

FINANCIAL OPPORTUNITIES AND BARRIERS TO PROVIDING HEALTH-CARE SERVICES TO PEOPLE WITH DISABILITIES: THE EXPERIENCE OF PHYSICIANS

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Abstract

The World Health Organization acknowledges that the health of people in the European region has improved significantly, but not everywhere and not equally for all. It has set a strategic goal to improve the health of all, and reduce health inequalities. In meeting this goal, Lithuania purposefully strives to reduce inequalities in the health condition of individuals attributed to different social groups, and differences in accessibility to health care. The primary focus is on people with disabilities. In compliance with the UN Convention on the Rights of Persons with Disabilities, Lithuania seeks to provide people with disabilities with health-care services and programmes of the same availability, quality and level which are provided or applied to other individuals, free of charge or at a reasonable price. However, research has revealed a great deal of problems in fulfilling this obligation. The present article focuses on physicians' experience, and aims to understand, from a physician's perspective, the financial opportunities and barriers that they encounter in rendering health-care services to people with disabilities. A survey involving 107 physicians was carried out in 2019 and 2020. The research results showed that Lithuania is making progress in increasing funding to the health-care system in a targeted way covering a wide range of its domains. Therefore, physicians have plenty of opportunities to refer patients with disabilities to other professionals for consultation without any financial constraints, to prescribe reimbursable medication, to carry out laboratory and radiological tests, to give instructions to caregivers on patient care, and to hospitalise a patient or transfer him/her to another hospital. The situation is somewhat worse with prescribing the most appropriate reimbursable measures and reimbursable rehabilitation treatment, and the worst situation has emerged in the sphere of reimbursable psychological and social assistance, because these services are usually granted a minimum level of funding. The trends established verify that there is a strong need to develop a more effective public health policy in Lithuania, to reform the health-care system, and to invest in improving its quality, so that the country can take more measures to ensure the health of the population and the inclusive equality of people with disabilities in the health-care system.

KEY WORDS: health-care services, health-care barriers, quality of life, people with disabilities.

Anotacija

JT Pasaulio sveikatos organizacija pripažįsta, kad pastaraisiais dešimtmečiais Europos regiono žmonių sveikata pagerėjo, tačiau ne visur ir ne visiems vienodai. Ji iškelė strateginį tikslą – gerinti visų žmonių sveikatą ir mažinti sveikatos būklės skirtumus. Įgyvendindama šį tikslą, Lietuva kryptingai siekia mažinti skirtingoms socialinėms grupėms priskiriamų asmenų sveikatos būklės netolygumus ir sveikatos priežiūros paslaugų prieinamumo skirtumus. Didelis dėmesys skiriamas žmonėms su

Received 12/04/2024. Accepted 21/04/2024

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Published by Klaipėda University Press.

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negaliomis. Vadovaudamasi JT Neįgaliųjų teisių konvencija Lietuva siekia, kad žmonėms su negaliomis nemokamai arba už prieinamą kainą būtų teikiamos tokio paties prieinamumo, kokybės ir lygio sveikatos paslaugos bei programos, kokios teikiamos ar taikomos kitiems asmenims. Tačiau pastaraisiais metais atlikti tyrimai atskleidė gana daug problemų, kylančių vykdam šį įsipareigojimą. Šiame straipsnyje dėmesys sutelktas ties gydytojų patirtimi, siekiant suprasti, kokios jų finansinės galimybės ir trukdžiai teikiant sveikatos paslaugas žmonėms su negaliomis. 107 gydytojų apklausa parodė, kad Lietuva daro pažangą kryptingai didindama finansavimą sveikatos sistemai, plačiai apimant įvairias jos grandis. Tad gydytojai turi pakankamai daug galimybių be finansinių apribojimų siūsti pacientus su negaliomis konsultuotis pas kitus specialistus, skirti jiems kompensuojamuosius vaistus, laboratorinius ir radiologinius tyrimus, teikti nurodymus slaugytojams dėl pacientų slaugos, guldyti pacientus į ligoninę arba perkelti į kitą. Kiek prastesnė situacija su tinkamų kompensuojamų priemonių išrašymu ir kompensuojamo reabilitacinio gydymo skyrimu, o pati blogiausia – su kompensuojama psichologine bei socialine pagalba, nes, matyt, šios paslaugos mažiausiai finansuojamos. Nustatytos tendencijos patvirtina poreikį formuoti veiksmingesnę Lietuvos visuomenės sveikatos politiką ir investuoti į sveikatos sistemos kokybės gerinimą, siekiant užtikrinti gyventojų sveikatą ir įtraukią žmonių su negaliomis lygybę sveikatos sistemoje.

PAGRINDINIAI ŽODŽIAI: sveikatos paslaugos, sveikatos priežiūros barjerai, gyvenimo kokybė, žmonės su negaliomis.

DOI: <https://dx.doi.org/10.15181/tbb.v92i1.2622>

Introduction

Health financing is a core function of health systems that enables progress towards universal health coverage (WHO Health Financing). According to Kutzin, Witter, Jowett and Bayarsaikhan (2017), universal health coverage means that all people in a society can obtain the high-quality health-care services that they need, without the fear that what they will have to pay for health-care services might cause them severe financial difficulties. The authors suggest that universal health coverage has become a number one political priority in many countries, and that ever more attention is being paid to it on an international level in forming one of the targets of the Sustainable Development Goals.

According to the available data (from 2023), the Lithuanian health-care system is financed from several sources. Funding comes from payroll contributions from the working population and the general government budget to cover the non-working population to ensure universal coverage (OECD (Organization for Economic Cooperation and Development), State of Health in the EU, 2023). Additional (voluntary) health insurance is also effected in Lithuania (Article 2, Paragraph 3 of the Republic of Lithuania's Law on Health Insurance, 1996); however, its role is quite minor, it plays an important part only in the sphere of dentistry, cosmetic surgery, psychotherapy, primary care, and some other types of services (Murauskienė, Janonienė, Veniūtė, van Ginneken, Karanikolos, 2013).

As can be seen from the data presented, the main source of financing the health-care system in the country is compulsory health insurance, which is stipulated in

the Republic of Lithuania's Law on Health Insurance (1996) and other legal acts. On the basis of these documents, a system of compulsory health insurance has been created, seeking to ensure opportunities that in an insured event, a person covered by compulsory health insurance should receive health-care services, medication and medical aids (Article 2 of the Republic of Lithuania's Law on Health Insurance, 1996). A compulsory health insurance insured event is a health disorder or state of health of an individual insured by compulsory health insurance which is diagnosed by a medical doctor (Article 5 of the Republic of Lithuania's Law on Health Insurance, 1996). The Lithuanian compulsory health insurance system is based on two essential principles: the principle of universality, and the principle of obligation. The principle of universality means that all persons covered by compulsory health insurance must pay health insurance contributions; and the principle of solidarity means that although each individual covered pays health insurance contributions in the established procedure according to his or her possibilities, all individuals covered have equal rights to health-care services (Sveikatos priežiūra Lietuvoje: ką svarbu žinoti kiekvienam, 2015, 7). Since some of the population cannot afford to pay health insurance contributions, the state pays health insurance contributions on their behalf, and in this way, the financial possibilities are raised for them to get health-care services (Sveikatos priežiūra Lietuvoje: ką svarbu žinoti kiekvienam, 2015, 7). People with disabilities and their carers are also covered by compulsory health insurance, and when they cannot afford to pay health insurance contributions themselves, the contributions are paid by the state on their behalf (VLK, Apie draudžiamuosius privalomuoju sveikatos draudimu, 2020). Moreover, they are even provided additional free health-care services (SAM, Neįgaliesiems teikiamos paslaugos).

Nonetheless, residents of Lithuania have to pay for some services from their own personal resources when they: *are not covered by compulsory health insurance, *are provided with health-care services at an institution that has not agreed with the National Patients' Fund, *see a physician voluntarily without their physicians' referral (except some cases where a referral is not obligatory), *choose services and procedures of their own free will, *try to get services that they are entitled to sooner than appointed, *make use of services put on the List of Paid-For Services (Vilniaus teritorinė ligonių kasa. Sveikatos priežiūros paslaugų teikimas ir apmokėjimas, 2019).

It is sought to achieve that as many as possible residents of the country should be covered by compulsory health insurance following the example of OECD (Organization for Economic Cooperation and Development) countries where the number of people covered accounts for 100%; an upward trend in the growth rate of individuals covered is observed in Lithuania too, and their number is expected

to reach 94.5% in 2020 (Sveikatos priežiūros sistemos vertinimas, 2019, 6–7). Individuals who are not covered by compulsory health insurance only have the right to receive free emergency medical aid.

The Lithuanian health-care system financing model is like that of other member states of the European Union. However, funds spent on health care in Lithuania are the smallest in the European Union, and on average almost less than half the amount spent on average in the European Union per head is spent per head in Lithuania (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 11). Although health-care spending in the country amounted to 2.7 billion euros in 2017, and accounted for 6.4% of the Gross Domestic Product (the Lithuanian Department of Statistics [Statistics Lithuania]), they still remain lower than the European Union average. This is a serious problem that the health-care system faces, because, as has been proven by investigations, health spending is directly related to the average life expectancy of the population: the higher the spending the longer the average life expectancy (Jaba, Balan, Robu, 2014).

It stands to reason that substantially reduced financing is related to the fact that certain health-care services rendered to certain groups of individuals are simply granted more limited funding. The investigations show that from this point of view, people with disabilities find themselves in a worse situation: the World Report of Disability (the World Report of Disability. Summary, 2014) states that there is a three times greater likelihood that people with disabilities will be deprived of necessary health-care services. An opinion poll of people with disabilities carried out in Lithuania (Investigation of the Specific Needs of Persons with Disabilities Evaluating the Effectiveness of the Implementation of the Provisions of the UN Convention on the Rights of Persons with Disabilities in Lithuania, 2018) established that only half of the people with disabilities think they have the same opportunities as people without disabilities to receive qualitative health-care services, indicating in particular that they found it especially difficult to receive rehabilitative and care services. These facts are at variance with Article 25 of the Convention on the Rights of Persons with Disabilities (2006) which stipulates that the state shall ‘provide persons with disabilities with the same range, quality, and standard of free or affordable health care and programmes as provided to other persons’.

Data from the above-mentioned investigations show that people with disabilities encounter barriers to access to health-care services, which are possibly associated with the insufficient funding of the health-care system. However, there is a lack of investigations to address in detail these issues and analyse the situation from different positions and angles. The present article focuses on physicians’ experience, and is aimed at understanding what financial opportunities and barriers they encounter in rendering health-care services to people with disabilities.

1. Materials and methods

The subset of data from a 2019 and 2020 national survey aimed at understanding the situation of people with disabilities in the health system is used in the present article.

Participants. A convenience sample of 107 physicians. The majority of respondents were females ($n = 74$, 69.2%). Males accounted for 30.8% ($n = 33$). Almost two-thirds (61.7%) of the participants were from big cities, a quarter of them came from city-district centres (20.6%), and the remaining ones were from other cities, towns and villages (17.7%). The ages of the participants ranged from 23 to 73 years ($M = 49.25$, $SD = 13.4$).

Other important topic-specific characteristics are presented in Table 1.

Table 1. Professional characteristics of the participants

Characteristics	Variables	%
Level of institution	Health-care institution of Level III	38.7
	Health-care institution of Level III	43.4
	Health-care institution of Level I	17.9
Type of institution according to its founder	Private institution	9.3
	Public institution	90.7
Type of institution according to the time and place of services being rendered	In-patient institution	48.6
	Out-patient institution	24.3
	Institution of mixed type	27.1
Type of institution according to health-care services being rendered	Medical care institution (emergency, general, specialised medical aid)	70.1
	Institution of another type	29.9
Physician's (his/her) specialisation	General practitioner (he/she)	16.0
	Resident physician (he/she)	10.4
	Professional physician (he/she)	73.6
How often a physician works with PWD	Constantly or very often	31.8
	1–7 times per week	39.3
	Several times per year	29.0

Research instrument. In order to examine the financial opportunities and barriers that physicians encounter in their work with PWD, the nine-item Likert-type scale *Financial opportunities and barriers to providing health services* (FOBA)

was designed (see Table 2). When answering the questions, the respondents had to use a five-point scale (1 – Strongly disagree, 5 – Strongly agree).

After the assessment of the reliability of the FOBA scale, it was found that Cronbach's alpha coefficient was 0.801. It was calculated that the premovement of one item from the scale would increase Cronbach's alpha coefficients slightly. In addition, there was not a single item whose r_{iit} resolution was less than 0.2. Considering what is mentioned above, it could be argued that the scale is characterised by internal coherence, and is a suitable measurement instrument for financial opportunities and barriers to providing health services to people with disabilities on the basis of physicians' experience.

Data analysis. The data analysis was performed using SPSS.22. First of all, the total FOBA scale score was calculated. The range of scores was from 16 to 45. The median ($Mdn = 38$) was higher than the mean ($M = 36.77$, $SD = 7.08$), and was closer to the maximum score, showing that major outliers were at the lower end, and more scores were above the average. The Kolmogorov-Smirnov test was used to indicate the normality of the distribution of the FOBA score. Since the scores were not followed, neither the normal distribution ($p > \alpha = 0.05$) nor non-parametric tests were used to determine differences between the groups (Rupšienė, Rutkienė, 2016). The Mann-Whitney test and the Kruskal-Wallis test showed no significant between-group differences ($p > .05$) according to demographic characteristics (gender, age, workplace location) and the professional characteristics of the respondents (the level of the institution, its type according to its founder and the time and place of the provision of services, types of institution according to the services provided, specialisation and frequency of work with people with disabilities). Therefore, it was decided to calculate descriptive statistics (the percentage of answers, the mean, the standard deviation, the median) for the FOBA scale items and perform the Friedman test to distinguish differences in the score of the scale items.

2. Results

The Dunn-Bonferroni post hoc test showed a significant difference between the Mean Ranks for the item 'Refers a patient for psychological counselling' and the items 'Writes down instructions to caregivers on patients' health care' ($p = .009$), 'Prescribes the most effective reimbursable medication' ($p = .004$), 'Prescribes such laboratory and radiological tests and as many of them as in the physician's opinion are necessary' ($p < .001$), and 'Refers his/her patients to other professionals for consultation' ($p < .001$), with a lower Mean Rank for the item 'Refers a patient for psychological counselling'. In addition, significant differences were

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observed between the Mean Ranks for the item ‘Refers a patient for reimbursable social assistance’ and the items ‘Prescribes such laboratory and radiological tests and as many of them as in the physician’s opinion are necessary’ ($p = .009$), ‘Refers his/her patients to other professionals for consultation’ ($p = .001$), with the lower Mean Rank for the item ‘Refers a patient for reimbursable social assistance’. The Mean Rank for the item ‘Prescribes reimbursable rehabilitative therapy’ was significantly lower than for ‘Refers his/her patients to other professionals for consultation’ ($p = .049$).

Evaluations of all FOBA scale items ranged from 1 to 5. The median was 5 for six items, and for two items ‘Prescribes compensatory rehabilitation treatment’ and ‘Refers a patient for reimbursable social assistance’ the median was 4, and for the item ‘Refers a patient for psychological counseling’ it was 3. The Friedman test indicated that the items of the FOBA were evaluated statistically differently ($\chi^2(8) = 83.543, p < .001$). The Mean Ranks for the items ‘Refers a patient for psychological counselling’ (Mean Rank = 5.90), ‘Prescribes such laboratory and radiological tests and as many of them as in the physician’s opinion are necessary’ (Mean Rank = 5.65), ‘Hospitalises a patient or transfers him/her to another hospital’ (Mean Rank = 5.41) were higher, and they were lower for the items ‘Prescribes reimbursable rehabilitative therapy’ (Mean Rank = 4.56), ‘Refers a patient for reimbursable social assistance’ (Mean Rank = 4.12), and ‘Refers a patient for psychological counselling’ (Mean Rank = 3.74). Descriptive characteristics of the FOBA are summarised in Table 2.

Table 2. Descriptive characteristics of the FOBA scale

Without any financial constraints, the physicians:	Mean Rank	M	SD	Mdn	1*	2*	3*	4*	5*
1. Refers his/her patients to other professionals for consultation	5.90	4.62	0.73	5.00	1.0%	-	8.7%	16.5%	73.8%
2. Prescribes such laboratory and radiological tests and as many of them as in the physician’s opinion are necessary	5.65	4.46	0.93	5.00	3.0%	1.0%	9.9%	19.8%	66.3%

Without any financial constraints, the physicians:	Mean Rank	M	SD	Mdn	1*	2*	3*	4*	5*
3. Hospitalises a patient or transfer him/her to another hospital	5.41	4.39	0.97	5.00	2.0%	3.0%	14.0%	16.0%	65.0%
4. Prescribes the most effective reimbursable medication	5.36	4.35	1.11	5.00	6.3%	-	12.5%	14.6%	66.7%
5. Writes down instructions to caregivers on patients' health-care	5.28	4.19	1.18	5.00	7.1%	2.0%	12.1%	22.2%	56.6%
6. Prescribe the most effective rehabilitation measures	4.98	4.02	1.41	5.00	13.2%	3.3%	8.8%	17.6%	57.1%
7. Prescribes reimbursable rehabilitation treatment	4.56	3.88	1.38	4.00	11.6%	6.3%	12.6%	21.1%	48.4%
8. Refers a patient for reimbursable social assistance	4.12	3.49	1.56	4.00	18.3%	10.8%	16.1%	12.9%	41.9%
9. Refers a patient for psychological counselling	3.74	3.36	1.58	3.00	23.2%	5.3%	22.1%	11.6%	37.9%

* Respondents' answers: 1 – strongly disagree; 5 – strongly agree

The table shows that three-quarters (73.8%) of respondents send their patients for a consultation to other professionals without any financial barriers, and almost two-thirds of respondents: *prescribe such laboratory and radiological tests and as many of them as in the physician's opinion are necessary (66.3%), *prescribe the most effective reimbursable medication (66.7%), *hospitalise a patient or transfer him/her to another hospital (65.0%); more than half the participants prescribe the most effective rehabilitation measures (57.1%), write down instructions to caregivers on patients' health care (56.6%), less than half the respondents prescribe reimbursable rehabilitation treatment (48.4%) and refer a patient for reimbursable social assistance (41.9%), and only approximately one third of respondents (37.9%) refers a patient for reimbursable psychological counsel-

ing. Almost a quarter (23.2%) of the respondents experienced financial barriers when they had to refer their patients for psychologically reimbursable counselling, and less than a fifth of the participants (18.3%) encountered financial barriers when they wanted to refer a patient for reimbursable social assistance. A small proportion of participants faced financial barriers when they wanted to prescribe the most effective reimbursable measures (13.2%) or prescribe reimbursable rehabilitation treatment (11.6%), lay down instructions on patients' health care (7.1%), prescribe the most effective reimbursable medication (6.3%), prescribe such laboratory and radiological tests and as many of them as in the physician's opinion are necessary (3.0%), hospitalise a patient or transfer him/her to another hospital (20%), or refer their patients to other professionals for consultation (1.0%).

3. Discussion

In analysing the financial opportunities and barriers that the physicians taking part in the investigation encounter when rendering health-care services to people with disabilities, the possibility presented itself to get a deeper insight into the situation in Lithuania and to understand it better.

It follows from the respondents' answers that some health-care services that are rendered to people with disabilities are quite properly financed in Lithuania. This fact proves that Lithuania, in implementing the UN strategy of the World Health Organization (World Health Organization. Global Strategy on Human Resources for Health: Workforce 2030, 2016) is moving purposefully towards universal health coverage, and in this way the population of the country receives ever more health-care services, without fearing that the financial burden will become too heavy for them.

It is noteworthy that the financial opportunities that the physicians taking part in this investigation have in their work in rendering health-care services to people with disabilities are associated neither with such demographic characteristics as the respondents' gender, age, or workplace location, nor with professional characteristics (the level of an institution, the type of institution according to its founder and according to the place and time of rendering services, the type of institution according to the services rendered, the specialisation and frequency of working with people with disabilities). This result is to be treated as positive, because it suggests that the financing of services rendered to people with disabilities does not depend on the level, type or kind of an institution a person with a disability attends, or on the gender, age and specialisation of a physician who renders health-care services to him/her, or on what settlement his workplace is located in. This means that improving the Lithuanian health system encompasses a wide range of health

institutions of different natures, and affects physicians of different ages, genders and specialisations.

The conclusion can be drawn from the respondents' answers that alongside many financial opportunities, there are also some barriers for people with disabilities to receive health-care services in Lithuania.

During the course of the investigation, it became clear that the best situation is in financing consultations given by professional physicians: as many as 90.3% of the respondents indicated that they had no, or hardly ever had, financial constraints when referring patients with disabilities to other professionals for consultation (1% of the respondents indicated that he/she had a lot of such constraints). It is quite possible that this is related to the fact that the number of physicians in Lithuania, as all over Europe, has been on the increase over the years (Health-Care Personnel Statistics – Physicians. Explained statistics, 2019), and even exceeded the European Union average (4.6 and 3.6 physicians per thousand population respectively) (Sveikatos priežiūros sistemos vertinimas, 2019, 16). However, although the number of physicians per thousand population is greater in Lithuania than the average of the European Union, and visits to health-care institutions are relatively more frequent (on average, such institutions are visited 8.6 times per year, while the EU average is 6.5 times), serious concerns arise because the life expectancy of the Lithuanian population is on average six years shorter than that of the statistical average of Europeans, and the number of deaths which could have been avoided after attending a health-care institution is twice as high in Lithuania than the average in Europe (431 and 204 cases per hundred thousand population, respectively) (Asmens sveikatos priežiūros paslaugų kokybė: saugumas ir veiksmingumas, 2018). This problem is not directly related to a lack of financial opportunities, as the OECD claims, but rather to a shortage of specialists (Sveikatos priežiūros sistemos vertinimas, 2019, 16).

Most of the respondents indicated that they had a sufficient amount of financial freedom when working with people with disabilities, prescribing them reimbursable medication, and laboratory and radiological tests, giving instructions to caregivers on patients' health care, hospitalising patients, or transferring them to another hospital. However, only 6.3% of respondents indicated that they had severe financial constraints when prescribing reimbursable medication, 4% of them said that they faced financial constraints when prescribing laboratory and radiological tests, 5% when hospitalising or transferring patients to another hospital, and 9.1% faced constraints when issuing instructions to caregivers on patients' health care.

The situation with reimbursable medication might seem paradoxical when we take into consideration the fact that, as compared with other countries, a much larger part of the funds is allocated to reimbursable medication in Lithuania (29%)

(Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 11). However, it is necessary to take into account the fact that, as compared with the average of the European Union, contributions from the population constitute a larger part of health spending; for example, in 2016, as much as 67% of health spending was paid by the state and from the compulsory insurance fund, and 32% was paid from the personal resources of the population, whereas personal payments for health-care services of residents of the European Union account for 18% (Sveikatos priežiūros sistemos vertinimas, 2019, 6–7). Personal payments for health-care services in Lithuania are higher than those on average in the European Union, for two reasons: one is that it is quite often that people have to buy medication themselves because some of it is not reimbursed, or reimbursed only in part (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 11). By consistently applying special measures, it has become possible to considerably reduce personal spending by the population on medication taken on an out-patient basis (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 18). However, as our investigation shows, the situation needs a more effective solution, so that all people, including those with disabilities, can receive the reimbursable medication necessary for them.

The situation is somewhat worse with prescribing the most effective reimbursable measures and reimbursable rehabilitation treatment. Even though the majority of respondents (74.7% and 69.5%, respectively) indicated that they had no, or almost no, financial constraints, approximately every sixth or seventh respondent was faced with severe constraints. Speaking about rehabilitation, Lithuanian people with disabilities are entitled to rehabilitation treatment pursuant to the law (Medicininės reabilitacijos ir sanatorinio (antirecidyvinių) gydymo organizavimo aprašas, 2008). Despite the legal regulation, there are still problems with rehabilitation services in the country: according to the results of an investigation carried out by the Lithuanian Association of People with Disabilities (2018), the needs of people with disabilities for rehabilitation services are not sufficiently satisfied. This is not only Lithuania's problem. It is not by chance that currently (2020) the motion to adopt the Resolution on the European Disability Strategy is being considered at the European Parliament, which would commit member states to ensure greater possibilities for people with disabilities to make use of gender-adapted rehabilitation services.

The investigation suggests that psychological and social assistance are spheres in the health-care system of the country that are granted the most inadequate funding: 28.5% of respondents indicated that they encountered severe and very severe financial constraints when referring a patient with a disability for psychological assistance, and 29.1% when referring patients for reimbursable social assistan-

ce. The problem with the provision of psychological and social assistance was also stated earlier in other investigations and political documents; for example, in 2016 the National Health Council stated that primary health-care service teams did not operate in the country yet, in which social workers and psychologists had to work together with family practice physicians and caregivers (Dėl šeimos gydytojo modelio įgyvendinimo, 2016); in 2017 it was stated that accessibility to mental health services was rather limited (Visuomenės sveikatos netolygumai, 2017); in 2018, according to the data of the research carried out by the Lithuanian Association of People with Disabilities, only one third of people with disabilities received psychological services, although the number of people who would like to receive these services free of charge is much greater (Neįgaliųjų individualių specialiųjų poreikių tenkinimo tyrimas, įvertinant jungtinių tautų neįgaliųjų teisių konvencijos nuostatų įgyvendinimo efektyvumą Lietuvoje, 2018). The problem identified of financing psychological and social assistance allows the conclusion to be drawn that more attention should be paid to this part of the health-care system in Lithuania, so that qualitative social and psychological services, and the quality of life of people with disabilities, can be assured.

Conclusions

Lithuania is making progress in purposefully increasing financing to the health-care system covering a wide range of spheres. Even though physicians have sufficient opportunities to refer patients with disabilities, access to rehabilitation, psychological and social services remains limited due to lower funding.

The facts mentioned above suggest that we should agree with the conclusions of the health-care system evaluation carried out in these latter years, that there is a dire need to develop a more effective public health policy in Lithuania, reform the health-care system, and invest in the improvement of its quality (State of Health in the EU, Lietuva: 2019 m. sveikatos būklės šalyse apžvalga, 2019, 14), and that Lithuania should take more measures to ensure the health of its population and qualitative health services, reducing imbalances in accessibility to and the quality of health-care services (Sveikatos priežiūros sistemos vertinimas, 2019, 17). It is important to include disability rights in the health-care reforms, to ensure equal access and prevent discrimination (Ruškus, 2017).

Acknowledgments

This research was funded by the European Social Fund according to 'Improvement of Researchers' Qualifications by Implementing World-Class R&D Projects' of Measure No 09.3.3-LMT-K-712.

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