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1 Executive Summary

The year 2012 might be described as a continual “battle” between the lower house of parliament (with a government consisting of a weak coalition of right-wing and centrist parties) and the upper house of parliament controlled by a left-wing opposition.

The government had many internal problems and was faced with allegations of corruption and political scandals which were used by the opposition as a pretext for a vote of no confidence in the government. A further vote of no confidence was forced by the opposition in connection with social reform legislation approved by the lower house of parliament in 2011. Both of the no-confidence motions were unsuccessful and the social reform legislation, including the pension reform law, came into force.

The political situation was reflected in the mood of the general public; Czech society in general was disillusioned with the political culture and the government began to lose support even among centrist and right-wing voters. According to one public opinion poll (CVVM 2013) 79% of the population was dissatisfied with the performance of the government at the beginning of 2013 and only 28% of the population held a positive view of the government’s overall programme.

Once the pension system reforms had been approved the main aim of the government was to explain the new legislation to the wider public. However, according to at least one public opinion poll (Stem: trends 04/2012), the government was singularly unsuccessful in this respect – it received most criticism for the lack of openness in terms of the communication of the impact of the reforms. The government even ran a campaign in several stages and opened a dedicated web portal specifically devoted to the funded scheme in November 2012. Nevertheless, the newly-introduced fully-funded defined contribution element of the first pillar failed to become popular.

In 2012, following a series of detailed and wide-ranging discussions aimed at alleviating the impact of increases in the pension age involving the government, the opposition, parliament and social partners, the government succeeded in finding consensus on the so-called pre-retirement benefit (a part of the existing third pillar of supplementary pension savings) which was introduced on 1 January 2013.

The Czech health care system is based on a model of social health insurance. All permanent residents are mandatorily insured by the public health insurance scheme. Insurance contributions are paid by employers, employees, self-employed persons and persons that don’t belong to a category of insurees for whom the state budget takes over payment of contributions. The public health insurance scheme offers a rather generous package of benefits that is reflected in a high share of public expenditures in the Czech health care system. The insurance scheme is administered by currently eight health insurance agencies that compete for insurees. Health insurance agencies collect contributions and contract health facilities separately but revenue is totally redistributed among insurers according to age and sex of their insurees. Space for competition among insurers is rather limited as contribution rates and the benefit package are determined uniquely by the insurance law. Political discussions focus on justification and impact of co-payments introduced five years ago and on attempts to limit the benefit package only to the cheapest variants of health services with the same therapeutic effect. Debates pivot around the risk of getting to a two-tier health care system on the one hand and of jeopardising the financial sustainability of the public health insurance scheme on the other hand. Naturally, the argumentation follows the left-right split of the political spectrum. The same applies to discussions on the role of competition. There

are proposals for a re-organization of the landscape of health insurers towards a single purchaser coming mostly from left oriented political parties and quite opposite proposals for strengthening incentives for competition among health insurers supported mostly by right oriented political parties

Long-term care is provided partly within the rather centralized public health insurance system and partly within a rather decentralized social care system. Persons dependent on assistance of other persons are entitled for care allowance scaled according to the level of dependency. Care allowance can be used for purchasing formal social services; nevertheless only around a quarter of the total amount of care allowance is used for this purpose. Care allowance and own income of recipients of social care (mostly pensions) are the major source of financing of formal social care providers that is complemented by subsidies from state, regional and municipal budgets. The most relevant issue in long-term care is efficiency of care allowance that despite original intentions haven't led to an acceleration of development of formal especially community-based social services. There is still rather high backlog of unsettled applications for residential social services. Discrepancy of real conditions of provision of long-term care in health facilities and in residential social care institutions is definitely also a problem that is considered as one of priority tasks by majority of political parties.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

During the communist era social security (including the pension system) was the sole responsibility of the state. Separate funds for the different branches of the social security system did not exist; expenditure was financed directly from the state budget. Neither insurance nor equivalence principles existed within the pension system. However, a number of employment categories received preferential treatment within the system.

Following the revolution of 1989 a number of urgent changes were introduced to the pension system. Discrimination against the self-employed was abolished, rules were set for pension indexation, pension insurance was removed from the tax system and a pension insurance institution, the Czech social security administration, was established. This formed the background for the preparation of the pension system reform process which resulted in the passing of the Pension Act (No. 155/1995) in 1995. The Act introduced the universal first pillar of the current pension system based on the social insurance principle and was to be PAYG financed. In parallel with the Pension Act, law No. 42/1994 on Supplementary Pension Insurance with a State Contribution established the third pillar slightly earlier in 1994. During the period 1996 – 2010 parametrical changes were made to the first pillar. In 1998 the amount of non-contributory periods was reduced and conditions for early retirement tightened. In 2001 the reduction of the early retirement pension was increased, and new rules regarding pension indexation were set in 2002. The first gradual increase in the retirement age to 63 years was introduced in 2003.

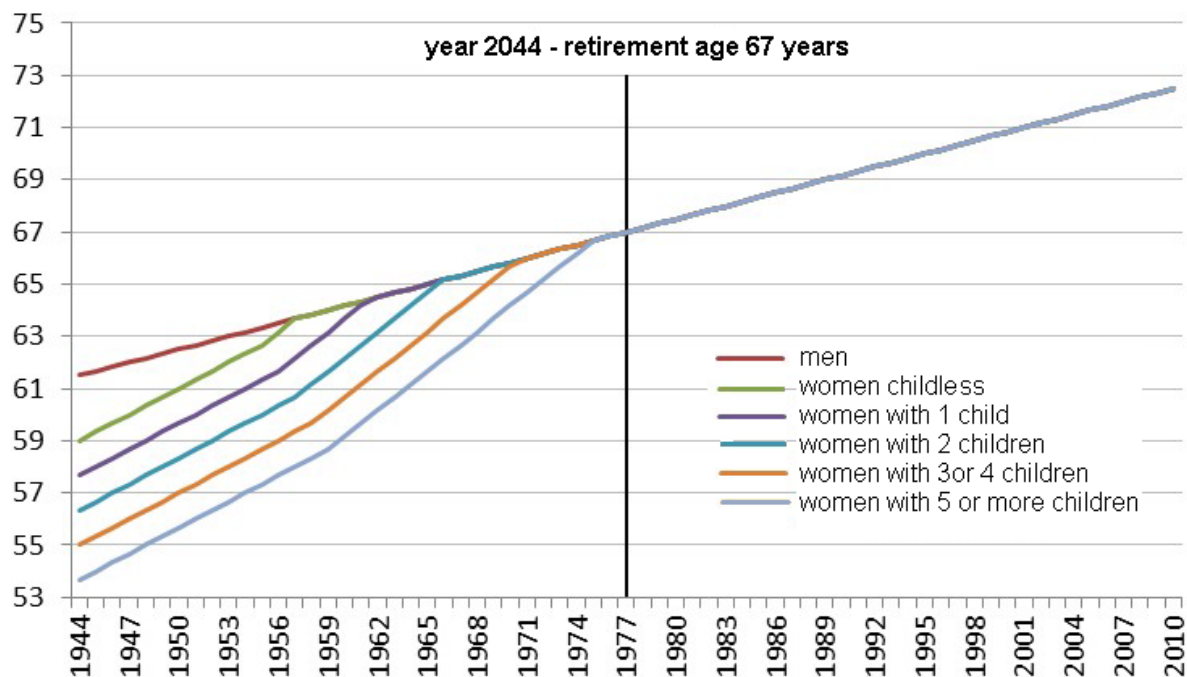
Changes implemented on 1 January 2010 can briefly be described as parametric changes to the existing pay-as-you-go system, consisting namely of: a restriction with regard to the non-contributory period, the gradual extension of the mandatory insurance period to 35 years by 2019, a gradual increase in the legal retirement age to 65 years for men, childless women and women who have raised one child up to 2031 (for women who have raised more than one child, the legal retirement age will vary from 62-64 according to the number of children raised) and changes in the pension formula regarding the period of gainful activity and the acceptance of pension benefits after 1 January 2010. At the same time as the increase in the legal retirement age came into force, the early retirement period was extended to five years prior to reaching the legal retirement age; however, the consequent reduction in the amount of the pension was increased¹.

On 30 September 2011 a further important change came into force, i.e. the so called “small” pension reform as the result of the requirement to fulfil a recent Constitutional Court legal ruling regarding the strengthening of the principle of equivalence within the social insurance pension system. The second earnings threshold was abolished with the aim of taking earnings during an individual’s period of economic activity more into account in the pension calculation. In order to avoid a consequent steep decrease in the amount of pensions, the second earnings threshold is gradually being increased to the level of the third (which is equivalent to the ceiling for paying social insurance contributions at 400% of the average wage) over a transition period of five years. The first threshold was changed to 44% of the average wage. This measure was complemented by the amount of income taken into account

¹ For more details see Annual Report 2010 available at:
http://www.socialprotection.eu/files_db/887/asisp_ANR10_Czech_Republic.pdf.

by the pension calculation; income up to the first threshold remains the same - 100% is taken into account, however income between the first and second thresholds will be changed, following a transition period of five years, to 26% from 30% in 2011. Further stricter rules regarding the indexation of pensions, which should contribute to the overall sustainability of the pension system, were also introduced. A further impact of the amendment consisted of changes in the setting of the pension age. The pension age of women is being increased more quickly than that of men and it is intended that the retirement age will eventually be the same for both sexes, namely 67 years. Once this legal retirement age has been reached (in 2044) it will increase continuously by two months every year for both sexes without any stated limit. The future legal retirement age development is shown in following chart.

Chart 1: Legal retirement age for generation of people born in the specific year



Source: MLSA 2012, The Czech pension system in the context of the EU
<http://www.mpsv.cz/files/clanky/11969/Analyza.pdf>

It is envisaged that these measures will fundamentally follow life expectancy development and that the period spent in retirement should not sink below 20 years on average. Together with these measures, the gradual extension of the reference period from the last 30 years of earnings to lifelong earnings has been introduced and stricter rules for the calculation of early retirement have been adopted. This amendment also set the legal rules for the assessment of the flat rate element of the pension which in future will consist of 9% of the average wage. Certain modifications to the survivor's pension were introduced by the amendment which will lead to stricter conditions being applied to widow/widower pensions while, conversely, the conditions for entitlement to the orphan's pension will be slightly relaxed.

By means of a further amendment, which came into force on 28 November 2011, the Czech Republic reacted to a European Court of Justice legal ruling² regarding discrimination in terms of Czech citizens and those of other EU countries.

On 1 January 2012 the the range of persons insured was extended and unified with that of sickness-insured persons.

² <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2011:232:0006:0006:CS:PDF>

Retirement Savings Act of December 2011

In December 2011 the Government approved the Retirement Savings Act³, which will come into force on 1 January 2013, and which will fundamentally change the current system of pension insurance in the Czech Republic. This Act creates a fully-funded defined contribution second part for the current PAYG first pillar. Participation in this funded part will be indivisibly associated with participation in the mandatory PAYG first pillar. The pension contributions levied will be managed by pension institutions after first obtaining the necessary licensing from the Czech National Bank. Each pension company will be required to offer four pension funds which will involve different levels of risk and investment strategy. Participants will be able to change their strategies over time. Participation in the funded part of first pillar will be voluntary and irreversible. Premiums paid to the first pillar (28%) will be distributed 25% in favour of PAYG and 3% for the fully-funded scheme. However, participants in the funded part will have to pay an extra 2% (thus the overall contribution rate will be 30%). The monies saved via retirement savings will have to be used to purchase retirement plans from life insurance companies. There will be three types of pension – a life-type annuity, a life-type annuity with a 3-year survivor's pension and a 20-year annuity. In the savings phase, the accumulated capital and unspent 20-year annuity will be inheritable. Participation in the funded part of the first pillar will affect the pension amount from the PAYG pillar - every year of full contribution to the first pillar will be awarded an accrual component of 1.5% of the personal calculation basis – for those who participate in the funded part, this figure will be only 1.2%. The established reforms aim principally to diversify the means by which to ensure financial security in old age.

These reforms should, according to government calculations, reduce the pension system deficit from more than 4% of GDP to 0% or a maximum of 1% of GDP post 2060 (MLSA, 2012). These optimistic figures however presuppose a high level of public participation; therefore it is essential that the reasons for pension reform as well as the advantages and potential risks of this type of reform be carefully explained to the public. In the short term the proposed pension reforms will lead to a worsening in the fiscal position of the Czech Republic due to opt-out from the first pay-as-you-go pillar; the shortfall is supposed to be recuperated through increases in VAT

Reform of the third pillar

In December 2011, reform of the 3rd pillar was approved by the Government with the aim of increasing the security of the capital of participants and of encouraging people to increase their contributions to the system. A further major change, which will be valid from 1 January 2013, will be the separation of the accumulated capital of participants from the assets of pension institutions. For contracts signed after 1 January 2013 there will no longer be a guarantee of at least zero returns since strict state regulation will come to an end. Pension institutions will be allowed to offer new investment strategies with higher rates of return (with a consequent higher rate of risk). A further change concerns state contributions (subsidies) provided based on the level of participant contribution according to which the thresholds for the minimum and maximum state contributions will be increased in order to encourage participants to save more. Changes to the level of state contributions are illustrated in the following table.

³ Also known as the “major” reform “large” reform or “big” reform.

Table 3: State contributions to pension savings in the third pillar according to participant contributions

Participant contribution	State contribution 2012	State contribution 2013
100 CZK	50 CZK	0 CZK
200 CZK	90 CZK	0 CZK
300 CZK	120 CZK	90 CZK
400 CZK	140 CZK	110 CZK
500 CZK	150 CZK	130 CZK
600 CZK	150 CZK	150 CZK
700 CZK	150 CZK	170 CZK
800 CZK	150 CZK	190 CZK
900 CZK	150 CZK	210 CZK
1,000 CZK and more	150 CZK	230 CZK

Source: own calculation based on Act No. 427/2011 Coll., on Supplementary Pension Savings, and Act No. 42/1994 Coll., on Supplementary Pension Insurance with a State Contribution

2.1.2 System characteristics

The Czech pension system is based on the first and third pillars, with the first pillar, operated by the state, playing the dominant role. The third pillar consists of supplementary pension insurance with a state contribution and other forms of individual security consisting of products offered by commercial insurance companies.

The first pillar is based on social insurance and consists of a pay-as-you-go scheme with defined pension benefits. The state pension system in the Czech Republic is universal for the various groups of participants, e.g. employees and self-employed persons. Participation in the basic pension insurance system is compulsory for all economically active persons and allows restricted voluntary participation for the economically non-active. The coverage rate is almost 100%.⁴ The basic pay-as-you-go pension insurance system is economically guaranteed by the state. The mandatory first pillar covers three main benefits: old age, disability and the survivor's pension. The principle of equivalence is reflected in the Czech pension system only to a limited extent due to the application of the principle of solidarity, a characteristic criticised by the Czech Constitutional Court in March 2010. The dynamic nature of the basic pension insurance system is ensured by an annual update of the income levels used for the calculation of the percentage-based assessment of pensions and increases in the amount of pensions paid out. The value of the pension depends principally on the number of years of contribution, each of which is awarded an accrual component (1.5% of the personal calculation basis), earnings during these years, the income ceiling and earnings thresholds. Since the pension formula contains a whole series of elements, those related to earnings, which are decisive in terms of the amount of the pension, are adjusted annually according to general wage development. The pension consists of two elements: the basic amount (flat rate) which is the same for all types of pension and is equal to 9% of the average wage, regardless of the insured period and total earnings, and a percentage-based component based on the insured period and earnings reduced in accordance with defined earnings thresholds. The basic rules for the indexation of pensions are as follows: pensions paid out are increased on an

⁴ http://www.mpsv.cz/files/clanky/2235/zaverecna_zprava.pdf.

annual basis each January; this does not apply in periods of very low inflation (where the pension increase would be less than 2%) and in cases of high inflation (at least 5%); increases in the pension are set so that for the average old-age pension it corresponds to at least 100% of the retail price index, as well as to at least one third of growth in real wages. Both pension elements are increased – the flat rate by a lump sum so as to reach the level of 9% of the average wage and the percentage element by a certain proportion. Czech pensions are not subject to taxation.⁵ Contributions are paid by employees, employers and the self-employed. The contribution rate in 2012 (and 2013) was 28% which was split between employees (6.5%) and employers (21.5%). The possibility exists in the system to opt for early retirement no sooner than 5 years before the legal retirement age for those whose legal retirement age is at least 65 years. For those whose retirement age is lower than 63 years, early retirement can be taken no sooner than 3 years before the legal retirement age. The effective labour market exit age in 2010 in the Czech Republic was 60.5 years (Eurostat 2013). The average pension (single paid out) in March 2013 was CZK 10,929⁶, with an average pension for women of CZK 9,923 and that for men of CZK 12,109.

The third pillar

The third pillar consists principally of a voluntary supplementary personal pension savings scheme which is fully funded, receives a state contribution and is run on a defined-contribution basis. In addition to the state contribution the Government also provides tax incentives for private saving. The system is administered by supplementary pension insurance funds which provide defined-contribution plans only. Legislation does not guarantee a minimum return on pension insurance funds; however, any shortfall must be covered by previous (undistributed) profits. Members of pension insurance funds are allowed to switch between pension fund providers – free of charge in specified cases.

The third pillar pension insurance scheme is available on a voluntary basis for those who participate in the first pillar or in public health insurance in the Czech Republic. The participation rate is over 70% of the economically active population⁷. There were a total of 9 pension funds in the Czech Republic in 2012. The average return on such pension funds for 2012 is expected to be slightly lower than the rate of inflation, according to the Association of Pension Funds.

Contributions to the system can be made by participants themselves, employers or others. Participant contributions are supplemented by a state contribution up to a certain threshold (to qualify for which, a minimum participant contribution of CZK 300 per month was required from 1. January 2013). The minimum monthly participant contribution is CZK 100. Roughly 25% of participants receive a contribution to their supplementary pension plan from their employer; however, the state subsidy is paid based on the personal contribution only. On the other hand, employer contributions up to a certain ceiling (CZK 24,000 per year in 2011) are exempt from employee income tax and social and health insurance deductions. Employers are entitled to include contributions in expenses if such contributions are specified in a collective agreement or internal regulation.

The average monthly participant contribution (not including employer contributions) for 2012 was, according to the Ministry of Finance, merely 2.2%⁸ of average gross wages. The

⁵ With the exception of high pensions which yearly exceed a multiple of 36 of the minimum monthly wage.

⁶ Czech social security administration - <http://www.cssz.cz/cz/o-cssz/informace/media/tiskove-zpravy/tiskove-zpravy-2013/2013-05-14-pocty-duchodcu-a-duchodu-za-1-ctvrtleti-2013.htm>

⁷ The Association of pension funds, Annual Report 2012 - http://www.apfcr.cz/publikace/2011/cz_verze.html

⁸ <http://www.mfcr.cz/cs/soukromy-sektor/monitoring/vyvoj-penzijniho-pripojsteni/2013/zakladni-ukazatele-vyvoje-penzijniho-pri-14030>

participant contribution level is low and cannot be expected to compensate for the inevitable drop in earnings upon retirement which is considered to be the biggest problem of the system.

2.1.3 Details on recent reforms

Since major reforms to the Czech pension system had already been approved in previous years, no significant changes were made to the system in 2012.

The biggest change to the pension system as a whole consisted of the afore-mentioned introduction of the pre-retirement benefit.

With the aim to alleviate the impact of an increase in pension age, broad discussions involving the Government, Parliament and social partners were held to find consensus on the so-called pre-retirement benefit (part of the existing third pillar of supplementary pension savings) which was introduced on 1 January 2013.

The pre-retirement benefit allows the drawing of savings accumulated within the third pillar a maximum 5 years before reaching the legal retirement age provided that the benefit represents a minimum of 30% of the average wage. The pre-retirement benefit will be paid until the recipient reaches the legal retirement age. The drawing of the pre-retirement benefit must not involve using up all the funds accumulated in an individual savings account and the remaining amount can be used for the payment of the regular pension from the third pillar after reaching the legal retirement age. It is assumed that in the case of those professions which are vulnerable to reduced performance in old age, the employer will contribute a greater amount to employee savings accounts in the third pillar than at present. In order to promote this the pre-retirement benefit will be accompanied by an increased employer contribution ceiling which will be exempt from employee income tax and social and health insurance deductions. It is envisaged that this measure will decrease the risk of poverty of those persons working in physically demanding occupations. Since the payment of the pre-retirement benefit is possible only from the accumulated savings of an individual, there will be no direct pressure on payments from the first pillar. In contrast to the standard early retirement benefit, the pension paid from the first pillar, after receiving the pre-retirement benefit from the third pillar, will not be reduced. However, in those years in which a person receives the pre-retirement benefit, he/she will earn no pension rights from the first pillar pension scheme. On the other hand it is possible for a person receiving the pre-retirement benefit to be employed and therefore gain pension rights from the first pillar in this way.

The most important change in terms of the first pillar consisted of a modification in the way in which pensions are indexed. As part of a package of austerity measures, pension indexation was modified, on a temporary basis, for the period 2013-2015. According to Pension Act 155/1995 any increase in pensions paid out must correspond to at least 100% of the relevant increase in the retail price index as well as to at least one third of the growth in real wages. However, for the period 2013-2015 only one third of the relevant increase in the retail price index will be taken into account in this respect.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

The first pillar of the pension system in the Czech Republic is compulsory for almost the whole of the economically-active population; therefore the coverage rate is very high. The third pillar of the Czech pension system is voluntary for those who participate in the first pillar or the health insurance system. The third pillar coverage rate in 2012, according to the

Association of Pension Funds, was 70% of the economically-active population with an average contribution of 2.2% of gross average salaries.

The first pillar of the Czech pension system features a high degree of solidarity which ensures sufficient protection against poverty for elderly people, especially those who received low incomes during their working lives. According to the CZSO (2013), in 2012 pension payments from the first pillar represented 93% of the total income of pensioners. A further 2% consisted of income from work and the remaining 5% consisted of other income including that from the third pillar. The proportion of pension income paid from the third pillar of the total income of pensioners continued to follow the growth trend of recent years, i.e. 2.9% in 2010 and 3.1% in 2011 (MPSV 2013).

The replacement rate of the Czech pension system is almost the same as the OECD average, i.e. a gross replacement rate of 57% (OECD 60.6%) and a net replacement rate of 72.2% (OECD 72%). (OECD 2011)

Replacement rates provided by the Czech pension system vary according to income level as illustrated by the following table.

Table 4: Replacement rates in the Czech Republic 2010

indicator	individual earnings, multiple of average				
	0.5	0.75	1	1.5	2
gross replacement rate	80.2	60.2	50.2	37.4	29.7
net replacement rate	94	75.8	64.4	48.9	39.3

Source: OECD 2011 – Pension at a glance

However, Czech replacement rates are only theoretical, i.e. they are constructed with certain income and insurance period assumptions and thus do not fully reflect reality – the hypothetical insurance period taken into account could be overestimated in comparison with real data.

Therefore, in terms of international comparison, the aggregate replacement ratio is probably more appropriate and is defined as the ratio of the median of the individual pensions of retired persons aged 65-74 relative to the median of the individual earnings of those in work aged 50-59 excluding other social benefits. The aggregate replacement ratio (Eurostat 2013) for the Czech Republic stands at 55%

Table 5: At-risk-of-poverty rate of elderly people 60+

Total	2008	2009	2010	2011	2012
EU 27	17.7	17	15.3	15.6	n/a
Czech R.	6.7	7.1	6.4	6.5	6.1
Male					
EU 27	15	14.7	13	13.5	n/a
Czech R.	3.2	3.5	2.5	3	3.6
Female					
EU 27	19.8	18.9	17.1	17.2	n/a
Czech R.	9.4	9.9	9.4	9.2	8.1

Source: Eurostat tables 2013

Table 6: At-risk-of-poverty rate of elderly people 65+

Total	2008	2009	2010	2011	2012
EU 27	19.0	18.0	16.0	15.9	n/a
Czech R.	7.4	7.2	6.8	6.6	6.0
Male					
EU 27	15.7	15.0	12.9	13.2	n/a
Czech R.	3.3	3.0	2.1	2.0	2.7
Female					
EU 27	21.4		18.3	18	n/a
Czech R.	10.2	10.3	10.3	10.1	8.4

Source: Eurostat tables 2013

Table 7: At-risk-of-poverty rate of elderly people 75+

Total	2008	2009	2010	2011	2012
EU 27	21.7	20.4	18.2	17.9	n/a
Czech R.	7.9	8.3	8.7	7.2	6.7
Male					
EU 27	17.6	16.9	14.5	14.7	n/a
Czech R.	2.5	2.9	3.2	2	3.1
Female					
EU 27	24.3	22.7	20.7	20.1	n/a
Czech R.	11.2	11.8	12.3	10.8	9.0

Source: Eurostat tables 2013

According to the figures provided by Eurostat, just 6.0% of the population over the age of 65 years was at risk of poverty in 2012 which represents an improvement on 2011 (6.6%). The share of the population over the age of 60 (75) years for 2012 was almost the same as for 2011 and stood at 6.1% (6.7%). The reason for the difference in the indicators is that newly-approved pensions grow more quickly than “old” pensions (granted 10 years before) due to indexation.

The low rate of income disparity and the relatively high level of effectiveness of social transfers in combination with a low median income level represent significant factors in the low rate of relative poverty in the Czech Republic. The at-risk-of-poverty indicator for people aged 65 and over in the Czech Republic is 9.3 p.p. lower than the EU 27 average and the Czech Republic is in the top 5 countries with the lowest risk of poverty in the EU 27, the main reason for which is the generally low level of wages in the Czech Republic rather than the high level of pensions.

The at-risk-of-poverty rate for people 65 and over dropped by 1.4 p.p. from 7.4% in 2008 to 6% in 2012 which was principally the result of the continuous increase in the retirement age which allows the earning of more pension rights and thus higher pensions. This was supported by the effect of the slowdown in wages growth during the economic crisis which lowered the equalised income level in the Czech Republic and thus lowered the at risk of poverty .

The difference between men and women aged 65 and over in the Czech Republic in terms of the risk of poverty remains substantial with men at only 2.7% and women at 8.4%. This is the result of the generally lower level of the female pension which, in turn, is the result of life-long lower incomes and fewer years spent in work. However, the figures for men and women converged slightly in 2012 which was probably due to the retirement age of women

increasing twice as quickly as that of men (the retirement age for women in the Czech Republic is still 3 years lower than the EU 27 average).

Table 8: Employment rates in 2012 by age and gender

Total	15-24	25-49	50-64	65-74	15-64
EU 27	32.9	77.5	58.6	8.3	64.2
Czech R.	25.2	82.4	60.6	7.1	66.5
Male					
EU 27	34.9	83.5	65.6	11.1	69.8
Czech R.	29.2	91.2	69.3	9.6	74.6
Female					
EU 27	30.9	71.4	51.8	5.9	58.6
Czech R.	21	73.1	52.2	5.1	58.2

Source: Eurostat tables 2013

According to Eurostat figures, the overall employment rate of the Czech population aged 15 – 64 years was slightly higher than that of the EU 27 average in 2012. This was principally due to the employment rate of men which is almost 5 p.p. higher than the EU 27 average. The employment rate of women in 2012 was 16.4 p.p. lower than that of men, the reason being that women accept significantly more responsibility for caring for children, elderly parents and the household than do men. The employment rate of women has not changed significantly over the last few years (in 2008 it was 57.6%) and remains one of the basic reasons for the generally lower level of pension benefits received by women in comparison with men. Nevertheless, the situation in the Czech Republic is practically the same as the EU 27 average.

As in previous years the employment rate of young workers (aged 15-24 years) is, on average, significantly below the EU average. That said, the Czech Republic has been unable to reduce this figure despite young workers being classified as a risk group and the consequent targeting of the problem with the introduction of special ALM policy measures; there has been no improvement in this indicator since 2005.

Table 9: Employment rates in 2012 by age and education

Total	15-24	25-49	50-64	65-74	15-64
EU 27	32.9	77.5	58.6	8.3	64.2
Czech R.	25.2	82.4	60.6	7.1	66.5
Pre-primary, primary and lower secondary education					
EU 27	20.6	60.7	43.7	6.7	44.7
Czech R.	4.1	48.8	32.8	1.9	21.1
Upper secondary, post-secondary and non-tertiary education					
EU 27	43.7	79.3	61.3	8.5	68.1
Czech R.	41.7	84.5	60.6	6.2	71.7
First and second stage of tertiary education					
EU 27	54.5	86.5	75.7	15.9	81.8
Czech R.	37.3	83.8	83	20.7	81.1

Source: Eurostat tables 2013

The figures above show that those with the lowest levels of education were most at risk of unemployment in 2012. Interestingly, the employment rate of young workers with primary

education only in the Czech Republic is a surprising 16 p.p. lower than that of the EU 27 average. Surprisingly, even the employment rate of young workers with tertiary education was below the EU 27 average in 2012. Nevertheless, this figure remains high and can most probably be attributed to the structure of (not only) tertiary education in the Czech Republic which continues to produce a high number of graduates with degrees in the humanities and economics-related subjects whilst the greatest demand from prospective employers is for graduates with scientific and technical qualifications.⁹

This fact was latest criticised in autumn 2013 by president of the Czech Republic Miloš Zeman.¹⁰ According to a survey published by the Czech Chamber of Commerce, the situation could potentially pose a threat to the competitiveness of the Czech economy within the next 10 years.¹¹ The low labour market participation of specific groups of the population – women, young workers and those with low levels of education will have a knock-on effect in terms of future pension rights since the number of years of paid insurance makes up one of the main factors in the pension calculation formula. Despite certain periods of economic inactivity such as child care, registered unemployment (for a limited number of years) and care for dependant relatives being taken into account in terms of pension insurance as non-contributory periods, the pensions of these groups are significantly lower than the average in the Czech Republic. In the future the low labour market participation of these groups could lead to the non fulfilment of one of the basic conditions for receiving a pension, i.e. the payment of a minimum number of years of insurance contributions (28 years in 2012) which will be gradually extended to reach 35 years by 2019.

⁹ According to survey of Union of Industry and Transportation available at <http://www.businessinfo.cz/cs/clanky/skoly-chrli-absolventy-bez-sance-najit-praci-pritom-chybi-tisice-techniku-37964.html>

¹⁰ <http://zpravy.ihned.cz/c1-60931180-zeman-mame-hodne-pravniku-a-ekonomu-ale-ponekud-nam-chybi-technici-a-inzenyri>

¹¹ <http://mediafax.nova.cz/clanek/ekonomika/chybi-technicti-absolventi-do-10-let-to-ohrozi-konkurenceschopnost-ceske-ekonomiky.html>

Table 10: Employment rates of older workers (55-64)

Total	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
EU 27	40	40.7	42.3	43.5	44.6	45.6	46	46.3	47.4	48.9
Czech R.	42.3	42.7	44.5	45.2	46	47.6	46.8	46.5	47.7	49.3
Male										
EU 27	49.9	50.4	51.6	52.6	53.9	55	54.8	54.6	55.2	56.4
Czech R.	57.5	57.2	59.3	59.5	59.6	61.9	59.6	58.4	58.9	60.3
Female										
EU 27	30.7	31.6	33.6	34.8	35.9	36.8	37.8	38.6	40.2	41.8
Czech R.	28.4	29.4	30.9	32.1	33.5	34.4	35	35.5	37.2	39

Source: Eurostat tables 2013

The employment rate of older *workers* aged 55 – 64 years in the Czech Republic continues to follow the long-term trend of being slightly above the EU 27 average and is due principally to the employment rate of older men which is significantly higher than EU 27 average. Conversely, the employment rate of older women in Czech Republic is lower than the EU average and is due to the low take-up rate of part-time jobs by Czech women; indeed, the vast majority of those older women who are employed work in full-time jobs. The difference in the employment rate of older men and women might be explained by the difference in the age of retirement between the sexes which remains significantly higher for men. A further reason could lie in the fact that a greater number of older women than men care for aged parents and other relatives thus limiting the time available for work.¹²

With respect to combating poverty and social exclusion, the Active Ageing Strategy for 2013-2017, prepared and approved by the government in February 2013, sets out the following objectives: the securing and protection of human rights for older people, life-long education, the employment of older workers in harmony with the pension system, voluntarism and inter-generational cooperation, a quality environment for older people, healthy ageing and care for disabled older people.

2.2.2 Sustainability

The structure of the Czech population will change significantly over the next few decades due to increasing life expectancy and a decrease in the fertility rate. Whereas in 1960 the total fertility rate was 2.0 children per woman and in 1973, as a result of population politics, even reached 2.5 children per woman, the fertility rate in the late 1990s was just 1.16. Projections suggest that the total fertility rate should stabilize in the future at around 1.5 – 1.7 children per woman. On the other hand, the life expectancy of those aged over 65 has increased steadily by 2 months per year since 1990 which is forecast to eventually stabilize at 1.5 months per year.

All the projections for the social insurance system presented by the Czech MLSA are based on demographic forecasts provided by the Faculty of Natural Sciences of the Charles University, Prague with a time horizon of 2065 which has recently been extended by the development of a demographic projection for 2066 - 2100. The projections suggest that the main factors affecting the pension system, i.e. total fertility rate, live expectancy and migration will develop as follows:

Table 11: Basic characteristics of future demographic development

¹² Gender studies 2013 – How is the (working) life of women 45+ in the Czech Republic? available at: http://www.genderstudies.cz/download/Prez_pecujici_zeny_pro_TK_fin.pdf

	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
total fertility rate	1.34	1.51	1.57	1.61	1.64	1.67	1.68	1.70	1.72	1.73
Life expectancy (years)										
Men	74.1	76.5	78.7	80.4	82.0	83.4	84.6	85.8	86.9	88.0
Women	80.3	82.4	84.0	85.4	86.7	87.6	88.8	89.7	90.6	91.4
Migration (1000s)	20.0	24.9	25.9	25.7	25.4	24.6	25.2	25.4	25.5	25.3

Source: Actuarial report on social insurance, MLSA 2013

It is clear from the table that the TFR projections are relatively optimistic in terms of the pension system in that an increasing trend is expected in future years with an eventual return to levels last seen in the early 1990s. The following table shows the expected development of life expectancy at 60 and 65 years

Table 12: Life expectancy at 60 and 65 years

	2005	2010	2020	2030	2040	2050	2060	2070	2080	2090	2100
Life expectancy - men											
at 60 years	20.2	21.1	22.7	24.1	25.5	27.0	28.3	29.5	30.7	31.8	32.7
at 65 years	17.0	17.7	19.1	20.2	21.5	22.8	24.1	25.2	26.3	27.4	28.3
Life expectancy - women											
at 60 years	25.0	25.8	27.2	28.4	29.9	31.4	32.9	34.1	35.6	37.3	38.4
at 65 years	20.9	21.6	22.9	24.1	25.5	26.9	28.4	29.5	31.0	32.8	33.9

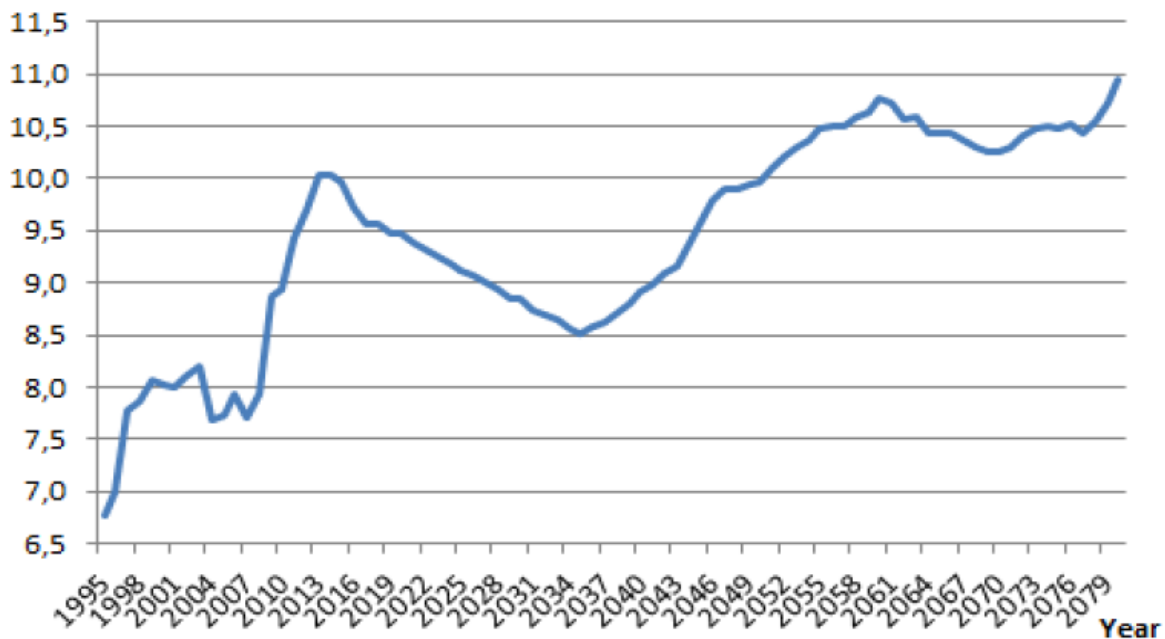
Source: Actuarial report on social insurance, MLSA 2013

The increase in life expectancy at retirement age (60 or 65 years) is projected to be significant and, were no action to be taken, would pose a major threat to the sustainability of the pension system. However, the Czech Republic has already implemented parametrical changes which reflect the expected future development of life expectancy. The retirement age is increasing at the same rate as life expectancy and the required minimum number of years of insurance contribution is gradually being extended.

As mentioned previously, the Czech Republic has adopted a number of parametrical changes in the current first pillar of the pension system. The following charts show future projections of basic pension system indicators.

The changes already approved in the first stage of pension reform will contribute significantly towards improving the financial sustainability of the basic pension insurance system. Should all the measures be implemented, total expenditure on pensions will see a gradual decrease over the medium and long terms of around 1% of GDP.

Chart 2: Pension expenditure as % of GDP
Pension expenditure as % of GDP

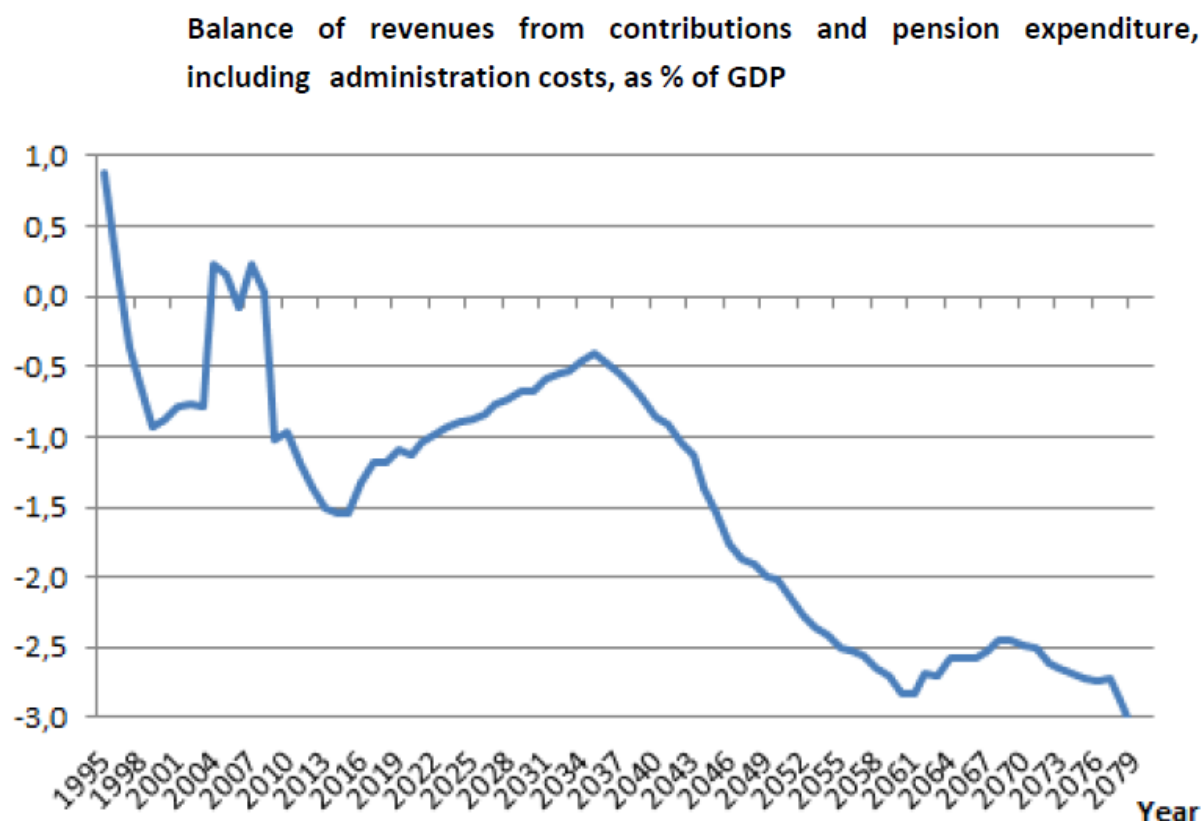


Source: Actuarial report on social insurance, MLSA 2013

According to projections an increase in the ratio of total pension expenditure to GDP to 10% is anticipated in 2013 and 2014, the primary cause consisting of lower GDP dynamics according to Ministry of Finance forecasts. In the mid term it is expected that pension expenditure will gradually fall to slightly above 8.5% in 2035 due to the retirement of numerically weak cohorts born in the 1960s. Subsequently, pension expenditure is expected to increase gradually to roughly 10.7% despite the increase in the retirement age since numerically strong generations will reach retirement age.

The Czech Republic has been classified in the long term by both the EPC and the EC as likely to face one of the highest increases in expenditure on pensions from the first pillar of the pension system of any European country; however, following the implementation of first pillar parametrical changes it can be anticipated that the balance of the pension system will improve significantly up to at least 2035.

Chart 3: Balance of revenues from contributions and pension expenditure, including administration costs, as % of GDP



Source: Actuarial report on social insurance, MLSA 2013

A sudden increase in expenditure attributable to the economic recession (2008-2011) plunged the system into deficit which stood at roughly 1.3% of GDP in 2011. It is anticipated that the deficit will increase to 1.5% of GDP in 2015 to be followed by a reduction to just below 0.5% of GDP by around 2035. According to projections of anticipated increases in expenditure, this figure will then increase up to 2060 whereupon it will stabilize at somewhere between 2.5% and 3% of GDP.

As in other European countries the effective labour market exit age (ELMEA) in the Czech Republic is lower than the statutory retirement age. The following table compiled by Eurostat compares the ELMEA of the Czech Republic with the EU 27 average.

Table 13: Effective labour market exit age in the Czech Republic and EU 27 (2010)

	total	men	women
EU 27	61.5	61.7	61.3
Czech Republic	60.5	61.4	59.6

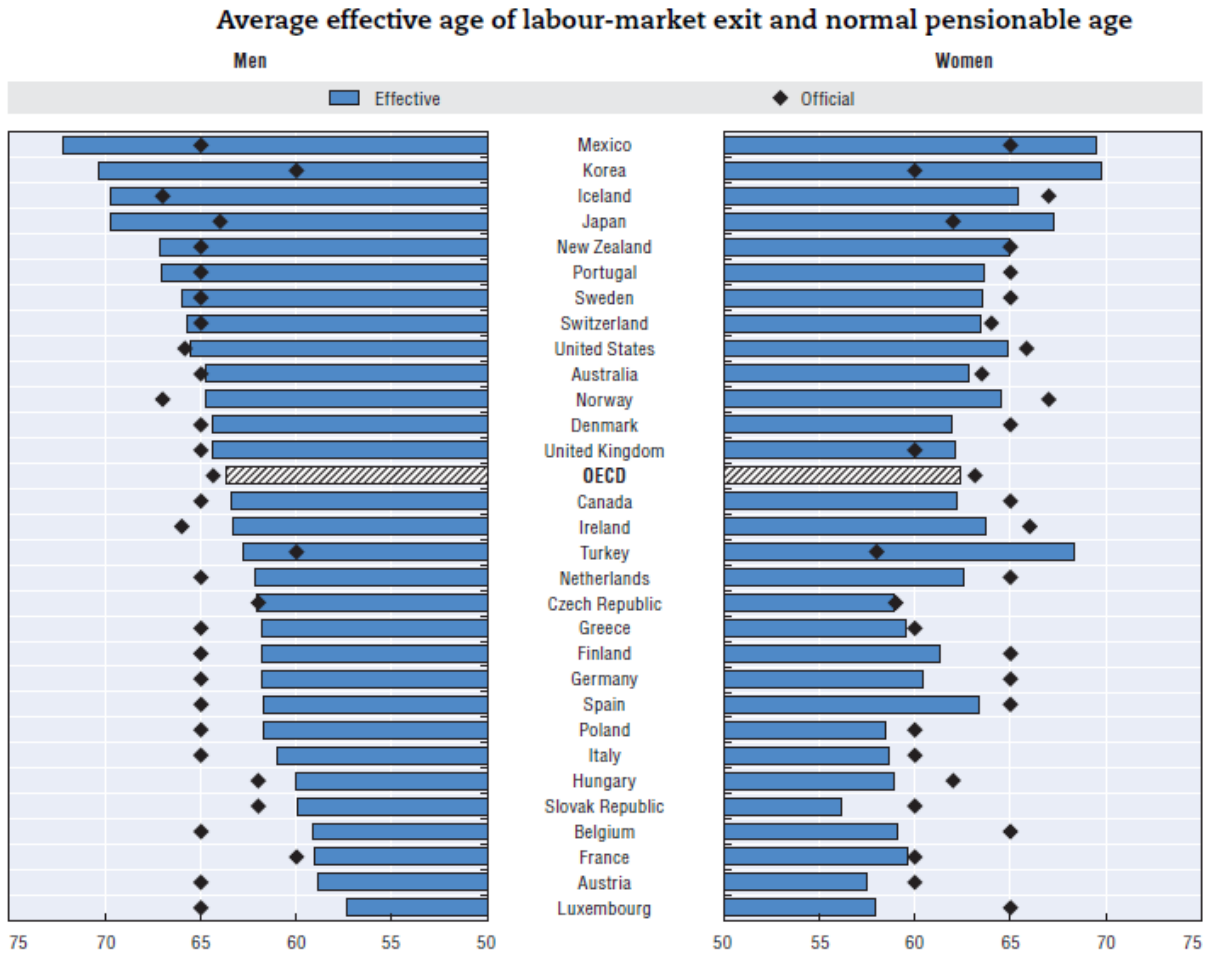
Source: Eurostat tables 2013

However, the effective labour market exit age indicator in fact says very little about the actual period over which a pension is drawn; indeed this period could differ significantly from the period calculated on the basis of the ELMEA indicator. While the effective retirement age in the majority of OECD countries is significantly lower than the statutory retirement age, they are almost the same in the Czech Republic, which would tend to suggest that the system (in

particular the statutory retirement age combined with reductions/increases connected with early/deferred old age pensions) has been set correctly.

The average effective labour market exit age and effective retirement age in OECD countries is shown in the following chart.

Chart 4: Average effective age of labour-market exit and normal pensionable age



Source: OECD Pension at a glance 2011

The first pillar of the pension system in the Czech Republic offers two early exit pathways. The first consists of the standard early retirement scheme concerning which the final amount of the pension is reduced by means of a deduction from the accrual rate of 0.9% for every 90 days of early retirement within the first 360 calendar days, of 1.2% for every 90 days of early retirement between 361 – 720 days of early retirement and of 1.5 % for every 90 days of early retirement from the 721st day of early retirement. These deductions in the accrual rate are set neutrally in terms of the total amount of pension paid out from the pension system to the beneficiary, i.e. the early retirement scheme, on average, does not influence the financial stability of the pension system. The same principle is applied to the deferred pension.

The second early exit pathway consists of the pre-retirement scheme. The pre-retirement benefit allows the drawing of savings accumulated within the third pillar a maximum of 5 years before reaching legal retirement age provided that this benefit represents a minimum of 30% of the average wage and is paid until the recipient reaches the legal retirement age. The drawing of the pre-retirement benefit must not involve the using up of all the funds accumulated in an individual savings account and the remaining amount is then used for the payment of the regular pension from the third pillar after reaching the legal retirement age.

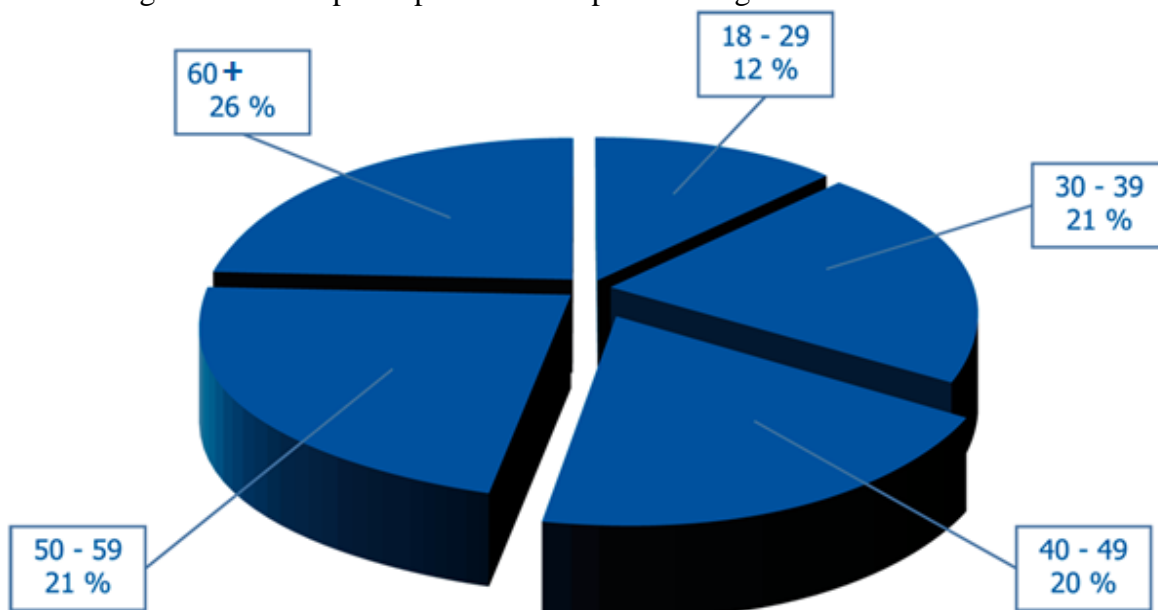
The amount of pension from the first pillar is not reduced; however, the insured person receives no pension rights during the time he/she draws the pre-retirement benefit.

There is no obligation to retire in the Czech Republic therefore it is possible to earn pension rights even after reaching statutory retirement age. There are three ways in which to gain pension rights: the first consists of the deferred pension wherein every 90 days of deferred pension (accompanied by employment) is remunerated by means of a 1.5% increase in the accrual rate, the second way is to draw one half of the pension upon which every 180 days of employment is remunerated by means of a 1.5% increase in the accrual rate, and the third way which involves claiming the full pension and continuing in employment in which case every 360 days is remunerated by means of a 0.4% increase in the accrual rate.

2.2.3 Private pensions

The role of private savings in the Czech Republic continues to be inadequate. Despite several reforms, the system remains immature. The principal problem in this respect is that saving for old age has no tradition in the Czech Republic and people continue to rely, to a great extent, on the state to provide retirement benefits. The third pillar of the pension system in the Czech Republic is seen by many people more as an opportunity to take advantage of associated state financial incentives and tax deductions rather than an instrument for securing adequate income in old age. The main problem in terms of the adequacy of future pensions from the third pillar remains the high average age of participants and thus the short savings period and consequent low level of contributions (according to the Ministry of Finance the average monthly contribution to the third pillar is a mere 2.2% of the average wage). In addition, upon completing the saving phase, people often choose to receive the payment of their savings in the form of a lump sum rather than in the form of regular monthly payments. A further problem associated with the current third pillar consists of the performance of pension institutions. In 2012 none of the nine pension institutions in the Czech Republic provided returns in excess of the rate of inflation. In 2011 only 4 pension institutions managed to increase the value of their clients' savings above the inflation rate, albeit slightly (Association of pension funds 2012, 2013). Therefore private pensions do not play a significant role in terms of securing adequate income in old age in the Czech Republic.

Chart 6: Age structure of participants in third pillar savings schemes



Source: Association of pension funds yearbook

In a further attempt to increase the amount of private savings a fully-funded defined contribution scheme was introduced as a supplementary element of the first pillar on 1 January 2013. The scheme allows the partial opt out of participants in the first pension pillar with a contribution of 3% from this pillar which must be invested together with a 2% personal contribution in pension funds administered by pension institutions. But the expectations of the government notwithstanding, the number of people who have, to date, chosen to join the scheme is very low – during the first 6 months of 2013 according to the Association of pension funds only 75 000 people decided to participate in the funded DC scheme. This figure represents only 30% of the 250 000 people who were expected to enter the funded DC scheme within the first 6 months. The envisaged 20% of the economically active population (i.e. 1 000 000 participants) which, it was anticipated would join the funded DC scheme over the long term, appears, based on the current participation rate, unattainable.

The prospects for the future development of private pension savings in the Czech Republic are less than optimistic. Since the level of the pension from the first pillar is relatively high most people have very little motivation to save privately. The government has tried to encourage people to join private pension savings schemes by means of financial contributions and tax deductions; however, such schemes have been taken up principally by those already approaching the statutory retirement age for whom the advantages are relatively low due to the short contribution period. Furthermore, it is probably fair to say that given the current performance of pension institutions, saving privately for retirement is not seen as an attractive option by a large part of the population.

2.2.4 Summary

The Czech pension system has been, over the long term, successful in terms of combating the poverty of elderly people. Indeed, according to at-risk-of-poverty rate indicators, the Czech Republic rates among the top 5 best European performers.

The Czech Republic has in recent years implemented several fundamental reforms in its pension system, all of which were in compliance with EC recommendations and due to which the Czech Republic was mentioned positively in the EC publication WHITE PAPER - An Agenda for Adequate, Safe and Sustainable Pensions.

Compared with other EU and OECD countries, the Czech pension system does not deviate from other pension systems in terms of international comparative indicators according to which it displays predominantly average values. The Czech Republic fulfils practically all the conditions set by the international conventions of both the ILO and the European Code of Social Security.

According to the latest demographic projections the trend of population ageing will continue in the Czech Republic. Since most forecasts envisage stabilization in the total fertility rate, the major factor in terms of the ageing process consists of the decreasing mortality rate.

The key aspect in terms of the success or failure of the recent reforms lies in the prolonging of working life, i.e. an increase in the effective labour market exit age. However this depends greatly on the performance of the labour market – the pension system merely provides support by ensuring that the period of the economic inactivity of older people will not necessarily represent the period over which a pension is drawn (e.g. by an increase in the retirement age or by restricting early retirement pathways).

In terms of increasing labour market participation it is essential that more vulnerable groups in the labour market, i.e. young workers, women and people with low levels of education

continue to be targeted by the state. Moreover, it is necessary to reconcile family and working lives of Czech parents, e.g. by the extension and support of part-time employment.

As mentioned earlier in the report, the lower income levels and number of years of economic activity of women compared to men are reflected in the lower levels of women's pensions in the Czech Republic. On the other hand women enjoy overall higher life expectancy which means that the time they spend in retirement is, on average, 6.8 years more than that of men.

The major risk for the Czech pension system according to projections consists of an increase in the number of disability pensions granted following increases in the retirement age. The major risks in terms of the political decision-making process remains the potential moderation of the conditions governing early retirement and a slowdown in, or complete halt to, increases in the retirement age (as has been mooted by left-wing parties in their election manifestoes).

According to projections of the development of the pension system¹³ it is expected that the aggregate replacement ratio will decline slightly in the future since it is expected that more people will take advantage of the early retirement scheme. Thus lower levels of pension in the future will not be the result of restrictions in the system as a whole, but rather the result of the behaviour of the Czech public and the decisions they make concerning retirement age.

Projections also point in the long-term to a worsening of the pension account balance and thus an increase in the ratio of expenditure on pensions to GDP; therefore, it is inevitable that further parametrical changes will have to be introduced into the pension system in future years.

Private pension savings are faced with both the poor performance of the pension funds involved and the low contributions of participants as a result of which, since 1 January 2013, a higher monthly personal contribution has been required in order to qualify for the maximum state contribution. It is hoped that this measure will increase the general level of private pension scheme savings.

The funded scheme within the first pillar of the Czech pension system remains unpopular with the general public; in the first six months of 2013 a mere 75 000 people joined the funded system. It would seem therefore that this element of pension reform will not be as successful as anticipated.

2.3 Reform debates

To all intents and purposes, there has been no rational debate on pension reform in the Czech Republic in recent years. The biggest problem in this respect was the result of the last general election which revealed a society divided almost equally between right-wing and left-wing supporters. The result of the election was a fragile coalition of right-wing and centrist parties with a small majority in the lower house of parliament. The government, in compliance with the country-specific recommendation of the EC, introduced pension reform legislation without the support of the left-wing opposition. Therefore, debate in 2012 concerned solely how the impact of pension reform could be moderated and even the potential abolition of certain reform measures (e.g. ČSSD – the strongest opposition party publicly declared that, should it form a government following the 2013 election, it would abolish the funded part of the first pillar, halt the increase in the retirement age and moderate conditions governing early retirement). The opposition is strongly supported by the trade unions which have failed to suggest any alternatives to the existing reforms, preferring instead to concentrate their attention on criticising the existing government's proposals and implemented legislation.

¹³ Actuarial report on social insurance 2012, http://www.mpsv.cz/files/clanky/14299/PMZ_2012_en_final.pdf

The only constructive discussion involving the government, opposition, parliament and social partners during the tracking period concerned finding consensus on the pre-retirement benefit (part of the existing third pillar of supplementary pension savings) which was introduced on 1 January 2013.

Rather than preparing new reform proposals, political players preferred to devote attention to campaigning for the presidential election which was held in January 2013.

The only organisation which continues to be engaged in pension reform is the apolitical Actuarial Department of the MLSA. The department has enhanced its dynamic micro-simulation model the outputs of which are used for the preparation of long-term projections of pension system development. The Actuarial Report on Pension Insurance 2012, the most important publication in terms of the description, projection and analysis of the pension system, was published with help of this model.

Last year the MLSA held an internal debate on the possibility of replacing the survivor pension with the sharing of pension rights or the splitting of pensions between married couples. In 2012 the Research Institute for Labour and Social affairs worked on three separate studies on this topic which will be released during the third quarter of 2013.

In June 2013 the Czech government resigned and pension reform became one of the main topics of the election campaign. However, electioneering has tended to consist of populist rhetoric rather than serious pension reform proposals.

Country specific recommendations became one of the topics of the reform debate following the preparation of the National Reform Programme the publication of which led to both formal and informal discussions on the reform issue involving government ministries, representatives of the lower house of parliament, social partners, regional and municipal representatives, academics, independent researchers, representatives of NGOs and EC deputies.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

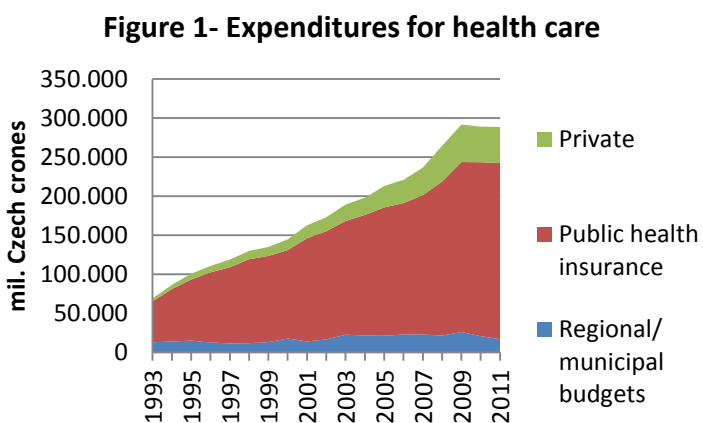
The Czech health care system underwent a major reform in the early nineties of the last century that determined the current shape of the system. The former Semaskho model was replaced very quickly by a model of social health insurance based on splitting of funding and provision of health care. At the provision side a rather deep process of privatization of health care providers was launched especially in out-patient care. A concept of plurality of health insurers was adopted at an early stage of the transformation of the health care system and also universal adoption of fee-for-service remuneration in nearly all segments of health care was anchored in the health insurance law¹⁴. So, the Czech health care system was rather liberal in early nineties on the one hand and heavily reliant on public sources of funding on the other hand. These reforms were facilitated by a remarkable increase of public financial means that the Czech Republic was able to allocate for funding of health care after the split of the former Czechoslovakia and ceasing of redistribution of the state budget among both successor states - the Czech Republic and Slovakia. However, the effect of this one-time increase evaporated soon and the original reforms had to be corrected later on especially in the areas of

¹⁴ The law 550/1991 that was replaced by the law 48/1997 later on.

remuneration of health care and consolidation of the health insurance market. The open-ended remuneration on the basis of fees for services had to be modified by introducing of global budgets for health care providers. Rules of behaviour for health insurers had to be enforced and a wave of mergers and bankruptcies reduced the number of acting insurers remarkably.

3.1.2 System characteristics

The major source of funding (around 80%) of the Czech health system is a public health insurance scheme. The scheme is mandatory for all permanent residents of the Czech Republic and all employees working for Czech employers even they come from abroad. Health insurance contributions are paid by all employed and self-employed insurees and also by insurees without earnings but not belonging to a category of so called state insurees. The category of state insurees encompasses pensioners, children until they finish their education, registered unemployed person, women on maternity leave, disabled persons, parents caring for small children, prisoners etc. The contribution rate for active payers is determined by the law¹⁵ and it has remained fixed for already 20 years (13.5%; 9.0% paid by the employer and 4.5% by the employee without any ceiling now). The contribution rate for state insurees is determined by the Government now and it serves de facto as a tool for regulating the volume



of funding of the public health insurance scheme. The revenue for the state insurees has oscillated in the range 20% - 27% of the total revenue of the public health insurance scheme since 1993¹⁶. Actual expenditures for health care provided to the state insurees are more than two times higher than the share of the revenue on behalf of them. So, a cross-subsidization between the group

of state insurees and the group of wage-earning insurees takes place inside the public health insurance system.

The public health insurance scheme is administered by several (currently 8) health insurance agencies. One of them – the General Health Insurance Agency of the Czech Republic - has a dominant position from historic reasons as it had a monopoly position at the outset of the reform. It insures currently around 60 % of the population. All health insurance agencies are open for any insuree. They are all non-profit and their activities are governed by the same or very similar rules. Contributions are collected by health insurance agencies separately but the collected contributions including contributions of the state budget for state insurees are fully redistributed according to the age and gender structure of the portfolio of insurees among the health insurance agencies. The health insurance agencies contract separately also health care providers. Prices for health care are determined to a high extent uniformly by the Ministry of Health although the resolution of the Ministry on prices is formally preceded by a negotiation between health insurers and representatives of health care providers. The benefit package is

¹⁵ The law 591/1992 on health insurance contributions

¹⁶ See [UZISa]

determined also for all health insurers in a uniform manner by the health insurance law 48/1997. Thus, although health insurers compete for insurees, the space for such competition is rather narrow.

Other sources of funding are direct payments of patients either for services not covered by the public health insurance scheme or for cost sharing (16 % of total expenditures for the health care sector in 2011) as well as steadily decreasing subsidies of regional and/or municipal budgets (5,8 % in 2011) - see the figure 1¹⁷. The share of private health insurance is rather negligible as a comprehensive coverage of the public health insurance scheme does not provide much space for deployment of viable and profitable supplemental health insurance products¹⁸. Private insurance plays a major role only for persons living on the territory of the Czech Republic that are not qualified for the public health insurance scheme, for example for persons from non-EU countries without formal employment.

The benefit package is rather generous and encompasses services in primary, secondary and tertiary health care. There are some exclusions of coverage such as e.g. cosmetic surgery, dental prostheses, etc. The benefits are usually provided with some cost sharing. Major cost sharing of patients is used in the case of prescribed drugs. The mandatory health insurance system uses reference pricing for determination of the benefit for each drug. It means that cost sharing varies among drugs and also in dependency of selling prices of pharmacies. There are some co-payments for services. A small co-payment (around 1.2 EUR) has to be paid by a patient for each out-patient visit and around 4 EUR for each day of stay in a hospital. These co-payments are re-considered currently and the co-payment for a day of stay in hospitals has been even rejected by the Constitutional Court recently because of its amount. It can be expected that it will be re-introduced again but with some limitations and in a smaller amount. There is an annual ceiling (not means tested) for cost sharing of individual patients. However, this ceiling includes only cost sharing for some types of benefits. For example, the co-payment for a day in hospital was excluded from the calculation of the annual ceiling.

On the provision side, there is a mix of private and public health facilities. The vast majority of health facilities are contractually bound to the public health insurance scheme. The majority of out-patient facilities is run by self-employed private doctors whereas public ownership prevails in the case of in-patient facilities. Big hospitals are owned by the state whereas regional hospitals are usually owned by regional governments. Patients have a free choice of health facility within the public health insurance scheme and they have direct access to specialized health care without any gate keeping. Health facilities have usually separate contracts with all or several health insurance agencies relevant for their catchments areas.

Different remuneration mechanisms are used for different types of health care. Primary health care is remunerated by a combination of capitation and fee-for service, specialized care predominantly by fee-for-service and hospital care is remunerated by DRG based prospective

¹⁷ Source:[UZISa]

¹⁸ According to the Annual Report [CAP 2012] of the Czech Insurance Association (uniting commercial insurers) the total volume of premiums written for the category of private health insurance products was 2,563 million Czech crowns. It is less than 1 % of the total health care expenditures. However, the majority of insurance products in this category are fixed amount insurance products. It means that a beneficiary gets some defined cash benefits in the case of a claim. Only a portion of indemnification is actually used for health care and generally only around one third of premiums written is used for indemnification in the current year. It can be estimated that less than 0.1 % of the total health care expenditures is covered by supplemental health insurance in the Czech Republic.

payments. However, limits on remuneration from the public health insurance scheme are imposed on each health care provider, so remuneration mechanisms resemble more to global budgets.

3.1.3 Details on recent reforms

One major reform step with potential far reaching consequences was undertaken lately and relates to the definition of the benefit package for the public health insurance system. This reform step had de facto two parts; Firstly, the provision stipulating that the public health insurance scheme should cover only the most economical (cheapest) variant of a service with the same therapeutic effect was included into the health insurance law 48/1997. The previous provision was such that it was at the discretion of a treating doctor which way of provision of a service should be provided taking into account the health status of a patient. Secondly, this new provision was followed by another one that if a patient opts for a more expensive way of provision of a given service he/she has to pay the difference between the cheapest variant and the variant that the patient opted for. There were some other accompanying conditions ensuring that a patient will not be exposed to any manipulation from the side of medical personnel aiming to persuade the patient to decide for a more expensive option. The former legal status was such that if a patient insisted on an alternative way of provision of a service despite decision of his/her treating doctor he/she had to pay the whole price of the service. The purpose of the former legal arrangement was to prevent withdrawing of non-justified fees from patients for health care covered by the public health insurance system. The cheapest variants for services had to be determined by a resolution of the Ministry of Health. The difference between the price of the cheapest variant of a service and the more expensive variant that should be borne by a patient was at the discretion of health facilities. The new provision was successfully sued at the Constitutional Court quite recently. The Constitutional Court justified its rejection of this provision by procedural reasons as benefits within the public health insurance system have to be defined according to the Czech constitution only by a law and not by a ministerial resolution as was the case.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

There is universal coverage of the whole population by the public health insurance system. A person remains covered without any restriction even if he/she does not meet his/her obligations to pay contributions. The benefit package is rather generous and definitely encompasses all necessary health care. Some question marks arise around dental care for future. The chamber of dentists tries to push through that fillings are taken out of the benefit package. This is in line with a long-term goal of Czech dentists to detach dental care as much as possible from the public health insurance system¹⁹.

The access to services might be a problem for low income groups due to cost-sharing. The fee of 4 EUR for a day of stay in a hospital without any limitation is definitely very high for some low income persons especially for pensioners as the average pension in the Czech Republic is roughly only 400 EUR. As was mentioned above this co-payment has been cancelled by decision of the Constitutional Court quite recently because it might create a financial barrier

¹⁹ See for example www.dent.cz/cs/download/Navrh-CSK-vycleneni-pece-LKS-09-2007.pdf

for access to health care. Another problem may arise for some patients needing only drugs which are partially covered by the benefit package. Generally, out-of-pocket expenditures for health care accounted for 2.8% of total expenditures of households in 2011. For households of pensioners the share amounted to nearly 5 %. There is a sharp increase in comparison to 2005 when the figures were 2% for an average household and 3.2% for an average pensioner's household²⁰. Around 70 % of out-of pocket expenditures for health care represent expenditures for drugs and medical devices. The upward trend of development of out-of-pocket expenditures for health care indicates slowed down in the last two years (see the figure 1) but still there are groups of population for which their out-of-pocket spending for health care may create a major problem. The table 1 indicates a growing trend in self-reported unmet needs for medical examinations in lower income quintiles for the period 2005-2011, which is in coincidence with the decreasing trend of the public funding of health care in the Czech Republic²¹.

Self-reported unmet need for medical examination (the share in % of the population perceiving an unmet need for medical examination or treatment) ²²						
	Total population (2005)			Total population (2011)		
	<i>1st income quintile</i>	<i>2nd income quintile</i>	<i>3rd income quintile</i>	<i>1st income quintile</i>	<i>2nd income quintile</i>	<i>3rd income quintile</i>
EU 27	7.6	4.4	3.2	4.8	2.8	2.0
Czech Republic	0.6	0.4	0.4	1.0	0.7	0.2

Table 1

Regarding spatial accessibility, the Czech Republic is a country with a rather small and densely populated territory. There is a dense network of around 200 hospitals providing acute, emergency and also long-term care. Out-patient care is provided by both hospitals and by a dense network of field specialists. There is some overcrowding of specialists in big cities that is only partially regulated by contractual policy of health insurers. The Ministry of Health has defined minimal requirements for accessibility of health facilities of different types recently that should be respected by the contractual policy of health insurers²³.

²⁰ See the statistics on living conditions of households at the website of the Czech Statistical Office www.czso.cz/csu/redakce.nsf/i/zivotni_uroven_spotreba_domacnosti_prace

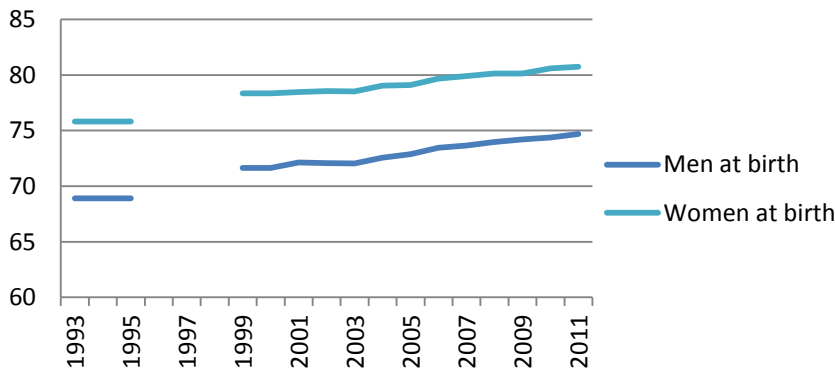
²¹ The indicator of reported unmet needs is still low in comparison to EU average but EUROSTAT does not recommend using the indicator for cross-country comparisons as there may be a bias due to cultural differences.

²² Source: Eurostat, retrieved on October 26, 2013 at epp.eurostat.ec.europa.eu/portal/page/portal/employment_social_policy_equality/social_protection_social_inclusion/indicators/health_long_term_care

²³ The resolution 307/2012 of the Government (see www.mzcr.cz/Legislativa/obsah/zdravotni-pojisteni_1791_11.html)

3.2.2 Quality and performance indicators

Figure 2- Life expectancy



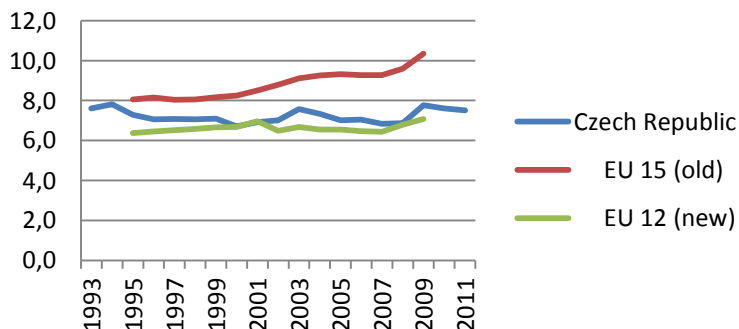
The Czech Republic ranks traditionally high in international comparisons in the area of maternity care and new-born mortality. The life expectancy increases relatively steadily with an approximate 0.3 yearly gain per calendar year²⁴ - see figure 2. There were several attempts to

monitor more detailed quality indicators of health care provision accomplished by health insurers or by the Ministry of Health. However, they were not durable enough. A national set of quality indicators for hospital care has been elaborated quite recently under supervision of the Ministry of Health²⁵. Reporting according to this set of indicators is obligatory for big university hospitals controlled by the Ministry from January 1, 2013. There are several accreditation programs for health facilities in use that concentrate mainly on structural and procedural aspects of provision of quality health care.

Regarding performance measured just technically as number of out-patient visits or number of hospital stay we observe steady decrease, e.g. from visits per out-patients doctor in 1995 to visits per out-patients doctor in 2011 or a less dramatic decrease in number of hospital stays per doctor from in year 1995 to in year 2011²⁶. The reason is rather steep increase of acting doctors in the given period on one hand and decreasing number of out-patient visits per inhabitant on the other hand. However, it should be noted that the initial baseline in early ninetieths was rather high.

3.2.3 Sustainability

Figure 3-Share of health care expenditures on GDP (in %)



The Czech Republic shows relatively steady share of public health care expenditures on GDP since early nineties. The share of private expenditures exhibits a higher growth nevertheless the share of private expenditures is relatively low (see the figure 1). The share of total expenditures for health care on GDP oscillates in the range 6.9-7.7 % for nearly twenty years - see figure 3²⁷.

²⁴ Valid for the period 2000 onward. Source: [UZISa]

²⁵ See www.mzcr.cz/KvalitaABezpecni/obsah/indikatory-kvality-zdravotni-pece-2907_29.html

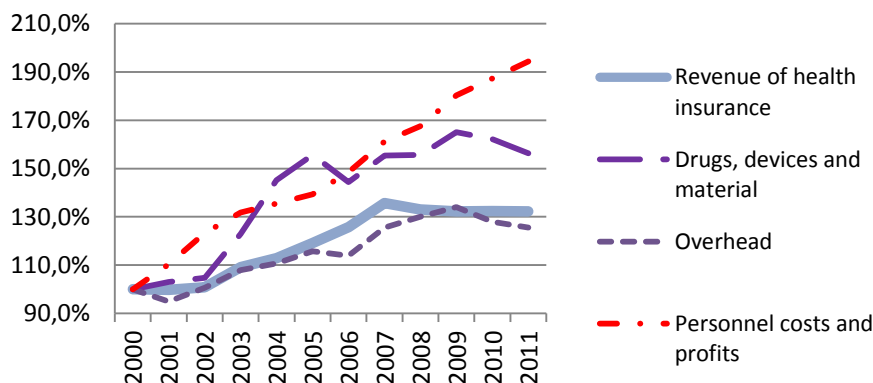
²⁶ See [UZISa]

²⁷ Source: [UZISa]

This share is more influenced by the volume of GDP than by the volume of health care expenditures. The latter exhibits steady growth. One comment is important. Definitely, this share of health care expenditures on GDP is lower than in the old EU countries. It does not necessarily mean that the Czech health sector is comparatively underfinanced. It should be taken into account that the Czech average salary corresponds to remarkably lower share on GDP per capita in comparison to old EU countries. The Czech average salary corresponds to 75% of Czech GDP per capita whereas for example in Germany the average salary corresponds to much higher share of GDP per capita (1.4²⁸). So, funding of the same workforce with the same salaries in relation to the average in the national economy requires generally lesser share of GDP in the Czech Republic in comparison to majority of old EU countries.

High share of public funding of the Czech health care, especially from the public health insurance scheme, creates a funding envelope that determines to much extent the trend of total expenditures for health care. As revenues of the public health insurance system are dependent on the volume of salaries in the national economy, the trend of health care expenditures copies more or less the trend of the average salary and the GDP in the country with only light deviations as for example in crisis years 2008-2009. However, the share of private expenditures is steadily increasing because of higher cost sharing in the public health insurance scheme. For example, the public health insurance scheme covered 82% of total expenditures for drugs in 1996 but less than 59% in 2011²⁹. One reason is rising costs of drugs but it is not the most important one. Costs for drugs

Figure 4 - Real growth of costs in comparison to real growth of health insurance revenue (2000=100%)



and medical devices and materials rose by around 56% in real terms between 2000 and 2011. In the same period, revenue of the public health insurance system rose by around 32% in real terms. Personnel costs and profits³⁰ are the most important cost driver with 89% increase in real terms - see figure 4³¹. The rise of personnel costs is composed of three components – a general increase of real value of salaries in the Czech economy, increase of workforce in health care (see below) and specific increase of salaries and profits in the health care sector. Especially the third one is very sensitive both for medical workers and also for the rest of population. The average salary of an employed doctor was around 2.4 times the average salary in the national economy, it was 1.15 for nurses and the gross profit of private doctor

²⁸ Source: EUROSTAT at epp.eurostat.ec.europa.eu/portal/page/portal/statistics/themes. It is the ratio of the average salary and the average GDP per capita in the country. The ratios given here are for 2006 but they change only marginally in a short-term to mid-term time span.

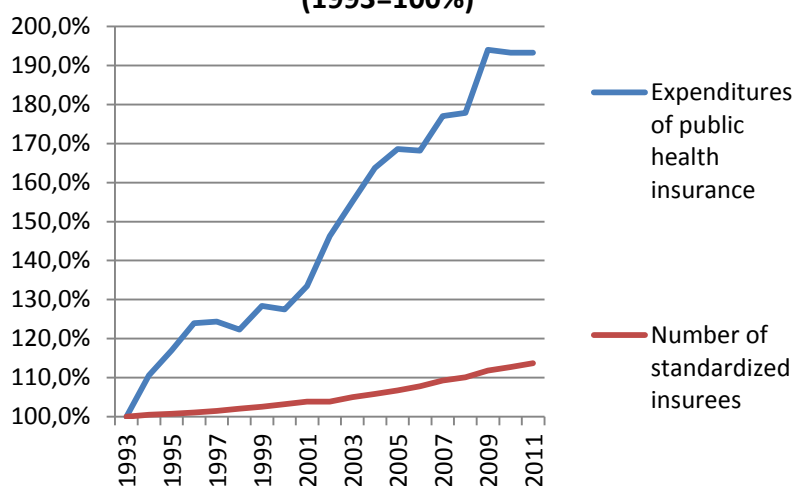
²⁹ See [UZISa]

³⁰ Profits included are profits of private doctors (the difference between their revenue and costs) and profits of pharmacies.

³¹ Source:[UZISb]

was around 2.8 times average salary in the national economy in 2011³². This level of personal income is considered as not satisfactory by medical workers with reference on apparent underfinancing of the Czech health care sector. Some pressure actions were arranged by hospital doctors in 2010-2011 that resulted in an agreement of the medical trade unions with the Government on increasing medical salaries gradually in the next three years³³. It has created a tension in funding of the health sector as there is no major increase of revenue of the public health insurance system as the Czech Republic exhibits a longer recession in the last few years. Personnel costs and profits represent around 50% of costs of provision of health care in the Czech Republic. They are the most important cost category leaving drug and material costs with the share around 32% share well behind. So, personnel costs and profits of the health care sector are a question mark for sustainability of the public health insurance scheme and its benefit package in the future.

Figure 5 - Real growth of health insurance expenditures in comparison to impact of aging (1993=100%)



One of frequently cited factors of increasing health care costs is the aging of the population. This factor seems to have played a limited role in the Czech Republic in the last twenty years. Whereas health care expenditures increased by 90% in real terms in the period 1993-2011, the number of so called standardized insurees³⁴ used as an indicator for redistribution of revenue of the public health insurance system increased only by 13% (including a slight increase of the number of population³⁵)

in the same period. The number of standardized insurees can serve as a proxy indicator for estimation of pure impact of aging on health care expenditures eliminating other factors of growing costs like increase of price level. The number of standardized insurees can even serve as a worst case proxy for assessing the impact of the population aging³⁶. Therefore, the actual impact of the aging of population can be even below 11% during last twenty years and similar figures can be expected also for future.

³² See [UZISb]

³³ Actually, there was further increase in salaries of medical workers in 2012 (official statistical data not available yet) but definitely to the level agreed between the Government and the trade unions.

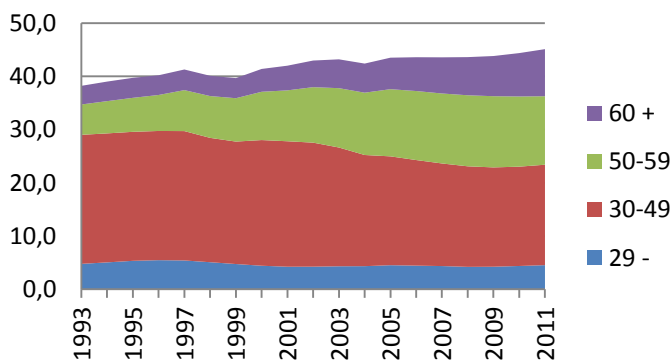
³⁴ A standardized insuree stands for average expenditures for health care for a male insuree at age 20. A physical person is equivalent to the number of standardized insurees that equals to the sex/age coefficient corresponding to the sex and age of the physical person. The sex/age coefficient expresses how many times an average person of given sex/age consumes more health care (in monetary terms) than a men of 20. This concept is used for redistribution of revenue among the ealth insurance agencies.

³⁵ The number of the population increased by around 3% within the same period.

³⁶ For reasons see for example [Pavloková 2009]

Regarding workforce in the health care sector, there has been a visible increase of the number of doctors in past 20 years – see the figure 6³⁷. This increase was caused by two phenomena. Firstly, there was a comparably small number of doctors in age 50 and more in early nineties of the last century. So, relatively numerous younger cohorts of doctors became older within last two decades and replaced less numerous older cohorts of doctors that retired. Secondly, new working conditions especially the possibility to run own private practices motivates more doctors to work longer than before. There is a rather moderate negative balance (around

Figure 6 - Number of doctors per 10,000 inhabitants



several hundred per a calendar year) of Czech doctors leaving the country and foreign doctors that settle down in the Czech Republic³⁸. Looking back on numbers of students of medical faculties it seems that the increase of the number of acting doctors should stop in around five years and a mild decrease can take place after that.

One of factors of sustainability that is frequently discussed in the Czech Republic is the impact of preventive measures on overall expenditures on

health care. The public health insurance system covers a range of preventive services³⁹. However, it is a problem of motivation of insures for broader utilization of such services. Time from time some proposals emerge in the Ministry of Health for increasing the motivation of insurees to participate in preventive measures in a form of bonuses to health insurance contributions or higher coverage of some curative services. However, no analysis of cost effectiveness of such proposals is submitted so that such attempts can be hardly regarded as anything more than political proclamations.

Organizational sustainability of the public health insurance scheme is also of some interest. The current setup of competition among health insurers is not considered to be satisfactory by any relevant political party; nevertheless proposals for a remedy differ a lot. Although the current organizational setup of administration of health insurers seems to be unsustainable in long-term perspective, a question is, whether some political parties will be willing to invest their political capital into its transformation in near future.

The public health insurance system has solved a dilemma of balancing of motivation of health care providers to performance and preserving of the financial stability of the system for already twenty years. Whenever open-ended remuneration mechanisms were used, for example fee-for-service in the years 1992-1997 or payment per admission in 2001-2003, always major deficits in the public insurance system emerged that had also a negative impact on the financial health of the insurance system in subsequent years. The problems of deficits of the public insurance system were usually solved by a combination of some infusion of money in the system from the state budget and imposing some ceilings on funding of individual health care providers. This had one disadvantage that a proportion between funding

³⁷ Source:[UZISa]

³⁸ According to [CLK 2012] 501 doctors (around 1 %) and 172 graduates of medical faculties (around 16 %) moved abroad in 2011. The outflow of doctors is partly compensated by inflow of doctors mainly from Slovakia and Ukraine.

³⁹ It can be estimated from [VZP 2012] that the health insurance agencies spend around 2 % of their revenue for funding of preventive measures.

of individual health care providers and provided health care gradually deteriorated with the time and it resulted in an inefficient allocation of financial resources. A prospective payment according to the DRG classification system is currently implemented for remuneration of the Czech (acute) hospitals. The whole implementation process is challenged by remarkable differences of the performance of hospitals measured according to DRG terms in relation to their remuneration in the previous mechanism. A viable strategy how to overcome this problem and to find a reasonable compromise between sustainability of funding and performance of the health care system still has to be found.

3.2.4 Summary

Rather free access to quality health care can be definitely regarded as a major strength of the Czech health care system. It is true that the share of private health care expenditures increased since nineties and rather sharply in year 2006-2009; nevertheless it stopped last two-three years at still reasonable 16 % of the total expenditures for health care. Certainly, there are groups of population (especially pensioners) for which such moderate share of private expenditures can provide a barrier to access to health care; especially in the area of pharmaceuticals and dental care. A bit more elaborated scheme of cost sharing taking into account the social situation of patients may alleviate such problems while keeping pace with financial possibilities of the insurance system.

A relatively good spatial accessibility in major parts of the territory of the Czech Republic is also beneficial for the population. Remuneration of medical personal can be also considered as decent; although some medical professionals may challenge this statement. There is nearly no unemployment among medical workers.

The organization of the Czech health insurance system can be identified as a weakness because of quite different ideas of relevant political parties on reforming of the system.

The public health insurance system tries to find a long-term equilibrium between motivation of health care providers to a reasonable performance and a financial stability of the public health insurance system that is materialized in used remuneration mechanisms. Actually, such equilibrium is still searched for and the pluralistic model of the organization of health insurers doesn't help to find it.

3.3 Reform debates

There are two hot reform topics in the Czech health care system already for years. The first topic relates to the degree of cost sharing in the Czech health system. The Czech health system has been traditionally funded with a high share of public sources. Although the public share steadily decreases still cost sharing in the public health insurance system is relatively low in comparison to other countries of the Central and Eastern Europe. Supporters of higher cost sharing claim that higher financial participation of patients positively influences their behaviour towards more healthy lifestyle and lower utilization of health care. However, behind supporting of higher cost sharing quota there is also interest of providers' community to open another not so regulated source of their revenue. Opponents of higher cost sharing argue that cost sharing already in place creates barriers for accessibility of health care for some vulnerable groups of population.

Related to cost-sharing is another hot question of re-definition of the benefit package in the mandatory health insurance scheme. There were attempts mentioned above to cover only most cheapest way of provision of services in the public scheme. There is a hard debate whether it

is acceptable from the point of view of constitutional rights of citizens and what might be consequences to equal access of population to health care. As was mentioned above, the Constitutional Court rejected attempts to link way of provision of services to patient's ability to pay quite recently but more or less from procedural reasons.

The second topic of hard reform debates is the role of competition in the public health insurance system. The Czech public health insurance system is pluralistic; nevertheless space for competition of insurers is very narrow now. There are again two radical positions in the debate on the organization of the insurers. Supporters of the pluralistic model say that this model has to be elaborated to enable real competition of health insurers on a regulated market. Measures enabling competition of health insurers are proposed especially on the income side. So, the current rigid arrangement relating to contribution rates should be freed somehow to allow to insurers to manipulate within some corridors with them. It is interesting that propagators of the pluralistic organization of health insurers are often representatives of health care providers under buzzword of efficiency of the public health insurance system.

Opponents of a course of the public insurance system towards the regulated market claim that plurality of insurers within the public health insurance brings about additional overhead costs both on the side of insurers and providers, excludes usage of effective remuneration mechanisms based on global views on performance of health care providers and weakens negotiating position of purchasing side with a reference on negative Czech experience with a wilder competition among insurees in early nineties of the last century. The remedy they offer is to abolish or at least remarkably limit the current pluralistic system of health insurers.

It should be noted that positions in the reform debates are prevalently linked to political positions of debaters. There have been right oriented governments in the Czech Republic for last seven years that pushed through measures towards higher cost sharing and a more market oriented health insurance system. However, there are revisions of such measures on the agenda of left parties that might go to power after upcoming parliamentary elections.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

There were two major reform steps that shaped the current system of long-term care in the Czech Republic. The health care component of long-term care was strongly influenced by the introduction of the public health insurance system in early nineties of the last century. This reform step determined the way of financing health services within long-term care on the one hand and contributed to a divide between financing and provision of health and social services in the country on the other hand. There was constant pressure on removing any elements of social care from the public health insurance system with the intention to use well defined revenue of the public health insurance system just for health care. This had an impact not only on funding but also on provision of long-term care. Providers of health care services and social services had to be distinct entities several years after introduction of the public health insurance system. This problem has been already solved⁴⁰. Social care institutions can provide

⁴⁰ In 2006

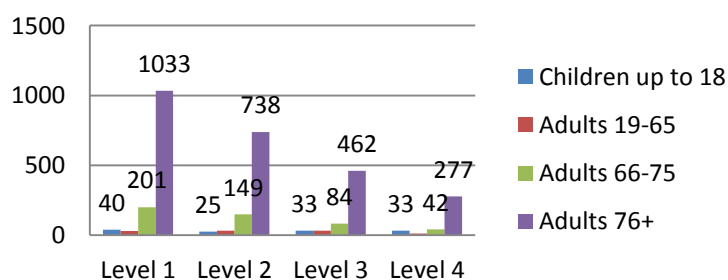
distinct types of health care covered by the public insurance scheme now. There were also attempts to anchor legislatively long-term care as a union of health and social care services, but these have not yet been successful,

The second reform step was accomplished in the area of social services in 2007. The new law on social services⁴¹ not only recognized a much broader scope of types of social care services and institutions than before but also decided on handing over a remarkable share of public funds to recipients of social services in a form of care allowance. There was an expectation behind such step that recipients will decide by themselves on the most suitable way of acquiring social services and that recipient's decisions will shape the network of formal providers of social services in a desirable way. These expectations have not been met fully.

4.1.2 System characteristics

Funding and also provision of long-term care is to a certain extent separated for health care and social care. Funding of health care is performed within the public health insurance system. Health care services at home are provided by home care agencies that are contractually bound to health insurers. Health care is remunerated to home care agencies by the public health insurance system only if it is indicated by general practitioners. Fee-for-service mechanism is used for remuneration of health care provided by home care agencies. In-patient health care services for long-term patients are provided in establishments for long-term patients or in residential social care establishments, but in residential social care establishments predominantly nursing care is provided as residential social care establishments employ a very limited number of doctors. It is remunerated on fee-for-service basis to residential establishments directly by health insurers. Establishments for long-term patients are remunerated predominantly by health insurers. Differences of remuneration for patients in facilities for long-term patients and in residential social care establishments is one of weak points in long-term care system in the Czech Republic.

Figure 7 - Number of recipients of care allowance per 10,000 inhabitants (in given age category)



Persons dependent on support of others are entitled for care allowance which is scaled to four levels according to the recipient's dependency on support. The highest level of dependency entitles a recipient to a care allowance around half of the average salary and slightly than the average pension in the country⁴². The criteria for awarding of a specific level are

specified in the law on social services. They are based on recipient's mobility, ability to master daily activities etc. Care allowance is not means tested with exception of recipients below 18. In that case the parents can get a bonus on top of a standard care allowance provided they do not earn more than a specified threshold. Care allowance is atypical allowance for seniors. More than 25 % of inhabitants above 76 are recipients of some level of care allowance – see figure 7⁴³. The number of recipients of care allowance increased from

⁴¹ The law 108/2006, see at www.mpsv.cz/cs/7334

⁴² Care allowance for the first level is currently 800 Czech crowns, for the second level 4,000 Czech crowns, for the third level 8,000 Czech crowns and for the fourth one 12 000 Czech crowns monthly.

⁴³ Source:[MLSA2010]

260,000 in the year 2007 to its peak 313,000 in 2010 but adjustments of care allowance at the first level (see below) decreased the number to 302,000 in 2011⁴⁴.

Social care services are provided either by informal carers (family members etc.)⁴⁵, by professional providers of social services or by a combination of both. Providers of social services are either registered or unregistered. If registered they have to follow price regulation imposed by the Ministry of Labour and Social Affairs in order to be eligible for public subsidies. Unregistered providers of social services (e.g. private residential home for seniors) are free in their pricing policy; however they have to cover all costs out of payments done by recipients of their services. The price regulation stipulates maximal prices for individual social services. Some services, e.g. social prevention or social rehabilitation are provided free of charge for recipients. For residential services the price regulation determines a ceiling for accommodation and food in the amount around an average pension in the Czech Republic and the law on social services stipulates that maximum 85 % of inhabitant's pension can be transferred to a residential social care institution to cover the costs of a full-time inhabitant (75% for week care centres). Payment for other social services in residential social care establishments (on top of accommodation and catering) is capped by care allowance that is awarded to the inhabitant. Social services are provided according to a contract between a recipient of social services and a registered provider of social services. The recipient pays social services out of his/her own financial means or financial means of his/her relatives. In addition, recipient's care allowance can be used.

As regulated recipients' payments cover only part of costs of registered providers of social services they are entitled to subsidies for their operations. Subsidies are granted by the Ministry of Labour and Social Affairs through offices of regional governments. Other subsidies are also provided by municipalities. However, there are no formal rules for determination of amounts of any type of subsidies mentioned above.

4.1.3 Details on recent reforms in the past 2-3 years

There were only minor reform steps adopted in the last few years. One more or less organizational change was transferring of responsibility for decision on and payment of care allowance to Labour Offices. This was not an isolated step as also payments of other social related allowances were transferred to this authority hand in hand with some consolidation and merging of them. This step has been taken with the aim of administrative savings and also the possibility of unification and computerization of payment channels⁴⁶.

The other adjustments related to the amount of care allowance. Care allowance for the lowest level of dependency was two times adjusted from original 2 000 Czech crowns monthly (around 80 EUR) to earmarking of a half of the contribution for using of formal social services provided by registered providers of social services and finally to current amount of 800 Czech crowns (around 32 EUR) without any preconditions.

There were attempts to anchor legislatively long-term care as separate type of care merging both social and health care along with an adequate type of long-term care institutions. This

⁴⁴ Source:[MLSA2012]

⁴⁵ There were 231,000 informal carers in 2011 [Hrkal 2011].

⁴⁶ The project of implementation of so called social cards has been launched three years ago. The social cards were intended as a tool for unification of payment channels of all types of social allowances and even of pensions in the future. However, severe objections emerged against this concept because of data protection, stigmatization of holders and comfort of recipients of social allowances. One of private banks (Česká spořitelna) was selected to serve as an administrator of social cards. The obligatory usage of the social cards for receiving social allowances has been recently cancelled by the Parliament.

attempt failed because of not quite clearly defined intentions and the draft law on long-term care was rejected in an early stage of the legislative process.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

There are uniform rules regulated by the state for granting care allowance for dependent persons and for pricing of formal social care services⁴⁷. Residential social services are covered by the income (usually pension) of dependent persons. Health services are provided with only moderate co-payments. So, in theory there should be no major financial barriers for access to long-term care. The major problem that the Czech long-term sector faces long time is a big surplus of applications for long-term stays in residential social institutions⁴⁸ that apparently exceeds capacity of beds more than one and half times (for example a backlog of unsettled applications for homes for elderly is 160 %, for sheltered houses 125 % of their bed capacity in 2011⁴⁹). However, it should be taken in mind that the statistics includes multiple applications of one applicant to several institutions and most probably well ahead before actual need arises. So, definitely it is a problem; nevertheless its severity can be hardly assessed from statistics at disposal. There are also minor regional differences in availability of social services including social services for long-term care. The differences have mostly historical reasons and also they are results of regional differences in attitude to informal care. Planning for provision of social services is a legal obligation of regional authorities. Municipal authorities are obliged to provide necessary information for such planning process; nevertheless many of them elaborate deliberately their own municipal plans.

4.2.2 Quality and performance indicators

Regarding quality assessment in social care establishments, there is a set of mostly structural, personnel and procedural standards of quality of provision of social services that should be met by all registered providers of social care. The standards are published in a resolution of the Ministry of Labour and Social Affairs⁵⁰. Compliance with the standards is checked on a sample basis both by inspectors of the Ministry of Labour and Social Affairs and regional authorities. However, several problems are reported by the Ministry in relation of assessment of quality of provision of social services; especially financing of inspections, unification of criteria of assessment and the level of training of inspection teams. There are also structural and personnel standards that applies to providers of health care services. Obligation to comply continuously with these standards is a subject of contracts with health insurers in the public health insurance scheme. Regarding informal carers, they can be also checked by regional authorities (the regional branches of the Labour Office); nevertheless the checking procedure concentrates mostly on justification of contribution of care rather than on quality of provided assistance.

There is public support for new ways of coordination and provision of social and long-term care financed from EU funded operational program “Human resources and employment”. One of declared objectives is ensuring of availability and development of social services and their

⁴⁷ The resolution 505/2006 of the Ministry of Labour and Social Affairs. See at www.mpsv.cz/cs/7334

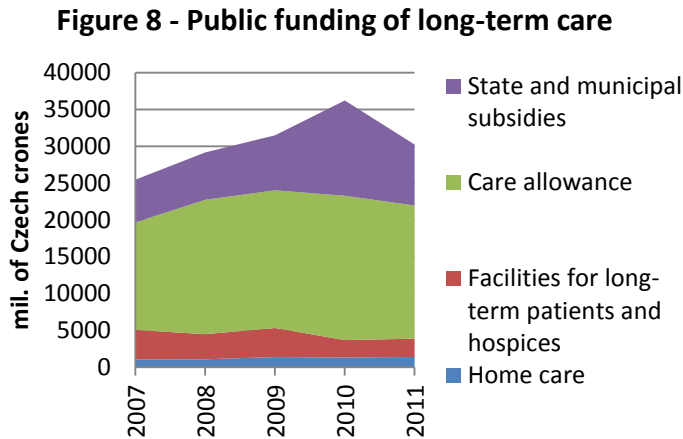
⁴⁸ Around 2.8% of inhabitants above 65 used services of residential social institutions in 2011-see [MOLSA 2011] plus another 3 % used services of hospitals for long-term patients and hospices in the same year-see [UZISa]

⁴⁹ See the website of the Czech Statistical Office at www.czso.cz/csu/redakce.nsf/i/cr_od_roku_1989#13

⁵⁰ The resolution 505/2006 of the Ministry of Labour and Social Affairs. See at www.mpsv.cz/cs/7334

coordination. However, a lot of smaller projects (with an average volume of around 100 000 EUR) are implemented more or less staying within the current technological and organizational framework.

4.2.3 Sustainability



Around 0.8 % GDP were spent for public funding of long-term-care in 2011⁵¹. The trend of the public funding of long-term care is characterized by a slightly increasing share for the care allowances and the state and municipal subsidies for social care providers – see the figure 8⁵². The increasing trend was corrected by the austerity policy of the Government in 2011. According to prognoses under different

scenarios⁵³ the share of public funding of long-term care should be 1.3-1.6% in 2060 provided current policies will be retained. The share of public funding of long-term care deserves the same comment as in the case of health care. Personnel costs represent some 60 % of costs of provision of long-term care⁵⁴ in the Czech Republic and the lower ratio of the average salary to the GDP per capita in the country predetermines lower share expenditures for long-term care in the relation to the GDP. Further, public expenditures considered are gross public expenditures. Due to the high share of personnel costs in provision of long-term care, remarkable share of gross public expenditures goes back into public accounts in the form of social contributions and taxes. For example, the volume of the state and municipal subsidies for social care establishments in the Czech Republic is comparable with social contributions and taxes paid for and by their employees⁵⁵. It alleviates the problem of sustainability as recipients of care contribute to funding from their pockets (mostly from pensions and also from care allowance). Public budgets just borrow to social care establishments financial means in advance and get it back in social contributions and taxes. Real funding is done mostly on charge of pockets of recipients of care. Recipients of long-term care spent out-of-pocket around 30% of the total volume of the public funding of long-term care in 2011⁵⁶. Expenditures for long-term care are dependent not only on the share of the older population but also on the duration of living in good health in older age. The table 2⁵⁷ shows a relatively favourite trend of increasing of the time of living in a good health in comparison to life expectancy of persons above 65 in the Czech Republic. However, the time serie for the HLF indicator is still rather short for a comprehensive assessment.

⁵¹ See [MLSA2010]
⁵² Source:[MLSA 2012]
⁵³ See [Lipszyc 2012]
⁵⁴ See [MLSA2011]
⁵⁵ See [Prusa 2013]
⁵⁶ See [MLSA 2011]
⁵⁷ See [UZISa]

	1995	2000	2005	2010	2011
Life expectancy at 65 (men)	12.1	13.72	14.38	15.26	15.47
Life expectancy at 65 (women)	15.3	17.08	17.55	18.71	18.82
Healthy Life Years at 65 (men)			6.6	8.5	8.4
Healthy Life Years at 65 (women)			7.0	8.8	8.7

Table 2

4.2.4 Summary

The Czech system of long-term care provides to persons in need of long-term care universally at least financial assistance that is scaled according to the level of needs. Universality of such approach can be regarded as strength of the Czech health care system. As a positive feature can be also regarded ensuring of de facto free access to health care within the public health insurance system. The fact that the Czech Republic spends relatively small share of GDP for public funding of long-term care is mostly caused by generally small level of Czech salaries in comparison to a GDP per capita. Thus, the system of long-term care can be run by a comparable engaging of workforce with a smaller share of GDP in comparison to old EU states.

On the other hand, there are weaknesses as well. The first problem is a discrepancy of conditions between provision of long-term care in health facilities and social institutions. There is a special arrangement for long-term patients staying in health facilities just because there is no way of moving them to their homes or to a social institution because of their dependency on someone's other support and a lack of adequate home care services. They get a status of "social" patients with comparable cost sharing of patients as in residential social institutions and comparable state subsidies for provision of social services. However, health facilities generally prefer keeping such persons as standard health patients with a full coverage from the public health insurance scheme. The reason is that total revenue for health patients is still higher than for social patients on one hand and that it is administratively simpler to get money from the public health insurance than from the patient himself/herself and from the state budget.

4.3 Reform debates

Reform debates about long-term care focuses on crucial problems of the current setup. The first problem is a discrepancy of conditions in provision of long-term care in health facilities and in social institutions. Measures enabling so called "mirroring" of health facilities and social facilities are discussed and some attempts to legislatively anchor "long-term" patient were undertaken, up to now without tangible results.

The other issue is effectiveness of care allowance that is paid directly to persons dependent on support of other persons. These contributions were considered as a tool supporting development of provision of formal social services according to recipients' preferences. However, these expectations were not met as nearly three quarters of contributions are retained by recipients and not used for purchasing of social services. Proposals for differentiating of care allowance according to whether formal social services are used or not and according to type of purchased services are discussed in experts' community.

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Annex – Key publications

[Pensions]

CIPRA, Tomáš, Penze. Kvantitativní přístup. Praha, Ekopress 2012. 409 s. - ISBN 978-80-86929-87-3.

„Pension. Quantitative approach”

This publication discusses the political, legal, sociological, economic, financial, demographic and mathematic dimension of old age pensions. The book also presents pension system projections, individual investment strategies and public finance theory.

JANSKÝ, Petr, Účastníci penzijního připojištění., Praha, Národohospodářský ústav AV ČR, v.v. i. 2013. 11 s., lit., obr., tab. Studie Institutu pro demokracii a ekonomickou analýzu - Studie 3/2013

http://idea.cerge-ei.cz/files/IDEA_Studie_3_2013.pdf

“Participants of supplementary pension savings scheme”

A crucial question related to the pension reform is who will be willing to enter into the new funded part of first pillar. The study provides with microeconomic analysis of Participants of supplementary pension savings scheme behaviour. The study researches basic characteristics by decision making of participation in pension savings plans and the factors which influence the high of contribution.

LOUŽEK, Marek, Důchodová reforma v ČR po roce 2010. FÓRUM sociální politiky, Prague, 7, 2013, č. 2, s. 10-17, tab., lit., příl.

http://praha.vupsv.cz/Fulltext/FSP_2013-02.pdf

„Pension reform in Czech Republic after 2010“

The goal of the article is to analyse pension reform in Czech Republic after 2010. The process of pension reform accelerated within last years. The article analyses the political risks of pension reform and proposes further parametrical changes in pension system with the aim keep the pension system long-term balanced and sustainable. The article devotes detailed to replacement rates and the increase in retirement age.

MLSA, Actuarial Report on Pension Insurance 2012, Prague 2012,

http://www.mpsv.cz/files/clanky/14299/PMZ_2012_en_final.pdf

The first two parts of the Actuarial Report describe the current state of the pension system from legislative and statistical viewpoints. The legislative part briefly describes the changes made since 2008. The statistical part quantifies the present state of the pension system. Next comes a part setting the Czech Republic's pension system into the international context. The body of the report consists of analytical chapters, which contain a description and analysis of demographic and economic factors influencing the pension system. Their impacts are summarized in the final part, which presents a projection of the pension system development in the next almost seventy years.

SCHNEIDER, Ondřej, Jaký důchod nás čeká? Alternativy vývoje státního průběžného důchodového systému . Praha, Národohospodářský ústav AV ČR, v.v. i. 2012. 10 s., lit., obr., tab. IDEA CERGE EI - Krátká studie 7/2012

http://idea.cerge-ei.cz/documents/kratka_studie_2012_07.pdf

„What pension one can expect? Alternatives of the PAYG pension system development“

This study shows two possible alternatives of the first pillar of Czech pension system development. The main findings are that without pension reform approved the pension system will either suffer from a huge deficit or the replacement rate will significantly decrease.

VOSTATEK, Jaroslav, *Důchodová reforma: břímě mladých?*, Prague, CESTA - Centrum pro sociálně-tržní ekonomiku a otevřenou demokracii 2012. 39 s. - ISBN 978-80-905134-8-8.

Studie Research Paper; 1/2012

<http://www.centrum-cesta.cz/files/projekty/socialne-ekonomicka-skupina/RP1-2012-Vostatek.pdf>

„Pension reform – burden for the young generation?“

Pension reforms may significantly change the “intergenerational contract”, contained in the public pension system; today's youth might pay for the current Czech pension reform, according to the approaches of some pro-government theoreticians. Opt-out to the “second” pillar pension shall be beneficial for up to half the insured - those with higher incomes, while authors of studies with these conclusions do not take into account the negative fiscal and macroeconomic effects of governmental pension reform. The results of these analyses suggest that the devil is not only in detail, but also in the very concept of privatization of public pensions. Therefore, the key experts of the World Bank recommended no privatization of public pensions, but their split into two completely distinct pillars: the core pillar has to be the NDC social old-age insurance, and in addition there should be an exclusively solidarity pension pillar and also a fully voluntary private pillar. Pension savings in the form of “second” pillar are associated with significantly higher costs and thus are not able to compete with any FDC social insurance scheme. Pension reform recommended by the experts of the World Bank cannot be a burden for the young generation.

[Health care]

NĚMEC, Jiří, *Konkurence zdravotních pojišťoven-spása zdravotnictví*, an article in *Zdravotnické noviny*, December 2011, Prague

“Competition of insurance companies-a salvation for health care system?“

Experience with competition among health insurance agencies in the Czech public health insurance system in the past twenty years is reviewed. Pros and cons of plurality of health insurers are summarized and lessons for formulating politic decision on the issue are derived.

NĚMEC, Jiří, *Je české zdravotnictví podfinancované?*, an article in *Zdravotnické noviny*, February 2012, Prague

“Is the Czech health care system underfinanced ?“

A comparison of funding of the Czech and German health care systems is provided and an explanation of differences in the share of health care expenditures on GDP in both countries is elaborated. Basic cost indicators are identified and compared between both countries. Hypothesis that remarkable difference of the share on health care expenditures on GDP is caused mainly by major difference of the share of an average salary on the GDP per capita is formulated.

PAVLOKOVÁ, K., Time to Death and Health Expenditure of the Czech Health Care System, Charles University Prague, Faculty of Social Sciences, Institute of Economic Studies in its series Working Papers IES, no. 2009/05.

An analysis of relationships between individual expenditures for health care, the age and the proximity to death of an individual based on the detailed internal data of the General Health Insurance Agency. A prognosis of health care expenditures based on revealed relationships.

VACHEK, Stanislav, Spotřeba zdravotní péče příjemci příspěvku na péči, research report, 2011, Prague, retrieved on August 29, 2013 from: podporaprocesu.cz/wp-content/uploads/2013/01/spotreba_zdravotni_pece_B.pdf

“Consumption of health care by recipients of care allowance”

An analysis of expenditures for health care for recipients of health care allowance in dependence on the place of dwelling of a recipients of care allowance. Estimation of volume of informal care in household is provided.

[Long-term care]

PRŮŠA, Ladislav, Ekonomická efektivit zajišťování péče o příjemce příspěvků na péči, research report, 2013, Prague, retrieved on August 29, 2013 from: www.vupsv.cz

“Economic efficiency of providing care for the recipients of the care allowance”

The aim of this research report is an evaluation of long-term care provided to recipients of care allowance. A basic theoretical background for assessment of efficiency is formulated and available data on long-term care for recipients is evaluated. Attention is also paid to the possibility of using data on the structure of recipients of care allowance for the needs of social care service planning at both national and regional levels.

HALÁSKOVÁ, Renáta, Význam standardizace sociálních služeb v době jejich liberalizace, research report, 2013, Prague, retrieved on August 29, 2013 from: www.vupsv.cz

“Importance of standardization of social services in the period of their liberalization”

The research report aims to define social services in the Czech Republic as an important segment of public services at a time when a number of these services are in the process of liberalization and privatization. Attention is paid to the standardization of services in general and standardization of social services from the qualitative and quantitative view. One of the outputs is a proposal of a new financial standard of services of social care. The level of availability of social services facilities on the territory of the Czech Republic according to regions is analysed and then confronted with the recommended standards for selected social care services.

HRKAL, Jakub et al., Analýza kapacit a sítě poskytovatelů dlouhodobé péče, research report, 2011, Prague, retrieved on August 29, 2013 at: podporaprocesu.cz/wp-content/uploads/2013/01/Analyza_kapacit.pdf

“Analysis of capacities and network of long-term care providers”

A comprehensive analysis of the network of providers both from health care and social care sectors that provide long-term care with data on their capacities and performance retrieved

from different data. The research report is intended to serve as a foundation for subsequent analytical work.

DAŇKOVÁ, Šárka et al., Analýza příjemců příspěvku na péči a potenciálních klientů dlouhodobé péče, research report, 2011, Prague, retrieved on August 29, 2013 at: podporaprocesu.cz/wp-content/uploads/2013/01/Analyza_prijemcu.pdf

“Analysis of recipients of care allowance and of potential clients of long-term care”

An analysis of needs of long-term care, identification of persons in a need of long-term care and quantification of their needs. The research report is intended to serve as a foundation for subsequent analytical work.

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