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The Healthcare System in Lithuania

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Background

Lithuania is a country in Northern Europe, the largest of the three Baltic states. The Republic of Lithuania is a parliamentary Republic with some attributes of a semi-presidential system. The country is divided into 10 counties that are further subdivided into 60 municipalities. Lithuania declared its independence from Soviet Union in the March of 1990. After a transition from a planned economy to a free market one, Lithuania became a full member of NATO and the European Union in the spring of 2004 and a member of the Schengen Agreement on 21 December 2007. Since 1 July 2013, Lithuania has held the rotating Presidency of the Council of the European Union.

According to the national census carried out in March 2011, the population of Lithuania was 3,043,429. There has been a decrease of 441,000 (13%) since the previous (2001) census, of which 102,000 was through natural decrease and 339,000 through negative net migration (Statistics Lithuania, 2011b). Ethnic Lithuanians account for 84% of the population, about 6.6% are Polish, 5.8% are Russian and 1.2% are Belarusian. According to national statistics, at the beginning of 2013 there were 2,972,900 people residing in Lithuania (Statistics Lithuania, 2013b). Since the country joined the EU, net migration has increased markedly: from 6.8 per 1000 population in 2003, peaking at 26.9 in 2010 and then reducing to 14.3 in 2012 (Statistics Lithuania, 2013b).

Life expectancy at birth has been fluctuating greatly since the early 1990s, reaching 73.6 years in 2011 (68.1 years for men and 79.3 years for women) (World Bank, 2013). Substantial gender differences are noted as men in Lithuania are expected to live, on average, 11 years less than women (the widest gap in the EU countries). Similarly, there is a gap in healthy life-years between men and women: 57.8 and 62.4 years, respectively (European Commission, 2013).

Prior to the global financial crisis of 2007–2010 and now in its aftermath, Lithuania has one of the fastest growing economies in the European Union. In 2011, Lithuania was categorised as a country with high human development; it had a Human Development Index of 0.81, ranking 40th among 187 countries (UNDP, 2011).

Healthcare System

Since the years of restoration of Independence (1990) there have been several stages in the development of the national health system. The first stage (1990–1992) was characterised by devolution, as the role of municipalities in administering outpatient care and managing most small and medium-sized hospitals was increased. The next stage (1993–1994) was characterised by debates on private versus public administration of healthcare institutions and free patient choice of physician versus a gatekeeping role for GPs. The outcome was in favour of a public healthcare system and the introduction of family medicine. In 1994–1995, a number of political decisions were taken, among them to implement a statutory health insurance scheme and to decentralise specialist healthcare services administration from the Ministry of Health to the 10 counties.

Many strategic policy documents and many new key laws were adopted: the key document was the National Health Concept (adopted in 1991 by Supreme Council of the Republic of Lithuania), outlined new approaches to healthcare, including introduction of the concept of health insurance, prioritising disease prevention and developing primary care. Another core document, which ensured continuity of health system reform, was the Lithuanian Health Programme adopted by Parliament of the Republic of Lithuania in 1998. The latest introduced a set of three major objectives for population health: to reduce mortality and increase average life expectancy, to improve quality of life, and to increase health equity. This Programme was like a certain guarantee of health policy principles' continuity despite the quite frequent change of government during the last decades.

Currently, a new Lithuanian Health Programme 2020 is under development. The programme aims at improving population health through safer social environment, healthy lifestyle and effective healthcare. It is being designed with an "health in all policies" approach by building and strengthening partnerships with other related sectors transferring and giving more responsibility for population health. "We hope that Lithuanian Health Programme will reflect modern thinking and criteria for assessment of activities how to improve people's health and will address the system of values, which should be the base for health system activities in each European country: universality, justice, solidarity, sustainability, society participation, dignity, nondiscrimination, transparency, accountability." (V.P. Andriukaitis, Minister of Health, WHO/EURO/RC63).

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Substantial changes in the health system have been prompted by two major factors: the appearance of a third party payer in the form of the National Health Insurance fund (NHIF) and enforcement of legislation redefining property rights and the status of healthcare institutions. The country has a mixed system funded by the national health insurance based on compulsory participation in the health insurance scheme and by the state budget. The vast majority of Lithuanian healthcare institutions are nonprofit-making enterprises. Property rights and administrative functions fall under the jurisdiction of the central government (Ministry of Health), or the local municipalities.

Table 1: Lithuanian Economy at a Glance
Sources: ¹ Eurostat ² Bank of Lithuania

	2006	2007	2008	2009	2010	2011	2012	2013 (forecast)
GDP at current prices, € billion	24.1	28.7	32.4	26.7	27.7	31.0	32.9	34.8 ²
GDP growth (annual), %	7.8	9.8	2.9	-14.8	1.6	6.0	3.7	3.1 ¹
Annual inflation, %	3.8	5.8	11.1	4.2	1.2	4.1	3.2	1.4 ²
Cumulative FDI, € billion	8.4	10.3	9.2	9.2	10.0	11.0	11.9	-
Unemployment, %	5.6	4.3	5.8	13.7	17.8	15.4	13.4	11.6 ²

The Ministry of Health of the Republic of Lithuania is the main institution at the national level, responsible for general supervision of the entire health system. The National Health Insurance Fund, under the Ministry of Health, is responsible for financing of healthcare services. 60 councils of municipalities are responsible for primary health and secondary healthcare. Tertiary care level is mostly concentrated in university hospitals and responsibility falls to the governmental level. A patient usually enters the health system through their GP or directly through a specialist doctor if urgent care is needed; for non-urgent care and with no GP referral a user fee is paid. When specialised care is needed, a patient can choose a service provider and a consultant. Inpatient and outpatient rehabilitation facilities are available to improve a patient's recovery.

A combination of payment methods exists for publicly funded health services. Primary care is financed predominantly through capitation, with a smaller share from fee-for-service and performance-related payments. Outpatient care is financed mainly through case payment, and through fee for service for diagnostic tests. Inpatient care is financed mainly through case payment and historical budgets. Public health is mainly financed through historical budgets. There is a cost-sharing element across most areas of health service provision. Diagnosis-related groups (DRGs) introduction started in 2012.

In 2010, total health expenditure accounted for 7% of GDP, which is similar to the average for the new EU Member States (7.1%), and less than the average for the 15 EU Member States before May 2004 (EU-15) (10.6%). Total health expenditure per capita (measured in purchasing power parity US dollars) in Lithuania has remained stable in 2008–2010, amounting to about \$1300. Since 1995, total health expenditure per capita in Lithuania has more than tripled (WHO Regional Office for Europe, 2013). In 2010, 81% of public expenditure on health was attributed to medical services, of which over 50% was spent on inpatient care, 20% on outpatient services and 9% on home care. Health administration accounted for 2.8% of public expenditure on health, while public health and prevention accounted for only 1.1% (HiT Lithuania 2013)

In 2003–2012, the network of hospitals was restructured, as part of wider healthcare service reforms. It started in 2003–2005 with the expansion of ambulatory services and primary care. In 2006–2008 of day care and day surgery was introduced and in 2009–2012 long-term and nursing services were developed and the service provider network was optimised and restructured.

Between 1990 and 2011, the total number of hospitals in Lithuania decreased from 197 to 145, and currently there are 66 general hospitals, 49 nursing hospitals, 26 specialised hospitals and 4 rehabilitation hospitals (Health Information Centre, 2012).

The Main Trends for the Health Workforce in Lithuania

Overall, the health workforce has decreased by approximately 18%: from 65,000 in 1990 to 47,000 in 2010, mostly through a large decrease in nursing personnel (Health Information Centre, 2013). The overall number of physicians per 100,000 population in Lithuania fluctuated between 360 and 375 in the period between 1992 and 2010. In 2010, it was 372 – higher than the EU averages. The number of nurses per 100,000 population over that period has decreased from 944 to 722 – higher than the EU-12 and lower than the average for the EU-15. The number of dentists has increased from 55 to 75 per 100,000, a figure similar to the EU-15 average. The number of pharmacists increased from 52 to 66 per 100,000 in the period from 1994 to 2003. In 2010, there were 88 licensed pharmacists per 100,000 population (European Commission, 2013). A more recent analysis (Lithuanian University of Health Sciences, 2011) reported that 3% of health professionals left the country between 2004 and 2010.

A number of challenges for national health system remain. The primary care system needs strengthening so that more patients are treated within it instead of being referred to a specialist, which will also require a change in attitude by patients. Transparency and accountability need to be increased in resource allocation, including financing of capital investment and in the payer–provider relationship. Finally, population health, while improving, remains weak, and major progress could be achieved by reducing the burden through health promotion and disease prevention. The greatest challenges for Lithuanian health system are a maintenance of sustainable financing and to convince other sectors that health should be the state goal and responsibility and to motivate other policy sectors for joint actions on public health and welfare.

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