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Pensions, health and long-term care

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1. Executive Summary

In 2012, Lithuania continued its slow recovery from recession. GDP increased by 3.7% (preliminary data), unemployment dropped from 15.4% to 13.4%. The average wage increased in absolute terms, but the purchasing power from the time before the crisis was not restored. The social insurance pensions from 2012 were paid at the same level as before the crisis. As a result, the macro replacement rate (average pension related to average net wage in the country) has increased, but the purchasing power of pensions was also lower than before the crisis and still remains lower until now. The at-risk-of-poverty indicators for older people (especially women) almost doubled, due to the increased median income of the population. In 2011, these indicators had considerably decreased, which means they are now returning to the pre-crisis levels.

The financial situation of the pension system has worsened. In 2012, the Social Insurance Fund was indebted by an additional LTL 1.86 billion; this process continued in 2013 and the full debt reached the amount of yearly expenditures of social insurance fund.

After the elections in autumn 2012, the former ruling coalition of conservative party and liberals was replaced by a coalition formed of social democrats, labour and a number of smaller parties. Before the elections, the former coalition managed to adopt the package of laws reforming the second pillar pensions. The modified system now includes a new element of voluntary additional contribution into a personal account at selected pension funds; this contribution is subsidised by the state. The new ruling coalition has not changed this approach. Nevertheless, some influential members of parliament within the current majority, as well as some experts, are against the reform and propose to stop contributions into the second pillar.

Within the last few years, health care has been facing changes related to the restructuring of health care institutions, the balancing of the health insurance budget, the financing of prophylactic health programmes and reduction of prices for pharmaceuticals. In terms of prevention, the implementation of political decisions was successful in traffic accidents control. It allowed for the improvement of the average life expectancy and the achievement of the national health programme's targets. But the consumption of alcohol is still very high. The financial and economic crisis had little effect on health care institutions, because the health care financing was not reduced significantly and the restructuring measures were put in place in good time.

The most problematic issues in respect of public health and the health care sector remain the same, i.e. public health primary prevention problems related to healthy lifestyles and the questions of how to increase incentives for institutions other than health care sector institutions to become active in this area, how to involve the population to care more about their health themselves, and how to improve the effectiveness of the health care sector and to reduce inequalities in health. Health care access and integration in terms of organisation of health care are also on the agenda, as waiting times for family doctors and for specialised health care are too long and are also subject to the payment of illegal fees to medical staff. All those measures are under negotiation in preparation of new plans. More discussions on how to change the recent health care organisation model are also on the agenda.

Long-term care and the ageing of the population is a challenge in Lithuania. The reforms aiming to improve social and health protection in terms of adequacy, quality and sustainability, together with the pressure to consolidate public finances, are the most urgent problems requiring solutions. The major problem in LTC is the coordination of the work between social and health care.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

The current Lithuanian pension system was shaped by two essential reforms.

After the restoration of the independence in 1990, Lithuania inherited the system common for all former Soviet Union. Until 1995, this system was applied with some necessary modifications and numerous recalculations of pensions granted by former rules.

The first national pension system was designed in the years leading up to 1995 and became applicable from that year. Until now the main principles and the rule of pension calculation remain fairly unchanged. The increase of the retirement age from 55/60 to 65 for women and men during a long transitory period was legislated in 1994 and will finally be reached in 2026, with some stops and changes on the way.

The second essential reform was legislated before 2004 and started from that year. The reform introduced a “second” and “third” pillar of funded pensions. At the end of 2012, this system was modified (see below).

As a result of these reforms, the main system characteristics of the Lithuanian pension system are as follows.

2.1.2 System characteristics

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 unfunded and defined-benefit financed by contributions (PAYG). It is designed to replace parts of the work income when an insured 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 as well as sickness, maternity and labour accident benefits.
- *Social pensions.* This pension 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 pension systems:

- The “second pillar” is a fully funded defined-contributions pension system. It is financed by parts of the obligatory pension insurance contributions. A working person is allowed to direct a part of their contributions to a funded personal account managed by a private pension fund. 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, and the scale of the system was diminished by the reduction of contribution rates in the last few years, it still only plays a minor part in pension payments today, but a matured system will probably gain importance in the future.
- “Third-pillar” funded defined-contributions 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 from social insurance pension contributions. This pillar is just a voluntary savings system with certain tax advantages.

Occupational pensions still do not exist in Lithuania, despite the fact that the Law on Occupational Pensions was adopted in 2006 in order to implement the Directive 2003/41/EC on the activities and supervision of institutions for occupational retirement provision.

The details of the calculation of first-pillar pensions (pension formula) are described in the Lithuanian ASISP report of 2010. Nevertheless, due to the important changes at the end of 2012, there is a good reason to present calculation details here once more.

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

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

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

$$\text{Main} = \alpha \cdot 1.1 \cdot B$$

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

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 every year of insurance above 30 years.

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

The earnings-related part (ERP) of the 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:

$$\text{ERP} = 0.005 \cdot W_1 + 0.005 \cdot W_2 + \dots + 0.005 \cdot W_n$$

Bearing in mind that values of W_1, W_2, \dots, 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 W_t , the so-called “insured income” 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

$$ERP = 0.005 \cdot (W_1 / D_1) \cdot D_T + 0.005 \cdot (W_2 / D_2) \cdot D_T + \dots + 0.005 \cdot (W_n / D_n) \cdot D_T$$

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

$$ERP = 0.005 \cdot (k_1 + k_2 + \dots + k_n) \cdot D_T$$

The earnings-related part is equal to the sum of collected pension points ($k_1 + k_2 + \dots + k_n$) multiplied by 0.5% of the current insured income 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 was divided into two parts – before the year 1994 and after. Finally, the earnings-related part until the year 2013 was calculated as follows:

$$ERP = 0.005 \cdot S \cdot K \cdot D_T + 0.005 \cdot s \cdot k \cdot D_T$$

Here, 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 the full data of personal income before 1 January 1994 are incomplete in the social insurance database, it is difficult to calculate the value of K – average number of points from that period. So the value of K was calculated by the data of five consecutive years in the ten years leading up to 1 January 1994. Data from the years 1984-1993 were collected by retiring persons in archives, with the help of state social insurance fund; but with each year that went by, this was proving more and more difficult.

In order to solve this problem, in 2008, the amendment of the law was adopted to calculate K from the five best years *after* 1994 (these data are available in the database). Unfortunately, the new rule of calculation could increase pension expenditures and was, therefore, postponed in line with all the immediate measures to curb the recession. Postponement was prolonged a few times until the end of 2012, when the new ruling coalition decided to abolish the rule of 2008 completely and introduced the new simplified (and much worse) rule of pension calculation¹ (see 1.1.3 – details of recent reforms).

Like in former years, Lithuania still has no formal pension indexation rule. 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. Despite the fact that in the last two years the European Council’s country-specific recommendations have required Lithuania to “establish clear rules for the indexation of pensions”, still no rules are introduced. The basic pension remains at the level of LTL 360, insured income at LTL 1,488.

¹ Lietuvos Respublikos valstybinių socialinio draudimo pensijų įstatymo 19, 24 ir 56 straipsnių pakėtimo įstatymas. 2012-12-20, XII-91. http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=440393&p_tr2=2

Pensions are not taxed in Lithuania. This fact sometimes makes it difficult to compare the level of Lithuanian pensions with other countries where the data of pensions before tax are presented. The real income of Lithuanian pensioners then looks smaller than they are in reality.

The pension insurance contribution rate in the PAYG system remained at the level of 26.3% (23.3 points employer's part and 3 points employee's part) in 2011, 2012 and 2013². The contribution into the second pillar is 2.5% in 2013 (as a part of 3 employee's point for second pillar participants).

2.1.3 Details on recent reforms

At the end of 2012, the new ruling coalition modified the formula for pension calculation (the earnings-related part of it). As it was described above (see 1.1.2), the simplified rule was introduced in order to avoid the difficulties related to the collection of personal wage data in the years 1984-1993. ERP of pension is now calculated by the one-part formula

$$\text{ERP} = 0.005 \cdot S \cdot K D_T$$

Here S stands for the full number of contributory years before retirement, K stands for the average number of points (coefficients) collected from 1 January 1994, and D_T – current insured income of the month T of pension payment. The amount of K is limited by a ceiling equal to 5 (as it was before)³.

The amendment looks simple, but unfortunately has the wrong consequences. First of all, it means that if a person has years with relatively low income before retirement, this fact decreases the amount of his/her pension instead of increasing it. This was neither possible in the former formula of two parts nor in the version of the law of 2008, but it is possible now (see example presented in the box). Secondly, the same effect may arise if a person, after retirement, takes a job which is paid less than the average of his/her working career. In this case, the contributory years also may decrease the calculated amount of pension and then the bigger amount granted at the time of retirement will be paid.

Box. The fault of the new rule of pension calculation

A person has 21 years of insurance before 1994 and coefficients equal to 3.5 in the years 1994- 2009 (16 years). Then the person loses their job and can only find a low-paid new one with coefficients equal to 0.5. The person retires in 2013. What are the pension ERP part consequences if he/she takes the job or not?

If a person takes this job, his/her years of insurance are $S=21+16+3=40$, average coefficient is $K=(3.5 \cdot 16+0.5 \cdot 3)/19=3.026$. Then $\text{ERP} = 0.005 \cdot 40 \cdot 3.026 \cdot 1488 = \text{LTL } 900.63$

If a person does not take the job, his/her years of insurance are $S=21+16 = 38$, average coefficient is $K=3.5$. Then $\text{ERP} = 0.005 \cdot 38 \cdot 3.5 \cdot 1488 = \text{LTL } 963.48$

The paradox is that three contributory years would decrease the pension by more than LTL 60 per month. This happens because the average coefficient is calculated based on the shorter period, but applied for the longer one.

² It covers not only old-age, but also incapacity for work and survivorship.

³ It also should be noted that a former version of the formula might be applied if it is required by a person and reliable personal wage data from the years 1984-1993 are possible to collect.

Due to this unfortunate amendment of the law, the pension system now creates disincentives to take a job in pre-retirement years and after retirement, and thus may work against the aim of employment of older persons. People are not much aware about this effect but after few years of work after retirement they may realise that their pension did not increase despite payment of contributions. Even if it is not a strong disincentive to take a job it is still unfair.

The most important reform was implemented in the second-pillar pensions. The legal acts were adopted in autumn 2012 (before the elections) by the former ruling coalition. From the year 2014, the second pillar will be financed by three sources: part of person's obligatory social insurance contributions, personal contribution and state subsidy. The contribution rates are presented in the following Table 1.

Table 1: Contributions directed to personal account of second pillar pension fund participant in the coming years

	2014-2015	2016 - 2019	from 2020
Percentage points of obligatory pension insurance contributions	2%	2%	3.5%
Personal contribution as percentage of a person's wage	1%	2%	2%
State subsidy as percentage of average wage in the country	1%	2%	2%

In this way it is intended to reduce the part taken away from the current PAYG system on the one hand, but to make contributions big enough to enable saving an amount which would be an essential supplement to the general PAYG pension on the other hand. It is also evident that people are asked to contribute more if they wish to have decent protection in retirement. Without this change only a very low replacement rate can be promised by the middle of the century.

The new rules will be fully applicable for the persons who join the system in 2013 and later. Participation is voluntary – every person insured for full pension may decide to join the system or to stay only in the general social insurance (PAYG) system. In this case, no part of his/her contributions is directed to the personal account, but also no personal contribution is required and no state subsidy granted.

Second-pillar participants who joined the system before 2013 are additionally allowed to choose other options. They may decide to stop their participation in the second pillar. In this case, their accumulated accounts will be managed by pension accumulation companies until their retirement age. Another option is to continue participation in the second pillar with no additional personal contribution (and with no state subsidy). This latter option was chosen as a default option for those former participants who will not communicate their decision before 30 November 2013.

According to data of mid November 2013, around 24 per cent of second pillar participants made the decision to join the new system. Slightly more than 1 per cent decided to stop the participation in the second pillar. The majority – around 75 per cent still did not make their decision. As it is known from the earlier reform experience, the picture may considerably change in the last days of November.

Some amendments concerning the fees allowed to be charged by pension funds were also adopted. The fee allowed to be charged on contribution (contribution fee) was decreased from 10% to 2% and a further decrease by 0.5% each year in the following years is legislated. This

means that in 2017 this fee will disappear. Other fee chargeable on accumulated capital (assets fee) remained at a maximum of 1%, but for conservative funds was decreased to a maximum of 0.65%.

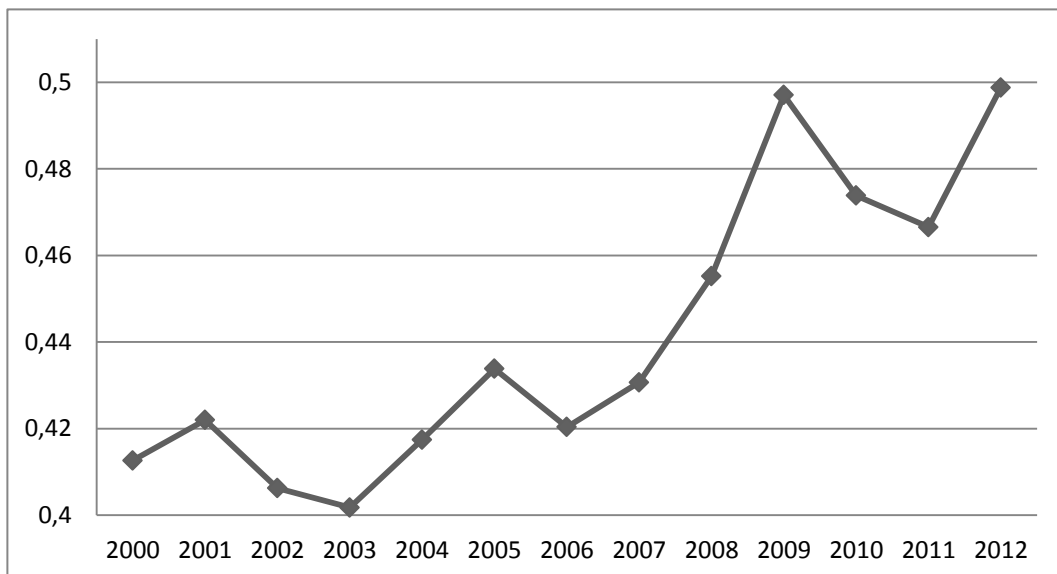
2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

In 2012, the values of pensions were restored to the pre-crisis level (except in the case of some additional state pensions). The average monthly old-age social insurance pension in 2012 was LTL 815.57 (EUR 226.20); recipients with full insurance record (30 years or more) received an average amount of LTL 841.91 (EUR 243.83). Similar values are also paid in 2013. The average value of old-age pensions increased by approximately 9% in 2012 compared to 2011.

Average net wages in 2012 did not reach the pre-crisis level, thus, the macro replacement rate (net average pension related to net average wage in the country) in 2012 increased again, to the level of almost 50% (see Graph 1). Despite this development, the purchasing power of pensions at the end of 2012 was 10% lower than at the end of 2008; the purchasing power of the net average wage was also down by about 13%.

Graph 1: Macro replacement rate of old-age pensions (net values)



Source: own calculations

On the one hand, the replacement rate of 50% is still unusually high in Lithuania and hardly sustainable in the current economic circumstances. On the other hand, the absolute value of average pension is still much lower than in many EU member states.

The at-risk-of-poverty indicators of people above the age of 65 doubled in 2012 (see Table 2, marked in red), mainly due to poverty amongst elderly women. A similar increase is noticed in the at-risk-of-poverty rate of pensioners (see Table 3). It should be remembered that data of the year 2012 are based on the household income of the year 2011. The pensions in that year were not restored, but the wages and average income of the population have increased. The threshold of poverty rate in 2012 increased by 12.5% and was LTL 749 (EUR 246.9) for a single person.⁴ Bearing in mind that the average pension is very close to this threshold, every

⁴ 2012 metų skurdo rizikos rodikliai. Pranešimas spaudai. Statistikos departamentas. Vilnius, 2013-09-11.

upward change of the threshold results in significant changes of at-risk-of-poverty rate indicators. It is important to notice that women are much more affected by this process.

It looks reasonable to conclude that “improvement” of the poverty rate of pensioners is relative and the situation in the coming years will return to the pre-crisis status. This conclusion may also be supported by the data of people at risk of poverty and social exclusion (see Table 4). These data are not so sensitive to threshold changes and show that risk of poverty or social exclusion of older persons is permanently slightly above the country average (lower for men, but much higher for women).

Table 2: At-risk-of-poverty rate by poverty threshold, age and sex

	2008	2009	2010	2011	2012
Total	20.0	20.6	20.2	19.2	18.6
Males	17.6	19.1	20.7	19.1	18.2
Females	22.0	21.9	19.8	19.3	19.0
Total under 65	18.2	19.7	22.1	21.3	18.6
Males under 65	17.7	19.9	22.3	20.7	18.0
Females under 65	18.7	19.6	21.9	21.9	18.4
Total above 65	29.7	25.2	10.2	9.7	18.7
Males above 65	16.8	13.2	8.1	8.6	13.8
Females above 65	35.9	31.3	11.2	10.2	21.2

Source: Eurostat SILC [ilc_li02]

Table 3: At-risk-of-poverty rate for pensioners

	2008	2009	2010	2011	2012
Total	30.8	27.6	13.3	12.1	20.8
Males	19.1	16.5	11.9	10.6	15.4
Females	36.4	32.7	14.0	12.8	23.4

<http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tespn100>

Table 4.: People at risk of poverty or social exclusion by age and sex

	2008	2009	2010	2011	2012
Total	27.6	29.5	33.4	33.1	32.5
Males	25.3	27.3	32.9	33.0	31.4
Females	29.7	31.4	33.8	33.3	33.4
Total less than 65	25.7	28.3	34.1	33.6	31.8
Males less than 65	25.2	27.8	34.0	33.9	31.7
Females less than 65	26.1	28.8	34.1	33.3	31.8
Total above 65	38.1	35.8	30.0	30.9	35.7
Males above 65	25.8	23.4	24.7	26.5	29.7
Females above 65	44.4	42.2	32.6	33.2	38.8

Source: Eurostat [ilc_peps01]

Adequacy of pensions is endangered in the coming years by the huge deficit of the social insurance system (see 1.2.2 below). Latest budgetary projections of the Social Insurance Fund foresee the decrease of pension replacement rates in 2016 by approximately 5 percentage points if the value of pensions will be frozen at the current level⁵. A similar figure is presented in the 2012 Ageing Report.⁶

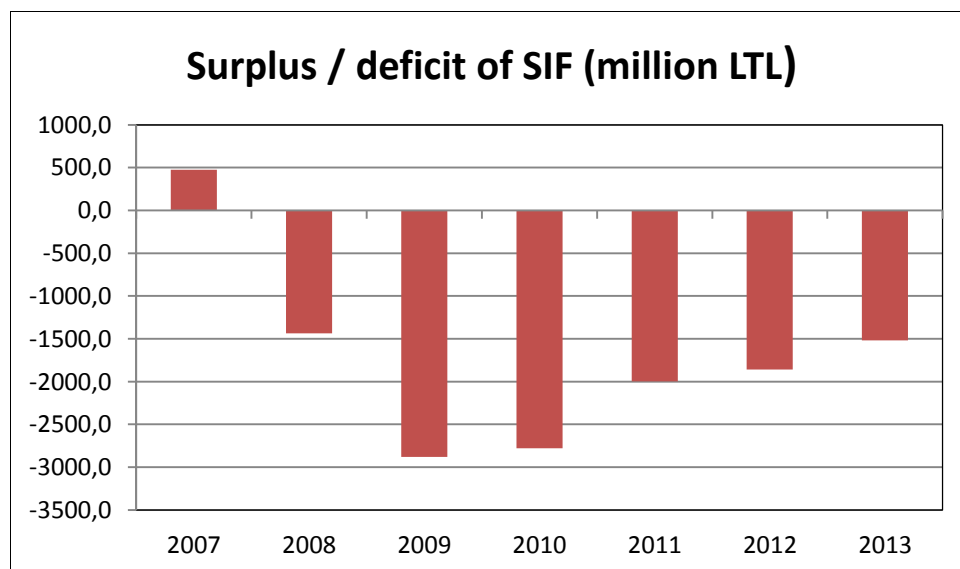
Some recent decisions and amendments may also result in unjust distribution of pensions between generations. The fault of the new rule of pension calculation (see 1.3.1) may result not only in “penalties” for people working after retirement, but may also be abused by recipients who have a short insurance period after the year 1994 with high coefficients. As wages before 1994 now are not taken into account, the recalculation of a pension according to the new rule may result in an unfairly high pension payment in comparison with other recipients.

The decision of the Constitutional Court to pay back the amount of pensions that were reduced in the years 2010-2011 may also result in unjust inequalities. More than LTL 1 billion (more than EUR 300 million) is requested for this purpose. This means that pensions might be frozen for several years, in order to finance these repayments. Persons who retired in the years of the crisis will receive compensation, but those who retired in 2012 or later will not be entitled to compensation. Their situation may be even worse because it is most likely that their pensions will be lower, due to the fact that their wages were reduced before retirement as a result of the crisis; this reduction will be especially painful because of the faulty amended rule of pension calculation (see 1.1.3).

2.2.2 Sustainability

The financial situation of the pension system remains very difficult. The balance of the Social Insurance Fund (SIF) has been negative every year since 2008 (see Graph 2).

Graph 2: Balance of Social Insurance Fund



Source: State Social Insurance Fund data <http://atvira.sodra.lt/>

⁵ See also the Graph 2 in Asisp Lithuanian report 2012.

⁶ http://ec.europa.eu/economy_finance/publications/european_economy/2012/pdf/ee-2012-2_en.pdf

The debt of the Social Insurance Fund in October 2013 was LTL 10,688 million (approx. EUR 3.1 billion). However, not the full amount is attributed to a pension system debt. Nevertheless, the debt amounts to almost 110% of the yearly total SIF expenditures in 2013.

The money necessary for pensions and other social insurance benefit payments were borrowed by the state. The Ministry of Finance insists that the debt should be paid back in the future years by the SIF, which means that the debt should be paid by future social insurance contributions (or future retirees). SIF is also obliged to pay interest on the loan – around LTL 500-600 million per year. It has been decided by the Government that interest only for the loans taken from 2014 will be paid by the Ministry of Finance (general tax sources), whereas the former loans have to be covered by SIF.

As mentioned above, the Constitutional Court has ruled, and the president and government have promised, that the difference between the full and the reduced pensions of 2010 and 2011 will be repaid to affected retirees in the coming years. An additional LTL 1,115 million is needed for this purpose. However, so far no real movement towards payment of such compensation can be seen in budgetary projections for the next year.

One more factor increasing the deficit of the SIF in the years to come is the decision that the state budget will no longer reimburse a part of the transfers from SIF to the second-pillar pension funds. Due to the change of the second-pillar funded system (see 1.1.3), the transfers will not be as big as before 2009, nevertheless, they may still cost around LTL 450 million (EUR 130 million).

Bearing all this in mind, the aim of financial balance of the SIF (and the pension system as a part of it) looks very difficult to achieve. The projections presented in last year's ASISP report estimate that, by 2015, the pension system will show a slight surplus and that this trend will continue until 2025. After 2025, the report states, the system will enter into deficit, reaching approx. 2% of GDP or 25% of full pension expenditures by 2060. The circumstances presented above, however, may alter previous projections.

2.2.3 Private pensions

Private pensions still play a minor role on the benefit side and not a lot contribute to the full amount of pension payments. Savings in the second and third pillar only started in 2004 with low contribution rates which subsequently were even more reduced, so retiring participants of funded systems as a rule receive a lump sum instead of annuity (annuity is obligatory if it amounts to more than half of the basic pension, i.e. LTL 180 (EUR 52.1) per month. The savings needed to receive this amount are in the region of LTL 30,000 (EUR 8,689) or more. At the beginning of 2013, only 112 cases of annuity payments were known.)

In these circumstances, it is interesting to compare the losses participants of the second pillar suffered in the years 2004-2012 in the social insurance system to their benefits in the second-pillar funded system. The results of the research⁷ on this issue are presented in Table 5.

The participants are divided into minimal, average and high (3 times average) wage earners. For each group, the amount of pension lost in the social insurance pensions system is calculated. For each group, the amount of savings in conservative funds and in the funds investing a small or medium part of assets into equities or pure equity funds is also calculated.

⁷ T.Medaikis, T.Gudaitis. Assessing the impact of the second pillar component on old-age pension in Lithuania. (2013). To be published in *Ekonomika*, Vol. 92, Vilnius University.

Table 5: Comparison of gains and losses (LTL) in the second pillar

Wage earner	Lost part of pension	Accumulated amount in funds (classified by part of equities)			
		Conservative	Small	Medium	Pure equity
Minimal wage	11.66	2,670	2,816	2,563	2,186
Average wage	31.80	7,587	7,998	7,421	6,320
High wage	95.40	22,587	23,819	22,267	18,963

Source: T.Medaikis, T.Gudaitis. Assessing the impact of the second pillar component on old-age pension in Lithuania

It is not easy for the average wage earner to decide, for example, whether it is better to receive a lump sum of about LTL 7,500 or LTL 31.80 per month for the rest of their life. Theoretical calculations of annuities show that the so-called basic unisex annuity approved by the Bank of Lithuania slightly exceeds the loss of the social insurance pension. Nevertheless, the basic annuity is just the official instrument to define whether annuity is obligatory or not (then a person is allowed to take a lump sum). Commercial annuities available in Lithuania are significantly lower (partly due to the undeveloped market of annuities). It is also important to point out that the loss in the social insurance system is related to pension indexation and, within a few years, the current loss of LTL 31.80 may turn into a much bigger amount. Because of these reasons, the gain in the second pillar might easily turn into a loss in the future.

However, the results of the research cannot be applied for the future, especially when the whole approach to the second pillar is revised.

Comparing the performance of second pillar pension funds to the previous years shows improvement (see Table 6). The value of the investment unit increased by 11% in 2012.

In the middle of 2013, there were 30 pension funds managed by 5 investment and 2 insurance companies. All funds managed a total of assets of LTL 5 billion (EUR 1.43 billion) or 4.4% of GDP and counted 1.09 million participants.

Table 6: The growth of value of pension funds unit (% per year).

	2008	2009	2010	2011	2012	2013 08
Conservative	2.94	8.01	3.12	1.41	6.47	-0.24
Small equity part	-12.00	13.36	6.17	-0.41	10.94	0.47
Medium equity part	-27.47	21.60	10.60	-4.15	12.24	0.74
Pure equity	-54.91	27.56	18.82	-10.82	13.06	2.83
<i>Weighted average</i>	-19.71	17.31	9.05	-2.88	11.21	0.74

Source: Bank of Lithuania. http://www.lb.lt/finansu_istaigu_finansines_ataskaitos

Third-pillar funds are much less popular. In the middle 2013 only 9 funds were managed by 5 investment companies. The value of assets was LTL 108.65 million (EUR 31.5 million). The number of participants was 28,615. The financial performance was similar to the second-pillar equity funds: the value of investment unit in 2010 increased by 14.42%, in 2011, it dropped by 8.7% and, in 2012, increased again by 11.05%.

2.2.4 Summary

During the crisis, pensions were not reduced as much as the income of the population had dropped. Due to this, the situation of retirees in relative terms even improved (replacement rates of pensions increased to the highest levels in the whole history of the Lithuanian pension system and at-risk-of-poverty indicators more than halved). Unfortunately, this result was only achieved by plunging the pensions system into a serious amount of debt. A modest economic recovery has increased the median income of the population and the at-risk-of-poverty rate is slowly returning to the level before the crisis. The replacement rate until now is relatively high, but projections foresee a decrease in the coming years. Recent amendments of the pension calculation formula and required compensation of the reduced part of pensions in the two years of crisis may result in inequality between different cohorts of pensioners.

The financial situation of the Social Insurance Fund is very grave. The debt of the SIF is equal to the amount of yearly expenditures. Additionally, huge sums are now needed as a result of the ruling of the Constitutional Court in favour of the right to compensation for the reduced part of pensions in the two years of crisis. Transfers to the second pillar system will not be reimbursed by the state anymore and high interest payments are due because of the huge debt. These facts seriously endanger the sustainability of the pension system and require appropriate reaction by the state. Former projections that the SIF will have a surplus for several years from 2015 will probably have to be revised if the fund is to bear all the expenditures mentioned above.

The funded system until now has had a modest role in pension payments. The reform measures may increase the weight of this system, due to the expected additional personal contributions of participants and state subsidies for them. This means that appropriate protection in old age requires more funds coming from both participants and the state; in an opposite case the replacement rates or financial balance of the pension system will be unacceptable.

2.3 Reform debates

Both the redistributive (pay-as-you-go) and funded systems, including the interaction between the two, was a subject for reform debates in the past years. The main actors of debate were politicians from parliament and government, experts, representatives of pension funds and their clients and representatives of the supervisor of pension funds (Bank of Lithuania), with active participation of the mass media. The voice of the social partners (employer and employee organisations) was not intense in these debates.

Until now, the main document of social insurance system reform (including pensions) is the *Guidelines of Social Insurance and Pension System Reform* approved by the parliament on 24 May 2011 (further referred to as *Guidelines*)⁸. In June 2011, the government approved the *Plan of Implementation of the Concept of Social Insurance and Pension System Reform*.

Among other tasks, the *Plan of Implementation* envisaged the establishment of a work group to analyse and define the pension calculation principle (NDC or “points” system) in 2011-2012. It also envisaged the drafting and approval of the Concept of State Pension Reform in 2012-2013.

⁸ See more detailed description in Lithuanian asisp reports of 2011 and 2012.

A work group of experts presented the Report on Analysis of Pension Calculation and the Concept of State Pension Reform in August 2012⁹. The findings of the report were presented to the Ministry of Social Security and Labour, the parliament, the presidential office.

In respect of the pension calculation mode, the work group supported the “pension points” approach, as it is more similar to the current system and easier to implement. It was the opinion of the work group that the advantages of the NDC system do not outweigh the difficulties of implementation. It is, however, possible to integrate these advantages into the “points” system without the disadvantages of the NDC system. Concrete solutions were proposed for implementation, for example, the rule of calculation of pension when a person decides to postpone the retirement.

At the beginning of 2013, another work group expressed their opinion on this issue. This work group was established by the prime minister’s office to analyse and to revise the tax system. This work group supported the NDC approach (albeit not unanimously) as more transparent and ensuring a stronger link between contributions and benefits. The Ministry of Social Security and Labour was not represented in this work group and immediately opposed the proposition.

The discussion which approach should be chosen is not finished has still not ended. The new ruling coalition is more reluctant to implement revolutionary changes. It seems extremely likely that the system of pension points will be chosen with all the necessary modifications. The points system may also resolve the fault created by the amendment of the current system, as described above (see 1.1.3). A person will earn additional points for every year of work, before and after retirement, without suffering a reduction of pension due to lower than average wage in a specific time frame.

Both work groups agree with the idea of changing the financing of the basic pension. According to the work groups, the basic pension should be changed into a national pension and financed through the state budget (general tax sources). Then the rest, i.e. the insurance part of pensions, will be more transparent, with a clear link between contributions and benefits. However, the opinions differ on whether the national pension should be universal or treated as social assistance that is granted in relation to acquired earnings-related rights: full assistance for recipients with a small income throughout their working life and no assistance granted at all for those who have had big earnings throughout their working life.

The report of the first work group also presented the analysis and reform proposition for non-contributory state pensions. Despite some positive features (possibility to retire earlier for some professional groups like military or police officers or some groups of artists, possibility to remunerate years of exile or imprisonment for deprived persons, possibility to increase replacement rates for academic teachers, judges and some other professional groups), the state pension system is seen as privileged, duplicating pension benefits, in the long run not acceptable in a modern democratic society and, as a rule, applied for other than social protection purposes. The work group proposed to reform the current system into a contributory professional pension system for most professional groups. Only the pension for military and other statutory officers is proposed to be changed into a special remuneration paid between the period of their retirement and the official retirement age (instead of payment of an additional pension until the end of life, as is currently the case). It is also proposed to abolish the use of the pension system as a remuneration measure for merited or deprived persons in the future.

⁹ Bartkus A., Kazakevičiūtė J., Lazutka R., Medaiskis T., Skučienė D. Pensijų skaičiavimo būdo analizė ir valstybinių pensijų reformos koncepcija. Baigiamoji ataskaita. 2012. <http://www.socmin.lt/index.php?-2063405871>

The report of the work group was approved by the Ministry of Social Security and Labour, but so far no legal acts of implementation have officially been proposed for government and parliament consideration. Only the proposal to transfer the administration of state pensions from different institutions to Sodra is now implemented step by step.

The most debatable issue in the last few years was especially the design, place and role of the funded part of the second pillar in the whole pension system. The scepticism towards the second-pillar system increased in the time of recession, when the SIF began to suffer huge deficits year after year, despite the reduction of the pension payments. In this situation, the state had to borrow in order to subsidise the current pension expenditures, but at the same time parts of the SIF income were drained away into the personal accounts of the second-pillar participants. It seemed unfair, especially considering the circumstances, with the performance of pension funds being far from successful (see Table 6). Thus, contributions into the second pillar in 2009 were decreased from 5.5% to 2%. Initially, the government promised to restore the contribution rate after the crisis; however, the promise was later broken and a new system with additional personal contribution and state subsidy was introduced (see 1.1.3).

The new ruling coalition (social democrats and labour party) did not abolish this reform and the new system is likely to start from 2014. Nevertheless, the voices against this new system, and against the second pillar as such, have been getting louder and louder recently. It seems that opinions in the new ruling coalition are divided.

An important contribution to the discussions about the second pillar was presented by the Bank of Lithuania in April 2013, when it published a research paper called “The Impact of the Second-Pillar Pension System on Public Finances and Income of the Population”¹⁰. The results of the research prove that the reform of the second pillar is “well balanced”. From the point of view of a participant this means that the expected value of the pension may increase by 15-34% (in comparison with non-participants). From the point of view of public finances this means that state expenditures will not be too high: 0.29% of GDP in the years 2014-2020 and 0.48% of GDP after that. From 2036, a positive result is expected: the pension system with second pillar will be less expensive for the public finances than a system with no second pillar. The research concluded that the reformed system “should be evaluated as investment which in the short-term period increases state expenditures, but in the long run is less expensive, and simultaneously results in a considerable positive impact on the income level of the old-age population. Nevertheless, it does not solve the current debt problem of the social insurance system.”

The opponents of the second pillar were not convinced. They argued that it is not reasonable for public finances to subsidise contributions into personal accounts and then to borrow from pension funds in order to subsidise them again next time. The system is too expensive: borrowing money now for subsidies means that, in the future, the same people who are now being subsidised will be obliged to pay higher taxes in order to cover the loan and interest. The second-pillar system, according to opponents, is completely redundant because the same value of pensions may be achieved without this pillar.

The proposition to stop all contributions into the second pillar from 2014 was expressed by an adviser of the prime minister as his personal opinion¹¹ and was supported by some members of parliament.

¹⁰ http://www.lb.lt/n21017/pensiju_sistemas_modeliavimas_2013_03_301.pdf

¹¹ <http://www.delfi.lt/verslas/verslas/lietuva-dairosi-i-lenkijos-pensiju-reforma-kuriai-kabinama-etikete-stalinistine.d?id=62977526>; <http://www.delfi.lt/verslas/verslas/siulo-dar-viena-pensiju-reforma.d?id=62977110>

Officially, the government did not support this position. It was supported by some influential members of ruling parties, but not officially by their parties.

Negative opinion about this proposition was expressed by the Lithuanian Association of Pension Funds. The president of the association stated that the a person's right to choose where they wish to save for their pension is a democratic principle. Even before the deadline of 30 November 2013, 261 thousand former participants and 45.7 thousand new people have already decided to join the new system¹².

A negative opinion was also expressed by the Lithuanian Free Market Institute. The experts of the institute see the social insurance system as too redistributive and, in their opinion, a shift to a funded system is justified¹³.

Some experts pointed out that the new system is not well enough defined. It is not clear how state subsidy will be paid in the case of self-employment or non-regular activity of a person¹⁴.

It seems likely that the new system will start from 2014 as planned. Opponents are not strong enough in parliament and influential enough in their political parties to change the law in the last few months. The parliamentary minority, i.e. the conservative and liberal parties, will not support them because this system was designed by them in the first place.

In my opinion, the reformed system just confirms the fact that appropriate old-age security requires more funds, due to well-known demographic tendencies. Additional personal contribution is necessary for this purpose. The state encourages contribution and softens this somewhat hidden increase in taxation by subsidy (or tax advantages). However, it seems unfair that additional contributions are subsidised only within the funded system. It is not guaranteed that the performance of pension funds will be better than the performance of the PAYG system. People should be allowed to choose whether to additionally contribute to pension funds or to the Social Insurance Fund. State subsidy should apply in both cases.

3 Health care

3.1 System description

3.1.1 Major reforms that shaped the current system

In the 1990s, after Lithuania had regained independence, the country's core health legislation and health reforms were adopted. The Health System Law (1994) describes the structure and the main principles of the national health system¹⁵. The health system consists of public administration institutions (the government, ministries and municipalities, as well as other specific governance and control bodies), providers of health care services, and health system resources and services (see Graph 3). In the late 1990s, Lithuania moved away from a system predominantly funded through local and state budgets to one funded by the National Health Insurance Fund (NHIF) through the national health insurance scheme based on compulsory participation¹⁶. Urgent and emergency health care is provided for all residents. Other health

¹² <http://atvira.sodra.lt>, retrieved on 14 November 2013.

¹³ K.Leontjeva. <http://www.llri.lt/naujienos/ekonomine-politika/pensijos/k-leontjeva-kodel-kalbama-apie-pensiju-kaupimo-panaikinima/kaetana-leontjeva>

¹⁴ R.Vainienė. <http://www.balsas.lt/naujiena/756624/suvystytas-pensiju-kaupimas>

¹⁵ Parliament of the Republic of Lithuania 1994. Health System Law of the Republic of Lithuania. No. I-552

¹⁶ Liubove Murauskiene, Raimonda Janoniene, Marija Veniute, Ewout van Ginneken, Marina Karanikolos. Lithuania Health System Review. Health Systems in Transition, Vol. 15, No. 2, 2013,

services are available for insured persons, with the main costs of treatment covered by health insurance. People who do not pay compulsory contributions and are not insured by the state must cover the cost of treatment personally, except in the case of urgent and emergency health care, which is always covered by the state.

In 2005, the mechanism for the regulation of compensation for damage caused to patients' health was introduced. Thus, since 1 January 2005, health care institutions must insure their civil liability for any damage caused to patients' health. In the 1990s, many health administration functions were decentralised and moved from the Ministry of Health to the regional authorities. Municipalities have become responsible for the provision of a substantial share of primary health care services through primary care centres, polyclinics, and for the running of small and medium-sized hospitals. However, more recently, a return to increased centralisation could be observed. Before 2011, the health system was organised in three levels: national, regional and local. After the reform of county councils in the middle of 2010, ten county councils were abolished and regional governance was given to the boards of the regions, but only as the collective management body without any administrative function. Regional hospitals which were under administration of county councils before were transferred to the subordination of either the municipalities or the Ministry of Health. Privatisation of the health sector has been limited, particularly in inpatient care. The private sector plays a significant role in dental care, cosmetic surgery, psychotherapy, some outpatient specialities and primary care. Since 2008, the NHIF has increasingly been contracting private providers for specialist outpatient care.

3.1.2 System characteristics

The health sector in Lithuania is organised by a mixed health care financing consisting of statutory compulsory health insurance, budget allocations and direct payments of patients. In 2010, the total health expenditure accounted for 7% of GDP, in 2011 it was 6,9%. A major financing source is the compulsory health insurance, which was LTL 4,233 million in 2012. The trends in health expenditure between 1995 and 2010 are shown in Table 7.

Table 7: Trends in health expenditure in Lithuania, 1995 to 2010

	1995	2000	2005	2010
Total health expenditure, PPP\$ per capita, WHO estimates	333.6	559.5	833.0	1299.5
Total health expenditure as % of gross domestic product (GDP), WHO estimates	5.4	6.5	5.8	7.0
Mean annual real growth rate in total health expenditure (%)		9	18	-3
Mean annual real growth rate in GDP (%)		5	15	3
Public sector health expenditure as % of total health expenditure, WHO estimates	74.2	69.7	67.8	73.5
Private sector expenditure on health as % of total health expenditure, WHO estimates	25.8	30.3	32.2	26.5
Public sector expenditure on health as % of total government expenditure, WHO estimates	11.6	11.6	11.9	12.6
Public sector expenditure on health as % of GDP, WHO estimates	4.0	4.5	4.0	5.2
Private households' out-of-pocket payment on	22.4	26.1	31.7	25.8

health as % of total health expenditure				
Private households' out-of-pocket payment on health as % of private sector health expenditure	86.6	86.2	98.5	97.3

Source: Liubove Murauskiene, Raimonda Janoniene, Marija Veniute, Ewout van Ginneken, Marina Karanikolos. Lithuania Health System Review. Health Systems in Transition, Vol. 15, No. 2, 2013, http://www.euro.who.int/_data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

After the administrative reform in 2010, the health system is organised in two levels: national and municipal; nevertheless, there are health care institutions which perform regional level functions and treat patients from the entire region. The Ministry of Health has been a major player in the health system regulation through setting standards and requirements, licensing and approving of capital investments. Outside the ministry, the number of regulatory agencies has declined in the period 2008-2012, as a result of the government's policy to reduce bureaucracy and related costs.

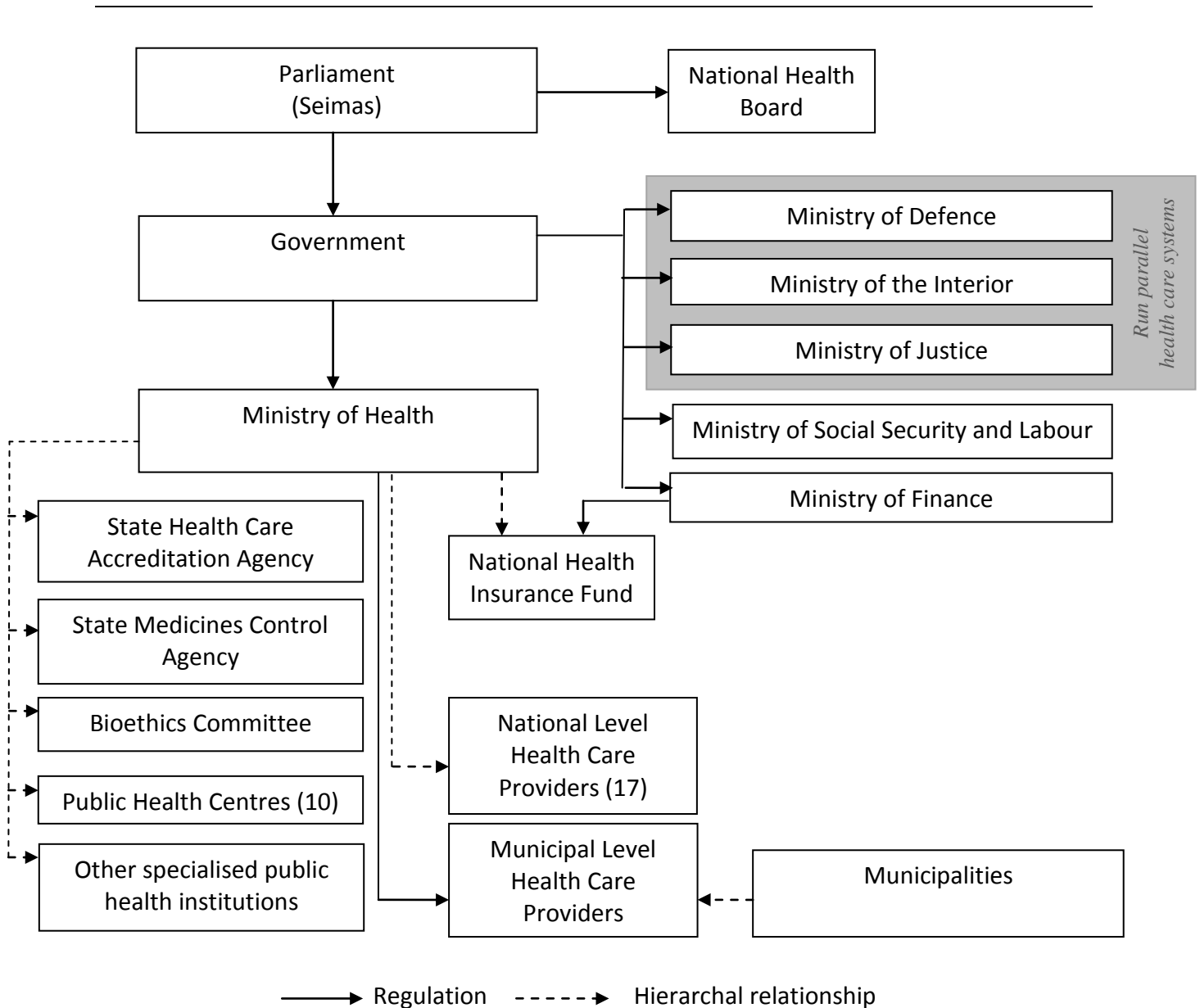
Strategic planning and programme budgeting in the health sector take place through three-year strategic plans and annual plans. Reporting on the plans' implementation takes place on an annual basis. The plans are directly linked with the budget allocation of corresponding institutions.

Overview of the health system

After regaining independence in 1991, the focus was put on introducing health legislation. During the 1990s, key laws such as the Health System Law (1994), the Health Institutions Law (1996) and the National Health Insurance Law (1996) were adopted. At the same time, numerous more specific health regulations were prepared and introduced. The intense legislative process led to sometimes conflicting regulatory provisions. This required a harmonisation and clarification of the legislation during the 2000s.

The Health System Law (Parliament of the Republic of Lithuania, 1994) describes the structure and the main principles of the national health system. The health system consists of governance institutions (the government, ministries and municipalities, as well as other specialist governance and control bodies), providers of health care services, and health system resources and services. An overview of the Lithuanian health system is shown in Graph 3.

Graph 3: Organisation of the health system in Lithuania, 2013



Source: Liubove Murauskiene, Raimonda Janoniene, Marija Veniute, Ewout van Ginneken, Marina Karanikolos. Lithuania Health System Review. Health Systems in Transition, Vol. 15, No. 2, 2013, http://www.euro.who.int/_data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

The country has a national health insurance system based on compulsory participation. The vast majority of Lithuanian health care institutions are non-profit-making enterprises. Property rights and administrative functions fall under the jurisdiction of the central government (Ministry of Health) or the local municipalities.

The policy agenda is set by the parliament through legislative changes and by the government through national government programmes. The ministries develop strategic programmes and plans with specified priorities and ways of programme implementation. To date, programme evaluation has been the most fragile area: regular (mostly annual) institutional reporting of public authorities focuses mainly on financial accountability and often lacks more comprehensive and analytical evaluation. Nevertheless, certain progress in developing evaluation and accountability has been achieved, due to the need to account for spending from the EU structural funds.

3.1.3 Details on recent reforms

In the past years, three strategic goals of the following reforms were implemented: a new pharmaceutical policy introducing more generic medicines and changing pricing methodology; reorganisation of the hospital network merging and closing some hospital department in rural areas; reform of budgetary health institutions merging public health institutions. Maintaining the same level of funding for public health and healthcare during the crisis was a major challenge. Discussion on how to improve patient pathways and to ensure more integration in personal healthcare is undergoing in 2013.

Currently, the new Lithuanian Health Programme 2020 is under development. The programme aims at improving the health of the population through a safer social environment, healthy lifestyles and effective healthcare. It has been designed with an intersectoral approach and more responsibility for public health has been transferred to other related sectors.

Anticipating EU accession, the National Long-term Development Strategy outlined several development goals for the year 2015 (Parliament of the Republic of Lithuania, 2002). The strategy set out the following broad themes for health system development:

- Developing legislation on public health and promotion of healthy lifestyles
- Reducing mortality and prolonging average life expectancy;
- Strengthening governance and financing of healthcare providers;
- Ensuring that only safe, effective and affordable medicines complying with EU standards are available in the Lithuanian market.

The parliament has declared 2013 as the Year of Health Promotion. Many public and private organisations working outside health sector as well as NGO's have organised many activities promoting healthy lifestyle of population in physical and nutritional issues, protection of harmful behaviour etc.. Public relations campaigns in the media were quite successful.

The financing method of hospitals based on diagnostic-related groups (DRG) started on 1 January 2012. The Institution of National Public Health Services has been reorganised. Its functions have been redistributed to the Ministry of Health and other public health institutions. A further seven public health institutions were also reorganised. At the end of 2012, a new government and new coalition of the political parties came into power and, thus, a new government programme is currently under implementation.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

Theoretically, health care is free of charge. But there is a list of health care services which are approved as paid services that are financed entirely from the person's own resources according to a set price list. When assessing health care coverage it becomes obvious that there is some disproportion between health care coverage declared by law and practical access. In particular, there are differences in terms of access between socio-economic groups. Health care access in terms of organisation of health care are also on the agenda for future reforms. Waiting times for family doctors and for specialised care are too long; patients require more consultation time and attention to their specific problem, there are local inequalities in terms of access to emergency services, The occurrence of informal payments to medical staff is also a problem. Measures to deal with all those issues are under negotiation and new plans are being drawn up. Health care coverage, the benefit package and co-payments have not changed considerably, even in the crisis period. Nevertheless, patients

have begun to claim that official payments in hospitals are too high and unclear. Private expenses in 2010-2012 remained the same as before, i.e. 2% of GDP. Private expenses account for 28% of all general expenses for health. There are big health inequalities by age, gender and especially between the urban and rural population. Those inequalities even show in the distribution of health risk factors (Table 8) and continue in population morbidity and mortality (Graph 4).

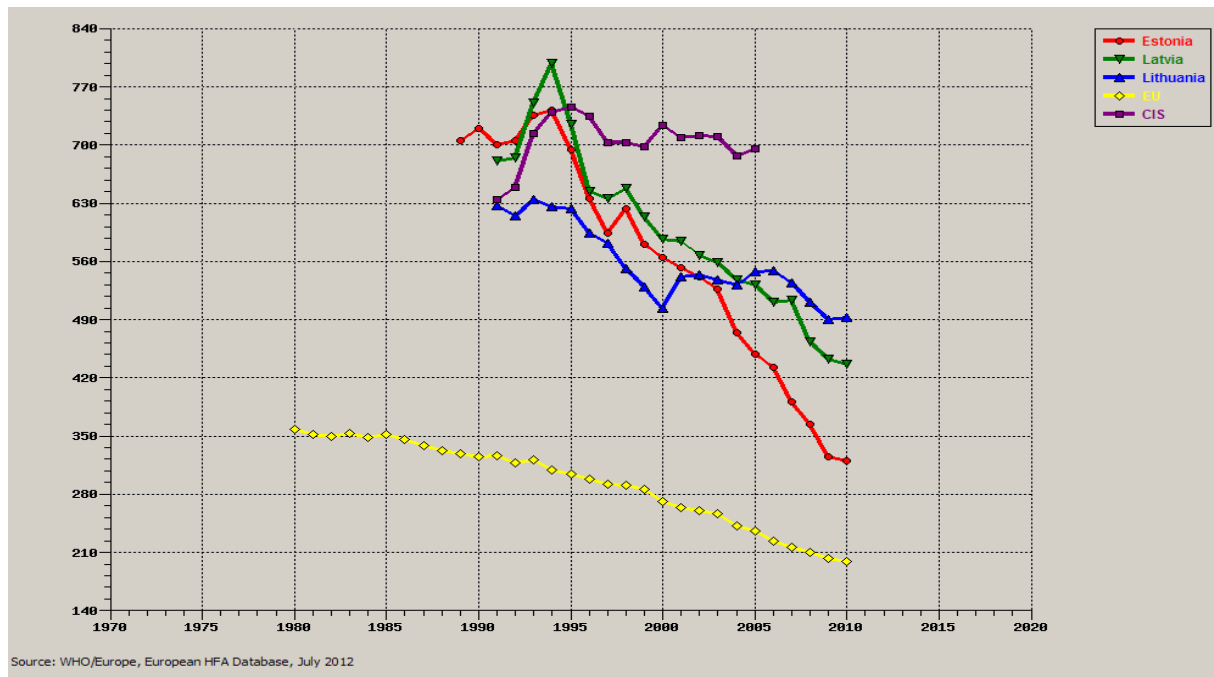
Table 8: Prevalence of major risk factors (%) in Lithuanian urban and rural population aged 35-64

Risk factors	Urban		Rural	
	Males	Females	Males	Females
Hypertension (BP \geq 140/90 mmHg or under treatment)	49.8	39.6	68.9	51.5
Hypercholesterolemia (CHOL \geq 5.0 mmol/l)	80.7	82.7	69.8	70.7
Overweight (BMI \geq 25)	70.7	70.5	70.0	73.8
Smoking (1 cig/day at least)	41.4	11.3	41.8	9.0
Lack of physical activity (national figures)	Males: ~ 20%		Females: ~ 25%	

Source: Lithuanian University of Health Sciences, WHO CINDI Project, 2012.

Lithuanian health and mortality indicators are worse than the EU average, but some of them are below the average in the Baltic States.

Graph 4: Age-standardised smoking-related mortality in the Lithuanian population per 100,000 inhabitants



Territorial inequalities in the allocation of physicians per 10,000 of population have remained at the same level for ten years. The Hygiene Institute periodically issues a publication called „Public Health Inequalities“. In 2013, the topic of this publication was inequalities in cardiovascular diseases¹⁷.

The Ministry of Health carried out a scientific analysis of the need for and workload of health personnel. It showed that the planning and distribution of personnel, due to the ageing of doctors in health care institutions, migration, planning numbers of students and unequal distribution among the territories, is a big problem which requires solution. It is planned to propose the “National request” based on the needs of medical doctors all over the country for financing of state funded medical students with the legal commitment of the student to work in the countryside too.

3.2.2 Quality and performance indicators

Health care quality was recently analysed by nationwide public opinion surveys. The surveys in 2010 and 2011 showed that the most problematic issue in terms of health care organisation is access: waiting times for family doctors and specialised care are too long, patients require more consultation time and attention to their specific problem, there are local inequalities in terms of access to emergency services. The patients of those regions where inpatient care had been reorganised during the third stage of the restructuring plan of the Ministry of Health evaluated health quality and especially access to inpatient care as not much worse in 2011 compared to 2010. But they mentioned the need for increased ambulatory health care. The health care providers pointed out an increase in their workload.

In 2012, the task force of the Ministry of Health prepared a set of quality assessment indicators for hospital-based care. This has not been implemented yet, but it is planned that all

¹⁷ Public Health Inequalities. No3.
http://www.hi.lt/images/PASAULINEI%20SIRDIES%20DIENAI_09,26_galutinis.pdf

hospitals will be ranked annually according to health quality and health performance assessment indicators¹⁸, which include patient satisfaction, the occurrence of nosocomial infections and adverse effects rates, as well as performance indicators for services such as surgeries performed in the day surgery units, caesarean section rates among all deliveries, etc. Those indicators with their analysis will be published on the internet.

3.2.3 Sustainability

Sustainability of the health care system in terms of health care resources in 2012 is shown in Table 9 and in 2011 in Table 10. An increase in the financing of prophylactic health programmes every year since 2005 (from LTL 2.7 million in 2005 to LTL 37.7 million in 2013) also gives sustainability in the future.

¹⁸ All hospitals will be ranked. Delfi news: <http://www.delfi.lt/news/daily/health/lietuvos-ligonines-bus-reitinguojamos.d?id=59736349>

Table 9: Number of medical personnel and hospital beds in Lithuania in 2012

	Abs. number	Per 10,000 pop.
Physicians	13552	45.6
Practising physicians	12604	42.41
Dentists	2685	9.03
Nurses (incl. midwives)	23585	79.36
Pharmacists	3050	10.26
Hospital beds	27079	91.12
Hospital beds (excl. nursing)	22206	74.7

Source: data of Institute of Hygiene, Health of Lithuanian inhabitants and activities of health care institutions
http://www.hi.lt/content/sveik_stat_leid.html

Nevertheless, financing of health care is quite low in Lithuania in comparison with other EU countries (Table 10).

Table 10: Expenditure on health (in million EUR) according to the OECD methodology of the system of national health accounts

	2005	2006	2007	2008	2009	2010	2011
Total expenditure on health	1,223.4	1,493.5	1,788.7	2,142.0	2,007.8	1,963.8	2,122.0
out of which:							
Public sector	829.0	1,038.1	1,305.4	1,550.7	1,462.1	1,390.5	1,467.4
%	67.8	69.5	73.0	72.4	72.8	70.8	69.2
Private sector	394.1	455.2	483.1	591.2	545.5	538.9	586.8
%	32.2	30.5	27.0	27.6	27.2	27.4	27.7
Expenditure on health per 1 inhabitant in EUR	358	440	530	638	601	598	659

Source: Department of Statistics in Lithuania

3.2.4 Summary

Summarising the strengths and weaknesses in health care the restructuring of health care institutions, the efforts to balance the health insurance budget and measures to reduce the prices of pharmaceuticals, as well as the financing of prophylactic health programmes should be mentioned among the positive aspects particular to the last few years. The political decisions and measures of the past three years were successful in traffic accidents control. It allowed for the improvement of the average life expectancy and the achievement of the national health programme's targets. A new mother and child health programme, drawn up with extensive support from the Swiss government, providing three levels of qualitative health care to pregnant women and new-borns caused the reduction of infant mortality to the EU average level. The financial and economic crisis had little effect on the health care

institutions, because their financing was not reduced significantly and restructuring measures were put in place in good time.

Nevertheless, the most problematic issues within the public health and health care sector are the public health primary prevention problems related to healthy lifestyles and the questions of how to increase incentives for institutions other than health care sector institutions to become active in this area and how to involve the population to care more about their health themselves. The major goals for the new national health programme, thus, are to involve other sectors in health promotion, to succeed in raising awareness of healthy lifestyles and to protect the people from unhealthy environments and to reduce inequalities. Health care access in terms of organisation of health care are also on the agenda: waiting times for family doctors and specialised care are too long; patients require more consultation time and attention to their specific problem, there are local inequalities in terms of access to emergency services, as well as informal payments to medical staff. Measures to deal with all those issues are under negotiation and new plans are being drawn up.

3.3 Reform debates

In 2011, a comprehensive analysis and the evaluation of the national health programme for the period 1998-2010 was made by a group of experts and presented to the Ministry of Health, the National Health Board, the parliament and the general public. The goals of the programme were to reduce mortality and increase the average life expectancy of the population up to the age of 73, to secure equality in health and health care and to improve the quality of life. By the year 2010, it was planned to achieve a reduction in differences in health and health care between various socio-economic population groups by 25%. Unfortunately, not all targets were achieved. A national debate as to why those targets were not achieved and what can be done by other (not only health) sectors was ongoing in the last few years. The so-called Health Forum as a platform for the discussion among the public, politicians, decision makers and medical personnel was established with the support and participation of the medical industry, universities and public institutions, such as the National Health Board and the Ministry of Health. The first round of discussions took place in Vilnius on 16 December 2011, the second in November 2012. Points of discussion were not only the results of the national health programme, but also the goals and expected health indicators of the national health programme for the next decade and the measures needed to involve other sectors and the population themselves to care about and improve health as a personal and public value (see conference webpage¹⁹).

Problems of inequalities in health and health care were discussed in the Baltic health policy dialogue, organised by the WHO in Vilnius on 4 November 2011. Senior representatives of the health ministries of Estonia, Latvia and Lithuania exchanged their views and experiences of how to reduce inequalities. This issue will be the major target for Lithuania in its new national health programme, which is expected to be accepted in parliament in 2013. Efforts to improve health promotion of the population coming as initiatives from various institutions including media was obvious in 2013. Furthermore, in 2012, the new cabinet has announced the intention to change the existing health system model. There is an on-going discussion and negotiation on the vision of the new model in terms of financing, structure, health care services provision and management.

Discussions on the quality of the performance of health care institutions and inequality in the access to health care personnel, especially doctors, have been arising periodically in conferences and the media throughout the year. The recent discussions on how to improve

¹⁹ Health Forum webpage: <http://www.sveikatosforumas.org/>

patient pathways through the clusterisation of health care institutions and how to ensure more integration in personal health care are ongoing.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Since independence was declared in 1990, long-term services have been provided irrespective of age, but taking into account the person's level of independency and the need for services. In Lithuania, long-term care is provided in two sectors: health and social care. The main recipients of social services are elderly people and people with disabilities (children and adults). The need for social services is determined considering a combination of principles of cooperation, participation, complexity, accessibility, social justice, relevance, efficiency, and comprehensiveness. This need is established on an individual basis according to the person's dependency level and possibilities to develop, taking into account the individual's interests and needs, and the social services are aimed at compensating for the lack of independence. Long-term medical treatment is provided considering the health condition. Disabled people, taking into account their special needs, may receive permanent care (assistance) or permanent nursing care. The special need of a disabled person is determined by a certified list of health conditions. In the health care sector, long-term care is mostly provided as inpatient services in separate nursing homes or specific departments in general hospitals. During the period 2005-2010, the number of beds in separate nursing homes in the health care sector increased from 2,735 to 2,835, while the number of hospitals decreased from 59 to 49. During the same period, the total number of nursing beds (both in nursing homes and in other health care facilities) increased from 3,527 to 4,614.

4.1.2 System characteristics

Long-term care in Lithuania is organised as a central system which is supplemented on a regional level: the government devises long-term national programmes, strategies, requirements and standards. The municipalities prepare and implement municipal programmes of social integration of disabled people. They are directly responsible for the organisation of the provision of social services; for the determination of the needs for social services; for the supervision of common and special social services; and for the organisation and provision of primary health care including nursing hospitals. Long-term care is organised in day centres, home care services, residential social care institutions and nursing hospitals.

There is no united special legislation; long-term care is granted through several channels: social services, invalidity and sickness. Social services are provided for all residents in need. Health care is based on social insurance and financed by the state, local budgets and the Health Insurance Fund, as well as co-payments of the person (family). Benefits in kind are provided for long-term care, and there are cash benefits for people with severe disabilities.

4.1.3 Details on recent reforms in the past 2-3 years

The current status of organisation and institutional responsibilities for long-term care, long-term care financing, management and service provision as well as benefits, were not changed in the past years. The system of long-term care is provided and financed through the state budget and municipalities (in this case, the Ministry of Social Security and Labour acts as the

policy body) and by the National Health Insurance Fund (NHIF) through health insurance. In the case of inpatient care, the health services finance long-term stays up to 120 days. TB, mental health, palliative care and rehabilitation patients are financed by the NHIF.

In 2008, nursing and palliative care services at home were introduced as new services financed through the NHIF. There are plans to establish 180 beds in the hospitals for palliative care by the end of 2013. In 2011, the Ministry of Health acknowledged the special requirements for geriatric services. This allowed for the development of more and specialised inpatient health services for elderly people over 60 years of age with geriatric problems.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

Institutional care is quite developed Lithuania. During 2010 and 2011, the accessibility of health care and long-term care was reviewed by six surveys of population and health care providers, conducted by the Ministry of Health²⁰. The aim was to assess the opinion of the general population and health care providers on accessibility and quality of care throughout the country. The results show that there are some problems in respect of access to inpatient care, especially in the municipalities where inpatient services were reduced. Those concerns and more difficulties in access are predominantly expressed by health care providers and elderly people rather than by the general population. The population has expressed the need to increase ambulatory health care services, which was perceived by one fifth of the elderly population as having deteriorated.

4.2.2 Quality and performance indicators

Long-term care institutions are, like all health care institutions, supervised by the State Health Care Accreditation Agency under the Ministry of Health. Licensing of the health care organisations is mandatory by law. Licences have to be renewed every 5 years. Institutions have to prove their staff qualifications, quality of equipment and facilities, and must also have local quality assurance procedures in place. The same agency provides supervision and control of the quality of health care procedures at the national level and supervision of patients' rights. Medical staff also has to renew their licences every 5 years, showing the improvement of qualifications, undergraduate medical training and assessment of work results. Each health care institution has the obligation to have their own local quality assurance system, with a quality assurance policy and plan of work, quality assurance procedures and work manuals, in place. It Also has to evaluate annually the patient satisfaction surveys, reports on nosocomial infections, adverse events, treatment results, patient deaths, etc.

On the social sector side, the Department of Supervision of Social Services under the Ministry of Social Security and Labour is responsible for the supervision of long-term care institutions. Licensing of care institutions will be mandatory by law from 2015. In January 2013, the process of licensing was initiated. Ten types of licences are provided for by law (with different requirements for institutions providing care for children, disabled persons, elderly people, etc.).

²⁰ Report of the national surveys' results to the Ministry of Health „Evaluation of Quality and Access of Health Care Services in Lithuania Based on the Opinion of Patients and Health Care Providers“. Social Information Centre, 2012. http://www.sam.lt/go.php/lit/Pacientu_ir_sveikatos_prieziuros_paslaug/118 , retrieved on 11 April 11 2013.

4.2.3 Sustainability

Long-term care expenditures are 1.2% of total GDP in Lithuania: 0.51% accounts for care in institutions, 0.48%– for care at home and 0.23% are benefits. These figures are expected to double by 2060. Means by sources of financing for elderly and disabled persons in institutional care for 2011 are presented in Table 11.

Table 11: Means by sources of financing for elderly and disabled persons in institutional care (million LTL)

	State	Municipalities	Persons	Other	Total
Care institutions for elderly	21.8 (23%)	27.6(28%)	41.9 (44%)	4.6 (5%)	95.9 (100%)
Care institutions for disabled	76.7 (57%)	7.2 (5%)	41.3 (30%)	10.2 (8%)	135.4 (100%)
Total	98.5 (43%)	34.8 (15%)	83.2 (36%)	14.8 (6%)	231.3 (100%)
	133.3 (58 %)				

In 2011, expenses of long-term nursing services in the health care sector were 0.5% of GDP. Long-term nursing care financing accounts for 8% of the national health account.

The number of workers in care institutions is presented in Table 12. Figures in parentheses show the number of full-time workers.

Table 12: The number of workers in care institutions

	Number of staff	Number of social workers	Number of assistants of social workers
Care institutions for elderly	2,726 (2,157)	228 (196)	640 (549)
Care institutions for disabled	3,208 (2,890)	343(328)	1,481 (1,406)
Houses of independent living	174 (135)	28 (28)	63 (51)

Source: Lithuanian Department of Statistics²¹

The level of education of social workers is usually at university bachelor degree level (college education is rather a rare exception). Minimum requirements for social workers and their assistants are set by the Law on Social Services. Special high education is required for social workers, and there is a discussion of introducing licencing them in future.

There were 4,833 nursing long-term care beds in the health care sector in 2012. 272 doctors and 1,134 nursing staff work in long-term care homes in the country. There is no shortage of nurses, but there are shortages of doctors in the local health care institutions, particularly in rural areas.

Increased availability and quality of outpatient rehabilitation for elderly is one of the objectives of the strategic health policy documents, which is being implemented through the establishment of outpatient rehabilitation units in municipal health care facilities, the allocation of capital investments towards infrastructure, as well as through regulatory measures, such as prohibiting the primary health care providers to refer adult patients to

²¹ Lietuvos statistikos departamentas. Socialinės paslaugos 2012 m. Informacija 2013-06-28, Table 16.

specialised inpatient rehabilitation, thus directing patient flows towards outpatient rehabilitation. Since 2005, outpatient rehabilitation services have increased by 30%, thanks to the implementation of special projects of Structural Funds and the establishment of special departments for ambulatory rehabilitation.

4.2.4 Summary

Long-term care and population ageing is a challenge in Lithuania. The attitude of the population is a big concern in the country, with passive waiting for the goods, dissatisfaction with life and demanding from the government to take care of all kinds of problems being the general mentality. However, reforms aiming to improve social and health protection in terms of adequacy, quality and sustainability, together with the pressure to consolidate public finances, are the most urgent problems requiring solutions.

One of the major problems in LTC is the coordination of work between social and health care.

4.3 Reform debates

At the end of 2012, the Guidelines for Deinstitutionalisation of the Social Care Homes of Disabled Children Deprived of Parental Care and Adult Disabled Persons were approved. The guidelines provide the trends of transition from institutional social care to the services of assistance in the community until 2030. Deinstitutionalisation aims at forming consistent and coordinated system assistance and services, which would create possibilities for each disabled child deprived of parental care and disabled person to receive individual personalised services and required assistance, be involved and participate in community life without experiencing social exclusion. Pursuant to the approved guidelines, it is planned to create and implement a programme of such deinstitutionalisation, by the end of 2013. Experts in different areas, as well as non-governmental organisations working in the areas of children's rights and the rights of persons with disabilities will be included in the interdepartmental working group. A program is drafted by Ministry of Social Security and Labour and is currently discussed with relevant institutions.

Ambulatory nursing and care services were established a few years ago. Those services are well received by the population and have increased the access to long-term care services. The extension of 'cash for care' measures enables informal carers, as providers of care, to be financially compensated for the care they deliver (e.g. by care or attendance allowances) and to benefit from some training and social rights, but also from the recognition that informal carers are also clients of formal services, with needs for their own support measures. The extensive use of live-in (and live-out) migrant care workers, whose status lies between the two distinct categories of formal and informal carers, is a relatively new trend in LTC provision. These workers may be initially selected by families, mainly on the basis of trustworthiness

There is a duration ceiling of four month per year on each inpatient nursing care episode, as services provided in public hospitals are paid from the National Health Insurance Fund (NHIF)²². After the maximum four month of treatment, a patient is transferred to the care institution which is set in the municipality by the social sector. A proposal to increase the duration limit in the inpatient health care nursing departments from 120 to 180 days is under negotiation.

²² Health Systems in Transition: Lithuania (2012). WHO Health Observatory.
http://www.euro.who.int/_data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf, P.104.

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Annex – Key publications

[Pensions]

BARTKUS A., KAZAKEVIČIŪTĖ J., LAZUTKA R., MEDAIŠKIS T., SKUČIENĖ D. Pensijų skaičiavimo būdo analizė ir valstybinių pensijų reformos koncepcija. Baigiamoji ataskaita. 2012. <http://www.socmin.lt/index.php?-2063405871>

"Analysis of Pension Calculation and the Concept of State Pension Reform". The Report.

The research paper presents the comparative analysis of NDC and points approach for the pension calculations and evaluation of the possibility to apply these systems in Lithuania. Authors recommend improvement of the current pension points systems and do not see the essential need to change it into NDC approach. The current state pension system is also analysed and propositions for the reform of different parts of this system are presented. The main idea is to decrease the scale of these pensions. Some state pensions are proposed to be changed into professional pensions, some others to be included into the projected national pension.

GUDAITIS, Tadas, MEDAIŠKIS, Teodoras. Was the Participation in the Second Pillar Successful in Lithuania? 2013. Athens: ATINER'S Conference Paper Series, No: ECO2013-0605.

The evaluation of participation in the Lithuanian private second pillar is analysed in the paper. The analysis is based on qualitative, quantitative and statistical analysis of pension accumulation results during the 9-year period, starting from 2004. The average monthly wage earner's scenario is analysed by calculating the accumulated amount in fully funded private second-pillar pension funds and comparing it with the reduced values of the first pillar pension, based on the pay-as-you-go principle. The results of participation in the second pillar are compared with the values of old-age pension of persons who had not joined the fully funded system. The results show that the investment management of fully funded private second-pillar pension funds in general should be assessed as positive. However, due to the longer life expectancy, the capital accumulated by women in the fully funded second pension pillar does not exceed the present value of loss in the first pension pillar, based on the pay-as-you-go principle. The comparison of basic annuities exposes more optimistic results for both genders of participants of fully funded private second-pillar pension funds.

BARTKUS Algirdas. On Future Pensions from Second Pillar Pension Funds. Organisations and Markets in Emerging Economies, 2013, Vol. 4, No. 1(7) ISSN 2029-4581.

The main focus of this paper lies in the possibility for particular second-pillar pension fund participants to achieve a higher pension compared with non-participants. These particular participants are employees with average wages and average employment histories. This analysis is of main importance when it comes to the decision on whether to participate in the second pillar or not. Unit roots tests and co-integration analysis are used as the possible tools to investigate the dynamics of retirement income for participants and non-participants. This research has the intention to determine the conditions when replacement from the second pillar will offset the loss from the pay-as-you-go system.

BARTKUS Algirdas. Ilgalaikis socialinio draudimo reformų poveikis socialinio draudimo biudžeto stabilumui. Taikomoji ekonomika: sisteminiai tyrimai, 2012, Vol. 6, No 2. ISSN 1822-7996.

"Long-term Effects of Reforms in Social Insurance on the Stability of the Social Insurance Budget"

This paper attempts to evaluate the introduction of the second-pillar pension funds and increase of the retirement age on long-term stability of the public pension scheme in Lithuania during the post-crisis period. The research is focused on public pension income and expenditure forecasting. The analysis was performed and the conclusions were drawn on the basis of univariate econometric models. The econometric modelling of the public pensions has one advantage compared with other techniques: forecasts mimic trends observed in the past. The analysis revealed that the Russian financial crisis of 1998 and the accession to the EU have not had any statistically significant effect on the long-term development of the social security system. Structural changes which had statistically significant effect on the development of the public pension scheme were: social insurance reform of 1995, the financial crisis of 2008 and a possibly free labour movement within the EU. In the long run, the second-pillar pension funds reduced the amount of public pension expenditures and increased financial stability. In the absence of such pension funds, the system would be imbalanced until the 3rd quarter of 2023. In the presence of them, the system will be imbalanced until the 4th quarter of 2021. It is likely that delaying retirement means that the number of pensioners will be reduced by approximately 120,000 by 2026. Increasing the retirement age also results in positive financial effects and the first surplus in the public pension schemes may occur in the 3rd quarter of 2015. Overall, it is likely that pension funds and increases in retirement age may have a positive effect on the financial stability of the public pension scheme.

PETRYLAITĖ, Vida. Pamatiniai socialinės apsaugos teisės principai. Doktoro disertacija. Vilnius, 2012.

"Fundamental Principles of Social Security Law" Doctoral Dissertation Paper

Some chapters of the dissertation discuss the pension rights from the point of view of the principle of property right protection. The author states that the implementation of the principle of property right protection in practice is impeded by a too broad application of the principle in respect of social security by the Constitutional Court of Lithuania, i.e. by placing insufficient emphasis on ensuring the proportionality between the public interest and the rights of a specific person. Therefore, future development and implementation of the social security system will face difficulties in striking a proper balance between protecting property rights and other principles of social security, particularly the principle of solidarity.

[Health Care]

MURAUŠKIENE, Liubovė, JANONIENE, Raimonda, VENIUTE, Marija, van GINNEKEN, Ewout, KARANIKOLOS, Marina. Lithuania Health System Review. Health Systems in Transition, Vol. 15, No. 2, 2013, World Health Organization, retrieved from http://www.euro.who.int/_data/assets/pdf_file/0016/192130/HiT-Lithuania.pdf

This analysis of the Lithuanian health system reviews the developments in organisation and governance, health financing, health care provision, health reforms and health system performance since 2000. The Lithuanian health system is a mixed system, predominantly funded from the National Health Insurance Fund through a compulsory health insurance scheme, supplemented by substantial state contributions on behalf of the economically inactive population amounting to about half of its budget. Public financing of the health sector has gradually increased since 2004 to 5.2% of GDP in 2010. Although the Lithuanian health system was tested by the recent economic crisis, Lithuania's counter-cyclical state health insurance contribution policies (ensuring coverage for the economically inactive population) helped the health system to weather the crisis, and Lithuania successfully used the crisis as a lever to reduce the prices of medicines. Yet the future impact of cuts in public health spending

is a cause for concern. In addition, out-of-pocket payments remain high (in particular for pharmaceuticals) and could threaten health access for vulnerable groups. A number of challenges remain. The primary care system needs strengthening so that more patients are treated instead of being referred to a specialist, which will also require a change in attitude by patients. Transparency and accountability need to be increased in resource allocation, including financing of capital investment and in the payer-provider relationship. Finally, population health, albeit improving, remains a concern, and major progress can be achieved by reducing the burden of amenable and preventable mortality.

JANKAUSKIENE, Danguolė, Sveikatos priežiūros paslaugų kokybės vertinimo pacientų požiūriu palyginimas Lietuvoje ir kai kuriose Europos šalyse, Sveikatos politika ir valdymas, 2012 (4), P. 84-101 Mykolo Romerio universitetas, retrieved from http://www.mruni.eu/lt/mokslo_darbai/spv/paskutinis_numeris/

“Quality of Health Care Based on the Opinion of Patients in Several European Countries“

The aim of the study is to evaluate and compare the quality of health care systems based on the opinion of patients of several European countries and Lithuania. Methods: A systematic review and comparative analysis of the data from the European surveys, published since 2007, were used in order to compare the indicators of patients' satisfaction with the access and quality of health care systems in ten EU countries: Austria, Germany, Denmark, Sweden, Estonia, Latvia, Lithuania, Romania, the UK and Slovenia. The systematic review inclusion criteria were: systematic review has to be performed in the latest available year, but not earlier than 2007, representative sample of the public opinion survey; the study had to be performed on an international scale (i.e. in all comparative countries), target groups of the study had to be all users of health care services. Two groups of indicators were assessed: quality by the variables examined in the selected studies and by the model of quality evaluation according to value for money. Overall evaluation was made by the value-for-money-adjusted evaluation using a scatter diagram in the SPSS statistical package program. Facts findings and conclusions: the overall assessment of quality in ten selected European countries considering value-for-money-adjusted evaluation showed that the leading countries in terms of health care quality are Austria, Denmark, Sweden and Germany, whereas the worst quality is evaluated in Latvia, Romania, Lithuania and Estonia.

STARKIENE, Liudvika, Gydytojų skaičiaus planavimas: nuo mokslinių tyrimų iki sveikatos politikos Sveikatos politika ir valdymas, 2012 (4), P.102-115, Mykolo Romerio universitetas, retrieved from http://www.mruni.eu/lt/mokslo_darbai/spv/paskutinis_numeris/

“Planning the Number of Physicians: from Research to Health Policy Decisions“

The first planning projections of physician numbers in Lithuania were drawn almost two decades ago; however, the accuracy of those and later planning efforts (conducted in 2003, 2004 and 2007) was never evaluated. This study aimed to overview the actual changes in the physician numbers in Lithuania in 1994-2011 and to compare them with previously drawn planning projections. Moreover, the study reviewed health policy decisions and other important factors, which possibly influenced actual changes in physician numbers. Lithuania retained a stable physician-per-population ratio between 1994 and 2011. This was influenced by a combination of various factors as well as health policy decisions. First of all, the influence of a declining overall population number should be noted; the number of population decreased by almost half a million (427,000) in the period 1994-2011. Because of that, while the overall number of physicians decreased by 12.3%, the physician-to-population ratio remained stable (41.7 per 10,000 population). None of the planning projections proved to be

very accurate; however, they served as an important tool for policy makers in taking decisions regarding physician human resources. Financial support of the EU structural funds, which enabled renovation of most hospitals and supply of new medical equipment, contributed to significant changes in working conditions of physicians. The support was also given to physicians' continuous professional development. Health policy decisions to increase the salaries (they increased by 2.5 times between 2005 and 2011) also played an important role in retaining physicians. Increased enrolment to physician training programmes since 2002 as well as change in the legal status of medical residents contributed to ensuring at least partial substitution for the number of those physicians who leave the profession annually. Establishment of a re-entry programme into the profession in 2009 was a positive development, especially with coverage of 90% of traineeship costs. Unfavourable retirement conditions, while not a specific physicians' retention policy, contributed to retaining practising physicians after their retirement age. Immediate challenges that need to be addressed by policy makers are rapid physician ageing (especially in some specialties), which will inevitably cause shortages of physicians in the next decade, and numerous student drop-outs from studies. Increasing training enrolments is relevant only as part of a broader policy portfolio for medium- to long-term solutions. The effect of reducing drop-out occurs immediately and also avoids the substantial costs of extra capacity in study programmes as well, representing a more efficient use of resources. Therefore, the author recommends modifying the selection procedure for medical students, including assessment of applicants' non-cognitive and cognitive abilities. As in other countries, the establishment of a comprehensive monitoring system and the harmonisation of physician human resources planning with ongoing health care reform objectives remains one of the biggest future challenges for Lithuania.

ŠPOKIENE, Indrė, Lietuvos teisės aktuose asmeniui ir valstybei adresuotų pareigų „rūpintis sveikata“ teisinis vertinimas, Sveikatos politika ir valdymas, 2012 (4), P.7-23, Mykolo Romerio universitetas, retrieved from http://www.mruni.eu/lt/mokslo_darbai/spv/paskutinis_numeris/

“Legal Assessment of the Duties to “Take Care of one’s Health” of the Person and the State According to Lithuanian Legislation“

The paper analyses the peculiarities of the duties to “take care of health” in respect of the person and the state in the legal acts of Lithuania. The duties of the person apply both in respect of the person as the resident of Lithuania and in respect of the person as the patient. As the patient, the person, according to the law on the rights of patients and compensation for the damage to their health and the internal regulations of health care institutions, is obliged to take care of their own health. As the resident of the Republic of Lithuania, the person according to the law on the health system, has to fulfil the duty to take care not only of their own, but also of the health of the parents and under-age children. The conclusion is made that the requirement for the person, who has the legal status of the person, is more important, because in the case of failure to fulfil it, certain legal consequences may arise. Meanwhile, the duty of the resident to take care of their own health is evaluated as declarative. The general peculiarity that complicates the implementation of the duty “to take care of one’s own health”, and at the same time, the legal assessment, is the lack of clarity and wideness of the concept of “health”. This also applies with the aim of assessing the possibilities of the implementation of the resident’s duties to take care of the health of “their own under-age children” and “their own parents.” Nevertheless, the analysis of provisions of the Civil Code of the Republic of Lithuania and other legal acts that provide the duty of the parents to maintain their under-age children and, adequately, the duty of adult children to maintain parents who are in need of support (fulfilling the health care needs in both cases) allows the claim that both the duty of

the parents and the duty of the children to take care of each other's health under the law on the health system of the Republic of Lithuania, are not only declarative norms. The second part of the paper is aimed at analysis of the provision "the state shall take care of people's health" of the Constitution of the Republic of Lithuania. It has been established that the crucial presumption of the duty is the implementation of the rights to health care established under international human rights documents (that Lithuania adhered to or ratified). It has been revealed that this duty under the constitutional doctrine of Lithuania is treated more as the function of the state, the public interest, and not the individual right to achieve certain health care services guaranteed by the constitution. In consideration of the constitutional doctrine, it has to be recognised that the implementation of this duty cannot be separated from the state's social and economic situation, the needs and possibilities of the society and the state, and other factors. However, it can be claimed that in certain cases it is possible to argue whether the state, which has established a certain requirement, really does not infringe the rights of the specific patient/resident in the field of health care.

[Long-term Care]

MARKEVICE, Rūta, VALENTELIENE, Rolanda, Su sveikatos priežiūra susijusių infekcijų valdymas Lietuvos palaikomojo gydymo ir slaugos ligoninėse, Visuomenės sveikata, No3, 2012, P.44-51, Higienos institutas, retrieved: [http://www.hi.lt/images/sv_3\(58\)_inetui.pdf](http://www.hi.lt/images/sv_3(58)_inetui.pdf)

„Control of Health Care – Associated Infections in Lithuanian Long-term Care Hospitals“

The aim of the study is to identify the situation of control of health care-associated infections in Lithuanian long-term care hospitals and to describe conditions to perform hand hygiene. Material and methods: the study was carried out in 2008, in 48.8% of Lithuanian long-term care hospitals. Participation in the study was voluntary. To describe and evaluate the infection control situation, the hospital administration was interviewed with a questionnaire asking about infection prevention and control measures. To identify the situation of hand hygiene, a specific questionnaire was created in respect of hand hygiene. In each hospital, workplaces (depending on hospital size) were selected and a descriptive observational study performed. Results: On average, there are 3.5 beds in each ward, each doctor provides health care services for 18 beds and there is one nurse per 4 beds. In 71.4% of hospitals there are those responsible for infection control. Epidemiological surveillance of infections is performed in 61.9% of hospitals. The ability to isolate in the case of infection has 81.0% of hospitals. Written recommendations of hand hygiene and the prevention of pressure ulcers have 90.5% of hospitals, of urinary catheter care 81.0%, of stoma care 70.0%. On average, 2 ml hand antiseptic is used per day per patient. In the training and seminars on infection control, hospital hygiene was covered in 76.2% of hospitals within the last 11 months before the study, on average. Microbiological tests are carried out in 33.3% of hospitals. Antibiotics-resistant microorganisms screening is performed in 9.5% of hospitals. The situation of hand hygiene was assessed through the basins at 57 workplaces: mainly 41 % procedural, 28% staff toilets. Hand hygiene antiseptics were present in 71.9%, soap in 96.5% and towels in 89.4% of workplaces. Appropriate soap was in 82.5%, suitable towels in 61.4%, a suitable bin in 77.2% of workplaces. Appropriate hand hygiene conditions in all workplaces could only be found in 19% of hospitals. Conclusions: for the first time in Lithuania such a study was carried out and it showed that infection control in long-term care hospitals requires improvement, although the vast majority of requirements, governed by the regulations of the Republic of Lithuania, are complied with. Greater attention should be paid to staff training about the risk factors of health-care associated infections, their prevention and control, the spread and control of antibiotics-resistant microorganisms. It is important to encourage

hospitals to participate in the surveillance of health-care associated infections, and address greater attention to hand hygiene, as the key to infection prevention.

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„Life Satisfaction and its Sources Among Adults with a Family Member with Chronic Disease“

The aim of the study is to investigate life satisfaction and its sources, i.e. a sense of coherence and social support, among adults who have a family member with chronic disease. Materials and methods: the research was carried out at the Institute of Oncology of Vilnius University, at Vilnius University Emergency Hospital and at Marijampole Hospital by applying three different questionnaires and an especially prepared form for common data collection. The group of participants consisted of 101 relatives, 55 of them having relatives with chronic non-oncologic illnesses and 46 having relatives with chronic oncologic disease. The average age of the participants was 47. Satisfaction with Life was assessed by using the *Satisfaction with Life Scale* (SWLS, Diener, Emmons, Larsen, Griffin, 1985), the sense of coherence was surveyed by using the *Sense of Coherence Scale* (SOC, Antonovsky, 1987), and social support was measured with the *Multidimensional Scale of Perceived Social Support* (MPSSS, Zimet, Dahlem, Zimet & Farley, 1988). Results and conclusions: females with relatives with chronic disease perceive to have more general social support and more social support from their family than males. Relatives not living with their sick family member perceive to have more general social support and their sense of coherence does not differ between male and female and does not differ from participants living separately from their sick family member. There is no difference in satisfaction with life and perceived social support among adults with a relative with chronic disease according to family status. Social support does not differ according to family relationship and according to the type of chronic illness (oncologic or non-oncologic). The hypotheses that levels of sense of coherence and satisfaction with life are lower in adult children and spouses with a relative with chronic disease than in other family members, and also that adults with a family member with chronic oncologic disease tend to have lower levels of satisfaction with life and lower levels of sense of coherence than adults with a relative with chronic non-oncologic illness, were disconfirmed.

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