Lithuania

Health Care & Long-Term Care Systems

An excerpt from

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

published in October 2016
as Institutional Paper 37
Volume 2 - Country Documents

Economic and Financial Affairs
Economic Policy Committee

Lithuania

Health care systems

1.17. LITHUANIA

General context: Expenditure, fiscal sustainability and demographic trends

General statistics: GDP, GDP per capita; population

In 2013, Lithuania had a GDP per capita of 17.9 PPS (in thousands), below the EU average of 27.9.

Population was estimated at 3 million in 2013, which is expected to decrease down to 1.8 million by 2060.

Total and public expenditure on health as % of GDP

Total expenditure ([175]) on health as a percentage of GDP (6.2% in 2013) is below the EU average ([176]) of 10.1%. Public expenditure is, at 4.2% of GDP, equal to the EU average, far below the average of 7.8% in 2013.

When expressed in per capita terms, total spending on health at 1243 PPS in Lithuania is below the EU average of 2988 in 2013. So is public spending on health care: 827 PPS vs. an average of 2208 PPS in 2013.

Expenditure projections

As a consequence of demographic changes, health care expenditure is projected to increase by 0.1 pp of GDP, below the average growth expected for the EU (0.9) ([177]), 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 0.9 pp of GDP from now until 2060 (EU1.7).

Overall, Lithuania presents no significant risks of fiscal stress over the short run. Likewise, low risks appear in the medium term from a debt sustainability analysis perspective, given the relatively moderate level of public debt, and they are due to the unfavourable projected cost of ageing. Medium sustainability risks also appear for Lithuania over the long run. These risks are primarily related to the strong projected impact of age-related public spending (notably pensions and, to a lesser extent, healthcare and long-term care).

Health status

Life expectancy at birth (79.6 years for women and 68.5 years for men in 2013) is far below the respective EU averages (83.3 and 77.8 years of life expectancy). ([178]) Healthy life years, at 61.6 years for women and 56.8 for men, are below the EU averages of 61.5 and 61.4 in 2013. The infant mortality rate of 3.7‰ is equal to the EU average of 3.97‰ in 2013, having gradually fallen over the last decade (from 8,1‰ in 2004).

As for the lifestyle of the Lithuanian population, there is a proportion of regular smokers of 24.2% in 2008 higher than the EU average of 23.2% in 2009. Alcohol consumption is, at 14.3, higher than the EU average of 9.8.

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

([175]) 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.

([176]) 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.

([177]) I.e. considering the "reference scenario" of the projections (see The 2015 Ageing Report at http://europa.eu/epc/pdf/ageing_report_2015_en.pdf).

([178]) 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 (33.4% in 2013) is far higher than the EU average (22.6). Out-of-pocket expenditure constitutes about 32.6% of total health expenditure, well above the EU average (14.1% in 2013).

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:

11. 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;

12. 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 (428 in 2013) 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 (86 in 2013), 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 (8.3 in 1998). The number of nurses (755 in 2013) per 100 000 inhabitants is below the EU average (837 in 2013), having registered an important reduction since 2003 (759). 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 (530 in 2013) in the EU (EU average of 356 in 2013), although it has seen a large reduction in the last two decades (700 in 1998).

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 services 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. 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 2568 day cases per 100 000 inhabitants in 2013 vs. the EU average of 7031). On the contrary, the number of inpatient cases per 100 inhabitants was 23.2 in 2013, above the EU average of 16.5.

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

Imported medicines now come mainly from Western Europe but not from the former Soviet Union, which resulted in a large increase in prices. The reimbursable price is set on the basis of international prices, which may make pharmaceuticals rather expensive depending on the countries used. As a result, to control overall expenditure, the authorities have implemented some policies: a) the reimbursable price is determined on the basis of 95% of the average of manufacturer prices in 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) there are the positive lists (the list of pharmaceuticals that can be reimbursed) 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, there are some novelties in the reimbursement system in Lithuania. 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. According to the new provisions, every year the price list is renewed in the case when the group of reimbursed medicinal products consists of more than 3 medicinal products of different manufacturers. In this case, the most expensive medicinal product can be only 40% more expensive than the second cheapest in that group. Therapeutically interchangeable pharmaceuticals with different INN are going to be put in one cluster. The pharmaceuticals will be clustered regarding the therapeutic effect, indication of reimbursement, presentation form and age groups 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.

The Ministry of Health of the Republic of Lithuania has coordinated the is National Electronic Health System Development Program for the period of 2009 – 2015, including the development of e-prescription, data exchange between healthcare institutions, as well as an electronic health record (HER) for patients.

Establishment, deployment and development of the infrastructure and Electronic Health Record services of national eHealth system (ESPBI IS) was one of the most important directions of headway foreseen in the National Electronic Health System Development Programme for the period of 2009–2015 and it remains such in the period of 2015–2025. A key feature of the Lithuanian eHealth system is that it enables faster,

safer and more efficient exchange of the data about the patients' treatment services, procedures and lab tests results among healthcare institutions and enables secondary usage of patient health records. 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 will carry only the most important information of patient health 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 2015-2025 was approved by Order No V-1006 of the Minister of Health of the Republic of Lithuania of 27 August 2015, 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 www.esveikata.lt.

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

However, total (0.08%) and public (0.08%) expenditure on prevention and public health as a share of GDP is much lower than the EU average (respectively 0.24% and 0.19% in 2013).

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 July 2014. 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 health centres. 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 1.17.1: **Statistical Annex – Lithuania**

General context												EU- latest national data		
GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
GDP, in billion Euro, current prices	17	18	21	24	29	33	27	28	31	33	35	9289	9800	9934
GDP per capita PPS (thousands)	14.3	15.0	15.5	16.1	17.0	16.1	14.1	15.3	16.2	17.1	17.9	26.8	28.0	27.9
Real GDP growth (% year-on-year) per capita	11.2	8.6	9.6	9.5	11.1	4.0	-13.9	3.7	8.5	5.1	4.4	-4.8	1.4	-0.1
Real total health expenditure growth (% year-on-year) per capita	12.8	-5.1	12.7	16.4	11.5	10.5	-1.9	-2.4	5.0	2.2	-2.3	3.2	-0.2	-0.4

Expenditure on health*												**2009**	**2011**	**2013**
Total as % of GDP	6.5	5.7	5.8	6.2	6.2	6.6	7.5	7.1	6.9	6.7	6.2	10.4	10.1	10.1
Total current as % of GDP	:	5.5	5.7	5.8	5.8	6.3	7.4	6.9	6.6	6.4	6.1	9.8	9.6	9.7
Total capital investment as % of GDP	:	0.2	0.2	0.4	0.4	0.3	0.1	0.2	0.3	0.3	0.1	0.6	0.5	0.5
Total per capita PPS	539	515	618	768	941	1139	1078	1071	1189	1253	1243	2828	2911	2995
Public as % of GDP	4.9	3.8	4.0	4.3	4.5	4.8	5.5	5.0	4.7	4.4	4.2	8.1	7.8	7.8
Public current as % of GDP	:	3.7	3.8	3.9	4.1	4.5	5.4	4.9	4.7	4.3	4.1	7.9	7.7	7.7
Public per capita PPS	409	333	399	489	619	772	769	736	822	817	827	2079	2218	2208
Public capital investment as % of GDP	:	0.2	0.2	0.4	0.4	0.3	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1
Public as % total expenditure on health	76.0	67.5	67.8	69.5	73.0	72.3	72.9	70.8	69.1	65.2	66.6	77.6	77.2	77.4
Public expenditure on health in % of total government expenditure	14.8	14.4	16.8	15.5	15.0	14.8	14.9	16.5	17.3	16.3	:	14.8	14.9	:
Proportion of the population covered by public or primary private health insurance	:	:	:	:	:	:	:	:	100.0	100.0	:	99.7	99.7	98.7
Out-of-pocket expenditure on health as % of total expenditure on health	23.2	32.9	32.8	31.9	28.4	28.2	26.8	27.6	28.2	31.8	32.6	14.1	14.4	14.1

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

Population and health status												**2009**	**2011**	**2013**
Population, current (millions)	3.4	3.4	3.4	3.3	3.2	3.2	3.2	3.1	3.1	3.0	3.0	502.1	504.5	506.6
Life expectancy at birth for females	77.7	77.7	77.4	77.1	77.2	77.6	78.7	78.9	79.3	79.6	79.6	82.6	83.1	83.3
Life expectancy at birth for males	66.4	66.2	65.2	65.0	64.5	65.9	67.1	67.6	68.1	68.4	68.5	76.6	77.3	77.8
Healthy life years at birth females	:	:	54.6	56.5	58.1	59.6	61.2	62.3	62.0	61.6	61.6	:	62.1	61.5
Healthy life years at birth males	:	:	51.4	52.6	53.3	54.5	57.2	57.4	57.0	56.6	56.8	:	61.7	61.4
Amenable mortality rates per 100 000 inhabitants*	128	129	135	140	132	134	131	125	262	255	:	64.4	128.4	:
Infant mortality rate per 1 000 life births	6.7	8.1	7.1	7.2	6.3	5.5	5.6	5.0	4.8	3.9	3.7	4.2	3.9	3.9

Notes: Amenable mortality rates break in series in 2011.

System characteristics												EU- latest national data		
Composition of total current expenditure as % of GDP	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2009**	**2011**	**2013**
Inpatient curative and rehabilitative care	:	1.72	1.77	1.83	1.77	1.84	2.11	1.96	1.90	1.89	1.73	3.13	2.99	3.01
Day cases curative and rehabilitative care	:	0.07	0.08	0.11	0.14	0.18	0.22	0.22	0.20	0.11	0.10	0.18	0.18	0.19
Out-patient curative and rehabilitative care	:	0.99	0.97	1.15	1.13	1.31	1.53	1.41	1.42	1.33	1.41	2.29	2.25	2.24
Pharmaceuticals and other medical non-durables	:	1.87	1.94	1.81	1.66	1.66	1.98	1.84	1.71	1.84	1.73	1.60	1.55	1.44
Therapeutic appliances and other medical durables	:	0.19	0.19	0.23	0.20	0.22	0.22	0.24	0.20	0.18	0.18	0.31	0.31	0.32
Prevention and public health services	:	0.11	0.11	0.09	0.12	0.08	0.09	0.06	0.08	0.07	0.08	0.25	0.25	0.24
Health administration and health insurance	:	0.12	0.12	0.10	0.12	0.20	0.15	0.14	0.13	0.13	0.11	0.42	0.41	0.47
Composition of public current expenditure as % of GDP														
Inpatient curative and rehabilitative care	:	1.57	1.60	1.65	1.60	1.68	1.93	1.82	1.78	1.77	1.59	2.73	2.61	2.62
Day cases curative and rehabilitative care	:	0.07	0.08	0.10	0.14	0.17	0.21	0.21	0.20	0.09	0.10	0.16	0.16	0.18
Out-patient curative and rehabilitative care	:	0.69	0.70	0.79	0.82	0.91	1.09	0.99	0.96	0.83	0.81	1.74	1.71	1.80
Pharmaceuticals and other medical non-durables	:	0.65	0.67	0.65	0.64	0.62	0.77	0.69	0.59	0.58	0.58	0.79	1.07	0.96
Therapeutic appliances and other medical durables	:	0.05	0.04	0.05	0.05	0.05	0.06	0.05	0.05	0.04	0.04	0.13	0.12	0.13
Prevention and public health services	:	0.11	0.11	0.09	0.12	0.08	0.09	0.06	0.08	0.07	0.08	0.25	0.20	0.19
Health administration and health insurance	:	0.12	0.10	0.09	0.11	0.19	0.15	0.13	0.12	0.11	0.03	0.11	0.27	0.27

Sources: EUROSTAT, OECD and WHO

Table 1.17.2: **Statistical Annex - continued – Lithuania**

Composition of total as % of total current health expenditure	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
Inpatient curative and rehabilitative care	:	31.3%	31.3%	31.4%	30.4%	29.0%	28.4%	28.4%	29.0%	29.7%	28.2%	31.8%	31.3%	31.1%
Day cases curative and rehabilitative care	:	1.3%	1.4%	1.9%	2.4%	2.8%	3.0%	3.2%	3.0%	1.7%	1.6%	1.8%	1.9%	1.9%
Out-patient curative and rehabilitative care	:	18.0%	17.2%	19.7%	19.4%	20.7%	20.6%	20.5%	21.6%	20.9%	23.0%	23.3%	23.5%	23.2%
Pharmaceuticals and other medical non-durables	:	34.0%	34.3%	31.0%	28.5%	26.2%	26.6%	26.7%	26.1%	28.9%	28.2%	16.3%	16.2%	14.9%
Therapeutic appliances and other medical durables	:	3.5%	3.4%	3.9%	3.4%	3.5%	3.0%	3.5%	3.0%	2.8%	2.9%	3.2%	3.3%	3.3%
Prevention and public health services	:	2.0%	1.9%	1.5%	2.1%	1.3%	1.2%	0.9%	1.2%	1.1%	1.4%	2.6%	2.6%	2.5%
Health administration and health insurance	:	2.2%	2.1%	1.7%	2.1%	3.2%	2.0%	2.0%	2.0%	2.0%	1.8%	4.2%	4.3%	4.9%
Composition of public as % of public current health expenditure														
Inpatient curative and rehabilitative care	:	42.9%	42.4%	41.9%	38.6%	37.2%	35.8%	36.9%	38.3%	41.5%	39.1%	34.6%	34.1%	34.0%
Day cases curative and rehabilitative care	:	1.9%	2.1%	2.5%	3.4%	3.8%	3.9%	4.3%	4.3%	2.1%	2.5%	2.0%	2.1%	2.3%
Out-patient curative and rehabilitative care	:	18.9%	18.6%	20.1%	19.8%	20.1%	20.2%	20.1%	20.6%	19.4%	19.9%	22.0%	22.3%	23.4%
Pharmaceuticals and other medical non-durables	:	17.8%	17.8%	16.5%	15.5%	13.7%	14.3%	14.0%	12.7%	13.6%	14.3%	10.0%	13.9%	12.5%
Therapeutic appliances and other medical durables	:	1.4%	1.1%	1.3%	1.2%	1.1%	1.1%	1.0%	1.1%	0.9%	1.0%	1.6%	1.6%	1.6%
Prevention and public health services	:	3.0%	2.9%	2.3%	2.9%	1.8%	1.7%	1.2%	1.7%	1.6%	2.0%	3.2%	2.7%	2.5%
Health administration and health insurance	:	3.2%	2.6%	2.3%	2.7%	4.3%	2.8%	2.6%	2.5%	2.6%	0.8%	1.4%	3.5%	3.5%

Expenditure drivers (technology, life style)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU- latest national data 2009	2011	2013
MRI units per 100 000 inhabitants	0.09	0.12	0.15	0.29	0.33	0.42	0.51	0.47	0.59	1.00	1.05	1.0	1.1	1.0
Angiography units per 100 000 inhabitants	:	:	:	:	0.5	0.6	0.7	0.7	0.7	0.6	0.7	0.9	0.9	0.8
CTS per 100 000 inhabitants	0.9	1.1	1.2	1.2	1.0	1.3	1.5	1.8	2.0	2.4	2.4	1.8	1.7	1.6
PET scanners per 100 000 inhabitants	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Proportion of the population that is obese	:	:	:	:	:	:	:	:	:	:	:	14.9	15.4	15.5
Proportion of the population that is a regular smoker	:	27.0	24.5	26.5	:	24.2	:	:	:	:	:	23.2	22.4	22.0
Alcohol consumption litres per capita	11.3	12.1	12.3	12.7	13.4	13.3	12.4	12.9	12.7	14.4	14.3	10.3	10.0	9.8

Providers	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Practising physicians per 100 000 inhabitants	363	356	362	365	372	370	365	383	409	422	428	329	335	344
Practising nurses per 100 000 inhabitants	724	713	710	711	705	711	697	716	753	759	755	840	812	837
General practitioners per 100 000 inhabitants	65	65	66	67	69	68	69	72	85	85	86	:	78	78.3
Acute hospital beds per 100 000 inhabitants	581	555	528	510	509	505	502	513	538	538	530	373	360	356

Outputs	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2009	2011	2013
Doctors consultations per capita	6.5	6.7	7.0	6.8	7.2	7.3	7.2	7.3	7.7	8.0	8.1	6.3	6.2	6.2
Hospital inpatient discharges per 100 inhabitants	22.0	22.2	22.1	21.3	21.6	21.7	21.9	22.6	23.8	:	23.2	16.6	16.4	16.5
Day cases discharges per 100 000 inhabitants	523	610	822	982	1,374	1,605	1,729	1,927	2,349	:	2,568	6368	6530	7031
Acute care bed occupancy rates	73.0	77.0	79.0	76.0	76.0	72.7	72.4	72.0	73.1	72.5	71.6	72.0	73.1	70.2
Hospital curative average length of stay	7.5	7.4	7.3	7.1	6.9	6.7	6.4	6.3	6.4	6.3	6.3	6.5	6.3	6.3
Day cases as % of all hospital discharges	2.3	2.7	3.6	4.4	6.0	6.9	7.3	7.9	9.0	:	10.0	27.8	28.7	30.4

Population and Expenditure projections

Projected public expenditure on healthcare as % of GDP*	2013	2020	2030	2040	2050	2060	Change 2013 - 2060	EU Change 2013 - 2060
AWG reference scenario	4.2	4.4	4.6	4.7	4.5	4.3	0.1	0.9
AWG risk scenario	4.2	4.7	5.3	5.5	5.4	5.1	0.9	1.6

Note: *Excluding expenditure on medical long-term care component.

Population projections	2013	2020	2030	2040	2050	2060	Change 2013 - 2060, in %	EU - Change 2013 - 2060, in %
Population projections until 2060 (millions)	3.0	2.6	2.2	2.0	1.9	1.8	-38.1	3.1

Sources: EUROSTAT, OECD and WHO

Lithuania

Long-term care systems

2.17. LITHUANIA

General context: Expenditure projections, fiscal sustainability and demographic trends

GDP per capita in PPS, at 17,900 PPS per capita is below the EU average GDP per capita of EUR 27,900 in 2013. Lithuania has a population of around 3 million inhabitants. Over the coming decades, the population of Lithuania will gradually decline, from 3.0 million inhabitants in 2010 to 1.8 million inhabitants in 2060. This 38% fall is very different from the EU average increase of 3%.

Health status

Life expectancy at birth for both men and women was, in 2013, respectively 68.5 and 79.6 years, which is below the EU average (77.8 and 83.3 years respectively). In 2013 the healthy life years at birth for both sexes were 61.6 years (women) and 56.8 years (men) below (particularly for men) the EU-average (61.5 and 61.4 respectively). At the same time, the percentage of the Lithuanian population having a long-standing illness or health problem is lower than in the Union as a whole (31.2% and 32.5% respectively in 2013). The percentage of the population indicating a self-perceived severe limitation in its daily activities was in 2013 8.2%, below the EU-average (8.7%).

Dependency trends

The share of people depending on others to carry out activities of daily living in Lithuania is almost doubling over this period, from 8.5% in 2013 to 11.3% of the total population in 2060, an increase of 34%. This is slightly below the EU-average increase of 36%. From 0.25 million residents living with strong limitations due to health problems in 2010, an decrease of 17% is envisaged until 2060 to 0.21 million. That is in contrast with the increase in the EU as a whole (40%).

Expenditure projections and fiscal sustainability

With the demographic changes, the projected public expenditure on long-term care as a percentage of GDP is steadily increasing. 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 0.9 pps of GDP by 2060 ([410]). 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 3.5 pps of GDP by 2060.

Overall, Lithuania presents no significant risks of fiscal stress over the short run. Likewise, low risks appear in the medium term from a debt sustainability analysis perspective, given the relatively moderate level of public debt, due to the unfavourable projected cost of ageing. Medium sustainability risks also appear for Lithuania over the long run. These risks are primarily related to the strong projected impact of age-related public spending (notably pensions and to a lesser extent healthcare and long-term care). ([411])

System Characteristics ([412])

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 reached 0.8% of GDP in 2013 in Lithuania, below the average EU level of 1% of GDP. 64.8% of the benefits were in-kind, while 35.2% were cash-benefits (EU: 80 vs 20%).

In the EU, 53% of dependents are receiving formal in-kind LTC services or cash-benefits for LTC. This share is with 93.1% higher in Lithuania. Overall, 7.9% of the population (aged 15+) receive formal LTC in-kind and/or cash benefits (EU: 4.2%), one of the highest shares in the EU. On the one hand, low shares of coverage may indicate a

([410]) The 2015 Ageing Report: http://europa.eu/epc/pdf/ageing_report_2015_en.pdf.
([411]) Fiscal Sustainability Report 2015: http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip018_en.pdf.
([412]) This section draws on OECD (2011b) and ASISP (2014).

situation of under-provision of LTC services. On the other hand, higher coverage rates may imply an increased fiscal pressure on government budgets, possibly calling for greater needs of policy reform.

The expenditure for institutional (in-kind) services makes up 55.8% of public in-kind expenditure (EU: 61%), 44.2% being spent for LTC services provided at home (EU: 39%).

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. This share can increase in case the patients' income is above a certain level. 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). About 50 000 inpatient rehabilitation services were provided (15.2 per 1,000 population) in 2010.

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. Furthermore, the outpatient rehabilitation service volume has increased by 20% in 2010 (in comparison with 2009), although with 8.1 treatments per 1,000 population it is only around half of total inpatient services.

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 are 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 2.17.1: **Statistical Annex – Lithuania**

GENERAL CONTEXT

GDP and Population	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
GDP, in billion euro, current prices	17	18	21	24	29	33	27	28	31	33	35	9,289	9,545	9,800	9,835	9,934
GDP per capita, PPS	14.3	15.0	15.5	16.1	17.0	16.1	14.1	15.3	16.2	17.1	17.9	26.8	27.6	28.0	28.1	27.9
Population, in millions	3.4	3.4	3.4	3.3	3.2	3.2	3.2	3.1	3.1	3.0	3.0	502	503	504	506	507
Public expenditure on long-term care																
As % of GDP	:	0.6	0.6	0.5	0.7	0.7	1.0	1.0	0.9	0.8	:	1.0	1.0	1.0	1.0	:
Per capita PPS	:	74.3	76.5	77.9	108.6	111.2	136.0	155.8	155.8	156.3	:	297.1	316.7	328.5	317.8	:
As % of total government expenditure	:	1.9	1.8	1.6	1.9	1.8	2.2	2.4	2.3	2.3	:	2.1	2.2	2.2	2.1	:
Note: Based on OECD, Eurostat - System of Health Accounts																
Health status																
Life expectancy at birth for females	77.7	77.7	77.4	77.1	77.2	77.6	78.7	78.9	79.3	79.6	79.6	82.6	82.8	83.1	83.1	83.3
Life expectancy at birth for males	66.4	66.2	65.2	65.0	64.5	65.9	67.1	67.6	68.1	68.4	68.5	76.6	76.9	77.3	77.4	77.8
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	:	62.6	62.1	62.1	61.5
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	:	61.8	61.7	61.5	61.4
People having a long-standing illness or health problem, in % of pop.	:	:	30.3	33.5	31.7	29.1	29.7	28.1	29.0	29.6	31.2	:	31.4	31.8	31.5	32.5
People having self-perceived severe limitations in daily activities (% of pop.)	:	:	11.3	10.3	9.4	7.6	7.6	7.0	8.0	8.2	8.2	:	8.1	8.3	8.6	8.7

SYSTEM CHARACTERISTICS

Coverage (Based on data from Ageing Reports)	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	EU 2009	EU 2010	EU 2011	EU 2012	EU 2013
Number of people receiving care in an institution, in thousands	:	:	:	:	32	40	48	56	56	57	61	3,433	3,771	3,851	3,931	4,183
Number of people receiving care at home, in thousands	:	:	:	:	7	38	69	100	102	104	67	6,442	7,296	7,444	7,569	6,700
% of pop. receiving formal LTC in-kind	:	:	:	:	1.2	2.4	3.7	5.0	5.2	5.4	4.3	2.0	2.2	2.2	2.3	2.1
Note: Break in series in 2010 and 2013 due to methodological changes in estimating number of care recipients																
Providers																
Number of informal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
Number of formal carers, in thousands	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:

Source: EUROSTAT, OECD and WHO

Table 2.17.2: **Statistical Annex - continued – Lithuania**

PROJECTIONS

Population	**2013**	**2020**	**2030**	**2040**	**2050**	**2060**	**MS Change 2013-2060**	**EU Change 2013-2060**
Population projection in millions	3.0	2.6	2.2	2.0	1.9	1.8	-38%	3%
Dependency								
Number of dependents in millions	0.25	0.26	0.24	0.24	0.24	0.21	-17%	40%
Share of dependents, in %	8.5	9.6	11.1	12.2	12.3	11.3	34%	36%
Projected public expenditure on LTC as % of GDP								
AWG reference scenario	1.4	1.5	1.9	2.2	2.4	2.3	65%	40%
AWG risk scenario	1.4	1.7	2.5	3.3	4.3	4.9	254%	149%
Coverage								
Number of people receiving care in an institution	61,304	62,136	58,675	58,561	58,008	51,637	-16%	79%
Number of people receiving care at home	66,689	73,409	76,277	82,028	91,086	84,736	27%	78%
Number of people receiving cash benefits	105,541	110,511	110,689	117,031	122,847	111,679	6%	68%
% of pop. receiving formal LTC in-kind and/or cash benefits	7.9	9.3	11.3	12.9	14.3	13.5	71%	68%
% of dependents receiving formal LTC in-kind and/or cash benefits	93.1	96.4	100.0	100.0	100.0	100.0	7%	23%
Composition of public expenditure and unit costs								
Public spending on formal LTC in-kind (% of tot. publ. spending LTC)	64.8	62.6	63.7	62.8	61.1	60.4	-7%	1%
Public spending on LTC related cash benefits (% of tot. publ. spending LTC)	35.2	37.4	36.3	37.2	38.9	39.6	13%	-5%
Public spending on institutional care (% of tot. publ. spending LTC)	55.8	53.7	51.7	50.2	49.1	49.8	-11%	1%
Public spending on home care (% of tot. publ. spending LTC in-kind)	44.2	46.3	48.3	49.8	50.9	50.2	14%	-1%
Unit costs of institutional care per recipient, as % of GDP per capita	24.0	22.1	23.8	23.6	23.6	24.2	1%	-2%
Unit costs of home care per recipient, as % of GDP per capita	17.5	16.1	17.1	16.7	15.6	14.9	-15%	-3%
Unit costs of cash benefits per recipient, as % of GDP per capita	13.6	13.8	13.9	14.0	14.5	14.8	9%	-2%

Source: Based on the European Commission (DG ECFIN)-EPC (AWG), "The 2015 Ageing Report – Economic and budgetary projections for the 28 EU Member States (2013-2060)