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**ECONOMIC GROWTH AND IMPACT OF INSTITUTIONS ON QUALITY  
OF HUMAN CAPITAL: A CASE STUDY**

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**Abstract.** The article presents the basic principles of access to health care from the perspective of economics. Accessibility to health care implies adequate health expenditures and is based on the principle of equity. Based on a statistical analysis of international survey data, the article provides a comparative assessment of the accessibility to health care in Latvia, offers realistic solutions to one of the most pressing problems to improve the quality of life of the population. The results of the original studies carried out by research teams from Lithuania and other countries are widely used. The accessibility to health care is determined by two areas of a positive development of a country – economic growth and institutional maturity synthesized by social justice. In other words, the population's greater access to health care-related services can and should be achieved not only by increasing the labour productivity of the employed through the introduction of new technologies and other components of economic growth, but also by adjusting higher-quality state and non-state institutions, their effective interaction in order to achieve economic growth and quality of life of the population.

**Keywords:** economic growth, health care; out-of-pocket payments; catastrophic health expenditures

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## **1. Introduction**

One of the major driving forces of economic growth is human capital. Quality of human capital is affected by wide range of factors, e.g. such as living (Omelchuk 2018) and working conditions (Lincaru et al. 2018; Kaźmierczyk, Chinalska 2018; Mamedov et al. 2018), education quality (Labanauskis et al. 2018), accesability to health care (Panfiluk, Szymańska) etc. This paper will tackle, specifically, accessibility to health care in Latvia with the aim to reveal the role of the institutional maturity of the system.

According to Eurobarometer 2018, the Latvians consider health care and social security system one of the most pressing issues in their country – 37 pct. (Euro Commission 2018). The topicality of the given issue is evidenced by numerous articles that regularly appear in the Latvian media; they are devoted to the existing problems with human resources in the health care, insufficient funding of the sectoral activities and the depressing consequences of the limited access to health care-related services among the population. The underestimation of the severity of health care problems leads to serious consequences in the field of national security (Menshikov et al. 2017).

Access is a generic term used to refer to a wide range of issues focused on the extent to which individuals and groups can receive necessary services provided by a health care system. In scientific literature, there are various approaches to the formulation and operationalization of this concept. In the 1970s, David S. Salkever (1976)

classified access to health care as physical and financial accessibility. More than 30 years ago, Penchansky and Thomas (1981) identified five main dimensions to categorize access to health care-related services: availability, accessibility, accommodation, affordability, and acceptability. Later, numerous studies used various modifications of this concept (Frost et al. 2016). Researchers added such dimensions as reachability, coverage, outcomes and impacts, appropriateness, adequacy, quality, and many others (Levesque et al. 2013).

Unmet health care needs, defined as a difference between the services deemed necessary to adequately deal with health problems and the ones actually received, are treated just as tools to control the access and the degree of inequity in the use of health care (Allin, Masseria 2009). To study the accessibility to health care, Eurostat uses data provided by two surveys: “EU Statistics on Income and Living Conditions” (EU-SILC) that is conducted annually, as well as “European Health Interview Survey – second wave” (EHIS), which was carried out between 2013 and 2015. For the second wave (EHIS2) the baseline year is 2014, and for EU-SILC statistics the reference year is 2016. The results of EU-SILC are calculated over the entire population of the European Union aged 16 and over. While EHIS covers the population aged 15 years and over that were in need of health care in the previous 12 months prior to the survey (Eurostat 2018).

Eurostat data identifies three main reasons for the unmet needs of the population for specific health care-related services: cost of services (too expensive), distance or transportation problems (too far to travel) and timeliness (long waiting lists). According to EHIS, in 2014, a total of 26.5 pct. of the EU-28 population aged 15 and over in need of health care reported to have unmet needs for health care because of the reasons of financial barriers, distance or transportation problems and/or long waiting lists (Figure 1). In this rating, Latvia is at the 1<sup>st</sup> position among all the EU states – 41.8 pct. If to consider only financial reason for unmet needs, then Latvia is again among the “leaders” in the ranking – the 2<sup>nd</sup> position after Ireland among the EU states, with an indicator of 34.2 pct. (Eurostat 2018).

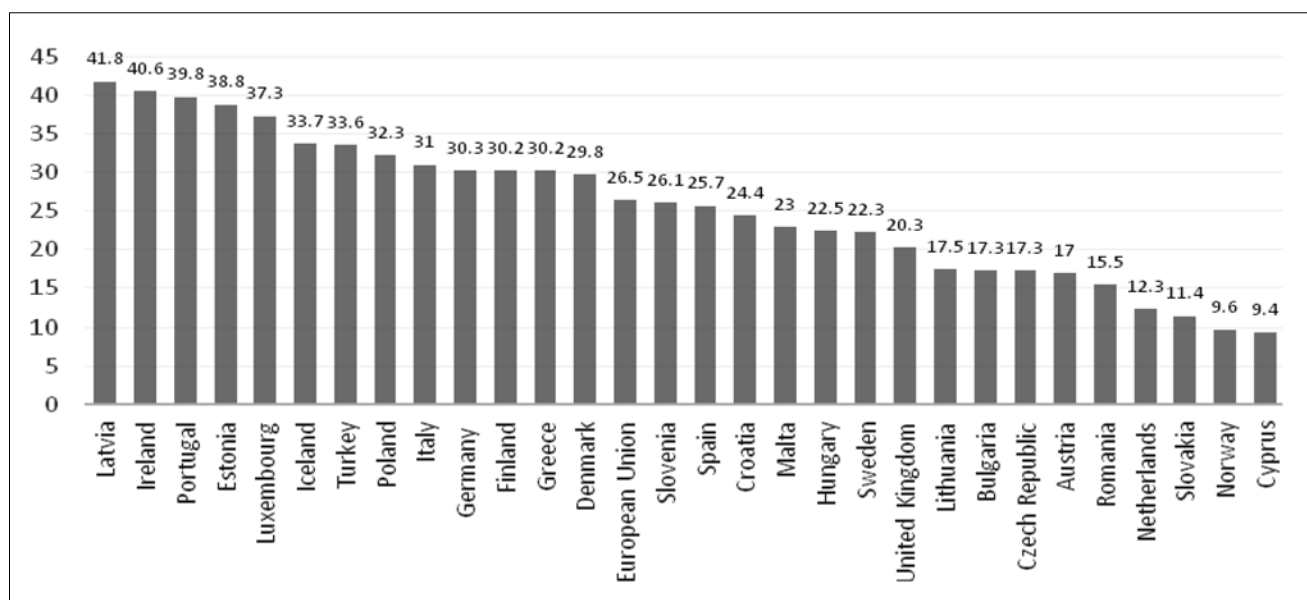


Figure 1. Share of persons aged 15 and over that report unmet needs for health care by various reasons, 2014, %

Source: compiled by the authors from Eurostat data

Countries with a low level of financial protection of the population often report a high level of unmet need for health care-related services. Economic accessibility to health care implies adequate health expenditures and is based on the principle of equity. Ability to pay for health care-related services is a widely used concept in the field of health economics (Levesque et al. 2013); it is determined by such indicators as prices for services, direct costs, indirect costs, etc.

To measure economic accessibility two methods are traditionally used: “catastrophic payment method”, based upon the ratio of the payment for a specific commodity to a household’s total resources, and “impoverishment method”, which considers household’s residual income after paying for the needed goods or services. These practical methods are also considered essential when measuring financial protection of health care (Niëns 2014). The catastrophic expenditures method measures the proportion of population, whose resources will be drastically reduced after paying for health care-related services and goods. Catastrophic health care expenditures occur, when a household’s out-of-pocket health spending exceeds a defined threshold of the household’s expenditures; as a result, the household may face difficulties meeting other basic needs (WHO, Regional Office for Europe 2018). The impoverishment method estimates the proportion of population that will be pushed below the poverty line after health expenditures. The international poverty line is used to calculate the indicators of impoverishment – \$ 1.25 per person per day. The established methods used to measure the level of financial protection and the underlying assumptions and limitations are described in detail in the works by A. Wagstaff (2008) and O. O’Donnell et al. (2008).

Catastrophic expenditures and out-of-pocket payments for health care with their impoverishing effect have become the key indicators in assessing the financial protection of health care, which has been actively investigated by the WHO Regional Office for Europe in recent years. In 2018, WHO released a series of publications entitled “Are people able to pay for health care-related services?” and devoted to financial protection in various countries, including Latvia (Taube et al. 2018), as well as a comparative analysis of the financial protection of health care in Latvia, Estonia and the Czech Republic that are high-income countries, but with different levels of financial constraints (Thomson et al. 2018). Catastrophic health care expenditures are heavily concentrated among the poorest households in all the three countries and among retirees in Estonia and Latvia, but not in the Czech Republic. In these countries, the degree of financial constraints, caused by catastrophic expenditures, varies. On average, Estonian and Latvian households with catastrophic out-of-pocket payments spend a much larger share of their budget on health care-related services rather than the ones in the Czech Republic. The analysis has showed that the differences in financial constraints are partly due to the differences in health expenditures in all the three countries, especially with regard to changes in the priority of health care in the allocation of public spending.

WHO experts recognize state health insurance policy as a no less important factor. For example, the system of state co-payment for pharmaceutical expenditures, when a patient pays a certain percentage for health-related prescriptions or services, is recognized as weak and ineffective, because out-of-pocket payments increase as drug prices rise. In Latvia and Estonia, a significant part of cost-sharing falls on the shoulders of that part of the population that cannot afford it – the poor, people with chronic diseases, retirees. In its turn, the Czech Republic is one of the few EU countries, where a limit on all types of co-payments has been introduced, as a result, catastrophic expenditures are very low, outpatient medicines are affordable, and retirees do not experience excessive financial constraints (Thomson et al. 2018).

Co-payment is an official payment imposed on users (money that people need to pay when they receive health care-related services), which is paid by a third party, for example, by government, health insurance fund or private insurance company. Annual per-person limitation on all types of co-payment (exemption of people from co-payment) plays an important role, as it either ensures that the respective target groups do not have to pay anything at their own expense or limits the amount of the sum that must be paid out of pocket, giving a protective effect to the poorly protected segments of the population. Limits can be applied to the payment for a commodity or a service or to the amount of per person or household’s expenditures for a certain period of time. If they cover the amount of the expenditures of one person, they can be set as a fixed amount or as a certain share of one’s income. The limits on the amount of expenditures for a certain period of time provide a higher level of protection than the limits on payment for a certain commodity or a service. The application of limits set in relation to one’s income provides greater social equity by ensuring that a larger part of financial burden, associated with direct payments, will be placed on more affluent households (WHO, Regional Office for Europe 2018).

As the WHO study shows, Estonia has already taken steps to simplify and improve its co-payment policy – it sets a threshold for direct payments for certain prescription products; if the set threshold amount is reached, the co-payment amount charged as a percentage of the cost decreases (Vörk, Habicht 2018). Data on the positive consequences of the exemption of poor citizens from co-payment also come from Latvia. By taking measures in response to the economic crisis, in 2009, Latvia exempted the very poor from making co-payments for services; in 2010, it extended this norm to other poor groups of the population; and then, in 2012, Latvia repealed this norm for all persons, except for the representatives of the poorest households (Taube et al. 2018). These changes in co-payment policy coincide with a reduction of the prevalence of catastrophic direct payments in the quintile of the poorest consumers (WHO, Regional Office for Europe 2018).

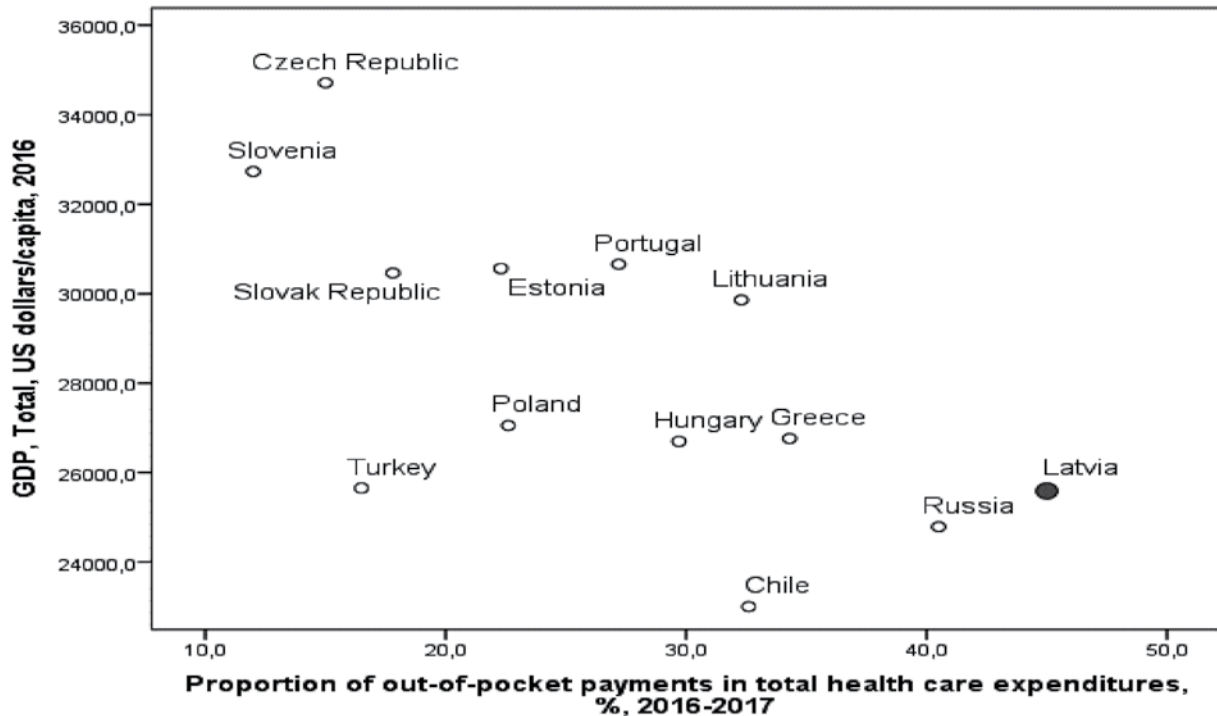
Empirical evidence demonstrates that one of the main indicators of the financial protection of health care (personal payments / out-of-pocket payments) reflects the risk of financial catastrophe and impoverishment. When patient personal payments do not exceed 15-20 pct of the total health care costs, the risk of experiencing catastrophic expenditures and impoverishment is minimal (Evans et al. 2010). Experts often define personal payments as catastrophic ones, if a household's financial contribution to the health care system exceeds 40 pct. of its income. Not only consumers' out-of-pocket payments can cause financial stress and rejection of health care-related services, but they also cause inefficiency and inequity in the use of resources. The use of this form of payment leads to excessive consumption of health care-related services by those, who can pay for them, and to under-use of the health services by those, who are not able to pay for them (Evans et al. 2010).

OECD statistics show that of the three countries mentioned above, in 2016, the smallest proportion of out-of-pocket payments was observed in the Czech Republic – 15 percent, in Estonia – 22 pct. and the most depressing situation was found in Latvia – 45 pct.

In one of her interviews, Anda Čakša, Minister for Health of the Republic of Latvia, emphasized that in our country patient out-of-pocket expenditures are high, since the accessibility to state-paid services had been low for a long time, which made patients pay for health care-related services themselves (LETA 11.10.2017). It means that it is possible to reduce the volume of direct payments, first of all, by improving the accessibility to state-paid services.

In the Global Competitiveness Index, all the three countries (Latvia, Estonia, and the Czech Republic) have the highest scores for the indicator “Health and Primary Education”, but they differ among themselves in the following parameters: Estonia – 6.51; the Czech Republic - 6.35; Latvia - 6.16. Latvia is behind Estonia and the Czech Republic in the specific indicators of public health: life expectancy (years) – Estonia –77.2; the Czech Republic – 78.3; Latvia – 74.2, child mortality (per 1000 live births) – Estonia – 2.3; the Czech Republic – 5.5; Latvia – 6.9; tuberculosis incidence (per 100.000 population) – the Czech Republic – 4.6; Estonia – 20.0; Latvia – 49.0 (Schwab 2016).

Let us consider the accessibility to health care in the aspect of the most important indicators of a country's economic development – GDP and living standards. According to OECD statistics, in 2016, Latvia's GDP was equal to \$ 25.589 per person. If we illustrate the share of direct payments from the total health care expenditures in countries with approximately the same level of GDP (\$ 20.000 – \$ 35.000 per person), we will see that Latvia has the highest share of direct payments among these countries (Figure 2):



**Figure 2.** Ratio of GDP/number of out-of-pocket payments among countries with the level of GDP per capita in the range of \$ 20.000- \$ 35.000

*Source:* compiled by the authors from the data <https://data.oecd.org/gdp/gross-domestic-product-gdp.htm>, <https://data.oecd.org/healthres/health-spending.htm> using SPSS programme

To measure the standard of living in a country, indicators related to income, expenditure and consumption are traditionally used. One of the main indicators is equivalised disposable income (Eurostat 2016). Real adjusted income is based on money income for a given time period less mandatory payments and taxes adjusted for the consumer price index.

Thus, if to consider the share of direct payments for health care-related services and disposable incomes of residents in accordance with OECD statistics (Figure 3), we will see that in most of the countries the level of disposable income is above the average, and the share of out-of-pocket payments is below the average. However, Latvia is in the group of the countries with the lowest level of disposable income, while it has the largest percentage of direct payments.

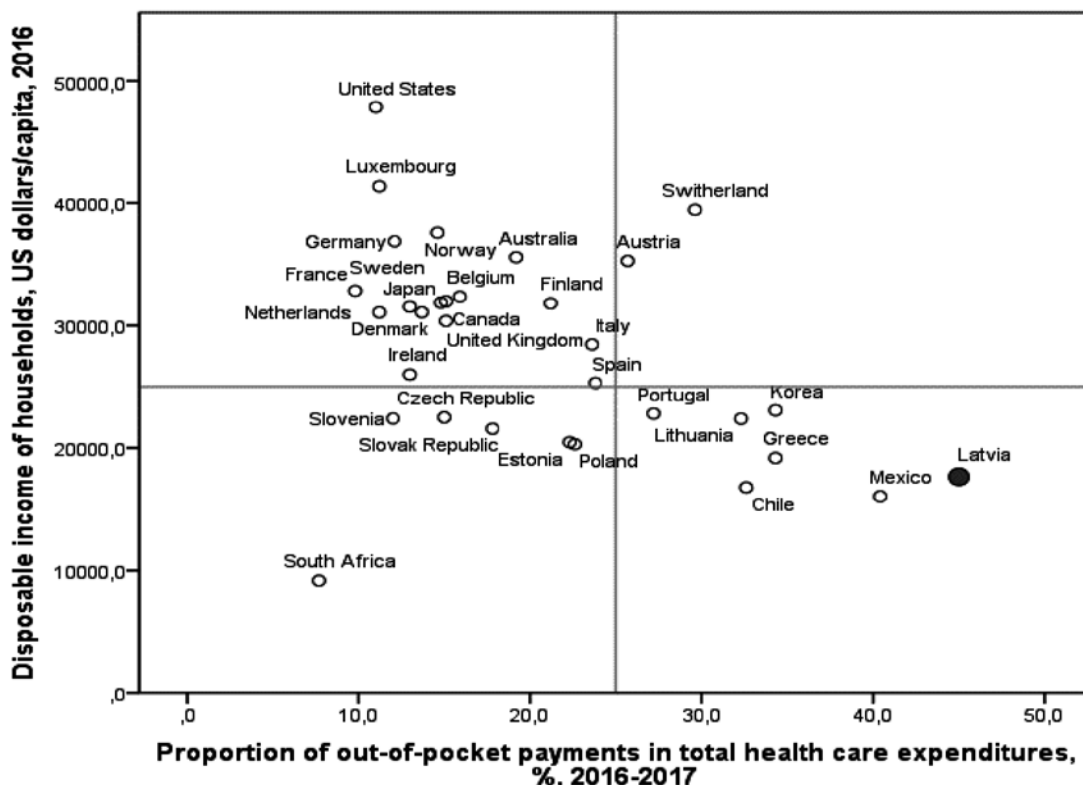


Figure 3. Ratio of personal payments for health care-related services and adjusted disposable income of residents, 2016–2017.

Source: compiled by the authors from the data  
<https://data.oecd.org/healthres/health-spending.htm> using SPSS programme

How is it possible that in the countries of approximately the same size of economy as well as the level of disposable income of households the out-of-pocket expenditures of the population for health care-related services differ so significantly?

It turns out that these are not solely the economic parameters of a country that determine the accessibility to health care. Experts of a large-scale study carried out by *The Economist Intelligence Unit* (analytical division of the British magazine *The Economist*) proved a direct link between accessibility to health care and the Human Development Index (HDI). In this case, accessibility to health care was measured by the Global Access to Healthcare Index, which analyses how health care systems in 60 countries work to meet the population demand for the most urgent health care needs. The analysis of the index suggests that at all income levels many countries have made more progress in distributing basic primary health care among their citizens rather than in building sustainable health care systems. Public trust in civil society and good governance are the key components for a successful increase of access to health care. This was confirmed by a strong correlation between the Global Access to Healthcare Index and the Corruption Perception Index. Experts emphasize the particular importance of confidence in a state as a basis of a politically sustainable system. Taking into account the role of a state in regulating health care, it seems that political leadership and commitment are also crucially important. In the reports of the research, it is indicated that state institutions often lack sufficient capacity to manage or ensure their quality (The Economist Intelligence Unit, 2017). It can be stated that, in this context, we can consider the quality of institutions.

New institutional economics with particular attention examines the processes and consequences of the institutional regulation of economy and the quality of institutions. The quality of institutions or institutional environment includes the existing system of public and private organizations, as well as the existing rules and business practices that define the relationship of economic entities in the country. In particular, the quality of institutions is one of the 12 control components that determine national competitiveness (The Global Competitiveness

Index) and is measured by several dozen indicators using expert assessments (Schwab 2016). The data in Figure 4 show that Estonia, in contrast to Latvia, is very similar to the Czech Republic in terms of economic indicators (GDP, disposable household income), but in terms of the quality of institutions it significantly outperforms not only Latvia, but the Czech Republic as well. Another global index, the Institutional Quality Index (IQI), also shows that the quality of Estonian institutions is higher than the one in the Czech Republic and Latvia, which is demonstrated by the indicators: in accordance with the IQI, in 2017, in the world ranking Estonia was on the 15<sup>th</sup> place, the Czech Republic – on the 25<sup>th</sup>, and Latvia – on the 31<sup>st</sup> place (Krause 2017).

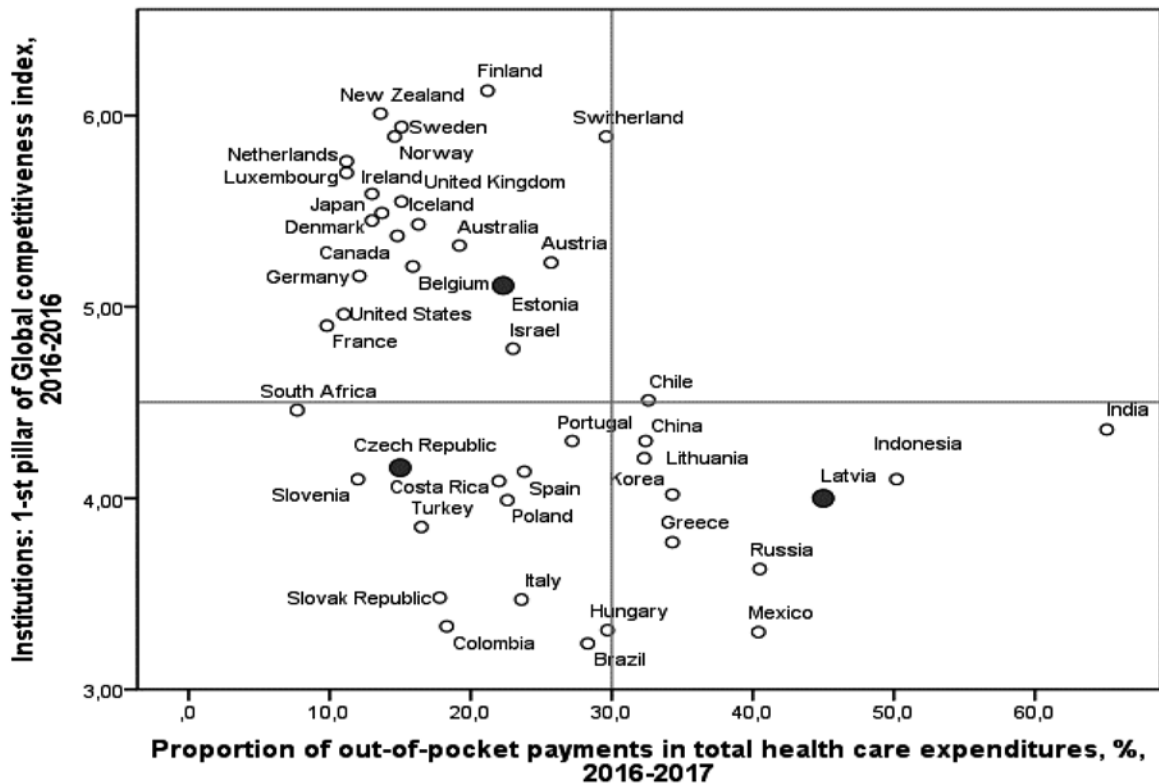
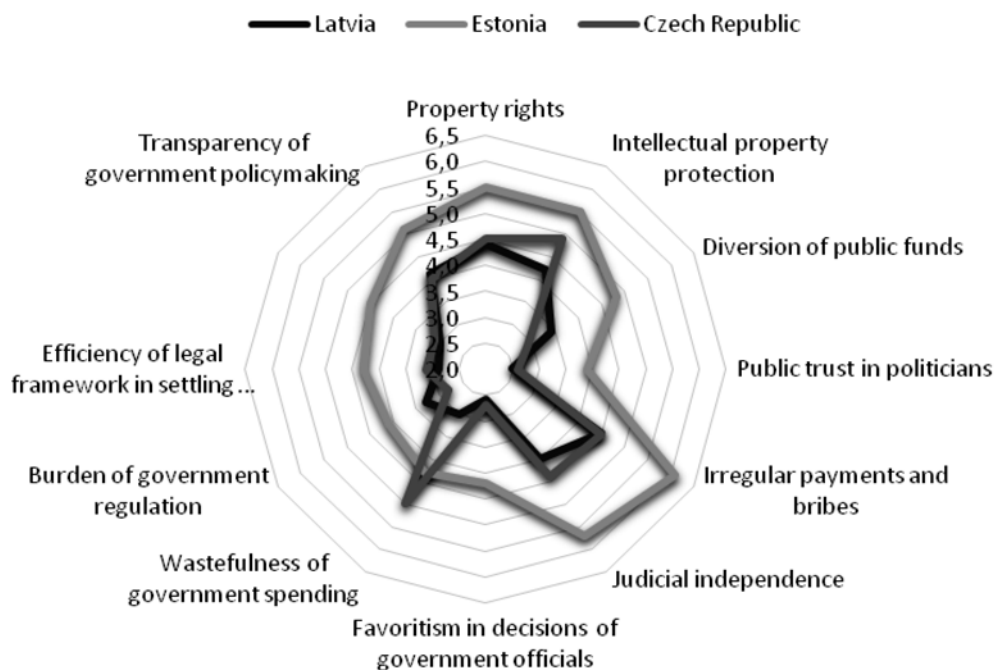


Figure 4. Ratio of personal payments for health care-related services and quality of institutions, 2016–2017

Source: compiled by the authors from the data [http://www3.weforum.org/docs/GCR2016-2017/05FullReport/TheGlobalCompetitivenessReport2016-2017\\_FINAL.pdf](http://www3.weforum.org/docs/GCR2016-2017/05FullReport/TheGlobalCompetitivenessReport2016-2017_FINAL.pdf), <https://data.oecd.org/healthres/health-spending.htm> using SPSS programme

Among the indicators of the Global Competitiveness Index, as was to be expected, the indicator “Quality of Institutions” attracts attention: it is noticeably and positively distinguished in Estonia (the 23<sup>rd</sup> place in the ranking with 5.11 points), the Czech Republic ranks 54<sup>th</sup> with 4.16 points, Latvia is in the 64<sup>th</sup> place with 4.00 points. Taking into account the fact that it is not possible to quickly and significantly positively improve the lowest indicators of competitiveness (such as “Innovation Potential” and especially “Size of Domestic Markets”) for all the three countries surveyed, it seems realistic to strive for achieving faster and more significant positive changes in their institutional development. Analysis of statistical data (Figure 5) shows that a relatively low quality of Latvian institutions is determined by wastefulness of government spending (3.0 points), low level of efficiency of legal regulation in complex issues of public administration and business (3.0 points), low efficiency in solving controversial issues (2.9 points) and a particularly low level of public trust in politicians (only 2.5 points).



**Figure 5.** Assessment of the component indicator “Quality of Institutions” of the Global Competitiveness Index in Latvia, Estonia and the Czech Republic, 2016-2017

*Source:* compiled by the authors from the data of Schwab 2016

Thus, the economic accessibility to health care for the population of Estonia is determined by two areas of positive development of the country – economic growth and institutional maturity that are synthesized by social justice. In other words, greater accessibility to health care-related services for the population can and should be achieved not only by increasing the labour productivity of the employed, introducing new technologies and other components of economic growth, but also by adjusting higher-quality state and non-state institutions, their effective interaction for achieving economic growth and higher quality of life.

On the basis of the proposed methodology, Lithuanian researchers tested the hypothesis that institutional maturity of a country is extremely important for the process of sustainable development (Tvaronavičiene et al. 2009). Scientists claim that institutions have to be perceived as a coherent part of sustainable development: from the one point, it reflects level of development, and, from the other one, it serves as a driving force pushing towards quantitative and qualitative prosperity of a country. It has been convincingly proven that the dominance of Estonia can be primarily explained not only and not so much by the country’s more substantial economic indicators, but also by the indisputable advantages of its institutional maturity. In our opinion, this is largely determined by at least three historical circumstances: the fact that some of the Estonian towns, Revel (Tallinn) and Dorpat (Tartu), belong to the Hanseatic Union, the cultural factor – deeply rooted Protestantism, as well as the experience of the democratic and market development of Estonia in the 1920s-1930s.

Solving the problems of improving the quality of institutions will require not as much additional financial resources as a raise of the level of legal culture, the quality of law-making and law enforcement. The sphere of health care in Latvia is a field of all new scandals rooted in the low quality of institutions formed to achieve high levels in the health sector and to ensure access to health care-related services in Latvia: frequent changes of responsible officials (almost an annual rotation of the state secretaries of the Ministry of Health), poor quality of public procurement held in the industry, inefficient use of financial resources allocated to e-health system, irresponsibility of the government in the implementation of the law on increasing salaries of doctors.



## Conclusions

It is quite obvious and has been repeatedly proved in various world studies that such indicators of the financial protection of health care as public health expenditures, the share of out-of-pocket payments and catastrophic household expenditures are interrelated. In particular, for Latvia, low access to health care is largely determined by relatively modest indicators of economic growth, therefore, by the size of the state budget.

However, our data of the statistical analysis indicate a possibility for Latvia (with its approximately identical economic development indicators) to achieve a significant increase in the level and quality of life of the population by both increasing the accessibility to health care and improving the quality of institutions. In this regard, without delay the Latvian society should make full use of the experience of its neighbours, especially the one of Estonia. Unfortunately, so far, in the academic environment of Latvia, little attention has been paid to the promising direction of theoretical thought – institutional economics.

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