Joint Action on Chronic Diseases and Promoting Healthy Ageing Across the Life Cycle

Good Practice in the Field of Health Promotion and Primary Prevention

Lithuania Country Review

Prepared by by the Ministry of Health of the Republic of Lithuania

CHRODIS
ADDRESSING CHRONIC DISEASES & HEALTHY AGEING ACROSS THE LIFE CYCLE

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This country review has been developed based on the questionnaire 'Good practice in the field of Health Promotion and Primary Prevention' developed by EuroHealthNet, as part of Work Package 5, Task 1 of JA-CHRODIS.

Background

JA-CHRODIS is a European collaborative initiative that brings together over 60 partners from 26 European Union Member States. The collaborative partners are from areas including the national and regional departments of health and research institutions. They work together to identify, validate, exchange and disseminate good practice approaches for chronic diseases across EU Member States, and facilitate the uptake of these approaches across local, regional and national borders. The focus of JA-CHRODIS is on health promotion and primary prevention, with an additional focus on the management of diabetes and multi-morbid chronic conditions. One of the key deliverables will be a 'Platform for Knowledge Exchange', which will include both an online help-desk for policy makers and an information portal which provides an up-to-date repository of best practices and the best knowledge on chronic care.

Work Package (WP) 5 focuses on these objectives in relation to the package's theme: *Good Practice in the Field of Health Promotion and Primary Prevention*. Furthermore, **the objectives of WP 5 are to promote the exchange, scaling up, and transfer of highly promising, cost-effective and innovative health promotion and primary prevention practices for older populations.** This will involve the identification, review, and validation of health promotion and primary prevention interventions for **cardiovascular diseases, stroke, and type 2 diabetes and their modifiable behavioural and social risk factors**. WP 5 will not only take into account lifestyles and health-related behaviours, but also the wider social and economic determinants that influence them.

The following **Country Review** provides an **overview of the health promotion and primary prevention situation and approaches for cardiovascular disease, stroke and type 2 diabetes in Lithuania**. This review outlines relevant policies; implementation mechanisms; good practices, and whether and how they have been identified; and forecasting and cost-effectiveness studies that have been undertaken on the topic in Lithuania. The authors of this report have also identified current gaps and needs of promotion and primary prevention of chronic diseases. The information in this report will contribute to subsequent WP tasks, namely the identification, exchange and transfer of promising practices to promote health and prevent strokes, cardiovascular disease and type 2 diabetes in Lithuania.

The Health Promotion and Chronic Disease Prevention Landscape

Policy design and implementation

National level

In Lithuania, parliament is the legislator; the government and the Ministry of Health are regulators; the Ministry of Finance is the contributor to the Compulsory Health Insurance Fund; and the Ministry of Health and Ministry of Defence are the owners of health care facilities. In addition to ensuring the implementation of the state health programmes, the Government of Lithuania is responsible for intersectoral collaboration and drafting legislation.

Ministry of Health

Overall responsibility for general supervision of the entire health system is held by the Ministry of Health (MoH). The MoH is strongly involved in drafting legal acts and issuing regulation for the health sector. It also runs health care facilities and public health institutions and has the overall responsibility of health system performance. In addition, the MoH develops health care infrastructure and prepares national health programmes. In conjunction with the Ministry of Economy and the Ministry of Finance, it makes decisions on major investments.

The main aims of the Ministry of Health are the development, organisation, coordination and control over the implementation of state policy in four fields: individual health care, public health, pharmaceutical activities and health insurance. Other major functions of the Ministry of Health include drafting legal acts, licensing, implementing state policy in subordinated institutions, formulating and implementing health strategies and programmes, international collaboration, analysing and disseminating information, and handling patients' complaints. In addition, many institutions subordinate to the Ministry of Health (listed below) have been established in order to carry out regulatory and governing functions.

Other ministries running parallel health systems. In 2001, the Ministry of Justice established a Prison Health Care Division in charge of overseeing health-care provision in all prisons in cooperation with the Ministry of Health. Also there are the Health service office and Medical Centre under the Ministry of Interior in Lithuania.

The National Health Insurance Fund (NHIF)

The state health insurance scheme is implemented by the NHIF, which also manages the Compulsory Health Insurance Fund. The NHIF mission is to ensure access to health care, for those who are

insured (Emergency health care is provided for all Lithuanian citizens), by remunerating the costs and using funds in a transparent and efficient manner.

The NHIF coordinates the activities of five existing territorial health insurance funds. The central NHIF office is in charge of budget planning and control, including decisions on the financial reserves, supervision, and audit of the territorial branches. The territorial branches of the NHIF sign contracts with health care providers and pharmacies. The branches also reimburse health care providers and pharmacies, disseminate information, control service provision in the regions, and finance municipal public health programmes. Supervisory boards of territorial NHIF branches have advisory functions and consist of representatives from the Ministry of Health, the central NHIF and the municipalities.

Budgetary Institutions under the Ministry of Health

The eight budgetary institutions have specialized functions: State Forensic Psychiatry Agency, National Public Health Surveillance Laboratory, Centre for Communicable Diseases and AIDS, State Mental Health Centre, Centre for Health Education and Disease Prevention, Nursing Training and Specialization Centre, the Lithuanian Medical Library and the Institute of Hygiene.

National Health Board

Among the national level institutions in charge of health policy implementation, the National Health Board, which is subordinate to parliament, plays the most active role. The board consists of representatives from municipal health boards, universities, nongovernmental organisations (NGOs) and public health professionals. The National Health Board coordinates public health policy areas while the municipal health boards implement health policy at the local level.

Local level

In the 1990s, many health administration functions in Lithuania were decentralized from the Ministry of Health to the counties. However, more recently, there has been increasing centralization of administration. At present, municipalities are responsible for organizing, and have a wide range of responsibilities in the implementation of local health programmes and public health activities. The municipality board approves health programmes and sets health budgets, while the director of administration ensures programme implementation.

A lack of institutional capacity in relation to the volume of responsibilities had been recognized at the local level. In response, since 2006, municipal public health bureaus have provided public health services to municipality residents. At the primary health-care level, some public health functions, such as health promotion, primary prevention and immunization, are carried out by GPs. They, along with other medical specialists and dentists, implement national screening programmes financed by the NHIF. Women aged 25–60 years are offered cervical cancer screening every three years, and those aged 50–69 years are offered breast cancer screening every two years. Men aged 50–75 years (and over 45 for those at risk) are eligible for prostate cancer checks every two years. In addition,

biannual colorectal cancer screening is available for adults aged 50–75 years; annual screening for those with high cardiovascular risk is available to men aged 40–55 years and women aged 50–65 years, and a dental programme that provides for teeth coating is offered to children aged 6–14 years.

Main stakeholders at the national, regional and local level

National Level

The main public body at the national level is the Ministry of Health (MoH) of the Republic of Lithuania. The MoH is responsible for policy development, organisation, coordination and monitoring of implementation, and implementation for areas assigned to the Minister of Health.

Other public bodies which are responsible for health promotion and primary prevention are institutions under the MoH which includes: the Centre for Health Education and Disease Prevention, and the Institute of Hygiene.

> *Centre for Health Education and Disease Prevention* activity areas include: non-communicable diseases and injury prevention, child health, health promotion, physical activity and nutrition, environmental health and health specialist training.
>
> The *Institute of Hygiene* activity areas include: monitoring of health and its factors at the population level; researches on health inequalities and work environmental effect on health; health technology assessment in public health and occupational health; developing and testing innovative interventions in public health; evaluation of health strategies and measures of programmes.

The *National Health Insurance Fund* finances screening programmes including a programme which screens for cardiovascular disease prevention (target population – 40-55 year old males and 50-65 year old females).

The *Drug, Tobacco and Alcohol Control Department*, under the Government of the Republic of Lithuania, is the main institution responsible for tobacco and alcohol control.

The *State Mental Health Centre*, which engages in implementation of mental health policy and public mental health measures, including coordination of primary mental health care and monitoring and strengthening population mental health.

Other institutions include the: Communicable Disease and AIDS Centre, Health Emergency Situation Centre, National Public Health Care Laboratory, State Mental Health Centre and others (see the full list here: http://www.sam.lt/go.php/Institutions%20under%20the%20Ministry%20of%20Health743).

Regional/ Local Level

The Bureaus of public health are the main institutions at the local level. Each municipality has to have a Bureau of public health or otherwise buy these services from another municipality. The Bureaus, as a public body, are responsible for health promotion, public health monitoring, communicable disease prevention, prevention of non-communicable diseases and injuries, implementation of public health programmes in the municipal community, child and youth health promotion, and evaluations of the effect of the decisions of municipalities on public health.

NGOs

Among voluntary organizations, the *Red Cross Society*, the *Caritas Federation*, the *Diabetes Association*, the *Association of the Blind* have been influential in public debates. In 2012, there were about 80 patients' organizations, with 30 of them united in the *Council of Representatives of Patients' Organizations*. Another umbrella organization is *POLA*, established in 2011, which unites 12 NGOs working in the area of oncology. Some patient organizations are active in lobbying the interests of certain patient groups.

The *National Tobacco and Alcohol Control Coalition* works in the area of tobacco and alcohol use.

The *Diabetes Association* provides mutual aid and assistance to all diabetics; promotes the study, the spread of knowledge and the proper treatment of diabetes; removes all present limitations of diabetics discrimination in their rights to labour, studies, insurance.

The *Lithuanian Heart Association* is one of most active organisations. The association helps those who are suffering from heart disease, and those who want to avoid it, improves Doctors' professional skills, informs society.

Strategies and programmes

Legal Guidelines

The principal guidelines for public health services have been outlined in the Health System Law (1994), the Lithuanian Health Programme (1998–2010), and the National Public Health Strategy (2006–2013). In 2002, the parliament adopted the Public Health Care Law and the Public Health Monitoring Law. Other relevant legal documents related with public health include: the Law on Alcohol Control (1995), the Law on Tobacco Control (1995), and the Law on Food (2000).

A policy document, *Lithuania's Health System Development Dimensions 2011–2020*, was adopted in 2011 and defined the main directions for health system development until 2020 (Parliament of the Republic of Lithuania, 2011a). The document is intended to provide consistency to the future development of the system and make it more efficient and competitive. The key areas of focus are health improvement and disease prevention; expansion of the health-care service market through

fair competition; increasing transparency, cost–effectiveness and rational use of resources; and ensuring evidence-based care and access to safe and quality services.

National progress program for 2014-2020, horizontal priority inter institutional action plan „Health for all“ approved by government of Republic of Lithuania 2014-april-05

Alcohol and drug control program approved by government of Republic of Lithuania in 2011, 14th September.

Programmes

Ministerial Order: Action plan for healthy ageing protection in Lithuania 2014-2023
(Legislation, 2014, No. 2014-10374)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=478443&p_tr2=2
An Action Plan for older people, to encourage them to take care of their health. It is a broad health policy that includes not only cardiovascular disease, stroke, and diabetes; but also physical activity, injuries, cancer and others. Older people in this policy are undefined. This policy also involves health promotion and personal health care.

Ministerial Order: Action plan approval for reducing health inequalities in Lithuania 2014-2023
(Legislation, 2014, No. 2014-10332)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=478355&p_tr2=2
An Action Plan to reduce health inequalities in Lithuania. This plan also includes the socio-economic gradient. The main purpose of this plan is to reduce heath inequalities in certain Lithuanian regions and for different social groups of the health disparities. In addition, the plan aims to reduce inequalities in access to health care, and improve the target group’s access to disease prevention, health promotion, and primary and specialized health care services.

Ministerial Order: Cancer prevention and control program 2014-2025
(Legislation, 2014, No. 2014-10275)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=478197&p_tr2=2

Resolution for Lithuanian Health Program Approval 2014-2025
(Legislation, 2014, No. 2014-09403)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=476512
The Lithuanian Health Program 2014-2025 is the main health policy in Lithuania. The main purposes of this programme are listed in the table below:

Main Purposes of the Lithuanian Health Program 2014-2025

<table>
<tr><td>Strategic purpose</td><td colspan="4">To achieve a healthier and longer-living population, improve population health, and reduce health inequalities by 2025</td></tr>
<tr><td>The main indicator</td><td colspan="4">Life expectancy (achieve average life expectancy of 77.5 years by 2025)</td></tr>
<tr><td>Purposes</td><td>1. To create a safer social environment, reduce health inequalities</td><td>2. To create healthy occupational and living environments</td><td>3. Formation of a healthy lifestyle and its culture</td><td>4.To ensure high quality and efficient health care for the needs of the population</td></tr>
<tr><td rowspan="7">Tasks</td><td>1.1 To reduce poverty and unemployment</td><td>2.1 To create safe and healthy working conditions, increase the safety for consumers</td><td>3.1 To reduce alcohol and tobacco use, and prevent drug diversion and psychotropic substance use and accessibility</td><td>4.1 To ensure the sustainability and quality of the health system by developing evidence-based health technologies</td></tr>
<tr><td>1.2. To reduce socio, economic population differentiation at country and community levels</td><td>2.2 To create favourable conditions for leisure</td><td>3.2 To promote habits of healthy nutrition</td><td>4.2 To develop the health infrastructure and improve the quality of healthcare, safety, and accessibility to patient-centred care</td></tr>
<tr><td rowspan="6"></td><td>2.3 To reduce road accidents and injuries</td><td>3.3 To develop habits of physical activity</td><td>4.3 To improve maternal and child health</td></tr>
<tr><td rowspan="2">To reduce pollution of air, water, soil and noise</td><td rowspan="5"></td><td>4.4 To strengthen chronic non-communicable disease prevention and control</td></tr>
<tr><td>4.5 To develop a Lithuanian electronic health system</td></tr>
<tr><td rowspan="4"></td><td>4.6 To maintain the health care during crisis and emergency situations</td></tr>
</table>

Evaluation of the Lithuanian Health Programme (1998–2010) showed that by 2010 some of the targets set for population health had been achieved: average life expectancy increased to 73 years,

infant mortality decreased twice as fast as expected and the incidence of tuberculosis decreased by 30%. Lithuania Partial success has been achieved in reducing mortality from injuries and in reducing premature mortality from cancer and ischaemic heart disease. No substantial reductions have been achieved in mortality from circulatory diseases in those under 65 years of age, from breast cancer or from suicides, or in reducing prevalence of cervical cancer and mental illness. Mortality from conditions amenable to health care (deaths that should not occur in presence of timely and effective medical care) increased in males and barely reduced in females between 1991 and 2008. Preventable mortality (deaths that could be prevented through changes in lifestyle and intersectoral measures that have impact on public health) has also increased over the same period. Lithuania is the country with the largest gender gap in life expectancy at birth in the EU. In 2010, men were expected to live 68 years compared with 79 years for women.

Ministerial Order: Screening and prevention program funding approval for people at high risk for cardiovascular diseases
(Official Gazette, 2005, No. 145-5288, last updated Official Gazette, 2013, No. 36-1770)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=445770
Goals of the programme: reduce the incidence of acute cardiovascular syndromes, and identify new latent atherosclerosis conditions and diabetes cases in order to reduce patient morbidity and mortality due to cardiovascular disease.

Ministerial Order: Stroke control and prevention programme 2006-2008
(Official Gazette, 2006, No.83-3304)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=281051&p_query=insultas%20prevencija&p_tr2=2

Ministerial Order: Description of the procedure for medicines reimbursed diabetes
(Official Gazette, 2012, No. 27-1228)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=419228&p_query=diabetas&p_tr2=2

Ministerial Order: Description of the procedure for the health promotion of cardiovascular disease risk group individuals
(Legislation, 2014, No. 13068)
http://www3.lrs.lt/pls/inter3/dokpaieska.showdoc_l?p_id=483457&p_tr2=2
The objective of this document are to integrate primary health care services with municipal public health services, effectively strengthen health of risk groups, educate population about cardiovascular diseases risk factors, healthy lifestyle principles, choosing the healthy diet and physical activity.

Financing

The *Ministry of Finance* has an important role in allocating the funds for the Ministry of Health and forming the annual health insurance budget, which is decided together with the national budget. It also makes decisions on investments, either under the state investment programme or from the EU structural funds, and performs strategic planning and programme budgeting in state budget allocations.

National public health institutions are financed by the state budget. These institutions include: specialized public health institutions directly subordinate to the Ministry of Health; the State Food and Veterinary Service, the State Labour Inspectorate, and the Drug, Tobacco and Alcohol Control Department.

Municipal public health bureaus are financed by both targeted Ministry of Health budget allocations and local budgets. All policies mentioned above are funded by state and municipalities' budgets; the National Health Insurance Fund; EU funds and other international funds; the promoters' own funds; and other funding sources. An estimation of the percentage is not available due to different appropriation every year.

Forecasting studies

Egidija Rinkūnienė, Aleksandras Laucevičius, Žaneta Petrulionienė, Jolita Badarienė (2012 Department of Cardiovascular Medicine Vilnius University **„Lithuanian high cardiovascular risk (LitHir) primary prevention programme - prevalence of dyslipidemia in the middle-aged adult population of the Lithuania"**, Vilnius University Hospital Santariskiu Clinics, „Informeda enterprise").
According to the latest World Health Organization data Coronary heart disease deaths in Lithuania reached 38.26 % of total deaths. Dyslipidemia is one of the most important risk factors for cardiovascular diseases which are a major cause of morbidity and a leading contributor to mortality worldwide.
Material and methods. In 2006 the Lithuanian High Cardiovascular Risk programme was started. The two-level approach – primary health care institutions and specialized cardiovascular prevention units – was applied. The prevalence of dyslipidaemia and cardiovascular risk factors is presented in the group of 17,031 subjects included into the programme on the primary level.

Results. Among the persons analyzed 61.8 % (10,519) were females whereas 38.2 % (6,512) were males. Arterial hypertension was present in 60.2 % of these subjects. The estimated prevalence of dyslipidaemia was 88.8 %. Total cholesterol was 6.02 ± 1.23 mmol/l; low-density lipoprotein cholesterol – 3.74 ± 1.09 mmol/l; high-density lipoprotein cholesterol – 1.53 ± 0.52 mmol/l and trygicerides – 1.61 ± 1.27mmol/l.
Conclusions. So dyslipidaemia requiring drug treatment is common in the middle-aged adult population of the Lithuania among persons with no evidence of clinical cardiovascular disease.

Almost nine out of ten of middle aged subjects in Lithuania have established dyslipidaemia. Undertreatment of persons with dyslipidaemia is a major public health challenge.

Ramazauskiene Vitalija, Petkeviciene Janina, Klumbiene Jurate, Kriaucioniene Vilma, Sakytė Edita **"Diet and serum lipids: changes over socio-economic transition period in Lithuanian rural population"** (2011).
Since regaining of independence in 1990, Lithuania has been undergoing substantial political, economic, and social changes that affected the nutrition habits of population. Dietary changes might have impact on the trends of dietary related risk factors of chronic diseases. The aim of the study was to compare trends in diet and lipid profile of Lithuanian rural population aged 25-64 during two decades of transition period (1987-2007). Methods Four cross-sectional surveys were conducted within the framework of the Countrywide Integrated Noncommunicable Diseases Intervention Programme in five regions of Lithuania in 1987, 1993, 1999, and 2007. For each survey, a stratified independent random sample was drawn from the lists of the inhabitants aged 25-64 years registered at the primary health care centres. Altogether 3127 men and 3857 women participated in the surveys. 24-hour recall was used for evaluation of dietary habits. Serum lipids were determined using enzymatic methods. Predicted changes of serum cholesterol were calculated by Keys equation. Results The percentage of energy from saturated fatty acids has decreased from 18.0 to 15.1 among men and from 17.6 to 14.8 among women over the period of 20 years. The average share of polyunsaturated fatty acids in total energy intake increased from 5.3% to 7.1% among men and from 4.9% to 7.3% among women. The mean intake of cholesterol declined among women. Favourable trends in fatty acids composition were caused by increased use of vegetable oil for cooking and replacement of butter spread with margarine. Since 1987, the mean value of total cholesterol has decreased by 0.6 mmol/l. Total dietary effect accounts for a 0.26 mmol/l (43.3%) decline in serum cholesterol among men and 0.31 mmol/l (50.8%) decline among women. Conclusions Improvement in the quality of fat intake was observed in Lithuanian rural population over two decades of transition period. Positive changes in diet, mainly reduction in saturated fatty acids intake, contributed to decline in serum cholesterol level. Strengthening of favourable trends in nutrition habits in Lithuanian population should be one of the most important strategies of cardiovascular diseases prevention.

Gaps and Needs

The **evaluation of health promotion programme implementation** is usually done in the middle of the programme and at the end of the programme. However, the analysis does not take into account the impact on vulnerable groups, socio-economic groups, or other groups. The lack of clear mechanism for health promotion and risk factors related programs implementation in municipal level.

There is no development **of public health technologies assessment system** in order to implement effective health promotion and chronic disease prevention interventions.

There are no **Health Impact Assessment** Tools that are applied to evaluate the potential impact of other policy sectors. In addition, the Centre for Health Education and Disease Prevention prepared recommendations on how to integrate Health Impact Assessments into the decision making process, but they are still not obligatory.

The system of **health leans on personal medicine**. One of the biggest reasons is because of post-soviet heritage. Due to that, there is limited funding for primary prevention or health promotion. It is hard to change this approach as it is taken by a huge part of society and policy makers, which also leads to other problems.

Health education is also underfunded so there are currently few good practices. Booklets or other releases are usually not printed, but put on the internet only. Thus very few people get the information they are seeking about health issues, and this particularly affects older persons. Medical practitioners do not spend a lot of time with their patients to inform them about prevention, and rather only give information about treatment procedures.

The publicly available knowledge and transparency of processes for allocating funding for primary prevention and health promotion is currently unknown.

Another huge problem is the lack of **research on primary prevention or health promotion**. Many researchers study prevalence, but there are no studies about cost-effectiveness or forecasting studies, or if they exist, those studies have low value. This problem is strongly related to funding issues.

An additional problem is that public health interventions are not sensitive to the specific needs of more vulnerable groups. There are some programmes, but they are for children or the elderly, or male or female only (such as screening programmes).

Moreover, the main institution responsible for **screening programmes** is the National Health Insurance Fund, but health care facilities are responsible for informing their own patients. Thus another gap is that there is no centralized coordination for screening programmes – every health care facility informs patients in different ways and not all of these ways are effective.

Multidisciplinary primary health care teams that can address health promotion/primary prevention currently do not exist in Lithuania. Many health care services that can respond to special needs and priorities of more vulnerable or disadvantaged groups are directed at children and not at the elderly.

There is also a lack of **partnerships** between different sectors and non-governmental organisations. This leads to other problems such as ineffective resource use and inefficient programme implementation.

Knowledge development also has some gaps. There are some universities in Lithuania, but research institutes that engage in research on effective primary prevention and health promotion programmes/interventions do not exist, or they do not research these items. In addition, many findings do not reach policy makers. If there is sufficient capacity for knowledge development in Lithuania, it is currently not fully exploited.