

INDIVIDUAL RESPONSIBILITY INTEGRATION IN LATVIAN HEALTH FINANCING MODEL – CHALLENGES AND OPPORTUNITIES

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ABSTRACT

Wherewith actualisation of health promotion as an important aspect in the context of public health maintenance, the questions which are connected to public joint responsibility in their health maintenance and improvement attain even greater importance. Taking into consideration the insufficient health quality of Latvian population which ranks Latvia in one of the last places among the European countries, actualisation and implementation of individual responsibility dimension in the health care financing model, is viewed as a possibility of improvement of the current situation. The research overlooked the approaches of individual responsibility integration in health care models employed by the developed countries, classifying those several parameters, established the insufficient Latvian population involvement level which is characterised by large health influencing harmful habit prevalence and low involvement level in illness prevention measures, as well as marked the main challenges and possibilities, introducing individual responsibility dimension in Latvian health care financing model which are referred to both increasing the payment solidarity and lifestyle and behaviour changes.

KEYWORDS: *health, individual responsibility, health incentives.*

JEL CODES: I120, I130

Introduction

With acceptance of sustainable economic development as a modern national economy development base direction, public health maintenance and improvement of public health indexes is viewed as preconditions for provision of the human capital development. Matters concerning the health inequalities reduction are currently defined as priority both in global and at the level of certain countries.

Based on the research on health influencing factors which have proved that lifestyle and socio – economic factors form 49–53 % of total external factor influence on health, surrounding environment factors – 17–20%, inheritance 18–22 %, but health care – only 8–10 % (Bezrodnaja, 2011: 241), even larger role in the public health care maintenance is allocated to the health promotion, emphasising public responsibility for health influencing factors which are in their sphere of influence. Thus the problem connected to population involvement and individual responsibility in their health maintenance and improvement, conducting to the overall public health index improvement, is fundamental in this research.

Although the problem is widely researched in developed countries, in Latvia it has not been actualised enough, thus leaving remarkable part of public health influencing factors completely outside the healthcare system influence sphere. However, the insufficient Latvian public health quality, which has taken 22 place

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among 27 EU countries (Jeremic et al., 2011: 1764), indicates that Latvian health care system, i.e. health care financing, needs serious reforms by incorporation of additional dimension.

The aim of the research is to evaluate individual responsibility dimension integration possibilities in Latvian health care financing model, reviewing the possible challenges and possibilities. Public health characterising indexes and the implemented tools for the stimulation of their quantitative and qualitative changes serve as the research object. In the course of the research the following tasks were solved: evaluation of approaches implemented by the developed countries in integration of individual responsibility in the health care financing models, analysis of several Latvian public health indexes and their influencing factors connected to the individual behaviour, i.e. health influencing harmful habit prevalence and participation in illness prevention, as well as inspection of possibilities of individual responsibility dimension integration in Latvian health financing model, taking into consideration the possible limitations. The research is based on WHO, European Commission, National Health Service, Health Economic Centre, CSB, SRS statistical and published research numeral data, applying syntheses, analysis, monographic and statistical methods.

1. Experience of developed countries in public responsibility implementation in health care model – classification of existing approaches

Strengthening the recognition that illness prevention financially is more beneficial to the government than illness treatment; the health care system focus of developed countries gradually changes from health care to health promotion. Based on WHO international health promotion conferences, health promotion is being recognized as an essential element of health development. It is a process of enabling people to increase control over, and to improve, their health. People have to be at the centre of health promotion action and decision-making processes for them to be effective (WHO, 2009: 17, 19).

Although health promotion activities are oriented on the wider public joint involvement and responsibility on decisions in the health care maintenance, it forecasts definite individual involvement and joint responsibility. Thus, for example, WHO program defines that Community involvement in health basically means that communities take responsibility for their own health through:

- adoption of behaviour to prevent and treat diseases;
- effective participation in disease control activities;
- contribution to the design, implementation and monitoring of health programmes;
- provision of resources for health (WHO, 2006: 1). The mentioned function directions serve as the fundament for health strategy development in certain countries and are integrated in various health promotion programs, but the first and the second of those are successfully implemented in the framework of healthcare financing models.

Unfortunately, reviewing the existing practice of developed countries, it can be concluded that the aspect of health promotion not always is successfully integrated in existing health care models. Despite the call for health promotion and disease prevention in the Declaration of Alma-Ata and the appeal for the reorientation of health services in the Ottawa Charter, the prevailing models of health care throughout the world are still primarily curative. Curative care still predominates over preventive and developmental activities, such as health promotion (Moulton et al., 2006: 274). Therefore, analysing the previous experience of various factors directly unconnected to the health care, i.e. public behaviour and lifestyle factor, integration in health care models, it must be mentioned that the discussed approach has not achieved all-embracing character. Although the concept of individual responsibility is a necessary consequence of any substantial amount of freedom and therefore present in practically all areas of society, it is rarely articulated or used as a rationing principle in the health-care context (Tinghog et al., 2009: 203). Nevertheless individual responsibility dimension in the health care models of several countries is described and analysed in detail, promoting the development of this public behaviour influencing instrument. For example, lifestyle influencing factor integration in Netherlands health care model has proposed a framework, depicted as a funnel with sieves, consisting of

four explicit selection criteria to be used in funding decisions: necessity, effectiveness, cost-effectiveness (or efficiency) and own responsibility/payment. (Rappange, Brouwer, 2012: 245).

Investigating the experience of developed countries in exploitation of individual responsibility dimension, implementing it both as an element of health care promotion and incorporation as the separate health financing model component, it can be concluded both differentiating and joint features, which allow to classify the existing approaches by several criteria, i.e.:

- by expected action manner (service choice influencing and consumer behaviour influencing solutions) – is distinguished service rationalisation, when financing for such health care services which are expensive and not critical in health maintenance aspect is not provided, leaving the possibility to the population- to finance it from their own means, e.g., in vitro fertilization, dental care for adults (Tinghog et al., 2009: 203), and stimulation of lifestyle habit change, motivating to quit smoking, turn to physical activities, and other;
- by healthcare level (primary, secondary care) – allocation of certain privileges and bonuses for participation in regular examinations at the primary health care level, for example, screening test (Schmidt et al., 2009: 727), or cash rewards to sickness funds enrollees who were not hospitalised for the previous year (Voigt, 2010: 13) at the secondary healthcare level;
- by the target group (individual oriented strategies, group strategies, community strategies, organizational strategies [Moulton et al., 2006: 271]) – parting programs that are oriented on an individual health risk reduction concerning the habits of food and physical activities, immunisation, preventive measure implementation, etc., which are oriented on certain population group, e.g., infant parents allocating certain privileges for their health care on certain conditions which are done regarding their child immunisation (Lagarde et al., 2007: 1904), as well as the strategies oriented on the wider society groups which basically are focused on healthy work environment facilitation;
- by responsibility object (responsibility for health(factors) and responsibility for health care (outcomes) [Tinghog et al., 2009: 205]) – implementation of different approaches concerning negative health influencing habit reduction (factors) as well as participation in illness prevention measures and timely treatment inception (outcomes);
- by the achieved result (participation or result achievement approach) – there is discussion on the best choice between the cost – effectiveness and provision of equality principle, at the same time USA has legal regulation of this matter, allowing financial individual responsibility implementation for implication in healthy lifestyle programs but forbidding financial discrimination by the achieved results (Mello, Rosenthal, 2008: 196);
- by characterization of chosen incentives (positive and negative incentives-or ‘carrots’ and ‘sticks’ [Voigt, 2010: 4]) – are widely implemented different kinds of positive incentives as compensation of fitness subscription expenses, reduced insurance premiums or co-payment rates for non-smokers, money prizes for weight loss etc., less popular are negative incentives which come in increased insurance premium and co-payment forms for those who practice unhealthy lifestyle refusing to give it up.

As the successful examples of individual responsibility integration in the health financing system can be mentioned the instruments implemented in health care models of Germany, Netherlands, United Kingdom, and USA. The results indicate that broader health-system structures, such as Beveridgian or Bismarckian financing arrangements or gatekeeping, are not significant determinants of efficiency. Significant contributors to efficiency are policy instruments that directly target patient behaviours, such as insurance coverage and cost sharing, and those that directly target physician behaviours, such as physician payment methods (Wranik, 2012: 197).

The existing approaches integrated in health financing models are evaluated ambiguously, as the most common arguments of critics can be mentioned the following-patients responsibility for factors that may be out of their control, holding some patients to a standard of behaviour that is not required of other patients (Bishop, Brodkey, 2006: 756) as well as other circumstances which creates unequal conditions to the

certain patient groups causing risk of inequity that would further disadvantage the people most in need of health improvements, doctors might be assigned watchdog roles that might harm the therapeutic relationship (Schmidt et al., 2010: 1), hereto doctors of primary care potentially can be uninterested in population lifestyle habit changes, as in cases when patient participation results are not included in the system of primary health care doctors quantitative judgment, treating disease is reimbursable but preventing is not (Foege, 2010: 9). Although varied possibilities for individual involvement facilitation allow to choose instrument range in conformance with the situation of specific country, taking into consideration actual indexes which characterize public education level, average income level, harmful health influencing habit prevalence, lifestyle traditions, etc. Thus it can be concluded that incentives for healthy behaviour may be part of an effective national response to risk factors for chronic disease (Schmidt et al., 2010: 3).

2. Latvian population health and participation in its maintenance – actual situation

According to the WHO data, non-infectious diseases can be considered as the cause of death in 2/3 of all death cases in the world (WHO, 2011: 9). Unhealthy lifestyle habits as smoking, exceeding alcohol consumption, unbalanced diet and insufficient physical activities can be considered as one of the important causes of non-infectious disease source, therefore it is important to evaluate separate health affecting harmful habit prevalence in Latvia in comparison to the average EU level as well as the indexes of separate countries of Baltic sea region considering common geographical and historical facts. As it was mentioned previously Latvian public health indexes demonstrate one of the lowest performance levels among the EU countries which is confirmed by:

- noticeable falling behind from the average EU levels in terms of expected healthy years of life – according to the authors calculation life expectancy for males at the age of 65 comprises 57 %, but for females 68 % from the average EU level and only 32 % for males and 39 % for females from life expectancy at the age of 65 in Sweden (EC, 2009);
- high morbidity with circulatory system diseases – the calculations are proving that Latvian standardized mortality index from circulatory system diseases in Latvia by 220 % exceeds the average EU level, but differences from northern countries are even more noticeable, exceeding even 300 % in comparison to the Danish indexes (EC, 2009);
- unsatisfactory situation in the mental health area – based on the calculations, standardized mortality index from suicides and intentional self harm by 201 % exceeds the average level of EU countries and by 209 % – respective index of Denmark (EC, 2009).

Data on health affecting harmful habit prevalence in comparison to the average indexes of EU countries are gathered in Figure 1.

The data in Figure 1 demonstrates the existing relevance between harmful health affecting habit prevalence and it's caused harm to the health providing the coherences which are analogical to the tendencies in the area of public health quality described above. Latvian daily smokers' density among the adult population, which in 2009 reached 33.7 % from the adult population is the highest index among the Baltic countries, it exceeds the average EU index by 39 % and is noticeably higher than northern countries indexes, exceeding Danish index by 77 %, Finnish – by 81 %, but Swedish even by 136 %. As a negative tendency can be considered increasing number of regular smokers, according to the research of National Health Service in 2011 the number of daily smokers reached 40 %, i.e., in comparison to the 2009 is noted the density increase of regular smokers by 19 % (National Health Service, 2011: 16). Although the obesity indexes among the adult population do not differ sharply from the average EU indexes demonstrating only 9 % exceed over the average EU countries level, the difference from northern countries is much larger – even 66 %, in comparison with the index that characterises the obesity among adult population in Sweden. Additionally insufficient perception on obesity is observed among the Latvian population as only 53 % from the responded males with increased body mass index have admitted the problem (Health Economic Centre, 2011: 20). This situation can be explained with unhealthy diet

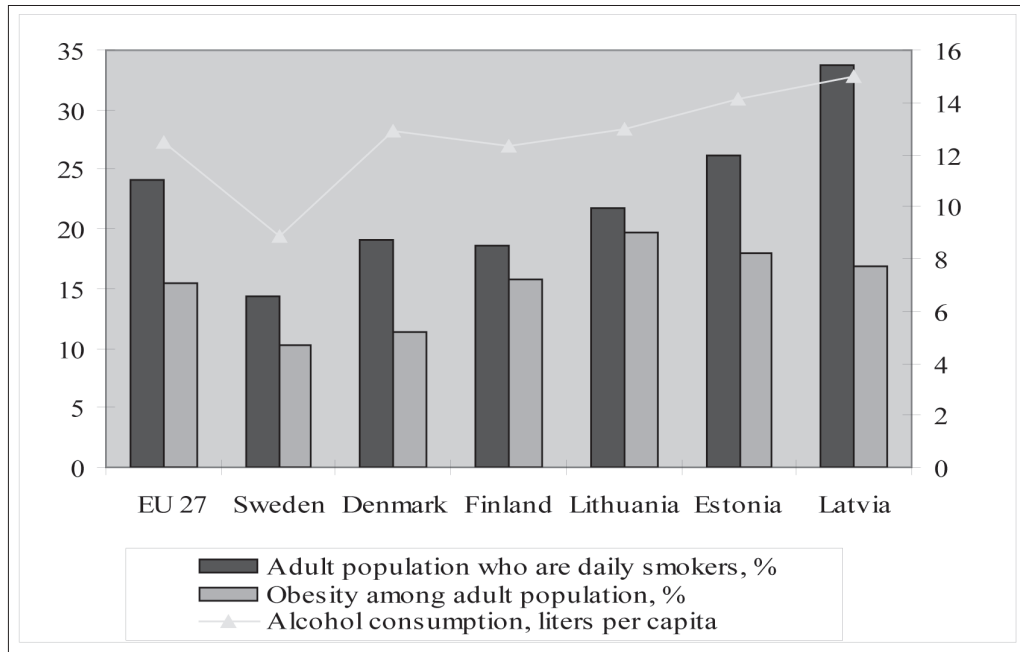


Figure 1. Non-medical health affecting factors prevalence in EUR countries, 2009

Source: OECD, 2011; Health in Baltic countries, 2010; WHO, 2011, author's estimates

habits – in Latvia fresh vegetables on a daily basis are consumed only by 35.3 % from population, i.e., in the young adult group only by 26.3 %, at the same time 54.3 % of population have completely excluded milk from their diet, 47.5 % – dairy products, – and with Latvian population sedentary lifestyle – 49 % of population does not take up physical activities (Health Economic Centre, 2011: 16, 22).

Dangerous situation is observed in the matter of alcohol consumption which together with causing other health problems, leaves direct impact on mental health which is characterised by previously viewed suicide and intentional self harm occasion number. According to the population research data, alcohol is consumed by 85.4 % from Latvian population, i.e., 87.4 % Latvian adult males and 83.6 % females, but at least 6 alcohol doses at least once a week are consumed by 10.1 % males and 0.7 % females (National Health Service, 2011: 31). Although there are no available believable statistical data on the quantity of consumed alcohol, taking into consideration the massive density of unregistered alcohol in Latvia, by the authors estimates it composes 14–16 litres per capita, taking the 1st place among the Baltic countries and exceeding the average EU index by 20 % (WHO, 2011) Taking into consideration the different quality of consumed alcohol, which is determined by the eminent density of illegal, self-made and surrogate alcohol, its influence on public health is much more destructive than in countries, where mainly qualitative alcohol is consumed.

It is clear that maintaining the existing harmful health influencing habit prevalence among the Latvian population, decreasing of non infectious disease morbidity and mortality indexes is not expected in the near future.

Individual involvement in their health maintenance demonstratively illustrates the data on public involvement in illness prevention measures, i.e., regular health checks and vaccination level, which is gathered in Figure 2. For better interpretation of the mentioned indexes, density of Latvian population which, according to the research data, evaluates their health condition as insufficiently good, bad or very bad is marked.

The data in Figure 2 allows concluding that despite the high Latvian population density that evaluates their health quality as insufficient, only part of the population group implement regular measures in their health maintenance and improvement. Although the blood pressure, cholesterol and sugar level tests are done in the framework of GP visit, thus are not connected to the additional time and finance contribution, the survey showed that 34.3 % of respondents have never had the sugar level blood test, but 41.1 % have never had

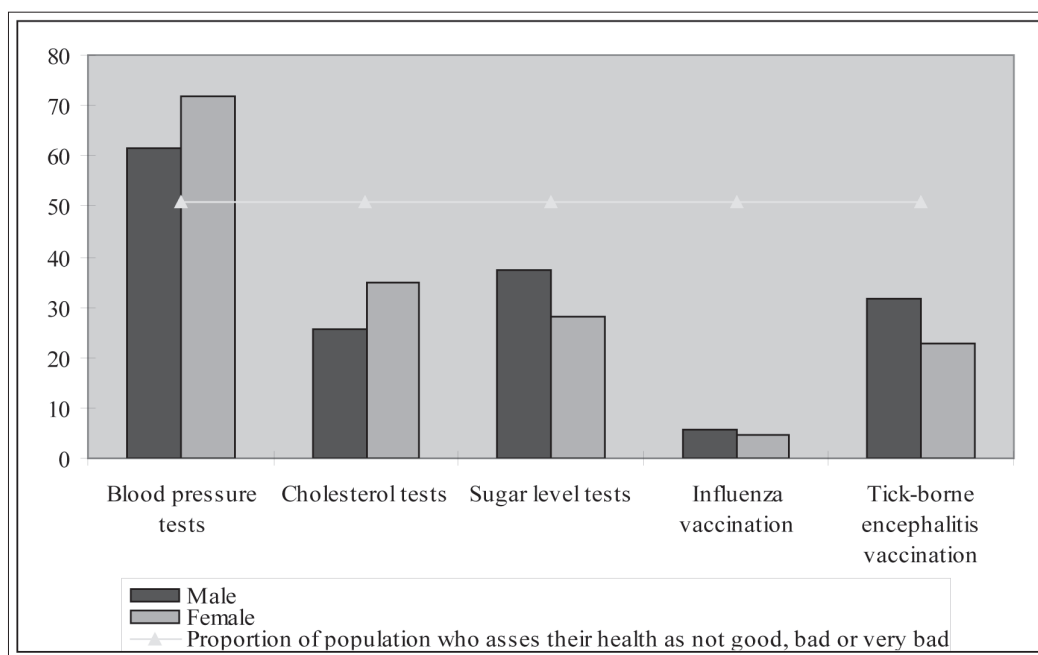


Figure 2. Proportion of population involved in illness prevention activities in Latvia, 2010, %
Source: Health Economic Centre, 2011: 11

a cholesterol test (Health Economic Centre, 2011: 12). Vaccination level has also been very low, especially against the flu diseases, i.e. the high risk group, in the population group of over 65 years old in Latvia only 2.9 % has been vaccinated, whilst the average EU countries vaccination level in this group reached 27.9 % (European Commission, 2009).

Thus it can be concluded that Latvian population involvement in their health maintenance and illness prevention can be rated as insufficient and the potential of preventive measures in disease prevention is not fully exploited due to the low activity of Latvian population.

Overall it can be affirmed that the wide prevalence of harmful health affecting habits among the Latvian population and insufficient involvement in their health maintenance has left quintessential negative influence on public health indexes, therefore, to facilitate the improvement of Latvian population health quality the integration of individual responsibility dimension in the health care model is considered an acute necessity.

3. Possible action direction in Latvian individual responsibility determination, integrating it in the health financing model

Considering the existing situation in Latvia discussed above, it can be concluded that previous actions in the health maintenance area have not substantially influenced the lifestyle and health behaviour of Latvian population. It is confirmed by the evaluation of Public health strategy goal achievement done by Health Economic Centre, admitting that from goals which are referred to non infectious diseases and reduction of the negative influence of external factors, the goal of accident reduction is achieved till 2010, i.e., reduction of road accident caused health harm frequency, however goals, which are referred to the population diet and physical activities habit change and its caused obesity indexes, as so as smoking and alcohol consumption prevalence are not achieved (Health Economic Centre, 2010: 93, 108, 114, 116). Cardinal population lifestyle changes which would increase the population responsibility for their health maintenance and illness prevention measure implementation can be reached only with measures which supplement the moral and

social responsibility with financial joint responsibility. Thus it is important to evaluate the possibilities of integration of population joint responsibility dimension in Latvian health care financing model.

It must be admitted that the existing health financing model, which is based on the general tax revenues, does not contribute Latvian population involvement in the healthcare financing, thus not providing the abundance of health care solidarity principles. Considering the illegal employment as well as the noticeable density of population who leave the country in order to work seasonal jobs abroad, on average only 66.4 % from economically active population and 80.2 % from employed, in 2011 have paid taxes from their regular income (CSB, 2011; SRS, 2011). Simultaneously the state paid health services in the framework of existing quota are available to all state population without reference of joint involvement in the health care financing, thus reducing the availability of state paid health care services. The existing model generates the restrictions to the certain population financial contribution and accounting and comparison of health care service utilization.

Thus, as one of the resolves to the optimization of the health financing system can be considered the health financing individual responsibility personalization, implementing health financing model, which is based on compulsory health insurance principles. Therefore the following order would be implemented: state paid health care besides the emergency medical services would be provided only for the working population in work capacity-age who has made the certain payments. Thus, as an additional gain of such system the potential increasing of overall tax income, increasing the basis of tax payers can be viewed.

Considering the conclusions that health systems would find it profitable to more aggressively encourage tobacco cessation, healthful diets, physical activity, blood-pressure control and diabetes control (Foege, 2010: 10), as well as the conclusions on Latvian population insufficient involvement in their health maintenance done in the previous chapter, Latvian joint responsibility in the health financing system should be based on health affecting lifestyle habits and participation in illness prevention measures, i.e., smoking, alcohol consumption, diet and physical activity indexes, regular examination and vaccination indexes. Further research is necessary for fuller quantitative measurements analysis of certain health incentives, considering the most appropriate tools for the Latvian situation such positive incentives as lower general insurance rates or reduced health services co-payments for individuals who practise healthy lifestyle and participate in regular illness prevention measures. In addition, the gradual remission plan for the individuals, who improve their health condition at the longer time period, e.g., giving up smoking, joining physical activities and the like, would be efficient. Thus, the reward system would stimulate the following: achievement of certain results and their maintenance, the involvement in the health maintenance and improvement activities, thus contributing gradual changes in the public behaviour.

Resistant reaction of the certain part of population on restrictions which possibly could be caused to the practisers of the unhealthy lifestyle is viewed as a potential barrier in the implementation of such system. For reduction of this negative influence insurance of additional informative campaigns would be necessary, popularising healthy lifestyle habits and providing the information on unfavourable consequences of harmful habits.

Employer involvement in its turn can be viewed as a separate challenge in reduction of health affecting harmful habit prevalence, e.g., offering reduced employer tax rates for those employers who cover the expenses of employee physical activities, implement smoking restrictions in workplace etc.

For the health care specialists, especially for the stimulation of primary care doctor involvement, additional awarding would be required from the state or insurer for certain doctors, whose patients have implemented positive health affecting behaviour changes at the certain time period.

As a substantial challenge in this aspect, is considered to be the establishment of new practise, providing the development of effective system for the data registration and maintenance, such approach is viewed as real, considering the well developed practise of GP institution in Latvia. The question of the development of overall, accessible to all primary care specialists system must be actualized at the state level, thus providing unified methodological approach.

Without a doubt, the implementation of all mentioned action directions must be integrated in overall national economy and state health care strategy in addition to the implementation of individual responsibility dimension in health financing model, anticipating not only the other health care system components, but also

other national economy industries support in health promotion, i.e., education, socio- cultural environment, improving the condition of surrounding environment, thus providing coordinated action program in provision of public health maintenance.

Conclusions

Examining the developed countries experience in individual responsibility dimension integration in the health financing models, it can be concluded: despite that the individual responsibility integration in health financing models is not considered as generally accepted practice, many of the developed countries are implementing various approaches which can be classified by several features as expected action manner, healthcare level, target group, responsibility object, achieved result, characterization of chosen incentives, and the like. The employed approaches are evaluated not unequivocally, marking the following as the potential risks: inequality raise in the health care services access, the dual role of primary care service providers, which can lead to the reduction of provided service quality and low interest of the service provider in the result achievement. However, overall the positive role of individual responsibility integration in facilitation of population behaviour change is recognized, facilitating reduction of harmful health affecting habit prevalence and wider public involvement in illness prevention measures. Therefore it can be affirmed that the individual responsibility integration in the health financing model would be successfully brought into effect regarding it as one of the perspective development directions in improvement of Latvian health care financing.

Analysing the current Latvian public health indexes and performing the individual health quality affecting factor research can be concluded that the insufficient health quality of Latvian population is linked with the wide negative health affective habit prevalence as well as the insufficient individual involvement in illness prevention measures. Therefore, the individual financial joint responsibility dimension integration in health financing model is considered as necessary precondition for the improvement of the situation in public health field, promoting broader population involvement in their health maintenance and improvement.

Although the individual responsibility integration in the health care system is positively evaluated in the aspect of population health quality, however, the potential barriers for implementation of such system can be considered the following: inimical reaction of the certain part of population, low interest level of primary health specialist, deficiency of appropriate evaluation and calculate methodology as well as lack of unified state database for data calculation and maintenance.

Considering the developed countries experience and the current Latvian situation the most corresponding financial joint responsibility mechanisms are considered the positive incentives, i.e., certain reduction from standard insurance premium, for those citizens who implement healthy lifestyle and perform regular illness prevention measures, in parallel foreseeing certain privilege program for those who move towards reaching this status.

The changes in the health financing model are viewed as additional challenges of individual responsibility integration in the health financing system. It is necessary to implement the health financing model change in order to provide the individual financial joint responsibility, declining the financial model, which is based on general tax revenues in favour of compulsory health insurance model, which would facilitate involvement of larger part of public in the health care financing.

Taking into consideration that individual responsibility integration in Latvian health financing model is viewed as one of the possibilities for improvement of public health indexes and Latvian health care system effectiveness further research is necessary in the aim to perform intensified analysis of instruments suitable for individual financial joint responsibility and system development of certain qualitative indexes.

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INDIVIDUALIOS ATSAKOMYBĒS ĪTRAUKIMAS Į LATVIJOS SVEIKATOS PRIEŽIŪROS FINANSAVIMO MODELĮ – IŠŠŪKIAI IR GALIMYBĒS

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Santrauka

Sveikatos gerinimas yra svarbi visuomenės sveikatos išsaugojimo dalis, todėl klausimai, susiję su atsakomybe už sveikatos išsaugojimą ir jos gerinimą, tampa ypač svarbūs. Turint omenyje nepakankamą Latvijos visuomenės sveikatingumo lygį – vieną žemiausių tarp Europos Sąjungos narių, asmeninės atsakomybės dimensija sveikatos finansavimo modelyje suvokiama kaip galimybė esamą situaciją gerinti. Šiame tyrime apžvelgtos asmeninės atsakomybės įtraukimo į sveikatos priežiūros modelius priegigos, taikomos išsivysčiusiose šalyse, suklasifikuoti keletas parametrų, nustatytas nepakankamas Latvijos gyventojų įsitraukimas, kuris apibūdinamas dideliu žalingų sveikatai įpročių paplitimu ir menku domėjimusi sergamumo prevencijos priemonėmis. Nustatyti pagrindiniai iššūkiai ir galimybės, susiję su asmeninės atsakomybės įtraukimu į Latvijos sveikatos priežiūros finansavimo modelį, kas leistų sutelkti mokėjimus ir padėtų keisti gyvenimo būdą bei elgseną.

PAGRINDINIAI ŽODŽIAI: *sveikata, asmeninė atsakomybė, sveikatos skatinimas.*

JEL KODAI: I120, I130