

# FINANCIAL SCHEMES FOR ACTIVE AGEING AND ELDERLY WELL-BEING IMPROVEMENT

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## 1. Introduction

The ageing population (Pestieau and Jackson 2000) is a big challenge for all advanced systems of social security (Tinker 2002; Soest et al. 2010). The problems are twofold: with prolonging human life expectancy individually, and with imbalances between generations, where different population behaviour can create unfavourable demographic pyramids and introduce tough issues of intergenerational relationships and solidarity. Similarly split are the tasks for resolve: how to handle the specific needs and high costs of the care for the elderly (regardless of their count), and how to resolve imbalances that are emerging in public budgets because of unfavourable demographic development in general (because of their count).

Challenges of prolonging active participation emerged, as the developed countries face the pressure of increasing the pension age, which is connected with health status, politically sensitive and has got many risks and caveats, as well as opportunities for those individuals and jobs that can extend their productive activity with adequate support from social systems (Gessa et al. 2017). Also, ability to individually adjust workload is important. (Virtanen et al. 2014). In part, pension age problems can be solved by schemes that allow for individual adjustment of retirement age and the expansion of work activity; this may be better than changing the statutory retirement age for each participant. However, a recent OECD's editorial (OECD 2017) also states that "older workers are a diverse group and the flexibility of retirement is double-edged because it can increase the participation rate and standard of living of those who want and can work longer, but can also lead to an underestimation of financial needs in retirement and early retirement with reduced benefits and living standards". It can also be difficult to plan flexibly for those with lower working incomes or fail to find good opportunities in the labour market, on the contrary, it can be easy for those with higher working incomes and want and can work in their profession longer than statutory retirement age.

Various pension and health systems have responded to this issue differently. We could observe the reaction in different types of health care systems, such as introduction of government-financed health plans like Medicare in the USA since 1960s (Berkowitz 2005), compulsory social insurance payments for health care and long-term care and special disease management programs for pensioners in Germany and the willingness to pay for health insurance there (Bock et al. 2016) or public administration's efforts to improve the care for the elderly in

government-run systems like Great Britain's one (Bowman et al. 1999; Ajayi et al. 1995).

This paper aims to enlighten those issues and suggests prepaid health schemes as a supplementary financing scheme for voluntary healthcare provision, provided that the solid universal health care system is maintained well. At the same time, it tracks the changes in specific needs of the elderly and emphasizes the link to pension systems and their extensions as the reliable resource of financing voluntary care for the elderly.

Methodologically we use empirical analysis of social system settings, SWOT analysis for the prepaid programmes, theoretical explanation of the financing mechanisms targeted at older age and general theory of public finance and social security.

## **2. The importance of public financing of universal standards**

Generally, when a public financed universal health system is run, the question of pensioners' health financing is whether they ought to pay some contribution or tax for health care. The practice in OECD countries differs in this case, for example in Czechia, pensioners currently pay neither income tax, neither health contributions from their pensions, but in some countries like Germany or the Netherlands they must pay some compulsory contributions. Of course, if we impose some health contribution on pensioners, we must take it into account when doing pension system design, as it will decrease the "net pension" (disposable income) that the elderly will have for other expenditure. In this regard, the financing of the universal part of the system is mainly a question of public choice and configuration of the fiscal space for health (Cashin and Tandon 2010; WHO 2018). according to the incomes and pension schemes for the elderly. Usually, when a person enters pension age or retires, his or her social status changes, however and this has consequences on the rules of health contributions, too.

We can see that with changes according to age works also the USA system, where reaching 65 years of age means that you can enrol to the government-subsidized and organized health plan called Medicare. It is obvious, that its existence is determined by the needs of the elderly and the behaviour of private health insurance, where the premiums can rapidly rise with age and therefore can be unattainable for many older people. The dilemmas associated with this can be very complicated, as can be seen on the following quote (which we cite in full because it shows well how it empirically works in the USA) about termination of company-based coverage at 65.

"If you're not yet 65 but are retired and receiving retiree health benefits from your former employer, make sure you're aware of the employer's rules regarding Medicare. Some employers don't continue to offer retiree health coverage for former employees once they turn 65, opting instead for retirees to transition to being covered solely by Medicare. Without coverage from your company, you'll need Medicare to ensure that you are covered for potential health issues that arise as you age.

Some companies will not cut a retiree off completely at the age of 65, but instead continue to offer supplemental retiree benefits, which can be used in conjunction with Medicare (they may require you to enrol in both Medicare Part A and Part B

in order to receive full benefits—as secondary coverage—from the retiree health plan). The supplemental retiree health benefits may include prescription drug coverage, doctor visits, and other outpatient health care. Medicare will be your primary coverage if you're covered under a retiree health plan, with the plan offered by your former employer serving as secondary coverage.

If you have individual market coverage, purchased in the exchange or outside the exchange, you'll need to contact the exchange or your insurer to ask them to cancel your coverage when you transition to Medicare. Prior to the Affordable Care Act, individual market insurers typically wouldn't insure anyone over the age of 64, so plans were automatically terminated when people turned 65. That is no longer the case, so enrollees need to make sure that they actively cancel their individual market coverage when they switch to Medicare.” (Montgomery 2019).

From the cited example, we can see that the differentiation of coverage according to age, albeit it can be defended from the individual freedom principle arguments, does not bring much when we must cover the necessary and required care. Therefore, in most health care systems, the public contributions as the share of income are the preferred way to finance health, the American approach of the government being one of the plans' provider targeted on the elderly works in American context only. The same applies to pension schemes – we can say that the replacement rate to some level (e.g. 50-60% of previous wage – OECD average net replacement rate is approx. 58% in 2018) ought to be achieved from publicly (compulsory) financed and guaranteed scheme, so that the pension system is similarly stable as the health one in its basic functions.

### **3. Lifestyle changes and the role of voluntary schemes for older age**

Given the importance of universal care and financing, there is a possibility to utilize also voluntary schemes that consist of the care that primarily help to the well-being, quality of life, comfort and responsiveness of health services consumed by the elderly. They are not limited to the elderly and can be used at any age, but the older age is especially suited for them as the needs of seniors are both higher and more specific than general population in productive age.

Paradoxically, a person with a certain health limit who wants to lead an active life requires a greater range of better-quality services from the health system than if he would only passively experience his illness. At the same time, a far larger proportion of patients previously isolated or largely excluded from normal life are actively involved in it, which is certainly desirable from the point of view of national economic and others, but on the other hand, it puts increased demands on the health system because the direct quantified costs of "putting" such a person in an adequately compensated state are higher than in the past. The financial benefits of integrating people into society are quantifiable only in the long run, if at all, and we will add to it the probably difficult-to-quantifiable contribution of moral and ethical, especially in relation to the specific fate and life feelings of a particular person. In addition, people who can live a normal life through health care, in most cases, thanks to the experience of life, are very grateful to patients

and are subsequently able to improve their health, which they have acquired through adequate treatment of their disease, really translate into your performance at work and improve the quality of your life as a whole. This is already the reason for which it is worth looking for ways that will improve the possibilities of such people to engage in everyday life.

In other words, the current standard of living places far greater demands on health care than in the past, as many life activities are conditional on at least compensation for the patient's negative health in a particular area, which is not necessary for its "normal" survival, but for the conduct of modern, active life is necessary. Even the range of activities that people perform in life is increasing. People of a high age play sports, travel, work in responsible positions, even if part-time. This puts increased demands on the system, as these "patients" come to the doctors, saying they do not want to put up with their illness or their limitations and want to overcome them. That is why people who, due to their profession or penchant, need to be in good health and simply want to be "fit" and, in the case of health problems, if they already arise, want to solve them effectively, preferably with minimal impact on their employment or leisure activities. The difficulty of these patients is also manifested in the level of the services required, comfort in terms of time, etc. This leads to a significant differentiation of patients in terms of needs, as the aforementioned groups mix with those who do not require or need these services.

The above factors cause current medicine, of course, to continue to face problems of medical nature in the treatment of a particular patient, but increasingly with socio-economic constraints. This is exacerbated by the increasing dependence of effectively performed medicine on medical equipment and advanced pharmaceutical procedures. Thus, the results of the health system are closer to integration with the economic level and the mechanisms of allocation of funds to the health sector.

The current society has brought about fundamental changes in the view of the individual and his lifestyle. From the pursuit of mere survival, the emphasis is on the effective and responsible conduct of all actors in the economy. The economization of all areas of life and the emphasis on individual responsibility of the individual assume that each person will be able to take into account for their own actions and thus his own health, as well as the position of man in society and the relative level his remuneration is mainly due to his currently award-winning performance.

The corresponding health situation thus becomes one of the basic conditions for one to be able to take advantage of the possibilities offered by the market economy, both in terms of the long-term life perspective and in terms of exercising its capabilities at a certain time. Therefore, in the market economy, the pursuit of a person's good health is not only an objective finding, which results from a general desire and an effort to survive, but also an important condition for a person's optimal position in individual life situations and the whole economy. Therefore, we can well justify that at least part of the population that has got "health investor's" approach (Chytil et al. 2015) will have higher requirements that the universal part of pension and health system can adequately cover. So, we can

construct additional schemes of services' provision. However, for financing such a program on a regular basis, the elderly need a reliable source of financing, and since their working capabilities can gradually decrease, they rely on pension system to supply them disposable income that they can spend also on the health and social care. Simultaneously, in some countries like Czechia, the current pension pillars have not been designed with this requirement in mind, rather they followed the assumption that the universal system will cover all the services that seniors are going to need. This philosophy is good concerning the universal segment of care, but cannot cope with the individual needs of those, who can and want to have a higher level of well-being at the older age.

Therefore, a model of voluntary incentive pension system extension had been created and published (Mertl et al. 2019) which features the required scheme that allows the participants to gradually decrease the work load and provides supplementary pension benefits. Part of those benefits can be used also for financing health care, including the prepaid packages shown in this paper.

The main advantage of the model is that it shows the real possibility of creating an economic base for the expansion of productive services enabling the acquisition, preservation, and employment of human capital. Therefore, it is not only about how to ensure a decent standard of living and quality realization for people in older age, but primarily that a very strong and big demand for productive services and, at the same time, sources for their financing, which are created on a purely economic basis, is created by employing these people (to which the incentive extension motivates). This is not the only one, but significant and easily achievable, and concrete form of transforming the development of human abilities into the most dynamic factor of economic growth and the change in the character of this growth.

At this point, it is important to show how the benefits from the incentive extension can be utilized. There are various possibilities and various life situations, but in the context of this paper, the following usage may become essential (Mertl et al. 2019):

- 1) Voluntary forms of health care and services financing, which are oriented to prolonging the productive time and quality of life. From the pure point of view of financial flows, we consider this area to be the most important. As a practical alternative to private health insurance, which has strong limitations caused especially by the necessity of individual health risk evaluation (medical underwriting) and related information asymmetry, prepaid schemes for individually adjusted health packages can be considered.
- 2) Providing at older age social and support services that can enable the relevant productive person to spare time and energy in order to continue performing the relevant work activities. Still nowadays in Czechia, this is an underdeveloped sector of economy, which, of course, for many older citizens' case with retained abilities and qualification, means a waste of human resources.

#### **4. The role of voluntary prepaid programmes**

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

The first option is logically private health insurance. Although it has suitable features for some scenarios, it also has got many problems that are not addressed well using the market mechanism. This is mainly due to the information asymmetry and adverse selection issues, which in many cases lead to the failure of the health insurance market (Cutler and Zeckhauser 1997; 1999). The individual's health risk is one of the worst quantifiable and insurable risks on the market, develops unpredictably among individuals, and its possible evaluation through medical underwriting constitutes a reason for major legal and ethical disputes. Moreover, health risks of the elderly are very high and therefore insuring them is very difficult. In addition, in case of high-quality healthcare, it is sometimes difficult to look for a randomness element that is generally necessary for the use of insurance mechanisms. Still, accident insurance, critical illness insurance, hospitalization or long-term care insurance can work. Even general private health care insurance can be offered, but its marketability is low for the stated reasons, especially for older people who had not bought such insurance product when they were younger and had lower risk.

It is also possible to pay for optional health care directly out-of-pocket, which is the simplest form, but it has many limitations (Arrow 1963) (e.g. financial hardship at the moment of the treatment, time-limited decision in asymmetric position, highly limited ability of typical patient to "shop around" for the best price) leading to marginal role of these schemes in developed countries (OECD 2017).

Suitable possibility for extending schemes of optional healthcare financing comprises prepaid health care programmes. Their economic construction is relatively simple and consists in the regular allocation of the amount chosen (e.g. monthly or yearly), for which the client receives a healthcare package according to their preferences and needs. Therefore, we need not quantify health risks or otherwise restrict access into the product, although it is of course really useful to adapt the package to the needs and health of the client according to their preferences or as a result of expert advice when purchasing the product. Different clients can consequently have different packages for the same money, as will be shown below.

Let us assume that a patient can give 1 000 CZK for his health services monthly, e.g. 12 000 CZK annually (can be lower or higher amount according to the individual budget limitation and willingness to pay). Therefore, he can buy a prepaid package for this price, which we can see also as a subscription price.

He then is offered, according to his preference and/or health status, a package of health services that he can consume for that money during a year. It can be offered purely according to his demonstrated preference, or he can get advice from a doctor according to his health status, which services he would the most benefit from. Model (theoretical) example of such program can be found in Table below.

**Table 1.** Prepaid packages’ model examples for 12 000 CZK yearly subscription

Healthy	Already sick (e.g. cardiovascular condition)
1 000 CZK for services of nutrition advisor 3 000 CZK for wellness services 2 000 CZK for annual specific complex screening of civilization diseases 2 000 CZK for lifestyle activities and therapies (exercise, relaxation) 2 000 CZK for better services at general practitioner (email/callback/SMS), additional consultations/screening 2 000 CZK for vitamins, vaccination and reimbursement of regulation expenditures if introduced/expanded in universal part of the system	3 000 CZK for additional services/consultations at cardiologist, lower co-payments for advanced drugs that he takes regularly 2 000 CZK advisory services of physiotherapist and physical training aimed at cardiovascular rehabilitation 1 500 CZK for vitamins and dietary supplements 1 500 CZK contribution for a home cardio monitoring device 2 000 CZK for better services at general practitioner (email/callback/SMS), regular monitoring of health status 2 000 CZK for lifestyle activities (exercise, relaxation) specific for cardiovascular diseases

*Source: (Mertl 2018), updated.*

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

A real example from one provider’s content in the branch of rehabilitation care is cited lower in the Silver Card content (Klinika Malvazinky 2020):

- comprehensive examination by a rehabilitation specialist,
- package of rehabilitation services (7 x individual physiotherapy, 6 x massage services, 6 x group workout or gym, 12 x entrance to the pool, 2 x sauna access, 6 x full body bath, 50% discount on entrance to the rehabilitation pool, hydrotherapy procedures, group exercises and access to the fitness and functional zone at times designated for the public),
- individual approach in planning examinations and procedures according to the client's wishes,
- extended basic medical check-up at the general practitioner,

- free inclusion in the preventive-rehabilitation program (once a year in the chosen term and to the extent corresponding to the individual needs of the client),
- preferential approach and mediation of appointment when ordering for expert examinations in our clinic: internal medicine, cardiology, surgery, orthopaedics, rehabilitation, neurology, general practitioner, clinical psychology, etc.,
- free coffee and water at the Malvazinky Rehabilitation Clinic Cafe (1 x per visit).

As we can see, in Czechia's reality, we can already find some examples of those packages at the level of health providers and management organizations. They offer prepaid programmes with specified content, either general or medical branch specific (Santé 2020; Klinika Malvazinky 2020). It is possible to provide them on this basis, but systemically there are some disadvantages with integrating the provider and the payer, as it could be seen on the example of American Preferred Provider Organizations and Health Maintenance Organizations (Shin and Moon 2006; California State University 2020). Therefore, it would be better if also the health insurance companies could offer them to their clients, with strict separation of public and private resources, of course. The reasons are that they have better information about prices and providers, can target much higher number of clients and can combine multiple providers into integrated packages. Therefore, synergic effects and economies of scale would be higher when health insurance companies provide those programmes.

In practice, these schemes make sense especially as an extension of a universally available system because international experience with health savings accounts shows that they have disadvantages that become highly prominent if they are not supported with the aid of compulsory universal system – then they quickly fail with the poorer or sicker population or when clients grow old and require more expensive care. One of the disadvantages of health savings accounts is also the “pressure to save”, which means adverse health care seeking behaviour to preserve money saved into the account. Therefore, suggested prepaid health packages supply no special incentives to save money there and the amount paid should be fully spent for specified health services during chosen period.

Employer can contribute to financing of these programmes, even in relation to workload compensation by influencing their content. Similarly, if the client is involved in the voluntary extension of the pension system (Mertl and Valenčík 2017), then a part of the benefits from this extension may also be used to pay for the subscription.

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



have created based on the socioeconomic characteristics of prepaid health programmes as a voluntary extension of universal system.

**Table 2.** SWOT analysis of prepaid health programmes' role

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

Source: (Mertl 2018), updated.

## 5. Conclusion

The importance of universally financed health schemes and solid government guaranteed pension pillar is clear, but there is also space for voluntary extensions that can improve the well-being for the elderly. This is supported by the fact that the lifestyle and requirements of older population change and increase, and some countries face unfavourable population pyramid shapes that must be handled within social policy framework. Such schemes can be created both in pension and health systems, and the benefits from pension systems extension (additional pillars) can be used amongst other expenditure also for financing prepaid health care programs. In pension system, we can utilize the incentive extension described here (Mertl et al. 2019). The client can either have full engagement and then fully retire, or since some point, he can gradually decrease his engagement and start to receive the partial benefits during relaxed phase. The model can work with any realistic parameter settings.

The health status and available care is closely connected with pension age and prolonging active participation, both being key issues of pension reforms.

As a possible alternative to private health insurance, which has strong limitations caused by individual health risk evaluation (medical underwriting), prepaid schemes can be considered. Systemically in the form of health savings accounts they also have got disadvantages that become highly prominent if they are not supported by solid universal system – then they can quickly fail with poorer or sicker population, or when the clients get older and demand more expensive care. In this paper, we have shown the prepaid schemes as an extension to well-covering universal health care system, with link to incentive pension system extension as a financing resource and without special incentives to save money there, overcoming those disadvantages largely.

As seen from SWOT analysis, they have got some unique properties that are lower transaction costs and high economies of scale, non-discriminatory approach to the health status of clients and voluntary allocation of money for concrete health services chosen individually with possible medical advice. These prepaid schemes are also more suitable for “health investor” than “health consumer” human behaviour (Chytil et al. 2015).

We showed that some attempts of such prepaid schemes have been occasionally spotted in Czechia already, but they are highly selective, elementary and usually they are provided by larger hospitals or network of ambulances, being a limited offer to their patients.

We do not want to pretend that prepaid schemes are a miracle that can resolve the issues of well-being for the elderly. The analysis shows also their threats and weaknesses and for some scenarios other financing schemes can be more appropriate. But we suggest that they should be seriously considered as an option for specific health packages consumption and financing especially in the form of voluntary extension of universal system, and pension system could provide reliable cashflow resources for them when the clients partially or fully retire.

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