KAREL ENGLIŠ'S TELEOLOGICAL APPROACH AND THE CONFIGURATION OF HEALTH CARE SYSTEMS

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Abstract

This paper's aim is to reintroduce the teleological approach formulated by professor Karel Engliš approximately hundred years ago showing it as a highly useful analytical tool for social systems, including the health one. Engliš enriched the positive and normative approach of scientific analysis with teleological one, using postulates based on the principle of finality, and distinguished it both from positive causality and narrow normative measures or legal norms. Because health economics often struggles with handling the plurality of health systems, it is worth to search in theory for approaches that will improve this deficit and Engliš's approach has shown as perfectly suitable for this purpose. We therefore briefly explain the logic behind it, that was thoroughly defended in the literature in 1920s and 1930s. Then we search for specific attributes of four different health systems and sum the up into a table which briefly combines social models, fiscal and tax policy measures and ideals/postulates that those systems are based on. The result is better understanding of the health systems configuration and solid theoretical knowledge behind it, easing the need for finding the optimal or "most effective" health system by recognizing that more important is to know which properties and characteristics it should have and which principles it is built on.

Keywords

Health System, Teleological Approach, Fiscal Policy, Health Insurance

I. Introduction

Some economists worldwide are searching for single "optimal" configuration of health care system. They are assuming that using the tools of positive economic analysis such a configuration can be found. While creating abstract positive economic models, even for health economics, can prove highly useful for analysing healthcare as an economic entity, as shown e.g. by Grossman (1972) and Becker (2007), the empirical experience from world health care systems suggests different knowledge concerning searching what can be optimal for the health policy. It seems that multiple configurations do exist in practice, and while we might dispute the quality of their actual implementation, we can distinguish amongst various typologies of health care systems.

There are multiple main criteria in the typology of health systems that are usually important for classification. These are the resources of the system and the schemes of its financing (OECD, 2015), health care providers, their ownership structure and methods of payment (Culyer & Newhouse, 2000), the extent of availability of health care in the population and the method of its provision, the degree and method of regulation of individual actors. The traditional division into Beveridgean, Bismarckian and market models (Durdisová, 2005) is based on the setting of resources and schemes of financing the system.

The rational classification of health care systems related to the theory of public finance was made by Vostatek (2010; 2013), who extended the classical typology of welfare state models according to Esping-Andersen – social democratic (universalistic), christian democratic (conservative) and liberal model (Esping-Andersen, 1990) – by neoliberal model, which has

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developed approximately in the last 30 years. The benefit of this classification lies both in compatibility with classical models of social policy (Titmuss, 1958; Titmuss, 1974) and in the identification of typical economic and financial characteristics of individual models within the framework of public choice and tax policy. In analysing the use of these models in OECD countries (Vostatek, 2019), he shows examples from the setting of individual systems, such as the Swiss, Dutch and American examples of the neoliberal model, the German example of the christian democratic model, the Swedish example of the social democratic model and historical examples of liberal models. At the same time, he demonstrates deviations from the "pure" setting of these models, such as the German tendency to unify the scope of covered health care in the German statutory insurance and the partial consolidation of the number of insurance companies. He has also shown and emphasized the discrepancies between logic of social insurance and the universality of care (leading to problems with the usage of social insurance in health care) and the nature of regulation of compulsory insurance in neoliberal systems (Holub, Mertl, Šlapák, Vostatek et al, 2019).

There are also other remarkable typologies in theory that are worth considering (e.g. Field, 1973; Reibling, Ariaans, & Wendt, 2019); actually, health systems have one of the richest and diverse classifications amongst socioeconomic systems. We observe that many theorists tried to cope with this fact. Still, the economic theory sometimes struggles to capture healthcare within its framework of positive models and "laws" accompanied by normative policy suggestions and their actual implementation (Fuchs, 2000). It seems, that there is something more behind the observed plurality of health care system than just searching for the most effective or public choice-approved solution. This is to some extent valid for all social systems, but for health one is given the reality in world's health care systems very prominent.

I think that this research problem can be well resolved using the Karel Engliš's teleological approach, which I consider being a hidden gem of Czech economic thinking. Using the postulates and principle of finality, we can explain why in particular country such a system exists, what are its principles and ideals and determine the principal logic which it is based on. The teleological approach enables the researcher to overcome the limitations of both positive economic models and normative policies or analyses based on application of valid rules and possible regulations. Identifying the postulates which the health systems are created on, suddenly we can see much better their logic and we know why they are configured in a particular way, and we can even judge whether their configuration is right within the postulate's framework or not. This is especially important for health care systems as they typically are deeply rooted within a country's history, priorities, preferences, and institutional arrangements. It thus enables us to understand what is going on, not just apply positive model or suggest/evaluate normative policy.

This paper thus has got the following main aim: to reintroduce the teleological approach formulated by professor Karel Engliš approximately hundred years ago showing it as a highly useful analytical tool for social systems, including the health one.

As for the overall methodology, given the space available within the paper, we shall not describe the health systems' reality in detail, also because the reader can already find them e.g. in the European Observatory's Health in Transition series (Van Ginneken & Saltman, 2013; Cylus & Richardson, 2015; Busse, Blümel, Knieps, & Bärnighausen, 2017; Busse & Blümel, 2014; Boerma, Kroneman, Berg, & Groenewegen, 2016) and OECD Health at a Glance series (OECD, 2019). We shall rather focus first on explaining the teleological approach as defined by Engliš, then secondly on fiscal models of financing health care and then thirdly construct a synthetic table of four significant health systems (USA, the Netherlands, Germany, Great Britain) that demonstrates the different settings in practice.

II. Karel Engliš's teleological approach

An important element for the methodology of health care systems' analysis is to utilize the work of the Czech economist Karel Engliš, whose hundred-year-old work contains an elegant way to deal with the plurality of health systems at the level of economic theory and how to approach their analysis. Engliš, referring to the philosophical approaches of Immanuel Kant, in his work distinguishes the world into phenomena as they are ("simply existing") and as they should be (Engliš, 1930). This corresponds to the division of economics into positive and normative that is usual at present. There is no room for a logical intermediate between these two worlds. Engliš agrees with that and "does not insert any element into this fork" (Engliš, 1929, p. 281), but convincingly and in a number of specific polemics (Engliš, 1929; Engliš, 1929a; Engliš, 1932a) proves that the world as it should be ("other than existing") contains two aspects, two forms: the world of the wants/desirability (postulates) and the world of the obligations (norms). The very normative regulation and the form of the world to be is in Engliš's conception only subsequently created logically explainable structure based on the will of the subjects, which is attributed to them not in terms of psychic will, but the arrangement of desirable states, contents, materiality and their observation by teleological method. This is how Engliš understands the creation of economic systems (in the sense of finality and organizational purpose) based on postulates containing this will. The normative method therefore uses logical reasons to clarify certain measures (applicable specific standards) changing or regulating existing causality (if they are perceived as inadequate for a predetermined purpose or if it has proved necessary to establish certain rules for interaction between economic entities), while the teleological method is based on purpose and formulated postulates, examining the means to fulfil them and looking for usefulness in relation to purpose on the principle of finality (Engliš, 1930).

Engliš realizes that "the difference between positive (causal) thinking on the one hand and between teleological and normative thinking on the other is deeper than between the two then mentioned." (Engliš, 1930, p. 33). That might be why, at present, the normative method is often identified (without further distinction) with the principle of "as it should be" in the sense of the opposite of "as it is". However, in his time, Engliš paradoxically often defended the teleological method against the causal (positive) method and the subjective will (individual motive) leading to the observed causality (see his polemics with Bilimovič and Weyr about the impossibility of transposing teleology into causality and rejecting teleology as reversed causality). At the same time, however, Engliš points out that "normative theory is not right in that it occupies the whole area of thought outside of causal thinking, because it assumes tasks for which it is not sufficient in its formally logical construction" (Engliš, 1930, p. 25). Thus, the term *normative is seen* by Engliš *as narrower than we usually understand it today*, making space for teleological one. In the field of social policy (Engliš, 1916), this distinction is particularly important because it allows to define or understand a number of desired and desirable elements of social systems without pressure on their normative determination, or to find out on what and why valid standards (e.g. legislative, ethical or economic policy regulations) have emerged.

Table 1 Positive, teleological and normative approach as defined by Karel Engliš

	World as it is (existing)	**Other world than it is (non-existing), thus such a world that should be, either in the sense of being desirable or having an obligation.**	
Character of world	causal, natural world as seen by natural sciences and positive analysis	desirable (wanted) world, teleological approach	world of norms and obligations, normative approach

Basic knowledge	something exists	something is wanted (postulate)	something ought to be, in narrower sense (a norm)
Subject	things that we see as existing ones	postulates	norms
Understanding works by	causality (cause – result)	finality (purpose – means)	logical arrangement (application of the norms and their structure)

Source: (Engliš, 1930), adapted

Engliš states that "teleological vision sees measures forming state policy (e.g. in the form of regulation and other elements of economic policy) as a complex of means pursuing a certain common purpose, which binds them and makes them a system, produces certain benefits and prevents damage visible only from the point of view of the purpose, which forms a central valuable point ... without this purpose there is neither harm nor benefit." (Engliš, 1929). Today, we speak more about public policy or social policy then state policy, but the sense for application of teleological principle remains the same as when Engliš used it, amongst other usages because he designed this approach as a general and universally applicable, for central authority assignment. Therefore, this can be applied to health policy in specific countries by each system being constructed on certain foundations. principles and ideals; its functioning must also be assessed in relation to the postulates (in Engliš's terminology) according to which it was created.

This concept is useful for health policy, as health care is typically based on several postulates, which vary from country to country. However, the observation of causality alone cannot identify them, and in practice normative codification is typically the result of previous teleological efforts to implement them. Thus, the postulates themselves cannot be explained by a logical reason or obligation, but by a wish and a certain intention in relation to the content effects which we want to achieve on the principle of finality. We often work out their definition by creating a logical pyramid, on the top of which they exist or in the construction of which we follow a certain original purpose or principle that determines its character, and gradually decompose it into a set of partial postulates. In this way, in fact, most of the elements of health care systems are created, including the relevant normative legislation, which can already be explained for a logical reason. Including highly technically sophisticated systems such as redistribution of premiums, reimbursement of health care and medicines or construction of private health insurance products. However, their technical and logical sophistication need not determine their use within a health system – *it is the teleological view that determines whether they will be understood as a useful tool or not.* We can say that the "central maximum purpose" (Engliš, 1930, p. 95) in the teleological understanding of health care is human health. In this context, the problem of limited resources for health care can also be understood, which Engliš was aware of at a general theoretical level in relation to teleology (Engliš, 1930, pp. 89–130).

III. Three fiscal models for financing health care

In general, there are several options for setting up the health system. First, we can consider the health care system to be like the police, the military, justice and other "traditional" sectors of public finance and public services financed from general taxation. In this approach, the health care system is one of the important economic sectors and the level of health care expenditure is determined centrally through public choice and the priorities of budgetary and fiscal policy. In this sense, the position, power, and quality of governance of the Ministry of Health is particularly important, because the fiscal process is determined mainly through the legislative procedures of governments and public policy negotiations. The risks of this approach include

poor public governance practices (Greer, Wismar, & Figueras, 2015), poor public administration, and the health budget may be under pressure, especially at times when the entire state budget is tight (economic crises).

Secondly, we can set up one or more independent institutions (health insurance companies) that work on the principle of solidarity according to health status and usually income (in the case of compulsory participation). In history, these institutions were formed spontaneously on the principle of reciprocity and mutuality, then there was a tendency to use the average cost rate of the group, in the current terminology of community rating, because solidarity by income is difficult to implement on a voluntary basis. This creates a parafiscal payment that becomes the income of these health insurers. They then have their own balance sheet and budget, usually under supervision, but not through direct management of the public interest. When there are multiple insurance companies, the question of risk selection and the nature of the competition between them arises (Cutler & Zeckhauser, 1999). Examples are German statutory health insurance companies or French "mutuelles" (Brouland & Priesolová, 2016). This method is usually based on the allocation of a share of earnings or income to health care, either as social health insurance or premium payments to a mutual insurance company (in its pure form, especially in history), income tax or earmarked health tax (Bloom, Cashin, & Sparkes, 2017). Special question is whether we should have one or more of those institutions – single or multi payer model, given the scope of this paper we can only make reference to literature which clearly shows that (again) we cannot say generally which option is better (Petrou, Samoutis, & Lionis, 2018; Liu & Brook, 2017).

Third, we can make fundamental regulation (especially in terms of limiting the classification of health risks) of commercial entities that sell private health insurance on the market and provide a government subsidy for low-income or economically inactive citizens so that everyone can afford this product. at least as far as the universal (standard) level is concerned. This approach appeared in the private health insurance markets, where the public choice decided to keep their benefits as viable and at the same time wanted to achieve the goals offered by solidarity systems. There are still questions about the effectiveness of these (generally large) subsidies, and in some countries, the government is entering the market by creating large programs for poorer or more sick social groups (USA: Medicare, Medicaid). This system occurs in only a few countries around the world, such as the United States, Switzerland or the Netherlands.

These are model approaches; in many countries there is a slight overlap or creation of a dominant main system of one nature and at the same time a small "aside" system is run on another principle - for example Germany and its social (90% of the population) and private (10% of the population) health insurance (although we can see the private health insurance clients also as a social group which is compatible with the general German approach). To grasp this at the level of theory, we can usually identify the main or dominant approach to health care financing and then the complementary ones used in a given country.

From the fiscal policy point of view, these options mean the following fiscal models with corresponding funding schemes (Mertl, 2016):

- *Government expenditure program for health care* (with a significant share of budget funds within public finances) - allocation to the budget chapter of health care as a part of central systems of public finances. In the allocation of resources at the central level, supported by appropriate legislation determining the price level and volume of health care provided, health care is funded by "pure" allocation principles in the public sector. In this scheme, health care expenditures are more fiscally discrete, as the government decides on their amount and structure separately and annually, even if it does not have direct control over some variables that affect their volume (e.g. drug prices, etc.).

- *An independent institutional framework for health care financing*, where impact of political cycle and the role of the central government in health system management and running are limited. The main fiscal task is to collect and allocate the agreed amount of money to specialized autonomous institutions (health insurance companies defined by law, formerly also spontaneously created based on mutuality). In this public finance scheme, the relevant financial flows can be considered as mandatory elements and automatic stabilizers, as they are automatically allocated to health care as defined by law.
- *Subsidized / regulated scheme of private insurance products*, where people are obliged to buy a health insurance product on a regulated market, or receive support based on their social status so that they can buy a highly regulated health insurance product commercially. In this model, the degree of income differentiation and the level of regulation required are important for the government's position and fiscal volume of health care expenditures.

It is worth noting that the selection of these systems is the result of a long-term development of the financing of the health system and its configuration, public policy actors and fiscal policy alone cannot (or even ought not) oscillate between these schemes according to momentary priorities. At the same time, the question is whether and how the reserve funds of public health insurance companies should be filled, whether the cyclical development will be reflected directly in the state budget balance and will be an effort to optimize the flow of funds continuously (as does the British NHS, which moreover does not use a public health insurance institution), or whether health insurance companies will have a certain buffer to cover cyclical fluctuations (as partly is done by German statutory health insurance companies).

The individual schemes can then use earmarked payments for health care to varying degrees according to the following formula:

$$E = r_h \times w + N$$

where *E* is the obligatory earmarked payment for health care, *w* is the earnings (income – base for calculation) from which the earmarked payment for health care is paid, r_h is the rate of health insurance or health tax, *N* is the variable amount of nominal premium, paid either in full by participant or partly from a social transfer that the participant receives in connection with the obligation to pay a nominal premium.

The total amount of government and compulsory resources for health care (health resources/revenues – HR, which when we consider zero annual balance of health system are equal to health expenditure) can then be computed as follows:

$$HR = \sum_{i=1}^{n} E_i + G_T$$

It holds that for a given volume of HR, the volume of resources from general taxes (G_T variable) is inverse to the total of earmarked payments of participants $\sum E$ given their number n. The G_T variable therefore reduces the relative fiscal significance of the earmarked payment; the percentage rate r_h and the nominal payment N, on the other hand, increase it. Financing from general G_T taxes corresponds to the general setting (degree of progressivity) of the tax system, the obligatory earmarked payment is proportional at a uniform rate r_h and the nominal amount N has the character of a poll tax, i.e. without income solidarity. Individual items can be zero in specific systems. These equations can be directly computed for systems with payments defined by law, e.g. British, German and Dutch one; in the American system we could “only” sum up nominal payments and add government expenditure for government-run plans such as Medicare to get a rough estimation of these values (and then resolve the issue of tax exemptions which are very prominent there).

IV. Selected systems' configuration

When we look at the world's health systems, we can find typical representants of the particular postulates in the form of country health profiles, whose elements can be summarized in the following table. Fiscally they can fall into one of the models from previous chapter, which define the fiscal approach which is dominant for the country. This is not an attempt to create a new typology, but a comparison and synthesis of important elements of individual countries available at the Health in Transition database. The American and Dutch systems are unique in their kind, while the German performance-based (conservative) system created by the evolution of Bismarck's social insurance occurs in several OECD countries and the British universalist system of the Beveridgean type even more often. We can see that every system is based on its own ideals, principles or in Engliš's terminology postulate that determines its configuration and tools and measures used. It becomes then clear why they are utilized in particular country. The only common denominator here is the health status of the population, that is the goal that all the countries currently strive for (although e.g. 50 years ago the American system spoke rather about the individual health utility gained).

The sense of this table within this paper is to show what principle/postulate is utilized in the selected countries, which fiscal implications it has got and how it is connected with the social models which are included at the last row. We can observe, that until we identify the postulate(s), it can be hard to understand why particular system utilizes this or that norm or tool, and vice versa, when we do the identification "what is wanted" correctly, suddenly the logic of norms and policy trees become apparent. So we can clearly see, that the same element (in the first column) is fulfilled completely differently in observed countries, and still we cannot say that one of those ways is in principle wrong – as long as it is compatible with the general ideal/postulate in the first row. Thus, the table shows not only a description of the systems' properties, but it also makes link between social policy, fiscal policy and teleological postulate that the systems are built on. Understanding this link is crucial for understanding health policy, and the researchers should not get misguided by the "performance analysis" of health care systems leading to conclusions that one element is more effective than the other. As I wrote in the beginning, they are scientifically important, but all these analyses are then confronted with this framework and the only common denominator defined above. Thus e.g. the human capital model is highly useful, but whether the investment into health as a human capital will be done from public or private resources, using more equivalency or solidarity, using single-payer or multi-payer model is not given by the concept alone, but by the framework where it will be realized.

We can also say that the health systems often choose different paths to achieve common goals. At the same time, they differ in properties and values that are important for their constructions and actors, so the nature of the systems can radically differ – e.g. it would be unattainable in the USA to pay insurance premiums as a percentage of wage, and German citizens would probably not accept if large social groups are uninsured. But within the postulate that is valid in a country, we can see the payments according to income as a way to include everybody who is working into the system, we can see the uninsured as a result of free choice not to buy a plan, and so on. The same logic applies for the fiscal configurations, e.g. in Germany, where the solidarity is realized by the percentage earmarked payment, there is much less need for additional government transfers, and e.g. in the Netherlands, they accept the fiscal subsidies (health benefits) provided to large social groups as a tool enabling the people to choose the plan with a nominal (absolute) premium. This does not speak about the effectiveness of those tools, which ought to be analysed separately (and as written these analyses can be also very useful and have merit), but about their acceptance and compatibility with particular "pyramid of postulates" that applies in a country.

Table 2 Typical elements of American, Dutch, German and British health system

	USA	Netherlands	Germany	Great Britain
Ideal/postulate	purchase of insurance plan or health care on the market	managed competition of insurance companies and providers leading to improved care for all	compulsory insurance with social group differentiation and institutional autonomy of insurance companies	healthcare provided as a public service free of charge at the time of consumption
Character of earmarked payments to the system	absolute amount (individual premiums or community rating)	two-component payment (percentage rate + nominal premiums)	percentage rate of earnings up to the ceiling + percentage surcharge set by the insurance company	no specially earmarked payments
Role of general taxes (excluding general expenditures on public health and health administration)	subsidies of government programs and plans , support of community care, tax incentives and reliefs	subsidies for the purchase of insurance products, payments for children under the age of 18 years	payment of insurance premiums for the longer unemployed, contribution to central health fund, investment in the hospital network	dominant source of funding for the system
Correction / regulatory mechanisms (excluding patient participation)	rules for Medicare, Medicaid, regulation of insurance plans, FDA (drugs and treatment methods) activities, managed care	obligation to choose a product, prohibition of client rejection, redistribution of part of premiums, regulation of insurance companies and contracting of providers	redistribution of (almost) all premiums, possibility of insurance companies to set a surcharge to a uniform premium rate, regulation of legal and private insurance	waiting lists, mechanisms of effective allocation in the public sector, contracting in public sector with providers
Patient position/main task	choose an insurance plan adequate priorities and budgetary constraints and according to its content to move in the system to	choose an insurance company providing the optimal combination of nominal premium, nature and scope of services (with a guarantee of the basic package)	choose an insurance company and the amount of additional rate applied; a minority, if the income is above a certain threshold, consider switching to private insurance	to pay taxes and use health care and services according to objective needs; optionally purchase additional care and services not covered by the state
Manifestation of system imbalance, specific indicators of its development or problems	uninsured persons, insurance plans subject to "insurance health spiral", amount of administrative and legal expenses, costs of hospital emergency	number of persons non-paying premiums (defaulters), of those who get the health subsidy to buy insurance, balance of health insurance	balance of health insurance companies, movements between legal and private insurance	number of patients on waiting lists, waiting times for hospital treatment, forced use of private clinics paid for by direct payment
Health risk sharing	within individual insurance plans	at the level of individual insurance companies and at the national level accord. to % pay (6.95%)	at the national level through the central health insurance fund (14.6%)	at the national level
Mand. solidarity rate	low, need for charity	medium	high	full
Cost	high	medium	medium	lower
Root social policy model	liberal, neoliberal	neoliberal	performance based (conservative)	universalistic (social. dem.)

Source: author

IV. Conclusion

Enriching the common methodology of positive and normative economics by Karel Engliš's teleological approach proves useful also for analysis of social systems, because it works with the postulates that the systems are based on and which are behind the norms, settings and mechanisms that we see in practice; to some degree they also determine their usefulness within particular country regardless of their theoretical value or technical advance. To make space for teleological thinking, it is necessary to shrink a little the space that is currently occupied by

normative approach, Engliš was well aware of this fact and in his point of view the normative analysis is focused on the norms, mainly legal or otherwise compulsory, actually the teleological approach is seen by Engliš as a necessary prerequisite to construct and explain a "normative world". Engliš designed his theory as a general one, creating pure form of outlook, independently on any teleologically thought content. So the application of his theory on health systems can be seen as original contribution of this research paper, while Engliš mentioned the "health of the nation" several times in his books as a top priority in national economy, he did not specifically apply his theory on health systems focusing on making it as universal and general as possible, which proved to be very useful. Noteworthy is also the fact that Engliš during his career successfully defended his approach in several scientific polemics, which makes it more durable and possible current critics today ought to first be acquainted with these articles before dismissing teleology as a concept.

The institutional configuration of the universal part of the system can be organized on three basic principles which have got their fiscal implications. First, it is the provision of health care as a public service funded and organized by government and public administration. Secondly, it is an independent institutional structure of public (social, non-profit, mutual) health insurance companies with legislatively given revenues in interaction with the pluralistic ownership structure of health care facilities. Third, it is a mandatory or fiscally stimulated purchase of private insurance products on a regulated market. Decisive for health insurance is the problem of quantification and sharing of health risk connected with medical underwriting in private insurance, which has been highlighted by the development of medicine, demography and the cost of care, which has gradually changed the functioning of social and private health insurance. In the last half century, this has led to the construction of a central (national) redistribution of compulsory insurance premiums in a multi-payer system and to the significant regulation of private health insurance. Considering the teleological principle, we must decide which of those three principles we want to use as dominant in particular country, or at least correctly identify which one has there spontaneously evolved. *It is of no use just to replace one with the other claiming that this change alone will bring higher effectiveness or better performance, although it can change the nature and quality of the system.*

The basic postulate of the American system is participation in the chosen insurance plan and its individual selection on a (regulated) market. The key dispute over Obamacare was the extent to which these plans were to be regulated in terms of entry criteria for participation and pricing, and whether Americans had to buy a plan. Insurance plans with social criteria for participation and significant fiscal support are also offered by the US state (Medicare, Medicaid). The universal part of the system is reduced to catastrophic, life-saving care and is complemented by selective charity. The system has got an extremely high cost, it costs from public sources the same level as lower expenditure European countries and from private resource it adds once more again. Nevertheless, developments over the last 10 years show that the choice of insurance plans, plurality at all levels of the system, and compatibility with a socio-cultural environment based on individual choice is likely to be so important to Americans that they will not leave their system.

The Dutch system was created by unifying the previously dual system of social and private insurance based on the deliberate construction of three health markets with managed competition. This has been the main postulate, although the practical implementation must have made some compromises. The two-component fiscal space consists of a percentage rate of earnings entering the redistribution of premiums and an absolute nominal rate paid to the selected health insurance company. For its operation, the system needs significant fiscal support in the form of payments for children and contributions to the population to pay the nominal premium. The non-profit principle is significantly applied.

The German system is based on the insurance of individual social groups and the considerable autonomy of statutory health insurance companies. To participate in the (predefined or later chosen) social group covered by insurance has become main postulate. Socioeconomic development have forced the abandonment of the employee principle of social insurance and extensive central redistribution of premiums associated with the consolidation of the number of insurance companies, but at the same time from 2015 statutory health insurance companies can again set their own percentage surcharge to the central redistributed premium rate and provide specific programs for your insured. Participants in private health insurance with significant regulation are also a separate social group in Germany.

The British system is a classic example of the provision of health care as a public service organized by public administration (postulate). The volume of health care expenditures is decided centrally; health care is financed directly from the state budget and provided through a structure of general practitioners, hospital trusts and community health and social care. This determines the functioning of this model in both positive and negative terms. There has been a repeated public debate on the amount of resources allocated to British health care amongst other fiscal priorities, and the government has a major influence on the practical functioning of the system. Partial initiatives to increase internal competition and public sector management reforms usually do not last too long, but in general they follow each other and respond to the problems or bottlenecks sensitively perceived by the British public (e.g. waiting lists, low responsiveness and limited patients' choice).

We should recognize that using the teleological method, we can also analyse and formulate the implications for Czech health care, based on the conditions and context specific to Czech conditions, as the health care system has gradually developed here and what priorities in public choice appear here. It is possible to maintain principles such as solidarity-based financing, general availability of health care and a uniform rate of health insurance premium (earmarked health tax). At the same time, adjustments could be made to those elements where development since year 1993 showed the appropriateness of corrections (for example, the construction of fiscal space, reimbursement and redistribution of premiums, understanding the standard of health care and the employment of health insurance companies). We can preserve system of multiple health insurance companies, enhance the mechanisms of its operation and dynamics, pursue exploration of synergistic effects, and ways in which it can be beneficial in the universal and optional part of the system (Mertl, 2018) – if *we make these things a postulate that we shall want to achieve*. As a secondary option, we can examine the characteristics of the system managed by the government and regional health administrations as a theoretical variant, because currently the conditions under which it can be considered and work well are not met in Czechia. Czech situation is for sure out of scope of this paper, but we dare say that the teleological approach can help us in this process the same way it has been demonstrated here.

Based on an international comparison, it can be concluded that health care financing reforms cannot simply be replanted between countries; each country has a unique context, initial conditions and ideals that it reflects in the construction of its health care system. This is in line with the teleological approach of Karel Engliš, who, based on the definition of these postulates, defined a suitable approach to the analysis and conception of national economic systems, including health care. It is necessary to know the characteristics of individual forms of health care financing and in this paper I have shown the principles on which individual systems are primarily based, but their use depends on the priorities of public choice and ideals of citizens of the country, the quality of implementation of individual schemes and national targeting for specific conditions and causality.

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