# THE UNIVERSAL AND OPTIONAL PART OF A HEALTH SYSTEM: A WAY TO HANDLE THE HEALTH CARE SUPPLY AND FINANCING

**Jan Mertl**[1]

**Abstract**

Since the shift to market economy in 1990s, the issue of health care standard setting has emerged in Czechia. While many attempts were tried to set the standard of care "right", they never fully succeeded, causing many controversies. It seems this issue needs to utilize another approach to move on and improve. This defines this paper's scope, which addresses the universal and optional part of health system, treating them as general categories and discussing their construction and financing principles. It performs theoretical analysis and synthesis, utilizes egalitarian and liberal approach to health care and depicts the character of both parts on theoretical level. Also, it tackles the problem of discrepancy between the ideal and real content of the universal part. The actual empirical setting of main financing schemes in OECD countries is shown. The results have got theoretical value by themselves and can help to overcome the problems of "standard and above-standard" care in Czechia.

**Keywords**

Universal Health Care, Health Care Financing, Health Insurance, Health Financing Schemes

## I. Introduction

Since the transition to a market economy, the question of the standard and above-standard care has arisen in the Czech healthcare system. However, even after more than 30 years, it has not been conceptually resolved. It can be assumed that an important reason for this state of affairs is a misunderstanding of the meaning and purpose of the two basic parts of the health care system and a narrow concentration on the categorisation of health care. However, we dare say that the categorisation itself is not the root of the problem. This can be illustrated by the notion of a standard of health care, which focuses on its substantive content, but does not focus on financing and reimbursement schemes, the purpose of this standard within the national economy and health system, and the acceptance of the construction of the standard as a dynamic outcome of public policy and choice in interaction with the phenomenon of health care need and available resources at the macro and micro levels.

A separate issue is the characteristics of health care as an economic good. Although the increasing heterogeneity of health care complicates classification in this respect, a simplistic identification of standard care with a mixed public good and of above-standard care with a private good and their subsequent treatment according to their economic logic is offered. Only a very small part of health care (e.g. hygiene service and sanitation) is a pure public good in the sense of the economic criterion of non-excludability and non-rivalry. Empirically, however, this is not a reliable guide for filling each part with specific content, because the way health care is financed is ultimately a public choice, guided by criteria other than the purely economic characteristics of the goods. The so-called institutional criterion for the classification of goods offers some solution in this respect (Bénard, 1985), but this no longer works within the framework of positive economics and therefore does not provide generally valid criteria for the breakdown of care.

The problems with standard can be – at least to some degree – addressed by moving to a different paradigm of health care and its financing schemes, i.e. universal and optional parts (components) of the healthcare system. While it might be tempting to simply say that the universal part will provide standard care and the optional part will provide above-standard care, the suggested paradigm provides

[1] doc. Ing. Jan Mertl, Ph.D., Department of Finance, University of Finance and Administration, Estonská 500, 101 00 Prague, Czechia. E-mail: jan.mertl@outlook.com.

a much broader framework that allows the principles on which these parts are based on to be included in their design, to justify the use of specific financing schemes and, above all, to show both parts of the health system as essential to its desirable functioning and adequate development. This paradigm change may seem subtle at first sight, but we believe it has got the potential to overcome many loops and pitfalls that have been occurring when we try to "set the standard right".

In the last decades, the dynamics of change and the heterogeneity of health care has been increasing, and the frequency of new incentives, treatments or optimised financing schemes is not likely to decrease in the future. On the one hand, this allows for an unprecedented development and scope of health care supply in the optional part of the system, but on the other hand, it puts pressure on the rational definition and cost-effectiveness of the universal component.

## II. Aim and methodology of the research

The aim of this paper is to *clarify the meaning and purpose of the universal and optional part of the health system, explain how they are created and financed, and why they are important for health policy*. We are going to show that the universal and optional part (component) of the health system are *general categories, whose specific content is shaped in time and space* by exogenous impulses from evidence-based medicine, the dominant social model and socio-economic conditions in a given country, while it ultimately depends on public choice.

To accomplish this, we shall use theoretical analysis of the principles and mechanisms of their construction, classify the resources than can be used for their financing, compare the cost control mechanisms between them and show the possibility of variability in the universal part. Then to conclude, we shall do a theoretical synthesis of the important knowledge gathered throughout the analysis and formulate the socio-economic characteristics of universal and optional part and their significance for health policy.

Methodologically it is important to explain, that we do not believe that it is at theoretical level possible to *ex ante* specify the optimal configuration or create single ideal content of the universal and optional part. This would get stuck on ideological disputes, differences amongst countries, and overall dynamic nature of health care. But we can and should explain the processes and logic how they are created, which principles can be used in this regard, and what purpose they have got. Then *ex post*, researchers can look at individual countries and say what is the normative content of universal and optional part there, what is the result of the health policymaking there. Also later, they can look at the effectiveness of both parts and possibly suggest the change in the principles of their construction and mechanisms of their financing and content creation. That is why we present and work with those two parts as general theoretical concept, which is then filled with country-specific content.

Highly relevant is the question of synergies or substitutions (antagonisms) between the two parts of the system. From the clients' point of view, it seems that synergistic effects can bring several positives if the system is properly designed, since health care is in principle multidimensional and the health care and services act on health status or increase individual utility in a comprehensive way. On the other hand, there are systems operating in the world that do not take advantage of these synergies or even deliberately separate the elements by design.

In terms of sources of funding, we shall primarily focus on indirect financing schemes – i.e. third-party payments for care – as they clearly have got the dominant share of total resources in developed countries today (OECD, 2020).

Health economics has accepted that health care has got several specific attributes that need to be recognized and accounted for. Thus, they are an inevitable pre-requisite for socio-economic analyses of health, health markets and health care. Kenneth Arrow was one of the first to recognize these specificities when he published his pioneering article on the economic characteristics of health care (Arrow, 1963), and Avedis Donabedian on the quality of health care and its evaluation (Donabedian, 1966). A separate topic is the value frameworks and perceptions of health care as a socio-economic

category and its importance for individuals, society and the national economy (Williams, 1988; Figueras & McKee, 2012). A fundamental overview of the theoretical economics of health care, including an analysis of the supply of and demand for health care, is provided by a comprehensive monograph euphemistically entitled Handbook of Health Economics (Culyer & Newhouse, 2000). The links between the need for and demand for health care (Mooney, 1992) are key to understanding the mechanisms of health care consumption. Relevant principles and approaches are contained in social policy theory and methodology (Engliš, 1916; Tomeš, 2010; Krebs et al., 2015; Kliková & Kotlán, 2019). Empirical data of OECD health systems are based on the series "Health in Transition" publications on individual countries (European Observatory, 2021).

In terms of cognition and definition of socio-economic phenomena, noetic trialism, i.e. a positive, teleological and normative approach and outlook, is essential. The author of the teleological approach, Karel Engliš, proceeded from the duality of the world in the sense of what it is and what it ought to be. The positive approach shows how existing things work based on causality (ontologically). However, *the world as it ought to be*, which contemporary economics often refers to in its entirety as normative, *can, according to Engliš, be viewed from two perspectives* (ways of knowing): *the desired teleological and the obligatory normative* (norm-defined). The teleological approach builds on the desired postulates attributed to individual subjects (points of attribution, which may be also an institution or the government) and is concerned with what means are chosen to achieve desired ends on the principle of finality. Thus, teleology makes it possible to define a general concept (or postulate) having a certain purpose, for the fulfilment of which adequate means are chosen and which may subsequently have its obligatory normative content. Engliš also worked with "thinking under a central maximal purpose", which in the case of health care can be defined as the (good) health of the population, or of the individual (Engliš, 1929; Engliš, 1930).

An important theoretical background is the theory of public finance (Rosen & Gayer, 2008; Auerbach, 2010; Tresch, 2015) reflected in national monographs (Vančurová & Klazar, 2008; Hamerníková & Maaytová, 2010; Kubátová, 2018). These insights are complemented and concretized in the fiscal dimension of health systems configuration (OECD, 2015; McCoy, Chigudu, & Tillmann, 2017) and the effectiveness of health provision and payments (Maaytová, 2011). Mertl showed the possibilities of financing the universal and optional part of the Czech healthcare system (Mertl, 2018). The fundamental insights of insurance theory and policy regarding social and private insurance are defined by Vostatek (2000), who also discusses the application of social models to health systems (Vostatek, 2013), elaborates on the use of the single-payer model in Czechia and the possibilities of reconfiguring insurance and tax rates in Czech public finance (Vostatek, 2018, 2020, 2021).

## III. The content of the universal and optional part

The health economics has long been working with two basic principles of health care provision and financing – egalitarian and liberal. Both have got perfect theoretical reasoning and logical arguments behind them, and we needn't repeat it here (Williams, 1988; Krebs et al., 2015). Based on their differentiated application, the division of the system into a universal and an optional part makes sense, where in the universal part we can assume the predominance of the egalitarian concept and in the optional part the predominance of the liberal concept.

It should be noted that during the history of the development of health systems, these principles have also been understood as the underlying principles for the system as a whole – based on the idea that the whole health system can be organised according to one of them, or according to the utilitarian principle based on the differentiation of social groups, the merits of the individual and the assessment of expediency and the degree of solidarity (Durdisová, 2005). Given the importance of solidarity-financed universally accessible care on the one hand, and the emphasis on patient rights, system responsiveness and choice on the other, it seems more appropriate for today's health systems to divide the application of these concepts into universal and optional components. This is also related to the increasing heterogeneity of health care, where in the past it was easier to think of concepts of a unified system (e.g. in Semashko's model of health care in former Czechoslovakia, when some of the

available treatment options were not even made public, or in earlier history, when the possibilities of medicine were much lower than today and the pressure to centralise resources was absent), whereas nowadays the range of health care and its role in people's lives is so wide that the idea of a unified system based on one of these concepts is effectively unrealistic.

The starting principle for the universal part of the system is therefore the need for health care (Mooney, 1992) in relation to an objectively recognised patient entitlement, usually financed using the principle of solidarity. Unlike many other types of goods, health care has the specificity that the effect on health status (being an ultimate goal of health care in general) can be demonstrated through evidence-based medicine, double-blind studies and international comparison of expertise, and this forms a standard part of the methodology of medicine as a science. Thus, if we recognise health (of a population or an individual) as the central goal of health care, this knowledge is the means to achieve it. However, even this objectification needn't provide a clear guide to the use and assessment of these objectively medically ascertained effects from a socio-economic perspective. This is due to the different levels of acceptance of this objectification in a given system, in particular

- acute life and health rescue
- not worsening the state of health and its stabilization
- improvement or maintenance of health status or alleviation of suffering where no realistic possibilities of improvement exist (this level corresponds to the current Czech legislation – see § 13 of Act No. 48/1997)
- the benefit of the patient in the wider context, including the responsiveness of the system (Robone & Rice, 2011)

At the same time, these levels significantly influence the real definition of the universal component in different countries and periods, especially in the past also according to social groups. There is a lot of experience with the categorisation of these levels, especially in systems where the universal component is underdeveloped – health facilities there must provide care only at the level they are reimbursed, or rely on various forms of charity, and thus have methodologies on how to proceed in individual cases in relation to reimbursement limitations. An example of how the reduced concept can be applied in the Czech context in certain circumstances is the conditions for reimbursement of care in non-contracted healthcare facilities. By law, only necessary and urgent care is covered by health insurance companies for non-contractual healthcare providers, which means the provision of health care in an acute case where a delay in health care could lead to a life-threatening situation or a serious deterioration in health. Further treatment then continues in a contracted provider, in accordance with the aforementioned Article 13 of Act No 48/1997.

In the construction of the universally available package of care and the normative regulation of the content of the universal part of the system, the following principles are applied in developed countries according to (Němec, 2008) and (Eddy, 1994):

- Financial resources in the universal part of the system are limited, which implies the need to consider the cost of treatment and to set priorities.
- The goal is to maximize population health with available resources, not to pay for everything that somehow increases patient benefit.
- Prioritization for treatment does not depend on the individual doctor and his patients.
- Prioritising treatments requires information on their benefits, side effects and costs.
- This information should be based primarily on empirical evidence and evidence-based medicine (convincing evidence of a positive impact on health).
- The comparison of treatment methods respects the criterion of optimal use and resource limitation (Hauck et al. 2019).

- Considerations of benefits, risks and costs should respect the preferences of the persons concerned (treated).

On the other hand, the explicit declaration of entitlements, e.g. in legislation or in the reimbursement methodologies of public insurance companies, does not mean that they will always be met in practice. The empirical experience of health systems shows many examples where the discrepancy between the legal entitlement (often broadly defined) and the actual level of care available (implicit limitation) is significant – in such systems there is then a large scope for corruption and other negative phenomena resulting from the absence of formal mechanisms for the provision and reimbursement of health care across its entire spectrum.

In principle, no health system can cover in the universal part of the system everything that will bring some benefit or advantage to the patient. Furthermore, the amount of resources available for the universal part of the system is always limited and ultimately determined by public choice and the various levels of accepted categorisations already mentioned. Thus, rationalisation of normative content and optimisation of cost-effectiveness is a permanent imperative for the universal part of the system. At the same time, the uniform specification of entitlements at the system level gives (paradoxically) more scope for this rationalisation than in the optional part, where the sovereignty of the client in relation to equivalently allocated resources is considerably greater.

A controversial, sensitive and difficult problem is the contradiction between the ideal and real content of the universal part of the system. If we want to maintain the methodologically positive character of its analysis, we must accept that the real content may differ from the offer of evidence-based medicine for various reasons. The most obvious of these is the simple consensus of public choice on some realistic version of the content of the universal part of health care – at the extreme, even only acute life and health saving through emergency care, as has been the case in the US in the past.

If there is a significant difference between the universal and optional part of the system, a difficult situation can arise where the chances of achieving one's health potential – the level of health equity (Whitehead, 1992) will differ substantially between the two parts. This can be demonstrated, for example, by comparative studies of treatment outcomes for participants divided into two groups, each of which will be treated in one part of the system. If their health status will be significantly different in the long term, e.g. with the same baseline diagnosis, this creates significant questions for a country's health policy to answer and address.

The evolution of medicine and the socio-economic environment has brought with it new treatment and service options for patients. Likewise, the demands of some patients for comfort, the time of health professionals, and the level and range of services consumed are increasing. Although this has several ethical implications, it is now recognised in developed countries that health professionals can provide care to patients who have higher demands than others, without these demands being strictly necessary in terms of their health status. This moves us from the category of care that must be provided to the category of care that the patient can or wants to consume. It is in this context that schemes for optional health care can be created and used to enable its provision. Where there are problems with the level of the universally available standard, dilemmas arise in assessing the utility and potential purchase of care in the privately funded voluntary part, that can be economically modelled (Propper, 2000).

The optional component of the system can be approached in a substitutive, complementary, or supplementary manner. The substitutive method means to replace whole universal care scheme with private scheme (including the universal content and possibly adding above-standard care from the points below). The complementary method covers the part of the universally covered care that is subject to patient co-payments or is only partially covered. The supplementary way is that optional elements and financing schemes in the system supplement the universally covered care with more:

- choice (financial product, healthcare provider, form and method of care, medicine, compensatory aid or medical device);

- comfort for those interested in above-standard treatment conditions, individualization of services provided;
- responsiveness of the system (waiting times, patient information, choice of appointments);
- innovation of treatment methods and disease management programmes, also in relation to the lifestyle and specific needs of individual patients.

## IV. Sources and schemes of financing

Different funding sources can be chosen to finance the universal part of the system. In principle, they differ in the degree of compulsory solidarity, which has got two forms: solidarity according to health status and solidarity according to income. While health solidarity in the universal part of the scheme is high (or even full) and enforced by the compulsory participation in the scheme itself, the level of income solidarity depends on the setting of compulsory payments into the scheme in line with current knowledge of tax theory and policy on income taxation. The principle of solidarity is crucial for health care, the prosaic reason for the necessity of its use being that there will always be a significant group of patients who pose a high health risk or have a costly diagnosis. Those will not be able to cover the necessary medical expenses out of their income at some stage in their lives or even for whole life.

One pole is *financing from general taxes*, in line with classical public finance theory (Hamerníková & Maaytová, 2010; Tresch, 2015; Vostatek, 2020), where the degree of income solidarity depends on the degree of progressivity of the tax system, especially for income tax. The underlying principle here is non-purposeful tax collection based on the principles of tax theory and policy, which form a unique tax mix in each country. Expenditure is not reflected in a special tax rate or a separate tax (there is no signalling function). This source – general taxes, respectively the government budget – is the most susceptible to being affected by the political-economic cycle.

The second pole is the *absolute amount*, which in the case of compulsory payment can also be characterised as a "poll tax on health care". In this case, income solidarity is completely abolished, leaving only solidarity according to health status, determined by a single payment regardless of it. This concept appeared in Germany around 2005 as a proposal for a so-called Kopfpauschale which has not been implemented – but there is similar approach, so-called Basistarif, in substitute private insurance. In the Netherlands it is used as one *nominal component* of the two-component compulsory insurance there (the other component is a percentage rate).

Another option is an *earmarked health tax*, which is most often a proportional tax on wages or some other types of income. (Bloom, Cashin, & Sparkes, 2017; WHO, 2020) i.e. the earmarking of a special tax rate or separate health tax as a source of health care funding has a signalling function for taxpayers (like other earmarked mandatory payments). In some cases, certain elements of the social health insurance premium (which is earmarked in principle), such as the ceiling on premiums, have remained in the setting of this resource. Alternatively, the funding scheme in question may still be referred to as public, social or statutory health insurance, but no longer has social insurance payment as its source in the classical sense (Vostatek, 2000).

The government budget expenditure on health covered by general taxes on the one hand and earmarked compulsory payments on the other hand make up the total amount of resources in the universal part of the system. There is still the possibility of supplementing these resources with fees and co-payments, where it is important to distinguish between their regulatory function and the simple reimbursement of part of the costs by the patient directly.

In any case, the drawdown under the universal part of the scheme is currently not in any predefined proportion to the compulsory contributions paid by the participant (insured). It is governed by the normative statutory entitlement and the need for care identified within the contracted health facilities. Entitlement is therefore unrelated to the level of payment and the use of care is linked to the resources of the system at macro level.

As we shall show further, the universal part of the system can also have a variable component; then a part of the compulsory payments can be differentiated, and the amount can be chosen beyond a uniform level in percentage or absolute terms. This gives rise, for example, to the German percentage surcharge on the statutory premium, or to a higher than minimum nominal premium in the Netherlands. The variation in question is then available as a differentiator in a multi-payer system without creating a (significant) incentive for cream-skimming (if the system regulator enforces an adequate redistribution of the aggregate collection from the mandatory uniform payment).

Two main types of sources are offered as indirect sources of funding for the optional component of the system.

1) *Private health insurance premiums*, which are based on individual or group medical underwriting and may be substitutive, complementary or supplementary. In principle, it is a market-based coverage of the client's health risk by the insurer using equivalence. In the case of comprehensive or lifetime cover, private insurance schemes cannot achieve effective health risk sharing on a commercial basis without significant regulation, since health insurance itself suffers from information asymmetry and adverse selection, which can lead to a 'death spiral' of premiums. In such a spiral, some clients of a given insurance pool leave the product (pool of insured) when premiums increase due to the increase in risk and costs for other clients, thus further increasing premiums for the remaining clients, and the whole market is primarily all about which group (pool of insured) individual clients will be in (Frech & Smith, 2015).

If the regulations apply on medical underwriting and compulsion is used for the purchase of products, then their characteristics may get closer to mandatory schemes with significant variation in content and nominal amount of premiums. This process can deepen if hard compulsion is used, or if the purchase becomes mandatory by law (individual mandate). Indeed, if the client is locked into the scheme or motivated to participate in it for a long time also by other factors than the product’s price (premium) itself, it limits the possibility of cream-skimming and failure of the insurance scheme that could otherwise occur. After all, this principle (belonging to a particular social group, or spontaneous mutual association of clients) has been commonly used by health insurers in the past – see the example of French mutuelles (Brouland & Priesolová, 2016). Also, optional insurance products containing partial, complementary or more narrowly defined health risk coverage do not need that specific regulation and can be sold similarly to other private insurance products on the market.

2) *Health savings*, which has no risk component, thus individualizing financing and relying on capital reserve formation, with possible earmarking for health care. A subset of this principle are the prepaid plans, which even needn’t have a savings component and can be used to purchase packages of care tailored to the client's needs, financed by a *subscription* (Mertl, 2018).

Exceptionally, health savings can also be used to finance the universal part of the scheme if we want to compulsorily include participants without sharing their health risk (Singapore, a small proportion of participants refusing insurance for reasons of faith or conscience “gemoedsbezwaarden” in the Netherlands).

## V. Comparison of the universal and optional part’s main attributes

Real world differences between health systems are significant. Therefore, also the content and character of the universal and optional part cannot be the same amongst various countries. But if we stay on theoretical level, we can say, that the universal part provides entitlements normatively defined by law for every participant and is financed from compulsory financing schemes that employ principle of solidarity. Its content corresponds to the health care that must be provided and paid from those schemes and evolves in time based on approaches shown in section III. Health care consumption is primarily based on objectively assessed need.

The optional part provides care based on voluntary individual clients’ contracts with payers or healthcare providers. The financing schemes utilize the principle of equivalency corresponding to the

individual utility of the client. Healthcare consumption is based on the interaction of provider's supply and patient's effective demand. The products used for financing optional health care are sold on the market without obligation to buy them.

The key characteristics of the universal and optional components of health care can be summarised in the following table.

**Table 1 Main attributes of the universal and optional part**

| | Universal part | Optional part |
|---|---|---|
| Patient care | must have (get) based on objective indications and lege artis procedures | wants or can have, based on the interaction of patient's demand with the provider's supply of care |
| Funded from | compulsory financing schemes | voluntary resources/financing schemes |
| The content is defined | by law and by public choice | in the interaction of supply and demand |
| The price and volume of care are determined by | the process of mass production and purchasing care for collected resources | the market relationship between clients, healthcare providers, and payers |
| Funded on the principle of | solidarity and tax burden sharing | equivalence |
| Provision and consumption of care is limited by | available collected resources for health at macroeconomic level | individual budget constraint |

*Source: own processing*

Let us emphasize that the modal verbs "must, can, wants" have their specific meaning due to the actual time and space in which they are realized. They do not imply a general imperative, as the verb "must" in particular sometimes tempts us to do. It is not, therefore, that it must be so in general (always and everywhere), but that it is *an entitlement* which, in a given system, is linked to compulsory participation in the universal part of the system and is granted based on an objectively assessed patient's state of health.

A verb "can" means, that the patient can have that care, the doctors know which benefit he can have from its consumption, but he needn't get it in the sense of previous definition of "must". It is the care that has been excluded from the universal entitlement when setting up and updating its content. Finally, the verb "want" means, that the client wants that care or services based on his own decision-making, without direct relationship to the universal part (it may not even have been evaluated or suitable for objectively assessed entitlement). These verbs are therefore telling how things work in a particular health system – which, paradoxically, in retrospect can always be well identified, although the actual genesis is a very complicated process.

From a methodological point of view, it is necessary to point out the problem of the generality of the categories versus the specific content of the two parts of the system. It is obvious that their specification can slide towards the fact that we already start to define the specific normative filling of these parts, or to comment on how it should be, perhaps even under the influence of the social environment we are used to. Sometimes this also happens to the author of this paper, especially when it comes to a debate somehow related to the Czech health care system, and it is therefore necessary to stress that these categories are in principle general. While it is possible to assign to them an initial principle, as described above, their concrete form in time and space (specific country) varies and evolves, and this genesis is in principle highly controversial and difficult. Paradoxically, however, in retrospect, in a particular country, we can always well define "how it turned out", i.e. what is the substance and nature of funding at a given time. The specific normative definition of the universal part is then the reimbursement legislation of mandatory funding schemes.

## VI. Variability in the universal part of the system

The universal and optional part of the system can also be illustrated by the following figure, including the variable component. This variability is conditional on payment into and participation in the

universal part and exists because of this universal part, even though it allows a choice for the participant. It is therefore not an optional part of the system, that is financed separately and unconditionally.

**Figure 1 Universal and optional part of the health system (in a multi-payer system)**


Note A – basic care package (normatively defined uniform entitlement within the universal system) – financed by compulsory solidarity payment, often proportional to income
B – possible variability in the universal part – financed within the compulsory payment (see A) or by its selective increase (typically group-based)
A + B – universal part of the system
C – optional part – available for an absolute amount of insurance premium or subscription, price based on equivalency
*Source: (Mertl, 2018), descriptions adapted for theoretical analysis*

Variability in the universal part of the system is possible primarily in a multi-payer system, which can also differentiate itself towards the participants in this way, which is desired in some countries (e.g. Germany). Purely theoretically, this would also be possible in a single-payer system in the sense of variability in the part of the care covered by choosing between certain types of entitlement, but it would only be the offer of this single payer, not multiple offers of health insurers between which the insured can choose.

As far as the financing of variability in the universal component is concerned, this can be done either by allocating a small share of the already available resources for its financing, e.g. in the form of a special fund with a legislatively determined volume (then the payment to the system remains uniform), or it is possible to differentiate part of the mandatory payments in relation to the choice of a particular insurance company in the form of a surcharge on the uniform payment (in a multi-payer system). Variation in the universal component must not distort the content and reimbursement of universally available care. It is an option for those clients who do not purchase voluntary schemes and at the same time it gives the possibility, especially in a multi-payer system, to adapt their offer to the needs of the insured even within the universal part of the system.

## VII. Cost control mechanisms

From an economic point of view, the issue of health care costs and cost-containment is very important (Stadhouders, Kruse, Tanke, Koolman, & Jeurissen, 2019). Its handling in the universal and optional parts of the system however differs fundamentally. In the universal part, we optimize health care spending as a whole, at the level of individual payers and care segments. If there is only one payer, reimbursements can also be centrally determined; in the case of multiple payers, variation in reimbursement across the network of contracted facilities is common. Objectification and rationalisation of these expenditures is possible in relation to the volume of care required and delivered, not to individual payments to the system. In terms of cost-containment practices, this offers these possibilities:

- an increase the efficiency of care obtained for the resources invested, e.g. through pay for performance (P4P) practices (Brunn, 2021)
- promote a healthy population, fund prevention and thus reduce the need for care
- optimise reimbursement methods and budgets of healthcare facilities
- control of prices of medicines and medical devices and other prices in the health sector (Stadhouders, Kruse, Tanke, Koolman, & Jeurissen, 2019)
- in a multi-payer system where health insurance companies have got its own budgets with variability of payments for care, compare their allocative efficiency and balance over time (assuming no cream-skimming)

Implementation then stems mainly from the specific configuration of health care facilities and payers, which varies between systems and is beyond the scope of this paper, as is the analysis of other methods affecting the supply and demand side of health care.

In the optional part, the expenditure results from individual contractual relationships (products) and the entitlements contained therein. The cost of these contractual relationships (premiums, subscriptions) is then information about their setting, both in terms of content and efficiency of payments and contracted care or services. The quality of the individual products and the associated efficiency of the respective schemes is then (theoretically) determined by the competition between them in the market. While there are many examples of market failures in the USA, for example, several known sticking points can be eliminated with adequate regulation (see e.g. mandatory lifetime substitutive health insurance in Germany or some elements of the Obamacare reform in the USA). Paradoxically, the design of optional products can also be helped by the existence of a robust universal component, as products covering partial risks or specific healthcare packages can be offered and sold on an optional basis better than when all or most of a client's health risk is the subject of the transaction.

In terms of the subject of this paper, let us also show how healthcare financing behaves between the two analysed parts. Obviously, if a given care is covered in the universal part of the system, it will increase its total cost on the principle of universal entitlement, and thus will be available for the payment we define as its source. If the care in question is paid for in the optional part, it will not increase the cost in the universal part but will only be available to clients of optional schemes, where their private payments will already increase. This raises the much-publicised question of whether these clients should be able to draw reimbursement at the level of the option of treatment covered in its universal form (if any). Again, it depends on the purpose to be achieved. By allowing the consumption of optional care in a "surcharge way" (the client pays the difference compared to the reimbursement in the universal part), the optional consumption pushes at the same time the volume of resources of the universal part. When the client pays for the optional care in full, the client does not draw any reimbursement from the universal part.

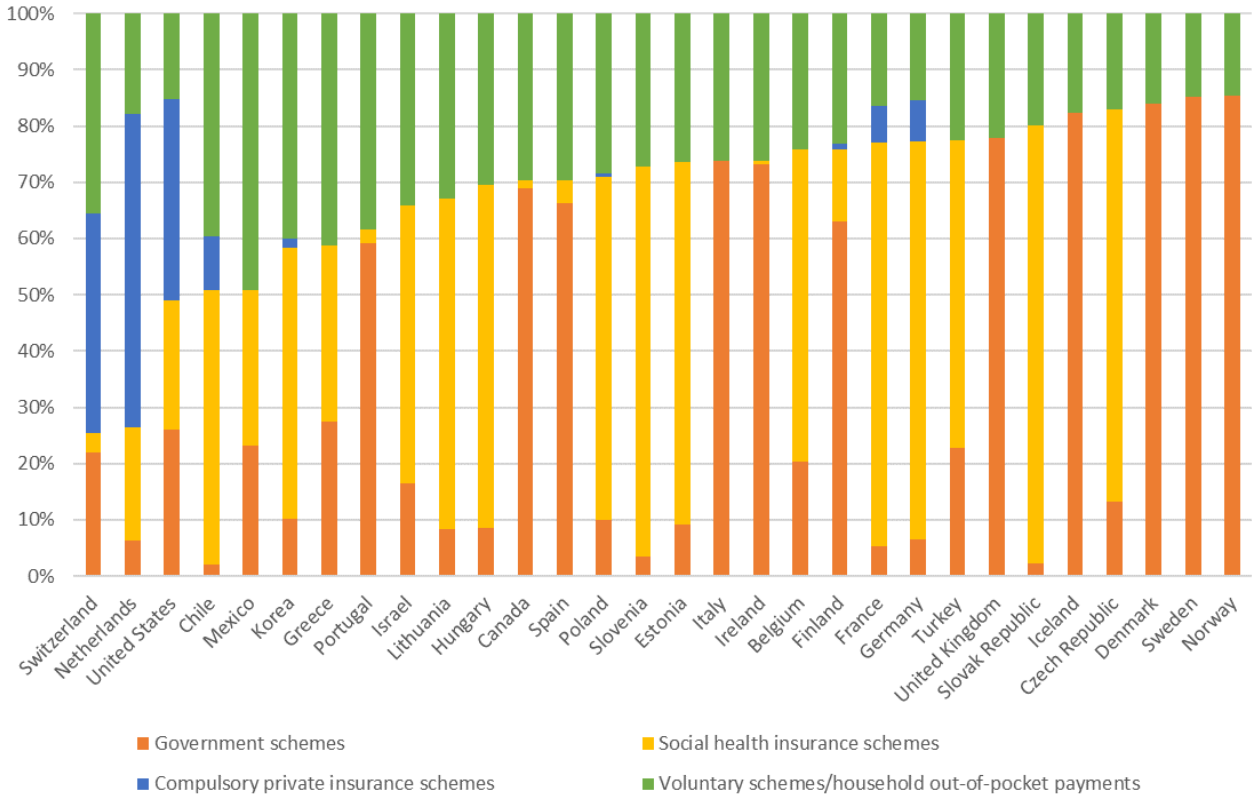
## VIII. Situation in OECD countries

Based on empirical data (OECD, 2020), we shall now show how universal and optional financing schemes are used in the health systems of OECD countries. The classification follows the OECD methodology, which is designed for the purposes of international comparability of relevant statistics (OECD, 2020a). In terms of this paper, the universal part of the system includes government schemes, public (social) health insurance and compulsory private insurance, while the optional part includes voluntary insurance and direct payments. A particular financing scheme may in some cases consist of more than one source of funding, so sources and schemes are separated in the OECD methodology In the figure we see that compulsory private insurance is used in only a few countries (e.g. USA, Netherlands, Switzerland, Germany) – the other countries use a mix of government schemes, whose source is universal taxes, and public (statutory, social) health insurance schemes, whose dominant source is earmarked health tax or social health insurance payments, as discussed in the section IV. Compulsory private insurance is effectively an attempt – in the few countries that have adopted it – to allow the purchase of differentiated products on a highly regulated market while maintaining enforced health risk sharing to the extent that the system works and is accepted by the public in that country. Because this achieves universal availability of the schemes in question, it belongs to the universal part of the system, where it offers (usually) significant variability.

It is also noticeable that the share of the optional component is approximately between 15–30 per cent of total expenditure only – this may come as a surprise to some readers. Countries with a high share of the optional component (above 30 per cent) tend to be countries with a less systematic approach to health financing and reimbursement (except for Switzerland). In the case of countries with compulsory private insurance, this scheme increases the share of the universal component. We can

also see public resources (general taxation, earmarked taxation) clearly prevail in the majority of OECD countries worldwide.

**Figure 2 Share of expenditure schemes in total health expenditure, OECD 2018, %**




*Source: own processing, data (OECD, 2020). The original English descriptions of the categories from OECD statistics are added in the description to avoid any doubt about the inclusion of the relevant data. Countries are ranked according to the share of public expenditure schemes (government + social health insurance) in total expenditure from smallest to largest.*

## IX. Conclusion

There are two basic approaches to health care financing and provision – egalitarian and liberal. The first one works with the link between the need for health care (determined by the fact that illness is usually not a choice) and the objectively recognised entitlement of the patient, financed using the principle of solidarity. The second is based on the client's decision in relation to the health care provider and the subjective benefit financed with private money on the principle of equivalence. In terms of reimbursement, the government, public or private insurers can come between the patient and the doctor; this creates triangulated, indirect schemes for financing care.

Two basic parts of contemporary health systems can be defined following those approaches: universal and optional. The boundary between them is clearly definable in theory, but not entirely sharp in practice, and above all their specific content evolves over time and space. From a theoretical point of view, to distinguish between them and identify them in a particular health system is essential. The use of these terms (categories) tends to gravitate towards their normative conception, because when discussing a particular system, we project our ideas of what they should look like onto them. However, it is important to know that they are also *meaningful in their own right, without specific normatively defined content*. Namely, they are desirable general categories of health system that allow health policy makers in a particular country to rationally and systematically deliver and finance health care with predictable effects, a defined level of solidarity, in the universal part, macro-level cost control in the universal part, and also adequate space for choice, optionality and voluntary financing schemes.

The objective knowledge of medicine and the impact of the care provided on health status can thus be used in practice to varying degrees, depending on which concept is accepted by the public choice in a given social model. This must be respected in any case – but at the same time, if the gap between the possibilities of medicine to influence health status and the content of the universal part of the system widens, policymakers get confronted with this fact. Evidence-based medicine thus serves in the case of health care as an *objective, exogenous impulse for possible adjustments to the system* and the inclusion of particular treatments and procedures.

The universal part in European health systems (and also in Czech legislation) *ideally* corresponds to the health care that the patient must receive because it demonstrably improves or maintains his/her health or reduces his/her suffering. The analytical advantage of health care is that most health effects in this part can be objectively demonstrated using evidence-based medicine, double-blind studies and statistically valid methods, even in international comparison. However, *in practice* this principle may not be adequately implemented, leading to poorer health and unmet health needs of patients. The de facto unavailability or poor availability of such care, while formally explicitly guaranteed by law, can also be a problem.

The universal part of the system is financed by compulsory solidarity payments, but the degree and nature of solidarity varies between different types of sources and financing schemes (general taxes, earmarked health tax, compulsory insurance schemes with income-proportional and nominal premiums, and very rarely, compulsory health savings).

The optional part *ideally* corresponds to the health care and services that the client requires because he wants or can have them, and the health care provider offers them. Thus, he increases his individual subjective utility from the consumption of health care above or beyond what the universal part provides. *In practice*, the optional part may also include the part of health care with an objectively necessary indication if the universal system in a given country is not sufficiently developed or solidarity based. It is not necessary to objectify the consumption of care and services in the optional part; the main criterion here is the client's utility and effective demand in relation to its budgetary constraints. At the same time, optional health care can be medically rationally indicated and offered as a professionally valid treatment option beyond the universally available standard.

Financing of the optional component can be done either through private insurance products, health savings (without the risk component) or prepaid plans (without both savings and risk components).

At the same time, the inclusion of care in the universal part of the system needn’t necessarily exclude the patient's choice in relation to that care. On the one hand, some variability can be allowed even within the universal part of the system, especially in a multi-payer system, and on the other hand, choice promotion can be used in the optional part. If we want to *develop synergies for patients* between the universal and the optional part of the system, it is optimal to design the optional part in such a way that it effectively enhances and builds on the universally available care, provides different forms, more comfortable variants of its use and above-standard treatment methods, additional services, and enables faster and more pleasant patients’ pathways through the system. Their financing schemes are supplementary or complementary.

The second possible approach is *a substitution, antagonistic relationship* between the two components of the system. Then participation in the optional component implies partial or full substitution of the care in question. However, this procedure has not been systemically established in the Czech Republic and is little used in the world (it was applied especially during the development of the American system, where the universal component was very narrow or partially replaced by voluntary solidarity), or it is designed only for a certain social group (e.g. in Germany – people with a monthly income above 5 362 EUR in 2021). A separate concept is the British approach, which provides universal health care as a public service, leaving the optional component largely outside the interest of public administration. There is thus a separation between the two, even though there are no substitutive funding schemes. Supplementary schemes in Britain then operate without synergies with the universal part of the system.

The general issue of the relationship between the universal and optional parts of the system is the degree of equity, which is important not only from a philosophical and ethical point of view, but also in terms of the specific outcomes of the system in terms of the health status of the population in relation to its cost-effectiveness. In the European context, perhaps the most acceptable and common concept is the one already mentioned, where the universal component guarantees universal access to quality and safe care, and the optional component provides a real choice to achieve greater individual benefit. However, this concept is not the only one possible and the universal part of the system may be subject to both explicit and implicit constraints with implications for the behaviour of the individual actors in the system (in particular patients and doctors) and its overall character.

Cost control in the universal part of the system is carried out at the aggregate level of individual payers and segments of care, and the aggregate cost-effectiveness is then reflected in the required volume of resources of the universal part of the system and therefore also in the setting (rates) of mandatory payments. These serve as an aggregate indicator of the cost-effectiveness of the system. Whereas in the optional part, it is the result of the sales of the relevant products and the quality of their design in relation to the utility of clients and the supply of healthcare facilities. The price of these products is information for the client and the products in question can be competitively compared, albeit sometimes with difficulty or with the need for expert experience.

We have defined the meaning and purpose of the universal and optional part of the system at the level of theory. Thus, the results presented in this paper have got independent theoretical value and can be used as a basis for further research. Additionally, in practice the knowledge and awareness of the two parts' significance, characteristics and behaviour can help to overcome the long-time issues with handling standard and above-standard care in Czech health policy.

The important point in this regard is that the classification and financing of a particular treatment should not get stuck in an endless, complex debate about what should be standard and what should be above-standard in all its dimensions (ethical, medical, social, economic), but should systemically proceed further – in which part of the system they will be included and what financing scheme will be used to enable their consumption. Regular and transparent procedures for this classification ought to be established that will include all relevant stakeholders (health insurance companies, medical associations according to branches, Ministry of health, patients' representatives). If the universal component of the system be made sufficiently robust and close to the objective need for health addressed in a cost-effective way, then the ethical objections to the optional component, whose development is also desirable, will disappear or be significantly reduced in the Czech environment. We recommend this approach not because we would underestimate the complexity of health care, but because of the experience with several reform attempts that were done in Czechia in last 30 years, that could not accomplish the handling of both parts well.

## Acknowledgements

The result was created in solving the junior project "Possibilities of Supporting Cross-generational Cooperation in the Workplace" using institutional support for long-term conceptual development of research of the University of Finance and Administration.

## References

Arrow, K. (1963). Uncertainty and the Welfare Economics of Medical Care. *American Economic Review*, 53(5), 941–973.

Auerbach, A. J. (2010). Public Finance in Practice and Theory. *CESifo Economic Studies*, 56(1), 1-20. Retrieved April 14, 2020, from http://iipf.org/rmvp08_auerbach.pdf.

Bénard, J. (1985). *Economie Publique.* Paris: Economica.

Bloom, D., Cashin, C., Sparkes, S. (2017). *Earmarking for Health. Theory and Practice.* Geneva: WHO.

Brouland, P., & Priesolová, J. (2016). Doplňkové zdravotní pojištění ve Francii, insitut "mutuelle" a jeho terminologie. *Acta Oeconomica Pragensia*, 24(6), 69–77.

Brunn, M. (2021). Tools of Power: Pay-for-Performance in French and German Health Reforms. *Journal of Health Organization and Management*, 35(3), 265–286.

Culyer, A. J., Newhouse, J. P. (2000). *Handbook of Health Economics.* Elsevier.

Czechia. (1997). *Act No. 48/1997 on Public Health Insurance.*

Donabedian, A. (1966). Evaluating the Quality of Medical Care. *The Milbank Memorial Fund Quarterly*, 44(3), 166–203.

Durdisová, J. (2005). *Ekonomika zdraví.* Praha: VŠE.

Eddy, D. (1994). Principles for Making Difficult Decisions in Difficult Times. *Journal of the American Medical Association*, 271(22), 1792–1798.

Engliš, K. (1916). *Sociální politika.* Praha: F. Topič.

Engliš, K. (1929). Teleologická theorie hospodářská a normativní theorie právní. *Obzor národohospodářský*, XXXIV., 267–282.

Engliš, K. (1930). *Teleologie jako forma vědeckého poznání.* Praha: F. Topič.

European Observatory. (2021). *Health System Reviews (HiT series).* Retrieved July 1, 2021 from European Observatory on Health Systems and Policies: https://eurohealthobservatory.who.int/publications/health-systems-reviews.

Figueras, J., McKee, M. (2012). *Health Systems, Health, Wealth and Societal Well-Being. Assessing the Case for Investing in Health Systems.* Copenhagen: WHO/European Observatory on health systems and policies.

Frech, H. E., Smith, M. P. (2015). Anatomy of a Slow-Motion Health Insurance Death Spiral. *The North American Actuarial Journal*, 19(1), 60–72.

Hamerníková, B., Maaytová, A. (2010). *Veřejné finance* (2nd ed.). Praha: Wolters Kluwer.

Kliková, C., Kotlán, I. (2019). *Hospodářská a sociální politika* (5th ed.). Ostrava: Vysoká škola sociálně správní.

Krebs, V. et al. (2015). *Sociální politika* (6th ed.). Praha: Wolters Kluwer.

Kubátová, K. (2018). *Daňová teorie a politika* . Praha: Wolters Kluwer.

Maaytová, A. (2011). *Otázky ekonomiky zdravotnictví s ohledem na zvyšování efektivnosti.* Praha: Wolters Kluwer.

Mertl, J. (2018). The Relationships and Configuration of Universal and Optional Healthcare Financing Schemes in Czechia. *Danube: Law, Economics and Social Issues Review.* Berlin: De Gruyter, 9(3), 177–192.

McCoy, D., Chigudu, S., Tillmann, T. (2017). Framing the Tax and Health Nexus: a Neglected Aspect of Public Health Concern. *Health Economics, Policy and Law*, 12(2), 179–194.

Mooney, G. (1992). *Economics, Medicine and Health Care.* (2nd ed). Essex: Prentice Hall.

Němec, J. (2008). *Principy zdravotního pojištění.* Praha: Grada.

OECD. (2015). *Fiscal Sustainability of Health Systems: Bridging Health and Finance Perspectives.* Paris: OECD.

OECD. (2020). *OECD Health Data Statistics.* OECD ILibrary: OECD. Retrieved March 1, 2021, from http://www.oecd.org/els/health-systems/health-data.htm.

OECD. (2020). *Public Funding of Health Care: OECD Policy Brief*. OECD. Retrieved July 31, 2021, from https://www.oecd.org/health/Public-funding-of-health-care-Brief-2020.pdf.

Propper, C. (2000). The Demand for Private Health Care in the UK. *Journal of Health Economics*, 19(6), 855–876.

Robone, S., Rice, N. (2011). Health Systems' Responsiveness and Its Characteristics: A Cross-Country Comparative Analysis. *Health services research*, 46(6), 2079–2100.

Rosen, H. S., Gayer, T. (2008). *Public Finance.* New York: McGraw-Hill Education.

Stadhouders, N., Kruse, F., Tanke, M., Koolman, X., Jeurissen, P. (2019). Effective healthcare cost-containment policies: A systematic review. *Health Policy*, 123(1), 71–79.

Tomeš, I. (2010). *Úvod do teorie a metodologie sociální politiky.* Praha: Portál.

Tresch, W. (2015). *Public Finance: A Normative Theory* (3rd ed.). London: Academic Press.

Vančurová, A., Klazar, S. (2008). *Sociální a zdravotní pojištění.* (2nd ed.). Praha: ASPI.

Vostatek, J. (2000). *Sociální a soukromé pojištění.* Praha: Codex Bohemia.

Vostatek, J. (2013). Politická ekonomie financování zdravotní péče. *Politická ekonomie, 61*(6), 834–851.

Vostatek, J. (2018). Technical Pension and Tax Reform for Czechia. *Proceedings of the 22nd International Conference Current Trends in Public Sector Research 2018*, 211–218.

Vostatek, J. (2020). Český důchodový (ne)systém vyžaduje zásadní reformu. *Fórum sociální politiky*, 14(1), 2–9.

Vostatek, J. (2021). Český (ne)systém financování dlouhodobé péče. *Fórum sociální politiky*, 15(1), 2-6.

Whitehead, M. (1992). The Concepts and Principles of Equity and Health. *International Journal of Health Services* (3), 429–445.

WHO. (2020). *Arguments for and against Earmarking*. Retrieved July 1, 2021 from https://www.who.int/health_financing/topics/sin-taxes/earmarking-table.jpg?ua=1.

Williams, A. (1988). Priority Setting in Public and Private Health Care: a Guide through the Ideological Jungle. *Journal of Health Economics*, 7(2), 173–183.