World Health Organization

European Region

Can people afford to pay for health care? New evidence on financial protection in Czechia: 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, 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 (UHC watch, 2025).

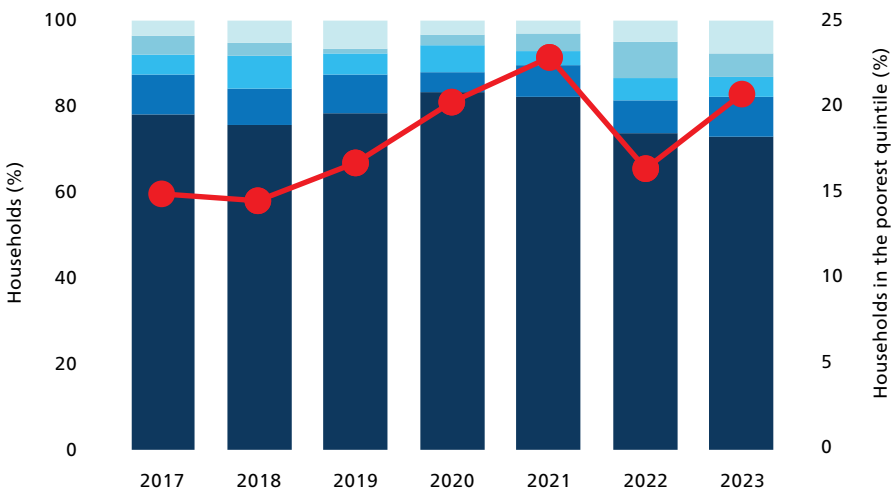
In 2023 3.0% of households were impoverished or further impoverished after out-of-pocket payments (data not shown) and 5.7% of households experienced catastrophic health spending (Fig. 1).

Catastrophic health spending is heavily concentrated in people with lower incomes (Fig. 1) and older people (data not shown; Kandilaki, 2025).

In the poorest quintile catastrophic health spending is driven by outpatient medicines; dental care is the main driver in other quintiles (Fig. 2). This is likely to reflect a substantially higher degree of unmet need for dental care in households with lower incomes over time (data not shown; Eurostat, 2025a).

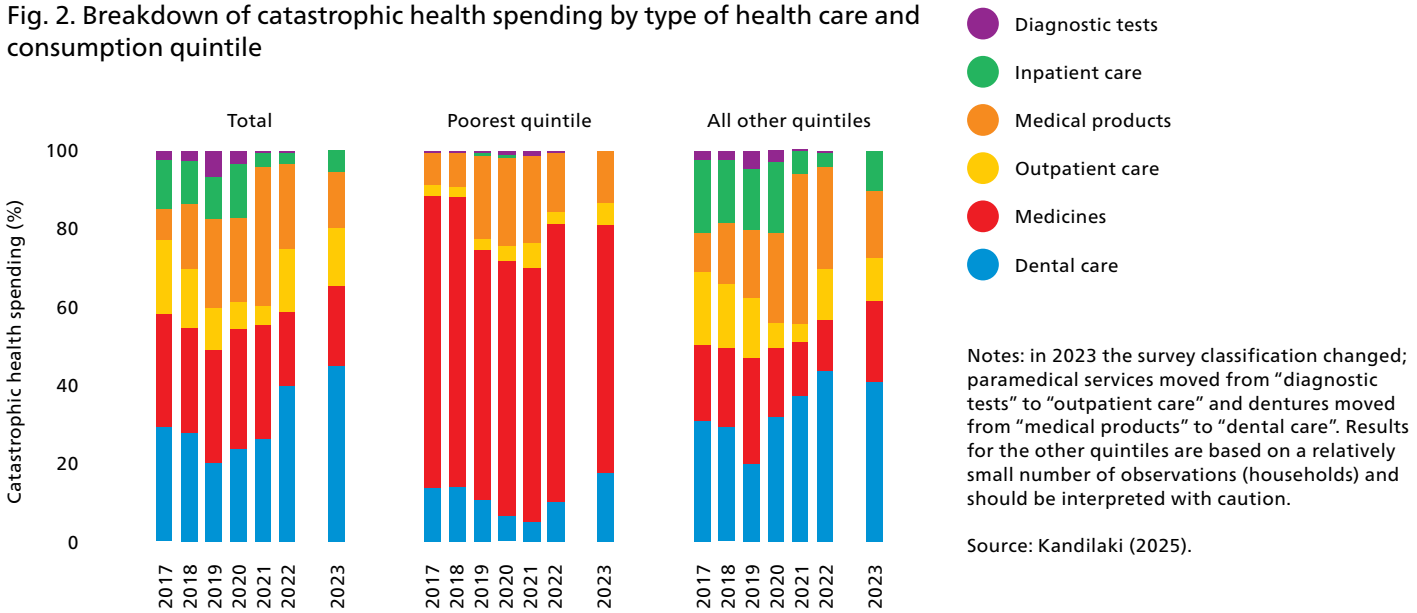
Unmet need is mainly driven by waiting time for health care and cost for dental care. Income inequality in unmet need is particularly marked for dental care and prescribed medicines (data not shown; Eurostat, 2025a; 2025b).

Fig. 1. Breakdown of households with catastrophic health spending by consumption quintile and incidence of catastrophic health spending in the poorest quintile



Source: Kandilaki (2025).

Fig. 2. Breakdown of catastrophic health spending by type of health 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: Kandilaki (2025).

How does Czechia compare to other countries?

The incidence of catastrophic health spending is lower in Czechia than in many European Union (EU) countries (Fig. 3). 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. 3). Catastrophic health spending in the poorest quintile is more heavily driven by out-of-pocket payments for outpatient medicines than most EU countries (Fig. 4). Unmet need for health care, dental care and prescribed medicines are below the EU average but have grown in recent years (data not shown; Eurostat, 2025a; 2025b).

What strengthens and undermines financial protection in Czechia?

Coverage policy in Czechia has notable strengths that offer examples of good practice to other countries. First, entitlement to social health insurance (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 social health insurance (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.

A higher than desirable prevalence of "avoidable co-payments" caused by reference pricing for outpatient prescribed medicines reflects:

- the absence (before 2025) of mandatory international nonproprietary name 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 value-added tax (VAT) on medicines and a shortage of pharmacists in border areas may also contribute to financial hardship and unmet need.

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.

Coverage of corrective lenses is limited to children and people with specific conditions. At the same time, all covered medical products are subject to reference pricing and there are no exemptions from these "avoidable co-payments", not even for people with low incomes.

Waiting times and informal payments are an issue for outpatient visits. Although waiting time targets are in place, they are not guaranteed because they are not systematically monitored. Informal payments are not systematically monitored.

Fig. 3. 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%. See page 5 for country codes.

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

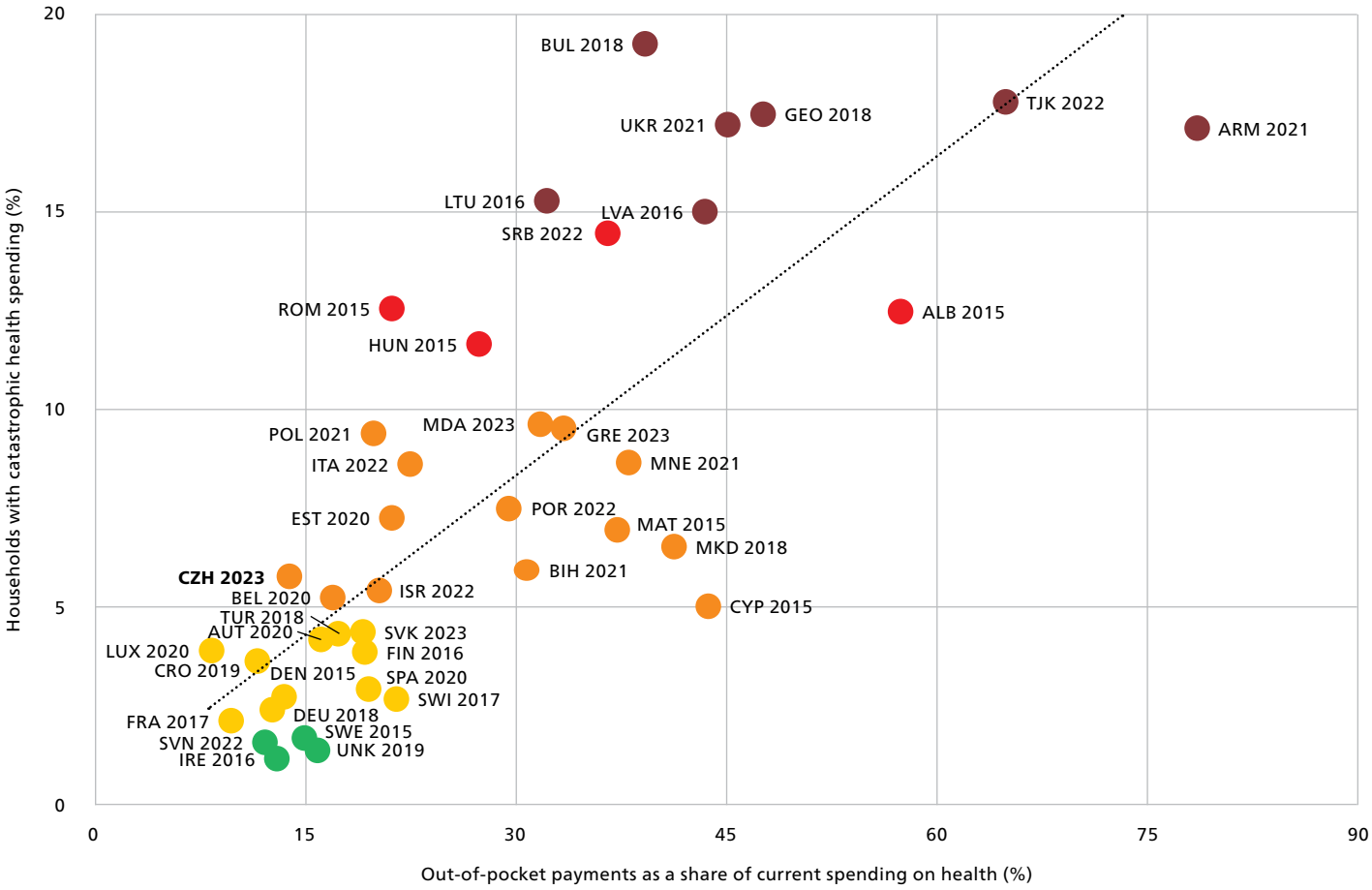
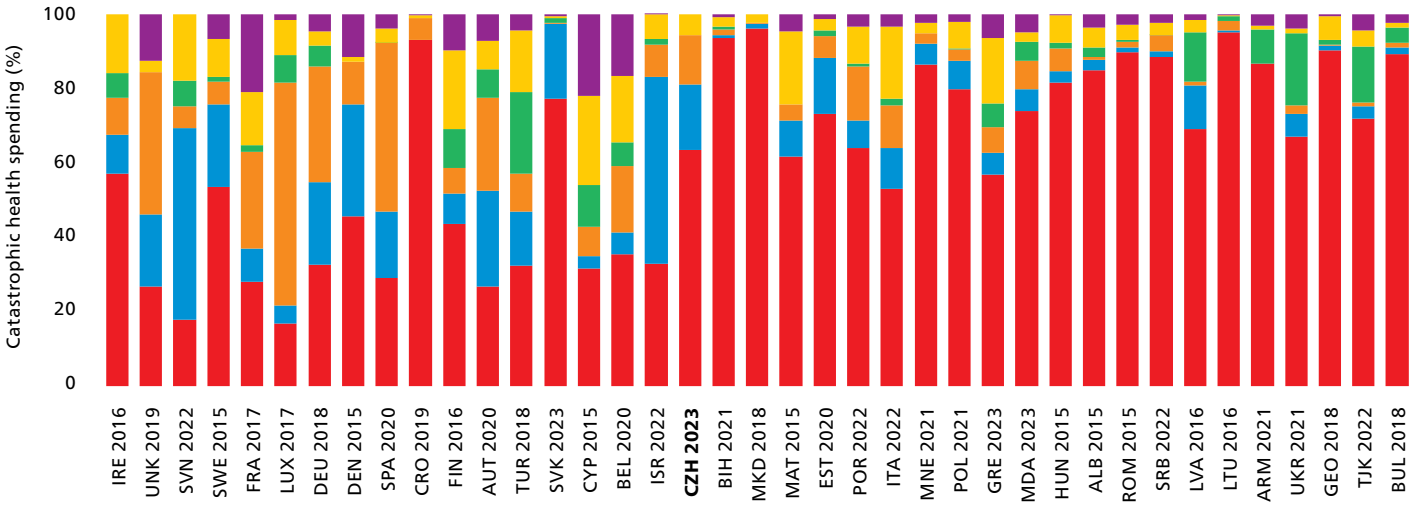


Fig. 4. Breakdown of out-of-pocket payments by type of care in households in the poorest quintile with catastrophic health spending, WHO European Region, latest available year

Notes: countries are ranked from left to right by the incidence of catastrophic health spending. Types on care are sorted by unweighted average across all households and all countries. See page 5 for country codes.

Source: UHC watch (2025).



How can Czechia improve financial protection?

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 extend the lowest cap (CZK 500 a year – around €22.51 in purchasing power parities) to people with low incomes; find other ways to link the cap to income (García-Ramírez et al., 2025); closely monitor "avoidable co-payments" and their causes; further reduce the VAT rate for covered medicines; and improve access to pharmacies in underserved areas.

Dental care: 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 (WHO Regional Office for Europe, 2023). It should also ensure that the SHI scheme's revenue base is broad enough to generate sufficient funding as the population ages (Cylus et al., 2025).

References[1]

Cylus J, Thomson S, Serrano Gregori M, Gallardo Martínez M, García-Ramírez JA, Evetovits T (2025). How does population ageing affect health system financial sustainability and affordable access to health care in Europe? Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380710). License: CC BY-NC-SA 3.0 IGO.

Eurostat (2025a). European Union statistics on income and living conditions (EU-SILC) [website]. Statistical Office of the European Union (https://ec.europa.eu/eurostat/web/microdata/european-union-statistics-on-income-and-living-conditions).

Eurostat (2025b). European Health Interview Survey (EHIS) [website]. Statistical Office of the European Union (https://ec.europa.eu/eurostat/cache/metadata/en/hlth_det_esms.htm).

García-Ramírez J, Thomson S, Urbanos-Garrido R, Bouckaert N, Czypionka T, Blümel M et al. (2025). Using income-based caps to protect people from user charges for health care. Lessons from Austria, Belgium, Germany and Spain. Improving affordable access to health care series. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/380709). Licence: CC BY-NC-SA 3.0 IGO.

Kandikali D (2025). Can people afford to pay for health care? New evidence on financial protection in Czechia. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/381966) Licence: CC BY-NC-SA 3.0 IGO.

UHC watch (2025). UHC watch [online database]. Copenhagen: WHO Regional Office for Europe (https://apps.who.int/dhis2/uhcwatch/).

WHO (2025). Global Health Expenditure Database [online database]. Geneva: World Health Organization (https://apps.who.int/nha/database).

WHO Regional Office for Europe (2023). Can people afford to pay for health care? Evidence on financial protection in 40 countries in Europe. Copenhagen: WHO Regional Office for Europe (https://iris.who.int/handle/10665/374504). Licence: CC BY-NC-SA 3.0 IGO.

1. All references were accessed on 18 July 2025.

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.

Acknowledgements

This summary is based on a review written by Daniela Kandilaki (Prague University of Economics and Business, Czechia). It was edited by Marcos Gallardo Martínez, Jorge Alejandro García Ramírez and Sarah Thomson (WHO Barcelona Office for Health Systems Financing). The authors of the review are grateful to the Czech Statistical Office for making the household budget survey data available to the author and the WHO Barcelona Office. WHO gratefully acknowledges funding from the Government of the Autonomous Community of Catalonia, Spain. This publication was co-funded by the EU4Health programme. Its contents are the sole responsibility of WHO and do not necessarily reflect the views of the European Union.

Co-funded by the European Union

Monitoring financial protection in Europe

This study is part of a series of country reports generating new evidence on financial protection – affordable access to health care – in health systems in Europe and central Asia. Financial protection is central to universal health coverage, an indicator of the Sustainable Development Goals, part of the European Pillar of Social Rights and at the centre of the European Programme of Work, WHO's strategic framework for the European Region. The WHO Regional Office for Europe monitors financial protection in over 40 countries through the WHO Barcelona Office for Health Systems Financing. See UHC watch for data, analysis and other resources (https://apps.who.int/dhis2/uhcwatch).

WHO Barcelona Office for Health Systems Financing

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage. The Office works with Member States in Europe and central Asia to promote evidence-informed policy making. It also offers training courses on health financing. A key part of the work of the Office is to assess country and regional progress towards universal health coverage by monitoring affordable access to health care. The Office supports countries to strengthen financial protection through tailored technical assistance and 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.

WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization
Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe

WHO/EURO:2025-12536-52310-80499 (PDF)
WHO/EURO:2025-12536-52310-80635 (print)