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The opinions of the key health care stakeholders towards patient payments in Lithuania

Key words: health care, patient payments policy, evaluation, Lithuania

Introduction

Patient payments are considered to be a significant issue in health policy across Europe. Although these payments constitute a relatively small share of the overall health care expenditure in a country, the accumulated patient charges may claim a major part of the household budgets especially among low-income patient groups and frequent health care users.

In Lithuania, there is also an essential social and policy debate on whether introduction or increase of patient payments would impose an additional financial burden to patients that could make essential health care unaffordable for vulnerable groups. This concern has never been explored in Lithuania systematically and therefore, the evidence reported in this paper appears important for the development of consistent patient payment policy.

In particular, the aim of the paper is to evaluate the opinions and attitudes towards patient payments in Lithuania. For this purpose, qualitative and quantitative research methods were applied in the study – focus group discussions and in-depth interviews combined with a self-administrated questionnaire filled in by each participant. The paper focuses on results relevant to policy.

Patient payments for public health care services in Lithuania

Statistical data of the recent years show that the direct household health expenditure in Lithuania constitutes a major part of the private health care expenditure in the country (the latter was almost 27 percent of the total health expenditure in 2007). Within the total household expenditure, about 5 percent is related to health, which in 2007 meant 139 EUR per year. Direct patient payments for both public and private health care services approximated 14 EUR per year. This average figure seems to be quite small, however certain groups of the population experience a significant burden of the out-of-pocket payments for health care. A survey revealed that every fourth adult among the 7 percent of adults in need of care, who did not receive medical treatment, could not afford to pay for the service. The same could be said about almost every second person among the 9 percent of those earning the lowest income [1]. It is also important to mention that private out-of-pocket payments constitute a stable source of financing for the public health care providers. Consequently, the issue of patient payments could hardly be considered a negligible one.

The review of the Lithuanian legal documents referring to patient payments revealed a lack of consistency in policy on patient payments since the issue is not comprehensively addressed. There appeared to be only general rules for patient payments set by the main legislation (Health System Law, 1994, and Health Insurance Law, 1996) [2, 3]:

1. The services are charged (reference prices should be applied) for:
   - non-residents (in the absence of particular agreements);
   - non-insured under obligatory health insurance arrangements;
   - non-registered by GP;
   - non-referred by GP.
2. The services under the negative list of services should be paid directly (according to the uniform pricelist and adjustment rules). An enforcement of the legal provision on possibility to charge so called additional health care services provided upon the request of the patient is unclear.

Additionally, Health System Law (art. 49) also defines cases when patient payments might be applied:

– when a patient on his own initiative chooses more expensive health care services, materials and proce-

dures than is set up, and covers the difference (e.g. hip joints, eye lenses, odontological materials in the outpatient clinics);
– when a patient on his own initiative chooses additional services or procedures (e.g. single bed wards in the hospital);
– co-payments for drugs (reimbursed is the basic price only), regulated in the Law on Health insurance (article 10);
– medical rehabilitation and sanatorium treatment.

Emergency health care is free for anyone in need in Lithuania. The insured population is eligible for all publicly financed health care services. Payments and co-payments for medicines present the major (about 75 percent) share of private health care expenditures.

Health care institutions exploit the existing uncertainty successfully asking patients to co-pay (contribute) for the provided health care services. The prevalence of existing practice varies across the country. Different health care stakeholders raise the question of legibility and ethics of the existing practices. A debate on tactical decisions (managerial actions) is continuing among various stakeholders, whereas the principal aim of patient payment policy remains unclear for all. Therefore, the paper focuses on this question considering the perspective of various health care system stakeholders.

Methods and materials

The evaluation of opinions and attitudes towards patient payments in Lithuania was done using qualitative and quantitative research methods. Focus group discussions and in-depth interviews were carried out in Lithuania in April–July 2009. Each participant in the study was also asked to fill in a self-administrated questionnaire. Four target groups were addressed in the evaluation: health care consumers (including working individuals, families with children, pensioners, students, disable and chronically sick individuals and individuals living in rural areas), health care providers (including GPs, out-patient specialists, physicians and nurses in city hospitals, GPs practicing in rural areas and physicians in district hospitals), health insurance representatives (including social health insurance representatives at national and regional level) and health policy-makers (including health policy-makers at national and regional level, financial policy-maker at national level and the chair of the three-party committee on health care in the country). The data among policy-makers and health insurance representatives were collected via face-to-face semi-structured in-depth interviews (10 respondents were interviewed in total). Focus group discussions were performed with health care consumers and providers – in total, 94 respondents representatively selected from all over the country. All target groups were surveyed additionally using the self-administrated questionnaire and the quantitative data were analysed using statistic methods.

Results and discussion

Attitudes of the various stakeholders' towards patient payments in Lithuania reflect a non homogenous opinion varying from strong negative opinions (expressed mainly by Lithuanian pensioners and working respondents, who have children under 18) to rather positive (expressed by family physicians working in rural areas, physicians working in rural and urban hospitals).

What do we mean by "official out-of-pocket" payments in the public sector?

The definition of "official out-of-pocket" payments in the public sector was first discussed with all the groups of respondents. Surprisingly, different understandings were behind this concept and the variation in understanding was inherent for all groups of respondents. The issue of how we should define whether the facility is a public one was also raised: either by the legal status of the facility or due to the dominance of the state/municipal ownership on it, or based on the major source of financing (e.g. the SHIF (State Health Insurance Fund)) that the facility receives.

Regarding "legality" of patient payments, the following two very extreme positions were defined by all groups of respondents:

- An opinion that there is no proper legal basis to speak about official or legally recognised co-payments and/or even user charges – this position was expressed mostly by the health system managers.
- And also the opinion that "official" payments presuppose a director's order or price-list where patients could obtain information about the fee of the local provider, and patients should also receive a receipt for the payment – an opinion expressed by health care consumers and providers.

Research results also showed that it is often too unclear when and why the patient should pay for health care services. One of the clearest points at the moment is the payment according to the negative list of auxiliary medical services (approved by the Ministry of Health). These services are a subject of user charges in the Lithuanian public health facilities, and the participants in the study referred frequently to these payments, especially when it is on their own choice and when there is a discrepancy between the possibilities to provide/receive respective services free of charge. Many questions came up during the study but the most important could be fomulated as follows: who has an interest and should have the power to decide on patient payments – medical doctor, chief of the facility, the Minister by issuing decrees?

What should be the main goals for the patient payments introduction?

The study revealed that there is no uniform opinion regarding the aims of the introduction of patient payments in Lithuania. Three main options were distinguished and mostly discussed in all stakeholder groups:

Changing behaviour of patients:

- Cutting excess consumption (in case of free-of-charge health care provision) by the introduction of fees for health care services (i.e. introducing consumer prices).
- Punishing risky behaviour since individuals with an unhealthy lifestyle use health care more frequently and pay higher accumulated charges than persons with a healthy lifestyle.
- Inducement for increasing awareness about the raising health care costs.

Actually, the above points refer to the belief that health care consumers could be educated to be more rational and optimize their needs/demands for health care services.

Changing behaviour of physicians:

- When patients pay to the physicians for services provided, this could create incentives for increasing quality of care by making physicians more sensitive to patients. It is interesting to note, that more physicians rather than patients spoke about this possibility and the idea was disliked commonly.
- Official fees could help combating with unofficial payments. Though the respondents see some possibility to reduce the bribes by the introduction of formal patient charges, the scope of this impact is not expected to be a significant one. In general, it could be concluded that the system of official patient payments is an additional one and managed according to the "statistical average" (relatively small payments, protectors set on general not individual criteria). Therefore, it could not seriously "damage" the individualised bribe pattern.

Generating revenues for the health care sector:

- According to the statistical data of the survey conducted via the self-administrated questionnaire, respondents considered that allowance to generate additional resources for the health care system (23.5%) is the principal aim of the official patient payments policy in Lithuania (**Figure 1**). Abreast, the ability to generate additional resources for the health care institutions is significantly important as well. As indicated by Figure 1, the least important aim of the patient payment policy appeared to be the objective to control the overall health care expenditure.
- An important difference in opinions was observed between the stakeholders groups. Health service providers and policy makers identify more frequently that discouraging unnecessary use of health care services should be the main aim of the patient payment policy. Whereas consumers tend to think that official patient payment policies should aim to generate more resources both for the health care system as well as health care institutions. Obviously this dichotomy of positions reflects a general disparity in the understanding of patient payment policy in the country.

What mechanism of official patient payments should be set up?

In the survey, respondents were asked to identify the potential beneficiaries of the patient payments (**Figure 2**). All stakeholder groups recognized that health care institutions providing services should be the beneficiary of the official patient payments. It appeared that neither state, nor territorial patient funds were prioritized as the potential beneficiaries. The problem of transparency, especially in collecting and distributing the revenues from patient payments (if it was performed by state and regional health funds) was strongly underlined in the focus groups discussions. This picture may disclose a general lack of trust in the state agencies in the country.

Some respondents stated that patient payments could be used to share the expenditure since the scarcity of the public funds is mostly presented as a reason or even necessity for the introduction of private payments for health care. Nevertheless, only a few respondents believed in this way of mobilising resources for health care. Commonly, people are sceptical about it because they do not believe that it is a substantial source of additional fund-

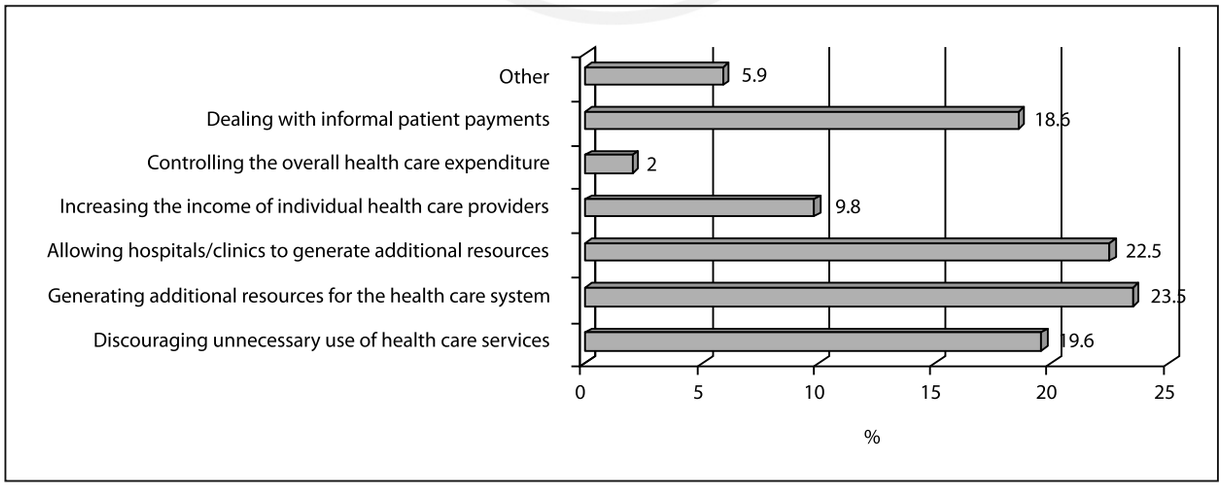

Figure 1. *Aims of patient payment policies.*

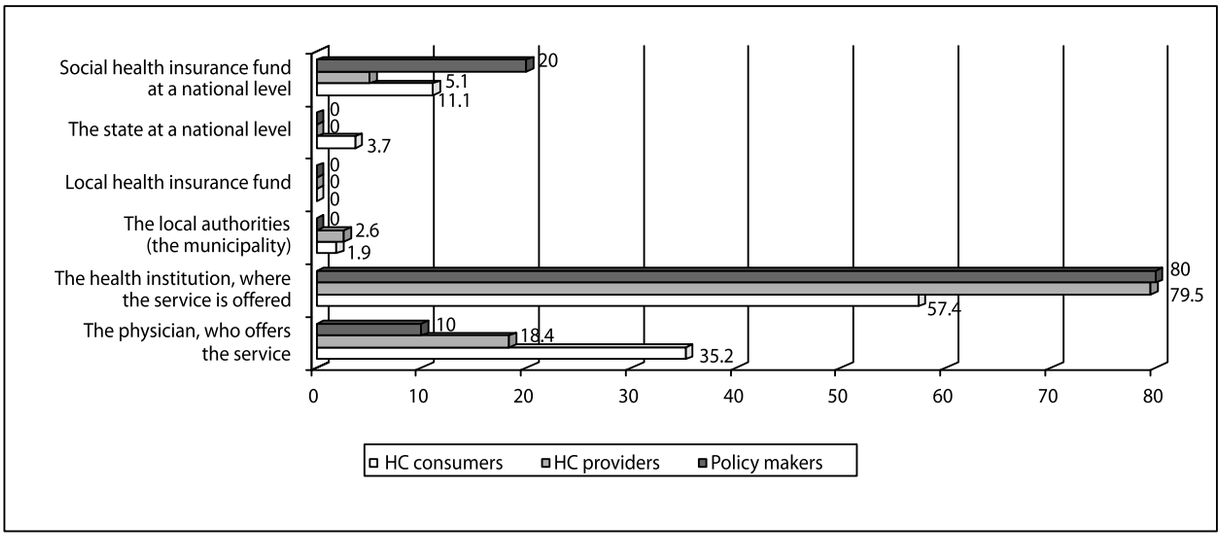

Figure 2. *Beneficiaries of patient payments.*

ing. One reason relates to the belief in mass poverty – "people do not have the money to pay more". The second reason is related to the social tension appearing due to the payments imposed, leading to the introduction of privileges/exemptions and consequently, not collecting sufficient revenues. The third reason is more technical – "collecting the payments will cost more than the inflow".

Regarding the later consideration, the issue of social justice appeared. Apparently, it is one of the hottest questions on the policy agenda. Respondents, especially in the health care consumers groups, identified the problems of two classes of medicine, VIP services, social privileges – various wordings for the description of current inequity problems. At the same time, it should be noted that the basic health system financing based on social solidarity is constructed in such a manner that rational behaviour is not appreciated. Individuals in extreme, vital need are the "winners" by getting most expensive services. One more aspect is considered – that the pensioners are the main mass consumers of health care.

Survey data revealed that the vast majority of stakeholders who participated in the survey expressed a rather strong support that some population groups should pay reduced fees or should be exempted from patient payments (**Figure 3**).

The issue of social justice was also challenging, though all stakeholder groups identified univocally that children and disabled people should be exempted or have reduced fees for health care services (difference in opinions in various respondent groups was statistically significant, $p < 0{,}001$) – **Figure 4**. In focus group discussions, family physicians both in cities and rural regions supported strongly the opinion that disabled persons should be exempted from payments.

Attitudes of key stakeholder groups towards official patient payments

The survey data collected via the self-administrated questionnaire showed that the respondents taken as general groups neither agree nor disagree with the existence of official patient payments in Lithuania (5-point Likert scale from 1 = strongly disagree to 5 = strongly agree; mean = 3.42; 95% confidence interval: 3.14–3.70). However, as indicated by figure 5, the means of the attitude in different groups of respondents vary. Health care consumers expressed the most negative attitude towards official patient payments (mean = 2.62; 95% confidence interval: 2.28–2.97) and the difference between attitudes of health care providers and policy makers is statistically significant ($p < 0.001$). The most positive attitude towards the introduction of official patient payments was expressed by policy makers and health insurance representatives (considered as the "others" on **Figure 5**), who took part in in-depth interviews (mean = 4.3; 95% confidence interval: 3.4–5.2) and health care providers, though the difference of attitude means between policy makers and providers was not statistically significant ($p > 0.05$).

As indicated by the focus group discussions, a rather negative attitude towards the introduction of patient payments in the country was expressed in all health care consumer groups (working and pensioners in cities and rural areas, also disabled people). Consumers fear that this will limit the accessibility to health care services especially for population groups with low income. Quality of health care services is another key issue worrying all the consumer group respondents: there is little belief that the quality of services will improve with the introduction of patient payments.

Health care providers, who expressed a positive attitude towards patient payments, presume that these payments will decrease the excess consumption of

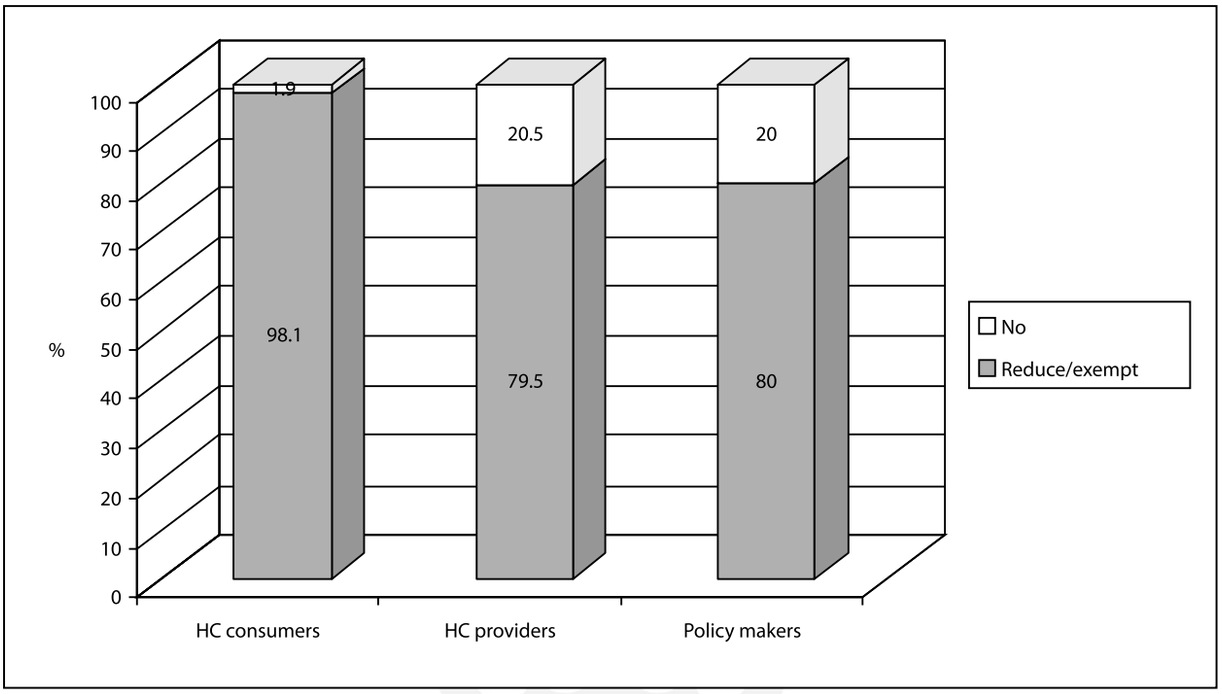

Figure 3. *Opinion on exemption or reduction of particular social groups from patient payments according to different stakeholder groups.*

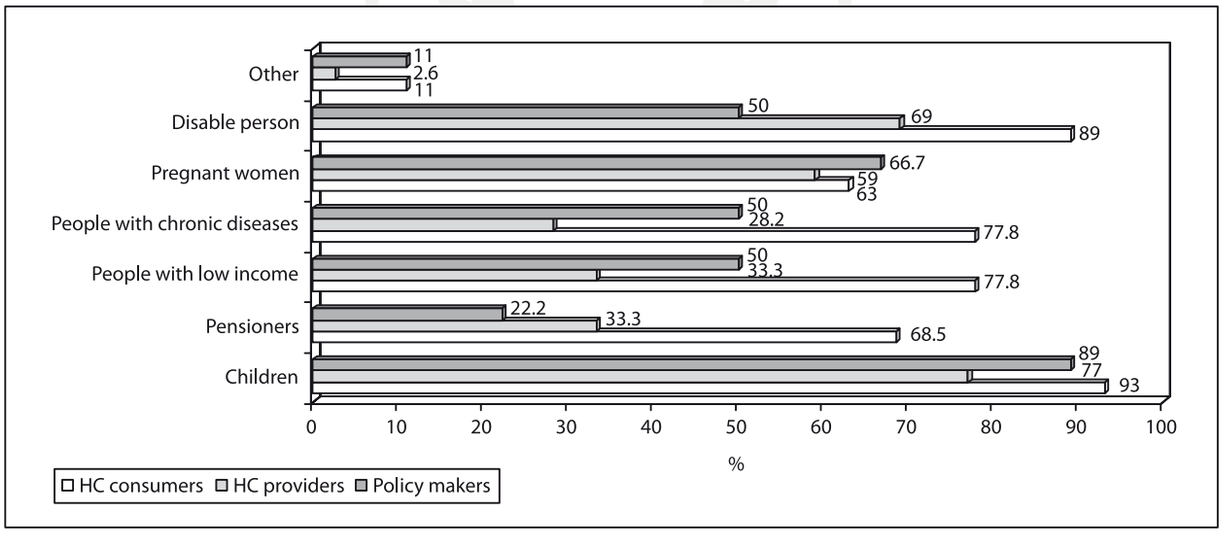

Figure 4. *Society groups, who should be exempted or pay reduced fee for health care services.*

health services and will optimize the working load of physicians. Besides, they consider that patient payments should be consistent with the economic situation in the country.

Overall, it seems that the direct private financing is still considered to be a complimentary mechanism. Therefore, a shift to the debates on the values behind the basic system was unavoidable. Within the current system, when the vast majority of funding is coming from the state funds, there is also an approach to private payments as an element of market filling in the gaps of the basic system by more flexible usage of available resources on the provider side. Only regarding the services chosen by the consumers, providers could be awarded by additional revenue. This consumer choice is the trickiest point: is it relevant for instance that now the patients could choose (and pay for) medical examinations though they are not necessary for diagnostics in the medical doctor's opinion?

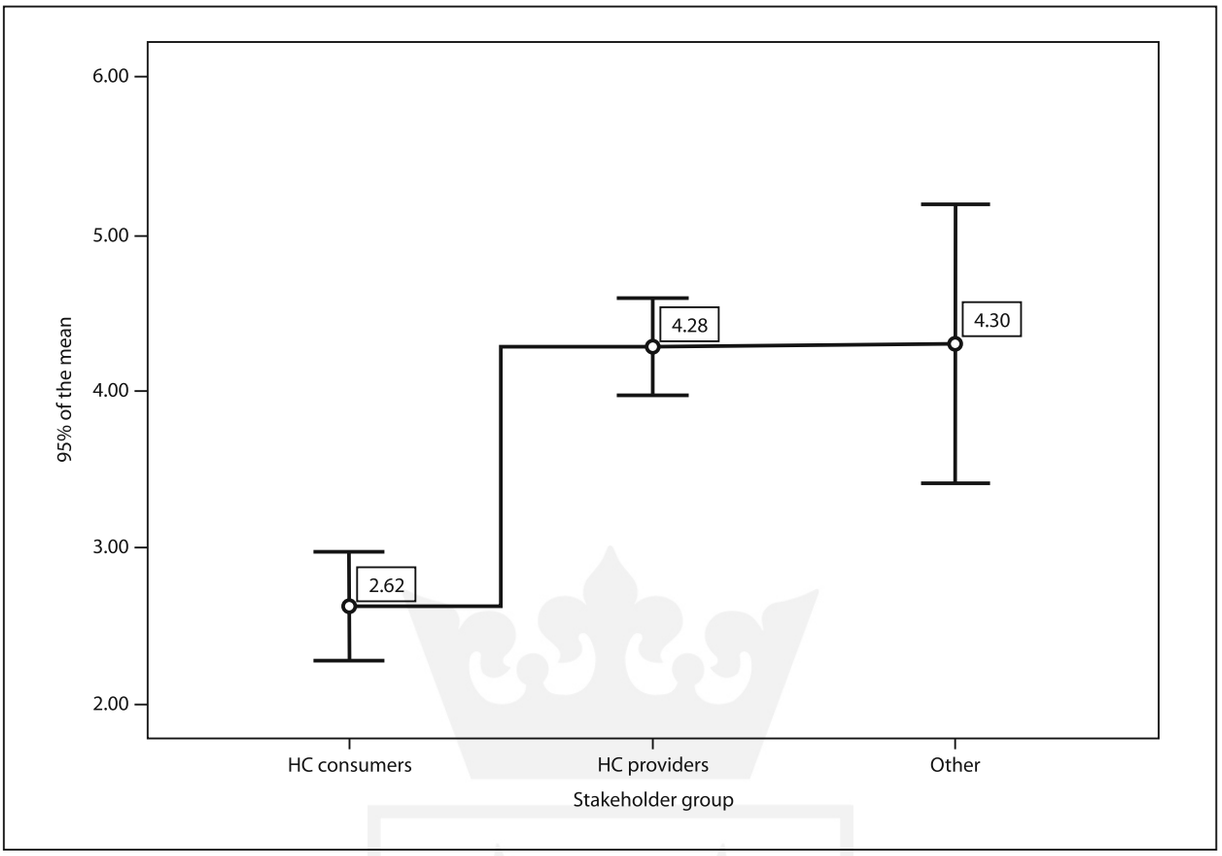

Figure 5. *Attitudes of key stakeholder groups towards official patient payments.*

In any case, in practical terms, more discussions on reasons for these or those actions are needed.

Finally, "consensus" was reached, not on the content – how the issue should be tackled. It was agreed that the policy should be changed, reviewed and updated.

Conclusion

The results reported here show that there is no consistent policy on patient payments in Lithuania. Obviously the attitudes of various health care stakeholders are not homogenous. Health care consumers are rather resistant towards the introduction of patient payments though if they support patient payments it would only be in case of improved quality of health care services. Health care providers sustain patient payment policy considering the needs of health professionals and health care institutions (higher salaries, better working conditions, more sophisticated medical techniques). Health policy makers and health insurance representatives remain dispersal in their opinions. While supporting the introduction of official patient payment, they expect systematic changes of health care system and higher flexibility. As a main conclusion it might the said, that this issue needs more research, more conceptual and strategic thinking in defining the aims of the patient payment policies in Lithuania and its governance rather than discussing the means of actions.

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Abstract:

Patient payments are considered to be a significant issue in health policy in Lithuania. Despite the unclear legislative framework, health care institutions are asking patients to co-pay (contribute) for services provided to them. Thus, patients and providers are facing challenging situation in legal, ethical and financial terms. The aim of the study was to evaluate the opinions and attitudes towards patient payments in Lithuania. Qualitative and quantitative research methods were applied in the study – focus group discussions and in-depth interviews combined with a self-administrated questionnaire filled in by each participant. The results suggest that there is no consistent policy on patient payments in Lithuania. Health care consumers are rather resistant towards the introduction of payments (they support fees only in case of services with better quality). Health care providers sustain patient payments considering the needs of health professionals and health care institutions. Health policy makers and health insurance representatives remain dispersal in their opinions. More conceptual and strategic thinking in defining the aims of patient payment policies in Lithuania and its governance is needed.

Streszczenie:

Opinie kluczowych udziałowców systemu opieki zdrowotnej na temat dopłat pacjentów na Litwie

Słowa kluczowe: opieka zdrowotna, polityka dopłat pacjentów, ewaluacja, Litwa

Dopłaty pacjentów są istotną kwestią polityki zdrowotnej na Litwie. Pomimo niejasnej podstawy prawnej placówki opieki zdrowotnej zobowiązują pacjentów do współpłacenia za świadczenia im dostarczane. Dlatego też zarówno pacjenci, jak i świadczeniodawcy znajdują się w niejasnej sytuacji pod względem prawnym, etycznym i finansowym. Celem prezentowanego badania było uzyskanie informacji na temat opinii i stosunku wobec dopłat pacjentów na Litwie. W badaniu zostały zastosowane jakościowe i ilościowe metody badawcze: zogniskowane wywiady grupowe oraz pogłębione wywiady, połączone z kwestionariuszem ankietowym wypełnianym samodzielnie przez każdego uczestnika badania. Wyniki wskazują na brak na Litwie spójnej polityki w zakresie dopłat pacjentów. Konsumenci opieki zdrowotnej są raczej przeciwni wprowadzeniu dopłat. Popierają dopłaty jedynie w przypadku świadczeń o wyższej jakości. Natomiast świadczeniodawcy opieki zdrowotnej popierają dopłaty, zważając na potrzeby profesjonalistów medycznych i placówek opieki zdrowotnej. Decydenci polityczni i przedstawiciele instytucji ubezpieczeń zdrowotnych prezentują opinie zróżnicowane. Wyniki badania wskazują, iż konieczne jest bardziej koncepcyjne i strategiczne podejście do polityki dopłat pacjentów, jak i też definiowania jej celów.

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