THE CONFIGURATION OF UNIVERSAL AND OPTIONAL HEALTHCARE FINANCING SCHEMES IN CZECHIA

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Abstract

Health systems in developed countries have their universal and optional part. This paper demonstrates the importance and fiscal position of the universally available care and shows the possibilities where it can be extended by optional financing schemes such as prepaid health packages. We use comparative approach, SWOT analysis and synthesis of included concepts into single health system. A simple scheme of possible health system financing configuration is created and the consequences of utilizing the described concepts are discussed. Overall this paper brings a theoretically substantiated overview of health policy options for Czechia, that support principles of universally available care, solidarity, fiscal neutrality, adequate fiscal space for health and possibilities of optional private health expenditure.

Keywords

Health System, Health Insurance, Earmarked Taxation, Health Savings, Solidarity

I. Introduction

Healthcare has long been the second most important fiscal subsystem and its role in the national economy is indisputable. Its analysis cannot be reduced to economic efficiency in the narrow sense of the word, as its result at best comprises the positive economic balance of its individual parts. This is certainly useful, but it is not enough for an accessible and well-functioning healthcare; such healthcare also has not only its ethical, civic, and solidarity dimension, but also an individual utility dimension. Similarly, healthcare constitutes a factor of competitiveness for both the entire economy and every citizen and thus a major determinant of economic development (Mertl and Vychová, 2009). We can theoretically classify health systems' configuration according to social models, which illustrate also their fiscal position and approach to their financing (Vostatek, 2013).

An important element of healthcare development comprises its availability and quality in both universal and optional parts of the system (Krebs, 2015). Although the optional part was considered problematic for ethical and ideological reasons in the past, the development of both economics and medicine shows that the availability of different treatment methods, the needs of social groups and the differentiation of patients' claims lead to accepting the possibility of offering health services that are not directly required to maintain and improve health, and can therefore be provided on an optional basis.

At the same time, the need for general availability of health care in the population, both for medical (effective prevention and treatment of illness) and for social reasons, continues to be urgent and indispensable. In the situation of increasing income and wealth differentiation (IMF, 2015), it is impossible at current stage of civilization development to expect that every citizen can obtain the needed health care individually or accept the reduction of universal health care to cover basic or only catastrophic care for the poor in the sense of the liberal social model (Titmuss, 1974). Such trends would mean a systemic creation of the so-called two-tiered healthcare system with weak, unclear and charity-based universal part, causing a negative impact on the health status of the population, availability of care, but also on the nature of medical practices themselves. Certain signals in this direction can be seen, for example, in Czech stomatology, where even the dentists themselves see the

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problem as there are considerable differences in the standards of care between dentists' groups, depending on the location, the individual approach of the doctor and the clientele's creditworthiness (Šmucler, 2016). It is hard to imagine the acceleration of these trends in other fields of medicine. Although some variations will always exist; the good universal system depends on their degree, character, and the existence and cultivation of standards available to every patient.

A tough issue for health care financing can be population ageing, which can put pressure on universal health care financing and complicate the affordability of optional one. There are projections made under various scenarios that suggest that the impact could be significant, especially when improperly or inadequately managed (European Union, 2017, 2018). Given the length and scope of this paper, we cannot cover this aspect in detail, but we recognize its importance.

The aim of this paper is to define the elementary attributes of universal and optional health care financing and show their possible application in Czech health care system. The used methods include comparison of health expenditures at macroeconomic level, SWOT analysis of prepaid health financing schemes, comparative approach about the universal and voluntary part of healthcare and synthesis on application of those two parts to single functional health care system. We have studied how particular schemes of health care financing (including health savings accounts – HSA), are defined in theory and have been working in developed countries and observed their socioeconomic characteristics. We also utilize deep empirical knowledge of situation in Czech health system[2]. When designing prepaid health programmes and their position in the system we tried to avoid common points of failure that have been observed internationally, and we classified their attributes into SWOT matrix so that the reader can see what they can offer and where are their limitations. We use positive economics to describe how health financing schemes work and what are their characteristics, but part of the statements concerning health system's configuration is normative, suggesting how the Czech health system should be configured to maintain and expand its performance for the future.

II. Macroeconomic dimension of health expenditure

The following Figure 1 shows the level of public (compulsory) and inversely (100-public) the level of private (voluntary) expenditures in selected OECD countries. Figure 1 shows that over 15 years, except for the Netherlands, Latvia, Slovakia, Switzerland and Turkey, this share remained relatively stable and the fluctuations were within 10 percentage points, e.g. one tenth of the health budget. In addition, it shows that Czechia is within a group of countries that have high share of public expenditure on health – above 80 percent. But we can also note that during the last 15 years this share has been decreased slightly, in 2000 being nearly 90 percent, so the trend can be characterized as slightly decreasing the role of public (compulsory and solidarity-based) financing.

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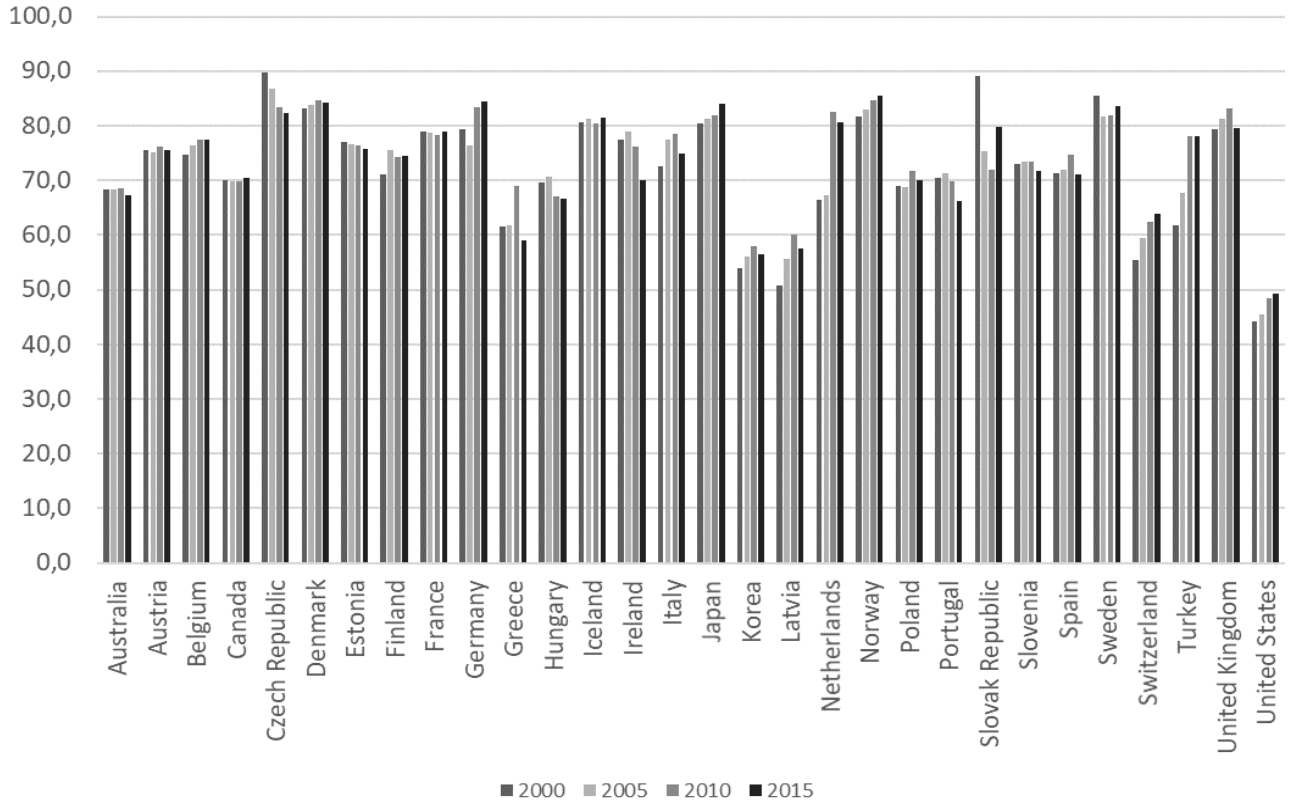
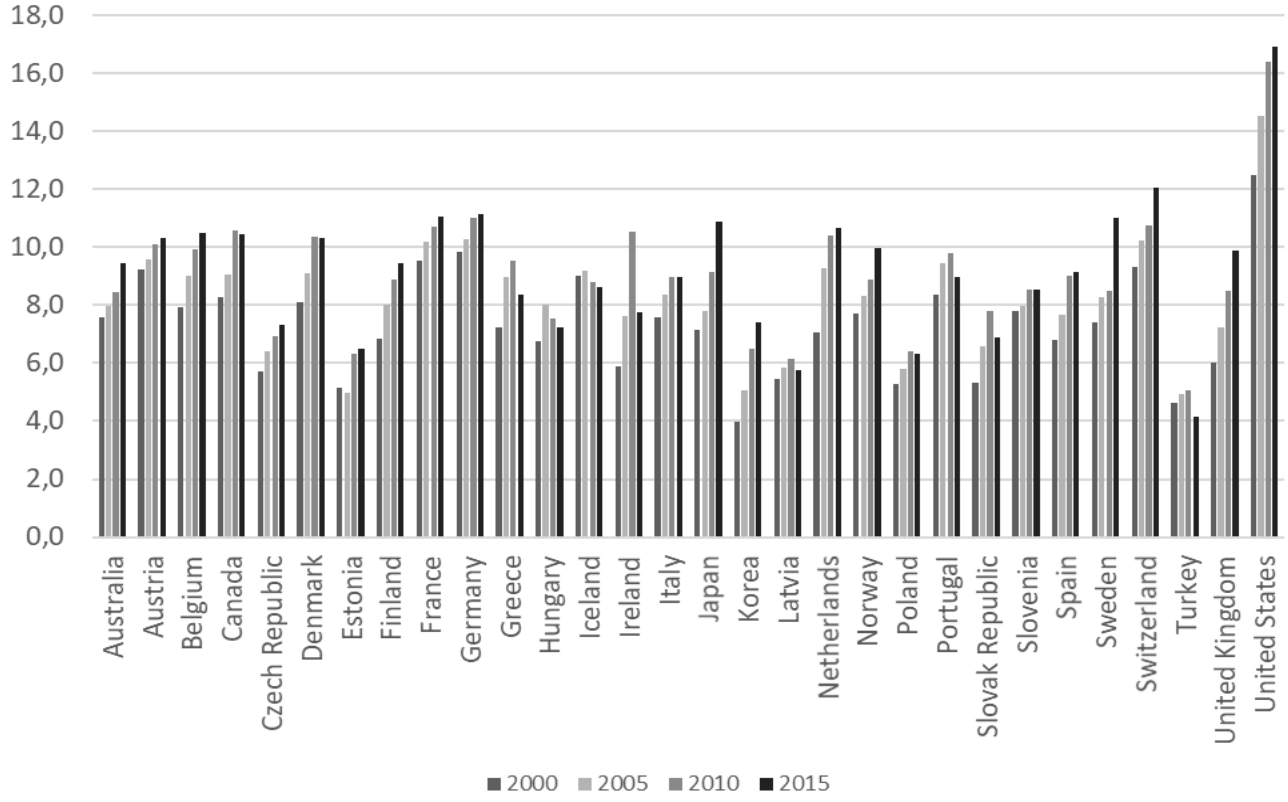
Figure 1 Share of public exp. on total health exp., selected OECD countries, 2000-2015



Source: (OECD, 2017). 2015 OECD Estimation

If we compare the overall expenditure for health care relatively to the GDP (Figure 2), Czechia ranks within the countries to those with low share of total health expenditure to the GDP – 7,3 % GDP in 2015 (OECD, 2017).

Figure 2 Share of total expenditure on GDP, selected OECD countries, 2000-2015



Source: (OECD, 2017). 2015 OECD Estimation

We can see that the significant differences between countries (e.g. Czechia – 7,3 % vs the Netherlands – 10,7 % vs USA – 16,9 % in 2015) support the statement about multifactorial causes of the health expenditure (and system effectiveness) level. Health spending growth has been moderate since 2000 but has been markedly slower since the global financial crisis in 2008-2010. Despite the recent slowdown in health spending, concerns about the fiscal sustainability of health system remain large (OECD, 2015). We can still say that countries with more centralized or government-budget based system tend to have lower share of health expenditure on GDP (which was a general rule of health economics e.g. 20 years ago), but the case of United Kingdom or Denmark shows that even their shares increased and can now be compared to system with more decentralized institutional structure with autonomous health insurance budgeting like Germany, France or Switzerland (OECD, 2015).

In this sense, we can imply that even if the Czech system might be perceived as having problems with internal effectiveness (Hrstková, 2015), which is often cited as a reason to limit public expenditure, statistical data (OECD, 2017) support (at least) keeping the Czech public health expenditure at current level, and possibly increase the private health expenditure if it is desired by public policy in order to decrease total solidarity and increase total equivalency.

III. The significance and financing of the health system's universal part

The universally accessible health care system must provide every citizen with the care he/she objectively needs to maintain and improve his/her health. Such care must therefore be medically complete and based on lege artis methods. Its content changes over time based on advances in medicine, the situation of patients and the incidence of diseases in the population. At the same time, it is expedient to support positive externalities - prevention, healthy lifestyle, dispensing of chronic diseases, complex multidisciplinary treatment of diseases. This is by no means merely a solidarity reimbursement to those in need or the remediation of an acute worsening of the health conditions - such care is usually the least effective (e.g. increased use of emergency services).

On the theoretical level, there are several ways to fund universally available health care.

- General taxation - healthcare is financed from the government budget as a mixed public good, similarly to primary and secondary education, the army, the police or the judiciary (Peková, 2011).
- Social health insurance - healthcare is funded through individual social insurance schemes for selected population groups, it is mandatory for these groups, premiums are set as a percentage of working income up to the ceiling and the range of covered health care is limited on the level of those groups (Vostatek, 2000), (Vostatek, 2010).
- Earmarked health tax (Bloom, Cashin, and Sparkes, 2017) - healthcare is funded by earmarked (hypothecated) proportional payroll or personal income tax, or part of excise taxes, in the form of automatic direct fiscal allocation of these resources for health care.
- Regulated competition for multiple health insurance plans - the so-called basic healthcare package offered by health insurers is sold at a market price, strong regulation and government support for the sale of these products is required.

If a model is to be used in a given country and there is a motivation to implement it within a public choice that subsequently occurs, typically, a country sticks with the chosen model in the long-term even with consciousness or manifestations of its disadvantages. At the same time, in practice the chosen model typically becomes dominant and is supplemented by a smaller system for situations or citizens that are not satisfactorily solved in the dominant model (Donabedian, 1971), (Williams, 1997). In Great Britain, it dominantly concerns the National Health Service (NHS) funded by the government and regional health authorities (Cylus and Richardson, 2015); in Germany, a significantly modified social health insurance funded through the central health insurance fund and the pluralist insurance companies structure (Busse and Blumel, 2014); in the Netherlands the compulsory two-component nominal premium funding basic package healthcare (Boerma, Kroneman, Berg, and Groenewegen, 2016), in the US the Obamacare system organizing a regulated market for exchange plans (Gineken & Saltman, 2013). The last option, i.e., the regulated competition of insurance plans with the pressure to provide the universally offered range of care, is the most complicated and costly, forming the basis for countries where there is no or weak consensus on universally accessible and financed health care for every citizen. In the European countries, there is no need to deal with it, because there is a long-term consensus on universality and there is no need to complicate it through the detailed and demanding regulation of commercial providers, who cannot, in principle, guarantee it in the long-term by means of market-based methods (Němec, 2008).

From the fiscal point of view, it is possible to directly allocate funds for healthcare and make up the fiscal space for health (Barroy, Dale, and Sparkes, 2016) based on the following techniques, mechanisms and principles:

- Proportional tax (% of income) – "earmarked" health tax (Mertl, 2017b). It is possible to collect it either from labour income/wages (§ 6, 7 of the Act No. 586/1992 Coll.), then it is a payroll health tax. Or also from all other categories of income (§ 8, 9, 10 No. 586/1992 Coll.), then it is a classic proportional income health tax.
- Insurance premium ceilings, the possibility of differentiating the premium rate at the level of individual insurance companies and social groups, defined benefits linked to the premiums paid and social groups – if they are introduced, these are individual elements of social insurance (Vostatek, 2000). At present, however, given the universality of the implementation and sharing of health risk at national level, social health insurance in its original pure form is virtually absent in health financing.
- Solidarity in health - the premium (health tax) depends only on income rather than on health status = prohibition of cream-skimming among insured. If this is desired, participation in the system must be mandatory at least for selected social groups (ideally for all citizens).

- Solidarity in income - given (as stated above) by a relative share (percentage rate) of income allocated for healthcare financing. That is important, since in case of a single absolute amount (as it is in private healthcare financing), there would be the destruction of income solidarity, and it would be a form of "earmarked poll tax on health", which would result in a significant burden on citizens with medium and lower incomes.
- Share of revenue (subsidy) from excise or general taxes - the result is, among others, a reduction in the direct burden of the labour factor (in the wake of wider aspects of the efficiency of the tax mix). This role is currently fulfilled in Czechia with the amount paid for the state insured persons (who generally are not expected to have working income), that health insurance companies receive from the government budget (969 CZK per one person since 1.1.2018). Ceteris paribus, the reduction or cancellation of this amount would put pressure on an increase in the existing health insurance rate (13.5%).

In case there exists a multi-payer system, central redistribution of collected health contributions is required based on the cost indices of the individual insurance groups or clients. This means that a particular health insurance company receives a different amount of money than individual client's compulsory payment (premium) is. Therefore, it does not make sense to continue pay premiums directly to individual health insurance companies (as it is done now in Czechia), but to the central fund organized by the Financial Administration or Ministry of Health, from which redistributed premiums will be paid to health insurance companies.

As far as direct payments are concerned in the universal part of the system, it is obvious that they have almost exclusively regulatory sense, as the patient does not gain additional benefit for them, but instead directs his behaviour in a system with possible problematic consequences. As demonstrated in the Czechia, they have a significant impact on public choice experience from Germany (Busse & Blumel, 2014) shows that they have been criticized for not having too high of an impact for high income people because of the amount, while they can limit access to care to low-income people. It seems possible to leave them where they are clearly penalizing (overuse of emergency services) or the patient pays for non-medical activities (hospital stay, administrative confirmation).

The choice between these models is constantly the subject of expert analysis and public discourse – theoretically we can choose between single-payer and multi-payer. At the same time, however, we have observed the surprising stability of each model within one country. The choice of single-payer versus multi-payer is typically a decision for decades, which must have political support for a long time ahead and therefore possible more radical reform in this direction should be approved for example by a three-fifth (constitutional) majority in parliament. That decision is primarily about the character and configuration of health system we want to have in particular country, which should be stable and dependable.

For Czech conditions, it is advisable to maintain the "earmarked" proportional tax on wages or whole personal income of individuals and their assigned allocation to the health service (Mertl, 2017b). Maintaining a subsidy from general or excise taxes to reduce the burden of the labour factor and partially offset when using the excise tax ratio, the negative externalities of tobacco, alcohol and transport are also possible (Bloom, Cashin, and Sparkes, 2017). Simultaneously, the degree of simplicity and transparency of the relevant tax mechanisms must also be considered as they are significant efficiency factor of public financing (Mertl, 2017b).

We ought to note that theoretically, the financing of healthcare purely from the government budget, directly from a share of general taxes and without insurance companies, or more precisely "one insurer" as a regional structure of public administration in the style of the British NHS (single-payer), is technically feasible and, from the point of view of classical public finance theory, the most effective. However, it depends significantly on the quality of governance, the consistent application of public governance practices, the willingness to introduce/increase the tax progression from personal income and the acceptance of a monopoly in health care payments in the existing pluralist structure of health care facilities, including outpatient care. These conditions are not fulfilled in the Czechia, and a multi-

payer system has already been put in place, the cancellation of which does not have significant political support.

Within the universal system, it is desirable to work more with techniques of positive motivation, i.e., systematically evaluation of participation in preventive activities and preventive examinations, effective behaviour (Madrian, 2014) within the system (e.g., patient movement between physician, specialist and hospitals, reduce the drug overuse and overtreatment etc.). If support is provided within public choice, consideration may also be given to allocating a specified small percentage of the health budget to the level of health insurers in the form of health tax credits or other benefits (e.g. once per year). All such measures, however, predict, first of all, the fiscal financial pillow, from which they will be funded before any positive effects from the better health of the insured can arise. Conversely, negative motivation in the sense of penalizing for undesirable behaviour cannot be recommended, even in accordance with the knowledge of behavioural economics (Matjasko, Cawley, Baker-Goering, and Yokum, 2016) works very weakly or not at all. Moreover, patients must be treated even when their health condition in relation to their behaviour or choice deteriorates.

Nevertheless, the universal part of the system must not be subject to permanent pressure for the erosion of a medical standard that it guarantees. It is not true that there are no additional options, as shown in the next chapter, current medicine and the development of associated services offer a range of voluntary options for private spending. The often-heard theory that "we should pay for banal illnesses directly so that the more serious could be paid through solidarity" is not applicable, especially when we know that the overall volume of health expenditure in Czechia is already relatively low within OECD. Moreover, serious illnesses often arise through neglect or non-treatment of malignancies or their early stages. Similarly, the costs of treating serious illnesses are such an essential component of reimbursements that any savings on "banal" care do not address the situation of their coverage. In any case, it is necessary to maintain the medical standard of treatment for all illnesses, while recognizing that it is a difficult task and that in the universal system there is always the risk that accessibility of care will become formal in a certain segment, region or diagnosis. However, this is better than when it is inaccessible apparently and ex ante, because in case of such unavailability it is always possible to claim the relevant rights of patients who are refused in commercial systems for simple financial reasons on the principle that there is no objective requirement for their treatment in those systems.

IV. Optional prepaid health programmes' role

The development of medicine and socio-economic environment has brought new treatment options and health services for patients. Likewise, some patients' demand for comfort, time of health professionals and the extent of consumed health services are increasing. Although it has several ethical connections, it is currently recognized in developed countries that health professionals can also provide care to those patients who have higher requirements than others, and these requirements are not strictly objectively justified by their health status. This moves us from the category of care that must be provided into the category of care a patient may or will want to consume. In this context, optional healthcare schemes can be created that can be used to finance and provide it.

The first option is logically private health insurance. Although it has suitable features for some scenarios, it also has many problems that are not addressed well using private resources and the market mechanism in this scheme. This is mainly due to the information asymmetry and adverse selection issues, which in many cases lead to the failure of the health insurance market (Cutler and Zeckhauser, 1997). The individual's health risk is one of the worst quantifiable and insurable risks on the market, develops unpredictably among individuals, and its possible evaluation through medical underwriting constitutes a reason for major legal and ethical disputes. In addition, in case of high-quality healthcare, it is sometimes difficult to look for a randomness element that is generally necessary for the use of insurance mechanisms. However, for example, in accident insurance, the usual risks (death, disability, permanent consequences, pain, hospitalization due to an accident) can be insured even without examining the state of health in the sense of a previous illness. Critical illness

insurance, hospitalization or long-term care insurance can also be sold, and, last but not least, general private health care insurance, albeit its marketability is low for the stated reasons.

It is also possible to pay for optional healthcare directly out-of-pocket, which is the simplest form, but it has many limitations (e.g. financial hardship at the moment of the treatment, time-limited decision in asymmetric position, highly limited ability of typical patient to "shop around" for the best price) leading to marginal role of these schemes in developed countries (OECD, 2017).

Suitable option for extending schemes of optional healthcare financing comprises prepaid health care programmes. Their economic construction is relatively simple and consists in the regular allocation of the amount chosen (e.g. monthly or yearly), for which the client receives a healthcare package according to their preferences and needs. Therefore, there is no need to quantify health risks or otherwise complicate entry into the product, although it is of course advisable to adapt the package to the needs and health of the client according to their preferences or as a result of expert advice when purchasing the product. Different clients can therefore have different packages for the same money, as will be shown below.

Let us assume that a patient can allocate 750 CZK for his health services monthly, e.g. 9 000 CZK annually (can be lower or higher amount in practice according to the individual budget limitation and willingness to pay). Therefore, he can buy a prepaid package for this price, which we can see also as a subscription price for participation in the programme.

He then is offered, according to his preference and/or health status, a package of health services that he can consume for that money during a year. It can be offered purely according to his demonstrated preference, or he can get advice from a doctor according to his health status, which services he would the most benefit from.

Table 1 Prepaid packages' examples for 9 000 CZK yearly subscription

Healthy	Already sick (e.g. cardiovascular condition)
1 000 CZK for services of nutrition advisor	2 000 CZK for additional services/consultations at cardiologist, lower co-payments for advanced drugs that he takes regularly
1 000 CZK for wellness services	1 500 CZK advisory services of physiotherapist and physical training aimed at cardiovascular rehabilitation
1 000 CZK for annual specific complex screening of civilization diseases	500 CZK for vitamins and dietary supplements
2 000 CZK for lifestyle activities and therapies (exercise, relaxation)	1 000 CZK contribution for a home cardio monitoring device
2 000 CZK for better services at general practitioner (email/callback/SMS), additional consultations/screening	2 000 CZK for better services at general practitioner (email/callback/SMS), regular monitoring of health status
2 000 CZK for vitamins, vaccination and reimbursement of regulation expenditures if introduced/expanded in universal part of the system	2 000 CZK for lifestyle activities (exercise, relaxation) specific for cardiovascular diseases

Source: author

It is clear, that the structure of benefits can differ according to the status of the patient and is highly dependent on the creativity of the scheme providers. In addition, we can imagine that the employers will provide partial or full financing of those packages as a specific employment benefit. Thus, it can serve also as the factor of market differentiation and choice. If desired, special prepaid schemes can be created for e.g. dental, eye or spa (wellness) care.

In practice, these schemes make sense especially as an extension of a universally available system because international experience with health savings accounts shows that they have disadvantages that become highly prominent if they are not supported by a compulsory universal system – then they quickly fail with the poorer or sicker population (Hoffman and Tolbert, 2006) or when clients grow old and require more expensive care (Avera, 2017). One of the disadvantages of health savings accounts is also the "pressure to save", which means adverse health care seeking behaviour (Dody,

2014) in order to preserve money saved into HSA. Therefore, suggested prepaid health packages provide no special incentives to save money there and the amount paid should be fully spent for specified health services during chosen period.

Employer can contribute to the payment of these programmes, even in relation to workload compensation by influencing the content of the respective programmes. Similarly, if the client is involved in the optional extension of the pension system (Mertl & Valenčík, 2017), then a part of the money received may also be used to pay for the subscription.

As opposed to out-of-pocket payments, these schemes have the benefits in a possibility for the creativity of health insurers and healthcare facilities in organizing and implementing care, economies of scale (large volumes of care can be planned and provided based on the batch of valid pre-paid contracts), promoting regional development, predictability and transparency of funding for the client and for healthcare facilities and reducing the difficulties with financing and decisions at the time of the treatment and health services' consumption. The overall position of these healthcare schemes can be summarized in the following table, which we have created based on the socioeconomic characteristics of prepaid health programmes as a voluntary extension of universal system.

Table 2 SWOT analysis of prepaid health programmes' role

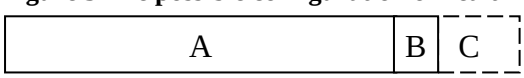
Strengths	**Opportunities**
Synergic effect with universal health coverage, while keeping public and private resources separated	Possibilities of truly voluntary allocation of private resources for health care
Non-discriminatory approach according to the health status of a client	Possibility of individual or group aiming of those schemes, e.g. at young people, employees of certain branches, the elderly people
Patient has real choice about the character and volume of provided services	Options for health providers and health insurance companies to be creative about the content of those packages
Lowering transactional costs, reducing information asymmetry and increasing economies of scale compared to situation when the patient buys the services individually and/or at the moment of treatment	Transparency for client about the allocation of his resources
Weaknesses	**Threats**
Construction of the package can be perceived as "not necessary for healthy and not enough for sick"	Some medical branches can offer more into packages than the others
The amount of resources that individual can allocate might be too low for programme to be useful	Character of competition and regulation on the market
Does not cover bigger (catastrophic) expenditures nor provides full coverage for listed situations (as health insurance does)	Unclear influence on the overall health system effectiveness
Those who can utilize it the most (sick/poor) might not afford to buy it	Requires to be backed up by universal system (which is present in Czechia but if not maintained well can threaten even the role of programmes)

Source: (Mertl, 2017a), updated

V. Possible configuration of health financing resources

If funding of these programmes is integrated at the level of health insurers (while maintaining the separation of public and private resources), they can function from the client's perspective transparently as one health insurance product, consisting from compulsory health income tax and optional subscription to the selected pre-paid programme.

Figure 3 The possible configuration of health financing resources



Source: author

The parts "A+B" together make up the compulsory universal system as described in the third chapter. Their fiscal volume is defined by the public resources that are collected through public finance techniques and are centrally redistributed according to the cost indexes. If we want to make fiscally neutral proposal for Czechia, current level of health insurance rate (13,5 %) can be preserved in the

form of earmarked health tax and the share of excise tax or general taxation can be added as the replacement of state insured persons' contribution (Mertl, 2017b). Now Part "B" is very small, consists only from preventive programmes financed from so-called "Prevention fund" of public health insurance companies. It can be abandoned if we want to have pure universal system as part "A" only. Or vice versa, if desired by public choice, part "B" can be slightly (it will always have marginal share) expanded to individual motivation strategies within the universal system, such as health tax credit or programmes for chronic diseases management as done by social health insurance companies in Germany (Busse and Blumel, 2014). Part "C" is the optional private amount, which can be primarily used for prepaid health packages.

The discussed scheme and configuration may appear a bit like system of so called two-component (income-related and nominal premiums) health insurance used in the Netherlands (Boerma, Kroneman, Berg, and Groenewegen, 2016). The very substantial difference is that the absolute (nominal) part "C" is strictly optional in our concept and delivers additional health services extending the standard; while the Dutch absolute (nominal) health insurance premium primarily targets the variation of the total amount paid for the basic health care package, and thus trying to utilize on price competition within the universal part of the system. Moreover, large social groups in the Netherlands must be fiscally subsidized (by health allowances) to be able to buy the basic package with nominal premium, whereas the prepaid packages needn't be subsidized at all (because their purchase is fully voluntary). Thus, in the Netherlands, there is strong hidden erosion of public funding and provision of a universal health care. On the contrary, the system of prepaid programmes as the extension of medically complete universal system enables a truly optional allocation of private resources, while preserving clear public financing of universal health care.

VI. Conclusion

The universal part of the system must be medically complete, but in the current healthcare systems there is space for both universal and optional funding schemes. The reason is the advance in medicine, the socioeconomic environment of developed countries and the population's increased expectations. At the same time, however, the construction of financing schemes cannot be left to invisible market hand only. Because of market failure, information asymmetry and significant differences in population's health status and incomes, such solutions in themselves nowhere in the world led to acceptable results.

In years 2000-2015, total Czech health expenditure has been low among the OECD countries and the share of public health financing has been higher than average. The focus of health policy has been to cover the needed care within limited fiscal space, which caused problems especially at the times of economic downturn while providing medically complete care for every citizen. Given this macroeconomic situation, it is not recommended to further decrease public spending and erode the standard care so that there is more space for private schemes. In order to respond to demand for care beyond the universally available standard and utilize the healthcare providers' potential, this should be done, if desired, by introducing private financial schemes that will increase total health expenditure level without lowering the current level of public spending. In this way, the ratio between public and private spending may in the long run change slightly in favour of private one (which may be desirable), but the public will still be able to cover the necessary and objectively needed care. This is important both for the citizens that rely solely (or mainly) on universally available care, and for the citizens that will participate in the voluntary prepaid programmes, since they assume the presence of medically complete universal system.

We showed several theoretical options how to finance the universal part of the health system. For Czechia we recommend the evolution of current health insurance to the earmarked proportional tax on wages/personal income and the distribution of its revenue according to cost indices of individual payers to health insurers. The current payment for state insured persons should be technically transformed to pure subsidy to the central health insurance fund from government budget. This will allow for a continuing reduction in the tax burden on labour, or in case of excise taxes' share even a

partial compensation of the negative externalities associated with the consumption of tobacco and alcohol. In this and previous (Mertl, 2017b) paper, we assumed fiscally neutral approach that technically transforms the public health financing, but suggested scheme allows also the change of public health expenditure (visible in earmarked tax rate) if required for example by population's ageing or simply decided by public choice. Determining the level of public financing and the content of universally available care is highly complex task beyond this paper's scope, but we are aware that regular update of care that will be provided universally in relation to socioeconomic effectiveness, available resources, demographic situation, medical necessity and benefits for the patients is generally needed.

The vast majority of OECD countries does not rely on the competitive market for necessary and needed care with variable insurance plans or the spill over effects from the private part of the system as a tool for increasing universal availability and effectiveness. Of course, there are synergy effects and we suggest using them, but the government's direct guarantee for universally available care including the fiscal financial flows shall be maintained. We also note the significant differences between suggested model for Czechia and the compulsory two-component (nominal) insurance premium according to the model in the Netherlands. This is a topic for further research because suggestions to implement Dutch two-component nominal health insurance have been sometimes appearing in Czech public discourse.

An optional part of the system is imaginable as a real extension and superstructure over the universal part. Paradoxically, the existence of a universally available base gives social, legal and medical legitimacy to the voluntary choice of care, because medically adequate and appropriate treatment is available for both groups of patients (both standard and above-standard) and, in addition, the consumption of health care in different situations and life stages is organically intertwined.

As a possible alternative to private health insurance, which has strong limitations, prepaid schemes can be considered. We introduced them as an extension of the universal health care system and with no special incentives to save money in these schemes. As we summarized in the SWOT table, they have some unique features such as lower transaction costs and high economies of scale, room for individual client customization and provider creativity, non-discriminatory access to clients' health, and optional money allocation for health care packages that are individually selected with possible medical advice and recommendations.

We dare not say that prepaid schemes are a miracle that can solve problems with health expenditure financing in Czechia (OECD, 2017). The analysis also shows their weaknesses and threats, and for some scenarios, other funding schemes may be more appropriate. Particularly in case of rare and random health incidents' occurrences with higher costs (such as an accident or hospitalization), it may be appropriate to offer supplementary private health insurance. However, we suggest that pre-paid programmes be seriously considered as a possibility for voluntary private spending on healthcare packages tailored to individual clients, especially when their health preferences and needs can be determined in advance. There they could help to achieve individual health benefits better than out-of-pocket payments or private health insurance, especially for people who want to invest in their health and maintain it regularly with the help of social and health services (Chytil, Klesla, & Kosička, 2015).

Generally, whenever we consider increasing the private expenditure or change the degree of solidarity in health, we must decide what we want to achieve. Whether we want to regulate the consumption by introducing co-payments (in fact forcing people to pay for the care they need with some regulatory effect) or whether we want to create extensions that provide additional health utility for those who effectively demand it. While not neglecting the regulatory effect (that can be appropriate for some situations), we believe that the second approach has bigger sense, given the advanced capabilities of today's medicine and related services, creating new additional voluntary health packages and programmes and offering them to those who want and can pay for them. In this way, it can be ensured that they provide additional value above the universal standard and at the same time will not

jeopardize the quality and safety of care for those who do not want or cannot pay more than statutory health payments. Certainly, most of health providers can today offer health care and services above universally needed range, which could bring benefits to those who can afford it. However, we need to remind that from a social policy point of view, pre-paid programmes can be socially selective, because there will be always large social groups that will not buy them or will participate only for short periods. So, equity problems can raise again, especially if Czech wages and incomes remain at the current level or the role of universally available care is underestimated.

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