



## PHS-QUALITY Project

Job Quality and Industrial Relations in the Personal and Household Services Sector - VS/2018/0041



COUNTRY REPORT: CZECH REPUBLIC  
Central European Labour Studies Institute

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## Executive summary

The Czech care system might be characterized as being in transition. While a significant part of the public sector still provides services in a residential form, the demand for homecare services, both in elderly care and in childcare, is increasing. There are expected changes in household attitudes to domestic work associated with the increased demand to provide care services for elderly people at home, but for now, the PHS sector as such remains at the periphery of public interest and only a limited number of actors pay attention to it.

In 2012, **the Czech parliament discussed but did not approve ILO convention no. 189/2011 on domestic workers**. The main argument was a very limited incidence of domestic work and no evidence about the violation of worker's rights. The argumentation was based on official statistics, which could not capture informality in the sector. Until now, no representative study about the extent of the sector has yet been provided. And as a consequence, there is no political will to tackle it.

The lack of interest to regulate the sector is attributed to four reasons identified in the report. First of all, the **size of the sector seems to be limited**, as this type of work is still perceived as 'exotic' or 'exceptional'. Despite this, there is a reported increase in household work since the 1990s'. Second, **limited demand** is closely connected to the family attitude to have domestic work provided by family members and relatives rather than strangers. Similarly, limited supply is connected to strict migration rules which prevent the inflow of a large number of migrants who would undertake the tasks in the sector. Third, the **public home and residential care services, designed for the elderly and the disabled, and for children above three years old, are able to satisfy a significant part of the demand**. Of course, there are gaps in public homecare services, but those have not grown to such an extent to make it an informal care services significant part of the sector. Fourth, the **domestic work is in vast majority of cases performed in the live-out form** which slightly decreases the precarity of work and vulnerability of workers. Even migrant workers, most usually Ukrainians, typically reside elsewhere and perform a live-out form of homecare services.

**There is no social dialogue in the sector specifically targeted at domestic workers**. Both social partners mostly address problems associated with the functioning of the public part of the sector (financing, quality of services and sustainability), while the informality and working conditions in the informal part of the sector are rarely revealed. Despite this, trade unions supported ILO convention adoption on domestic workers in a legislation process in 2012, however their activity in the sector is otherwise limited. The **trade union in healthcare and social care is trying to conclude a collective agreement at the sector level which would cover employees in social services employed in the public part of the sector**, including those providing homecare services. Nevertheless, most of their effort is targeted on the increasing protection of social workers in residential care services, while other subsectors in the care

sector, including the PHS sector, are less represented. Low rates of unionization in the PHS sector partially explain the reason.

The missing engagement of the trade unions in the informal part of the sector and towards foreigners is replaced by the activities of civil society organizations (CSOs). Active CSOs mostly point at the working conditions of migrant workers in the sector, while Czech citizen providing homecare services are mostly out of the scope of their activities. The most vocal organization, Sdružení pro integraci a migraci (Association for integration and migration - SIMI), conducted a campaign in 2014, which included lobbying, research and PR activities to draw the attention of politicians and the public to the ILO convention and to the labour rights of foreign workers.

## 1 Introduction

Personal and household services may contribute to the well-being of families and individuals. On the other hand, low regulation and high informality in the sector creates a risk of precarious working conditions for domestic workers who often come from abroad and thus are in vulnerable position. Domestic work is in a large extent undermined and badly valued which is mirrored in the low wages in the sector and is associated with a high incidence of informal employment relationships (Ezzeddine et al 2012).

In this report, we study the personal and household services (PHS) sector in Czechia. **The aim of this country study is to understand how regulations, public policy and social partners' action may contribute to the improvement of job quality in the sector** and how the informality in the sector is tackled.

We derive our evidence from an analysis of secondary data resources, statistical evidence and available literature, media releases and other sources (e.g. minutes of the actor's meetings). We also conducted seven interviews with the actors in the sector. For the list of interviews see Table 1. Interviews were conducted in 2019. The report further builds on the author's participation in discussions dealing with workers' organizing in the care sector in November 2019 in Brno and in December 2019 in Prague, and on the workshop of AdPHS project in February 2020 in Prague.

*Table 1 List of interviews*

Organization	Position of the respondent	Code of the interview
Trade union in healthcare and social care (Odborový svaz zdravotnictví a sociální péče, OS ZaSP)	Member of the supervisory board	INT1

Association of social care providers (Asociace poskytovatelů sociálních služeb, APSS)	Vice-president for home social care	INT2
Czech association of nurses (Česká asociace sester, ČAS)	Head of the home healthcare department	INT3
Agency for social inclusion (Agentura pro sociální začleňování, ASZ)	Expert on social care system in Czechia	INT4
Charles university in Prague and Organization for integration and migration (Sdružení pro integraci a migraci, SIMI)	Expert on research on migrant workers in Czechia	INT5
Center for trade unions organizing (COZZ)	Employee/recruiter	INT6
Union of employers' associations (Unie zaměstnavatelských svazů, UZS)	Head of the social care section	INT7

Source: Own compilation

In the following parts, we describe in detail the organization of the sector, provide statistical evidence on the extent of the sector and public regulations and employment relations. Subsequently, we analyze discussion on ILO convention ratification on domestic workers in Czechia in 2012. Then we introduce actors who influence the working conditions in the sector and highlight their best practices to narrow precarity and informality in the sector. In the last section we summarize our results.

## 2 PHS sector in Czechia

In this part we introduce the organization of the sector in Czechia, its financing, working conditions and the quality of the services provided. We pay special attention to working conditions where we analyze the sector from the perspective of formality in employment relations, introducing both ends, i.e. from formal employment relations between workers and employers backed by the respective labour legislation, to very informal employment relations between domestic workers and households without legal coverage.

There is no clear definition of the PHS sector in Czechia. In legislation, there are two sources of the definition of activities included into the PHS sector. First, entrepreneurship license for self-employment registration for providing household services define the activities as following: *“Services for families and households which encompass activities of household functioning (cooking, cleaning, washing, ironing, gardening etc.), individual care for children older 3 years in families, short-term and irregular care for children also younger 3 years, care for persons requiring intensive care, and providing them with shopping and other activities related to household functioning”*. As noted in Kotíková & Vychová (2014) care for children up to 3 years on a regular basis is excluded from this entrepreneurship license.

Second, an institutionalized form of personal and household services is rooted in legislation regulating social services, where care service is defined as personal and homecare service

provided to persons with the decreased ability to self-care because of either a higher age, or a chronic disease, or physical disability, or to families with children whose situation requires the help of other person (Matoušek 2007). The service offered in households may encompass the following activities<sup>1</sup>:

- a) help with regular care activities for a person
- b) help with personal hygiene or creating conditions for personal hygiene
- c) help with household functions
- d) intermediating social contact

The PHS sector in Czechia encompass mostly care for elderly people and partially childcare and housekeeping. Therefore, in the report, we mostly refer to these three activities as the prevailing form of domestic work in Czechia. We give special emphasis to elderly care (divided into social care and healthcare) as this sector encompass both formal and informal care regimes and is expected to grow rapidly in the future.

The Czech PHS sector can be divided into **public and private according to the sources of financing**. In the case of Czechia we argue that public financing ensures formal employment relations in the sector, while various private resources leads to precarity and informality in working conditions. **The public PHS sector** is regulated and controlled by public institutions and provides healthcare and social care services. **The private PHS sector** encompasses personal and household services provided at home such as childcare, cleaning services, and increasingly, care for elderly people on the basis of semi-formal and informal employment relations. While the first subsector is larger in terms of clients, formalized in terms of regulation, financed mostly from public resources, the second one, is in contrary, poorly regulated by public institutions, provided only by private subjects, and employees are exposed to far more precarious working conditions than in the formalized part of the sector.

A special category are family members providing home care (e.g. for elderly people) who are in the literature called ‘**informal care providers**’ (Riedel & Kraus 2011). We do not include them in our analysis but we pay attention to this groups because their presence or absence in care activities creates the demand for homecare services provided by outsiders (Carrera et al 2013).

We’ve summarized the main differences between the public and private PHS sector in the following Table 2:

*Table 2 Organization of the PHS sector*

	Public PHS services (healthcare and social care for elderly and disabled)	Private PHS sector (e.g. cleaning, childcare, elderly care)
Source of financing	Mixed, public financing prevail	Private, no public transfers

<sup>1</sup> According to the law on social services no. 108/2006 Coll. Par. 40 (2)

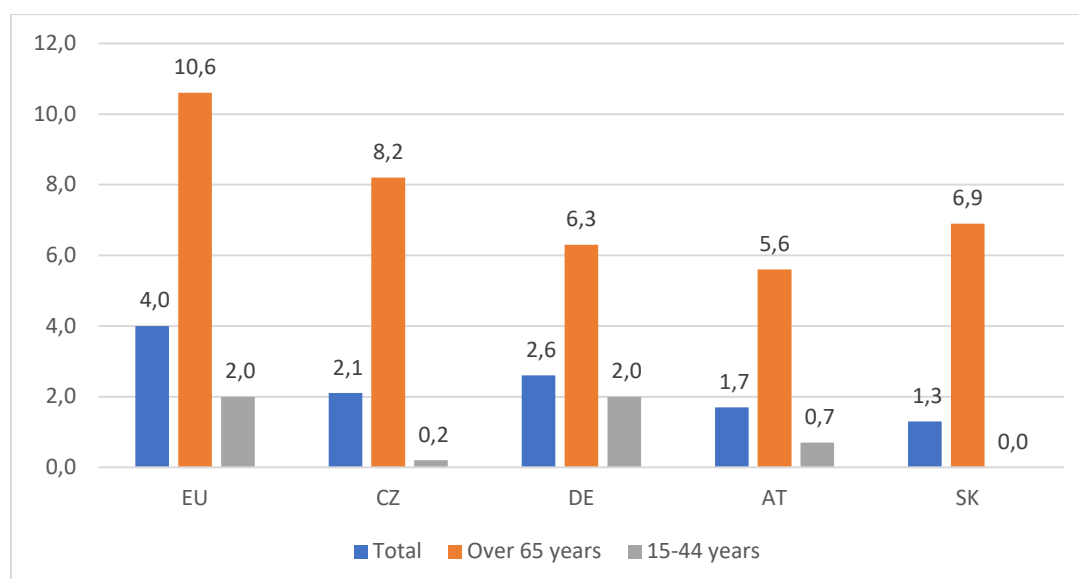
Regulation	Special regulations (Ministry of Healthcare, Ministry of Labour, municipalities and regions)	Regulated through standard commercial and labour legislation, no special regulations
Providers	Mix of public and private providers (incl. NGOs)	Only private providers (staffing agencies and individuals)
Scope of services	Live-out service dominates, live-in extremely rare and only short term in the form of palliative care	Live-out service dominates, live-in form occurs, especially migrants perform this work, but the incidence is still rather rare
Clients	Elderly, disabled	Families with children, households, elderly
Employment relations	Formal, regulated by the Labour Code (partially informal in the case of family care)	Semi-formal and informal, if formalized, should fall under the Labour Code regulation
Foreigners participation	In specific cases	More frequent, but not exclusive

Source: own contribution

## 2.1 Extent of the sector

Here we introduce the extent of the sector using two indicators, the self-reported use and employment statistics. The overall percentage of users of homecare services based on self-reported use is lower compared to the EU average at around 2,1% according to Eurostat (see Figure 1). The number increases to 8.2 % for those over 65 years old, which is interestingly, higher, compared to Austria or Germany. Nevertheless, the statistics do not tell us anything about the intensity of the services used by the cohort over 65 years. As we show later, Czech pensioners might be receiving homecare service in the form of meals-on-wheels provided by social services for a very long time until they need more intensive care (Kubalčíková & Havlíková 2016). The home social care service in the form of meal delivery thus enter statistics as a “use of care” but could not be considered as intensive care provided to the elderly.

Figure 1 Self-reported use of homecare services, in 2014, %





Source: Eurostat: hlth\_ehis\_am7e

Despite relatively high self-reported use, the number of employees working in personal care services is relatively low but has slowly been increasing since 2011 (see Table 3). In absolute terms, the number of workers in PHS services increased from 56,1 ths. to 84,9 ths. from 2011 to 2017. The share of women has slightly increased from 84 to 90 percent (see Table 5).

Table 3 Personal care employees (share on total employment), in %

	2011	2012	2013	2014	2015	2016	2017
EU 28	3,44%	3,42%	3,22%	3,21%	3,25%	3,25%	3,31%
CZ	1,17%	1,24%	1,33%	1,23%	1,36%	1,63%	1,68%
DE	1,64%	1,06%	1,13%	1,11%	1,12%	1,20%	1,24%
AT	2,46%	2,54%	2,63%	2,74%	2,80%	3,04%	2,91%
SK	1,48%	1,61%	1,88%	2,16%	2,06%	1,89%	2,15%

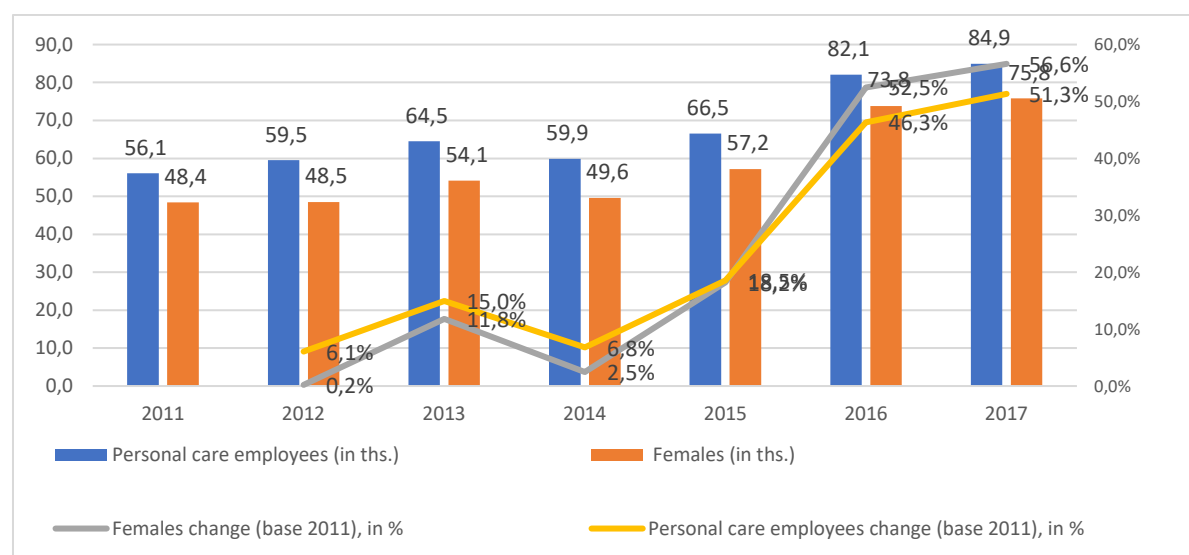
Source: Eurostat, lfsa\_eseeg

Table 4 Personal care employees

	2011	2012	2013	2014	2015	2016	2017
Personal care employees (in ths.)	56,1	59,5	64,5	59,9	66,5	82,1	84,9
females (in ths.)	48,4	48,5	54,1	49,6	57,2	73,8	75,8

Source: Eurostat, lfsa\_eseeg

Figure 2 Personal care employees



Source: Eurostat, lfsa\_eseeg

Table 5 Personal care employees (women's share on personal care employees)

	2011	2012	2013	2014	2015	2016	2017
EU 28	89%	89%	89%	89%	88%	89%	88%
CZ	86%	82%	84%	83%	86%	90%	89%
DE	85%	82%	82%	84%	84%	83%	83%

AT	87%	89%	91%	87%	87%	89%	90%
SK	91%	92%	89%	85%	91%	91%	91%

Source: Eurostat, ifsa\_esegg (socio-economic groups – personal care employees)

### 3 Public part of the PHS sector (healthcare and social care services)

#### 3.1 Organization of the sector

The Czech public PHS sector should be understood primarily as a part of a broader long-term care sector targeted at elderly and disabled people. The long-term care sector includes both home care and institutional care that are interwoven, although not systematically coordinated. This means that there is no clear policy of prioritizing homecare over institutional care and clients' decisions are made upon the service availability in the place they live, the financial resources they have available and their personal preferences. Moreover, the Czech long-term care sector, which also applies to its homecare subsector, remains split and poorly coordinated between healthcare and social care, which undermines its ability to provide efficient care services to different clients with various specific needs (Kubalčíková & Havlíková 2016). This is also the reason why the system of long-term care is criticized for its lack of services integration, their shortage and poor quality (Sowa 2010).

Homecare services within the public sector are not understood as an independent part, but is rather integrated into other healthcare or social care services. Responsibilities in the sector are split between the Ministry of Healthcare (MH), the Ministry of Labour and Social Affairs (MoLSA), and regions and municipalities. While ministries mostly allocate financial resources to health care and social care services, municipalities and regions are responsible for services delivery operating within the system of public financing, either through their own facilities or through the private providers (non-governmental organizations or private companies). The state thus defines the framework for service standards and working conditions, as well as allocates financing, while regional and municipality administrations are responsible for service accessibility.

Homecare services financed by the public sector are provided either through the Agencies of Home Healthcare Services (*Agentury domácí péče*) registered by the Ministry of Healthcare, or through the Providers of Social Care (*Poskytovatelé pečovatelské služby*) registered by MoLSA. In 2017 there were 658 providers of Home Healthcare services registered by the MH and 702 providers of social care registered by MoLSA. Those two types of providers may overlap in practice, especially when the provider aims to offer complex services for clients. This complex approach is preferred by users since elderly people typically need both

healthcare and social care assistance<sup>2</sup>. This variability of providers of homecare services is partially coordinated by the municipalities and regions that usually provide a catalogue of services providers in the area. Nevertheless, the case management is poorly developed in Czechia and there is a lack of coordination among the different types of services offered to the clients (Kubalčíková & Havlíková 2016).

Table 6 Organization of public PHS sector (home healthcare and home social care service)

	Home healthcare services	Home social care services
Main regulator at the state level	Ministry of Healthcare and healthcare insurance companies	Ministry of Labour and Social Affairs
Main coordinator in the area	Regions and/or municipalities	Regions and/or municipalities
Subjects that provide the service	Agencies of Home Healthcare Services ( <i>Agentury domácí péče</i> ) – nurses and other registered specialists	Providers of Social Care ( <i>Poskytovatelé pečovatelské služby</i> ), “social care assistants”, family members
Type of services provided	Healthcare, incl. palliative care	Social services, typically personal hygiene, housekeeping, meals delivery
Possible legal forms	Organizations established by municipalities or regions (public institutions), NGOs, private companies	Organizations established by municipalities or regions (public institutions), NGOs, private companies
Number of subjects registered in 2017	658	702
Sources of financing	Public (healthcare insurance, clients payments within cash-for-care benefits system and own contributions)	Public (subsidies of MoLSA, clients payments within cash-for-care benefits system and own contributions)
Number of clients	138,303 in 2017	100,673 in 2017

Source: own compilation

### 3.2 Financing of the public PHS sector

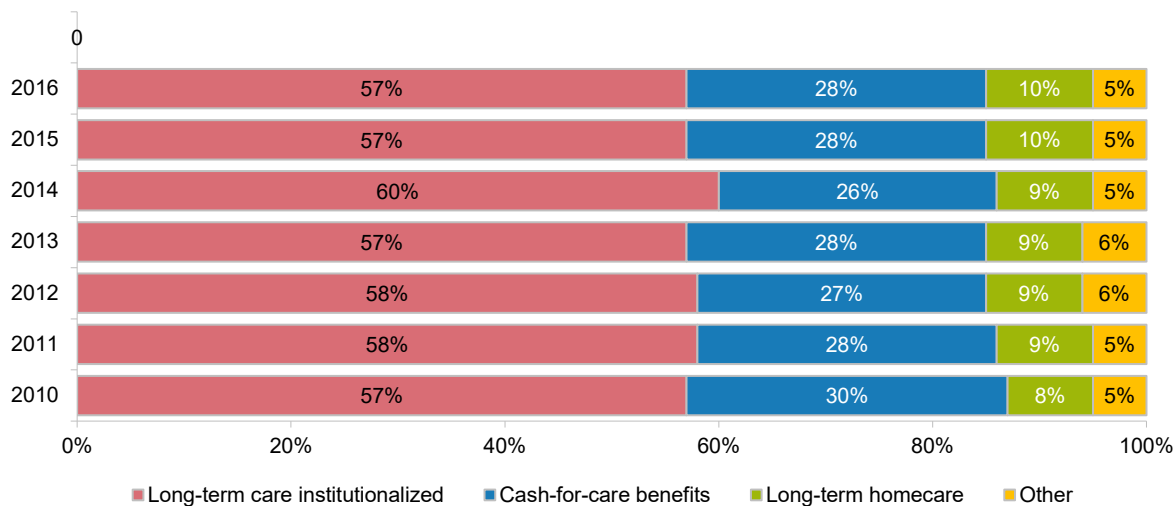
Homecare services within the public PHS sector are financed from several resources. Around 72 per cent of financial resources comes from cash-in-care benefits of clients and state subsidies to social services providers, and 28 per cent comes from healthcare insurance payments. Overall, expenditures in long-term care services constitute 17% of all healthcare and social care services expenditures, which is 3% above the OECD average (CSO, 2018)

As it was reported by the Czech Statistical Office (CSO), 65,3 CZK billions was spent in 2016 on long-term care, of which **10 % was spent on homecare services**, while 57 % was spent in

<sup>2</sup> Under healthcare assistance we understand the activities that need to be performed by a qualified nurse (or doctor) such and injections, bandages or surgery wound care. Physio-therapy falls under healthcare assistance, too. Under social care assistance, we understand the need for help with daily tasks such as cooking, shopping, laundry, and assistance in socializing. Elderly people usually need both kinds of care.

institutionalized care and 28 % was paid in social benefits (cash-in-care benefits) to the disabled and elderly (CSO, 2018).

Figure 3 Expenditures on long-term care in Czechia between 2010 and 2016 (in %)



Source: CSO (2018)

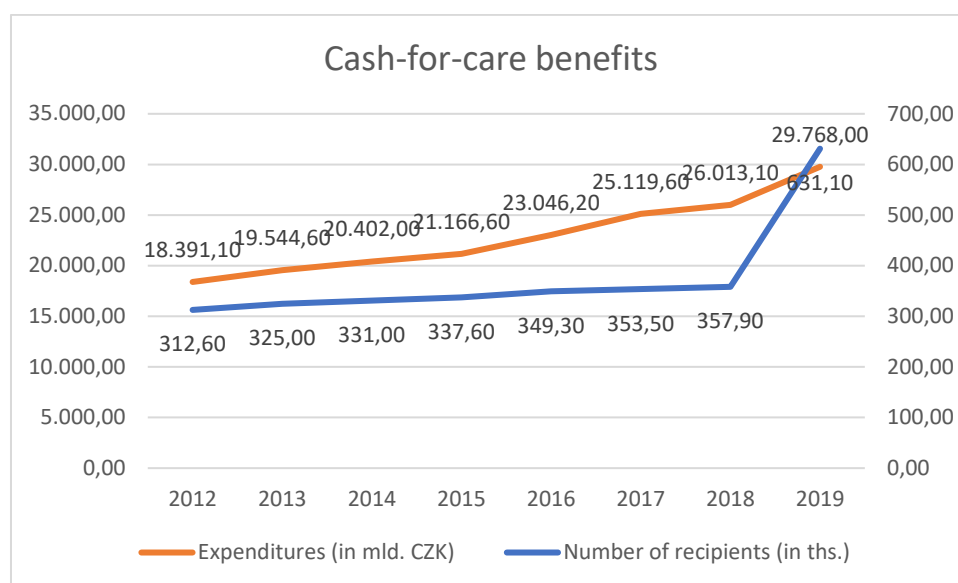
In 2006, Czechia introduced the **cash-for-care system** of social benefits, so that recipients would be allowed to buy care services directly from providers. The reason was to promote competition among private providers and increase efficiency as well as empower clients to choose the service providers according to their needs. The cash-for-care system assigns a person with disabilities to the one of the four categories based on the level of their dependence (disability). The eligibility criteria is to be ill or disabled for at least a year and/or no progress is expected in the next 12 months. Contributions for person under 18 years are lower than those for the adults. The final decision to social benefit entitlement is made by the Labour Office supported by the assessment of the doctor and social workers. The Labour Office also controls the use of social benefits. Those disabled older 18 years may obtain from 3300 CZK (124 EUR) in the first degree of dependence, to 6600 CZK in the second degree, 9900 in the third degree, up to 13 200 CZK (498 EUR) in the fourth degree as a monthly payment, which might be increased to 19 200 CZK (724 EUR) if the care is provided at home. For those younger than 18 years, the amounts are lower: 880 CZK in the first degree, 4400 in the second, 8800 CZK in the third (or 12 800 CZK if the care is provided at home), up to 13 200 CZK (498 EUR) in the fourth degree as a monthly payment, which might be increased to 19 200 CZK (724 EUR) if the care is provided at home (Act on social services no. 108/2006 Coll. §11).

Homecare assistance or an institutionalized form of service may be financed from these benefits. For those who require 24-hour service at home, the contribution of 13 200 CZK valid until April 2019 was not sufficient (INT1, 2019), but the recent increase to 19 200 CZK per month reacts to the increased demand for homecare for elderly people. In the case of home healthcare service provided by the qualified nurse, the costs are covered from the public

healthcare insurance system. Therefore, the social benefits for care are mostly used for social care assistance provided at home or in the institution.

The number of cash-for-care benefits recipients and the level of expenditures has been increasing since 2012 (see Figure 3). In 2019, 29 768 eligible recipients obtained the sum of 631 mil. CZK (24 mil EUR). The main critique of this system is that it does not provide control of the received amounts. In practice, recipients are not obliged to use the received benefits for care provided by registered providers, and in many cases thus serve as additional household income. According to available data, only 21 per cent of received benefits are spent for the social care services provided by the registered providers, while the remaining 79 per cent are used for informal care providers, including family members, or are not used on care services at all (Vostatek et al 2012)

Figure 4 Number of recipients of cash-for-care benefits and expenditures



Source: own compilation based on MoLSA data: <https://www.mpsv.cz/informace-o-vyplacenyh-davkach>

The system of cash-for-care payments that is based on the on-demand principle bear some other caveats besides inefficient allocation, such as lack of regulation of services provided, difficulties in ensuring their accessibility in the remoted areas, lack of information among users about providers and difficult coordination among providers. The system of cash-for-care benefits is supplemented by the health insurance transfers for home healthcare services, and subsidies for home social care services. The state transfers to social care administrated by the MoLSA were subject to the critique of the Supreme Audit Office of the Czech Republic for the lack of transparency in providing subsidies, lack of conceptual material that would guide the

decision in assigning the subsidy and also a lack of control in the subsidies' recipients (NKÚ 2014).

### 3.3 Accessibility of services

In the last 10 years, the number of providers in **home healthcare services** has increased from 503 in 2007 to the current 658<sup>3</sup>, however, the number of patients has remained stable since 2007, 134,436 patients used the home healthcare services while in 2017 their number increased only marginally to 138,303 patients (ÚZIS, 2018). On average, 10.94 people per 1000 inhabitants used home healthcare services in 2017, which was 13 people per 1000 inhabitants older than 65 years. This number has been almost consistent for the last 10 years.

Nevertheless, the number of persons employed in home healthcare services has slightly increased since 2007. For instance, the number of nurses has increased from 3090.7 in 2007 to 4752.2 in 2017, counted in average full-time equivalent<sup>4</sup>. Number of other specialists counted as average full-time equivalent has increased from 267.1 to 352.9 in the same period (ÚZIS 2018).

Home healthcare services are provided upon prescription of the practitioner who recognizes the patient's need to obtain healthcare at home. Therefore, it is difficult to deduce the demand for healthcare services at home. What is recognizable, is the economic efficiency of health home care as opposed to hospital care; 12-13 ths. CZK per day in institutionalized care, compared to 1200 CZK for home healthcare (INT3, 2019). Nevertheless, home healthcare is poorly supported within the system of financing of healthcare services when practitioners are not motivated to prescribe home healthcare, and healthcare insurance companies systematically reduce expenditures on home healthcare services, instead of its support (INT4, 2019)

**Home social care services** are provided by municipalities, NGOs, and private subjects, but also other subjects or even individuals may try to enter the public network of social care providers. Social care providers provide their services based on the Act on social services no. 108/2006 Coll. Since 2007, they have been entitled to provide their services directly to elderly and disabled people who are recipients of the cash-in-care benefit.

In this sector, the number of employees and providers has been increasing since 2007 while the number of clients has stagnated (see Table 7). This might be explained by the changing character of the services provided. **While for a long time, services, such as housekeeping, shopping or meals delivery were provided by social care services, currently, these services**

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<sup>3</sup> 84% of these providers are specialized Home healthcare service providers, the rest are hospitals (5%) and other providers (specialized centers, palliative care hospitals etc.)

<sup>4</sup> Respondent from Czech Nurses Association consider number on employment unreliable, as in the sector there is a struggle for nurses „everywhere“ (INT3, 2019).

are available on the open market supplied by private providers or ensured by family relatives, while social care services targets activities of personal services to elderly people, e.g. personal hygiene, or physiotherapy, which are much more time-demanding than meal delivery (INT4, 2019). Nevertheless, in many social care providers, meal delivery remains the most common service provided (INT2, 2019).

Table 7 Number of clients and employees in the formalized PHS sector

	2007	2017
<b>Healthcare services</b>		
- employees (nurses)	3,090.7	4,752.2
- clients	134,436	138,303
<b>Social care services</b>		
- employees (social care services)	4,478	10,571
- clients of homecare services	98,373	100,673
- clients of social care assistant	692 (in 2012)	4,020 (1.14%)
- recipients of cash-in-care benefit	308,165	353,020
- % of cash in care benefits outside the social care services	68%	71%

Source: ÚZIS and MoLSA databases, own compilation

Alternatively, home social care can be provided by “**social care assistant**” which is a non-family member who provides care for a senior who is the recipient of cash-for-care benefits. In 2018, 4020 of recipients of cash-for-care benefits indicated that they receive care from social care assistants according to the Labour Office<sup>5</sup>. This group of care providers can be considered partially informal, because their work is conducted without any standard employment contract but they are entitled to healthcare and social insurance covered by the state and they are exempted from income tax payments up to 12 ths. CZK.

Another option of care provision is the use of institutional care services. As is visible from Table 7, more than two thirds of cash-for-care beneficiaries receive other care than that provided by social homecare providers or social care assistance. The two thirds of care is thus served either by family members, institutions or by possibly informal caregivers.

### 3.4 Quality of services in the formalized sector

The act on social services provides guidelines on the quality of services. The “National Quality Standards of Social Services” is appendix to the Act and states the duties of social care services

<sup>5</sup> Source: response to the researcher’s request for the purpose of this study.

providers. The standards are split into three categories: procedural (goal, principles, human rights, conflict of interests, contract, documentation, complaint management, user centred attitude, etc.), personal (staff composition, education, personal goals and developments, volunteers, rewards, communication channels, etc.) and technical (equipment, information, critical situation, quality raising, etc.) (Horecký 2013).

The Ministry of Labour and Social Affairs and the regional Labour Offices are entitled to provide controls of quality based on these guidelines, and if some irregularities or maltreatment is found, it is reported and the subject of punishment (in the most serious cases in the form of licence withdrawal). According to the data available, the most common subject of inspection were social care services, 229 controls out of 347 (66%) of which 36 out of 229 (16%) were controls in social homecare services, while the most frequently controlled service was residential care services provided in institutions (MoLSA 2017).

There is discussion whether quality controls by MoLSA leads to increases in quality. On the one hand, standards implemented since 2007 were explicit in the focus of social services is client well-being. This was a significant improvement for clients who became defined from “mere objects to subjects” (Horecký 2013, p.6). On the other hand, social service providers consider quality standards too broad and their controls unhelpful and too administrative, and not leading to an increased quality of services (Janáčková 2019). According to the recent study of Supreme Audit Office (Národní kontrolní úřad, NKÚ), social services suffer from lack of quality (NKÚ 2019). The quality of service in homecare services is also highly dependent on the organization of work, which is highly dependent on organization’s management and is difficult to control (INT4 2019).

There are also alternative programmes of quality checks developed by non-government bodies. The most well-known is the brand “The mark of quality” introduced by the Association of social care providers in Czechia (APSS ČR). It offers external audits to social care providers applying the clients’ perspective on the provided services and assigning “stars” to the audited providers, which is also designed to increase their prestige among clients.

### 3.5 Working conditions in the public part of the PHS sector

Working conditions in the public part of the sector are relatively better than those in the private and informal part, however, there is evidence of internal flexibilization in the form of overtime work. Social care workers also suffer from low wages and are struggling with satisfactory health and safety working conditions in the households (INT2, 2019)

On average, homecare social workers worked 6 hours more per month compared to their colleagues in institutionalized care in the public sector (see Table 8). Wages at the public social services providers are 20 per cent lower compared to average wages. In the case of private providers operating in the publicly financed system of social care, the wage difference is even higher, 27 per cent lower compared to average wage. Wages of social care workers are even



lower when compared to the wages of nurses in hospitals, whose work is to some extent similar to home healthcare work; nurses in hospitals earn between 7 to 8 EUR per hour, while workers in the social care services receive between 4.3 to 4.7 EUR per hour (see Table 9). Moreover, wages are not even increasing in line with increases of other similar occupations in the public sector. While the average wage of nurses in hospitals reaches 35 ths. CZK (1320 EUR) per month, in home healthcare it is almost 400 EUR less, around 25 ths. CZK (943 EUR) per month<sup>6</sup>.

Table 8 Wages and hours worked in the PHS sector

ISCO category (5322) carers in social services in terrain works and home care	Wages	Hours worked	Hourly wage in CZK	Hourly wage in EUR
public sector	21,634	173.7	124.52	4.70
private sector	19,944	173.7	114.80	4.33
ISCO category (5321) carers in social services in institutional care				
public sector	23,265	167.2	139.19	5.25
private sector	20,904	171.2	122.13	4.61
ISCO category (2221) nurses with specialization				
public sector	39,859	173.8	229.33	8.65
private sector	33,104	171.8	192.68	7.27

Source: ISPV, 2017, own compilation, <https://www.mpsv.cz/cs/3869>

Health and safety issues relates to the working conditions of homecare workers in particular households. In many cases, lifting clients require special equipment, which the family of the client is expected to provide. If not, workers are exposed to undesired physical pressure. Another issue is the state of the clients' households, in some case, hygiene is at very low level which creates issues for the social services providers (INT2, 2019).

**Social care assistants** were introduced in 2011 in the law on social services No. 106/2006 Coll. as an effort to formalize non-formal care givers not being a family member. Social care assistants are not officially employed, their semi-formal employment status covers healthcare insurance, but they don't have a guaranteed wage, nor are they in an employment relationship with their clients. Social care assistants can provide their services only to recipients of cash-in-care benefits. Since 2012, the number of assistants in social care has increased from 693 in 2012 to 4020 in 2018, but in relation to all recipients of cash-in-care benefits, they provide help to only 3.3 per cent of people above 18. Data about their average income are not available. It is expected that despite this semi-formal character of work, a very limited number of foreigners are involved in this form of care and that it primarily serves as a way to formalize informal relations in homecare provided by neighbors and persons non-related to the family of disabled.

<sup>6</sup> [https://www.novinky.cz/domaci/508782-poskytovatele-domaci-pece-se-neshodli-s-pojistovnamy.html?fbclid=IwAR1jmwEEAxznwFrCS3fPO1rioxqZLJ6\\_AlJuyb9yGVuIHIdyQPZhAojSL88](https://www.novinky.cz/domaci/508782-poskytovatele-domaci-pece-se-neshodli-s-pojistovnamy.html?fbclid=IwAR1jmwEEAxznwFrCS3fPO1rioxqZLJ6_AlJuyb9yGVuIHIdyQPZhAojSL88)

## Conclusion

Publicly financed PHS sector provides a significant amount of care services, especially for elderly and disabled. The sector provides a wide spectrum of services from homecare, to social care to health care service. The main drawbacks of the system include ambiguous policies between preference for homecare or institutional care and inefficient form of financing. Nevertheless, the sector constitutes important part of the care services for elderly and disabled.

Expenditures on long term care in the sector are increasing while the number of clients is stagnating. The same can be said about the number of employees which is increasing as well. This may mean that only long-term care and more complicated cases are covered by the public home care services, while lower degrees of disabilities and needs are served by family members, “social care assistants”, or other informal caregivers or caregivers outside the regulated sector.

Working conditions in the sector, despite being mostly formalized and in line with the labour legislation does not fully prevent precariousness. Low wages, overtime work and client attitudes to service providers create a mixture of potentially difficult and precarious working conditions. In recent years, the lack of employees has also increased the pressure on the performance of the remaining workers.

## 4 Private part of PHS sector

### 4.1 Organization and financing of the sector

Private PHS sector in Czechia is regulated only by commercial and labour legislation, there are no special provisions for workers, nor providers in the PHS sector. The private sector is financed from a user’s own resources only. The sector encompass services either not provided within the public services schemes such as household services (cleaning, childcare) or it supplements the low availability of public health and social care services, especially for elderly people.

The providers in the private part of the sector are most usually agencies offering cleaning and childcare services at home. They are not registered as social or healthcare services providers, only as agencies providing homecare services based on entrepreneurship license. They employ workers on various short-term contracts. Self-employed also operate in the sector, although their numbers are unknown. Informal workers without any type of the contract are mostly students, retired, and unemployed.

### 4.2 Accessibility and quality of services provided

There is significant lack of statistical data and empirical evidence about the private part of the PHS sector in terms of employment, working conditions and providers. This is also the reason

it is challenging to propose any meaningful policies to increase the protection of workers in the sector, or to check the quality of services provided.

#### 4.3 Migrants in the PHS sector

In the perspective of migration, Czechia represents the case of a transition country encompassing both : Czechs migrating to provide PHS services in other countries, most usually Austria and Germany, and migrants providing homecare services in Czechia. Among Eastern-Europeans who provide care in Western-European countries, Czechs are the least numerous groups working in the PHS sector in Austria or Germany (Kleknerová 2013). Therefore, in the following part we concentrate on migrant workers providing services in Czech households within the PHS sector.

Among migrants residing in Czechia, Ukrainians are the second most numerous group, of which, many provide homecare services. The overall number of Ukrainians providing personal and household services is unknown. In general, 23 % of foreigners in Czechia are from Ukraine, 117 ths., out of 470 ths. foreigners registered in the country (CZSO 2018a). Migration of Ukrainians is perceived as economic, because of the poor economic conditions in their home country (Drbohlav 2001), and it is also characterized as a circular, because of the relative geographical proximity to Czechia (Ezzedine 2012). Migrants therefore use the strategy of circular migration because many of them need to support their own families left at home.

Migrant workers who work in the PHS sector, in majority women, work in the live-out form of employment, i.e. they work for household(s) but reside elsewhere. Migrant domestic workers perform jobs as a babysitters and cleaners and in some cases also care for elderly people.

The only research that studied domestic migrant workers was performed in 2014. From the research we know that average age of migrant women working in the PHS sector in Czechia was 36.4, and the average length of stay was 8 years. At least 50% of women had at least one child that was based in their country of origin. 91% of migrant workers had at least a secondary education, of which 25 % had a university diploma. Migrant women working in the PHS sector were thus more qualified than Czech domestic workers. 73% of them were able to speak Czech (Ezzedine & Semerák 2014).

The life-in form of household employment was still very rare and was observed only in several cases of Philippino women providing live-in service in the Czech or foreigners households (Ezzedine 2014). Households, where migrant workers are employed, were very often composed of migrants as well. In the survey, 30% of households were international, 63% were Czech households (Ezzedine & Semerák 2014).

#### 4.4 Working conditions in the private part of the PHS sector

Czech national legislation does not recognize work in household as a specific type of work and is considered to fall under the standard employment relationship and/or to the commercial code, which paradoxically pushes the majority of domestic workers and their employers (households) outside the scope of legal employment relations.

#### 4.1.1 Forms of employment

In the private part of the sector, especially in cleaning and childcare services, we find various forms of semi-formal and informal employment relations. Semi-formality refers to the situation when domestic worker officially has an employment contract, but this contract underestimates the actual hours worked in the sector and/or encompass only vague or incomplete specification of the working tasks. For instance, an agency signs a contracts with an employee, where the specification of the hours worked, or the tasks performed does not correspond to actual working time.

Another form of semi-formality in the sector is the use of self-employment to provide domestic works. The majority of foreigners use this form of employment to satisfy the legal obligations for their stay in the country. Since the migrant's permission to stay is related to official employment, their participation in the informal part of the sector is usually rather additional to official work.

Ukrainians, more than any other nationalities living in Czechia, use the self-employment status to perform work. Out of all foreigners who have an entrepreneurship license, 25 percent are Ukrainians (CZSO 2018b). The reason for this overrepresentation is connected to their non-EU nationality status which makes their employment on the labour market more complicated. Therefore, to legalize their stay they, opt for self-employment status. It is also connected to the character of the work performed, the entrepreneurship license is used in services (including PHS sector) and construction.

Domestic workforce is also employed in the PHS sector, most usually temporarily, performing cleaning and babysitting services. The precondition for participation in the PHS sector for the domestic workforce is covering the compulsory healthcare insurance, typically from the state. This means that mostly students, unemployed and retired people participate in the sector. They can be employed by the staffing agencies on short-term contracts, but they can participate as informal workers as well.

#### 4.1.2 Wages in the sector

The average wage in the informal PHS sector was in 2018 from 100 to 200 CZK (3.8 to 7.6 EUR) per hour. Childcare costs from 130 to 180 CZK per hour, cleaning is usually determined by the minimum hours spent in the household, e.g. 4 hours of work would cost around 800 CZK (200 CZK per hour). Migrant workers, however, reported even lower wages and, their satisfaction with the hourly wage was explained by the fact that domestic work is not their only source of

income or they work long hours to reach desired income, while in the case of live-in service it was explained by the coverage of other costs such as living costs and food (Ezzeddine 2012).

Compared to the public sector wages, the wages in the semi-formalized sector are similar, but what is important here is the comparison with the regimes of earning. First, wages in the public PHS sector includes social and healthcare insurance which is ruled-out in the majority of semi-formal employment relationships. Labour costs needed to pay all legally enforced requirements for labour costs are simply too high to be paid in the private part of the sector. Therefore, what is usually the burden of employer is not paid here. This is also the reason why various alternative forms of employment which encourage no contributions to social and healthcare insurance are spread. For the main differences in working conditions between formalized and semi-formalized PHS sector please, refer to Table 9.

Table 9 Working conditions in the PHS sector

	Formalized PHS sector social care	Semi-formalized PHS sector: Czech workers	Semi-formalized PHS sector: foreigners
Hourly wage	114 – 124 CZK per hour (4.33 – 4.70 EUR)	100-200 CZK (3.8 – 7.6 EUR) per hour	100-200 CZK (3.8 – 7.6 EUR) per hour
Prevailing form of employment	Full-time employment contract	Short-term, or small-job contract, no contract at all	Short-term, or small-job contract, self-employment, no contract at all
Health insurance coverage	Fully covered within the state health insurance system as an employee	Fully covered within the state health insurance system as non-active population (students, pensioners, unemployed)	Paying compulsory insurance for foreigners, insured in private companies outside the state system of healthcare insurance
Social insurance	Fully covered	Not covered	Not covered
Job stability	High	Low	Low
Employer	Officially registered (public institution, NGO, firm)	Staffing agency – registered, or household - unregistered	Staffing agency – registered, or household - unregistered
Collective bargaining	Possible but extremely rare	Not present	Not present

Source: own compilation

#### 4.1.3 Households as an employer: a lot of costs and no benefits

Since domestic work is not recognized as a specific job, according to the legislation, it is expected that a **household will register as an employer for a domestic worker**. The problem is that the administrative burden imposed on employer, in this case the household, discourages the formalization of working relations in the sector. If the household representatives decide to register as an employer, this would mean they would need to register in at least 3 different institutions (healthcare insurance, social insurance company and the tax office) and follow the accountant agenda as a regular employer. The household would

be thus obliged to pay social and healthcare contributions and tax to the three different offices on a monthly basis. Such administration burden is associated with increased costs on legal employment of domestic workers and also requires increased capabilities to administer the work. The costs of formal employment, where a household acts as an employer, may be as twice as high compared to informal employment or self-employment of a domestic worker. According to Faltová (2014), high administrative burden associated with high labour costs, discourages decent working conditions for domestic workers.

Households, logically, opt for the easier and cheaper options of either hiring agencies that employ domestic workers or hiring self-employed workers or hiring without any form of contract. In the case of hiring an agency worker, the household is in the position of user employer. The most common type of the contract for domestic workers working for an agency would be a small employment contract ensuring very low social insurance protection. Moreover, the content of a work contract may differ from the actual work, e.g. it refers to providing teaching activities at a household, or administrative work, while the performed work would be cleaning or babysitting (INT5, 2019).

#### 4.1.4 Working conditions of migrants

Within this setting, foreigners are found in a vulnerable position. If a household wishes to employ foreigners legally it would mean further administration and responsibility associated with employing said foreigners. Foreigner participation on the labour market is regulated by the Act no. 326/1999 Coll. on the Residence of Foreign Nationals in the Czech Republic which specifies conditions under which foreigners can be employed on the Czech labour market. Permission to stay in Czechia is related to the particular employer who employs the foreigner which for foreigners creates difficulties if they decide to change an employer. In the case of a household acting as an employer, this would mean additional administration associated with employing the foreigner especially from non- EU countries. All these administrative obstacles make legally employing domestic workers by households non-existent in practice. However, state representatives argue that specific rules on the employment of domestic workers is not necessary, since actual legislation allows for legally employing domestic workers (Faltová 2014). This is also the reason why most of the employment is realized through agencies, however there are restrictions for foreigners. Foreigners also cannot be employed as agency workers in the household sector. This is also the reason why their work contracts do not correspond to the realities of their working tasks.

Another problem connected to domestic work is the impossibility to perform Labour Inspection at the workplace. The reason is, that entering the households for the purposes of working conditions control would mean a violation of fundamental rights and freedoms in the privacy guarantee. This is also the reason health and safe working environment at households cannot be controlled by officials.

To conclude, foreigners experience dependent position on their employers, perform work that does not match their work contracts and/or participate on the PHS sector as self-employed. Work permission aligned with their permission to stay is pushing them to a highly dependent position on their employers. The possibility of being employed through an agency would increase domestic worker protection (Faltová 2014).

NGOs criticize this situation because the labour rights protection of foreign workers is poorly enforced. As Faltová (2014) points out, foreigners performing informal work at households may be fined up to 100 ths. CZK (approximately 3 ths. EUR) and also may be expelled from the country for 5 years (§119 par. 1b, Act on employment). Some sanctions might also be imposed on households which employ foreign workers without a contract (up to 5000 ths. CZK, 200 ths. EUR), but the probability is low: *“From advisory activities of NGOs we know that in many cases only foreigners are punished, while households are not even involved in the procedure”* (ibid, p. 66). Moreover, foreign workers in general do not trust in public institutions that are designed to enforce their protection which further weakens their position on the labour market.

#### Summary on PHS sector in Czechia

- The Czech PHS sector can be characterized as small in the number of workers and also in the number of users. It encompasses 2.1 % of households and 1.68 % of the workforce. The most frequent users of homecare services are elderly, among 65 years or older while 8.2% use homecare services.
- The public part of the sector ensures care for elderly and disabled people, the private part ensures a broader spectrum of activities, from cleaning to babysitting but also elder care.
- Expenditures and employment in the public part of the PHS sector have increased in the last 10 years, but the number of clients has stagnated. This indicates some unsatisfied demand among households for homecare services financed from public resources.
- The size of the private part of the sector is unknown, but is expected to rise
- Although households preferences may change in the future, for now, the demand for housekeeping and babysitting (ensured only through the private part of the sector) is limited to some socio-economic groups, living in larger cities and very often in families with a migrant background.
- Working conditions in the sector are precarious to some extent in both parts of the sector. Wages are low, and do not differ significantly between the subsectors, although job security and job stability is much higher in the public part of the sector where regular employment contracts dominate.
- In the private part of the sector we find mostly semi-formal employment relations, informal work is mostly performed by domestic workers, while foreigners usually have some form of employment contract or work as self-employed.

## 5 Ratification of ILO convention on domestic workers

ILO convention no. 189/2011 on domestic workers (further referred to as Domestic Workers Convention, or only Convention) was discussed but not ratified by the Czech government and Czech Parliament in June and July 2012. During this process, there was no public discussion about the issue. Obviously, one of the reasons was that the Government did not recognize the working conditions of domestic workers as a problem in the country. The Ministry of Labour in its reasoning argued that according to statistical evidence, there is only 49 foreigners employed in households (NACE category T – activities of households as employers)<sup>7</sup>, while it did not consider, not even mentioned the informal part of the sector that is according to various non-governmental organizations to some extent present in Czechia and involves mostly vulnerable groups of foreigners.

During the process of discussion, no opposition arose to the proposed Government statement of non-ratification of the Convention. In the inter-ministerial comment procedure, the biggest trade union confederation ČMKOS was the only organization which expressed the importance of the Convention and demanded the government introduce legislative changes, such that a labour law will comply with the Convention. Nevertheless, this demand was not accepted, and the Government only resumed Convention compatibility with the national legislation. According to the Government's view, the Czech legislation is not compatible with the Convention only in the following aspects:

- decent living conditions that respect the privacy of domestic workers (Article 6)
- working time and periods of rest, especially part 3 of article 10 since the Czech legislation does not recognize the on-call service of domestic workers as a working time
- the right to a safe and healthy working environment (Article 13) and the possibility of providing labour inspection controls in the households (Article 17) since **there is no possibility to provide controls in households** as the controls in the households would violate the Charter of Fundamental Rights and Freedoms in the article 7, par. 1 (privacy guarantee), article 10, par.2, and article 12 par. 1
- the way of reaching an agreement between domestic workers and employers about the residence in the households (Article 9) where the Czech legislation recognizes the freedom in decision, but does not positively formulate the possibility of bargaining between domestic workers and employers.

Even though the legal analysis recognized above mentioned rights that are not sufficiently regulated by the national legislation, Parliament in its debate in June 2012 did not ratify the Convention, nor proposed legal acts regulation in line with the above-mentioned drawbacks of the national legislation. During the discussion, no MPs voiced these facts and argued in favour of the Convention. Moreover, from that period, no media articles are available.

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<sup>7</sup> According to the Eurostat the overall number is much higher, in 2011 it was 2,000 people and in 2012 it was 1,500, although this is still quite low related to national employment figures.



Since the discussion in the Czech parliament, the legal framework on domestic work did not change. The reason is still the very limited incidence of the use of domestic work, especially in its precarious live-in form, but the sector is growing and domestic work might become a relevant issue in the upcoming years. First, because Czechia, as many other countries, experiences ageing and the associated increase in demand for homecare services. The second reason is better economic performance and very low unemployment levels that change family priorities in labour market participation and free time spending. As a result, the demand for household and childcare services is rapidly increasing, especially in the metropolitan areas of Prague and Brno (INT5 2019).

The refusal of the Convention was criticized by the Association for integration and migration (SIMI). They criticized reasoning, pointing out on the ridiculous number of foreigners working in the sector officially reported, while not considering the informal part of the sector. The SIMI representatives in next years had become involved into the discussion, trying to explain to politicians about the necessity to adopt the Convention and amend the labour legislation to increase the protection of domestic workers. Until now, they haven't found enough support to change the status-quo of policy makers in this issue. We describe the actor actions and activities in greater detail in the next part.

## 6 Actors and their activities in the PHS sector

Because of the absence of social dialogue in the sector in Czechia, we present here a broader spectrum of actors and initiatives that have tackled the issue of domestic work. The actors can be distinguished, according to who they represent, on a) home healthcare providers and social care providers and their associations and to b) NGOs which focus on increasing protection of foreign domestic workers and c) trade unions (see Table 10). Even though trade unions supported ILO convention adoption on domestic workers in legislation process (see Chapter 5), their activity in the sector is otherwise limited.

Table 10 Actors in the sector

Actors	PHS sub-sector	Legal form	Agenda	Activities
Asociace agentur domácí péče (Association of Agencies of Home Healthcare Services)	Home healthcare	NGO representing employers in the sector	Negotiating financing with health insurance companies and protecting working conditions of nurses in home healthcare service	Media presence with the topics of home healthcare service, declarations signed with another 68 providers,
Asociace poskytovatelů sociálních služeb (APSS)/Association of social care providers	Social care	Employers' association	Improving regulations and financing of social care services providers, proposing measures to reduce the informal economy in homecare services	Dialogue about legislation and financing rules for social care in general, but also specifically for home care

Unie zaměstnavatelských svazů / Union of employers' associations	Department on social care	Employer's association	Increase transparency and sustainability of social services financing, reduce the grey economy in homecare services	In collective bargaining about sector level agreement covering social care workers
Česká asociace sester – sekce domácí péče (Czech association of nurses – section of homecare)	Home healthcare	Professional association	Negotiating financing with health insurance companies and protecting working conditions of nurses in home healthcare service, nurses professional development	Improving working conditions in home healthcare, joining trade unions in strike alert in 2019
Odborový svaz zdravotnictví a sociální práce (Trade union in healthcare and social care)	In general health and social care	Trade union	Improving working conditions of healthcare and social care workers in formalized sector	Initiate sector level CB in both healthcare and social care; in social care negotiations on CB
Sdružení pro integraci a migraci (Association for intergration and migration)	Migrants in the sector	NGO	Increasing the protection of foreign domestic workers	Campaign on raising awareness about domestic workers working conditions
Ministry of Labour and Social Affairs (MoLSA)	Social care	State administration body	Employment and workers' protection, social affairs	Interest in 2013-2014 to tackle informality in the sector; currently no activity in the field

Source: own compilation

Social partners active in social services pay attention mostly to the formalized part of the sector, dealing with the financial and organizational difficulties of providing healthcare and social care services at home from public resources. On the provider side, there is the Association of social care providers (APSS), on the trade unions side, there is the Trade union in healthcare and social care (OS ZaSP). APSS is associated to the employers' association Union of employers' associations (UZS), and OS ZaSP is associated to the biggest trade union confederation, the Czech-Moravian confederation of the trade unions (ČMKOS). UZS through its affiliate APSS is much more vocal and active in proposing measures to tackle informality in the PHS sector, compared to trade unions.

Both social partners mostly address problems associated with the functioning of the public part of the sector (financing, quality of services and sustainability), while the informality and working conditions in the private part of the sector are rarely revealed. The trade union OS ZaSP are trying to conclude a collective agreement at the sector level which would cover employees in social services employed in the public part of the sector, including those providing homecare services. Nevertheless, most of their effort is targeted at increasing the protection of social workers in residential care services, while other subsectors in the care

sector, including PHS sector, are less represented. Low rates of unionization in the whole PHS sector are the main reason.

### 6.1 Activities of social partners in the public part of the PHS sector

The trade union in healthcare and social care (OS ZaSP) represents employees in the formalized part of the sector. They rely mostly on traditional tools, such as proposing and leading collective bargaining for healthcare and social care workers with ÚZS as well as lobbying for increasing the budget in the formalized part of the sector. Within this agenda, they find allies among providers and professional associations, because those are dependent on the allocated budget from the state as well. For instance, in 2019, The Czech association of nurses (ČAS) was ready to strike if hourly payments for their services in healthcare provided at home are not increased, and trade unions supported them, however despite only a limited wage increase, the strike was called off (INT3 2019)

#### **Box 1: The case of articulation of low wages in the home healthcare sector**

The professional association representing nurses (ČAS) is involved in the articulation of low wages together with trade unions in the healthcare and social care sector. While the trade union is trying to raise wages to all workers they represent, ČAS has been quite vocal in their demands to raise the wages of nurses in home healthcare. *“Home healthcare is much cheaper than hospital care, but doctors are not motivated to prescribe it and insurance companies do not support it neither. We are currently in a very bad financial situation, when payments from the compulsory insurance system are not sufficient for us”* claimed representative of ČAS in our interview. Also, the employer’s Association of Agencies of Home Healthcare Services was unsatisfied with the current payments and demanded the government increase them.

Insufficient payments have consequences on working conditions. Currently, providers need to allocate the majority of their resources to wages, while lacking funding for training and personal development for nurses in home healthcare. *“This undoubtedly affects the quality of the services provided. The profession of nurses in home healthcare is particularly demanding and these nurses need training and support to provide their services well”* (INT3 2019).

Despite pronounced dissatisfaction and plans to go on strike if payments are not increased in spring 2019, there has not been any unrest in the sector. Payments were increased by 12% in September 2019, which was still regarded as insufficient, but no form of protest or strike had occurred in that period, also because of the limited right to go on strike for healthcare workers in the whole sector.

### 6.2 RILSA’s research on PHS sector

In 2013, research of the RILSA institute operating under the Ministry of Labour and Social Affairs conducted a study on measures to decrease unemployment and fight informality in the PHS sector. According to this study, the proposal of the system should be similar to the one introduced in Belgium. The proposal expected to implement the voucher system in several

phases as demand for the services was expected to raise. The main opportunities to introduce the system identified in the study were help unemployed get back on the labour market, flexibilization of the labour market, better work-family reconciliation and decrease of undeclared work. On the other hand, the main risks were mostly related to the unsuccessful implementation because of the low demand for the services, or misused vouchers schemes (Kotíková&Vychová 2014). As RILSA representatives confirmed, since then, the interest to introduce the system on the ministry side only decreased due to the low unemployment levels.

### 6.3 Employers' activities in the sector

In line with the RILSA study, employer's association UZS has in their agenda introduction of the voucher system in Czechia. Their motivation is primarily lead by economic interests to increase employment and fight informality in the sector. ÚZS keeps measures in their agenda leading to legalization of informal care (see Box 2).

The most discussed model in UZS is similar to the one introduced in France or Belgium, encompassing a voucher system with state subsidies for the sector. The system proposed in 2014 was supposed to bring decreased unemployment rates as well as decrease informality in the sector while increasing demand for household services. As the representatives of the organization claimed in 2020, despite still being in their agenda, there is a significant lack of will on the government's side to deal with informality in the sector. First of all, there is a very low unemployment rate in Czechia<sup>8</sup>, second, there is no political will to introduce measures which would fight informality in the sector since the estimated extent of the informality in the sector seems to be too low to be worth dealing with. *"No one knows how big the sector is, but ministry representatives consider it negligible, despite claiming their effort is to reduce the informal economy."* (APSS representative 2020). Because of the similar reason, the ILO convention is less likely to be discussed again in the Parliament. *"There is no one to listen to us on this issue at ministries."* Claimed APSS representative on the workshop in February 2020.

#### **Box 2: UZS proposal to tackle informality in the PHS sector**

- The introduction of unemployed activation through providing PHS services while in unemployment
- creating incentives for legalization of activities in the PHS sector now performed within the grey economy (semi-formally) through the introduction of state contribution to family and household care services (similar to France or Belgium)

Apart from these measures APSS also aim to improve functioning of the PHS sector financed from public resources:

<sup>8</sup> Until January 2020 Czechia had unemployment rate 2.2% (CSO 2020)

- Increase the care allowance to cover the costs of necessary care.
- Support the creation of supplementary insurance schemes for social services payments.
- Introduce the obligation of towns and municipalities to provide care services in their territory.
- Introduce effective use of care allowance, so that it is used effectively to provide care for itself.
- Intensify control activities and introduce effective use of care allowance.
- Create a fixed amount of subsidy in relation to the care allowance for residential social care services.

Source: Priorities of the social services section at UZS, <https://www.uzs.cz/cz/nasi-clenove/sekce-socialnich-sluzeb>

#### 6.4 Trade union activities in the sector towards domestic workers

Trade unions are weak in the care sector in general and their ability to reach domestic workers is particularly limited. This is related to their strategic focus with formally employed workers and is explained in the literature by their post-socialist legacy associated with their lack of organizing activities and weak outreach to non-standard workers (Heimeshoff 2016). The trade unions remain less vocal in dealing with the specific problems of foreigners in the PHS sector in Czechia. On the other hand, the PHS sector is hard to organize, because of its fragmented structure, tight relationships between household and employee and the emotional character of their work (ibid). A low number of employees in one workplace in the institutionalized part of the sector does not contribute to the organizing in this part of the sector either.

Trade unions organizing models in the post-socialist countries are mostly based on class or profession identity, which does not fit to the case of domestic workers who are more identified with their migration status, or ethnicity, or gender (Ally 2005). As studied by Heimeshoff (2016) Czech trade unions apply an organizing model based on class and thus domestic workers are out of the trade unions reach. Also for domestic workers, trade unions are not perceived as an institution where they would search for help, while more often they search for help among NGOs, which also make an effort to be closer to the foreign workers and provide them with help.

Moreover, domestic workers even in the formalized part of the sector have a tendency to accept bad working conditions and low wages because they perceive their job as a mission where their needs are subordinated to their client's needs (Bonner & Spooner 2011). Another problematic aspect of the workers organizing the homecare sector is the feminization where women are double burdened with home care in their own household and have no time for self-organizing activities (see Box 3). There is also a perceived weak link between the quality of working conditions and quality of services provided. Most of the aspects of bad services is

not linked to the working conditions but more to management, work organization and personal relations (INT4 and INT6 2019). On the top of that, trade unions do not articulate the issue of the quality of services related to working conditions in the sector.

**Box 3: The case of organizing of care workers in Czechia**

This example focuses on organizing workers in social care services at the private provider of social care. Despite not being targeted at homecare workers, it points out the difficulties of organizing workers in care services in general, and on their own understanding of the link between the quality of working conditions and the quality of care. It also illustrates how important the role of clients and their family members might be when addressing the need to improve working conditions. We argue that these aspects are very similar in the case of home social care services, provided within the formalized part of the PHS sector.

Trade unions in the care provider SENEcura (member of French based OPREA social care services provider) were established in 2018<sup>9</sup>. In the beginning, there were difficulties organizing workers and establishing trade unions, despite very precarious working conditions such as breaking health and safety rules, e.g. lifting disabled without appropriate equipment, insufficient time allocated per client, low number of employees per client, low wages and overtime work. All of these issues were, however, not perceived as problems of working conditions for employees, but more as a management problem of the institution. *“Employees had a tendency to overlook their own working conditions and their altruistic profession prevented them to think about their own needs and employees rights. Only after they started to understand that they could deliver high quality service only when working conditions improve, there was a will to demand it and to establish trade unions.”*(INT6 2019).

As trade union organizer explained the effort to improve working conditions was difficult and standard collective bargaining was impossible to establish in the company. In this particular case, clients proved to be a big ally when it came to addressing working conditions, since they understood that the lack of personnel and exhausted employees could not facilitate good quality service. Clients and their relatives got engaged in petitions which addressed bad working conditions and the situation improved slightly thanks to this initiative. Currently, there is an ongoing initiative to establish a European work council in OPREA (SENEcura) to better tackle working conditions across countries.

## 6.5 CSOs activities in the sector

A missing engagement of the trade unions in the informal part of the sector and towards foreigners is replaced by the activities of civil society organizations (CSOs). Active CSOs mostly

<sup>9</sup> <http://www.zdravotnickeodbory.cz/cz/clanky/20-3-2018-senecura-poskytuje-socialni-sluzby-uz-i-v-cr.aspx>

point out the working conditions of migrant workers in the sector, while Czech citizens providing homecare services are mostly out of the scope of their activities. The most vocal organization, Sdružení pro integraci a migraci (Association for integration and migration - SIMI), conducted a campaign which included lobbying, research and PR activities to draw the attention of politicians and public to the ILO convention and labour rights of foreign workers (see details in the Box 4 below).

Their effort was unsuccessful because of the low number of migrants employed in sector, which is associated to strict migration policies and households preferences. First, strict migration policies prevent undocumented migrants being present in the country. Therefore, most of the migrants working in the PHS sector are either employed through an agency in an unrelated type of employment contract, or perform their job as self-employed (for details see part 4.1.4). This is mostly the case of Ukrainians who often undertake jobs in the PHS sector as their first job after coming to the country. Second, Czech people have strong ethnic preferences when it comes to foreigners. Even in the formalized part of the sector, or in the institutions, clients/patients are unhappy to receive care from foreign workers, and therefore end up in less attractive positions such as cleaners. Nevertheless, in the informal part of the household services, a foreigner's availability on the labour market changes households attitudes, especially in caring for children younger than three years or in cleaning services, where Ukrainians are the preferred option, but students, unemployed and others with a Czech background participate in the sector as well. SIMI representative confirmed, that because of the above-mentioned reasons, their future strategy will be to focus on the whole informal PHS sector to target much significant group of workers with similar problems on the labour market, not only migrants (INT5 2019).

***Box 4: NGO campaign on raising awareness on working conditions of foreign domestic workers***

In 2013, an Organization for Integration and Migration (Sdružení pro integraci a migraci - SIMI) launched a campaign on raising awareness on the working conditions of foreigners in PHS sector through promoting a fictive agency "Female Foreigners on Housekeeping" that was promoting migrant women in housekeeping to Czech households. During the campaign, 21 ths. people had visited the website of a fictive agency and 164 people got interested in services in their households by foreigners. After three weeks of promoting a fictive Agency and its services on the internet and Facebook, supported by media endorsement of publicly known person, the opening party was announced. During the event, the actual purpose of the agency was revealed to those who registered for its services, as well as to the media, and ten rules for responsible employers of domestic workers were released.

The campaign was part of the larger project "*Equal opportunities at the doors of Czech households*" within which migrant women were offered legal and social advisory services. A website for foreigners employed in households [www.pracovnicevdomacnosti.cz](http://www.pracovnicevdomacnosti.cz) was

launched. Moreover, the first research on workers in the PHS sector had been conducted within the project and serves as one of the resources also for this study. The project finished in 2014 and no such initiative has appeared since then. SIMI still provides help to foreigners in Czechia, but no activities are currently targeted at domestic workers.

Picture 1 Campaign website offering fictive services of foreigners titled *Female Foreigners for Housekeeping*



Source: [www.pracovicevdomacnosti.cz](http://www.pracovicevdomacnosti.cz)

## 7 Analysis: Drivers of informality in the PHS sector

As we have shown in this report, Czechia hasn't yet implemented policies targeted at improving the working conditions for domestic workers, nor has it committed to fight informality in the sector. In this part, we aim to explain why there is no interest in introducing policies for the PHS sector. We build our analysis on four factors which contribute to the existence of semi-formal and informal employment relationships in the sector (Triandafyllidou, 2017) as the main source of the precarity, and argue that these have not been resilient enough to provide incentives for change:

- a) the accessibility of the public homecare services and residential care facilities
- b) the level of generosity of publicly financed cash-for-care programs
- c) household attitudes to domestic work
- d) accessibility of the workforce and migration regimes

### a) The accessibility of public homecare services and institutionalized care facilities

The demand for semi-formal and informal personal and household services may be **shaped by the lack of accessibility of homecare services provided within the public sector schemes (in the case of the elderly) and partially by the lack of public facilities for children under 3 (in the case of childcare)**. In Czechia, institutional care and facilities suited for long-term care as



well as for childcare has a long tradition. In the case of the elderly, we have observed some prioritization of homecare since the fall of socialism and an effort to deinstitutionalize the long-term care, the structure of public services has not changed significantly yet and homecare services remains underdeveloped while various institutionalized forms remain accessible (Kubalčíková & Havlíková 2016). In the case of long-term care, only a fraction of the elderly is served at home, while the majority is placed in long-term care facilities even though families tend to prioritize homecare (only 15% out of 30 ths. clients of long-term care were served at home in 2017) (ÚZIS, 2018). Also, the stagnating number of clients served at home, as we showed in the previous part, and the ageing society means that there is still a growing pool of clients not yet served by the public services at all.

Opposite is the case of childcare. The public discourse absolutely prioritizes homecare for children under three to any form of institutional care, which mirrors in the public policies as well (Hašková et al. 2012). Public nursery facilities for children under three are rare and majority of children are raised at home until they are three years old. Therefore, for many families and especially women, the only way to return to the labour market earlier than three years after giving the birth, is to use homecare services for their children. Home childcare service is not offered as a service within the public schemes, therefore families embark on the services provided by the private agencies and individuals. On the other hand, the demand for childcare at home decreases significantly after children are three years old and are admitted to kindergarten. In fact, the majority of children in the age cohort 3-6 years attend the kindergartens<sup>10</sup>. Cleaning services are mostly preferred by socio-economic groups and are not that common in the country.

#### **b) The level of generosity of the cash-for-care programs**

**Cash-for-care system also provides to some extent incentives to participate in the private part of the PHS sector.** First of all, cash-in-care benefits are poorly controlled, which means that clients can use these benefits based on their own needs, even for the services outside the official public sector. Second, there is also a negative incentive for the recipients, because of the low payments to severely disabled people who need 24-hour care. In this case, families usually use institutional care services that are relatively accessible, or, in the case of homecare preference, services may also be provided by non-registered caregivers, and migrant workers providing their services for lower prices.

#### **c) Households attitudes to domestic work**

This leads us to the third driver, the **households attitudes to homecare and institutional care.** Homecare for the elderly financed from public sources was introduced only in the 1990s in Czechia (and Czechoslovakia), while the accessibility of institutional care has persisted from communism. At the same time Czech society very strongly insists on informal care being provided by family members. According to research from 2008, more than 60% of

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<sup>10</sup> In 2019, 362 ths. children attended kindergarten, while the whole cohort of age 3-6 was around 450 ths. children.

respondents insisted that “adult children must care for their disabled parents even if it means sacrificing their career”, which was the highest number along with Poland, among the EU countries (Kraus 2010). This attitude is translated to actual actions of the Czech families, when people older 65 receive to a large extent care from their relatives, around 43 per cent in 2006 compared to 21 per cent in France and Switzerland (Riedel & Kraus 2011). Somehow in contrary to care preferences, the survey among citizens and healthcare professionals discovered significant differences between where people want to die and where is the actual place of death. The results suggest that the most often place of death (an institution) is the least preferred one among people (Loucka et al. 2014).

In 2016, the policy to support informal family member caregivers was introduced. Family members who wish to provide care for his/her relative is compensated for 90 days with 60 percent of his/her last income and employer is obliged to preserve the workplace for the worker who temporarily take care about his/her relative. Therefore, families might wish to deliver intensive homecare to a larger extent. At the same time, public facilities still keep a significant amount of capacity which is used when the need for more intensive care increases. Intensive care is occasionally provided at home by hired workers.

#### **d) Accessibility of workforce and migration regimes**

The fourth driver is associated with the **accessibility of the workforce that engages in informal and semi-formal PHS provision and migration regimes**. In the Czech case, a significant part of the PHS providers are Czech inhabitants. Among them, we mostly find students, retired people or the unemployed who to a large extent engage in cleaning and childcare. Such domestic worker’s healthcare insurance is covered by the state, and therefore can undertake low paid and informal jobs in the personal and homecare services sector (Sekeráková Búriková 2017). They usually provide their services only temporarily, in the case of status change (e.g. from unemployment to employment, from student to employed) they leave the PHS sector.

A migration regime is another driver of workforce availability for informal homecare services. In Czechia, the migration regime is strict and prevents illegal workers being present in the country to a large extent. For that reason, foreigners are employed through agencies or perform domestic work as self-employed. In most of the cases they are not officially employed as domestic workers, and many of them remain in the sector only temporarily.

*Table 11 Drivers and their effects on informality in the PHS sector in Czechia*

	Czech context	Effect on existence of informality in the PHS sector
a) the accessibility of the public homecare services and institutionalized care facilities	Elderly: Institutionalized services more accessible, various options in homecare provision Childcare: Minimum facilities for children under three	Neutral  Increasing demand

b) the level of generosity of the cash-for-care programs	Elderly: Benefits can be spent on informal forms of services, which is partially supported by the legislation Childcare: Low levels of childcare benefits motivate to return to work before the child is three years old	Neutral  Increasing demand
c) households attitudes to domestic care	Elderly: Prefer homecare provided by relatives Households: some socio-economic groups look for housekeeping and childcare services	Neutral  Increasing demand
d) accessibility of workforce and migration regimes	Domestic workforce: those covered with healthcare insurance and outside the labour market (students, pensioners, unemployed)  Migrants: Strict stay regulations for foreigners, limited availability of foreigners	Increasing demand   Decreasing demand

Source: own compilation

The combination of homecare preference provided by relatives, increasing the demand on career development, an ageing society, and uncoordinated public homecare **services makes the Czech case the model of transition where demand for homecare increases, but residential services remain available and are extensively used.** Informal homecare provided by migrants is present mostly in urbanized areas of regions of Prague and Brno.

## 8 Conclusions

In the report, we differentiated between the public and private part of the PHS sector. The purpose of this distinction was to understand relationship between the officially regulated, and publicly financed part of the sector and another part which is mostly operated in semi-formal and informal relationships, being poorly regulated. In the case of publicly financed and regulated healthcare and social care services provided at home, workers have formal employment contracts in line with labour legislation. The problem for these workers is low wages that are in many cases not subject to increase in line with other occupations in the public sector. Precariousness also lies in overtime work, increased health and safety risk at work and emotionally difficult environment (INT2, 2019). The private part of the sector is characterized by an increased informality in employment relations and thus increased vulnerability of workers, especially migrant workers.

We presented the available data on the publicly financed part of the sector, while there is missing data about the private part of the sector. Our informants confirmed that the lack of

knowledge about the extent of the sector prevents any reasonable discussion and action in the sector with regards to the improvement of working conditions.

Based on our exploratory research in the sector, we can conclude:

1. The publicly financed and regulated part of the sector provides services to a significant part of the elderly, which includes both personal care and household care provided by one person.
2. The publicly financed and regulated part of the sector also offers a reasonable level of workers protection, where standard employment contracts are dominant. Issues related to working conditions encompass low wages, overtime work and issues in health and safety.
3. In the private part of the sector, agencies and individuals offer their services in households, most usually based on standard business licenses, self-employment contracts and/or various forms of casual employment contracts. A significant part of the domestic workforce being outside the official labour market (students, retired, unemployed) perform domestic work without a contract.
4. The number of migrant workers present in the sector remains unknown. From the research undertaken in Czechia, we know that the most widespread form of service provision done by foreigners is the live-out form of work which slightly decreases the risk of precarity for migrant workers.
5. Foreigners working in the PHS sector mostly provide their services as self-employed which increases their vulnerability in terms of job security and dependence on the household.
6. Cases on live-in form of foreigner's services provision in households occur in Czechia, but those are limited to individual cases, not being widespread.
7. There is no social dialogue in the sector. Social services providers associated with the employer association UZS tried to address the issue of informality in the sector, mostly from the point of view of tax and social contributions collection, less from the point of view of workers' rights.
8. Trade unions, on the other hand, supported the adoption of ILO convention as the only subject, but they do not undertake other activities aimed at domestic workers. This might be explained by their class-based approach towards organizing strategies, while workers in the PHS sector, especially migrants, do not perceive this as a profession. In the migrants case, CSOs are more active in protecting the labour rights of foreign domestic workers.
9. Relevant policy makers and institutions do not consider further sector regulation necessary. Since the extent of the sector is unknown, it remains impossible to address working conditions in the sector. Public policies mostly focus on the improvements of care services provided within the formalized part of the sector, targeted mostly on elderly and disabled.
10. Actors in the sector, willing to propose regulations in the unregulated part of the sector mention the lack of interest from the policy maker's side. Employers and NGOs seems

to be the most vocal about the issue, although their initiative took place in 2013-2014, partially as a campaign for ILO convention (NGOs), partially as an effort to decrease unemployment and reduce the informal economy in the post-crisis period (Ministry of Labour). After an unsuccessful trial to adopt ILO convention and after economic recovery, actors partially lost their motivation to further advocate for policy improvements and their effort was put on halt.

11. Nevertheless, with regard to an ageing society and changing household preferences, the demand for homecare services will raise, which should also attract attention of relevant actors in the sector and contribute to the improvement of working conditions of domestic workers.

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