THE FISCAL DIMENSION OF CZECH HEALTH SYSTEM IN THE MACROECONOMIC CONTEXT

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Abstract: *The article focuses on the fiscal aspects of health care financing in recent socio-economic development, which has been difficult for public finance. This is justified by the size of health budget and the importance of health care for economic performance and social well-being. Together with absolute and relative increase of health expenditure, the significance of health expenditure is rising and the public policy must be adjusted accordingly. The significant socio-economic characteristics of health care that influence the behavior of health system stakeholders are taken into account. The models of health care financing are discussed and the significant characteristics of health care are described. Then the Czech health system of multiple public health insurance companies is analyzed with special focus on "state insured persons" social group. The article brings an overview of the fiscal aspects of current health systems and discusses possible configurations in this area.*

Keywords: *Health insurance, Health expenditure, Fiscal policy, Health care.*

JEL Classification: *I13, I18, H51.*

Introduction

Health care systems became in the 20th century the significant part of public budgets, in developed countries utilizing approximately 6 – 9 % of GDP for public expenditure on health (and additional private resources, too). This is connected with the character of health care as a mixed good, whose majority of consumption is universal by decision of public choice and thus the techniques of public financing are used in this area [15]. In this sense, new segment of public finance emerged with certain level of autonomy on the expenditure side and this has its consequences in behavior of fiscal policy.

Sometimes, we see fiscal approaches that treat health care equally to the other significant public sectors like army, police, justice, education etc. While this corresponds to the general theory of public finance and fiscal policy, because theoretically there is no or little reason to give "preference" to health care before other (also important) sectors, we can also discuss the characteristics of health care and its position in national economy and seek for approaches that justify some special treatment [14].

The last economic crisis caught Czech health system in difficult situation, since it diminished reserves of health insurance companies that have been accumulated before its onset. Moreover, the fluctuating "W" trend of GDP made the sustainable financing of health system difficult. For health economics and health policy, however, this process brought an interesting research material.

In this sense, this article aims to cover important aspects of health care's fiscal dimension, which have been triggered by the recent socioeconomic development. To achieve this it is strongly rooted in knowledge of health economics and recent experiences from health policy in the Czech Republic.

To clarify these issues, the following research questions are highly relevant:

- What are the principal theoretical schemes of health systems and characteristics of health care financing?
- Which macroeconomic trends do we observe recently in health systems and what fiscal consequences does it have?
- How does the Czech system of multiple health insurance companies perform according to theoretical and empirical aspects of health care financing?
- What is the significance of state insured persons social group in the Czech public health insurance system and which measures are taken in this area?

Scientific methods used to write this article include macroeconomic analysis of health expenditure, public policy evaluation of health resources' settings in the Czech Republic and synthesis of observed trends from the health policy point of view.

1 The socio-economic characteristics of health care

Many times the importance of health care system has been assessed and defined [16], [22]. There is no doubt about its specific characteristics [1], however to discuss its position in macroeconomic context, it is useful to stress out particular aspects that seem to be crucial for its assessment. Health care expenditure is counter-cyclical by nature, because the volume of health care consumption does not depend of economic cycle and can even increase in economic downturns because of the socioeconomic problems that increase in those times.

The demand for health care is highly inelastic and is driven by determinants of health, thus the incomes of population not being a dominant factor. The volume of health expenditure is largely proportional to the volume of health care demanded, e.g. the variable costs are significant share of health budget [10].

In guaranteed health care systems [21], the government takes over a responsibility for the availability and accessibility of health care to the population. If this is not achieved, the guaranteed universally available health care becomes merely "written on the paper", causing vast problems in accessibility and rapidly decreasing the responsiveness of health system to the health issues of the citizen.

Since people are born with "full stock of health" (not considering inborn defects) and then the determinants of health imply how this stock of health is managed, the possible failures of health policy and/or financing usually emerge in longer perspective. In this sense if we miss the health care goals and the health status of the people decreases, within a given population this cannot be in many cases "repaired" later. The population health status is overall crucial for the economic performance and the social well-being of the people.

Social dimension and addressing of health inequality is important, it is actually one of the achievements of developed countries. We cannot put those goals aside for fiscal reasons because it directly undermines the health status, quality of living and social harmony, which we consider as key aspects of dignified life. In this sense, the sustainability, predictability and accountability of health expenditure on health care is important [7]. Since we deal with social and human capital, the only similarly important sector of national economy is education.

2 The fiscal schemes of health financing

Generally, several possibilities how to allocate resources for universal health care exist in theory. First, we can treat health care system equally to police, army, justice and other "traditional" public finance areas financed from general taxation. In this approach, the health system is one of the important economic sectors and the level of health care expenditure is determined centrally by public choice and fiscal priorities. Hence, the position, power and governance quality [6] of the Ministry of Health is crucial, because the fiscal process is mainly determined by the government legislation procedures and respected negotiations. The risks of this approach include poor public governance practices and health budget being under threat, especially at times when the whole government budget is tight.

Second, we can establish one or more independent health insurance companies, which operate on social health insurance principle – solidarity according to health status and usually wealth (income). This creates a parafiscal payment, which becomes an income of those health insurance companies (company). They then have their own balance and budget, usually supervised by the public policy. When there are more insurance companies, the question of risk selection and the issue of character of competition between them appears [2]. This method is usually based on allocating a share of personal (work) income to health care, either as social health insurance contribution, payroll tax or earmarked health tax [4].

Third, we can do a strict regulation (especially regarding risk classification targeting community ratings) of commercial subjects selling private health insurance on the market and provide a government subsidy for the citizens so that everyone can afford that product, at least on the universal (standard) level. This approach emerged from the private health insurance markets and their failures, when the public choice decided to keep its principles as viable, and simultaneously wanted to achieve also goals that social health systems achieved. Still the questions about effectiveness of those (usually large) subsidies appear, and in some countries, the government enters the market by creating large programs for the poorer or sicker social groups (USA: Medicare, Medicaid).

Those are model approaches; in many countries, they slightly overlap or a big main system of one character is created, simultaneously a small "side" system is run on different principle – e.g. the case of Germany and social (90 % of people) and private (10 % of people) health insurance there. The reasons for this approach are different characteristics and performance of the means of financing in the social groups' spectrum. If well organized, it does not have to possess a significant threat as every citizen can choose the subsystem, which he will participate in, however from the theoretical point of view some systems look like a mess. To overcome this, we can usually identify the main or dominant health care financing approach for that country and then the supplemental ones used [3], [5].

From the fiscal policy point of view, those possibilities imply the following budget schemes:

1) A government expenditure program for health care – allocation within a health budget as a part of central public finance schemes. When allocating resources on the central level, supported by respected legislation determining the price level and amount of health care provided, the health sector is financed at the "pure" principles of public sector financing and allocation. In this scheme, the majority of health expenditure can be seen as more discrete, because the government can decide about them individually

and annually, although it does not have direct control of some variables that influence their need (e.g. drug prices etc.)

2) An independent institutional framework for financing health care, where the public choice and central government role is limited and the principal fiscal goal is to collect and allocate the agreed amount of money to specialized institutions (health insurance companies). In this scheme, the public finance flows can be seen as more mandatory, since they automatically allocate for health the public resources defined by law [13].
3) A subsidy scheme, when the people receive support based on their social status so that they are able to buy a highly regulated health insurance product commercially. In this scheme the income differentiation and level of regulation is important for the government position and fiscal volume of health expenditure.

It is worth noting, that selection of those schemes is a result of the health financing system selection and configuration, fiscal policy alone cannot select a particular scheme on its own.

3 Health expenditure in the international and macroeconomic context

Purely theoretically, the public health financing should provide stable resource of financing relatively to GDP, as when we take a share of wages (personal income) and allocate it for health care, it should fluctuate with GDP proportionally and thus copying the economic cycle, in the same way as general taxation works macro economically. The problem is, among others, that the health care sector does not shrink and expand with the economy as a whole symmetrically, e.g. as the sectors of information technology or civil engineering. Therefore, the expenditure, which has to be paid, is not mainly the exact function of the actual resources available or even consumers' demand, but rather the function of health care determinants (life style, environment, health care itself, and genetics) and their management in the economy [5]. The problem of health care needs is also important, as demand for some types of treatment and some drugs is highly inelastic, causing the necessity to pay for and provide health care without strict relation to resources available [10]. As an extreme example we can show an epidemics of infectious disease, which would have to be managed on the national level. Moreover, health care sector is a significant employer and its employees, even if they usually exhibit higher degree of loyalty that in other sectors, also demand their wages to be paid and valorized as they see the macroeconomic development in sense of the labour market theories, including the stiffness of wages aspects.

This does not mean, however, that health care does not have to respect economic laws and budget limitations; rather it means just that sometimes the care is provided and the whole sector works while creating deficits or imbalances that are publicly perceived as inefficiencies. First part of those inefficiencies is caused at the microeconomic level by inadequate management, and the second part is determined at the macroeconomic level by inadequate schemes of financing in relation to the economic development. For example, in the first part the hospitals could be indebted, in the second part the public health care coverage could be diminished or not innovated, leaving those who can pay out-of-pocket to buy the care they need and those who cannot being under-treated.

As for the relationships of health care expenditure at the macroeconomic level, the following data are appropriate for consideration. Behind them is the fact, that the relative

health care expenditure to GDP[8] is driven by two factors: actual trend of health policy decisions and needs with results in absolute health expenditure, and the development of GDP caused by general trends, which provides resources for health care system. For example, during the economic crisis (2008-2011) the relative health expenditure in majority of OECD countries fluctuated, but the main factor was not only the health expenditure itself, but also the changes in overall performance measured by GDP.

Tab. 1: Share of health care expenditure on GDP, OECD, 2003-2013, %

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Index 13/03
Czech Republic	6,6	6,4	6,4	6,2	6	6,4	7,3	6,9	7	7,1	7,1	1,076
Germany	10,3	10,1	10,3	10,1	10	10,2	11,1	11	10,7	10,8	11	1,068
Slovak Republic	5,4	6,5	6,6	6,9	7,2	7,5	8,5	7,8	7,5	7,7	7,6	1,407
Sweden	8,5	8,3	8,3	8,2	8,1	8,3	8,9	8,5	10,6	10,8	11	1,294
Switzerland	10,4	10,4	10,3	9,8	9,6	9,8	10,4	10,5	10,6	11	11,1	1,067
United Kingdom	7,1	7,3	7,4	7,6	7,6	7,9	8,8	8,6	8,5	8,5	8,5	1,197
United States	14,5	14,6	14,6	14,7	14,9	15,3	16,4	16,4	16,4	16,4	16,4	1,131

Source:[13], index own calculations (2013/2003)

Available data [13] shows that (with the exception of five countries) the index of share of total health expenditure on GDP has risen in the majority of OECD countries during the selected period. However, we can also see that in some countries, this trend has slowed down in recent years and since 2010, many countries experienced stagnation or slight decline in relative health care expenditure. This is consequent with the hypothesis, that the observed values are not result of the health policy and the changes in health expenditure alone, but when we measure health care expenditure relatively to GDP they are also determined by the overall economic development – see also [8]. This is supported by the next table, which shows the trends of real health expenditure per capita.

Tab. 2: Health care expenditure per capita, constant prices, constant USD PPPs, OECD base year, 2003-2013

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Index 13/03
Czech Republic	1314	1341	1425	1474	1503	1618	1756	1701	1744	1743	1740	1,324
Germany	3260	3226	3298	3375	3440	3552	3684	3795	3825	3929	3993	1,225
Slovak Republic	805	1007	1094	1234	1432	1566	1677	1625	1587	1657	1657	2,057
Sweden	2729	2768	2840	2915	2960	3007	3041	3033	3846	3899	3978	1,458
Switzerland	3891	3986	4015	3969	4024	4126	4235	4345	4437	4595	4683	1,203
Un. Kingdom	2361	2467	2569	2672	2743	2811	2956	2918	2915	2922	2939	1,245
United States	6098	6304	6460	6619	6773	6885	7075	7211	7281	7395	7510	1,231

Source: [13], index own calculation (2013/2003)

Here we can see vast differences for some countries, e.g. Slovakia (2,057 vs 1,407 in Table 1). Also we can see e.g. in Sweden, that the per capita expenditure has been very similar in 2008-2010 (3007;3041;3033 USD PPP), but the relative expenditure fluctuated (8,3;8,9;8,5 %).

Those findings suggest that the macroeconomic imbalances in relation to health care expenditure are significant enough to be included in health policy considerations and thoughts. Actually empirically, we can see that the countries already employ mechanisms that help to compensate them.

[8] As consulted with the Institute of Health Information and Statistics of the Czech Republic, the slight differences between national and international statistics are caused primarily by the revisions of GDP performed recently at the level of European Union. To have international comparison consistent the latest data (11/2015) from OECD are used. Because of the limited extent of the article, data for the other OECD countries are available at the weblink in references.

To name the significant examples: in the United States, the health insurance companies set their premium based on (highly regulated) insurance policies and thus do not take into account the wages (incomes) of the people directly. The clients either accept the offer or decline it, in the past they could remain even uninsured, now they are required to buy a plan under "Obamacare" health reform. In Germany, the rate of social health insurance was in the past changing regularly and was even different between branches of economy on the principle of (true) social insurance, allowing to get required resources as a share of wages paid to the employees. Now we see the trend of decreasing the number of social health insurance companies there and unifying the social health insurance rate, even if the possibility to change it remains. In the Great Britain, where the health care is paid from the government budget, the amount allocated into health care is a (largely) direct decision of public choice in each year among other budget priorities.

This means that the health care systems take different approach to manage the imbalances in the health care expenditure and needs in relationship to the resources available and health care needed: either they simply charge and spread the price (costs) of health care through highly regulated insurance mechanisms among the insureds, changing the proportion of the health expenditures on a personal income directly (if individual budget constraint allows). Or they change the rate of social health insurance, changing the overall share of indirect health labor costs. Alternatively, they change simply the amount of public expenditure flowing to health care from public budgets. If those mechanisms fail, the system exhibits deficits and/or does not provide adequate health care to citizens. The deficits can actually act as a "buffer" for the discrepancy between health system incomes and expenditure; theoretically, they can emerge also in the form of surpluses (reserves) in the times of economic growth when the incomes become usually higher. In addition, this buffer could be realized at the level of (social) health insurance company (companies), or it can be a part of central government budget balance.

4 Discussion of Czech health insurance macroeconomic aspects

Following the theoretical outline, we can now analyze important characteristics of the Czech health insurance system. As for the basic macroeconomic indicators, the values for last 5 years are the following.

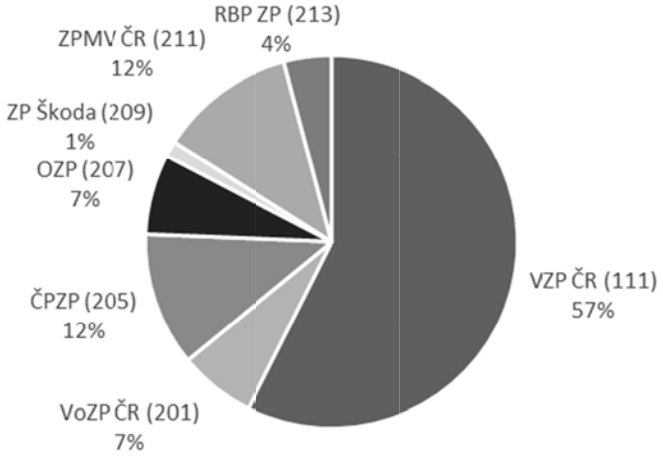
Tab. 3: Total expenditure on health care 2010–2014 (mil. CZK)

Expenditure items	2010	2011	2012	2013	2014 [1)]
Public expenditure	243 281	242 410	246 918	246 562	254 699
In: Direct expenditure from government budget	20 781	16 863	15 648	16 657	15 671
In: Health insurance companies	222 500	225 547	231 270	229 905	239 028
Private expenditure	45 754	45 358	46 388	44 381	45 224
Total expenditure	289 035	287 768	293 306	290 943	299 923

Source:[18], [1]) preliminary data

In the Czech Republic, kind of hybrid health system is running, and this has consequences in the measures taken. This hybrid character is rooted in the income structure of health insurance companies, their count and position and by different groups of the insured, although the coverage is universal by law.

Fig. 1: Shares of insured citizens in health insurance companies, 2014



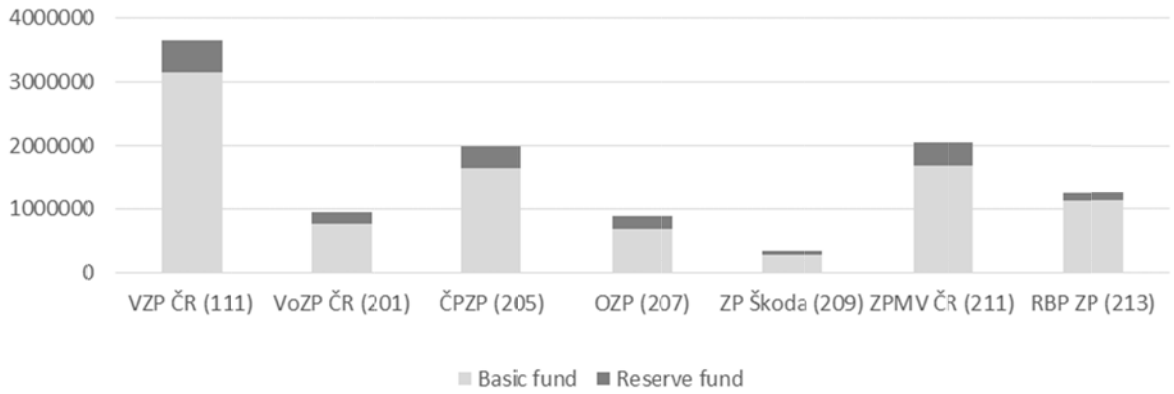
The names of insurance companies are original; their unique identification number is in parentheses.

Source: [12]

Figure 1 above shows that the insurance company VZP (111) retains dominant position on the market, all other companies having much smaller share of the insured. From micro economical perspective, this can be classified as an oligopoly with dominant firm. Behind this is also the issue on so-called state insured persons, which do not have taxable income and are not supposed to work (e.g. pensioners, students, unemployed, parents caring for children). Even if they can now choose a health insurance company freely, they originally were placed to VZP (111) by default and the incentives to change insurance company are rather limited and not price-based. Thus still, this company has largest share of state insured. By the way, this has significant solidarity implications, as there is a very high degree of solidarity within VZP's insured. Whereas the employees have paid, in 2014, 61 billion CZK annually and consumed 18,3 billion CZK, the state insured persons have in the same year paid just 26 billion CZK and consumed 94 billion CZK [11].

Next figure 2 shows the real balances on the basic and reserve fund of health insurance – e.g. "reserves" of the public health insurance system. We can notice, that some smaller companies have the reserves half as high as VZP (111), which has the largest number of insured, 5-6 times more than e.g. ZPMV (211).

Fig. 2: Balances on basic and reserve health insurance fund, 09/2015, K CZK



Source: [12]

Theoretically we can even sum up those balances and say that the system has "total" reserve at about 11,2 billion CZK, but since the companies operate independently of each

other, this is a purely theoretical calculation, and can be modified further through (annually returnable) government pre-payment, which was about 4,8 billion CZK in 2014. Moreover, the balance of health insurance companies is not determined solely by their operation (payments to health providers), by also by the government decision how to finance them and set the insurance redistribution scheme. This is necessary, because health costs now highly differ between the insured, and thus the issue of "cream-skimming" has to be avoided. These aspects mean that analyzing the performance of health insurance companies has several important factors to consider and they represent to some degree independent institutional framework for health financing.

Simultaneously, fiscal policy determines the overall balance of the health insurance companies significantly through the following measures.

- The health insurance rate, which is fixed at 13,5 % by law and was not changed since its introduction.
- The health insurance base and respective payment for so-called "state insured persons", changed arbitrarily (more on this later).
- Government pre-payments to health insurance (§ 12, Act No. 89/2012 Coll.) and subsidies to the health system or to big health providers (e.g. public health projects, hospitals).
- Changes in general taxation influencing health system (e.g. value added tax).

In this article, we can discuss in more detail the payment for so-called state insured persons. When the system of multiple health insurance companies (agents) was introduced in the Czech Republic at the beginning of the 1990's, among other elements this new category (social group) of the insured was introduced. The logic behind this was then to establish a system where every citizen must have a health insurance and has the right to choose health insurance company and for those who do not have disposable income will the government pay to the company chosen. Then it was assumed, that the insurance companies will be primarily employer based and the health expenditure did not so much differ between age and disease groups as it currently does.

Up to now, the category of state insured persons has vastly expanded and currently to this category belongs more than half of the citizens, with the total amount paid 59,9 billion CZK in year 2014 [9]. The following table shows its development in recent decade. Now no automatic changes take place so it depends on the public choice when and how much it is changed.

Tab. 4: Changes in amounts of stated insured persons, 2005-2016, CZK

Time	Base	Premium/amount
1.1.2005 - 31.12.2005	3 556	481
1.1.2006 - 31.01.2006	3 798	513
1.2.2006 - 31.03.2006	4 144	560
1.4.2006 - 31.12.2006	4 709	636
1.1.2007 - 31.12.2007	5 035	680
1.1.2008 - 31.12.2009	5 013	677
1.1.2010 - 31.10.2013	5 355	723
1.11.2013 - 30.06.2014	5 829	787
1.7.2014 - 31.12.2015	6 259	845
Since 1.1.2016	**6 444**	**870**

Source: [20]

Considering the structure of insureds and their burden, the indirect labour costs, including health insurance ones, are especially in the case of employees perceived as being high enough to stop any ceteris paribus changes (especially increases) of the current rate 13,5 %. In addition, the discrepancy between average amount of employee and state insured person is frequently stated and thus, when the overall balance of the system is challenged, there is an expressed demand for changing the amount paid for state insured persons [17]. Thus it can in the described environment act as a certain stabilizer of the health system overall balance. Generally said: although it is a theoretically controversial concept, the public policy and the stakeholders currently do not seem to have an intention to abandon it, actually the opposite is true and we can discuss the possible variants further.

The first aspect is how to set the base for the stated insured persons so that it is not dependent on public choice in the sense that if the public policy forgets about it, it is not changed and with the ongoing macroeconomic development is gets out-of-date; e.g. suggest some methods of its update (valorization). In this sense, the following possibilities exist [23]:

1. Make relationship to general average income base (used also for pensions valorization), or simply to the average wage in the national economy.
2. Administratively valorize the base regularly, e.g. by 5 % annually (percentage estimated from the average of growth of payments at other insured persons).
3. Unify the base with the base for persons without taxable incomes, which is currently the minimum wage.

Fiscally the third possibility is the most extensive, according to calculations done by the Ministry of Health [11] it would increase the resources by 30 billion CZK, in addition minimum wage is now set by discrete economic policy which compromises the rationality of related values. The second one, costing about 3 billion CZK is rather theoretical as it does not relate directly to the macroeconomic reality and thus is probably even more prone to being inadequate in time than the current scheme. The first one (currently being preferred at the stage of proposal) has fiscal dimension around 5 billion CZK in the first year and when utilizing similar schemes as pension valorization, the average values used for calculation cover longer term, which is macro economically favorable.

Within this first aspect, primarily the issue of changing the government expenditure for health care is resolved, in the conditions when we do not want to change the payments

of other social groups. In addition, as we have discussed the second aspect exists and this is the reaction to the economic cycle, which causes lowering absolute incomes of health insurance funds through macroeconomic channel as a whole.

This second aspects leads to the discussion about the anti-cyclical measures in health insurance. It is clear, macro economically, that with rising unemployment the number of state insured persons will also rise. Thus, the health insurance budget will lose its payment and in addition, the government will have to pay its amount for such a person. Actually it is theoretically interesting, that from the pure fiscal principle the decrease of public revenue from health insurance, similarly to the decrease from tax income, could be seen as an automatic macroeconomic stabilizer, however, in the current environment it causes deficits in health insurance budgets and creates additional expenditure pressure for the government budget. Therefore, the guardian of health budgets, or so called stewardship maker [21] Ministry of Health, to protect the interest of the health budget, discusses currently the introduction of weighted state insured person coefficient.

This coefficient measures the deviation of the actual number of state insureds from the average number of them during a selected period (seven years – approximately one economic cycle). It is computed as a linear share of the actual number of the state insureds to the average; when this number is equal to the average the coefficient is 1.

To simplify actual calculations and prevent constant changes its "resolution" is in current proposals set for every 2000 persons by 0,001, this number can be adjusted to the sensitivity desired. By this coefficient will be reduced/increased the total amount of money paid for the state insured persons, calculated with one of the valorization mechanisms described above. One of the discussed variants works with creating an lower and upper limit (0,95-1,05) for this coefficient to limit the extent of consequences for the government budget during large or sudden fluctuations of employment. This limits automatic fiscal dimension of the proposed anti-cyclical measure at the sudden big fluctuations of unemployment, which could be fiscally unsustainable.

Conclusion

While gaining fiscal importance and gradually moving from perceived "consumption only" branch of economy to the human capital investment approach [19], the health care system retains its specific characteristics. While some of them are similar to other sectors that have significant share of their budget filled from public resources, the degree of autonomy, strong presence of market imperfections and huge significance for social and human capital formation are an indispensable property of health systems. Simultaneously, usual factors of market demand do not drive health expenditure directly, but rather complex spectrum of health determinants influences their volume and trends.

In addition, the situation is complicated by inevitable existence of specific health system models, and the current analyses show clearly that it does not make much sense to try finding the "best" or "most efficient" one. Although it is important to analyze their effectiveness (and say what we mean by this term, too), the mix of resources collection and allocation differs from country to country and the theoretical models serve more like the schemes from which the actual practice is derived and combined.

Macro economically, the health expenditure is anti-cyclically based and keeps its volume and trend mainly based on health determinants' development. That is why the health budget and resources must be adjusted to those real needs and the macroeconomic fluctuations.

We identified three different basic approaches to the general fiscal position of the government. A government expenditure program (budget) for health care based on general taxation, an independent institutional framework for financing universally available health care based on social insurance or earmarked taxation and a subsidy scheme in highly regulated competition of health insurance companies, when the people receive support based on their social status.

Considering the position of central government, the degree of autonomy of other subjects (stakeholders) is important. This also influences where the government position is seen as more discretionary or more mandatory (automatic) in the relation to the health system. This is important for practice, because although the government with more mandatory position to the health financing can "simply engage the Parliament more frequently", changes of those mandatory budget agencies usually are more difficult to achieve [14].

A system of multiple health insurance companies has been running in the Czech Republic since 1990s. We can see it is a "practical compromise" between the theoretical models of health care organization and financing, struggling to fit them and therefore showing low adherence to pure public finance principles in some areas and often discrete fiscal adjustments. It also needs well risk-adjusted central redistribution of insurance payments and utilizes big fiscal subsidy for people who are not supposed to work (state insured persons).

This payment for state insured persons is theoretically debatable and could be minimized or replaced by the mechanisms of general taxation. However, there is little interest in Czech public policy to do it, and since the other parameters like health insurance rate remain fixed, this payment actually became one of the tools for optimizing the public health expenditure.

This is supported by recent public discourse about the methods of this amount determination that we discussed. They include its linking to the standard valorization procedure used for public pensions and introducing anti-cyclical measure which is sensitive to the number of state insured citizens and thus indirectly to the employment rate. Their acceptance and implementation depends on public choice, but technically, they strive for better automatic determination of the government payments fairly well.

For the future research and policymaking, the question of which health resources' allocation scheme will be the primary one in the Czech health system remains. This will determine also the fiscal schemes that are used. However, any such schemes will have to adjust to and deal with the macro economic development and actual characteristics and importance of health care, so the challenges for fiscal policy will, probably, stay very similar further.

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