European Commission

State of Health in the EU

Lithuania

Country Health Profile 2021

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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 Systems Performance Assessment (HSPA).

Contents

1. HIGHLIGHTS 3
2. HEALTH IN LITHUANIA 4
3. RISK FACTORS 6
4. THE HEALTH SYSTEM 8
5. PERFORMANCE OF THE HEALTH SYSTEM 12
   5.1 Effectiveness 12
   5.2 Accessibility 16
   5.3 Resilience 18
6. KEY FINDINGS 23

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 27 Member States unless otherwise noted. These EU averages do not include Iceland and Norway.

This profile was completed in September 2021, based on data available at the end of August 2021.

Demographic and socioeconomic context in Lithuania, 2020

Demographic factors	Lithuania	EU
Population size (mid-year estimates)	2 794 090	447 319 916
Share of population over age 65 (%)	19.9	20.6
Fertility rate[1] (2019)	1.6	1.5
Socioeconomic factors		
GDP per capita (EUR PPP[2])	25 878	29 801
Relative poverty rate[3] (%, 2019)	20.6	16.5
Unemployment rate (%)	8.5	7.1

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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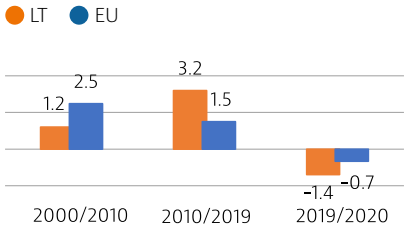
1 Highlights

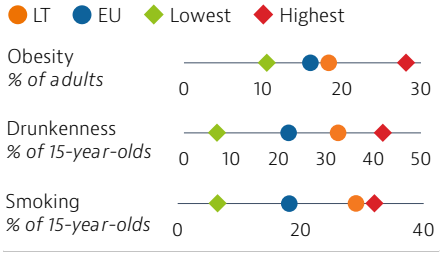
After years of steady gains in population health, the high mortality registered during the COVID-19 pandemic in 2020 in Lithuania temporarily caused a large drop in life expectancy of 1.4 years compared to 2019. The pandemic is also likely to undermine progress in disease prevention by disrupting priority programmes for the early detection of chronic conditions and cancers. Longstanding challenges remain, such as low uptake of health promotion measures, uneven distribution of human resources, weak primary care and varying quality in specialist care. COVID-19 gave a major impetus to the rapid further development of e-health, by transforming digital services, data collection and reporting.



Life expectancy gains, years

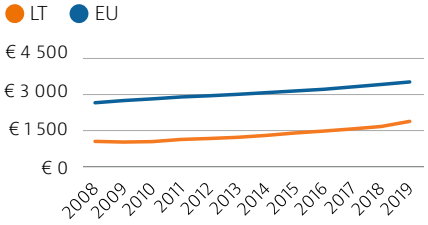
Health Status

Life expectancy in Lithuania in 2020 was the third lowest in the EU and 5.5 years below the EU average. Although the increase in life expectancy between 2010 and 2019 in Lithuania was the fastest in the EU, the impact of COVID-19 was a major setback, with 17 % more deaths registered in 2020 than 2019. Fewer than half the population, and only one quarter of low-income households, reported being in good health – the lowest shares in the EU.



Risk factors

Adolescents in Lithuania are more affected by risk factors such as smoking and excessive drinking than the average in the EU. Alcohol consumption remains a major public health issue, even though consumption levels fell by one quarter between 2012 and 2019 due to stricter alcohol control measures targeting younger people.



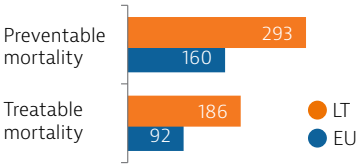
Per capita spending (EUR PPP)

Health system

Health expenditure in Lithuania in 2019 is comparatively low, at just under EUR 1 900, but it has grown slightly faster than the EU average. The share of out-of-pocket spending in the total is double the EU average, at 32 % in 2019. In 2020, a large share of the health insurance fund reserve was used to cope with the impact of COVID-19 on the health system.

Effectiveness

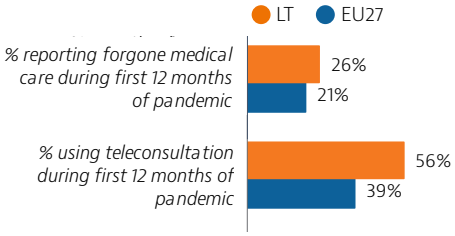
Treatable mortality in Lithuania was double the EU average in 2018, as effectiveness of primary and hospital care lags behind many EU countries. The COVID-19 pandemic caused major disruption for disease prevention programmes tackling cardiovascular diseases and treatable cancers, as well as for planned specialist care, but mental health care provision was enhanced.



Age-standardised mortality rate per 100 000 population, 2018

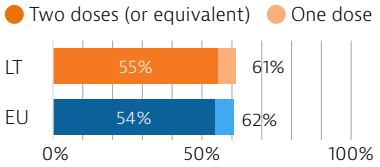
Accessibility

Despite comparatively low unmet needs before 2020, 26 % of Lithuanians reported forgoing medical care during the pandemic, although many used teleconsultations for the first time. Out-of-pocket payments and the limited availability of health care workers outside the major cities also contributes to inequitable access.



Resilience

The ability to use beds flexibly and redeploy health care workers helped Lithuania to cope with surges in demand during the pandemic, albeit by severely limiting non-COVID-19 service provision. Vaccination rollout has been on par with the EU average, with 61 % of the population receiving at least one dose and 55 % receiving at least two doses or equivalent by the end of August 2021.



Share of total population vaccinated against COVID-19 up to the end of August 2021

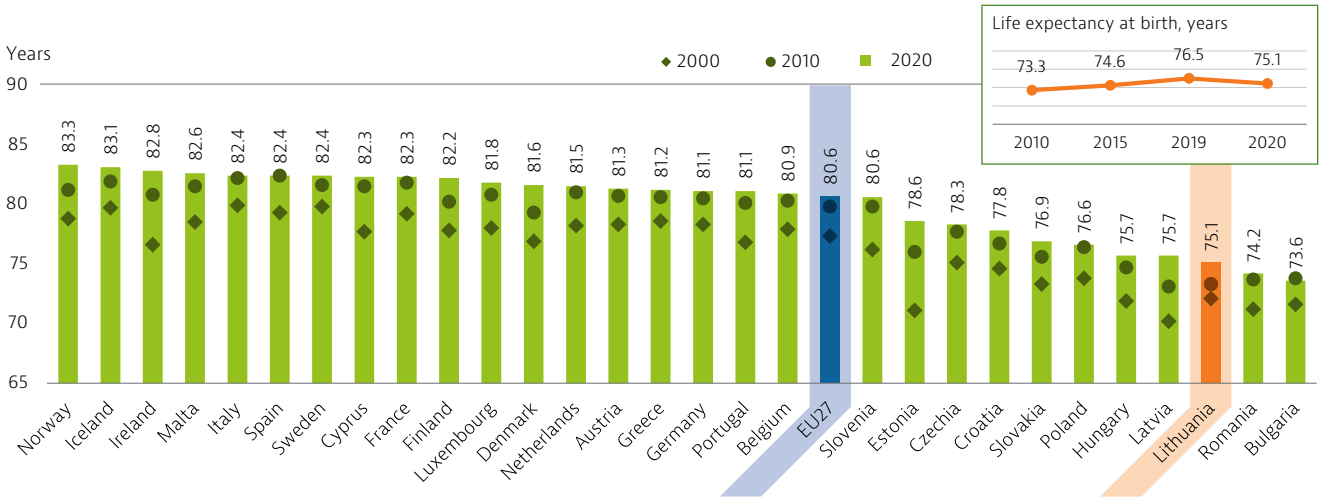
2 Health in Lithuania

Lithuanians have one of the lowest levels of life expectancy in the EU

Life expectancy at birth in Lithuania increased by more than four years between 2000 and 2019, from 72.1 years to 76.5 years. However, in 2020 life expectancy decreased by nearly 17 months to 75.1 years – a much larger drop than that observed in most other EU countries (Figure 1), which reflects the high excess mortality caused directly and indirectly by the COVID-19 pandemic.

On average, Lithuanian women live almost 10 years longer than men, at 80 years compared to 70.1 years. This gender gap in life expectancy is the largest in the EU, and is largely due to the very high mortality from ischaemic heart disease and external causes, which are more prevalent among Lithuanian men. The greater prevalence of harmful alcohol consumption among men is a major contributor to this difference in burden of disease by sex.

Figure 1. Life expectancy at birth fell by almost one year and a half during the pandemic



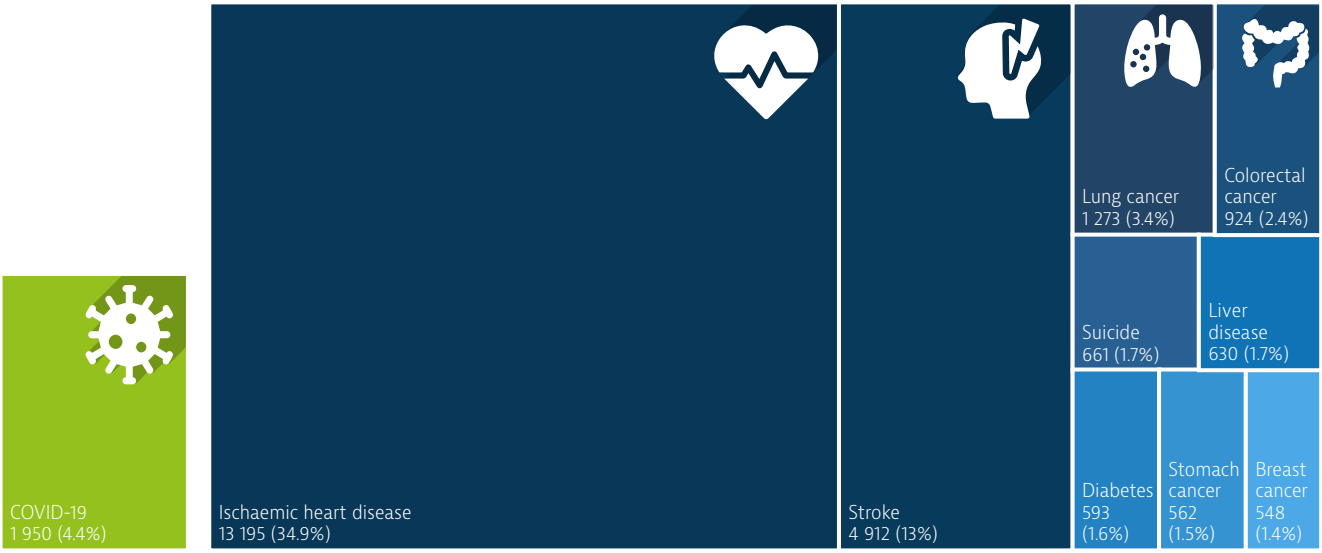
Note: The EU average is weighted. Data for Ireland refer to 2019.
Source: Eurostat Database.

Cardiovascular diseases are the leading cause of death in Lithuania

In 2018, ischaemic heart disease was the leading cause of death in Lithuania, accounting for more than one third of deaths. Mortality from ischaemic heart disease has decreased slightly since 2000, but it is still by far the highest among EU countries, exceeding the EU average four-fold. Mortality from stroke also decreased slightly over the same period, but still accounted for 13 % of all deaths in 2018 (Figure 2). Cancer is the second major cause of death in the country, with lung, colorectal and stomach cancer the most frequent causes of death by cancer. Although progress has been achieved in reducing historically high mortality rates from suicide, it nevertheless remains an important cause of death, particularly among men. Lithuania recorded the highest rate of mortality from suicide in the EU in 2018.

In 2020, COVID-19 accounted for 1 950 deaths (or 4.4 % of all deaths) in Lithuania. This mortality rate was lower than the EU average, at 698 deaths per million population compared with 746 in the EU. However, the broader indicator of excess mortality – defined as the number of deaths from all causes above what would normally be expected based on the baseline from previous years – suggests that the direct and indirect death toll related to COVID-19 is much higher. Indeed, the number of excess deaths from March to December 2020 was more than double that of registered COVID-19 deaths (4 378 deaths compared to 1 950). An additional 2 611 COVID-19 deaths were registered by the end of August 2021.

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



Note: The number and share of COVID-19 deaths refer to 2020, while the number and share of other causes refer to 2018. The size of the COVID-19 box is proportional to the size of the other main causes of death in 2018.
Sources: Eurostat (for causes of death in 2018); ECDC (for COVID-19 deaths in 2020, up to week 53).

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

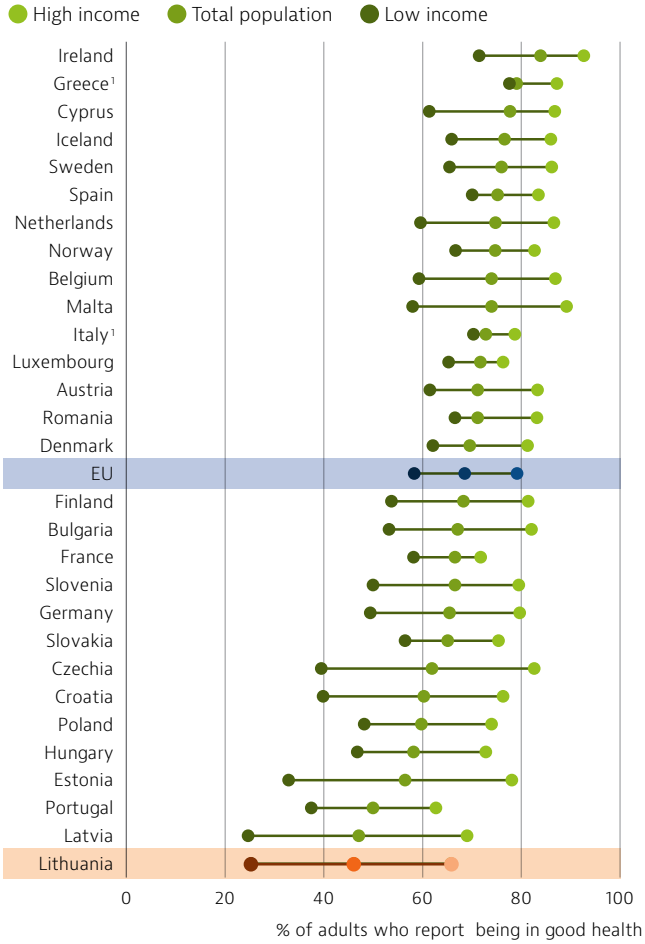
In 2019, only 46 % of the Lithuanian population reported being in good health – the lowest rate in the EU (Figure 3). As in other countries, people with higher incomes are more likely to report being in good health: two thirds of those in the highest income quintile considered themselves in good health, compared with only one quarter of those in the lowest. This income gap in self-reported health is among the highest in the EU.

Projected mortality from cancer is above the EU average

According to the latest estimates from the Joint Research Centre, based on trends from the previous year, around 16 600 new cancer cases and more than 8 000 cancer deaths were expected in Lithuania in 2020[1]. The overall mortality from cancer in Lithuania were expected to be higher than the EU average: 280 deaths from cancer per 100 000 population compared to 260 deaths in the EU as a whole.

Figure 4 shows that the main cancer sites among men are prostate (27 %), lung (13 %) and colorectal (11 %), while among women breast cancer is the most common cancer (22 %), followed by colorectal (12 %) and uterus cancer (10 %). Cancer prevention programmes have gradually been expanded over the past 15 years, but the COVID-19 pandemic had a detrimental impact on the availability of cancer screening services in 2020 (see Section 5.1).

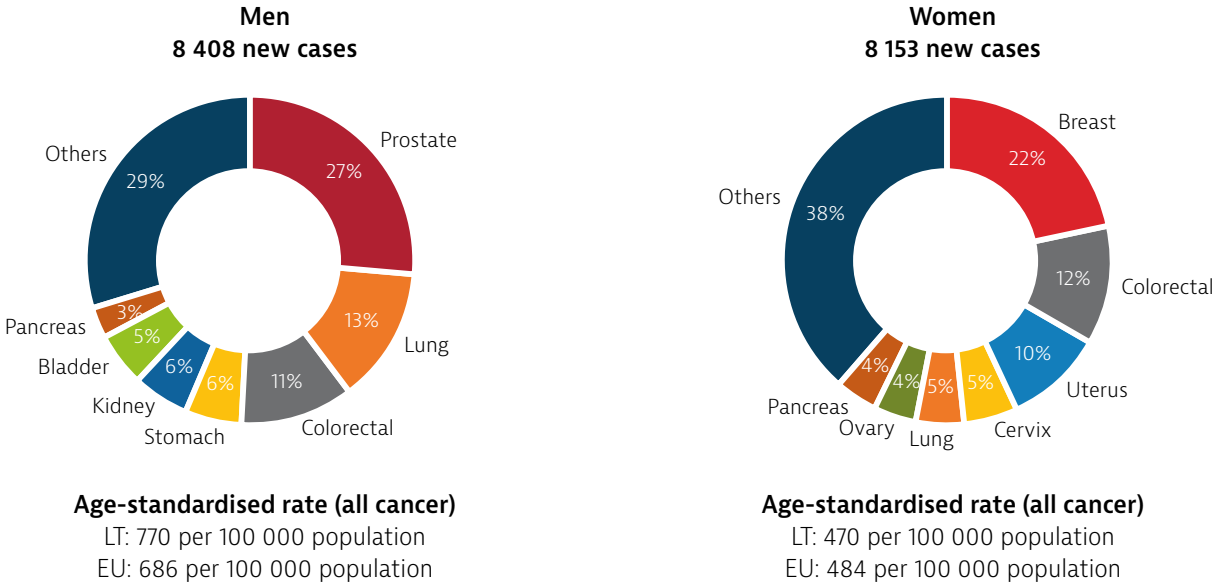
Figure 3. Lithuania has the lowest share of people reporting being in good health in the EU



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 2019).

1. *It should be noted that these estimates were made before the COVID-19 pandemic; this may have an effect on both the incidence and mortality rates of cancer during 2020.*

Figure 4. In 2020, more than 16 000 people in Lithuania were expected to be diagnosed with cancer



Note: Non-melanoma skin cancer is excluded; uterus cancer does not include cancer of the cervix.
Source: ECIS – European Cancer Information System.

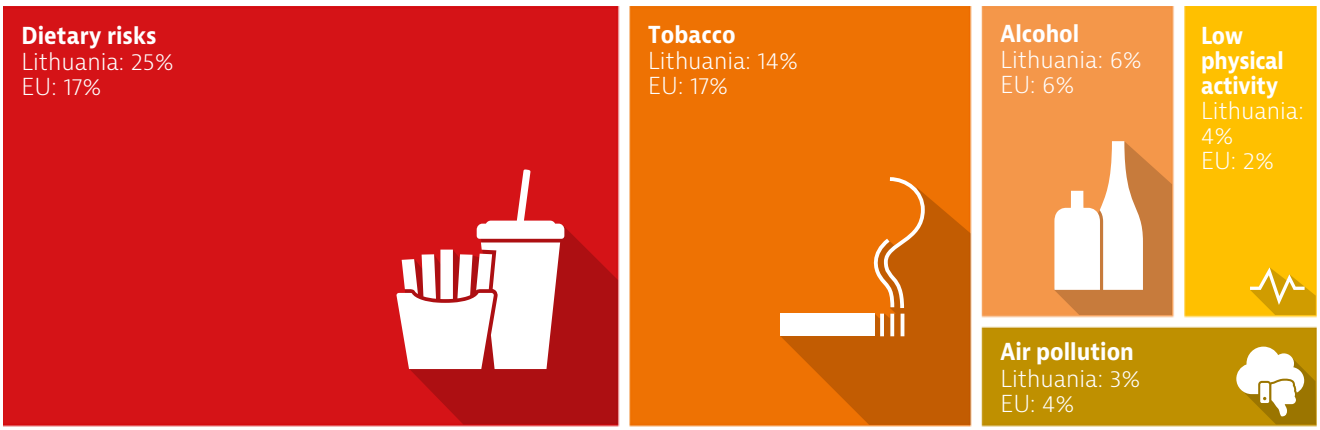
3 Risk factors

Lifestyle and environmental risk factors account for nearly 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 around half of all deaths in Lithuania can be attributed to behavioural and environmental risk factors, including dietary risks, tobacco smoking, alcohol consumption and low physical activity (Figure 5).

Some 25 % of all deaths in 2019 (9 500 deaths) were related to dietary risks (including low fruit and vegetable intake, and high sugar and salt consumption), which is significantly above the EU average (17 %). Tobacco consumption, including second-hand smoking, is responsible for an estimated 14 % (over 5 300) of all deaths. About 6 % of deaths were linked to alcohol consumption and 4 % to low physical activity. Air pollution in the form of fine particulate matter ($PM_{2.5}$) and ozone exposure alone accounted for about 3 % of all deaths.

Figure 5. The majority of deaths in Lithuania can be attributed to behavioural risk factors



Note: The overall number of deaths related to these risk factors is lower than the sum of each one taken individually, because the same death can be attributed to more than one risk factor. Dietary risks include 14 components such as low fruit and vegetable intake, and high sugar-sweetened beverages consumption. Air pollution refers to exposure to $PM_{2.5}$ and ozone.
Sources: IHME (2020), Global Health Data Exchange (estimates refer to 2019).

Excessive alcohol consumption is still a major risk factor

Although alcohol consumption decreased between 2010 and 2019, it remains a major public health concern in Lithuania. In 2018, one third of 15-year-olds reported having been drunk more than once in their life – the second highest share in the EU after Denmark (Figure 6).

In 2018, stricter measures were introduced, including a full ban on alcohol advertising on the TV, radio and internet, reduced sale times and an increase in the legal age for purchasing alcohol from 18 to 20. In 2020, bans on strong alcohol sales on beaches and in outdoor cafés, and on alcohol sales in temporary stalls were introduced. These actions were accompanied by several alcohol tax increases, and part of the revenue raised was earmarked for funding public health projects. Alcohol consumption among people aged over 15 was reduced by a quarter by 2019 from its peak in 2012, coinciding with substantial improvements in preventable mortality. In June 2021, however, amendments to the Alcohol Control Act suggesting the relaxation of some existing regulations were presented in Parliament; they are due to be voted on in autumn 2021 (see Section 5.1).

Smoking in adolescents has been increasing in recent years

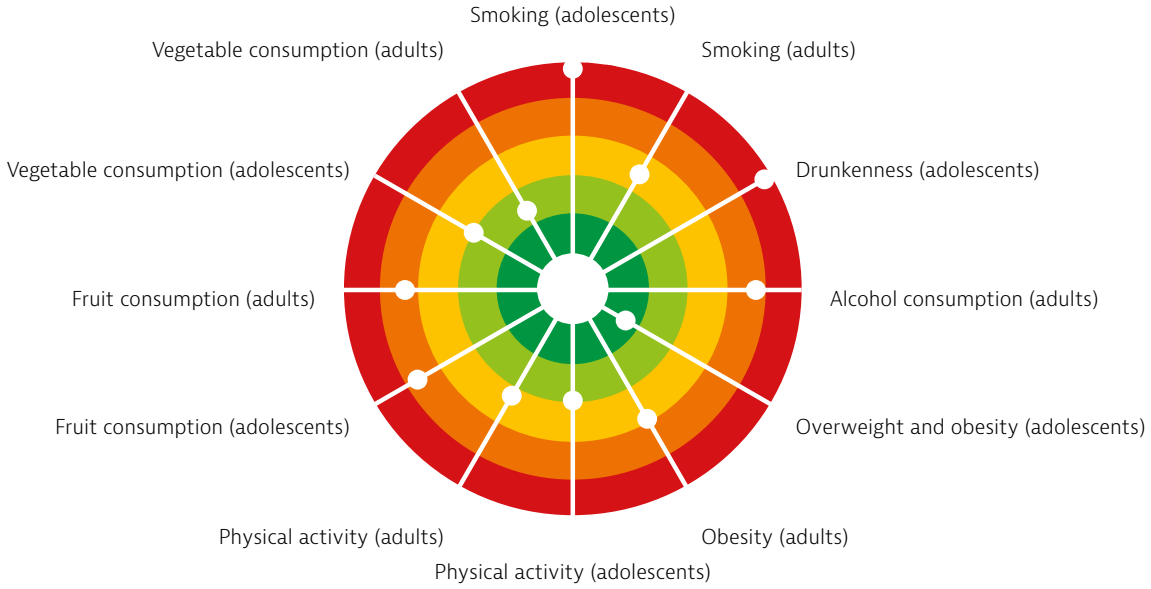
In 2019, 19 % of Lithuanian adults reported smoking every day, which is close to the EU average. Smoking is much more prevalent among men than women. While only 10 % of women reported smoking daily, 30 % of men smoked every day. Smoking among adolescents has increased in Lithuania in recent years, in contrast with most other countries where it has fallen. In 2018, 29 % of 15-year-olds reported having smoked during the past month (compared with an average of 18 % across the EU). A ban on tobacco advertising online and further restrictions on smoking areas were introduced in 2020 and 2021 (see Section 5.1).

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

One in six adults were obese (18 %) in 2019, compared to 16 % on average across the EU. This is linked to other dietary risks. In 2019, more than half of Lithuanian adults (53 %) reported not eating any fruit on a daily basis. The frequency of vegetable consumption is slightly better, but 46 % of adults reported that they were not eating at least one portion of vegetables every day. Overweight and obesity rates are also a growing issue among adolescents: the rates have tripled over the last two decades, reaching 15 % in 2018, although this remains below most EU countries.

In response, a policy on promoting healthy eating and physical activity was adopted in 2020. It sets out guidance for the planning and evaluation of these activities for municipal public health bureaus, and mainly relies on tackling population health literacy, improving the nutritional value of school meals and other foods, and creating an environment that enables a healthy lifestyle.

Figure 6. Dietary risks, alcohol and tobacco consumption are important public health issues



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.
Sources: OECD calculations based on HBSC survey 2017-18 for adolescents indicators; and OECD health statistics, EU-SILC 2019 and EHIS 2014 and 2019 for adults indicators.

4 The health system

Lithuania's National Health Insurance Fund covers the entire population

The Lithuanian health system is organised around a single payer – the National Health Insurance Fund (NHIF) – which purchases services on behalf of the insured population and aims to cover all residents. The Ministry of Health is responsible for formulating health policy and regulations; monitoring population health; licensing providers and health professionals; governing the NHIF; and managing the network of subordinated institutions, including some providers. It is also the lead authority in charge of organising the national response to the COVID-19 pandemic (Box 1).

Revenues for the NHIF come from mandatory earmarked payroll contributions; transfers from the state to cover the non-working population, such as children, students, disabled people, retired people and unemployed people; payments from self-employed workers or other residents not covered in the first two groups; and transfers from the state for specific programmes. Municipalities play an important role in service delivery, as they own many of the primary care centres and small to medium-sized hospitals. They also finance and provide some public health services. The private sector participates in the delivery of primary and dental care and, increasingly, publicly financed specialist outpatient care.

Box 1. The Minister of Health led implementation of the COVID-19 response

The State Emergency Operations Centre, led by the Minister of Health, is the main body responsible for management of the COVID-19 pandemic in Lithuania. Decisions are made by its Emergency Situation Committee, comprising representatives from all ministries, national and local authorities, and other relevant bodies. The way the Centre functions was determined through existing (pre-pandemic) legislation: it is responsible for implementation of emergency response and coordination of measures.

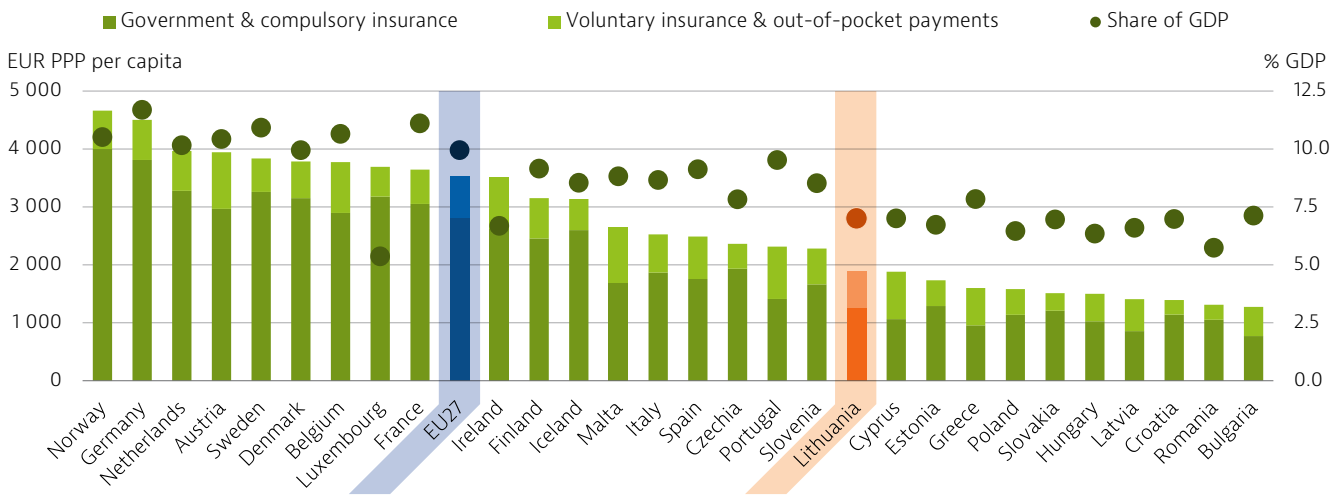
The government was also supported in its COVID-19 response by the Independent Advisory Expert Council, consisting mainly of clinicians and academics, as well as industry, business and professional union representatives.

Source: COVID-19 Health Systems Response Monitor.

Although spending on health in Lithuania remains low, growth has been steady in recent years

Health spending per capita in Lithuania in 2019 (EUR 1 885) was almost half the EU average (EUR 3 521, adjusted for differences in purchasing power), but is among the highest in central and eastern Europe (Figure 7). Between 2015 and 2019, health spending grew steadily at around 6 % per year, which led to a gradual reduction of the gap with the EU average. However, when measured as a share of GDP, health spending in Lithuania remained quite low, at 7.0 %, compared to the EU average of 9.9 %. Only two thirds (66 %) of health spending was publicly financed in 2019, with the remaining third coming from private sources – mainly out-of-pocket (OOP) payments. This contrasts with the EU average, where around 80 % of health spending is public.

Figure 7. Health spending per capita in Lithuania is half the EU average



Note: The EU average is weighted.
Source: OECD Health Statistics 2021 (data refer to 2019, except for Malta 2018).

In addition, EU Structural Funds play an important role in financing health care-related projects in Lithuania, amounting to EUR 238 million in 2007-13 and EUR 146 million in 2014-20 (Ministry of Finance, 2021a). Extra funding was made available in 2020 and 2021 to cope with the pandemic (Box 2). The NHIF budget for 2020 was EUR 2.30 billion, with EUR 570 million in the reserve, which was used during the pandemic. In 2021, the plan was to increase the budget by 8 % from the previous year, giving EUR 2.48 billion, plus EUR 228 million in the reserve. The long-term fiscal sustainability of health financing in Lithuania relies on the robustness of the NHIF as a single payer, to guard against the inefficiencies and inequities inherent in fragmented health financing systems. However, in April 2021 the government presented the Economic Recovery and Strengthening Resilience Implementation Plan 2021-26 (Ministry of Finance, 2021b), which suggests creating alternative sources of health financing.

Box 2. More than EUR 1 billion was allocated to the COVID-19 response in 2021

As of September 2020, the government had spent EUR 2.76 billion on the COVID-19 response (National Audit Office, 2020). The overall response budget for 2021 was EUR 1.08 billion (Ministry of Finance, 2021c), which was planned to cover:

- sickness, occupational hazard and economic relief pay-outs (EUR 573 million)
- loans and interest compensation for businesses (EUR 230 million)
- vaccine purchases (EUR 65 million)
- payments to the NHIF, including for increase in health workers wages (EUR 45 million)
- purchases of medical and laboratory equipment (EUR 80 million)
- functioning of other agencies engaged in COVID-19 response (EUR 90 million)

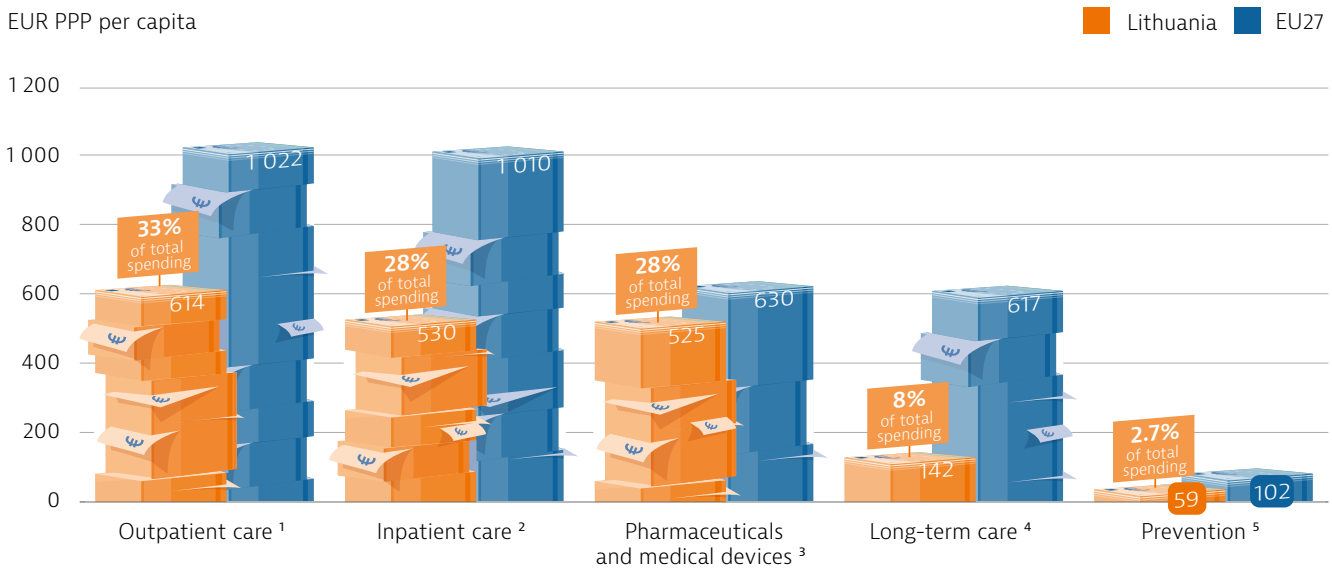
Source: COVID-19 Health Systems Response Monitor.

Outpatient care has overtaken inpatient care as the largest area of spending

The largest health spending area is outpatient care (33 % in 2019), which has grown from 26 % in 2010, reflecting the shift towards this setting. Inpatient care and pharmaceuticals and medical devices have both decreased slightly since 2010 (from 32 % for inpatient care and from 30 % for pharmaceuticals and medical devices), and in 2019 had equal shares at 28 %.

These are followed by long-term care (7.5 %) and prevention (2.7 %). Per capita spending on pharmaceuticals and medical devices is close to the EU average (Figure 8), but as a share of total health expenditure it is much higher than the average in the EU (18 %).

Figure 8. Health spending on pharmaceuticals and medical devices is relatively high



Note: The costs of health system administration are not included. 1. Includes home care and ancillary services (e.g. patient transportation); 2. Includes curative-rehabilitative care in hospital and other settings; 3. Includes only the outpatient market; 4. Includes only the health component; 5. Includes only spending for organised prevention programmes. The EU average is weighted.
Sources: OECD Health Statistics 2021; Eurostat Database.

Despite broad population and service coverage, out-of-pocket spending on health remains high

The publicly financed benefits package is broadly defined and covers all residents for prevention, primary care, specialist services, nursing and rehabilitation, as well as reimbursement for medicines and medical devices (see Section 5.2). Pharmaceutical spending accounts for the largest share of OOP payments, but since 2017 a series of changes have been made to reimbursement policy, leading to improvements in coverage for medicines.

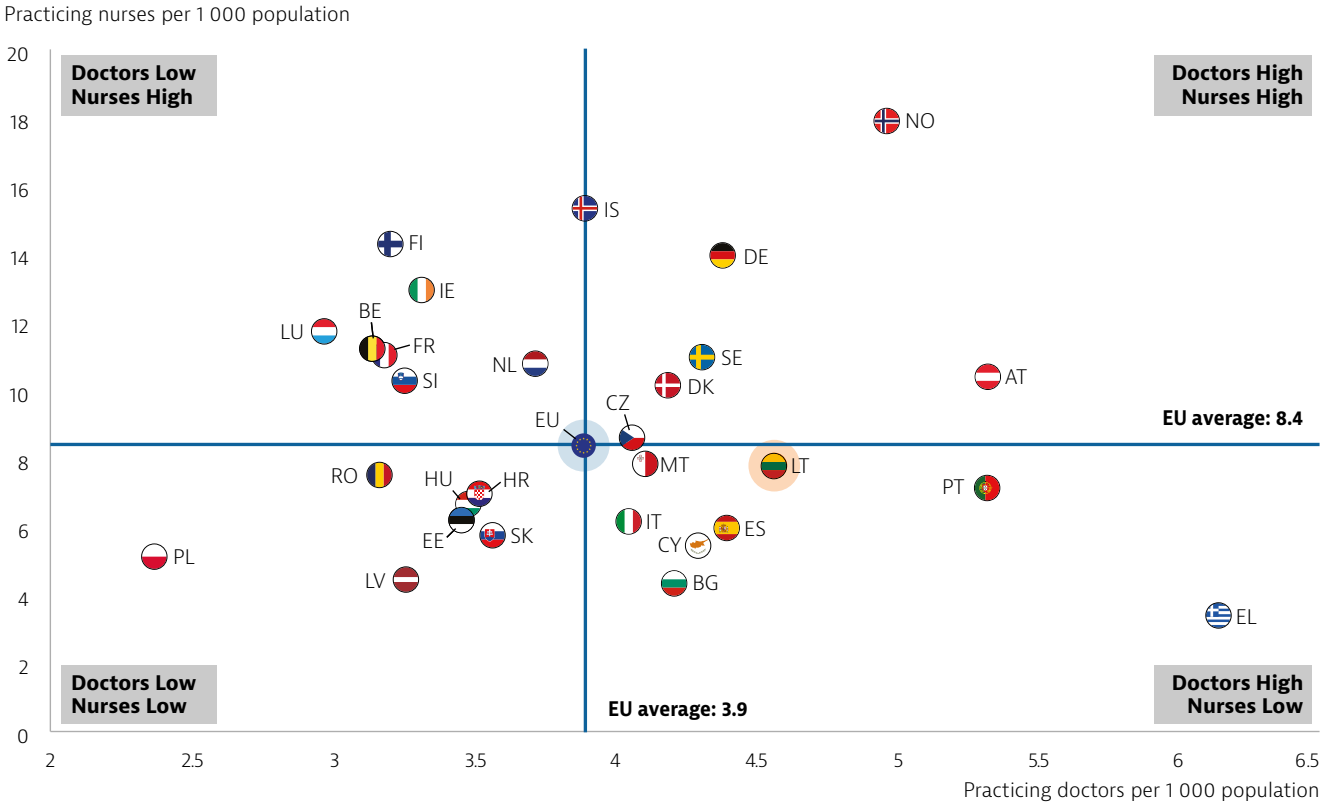
Having a large number of beds was seen as an asset during the COVID-19 pandemic

Lithuania's publicly owned health care system infrastructure includes 125 hospitals (of which 63 are general hospitals) and 357 ambulatory care facilities, including specialist outpatient clinics and primary care providers. In addition, there are a large number of private primary care facilities and outpatient clinics (around 500 in 2019), many of which have contracts with the NHIF. In 2019, Lithuania had more hospital beds per 1 000 population (6.4) than the EU average (5.3). This number has steadily decreased since 2014, while the number of long-term care beds has increased. This large number of acute care beds, including intensive care unit (ICU) beds, created a sense of security in the early stages of the COVID-19 pandemic, when the number of infections in the country was low. Nevertheless, it was not enough to ensure uninterrupted delivery of non-COVID-19 services at the highest peaks in demand during the pandemic (see Section 5.3).

Nurse shortages remain a persistent issue, but the number of doctors is increasing

Lithuania had 7.7 nurses per 1 000 population in 2019, which is below the EU average of 8.4 (Figure 9). At the same time, the number of doctors is the fifth highest in the EU, at 4.6 per 1 000, compared to the EU average of 3.9. While the number of doctors continues to grow, the number of nurses has not kept pace, leaving 1.7 nurses per doctor in 2019 – the lowest ratio since 2000 (see Section 5.2). Despite demand for nurses, the number of nursing graduates has decreased since 2000s, from an annual average of 626 in 2000-09 to 554 in 2010-19. The aim of the National Health Strategy 2014-25 to restore the nurse to doctor ratio to 2:1 by 2020 has therefore not been achieved.

Figure 9. Lithuania has a high number of doctors, but nurse numbers remain below the EU average



Note: The EU average is unweighted. In Portugal and Greece, data refer to all doctors licensed to practise, resulting in a large overestimation of the number of practising doctors (e.g. of around 30 % in Portugal). In Greece, the number of nurses is underestimated as it only includes those working in hospitals.
Source: Eurostat Database (data refer to 2019 or the nearest year).

Progress has been achieved on increasing salaries for health workers

A recent analysis (MOSTA, 2019) showed that the composition of the physician workforce in Lithuania is imbalanced by specialty and that the health care system suffers from a significant shortage of nurses, which is expected to worsen over the next few years. The most significant measure to attract and retain health professionals in recent years has been substantial increases in salaries. Between 2017 and 2020, gross monthly average salaries in public providers increased from EUR 1 008 to EUR 1 659 for nurses and from EUR 1 950 to EUR 3 017 for physicians. Extra salary bonuses were also given in 2020 in response to the pandemic. However, the rise due in January 2021 was not released as the new government was in the process of renegotiating a collective agreement with the medical community.

The use of both outpatient and inpatient care is high in Lithuania

Primary care in Lithuania is delivered in public and private health care centres, where general practitioners (GPs) play a gatekeeping role and often practise alongside other primary care specialists, such as paediatricians and gynaecologists. Patients can access publicly financed specialist care either through a referral or by paying a charge for direct access. Specialist outpatient care is delivered by outpatient departments of hospitals and in polyclinics, as well as by private providers. Increasingly, GPs play a greater role in prevention and management of non-communicable conditions through priority programmes such as cancer screening and management of cardiovascular disease (CVD) and diabetes, for which they receive additional funding based on results.

Lithuania has among the highest hospital discharge and doctor consultation rates in the EU. While outpatient consultations have increased markedly over the past 10 years (from 6.4 consultations per person in 2000 to 9.5 in 2019), hospitalisations fell only slightly (from 23.9 in 2000 to 22 in 2019). The high reliance on the inpatient sector remains a longstanding issue, yet efforts to streamline and optimise hospital care did not lead to major shifts in hospital infrastructure. In April 2021, the Ministry of Health announced renewed plans to reorganise primary and specialist care to improve quality and access (see Section 5.3)

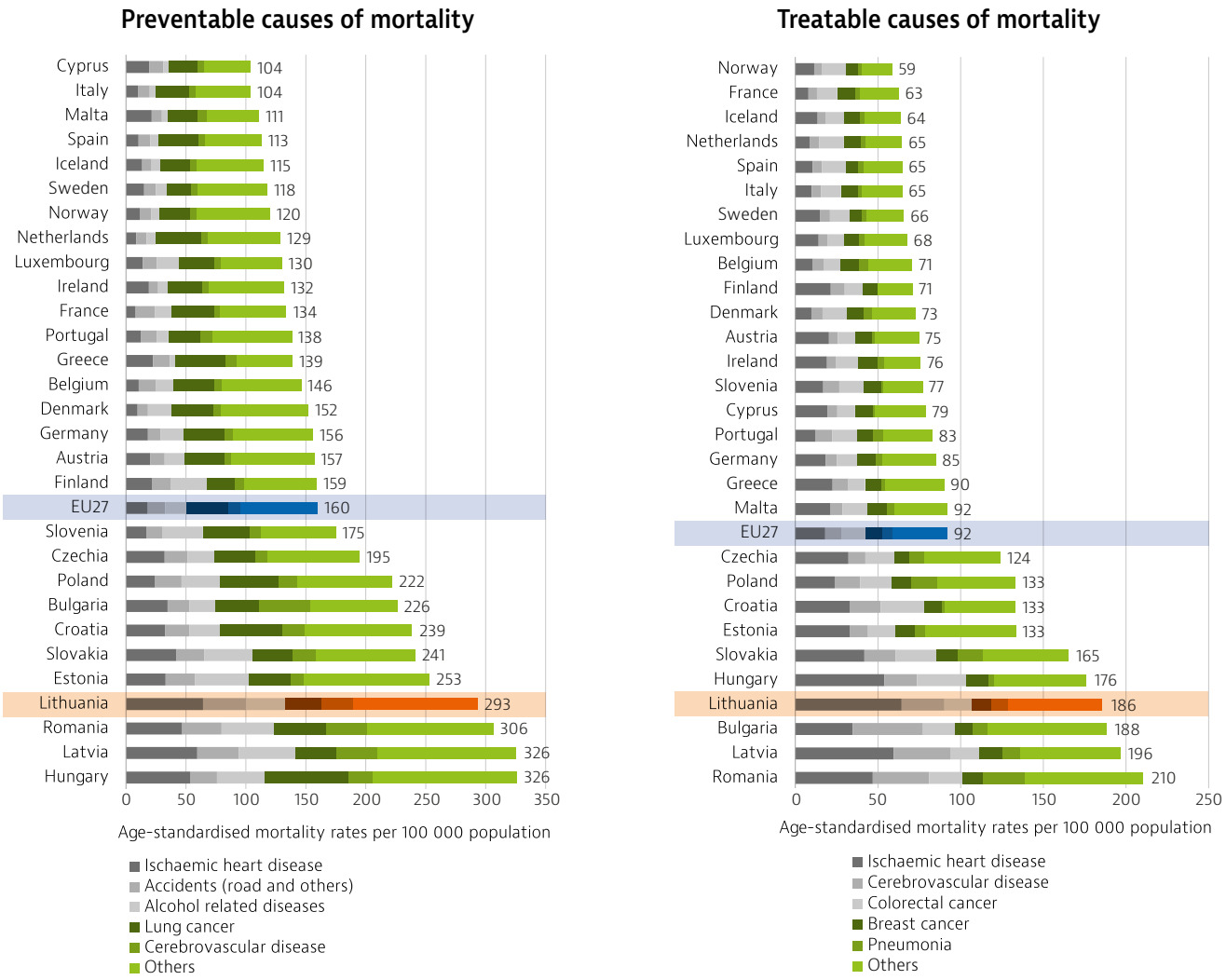
5 Performance of the health system

5.1 Effectiveness

Many premature deaths could be avoided with more effective public health, prevention and treatment

Lithuania's high rates of both preventable and treatable mortality reflect, among other factors, one of the highest burdens of ischaemic heart disease and stroke in people under 75 across the EU (Figure 10). Although the number of deaths from preventable causes declined by 23 % between 2011 and 2018, mortality rates remain the fourth highest in the EU. Other major causes of preventable deaths are alcohol-related diseases, lung cancer, accidents and suicides – all of which are a reflection of the need for strong public health policies, such alcohol and tobacco control, road and other safety measures, and mental health support. Similarly, Lithuania's treatable mortality rate declined by about 16 % over the same period – from 221 to 186 per 100 000 population – but remains the fourth highest among EU countries. Ischaemic heart disease and stroke (which are considered to be both preventable and treatable) are responsible for half the deaths that could be avoided through health care interventions, while colon and breast cancer are responsible for a further 15 %.

Figure 10. Preventable and treatable mortality rates in Lithuania are among the highest in the EU



Note: Preventable mortality is defined as death that can be mainly avoided through public health and primary prevention interventions. Treatable mortality is defined as death that can be mainly avoided through health care interventions, including screening and treatment. Half of all deaths for some diseases (e.g. ischaemic heart disease and cerebrovascular disease) are attributed to preventable mortality; the other half are attributed to treatable causes. 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 2018, except for France 2016).

Key public health policies have focused on strengthening alcohol and tobacco control

In response to historically high alcohol consumption rates, Lithuania has launched major public health measures in recent years aimed at strengthening alcohol control, with a particular focus on reducing consumption among children and young people. Alcohol policies introduced since 2018 have proved successful in reducing consumption levels (see Section 3). Nevertheless, in June 2021 an amendment aiming to relax alcohol control legislation through extending sales hours, allowing more advertising and lowering the legal age for purchasing drinks with less than 15 % of alcohol content was registered in Parliament to be voted on in autumn 2021.

A number of steps have also been taken in tobacco control, including a ban on tobacco advertising online and enforcement of a ban on online sales from November 2020, and a ban on smoking in common areas of apartment buildings, public transport stops and playgrounds, as well as a requirement to mark smoking and non-smoking tables in outdoor catering spaces from January 2021. In 2021 the Drug, Tobacco and Alcohol Control Department expanded the content of an interactive website containing information, guidance and contact details of services for people wishing to quit smoking.

Availability of mental health support was stepped up during the COVID-19 pandemic

Very high suicide rates (see Section 2) reflect aspects of poor mental health among the Lithuanian population. In 2019, the Mental Health Act was amended to improve regulation of mental health care provision. The changes sought to improve access to mental health services at the community and primary care levels. During the COVID-19 pandemic, mental health services were strengthened by establishing additional emotional support helplines and piloting mobile crisis intervention teams. From September 2020, municipal public health bureaus started to provide mental health support free of charge, without the need for a referral.

Care for people with chronic conditions in Lithuania is less effective than in other EU countries

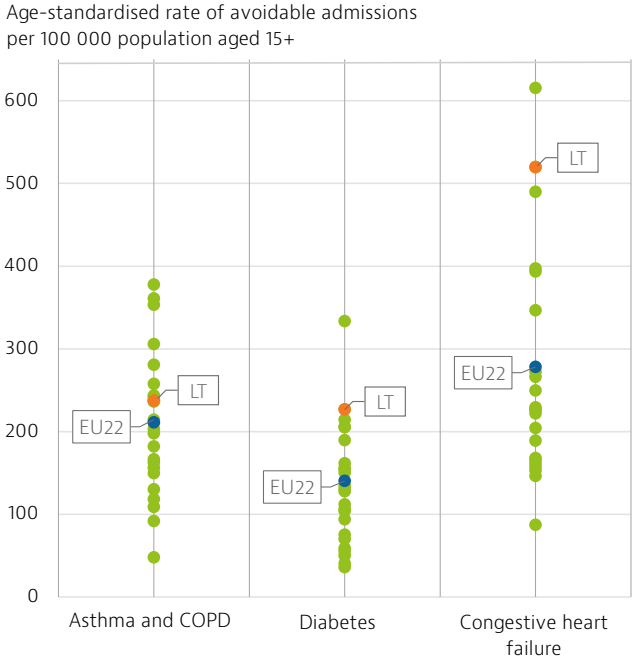
The high levels of avoidable hospital admissions in Lithuania shed light on health care effectiveness. Figure 11 shows that in 2019 the country had the second highest admission rate for congestive heart failure among the 21 EU countries for which data are available, and the second highest rate for diabetes.

The high rates of avoidable hospital admissions for these conditions indicate weaknesses in primary care. However, hospitalisation rates for congestive heart failure fell by one third between 2012 and 2017, alongside increased focus on prevention of CVD and its complications in primary care through priority programmes, such as free health checks for men aged 40-55 and women aged 50-65.

In December 2019, seeking to improve the quality of primary care and encourage prevention, the NHIF began publishing rankings of primary health care providers according to 14 criteria covering a range of areas, including implementation of cancer screening programmes. The ranking determines the size of their share of results-based financing.

In terms of the quality of hospital care, in 2019 Lithuania had the third highest 30-day mortality after admission to hospital for acute myocardial infarction (AMI), at 13.3 per 100 admitted patients, and the second highest for haemorrhagic (41.1) and ischaemic (18.2) stroke. In 2020, the State Health Care Accreditation Agency conducted checks on AMI and stroke services across selected providers. It found that some district hospitals were not complying with care quality standards, particularly in terms of 24/7 availability of qualified specialists and rapid access to the necessary diagnostics.

Figure 11. Lithuania has high rates of avoidable hospital admissions for diabetes and congestive heart failure



Note: The EU average is unweighted, Latvia and Luxembourg not included.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Cancer services in Lithuania lag behind those in many EU countries

Cancer survival in Lithuania in 2010-14 was below the EU average for most cancers, except prostate cancer (Figure 12). However, important progress has been achieved since 2000-04. The five-year survival rate has improved by 19 percentage points for prostate, 12 percentage points for colon and 9 percentage points for breast cancer. Survival for acute lymphoblastic leukaemia in children is the second lowest in the EU (75 % compared to 85 %), however, and has not shown signs of improvement since the 2000s.

Figure 12. Five-year survival for many major cancers is below the EU average

Prostate cancer
Lithuania: 94 %
EU23: 87 %

Childhood leukaemia
Lithuania: 75 %
EU23: 85 %

Breast cancer
Lithuania: 74 %
EU23: 82 %

Cervical cancer
Lithuania: 59 %
EU23: 63 %

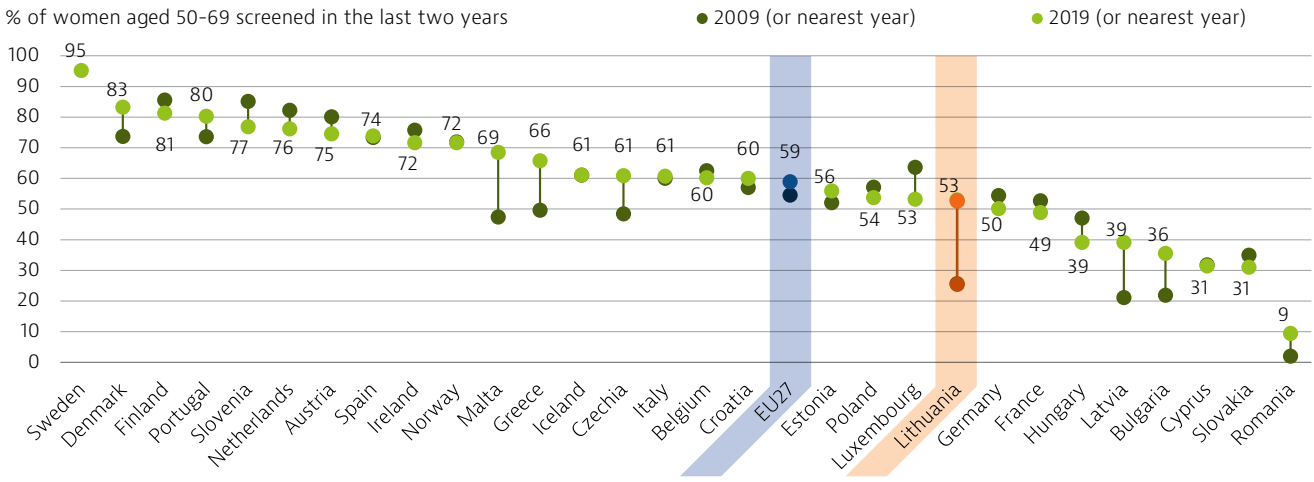
Colon cancer
Lithuania: 57 %
EU23: 60 %

Lung cancer
Lithuania: 10 %
EU23: 15 %

Note: Data refer to people diagnosed between 2010 and 2014. Childhood leukaemia refers to acute lymphoblastic cancer.
Source: CONCORD Programme, London School of Hygiene and Tropical Medicine.

Fewer women in Lithuania accessed routine screening for breast and cervical cancer in 2019, at 53 %, compared to 59 % in the EU on average. However, screening uptake steadily increased over the past decade for breast cancer, more than doubling from 26 % to 53 % between 2009 and 2019 (Figure 13). Progress has been slower for cervical cancer screening, where the increase over the same period was from 43 % to 53 %. To address these issues Lithuania is implementing a national cancer plan (Box 3).

Figure 13. Uptake of breast cancer screening doubled in a decade, but remains below the EU average



Note: The EU average is unweighted. For most countries, the data are based on screening programmes, not surveys.
Sources: OECD Health Statistics 2021 and Eurostat database.

Box 3. Lithuania's National Cancer Prevention and Control Plan sets a number of targets

The National Cancer Prevention and Control Plan 2014-25 sets eight key objectives:

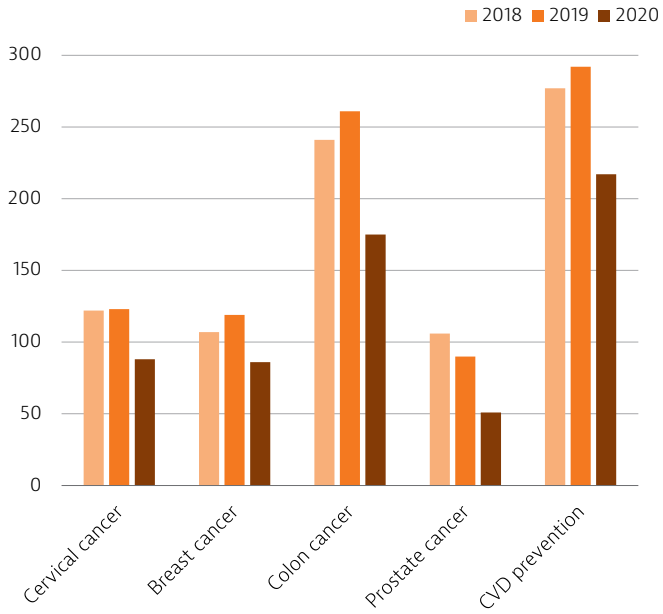
- Improvement of cancer care management and coordination
- Expansion of cancer prevention and creation of informed and healthy societies
- Strengthening of cancer screening programmes and their uptake
- Ensuring quality of cancer care, including detection and treatment, while reducing inequalities in access
- Improvement of quality of life and end-of-life care for cancer patients
- Strengthening cancer research and oncology education and training
- Collaboration with non-governmental organisations (NGOs) on cancer care and expansion of NGO activities
- Strengthening cancer data collection and ensuring data quality and availability

These objectives align with the recent Europe's Beating Cancer Plan, presented by the European Commission in February 2021, which itself has four key action areas, focusing on prevention, early detection, diagnosis and treatment, and improving quality of life (European Commission, 2021a).

COVID-19 had a detrimental impact on services in Lithuania

The full impact of delays in seeking care during the pandemic is still unknown, but attendance at CVD prevention programmes fell by one quarter in 2020 compared to 2019 (Figure 14). At the same time, attendance at cancer prevention programmes fell by between one quarter for breast and cervical cancer and almost half for prostate cancer (NHIF, 2021a). Early data also indicate increases in hospital mortality from AMI and stroke in 2020, compared to 2019.

Figure 14. Substantially fewer people participated in non-communicable disease prevention programmes in 2020



Source: NHIF (2021a).

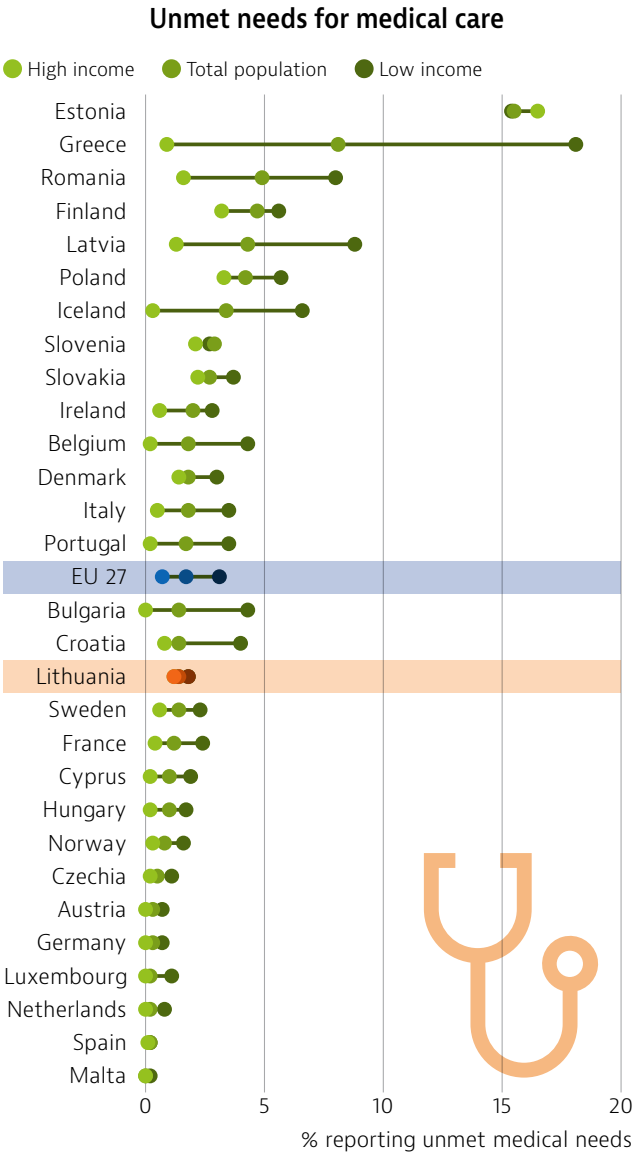
5.2 Accessibility

Unmet needs for medical care in Lithuania were low, but increased markedly during the pandemic

According to the EU-SILC survey, Lithuanians reported comparatively low unmet medical needs due to cost, waiting time or travel distance, at 1.4 % in 2019, while the EU average was 1.7 %. There was also little variation across income groups (Figure 15). However, according to the Eurofound (2021) survey[2], more than one quarter (26 %) of people reported unmet medical needs during the early part of the pandemic. Issues of access to health care were raised over this time in relation both to delays in receiving services and to patients being reluctant to seek care.

2. *The data from the Eurofound survey are not comparable to those from the EU-SILC survey because of differences in methodologies.*

Figure 15. Prior to the pandemic there was little variation in self-reported unmet medical needs



Note: Data refer to unmet needs for a medical examination or treatment due to costs, distance to travel or waiting times. Caution is required in comparing the data across countries as there are some variations in the survey instrument used.
Source: Eurostat Database, based on EU-SILC (data refer to 2019, except Iceland 2018).

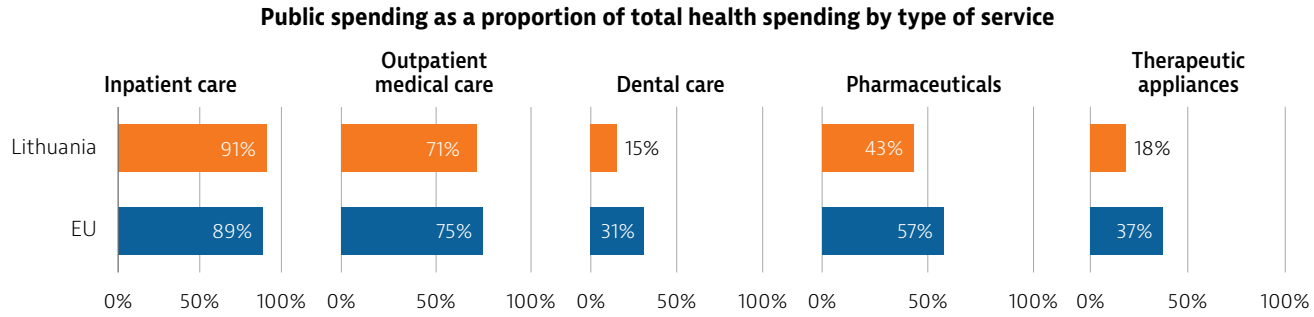
Population coverage is comprehensive, and the state covers many vulnerable groups

In 2020, 99 % of the population were covered by compulsory health insurance (NHIF, 2021a). People who are employed and self-employed, as well as some other groups (such as farmers, artists and small business owners) make mandatory contributions. The non-working population is insured by the state. Lithuanian residents who are not covered through employment contributions or covered by the state make payments based on a share of the minimum wage. The small percentage (<1 %) of people who are not covered by compulsory health insurance are most likely to be those who are not residents in the country. People who are not insured are still entitled to access emergency services. COVID-19-related services, including testing for symptomatic people and treatment, are offered free of charge to anyone, regardless of health insurance status.

Health insurance does not cover all outpatient pharmaceuticals, medical devices and dental care

The benefits package in Lithuania is broadly defined. It includes prevention, primary and specialist care, rehabilitation and nursing services. For primary, specialist outpatient and inpatient care some user charges are applied by public providers, including for some tests and consumables, as well as specialist visits without referrals. Reimbursable outpatient pharmaceuticals are covered at 50 % or 100 % and medical devices at 80 % or 100 %. Dentist fees are covered in primary care centres, while materials for adult dental care are not covered. Figure 16 shows that the publicly funded shares of outpatient care, pharmaceuticals, medical devices and dental care remain below the EU averages, despite recent improvements.

Figure 16. Inpatient and outpatient care are mostly publicly funded, but other categories are not



Note: Outpatient medical services mainly refer to services provided by generalists and specialists in the outpatient sector. Pharmaceuticals include prescribed and over-the-counter medicines as well as medical non-durables. Therapeutic appliances refer to vision products, hearing aids, wheelchairs and other medical devices.
Source: OECD Health Statistics 2021 (data refer to 2019 or nearest year).

Substantial reductions in out-of-pocket spending for pharmaceuticals have been achieved

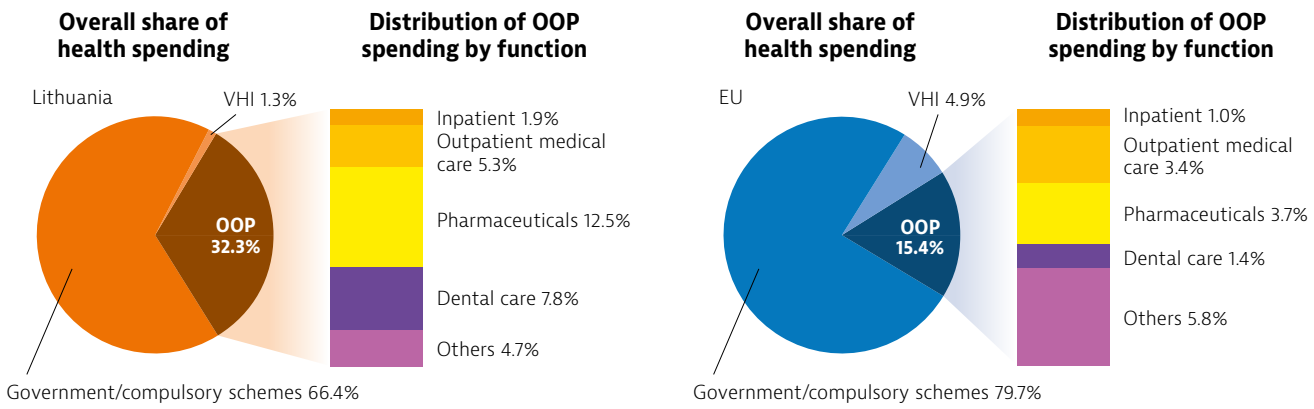
Despite high levels of publicly funded coverage for many health care services, the level of OOP payments in Lithuania is very high, at 32 %, and double the average across the EU (Figure 17). This high level of OOP spending remained stable between 2012 and 2019. Pharmaceuticals make up the largest share of OOP expenditure (13 % of overall health expenditure), followed by dental care (8 %).

Reforms have lessened the burden of OOP payments for pharmaceuticals, particularly for the most vulnerable groups. In July 2020, the government broadened the population groups entitled to 100 % reimbursement for listed medicines and medical products. As well as children under 18, people with severe disabilities and retired people on low incomes, this group now also includes everyone aged over 75 years. Other population groups (recipients of the retirement pension and people with less severe disabilities) remain entitled to 50 % reimbursement. Further exemptions from full user fees include 50 % or 100 % reimbursement for medicines for the treatment of specific conditions. These policies are aligned with the European Commission's pharmaceutical strategy for Europe, which aims to ensure access to affordable medicines for patients as one of its four central pillars (European Commission, 2020).

Prior to these reforms, changes to pharmaceutical policy were made in 2017 to control prices by introducing a tighter reference pricing system, placing caps on price differences between the reimbursement tariff and the retail price, and increasing reimbursement levels. These measures led to substantial reductions in OOP payments for pharmaceuticals – from an average of EUR 267 per capita in 2016 to EUR 236 in 2019, adjusted for differences in purchasing power. For patients, the average cost of a single prescription for reimbursed medicines in Lithuania fell substantially between 2016 and 2020 (NHIF, 2021b). Publicly funded prescription reimbursement costs were EUR 20.10 in 2016, increasing to EUR 35.60 in 2020, but for patients, the average cost per prescription reduced from EUR 5.10 to EUR 3.09 over the same period. In 2021 changes to pharmaceutical reimbursement were made, allowing patients to choose a wider range of medicines, with a more expensive alternative still being compensated from NHIF. The change will be implemented from January 2022.

Limited coverage of dental care is due to a lack of availability and the lower quality of dental services in the public sector. Every primary care provider is obliged to organise dental care for its registered patients, either by providing services or by contracting a provider. However, private dental clinics lack financial incentives to provide publicly financed services, as reimbursement tariffs are set too low. Despite this, according to the EU-SILC survey, unmet needs for dental care fell in recent years from 4.5 % in 2016 to 3.4 % in 2019, but they remain above the EU average of 2.8 %.

Figure 17. The share of out-of-pocket spending is double the EU average in Lithuania



Note: The EU average is weighted. VHI = voluntary health insurance, which also includes other voluntary prepayment schemes.
Source: OECD Health Statistics 2021; Eurostat Database (data refer to 2019).

One in seven households experience catastrophic spending

Lithuania has a high level of catastrophic payments (15.2 % in 2016). Two thirds of these are experienced by households in the two poorest income quintiles (Figure 18). Moreover, the level of catastrophic payments doubled from 7 % in 2005, with household spending on pharmaceuticals the key driver (Murauskienė & Thomson, 2018). It is expected that the policies introduced in 2017-20, aimed at reducing the cost of medicines for households, will improve financial protection in this area.

Availability of care is low because of long waiting times and a lack of planning

The National Audit Office (2018) highlighted that the key challenges for availability of health services in Lithuania are waiting times. Although comprehensive provider-level data are lacking, a population survey showed that in 2017 more than one in four patients waited longer than four weeks for an outpatient specialist consultation. Another survey of selected providers showed that in 2018 most specialist services had a 2-4-month wait for a cardiologist, endocrinologist or ophthalmologist appointment. Although data on waiting times in 2020-21 are not available, it is expected that lockdowns will have resulted in further increases, despite rapid expansion of digital services.

Poor planning of human resources also exacerbates poor availability of services, and the National Audit Office report highlighted the lack of instruments to plan demand and supply for medical specialist training. In response, in 2018 the Ministry of Health set a modest target of 20 medical residency places to be funded for trainees agreeing to work for at least two years for providers in rural areas that lack certain specialists.

5.3 Resilience

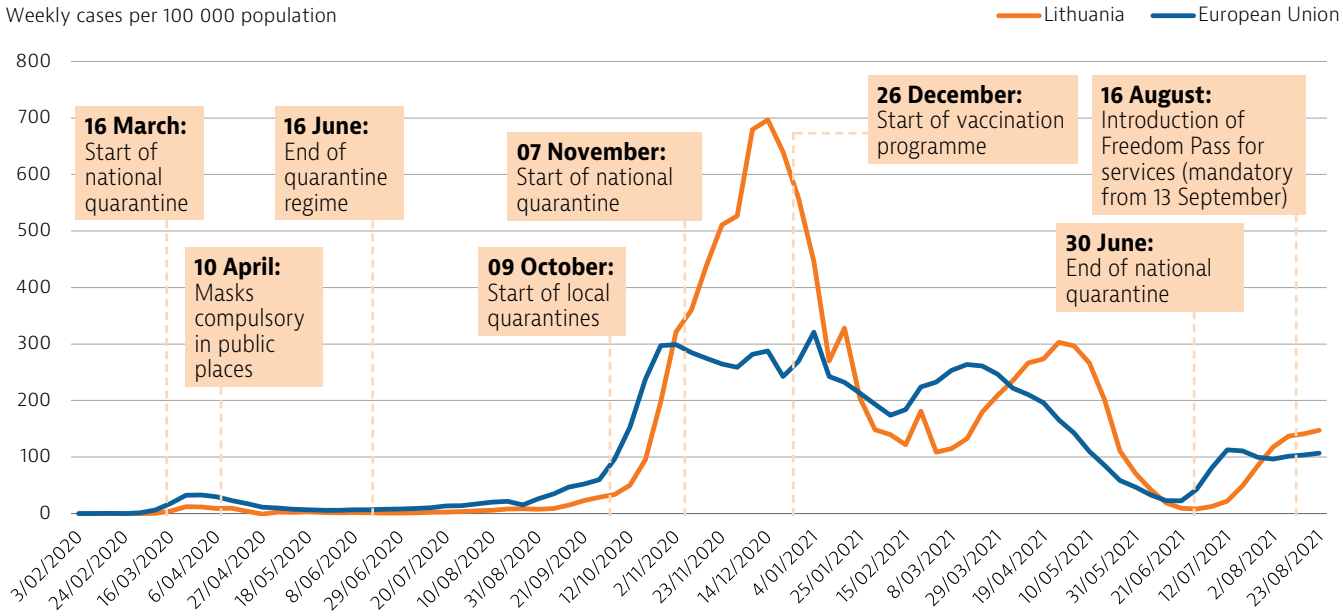
This section on resilience focuses mainly on the impacts of and responses to the COVID-19 pandemic[3]. As noted in Section 2, the COVID-19 pandemic had a major impact on population health and mortality in Lithuania in 2020. This continued into 2021 as COVID-19 infection rates only peaked in December 2020 at 697 cases per 100 000 people and there were further surges in April and August, meaning that by the end of August 2021, officially many more people in Lithuania had died of COVID-19 than in all of 2020 (see Section 2). The measures taken to contain the pandemic also had an impact on the economy, with estimates showing that Lithuania's GDP decreased by 0.8 % in 2020, compared to an average fall of 6.2 % in the EU.

A mild first wave of the pandemic was followed by very high numbers of cases and deaths

At the start of the pandemic, on 16 March 2020, Lithuania introduced the first quarantine regime (lockdown), which lasted until 16 June 2020. Until that week, Lithuania had reported relatively few cases but in October 2020 there was an exponential rise in cases (Figure 18), prompting initially only local restrictions and limited response, coinciding with parliamentary elections on 11 and 25 October. The second national lockdown was declared by the outgoing government only from 7 November 2020 and was continued by the new government until 30 June 2021. The second wave peaked in December 2020, leading to some of the highest COVID-19 incidence rates in the EU at the time. The third – somewhat smaller – wave happened in April-May 2021. Both lockdowns were characterised by restrictions on household mixing; restrictions on movement between municipalities; closure of non-essential retail, sports, culture and entertainment venues; and shifts to online education. Access to non-emergency health services was also limited, particularly in the first lockdown owing to restrictions, but also in the second lockdown owing to the need to treat large numbers of COVID-19 patients. The Freedom Pass, proving vaccination, testing or immunity status – which allows in-person access to most non-essential retail and services, mass gatherings, university education and so on – was introduced on 13 September 2021.

3. In this context, health system resilience has been defined as the ability to prepare for, manage (absorb, adapt and transform) and learn from shocks (EU Expert Group on Health Systems Performance Assessment, 2020).

Figure 18. Lithuania experienced among the highest COVID-19 incidence in the EU in December 2020

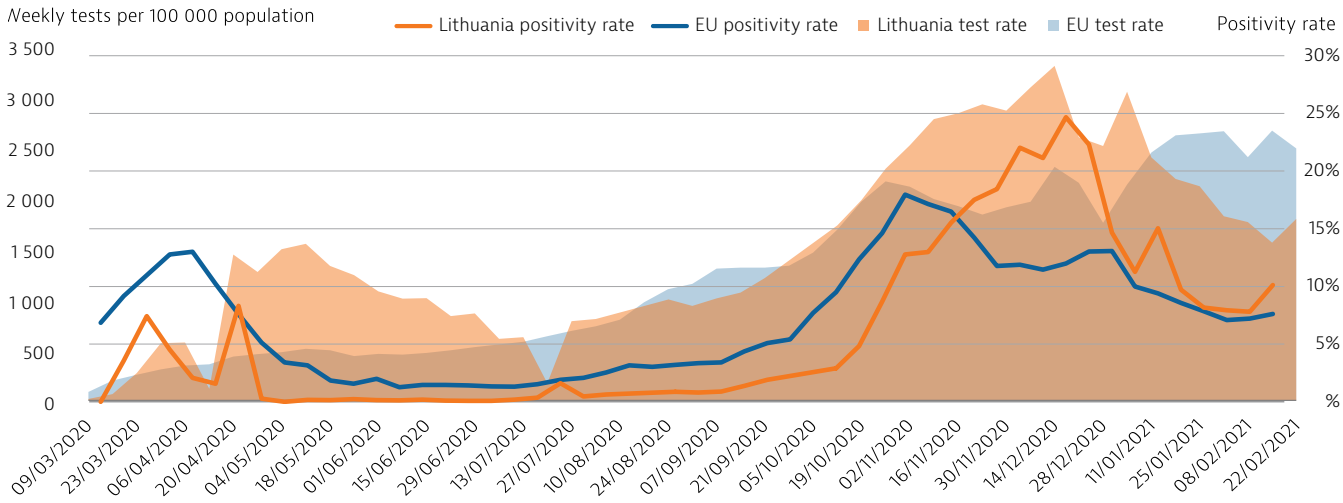


Note: The EU average is unweighted (the number of countries used for the average varies depending on the week).
Sources: ECDC for COVID-19 cases and authors for containment measures.

Use of private laboratories and purchases of testing kits led to rapid expansion of testing capacity

In March 2020, only five laboratories with a total capacity of 1 500 tests a day were able to perform COVID-19 PCR testing in Lithuania. At this stage, shortages of testing kits, lack of access to testing even for symptomatic people, and long delays in receiving test results were reported. The government drew more laboratories, including private ones, into the testing network, but increasing testing capacity was also dependent on the supply of reagents, which only started arriving in large quantities in April 2020. By May 2020, Lithuania overtook the EU average for the number of weekly tests per 100 000 population (Figure 19) and launched regular testing of health care workers and other mass testing programmes. By November 2020, 20 laboratories were operating with a total capacity of about 17 000 PCR tests a day. The positivity rate surged to almost one in four with the rapid increase in community infections in December 2020, showing that testing capacity was being considerably stretched.

Figure 19. In May 2020 Lithuania had among the highest testing rates in the EU



Note: The EU average is weighted (the number of countries included in the average varies depending on the week).
Source: ECDC.

Hospitals flexibly increased COVID-19 bed capacity

Initially, five major hospitals across Lithuania were designated to treat all COVID-19 patients, but eventually more hospitals started taking cases. Despite having excess beds, the pandemic challenged Lithuania's health care services at peak times, exceeding designated COVID-19 capacity in the major hospitals in the second and third wave. In December 2020, over 2 500 patients were hospitalised with COVID-19, and around 220 ICU beds were designated as COVID-19 beds, reaching full capacity for some hospitals. During peak times, additional curative and ICU beds were redesignated as COVID-19 beds by expanding provision in other departments within hospitals and in other public hospitals in the regions. After the peak, the number of designated COVID-19 hospital and ICU beds was scaled back, reflecting patient flows. It was then expanded again when required.

Hospitals also borrowed health care staff to cope with patient surges

Availability of health care workers was also a challenge, owing to both the greater patient to staff ratio needed for COVID-19 patients and reduced staffing levels due to health workers contracting COVID-19 themselves and having to isolate. Providers contracting with the NHIF and treating COVID-19 patients were classified as civil protection forces, allowing hospitals to apply to the Ministry of Health and other medical facilities for reinforcements in cases of staff shortages. Employees who were posted to other institutions retained their salaries and received daily allowances and reimbursement of other expenses, such as for travel. Salaries of health care workers who provided services to COVID-19 patients were adjusted upwards temporarily by 60-100 % due to hazardous working conditions. Other assistance to health care workers included organised childcare and vouchers for tourism and leisure activities worth EUR 200.

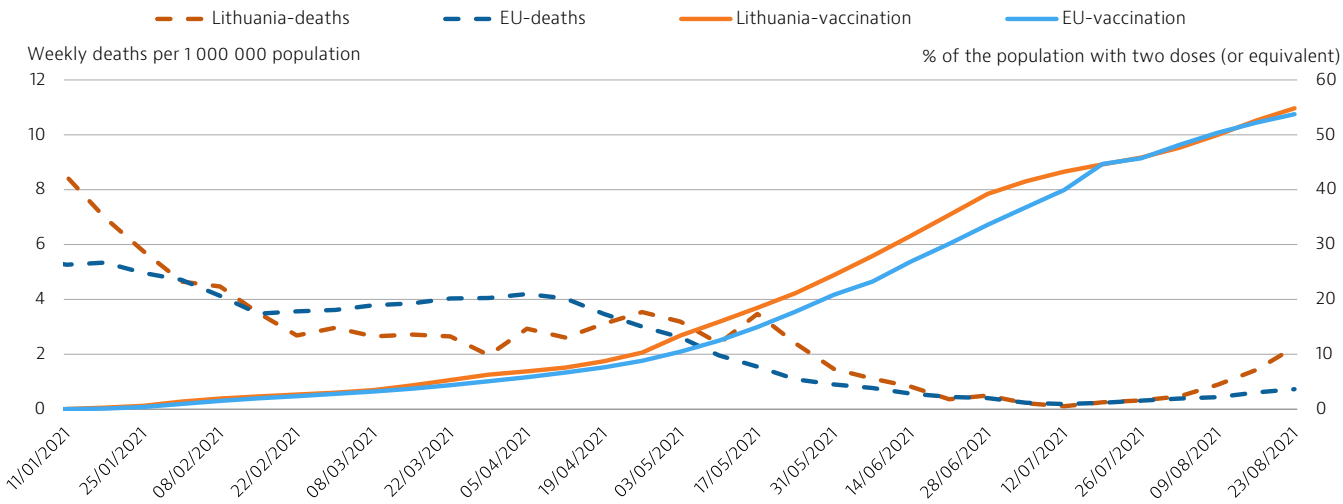
Primary care services were instrumental in assessing and testing COVID-19 patients and vaccinations

From March 2020, municipalities had to set up fever clinics (delivered through ambulatory care providers) and mobile testing units, usually staffed by general practice nurses. People aged 18-60 with raised temperatures and respiratory symptoms were referred to fever clinics by their GPs to be assessed and tested for COVID-19. People who met the COVID-19 testing criteria were directed to mobile testing points via the dedicated COVID-19 hotline. Patients with symptoms could also contact their GPs, who gave advice on self-monitoring, made referrals for assessment or for hospital treatment, or conducted home visits for patients in higher risk groups. From January 2021, municipalities were also responsible for implementing the vaccination programme, which was conducted in designated centres.

The initial vaccine rollout was among the fastest in the EU

Municipalities appointed vaccine coordinators to roll out the vaccination programme and manage the distribution of vaccines. Initially, the pace of vaccination in Lithuania was ahead of most other EU countries; however, after the European Medicines Agency conducted a review into the safety of the AstraZeneca vaccine, uptake decreased. By the end of August 2021, 55 % of the population in Lithuania were vaccinated with two doses (or equivalent), compared to 54 % across the EU (Figure 20). Health and social care workers were the first priority group, followed by high-risk patients, teachers and then older age groups. Despite the quick initial rollout, vaccine coverage in the oldest age groups in August 2021 was sixth lowest in the EU, at only 57 % for people aged over 80.

Figure 20. Vaccination coverage is slightly above the EU average



Note: EU unweighted average, the number of countries used for the average varies depending on the week.
Source: ECDC for COVID-19 cases and Our World in Data for vaccination rates.

COVID-19 radically changed the usual speed of data reporting

The Ministry of Health is responsible for running the national e-health system, which became operational in 2015. All health care providers (except dentists) are connected to the system, which links to a register of insured people. Until 2019, e-prescribing was the most advanced section of e-health, but the system was substantially developed over 2020, adding records for outpatient and inpatient care, vaccinations, health certificates and COVID-19 test results, as well as allowing a greater degree of information exchange. There are also plans to increase data maturity and interoperability of the system with a view to contributing to the creation of the European Health Data Space (European Commission, 2021b) and cross-border services.

The pandemic presented a major impetus for timely data collection in Lithuania. Initially, only the numbers of cases and deaths were reported in real time. By April 2020, data on testing and distribution of personal protective equipment were available. By April 2021, a common dashboard, run by the National Public Health Centre, was reporting both national and municipal level data on the numbers of cases (including the daily number, 14-day rate per 100 000 and weekly change), deaths (due to COVID-19 and due to other conditions but that had also tested positive for COVID-19), tests, vaccinations and details of outbreaks. Statistics Lithuania also reported daily on contact tracing, laboratory capacities and total hospital capacity.

Major health system reorganisation and digitalisation are being funded

Lithuania's National Resilience and Recovery Plan was endorsed by the European Commission in July 2021 and will be financed by EUR 2.2 billion in grants. A commitment of EUR 268 million has been made to three major reforms to create a stronger and more resilient health system.

The first strategy will improve access to and quality of care, as well as promoting innovation through the creation of centres of competence that deliver tertiary care, and development of a health workforce competences platform which is linked to licensing. Other elements are the creation of a quality-of-care assessment model and development of a digital health system.

The second involves investing in long-term care infrastructure and workforce so that growing needs can be met and the sustainability of social and health care can be improved.

The final strategy aims to strengthen the emergency response of health care services by designating five regional hospitals to provide care for infectious diseases and adapting the emergency departments of 10 regional hospitals to cope with emergency situations.

Among other initiatives planned for 2021-27, the Ministry of Health envisages a reorganisation of service delivery based on levels of care, and plans to establish community health centres – a new type of provider that incorporates public health, primary care, ambulatory specialist care, day surgery and long-term and social care services. The reforms are to be financed from EU funds, assigning EUR 530 million to the health sector over the next seven years.

6 Key findings

- The COVID-19 pandemic caused major loss of life in Lithuania, accounting for a 1.4-year drop in life expectancy in 2020 and becoming the third largest cause of death. Overall, 16 % more deaths were recorded that year compared to the average of the previous five years, suggesting that the pandemic had an even wider impact on population health and health services.

- Population health was improving before the pandemic. Following the introduction of stronger alcohol control measures, alcohol consumption was falling, particularly among young people. However, there is still scope to strengthen public health measures, as half of the deaths in Lithuania can be attributed to behavioural risk factors.

- Levels of preventable and treatable mortality in Lithuania remain high. Recent quality checks on the treatment of heart attack and stroke patients show that not all providers are adequately equipped to provide high-quality care for conditions that are among the deadliest for the population. There is also scope for improvement in cancer care – in both screening coverage and survival rates for many treatable cancers. Indeed, screening rates fell even lower during the pandemic.

- High out-of-pocket and catastrophic spending show that while population coverage is very broad, some services (particularly medicines, dental care and medical devices) are less financially accessible. Nevertheless, important steps have been taken in the past few years to reduce co-payments for medicines and improve equity, particularly by covering the full cost of essential medicines for older people and those in low-income households.

- The initial swift reaction to the pandemic in Lithuania – national lockdown and border restrictions from 16 March 2020 – translated into a relatively small first wave of COVID-19. However, the response to increasing case numbers in autumn 2020 came late, and by December 2020 Lithuania was among the countries with the highest number of COVID-19 cases and mortality in Europe.

- Spare capacity in terms of hospital beds, including intensive care beds, helped the health care system cope with the large influx of patients at peak times in December 2020 and April 2021, allowing hospitals to allocate more space to COVID-19 patients either within the same hospital or by tapping into regional capacity. Similarly, regulations allowed reallocation of health workers between providers to ensure that essential staffing levels were maintained.

- Lithuania was ahead of many EU countries in purchasing the necessary equipment for testing, allowing the country to expand testing capacity relatively quickly. Similarly, the country was ahead of many on vaccination planning, and by end of August 2021, 55 % of the population had received at least two doses of vaccine or equivalent. However, the pandemic severely limited accessibility of non-COVID-19 services.

- At the start of the pandemic, the Lithuanian e-health system was in the process of redevelopment. An important shift towards digitalisation of services, as well as the need for rapid, accurate and wide-ranging data collection, prompted much wider use of e-health by residents, providers and public administrations.

Key sources

WHO Regional Office for Europe, European Commission, European Observatory on Health Systems and Policies (2021), COVID-19 Health Systems Response Monitor – Lithuania.

OECD/EU (2020), *Health at a Glance: Europe 2020 – State of Health in the EU Cycle*. Paris, OECD Publishing.

References

EU Expert Group on Health Systems Performance Assessment (HSPA) (2020), *Assessing the resilience of health systems in Europe: an overview of the theory, current practice and strategies for improvement.* Luxembourg.

Eurofound (2021), *Living, working and COVID-19 survey, third round* (February-March 2021). Dublin.

European Commission (2020), *A pharmaceutical strategy for Europe*. Brussels.

European Commission (2021a), *Europe's Beating Cancer Plan*. Brussels.

European Commission (2021b), *The European Health Data Space*. Brussels.

Ministry of Finance (2021a), *ES fondų panaudojimo statistika*, Vilnius. https://esinvesticijos.lt/lt//rezultatai-ir-statistika/es-fondu-panaudojimo-statistika-1

Ministry of Finance (2021b) *Naujos kartos Lietuva - Ekonomikos gaivinimo ir atsparumo didinimo priemonė 2021-2026*, https://finmin.lrv.lt/uploads/finmin/documents/files/LEGADP%20projektas%202021-04-16(2).pdf.

Ministry of Finance (2021c), *Seime priimtas 2021 metų biudžetas*, Vilnius, https://finmin.lrv.lt/lt/naujienos/seime-priimtas-2021-metu-biudzetas.

MOSTA (2019), *Medicinos darbuotojų poreikio prognozavimo modelis*. Vilnius, Government Strategic Analysis Centre,

Murauskienė L, Thomson S (2018). *Can people afford to pay for health care? New evidence on financial protection in Lithuania.* Copenhagen, WHO Regional Office for Europe.

National Audit Office (2018), *Asmens sveikatos priežiūros paslaugų prieinamumas ir orientacija į pacientą*. Vilnius.

National Audit Office (2020), *Vertinimo ataskaita Nr YE-10 COVID-19 krizės ir ekstremaliosios situacijos valdymas* [Evaluation report No.YE-10 on the management of COVID-19 crisis and emergency situation]. Vilnius.

NHIF (2021a), *2020 Metų strateginio veiklos plano sveikatos draudimo sistemos plėtojimo programos įgyvendinimas*. Vilnius.

NHIF (2021b), *2020 m. PSDF biudžeto išlaidų ir pacientų priemokų kompensuojamiems vaistams ir medicinos pagalbos priemonėms analizė.* Vilnius.

State Health Care Accreditation Agency (2020) *News Archive*, https://vaspvt.gov.lt/archive/all/2020

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		

European Commission

State of Health in the EU
Country Health Profile 2021

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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