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THE PRICE OF EFFICIENCY: URBAN-RURAL DIVIDES IN LITHUANIA'S PATIENT-ORIENTED APPROACH DURING HEALTHCARE REFORM

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Abstract. *Healthcare systems face ongoing challenges that require reforms to enhance innovation, accessibility, and efficiency. Lithuania's healthcare reform aims to enhance equity, quality, and sustainability by reorganising its service network. However, implementation has revealed unintended effects, including "network compression", where large hospitals absorb services from smaller regional facilities, deepening regional inequality and limiting accessibility for rural populations. A qualitative research method with 22 informants was employed. Healthcare professionals are reporting growing fatigue, increased administrative burdens, and a decline in empathy in patient care. These outcomes highlight how efficiency-oriented policies can unintentionally depersonalise services and marginalise regional healthcare providers. Based on interviews with healthcare professionals, this study examines how reforms transform everyday clinical practices and local service delivery. The findings underscore the need to balance efficiency-driven reforms with empathy, professional autonomy, and equitable access to healthcare.*

Keywords: *unintended consequences, urban–rural divide, health service, reform*

Raktiniai žodžiai: *nenumatytos pasekmės, miesto ir kaimo atskirtis, sveikatos paslaugos, reforma.*

1. Introduction

Healthcare systems continually face numerous challenges that necessitate the implementation of significant reforms aimed at enhancing innovation in services, improving accessibility, and increasing efficiency. Several key factors are driving change in health systems. First, there is a critical need for these systems to move beyond merely responding to disease symptoms and instead prioritise prevention, early diagnosis, and effective disease management (Alyousef et al. 2022). Second, despite global efforts to enhance universal health coverage, a significant disparity remains in the accessibility, quality, and health outcomes of services between rural and urban populations (Weeks et al. 2023). Third, the ongoing shortage of medical professionals presents a notable challenge, particularly in remote regions (Adynski and Morgan 2022). The emphasis on a patient-centred approach to healthcare is fundamentally transforming perceptions of healthcare quality (Khatri et al. 2023). Finally, one of the most pressing challenges is the lack of adequate budgets and financial resources necessary to implement effective health policies (Lim et al. 2023). Such challenges prompt governments to swiftly implement policy changes, either as isolated actions in specific situations or as comprehensive public policy reforms (Tynkkynen et al. 2022; Balasubramanian and Short 2021; Chen et al. 2021; Schulmann et al. 2024). Unfortunately, the changes that are initiated do not always achieve the planned results, and it is not always possible to accurately predict and evaluate their impact at the policy planning stage (Head 2022).

The Lithuanian healthcare system faces common issues seen in many countries, including demographic challenges such as migration to larger cities and abroad, a general shortage of healthcare specialists, especially in rural areas, and inefficiencies in budget spending due to uneven infrastructure utilisation in different regions. Access to healthcare services remains inconsistent, with high service standards difficult to maintain in remote areas. These social problems have prompted policy reforms aimed at ensuring accessible, high-quality medical care that meets patient needs (Vanckavičienė et al. 2024).

Despite extensive discussions on improving the efficiency of health systems at both the national and international levels, there is still a lack of empirical evidence on how the pursuit of health system efficiency affects less controllable dimensions of reform, and in this case, how the pursuit of efficiency and unified quality standards actually affects the dimension of service accessibility. The aim of the study is to assess how the focus of healthcare reforms on efficiency and institutional coordination affects the availability of services in the regions and to reveal the systemic consequences of centralisation for territorial equality.

The study is structured as follows: Section 2 discusses the theoretical background of the research; Section 3 describes the methodology; Section 4 presents the findings of the research, comprising the reform impact on healthcare systems, the reform communication to the healthcare institutions and municipalities, the reform implementation processes, and the attitudes towards the reform evaluation on the performance of healthcare institutions; Section 5 offers a discussion on possible wider implications of the findings obtained; and Section 6 concludes the paper.

2. Background

Policy changes in healthcare serve as a transformative reform

Reforming the health sector has become urgent in many countries due to demographic shifts, rising chronic disease burdens, inequalities in healthcare access, shortages of specialists, changing patient needs, and limited funding. Scientific studies describe reforms where central governments establish policies and standards and where local authorities define their roles and functions to support and improve service accessibility and quality for specific populations (Kwon and Choi 2023).

Factors determining changes in the healthcare sector policy

Urban–rural divide in healthcare. Differences in access to healthcare services between rural and urban areas are well documented. Urban residents tend to use preventive and specialised services more frequently than those in rural areas, due to factors such as physical distance, limited service availability, and lower confidence in service quality (Liepins, Nixon, and Stokes 2024). Regional inequality arises because services, capital, and resources are often concentrated in urban centres, creating a geographic imbalance that favours city residents and leads to centralisation that disadvantages remote regions (Fayet et al. 2020).

Shortage of healthcare professionals. Europe faces a persistent shortage of healthcare professionals, threatening the long-term stability of healthcare systems (Kuhlmann 2025). This issue is not just about having fewer professionals overall but also about their unequal distribution across cities and regions.

Orientation of health services to patient needs. The healthcare system is shifting from a traditional approach that focuses on symptom management to a patient-centred model that emphasises the needs and experiences of the patient. This transition requires healthcare professionals' efforts. Patients' perceptions of care quality depend on staff behaviour and organisational and financial accessibility (Servetkienė et al. 2023).

Unintended consequences of policies. Reforming a healthcare system is a complex process, influenced by human factors, organisational choices, budgets, infrastructure, geographic differences, and the inherent "wicked" nature of the problem (Head 2022). This complexity makes predicting the outcomes of reforms challenging. Health policy initiatives

often fall short of their goals due to the influence of political, economic, and cultural factors (Bayat et al. 2023).

The scope of reforms in Lithuania and their connections with the regions

In 2023, Lithuania launched several health system reforms, including overhauls of public healthcare, centralisation of emergency medical services, expansion of the personal healthcare network, mental healthcare reform, implementation of a patient transport service, and enhancement of long-term care services. These initiatives aim to ensure all residents have access to high-quality, safe public and personal healthcare, regardless of their location or socioeconomic status, by improving service availability across geographical, communication, organisational, and economic aspects (SAM 2023). It is essential to note that although each of these reforms has its own objectives, they were all directly initiated in response to regional needs.

3. Methodology

Region: The Marijampolė geographical area, situated in southwestern Lithuania, was chosen as a case study to examine the regional effects of healthcare policy reform. This area comprises five municipalities: Kalvarija, Kazlų Rūda, Marijampolė, Šakiai District, and Vilkaviškis District, with a total population of approximately 150,000. There are 24 healthcare facilities of varying sizes and functions, including a hospital, emergency medical services, several private healthcare providers, and other primary care centres, all serving the local community.

Study design: A qualitative research method was used, specifically employing semi-structured interviews. This approach enables a detailed exploration of issues and uncovers the experiences of participants (Tümen-Akyıldız and Ahmed 2021). The interviews aimed to understand how healthcare policy reform was introduced and influenced the daily operations of healthcare institutions from the perspective of medical personnel, focusing on their attitudes and skills related to the changes.

Sample: The study employed a targeted sampling approach combined with snowball sampling to select participants from the population, specifically individuals working in healthcare or involved in healthcare reform decision-making in the Marijampolė region. Twenty-two respondents took part, a number determined by data saturation, when additional responses no longer yielded new information. Details regarding the sample are listed in Table 1.

Table 1. Study participants

No.	Informant's code	Occupation	Managerial duties	Municipality
1	G1-G8	Doctors	Six of them perform managerial functions	Šakiai, Marijampolė, Vilkaviškis
2	S1-S7	Nurses	Six of them perform managerial functions	Šakiai, Marijampolė, Vilkaviškis
3	V1-V3	Administrators/ Directors	Top-level managers	Šakiai, Marijampolė, Vilkaviškis, Kalvarija
4	P1-P4	Politicians	Top-level policy makers	Šakiai, Marijampolė, Vilkaviškis, Kalvarija

Data collection instrument. A 10-question semi-structured questionnaire was created to identify key managerial aspects of the reform and gather data on its implementation. Respondents shared their 1) experiences with the latest healthcare reform, 2) views on its positive and negative elements, and 3) opinions on regional healthcare services and their abilities to meet the reform goals.

Data collection. Interviews with respondents were conducted by four researchers from 20 May 2025 to 29 May 2025, using the Microsoft Teams platform. The conversations were audio-recorded and transcribed. The average duration of each interview was approximately 30–60 minutes. The names and surnames of the informants and any other names mentioned in the interviews were changed to ensure their confidentiality and anonymity.

Data analysis. All transcribed texts were analysed using an inductive qualitative content analysis approach (Elo et al. 2014), which does not rely on a predefined theory or specific hypotheses.

For this study, a list of qualitative categories was created to facilitate the thematic coding process. These categories were deduced from official reform policy documents and prior research on healthcare system reform. They mainly represent the objectives and strategic directions outlined in the new healthcare policy.

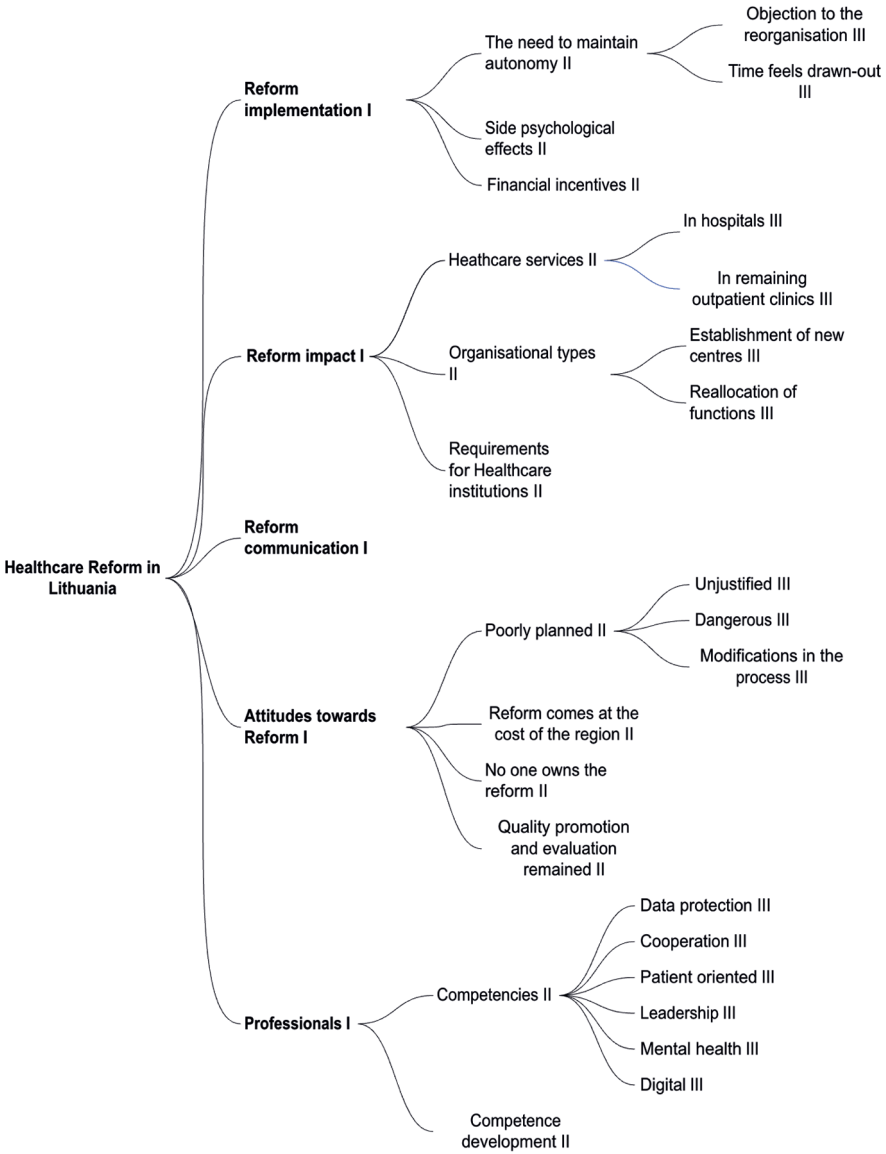

Fig. 1 The hierarchy tree of categories for data coding

The qualitative content analysis was based on coding categories, which were structured into a category tree that extended to level IV. Level IV corresponds to the raw data

categorisation from the observed data, and level I corresponds to the main themes of the study. The category tree with I, II, and III levels of categories is shown in Fig. 1. The initial list of coding categories corresponding to level I of the hierarchy was created according to the research objectives (reform impact, reform communication, reform implementation, and attitudes towards reform). To ensure coding consistency, the initial coding was performed by a single coding specialist according to the list of level I categories, aiming to identify the lowest possible level categories. During the second reading, another coding researcher double-checked the categories, grouping them into level II and level III category codes.

It is important to note that the category "unintended consequences" was not included in the initial coding model. This decision was deliberate. The concept of unintended consequences is regarded here as a new construct rather than a predefined analytical category. It is expected to emerge inductively from the empirical material by identifying discrepancies between policy intentions and observed outcomes. By not including "unintended consequences" in the initial list of codes, the study maintains analytical openness and avoids interpretative bias. This approach ensures that the construct emerges naturally from the data rather than being influenced by preconceptions.

Ethical consideration. The scientific research and its implementation were based on the Declaration of Helsinki as well as the following ethical principles: reliability, integrity, respect, and accountability.

4. Findings

The interview analysis clarified the common regional views on healthcare issues targeted by the reform. While the study aimed to equally explore all categories, certain problems garnered more focus. The shortage of specialists and their skills were discussed more extensively than the content or progress of the reform. The themes identified during coding, along with their occurrence frequency, are shown in Fig. 2.

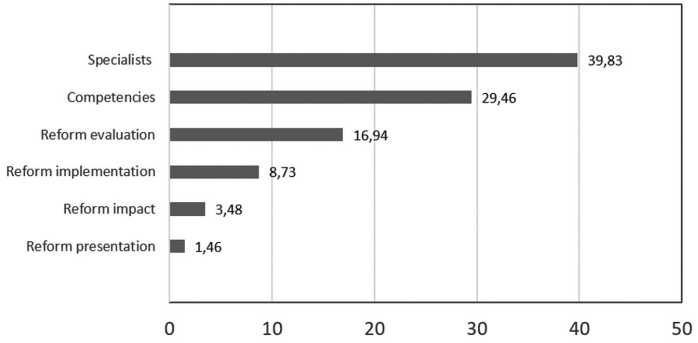

Fig. 2 Principal themes of the research, based on the frequency of categories

Despite the stated objectives, the implementation of the reform unveiled numerous challenges. Below, we address the most significant topics corresponding to level I of the category tree (Fig. 1) and the underlying constructs of the category tree elements that elucidate them.

Reform impact (level I)

• **Healthcare services (level II).** The impact of healthcare system reforms on services varies across different levels of care, both in **hospitals** and **outpatient clinics**.

a) The reform had a dual impact **on hospitals (category level III)**. On the one hand, "The range of competencies and services has expanded" (S1), and there are increased transport services (S7), which means that hospitals have strengthened their functions and can now offer **new services (category level IV)** and improve accessibility, especially in the area of patient mobility.

b) The situation of the remaining **outpatient clinics (category level III)** appears to be much more complicated. In most of them, "There is a noticeable decline in outpatient services; We do not know if they will survive and what will happen in a year's time" (P3), which indicates a sense of uncertainty and **a decline in the availability of services in the regions (category level IV)**.

• **Organisational types (level II).** The reform is clearly changing the organisational structures of healthcare institutions and their interrelationships. There is a noticeable **creation of formal structures** and a **redistribution of functions**.

• **New established integrated centres (category level III)**. According to the informants, most municipalities "have decided to establish health centres" (S4). Such centres should ensure a wider range of services and coordinated activities between primary and secondary healthcare providers.

• **Functional distribution (category level III)**. Others, however, refused to join the new entity and agreed only **to share functions (category level IV)**. "We will join the centre at the functional level" (G2), which signifies a concerted effort to consolidate services and enhance cooperation among various healthcare institutions. In terms of the redistribution of functions, a positive aspect is noticeable in some cases: "It is easier to share those functions and responsibilities; <...> to monitor and control activities" (S4), which shows that the new structure allows for a more flexible distribution of responsibilities and improved work organisation among institutions.

However, these changes are not proceeding smoothly everywhere due to **the dominance of the "stronger" (category level IV)**. According to some informants, "Another municipality offered more" (S4); unfortunately, these reforms are not designed to benefit remote regions/municipalities (G3). This indicates that stronger regional centres tend to dominate in the formation of health centres and the redistribution of functions, while smaller municipalities experience greater inequality.

• **Requirements for healthcare institutions (level II)**. The reform has had a significant impact on the operating conditions of healthcare institutions, particularly in terms of their compliance with new standards and requirements. It has been noted that these

requirements are often **disproportionate to the size of the institutions (category level IV)** or regional resources, which poses challenges for smaller regional centres in ensuring continuity of operations. According to the informants, "It is more difficult in the regions" (G8) and "Requirements are increasing" (S4), which shows that in the context of reform, smaller or more remote institutions face greater pressure to adapt to new standards.

Reform communication (level I)

The way in which the ideas and objectives of the reform were presented to healthcare institutions and municipalities was crucial to its success.

• **Threat rhetoric (level IV)**. The evaluations indicate that the communication process was not always constructive, as it was often dominated by threat rhetoric and formal slogans rather than clear dialogue or reasoned arguments. The informants' statements, "Everyone threatened that we would close those regions; Maybe you should stop scaring people" (G8), show that the presentation of the reform was accompanied by pressure and intimidating messages in some cases.

• **Slogans (level IV)**. The informants' observation that "There have been slogans from the ministry and the government, at least until now" (G8) reflects excessive declarativeness and a lack of specificity.

Reform implementation (level I)

• **The need to maintain autonomy (level II)**. The process of implementing healthcare system reforms reveals a strong need to preserve autonomy, which becomes a key factor in shaping institutions' attitudes towards change.

• **Objection to the reorganisation (category level III)**. There is noticeable resistance to centralisation, a desire to maintain independence, and a preference for local control, while the pace of reform is considered slow and often accompanied by uncertainty. The desire of institutions to maintain self-government is clearly reflected in the assessments that "There were all kinds of resistance" (S1). This indicates that the idea of reforming institutions into joint structures is not universally welcomed. Although there is resistance, there are also positive attitudes – "There is now even stronger cooperation between all of us, between local government and healthcare institutions" (S4) and "We communicate with both private and public institutions" (P3). This shows that constructive **cooperation is possible when the partnership is based on the principle of equality (level IV)** rather than hierarchical subordination.

• **Time feels drawn out (category level III)**. When assessing the pace and style of implementation of the reform, several informants emphasise that "Time is constantly being dragged out without anything concrete being said" (S5), and the reform is perceived as delayed and lacking clear guidelines.

• **Side psychological effects (level II)**. The implementation process of reform is characterised by tension between centralisation and maintaining autonomy. Although institutions value cooperation and sharing of functions, they want to do so as equal partners, not as subordinate participants.

• **Financial incentives (level II)**. Financial instruments are becoming one of the

primary tools for implementing the reform, with the goal of attracting and retaining specialists, particularly in the region of Marijampolė.

Most attention is focused on direct financial support, compensation, and incentives. The informants said, "We compensate, we cover the costs of attracting doctors; Everything is expressed in financial terms; A three-year payment is provided as needed" (S4), indicating that the reform emphasises financial motivation as a means of addressing the problem of human resource shortages.

Attitudes towards reform (level I)

The evaluation of healthcare reform among sector participants remains quite critical.

• **Poor planning (level II)**

a) **Unjustified**. The uncertainty that has arisen complicates planning and raises doubts about the direction of the reform. However, when evaluating the current situation, some changes are viewed more positively – "There are no drastic decisions, everything is being implemented gradually" (G5).

b) **Threat (level III)**. Critical attitudes are further reinforced by statements such as, "It is somewhat unmeasured, perhaps threatening" (G8) and "What are you doing? You will destroy the districts" (G7). Some also note political dishonesty – "A politician comes and lies" (P2) – which means that the presentation of the reform is sometimes perceived as declarative.

c) **Modification of the process (level III)**. It is perceived as insufficiently planned, overly risky, and unstable. Many informants report that changes are occurring without a clear, long-term vision, and that **the process itself is often adjusted (level IV)** along the way, which creates a sense of uncertainty and hinders systematic work. Some informants emphasise poor planning, stating that the reforms are "somewhat unfounded, perhaps even threatening (G8)", which reflects the opinion that the changes are being implemented without **a detailed impact assessment (level IV)**.

• **Reform on the cost of regions (level II)**

The impact of the reform has been particularly acute in regions where access to services and staffing have become major challenges. Although the aim of the reform is to ensure a higher quality and more coordinated healthcare system, some of its decisions are actually implemented at the expense of the regions, **weakening the local service base (level IV)** and **deepening the divide between cities and villages (level IV)**. The informants' opinion that "Outpatient services have been reduced" (S1) shows that **financial savings decisions (level IV)** are often implemented by reducing the volume of services.

• **No one owns the reform (level II)**

One of the most notable shortcomings of the reform is the lack of responsibility and leadership. Representatives of institutions argue that the reform process seems to be proceeding without a clear "owner". According to the informants, "There could be more clarity" (G6) and "The overall healthcare strategy is unclear" (G8). These observations reflect a general sense of uncertainty in the sector.

• **Service quality promotion and evaluation remain unchanged (level II)**

Although the reform sought to change the structure and operating principles of the healthcare system, the evaluation and performance measurement system remained largely unchanged. Institutions continue to be evaluated based on quantitative indicators, most often related to quotas. The informants said, "We are bound by quotas that we cannot meet" (G8) and "The quotas between districts are not fair" (S1). This means that the performance of institutions is still assessed according to pre-set quantitative indicators.

5. Conclusion

Lithuania's healthcare reform aims to enhance equity, efficiency, and quality in healthcare, thereby creating a sustainable network that addresses both urban and regional needs.

1 Network restructuring leads to:

1.1 Network compression

The reform has led to the concentration of healthcare services within larger hospital networks, a trend that is also prevalent throughout Europe (Kristensen and Olsen 2021). It results in what can be described as "network compression".

1.2 Regional inequality

The pursuit of standardised quality and operational efficiency through network restructuring has led major healthcare institutions to concentrate their efforts on expanding complex, technology-dependent services in large, integrated hospitals – predominantly located in urban areas.

1.3 Limited physical equity

A hallmark of the reform has been the creation of new centralised healthcare centres. However, these new institutions have often replaced local outpatient clinics, reducing the overall number of care points available to rural residents.

2 Compensation for losses → specialist shortage and resource drain

The reform has also intensified pre-existing shortages of medical specialists. Despite clear evidence of workforce strain, the issue has not been prioritised within policy implementation. The new service structure – shaped by efficiency and specialisation goals – often fails to align with specialists' career aspirations or competencies, discouraging retention and recruitment.

3 Development of geriatric and nursing-oriented services → nursing service gaps

One of the reform's notable gaps lies in the lack of progress in developing nursing and long-term care services. Policy criteria for efficiency, quality, and reimbursement were primarily designed around the needs of specialised, hospital-based care – particularly surgical services – rather than community or nursing care.

4 Concentration of specialised care → service elitisation

The reform has spurred the development of sophisticated and high-value medical services that necessitate advanced technology and specialised expertise. These services – such as plastic surgery, ophthalmology, and kidney procedures – have recently emerged and

present significant commercial potential. While this focus on high-end services encourages technical excellence and innovation, it also results in the elitisation of healthcare, neglecting other essential services that are more urgently needed in the community. This outcome contradicts the original goals of the policy change.

5 Better overall quality → reduced patient-oriented quality approach

Although research indicates that patient-centred care enhances patient satisfaction, improves health outcomes, increases patient engagement in their care, and can reduce healthcare costs (Alsagoor et al. 2024), recent policy shifts have demonstrated a trend towards change. Discussions with informants regarding the competencies of healthcare specialists have been quite revealing. Among the six competencies evaluated, patient orientation emerged as the most significant, often regarded as a defining characteristic of regional healthcare institutions (see Fig. 3). This competency fosters strong relationships with patients through long-term contact.

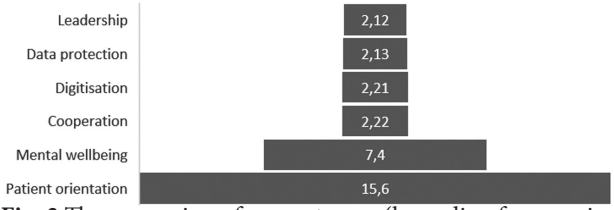

Fig. 3 The expression of competences (by coding frequencies)

6 Unified quality requirements → compliance pressure

Finally, the reform's emphasis on quantitative performance metrics has produced a new form of compliance pressure. Healthcare institutions are compelled to adapt their strategies to meet stringent and often disproportionate requirements. While institutions aspire to act as autonomous partners in reform implementation, they often experience manipulative pressure to conform to unrealistic performance standards. This dynamic has particularly negative effects on smaller regional centres, which lack the resources to meet these expectations and therefore struggle to ensure operational continuity.

6. Conclusions

1. The results of this study show that the focus on the effectiveness of healthcare reform and improving institutional coordination reflects a forward-looking approach that is in line with broader trends in European healthcare. Nonetheless, prioritising efficiency in health policy does not shield against systemic unintended consequences that mainly impact geographically remote areas.
2. The results of the study complement research on the vulnerability of regions in terms of access to health services, as regions often suffer more than they benefit

from large-scale efficiency efforts, because systemic optimisation policies tend to favour centralisation over territorial equity. Phenomena such as the elitisation of services, rather than the pursuit of accessibility for the most popular services, only prove that efficiency alone is insufficient for the realisation of reform.

3. Therefore, policymakers could pay closer attention to regions by differentiating both the performance indicators being reformed and maintaining the health quality results already achieved, such as patient orientation.

7. Acknowledgements

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Data Availability Statement

The data used to support the findings of this research are available from the corresponding authors upon request.

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EFEKTYVUMO KAINA: MIESTO IR KAIMO SKIRTUMAI TAIKANT Į PACIENTĄ ORIENTUOTĄ POŽIŪRĮ SVEIKATOS PRIEŽIŪROS REFORMOS METU

Santrauka. *Sveikatos priežiūros sistemos susiduria su nuolatiniais iššūkiais, dėl kurių būtina įgyvendinti reformas, siekiant didinti inovacijų diegimą, sveiktos paslaugų prieinamumą ir jų efektyvumą. Lietuvos sveikatos priežiūros reforma siekia didinti lygybę, paslaugų kokybę ir tvarumą, reorganizuojant sveikatos priežiūros paslaugų tinklą. Tačiau įgyvendinant reformą paaiškėjo, kad ji turi nenumatytų padarinių, įskaitant „tinklo suspaudimą", kai didelės ligoninės perima paslaugas iš mažesnių regioninių įstaigų, didindamos regioninę nelygybę ir ribodamos prieinamumą kaimo gyventojams. Buvo atliktas kokybinis tyrimas naudojant pusiau struktūrizuotą interviu su 22 informantais. Informantai įvardijo didėjantį nuovargį, didėjančią administracinę naštą ir mažėjančią empatiją pacientų atžvilgiu. Šie rezultatai parodo, kaip į efektyvumą orientuota sveikatos politika gali netikėtai depersonalizuoti paslaugas ir marginalizuoti regioninius sveikatos priežiūros paslaugų teikėjus. Remiantis interviu su sveikatos priežiūros specialistais, šiame tyrime nagrinėjama, kaip reformos keičia kasdienę klinikinę praktiką ir vietinių paslaugų teikimą. Rezultatai pabrėžia būtinybę suderinti efektyvumu grindžiamas reformas su empatija, profesine autonomija ir lygiateise prieiga prie sveikatos priežiūros.*

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