COUNTRY REPORT

LITHUANIA

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Lithuania

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TABLE OF CONTENTS

READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	2.943.472	●●○○○
GDP per capita (2014) [EU mean = 100]	74	●●○○○
Accession to the European Union	2004	

Geography: Located in Northern Europe, Lithuania is the largest and most southerly of the three Baltic States. It is bordered by the Baltic Sea, Latvia, the Russian Federation, Poland, Kaliningrad Oblast (a Russian exclave) and Belarus. The terrain mainly consists of a fertile lowland with many small lakes. The most populated city is the capital Vilnius (517.000); two-thirds of population lives in urban settings. A low birth rate and significant economic emigration have resulted in a shrinking population and a diminishing proportion of working age citizens – trends that are becoming a real challenge for the country.

Historical background: The Kingdom of Lithuania was created in 1253. During the 14th century, the Grand Duchy of Lithuania was the largest country in Europe; its territories included Belarus, Ukraine, as well as parts of Poland and Russia. From 1569, Lithuania and Poland formed a voluntary union which lasted for two centuries, after which most of Lithuania was annexed by Russia. Lithuania was occupied by German troops in 1915, but regained independence after the war. During the Second World War it was re-occupied by the Soviets, the Germans, and then again by the Soviets. The country regained its independence in 1990. It was the first of the Soviet republics to declare its independence.

Government: Lithuania is a parliamentary republic with some attributes of a semi-presidential system. The country is divided into 10 counties and 60 municipalities. It joined the European Union in 2004 and the Eurozone in 2015.

Economy: Lithuania's recent fortunes have fluctuated in much the same way as the other Baltic States, Latvia and Estonia. The breakup of the Soviet Union was followed by a disastrous decline in living standards: life expectancy for both sexes during 1990–1995 fell by 2,2 years in Estonia, 2,4 years in Lithuania and 3,2 years in Latvia (Krumins & Dubkova 2012). As the new market economies developed, GDP increased steadily from 1994 until 2009, when all three countries were severely hit by the financial crisis. Recovery started again in 2011, and growth in Lithuania for 2017 and 2018 is expected to be around 3%, with unemployment at around 7,5%.[2]

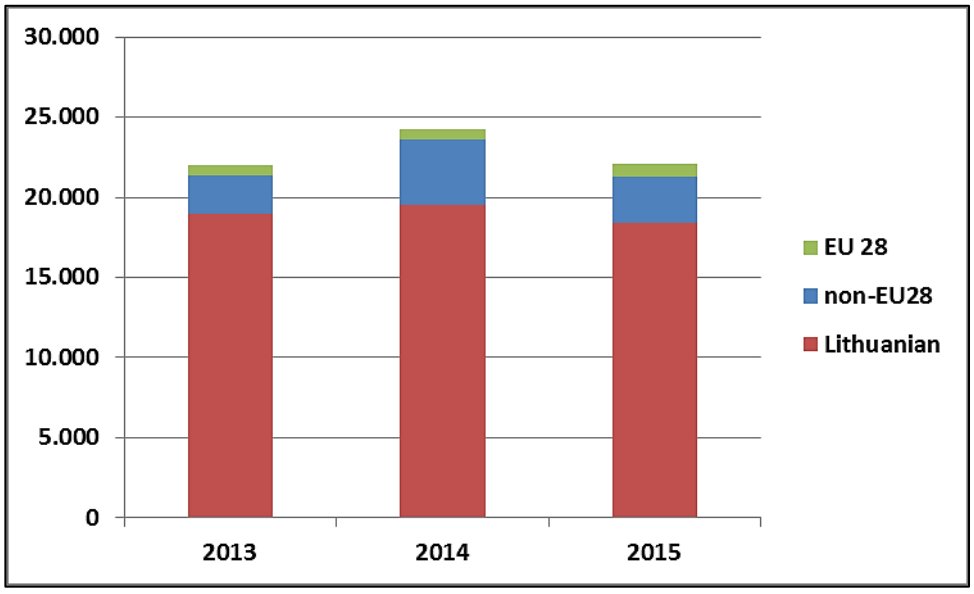
[2] https://ec.europa.eu/info/sites/info/files/ecfin_forecast_spring_110517_lt_en.pdf

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	4,7	●●○○○
Percentage non-EU/EFTA migrants among foreign-born population	86	●●●●●
Foreigners as percentage of total population	0,7	●○○○○
Non-EU/EFTA citizens as percentage of non-national population	74	●●●●●
Inhabitants per asylum applicant (more = lower ranking)	6.690	●●○○○
Percentage of positive asylum decisions at first instance	39	●●●○○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	39	●●●○○
Average MIPEX score for other strands (MIPEX 2015)	38	●○○○○

Emigration and return migration by Lithuanian citizens, as well as immigration by foreigners (especially refugees), are important topics discussed regularly in Lithuanian mass media. In recent years most immigration has been return migration: as Figure 1 shows, about 19.000 Lithuanian nationals a year returned to their country in 2013-2015, while EU28 immigrants averaged only about 700 and non-EU28 nationals about 3.000 a year.

Figure 1. Citizenship of immigrants to Lithuania, 2013-2015



(Source: Eurostat, file migr_imm1ctz)

Due to the low birth rate, rapid ageing of the population, higher mortality, and (especially) increasing emigration, the Lithuanian population shrank between 1990 and 2014 from 3.698.000 to 2.919.000, a

reduction of 779.000 persons. Eurostat expects it to fall further to below the two million mark by 2040 (European Commission 2015).

Lithuania's accession to the EU in 2004 and the Schengen Area in 2007 boosted migration. The country became more interesting for labour migrants, as well as a destination country for irregular migrants mainly coming from neighbouring CIS countries like the Russian Federation, Belarus, Georgia and Ukraine, as well as some Asian and African countries. Lithuania's Schengen status and its borders with the Russian Federation and Belarus have presented the country with numerous specific migration challenges. Among them are:

1. high labour emigration of Lithuanian nationals to Western European countries;
2. smuggling of migrants entering illegally from the territory of Belarus;
3. the facilitated, but well controlled transit of Russian citizens from the Russian mainland to Kaliningrad Territory (Oblast) via Lithuania;
4. cases of human trafficking.

Recently, another issue which is discussed by the government and mass media has been Lithuania's decision to take in refugees transferred from Mediterranean countries. National and international experts agree that labour emigration from Lithuania, return migration of Lithuanian citizens, and integration of irregular migrants and third country nationals are some of the priority issues to be solved (IOM 2015).

Emigration: Between 1990 and 2014, 77% of the reduction in Lithuania's population (i.e. 600.000 persons) was due to emigration (Damulienė 2013). Half of this emigration took place after Lithuania's accession to the EU in 2004: between 2005 and 2013 emigration accounted for 73% of population decline, the remaining 27% being due to natural causes. In the early period (1990-1995), the main destination countries for emigrants were Russia, Ukraine, and Belarus. (In addition, it is estimated that in 1990-1995 about 60% of emigration was neither declared nor accounted for.) Later the stream of emigrants changed direction towards Western European countries (United Kingdom, Germany, Ireland, Norway, Sweden, etc.) and the USA. Sometimes the emigration was only for a short period; later, these temporary stays tended to turn into various forms of employment abroad, so that many became long stays or permanent emigration (Čiarnienė & Kumpikaitė 2011).

Immigration: In the past, immigration from other countries was not considered a major political or economic issue by Lithuanian governments, but recently migration policy has become more salient. This is related to the increasing return migration of Lithuanian nationals, as well as the refugee crisis on Europe's southern borders. Neighbouring Belarusians, Russians, and Ukrainians are increasingly attracted to Lithuania for work or study. More attention is now being paid to the issue of filling labour shortages with employees from the EU or third countries. Residence permits can be **temporary** or **permanent**; a permanent visa can only be issued after living in Lithuania for five years,[3] and confers the same rights as citizenship except the right to vote.

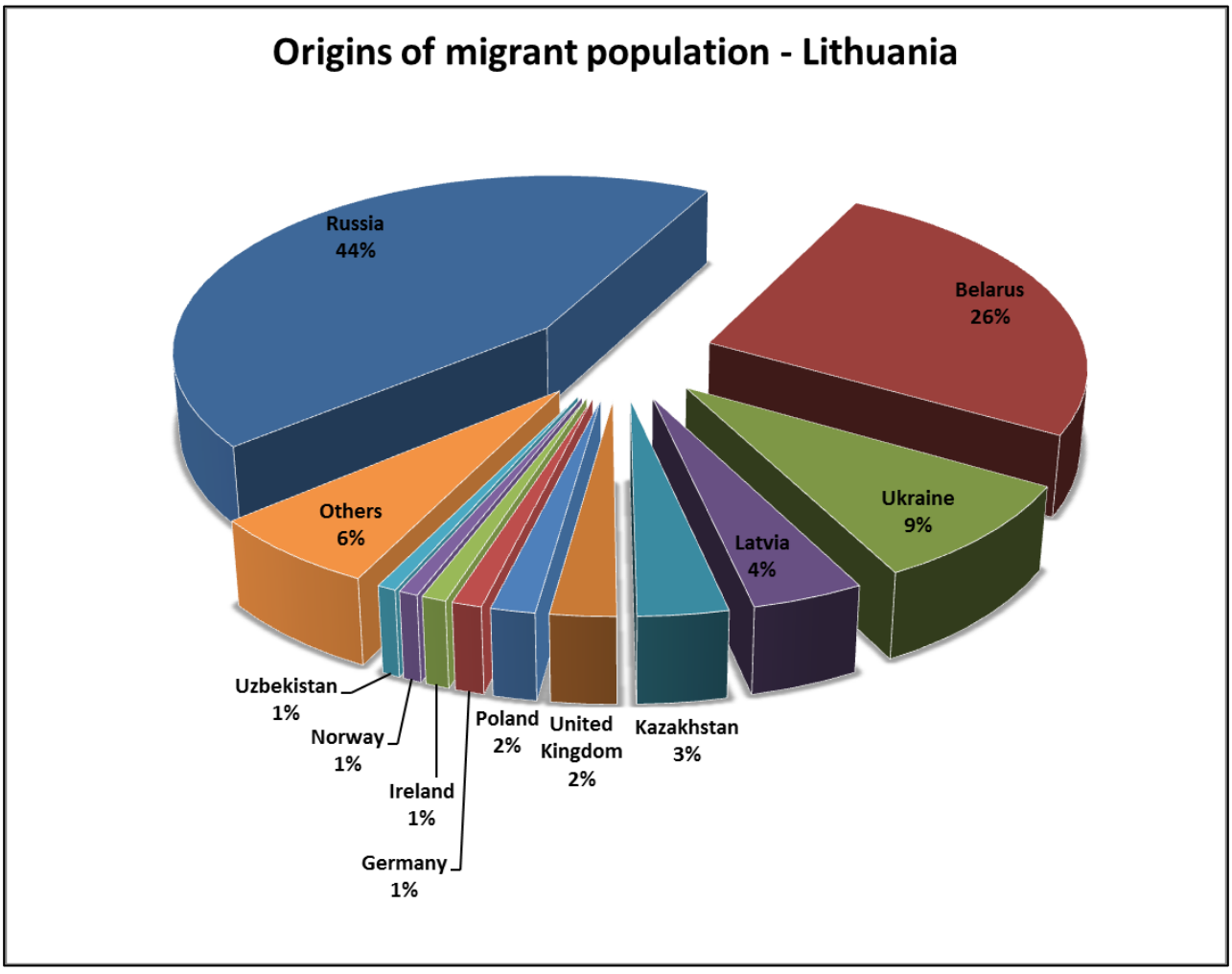
Integration policies: According to MIPEX (2015), Lithuanian policies still provide non-EU newcomers with poor integration opportunities, resulting in one of the lowest scores in the EU28/EFTA. Because of

[3] http://www.migracija.lt/index.php?-1488882078

EU law, the chances for migrants to reunite with their families, settle as long-term residents, or fight a discrimination case are average for Europe. Since 2007, discrimination victims have marginally better options to enforce their rights, following European trends. Due to relatively low wages in comparison with most EU countries, the labour market makes the country less attractive to potential immigrants. Some barriers for third country nationals also diminish employment opportunities. Lithuania, like the other Baltic States, restricts political opportunities and citizenship paths more than most European countries, while schools are some of the least prepared to welcome all types of migrant pupils. The major challenge across integration policies is the discretion left to authorities and the uncertainty this creates for foreign residents. MIPEX experts concluded that migrant workers, their family members, long term residents, and naturalized migrants in Lithuania are some of the most insecure in their status in Europe (MIPEX 2015).

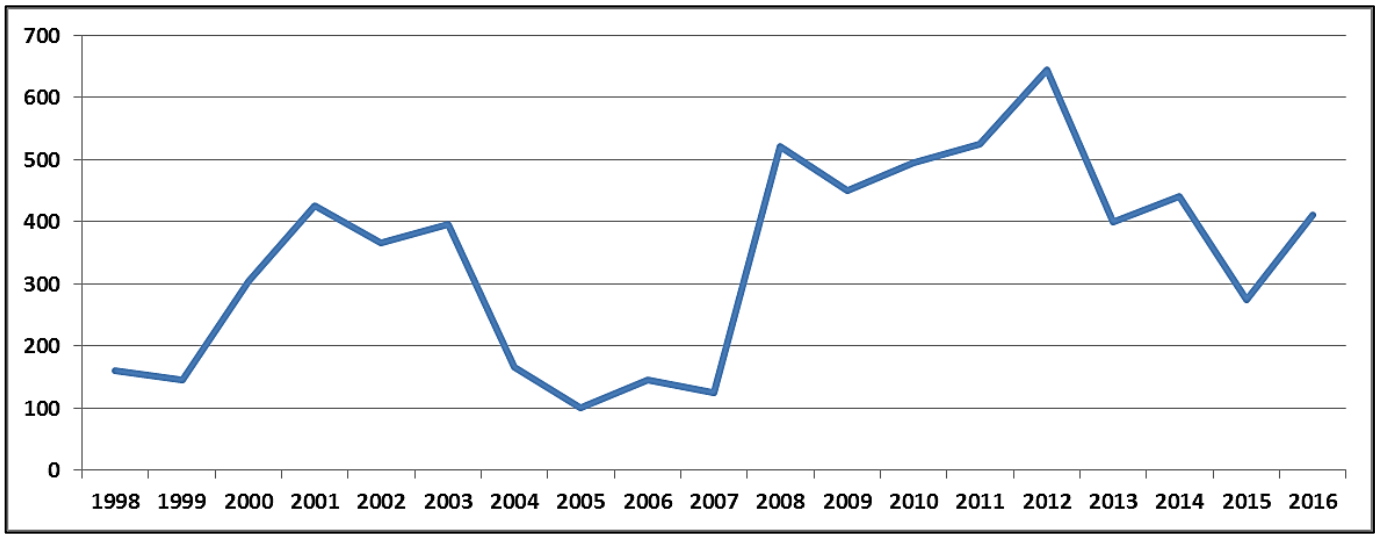
Migrant population: A migrant can be defined in terms of either nationality (citizenship) or country of birth. In Lithuania it makes a big difference which definition is used, because many among the major groups of migrants have obtained Lithuanian citizenship. This is why, in the Key Indicators listed at the beginning of this section, 4,7% of the population are listed as foreign-born, but only 0,7% as foreign citizens. This applies particularly to migrants from Latvia, Belarus, Poland, Ukraine, Russia and Kazakhstan in the chart below: if the chart were based on citizenship, their numbers would be smaller.

Figure 2. Foreign-born population in 2014 by country of birth (Eurostat)



Asylum seekers: By ratifying the Geneva Convention in 1997, Lithuania accepted an obligation to grant asylum to foreign nationals who were forced to leave their home countries because of war, persecution or human rights violations. Lithuania has three forms of asylum: refugee status (permanent), subsidiary protection (granted for two years with the possibility to be prolonged) and temporary protection (can be granted by the government if there is an increased number of people asking for asylum). Lithuania usually grants subsidiary protection (EMN Lithuania 2016). Figure 3 shows how applications have fluctuated in recent years. (Note that the enormous influx in most of the EU during 2015-2016 did not affect Lithuania.)

Figure 3. First-time asylum applicants to Lithuania, 1998-2016 (Data from Eurostat)



The majority of asylum seekers (up to 80%) come from Russia and CIS countries. During 1997-2013 refugee status was granted to only 176 migrants, but supplementary protection was offered to 3.634.

Out of 496 applicants in 2014, most came from Georgia (117), Afghanistan (99), and the Russian Federation (74). The number of asylum applicants from Ukraine also increased significantly as a result of the war in the Eastern Ukraine (70 asylum requests in 2014, after only 5 applications were filed in 2013). In 2014, 39% of decisions at first instance were positive, which is representative of decisions over the last decade. Readmission agreements were made with more than 20 countries; the number of deported persons varied during from 312 in 2002 and 149 in 2006 to 362 in 2014.

In 2012, Lithuania joined the EU Solidarity Initiatives and four asylum applicants (citizens of Eritrea) were relocated from Malta and were granted refugee status in Lithuania. Fourteen Syrians received asylum in Lithuania in 2013, while more recently, a small number of Syrian refugees have also been resettled from other parts of Europe.

Undocumented migrants: Lithuania is a transit country for migrants on their way to Western Europe and other countries. In most cases, migrants attempt to cross the border illegally or with false documents. Currently there are no reliable statistics on the number of irregular migrants in the country.

EMN Lithuania (2016) has an interactive web page with detailed statistics on many aspects of migration: this shows that in the period 2011-2015, an average of 1.600 migrants a year were apprehended and

ordered to leave, while 290 were deported. The average annual number without valid documents was 1.400. (Of course, we have no idea how many irregular migrants were *not* apprehended.) In 2013 and 2014 the number of violations at the state border decreased on both EU borders with Belarus and Russia.

An undocumented migrant in Lithuania has very limited rights – they cannot sign lease agreements, work legally, or access social security. Also, there is no entitlement to education for children of UDMs, as proof of residency status is required for school enrolment (Björngren Cuadra 2010).

Ethnic minorities: Lithuanians constituted a significant majority (86,3%) of the population in the 2011 Census. After the Second World War, the country's Russian-speaking population migrated extensively within the USSR, mainly as a labour force for huge factories, but also as part of Soviet military or political personnel. Lithuania as an occupied territory was also exposed to this type of immigration, but to a much smaller extent than the other Baltic States, Latvia and Estonia. Ethnic Russians comprised 9,4% of the population in Lithuania in 1989. Twenty-one years after the restoration of independence, the percentage of Lithuanians had increased to 86,3% and the proportion of Russians (5,0%), Polish (5,6%), Belarusian (1,4%), Ukrainian (0,7%), and Jewish (0,1%) people had decreased (Census Lithuania 2012).

The Lithuanian Citizenship Law of November 3, 1989 made all permanent residents, regardless of their ethnicity, language, or religion, eligible for Lithuanian citizenship. This liberal law and other inclusive citizenship mechanisms encouraged nearly 90% of all permanent residents to become Lithuanian citizens in the 1990s. This contrasts with the situation in Estonia and Latvia, where high percentages of the ethnic minority (migrant) population were granted only the status of permanent residents without citizenship.

The **Roma population** in Lithuania is not numerous and the total number of this ethic minority recorded in the 2011 national census was only 2.115 persons (Census Lithuania 2012). The majority of Roma people live in Vilnius region.

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	1.190	●●○○○
Health expenditure as percentage of GDP	6,6	●○○○○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	11	SHI
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	31	●○○○○
Score on Euro Health Consumer Index (ECHI, 2014)	510	●○○○○
Overall score on MIPEX Health strand (2015)	27	●○○○○

Lithuania has developed a statutory health insurance system, resulting in a mixed financing system based on both social insurance contributions and taxation. During the years of reforms, substantial investments were provided for the medical sector. The Ministry of Health, the National Health Board, and the National Health Insurance Fund are the main stakeholders in the system. Contributions from employers, employees, and from revenue created through state and social insurance activity are accumulated by the National Health Insurance Fund.

Lithuania provides free centrally-funded healthcare to all citizens and registered long-term residents. According to Lithuanian legislation (Law on Health Insurance), the majority of the country's working residents as well as children, students, and retired people have coverage for health services (Murauskiene et al. 2013). Employees must be registered by their employer upon starting work. Dependant family members are covered by the contributions paid by employed family members. Self-employed persons are obliged to make their own contributions. The unemployed, old age pensioners and people on long-term sickness benefit or maternity leave do not have to pay contributions. The state fund covers most medical services, including treatment by specialists, hospitalization, pregnancy and childbirth, rehabilitation, and part of prescription costs. Out-of-pocket payments are relatively high (31% of total expenditure in 2013); they concern mostly pharmaceuticals, and could threaten access for low-income and vulnerable groups (Murauskiene et al. 2013).

Experts consider Lithuanian healthcare standards as moderate, despite a drop in the 2014 European Health Consumer Index (EHCI) score from 610 in 2008 to 510 in 2014 (Health Consumer Powerhouse 2015). General practitioners are the first point of contact within the healthcare system. They are responsible for establishing the initial diagnosis, treating acute and chronic illnesses, prescribing drugs, and providing preventive care and health education to the general population of Lithuania. The gatekeeper function of general practitioners can however be by-passed by paying for a specialist consultation out-of-pocket, which creates another potential source of inequity.

Health care centres in Lithuania provide outpatient care and a wide range of specialist services. Medical services offered by these centres include general practice, maternity care, child health, mental health, and dental care. The network of health centres is well developed, and staffed with qualified doctors and other medical professionals.

The public health care system accounts for about 90% of all health services provided. Private medical services and health insurance exist, but because access to state-provided, free-of-charge services is good, few patients use them regularly. There are not many private practitioners, but in dentistry they are the norm. However, the number of private health services which are partially involved in free health care provision through contracts with the State Patient Fund has recently increased. Charitable organizations such as Caritas have small networks of health care services as well, but they are not generally supported by the Government (Lietuvos Caritas 2014).

4. USE OF DETENTION

Asylum seekers can only be detained when it is necessary to ensure national security and public order, to protect public health or morals, to prevent crime, or to safeguard the rights and freedoms of other persons, and only when specific grounds for detention, enumerated in the Aliens' Law, exist (Lithuanian Centre for Human Rights 2011).

Since the Amendments to the Law on the Legal Status of Aliens were adopted in 2006, asylum seekers and irregular migrants have generally not been detained. Instead, they have been housed in a non-secure section of the Foreigners Registration Centre (FRC) in Pabradė, Švenčionys district (Law on the Legal Status of Aliens 2004).

The number of immigration detainees has remained relatively stable for several years. In 2015, 353 persons were held in immigration detention; 292 in 2014; 363 in 2013; and 375 in 2012. The largest proportion of detainees is from Asia. In 2015, of the 353 people placed in immigration detention 203 were from Vietnam.[4]

At the moment, the majority of irregular immigrants as well as asylum seekers (up to 90%) are accommodated at the FRC. This centre provides primary outpatient health care both to irregular immigrants and asylum seekers. In case more advanced and specialized services are required, migrants can be sent to inpatient hospitals or secondary and tertiary health care institutions for specialist consultations. The FRC is responsible for the further transfer of those who granted temporary territorial asylum in Lithuania to the Refugees Reception Centre (RRC) in Rukla, Jonava district (Lithuanian Centre for Human Rights 2011).

[4] https://www.globaldetentionproject.org/immigration-detention-in-lithuania

5. ENTITLEMENT TO HEALTH SERVICES

Score 33 **Ranking** ●○○○○

A. Legal migrants

Inclusion in health system and services covered

Foreigners with **permanent residence** in Lithuania enjoy health care coverage on the same conditions as national citizens. However, legal migrants with **temporary residence** are only covered by the State Patient Fund if they are in paid employment. An employer based in Lithuania and employing foreign nationals without permanent residence pays premiums for health insurance on their behalf for the duration of the employment (Murauskiene et al. 2013). A child of legally working foreign nationals born in Lithuania is entitled to health care in the same way Lithuanian children are (see Art. 6, Act No I-1343/1996) (Law on Health Insurance 1996).

Foreign students from third countries who study at Lithuanian universities are not covered: usually, they must purchase private health insurance.

Foreign nationals and stateless individuals temporarily residing in Lithuania with study or work visas which allow **fixed-term residence** (such as foreign students, workers with fixed term contracts, etc.), and legal migrants who are not employed (and not registered as unemployed), cannot participate in the National Health Insurance Fund. However, they can purchase private health insurance from commercial insurance companies.

EU citizens with temporary stay in Lithuania are guaranteed the same rights to health care as apply to them in their countries of origin. In practice, this means they receive health care covered by the insurance which was established in their country of origin. The respective EU state provides guarantees for the settling of financial claims for the care provided.

The priorities of the health care system in the coming years will include improving the availability of health care for foreign nationals and especially students, as well as ensuring sufficient awareness of their rights and obligations in the social and public care field.

Special exemptions

Minors and pregnant women in the families of legal foreign migrants, regardless of their legal status inside the country, receive health care services in Lithuania free of charge.

Barriers to obtaining entitlement

Theoretically, there are no administrative restrictions, but in practice there may be as not all policies and procedures have been fully implemented.

B. Asylum seekers

Inclusion in health system and services covered

The Law on Health Insurance provides that all persons have the right to emergency care, even if the person has not paid compulsory statutory insurance contributions (this also applies to undocumented migrants). According to the same law, asylum-seekers become medically insured after they apply for protection status, and are therefore entitled to receive all services of emergency care, primary care, and specialised medical services. The costs of these medical services are covered by national budget funds in accordance with the procedure laid down by the Government of the Republic of Lithuania.

However, not all the procedures have been adopted so far. A precondition for obtaining free health care coverage is residing in the Foreigners Registration Centre (FRC). Asylum seekers accommodated there are entitled not only to emergency aid, but also to primary health care services free of charge. These services are provided by the medical staff working at the centre. All asylum seekers are subject to the discretion of medical staff whether to consider a situation as a medical emergency and to send them for specialized health care services. Those living in the FRC are also subject to the decision of the Red Cross whether to subsidize the cost of extra services beyond the primary health care outside the FRC.

Asylum seekers who are not accommodated at the FRC are entitled free of charge only to emergency medical services. This means that complete primary health care services are not provided for this group. Regulations as to what services are covered are not detailed and not clear enough at the moment.

Provisions for those granted asylum. The support for the integration for the foreigners granted asylum is provided in the Refugees Reception Centre (RRC) according to the Order No A1-438 of the Minister of Social Security and Labour of July 3, 2009, “Relating to the Approval of the Description of the Support of the State of Lithuania for the Order of the Integration for the Foreigners Granted Asylum in the Republic of Lithuania.” Also, the RRC conducts locally the implementation of the social integration of foreigners granted asylum. Usually, integration support is provided for a period of up to eight months. If during this period of time the foreigners have not prepared for the integration in the municipality because of objective reasons, the duration can be extended up to 12 months. If a refugee belongs to a vulnerable group (e.g. unaccompanied minors, pregnant women, victims of torture, people with a mental disorder, people of retirement age, disabled people, members of incomplete families with minors), this period can be extended on request until 18 months. In the best interests of children, support for unaccompanied minors can be extended until they turn 18. In some unforeseen cases, the support also can be continued longer in the RRC.

A municipality or an NGO assigns every foreigner or family through a tutor who facilitates the integration process, helps to find accommodation and employment, and assists with other issues. Foreigners granted asylum and their families are entitled to health care and have compulsory insurance paid by the state through the integration process. They receive a health insurance certificate from the National Health Insurance Fund, which enables them to get registered at a local health care centre and receive health care services on all levels. It means that refugees and asylum seekers enter into the same system of compulsory health insurance applicable to the rest of Lithuanian citizens in the country.

The Lithuanian Red Cross is also extensively involved in providing health and social care programs for refugees. This organization offers 10 programs and activities, which are addressed at the refugees: Humanitarian assistance for asylum seekers and refugees; Work with children; Social integration of refugees; Cultural and social activities in the RRC and FRC; Legal assistance project for asylum seekers and refugees; Border monitoring project; Search for relatives activities; Monitoring of asylum policy; Provision of information to the public; Refugee Social Clinic Project, and Refugee Law Clinic Project.

Special exemptions

According to the Law on Health Insurance, **unaccompanied minors** and **pregnant women** receive state health care services free of charge. Unaccompanied minors of foreign nationality, regardless of their legal status and where they are accommodated, receive health care services in Lithuania free of charge.

Barriers to obtaining entitlement

Theoretically, there are few administrative restrictions, but practically some barriers could occur for asylum seekers to obtain entitlement. Potential barriers are related to the definitions of emergency and primary health care, which is provided at the FRC. Procedures organising and financing secondary and tertiary health care have not yet been fully implemented.

C. Undocumented migrants

Inclusion in health system and services covered

This group of migrants is heterogeneous and can be divided into two sub-groups: 1) undocumented migrants who enter Lithuania and live without official registration outside the FRC; 2) undocumented migrants who live at the FRC.

At the moment, undocumented migrants who live outside the FRC are not reached or targeted by any civil society organisation in Lithuania. This group is entitled to receive free emergency aid only. In case additional medical care is needed, they need to pay the full costs of the extra services at the point of use. It is generally considered that this group is small, not visible, attempting to stay in the shadow, and often related to human trafficking which aims to transfer these people to Western European countries. Because reaching this group is difficult, they do not receive assistance from the Lithuanian Red Cross or other NGOs. This means that undocumented immigrants who are not accommodated at the FRC face various difficulties when they seek out medical care.

Special exemptions

Same as for asylum seekers (see above).

Barriers to obtaining entitlement

For undocumented migrants living outside the FRC, problems of documentation can arise because of formal health insurance system requirements to report the identity of the patient. The definitions of emergency and primary health care are also subject to administrative discretion.

6. POLICIES TO FACILITATE ACCESS

Score 40 Ranking ●●○○○

Information for service providers about migrants' entitlements

Very limited and fragmentary information on migrants' entitlements to health care is provided to healthcare staff by authorities, health care administrators, or NGOs. No special training on this topic is organized.

Information for migrants concerning entitlements and use of health services

Only limited information on entitlements and use of health services for the migrant population is provided. Some websites contain information on entitlement to health care in the country in Lithuanian and English.[5]

Health information policy for migrants is fragmented and not coherent. Some information campaigns for migrants have been conducted by both state and nongovernmental organisations. The International Organization for Migration (IOM) is one of the most active in providing such information by disseminating publications and providing information on its website.[6]

The language of targeted information is mainly Russian (English as well, but less frequently) because the majority of undocumented migrants and asylum seekers come from CIS countries (Georgia, Chechen Republic, etc.). In addition, most social workers at the Foreigners Registration Centre speak Russian.

All three groups - legal migrants, asylum seekers, and undocumented migrants - are coved by some information on entitlement and use of health care services to various extents. Legal migrants and asylum seekers who are housed at the FRC and later at the RRC have reasonably good access to information.

Health education and health promotion for migrants

Only limited information on education and health promotion is provided for migrants. There is no systematic approach to health education for migrants in the country. Migrant health is not a priority area in health policy at the moment.

The targeted information is mainly in Russian (and partially in Lithuanian for those who are learning this language), and at FRC and RRC, also in English. Legal migrants and asylum seekers are covered by some information on health education, but not in a systematic way.

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

Use of cultural mediators and patient navigators is not implemented extensively for migrants who live outside the FRC and RRC.

[5] For example http://renkuosilietuva.lt/eng/pradzia/health-care/how-does-health-insurance-work-in-lithuania or http://www.vlk.lt/sites/en

[6] http://www.iom.lt/en/home.html

Is there an obligation to report undocumented migrants?

According to Björngren Cuadra (2010) health care staff are obliged to report a patient to the authorities; in practice, however, they are more likely to follow their medical codes, which stress confidentiality and regard for the patients' interests.

Are there any sanctions against helping undocumented migrants?

Providing medical services to undocumented migrants does not constitute illegal or criminal activity under applicable laws. Medical staff interviewed for this report showed a willingness to help migrants, as well as others who may be inadequately insured.

7. RESPONSIVE HEALTH SERVICES

Score 8 **Ranking** ●●○○○

Interpretation services

Each health services provider and health worker deals with the issue of interpretation in their own way. Many migrant patients speak Russian; older health staff also frequently speak Russian, but younger ones tend not to. At the same time, some older patients of Russian and Polish ethnicity do not speak Lithuanian (in some major cities as Vilnius, Klaipėda or regions of the Eastern Lithuania).

No interpretation services are available within the health system. Civil society organisations assisting asylum seekers often provide voluntary interpreters or engage other asylum seekers as cultural mediators when the need emerges and there are volunteers available.

Requirement for 'culturally competent' or 'diversity-sensitive' services

Such requirements are not yet applied in the context of migrant or ethnic minority health in Lithuania. Therefore, medical doctors and health care managers as a rule follow the general standards of medical ethics. A study by Stankunas et al. (2016) in the framework of the EU project EUGATE compared views of Swedish and Lithuanian experts on good practice in health care for migrants: the views of the two groups of experts broadly concurred, indicating that diversity-sensitive principles are far from unknown in Lithuania.

Training and education of health service staff

Issues related to migrant health and topics on human relations and communication are taught during in-service professional training, as well as in the university curriculum for medical students. The IOM in Vilnius has carried out a training programme in 2014-2015 entitled “Assistance to Children and their Families: Building Specialists’ Intercultural Competence II”. Though not specifically targeted at health workers, this continuous project was aimed at building intercultural competence among the specialists of Lithuanian state institutions and strengthening the ability to fulfil their functions while working with third country nationals and mixed families.[7]

Involvement of migrants

Involvement of migrants in provision, planning of service delivery is very limited. None of the mentioned activities (involvement in service delivery; in the development and dissemination of information; in research; or in the evaluation, planning, and running of services) are currently undertaken in Lithuania. On the other hand, when we talk about the involvement of Polish or Russian ethnic minority populations in similar activities, the situation is much better – both ethnic minorities are significantly represented in all the categories of the above mentioned activities.

Encouraging diversity in the health service workforce

A significant number of ethnic minority citizens (Polish and Russian speaking) are working in health services delivery or research.

[7] http://www.iom.lt/en/what-we-do/intercultural-competences

Development of capacity and methods

Until recently there has been very little attention for migrants and the special health needs that they may have. They have not been much discussed in the Lithuanian medical community. Recently, however, the topic has become more salient in public discourse: mass media (radio, TV, newspapers) have been bringing up cultural and social issues related to immigrants from different cultures (e.g. dietary habits; alternative treatments; gender equity; religion, women's rights, female genital mutilation). Such potentially sensitive topics were not openly discussed before in Lithuanian society. So far, it has had little impact on standard medical treatments and diagnostic procedures.

8. MEASURES TO ACHIEVE CHANGE

Score 25 **Ranking** ●●○○○

Data collection

Country of origin is emphasized as an essential variable for general statistics on health. In health care databases this variable is considered as optional.

Support for research

In general, there is little research on issues related to migrant health. Despite this, we can list at least two topics which enjoyed a degree of funding from research agencies:

- occurrence of health problems among migrant or ethnic minority groups;
- issues concerning service provision for migrants or ethnic minorities.

Some funding was provided by the national COST agency in relation to the COST actions IS0603 (HOME) and IS1103 (ADAPT). Also, some publications and PhD theses on migrant health and ethnic minorities were published by researchers from the Lithuanian University of Health Sciences, Vilnius University, and Vytautas Magnus University.

"Health in all policies" approach

Very little or no consideration is taken of the impact on migrant or ethnic minority health of policies in sectors other than health. Also, social and economic issues tend to prevail over the issues related to migration. Recently, however, more attention is being paid to the health of ethnic minorities in the framework of projects on tackling health inequalities at the national and international level.

Whole organisation approach

Migrant health is not perceived as a priority either by civil society or by the government.

Leadership by government

As stated above, incoming migration of foreigners to Lithuania is not a priority issue for the government. This is why very few activities focused on immigration are carried out. Attention is focused on encouraging return migration by former Lithuanian émigrés, because Eurostat predicts further shrinking of the national population to below the two million mark by 2040.

Recently, the government adopted new Guidelines of Lithuanian Migration Policy (Lithuanian Government 2014). This document has focused not only on emigration but also on immigration of foreign nationals. Some activities for facilitating migrant social integration, as well as collaboration with international partners, were defined in this policy paper. This could be considered as step forward in implementing more a detailed policy on migration in Lithuania.

At the same time, the government has not decided yet which ministry should have responsibility for developing the official migrant health policy. The issue of health services for asylum-seekers is being discussed under the Ministry of Health, as well as at the Ministry of Interior.

A positive sign is that the government and health authorities have shown a political will to increase the financing of the health care sector during the next decade by increasing the percentage of funding from 6,7% of GDP in 2012 to 7,5% in 2020 and 8,0 % 2025 (Lithuanian Parliament 2014). The new programme initiatives to increase public health spending, to focus more on social context, and to tackle health inequalities.

Involvement of stakeholders

There is a pronounced lack of more systematic intersectoral cooperation, in which for example intergovernmental and civil society organisations would be invited to join in discussions on relevant issues.

Migrants' contribution to health policymaking

Immigrant organisations are not numerous and not very active in Lithuania. Also, these organizations are more oriented towards consulting and collaborating on social support issues, rather than health care initiatives.

Civil society organisations in Lithuania are not explicitly involved in migrant health policy. When there are urgent issues that need to be solved, NGOs initiate meetings with state institutions in order to raise their awareness about existing gaps and to propose possible solutions. This is not a systematic practice but rather conducted on an ad hoc basis.

CONCLUSIONS

Like the other Baltic States, Latvia and Estonia, Lithuania obtains low scores on all four dimensions of the MIPEX Health strand. Indeed, scores are also low on the other strands of integration policy measured by MIPEX – also in the earlier rounds in 2007 and 2010 before Health was included.

To some extent the lack of attention for immigration in the Baltics can be explained by its low frequency. As we saw in Section 1, according to Eurostat data only about one in 20 of Lithuanian residents in 2014 was born in another country, while even fewer (one in 140) lack Lithuanian citizenship. Between 2013-2015, only about 3.700 foreign citizens a year migrated to Lithuania, i.e. one for every 800 Lithuanian residents.

Why is Lithuania, along with the other Baltic States, not more attractive for migrants? Part of the reason is economic: though economic growth in this region has on the whole been steady since the chaotic transition to a market economy in the early 1990's, building up their economies has taken a long time and opportunities for migrants have been fewer than in the EU15 countries. The Baltic States were hit very hard by the 2007-2008 financial crisis, though they have since resumed their upward march.

However, another reason is that migration is strongly influenced by existing social networks. Migrants show a preference for countries in which they have already built up communities. Only if countries were to adopt proactive policies for recruiting them and helping them to integrate would it be possible to reverse this trend. Although politicians in the Baltic States do not seem to have exploited nationalistic and xenophobic anxieties to the extent that populists elsewhere in the EU have been doing, such a positive attitude to immigration seems far removed from their current mind-set. Understandably, they would prefer that Lithuanians to come back from other countries and fill the vacancies that are now arising themselves.

Nevertheless, the argument for improving migrant heath policies is to a certain extent independent of whether immigration is considered good or bad: from a health system point of view, good policies are simply a matter of delivering care efficiently in order to maintain public health and uphold human rights. We will examine results on the four sections of the Health strand in turn.

Entitlements. Legal migrants are only fully included in the state system of coverage if they have a permanent residence permit – i.e. after at least five years. For those with a temporary permit, coverage depends on being economically active. If the migrant becomes unemployed or incapacitated, or reaches retirement age, they have to insure themselves privately – precisely when they are financially least able to do so. It seems that their presence on the territory is only regarded as justified if they work. Asylum seekers and undocumented migrants receive the minimum level of entitlement to care that is compatible with EU and international legal obligations.

Policies to facilitate access. Little is done to help migrants find their way into the health system and make optimal use of the services available. Far more could be done using websites and social media, which are highly cost-effective.

Responsive health services. Notions like 'cultural competence' are not unknown in Lithuania, but they are not often implemented in practice. To this end it might be productive to stress that 'cultural competence' is simply an aspect of 'patient-centredness', i.e. the idea of tailoring care effectively to the needs of patients. Learning to respond to the different needs and situations of patients is simply a matter of a fair and effective use of resources.

Measures to achieve change. In relatively centralised health systems, such as those found in the Baltic States (even where they are based on social health insurance), MIPEX has demonstrated that it is easier to coordinate change than it is in devolved and market-based systems (IOM 2016). However, the other side of the coin is that if the Health Ministry does not make migrant health a priority, very little happens.

At the present time, with economies growing steadily, unemployment falling, and a resulting potential for immigration, it would seem a good moment to advocate among politicians and policymakers in Lithuania and other Baltic countries for a new vision on migrant health policies.

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