



Building a Viable Health Care System in Lithuania

A study developed by the Lithuanian Free Market Institute

This study is targeted to elucidate how to create an efficient and sustainable health care system in Lithuania that would meet people's needs in the best possible manner. It covers the following topics:

- obstacles to private health insurance and ways to remove them;
- principles to be followed in compensation of medicines;
- principles to be followed in compensation of health care services at different levels of health care.

This study is focused on the financial aspect of health care reform. Institutional and legal aspects are discussed insofar they are related with the issue of funding.

1. The concept of health care reform

The baseline thesis of this study is the following: the birth of the market for health care services would lead to implementing the patient's right to choose a health care establishment and a method of treatment; it would encourage a wider variety of services and a sufficient level of quality services; it would also ensure equal rights to health care, increase the significance of, and opportunities for, charity, reduce the pressure for public finances, and create conditions for the protection of patients' rights.

Simultaneously, intermediary problems would be solved, such as the optimisation of the network of medical establishments, wages and the professional prestige of physicians, efficiency of individual health care institutions, transparency of government funding, restrictions imposed on private health care services and the gap between specific health sectors.

Although individual countries have entirely different health care systems, all of them are dealing with basically the same problems today - how to improve the quality of health care services and their accessibility while maintaining stability in public finances.¹ Subject to the system applied and the priority given to these three dissimilar objectives, certain drawbacks arise in each country, for instance, a poor quality of services, long waiting lists to receive services, and patients' unequal rights to health care. The role of the private sector and the patient himself is among the factors that determine the quality of the health care system (providers of health services and funding). Private agents are essential not just because they

¹ Communication from the Commission to the Council, the European Parliament, the Economic and Social Committee and the Committee of the Regions. The future of health care and care for the elderly: guaranteeing accessibility, quality and financial viability, Brussels, COM (2001) 723, 05.12.2001.

J. S. Hixson. Six Questions Everyone Should Ask About Health System Reform: An Application of Basic Economics. Galen Institute, USA, 2002.

C. Ramsay, E. Consulting, N. Esmail. The Rebirth of Medicare in Saskatchewan: Steps Toward an Accessible, High Quality, and Sustainable Health Care System. Fraser Institute, Canada, 2003.



are able to provide the patient with high-quality services and to allocate funds efficiently. They are also important because they exert influence on other – public – players of the system by moving their inter-relations from administrative to market-based.² In health care systems of European countries, private players and market relations historically have been weaker than those in the United States. Even though a cautious, if not sceptic, attitude to private health care prevails in Europe, an increasing number of specialists are recognising its necessity, and some countries (for example, Sweden and Germany) are beginning to reform their health care systems by introducing certain elements of the market. In Lithuania the authorities maintain that health care reform is taking place, however, it is being restricted to administrative measures only (the revision of the list of compensated medicines, the improvement of compensation for health care services, the restructuring of public health care institutions, the introduction of treatment algorithms, etc.). Such measures may produce some positive results in the short-run, but they are far from being able to resolve the fundamental problems underlying the health care system in Lithuania.

The defects of the existing health care system in Lithuania

The current health care system is inefficient owing to the following:

- patients do not receive quality treatment;
- informal payments for treatment exist, and legal co-payments are only fragmental;
- the network of health care services is extensive, and their management is feeble;
- patient accounts are continuously indebted to health care establishments for services, and to pharmacies for medicines; the debts are swelling and penalty fees for delayed payments are not being paid;
- doctors' conditions of work are poor, wages are low, the prestige of this profession is constantly falling;
- doctors must deal with an array of bureaucratic work;
- doctors bear administrative (e.g., revoking of a licence) and criminal responsibility for malpractice rather than pay fines as compensation to the injured patient;
- doctors are accountable to the government but not to the patient;
- private health insurance is only emerging, and the conditions for its development are disadvantageous;
- private health care institutions are scarce, the conditions for their operation are adverse, and their patients lose their contributions made to mandatory health insurance fund;
- the setting of quotas on health care services and compensated pharmaceuticals has heightened the conflict within the system - among the patients, among the doctors, between doctors and patients, between consumers and pharmaceutical companies, between pharmacies and manufacturers, etc.*

² F. Colombo, N. Tapay. Private Health Insurance in Australia. A Case Study. OECD Health Working Papers, 2003.

* When health care expenses for compensated medicines in 2001 surmounted sharply the expenses of the previous year, a limit for health care expenses was set per patient and quotas were established on compensated pharmaceuticals and health care services distributing them among health care institutions. This resulted in a



The goals of the reform

The reform is designed to build the effectiveness and financial stability of the health care system, to change the inter-relations among its players from antagonistic to co-operative, and to create physicians' incentives to provide high-quality treatment and patient's motivation to prevent diseases.

The essence of the reform

The essence of the proposed health care reform in Lithuania is to change the administrative model of the system where its players (patients and providers of products and services) were governed by the rules, legal acts, etc. established by the Ministry of Health and a State Patient Fund so that they acted by themselves and were led by a personal, professional or entrepreneurial interest. Under such conditions, the players of the system would be driven by a financial interest and thus would work to satisfy the patient, the central agent of the system. The system would be flexible and could adapt to changing needs and resources.

To institute these changes, it is necessary to build favourable conditions for private health insurance, to introduce mechanisms alternative to quotas that would (self)-restrict demand, to make public financing of health care services and medicines as much transparent as possible, and to minimise the number and minuteness of administrative restrictions.

The principles of the reform

The proposed health care system would redistribute resources from the healthy to the diseased individuals within the scope of state compensation.

Demand for health care would be hedged up by the patient's co-payment.

As prices of health care services and medicines are unregulated, they would be harnessed by competition.

Patient's personal contribution for health care services is indispensable not just for balancing health care resources, but also for ensuring the quality of health care services and ethics.

The guidelines for the reform

A. Private health insurance

The Lithuanian Law on Health Insurance specifies two types of health insurance: mandatory and supplementary (voluntary). Resources of mandatory health insurance are formed in a separate fund (the Mandatory Health Insurance Fund - MHIF) from the personal income tax, a share of mandatory social insurance contribution, payments from the state budget for

battle for getting prescription for quota medicines provoking bitter conflicts among the patients and the doctors while the needs of a large number of patients were not satisfied.



state insured individuals, and from other resources. Institutions effecting mandatory health insurance are the following: Mandatory Health Insurance Council, a State Patient Fund and regional patient funds (RPF). All residents in the country are insured by mandatory health insurance: contributions for the working population are transferred by employers, self-employed individuals pay to insurance themselves, and the state pays for the majority of non-working population (pensioners, children, unemployed people, etc.). It is guaranteed that the insured individuals will receive health care services and compensation for health care expenses within the terms and the scope established in the Law. The reimbursed health care services also include medicines and medical aids, treatment at sanatoria and resorts, and the limb and organ prosthetics. The basic cost of these items is covered from RPF according to the contracts concluded with health care institutions.

Supplementary (voluntary) health insurance is defined in the Law as insurance effected according additional health insurance contracts with legal persons, occupied in health insurance provision.

At present, supplementary health insurance services are provided only on a small scale, but their demand is on the rise. The reasons are numerous: the quality of state-rendered health care services is constantly falling, charges for certain medicines are tending upwards, co-payments for certain services are emerging in public health care institutions, while medical bills in private health care establishments should be covered in full. In addition, employers are increasingly applying diverse employee-incentive measures, and supplementary health insurance is one of them.

The following presents the existing roadblocks to private health insurance:

Today the result of health care institutions' work is viewed as a mere activity rather than a *service*. This approach has been mirrored at all levels in Lithuania:

In rhetoric. Everyone avoids referring to medical treatment as to a market service.

In the activities of health care institutions. First, physicians of state-run health care establishments have no legal incentives to provide superior services; however, there are illegal incentives. Second, private institutions experience difficulties in their activity because the patient loses his tax money if he undergoes treatment in private organisations that have not signed a contract with RPA. If the contract is concluded, it is mandatory for private institutions to charge government-set prices that are utterly insufficient to ensure the quality of a number of services.

If legal co-payments were introduced into the funding of the health care system, demand for private health insurance should rise markedly.

In the mechanism of financing. First, the range of emergency and vital medical treatment is very wide. Second, mandatory health care insurance *de jure* covers all costs of the treatment, while *de facto* – only some of them. However, no lists of the contents of reimbursed services or their criteria have been prepared. Consequently, the patient does not know in advance which services will be rendered for free and which of them he will have to pay for officially or



unofficially. For this reason, the patient is unable to plan his future expenses. Third, after an introduction of quotas on compensated services and medicines, the pressure and control have been tightened, so physicians have been increasingly reluctant to write prescriptions for compensated drugs or to inform patients about costlier methods of treatment (fearing complaints from patients who are unwilling or unable to pay more). As a result, patients are sheared of an opportunity to acquire such services for their own money or from private health insurance.

In the management of state-owned health care institutions. As these institutions do not treat their activity as services rendering to the consumer, they do not issue financial bills (this problem is but one aspect of a more general problem related to accounting of public health care institutions). Additional efforts which the patient has to put forth to receive financial documents verifying his medical expenses discourage him from using private health insurance services.

In tax legislation. The Law on Corporate Profit Tax stipulates that when a company covers health insurance for its employee's expenses incurred by the company are not attributed to its costs. According to the Law on Income Tax of Individuals, health care insurance that is purchased by employers to their employees is classified as the latter's non-cash income and is taxed by the personal income tax.

Promoting competition in health insurance

Currently, the state-run health insurance is a monopoly in the market of health insurance services. According to the national health account, in the year 2001 sixty-one percent of total health care costs were covered from patient funds, 0.1 percentage point by private health insurance, and 26.5 percent by residents themselves (including informal payments).³

Competition in the market of financing health care can be furthered by taking the following two directions:

- by allowing patients to choose between a state-run and a private health insurance company that would compete for the insurance of the same services, or
- by clearly separating services to be insured by mandatory state health insurance and services to be insured by private insurance companies.

It would be easier to bring in the second model. First, politically it would be more favourable because the MHIF coverage would not be reduced, and the state would not have to transfer contributions for state insured individuals into accounts held in private health insurance companies. Second, it is evident already today that compensations from patient accounts are insufficient to acquire even minimal health care services and medicines.

Separation of state and private health insurance services could be structured in two ways. First, it could be service-based, that is, by defining the list of services and medicines which are reimbursed from patient funds. Second, it may well be based on the price, that is, by

³ Nacionaline sveikatos saskaita. Sveikatos teises ir informacijos centras. Vilnius, 2004.



setting a certain amount for each group of services and medicines that is compensated from patient funds, but the price would not be set administratively for the patient (this would mean the establishment of patient's co-payment in the law). The difference between the market price and the compensation would provide space for private insurance (see Part C for more about compensation schemes).

The first model is applied in compensation of medicines. Medicines are reimbursed according to a separate list of compensated medicines and medical aids, while those not included in the list should be covered by the patient in full. Such model is discriminatory and non-transparent in the first place, that is why it prompts a conflict among patients, increases a business risk and creates conditions for corruption. If it was applied to services (for example, by compensating only for medical treatment according to endorsed methodologies), problems in the health care system would amount. And not just financial problems - all sorts of restrictions imposed on methods of treatment and health care services curtail the patient's opportunity to get proper treatment.

For this reason, it is expedient to promote competition in health care insurance by separating the domains of mandatory state-run insurance from private insurance based on the principle of price. More precisely, the size of compensation from MHIF should be fixed, and private health insurance would cover the difference between the price of services and medicines and the compensation thereof.

B. Health care services: the price and the demand

Despite capital importance in terms of human needs, health care services have their price just as any other service. Historically, people used to cover health care costs themselves. Written texts from the ancient times testify that even back then treatment services differed in their quality and price (both in terms of substances and measures used and a physician's qualification).⁴ Moreover, the code of ethics of physicians – as of a free profession (the Oath of Hippocrates) – encompassed, among other moral rules, a flexible attitude towards remuneration for work. In other words, philanthropy was common in physicians' work at that time.

The essence of health care services has not changed over two centuries:

- health care services remain exclusively significant because health is the man's primary need, and a diseased individual is dependant on a physician,
- health care services are not possible without remuneration,
- remuneration can differ subject to the level of services rendered,
- the patient is not always able pay for indispensable health care services himself, therefore he can get treatment only when support exists.

⁴ The Medical Works of Hippocrates. Charles C Thomas Publishers, Springfield. L. Edelstein. Ancient medicine. The Johns Hopkins University Press, 1967, Baltimore and London. J. Jouanna. Hippocrates. The Johns Hopkins University Press, Baltimore and London.



The specifics of health care in recent times:

1. Society is aging. People live and use health care services longer.
2. Scientists have invented more methods of treatment, so people undergo treatment from various maladies and with a growing diversity of measures.
3. Certain methods of treatment are expensive in particular. The cost of treatment fluctuates on a notably wide range.
4. In the 20th century, the role of support giving was occupied by the state which has ousted the physician, as an individual, the community and the church from pursuing this mission.

When the function of support giving is taken over by the state, first, the help provided to the patient is no longer a support but turns into a subsidy (redistribution of taxes through the state and municipal budgets or a separate health care budget). Second, support becomes anonymous, that is, the patient does not feel indebted to a specific person or a group of people, and he simply feels to have exercised his “right.” As modern and costly methods of treatment evolve, people naturally want to be cured according to these specific methods and thus continuously increase the need of support. As people get this support not from an individual or a group of individuals and do not feel any concrete obligations, the demand for support rises uncontrollably. This entails dual consequences: first, it triggers off permanent pressure to increase the funding of the health care system, and, second, the patient acquires the right to medical treatment regardless of the physician’s conclusions. In other words, the significance of mutual agreement between the patient and the doctor, and their mutual responsibility, vanishes entirely or shrinks quite markedly.

The first consequence raises the problem of how to redistribute the health care budget. The second effect poses the problem of the quality of treatment. The following will present analysis about the redistribution of the health care budget.

C. Compensating for health care services and medicines from the mandatory health insurance fund

It is laid down in the Law on Health Insurance that people insured in Lithuania are compensated for health care services (including medicines, treatment at sanatoria and resorts, and limb, joint and organ prosthetics) from the mandatory health insurance fund (MHIF). Health care services are covered from regional patient funds (RPF) in accordance to the basic costs which are determined by the Ministry of Health, under the terms and within the scope specified in the contracts between RPF and individual health care institutions. RPF reimburse to the insured only part of incurred expenses for over-quota services. The Law establishes the duty for RPF to enter into a contract for service provision with all state and municipal health care institutions and all willing and accredited health care establishments that have an operating licence. Health care institutions have no right to demand from the insured additional charges for health care services guaranteed by the mandatory health insurance. Health care establishments that have no contracts with RPF may apply free prices but they do not receive reimbursement from RPF.



The major problems related to the compensation of health care services are twofold:

- the amount of compensation does not cover all expenses for health care services,
- it is difficult to allocate compensation resources among health care institutions.

Although, according to the Law, patients have the right to choose a physician and a health care establishment, the ability to do so is significantly restricted by the size of compensation allocated to individual institutions. This is especially the case with patients who receive treatment in private health care establishment (it should be added though that even the Law does not ensure the right to choose an institution which has not concluded a contract with RPF). As fixed prices for health care services, which are mandatory when operating under the contract with RPF, are insufficient to set up a health care institution and to render quality services, some institutions choose to operate at free prices, but without the reimbursement. Private establishments operating under the contracts with RPF subsidise these services from other services that are not covered by mandatory health insurance, or sometimes they receive initial support for to set up an office (for example, the World Bank's project to provide financial assistance in setting up general practitioner's clinics).

Patients of private health care institutions with no contracts with RPF do not receive compensation despite the fact that they have paid compulsory health insurance contributions. This is the reason why the private sector has a limited number of patients. If health care institutions (not just the private ones) were allowed to apply prices higher than the established compensation, the price of private services would go down, and the services would be accessed by wider ranks of people. Legalizing this co-payment would lay down the foundations for the rise of private health care services and would promote competition among all health care institutions.

The essential reason why co-payment is not legalized is political, notwithstanding the fact that informal payments are the highest, as compared with other services.* Not a single government in Lithuania has recognised that health care services *de facto* are fee-paying. Disregard for the fact that material resources are scarce leads to creating patients' rights only in declarations rather than in reality, provokes corruption and into-pocket payments to doctors, inhibits managers of health care establishments from running institutions effectively, and distorts the motivations of the medical community.

Currently, a European model of compensating for health care costs is operating in Lithuania and is based on the mandatory health care insurance. Its basic defects have been determined by its nature – its mandatory and state dimensions. The first circumstance is to be blamed for shutting out competition in health care services, and the second is responsible for absent motivation both on the patient's and the doctor's side in using resources economically. The lack of resources in MHIF becomes quickly apparent, so the service provider is forced to limit resources with the help of administrative means – standardised charges, quotas, etc. The patient starts saving only when he has to pay himself, but this additional contribution should not be just symbolic.

* According to opinion polls, more than a half of the Lithuanian population pays physicians unofficially. The average amount of the bribe ranges from 90 to 160 litas (from 26 to 46 euro).



Limited health care resources can be distributed based on several principles:

- a) the cost of treatment should be covered in full but not of all diseases (for instance, only severe diseases and conditions),
- b) the cost of treatment should be compensated in full but only for certain social groups (for example, children, pensioners, and people with disability),
- c) the cost of treatment should be reimbursed in full but only for low-income individuals (by applying an income and property test),
- d) the cost of treatment should be compensated for all individuals but only partially (to legalize patient's co-payment).

Three of the said principles are applied in the Lithuanian health care system, however, inconsistently. One thing is that medicines are compensated for the treatment of diseases which are included in a special list of compensated diseases, except of stomatology. However, such compensation is provided for virtually all diseases. Treatment costs are covered in full for some social groups (for example, for children). Compensated medicines and health care services are charged additionally (however, the co-payment set for 100-percent reimbursed medicines is only negligible, while health care services are charged only in separate cases). Inconsistent application of principles of compensation is one of the factors reducing the effectiveness of the health care system and heightening patients' insecurity.

Compensating for health care costs according to the list of diseases. Theoretically, such principle has some advantages: first, its implementation would enable the control of the MHIF budget; second, people would be aware about the diseases that are compensated and would plan their expenses accordingly. However, it would be difficult to establish this principle because it is impossible to compile a list of compensated diseases objectively (according to severity, hazardousness of the disease, etc.). It is more complicated politically to provide coverage only for some of diseases, especially if they have been reimbursed some time earlier. Yet, if such lists were compiled, this would eventually prompt diagnosing more cases of compensated diseases or their stages (chronic, non-chronic, etc.).

Compensation of health care costs for certain social groups would be a step towards integrating the systems of social security and health care. Under such a model, health care resources would be redistributed in two directions – from the rich to the poor, and from the healthy to the diseased individuals. Looking from the point of view of demand, this integration would be quite logical although tough to implement due to feeble capacities of the public administration. However, belonging to a certain social category is an improper social criterion because then social groups are defined by law rather than are being based on the income level. If we adopt the attitude that medical treatment is service rendering to an individual and therefore an individual should pay for it himself and that only the needy should be eligible for support from others, then it would be logical to provide compensation according to an **income and property test**.

The most reasonable solution would be to compensate health care expenses for all patients but only partially. Given that health insurance contributions are mandatory and are collected



from all citizens, it is natural that all residents have the right to some amount of benefits in case of disease. Besides, it would be a politically favourable way out in not restricting benefits according to diseases or social criteria. Politically, it would be undesirable only to admit that all patients are covered only a certain portion of their health care expenses. But as it was explained in Part C, it is never possible, and will remain so, to cover absolutely all expenses.

If a certain amount of expenses is compensated, this can be structured in various ways, each of them having advantages and drawbacks. The following are the proposed schemes of compensation:

- 1) to cover a fixed amount when the price is fixed,
- 2) to cover a fixed amount when the price is free,
- 3) to cover a fixed percentage* from the fixed price when the retail price is fixed,
- 4) to cover a fixed percentage* from the fixed price when the retail price is free,
- 5) to cover a fixed percentage* from the free price,
- 6) to cover a growing percentage* subject to the amount spent on health care in the course of one year. Compensation would be started to be paid when the patient exceeded the limit set on average expenses for health care services per year,
- 7) to designate to all patients a certain amount, the remainder of which was accumulated in personal health accounts.

Let us discuss these different schemes of compensation:

	Redistribution from the diseased to healthy individuals (solidarity)	Patient's motivation to use resources rationally	Predictability of MHIF	Competition in prices of services and medicines
1.	+	Depends on the size of co-payment	+	-
2.	+	Depends on the size of co-payment	+	+
3.	+	Depends on the size of co-payment	+	- (with some reservations)
4.	+	Depends on the size of co-payment	+	+
5.	+	Depends on the size of co-payment	-	+
6.	+	+	- (in the short-run)	
7.	-	+	+	

* The compensation of a fixed percentage can be of several levels, depending on how hazardous the disease is to society, whether a certain medicine is vital for the patient and if cheaper substitutes of the needed medicine exist.



The only out of the presented schemes of compensation for health care services, scheme no. 7, does not redistribute funds from the healthy to the diseased individuals, that is, it does not implement the so-called solidarity of society which is one of the primary reasons why mandatory state health insurance has been introduced. (If all people had more or less similar maladies, expenses for health care could be financed through personal accounts, as it is with pensions.) We have mentioned this scheme of compensating because it is frequently proposed and is acceptable to part of society.

As the table shows, if compensation schemes no. 1-5 are applied, the patient's motivation to use resources rationally depend on the size of his co-payment. Currently, the size of the patient fee is meagre; therefore compensation schemes no. 1 (for health care services) and no. 3 (for medicines) do not motivate patients to economise resources of the MHIF budget. If co-payment was substantial, the patient, saving his own money, would assume greater responsibility in using his compensation ("free" services and medicines). If the patient is disinterested in doing so, it is needless to hope that the MHIF resources will be economised. First of all, subsidised services invariably inflate demand and deficit. Second, a physician should offer his patient the best method of treatment, which often means a maximal price. Third, administrative means of restriction imposed on physicians (for example, quotas) do not allow patients to choose quality, force physicians to fulfil secondary rather than primary functions, raise hostility among patients and doctors, and paves the way for corruption.

In any case, if compensation schemes no. 1-5 are adopted, it is necessary to introduce a tangible, not symbolic, co-payment for health care services and medicines in order to ensure an effective use of resources.

Ability to forecast the MHIF budget is an important criterion, however, it is not satisfied in the following two compensation schemes: when a fixed percentage is covered from the free price and when the patient is reimbursed only when he starts exceeding a set limit of health care expenses allowed per year. It is worth to note that in the latter case problems in projecting the MHIF budget would emerge only at the beginning. In several years it would be possible to discern trends in spending - how much funds people tend to spend for health care that exceed the set limit, - and the budget could be forecast with a reasonable error.

Seeking effectiveness in health care services, both for the sake of the patient and the system itself, it is crucial to have competition in prices. Although fixed prices do not eliminate competition entirely, they do undercut it substantially. Moreover, they do not build opportunities for new services to evolve or to enhance the quality of the existing ones. (Although, in fact, free retail prices are not a sufficient precondition to have optimal competition.) Currently, retail prices of medicines are free in Lithuania, but wholesale prices and the profit margin of pharmacies are fixed. This empowers some pharmaceutical manufacturers to subsidise a share of the co-payment through pharmacies. Such practice is beneficial to patients, however, it distorts competition and, most importantly, removes the patient's co-payment - the central source of (self-)restricting demand. Consequently, the use of MHIF resources is not transparent and predictable. To resolve this problem, it is commonly proposed to fix the retail price of pharmaceuticals. However, even if such



provision was laid down in the law, it would still be possible to subsidise medicines through pharmacies, while the crux of the problem would remain intact.

The major cause of this problem is in the compensation. Seeking to “use up” the compensation of a certain medicine, manufacturers subsidise the patient’s co-payment. If the manufacturer finds resources to subsidise the medicine through pharmacies, it means that he is able to lower its price. That is why information about such cases could be included among the criteria for setting the size of compensation of medicines, and at the next stage of negotiations the size of compensation could be reduced for such manufacturers.

The least number of pitfalls are in the compensation scheme no. 6 when the reimbursement is started to be paid only when the patient exceeds the limit set on expenses for health care per year. This limit could be set one both on services and medicines, or there could be two separate limits (as it is in Sweden). Under such a compensation scheme, a patient “with normal diseases” would cover expenses incurred for health care himself (from health insurance or out of the pocket), while patients with severe diseases would receive a progressive subsidy. This scheme would be favourable both as regards the motivation to use resources rationally and social solidarity. However, it would be utterly problematic to accommodate this scheme to the Lithuanian health care system because there is an extremely big differential in patients’ ability to pay. If the amount of co-payment is set such that it will be afforded by people at the retirement age, which comprise the largest portion of health care consumers, individuals with higher income would have ample opportunity to abuse the subsidy because the amount from which the subsidy is paid is rather small. For this reason, it would not be expedient to adopt this scheme in spite of its theoretical advantages.

Given the arguments provided here and the system currently existing in Lithuania, it could be concluded that the most appropriate and expedient compensation scheme in the country would be no. 2 and 4, that is, covering a fixed amount for health care services when the price is free, and compensating a fixed percentage from the fixed price for medicines when the retail price is free.

The size of compensation should be defined in accordance with the financial capacities of MHIF and based upon the statistics of morbidity, the rate of consumption of medicines and research. In addition, the following factors should be taken into account: first, the virulence of the disease; second, the importance of medicines and services for the diseased individual; and third, the existing alternatives of treatment in terms of the price.

A hundred-percent compensation should be provided only in cases which are agreed upon by the medical community, such as medicines for the treatment of severe and contagious diseases (tuberculosis) and medicines and services indispensable to sustain life (insulin, pain-relievers, etc.). Vitally indispensable treatment and pharmaceuticals that have no cheaper substitutes should be reimbursed in a relatively higher rate.

The effective Law on Health Insurance specifies that the manufacturer’s price used in calculating the basic price of compensated medicines and medical aids should not exceed the minimal compensation level of corresponding prices applied in EU countries more than five percent. Although this provision is rational in that it provides a clear-cut criterion, yet it is



unrealistic: the Lithuanian market is not attractive enough to have prices the lowest in entire Europe. In the course of implementing the Law, this problem has been perceived, and a more flexible method is now applied in practice. On the other hand, the scope of compensation existing in other countries may well serve as a source of information in establishing the compensation both of medicines and services, even more so that after Lithuania's accession into EU prices will be converging at a faster pace. However, the landmark for Lithuania should be the average, not the minimal, compensation applied in EU countries.

D. Institutional aspects

Formally, health care in Lithuania is funded from health insurance but as insurance is state-run, mandatory and monopolistic, the contribution of health insurance has actually all features of a tax. So in a general sense we can refer to it as to a subsidy from the budget. Patient accounts receive capital funding from the personal income tax, however, they duplicate the majority of functions carried out by municipalities. But given municipalities' weak institutional capacities, it would be too risky to transfer the functions of patient accounts to them. More than that, municipalities would clash at their own interests as they are owners of the majority of health care institutions and patients' representatives at the same time. On the other hand, in a balanced system, municipalities should represent people's interests by purchasing health care services from the most effective providers. Today decisions about the acquisition of services are made and contracts with service providers of services and medicines are signed by patient funds, which, being a non-political institution, basically fulfil political functions. The criteria for selecting the said items are not adopted, and this builds conditions for discrimination.

Municipalities, in their turn, being obliged by the Law on Local Self-Government to organize primary health care for residents, use additional leverage, such as restricting permits to private service providers (in primary health care) based on the principles of territorial distribution, years in operation, etc.

Given the above mentioned multiple criteria and municipalities' feeble institutional capacities, the functions should be improved in the following way:

- by removing municipalities' obligation to organize primary health care for residents, by retaining their duty to organise public health care and to exert influence on the health care system through rendering social support to those who are unable to pay additionally;
- by privatising all institutions of primary health care;
- by incorporating representatives from municipalities into taking decisions at regional patient funds. No longer being the owners of health care service providers, they could represent patients' interests in buying services for resources from MHIF.

Another problem that was identified a long while ago, but that has not been settled so far, is the ownership of assets of health care institutions. Presently, these assets belong to the founders of these institutions – the municipalities and the state, while health care institutions



administer them only on the basis of trust. Fixed assets (buildings, equipment) are not reflected in the balance sheet of these institutions that are public by type of organisation. This essentially distorts their financial accounting and leads to ineffective decisions.

This circumstance also acts as a considerable drag on the processes of restructuring.

In addition to that, such situation poses a weighty and negative influence on the mechanism of financing. As fixed assets do not belong to health care institutions, they have no right to calculate depreciation of these items as costs. Thus the compensation from the MHIF budget does not encompass depreciation, which moves health care institutions to search for other funding sources for such items as repair works or acquisition of equipment. These sources usually turn to be various government programmes financed from the budget (that usually have completely different goals) or internal resources (this, as a rule, harms other needs of patients and personnel).

The reasons why the problem is not solved by giving fixed assets into the hands of health institutions are political. If assets were handed over to institutions, it would appear that some health care establishments (of tertiary health care in particular) are forced to declare bankruptcy according to the results of the existing financial accounting.

2. Proposals

Building conditions for private health care

- Patient funds should pay the set compensation for health care expenses to all patients, irrespective of the forms of ownership of health care institutions and prices charged by them.
- All health care establishments – both public and private – should have prices of their services and have to disclose them publicly.
- All health care institutions must issue to patients financial documents, verifying their payments.
- Fixed assets needed for activity, which are administered on the basis of trust, should be transferred to the balance-sheet, and accounting should be settled accordingly.
- Health care institutions should not receive any other funding from the budget, only the compensation for patients from patient funds (when fixed assets are handed over to health care institutions, their depreciation could be calculated as costs), except unless resources for specific programmes whose accounting is carried out separately (for instance, for scientific research or education).
- Quotas on services and compensated medicines, assigned to health care establishments, should be altered based on other mechanisms of restricting demand (see below).
- It should be laid down in the Law on Corporate Profit Tax that companies' expenses incurred to provide supplementary health care insurance for their employees are attributed to costs and the profit tax is not calculated from them.



- The provision should be removed from the Law on Income Tax of Individuals which stipulates that supplementary health care insurance purchased by the employer should be treated as the employee's non-cash income.

Compensating for health care expenses

- a fixed amount of health care expenses should be covered for the patient's visit in primary and secondary health care and a fixed differing amount for services provided in tertiary health care should be compensated according to the list of services compiled by the Ministry of Health;
- a fixed percentage from prices that were agreed upon with manufacturers should be reimbursed for medicines. The size of compensation for individual groups of pharmaceuticals should be differentiated by setting a different percentage;
- the list of compensated medicines should be abolished and expenses for all pharmaceuticals that are registered to cure compensated diseases should be covered;
- only medical, not social, criteria should be applied in rotating the compensation for services and medicines, that is, different criteria for compensating based on the patient's belonging to a certain social group should be eliminated. Social problems should be solved by the means of social support;
- the size of compensation should be set according to financial capacities of MHIF, morbidity rate, existence of cheaper alternatives of medical treatment, and the average size of compensation applied in EU countries;
- a hundred-percent reimbursement of services and medicines should be provided only in exceptional cases.

Promoting competition and effective services

- patient accounts should treat equally all legally operating health care institutions, regardless of the form of their ownership and methods of treatment applied;
- the algorithm of treatment should be adopted only as recommendatory and should not be linked to the compensation from patient account or its size;
- retail prices of health care services and medicines should not be regulated;
- health care institutions should be privatised, those rendering primary health care services in the first place;
- the management of non-privatisable health care institutions should be transferred into private hands;
- the establishment of private health care institutions should not be limited according to the principles of territorial distribution, years in operation and other non-qualification principles;
- the law should envisage that payments from the state budget into MHIF for state "insured" individuals cannot be smaller than the average of normal contribution to MHIF;
- patient funds should be made to conform to the law and implement their duty of paying penalty fees for delayed payments;
- philanthropic incentives of health care institutions should be encouraged by laying down in the Law on Corporate Profit Tax that expenses incurred by health care



institutions in providing services without getting remuneration are attributed to their costs and thus reduce the taxable profit. Also, they should not be classified as income received by the individual.

Launching the reform

The proposed health care reform should be launched by handing over fixed assets administered on the basis of trust to public health care institutions (the best solution would be transform them into companies with shared capital as well). This would create conditions to improve the funding, that is, to calculate depreciation of fixed assets as costs of health care institutions covered from MHIF, and would also allow the improvement of institutions' financial accounting. Without these changes, it is impossible to better the effectiveness of management of health care institutions: neither the planned restructuring nor the private sector (as a purchaser or a temporary manager) would help attain these ends. At the same time the existing discriminatory restrictions should be removed that inhibit the setting up of private health care institutions of all levels; the new ones should not be imposed. Also, the ban should be lifted from private health care establishments, operating under the contract with RPF, to charge patients (in addition to the compensation) for their services.

When the financing of public health care institutions is reformed so that they receive funding from a single source – the MHIF budget, they could be obliged to set and declare prices of all of their services. At the start, it would be expedient to levy a symbolic charge, for instance, 3 litas (0.7 euro) for a visit in primary and secondary health care, 5 litas (1.4 euro) per day in tertiary health care, 5 litas for an ambulance service, etc. Given the existing practice, there is no need to be concerned that prices will go much higher than the set compensation. Quite the contrary. Institutions will take some time to disclose their prices because of objective reasons (they will need time to balance and set the prices) and because of certain interests (the introduction of co-payment will diminish the possibility of informal payments). Moreover, competition will prevent health care institutions from pushing prices too much up, especially if favourable conditions are ensured to set up and run private health care institutions.

In line with prices of health care services, the market for health care services will emerge: competition will force institutions to boost the effectiveness of management, the quality of services and attendance and the variety of services. When the size of co-payment is settled, people's interest in private health insurance will be piqued. When patients start paying fees for health care services, the final decision in what treatment to take will depend not just on the physician's recommendations but also on the patient's priorities (money, time, etc.). This will lead to revoke quotas on health care services.

It would be expedient to expand the list of compensated medicines into the list of compensated diseases, that is, to cover a fixed amount of expenses for all medicines registered to treat compensated diseases. This would increase the assortment of pharmaceuticals and the competition among manufacturers, which would mark down the price of their products (along with the reimbursement from MHIF). Also, it would be desirable to shorten the list of 100-percent compensated medicines and to introduce more levels of compensation of medicines. In establishing the size of compensation, the guideline



A study by the Lithuanian Free Market Institute (LFMI) (2003-2004)

should be the average, not the minimal, size of compensation of corresponding health care costs in EU countries (the Law on Health Insurance should be amended accordingly).

The major pitfalls in adopting this scheme in Lithuania would be related with the health care of low-income individuals. For this reason, co-payment in health care establishments should be instituted gradually, in parallel with the birth of a competitive market in this sphere. In addition, integration of health care and social security policies should be stepped up, so that people unable to pay additionally could be extended social support in their municipalities.

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