NATIONAL AUDIT OFFICE OF LITHUANIA

ENSURING SUSTAINABILITY OF HEALTH CARE IN EMERGENCIES

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SUMMARY

Relevance of the Audit

European Commission focuses on the sustainability of health systems[1]. Since 2004, the sustainability of these systems has been mentioned alongside important issues such as health inequalities, rising rates of chronic and non-communicable diseases, ageing population, patient safety etc.[2] It underlines the need to make modern health care systems sustainable in the long term while remaining accessible and efficient[3]. The Organisation for Economic Co-operation and Development (OECD) points out that, in the absence of societal change and changes in health systems, the current coronavirus pandemic is unlikely to reduce the likelihood of the emergence in the near future of other pandemics of low-probability though posing a serious threat to health systems, economies, and societies[4].

The COVID-19 pandemic had a major impact on the health of the Lithuanian population in 2020–2021. In 2020, life expectancy in our country dropped by 17 months (from 76.5 to 75.1 years) due to this infection, making it the third most common cause of death[5]. In 2020, hospital mortality from myocardial infarction and stroke has increased compared to 2019, with a 16% increase in deaths compared to the previous five-year average. Priority prevention programmes for chronic diseases and cancer have been disrupted, with 26%

[1] European Parliament's Resolution of 9 October 2008 "Together for Health: A Strategic Approach for the EU 2008–2013", p. 3.

[2] EU Council 05/06 December 2007 conclusion on the Commission's White Book "Together for Health: A Strategic Approach for the EU 2008-2013", Point 4 on page 14, Point 6 on page 15.

[3] 04/04/2014 Communication from the Commission on effective, accessible and resilient health systems, p. 10.

[4] Internet access: OECD iLibrary | Health at a Glance: Europe 2020: State of Health in the EU Cycle (oecd-ilibrary.org) (accessed on 07/01/2022).

[5] Internet access: https://www.oecd-ilibrary.org/migration-health/lithuania-country-health-profile-2021, p.p. 4, 15, 22. (accessed on 07/01/2022)

of the country's population reporting that they refused medical care during the pandemic[6].

The Eighteenth Government Programme approved by the Seimas[7] stipulates that the health system, both in terms of the available infrastructure and the competence of professionals, must be ready to respond quickly and effectively to emerging crises, pandemics, and other potential disasters, and to be able to react quickly to changes and manage them efficiently, adapting flexibly to the conditions of the new reality, and to ensure the proper and uninterrupted functioning of the health system during the entire period of the transition, in order to protect people's health and life. Availability of civil protection measures, an adequately accumulated and accessible reserve of measures, clear and adequate compensation measures, competence development of health professionals – these are main disaster preparedness measures.

To assess whether the sustainability of the health system was ensured during emergencies and to identify areas that need to be strengthened in order to make the country's health system better prepared for emergencies, we carried out a public performance audit.

Objective and Scope of the Audit

The objective of the audit is to assess whether the sustainability of the health care system during emergencies is ensured.

Key audit questions:

- Whether the management of health emergencies caused by communicable diseases effective?
- Whether health care system resources (human, financial, personal protective equipment) are managed in such a way that the system remains sustainable during emergencies?
- Whether the quality of health care services is ensured during emergencies, i.e. accessibility and safety?

Audited entities:

- Ministry of Health – as it forms, organises, coordinates and monitors public and personal health care policy, and is responsible for organising the response to, and the aftermath of, a state-level communicable disease emergency;
- National Public Health Centre – as it participates in the management of health emergencies of biological and chemical origin, organises and plans preparedness for health emergencies, carries out state control of public health safety in personal health care institutions, and carries out prevention and control of communicable diseases;
- Health Emergency Situations Centre – as it implements the national policy on health emergencies management, creates and develops the national emergency

[6] Ibid.

[7] 11/12/2020 Resolution No XIV-72.

management system, and coordinates the emergency preparedness and activities of the Lithuanian national health system institutions.

During the audit, we collected information from the National Health Insurance Fund, Institute of Hygiene, 5 personal health care institutions providing treatment for the COVID-19 disease[8], and 60 municipalities. A representative survey of the population[9] was carried out at the request of the National Audit Office. 191 institutions providing personal health care services and 11 non-governmental organisations representing medical professionals were surveyed. We collected information from non-governmental organisations representing the interests of health system participants: the Association of Local Authorities of Lithuania, Lithuanian Medical Movement (Lith. Lietuvos medikų sąjūdis), The Lithuanian Nurses Association, The Head of the Pain Service of Cambridge University Hospital, Lithuanian Cancer Patient Coalition (POLA), Council of Representatives of Lithuanian Patients' Organisations (LPOAT).

The audited period – 2019–2021.

The audit was carried out in accordance with the requirements of the National Audit Office (NAO) in force until 30 June 2021 and the International Standards for Supreme Audit Institutions. The scope and methods of the audit are described in greater detail in Annex 2, Audit Scope and Methods (p. 52).

Key Results of the Audit:

The country's health system participants need to take action to make the system more sustainable in emergencies by improving processes for managing health emergencies and access to and safety of health care services; organising the accumulation and distribution of medical supplies; and addressing human resourcing and competence development issues.

1. Health emergency management needs to be improved

- The Ministry of Health, as the responsible authority, has organised the management of the pandemic and has taken steps to address the increased workload of its subordinate institutions. As a result of the new activities of the National Public Health Centre and the significant increase in previous activities (compared to 2019, the number of communicable diseases investigated has increased by a factor of 6.7 in 2020 and by a factor of 9 in 2021), the National Public Health Centre has been provided with additional funding for 38 positions in June 2020. The information system entrusts the epidemiological surveillance and monitoring of communicable diseases to a single body, the National Public Health Centre. Other health and non-health sector institutions and bodies were involved in pandemic containment[10]. The additional assignment by the Ministry to 5 subordinate personal health care institutions to coordinate and organise the provision of COVID-19 treatment services in the assigned

[8] VšĮ Vilnius University Hospital Santaros klinikos; VšĮ Kaunas Hospital of LSMU; VšĮ Klaipėda University Hospital; VšĮ Šiauliai Republican Hospital; VšĮ Panevėžys Republican Hospital.

[9] A representative survey of the Lithuanian population conducted by VILMORUS at the request of the National Audit Office on 15–10/22/2021 "Assessment of the Work of Health Care Institutions During the Pandemic".

[10] National Health Insurance Fund, Hygiene Institute, Lithuanian Armed Forces, Ministry of Transport and Communications, Lithuanian Post, non-governmental organisations.

territory (98 health care institutions) has led to problems of storing a large number of supplies due to underestimated capacity of these institutions. No additional costs in terms of human resources and transport freight were reimbursed. The position of the Chief Epidemiologist of the Republic of Lithuania is held not by an official appointed by the Ministry, as stipulated by law[11], but by a civil servant - the head of the structural unit to which the Chief Epidemiologist's functions have been delegated on the basis of the job description. The head of the department has to be involved in the formulation of policy in the field of epidemiological surveillance, prevention and control (management) of communicable diseases and, as the Chief Epidemiologist has to take decisions on the application of measures for the prevention and control of communicable diseases, however, as the Ministry states, in the case of an emergency, the Chief Epidemiologist is not responsible for making decisions regarding the management of the communicable disease. Ensuring the human and financial resources of subordinate bodies and establishing the authority of the country's Chief Epidemiologist for Communicable Disease Management will make the management of potential pandemics more effective (Sub-section 1.1, p. 16).

- During the pandemic, epidemiologically relevant data on communicable diseases captured in the information systems[12] had deficiencies: the data entered was not fully accurate, there was duplication, a lack of links with various national registers, and a lack of summarised information needed by epidemiologists. Recommendations made to improve [13] the State information system for the monitoring and control of communicable diseases that can spread and pose a threat are being implemented. The modernisation of the State Information System on Communicable Diseases and Agents Thereof was launched in Q1 2021 for decision-making on pandemic management based on valid data (Sub-section 1.2, p. 19).
- In November 2021, monitoring of the emergency preparedness of health care institutions, performed by the Health Emergency Situations Centre, covers up to 10% (out of 241) of health care institutions whose founders or shareholders are the State or municipalities. The Centre does not monitor private institutions that have concluded contracts for reimbursement of health care services from the State Social Insurance Fund. Private health care institutions submit their preparedness plans for assessment on their own initiative: in 2021, only one (of 598) submitted a plan. The monitoring of the Centre showed that in 2017–2019, 39% of health care institutions (VšĮ, public undertaking) did not carry out a risk analysis of potential hazards, 67% did not foresee structural units for the care of patients exposed to hazardous substances, and 26% did not have premises to separate the flow of contaminated and uncontaminated patients. In 2020, the detected irregularities were repeated: 21% of health care institutions did not have emergency management plans and 32% did not carry out a risk assessment analysis. Without adequate monitoring, the preventive objective of correcting deficiencies in emergency preparedness in a timely manner will not be achieved (Sub-section 1.3, p. 20).

[11] Law on the Prevention and Control of Communicable Diseases in Humans, Article 2(32).

[12] State information systems for the monitoring and control of communicable diseases that can spread and pose a threat.

[13] Assessment of the information system by the internal auditors of the National Public Health Centre. 06/04/2021 internal audit report No 061.19EBV-4959.

2. Health system resources management during emergencies needs to be improved

- The Ministry has additionally financed (EUR 1.2 million in 2020) the training of 3.4 thousand personal health care professionals during the pandemic, taking into account the needs expressed by health care institutions, however, it has not identified the number of professionals and their professional qualifications that need to be improved, as 69% of the surveyed health care institutions, as well as 85% of the municipalities, as founders of the health care institutions, do not assess the adequacy of the professionals' competences. Failure to link the content of competency development programmes to the management of the various emergency risks will not ensure that professionals are adequately prepared to carry out their roles, or new roles, in the event of the declaration of an emergency (Sub-section 2.1, p. 22).

- Lithuanian Society for Infectious Diseases and 57% (of 178) of the surveyed health care institutions reported an insufficient number of infection control practitioners. During the pandemic, doctors of other specialities (e.g. anaesthesiologists, paediatric intensive care physicians, internal medicine physicians, pulmonologists) were deployed to provide emergency care, health monitoring and symptomatic treatment. 5% of health care institutions' employees were recruited from other health care institutions within the national health system. 6 out of 17 municipalities failed to attract employees from private health care institutions. No health care institution used employees from outside the national health system (private health care institutions that do not have contracts for reimbursement of health care services from the Compulsory Health Insurance Fund). 21% of the surveyed health care institutions have benefited from the volunteers' work; one of these institutions has a reserve list of volunteers. In 2020, 6 EU countries [14] had official reserve lists of health care professionals during the pandemic, from which they were called upon to contribute to infection control and patient treatment. In Lithuania, a human resources reserve (data analysts, epidemiologists, other health care professionals, academics, NGOs, business, civil service specialists) was planned for the end of 2020, however, the draft laws[15] have not been discussed. In emergencies, without the capacity of private health care institutions and a sufficient number of volunteers, adequate access to health services other than COVID-19 will not be ensured (Sub-section 2.1, p. 22).

- During the pandemic, personal protective equipment was accumulated and distributed to health care institutions from three funding sources[16], the largest of which was the EUR 106.55 million (99%) COVID-19 Reserve, the accumulation, storage, use and administration procedure of which has not been established. We have found that

  - the replenishment of part of the medical supplies of the State Reserve was delayed by 9 months (foreseen for 31/12/2020, to be reconstituted in Q3 2021), and that a part of the accumulated supplies[17] was inventoried in 2020. 3 of 5 health care institutions organising services supply and 19% (of 53) municipalities that responded indicated that the resources received from the State were insufficient;

[14] Belgium, France, Ireland, Iceland, Luxembourg, Norway.
[15] Draft Law No XIIIP-4555, amending Articles 8, 12, 14, 15, 16, 18, 19, 22, 25, 26, 27, 28 and 31 of the Law on Civil Protection No VIII-971, and the draft laws accompanying it.
[16] State Reserve for Medical Supplies – EUR 0.058 million, COVID-19 Reserve – around EUR 106.55 million, received support – EUR 1.18 million.
[17] Information on the quantities of State reserve for medical supplies is "limited".

- 49% of municipalities do not accumulate necessary medical supplies, 26% of them do not have sufficient funds, 23% – premises. For the same reasons, 28% of the surveyed health care institutions have only part or none of the supplies required to be accumulated. The Ministry does not have feedback information on the accumulation of personal protective equipment in health care institutions, although responsible authorities have been designated to monitor and control the accumulation[18].

The Ministry's failure to establish a procedure for the creation and use of the COVID-19 Reserve, the failure to recover personal protective equipment used in the State reserve and to inventory it in a timely manner, the lack of effective monitoring of the supplies accumulation model, and the irresponsible accumulation by municipalities and health care institutions do not ensure adequate preparedness for new emergencies (Sub-section 2.2, p. 26).

- By applying the 1/12 payment principle[19], during 2020, EUR 201.3 million were allocated from the State Social Insurance Fund and till 01/10/2021 – EUR 97.4 million more funds than provided health care services. According to the data of the National Health Insurance Fund, comparing 9 months of 2021 and 9 months of 2020, the number of health care institutions with a negative financial result has more than doubled, due to the following cost increases: wages (42%), the implementation of the collective agreement of the national health care system branch, the treatment of the COVID-19 infection (29%), and the increase of the minimum monthly salary (14%). Around 30% (of 182) surveyed health care institutions, their financial situation has deteriorated. Due to a change in the institutions[20] responsible for the reimbursement of additional costs, in 2021, the additional costs of medical equipment and supplies of health care institutions under municipalities were reimbursed by the State budget, while the institutions under the Ministry covered the same costs from their own income, even though they were not included in the established basic tariffs for services. 29% of health care institutions reported that payment for services was insufficient and 32% reported that the additional costs of treatment for COVID-19 were not reimbursed. The lack of financial stability of health care institutions during an emergency has a negative impact on their capacity to guarantee the continuity of health services (Sub-section 2.3, p. 32).

3. Processes of accessibility and safety of health care services need to be developed

- A comparison of data from the National Health Insurance Fund of Q2 2020 and Q2 2019 shows that in 53% of municipalities, the volume of GP services accounted for less than 80%, which was updated to 108% by Q3 2021 through teleconsultations. However, in 2021, compared to 2019, there is still a low level of services for early diagnosis of malignant tumours (66%), prostate (prostate gland) cancer (64%), cervical malignant tumours (63%) and for testing of biopsy material (60%). Comparing the 2021 and 2017

[18] The National Public Health Centre monitors the provision of personal protective equipment in health care institutions, while the Fire and Rescue Department monitors the provision of personal protective equipment in municipalities.

[19] The 1/12 payment principle means that the amount agreed in the contract on reimbursement of health care services by the Compulsory Health Insurance Fund concluded between the Territorial Health Insurance Fund and the health care institution is paid to the institution on a monthly basis, in equal instalments, irrespective of the volume of health care services provided.

[20] Ministries of Finance and Health.

public opinion surveys, 8% fewer people were able to see a family doctor on the same day, 6% more people waited more than 10 working days for services, and the number of people waiting more than 20 working days to see a specialist increased by 17%. In September 2021, the waiting time for specialised elective outpatient services of haematologists, infectologists, pulmonologists, early rehabilitation for childhood developmental disorders, child and adolescent psychiatry, and cardiac interventional radiology day hospital services were waited for more than before the pandemic. 30.6% of the people indicated that during the pandemic there were cases when they did not go to a health care institution even though it was needed. The most common reasons were: waiting queues for doctors (16.7%), and no possibility to call the reception (14.1%). Without restoring access to treatment for chronic diseases, oncology and other illnesses, the health of the country's population will deteriorate (Sub-section 3.1, p. 37).

- 91% (64) of the 37% (70) of the 191 surveyed health care institutions having issues with waiting queues; used new measures to manage queues and increase access to services: teleconsultations, teleradiology, telemedicine, call management centres, call transfer systems at the reception desk, the formation of mobile teams to provide home-based services, and the use of community nurses to provide advice to patients with chronic non-communicable diseases. However, we found that health care institutions registered patients in different information systems, 36% (out of 942) of the health care institutions did not conclude contracts for the use of the pre-registration information system, and 31% (189 out of 607) of those that concluded, did not provide registration schedule. The timely implementation of the 2018 public audit[21] recommendations could have helped to manage waiting queues for services (Sub-section 3.1, p. 37).

- There has been a 25% increase in the number of people who believe that the likelihood of being exposed to harmful health services is increasing (27% in 2017 and 52% in 2021). 15% of the municipalities surveyed (out of 58) indicated that they collected information on patient satisfaction with services from subordinate health care institutions during 2019–2021. 94% (out of 135) of the surveyed health care institutions indicated that patient satisfaction with services has not deteriorated in 2020 compared to 2019, however, according to the Ministry's assessment, the data are not reliable. The Ministry has developed a health system performance assessment model on 31/12/2021, which includes indicators to assess patient satisfaction with health services, which should help to improve the quality of health services (Sub-section 3.2, p. 42).

- According to the National Public Health Centre, in 2020, outpatient health care institutions have had almost twice as many breaches of infection control requirements (from 9.2% to 16.9%) compared to 2019. The most frequent breaches are non-compliance with instructions and rules for disinfection of surrounding environment surfaces, disinfection of medical devices with chemical disinfectants and/or sterilisation, failure to prepare, or inadequately prepare, infection control procedure manuals and hygiene plans. Difficulties in the implementation of infection control requirements were faced by 22% (out of 190) of the surveyed health care institutions, and in more than half of them (27 out of 42), the infrastructure of buildings and premises and premises themselves are not suitable to provide services to patients with highly infectious diseases. The safety of health care services will not be ensured if infection control requirements are not met (Sub-section 3.2, p. 42).

[21] 16/11/2018 public audit report No VA-2018-P-10-1-10 "The Accessibility of Health Care Services and the Orientation Towards the Patient".

- The Ministry, implementing the recommendations made by the National Audit Office in 2018, has developed an adverse event management model in the Public Health Monitoring Information System, and in 2021, 278 health care institutions (out of 835) joined it, of which 54 registered adverse events by November. In 2019, 11% of health care institutions reported adverse events to the Institute of Hygiene and 19% in 2020. The Institute of Hygiene did not have data on reported adverse events related to COVID-19 virus infection. The failure of health care institutions to record adverse events is a missed opportunity to ensure the safety of health care services more effectively (Sub-section 3.2, p. 42).

Changes during the audit

- As of 1 July 2022, an amendment to Article 24 of the Law on Health Care Institutions will come into force: the communicable disease monitoring function will be carried out by a single body, the National Public Health Centre, as the Centre for Communicable Diseases and AIDS will no longer be part of the Lithuanian national health system.
- Modernisation of the State Information System on Communicable Diseases and Agents Thereof was launched in Q1 2021, with plans to modernise the existing components of the Information System on Electronic Health Services and Collaboration Infrastructure, to develop new functionalities and increase the system's speed, and develop an information system for pre-registration of patients.
- By Q4 2024, it is planned to improve the model for the organisation of the professional development process (identification of the need for development, planning, monitoring, links to the monitoring of compliance with licence conditions).
- In December 2020, the descriptions of the procedures for conducting tests for COVID-19 disease (coronavirus infection) and the procedures for organising the vaccination of the population with the COVID-19 disease (coronavirus infection) vaccine purchased with State budget funds will be revised in order to speed up the settlement of the payment of the State budget for the services provided during October-November 2021.
- Health Emergency Situations Centre inventoried all medical supplies accumulated in the State Reserve.
- As of 1 January 2022, a premium on active treatment services, paid according to the method of diagnosis-related groups, entered into force. The purpose of this premium is to compensate for the increased costs incurred by supporting health care institutions for organising the treatment of COVID-19.
- By Q4 2023, it is planned to develop and deploy an instrument for the assessment of patient feedback (including patient satisfaction) on the health care services provided in selected personal health care institutions, using information technology directly focused on the monitoring and evaluation of patient feedback (patient opinion).

Recommendations

To the Ministry of Health

1. Having assessed the role of the institution of the chief epidemiologist in the decision-making process of communicable disease management, to amend legislation in order to define the powers of the Chief Epidemiologist of the Republic of Lithuania in emergencies (1 key audit result).

2. In order to ensure sustainable provision of health services during emergencies, create the legal preconditions for using the capacities of private health care institutions under the Lithuanian national health system and monitor their preparedness for these situations (1 and 2 key audit results).

3. In order to ensure sustainable provision of health services during emergencies, improve the model of cooperation with NGOs to allow for more rapid use of volunteers (2 key audit result).

4. To ensure that personal and public health professionals are properly prepared for the management of potential emergencies, an instrument to identify health professionals having competences to provide health services in emergencies, their development and training needs should be introduced in the common health professionals' competences platform (2 key audit result).

5. To ensure that the new three-part medical supplies accumulation model works effectively and that the supplies accumulated during emergencies meet the increased needs of health care institutions, the procedures for monitoring the accumulation and use of supplies by health care institutions need to be clarified (2 key audit result).

Measures and deadlines for the implementation of recommendations are provided in the Section Recommendation Implementation Plan of the report (p. 47).