

Czech Republic



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The Czechoslovak State came under a communist administration in 1948. The process of democratization began in 1989, leading to democratic elections in 1990. A legal separation of the Czech and the Slovak Republics took place in 1992, and the Czech Republic was established on 1 January 1993. The Czech Republic is located in the middle of Europe covering an area of 78 867 km². An administrative structure introduced on 1 January 2000 divides the country into 14 regions with self-governing units and some delegated powers. The western part of the Czech Republic is called Bohemia and the eastern part consists of Moravia bordering Poland to the north and Slovakia to the east, and is part of former Silesia. The Czech Republic is a multiparty parliamentary democracy headed by a president. The constitution provides bicameral parliament - 200 members of the House of Representatives and 81 members of the Senate. The Czech Republic has been a member of the OECD since December 1995, NATO since February 1999 and EU since May 2004.

HEALTH & DEVELOPMENT

Czech Republic has achieved almost universal coverage of its population with mandatory health insurance. Health insurance is the main source of public funding for the health sector. Participation in health insurance scheme is mandatory for everyone who works in the Czech Republic. A large section of the population does not contribute but is nevertheless covered. Due to high unemployment rate, tax evasion, cost inflation and ageing and low co-participation of patients the universal coverage and the comprehensive benefit package are difficult to sustain, resulting in continuous budget deficit. The government is attempting to introduce measures to increase efficiency benefit package and increase co-payments.

The stewardship role of the Ministry of Health is improving very slowly. Since the beginning of 2003, a reform of public administration has been under way in the Czech Republic, which consists of decentralizing the execution of public administration and transferring it to a regional level and of transferring a large volume of competencies to self-governing regions. Those changes have significant consequences for the provision and management of the health services and the public health services. Regions are responsible for health care provision. Role of the Ministry of Health could be strengthened.

Noncommunicable diseases are the leading causes of morbidity and mortality. The three most frequent causes of death - diseases of the circulatory system, neoplasms and external causes - resulted in 83 % of all deaths. The most feared diseases are malignant neoplasms (MN), the second most frequent cause of death. The number of new cases reported for men (per 100 000) increased in 2002 by 4%, in women only by 0,5%. This increase is partly influenced by ageing of the population and by earlier and more accurate diagnostics but it is apparent that malignant neoplasms affect gradually more and more people. The most often diagnosed oncological disease for men is colorectal carcinoma, followed by MN of trachea, bronchus and lung and of prostate. The most frequent diagnosis for women is MN of breast. Selected screening programs of early detection were introduced in 2005.

Lifestyle related risk factors are prevalent, particularly smoking, unhealthy diet and insufficient physical activity. Although public health and disease prevention have featured high on the agenda of the health sector reform process, throughout the last decade less attention has been given to systematic efforts to address disease prevention and health promotion. The situation was improved but health promotion policy continued to be ineffective especially in its primary health care and also multi-sectoral context. Some progress was made in settings initiatives such as healthy schools and healthy cities. The Government adopted a long-term programme for improving the public health status of the Czech citizens based on the strategy – Health21 at a multi-sectoral approach. Smoking has decreased significantly over the last decade although the problem persists amongst the young and should be addressed as a priority of action.

Communicable disease incidence is very low. Compulsory vaccination programmes with high coverage and an effective alert and response system for outbreaks have kept most diseases under control. Exceptions in the latter group were tick-borne viral encephalitis and viral hepatitis, which both slightly increased although vaccination was offered. No significant changes were registered in respect to the numbers of reported cases of venereal diseases in spite of considerable migration of persons occurring. HIV/AIDS incidence is low compared to other EU countries and it remains stable. So is the status of reported incidences of tuberculosis in the Czech Republic (less than 10 per 100 000), however it should be noted that the cases caused by mycobacterium tuberculosis for special risk groups in the population – homeless, drug addicts, asylum seekers, ex-prisoners – are being discovered.

Environmental health – Around two-third of the Czech population lives in areas with severe air pollution. Air and water pollution in areas of northwest Bohemia and in northern Moravia were important health risk factors, but the situation is improving. In the area of nitrates, the designation of vulnerable zones is ongoing and the main sources of pollution from dangerous substances have been identified. Concerning the protection of the natural environment further efforts are needed to keep the foreseen timetable. Some progress has been made as regards strengthening of the administrative, monitoring and enforcement capacity at national and regional level.

Total population (2007) ¹	10 381 130
% under 15 (2004) ¹	15,1
Population distribution % rural (2007) ²	26
Life expectancy at birth (2007) ³	76,8
Under-5 mortality rate per 1000 live births (2007) ²	3,86
Maternal mortality ratio per 100 000 live births (2007) ²	2,62
Total expenditure on health as % of GDP (2006) ³	7,0
General government expenditure on health as % of general government expenditure (2003) ³	12,7
Human Development Index Rank, out of 117 countries (2003) ⁴	31
Gross National Income (GNI) per capita USD (2004) ⁵	9170
% population with sustainable access to improved water sources (2004) ⁵	100
% population with sustainable access to improved sanitation (2004) ⁵	99

¹Czech Statistical Institute

²HFA Database (WHO)

³World Health Report 2006 (WHO)

⁴Human development report 2005 (UNDP)

⁵World development indicators 2006 (World Bank)

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> Joining the EU in May 2004 has created new opportunities for strengthening public health services and scaling up investment in the health sector The Czech economy has been growing as a result of higher foreign trade investment, industrial production and household spending The Government adopted a long-term programme for improving the public health status of the Czech citizens based on the strategy – Health21 Abundant accessible health information which, if used effectively, can provide valid evidence for policy-making in various areas Universal health insurance coverage provides the opportunity to deliver cost-effective, evidence-based interventions and address major public health challenges Infant mortality decreased to the level 3,9 per mille in the year 2005 and the rate is one of the lowest at the world; high immunization coverage rates between 95% and 98% for all (obligatory) immunization programmes 	<ul style="list-style-type: none"> Precarious long-term financial sustainability of the health insurance system Ageing population and related increases in resources needs for the health system High expenditures on pharmaceuticals and health care service Weak stewardship role of the MoH in policy development and sector regulation Developing and implementing a comprehensive national policy and strategy Health care reforms with a focus on health financing, quality of care and human resource development Strengthening public health functions and capacity at the regional level

PARTNERS

The Czech Republic has extensive cooperation with different countries and international organizations. Integration with the EU provides new opportunities as well as challenges for the health sector. Additional funds are available to support national and regional level – EHP Norway, Netherlands cooperation (MATRA project). The Ministry of Foreign Affairs declared 9 countries (worldwide) as priority areas for bilateral development assistant of the Czech Republic. Montenegro is one of these priority countries where the Czech Republic is main technical partner of the project PACT in Montenegro focused on establishment of Nuclear medicine Centre and delivery of appropriate equipment and medicaments.

OPPORTUNITIES	CHALLENGES
<ul style="list-style-type: none"> • Integration with the EU • Compliance with the EU health system standards • Potential financial assistance from the EU for structural adjustments in different sectors • The Czech Republic was officially graduated among the developed countries 	<ul style="list-style-type: none"> • Moderate stewardship, coordination and management capacity of the government • Slow, incremental approaches to the implementation of health sector reforms

WHO STRATEGIC AGENDA

The overall goal of the WHO in Czech Republic is to contribute strategically to health sector development, advocating health promoting policies and providing technical leadership in collaboration with the government and other actors in the health sector. The strategic support that WHO is able to provide to the Czech Republic will focus on a *process* of involvement and support to health system development in the country. Many content areas of WHO collaboration with Czech Republic over the next six years will be linked to the development and implementation of the Health Strategy with emphasis on organization of the stewardship and financing functions:

- **Developing and implementing a comprehensive national public health policy and strategy**

The involvement of a broad range of key stakeholders in the country; relevance to all levels of government; emphasis on health promotion and healthy lifestyles (tobacco, alcohol, diet/obesity, drugs, physical activity); emphasis on the needs of children, youth and vulnerable groups including older people and migrants; emphasis on partnership with NGOs and involvement of citizens and academic community; emphasis on participatory process to ensure ownership and long-term, support; emphasis on ability to manage public health threats and emergencies (floods, bioterrorism, epidemics); emphasis on the control of environmental hazards, accidents; emphasis on coordination, effective information management and media communication and evidence-based interventions.

- **Health care reforms with a focus on health financing, quality of care and human resource development**

Improving the macro and micro efficiency and monitoring of quality performance of the system; nursing and public health specialist development; and rational use of medicines.

- **Strengthening public health functions and capacity at the regional level**

Skill development in health impact assessment; partnership-based approaches to health development; national-regional cooperation as well as cooperation with the health services and in particular Primary Health Care; information technology management and use of science/evidence based methodology; population-based health profiling; links with sustainable development/agenda21 initiatives

- **Cooperation with the EU members and maximizing public health benefits and incentives**

Encouraging/supporting/facilitating dialogue, exchange and cooperation with EU member states through bi-lateral and multi-lateral agreements; participation/bidding in EU public health and environmental programmes.

ADDITIONAL INFORMATION

WHO country office website <http://www.who.cz>
 EURO country page <http://www.euro.who.int/countryinformation/CtryInfoRes?COUNTRY=CZH&CtryInputSubmit>
 WHO country page <http://www.who.int/countries/cze>

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