

Position of caregivers in the Czech Republic

Analysis of the concept and implementation
of social policy in the Czech Republic with focus
on care for seniors

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1 Gender aspects of the position of caregivers

1.1 Problem areas

- Gender-unbalanced division of care – significant predominance of women among caregivers.
- Different expectations for genders regarding the provision of care from women and from men.
- Care understood as an expression of love and a “natural” ability of women, not as work requiring specific expertise.
- Negative impacts associated with the provision of long-term care have a greater impact on women in the full life cycle.

1.2 Designation of the greatest problems

- Significant predominance of women among caregivers and association of care primarily with women
- Economic impacts of care that contribute to greater risk of poverty and insecurity on the job market for women
- Demanding return to the labour market after a longer period of care – in particular in the case of cumulative disadvantage (women, older age, etc.).

1.3 Proposed solutions

- Support of more equal sharing of caring work in the family
- Support of formal care services
- Support of the employment of men in social services
- Preventing negative effects of long-term care provision
- Changing stereotypical ideas of care

1.4 Areas where changes are necessary

- Social and mainly pension insurance – conditions of alternative and excluded periods
- Social services: availability of outreach and respite services; care allowance; improvement of working conditions of professional caregivers
- Labour Code: protection of job position during providing care; entitlement to flexible organization of work hours
- Labour Offices: emphasis on directing men toward social services; support of the return to the labour market after the end, and during the course of caregiving

1.5 Description of problems

In the Czech Republic, more than 80 % of long-term care is provided by family members (Nešporová, Svobodová and Vidovičová, 2008). After **Poland**, the Czech Republic is the **country with the highest proportion of informal care in Europe** (SHARE, 2006-2007). In terms of occasional needs, care is provided by family and friends in 97 % of cases, and in terms of daily care, 78.5 % (Bettie, Verashchagina, 2010). Mostly, however, primary caregivers are women. **With regard to care for seniors**, according to research (Eurofamcare, 2006), in six European countries **women provided this type of care in 76 % of cases, and their average age was 55**. Most often, care is taken on by adult children and life partners of seniors (international data do not agree on the distribution). Men usually most often receive care from their partners and wives, while female relatives - daughters or daughters in law - care for women (Abel, 1990; Bracke, Christiaens and Wauterickx, 2008; Stark, 2005).

Nešporová, Svobodová and Vidovičová (2008) state that 70 – 80 % of family providers of care for seniors in the Czech Republic are women. On the basis of international research, Příkladová (2007) estimates that three-quarters of caregivers are women. The results of the research of Vidovičová and Rabušic (2003) show that the **intensity of aiding aging parents is largely affected by the sex of the child who provides the care**. With regard to the time frequency of care, the authors state that often 34 % of men and 50 % of women help their parents, while 36 % of men and 19 % of women seldom help their parents. Data from the research carried out by the Institute of Sociology in 2010¹ confirms that women become the primary caregivers (i.e. those on whom care primarily depends) more often than men, and that women provide care more often than men in all of the researched areas. A significantly higher proportion of women are thus involved in activities that include personal hygiene, food preparation and feeding and washing. If men are somehow involved, they tend to rather provide help with shopping, ensuring medical care and accompaniment to a doctor, and with management of the financial affairs of a senior - i.e. activities involving contact with the "outside" rather than the family environment and the corresponding stereotypes about the division of men's and women's work (as well as those that are not as time consuming).

Analysis of the SHARE data file indicates that the **gender difference is not that significant** (approximately 60 % of women and 40 % of men care for seniors in a family); **however, men spend less time on care and devote their time to other types of caregiving activities**. With regard to differences in the involvement of men and women in care, according to SHARE data, there are differences in the time men and women spend on care. In terms of care for a person outside of the household, it was possible to monitor the number of hours spent on personal care. Caregiving women devoted more time to care than caregiving men (on average, women cared for a senior 10 hours per week, whilst men 5 hours per week). Differences can also be found in the type of persons that men and women cared for: for men, there was predominant care for their partners (55 %), and 25 % men provided care for their mothers. Women also most often took care of their partners (45 %), but they cared for their mothers more often than men (37 %). From the total amount of people that provided care to a senior, 8 % of men and 6 % of women provided care for their fathers (own analyses).² This data shows that women who provide care to seniors still prevail, but it cannot be stated that men do not participate at all. Rather, we can confirm the argument that **if men do provide care, they are less frequently engaged in daily personal care, and spend less time overall on providing care, and often provide care to their partner rather than to their parents**. As soon as the need for daily intensive care (in terms of the need of being present for several hours and assistance with personal and physical actions) for an aging parent arises, the primary caregiver will likely be a woman.

With regard to **care for a person with a disability** (beyond seniors), the proportion of women amongst caregivers is even higher: according to a study by M. Valenta and J. Michalík

¹ / Life courses data file 2010, Institute of Sociology, AV ČR v.v.i.

² / The differences are statistically significant at a significance level of 1 – 5 %

from 2008 that was limited to Prague, **women – caregivers made up 81 %, whilst men 19 %**. If care is provided for a child with a disability, there is likely an even greater proportion of women – caregivers. Only a quarter of the surveyed caregivers in this study were younger than forty years, and the largest group (43.5 %) were aged between 50 and 70 years.

Caregiving is “gendered” work. In the absolute majority of the world it is perceived as “women’s work” – particularly regarding actions involving body care, food and general hygiene. For women, greater concern for others is “naturally” assumed. Caregiving has a feminine connotation: care duties usually pertain to women, in particular due to cultural **assumptions and stereotypes**, according to which women should give priority to the needs of their families and loved ones ahead of their own personal interests. The proportion of **women, who are engaged in care, whether in the informal or formal sectors, thus significantly exceeds the proportion of men worldwide**.

In the informal sector, men usually receive the most care from their partners and wives, whilst the female relatives most often receive care from women. **Women tend to lack paid employment more often than men, or they are willing to give it up** or reduce their work hours, if their caregiving obligations require as such (Křížková, Maříková, Hašková et al., 2011). **Women are perceived as “naturally more suitable and better caregivers”** not only because they are not usually the primary financial providers in the family and it is therefore easier for them to abandon a gainful activity, but also because they have been socialized to provide care since birth. The ability and willingness to develop affective relationships, provide care and put first the interests of others before their own interests becomes part of their identity in most cases (Graham, 1983).

Although care is guided and motivated by affection, solicitude and a sense of personal or moral responsibility, it also **represents** (mostly) for women **work** that is invisible, yet has very real costs. Due to their involvement in unpaid caregiving work, women’s working incomes are often lower, and their **risk of poverty increases** (Stark, 2005). In the Czech Republic, the gender pay gap, defined as the percentage difference between the average gross hourly pay of working men and women, is 22.1 %, which is one of the highest in the European Union (Eurostat, 2015, data from 2013). The poverty rate risk for women³ is 10.5 % compared to 8.9 % for men. The poverty rate risk amongst women increases with age and if they become widows (and cease to share income with their spouses). Women living alone face a 17.9 % risk of poverty, while men 11.7 % (CSO, 2015, data from 2014). Providing care represents an economic “risk”, even a large risk of poverty (see Chapter 3.5).

In most countries, women adapt to rising demands for care by reducing the number of hours they work in paid employment (Spies and Schneider, 2003; Gerstel and Gallagher, 2001; Kotsadam, 2011). **In the Czech Republic, the employment rate of women in the 55+ age group**, in which they most often become informal caregivers (Klímová Chaloupková, 2013), **is dramatically reduced - to 65.3 % in the 55-59 category and 7 % in the 60+ category. Men’s employment, however, remains high at 82 % in the 55-59 category** (comparable to the level in previous age categories), and is also significantly higher in the 60+ category - 18.5 % (CSO, 2014a, data from 2013). Women become economically inactive much more than men due to care for their families and households: for this reason, 319,000 women but only 3,200 men remain at home in the Czech Republic.

Providing unpaid care decreases the position of women on the job market, often leads to poorer wage conditions, fewer adequate job opportunities and also to the fact that their pensions are lower (Stark, 2005). In 2013 in the Czech Republic, the average old-age pension amounted to 9,951 CZK for women, whilst men earned 11,239 CZK, i.e. 13 % more. In newly granted pensions, the relative difference is even higher: 10,505 CZK for women, and men 12,517 CZK, a difference of 19 % (CSO, 2014b: data from 2013).

^{3/} Calculated as failure to reach the 60 % median of the equalized available income.

If a caregiver interrupts his or her gainful work activity, it will then be very difficult for them to go back and find opportunities on the job market. Compared to the previous age categories, in the 55-59 age group, the unemployment rate increases - 7.1 % for women and 5.8 % for men in 2013 (CSO, 2014c). FDV research has shown that it is complicated to maintain full-time employment or to find work when providing care (Geissler, 2015). **Returning to work after a period of providing care is therefore difficult, and in some cases (higher age, previous unemployment, etc.) unlikely.**

1.6 Proposed solution

Support of equal sharing of caregiving work in families

The aim of the measure is intended not only so that long-term care is not associated with women as much as it is today, but also that family members become involved in it regardless of gender. This may be achieved, for example, by not restricting support to caregivers to only one person in the family, but rather that it permits or even encourages directly dividing it amongst several persons. An example is the **care allowance, which is not bound to one person** providing care, but may be divided among several people.

Recognition of the time for care for a person in the second and higher degree of dependence as substitute social insurance period should work similarly. Ideally, this **replacement time for social insurance could be recognized for two or more persons who would be alternating in care**, or that at least all such persons would have the option to exclude the provision of care period from the insurance period decisive for calculating the pension amount.

Support of formal care services

Greater gender balance of care can be secured by a **financially and geographically accessible opportunity to use formal care services, especially** those which cover the types of care currently **provided mostly by women** - personal hygiene, feeding, washing, cleaning. Currently there are services available aimed at activities that are only occasional and cover areas of care in which men (also) participate: transport and accompaniment to a doctor and help with shopping. Development of social services in the field generally reduces the complexity of informal care, and thus on the one hand, it **simplifies the situation of women** - the primary caregivers, and on the other hand **motivates men to become caregivers**, as men prefer to accept less time-consuming care during which they will not be forced to interrupt their work activities.

Support of employment for men in social services

The symbolic and factual connection of caregiving work with women is also supported by the predominance of women employed in social services, particularly at levels where there is an actual provision of care (i.e. outside of administration and management). This is due not only to the social and cultural stereotypes about the "suitability" of particular work for men and women, but also due to the low assessment of this work and poorer working conditions. **An overall improvement of the position of persons working in the formal care services will not only help improve the conditions of professional caregivers, but will also motivate more men to enter into this area.**

Avoiding the negative effects of long-term care provision

Long-term provision of care will cease to have negative gender impacts not only when it is carried out equally by men and women, but in particular when the negative effects of caring are eliminated for both women and men. **The fact that women are engaged in the provision of care at a significantly greater rate does not have to be a problem if a series of economic and social disadvantages does not stem from this practice.**

Measures that limit these negative impacts include:

- job protection in the case of long-term care (time off for providing care)
- financial support in care for a caregiving person
- flexible adjustment of work hours in the case of care
- support of a return to the job market after the care is over
- availability of field and relief social services
- higher coefficient of counting of the care period into the entitlement to old-age pension

Changing stereotypical ideas about care

It is necessary to change the cultural and social stereotypes so that long-term care is not automatically associated with women. **Care must be presented as responsible and skilled work, which is demanding in terms of time, as well as mentally and physically demanding, and requires skills that are not naturally given to one sex**, but rather skills that must be learned throughout a lifetime. Care is an activity that cannot be successfully automated and replaced by a machine, and thus it requires significant “know-how” that must be appreciated. In addition, care provided by family members and close persons reduces the demands on the number of formal care services positions, which **brings savings to public budgets**. Finally, care provided in a natural home environment improves the quality of life of persons who require care. **Therefore, informal care must be sufficiently appreciated both financially and symbolically.**

2 The issue of caregivers in employment and on the job market

2.1 Problematic areas

- Difficult to combine work and care
- High economic inactivity of caregivers, in particular in terms of care for children with disabilities
- Higher unemployment of caregiving women and men
- Uncertain/ precarious work of caregivers
- Low job protection, lack of tools and measures for job retention
- Difficult to return to the job market after the end of (or during) care

2.2 Designation of the greatest problems

- Inadequate job protection when the need arises for care in a family
- Lack of tools enabling the combination of work and care

2.3 Proposed solutions

- Support of geographical and financial availability of social services in the field
- Time off for care
- Enforceability of adjustments (decreases) of work hours and flexibility of place of work

2.4 Areas where changes are necessary

- Labour Code (time off for care, enforceability of adjustment of the length of work hours, flexible type of work)
- Social services (financial and geographical availability of social services in the field); establishment of coordinator position for care support
- Sickness insurance; health insurance

2.5 Description of the problem

On the basis of an ISSP data analysis, Klímová Chaloupková (2013) learned that **most caregivers are in their productive age**. Most of them are also economically active (in terms of men, just about all of the caregivers, and in terms of women, only about one fifth of caregivers ages up to 55 were inactive), **and are thus forced to combine care with paid work** (Klímová Chaloupková, 2013).

According to research by the Fund for Further Education within the Support of Informal Caregivers⁴ project, in the set of **long-term caregivers, a total of 58 % of women and 49 % of men were economically inactive** – either they only devoted their time to care, or their inactivity was associated with some other status (retirement, parental leave). In the group of economically active women, 14.3 % were unemployed, 38 % worked full-time, and the rest (48 %) worked in some other way. Of economically active men, only 6 % were unemployed; 59 % of those who were economically active worked full-time. **The relatively low level of unemployment can be explained by the fact that a number of caregivers prefer to become economically inactive** if they are unsuccessful in finding suitable work over the long-term.

The dynamics of the development of job status for long-term care, or what happens when a person becomes a caregiver:

- If he or she worked full-time before providing care:
 - They kept their job while providing care (28 %)
 - Left to become economically inactive (27 %)
 - Retired (18 %).
- If they worked part-time before providing care
 - They kept their job while providing care (60 %)
 - Left to become economically inactive (5 %)
- If they were unemployed before providing care
 - Remained unemployed (44 %)
 - Left to become economically inactive (48 %)

Part-time work is likely much easier to combine with provision of care. And it also seems that the chance to return to the job market when providing care is zero. The worst situation is for mothers of children with disabilities, namely those that have begun to provide care after parental leave – almost half (48 %) remain economically inactive. According to FDV analyses, in particular, higher achieved education and living with a partner (i.e. the attainable help and support of another person), as well as older age and available help with care had a positive impact on the employment of caregivers. On the contrary, high intensity of care and the degree of dependence of the person being cared for had a negative impact (Geissler, 2015).

The results of recent quantitative and qualitative research of caregiving women conducted at the Institute of Sociology of the ASCR (Dudová and Hašková, 2014) shows that an **ever greater proportion of women caring for a small child, an elderly person or a disabled person can only find jobs on the job market in the form of insecure, low-rated, short-term work without social security**. This is also pointed out by the results of the FDV research, according to which 48 % of women worked in some other way than standard full-time, and from this total, 20 % worked on various contracts for work or work activities, and 25 % were self-employed (the rest represented shortened employment time; of economically active male caregivers, 34.6 % carried out nonstandard forms of work).

⁴/ Representative sample of caregivers, N = 858, women 711, men 147. A total of 388 surveyed economically active caregivers.

There was a particularly **striking situation with regard to mothers who were long-term caregivers for children with disabilities** (according to FDV research). The “Care for Persons with Disabilities”⁵ qualitative research (Dudová, 2013b) showed that these women either voluntarily chose to leave the job market, or they alternated periods of precarious work with periods of unemployment. Those who found themselves in particularly difficult situations were women who could not depend on the income of a partner (single mothers). They were primarily prevented from finding better types of employment by the **shared conviction of employers that these women did not have the necessary competence after years spent providing care, as well as the limited operation time of institutions providing care and education to their children** (morning operation of special schools and care centres, and the impossibility of accepting a child in an after-school club), along with the necessity of long commutes.

For those providing care to seniors, a key aspect was whether or not they had reached retirement age. According to “Care for the Elderly”⁶ research (Dudová, 2015), **women aged 50-60 encountered the greatest difficulties, as they were not yet entitled to retire**. They did not consider it desirable to leave their jobs to go and care for their parents because they realized the risks that this would bring: a reduction in current income, reduction in future income in the form of a diluted pension, and the difficulty of finding a new job after their care is no longer necessary and they will be at the end of their active working age.

In the “Care for the Elderly” research, when they were caring for their mothers or parents, more than half of the respondents were in pre-retirement age. Other respondents, although they were already officially retired, continued doing paid labour activities for various reasons, and therefore the **possibility to combine work and care was crucial for them**. In order for the surveyed women to be able to provide care in a situation where their mother or father required time-consuming daily care, they had to either have the flexibility to adjust their work hours, or to utilize assistance from other persons (e.g. having their spouses, siblings, neighbours or paid caregivers stand-in when they were at work). Another option was to cover a certain period when care was particularly demanding, or before they could retire, with institutional residence care. **Due to the fact that the retirement age will be later (especially for women), it will be necessary to combine care for seniors and paid work even more acutely**.

The period during which a person provides care to a person who is dependent in the second to fourth level of dependence is counted as a compensatory pension insurance period, and thus there is no dilution of the calculation basis, and the years of care are also counted as years worked. As soon as this period is over and the caregiver is unable to return to their original employment, they may register with the Labour Office as an applicant for employment, but they will only be entitled to a minimum assessment of unemployment support (granted in the cases where it is not possible to prove the amount of income). A problem also occurs when a person who previously provided care accepts less skilled and paid work (which can be expected due to the difficult employability of people in pre-retirement age). Less income then reduces the basis for calculating the pension.

Leaving a job due to care for a senior or a person with disabilities thus represents a risk in a family that is not fully revealed until the time when the care ends. **As long as the provision of care persists, the caregiver is protected by the compensatory pension insurance time period and can be financially supported by a care allowance. Once the care ends, so does this protection**. Caregivers may therefore find themselves in quite a difficult material situation, not only in terms of current income, but also in terms of future retirement income.

5/ 13 interviews with mothers caring for children with disabilities, collection of interviews in 2013 carried out within the ESF OPLZZ project “We are not poor, we are heroines!” Reg. No. CZ.1.04/3.4.04./88.00315

6/ 27 biographical interviews with women and men caring for their aging parents, Radka Dudová project “Discursive Framing and Everyday Experience of Care for Elders in the Czech Republic”, CSF, Reg. No. P404–12-P053.

2.6 Proposed solution

On one hand, the situation can be improved by **expanding the offer of formal services**, which will cover care when the caregiver is working, and on the other hand, the time off policy to provide care, allowing the caregiver to stay at home temporarily if the need to care for a loved one who is recovering after intensive or long-term illness or injury. Both are thus far still poorly developed in the Czech Republic. The services of field caregivers are not available for many families both geographically and financially, and research suggests that their utilization faces a number of cultural barriers among caregivers and those receiving care. **Special time off for Care for an elderly family member with the possibility of returning to one's original employment does not exist in the Czech Republic.** Caregivers may use the so-called "paragraph" - i.e. time off for care of a sick child or other family member. However, it is limited to nine days, and a senior must live with the caregiver in the same household and the caregiver must be employed (a self-employed person is not entitled to a care allowance, even if they pay sickness insurance). Another option is unpaid leave, but this depends on the benevolence of the employer. **For many caregivers, the only alternative is to completely abandon their jobs. Yet this poses a risk in terms of further employment after their care is no longer is needed.** The starting point is to therefore seek measures that allow the preservation of a job at a time when care is being provided.

Time off for care

The aim of this measure is to support care for people who are recovering after intensive or long-term illness or injury which leads to the need for long-term care, and to provide informal caregivers the possibility to provide care and orient themselves in the new situation of caregiving commitment without fear of loss of employment. **The measures include three new institutes: Time off for care, financial assistance for care and extended time off for care.**

- Time off for care would be a claimable institute; analogous to maternity leave. This would consist of a 3-6 month release from employment, but only up to 3 months could be drawn per one dependent person. After the time off for care is over, the employer would be obliged to allow the employee to return to their original job and workplace. Repeated drawing would be possible after repeated, marked deterioration in health. Other close persons could gradually draw time off.
- For the period time off for care is drawn, to the employee would pertain sickness benefits – monetary aid for care. For the self-employed, the state would pay their health insurance during the time off for care, and the self-employed person would be absolved of obligations to pay the prescribed advance payments for social insurance (first 90 days).
- After time off for care, a further extension would be possible, but this time it would not be claimable – dependent on an agreement between the employee and employer. For the self-employed, the state would also pay their health insurance, and the self-employed person would be absolved of obligations to pay the prescribed advance payments for social insurance.

Support of geographical and financial availability of social services in the field

According to a RILSA study (Průša, 2013), **only less than a tenth of recipients utilize the care allowance to pay caregivers working in the field.** The amounts of subsidies for various types of services show that social services grants from the MLSA were not used to support the declared shift from residential services to services in the field (Průša, 2013). According Průša et al. (2010), in 2009, financial unavailability of caregiving services was the most important factor limiting access to this social service compared with other types of services. **However, the shared care model, which combines care of family members and professional caregivers working in the field, has an impact on increasing the quality of care whilst reducing the burden on family caregivers**

(Formánková, Novotný, Efenberková, 2012). The solution thus consists of the development of caregiving services in the field in such a way that it is financially and geographically accessible.

Another serious problem is the lack of awareness of local government representatives about the number of people receiving the care allowance, or persons who are entitled to it. This lack of awareness is due to lack of interoperability and cooperation of the local governments and Labour Offices that pay out the allowance. **Local governments thus do not have enough information about the needs of their citizens and cannot use it for strategic planning of social services development** in their territory. The solution is to establish care support coordinators in municipalities, whose goal will be to provide information, consulting and other support to caregivers and persons in need of care, provide support in care crisis situations, monitor the situation in the municipalities and collect data for effective planning of care support at all levels, and to ensure the continuity and integration of various (kinds, types of) services.

Possibility of flexible work – enforceability of regulation (reduction) of work hours or flexibility of the workplace

In the Czech Republic, according to the Labour Code, employers are obliged to adjust the length of work hours for parents caring for a child up to the age of 15, pregnant women and people who prove that they are consistently providing long-term care on their own to a predominantly or completely helpless person – but only if operational reasons do not prevent as such. **This measure is rarely exercised in practice and is essentially legally unenforceable**, and employees are not sufficiently informed of its existence. A change to the formulation of the law, or methodological recommendations for stricter monitoring of the enforceability of this measure would allow caregivers to combine work and care.

3 Care and social benefits: care allowance vs. allowance for caregivers

3.1 Problematic areas

- Lack of economic security for caregivers if they suspend or restrict gainful activity due to providing care
- Economic inequality stemming from reproductive work (providing care)
- Lack of appreciation for caregiving work by society
- Insufficiently rapid and flexible process of assessing entitlement to care allowances and the resulting situation where a family is without income

3.2 Designation of the greatest problems

- Insufficient financial and social appreciation of informal care

3.3 Proposed solution

- Overall reform of financing of informal care and social services – separation of financing of social services and care allowance for loved ones.
- Preservation of care allowance with the implementation of new benefits directly supporting caregivers financially.
- Time off for care
- Speeding up the process on the part of the Labour Offices and medical assessors

3.4 Areas where changes are necessary

- Act on Social Services
- Act on Aid in Material Distress and Act on Life and Subsistence Minimum
- Financing of social services

3.5 Description of problems

Even though informal care in a family is usually provided from love, it is also work that is very demanding in terms of time, as well as physically and mentally. When someone decides to care for their loved one at home, if they are not already retired and inactive on the job market, they must generally reduce their work activity, thereby depriving themselves of earned income. **With regard to very intensive care, they must leave their jobs and are risking that they will later have a hard time finding a new job.** In addition, by providing care they are saving public expenditures on social and health care services. In addition to the moral recognition of the value of this caregiving work, it is therefore appropriate to also consider adequate **valuation which would partially compensate caregivers for the cost of lost job opportunities, or at least ensure a decent standard of living**, even with a view to the future.

According to the results of quantitative research of the Fund for Further Education within the Support of Informal Caregivers project⁷, **23 % of caregivers experienced a severe worsening of the standard of living in the moment of providing care.** 60 % of respondents said that they could not afford an unexpected expenditure of 9,600 CZK (compared to 42 % of the general population). The research showed that significant differences were found in the living standards of caregivers according to the type of person who was being informally cared for; **those providing care for seniors were in the best situation, while single mothers caring for children with disabilities were in the worst situation.**

The current Czech social system envisages the recognition of the care period as a substitute period of pension insurance, and also provides a non-self-sufficient person with a care allowance graded according to the degree of dependency. The care allowance should also serve to “pay” for the informal care of a family member if he or she is a care provider. In its beginning, the care allowance was designed, among other things, as a way to increase public support for informal care. The previous system, where the person providing the care was entitled to a relatively low allowance whilst the majority of the public support was directed towards institutional residential care, was criticized by most participants for its lack of support for informal care in the home environment.

The care allowance intended directly for a person dependent on the help of others to purchase the service they need replaced the previous “care allowance for a loved one” intended for the person providing care (as of 31 December 2006 it amounted to 5,400 CZK; it was based on the specified minimum subsistence), and “increase in pension for helplessness”, which was received directly by a helpless person in the amount of 480 CZK for partial helplessness, 960 CZK for overwhelming helplessness and 1,800 CZK for complete helplessness (status as of 31 December 2006). The new “care allowance” was paid out in four categories: 2,000 CZK, 4,000 CZK, 8,000 CZK and 11,000 CZK, depending on the health assessment of the eligible person. Its amount was gradually adjusted, and it is currently 800 CZK, 4,000 CZK, 8,000 CZK and 12,000 CZK for persons over 18; it is higher for younger people in the first three levels.

The main idea behind this change was to strengthen the position and possibility of free choice of care for a person who is dependent on others. The implementation of the care allowance was accompanied by the assumption that a quasi-market will be created with different types of social services, while the most successful ones will stay and develop, and that it will free up places in residential care facilities by those persons who do not need such intensive care. **Soon after it was implemented, it became apparent that implementing a care allowance intended directly for dependent persons has led to an increase in the total cost of the state for social services, but the beneficiaries of the allowances did not use them to purchase formal care services.** At the same time, it was not possible to check whether and how the allowances were being used in the sphere of providing informal care by family members: “What ratio of care allowance is really

^{7/} Representative sample of caregivers, N = 858, women 711, men 147. A total of 388 surveyed economically active caregivers. Project for the Support of Informal Caregivers, Reg. No. CZ.1.04/3.1.00/C6.00002.

paid out to close persons or other persons for the care they provided. And, among other things, whether this means ad hoc care or systematic and regular care" (Horecký, 2012, p.8). Likewise, there was **no freeing up of places in residential institutions as was expected**, and a certain percentage of people who did not need intensive social care continue to remain in them."

The implementation of the care allowance did increase the amount of the allowance that family members could receive for providing care, but due to the fact that it was no longer intended for a caregiver but rather a person needing care, **the allowance lost the significance of direct reward and public appreciation for providing care**. Many media articles from the period after the implementation of the care allowance pointed out that it was not clear whether the money paid out via the care allowance actually made its way to those who physically provided the care. The only thing that is clear is that the money was not getting to the places the creators of the reform were expecting, i.e. as support for various formal services, including field and outpatient care. Accusations appeared in the media that seniors were keeping the money for themselves and were receiving the allowance even if they were able to take care of themselves, or that their children and grandchildren were taking the allowance without actually providing any care.

That the allowance is not perceived as a reward for caregiving work is amplified by the fact that it does not establish any entitlement to holidays, and when a senior must spend a longer period of time (an entire calendar month) in a hospital, they lose the allowance. Without any fault on their part, caregivers found themselves without funds, and in this short period they did not become entitled to state social support benefits and they did not have the chance to make any income.

According to the research of the Fund for Further Education, **caregivers informally stated that their main household income was the income of their partner** (42 %), and/or their personal income (36 %). 87 % of respondents stated that the person being cared for received a care allowance, but only 74 % stated that it was a part of their income. 16 % of those who were theoretically entitled to a care allowance because a dependent person was receiving it and they were caring for them as the primary caregiver, did not specify it as their household income. The care allowance was the primary income for 13 % of caregivers. It was most significant for parents caring for minor children with disabilities, and least significant for persons up to the age of 44 caring for parents or grandparents, and for persons who were retired and caring for parents (Horová, 2015).

Qualitative research of informal caregivers carried out at the Institute of Sociology of the ASCR, v.v.i. from 2012 to 2014 clearly showed the difference in the perception of the care allowance by various groups of caregivers. Respondents who were daughters (and sons) providing care for their aging parents primarily perceived the allowance as their parents' money, for which it was suitable to buy superior aids or food, or rarely, to also pay for formal paid care services. They identified with the expectation that as their children, they would take care of their parents for free and selflessly. In some cases, some of the female respondents did not even know about the care allowance, or did know about it but deliberately did not apply for it, saying that they had sufficient income and considered care as their obligation. **In most cases, they did not think of the care allowance as of money that belonged to them as recognition for their caregiving work** (Dudová, 2015).

Their perception of the care allowance differed from the understanding of the same allowance by another group of caregivers, namely mothers taking care of children with disabilities. These women regularly interrupted their working activity due to the need to care for a child (or rather continued after their parental leave) and remained at home over the long-term. The care allowance was their main and often only income. Qualitative research in this group of caregivers revealed that **mothers caring for children with disabilities attached great importance to it in their testimonies** (as opposed to sons and daughters caring for their parents). They perceived it as their personal income, which does enter into the budget of the entire household, but it is essentially a reward for their work consisting of care for a child.

Women were in a somewhat paradoxical situation: they understood the allowance as an appreciation of their work with children. Yet if they succeeded in developing the children and teaching them something new, or guiding them toward greater independence, they had to take into account that in the next assessment the allowance would be reduced and they would lose part of their primary income. **On one hand they were internally motivated to work intensively with the child so that his or her condition would improve, but they also risked that if they were successful in this endeavour, they faced the risk that their family budget would be endangered by a lower care allowance.** Periodic re-evaluation of the degree of dependence (every year or every two years) represented stress for them – either because they feared a reduction in income, or because it was not pleasant for them to deal with social workers or officials. These women did not perceive the care allowance as a social benefit; rather, they understood it as a reward for their work with the sick child (Dudová, 2013a).

Among other things, this difference is probably due to the fact that the allowance intended for a child is formally received by the child's legal representative, i.e. the caregiving mother, whilst an allowance intended for a senior is formally received by the senior and not by a caregiver (although it may in fact be paid to the caregiver's account). Therefore, the formal configuration of the allowance likely influences how recipients and caregivers perceive the allowance and how they use it.

The configuration of the care allowance as a benefit directly pertaining to a user of services, and the fact that the users can freely choose what types of services they purchase for it, in the area of care (in particular care for seniors) it encounters social standards and expectations according to which care for non-self-sufficient relatives is a certain obligation that is to be carried out selflessly and out of love. Reports from caregiving women and men suggest that in many cases, despite the existence of an entitlement to an allowance, in some cases a family does not request any money, because it does not want to be exposed to the suspicion (either externally or among family members) that it provides care for personal gain. **The caregiver is thus practically trying to avoid the commodification of care,** i.e. in this case transferring the care motivated by a close affective relationship and reciprocity on monetary value and bringing market relations into the private sphere. In other cases, this money is similarly understood as a source to cover the special needs and aids of dependents, not as a reward which should belong to the person who provides the personal care. The care allowance thus does not fulfil the function of appreciation of caregiving work.

Another issue is the long duration of proceedings on granting of care allowances. The average length of the issuing of a first instance decision is six months (not including the period of interrupted proceedings for the work of the assessment commission), and there are known cases that even unreasonably last several years (Klára pomáhá, 2015). For this period of time, usually the need for providing care is not always compatible with economic activity, and the **caregiver is without funds during this period.**

Another issue is also the very principle of joint financing of social services and informal care through a care allowance. A quasi market with social services was not opened in the Czech Republic along with the implementation of the care allowance, and hence there was not a greater availability and more diverse offer of social services. As the report from the *Klára pomáhá* organization states, a care allowance is not returned to the system through the purchase of social services, not because the amount contributed is so high that it is worthwhile for the caregiver to stay home and provide care to the full extent, but rather because its amount is too low in relation to the prices of social services. **It does not allow recipients of allowance or caregivers to buy services to the extent that it is possible to combine employment and care.** If they leave their employment due to providing care, the allowance amount is usually but a weak compensation of lost wages or opportunities on the job market - i.e. after a family member leaves their employment in order to provide care, the purchasing of services becomes a luxury that they can afford at best sporadically (Klára pomáhá, 2015).

3.6 Proposed solution

Aside from whether the current care allowance amount adequately replaces the cost of lost jobs and provides to the caregiver a decent standard of living if they cannot have other income due to the demanding care, it seems that the adequate form of support for informal caregivers is rather a benefit intended directly for the caregiver. There are two possible solutions:

Overall reform of financing of informal care and social services – separation of financing of social services and care allowance for a loved one.

The need and demand for social services would be systematically evaluated via care support coordinators working in class III and II municipalities, and **social services would be funded directly** (not through a care allowance). The social services would also include the position of care assistant who would have a contract with a municipality, not with the person dependent on care. This would ensure higher quality of care provided by care assistants and their working conditions would be protected.

In addition, a **care allowance for a loved one would also be implemented, which would be received by a caregiver**. Its amount would be given by the intensity of the necessary care (degree of dependence) and the intensity of the provided care (i.e. it would be possible to receive it from 50 % when drawing accommodation or field services up to a certain limit, or it could be divided between two people providing care from 50 %). **The benefit would also apply in the event of the temporary hospitalisation of a person with the necessary care** and would end only when informal care at home was no longer expected.

Preservation of care allowance with the implementation of new benefits directly financially supporting caregivers.

The care allowance would further be intended for a person dependent on the help of others, and it would be possible to purchase with it social services or another type of care. **A person providing care to a loved one would also be entitled to a benefit** (support in care for a loved one). Its amount would once again be given by the intensity of the necessary care (degree of dependence) and the intensity of the provided care (i.e. it would be possible to receive it from 50 % when drawing accommodation or field services up to a certain limit, or it could be divided between two people providing care from 50 %). **Grant support of social services would concurrently be increased**. It would also be possible to consider **decreasing the care allowance** (released financial resources would be used to finance these new benefits for caregivers, and for direct support of social services).

Other measures

The social system should also deal with situations wherein the **need for care suddenly appears** (health deterioration, injury, loss of self-sufficiency), but assessment proceedings have not yet been carried out and care allowance is not granted. **One solution is the implementation of the “time off for care” institute** (see chapter 2.6).

A separate issue is the economic situation of those caregivers who, due to a sudden need to take care of a loved one, have lost the opportunity to be gainfully employed, while (still) not being entitled to any social benefits. It would therefore be appropriate to include this life situation in the list of situations in which it is possible to provide emergency assistance immediately.

However, in particular the speeding up of the process of assessment by the Labour Office and the medical assessors would make the situation easier for caregivers. The unbearably long duration of the process of granting a care allowance can be resolved by a provision that allows for proceeding according to the legal presumption that if the competent Labour Office does not make a decision within the extended statutory period, it will be considered that the entitlement was recognized. (Klára pomáhá, 2015).

4 Care and pension system

4.1 Problematic areas

- Disadvantage of caregivers in the social insurance system
- Very low retirement incomes of persons who devoted their time to care in their working age
- Endangering of retirement pension in the event of long-term care and failure to meet the minimum insurance period
- Deepening of the issue because of the extension of the retirement age

4.2 Designation of the greatest problems

- Low retirement income of persons who devoted their time to care in their working age; endangering of entitlement to retirement pension in the event of long-term care and failure to meet minimum insurance period

4.3 Proposed solutions

- Greater enforceability of regulation (decrease) of work hours or flexibility of place of work
- Time off for care
- Establishment of the support and care coordinator position
- Activities of the Labour Office, which will lead to employing persons in pre-retirement age
- Improvement of conditions for drawing early retirement
- Change to the formula for calculating the pension amount

4.4 Areas where changes are necessary

- Act on Social Insurance, conditions for entitlement to old-age pension, conditions for calculating old-age pension.
- Labour code - time off for care, enforceability of regulation of work hours.
- Act on Health Insurance and Pension Insurance - insurance payments; payment of health insurance by the state during caregiving leave.
- Labour Offices - specific support of former caregivers.

4.5 Description of problems

In the Czech Republic, the retirement age has been gradually increasing since 1996, and it is becoming similar for men and women (due to the fact that the pension age for women was increasing faster). **Since 2013, there has been a further acceleration in raising the retirement age for women.** In addition, in 2011 the fixed target limit for the retirement age was cancelled, with the expectation that in the future it will be indirectly linked to the current life expectancy. After 2044, the retirement age should thereby increase by 2 months each year.

In the Czech Republic, participation in the public pension system is currently subject to a gainful activity in the form of employment or self-employment; contributions are paid from this gainful activity to the pension insurance system. **Participation in the public pension insurance is relatively inclusive in the Czech Republic - the majority of workers, both men and women, have compulsory pension insurance.** The issue may relate to contracts for work and jobs with earnings of less than 10,000 CZK, which does not establish participation in pension insurance. People who work long-term only based on work agreement not exceeding this amount of earnings may have a problem with reaching the minimum mandatory period of insurance, which is an important criterion for entitlement to a pension. This means the minimum number of years during which contributions (payments) were paid to the pension insurance system. In Central and Eastern European countries, including the Czech Republic, this minimum period is relatively long.

This system theoretically suits those working long-term and continuously, which is an issue for persons providing care at certain times in their lives (whether to children or other family members). In 2010, the **required insurance period for entitlement to old-age pension in the Czech Republic** amounted to a total of 25 years upon reaching retirement age. This period will be gradually increased to **35 years in 2018.**

In a European comparison, this is a relatively long period of time, and for example for college students, it currently covers almost their entire period of economic activity⁸. **Such a long mandatory period of insurance for entitlement to old-age pension may be problematic not only for caregivers, but also for people with precarious positions on the job market,** whose numbers are growing in the Czech Republic in connection with the economic crisis, and there are more among women than men (Hašková, 2011). Moreover, since 2010, a study period is not counted as a compensatory insurance period. According to the MLSA model (2012), it can be assumed that **10 % of people will not meet the insurance condition at age 66 in 2050;** in 2012 the insurance condition was not fulfilled by only about 3 % of people at retirement age).

The total amount of pension benefits consists of two parts – the basic minimum lump sum benefits, to which anyone who meets the retirement requirements is entitled, and of the benefit which is derived based on a percentage from previous income. In order to calculate pension benefits, it is crucial which period is monitored in terms of income as decisive for determining the amount of pension benefits. This period gradually changed and lengthened in the Czech Republic. **The decisive period of calculating retirement benefits will gradually cover the entire working career of individuals. This calculation method is less suitable for people who interrupt their working career throughout their lives or reduce their work activities to provide care,** which is significantly higher for women than it is for men (Dudová, 2013a).

Currently, the system in the Czech Republic is trying to minimize the impact of long-term provision of care for calculating pension using a so-called compensatory insurance period. This is a specific time period which, when calculating pension entitlement, is perceived as a period of participation in the job market and contributing to the pension insurance system, although in fact the concerned person devoted their time to unpaid caregiving work. **The compensatory**

8/ According to Ivoševic (2009), this minimum insurance period for entitlement to old age pension is longer in Central and Eastern European countries, where in 2008 it was longer by 15 or more years than in countries in Western Europe, where it was around 5 years.

insurance period is considered the period of personal care for a child up to the age of four, care for slightly disabled children (degree of dependence I) up to ten years of age, or care for moderately, severely or very severely disabled person (degree of dependence II-IV). These periods are also not counted when determining income for calculating pension, so they do not dilute the actually-achieved incomes. However, if the care lasts for 15 years and longer, the pension amount is calculated in such a way that instead of the period, a “fictitious income” is substituted, which is calculated as a monthly care allowance amount received by a dependent person.

Research shows that about a quarter of caregivers are **retired** (according to FDV research, out of 858 surveyed informal caregivers, 24 % of women and 27 % of men were retired), and achieving the entitlement to a pension is likely to make it easier to make the decision to provide care, as well as practical organization of care (in particular in care for seniors). **However, during the period of providing care, a large group of caregivers are in the pre-retirement age and the configuration of the conditions for achieving pension entitlement affects them acutely.**

Although in the Czech Republic the regulation tries to count, for persons providing care to persons dependent in the 2nd to the 4th degree, their years of care as worked, and also excludes these years for calculating the amount of the pension (so that the pension amount is not decreased by small incomes at the time of providing care), certain drawbacks associated with care continue to appear.

However, the period for which a man or a woman provides care cannot be used to advance a career or increase income; on the contrary, interrupting a career path due to care likely leads to stagnation or an income reduction. This is quite important due to the fact that between age 50 to 54, (during which they most often provide long-term care) women reach on average the highest income in their career path.

When the period of care is over and the caregiver is unable to return to their original employment, **they can register with the Labour Office** as an employment applicant, but they **will only be entitled to the minimum assessment in unemployment support** (granted in cases where it is not possible to prove the amount of income). Since 2010, the time of registration at the Labour Office counts as a compensatory period only for a maximum of one year (three years for people 55+), and this period only counts from 80 percent. Therefore, if during their life a former caregiver is unemployed for more than three years, this time will not count as a compensatory period insurance.

An issue will also occur if a person who previously provided care accepts less qualified and paid work (which can be expected for people in the pre-retirement age due to the difficulty of finding employment). **A lower income thus dilutes the basis for calculating pension.** If the person does not accept such work and remains inactive in terms of work, they will face the risk of not reaching the pension entitlement at all due to the lengthening of the minimum insurance period necessary for granting a pension to 35 years (Dudová, 2015).

Leaving a job due to providing care for a senior in a family poses the risk that it will fully manifest after the care has ended. So long as the care persists, the caregiver is protected by the compensatory pension insurance period and may be financially supported via a care allowance. After the care ends, then so does this protection. Caregivers can therefore find themselves in rather difficult material situations, not only from the view of current income, but also future income in retirement.

For persons caring for seniors, the risk lies mainly in the fact that they provide care mostly in the period in their lives when they could theoretically reach their highest income; if they leave their job due to care, **they will later become difficult to employ** (due to age discrimination or loss of work competence), and their entitlement to pension and its amount are endangered by their subsequent unemployment, acceptance of poor working conditions or involuntary inactivity. **Caregivers thus often choose to go into early retirement**, but this will reduce their pension benefit, to which they have a monthly entitlement, for life.

Persons providing care to children with disabilities are considerably endangered if the care lasts a very long time, and if before starting care they did not work, or worked only at low-paid jobs. Although their years of care are counted as a compensatory insurance period, their calculation base for calculating the pension amount is zero or very low. These people (usually women) are then only entitled to the minimum pension assessment, which currently amounts to 3,110 CZK.

The disadvantages of women on the job market due to providing care are thus manifested by lower income in employment, and later in their pensions. In 2014, a total of 17,177 women received old-age pension of less than CZK 5,000 per month; for men, it amounted to 7,366 pensioners (ČSSZ, 2014).

4.6 Proposed solution

On the one hand, the situation can be improved by **measures making it easier for caregivers to combine paid work with care** so that when providing care they can continue with paid employment, thus entitling them to a pension, and measures to making it easier for them to return to the job market after the care has ended. On the other hand, improving the conditions for **recognition of the period of care** can help with **entitlement to a pension**. The possibility of combining work and care will be supported by the expansion of formal services, which will provide care when the caregiver is working. Another possibility is to **implement the institute of time off from work for care**.

The services of field caregivers are not currently geographically and financially available to many families. Special time off for care for an older family member with the possibility of returning to original employment does not exist in the Czech Republic. Another option is unpaid leave, but this depends on the benevolence of the employer; or leaving the job.

The combination of work and care will also be supported by the possibility of flexible work hour arrangements, i.e. more **real enforceability of the right to adjust work hours in the case of care for a person dependent on care in the 2nd and higher degrees** (Section 241, paragraph 2, Labour Code). A positive contribution would also be the support and expansion of other flexible forms of work, including work place flexibility or job sharing. **An easier return to the job market after the care is over will be aided by the support and care coordinator institute**. The job description of a coordinator working for a municipal office will include, among other things, counselling for caregivers, providing information about available formal care services, gathering of information about their needs and their appropriate professional direction after the care is over. Cooperation and the **activity of the Labour Office, which must not automatically consider people in pre-retirement age as unpromising in terms of employment** and should actively help them to find suitable jobs, will be assumed.

In order to ensure that the care period is not negatively reflected in the pension amount, it would be helpful to further improve the conditions of including of compensatory insurance periods. **The registration time at the Labour Office at age 55 and over should be counted as a compensatory period for a longer period** (e.g. until reaching the age of entitlement to pension), and should be 100 percent counted. An alternative is to **improve the conditions for drawing early retirement** (allow under certain conditions - e.g. fulfilling the 25 year insurance condition and providing care to a loved one – drawing of early pension under the same conditions as a normal old-age pension).

The specific question is the formula for calculating the pension. Exclusion of the period of providing care from the calculation is inherently beneficial for persons who had higher incomes when they were employed. The compensatory period (and the same period lasting for the same time) will manifest differently for two people in their pension amounts with respect to incomes generated outside compensatory periods. Long-term (life-long) informal caregivers who were not employed or were only employed at the beginning of their career path with low incomes find themselves in a particularly disadvantageous situation

Instead of excluding period of care for all caregivers, one solution is to count fictitious income during the period of providing care, but which will be high enough to ensure a decent standard of living when receiving a pension, and also will not lead to making caregiving (reproductive) work disadvantageous versus productive work, or to make it disadvantageous for certain groups of caregivers over others. This fictitious income should be derived from the average wage and should not be less than 80 % of the average wage.

5 Economic perspective of support of informal caregivers

Support of informal caregivers is economically advantageous for the state despite the initial increase in costs. However, the implementation of short-term leave for care covered by sickness insurance benefits may well pose increased demands on the sickness insurance system. Yet short-term job protection allows caregivers to provide care during recovery, and allows them to orient themselves in a new caregiving commitment situation without losing their jobs. **This will reduce funds spent on an employment policy** (unemployment support benefits, retraining, etc.). At the same time, these individuals will not require other state social support benefits, to which they would be entitled if they lost their employment due to care and their household income was substantially reduced.

Financial support of short-term care, job protection and pension benefits for long-term caregivers will also motivate people to provide care at home instead of using hospital care (LDN) (Hospitals for Long-Term Sick) and residential social services, which will save on costs for these institutions. Costs for a bed in a retirement home are 21,863 CZK per month, and in institutional health care facilities the costs amount to 27,178 CZK. Social care services are financed from 49 % by users, 27.5 % are financed by MLSA subsidies and other 14-15 % from the budgets of local governments and founders (available data from 2010, MLSA 2010). The quality of life of a person who requires care may also be incomparably higher at home.

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About Alternativa 50+

Alternativa 50+, o.p.s., founded in 2008, is a non-profit non-governmental organisation advocating for equal opportunities for women and men and for people of different ages in the Czech Republic and in Europe. We believe that diversity at the level of employers, organisations and in the society overall is the best way to involve different communities and to tap their talent. We also think that diversity is the most effective instrument for the prevention of discrimination.

Alternativa 50+ provides direct counselling and follow-up assistance to victims of gender, age or multiple discrimination. We specialise in counselling caregivers looking after dependents.

Our Mission

- We advocate for equal opportunities for people over 50 in the context of equal opportunities for women and men.
- We promote and help to implement age management strategies among employers – businesses and public administration bodies
- We provide expertise in age discrimination and age diversity issues
- We advocate for equal opportunities for young people and for inter-generational cooperation/cooperation among different age groups
- We provide legal and social counselling to people over 50

What We Offer

- Social, legal, psychological counselling and other support services
- Equal opportunity and work-life balance audits
- Educational workshops
- Educational materials and resources



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