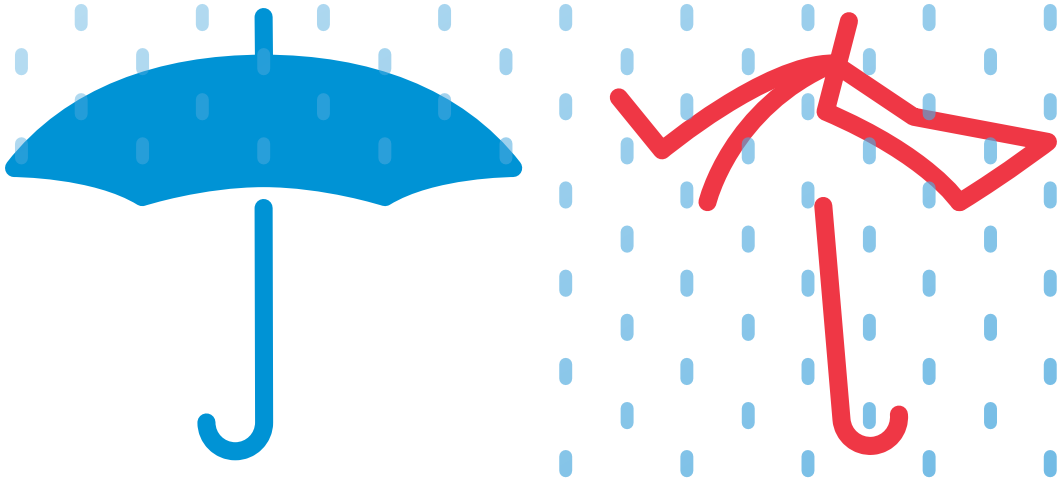
World Health Organization

European Region

Can people afford to pay for health care?

New evidence on financial protection in Czechia

Daniela Kandilaki



Czechia

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing.

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The Office disseminates country-specific and internationally comparable data and policy analysis through UHC watch, a digital platform tracking progress on affordable access to health care in Europe and central Asia.

Established in 1999, the Office is supported by the Government of the Autonomous Community of Catalonia, Spain. It is part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe.

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Abstract

This review is part of a series of country-based studies generating new evidence on affordable access to health care (financial protection) in health systems in Europe. Financial protection is central to universal health coverage and a core dimension of health system performance. Catastrophic health spending is lower in Czechia than in many European Union countries. It is heavily concentrated in the poorest quintile and older people and mainly driven by outpatient medicines. Levels of unmet need are below the European Union average but there is notable income inequality in unmet need for dental care. Financial protection is undermined by persistent gaps in health care coverage: mechanisms to protect people from co-payments are not designed to protect people with low incomes; corrective lenses are not well covered for adults; although dental care is covered, many dentists avoid offering covered services or using covered materials; and waiting times and informal payments are an issue for outpatient visits. Efforts to improve financial protection should focus on minimizing "avoidable co-payments" for outpatient prescribed medicines; expanding coverage of dental care, including the use of higher-quality materials and improved access in underserved areas; expanding coverage of medical products for people with low incomes; addressing long waiting times and informal payments and enforcing laws prohibiting extra billing; and finding ways to ensure the whole population is covered. To meet equity and efficiency goals now and in the future, the Government should ensure that public spending on health is carefully targeted to reduce financial hardship and unmet need for households with low incomes and that the social health insurance scheme's revenue base is broad enough to generate sufficient funding as the population ages.

Keywords

AFFORDABLE ACCESS
COVERAGE POLICY
CZECHIA
FINANCIAL PROTECTION
HEALTH FINANCING
OUT-OF-POCKET PAYMENTS
POVERTY
UNIVERSAL HEALTH COVERAGE
USER CHARGES (CO-PAYMENTS)

About the series

This series of country-based reviews monitors financial protection in European health systems. Financial protection – ensuring access to health care is affordable for everyone – is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? Out-of-pocket payments can create a financial barrier to access, resulting in *unmet need*, and lead to *financial hardship* for people using health services. People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection can undermine health, deepen poverty and exacerbate inequalities. Because all health systems involve a degree of out-of-pocket payment, unmet need and financial hardship can occur in any country.

How do country reviews assess financial protection? Each review is based on analysis of common indicators used to monitor financial protection: the share of people foregoing health care due to cost (*unmet need*) and the share of households experiencing financial hardship caused by out-of-pocket payments (*impoverishing* and *catastrophic health spending*). These indicators are generated using household survey data.

Why is monitoring financial protection useful? The reviews identify the health system factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Financing, part of the Division of Country Health Policies and Systems of the WHO Regional Office for Europe. To facilitate international comparison, the reviews follow a standard template, draw on similar sources of data and use the same equity-sensitive methods. Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by WHO

headquarters and the WHO Regional Office for Europe. The UHC watch website has more information on methods and indicators.

What is the basis for WHO's work on financial protection in Europe?
Financial protection is a Sustainable Development Goal, part of the European Pillar of Social Rights and at the heart of the European Programme of Work, 2020–2025 – "United Action for Better Health in Europe" – the WHO Regional Office for Europe's strategic framework. Through the European Programme of Work, WHO supports national authorities to reduce financial hardship and unmet need for health services (including medicines) by identifying gaps in health coverage and redesigning coverage policy to address these gaps. The Tallinn Charter: Health Systems for Health and Wealth and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region include a commitment to work towards a Europe free of impoverishing out-of-pocket payments. Other regional and global resolutions call on WHO to provide Member States with tools and support for monitoring financial protection, including policy analysis and recommendations.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

UHC watch

5 things to know about UHC watch

A digital platform tracking progress on affordable access to health care in Europe and central Asia

#1

Indicator explorer for the latest numbers and charts

#2

Policy explorer for up-to-date analysis of coverage policy

#3

Country pages with data, policy options and resources

#4

Country-level and comparative analysis

#5

Examples of good practice

UHC watch
apps.who.int/dhis2/uhcwatch

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Abbreviations

COICOP	Classification of Individual Consumption According to Purpose
COVID-19	coronavirus disease
CZK	Czech koruna (official currency)
EHIS	European Health Interview Survey
EU	European Union
EU14	European Union Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom.
EU27	European Union Member States as of 1 February 2020
EU-SILC	European Union statistics on income and living conditions
GDP	gross domestic product
GP	general practitioner
INN	international nonproprietary name
OECD	Organization for Economic Cooperation and Development
SHI	social health insurance
VAT	value-added tax
VHI	voluntary health insurance
VZP	*Všeobecná zdravotní pojišťovna* [General Health Insurance Fund]

Countries

ALB	Albania
ARM	Armenia
AUT	Austria
BEL	Belgium
BIH	Bosnia and Herzegovina
BUL	Bulgaria
CRO	Croatia
CYP	Cyprus
CZH	Czechia
DEN	Denmark
DEU	Germany
EST	Estonia
FIN	Finland
FRA	France
GEO	Georgia
GRE	Greece
HUN	Hungary
IRE	Ireland
ISR	Israel
ITA	Italy
LTU	Lithuania
LUX	Luxembourg
LVA	Latvia
MAT	Malta
MDA	Republic of Moldova
MKD	North Macedonia
MNE	Montenegro
POL	Poland
POR	Portugal
ROM	Romania
SPA	Spain
SRB	Serbia
SVK	Slovakia
SVN	Slovenia
SWE	Sweden
SWI	Switzerland
TJK	Tajikistan
TUR	Türkiye
UKR	Ukraine
UNK	United Kingdom

Executive summary

This review assesses the extent to which people in Czechia face financial barriers to access or experience financial hardship when they use health care. It covers the period from 2017 to 2025 using data from household budget surveys from 2017 to 2023 (the latest available year), data on unmet need for health services up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025.

The review's main findings are as follows.

- Financial hardship caused by out-of-pocket payments is lower in Czechia than in many European Union countries but has increased over time. In 2023 (the latest available year of data) 5.7% of households experienced catastrophic health spending, which is higher than in several countries with a similarly low reliance on out-of-pocket payments to finance the health system.

- Catastrophic health spending is heavily concentrated in the poorest quintile, where incidence has grown over time. In 2023 21% of households in the poorest quintile experienced catastrophic health spending, up from 14% in 2018. Older people are also at high risk of catastrophic health spending.

- Catastrophic health spending is driven, on average, by out-of-pocket payments for dental care, outpatient medicines, outpatient care and medical products. In the poorest quintile, however, it is consistently heavily driven by outpatient medicines. Dental care is the main driver in the other quintiles.

- Levels of unmet need for health care, dental care and prescribed medicines are below the European Union average in Czechia but have grown in recent years. Unmet need is mainly driven by waiting time for health care and cost for dental care. Income inequality in unmet need is notable for dental care.

Coverage policy in Czechia has some strengths.

- Entitlement to social health insurance benefits (SHI) is based on permanent residence rather than payment of mandatory SHI contributions – an example of good practice for other countries with SHI schemes.

- Co-payments are not widely used in the health system.

Gaps and weaknesses in coverage persist, however. Outpatient medicines are the overwhelming driver of catastrophic health spending in the poorest quintile and the second-largest driver in the other quintiles. This is likely to reflect a higher than desirable prevalence of "avoidable co-payments" for outpatient prescribed medicines – out-of-pocket payments that would have been avoided if prescribers, pharmacists and patients had all opted for the outpatient medicine in each reference group that is fully covered and should be available without any co-payment. These "avoidable co-payments" may arise due to the following issues with the design and implementation of reference pricing for outpatient medicines.

- Before 2025 there was no mandatory international nonproprietary name prescribing or mandatory generic substitution to reduce "avoidable co-payments". As a result, doctors often prescribed branded medicines and pharmacists did not always offer patients lower-priced alternatives.

- There is no exemption from "avoidable co-payments" for people with low incomes.

- Although there is a cap on "avoidable co-payments", it does not cover all co-payments, which undermines transparency. The cap applies only to the cheapest available version of a not fully covered medicine in the same reference group. If a more expensive alternative is selected, any co-payments paid do not count towards the cap. This might make it harder for people to know if they have reached the cap.

- The cap was not applied automatically before 2025. Before 2025 people did not stop paying co-payments once they reached the cap and would have to be retrospectively reimbursed for any eligible co-payments above the cap on a quarterly or annual basis.

- The cap is set too high to benefit enough people with low incomes. In 2023 only 10% of the population benefited from the cap. The cap is set at 5000 Czech koruna (CZK) a year (around €225.11 in purchasing power parities) for the general population, equal to 27% of the monthly minimum wage in 2024. There are two lower (more protective) caps – one set at CZK 1000 for children under 18 years and people aged over 65 years, the other set at CZK 500 for people with moderate to severe disabilities and pensioners aged over 70 years. However, adults of working age with low incomes or chronic conditions are subject to the general cap.

- The design of the reference groups used in reference pricing may encourage "avoidable co-payments".

Furthemore, there are gaps in the SHI benefits package for corrective lenses for adults. Although dental care is covered, many dentists are not willing to offer covered services or use covered materials. Waiting times and informal payments are an issue for outpatient visits.

To address these issues, the Government can consider the following options.

- **Outpatient medicines:** ensure that the fully covered medicine in each reference group is available in pharmacies; waive the co-payment when the fully covered medicine is not available at the pharmacy; exempt people with low incomes from co-payments currently eligible for the cap or extending the lowest cap (CZK 500) to people with low incomes; find other ways to link the cap to income; closely monitor "avoidable co-payments" and their causes; further reduce the value-added tax rate for covered medicines; and improve access to pharmacies in underserved areas.

- **Dental care:** require dental care providers to offer covered services and materials; expand coverage of dental care, including the use of higher-quality materials; and improve access to dental care in underserved areas.

- **Medical products:** expand coverage of medical products, especially for people with low incomes.

- **Outpatient visits:** remove administrative barriers to exemption from co-payments for emergency care or abolish this co-payment since it is unlikely to be addressing the root cause of inappropriate use of emergency care; enforce laws prohibiting extra billing; take steps to systematically monitor and address long waiting times and informal payments, which reduce transparency and are likely to be particularly detrimental for people with low incomes; address administrative and language barriers that hinder asylum seekers and migrants from accessing entitlements; and expand access to publicly financed health care for undocumented migrants.

To meet equity and efficiency goals now and in the future, the Government should ensure that public spending on health is carefully targeted to reduce financial hardship and unmet need for households with low incomes and that the SHI scheme's revenue base is broad enough to generate sufficient funding as the population ages.

1. Introduction

This review assesses the extent to which people in Czechia experience financial hardship when they use health care. It covers the period from 2017 to 2025 using data from household budget surveys carried out by the Czech Statistical Office between 2017 and 2023 (the latest available year), data on unmet need for health care up to 2024 (the latest available year) and information on coverage policy (population coverage, service coverage and user charges) up to May 2025. See UHC watch (2025) for updates.

Research shows that financial hardship is more likely to occur when public spending on health is low relative to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; 2007; WHO, 2010; WHO Regional Office for Europe, 2019; 2023). Increases in public spending on health or reductions in out-of-pocket payments are not in themselves guarantees of better financial protection, however; policy choices are also important.

The Czech health system is organized through a social health insurance (SHI) scheme with seven health insurance funds. Entitlement to SHI benefits is based on permanent residence rather than payment of SHI contributions and user charges (co-payments) are not widely applied. As a result, out-of-pocket payments accounted for 14% of current spending on health in Czechia in 2022, below the European Union (EU)27[1] average of 19% and the EU14[2] average of 16%). In the same year public spending accounted for 7.5% of GDP, higher than the EU27 average of 6.7% but lower than the EU14 average of 7.8% (WHO, 2025).

This review is the first in-depth analysis of financial protection in Czechia. Earlier studies are typically part of global and regional studies, use different methods and data sources and do not provide country-specific analysis (Xu et al., 2003; 2007; Masood, Sheiham & Bernabé, 2015; Palladino et al., 2016; Bernabé, Masood & Vujicic, 2017; Yerramilli, Fernández & Thomson, 2018).

The review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of coverage policy, drawing on information from UHC watch. Sections 4 and 5 present the results of the statistical analysis in financial protection, with a focus on out-of-pocket payments in Section 4 and financial protection in Section 5 (covering both financial hardship and unmet need). Section 6 provides a discussion of the results of the financial protection analysis and identifies factors that strengthen and undermine financial protection. Section 7 highlights implications for policy.

1. European Union Member States as of 1 February 2020.

2. European Union Member States from 1 January 1995 to 30 April 2004, excluding the United Kingdom.

2. Methods

This section summarizes the study's analytical approach and main data sources. More detailed information can be found on the Methods page of UHC watch (2025).

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe (Cylus, Thomson & Evetovits, 2018; WHO Regional Office for Europe, 2019; 2023), building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003).

2.1 Financial hardship linked to out-of-pocket payments

Financial hardship is measured using two main indicators: impoverishing and catastrophic health spending. Table 1 summarizes the key dimensions of each indicator.

Table 1. Key dimensions of impoverishing and catastrophic health spending

	Impoverishing health spending
Definition	The share of households *impoverished* or *further impoverished* after *out-of-pocket payments*
Poverty line	A *basic needs line*, calculated as the average amount spent on food, housing (rent) and utilities (water, electricity and fuel used for cooking and heating) by households between the 25th and 35th percentiles of the household *consumption* distribution who report any spending on each item, respectively, adjusted for household size and composition using Organisation for Economic Co-operation and Development (OECD) equivalence scales; these households are selected based on the assumption that they are able to meet, but not necessarily exceed, *basic needs* for food, housing and utilities; this standard amount is also used to define a household's *capacity to pay for health care* (see below)
Poverty dimensions captured	The share of households further impoverished, impoverished and at *risk of impoverishment after out-of-pocket payments* and the share of households not at risk of impoverishment after out-of-pocket payments; a household is impoverished if its total consumption falls below the basic needs line after out-of-pocket payments; further impoverished if its total consumption is below the basic needs line before out-of-pocket payments; and at risk of impoverishment if its total consumption after out-of-pocket payments comes within 120% of the basic needs line
Disaggregation	Results can be disaggregated into household *quintiles* by consumption and by other factors where relevant
Data source	Microdata from national *household budget surveys*
	Catastrophic health spending
Definition	The share of households with out-of-pocket payments that are greater than 40% of household capacity to pay for health care. This includes all households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay before or after out-of-pocket payments).
Numerator	Out-of-pocket payments
Denominator	A household's capacity to pay for health care is defined as total household consumption minus a standard amount to cover basic needs; the standard amount is calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, as described above; this standard amount is also used as a *poverty line* (basic needs line) to measure impoverishing health spending
Disaggregation	Results are disaggregated into household quintiles by consumption per person using OECD equivalence scales; disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant
Data source	Microdata from national household budget surveys

Note: see the Glossary provided by UHC watch (2025) for definitions of words in italics.

Source: WHO Regional Office for Europe (2019).

Financial hardship indicators are generated by analysing data from household budget surveys. This study analyses anonymized microdata from the household budget surveys conducted by the Czech Statistical Office between 2017 and 2023 (the latest available year). Data are usually collected throughout the year of study. The data sample consisted of 2759 households in 2017 (with a response rate of 47.2%), 2759 in 2018 (response rate 53.4%), 3552 in 2019 (response rate 60.0%), 3666 in 2020 (response rate 56.1%), 3497 in 2021 (response rate 54.5%), 3428 in 2022 (response rate 54.8 %) and 3368 in 2023 (response rate 53.5%).

In 2017 the Czech household budget survey underwent significant methodological changes to align with European Union statistics on income and living conditions (EU-SILC). As a result, only households randomly selected for EU-SILC are eligible to participate in the household budget survey and pre-2017 household budget survey data are not comparable to data from 2017 onwards.

Household budget surveys typically collect information on health spending in six broad categories: medicines, medical products, outpatient care, dental care, diagnostic tests (which includes other paramedical care until 2018) and inpatient care. These categories are agreed at international level through the Classification of Individual Consumption According to Purpose (COICOP) and the European COICOP systems.

In 2023 the household budget survey classification system in Czechia was updated to COICOP 2018, which allows data to be collected in alignment with the International Classification of Health Accounts (United Nations Department of Economic and Social Affairs, 2018). This led to the following changes in health spending categories:

- dental care: dentures moved from medical products to dental care, outpatient dental care grouped under dental care;
- inpatient care: overnight dental care shifted to inpatient care;
- diagnostic tests: medical analyses and x-rays moved from inpatient care to diagnostic tests; and
- outpatient care: immunization, preventive care and general medical services provided in hospitals (without an overnight stay) moved from inpatient care to outpatient care; laboratory and imaging services for preventive care, when billed with health workers' time and skills, moved from diagnostic tests to outpatient care; some outpatient curative and rehabilitative care (e.g. physical, psychological and speech therapy) moved from paramedical services (diagnostic tests) to outpatient care.

Due to these changes in the Czech household budget survey, data for 2023 should be compared to earlier data with caution. Breaks in series are signalled in the figures in sections 4 and 5.

The review also draws on data from national health accounts, which use the standardized System of Health Accounts to collect internationally comparable data on health spending at national level (OECD, Eurostat & WHO, 2017).

All currency units in the study are presented in Czech koruna (CZK), with notes on inflation-adjusted spending where relevant. In 2024 CZK 100 had the equivalent purchasing power of €4.50 in the average EU country.

2.2 Unmet need for health care

Unmet need for health care due to cost, distance and waiting time (health system factors) is measured using data from European or national surveys (Box 1).

Box 1. Unmet need for health care

Unmet need is defined as instances in which people need health care but do not receive the care they need because of access barriers. Self-reported data on unmet need should be interpreted with caution, especially across countries. However, analysis has found a positive relationship between unmet need and a subsequent deterioration in health (Gibson et al., 2019) and between unmet need and the out-of-pocket payment share of current spending on health (Chaupin-Guillot & Guillot, 2014), which suggests that unmet need can be a useful indicator of affordable access to health care.

Every year EU Member States collect data on unmet need for health care (medical examination or treatment) and dental care (dental examination or treatment) through EU-SILC (Eurostat, 2025a). EU Member States also collect data on unmet need through the European Health Interview Survey (EHIS), carried out every 5–6 years (Eurostat, 2025b). The third wave of this survey was launched in 2019. EHIS provides information on unmet need among people reporting a need for health care and asks households about unmet need for prescribed medicines, in addition to health care and dental care. EU-SILC typically provides information on unmet need as a share of the population but in recent years it has started to provide this information among people reporting a need for care for a limited number of years (Ingleby & Guidi, 2024).

Financial protection analysis that does not account for unmet need could be misleading. A country may have a relatively low incidence of catastrophic health spending because many people face barriers to access and are unable to use the health care they need. Conversely, reforms that increase the use of health care can increase people's out-of-pocket payments – through, for example, user charges – if protective policies are not in place; in such instances, reforms might improve access to health care but at the same time increase financial hardship.

Source: WHO Regional Office for Europe (2019; 2023).

3. Coverage policy

This section briefly describes the governance and key dimensions of publicly financed health coverage – population coverage, service coverage and user charges (co-payments) – and reviews the role played by voluntary health insurance (VHI). It draws on information from the policy explorer on UHC watch (2025).

3.1 Population coverage

Entitlement to publicly financed health care, including SHI benefits, is based on permanent residence. People can choose between one of seven health insurance funds and can change insurer once every 12 months. The largest health insurance fund, *Všeobecná zdravotní pojišťovna* (VZP) [General Health Insurance Fund] has a share of 55% of covered people, followed by Česká průmyslová zdravotní pojišťovna [Czech Industrial Health Insurance Company] (12%), *Zdravotní pojišťovna ministerstva vnitra České republiky* [Health Insurance Company of the Ministry of the Interior of the Czech Republic] (12%), *Vojenská zdravotní pojišťovna* [Military Health Insurance Company] (6%), *Oborová zdravotní pojišťovna* [Sectoral health insurance company] (6%), RBP, *zdravotní pojišťovna* [RBP Health Insurance Company] (4%) and *Zaměstnanecká pojišťovna Škoda* [Škoda Employee Insurance Company] (1%).

Permanent residents, refugees, asylum seekers and anyone working for a company that is permanently resident in Czechia are required to pay SHI contributions, which are set at 13.5% of the assessment base wage, with 4.5% paid by the employee and 9% paid by the employer. Self-employed people pay a monthly contribution (CZK 3143 per person in 2025) that is subsequently adjusted (up or down) to reflect actual annual earnings.

The Government pays monthly contributions (CZK 2127 per person in 2025) on behalf of the following groups of people (around 50% of the population):

- dependent children and students under 26 years, full-time doctoral students (under 26 years for their first time of study), juveniles in institutional education;
- parental allowance recipients, people on parental leave, caregivers for children under 10 years with mild dependence (degree I), full-time caregivers for at least one child under 7 years or two children under 15 years;
- pensioners (over 65 years, with disabilities), widows, widowers or orphans receiving an allowance, job seekers, long-term volunteers, social beneficiaries and their dependants, recipients of employee sickness benefits who have no income and are not covered under other categories and spouses or registered partners of civil servants abroad;
- people with moderate to complete dependence (degree II–IV) and their caregivers, people with disabilities (degree III) or older people without a pension;

- people in detention, prison or institutional treatment, foreigners with temporary protection or visas for stays over 90 days with children born in Czechia, applicants for international protection and their children born in Czechia; and

- some other minor groups.

People without taxable income or not included in the previous categories must pay a minimum monthly contribution of CZK 2808 in 2025. People who are required to pay contributions but do not do so in full or on time become indebted to the health insurance fund. They do not lose their entitlements to SHI benefits and can continue to access publicly financed health care in the same way as people who have paid their contributions. However, they incur a daily penalty of 0.0322% of the amount owed and can also face fines of up to CZK 10 000 for individuals or CZK 200 000 for employers; these fines may be doubled for repeated non-compliance (Public Defender of Rights, 2022a). The debt cannot be forgiven but people can apply for a penalty waiver. The largest health insurance fund, VZP, commonly forgives some or all of the penalty (Public Defender of Rights, 2022b). In 2022 penalties and some enforcement costs were waived for any person (covered by any public health insurance fund) who repaid their debt.

People who do not have to be covered by the SHI scheme include EU citizens who are covered in their home country or privately insured in Czechia. Temporary migrants (students or workers) are required to have some form of health insurance; they can join the SHI scheme if they meet the criteria or must buy private health insurance. Non-EU nationals who are not permanent residents and who are not employed in Czechia must buy private health insurance.

The law entitles anyone living in Czechia (including undocumented migrants) to emergency care, care in childbirth and other acute care (including for mental health issues), although receiving care does not guarantee that the costs are covered and out-of-pocket payment may still be required from the patient.

Homeless people in Czechia can have a "permanent residence" at the local townhall but those who do not do this or lack an employment permit often do not fall under the SHI scheme and remain in a "grey area". However, even when they do not pay contributions to the SHI scheme, they are generally able to access publicly financed health care through a combination of SHI, city and municipality budgets and nongovernmental organizations. A Ministry of Health survey counted 23 830 homeless people in Czechia in 2019, including 2600 children (Ministry of Labour and Social Affairs, 2019).

Migrants from non-EU countries who wish to stay in Czechia can either be insured under the SHI scheme, if eligible, or must purchase private health insurance.

Refugees and asylum seekers are entitled to the same health care benefits as permanent residents. Eurostat data indicate that in 2023 there were 1405 applications for asylum in Czechia, down from 1685 applications in 2022 (Eurostat, 2025c).

Undocumented migrants and others in Czechia without a valid resident permit are entitled to emergency care, care in childbirth and other acute care (including for mental health issues) but they have to pay out of pocket. In 2023 there were 11 185 migrants (around 0.1% of the population) without resident permits in Czechia (Czech Statistical Office, 2025). Undocumented migrants usually do not stay in Czechia; most continue on to France, Germany or the United Kingdom (ProSestru, 2024).

At the end of 2024 1 056 626 foreigners were registered in Czechia for legal residence (for a period longer than 90 days) (Ministry of the Interior, 2024). EU citizens are not yet required to register, so the number of foreigners actually present in Czechia is certainly larger than this.

Permanent residents need a health insurance card issued by a public health insurance fund to access non-urgent health care. Migrants and asylum seekers need to have some form of identification and a health insurance certificate – a special document issued by the VZP. Cards and certificates are not required for access to emergency care but SHI status needs to be checked before or after care is delivered. Migrants and asylum seekers may face administrative and language barriers to accessing entitlements.

Key changes to coverage policy are summarized in Table 2.

Table 2. Changes to coverage policy, 2008–2025

Year	Month	Change
2008	January	A fixed co-payment of CZK 30 is introduced for doctor visits, dental visits and for outpatient prescribed medicines (per item), CZK 60 per day in hospital and CZK 90 for outpatient emergency visits and dental emergency visits
2008	January	An annual cap of CZK 5000 is introduced for co-payments for outpatient prescribed medicines
2008	January	Generic substitution by the pharmacist is allowed for the same active substance and the same mode of administration but it is not mandatory
2008	August	The fixed co-payment of CZK 60 per day in hospital is abolished for inpatient care of a newborn child (but the mother continues to pay for herself per day in hospital)
2009	April	All user charges except co-payments for outpatient emergency visits are abolished for children < 18
2009	April	Institutionalized older people with low incomes (people with monthly income < CZK 800 after accommodation and food) are exempt from all fixed co-payments (doctor visits, dental visits, inpatient care, emergency care and outpatient prescribed medicines)
2009	April	The annual cap on co-payments for outpatient prescribed medicines is strengthened by being reduced from CZK 5000 to CZK 2500 for children < 18 and pensioners > 65
2011	December	The fixed co-payment per day in hospital is increased from CZK 60 to CZK 100
2012	January	Co-payments for outpatient prescribed medicines are changed from a fixed co-payment of CZK 30 per item to CZK 30 per prescription
2012	October	User charges are abolished for people receiving social services

Source: UHC watch (2025).

Table 2. Contd

Year	Month	Change
2014	January	Fixed co-payments for inpatient care are abolished
2015	January	The value-added tax (VAT) rate for medicines is reduced from 15% to 10% for radiopharmaceuticals and hormonal contraceptives; the VAT rate for all other medicines remains at 15%
2015	January	Fixed co-payments for outpatient visits, dental visits and outpatient prescribed medicines are abolished
2016	January	The annual cap on co-payments for outpatient prescribed medicines is increased from CZK 2500 to CZK 5000 for people with low incomes
2018	January	The annual cap on co-payments for outpatient prescribed medicines is strengthened by being reduced from CZK 2500 to CZK 1000 for children < 18 and pensioners > 65 and to CZK 500 for pensioners > 70
2020	January	The annual cap on co-payments for outpatient prescribed medicines is strengthened by being reduced from CZK 5000 to CZK 500 for people with disabilities. This change was not defined by the authorities as a response to the coronavirus disease (COVID-19) pandemic
2021	May	Stricter regulations, better oversight and improved traceability for medical products are introduced, enhancing transparency, enforcing higher quality standards and ensuring safer medical products and a clearer co-payment policy. This change was not defined by the authorities as a response to the COVID-19 pandemic
2021	August	The newborn children of foreigners (including children with undocumented parents) are compulsorily covered by the SHI scheme. This change was not defined by the authorities as a response to the COVID-19 pandemic
2022	January	The aggregated provider payment system is set to provide dentists with a fixed monthly payment per registered patient (CZK 16–18), regardless of the number of visits per person. This aims to encourage patient registration and the provision of regular preventive and therapeutic care. This change was not defined by the authorities as a response to the COVID-19 pandemic
2022	February	Ukrainian refugees are covered by the SHI scheme. This change was not defined by the authorities as a response to the COVID-19 pandemic
2022	June	Ukrainians of working age (18–65 years) in the temporary protection scheme are required to pay their own contributions at the same rate as permanent residents without taxable income (CZK 2187 a month in 2022) unless they can prove to their health insurance fund that they belong to one of the groups for whom the Government pays contributions. This change was not defined by the authorities as a response to the COVID-19 pandemic
2023	January	The minimum contribution paid by people without taxable income is raised from CZK 2187 to CZK 2336 a month
2023	September	Foreigners can now obtain health insurance from any authorized insurance company; previously they were required to obtain it from VZP. The coverage limit is increased from €60 000 to €400 000
2024	January	Both VAT rates of 10% and 15% for medicines are changed to 12%
2024	January	The aggregated provider payment system set to provide dentists with a fixed monthly payment per registered patient is raised from CZK 16–18 to CZK 21–23
2024	June	Companies that hold market authorization must ensure their medicines are available, even if they report shortages. The State Institute for Drug Control can also limit the export of medicines that are in short supply
2024	June	E-prescriptions now include information on which pharmacies have medicines with limited availability in stock

Table 2. Contd

Year	Month	Change
2024	July	General practitioners (GPs) can now prescribe some diabetes, asthma, cardiovascular, dermatological, ophthalmological and urological medicines that previously only specialists could prescribe. These medicines are now covered by the SHI scheme, regardless of the prescriber's specialty
2024	October	Teleconsultations with health care providers are established and regulated
2025	January	GPs are obliged to prescribe using international nonproprietary names (INN) (mandatory INN prescribing) and pharmacists are required to offer people the cheapest available option (mandatory generic substitution)
2025	January	Co-payments for outpatient prescribed medicines are now recorded in the e-prescription system, which allows the cap on these co-payments to be applied automatically, replacing retrospective reimbursement of co-payments exceeding the cap

3.2 Service coverage

Decisions related to the benefits package are made in a systematic way. A broad benefits package is defined in law. The law also includes a negative list defining what is not covered (e.g. acupuncture, plastic surgery, voluntary termination of pregnancy, occupational examinations, medicines and food supplements that are not prescribed by a doctor). The broad legal definition of who is entitled and to which services is further defined by a range of actors.

The State Institute for Drug Control defines coverage policy rules, sets prices and publishes a positive list of covered medicines; it draws on evidence from health technology assessment (including evidence of cost-effectiveness, defined as CZK 1.2 million per quality-adjusted life year). Health insurance funds can create their own lists, highlighting preferred alternatives for medicines on the State Institute for Drug Control list (VZP, 2021). External reference pricing is used to set the SHI scheme reference price for covered medicines, which usually corresponds to the lowest price of a comparable medicine in the EU. At least one medicine in each of the 300 reference groups should be fully covered (i.e. without any co-payment), typically the cheapest generic option (State Institute for Drug Control, 2025). The Government also regulates the maximum retail price of medicines; when a new medicine enters the market, the State Institute for Drug Control sets its maximum price as the average of the three lowest prices in selected EU countries (Skoupá, 2017).

The Ministry of Health issues an annual reimbursement (coverage) decree setting out reimbursement (coverage) rates and regulations following negotiations with the health insurance funds and health care providers in which the ministry has the final say. The Ministry also issues an annual decree called "The list of health services", which defines most of the services covered by the SHI scheme. Individual health insurance funds can

also develop their own additional lists covering additional services. The SHI benefits package is relatively comprehensive, but some types of care are not so well covered.

Dental care is covered but limited in terms of scope and materials and not all dentists are willing to use covered materials. Only contracted dental care providers can offer covered services; most provide a combination of covered care (including preventive check-ups, basic fillings and necessary extractions), which is free at the point of use, partially covered care involving co-payments for higher-quality materials or advanced procedures (e.g. composite rather than amalgam fillings) and non-covered treatment like implants or cosmetic work.

An aggregated provider payment system was introduced in 2022 to improve access to dental care. The system provides dentists with a fixed monthly payment per registered insured patient, regardless of the number of visits per person. It covers some administrative costs and minor services and aims to increase the number of covered people registered with dental care providers and encourage dentists to provide preventive treatment.

Access to dental care is uneven, particularly in smaller municipalities, where finding a dentist accepting new patients is difficult. This is due to an uneven distribution of dentists and some choosing not to contract with health insurance funds, providing care only for non-covered treatment.

Coverage of corrective lenses is limited to children under 18 years and people with severe eye disorders.

Extended rehabilitation programmes may require co-payments. Psychotherapy is typically only partially covered, with patients having to pay out of pocket if they opt for private therapists or need frequent sessions.

Publicly financed health care is provided in public and contracted private facilities. Covered people need to register with a GP, a paediatrician (children under 18 years), a gynaecologist and a dentist. A change can be made quarterly. Access to outpatient specialist care does not require referral. Although GPs, dentists and gynaecologists can refer people to other specialists, in practice people contact specialists directly. Laboratory tests, occupational therapy, diagnostic imaging facilities and inpatient care require referrals. Access to covered medicines and medical products requires a prescription.

User charges are applied to emergency care, outpatient prescribed medicines and medical products. There is no retrospective reimbursement; all health care is provided as a benefit in kind. There are no caps on the volume of covered health care.

Systematic data on waiting times are not available but due to a shortage of paediatricians, paediatric care involves waiting times of 2–3 months (Bryndová et al., 2023 Maximum waiting times defined in law range from 2–52 weeks for diagnostic tests, screening and surgical procedures. However, these maximum waiting times are not effectively guaranteed because they are not systematically monitored.

Informal payments are not monitored but international data sources suggest they are higher in Czechia than in most EU countries and typically occur in maternity care to shorten waiting times or see a specific doctor (see section 4.3).

3.3 User charges (co-payments)

User charges are applied to emergency care, outpatient prescribed medicines and medical products (Table 3).

Co-payments for outpatient prescribed medicines are in the form of reference pricing, where people pay the difference between the reference price and the retail price. Each reference group should include at least one medicine that is fully covered (i.e. without any co-payment). If a person is prescribed and dispensed the fully covered alternative, they will be able to avoid paying anything out of pocket. If people opt for more expensive alternatives, however, the amount of the "avoidable co-payment" will vary depending on the alternative they opt for and may also vary across pharmacies due to differences in mark-ups in the supply chain (Krůtilová & Doubková, 2021).

The design of the reference groups used in reference pricing may encourage avoidable co-payments.

There are no exemptions from the "avoidable co-payments" caused by reference pricing but there is an annual cap on some "avoidable co-payments". The cap typically only applies to the lowest-priced available version of a not fully covered medicine in each reference group; it does not apply to more expensive alternatives in the same group (unless a physician deems the more expensive alternative to be needed) or (for working-aged people) to partially covered supportive or supplementary medicines (prescribed vitamins and food supplements) (VZP, 2022a). In 2023 around 11% of the population (1 246 629 people) benefited from the cap and the public cost of the cap was CZK 1.32 billion.[3]

Three changes introduced in January 2025 are likely to reduce "avoidable co-payments" for outpatient prescribed medicines:

- INN prescribing has become mandatory for GPs, so people may be more likely to be prescribed the fully covered medicine or a lower-priced alternative (although GPs are still allowed to indicate that some prescriptions should be paid fully out of pocket if they want to bypass volume controls or if patients insist on a particular medicine);

- pharmacists are now required to offer people the cheapest available option (generic substitution has become mandatory), so people may be more likely to be dispensed the fully covered medicine or a lower-priced alternative; and

3. Author calculations based on annual reports of the public health insurance funds.

- pharmacies now use the e-prescription system to provide health insurance funds with information on co-payments for covered medicines, indicating a person's unique user number, the date and the amount paid in co-payments – as a result, people will no longer have to wait to be reimbursed for co-payments that exceed the cap but will automatically be exempt from eligible co-payments once they have reached the cap.

Extra billing is not permitted but sometimes occurs in practice when health care providers impose charges for non-clinical services (e.g. scheduling appointments at specific times or sending people text message reminders). This practice is more common in larger cities (VZP, 2022b).

Table 3. User charges (co-payments) for publicly financed health care, 2025

Notes: NA: not applicable. In 2024 CZK 100 had the equivalent purchasing power of €4.50 in the average EU country.

Source: UHC watch (2025).

Service area	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Outpatient primary care visits	No formal user charges but in larger cities some gynaecologists ask people to pay an unregulated annual registration fee to cover appointment scheduling and other benefits	NA	NA	NA
Outpatient specialist visits	No user charges	NA	NA	NA
Outpatient emergency visits	Fixed co-payment per visit: CZK 90 if the visit is on Saturday, Sunday and holidays or on working days between 1700 and 0700; the co-payment is waived if a covered person is subsequently admitted to hospital	No	Income: people with low incomes (if they provide proof of income through a decision, notification or confirmation issued by the authority providing social assistance within the last 30 days) Other: children in orphanages and people living in social institutions, residential homes for older people or inpatient facilities	No
Outpatient prescribed medicines	None: one fully covered medicine in each reference group Reference pricing (people pay the difference between the reference and retail price): other covered medicines	No	No	Annual cap per person on selected co-payments: • CZK 500 for people with disabilities and pensioners > 70 • CZK 1000 for children < 18 and people > 65 • CZK 5000 for all other people The cap only applies to the cheapest available version of a not fully covered medicine in each reference group (with the exception of supplementary medicines for people > 65 and more expensive medicines medically justified by the prescribing doctor)

Table 3. Contd

Service area	Type and level of user charge	Reduced user charges	Exemption from user charges	Cap on user charges
Medical products	Balance billing for corrective lenses and medical products for chronic conditions: people pay the difference between the amount covered by the SHI scheme and the retail price No user charges for mobility aids when doctors issue people a voucher	No	No	No
Diagnostic tests	No user charges	NA	NA	NA
Dental care visits	No user charges	NA	NA	NA
Dental care treatment	No user charges if covered materials are used but many dentists do not use covered materials	NA	NA	NA
Inpatient care	No user charges	NA	NA	NA
Inpatient medicines	No user charges	NA	NA	NA

3.4 The role of VHI

VHI plays a minor substitutive role, covering non-EU nationals who are obliged to buy private health insurance. In 2023 VHI accounted for 0.1% of current spending on health (WHO, 2025).

Table 4 summarizes the main gaps in publicly financed coverage and describes the role of VHI in filling these gaps.

Table 4. Gaps in coverage

Coverage dimension	Main gaps in publicly financed coverage	Are these gaps covered by VHI?
Population coverage	Access to publicly financed health care, including SHI benefits, is based on permanent residence, so all permanent residents are covered. The people most likely to lack SHI coverage are undocumented migrants, who are not entitled to any publicly financed health care.	No. VHI does not fill gaps in population coverage.
Service coverage	Coverage of corrective lenses is limited for adults and although dental care is fully covered, it is limited in terms of scope and materials and most dentists are not willing to offer covered procedures or use covered materials. Specialist health care is less accessible outside large cities and there is a shortage of pharmacies and dentists in border areas. Waiting times are an issue in outpatient specialist paediatric care. Waiting time targets are in place but are not guaranteed because they are not systematically monitored. Informal payments are not systematically monitored either but international data sources suggest they are higher in Czechia than in most EU countries and typically occur in maternity care to shorten waiting times or see a specific doctor.	No. VHI does not fill gaps in service coverage.
User charges (co-payments)	User charges are applied to outpatient emergency care (fixed co-payments) and outpatient prescribed medicines and medical products (reference pricing). People with low incomes are exempt from co-payments for emergency care. There are no exemptions from other co-payments but there is an annual cap on some co-payments for outpatient prescribed medicines, which is lower (more protective) for children, older people and people with disabilities. There is no cap on all co-payments. Although extra billing is not permitted, some health care providers charge people for non-clinical services (e.g. scheduling appointments at specific times or sending people text message reminders), particularly in larger cities.	No. VHI does not cover user charges.

Source: UHC watch (2025).

3.5 Summary

Entitlement is based on permanent residence. People who are required to pay SHI contributions and do not do so incur a debt that must be repaid but do not lose their entitlement to SHI benefits and can continue to access publicly financed health care in the same way as people who have paid their contributions. The people most likely to lack SHI coverage are undocumented migrants, who can access emergency care, care in childbirth and other acute care (including for mental health issues) but have to pay for it out of pocket.

The publicly financed benefits package is relatively comprehensive but the following types of care are not so well covered: coverage of corrective lenses is limited to children and people with specific conditions and, although dental care is covered, many dentists do not offer covered services or use covered materials.

Waiting times are an issue in outpatient specialist paediatric care due to a shortage of paediatricians. Waiting time targets are in place but are not guaranteed because they are not systematically monitored.

Informal payments are not systematically monitored either but international data sources suggest they are higher in Czechia than in most EU countries and typically occur in maternity care to shorten waiting times or see a specific doctor (see section 4.3).

User charges are limited to fixed co-payments for emergency care and reference pricing for outpatient prescribed medicines and medical products. There are some protections in place but not all of them apply to people with low incomes or automatically. Although not permitted, there is extra billing for non-clinical services, especially in larger cities.

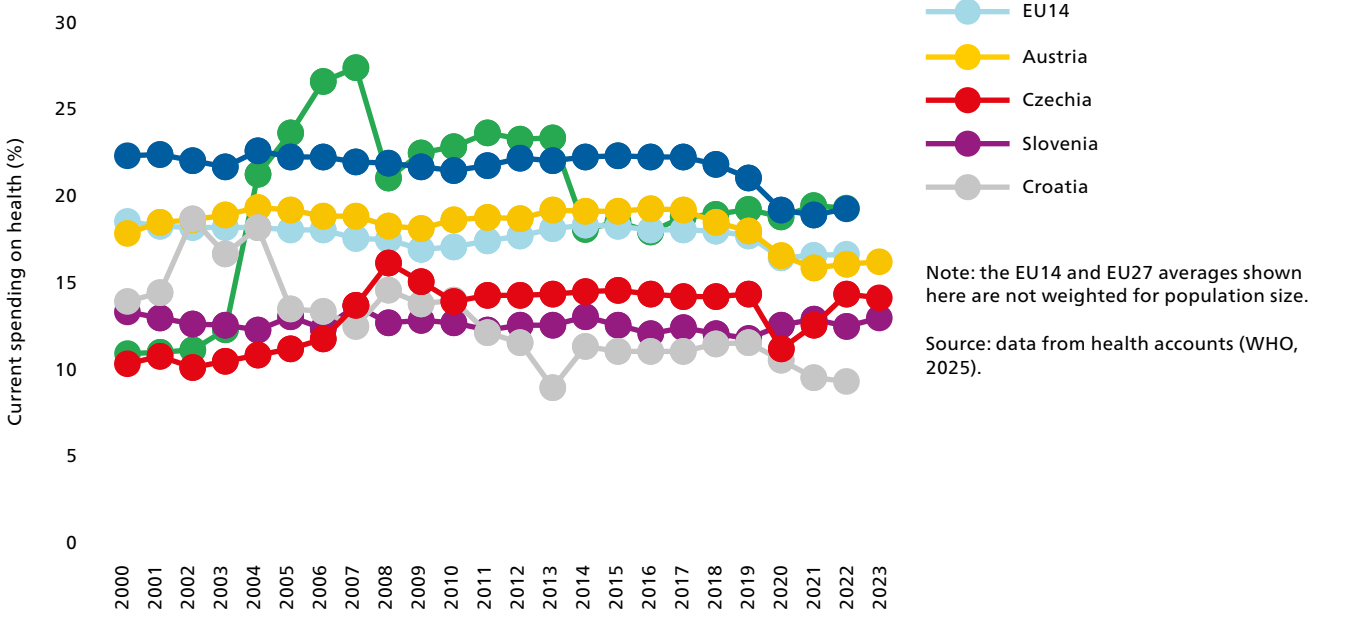
4. Spending on health

The first part of this section uses data from national health accounts to present patterns in public and private spending on health. The second and third parts use household budget survey data to review out-of-pocket payments (the formal and informal payments made by people at the time of using any good or service delivered in the health system) and household spending on VHI. The fourth part considers the role of informal payments. The indicator explorer on UHC watch (2025) provides further data behind the figures in this section.

4.1 Public and private spending on health

Data from national health accounts indicate that out-of-pocket payments in Czechia accounted for 14% of current spending on health in 2023 – lower than the EU27 average of 19% in 2022 and the EU14 average of 17% and lower than most central European countries except Slovenia (12%) and Croatia (9%) (Fig. 1). This share was relatively stable between 2010 and 2019 (Fig. 2). The out-of-pocket payment share fell in 2020 due to a sharp increase in public spending on health in response to the COVID-19 pandemic but was back at its 2019 share by 2023.

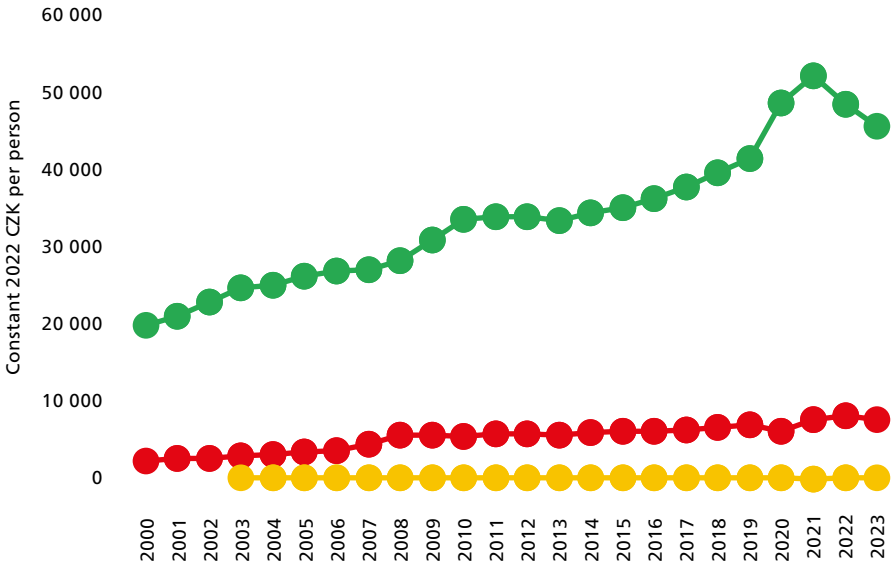
Fig. 1. Out-of-pocket payments as a share of current spending on health, Czechia and selected EU countries



Note: the EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (WHO, 2025).

Fig. 2. Health spending per person by financing scheme



Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. VHI is defined here as a coverage scheme provided on a voluntary basis by enterprises or purchased by individuals.

Source: data from health accounts (WHO, 2025).

In 2022 public spending on health accounted for 7.5% of GDP in Czechia, higher than the EU27 average (6.7%) but lower than the EU14 average (7.8%) (Fig. 3). This reflects a relatively high "priority to health" in allocating government spending in Czechia: public spending on health accounted for 17% of total government spending in 2022, above the EU27 average of 15% and the EU14 average of 16% (Fig. 4).

Fig. 3. Public spending on health and GDP per person, Czechia and the EU, 2022

Notes: public spending on health is defined here as revenue from the government budget and SHI contributions. The figure excludes Ireland and Luxembourg because they are outliers in terms of GDP per person and Netherlands (Kingdom of the) because Dutch data on public spending on health are not internationally comparable.

Source: data from health accounts (WHO, 2025).

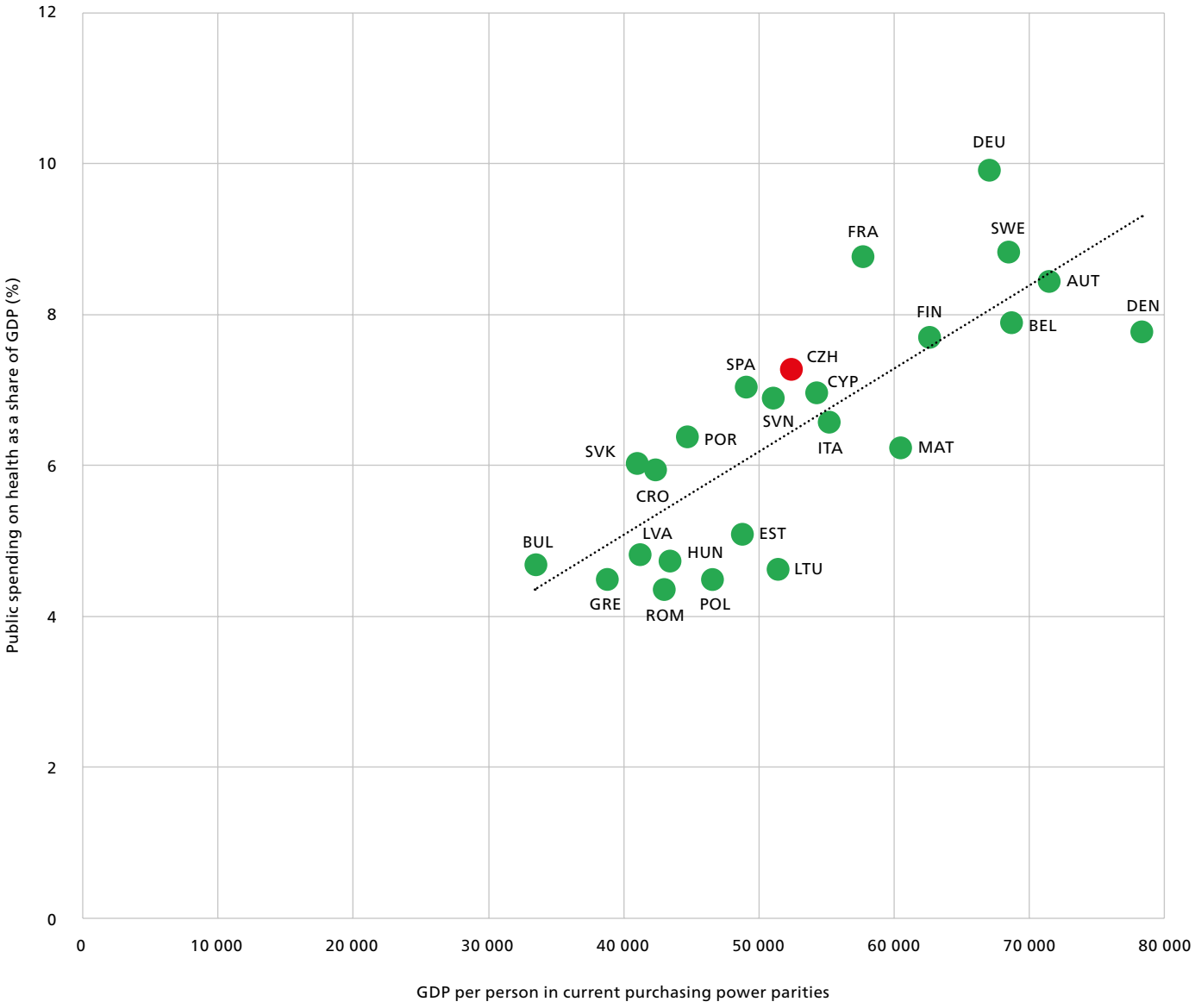
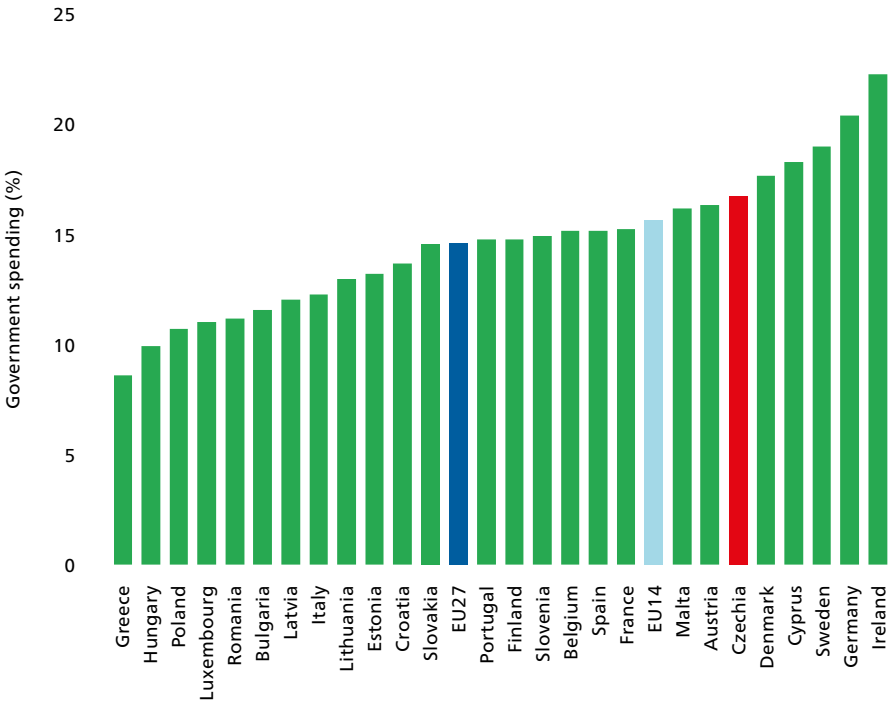


Fig. 4. Public spending on health as a share of the government budget in the EU, 2022



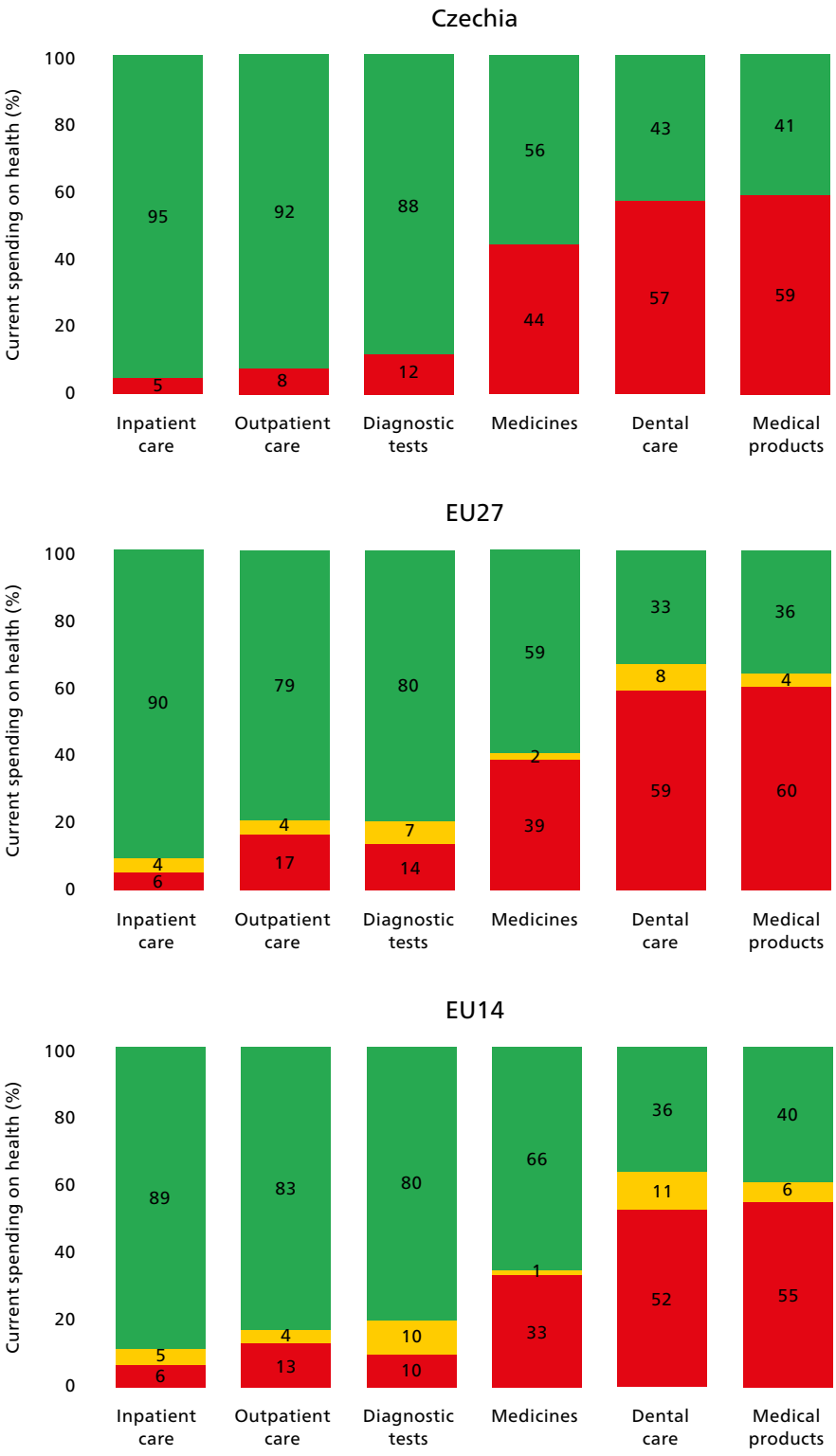
Notes: public spending on health is defined here as revenue from the Government budget and SHI contributions. The figure excludes Netherlands (Kingdom of the) because of lack of comparability of the data on public spending on health. The EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (WHO, 2025).

Broken down by type of care, the out-of-pocket payment share of current spending on health in Czechia is highest for medical products (59%), dental care (57%) and outpatient medicines (44%) (Fig. 5). These shares are well above the EU14 average, particularly for outpatient medicines and dental care; the share for outpatient medicines is also above the EU27 average (Fig. 5).

In 2022 57% of out-of-pocket payments for outpatient medicines was for medicines sold over the counter (data not shown; OECD, 2025). This figure should be interpreted with caution because it could include some prescribed medicines and, as with all health accounts data, it is not possible to disaggregate by income.

Fig. 5. Breakdown of current spending on health by type of care and financing scheme, Czechia and the EU, 2022



Public spending on health

VHI

Out-of-pocket payments

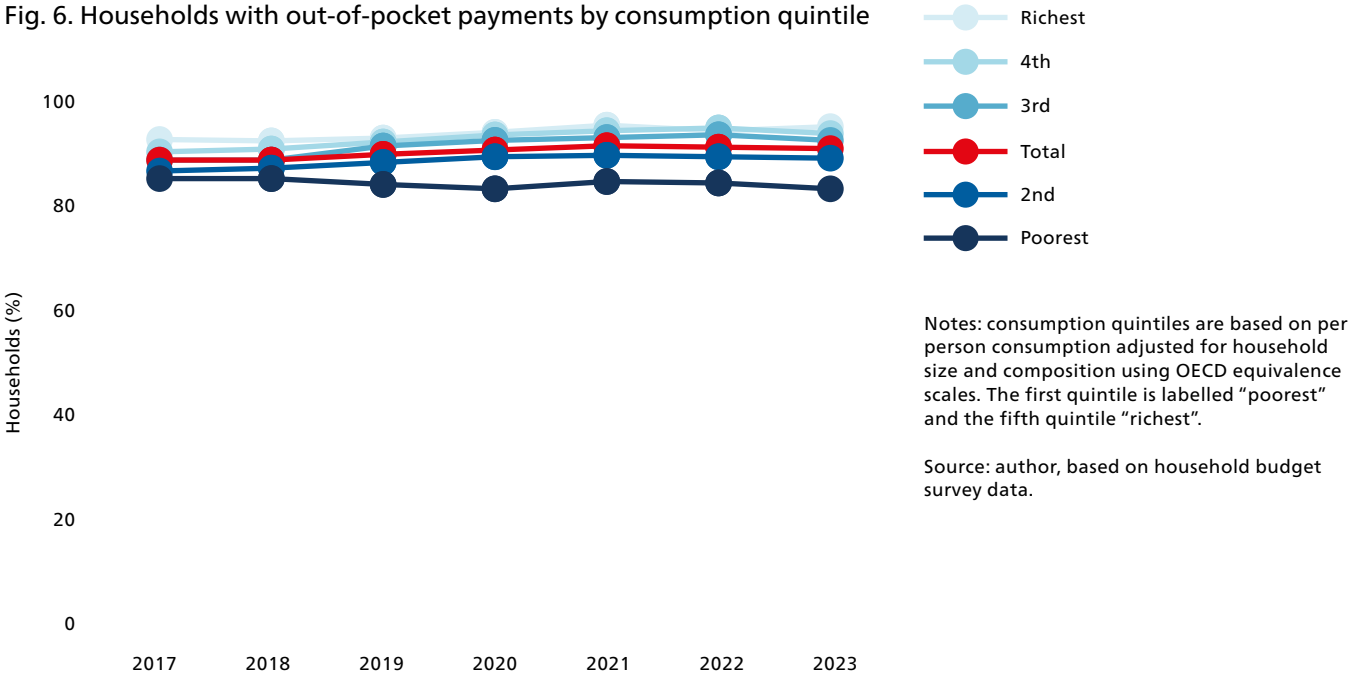
Notes: the EU average for outpatient care excludes Ireland, Italy and Portugal as these countries do not report dental care separately from other types of outpatient care. The EU average for diagnostic tests excludes Denmark, Ireland, Italy and Portugal as these countries do not report patient transport separately from ancillary services. The EU14 and EU27 averages shown here are not weighted for population size.

Source: data from health accounts (OECD, 2025).

4.2 Out-of-pocket payments

Around 90% of households reported out-of-pocket payments on average in 2023, ranging from 83% in the poorest consumption quintile to 95% in the richest (Fig. 6). These shares have not changed much over time.

Fig. 6. Households with out-of-pocket payments by consumption quintile

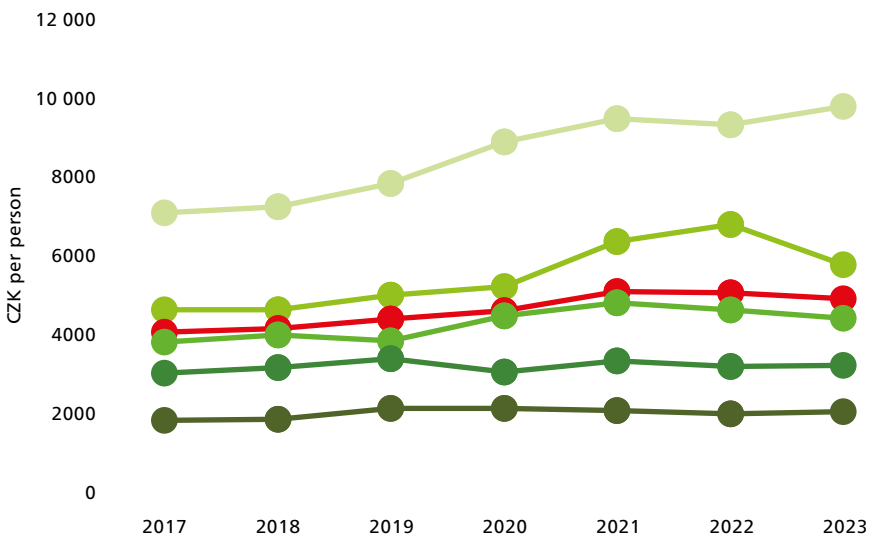


Notes: consumption quintiles are based on per person consumption adjusted for household size and composition using OECD equivalence scales. The first quintile is labelled "poorest" and the fifth quintile "richest".

Source: author, based on household budget survey data.

The average amount spent out of pocket per person was CZK 4876 in 2023, ranging from CZK 2029 in the poorest quintile to CZK 9772 in the richest (Fig. 7). The average amount spent generally increased over time in all quintiles. The slight drop in 2023 was driven by a drop in the 3rd and 4th quintiles.

Fig. 7. Annual out-of-pocket payments per person by consumption quintile

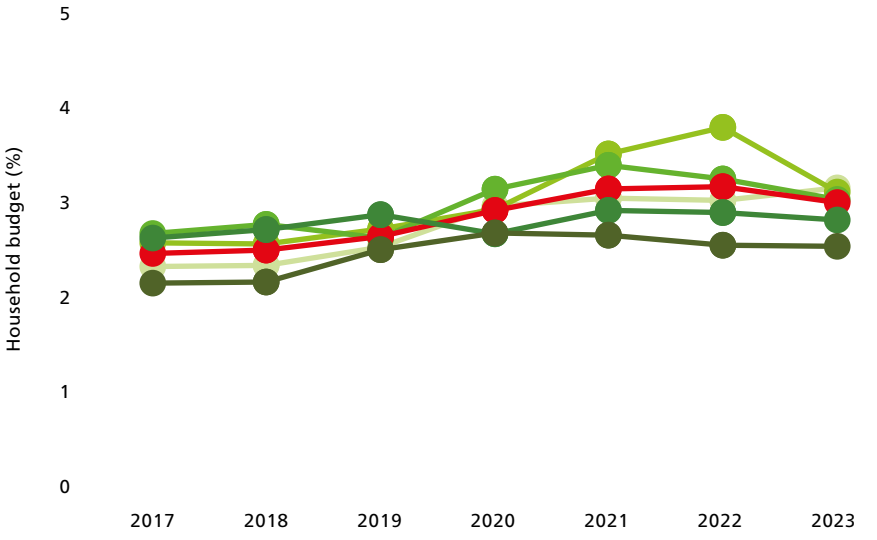


Notes: consumption quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales. Amounts are shown in real terms (base year 2020).

Source: author, based on household budget survey data.

In 2023 out-of-pocket payments accounted for 3.2% of total household spending (the household budget) on average, up from 2.6% in 2017 (Fig. 8). This share ranged from 2.7% in the poorest quintile to 3.2% in the richest (Fig. 8) and increased in all quintiles between 2017 and 2021.

Fig. 8. Out-of-pocket payments as a share of household consumption by consumption quintile

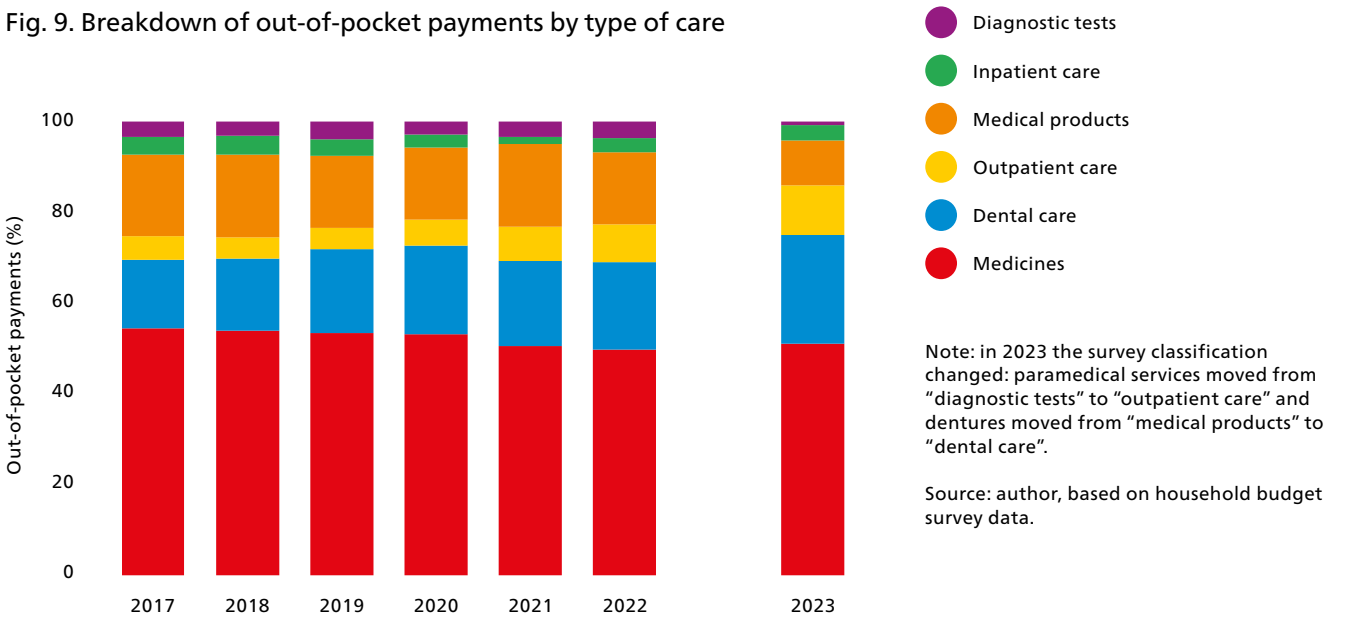


Note: consumption quintiles are based on per-person consumption, adjusted for household size and composition using OECD equivalence scales.

Source: author, based on household budget survey data.

Outpatient medicines consistently account for the largest share of out-of-pocket payments. In 2023 out-of-pocket payments were driven by spending on outpatient medicines (51%), followed by dental care (24%), outpatient care (11%) and medical products (10%) (Fig. 9). The shares spent on outpatient medicines and medical products have fallen over time as the dental care and outpatient care shares have grown. The fall in the medical products share and increase in the dental care share in 2023 reflects a change in the survey (dentures were previously classified as a medical product but are now classified as dental care).

Fig. 9. Breakdown of out-of-pocket payments by type of care

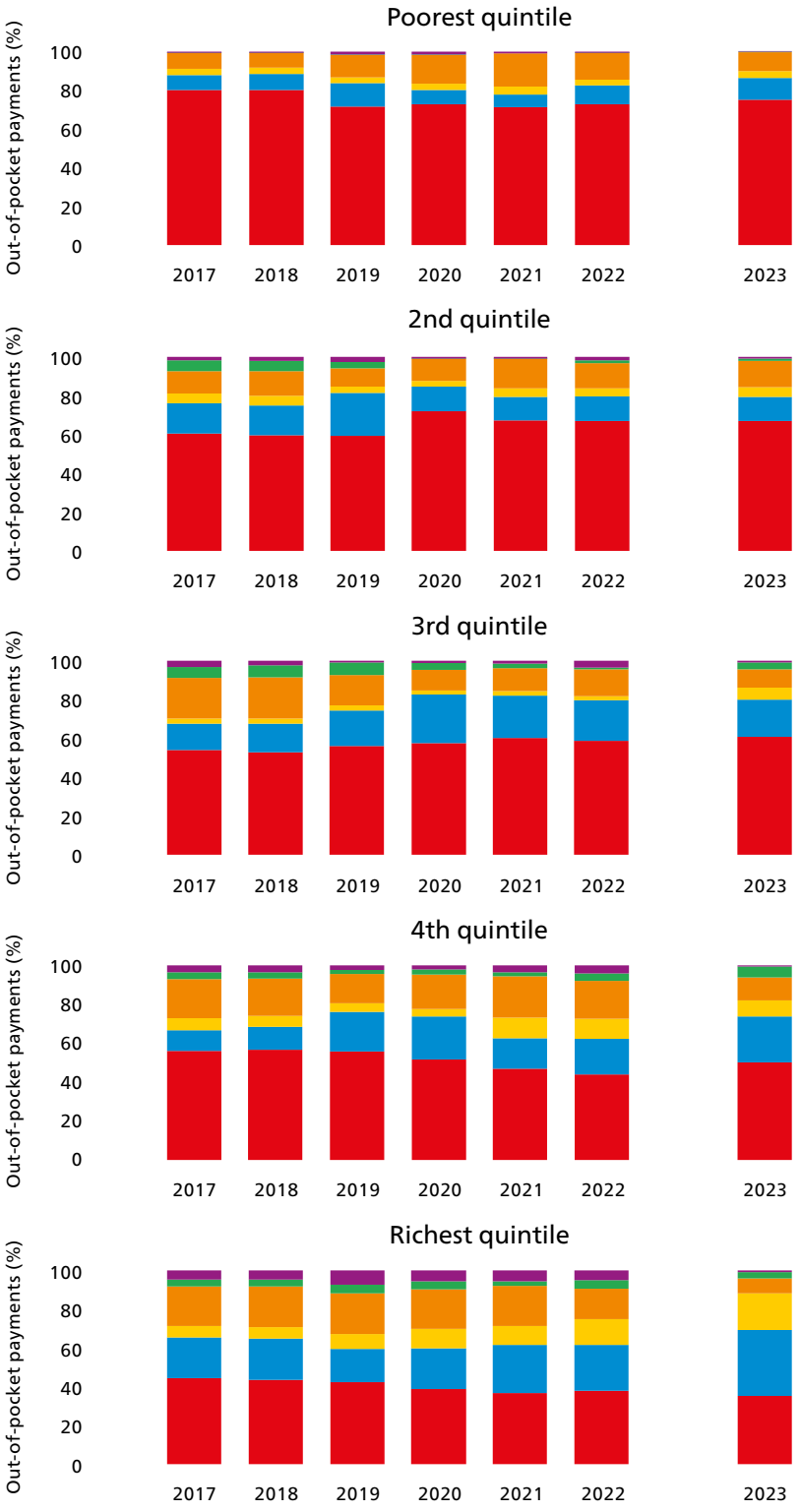


Note: in 2023 the survey classification changed: paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care".

Source: author, based on household budget survey data.

Although households with lower incomes consistently spend a much higher share of out-of-pocket payments on outpatient medicines than households with higher incomes – a pattern that is reversed for dental care – outpatient medicines are the main driver of out-of-pocket payments in all quintiles (Fig. 10). In 2023 outpatient medicines accounted for 75% of out-of-pocket payments in the poorest quintile compared to 35% in the richest quintile. During the COVID-19 pandemic the outpatient medicines share decreased in the two richest quintiles but increased in the other quintiles. The much lower share of spending on dental care in the poorest households is likely to reflect a higher degree of unmet need.

Fig. 10. Breakdown of out-of-pocket payments by type of care and consumption quintile

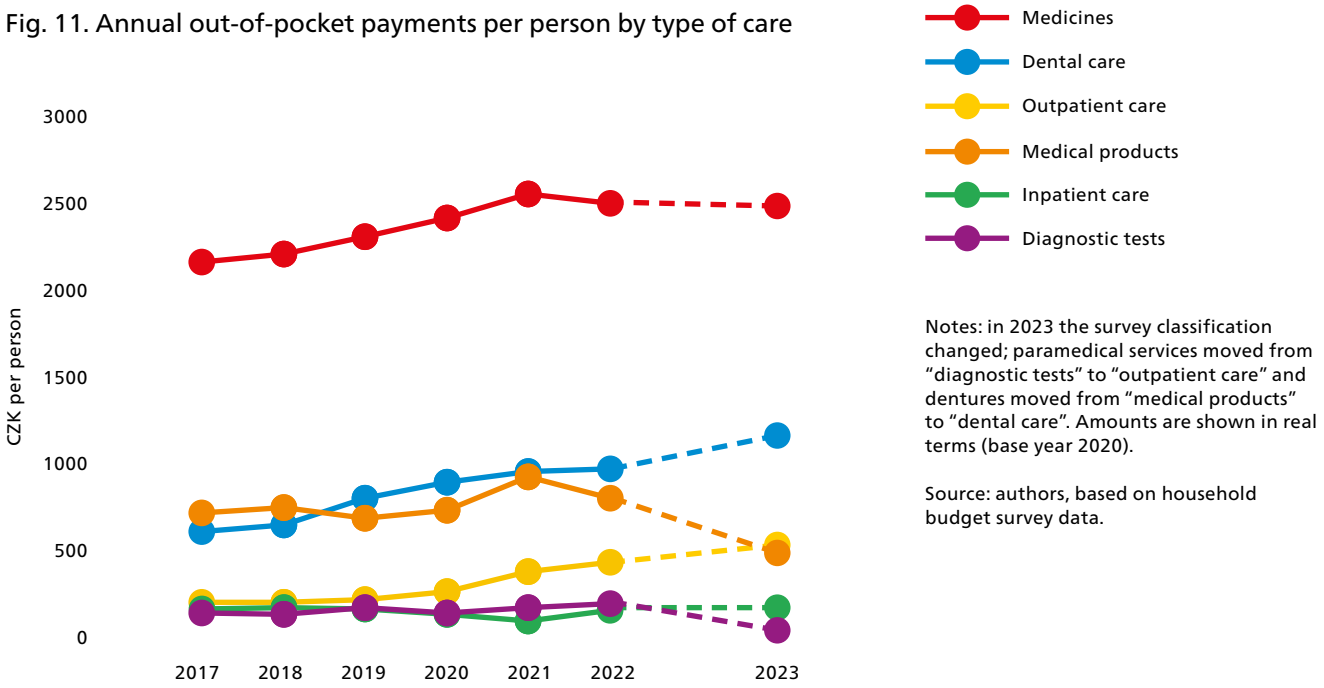


Notes: in 2023 the survey classification changed; paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care". The first quintile is labelled "poorest" and the fifth quintile "richest".

Source: author, based on household budget survey data.

Out-of-pocket payments per person generally increased over time for dental care, outpatient care and outpatient medicines (Fig. 11), mainly driven by higher spending in the richest quintile (Fig. 12).

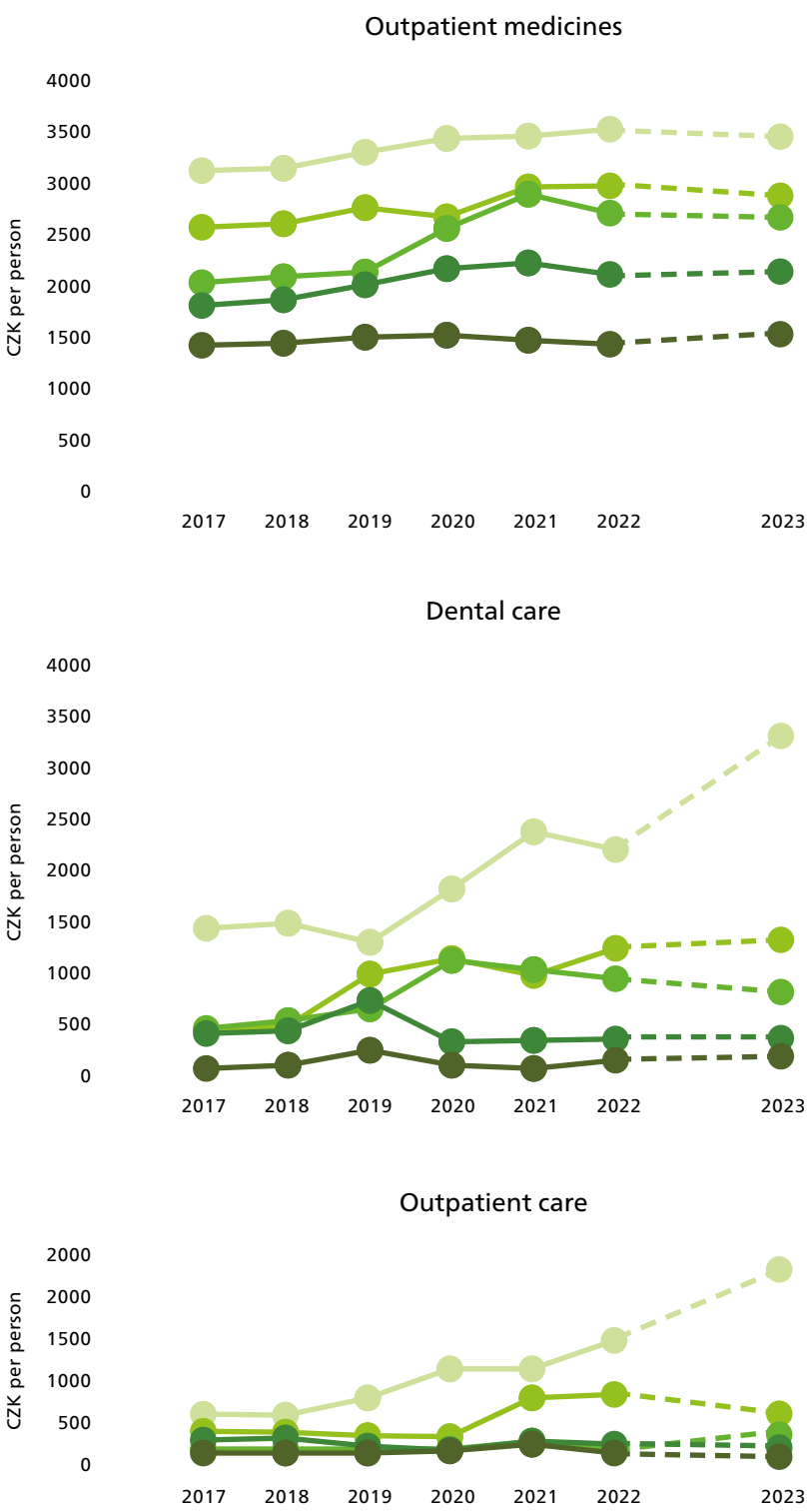
Fig. 11. Annual out-of-pocket payments per person by type of care



Notes: in 2023 the survey classification changed; paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care". Amounts are shown in real terms (base year 2020).

Source: authors, based on household budget survey data.

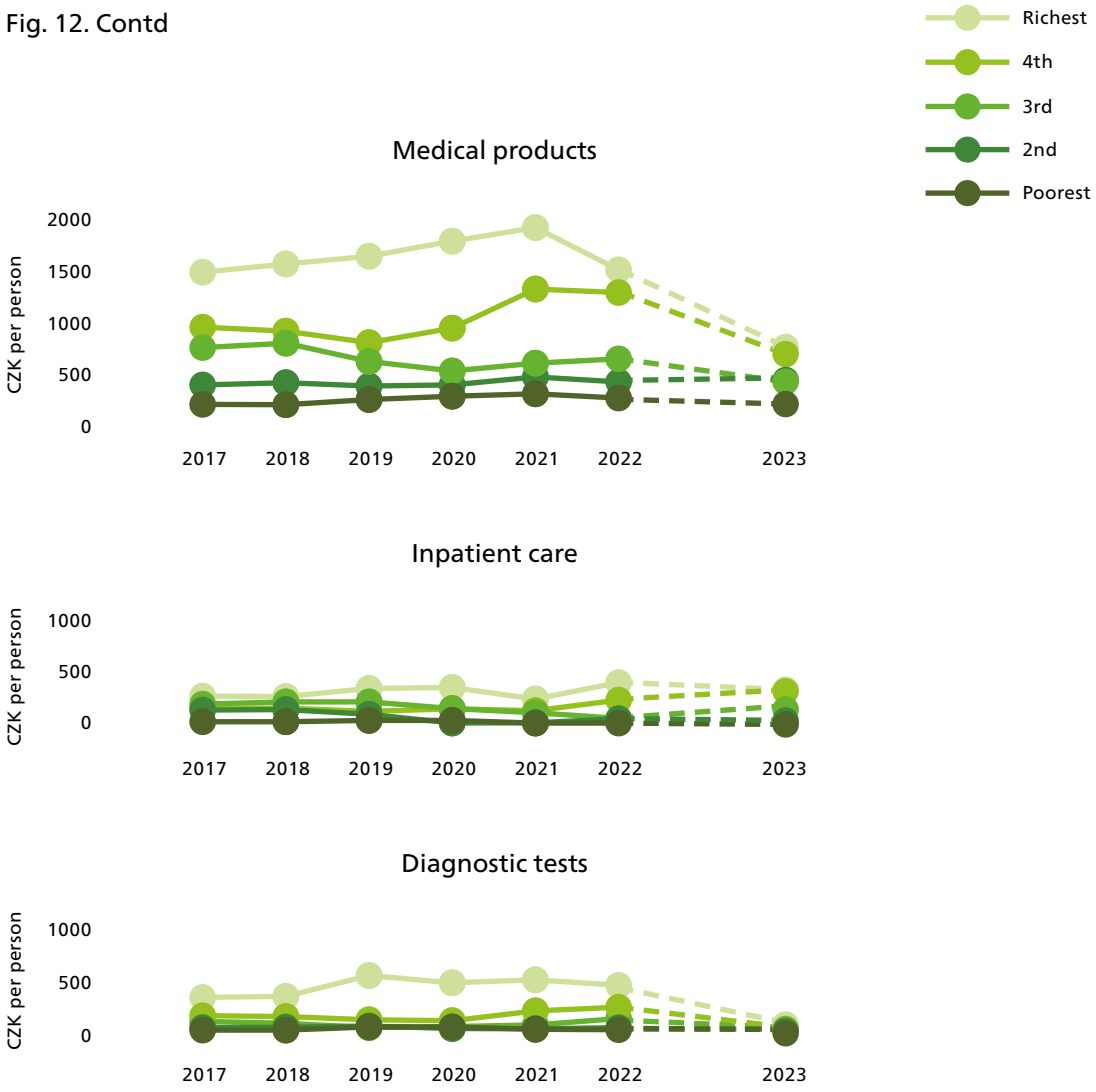
Fig. 12. Annual out-of-pocket payments per person by type of care and consumption quintile



Notes: in 2023 the survey classification changed; paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care". Amounts are shown in real terms (base year 2020).

Source: author, based on household budget survey data.

Fig. 12. Contd


Richest
4th
3rd
2nd
Poorest
Medical products
CZK per person
2000
1500
1000
500
0
2017
2018
2019
2020
2021
2022
2023
Inpatient care
CZK per person
1000
500
0
2017
2018
2019
2020
2021
2022
2023
Diagnostic tests
CZK per person
1000
500
0
2017
2018
2019
2020
2021
2022
2023

4.3 Informal payments

Informal payments reduce transparency and increase barriers to access and financial hardship. They are likely to be regressive and affect the poorest households most (Jakab, Akkazieva & Kutzin, 2016). A major challenge in health systems with pervasive informal payments is that it is difficult to introduce policies to protect people with low incomes and regular users of health care from exposure to out-of-pocket payments.

The 2024 Special Eurobarometer survey on corruption finds that 3% of respondents in Czechia who had visited a public health care provider in the previous 12 months reported informal payments (on par with the EU average of 3%) (European Commission, 2024). In the same survey, a quarter of the respondents reported having been asked for money, favours or gifts valued at more than €200. Only 28% of Czech respondents considered corruption unacceptable, however – a figure far below the EU average of 61% (European Commission, 2024).

According to Transparency International's Global Corruption Barometer, 11% of the Czech population made informal payments for health care in 2021, much higher than the EU average of 7% and most other EU countries (Transparency International, 2021).

Czech analysis suggests that informal payments are usually made for maternity care, to shorten waiting times or to see a specific doctor. In larger cities, some gynaecologists ask people to pay an annual registration fee to cover appointment scheduling and other benefits, which could be seen as a form of informal payment (Chalupová, 2025).

Informal payments are not regularly monitored and there are no policies to reduce them. However, the Ministry of Health developed a Sectoral analysis of corruption in health care as part of the Government anticorruption strategy for 2018–2022 (Ministry of Health, 2020). The Institute of Sociology of the Czech Academy of Sciences has also researched informal payments and corruption.

4.4 Summary

Data from national health accounts indicate that out-of-pocket payments in Czechia accounted for 14% of current spending on health in 2023 – lower than the EU27 average of 19% in 2022 and the EU14 average of 17% and lower than most central European countries except Slovenia (12%) and Croatia (9%).

The out-of-pocket payment share was relatively stable between 2010 and 2019. In 2022 public spending on health accounted for 7.5% of GDP in Czechia, higher than the EU27 average (6.7%) but lower than the EU14 average (7.8%). This is due to a relatively high "priority to health" in Czechia: public spending on health accounted for 17% of total government spending in 2022, above the EU27 average (15%) and the EU14 average (16%).

Broken down by type of care, the out-of-pocket payment share of current spending on health in Czechia is highest for medical products, dental care and outpatient medicines and higher than the EU14 average, particularly for outpatient medicines and dental care. The share for outpatient medicines is also above the EU27 average.

Around 90% of households reported out-of-pocket payments on average in 2023, ranging from 83% in the poorest consumption quintile to 95% in the richest. These shares have not changed much over time.

The richest households spend over four times more than the poorest households on health care on average but out-of-pocket payments impose a relatively heavy financial burden on poorer households. In 2023 out-of-pocket payments accounted for 2.7% of a household's budget in the poorest quintile and 3.2% in the richest. These shares generally grew over time.

Outpatient medicines consistently account for the largest share of out-of-pocket payments, followed by dental care. Poorer households spend a much higher share on outpatient medicines, while richer households spend a higher share on dental care.

Informal payments are an issue in Czechia, particularly in maternity care, where they are used to shorten waiting times or see a specific doctor. However, they are not systematically monitored and there are no policies in place to address them.

5. Financial protection

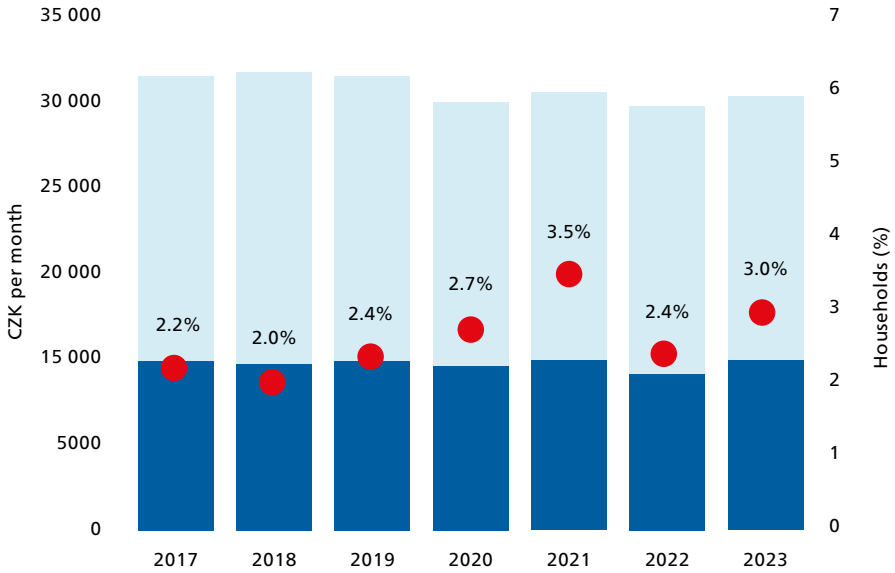
This section uses data from the Czech household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households that use health care. It looks at household capacity to pay for health care, the relationship between out-of-pocket spending on health and poverty – impoverishing health spending – and the incidence, distribution and drivers of catastrophic health spending. The section also draws on other survey data to assess unmet need for health care. See the indicator explorer on UHC watch to access and download the data for most of the figures in this chapter (UHC watch, 2025).

5.1 Household capacity to pay for health care

Household capacity to pay for health care is what is left of a household's budget after spending on basic needs. In this study, basic needs are defined as the average cost of spending on food, housing and utilities (water, electricity and fuel) among a relatively poor part of the Czech population (households between the 25th to 35th percentiles of the consumption distribution), adjusted for household size and composition. In 2023 the monthly cost of meeting these basic needs (the basic needs line) was CZK 11 549, which was low compared to Czech's monthly national poverty line of CZK 16 774 in 2023 (42.4% of median income) (Czech Statistical Office, 2024).

On average household capacity to pay for health care fell in 2020 in response to the COVID-19 pandemic and was lower in 2023 than it had been in 2017 (Fig. 13). The share of households living below the basic needs line rose steadily from 2.0% in 2018 to 3.5% in 2021 before falling in 2022 (Fig. 13).

Fig. 13. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic-needs line

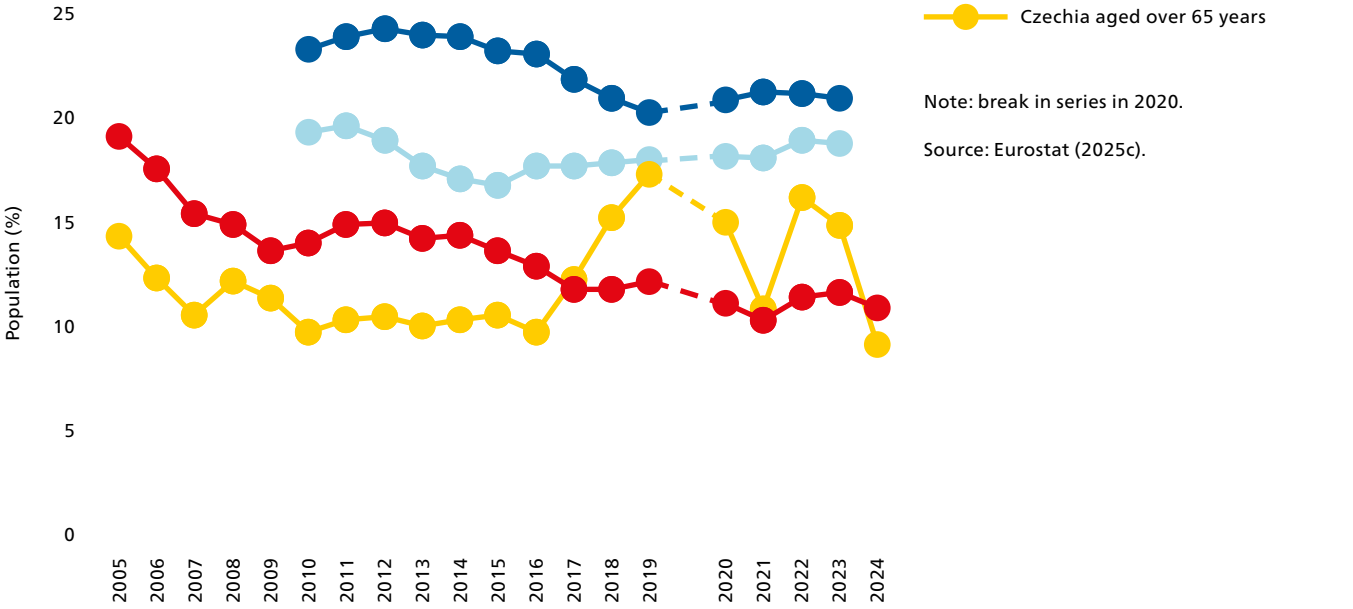


Notes: capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. Amounts are shown in real terms (base year 2020).

Source: author, based on household budget survey data.

The share of the population at risk of poverty or social exclusion is low on average in Czechia compared to the EU average (Fig. 14). However, poverty rates are higher than average among older people in Czechia yet still lower than the EU average. Although the rate has been increasing in this population age since 2016, it has dropped twice; in 2020–2021 during the COVID-19 pandemic and in 2023–2024 (Fig. 14).

Fig. 14. Population at risk of poverty or social exclusion by age in Czechia and the EU



Note: break in series in 2020.

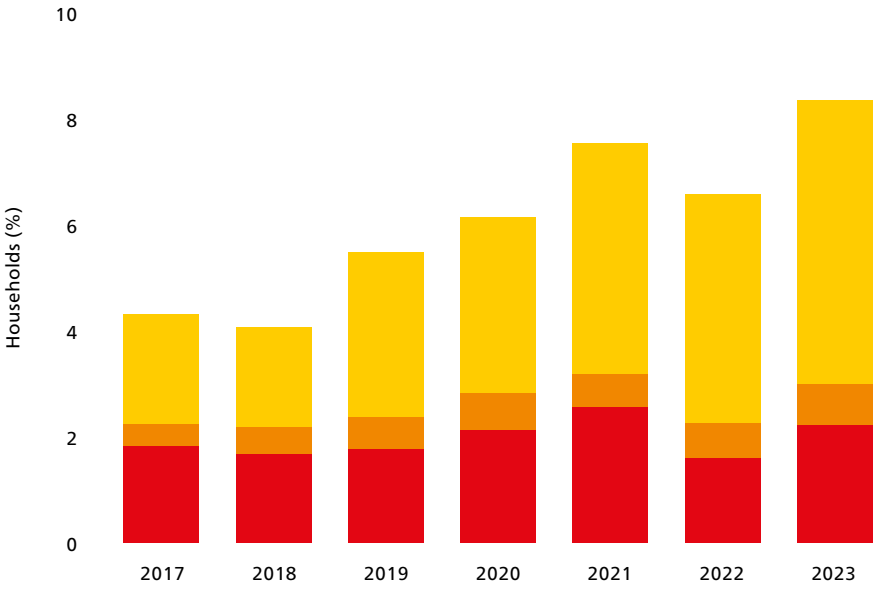
Source: Eurostat (2025c).

5.2 Financial hardship

How many households experience financial hardship?

Impoverishing health spending is defined in this study as out-of-pocket payments that push people into poverty or deepen their poverty. In 2023 3% of households were impoverished or further impoverished after out-of-pocket payments, up from 2.2% in 2017 (Fig. 15). This share rose steadily between 2018 and 2021 and again in 2023. The share of households at risk of impoverishment more than doubled over time, rising from around 2% in 2018 to just over 5% in 2023 (Fig. 15).

Fig. 15. Households at risk of impoverishment after out-of-pocket payments



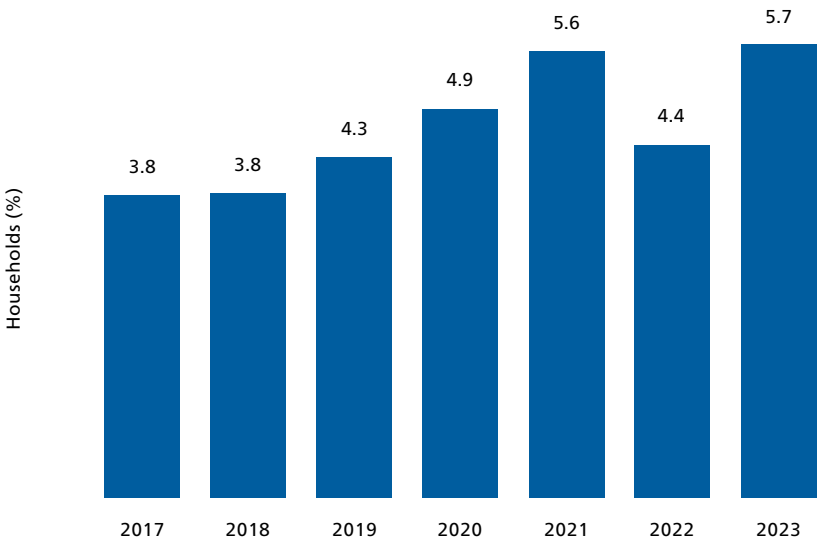
Notes: a household is impoverished if its total spending falls below the basic-needs line after out-of-pocket payments; further impoverished if its total spending is below the basic-needs line before out-of-pocket payments; and at risk of impoverishment if its total spending after out-of-pocket payments comes within 120% of the basic-needs line.

Source: author, based on household budget survey data.

Households with catastrophic levels of out-of-pocket spending are defined (in this review) as those who spend more than 40% of their capacity to pay for health care. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they had no capacity to pay before paying out of pocket for health care).

In 2023 5.7% of households – around 600 000 people – experienced catastrophic health spending, up from 3.8% in 2017 (Fig. 16). This share rose steadily between 2018 and 2021 and again in 2023.

Fig. 16. Households with catastrophic health spending



Note: households with catastrophic health spending are households with out-of-pocket payments that are greater than 40% of their capacity to pay for health care, which may mean that they can no longer afford to meet other basic needs (food, housing and utilities).

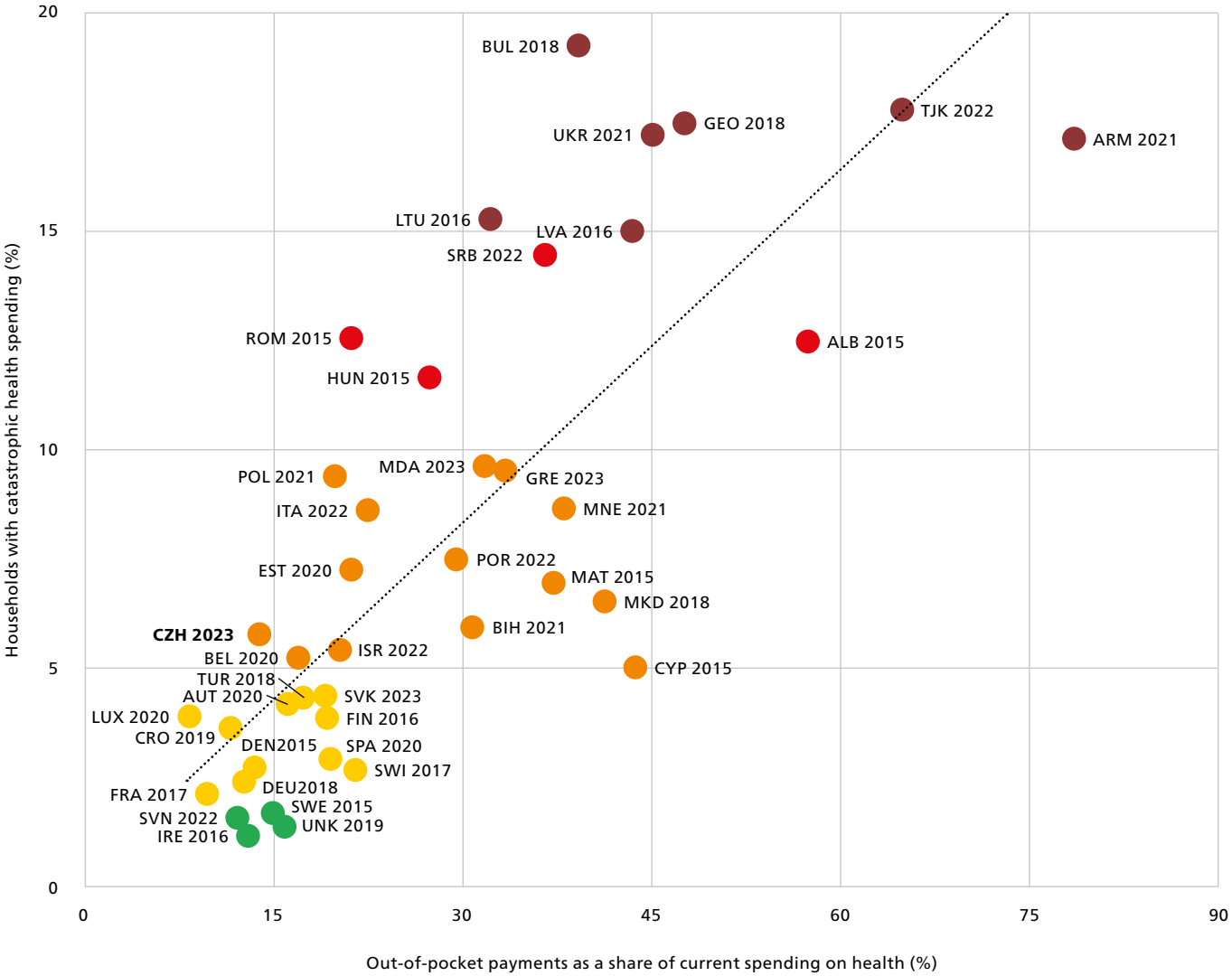
Source: author, based on household budget survey data.

The incidence of catastrophic health spending is lower in Czechia than in many EU countries (Fig. 17). However, it is higher than in several countries with a similar degree of reliance on out-of-pocket payments to finance the health system (Fig. 17).

Fig. 17. Households with catastrophic health spending and out-of-pocket payments as a share of current spending on health in the WHO European Region, latest available year

Notes: data on catastrophic health spending and out-of-pocket payments are for the same year, except for Greece, the Republic of Moldova and Slovakia where out-of-pocket payments are for 2022. Dots are coloured by the incidence of catastrophic health spending: green < 2%, yellow < 5%, orange < 10%, red < 15%, dark red > 15%.

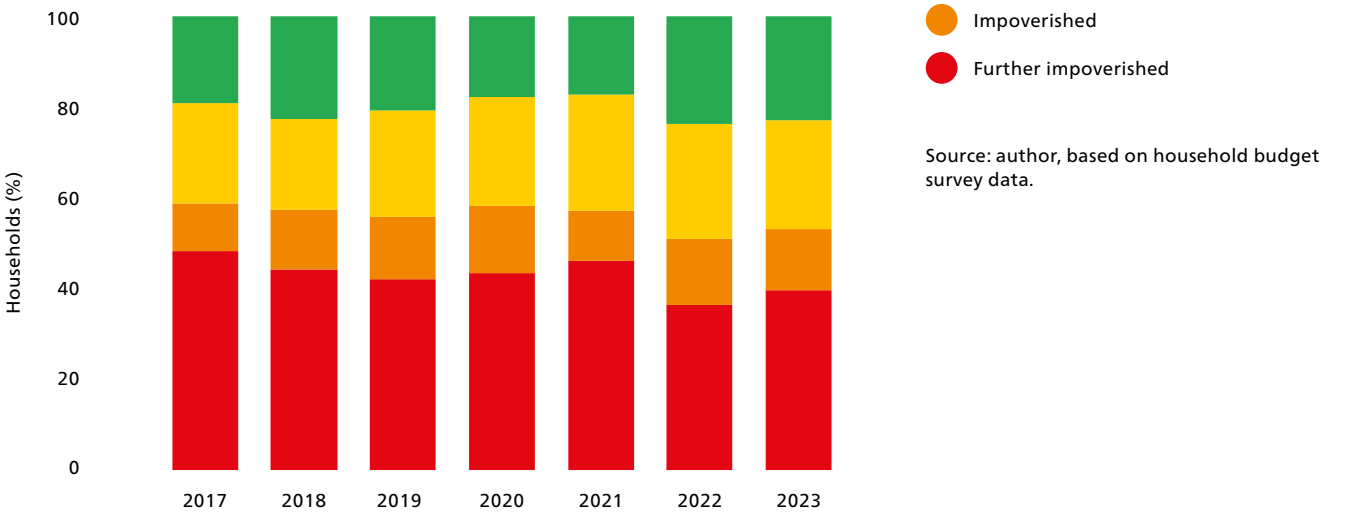
Source: UHC watch (2025) and WHO (2025) for data on out-of-pocket payments.



Who experiences financial hardship?

Most households with catastrophic health spending are further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments (Fig. 18). In 2023 further impoverished households accounted for 40% of households with catastrophic health spending, down from 48% in 2017.

Fig. 18. Breakdown of households with catastrophic health spending by risk of impoverishment

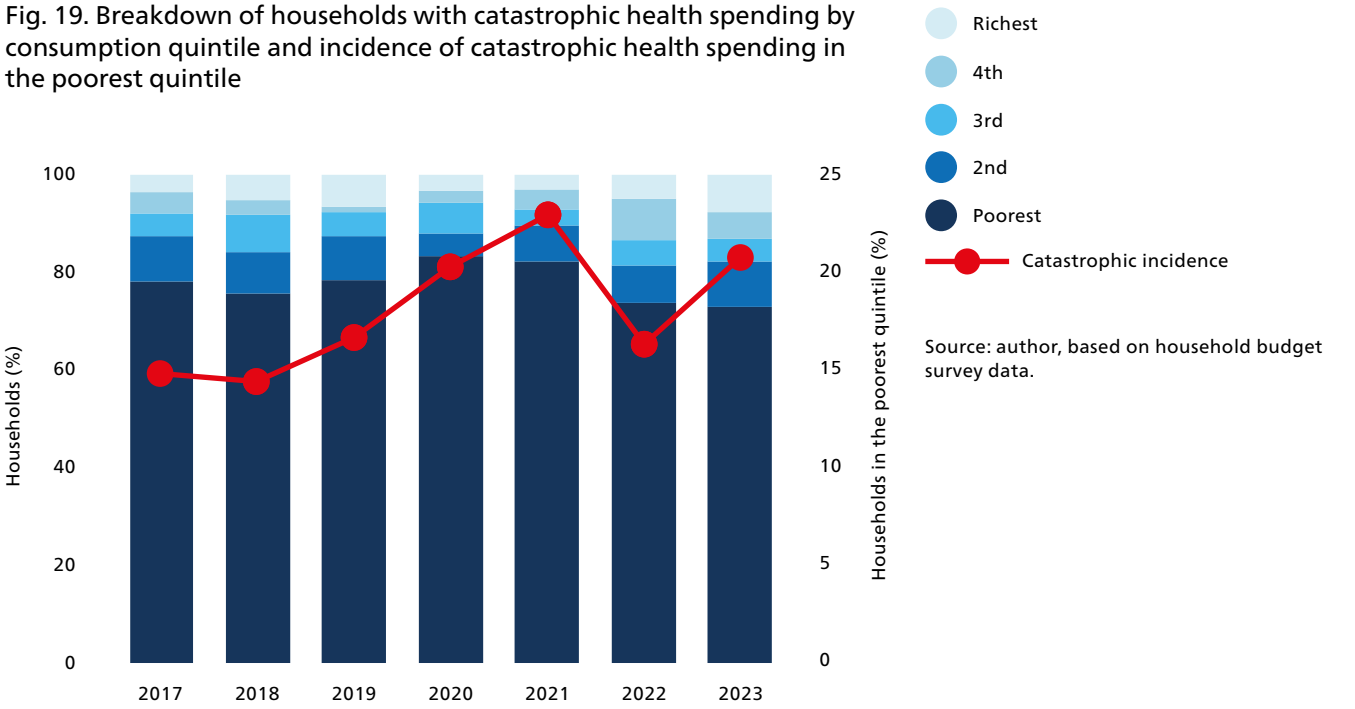


Source: author, based on household budget survey data.

Households experiencing catastrophic health spending are consistently heavily concentrated in the poorest consumption quintile (Fig. 19). The share of households with catastrophic health spending in the poorest quintile rose to around 83% in 2020 and 2021 before falling to around 73% in 2022 and 2023.

In 2023 21% of households in the poorest quintile experienced catastrophic health spending (Fig. 19), compared to around 2% in the other quintiles (data not shown). The incidence of catastrophic health spending in the poorest quintile rose sharply from 14% in 2018 to 23% in 2021 before dropping to 16% in 2022 (Fig. 19).

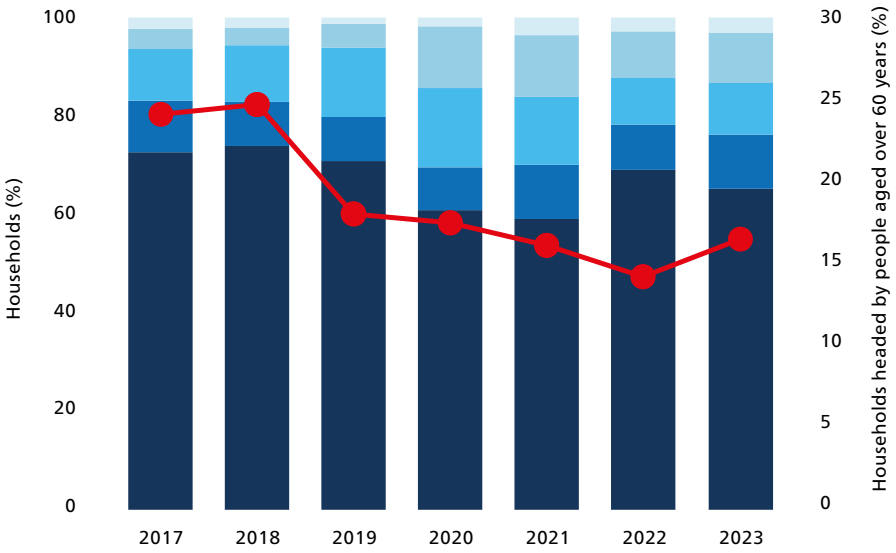
Fig. 19. Breakdown of households with catastrophic health spending by consumption quintile and incidence of catastrophic health spending in the poorest quintile



Source: author, based on household budget survey data.

Looked at by age and occupational status, catastrophic health spending is heavily concentrated in households headed by older people (Fig. 20) and pensioners (data not shown) and the incidence of catastrophic health spending is also generally much higher than average in households headed by older people (16.5% in 2023; Fig. 19) or pensioners (11.6%; data not shown). This indicates that older people are at relatively high risk of experiencing financial hardship due to out-of-pocket payments, probably reflecting higher levels of health care use and poverty than younger households (see Fig. 14).

Fig. 20. Breakdown of households with catastrophic health spending by age of the head of the household and incidence of catastrophic health spending in households headed by older people

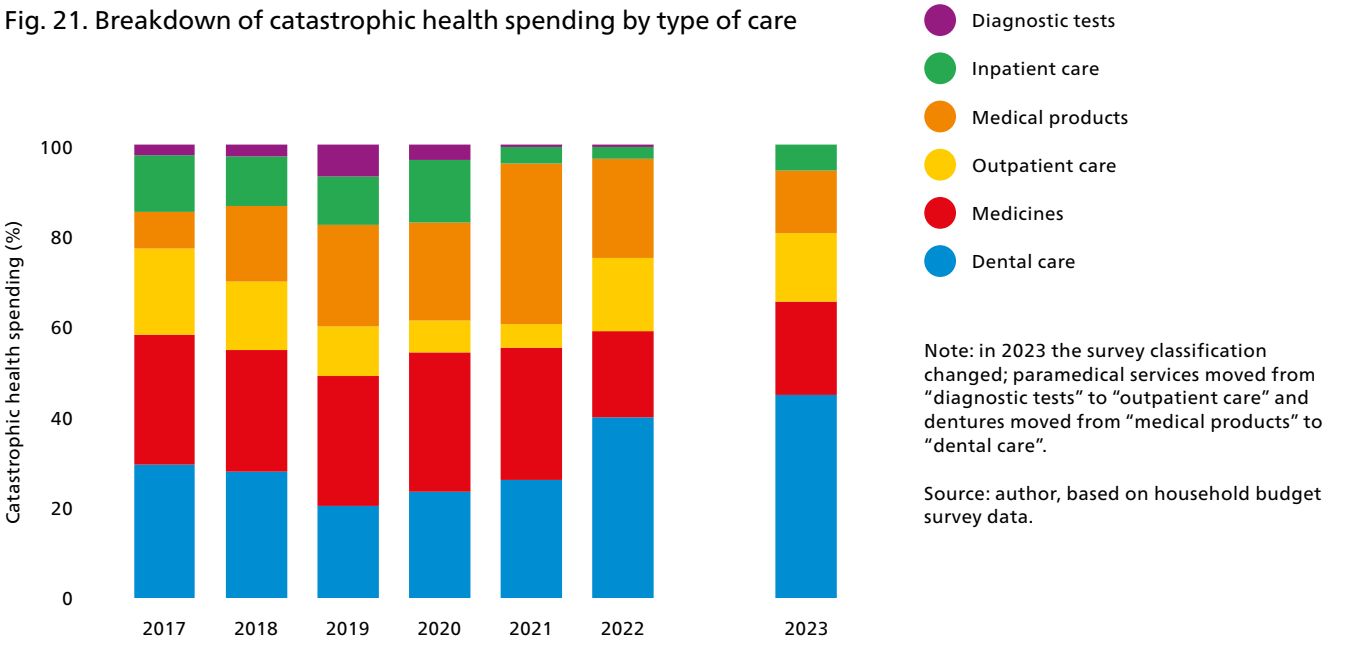


Source: author, based on household budget survey data.

Which health services are responsible for financial hardship?

In 2023 catastrophic health spending was on average driven mainly by dental care (45%), followed by outpatient medicines (21%), outpatient care (15%) and medical products (14%) (Fig. 21). Over time the share spent on outpatient medicines and outpatient care declined and the share spent on dental care and medical products increased.

Fig. 21. Breakdown of catastrophic health spending by type of care

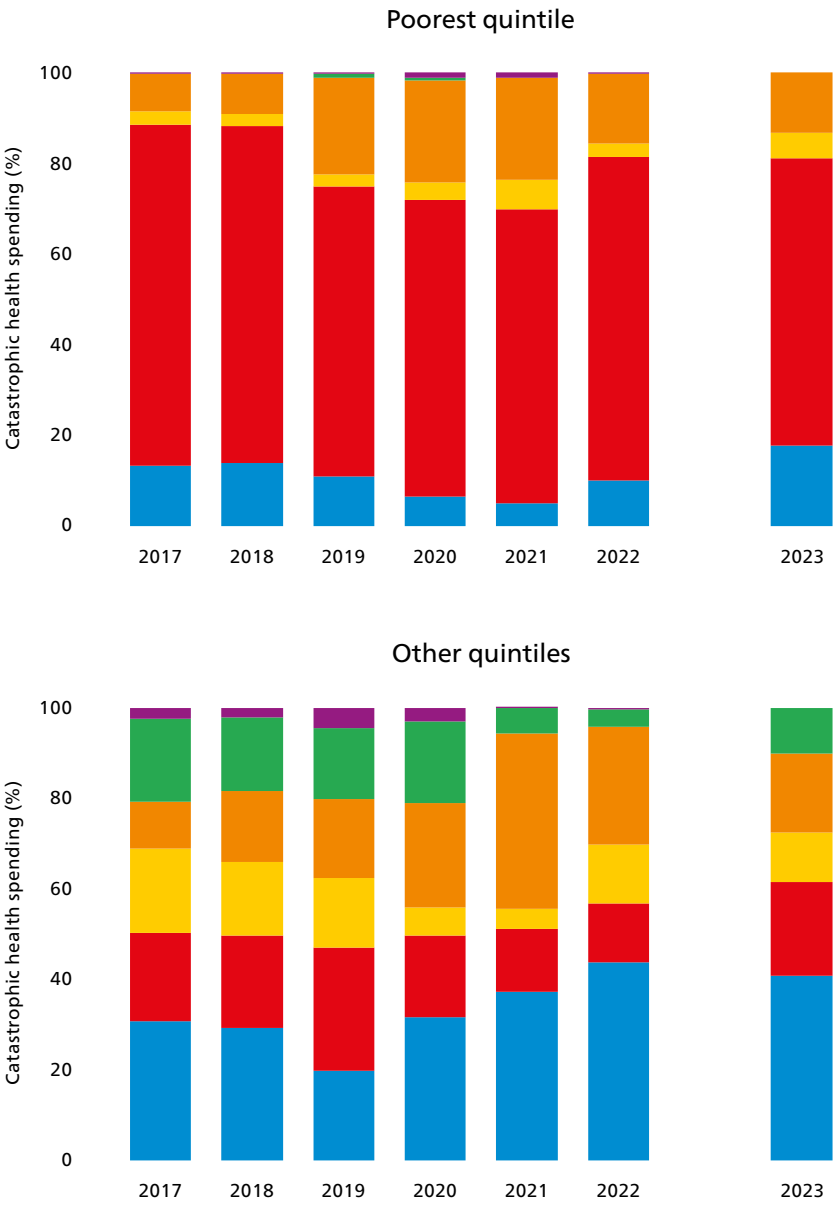


Note: in 2023 the survey classification changed; paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care".

Source: author, based on household budget survey data.

In the poorest quintile, however, outpatient medicines are consistently the largest driver of catastrophic health spending (63% in 2023), followed by dental care (18%) and medical products (13%) (Fig. 22). Dental care is the main driver in the other quintiles (41% in 2023).

Fig. 22. Breakdown of catastrophic health spending by type of care and consumption quintile



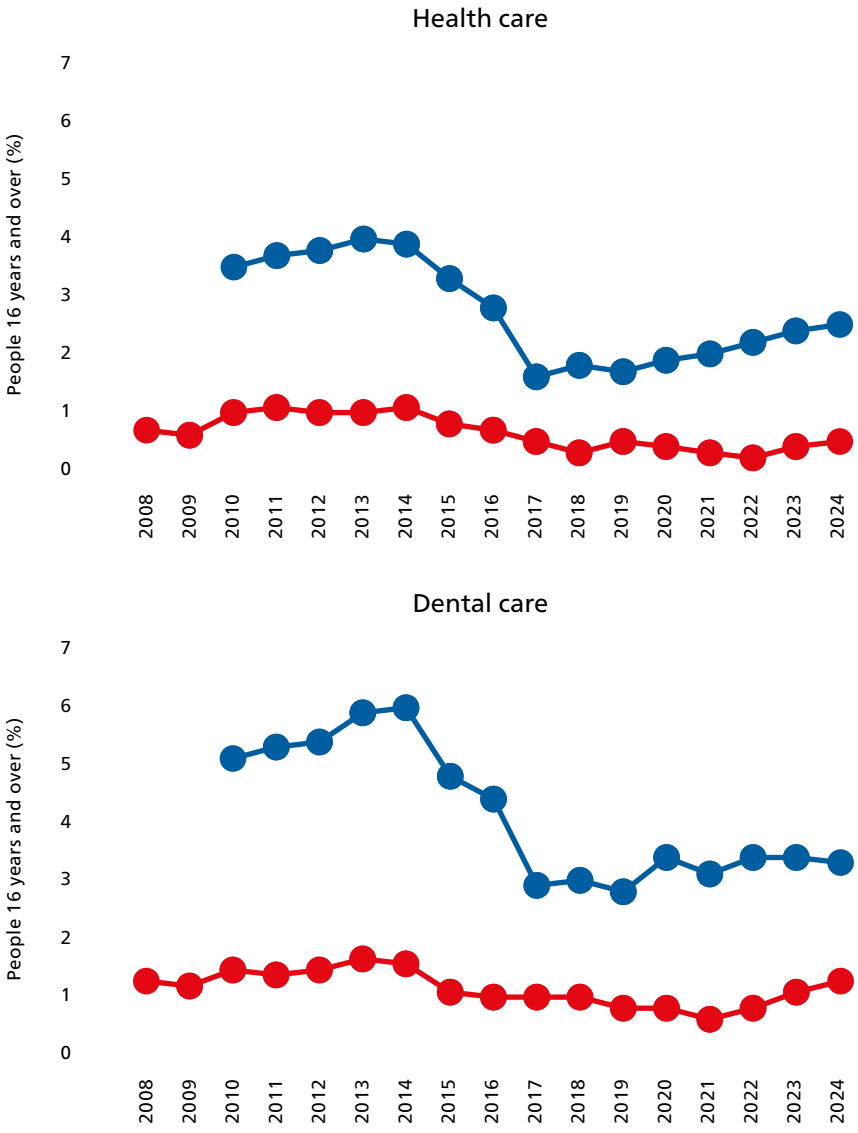
Notes: in 2023 the survey classification changed; paramedical services moved from "diagnostic tests" to "outpatient care" and dentures moved from "medical products" to "dental care". Results for the other quintiles are based on a relatively small number of observations (households) and should be interpreted with caution.

Source: author, based on household budget survey data.

5.3 Unmet need for health care

EU-SILC data on unmet need (see Box 1) due to cost, distance or waiting time show that unmet need for health care and dental care is consistently below the EU average in Czechia, particularly for health care (Fig. 23). Although unmet need for both types of care had been falling in Czechia, it has grown again in the last few years (Fig. 24). Waiting time is the main driver of unmet need for health care in Czechia, and cost is the main driver of unmet need for dental care.

Fig. 23. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, Czechia and the EU

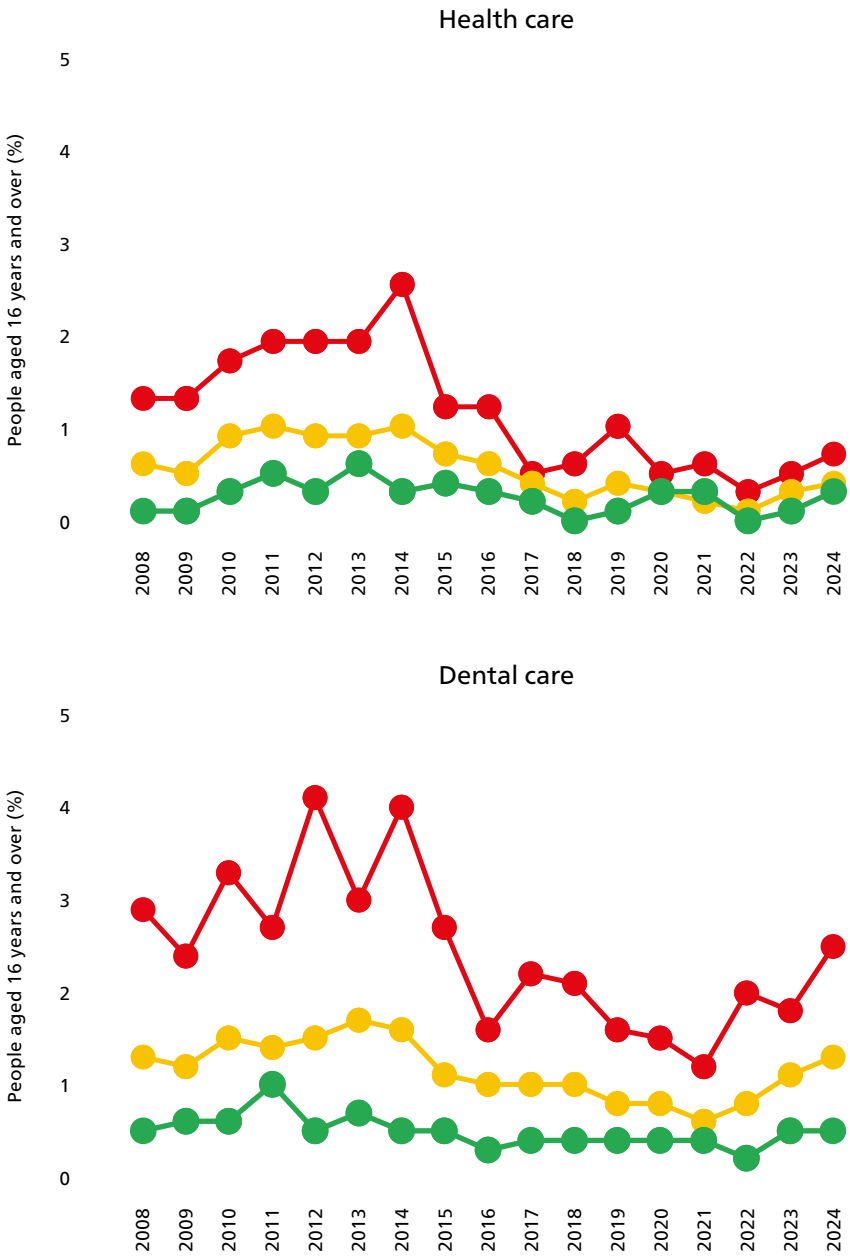


Note: the EU-SILC denominator for unmet need is people aged 16 and over.

Source: EU-SILC data from Eurostat (2025c).

There is significant income inequality in unmet need for dental care. After falling for several years, income inequality in dental care has grown again in the last four years (Fig. 24).

Fig. 24. Income inequality in self-reported unmet need for health care and dental care due to cost, distance and waiting time

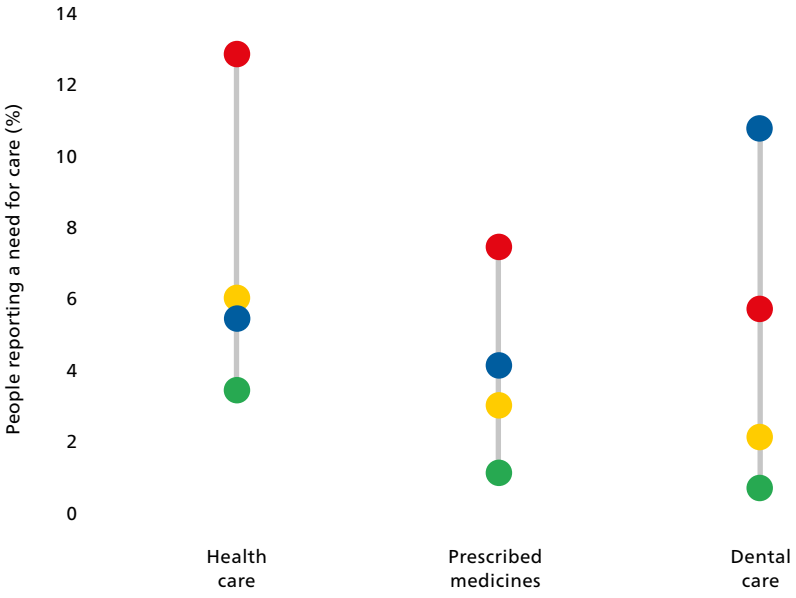


Notes: the EU-SILC denominator for unmet need is people aged 16 and over. Quintiles are based on income.

Source: EU-SILC data from Eurostat (2025c).

EHIS data from 2019 (the latest available year) show that unmet need due to cost was below the EU average in Czechia for dental care and prescribed medicines and just above it for health care (Fig. 25). In 2019 income inequality in unmet need due to cost was substantial for all three types of care, however, and particularly so for dental care and prescribed medicines.

Fig. 25. Income inequality in self-reported unmet need for health care, prescribed medicines and dental care due to cost, Czechia and the EU, 2019



EU27 total
Czechia poorest quintile
Czechia total
Czechia richest quintile

Notes: the EHIS denominator for unmet need is people aged 15 and over reporting need for care. Quintiles are based on income.

Source: EHIS data from Eurostat (2025c).

5.4 Summary

In 2023 3% of households were impoverished or further impoverished after out-of-pocket payments, up from 2% in 2017.

In the same year 5.7% of households – around 600 000 people – experienced catastrophic health spending, up from 3.8% in 2017. This share rose steadily between 2018 and 2021 and again in 2023.

The incidence of catastrophic health spending is lower in Czechia than in many EU countries but it is higher than in several countries with a similar degree of reliance on out-of-pocket payments to finance the health system.

Catastrophic health spending is heavily concentrated in the poorest quintile. In 2023 21% of households in the poorest quintile experienced catastrophic health spending (compared to around 2% in the other quintiles) and this share grew steadily from 14% in 2018 to 23% in 2021.

Looked at by age and occupational status, catastrophic health spending is heavily concentrated in households headed by older people and pensioners. The incidence of catastrophic health spending is also generally much higher than average in households headed by older people (16.5% in 2023) or pensioners (11.6%). This indicates that older people are at relatively high risk of experiencing financial hardship due to out-of-pocket payments, probably reflecting higher levels of health care use and poverty than younger households.

Catastrophic health spending is driven, on average, by out-of-pocket payments for dental care, outpatient medicines, outpatient care and medical products. In the poorest quintile, however, it is consistently heavily driven by outpatient medicines. Dental care is the main driver in the other quintiles.

EU-SILC data show that unmet need for health care and for dental care is consistently well below the EU average in Czechia, particularly for health care, but has been growing in recent years. Unmet need is mainly driven by waiting time for health care and cost for dental care. Income inequality in unmet need is significant for dental care; it had been falling but has grown in the last four years.

EHIS data from 2019 show that unmet need due to cost was below the EU average in Czechia for dental care and prescribed medicines and just above it for health care (Fig. 25). Income inequality in unmet need due to cost was substantial for all three types of care, however, and particularly so for dental care and prescribed medicines.

6. Factors that strengthen and undermine financial protection

This section considers factors within the health system that may be responsible for financial hardship caused by out-of-pocket payments in Czechia and which may explain the trend over time.

6.1 Coverage policy

Coverage policy in Czechia has notable strengths that offer examples of good practice to other countries:

- entitlement to SHI benefits is based on permanent residence rather than being linked to payment of mandatory SHI contributions; people who fail to pay their SHI contributions incur a debt that must be repaid but do not lose their entitlement to SHI benefits – an example of good practice to many other countries with SHI schemes: as a result the SHI scheme is likely to cover all eligible people; and

- co-payments are not widely used in the health system; when they are used, there are no percentage co-payments and there are mechanisms in place to protect some people (mainly children and older people).

Gaps in coverage remain, however, and help to explain why:

- the incidence of catastrophic health spending is much higher than average (6%) in the poorest households (where it has grown over time, rising from 14% in 2018 to 23% in 2021 and 21% in 2023) and in households headed by older people (16%; see Fig. 19 and Fig. 20);

- catastrophic health spending is mainly driven by out-of-pocket payments for outpatient medicines, dental care and medical products (see Fig. 21) – a finding that is underlined by health accounts data showing that Czechia relies more on out-of-pocket payments than the EU14 average to finance spending on these types of care (see Fig. 5); outpatient care is also a driver of catastrophic health spending but mainly in the richer quintiles; and

- unmet need for health care and dental care and income inequality in unmet need for dental care have been growing in recent years (see Fig. 24); there is also substantial income inequality in unmet need for prescribed medicines (see Fig. 25).

The following paragraphs discuss the main drivers of catastrophic health spending in turn, starting with the smaller drivers.

Catastrophic health spending on **outpatient care** may reflect gaps in service coverage leading to waiting times and informal payments. Waiting times are an issue in outpatient specialist paediatric care due to a shortage of paediatricians. Although waiting time targets are in place, they are not guaranteed because they are not systematically monitored. Informal payments are not systematically monitored either but there is some evidence to suggest that they are an issue (see section 4.3) and typically occur in maternity care to shorten waiting times or see a specific doctor.

Extra billing for non-clinical services (e.g. scheduling appointments at specific times or sending people text message reminders) also results in out-of-pocket payments, particularly in larger cities.

User charges for outpatient care are limited to visits to the emergency department and the fixed co-payment is relatively low (CZK 90 per visit that does not result in admission to hospital – around €4.05 in purchasing power parities). Although people with very low incomes are exempt from these co-payments, some may face administrative barriers to proving their exemption status and end up paying out of pocket (see section 3.3).

These issues affecting the accessibility of outpatient care may also be reflected in the above average unmet need for health care in the poorest quintile.

Catastrophic health spending driven by **medical products** reflects gaps in the benefits package, particularly for adults, and user charges. Coverage of corrective lenses is limited to children and people with specific conditions. At the same time, all covered medical products are subject to balance billing and there are no exemptions from these out-of-pocket-payments, not even for people with low incomes. There are no data on unmet need for medical products.

Although **dental care** is covered and available without user charges, it is limited in scope and in terms of the materials covered and many dentists do not offer covered services or use covered materials. As a result, many households are likely to pay out of pocket for covered and non-covered dental care. A lack of dentists in border areas is also an issue. Income inequality in unmet need for dental care, which has grown in recent years, may explain why dental care is less of a driver of catastrophic health spending in the poorest quintile than in richer quintiles (see Fig. 23).

Outpatient medicines are the overwhelming driver of catastrophic health spending in the poorest quintile and the second-largest driver in the other quintiles (see Fig. 23). There is also substantial income inequality in unmet need for prescribed medicines (see Fig. 25). At first glance this evidence is puzzling because:

- all those eligible for SHI coverage are likely to be covered because even people who do not pay mandatory contributions continue to have access to all SHI benefits;
- undocumented migrants, who are not eligible for coverage, account for a very small share of the population (0.1% in 2023);
- there do not seem to be issues with the scope of the benefits package for outpatient medicines;
- user charges are limited to reference pricing and there is one fully covered medicine in each reference group (i.e. without any co-payment);
- there is a cap on some avoidable co-payments arising from reference pricing; and

- this cap is lower (more protective) for children, people with disabilities and older people (see Table 3).

It is evident, however, that there are gaps in coverage and other issues affecting affordable access to outpatient medicines, not only because of data on catastrophic health spending and unmet need, but also because health accounts data show that out-of-pocket payments accounted for 44% of all spending on outpatient medicines in Czechia in 2022, which was well above the EU27 average of 39% and the EU14 average of 33% (see Fig. 5). Although health accounts data suggest that 57% of out-of-pocket payments in 2022 were for medicines sold over the counter, this figure needs to be interpreted with caution: it may include some prescribed medicines sold over the counter and, as with all health accounts data, there is no disaggregation by household income.

There is likely to be a higher than desirable prevalence of "avoidable co-payments" for outpatient prescribed medicines – out-of-pocket payments that would have been avoided if prescribers, pharmacists and patients had all opted for the outpatient medicine in each reference group that is fully covered and should be available without any co-payment. This could be due to the following issues with the design and implementation of reference pricing for outpatient medicines.

- **Some aspects of the design of the reference groups may encourage "avoidable co-payments".**

- **Before 2025 there was no mandatory INN prescribing or mandatory generic substitution to reduce "avoidable co-payments".** As a result, doctors often prescribed branded medicines and pharmacists did not always offer patients lower-priced alternatives (Czech Chamber of Pharmacists, 2013). Mandatory INN prescribing and mandatory generic substitution were introduced in January 2025 and should reduce the number of medicines dispensed with "avoidable co-payments". However, GPs are still allowed to indicate that some prescriptions should be paid fully out of pocket if they want to bypass volume controls or if patients insist on a particular medicine.

- **There is no exemption from "avoidable co-payments" for people with low incomes.** People with very low incomes are exempt from co-payments for emergency care but not from other co-payments.

- **Although there is a cap on "avoidable co-payments", it does not cover all co-payments, which undermines transparency.** The cap applies only to the cheapest available version of a not fully covered medicine in the same reference group. If a more expensive alternative is selected, any co-payments paid do not count towards the cap (VZP, 2022a). This might make it harder for people to know if they have reached the cap.

- **The cap was not applied automatically before 2025.** Before 2025 people did not stop paying co-payments once they reached the cap and would have to be retrospectively reimbursed for any eligible co-payments above the cap on a quarterly or annual basis (Bryndová et al., 2023). From 2025 pharmacies use the e-prescription system to provide health insurance funds with information on co-payments for covered

medicines. This change ensures that as soon as people reach the cap they are automatically exempt from paying any further eligible co-payments.

- **The cap is set too high to benefit enough people with low incomes.** In 2023 only 10% of the population benefited from the cap. The cap is set at CZK 5000 a year (around €225.11 in purchasing power parities) for the general population, equal to 27% of the monthly minimum wage in 2024. There are two lower (more protective) caps – one set at CZK 1000 for children under 18 years and people aged over 65 years, the other set at CZK 500 for people with moderate to severe disabilities and pensioners aged over 70 years (see Table 3). However, adults of working age with low incomes or chronic conditions are subject to the general cap unless they also have a disability, and many are unlikely to benefit from it.

International evidence and experience indicate that financial protection can be strengthened when co-payments are kept to a minimum, people with low incomes are exempt, caps are linked to income and protection mechanisms are applied automatically, with the help of digital tools (Box 2) (Thomson et al., 2023; WHO Regional Office for Europe, 2023; Cylus et al., 2024; García-Ramírez et al., 2025; Kasekamp & Habicht, 2025).

Other factors that may contribute to financial hardship or unmet need for outpatient medicines include a shortage of pharmacists in border areas and VAT on medicines (12%, reduced from 15% since 2024). In 2024 only three EU countries had a VAT rate above 10% for medicines (Bulgaria, Denmark and Germany) (European Federation of Pharmaceutical Industries and Association, 2025).

Box 2. User charges (co-payments) can be redesigned to make them less harmful

User charges are a major driver of financial hardship for households in many countries in Europe. Analysis suggests that they are most likely to undermine affordable access to health care when they are applied without multiple mechanisms to protect people (e.g. exemptions and caps) or when protection mechanisms exist but are poorly designed (Thomson et al., 2023; Cylus et al., 2024).

User charges in many countries are also complex and bureaucratic, which undermines transparency, leads to confusion and financial uncertainty and prevents people from accessing entitlements (Salampessy et al., 2018). Percentage co-payments, balance billing (including reference pricing) and extra billing are particularly non-transparent; they also shift financial risk from the purchasing agency to households and expose people to out-of-pocket payments arising from health system inefficiencies.

The harm caused by user charges can be reduced if they are applied sparingly and carefully designed in the following ways:

- exemptions for people with low incomes or chronic conditions;
- an income-based cap on all user charges for everyone;
- exemptions and caps are applied automatically, using digital solutions;
- percentage co-payments are avoided or replaced by low fixed co-payments;
- balance billing and extra billing are avoided or abolished; and
- user charges are as simple as possible, aim to protect people rather than diseases and minimize administrative barriers.

When user charges are carefully designed, people know exactly how much they must pay out of pocket before they visit a doctor, undergo a diagnostic test or collect a prescription; they know that they do not have to pay more than a certain amount a year; and they automatically benefit from exemptions and caps, without having to apply for them.

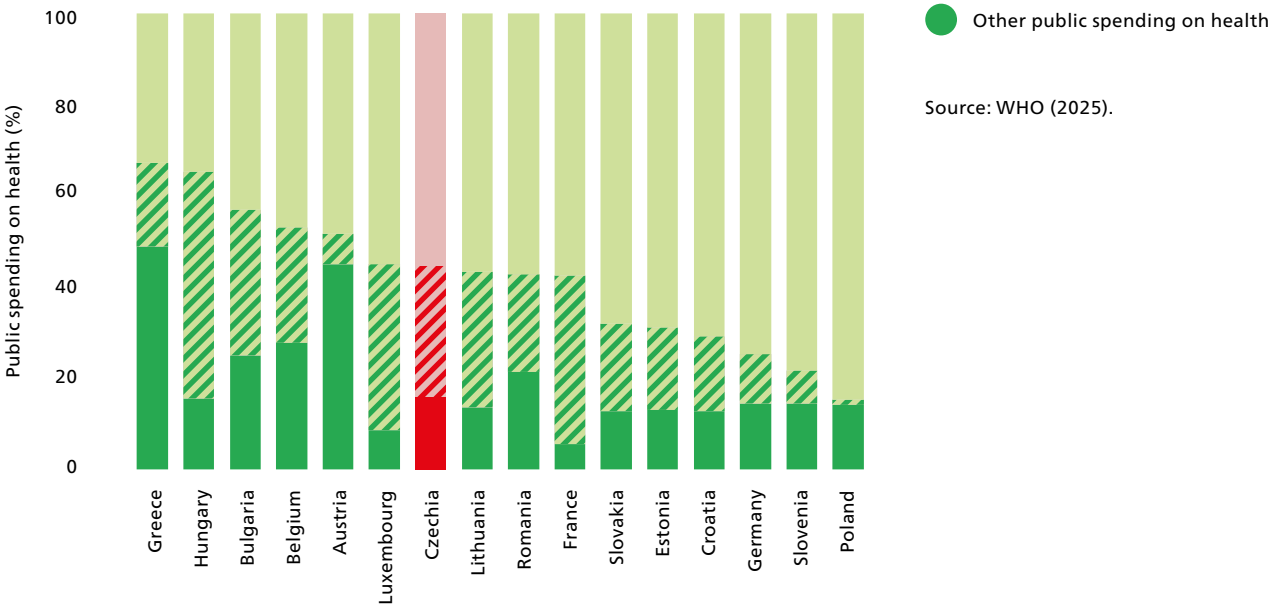
Source: adapted from WHO Regional Office for Europe (2023).

6.2 Spending on health

Levels of public spending on health were relatively high in Czechia in 2022, compared to EU27 and EU14 averages, when measured in terms of share of GDP (see Fig. 3) and share of total government spending (see Fig. 4). However, data on financial protection in Czechia indicate some scope to increase public spending on outpatient medicines, dental care and medical products and, at the same time, to improve equity and efficiency in the use of these funds, so that they reduce unmet need and financial hardship for people with lower incomes.

In thinking about potential sources of additional public funding, it is worth noting that Czechia's relatively heavy reliance on employment (wages) to finance health care could put pressure on the public revenue base for the health system as the population ages. In 2022 about 55% of public spending on health in Czechia came from SHI contributions levied on wages (Fig. 26). This is lower than in Slovenia (78%) or Slovakia (68%) but higher than in several other EU countries with SHI schemes (e.g. Bulgaria, 43%) and much higher than in EU countries without SHI schemes (e.g. countries like Denmark, Ireland, Italy, Spain and Sweden).

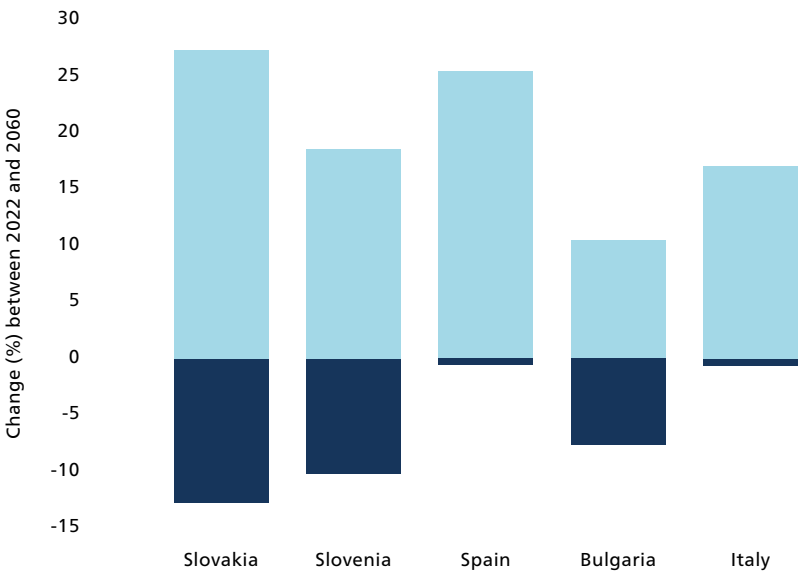
Fig. 26. Breakdown of public spending on health in EU countries predominantly financed through SHI schemes, 2022



Source: WHO (2025).

Recent analysis focusing on five EU countries has found that as the working-aged share of the population falls, countries that rely more heavily on SHI contributions to finance health care (e.g. Bulgaria, Slovakia and Slovenia) are likely to experience a significant decline in public revenue for health over the next 30 years, increasing budgetary pressure in the health system; in contrast, public revenue for health is likely to be more resilient to population ageing in countries that have broadened the public revenue base for the health system and draw on a more diverse mix of taxes to finance health care (e.g. Italy and Spain) (Fig. 27). The ageing-related gap in public revenue for health in Czechia would probably sit somewhere between that of Bulgaria and Slovakia or Slovenia.

Fig. 27. The population ageing-related gap in public spending on health and public revenue for health in selected EU countries, 2022 to 2060

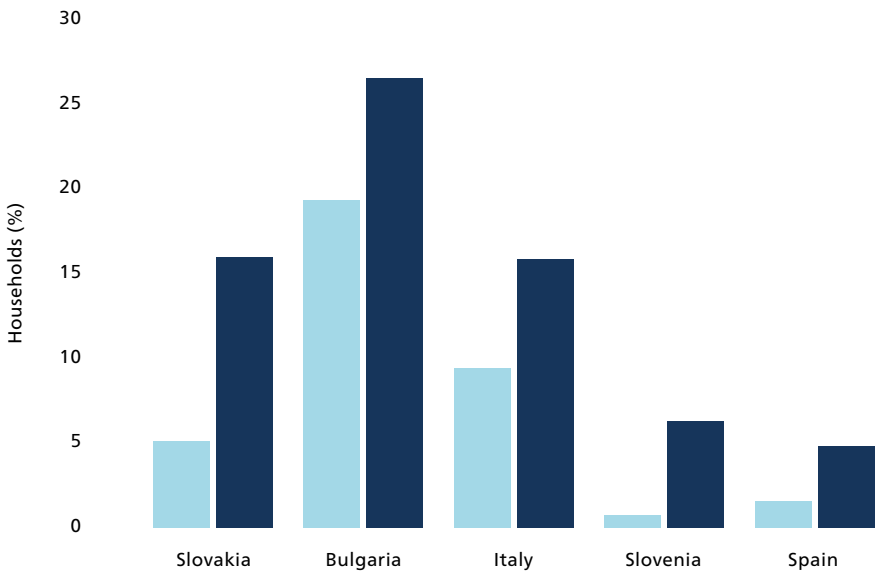


Notes: revenue and spending refer to public revenue for health and public spending on health per person. Countries are sorted from left to right from the largest (Slovakia) to smallest (Italy) gap. Countries were selected based on the availability of data and to reflect a range of health financing mixes.

Source: Cylus et al. (2025).

The same analysis looked at what would happen to catastrophic health spending if the population ageing-related "gap" were to be filled through out-of-pocket payments rather than an increase in public spending on health. It found that there would be sharp increases in the share of households with catastrophic health spending, even in countries with relatively strong financial protection now (Fig. 28).

Fig. 28. Increase in the share of households with catastrophic health spending if the gap is filled through out-of-pocket payments in selected EU countries, baseline to 2060



Notes: countries are sorted from left to right from largest (Slovakia) to smallest (Spain) absolute increase over time. The largest relative increase is in Slovenia (baseline year 2018), followed by Slovakia (2015), Spain (2019), Italy (2019) and Bulgaria (2018).

Source: Cylus et al. (2025).

These findings suggest that countries with SHI schemes, like Czechia, should take steps to reduce reliance on wages to finance health care and to strengthen coverage policy so that out-of-pocket payments are not borne by households that cannot afford them (Box 3). This will protect households now and help to future-proof the health system from demographic changes and other shocks.

Box 3. How France broadened the SHI revenue base and changed the basis for entitlement to SHI benefits

Starting in the late 1990s, France began to broaden the revenue base for the SHI scheme in two ways.

- It replaced employee wage-based contributions with a contribution levied on all sources of income (including wages, pensions, unemployment benefits, rental and investment income and capital gains) and paid by all resident adults. The new income-based contributions now account for a large share of the SHI scheme's revenue.

- It increased the level of government budget transfers to the SHI scheme.

The French Government also changed the basis for entitlement to SHI benefits from employment and payment of contributions to residence (in 2000) and granted all legal residents an individual, automatic and continuous right to health care, without the need for administrative formalities when a person's circumstances change (in 2016). This has helped to ensure that all legal residents are covered and have access to all SHI benefits, regardless of employment status or whether they have paid mandatory contributions.

Source: adapted from WHO Regional Office for Europe (2019; 2023) and Bricard (2024).

6.3 Summary

Coverage policy in Czechia has notable strengths that offer examples of good practice to other countries. First, entitlement to SHI benefits is based on permanent residence rather than being linked to payment of mandatory SHI contributions; people who fail to pay their SHI contributions incur a debt that must be repaid but do not lose their entitlement to SHI benefits. Second, co-payments are not widely used in the health system.

However, gaps in the coverage of outpatient medicines, dental care, medical products and outpatient visits remain and help to explain why levels of catastrophic health spending and unmet need are much higher than average in households with the lowest incomes.

Waiting times and informal payments are likely to lead to unmet need for health care in households with low incomes and financial hardship driven by spending on outpatient care for households with greater capacity to pay for health care.

Catastrophic health spending driven by spending on medical products reflects gaps in the coverage of corrective lenses for most adults and balance billing without mechanisms to protect people with low incomes.

Although dental care is covered and available without co-payments, many dentists do not offer covered services or use covered materials, resulting in growing income inequality in unmet need for dental care in recent years. This is likely to be why dental care is less of a driver of catastrophic health spending in the poorest quintile than in richer quintiles.

The role of outpatient medicines in driving financial hardship and income inequality in unmet need is puzzling because most of the population is covered; there do not seem to be issues with the benefits package for medicines; co-payments for outpatient prescribed medicines are limited to reference pricing; and there is a cap on some of these "avoidable co-payments". A higher than desirable prevalence of "avoidable co-payments" for outpatient prescribed medicines reflects the absence (before 2025) of mandatory INN prescribing and mandatory generic substitution; the lack of exemption from "avoidable co-payments" for people with low incomes; and weaknesses in the design of the cap, which does not apply to all "avoidable co-payments", was not applied automatically before 2025 and is set too high to benefit enough people with low incomes. The high rate of VAT on medicines and a shortage of pharmacists in border areas may also contribute to financial hardship and unmet need.

Public spending on health as a share of GDP was close to the EU14 average in 2022, but data on financial protection indicate some scope to increase public spending on outpatient medicines, dental care and medical products and, at the same time, to improve equity and efficiency in the use of these funds, so that they reduce unmet need and financial hardship for people with lower incomes.

In thinking about potential sources of additional public funding, it is worth noting that Czechia's relatively heavy reliance on employment (wages) to finance health care could put pressure on the public revenue base for the health system as the population ages.

7. Implications for policy

Financial hardship caused by out-of-pocket payments is lower in Czechia than in many EU countries but has increased over time. In 2023 (the latest available year of data) 5.7% of households – around 600 000 people – experienced catastrophic health spending. This share rose steadily between 2018 and 2021 and again in 2023. It is higher than in several countries with a similarly low reliance on out-of-pocket payments to finance the health system.

Catastrophic health spending is heavily concentrated in the poorest quintile, where incidence has grown over time. In 2023 21% of households in the poorest quintile experienced catastrophic health spending, up from 14% in 2018. Older people are also at high risk of catastrophic health spending.

Catastrophic health spending is driven, on average, by out-of-pocket payments for dental care, outpatient medicines, outpatient care and medical products. In the poorest quintile, however, it is consistently heavily driven by outpatient medicines. Dental care is the main driver in the other quintiles.

Levels of unmet need for health care, dental care and prescribed medicines are below the EU average in Czechia but have grown in recent years. Income inequality in unmet need is particularly marked for dental care and prescribed medicines.

Coverage policy in Czechia has notable strengths that offer examples of good practice to other countries. First, entitlement to SHI benefits is based on permanent residence rather than being linked to payment of mandatory SHI contributions, people who fail to pay their SHI contributions incur a debt that must be repaid but do not lose their entitlement to SHI benefits. Second, co-payments are not widely used in the health system.

However, income inequality in financial hardship and unmet need indicate gaps in the coverage of outpatient medicines, dental care, medical products and outpatient visits. There are gaps in the benefits package for corrective lenses for adults. Although dental care is fully covered, many dentists are not willing to offer covered services or use covered materials. Waiting times and informal payments are an issue for outpatient visits. Factors likely to contribute to financial hardship and unmet need for outpatient medicines include the "avoidable co-payments" arising from weaknesses in the design of reference pricing, a high rate of VAT on medicines and a shortage of pharmacists in border areas.

Building on recent efforts to reduce "avoidable co-payments" for outpatient prescribed medicines, the Government can consider further steps to reduce out-of-pocket payments, particularly for people with low incomes. These include the following options.

- **Outpatient medicines:** ensure that the fully covered medicine in each reference group is available in pharmacies; waive the co-payment when the fully covered medicine is not available at the local pharmacy; exempt people with low incomes from co-payments currently eligible for the cap or extending the lowest cap (CZK 500) to people with low incomes; find other ways to link the cap to income; closely monitor "avoidable co-payments" and their causes; further reduce the VAT rate for covered medicines; improve access to pharmacies in underserved areas; address administrative and language barriers that hinder asylum seekers and migrants from accessing entitlements; and expand access to publicly financed health care for undocumented migrants.

- **Dental care:** require dental care providers to offer covered services and materials; expand coverage of dental care, including the use of higher-quality materials; and improve access to dental care in underserved areas.

- **Medical products:** expand coverage of medical products for people with low incomes.

- **Outpatient visits:** remove administrative barriers to exemption from co-payments for emergency care or abolish this co-payment since it is unlikely to be addressing the root cause of inappropriate use of emergency care; enforce laws prohibiting extra billing; and take steps to systematically monitor and address long waiting times and informal payments. Informal payments reduce transparency and are likely to be particularly detrimental for people with low incomes.

To meet equity and efficiency goals now and in the future, the Government should ensure that:

- public spending on health is carefully targeted to reduce financial hardship and unmet need for households with low incomes; and

- the SHI scheme's revenue base is broad enough to generate sufficient funding as the population ages.

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The WHO Regional Office for Europe

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