European Commission

State of Health in the EU

Lithuania

Country Health Profile 2019

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European Observatory on Health Systems and Policies
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The Country Health Profile series

The *State of Health in the EU*'s Country Health Profiles provide a concise and policy-relevant overview of health and health systems in the EU/European Economic Area. They emphasise the particular characteristics and challenges in each country against a backdrop of cross-country comparisons. The aim is to support policymakers and influencers with a means for mutual learning and voluntary exchange.

The profiles are the joint work of the OECD and the European Observatory on Health Systems and Policies, in cooperation with the European Commission. The team is grateful for the valuable comments and suggestions provided by the Health Systems and Policy Monitor network, the OECD Health Committee and the EU Expert Group on Health Information.

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Data and information sources

The data and information in the Country Health Profiles are based mainly on national official statistics provided to Eurostat and the OECD, which were validated to ensure the highest standards of data comparability. The sources and methods underlying these data are available in the Eurostat Database and the OECD health database. Some additional data also come from the Institute for Health Metrics and Evaluation (IHME), the European Centre for Disease Prevention and Control (ECDC), the Health Behaviour in School-Aged Children (HBSC) surveys and the World Health Organization (WHO), as well as other national sources.

The calculated EU averages are weighted averages of the 28 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in August 2019, based on data available in July 2019.

To download the Excel spreadsheet matching all the tables and graphs in this profile, just type the following URL into your Internet browser: http://www.oecd.org/health/Country-Health-Profiles-2019-Lithuania.xls

Demographic and socioeconomic context in Lithuania, 2017

Demographic factors	Lithuania	EU
Population size (mid-year estimates)	2 828 000	511 876 000
Share of population over age 65 (%)	19.3	19.4
Fertility rate[1]	1.6	1.6
Socioeconomic factors		
GDP per capita (EUR PPP[2])	23 500	30 000
Relative poverty rate[3] (%)	22.9	16.9
Unemployment rate (%)	7.1	7.6

1. Number of children born per woman aged 15-49. 2. Purchasing power parity (PPP) is defined as the rate of currency conversion that equalises the purchasing power of different currencies by eliminating the differences in price levels between countries. 3. Percentage of persons living with less than 60 % of median equivalised disposable income.
Source: Eurostat Database.

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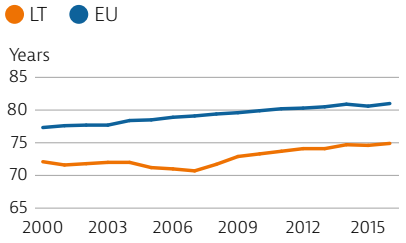
1 Highlights

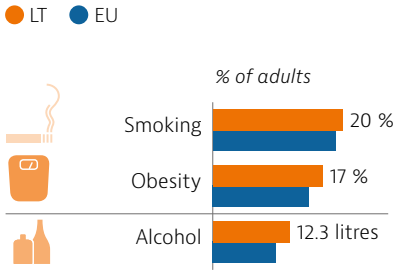
Life expectancy has increased in recent years in Lithuania but remains among the lowest in the EU. Mortality rates from both preventable and treatable causes are well above the EU averages. The country also faces challenges with mental health and the control of tuberculosis. Although some progress has been made in recent years, alcohol consumption remains a major public health concern. Reducing out-of-pocket payments, overhauling the hospital sector, further strengthening primary care and scaling up prevention measures would contribute to improving the health of the population, but the current level of spending in health care remains too low to address all the ongoing challenges effectively.



Life expectancy at birth

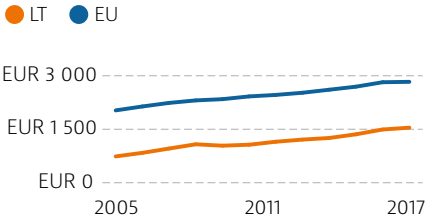
Health status

Health outcomes in Lithuania remain among the worst in the EU. Life expectancy at birth was 75.8 years in 2017, more than five years below the EU average (80.9 years), while the gender gap in life expectancy is almost double the EU average. Following a reduction in life expectancy between 2000 and 2007, there have been steady improvements, thanks to a reduction in deaths from cardiovascular diseases and other major causes of death.



Risk factors

Lifestyle-related risk factors account for more than half of all deaths in Lithuania. Alcohol consumption is higher than in any other EU country, although it has started to decline in recent years following the introduction of stricter alcohol control measures. In 2014, one in five adults reported smoking on a daily basis, with a rate of over one in three among men. In 2017, 17 % of adults were obese, a proportion also higher than the EU average of 15 %.



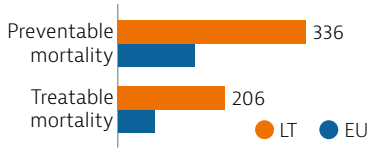
Per capita spending (EUR PPP)

Health system

A single health insurance fund provides care to nearly the entire population, but underfunding of the health system undermines accessibility and equity. Lithuania spends much less on health than the EU as a whole, both in absolute terms and as a share of GDP. In addition, only two-thirds of current health expenditure is publicly financed, compared with 79 % in the EU.

Effectiveness

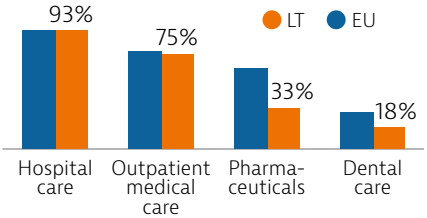
Lithuania has among the highest mortality rates from preventable and treatable causes in the EU. The quality of outpatient and inpatient care is well below EU averages, although some initiatives to support improvements in quality of care have been undertaken in recent years.



Age-standardised mortality rate per 100 000 population, 2016

Accessibility

General accessibility of health services is good in Lithuania and the level of unmet medical needs reported by the population is low. While hospital and outpatient services are widely accessible, coverage of pharmaceuticals and dental care is more limited, which hampers accessibility.



Coverage for selected goods and services, 2016

Resilience

Addressing the persistent underfunding of the Lithuanian health system is a precondition for the attainment of significantly better health outcomes. At the same time, substantial efficiency gains could be reaped through a reorganisation and downsizing of the hospital sector, while making the necessary investments to strengthen primary care and scale up prevention measures.

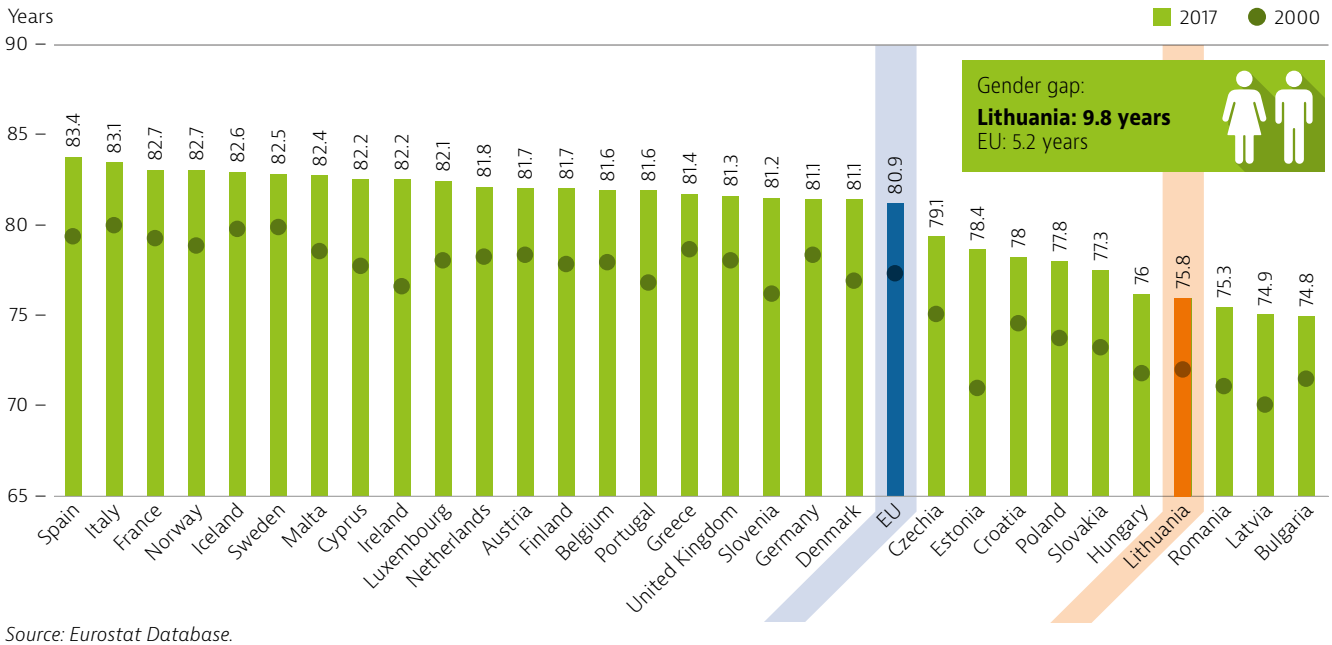
2 Health in Lithuania

Lithuanians have one of the lowest life expectancies at birth in the EU

Life expectancy at birth in Lithuania increased by nearly four years between 2000 and 2017, from 72.1 years to 75.8 years. However, progress has been slower[1] than in other Baltic states (4.7 years in Latvia and 7.3 years in Estonia). In 2017, Lithuania (together with Romania, Latvia and Bulgaria) had one of the lowest levels of life expectancy at birth in the EU (Figure 1).

On average, Lithuanian women live almost ten years longer than men: 70.7 years compared to 80.5 years. This gender gap is the second highest in the EU, after Latvia, and is largely due to greater exposure to risk factors among men, including tobacco smoking and excessive alcohol consumption (see Section 3).

Figure 1. Life expectancy at birth is more than five years below the EU average

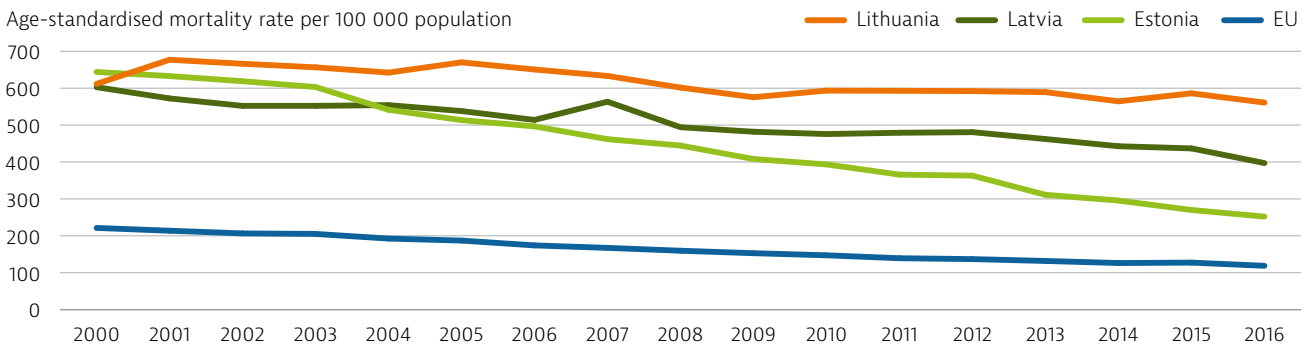


Source: Eurostat Database.

Cardiovascular diseases are the leading cause of death in Lithuania

In 2016 ischaemic heart disease was the leading cause of death in Lithuania, accounting for nearly two in five deaths (15 000 deaths). The mortality rate from this condition has decreased slightly since 2000, but at a much slower rate than in other Baltic countries, and it is now by far the highest among EU countries (Figure 2).

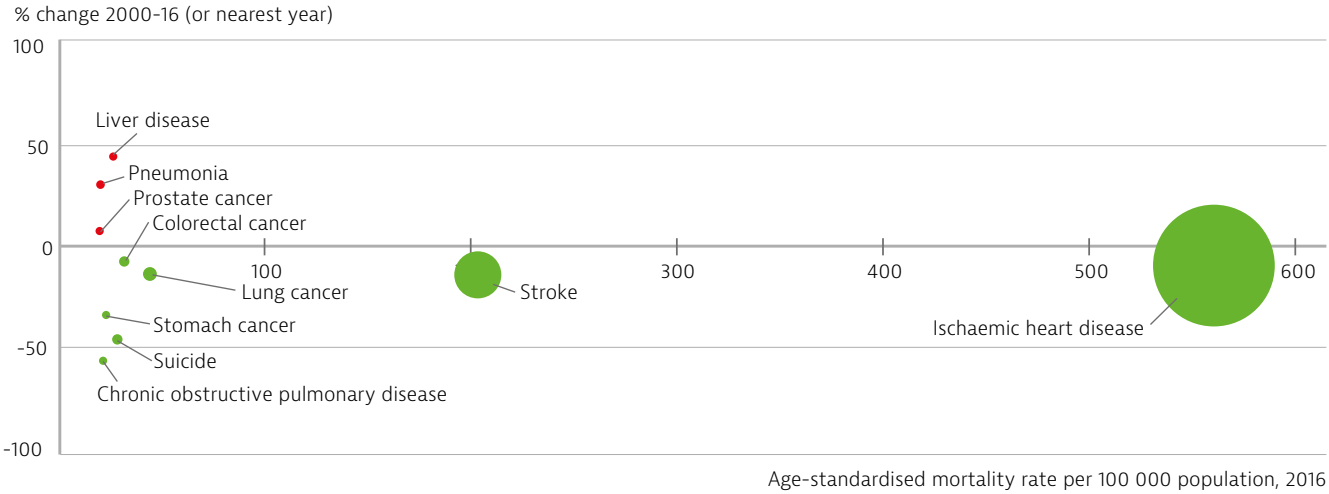
Figure 2. Lithuania has the highest mortality rate from ischaemic heart disease in the EU



Note: OECD estimates of EU average for 2000 and 2001.
Source: Eurostat Database.

1: *Between 2000 and 2007, the country even witnessed a reduction in life expectancy.*

Figure 3. Cardiovascular diseases account for the majority of deaths in Lithuania

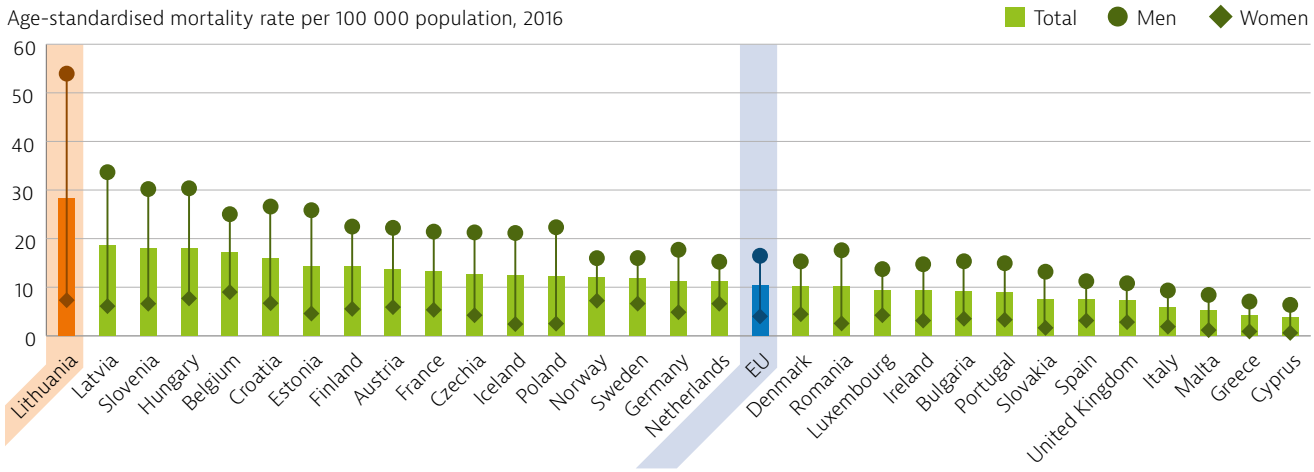


Note: The size of the bubbles is proportional to the mortality rates in 2016.
Source: Eurostat Database.

Mortality from stroke decreased slightly more over the same period, but still accounted for 14 % of all deaths in 2016 (Figure 3). Cancer is the second major cause of death in the country, with lung, colorectal, stomach and prostate cancer the most frequent causes of death by cancer. Mortality rates from cancer decreased overall between 2000 and 2016.

Although the authorities have achieved some progress in reducing historically high mortality rates from suicide, it nevertheless remains an important cause of death, particularly among men, as Lithuania recorded the highest rate of mortality from this cause in the EU in 2016 (Figure 4). In recent years, the authorities have launched a number of suicide prevention campaigns that led to a 45 % decrease in the number of deaths between 2000 and 2016 (see Section 5.1).

Figure 4. Suicide is a serious public health concern in Lithuania, particularly for men

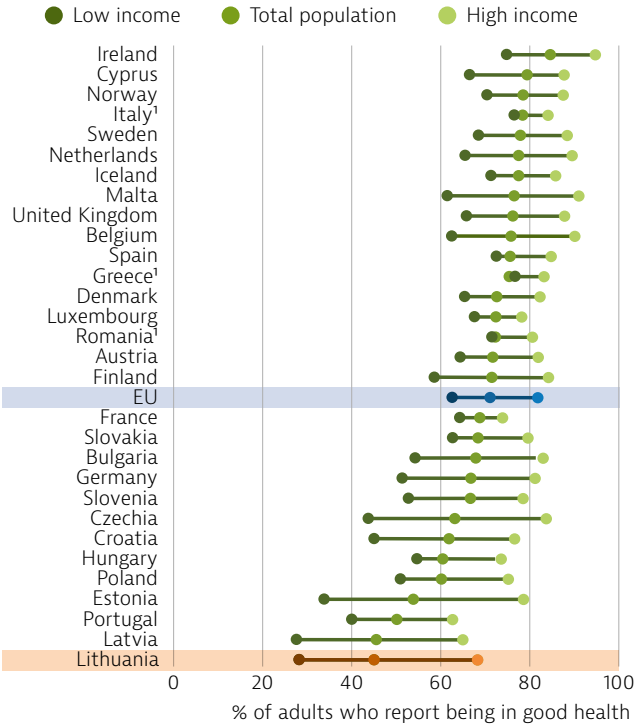


Source: Eurostat Database.

The majority of Lithuanians do not perceive themselves to be in good health

In 2017, only 44 % of the Lithuanian population reported perceiving themselves to be in good health – the lowest rate in the EU (Figure 5). As in other countries, people with higher incomes are more likely to report being in good health: two-thirds of those in the highest income quintile considered themselves to be in good health, compared with only one-quarter of those in the lowest quintile. This income gap in self-reported health is the second highest in the EU, just behind Estonia, and has even increased compared to 2015 data.

Figure 5. The Lithuanian people report the lowest self-reported health status level in the EU



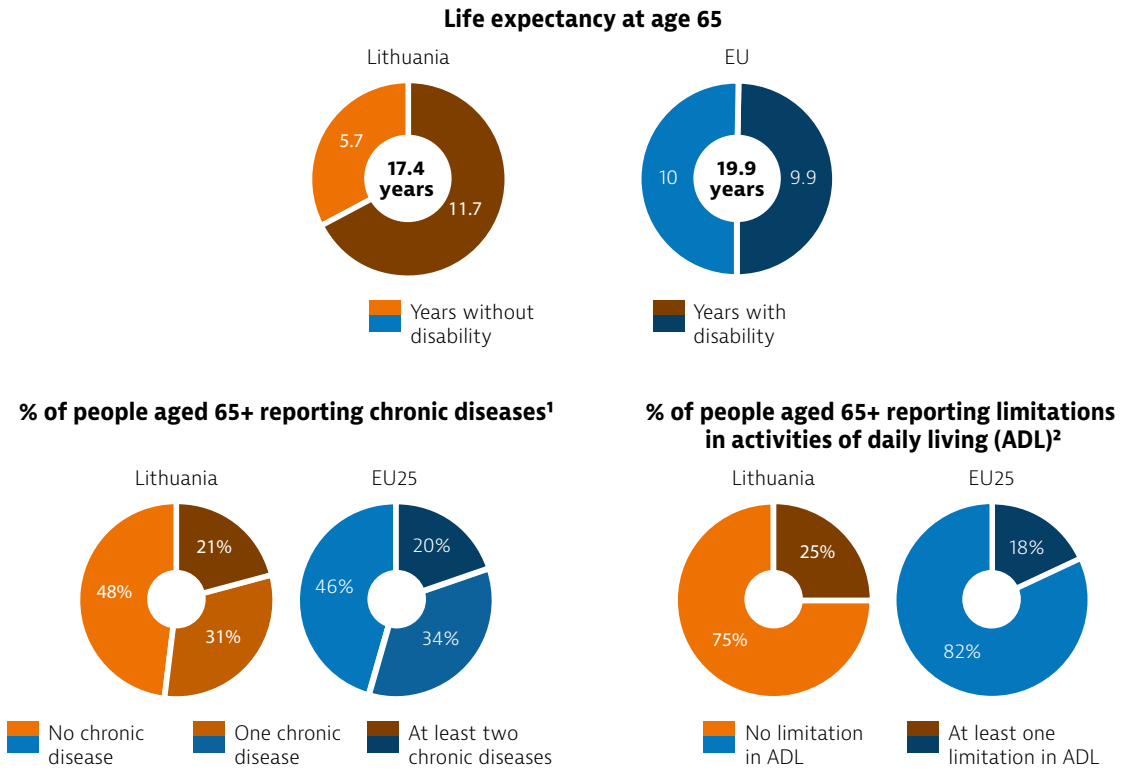
Note: 1. The shares for the total population and the low-income population are roughly the same.
Source: Eurostat Database, based on EU-SILC (data refer to 2017).

Many years of life after 65 are lived with some chronic diseases and disability

In 2017, Lithuanians aged 65 could expect to live an additional 17.4 years, which is 1.3 years more than in 2000 but still 2.5 years less than the average across the EU. Moreover, on average Lithuanians can expect to live about two-thirds of their lives after age 65 enduring some chronic diseases and disabilities (Figure 6). This is particularly the case among women: while the gender gap in life expectancy at age 65 is still five years in favour of women, there is no gender gap in the number of healthy life years[2] because Lithuanian women tend to live a greater proportion of their lives after 65 with chronic diseases and disability.

More than half of Lithuanians aged 65 and over report having at least one chronic condition, a proportion lower than in the EU as a whole. These health problems in old age often result in disability. One in four Lithuanian people aged 65 and over report some limitations in basic activities of daily living, such as bathing, dressing or getting out of bed, which may require long-term care.

Figure 6. More than half of Lithuanians aged 65 and over have at least one chronic disease



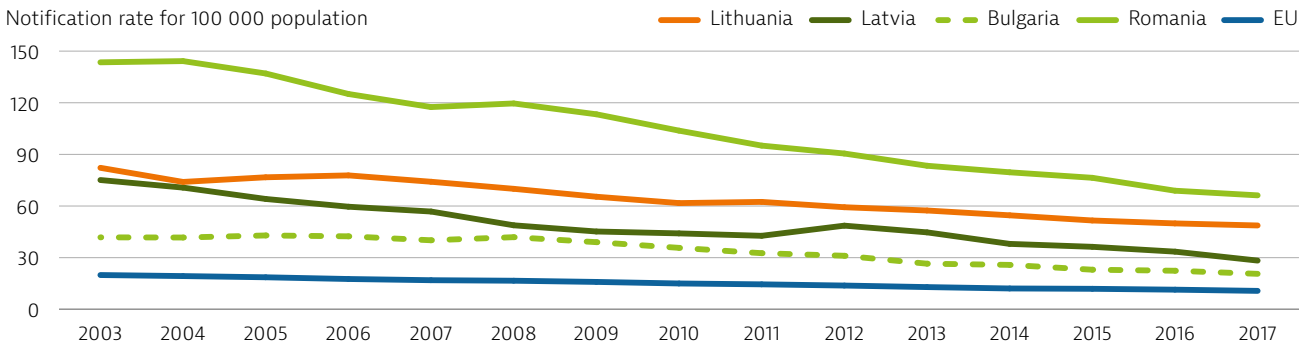
Note: 1. Chronic diseases include heart attack, stroke, diabetes, Parkinson disease, Alzheimer's disease and rheumatoid arthritis or osteoarthritis. 2. Basic activities of daily living include dressing, walking across a room, bathing or showering, eating, getting in or out of bed and using the toilet.
Source: Eurostat Database for life expectancy and healthy life years (data refer to 2017); SHARE survey for other indicators (data refer to 2017).

2: *'Healthy life years' measures the number of years that people can expect to live free of disability at different ages.*

Containment of some communicable diseases constitutes a public health challenge

In addition to issues linked to the growing number of people living with chronic conditions, Lithuania also faces important challenges with the control of some infectious diseases. In 2017, the notification rate for all tuberculosis cases was the second highest in the EU after Romania (Figure 7), with 1 387 cases reported. Even though the number of cases notified has decreased over the past decade, tuberculosis remains a major public health issue in Lithuania, now compounded by the rising prevalence of multidrug-resistant disease forms. As reported in several other EU countries, the control of measles is also an issue in Lithuania (see Section 5.1): a major measles outbreak occurred in the first half of 2019, raising concerns about the immunisation coverage of children and adults in some areas of the country.

Figure 7. Lithuania has the second highest notification rate for tuberculosis in the EU



Source: ECDC Surveillance Data.

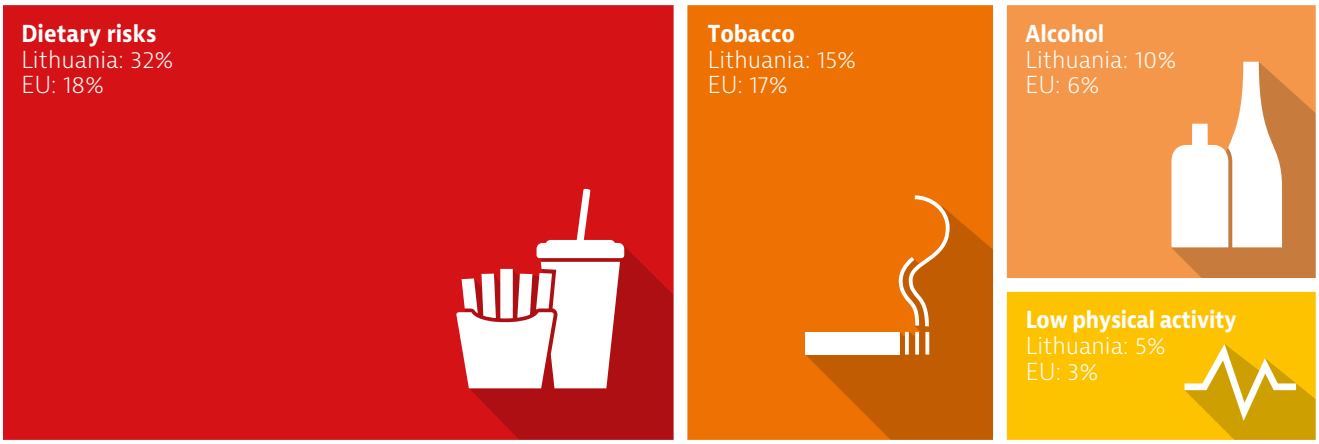
3 Risk factors

Lifestyle risk factors account for more than half of all deaths in Lithuania

The high mortality rates and poor health status of the Lithuanian population are largely linked to behavioural risk factors. It is estimated that more than half of all deaths in Lithuania can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity (IHME, 2018; Figure 8). This proportion is far above the 39 % EU average.

One-third of all deaths in 2017 (13 000 deaths) were related to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), which is nearly twice the EU average. Tobacco consumption, including direct and second-hand smoking, is responsible for an estimated 15 % (over 6 000) of all deaths. About 10 % (4 000) of deaths were linked to alcohol consumption and 5 % (2 000) to low physical activity.

Figure 8. The majority of deaths in Lithuania can be attributed to behavioural risk factors



Note: The overall number of deaths related to these risk factors (21 000) is lower than the sum of each one taken individually (25 000), because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable consumption, and high sugar-sweetened beverages and salt consumption.
Source: IHME (2018), Global Health Data Exchange (estimates refer to 2017).

Excessive alcohol consumption is still a major risk factor

Although alcohol consumption has decreased by about 10 % between 2010 and 2017, it remains a major public health concern in Lithuania: at 12.3 litres consumed per adult in 2017, Lithuanians were the heaviest drinkers in the EU, exceeding the EU average by 25 % (Figure 9). In 2014, one-third of men in Lithuania still reported engaging in binge drinking[3] at least once a month over the past year, which was also above the EU average (34 % compared to 28 %). Between 2016 and 2018, the government adopted a number of policies to tackle excessive alcohol consumption. Measures included an increase in excise taxes, a prohibition of alcohol sales in some places such as petrol stations, an increase in the legal age for purchasing and consuming alcohol to 20 years, and a limitation of operating hours of sale (see Section 5.1).

Men in Lithuania smoke more than in most other EU countries

In 2014, one in five Lithuanian adults reported smoking every day, which is slightly higher than the EU average (20 % compared to 19 %; Figure 9). However, this average masks substantial gender differences. While only 9 % of women reported smoking daily, more than one in three men still smoked every day – the fourth highest rate in the EU. Smoking among adolescents has declined in Lithuania over the past decade but remains relatively high: among 15- and 16-year-olds, 22 % of girls and 27 % of boys reported smoking regularly in 2015.

Lithuania achieved substantial positive policy developments to reduce tobacco consumption. The government ratified WHO's Framework Convention on Tobacco Control in 2004 and in 2017 adopted a complete ban on all forms of sponsorship from the tobacco industry. Yet the estimated prevalence of smoking among men calls for more gender-specific interventions targeting male smokers (see Section 5.1).

Overweight and obesity rates among adults are slightly above the EU average

The obesity rate in Lithuania is above the EU average. Obesity is a known risk factor for numerous conditions including cardiovascular diseases and cancers. One in six adults were obese (17 %) in 2017, compared to one in seven (14 %) on average across the EU. This is partly the result of poor nutritional and lifestyle habits. In 2017, nearly two-thirds of Lithuanian adults (63 %) reported not eating any fruit on a daily basis. The frequency of vegetable consumption is slightly better, with 55 % of adults reporting that they eat at least one portion of vegetables every day.

While overweight and obesity rates in children are lower than in most countries, this is becoming a growing concern. In 2013-14, obesity rates had nearly doubled since the mid-2000s, to reach 13 % among 15-year-old Lithuanians.

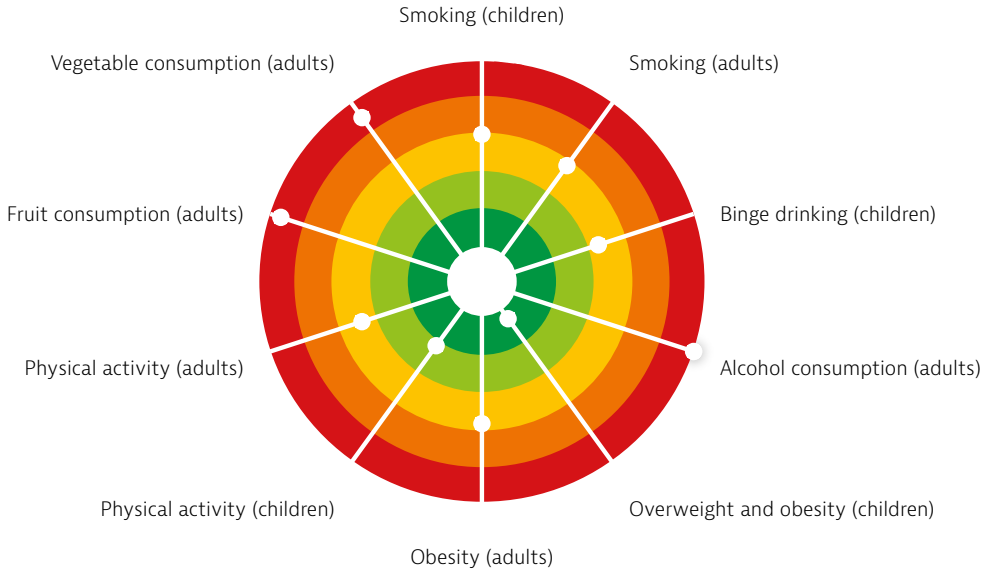
Socioeconomic inequality contributes to health risks

Many behavioural risk factors in Lithuania are more common among people with lower education or incomes. In 2014, more than a quarter of adults (27 %) in the lowest income quintile smoked daily, compared to less than one in five (18 %) of those in the highest income quintile, a gap slightly above the EU average.

3: Binge drinking is defined as consuming six or more alcoholic drinks on a single occasion for adults, and five or more alcoholic drinks for adolescents.

In the same vein, 18 % of people without a secondary education were obese in 2017, compared to only 10 % of those with higher education; this gap is much lower in the EU as a whole. This higher prevalence of risk factors among socially disadvantaged groups contributes importantly to inequalities in health and life expectancy.

Figure 9. Alcohol consumption in Lithuania is the highest in the EU by a wide margin



Note: The closer the dot is to the centre, the better the country performs compared to other EU countries. No country is in the white 'target area' as there is room for progress in all countries in all areas.
Source: OECD calculations based on ESPAD survey 2015 and HBSC survey 2013-14 for children indicators; and EU-SILC 2017, EHIS 2014 and OECD Health Statistics 2019 for adults indicators.

4 The health system

A single health insurance fund covers the entire population

The Lithuanian health system is organised around a single insurance fund providing health coverage to nearly the entire population (98 % in 2018, see below). The Ministry of Health, which governs the National Health Insurance Fund (NHIF), formulates health policy and regulation and is responsible for licensing providers and health professionals, as well as for approving capital investment in health care facilities. The two main revenue sources of the NHIF consist of a compulsory earmarked contribution from payrolls, and direct transfers from the state to cover (mostly) economically inactive population groups, such as children, students, pensioners and unemployed people (OECD, 2018).

The NHIF purchases health services through five regional branches. Local administrations (60 municipalities) play an important role in service delivery as they own a large share of primary care centres (particularly the polyclinics) and the small- to medium-sized hospitals. They also provide some public health services. The private sector also plays a role in the delivery of primary and dental care, and the NHIF increasingly contracts private providers for a series of outpatient specialist care services.

Coverage through the NHIF is mandatory and, in theory, provides services for all residents, subject to confirmed insurance status. Uninsured people remain officially entitled to free emergency care. As of December 2018, about 2 % of the population were uninsured. These may be people not in regular employment, who failed to make statutory contributions, or people registered as residents but living abroad.

In the Lithuanian system, primary care routinely acts as a first contact point with the health system for patients. It is delivered in public or private health care centres, where general practitioners (GPs) often practise alongside other primary care specialists such as paediatricians, gynaecologists and mental health practitioners. Primary care physicians play a gatekeeping function to more intensive levels of care; however, patients can reach specialists practising in publicly financed settings directly. Specialist outpatient care is delivered by the outpatient departments of hospitals or polyclinics, as well as by private providers.

Spending on health is comparatively low

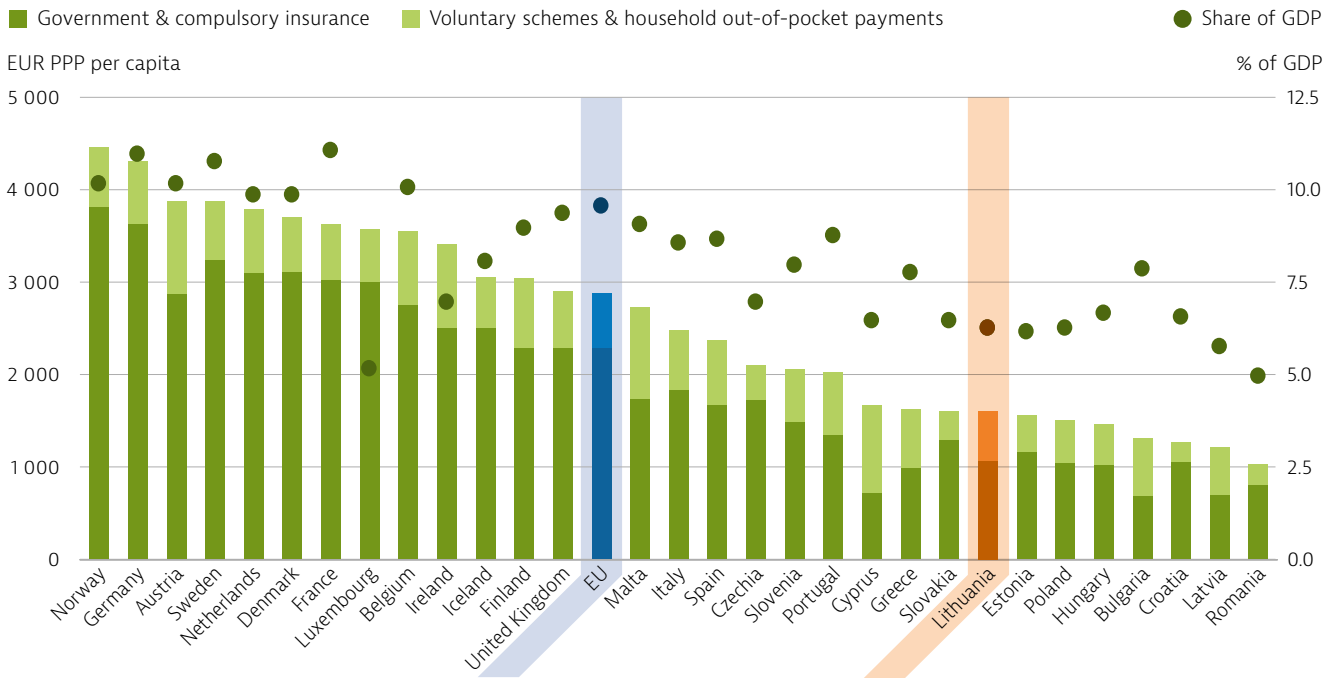
Lithuania's spending on health care is among the lowest in the EU. In 2017, current health expenditure accounted for 6.5 % of GDP, the fifth lowest in the EU and substantially lower than EU average of 9.8 % (Figure 10). In terms of spending per person, in 2017 Lithuania spent EUR 1 605 (adjusted for differences in purchasing power) – slightly more than half the EU average of EUR 2 884 per person. Furthermore, only about two-thirds (67 %) of health expenditure are publicly funded, a significantly lower share than the EU average (79 %). Out-of-pocket (OOP) payments[4] cover the remaining third of health spending – one of the highest shares in the EU (see Section 5.2).

In addition, EU Structural and Investment Funds play an important role in financing health care-related projects in Lithuania, amounting to EUR 238 million in 2007-13 and EUR 131 million for 2014-20 (Ministry of Finance, 2019a; 2019b).

Inpatient care and pharmaceuticals absorb most of the Lithuanian health care budget

Spending on inpatient care was the largest cost item in 2017, accounting for 30 % of the total health care budget. A similar share was spent on pharmaceuticals and medical devices (29 %). This allocation of health system resources differs substantially from that of most EU countries: the percentage spent on pharmaceuticals and medical devices is much higher in Lithuania (29 % vs. 18 % in the EU), while that spent on long-term care is much lower (8 % vs. 16 %). Important variations can also be noticed when comparing data from countries with similar levels of health expenditure per capita: while the spending patterns across health care functions in Lithuania are very similar to those in Latvia, they differ substantially from those in Estonia, which allocates relatively more resources to outpatient care and fewer to pharmaceuticals and hospital care (Figure 11).

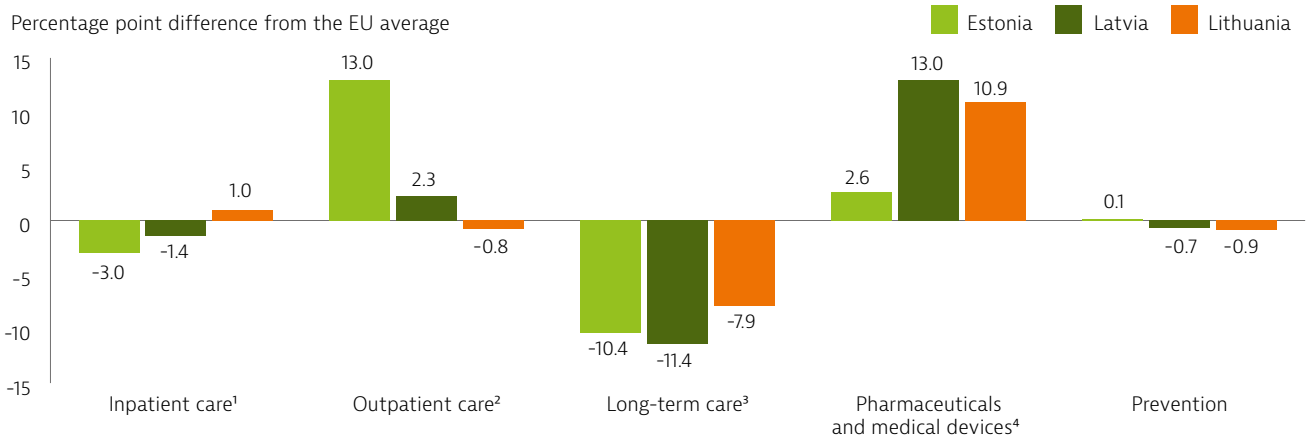
Figure 10. Lithuania spends significantly less on health care than most other EU countries



Source: OECD Health Statistics 2019 (data refer to 2017).

4: OOP payments include direct payments, cost-sharing for services outside the benefit package and informal payments.

Figure 11. Allocation of resources across health services in Lithuania differs substantially



Note: Administration costs are not included. 1. Includes curative-rehabilitative care in hospital and other settings; 2. Includes home care; 3. Includes only the health component; 4. Includes only the outpatient market.
Sources: OECD Health Statistics 2019, Eurostat Database (data refer to 2017).

A wide range of services are covered but co-payments are substantial

The NHIF benefit package is not explicitly defined but covers a relatively broad range of health services. All permanent residents are entitled to free emergency care, even if they are not insured (WHO Regional Office for Europe, 2018). Outpatient pharmaceuticals and dental care are the two main drivers of OOP expenditure on health (see Section 5.2). The Ministry of Health has defined a positive list for outpatient prescription medicines accompanied by a complex co-payment system, which is currently being revised (Box 1). Adults do not have coverage for dental care, which is provided free of charge only to children and people receiving income support.

A national health strategy aims to address health workforce imbalances and shortages

Lithuania has a high number of doctors compared to the EU average (4.6 compared to 3.6 per 1 000 population in 2017), of which slightly over one-fifth are GPs. At the same time, the number of nurses is slightly lower than the EU average (7.7 vs. 8.5, Figure 12).

Over the past 20 years, the supply of doctors has increased while the number of practising nurses has remained stable, leading to a reduction in the nurse-to-doctor ratio from 2.1 in 2000 to 1.7 in 2016. The National Health Strategy 2014-25 aims to restore the nurse-to-doctor ratio to 2.0 by 2020, although recent data suggest that there has not yet been any progress in this direction. The Strategy also intends to document and address other mounting concerns regarding the present and future supply of health workforce in Lithuania, including shortages of medical specialists outside larger cities, ongoing outward migration flows of younger doctors and other health professionals, and the consequences of ageing of currently practising clinicians. This last issue is especially worthy of government attention in the short term, as 39 % of physicians were aged over 55 in 2017, suggesting that many will retire in the next ten years.

Box 1. The outpatient medicines reimbursement scheme is being revised

Currently, there are two lists of reimbursable outpatient medicines:

- List A contains medicines used to treat specific listed conditions (e.g. tuberculosis, cancers, schizophrenia, epilepsy, metabolic diseases, asthma, some rare and progressive disorders). Since April 2019, all medicines in this list are fully reimbursed.
- List B contains certain medicines that are reimbursed for specific social groups at two levels: a 100 % reimbursement for children, people with severe disabilities and people with specific conditions; and 50 % for pensioners and people with less severe disabilities and reduced capacity to work.

Everyone purchasing reimbursed medicines still needs to pay the difference between the reimbursed price and the pharmacy retail price. Ongoing efforts are made to reduce pharmaceutical expenditure, along with the levels of OOP payments for medicines. As part of those efforts, the lists are revised on a regular basis with the aim of reducing use of the 50 % reimbursement level and broadening the list of medicines with 100 % reimbursement (see Section 5.2).

To attract primary care physicians to practise in peripheral areas, the NHIF introduced a higher capitation payment for patients living in rural areas. Hospitals located in these places also have started offering increased wages to doctors (+28 %) and nurses (+30 %). In conjunction with municipalities, the government has also recently put in place grants for medical students willing to work in remote areas (OECD, 2018).

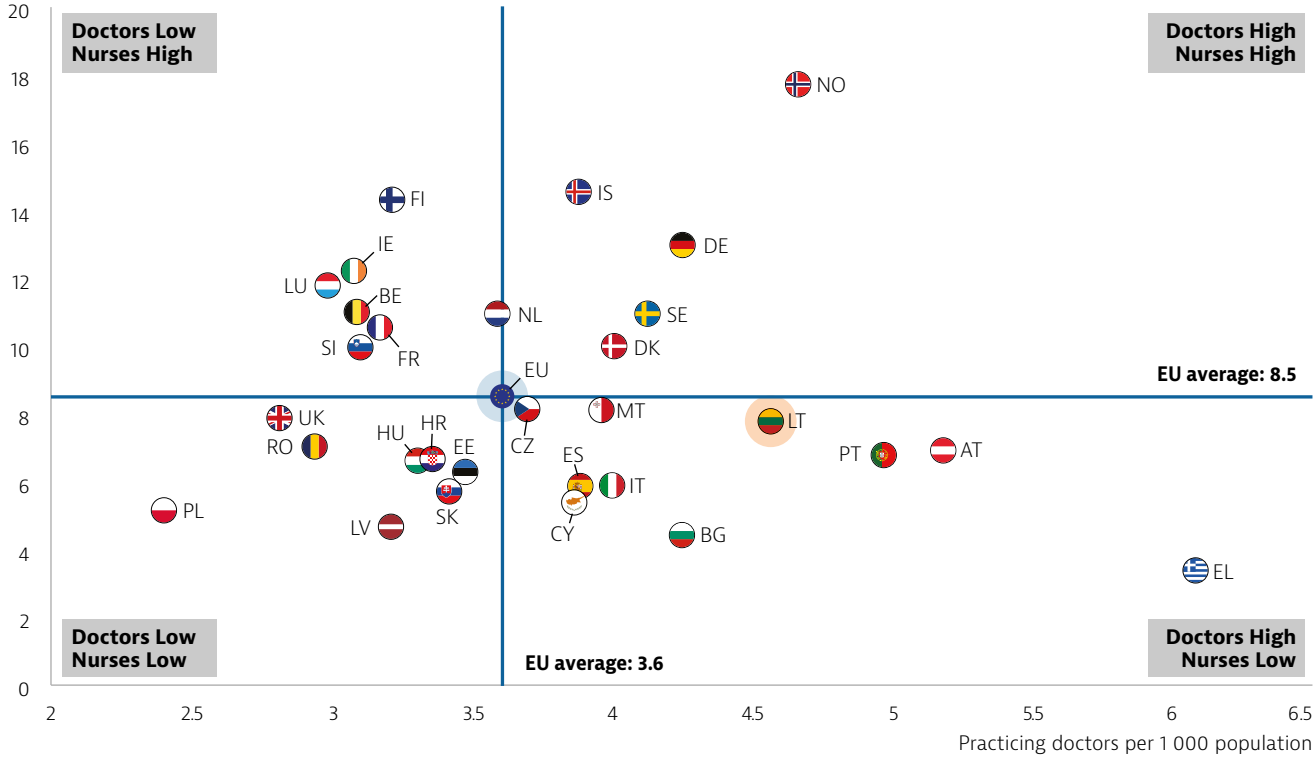
The Lithuanian health system remains excessively hospital-centric

Health service delivery in Lithuania relies heavily on inpatient care. The country has one of the highest ratios of hospitals beds per population in the EU: 6.6 beds per 1 000 population, 30 % more than the EU average (5.0 beds). High hospital discharge rates[5] also suggest overuse of hospital care. In addition, the occupancy rate of acute care beds was in 2016 less than 75 % – below the EU average – pointing to some degree of hospital overcapacity.

Progress in streamlining the number and allocation of hospital beds in Lithuania stalled in the mid-2000s and only resumed in recent years. While there have been several attempts to concentrate specialist services in larger centres and re-profile smaller hospitals (OECD, 2018), implementation of a full-scale hospital restructuring reform was suspended in 2018 (see Section 5.3).

Figure 12. Lithuania has a high number of doctors and an average number of nurses

Practicing nurses per 1 000 population



Note: In Portugal and Greece, data refer to all doctors licensed to practice, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Austria and Greece, the number of nurses is underestimated as it only includes those working in hospital.
Source: Eurostat Database (data refer to 2017 or nearest year).

5 Performance of the health system

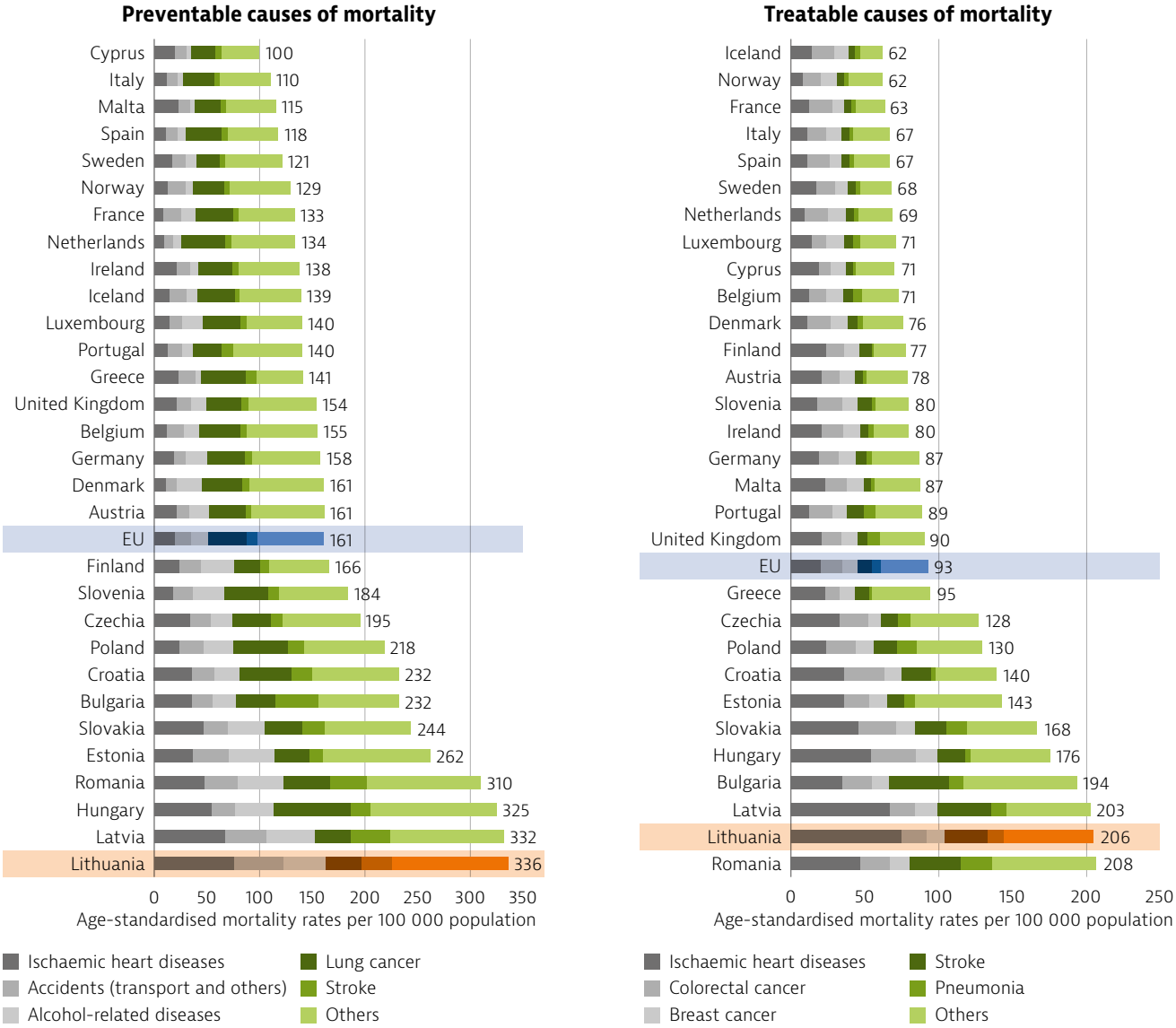
5.1. Effectiveness

Lithuania has the highest mortality rate from preventable causes in the EU

Lithuania had the highest preventable mortality rate and second highest mortality rate from treatable causes in the EU in 2016. Over 8 500 deaths could have been avoided in Lithuania in 2016 through effective public health and prevention interventions, and a further 5 000 through more effective and timely health care provision. This highlights a substantial need to develop more effective public health policies, as well as to reform and invest in improving the quality of the health care system (Figure 13).

5: Hospital discharge is a measure of overall hospital activity through the number of patients who leave a hospital after staying at least one night.

Figure 13. Many deaths in Lithuania could be avoided through better prevention and health care



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Mortality from treatable (or amenable) causes is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Both indicators refer to premature mortality (under age 75). The data are based on the revised OECD/Eurostat lists.
Source: Eurostat Database (data refer to 2016).

Government implemented several measures to reduce alcohol and tobacco consumption

As described in Section 3, the majority of deaths in Lithuania can be attributed to lifestyle-related risk factors. This situation called for strong action from the authorities and led to the adoption of the National Health Strategy 2014-25, which aims to reduce harmful alcohol consumption and smoking, and encourage intersectoral action to promote healthy diet and physical activity. The Strategy has a cross-sectoral framework involving nearly all ministries; every year the Institute of Hygiene monitors progress and prepares a report on the Strategy's implementation.

As an illustration, Lithuania has introduced measures in recent years to tackle the country's high levels of alcohol consumption. The parliament adopted a number of alcohol control measures, such as a ban on sales of alcohol in gas stations in 2016, as well as increased excise taxes on most alcoholic beverages in 2017 (see Section 3). Further alcohol restrictions came into effect in 2018, including restrictions on selling hours, a full ban on alcohol advertisements on TV, radio and the internet, and an increase in the minimum legal age for buying and consuming alcoholic beverages to 20 years.

Tobacco control has also been strengthened in recent years: smoking was banned in restaurants, bars and cafés in 2007, tobacco excise duties were increased regularly in 2004, 2007, 2010, 2012 and 2015, and the WHO Protocol to Eliminate Illicit Trade in Tobacco Products was ratified in 2016. However, despite these efforts some gaps remain, such as the persistent low prices of tobacco products and limited smoking cessation programme availability (OECD, 2018).

Immunisation coverage of the Lithuanian population is below WHO's recommendations

The national immunisation programme sets Lithuania's objectives regarding population vaccination. It aims to decrease the risk of outbreaks and ensure the safety, accessibility and effectiveness of vaccination. The targets also include the eradication of measles and the introduction of new vaccines such as pneumococcal and rotavirus vaccines (Rechel, Richardson & McKee, 2018). Vaccinations in Lithuania are not mandatory but only recommended. All recommended vaccinations included in the national immunisation schedule are free of charge, including influenza vaccination for elderly people and other at-risk populations. In addition, the national immunisation schedule has been expanded significantly in last years: HPV vaccine for girls was introduced in 2016, and MenB (B type meningococcal) and rotavirus vaccine in 2018.

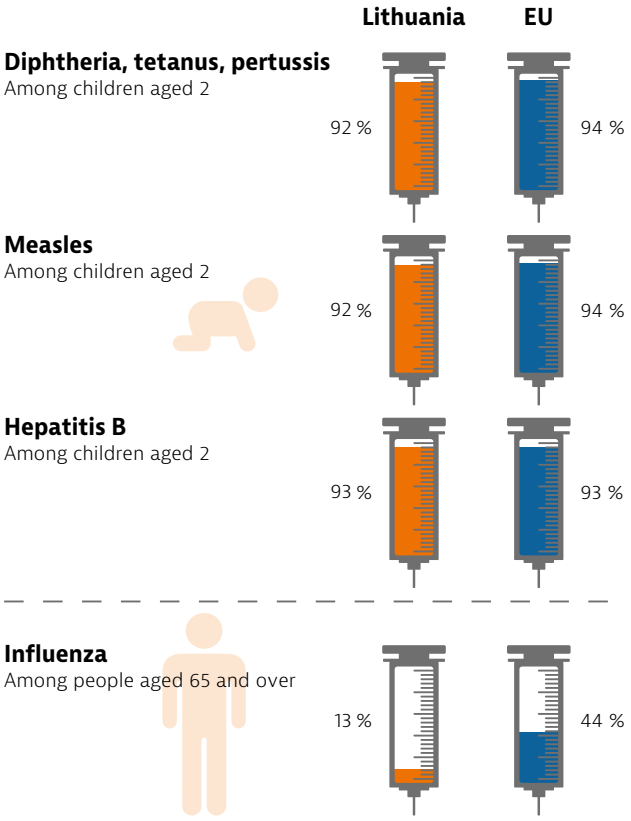
Current immunisation rates among Lithuanian children are under the 95 % target recommended by WHO for the population to benefit from herd immunity (Figure 14). This could in part explain why, as in many other EU countries, measles outbreaks still occur: a major outbreak happened during the first half of 2019, with more than 650 measles cases reported.

Influenza vaccination coverage for people above 65 is very low, with only 13 % of people in that age group vaccinated in 2017, well below the EU average of 44 % and even further from the WHO target of 75 %.

Management of chronic conditions in primary care can be improved

Timely and effective provision of primary care services to patients suffering from chronic conditions such as chronic obstructive pulmonary disease or diabetes can generally prevent their hospitalisation. Since 2005, the share of avoidable hospitalisations has decreased in Lithuania, yet it remains the highest among all EU countries reporting these data (Figure 15). Expanding the role of GPs and, more broadly, of primary care teams in chronic disease management could contribute to reducing levels of avoidable hospitalisations. In this respect, the current government has expanded the clinical competencies of general practice nurses and nurse assistants. The new clinical competencies of general practice nurses give them the right to coordinate the tasks of nurse assistants, prescribe some medicinal products, monitor the progression of chronic diseases and prescribe routine urine and blood sample analysis.

Figure 14. Current immunisation rates in Lithuania are not sufficient

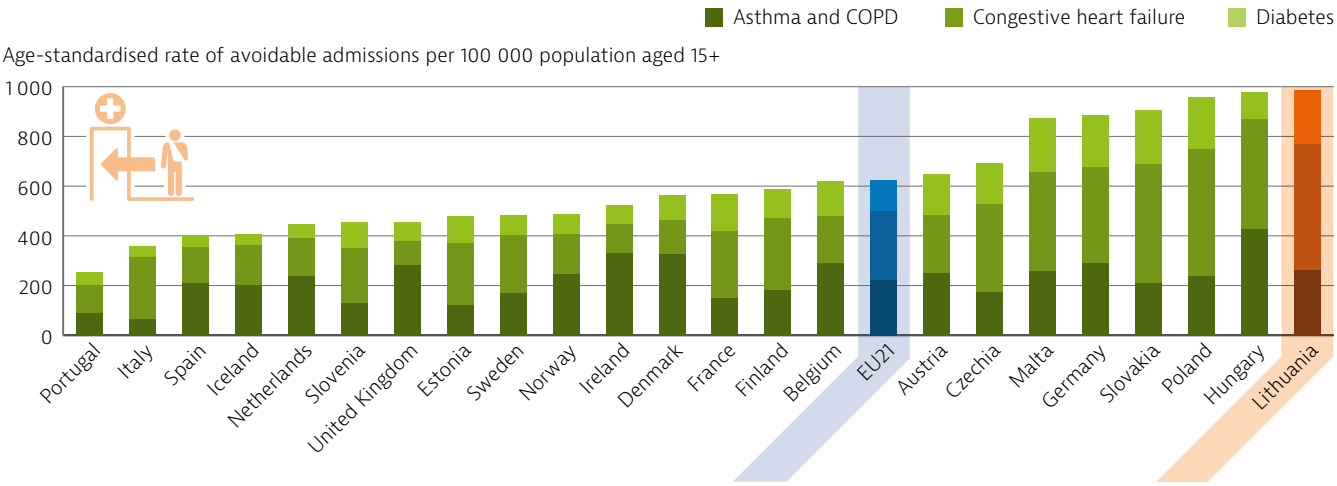


Note: Data refer to the third dose for diphtheria, tetanus, pertussis and hepatitis B, and the first dose for measles.
Source: WHO/UNICEF Global Health Observatory Data Repository for children (data refer to 2018); OECD Health Statistics 2019 and Eurostat Database for people aged 65 and over (data refer to 2017 or nearest year).

The quality of acute hospital care appears to be far below the EU average

Mortality after hospitalisation for life-threatening conditions is an indicator frequently used to assess the quality of hospital care. The 30-day mortality rates after hospital admission for acute myocardial infarction (AMI) and stroke are very high in Lithuania (Figure 16), the second highest across all EU countries reporting these data (after Latvia). This suggests that substantial room exists to improve the quality of acute hospital care.

Figure 15. A large number of hospital admissions could be prevented through stronger primary care



Source: OECD Health Statistics 2019 (data refer to 2017 or nearest year).

Cancer care is improving, but outcomes still lag behind most EU countries

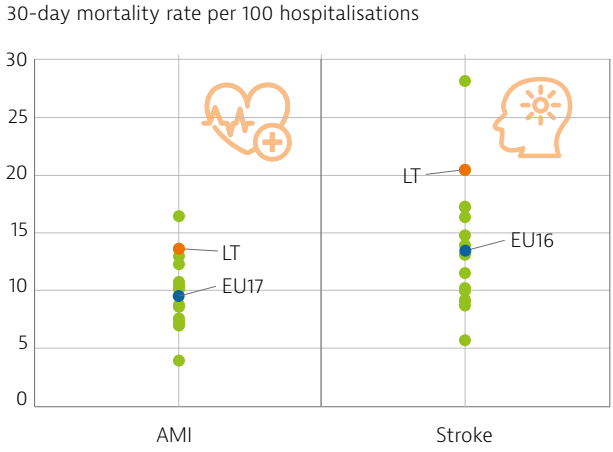
In an effort to improve early detection of cancer and increase survival rates, the Lithuanian health authorities have set up publicly funded, population-based screening programmes for breast, prostate, colorectal and cervical cancers. Screening coverage rates for the target populations have increased over the last decade, although they remain below EU averages. For instance, in 2017, 48 % of Lithuanian women aged 50-69 years had been screened for breast cancer over the past two years, up from only 22 % in 2007 but still below the EU average of 60 %.

The effectiveness of cancer care in Lithuania has improved considerably, but still lags behind most EU countries. Five-year survival rates after cancer diagnosis for most forms of cancer have increased steadily over the past decade but remain among the lowest in the EU, with the exception of prostate cancer. For instance, breast cancer survival increased from 65 % to 74 % between 2000–04 and 2010–14, but it remains behind those of neighbouring Baltic countries Latvia and Estonia and almost 10 % below the EU average.

Efforts to improve mental health services have been made

As shown in Section 2, although Lithuania's mortality rate by suicide has come down over the past decade, in 2017 it was still the highest reported in the EU. Many strategies have been developed not only to prevent suicide but also to detect depression symptoms earlier and provide more appropriate treatment for other mental health issues. Over the last 15 years, a substantial share of institutionalised psychiatric and substance abuse services have moved into general hospitals and outpatient mental health centres to reduce the stigma associated with mental health disorders. At the primary care level, services are delivered in 115 mental health care centres, which are sometimes co-located with primary care centres. Patients can be referred to these primary mental health services by their GP or the hospital, but they can also access them directly.

Figure 16. 30-day mortality rates for AMI and stroke are very high in Lithuania



Note: Figures are based on patient data and have been age-sex standardised to the 2010 OECD population aged 45+ admitted to hospital for AMI and ischaemic stroke.
Source: OECD Health Statistics 2019 (data refer to 2017 or the nearest year).

Coordination across different health care providers nonetheless remains a major issue. The availability of mental health and primary care services does not systematically translate into a functional team approach with effective mechanisms to detect illness early and meet patients' needs. Coordination between hospital and outpatient care is also insufficient. This may explain, at least in part, why the suicide rate after hospitalisation among patients diagnosed with a mental disorder is among the highest reported in the EU.

In 2017, the National Audit Office called for renewed efforts to identify and support individuals at risk of mental health issues and to ensure immediate and continuous support to people who have attempted suicide, emphasising the need for information sharing between institutions (National Audit Office, 2017). A recent ministerial order states that, from November 2019, new health care services will be provided in mental health care institutions to children and adolescents. In addition, the network of institutions providing psychiatric day care treatment for children and adolescents will expand from five institutions to ten.

Since 2019, the Ministry also started financing municipal Public Health Bureaus to promote mental health prevention in schools. The objectives of this program are to enhance the competences of school staff in detecting and addressing mental health issues and improve overall mental health literacy.

Initiatives to support improvements in quality of care are in their infancy

In 2016, the State Health Care Accreditation Agency – the public body responsible for licensing health care organisations and most professionals – launched an accreditation programme with the objective of improving quality of health service delivery. However, only a limited number of primary care organisations have gone through this process, despite the development of financial incentives by the authorities to increase their interest in doing so (OECD, 2018).

Primary care physicians in Lithuania are paid using a combination of a capitation fee and a pay-for-performance component. Currently, facilities receive an age- sex- and location-adjusted capitation rate (accounting for roughly three-quarters of facilities' revenues) associated with activity-based payments for a list of specific services, such as immunisation or monitoring of pregnant women. The final element of remuneration is a result-based payment linked to a list of performance indicators, accounting for roughly 10 % of revenue. The indicators currently used include, for instance, cancer screening coverage rates and hospitalisation referrals for chronic conditions such as diabetes. In recent years, the share of capitation in total revenue for primary care providers has declined in favour of the performance-based component. This performance-based payment appears to be well designed and monitored, and some indicators (such as screening rates) show improvement. Nevertheless, the current scheme could be improved with inclusion of other indicators such as process indicators (OECD, 2018).

The Ministry of Health has issued around 120 diagnostic and treatment protocols to promote more appropriate and effective care (in cardiology, oncology, neurology, traumatology and paediatrics). All providers are encouraged and expected to follow them, but no mechanisms are in place to monitor compliance or to support providers in implementation.

5.2. Accessibility

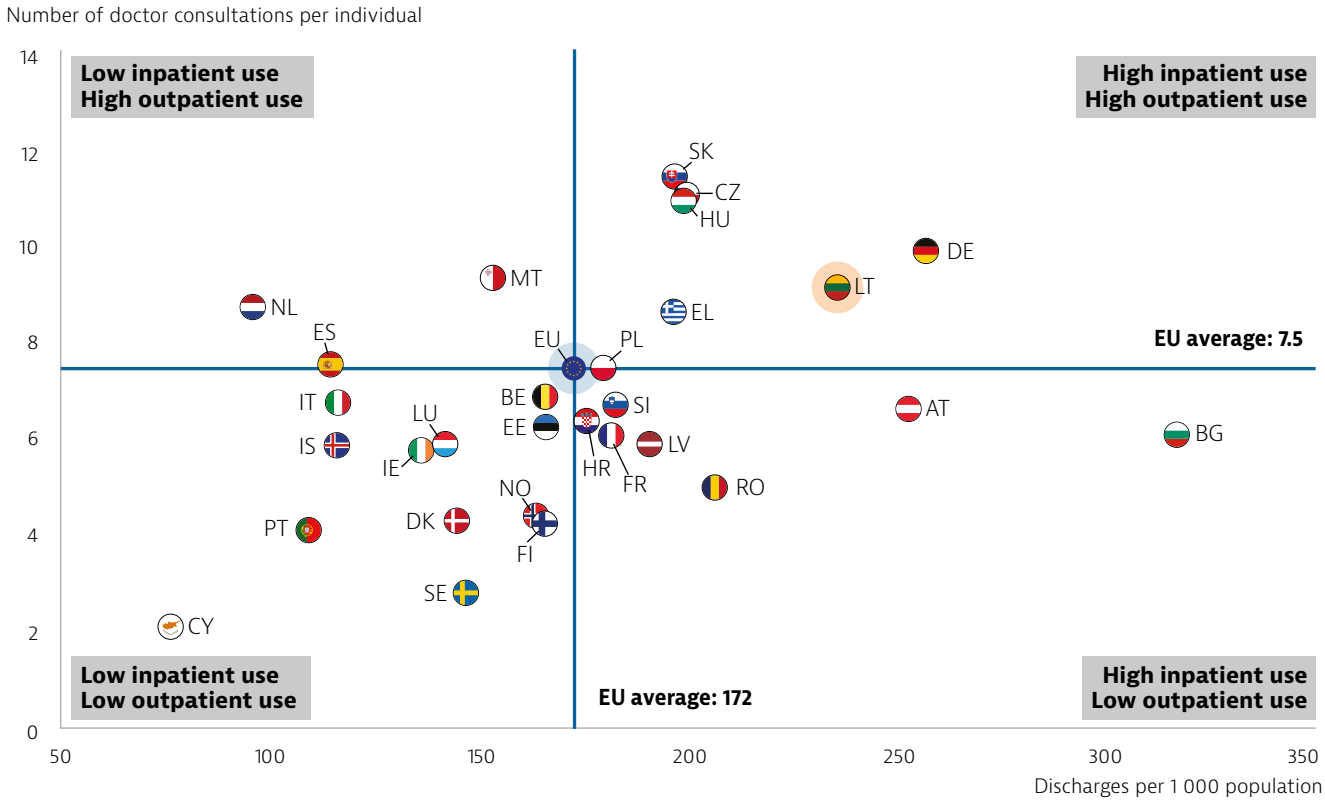
Unmet medical needs are low in Lithuania

The proportion of Lithuanians reporting unmet needs for medical examination and treatment is relatively small. Only 1.5 % of the population reported barriers in access to care in 2017 due to waiting time, costs or distance to travel. In addition, the difference across income groups was relatively small. However, the levels of unmet needs are higher for services that are less well covered, such as dental care (see Section 4).

The number of contacts with the health system are high

People in Lithuania tend to consult health services more frequently than other EU citizens. In 2016, Lithuanians consulted physicians more than nine times on average, which is 20 % above the EU average (Figure 17). The same year, the number of people admitted and discharged from the hospital was the fourth highest among EU countries (see Section 4). These high utilisation rates suggest that access to doctors and hospitals is good, with the caveat that such measures overlook important elements that are also aspects of accessibility (e.g. quality).

Figure 17. People in Lithuania use health services frequently



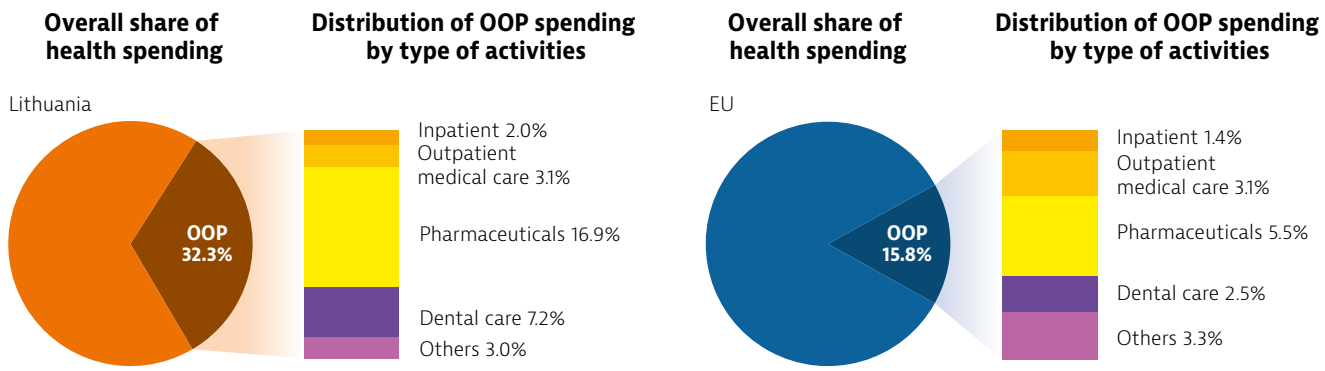
Note: Data for doctor consultations are estimated for Greece and Malta.
Source: Eurostat Database; OECD Health Statistics (data refer to 2016 or the nearest year).

High out-of-pocket payments result in catastrophic spending for low-income households

Although few Lithuanians report unmet needs for medical care due to financial reasons, OOP payments represented almost one-third (32 %) of health spending in Lithuania – more than twice the EU average (Figure 18). Most OOP spending is used to pay for pharmaceuticals, but dental care represents also a sizeable share of OOP spending.

These high levels of OOP payments create financial hardship, especially in low-income households. Over 15 % of households in Lithuania faced catastrophic spending on health[6] in 2016, the highest level across the EU countries for which data are available. Such catastrophic spending is heavily concentrated among the poorest quintile of the population and most is related to OOP payments for medicines (WHO Regional Office for Europe, 2018; 2019).

Figure 18. Out-of-pocket payments in Lithuania are double the EU average



Source: OECD Health Statistics 2019 (data refer to 2017).

6: *Catastrophic expenditure is defined as household OOP spending exceeding 40 % of total household spending net of subsistence needs (i.e. food, housing and utilities).*

While there are no formal user charges for primary, outpatient and inpatient care, until recently, patients faced substantial co-payment rates for outpatient medicines (see Box 1). A number of measures have been taken since 2017 to decrease the level of OOP payments on medicines. These include the addition of 45 new molecules in the reimbursement list, an increase in the reimbursement levels and caps on the price differences between the prices paid at pharmacy level and the reference reimbursement prices. As a result, the average co-payment per prescription decreased from EUR 3.4 in 2017 to EUR 2.3 in 2019, and the share of OOP expenditure on reimbursable medicines decreased from 21.2 % in 2016 to 6.8 % in the first two months of 2019 (Figure 19).

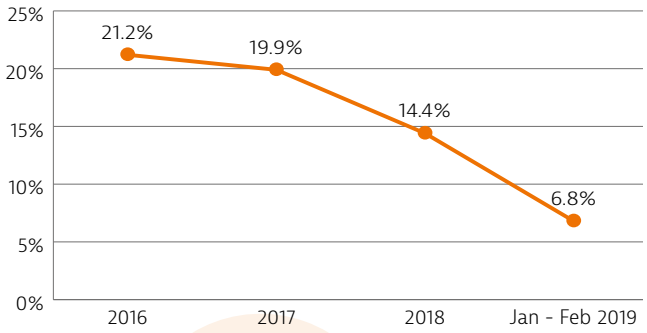
Furthermore, as of April 2019, all co-payments for medicines included on list A have been substantially reduced[7]. The development of a separate model for reimbursement of medicines for people on low incomes is also under discussion. Additional measures to promote the use of generics and inter-country collaboration are being considered by the authorities (Box 2).

Accessibility for disabled people is limited

NHIF provides sign language interpreters and assistants for patients who are deaf and blind. However, centres for sign language interpreters are only located in the biggest cities, so accessibility in rural areas is limited. Further, disabled patients with behavioural disorders are not able to use regular dentist services and are therefore sent for treatment with general anaesthesia. Few institutions provide dental treatment with anaesthesia as day surgery, as required by existing legal regulation, leading to limited availability of services.

Figure 19. Reforms led to a substantial reduction of out-of-pocket payments on pharmaceuticals

Share of expenditure on reimbursable medicines paid out-of-pocket



Source: Ministry of Health of Lithuania, 2019.

Box 2. Lithuania engages in regional collaboration to improve access to medicines

The Fair and Affordable Pricing (FAAP) initiative, established in March 2017, is an inter-country regional collaboration platform to improve access to medicines for the citizens of member countries. This project was established among the Visegrád Group (Czechia, Hungary, Poland, Slovakia), but is also open to other countries: Lithuania is one of its founding members and Latvia is an invited guest.

Several regional meetings and technical consultations have been organised. The project is being shaped as a complementary platform allowing better, proactive preparation of national reimbursement and pricing decisions. A pilot joint negotiation is under way to define possible mechanisms for future regional negotiation strategies.

7: See Box 1 for more information on the different types of reimbursement lists in Lithuania.

5.3. Resilience[8]

Public spending on health was affected by the economic crisis

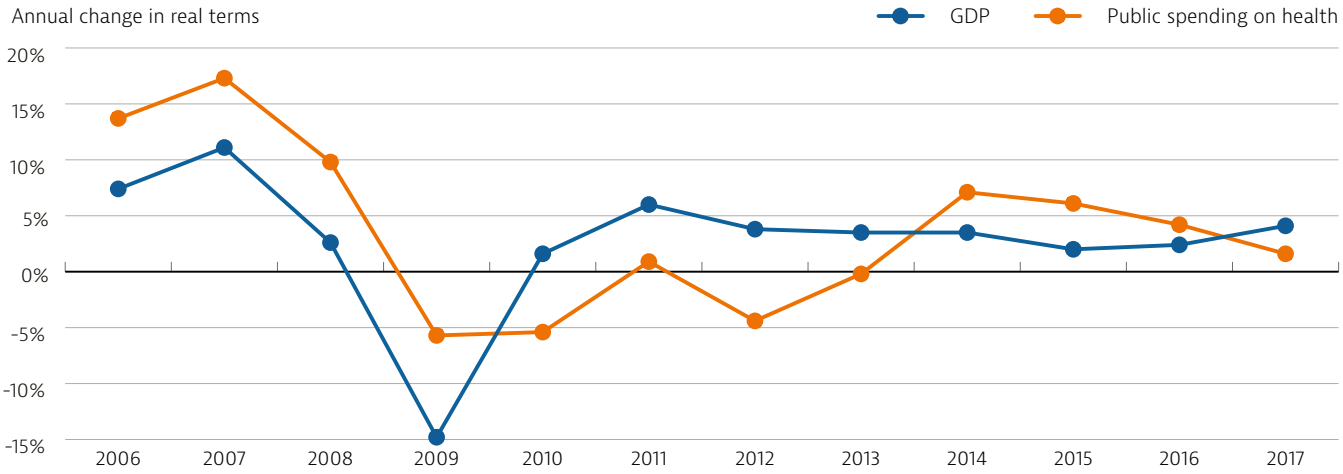
In the aftermath of the economic crisis of 2008-09, public spending on health in Lithuania fell substantially until 2013 (Figure 20). As a result, health expenditure as a share of GDP decreased between 2009 and 2013 (from 7.4 % of GDP to 6.1 %). It was only in 2014 that public expenditure on health started to rise again in line with economic growth.

Overall, solid budget management procedures are in place in Lithuania. By law, the NHIF must balance revenues and expenditure each year. In each budget cycle, it sets aside provisions to adjust payments to service providers based on the services delivered at the end of the year. The NHIF also earmarks funds, which can be used in case of revenue shortages or unexpected expenditure increases. These served as a buffer during the financial crisis and have also been used to increase tariffs and compensate facilities for increases in health workers' salaries decided by the Ministry of Health (OECD, 2018).

As noted in Section 4, Lithuania spends much less on health on a per capita basis and as a share of GDP than most other EU countries. Such low levels of public spending on health are the result of Lithuania's relatively small overall budget (public spending represents 35 % of GDP), but also relatively low prioritisation of health, as only 10 % of overall public spending is allocated to this sector compared with almost 17 % in the EU (OECD/EC, 2018).

These elements partly explain why economic projections in terms of sustainability of public finance are favourable to the Lithuanian health system (see Box 3). However, further investments and reforms may still be needed to achieve better health outcomes, as recommended by the Council of the European Union in the context of the 2019 European Semester[9] (Council of the European Union, 2019).

Figure 20. Public spending on health decreased following the economic crisis



Source: OECD Health Statistics 2019; Eurostat Database.

Efforts to overhaul the hospital sector could result in more efficient use of resources

Lithuania stands out as having high treatable mortality rates compared to other EU countries, given its level of health care spending (Figure 21).

The hospital sector has not yet been substantially reformed. In 2015, there were 79 public hospitals and, as noted in Section 4, overreliance on inpatient care persists, with the number of beds per 1 000 population remaining much higher than the EU average (Figure 22).

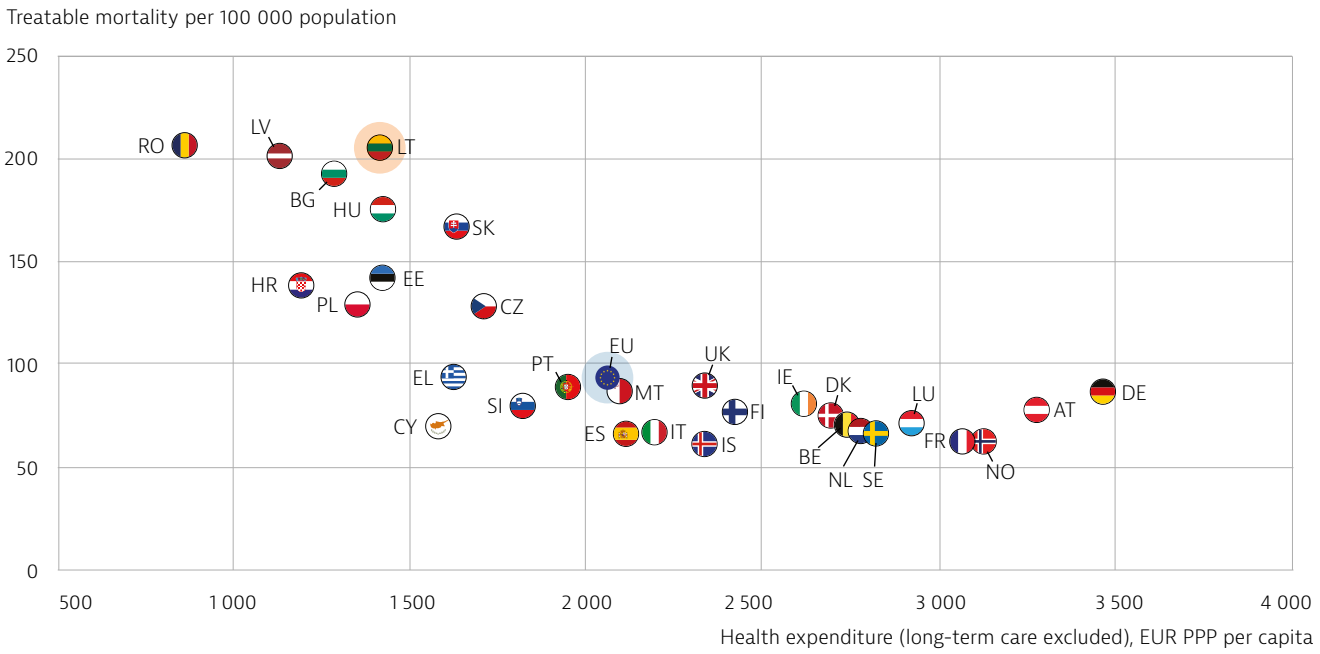
A payment system based on diagnosis-related groups (DRGs) has been rolled out since 2012 to incentivise more efficient use of hospital resources. The system is still being fine-tuned, with new cost weights in development to ensure that relative prices more closely reflect the local cost structure of service production. Implementation of DRGs has contributed to increasing the share of day surgery for selected procedures, although the rates still lags behind most other EU countries (Figure 23). In 2016, 45 % of cataract surgeries were carried out on a same-day basis in Lithuania, while they were almost never done this way ten years ago.

8: Resilience refers to health systems' capacity to adapt effectively to changing environments, sudden shocks or crises.
9: In July 2019, the Council of the European Union issued Lithuania a country-specific recommendation to take action in 2019 and 2020 to 'increase the quality, affordability and efficiency of the healthcare system'.

Box 3. Projections of future growth in public expenditure on health and long-term care show that these are sustainable

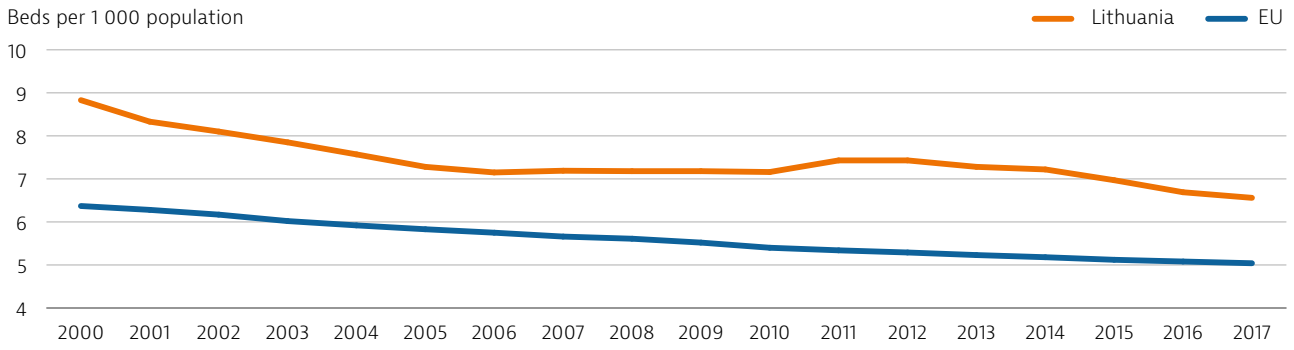
Lithuania's health expenditure is not projected to grow as swiftly as that of other EU Member States. As a consequence of demographic changes anticipated in the reference scenario of the 2016-70 EU projections, public health care expenditure is projected to increase by 0.4 percentage points of GDP, below the average growth expected for the EU (0.9) between 2016 and 2060. When taking into account the impact of non-demographic drivers on future spending growth, health care expenditure is expected to increase by 1.2 percentage points of GDP over the same period, compared to 1.6 in the EU (European Commission-EPC, 2018). The overall picture is thus one of low risk to medium/long-term fiscal sustainability, as the anticipated levels of health expenditure remain relatively low considering the expected GDP growth and fiscal evolution (European Commission, 2019).

Figure 21. Many countries with comparable levels of health spending achieve better outcomes



Source: Eurostat Database; OECD Health Statistics 2019.

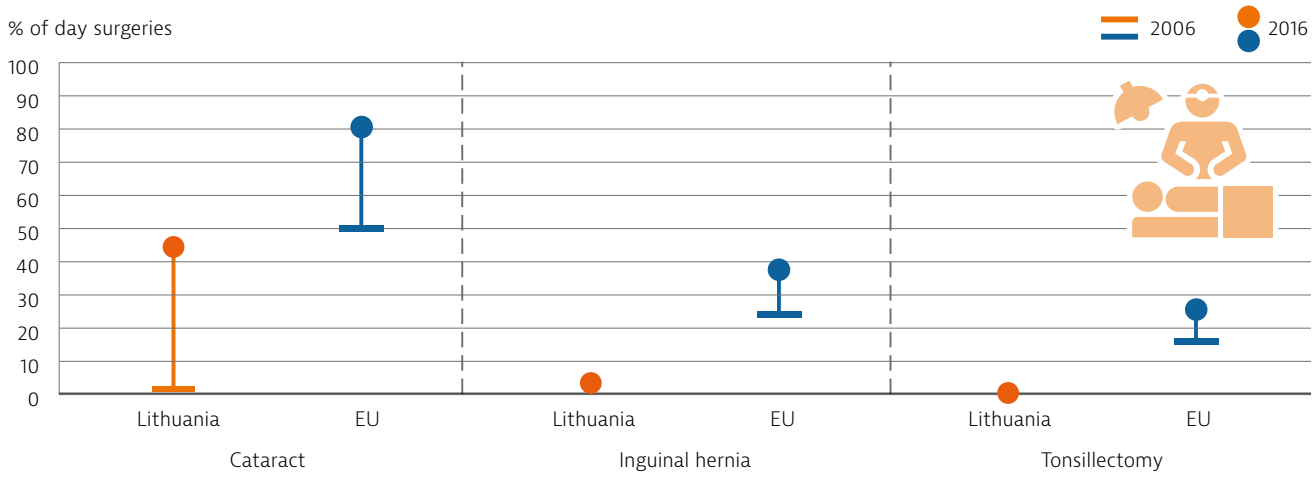
Figure 22. The number of hospital beds per 1 000 population is far above the EU average



Source: Eurostat Database.

Efforts to consolidate hospital services need to be continued: many hospitals in Lithuania carry out too few surgical procedures in some clinical areas to ensure an acceptable level of quality of care and patient safety. The restructuring of the hospital sector regained momentum in 2018 but was halted soon after. Legislative amendments aimed at centralising the governance and ownership of hospitals at the national level. The objective of the legislative proposal was to enable the Ministry of Health to form a network of public providers of health services, to organise the delivery of services across the borders of municipalities and allow the NHIF to prioritise public providers when contracting services. However, this piece of legislation did not come into force due to a presidential veto, on the grounds that the amendments infringed existing rules on patient choice and competition (OECD, 2018).

Figure 23. Day surgery rates could be boosted substantially



Source: OECD Health Statistics 2018: Eurostat Database (data refer to 2006 and 2016, or nearest years).

Improving health is a political priority for Lithuania

Health features as a prominent intersectoral priority across Lithuania's main strategic planning documents. A large number of interconnected strategies and related action plans outline the country's strategy when it comes to health. 'Health for All' is one of three horizontal priorities of the country's national development strategy, Lithuania 2030. Implementation of this horizontal priority is provided for in a specific intersectoral action plan, coordinated by the Ministry of Health and involving nine other ministries, which are in charge of developing – and funding – their own related action plans. Another set of inter-ministerial strategies and plans includes, among others, actions on drug, alcohol and tobacco control and prevention (see Section 5.1).

Overall, these documents demonstrate a recognition that improving health requires efforts beyond the health sector; for instance, in education. The National Health Strategy 2014-25, adopted in 2016, builds on an earlier plan (Lithuania's health programme for 2014) and is articulated around a life-course approach that emphasises the importance of tackling health determinants and reducing inequalities. However, such high-level political commitments will have tangible outcomes only if solid monitoring procedures are also set up.

The audit by the State Control office confirmed the challenges in health policy

In April 2019, the State Control office performed an audit of NHIF activities over the period 2010-18 (State Control, 2019). The evaluation pointed out a number of issues, including the question of over-reliance on hospital care, suggesting that ambulatory and primary care could help to reduce hospitalisations by further 20 %. Overall, the health system itself was found to lack mechanisms to ensure optimal quality and accessibility of services.

6 Key findings

- Lithuania has one of the lowest levels of life expectancy in the EU. Although it has increased steadily since 2007, it only reached 75.8 years in 2017, more than five years below the EU average. In addition, substantial inequalities persist by gender: women live nearly ten years more than men, mainly because men have greater exposure to risk factors. Overall, the majority of the population – particularly people on low incomes – reports not being in good health.

- More than half of all deaths in Lithuania can be attributed to behavioural risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity. Despite some recent reductions brought about by alcohol control measures, alcohol consumption is still the highest across EU countries, 25 % above the EU average. High smoking prevalence, especially among men, and obesity rates add to this challenge. In recent years, the authorities have taken action to curb unhealthy behaviours, including through the National Health Strategy 2014-25. Some of the measures have started to bring positive results, as testified by the recently observed reduction in alcohol consumption.

- Lithuania also grapples with some specific health challenges. Mental health is a major public health issue, with the country reporting the highest mortality rate from suicide in the EU. Important efforts have been made in recent years to improve mental health services, which have contributed to initiate a reduction in the number of deaths by suicide. Containment of some infectious diseases, such as tuberculosis and measles, also constitutes a public health challenge.

- Lithuania spends considerably less on health than most other EU countries. In 2017, health expenditure accounted for 6.5 % of GDP, the fifth lowest in the EU, and well below the EU average of 9.8 %. Furthermore, only about two-thirds of health expenditure is publicly funded in Lithuania, with out-of-pocket spending accounting for a much greater share than nearly all other EU countries. Greater public funding for prevention and health care could help improve health outcomes and reduce the financial burden for patients.

- General access to health services is good, yet high out-of-pocket payments on outpatient medicines remain a major barrier. Pharmaceuticals are the main driver of catastrophic expenditure on health, disproportionately affecting low-income populations. It is expected that the recent reform of the co-payment system will contribute to reducing the number of patients enduring financial hardship when accessing pharmaceuticals. Continuing the monitoring and evaluation of these measures and their impact on health will help to guide future policy actions.

- Lithuania stands out as having much higher mortality rates from preventable and treatable causes than other EU countries, even those with similar health expenditure levels. The quality indicators of outpatient and inpatient care also lag behind those of most other EU countries. These indicators suggest that the system could improve its effectiveness substantially. A further shift from inpatient to primary care appears necessary to improve health service quality and responsiveness. Although health care quality monitoring and analysis have gained attention in recent years, Lithuania lacks system-wide support for continuous health care quality improvement.

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Country abbreviations

Austria	AT	Denmark	DK	Hungary	HU	Luxembourg	LU	Romania	RO
Belgium	BE	Estonia	EE	Iceland	IS	Malta	MT	Slovakia	SK
Bulgaria	BG	Finland	FI	Ireland	IE	Netherlands	NL	Slovenia	SI
Croatia	HR	France	FR	Italy	IT	Norway	NO	Spain	ES
Cyprus	CY	Germany	DE	Latvia	LV	Poland	PL	Sweden	SE
Czechia	CZ	Greece	EL	Lithuania	LT	Portugal	PT	United Kingdom	UK

European Commission

State of Health in the EU
Country Health Profile 2019

The Country Health Profiles are an important step in the European Commission's ongoing *State of Health in the EU* cycle of knowledge brokering, produced with the financial assistance of the European Union. The profiles are the result of joint work between the Organisation for Economic Co-operation and Development (OECD) and the European Observatory on Health Systems and Policies, in cooperation with the European Commission.

The concise, policy-relevant profiles are based on a transparent, consistent methodology, using both quantitative and qualitative data, yet flexibly adapted to the context of each EU/EEA country. The aim is to create a means for mutual learning and voluntary exchange that can be used by policymakers and policy influencers alike.

Each country profile provides a short synthesis of:

- health status in the country
- the determinants of health, focussing on behavioural risk factors
- the organisation of the health system
- the effectiveness, accessibility and resilience of the health system

The Commission is complementing the key findings of these country profiles with a Companion Report.

For more information see: ec.europa.eu/health/state

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