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Financing social protection

Lithuania

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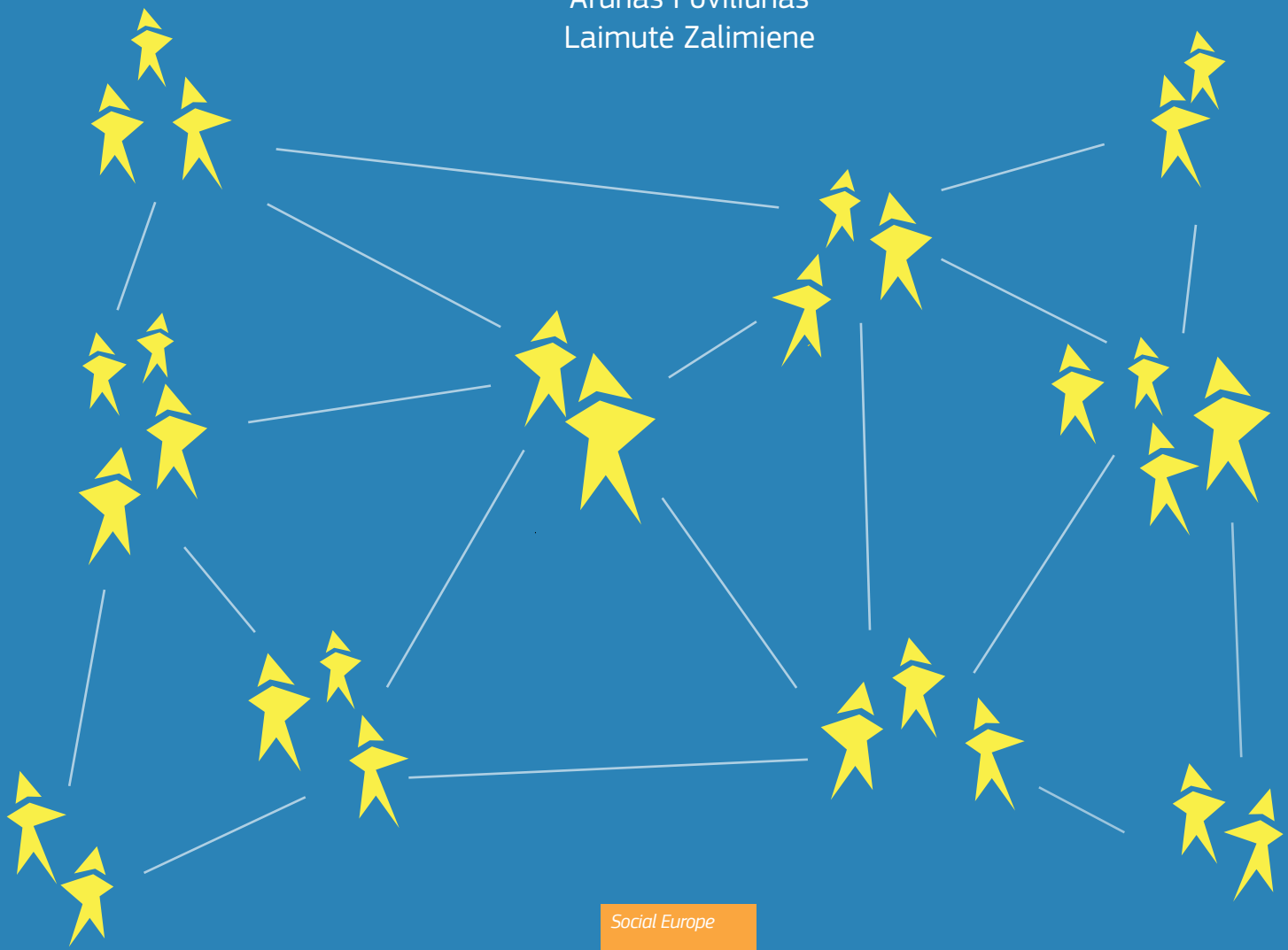

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European Social Policy Network (ESPN)

ESPN Thematic Report on Financing social protection

Lithuania

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Summary

In Lithuania the share of gross expenditure on social protection in total GDP was about half that in the EU28 as a whole in 2016. The underfunding of social protection is formally acknowledged as a problem at the highest governance level in Lithuania. Despite that, current tax and pension reforms continue to follow previous long-standing discourses on 'small government', which will supposedly stimulate economic competitiveness on the basis of cheap labour and low social protection spending.

The reliance of the social protection system on social insurance safeguarded it from attempts to reallocate resources to other public sector areas. On the other hand, it may be seen as a factor in underfunding, due to the low share of wages in national income, the low salaries of public sector employees, widespread undeclared income and 'envelope' wages, and numerous exemptions for the self-employed. Demographic, technological and other pressures on the system of social protection call for additional sources of revenue, which could be achieved through expanding the tax base. The European Commission and the OECD have criticised the high tax burden on employed people in Lithuania, compared with underdeveloped real estate and property taxation, as well as loopholes in personal and corporate income tax systems. There is, however, no coherent reform programme for strengthening the tax base so as to make it possible to increase funding for either social protection or the public sector in general. The latest reforms in the financing of pensions and healthcare are incoherent. On the one hand, the latest initiative (2019) is to partially shift the financing of old-age pensions from the social insurance budget to the general budget. On the other hand, the reform of healthcare financing in 2009 went in the opposite direction.

The introduction of indexation in the system of social insurance old-age and disability pensions reduced the scope for political manipulation and promoted greater transparency. However, the current system of indexation ensures fiscal sustainability at the expense of benefit adequacy. Current debates on pensions are limited exclusively to the enlargement of private pension schemes, without appropriate attention being paid to the financing of the statutory public pension scheme. At the same time, public subsidies for the second-pillar funded pension scheme raise concerns over financial sustainability and both the intra- and intergenerational justice of such an arrangement. Other social protection benefits in Lithuania remain largely unindexed and subject to fluctuations in line with the political cycle, or gradual depreciation. The financing of social assistance and housing is among the least developed areas of social protection in both relative and absolute terms in Lithuania. The financing of active labour market policies (ALMPs) and capital investments in the health sector have been mostly paid for from EU structural funds. There is no plan for how to replace this source of funding with national funds, either after the end of the current EU programming period or in the longer term.

The counter-cyclical mechanism of credited health insurance contributions by the state helps to sustain funding for the health insurance budget. Lithuania's Health System Development Dimensions 2011-2020 stipulate that cost–effectiveness and the rational use of resources is one of the main directions for health system development until 2020. Although Lithuania has adopted a relatively generous approach with respect to coverage of healthcare services, this is not the case for pharmaceuticals and medical aids. Out-of-pocket payments in Lithuania remain very high (in particular for pharmaceuticals) and could threaten healthcare access for vulnerable groups. There is a lack of transparency in co-payments for healthcare. Low public spending on health in relation to GDP, and informal and out-of-pocket payments remain a challenge for the Lithuanian healthcare system.

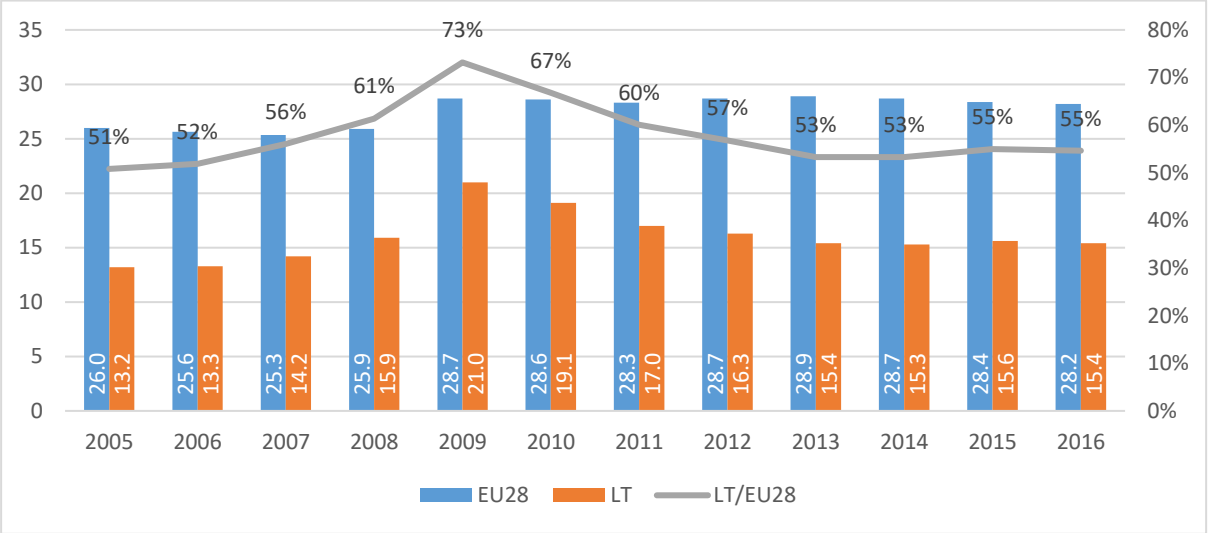
Extensive and coherent tax reform has to be planned and implemented, with the aim of increasing public revenue, and in the first instance improving the funding of social protection, public pensions, pharmaceuticals and social assistance.

1 Current levels and past changes in financing social protection

In this Section current levels and past changes in the financing of social protection in Lithuania are discussed, with an emphasis on the period of 2005-2016 (for which data are available). We discuss the general level of financing as compared with the EU and changes over time. We put special emphasis on the spheres of pensions and healthcare, as these are the two major parts of the Lithuanian social protection system.

During the period examined the share of gross social protection expenditure in total GDP in Lithuania was generally about half that in the EU28 as a whole (see Figure 1). The share increased in 2008 and 2009, but only by 2.2 p.p. overall for 2005-2016. Hence, social protection remains strongly underfunded compared with the rest of the EU. This results in inadequate levels of social benefits and high at-risk-of-poverty and inequality rates in Lithuania (see e.g. OECD 2018).[1]

Figure 1. Share of gross expenditure on social protection in total GDP, 2005-2016: Lithuania and EU28, %



Source: Spasova and Ward (2019), Annex ESSPROS (European System of integrated Social PROtection Statistics) tables.

The increased levels of social protection spending in 2008 and 2009 should be further commented on. Before the onset of the crisis, there was an increase in the generosity of social transfers, including pension increases and the introduction of universal child benefits. The rapid increase in wages was also a causal factor, because of the way wages are used as the base for estimating social insurance benefits. During the crisis the share of GDP spent on social protection increased, mainly due to a rapid contraction of GDP itself. Major cuts in social benefits started in 2010 with the Temporary Law on Recalculation and Payment of Social Benefits.[2] Fiscal consolidation measures had already begun in 2009, including a cut in unemployment, sickness and family benefits (see e.g. Avram et al. 2012). Universal child benefit was partially abolished in 2009 and means-tested more strictly from 2010.

The above-mentioned changes are even clearer when gross social protection expenditure is analysed in real terms. At constant 2005 prices it rose by 14.1% each year between 2005 and 2008 (compared with 2.1% in the EU28), before falling by 0.9% annually

[1] OECD (2018).
[2] Republic of Lithuania (2009).

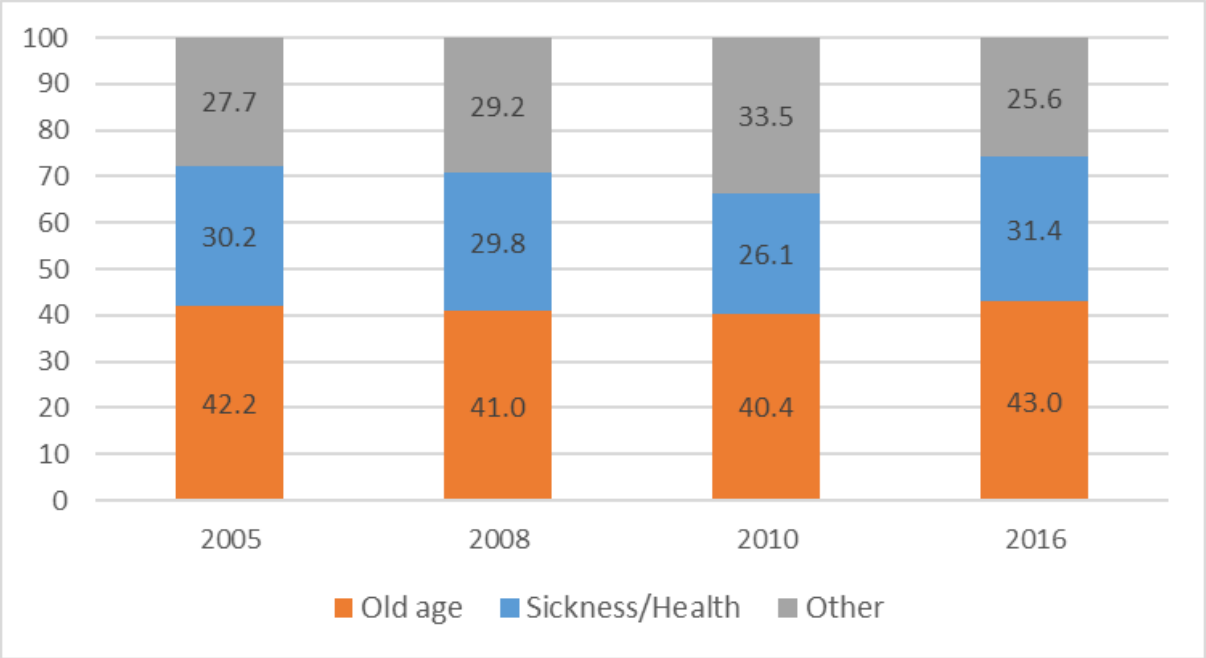
between 2008 and 2010 (4% in EU28) and then remaining relatively constant (0.3% average annual increase) between 2010 and 2016 (1% in EU28).[3]

Gross social protection expenditure in Lithuania was only 0.3-0.4 p.p. higher than net expenditure during the period (compared with a difference of around 2 p.p. in the EU).[4] Because of their low level in Lithuania, social benefits are in general not subject to taxation or social insurance contributions, with the exception of contributory childbirth-related and sickness benefits.

On average only 3.5% of total social protection spending was means-tested between 2005 and 2016. This was a very low share compared with around 12% on average for the same period in the EU28. The share of means-tested benefits increased during the financial crisis and amounted to around 6% of total expenditure at its peak in 2011-2012.[5] This was due to an increased demand for social assistance, weak unemployment insurance and the reintroduction of means-testing in the system of family benefits. The latter, however, were universalised again in 2018, when a universal child benefit was reintroduced in Lithuania. Hence, it can be expected that the share of means-testing in Lithuania will decrease further, provided the situation in the labour market remains stable or improves.

In terms of the breakdown of gross expenditure on social protection by function, old age and sickness/health are the major components (Figure 2). These are discussed in more detail below.

Figure 2. Breakdown of gross expenditure on social protection in Lithuania by function, 2005-2016 (% total expenditure)



Source: Spasova and Ward (2019), Annex ESSPROS tables.

1.1 Old age expenditure

Lithuania allocates modest resources to old age protection. Gross expenditure on old-age pensions fluctuated in the range 5-6.5% of GDP during the period 2005-2016 (Table 1). That was only about 60-70% of the EU average. The GDP share of expenditure on old-age

[3] For more information, see: ESSPROS, Statistical annex on financing social protection: levels and structure (2005-2016).
[4] Ibid.
[5] Ibid.

pensions increased during the crisis and initial post-crisis periods purely because of a sharp fall in GDP. That did not mean an increase in pensions spending in real terms. Moreover, the economic crisis resulted in a deficit on the Social Insurance Fund (SIF), and pensions were reduced by 5% on average for the period 2010-2011. Later these cuts were reversed; nonetheless the share of old age expenditure in GDP fell again to the level of the pre-crisis period, as GDP grew more quickly than spending on old-age pensions during the economic recovery. On the other hand, the share of old age expenditure in total social security expenditure rose after the economic crisis (Table 1), from 40.4% in 2010 to 43% in 2016. The latter was similar to the EU average (40.1%) in 2016 (Table 1).

Population ageing has had no profound impact on old age expenditure yet, because the number of old-age pensioners is kept stable by a rising statutory retirement age. The number of pensioners stayed at around 590-600,000 during the period examined. Although the pension expenditure is low as compared to the GDP, it represents a similar share of the total social security expenditure as the EU average, i.e. about 40% (Table 1). This is due to others areas of social protection being financed at a similarly low level in Lithuania.

Table 1. Gross expenditures on old age in Lithuania (LT) and EU average

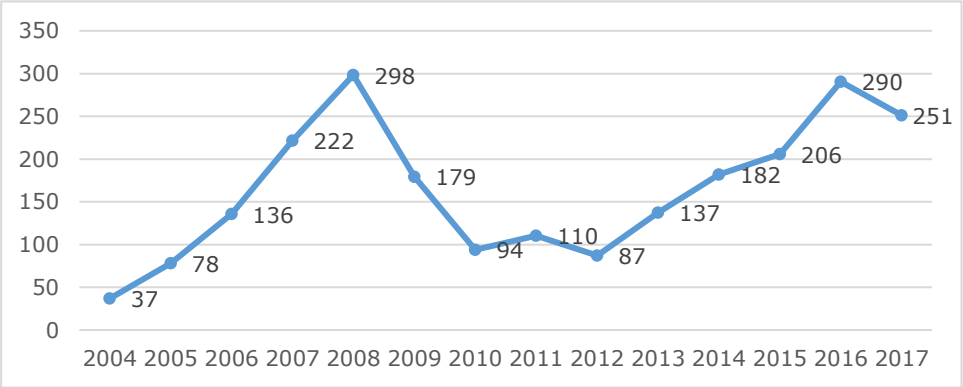
	2005	2008	2010	2016	2005	2008	2010	2016
	% of GDP				% of total expenditure on social protection			
EU	8.2	8.3	9.2	9.7	38.6	39.4	39.1	40.1
LT	5.0	5.6	6.5	5.4	42.2	41.0	40.4	43.0

Source: Eurostat, Pensions, [spr_exp_pens]. Extracted on 31 January 2019.

Box 1. Financing of statutory funded (second pillar) pension scheme in Lithuania

Almost all pension expenditure goes to three public unfunded pension schemes: social insurance pensions, social assistance pensions and state pensions. Only 0.6-0.7% of GDP is directed to the statutory funded (second pillar) pension scheme.[6] The latter is a fully funded and defined-contribution scheme, administered by private fund managers. People can join the scheme voluntarily, but there is no way to exit the scheme until after retirement age. It was introduced in 2004 and initially its funding from the SIF grew, due to a growing number of participants and an increase in the contribution rate from 2.5% to 5.5% of gross wages (Figure 3). The rate was later reduced to 3% from January 2009 and 2% from July 2009, due to the crisis. The pre-crisis rates have not been restored during the recovery. In 2017 a political debate on the reform of the pension scheme started. This reduced the number of new entrants and thus funding of the scheme. The detailed history of past changes and the current mix in the sources of funding for the scheme are further discussed in Section 2.

Figure 3. Financing of funded pension scheme in Lithuania, 2004-2017, million €



Source: Social Insurance Fund (SODRA).

1.2 Sickness/healthcare expenditure

Public social protection expenditure on sickness/healthcare in Lithuania during 2005-2016 increased in absolute terms by 81.5% (i.e. from €1,677.3 million at purchasing power standard [PPS] in 2005 to €3,043.7 million in 2016). Relative to GDP, it was 3.9% in 2005 and 4.6% 2016, which was a little over half the EU average (see Table 2).

Table 2. Social protection expenditure on sickness/healthcare function in Lithuania and EU28, 2005-2016, as % of GDP

	2005	2008	2010	2016
Lithuania	3.9	4.6	4.8	4.6
EU28	7.2	7.3	8.0	8.0

Source: Eurostat. Social protection expenditure. Expenditure: main results (spr_exp_sum).

Total healthcare expenditure, including non-public spending, as a share of GDP also remained very low, fluctuating between 6% and 7% in 2008-2016.[7] Government schemes and compulsory contributory healthcare financing schemes together accounted for 66.9% of total current health expenditure in 2016, which was less than in the majority of EU countries. This share had constantly fallen since 2009, when it accounted for 72.5%.[8]

[6] In Lithuania, the second-pillar pension scheme is a privately managed funded pension scheme partly financed from social insurance contributions – not occupational pensions as they are usually called in most EU and OECD countries. Occupational pensions do not exist in Lithuania, despite the fact that a special 'Law on Funded Occupational Pensions' was adopted in 2006 (No X-745).

[7] Eurostat, Healthcare expenditure by financing scheme. (hlth_sha11_hf). URL: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hp&lang=en.

[8] ibid.

A high share (nearly one third) of health expenditure in Lithuania is funded by out-of-pocket payments, which was double the EU average during the period examined and increased more rapidly than in the rest of the EU. Out-of-pocket payments made up 28.2% in 2008 and 32.3% in 2016.[9] They were mainly due to high spending on outpatient pharmaceuticals, with only some vulnerable groups eligible for full or partial reimbursement.

Lithuania has one of the lowest rates of compensation for pharmaceutical costs. Prices for pharmaceuticals are high because there is no effective health technology assessment (HTA) in place, and there is a low reliance on generics among the population. In 2009, in response to the effects of the crisis on the pharmaceutical market, the National Health Insurance Fund (NHIF) stepped up efforts to lower the price of medicines and encourage more appropriate prescribing and dispensing (Murauskienė & Thomson 2018). Similar efforts are being continued by the current government.

The share of total health expenditure spent on voluntary health insurance (VHI) is low, less than 1%.[10] An attempt to develop complementary voluntary health contributions within the state health insurance scheme was not successful, mainly because of the formally generous scope of services provided free of charge, and negative popular attitudes towards additional payments in healthcare.[11]

The economic crisis and the need to reduce the public deficit have affected public spending on healthcare. The cuts mostly focused on cost-reduction in health services and pharmaceuticals. The sickness benefit amount was also reduced from 2009. On the other hand, reduced social contribution income resulting from falling employment was partially compensated for by increased state contributions on behalf of the economically inactive population. Factors increasing expenditure on sickness benefits after 2010 included increases in employment rates, insured income (i.e. earnings) and the proportion of people insured.

Table 3. Breakdown of gross expenditure on sickness/healthcare in Lithuania and EU28, 2005-2016 (% total social protection expenditure)

	2005	2008	2010	2016
Lithuania	30.2	29.8	26.1	31.4
EU28	28.7	29.3	29.1	29.5

Source: Eurostat: Healthcare expenditure by function [hlth_sha11_hc].

Spending on sickness/health ranged between 26.1% of gross expenditure on social protection in 2010 and 31.4% in 2016. The low share in 2010 reflected, besides reduced sickness payments, overcrowded public spending in other spheres of social protection due to the economic crisis (e.g. on unemployment and social exclusion). Competition between programmes in 2008-2010 meant that spending on sickness/health fell by 9%, while expenditure on social exclusion increased more than threefold.[12]

Lithuania stands out in Europe in relation to population ageing, and long-term care (LTC) is a new and developing area of social policy.[13] In 2008, nursing and palliative care services at home were introduced as new services financed through the NHIF. Spending on LTC accounted for 1.2% of Lithuania's GDP in 2016 (spread across healthcare and social

[9] Ibid.
[10] Eurostat: Healthcare expenditure by financing scheme [hlth_sha11_hf] URL: http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_sha11_hp&lang=en.
[11] Murauskiene et al. (2013).
[12] Eurostat: Social protection expenditure. Expenditure: main results [spr_exp_sum] Tables by benefits - sickness/healthcare function [spr_exp_fsi].
[13] SocMin (2008).

services) (Table 4);[14] the main sources of funding were central government and local budgets. Only a small part was financed by social insurance. LTC services are also financed by EU structural funds.

Table 4. Healthcare expenditure on long-term care in Lithuania, 2008-2016

	2008	2010	2016
Share of GDP (health)	0.46	0.61	0.55
Share of GDP (social)	0.49	0.52	0.68
Share of total health expenditure (health)	7.4	8.9	8.3
Share of total health expenditure (social)	7.8	7.7	10.2

Source: Eurostat: Healthcare expenditure by function [hlth_sha11_hc].

1.3 Other expenditure

Other social protection expenditure totalled around a quarter of total gross expenditure on social protection both at the beginning and at the end of the period analysed. This was below the EU average of 30%. Spending on other areas rose during the pre-crisis and crisis periods due to:

- an increase in the generosity of birth-related family benefits and universalisation of child benefits before 2008 (+3 p.p. of the total social protection expenditure);
- an increase in the number of recipients of unemployment and social assistance benefits during the crisis (+4.5 p.p. of the total social protection expenditure).

It should be noted that all other benefits (disability, survivors, family, unemployment, social exclusion) constituted a similar share of total social protection expenditure in Lithuania to that in the EU28. It should be stressed, however, that spending was well below the EU average in absolute terms and as a percentage of GDP. Spending on housing was especially low. According to research, Lithuanian housing policy is very weak in the face of high demand pressures, (housing space per resident is still very low relative to the rest of the EU).[15]

Spending on means-tested social benefits was also comparatively low, and on social assistance was even more underfunded. On average only 3.5% of total expenditure on social protection was on means-tested benefits during 2005-2016.[16] The share of cash social assistance recipients was about 1-2% of the population before the crisis and currently is less than 3%, despite record high at-risk-of-poverty rates (Lazutka et al. 2015).[17] The low coverage of social assistance is due to the low amounts of benefit (maximum of €122) and restrictive rules.[18]

[14] As LTC expenditure is allocated between health, disability and old age function, we believe, that this share does not reflect the level of financing in full.

[15] Brazienė (2018).

[16] ESSPROS, Statistical annex on financing social protection: levels and structure (2005-2016).

[17] Lazutka et al. (2015).

[18] Matulionytė & Navickė (2018).

2 Current mix and past changes in the sources of financing for social protection

In this Section we aim to analyse the current structure and past changes in the financing of social protection by source. First, we discuss the structure of funding, followed by an analysis of old age, healthcare and other expenditure.

Table 5. Division of financing for social protection in Lithuania and EU28, by main source, 2005-2015 (% of total financing)

	Lithuania			EU28		
	Social contrib. (total)	Govt. revenue	Other receipts	Social contrib. (total)	Govt. revenue	Other receipts
2005	61.2	38.2	0.6	528.7	37.8	3.5
2008	64.3	34.9	0.8	55.7	38.4	6.0
2010	65.4	33.6	1.0	54.9	39.4	5.7
2015	72.1	27.2	0.7	52.8	41.7	5.5
2016	75.6	23.6	0.8	54.5	40.4	5.1

Source: Spasova and Ward (2019), Annex ESSPROS tables.

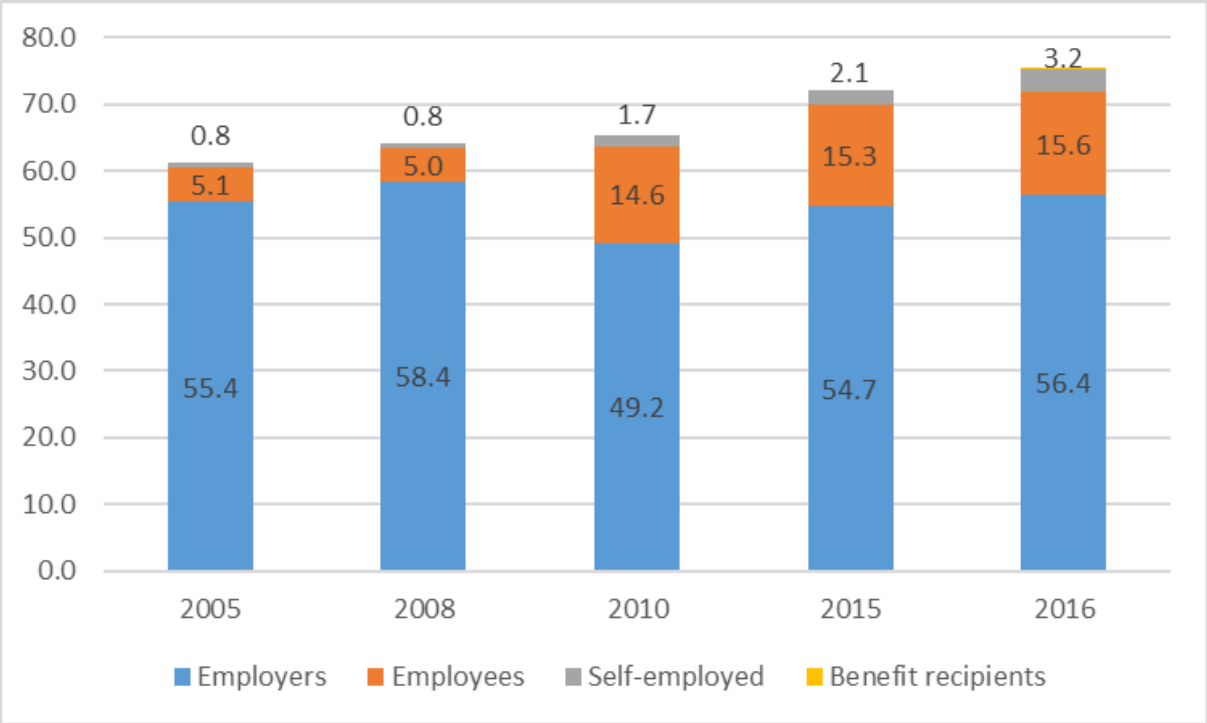
The Lithuanian system of social protection relies on social insurance contributions as the main source of financing. At the end of the period social contributions made up around 75% of total financing, compared with around 55% on average in the EU (Table 5). General government revenue is the second major source of social protection financing, while other receipts accounted for less than 1% on average during 2005-2016.

That financing model is the reason Lithuania is often described as a Bismarckian-type welfare state (e.g. Aidukaite et al. 2012).[19] Furthermore, Lithuania is often criticised by major international institutions for disproportionately high effective taxation rates on labour, with social contributions being the main instrument. However, this should be treated with some caution as the disproportion is amplified by below-average income and property taxation (OECD 2018).[20]

With regards to the dynamics of financing for social protection, there was an increase in the share of social contributions in total financing from around 61% in 2005 to 75% in 2016. The structure and main drivers of this increase are discussed in more detail below.

[19] Aidukaitė et al. (2012).
[20] OECD (2018).

Figure 4. Breakdown of social contributions by employers, employees, self-employed people and benefit recipients in Lithuania, 2005-2016 (% of total social protection financing)



Source: Spasova and Ward (2019), Annex ESSPROS tables.
Note: Figures for benefit recipients not identified numerically

As is typical of the Baltic states, the main burden of social contributions is carried by employers. However, within the period 2005-2016 the social contributions paid by employees and the self-employed increased.

A threefold increase in the share of employee social contributions in total social protection spending after 2009 was caused by the shifting onto it of the part of personal income tax (PIT) dedicated to paying for health insurance. The latter, at the rate of 9%, became universal and also needed to be paid by the non-employed.

There was also a fourfold increase in the share of total social protection spending paid for by the self-employed. The coverage of social insurance for the self-employed was gradually increased – initially only for the basic component of pensions, but later for almost all standard risks.

It should be noted that there are also credited state contributions, which are not reflected in Figure 4. Hence the actual share of social contributions in the total financing of social protection is even higher.

Furthermore, the latest tax reform, implemented from 2019, shifts the major part of social insurance contributions from employers to employees (compensated for by an increase in gross wages) However, the total sum of social contributions paid remains unchanged.(see Box 2).

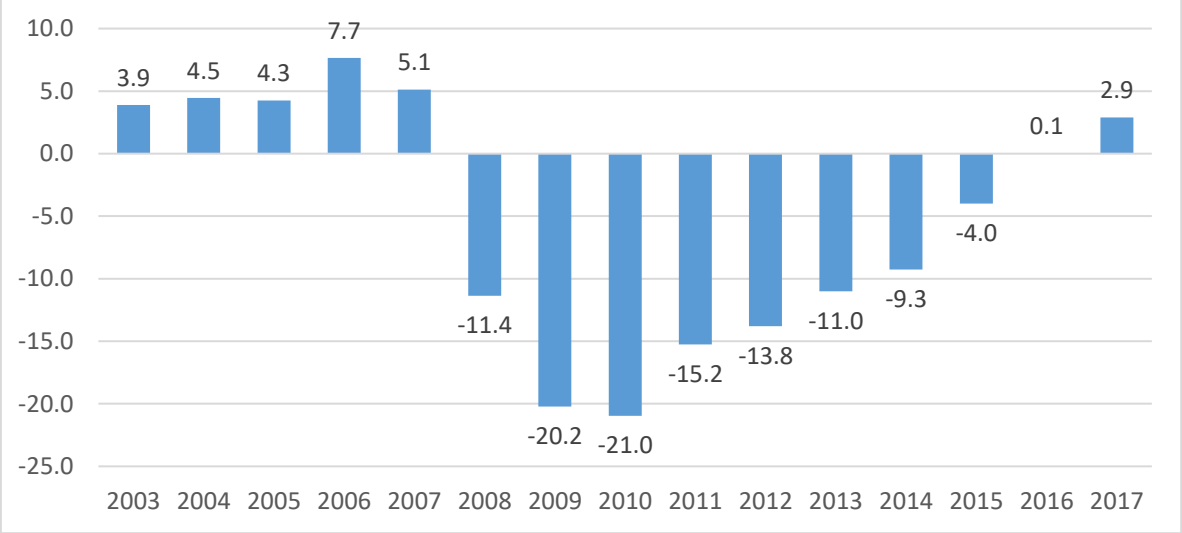
Box 2. Tax reform implemented in Lithuania from 1 January 2019

The government recently introduced more changes in the individual income tax and social insurance contributions system, which took effect in 2019. The main goals of the reform are to ease the overall tax burden on labour and to make the social security contribution system clearer and more transparent. From 1 January 2019 the calculation of state social insurance contributions for employees was changed. The burden of paying the larger part of social insurance contributions (i.e. the 28.9% rate paid by employers) will be transferred to employees. Employers will be obliged to recalculate the gross wages of employees, increasing them by a factor of 1.289 so that there is no reduction in the net wage after contributions. (As a result of this reform, the minimum wage [MW] also rose from €430 to €555.) From 1 January 2019, the current 15% rate of the PIT applicable to wages was increased to 20%. If an individual wage exceeds 120 times average wages, the excess amount will be taxed at 27%. The increase in PIT is being accompanied by a cut in social insurance contributions, because of the transfer of financing for the 'general' (basic) flat-rate social insurance pension component from the SIF to the state budget. Tax-exempt income will be reduced from €380 to €300 per month, but the rate of exemption will be at the new higher rate of 20% instead of 15% (hence no change in the total sum). Where the monthly wage exceeds the MW, the applicable monthly tax-exempt amount is calculated according to the formula: 300 – 0.15 × (W – MW), where W is the actual wage. The tax-exempt amount will be increased gradually from €300 in 2019, up to €400 per month in 2020, and from 2021 will be fixed at €500.

The net result of all these changes to income tax and social insurance contributions, and the recalculation of employees' gross wages, should be that the overall tax burden declines.

Finally, it should be noted that social insurance receipts and expenditures are strongly dependent on economic cycles. Hence there is a lot of volatility in the surpluses and deficits on the SIF (Figure 5).

Figure 5. Surpluses and deficits on the Social Insurance Fund in Lithuania, 2006-2017 (% of total annual social protection expenditure)



Source: State Social Insurance Fund Board (http://atvira.sodra.lt/en-eur/), own calculations.

There was a surplus on the SIF budget up to 2007. This was despite a rapid increase in social insurance benefits before the crisis, especially those covered by maternity insurance and pensions. This was followed by the deficit period of 2008-2015. The latter was due to a number of factors. The major factor was the economic crisis, when receipts of social insurance contributions dropped, while liabilities to pay social benefits such as unemployment benefits remained the same or even increased. Moreover, part of the social insurance contributions for pensions was transferred to the statutory funded pension scheme and could not be used for current pension payments. The SIF deficit was covered via loans from the government and commercial banks, which incurred interest. Only in 2016-2017 did social insurance contributions again exceed SIF expenditure.

Statistics on the sources of surplus or deficit by insurance type are only available from 2012. Within the period, the main imbalance was observed in the receipts and liabilities for maternity/sickness insurance, for which there was a 21.2% average annual deficit during 2012-2017.[21] Pensions and unemployment benefits were also among the deficit areas. However, it should be noted that cross-financing between different social insurance types is not forbidden. Hence, it is the balance of the general social insurance budget that is being monitored, rather than that by insurance type.

As a result, and in the absence of SIF reserves, a total debt of €3,682.3 million (i.e. around 100% of SIF annual expenditure) had been accumulated by December 2017. The debt was recognised as a government debt in 2018.[22] This was accompanied by new legislation on the indexation of social insurance pensions,[23] as well as rules for accumulating and managing the SIF reserves.[24] The former should prevent manipulation of pension amounts, which constitute the major source of social insurance expenditure. The latter should help balance the SIF budget during future periods of economic recession. Furthermore, as of 2019 there are no more transfers to the statutory funded pension scheme from the social insurance budget (see Table 7 and Section 2.1 for details). These reforms should help avoid major deficits in the Lithuanian social insurance system in the short and medium term.

2.1 Old age financing

The financing of old age in Lithuania mainly relies on social contributions paid by employers, employees and the self-employed. Government revenue makes up only 15-20% of total financing, covering only small pensions schemes (state pension and social assistance pension) and LTC for the elderly. 70-80% of all social insurance contributions are paid by employers. (Table 6).

Table 6. Division of financing of old-age benefits in Lithuania by main source, 2005-2015 (% of total financing)

	Total old-age benefits financing =100%			Social contributions = 100%		
	Social contrib. (total)	Govt. revenue	Other receipts	Employers	Employees	Self-employed
2005	86.4	13.1	0.5	76.8	8.2	1.4
2008	87.0	12.5	0.4	78.3	7.4	1.3
2009	80.4	19.2	0.5	70.0	8.9	1.5
2015	83.5	16.1	0.4	71.7	9.6	2.2

Source: ESSPROS, Statistical annex on financing social protection: levels and structure (2005-2016), own calculations.

The social insurance pension scheme in Lithuania covers all employees and the self-employed. Social insurance old-age pensions are exclusively financed from social contributions.

While social contributions for pensions are paid on employment and self-employment income, the effective tax rates differ due to differences in the social contribution base, as follows:

- employers pays 22.3%, and employees 3%, of gross wages;
- self-employed people pay 25.3% on 50% of their declared income;

[21] State Social Insurance Fund Board (http://atvira.sodra.lt/en-eur/), own calculations.

[22] Ministry of Finance: https://finmin.lrv.lt/lt/naujienos/3-7-mlrd-euru-sodros-skola-perkeliama-i-valstybes-izda.

[23] Republic of Lithuania (2016a).

[24] Republic of Lithuania (2016b).

- self-employed people with a licence contribute 26.3% of the minimum monthly wage; and
- farmers and their partners pay 25.3% on their declared income, but not more than 14 times the average gross monthly wage per year (data as of 2018).

The above contribution rates for pensions cover old-age, disability and survivors' pensions. There is no split of contributions for each type of pension. However, looking on the expenditure side, we can assume that old-age pensions are financed by about 20 p.p. of the 26% of gross wages allocated for all three types of pensions.

There were limited variations in employer and employee contributions after 2005. Employer contributions were 23.5-23.8% between 2005 and 2008, and 23.3% in 2009-2017. Employees were paying 2.5-3% in 2005-2008, and 3% in 2009-2018.

Neither ceilings nor floors were applied to employer and employee contributions until 2017. From 2018, it was decided to introduce floors for social insurance contributions with the aim of reducing widespread undeclared wages. Contributions must now be paid on at least the official minimum wage even in the case of part-time jobs (except for old-age and disability pensioners, and young people). Ceilings for social insurance contributions have been introduced at the level of 10 times average wages in 2019. The ceiling will be gradually lowered to five times average wages over a period of a few years. Ceilings on contributions were introduced with the aim of bringing contributions in line with the ceilings applied to pension payments.

Social contributions for the self-employed were reformed several times during the period after 2005. In 2005-2008, self-employed people were insured only for the basic flat-rate component of the social insurance pension. They were required to pay contributions equal to 50% of the basic pension. In 2009-2017 they were covered by insurance for a full pension and had to pay 26.3% of their declared income. In 2018, the contribution rate was reduced by 1 p.p. One category of self-employed people – the owners of business certificates – do not have an income record. Thus, their contributions are not linked to their income. They paid contributions equal to 50% of the basic pension during 2005-2016. In 2017-2018, they were required to pay 26.3% of the minimum monthly wage.

There are several population groups whose contributions for pensions are calculated by reference to the minimum wage and who are covered by means of the state budget. Such credited contributions are paid on behalf of (for example) people taking care of children aged under 3 or of disabled persons, individuals having the status of an artist, and priests.

The statutory funded defined-contribution (so-called second pillar) pension scheme was introduced in 2004. It was financed by a fraction of the social insurance contribution (increased from 2.5% to 5.5% of gross wages in 2004-2007, then reduced to 3% from January 2009 and further to 2% from July 2009 due to budget constraints). The pre-crisis rates have not been restored during the recovery.

At the end of 2012, the Parliament adopted changes in the funded pension scheme. From 2014 the contributions to the pension funds came from three sources: 2 p.p. of the obligatory social insurance pension contribution (originally planned to rise to 3.5 p.p. from 2020), 1% paid by members (2% from 2016) and 1% of the country's average wage additionally paid by the state (2% from 2016).

Table 7. Contributions to the Lithuanian statutory private funded pension scheme 2014-2019, %

	Fraction of the social insurance pension contribution	Additional contribution paid by members	Contributions paid by the state (% of average wage in the country)
2004	2.5	0	0
2005	3.5	0	0
2006	4.5	0	0
2007-2008	5.5	0	0
2009	2.5	0	0
2010-2011	2	0	0
2012	1.5	0	0
2013	2.5	0	0
2014-2015	2	1	1
2016-2018	2	2	2
2019	0	4	2

Source: Law on the Accumulation of Pensions.

In 2019 a new mode of financing was set up, and the transfer of the 2 p.p. portion of the state social insurance contribution from the SIF into the second-pillar pension fund has been ended.[25] Instead, a new formula (4%+2%) for pension accumulation has been established. The contribution into the pension fund will now be comprised of 4% of the participant's personal income and 2% of the national average salary as a supplementary contribution paid out of the state budget. However, the reduction in social insurance contributions tax by 1 p.p. will reduce the financing of the social insurance pension and provide space for people to allocate more private contributions to funded pensions. Employers and employees can voluntarily make contributions above 4%, qualifying for further tax relief. With completion of PIT reform (see Box 2), the accrual rates will become 3%+1.5%.

The new legislation lays down a new procedure for involvement in the supplementary accumulation of pensions in the second-pillar pension fund. The reform stipulates auto-enrolment for workers aged under 40, with the right to opt out, delay or temporarily suspend payments. The procedure of inclusion will be repeated every three years until the person reaches the age of 40. People over 40 who do not contribute to the accumulation of pensions will be entitled to voluntarily contribute to the accumulation process. People who were participants of pension funds on 31 December 2018 have the right to submit, by 30 June 2019, a request for the termination of their participation in the accumulation of pensions or suspension of the transfer of pension contributions.

The transfer of a part of social insurance contributions into quasi-mandatory private pension funds in 2004–2007 was partially (by 50%) funded by state allocations from the Reserve (Stabilisation) Fund. During the economic crisis and later in 2009-2013, the transfers were fully funded by state budget allocations, but this stopped from 2014. In overall terms, fully funded privately managed funded pension schemes have been funded mainly by public money until now (Table 8). The current reform means the shifting of financing from public sources to contributions of members, making the scheme private at least by two thirds (see Table 7).[26]

[25] Law on the Accumulation of Pensions and related secondary legislation.

[26] Lazutka (2017).

Table 8. Division of financing of funded pension scheme in Lithuania, 2004-2017 (% of total financing)

	2004-2013	2014	2015	2016	2017
Social Insurance Fund	100	72	67	53	50
State budget	0	15	18	24	25
Member of scheme	0	12	15	23	25

Source: Social Insurance Fund (SODRA).

The remaining part of old-age expenditure goes to state pensions, social assistance pensions and LTC. These are briefly discussed below.

State pensions are public unfunded payments supplementary to the social insurance pension scheme. They are granted mainly to two rather large groups of the population. The first group includes post-war anti-Soviet resistance fighters and people who suffered from the former Soviet regime. The second group are military and police officers, judges, scientists, artists, and some other smaller professional groups. As they are covered by the social insurance pension scheme, state pensions provide supplementary income protection. The state pension system is financed directly from the state budget. 11% of pensioners receive this type of pension, and state pension expenditure comprised 0.34% of GDP in 2016.[27]

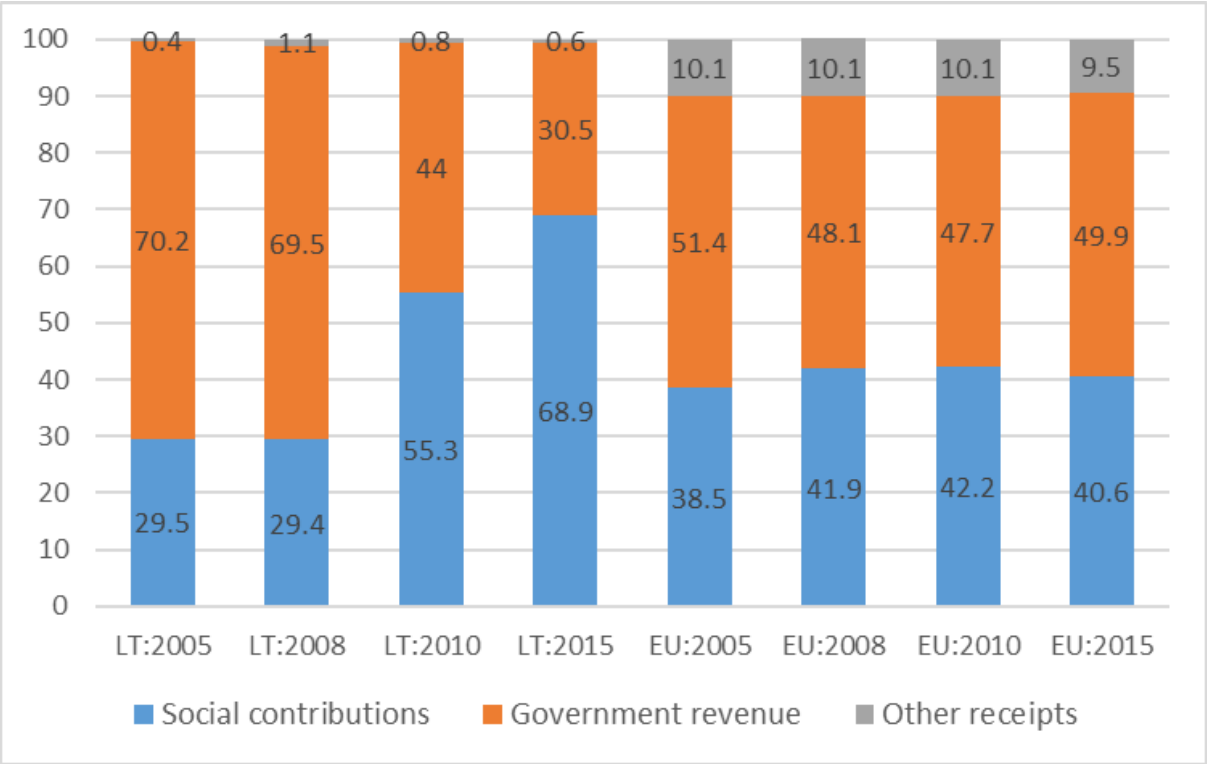
The social assistance pension is designed as a minimum income pension for those not protected by social insurance pension schemes. Social assistance pensions are paid to elderly or disabled persons who were not able to acquire social insurance rights, because of an insufficient contribution record. Most recipients of this pension are people who have been disabled from childhood. The social assistance pension is not means-tested; it is paid to those having no entitlement to contributory social insurance pension, because of an insufficient contribution record. Social assistance pension expenditure was 0.19% of GDP in 2016 and covered about 5% of pensioners.[28]

2.2 Sickness/healthcare financing

The healthcare sector in Lithuania relies on mixed financing, consisting of statutory health insurance, government budget allocations and direct out-of-pocket payments by users. Employees, self-employed people and even those not employed but able to work have to pay mandatory health insurance contributions to the NHIF. In Lithuania the financing pattern observed for healthcare is currently more oriented towards social contributions: social contributions in 2015 made up 68.9% of the receipts used to finance healthcare schemes. Back in 2005, the figure was only 29.5%, with general government contributions representing 70.2%. The change was due to a shift in health-related payments from the PIT tariff to social insurance contributions in 2009 (see Box 3). During the crisis, contributions from the economically active population fell, but reduced NHIF revenues from falling employment were partially compensated for by increased state contributions for the economically inactive population. After 2011, contributions from the economically active population began rising again and in 2015 constituted the largest share.

[27] Data from the Ministry of Social Security and Labour.
[28] Data from the Ministry of Social Security and Labour.

Figure 6a. Division of financing of healthcare expenditure and sickness benefits in Lithuania and EU by main source, 2005-2015 (% of total financing)



Source: Spasova and Ward (2019), Annex ESSPROS tables.

The public spending mix in healthcare fosters inclusive growth, but spending efficiency in healthcare is weak. The healthcare system remains centred on hospital care, while outpatient services and LTC for the elderly lag behind.[29]

Although most public spending on health comes from the NHIF, a substantial share (30% in 2015 and 41% in 2016) of revenue comes from the state budget,[30] which funds the insurance coverage of the non-working population: children, high school and higher education students, unemployed people, pensioners and others. In 2003, the minimum size of the annual state contribution was set at 35% of an insured individual's average monthly income. In 2006, the denominator was switched to average gross monthly wages lagged by two years, with the size of the contribution steadily increasing from 26% in 2007 to 35% in 2012, with a ceiling of 37% in 2014.[31] Other government revenues cover LTC, health administration, education and training, capital investment and public health services, which in total accounted for about 17% of total health expenditure in 2016. Other receipts do not play an important role in health funding in Lithuania; they accounted for less than 1% in 2005-2015.[32]

Contribution-based funding was mainly paid by employers in 2005 and 2008 (equal to about 28% of sickness/healthcare spending), with only less than 2% by employees (see Figure 6b). The proportion of spending financed by employers increased during 2005-2015, except for 2010 when it accounted for 19% of the total. The share financed from employees rose dramatically after 2009. As already mentioned, this was due to a shift in health-related payments from the PIT tariff to social insurance contributions in 2009 (see Box 3).

[29] OECD (2018).
[30] Eurostat: Expenditure for selected healthcare functions by healthcare financing schemes [hlth_sha11_hchf].
[31] OECD and European Observatory on Health Systems and Policies (2017).
[32] Eurostat: Expenditure for selected healthcare functions by healthcare financing schemes [hlth_sha11_hchf].

Figure 6b. Breakdown of the financing of healthcare and sickness benefits by social contributions sub-category, Lithuania and EU, 2005-2015 (% of total financing)

Source: Spasova and Ward (2019), Annex ESSPROS tables.

The share of employee contributions going towards healthcare is about three times higher than the EU average according to the latest available data. This share will increase further from 2019, as within the framework of the latest tax reform all sickness and health contributions will now be accounted for as employee contributions. As a result of gross wages being recalculated as part of the reform, health contributions will be equal to 6.98% from 2019 (i.e. [6% employee rate + 3% employer rate] ÷ 1.289).[33]

Other sources of financing for the health system are as follows.

- EU funding between 2004 and 2013 reached over €1.5 billion and became the main source of capital investment in the health system in Lithuania. Healthcare providers also received financial support (over recent years €180 million) from such funds as the EEA, Norway Grants, and the Swiss–Lithuanian Collaboration Programme for energy-saving projects through premises renovation, as well as human capacity development and training.[34]
- The Ministry of Finance funds healthcare delivery under the supervision of the Ministry of Defence and Ministry of Interior, which run parallel healthcare provider networks. The hospital run by the Prison Department is mainly financed through the Ministry of Justice budget.

Currently, there is a legal requirement to balance the healthcare budget during every three-year period, and two upper thresholds are applied when the NHIF budget is set: 2% of total NHIF expenditure for administration costs, and 10% of the NHIF revenue as a financial reserve.

[33] Republic of Lithuania (2018a).

[34] Murauskiene et al. (2013).

Box 3. The shift of health contributions from personal income tax to the social insurance system in 2009

Until 2009 health contributions were an integral part of PIT and social insurance. However, to improve collection of health contributions, reduce competition with other types of public spending and raise population awareness regarding the size of the obligatory health insurance tax, the health insurance contribution became a separate tax in 2009. From 2009 health insurance contributions were made mandatory for all citizens and were set at: for employees, 6% of taxable income; for employers, 3% of taxable income; for self-employed people, 9% of taxable income; and for farmers, 3% or 9% of the monthly minimum wage. Credited contributions for the economically inactive population (insured by the state) are set as a % of the official average monthly gross income lagged by two years.[35] This share made up 35% in 2012, 37% in 2015 and 44% in 2019. As this credited payment is about two or three times lower than the average contribution by employed people, and even though credited payments are paid for more than half of the Lithuanian population, expenditure on healthcare for those covered by credited contributions (e.g. pensioners, children, inactive persons) exceeds the income from credited contributions.[36] Hence the Parliament approved a plan for gradually increasing credited contributions until they reach 9% of the annual minimum gross wage.[37]

Economically inactive people who are able to work and are not insured by the state[38] have to pay a monthly contribution of 9% of the minimum wage (€38.70 from 2019) even if they do not have an income (from 2019, 6.98% of the recalculated minimum wage). In 2009, the government introduced penalties for non-payment of healthcare contributions and set up a register of people eligible to contribute.

2.3 Financing of other areas

Within the other types of social protection, survivor pensions are financed almost entirely from social insurance contributions (to the extent of 80-90%). There was a twofold increase in the share of financing from government revenue for this type of benefit within the analysed period, from 8-10% before 2009 to 17-19% thereafter.[39]

Disability benefits are also to a major extent funded from social contributions (around 55-60%). This is due to the existence of non-contributory disability benefits, compensations and services, which are funded from general government revenue. There were no major changes in the financing of disability benefits in 2005-2016.

Social protection in the case of unemployment is also to a major extent funded from social contributions (around 80%). There are only social insurance-based unemployment benefits in Lithuania. The general budget covers active labour market policies (ALMPs), which are also heavily co-funded from EU structural funds. Hence an increase in the government's spending on unemployment during the crisis, when demand for ALMPs and subsidies was the greatest.

The funding of family benefits is mixed, with the share of social insurance contributions gradually increasing from 27.1% in 2005 to 48.3% in 2015. This was due to the increased generosity of contributory childbirth-related benefits compared with non-contributory family benefits. First, one month's paternity leave was introduced in 2006 with a replacement rate of 100% of the insurance base, with ceilings. Second, paid childcare leave in Lithuania was extended to two years with a replacement rate of 100% for the first year and 85% for the second year in 2008. Currently, paid childcare leave is being reduced, to

[35] Credited contributions for healthcare are approved annually by the Parliament.

[36] Seimas approved the increase of the credited health insurance contributions. URL: https://www.lrs.lt/sip/portal.show?p_r=10165&p_k=1&p_t=201469.

[37] Lietuvos Respublikos sveikatos draudimo įstatymas [Health Insurance Law of the Republic of Lithuania], art. 16 part 2.

[38] It is estimated that in total 92% of the population is covered.

[39] Statistics in this section are based on ESSPROS, Statistical annex on financing social protection: levels and structure (2005-2016), if not specified otherwise.

an optional one year of leave at a 100% replacement rate or two years of leave at a 70% replacement rate during the first year and 40% thereafter.

Housing and social assistance are funded entirely out of the general budget. Although there was a major reform in 2012, decentralising social assistance and delegating its administration to municipalities, the funding still comes as a grant (previously as a direct subsidy) from the general budget. Only 2-3% of the total funding on social assistance comes from other sources; that is, from municipal budgets.

3 Strengths and weaknesses of the existing mix of financing options and potential future sources of financing

To sum up, the following strengths and weaknesses of the existing mix and future sources of financing can be highlighted.

1. **Low levels of social protection funding compared with the EU are acknowledged as a problem at the highest governance level in Lithuania.** The links between the underfunded social protection system and the extremely high levels of poverty risk (particularly in old age) and inequality in Lithuania are of great political concern. The government's programme includes the aim of insuring adequate levels of social protection, at the EU average level.[40] However, this plan has not yet been put into action. Tax reforms implemented since 2019 may even weaken the financial capacity of the state, due to higher income tax allowances and lower social insurance contributions.
2. **Reliance on social insurance contributions safeguarded social protection from attempts to reallocate resources to other public sector areas** in the pursuit of 'small government' – with the exception of the funded pension scheme, which was financed from social insurance contributions until 2019. **On the other hand, the heavy reliance on social insurance contributions may be seen as a factor in the underfinancing of social protection**. The low share of wages in national income, the low salaries of public sector employees, widespread undeclared income and 'envelope' wages, and numerous exceptions for the self-employed do not allow the raising of adequate resources via social contributions (Lazutka et al. 2018). Major reforms aimed at tackling this problem have included extending coverage to the expanding numbers of self-employed people, and the introduction of a contributions floor for part-time employees.
3. In the longer-term, reliance on social insurance contributions is problematic within the context of rapid population ageing, high levels of emigration in Lithuania, an extensive shadow economy, technological change, etc. Population ageing has not yet had a major effect due to the increases in the statutory pension age planned until 2026. Nonetheless, **pressures on the system of social insurance, coupled with the substantial underfunding of the Lithuanian social protection system compared with the rest of the EU, call for additional sources of revenue, which could be achieved through expanding the tax base.** In line with this, international institutions, including the European Commission and the OECD have criticised the high tax burden on the employed, compared with under-developed real estate and property taxation, as well as loopholes in personal and corporate income tax systems (OECD 2018). This socially unjust imbalance is termed 'an animal farm' (lit. 'gyvulių ūkis'; an allusion to George Orwell's well known satirical tale) in the popular Lithuanian debate on financing social protection and the public sector in general. There is, however, no coherent reform programme for strengthening the tax base aimed at increased tax revenues and strengthening the ability to fund either social protection spending or the public sector in general.
4. On the contrary, **current tax and pension reforms are in line with the earlier long-standing discourse of 'small government'**, which will supposedly stimulate national economic competitiveness on the basis of cheap labour and low social protection spending. The acting minister of finance declared, at the very beginning of his term, that no taxes will be raised in order to increase tax revenue and improve the adequacy of social protection or public spending in general. The broader goals of

[40] Republic of Lithuania (2016c).

reducing inequality and poverty are planned to be achieved solely through tackling tax avoidance and using the fiscal space provided by rapid economic growth. However, without structural tax reform, there is no possibility that Lithuania will converge towards the EU average share of GDP spending on social protection, in either the short or long term. Moreover, among the public spending priorities the only clear and approved direction is towards gradually increasing national defence funding until 2030.[41]

5. **The latest reforms in the financing of pensions and healthcare are incoherent. On the one hand, a recent initiative has been to partially shift the financing of old-age pensions from the social insurance budget to the general budget**. The intention was to place its financing on a broader basis, not dependent only on the income of employed people. However, there are no extra resources in the state budget without substantial tax reform, and spending on old-age pensions is now exposed to competition from other areas of the public sector. Most of them are short of resources, just like social protection. **On the other hand, the reform of healthcare financing in 2009 went in the opposite direction – shifting it from the general budget (previously funded through PIT revenue and social tax) to the social insurance system.** This can be explained by an effort to have a direct source of revenue for healthcare, safeguarding it from political manipulation and competition with the other areas of public expenditure.
6. **Finding a financially sustainable and socially just mechanism for financing the second-pillar funded pension scheme remains a challenge.** An increase in private financing of funded schemes is welcome, because this could mean a total increase in the financing of old age in the country. However, subsidised financing of private assets in the funded pension scheme is unfair, looked at from both an intra- and intergenerational perspective. From an intergenerational perspective, public subsidies for funded pensions were implemented in parallel with a lower social insurance contribution to the pay-as-you-go (PAYG) pension scheme. This further reduces the social contribution revenues available for current pension payments. Moreover, currently retired people are poorly protected by the functioning pension scheme, but still subsidise the private assets of the younger generation via the tax system. Similarly, employees of pre-retirement age not participating in the funded scheme also subsidise the private pension assets of the younger and even better-paid generation. From an intragenerational perspective, while the public subsidy for funded pensions is financed from general revenues, it is only paid for those participants of the funded pension schemes who voluntarily pay additional contributions. Those who cannot afford these additional contributions or decide to remain solely in the public social insurance scheme remain unsubsidised. Moreover, the funded scheme is organised as a defined-contribution scheme with wide opportunities for the inheritance of accumulated assets and without indexation of benefits. All this means less secure future income protection compared with the PAYG scheme in old age.
7. **The introduction of indexation into the system of social insurance old-age and disability pensions is intended to reduce the possibilities for political manipulation and promote greater transparency. However, the current system of indexation ensures fiscal sustainability of the system at the expense of benefit adequacy.** The indexation rules foresee automatic balancing of payments and revenues, which depends on the contribution rate and the number of contributors. There is no rule safeguarding social insurance pensions from gradual

[41] Republic of Lithuania (2018b).

deterioration in relation to the average wage of the population or that of the insured people themselves.

8. **Current debates on pensions are limited exclusively to the enlargement of private pension schemes without appropriate attention to the financing of the fundamental public scheme.** Officials and interest groups predict a halving in the replacement rate of social insurance pension benefit over the coming decades.[42] However, this argument is employed only for the purpose of encouraging entrants to the private scheme, not to address the problem of underfinancing in the public one. Even if private accumulation becomes universal, for decades the only source of income for retirees will remain the public scheme. It is imperative to address the problem of underfunding of the public scheme right now. More than one third of retirees are at risk of poverty and average pension benefits do not reach the at-risk-of-poverty threshold. This problem cannot be solved by expanding private pensions. The outcomes of the latter will be far in the future, and remain uncertain.
9. **Other benefits within the Lithuanian social protection system remain unindexed and subject to fluctuations in line with the political cycle (i.e. increases before general elections) or gradual depreciation. While spending on other areas besides old age and health constitutes a similar share of total expenditure on social protection to that in the rest of the EU, these areas are generally significantly underfinanced in absolute terms and in relation to GDP.** This especially concerns social assistance and housing.
10. The financing of ALMPs, and of capital investments in the health sector, has mostly come from EU structural funds – the country almost entirely depends on this source. **There is no plan on how to replace it with national funding, either after the end of the current EU financing period or in a longer term**.
11. **The counter-cyclical mechanism of credited state contributions for health insurance helps to sustain funding for the health insurance budget** despite falling revenues from the employed as a result of decreasing wages or increasing unemployment. Lithuania successfully used the crisis as a lever to reduce the prices of medicines. Yet the future impact of cuts in public health spending is a cause for concern.
12. **Lithuania's Health System Development Dimensions 2011-2020[43] stated that cost-effectiveness and rational use of resources is one of the main directions for health system development until 2020.** The document makes suggestions including: the introduction of budgetary ceilings for healthcare providers; an increase in cost-sharing through VHI; and legalising co-payments. Since 2017, the government has introduced further measures to contain spending on medicines (European Observatory on Health Systems and Policies, 2018).
13. **While Lithuania has adopted a relatively generous approach with respect to coverage of healthcare services, this is not the case for pharmaceuticals and medical aids**. The NHIF uses different reimbursement levels for prescription costs. Insured adults who do not fall into any of the exception groups must pay the full cost of both prescribed and over-the-counter pharmaceuticals through out-of-pocket payments. **Out-of-pocket payments in Lithuania remain very high** (in particular for pharmaceuticals) and could threaten health access for vulnerable groups.

[42] Žilionis (2018); Pastukiene (2017); Mykolaitytė (2018).
[43] Parliament of the Republic of Lithuania (2011a).

14. **There is a lack of transparency in co-payments for healthcare**. There are legal provisions for charging patients the difference between the basic price of a treatment and the actual cost in case they opt for more expensive treatment components. However, in many cases, there are no clear evidence-based guidelines. There are no official statistics on user charges for areas other than pharmaceuticals and medical goods. A Transparency International Lithuania report of 2009 showed that 14% of respondents said they made informal payments for public healthcare. In spring 2012, based on an initiative of the Parliament Anti-corruption Commission, a working group in the Ministry of Health proposed a legal mechanism for penalising the heads of public facilities that accept informal payments.[44] Research shows that financial hardship is more likely to occur where public spending on health is low in relation to GDP, and out-of-pocket payments account for a relatively high share of total spending on health (WHO 2010).[45] Both remain a challenge for Lithuania.

3.1 Policy recommendations

1. Extensive and coherent tax reform has to be planned and implemented with the aim of increasing public revenue – in the first instance for improving the financing of social protection, public pensions, pharmaceuticals and social assistance.

2. To raise revenue for social protection, disparities in taxation for different forms of economic activity should be eliminated and extra taxation should be focused on the highest-income groups.

3. Recent pension reforms opened space for more generous financing of the basic part of statutory public pensions, as it now relies on the state budget. Similar reform of healthcare financing is needed; that is, shifting healthcare financing from the social insurance system to the state budget.

4. State budget subsidies for the statutory funded pension scheme should be reallocated to the statutory public pension scheme, with an aim of reducing poverty among current pensioners, which is at a very high level in Lithuania. Current state subsidies to the statutory funded pension scheme could be replaced by members' own contributions.

5. The current indexation of pensions should be reviewed, so as to ensure they increase in line with the rising living standards of the working population. Adequate indexation rules need to be introduced for other types of social benefits, such as family benefits and social assistance.

6. There should be a plan for how to replace EU structural funds by national funding in the areas of ALMPs and capital investments in the health sector.

7. Public financing to help compensate for the cost of pharmaceuticals and medical aids should be increased; and out-of-pocket payments in the healthcare sector should be reduced, to ensure the transparency of co-payments.

[44] Parliament of the Republic of Lithuania (2011b).
[45] WHO (2010).

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