

Can people afford to pay for health care?

New evidence on financial protection in Lithuania

Liuba Murauskienė
Sarah Thomson



Lithuania

WHO Barcelona Office for Health Systems Strengthening

The WHO Barcelona Office is a centre of excellence in health financing for universal health coverage (UHC). It works with Member States across WHO's European Region to promote evidence-informed policy making.

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This review is part of a series of country-based studies generating new evidence on financial protection in European health systems. Financial protection is central to universal health coverage and a core dimension of health system performance.

Healthcare Financing
Health Expenditures
Health Services Accessibility
Financing, personal
Lithuania
Poverty
Universal Coverage

About the series

This series of country-based reviews monitors financial protection in European health systems by assessing the impact of out-of-pocket payments on household living standards. Financial protection is central to universal health coverage and a core dimension of health system performance.

What is the policy issue? People experience financial hardship when out-of-pocket payments – formal and informal payments made at the point of using any health care good or service – are large in relation to a household's ability to pay. Out-of-pocket payments may not be a problem if they are small or paid by people who can afford them, but even small out-of-pocket payments can cause financial hardship for poor people and those who have to pay for long-term treatment such as medicines for chronic illness. Where health systems fail to provide adequate financial protection, people may not have enough money to pay for health care or to meet other basic needs. As a result, lack of financial protection may reduce access to health care, undermine health status, deepen poverty and exacerbate health and socioeconomic inequalities. Because all health systems involve a degree of out-of-pocket payment, financial hardship can be a problem in any country.

How do country reviews assess financial protection? Each review is based on analysis of data from household budget surveys. Using household consumption as a proxy for living standards, it is possible to assess:

- how much households spend on health out of pocket in relation to their capacity to pay; out-of-pocket payments that exceed a threshold of a household's capacity to pay are considered to be *catastrophic*;
- household ability to meet basic needs after paying out of pocket for health; out-of-pocket payments that push households below a poverty line or basic needs line are considered to be *impoverishing*;
- how many households are affected, which households are most likely to be affected and the types of health care that result in financial hardship; and
- changes in any of the above over time.

Why is monitoring financial protection useful? The reviews identify the factors that strengthen and undermine financial protection; highlight implications for policy; and draw attention to areas that require further analysis. The overall aim of the series is to provide policy-makers and others with robust, context-specific and actionable evidence that they can use to move towards universal health coverage. A limitation common to all analysis of financial protection is that it measures financial hardship among

households who are using health services, and does not capture financial barriers to access that result in unmet need for health care. For this reason, the reviews systematically draw on evidence of unmet need, where available, to complement analysis of financial protection.

How are the reviews produced? Each review is produced by one or more country experts in collaboration with the WHO Barcelona Office for Health Systems Strengthening, part of the Division of Health Systems and Public Health of the WHO Regional Office for Europe. To facilitate comparison across countries, the reviews follow a standard template, draw on similar sources of data (see Annex 1) and use the same methods (see Annex 2). Every review is subject to external peer review. Results are also shared with countries through a consultation process held jointly by the WHO Regional Office for Europe and WHO headquarters. The country consultation includes regional and global financial protection indicators (see Annex 3).

What is the basis for WHO's work on financial protection in Europe? WHO support to Member States for monitoring financial protection in Europe is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include a commitment to work towards a Europe free of impoverishing out-of-pocket payments for health. Resolution EUR/RC65/R5 calls on WHO to provide Member States with tools and support for monitoring financial protection and for policy analysis, development, implementation and evaluation. At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. The Sustainable Development Goals (SDGs) adopted by the United Nations in 2015 also call for monitoring of, and reporting on, financial protection as one of two indicators for universal health coverage. Resolution EUR/RC67/R3 – a roadmap to implement the 2030 Agenda for Sustainable Development, building on Health 2020 – calls on WHO to support Member States in moving towards universal health coverage.

Comments and suggestions for improving the series are most welcome and can be sent to euhsf@who.int.

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Abbreviations

EFPIA	European Federation of Pharmaceutical Industries and Associations
EHIS	European Health Interview Survey
EU	European Union
EU13	European Union Member States joining after 30 April 2004
EU15	European Union Member States from 1 January 1995 to 30 April 2004
EU27	European Union Member States as of 1 January 2007
EU28	European Union Member States as of 1 July 2013
EU-SILC	European Union Statistics on Income and Living Conditions
EXPH	Expert Panel on Effective Ways of Investing in Health
GDP	gross domestic product
NHIF	National Health Insurance Fund
OOP	out-of-pocket payment
VHI	voluntary health insurance

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Executive summary

The health system in Lithuania relies heavily on out-of-pocket payments. In 2015, out-of-pocket payments accounted for 32% of total spending on health – well above the European Union average of 22%. This high share is in part due to a fall in public spending on health in the years following the economic crisis. It also reflects the design of coverage policies.

Entitlement to National Health Insurance Fund benefits is linked to payment of contributions rather than residence, leaving around 6–10% of the population without coverage of non-emergency care. Adults covered by the National Health Insurance Fund benefit from free access to doctors and hospitals, but face significant gaps in coverage for outpatient medicines and dental care. Voluntary health insurance does not cover these gaps; it is purchased by less than 1% of the population – mainly higher-paid employees – to obtain access to private providers.

As a result, financial protection is weak in Lithuania compared to other European Union countries. In 2012, just over 9% of households experienced catastrophic out-of-pocket payments – up from 7% in 2005. Around 4% of households were impoverished or further impoverished as a result of having to pay out-of-pocket for health. Catastrophic spending on health affects the poorest households the most. It is also heavily concentrated among older households. In contrast to adults, children up to the age of 18 benefit from free access to all publicly financed health care. This strongly protective policy towards children is reflected in the very low share of households with children among households with catastrophic out-of-pocket payments.

Out-of-pocket spending on medicines is the most important cause of financial hardship. Policy attention should focus on improving the accessibility and affordability of outpatient prescribed medicines. Reforms introduced in 2009, 2017 and 2018 to lower medicine prices and encourage appropriate prescribing and dispensing are essential steps in the right direction, but further action is needed. Lithuania's high use of non-prescribed medicines, especially among people aged over 65, also warrants policy attention.

Major improvement in financial protection is only likely to be achieved by strengthening the design of coverage and co-payment policy. At present, co-payment policy for outpatient prescribed medicines shifts the financial risk associated with high prices and inappropriate prescribing and dispensing onto households. A more protective approach would be to exempt poor households and regular users of outpatient medicines; introduce an income-related cap on all co-payments; and use fixed rather than percentage co-payments.

Dental care is the second largest cause of catastrophic spending on health, but mainly affects richer households due to the high level of unmet need for dental care experienced by poorer households. Limited coverage of dental care for adults is an additional concern.

Stronger financial protection will require extra public investment in the health system. Public spending on health is lower than Lithuania can afford given its level of gross domestic product. Any increase in public spending should be used to prioritize stronger protection for poor households and regular users of outpatient medicines and other health services.

1. Introduction

This review assesses the extent to which people in Lithuania experience financial hardship when they use health services, including medicines. Research shows that financial hardship is more likely to occur where public spending on health is low in relation to gross domestic product (GDP) and out-of-pocket payments account for a relatively high share of total spending on health (Xu et al., 2003; Xu et al., 2007; WHO, 2010). Increases in public spending or reductions in out-of-pocket payments are not, in themselves, a guarantee of better financial protection, however. Policy choices are also important.

During the early 2000s, public spending on health in Lithuania grew substantially, more than doubling per person in real terms between 2000 and 2008. In 2009, the economic crisis led to a huge drop in GDP followed by a large rise in unemployment (Eurostat, 2018a). Public social spending fell in response to budget cuts and unemployment (Kacevičius & Karanikolos, 2015; Murauskienė et al., 2013) and out-of-pocket payments for health care increased. By 2012 the out-of-pocket share of total spending on health had grown considerably. As a result, Lithuania's out-of-pocket share of total spending on health is now one of the highest in the European Union (EU), while the public share of total spending on health – 66% in 2015, down from 72.5% in 2009 – is well below the EU average of 72.5% (WHO, 2018).

The analysis in this review draws on household budget survey data collected in 2005, 2008 and 2012. These data show that between 2005 and 2008, a time of rapid economic growth, older people experienced an increasing risk of poverty compared to the rest of the population, largely because pensions failed to keep pace with growth in other sources of income. The situation was reversed between 2008 and 2012, as unemployment rose and wages fell. Since 2012, however, the income gap between older people and people of working age has grown once again. Pensioner poverty is a particular challenge for financial protection due to higher rates of health care need among older people.

In spite of the financial upheaval faced by society and the health budget between 2005 and 2012, the health system did not undergo major changes, but two reforms are worth noting for their potential impact on financial protection. In 2009, the Government of Lithuania strengthened the link between payment of contributions to the National Health Insurance Fund (NHIF) and entitlement to publicly financed health services, introducing significant penalties for non-payment of contributions and setting up a register of people eligible to contribute. This process drew attention to the number of uninsured people – around 6–10% of the population – mainly men and people of working age, some of whom had probably left Lithuania but continued to be registered as residents. In the same year, in response to the effects of the crisis on the pharmaceutical market, the NHIF stepped up efforts to lower the price of medicines and encourage more appropriate prescribing and dispensing (Murauskienė et al., 2013). Since 2017, the Government has introduced further measures to contain spending on medicines (European Observatory on Health Systems and Policies, 2018).

This review is structured as follows. Section 2 sets out the analytical approach and sources of data used to measure financial protection. Section 3 provides a brief overview of health coverage and access to health care. Sections 4 and 5 present the results of the statistical analysis of household budget survey data. Section 4 analyses out-of-pocket payments. Section 5 analyses financial protection. Section 6 discusses the results of the financial protection analysis

and identifies factors that strengthen and undermine financial protection: those that affect people's capacity to pay for health care and health system factors. Section 7 highlights implications for policy. Sections 3, 4, 5 and 6 each end with a short summary of the section's main points. Annex 1 provides information on household budget surveys; Annex 2 discusses the methods used. Annex 3 presents regional and global financial protection indicators, and Annex 4 has a glossary of terms.

2. Methods

This section summarizes the study's analytical approach and its main data sources. More detailed information can be found in Annex 1 and Annex 2.

2.1 Analytical approach

The analysis of financial protection in this study is based on an approach developed by the WHO Regional Office for Europe, building on established methods of measuring financial protection (Wagstaff & van Doorslaer, 2003; Xu et al., 2003). Financial protection is measured using two main indicators: catastrophic out-of-pocket payments and impoverishing out-of-pocket payments. Table 1 summarizes the key dimensions of each indicator.

2.2 Data sources

The study analyses anonymized microdata from the Lithuanian household budget survey, which is carried out every three years or so. Since 2000, the household budget survey has been carried out in 2005, 2008 and 2012. The survey involved 10 866 households (a response rate of 70%) in 2005, 11 028 households (response rate 55%) in 2008 and 14 400 households (response rate 51%) in 2012.

All currency are presented in euros. Litas reported in the household budget survey were converted into euros at the standard conversion rate of 3.45 litas to 1 euro.

Table 1. Key dimensions of catastrophic and impoverishing spending on health

Catastrophic out-of-pocket payments	
Definition	The share of households with <i>out-of-pocket</i> payments that are greater than 40% of household <i>capacity to pay for health care</i>
Numerator	Out-of-pocket payments
Denominator	Total household <i>consumption</i> minus a standard amount to cover basic needs. The standard amount to cover basic needs is calculated as the average amount spent on food, housing and <i>utilities</i> by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition.
Disaggregation	Results are disaggregated into household <i>quintiles</i> by consumption. Disaggregation by place of residence (urban–rural), age of the head of the household, household composition and other factors is included where relevant.
Impoverishing out-of-pocket payments	
Definition	The share of households <i>impoverished</i> or <i>further impoverished</i> after out-of-pocket payments
Poverty line	A <i>basic needs line</i> , calculated as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition
Poverty dimensions captured	The share of households further impoverished, impoverished, <i>at risk of impoverishment</i> and <i>not at risk of impoverishment</i> after out-of-pocket payments
Disaggregation	Results can be disaggregated into household quintiles by consumption and other factors where relevant.

Note: See Annex 4 for definitions of words in italics.

Source: Thomson et al. (2018).

3. Coverage and access to health care

This section briefly describes the governance and dimensions of publicly financed health coverage (population entitlement, service coverage and user charges) and reviews the role played by voluntary health insurance (VHI). It then summarizes some key trends in rates of health service use, levels of unmet need for health and dental care, and inequalities in service use and unmet need.

3.1 Coverage

3.1.1 Population entitlement

The Health Insurance Law grants free access to health care on the basis of payment of contributions to or participation in the health insurance scheme run by the NHIF, which is compulsory for all permanent and temporary residents. The state pays contributions for the majority of the population (around 55% in 2015), including children up to the age of 18, old-age pensioners (in 2017 the formal retirement age was 63 years 6 months for men and 62 years for women), disabled people, people registered as unemployed, social assistance beneficiaries and people with specific communicable diseases.

In 2009, to encourage NHIF enrolment and payment of contributions, the Government of Lithuania introduced penalties for non-payment, a waiting period of three months between payment of first contribution and ability to benefit, and a new rule that means entitlement expires one month after non-payment. These penalties were abolished in 2014 and replaced by a system in which a maximum of five years' worth of unpaid contributions must be recouped. In 2009, the NHIF also established a register of people eligible to pay contributions, and in 2010 the number of uninsured people was found to be 296 000 in 2013 (equal to around 10% of the population), falling to 225 510 in 2016 (around 8%). Most of the uninsured are Lithuanian citizens. Two thirds are men and over three quarters are aged between 20 and 49 years. Some of these people are likely to be working abroad without having formally declared their absence.

3.1.2 Service coverage

All permanent residents are entitled to free emergency care, even if they are not insured (Article 49 of the 1994 Health System Law). The NHIF benefits package is not explicitly defined. It covers a relatively broad range of health services. The Ministry of Health has defined a positive list for medical products and two positive lists for outpatient prescription medicines. The main gap in NHIF service coverage is dental care for adults, which is only offered to people receiving income support. Waiting times were not guaranteed by law during the study period.

3.1.3 User charges

People covered by the NHIF have free access to primary care, outpatient specialist care with referral and inpatient care. However, most must pay

out-of-pocket at the point of use for NHIF-covered outpatient prescription medicines, medical products not on the positive list, dental care and inpatient rehabilitation (Table 2).

Enhanced protection is available for children, who are entitled to free dental care and are also exempt from user charges for outpatient prescription medicines. Pensioners, disabled people, people receiving income support and people with specific conditions are protected against some of the cost of user charges for outpatient prescription medicines and dental care, although this protection is limited, as Table 2 shows.

NHIF data collected from retailers indicate that, in total, patients pay about 20% of the cost of NHIF-covered outpatient prescription medicines, with the NHIF paying the rest (Garuoliene, 2015). Around two thirds of all NHIF spending on outpatient medicines is for people who are exempt from user charges.

User charges policy did not change during the study period.

Extra billing is prohibited for faster access to treatment (Article 49 of the 1994 Health System Law). However, providers contracted by the NHIF can charge more for patients who choose to see specialists without a referral and patients who opt for more expensive or additional services. Providers are free to determine how much they charge such patients. According to data held by local facilities contracted by the NHIF, patients pay out of pocket for about 4% of outpatient physician visits (Health Information Centre, 2016). In 2014, the body in charge of anti-corruption activities judged the regulation on extra billing to be lacking in clarity and therefore likely to result in unfair charges to patients (Special Investigation Service, 2014). The Government has since tried to clarify the rules, but NHIF-contracted providers are still free to determine how much to charge patients, so the potential for unfair charges remains.

3.1.4 The role of VHI

VHI plays a very minor role in the health system, covering less than 1% of the population in 2009 and accounting for less than 1% of total spending on health in 2014 (Murauskienė et al., 2013). People prefer to pay providers out of pocket when they need health care rather than paying premiums for VHI on a regular basis. VHI mainly plays a supplementary role, providing access to private providers. As a result, it is more likely to cover middle- to high-income people living in large cities and those employed by large companies (Kacevičius, 2016).

Table 3 highlights key issues in the governance of coverage, summarizes the main gaps in publicly financed coverage and indicates the role of VHI in filling these gaps.

Table 2. User charges for publicly financed health services

Source: authors.

Service area	Type and level of user charge	Exemptions	Cap on user charges paid
Outpatient visits	None: primary care and specialist care with referral Fixed co-payment: services on a negative list based on prices set by the Ministry of Health	NA	NA
Outpatient prescription medicines	Adults pay percentage co-payments for medicines on the positive list (co-payment rates of 20% and, less commonly, 10% or 50%) A system of internal reference pricing is also in place for medicines on the positive list; all users pay the difference between the retail and reference price	Exemption from payment of the reference price for children under 18, people recognized as not able to work and people of pensionable age with major special needs Reduced rates for people with specific conditions (e.g. mental illness, diabetes, cancer, stroke, myocardial infarction, HIV/AIDS, tuberculosis etc.), who pay 50%, 20%, 10% or 0% of the price for medicines on List A (disease-specific list); old-age pensioners, partially disabled people and recipients of social benefits pay 50% of the reference price for medicines on List B (medicine-specific list)	No
Diagnostic tests	None: tests on the positive list Fixed co-payment: tests not on the positive list	NA	No
Medical products	None: supplies on the positive list for medical aids Users pay the full price: supplies not on the positive list	Exemption for people with selected conditions	No
Dental care	Adult users pay the full price: treatment and materials	Free treatment by public providers for children under 18, students under 24 and people receiving income support Pensioners, disabled people and children under 18 are exempt from dental prosthesis costs; for everyone else, dental prostheses are covered once every three or five years	No
Inpatient care	None	NA	NA
Inpatient medicines	None	NA	NA

Table 3. Gaps in coverage

Source: authors.

	Population entitlement	Service coverage	User charges
Issues in the governance of publicly financed coverage	Entitlement depends on payment of contributions	Limited positive list for medical products; lack of waiting time guarantees during the study period	Use of percentage co-payments; weak protection for adults; inadequate regulation of extra billing
Main gaps in publicly financed coverage	Around 6–10% of the population are uninsured, although some of these people are likely to be working abroad	Dental care for adults; waiting times	Outpatient prescription medicines for adults
Are these gaps covered by voluntary health insurance?	No	No; VHI covers less than 1% of the population; its main role is to provide access to private providers	No

3.2 Access, use and unmet need

Outpatient contacts per person and acute hospital discharge rates are both high in comparison to the EU average (WHO Regional Office for Europe, 2017). Between 2005 and 2015 the number of physician visits increased slightly but with no significant change in the number of hospital admissions. In both cases, however, the rate of use increased, probably due to a fall in the size of the population; between 2005 and 2013 the population fell by over 10%, largely as a result of migration. The number of physician visits per person per year rose by 29% (from seven to nine visits), while the rate of hospital admissions rose by 9% to reach 267 admissions per 1000 population (Health Information Centre, 2018).

Substantial variation in the supply of health workers means some areas have more than 10 times as many doctors and nurses as other areas, resulting in regional inequality in the use of physician services. In 2015, for example, specialist visits accounted for 32% of all outpatient physician visits in total, but only 21% in rural areas, suggesting that people in rural areas have limited access to specialists in comparison to the population as a whole.

EU data indicate that access to dental care is more of a problem in Lithuania than access to health care (Fig. 1). Cost is the most common reason people give for unmet need for dental care, whereas waiting time is the main reason given for unmet need for health care. Unmet need due to waiting time is the only area of unmet need in which Lithuania is above the EU average (Box 1).

Box 1. Unmet need for health care

Source: WHO Barcelona Office for Health Systems Strengthening.

Financial protection indicators capture financial hardship among people who incur out-of-pocket payments through the use of health services. They do not, however, indicate whether out-of-pocket payments create a barrier to access, resulting in unmet need for health care. Unmet need is an indicator of access defined as instances in which people need health care but do not receive it due to access barriers.

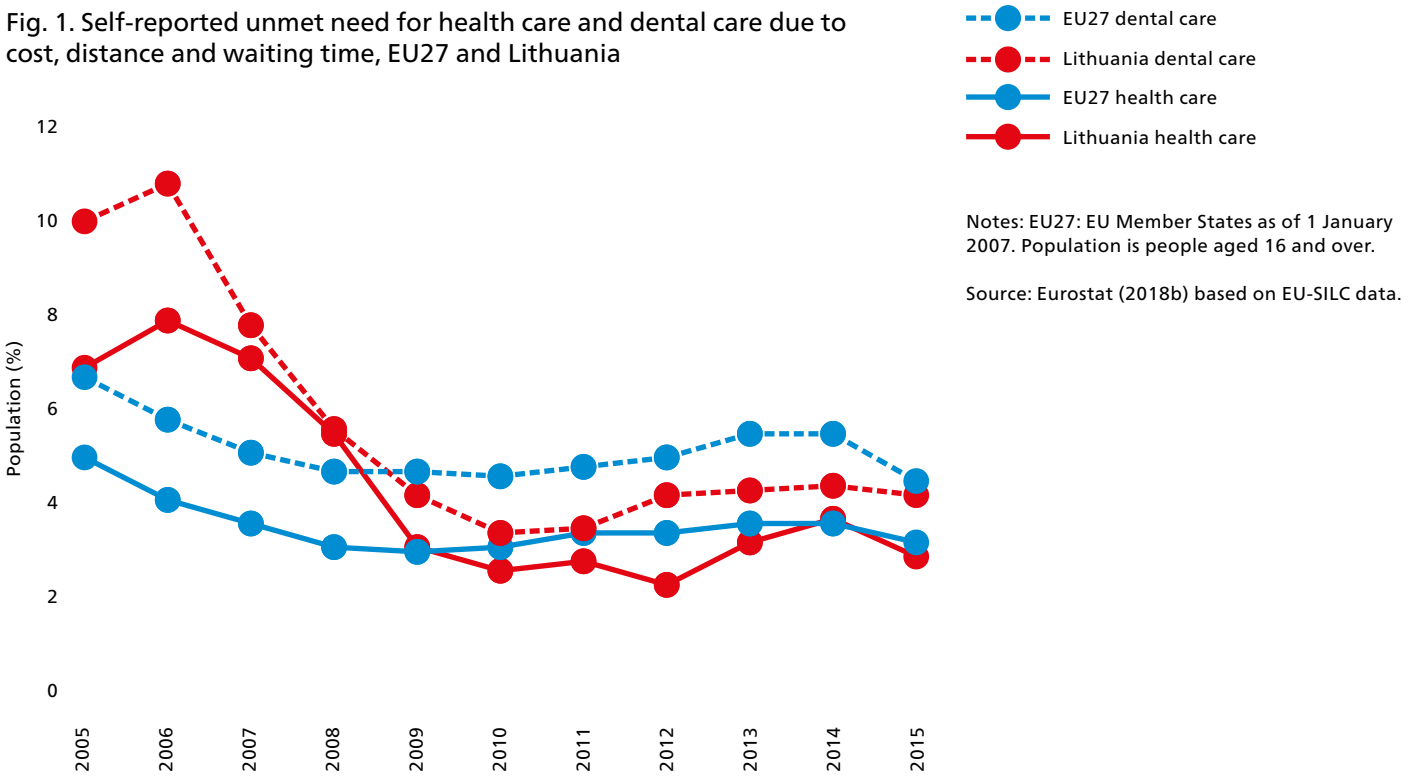
The household budget surveys used to analyse financial protection do not routinely collect information on health care use or unmet need. They show which households have no out-of-pocket payments, but do not explain the reason for this. It could be that households with no out-of-pocket payments: (a) have no need for health care; (b) are exempt from user charges; or (c) face barriers to accessing needed health services.

Without accounting for unmet need, financial protection analysis could be misinterpreted. A country may have a relatively low incidence of catastrophic out-of-pocket payments because many people are prevented from using health care due to the limited availability of services and other access barriers. Conversely, reforms that increase the use of services can increase people's exposure to out-of-pocket payments – for example, through user charges – if protective policies are not in place. In such instances, reforms might improve access to health care but, at the same time, increase financial hardship.

This review draws on data on unmet need to complement the analysis of financial protection (section 3.2). It also draws attention to changes in the share and distribution of households without any out-of-pocket payments (section 4.1). If increases cannot be explained by changes in the health system – for example, increased protection for certain households – they may be driven by increases in unmet need.

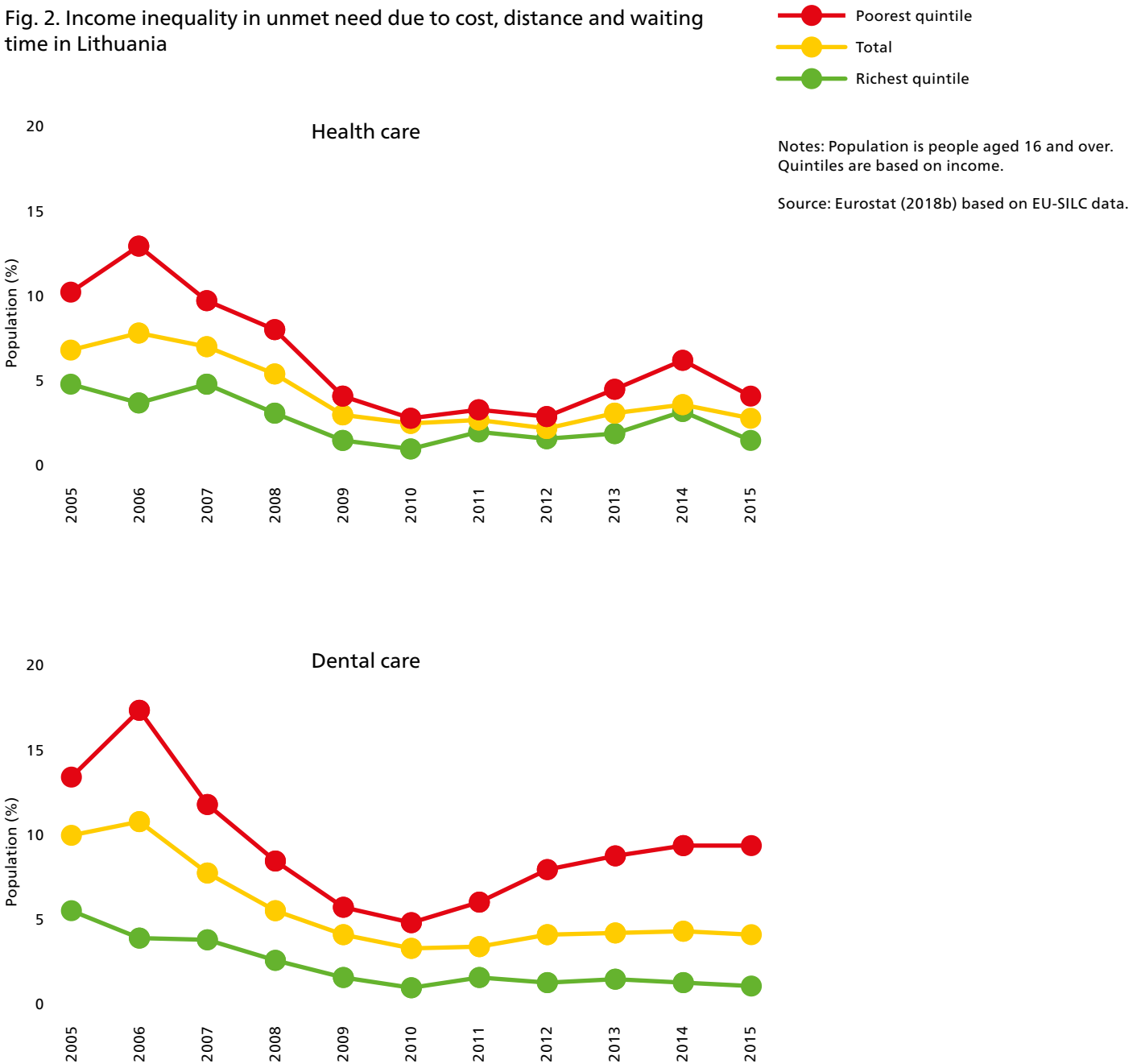
Every year, EU Member States collect data on unmet need for health and dental care through the EU Statistics on Income and Living Conditions (EU-SILC). Although this important source of data lacks explanatory power and is of limited value for comparative purposes due to cross-country variation in reporting behaviour, it is useful for identifying trends over time within a country (Arora et al., 2015; EXPH, 2016; EXPH, 2017).

Fig. 1. Self-reported unmet need for health care and dental care due to cost, distance and waiting time, EU27 and Lithuania



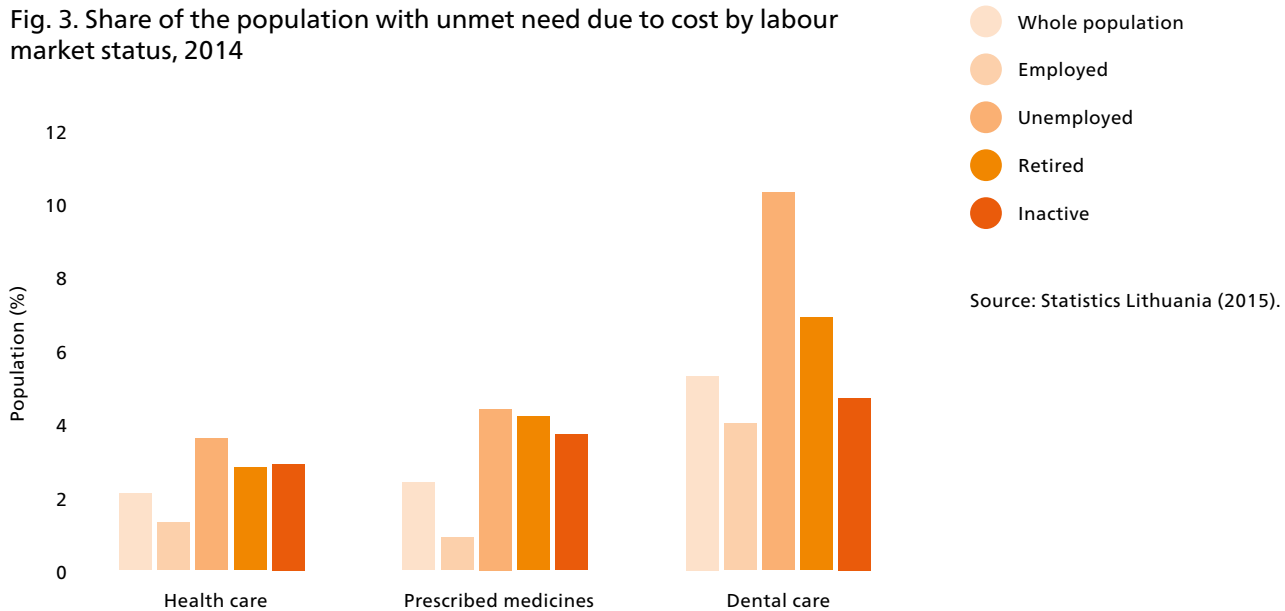
In the past there has been large income inequality in unmet need due to costs for health and dental care, but the gap has narrowed for health care (Fig. 2). Unmet need for health and dental care has fallen substantially in Lithuania since 2006/2007. However, more recent trends suggest an increase in unmet need for dental care, on average, since 2010, and a steep increase for the poorest fifth of the population, exacerbating inequality in access to dental care (Fig. 2). inequality in unmet need for health or dental care due to waiting time is small in comparison.

Fig. 2. Income inequality in unmet need due to cost, distance and waiting time in Lithuania



Data from a large national survey carried out in 2014 indicate that barriers to access are more widespread than the EU-SILC data suggest. For example, while EU-SILC does not distinguish between health care and medicines, national data show that vulnerable groups of people (unemployed, retired and inactive) report higher levels of unmet need for prescribed medicines than for health care in general (Fig. 3). National data also show that income inequality is an issue: unmet need for any type of care is more likely to be experienced by unemployed, retired or inactive people than employed people (Fig. 3).

Fig. 3. Share of the population with unmet need due to cost by labour market status, 2014



Smaller-scale national surveys suggest the problem may be more widespread. For example, one survey finds that one in two people surveyed believe that a significant share of the population experiences barriers to accessing health care (GESIS, 2011). In a 2015 survey, 56% report long waiting times for specialist consultations, 24% report long waiting times for medical examinations, 20% think that paying out-of-pocket for health care (formally or informally) is unavoidable and that people pay out-of-pocket mainly to get more attention for their health problem and to obtain faster treatment and better quality care (Ministry of Health, 2015).

3.3 Summary

Health coverage is relatively complete for children up to the age of 18. Adults also benefit from free access to outpatient visits and inpatient care.

The main gaps in coverage are related to:

- percentage co-payments for outpatient prescribed medicines for adults
- limited coverage of dental care for adults
- the linking of entitlement to health care to payment of contributions to the NHIF

As a result, around 6–10% of the population is uninsured and only has access to emergency health care. This group of uninsured people is dominated by men and people of working age, some of whom may be living abroad but continue to be registered as resident in Lithuania.

VHI does not play a role in covering these gaps; it is purchased by less than 1% of the population – mainly higher-paid employees – and provides people with access to private providers.

EU-SILC data indicate that self-reported unmet need for health and dental care fell between 2006 and 2010 but rose after 2010 (Fig. 3). Inequalities in unmet need for dental care are substantial and have been growing since 2010. Inequalities in unmet need for health care are smaller than for dental care but have also been growing since 2012. For both health and dental care, the increase in inequality reverses the previous positive trend.

National survey data suggest that barriers to access may be more widespread than the EU-SILC data show. They also show that unmet need for prescribed medicines is higher than unmet need for health care among retired, inactive and unemployed people.

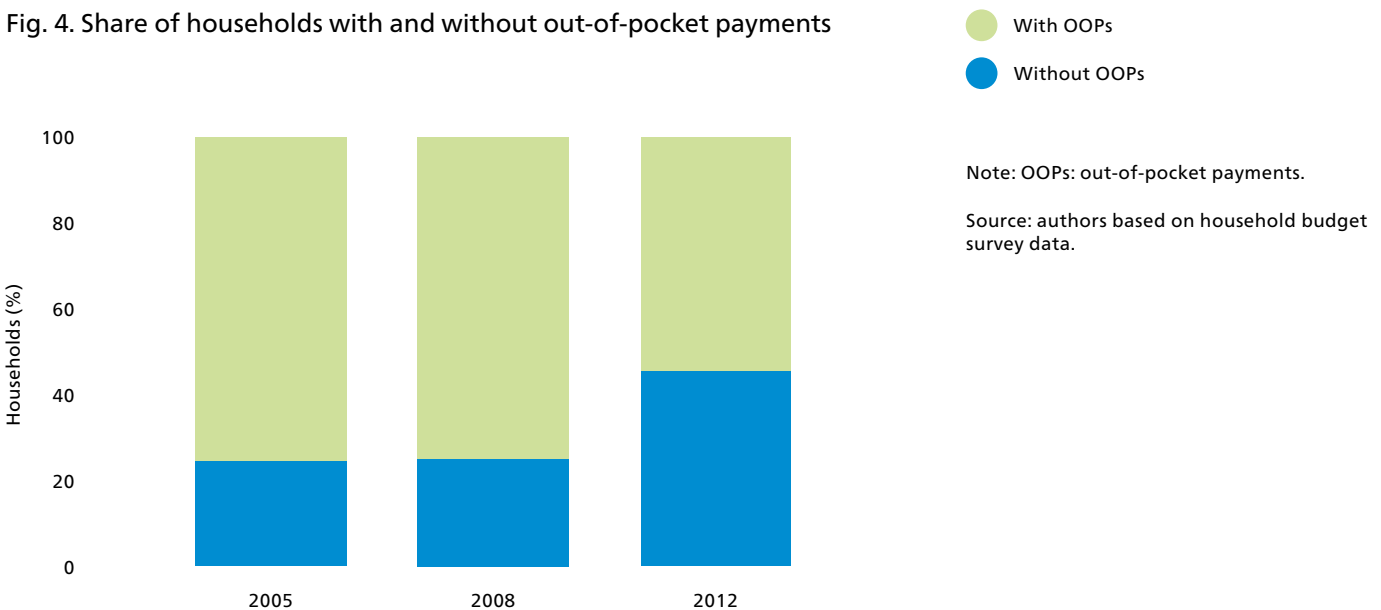
4. Household spending on health

The first part of this section draws on data from the household budget survey to identify trends in household spending on health: out-of-pocket payments. Out-of-pocket payments refer to formal and informal payments made by people at the time of using any good or service delivered in the health system. The section also briefly discusses the role of informal payments and the main drivers of changes in out-of-pocket payments over time.

4.1 Out-of-pocket payments

In 2012, 55% of households paid for health care out of pocket. Over time, the share of households with out-of-pocket payments has fallen substantially. In 2005 and 2008, 75% of households incurred out-of-pocket payments (Fig. 4).

Fig. 4. Share of households with and without out-of-pocket payments

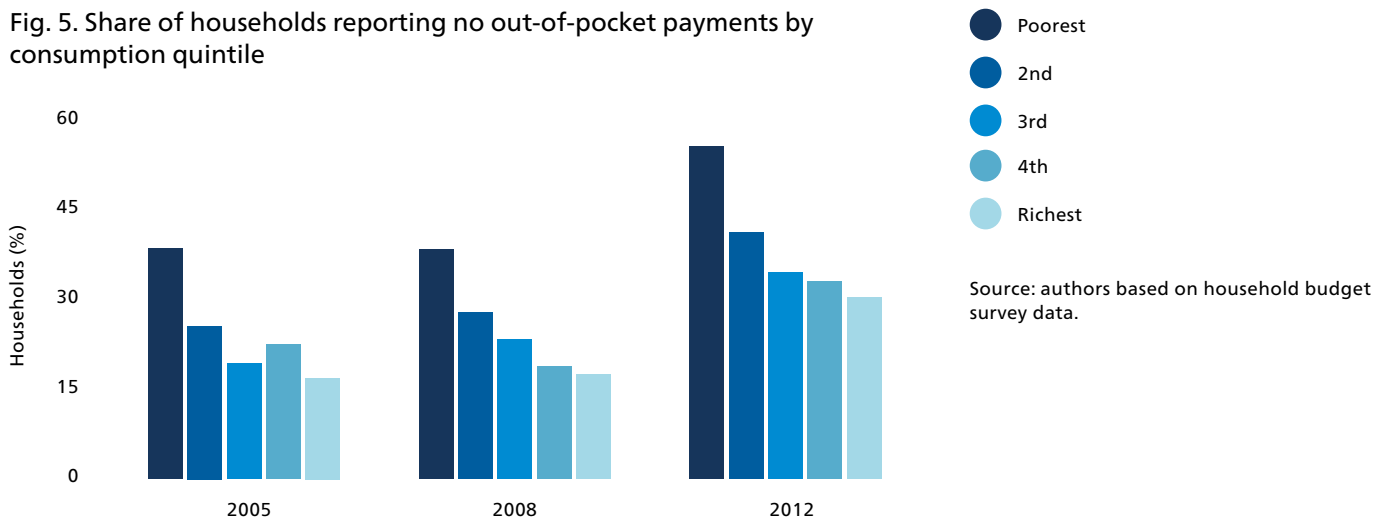


Across all three years, households without out-of-pocket payments are more likely to be poor than rich (Fig. 5). In 2012, 55% of households in the poorest quintile had no out-of-pocket payments, compared to 30% in the richest quintile.

The Lithuania household budget survey does not include questions on health status, health service use or unmet need for health care, so it is not possible to say whether these households are not spending on health care due to lack of need for health care, due to exemptions from user charges or because they face barriers to accessing health services. However, the large increase in the share of households with no out-of-pocket payments over time occurred in spite of the fact that there was no change in exemption from user charges during the study period.

It is possible that as incomes were squeezed by the deep recession of 2009 and rising unemployment (Eurostat, 2017a), households used some health services less – or less intensively – than before. This might be true for dental care, for which unmet need rose between 2010 and 2015, especially for the poorest quintile (Fig. 2).

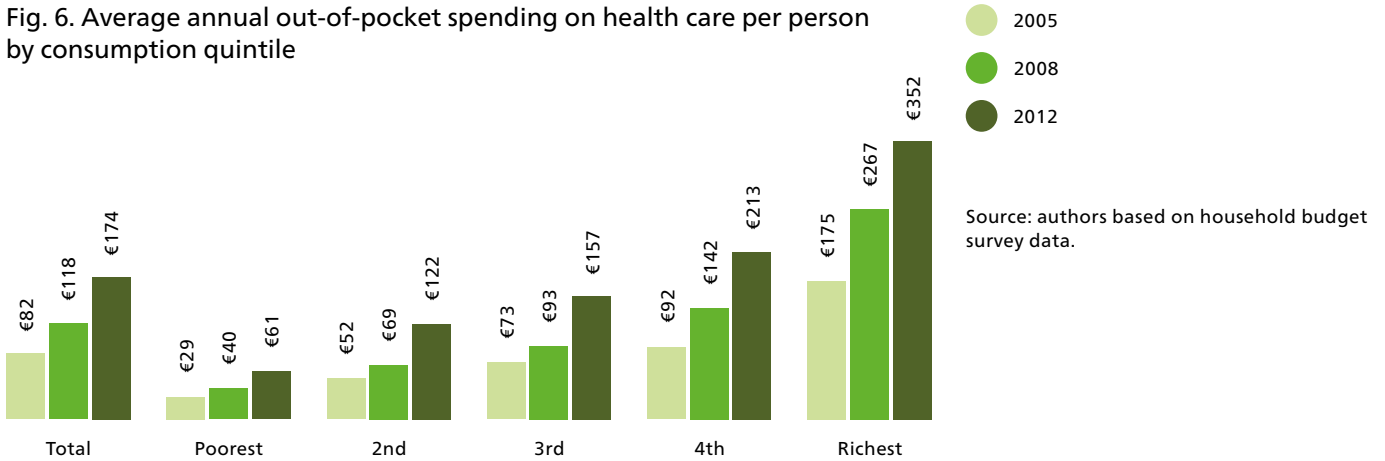
Fig. 5. Share of households reporting no out-of-pocket payments by consumption quintile



Out-of-pocket payments have increased steadily over time, doubling in nominal terms between 2005 and 2012 (Fig. 6). The average amount spent out-of-pocket in a year rose from €82 per person in 2005 to €118 in 2008 to €174 in 2012. Out-of-pocket payments increased in all household quintiles, with the steepest increase in the second and fourth quintiles and the smallest increase in the richest quintile.

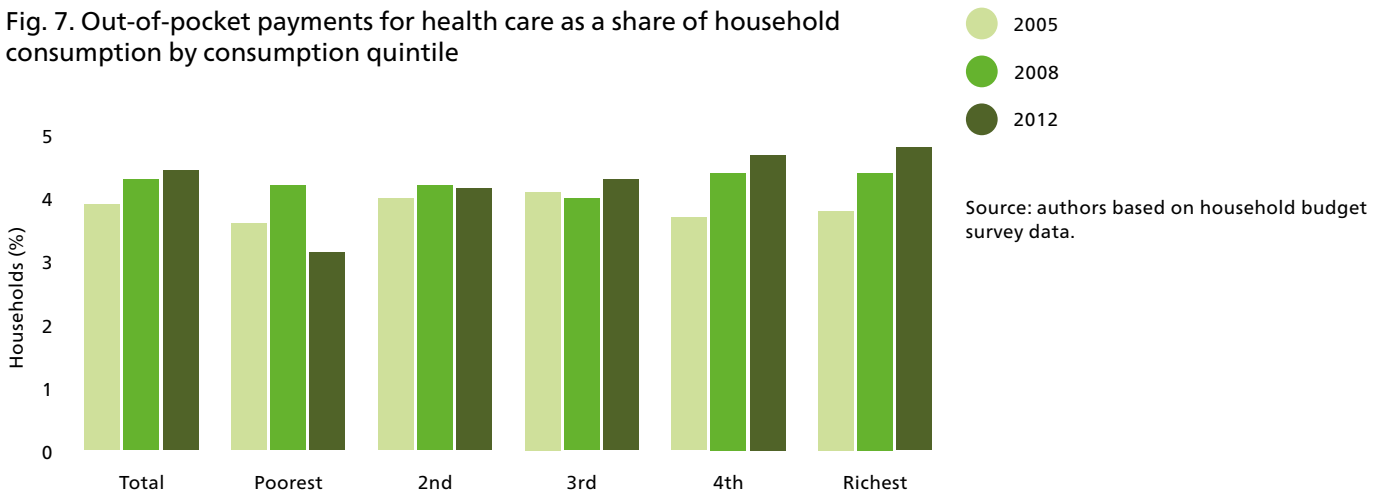
In 2012, the richest quintile spent nearly six times as much out-of-pocket per person as the poorest quintile (€352 vs €61). The ratio between the poorest quintile and the other quintiles – roughly 1:2, 1:2.5, 1:3 and 1:6 – has not changed over time.

Fig. 6. Average annual out-of-pocket spending on health care per person by consumption quintile



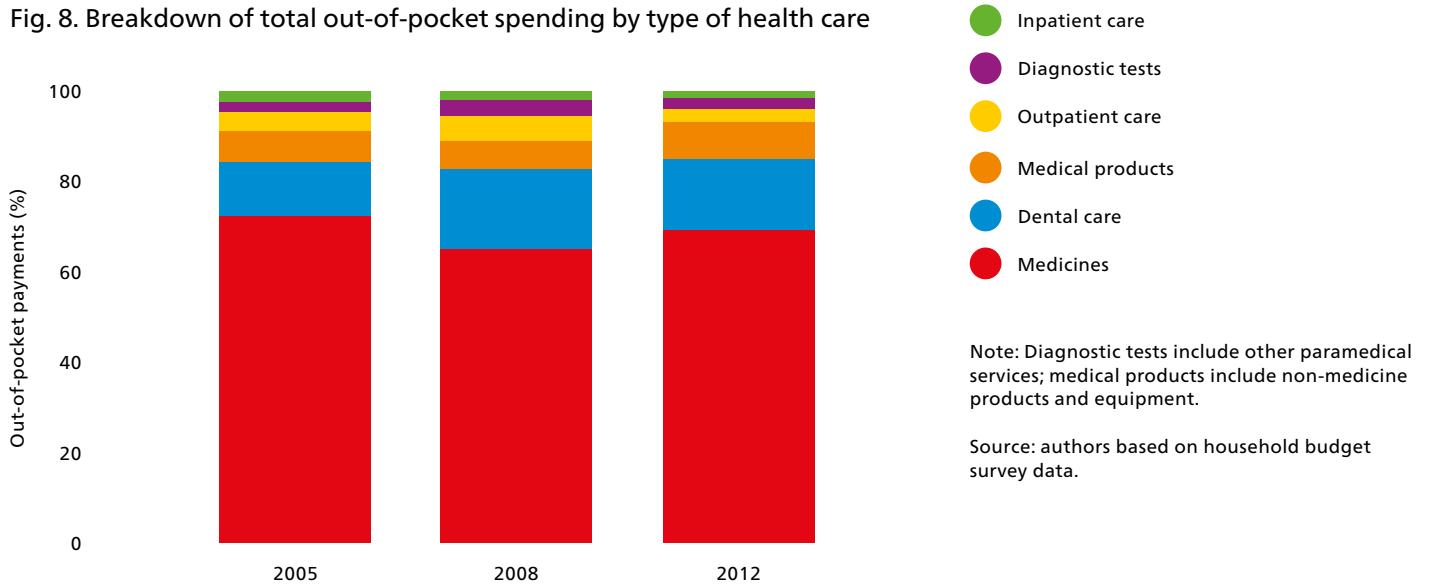
On average, out-of-pocket payments have also increased as a share of household spending (consumption), rising from 3.9% in 2005 to 4.3% in 2008 to 4.4% in 2012, driven largely by increases in the two richest quintiles (Fig. 7). Between 2008 and 2012, however, the out-of-pocket share fell for the poorest quintile. As a result, in 2012 the difference between the out-of-pocket share of the poorest and richest quintiles was close to two percentage points.

Fig. 7. Out-of-pocket payments for health care as a share of household consumption by consumption quintile



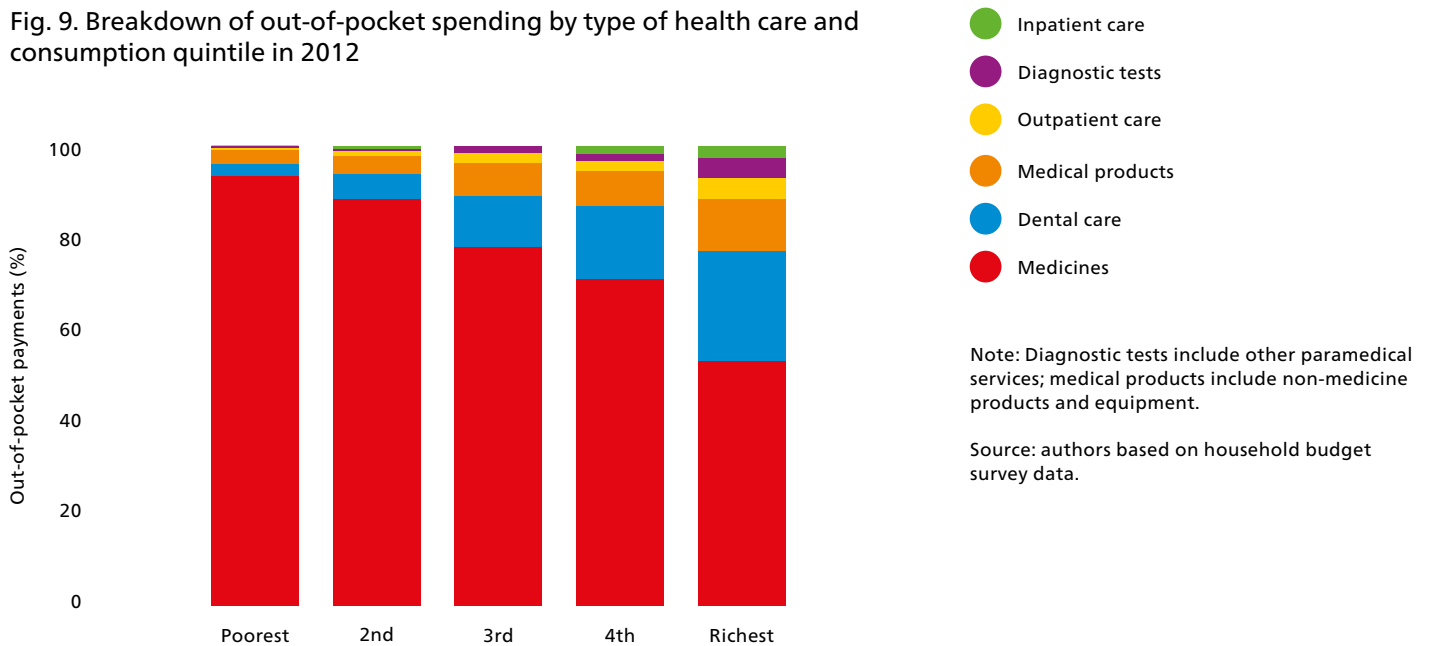
In all three years, medicines account for the largest share of out-of-pocket spending – around 70% on average (Fig. 8). The second-largest share goes to dental care, which rose from 12% to 18% and then fell slightly to 16%. The share spent on inpatient care is only significant among the richest quintile, and even then it is very small.

Fig. 8. Breakdown of total out-of-pocket spending by type of health care



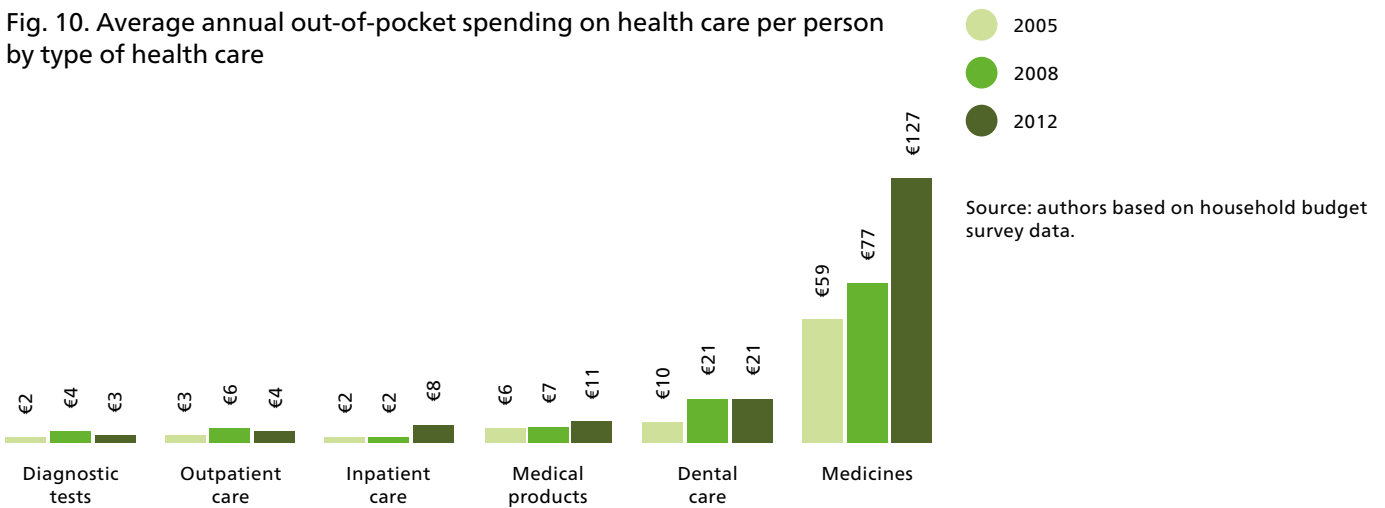
Medicines are the single largest out-of-pocket spending item for all quintiles, rising from around 50% in the richest quintile to about 90% in the poorest quintile (Fig. 9). The second largest expenditure item for the four higher quintiles is dental care. Spending on dental care is progressively higher among the richer quintiles; the poorest quintile barely spends anything on dental care. These shares have remained stable over time.

Fig. 9. Breakdown of out-of-pocket spending by type of health care and consumption quintile in 2012



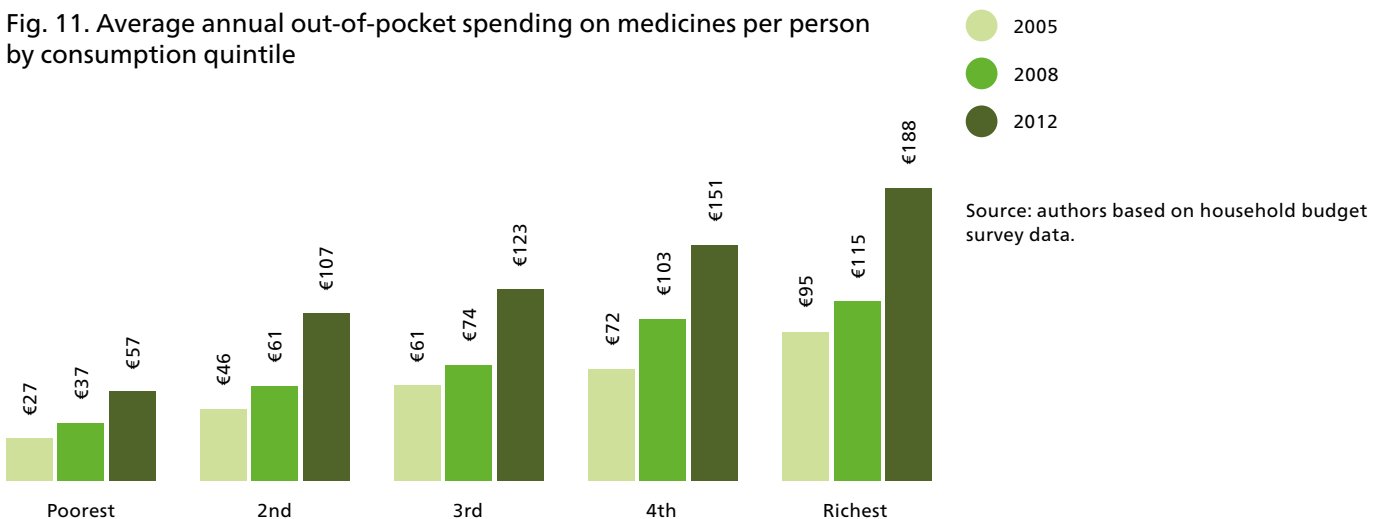
Between 2005 and 2012, out-of-pocket spending per person increased in nominal terms for all types of health care, doubling for medicines, medical products and dental care and increasing four-fold for inpatient care, but from a very low base (Fig. 10). Between 2008 and 2012, however, out-of-pocket spending on outpatient care fell and spending on dental care remained the same. The lack of increase in out-of-pocket payments for dental care lends support to the possibility that households cut back on some areas of health spending in response to the economic crisis.

Fig. 10. Average annual out-of-pocket spending on health care per person by type of health care



Across all quintiles, out-of-pocket spending on medicines per person grew much more rapidly between 2008 and 2012 than between 2005 and 2008 (Fig. 11).

Fig. 11. Average annual out-of-pocket spending on medicines per person by consumption quintile



4.2 Informal payments

Informal payments are more widespread for inpatient care than other types of care. National survey data from 2010 suggest that 17% and 48% of respondents paid informally for outpatient and inpatient services, respectively (Murauskienė et al., 2013).

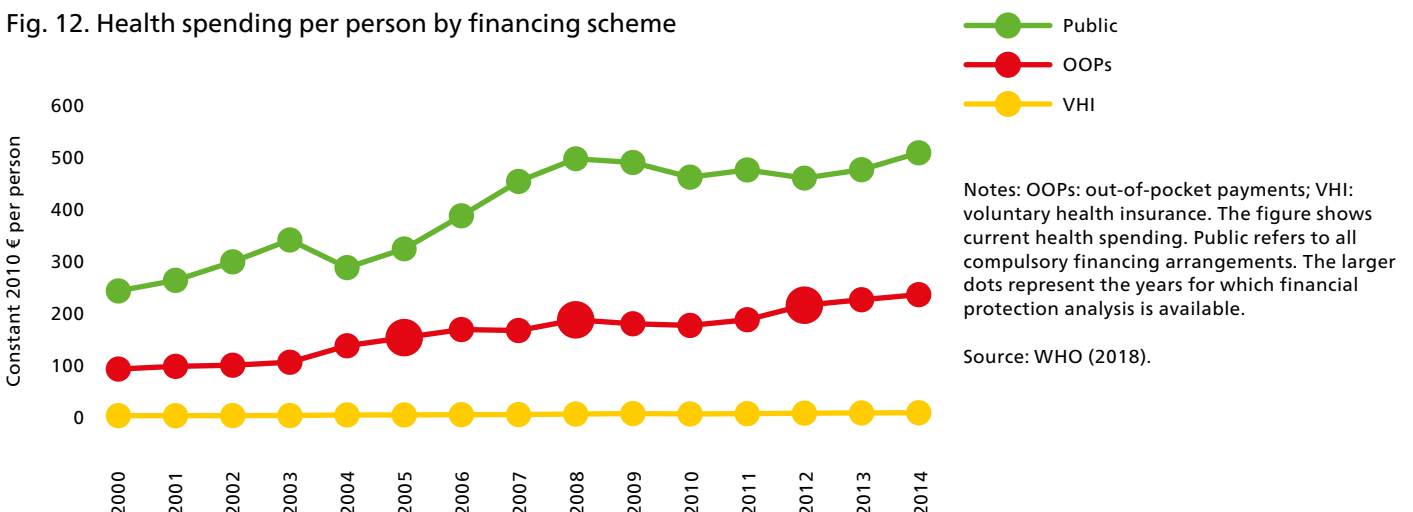
One in five people report paying informally to medical professionals, with a strong social gradient: women, people aged 50–74 years old, people living in rural areas and people with monthly household incomes of less than €450 are more likely to pay staff informally. Informal payments to staff range from €3 to €800, with an average annual amount of €174 per patient (Ministry of Health, 2015).

The main reason people give for informal payment (46% of respondents) is to obtain better quality of care (Ministry of Health, 2015). People also indicate a preference for using privately provided services if they have to pay informally for NHIF-covered treatment (Murauskienė et al., 2012).

4.3 What drives changes in out-of-pocket payments?

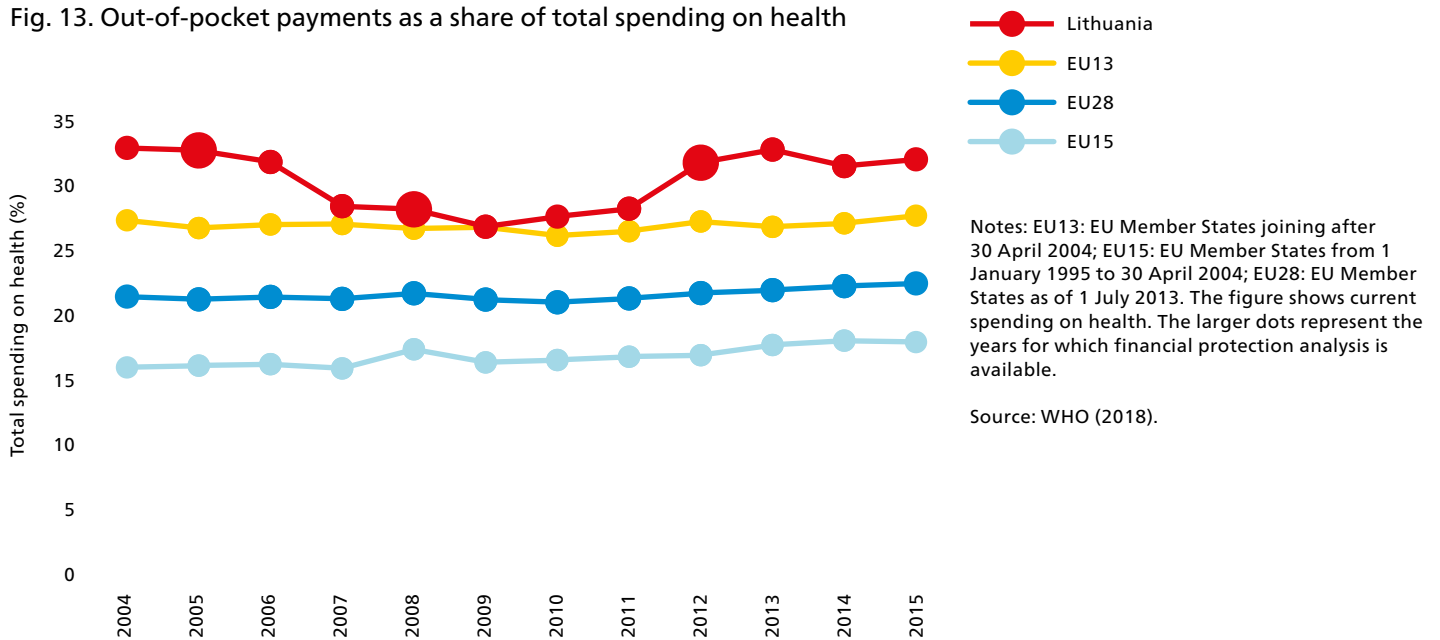
National health accounts data also show out-of-pocket payments per person have grown steadily over time, with very small reductions experienced only at the height of the economic crisis, in 2009 and 2010 (Fig. 12). Public spending on health grew rapidly between 2004 and 2009, rising from €264 per person in 2004 to €462 in 2009 in real terms. During this period the out-of-pocket share of total (current) spending on health fell by around six percentage points, driven almost entirely by growth in public spending on health (Fig. 13).

Fig. 12. Health spending per person by financing scheme



Between 2009 and 2012, public spending on health per person fell in response to the deep recession of 2009 (Fig. 12). Out-of-pocket payments per person fell slightly in 2009, remained stable in 2010 and have risen steadily since 2011. The out-of-pocket share of total spending on health rose sharply in 2012 and is now among the highest in the European Union (Fig. 13). In 2015, only Bulgaria, Cyprus, Greece, Latvia and Malta had a higher out-of-pocket share than Lithuania (WHO, 2018).

Fig. 13. Out-of-pocket payments as a share of total spending on health



4.4 Summary

Household budget survey data indicate that just over half of all households in Lithuania (55%) pay for health care out of pocket. Households without any out-of-pocket payments are more likely to be poor than rich, perhaps reflecting exemption from co-payments for dental care and medicines for some very vulnerable households. It may also reflect greater unmet need for health and dental care among poorer households.

Between 2008 and 2012, the share of households without any out-of-pocket payments rose from 25% to 45%. This large increase occurred in spite of the fact that there was no change in exemption from user charges during this period. It may reflect unmet need for dental care, which rose between 2011 and 2014, especially for the poorest quintile.

Household budget survey data show that out-of-pocket payments have increased steadily over time. They are mainly driven by spending on medicines. Dental care is the second-largest item of household spending on health, but it is heavily concentrated among richer households. The average amount spent out of pocket on dental care did not change between 2008 and 2012, while the average amount spent out of pocket on medicines grew considerably.

Data from other surveys suggest that informal payments are a problem, but more so for inpatient care than for outpatient care.

National health accounts data show that the out-of-pocket share of total spending on health fell between 2004 and 2009, driven by a rapid increase in public spending on health. However, this was reversed after 2009, when public spending on health fell as out-of-pocket payments continued to grow. By 2015, the out-of-pocket share was once again one of the highest in the European Union, well above the average for EU13 countries.

5. Financial protection

This section uses data from the Lithuanian household budget survey to assess the extent to which out-of-pocket payments result in financial hardship for households who use health services. It shows the relationship between out-of-pocket spending on health and risk of impoverishment, and then estimates the incidence, distribution and drivers of catastrophic out-of-pocket payments.

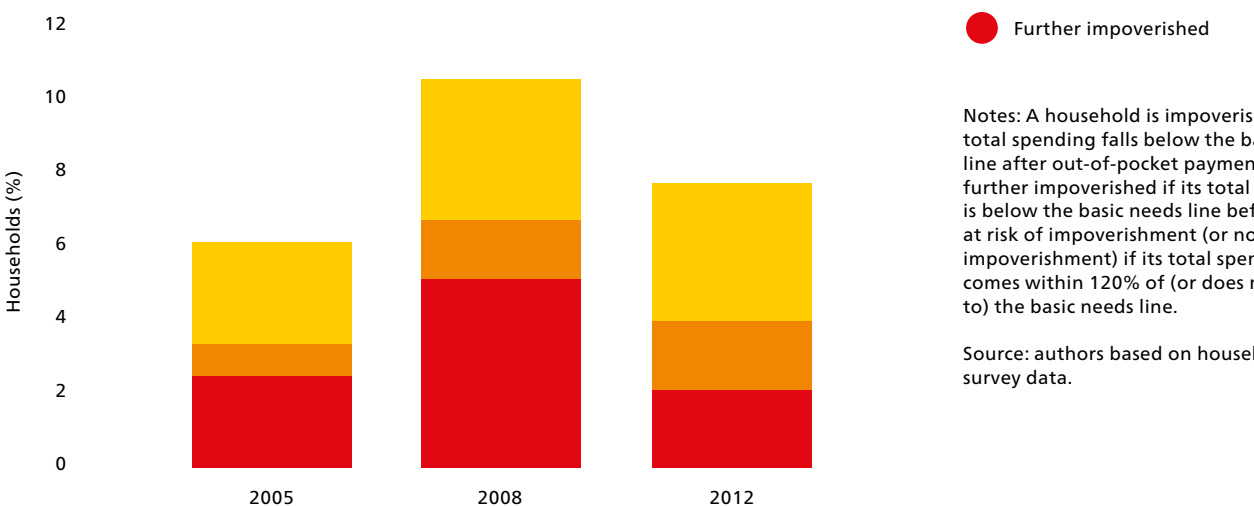
5.1 How many households experience financial hardship?

5.1.1 Out-of-pocket payments and risk of impoverishment

Fig. 14 shows the share of households at risk of impoverishment after out-of-pocket spending on health care. The poverty line reflects the cost of spending on basic needs (food, rent and utilities) among a relatively poor part of the Lithuanian population (households between the 25th and 35th percentile of the consumption distribution, adjusted for household size and composition). In 2012 the monthly cost of meeting these basic needs – the basic needs line – was €242.

The share of households further impoverished, impoverished or at risk of impoverishment after out-of-pocket payments rose steeply from around 6% in 2005 to over 10% in 2008 and then fell to just under 8% in 2012. However, this trend is almost entirely driven by a fall in the share of households further impoverished after out-of-pocket payments, from 5% in 2008 to 2% in 2012. The share of households impoverished after out-of-pocket payments has actually increased steadily over time, rising from 0.9% in 2005 to 1.6% in 2008 to 1.9% in 2012.

Fig. 14. Share of households at risk of impoverishment after out-of-pocket payments



Notes: A household is impoverished if its total spending falls below the basic needs line after out-of-pocket payments (OOPs); further impoverished if its total spending is below the basic needs line before OOPs; at risk of impoverishment (or not at risk of impoverishment) if its total spending after OOPs comes within 120% of (or does not come close to) the basic needs line.

Source: authors based on household budget survey data.

Between 2008 and 2012 the share of households that are further impoverished fell sharply. This sharp fall may reflect the large increase in the share of households not spending anything on health (that is, with no out-of-pocket payments), which rose from 25% in 2008 to 45% in 2012 (Fig. 4) and was marked across all quintiles (Fig. 5).

5.1.2 Catastrophic out-of-pocket payments

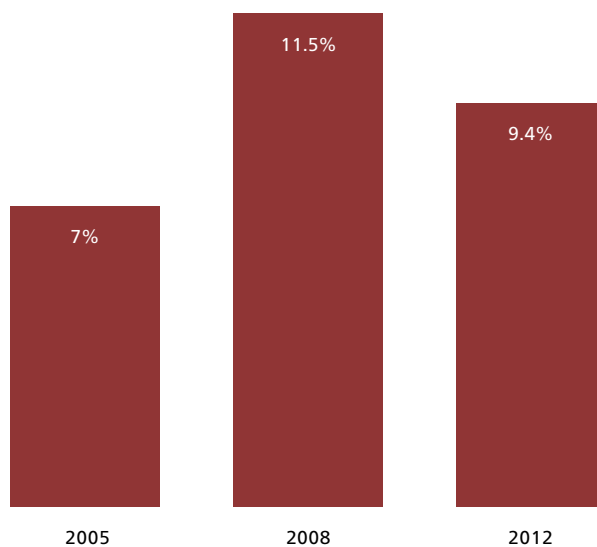
Households with catastrophic levels of out-of-pocket payments are defined (in this review) as those who spend more than 40% of their capacity to pay. This includes households who are impoverished after out-of-pocket payments (because they no longer have any capacity to pay) and further impoverished (because they have no capacity to pay).

In 2012, it is estimated that nearly 10% of households – around 250 000 people – experienced catastrophic levels of spending on health care (Fig. 15). Overall, the incidence of catastrophic out-of-pocket payments rose sharply between 2005 and 2008 and fell between 2008 and 2012. It was higher in 2012 than in 2005.

The overall level masks important differences in distribution, both at a given point in time and over time.

Fig. 15. Share of households with catastrophic out-of-pocket payments

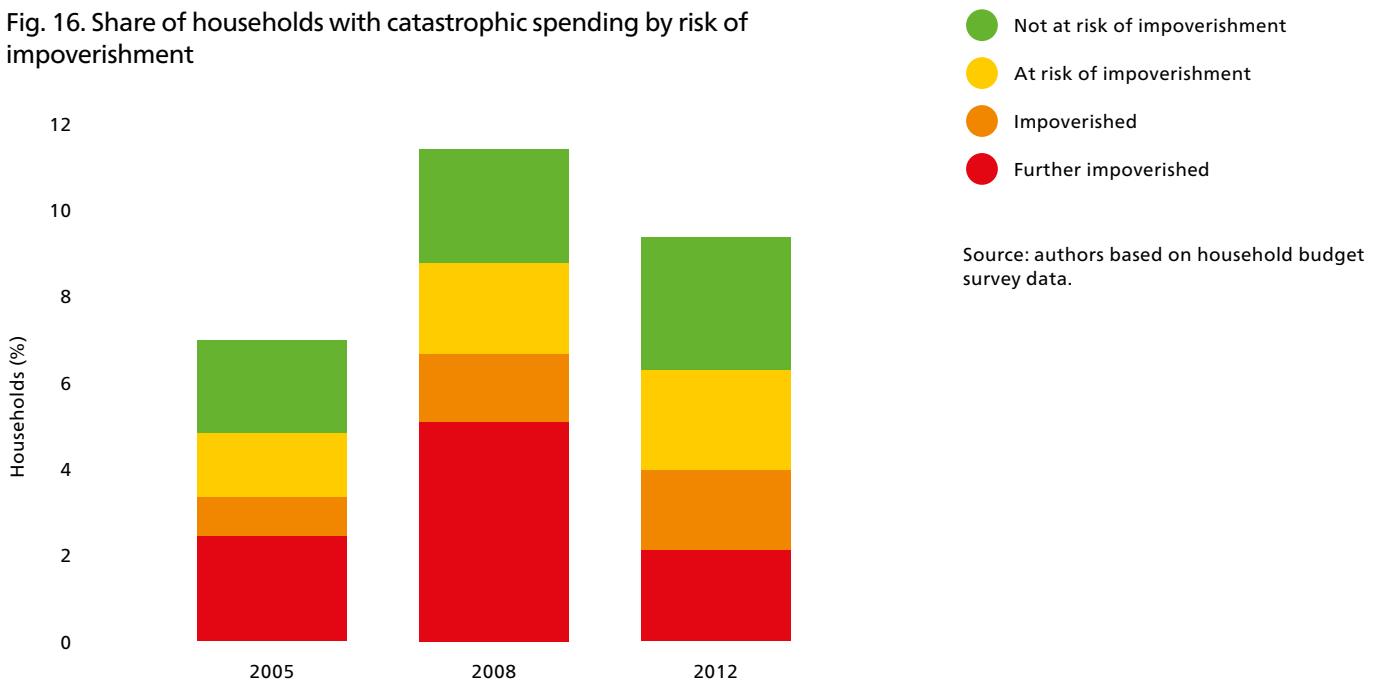
Source: authors based on household budget survey data.



5.2 Who experiences financial hardship?

Catastrophic out-of-pocket payments are heavily concentrated among households who are already poor or at risk of impoverishment after out-of-pocket payments in all years, but slightly less so in 2012 than in earlier years (Fig. 16).

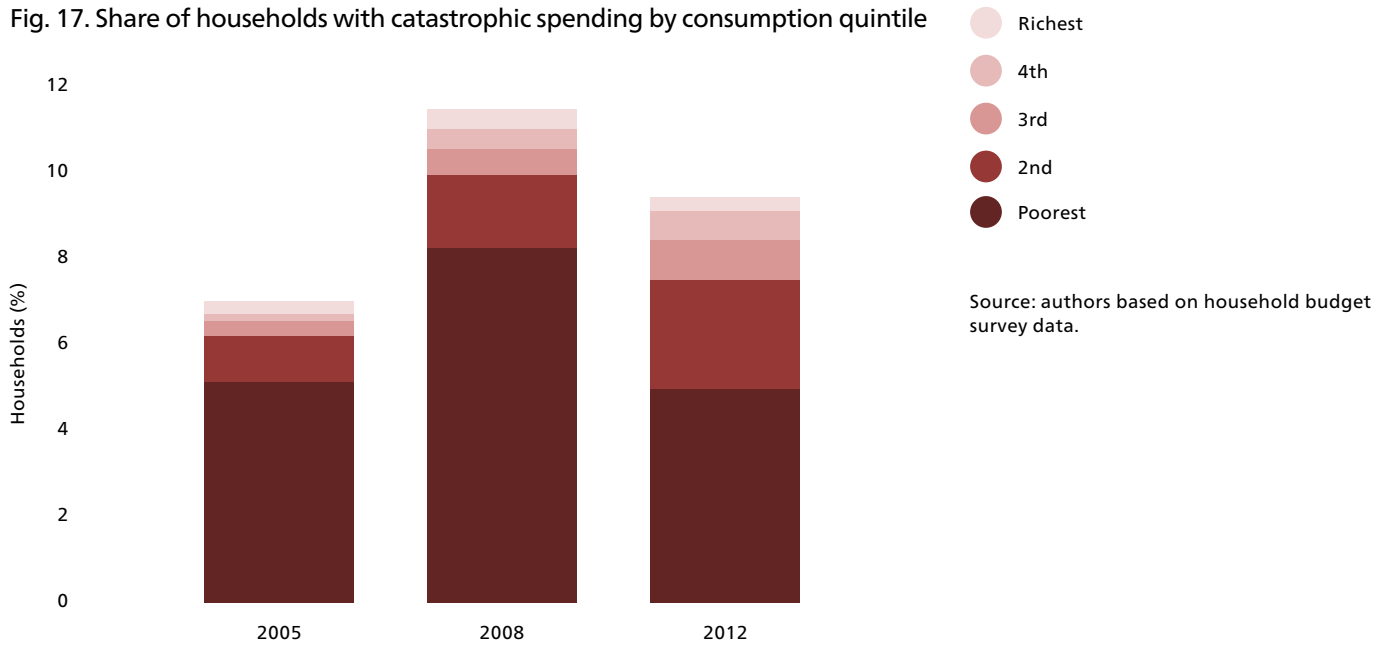
Fig. 16. Share of households with catastrophic spending by risk of impoverishment



The incidence of catastrophic out-of-pocket payments varies significantly across quintiles and is highly concentrated among the poorest quintile (Fig. 17). In 2012, one in four households in the poorest quintile incurred catastrophic out-of-pocket payments, equal to 5% of households overall.

Between 2005 and 2012, the incidence of catastrophic spending increased steadily for the three middle quintiles, but grew and fell for the richest and poorest quintiles. Fig. 17 shows that the decline in the overall incidence of catastrophic out-of-pocket payments between 2008 and 2012 was driven entirely by a decline in incidence for the poorest quintile.

Fig. 17. Share of households with catastrophic spending by consumption quintile

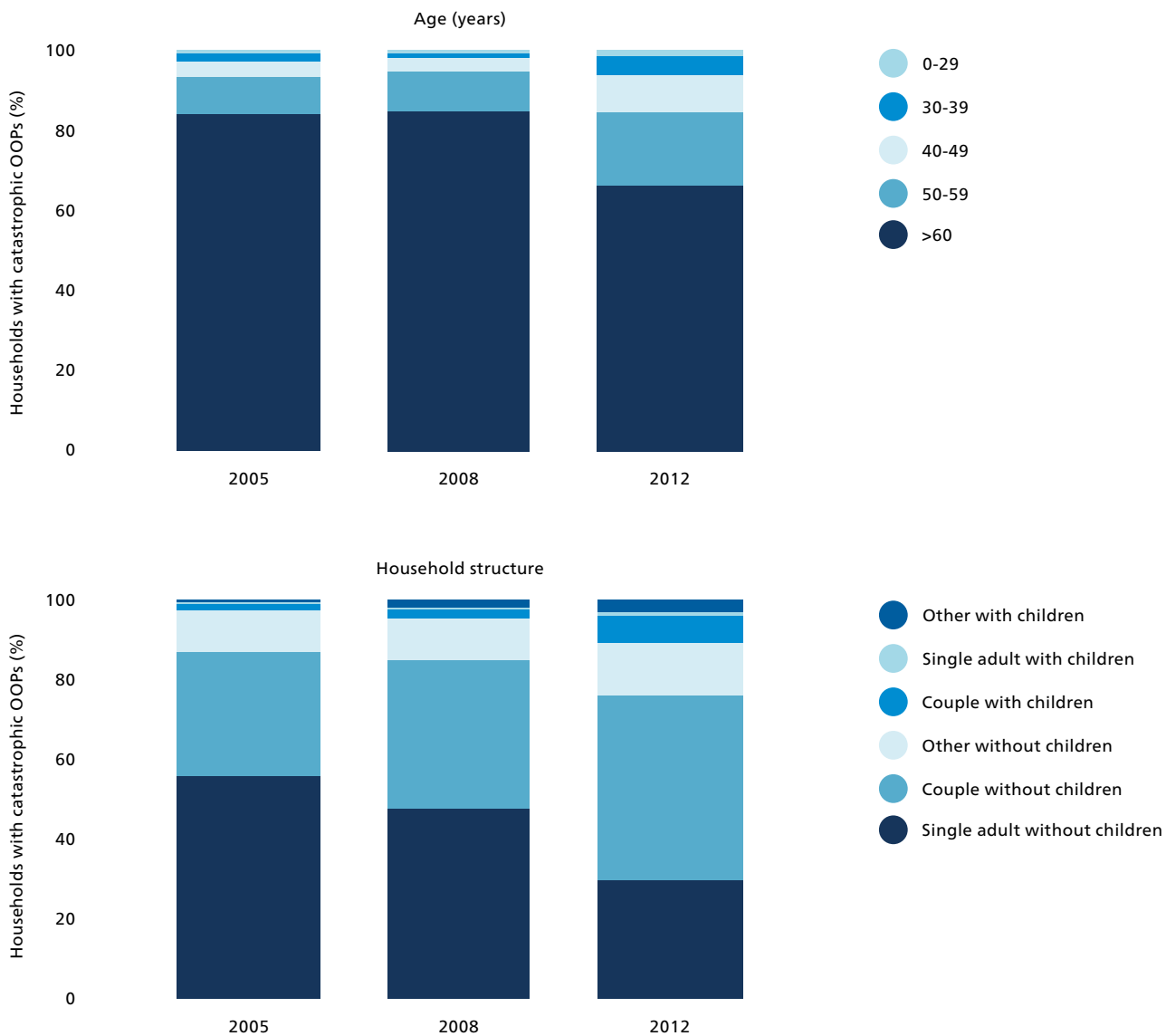


Catastrophic out-of-pocket payments are heavily concentrated among people aged 60 and over and among households without children – categories that may largely overlap (Fig. 18). In 2005 and 2008, around 85% of catastrophic spenders were over the age of 60. In 2012, this share had fallen to 66%. Couples without children account for a growing share of households with catastrophic out-of-pocket payments, rising from 31% in 2005 to 46% in 2012.

Fig. 18. Breakdown of households with catastrophic spending by age and household structure

Note: OOPs: out-of-pocket payments.

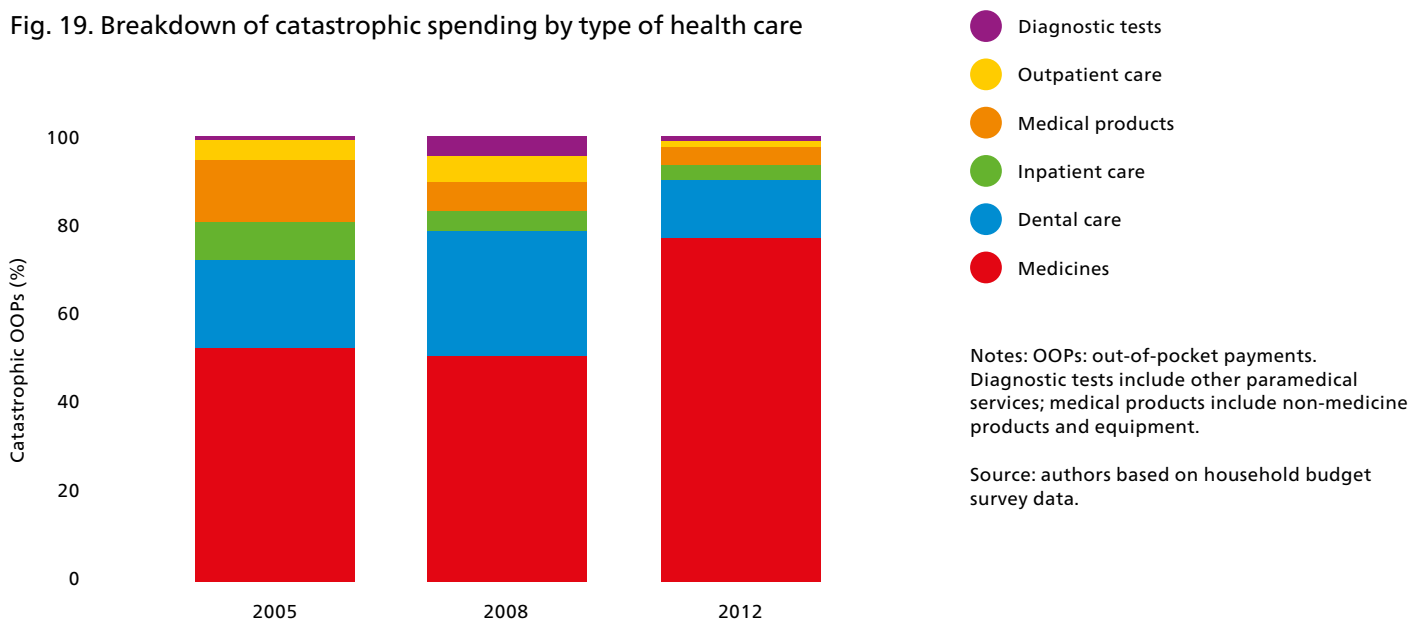
Source: authors based on household budget survey data.



5.3 Which health services are responsible for financial hardship?

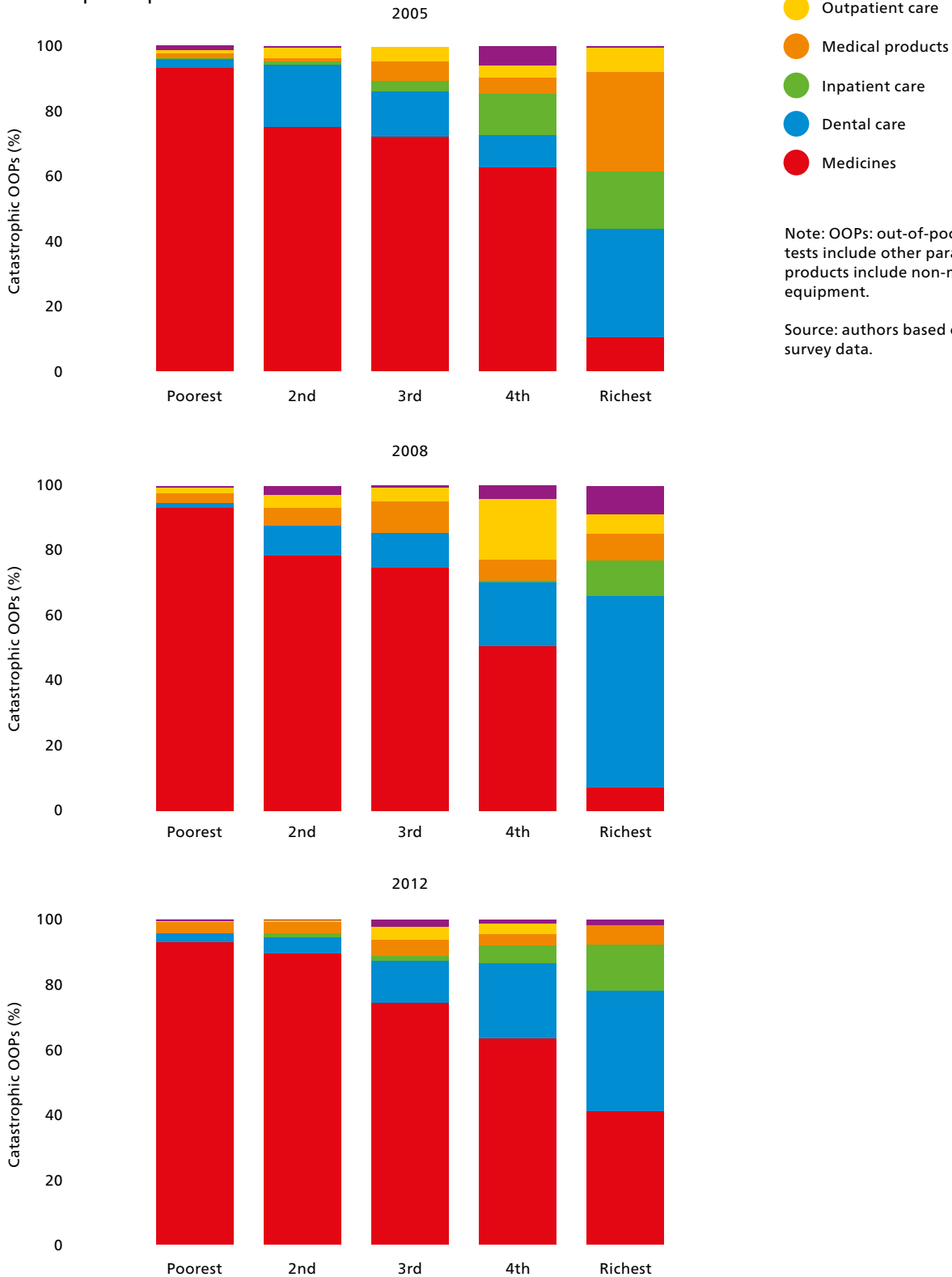
Medicines are the largest single driver of catastrophic spending, followed by dental care (Fig. 19). The medicines share of catastrophic spending rose dramatically from around 50% in 2005 and 2008 to 77% in 2012. The dental care share rose from 20% to 28% between 2005 and 2008, then fell to 13% in 2012, as the medicines share grew.

Fig. 19. Breakdown of catastrophic spending by type of health care



In 2005 and 2008 medicines are the largest single driver of catastrophic out-of-pocket payments for all except the richest quintile (Fig. 20). Their share becomes progressively lower among richer households. In all three years, medicines account for over 90% of catastrophic out-of-pocket payments among the poorest quintiles. Between 2005 and 2012, medicines grew as a share of catastrophic out-of-pocket payments among the second, third and fifth quintiles. For the richest quintile the medicines share quadrupled, rising from 10% in 2005 to 41% in 2012. Dental care plays a progressively greater role among richer households. Inpatient care only plays a role among the two richest quintiles.

Fig. 20. Breakdown of catastrophic spending by type of health care and consumption quintile



Note: OOPs: out-of-pocket payments. Diagnostic tests include other paramedical services; medical products include non-medicine products and equipment.

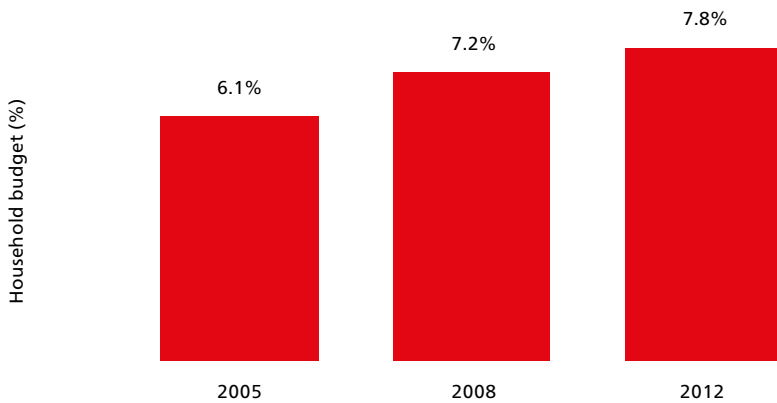
Source: authors based on household budget survey data.

5.4 How much financial hardship?

The average out-of-pocket share among the very poorest households already living below the basic needs line – those that are further impoverished after out-of-pocket payments – was close to 8% in 2012 and has risen steadily over time (Fig. 21).

Fig. 21. Average out-of-pocket payments as a share of total household spending among further impoverished households

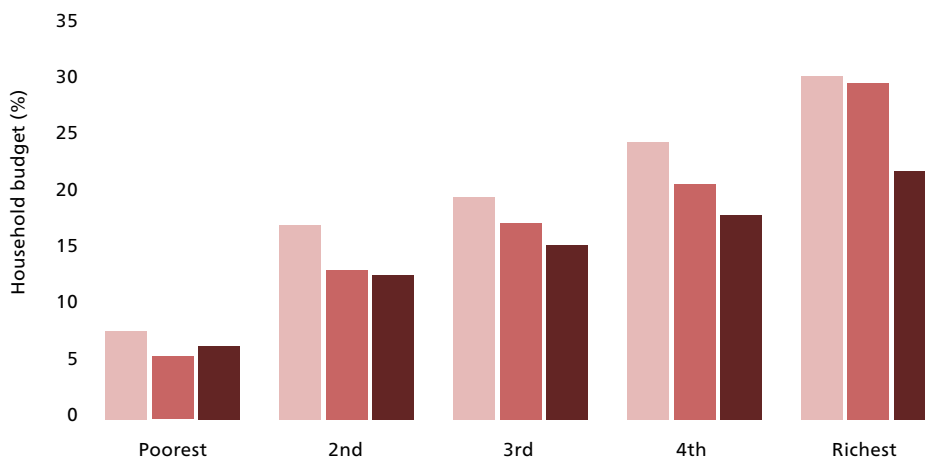
Source: authors based on household budget survey data.



Among households with catastrophic spending, on average the richest quintile spent 38% of their total budget on health in 2012, while the poorest quintile spent 11% (Fig. 22). Over time the out-of-pocket share declined for the three richest quintiles.

Fig. 22. Out-of-pocket payments as a share of total household spending among households with catastrophic spending by consumption quintile

● 2005
● 2008
● 2012



Source: authors based on household budget survey data.

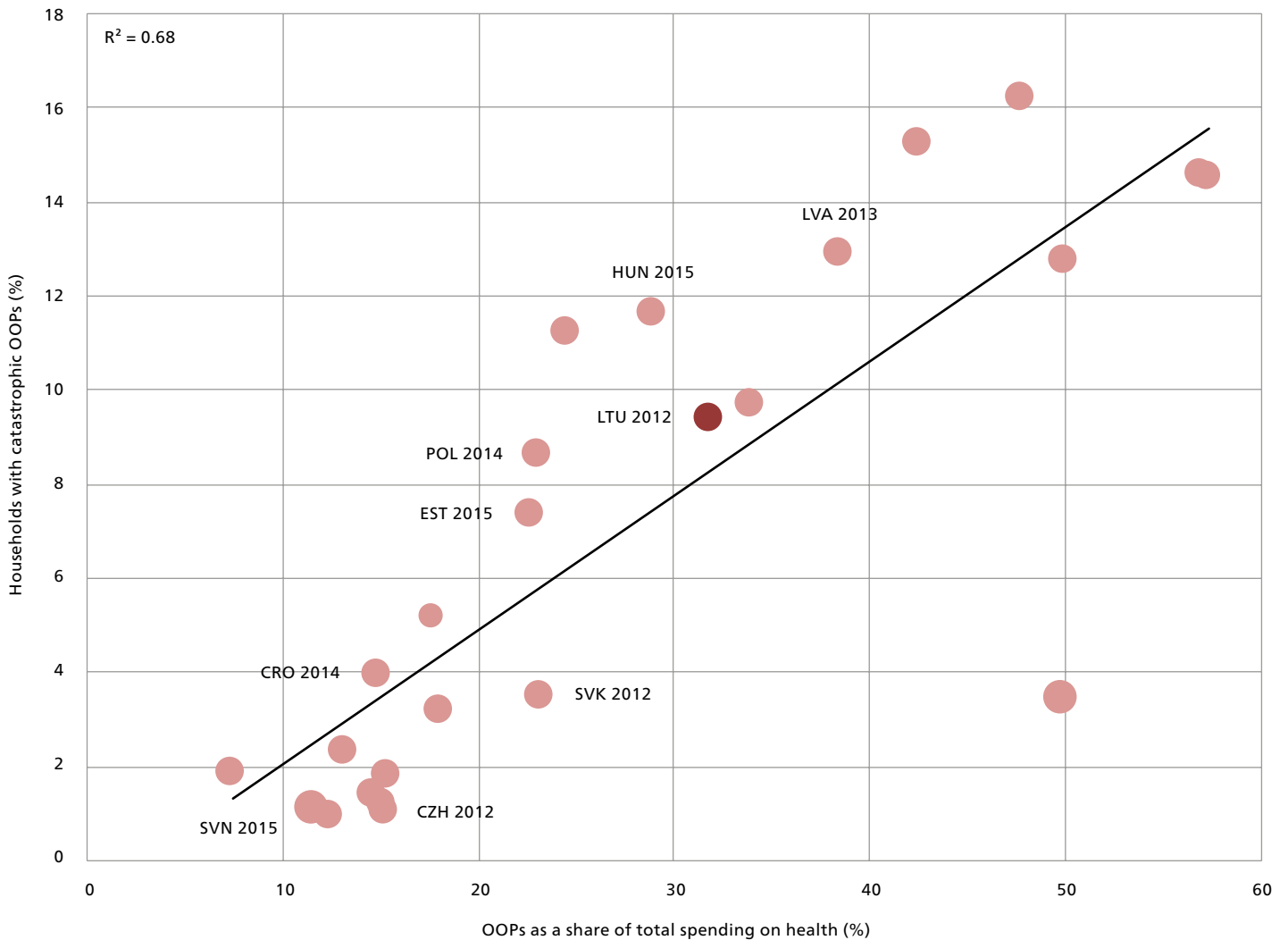
5.5 International comparison

The incidence of catastrophic out-of-pocket payments is high in Lithuania in comparison to many other EU countries, including other EU13 countries (Fig. 23). In terms of comparator countries, it is lower than in Latvia and higher than in Estonia.

Fig. 23. Incidence of catastrophic spending on health and the out-of-pocket share of total spending on health in selected European countries, latest year available

Notes: CZH: Czechia; EST: Estonia; CRO: Croatia; HUN: Hungary; LTU: Lithuania; LVA: Latvia; OOP: out-of-pocket payments; SVK: Slovakia; SVN: Slovenia; POL: Poland. Lithuania is highlighted in dark red. The OOP data are for the same year as the catastrophic spending data. R²: coefficient of determination.

Sources: WHO Barcelona Office for Health Systems Strengthening and WHO (2018).



5.6 Summary

Financial protection is weak in Lithuania compared to other EU countries, including EU13 countries. It is largely driven by out-of-pocket spending on outpatient medicines and dental care.

Nearly 10% of households experienced catastrophic out-of-pocket payments in 2012. Catastrophic spending affects the poorest households the most. It is also heavily concentrated among older households. Over time, however, it has become an increasing problem for younger households. Among households with catastrophic spending, the share of households headed by a person aged between 30 and 60 years rose from 14% in 2008 to 32% in 2012.

In 2012, one in 25 households was impoverished or further impoverished as a result of having to pay out-of-pocket for health.

Outpatient medicines are the largest single cause of catastrophic spending for the population as a whole. They account for almost all catastrophic spending among poorer households. The outpatient medicines share of overall catastrophic spending has grown substantially over time, rising from 50% in 2008 to 77% in 2012.

Dental care is the second largest driver of catastrophic out-of-pocket payments, but mainly affects richer quintiles due to the access barriers and unmet need experienced by poorer households. The dental care share of catastrophic spending halved between 2008 and 2012, perhaps in response to the financial pressure households faced during and after the economic crisis.

Inpatient care accounts for around 15% of catastrophic spending among the richest quintile, but a much lower share for the other quintiles.

The incidence of catastrophic out-of-pocket payments was higher in 2012 than in 2005. It has grown steadily over time for households in the three middle quintiles. A small reduction in the overall incidence of catastrophic spending on health between 2008 and 2012 was driven entirely by a fall in incidence among the poorest quintile.

6. Factors that strengthen and undermine financial protection

This section considers the factors that may be responsible for financial hardship caused by out-of-pocket payments in Lithuania and that may explain the trend over time. It begins by looking at factors outside the health system that affect people's capacity to pay for health care – for example, changes in living standards and the cost of living – and then looks at factors within the health system.

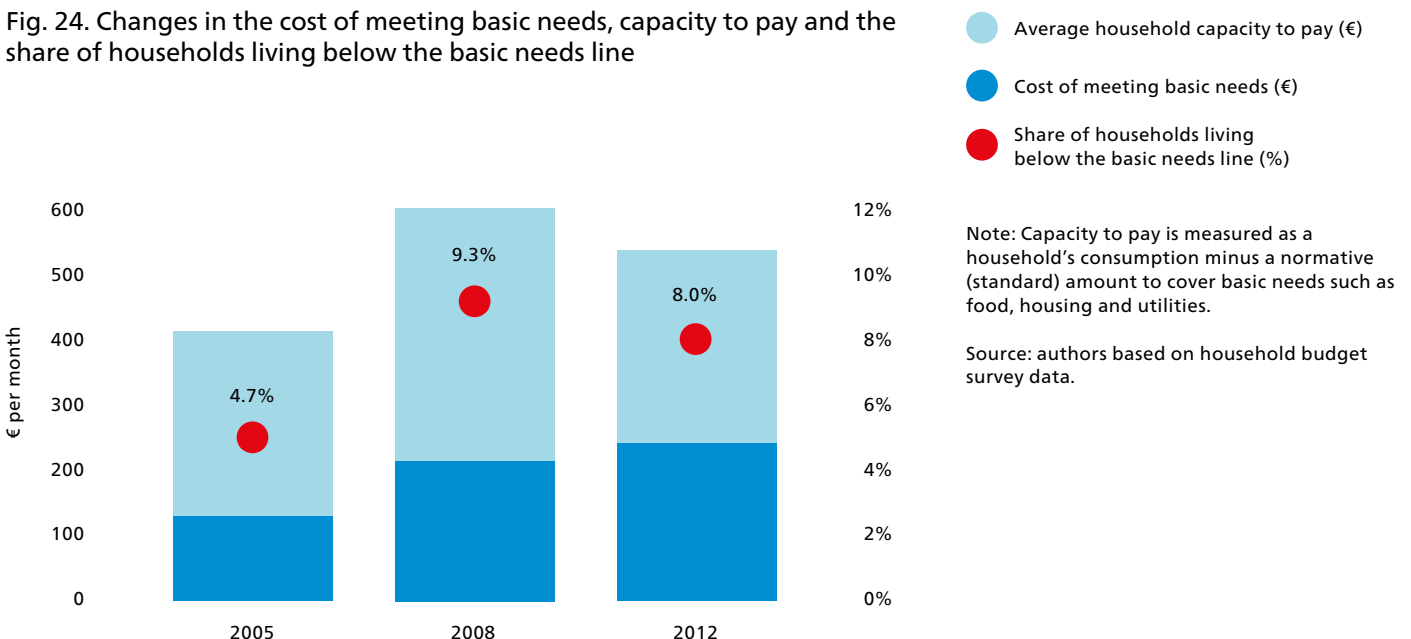
6.1 Factors affecting people's capacity to pay for health care

The following paragraphs draw on data from the household budget survey and other sources to review changes in people's capacity to pay for health care. Poverty among people more likely to need health care is a particular challenge for financial protection.

Lithuania experienced rapid economic growth between 2005 and 2008, followed by a close to 20% drop in GDP in 2009 and a large increase in unemployment (Eurostat, 2018a). In response to the economic crisis, the government introduced serious cuts in social spending (Kacevičius & Karanikolos, 2015).

Between 2005 and 2008, the average cost of meeting basic needs (food, housing and utilities) - the basic needs line - rose by 65% (Fig. 24). Household capacity to pay for health care also rose, but only by 36%. Between 2008 and 2012, living costs remained stable, while household capacity to pay fell in response to the deep recession of 2009 and rising unemployment.

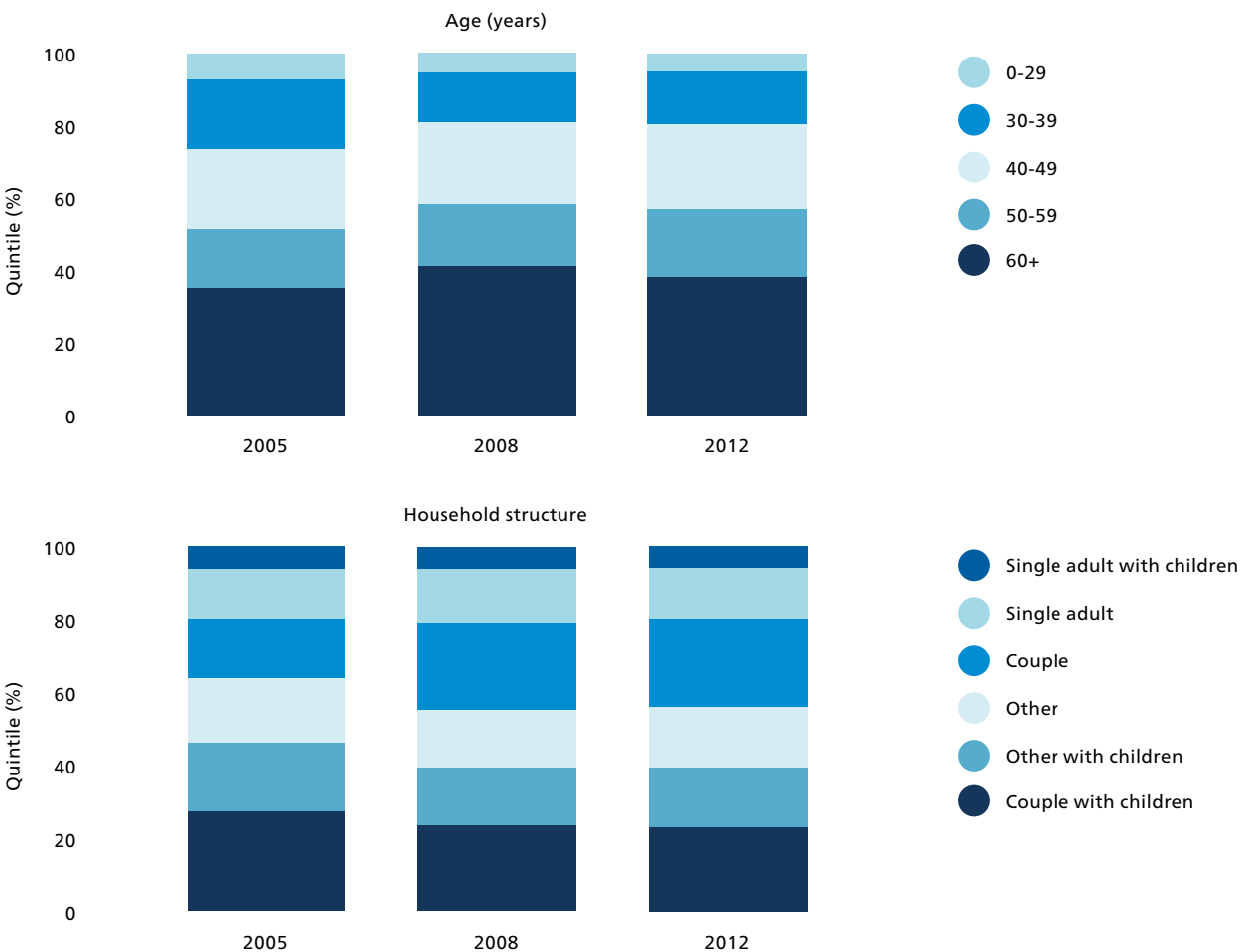
Fig. 24. Changes in the cost of meeting basic needs, capacity to pay and the share of households living below the basic needs line



The composition of households in the poorest fifth of the population also changed over time. Between 2005 and 2008, the share of people aged 60 and over and the share of pensioners in the poorest population quintile grew (Fig. 25). Pensions nearly doubled during this time, but failed to keep pace with growth in other sources of income (Fig. 26), and older people experienced an increasing risk of poverty compared to the rest of the population. This situation was reversed between 2008 and 2012, when pensions and wages stagnated, but unemployment rose steeply.

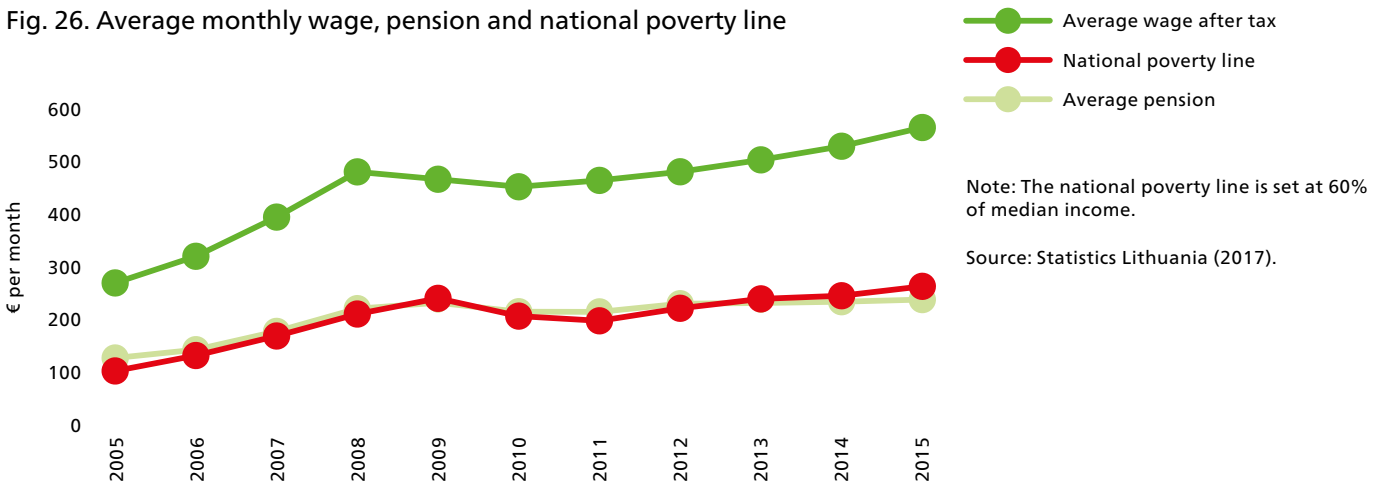
Recent survey data indicate that the share of people at risk of poverty and social exclusion is highest for unemployed people (73%) and then for single parents, single people and economically inactive people (50%) (Zabarauskaite & Gruzevskis, 2015). Fig. 26 shows how, on average, pensions are consistently around the level of the national poverty line. In general, social protection benefits per person are very low in Lithuania in comparison to the EU average; support for single people is especially inadequate when compared to support for families with children (Lazutka, 2014).

Fig. 25. The poorest consumption quintile by age and economic activity



Source: authors based on household budget survey data.

Fig. 26. Average monthly wage, pension and national poverty line



Changes in financial protection over time appear to be partly driven by an increase in the share of older people in the poorest population quintile in 2008 and then a decrease in 2012. Before looking at health system factors, it is worth drawing attention to three things.

- Old-age pensioners appear to be highly vulnerable to financial hardship caused by out-of-pocket payments due to their relatively high risk of poverty – a situation that is compounded by their relatively high need for health care. Although the share of older households with catastrophic out-of-pocket payments fell between 2008 and 2012 (Fig. 18), this seems to be due to other groups becoming poorer rather than as a result of an improvement in the economic situation of pensioners – on average, pensions did not really grow between 2008 and 2012.
- Unemployed people and others affected by the economic downturn are also likely to be vulnerable to health-related financial hardship. Rising unemployment and falling incomes among people of working age may account for the doubling in the share of people aged 30–59 among households with catastrophic spending between 2008 and 2012, from 14% to 32% (Fig. 18).
- Households with children do well in terms of social protection and are also much less likely to experience catastrophic out-of-pocket payments than households without children (11% vs 89% in 2012). However, their share among households with catastrophic spending has grown over time, rising from 2.7% in 2005 to 4.6% in 2008 to 11% in 2012 (Fig. 18).

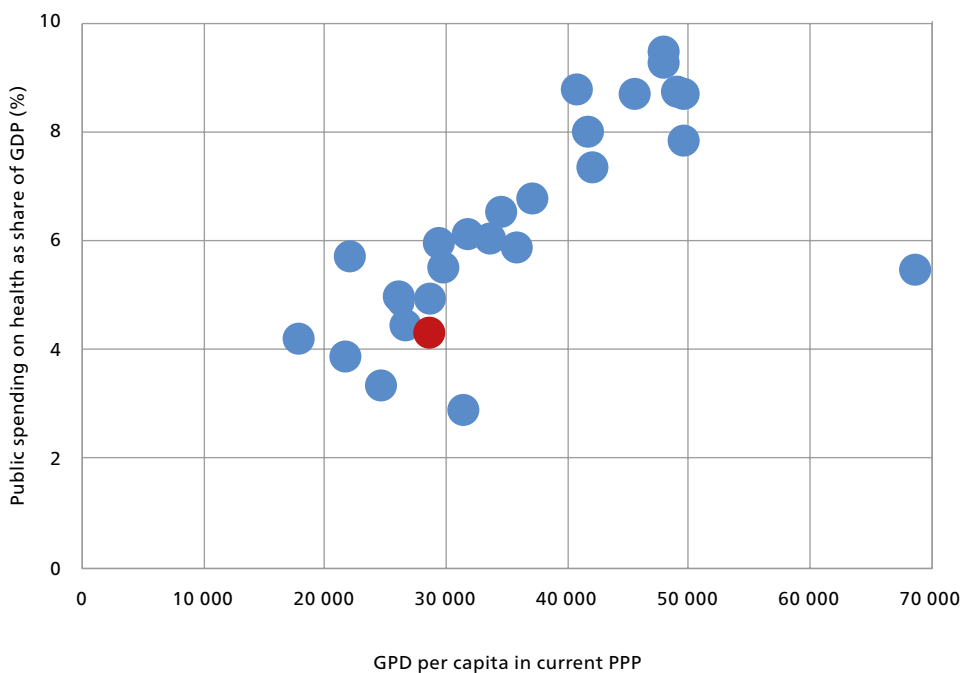
6.2 Health system factors

The following paragraphs look at health spending and health coverage, and then focus in more detail on outpatient medicines coverage, prices and use. A final section considers health-seeking behaviour and the relationship between unmet need and financial protection.

6.2.1 Spending on health

Public spending on health per person fell in the years following the crisis (Fig. 12), pushing up out-of-pocket payments in absolute terms and substantially increasing their share of total spending on health (Fig. 13). Some of the negative effects of this shift in spending may have been mitigated by stronger pharmaceutical policies introduced in 2009 to lower prices for medicines (see below). The shifting of costs onto households appears to have had most impact on the three middle quintiles, all of which experienced an increase in the incidence of catastrophic spending between 2008 and 2012. In 2014 public spending on health in Lithuania was lower than what would have been expected given its level of GDP (Fig. 27).

Fig. 27. Public spending on health and GDP per capita, EU countries, 2015



Notes: PPP: purchasing power parity. Public refers to all compulsory financing arrangements. Lithuania is highlighted in red. The figure excludes Luxembourg.

Source: WHO (2018).

6.2.2 Health coverage

The only significant change to health coverage between 2005 and 2012 was the introduction of penalties for non-payment of NHIF contributions in 2009. There were no important changes to service coverage or user charges.

Regarding **population entitlement**, in 2009 the creation of a register of people who should be contributing to the NHIF revealed that a significant share of the population was uninsured (6–10%). Most of this group of uninsured people are men and people of working age – not surprising given that the Government of Lithuania makes contributions on behalf of children, pensioners, disabled people, registered unemployed and social assistance beneficiaries. It is also likely that some of these people are working abroad but have not formally declared their absence.

The rise in unemployment after 2009 may explain the growing share of working-age households experiencing financial hardship in 2012. Among all those with catastrophic spending, the share of households headed by people aged 30–59 more than doubled between 2008 and 2012, rising from 14% to 32%.

Dental care for adults is the main gap in **service coverage**. Because adults have to pay for dental care in public facilities, many choose private dentists instead. Long waiting times for specialists in public facilities also encourage people to seek care from private providers.

Catastrophic spending on dental care mainly affects the three richest quintiles. The dental care share of catastrophic spending grew during the period of economic growth (2005 to 2008) and halved afterwards (2008 to 2012). This suggests that even the richest households limited their use of dental care in response to financial pressures.

The very minor role of dental care in driving catastrophic spending among the poorest 40% of households probably reflects unmet need for dental care, which rose between 2011 and 2014, especially for the poorest quintile (Fig. 2). Inequalities in unmet need for health care have also grown in recent years (Fig. 2).

User charges policy aims to provide very strong protection for children up to the age of 18, giving them free access to almost all standard services, including outpatient prescription medicines, dental care and inpatient rehabilitation – services for which adults are required to pay unless they are exempt (Table 2). Probably largely as a result of this policy, households with children accounted for only 3% of households with catastrophic spending in 2005, although their share rose to 5% in 2008 and 11% in 2012. Although children and some very vulnerable groups of people are exempt from user charges for outpatient medicines, the existence and design of these user charges are important drivers of catastrophic spending on health (see below).

6.2.3 Outpatient medicines

User charges apply to almost all outpatient prescribed medicines. This contrasts with the bulk of other health services, which are largely provided to patients without formal user charges. Several aspects of the **design of user**

charges for outpatient medicines are worth highlighting as factors that are highly likely to undermine financial protection.

User charges for outpatient prescription medicines are in the form of percentage co-payments, meaning people must pay a share of the medicine price or the full price. As a result, their exposure to out-of-pocket payments depends on the price and quantity of medicines they require. Also, unless the price is clearly known in advance, people may face uncertainty about how much they have to pay out-of-pocket.

The negative effect of this form of user charge is magnified:

- for people who are regular users of medicines;
- for people who have a condition that requires higher-cost medicines;
- when medicine prices are relatively high; and
- when physicians and pharmacists are not required or do not have incentives to prescribe and dispense cheaper alternatives.

Mechanisms to protect people are inadequate. There is no exemption from co-payments for adults with low incomes. Full exemption from co-payments for outpatient medicines on the positive list is systematically applied to children, people unable to work, pensioners with major special needs and people with some chronic or communicable conditions (for example, tuberculosis, cancer, schizophrenia etc.). Other pensioners, people who are partially disabled, social beneficiaries and people with other chronic or communicable conditions pay reduced co-payments but are not fully exempt.

There is no overall cap (ceiling) on out-of-pocket payments arising from user charges for outpatient medicines or for other health services. This is especially worrying when user charges are in the form of percentage co-payments.

In terms of **prices**, Lithuania has a relatively high rate of value-added tax for medicines (21% for non-prescribed and 5% for prescribed medicines) (European Federation of Pharmaceutical Industries and Associations (EFPIA), 2016). In 2013, the share of generic medicines was one of the highest in the EU, at 34% of total consumption (EFPIA, 2015). However, in 2015 only a quarter of the NHIF's reimbursement of covered medicines was for generic medicines; half was for patent-protected medicines and a quarter for other branded medicines (Garuoliene, 2015).

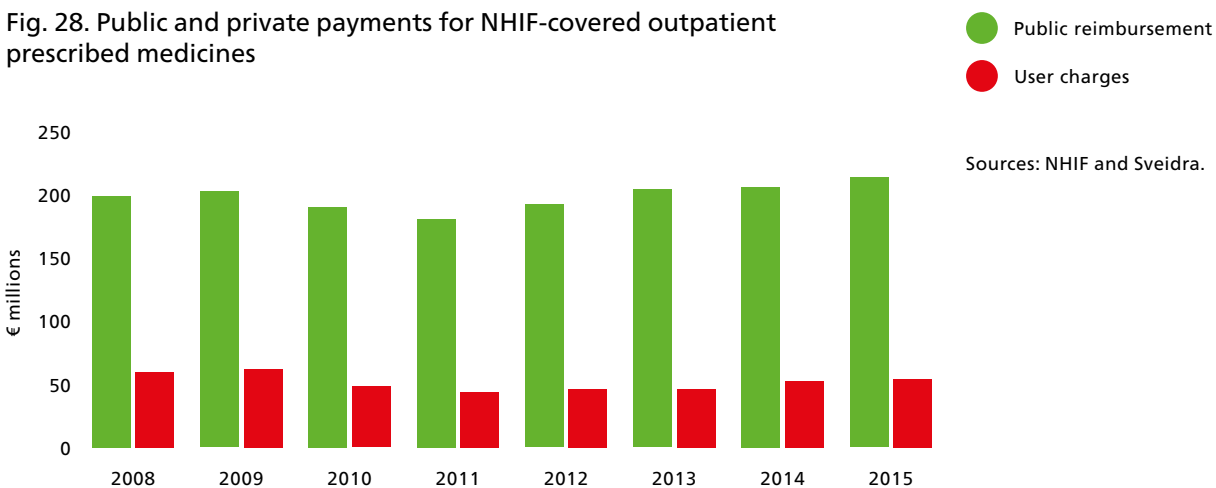
The Government took several steps to reduce public and private spending on medicines in 2009. The Plan for the Improvement of Pharmaceutical Accessibility and Price Reductions introduced international non-proprietary name prescribing, external reference pricing, price-volume agreements with manufacturers, stricter pricing for generics pricing and requirements for pharmacists to suggest medicines with the lowest co-payment (Murauskienė et al., 2013).

Many aspects of the Plan brought Lithuania closer to international good practice, and the Plan is therefore likely to have had a positive impact in terms of reducing public and private spending on prescribed medicines, although its impact has not been formally evaluated. Fig. 28 indicates that both public and private spending on NHIF-covered outpatient prescribed medicines fell in 2010 and 2011, and private spending remained below the 2009 level, even in 2015.

Some of the Plan's measures were short-lived, however. For example, the NHIF had to increase reference prices for some medicines to prevent companies from withdrawing them from the market. A recent analysis by the Competition Council of the Republic of Lithuania (2016) reports numerous failures in the pharmaceutical sector due to market concentration, unfair advertising and inadequate regulation. A recent report by the National Audit Office (2016) also highlights problems with access to generic medicines.

Since 2017, the Government has introduced additional policies intended to reduce public and private spending on medicines; the emphasis, however, is mainly on reducing prices as opposed to making coverage more protective (European Observatory on Health Systems and Policies, 2018).

Fig. 28. Public and private payments for NHIF-covered outpatient prescribed medicines



According to data from the European Health Interview Survey (EHIS), the **use of prescribed medicines** is on average lower in Lithuania than in the EU as a whole (Fig. 29), but the use of non-prescribed medicines is on average substantially higher, especially among people aged 65 and over (Fig. 30). Within Lithuania, the use of non-prescribed medicines is also slightly higher among poorer quintiles. Although the household budget survey data do not distinguish between spending on prescribed and non-prescribed medicines, in the light of the EHIS results it is plausible that the use of non-prescribed medicines may be an important driver of catastrophic spending and therefore warrants policy attention.

In contrast to the NHIF data shown in Fig. 28, household budget survey data indicate a large increase in the level of out-of-pocket spending on medicines between 2008 and 2012 (Fig. 10). This, combined with the very high rate of use of non-prescribed medicines, suggests that some people may have turned to over-the-counter medicines as a substitute for prescribed medicines.

Fig. 29. Use of medicines in EU countries, 2014

Note: Share of the population who used medicines prescribed by a doctor or medicines, herbal medicines or vitamins not prescribed by a doctor in the past two weeks.

Source: Eurostat (2018c).

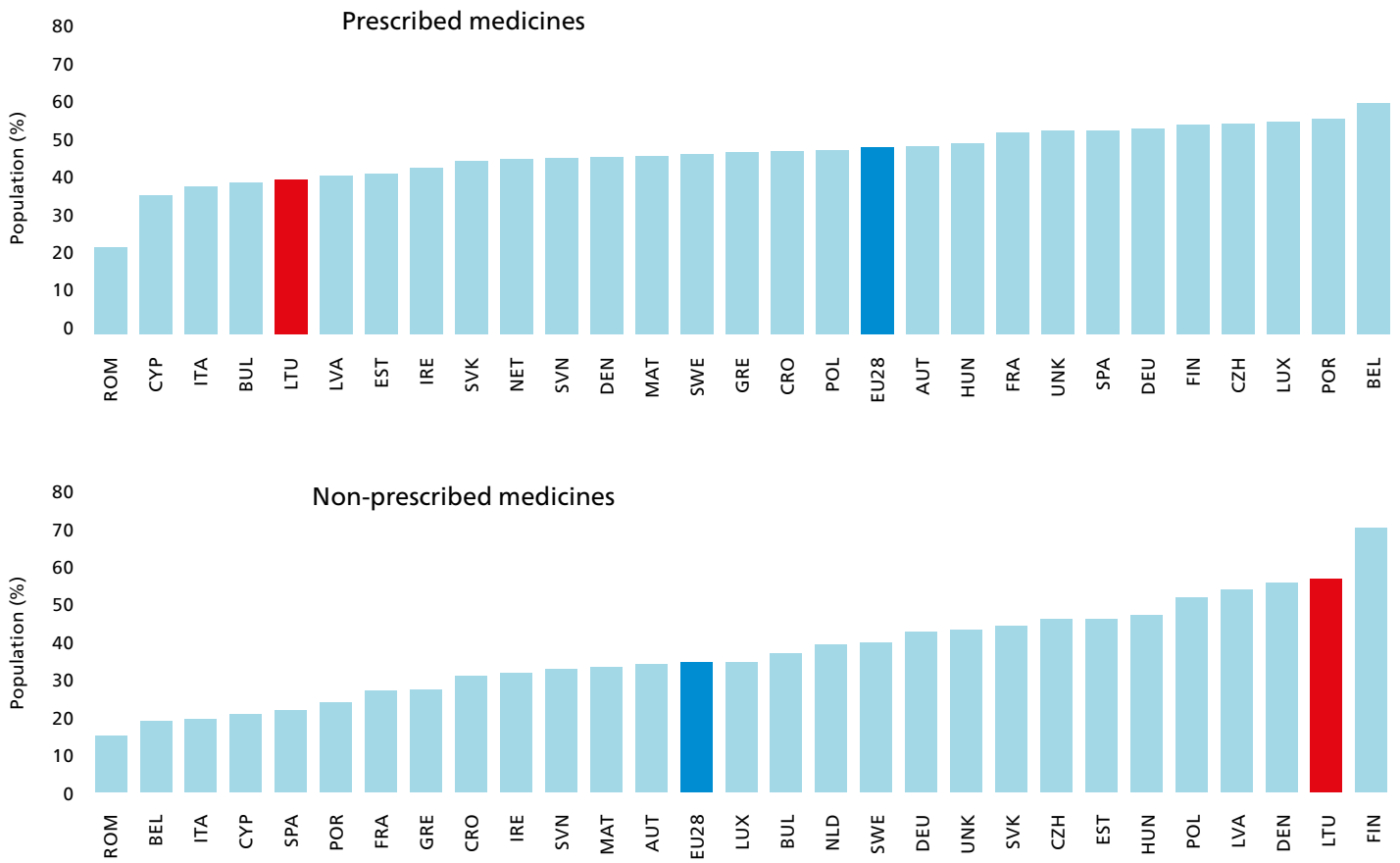
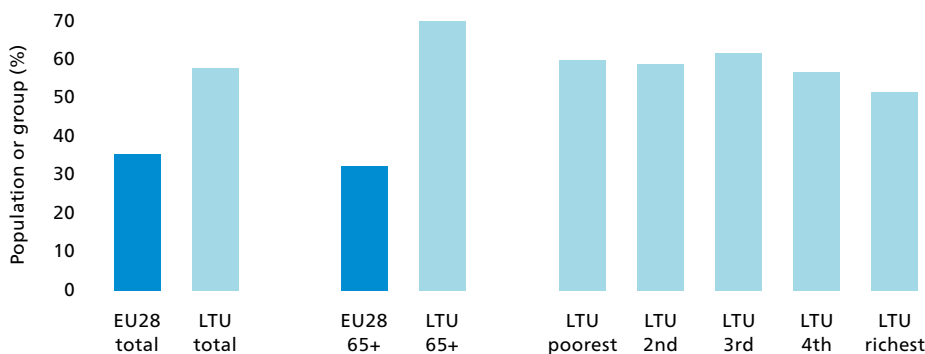


Fig. 30. Use of non-prescribed medicines by age and income, EU28 and Lithuania, 2014

Notes: LTU: Lithuania. Share of the population or group who used medicines, herbal remedies or vitamins not prescribed by a doctor in the past two weeks.

Source: Statistics Lithuania (2015).



6.2.4 Health-seeking behaviour and its impact on financial protection

The apparent improvement in financial protection experienced by the poorest quintile between 2008 and 2012 cannot be explained by pro-poor changes in the health system and must therefore be attributed to two other factors.

First, a substantial decline in the share of older people in the poorest fifth of the population may mean that fewer people in the poorest quintile needed to use health services. This could also explain some of the huge increase in the share of households with no out-of-pocket payments, which rose from 25% in 2008 to 45% in 2012 (Fig. 4).

Second, the increase in households with no out-of-pocket payments may reflect the impact of the crisis on people's health-seeking behaviour. Unmet need for dental care rose sharply for the poorest quintile between 2011 and 2014 (Fig. 2), while out-of-pocket spending on dental care did not increase between 2008 and 2012, suggesting some households cut back on dental care.

Because of the increase in households without any out-of-pocket spending and rising unmet need for dental care, it is not possible to conclude that financial protection genuinely improved for the poorest households between 2008 and 2012.

6.3 Summary

Household budget survey data suggest that people's capacity to pay for health fell as a result of the crisis. At the same time, a marked decline in public spending on health per person in the years following the crisis pushed up the out-of-pocket share of total spending on health. Both factors may explain why the incidence of financial hardship has grown over time among the middle three quintiles.

For the poorest quintile, financial protection deteriorated between 2005 and 2008 and improved between 2008 and 2012 (Fig. 17). The apparent improvement is likely to reflect changes in the composition of this quintile over time. Between 2005 and 2008, older people experienced an increasing risk of poverty compared to the rest of the population, largely because pensions failed to keep pace with growth in other sources of income; as a result, they accounted for a greater share of the poorest quintile in 2008 than 2005. Pensioner poverty is a challenge for financial protection due to higher rates of health care need among older people. The situation was reversed between 2008 and 2012, as pensions remained stable while unemployment rose and wages fell. People of working age became poorer as a result, and the share of older people in the poorest quintile fell. During this period the share of households with catastrophic spending headed by people under the age of 60 more than doubled.

Lithuania's limited coverage of outpatient medicines for adults is the most important health system factor leading to financial hardship. The weak design of co-payment policy for outpatient prescribed medicines – for example, the use of percentage co-payments, very limited protection for poor households and regular users, and the lack of a cap on co-payments

– means patients bear much of the financial burden of high prices and of inappropriate prescribing and dispensing.

Pharmaceutical policy changes introduced in 2009 and since 2017 are likely to have reduced medicine prices, but not enough to achieve a significant improvement in financial protection.

The relatively high use of non-prescribed medicines in Lithuania, reflecting easy availability and incentives encouraging people to use them, may also play a role in causing financial hardship.

Limited coverage of dental care for adults means dental care leads to financial hardship, but only among those who can afford to access services. It would be a much greater cause of financial hardship if poorer households did not experience high levels of unmet need for dental care.

Children up to the age of 18 benefit from the most complete health coverage. They enjoy free access to all publicly financed health care. This strongly protective policy towards children is reflected in the very low share of households with children among households with catastrophic out-of-pocket payments.

7. Implications for policy

Catastrophic out-of-pocket payments affect the poorest households the most and are also heavily concentrated among older households.

Financial protection has deteriorated over time. The share of households experiencing financial hardship was higher in 2012 than in 2005. Between 2008 and 2012, this share rose in the three middle quintiles but fell significantly in the poorest quintile.

Strengthening the income support system for pensioners and unemployed people would help to break the links between poverty, ill health and financial hardship. The apparent improvement in financial protection for the poorest quintile between 2008 and 2012 cannot be explained by pro-poor changes in the health system. Rather, it is likely to be related to the effects of the crisis. Following the crisis, the share of pensioners in the poorest quintile fell and unmet need for dental care rose. More recently, as unemployment has declined and wages grown faster than pensions, the incidence of catastrophic out-of-pocket payments in the poorest quintile is likely to have increased.

Outpatient medicines are by far the most important cause of financial hardship and a relatively important factor behind self-reported unmet need for health care. The medicines share of catastrophic spending has grown substantially over time, rising from 50% in 2008 to 77% in 2012. Among the poorest 40% of households, medicines account for 90% of catastrophic spending.

Policy attention should focus on improving access to and the affordability of outpatient prescribed medicines. Reforms introduced in 2009, 2017 and 2018 have aimed to lower medicine prices and encourage appropriate prescribing and dispensing. These are essential steps in the right direction, but further action is needed. The reasons for Lithuania's relatively high use of non-prescribed medicines, especially among people aged over 65, and the impact of this form of self-treatment on financial protection, should also be explored further.

Major improvement in financial protection is only likely to be achieved by strengthening the design of coverage and co-payment policy, especially for outpatient medicines. At present, co-payment policy for outpatient prescribed medicines shifts the financial risk associated with high prices and inappropriate prescribing and dispensing onto households. A more protective approach would be to exempt poor households and regular users of outpatient medicines; introduce an income-related cap on all co-payments; and use fixed rather than percentage co-payments.

Barriers to accessing dental care should be a matter of policy concern. The limited coverage of dental care for adults results in financial hardship for richer households and a high level of unmet need among poorer households.

Extending the coverage all children currently enjoy to poorer adults would do much to alleviate financial hardship and break the link between poverty and ill health. Children up to the age of 18 benefit from free access to all publicly financed health care. This strongly protective policy towards children is reflected in the very low share of households with children among households with catastrophic out-of-pocket payments.

The creation of a register of people eligible to contribute to the NHIF reveals that around 6–10% of the population is uninsured, mainly men of working age. Although some of these people are likely to be living abroad, this issue warrants policy attention. Many other EU countries cover the whole population, most often by linking entitlement to residence rather than payment of contributions.

Stronger financial protection will require additional public investment in the health system. Public spending on health is lower than Lithuania can afford given its level of GDP (Fig. 7), partly due to a decline in public spending in the years after the crisis, but also as a result of the very small size of its government – in 2015 Lithuania had the second-lowest ratio of public spending to GDP in the European Union.

Any increase in public spending on health should be used to prioritize stronger protection for poor adults and regular users of outpatient medicines and other health services. It may also be possible to pay for some improvement in financial protection through better use of existing resources.

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Annex 1.

Household budget surveys in Europe

What is a household budget survey? Household budget surveys are national sample surveys that aim to measure household consumption of goods and services over a given period of time. In addition to information about consumption expenditure, they include information about household characteristics.

Why are they carried out? Household budget surveys provide valuable information on how societies and people use goods and services to meet their needs and preferences. In many countries, the main purpose of a household budget survey is to calculate weights for the Consumer Price Index, which measures the rate of price inflation as experienced and perceived by households (Eurostat, 2015). Household budget surveys are also used by governments, research entities and private firms wanting to understand household living conditions and consumption patterns.

Who is responsible for them? Responsibility for household budget surveys usually lies with national statistical offices.

Are they carried out in all countries? Almost every country in Europe conducts a household budget survey (Yerramilli et al., 2018).

How often are they performed? EU countries conduct a household budget survey at least once every five years, on a voluntary basis, following an informal agreement reached in 1989 (Eurostat, 2015). Many countries in Europe conduct them at more frequent intervals (Yerramilli et al., 2018).

What health-related information do they contain? Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP). Information on health-related consumption comes under COICOP code 6, which is further divided into three groups, as shown in Table A1.1. In this study, health-related information from household budget surveys is divided into six groups (with corresponding COICOP codes): medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3).

Surveys will usually specify that household spending on health services should be net of any reimbursement to the household from a third party such as the government, a health insurance fund or a private insurance company. Some surveys ask households about spending on voluntary health insurance, but this is reported under a different COICOP code (12.5.3 Insurance connected with health, which covers "Service charges for private sickness and accident insurance") (United Nations Statistics Division, 2018).

Are household budget surveys comparable across countries? Household budget surveys vary across countries in terms of frequency, timing, content and structure. These differences limit comparability. Even among EU countries, where there have been sustained efforts to harmonize data collection, differences remain.

An important methodological difference in quantitative terms is **owner-occupier imputed rent**. Not all countries impute rent and, among those that do, the methods used to impute rent vary substantially (Eurostat, 2015). In this series, imputed rent is excluded when measuring total household consumption.

Table A1.1. Health-related consumption expenditure in household budget surveys

Source: United Nations Statistics Division (2018).

COICOP codes	Includes	Excludes
06.1 Medical products, appliances and equipment 06.1.1 Pharmaceutical products 06.1.2 Other medical products 06.1.3 Therapeutic appliances and equipment	This covers medicaments, prostheses, medical appliances and equipment and other health-related products purchased by individuals or households, either with or without a prescription, usually from dispensing chemists, pharmacists or medical equipment suppliers. They are intended for consumption or use outside a health facility or institution.	Products supplied directly to outpatients by medical, dental and paramedical practitioners or to inpatients by hospitals and the like are included in outpatient services (06.2) or hospital services (06.3).
06.2 Outpatient services 06.2.1 Medical services 06.2.2 Dental services 06.2.3 Paramedical services	This covers medical, dental and paramedical services delivered to outpatients by medical, dental and paramedical practitioners and auxiliaries. The services may be delivered at home or in individual or group consulting facilities, dispensaries and the outpatient clinics of hospitals and the like. Outpatient services include the medicaments, prostheses, medical appliances and equipment and other health-related products supplied directly to outpatients by medical, dental and paramedical practitioners and auxiliaries.	Medical, dental and paramedical services provided to inpatients by hospitals and the like are included in hospital services (06.3).
06.3 Hospital services	Hospitalization is defined as occurring when a patient is accommodated in a hospital for the duration of the treatment. Hospital day care and home-based hospital treatment are included, as are hospices for terminally ill persons. This group covers the services of general and specialist hospitals; the services of medical centres, maternity centres, nursing homes and convalescent homes that chiefly provide inpatient health care; the services of institutions serving older people in which medical monitoring is an essential component; and the services of rehabilitation centres providing inpatient health care and rehabilitative therapy where the objective is to treat the patient rather than to provide long-term support. Hospitals are defined as institutions that offer inpatient care under the direct supervision of qualified medical doctors. Medical centres, maternity centres, nursing homes and convalescent homes also provide inpatient care, but their services are supervised and frequently delivered by staff of lower qualification than medical doctors.	This group does not cover the services of facilities (such as surgeries, clinics and dispensaries) devoted exclusively to outpatient care (06.2). Nor does it include the services of retirement homes for older people, institutions for disabled people and rehabilitation centres providing primarily long-term support (12.4).

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Annex 2.

Methods used to measure financial protection in Europe

Background

The indicators used for monitoring financial protection in Europe are adapted from the approach set out in Xu et al. (2003, 2007). They also draw on elements of the approach set out in Wagstaff & Eozenou (2014). For further information on the rationale for developing a refined indicator for Europe, see Thomson et al. (2016).

Data sources and requirements

Preparing country-level estimates for indicators of financial protection requires nationally representative household survey data that includes information on household composition or the number of household members.

The following variables are required at household level:

- total household consumption expenditure ;
- food expenditure (excluding tobacco and alcohol if possible) ;
- housing expenditure, disaggregated by rent and utilities (such as water, gas, electricity and heating); and
- health expenditure (out-of-pocket payments), disaggregated by type of health care good and service.

Information on household consumption expenditure is gathered in a structured way, usually using the United Nations Classification of Individual Consumption According to Purpose (COICOP) (United National Statistics Division, 2018).

If the survey includes a household sampling weight variable, calculations should consider the weight in all instances. Information on household or individual-level characteristics such as age, sex, education and location are useful for additional equity analysis.

Defining household consumption expenditure variables

Survey data come in various time units, often depending on whether the reporting period is 7 days, 2 weeks, 1 month, 3 months, 6 months or 1 year. It is important to convert all variables related to household consumption expenditure to a common time unit. To facilitate comparison with other national-level indicators, it may be most useful to annualize all survey data. If annualizing survey data, it is important not to report the average level of out-of-pocket payments only among households with out-of-pocket payments, as this will produce inaccurate figures.

Total household consumption expenditure not including imputed rent
Household consumption expenditure comprises both monetary and in-kind payment for all goods and services (including out-of-pocket payments) and the money value of the consumption of home-made products. Many household budget surveys do not calculate imputed rent. To maintain cross-country comparability with surveys that do not calculate imputed rent, imputed rent (COICOP code 04.2) should be subtracted from total consumption if the survey includes it.

Food expenditure

Household food expenditure is the amount spent on all foodstuffs by the household plus the value of the family's own food production consumed within the household. It should exclude expenditure on alcoholic beverages and tobacco. Food expenditure corresponds to COICOP code 01.

Housing expenditure on rent and utilities

Expenditure on rent and utilities is the amount spent by households on rent (only among households who report paying rent) and on utilities (only among households who report paying utilities) including electricity, heating and water. These data should be disaggregated to correspond to COICOP codes 04.1 (for rent) and 04.4 and 04.5 (for utilities). Care should be taken to exclude spending on secondary dwellings. Imputed rent (COICOP code 04.2) is not available in all household budget surveys and should not be used in this analysis.

Health expenditure (out-of-pocket payments)

Out-of-pocket payments refer to formal and informal payments made by people at the time of using any health service provided by any type of provider (COICOP code 06). Health services are any good or service delivered in the health system. These typically include consultation fees, payment for medications and other medical supplies, payment for diagnostic and laboratory tests and payments occurring during hospitalization. The latter may include a number of distinct payments such as to the hospital, to health workers (doctors, nurses, anaesthesiologists etc.) and for tests. Both cash and in-kind payments should be included if the latter are quantified in monetary value. Both formal and informal payments should also be included. Although out-of-pocket payments include spending on alternative or traditional medicine, they do not include spending on health-related transportation and special nutrition. It is also important to note that out-of-pocket payments are net of any reimbursement to households from the government, health insurance funds or private insurance companies.

Estimating spending on basic needs and capacity to pay for health care

Basic needs expenditure is a socially recognized minimum level of spending considered necessary to ensure sustenance and other basic personal needs. This report calculates household-specific levels of basic needs expenditure

to estimate a household's capacity to pay for health care. Households whose total consumption expenditure is less than the basic needs expenditure level generated by the basic needs line are deemed to be poor.

Defining a basic needs line

Basic needs can be defined in different ways. This report considers food, utilities and rent to be basic needs and distinguishes between:

- households that do not report any utilities or rent expenses; their basic needs include food;
- households that do not report rent expenses (households that own their home outright or make mortgage payments, which are not included in consumption expenditure data), but do report utilities expenses; their basic needs include food and utilities;
- households that pay rent, but do not report utilities expenditure (for example, if the reporting period is so short that it does not overlap with billing for utilities and there is no alternative reporting of irregular purchases); their basic needs include food and rent;
- households that report paying both utilities and rent, so that their basic needs include food, utilities and rent.

Adjusting households' capacity to pay for rent (among renters) is important. Household budget surveys consider mortgages to be investments, not consumption expenditure. For this reason most do not collect household spending on mortgages. Without subtracting some measure of rent expenditure from those who rent, renters will appear to be systematically wealthier (and have greater capacity to pay) than identical households with mortgages.

To estimate standard (normative) levels of basic needs expenditure, all households are ranked based on their per (equivalent) person total consumption expenditure. Households between the 25th and 35th percentiles of the total sample are referred to as the representative sample for estimating basic needs expenditure. It is assumed that they are able to meet, but not necessarily exceed, basic needs for food, utilities and rent.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to rank households by per equivalent person non-out-of-pocket payment consumption expenditure.

Calculating the basic needs line

To begin to calculate basic needs, a household equivalence scale should be used to reflect the economy scale of household consumption. The Organisation for Economic Co-operation and Development equivalence scale (the Oxford scale) is used to generate the equivalent household size for each household:

equivalent household size = $1 + 0.7 * (\text{number of adults} - 1) + 0.5 * (\text{number of children under 13 years of age})$

Each household's total consumption expenditure (less imputed rent), food expenditure, utilities expenditure and rent expenditure is divided by the equivalent household size to obtain respective equivalized expenditure levels.

Households whose equivalized total consumption expenditure is between the 25th and 35th percentile across the whole weighted sample are the representative households used to calculate normative basic needs levels. Using survey weights, the weighted average of spending on food, utilities and rent among representative households that report positive values for food, utilities and rent expenditure, respectively, gives the basic needs expenditure per (equivalent) person for food, utilities and rent.

Note again that households that do not report food expenditure are excluded as this may reflect reporting errors. For households that do not report any rent or utilities expenses, only the sample-weighted food basic needs expenditure is used to represent total basic needs expenditure per (equivalent) person. For households that report utilities expenditures but do not report any rent expenses, the two basic needs expenditure sample-weighted averages for food and utilities are added to calculate total basic needs expenditure per (equivalent) person. For households that report rent expenditures but do not report any utilities expenses, the two basic needs expenditure sample-weighted averages for food and rent are added to calculate total basic needs expenditure per (equivalent) person. For households that report both rent and utilities, the three basic needs expenditure sample-weighted averages for food, utilities and rent are added to calculate total basic needs expenditure per (equivalent) person.

Calculating basic needs expenditure levels for each household

Calculate the basic needs expenditure specific to each household by multiplying the total basic needs expenditure per (equivalent) person level calculated above by each household's equivalence scale. Note that a household is regarded as being poor when its total consumption expenditure is less than its basic needs expenditure.

Capacity to pay for health care

This is defined as non-basic needs resources used for consumption expenditure. Some households may report total consumption expenditure that is lower than basic needs expenditure, which defines them as being poor. Note that if a household is poor, capacity to pay will be negative after subtracting the basic needs level.

Estimating impoverishing out-of-pocket payments

Measures of impoverishing health spending aim to quantify the impact of out-of-pocket payments on poverty. For this indicator, households are divided into five mutually exclusive categories based on their level of out-of-pocket payments in relation to the basic needs line.

No out-of-pocket payments are those households that report no health expenditure.

Not at risk of impoverishment after out-of-pocket payments are non-poor households with out-of-pocket payments that do not push them below the multiple of the basic needs line.

At risk of impoverishment after out-of-pocket payments are non-poor households with out-of-pocket payments that push them below a multiple of the basic needs line. This review uses a multiple of 120%, but the author also prepared estimates using 105% and 110%.

Impoverished after out-of-pocket payments are non-poor households that are pushed into poverty after paying out of pocket for health services. For them, the ratio of out-of-pocket payments to capacity to pay is greater than one. In the exceptional case that capacity to pay is zero and out-of-pocket payments are greater than zero, a household would be considered to be impoverished by out-of-pocket payments.

Further impoverished after out-of-pocket payments are households already below the basic needs line with out-of-pocket payments. Any household whose ratio of out-of-pocket payments to capacity to pay is less than zero (that is, negative) is pushed further into poverty by out-of-pocket payments.

Estimating catastrophic out-of-pocket payments

Catastrophic out-of-pocket payments are measured as out-of-pocket payments that equal or exceed some threshold of a household's capacity to pay. Thresholds are arbitrary. The threshold used most often with capacity to pay measures is 40%. This review uses 40% for reporting purposes, but the author also prepared estimates using thresholds of 20%, 25% and 30%.

Households with catastrophic out-of-pocket payments are defined as:

- those with out-of-pocket payments greater than 40% of their capacity to pay; this includes all households who are impoverished after out-of-pocket payments, because their ratio of out-of-pocket payments to capacity to pay is greater than one; and
- those with out-of-pocket payments whose ratio of out-of-pocket payments to capacity to pay is less than zero (negative) – that is, all households who are further impoverished after out-of-pocket payments.

Households with non-catastrophic out-of-pocket payments are defined as those with out-of-pocket payments that are less than the pre-defined catastrophic spending threshold.

For policy purposes it is useful to identify which groups of people are more or less affected by catastrophic out-of-pocket payments (equity) and which health services are more or less responsible for catastrophic out-of-pocket payments.

Distribution of catastrophic out-of-pocket payments

The first equity dimension is expenditure quintile. Expenditure quintiles are determined based on equivalized per person household expenditure. Household weights should be used when grouping the population by quintile. Countries may find it relevant to analyse other equity dimensions such as differences between urban and rural populations, regions, men and women, age groups and types of household.

In some countries it is common to finance out-of-pocket payments from savings or borrowing, which might artificially inflate a household's consumption and affect household ranking. Where this is an issue, it may be preferable to calculate quintiles based on non-health equivalized per person household expenditure.

Structure of catastrophic out-of-pocket payments

For households in each financial protection category, the percentage of out-of-pocket payments on different types of health goods and services should be reported, if the sample size allows, using the following categories, with their corresponding COICOP categorization: medicines (06.1.1), medical products (06.1.2 and 06.1.3), outpatient care (06.2.1), dental care (06.2.2), diagnostic tests (06.2.3) and inpatient care (06.3). Where possible, a distinction should be made between prescription and over-the-counter medicines.

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Annex 3. Regional and global financial protection indicators

WHO uses regional and global indicators to monitor financial protection in the European Region, as shown in Table A3.1.

Table A3.1. Regional and global financial protection indicators in the European Region

Regional indicators (R1, R2)	Global indicators (G1–G4)
Catastrophic out-of-pocket payments	
Indicator R1: the proportion of households with out-of-pocket payments greater than 40% of household capacity to pay	Indicator G1: the proportion of the population with large household expenditure on health as a share of total household consumption or income (greater than 10% or 25% of total household consumption or income)
Impoverishing out-of-pocket payments	
Indicator R2: risk of poverty due to out-of-pocket payments – the proportion of households further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment after out-of-pocket payments using a country-specific line based on household spending to meet basic needs (food, housing and utilities)	<p>Indicator G2: changes in the incidence and severity of poverty due to household expenditure on health using an international poverty line of PPP-adjusted US\$ 1.90 per person per day</p> <p>Indicator G3: changes in the incidence and severity of poverty due to household expenditure on health using an international poverty line of PPP-adjusted US\$ 3.10 per person per day</p> <p>Indicator G4: changes in the incidence and severity of poverty due to household expenditure on health using a relative poverty line of 60% of median consumption or income per person per day</p>

Note: PPP: purchasing power parity.

Sources: WHO headquarters and WHO Regional Office for Europe.

Regional indicators

Indicators R1 and R2 reflect a commitment to the needs of European Member States. They were developed by the WHO Barcelona Office for Health Systems Strengthening (part of the Division of Health Systems and Public Health in the WHO Regional Office for Europe), at the request of the WHO Regional Director for Europe, to meet demand from Member States for performance measures more suited to high- and middle-income countries and with a stronger focus on pro-poor policies, in line with Regional Committee resolutions (see Annex 2).

At the regional level, WHO's support for monitoring financial protection is underpinned by the Tallinn Charter: Health Systems for Health and Wealth, Health 2020 and resolution EUR/RC65/R5 on priorities for health systems strengthening in the WHO European Region 2015–2020, all of which include the commitment to work towards a Europe free of impoverishing payments for health.

Global indicators

Indicators G1–G4 reflect a commitment to global monitoring. They enable the performance of Member States in the European Region to be easily compared to the performance of Member States in the rest of the world.

At the global level, support by WHO for the monitoring of financial protection is underpinned by World Health Assembly resolution WHA64.9 on sustainable health financing structures and universal coverage, which was adopted by Member States in May 2011. More recently, with the adoption of the 2030 Agenda for Sustainable Development and its concomitant Sustainable Development Goals (SDGs) in 2015, the United Nations has recognized WHO as the custodian agency for SDG3 (Good health and well-being: ensure healthy lives and promote well-being for all at all ages) and specifically for target 3.8 on achieving universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all. Target 3.8 has two indicators: 3.8.1 on coverage of essential health services and 3.8.2 on financial protection when using health services.

The choice of global or regional indicator has implications for policy

Global and regional indicators provide insights into the incidence and magnitude of financial hardship associated with out-of-pocket payments for health, but they do so in different ways. As a result, they may have different implications for policy and suggest different policy responses.

For example, global indicator G1 defines out-of-pocket payments as catastrophic when they exceed a fixed percentage of a household's consumption or income (its budget). Applying the same fixed percentage threshold to all households, regardless of wealth, implies that very poor households and very rich households spending the same share of their budget on health will experience the same degree of financial hardship.

Global studies find that this approach results in the incidence of catastrophic out-of-pocket payments being more concentrated among richer households (or less concentrated among poorer households) (WHO & World Bank 2015; 2017). With this type of distribution, the implication for policy is that richer households are more likely to experience financial hardship than poorer households. The appropriate policy response to such a finding is not clear.

In contrast, to identify households with catastrophic out-of-pocket payments, regional indicator R1 deducts a standard amount representing spending on three basic needs – food, housing (rent) and utilities – from each household's consumption expenditure. It then applies the same fixed percentage threshold to the remaining amount (which is referred to as the household's capacity to pay for health care). As a result, although the same threshold is applied to all households, the amount to which it is applied is now significantly less than total household consumption for poorer households but closer to total household consumption for richer households. This implies that very poor households spending small amounts on out-of-pocket payments, which constitute a relatively small share of their total budget, may experience financial hardship, while wealthier households are assumed to not

experience hardship until they have spent a comparatively greater share of their budget on out-of-pocket payments.

This approach results in the incidence of catastrophic out-of-pocket payments being highly concentrated among poor households in all countries. For countries seeking to improve financial protection, the appropriate response to this type of distribution is clear: design policies that protect poorer households more than richer households.

Recent global studies most commonly report impoverishing out-of-pocket payments using absolute international poverty lines set at US\$ 1.90 or US\$ 3.10 a day in purchasing power parity (indicators G2 and G3) (WHO & World Bank 2015; 2017). These poverty lines are found to be too low to be useful in Europe, even among middle-income countries. For example, the most recent global monitoring report suggests that in 2010 only 0.1% of the population in the WHO European Region was impoverished after out-of-pocket payments using the US\$ 1.90 a day poverty line (0.2% at the US\$ 3.10 a day poverty line) (WHO & World Bank, 2017).

European studies make greater use of national poverty lines or poverty lines constructed to reflect national patterns of consumption (Yerramilli et al., 2018). While national poverty lines vary across countries, making international comparison difficult, poverty lines constructed to reflect national patterns of consumption – such as that which is used as the poverty line for the regional indicator R2 – facilitate international comparison (Saksena et al., 2014).

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Annex 4. Glossary of terms

Ability to pay for health care: Ability to pay refers to all the financial resources at a household's disposal. When monitoring financial protection, an ability to pay approach assumes that all of a household's resources are available to pay for health care, in contrast to a capacity to pay approach (see below), which assumes that some of a household's resources must go towards meeting basic needs. In practice, measures of ability to pay are often derived from household survey data on consumption expenditure or income and may not fully capture all of a household's financial resources— for example, savings and investments.

Basic needs: The minimum resources needed for sustenance, often understood as the consumption of goods such as food, clothing and shelter.

Basic needs line: A measure of the level of personal or household income or consumption required to meet basic needs such as food, housing and utilities. Basic needs lines, like poverty lines, can be defined in different ways. They are used to measure impoverishing out-of-pocket payments. In this study the basic needs line is defined as the average amount spent on food, housing and utilities by households between the 25th and 35th percentiles of the household consumption distribution, adjusted for household size and composition. Basic needs line and poverty line are used interchangeably. See poverty line.

Budget: See household budget.

Cap on benefits: A mechanism to protect third party payers such as the government, a health insurance fund or a private insurance company. A cap on benefits is a maximum amount a third party payer is required to cover per item or service or in a given period of time. It is usually defined as an absolute amount. After the amount is reached, the user must pay all remaining costs. Sometimes referred to as a benefit maximum or ceiling.

Cap on user charges (co-payments): A mechanism to protect people from out-of-pocket payments. A cap on user charges is a maximum amount a person or household is required to pay out of pocket through user charges per item or service or in a given period of time. It can be defined as an absolute amount or as a share of a person's income. Sometimes referred to as an out of pocket maximum or ceiling.

Capacity to pay for health care: In this study capacity to pay is measured as a household's consumption minus a normative (standard) amount to cover basic needs such as food, housing and utilities. This amount is deducted consistently for all households. It is referred to as a poverty line or basic needs line.

Catastrophic out-of-pocket payments: Also referred to as catastrophic spending on health. An indicator of financial protection. Catastrophic out-of-pocket payments can be measured in different ways. This study defines them as out-of-pocket payments that exceed 40% of a household's capacity to pay for health care. The incidence of catastrophic health spending includes households who are impoverished (because they no longer have any capacity to pay after incurring out-of-pocket payments) and households who are further impoverished (because they have no capacity to pay from the outset).

Consumption: Also referred to as consumption expenditure. Total household consumption is the monetary value of all items consumed by a household during a given period. It includes the imputed value of items that are not purchased but procured for consumption in other ways (for example, home-grown produce).

Co-payments (user charges or user fees): Money people are required to pay at the point of using health services covered by a third party such as the government, a health insurance fund or a private insurance company. Fixed co-payments are a flat amount per good or service; percentage co-payments (also referred to as co-insurance) require the user to pay a share of the good or service price; deductibles require users to pay up to a fixed amount first, before the third party will cover any costs. Other types of user charges include extra billing (a system in which providers are allowed to charge patients more than the price or tariff determined by the third party payer) and reference pricing (a system in which people are required to pay any difference between the price or tariff determined by the third party payer – the reference price – and the retail price).

Equivalent adult: To ensure comparisons of household spending account for differences in household size and composition, equivalence scales are used to calculate spending levels per equivalent adult in a household. This review uses the Oxford scale (also known as the Organisation for Economic Co-operation and Development equivalence scale), in which the first adult in a household counts as one equivalent adult, subsequent household members aged 13 or over count as 0.7 equivalent adults and children under 13 count as 0.5 equivalent adults.

Exemption from user charges (co-payments): A mechanism to protect people from out-of-pocket payments. Exemptions can apply to groups of people, conditions, diseases, goods or services.

Financial hardship: People experience financial hardship when out-of-pocket payments are large in relation to their ability to pay for health care.

Financial protection: The absence of financial hardship when using health services. Where health systems fail to provide adequate financial protection, households may not have enough money to pay for health care or to meet other basic needs. Lack of financial protection can lead to a range of negative health and economic consequences, potentially reducing access to health care, undermining health status, deepening poverty and exacerbating health and socioeconomic inequalities.

Further impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments made by households living below a national or international poverty line or a basic needs line. A household is further impoverished if its total consumption is below the line before out-of-pocket payments and if it incurs out-of-pocket payments.

Health services: Any good or service delivered in the health system, including medicines, medical products, diagnostic tests, dental care, outpatient care and inpatient care. Used interchangeably with health care.

Household budget: Also referred to as total household consumption. The sum of the monetary value of all items consumed by the household during

a given period and the imputed value of items that are not purchased but procured for consumption in other ways.

Household budget survey: Usually national sample surveys, often carried out by national statistical offices, to measure household consumption over a given period of time. Sometimes referred to as household consumption expenditure or household expenditure surveys. European Union countries are required to carry out a household budget survey at least once every five years.

Impoverishing out-of-pocket payments: An indicator of financial protection. Out-of-pocket payments that push people into poverty or deepen their poverty. A household is measured as being impoverished if its total consumption was above the national or international poverty line or basic needs line before out-of-pocket payments and falls below the line after out-of-pocket payments.

Out-of-pocket payments: Also referred to as household expenditure (spending) on health. Any payment made by people at the time of using any health good or service provided by any type of provider. Out-of-pocket payments include: (a) formal co-payments (user charges or user fees) for covered goods and services; (b) formal payments for the private purchase of goods and services; and (c) informal payments for covered or privately purchased goods and services. They exclude pre-payment (for example, taxes, contributions or premiums) and reimbursement of the household by a third party such as the government, a health insurance fund or a private insurance company.

Poverty line: A level of personal or household income or consumption below which a person or household is classified as poor. Poverty lines are defined in different ways. This study uses basic needs line and poverty line interchangeably. See basic needs line.

Quintile: One of five equal groups (fifths) of a population. This study commonly divides the population into quintiles based on household consumption; the first quintile is the fifth of households with the lowest consumption, referred to in the study as the poorest quintile; the fifth quintile has the highest consumption, referred to in the study as the richest quintile.

Risk of impoverishment after out-of-pocket payments: After paying out of pocket for health care, a household may be further impoverished, impoverished, at risk of impoverishment or not at risk of impoverishment. A household is at risk of impoverishment (or not at risk of impoverishment) if its total spending after out-of-pocket payments comes close to (or does not come close to) the poverty line or basic needs line.

Universal health coverage: All people are able to use the quality health services they need without experiencing financial hardship.

Unmet need for health care: An indicator of access to health care. Instances in which people need health care but do not receive it due to access barriers.

User charges: Also referred to as user fees. See co-payments.

Utilities: Water, electricity and fuels used for cooking and heating.

The WHO Regional
Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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