Access to health care
and the financial burden
of
out-of-pocket health payments
in Latvia
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The views expressed in this "Technical Brief for Policy-Makers" are those of the authors, and do not necessarily reflect the official position of WHO.
ACCESS TO HEALTH CARE
AND
THE FINANCIAL BURDEN OF
OUT-OF-POCKET
HEALTH PAYMENTS IN LATVIA

by

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Matthew Jowett, Joe Kutzin and Aiga Rurane

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1. Basic Country Information

Latvia is located on the eastern Baltic coast. Its total population was 2.3 million in 2006. It gained independence from the former Soviet Union in 1991 and became a European Union member in 2004. Gross domestic product (GDP) per capita was 4913 Latvian lats (Ls) or US$ 8851 in 2006. Life expectancy at birth is 65 for males and 76 for females. Infant mortality is 8 out of 1000 live births.

2. Key features of the Latvian health financing system

Latvia spent 6.4% of its GDP on health in 2005, the highest of all the Baltic countries (5.9% for Lithuania and 5.0% for Estonia). Per capita health expenditure was Ls 296 (US$ 533). The state compulsory health insurance scheme covers the whole population. Unlike other national insurance systems where the main funding is from payroll tax and other contributions, in Latvia since 2005, national insurance is funded from general government taxation.

Overall government spending has been increasing in Latvia in recent years and accounted for 63% of total health expenditure in 2006. Meanwhile, out-of-pocket health expenditure (OOP) as a share of total health expenditure decreased to 35.8% in 2006 from 45.5% in 2002. However, the share of out-of-pocket payments in total health expenditure is still higher in Latvia than in Lithuania (29.5%) or Estonia (24%)

Table 1. Main indicators of health system financing

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure on health (THE) as % of GDP</td>
<td>6.2%</td>
<td>6.1%</td>
<td>6.8%</td>
<td>6.4%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Per capita health expenditure in US$ (at exchange rate)</td>
<td>246</td>
<td>292</td>
<td>402</td>
<td>443</td>
<td>533</td>
</tr>
<tr>
<td>General government expenditure on health (GGHE) as % of THE</td>
<td>51.8%</td>
<td>52.4%</td>
<td>58.6%</td>
<td>60.5%</td>
<td>63.2%</td>
</tr>
<tr>
<td>OOP as % of THE</td>
<td>45.5%</td>
<td>46.1%</td>
<td>40.6%</td>
<td>38.6%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Private prepaid and risk-pooling plans as % of THE</td>
<td>2.7%</td>
<td>1.5%</td>
<td>0.8%</td>
<td>0.9%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

Source: WHO National Health Accounts 2008

Health financing scheme in Latvia is organized principally through public health insurance. Voluntary health insurance is very small scale. However, the health services covered by the public insurance scheme are not clearly defined. All services require cost-sharing, which is referred to as patient fees. A ceiling exists on patient fees, with each person liable for up to Ls 150 (US$ 283) per year; if any additional fees are incurred,
the patient is exempt. However, the exemption only applies to services, not to drugs. Patients pay the full price of all over-the-counter drugs and a significant number of prescription drugs for outpatient use.

Outpatient drugs covered by the insurance are limited to certain medical conditions, such as diabetes, cancer and mental disorders. Inpatient drugs are covered by the insurance as part of the treatment cost.

3. Key evidence for policy

Whose health service needs are not met?
In 2005, 30% of the population did not access the health services they needed. Lower income groups were less likely to access necessary services than higher income groups. Females were less likely to access required services than males (Figure 1). Among the reasons for not seeking care, 56% of non-users reported financial constraints. For the poorest quintile, over 70% of people reported financial constraints as the reason for not accessing services, compared to only 25% of people in the richest quintile. Another 25% of people in the richest quintile reported long waiting lists as a reason for not seeking care (Figure 2).

Who pays how much and on what services?
Households' OOP include cost sharing for services covered by the insurance, the full cost of services not covered by insurance, outpatient non-prescription drugs, some prescription drugs and some informal payments.

In 2006, the average monthly household OOP was Ls 14.5 (US$ 27.4) which was 4.7% of total household expenditure (EXP) and 7.3% of household's capacity to pay (CTP), which is measured in terms of household non-subsistence expenditure; this compares with 4.0% and 8.8% respectively in Estonia in the same year. Between 2002 and 2006, household OOP increased both in absolute terms and as a share of total household expenditure (Table 2).
Table 2. Monthly household OOP

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly OOP (Ls)</td>
<td>7.60</td>
<td>9.37</td>
<td>11.53</td>
<td>12.93</td>
<td>14.52</td>
</tr>
<tr>
<td>OOP/EXP</td>
<td>4.09%</td>
<td>4.26%</td>
<td>4.66%</td>
<td>4.86%</td>
<td>4.69%</td>
</tr>
<tr>
<td>OOP/CTP</td>
<td>6.85%</td>
<td>6.92%</td>
<td>7.40%</td>
<td>7.73%</td>
<td>7.27%</td>
</tr>
</tbody>
</table>

Higher income groups spend much more on health services compared to lower income groups in absolute terms. In 2006, the average OOP for the richest quintile was Ls 25.6 (US$ 48.3), while it was only Ls 5.9 (US$ 11.1) and Ls 10.9 (US$ 20.6) for the two poorest quintiles respectively (Figure 3). However, when measured as a percentage of EXP or CTP, lower income groups spend a much larger share. This pattern holds from 2002 to 2006. In 2006, OOP comprised of 5%-6% of EXP for the lowest two quintiles and 3% for the richest quintile.

The policy of having an OOP ceiling at Ls 150 per person per year mainly benefits higher income households. In 2006, the average annual per capita OOP for the three lowest quintiles was less than half of Ls 150 and hence very few of the poor would be eligible to benefit from this policy.

In 2006, more than 60% of OOP was on drugs, compared to a lower average share of around 53% in Estonia. Only around 27% of OOP in 2006 was on outpatient services. There are significant variations across quintiles. Drug expenditure was more than 80% of household health spending among the poorest quintile, while it was less than 50% among the richest quintile (Figure 4). A similar pattern is observed in previous years.
What is household financial burden by health payments?

It is not desirable in any system that households reduce other necessary spending in order to cope with medical bills. In 2006, the survey showed that 8.2% of households or around 73,000 households (corresponding to around 128,000 individuals) spend 20%–40% of their non-subsistence expenditure on health and 3.2% of households or around 28,000 households (corresponding to around 45,000 individuals) spend more than 40%, which is considered to be catastrophic health expenditure. There was a slight increase in catastrophic health expenditure between 2002 and 2005, followed by a decrease between 2005 and 2006 (Figure 5). In Estonia, 3.31% households faced catastrophic levels of OOP in 2007.

Catastrophic health expenditure was largely driven by spending on drugs, especially for lower income households (Figure 6). The current system covers only limited outpatient drugs and some prescription drugs require full user payment. Instead of further tighter control on the consumer side, in recent years several measures have been introduced on drug price setting, the control and monitoring of pharmacies and doctor’s prescription behavior in order to control the increase in drug expenditure. Meanwhile, more health conditions for which drugs are reimbursed have been added, while reimbursement rates vary according to the degree of severity of the condition.
Catastrophic levels of OOP occur in households across all income groups in Latvia. Even though those officially identified as poor are exempt from cost sharing, lower income households are much more likely to face catastrophic health expenditure than the higher income households. This may be partly explained by the difficulties in identifying the poor and partly by the fact that patients have to pay for the services and drugs which are not covered by insurance.

Apart from income, households with members over 65 are also far more likely to encounter catastrophic health expenditure. Other indicators making catastrophic health expenditure more likely include female headed households, households headed by an unemployed person or a person with a lower level of education, and rural households. These results are similar to Estonia.

**What is the impact of OOP on poverty?**

In addition to causing financial catastrophe, large OOP can also impoverish households or force them deeper into poverty. Around 1.4% of households, corresponding to 12,000 households (or 21,000 people) became poor after paying for health services in 2006. Additionally, people living below the poverty line became poorer as a result of paying for health services.

![Figure 7. Impoverishments due to health payments](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage of Households</th>
<th>Number of Households</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1.49%</td>
<td>13200</td>
</tr>
<tr>
<td>2003</td>
<td>1.44%</td>
<td>12735</td>
</tr>
<tr>
<td>2004</td>
<td>1.39%</td>
<td>12299</td>
</tr>
<tr>
<td>2005</td>
<td>2.33%</td>
<td>20593</td>
</tr>
<tr>
<td>2006</td>
<td>1.36%</td>
<td>12120</td>
</tr>
</tbody>
</table>

4. **Key messages**

When patients' OOP reach a certain level, some people forgo health care due to the price and others who access services face financial difficulties. In 2005, the World Health Assembly passed the resolution WHA58.33, (Sustainable health financing, universal coverage and social health insurance) which set the target that everyone should receive needed services without facing financial catastrophe and impoverishment. Universal coverage has three dimensions: population coverage, service coverage and cost coverage as a direct result.

Latvia reached universal population coverage by national health insurance, but around 30% of people still cannot access health care when they need it mainly due to financial reasons. For those who accessed health services, OOP resulted in over 40,000 people facing financial catastrophe and over 20,000 people falling into poverty. Inequality exists in both access to care and in the financial burden of OOP.
The following issues need to be addressed in order to improve access to care and financial risk protection.

1. Further reduction of out-of-pocket payments and increased prepayment in revenue collection for health services is necessary to improve access and financial protection.

2. The current insurance benefit package needs to be rationalized and expanded. Drug expenditure is the main driver of catastrophic payments. Expansion of the benefits package to cover a wider range of pharmaceutical products could contribute significantly towards reducing the burden on households. However, this requires strategies on drug production, price setting, marketing, sales, doctor’s prescribing behavior and patient’s consumption behavior.

3. Special attention should be paid to low income households, households with elderly members and those residing in rural areas. They are more vulnerable to catastrophic health expenditures, and as a result have larger financial barrels to access needed services.