

Czech Republic

General Information

Czech Republic is a country with an approximate area of 79 thousand sq. km. (UNO, 2001). Its population is 10.226 million, and the sex ratio (men per hundred women) is 95 (UNO, 2004). The proportion of population under the age of 15 years is 15% (UNO, 2004), and the proportion of population above the age of 60 years is 19% (WHO, 2004). The literacy rate is 99% for men and 99% for women (UNESCO/MoH, 2004).

The country is a higher middle income group country (based on World Bank 2004 criteria). The proportion of health budget to GDP is 7.4%. The per capita total expenditure on health is 1129 international \$, and the per capita government expenditure on health is 1031 international \$ (WHO, 2004).

The main language(s) used in the country is (are) Czech. The largest ethnic group(s) is (are) Czech (four-fifths), and the other ethnic group(s) are (is) Slovak. The largest religious group(s) is (are) those without religious affiliation, and the other religious group(s) are (is) Roman Catholic.

The life expectancy at birth is 72.4 years for males and 79 years for females (WHO, 2004). The healthy life expectancy at birth is 66 years for males and 71 years for females (WHO, 2004).

Epidemiology

Dragomirecka et al (2002) assessed 1534 subjects aged 18 to 79 years using the Composite International Diagnostic Interview (CIDI). At least one mental disorder was detected in almost 27% of respondents (30% of women). The most frequently reported mental disorders were: neurotic disorders (18%), alcohol and tobacco use disorders (13%) and affective disorders (13%). Baudis et al (2002) reported findings on comorbidity from the same study. Lifetime comorbidity was found in 10.5% of respondents (8.6% men and 12.2% women) and 1-year comorbidity was found in 5.2% of the sample (5.0% men and 5.6% women). A significant association existed for the following sets of disorders: alcohol and tobacco use disorders, tobacco use disorders and affective disorders (mainly depression) and between affective disorders and neurotic disorders. Alcohol use disorders were correlated with all other groups of mental disorders in women. Psychiatric comorbidity was significantly associated with age and number of years of education. Koukolik (1996) reported a prevalence rate of 7.5% for Alzheimer's disease based on 2197 autopsies on patients aged 65 years and above. Beckova et al (1999) investigated drug use in over 550 university students. The most frequently used drug was marijuana (26.6%). Data from 142 treatment centres across the country showed that the commonest drugs being used were methamphetamine, heroin, marijuana and toluene. One-third of users were in the 15-19-year age group. Regional differences in prevalence and drug preferences and a trend towards an increase in intravenous drug was also noted (Polanecky et al, 1996). The current figure for drug misuse in the 15-39 years age range is 10.37/1000 (Polanecky et al, 2004). Sejda et al (1998) also reported that there was a gradual decrease in the average age of use and problematic use, especially in women. Consequently, the most affected age group was 15-19 years old and the male to female ratio stood at 2:1. Kubicka et al (1995) found an increase in alcohol use among 608 women interviewed twice in 1987 and 1992. Rate of heavy drinking increased from 7.2% to 14.0% and self-employed and independent women showed a greater increase in alcohol use. Topinkova and Neuwirth (1997) interviewed 1162 long-term residential elderly patients and

found the prevalence of depression to be 47.7% (nearly 70% of the depressed individuals were more than 75 years old). Poor cognitive ability and physical disability was associated with depression. Jablensky et al (1992) discussed the results of the WHO Collaborative Study on the Determinants of Outcome of Severe Mental Disorders (DOS) in which Prague was one of the centers. The study showed that schizophrenia has similar incidence in different cultures but the outcomes were better in developing countries. In a six-country study in Europe, Wiersma et al (2000) assessed patients with schizophrenia at 1, 2 and 15 years intervals after the initial contact using the WHO Disability Assessment Schedule. Almost 83% of subjects had disability and 24% suffered from severe disability. A deteriorating course was more frequent than late improvement. Severity of disability at the first three assessments of the illness contributed significantly to the explanation of its variance at 15 years. In a study conducted on 981 adolescents, using standardized tools, bulimia nervosa (DSM-IV) was reported in 5.7% women with another 15% being at risk. None of the males met the criteria for eating disorders (Krch & Drabkova, 1996). Horazd'ovsky (1993) found a decline in the rate of suicides during 1975-1990 in a study based on statistical registers. Kvasnicova et al (1992) examined the records of 23 510 children from special schools and social care institutes and identified 510 with mental retardation (prevalence 2.2%). The prevalence of mental retardation was much higher in Gypsy children. Out of the 106 children in whom genetic analysis was done, 31.1% showed an evidence of chromosomal abnormality and a non-genetic etiology was found in 19.8%. The mean incidence of Down syndrome was 7.91 per 10 000 liveborn infants during 1961-1997 (Sipek et al, 1999). Gebhart et al (1990) screened 5080 children for minimal brain disorder in three districts by interviewing mothers. They found that 14.8% had minimal brain disorder and this was reflected in their poor academic performance.

Mental Health Resources

Mental Health Policy

A mental health policy is present. The policy was initially formulated in 1953.

The components of the policy are advocacy, promotion, prevention, treatment and rehabilitation. The last amendment was in 2001. The policy in the field of mental health is formulated by the Psychiatric Society of the Czech Medical Association. This policy in the form of a programme document is presented to the Ministry of Health. The goals were published in 1997 and are known as Psychiatric Care in the Czech Republic - Programme Document and Mental Health Care Policy. This programme defines the status of psychiatry in the health care system and underlines requirements and conditions of modern trends in treatment, rehabilitation and social reintegration of mentally ill people.

Substance Abuse Policy

A substance abuse policy is present. The policy was initially formulated in 1989. The policy is a part of a law amended in 1989 (Act No. 37/1989).

National Mental Health Programme

A national mental health programme is present. The programme was formulated in 1953.

National Therapeutic Drug Policy/Essential List of Drugs

A national therapeutic drug policy/essential list of drugs is present. It was formulated in 1997.

The national therapeutic drug policy/essential drug list was formed through the Act No. 48/1997 on Public Health Insurance, which defines 521 groups of pharmaceutical products.

Mental Health Legislation

There is no specific law on mental health. The legislative regulation in the field of mental health is covered by the Law on Health Care for the Population (Act No.20/66 Coll.). This act, adopted in 1966, has been changed and amended by a series of health care reform legislation, most recently in 1999. More details can be obtained from the document: Health Care Systems in Transition - Czech Republic. European Observatory on Health Care Systems (WHO, 2000). There is another civil law bill on Involuntary Hospitalisation and Withdrawal of Legal Disposition, but it is yet to be passed.

The latest legislation was enacted in 1966.

Mental Health Financing

There are budget allocations for mental health.

The country spends 3% of the total health budget on mental health.

The primary sources of mental health financing in descending order are social insurance, tax based, out of pocket expenditure by the patient or family and private insurances.

The country has disability benefits for persons with mental disorders.

Mental Health Facilities

Mental health is a part of primary health care system. Actual treatment of severe mental disorders is available at the primary level. In principle, the primary health care is available for severe mental health disorders, but practically the preferred and common option is to use the services of ambulatory specialists.

Regular training of primary care professionals is carried out in the field of mental health. There are various options of training and education. Mental health care is a part of the training of general practitioners and nurses in primary care.

There are community care facilities for patients with mental disorders. There has been a substantial improvement in the quality of treatment provided in hospitals and also improvement in the living conditions of patients. Despite this positive changes, the current situation in rehabilitation and social reintegration of mentally ill patients is not satisfactory. The current status is partly due to limited financial resources. The costs of treatment are covered by health insurance fund, but for other interventions like social rehabilitation, coverage does not exist. The majority of work in this field is done by various non-governmental organizations and in few places by establishments supported by the churches, but they are unable to meet the demands. However, a number of very promising initiatives in day care (35 centres), sheltered housing, sheltered work and reintegration to the community have been started.

Psychiatric Beds and Professionals

Total psychiatric beds per 10 000 population	11.4
Psychiatric beds in mental hospitals per 10 000 population	9.8
Psychiatric beds in general hospitals per 10 000 population	1.5
Psychiatric beds in other settings per 10 000 population	0.2
Number of psychiatrists per 100 000 population	12.1
Number of neurosurgeons per 100 000 population	1.7
Number of psychiatric nurses per 100 000 population	33
Number of neurologists per 100 000 population	12.7
Number of psychologists per 100 000 population	4.9
Number of social workers per 100 000 population	

The total number of beds in residential facilities has decreased markedly within the last one and a half decade (by approximately one-fourth).

Non-Governmental Organizations

NGOs are involved with mental health in the country. They are mainly involved in advocacy, promotion, prevention, treatment and rehabilitation. Sheltered housing is also provided by NGOs.

Information Gathering System

There is mental health reporting system in the country. Mental health is reported as a part of the report of the health sector.

The country has data collection system or epidemiological study on mental health. The Institute for Health Information and Statistics is responsible for data collection in the health care sector. The information on psychiatric care are systematically collected and regularly published since 1963.

Programmes for Special Population

The country has specific programmes for mental health for minorities, refugees, disaster affected population, elderly and children. There are also programmes for patients with eating disorders.

Development of the community mental health care led to the establishment of the Network of Crisis Services.

Therapeutic Drugs

The following therapeutic drugs are generally available at the primary health care level of the country: carbamazepine, ethosuximide, phenobarbital, phenytoin sodium, sodium valproate, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, lithium, biperiden, carbidopa, levodopa.

Other Information

Socio-political changes in 1989 have started a process of rapid transformation of the whole society. The system of health care underwent a fundamental reform which affected the organizational structure of services as well as the system of funding and management. The major elements of the transformed health care system are 1) compulsory health insurance and establishment of health insurance funds; 2) decentralization, diversity and autonomy of service providers; and 3) the supervising and regulating role of the Government in negotiations between health insurance funds and health care providers on coverage and reimbursement issues. In the recent years, there were positive shifts in the attitudes of the public towards mentally ill persons and this continuing process will contribute to destigmatization and easier reintegration of patients to the community.

Additional Sources of Information

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