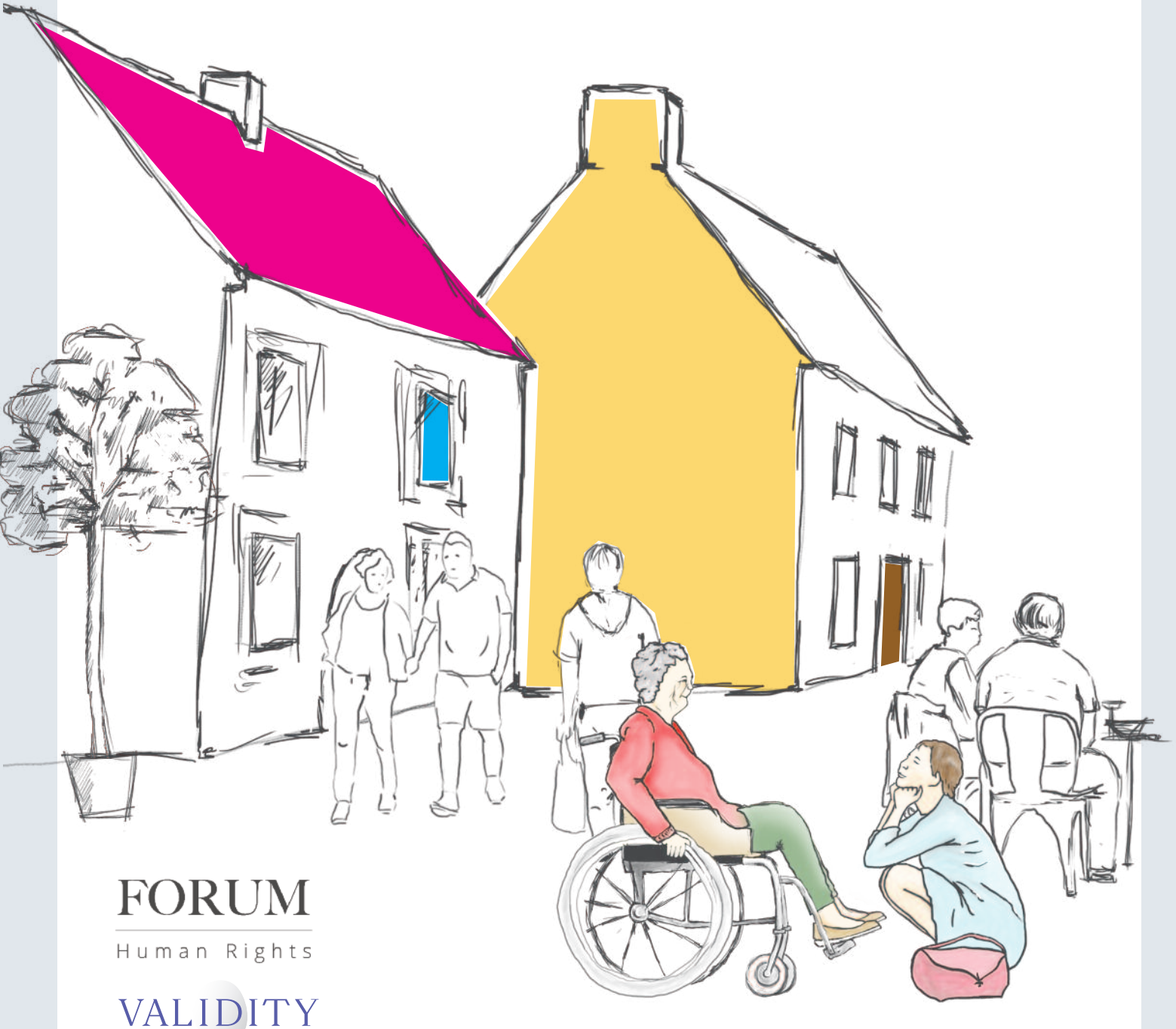
INSTITUTIONALISATION, DISABILITY AND AGEING

Institutional care for older persons with disabilities in the Czech Republic



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INSTITUTIONALISATION, DISABILITY AND AGEING

Institutional care for older persons with disabilities in the Czech Republic

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ABBREVIATIONS

MoLSA – the Ministry of Labour and Social Affairs of the Czech Republic: the central executive authority responsible for the social services system and social security schemes.
UN CESCR – UN Committee on Economic, Social and Cultural Rights.
UN CRPD – UN Committee on the Rights of Persons with Disabilities.

DEFINITIONS AND GLOSSARY

In this glossary, we define several key concepts that are used in this report. In concrete terms, we distinguish between two groups of older persons, one that is defined (i) only by age, and the other that is defined (ii) by age and their need for support. These groups overlap. However, within the latter group, one may also distinguish those who may require support because of their age and those who may require support because of their disability or through a combination of age and disability. However, such a subtle distinction requires the ava ilability of appropriate data, which is not the case in the Czech Republic. Hence, this research is limited in this way.

This research aims to describe the extent of the institutionalisation of people of advanced age regardless of their requirement for support. In other words, it is inclusive in terms, since it covers all groups of older persons, including older persons with disabilities. If the research shows that there is a lack of community-based services for older persons in general, and such a lack is also demonstrable on the basis of all available information concerning specific institutions housing only older people with mental disabilities, then it shows that all people of advanced age are at risk of institutionalisation. In other words, the absence of alternatives affects everybody, including those who fall within the category of an older person (i) above, some of whom one can expect in the future to fall into the second category, considering, for example, the nature of certain progressive impairments such as dementia. Put differently, as one will see, in a number of situations we were unable to make a clear distinction between elderly people in general and elderly people with disabilities. Yet, it does not affect the core of the argument presented in this report, that the extent of institutionalisation of older persons, including those with disabilities, is massive, alternatives are scarce, and Government policies do not consider it problematic from the perspective of international human rights law.

Further, we provide definitions of several types of "social services". These definitions are primarily based on Czech legislation, namely the Social Services Act. The law defines a number of "social services", which provide and ensure a range of activities, including accommodation, food, and nutrition, but which also can be characterised as "support". The word "support" refers inter alia to the obligation of care providers, including institutions, to *"assist with realising one's rights, justified interests and with realising personal matters"*.[1] In practice, informal supported decision-making is also frequent.

[1] See, Act no. 108/2006 on Social Services (*hereinafter* "Social Services Act"), Article 35(1)(j).

Following this brief introduction, first, we need to explain who we consider to be an **older person**. In international human rights law, there is no clear definition of older persons. The UN CESCR in its General Comment no. 6 considered that *older persons* are those over the age of 60.[2] Yet, as is apparent from the most recent soft-law,[3] there is no explicit connection between the status of an older person and her concrete age. This approach mirrors the presumption, similar to the case of *disability*, that a single objective characteristic, such as one's age, is not decisive. Rather, it is one's social status and social barriers, two constellations, which are influential here. Still, it seems necessary to have a clear navigation point for studies such as this one. Hence, both quantitative and qualitative data presented below reflect biological age. In the Czech Republic, older persons captured in the statistics and research are either those of 60 or 65 years of age. Whenever we present these data, we specify the age limit.

In relation to disability, the situation is different. International human rights law provides for a normative definition. According to Article 1 of the CRPD, persons **with disabilities** *"include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."* As indicated, a group of older persons can be further distinguished by additional characteristics. Where possible, we indicate that data or information relate to older persons with disabilities. However, for reasons explained above we distinguish older persons on the grounds of a more general additional characteristic, that of "support". Thus, for the purposes of this study, an **older person who is dependent on the support of others** is an older person whose self-sufficiency is affected, either by age or disability, or age and disability, to the extent that she needs support from another or others to manage her basic necessities of life. Considering the focus of this research and bearing in mind that only older persons who are dependent on the support are entitled to social services under Czech law, we use the abbreviated form of "an older person", unless stated otherwise, to refer to this group.

In relation to "social services", we distinguish **residential facilities for persons with disabilities** [in Czech *"domovy pro osoby se zdravotním postižením"*]. According to Czech legislation, these are residential social care facilities that provide accommodation, food and support to those who require regular assistance of other people due to their *disability*.[4] These facilities accommodate a wide range of users of different age and disabilities and they are currently the only ones that are part of the deinstitutionalisation discourse (see below chapter 4.3). Nevertheless, even in the case of these facilities, deinstitutionalisation particularly concerns younger persons with lower need of support.

There are further residential facilities for seniors [in Czech *"domovy pro seniory"*] that are defined by law as residential social care facilities that provide accommodation, food and support to those who require regular assistance from others due to their age.[5] The Social Services Act also defines **special regime facilities** [in Czech *"domovy se zvláštním režimem"*]. These are residential social care facilities that provide accommodation, food and support to those who require regular assistance from others due to their *"chronic mental disorder, dependence on addictive substances, old-age*

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2 General Comment of the UN Committee on Economic, Social and Cultural Rights no. 6 (1995): The economic, social and cultural rights of older persons, para. 1.

3 A/74/186, 2018.

4 Social Services Act, Section 48.

5 Social Services Act, Section 49.

dementia, Alzheimer's disease, or other types of dementia".[6] Special regime facilities are strictly organised institutions with intensive surveillance and control, hence "regime" in their designation. The law requires the regime to be adjusted to the specific needs of those persons.

The non-residential and community based "social care services" may be further divided into ambulatory and outreach services. The ambulatory "social care services"[7] providing support to older persons are especially **day services centres** and **day care centres**. Both services are very similar and differ only in slight details. They provide services to persons with reduced self-sufficiency due to their age, chronic ailment, or disability, whose situation requires assistance from others.[8] The services provided by day services centres and day care centres include:

- assistance with personal hygiene or arranging for personal hygiene conditions;
- provision of food or assistance with arranging for food[9];
- pedagogical, educational and activation activities;
- mediating contacts with the social environment;
- social therapeutic activities;
- assistance with asserting rights, justified interests and looking after personal matters;
- assistance with the handling common self care acts.[10]

The outreach services are personal assistance and domiciliary service.[11] **Personal assistance** is an outreach social care service provided to persons with reduced self-sufficiency due to their age, chronic ailment, or disability where they require assistance from another person.[12] It is provided without time limitation, in the natural social environment. It covers activities needed by a person, but it also includes the following:

- assistance with handling ordinary self-care acts;
- assistance with personal hygiene;
- assistance with arranging for food;
- assistance with running a household;
- pedagogical, educational, and activation activities;
- mediating contacts with the social environment;
- assistance with asserting rights, legitimate interests, and looking after personal matters.

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6 Social Services Act, Section 50.

7 We intentionally do not mention another ambulatory service that does not fall within the category "social care services", but is one of the social prevention services – social activation services for older persons and persons with disabilities (Social Services Act, Section 66). This is because these services do not provide support in care and thus are not sufficient to ensure independent living for persons who are dependent on the support of others.

8 Social Services Act, Section 45. The legal definition of the target group of the day care centres differs only in that it mentions persons with a chronic mental disorder instead of persons with a chronic ailment. See Social Services Act, Section 46.

9 In the case of the day care centres this activity only includes the provision of food, not assistance with arranging for food.

10 Only in the case of the day care centres.

11 The domiciliary service may also be provided, according to the law, in an ambulatory form, but in practice it is provided predominantly as an outreach service. Thus, we will address below the service as an outreach one.

12 Social Services Act, Section 39.

The **domiciliary service** is an outreach or ambulatory social care service provided to persons with reduced self-sufficiency due to their age, chronic ailment, or disability, and to families with children whose situation requires the assistance from another person.[13] The service provides support in the person's household or in the social services facilities at the specified time. The support includes:

- assistance with the handling ordinary self-care acts;
- assistance with personal hygiene or arranging for personal hygiene conditions;
- provisions of food or assistance with arranging for food;
- assistance with running a household;
- mediation contacts with the social environment.

[13] Social Services Act, Section 40.

INTRODUCTION

Older persons, including older persons with disabilities, are the most institutionalised vulnerable group in the Czech Republic. The extent of their institutionalisation is massive. It is approximately five times the level of institutionalisation of persons with disabilities below 60 years of age and nine times that of children. Even though the exact number is difficult to determine, the estimation is that it exceeds 55 000 persons. According to the 2019 thematic report published by the Czech Statistical Office, "more than two-thirds of clients of residential social services are over 65, specifically 10,5 thousand clients in the age of 66-75, 19,1 thousand clients in the age of 76-85, 21,5 thousand clients in the age of 86-95 and more than 1,5 thousand clients over 95."[14] These data are of 31 December 2017 and since then the number of older clients in residential social care facilities has grown. Women were disproportionately represented. They represented 75 % of clients in residential facilities for seniors and 70 % of clients in special regime facilities,[15] which predominantly institutionalise older persons. It has been reported that 85 % of clients in facilities for seniors and special regime facilities are over 65.[16]

Older persons are institutionalised within two distinct systems: (i) social services, and (ii) health care services. The choice of the system and its institution is often simply a matter of chance. Both systems institutionalise the same groups and overlap significantly. These two systems operate in mutual symbiosis. The unavailability or unaffordability of outpatient health care services may cause an individual's placement in residential social care services, and the unavailability or unaffordability of outreach or even residential social care services may prolong the stay in health care institutions. Yet, there is no coordination or central planning. This creates grey zones where older persons may stay without appropriate safeguards, both substantive and procedural.

Despite this massive institutionalisation, older persons are left outside of the national deinstitutionalisation discourse. Their institutionalisation is commonly considered as 'natural' in a situation when they become dependent on the support of other persons. Due to the population ageing, the demand for social and health care support has been continuously growing while the authorities rely predominantly on the extension of institutional care, either by the renovation and enlargement of existing institutions or the establishment of new ones. The amount of public resources consumed by institutional care for older persons is also growing disproportionately compared to the allocations for its outreach and ambulatory alternatives. The system is primarily institutional.

From the perspective of law, this situation raises serious concerns. Even though there is no international convention on the rights of older persons, the UN Independent Expert on the enjoyment of all human rights by older persons has emphasized that the autonomy standards deriving from the UN Convention on the Rights of Persons with Disabilities (hereinafter "the CRPD") are equally applicable for older persons. These standards undoubtedly contain the right to live

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[14] The Statistical Office of the Czech Republic. Děti se zdravotním postižením a osoby se zdravotním postižením žijící mimo soukromé domácnosti 2018 [Children with disabilities and persons with disabilites living outside the private households 2018], p. 31. The report is available in Czech at: https://www.czso.cz/documents/10180/130887156/26002319.pdf/4285473c-ec3e-4725-bf09-5860ee0f9757?version=1.3 [accessed 11 November 2020].

[15] *Ibid*., p. 32.

[16] *Ibid*., p. 31.

independently and be included in the community (hereinafter "the right to independent living") guaranteed under Article 19 of the CRPD. This right is sometimes understood as a crucial pre-condition and component of personal autonomy and self-determination, two principles governing the CRPD.[17]

The right to independent living guarantees persons with disabilities the right to live in the community, with choices equal to others, and their full inclusion and participation in the community, including by ensuring:

- the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and the right not to be obliged to live in a particular living arrangement;
- access to a range of in-home, residential, and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;
- community services and facilities for the general population available on an equal basis to persons with disabilities and responsive to their needs.

Outside the UN system, the right to independent living has also been recognised by the Council of Europe and its bodies. The European Committee of Social Rights invoked Article 19 CRPD in a decision concerning accessibility of social services by persons with disabilities under Article 14 of the European Social Charter (*hereinafter* "the ESCH").[18] The personal scope of Article 14 of the ESCH is broader than Article 19 of the CRPD because it guarantees access to social welfare services "to those who lack personal capabilities and means to cope".[19] Put differently, it also covers persons who are not disabled. Yet, the aim of Article 14 of the ESCH is to ensure that the support needed to live independently and be included in the community is provided.[20] To achieve it, an essential component of the right guaranteed under Article 14 (1) of the ESCH is required, namely, there must exist a diversity and plurality of social welfare services offered to the eligible persons.[21] If the only suggested solution is to live in an institution, there is actually no choice.[22]

Article 14 of the ESCH is formulated the same way, both in the 1961 European Social Charter as well in its 1996 Revised version. However, the Revised Charter, which has not been ratified by the Czech Republic, includes a provision covering specifically the situation of older persons and thus constituting a special provision to the general Article 14.[23] It is Article 23 of the Revised European Social Charter of 1996 that provides for the right of older (elderly) persons to social protection. It is still relevant for the Czech Republic as it has ratified the Additional Protocol of 1988 containing the very same provision in its Article 4. The Czech Republic thus not only recognizes the right of older persons to social protection – including the right to appropriate measures designed in

17 CRPD/C/GC/5, para. 3, 16 (a) and (c).

18 *Fédération Internationale des Ligues des Droits de l'Homme v. Belgium,* decision on the merits of 18 March 2013, complaint no. 75/2011, para. 113.

19 Digest of the case law of the European Committee of Social Rights, December 2018, p. 155. Available at: https://rm.coe.int/digest-2018-parts-i-ii-iii-iv-en/1680939f80 [accessed 11 November 2020].

20 See the Digest: "The goal of welfare services is the well-being, the capability to become self-sufficient and the adjustment of the individual and groups to the social environment." – *Ibid*., p. 155.

21 *Fédération Internationale des Ligues des Droits de l'Homme v. Belgium,* decision on the merits of 18 March 2013, complaint no. 75/2011, para. 122.

22 *Ibid*., para. 114.

23 *The Central Association of Carers in Finland v. Finland*, decision on the merits of 4 December 2012, paras. 49 and 55.

particular to enable them to remain full members of society for as long as possible, choose their lifestyle freely and lead independent lives in their familiar surroundings for as long as they wish and are able – but is also bound by its content.

The present research does not offer legal arguments on why the institutionalisation of older persons is unlawful. This work is not normative but empirical. It describes the existing situation in the Czech Republic and demonstrates the extent of institutionalisation of older persons. Even though the research builds on the analysis of national legislation and policies, as well as available qualitative and quantitative data, still these data and information are self-explanatory and raise serious concerns about whether the Czech Republic complies with the above-cited human rights standards. What is particularly striking is the absence of choice in both systems, i.e. in social care as well as health care.

Data processing for this research was completed by the end of 2020. Some relevant up-to-date information from the spring of 2021 was then also included in the report.

We cannot exclude that the report may contain some inaccuracies that result from processing large amounts of data. These inaccuracies do not, however, change anything on the described situation and used arguments. Please note that hyperlinks are not static and may have changed since this report was published.

I. NATIONAL LAW

This chapter provides basic information on relevant national legislation. It is divided into three subchapters corresponding to the relevant areas of interest: (1) social services; (2) health care services; and (3) informal care. The subchapters on social services and health care services follow the same structure, bringing information on the legal regulation of (i) fundamental principles governing provision of these services; (ii) availability; (iii) funding; (iv) affordability; and (v) acceptability and adaptability of social services and health care services. The subchapter on informal care provides basic information on existing legal mechanisms of support for informal carers, emphasizing material support.

1.1 Social services

The provision of social services is regulated by Act no. 108/2006 Coll. on social services (*hereinafter* "the Social Services Act") and the following ministerial decree no. 505/2006 Coll., further specifying certain provisions of the Social Services Act.

1.1.1 Fundamental principles

The Social Services Act formulates several principles governing the system of social services, namely the recognition of dignity, autonomy, empowerment, and social integration. These principles are not accompanied by enforceable legal mechanisms and remain declarative (for more information see below chapters 1.1.2 and 4.2).

Under Section 2 (2) of the Social Services Act, *"[t]he extent and form of the assistance and the support provided through social services have to preserve the human dignity of persons. The assistance shall be based on individually determined needs of persons and it has to have an active impact on persons, it has to support the development of their independence, to motivate persons to carry out activities that would not lead to long-term preservation or deepening of their adverse social situation and strengthen their social integration. Social services shall be provided in the interest of persons and due quality, in a manner always strictly ensuring compliance with human rights and fundamental freedoms of persons."*[24]

The Social Services Act divides all types of social services into three categories:[25] (i) social counselling; (ii) social care services; and (iii) social prevention services.

Those social services that provide support to persons who find themselves in a situation of reduced self-sufficiency and thus need support in taking care of themselves, their household, and interacting with their social environment, are *social care services*.[26] They are provided in three forms (i) outreach, (ii) ambulatory, and (iii) residential form.

Section 38 of the Social Services Act specifies that social care services must be provided in the least restrictive environment. The provision reads as follows: *"Social care services assist persons to arrange for their physical and mental self-sufficiency, to enable them integration in the common*

[24] The Social Services Act is available in English in one of its older versions at: https://www.unece.org/fileadmin/DAM/pau/_docs/age/2007/AGE_2007_MiCA07_CntrRprtCZEAdd3_e.pdf [accessed 2 November 2020]. Even though it has been amended since the publication of the translation, the amendments did not concern the cited provisions.

[25] Social Services Act, Section 32.

[26] Social Services Act, Section 38.

social life to the maximum possible extent and, in the case that their health condition excludes such possibility, to arrange for them the dignified environment and treatment. Everyone has the right to be provided with social care services in the least restrictive environment."[27]

The principle of the "least restrictive environment" was introduced in January 2012 by amendment no. 366/2011, with an aim to ensure implementation of Article 19 of the CRPD.[28] However, as data show, this amendment has had no practical impact and the right to independent living has not been being implemented.

1.1.2 The availability of social services

Self-governing regions play a crucial role in ensuring the availability of social care. In the Czech Republic, there are 13 self-governing regions (hereinafter "regions"). The capital city of Prague has the status of a region as well, for the purposes of a social care system.[29] In our analysis, we consider Prague as the 14th region.

The Social Services Act provides that regions are responsible for ensuring the availability of social services in their territory.[30] They are under an obligation to adopt a so-called "mid-term social services development plan" which has to result from cooperation with other stakeholders, namely municipalities in the region's territory and representatives of social services providers, as well as clients of social services.[31] Every region is also required to monitor the implementation of the plan. It must be evaluated jointly with representatives of municipalities, social services providers, and clients.[32] The MoLSA is informed about the implementation.[33]

The mid-term social services development plan is adopted for 3 years and may be accompanied by specifying action plans adopted for 1 year.[34] The Social Services Act provides for only a general definition of the plan's content.[35] In accordance with the amendment to the ministerial decree no. 505/2006 Coll., effective since 1 January 2018,[36] the mid-term social development plan has to contain a descriptive part, an analytical part, an evaluative part concerning the previous mid-term plan, a strategic part, and a part describing the method of arranging for the net of social services.[37]

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27 The last sentence is not included in the English translation of the Social Services Act referred to in the note no. 13 since it was adopted later.

28 Explanatory report to the Amendment no. 366/2011 Coll.

29 The position of the capital city of Prague is regulated by a separate law which grants it at the same time the position of a municipality and a region.

30 Social Services Act, Section 95 (g).

31 Social Services Act, Section 95 (d).

32 *Ibid*., Section 95 (e).

33 *Ibid*., Section 95 (f).

34 *Ibid*., Section 3 (h).

35 "For the purposes of this Act, the following shall be understood to mean (…) mid-term social services development plan a strategic document of a community or region adopted for 3 years which is the result of the process of active determination of persons' needs within a municipal or regional territory and search for manners of their satisfaction while using available resources; the content of the plan comprises the summary and outcomes of background analyses and data, description of the plan's elaboration, including determination of cooperation with municipalities, social services providers and social services clients, description and analysis of available resources and needs of social services clients, including economic evaluation, strategy for arranging for and development of social services, including description of the future desired state and measures to achieve this state, obligations of participating entities, the process of monitoring and evaluation of the plan's implementation, including the process of imposing changes in the social services provision and arranging for the net of social services in the region's territory; the mid-term social services development plan may be completed by action plans deriving from the mid-term social services development plan, processed for the period of one year."

36 Amendment no. 387/2017.

37 Ministerial decree no. 505/2006 Coll., § 39a (1).

None of these provisions governing planning provide any reference to deinstitutionalisation or preference for other forms of social services aside from the institutional one (for more information see chapter no. 4.2).

1.1.3 Funding of social services

The system of social services is built on multi-source funding. Social services are funded by:

- Clients of social services in the form of payments for their provision;
- State subsidies;
- Subsidies provided by the maintainer of the service. In the case of public maintainers, these financial resources are part of public funds;
- Other resources, such as donations, contributions by foundations, legal entities or individuals, etc.

State subsidies are provided by the MoLSA on an annual basis. The MoLSA transfers a certain amount from the state budget to regions which consequently allocate these resources to concrete social care providers. It is based on the decision of the regional assembly.[38] There are no qualitative requirements as to which social services can or should be supported by these subsidies, except for the requirement of registration in the registry and the provider's insertion into the region's net of social services.

The Social Services Act further enables the MoLSA to directly allocate financial resources from the state budget to support:

- social services of national or supra-regional nature;
- development activities such as education and training of workers employed in social services; and
- in case of extraordinary situations (natural disasters; ecological or industrial accident, etc.).[39]

The Social Services Act explicitly sets forth that in the listed cases the financial resources may be allocated also through ESIF funds programmes and other EU programmes.[40]

1.1.4 The affordability of social services

The Social Services Act further regulates the provision of material support to persons who are in a situation of reduced self-sufficiency or complete dependency on the support of others. This material support takes the form of the *care allowance*. Concrete amounts differ and depend on the person's "level of dependency". There are four levels, while the last two (the third and the fourth) are further divided into two subcategories depending on whether the person is supported by residential social services or by another form of support. Table no. 1 gives an overview of these amounts.

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38 Social Services Act, Section 101a.

39 Ibid., Section 104 (1) and (3).

40 Ibid., Section 104 (4).

Table no. 1: Care allowance for people over 18

Level of dependency	Care allowance amount	
	CZK	EUR[41]
1st	880	32,3
2nd	4 400	161,5
3rd for persons provided with residential social care services	8 800	323
3rd for persons provided with other forms of support	12 800	469,7
4th for persons provided with residential social care services	13 200	484,4
4th for persons provided with other forms of support	19 200	704,6

Source: *Social Services Act*

Viewed from the perspective of the right to independent living, the legal construction of the care allowance may be problematic, since it is built predominantly on the functional model of self-sufficiency and, therefore, does not take into account the support these persons need for their interaction with a natural environment.[42]

Further, even though the primary aim of the care allowance is to support the person in the use of social services, there is no adequate linkage between its amount and the price for social services provision. It exists in the Social Services Act only for residential social care services[43] and not for outreach or ambulatory services. Concerning outreach and ambulatory social care services, the only mechanism to ensure their affordability is the regulation of their maximum price in the ministerial decree no. 505/2006. However, not even the maximum price reflects the amount of the care allowance a person is entitled to receive. To give a concrete example, in the fourth level of dependency (full dependency) the care allowance is 19 200 CZK. It covers as much as 147,7 hours of support per month of personal assistance or domiciliary service (considering

41 We use the Exchange rate of the European Central Bank for 30 October 2020: EUR 1 = 27,251 CZK.

42 Following section 7(2) of the Social Services Act the person is entitled to the care allowance if, due to her long-standing adversary health condition, she needs assistance in coping with basic necessities of life. The ministerial decree no. 505/2006 Coll. then gives in section 1 (4) a functional definition of inability to cope with basic necessities of life when determining this inability as "a state when the functional abilities disorder reaches the level of full or serious disorder and despite the use of the person's preserved potentialities and competencies and commonly available aids, resources, daily necessities or household equipment, public spaces equipment or health products the person cannot manage the necessity of life in an acceptable standard. The inability to manage basic necessity of life covers also the state when the regime ordered by a specialized doctor providing specialized health services does not enable to manage the necessity of life in an acceptable standard. The acceptable standard is managing basic necessities of life in such a quality and manner that are common and usual and that enable to manage the necessity without daily support of another person."

43 Except for supported housing which is a residential social care service that is often conceived as an alternative to institutional care. The price for care provided by the service of protected housing is the same as in the case of personal assistance and domiciliary service (130 CZK – 4,8 EUR) while the person using this service needs to pay also for housing and in certain cases also for food provided to her by the service. The costs of housing and food do not necessarily need to reflect the financial situation of the person even though in the case of other social care facilities, like the above-mentioned facilities providing 24-hour care during the whole year, such a mechanism exists and the person is guaranteed that he/she will be never be obliged to pay more than such an amount that leaves him/her with 15 % of his/her income. A similar mechanism exists also in the case of week care centres with respect to which the law requires to leave the person with at least 25 % of his/her income – see the Social Services Act, section 73 (3).

the maximum price[44]).[45] In other words, a person that is granted the maximum care allowance, and thus recognized as being fully dependent on the support of other persons,[46] can pay only for 9 days of 16 hour-a-day support, or 18,5 days of 8 hour-a-day support. If the person who is fully dependent on the support of others would like to use personal assistance every day, which is indeed an understandable requirement, the existing amount of the care allowance would suffice to cover only 5 hours a day.[47] Table no. 2 gives a more detailed overview of the extent of outreach social service that can be purchased by the care allowance within different levels of dependency.

Table no. 2: The extent of outreach services that can be purchased by the care allowance

Degree of dependency[48]	Extent of outreach services to be purchased[49]		
	Hours	Days (8 hours of support a day)	Days (16 hours of support a day)
1st	6,77	0,85	0,42
2nd	33,85	4,23	2,12
3rd	101,54	12,69	6,35
4th	147,69	18,46	9,23

Source: *Social Services Act; Ministerial Decree no. 505/2006 Coll.*

The costs of housing and food do not necessarily need to reflect the financial situation of the person concerned. In the case of social care facilities, like the above-mentioned facilities providing

[44] 130 CZK (4,8 EUR) per hour. Concerning the domiciliary service, there may be extra costs for food, food delivery, big shopping (like weekly shopping), and for clothes washing.

[45] It is to be noted that the degree of dependence and thus also the amount of the care allowance is determined on the basis of the person's functional abilities rather than the support the person needs to live independently – see the ministerial decree no. 505/2006 Coll., § 1 (4), defining the inability to manage basic necessities of life as follows: "a state when the functional abilities disorder reaches the level of full or serious disorder and despite the use of the person's preserved potentialities and competencies and commonly available aids, resources, daily necessities or household equipment, public spaces equipment or health products the person cannot manage the necessity of life in an acceptable standard. The inability to manage basic necessity of life covers also the state when the regime ordered by a specialized doctor providing specialized health services does not enable to manage the necessity of life in an acceptable standard. The acceptable standard is managing basic necessities of life in such a quality and manner that are common and usual and that enable to manage the necessity without daily support of another person."

[46] The person in the fourth degree of dependency is defined by the law as a person who is not able to manage his/her nine or ten basic necessities of life and requires, therefore, everyday support, supervision or care of another person [Act no. 108/2006 Coll. on social services, § 8 (2) (d)]. The Annex no. 1 to the ministerial decree no. 505/2006 Coll. determines basic necessities of life as follows:

Mobility; Orientation; Communication; Eating; Dressing and footwear; Body hygiene; Excreting; Care for health; Personal activities; Care for household.

[47] Value for a 30-day month. It is to be noted that the National Strategy for the Development of Social Services 2016-2025 mentions itself that "especially for higher degrees of dependence the amount of the care allowance does not correspond to the real needs related to the care for such persons. Although it corresponds to the concept of this allowance which has been really created as a "contribution" and not a social benefit to cover the whole care, this concept is currently proving insufficient. There are no effective tools that would ensure covering real costs to the client incurred in connection with the provision of the social service and the same applies to providers of social services." – see The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 22. The Strategy is available in Czech at: https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [cited 1 October 2020].

[48] For the third and fourth degree we calculate only with the amount the person is granted in case she is not supported by residential social care services.

[49] We calculate the values using the maximum price for one hour of personal assistance or domiciliary service as regulated by the ministerial decree no. 505/2006 Coll.

24-hour care during the whole year, such a mechanism exists and the person is guaranteed to receive housing and food, even if she cannot cover the full price. Moreover, she must be left 15 % of her income.[50] Thus, the system provides some safeguards, however only within the institutional care.

1.1.5 The acceptability and adaptability of social services

The Social Services Act provides for an obligation on social services providers to plan the course of social services provision according to the client's personal aims, needs, and skills, and its evaluation jointly with the client, if possible, given her health condition and type of social service provided, or in the presence of a guardian.[51]

The Czech legislation does not provide for any requirements on the maximum number of clients per one social worker or worker providing direct support to the client (so-called "worker in social services"), or on the material and technical conditions of social services. The MoLSA tried to fill in the legislative gap in 2016 and issued a recommendation on the "material and technical standard for social care services provided in the residential form"[52]. The recommendation is not binding and may play a role only in subsidy programmes, except for the main financial State subsidies allocated to social services providers via regions (see above chapter 1.1.3).

1.2 Health care services

There are two systems of support for older persons, and especially for older persons with disabilities (who are primarily affected by such systems), that may lead to their institutionalisation: the social and health care systems. Both systems target almost identical individuals, they overlap significantly, and the institutionalisation, within the former or the latter, is often a question of chance.[53] There are two acts regulating health care services. The act no. 372/2011 on health care services and conditions of their provision (*hereinafter* "the Health Care Act"), and the act no. 48/1997 on public health insurance (*hereinafter* "the Public Health Insurance Act"). The former regulates conditions under which health care services are provided, as well as the relationship between health care providers and patients. The latter regulates structural issues, including the question of responsibility for the availability of health care services.

1.2.1 Fundamental principles of health care services

The Health Care Act contains provisions on the qualifications of health care professionals and technical equipment.[54] It introduces a list of patients' rights. The right to informed consent has a prominent place.[55] The Act further sets forth, *inter alia*, these rights:

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50 A similar mechanism also exists in case of week care centres with respect to which the law requires to leave the person with at least 25 % of his/her income.

51 Social Services Act, Section 88 (f).

52 Recommendation no. 2/2016, available in Czech at: https://www.mpsv.cz/documents/20142/225517/Doporuceny_postup_Materialne_technicky_standard.pdf/cefaea04-4b3d-ed52-e383-4ebbd7609f96 [accessed 2 November 2020].

53 The National Strategy for the Development of Social Services 2016-2025 mentions that due to inadequate legal regulation, the target groups of both segments of care may overlap significantly. – see The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 24. The Strategy is available in Czech at: https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [accessed 1 October 2020].

54 The Health Services Act, section 11.

55 *Ibid*., section 28 (1).

- to respect, dignified treatment, thoughtfulness, and respect for privacy when being provided with health care services considering the nature of these services;[56]
- to choose a health care provider that is entitled to provide health care services corresponding to the patient's health condition and the provider's facility.[57]

The law does not contain any legal provision preferring outreach and ambulatory forms of health care. It provides for neutral definitions of different forms of health care services,[58] including the definition of long-term residential care and care provided in the patient's natural environment. Long-term residential care is defined as care that *"is provided to the patient whose health condition cannot be significantly improved through health-care and is deteriorating without constant provision of nursing care; …"*.[59]

Health care can also be provided in the patient's natural environment and may take three forms:

1 visiting service by the patient's general practitioner;[60]
2 home care, understood as nursing care, medical rehabilitation care, or palliative care;
3 provision of artificial lung ventilation or dialysis.[61]

The Health Care Act provides for limitations and conditions to these forms. Concerning visiting service by the patient's general practitioner, the law presumes that it is provided particularly in cases when the patient is not able, due to her health condition, to come to the health care facility. Further, the health care to be provided must be eligible for home provision.[62] The other two outreach forms are possible only if the health care to be provided does not require such technical or material equipment, that is available only in health facilities.[63]

Amendment to the Health Care Act no. 290/2017, effective since 1 January 2018, introduced a new form of a long-term health care service, "hospice". The hospice *"is understood as a provider that provides health care to terminally ill patients in the terminal state in special residential health care facilities of hospice nature or the patient's natural social environment."*[64]

The Health Care Act understands "the patient's natural environment" broadly. It includes also residential social care facilities,[65] and not necessarily only the patient's home.

1.2.2 The availability of health care services

The responsibility for ensuring the availability of health care services is regulated by the Public Insurance Act. The law understands the availability of health care services in terms of accessibility, both local and temporal. Responsibility for ensuring availability is placed on the shoulders of public and private health care insurance companies. Participation in public health insurance is mandatory for all. The law further defines those groups, which do not pay, and their insurance is covered by the State. Namely, the law provides:

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56 *Ibid*., section 28 (3) (a).

57 *Ibid*., section 28 (3) (b).

58 *Ibid*., sections 6 – 10.

59 *Ibid*., section 9 (2) (d).

60 Especially in case the patient is not able, due to her health condition, to come into the health facility.

61 *Ibid*., section 10 (1) and (2).

62 *Ibid*., section 4 (2).

63 *Ibid*., section 10 (3).

64 *Ibid*., section 44a.

65 *Ibid*., section 4 (3).

"Health insurance companies are obliged to ensure to their insured persons

a l*ocal accessibility of covered services. Local accessibility shall be understood as an adequate [territorial] distance of the place of covered services provision from the insured person's place of permanent residence or residence. Local accessibility is expressed in terms of travel time. (…) Travel time shall be understood as the time in full minutes which corresponds to the effective accessibility of the place using transport driving at a speed commensurate with the type of the road and compliant with the Act regulating traffic on roads. Travel times are to be determined by the government's regulation,*

*b time accessibility of covered services. Time accessibility shall be understood as ensuring the provision of emergency and acute covered services in a time corresponding to their urgency. Deadlines expressing time accessibility are to be determined by the government's re*gulation."[66]

The Public Insurance Act does not determine any qualitative criteria for health care providers. There is neither the "least restrictive environment principle", nor a preference to ensure health care services in a patient's home or her natural environment.

1.2.3 Funding of health care services

The main source of funding is the public health insurance scheme.[67] Health insurance companies are key players. They negotiate contracts with health care providers and the health care, covered by public health insurance, is provided on the basis of these contracts.[68] Individual contracts must respect the framework contract. The framework contract is concluded between health insurance companies and associations of health care providers, representing different branches of health care. The framework contract is reviewed by the Ministry of Health. The ministry assesses its compliance with the legislation and the public interest in ensuring the quality and availability of health care services, as well as the functioning of the whole health care system, including its stability, and taking into account the financial possibilities of the public health insurance. If the Ministry finds the framework contract compliant with both the legislation and the public interest, it issues the contract as a ministerial decree. If it does not, it decides by itself in the form of a ministerial decree.[69]

The extent of health care covered by the public health insurance is determined based on a list. The list provides for so-called "health acts" [in Czech *zdravotní výkony*]. These are evaluated by points with certain values. The point values are subjected to negotiations between the representatives of public health insurance company [in Czech *Všeobecná zdravotní pojišťovna*], private health insurance companies, and representatives of relevant professional associations. The process is practically identical to that of the framework contract. The negotiation outcome

66 The Public Insurance Act, section 40 (7).

67 In the Country Health Profile 2019 on the Czech Republic, the OECD mentions that "public spending accounts for more than 80 %, which is among the highest in the EU. Nevertheless, out-of pocket spending, mainly from cost-sharing, has slightly increased from 2015-2016. Outpatient (or ambulatory) care absorbs most health funding followed by inpatient care, together reflecting a dense provider network and a high level of utilisation." – see OECD. Czech Republic: Country Health Profile 2019, p. 9. Available at: https://www.oecd-ilibrary.org/docserver/058290e9-en.pdf?expires=1604402547&id=id&accname=guest&checksum=3225DF317E5BF65225FB470EBE7AEF79 [accessed 3 November 2020].

68 The Public Health Insurance Act, section 17 (1).

69 *Ibid*., section 17 (2).

is submitted to the Ministry of Health. The ministry assesses compliance with the law and the public interest and either issues it in the form of its decree or decides by itself, again, in the form of its decree.[70]

The system does not guarantee that health insurance companies cover all the real expenses. Due to the existing points values, the covered expenses do not necessarily have to reflect reality. The home care providers have pointed out that they have to cover approximately 40 % of their actual expenses from their own sources since these cannot be covered by public health insurance.[71]

Further, the funding does not depend on direct contributions by patients or their families. This circumstance may lead to a situation when patients and their families prioritise health care services over social care services. This situation has been recognised as a structural problem in the National Strategy for the Development of Social Services 2016 – 2025.[72] The prioritisation of health care services may have serious adverse impacts since health care services employ significantly fewer nursing staff than social care services.[73]

1.2.4 The affordability of health services

The affordability of health care services depends on whether the health care services provider has a contract with the patient's health insurance company. The largest health insurance companies usually have a fairly broad net of health services providers and affordability is not an issue.

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70 *Ibid*., section 17 (4) and (5).

71 Reportage by the Czech Public Broadcast, published on 3rd July 2019, available in Czech at: https://www.irozhlas.cz/zpravy-domov/domaci-pece-charita-spor-petice-finance-penize-rozpocet-nedostatek_1907031753_mpr [accessed 3 November 2020].

72 The National Strategy for the Development of Social Services 2016-2025 mentions that placing a person that is dependent on the support of other persons in social care facilities requires significantly higher co-funding either by the client herself or her family, while hospitalisation is much cheaper, without any direct payments to the hospital. "As a consequence, this situation causes that for the non-self-sufficient person and her family it is the most advantageous solution to stay as long as possible in the health care setting what is, however, more costly." The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 25. The Strategy is available in Czech at: https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [accessed 1 October 2020].

73 In its Report on Dementia 2016 the Czech Alzheimer Society highlights that according to the last available data, the data of 2013, the average hospitalisation of persons with dementia lasted 78 days, which is according to the data published by Eurostat the lengthiest average hospitalisation among all EU Member States while in other states the most common length was 20 days. The Czech Alzheimer Society further draws attention to the fact that health facilities do not have enough auxiliary nursing staff who would be able to provide support to persons with reduced self-sufficiency. These persons thus stay placed in the hospital environment in their bed with all the consequences that may be particularly negative for persons with dementia. – see Czech Alzheimer Society. Report on Dementia 2016, pp. 20 and 32. The Report is available in Czech at: http://www.alzheimer.cz/res/archive/004/000480.pdf?seek=1492589048 [accessed 6 October 2020].

Table no. 3: Examples of home care providers rates if not covered by public health insurance[74]

Provider		Rate (CZK)	Rate (EUR[75])
Cesta domů[76]		100[77]/200 per hour	3,67/7,34
Agentura domácí péče LUCI[78]		400 per hour[79] + 150 transport fee	14,69 + 5,5
Středisko sociálních služeb města Kopřivnice[80]		240 per hour	8,81
ProCare Medical[81]	Intensive care by nurse	500 per hour	18,35
	Standard care by nurse	400 per hour	14,68
	Support in self-care	300 per hour	11
Centrum sociální a ošetřovatelské pomoci[82]		340 per hour	12,45

However, the situation of home care providers may differ. To cover the expenses of home care by the public health insurance, a patient needs a recommendation from her general practitioner, the physician responsible for her care during the hospitalization or, when the person is terminally ill and should be provided with palliative care, a specialist.[83] If the patient does not have such a recommendation, she must cover the expenses. Moreover, home care providers have pointed out that the extent of home care covered by public insurance usually does not exceed 3 hours a day.[84] The rate for home care, if provided without a recommendation, is not regulated. Table no. 3 provides several examples of these rates.

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74 We use only the basic rate and do not take into account different surcharges, for instance for provision of home care at night (which can constitute for instance 50% of the basic rate).

75 We use the Exchange rate of the European Central Bank for 30 October 2020: EUR 1 = 27,251 CZK (available at: https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-czk.en.html) [accessed 2 November 2020].

76 Leading provider of mobile hospice services in the Czech Republic, providing services in the capital city of Prague. Information available in Czech at: https://www.cestadomu.cz/sites/default/files/cenik_sluzeb_prime_pece_cd_06_2020_.pdf [accessed 3 November 2020].

77 Rate for citizens of one part of the capital City of Prague.

78 Information available in Czech at: http://www.lusi.cz/cenik/ [accessed 3 November 2020].

79 The minimum extent of the service provision is 30 minutes for 200 CZK/7,34 EUR + 150 CZK/5,5 EUR transport fee.

80 Information available in Czech at: http://sssmk.cz/domains/sssmk.cz/old/download/cenikZP.pdf [accessed 3 November 2020].

81 Information available in Czech at: https://www.procare.cz/uhrady/ [accessed 3 November 2020].

82 Information available in Czech at: https://www.csop10.cz/nase-sluzby/terenni-sluzby/domaci-zdravotni-pece/cenik.aspx [accessed 3 November 2020].

83 The Public insurance Act, section 22 (a).

84 Information available on the website of one home care provider in the Středočeský region (Central-Bohemia Region); see: https://www.homecare.cz/#msg-box8-e [accessed 3 November 2020].

1.2.5 The acceptability and adaptability of health care services

In the health care system, there is no limitation on the capacity of the institution or any other regulation on technical and material parameters, except for professional medical standards related directly to the provision of health care.[85]

The law does not presume that health care services become surrogate homes for their patients. There are no safeguards to prevent long-term institutionalisation. The law does not regulate the quality of services, e.g. from the viewpoint of patients' empowerment or their relationships with the world outside the facility. From this perspective, patients in long-term health care institutions are in a more precarious situation compared to those who are institutionalised in social care institutions.[86] There is no obligation to create an individual social care plan, or any planning of social integration.

The law stipulates minimum requirements concerning numbers and qualifications of health professionals. These requirements focus exclusively on expert medical issues. Social work competencies are irrelevant. The annex no. 3 to the ministerial decree no. 99/2012 on requirements on minimum staffing of health care services mentions the social-health worker or social worker in the area of long-term care only in relation to patients who require long-term intensive nursing care. The decree clearly states the numbers of medical and nursing staff on the basis of beds. The situation differs in relation to social-health workers or social workers. The decree only has requirements ensuring their availability, without any determination of the minimum number and regardless of the facility's capacity. As a consequence, social workers are significantly underrepresented in health care facilities.[87]

1.3 Informal care

In the Czech Republic, the absence of legislation providing specific support to informal carers[88] has been a concern for many decades. Informal carers have been dependent on the care allowance received by their relatives to whom they provide support. In many cases, it became the main source

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85 Ministerial decree no. 92/2012 Coll. on requirements on minimum technical and material equipment of health facilities and home care contact points.

86 Ministerial decree no. 99/2012 Coll., on requirements on minimum staffing of health services, Annex no. 3, point 4.4.

87 The long-term care department of Motol University Hospital employs four social workers for 281 clients. – Information obtained from the presentation video available in Czech at the Hospital's website: http://www.fnmotol.cz/kliniky-a-oddeleni/cast-pro-dospele/lecebna-dlouhodobe-nemocnych-ldn-i/ [accessed 5 November 2020].

88 There are no exact data on the number of families that ensure care for their older relatives who become dependent on their support to be able to stay in their home and not need to be institutionalised, either in social care or health settings. According to the OECD, the Czech Republic is the country with the highest number of informal carers in the age group over 50. Nearly 20 % of persons belonging to this age group provide informal care at least weekly, whereas the percentage of those who provide informal care daily is 11,6 %, which is also the highest among the EU member states. - OECD: Health at a Glance 2019: OECD Indicators. Informal Carers. Available at:https://www.oecd-ilibrary.org/sites/a80d9f62-en/index.html?itemId=/content/component/a80d9f62-en [cited 9 October 2020].

The Czech Alzheimer Society points out its Report on Dementia 2016 that "according to the OECD 70-90% of all long-term care providers are informal carers. In the yearbook of the European Alzheimer Society is the number of persons with dementia in the Czech Republic cared for by informal carers estimated at 100 thousand, which corresponds to the lower number of the cited interval." - Czech Alzheimer Society. Report on Dementia 2016, p. 25. The Report is available in Czech at: http://www.alzheimer.cz/res/archive/004/000480.pdf?seek=1492589048 [cited 19 October 2020].

However, the total number of informal carers is even higher – the National Strategy for the Development of Social Services for 2016-2025 estimates this number between 250 and 300 thousand informal carers. - The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 24. The Strategy is available in Czech at:

https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [cited 19 October 2020].

of income for the entire household. This situation has resulted in the care allowance not being used to purchase professional social services and in older persons, including those with disabilities and including their relatives, facing deepened social isolation and aggravated risk of poverty.

The Government intended to change the situation by an amendment to act no. 187/2006 on sickness insurance,[89] effective of 1 June 2018. Yet they obviously failed. The Amendment introduced a new type of sickness insurance allowance called "long-term caregiver's allowance" [in Czech dlouhodobé ošetřovné]. The allowance is designated for employees or self-employed persons who take care of a relative after her hospitalisation that lasted more than 7 days,[90] under the condition that the relative is assessed as needing further care for at least 30 days.[91] The assessment is carried out by the hospital doctor responsible for the care during the hospitalisation. The limit of the allowance is set at 60 % of the informal carer's salary,[92] and it may be provided for the maximum period of 90 days.[93] During this period, the person cannot be dismissed from work[94] and her position is guaranteed.[95]

There are several issues of concern. First, legal conditions are narrowing the group of allowance beneficiaries. The allowance is designated only for those who have been employed or self-employed at the time when they started caring. This condition by itself can make many persons ineligible, despite their objective need for material support. Second, even though explicitly called "long-term", it is actually "short-term". The allowance is designed to cover only a short period necessary to find an alternative solution. The explanatory note to the amendment is explicit. It states that "the proposed legal regulation … addresses for a temporary period the long-term need to care ..."[96]

The third restrictive condition concerns the supported relative. The requirement of the previous hospitalisation means that the allowance targets those whose health condition deteriorated immediately to such a degree that they required acute residential health care. The explanatory report to the amendment is again explicit. It mentions that the objective is to tackle situations when a relative or another close person suffers an immediate deterioration of her health condition,[97] typically due to an injury or heart attack.[98] Others, whose health condition deteriorated progressively, are very likely to drop out of the target group of the allowance. It is also remarkable that in January 2019 the Minister of Labour and Social Affairs, Ms Jana Maláčová, plainly mentioned that the allowance has not been designed for those who care for their dying relatives or close persons, or for those who need palliative care.[99] Ms Ruth Šormová, a hospice director, noted half a year after the amendment had entered into effect that in that period they had provided care to 180 terminally ill-persons, while not a single family has benefited from the allowance.[100]

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89 Act no. 310/2017 Coll.

90 Act no. 187/2006 Coll. on sickness insurance, § 41a (2) (a).

91 *Ibid*, § 41a (2) (b).

92 Act no. 187/2006 Coll. on sickness insurance, § 21 (1) (a).

93 *Ibid*., § 41a.

94 Act no. 262/2006 Coll., the Labour Code, § 53 (1) (f).

95 Act no. 262/2006 Coll., the Labour Code, § 47.

96 The explanatory report to the Act no. 310/2017 Coll. is available in Czech at: ttps://www.psp.cz/sqw/text/tiskt.sqw?o=7&ct=1029&ct1=0 [cited 8 October 2020].

97 *Ibid*.

98 Information provided directly by the Minister of Labour and Social Affairs, Jana Maláčová, to the Czech Television for the purpose of the reportage broadcasted on 13 January 2019. The reportage is available in Czech at: https://ct24.ceskatelevize.cz/domaci/2704871-cast-lidi-na-dlouhodobe-osetrovne-nedosahne-zjistili-po-pul-roce-poslanci [cited 8 October 2020].

99 *Ibid*.

100 *Ibid*.

II. THE EXTENT OF INSTITUTIONALISATION - SOCIAL CARE SERVICES

In this part, we introduce an overview of the extent of institutionalisation within the system of social care services, relying on available official statistical data. First, the information about the size of social care facilities is presented in order to demonstrate their predominantly institutional character (2.1). Further, statistical data mapping the development of social care services over time – both residential (2.2) and outreach (2.3) – enable us to make a comparison between the extent of institutional and community-based services to show that the State clearly favours the institutional form to the detriment of its outreach alternatives. And finally, in the last part (2.4) we show concrete examples of several institutions. These institutions that are presented in this report are among the largest in the Czech Republic. They together house thousands of older people and older people with disabilities, and, as is apparent from photographs, they are territorially segregated, located on the outskirts of cities.

2.1 Size of facilities

The existing system of care for older persons dependent on the support of others is built predominantly on residential services. These services can be described as *institutions*. The average capacity of facilities for older persons is 70 clients per facility; for special regime facilities (where mainly older persons are institutionalised) as well as for facilities for people with disabilities (where adults with mental disabilities are typically placed) the average capacity reaches nearly 60 clients per facility. Regions are the most common founders and maintainers of institutions. Their institutions house, on average, even more persons – nearly 90 clients per facility in the case of *facilities for seniors* and more than 60 clients per facility in the case of *special regime facilities* and *facilities for people with disabilities*. Table no. 4 provides data on the number of facilities and their capacity. Table no. 5 gives information on the average capacity of residential social care facilities. In both tables, the data are disaggregated by the maintainer of the facility.

Table no. 4: The total number of social care facilities and their capacity[101]

	State facilities		Regional facilities		Municipal facilities		Church facilities		Other facilities	
	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds	Facilities	Beds
Facilities for PWDs	5	626	142	9 405	26	1 099	14	295	17	429
Facilities for seniors	0	0	177	15 655	167	13 765	65	2 404	115	4 864
Special regime facilities	0	0	125	7 540	74	4 552	23	678	127	7 779

Source: *MoLSA*

[101] Data from the Statistical Yearbook of the MoLSA 2019, table no. 6.4. Available in Czech at: https://www.mpsv.cz/documents/20142/975025/Statisticka_rocenka_z_oblasti_prace_a_socialnich_veci_2019+%281%29.pdf/9da5cc00-7d78-7caa-6bf2-01eeccdeabd7 [accessed 4 November 2020].

Table no. 5: Average capacity of social care facilities

	State facilities	Regional facilities	Municipal facilities	Church facilities	Other facilities	Total Average
Facilities for persons with disabilities	125,2	66,2	42,3	21,1	25,2	58,1
Facilities for seniors	0	88,4	82,4	37	42,3	70
Special regime facilities	0	60,3	61,5	29,5	61,3	58,9

Source: *MoLSA*

It is to be emphasised that these numbers are average numbers. There are many complex institutions, operating as large complexes of different facilities, housing together hundreds of people in different types of facilities in one place – either in one building or in one area. Approximately[102] there are 10 facilities for older persons who are dependent on the support of others – *facilities for seniors and special regime facilities* – that exceed a capacity of 300 clients, 29 with a capacity of 200-299 clients, and 176 with a capacity of 100-199. On the other side, only four facilities have a capacity lower than 9. Only 45 facilities have a capacity of 10-19, and there are 48 facilities with a capacity of 20-29.

Table no. 6: Capacity of *facilities for seniors and special regime facilities* - I

	Prague	**Středočeský Region**	**Plzeňský Region**	**Karlovarský Region**	**Jihočeský Region**	**Liberecký Region**	**Ústecký Region**
> 300 clients	0	1	1	0	0	0	1
200-299 clients	6	4	2	0	2	1	2
100-199 clients	10	24	9	6	10[103]	7	21
50-99 clients	11	33	12	7	22	9	18
30-49 clients	14	16	4	7	10	6	9
20-29 clients	2	5	3	3	2	1	4
10-19 clients	4	4	4	1	1	1	7
5-9 clients	2[104]	0[105]	0	0	0	0[106]	1
1-4 clients	0	0	0	0	0	0	0

Source: *MoLSA*

[102] The data may not be completely accurate. We tried to identify the cases when the services are provided in the same building or area as other residential social care services, but it is possible that we did not manage to capture all such cases. Furthermore, we took into account only those residential services that are provided during the whole year, 24 hours a day, 7 days a week and that should, therefore, become for the accommodated persons their new home. Finally, we gathered the data going through the register one service by one and this process as such might have generated slight mistakes caused by the human factor. Nevertheless, the gathered data are still able to give a general overview of the structure of the whole system of residential services for older persons who are dependent on the support of other persons in the Czech Republic.

[103] We did not include the special regime facility Domov Libníč a Centrum Sociálních služeb Empatie with a capacity of 113 clients since it seemed to be designed for a different target group than older persons.

[104] One special regime facility with a capacity of 8 beds (Domov NAUTIS Bohnice) is not included since they provide services to clients up to 64 years of age. These facilities are maintained by Nautis: National Institute for Autism.

[105] One special regime facility with a capacity of 8 beds (Domov NAUTIS Libčice) is not included since they provide services to clients up to 64 years of age. These facilities are maintained by Nautis: National Institute for Autism.

[106] We did not include two special regime facilities – Domov Maxov with a capacity of 8 clients and FOKUS Liberec, o. p. s. with a capacity of 9 clients since these services did not seem to be designed for older persons.

The total number of facilities with a capacity below 49 is approximately 206. That is a little less than one-third of the total number of all buildings and areas providing social care services for older persons who are dependent on the support of others. This number practically equals the number of facilities with a capacity exceeding 100 clients, which also represents nearly one-third of the whole system. Together with facilities with a capacity of over 50 clients, they represent more than two-thirds of the total number of all facilities. For more details see tables no. 6 and 7. These tables provide information on the capacity of *facilities for seniors* and *special regime facilities* disaggregated by regions. Table no. 8 gives an overview concerning the Czech Republic as a whole.

Table no. 7: Capacity of *facilities for seniors* and *special regime facilities* – II

	Královéhradecký Region	Pardubický Region	Vysočina Region	Jihomoravský Region	Zlínský Region	Olomoucký Region[107]	Moravskoslezský Region
More than 300 clients	1	1	0	2	0	1	2
200-299 clients	0	1	0	3	3	5	0
100-199 clients	9	10	14	19	9	7	21[108]
50-99 clients	17	15	14[109]	22	14	17	32
30 – 49 clients	14[110]	1[111]	4[112]	11	11	11	21[113]
20 – 29 clients	2	1	2[114]	4	4	2	13
10-19 clients	4	2	0	3	9	1	4[115]
5-9 clients	0	0	0	0	0	0	1
1-4 clients	0	0	0	0	0	0	0

Source: *MoLSA*

[107] We did not include the facility Vincentinum since it did not seem to be designed for older persons.

[108] We did not include the special regime facility Náš svět, that is part of a facility for persons with disabilities since it did not seem to be designed for older persons.

[109] We did not include the special regime facility Nové Sýkořice since it is designed for persons with substance dependence.

[110] We did not include the special regime facility Na Stříbrném vrchu since it did not seem to be designed for older persons.

[111] We did not include the special regime facility Domov Na Cestě since it did not seem to be designed for older persons.

[112] One facility is part of the Hospital Počátky – Geriatrické centrum [Geriatric Centre] what may make its real capacity much bigger. For more information see: https://www.ldn-pocatky.cz/ [accessed 29 October 2020].

[113] We did not include the special regime facility Benjamin that is designed for children and young persons.

[114] We did not include the special regime facility Domov Jeřabina that is part of a facility for persons with disabilities since it did not seem to be designed for older persons. Furthermore, one facility is part of the hospital and its real capacity is thus much bigger.

[115] We did not include the special regime facility Čtyřlístek since it did not seem to be designed for older persons.

Table no. 8: *Facilities for seniors* and *special regime facilities* in the Czech Republic

<table>
<tr><td>More than 400 clients</td><td>1</td><td rowspan="3">39

5,9%</td><td rowspan="3">215

32,4%</td><td rowspan="4">458

69%</td></tr>
<tr><td>300 – 399 clients</td><td>9</td></tr>
<tr><td>200 – 299 clients</td><td>29</td></tr>
<tr><td>100 - 199 clients</td><td>176</td><td rowspan="5"></td><td rowspan="2"></td></tr>
<tr><td>50 – 99 clients</td><td>243</td></tr>
<tr><td>30 - 49 clients</td><td>139</td><td rowspan="4">206

31%</td></tr>
<tr><td>20 – 29 clients</td><td>48</td><td rowspan="3">67

10,1%</td></tr>
<tr><td>10 – 19 clients</td><td>45</td><td rowspan="3">49

7,4%</td></tr>
<tr><td>5 – 9 clients</td><td>4</td></tr>
<tr><td>1 – 4 clients</td><td>0</td></tr>
<tr><td>Total</td><td>664</td><td colspan="3"></td></tr>
</table>

Source: *MoLSA*

2.2 The growing extent of institutionalisation of older persons

Data shows that the extent of the institutionalisation of older persons is progressively growing. Since 2012, when the "least restrictive environment" principle was introduced in the Social Services Act,[116] only *facilities for persons with disabilities* have decreased in total numbers, as well as in capacity, although this decrease is very low. The reason is probably the limited extent of deinstitutionalisation, accompanied by the lack of community-based services and stable or growing demand for social services. On the other hand, the number and capacity of *facilities for seniors* remained practically unchanged, but the number and capacity of *special regime facilities* have increased significantly. The increase is equivalent to 1.5x as regards the number of institutions, and nearly 2x as regards their capacity (compare table no. 9).

The absence of support for community-based services is demonstrable also by the pattern of distribution of resources. On 6 May 2020, the MoLSA publicly announced its intent to allocate more than 753 million CZK (29,35 million EUR[117]) for constructions, extensions, reconstructions, building modifications of new buildings, and purchasing internal equipment for newly-built capacities. The program should concern *facilities for seniors, facilities for persons with disabilities, special regime facilities, sheltered housing,* and *weekly social care facilities*.[118] Although the call proposal listed

[116] Amendment to section 38 of the Social Services Act.

[117] The Exchange rate of the European Central Bank for 18 October 2019 which was the date of publication of the call for proposals: EUR 1 = CZK 25,659. Available at: https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-czk.en.html [accessed 6 November 2020].

[118] The programme "013 310 Development and Renovation of the Material and Technical Equipment of Social Services 2016-2022". The text of the call for proposals. Available in Czech at: https://www.mpsv.cz/documents/20142/225517/V%C3%BDzva+%C4%8D.3+%281%29.pdf/55161dff-c323-810e-7670-3e1eb3e74c72 [accessed 6 November 2020].

services not exclusively designed for older persons, it was presented by the MoLSA as targeting especially services older persons. Due to the allocation, the capacity of residential social care services should increase by 1174 beds.[119]

Table no. 9: Developments of residential social care facilities in 2012 and 2019[120]

		Facilities for persons with disabilities		Facilities for seniors		Special regime facilities	
		2012	2019	2012	2019	2012	2019
Number of services		212	204	480	524	210	349
Number of places		13 820	11 854	37 477	36 688	10 740	20 904
Number of clients[121]		13 597	11 472	35 859	35 275	9 390	19 833
Total expenses of social services[122]	CZK	4 865 729	6 948 209	10 198 854	15 558 982	3 343 902	9 735 335
	EUR[123]	193 460,7	273 465,4	405 505	612 365,5	132 953	383 160,2
Amount of finances allocated for these services in the form of public subsidies[124]	CZK	1 980 066	3 868 082	2 819 975	5 720 204	905 997	2 939 644
	EUR[125]	78 727,1	145 075,6	112 121,8	225 134	36 022,3	115 697,6
Number of unsatisfied applications		2 931	3 228	59 028	60 643	15 261	26 145

Source: *MoLSA*

[119] Press release of the MoLSA, published on 6 May 2020. Available at: https://www.mpsv.cz/documents/20142/1248138/06_05_2020_TZ_Rozvoj_a_obnova_socialnich_sluzeb.pdf/71ecd1fa-5eec-2b7c-e344-33d7da2d20c2 [accessed 6 November 2020].

[120] Data from the Statistical Yearbook of the MoLSA 2012, table no. 6.6. Available in Czech at: https://www.mpsv.cz/documents/20142/372765/rocenka_2012.pdf/582a049f-ded3-ee19-b969-c1914f94e69f [accessed 4 November 2020].

And data from the Statistical Yearbook of the MoLSA 2019. Available at: https://www.mpsv.cz/documents/20142/975025/Statisticka_rocenka_z_oblasti_prace_a_socialnich_veci_2019+%281%29.pdf/9da5cc00-7d78-7caa-6bf2-01eeccdeabd7 [accessed 4 November 2020].

[121] The data are of 31st December 2011 for the year 2012 and of 31st December 2019 for the year 2019.

[122] The expenses spent by social services providers (in thousands).

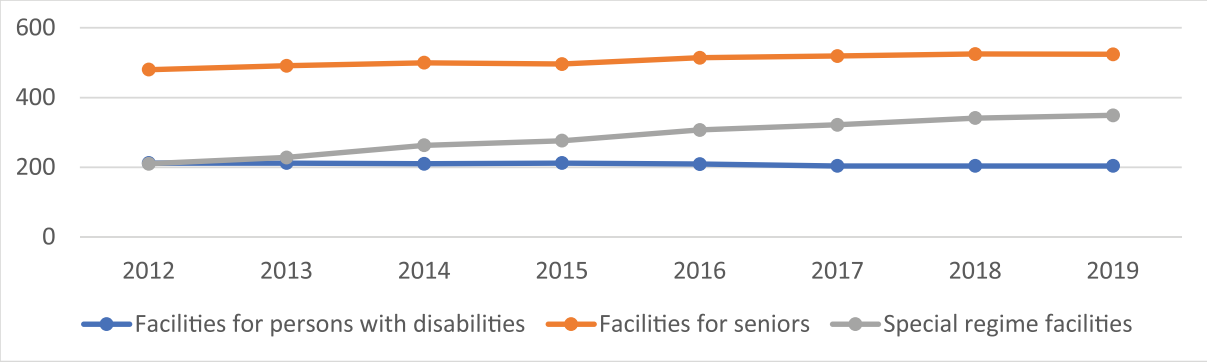
[123] We use the exchange rate of the European Central Bank for 31 December 2012: EUR 1 = CZK 25,151; and for 31 December 2019: EUR 1 = CZK 25,408. Available at: https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-czk.en.html [accessed 6 November 2020].

[124] In thousands. The amount is not complete – it includes only State subsidies and subsidies provided of municipalities and regions in their role of the maintainer of the service but excludes all the services provided by private subjects since the data provided by the MoLSA give the total amount of State subsidies and subsidies provided by the maintainer which are not part, in case of private maintainers, of public budgets. We thus prefer not to include this amount at all and present a pure view of the development of part of public funds invested in these types of services.

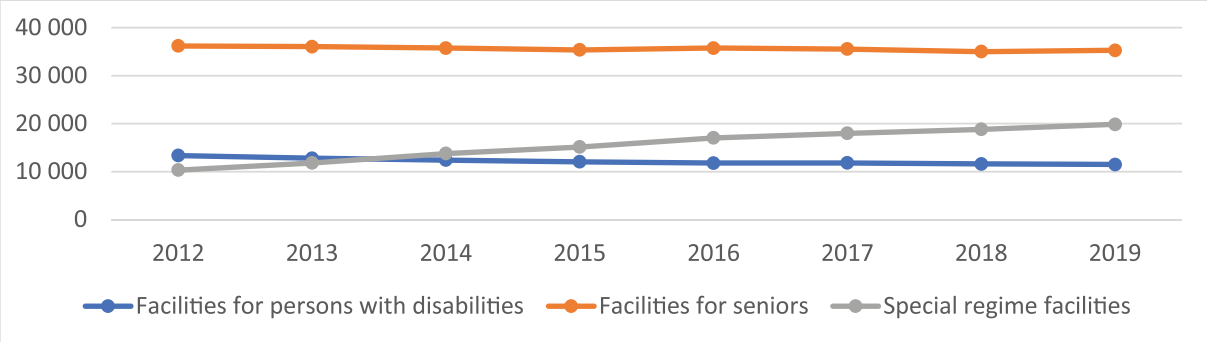
Furthermore, the amount does not include another source of public services – the care allowance, which still belongs among the most important funds of social services. Even though paid by the clients, it may be considered as public funds since it is paid to the clients from the state budget. If no alternatives are available, the client then has no choice than to invest his/her care allowance to the residential service.

[125] We use the exchange rate of the European Central Bank for 31 December 2012: EUR 1 = CZK 25,151; and for 31 December 2019: EUR 1 = CZK 25,408. Available at: https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-czk.en.html [accessed 6 November 2020].

Charter no. 1: Number of residential social care facilities 2012-2019[126]



Charter no. 2: Number of clients of residential social care facilities 2012-2019[127]



Source: *MoLSA*

2.3 The development of community-based services

In the same period, i.e. between 2012 and 2019, the development of outreach social care services hardly reached the level of institutions. In this report, we discuss two particular outreach social care services, namely *personal assistance and domiciliary service*, and two particular ambulatory services, namely *day services centres and day care centres*. The reason is that these two services usually provide support both to older persons in general, and to older persons with disabilities in particular.

In the period of 2012-2019, the number of clients increased only for *personal assistance*. At the same time, the number of *domiciliary service* clients decreased by 7,4 %, 8 383 in absolute values. The increase in *personal assistance* clients was 54,5 %. At first sight, it seems significant. In absolute values, it, however, comprises only 3 569 persons (compared to the increase of 10 443 clients of *special regime facilities*). Thus, in 2019, there were in total 10 123 clients of *personal assistance*, while, at the same time, there were approximately 363 500 persons who were in a certain degree

[126] Data from the Statistical Yearbooks of the Ministry of Labour and Social Affairs 2012-2019, table no. 6.3. Available in Czech at: https://www.mpsv.cz/web/cz/statisticka-rocenka-z-oblasti-prace-a-socialnich-veci [accessed 18 November 2020].

[127] *Ibid*.

of dependency on the support of others. Out of this number, approximately 267 700 persons were over 60. Further, approximately 87 300 persons in 2019 were assigned the third level of dependency (of whom approximately 65 200 were over 60), and approximately 52 000 persons the fourth, the highest level of dependency (full dependency; of whom approximately 36 000 were over 60).[128] The disproportion is obvious.

Moreover, it is also significant that even though the number of *domiciliary service* clients decreased, the number of unsatisfied applications increased significantly – by 265,2 % (3 731 applications). A similar trend is apparent also for *personal assistance*, where there was an increase of unsatisfied applications by 924,8 % (2 730 applications in absolute values).

Table no. 10: Developments of outreach social care services between 2012 and 2019

		Personal assistance		Domiciliary service	
		2012	**2019**	**2012**	**2019**
Number of clients[129]		6 554	10 123	113 041	104 658
Amount of finances allocated for these services[130] (in thousands)	**CZK**	364 244	1 054 875	2 132 883	3 846 766
	EUR[131]	14 482,3	41 517,4	84 803,1	151 399,8
Number of unsatisfied applications for the service		331	3 061	1 407	5 138

The amount of funds allocated for *personal assistance* and *domiciliary service* increased significantly between 2012 and 2019, especially as regards the percentage change. Funds allocated for *personal assistance* increased by 189,6 % and for *domiciliary service* by 80,4 %. However, again, in absolute values, the increase was trivial, 690 631 000 CZK (27 035 000 EUR) for *personal service* and 1 713 883 000 CZK (66 597 000 EUR) for *domiciliary service*.

These values are hardly comparable to the increase in public expenditure for social care institutions, even though they include, in addition to the public subsidies, other financial allocations. Thus, in comparison, the increase in the amount of finances allocated for *personal assistance* represents only 36,6 % of the increase in public subsidies for *facilities for persons with disabilities*, 23,8 % of the increase in public subsidies for *facilities for seniors*, and 34 % of the increase in public subsidies for *special regime facilities*. For *domiciliary service*, the percentage values compared are as follows,

128 The Statistical Yearbook of the MoLSA 2019, table no. 14.5, p. 115. Available in Czech at: https://www.mpsv.cz/documents/20142/975025/Statisticka_rocenka_z_oblasti_prace_a_socialnich_veci_2019+%281%29.pdf/9da5cc00-7d78-7caa-6bf2-01eeccdeabd7 [accessed 6 November 2020].

129 The number covers all clients of the service during the year. It does gives us different data from those on residential services that give the number of clients on the specified date.

130 It is to be noted that this amount does not correlate to the amount in table no. 1 since the official statistics do not provide data on the amount on the public subsidies to these services (contrary to services that are provided in social services facilities). Nevertheless, it still should be used to map the developments in the area of these services between 2012 and 2019 and give an answer to the question whether there have been any improvements in the support, including financial support, given to these services.

131 We use the exchange rate of the European Central Bank for 31 December 2012: EUR 1 = CZK 25,151; and for 31 December 2019: EUR 1 = CZK 25,408. Available at: https://www.ecb.europa.eu/stats/policy_and_exchange_rates/euro_reference_exchange_rates/html/eurofxref-graph-czk.en.html [accessed 6 November 2020].

90,8 % of the increase in public subsidies for *facilities for persons with disabilities*, 59,1 % of the increase in public subsidies for *facilities for seniors*, and 84,3 % of the increase in public subsidiaries for the *special regime facilities*.

It is to be noted that these values would be even more disproportionate if we could compare the same categories of allocated resources. However, it is impossible due to the Government statistics and the lack of information on the amount of State subsidies for outreach social care services. Therefore, we could only compare the overall expenses of outreach social care services with the State subsidies for residential social care services. Yet, it does not give us exact information on the whole system. However, even this comparison is still able to show that in practice residential facilities (very often institutions) remain prioritized over outreach services, and instead of being progressively eliminated they are developing faster than their outreach alternatives.

Concerning ambulatory services, there were only minor developments between 2012 and 2019. Since both monitored services – (i) day services centres, and (ii) day care centres – are very similar in terms of the services they offer and their target groups,[132] it is useful to consider their developments together. The number of these ambulatory services increased only by 1,8 %, as many as 6 services in absolute values for the whole country. On the other hand, the number of their clients in total decreased by 4 %, 454 persons in absolute values. This decrease was accompanied by an increase in the number of unsatisfied applications by 14,1 %, 39 applications in absolute values. Data on allocated resources are not available.

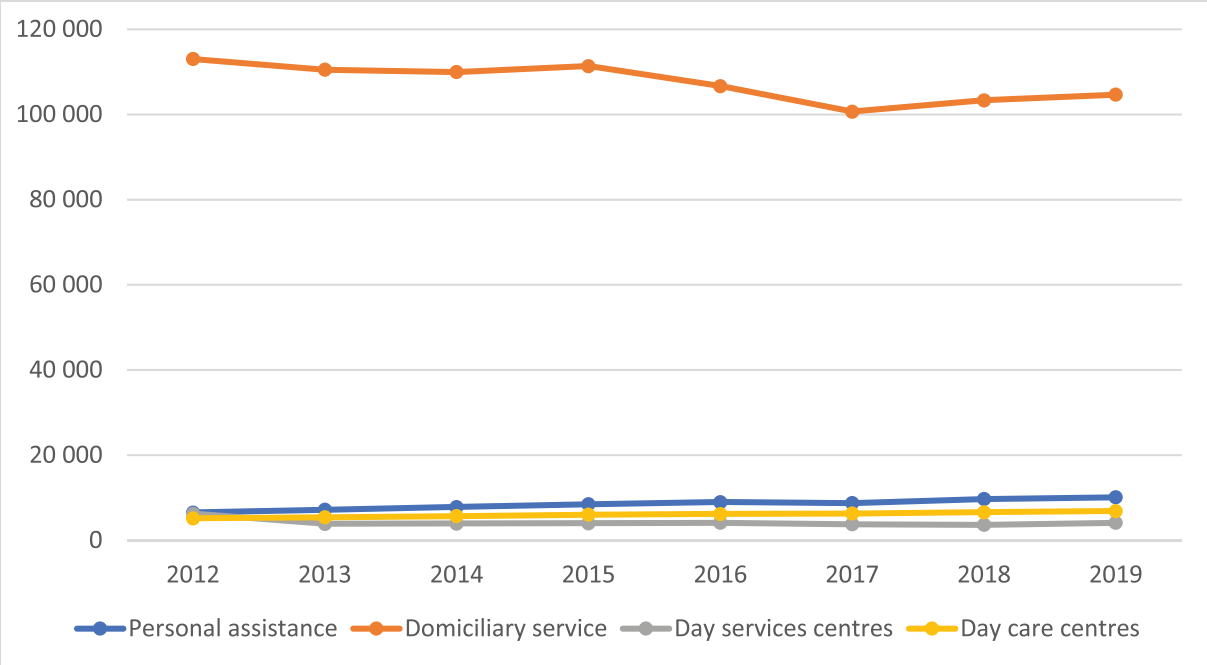
Table no. 11: Developments of ambulatory social care services between 2012 and 2019

	Day services centres		Day care centres		In total	
	2012	**2019**	**2012**	**2019**	**2012**	**2019**
Number of services	85	78	253	266	338	344
Number of clients[133]	6 267	4 115	5 176	6 874	11 443	10 989
Number of unsatisfied applications	17	72	259	243	276	315

[132] Yet, this does not mean that all the existing day services centres and day care centres are designed for older persons with disabilities. The specific target group of a concrete day services centre or day care centre is recorded in the National Registry of Social Services Providers.

[133] The number covers all clients of the service during the year. It does gives us different data from those on residential services that give the number of clients at on the specified date.

Chart no. 3: Number of clients of outreach and ambulatory social care services 2012-2019[134]



The data indicates that the number of clients of outreach and ambulatory social care services has been rather stable, compared to the number of people institutionalised in special regime facilities. Chart no. 3 shows that between 2012 and 2019, the number slightly grew for *personal assistance* (by 3 569 clients). However, it must be noted that this total number also includes children and younger persons with disabilities. For *ambulatory services* – considered jointly – there was a slight decline by 454 clients while this number also includes children and young persons with disabilities. For *domiciliary service*, which is used by older persons more than *personal assistance*, the number of clients between 2012 and 2019 declined by 8 343 clients. Also, these data show that the whole system puts more emphasis on developing the capacities of residential facilities rather than their alternatives.

2.4 Concrete examples of the largest facilities for older persons in the Czech Republic

Relying on official sources and the register of social care services, we may identify several extremely large institutions for older persons.[135] In the Czech Republic, the largest institution is *Domov pro seniory Věstonická* (facility for seniors Věstonická), with a capacity of 404 clients.[136] The facility is situated in the Jihomoravský Region (South Moravia).

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134 Data from the Statistical Yearbooks of the Ministry of Labour and Social Affairs 2012-2019, table no. 6.3. Available in Czech at: https://www.mpsv.cz/web/cz/statisticka-rocenka-z-oblasti-prace-a-socialnich-veci [accessed 18 November 2020].

135 The register is available in Czech at: http://iregistr.mpsv.cz/socreg/vitejte.fw.do?SUBSESSION_ID=1603893260664_1 [accessed 29 October 2020].

136 The special regime facility with a capacity of 300 clients and facility for seniors with a capacity of 104 clients; both services are provided at the same address. See the information from the register of social services providers, available in Czech at: http://iregistr.mpsv.cz/socreg/vypis_sluzby.do?SUBSESSION_ID=1603969391394_2&706f=8e13c85336f50309 [accessed 29 October 2020].

See photographs of the facility that are available at: https://www.mujduchod.cz/domov-pro-seniory-vestonicka-114 [accessed 30 September 2020].

Photo no.1: The main building of the facility for seniors Věstonická[137]

Photo no. 2: The garden of facility for seniors Věstonická[138]

137 Available at: http://www.znackakvality.info/certifikovana-zarizeni/domov-pro-seniory-vestonicka/ [accessed 2 November 2020].

138 Available at: https://www.ves.brnods.cz/o-nas/domov-se-zvlastnim-rezimem [accessed 2 November 2020].

Photo no. 3: Satellite view of facility for seniors Věstonická

Another particularly large facility is *Domov Slunečnice Ostrava* (facility for seniors Slunečnice Ostrava), housing 395 clients.[139] It is located in the Moravskoslezský Region (North Moravia) and *Domov pro seniory Kociánka* (facility for seniors Kociánka), with a capacity of 381, and located in the Jihomoravský Region (South Moravia).[140]

Photo no. 4: Facility Slunečnice Ostrava[141]

[139] The facility for seniors with a capacity of 272 clients and special regime facility with a capacity of 123 clients; both services are provided at the same address. See the information from the register of social services providers, available in Czech at: http://iregistr.mpsv.cz/socreg/vypis_sluzby.do?SUBSESSION_ID=1603969584077_4&706f=b2ee96b454ec854f [accessed 29 October 2020].

Photographs of the facility are available on the facility's website: https://domovslunecnice.ostrava.cz/ [cited 30 September 2020].

[140] The facility for seniors with a capacity of 279 clients and the special regime facility with a capacity of 102 clients; both services provided at the same address. See the information from the register of social services providers available in Czech at: http://iregistr.mpsv.cz/socreg/vypis_sluzby.do?SUBSESSION_ID=1603969175957_1&706f=bd947d6f49c69d8b [accessed 29 October 2020].

[141] Available at: https://domovslunecnice.ostrava.cz/ [accessed 2 November 2020].

Photo no. 5: Facility for seniors Kociánka[142]

Photo no. 6: Satellite view of the facility for seniors Kociánka[143]

142 Available at: https://www.koc.brnods.cz/o-nas [accessed 2 November 2020].

143 Available at: https://www.google.com/maps/place/Koci%C3%A1nka+1%2F8,+612+00+Brno-Kr%C3%A1lovo+Pole-Sadov%C3%A1/@49.2276737,16.6059587,641m/data=!3m1!1e3!4m5!3m4!1s0x4712938a9fac8829:0x8f14abb3627dd422!8m2!3d49.2275186!4d16.6085134 [2 November 2020].

Photo no. 7: Facility Domov U Biřičky[144]

Further, there are examples of *Domov U Biřičky* (Facility By Biřička), situated in the Královéhradecký Region (East Bohemia), and *Domov pro seniory POHODA Chválkovice* (a facility for seniors Pohoda Chválkovice). *Domov U Biřičky* has been housing older persons who are dependent on the support of others. In two large and connected buildings,[145] it combines two types of services – a facility for seniors and the special regime facility.

The capacity is 340 beds. The website proudly presents the institution as "the facility belonging to the largest providers of social services in the Czech Republic and has been available for seniors since 1965."[146]

Domov pro seniory POHODA Chválkovice has a capacity of 334 beds[147] and is situated in the same area as another form of residential social care service – sheltered housing.

Sheltered housing has a capacity of 34 clients.[148] In total, there are more than 368 persons institutionalised in one single area. The whole area is moreover situated on the outskirts of the regional city Olomouc, with poor general services and transport infrastructure. The territorial segregation is apparent.[149]

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144 Available at: https://hradecka.drbna.cz/zpravy/6970-v-domove-duchodcu-u-biricky-ma-jedna-z-pracovnic-koronavir.html [accessed 2 November 2020].

145 Photography of the facility can be seen on the facility's website: http://www.ddhk.cz/index.asp.

146 The text is available in Czech at: http://www.ddhk.cz/o-nas/ms-1012/p1=1012 [accessed 29 September 2020].

147 The information on the capacity is available in Czech at the website of the facility: https://www.ddol.cz/sluzby/domov-pro-seniory.

148 Protected housing is very often conceived as an alternative to institutional care; however, the case of the Facility for seniors POHODA Chválkovice shows well that very often it does not comply with the requirement not to revolve around institutions (CRPD/C/GC/5, para. 49).

149 Both the institutional character of the facility and its territorial segregation are clearly visible from the online tour available on the facility's website (the sound track is unfortunately available only in Czech): https://www.domovyonline.cz/www/prohlidky/DS_Pohoda/. [accessed 29 September 2020].

Photo no. 8: Facility for seniors POHODA Chválkovice[150]

Photo no. 9: Facility for seniors POHODA Chválkovice[151]

Similarly, *Domov Kladno-Švermov* (Facility Kladno-Švermov) is situated in the suburbs of city Kladno (the Středočeský Region – Central Bohemia). The facility is made up of 11 buildings situated in the same area. It can accommodate 230 clients older than 60.[152] Another institution is *Centrum Rožmitál pod Třemšínem*, located in the same region. It has practically the same capacity – 220 clients.[153]

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150 Available at: https://www.ddol.cz/o-nas/areal-domova [accessed 2 November 2020].

151 Available at: https://olomoucka.drbna.cz/z-kraje/olomoucko/20361-ve-chvalkovickem-domove-senioru-se-vyskytla-nakaza-covid-19-mezi-klienty-i-personalem.html [accessed 3 November 2020].

152 Information available in the register of social services providers: http://iregistr.mpsv.cz/socreg/vypis_sluzby.do?SUBSESSION_ID=1603971924073_14&706f=bda069270d03c019 [accessed 29 October 2020].

153 The information is obtained from the presentation video of the facility available in Czech on the facility's website: http://www.centrumrozmital.cz/domov-pro-seniory/ [accessed 30 September 2020].

Photo no. 10: Facility for seniors Kladno-Švermov[154]

Photo no. 11: Facility for seniors Kladno - Švermov[155]

[154] Available at: https://www.domovkladno-svermov.cz/ [accessed 2 November 2020].

[155] Available at: https://www.google.com/maps/place/Vojt%C4%9Bcha+Dundra+1032,+%C5%A0vermov,+273+09+Kladno/@50.164591,14.1123073,414m/data=!3m1!1e3!4m5!3m4!1s0x470bc83c8ee0c39f:0xb9790cc6f1dc0d51!8m2!3d50.1637898!4d14.1120285 [accessed 2 November 2020].

Photo no. 12: Centrum Rožmitál pod Třemšínem[156]

Photo no. 13: Satellite view of Centrum Rožmitál pod Třemšínem[157]

156 Available at: http://www.centrumrozmital.cz/domov-pro-seniory/ [accessed 2 November 2020].

157 Available at: https://www.google.com/maps/@49.5959724,13.8676273,456m/data=!3m1!1e3?hl=cs [accessed 2 November 2020].

III. THE EXTENT OF INSTITUTIONALISAITON - LONG-TERM HEALTH CARE

The following chapter provides basic data on long-term health care in the Czech Republic and its developments over time (3.1). It also introduced concrete examples of certain long-term health care institutions that accommodate more than one hundred clients and belong among the largest in the Czech Republic (3.2).

3.1 The situation in the system of long-term health care

As mentioned in chapter 1.2, older persons who are dependent on the support of others, including older persons with disabilities, may become users of health care services, as well as social services. Especially concerning residential forms of these services, the line is not at all sharp and it is rather a matter of chance in what type of services the person is placed. Indeed, those older persons who are dependent on others' support may end up in residential social care facilities not just because outreach and ambulatory forms of social services are unavailable, inaccessible, or unaffordable, but because outpatient health services have those qualities as well.

Residential health services providing long-term care to older persons who are dependent on the support of others are not so numerous as residential social care facilities. However, they do not significantly differ from those facilities in their capacity and organisation, and thus constitute an indispensable part of the problem of the institutionalisation of older persons due to these individuals' dependency on others.

Table no. 11: Hospitals for the long-term sick and hospices in the Czech Republic in 2017

	Facilities	Beds	Average capacity
Hospitals for the long-term sick	35	3 472	99,2
Hospices	18	484	26,9

Source: *Institute of Health Information and Statistics*[158]

[158] Institute of Health Information and Statistics: Health Care in the Czech Republic: Residential Capacity, p. 7. Available in Czech at: https://www.uzis.cz/sites/default/files/knihovna/nzis_rep_2018_E03_luzkovy_fond_2017.pdf [accessed 23 September 2021]

Table no. 12: Health facilities providing long-term and hospices in the Czech Republic in 2020

	Long-term care departments (including hospitals for the long-term sick)[159]	Hospices[160]
The Capital City of Prague	15	4
Středočeský Region	14	2
Jihočeský Region	10	2
Plzeňský Region	8	1
Karlovarský Region	6	2
Ústecký Region	14	1
Liberecký Region	7	1
Královéhradecký Region	5	1
Pardubický Region	10	1
Vysočina Region	8	1
Jihomoravský Region	11	2
Olomoucký Region	5	1
Moravskoslezský Region	16	2
Zlínský Region	8	2
Total	**137**	**24**

Source: *Všeobecná zdravotní pojišťovna (public health insurance company)*

According to the data provided by the Institute of Health Information and Statistics of the Czech Republic, which is a public institution under the Ministry of Health, in 2017 there were 5 184 beds of long-term care in different facilities.[161] Table no. 11 provides information on two main types of residential long-term care health facilities – hospitals for the long-term sick (the Czech abbreviation "LDN") and hospices. The Institute of Health Information and Statistics draws attention to the fact that there is an apparent decrease in the number of beds in hospitals for the long-term sick, but this decrease may be explained by a change in administrative reporting that took place in 2016 when hospitals for the long-term sick started to become parts of hospitals' aftercare departments. Table no. 12 provides data on all the health facilities providing long-term care – long-term care departments (including hospitals for the long-term sick), the total of which exceeds the number of hospices by more than a hundred.

[159] Information available on the website of the public health insurance company – Všeobecná zdravotní pojišťovat at: https://www.vzp.cz/poskytovatele/informace-pro-praxi/seznamy-center-a-szz/lecebny-dlouhodobe-nemocnych [accessed 4 November 2020].

[160] Information available on the website of the public health insurance company – Všeobecná zdravotní pojišťovna at: https://www.vzp.cz/poskytovatele/informace-pro-praxi/seznamy-center-a-szz/hospice [accessed 4 November 2020].

[161] Institute of Health Information and Statistics: Health Care in the Czech Republic: Residential Capacity 2017, p. 8. Available in Czech at: https://www.uzis.cz/sites/default/files/knihovna/nzis_rep_2018_E03_luzkovy_fond_2017.pdf [accessed 4 November 2020].

In relation to alternatives to institutions, the 2019 report of the Institute of Social Policy and Research and the Institute of Health Information and Statistics shows that in the last five years the number of home-care providers has increased by 1/4, in absolute numbers by 130 providers. In 2017 there were 558 providers.[162] However, the document also points to the fact that at the same time the number of home-care clients decreased, although the number of persons in need of care –even after their release from acute hospitalisation – increased (see above). In concrete terms, the document emphasizes that "the total number of home-care patients calculated per one thousand inhabitants has decreased since 2009 to 13 persons from nearly 14. … home care has been used by nearly 58 older persons over 65 (per one thousand inhabitants), which is 19 % less than in 2009 when there were more than 73. Nevertheless, regarding the demographic ageing, we may expect the increasing need for this kind of care, if it does not continue to be massively compensated by residential health care."[163] As it appears from the statistics, home-care has been "massively" substituted by institutions.

3.2 Examples of hospitals' aftercare departments providing long-term care

As with our treatment of social services above, we are able to present concrete examples of large long-term care facilities or hospital wards where older persons, including older persons with disabilities, are institutionalised. The extent is very similar.

The first example is the aftercare department at the Motol University Hospital in Prague.[164] The aftercare department, previously operating as a hospital for the long-term sick, conserved its target group. It accommodates predominantly older persons who do not need acute health care but are still in need of support. The capacity is 381 beds and the department is located in two buildings within an extensive hospital area.

Photo no. 14: The area of Motol University Hospital[165]

[162] Atlas dlouhodobé péče ČR [Atlas of the Long-Term Care of the Czech Republic], p. 21. The Atlas is available in Czech at: https://socialnipolitika.eu/wp-content/uploads/2019/09/Atlas-dlouhodobe-pece-CR.pdf [cited 5 October 2020].

[163] Analýza sociálních a zdravotních služeb dlouhodobé péče v ČR (2019) [Analysis of Social and Health Long-Term Care Services in the Czech Republic], pp. 64-65.. The Analysis is available in Czech at: https://socialnipolitika.eu/wp-content/uploads/2019/09/Analyza-socialnich-a-zdravotnich-sluzeb-dlouhodobe-pece-v-CR.pdf [cited 1 October 2020].

[164] A short video presentation of the department documenting that the department focuses predominantly on older persons is available in Czech at: https://www.fnmotol.cz/kliniky-a-oddeleni/cast-pro-dospele/lecebna-dlouhodobe-nemocnych-ldn-i/ [accessed 4 November 2020].

[165] Available at: https://www.arc.cz/energie-krajiny-arealu-fn-motol-v-praze-5/ [accessed 4 November 2020].

Photo no. 15: The aftercare department of Motol University Hospital[166]

Another example is *Odborný léčebný ústav Paseka* (the Specialized Medical Institute Paseka). It is isolated and situated in the area of a former treatment centre for patients with tuberculosis, in the woods of Nízký Jeseník (central Moravia). The nearest village is 2,3 kilometres away and the nearest district town of Olomouc is nearly 30 kilometres (see photo no. 16). The area accommodates a wide range of health care services, including long-term care for older persons. The overall capacity is 328 persons.[167]

Photo no. 16: The location of the Specialized Medical Institute Paseka[168]

[166] Available at: https://www.fnmotol.cz/kliniky-a-oddeleni/cast-pro-dospele/lecebna-dlouhodobe-nemocnych-ldn-i/ [accessed 4 November 2020].

[167] 2020 Annual Report of the Specialised Medical Institute Paseka, p. 10. Available in Czech at: https://www.olupaseka.cz/dokumenty/vyrocni-zpravy [accessed 23/09/2021].

[168] Available at google maps: https://www.google.com/maps/dir//Paseka+145,+783+97+Paseka/@49.809395,17.2225018,1385m/data=!3m1!1e3!4m8!4m7!1m0!1m5!1m1!1s0x47123bd6adfc967b:0x7fb04f3de6f6904d!2m2!1d17.228039!2d49.8095695 [accessed 4 November 2020].

Photo no. 17: The area of the Specialized Medical Institute Paseka[169]

The last example may *be Léčebna dlouhodobě nemocných* Rybití (the Hospital for the Long-Term Sick Rybití) providing both health care and social care services. The total capacity is 122, out of which there are 105 health-care beds and 17 social-care beds.[170] The facility is housing predominantly older persons.[171]

Photo no. 18: The Hospital for the Long-Term Sick Rybití[172]

169 Available at: https://www.olupaseka.cz/seniori/olu-paseka/fotogalerie/rok-2016/olu-paseka-2016-96cs.html#&gid=1&pid=10 [accessed 4 November 2020].

170 Information available in Czech at: https://www.novinykraje.cz/pardubicky/2019/10/16/ldn-v-rybitvi-ziskala-oceneni-kvalitni-a-bezpecna-nemocnice/ [accessed 4 November 2020].

171 For more information consult the facility's website at: https://www.ldn-rybitvi.cz/ [accessed 4 November 2020].

172 Available at: https://www.pardubicezive.eu/bezpecnost-predevsim-investice-kraje-usnadni-evakuaci-v-ldn-rybitvi/ [accessed 7/7/2021].

Photo no. 19: A room in the Hospital for the Long-Term Sick Rybitví[173]

[173] Available at: https://www.ldn-rybitvi.cz/o-lecebne/fotogalerie/ [accessed 7/7/2021].

IV. NATIONAL POLICIES

In the following chapter, we discuss the Czech legislation and policies from the perspective of the commitment to the deinstitutionalisation of social protection for those dependent on the support of others. First, we described the commitment to non-institutional support and deinstitutionalisation (4.1), followed by discussing both the law (4.2) and national strategies (4.3).

4.1 Commitment to non-institutional support and the process of deinstitutionalisation

The information and data presented in the first part of this document shows that institutionalisation has become a common solution for older persons who require support. It is not guaranteed that non-institutional supportive measures will be available or affordable to them. Thus, instead of sustaining the existing supportive environment or ensuring inclusion, the Czech Republic has opted for segregation in institutions as the primary measure.

This approach contradicts obligations stemming from the CRPD (Article 19) and the European Social Charter (Article 14), with its Additional Protocol of 1988 (Article 4). In our opinion, international human rights law obliges the Czech Republic to adopt all appropriate measures to ensure that older persons, and especially older persons with disabilities requiring support, have a right to choose and are not forced to live in a specific environment because of their age-dependent, disability-dependent, or age- and disability-dependent situation. Measures should aim not only to prevent their institutionalisation, either in social or health care facilities, but also to facilitate their return to their natural environment.

In the Czech Republic, the support system historically relies on institutions, rather than non-institutional supportive measures. In that case, the State has an obligation "to enter into strategic planning, with adequate time frames and resourcing, in close and respectful consultation with representative organisations of persons with disabilities, to replace any institutional settings with independent living support services."[174] In other words, the State should transform and deinstitutionalise the system of support. This obligation includes, inter alia, the obligation not to extend the existing institutionalisation system or establish "satellite" living arrangements that branch out from institutions, i.e. those that have the appearance of individual living (apartments or single homes) but revolve around institutions,[175] as well as the obligation to "ensure that public or private funds are not spent on maintaining, renovating, establishing building or creating any form of institution or institutionalization."[176]

4.2 Czech law in the light of non-institutional measures and deinstitutionalisation

Czech law does not contain any legal mechanism explicitly allowing or regulating progressive deinstitutionalisation or preventing the enlargement of existing institutions or the establishment of new ones.

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174 CRPD/C/GC/5, para. 42.

175 *Ibid*., para. 49.

176 *Ibid*., para. 51.

Concerning social services, although the Social Services Act regulates the process of planning, including development and the creation of a net of services, it neither puts an emphasis on those services that respect the right to independent living, nor does it presume deinstitutionalisation. It is legal for a region's mid-term plan to rely predominantly on the development of institutional care, instead of community-based services. This is often the practice in cases of older persons who are dependent on the support of others and who are not part of the deinstitutionalisation discourse.

The latest draft amendment to the Social Services Act, submitted by the MoLSA to the commentary procedure at the end of 2019,[177] does not remedy this situation. Even though it contains proposals for significant changes in funding which will inevitably affect the net of social services and its development, it still remains neutral in terms of the right to independent living. It does not guarantee that the funding will support progressive deinstitutionalisation and the development of social services that are available and accessible to any person's natural environment.

The law regulating the health care system is even more laconic. It is practically limited to enacting social insurance companies' responsibility for ensuring the availability of healthcare services (see above chapter 1.2.2). Contrary to social services (Section 38 of the Social Services Act), the Health Care Act does not contain any provision expressing a preference towards outreach and ambulatory services. It is identified as an apparent gap, considering that healthcare institutions in many instances take the place of social care services for older persons who require the support of others.

4.3 National policies and deinstitutionalisation

The commitment to deinstitutionalise is not part of existing law, but policy. However, these policies can be criticised for several shortcomings. First, existing or planned policies do not recognise the deinstitutionalisation of older persons' institutional care. Second, even those policies already in existence are not properly implemented.

Starting with the first problem, the institutionalisation of older persons who are dependent on the support of others is usually not covered by national policies. In the social care system, the deinstitutionalisation discourse and efforts, if ever undertaken, focus on younger persons with intellectual or psychosocial disabilities who have been institutionalised in *facilities for persons with disabilities*. The reason for their institutionalisation is the lack of support outside institutions, and the problem is complex. Yet, what is especially worrying is that a whole group of older persons dependent on the support of others, usually either due to one or more of Alzheimer's disease, other age-related neurological diseases, mobility impairments, or any other form of impairments, is totally left out.

The situation is well documented by a recent joint statement of the largest social care providers association in the Czech Republic [in Czech *Asociace poskytovatelů sociálních služeb*] and two umbrella NGOs, the Council of Seniors [in Czech *Rada seniorů*] and the Czech National Disability Council [in Czech *Národní rada osob se zdravotním postižením ČR*].[178] According to the statement, older persons (seniors) are considered to be a group that cannot benefit from deinstitutionalisation, deinstitutionalisation itself is not fully achievable, and new institutions

[177] The draft is available in Czech at: https://apps.odok.cz/veklep-detail?p_p_id=material_WAR_odokkpl&p_p_lifecycle=0&p_p_state=normal&p_p_mode=view&p_p_col_id=column-1&p_p_col_count=3&_material_WAR_odokkpl_pid=KORNBJZK6G9V&tab=detail [accessed 5 November 2020].

[178] The joint statement is available in Czech at: http://www.apsscr.cz/files/files/Spole%C4%8Dn%C3%A9%20stanovisko_deinstitucionalizace1_FINAL.pdf [accessed 5 November 2020].

(including facilities with a capacity of up to 120 beds) are welcome.[179] Although this statement was opposed by other NGOs – organisations providing community support for persons with psychosocial disabilities,[180] and a coalition of NGOs supporting deinstitutionalisation[181] – it marks the mainstream discourse.[182]

In the health care system, deinstitutionalisation is discussed in the context of psychiatric care. It may concern certain older persons who are currently institutionalised or will soon be institutionalised in psychiatric hospitals,[183] but surely not all of them. Community care for older persons is not the objective of this policy.

To summarize, currently there is no policy that would thematize the deinstitutionalisation of residential care for older persons. All existing policies that contain deinstitutionalisation objectives,[184] if they mention older persons, concentrate on the need to develop community alternatives and the support of informal care. Yet, they fail to include as an objective the progressive elimination of existing institutions and the prevention of the establishment of new institutions or enlargement of existing ones. The National Strategy for the Development of Social Services 2016-2025 is an example. It explicitly provides that the objective of the transition from institutional to community-based care should not be understood "as the elimination of the necessary capacities or new capacities, for instance, in the domain of services for seniors. However, a suitable way to resolve this situation is to plan new capacities of community services."[185]

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179 *Ibid*., pp. 2-3.

180 Joint statement by the Association of Community Services in the Area of Mental Health and FOKUS Czech Republic. The Statement is available in Czech at: https://www.fokus-cr.cz/images/Stanovisko_AKS_a_FOKUS_8.10.2020.pdf [accessed 5 November 2020].

181 The statement is available in Czech at: http://jdicz.eu/vyjadreni-jdi-ke-spolecnemu-stanovisku-apss-cr-nrzp-a-rs-cr-k-deinstitucionalizaci-socialnich-sluzeb/ [accessed 5 November 2020].

182 The discourse disrespects prevailing views of older persons themselves. Organisations advocating for the rights of older persons and providing older persons with outreach or ambulatory support services point out that most older persons wish to stay and die at their homes and not have to be institutionalised. The Institute on Dignified Aging established by Diaconia – Evangelical Church of Czech Brethren focuses on development of community-based services for older persons: https://www.dustojnestarnuti.cz/en/ [accessed 17 May 2021]. In 2018 the Institute published a publication Grow old at home, in the community, in place, having for its aim to support local authorities in developing the system of coordinated outreach and ambulatory services: https://www.dustojnestarnuti.cz/res/archive/003/000560.pdf?seek=1543303680 [accessed 17 May 2021]. Also, the best-known non-governmental organisation supporting older persons in the Czech Republic – Life 90 [in Czech Život 90] advocates for the availability of community-based services and deinstitutionalisation of care of older persons. In 2011 it started a charitable organisation – Gerontologic Institute to perform analytical, educational, conceptual, methodologic, and counselling activities in the field of old age and ageing. The Gerontologic Institute regularly organises trainings and conferences to promote deinstitutionalisation and community-based support, as is clear from its annual reports. See for instance Annual Reports 2015 – 2019. Available at: https://www.zivot90.cz/cs/institut/dokumenty-ke-stazeni [accessed 17 May 2021].

183 The government adopted in January 2020 the National Action Plan for Mental Health 2020 – 2030 which includes an objective focusing on the development of community-based services for persons with Alzheimer's disease and other types of age neurological diseases, but it would be a mistake to interpret this objective as a commitment to deinstitutionalising existing residential social care or long-term health care facilities. The aim is to deinstitutionalise psychiatric care. The National Action Plan for Mental Health, pp. 56-57. The Plan is available in Czech at: https://www.mzcr.cz/narodni-akcni-plan-pro-dusevni-zdravi-2020-2030/ [cited 22 October 2020].

184 Especially the National Strategy for the Development of Social Services 2016 – 2025 and the Strategy for the Reform of Psychiatric Care and the National Action Plan for Mental Health 2020 – 2030.

185 The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 16. The Strategy is available in Czech at: https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [cited 1 October 2020].

A specific strategic document directly targeting older persons has not yet been adopted and is still in preparation – the Strategic Framework for the Preparation for Population Ageing 2019 (2020) – 2025.[186] The draft also promotes community-based and informal care. However, it is silent on deinstitutionalisation.[187]

Further, the Czech government have in general serious problems implementing their own strategies. Any policy adopted in the form of "strategy", or "action plan", unless accompanied with legal obligations, should not be overestimated. The National Strategy for the Development of Social Services 2016-2025 is a good example. To achieve one of its strategic objectives, namely to ensure the transition from the institutional to community-based care for persons with disabilities, a transition action plan should have been adopted. The Strategy had already anticipated its adoption in 2016-2017 and then its implementation during the whole period of the Strategy's timeframe, i.e. until 2025.[188] However, it has not been adopted yet. The absence of an action plan makes the objective of deinstitutionalisation unrealisable.

Besides the transition action plan, the objective should also have been achieved by creating conditions to ensure necessary capacities within outreach, ambulatory, and residential community social care services. The National Strategy linked this specific objective, *inter alia*, with the amendment to the Social Services Act.[189] The amendment's entry into force had been previewed for 2018. The so-called "big amendment" of the Social Services Act has not been adopted yet. Moreover, the amendment introduced by the MoLSA at the end of 2019 significantly deviates from the Strategy and its original objectives.

The Strategy's absence of efficiency is also apparent from the fact that the action plan to its own implementation had been adopted only for 2017-2018, and since 2019 the document has not been accompanied by any following plan, while at the same time the Government failed to comply with even this very first action plan. Steps that were planned for 2017-2018 have not been fulfilled.

It is noteworthy that the Czech Supreme Audit Office criticised the Government's failure to comply with their own major policy document for social services. In their 2019 Annual Report, the national controlling authority stated that "in the controlled period the MoLSA [*note: Ministry of Labour and Social Affairs*] did not achieve the fulfilment of the long-term visions, objectives, and measures set up in the NSDSS [*note: National Strategy for the Development of Social Services*]. In 2017, at the latest 17 measures should have been accomplished, but the MoLSA did not manage to complete 14 of them. One of the main reasons was that the amendment to the Social Services Act that should have entered into force already in 2017 and that should have stabilized funding of social services has not yet been adopted."[190]

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186 The document has a long history of its approval and still has not been adopted by the government even though it was first discussed by them in September 2019. Nevertheless, the discussion was interrupted and opened again in February 2020 when it was interrupted again. Since then the Strategic Framework has not been included in the government's agenda and, therefore, has not been adopted yet.

187 The draft Strategy Framework for the Preparation of Population Ageing 2019-2025 (version of August/September 2019). Available in Czech at: https://amsp.cz/wp-content/uploads/2019/08/Strategie-p%C5%99%C3%ADpravy-na-st%C3%A1rnut%C3%AD-spole%C4%8Dnosti-2019-2025-ma_ALBSBADJYUA2.pdf [cited 22 October 2020].

188 The National Strategy for the Development of Social Services for 2016-2025, adopted by the government on 21st March 2016. p. 57 and 63. The Strategy is available in Czech at: https://www.mpsv.cz/documents/20142/577769/NSRSS.pdf/af89ab84-31ac-e08a-7233-c6662272bca0 [cited 1 October 2020].

189 *Ibid*., p. 64.

190 Annual Report of the Supreme Audit Office of the Czech Republic 2019, published in March 2020, p. 42. The Annual Report is available in Czech at: https://www.nku.cz/assets/publikace-a-dokumenty/vyrocni-zprava/vyrocni-zprava-nku-2019.pdf [cited 21 October 2020].

V. CONCLUSIONS AND RECOMMENDATIONS

The data provided in chapters I. and II., together with concrete examples of several institutions for older persons, document that elderly people, including elderly people with disabilities, are the most institutionalised group in the Czech Republic. The extent of their institutionalisation is enormous and the absence of alternatives critical. Taking into account exclusively social care facilities, data shows that there are more than two times more *facilities for seniors* than for *persons with disabilities*, though the latter, among others, also institutionalise older persons with mental disabilities. Moreover, data also shows that the number of institutions predominantly housing older persons with disabilities (*special regime facilities*) is almost double the number of institutions predominantly designed for adults with mental disabilities (facilities for *persons with disabilities*). In terms of capacity, the difference is even more significant. Facilities for seniors accommodate three times more clients than facilities for persons with disabilities, and special regime facilities for older people with disabilities contain almost two times the number of adults institutionalised in facilities for persons with disabilities.

Thus, in concrete terms, taking into account *facilities for seniors* together with *special regime facilities* that predominantly operate as institutions for older persons – typically with Alzheimer's disease or other types of age-neurological diseases and challenging behaviour – the disparity is even larger. The number of facilities is 4,3 times higher, and the capacity even 4,9 times higher, than for persons with disabilities (see table no. 9 in chapter 2.2).

Despite their massive institutionalisation, older persons, as well as older persons with disabilities, were excluded from the national deinstitutionalisation discourse (see chapter 4.3), as well as from transformation practice. This can be documented by available statistics. As mentioned above (chapter 1.1), there are different types of residential social care services. Yet only the number of facilities for persons with disabilities decreased between 2012[191] and 2019, though slowly and not by enough. However, the number of *facilities for seniors* and *special regime facilities* has been growing, as has their capacity (see chapter 2.2).

Recommendation: Ensure that national, regional and local deinstitutionalisation policies target *all* institutions, regardless of whether they institutionalise children, adults, or people of advanced age, and that *all* people, regardless of their age and disability, can benefit from national, regional and local deinstitutionalisation policies.

Recommendation: Adopt legal changes in order to unambiguously ensure continuing deinstitutionalisation that targets all institutions, regardless of whether they institutionalise children, adults or people of age.

Recommendation: Introduce a legal ban on new institutions and encourage the development of alternative community-based services.

Further, as data shows, since older persons, including older persons with disabilities, may be institutionalised not just within the social services system but also in the health-care system, they

[191] We choose this year since it is the year when the amendment to the Social Services Act requiring social care services to be provided in the least restrictive environment (amendment to section 38) entered into force.

face a higher risk of long-term institutionalisation. What is apparent is a lack of coordination between the system of social services (governed principally by the MoLSA) and the health care system (governed principally by the Ministry of Health). Both systems are administered on the grounds of different rules, including funding, staff requirements, and organisation of care, yet, both systems target the very same group. The situation can be described as fragmentation, and fragmentation may constitute a significant barrier to any structural change.[192]

Recommendation: Develop the legal and institutional architecture for unified long-term care, inter alia by identifying one responsible authority for long-term care and introducing new laws on long-term care based on the CRPD requirement to prefer community-based services.

The current situation, as is apparent from the data, creates a risk of "grey zones" – spaces where crucial issues relevant to the support of older persons can remain unresolved. There is one obvious consequence. Not only do older persons who are dependant on the support of others continue to be institutionalised on a massive scale, but the demand for institutionalisation has, paradoxically but evidently within the logic of an absence of alternatives, still been growing (see table no. 9 in chapter 2.2). The existing system is thus constantly advancing towards more institutionalisation without any concrete and tangible prospect of change. The situation is becoming reified and significant changes are required to stop and reverse this trend. Besides legislative changes, as recommended above, what is required is the drastic reconstruction of both systems and massive re-allocation of adequate resources towards community-based services, namely *personal assistance* and *domiciliary service*, as well as *day services centres and day care centres*. This is because what is also evident (see chapter 2.3) is the growth in expenditure, not just on care in general, but in particular on institutionalisation. In other words, the existing institutions and continuing expansion of institutionalisation have been consuming more and more public resources.

Recommendation: Introduce legal changes preferring community-based services over institutions across the social and health care systems and introduce budgetary schemes clearly prioritising community-based services for people of advanced age and particularly for elderly people with disabilities.

[192] The problem of the so-called "health and social boundaries" is a long-standing theme discussed between the Ministry of Health and MoLSA without any significant outcomes or improvements.