Annual National Report 2010

Pensions, Health and Long-term Care

Lithuania

May 2010

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On behalf of the
European Commission
DG Employment, Social Affairs and
Equal Opportunities

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1 Executive Summary

The most important factors which significantly influenced Lithuanian social protection and health policy in 2009 were the accelerating financial and economic downturn and the new political majority in Parliament, emerging at the end of 2008. The Lithuanian Ministry of Social Security and Labour fell under the power of the Homeland-Union Christian Democrat and the Ministry of Health under the power of the Liberal and Centre political group. Economic recession and the new political majority caused the important changes in the social protection system and also played an important role in attainment of the objectives in the area of the Lithuanian health care system and significantly altered the planned changes.

The principles of the Lithuanian pension system were not essentially changed. In 2009, only some structural adjustments were made to improve its financial viability. The transfer rate from pay-as-you-go into funded system was reduced, the new (more expensive) pension calculation rule postponed, obligatory pension insurance extended to more groups of self-employed. As these measures were insufficient, the difficult decision to decrease pensions was taken. Pension reduction was realised by a progressive scale: bigger pensions were reduced more, pensions of working pensioners were also reduced more than pensions of non-working retirees. Some reductions in other social insurance branches – sickness, maternity and unemployment were also introduced. These measures are seen as only the first immediate steps before the more fundamental social insurance system reform. The concept of this reform has been drafted and proposes the increase of the retirement age, a new pension calculation rule and reformed financing of the earnings-related and basic part of pensions.

In 2009, the income of retired people did not changed for the worse. The pensions were not reduced, and due to the fall of the average wage, the average replacement rate increased to a level it had never reached before. On the other hand, the social insurance budged reported an essential deficit, 3% of GDP. Only from 2010 did the reduction of pensions hit the living standard of retirees, especially when heating, transportation and electricity prices rose.

The outlines for the reorganisation of health care and the programme for the restructuring of health care institutions were discussed and approved in 2009. Seven public health institutions were restructured. The preparation for restructuring of inpatient health care institutions as well as the reorganisation of policy for the reduction of prices for pharmaceutical products was undertaken. During the financial and economic downturn, the funding of the health care system for 2009 remained at the same level as in 2008. However, political obligations conditioned the increase in wages of medical doctors, which, in turn, reduced the funding available for health care services. Collection of premiums for the Health Insurance Fund was reorganised by introducing a separate health insurance tax amounting to 9% of personal income tax and increasing the amount of the premiums payable for the state insured. Preparation for the new system of funding for health care institutions on the basis of diagnostic related groups (DRG) was undertaken. During the entire year, all sectors made every effort to stabilise funding in all areas. A number of instruments were applied to balance the budget of the compulsory Health Insurance Fund. Funding for prevention programmes as well as nursing and long-term care was increased rather than reduced.

In the period of financial crisis no major negative changes in health indicators of residents were registered, except some increase in morbidity of myocardial infarct. Preventive public health measures resulted in a positive shift of morbidity and average life expectancy indicators. In 2010, the budget of the Compulsory Health Insurance und was additionally reduced by 8.7%. The third stage of the restructuring of health care institutions commenced. Future health indicators might depend on these instruments.

2 Current Status, Reforms as well as the Political and Scientific Discourse

General background

The year 2009 was a year of considerable economic recession. GDP dropped by 15% (by 12.8% in Q4 2009 compared to Q4 2008) and the average unemployment rate, according to labour survey data, was 13.7% (7.9% higher than in 2008). The real average wage in the country decreased by 7.3% (by 8.4% in Q4 2009 compared to Q4 in 2008). Inflation (December 2008 to December 2009) was 1.3% and the average consumer price index was 4.5%.[1]

Moreover, the global recession has led to a sharp deterioration in almost all economic sectors of Lithuania. However, the Government have managed to go through significant fiscal policy cuts and convinced financial markets and/or global organisations about the decisiveness of their policies.

Seeking to reduce the budget deficit, the Government decided to cut public spending in many important branches like public administration, education, social protection, health and others. The so-called "internal devaluation" was evident, not only as cuts in public spending, but also in the wage adjustment process. It has not only allowed to maintain currency pegs, but also helped regain business competitiveness and prevented serious interruptions in foreign funding. As a result, financial stabilisation was achieved, the banking system survived with no bankruptcies, and the country was able to borrow EUR 500 million at the end of 2009.

The year 2009 was the year of the presidential election. Ms. Dalia Grybauskaite was elected in May 2009 by the almost of 70% of votes (voter turnout was about 52%).

A conservative government led by the Homeland-Union Christian Democrat Party, supported by three other coalition parties, came into power and has a slight majority in Parliament (Seimas).

The newly elected President replaced the former Minister of Social Protection and Labour and demanded from the newly appointed minister to devise and present a comprehensive plan of social protection reform, especially a reform of the social insurance system.

The current population of Lithuania is 3.33 million (February 2010).

The exchange rate of the LTL against the EUR is fixed at EUR 1 = LTL 3.4528, due to the currency board regime. One of the achievements of 2009 was the stability of the national currency despite several propositions to give up the currency board regime and to devaluate the litas.

2.1 Pensions: overview, main problems and actions assessment

In Paragraphs 2.1.1 – 2.1.6 of this section the basic information on the Lithuanian pension system is presented in details. The description of each part of the system is supplemented by the relevant overview of the problematic issues, related debates and assessment of most recent changes. The main statistics are also presented in this section; some of them are supplemented in Chapter 3, where the impact of recession is discussed. Paragraph 2.1.7 reports in details on the current debate on further pension and social insurance reforms. Paragraph 2.1.8 presents

[1] Statistics Department webpage, www.stat.gov.lt. (17 April 2010).

the critical assessment of the current situation of the pension system and reforms that have just been implemented or drafted.

2.1.1 Types of pensions

There are three types of public pensions in Lithuania, with different purpose, financing and administration:

- *Social insurance pensions*. This is the main pension system, and includes old-age, incapacity for work (disability) and survivor's (orphan's and widow(er)'s) pensions. The system is PAYG and contribution-based. It is designed to replace parts of the work income when a person retires (or becomes disabled or dies). Pension insurance contributions for this system are paid by employers, employees, self-employed and other persons who perform gainful activities. The contributions are collected into the State Social Insurance Fund. This fund is not included in the state budget and is managed by the State Social Insurance Fund Board (Sodra). Sodra collects contributions and pays pensions.
- *Social pensions*. This pensions system is designed as a social assistance pension system. Social pensions, as a rule, are paid to the elderly or disabled persons who were not able to acquire social insurance rights, because they did not enter the labour market due to incapacity from childhood, raising children, taking care of disabled family members, etc. Despite the "assistance" purpose, social pensions are not means-tested. They are paid by the state budget (general tax income) and are administered by local government social protection offices.
- *State pensions*. These pensions are additional to social insurance pensions. Their purpose is to provide a higher level of protection to some groups of citizens. These pensions are granted to certain "merited" or professional groups. The first group includes people with important contributions to national achievements, such as resistance fighters and people deprived by the former Soviet regime. The second group are military and police officers, judges, scientists, artists, and some other professional groups. As a rule, they are insured by the main pension insurance system, but they have supplementary rights to state pensions. These pensions are financed by the state budget and administered partially by Sodra, partially by relevant institutions (Ministry of Defence, Ministry of the Interior, etc.)

Since 2004, Lithuania also has two types of private pensions systems:

- The "second pillar" funded pensions system is financed by parts of obligatory pension insurance contributions. A working person is allowed to direct a part of their contribution to a funded personal account managed by a private pension accumulation company. This person loses a proportional part of their social insurance pension rights, but they expect to get more from the funded system at the time of retirement. Bearing in mind that the system only started in 2004, today it still plays only a minor part (if at all) in pension payments, but will become more important in the future.[2]
- "Third pillar" funded pensions are also based on the system of personal accounts. The difference from the "second pillar" is that contributions to this pillar are not deducted

[2] It should be noted that in the EU the "second pillar" often means the system of occupational pensions. In Lithuania the occupational pensions system does not exist, despite the fact that a special "Law on Funded Occupational Pensions" was adopted in 2006 (No. X-745).

from social insurance pension contributions. This pillar is just a voluntary savings system with certain tax advantages.

2.1.2 Social insurance old-age pensions

2.1.2.1 Entitlement

An old-age pension is granted under two conditions: retirement age and obligatory record of pension insurance contributions. The retirement age is currently 62.5 years for men and 60 years for women. Required contributory years – at least 15 years.

Early retirement is possible five years before the official retirement age for a person who was registered as unemployed during the entire previous year and had acquired a minimum of 30 contributory years (with some exceptions for certain groups). The pension is decreased by 0.4% for every month of retirement before the official retirement age.

2.1.2.2 Composition and calculation

The old-age social insurance pension is calculated from three components:

$$\textbf{Pension = Main + Supplement + Earnings-related part}$$

The so-called "main" part of pension is designed as a flat-rate redistributive component dependent on the years of insurance. It is calculated according to the formula

$$\textbf{Main} = \alpha \cdot 1.2 \cdot \textbf{B}$$

In this formula, **B** is the basic pension. The value of the basic pension is discretionarily approved by the Government. It is currently LTL 360.

The multiplier 1.2 means, that 120% of the basic pension is taken into account. This multiplier was introduced in 2008, when the Government decided to increase the main part of the pension, but was not able to increase the basic pension (because social pensions are also connected to basic pension, and there were no means to also increase social pensions). Before 2010, this multiplier was equal to 1.1, but in 2010, when the earnings-related part was decreased, the increase of the main part was a compensation for the poorest pensioners.

The multiplier α is equal to contributory years acquired by a person, divided by 30 years, but it never exceeds 1. So, if a person has 20 contributory years, their multiplier α is equal to 2/3; if a person has 30 or more years of insurance, their multiplier is equal to 1.

The "supplement" was introduced in 2007, when politicians gave in to the demand to increase the influence of working years on the pension amount. It decided to pay 3% of the basic pension for the every year of insurance above 30 years.

$$\textbf{Supplement} = 0.03 \cdot (\textbf{S}-30) \cdot \textbf{B}, \text{ if } \textbf{S} > 30$$

The earnings-related part (ERP) of social insurance pension is the only part dependent on the work income of a retired person before retirement. The calculation of this part is based on a simple idea: 0.5% of the monthly average wage of a person is added to their monthly pension:

$$\textbf{ERP} = 0.005 \cdot W_1 + 0.005 \cdot W_2 + \ldots + 0.005 \cdot W_n$$

Bearing in mind, that values of W_1 , W_2 ,..., W_n are not comparable in the year of retirement (n), these values are related to the average wage in the country. For a more precise approach, instead of the average wage $\mathbf{W_t}$, the so-called "insured income" $\mathbf{D_t}$ was used, i.e. the average

income from which contributions were paid or based on (sickness, unemployment insurance benefits, etc.). Then the formula changes into

$$\mathbf{ERP = 0.005 \cdot (W_1 / D_1) \cdot D_T + 0.005 \cdot (W_2 / D_2) \cdot D_T + ... + 0.005 \cdot (W_n / D_n) D_T}$$

Values of $\mathbf{k_t = W_t / D_t}$ are pension points (coefficients) earned by a person in a year t, so the whole formula may be written as

$$\mathbf{ERP = 0.005 \cdot (k_1 + k_2 + ... + k_n) \cdot D_T}$$

So the earnings-related part is equal to the sum of collected pension points ($k_1 + k_2 + ... + k_n$) multiplied by 0.5% of the current insured income $\mathbf{D_T}$ of the month T of pension payment. The advantage of this approach is that all retired persons with the same number of collected points receive the same earnings-related part of pensions with no difference when they retired.

Due to the fact, that data of personal wages are available in the data base only from 1994 onwards, the calculation formula is divided into two parts – before the year 1994 and after. Finally the earnings-related part is calculated as follows:

$$\mathbf{ERP = 0.005 \cdot S \cdot K \, D_T + 0.005 \cdot s \cdot k \, D_T}$$

S stands for the number of contributory years before 1 January 1994, s stands for the number of contributory years from 1 January 1994, k stands for the average number of points collected from 1 January 1994, and D_T **–** current insured income of the month T of pension payment. As data of personal income before 1 January 1994 are not known, it is difficult to calculate the value of K – average number of points from that period. So the value of K is calculated by the data of five consecutive years in ten years before 1 January 1994.

Both K and k can never exceed 5. The first limit is reasoned by the impossibility to check personal information; the second one aims for stronger redistribution within the pension system. This argument seems very doubtful (especially bearing in mind that the redistributive role is played by the main part and by the supplement of pensions). Time and time again demands are made to abolish the limit of **k** (or not to collect contributions from incomes above this limit of insured income). For example, the Lithuanian Investors Forum strongly fights for setting a contributions "ceiling", arguing that this measure would help to attract well-paid specialists to the country's labour market.[3]

The first element of ERP calculation, as it was mentioned above, is more and more difficult to define, because the data of personal income from the years 1984-1993 are hardly available. In mid 2008, the amendment of the law was drafted and it was proposed to calculate **K** from the five best years after 1994 (these data are available in the data base). Amendments of this kind could help the retiring people and the administration to do away with boring procedures in archives. Unfortunately, the new rule of calculation could increase pension expenditures and was, therefore, refused in line with all the immediate measures to curb recession.

When the pension calculation formula was introduced (in 1994), the value of insured income was calculated according to the social insurance average contribution base data. Later, the Government decided to discretionarily approve both components – basic pension and insured income. This made it easier to manipulate the flattening (increasing the basic part) and differentiation (increasing the insured income) of pensions.

While in the years 1995-2000 the nominal value of basic pensions increased by 84%, the insured income increased by 152%. In 2000, the policy was changed into progressive flattening of pensions: basic pensions in the years 2000-2008 (social democracy ruling) increased by 161%, and the insured income only by 68%. In 2009, the value of insured

[3] http://www.investorsforum.lt/lt/news/view/?id=31.

income was LTL 1,488, and from 1 January 2010 it was lowered to LTL 1,170, in order to decrease social insurance expenditure. In this way, for the first time in pension system history, the nominal amount of almost all pensions was decreased.

One of the most controversial issues concerning the pensions system is payment of pensions to working pensioners. Different arguments are presented in the discussions on this problem.

On the one hand, it is argued, that a pensioner has the right to receive full benefit at statutory age, and this right should not depend upon any income of a pensioner. A pensioner "has earned" the pension, the benefit is their property, so there is no reason to reduce the pension if a pensioner works.

On the other hand, it is argued, that the previous argument is relevant only in the case of the funded system. In the *pay-as-you-go* case, a pension is a replacement of work income lost due to old age (or incapacity for work). If a person still works and a wage is paid, there is no reason to pay pension because the work income is not lost. It is only possible to evaluate, that due to the old age a person does not have the wage they had before, being younger and healthy. So there is a reason to pay a part of the old-age pension as a replacement, but not the full amount. It is also not reasonable to use limited sources of the pension budget to pay pensions to people who have income from work, in this way taking money away from those who have no other income, but pensions. This logic was applied in Lithuania before 2002, when the Constitutional Court ruled, that it violates the constitutional right of property[4]. From that time on, the full pension is paid to a working pensioner, and even more – the Government is obliged to repay the difference deducted from the pensions of working pensioners.

The ruling of the Constitutional Court diminished the importance of deferred retirement. It is still possible to postpone the beginning of pension payment, with an increase of pension value by 8% for each year of postponement. In the situation when a full pension and a full wage are paid, this incentive looks insufficient to postpone retirement.

2.1.2.3 Main data

The average number of old-age social insurance pensioners in 2009 was 597,900. In comparison with 2008 it increased by 0.5%. There were two contributors for one old-age retiree in 2009 (comparing to 2.24 contributors in 2008).

Pension payments are rather low: the average old-age pension in 2009 was around LTL 811 (EUR 235) per month (LTL 833 or EUR 241 per month for pensioners who have 30 or more years of insurance). In comparison with 2008 it increased by 5.88%.

The expenditures for old-age social insurance pensions in 2009 were LTL 5.86 billion, or 6.35% of GDP[5]. In comparison with 2008, the expenditures increased by 6.5%, but in 2008 the expenditures for old-age social insurance pensions were only 4.95% of GDP.

2.1.3 State social insurance work incapacity pensions

2.1.3.1 Entitlement

A pension is granted under two conditions: limited capacity to work and obligatory record of pension insurance contributions. The person is entitled to receive work incapacity pension if

[4] The Decision of the Constitutional Court of 25 November 2002, case 41/2000. http://www.lrkt.lt/dokumentai/2002/n021125.htm.

[5] All comparisons with GDP of 2009 - by preliminary evaluation of GDP value.

they have lost 45% or more of capacity for work. The level of lost capacity for work is approved and periodically revised by the Disability and Working Capacity Assessment Office at the Ministry of Social Security and Labour. The required obligatory record of contributions depends on the age of person – from two months at the age of 22 or under to 15 years at the age of 62.

2.1.3.2 Composition and calculation

Incapacity for work pensions are calculated according to the same approach as old-age pensions (see 2.1.2.2).

$$\textbf{Pension} = \alpha \cdot \delta \cdot B + \textbf{Supplement} + 0.005 \cdot S \cdot K \cdot D_T + 0.005 \cdot s \cdot k \cdot D_T$$

As above, B is the amount of basic pension, the multiplier α is equal to contributory years acquired by a person, divided by the number of required obligatory years to acquire full insurance rights at the person's age when the pension is granted. **α** never exceeds 1. So, if a person at age 38 has five years of insurance, but six years are required at this age for full insurance rights, their multiplier α is equal to 5/6; if a person at this age has six or more years of insurance, their multiplier is equal to 1. The required number of years for full rights of insurance also depends upon the age of a person – from one year at age 24 to 30 years at age 62.

The multiplier δ depends upon the level of lost capacity for work. For a person who lost 75% or more capacity for work, δ is equal to 1.5; for others it is equal to 1.2 (see explanation in 2.1.2.2).

The supplement is granted according to the same rules as in the case of old-age pensions.

The earnings-related part of pension is also calculated according to the same rules, except that the number of years of insurance **s** is increased by the number of years missing to reach the person's retirement age:

$$s = s_f + \alpha \cdot (A - a)$$

s_f means the number of years of insurance factually earned, **a** is the age of the person, and **A** the official retirement age. So if a woman at age 38 has five years of insurance, and her retirement age is 60 years, then s = 5 + (5/6)(60-38) = 23.33. The other components are calculated in the same manner as in the old-age case.

If a person lost less than 60% of capacity for work (but is aged 45 or more), only half of the pension is paid (presuming that this person is 50% capable of gainful activity).

2.1.3.3 Main data

The average number of work incapacity social insurance pensioners in 2009 was 225,200. In comparison with 2008 it increased by 3.75%.

Like in the old-age case the pensions are rather low: the average pension in 2009 was around LTL 650.80 (EUR 188.50) per month (LTL 825 if 75% or more of capacity for work was lost; LTL 698 if 60 to 70% of capacity for work was lost; LTL 334 in other cases[6]). In comparison with 2008, the average work incapacity pension increased by 4.6%.

[6] Data of December 2009.

The expenditures for work incapacity social insurance pensions in 2009 were LTL 1.81 billion, or 1.95% of GDP. In comparison with 2008, the expenditures increased by 8.1%. Work incapacity pensions increase in the same manner as old-age pensions, so 6.5 percentage points may be explained as a consequence of the increase of all pension values, the rest by the increased number of recipients (by almost 4% in 2009).

2.1.4 State social insurance survivor's pensions

2.1.4.1 Entitlement

Social insurance survivor's pensions are granted to orphans and widow(er)s of insured persons who, before the time of death, earned the right to receive work incapacity pension. All children of deceased persons under the age of 18 (students – until 24 years old, disabled children –forever) have the right to get orphan's pension.

Widows and widowers have the right to receive widow(er)'s pension if they are not remarried, and are above official retirement age. Disabled widow(er)s are also granted this pension (even if they became disabled in the five years after their spouse's death) as well as those widow(er)'s who take care of disabled children of the deceased person. Widow(er)'s pension is supplementary to the recipient's own pension. Widow(er)s who have no children with the deceased person can only receive the pension if the person died at least a year after the legal registration of marriage.

2.1.4.2 Composition and calculation

In the case of death of an insured person the work incapacity pension for this person is calculated (see 2.1.3.2) and divided between all orphans. If there is only one orphan, 50% of pension is paid, two orphans receive 50% each, three orphans – one third each, etc.

Widow(er)'s pension has been one of the most controversial issues in the country for a long time. According to the initial version of the law, it was granted as a percentage of the deceased person's pension. Later, it was decided that a pension of this kind should rather follow the assistance logic of being a support for a single retired or disabled person. Then, the orphan's pensions were increased, and the widow(er)'s pension changed into a flat rate. Now it is granted at the value of LTL 70 (EUR 20.30).

2.1.4.3 Main data

In 2009, 225,800 widow(er)s and 39,600 orphans received pensions. The average orphan's pension was LTL 298.30 (EUR 86.40), the average widow(er)'s pension LTL 77.70 (EUR 22.50). The expenditure for survivor's pensions in 2009 was LTL 419.7 million (increased by 1.7% in the last year).

2.1.5 State social insurance pensions: contributions and finances

Every year, social insurance contribution rates are approved by the Parliament (Seimas), in line with the whole social insurance budget (this budget as well as the health insurance budget is separate from the state budget). Contribution rates of employed persons and their employers are presented in the following table.

Since 2009, the following groups are also included in the compulsory social insurance system: farmers with medium and big-sized farms as well as their partners, persons receiving royalties under the author's agreements and persons receiving income from performance or sports activities. Temporarily, they are obliged to pay only a 16% contribution rate. The aim was to abolish the wrong practice of numerous "exceptions". It was also argued that the social insurance system loses too much income due to the mentioned exceptions. It does not seem that the income situation has improved much: contributions of self-employed and other persons still represent the smallest part of all income.

Contributions are the main source of social insurance system income. By design this system should be self-sufficient and operate with no financial intervention of the state. The exception was introduced in 2004, when the funded system began to operate. At that time it was informally agreed, that the state budget should reimburse 50% of the money transferred from social insurance pension contributions to the funded system. This rule was not fully followed. For example, in 2008, the Ministry of Finance only paid LTL 80 million, while social insurance transferred more than LTL 1 billion to the funded system. In 2009, the state subsidy was LTL 495.7 million, while social insurance transferred LTL 433.8 million to the funded system. Nevertheless, 95% and more of the social insurance system income comes from contributions.

Table 2.1.5: Social insurance contribution rates in 2010 (in % of wage)

	Employer	Employee	Total
Pensions	**23.3**	**3.0**	**26.3**
Sickness and maternity	**3.4**	**0**	**3.4**
Health	**3.0**	**6.0**	**9.0**
Unemployment	**1.1**	**0**	**1.1**
Occupational accident	**0.2 (0.9 – 0.18)**	**0**	**0.2**
TOTAL	**31.0**	**9.0**	**40.0**

Before the economic recession, the state social insurance budget had significant surplus. In 2008 and 2009, social insurance expenditures increased considerably, due to unsound decision by the Parliament in 2008 to increase some social protection benefits (maternity and pensions) (see Chapter 3).

2.1.6 Funded pensions: principles

2.1.6.1 The principles of the "second pillar" system

The system of funded pensions began to operate in 2004, after long discussions and a lot of preparatory work[7].

Every person insured in the full pension insurance before the official retirement age may voluntarily choose to transfer a part of their pension insurance contributions into a personal account operated by a selected pension fund company.

Once the decision to join the funded system is taken, there is no way back to the full *pay-as-you-go* system. This principle is justified by arguments of financial stability of pension funds

[7] For more details see T.Medaiskis, A.Morkūnienė (2004) and R.Lazutka (2006).

as well the *pay-as-you-go* system. Nevertheless, time and time again, the proposition to abolish this principle is made by politicians and pension fund participants, especially in the time of recession, when the performance of the funded system is not profitable.

Each pension fund company manages several pension funds with different policies of investment. One of the funds must be a so-called "conservative" fund, and is allowed to invest into securities issued by the Government or central banks of EU, EEA, OECD countries. Other funds are allowed to also invest into equities and other securities.

The percentage of contribution allowed to be directed into a personal account has changed year on year (and was up to a maximum of 5.5%). The development in the last six years is as follows:

Table 2.1.6: Contribution rates to funded system (in %)

	2004	2005	2006	2007-8	2009	2010
Employee's part	2.5	2.5	2.5	2.5	3.0 (2.0)	2.0
Employer's part		1.0	2.0	3.0	0	0
Total	2.5	3.5	4.5	5.5	3.0 (2.0)	2.0

In 2009, the transfer rate into the funded system was reduced from 5.5 to 3%, and later to 2%. Because of this decision, the funded system received less money from social insurance revenues, but the Government argued, that in times of recession the priority is to ensure the income of the current, not the future pensioners. Some participants of the funded system have appealed to the Constitutional Court, as they argue that pension contributions are their private property, and the Government violates constitutional principles. It is also argued, that the investment activity in 2009 and the coming years will be more and more gainful, so contributors to pension funds are deprived of potential income.

Only two types of deductions from pension fund assets in favour of management companies are allowed: deductions from contributions and deductions from assets. In order to have as much of a universal and homogenous system of administrative deductions as possible, it was decided to set quite low limits on the deductions from assets, allowing the management companies to compete on the deductions on contributions. The maximal limits on the deductions are 10% from contributions and 1% from assets. The only other deductions possible will be fund-switching charges. Actually not a single pension fund company applies the maximal limit of the deduction on contributions. The average value of this deduction in mid 2009 was around 3%.

Benefits from the funded system are payable from the official retirement age. The assets in the personal accounts should then be diverted into obligatory annuities. The law foresees that annuity payments should not decrease in size (at least in nominal terms).

Taking into account that there are no age limits for the participation, and even persons in pre-retirement age could start to accumulate their personal pension, the obligation to acquire an annuity is not always pursued. In case of very small amounts (annuities of less than half of the basic pension) one can take lump sums or periodical withdrawals. If the accumulated personal amount is bigger than needed to purchase the annuity equal to three times the basic pension, then the exceeding amount may be taken as lump-sum.

After the accumulation period, the social insurance old-age pension has to be calculated taking into account the proportion of the contribution transferred to the personal account. The

main part and the supplement of social insurance PAYG pension (see 2.1.2.2) will be left intact. Only the earnings-related component will be decreased proportionally to the contributions paid to the funded system and the years of participation. This component will now be calculated with reduced coefficients as follows:

$$\mathbf{ERP = 0.005 \cdot (k_1 + k_2 + ... + k_{m-1} + d_m k_m + d_{m+1} k_{m+1} + ... + d_n k_n) \cdot D_T}$$

If a person joins the funded pillar from year m-t with contribution rate r_m, and the pension insurance contribution rate for the supplementary part of old-age pension is R_m, then the earnings related component for each year of participation is proportionally reduced by $d_m = (R_m - r_m)/R_m$. For example, in 2010, the contribution rate for the supplementary part of old-age pension is 9.3%. The participant of the funded system transfers 2% into their personal account. So their coefficient of this year $\mathbf{k_{2010}}$ is reduced by $\mathbf{d_{2010}} = (9.3-2)/9.3 = 0.785$, i.e. by 21.5%.

As the "second pillar" scheme is intended to provide accumulation for the old-age pension, disability and survivor benefits are left within the pay-as-you-go social insurance system. This means that second pillar participants becoming disabled are entitled to the social insurance pension and retain their savings account until retirement.

2.1.6.2 Main data of the "second pillar"

According to the report of the Securities Commission[8], at the end of 2009, there were 29 "second pillar" pension funds managed by nine pension fund companies. The number of participants was 997,500 or around 80% of all social insurance pension contributors.

The portfolio of all funds to that date was worth LTL 3.262 million (EUR 945 million).

2.1.6.3 "Third pillar" pensions

"Third pillar" pension funds began to operate at the same time as the "second pillar", i.e. from 2004. Participation in these funds is fully voluntary and is based on personal savings. The legal regulation for these funds is not as rigid as for the "second pillar" and leaves more freedom in designing the operation rules of concrete funds. The retirement age is allowed five years before the official one, annuity is not obligatory, limits of the deductions from pension assets are not set in the law. Participants are entitled to tax advantages: contributions are tax-exempt (not more than 25% of all personal income). The benefits are taxed only on the part of the accumulated amount comprising the contributions paid. This means that the investment return on these contributions is not taxed at all.

According to the report of the Securities Commission[9], at the end of 2009, there were nine "third pillar" pension funds managed by five pension fund companies. The number of participants was 21,200.

The portfolio of all funds to that date was worth LTL 79.5 million (EUR 23 million), and increased by 30.5% in 2009. Nevertheless, the value of total assets was 23.6% lower than the maximum value achieved two years ago.

The value of investment units during 2009 increased by 28.95% on average, all pension funds reported profits.

8 See www.vpk.lt.
9 See www.vpk.lt.

In comparison with the "second pillar", the "third pillar" is much less popular. Probably the main reason is that contributions into this pillar should be paid by additional means that could be used for consumption or used in another way (this is not the case in the "second pillar").

2.1.7 Overview and assessment of implemented and debated reforms

The main efforts of the Government were directed to ensure the financial balance of the public sector, including social protection. VAT was increased to the level of 21%, public sector wages were reduced, workers were asked to take unpaid leave, the Government borrowed money to ensure current payments. Some actions in the social protection sector were taken immediately, some implemented from the beginning of 2010, some are under discussion now.

2.1.7.1 Immediate actions in 2008-2009

Actions in social protection aimed to increase income and decrease expenditures were implemented at the end of 2008. As reported and discussed above, they are as follows:

- The transfer rate into the funded system was reduced from 5.5 to 3, and later to 2% (see 2.1.6.1).
- A new pension calculation rule was postponed (see 2.1.2.2).
- Some additional groups of people were included in the obligatory insurance system (see 2.1.5)

Some other measures aimed at decreasing social insurance expenditures were as follows:

- The sickness benefit was decreased. Before the recession, the benefit was equal to 80% of the average wage before sickness, now it is only 40% during the first week of sickness; from the 8th day it is 80%. However, it gives the wrong incentive to people to go to work despite being sick in the hope to save some money.
- The payment of child benefit for children above three years was changed from universal to income-tested. Thus, the universal approach to child benefit was abolished. Despite this decision, the number of people who applied for this benefit doubled compared to last year, and twice the money was spent.

2.1.7.2 Actions from the beginning of the year 2010

As the immediate measures were not sufficient, from the beginning of 2010 the new package of social protection benefit reduction came into power. The temporary Law on Social Benefits Recalculation and Payment[10] was adopted at the end of 2009.

One of the most important and difficult actions was the temporary reduction of pensions for a period of two years (2010-2011).

As reported above, in 2009 pensions were not decreased, despite the fact that the average wage had fallen by 7.6%. It was impossible to continue with the increasing deficit, and social insurance pensions were reduced by 4.5% on average from 1 January 2010. In order to protect

[10] Lietuvos Respublikos socialinių išmokų perskaičiavimo ir mokėjimo laikinasis įstatymas. 9 December 2009.XI-537.

people with smaller pensions, the reduction was progressive. It was decided to slightly increase the flat rate and to proportionally decrease the earnings-related part (see 2.1.2.2). Thus, all pensions were flattened, and progressive reduction achieved. Only the threshold of LTL 650 (EUR 188, considered as the minimal income level, remained intact.

The social insurance pensions of working pensioners were reduced much more (13% for minimal wage earners, 40-45% for average wage earners, and up to 70% for highly paid pensioners).

State pensions were also progressively reduced from 5% (for earners below LTL 70) to 20% (for earners above LTL 1,800).

The decision to decrease pensions was reasoned by *pay-as-you-go* logic. As the source of pension payment is the income of the working population, the more working people earn, the better is also the situation of the retirees. In Lithuania, this rule was generally followed: for many years before the recession, pensions increase in line with (and even beyond) the growth of wages. Reduction of pensions, then, is the other side of the same coin: when the working part of the population earns less and unemployment rises, pensions should be proportionally reduced.

The reduction of pensions of working pensioners is also reasoned by *pay-as-you-go* logic: a pension is a replacement of work income lost due to incapacity to work in old age. If a person works, then there is nothing to replace (or only the partially lost capacity should be replaced).

Not everybody in Lithuania agreed with this argumentation. Some people argued that a pension is a property, and the decision to decrease it is a violation of property right. As a consequence, they appealed to the Constitutional Court. The decision of the Court will be taken in the nearest future.

Some others argued that a decrease of pensions is not relevant, when pensions are so small and the replacement rate is rather low. As the Lithuanian expenditures for pensions (as well as for whole social protection) in comparison with GDP are almost twice as low as the EU average, the Government must make more efforts to collect taxes and contributions, to curb the shadow economy, and in this way to find the money for decent pension payments.

As the reduction of pensions was declared as a temporary decision, then the question of repayment after two years is raised. The president has urgently requested that the Government must take the obligation to repay the difference in later years. If it is additionally decided to repay non-paid amounts in the funded system and to repay the loan of LTL 3 billion, then a considerable amount of social protection means will be redirected in coming years to repay the loans, and pension payments in those years will be even more reduced than now.

Other social insurance benefits like maternity and unemployment benefits were also reduced, all child benefits became income-tested and all payments for children above seven years old abolished (except for families with three or more children).

2.1.7.3 Further steps: Concept of the reform

The Government declared that actions taken were only preliminary and introductory steps to the essential social insurance system reform. A reform of this kind was also requested by the newly elected president.

In October 2009, the Minister of Social Security and Labour appointed a work group of experts to draft the concept of social protection reform. The work group was authorised to draft a concept for further discussion with social partners, pensioners, NGOs and academic researchers.

In the meantime, the Free Market Institute published their concept of the reform (in January 2010).[11] They argued that the social insurance system is a financial pyramid (Ponzi scheme), and that it should be completely abolished as an outdated Bismarckian system and replaced by privately-managed funded arrangements supplemented by means-tested social assistance. They also argued that social insurance in general was a bad mix of insurance and assistance, and that the system had proved its full unsustainability, especially unable to cope with the problem of population ageing.

The ministerial work group published the draft of the reform concept in March 2010[12]. The main aim of the reform is declared to be financial sustainability of the social insurance and pension system, adequacy of benefits and efficiency of administration.

In the opinion of the work group, the current system is financially vulnerable. One of the reasons is the absence of a reserve fund and necessary sources to cope with economic and ageing problems, despite the rather high contribution rates. Another reason are the benefits indexation procedures, which are not connected with demographic and economic realities, but strongly influenced by political risk. A clear financing policy of the funded pension pillar is also absent. There is no clear distinction between social insurance and social assistance: state pensions and some other universal benefits, resulting in the overlapping of benefits, where the redistributive part of social insurance pension dominates, and the earnings-related part does not influence the amount of pension in the appropriate way. This reason creates important disincentives to pay contributions. Pensions are paid with no regard to work income of the beneficiary; this does not fit in with the role of pensions as the replacement of work income and creates the incentive to receive the benefit as early as possible, instead of the postponement with increased benefit. The work incapacity pension entitlement system is not transparent enough and does not create incentives to return to the labour market either. Problems of inadequacy of maternity benefits and contribution collection administration were also addressed in the opinion of the work group.

To cope with these problems, the work group proposed to implement measures in two stages.

In the first stage (to implement not later than 2012) it was proposed:

- To begin to increase the retirement age by six month per year until 65 years for men and women.
- To make participation in the "second pillar" pension funds obligatory for labour market newcomers, and not to allow people to begin to participate 10 or less years before retirement. This proposal was not supported by all work group members, and as an alternative, the voluntary participation of newcomers was formulated. Some other proposals concerning the funded system were also expressed: introduce a "life-cycle" regime of investment, make deductions from pension assets dependent on pension fund performance, etc.
- To gradually abolish the state pension system by stopping acquirement of new rights.
- to make borrowing possible only by the state, not by the Social Insurance Fund.
- to equalise contribution rates between employer and employee.
- to discuss pension system perspectives in the Parliament at least every four years.
- to replace a part of assistance benefits for disabled by social services.

[11] http://www.lrinka.lt/Pranesim/LLRI_Sodros_permaina.pdf.
[12] http://www.socmin.lt/index.php?776874557.

- to rationalise maternity benefits
- to privatise the occupational accident and professional diseases insurance system.

In the second stage (as long-term reforms) it was proposed:

- To change the calculation of pensions into a "pension points" system. According to this proposal, every insured person would collect in their work life a number of points (one point for contributions from one average wage). The value of a point will be evaluated according to available finances, ratio of contributors and beneficiaries, life expectancy and other relevant factors. An alternative proposal was presented by one work group member who argued for a change into a notional defined-contribution (NDC) system. Despite the fact that NDC systems seem more transparent, the "points" system ensures, that everybody with the same work career will receive the same pension, no matter when they retire. NDC, on the other hand, may result in essential differences between older and younger retirees.

- To move the financing of the flat (basic) part of pensions from the Social Insurance Fund to the state budget, i.e. to make it tax-based instead of contribution-based. Thus, this part of the pension would not remain an integral part of pensions and would only play the role of assistance in cases when earnings-related pensions are below a certain minimum.

In line with the reform concept, the Ministry of Social Security and Labour announced the programme of seven immediate steps. These steps partially overlapped with work group concept proposals to increase the retirement age and to revise and abolish the state pension system.

On behalf of the Ministry of Social Security and Labour ,the Reform Concept and Seven Steps Programme was discussed with about 20 various groups of interest: employers, employees, politicians, pensioners and family organisations, researchers, etc.[13]

Most objections were expressed against the increase of the retirement age. It was argued, that the labour market will not be able to absorb the additional number of people, and that the actual retirement age in Europe is below 65 years[14]. The Free Market Institute argued that this proposition represents a hidden increase of taxes, because for the same contribution rate a person receives pension payments for a shorter period.[15]. The trade unions were also rather unhappy with this proposition. The opposition party "Order and Justice" collected 120,000 signatures against this proposition. They argued that life expectancy in Lithuania is below the EU average, so there is no reason to increase the retirement age. Even those who supported the idea to increase the retirement age advised to wait with this process until unemployment rates are lower and to increment the retirement age in small steps (not six months per year). Eventually, it is expected, the Government will propose a modest rate of retirement age increase.

Other propositions were not discussed so much. Nobody strongly defended the state pension system. The proposed changes of pension financing or calculation rules were not much discussed and were, at this stage, rather seen as technical problems.

As it was stated in last year's report, "the size of the research community in Lithuania matches the size of the country; it is relatively small. Research into social policies is, therefore, very limited"[16]. Nevertheless, there is a lot of discussion on social issues, including

[13] http://www.socmin.lt/index.php?776874557.
[14] http://www.delfi.lt/news/ringas/lit/article.php?id=23075880.
[15] http://www.lrinka.lt/index.php/meniu/ziniasklaidai/pranesimai_spaudai/pensinio_amziaus_didinimas_valdzia_aukoja_zmogu/5614.
[16] Lithuania asisp Annual Report 2009.

pensions, in the mass media, such as newspapers, TV, internet, etc. So, public debate is very intense. On the other hand, strictly scientific research on pension and on whole social protection issues is rare. As one of last year's research project may be mentioned the research project "Inclusive Lithuania: through analysis-based policy dialogue towards effective decision making" supported by UNDP and European Commission Representative. The report of this project, however, concentrates on the overall assessment of the social consequences of recession and does not particularly discuss pension or health issues.

2.1.8 Critical assessment of actions in the pension system

Economic recession forced the Government to change the centre of attention in pension policy from adequacy into short and long-term financial sustainability. The main decisions to reduce social protection expenditures were made in other than pension branches of social insurance (maternity, unemployment, contributions). Until the late summer of 2009, the Government believed it would be possible to avoid the reduction of pensions. In the meantime, the extended pensions were regularly paid (by decisions in mid 2008), and the deficit of social insurance dramatically increased.

It was impossible to ensure the payment of pensions at value of mid 2008, due to the shrinking number of contributors, decreased average wage and exhausted reserve fund. Due to the many other problems, the state budget was not able to subsidise social insurance. These circumstances were clear at the end of 2008. Thus, it was a mistake to wait so long with reduction of pensions – LTL 3 billion had to be borrowed, but dissatisfaction in society was not avoided, only postponed. One more mistake was to promise to repay the difference in "better" years. According to some evaluations this means, that the pensions of people who will retire in these "better" years will be lower by 15-25%, due to the redemption of all debts. The Government was forced to take this obligation, because it was not able to persuade the society to respect the logic of the PAYG contributory system: the better the situation of the working population, the better the situation of the retired and *vice versa*. Instead of this, arguments like "pension is a property" shouted down the reasonable voices.

On the other hand, the argument that instead of reducing pensions the Government should improve tax and contributions collection is still current. Having rather high tax and contribution rates, in comparison with GDP Lithuania spends half as much on pensions (and for all social protection) as the EU average. Most experts argue that this is a consequence of the shadow economy. Unfortunately, the recession just extended the shadow part of the economy. The research document "Inclusive Lithuania" states: "As the Lithuanian and foreign experience shows, the scope of the shadow economy tends to increase in the face of the economic downturn. This is particularly relevant in the area of labour relations, where the shadow economy manifests itself as employment without formalising labour relations and failure to pay relevant taxes (income, social insurance). It can be forecasted that the extent of the shadow economy could go up to 20-22% by 2015, as a result of the decreasing profitability of business entities, increasing taxes and labour costs, and deteriorating macroeconomic environment. It is particularly important to mention that shadow economic activities develop very fast (usually 12 to 18 months) but their restraint (elimination) requires a much longer period (three to five years on average)".[17] According to the Free Market Institute survey, the part of shadow economy in 2009 was 23% of GDP and increased by five

[17] Inclusive Lithuania: Through Analysis-Based Policy Dialogue Towards Effective Decision Making. Economic Crisis Poverty and Social Impact Analysis (PSIA). UNDP. http://www.undp.lt/uploads/Publications%20ENG/PSIA-LITHUANIA_ENG.pdf.

points from 2008[18]. In this situation, the requirement to improve tax and contributions collection is even more actual, but, on the other hand, it is less realistic to expect to cover the pension deficit with improved tax collection.

The proposition to increase the retirement age is correct in the current demographic situation. However, it was unreasonable to propose an increase by six months per year. The increase rate should be much slower, to start not earlier than in 2012. On the other hand, the decision must be taken now – people should be informed about their retirement age as much in advance as possible.

2.2 Health Care

A few political events played an important role in attainment of the Lisbon Strategy Implementation programme objectives in the area of the Lithuanian health care system in 2009: a new political majority emerging at the end of 2008 (the Ministry of Health (MoH) fell under the power of the Liberal and Centre Political Group) as well as the accelerating financial and economic downturn, which significantly altered the planned changes.

2.2.1 Overview of the system's characteristics and reforms

To execute the National Lisbon Strategy Implementation Programme in the field of health care, the following actions were planned for 2009 in Lithuania:

- Changes in management and financing.
- Development of primary health care, outpatient care and nursing.
- Reorganisation of inpatient institutions.
- Changes in price policy on pharmaceuticals
- Strengthening public health and involvement of people[19].

As per Programme of the Fifteenth Government of the Republic of Lithuania, the health care system was commissioned with four key objectives:

1. Reorganise the health care system according to the conceptual design of the contemporary public health as well as strategic principles pertaining to the European Union public health policy and the World Health Organisation strategy *Health for All in the 21st Century*;

2. Undertake a more rational management and funding of the public health system to improve accessibility and quality of services;
3. Design a friendly and patient-focused health care system that would respect patient rights, ensure accessibility and quality of services and involve the public in decision-making;
4. Vanquish bureaucracy and corruption in the health care system.[20]

The following actions were anticipated by the Ministry of Health in 2009:

- Undertake operational analysis of institutions subordinate to the Ministry of Health to optimise their quantity and functions.

[18] http://www.lrinka.lt/Pranesim/LET2010.pdf.

[19] Annual Progress Report on Implementation of the National Reform Programme of Lithuania, 2009. http://ec.europa.eu/growthandjobs/pdf/nrp2009/lt_nrp_en.pdf.

[20] Resolution of the Seimas of the Republic of Lithuania as of 9 December 2008 on the Programme of the Government of the Republic of Lithuania: http://www.smm.lt/veikla/docs/lrv/15_vyr_programa.pdf.

- Design the plan of instruments for improvement of accessibility of medicinal products and reduction of prices.
- Design and sign off the programme for development of e-health in 2009-2015.
- Effectively absorb the aid of the European Union structural funds.
- Revisit and regulate workloads of health care professionals.
- Design the action plan for reorganisation of the health care system[21].

In 2009, the outline for reorganisation of the Lithuanian health care system was designed, establishing the key directions for reorganisation of the Lithuanian health care system. The Government greenlighted the programme for the third stage of the restructuring of health care institutions and services, which anticipates the distribution of inpatient institutions into three levels — local, regional and national — each providing a set range of services without duplication of functions[22]. For the implementation of the programme in 2010, it is planned to optimise the network of inpatient institutions and restructure the makeup of supplied health services, meanwhile channelling savings made thereof into development of services provided by the outpatient level family doctors and specialist-consultants. It is planned to differentiate the payment for inpatient services, permit personal health care institutions to choose the form of service that fits the patient and the institution the most, stimulate the most cost-efficient forms of service provision, and compensate for inpatient services on the basis of approved general and detailed service provision requirements. Specific actions, measures, dates and parties responsible for implementation of this programme are provided in the Plan of Measures for Implementation of the Third Stage of the Restructuring of Health Care Institutions and Services, approved by the Order No. V-1114 of the Minister of Health of the Republic of Lithuania as of 30 December 2009. [23]

Reorganisation of the primary care involved enlargement of family doctor competencies by awarding the right to deliver more laboratory tests, which increased funding for the primary care level. Home nursing services were initiated for the elderly with special needs. The scope of palliative care services was expanded with a new service, i.e. home palliative rehabilitation.

Funding of the Compulsory Health Insurance Fund remained on the same level as in 2008, but since 1 January 2009, changes in revenue collection have been introduced. An independent health insurance tax detached from the personal income tax as well as a uniform rate of premiums amounting to 9% of earnings was introduced and redirected tax collection: 6% of income tax are paid by employees and 3% employers directly to the Social Insurance Fund instead of being paid separately to tax authorities and the social insurance office. Furthermore, the list of health insurance tax payers was expanded, and more robust controls of tax collection were established. Since 2009, the international personal health care service classification system DRG (diagnosis-related groups) has been procured and required

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[21] Ministry of Health of the Republic of Lithuania, Performance in 2008 and Strategic Action Plan for 2009: http://www.sam.lt/get_file.php?file=bUdkbW4yS21hZEdmeG5Ka2NLcHFjc2FaWm1yR2E1bG5acGpFcDVXZWE1ZkVvV3FsYWFwcms4dlViNVp3b0c5bm1kRm1wcGxubUtobXFaV2FhWjFrbjVXYmFwYVZuMmJZbk01cW9XOWlhcXpFeG0yZm0yZVNwV3hqbTZWa2tKYWN3cUZxbzJPY1p0ZWZrSEtzbkpsb29wYlJaNWVYcTVsblpwcVhvV2VkYTV1VmI1ZHZabXRxa3A3UmNabHZtWmwwbGJobmM1dUZ3bGhvcEplcVk1cHJxWk9zWnBpU3EyUERtSk9jWlhCamJIS1ZrcFZpeVclMkJZWldWbGxHeHBYMlNtazV4bG5XSnlacCUyQmM=&view=1.

[22] Resolution No 1654 of the Government of the Republic of Lithuania as of 7 December 2009 on the Programme of the Third Stage of Restructuring of Health Care Institutions and Services (*Official Gazette Valstybės Žinios*, 2009, No. 150-6713).

[23] Ministry of Health of the Republic of Lithuania, Operating Report for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

adjustments commenced. Implementation of the system is planned to be finalised in 2011. It is expected that the DRG system should ensure a fairer compensation for inpatient health services as well as safe and high quality services.

To reduce the bureaucratic burden on businesses and implement the reorganisation of institutions subordinate to the MoH, optimisation and improvement of management was pursued. In 2009, seven budgetary institutions and establishments were reorganised by merger. In total, 273 posts were relinquished subsequent to the reorganisation of institutions and establishments subordinate to the MoH. This provided for almost LTL 1 million in savings, which was allocated for procurement of medicinal products during the influenza pandemic.

Working hours of health professionals were levelled to 38 hours per week as well as the duration of annual leave to up to 36 calendar days. Thus far, legislative acts contained numerous exceptions, hence the weekly working hours of health care professionals ranged from 30 to 39 hours and annual leave from 35 to 42 calendar days, depending on the nature of services provided by the health care professional. This measure has allowed for some improvement in the service accessibility for patients.

A number of reorganisation instruments were suggested in the pharmaceutical field. In the area of pharmaceutical policy, it was attempted to achieve a reduction in prices of pharmaceutical products and improve their accessibility for residents. With that in mind, the Plan of Instruments for Improvement of Accessibility of Pharmaceutical Products and Reduction of Prices was designed and approved by the Order No. V-572 of the Minister of Health of the Republic of Lithuania as of 10 July 2009.[24] The Plan covered all issues pertaining to production, sale and prescription of pharmaceutical products. Moreover, legal acts were drafted and amended in relation to pharmaceutical activities in pharmacies to ensure rational consumption of pharmaceutical products and improve the quality of pharmaceutical service. Regulations also comprised reimbursement and price formation pertaining to reimbursable pharmaceutical products and reimbursable medical aids; supply of pharmaceuticals to the market, giving special attention to regulation of progressive therapy and improvement of conditions for issuance of marketing authorisations as well as simplified registration procedures.

The procedure for the grouping of pharmaceutical products was amended providing a possibility to group them bearing a different generic name but being of similar therapeutic effect; besides, a new procedure for the estimation of prices for generic pharmaceutical products was established. Price criteria were validated for medications to be included into the group comprised of generic name-bearing pharmaceutical products produced by more than three manufacturers. The procedure for the estimation of basic prices for parallel imported pharmaceutical products was introduced. In 2009, all pharmacies implemented the operation quality assurance system based on the Quality Manual of Good Practice in Pharmacies. To improve information regarding consumption of pharmaceutical products, instructions on issuance of prescriptions and pharmaceutical products were revised, establishing new requirements for pharmacists to provide information on the cheapest available products and their expiration dates, as well as only dispense medicinal products with expiration dates that would provide a patient with a realistic possibility to consume them before such dates mature. To stimulate rational consumption of anti-infective medications, including antibiotics, as well as ensuring an improved control of dispensation of such products, storage of prescriptions for such medications in pharmacies was extended up to one year.

[24] Plan of Instruments for Improvement of Accessibility of Pharmaceutical Products and Reduction of Prices, Order No. V-572 of the Minister of Health of the Republic of Lithuania as of 10 July 2009.

Substantial efforts were made to improve public mental health, i.e. various information campaigns and events were organised, publications issued, and information on prevention of dependencies as well as maintenance of mental health was disbursed. In order to improve nutrition and stimulate physical activity within the Lithuanian population, international projects were attended, research delivered and legal acts drafted. 2009 saw a further strengthening of municipal supervision in the area of public health; four municipal public health bureaus were established ,in addition to the existing 30; training in the form of seminars and meetings for bureau specialists was provided to improve their knowledge in the area of public health. To reduce the bureaucratic burden on businesses, various procedures (issuance of licences for cosmetic products, hygiene licences, food supplement notifications, etc.) were simplified ,as well as the hygiene norms, i.e. relinquishing requirements that have no direct impact on public health safety, simplifying provisions for the establishment of education institutions, and discarding requirements or procedures pertaining to the establishment of certain types of businesses (e.g. to receive a hygiene licence for adult training, pharmacies, and etc.).

As per the National Programme on Immuniprophylaxis for 2009-2013, newborns, infants and children were vaccinated against tuberculosis, hepatitis B, pertussis, diphtheria, tetanus, poliomyelitis, measles, mumps, rubella, and Haemophilus infuenzae type B; people with animal-inflicted injuries against rabies; and post-traumatic patients against tetanus. In 2009, especially large vaccination volumes were maintained for measles, mumps and rubella in all age groups[25].

In 2009, the MoH continued implementing Objective 1 “Providing high quality and accessible health care services” of Priority 2 “Quality and accessibility of public services: health, education and social infrastructure” of the Operational Programme for Promotion of Cohesion and Strategy for the Use of EU Structural Funds for 2007-2013. However, as little as 26% of EU assistance were absorbed.[26]

The Draft Programme for Development of e-Health in 2010-2015 was prepared. With the assistance of external experts, the current status of the national e-health system was assessed as well as the suitability of the system for further utilisation and development; furthermore, basic requirements for electronic health records were prepared, as well as technical and organisational documents indicating requirements for interfacing information systems of health care institutions with the "core" of the system.[27]

Undertaking scientific studies in the area of evidence-based occupational health solutions, the Institute of Hygiene started preparing for the scientific project entitled “Assessing the Network of Lithuanian Occupational Health Bodies” focused on evaluation of legal regulation, operation and effectiveness of Lithuanian occupational safety and health care institutions. The following scientific studies were made in the area of public health: “Incidence of hospital infections and relevant risk factors as well as status of management in nursing hospitals”, “Features pertaining to consumption of antibiotics in Lithuanian general and nursing hospitals and influencing factors”, “Features pertaining to epidemiologic surgical wound infections in Lithuanian hospitals in 2003-2007”. Data of these studies was provided in scientific publications, international and Lithuanian issues and conferences.

[25] Operational Report of the Ministry of Health for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

[26] Ibid. p. 86.

[27] Operational Report of the Ministry of Health for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

The scientific studies "Assessment of Vulnerability of People Living with HIV/AIDS in Lithuania" and "Evaluation of the Programme for Development of the State Public Health in Municipalities in 2007–2010" commenced.

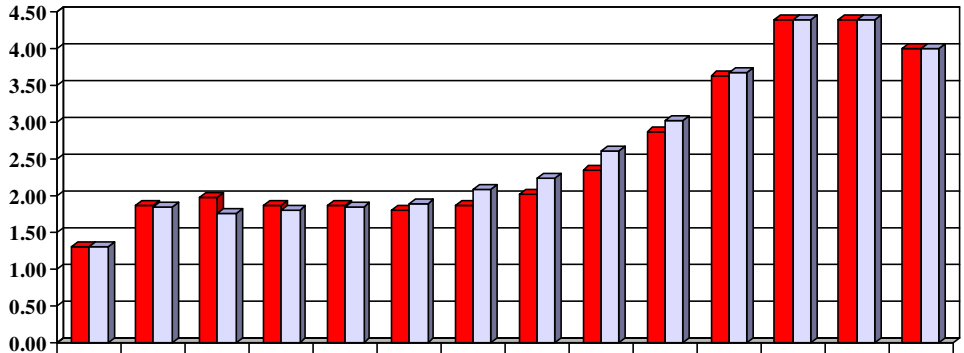
2.2.2 Overview of debates/the political discourse

For several years prior to the crisis, Lithuania had been enjoying economic growth. However, as the global economic crisis gave rise to disruptions in the global trade and industry, all EU member-states, including Lithuania, experienced the economic downturn. Therefore, one of the key objectives of the Government was to achieve stability and significantly improve the situation in areas that might ensure the economic breakthrough.

Consequently, the majority of discussions and debates concentrated on five key areas: health care funding; preparation for the third stage of the restructuring of health care institutions; reduction of prices and improvement of accessibility of pharmaceutical products; implementation of e-health; and reorganisation of public health institutions.

Subsequent to considerations regarding the stabilisation of health funding, advance payments to private health care institutions were relinquished, keeping to the procedure for settlement of accounts established in legislation (providing for a period of 30 days from the date or receipt of an invoice). A number of instruments were used to stop the growth of expenditures for pharmaceuticals: the inclusion of new items into the lists of reimbursable medications and services was postponed, agreements on limitation of expenditure were signed, and the inclusion of new programmes into the list of programmes financed from the compulsory State Health Insurance Fund budget was suspended. In 2009, the budget of the compulsory State Health Insurance Fund remained on the level of 2008 (Figure 2.2.2).

Figure 2.2.2: Revenues of the State Health Insurance Fund budget in 1997-2010



	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Revenues (planned)	1.30	1.88	1.97	1.86	1.87	1.81	1.87	2.03	2.34	2.87	3.62	4.39	4.39	4.01
Revenues (actual) in billion LTL	1.31	1.84	1.76	1.81	1.84	1.89	2.08	2.24	2.61	3.03	3.68	4.39	4.39	4.01

Source: State Health Insurance Fund, 2010, http://www.vlk.lt/vlk/kt/?page=list&kat_id=1.

Discussions regarding the plan for the restructuring of health care institutions lasted for almost six month. Health care institutions and the general public were especially active in debates on the topic. The political group in opposition of the Seimas attempted to initiate an appeal to the Constitutional Court to investigate the legitimacy of the reorganisation[28].

[28] The Parliament is to bring hospital reorganisation under the scrutiny of the Constitutional Court

However, the third programme for the restructuring of health care institutions was greenlighted. The programme of the third stage for the restructuring of health care institutions raised the following key objectives:

1) Design a more effective network of service providers through merger to establish larger legal entities and achieve integration of mono-profile institutions into the structure of multi-profile establishments;
2) Design a more rational structure of services by redistribution of patient flows and strengthening infrastructure of local hospitals for treatment of widely prevalent diseases, meanwhile concentrating diagnostics and treatment of complex diseases in large hospitals.

As a result of liquidation of the county council governors' administrations, planned for 1 July 2010, the objective to hand over previously owned health care institutions to the state or municipal level was formulated together with the new objectives[29].

Somewhat edgy discussions on the topic took place in the MoH and the medical community, the topic was widely discussed by the general public and the media. The principles and criteria of hospital structural changes and hospital beds needs were considered by the Committee on Health Affairs of the Parliament. The reduction of hospital beds and departments in rural areas and plans to merge them in urban areas was a big challenge.

2.2.3 Overview of impact assessment

Subsequent to a performance assessment for 2009, the Ministry of Health (MoH) underlined certain achievements[30]. The infant mortality rate is one of the most sensitive indicators representing the health of the population, as well as socioeconomic changes. Achievements in the reduction of the infant mortality rate (Figure 2) were significant. Since 2005, the infant mortality rate has started declining. In 2008, 172 infant deaths occurred in total, which amounts to five infant deaths per 1,000 live births (Fig. 2). The Lithuanian infant mortality rate for 2008 is better than the European average (amounting to 7.9 infant deaths per 1,000 live births) and is approaching the EU average (amounting to 4.4 infant deaths per 1,000 live births)[31]. As per advance estimations, the rate should total 4.9 infant deaths per 1,000 live births in 2009. The greatest impact on the reduction of the infant mortality was achieved through the successful delivery of prenatal, perinatal and neonatal health care, development of an infant-friendly network of hospitals, new equipment and pharmaceutical products, growing professionalism of health care specialists, as well as social policy.

2.2.3.1 Prevention programmes

One of the objectives initiated in the Lithuanian Health Programme is to reduce mortality of residents from cardiovascular diseases in the age group below 65. With this in mind, the Programme for Screening High-Risk Cardiovascular Patients and Funding of Preventive Measures was initiated in 2005, targeting males aged 40-55 and females aged 50-65. In 2009, approx. 120,000 patients were screened and more than 109,000 were provided with the

http://www.delfi.lt/news/daily/Health/del-ligoniniu-pertvarkos-seimas-nesikreips-i-kt.d?id=30052457.

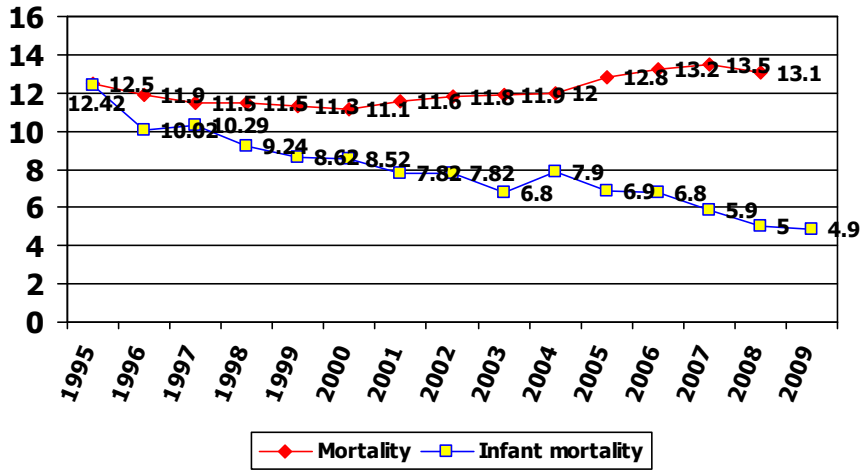
[29] Resolution No. 1654 on the Programme for the Third Stage of Restructuring of Health Care Institutions and Services of the Government of the Republic of Lithuania as of 7 December 2009 (*Official Gazette Valstybės Žinios*, 2009, No. 150-6713).

[30] Report on the Performance of the Ministry of Health for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

[31] WHO Health for all data, 2009: http://data.euro.who.int/hfadb/.

services of the programme. In comparison to 2008, five times more comprehensive cardiovascular assessment services were provided to patients in 2009. Besides, in 2009 the related mortality was 3.1% lower than in 2008. The Institute of Hygiene commenced with the scientific study on the topic of "Development of Inequalities in the Avoidable Mortality in Lithuania" aiming to analyse avoidable mortality inequalities and the urbanisation impact on their dynamics in Lithuania in 1965-2009 depending on age and gender, and considering actual life-years and the years of potential life lost[32]. It is expected that the comprehensive analysis of avoidable mortality would allow for a better understanding of health care quality over the past 45 years in Lithuania, as well as the comparison with respective indicators of other countries. The project is planned to finish in 2012.

Figure 2.2.3.1: Infant mortality per 1,000 life births and mortality rate per 1,000 inhabitants in 2000-2009 (* advance data for 2009)



Source: Department of Statistics Republic of Lithuania.

In 2009, four prevention programmes in the field of oncology were undertaken: cervical and breast cancer prevention programmes for women, and prostate and colorectal cancer early diagnostic programmes for men. In 2009, these prevention programmes were received LTL 27.03 million, which is LTL 3.13 million more than in 2008. In total, 70.3% of 630,800 people were screened in 2009.

The programme for prevention of malignant cervical tumours provides a possibility to provide free-of-charge screening for 25-60 year-old women once every three years. Between July 2004 and 2009, more than 627,000 women were screened for cervical cancer; cervical cancer symptoms were identified in 298 women, 7,220 were diagnosed with a precancerous condition. The cancer register data shows that 2005 was the first year when more cases of non-invasive (in situ) cancer were registered (517) rather than invasive cases (496); and the trend remained persistent in 2009 with 553 non-invasive and 426 invasive cases registered.

The programme for financing selective mammographic screening for breast cancer was targeted at 50-69 year-old women. In 2009, more than 57,000 women used the free-of-charge breast cancer screening services. During the period from 2006 to 2010, malignant tumours

[32] Development of Inequalities in the Avoidable Mortality in Lithuania. The Institute of Hygiene. 2010. http://www.hi.lt/images/Isvengiamas_mirtingumas_2009-2011.pdf.

were diagnosed for 478 women out of 17,980 women, who were diagnosed with malignant breast lesions.

The programme for funding early prostate cancer diagnostics was targeted at males in the age group 50-57 or from 45 years of age if a brother or father had prostate cancer. In 2009, more than 101,000 men were screened. 7,254 men have been diagnosed with prostate cancer since the beginning of the programme.

In 2009, the prevention programme for early diagnostics of colorectal cancer commenced[33]. Services of the programme are provided biennially to 50-74 year-old males. The programme is planned to be undertaken in the form of a pilot project in the counties of Vilnius and Kaunas for the duration of two years and, in the case of success, it would be further developed.

2.2.3.2 Health care access

The new inpatient observation service (4-24 hours stay in the hospital due to certain conditions) — introduced in 2007 — served the purpose: more than 150,000 monitoring services were provided in 2009, which is 11% more than in 2008.

In 2009, the differentiation of inpatient services continued. Besides, the procedure pertaining to payment for services was under improvement, aiming to provide as many services as possible at the outpatient level. To that end, yet another form of service provision was introduced in 2009, i.e. internal medicine services were provided in a day surgery setting. This is especially relevant to hospitals that are preparing for reorganisation of neurology, gastroenterology and other departments during the third stage of the restructuring.

The Order No. V-913 of the Minister of Health of the Republic of Lithuania, enlarging competencies of family doctors as of 30 October 2009, provides a possibility to prescribe and assess the greater amount of laboratory tests.

As working hours of health care specialists were extended in 2009, the number of personal health care institutions with waiting lists for specialist doctor consultations amounting to fewer than 10 working days increased by approx. 50% (there was a more than 10 days waiting list for a few specialists before). Accessibility of 40% of services provided by specialist doctors remained unchanged. And only in the case of 10% of services provided by specialist doctors, the waiting lists exceeded 10 working days; those were less frequently used personal health services (e.g. child neurologist or gastroenterologist); besides, there is a shortage of specialist doctors in those fields. Subsequent to changes in weekly working hours of doctors, accessibility of the majority of outpatient services have improved[34].

In 2009, the financial and economic downturn conditioned the reduction of types of adult rehabilitation care, with the exception of palliative rehabilitation, as well as duration of treatment; besides, rehabilitation service indications were specified. However, priority was given to paediatric medical rehabilitation and development of outpatient rehabilitation. Consequently, subsequent to the significant enlargement of the scope of outpatient medical rehabilitation, medical rehabilitation services were provided to a number of patients, which was similar to that of 2008[35].

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[33] The Order No. V-508 of the Minister of Health of the Republic of Lithuania on Approval of the Programme for Early Diagnostics of Colorectal Cancer as of 23 June 2009.

[34] Ministry of Health of the Republic of Lithuania, Operating Report for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

[35] Ministry of Health of the Republic of Lithuania, Operating Report for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

In the second half of 2009, the Plan of Instruments for Improvement of Accessibility of Pharmaceutical Products and Reduction of Prices was approved, involving all issues pertaining to production, sale and prescription of medications. This allowed for reduced spending of citizens on all medicinal products, as well as curbing the increasing expenditure of the State Health Insurance Fund (SHIF) for reimbursable medications; besides, the instruments conditioned the reduction of prices of medicinal products, facilitated the selection and helped making savings within the SHIF. The implementation of these instruments has already produced benefits in the second half of 2009: in comparison to the respective period of 2008, expenditure for pharmaceutical products and medical aids reduced by LTL 7 million. In 2004-2008 spending for pharmaceutical products and medical aids increased from LTL 40 million to LTL 58 million, while in the first six month of 2009, the growth amounted to LTL 20 million.

In 2009, pharmaceutical aids were grouped, more beneficial conditions were created for parallel import, groups of medicinal products of similar therapeutic effect were legalised, as well as groups of generic medicinal products; prices of generic pharmaceutical products were decreased, and patient co-payments were regulated.

Due to the increase in wages of health care professionals as well as the reduction of the health care budget — which amounted to 6.4% in 2009 — expenditure for payment for all types of personal health care services were reduced, establishing the point value of basic prices from LTL 1 to LTL 0.89. Personal health care institutions were encouraged to reorganise and rationally use the money of the SHIF, at the same time providing all services required by the patients and without reducing the scope of services, which forced institutions to look for more economically beneficial forms of service provision, i.e. to establish a day surgery, a day inpatient care department, initiate observation services or provide short-term care, etc. Compared to 2008, the number of services provided by day inpatient care departments increased by 9% in 2009; meanwhile the increase of services provided by day surgeries increased by 12%, and short-term treatment services grew by 9%. The total volume of services provided in the inpatient setting grew by 1% (Table 2.2.3). Consequently, accessibility of health care services remained unchanged and hospital mortality reduced. Although 44% of Lithuanian residents — while responding to the questions of the Eurobarometer — stated that it was more difficult to access health care services for them or their family members during the financial and economic downturn, the same portion of respondents indicated that the accessibility had not changed or had even improved (Fig. 9.).

Table 2.2.3: Hospital performance indicators for 2008 and 2009

Indicator	2008	2009	Change	
			Absolute (+,-)	In percentage (%)
Total number of patients in hospitals per 100,000 residents	803,979 239.41	811,398 242.97	7,419 3.56	0.92 1.49
Out of which: males 100,000 residents	339,369 217.11	343,877 220.54*	4,508 3.43	1.33 1.58
females 100,000 residents	464,610 258.84	467,521 261.09**	2,911 2.26	0.63 0.87
Number of inpatient deaths	20,278	19,536	-742	-3.66
Out of which: males	9,710	9,438	-272	-2.80
females	10,568	10,098	-470	-4.45
Deaths (in %)	2.52	2.41		-4.54
Male	2.86	2.74		-4.08
Female	2.27	2.16		-5.04
Average hospital stay	9.27	8.95	-0.32	-3.45

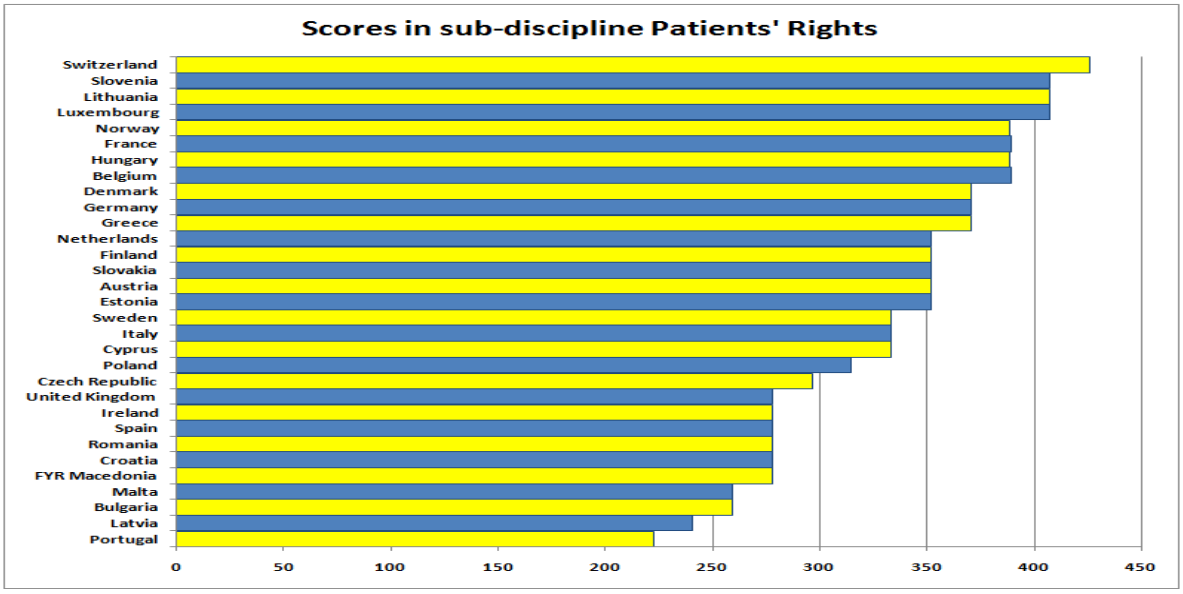
* The measure for 2009 was estimated on the basis of male population of 2009
** The measure for 2009 was estimated on the basis of female population of 2009

Source: Lithuanian Health Information Centre using the SVEIDRA information system of the State Health Insurance Fund)

2.2.4 Critical assessment of reforms, discussions and research carried out

Critical assessment of the Lithuanian Health Reform in 2009 spotlights a number of positive as well as some negative aspects. A successfully balanced health insurance budget devoid of deterioration of health care accessibility for residents should be named among the positive aspects particular to the year 2009. The Lithuanian method for collection of health insurance premiums contains the built-in variable for estimation of premiums for state insured (the list of which covers vulnerable groups of the population), which allows for a regulation of the State Health Insurance Fund without any substantial legislative adjustments. In 2009, a separate health insurance tax for the working population amounting to 9% was approved. During the economic downturn, the focus remained on prevention health programmes and primary health care funding. Many efforts were made to reduce expenditure on medicinal products.

Figure 2.2.4.1: Scores of patient rights as per data of the *Empowerment of the European Patient*

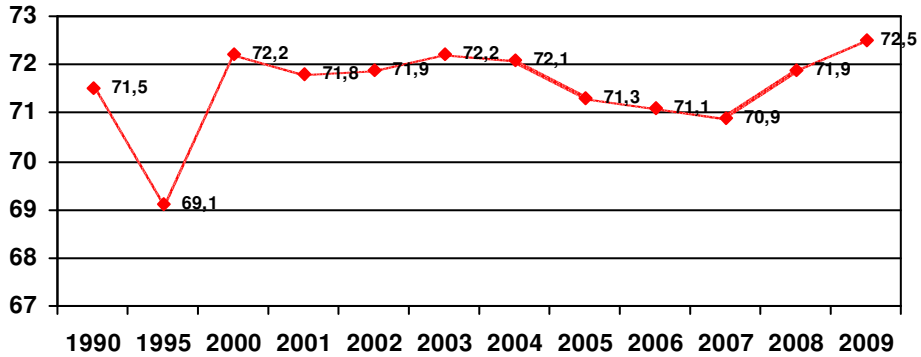


Source: Health Consumer Powerhouse 2009.

Lithuania succeeded in maintaining and further developing the system for the protection of patient rights and compensation for damages. In 2009, the Law on Patient Rights and Compensation of Damages was amended. As per data of the report *Empowerment of the European Patient,* issued by the Health Consumer Powerhouse in Brussels, patient rights in Lithuania are in third place, giving way only to Switzerland and Slovenia (Fig. 2.2.4.1).[36]

In 2009, Lithuania managed to avoid deterioration of health indicators. Although the average life expectancy is still lagging behind the European Union average, it was slowly increasing (Fig. 2.2.2.4.2). In 2009, there were 1,798 deaths less than in 2008.

Figure 2.2.4.2: Average life expectancy in Lithuania in 1990-2009.



Source: Report on the Performance of the Ministry of Health for 2009

The result was achieved through maintained accessibility of the health care system as well as continuous implementation of the alcohol consumption control and traumatism prevention

[36] Empowerment of the European Patient - Options and Implications. Health Consumer Powerhouse 2009, p. 31. http://www.healthpowerhouse.com/index.php?option=com_content&view=category&layout=blog&id=49&Itemid=68.

measures, especially in the area of traffic safety. In 2009, four prevention programmes in the field of oncology were undertaken.

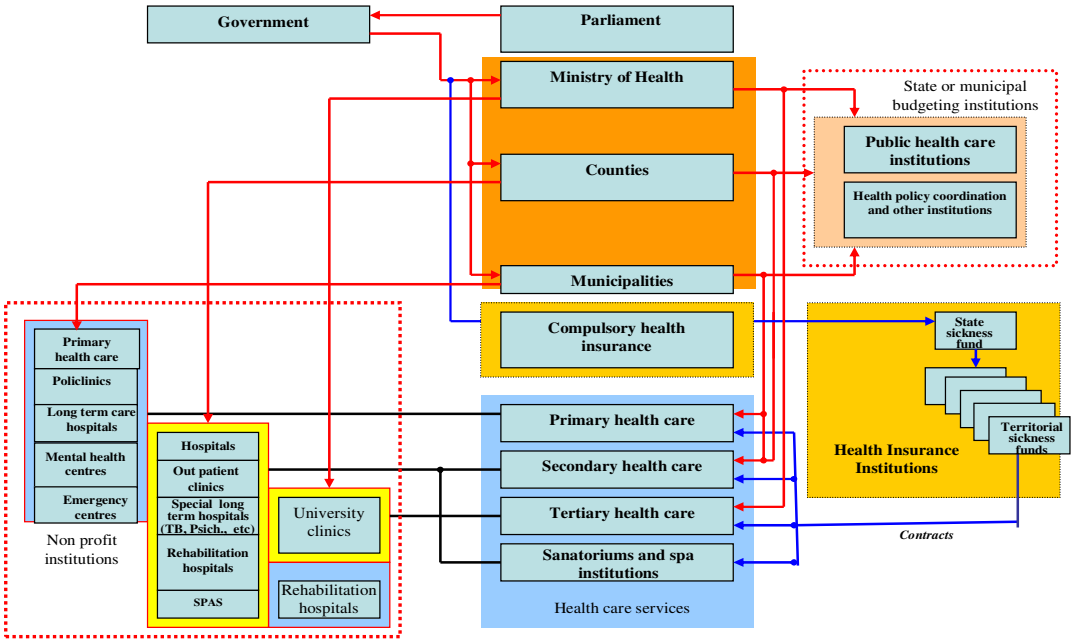
However, the structure of health care institutions in Lithuania is too extensive (Table 2.2.4.1). Lengthy discussions took place on the third stage of the restructuring of health care institutions. However, the planning lacked advance preparation, even in light of the fact that the second stage of the restructuring was to conclude in 2008. A diagram showing the health care system structure in Lithuania is provided in Figure 2.2.4.3. The structure remained unchanged in 2009. Health care institutions were neither closed down nor otherwise restructured during the economic downturn, with the exception of seven public health institutions.

Table 2.2.4.1: Comparison of key Lithuanian heath care system structure indicators with the EU Member State averages in 2007

No.	Title of the indicator	Lithuania 2009	EU average		
			total	Old member-states	New member-states
1	Number of hospitals per 100,000 population	4.88 3.41 without nursing hospitals	2.97	3.1 (2006)	2.58
2	Acute care/short stay hospitals per 100,000 population	2.5			
3	Number of family doctors per 100,000 population	82.3	96.7 (2006)	102.4 (2006)	65.21
4	Hospital beds per 10,000 population	81.6 68.3 without nursing hospitals	56.4	55.3 (2006)	60.4
5	Number of beds in acute care/short stay hospitals per 10,000 population (with the exception of nursing and palliative care, tuberculosis, mental health and medical rehabilitation)	50.1	39.5 (2006)	37.5 (2006)	46.8
6	Number of hospitalised patients per 100 population	24.7 23.8 without nursing hospitals	17.6	16.82	20.53
7	Number of patients hospitalised for acute care (with the exception of nursing and palliative care, tuberculosis, mental health and medical rehabilitation) per 100 population	22.1	15.6	15.4	18.8

Source: European health for all database: http://data.euro.who.int/hfadb/.

Figure 2.2.4.3: Organisation of health care in Lithuania



Source: Adapated from www.sec.lt

Changes to the structure of Lithuanian health care institutions commenced in 2004, subsequent to Resolution No. 335 of the Government of the Republic of Lithuania approving the Strategy for the Restructuring of Health Care Institutions as of 18 March 2003.[37] Theretofore, the opinion prevailed that the structure of health care institutions should be changed on the initiative of health care institutions and their promoters through the reduction of inpatient beds and rationalisation of service volumes. Meanwhile, health reform objectives to design the health care structure should be implemented through funding incentives.[38] Even though, in 2009, inpatient day services grew by as much as 9%, in day surgery services by 12%, and in short-term treatment services by 9%, compared to 2008, the total volume of inpatient services only grew by 1%. Therefore, the impact of changes remained insufficient. Still, the somewhat extensive system of health care institutions with relatively large volumes of inpatient health care prevailed in Lithuania, in comparison to the EU average (Table 2.2.4.1). Meanwhile, the number of primary health care institutions remained lower than the EU average.

Even though efforts to implement the Strategy for Restructuring of Health Care Institutions in the period 2003-2009 resulted in a reduction of hospitals and hospital beds, Lithuania is still significantly above the European Union average, including the old and new member states. At the same time, volumes of services provided in some hospitals are somewhat low, which is

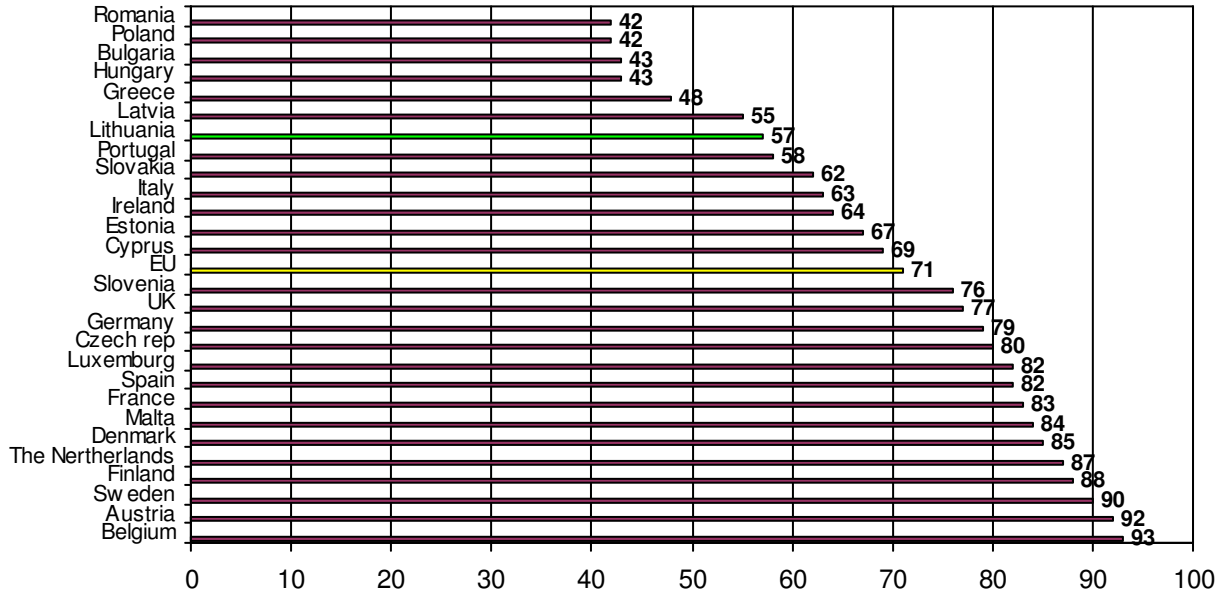
[37] Strategy for Restructuring of Health Care Institutions. Resolution No. 335 of the Government of the Republic of Lithuania as of 18 March 2003 (*Official Gazette Valstybės Žinios*, 2003, No. *28-1147*).

[38] D. Jankauskienė, Development of Health Policy and It's Further Perspectives in Lithuania. Regnum est. Monograhy. Mykolas Romeris University Press, 2010. p.p. 845-866.

insufficient for the assurance of patient safety and effective utilisation of human and material resources[39].

Yet another important and insufficiently developed health policy aspect in Lithuania remains in the area of improvement of the quality of services. Although Lithuania has the approved Programme for Quality Assurance of Health Care Services[40], the funding is not guaranteed, thus measures are only partially implemented. Therefore, results are not satisfactory. A poll regarding the quality of services in Europe showed that Lithuanian respondents rated the services provided by inpatient and outpatient institutions and family doctors lower than the average rating given by EU residents (Fig. 2.2.4.4)[41].

Figure 2.2.4.4: Positive assessment of inpatient care in the EU member-states (in percentage)



Source: Special Eurobarometer 283 (2007), Health and long-term care in the EU, European Commission

In 2009, the Institute of Hygiene — implementing the measures of the Programme for Quality Assurance of Health Care Services for 2005-2010 — undertook a study on "adverse events and causes from the point of view of health care specialists and patients", aiming to ascertain the adverse events experienced by health professionals and patients as well as respective attitude and causes[42]. The survey demonstrated that health care specialists are not yet ready to introduce the system for registration and monitoring of adverse events.

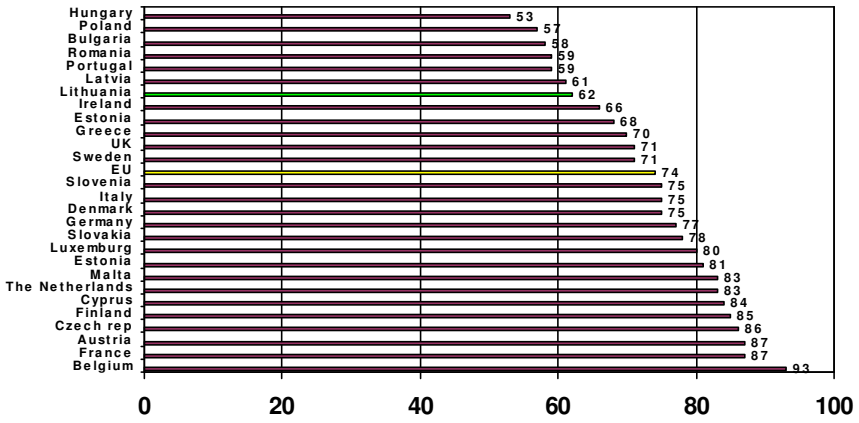
[39] Report on the Performance of the Ministry of Health for 2009: http://www.sam.lt/go.php/sveikatos_prieziuros_reforma.

[40] Programme for Quality Assurance of Health Care Services for 2005-2010, Order No V-642 of the Minister of Health of the Republic of Lithuania as of 14 September 2004, http://sena.sam.lt/lt/main/teisine_informacija/ministro_isakymai?id=25567.

[41] Survey, Health and Long-term Care in the European Union, Eurobarometer No. 283. 2007. http://ec.europa.eu/public_opinion/archives/ebs/ebs_283_en.pdf.

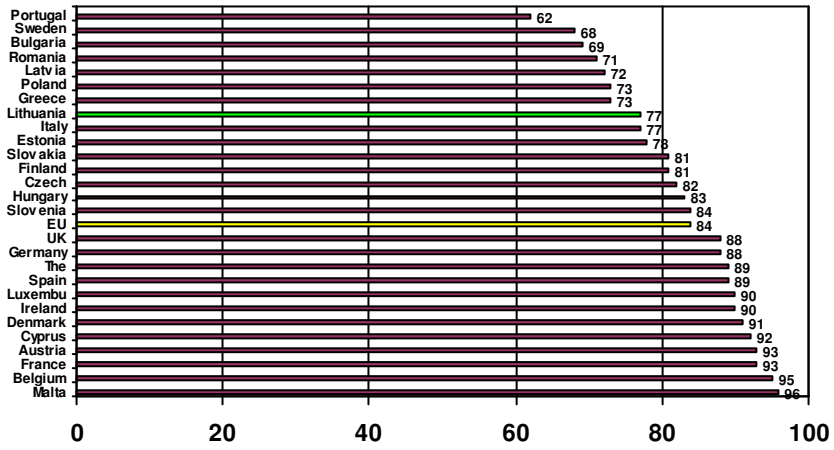
[42] Adverse Events and Causes from the Point of View of Health Care Specialists and Patients. http://www.hi.lt/images/NI-ataskaita-2009.pdf.

Figure 2.2.4.5: Positive assessment of outpatient care in the EU member-states (in percentage)



Source: Special Eurobarometer 283 (2007), Health and long-term care in the EU, European Commission

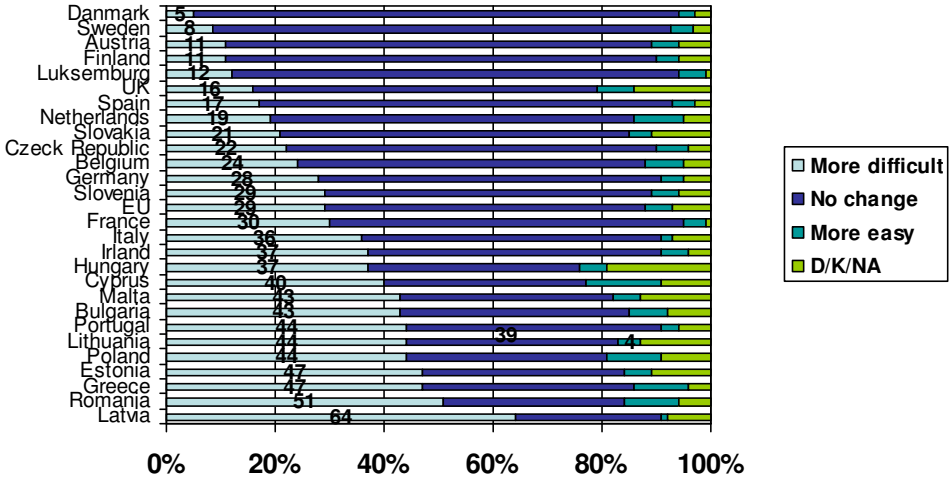
Figure 2.2.4.6: Positive assessment of GP practice in the EU member-states (in percentage)



Source: Special Eurobarometer 283 (2007), Health and long-term care in the EU, European Commission

Figure 2.2.4.7: Opinion of people of the EU member-states on outcomes of the crisis.

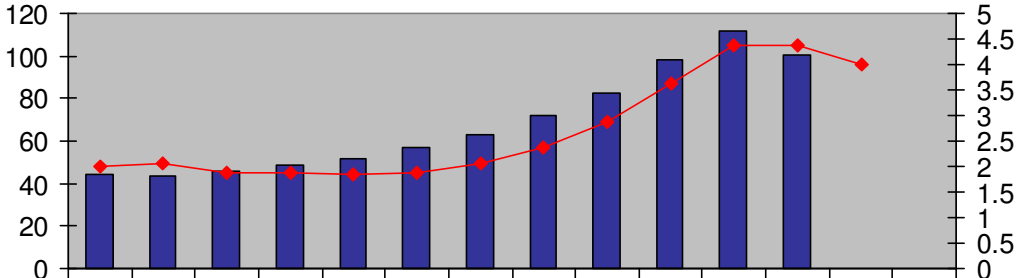
Question: "In the last six months, have you noticed any changes in your ability to afford health care for you or your relatives? (IF YES) Has it become much easier, somewhat easier, somewhat more difficult, or much more difficult?"
Base: all respondents n=1016, % by country



Source: Monitoring the social impact of the crisis downturn: public perceptions in the European Union/ Flash EB Series #286. Survey conducted by The Gallup Organisation, 8 July 2009[43]

Considerable tension remains in the area of stability of the health care system funding. In 2009, the SHIF budget remained on the level of 2008, meanwhile, in 2010 it was reduced by 8.7% (Figure 10.). Furthermore, the third stage of the Restructuring of Health Care Institutions will commence in 2010. Therefore, health indicators of the following period will rely heavily on these circumstances.

Figure 2.2.4.8: GDP and SHIF in Lithuania in 1998-2010



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	
GDP billion LTL	44.6	43.6	45.7	48.6	52.1	56.9	62.7	72.1	82.8	98.1	112	100		
GDP for SHIF billon LTL	1.99	2.05	1.88	1.89	1.83	1.89	2.05	2.36	2.89	3.64	4.39	4.39	4.01	

Source: Department of Statistics and the State Health Insurance Fund, 2010.

[43] Monitoring the social impact of the crisis downturn: public perceptions in the European Union/Flash EB Series #286. http://ec.europa.eu/public_opinion/flash/fl_286_en.pdf.

Summarising the reorganisation of the Lithuanian health care system during the second decade of the independence and after 2001, it should be stated that the deterioration of health indicators was mostly determined by population ageing and emigration, health sector funding and operational inefficiency of other factors external to the health sector, i.e. alcohol, tobacco, and policy on prevention of traumatism, which were not assured due to the priorities set in the health care sector. The public health reform was mostly undertaken in the sense of physical structure changes. Primary health care models ceased to develop. Mostly health care professionals partook in the design of health care policy. Initially, the population was hardly represented in decision-making. The involvement of citizens in the area has intensified just recently. Besides, constant change of senior officials impeded consistency of the continuous health care reform and conditioned the lack of one single sustainable direction. However, the approval of key conceptual documents on parliamentary level (such as the National Health Concept, the Lithuanian Health Programme and the Public Health Programme) conditioned the preservation of health care policy in evidence based conceptual frameworks.

Considering macro- and micro-economic indicators of health care funding, it could be stated that the reorganisation of funding provided health care institutions with more autonomy and stimulated them to undertake more effective planning and utilisation of financial resources. However, this autonomy was conditional due to the rigorous price formation mechanism for the estimation of basic prices for services, i.e., prices for services provided by health care institutions were regulated by the state rather than the market. Thus, according to different estimations, they only amounted to approx. 60-80% of the factual value. Another available management tool for achievement of effectiveness of the system was also used belatedly, i.e. the restructuring of health care institutions involving planning the number and structure of health care establishments on the regional and municipal scale. The Programme for Restructuring of Health Care Institutions was only approved at the end of 2003. As the process of restructuring only commenced in 2004, the results will emerge much later. Due to insufficient participation of the general population in the health care system process as well as the lack of political will, it is hardly likely that health care funding will increase soon (to bring Lithuania closer to the EU average). Thus, it is necessary to invest into prevention of diseases through a more substantial support of prevention programmes and control of implementation as well as search for instruments to stimulate the effectiveness of services.[44]

2.3 Long-term care

2.3.1 Overview of the system's characteristics and reforms

The system of long-term care in Lithuania remained unchanged in 2009. It is provided by health services and financed through the State Health Insurance Fund by health insurance and by municipalities (in this case, the Ministry of Social Security and Labour acts as the policy body). In the case of inpatient care, the health services finance long-term stays amounting up to 120 days. Services related to TB, mental health, palliative care and rehabilitation of patients are financed by the SHIF.

4,436 inpatient beds are allocated to long-term care in Lithuania. This figure amounts to 13.3/10,000 inhabitants. In addition, long-term residential care is provided in residential care homes or other institutions for people with long-term care needs.

[44] D. Jankauskienė, Development of Health Policy and Management. Health Policy and Management. Scientific publications, 2009 (1) p.p. 4-22. Mykolas Romeris University.

The last three years saw the increase in nursing and long-term care beds as well as in the number of hospital beds (Table 2.3.1). Meanwhile, numbers of rehabilitation, TB and mental health beds remained stable.

Table 2.3.1: Long-term care indicators in the Lithuanian health care system during 2007-2009

Indicator	2007		2008		2009	
	Long-term care beds	Hospital beds	Long-term care beds	Hospital beds	Long-term care beds	Hospital beds
Nursing and long-term care	4,243	29,025	4,400	30,765	4,436	31,020
Out of which palliative care	-	-	26	67	43	247
Rehabilitation	1,310	16,042	1,290	16,175	1,320	15,647
TB	1,277	6,132	1,267	5,720	1,231	5,510
Mental health	3,453	38,750	3,453	39,530	3,409	37,436

Source: Health Information Centre of the Hygiene Institute, 2010.

According to data of the national health accounts, long-term care amounts to approximately 7.4% of the Lithuanian health care spending. [45]

In 2009, the provision of home nursing services for people with special needs commenced. They were funded from the SHIF. Furthermore, the scope of palliative care provision was extended and a new service — long-term home medical rehabilitation — was initiated.

According to the data of the Department of Statistics, at the end of 2008, 104 social care homes for the elderly were operated, which housed 5,047 persons. The major part of these homes (56) were established by municipalities, 35 by non-governmental organisations and parishes, and the rest were established by country governors, privately-owned, etc. In 2008, also 26 institutional social care establishments (mainly subordinated to counties) provided social care for 5,300 adults with disabilities.[46]

2.3.2 Overview of debates/the political discourse

As long-term care and services are subject to two sectors, health care and social security, continuous debates on areas of responsibility took place. As inpatient long-term care service is financed by SHIF for stays up to 120 days, it is difficult for the patients and their families with longer-term needs to get continues aid. In this context the Ministry of Health is discussing the possibility of transferring the responsibility of financing long-term care to the municipalities in the hope to improve the continuity of long-term care. Only the crisis and the difficult financial situation of municipalities has postponed this decision so far. It should be underlined that lately the debates have settled down.

In 2009, discussions focused on funding and rates for nursing and long-term care. The special home nursing care service for patients was created and included into the basic package of SHIF services. There is a proposal to set a separate price for nursing services in primary health care too; however, this discussion is temporarily postponed as well. The basic price for

[45] Database of the Department of Statistics, 2009, http://db1.stat.gov.lt/statbank/SelectVarVal/saveselections.asp.

[46] Ministry of Social Security and Labour. Social Report 2009, p.121-122. Data of 2009 are not published yet.

nursing in hospitals is differentiated into five groups of prices, according to the difficulty of the problem. This allows for better nursing quality in health care nursing institutions. 2010 will be a new challenge for long-term care, because the general reduction of the budget is also planned for long-term care.

The Ministry of Social Security and Labour reports that in 2009, LTL 435 million were spent on nursing at home compensations. Those compensations are reduced by 15% in 2010. [47]

2.3.3 Overview of impact assessment

Lately, the social security sector has prioritised outpatient services, i.e. a strategy for the development of social services provided at a patient's home. Therefore, the burden of long-term inpatient nursing and long-term care — especially in rural areas — was placed on the shoulders of the health care sector.

The State Health Insurance Fund reported that the funding for long-term care was increased by LTL 8.5 million (14.8%). This allowed increasing the number of long-term care services (3.4%), even though the price is increasing.

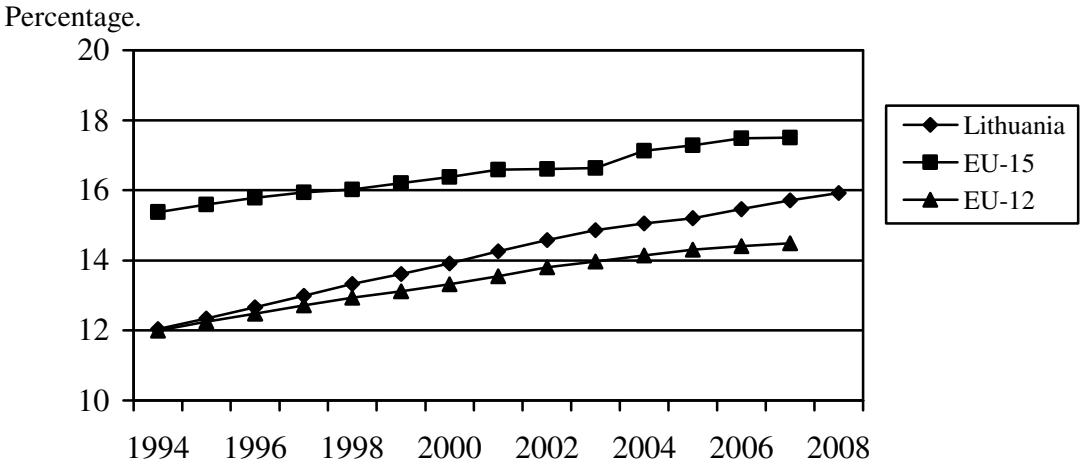
Long-term care services in social care homes for the elderly and disabled are partly paid by the persons themselves. As a rule, not more, than 80% of a person's income are taken as payment. This percentage is increased, in the case when a person's means are above the normative. The normatives are approved according to the local average house prices (as a normative the price of 12 square meters of living space is used). In most cases the difference between the cost of care services and personal payments is covered by the state and local budgets. According to the evaluation of the Social Services Supervision Department, in 2009, patients themselves covered about 34% of expenditures of social care homes subordinated to counties.

2.3.4 Critical assessment of reforms, discussions and research carried out

Long-term care needs are growing due to population ageing and the difficult socioeconomic situation of the elderly (Fig. 2.3.1). Compared to other countries, the average healthy life expectancy in Lithuania is low.

[47] http://www.respublika.lt/lt/naujienos/mokslas/sveikata/ligoti_senoliai_valstybei__nasta/.

Figure 2.3.1: Demographic ageing of the population in Lithuania and the European Union member states in 1994-2008 (the share of the population of 65 and more)



Source: Department of Statistics of the Republic of Lithuania and the WHO database, 2009.

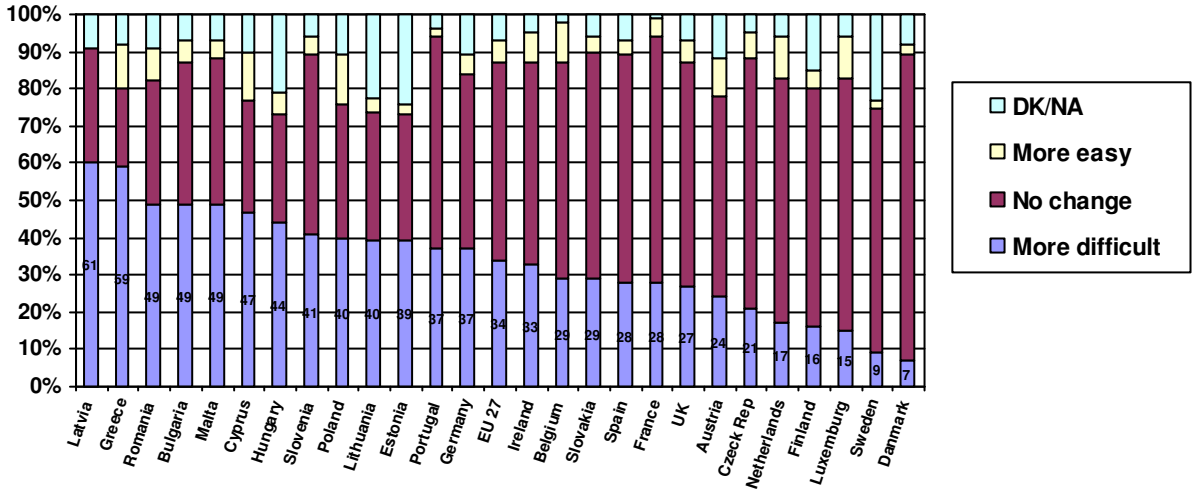
According to the Eurobarometer commissioned by the EC on outcomes of the crisis in 2009, 40% of Lithuanian respondents (those, who provided an answer) — while talking about themselves and their family members — stated that accessibility of long-term care services deteriorated. However, the same percentage of residents thought that the accessibility of such care either did not change at all or even improved[48]. The following Figure 2.3.2 presents the answers to the question: "In the last six months, have you noticed any changes in your ability to afford health care for you or your relatives? IF YES, has it become much easier, somewhat easier, somewhat more difficult, or much more difficult?"

Considering the fact that in 2009, there was no reduction in SHIF funding for long-term care, outpatient home nursing services were introduced and there was neither reduction in long-term care beds nor in the number of institutions, it may be stated that the volume and accessibility of long-term care services remained on a similar level.

[48] Monitoring the social impact of the crisis: public perceptions/ Flash EB Series #276, Survey conducted by The Gallup Organisation, 8 July 2009. http://ec.europa.eu/public_opinion/flash/fl_286_en.pdf.

Figure 2.3.2: Perceived changes in the ability to afford long-term care for the family

Base: those respondents where long-term care was applicable, % by country.



Source: Monitoring the social impact of the crisis downturn: public perceptions in the European Union/ Flash EB Series #286, Survey conducted by The Gallup Organisation, 8 July 2009

In 2008, the Ministry of Social Security and Labour commissioned the research "analysis of social care conformity with the conditions of the licensed activity". The result shows the lack of specialists able to ensure a high quality of social care. More attention should be paid to the development of specialist's qualifications. The layout of premises in many social care establishments is inadequate for the provision of high quality social care services (in particular, they lack facilities for encouraging the skills of personal independence, i.e. occupation, organisation of pastime activities, kitchens for individual cooking, etc.).Social care establishments do not have adequate equipment and facilities (for calling the staff, vehicles for disabled, etc.)[49].

3 Impact of the Financial and Economic Crisis on Social Protection

3.1 General framework

The economic recession accompanied by high unemployment and a decline of working population income strongly affected the social protection system. The main reason is a recession, but in Lithuania there are also some other reasons like unconsidered political decisions.

At the end of 2008, there were elections to the Parliament in Lithuania. The former ruling coalition was led by the Social Democratic Party and had no majority in Parliament. In this situation the Government was not able to resist against the unsound decisions to increase social protection benefits. The coming recession was underestimated.

By the adjustment of social protection benefits, the social insurance expenditures were increased by 36% in 2008. Expenditures for social insurance pensions were increased by 31%. For the support of the minority government the Conservative Party strongly insisted on

[49] Ministry of Social Security and Labour. Social Report 2009, p.123.

the extension of family policy. Amongst other measures, the two-year paid maternity leave was introduced, and expenditures for maternity and paternity benefits increased by around 130%[50]. In 2008, it was still possible to pay the benefits at such a relatively high level by using a social insurance reserve fund (around 10% of the whole annual social insurance budget).

At the end of 2008, after the elections the new ruling coalition, headed by Conservative Party, came into power. Before they were elected, they had declared very ambitious plans to extend social policy and especially family policy. When the new government realised how deep the recession was, however, it concentrated mainly on the aim to ensure financial viability of the social protection and its capacity to protect the most vulnerable people. The restructurisation of the social protection system was also declared as a necessary measure to reach the mentioned aim. It was also clear that the employment policy was of utmost importance, and that the Government should be concentrating on efforts to get the situation on the labour market stabilised, to increase the employment possibilities, to secure reintegration of dismissed employees into the labour market and to avoid long-term unemployment.

As it was reported above, the Government decided to take some immediate actions, other actions were postponed to the beginning of 2010, and some more actions declared as necessary structural changes for the future.

3.2 Pensions

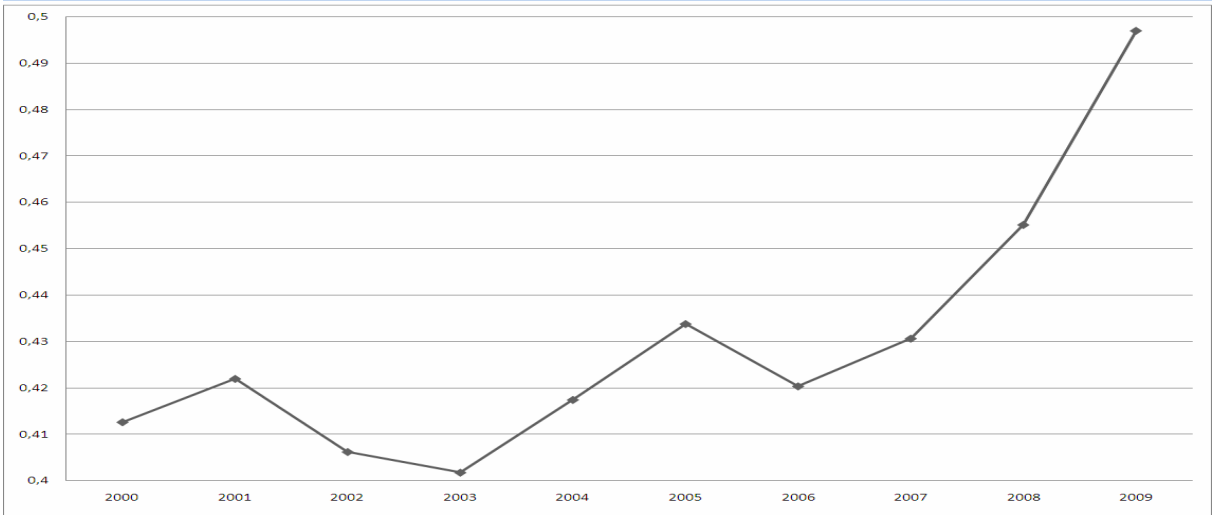
In 2009, the pensions were not decreased. The average old-age pension remained intact, it even increased by 5.88% (compared to the average of 2008) due to the decisions taken in mid 2008.

Because of the decline of the average wage in 2009, the average old-pension relation to the net average wage (macro replacement rate) increased considerably[51]. In Lithuania, the replacement rate had never been as high as it was in 2009 (see Figure 3.2.1).

It seems that in the first year of recession, the living standard of retired people was not much affected (and remained as low as it was before – see 2.1.2.2). According to the data of the Department of Statistics[52], the price index did not change much – inflation in 2009 was 1.3%. However, transportation costs increased by 12.4%, water supply and services related to housing by 14.8%, electricity by 6.8% (and, additionally, by 33% in 2010), health protection services by 14.4%. On the other hand, the prices of food decreased by 4.4%, clothing by 8.3%, hot water and centrally supplied heat by 11.3%.

[50] Valstybinis socialinis draudimas: statistiniai duomenys 2008 m. Vilnius, 2009.
[51] Pensions are not taxed in Lithuania, so the comparison to net average wage is reasonable.
[52] http://db1.stat.gov.lt/statbank/default.asp?w=1280.

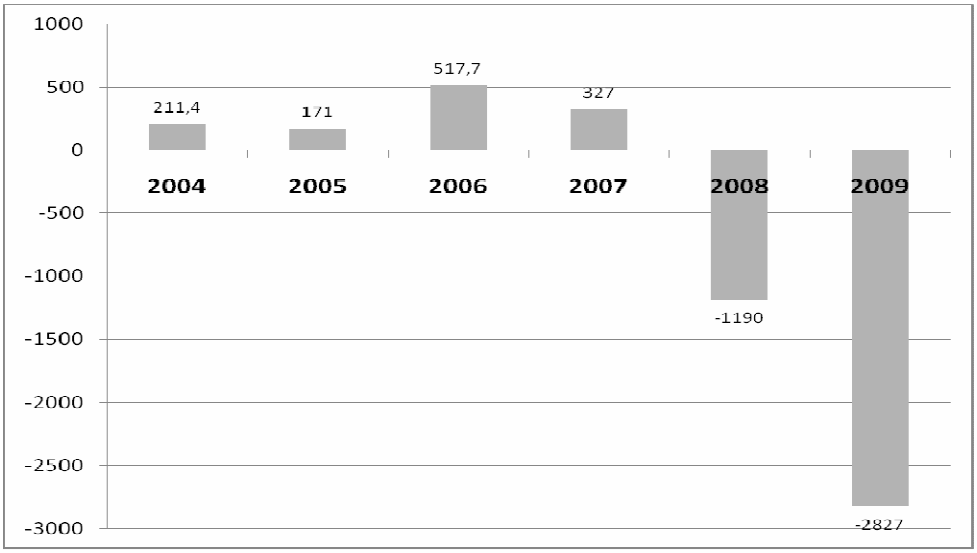
Figure 3.2.1: Average old-age pension related to the net average wage



Source: Author's calculations according to annual reports of Department of Statistics www.stat.gov.lt and annual reports of State Social Insurance Board. www.sodra.lt.

In the years 2008-2009, the social insurance budget entered into essential deficit. The number of social insurance contributors in 2009 decreased by more than 10%, and their contributory average wage was by 7.6% lower than in 2008. According to the State Social Insurance Board report, the first reason resulted in around LTL 1 billion, and the second in LTL 1.5 billion deficit. The total deficit in 2009 was LTL 2.83 billion (2.4 months of average monthly social insurance expenditures).

Figure 3.2.2: State Social Insurance budget surplus and deficit (million LTL)



Source: State Social Insurance Board Report to the Council. April, 2010.

The deficit was covered by borrowing money from national and international sources. The total amount of Social Insurance Fund loans at 31 December 2009 was LTL 3 billion, LTL 2.9 billion of this sum was borrowed by the Ministry of Finance and directed to the Social Insurance Fund, in order to ensure regular payment of benefits. It is no decided today who

will pay back the debt, the State or the Social Insurance Fund itself. However, the Law on State Social Insurance states, that the state should cover the deficit if it is a consequence of parliament or government decisions (Art.20).

The expenditures for all social insurance pensions in 2009 were LTL 8.26 billion, or 8.95% of GDP. In comparison with 2008, the expenditures increased by 3.5%.

In the Lithuanian case the level of almost 9% of GDP for pension expenditures was very high and never noticed before, but, unfortunately, achieved mainly due to the fall of GDP. In 2008, the expenditures for all social insurance pensions were only 7.2% of GDP, and in previous years also around 7% or even less.

A shrinking number or contributors changed the ratio of contributors and pensioners much to worse. In 2009, there were 1.45 contributors for one old-age and incapacity pension recipient, in 2008 this figure was 1.64.

The recession also affected savings in pension funds, but the main decline was noticed in 2008. The year 2009 was a year of modest recovery. The average value of investment unit of all "second pillar" funds during 2009 increased by 17.31% on average. Table 3.2 shows a list of the types of pension funds and their increase in 2008 and 2009. However, as can be seen in the table, in 2008, all types of pension funds (except conservative) lost a lot, and the growth in 2009 did not restore the losses.

It should be noticed, that the rate of growth of investment unit do not fully show the rate of growth of personal assets of the participants. Due to deductions from contributions, the latter is lower, especially in the first years of participation of pension funds.

Table 3.2.1: Performance of "second pillar" pension funds

Type of pension fund	Increase of investment unit value in 2009, %	Increase of investment unit value in 2008, %
Conservative	**8.01**	**2.94**
Small share of equities (up to 30%)	**13.36**	**-12.00**
Medium share of equities (30-70%)	**21.60**	**-27.47**
Large share of equities (up to 100%)	**27.56**	**-54.91**
Weighted average	**17.31**	**-19.71**

Source: Surveys of the Securities Comission, retrieved at:
http://www.vpk.lt/new/documents/vnt%20pokyčiai%20iki%202009-12-31.xls.

The annual reports of the State Social Insurance Board shows, that in the years 2004-2009 LTL 3.362 million were transferred to the „second tier" funds, but at the end of 2009 their total assets were worth LTL 3.262 million. So in six years of performance, pension funds rather lost than gained profit. Without any doubt, the economic recession strongly influenced this result.

The losses of pension funds do not affect the total level of pensions much, because there are no beneficiaries. Much more affected from the beginning of 2010 were social insurance pensioners. As reported above, the value of their pensions declined in average by 4.5%, but for those with bigger pensions as well as for working pensioners much more – up to 15% and up to 70%, respectively (see 2.1.7.2).

3.3 Health care

Prior to the economic and financial downturn, the growth of GDP conditioned a considerable increase of the SHIF budget. The increase was mostly related to the growth of health care staff salaries during 2005-2008. The SHIF budget for 2008 totalled LTL 4.387 billion (EUR 1.284 billion). LTL 4.687 billion (which is LTL 300 million or 6.84% more than in the previous year) were allocated and approved for 2009.[53] The reduction in tax revenue and the increase of unemployment aggravated the collection of SHIF budget. Thus, at the end of December 2008, the state budget was revised and LTL 4.388 billion (which is LTL 298.6 million or 6.4% less than initially planned) were approved[54]. As Table 3.3.1 shows, different budget items were reduced.

Table 3.3.1: Reduction in the approved SHIF expenditure for different types of services in 2009

Type of expenditure	Reduction in percentage
Overall decrease in expenditure	6.4
Personal health services	6.23
Compensations for medicinal products and medical aids	4.0
Compensations for stays in sanatoria and rehabilitation centres	10
Medical aids and centralised purchasing expenditure	4
Orthopaedic aids	9
Expenses for health service programmes	14.85
Administrative expenses	6.37

Source: data of the State Health Insurance Fund, 2009.

In 2009, following the reduction of the planned SHIF budget and aiming to avoid any deterioration in accessibility of health care services, the decision was made to reduce spending for all types of personal health care services, by setting the basic price point value at LTL 0.89. This measure aimed to stimulate health care institutions to reorganise as well as rationally use funds of the SHIF budget, still providing all services required by the patients, without the reduction of service volumes, yet aiming to identify the most economically effective forms of services, i.e. a day surgery, a day inpatient department, observation services, short-term care and etc. In comparison to 2008, the number of services provided by day inpatient departments increased by 9% in 2009, meanwhile the increase of services provided by day surgeries increased by 12%, and short-term care services grew by 9%. The overall volume of services provided in the inpatient setting increased by 1%. The wages of staff working in health care institutions were reduced by approx. 10%.

In 2009, seven budgetary public health institutions and establishments were reorganised by merger. In total, 273 posts were relinquished subsequent to reorganisation of institutions and establishments subordinate to the MoH. This provided for almost LTL 1 million in savings. In 2009, the SHIF budget savings reserve, amounting to LTL 331 million accumulated in 2008, came in handy, as it was utilised prior to initiation of other anti-crisis measures. In 2009, an

[53] Information supplied by the State Patient Fund to the MoH, August 2009. *Official Gazette Valstybės Žinios*, 30 December 2008, No.: 149, Publ. No.: 6021.

[54] Law on Approval of the State Patient Fund Indicators. *Official Gazette Valstybės Žinios*, 2009.05.12, No.: 54, Publ. No.: 2135.

independent health insurance tax detached from the personal income tax was introduced in the health care system as well as a uniform rate of premiums amounting to 9% of earnings (some exceptions apply). Furthermore, the list of health insurance tax payers was expanded, and a more robust control of tax collection was established. The premium for the state insured was increased from LTL 428 to LTL 605.3 (41.35%). In the budget for 2010, LTL 744.7 was approved.

The working hours of outpatient care specialists were levelled, as stated above (see page no 24).

After May 2009, the point value for all services reimbursed from the SHIF budget was reduced by 11%, although, exceptions were made considering the priorities given to primary health care and disease prevention. No cutbacks applied to primary outpatient health care, prevention programmes, specialised outpatient services alternative to inpatient care, and emergency care, as well as day inpatient department, day surgery, inpatient observation (up to 24 hrs.) and short-term care (up to 72 hrs.) services. Indications for inpatient care were tightened. The point value of the sum added to the annual basic price for PHC services provided to each resident of rural areas or small settlements was maintained at the same level (i.e. 1 point = LTL 1); as well as the point value used for calculation of premiums paid to family doctors for good performance. Priority was given to prevention services. An additional prevention programme targeting early diagnostics of colorectal cancer was initiated (LTL 1 million were allocated). Outpatient rehabilitation was encouraged, the duration of inpatient rehabilitation was optimised, and indications were tightened. Instruments for regulation of SHIF budget spending on reimbursable medicinal products were utilised: in the second half of 2009, a preferential 5% VAT rate applied for reimbursable medicinal products; no new medicinal products were included into the list of reimbursable medicinal products. The quantity of generic medicinal products was increased, i.e. reimbursement for a number of generic analogues commenced; the price for the first generic analogue was reduced by 30%; the state entered into agreements with manufacturers of pharmaceutical products regarding limitation of volumes of sold medicinal products (10 agreements have been made so far). As a result, the revenue and spending of the SHIF budget remained in balance. Health care institutions and pharmacies were paid in a timely manner, rather than early. Accessibility of services for the general population was ensured. Under conditions of the economic downturn, prevention was further developed.

No major deterioration of health indicators was registered, with the exception of an insignificant increase of morbidity with myocardial infarction and neoplasms (which could be due to the prevention programmes for early detection of diseases) (Table 3.3.2).

Table 3.3.2: Numbers of people diagnosed with listed disorders at least once, in 2008 and 2009 (data of the Lithuanian Health Information Centre using SVEIDRA information system of the State Health Insurance Fund)

Title of the diagnosis	Code according to TPF-10	2008	2009	Change	
				Absolute (+,-)	Percentage (%)
Mental and behavioural disorders (F00-F99),including	Abs. no.	85,451	81,090	-4,361	-5.1
	1,000 pop.	25.45	24.28	-1.16	-4.6
Mood (affective) disorders (F30-F39)	Abs. no.	12,812	12,271	-541	-4.2
	1,000 pop.	3.82	3.67	-0.14	-3.7
Diseases of the circulatory system (I00-I99), including:	Abs. no.	127,167	123,955	-3,212	-2.5
	1,000 pop.	37.87	37.12	-0.75	-2.0
Ischemic (coronary) heart disease (I20-I25), including:	Abs. no.	17,023	15,994	-1,029	-6.0
	1,000 pop.	5.07	4.79	-0.28	-5.5
Acute and subsequent myocardial infarction (I21-I22)	Abs. no.	6,902	7,003	101	1.5
	1,000 pop.	2.06	2.10	0.04	2.0
Cerebrovascular diseases (I60-I69)	Abs. no.	16,137	15,476	-661	-4.1
	1,000 pop.	4.81	4.63	-0.17	-3.6
Diseases of the nervous system (G00-G99)	Abs. no.	130,089	119,693	-10,396	-8.0
	1,000 pop.	38.74	35.84	-2.90	-7.5
Neoplasms (C00-D48)	Abs. no.	73,330	74,356	1,026	1.4
	1,000 pop.	21.84	22.27	0.43	2.0

Source: Health Information Centre of the Institute of Hygiene, 2010 (advance data).

In 2009, the number of outpatient specialised, short-term care and inpatient personal health care services provided to patients and paid by territorial sickness patient funds amounted to more than LTL 8.871 million, which is more than in 2008. Health care institutions and health care professionals had to carry a portion of the burden that emerged due to the economic downturn. Some health care institutions were already facing a number of challenges at the beginning of 2009, when patient funds had to relinquish the advance payment model and undertake payment only for actually delivered services afterwards.

In 2009, reimbursement of pharmaceutical products and medical aids amounted to more than LTL 700.5 million. In 2009, reimbursement of acquisitions amounted to LTL 51 million less than planned, as the value added tax relief for reimbursable pharmaceutical products and medical aids was extended until 1 January 2011. In 2009, 11.4 million prescriptions for reimbursable pharmaceutical products and medical aids were issued (approximately the same as in 2008); the average prescription price has slightly increased and amounted to LTL 61.

Thus, judging by the current data, the financial and economic downturn did not result in significant health losses in Lithuania. Health care institutions suffered through the reduction of funding and faced the challenge to ensure no deterioration in accessibility of health care services. No significant deterioration in accessibility of services was registered. However, subsequent to budget cuts in 2010 amounting to 8.7% and upon commencement of the third stage of the restructuring of health care services, even greater challenges are pending for the health care system in Lithuania.

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4 Abstracts of Relevant Publications on Social Protection

[R] Pensions
- [R1] General trends: demographic and financial forecasts
- [R2] General organisation: pillars, financing, calculation methods or pension formula
- [R3] Retirement age: legal age, early retirement, etc.
- [R4] Older workers activity: active measures on labour market, unemployment benefit policies, etc.
- [R5] Income and income conditions for senior workers and retired people: level of pensions, accumulation of pensions with earnings from work, etc.

[H] Health
- [H1] Health expenditures: financing, macroeconomic impact, forecasting, etc.
- [H2] Public health policies, anti-addiction measures, prevention, etc.
- [H3] Health inequalities and access to health care: public insurance coverage, spatial inequalities, etc.
- [H4] Governance of the health system: institutional reforms, transfer to local authorities, etc.
- [H5] Management of the health system: HMO, payments system (capitation, reimbursement, etc.)
- [H6] Regulation of the pharmaceutical market
- [H7] Handicap

[L] Long-term care

[R1, R2, R3] BARTKUS Algirdas, Senatvės pensijų ir laikinojo nedarbingumo išmokų finansinio tvarumo analisė. Daktaro disertacija. 2009, Vilnius, 185 p.
"The Analysis of Financial Sustainability of Old-Age Pensions and Sickness Benefits. Doctoral dissertation"

The impact of macroeconomic factors on the old-age pension system in Lithuania is analysed. The cyclical nature of pension system development is described. Special attention is paid to the indexation policy of the Lithuanian pension system. The ways to balance social insurance budget and to address the problem of ageing are proposed. The performance of "second pillar" pension funds and their place in the social protection system is analysed.

[R2] GUDAITIS Tadas (2009). Senatvės pensijų sistemos modelių teorinė analizė. Organizacijų vadyba: sisteminiai tyrimai. 2009 Nr. 50, p. 53-68.
"Models of old-age pension systems: theoretical analysis"

The models of old-age pensions are presented and analysed. Lithuanian model evaluated in this context.

[R2] LAZUTKA Romas, Lietuvos socialinio draudimo pensijų dalinio privatizavimo tikslai ir rezultatai. Ekonomika. 2008, t. 82. ISSN 1392-1258 pp. 104-126.
"The aims and results of partial privatisation of Lithuanian social insurance pensions"

In the article, the history of pension reform is presented and evaluated. The author argues, that financing pension reform transitional costs comes into conflict with the financing of current pensions. High transitional costs have a negative impact on the social insurance pension budget, and it will last for several decades. If these resources had been left for the financing of the social insurance pensions, they would have been 20% higher. These are implicit costs of the pension reform, which are paid by the present generation of pensioners. Prior to the reform, one of the arguments was the necessity to increase investment into the national economy. However, 90% of pension assets are invested abroad, and there are very few investments into shares of domestic companies. Moreover, heavy investments in public versus private assets, high

administrative costs, the oligopolistic pension industry, and low competition because of consumers' myopia have a negative impact on the future pension benefits.All the parties involved in the reform designing argued for the necessity of the reform implementation by referring to the current problems, which cannot be resolved by the reform. Moreover, they set objectives that may hardly be obtained by the reform in its implementation. The content of the reform is very narrow if compared with what was planned at the beginning of the reform discussion and what the initial reform documents mentioned. On the contrary, the reform has a list of negative consequences on the current and future pensioners' welfare.

[H] Health

[H2] POVILANSKIENE, Rasa/ JURKUVENAS, Vytautas, Visuomenes sveikatos programu vertinimas, 2009, Public health, Vo;.4, p.25-36
"Evaluation of Public Health Programmes"

Public health programmes should be evaluated during their early planning, after the programme has started and after their implementation. Programme evaluation can be defined as systematic and objective determination of the quality or value of the programme by gathering, analysing and interpreting information. Evaluation assesses not only the value of the programme, but also provides useful feedback by deciding that there is something good or bad, true or false. Broader speaking, by assessing the impact, value and quality of the programme, the programme's efficiency is enhancing and its implementation is improving. Well-conducted assessment provides reliable and useful information that enables decision-making and ensures continuous improvement of programme implementation. The article reviews the main types of programme evaluation, principles, models and methods, which need to be known when planning public health programme evaluations.

[H2] MIKELAITYTE Rita,/ JANKAUSKAS, Remigijus, Mokslinių tyrimų rezultatų panaudojimas formuojant visuomenės sveikatos politiką, 2009, Public health, Vol 3, p. 10-15.
"Impact of Scientific Research on Public Health Policy Making"

Nowadays, scientific information becomes more and more significant. Society is interested in scientific news, however, evidence-based information is not always accessible. The effective communication of scientific news does not only enlarge the privacy of society, but also promotes evidence-based decision making in politics. The aim of this article is to review certain scientific material in respect of the impact of scientific facts on public health policy and decision making. This article includes the information about the publication of the results of scientific research as well as employment of the results in the public health policy in Lithuania.

[H2] KENIAUSYTE, Inga/ CEPULIS, Rolandas, Lietuvos sveikatos programos demografinių ir sveikatos rodiklių įvertinimas 1997–2008 m. ir palyginimas su Europos Sąjungos šalimis, 2009, Public health, Vo; 3.p. 20-27.
"The Evaluation of the Lithuanian Health Programme Demographic and Health Indicators in 1997-2008 and Comparison with the European Union Countries"

The object of this research is the evaluation of the Lithuanian Health Programme demographic and health indicators implementation in 1997-2008 and the comparison of mentioned indicators with the appropriate indicators of the European Union countries. The comparative method, data regression analysis, using SPSS v.15.0 software package were used. The paper analyses the Lithuanian residents' health indicators in 1997-2008, which are compared with the indicators stated in Lithuanian Health Programme and other governmental programmes, also with the appropriate

indicators of the European Union countries. According to the implementation process, indicators can be divided into three groups. Implemented indicators are infant mortality, incidence of syphilis, gonorrhoea, HIV/AIDS. The incidence of active tuberculosis is a partly implemented indicator. Not implemented indicators are the average of future life expectancy, the morbidity of malignancies and alcohol psychosis.

[H2] BROGIENE, Daiva Brogienė/GUREVICIUS, Romualdas, Pacientų nuomonė apie stacionarinės sveikatos priežiūros paslaugų kokybę, 2009, Medicina Vol. 45(3), p 226-236. "Inpatients' opinion on quality of health care"

The aim of the study was to assess the inpatients' opinion on the quality of hospital care based on the factor analysis and to identify the problem-oriented fields in quality of care. A multistage stratified probability sampling was performed in 22 general hospitals in Lithuania. A total of 2,060 questionnaires were distributed during November 2006 and February 2007. The response rate was 97.38%; 2,006 inpatients responded to the questionnaire; 1,917 questionnaires (93.06%) were eligible for analysis. The modified survey instrument of Picker Institute Europe was used for inpatients. The method of survey was follows: each discharged inpatient filled out the questionnaire on the day of his/her discharge. The assessment of quality of care involved such aspects as patients' communication with medical personnel, organisational issues and coordination of care, patients' possibility of participation in medical decision-making, physical environment, accessibility to services, and safety of health care. Patients gave highly positive responses on the overall evaluation of the quality of health care services. The priority field in the improvement of health care quality is to create more possibilities for patients' participation in medical decision-making. Results of the present study indicate that future studies need to include more detailed measurements of patients' autonomy as dynamic changes are observed today in this field.

[H2] GRABAUSKAS, Vilius / PROCHORSKAS, Remigijus, Associations Between Mortality and Alcohol Consumption in Lithuanian Population, 2009, 45 (12): 1000-1012.

The objective of the study was to assess alcohol-related mortality, which might potentially explain an increasing trend in overall mortality of Lithuanian population, which started after 2000 and peaked in 2005. An empiric analysis of national mortality and other statistical data as well as their international comparisons was made. A comparative analysis demonstrated that mortality and alcohol consumption trends were going in parallel over the last decade. The systemic decline in mortality observed in Lithuania from 1995 stopped in 2000 after a decrease in alcohol taxes, which resulted in an increase in alcohol accessibility and consumption. An average annual increase in alcohol consumption over the period of 2001–2004 was 7%; it increased up to 17% in 2005 and accounted for 12% annual increase on average within 2005–2007. Negative trends in alcohol-related morbidity and mortality in the Lithuanian population, most notably registered in 2001 and 2005, were largely influenced by uncontrollable increase in alcohol consumption over the last decade. Economic and commercial arguments in decision-making process that neglected health interests of the Lithuanian population (decrease of alcohol taxes in 1999, other factors increasing alcohol accessibility and consumption) were those counteracting the implementation of a balanced health policy in the country.

[H3] GUREVICIUS, Romualdas/DRULYTE, Gerda, Prarastų gyvenimo metų dėl išorinių mirties priežasčių kiekis, dažnis ir vertė Lietuvoje 2000–2006 m., 2009, Public health, Vol. 4, p. 61-73.
"Years and Valued Years of Life Lost Due to External Causes of Death in Lithuania, 2000-2006"

The aim is to evaluate years of potential life lost (YPLL) and valued years of potential life lost (VYPLL) due to external causes of death in Lithuania, 2000-2006. Potential economic losses to society were estimated by use of YPLL with a cut-off point at age 65 and VYPLL using sex and rural/urban area-specific life expectancy and age-specific weights of investment-producer-consumer model. Mortality measures were calculated for all injuries and for six separate groups (traffic accidents, falls, drowning, alcohol poisoning, suicide and violence).YPLL and VYPLL provide higher weights for deaths at young age and can be used to highlight premature deaths. Those indices, as specific mortality measures, can be reliably used in the evaluation of premature deaths and potential economic loss to society caused by those deaths and should be taken into consideration when setting public health priorities and allocating public health recourses, especially, when they are limited.

[H3] GERASIMAVICIUTE, Vaida/ GUREVICIUS, Romualdas, Mirtingumo nuo išorinių priežasčių ir savižudybių dinamika Lietuvoje 1996–2008 metais: skirtumai tarp amžiaus ir lyties , 2009, Public health Vol 4, p.89-99.
"Mortality Trends from External Causes and Suicide in Lithuania –Age and Gender Differences"

The aim of the study was to determine the trends of mortality from external causes and suicide in Lithuania by age categories and gender in 1996-2007. Methods: Mortality from all external causes (by ICD-10 coding V01-Y98) and separately from suicide (by ICD-10 coding X60-X84) was analysed. The annual mean of the Lithuanian male and female population, numbers of deaths from external causes and from suicides based on five-year age groups was used. Mortality rates (per 100,000 persons), weighted standard error (SE), were calculated. The following indices were calculated: annual absolute change (AAC), annual percentage change (APC), 95% confidence intervals, changes were considered significant, when $p<0,05$. Results by gender were presented. There is a potential need of deeper studies, looking for socioeconomic risk factors of different age categories and gender in urban/rural places.

[H4] JANKAUSKAS, Remigijus, Sveikata restruktūrizavimo metu: ar esame pasirengę įgyvendinti Europos Sąjungos rekomendacijas Lietuvoje? 2009, Public health Vol 4, p.5-8.
"Health in Restructuring: Are We in Lithuania Ready to Implement EU Recommendations?"

Management of change that is escalating both on a qualitative and quantitative dimension demands for new knowledge, methods and experience, which in these crucial and difficult times were offered by the HIRES Plus Project promoters and experts. Although the relevance and timeliness of the issue raises no doubts, it revealed some internal problems particular to the country as well as the need to seek for new communication methods among the national social partners. Some important stakeholders, such as representatives of employer organisations, media and NGOs, are concerned about the impact of the restructuring on health. A presentation of round-table discussions that took place in the course of the seminar demonstrates the issues analysed and considered in the form of a social dialogue.

[H4] JANKAUSKIENE, Danguole, Sveikatos politikos raida Lietuvoje ir perpektyvos, Regnum est. Monograhy. Mykolas Romeris university, 2010. P. 845-866.

"Development of Health Policy and its Further Perspectives in Lithuania"

The evaluation of health policy development by explaining historical and public policy development aspects is presented in the monograph.

[H4] JANKAUSKAS, Remigijus/ JASIUKEVICIUTE, Toma, Restruktūrizavimo poveikis sveikatai, 2009, Public health, Vol 2. , p. 7-14.

"Restructuring and Health Outcomes"

This article is an attempt to systematise the scientific knowledge in this topic and describe the most relevant trends of outcome on health of restructuring. Scientific substantiation about potential effects of restructuring for people, who lost their jobs, "survivors" of layoffs and theirs families as well as for managers of the process and the society are represented. The probable after-effect of restructuring includes the psychosocial environmental changes, physical and psychological impairment as well as somatic illnesses.

[H5] KANAPECKIENE, Virinija/ JURKUVENAS, Vytautas, Nepageidautini įvykiai sveikatos priežiūros sistemoje ir jų priežastys, 2009, Public health, Vo;. 4, p.44-50.

"Adverse Events in Health Care and Their Causes"

Patient safety was declared as a priority direction of the health policy in the European Union. Patient safety is important for the structure and processes of heath care, and reduces the number of adverse events, which impact on health care. This publication reviews the definition of adverse events, their nature, sources, prevalence (frequency), patients' and doctors' attitudes to health care and adverse events, the possibility of patients' participation in improving patient safety, adverse events' reporting systems and their purpose, the situation in terms of adverse events in Lithuania and in the European countries.

[L] Long-term care

[L] BERZANSKYTE, Aušra Beržanskytė/VALENTELIENE, Rolanda, Antibiotiku vartojimas Lietuvos slaugos ligoninese, 2009, Public health, Vol 3, p.

"Antibiotic Use in Lithuanian Nursing Care Hospitals"

Antibiotic use has never been analysed in Lithuanian nursing hospitals. Therefore the study was carried out to evaluate antibiotic consumption and influencing factors in those institutions. 50 nursing hospitals were involved into the study. Their size varied from 10 to 268 beds. Data were collected in two stages: 1) data about the real consumption (antibiotics purchased by hospital during one year) and risk factors were collected by two questionnaires filled by hospital representatives; 2) the explication of the information was gained in discussions with focus groups. The consumption of antibiotics was analysed calculating the number of defined daily doses (DDD)/100 bed-days). The study showed that antibiotic consumption in Lithuanian nursing hospitals is not high, but broad spectrum penicillins prevailed more. The guidelines on antibiotic use were mentioned in just a few hospitals, the microbiological tests are rarely done.

5 List of Important Institutions

Lietuvos Respublikos Socialinės apsaugos ir darbo ministerija - Ministry of Social Security and Labour of the Republic of Lithuania

Address: A.Vivulskio str. 11, 03610 Vilnius, Lithuania
Webpage: http://www.socmin.lt

The mission of the Ministry of Social Security and Labour is to implement effective social security and labour policy seeking to create opportunities for qualitative employment and to ensure social safety within the society, family welfare, and social cohesion. In collaboration with subordinate institutions, municipalities, social partners, non-governmental organisations and other concerned institutions the ministry ensures functioning, regulation and improvement of the state social insurance, social support and labour system. The ministry drafts laws of the Republic of Lithuania, resolutions of the Government and other legal acts within the scope of its competence, implements labour marke policies, labour market vocational training policy, health and safety at work policy and labour remuneration policy, implements the state social insurance and pensions policy, implements the state policy on social assistance and social guarantees for low income residents, implements the policy on social assistance and labour of children, youth, families, sets the main trends for social integration of the disabled and manages their social integration process, analyses the policy on social security and labour, social groups policy, economic justification of policies, forecasts basic social indicators. The ministry also coordinates the preparation for administration of assistance of the EU structural funds to develop human resources.

Valstybinio socialinio draudimo fondo valdyba - State Social Insurance Fund Board

Address: Konstitucijos pr. 12, LT-09308 Vilnius
Webpage: www.sodra.lt

The State Social Insurance Fund Board, under the Ministry of Social Security and Labour (frequently referred to as "Sodra") is the institution engaged in administration of the public Social Insurance Fund, responsible for coordination and methodical management of the territorial offices under its direct subordination, in order to ensure effective and high quality work of such territorial offices and other subordinate institutions, as well as perform controls over them. The main function of "Sodra" is ensuring the enforcement of legal acts in regulation of the state social insurance. It collects social insurance contributions (including those covering unemployment insurance) from employers and the self-employed, and calculates and pays out contributory benefits (except unemployment benefits). The website, in Lithuania, provides a wide range of information on pension entitlements, contributions requirements, benefit types and entitlements etc. A limited version of the website is available in English.

Socialinių paslaugų priežiūros departamentas - The Social Services Supervision Department

Address: A.Vivulskio st. 16, LT-03115 Vilnius
Webpage: http://www.sppd.lt/

The Social Services Supervision Department under the Ministry of Social Security and Labour performs the following functions: provides methodological assistance regarding application of social care norms and control of quality of general social services and social care; establishes common practice of application of social care norms and requirements for

general social service and social care; licensing and monitoring against license requirements; controls the process of individual/family needs assessment; administers social programmes and projects at the state level and controls how the allocated funds are used; administers social programmes and projects at municipal levels and controls how the allocated funds are used; administers IT systems (registers) related to the implementation of state social programmes and projects; deals with citizens' and other persons' complaints and suggestions regarding the quality of services provided by social institutions; cooperates and shares good practice in the field of social security with relevant Lithuanian and foreign institutions and international organisations. The organisation has a limited English-language website.

Neįgalumo ir darbingumo nustatymo tarnyba - Disability and Working Capacity Assessment Office

Address: Švitrigailos g.10, 03223 Vilnius.
Webpage: www.ndnt.lt

The Disability and Working Capacity Assessment Office under the Ministry of Social Security and Labour is the public administration institution entitled to define the level of incapacity for work of insured persons of working age (above 18 years old and before retirement age). The institution is also responsible for the defining of the need of professional rehabilitation and special services for persons of working age incapable for work. The institution participates in implementing the policy of social integration of the disabled.

Lietuvos Respublikos sveikatos apsaugos ministerija - Ministry of Health of the Republic of Lithuania

Address: Vilnius str. 33, LT-01506 Vilnius, Lithuania
Webpage: http://www.sam.lt

The Ministry of Health coordinates and administers all issues concerning the health sector. To pursue its goals and tasks, the ministry implemented specialised departments (e.g. Health Policy and Economics Department; Personal Health Care Department) for the health sub-sections. Additionally, there are different institutions (e.g. Public Health Service, Medical Audit Inspection, State Health Care Accreditation Service, Lithuanian AIDS Centre; Hygiene Institute, Vilnius University Hospital Santariškių Clinics, Kaunas University Clinics, etc.) under the Ministry of Health.

Valstybinė ligonių kasa - State Patient's Fund (SPF)

Address: Kalvariju g 147, LT-08221 Vilnius
Webpage: www.vlk.lt

The State Patient's Fund, under the Ministry of Health, is responsible for the disbursement of funds to health providers in order to pay for treatment. These funds are collected from the tax system, the social insurance system (depending on the type of contributor) and the state budget, and then allocated to the SPF's five regional branches for disbursement. Each location in Lithuania has a branch of the regional SPF which can be accessed by members of the public who have questions in relation to their state health insurance coverage. The website has a (slightly flawed) and limited version in English, providing also information for tourists.

Lietuvos Higienos institutas – Hygiene Institute

Webpage: www.hi.lt

This organisation is a scientific institution. The Hygiene Institute under the Ministry of Health cooperates with the World Health Organisation and other international organisations. Its department Health Information Centre provides a range of statistical data in relation to Lithuanian health care, both in English and Lithuanian, although the Lithuanian version also allows a database search.

Vilniaus universitetas - Vilnius University

Ekonomikos fakultetas - Faculty of Economics

Address: Sauletekio 9, Vilnius

Webpage: www.ef.vu.lt

Filosofijos fakultetas. Socialinio darbo katedra. - Faculty of Philosophy. Social Work Department

Address: Universiteto g. 9/1, 309, 310, Vilnius

Webpage: www.fsf.vu.lt

Both mentioned faculties of Vilnius University carry out research and teaching courses on social protection issues, social protection economics at bachelor, masters and doctorate levels. Being also involved as experts in practical policy making, academic teachers of the university present the most in-depth understanding of Lithuanian social sector economics and politics.

Mykolo Romerio universitetas - Mykolas Romeris University

Address: Ateities 20, LT-08803 Vilnius. Phone: 00370 5 2714617

Webpage: http://www.mruni.eu

This is a social sciences university teaching four master degree 90 ECTS credits programmes for health care system: health law, health policy and management, health organisation administration and health economics. It carries out research into public policy and management in areas related to health care. The Lithuanian website has some information on publications in English. The English part of the website is limited.

Kauno medicinos universitetas - Kaunas University of Medicine

Address: A. Mickevičiaus 9, LT-44307 Kaunas . Phone: 00370 37 327201

Webpage: http://www.kmu.lt/index.php?cid=418

This department of public health in Kaunas Medical University teaches and carries out research into public health areas related to health care. The Lithuanian website has some information on publications in English, though is not currently up-to-date. The English part of the website is almost non-existent.

Lietuvos socialinių tyrimų centras - Lithuanian Centre of Social Research

Address: Saltoniškių g. 58, LT-08105 Vilnius

Webpage: www.dsti.lt; www.sti.lt

This centre is newly established on the base of two former research institutions. It is a public research institution with core activities consisting of theoretical, methodological and applied research in demography, ethnical issues, sociology of human resources, social aspects of eurointegration, social security and labour market areas. Until now, information is available via the web pages of the two former institutions.

Globali iniciatyva psichiatrijoje - Global Initiative on Psychiatry

Address: M.K Oginskio g.3, LT-10219 Vilnius.

Webpage: www.gip-vilnius.lt

This is part of an international NGO supporting the development of modern and community-based mental health care in different countries of the world. As part of this work, the organisation also carries out research into current systems, and provides policy feedback to the Government as required. Two of its publications, self-published, are abstracted in this document.

Sveikatos ekonomikos centras - Health Economics Centre

Address: P.Vileišio gatvė 18, 2 korpusas, 301, 10306 Vilnius

Webpage: www.sec.lt

This is a private company specialising in projects relating to health and social protection economic and policy issues. It has carried out projects and research for (or supported by) the following organisations: Ministry of Health, Ministry of Finance, Ministry of Economics, Ministry of Social Protection and Labour, National Health Board, State Patient Fund, SODRA, Social Protection Training and Research Centre, health care institutions and their founders, other institutions and enterprises, World Bank, Open Society Lithuania Fund, PHARE, World Health Organisation

Lietuvos laisvosios rinkos institutas - Lithuanian Free Market Institute

Address: Jasinskio g 16a, LT01112 Vilnius

Webpage: www.lrinka.lt

This organisation is both a political think-tank and a research organisation, occasionally carrying out research projects for clients, including the EU. In addition, it provides comments on government proposals, and writes articles in newspapers outlining its view on particular problems, and suggests ways to address these. It does, however, have a specific political orientation close to libertarian.

This publication is financed by the European Community Programme for Employment and Social Solidarity (2007-2013). This programme was established to support the implementation of the objectives of the European Union in the employment and social affairs area, as set out in the Social Agenda, and thereby contribute to the achievement of the Lisbon Strategy goals in these fields. The seven-year Programme targets all stakeholders who can help shape the development of appropriate and effective employment and social legislation and policies, across the EU-27, EFTA and EU candidate and pre-candidate countries. The Programme has six general objectives. These are:

(1) to improve the knowledge and understanding of the situation prevailing in the Member States (and in other participating countries) through analysis, evaluation and close monitoring of policies;
(2) to support the development of statistical tools and methods and common indicators, where appropriate broken down by gender and age group, in the areas covered by the programme;
(3) to support and monitor the implementation of Community law, where applicable, and policy objectives in the Member States, and assess their effectiveness and impact;
(4) to promote networking, mutual learning, identification and dissemination of good practice and innovative approaches at EU level;
(5) to enhance the awareness of the stakeholders and the general public about the EU policies and objectives pursued under each of the policy sections;
(6) to boost the capacity of key EU networks to promote, support and further develop EU policies and objectives, where applicable.

For more information see:
http://ec.europa.eu/social/main.jsp?catId=327&langId=en