

also depend on the income composition i.e. whether the person has only his / her pension or also other incomes. Bigger incomes have people who still work and have either postponed their pension or have both, the pension plus the salary they receive at work. In fact, most seniors continue to work after they have reached the retirement age. However, this situation occurs more frequently with men. Gender inequalities also resemble those of the middle age and are further augmented by the growing difference between the retirement age and life expectancy. Women, when compared to men, spend greater part of their lives dependent on their pensions. Income of a household depends primarily on the number of household inhabitants and those who are economically active. As there are mostly nuclear and one generation households, the decisive part of income is represented by the pension. The so-called other income and social income (apart from pensions) represent quite a small part of a pensioner's household budget. There are no substantial differences in incomes of older people living in cities compared to those living in the country. Nevertheless, people of the retirement age consider the removal from city to country to be one of the most common strategies to improve one's standard of living, reducing the costs of living and getting more products by gardening etc. These activities are widespread and are considered to be more or less a hobby and a welcome contribution to the rise of standard of living. According to objective data found in the questionnaire, the poverty is a marginal problem, however, subjectively it is felt by quite a significant part of pensioners' population (more than 25 %). Due to minimal intrastate migration of the Czech population, the older people in particular, the standard of living of seniors is very similar to that of younger individuals. The size of an average apartment provides good standard of living. As far as property is concerned, the older people's standard of living is lower compared to younger persons, due to the fact that there are more individuals with minimal property among seniors than among those of younger age.

Table 35: Households of pensioners

	the first 20 %	second 20 %	third 20 %	fourth 20 %	the last 20 %
Households	138	137	137	137	137
Members	197	224	207	202	180
Economically active members	0	0	0	0	0
Average members per household	1,43	1,64	1,51	1,47	1,31
Income from employment	2 298	2 127	2 376	2 510	3 442
from main employment	0	0	0	0	0
including: head of household	0	0	0	0	0
from secondary employment	2 298	2 127	2 376	2 510	3 442
Income from private enterprise	64	22	9	141	109
from main activity	0	0	0	0	0
including: head of household	0	0	0	0	0
from secondary activity	30	0	0	1	0
Social income	67 043	76 526	81 580	87 834	97 160
pensions	66 606	76 403	81 370	87 465	96 338
Gross money income, total	**69 830**	**79 568**	**85 070**	**91 928**	**108 592**

Source: Czech Statistical Office. 2004

7.1.1.8 % > 65 year-olds in different ethnic groups

Table 36: Number and percent of seniors of different nationalities

	Czech	Moravian	Slovakian	Roma	Vietnam-ese	unknown
65-69	388 003	15 378	14 696	179	41	5 397
70-74	364 720	13 998	12 416	108	17	4 938
75-79	292 764	10 505	7471	66	7	4 194
80+	222 988	7 838	4 234	32	3	3 952
Total of seniors	1 268 475	47 719	38 817	385	68	18 481
Total of inhabitants	9 249 777	380 474	193 190	11 746	17 462	172 827
% of seniors	13,71	12,54	20,09	3,29	0,39	10,70

Source: Czech Statistical Office. 2004

7.1.1.9 % Home ownership (urban / rural areas) by age group

Czech Statistical Office provided information on households of seniors. Data on home ownership are not available.

Table 37: Households, by social group

Selected housing characteristics	Average household	Pensioners
House (%)		
detached	37,4	35,7
others	62,6	64,3
Flat (%)		
in resident's own house / occupier-owned	49,1	49,7
co-operative	22,8	21,4
rented	28,2	28,9
Heating (%)		
central from district plants	47,4	51,4
heating system in detached h.	32,5	30,1
one-floor flat gas / electric system in blocks of flats	16,4	13,5
combined and others	3,8	5,0
Natural gas supply facility(%)	71,1	72,5
Rooms per dwelling	3,0	2,6
Habitable area, m² per capita	20,4	29,8

Source: Czech Statistical Office. 2004

7.1.1.10 Housing standards / conditions if available by age group e.g. % without indoor plumbing, electricity, TV, telephone, lift (if above ground floor), etc.

Table 38: Major household durables

Major household durables	number of durables per 100 households	
	Average household	Pensioners
Refrigerator	52,0	68,8
Freezer	44,9	40,7
Freezer-refrigerator	58,1	41,3
Automatic washing machine	88,7	70,4
Non-automatic washing machine	23,7	37,6
Dishwasher	8,6	0,5
Microwave oven	56,1	31,8
Colour TV set	120,3	107,1
Black-and-white TV set	9,2	11,8
Satellite set	9,7	7,5
Cable TV	27,1	25,1
Tape recorder / player	73,4	51,5
CD player	23,4	5,1
Stereo system	38,3	10,3
Video cassette recorder	54,0	19,7
Camcorder	7,8	1,1
Personal computer	28,4	2,4
Telephone	73,8	72,3
Mobile phone	98,1	31,9
Internet	7,9	2,7
Bicycle	155,3	56,6
Motor cycle	10,1	4,5
Passenger car	65,9	37,0
Garage	31,1	29,4
Recreational facility, cottage	12,8	15,7
Garden hut	4,4	4,5

Source: Czech Statistical Office. 2004

7.2 Examples of good or innovative practices in support services

Geriatrické centrum Krajské nemocnice Pardubice (the Geriatric Centre of Regional Hospital Pardubice) may be considered as a modern type hospital department which integrates and coordinates care for seniors. The previous long-term care department was restructuralised in the early 90's into a complex of

acute geriatric department, rehabilitation and aftercare. Physicians of the Geriatric Centre provide geriatric consultations to other departments of Regional Hospital Pardubice and it has also an out-patient department dealing with acute and chronic geriatric problems. It specialises in the care for chronic wounds and ulcers, osteoporosis and metabolism. Home care unit of the Centre provides home nursing care to patients who need skilled nursing care. Physicians of the Centre also consult general practitioners and other health and social care professionals including those from other home care agencies and residential homes. Geriatric centrum Krajské nemocnice Pardubice is a teaching base for students of nursing, medicine, social work in pregradual and postgradual programmes. It is also an open institution and consultations and support for family caregivers form an important part of its activities. The idea behind the Centre and its organisation has been followed by others.

Gerontologické centrum v Praze 8 – Kobylisích (the Centre of Gerontology, Prague 8 Kobylisy) is a community-based institution run by the Local Authority of Prague 8 District. It was founded in the early 90's as an integrated health and social care institution. The centre offers a rehabilitation unit, day care unit for patients with dementia, home nursing care, social service department providing meals on wheels, lunch club for seniors and consultations. The support and consultations to family caregivers are considered to be an important component of its activities. The Centre serves as a teaching base of social gerontology for students of the 1st and 2nd medical faculties of Charles University, students of social work, sociology, nursing, psychology, theology and others. Its research activities focus on health and social care interface, quality of care in gerontology, social aspects and early diagnosis of dementia.

Hospice movement in the Czech Republic started also in the early 90's. The first hospice was established in Červený Kostelec (Hospic Svaté Anežky České) in Eastern Bohemia. Now there are 6 hospices with 171 beds. Hospices provide palliative care for people in need, they support families during their relative's sickness and also provide them with support after bereavement.

Farní Charita Karlovy Vary and Domov Důchodců Bystřany established a day care unit for people with dementia. They succeeded in fund-raising and provided good quality care for people with dementia together with support and respite for their caregivers.

Town Chrudim in the Eastern Bohemia Region of Pardubice and the Social Department of its Town Office can be pointed out as a good example of a systematic planning and development of a whole spectrum of necessary services for older persons as well as their caregivers. The planning of social services respects the needs of older people. All necessary services such as residential care, home assistance together with support and consultations for caregivers, printed information etc. are available in Chrudim. Apart from it, there are other towns and municipalities that organize good quality services for seniors, i.e. Litoměřice, Ústí nad Orlicí printed also information brochure.

Domov důchodců Litomyšl, Diakonie Krabčice, Diakonie Dvůr Králové nad Labem and other institutions of residential type established specialised departments of care for people with dementia. An important part of their activity is also communication with family caregivers and their support.

The Czech Alzheimer Society was founded in 1997. Since its beginning it has been focusing on help and support of patients with dementia and their family caregivers. Contact and information centres of the Czech Alzheimer Society are located in Prague and other 30 places scattered among all regions of the Czech Republic. Caregivers get there basic information on dementia and care and also printed materials, leaflets and brochures (including “Help for Caregivers”). The Czech Alzheimer Society also organises self-support groups of family caregivers, counselling and respite care (“granny-sitting”) for people with dementia. Those who are interested in the problem of dementia or those who are looking for information on care can consult two web pages operated by the Czech Alzheimer Society. One of them provides general information on various issues of dementia. The second one is a database of services for older people especially those affected with dementia.

Web page for caregivers www.pecujici.cz (caregiver is pečující in Czech) was created by Dr.Tamara Tošnerová MD, consultant psychiatrist in the Teaching Hospital Královské Vinohrady (the 3rd Medical Faculty of Charles University). Information available on caring including caregivers’ booklet can be found on this website.

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