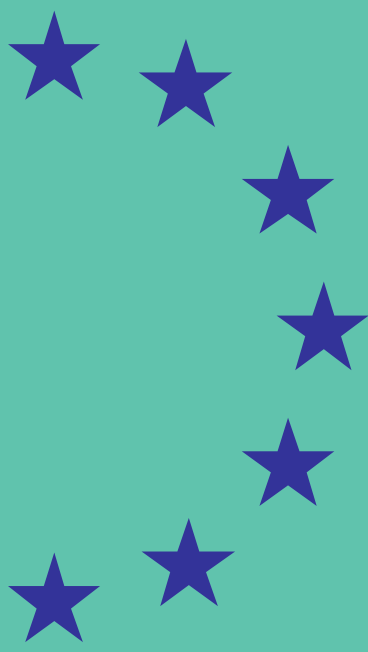




# Lithuania

## Health Care & Long-Term Care Systems



An excerpt from

**the Joint Report on Health Care  
and Long-Term Care Systems  
& Fiscal Sustainability,**

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Country Documents - 2019 Update

## Lithuania

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### Health care systems

From: *Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability*, prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Country Documents – 2019 Update

## 2.17. LITHUANIA

### General context: Expenditure, fiscal sustainability and demographic trends

*General statistics: GDP, GDP per capita; population*

GDP per capita in PPS, at 19,600 PPS per capita is below the EU average GDP per capita of EUR 29,600 in 2015. Lithuania has a population of around 2.9 million inhabitants. Over the coming decades, the population of Lithuania will gradually decline, from 2.9 million inhabitants in 2016 to 1.7 million inhabitants in 2070. This 40% fall is very different from the EU average increase of 2%.

### *Total and public expenditure on health as % of GDP*

Total expenditure <sup>(238)</sup> on health as a percentage of GDP (6.8% in 2015) is below the EU average <sup>(239)</sup> of 10.2%. Public expenditure is, at 4.7% of GDP, far below the average of 8% in 2015. Looking at health care without long-term care<sup>(240)</sup> reveals a smaller gap with the EU average (4.1% vs 6.8% in 2015).

When expressed in per capita terms, total spending on health at 1488 PPS in Lithuania is below the EU average of 3305 in 2015. So is public spending on health care: 1020 PPS vs. an EU average of 2609 PPS in 2015.

### *Expenditure projections*

As a consequence of demographic changes, health care expenditure is projected to increase by 0.4 pps of GDP, below the average growth expected for the EU (0.9) <sup>(241)</sup>, according to the Reference Scenario. When taking into account the impact of

non-demographic drivers on future spending growth (AWG risk scenario), health care expenditure is expected to increase by 1.2 pps of GDP from now until 2070 (EU1.6).

Overall, Lithuania presents low fiscal risks <sup>(242)</sup>.

### *Health status*

Life expectancy at birth (79.7 years for women and 69.2 years for men in 2015) is far below the respective EU averages (83.3 and 77.9 years of life expectancy) <sup>(243)</sup>. Healthy life years, at 58.8 years for women and 54.1 for men, are below the EU averages of 63.3 and 62.6 in 2015. The infant mortality rate of 4.2‰ is above the EU average of 3.6‰ in 2015).

As for the lifestyle of the Lithuanian population, there is a proportion of regular smokers of 20.4% in 2014 higher than the EU average of 20.9% in 2014. Alcohol consumption is, at 15.2%, higher than the EU average of 10.2% in 2015 according to Eurostat. The Lithuanian Statistical authorities report a continuous fall in alcohol consumption from 14.5% in 2013 to 13.2% in 2016.

### *System characteristics*

#### *Coverage*

Compulsory statutory health insurance, based on compulsory insurance contributions, plus transfers from the State budget, provide health care coverage to approximately 98-99% of the resident population. The National Health Insurance Fund (NHIF) and its regional branches, the Territorial Health Insurance Funds (THIFs), contract with care providers for the provision of services and reimburse the insured for medicines. The set of (mostly public) services organised at municipal, county and national level constitute the Lithuanian National Health Systems (LNHS). The services included in the statutory provision are defined by law. This is broad definition which is further detailed by decrees of the Minister of Health and by contracts among THIFs and providers. The

<sup>(238)</sup> Data on health expenditure is taken from OECD health data and Eurostat database. The variables total and public expenditure used here follow the OECD definition under the System of Health Accounts and include HC.1-HC.9 + HC.R.1.

<sup>(239)</sup> The EU averages are weighted averages using GDP, population, expenditure or current expenditure on health in millions of units and units of staff where relevant. The EU average for each year is based on all the available information in each year.

<sup>(240)</sup> To derive this figure, the aggregate HC.3 is subtracted from total health spending.

<sup>(241)</sup> I.e. considering the "reference scenario" of the projections (see The 2018 Ageing Report: [https://ec.europa.eu/info/sites/info/files/economy-finance/ip079\\_en.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf)).

<sup>(242)</sup> Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

<sup>(243)</sup> Data on health status including life expectancy, healthy life years and infant mortality is from the Eurostat database. Data on life-styles is taken from OECD health data and Eurostat database.

definition of benefit package is not revised annually.

Free emergency care is provided to the all permanent residents. Most of the other services are also free for insured people, but if patients want to have higher service standard or additional services not covered by compulsory health insurance they have to pay to different extents. Cost-sharing applies to some services: for instance, the majority of pharmaceuticals and dental services.

The share of private expenditure on health in total health expenditure (31.4% in 2015) is far higher than the EU average (21.6). Out-of-pocket expenditure constitutes about 32.1% of total health expenditure, well above the EU average (15.9% in 2015).

There are several cost-sharing exemptions: 19 categories of population are exempted from payment of compulsory health insurance contributions as they are insured by the government. In 2015, the number of such persons was 1.64 million (almost 56% of the total population). There are also two groups of people to whom a ceiling is applied:

1. various groups of self-employed people on the income calculated on the sum which does not exceed the sum of 48 amounts of the taxable income approved by the government of the Republic of Lithuania for the current year;
2. people on the income from individual agricultural activities of the natural persons, who engage in that type of individual activities, for whom contributions are being calculated on a sum which does not exceed the sum of 12 amounts of the taxable income.

In addition to formal payments, informal (non-official) payments are still reported. These do not encourage a more effective use of services and constitute an additional barrier to access as there are no exemptions for low income or high risk groups.

#### *Administrative organisation and revenue collection mechanism*

The NHIF allocates the budget to the THIFs according to a formula based on the number of

residents in each county, their age and gender. As it stands, it may be worth exploring if additional gains can be achieved through resource reallocation across the country to improve the geographic distribution of care (there appears to be an overconcentration of services in richer and urban areas and underfunding in other parts of the country). The THIFs then establish contractual arrangements with service providers.

Expenditure under the Compulsory health insurance fund is constrained by the sums approved by the Law on the Approval of Financial Indicators of the budget of CHIF. The budget of the CHIF is balanced out within a year. Once a month, the accounts for the provided health care services and dispensed medicines and minor medical aid equipment subject to compensation are being submitted by the health care institutions and pharmacies to the THIF wherewith it has concluded a contract. Under the conditions of the contracts, without exceeding the approved appropriations of the budget of the NHIF and not later than within 30 days from the receipt of a bill, the THIFs must settle the accounts submitted by the individual health care institutions and pharmacies wherewith the said funds have concluded contracts.

#### *Types of providers, referral systems and patient choice*

Primary care is provided by general practitioners (GPs) or GP teams, consisting of a district internist or district paediatrician together with a surgeon and an obstetrician-gynaecologist, nurses and other staff. Services are provided in primary care health centres or GPs private offices, community posts, ambulatories and polyclinics around the country. Specialist ambulatory care is provided in polyclinics and hospital outpatient departments, mostly state or municipally-owned facilities, although private provision of specialist outpatient care is growing. Inpatient care is provided in general and specialised hospitals. Providers establish contracts with the THIFs. Virtually all pharmacies (except for a few) and the majority of dental practices are private. Pharmacies establish contracts with THIFs and receive reimbursement for the pharmaceuticals (included into positive list) delivered to the patients. Dental practices operate on a totally private basis. The only exception is represented by those dental practices which are

within the structure of Primary health care centres. The payment for primary dental services is included into Primary Health Care capitation rate.

The total number of practising physicians per 100 000 inhabitants (434 in 2015) is above the EU average (344) and has increased gradually since 2003. Data on the physician skill-mix indicates that the number of GPs per 100 000 inhabitants (91 in 2015), excluding district internists and district paediatrician which are working very much like GPs, is above the EU average (78.3). This is due to a high increase throughout the last two decades as part of the authorities' efforts to improve primary care provision (42.7 in 1998). The number of nurses (766 in 2015) per 100 000 inhabitants is below the EU average (833 in 2015), having remained relatively flat since 2011 (753). This may be associated with staff, particularly nurses, migrating to other EU countries that need to provide nursing care and offer better wages. This skill mix, coupled with non homogenous physician distribution is still posing some difficulties to a well-functioning primary health care sector, which is acknowledged by the authorities.

Since the early 1990s, national authorities have made a significant and, to a large extent, successful effort to enhance primary care provision, to strengthen the referral system from primary care to specialist doctors and to strengthen the gate-keeping role of GPs to reduce the unnecessary use of specialist and hospital care. This is amongst other things done through a financial incentive to visit, one's own GP as the first step; i.e. imposing an extra cost for non-referred consultations. All inhabitants have to register with a GP who acts like a family doctor and refers patients to other types of care. Patients are able to choose their health centre and their GP and choose a hospital after referral. To implement a well-functioning referral system and choice, it is necessary to continue the efforts so far to change the skill mix and improve the distribution of primary care across the country and possibly to improve access to primary care / GPs after normal office hours (although office hours are already long compared to other countries). Shortages of GPs can lead to high waiting times to visit GPs and therefore individuals skipping the referral system and going straight to hospital, making unnecessary use of (free) emergency care.

Lithuania has one of the largest numbers of acute care hospital beds per 100 000 inhabitants (608 in 2015) in the EU (EU average of 402 in 2015), although it has seen a large reduction in the last two decades (631 in 2005).

These values were perhaps a result of the efforts to modernise care facilities and improve quality of care. However, for a country spending a relative small percentage of their overall GDP on health, it may be too high a value to allocate to infrastructure. It may be worth investigating if investment in infrastructure is still necessary and to carefully consider what type of infrastructure can be cost-effective given the size of the country, the budget for health and the economic situation.

#### *Treatment options, covered health services*

Health in the statutory provision basket are broadly defined by law. This definition is made more detailed by decrees of the Minister of Health and by contracts among THIFs and their providers. The definition of the benefit package is not revised annually.

#### *Price of healthcare services, purchasing, contracting and remuneration mechanisms*

Payment systems have evolved over the years. GPs (or GP teams) receive a mix of capitation, approximately 74.5 % of total payments in 2015, according to the number and age of their listed patients (age-adjusted capitation), fees for defined activities (health promotion and disease prevention), as well as bonuses for some performance indicators (the remaining 25.5 %). This mixed system intends to render primary care more attractive and provide incentives for primary care provision including some health promotion and disease prevention activities. The authorities are considering a further enlargement of the non-capitation share of GPs' payment, and there is a set of additional performance indicators related to reduction of avoidable hospitalisations elaborated for that. Specialists are paid per consultation, consisting of up to three visits for the same reason; if the patient needs to see specialist further on – the new episode of consultation is reimbursed to the provider. Remuneration is determined by the central government (Ministry of Health).

Hospitalisation rates are still high although progress towards primary care and reducing hospital capacity has been significant. The number of hospital surgery done as day cases was 2403 day cases per 100 000 inhabitants in 2015 vs. the EU average of 7635). On the contrary, the number of inpatient discharges per 100 inhabitants was 23.1 in 2015, above the EU average of 16.2.

Hospitals are paid mostly on the basis of cost per case (450 groups of diagnosis – nationally elaborated DRGs) according to annual contracts. The decision was made to switch to Australian Refined DRG system from 2012. Implementation was delayed until 2014 due to coding problems. The hospital budgets are very stringent in terms of budget caps. However, there is flexibility to provide more short-term, day and outpatient services (so-called priority services) instead of ordinary hospitalisations.

#### *The market for pharmaceutical products*

Medicines in Lithuania are mainly imported from other EU member states. The reimbursable price is set on the basis of international prices of a selected list of countries. In order to further control overall expenditure, the authorities have implemented the following policies: a) the reimbursable price is determined on the basis of 95% of the average of manufacturer prices in reference countries CZ, EE, HU, LV, PL, SK, RO, BG and b) there is a reference price mechanism, whereby the maximum reimbursement price of a new drug is based on other drugs that have both the same active ingredient and form and according to the disease, and c) positive lists (the list of pharmaceuticals that can be reimbursed) are based as much as possible based on economic evaluation information.

Compared to the range of policies used by neighbouring countries, there is perhaps room to explore other additional measures regarding product price regulation and direct expenditure control. On 1st of April 2010, new provisions of the Amendment of Law on Pharmacy concerning the regulation of prices of non-reimbursed pharmaceuticals entered into force. The government sets the maximum wholesaler and pharmacy mark-ups for prescriptions and OTC. The representatives of manufacturers shall provide manufacturer prices for the Lithuanian market, as

well as the prices at which the pharmaceuticals are distributed in the reference countries in order to compare them.

Since 2010, a number of measures aimed to reduce expenditures on pharmaceuticals have been adopted. The new rule about the price of generic is set by the Governmental Decree. The first generic in the group shall be 50 % cheaper than original, the second 15 % cheaper than the first and the third 15 % cheaper than the second generic. In the case when the group of reimbursed medicinal products consists of more than 3 medicinal products of different manufacturers, the most expensive medicinal product can be only 10% more expensive than the average of two cheapest pharmaceuticals of the same INN in reference countries.

Since 2011, therapeutically interchangeable pharmaceuticals with different INN are clustered if they have the same therapeutic effect, indication of reimbursement, presentation form and are used for the treatment of the same age group of patients.

Since 1st of May 2010 pharmacies are obliged to show prices of pharmaceuticals to patients in a special computer monitor.

Since 1st of June, 2010 prescribing medicinal product by INN is obligatory with some exceptions set by the Minister of Health.

#### *eHealth, Electronic Health Record*

Health aims to improve the accessibility and quality of healthcare services and to ensure the necessary information exchange using the information and communication technologies.

According to the plan of the implementation of E-Health System Development Programme for 2009-2015, the Ministry of Health of the Republic of Lithuania has finished three large public investment projects: the central part of the system (ESPBI IS), e. prescription and medical image exchange. According to the Implementation Plan, during period of 2009 – 2015 29 e-health projects have been already implemented, including 16 national and 13 regional projects. Information systems of the national-level and university hospitals, Online Booking System for outpatient consultation, and registers of licenses of health

care professionals and health care institutions, and register of medicines ensuring the development of high quality electronic services of health care institutions (HCI) have been developed under the national projects. Regional projects are focused on information systems of regional medical institutions that provide data to the central e-health information system.

150 HCI have already implemented the projects of e-health development information systems and currently they provide the electronic completion of patient medical records within the scope of the project: 12 clinical forms: referrals, epicrysis, description of visits, e-prescriptions, laboratory tests, radiological image reports and etc., as well as 8 medical certificates: health certificates for students, drivers, holders of weapons, birth or death certificates, and others.

The central e-health system (ESPBI IS) is capable of storing patient information from various HCI in one e-health history (One Resident – One EHR). This makes it possible to re-use health records, to avoid duplication of diagnostics procedures and provide health care services to patients more efficiently, safer and better quality. The system will enable to carry out disease prevention and health promotion programmes more effectively based on objective records, which will be available for re-use. Patient-needs-oriented EHR aims to assure lifelong and effective provision of healthcare services in Lithuania. EHR is being developed gradually, i.e. during the first years it is carry only the critical patient health information and certain certificates. Later it will be expanded and supplemented with more detailed medical data.

Lithuania strives to involve all healthcare institutions in participation and secure data exchange, to enable successful functioning of the ESPBI IS and to create, store and transfer data about patient health even between European countries according to the principle “one resident – one EHR”.

In order to ensure a coherent policy of development of the eHealth system in Lithuania, smooth operation of health care institutions, to save the time of doctors and patients, to receive health care services of a better quality, the eHealth System Development Program for period of 2017-

2025 was approved by Order No V-878 of the Minister of Health of the Republic of Lithuania of 17 July 2017., i.e. it is aimed that all health care institutions should participate in the eHealth system in order to create conditions for all health care institutions in Lithuania to provide patient’s electronic health records from the health care institutions information systems or through the portal <sup>(244)</sup>.

*Health and health-system information and reporting mechanisms/ Use of Health Technology Assessments and cost-benefit analysis*

Data has much improved in recent years although it is still lacking in a number of areas. Information and monitoring of physician and hospital activity can be used for example for establishing contracts and prospective budgets.

Currently there is no structure to conduct health technology assessment in great part due to the fact that it requires additional administrative capacity and scientific know-how, currently not available. Therefore, cost-effectiveness knowledge is used in a limited way to determine the benefit package, the extent of cost-sharing or develop treatment guidelines to harmonise and rationalise medical practices.

There is an HTA model developed and successfully deployed in Lithuania, which is based on the assessment of applications submitted to competent HTA bodies, responsible for assessing medical devices, medical procedures, public health technologies and medicines according to the priorities set by the Ministry of Health. The greatest priority is attributed to the technologies which have the greatest impact on morbidity, mortality and disablement.

As introduced earlier, there are indeed a number of risk factors to health that deserve attention and action. Consequently, the central government has set a number of public health objectives, some of which are very detailed and have been implemented with the help of the WHO. Currently there are six prevention programs carried out in Lithuania: Heart and vascular diseases prevention programme, Sealant program for children, Cervical

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<sup>(244)</sup> [www.esveikata.lt](http://www.esveikata.lt).

cancer, Mammography, Colorectal cancer and Prostate cancer screening programmes.

However, total (0.13%) and public (0.13%) expenditure on prevention and public health as a share of GDP is much lower than the EU average (respectively 0.3% and 0.25% in 2015).

### Recently legislated and/or planned policy reforms

In 2013 the creation of the Integrated Health Care and Functional Cluster System was started, thus seeking to start quality treatment of patients suffering from serious illnesses as soon as possible, to manage patient flows more efficiently and optimise the activities of hospitals.

In order to achieve a more effective operation of system of the national health care institutions, the next health care system development and hospital network consolidation strategic plan was approved by the Minister of Health in December 2015. The strategic plan foresees the directions and priorities of the Lithuanian national health system development and optimisation.

### Challenges

The analysis above shows that a wide range of reforms have been implemented over the years, to a large extent successfully (e.g. the development of a strong primary care system), and which Lithuania should continue to pursue. However, some policies have met with a number of obstacles and there may be room for improvements in a number of areas. The main challenges for the Lithuanian health care system are as follows:

- To improve, as acknowledge by the authorities, the basis for more sustainable and larger financing of health care in the future (e.g. considering additional sources of general budget funds), with a better balance between resources and demand, between the number of contributors and the number of beneficiaries and which can improve access and quality of care and its distribution between population groups and regional areas. If more resources are brought into the sector it is important that they do not remain fragmented but are pooled together maintaining the strong pooling mechanisms in place today.
- To continue to enhance and better distribute primary health care services and basic specialist services to improve equity of access and the effectiveness and efficiency of health care delivery as well as ensuring effective referral systems from primary to specialist care and improving care coordination between types of care. This can be helped through developing electronic patient records in the future.
- To continue the efforts to decrease hospital beds while increasing day-case surgery and concentrating high-tech hospital services.
- To implement a comprehensive human resources strategy to ensure a balanced skill-mix, avoid staff shortages and motivate and retain staff to the sector, especially in view of migration and ageing.
- To consider additional measures regarding price regulation and direct expenditure control, including incentives for good prescribing practices and a more explicit policy on generics and the monitoring of prescription of drugs.
- To continue to improve data collection and monitoring of inputs, processes, outputs and outcomes so that regular performance assessment can be conducted and use to continuously improve access, quality and sustainability of care.
- To gradually increase the use of cost-effectiveness information in determining the basket of goods and the extent of cost-sharing.
- On the basis of the defined public health priorities, continue to enhance health promotion and disease prevention activities, i.e. promoting healthy life styles and disease screening given the recent pattern of risk factors (diet, smoking, alcohol, lack of exercise, obesity) as detailed in the national plan, including the smoking ban and health education in schools and communities. Taxes on tobacco, alcohol and soft drinks, stricter regulation of tobacco advertisement and labelling as well as stricter road safety measures and bicycle lanes and greener areas are some of the measures that can encourage healthier life-styles.



Table 2.17.1: Statistical Annex - Lithuania

General context												EU- latest national data			
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2009	2011	2013	2015
<b>GDP</b>															
GDP, in billion Euro, current prices	21	24	29	33	27	28	31	33	35	37	37	12,451	13,213	13,559	14,447
GDP per capita PPS (thousands)	15.5	16.1	17.1	16.2	14.1	15.4	16.4	17.2	17.9	18.8	19.6	26.8	28.1	28.0	29.6
Real GDP growth (% year-on-year) per capita	9.5	9.1	12.4	3.7	-13.9	3.8	8.5	5.2	4.6	4.4	3.0	-4.7	1.5	0.1	2.0
Real total health expenditure growth (% year-on-year) per capita	:	16.0	12.8	10.2	-1.9	-2.3	5.0	2.3	3.3	3.8	7.5	3.7	0.2	0.2	4.1
<b>Expenditure on health*</b>															
Total as % of GDP	5.8	6.2	6.2	6.6	7.5	7.1	6.9	6.7	6.6	6.6	6.8	10.2	10.1	10.1	10.2
Total current as % of GDP	5.7	5.8	5.8	6.3	7.4	6.9	6.5	6.3	6.1	6.2	6.5	9.3	9.4	9.9	9.9
Total capital investment as % of GDP	0.2	0.4	0.4	0.3	0.1	0.2	0.4	0.4	0.5	0.4	0.3	0.9	0.6	0.2	0.3
Total per capita PPS	620	771	944	1,143	1,082	1,075	1,194	1,258	1,317	1,383	1,488	2,745	2,895	2,975	3,305
Public total as % of GDP	4.1	4.3	4.6	5.0	5.6	5.2	5.1	4.5	4.3	4.4	4.7	8.0	7.8	7.8	8.0
Public current as % of GDP	3.8	3.9	4.1	4.5	5.4	4.9	4.6	4.2	4.1	4.2	4.4	7.7	7.6	7.6	7.8
Public total per capita PPS	431	534	693	859	810	789	893	857	865	922	1,020	2,153	2,263	2,324	2,609
Public capital investment as % of GDP	0.28	0.35	0.43	0.45	0.25	0.28	0.52	0.31	0.27	0.19	0.33	0.2	0.2	0.2	0.2
Public as % total expenditure on health	69.5	69.3	73.4	75.2	74.9	73.4	74.8	68.1	65.6	66.7	68.6	78.1	77.5	79.4	78.4
Public expenditure on health in % of total government expenditure	17.8	18.4	17.8	14.4	16.0	17.4	14.7	16.3	16.2	15.8	16.4	14.8	14.8	15.2	15.0
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	90.9	91.4	91.9	91.8	92.0	92.4	99.6	99.1	98.9	98.0
Out-of-pocket expenditure on health as % of total current expenditure on health	32.8	31.9	28.4	28.2	26.8	27.6	28.2	31.8	32.8	31.5	32.1	14.6	14.9	15.9	15.9

Note: \*Including also expenditure on medical long-term care component, as reported in standard international databases, such as in the System of Health Accounts. Total expenditure includes current expenditure plus capital investment.

Population and health status												2009	2011	2013	2015
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015				
Population, current (millions)	3.4	3.3	3.2	3.2	3.2	3.1	3.1	3.0	3.0	2.9	2.9	502.1	503.0	505.2	508.5
Life expectancy at birth for females	77.4	77.1	77.2	77.6	78.7	78.9	79.3	79.6	79.6	80.1	79.7	82.6	83.1	83.3	83.3
Life expectancy at birth for males	65.2	65.0	64.5	65.9	67.1	67.6	68.1	68.4	68.5	69.2	69.2	76.6	77.3	77.7	77.9
Healthy life years at birth females	54.6	56.5	58.1	59.6	61.2	62.3	62.0	61.6	61.6	61.7	58.8	62.0	62.1	61.5	63.3
Healthy life years at birth males	51.4	52.6	53.3	54.5	57.2	57.4	57.0	56.6	56.8	57.6	54.1	61.3	61.7	61.4	62.6
Amenable mortality rates per 100 000 inhabitants*	135	140	132	134	131	125	346	338	328	311	326	64	138	131	127
Infant mortality rate per 1 000 live births	7.1	7.2	6.3	5.5	5.6	5.0	4.8	3.9	3.7	3.9	4.2	4.2	3.9	3.7	3.6

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data			
Composition of total current expenditure as % of GDP												2009	2011	2013	2015
Inpatient curative and rehabilitative care	1.8	1.8	1.8	1.8	2.1	2.0	1.9	1.9	1.7	1.7	1.8	2.7	2.6	2.7	2.7
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.2	0.2	0.3	0.3
Out-patient curative and rehabilitative care	1.0	1.2	1.1	1.3	1.5	1.4	1.4	1.3	1.4	1.4	1.5	2.5	2.5	2.4	2.4
Pharmaceuticals and other medical non-durables	1.9	1.8	1.7	1.7	2.0	1.8	1.7	1.8	1.7	1.7	1.7	1.2	1.2	1.5	1.4
Therapeutic appliances and other medical durables	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.4	0.4
Prevention and public health services	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.2	0.3	0.3
Health administration and health insurance	0.1	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.4	0.4	0.4
Composition of public current expenditure as % of GDP															
Inpatient curative and rehabilitative care	1.6	1.7	1.6	1.7	1.9	1.8	1.8	1.8	1.6	1.6	1.7	2.6	2.5	2.5	2.5
Day cases curative and rehabilitative care	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.2	0.3	0.3
Out-patient curative and rehabilitative care	0.7	0.8	0.8	0.9	1.1	1.0	1.0	0.8	0.8	0.8	0.8	1.8	1.8	1.7	1.8
Pharmaceuticals and other medical non-durables	0.7	0.7	0.6	0.6	0.8	0.7	0.6	0.6	0.6	0.6	0.6	0.9	0.9	1.0	1.0
Therapeutic appliances and other medical durables	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2
Prevention and public health services	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.3
Health administration and health insurance	0.1	0.1	0.1	0.2	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.3	0.3	0.3

Source: EUROSTAT, OECD and WHO.

Table 2.17.2: Statistical Annex - continued – Lithuania

Composition of total as % of total current health expenditure	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU- latest national data					
	2009	2011	2013	2015													
Inpatient curative and rehabilitative care	31.3%	31.4%	30.4%	29.0%	28.4%	28.4%	29.1%	29.7%	28.1%	27.5%	27.8%	29.1%	27.9%	27.1%	27.0%		
Day cases curative and rehabilitative care	1.4%	1.9%	2.4%	2.8%	3.0%	3.0%	3.1%	1.6%	1.6%	1.8%	1.8%	1.7%	1.7%	3.0%	3.1%		
Out-patient curative and rehabilitative care	17.2%	19.7%	19.4%	20.7%	20.6%	20.5%	21.7%	21.0%	23.0%	21.8%	22.4%	26.8%	26.3%	23.7%	24.0%		
Pharmaceuticals and other medical non-durables	34.3%	31.0%	28.5%	26.2%	26.6%	26.7%	26.0%	28.9%	28.2%	27.8%	26.7%	13.1%	12.8%	14.7%	14.6%		
Therapeutic appliances and other medical durables	3.4%	3.9%	3.4%	3.5%	3.0%	3.5%	2.9%	2.9%	2.9%	3.2%	3.4%	3.6%	3.6%	4.1%	4.1%		
Prevention and public health services	1.9%	1.5%	2.1%	1.3%	1.2%	0.9%	1.2%	1.1%	1.3%	1.8%	2.0%	2.8%	2.5%	3.0%	3.1%		
Health administration and health insurance	2.1%	1.7%	2.1%	3.2%	2.0%	2.0%	2.0%	1.9%	1.8%	2.1%	2.0%	4.5%	4.3%	3.9%	3.8%		
<b>Composition of public as % of public current health expenditure</b>																	
Inpatient curative and rehabilitative care	42.4%	41.9%	38.6%	37.2%	35.8%	36.9%	38.2%	41.4%	38.9%	37.3%	38.3%	33.9%	33.6%	32.1%	31.9%		
Day cases curative and rehabilitative care	2.1%	2.5%	3.4%	3.8%	3.9%	4.3%	4.3%	2.1%	2.2%	2.4%	2.5%	1.9%	2.0%	3.4%	3.5%		
Out-patient curative and rehabilitative care	18.6%	20.1%	19.8%	20.1%	20.2%	20.1%	20.6%	19.4%	20.0%	19.4%	19.0%	22.9%	23.5%	22.2%	22.5%		
Pharmaceuticals and other medical non-durables	17.8%	16.5%	15.5%	13.7%	14.3%	14.0%	12.6%	13.7%	14.3%	13.6%	13.3%	11.8%	11.9%	12.6%	12.7%		
Therapeutic appliances and other medical durables	1.1%	1.3%	1.2%	1.1%	1.1%	1.0%	1.1%	0.9%	1.0%	1.4%	1.1%	1.8%	1.9%	2.0%	2.1%		
Prevention and public health services	2.9%	2.3%	2.9%	1.8%	1.7%	1.2%	1.7%	1.7%	2.0%	2.6%	3.0%	2.9%	2.5%	3.2%	3.2%		
Health administration and health insurance	2.7%	2.3%	2.7%	4.4%	2.8%	2.6%	2.8%	2.8%	2.7%	3.1%	3.0%	4.1%	4.0%	3.6%	3.4%		
<b>Expenditure drivers (technology, life style)</b>																	
MRI units per 100 000 inhabitants	0.15	0.29	0.33	0.42	0.51	0.47	0.59	1.00	1.05	1.06	1.10	1.0	1.4	1.5	1.9		
Angiography units per 100 000 inhabitants	:	:	0.5	0.6	0.7	0.7	0.6	0.7	0.8	0.8	0.9	0.9	0.9	0.9	1.0		
CTS per 100 000 inhabitants	1.2	1.2	1.0	1.3	1.5	1.8	2.0	2.4	2.4	2.2	2.1	2.1	1.9	2.1	2.3		
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2		
Proportion of the population that is obese	16.0	:	:	:	:	:	:	:	:	16.6	:	15.0	15.1	15.5	15.4		
Proportion of the population that is a regular smoker	24.5	26.5	:	24.2	:	:	:	:	:	20.4	:	23.2	22.3	21.8	20.9		
Alcohol consumption litres per capita	12.3	12.7	13.4	13.3	12.4	12.9	12.7	15.1	15.0	15.2	:	10.4	10.3	10.1	10.2		
<b>Providers</b>																	
Practising physicians per 100 000 inhabitants	362	365	372	370	365	383	409	422	428	431	434	324	330	338	344		
Practising nurses per 100 000 inhabitants	710	711	705	711	697	716	753	759	755	760	766	837	835	825	833		
General practitioners per 100 000 inhabitants	65	67	69	68	69	72	85	85	86	89	91	77	78	78	78		
Acute hospital beds per 100 000 inhabitants	690	617	608	559	553	546	535	528	523	524	518	416	408	407	402		
<b>Outputs</b>																	
Doctors consultations per capita	7.0	6.8	7.2	7.3	7.2	7.3	7.7	8.0	8.1	8.6	8.8	6.2	6.2	6.2	6.3		
Hospital inpatient discharges per 100 inhabitants	22	21	22	22	22	23	24	:	23	23	23	17	16	16	16		
Day cases discharges per 100 000 inhabitants	822	982	1,374	1,605	1,729	1,927	2,349	:	2,568	2,197	2,403	6,362	6,584	7,143	7,635		
Acute care bed occupancy rates	79.0	76.0	75.5	72.7	72.4	72.0	73.1	72.5	71.6	72.8	72.2	77.1	76.4	76.5	76.8		
Hospital average length of stay	7.3	7.1	8.8	8.5	8.1	8.1	8.3	8.0	7.9	8.0	7.9	8.0	7.8	7.7	7.6		
Day cases as % of all hospital discharges	3.6	4.4	6.0	6.9	7.3	7.9	9.0	:	10.0	8.7	9.4	28.0	29.1	30.9	32.3		
<b>Population and Expenditure projections</b>																	
<b>Projected public expenditure on healthcare as % of GDP*</b>	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in pps.				
AWG reference scenario	4.1	4.2	4.3	4.4	4.5	4.6	4.7	4.7	4.7	4.6	4.6	4.5	Lithuania	EU			
AWG risk scenario	4.1	4.4	4.6	4.8	5.0	5.3	5.4	5.5	5.5	5.4	5.4	5.3	0.4	0.9			
Note: *Excluding expenditure on medical long-term care component.																1.2	1.6
<b>Population projections</b>	2016	2020	2025	2030	2035	2040	2045	2050	2055	2060	2065	2070	Change 2016-2070, in %				
Population projections until 2070 (millions)	2.9	2.7	2.6	2.4	2.3	2.1	2.0	2.0	1.9	1.8	1.8	1.7	Lithuania	EU			
																-40.3	2.0

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).

## Lithuania

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Long-term care systems

## 3.17. LITHUANIA

### General context: Expenditure projections, fiscal sustainability and demographic trends

GDP per capita in PPS, at 19,600 PPS per capita is below the EU average GDP per capita of €29,600 in 2015. Lithuania has a population of around 2.9 million inhabitants. Over the coming decades, the population of Lithuania will gradually decline, from 2.9 million inhabitants in 2016 to 1.7 million inhabitants in 2070. This 40% fall is very different from the EU average increase of 2%.

### Health status

Life expectancy at birth for both men and women was, in 2015, respectively 69.2 and 79.7 years, which is below the EU average (77.9 and 83.3 years respectively). In 2015 the healthy life years at birth for both sexes were 58.8 years (women) and 54.1 years (men) below (particularly for men) the EU-average (63.3 and 62.6 respectively). At the same time, the percentage of the Lithuanian population having a long-standing illness or health problem is higher than in the Union as a whole (34.7% and 34.2% respectively in 2015). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2015 around 7%, below the EU-average (8.1%).

### Dependency trends

The share of people depending on others to carry out activities of daily living in Lithuania is set to increase over the next 50 or so years, from 9.3% in 2015 to 12.2% of the total population in 2070, an increase of 31%. This is above the EU-average increase of 21%. From 0.27 million residents living with strong limitations due to health problems in 2016, a decrease of 21% is envisaged until 2070 to 0.21 million. That is in contrast with the increase in the EU as a whole (25%).

### Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is expected to increase. In the AWG reference scenario, public long-term expenditure is driven by the combination of changes in the population structure and a moderately positive evolution of the health (non-disability) status. The joint impact of those factors

is a projected increase in spending of about 1 pp of GDP by 2070 <sup>(531)</sup>. The "AWG risk scenario", which in comparison to the "AWG reference scenario" captures the impact of additional cost drivers to demography and health status, i.e. the possible effect of a cost and coverage convergence, projects an increase in spending of 3.6 pps of GDP by 2070.

Overall, Lithuania presents no significant risks of fiscal stress in the short, medium or long-term <sup>(532)</sup>.

### System Characteristics <sup>(533)</sup>

In Lithuania there is no unified specific legislation on the provision LTC. Care is granted through different channels: social services, invalidity and sickness services. Social services are provided for all residents who are in need. Health care is provided on the basis of social insurance and financed by the central government budget, local budgets and the Health Insurance Fund, as well as cost-sharing from the recipient (or their family). LTC recipients are provided with benefits in kind, and there are also cash benefits for severely disabled people.

Public spending on LTC <sup>(534)</sup> reached 1% of GDP in 2016 in Lithuania, below the average EU level of 1.6% of GDP. 64.8% of the benefits were in-kind, while 35.2% were cash-benefits (EU: 84 vs 16%).

In the EU, 50% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 76% higher in Lithuania. Overall, 7.1% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.6%), one of the highest shares in the EU. On the one hand, low shares of coverage may indicate a situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets,

<sup>(531)</sup> The 2018 Ageing Report: [https://ec.europa.eu/info/sites/info/files/economy-finance/ip079\\_en.pdf](https://ec.europa.eu/info/sites/info/files/economy-finance/ip079_en.pdf)

<sup>(532)</sup> Fiscal sustainability Report (2018), Institutional Paper 094, January 2019, European Commission.

<sup>(533)</sup> This section draws on OECD (2011b) and ASISP (2014).

<sup>(534)</sup> Long-term care benefits can be disaggregated into health-related long-term care (including both nursing care and personal care services) and social long-term care (relating primarily to assistance with IADL tasks).

possibly calling for greater needs of policy reform or, alternatively, relatively low benefits per recipients.

The expenditure for institutional (in-kind) services makes up 33.6% of public in-kind expenditure (EU: 66.3%), 66.4% being spent for LTC services provided at home (EU: 33.7%).

#### *Administrative organisation*

Long-term care in Lithuania is organised as a central system at national level supplemented by the municipalities at regional level. The central government is responsible for making long-term national programmes and strategies as well as setting requirements and standards. At the local level, municipalities prepare and implement municipal programmes aiming at social integration of disabled people, being responsible for the organisation of social services provision, the determination of local need for social services; for the supervision of social services as well as the organisation and provision of primary health care (including nursing hospitals). LTC is provided through day centres, home care services, residential social care institutions and nursing hospitals.

#### *Types of care*

Depending on their level of dependency and care needs, disabled people may receive permanent home care (assistance provided for recipients that continue living in their own home) or permanent nursing care in an institutional setting. LTC in the health sector is mostly provided as inpatient care in specialised nursing hospitals or in 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.

#### *Eligibility criteria*

The need for LTC is assessed on the basis of principles of cooperation, participation, complexity, accessibility, social justice, relevance, efficiency, and comprehensiveness. The level of

need is assessed on an individual basis of the person's dependency level and potential to develop, taking into account the individual's preferences and needs. The social services are aimed at compensating the level of dependency. Home care and institutional care may also be provided to disabled people. The level of need of a disabled person is determined by an official list of health conditions. Provision of long-term medical treatment depends on the health condition. In the health care sector, LTC is mostly provided as inpatient services in separate nursing homes or specialised departments in general hospitals.

#### *Co-payments, out of the pocket expenses and private insurance*

Recipients contribute through cost-sharing to pay for LTC services in social care homes for elderly and disabled. No more than 80% of the recipient's income can be taken as payment. In most cases the difference will be covered by the central government and local budgets. Nursing hospital stays are financed by the Compulsory Health Insurance budget (up to 120 days per year). Longer stays can be paid by municipalities or by the recipients themselves.

#### *Role of the private sector*

In cases where local authorities are not able to directly provide LTC to a recipient, they may provide the recipient with 'money for care' that should enable them to buy the services needed from private providers. Cash benefits are only paid directly to the recipient. Compensation for home care nursing expenses was between 1.5 and 2.5 times the social insurance basic pension and depended as well on the need category of the recipient. Since 1 January 2007, this allowance has been set at 2.5 times the social insurance basic pension for all categories. The compensation for care corresponds to 0.5 times the social insurance basic pension. Cost-sharing of the provision of these services depend on the income of the recipient and/or their family.

#### *Formal/informal caregiving*

The recent extension of 'money for care' measures enables informal carers to be financially compensated (e.g. by care or attendance allowances) as providers of care for the care they

deliver. They can also benefit from some training and social rights, as well as from the recognition that informal carers are also often clients of formal care services, with their own need for support. The extensive use of both live-in and live-out migrant care workers is a relatively new trend in LTC provision. Their status is somewhere between the two distinct categories of formal and informal carers, and they may be initially selected by families on the basis of factors such as trustworthiness.

#### *Prevention and rehabilitation policies/measures*

Rehabilitation services are paid by the NHIF and provided by licensed providers. The first rehabilitation stage comprises those interventions provided at the health care facility where the patient is treated and its cost is included in the price of the treatment. Second stage rehabilitation is provided in specialised units in general hospitals as well as in specialised hospitals/sanatoriums. Rehabilitation units are required to have a minimum number of beds as well as service availability of 6 days per week. The third rehabilitation stage involves rehabilitation either in an outpatient or tertiary level setting. In 2010 there were 4 rehabilitation hospitals (with 705 beds in total) and 7 other medical rehabilitation facilities (3 for children and 4 for adults). The number of rehabilitation beds has increased since 2002 from 1092 in 2002 to up to 1378 in 2010. Beds in rehabilitation hospitals have an occupancy rate of at 80% with the Average Length of Stay (ALOS) being about 20 days. In sanatoriums the bed occupancy rate is lower (at 74%), while the ALOS is higher (21 days). Increasing quality and availability of rehabilitation provided in an outpatient setting is one of the goals in the strategic health policy documents. This is being implemented by establishing outpatient rehabilitation units in existing municipal health care facilities and making larger investments in infrastructure, as well as through regulatory measures such as forbidding primary health care providers from referring adult patients to specialised inpatient rehabilitation and instead directing patient flows towards outpatient rehabilitation. Since 2005 outpatient rehabilitation services have increased by 30% due to implementation of specific projects financed by Structural Funds and the establishment of

specialised departments for ambulatory rehabilitation.

#### **Recently legislated and/or planned policy reforms**

New Guidelines for Deinstitutionalisation of the Social Care Homes of Disabled Children Deprived of Parental Care and Adult Disabled Persons were approved at the end of 2012. These guidelines are meant to provide the framework until 2030 for transition from institutional LTC towards home care. The aim of deinstitutionalisation is to form consistent and coordinated system care services that create the conditions for each disabled child deprived of parental care and each disabled person to receive individual personalised services and assistance while remaining involved and participating in community life without experiencing social exclusion.

Ambulatory nursing and care services are relatively recent. Those services have been well received by the population and have improved access to long-term care services in Lithuania. As explained above, 'money for care' measures enable informal carers to be compensated for the care they deliver and to benefit from some training, social rights and recognition as recipients of care themselves.

As explained above, there is a duration ceiling of four months (120 days) per year on each inpatient nursing care episode (financed, as all services provided in public hospitals, by the National Health Insurance Fund (NHIF)). After this period patients can be transferred to the social care institution in their municipality. A proposal to increase the duration limit in the inpatient health care nursing departments from 120 to 180 days is currently under negotiation.

From 2010 special compensation for care expenses and special compensation for attendance expenses were reduced to the 85% level. Since 2014 there has been a debate about whether to restore to the 100% level.

#### **Challenges**

The main challenges of the system appear to be:

- **Improving the governance framework:** to establish a coherent and integrated legal and governance framework for a clear delineation of responsibilities of state authorities concerning the provision of long-term care services; to strategically integrate medical and social services via such a legal framework; to define a comprehensive approach covering both policies for informal (family and friends) carers, and policies on the formal provision of LTC services and its financing; to use care planning processes, based on individualised need assessments, involving health and care providers and linking need assessment to resource allocation; to share data within government administrations to facilitate the management of potential interactions between LTC financing, targeted personal-income tax measures and transfers (e.g. pensions), and existing social-assistance or housing subsidy programmes; to deal with cost-shifting incentives across health and care.
- **Improving financing arrangements:** to explore the potential of private LTC insurance as a supplementary financing tool; to determine the extent of user cost-sharing on LTC benefits.
- **Providing adequate levels of care to those in need of care:** To adapt and improve LTC coverage schemes, setting the need-level triggering entitlement to coverage; the depth of coverage, that is, setting the extent of user cost-sharing on LTC benefits; and the scope of coverage, that is, setting the types of services included into the coverage; To provide targeted benefits to those with highest LTC needs.
- **Encouraging independent living:** To provide effective home care, tele-care and information to recipients, as well as improving home and general living environment design.
- **Ensuring availability of formal carers:** To determine current and future needs for qualified human resources and facilities for long-term care; To improve recruitment efforts, including through the migration of LTC workers and the extension of recruitment pools of workers.
- **Supporting family carers:** To establish policies for supporting informal carers, such as through flexible working conditions, respite care, carer's allowances replacing lost wages or covering expenses incurred due to caring, cash benefits paid to the care recipients, while ensuring that incentives for employment of carers are not diminished and women are not encouraged to withdraw from the labour market for caring reasons.
- **Ensuring coordination and continuity of care:** To establish better coordination of care pathways and along the care continuum, such as through a single point of access to information, the allocation of care co-ordination responsibilities to providers or to care managers, via dedicated governance structures for care coordination and the integration of health and care to facilitate care co-ordination.
- **To facilitate appropriate utilisation across health and long-term care:** To arrange for adequate supply of services and support outside hospitals, changing payment systems and financial incentives to discourage acute care use for LTC; To steer LTC users towards appropriate settings.
- **Improving value for money:** To invest in assistive devices, which for example, facilitate self-care, patient centeredness, and co-ordination between health and care services; To invest in ICT as an important source of information, care management and coordination.
- **Prevention:** To promote healthy ageing and preventing physical and mental deterioration of people with chronic care; To employ prevention and health-promotion policies and identify risk groups and detect morbidity patterns earlier.

Table 3.17.1: Statistical Annex – Lithuania

GENERAL CONTEXT															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
<b>GDP and Population</b>															
GDP, in billion euro, current prices	21	24	29	33	27	28	31	33	35	37	37	12,451	13,213	13,559	14,447
GDP per capita, PPS	15.5	16.1	17.1	16.2	14.1	15.4	16.4	17.2	17.9	18.8	19.6	26.8	28.1	28.0	29.6
Population, in millions	3.4	3.3	3.2	3.2	3.2	3.1	3.1	3.0	3.0	2.9	2.9	502	503	505	509
<b>Public expenditure on long-term care (health)</b>															
As % of GDP	0.2	0.2	0.3	0.5	0.7	0.6	0.5	0.5	0.5	0.5	0.5	1.1	1.2	1.2	1.2
Per capita PPS	:	:	:	:	93.1	92.8	89.8	89.7	91.9	113.8	122.7	264.1	283.2	352.1	373.6
As % of total government expenditure	0.7	0.6	0.9	1.2	1.5	1.4	1.2	1.3	1.3	1.5	1.5	1.6	1.8	2.5	2.5
Note: Based on OECD, Eurostat - System of Health Accounts															
<b>Health status</b>															
Life expectancy at birth for females	77.4	77.1	77.2	77.6	78.7	78.9	79.3	79.6	79.6	80.1	79.7	82.6	83.1	83.3	83.3
Life expectancy at birth for males	65.2	65.0	64.5	65.9	67.1	67.6	68.1	68.4	68.5	69.2	69.2	76.6	77.3	77.7	77.9
Healthy life years at birth for females	54.6	56.5	58.1	59.6	61.2	62.3	62.0	61.6	61.6	61.7	58.8	62.0	62.1	61.5	63.3
Healthy life years at birth for males	51.4	52.6	53.3	54.5	57.2	57.4	57.0	56.6	56.8	57.6	54.1	61.3	61.7	61.4	62.6
People having a long-standing illness or health problem, in % of pop.	:	33.5	31.7	30.7	29.7	28.1	29.0	29.6	31.2	32.3	34.7	31.3	31.7	32.5	34.2
People having self-perceived severe limitations in daily activities (% of pop.)	:	10.3	9.4	7.9	7.6	7.0	8.0	8.2	8.2	7.6	7.0	8.3	8.3	8.7	8.1
<b>SYSTEM CHARACTERISTICS</b>															
<b>Coverage (Based on data from Ageing Reports)</b>															
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	EU 2009	EU 2011	EU 2013	EU 2015
Number of people receiving care in an institution, in thousands	:	:	32	40	48	56	56	57	61	61	61	3,433	3,851	4,183	4,313
Number of people receiving care at home, in thousands	:	:	7	38	69	100	102	104	67	68	69	6,442	7,444	6,700	6,905
% of pop. receiving formal LTC in-kind	:	:	1.2	2.4	3.7	5.0	5.2	5.4	4.3	4.4	4.5	2.0	2.2	2.2	2.2
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients															
<b>Providers</b>															
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO.



Table 3.17.2: Statistical Annex - continued – Lithuania

PROJECTIONS									
	2016	2020	2030	2040	2050	2060	2070	MS Change 2016-2070	EU Change 2016-2070
<b>Population</b>									
Population projection in millions	2.9	2.7	2.4	2.1	2.0	1.8	1.7	-40%	2%
<b>Dependency</b>									
Number of dependents in millions	0.27	0.27	0.26	0.26	0.26	0.23	0.21	-21%	25%
Share of dependents, in %	9.3	9.7	11.0	12.4	13.2	12.7	12.2	31%	21%
<b>Projected public expenditure on LTC as % of GDP</b>									
AWG reference scenario	1.0	1.0	1.3	1.7	2.0	2.2	2.0	101%	73%
AWG risk scenario	1.0	1.1	1.6	2.3	3.3	4.1	4.6	360%	170%
<b>Coverage</b>									
Number of people receiving care in an institution	88,506	88,763	88,558	87,079	85,449	78,097	69,711	-21%	72%
Number of people receiving care at home	58,973	61,586	66,619	72,643	82,562	80,655	73,636	25%	86%
Number of people receiving cash benefits	55,425	55,934	57,427	59,841	63,148	60,259	55,399	0%	52%
% of pop. receiving formal LTC in-kind and/or cash benefits	7.1	7.5	8.9	10.4	11.8	12.0	11.6	63%	61%
% of dependents receiving formal LTC in-kind and/or cash benefits	75.8	77.5	81.1	83.9	89.9	93.8	94.4	24%	33%
<b>Composition of public expenditure and unit costs</b>									
Public spending on formal LTC in-kind ( % of tot. publ. spending LTC)	78.7	77.9	79.7	80.8	81.6	82.3	81.4	3%	5%
Public spending on LTC related cash benefits ( % of tot. publ. spending LTC)	21.3	22.1	20.3	19.2	18.4	17.7	18.6	-13%	-27%
Public spending on institutional care ( % of tot. publ. spending LTC in-kind)	33.6	32.9	31.8	30.8	28.9	28.0	27.9	-17%	0%
Public spending on home care ( % of tot. publ. spending LTC in-kind)	66.4	67.1	68.2	69.2	71.1	72.0	72.1	9%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	8.6	8.2	9.2	10.3	11.0	11.7	11.3	31%	10%
Unit costs of home care per recipient, as % of GDP per capita	25.5	24.1	26.3	27.6	28.0	29.2	27.7	9%	1%
Unit costs of cash benefits per recipient, as % of GDP per capita	11.1	11.2	11.4	11.5	11.6	11.6	11.7	5%	-14%

Source: EUROSTAT, OECD, WHO and European Commission (DG ECFIN)-EPC (AWG) 2018 Ageing Report projections (2016-2070).