

Czechia: Its Health Care System

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1. Introduction

This article analyses the Czech health care system, focusing on both physical and psychological health. The article is structured according to Bronfenbrenner's bioecological model, which frames development as a progressive process of co-adaptation between the individual and their context, highlighting interactions across systemic levels: microsystem (immediate environment, e.g., friends and health professionals), mesosystem (interactions between microsystems), exosystem (social structures affecting the individual indirectly), macrosystem (cultural norms, social policies, and systems), and chronosystem (changes over the life course) [1, 2].

Rather than examining individual trajectories, the article explores how interdependencies across these levels shape the Czech health care system. At the macrosystem level, it considers structural evolution, political and economic frameworks, demographics, and population health. The mesosystem corresponds to the system's internal functioning. The microsystem focuses on current health policies, especially in mental health. The chronosystem contextualizes reforms, crises, and epidemiological transitions over time.

2. Czech Republic

2.1. Geographic Location

The Czech Republic (Czechia) is located in Central Europe, bordering Germany to the west, Poland to the northeast, Slovakia to the east, and Austria to the south. Covering approximately 78,867 km², the country has a temperate continental climate, with hot summers and cold winters. Its capital is Prague. The country is divided into 14 regions, 6,258 municipalities, and 4 military districts. Among municipalities, 610 have city status, 27 are statutory cities with greater autonomy, and 232 have township status [3, 4, 5].

2.2. History of the Country

The Czech health care system originated in the Kingdom of Bohemia, under the Austro-Hungarian Empire and was shaped by Otto von Bismarck's introduction of health insurance within the Bismarckian social security model. After Czechoslovakia's independence in 1918,

the Bismarckian inherited from the monarchy was expanded and clearly defined [6]. Before World War II, Czechoslovakia was among the most developed European countries and had an excellent health care system [7].

This system collapsed with the events surrounding World War II. After the Munich Agreement of 1938, Bohemia and Moravia came under German protection, Slovakia became a pro-German state, and German troops occupied the territory. The country suffered severe human and material losses: parts of the population were decimated, resources were destroyed, malnutrition and disease spread, and medical and public health services were profoundly disrupted [7].

After the war, Czechoslovakia fell under Soviet influence and, following the 1948 communist coup, adapted its health care system to the Soviet socialist ("Semashko") model [3, 7]. Under the communist regime, health care was organized and financed by the state through central planning, general tax revenues, and highly bureaucratic management. Care was free at the point of use, as all facilities were public, but persistent underfunding led to declining quality [7].

This network was nationalized and integrated into regional and district health institutes combining hospitals, polyclinics, pharmacies, and hygiene/epidemiology and emergency services. Specialized outpatient services in polyclinics often became the first point of contact [6, 7, 8]. Polyclinics were outpatient centers with several specialties (e.g., pediatrics, gynecology, ophthalmology) and diagnostic services in one location, facilitating direct access to specialists but weakening the coordinating role of general practice and gatekeeping [7, 8]. Dispensaries, another key element, provided prevention and follow-up care for risk -or diagnosis-defined groups (e.g., tuberculosis, maternal and child health, occupational health), with nominal registration and periodic appointments based on uniform protocols ("dispensarization") [9, 10]. This model strengthened organized prevention and improved infection control and infant mortality, but was overly bureaucratic, target-driven, and poorly coordinated with other services, neglecting personalized care [7].

From the late 1960s onwards, centralized rigidity and specialization became increasingly inadequate for chronic and lifestyle-related

problems, such as hypertension and diabetes. Patients were often followed in parallel by cardiology and diabetology services at the polyclinics, leading to separate consultations and records, duplicated tests (e.g., analyses), and uncoordinated therapeutic recommendations, with a higher risk of conflicting messages and polypharmacy. Indicators stagnated or deteriorated until the late 1980s [7, 8, 10].

In 1989, federal health spending in Czechoslovakia was only 4.2% of GDP, and 5.4% in the constituent Czech Socialist Republic, roughly half of the European average, contributing to declining quality [7, 11]. Higher quality care was often reserved for members of the Communist Party and their families, while illegal “gratuities” were widespread and supplemented low medical incomes [7].

Health outcomes lagged behind those observed in Western European. Life expectancy among middle-aged and elderly men had stagnated since the 1960s, circulatory diseases accounted for 56% of all deaths in 1989, and infant mortality exceeded Western European levels. Internal criticism, fueled by Perestroika, highlighted the system’s inability to address “diseases of civilization,” including mental disorders [7, 11].

Structurally, the system favored hospitalization, with 7.9 beds per 1,000 inhabitants in 1988 and an occupancy rate of 81.7%. Because budgets depended partly on bed occupancy, long stays were encouraged and savings discouraged, as unused funds were returned and reduced the following year’s budget [7].

In mental health, institutionalization in large psychiatric hospitals persisted, with only marginal changes: a network of outpatient psychiatrists, a day clinic for anxiety disorders in Prague, and psychotherapeutic programs for people with schizophrenia in some psychiatric hospital departments [12].

The Velvet Revolution, the collapse of the socialist state in Czechoslovakia in November 1989, paved the way for health care reform in a context where the crisis had already been highlighted by the perestroika critique. The main goals were technological modernization, management decentralization, and stronger patient autonomy [11]. The hierarchical state monopoly was dismantled, with virtually all health leadership being replaced for political reasons. In Czechia, regional authorities were abolished in 1991, with responsibilities transferred to districts, municipalities, or the Ministry of Health. In parallel, physicians’ professional autonomy was restored through the legislative establishment of the Medical Chamber (as well as the Dental and Pharmaceutical Chambers), independent bodies responsible for registering professionals and negotiating with the future health insurers [7].

The tax-funded state model was abandoned, and a Bismarckian-type compulsory health insurance system was established, reviving the pre-Soviet experience [7, 11].

In December 1991, the General Health Care Insurance Office (VZP) was created, supported by mandatory contributions from citizens, employers, and the government, with the state responsible for

defining what constituted “adequate” care based on available resources. Medical remuneration became linked to the type and volume of work performed, and competition between insurers (up to 27) was allowed [7, 11]. Decentralization was accompanied by privatization: by 1992, more than 500 facilities, such as clinics and diagnostic centers, had become independent, and citizens could choose their doctor and hospital [7].

In mental health, transition opened space for civic initiatives and human rights enforcement. New health insurance arrangements allowed independent contracts with psychiatrists and outpatient psychologists, expanded community care, and supported non-governmental organizations (NGOs) offering psychosocial rehabilitation and case management, although large psychiatric hospitals remained the core providers of care [12].

The first transformation phase (1991–1997) was chaotic. The fee-for-service payments and weak regulation led to an economic crisis and insurer indebtedness, culminating in the first internal collapse of health insurance at the end of 1995. In 1997, vigorous regulatory measures were imposed: insurers were reduced (to 11) and payments to providers were no longer made after each service rendered, but were instead defined in advance, i.e., general practitioners began to be paid per capita (a fixed amount per user) and hospitals began to operate with global budgets [11].

After 1997, the system consolidated, despite tensions between market and solidarity principles. The stagnation in average life expectancy was interrupted, with notable increases between 1989 and 2001. Men rose from 68.1 to 72.1 years and women from 75.4 to 78.5 years, supported by technological modernization and reduced mortality, especially from cardiovascular disease. Health funding increased from 5.4% of GDP in 1989 to 6.7% in 2000 [11].

Patients’ rights were strengthened. Paternalism typical of the socialist period: the logic that the doctor decides for the patient because of superior knowledge was abandoned, and patient autonomy began to be valued, with clear information and effective participation in decisions. In 1992, a Code of Ethics for Patient Rights was approved, reinforcing the protection of users. The obligation to obtain informed consent ended the practice of “pia fraus,” the “white lie” used to withhold or soften clinical information. Freedom to choose providers and the right to complete information were firmly established in Law 372/2011 [11].

Internationally, Czechia joined the Organization for Economic Cooperation and Development (OECD) in 1995, the North Atlantic Treaty Organization (NATO) in 1999, and the European Union (EU) in 2004, milestones that supported the institutional and regulatory convergence in health [3].

Despite progress, mental health remained problematic. More than 50% of resources were still allocated to large psychiatric hospitals. The average hospital size was high (491.7 beds per hospital in 2014, compared to 184.6 in EU countries in 2015), community services were insufficient, and average stays exceeding 100 days for

schizophrenia in 2012. From 2013 onwards, the Strategy for Reforming Psychiatric Care accelerated structural change, aimed at reducing stigma, humanizing care, and deinstitutionalizing treatment. Mental Health Centers (MHCs), operated by specialized teams, designed for areas of around 100,000 inhabitants, emerged to provide multidisciplinary community services (mobile case management, crisis response) and accelerating deinstitutionalization [12].

Overall, the Czech trajectory illustrates a shift from a centralized, underfunded system to a decentralized, competitive Bismarckian model that improved efficiency, outcomes, and patient rights, while keeping mental health reform as a priority [7, 11, 12].

2.3. Demographic and Socioeconomic Context

The Czech population grew from 7.6 million in 1869 to 10.9 million in 2024, alongside progressive aging. In recent decades, growth has slowed due to low birth rates [13, 14]. In 2022, adults aged 35-54 formed the main active group, children up to 14 years represented 16% and people aged 65+ 21%, projected to reach 28% by 2050 [4, 15]. From age 60 onward, women significantly outnumber men. Among centenarians, there are about seven women for every man. This female predominance in the older age groups highlights the greater longevity of women, who represent between 51% and 52% of the total population. This difference was even more pronounced in the past, partly due to higher male mortality associated with wars and more demanding working conditions [4].

Central regions such as Prague and Středočeský kraj have a younger, more active population, drawn by economic opportunities and higher education institutions, whereas peripheral regions such as Zlínský and Olomoucký are older [4].

The population pyramid has a narrow base and a broad top, typical of aging societies with low generational renewal. This poses challenges for pension, long-term care, palliative medicine, and end-of-life services, further compounded by higher morbidity in older age groups (e.g., cancer, circulatory diseases, diabetes, neurodegenerative diseases). [16]

Educational attainment has risen. The share of individuals with only basic education has fallen, while secondary and higher education have expanded. In 2021, more than half of the population aged 15+ had completed at least secondary education, and about 19% had higher education [17].

In socioeconomic terms, gross domestic product (GDP) per capita in purchasing power parity (PPP) reached €31,953 in 2022, slightly below the EU average (€35,219). Per capita health expenditure, adjusted for PPP, was 2,993€ in 2021, about 26% lower than the EU average (€4,028). The unemployment rate remained very low (2.2% in 2022), significantly below the European average (6.2%) [15].

The average gross salary reached approximately €2,040 per month in the second quarter of 2025, but around two-thirds of workers earn salaries below this average, revealing an asymmetrical salary distribution [18, 19]. At the same time, prices for consumer goods and

services are around 88% of the EU average, indicating that the cost of living in the country is now only slightly lower than the European standard [20]. In contrast, the average adjusted full-time annual wage in the EU reached €39,800 in 2024 (approximately €3,317 per month), which highlights the gap between a cost of living that is relatively close to the European context and significantly lower average incomes in the Czechia case [21].

3. General Health System (Physical)

The Czech health system is a mandatory, virtually universal Social Health Insurance (SHI) model offering a comprehensive benefits package [13, 14, 15]. Financing relies on compulsory contributions managed by seven semi-public Health Insurance Funds (HIFs), like the Bismarck model, with Všeobecná zdravotní pojišťovna (VZP) as the largest fund, operating 77 district branches [6, 13].

However, strong state regulatory and virtually universal coverage give the system a mixed character. The Ministry of Health is the main regulator, overseeing and setting policy [13, 15]. Semi-public HIFs purchase and pay for services. Funding combines mandatory payroll contributions with state transfers from general taxation, which finance economically inactive groups. These transfers accounted for 30.4% of total SHI revenues in 2023 [13].

In practice, HIFs collect monthly SHI contributions from employers, employees, and individuals without taxable income who fall outside state insurance - a process known as “premium collection.” These funds, plus state transfers, are redistributed among the HIFs, through a mechanism administered by the VZP to balance risk profiles. Since 2018, redistribution has used age-gender risk adjustment and pharmacy-based cost groups, indirectly identifying chronic patients via medications dispensed in the previous year (e.g., diabetes, renal failure). Funds with more elderly or chronically ill enrollees receive more resources, while funds with younger, healthier populations contribute relatively more. This design discourages risk selection, promotes equity in financing, and stabilizes provider payment capacity [22].

The delivery system is diversified: outpatient care is mostly private and hospitals are mostly public, but both are free at the point of use. Access to primary care is not strictly regulated by a gatekeeping system (family doctor), allowing direct access to specialists, although referral is required for hospitalization, except in emergencies [13].

SHI and HIFs fully or partially cover the following services: outpatient and inpatient (hospital) care; emergency services and transport; preventive and dispensary care (scheduled and regular follow-up); medicines and medical devices/materials (e.g., hearing aids, bandages); balneotherapy (under medical prescription), specialized pediatric hospital care and inpatient institutions (e.g., functional rehabilitation); occupational health; reimbursement of travel expenses; and death examinations and autopsies. Co-financed procedures and devices (co-payments) exist outside the standard framework (e.g., part of dental care and certain medications). In each

therapeutic class, at least one medication must be fully reimbursed. During hospitalization, medications and devices are fully covered, with no direct patient payment [6]. Outpatient care outside normal hours (e.g., weekends/holidays) is subject to a fixed fee of CZK 90, waived if the visit results in hospitalization [22].

Mental health services are covered by SHI across all levels of care [15].

The system rests on five key pillars: solidarity – care provided according to need (separation between those who pay and those who provide), contributions based on income, implying solidarity between active and inactive populations (children, unemployed, retired) – a high degree of self-administration, multi-source financing with priority given to public health insurance, equal availability of care for all insured persons, and mandatory vaccination against infectious diseases. Vaccination coverage exceeds 97% in the relevant cohorts, following a national schedule that includes tetanus, diphtheria, whooping cough, and hepatitis B, among others [6].

Public funding predominates, accounting for 86.4% of total current health expenditure in 2021, the highest figure in the EU, reinforcing system resilience. Private expenditure is low, with direct payments by individuals/households when using health care (out-of-pocket, OOP) represented 12.7% of total spending in 2021 [13, 15].

OOP expenditure mainly reflects co-payments for prescription medicines (46%) and, to a lesser extent, dental care (21%). To protect users, especially the most vulnerable, annual ceilings on co-payments for prescription drugs are set at €206.5, reduced to €20.65 for people aged 70+ and, since 2020, for those with a level II or III disability. For people aged 65-69 and children aged 0-18, the limit is €41.30. Some groups are exempt from the fixed fee for out-of-hours outpatient care, such as recipients of material need benefits or residents of homes for people with disabilities or low-income older people. In short, the aim is to cap yearly expenditure and safeguard those at higher economic or clinical risk [14, 15].

Population coverage is virtually universal, including all citizens and permanent residents. Self-assessed unmet medical needs are very low: in 2022, only 0.2% of the population reported unmet needs due to costs, distance, or waiting times, far below Portugal, highlighting the high level of financial protection offered by the system [13, 15].

3.1. Relevant Indicators

In 2022, life expectancy at birth in the country was 79.1 years, lower than Portugal's 81.3 years. Infant mortality stood at 2.2 per thousand live births (2021). Medical density reached 4.3 doctors and 9.0 nurses per thousand inhabitants, both above the EU average. However, despite growth since 2010, health care needs have increased, and some hospitals report closed wards due to nurse staff shortages, reflecting an aging workforce and uneven geographic distribution. To address this issue, the government has taken measures to encourage an increase in the number of students enrolling in medical schools [15].

Avoidable and treatable mortality was 25% higher than the EU average (2020), revealing room for improvement in prevention and treatment. Hospital capacity remains high, with 6.7 beds per thousand inhabitants in 2021 [15].

Socioeconomic inequalities in self-assessed health are pronounced: 86% of adults in the highest income quintile report good health, compared to 46% in the lowest, representing the fifth largest disparity in the EU [14, 15].

3.2. Epidemiological and Health Context

During 2019, half of all deaths were attributable to behavioral risk factors, particularly dietary risks (23%) and tobacco use (20%) [14, 15].

In 2020, the leading causes of preventable mortality in Czechia were lung cancer (15%) and ischemic heart disease (14%), both strongly associated with the high prevalence of risk factors, particularly alcohol and tobacco consumption. In 2018, alcohol consumption among the adults reached 14.4 liters per person per year, above the European average (9.8 liters). Almost 70% of young people aged 15–19 engaged in episodic heavy drinking. In the same year, 25% of the population aged 15+ were smokers, contributing to approximately 16,000 deaths annually [14]. Excessive alcohol use among adolescents remained above the EU average in 2022, with 22% of girls and 24% of boys aged 15 reporting having been drunk several times [15].

This pattern is reflected in the country's overall mortality profile, where in 2021 the leading causes of death were diseases of the circulatory system (34.3%), cancer (19.4%), and COVID-19 (17.9%) [14, 15].

Cancer is the second leading cause of death, with more than 61,000 new cases expected in 2022. Among men, the most prevalent cancers were prostate (24%), colorectal (14%), and lung (11%) cancer; among women, breast cancer (27%), colorectal cancer (11%), and lung cancer (9%) were more prevalent. Czechia has population screening programs for breast, cervical, and colorectal cancer, with participation rates above the EU average, namely 58% for breast screening and 75% for cervical screening in 2021. Under the National Recovery Plan, €335 million were allocated to improve cancer treatment capacity and technologies, underscoring the centrality of oncology in public health policy [15].

Regarding mental health, around one in seven people (approximately 1.5 million) had a mental disorder in 2019. The most common were depression (3.8%), anxiety (3.6%), and alcohol or drug use disorders (3.6%). Depression was significantly more prevalent among women and individuals in the lowest income quintile, who were three times more likely to experience it [15].

Given the current global context, the situation of refugees represents a significant challenge. The war in Ukraine has forced thousands of people to seek shelter and residence in Czechia, where several problems have emerged, including insufficient access to medical care

and a high prevalence of moderate to severe depressive or anxiety symptoms (45%) [14].

To address these needs, the country has implemented several programs targeting children, adolescents and adults. The NUDZ (National Institute of Mental Health of the Czech Republic) developed a school-based mental health program for teachers and caregivers, training them to identify children who may require support. Moreover, TIA, an e-learning tool on Trauma-Informed Care, equips professionals to work with individuals who have experienced trauma. Access to mental health services has also been expanded through online platforms that allow users to locate resources by language and region. Psychological counseling is free, community centers have been improved, and the number of service providers has steadily increased. In 2023, these initiatives resulted in approximately 2,500 mental health consultations [23].

3.3. Sustainability

Air quality is a critical environmental determinant of health, accounting for a significant proportion of deaths. It is estimated that around 6% of all deaths are associated with exposure to fine particulate matter and ozone, with cardiovascular and respiratory diseases and certain types of cancer being the main consequences. In addition, climate change intensifies the risks to the population's health. Since 1961, the average annual temperature has increased by approximately 2°C, and it is projected to rise by at least another 2°C by 2050. This increase causes extreme events, such as prolonged droughts and extreme rainfall, which increase the incidence of heat-related diseases, aggravate respiratory problems, increase the potential for zoonoses, increase the prevalence of chronic diseases, and affect the mental health of the population [14, 15].

Policies that integrating environmental sustainability and health protection are essential. Key measures include reducing greenhouse gas emissions by promoting low-emission transport and clean energy, preparing the health system for emergencies and extreme weather, monitoring risks with early warning systems, investing in resilient infrastructure, and incorporating climate considerations into health programs, including vaccination campaigns [24]. Additionally, smoking has been banned in all public spaces since 2017, and tobacco taxes were increased in 2023 to reduce consumption [13].

3.4. National Health Strategy 2030

The Czech Republic's current health strategy, drafted in 2019 and effective from 2021 to 2030, is structured around three overarching objectives: (i) protecting and improving population health; (ii) optimizing the health care system; and (iii) supporting science and research [16].

At the core of the strategy lies a single overarching goal: improving the health of all population groups. Health outcomes are understood as the result of multiple determinants, including availability and quality of care, living conditions and lifestyle. Their estimated

contribution to health status is lifestyle (50%), genetics (20%), environment (15%) and health system performance (15%). This configuration underlines the importance of a biopsychosocial perspective, integrating biological, psychological, and social components in explaining health and guiding intervention [16].

Under the first objective, priorities include strengthening prevention, promoting healthy lifestyles and developing a robust epidemiological surveillance system, whose relevance was highlighted during the pandemic. The strategy also envisions reforming primary health care to enhance responsiveness, accessibility, and quality, while consolidating the role of general practitioners as gatekeepers - thereby improving coordination and continuity of care, optimizing referrals, and rationalizing hospital use. Additionally, the implementation of a National Health Literacy Program, focused on psychoeducation and on reducing avoidable mortality (which remains above the EU average), is planned [16].

In system optimization, the plan prioritizes effective integration between health and social services to address population aging and the rising burden of chronic conditions. This includes promoting integrated care models and advancing mental health reform by shifting care away from large inpatient institutions and toward community-based services.

The stability of human resources is identified as a key enabling factor. The strategy addresses the aging of physicians, particularly in primary care, and the shortage of nurses through a long-term workforce development plan. Digital transformation is conceived as a lever for efficiency and quality, based on a central infrastructure for secure health information exchange, the expansion of telemedicine and the responsible use of artificial intelligence. In terms of financing, the strategy promotes a sustainable and transparent model, including the optimization of payment mechanisms for acute hospital care and incentives that support integrated and community-based care, aligning remuneration with outcomes and continuity [16].

In science and research, the framework aims to bring health research and development closer to the level of the most developed EU countries by promoting applied research in prevention, diagnosis, treatment, and the study of risk factors [16].

3.5. Mental health system

The mental health system covers treatment, prevention, promotion and early intervention and is based on the Balanced Care model, which seeks an equilibrium between community and hospital responses, combining day services with mobile teams close to the place of residence [25].

Access begins in primary health care, which ensures early detection and intervention. Primary care providers offer initial management and refer patients, when necessary, to specialized outpatient clinics (psychology/psychotherapy, psychiatry, and mental health nursing consultations). Outpatient clinics operate in general hospitals and clinics and may also be embedded in MHCs [25].

At the community level, MHCs, opened in 2018, consist of multidisciplinary teams (psychologist, psychiatrist, nurse, social worker) that offer intervention in the territory (home, school, work), case management, psychosocial rehabilitation, formally coordinating with social services. The network includes day services/centers and crisis services, which function as alternatives to hospitalization and as bridges for post-discharge continuity. Acute hospital response (hospitalization) is preferably based in general hospitals, is mobilized for short-term episodes, maintaining direct continuity with MHCs, outpatient clinics, and day centers after discharge. At the same time, protective (forensic) treatment is court-ordered, stratified by risk levels, and focused on rehabilitation and reintegration. Once the acute phase ends, recovery is consolidated through supported housing and assisted employment, with community teams ensuring continuity [13, 25].

Despite free services, from primary to hospital care, access to psychotherapy is limited. Child mental health services are insufficient, with long waiting times, and low-income and vulnerable populations face barriers. Elderly care is also constrained. Support for families under high stress is scarce, increasing the risk of chronic mental illness. Community care remains underdeveloped, with weaknesses in prevention, rehabilitation, and integration. Human resources shortages aggravate these problems. Only 797 clinical psychologists work in the system (14.2 per 100,000 inhabitants), partly due to low salaries (€2,166 gross/month in the public sector) and demanding training (competition to enter the psychology program with acceptance rates around 5% and the demanding path to clinical practice - after graduation, it is necessary to complete a master's degree, a course in the health field, extensive certification training (lasting 5 years), and a final exam, which makes the process lengthy and rigorous) [15, 25, 26, 27]. Only 30 MHCs exist, limiting acute care availability [25].

The National Mental Health Action Plan 2020-2030 addresses these gaps through five objectives: (i) strengthening governance and mental health care provision based on reliable data, ensuring coordination between ministries, regions, and providers, and enabling the testing of innovative methods; (ii) ensuring equal opportunities in mental health throughout the life cycle, prioritizing vulnerable groups, by strengthening prevention and early intervention, promotion in schools, and combating stigma; (iii) ensuring that the human rights of people with mental health problems are respected, protected, and promoted; (iv) guaranteeing full access to mental health care (time, place, capacity, and price) via multidisciplinary teams, phased deinstitutionalization (reducing long-term hospitalization and strengthening acute care), creating other crisis/psychotherapy services (e.g., specialized centers for complex trauma, outpatient clinics for child clinical psychologists, outpatient clinics with extended care—two specializing in addiction); and (v) building a mental health system coordinated with other sectors (justice, housing,

education, employment), ensuring intra/interministerial cooperation and equitable access to physical and mental care [25].

By 2030, all mental health professionals are expected to be trained in multidisciplinary, empathetic, user-centered care. The plan aims to expand MHCs from 30 to 70. In hospitalization, it reinforces short-term acute care beds while reducing long-term beds, promoting community integration through supported housing and other social services [25].

In oncology, policy focuses on two main axes. The first emphasizes effective prevention across the life course, with structured education and information initiatives to increase health literacy - crucial given that lung cancer remains a leading cause of death, largely due to late diagnosis [28]. Motivational interviewing, as a collaborative and autonomy-respecting approach, enhances behavior change (e.g., smoking cessation), therapeutic adherence, and reinforces prevention efforts [29]. The second axis prioritizes person-centered care and quality of life, ensuring holistic care that integrates physical, psychological, social, and spiritual dimensions. Rehabilitation, psychosocial support, and palliative care are provided at all stages, with multidisciplinary teams trained in soft skills (interpersonal and communication skills, such as empathic and active communication, teamwork and cooperation, and adaptability). Psychologists play a key role in offering support, identifying needs, and improving quality of life. [28]. They also support families and caregivers, facilitating clinical communication, care planning, and anticipatory grief. Social and family conditions are assessed to determine the most appropriate care setting (home vs. hospital). This is particularly relevant given the underrepresentation of geriatric oncology in European guidelines, which often leads to inadequate responses to older patients' complex needs. Psychologists therefore help bridge health and social care, ensuring continuity, access to services, and mitigation of impacts such as income loss, poverty risk, housing issues, or community reintegration [28, 30].

In the literature, multidisciplinary oncology meetings are often dominated by biomedical information. When psychologists participate rarely or passively, psychosocial aspects (emotions, family context, social conditions, adherence) play a smaller role in decisions. Active psychological input allows this information to shape decisions, better aligning them with patients' needs and quality of life. Without such input, decisions tend to be one-dimensional and neglect essential needs [31].

On another note, suicide is a public health concern. Although rates have decreased, they remain above the EU average [15]. Around 1,300 people die by suicide each year ($\approx 3/4$ deaths per day), mostly men [25, 32]. In 2018 there were 1,352 deaths, 1,102 of them men, with risk increasing with age and suicide ranking as the second leading cause of death among 15–24-year-olds. The National Suicide Prevention Plan 2020–2030 includes measures such as restricting access to lethal means, training professionals, strengthening community services and crisis hotlines, and education and literacy in

schools. The country acknowledges shortcomings in outpatient clinics, crisis centres, post-hospital follow-up, and access to psychotherapy, and therefore promotes evidence-based psychotherapies, notably Cognitive Behavioural Therapy (CBT), for at-risk groups [32].

The widespread adoption of the biopsychosocial paradigm stands out. Public understanding of mental health is evolving, and contextual factors (work, school) are increasingly recognized. These settings are viewed as strategic contexts for intervention, enabling preventive action and risk mitigation with measurable effects at individual and population levels [25].

4. Czech Republic vs Portugal

Comparing Czechia and Portugal, the Portuguese system could benefit from gradually adopting some features of the Czech model, particularly regarding financial protection, care predictability, and network organization.

Czechia combines near-universal coverage with predominantly public social health insurance, minimal co-payments, and a comprehensive benefits package, resulting in low OPP expenses and minimal unmet care needs. Portugal, despite achieving a life expectancy above the EU average (≈ 81.7), operates a less protective financing structure. OPP payments are higher, pushing many users toward the private sector and delaying care. Only around 63% of health expenditure is publicly financed, while OPP payments account for approximately 29% of total expenditure, above the OECD average, and nearly 3% of the population reports unmet medical needs, mainly due to cost [15, 33, 34]. For the Portuguese NHS, while maintaining the Beveridge model and primary care gatekeeping, three strategies seem crucial: strengthening financial protection for families (e.g., by introducing annual copayment caps and automatic exemptions for vulnerable groups), clarifying the package of guaranteed services, and reorganizing the provision network (expanding primary care capacity, reinforcing outpatient consultations and exams, reducing waiting lists and reliance on the private sector for essential care) [35].

In mental health, both countries face a high burden of depressive and anxiety disorders. In Portugal, national health profiles show some of the highest levels of anxiety and depression in the EU, particularly affecting women and low-income populations, with persistent difficulties in accessing specialized care. In Czechia, mental illness prevalence is similarly high, but it has been addressed through multidisciplinary community teams and stronger integration between health and social services. This contrast suggests that Portugal could benefit from reinforcing a community-based mental health network to provide earlier responses to psychological distress and mitigate

social inequalities in access to care [15].

5. Reflection

The Czech health care system has a generally positive, yet ambivalent, impact on population health and well-being. Compulsory social health insurance with near-universal coverage reduces financial barriers and protects economically inactive groups, enhancing security and predictability in the face of illness [6, 13, 15]. However, structural factors limit these benefits: preventable and treatable mortality remains high, half of all deaths are linked to behavioral risk factors (alcohol, tobacco, diet), and socioeconomic inequalities in self-rated health persist, indicating that the system does not fully counteract social disadvantages or promoting healthy lifestyles equitably [14, 15].

Health psychology literature reinforces this ambivalence. Aging is a major challenge in developed societies, and adopting healthy lifestyles is essential for quality longevity, with psychological intervention central to promoting physical and mental health [36, 37]. In Czech context, marked by demographic aging and social inequalities, financial access alone is insufficient. Investing in life-cycle programs that foster healthy lifestyles is necessary.

Psychological interventions support adaptation to illness through emotional management, psychoeducation, and cognitive-behavioral strategies aimed at emotional regulation and self-care [37, 38]. Given that much mortality in Czech Republic is linked to behavioral risk factors, a system that does not integrate psychological prevention and monitoring risks remaining predominantly biomedical, limiting its impact on quality of life and subjective well-being.

Diagnosis also affects patients and their families emotionally, requiring multidisciplinary teams to operate from a biopsychosocial approach. Psychology is key to emotional stability, quality of life, stigma reduction, and adaptation to functional losses [37, 39]. In Czech system, behavioral and environmental risks, combined with the legacy of asylums, a low number of mental health centers, and insufficient psychologists in the public sector, indicate that many citizens, particularly low-income individuals and Ukrainian refugees, lack timely psychotherapeutic support.

In sum, the Czech Republic has a technically robust health system in ongoing reform, with strong potential to promote health and well-being, but a gap persists between institutional design and the realities of risk behaviours, social inequality, and effective service capacity. Three pillars seem essential: (1) consistent promotion of healthy lifestyles across the life course (e.g., through psychoeducation and health literacy); (2) systematic integration of psychological intervention in prevention and follow-up; and (3) development of genuinely multidisciplinary responses.

6. References

1. Dickens C, Suarez-Balcazar Y, Allen-Meares P, Brazil E (2025) Using ecological systems theory to enhance community health literacy. *Health Literacy Res Pract (HLRP)*. 9(1): e29–e36.
2. Papalia DE, Feldman RD (2013) *Desenvolvimento humano*. 12th ed. ArtMed Grupo Editorial.
3. Bryndová L, Pavloková K, Roubal T, Rokosová M, Gaskins M, et al. (2009) Czech Republic: Health system review. *Health Syst Transit*. 11(1): 1–122.
4. CSO (2023) *Demographic Yearbook of the Czech Republic – 2022*. Czech Statistical Office.
5. CSO (2025) *Territorial units Statistics*. Czech Statistical Office.
6. Kinkorová J, Topolčan O (2012) Overview of healthcare system in the Czech Republic. *EPMAJ*. 3(1): 1-8.
7. Raffel MW, Raffel NK (1992) Czechoslovakia's changing health care system. *Public Health Rep*. 107(6): 636-43.
8. Holčík J, Koupilová I (2000) Primary health care in the Czech Republic: Brief history and current issues. *Int J Integr Care*. 1:e06.
9. Malan RM (1963) Occupational health in Eastern Europe. *Br J Ind Med*. 20(2): 154-164.
10. Weinerman ER (1968) The organization of health services in Eastern Europe: Report of a study in Czechoslovakia, Hungary and Poland, Spring, 1967. *Med Care*. 6(4): 267–79.
11. Křížová E (2022) Transformace českého zdravotnictví po r. 1989 – příběh na pokračování (část 1 a 2). *Dějiny věd a techniky*. 55(3): 127–172.
12. Pec O (2019) Mental health reforms in the Czech Republic. *BJPsych Int*. 16(1):4–6.
13. Shuftan N, Šlegerová L (2024) *Czechia: Health System Summary 2024*. European Observatory on Health Systems and Policies.
14. World Health Organization Regional Office for Europe (2025) *WHO Country Cooperation Strategy: Czechia 2024–2030*. WHO.
15. OECD, European Observatory on Health Systems and Policies (2023) *Czechia: Country Health Profile 2023*. State of Health in the EU.
16. Ministerstvo zdravotnictví České republiky (2019) *Strategický rámec rozvoje zdravotní péče v České republice do roku 2030 (Zdraví 2030)*. MZČR.
17. Czech Statistical Office (2021) *Education Census 2021*.
18. Český Statistický Úřad (2025) *Average wages–1st quarter of 2025*. CSO.
19. Český Statistický Úřad (2025) *Average wages–2nd quarter of 2025*. CSO.
20. Eurostat (2025) *Comparative price levels of consumer goods and services*. Statistics Explained.
21. Eurostat (2025) *Annual full-time adjusted salary in EU up 5.2% in 2024*. European Commission. Eurostat.
22. Bryndová L, Šlegerová L, Votápková J, Hroboň P, Shuftan N, et al. (2023) *Czechia: Health system review 2023*. *Health Syst Transit*. 25(1): 1–216.
23. World Health Organization (2023) *Enhancing mental health and social cohesion for Ukrainian refugees through a systematic approach in the Czech Republic*. WHO.
24. World Health Organization, United Nations Framework Convention on Climate Change (2021) *Health and climate change: country profile 2021: Czechia*. WHO.
25. Ministerstvo zdravotnictví České republiky (2020) *Národní akční plán pro duševní zdraví 2020–2030*. MZČR.
26. Koslerov A (2025) *Proč je v Česku málo psychologů? Může za to netransparentní atestační zkouška, míní odbornice*. IROZHLAS.
27. Ústav zdravotnických informací a statistiky České republiky (2023) *Zdravotnická ročenka České republiky 2022*. ÚZIS ČR.
28. Ministerstvo zdravotnictví České republiky (2022) *Národní onkologický plán České republiky 2030*. MZČR.
29. Hall K, Gibbie T, Lubman DI (2012) Motivational interviewing techniques: Facilitating behaviour change in the general practice setting. *Aust Fam Physician*. 41(9): 660–7.
30. Pinker I, Lafont C, Liposits G, Vidra R, Cunqueiro-Tomás AJ, et al. (2025) Representation of geriatric oncology in cancer care guidelines in Europe: a scoping review by the International Society of Geriatric Oncology (SIOG). *ESMO Open*. 10(5): 105052.
31. Horlait M, Dhaene S, Van Belle S, Leys M (2019) Multidisciplinary team meetings in cancer care: Is there a psychologist in the house?. *Int J Integr Care*. 19(S1): A131.
32. Ministerstvo zdravotnictví České republiky (2020) *Národní akční plán prevence sebevražd 2020–2030*. MZCR.
33. OECD (2023) *Health at a glance 2023: Highlights for the Czech Republic*.
34. OECD (2023) *Health at a glance 2023: Highlights for Portugal*.
35. Fronteira I, Augusto GF, Maresso A (2025) *Portugal: Health system summary 2024*. European Observatory on Health Systems and Policies.
36. Camacho E, Soares L, Faria AL, Fernandes MC (2023) Healthy lifestyles in the elderly: State-of-the-art. *Biomed J Sci Tech Res*. 51(1): 42219-42226.
37. Soares L, Leal T, Faria AL, Aguiar A, Carvalho C (2023) Cardiovascular disease: A review. *Biomed J Sci Tech Res*. 2023: 51(3): 42696-42703.
38. Soares L, Abreu J (2025) *Courage CBT psychological intervention in prostate cancer alongside with poetry*. *J Clinical Research and Reports*. 20(4): 1-9.
39. Soares L, Da Silva SCM (2024) *Psychology as support for medicine on lung cancer: A literature review*. *Biomed J Sci Tech Res*. 55(1): 46643–8.