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IS THE CZECH HEALTHCARE STILL INEXPENSIVE?

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Abstract

Before covid pandemics, the Czech healthcare was considered in terms of health expenditure to GDP ratio as cheaper amongst OECD countries. This paper's objective is to explore to what level the expenditure for Czech healthcare arose recently and how it was achieved. The paper studies the dynamics of the relative level of expenses in Czech healthcare and interprets the observations in relation to the Wiseman-Peacock's displacement effect. The methods include the analysis of OECD data regarding the expenditure on health, identifying the trends in payment for state-insured person in Czechia and reflection of related events in Czech health insurance system and health policy. The authors conclude that there has been a notable health expenditure increase since 2020, in Czechia's case financed mostly from general taxation. Presented results explain what happened recently with Czech healthcare financing in comparison to the other OECD countries and what it means for Czech public finance.

Keywords

Healthcare, Fiscal Space, Health Insurance, Health Expenditure

I. Introduction

How much we spend on healthcare is a key question of health economics and policy, because it relates both to effectiveness of the system and the volume of available resources in the national economy. Traditionally, the Czech healthcare was considered in terms of expenditure to GDP ratio as one of the cheaper amongst OECD countries. Despite having a form of multi-payer configuration, the administrative costs were lower than in many other multi-payer countries and the total health expenditure in years 2010–2019 ranged around 7,5% GDP, before that even lower. The increase of health expenses and to some extent the stagnation of GDP led to the increase of this share, which does not seem to fully return to pre-covid levels.

The paper will analyse this development and aims to find factors that contributed to it and the consequences for Czech fiscal and health policy. It will also discuss whether and to what extent the Wiseman and Peacock's displacement effect theory can be applied to this observed phenomenon. We look at other OECD countries if similar development can be spotted there, too, and ponder about the consequences it can have for the Czech fiscal space for health.

Main research question contained in the paper is the same as its title: whether we can still consider the Czech healthcare being a cheap one. Following that, we are going to explore what fiscal and health policy consequences stemming from the observed development can occur.

In health economics, scientific methods are pivotal in unravelling the complexities of healthcare systems and their economic impacts. Utilizing OECD health data (OECD, 2023) provides a robust and standardized foundation for comparative analysis across different countries, allowing economists to draw meaningful insights from extensive, high-quality datasets. This data enables detailed examinations of health expenditure, healthcare access, and outcomes, facilitating cross-national comparisons and benchmarking. Studying secondary literature is equally essential, as it helps

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contextualize findings within the broader body of existing research, identifies trends, and highlights areas for further investigation. Analysing health budgets involves a thorough assessment of how financial resources are collected and allocated within healthcare systems. By integrating OECD data, secondary literature, and detailed expenditure analysis, we can provide evidence-based recommendations to enhance healthcare effectiveness, sustainability of public finance, and overall population health.

A certain limitation of this paper is caused by the fact that health expenditure data for OECD countries are available until year 2022 only at the time this research has been done. The data for year 2023, when offered by OECD, can shed more light on what happened when the economies got fully back on track. Preliminary 2023 data of health expenditure available at the time of reviewing this paper for some countries show that they experienced further slight decrease of relative health expenditure, but some of them still did not reach pre-covid levels yet even in 2023. Anyway, in 2022 there was already a partial improvement in the pandemic and economic situation, so the data we use in the paper have their merit for the analysis.

II. Theoretical background and concepts

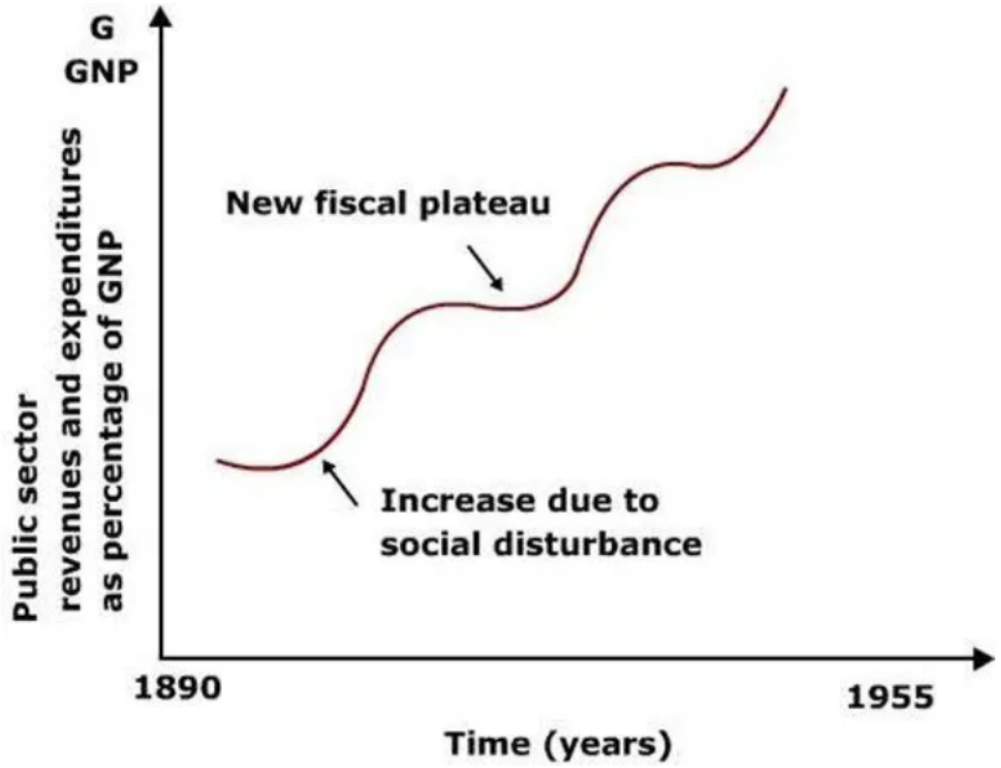
Although relative share of health expenditure (HE) to GDP is not a perfect indicator for health policy to manage how much we should spend on health care, it is the most widely used one, especially in international comparison (Fuchs, 2013). It is defined by a simple ratio HE/GDP. Thus, it is driven both by the absolute change in health costs (and related expenditure), and by the absolute change of GDP. Since healthcare is financed mostly from general and earmarked taxation, and additionally by private resources that mostly come from wages and other forms of active income, it makes sense to relate the healthcare to GDP, as the economic activity level also indicates the volume of resources that is available to allocate to various sectors, healthcare included. We can thus say, that if this share remains stable, then the healthcare also has got a stable position within the economy and the burden it poses for the budgets (public and private) does not change. If it goes up, we must pay relatively more to have the care available, if it goes down, the share of costs it poses for our budgets (public and private) is lower, freeing the resources for other goods and services. Theorizing about the level of health expenditure, even if it is burdened by the exceptions and variety of countries' arrangements, is a valuable component of health economics (Alderson, 1998).

Since the expenditure on health can be divided into main categories like wages (incomes of health professionals), investments to and running the health facilities, ancillary services, drugs, and administration of the system, the actual spending is closely related to the living standards of the employees in healthcare and their purchasing power in the context of overall economic development. Therefore, Baumol's effect can be to some extent seen there (Pomp & Vujić, 2008; Baumol, 1995), as increasing the effectiveness of health care provision itself is a task that is regularly maintained by health facilities' managers or even health policy authorities, but usually no big productivity changes can be expected, as the nature of most health care services does not allow that. For example, in the United States of America, health care services belong to steadily cost-rising category of goods and services compared to earnings (U.S. Bureau of Labor Statistics, 2023). Therefore, the cost management and cost containment in health care (and the differences in health expenditure amongst developed countries) is mainly related to the actual volume of care needed, and to the organization of health system, including a model of healthcare financing and provision that is chosen.

Considering the role that the public resources play in almost all OECD countries, Czechia included, we ought to point out that the theory of public finance knows what is called a Peacock-Wiseman effect (Peacock & Wiseman, 1961). This effect is a theory in public finance that elucidates the tendency for government expenditure to increase over time due to periodic displacements caused by significant societal events such as wars, economic crises, or other disruptions. According to this theory, during such crises, governments are compelled to ramp up public spending to address urgent needs and challenges. These extraordinary expenditures become more acceptable to the public under

the pressing circumstances. The displacement effect occurs when these crises push public spending to new heights, which, although initially perceived as temporary, tend to set a new baseline for acceptable government expenditure once the crisis abates. This results in a ratchet effect, where the level of public spending does not fully revert to pre-crisis levels, establishing a progressively higher trend in government budgets (Rowley & Tollison, 1994). It can be represented graphically as follows:

Figure 7 Peacock-Wiseman effect



Source: (Academistan, 2024)

Over time, this pattern leads to a long-term increase in government spending, as each crisis redefines what is considered a normal or acceptable level of expenditure. The public, having observed the benefits of increased spending during crises, becomes more amenable to sustained higher levels of government activity and taxation. This phenomenon underscores how public attitudes towards government spending and taxation can shift significantly in response to societal needs, making it easier for governments to justify and implement incremental increases in public expenditure (Magazzino et al, 2015).

The Peacock-Wiseman effect, when applied to public finance in healthcare, suggests that significant societal disruptions, such as pandemics or public health emergencies, can lead to a substantial and lasting increase in government healthcare spending. During a health crisis, governments often increase spending dramatically to manage the immediate needs, such as funding for hospitals, medical supplies, research, and public health campaigns. These elevated levels of spending, justified by the urgency of the situation, gain public acceptance as citizens recognize the necessity of robust healthcare infrastructure and services. As a result, the crisis-driven increase in healthcare expenditure establishes a new, higher baseline for public spending in this sector, leading to a long-term upward trend in healthcare budget.

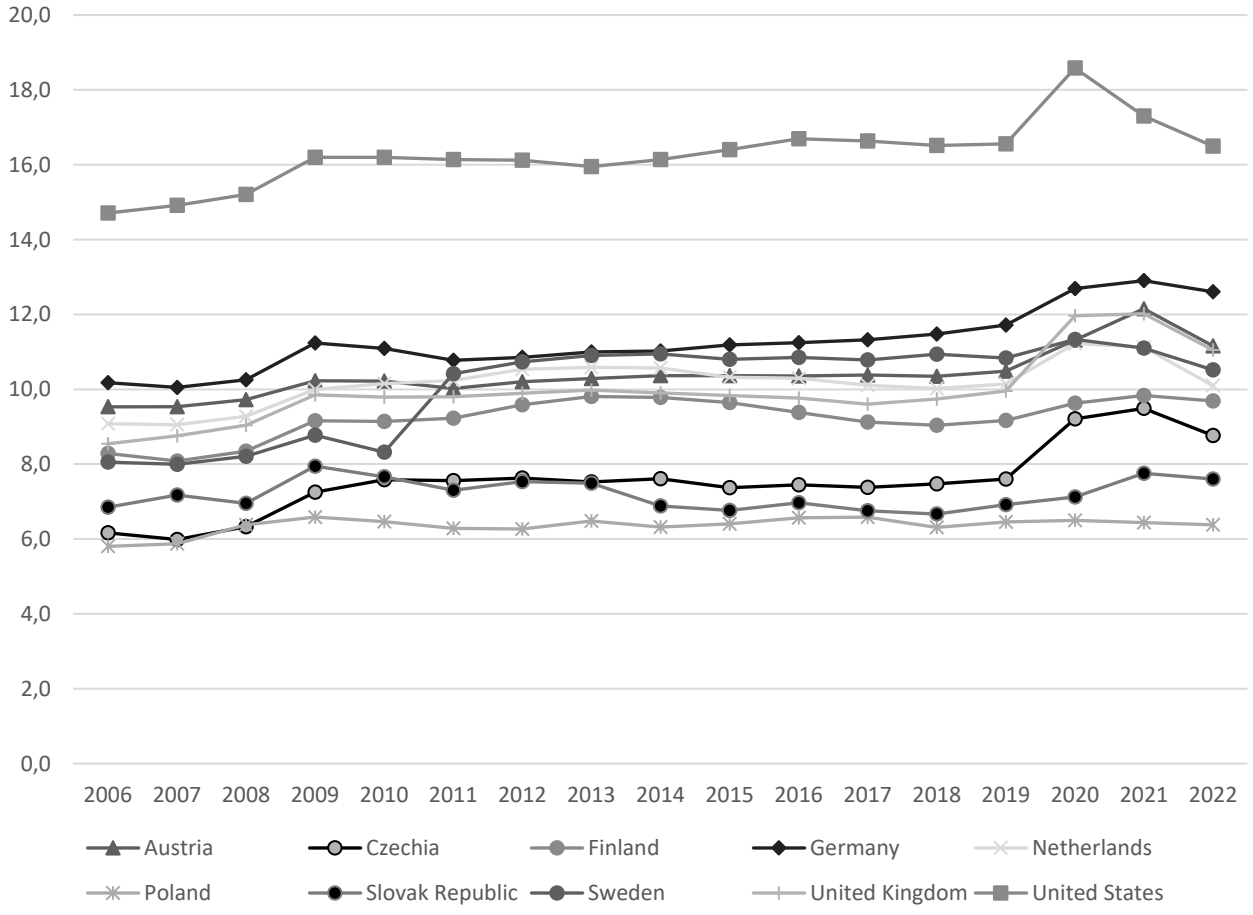
The concept of fiscal space is a general concept of fiscal policy in the sense of the ability of budgetary financing for a given purpose while maintaining fiscal stability (Nerlich & Reuter, 2016; Meheus & McIntyre, 2017). There is an intuitive consensus on the existence of fiscal space and its meaning

(PAHO, 2020); The definitions of individual authors differ slightly in their emphasis on its elements and definitions in relation to public finances on the one hand and targeted financing of specific sectors on the other. On a general level, it is closely related to the government's budget constraints (Hamerníková & Maaytová, 2010). It is essential to define the concept of fiscal space for health care and its importance in terms of health policy and the dynamics of resources for health care in the national economy. At the health level, it is understood as the ability of the government to mobilize and allocate resources to health care without jeopardizing the balance and sustainability of public budgets (Powell-Jackson et al, 2012). Quantitatively, it is related to the overall economic level, the tax quota and the share of public expenditure in GDP (Heller, 2006).

III. Trends in international health expenditure

When we look at selected OECD countries, we can see that both economic crises (2008 and 2020) caused a relative increase of health expenditure that mostly did not fully settle down after the GDP got back on track and the crisis was over. Simultaneously, there has been a clear tendency after 2010 not to increase the relative health expenditure further – often this was one of the goals of health policy in most of the countries, as further increase was seen as fiscally problematic or even hardly sustainable. However, the onset of covid was such an unexpected event, that those efforts were in vain quickly afterwards.

Figure 8 Health expenditure as a share of GDP, selected OECD countries, 2006–2022, %



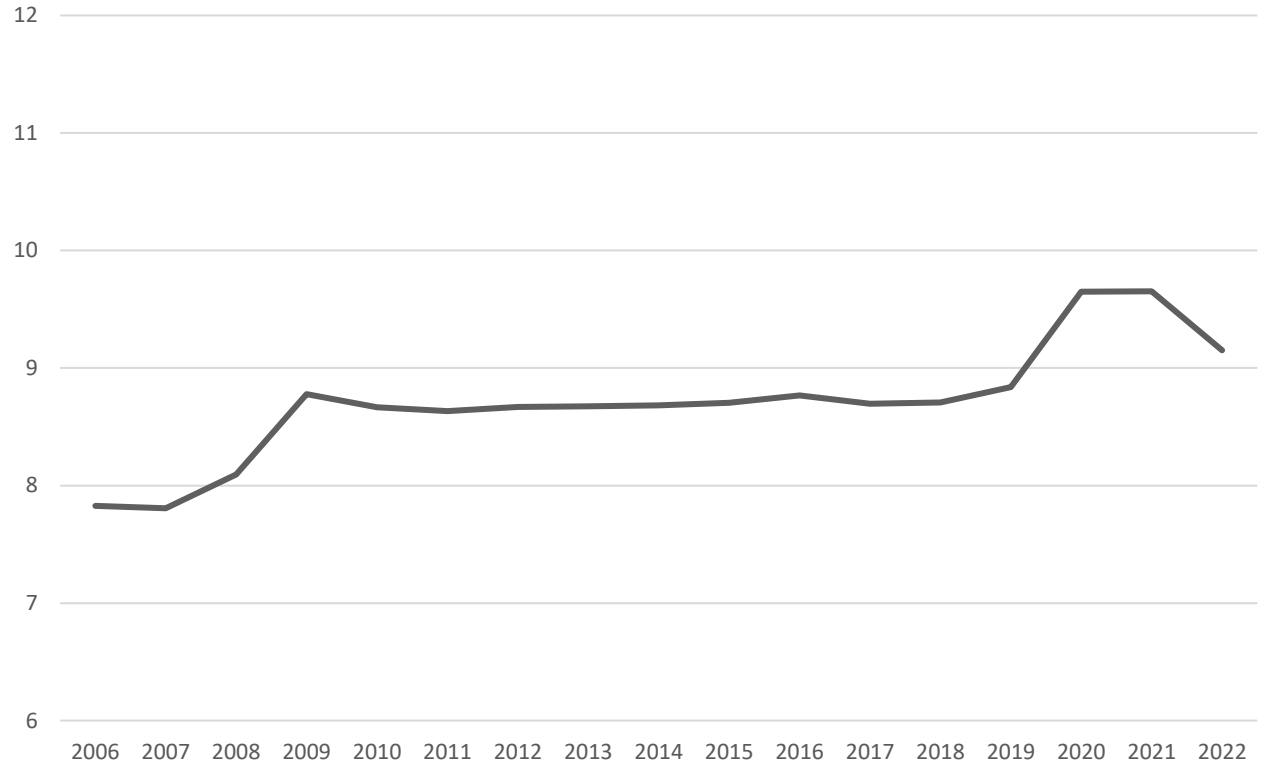
Source: OECD Health Data (2023)

Table 1 Health expenditure as a share of GDP, selected OECD countries, 2006–2022, %

Country/Year	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Austria	9,5	9,5	9,7	10,2	10,2	10,0	10,2	10,3	10,4	10,4	10,4	10,4	10,3	10,5	11,3	12,2	11,2
Czechia	6,2	6,0	6,3	7,2	7,6	7,6	7,6	7,5	7,6	7,4	7,4	7,4	7,5	7,6	9,2	9,5	8,8
Finland	8,3	8,1	8,3	9,2	9,1	9,2	9,6	9,8	9,8	9,6	9,4	9,1	9,0	9,2	9,6	9,8	9,7
Germany	10,2	10,1	10,3	11,2	11,1	10,8	10,9	11,0	11,0	11,2	11,2	11,3	11,5	11,7	12,7	12,9	12,6
Netherlands	9,1	9,1	9,3	10,0	10,2	10,2	10,5	10,6	10,6	10,3	10,3	10,1	10,0	10,1	11,2	11,1	10,1
Poland	5,8	5,9	6,4	6,6	6,5	6,3	6,3	6,5	6,3	6,4	6,6	6,6	6,3	6,5	6,5	6,4	6,4
Slovak Republic	6,9	7,2	7,0	7,9	7,7	7,3	7,5	7,5	6,9	6,8	7,0	6,8	6,7	6,9	7,1	7,8	7,6
Sweden	8,1	8,0	8,2	8,8	8,3	10,4	10,7	10,9	10,9	10,8	10,9	10,8	10,9	10,8	11,3	11,1	10,5
United Kingdom	8,5	8,8	9,0	9,8	9,8	9,8	9,9	10,0	9,9	9,8	9,8	9,6	9,7	10,0	12,0	12,0	11,1
United States	14,7	14,9	15,2	16,2	16,2	16,1	16,1	16,0	16,1	16,4	16,7	16,6	16,5	16,6	18,6	17,3	16,5

Source: OECD Health Data (2023)

Figure 9 Health expenditure as a share of GDP, OECD average, 2006–2022, %



Source: OECD Health Data (2023)

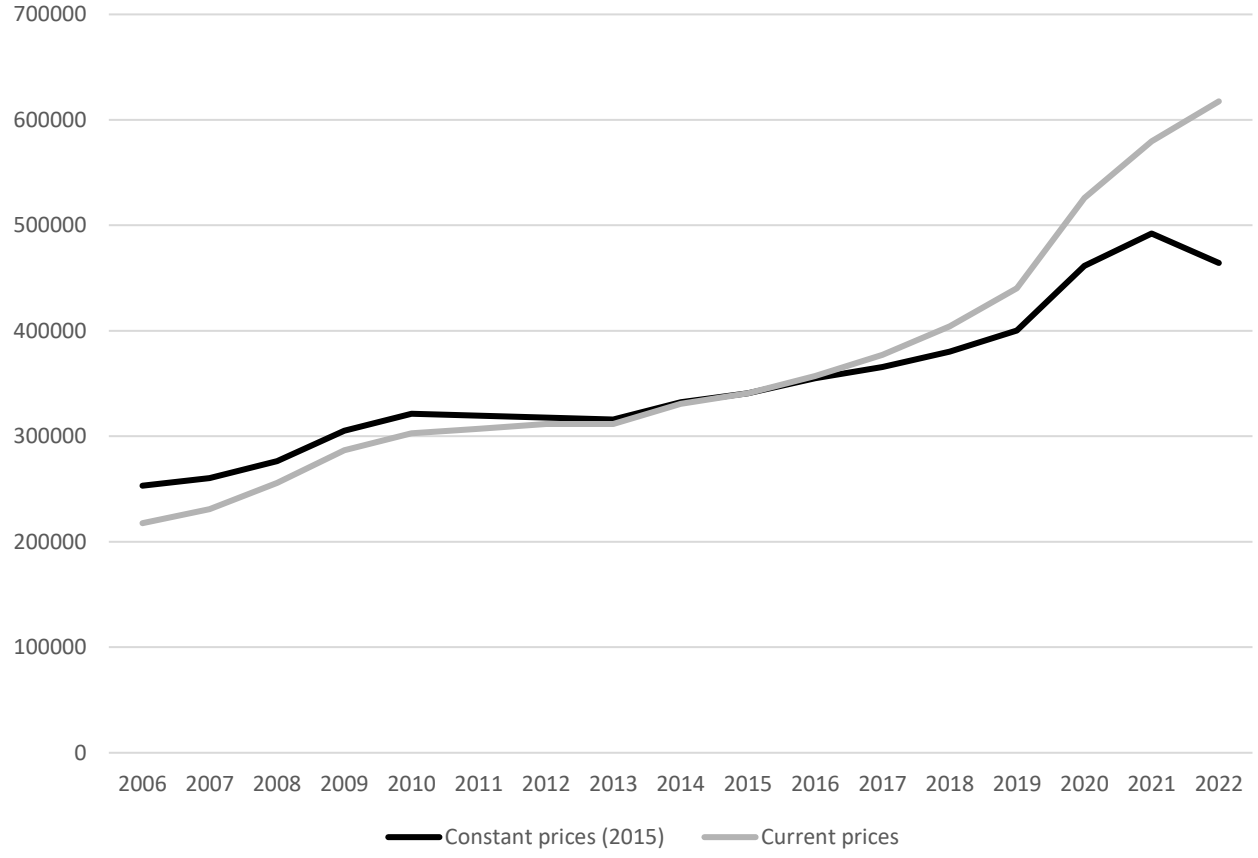
When we look at the development after 2020 in more detail, we can see that the average OECD health expenditure to GDP ratio declined from a peak of 9.7% at the height of the pandemic in 2021 to 9.2% in 2022. The share of GDP spent on health remains above the pre-pandemic level of 8.8% even if in 11 OECD countries the ratio in 2022 is estimated to have fallen below 2019 pre-pandemic levels (OECD, 2023).

Looking at country level data (OECD, 2023), the health expenditure to GDP ratio remained the highest in the USA at 16.5% in 2022, followed by Germany at 12.6%. A further 14 high-income countries, all spent more than 10% of their GDP on healthcare in 2022. In Czechia, the peak value was 9.5% in 2021, and it fell to 8.8% in 2022.

It is worth noting that on **Chyba! Nenalezen zdroj odkazů.** and **Chyba! Nenalezen zdroj odkazů.** th ere is a total health expenditure level. Nevertheless, looking at the OECD data for public component of health expenditure, the trend is remarkably similar, if not identical. We shall not include those graphs because of the size of this paper but considering that the Peacock-Wiseman hypothesis is a part of public finance theory, it is important to have verified whether the trends we are showing are true also for the public component of overall health expenditure. Average values on **Chyba! N enalezen zdroj odkazů.** also show, that in 2008 financial crisis, the Peacock-Wiseman effect seems to be more prominent than now, where in some countries, the return to pre-covid levels can happen.

If we look at the total health expenditure in Czechia in absolute terms (**Chyba! Nenalezen zdroj o dkazů.**), we see that in constant prices (real terms) it resembles the trend of the relative expenditure in OECD countries as shown above. The increases before 2020 were financed from the higher assessment bases for health insurance as the economy and wages grew, and from small increases of state-insured persons, as we shall show in the next chapter. The increases from 2020 and beyond were primarily driven by big changes of payments for state-insured persons. We shall delve into it more in chapter IV.

Figure 10 Total health expenditure, Czechia constant prices and current prices, 2006–2022, thousands CZK



Source: OECD Health Data (2023)

Looking at the data of OECD and Czechia in a comparative way, we see quite similar trends. On the other hand, in some OECD countries, the economic situation after covid has been improving faster and deeper than in Czechia. That may be behind the development at the end of the **Chyba! N enalezen zdroj odkazů.** (2021-2022), where in some countries the relative health expenditure fell faster than in Czechia. Also, their "economic pie", e.g. level of GDP and wages in Germany, is bigger than the Czech one, so they to some extent can better afford to finance and manage the increased health costs. Those thoughts however can be fully confirmed when reliable data for further years (2023 and beyond) become available.

IV. The role of payment for state-insured person and general taxation in Czechia's healthcare financing

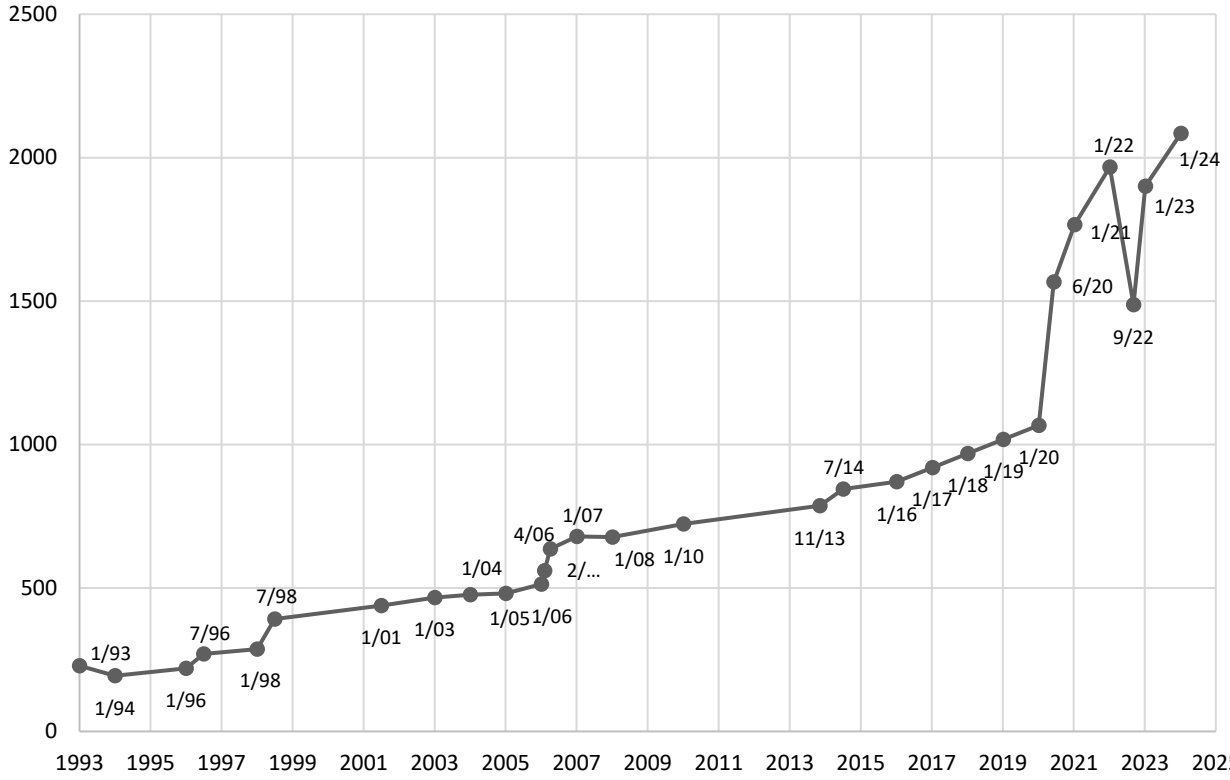
According to the applicable legislation (Act No. 48/1997 Coll.), the Czech public health insurance system is financed from insurance premiums that are compulsorily paid by employees, self-employed persons, so-called persons without taxable income ("OBZP" – in fact persons without active income from gainful activity under Sections 6 and 7 of the Income Tax Act No. 589/1992 Coll.) and the state as so-called state insured persons. From the point of view of the theory of public finances, there are two main sources of financing: a proportional health tax on earnings and a payment from the state budget, which can also be quantified in unit terms "per one state insured person", but in fact it is a fiscal transfer, or a simple subsidy to the public health insurance system from general taxes (Mertl, 2022).

The reasons for this setting are both economically rational and customary and historical. The volume of these two sources and the ratio between them is determined arbitrarily, the rate of 13.5 percent is surprisingly stable and has not changed since the start of the system in 1993, and the continuously increasing amount for state insured persons is set by public choice. Economically, there is an inverse relationship between these sources: a reduction in the collection of health tax (given by the base and rate) can be compensated by an increase in the subsidy from the state budget and vice versa. From a macroeconomic point of view, these sources behave differently. At a given rate, the collection from the proportional health tax is directly dependent on the volume of its bases – i.e. simply put, earnings, which depend on the development of the economy and the unemployment rate. Payments from the state budget are still significantly influenced by the political cycle and, in the current paradigm of relative debt, they are a significantly more flexible source than the collection of health tax.

In this paper, we shall continue to work with both components of the Czech fiscal space: a percentage of the earnings (income) of economically active persons and a subsidy from the state budget, which we can budget per insured person if we are interested, and overall, it significantly reduces the levy burden on work by covering part of the costs of health care from general taxes.

For any changes in the health tax rate in the future, its lower limit is to cover the total health care expenses for persons who are payers of health tax. The upper limit is the desired (or bearable) earmarked tax burden of the production factor of labour. Until now, the payment to the state has been subject to discretionary interference by politicians across the political spectrum, on whose decisions it has so far been fully dependent, and its development has looked accordingly. It is only since 2016 that we have seen more regular indexations, but the regularity has been lost since 2020 in connection with the covid-19 epidemic. The real development over the entire existence of this payment is summarized on **Chyba! Nenalezen zdroj odkazů.**. It shows that the increase of CZK 500 per insured p erson from June 2020 was massive, and overall, over the pandemic period (January 2020–January 2022) the payment from the state budget to the public health insurance system almost doubled (CZK 1 067 versus CZK 1 967).

Figure 11 Payment for one state-insured person, Czechia, 1993–2024



Source: (VZP, Vyměřovací základ a výpočet pojistného, 2024)

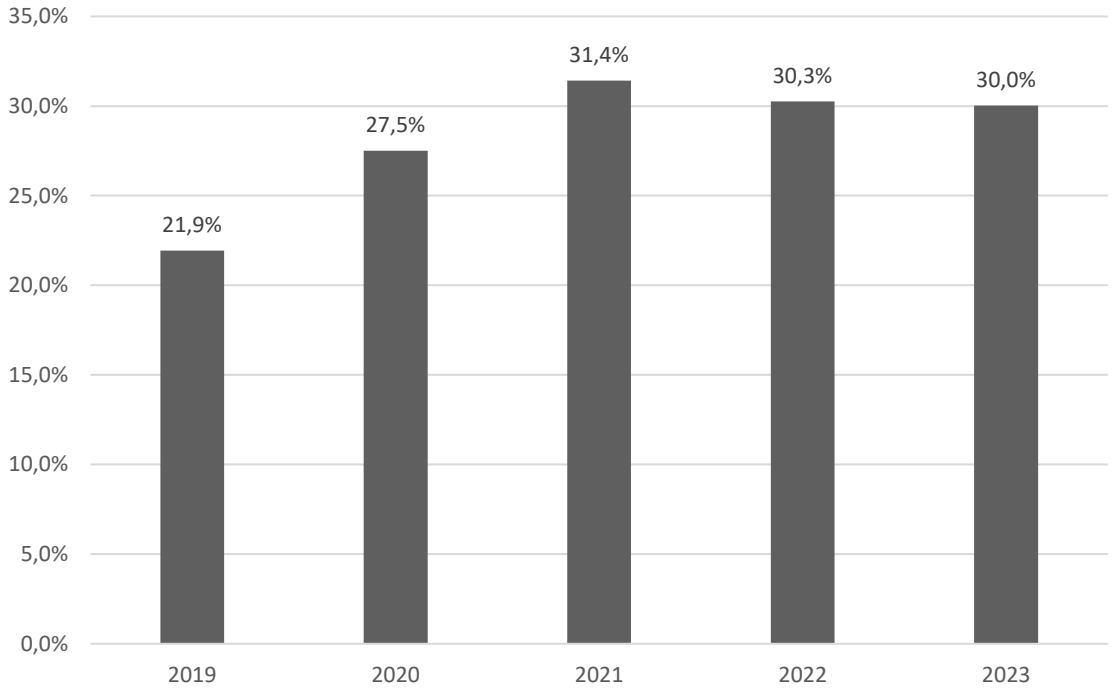
This trend encompasses the development of the entire amount. However, in terms of setting the fiscal space for healthcare, we distinguish three different effects that are reflected in this amount (Mertl, 2022):

1) simple indexation in the sense of maintaining its real value in relation to the development of the wage or price level,
2) a targeted change in the ratio between the earmarked health tax and the payment of the state – e.g. if we want to increase the payment of the state in a fiscally neutral way, then we should also reduce the rate of the health tax (insurance), as these two components of the fiscal space are in an inverse relationship - see further (Mertl, 2022),
3) increasing the volume of money for health care (real public expenditure on health care) from general taxes through this channel by a discretionary (deliberate) intervention – due to an epidemic or other turbulence, or simply by an interest in increasing public spending on health care regardless of the current conditions in the fiscal space.

The first two effects can be integrated into the system's adjustment processes, ceteris paribus, so they maintain the total amount of public resources for health care at the same real level corresponding to the selected indexation scheme). The third effect can be used to increase public health expenditure from general taxes if this is the intention of the government, regardless of the current conditions in the fiscal space. This is especially useful if the government wants to increase spending permanently (without time limit). If it is a one-off (or in principle temporary) expense, it may be more transparent to provide funds from the state budget to the central redistribution separately, outside of this regular payment. The transparency of the entire payment for the state-insured would be significantly helped by distinguishing and quantifying the individual factors affecting its setting. In the case of a rational setting of the first two, it is then possible to better distinguish its changes in the sense of adaptation and interconnection to other parameters of the system from a deliberate increase in resources for health care through this channel. In the case of covid-related changes of payments for state-insured persons, because the health insurance rate remained the same, it resulted in large (approx. 10 p.p.)

increase of the share of general taxation financing on total income of health insurance system (companies). The following figure can be also interpreted as a share of general taxation on total public health insurance revenues, the other part being a share of earmarked taxation.

Figure 12 Share of payments for state-insured persons on total health insurance revenues, Czechia, 2019–2023



Source: (MF ČR, 2023)

The previous ad hoc determination of the amount has been the subject of repeated criticism. Proposals for diverse options for determining this amount have also been published (Mechl, 2022; Zdravotnický deník, 2016; Gajdošová, 2018). Finally, Act No. 260/2022 Coll. modified the following method of indexation: "From 1 January of the calendar year, the assessment base is always increased by the sum of price increases and one half of the real wage growth according to paragraphs 3 to 5 and is rounded up to whole crowns." Subsequently, the law defines the method of calculating the real wage in the paragraphs mentioned in relation to the development of the price level and the temporal applicability of the mechanism for the first time from 1 January 2024. The positive aspect of this step is undoubtedly the introduction of the automatic indexation mechanism and the agreement of lawmakers on its specific form. The postponement of the start of the automatic indexation to 2024 (compared to the original intention from 2023), when inflation will hopefully be under control again, was probably influenced not only by the postponement of the date of approval of the law, but also by the aim of not applying the chosen scheme to the conditions of double-digit inflation that occurred. For 2023, this Act has therefore set a "fixed" assessment base of CZK 14,074, i.e. CZK 1,900 (which is still less than the original amount of CZK 1,967 for 2022).

A significant question is the chosen method of indexation and its fiscal demands. It is clear that an option has been chosen that guarantees the preservation of the real value of the payment for the state-insured and reflects half of its amount as well as the (potential) increase in real wages (i.e. the assessment bases for persons with earnings recalculated according to the development of the consumer price index, as defined in paragraph 4 of Article I of Act No. 260/2022 Coll.). From the point of view of the construction of the fiscal space for health care, this is a reliable and logical method, because the real value of the payment is linked to covering the costs of providing health care that are directly affected by the development of the price level, and the real wage growth reflects (in this case by half) the increase in another component of the fiscal space for health care, i.e. the collection of health tax, and transfers it partially to this component. However, it is also a method

that is relatively fiscally demanding in terms of general taxes, and therefore the state budget, which can complicate fiscal sustainability. So, the future will show whether the revenues from general taxes will be sufficient to finance this public expenditure on health. In other words, when drawing up future state budgets, it will be necessary to think about this automatically changing item and to secure resources for its financing from general taxes.

V. Discussion of related phenomena in health policy

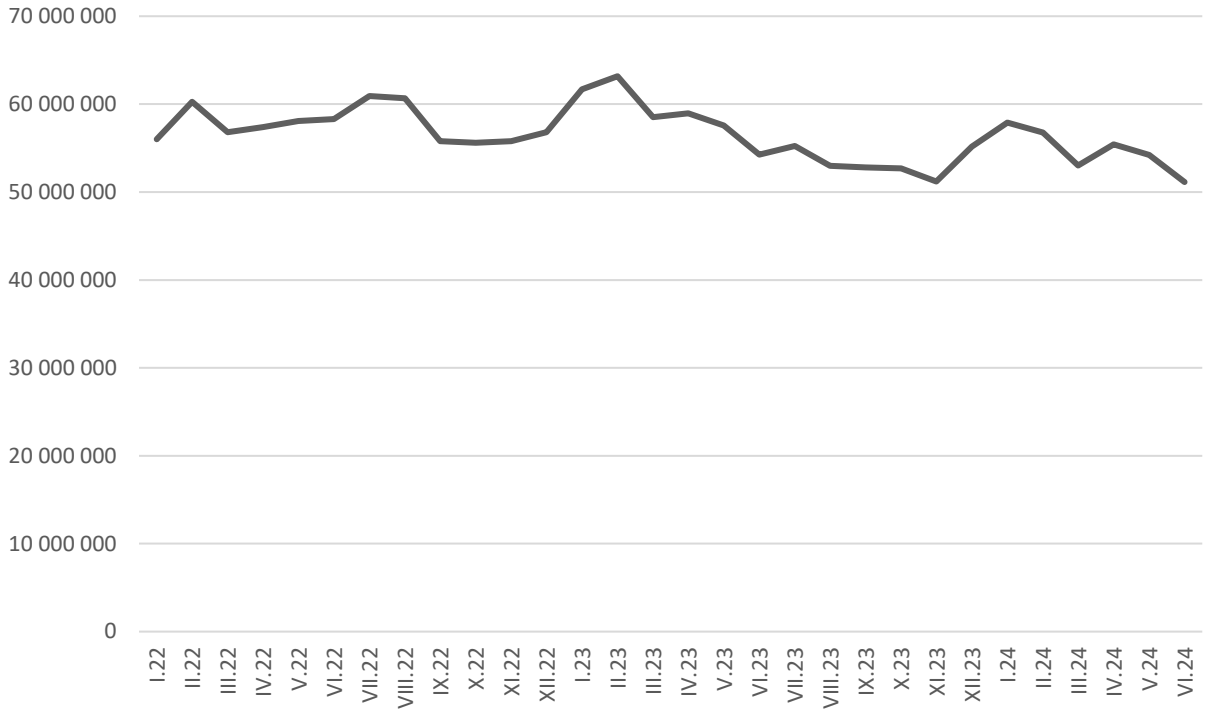
We have shown, that during the covid epidemics, the public Czech health care expenditure grew, and this growth was financed mainly with the increase of payment for state insured persons, in other words, with the increase of financing from state budget and thus general taxation. The data until 2022 also suggests, that Czechia has not get to the pre-covid level still, therefore there exists a possibility that to some extent the Peacock-Wiseman effect will happen.

Considering Czechia's health care expenditure level, before those changes, since the overall level of health expenditure was significantly lower than OECD average, there was a space to increase the total health expenditure, either from public, or private resources. Many times, when there were health reforms discussed, this space was seen as a viable path to increase the role of voluntary care (and related private expenditure) in the Czech healthcare. Now when to some extent this space was taken by the public expenditure, we may think whether the space for private expenditure has not been limited. If so, this can present a challenge for future systemic changes. When people pay a lot in general and earmarked taxes for health care, it may limit their resources available for private financing to some extent. Of course – this is not a zero-sum game, but especially households that live on wage income can encounter their budget limitation in this regard. This is facilitated by the fact, that Czech pensioners currently pay neither general taxes, nor health insurance (earmarked tax) from their pensions, thus the pressure on economically active people (that are supposed to pay both) is systemically even higher.

Additionally, it is uncertain what the future of Czech multi-payer system is going to be. This system has been established in the beginning of the 1990s and went through several changes. Recently, there again arose the suggestions to merge some of the remaining 7 health insurance companies (MZ ČR, Ministerstva zvažují sloučení dvou zdravotních pojišťoven, 2024), of course opposed by the targeted health insurance companies themselves. Therefore, the system suffers from unclear final, or in other words desired configuration of payers. That is a topic for different paper, at this place we can emphasize, that a country, including Czechia, can choose either a single or multi-payer system, but that choice must be stable for many years and there must be a clear public choice consensus on the desired outcomes, as well as the position and power of payer(s). If those conditions are not met, it is better not to make any substantial changes and improve the system as it has been created or evolved to its current form.

As we stated in the theoretical background, the volume of health expenditure is significantly influenced by the wages of health professionals. Therefore, it is noteworthy, that at the end of previous year (2023), their protest about working conditions and wages' structure was going on and unlike the other professions, like schools' employees or administrative jobs in public administration, they succeeded to a notable extent in wage increase. But the health insurance companies have been supposed to pay for those agreements mainly from their reserves. Therefore, as the year 2024 has been going on, we shall see which impact on their balance it is going to have and whether the promises they were given will hold up further. We can see the balances at the insurance companies' accounts (total balance for all of them in a given month) on the following figure 7. Up to now there can be observed that they hold well with a slight downward trend in last months, but there are signs that in the future, without increasing their incomes or optimalization of care provision network, sustainability of this financing can be lowered (VZP, 2023). Additionally, we can note, that the balances on basic health insurance fund (základní fond zdravotního pojištění, ZFZP) were 15 101 471 CZK in June 2024 (again total balance for all of them), exhibiting a decrease from 22 698 307 CZK in January 2024 (MZ ČR, Zůstatky na fondech zdravotních pojišťoven, 2024).

Figure 13 Balances of health insurance companies' accounts, 2022–06/2024 (CZK)



Source: (MZ ČR, Zůstatky na fondech zdravotních pojišťoven, 2024)

Related to this is the situation in Czech public finance in general. Given the huge negative balances of government budget (-360 billion CZK 2022, -280 billion CZK 2023), it is clear that the increase of the payment for the state insured persons described in chapter 4 was not backed up by adequate tax revenues. Therefore, it was achieved mostly by increasing the budget deficit, and subsequently, public debt. The situation in public finance is monitored and assessed by the Czech Fiscal Council, whose annual reports provide detailed information and projection about Czech budgets (Czech Fiscal Council, 2023). Considering healthcare, in short, we can say that the pressure on this sector's services in the future will not diminish, thus the current level of expenditure would be hard to lower. That however means the currently achieved equilibrium within the healthcare itself (demonstrated by the relatively adequate insurance companies' reserves on **Chyba! Nenalezen zdroj odkazů.**, at least i n the first quarter of 2024) is not backed up by adequate public resources, especially those from general taxation, and the increase of health expenditure done in covid would not be, at least part of it and to some extent, temporary.

VI. Conclusion

Although we saw a tendency that can lead to application of Wiseman-Peacock effect for Czech healthcare, similar development has been observed to some extent in other OECD countries, too. This was accompanied by the fact, that the last crisis was caused by health issue (covid infection), thus this effect which can be observed during social disturbances in general was even more prominent because of the health expenditure increase itself. On the other hand, even before covid, there is a notable effort in OECD countries to limit (not to increase further) the health expenditure (which was seen in years 2010–2019, when the share was almost stable). Therefore, we can expect, that the OECD countries will try in the next years to lessen the impact of this effect and possibly return to near pre-covid relative health expenditure.

To answer the research question simply, we can say, that no, the Czech healthcare is not cheap anymore, especially compared to the pre-covid situation. But the other OECD countries experienced similar trends, so relatively, the distance from e.g. German or American healthcare expenditure remains approximately the same, or not much smaller. So, the answer can be quite ambivalent: compared to the other OECD countries, Czechia is still cheaper, but compared to its own history, it

is already more expensive. This situation, however, can present a big challenge for Czech fiscal and health policy. In Czechia, this growth of healthcare expenditure has been driven mainly by the increase of payment for state-insured persons, i.e. from general taxation. Given the state of government budget and its big deficits, we can even say, that most, if not all this increase was done at the expense of increasing the public debt and thus is not covered by general tax revenue increase.

We are going to see, where the balance of public budgets and the relative expenditure on health will settle down after the Czech economy gets fully back on track, e.g. this year (2024) or next year (2025). But given the volume of the increase that was done during the epidemics, we may predict that a pressure on health budgets will remain strong, especially when simultaneously a pressure on fiscal consolidation will be executed. Therefore, three main options for health policy, that directly relate to the current situation, emerge.

First, to raise general taxation revenues so that the increased expenditure from the government budget is covered. That would be the cleanest option (balance income and expenditure properly when covid is over) but requires a support in public choice. Given the current taxation levels of income and property in Czechia, there is apparently a room for those adjustments. The history of Czech public finance teaches us however, that it can be difficult to obtain in practice. Second, to try make the system more effective, so that the health needs are met with less (or at least nominally the same) costs. This can be connected with the state of hospital networks and wages of health professionals, and also other methods of cost-containment in provision of universally available care. Third, to shift some of the care to the voluntary part of the system, that is paid for privately. This shift, however, should be done carefully and with respect to the basic universal healthcare rule – that patient should not be forced to choose care from voluntary part because his health status would worsen, or would not adequately improve otherwise.

In practice, a combination of them can be used, also because none of them itself is easy to do. Further, even more complex options, like the influencing the actual volume of healthcare needed by effective health promotion and prevention of diseases, or an improvement of pharmaceutical policy and dealing with medical equipment, we let in this paper aside, also because they are not causally connected with the analysed situation and need continuous improvement. We have however shown that a currently relatively stable public picture of Czech healthcare has been achieved by a large subsidy from a government budget. If this did not happen, the situation would have been worse, and some changes are still ahead.

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