European Commission



State of Health in the EU

Czechia

Country Health Profile 2023

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European Observatory on Health Systems and Policies
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The *Country Health Profile* Series

The *State of Health in the EU*'s *Country Health Profiles* provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policy makers and influencers with a means for mutual learning and voluntary exchange. For the first time since the series began, the 2023 edition of the Country Health Profiles introduces a special section dedicated to mental health.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in co-operation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Systems Performance Assessment (HSPA).

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Data and information sources

The data and information in the *Country Health Profiles* are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was finalised in September 2023, based on data that were accessible as of the first half of September 2023.

Demographic and socioeconomic context in Czechia, 2022

Demographic factors	Czechia	EU
Population size	10 516 707	446 735 291
Share of population over age 65 (%)	20.6	21.1
Fertility rate[1] (2021)	1.8	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	31 953	35 219
Relative poverty rate[3] (%)	10.2	16.5
Unemployment rate (%)	2.2	6.2

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income. Source: Eurostat Database.

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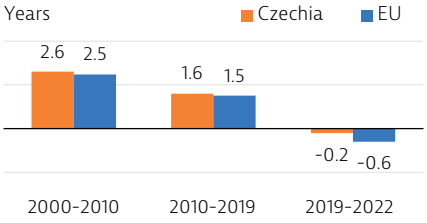
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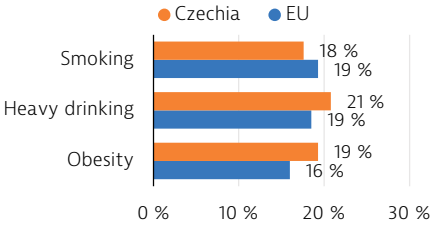
1 Highlights



Changes in life expectancy at birth

Health Status

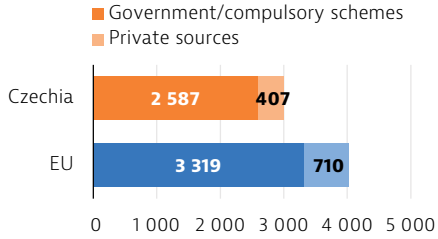
Life expectancy in Czechia grew at about the same rate as the EU average in the two decades before the pandemic; it fell between 2019 and 2021, before rebounding slightly to 79.1 years in 2022 – 1.6 years below the EU average of 80.7 years. Circulatory diseases, cancer and COVID-19 were the main causes of death in 2021, accounting for over 70 % of all deaths.



% of adult population, 2019

Risk Factors

Nearly half of all deaths in Czechia in 2019 could be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low levels of physical activity. Alcohol consumption and obesity rates were higher than the EU averages. The prevalence of behavioural risk factors in Czechia, as in other EU countries, tends to be higher among the least educated and lowest income groups.



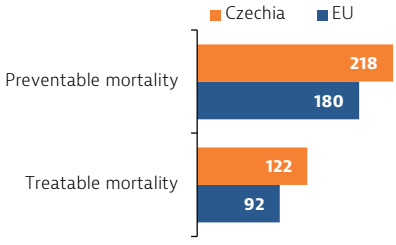
EUR PPP per capita, 2021

Health System

In 2021, Czechia spent EUR 2 994 per capita on health (adjusted for differences in purchasing power) – about a quarter less than the EU average of EUR 4 029. Health spending accounted for 9.5 % of GDP, a higher share than in pre-pandemic years but still below the EU average of 11.0 %. Most health spending in Czechia (86 %) came from public funds – the highest share in the EU and over 5 percentage points above the EU average.

Effectiveness

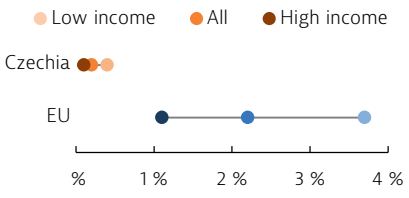
Mortality rates from preventable and treatable causes in Czechia are 25 % higher than the EU averages. Substantial room for improvement remains for public health interventions to reduce premature deaths from preventable causes and to provide more timely and effective healthcare to reduce mortality from treatable causes.



Age-standardised mortality rate per 100 000 population, 2020

Accessibility

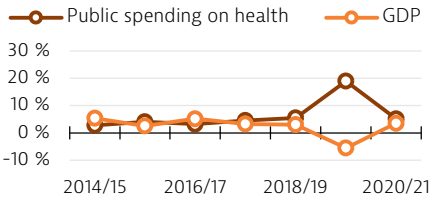
Unmet medical care needs in Czechia are very low, with small differences by income groups. The numbers of doctors and nurses per 1 000 population are slightly above the EU averages, but health workers are not evenly distributed across the country. At 7.8 per capita, doctor consultations are a third higher than the EU average.



% reporting unmet medical care needs, 2022

Resilience

Public spending on health increased by nearly 20 % in 2020 in response to the pandemic, while GDP fell by 5 %. In 2021, both growth rates returned to pre-pandemic levels. Czechia's National Recovery Plan allocates EUR 1.1 billion to health sector investments. The two main priorities are improving cancer care and expansion and modernisation of medical training facilities.



Annual change in real terms

Mental Health

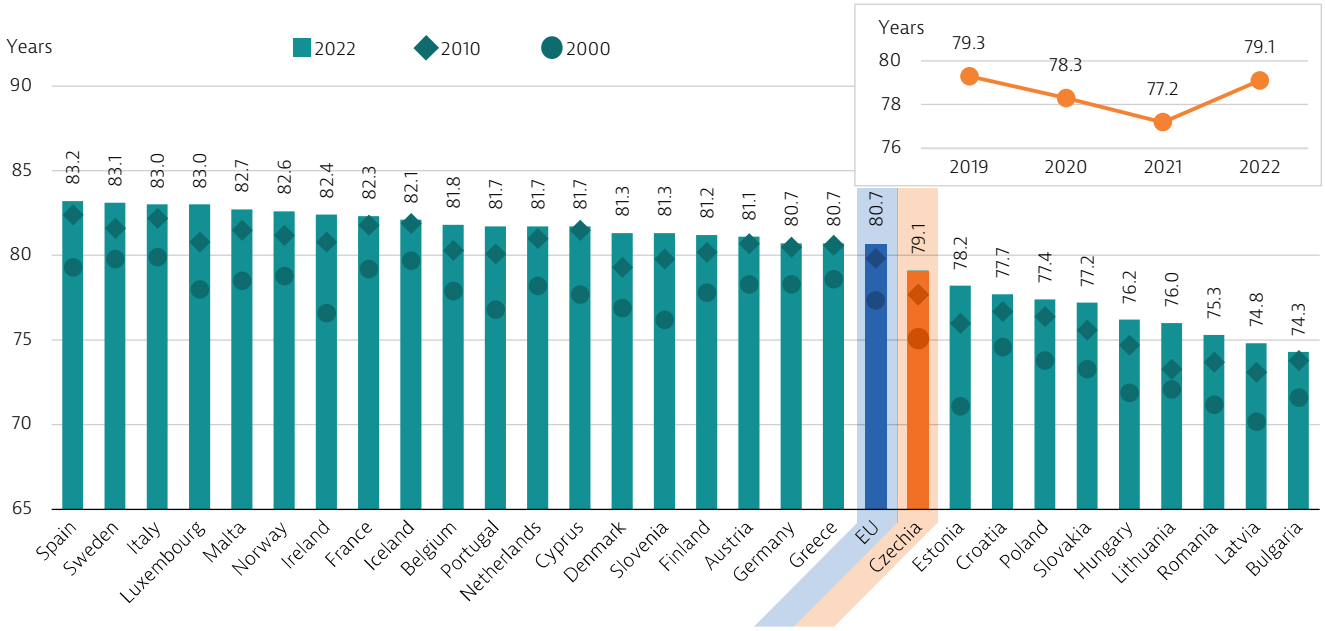
About one in seven people in Czechia were estimated to have some mental health disorders in 2019. Depression, anxiety and alcohol and drug-use disorders were the most prevalent mental health issues. The Strategic Framework for Healthcare Development to 2030 sets out major actions on mental health promotion and care provision, in line with ongoing mental healthcare reform, which emphasises strengthening community care, prevention and mental health promotion.

2 Health in Czechia

Life expectancy in Czechia dropped sharply during the first two years of the pandemic, but rebounded in 2022

In 2022, life expectancy at birth in Czechia was 79.1 years – 1.6 years below the EU average of 80.7 years (Figure 1). Life expectancy in Czechia increased by more than 4 years in the two decades before the pandemic, but it fell by more than 2 years between 2019 and 2021 before rebounding close to its pre-pandemic level in 2022.

Figure 1. Life expectancy in Czechia was about one year and a half lower than the EU average in 2022



Notes: The EU average is weighted. The 2022 data are provisional estimates from Eurostat that may be different from national data and may be subject to revision. Data for Ireland refers to 2021.
Source: Eurostat Database.

As in other European countries, men tend to live shorter lives than women in Czechia. In 2022, Czech women could expect to live on average 5.8 years longer than men (82.0 years compared to 76.2 years) – a slightly greater gender gap than the EU average gap of 5.4 years. This largely reflects gender-based differences in the prevalence of behavioural risk factors such as smoking and heavy alcohol drinking (see Section 3).

Circulatory diseases, cancer and COVID-19 were the main causes of mortality in 2021

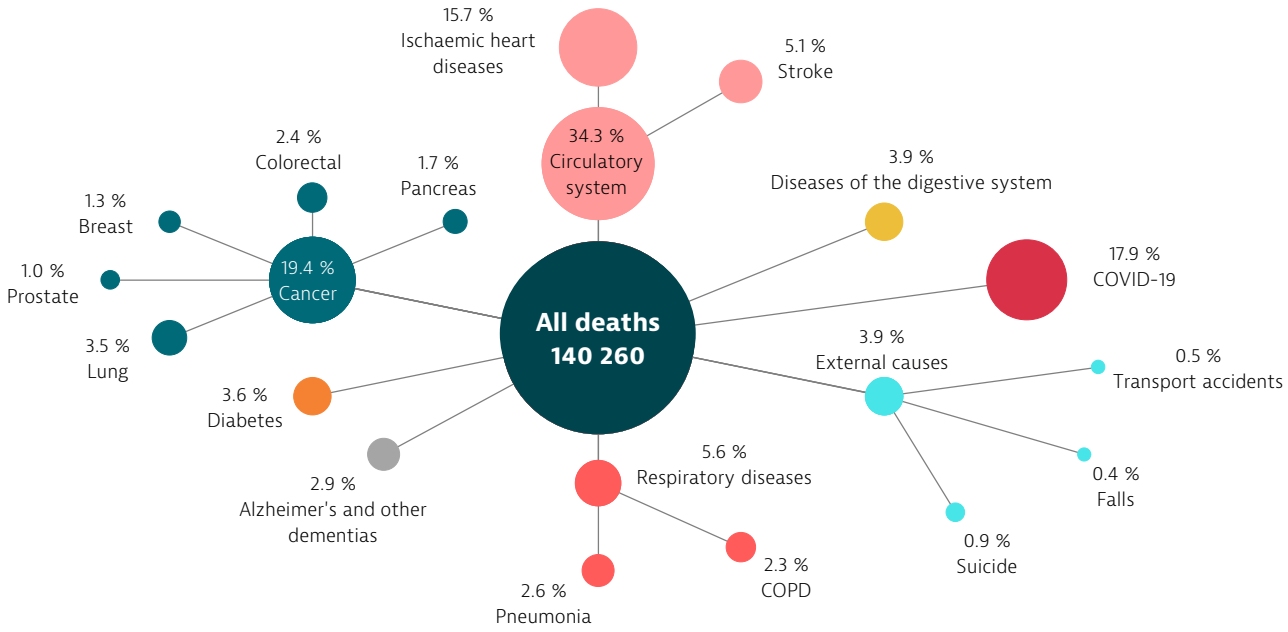
The increase in life expectancy in the two decades before the pandemic in Czechia was mainly driven by reductions in mortality from circulatory diseases. Nonetheless, these remained the leading cause of death in 2021, accounting for 34 % of all deaths, and ischaemic heart diseases were by far the most significant cause of death within this group. Cancer was the second leading cause of death in 2021 (19 %), with lung cancer remaining the leading cause of cancer death, followed by colorectal cancer (Figure 2). In 2021, COVID-19 accounted for 17.9 % of all deaths in Czechia (about 25 000 deaths) – one of the largest proportions among all EU countries.

Czechia experienced higher excess mortality than the EU averages in 2020 and 2021

The indicator of excess mortality, defined as the share of all-cause deaths above the average over the five years before the pandemic, can provide a more complete picture of the mortality impact of COVID-19. The more than 55 000 excess deaths that occurred in Czechia between 2020 and 2022 accounted for a mortality level 17 % above its pre-pandemic baseline – a much higher rate than that observed in most other EU countries (Figure 3). Excess mortality in Czechia peaked at 25 % in 2021 before falling to about 8 % above pre-pandemic levels in 2022.

Czechia's excess mortality was greater than reported COVID-19 mortality during 2020-22, when confirmed COVID-19 fatalities accounted

Figure 2. Circulatory diseases, cancer and COVID-19 accounted for over 70 % of all deaths in Czechia in 2021



Note: COPD refers to chronic obstructive pulmonary disease.
Source: Eurostat Database (data refer to 2021).

for 77 % of excess deaths. This higher level of excess mortality than COVID-19 deaths suggests some underreporting of COVID-19 deaths or a higher number of deaths from other causes where COVID-19 may have been a comorbidity factor.

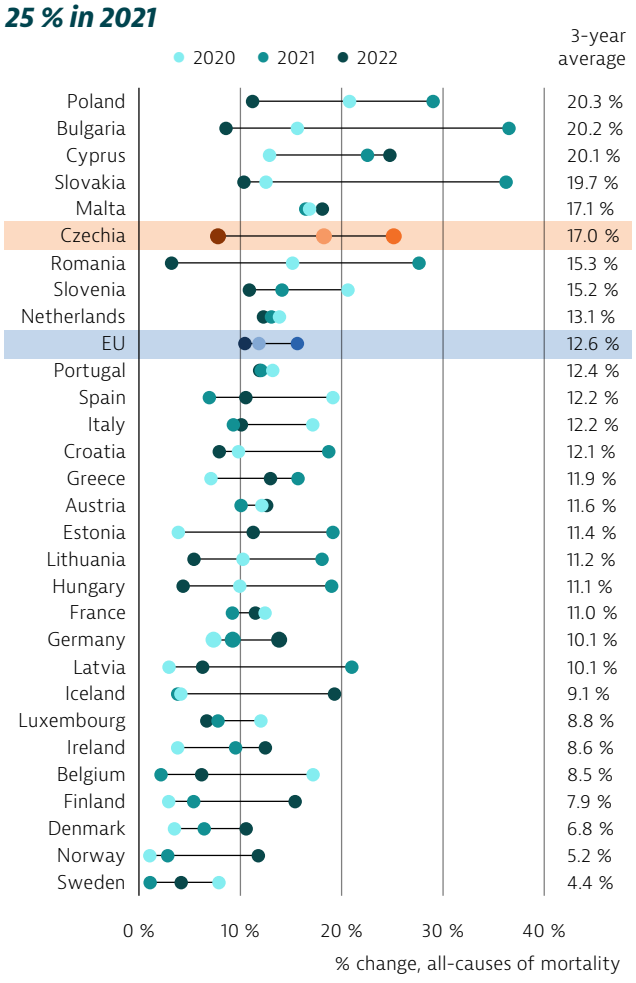
Most Czech adults report being in good health, but socioeconomic disparities are marked

In 2022, over two thirds (68 %) of Czech people reported being in good or very good health, matching the EU average. However, disparities across income groups are larger than in most other EU countries. While 86 % of Czech adults in the highest income quintile reported being in good health in 2022, the proportion was only 46 % among those in the lowest quintile – the fifth highest disparity across the EU.

Czech women at age 65 can expect to live longer than men, but in less good health

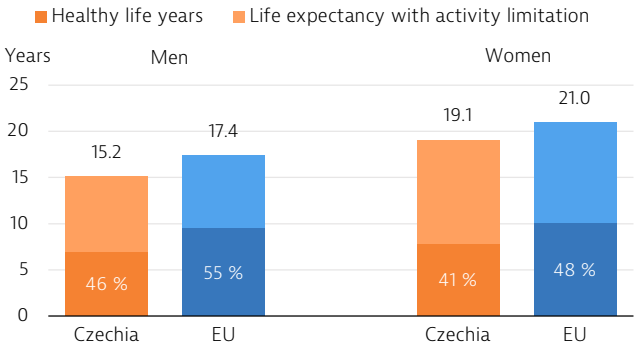
As in other EU countries, Czechia has experienced a demographic shift towards an older population over the past two decades: the proportion of people aged 65 and over rose from 14 % of the population in 2000 to 21 % in 2022, and is projected to increase to 28 % by 2050. In 2020, Czech women at age 65 could expect to live a further 19.1 years, while men could expect to live a further 15.2 years. However, the gender gap in expected healthy life years (defined as disability-free life expectancy) was much smaller (less than 1 year), because Czech women tend to live a smaller proportion of their life after age 65 without activity limitations (Figure 4).

Figure 3. Excess mortality in Czechia peaked at 25 % in 2021



Note: Excess mortality is defined as the number of deaths from all causes above the average annual number of deaths over the previous five years before the COVID-19 pandemic (2015-19).
Source: OECD Health Statistics 2023, based on Eurostat mortality data.

Figure 4. The gender gap in healthy life years at age 65 is much smaller than the gap in life expectancy



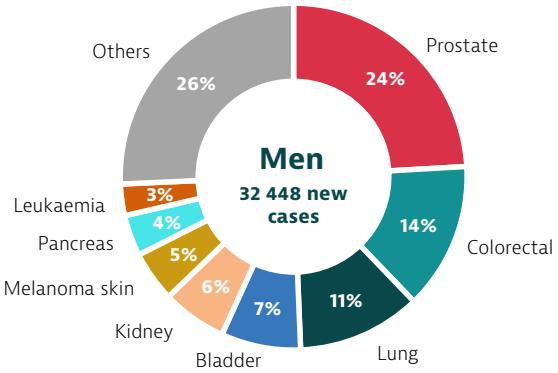
Source: Eurostat Database (data refer to 2020).

According to the SHARE survey, among those aged 65 and over, over 40 % reported being afflicted by multiple chronic conditions in 2020, which is above the EU average – particularly among men. The share of Czech men aged 65 and over who reported limitations in daily activities is also higher than the EU average, but for Czech women it is lower than the EU average. This is consistent with higher prevalence of health risks among men than women in the Czech population (see Section 3).

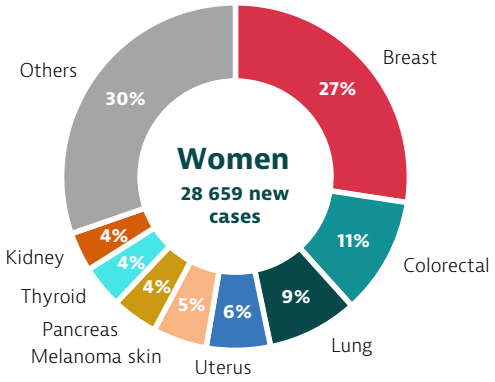
The burden of cancer in Czechia is considerable

According to the latest estimates from the Joint Research Centre, over 61 000 new cases of cancer were expected to be diagnosed in Czechia in 2022. The age-standardised incidence rate for all cancer types was expected to be close to the EU average for both men and women. The main cancer sites for men were prostate (24 %), followed by colorectal (14 %) and lung (11 %). Among women, the main cancer sites were breast (27 %), followed by colorectal (11 %) and lung (9 %) (Figure 5). Czechia has improved cancer care over the past decade (OECD, 2023a), and has achieved relatively high screening participation rates compared to other EU countries (see Section 5.1).

Figure 5. Over 61 000 cancer cases were expected to be diagnosed in Czechia in 2022



Age-standardised rate (all cancer): 685 per 100 000 population
EU average: 684 per 100 000 population



Age-standardised rate (all cancer): 484 per 100 000 population
EU average: 488 per 100 000 population

Notes: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

3 Risk factors

Behavioural and environmental risk factors contribute significantly to mortality

Nearly half of all deaths in Czechia in 2019 can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low levels of physical activity (Figure 6). Dietary risks were the most prevalent, contributing to 23 % of all deaths (well above the EU average of 17 %), closely followed by tobacco consumption contributing to 20 % of deaths (also above the EU average of 17 %).

Environmental factors such as air pollution contribute to a considerable number of deaths, with about 6 % of all deaths attributable to exposure to fine particulate matter ($PM_{2.5}$) and ozone alone. Deaths from air pollution are mainly linked to circulatory diseases, respiratory diseases and some cancer.

Figure 6. Dietary risks and tobacco contribute to significant share of deaths in Czechia



Notes: The overall number of deaths attributable to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to fine particulate matter ($PM_{2.5}$) and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Overweight and obesity are a major public health challenge

The adult obesity rate in Czechia has increased over the past 15 years and was 19.3 % in 2019, which was higher than in many other EU countries (Figure 7). Overweight and obesity levels are also rising among adolescents: 20 % of 15-year-olds were overweight or obese in 2022 (up from 17.5 % in 2014) – just below the 21 % EU average. Overweight issues were much more prevalent among boys (26 %) than girls (14 %).

Poor nutrition and physical inactivity are key determinants of overweight and obesity. Only 7.5 % of Czech adults (10.2 % of women and 5 % of men) reported consuming at least the WHO-recommended five portions of fruit and vegetables per day in 2019. Among adolescents, 32 % reported eating vegetables daily in 2022, which is close to the EU average (34 %), and 35 % reported eating fruit daily – a higher share than the EU average (30 %).

Only 25 % of adults (20 % of women and 31 % of men) reported engaging in moderate physical activity for at least 2.5 hours a week in 2019 – a proportion much lower than the EU average (33 %). Physical activity levels decreased substantially between 2014 and 2019 – more among women than men.

The COVID-19 pandemic has given the issue greater media attention. Health promotion and improvement of health literacy is a key objective of the Strategic Framework for Healthcare Development to 2030 (Health 2030 strategy) (see Section 5.1).

Comprehensive tobacco control legislation helped to decrease smoking rates

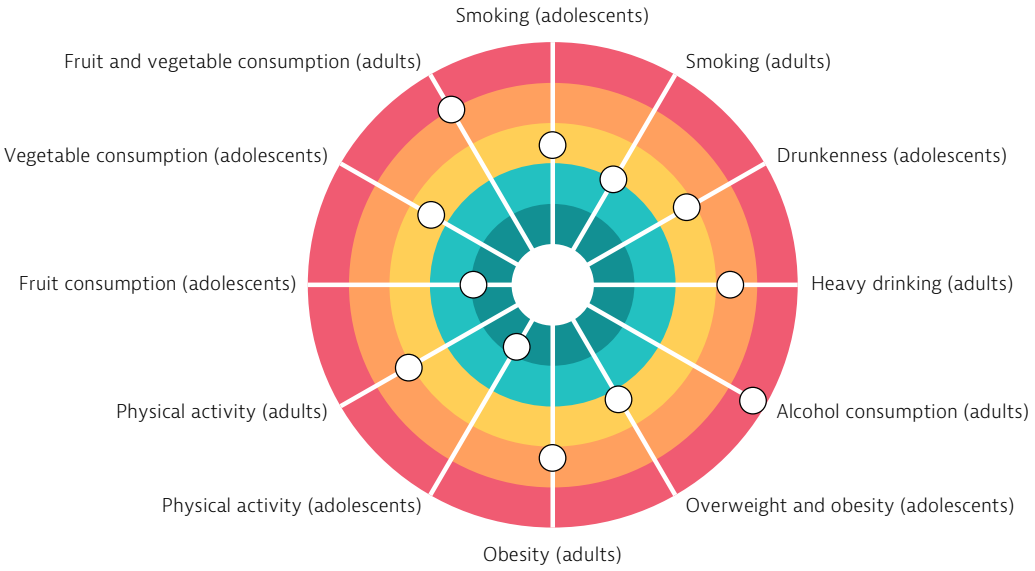
Although 16.6 % of adults smoked daily in 2020, daily tobacco consumption had decreased significantly over the past decade in Czechia (from 23 % in 2010), and was below the EU average (19.3 %) in 2019. This development has been supported by public health interventions, including the introduction of comprehensive tobacco control legislation in 2017, which banned smoking in public places. Smoking continues to be more prevalent among men (21 % smoking daily in 2020) than women (12.2 %). A survey by the National Institute of Public Health also showed that 20 % of people continued to be subject to second-hand smoke at their workplace in 2020.

Despite significant decline in recent years, tobacco consumption among adolescents remains a concern. In 2022, 14 % of 15-year-olds reported smoking during the past month, a lower share than the EU average (17 %).

Alcohol consumption in Czechia is among the highest in the EU

At 11.6 litres of pure alcohol per capita in 2020, alcohol consumption among Czech adults was well above the EU average (9.8 litres) and the second highest among EU countries, remaining at this high level since 2000. A contributing factor was increased affordability of alcohol in the past decade. Despite rising average wages, per-litre excise duty on alcohol remained unchanged in 2010-19, but it was increased in January 2020.

Figure 7. Czechia ranks poorly on alcohol consumption, obesity and dietary habits compared to most other EU countries



Notes: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white "target area" as there is room for progress in all countries in all areas.
Sources: OECD calculations based on HBSC survey 2022 for adolescents indicators; and EHIS 2019 for adults indicators (except for smoking which comes from a national survey).

One in five Czech adults (21 %) reported regular heavy drinking in 2019 – a proportion higher than the EU average (19 %)[1]. As in other EU countries, heavy drinking in Czechia is much more frequent among men (30 %) than women (12 %).

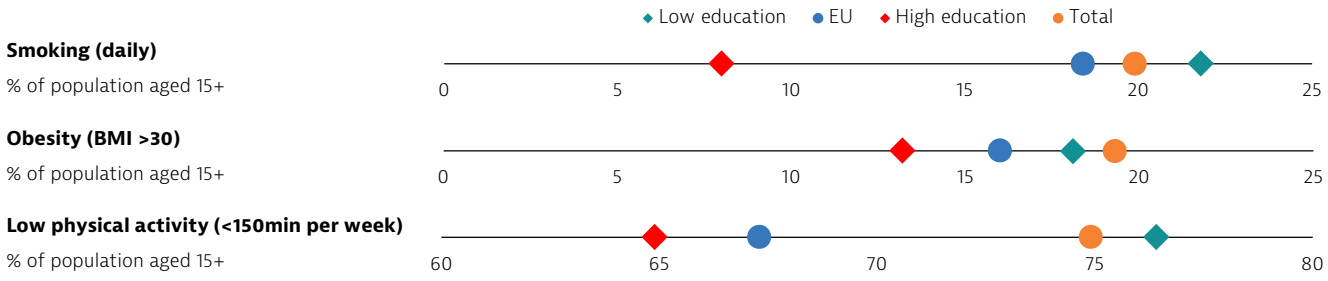
Excessive alcohol consumption among adolescents was slightly above the EU average in 2022: 22 % of 15-year-old girls and 24 % of boys reported that they had been drunk more than once, but these rates had fallen since 2014. Stricter regulations on underage drinking and purchases were introduced in 2017.

Socioeconomic inequalities are pronounced for healthy lifestyle habits

Some behavioural risk factors in Czechia are more common among people with lower education or income levels. Educational attainment is especially relevant for smoking habits, but also for physical activity rates (Figure 8).

In 2019, the smoking rate among people with lower education levels (22 %) was more than double the rate among those with higher education levels (8 %), which is a wider education gap than the EU average (19 % among those with lower and 13 % among those with higher education levels). People with lower education or income levels were also more likely to be obese, driven at least in part by lower levels of physical activity.

Figure 8. People with lower education are more likely to smoke and not to engage in physical activity



Note: Low education is defined as people who have not completed secondary education (ISCED 0-2), whereas high education is defined as people who have completed tertiary education (ISCED 5-8).
Source: Eurostat Database (based on EHIS 2019).

1 *Heavy drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults.*

4 The health system

The Ministry of Health has a strong regulatory role in the social health insurance system

Czechia's social health insurance (SHI) system is regulated by the government. Seven semi-public health insurance funds act as purchasers of care, and the largest fund covers 56 % of the population. The compulsory SHI system provides a broad benefits package and virtually universal population coverage. All permanent residents and third-country national employees of Czech companies are entitled to SHI coverage. Apart from the economically inactive population, whose health insurance contributions are paid directly by the state, all other residents are obliged to make monthly advance payments. Competition between funds is limited, but they can offer supplementary benefits to their members, such as non-SHI-covered immunisations.

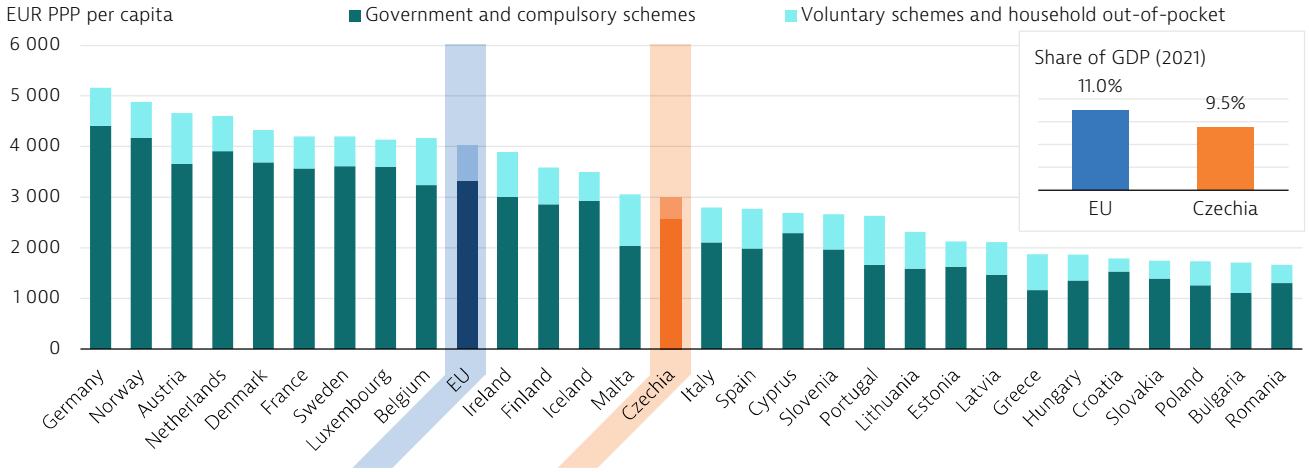
The Ministry of Health is the key regulatory body in charge of setting healthcare policy and supervising the system. Outpatient care providers are mainly privately owned, while many inpatient providers are owned by the state (including most teaching hospitals and specialised centres), the regions and municipalities. Primary care doctors do not have a gatekeeping role in Czechia.

Czechia spends less on health than the EU average, but the share of public funding is the highest in the EU

In 2021, Czechia's per capita health expenditure amounted to EUR 2 993 (adjusted for differences in purchasing power), which was a quarter (26 %) lower than the EU average of EUR 4 028 (Figure 9). Health spending as a share of GDP was 9.5 % in 2021 – below the EU average of 11.0 %, but significantly higher than the Czech share in 2019 (7.6 % of GDP). Most of this increase was due to the increase in public spending, mainly in the state contribution to the SHI system on behalf of the economically inactive population (see Section 5.3).

In 2021, public funding accounted for 86.4 % of total health spending in Czechia, the highest level in the EU (the EU average was 81.1 %). Out-of-pocket (OOP) payments consist mainly of copayments for outpatient pharmaceuticals, and represented 12.7 % of health spending in 2021 (see Section 5.2). Because of the broad statutory benefits package covered by the SHI, voluntary health insurance plays a negligible role in the Czech health system (less than 1 %).

Figure 9. Czechia spent less on health per capita and as a share of GDP than the EU average in 2021



Note: The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021, except Malta (2020)).

Most health spending goes to inpatient and outpatient care, followed by pharmaceuticals

In 2021, Czechia distributed health expenditure evenly between inpatient and outpatient care, with each accounting for 30 % of the total (Figure 10).

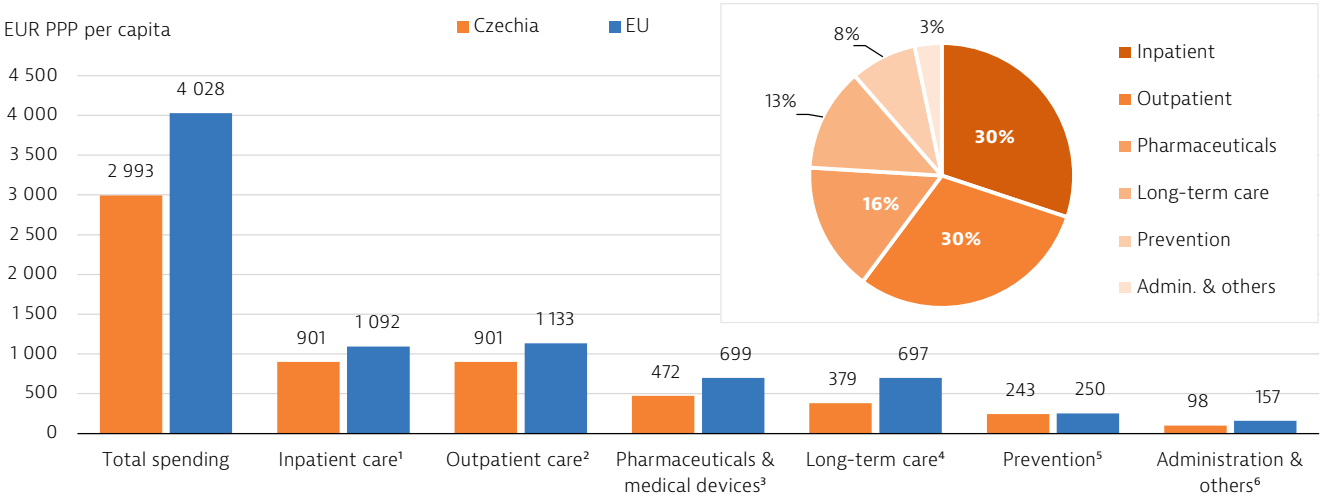
Pharmaceutical expenses represented 16 % of health spending[2], while long-term care (LTC) accounted for 13 %. Smaller proportions were allocated to prevention (8 %) and administration and other spending (3 %).

2 *Pharmaceuticals consumed during inpatient stays, which represent approximately one third of total pharmaceutical spending in Czechia, are not included in these data.*

In absolute per capita terms, Czechia's expenditure on all the main categories of spending remained below the EU averages – particularly on LTC, which was nearly half the EU average. Nevertheless, the increase in LTC spending over the past decade has been significant, encompassing direct subsidies to LTC facilities and home services and SHI payments. Furthermore, personal care allowances have been granted since 2007 to people with limitations in daily activities to finance their assistance services, including for informal caregiving. In 2018, a temporary caregiving leave allowance was introduced to compensate informal caregivers for wage losses when engaged in caregiving responsibilities.

Czechia's spending on prevention in absolute per capita terms was only slightly below the EU average in 2021. Between 2020 and 2021, it increased almost 2.5 times, reflecting COVID-19-related spending on preventive measures such as vaccinations and testing.

Figure 10. Czechia spends less than the EU average on all categories of health spending



Notes: 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care and ancillary services (e.g. patient transportation); 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes; 6. Includes health system governance and administration and other spending. The EU average is weighted.
Source: OECD Health Statistics 2023 (data refer to 2021).

Czechia has a high proportion of hospital beds and relatively low occupancy rates

Over the last decade, the number of hospital beds in Czechia decreased slightly, reaching 6.5 per 1 000 population in 2020, but increased to 6.7 per 1 000 in 2021 as a result of COVID-19-related efforts to boost capacity. This comparatively high number of beds (compared to the EU average of 4.8 per 1 000 population), combined with low occupancy rates (67 % in Czechia compared to 73 % across the EU before the pandemic in 2019), indicates potential for efficiency improvements in hospital care.

Over the past 15 years, Czechia has made use of various European funds to promote more equal access to quality care throughout the country through targeted investments. In selected medical fields, designated highly specialised care centres were accredited throughout the country, supported by capital investment. However, differences in regional availability of specialised services remain, some of which are addressed in current health policy strategies. For example, implementation of the National Cardiovascular Plan (in preparation in mid-2023) will facilitate targeted investment subsidies to address inadequate or outdated equipment in cardiovascular centres.

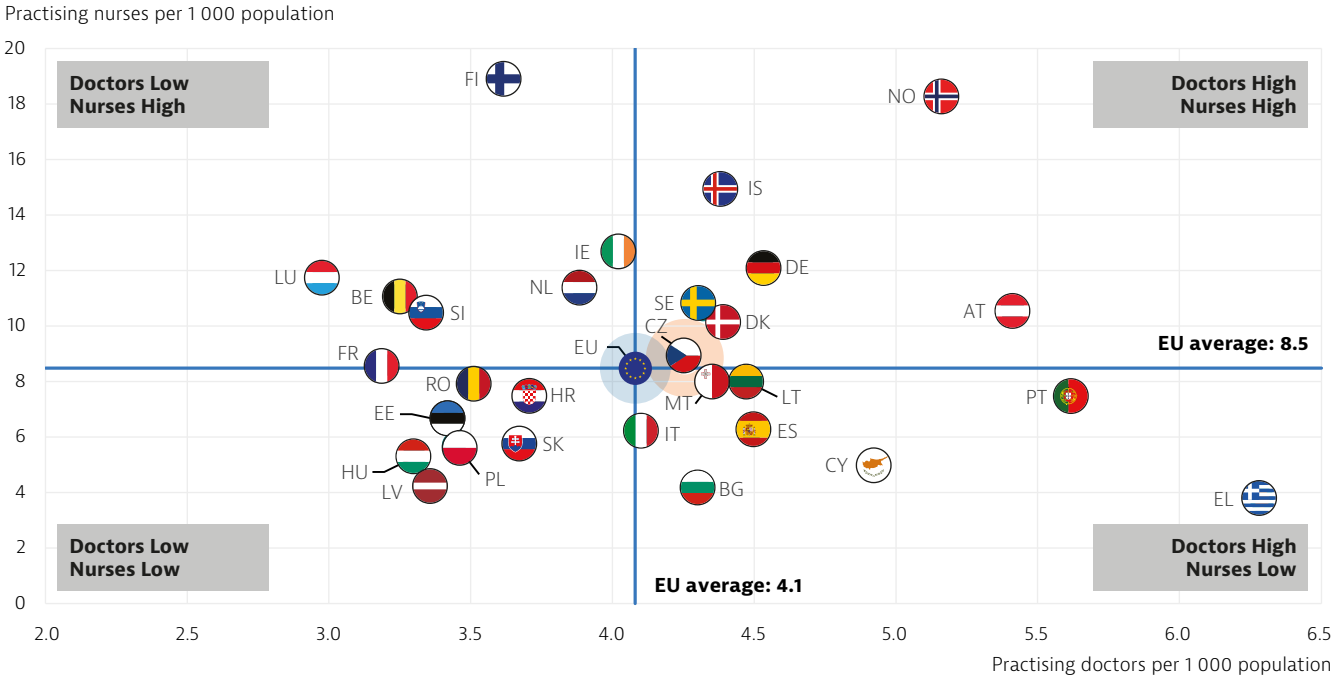
Some regions in Czechia face challenges associated with inadequate staffing levels

In 2021, Czechia had 4.3 doctors per 1 000 population – just above the EU average of 4.1 per 1 000 (Figure 11). The proportion of nurses (9.0 per 1 000 population) was also slightly above the EU average (8.5 per 1 000). While densities of physicians and especially of nurses have risen in Czechia since 2010, healthcare needs have also risen, and some hospitals report closed wards due to a lack of nurses and other healthcare workers.

Workforce ageing and unequal distribution across the country are longstanding concerns, although patients benefit from unlimited choice of providers and use it widely, especially for regions around the capital city Prague. The government has taken action to increase the number of students in medical schools (see Section 5.3). The Ministry of

Health also offers subsidies for opening primary care offices in underserved areas, and health insurers provide higher payments to providers serving less-populated regions.

Figure 11. Czechia's ratios of doctors and nurses per 1 000 population are just above the EU averages



Notes: The EU average is unweighted. The data on nurses include all categories of nurses (not only those meeting the EU Directive on the Recognition of Professional Qualifications). In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: OECD Health Statistics 2023 (data refer to 2021 or the nearest available year).

5 Performance of the health system

5.1 Effectiveness

Preventable and treatable causes of mortality are above the EU average

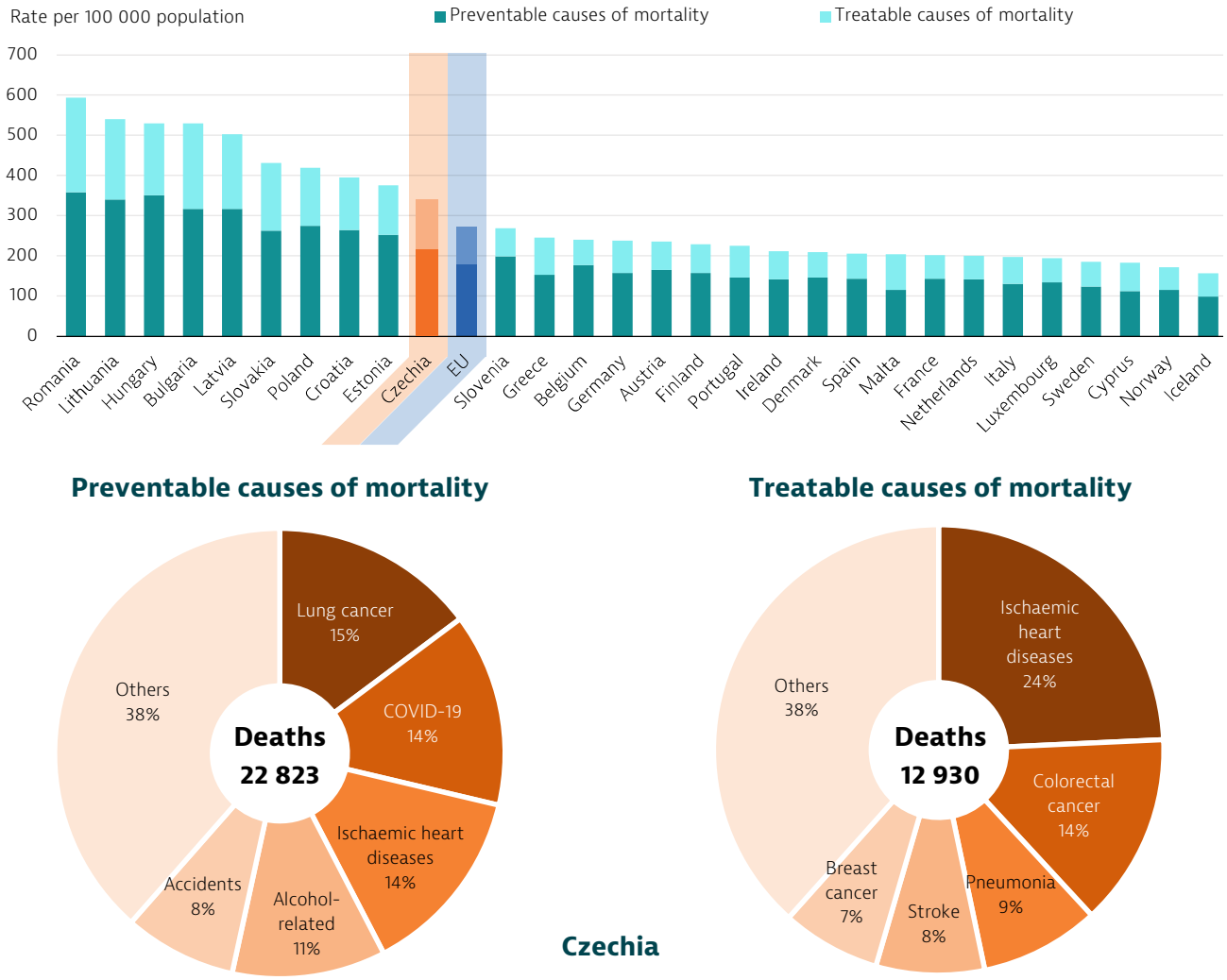
In 2020, Czechia's mortality rates from causes deemed to be preventable or treatable were 25 % above the EU averages (Figure 12). After a steady decline over the previous decade, preventable mortality rose in 2020, reflecting the high COVID-19 mortality rate (see Section 2). The main causes of preventable mortality in Czechia in 2020 were lung cancer (15 %), ischaemic heart disease (14 %) – both closely related to the high prevalence of modifiable health risks in the population (see Section 3) – and COVID-19 (14 %).

The mortality rate from treatable causes was 33 % higher than the EU average in 2020, although there had been gradual improvement over the previous decade. Together, ischaemic heart disease and colorectal cancer accounted for 38 % of treatable mortality.

Prevention and public health have gained policy attention recently, but financial support is unclear

Expenditure on prevention peaked in 2021 in Czechia at 8 % of total health expenditure, a much greater share than that usually allocated to prevention before the pandemic (around 3 %). The Health 2030 strategy, which was approved in 2019 and revised in 2020, identifies disease prevention, health promotion and improvement of health literacy among its seven objectives (MZČR, 2020). The previous health strategy suffered from low financing, which was mainly secured through the state budget. The Health 2030 strategy will benefit from funding from Czechia's Recovery and Resilience Plan to support cancer screening improvements (see Section 5.3). However, public health campaigns and educational programmes continue to rely on state budget funding, and the budget allocation for health promotion activities remains limited.

Figure 12. A substantial number of deaths could be avoided in Czechia through more effective prevention and healthcare interventions



Notes: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable (or amenable) mortality is defined as death that can be mainly avoided through healthcare interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The lists attribute half of all deaths from some diseases (e.g. ischaemic heart disease, stroke, diabetes and hypertension) to the preventable mortality list and the other half to treatable causes, so there is no double-counting of the same death.
Source: Eurostat Database (data refer to 2020).

Unlike childhood vaccination coverage, influenza vaccination coverage among older people is low

Czechia managed to maintain its high rate of childhood mandatory vaccination during the first pandemic year: 97 % of children aged 1 had their third dose of diphtheria, tetanus and pertussis vaccine in 2020. However, as the pandemic persisted, Czechia struggled to maintain the same high level, and the rate decreased to 94 % in 2021 and 2022. The reasons for the reduction are not yet clear; they may be related to temporary factors such as inability to follow the childhood vaccination schedule due to high COVID-19 infection rates (OECD/EU, 2022).

Czechia did not profit from the trend observed in many other EU countries during the pandemic of significantly increasing the share of older people vaccinated against influenza: the rate among people aged over 65 (25 % in 2021) remained well below the EU average (51 %).

The human papillomavirus (HPV) vaccination programme uptake among girls aged 13-14 years was 65 % in 2020 (OECD, 2023a), which is above the EU average (59 %), but below the EU's Europe's Beating Cancer Plan objective of vaccinating at least 90 % of the target population of girls by 2030. Very different HPV vaccination rates are reported across regions, ranging from 55 % to 71 % (OECD, 2023a). The reduction in HPV vaccination coverage among girls in the previous decade and low HPV vaccination awareness among boys are recognised

concerns, and actions are planned to stimulate uptake. From January 2024, the programme will be extended to 11-15 years for both sexes.

Screening rates are above the EU averages for breast cancer and cervical cancer

Czechia has well-established population-based cancer screening programmes for breast, cervical and colorectal cancers. These have been in place for over 20 years (15 years for cervical), and have included personalised invitations since 2014.

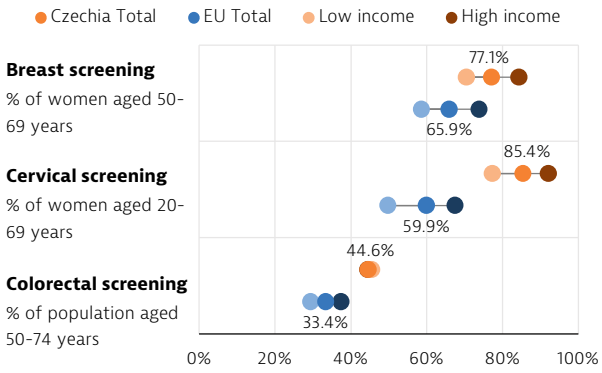
Based on administrative data, Czechia had higher screening rates among the target populations for breast and cervical cancer than the EU averages in 2021. The breast cancer screening rate was 58 % (compared to the EU average 54 %), while the cervical cancer screening rate was the second highest among EU countries, at 75 % compared to a 52 % EU average. However, the colorectal cancer screening rate was comparatively low, at 27 % (compared to the EU average 47 %), although the administrative data underestimate the rate as they do not include diagnostic exams used instead of screening exams, as shown in survey data. Uptake of cancer screening varies significantly across regions. The lowest participation in the three programmes was in the capital city Prague (OECD, 2023a).

According to survey data, screening rates also vary by socioeconomic status, but less so than the EU averages (Figure 13). Participation in breast cancer screening is 20 % more common among women with higher than lower levels of education, and 20 % more common among women in the highest than the lowest income quintile. Similarly, participation in cervical cancer screening is 20 % more common among women in the highest than the lowest income quintile, and 30 % more common among women with higher than lower education levels. While there is no income-based gap in colorectal cancer screening participation, people with higher education levels participate 30 % more often than those with lower levels.

The cervical and colorectal cancer screenings are performed as part of regular preventive check-ups – once a year for gynaecological examinations and every two years for colorectal screening of the target group by general practitioners (GPs).

The COVID-19 pandemic disrupted all three screening programmes. Based on administrative data, participation was lower in 2020 and 2021 than before the pandemic, suggesting that the backlog was not fully cleared, with consequences for rates of early cancer detection (OECD, 2023a).

Figure 13. Women in the highest income group are more likely to participate in breast and cervical cancer screening



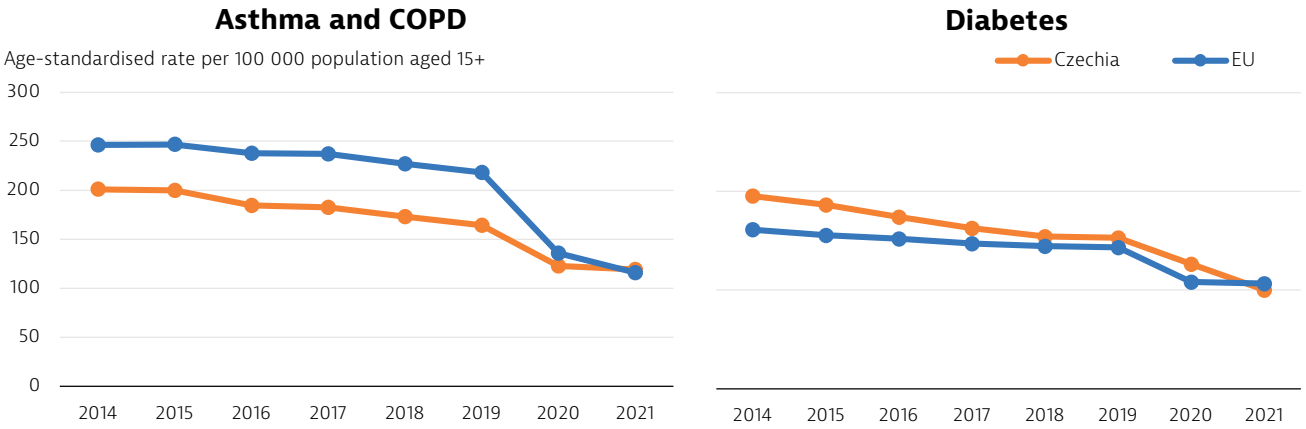
Notes: Low income is defined as the population in the lowest income quintile, whereas high income is defined as the population in the highest income quintile. The proportions refer to people who report having undergone a test in the two years preceding the survey.
Source: Eurostat Database (EHIS 2019 survey data).

High numbers of hospital admissions could be avoided by better management of chronic conditions

Admissions data for chronic conditions that can generally be managed outside hospitals provide insight into access to and effectiveness of outpatient care services. Before the pandemic, avoidable admissions for a set of chronic conditions (asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure and diabetes) were 7 % higher in Czechia than the EU average. While hospital admissions for asthma and COPD were lower in Czechia than the EU average, rates for diabetes and congestive heart failure were higher than the average in 2019 (Figure 14). Despite the decreasing trend before the pandemic, the significant decline in hospital admissions for these diseases observed in 2020-21 should be interpreted in the context of the pandemic, which severely affected the capacity of hospitals to provide acute care and modified patients' healthcare-seeking behaviour. These declines therefore cannot be understood as indicative of improved accessibility or quality of care for these conditions in outpatient settings.

A more systematic approach to disease management and preventing health status deterioration can help to reduce hospital admissions for chronic conditions. Primary care reform (see Box 1), development of integrated care models and better coordination across health and social care are among the objectives of the Health 2030 strategy.

Figure 14. Avoidable hospital admissions for chronic conditions decreased in Czechia before and during the pandemic



Note: Admission rates are not adjusted for differences in disease prevalence across countries.
Source: OECD Health Statistics 2023.

Box 1. Czechia has advanced its primary care reform

Primary care reform is one of the seven objectives of the Health 2030 strategy. The aim is to boost the competencies of primary care physicians, to use payment incentives to increase availability of care and promote prevention and to broaden the range of services provided by GPs.

Since 2019, GPs have gained new competencies over stabilised patients with diabetes and with a history of cancer. New GP competencies and tasks also include management and analysis of colorectal cancer screening, early dementia detection and care for patients with prediabetes. Integration of primary care and specialised care has been strengthened in these areas, supported by closer co-operation of relevant medical societies and the release of new clinical guidelines. The new competencies are also reflected in GP reimbursement through a fee-for-service scheme, in addition to general capitation payments.

Source: Bryndová et al. (2023).

5.2 Accessibility

Self-reported unmet needs for medical care are low

According to EU-SILC data, only 0.2 % of the Czech population experienced unmet needs for medical care (other than dental care) due to excessive costs, distance to travel or waiting times in 2022, which is much lower than the EU average (2.2 %) (Figure 15). The share was already low before 2020, and decreased during the pandemic.[3] The proportion was slightly greater among people in the lowest income quintile (0.4 %) than among the highest income (0.1 %), but this gap was smaller than in most EU countries.

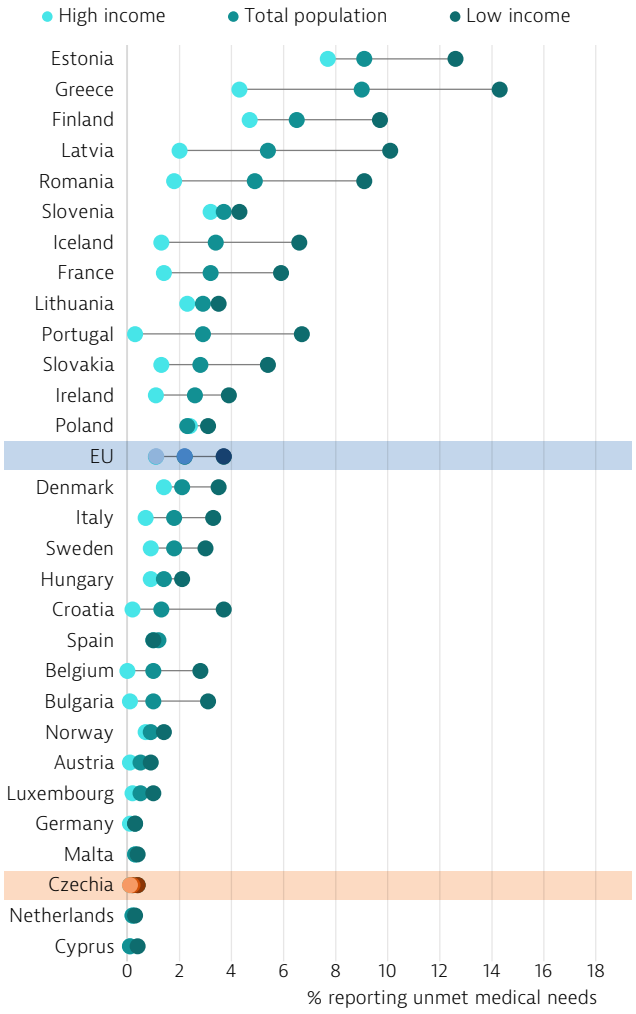
Reported unmet needs for dental care stood at 0.8 % in 2022, which is below the EU average of 3.4 %. In contrast to medical examinations, however, the difference in unmet needs for dental examinations between the lowest (2 %) and highest (0.2 %) income quintiles in 2022 were significant, explained mainly by the excessive costs reason.

The share of teleconsultations increased during the pandemic

Czechia reported 7.8 in-person physician consultations per capita in 2021, which was back to pre-pandemic levels after a drop in 2020, and well above the EU average. Use of teleconsultations increased significantly, helping to mitigate the in-person consultation reduction during the first pandemic year. In 2021, teleconsultations represented 14 % of all physician consultations (Figure 16).

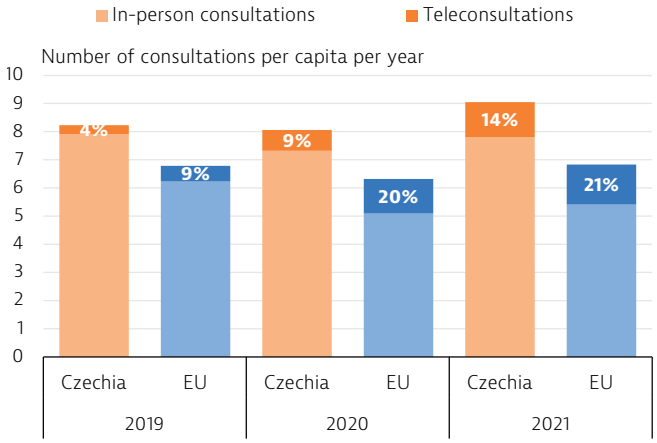
3 *According to the Eurofound (2022) survey carried out during the pandemic, the Czech population also reported very low unmet healthcare needs compared to other EU countries in spring 2021 and spring 2022. Note that the data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Figure 15. Low unmet medical care needs were reported in 2022 in Czechia



Notes: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2022, except Norway (2020) and Iceland (2018)).

Figure 16. Czechia has higher number of physician consultations than the EU average

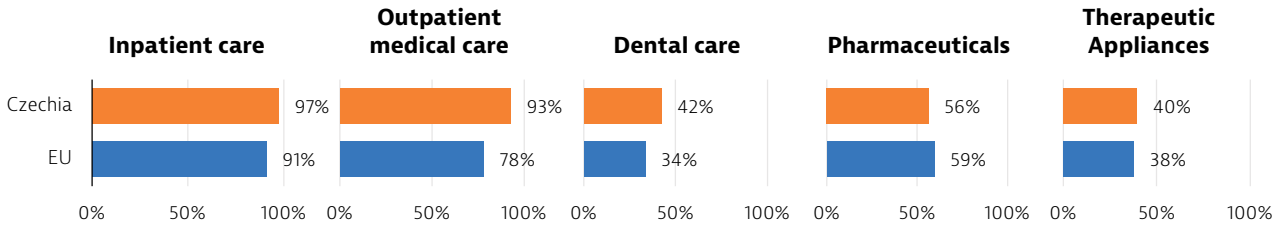


Sources: OECD Health Statistics 2023.

Czechia's benefits package is broad and comprehensive, including access to innovative pharmaceuticals

The range of benefits covered by the Czech SHI is broad and includes inpatient and outpatient care, prescription pharmaceuticals, some dental procedures, over-the-counter pharmaceuticals if prescribed by a physician, and rehabilitation and spa treatments under certain conditions. The shares of expenditure covered by SHI in 2021 were significantly above the EU averages for all healthcare goods and services except pharmaceuticals, which was below but close to the EU average (Figure 17). Public spending coverage of outpatient medical care in Czechia is among the highest in the EU.

Figure 17. Public coverage rate was higher than the EU averages across all services except pharmaceuticals in 2021



Notes: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines and medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices. The EU average is unweighted.
Source: OECD Health Statistics 2023.

Access to innovative pharmaceuticals is generally good in Czechia: the share of new pharmaceuticals registered by the European Medicine Agency in 2017-20 and accessible to Czech patients (59 %) was above the EU average (45 %) (Newton, Scott & Troein, 2022). Administering innovative pharmaceuticals is reserved for accredited highly specialised care centres, which are however not equally accessible across the country. For instance, there is no accredited oncology centre in

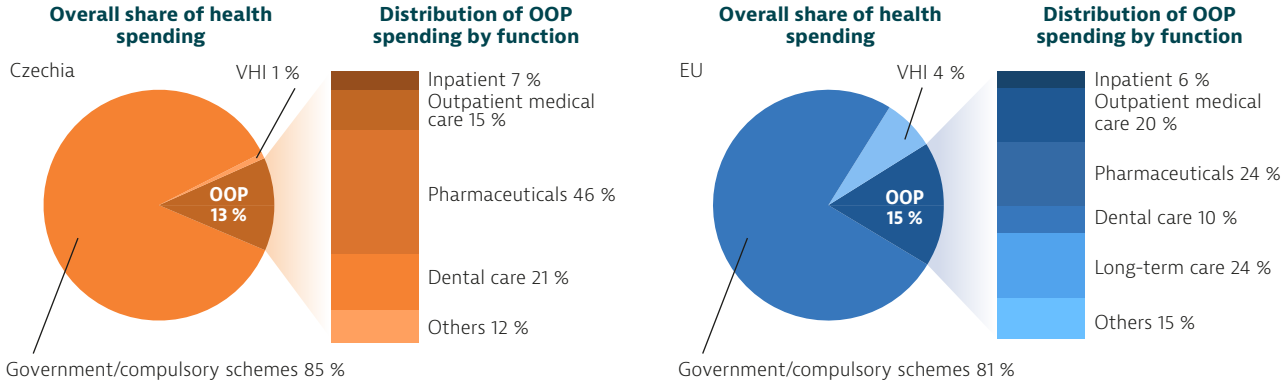
the Karlovarský region. Recent discussions have focused on extending administration of selected innovative pharmaceuticals to regional oncology providers to support equal access to cancer treatment across regions. Legislative changes were made in 2022 to the process by which innovative and orphan pharmaceuticals enter the Czech SHI reimbursement system, with the aim of further improving accessibility by speeding up the process.

Spending on pharmaceuticals accounts for nearly half of all out-of-pocket payments

Overall levels of cost sharing in Czechia were below the EU average in 2021: OOP spending made up 12.7 % of overall health expenditure compared to the EU average of 14.5 % (Figure 18). The share of OOP spending has decreased substantially in recent years, mainly due to increases in public health spending by increased state budget SHI contributions for the economically inactive population, especially during the pandemic (see Section 4).

The Czech SHI system applies almost no cost sharing for healthcare, and virtually all health services are free at the point of use. There are no user fees, except a small fee for out-of-hours outpatient care. As a result, almost half of OOP spending (46 %) is on pharmaceuticals – with the majority spent on over-the-counter pharmaceuticals – followed by dental care (21 %).

Figure 18. A large proportion of out-of-pocket payments in Czechia are pharmaceutical copayments



Notes: VHI refers to voluntary health insurance, which also includes other voluntary prepayment schemes. The EU average is weighted.
Sources: OECD Health Statistics 2023; Eurostat Database (data refer to 2021).

Low out-of-pocket payments make healthcare in Czechia affordable

OOP spending constituted 2.7 % of final household consumption in 2021, which was a higher share than in 2020 (2.4 %) but below the EU average of 3.3 %. A system of copayment caps for prescription pharmaceutical cost sharing is in place, stratified by age, economic and health status. Patients are reimbursed retrospectively after reaching the annual limit; assessment is done on a quarterly basis. In 2020, reimbursements for copayments above the cap amounted to EUR 37 million (Bryndová et al., 2023).

Despite copayment caps, 4.2 % of Czech households were affected by catastrophic healthcare spending[4] in 2019. Medicines and medical products created the most significant burden, accounting for over 50 % of household catastrophic spending, while dental care was responsible for 20 % – both values comparable to the EU averages.

5.3 Resilience

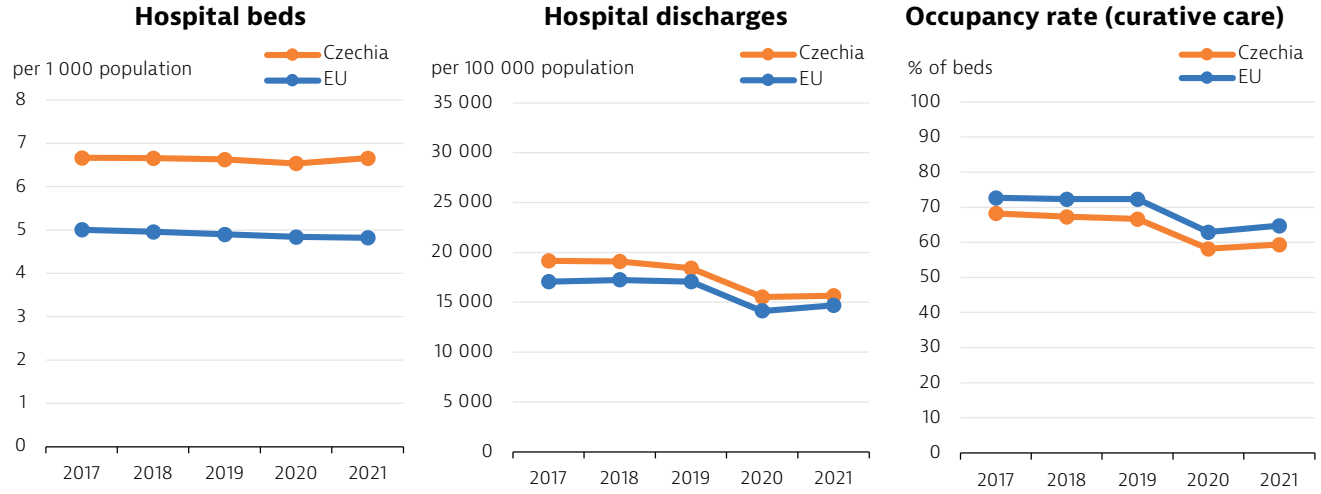
Despite high COVID-19 infection rates in 2021, Czech hospital occupancy rates were among the lowest in the EU

Before the COVID-19 pandemic, the number of hospital beds per 1 000 population in Czechia was higher than the EU average, while the occupancy rate was lower than the EU average. At the start of the pandemic, Czechia swiftly instigated interventions to contain the spread of the virus, and implemented measures to free up hospital capacity by postponing elective care and reassessing the need for inpatient stays for less severe cases. As a result, hospital discharges dropped by 15 % in 2020, and remained at this level in 2021. Acute care occupancy rates decreased from 67 % in 2019 to 58 % in 2020, rebounding slightly to 59 % in 2021 – a pattern similar to that observed across the EU (Figure 19). Despite the

4 *Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

high number of COVID-19 infections in 2021, the hospital bed occupancy rate remained low, and was among the lowest in the EU that year. Throughout the pandemic, Czechia benefited from 2.4 times higher numbers of intensive care unit (ICU) beds per 1 000 population than the EU average. The ICU bed occupancy rate was 64 % in 2021, compared to the EU average of 70 %.

Figure 19. Hospital discharges and bed occupancy rates fell sharply during the pandemic



Note: The EU average is unweighted.
Sources: OECD Health Statistics 2023 and Eurostat Database.

COVID-19-related hospital disruptions affected elective care

Elective (non-urgent) care was affected by postponements during the pandemic, as hospitals freed up capacity to deal with severe COVID-19 cases. The volume of knee replacements fell by 5 % in 2020 and decreased further in 2021; however, the volume of hip replacements continued to increase during the pandemic.

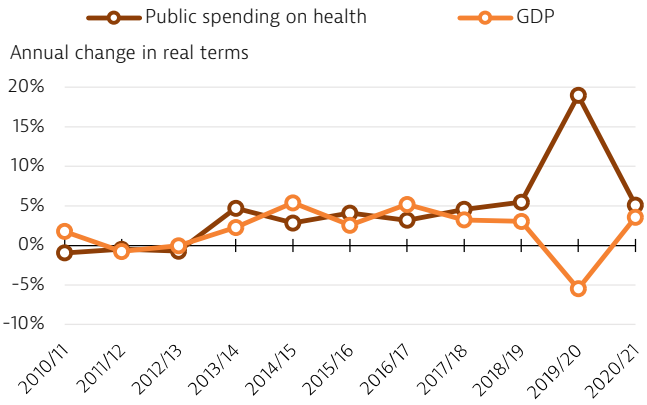
While the rise in some surgical activities in 2021 was modest, recovery in the number of diagnostic exams was strong. Following significant increases during pre-pandemic years and a temporary drop in 2020, the volume of most diagnostic exams in 2021 exceeded their 2019 levels.

There is no systematic monitoring of waiting times in Czechia. The introduction of an electronic referral system has recently attracted interest as a potential tool to monitor healthcare provider capacity and activity. Closer monitoring of waiting times is part of the new Czech health system performance assessment framework, launched in 2023. It is expected that national authorities will work towards developing the data sources needed to produce the related indicators (see Box 2).

Public spending on health in Czechia has increased, with a boost during the pandemic

Public spending on health in real terms increased steadily from 2014 (Figure 20), since when adjustments to per capita state budget payments had been made on an ad hoc basis to keep state transfers in line with economic growth. During the pandemic, the state payment was increased to offset SHI revenue losses, to compensate for extra COVID-19 costs, and to facilitate higher care reimbursements and health workforce bonuses. The state SHI contribution in 2021 was 78 % higher than in 2019, and accounted for 31 % of total SHI revenue (up from 22 % in 2019) (Bryndová et al., 2023). Along with the extra state spending on COVID-19-related measures, this contributed to the 19 % annual increase in public spending on health in 2020 and further 5 % increase in 2021. In 2022, a legislative change once again linked the state payment to economic performance and made annual adjustments automatic.

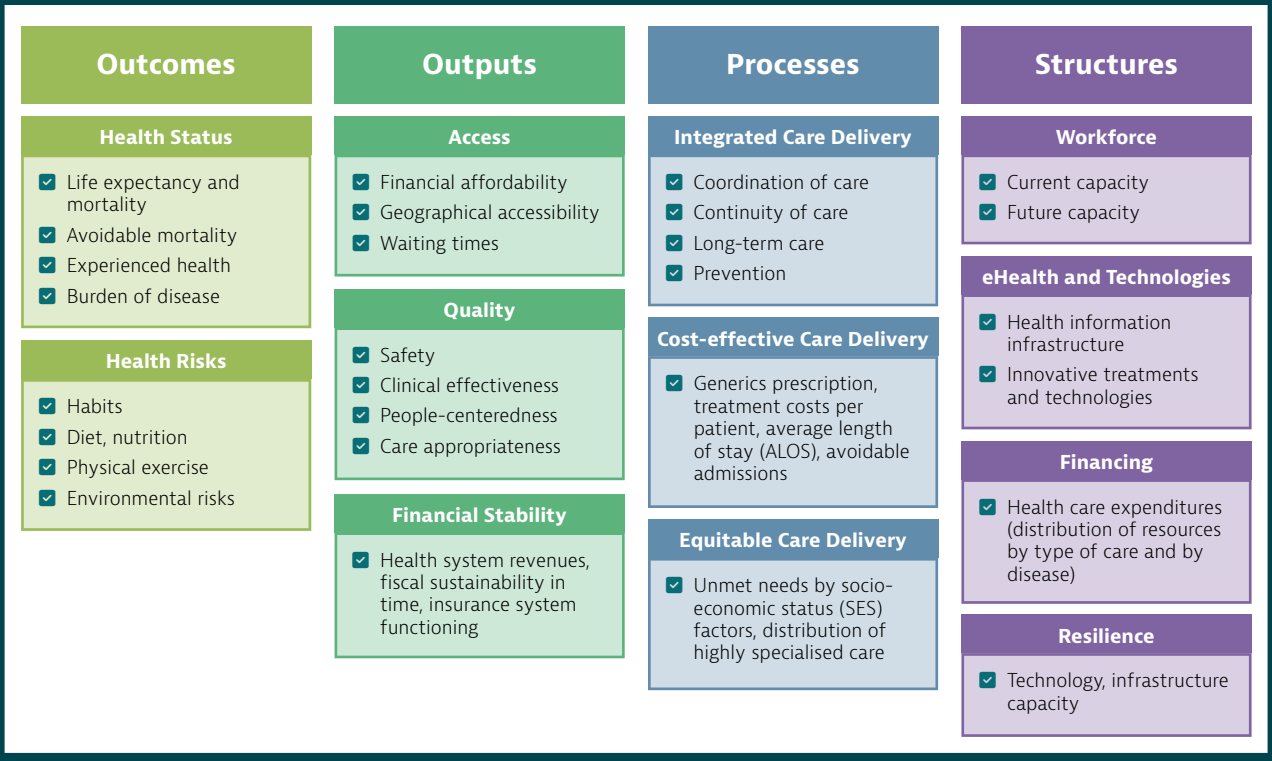
Figure 20. Public spending on health increased markedly during the first year of the pandemic



Source: OECD Health Statistics 2023.

Box 2. Czechia's health system performance assessment framework

In 2023, Czechia developed a country-specific health system performance assessment (HSPA) framework, with a plan to release its first HSPA report in early 2025. The HSPA framework, developed in co-operation with the OECD and with funding support from the European Commission, is designed to facilitate regular assessment of the strengths and weaknesses of the Czech health system, and to improve evidence-based policy planning and decision making. Its implementation will also improve accountability of national authorities and the principal healthcare stakeholders.



Source: OECD (2023b).

Infrastructure investments are the main priority in Czechia's National Recovery Plan

Czechia will invest EUR 1.1 billion in healthcare under its National Recovery Plan (Ministry of Industry, 2021), representing over 16 % of the Plan's total value – a higher proportion than the EU average. This investment mainly focuses on cancer care (EUR 335 million, including building a new oncological institute), expansion and modernisation of medical training facilities (EUR 334 million), and support for digital transformation of the health system (EUR 170 million).

These investments will be complemented by the rollout of the EU Cohesion Policy 2021-27 programming, through which Czechia is set to invest EUR 665 million in its healthcare system, of which three quarters will be co-financed by the EU. Of this amount, EUR 622 million, co-financed from the European Regional Development Fund, will be used mainly to develop e-health services and digitalisation, strengthen health infrastructure and modernise medical equipment. Furthermore, EUR 43 million, co-financed from the European Social Fund Plus, is designated to financing various measures to increase availability of social services and access to health services in underserved areas and for the most disadvantaged population groups.

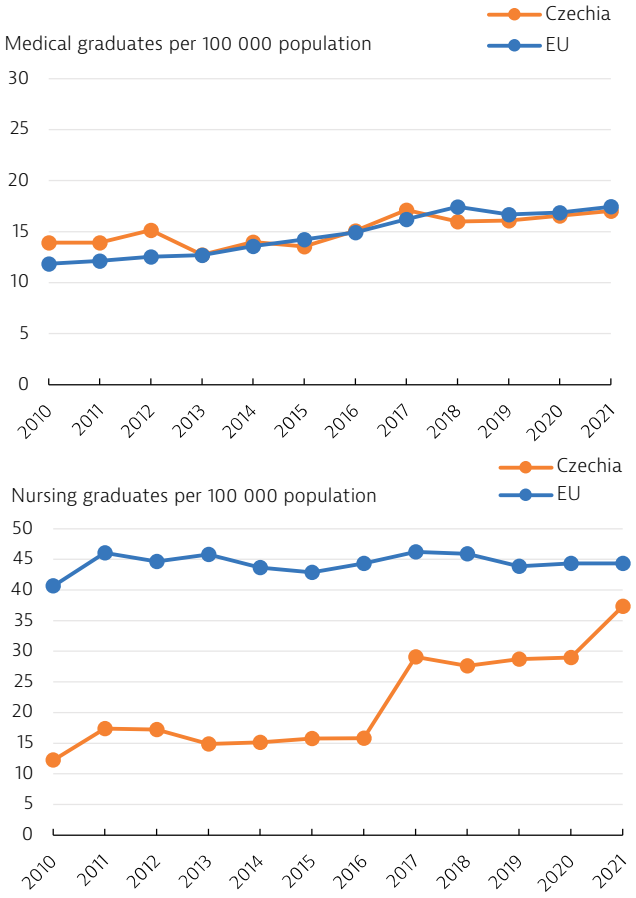
Czechia has taken steps to increase the number of doctors and nurses

While the densities of doctors and nurses per 1 000 population in Czechia have increased over the past decade to around the EU averages (see Section 4), demand has also increased owing to population ageing. Changes over time in the supply of doctors and nurses are determined by two main factors: inflow to the profession, which in Czechia is mainly from domestic education and training programmes; and outflow, which is mainly driven by doctors and nurses retiring, leaving the profession before retirement age or leaving the country to seek better job opportunities. In 2021, 35 % of all practising doctors were over 55, and nearly half of these were over 65, pointing to a large and imminent replacement need. The number of new medical

graduates per population in Czechia increased over the past decade to about the EU average in 2021 (Figure 21). Since 2019, the government has provided additional funding to increase the number of students in Czech medical schools. This resulted in a 20 % rise in first-year students in 2019/20 compared to the previous year, but it will take at least six years before these students complete their first medical degree.

The number of nursing graduates per population has also increased over the past decade, but this has been driven largely by a growing number of graduates from training programmes that provide lower nurse qualifications. One positive consequence of the pandemic was an increase in the number of young people applying for nursing education programmes. However, as in other countries, an important challenge in Czechia is attracting more men into nursing, as virtually all applicants are women.

Figure 21. The numbers of medical and nursing graduates have increased in recent years



Notes: The number of medical graduates includes both domestic and international students. The steep increase in the number of nursing graduates in 2017 was driven by the inclusion for the first time of nurses with a lower level of qualifications (not meeting the criteria spelled out in the EU Directive on the Recognition of Professional Qualifications). The EU average is unweighted.
Sources: OECD Health Statistics 2023; Eurostat Database.

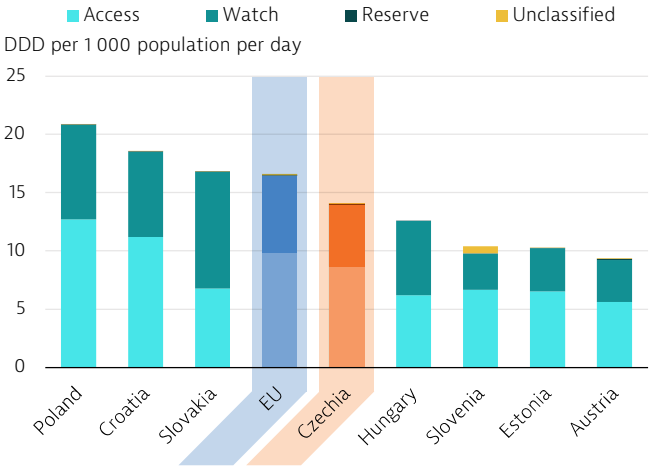
Improving working conditions and pay are key factors to attract and retain more nurses, doctors and other skilled health workers. Both doctors and nurses in Czechia obtained substantial pay rises between 2015 and 2020, although their salaries remained lower than those in most EU countries, even after adjusting for cost-of-living differences (OECD/EU, 2022). Czech doctors, nurses and other health workers also obtained COVID-19-related bonuses in 2020 and 2021, and permanent pay rises in 2021 and 2022.

Reducing the risks of other public health threats: Czechia's preparedness to antimicrobial resistance

Antimicrobial resistance (AMR) is a major public health concern in the EU, with estimates of about 35 000 deaths from antibiotic-resistant infections in the EU and European Economic Area (EEA) (ECDC, 2022), and healthcare-associated costs of around EUR 1.1 billion per year (OECD/ECDC, 2019). Because antibiotic overprescription and overuse in humans are major contributors to the development of antibiotic-resistant bacteria, antibiotic consumption data are a useful tool to evaluate the risk of AMR and the efficacy of programmes to promote their appropriate use.

In Czechia, the consumption of defined daily doses (DDDs) of antibiotics per 1 000 population was below the EU average in 2021, as was the share of antibiotics that only should be used for a limited number of specific indications (38 % compared to the EU average of 40 %) (Figure 22).

Figure 22. Czechia's consumption of antibiotics is below the EU average



Notes: WHO classification of antibiotics (Access, Watch and Reserve – AWaRe). Access: first- and second-choice antibiotics that should be widely available in all countries; Watch: antibiotics that only should be used for a specific, limited number of indications; Reserve: last-resort antibiotics for cases where other antibiotics have failed or for infections of multidrug-resistant bacteria; Unclassified: antibiotics that are not yet classified.
Sources: ECDC; WHO Regional Office for Europe (data refer to 2021).

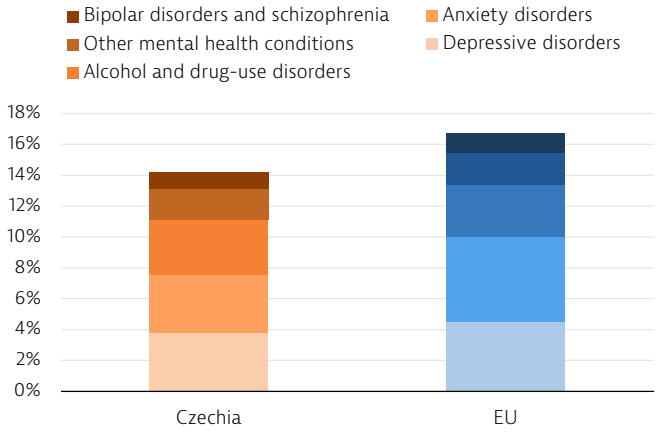
The Czech government launched the National Antibiotic Programme in 2009, aiming to ensure long-term availability, effectiveness and safety of antibiotic treatment for patients with infectious diseases. The latest Action Plan for 2019-22 targets AMR surveillance and responsible use of antibiotics, and promotes research support and health literacy (SZÚ, 2018). The National Institute of Public Health focuses on AMR prevention, and runs information campaigns for physicians and the general public, supported by funds from the EEA and Norway. These campaigns have been successful in increasing literacy on responsible use of antibiotics (SZÚ, 2023).

6 Spotlight on mental health

Although there are significant gaps in information about the prevalence of mental health issues in Czechia, as in other EU countries, the available evidence suggests that several hundred thousand people are affected. The economic costs of mental ill health in Czechia are substantial, with direct and indirect costs estimated at close to 2.5 % of GDP or about EUR 4 billion in 2015 (OECD/EU, 2018).

According to estimates from IHME, one in seven Czechs had a mental health issue in 2019, which is equivalent to nearly 1.5 million people. The most common mental disorders were depression (estimated to affect 3.8 % of the population), anxiety (3.6 %), and alcohol and drug-use disorders (3.6 %) (Figure 23).

Figure 23. About one in seven people in Czechia had a mental health issue before the pandemic



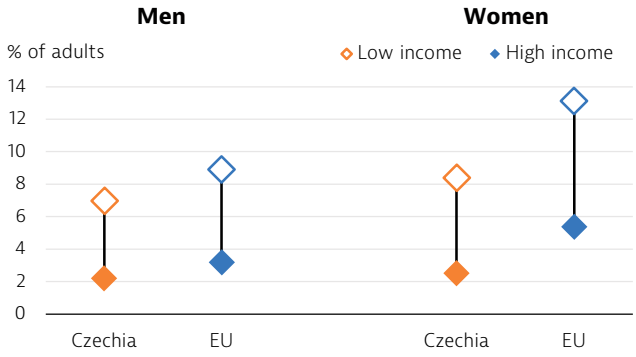
Source: IHME, 2020 (data refer to 2019).

Depression is reported more often by women and people in the lowest income group

Data from the 2019 EHIS survey show that over 4 % of Czech adults reported experiencing depression before the pandemic, and depression was reported more often by women (5.3 %) than men (3.3 %). Women and men in the lowest income quintile were over three times more likely to report depression than those in the highest quintile (Figure 24).

The links between low income and poor mental health persisted throughout the COVID-19 pandemic. Survey data collected during 2020-22 show that people in precarious financial circumstances were at significantly heightened risk of depression. According to Eurofound (2022) survey data, 60 % of people in Czech households that reported financial difficulties were at risk of depression, compared to 34 % in households that did not report financial difficulties. These proportions are close to the EU averages.

Figure 24. Women and people in the lowest income quintile are more likely to report depression in Czechia as in other EU countries

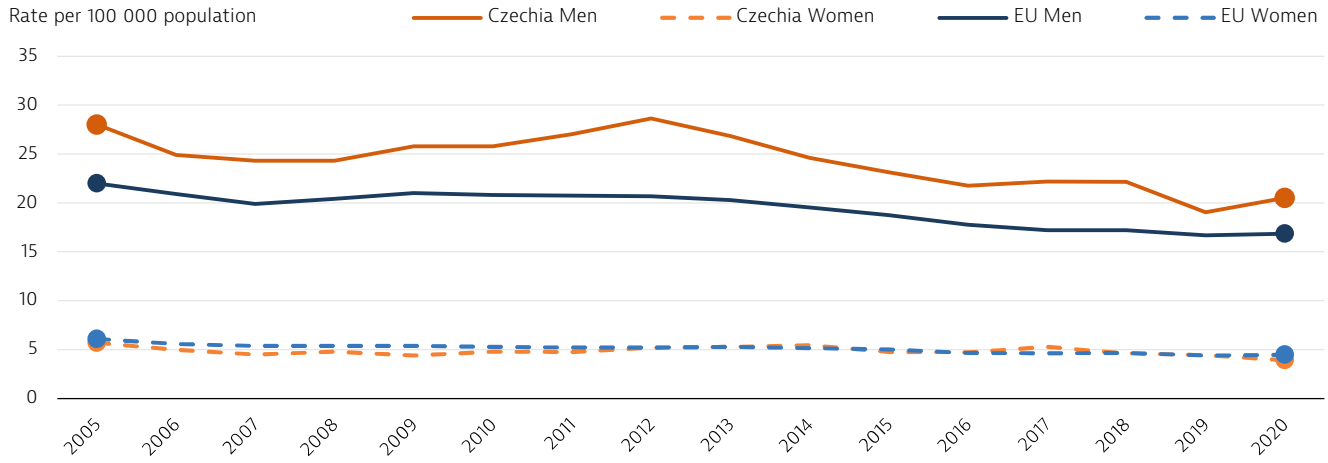


Source: Eurostat Database (based on EHIS 2019).

Suicide rates have decreased in Czechia over the past decade

Progress has been achieved in reducing mortality rates from suicide in Czechia, particularly among men, although they remain higher than the EU average (Figure 25). The highest number of deaths by suicide among men in 2020 occurred among those aged 35-44, while among women the highest number was among those aged 55-64.

Figure 25. The suicide rate has decreased over the past decade, particularly among men



Source: Eurostat Database.

Access to mental health services in Czechia is constrained by a lack of funding and trained workers

Mental health services are covered by the SHI and are free for all insured people for all levels of care. Patients can seek help directly from mental health specialists, there is no obligation for GP referrals.

Before the pandemic, effective access to mental health services was constrained by insufficient funding and workforce, as well as stigma. A major mental healthcare reform was launched in 2011 with EU funding support. The ongoing reform established multidisciplinary teams involving health and social care workers in the 100 new community mental health centres which are planned to be established throughout the country by 2030. These are designed to provide specialised mental healthcare in outpatient settings at the local level, and to facilitate coordination between health and social care services. The first centre was established in 2018, and the centres that opened before the COVID-19 pandemic – serving about 3 500 people by 2020 – were able to provide collateral support during the crisis, as some patients in psychiatric hospitals were discharged to reduce the risk of infection (Svačina et al., 2021). Despite the gradual shift towards deinstitution-alisation and providing more community-based care, much mental healthcare provision still relies on inpatient care in large psychiatric care facilities.

The lack of a trained workforce in mental health also remains a crucial barrier to access. Additional training on mental health conditions continues to be provided to GPs within the primary care reform. Czechia is also facing an acute shortage of child psychiatrists for both inpatient and outpatient care. As no systematic data are collected on waiting times, this issue is raised especially by physicians themselves.

Czechia's Health 2030 strategy includes action on mental health promotion and care provision

The Health 2030 strategy sets out major actions on mental health promotion and care provision. These include tackling stigma with national campaigns, greater integration of people with mental health conditions in society by improving living conditions, and enhancement of coordination between health and social care. The actions are in line with the Strategy to Reform Psychiatric Care, approved in 2011, which guides the ongoing mental healthcare reform (MZČR, 2021).

The specific measures for achieving the reform are described in three dedicated action plans of the Health 2030 strategy: the National Mental Health Action Plan 2020-30, the National Action Plan for Alzheimer's and Other Dementias 2020-30, and the National Suicide Prevention Action Plan 2020-30. These aim to take a whole-of-society approach in preventive measures, with a focus on vulnerable groups and specific targets related to children and young people. A joint programme of the ministries of health and education targets elementary school pupils, and aims to raise awareness on how to protect physical and mental health and well-being.

7 Key findings

- Life expectancy at birth in Czechia in 2022 (79.1 years) was about 1.5 years below the EU average (80.7 years). While it increased by more than 4 years in the two decades before the pandemic, it fell by more than 2 years in 2020 and 2021, before rebounding close to its pre-pandemic level in 2022. Circulatory diseases, cancer and COVID-19 were the leading causes of death in 2021.
- Nearly half of all deaths in Czechia in 2019 can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low levels of physical activity. While tobacco smoking has fallen below the EU average, excessive alcohol consumption rates remain among the highest in the EU, and obesity rates have increased to above the EU average.
- Health spending in Czechia accounted for 9.5 % of GDP in 2021, which is 2 percentage points above the pre-pandemic level, but well below the EU average of 11.0 %. Per capita spending was a quarter lower than the EU average, but the public share of health spending is the highest among EU countries (86 % compared to an EU average of 81 %).
- Czechia provides a broad benefits package, with relatively low unmet medical care needs for financial reasons. Nearly half of out-of-pocket spending by households goes on pharmaceuticals.
- Mortality rates from preventable and treatable causes were 25 % higher than the EU averages in 2020. Following previous improvements, preventable mortality increased during the pandemic because of COVID-19 deaths. Ischaemic heart disease and colorectal cancer are the leading treatable causes of mortality.
- Screening programmes for breast, cervical and colorectal cancer are well established, with participation rates above the EU averages, but the pandemic disrupted these programmes, causing backlogs that may hinder the early detection of cancer.
- The COVID-19 pandemic challenged the provision of elective (non-urgent) care. While recovery in the volume of diagnostic exams in 2021 was strong, surgical activities such as knee replacements had not yet recovered. The recent Czech health system performance assessment framework calls for development of a monitoring system of waiting times for elective surgery and other health services.
- Czechia will invest EUR 1.1 billion in healthcare under its National Recovery Plan, representing over 16 % of the Plan's total investment. This mainly focuses on improving cancer care capacity and technologies, expanding and modernising medical training facilities, and supporting the digital transformation of the health system.
- While the density of doctors and nurses has increased over the past decade, demand for care has also increased owing to population ageing. The medical workforce is ageing too: over one-third of all doctors in 2021 were aged over 55 and may be expected to retire in the coming decade. In response, the government has provided additional funding to keep increasing by at least 15 % the number of students in Czech medical schools compared to 2018. Actions have also been taken to attract more students in nursing and retain nurses in the profession by improving their pay rates.
- About one in seven people in Czechia were estimated to have a mental health disorder in 2019. The most prevalent were depressive, anxiety, and alcohol and drug-use disorders. The Health 2030 strategy sets out major actions for mental healthcare reform related to mental health promotion and care provision, including tackling stigma through national campaigns, greater integration of people with mental health conditions in society, and enhancement of coordination between health and social care.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT		

European Commission

State of Health in the EU
Country Health Profile 2023

The *Country Health Profiles* are a key element of the European Commission's *State of Health in the EU* cycle, a knowledge brokering project developed with financial support from the European Union.

These Profiles are the result of a collaborative partnership between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, working in tandem with the European Commission. Based on a consistent methodology using both quantitative and qualitative data, the analysis covers the latest health policy challenges and developments in each EU/EEA country.

The 2023 edition of the Country Health Profiles provides a synthesis of various critical aspects, including:

- the current state of health within the country;
- health determinants, with a specific focus on behavioural risk factors;
- the structure and organisation of the health system;
- the effectiveness, accessibility and resilience of the health system;
- For the first time in the series, an account of the state of mental health and related services within the country.

Complementing the key findings of the Country Health Profiles is the Synthesis Report by the European Commission.

For more information, please refer to: ec.europa.eu/health/state

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