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THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN LITHUANIA

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Contents

1. The long-term care system in Lithuania 1
   - 1.1 Overview (summary) of the system 1
   - 1.2 Assessment of needs 2
   - 1.3 Available LTC services 3
     - *1.3.1 Which services?* *3*
     - *1.3.2 Who is eligible?* *4*
   - 1.4 Management and organization 4
   - 1.5 Integration of LTC 4
2. Funding 5
3. Demand and supply 6
   - 3.1 The need for LTC (including demographic characteristics) 6
   - 3.2 The role of informal and formal care in the LTC system (including the role of cash benefits) 8
   - 3.3 Demand and supply of informal care 8
   - 3.4 Demand and supply of formal care 9
     - *3.4.1 Introduction* *9*
     - *3.4.2 Institutional care* *9*
     - *3.4.3 Home care* *10*
4. LTC policy 11
   - 4.1 Policy goals 11
   - 4.2 Integration policy 12
   - 4.3 Recent reforms and the current policy debate 12
5. Critical appraisal of the LTC system 13

References 14

List of Figures

Figure 1. Index of ageing by year (persons) 6
Figure 2. Number of care institutions for the elderly, by type of institution and year 9
Figure 3. Number of nursing beds in health care system 10
Figure 4. Number of carers and volunteers providing home-based social help and care 11
Figure 5. Persons receiving social services at home 11

List of Tables

Table 1. Expenditures on health care by providers of health care, nursing and residential care facilities 6
Table 2. Support for benefits related to old age, by type of benefit within the social sector 6
Table 3. Structure of the population by age (%) 7
Table 4. Selected demographic indicators, 2008–60 7
Table 5. Share of the population that has difficulty doing household chores 8

The Long-Term Care System for the Elderly in Lithuania

ENEPRI Research Report No. 82/June 2010

Izabela Marcinkowska*

1. The long-term care system in Lithuania

1.1 Overview (summary) of the system

In Lithuania, as in almost all Central and Eastern European countries, there is no separate, public service provision for long-term care (LTC). The social and health care services offered to the elderly are provided through three main sectors: health care, the social welfare system and the private sector together with non-governmental organizations. There is a lack of distinction across the service provision, for which no unified legal arrangements have been created, nor is there a central or regional institution that regulates LTC service procedures. The long-term care services provided by the health care system and social services concentrate on care for the disabled and chronically ill (under the heath system) and for dependant individuals (through social services), the latter of whom include the elderly. Only recently (in 2007) has the operational definition of long-term care been formalized for the first time.[1] According to the *Social Report 2007-2008* (Ministry of Social Security and Labour, 2009), the orientation in long-term care is shifting from institutional care towards home-based care. The philosophy of the LTC system is to develop flexible forms of LTC provision (at institutions, daycare centres and at home) and support informal long-term care (by relatives, family members, neighbours, non-governmental organizations and volunteers) in order to increase the support provided in natural, family environments.[2]

According to some studies, within the health care sector during the 1990s mostly institutional care prevailed. Up to 30% of hospital admissions were for nursing care alone due to the relatively large supply of hospital beds (WHO, 1996). After 1996 many small rural hospitals were transformed into nursing facilities. From 2007, long-term medical treatment has been provided at nursing and residential care facilities. Long-term medical treatment is provided irrespective of age, but takes into consideration an individual's health condition, the progress of disease and complications. Within the health care system, nursing hospitals have been established, offering nursing care, follow-up treatment, medical rehabilitation, sanatorium treatment and palliative care.

Up until 1990, the main focus of social care services was institutional care for the elderly and the physically and mentally disabled. Long-term care at home was an activity undertaken mainly by family members. Only recently has the strategy for long-term care provision been concentrated more on the new forms of care at home. New LTC services within the social sector have been defined and listed in the catalogue of social services developed under the

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[1] LTC is defined as the entirety of care and social services by which the care and social needs of a person are met and continuous comprehensive help and supervision by specialists are provided (see the *National Report on Lithuania on Social Protection and Social Inclusion Strategies, 2008–2010*, Ministry of Social Security and Labour, 2008).

[2] Ministry of Social Security and Labour (2008).

responsibility of the Ministry of Social Security and Labour. Long-term care in the social system is available irrespective of age, but takes into account the level of dependency and the need for care. The social system provides social help in daycare centres, home care services and care in social care institutions. Also, the support for informal care has been developing under social services.

The development of long-term care is a huge challenge resulting from demographic changes and the ageing tendencies of the population. Nowadays, the capacity of long-term care homes in both the health and social care sectors is estimated at 2.5 places per 10,000 persons, which is far less than the growing need and far below the average of the EU-15.

1.2 Assessment of needs

The assessment of needs and level of dependency required for long-term care is different in the social and health care sectors.

In the social sector, services are provided irrespective of age but consider the level of dependence and need for services. The eligibility criteria include the degree of dependence, the need for services, and the income and the property of the individual. The need for social services, including long-term social care, is determined by social workers. It may also be assessed by a team of specialists, which consists of a social worker, his/her assistant, a community caregiver and mental health caregiver. A social worker visits an individual, analyses that person's condition and decides which type of social help is needed. According to the scale used and scores determined, a person can be categorized as self-sufficient, partially self-sufficient or dependent. Each category relates to a complex system of indicators, and entitles the individual to different services, depending on the situation. Community relations, communicativeness, leisure activities, his/her ability to accept the help of others, nutrition, housework and financial ability along with cognitive, emotional, perception and other functions are evaluated to determine the need for social services.

Persons in need of care who require care no more than four hours per day, up to five days per week, may receive care at home. If they need care for up to eight hours per day and up to seven days per week, they might receive social care at home or stay in a daycare centre. If they need care for more than eight hours per day, they could receive temporary, short-term social care at home or in a care institution, but for no more than thirty days. Otherwise, they might obtain long-term social care for more than thirty days in a social care institution.

The amount of payment for long-term care depends on the financial situation of the care recipient (income and the property).

Long-term medical treatment with nursing services is available for all citizens, with the eligibility being based on health insurance coverage. Such services are provided irrespective of age, but consider the health condition, the progress of disease and complications. The special needs of disabled persons are assessed in relation to a certified list of health care conditions. They are evaluated by a doctor or medical advisory commission solely according to approved medical indicators, and there are no other indicators taken into account. There are no categories pertaining to long-term medical care. Disabled persons, in view of their special needs, may receive permanent care (assistance) or permanent nursing.

1.3 Available LTC services

1.3.1 Which services?

Long-term care is provided by the health care system and social services system. In the former system, services are concentrated on care of the disabled and chronically ill (palliative care is also included). Social services are addressed at all dependent individuals, including the elderly.

Within the health care system, as noted above there are nursing hospitals that offer nursing care, follow-up treatment, medical rehabilitation, sanatorium treatment and palliative care.[3] The social system provides help in daycare centres, home-based care services and care in social care institutions.[4]

Nursing services within the health care sector are available on both an in-patient and outpatient basis. Facilities for long-term medical treatment with nursing services are available for patients with chronic diseases or disabilities. Patients must be referred to long-term care by the physician of the ambulatory or health care institution. The patient can be treated in the long-term care institution (called 'supportive treatment hospitals') if s/he suffers from a disease included in list of medical indications approved by the Ministry of Health. Patients can be hospitalised after the final diagnosis without any additional tests.

A special need for **permanent nursing** may be indicated for persons with severe disabilities, who require permanent care and whose physical and psychical impairments seriously restrict their possibilities to orient, move, walk and independently maintain their private and social lives. A need for additional **permanent care (assistance)** may be identified for those with very serious functional disorders, who need the permanent care of another person at home for assistance in their private and social lives.

Home care includes nursing and social care services, which are provided by various professionally trained workers at the home of the care recipients. These services are provided to those who are unable to live at home independently and who have partly lost their independence through old age or disability.

Elderly and disabled persons can also receive day care in **daycare centres**, but for no more than eight hours per day and up to a maximum of five days per week.

In **social care institutions**, LTC is provided for those who are totally dependant and who need the permanent care of professionally trained caregivers. Still, the health status of persons admitted to social care institutions is relatively better than that of patients at nursing hospitals. Social care institutions are available in all the main regions of the country under the supervision of local governments. The minimum duration of stay is one month.

If local authorities are not able to offer the social services needed, they may pay so-called '**money for care**' to enable an individual to buy the services needed on a private basis. Benefits in cash are only paid directly to the dependant person. The amount of the target compensation for nursing expenses at home varied between 1.5-2.5 times the social insurance basic pension and depended on the category of the recipient. Since 1 January 2007 this allowance has been 2.5 times the social insurance basic pension without differentiation. The amount of the target

[3] See the Law on Health Care Institutions.

[4] See the European Commission website, Employment, Social Affairs & Equal Opportunities, Social Protection and Social Inclusion, "Comparative Tables on Social Protection", (http://ec.europa.eu/employment_social/missoc/db/public/compareTables.do;jsessionid=K44Ch7Dv2JTdqVRvRXGmZrFySB95QL1M5v19pM0N415QV2dGWmvp!-1209140689).

compensation for care corresponds to 0.5 times the social insurance basic pension. Financial contributions towards the provision of these services depend on the individual/family income.

1.3.2 Who is eligible?

The eligibility criteria for long-term care are different for the health care and social sectors.

All persons insured by the public health insurance are eligible for the long-term care provided by the health care sector. The eligibility criteria include an individual's health condition, the progress of disease and complications.

Services by the social sector are provided to a person who – by reason of age, disability or social problems – partially or completely lacks, or has not acquired or has lost the abilities or possibilities to independently care for his/her private (family) life and to participate in society. The eligibility criteria include the level of dependence, the need for services, and the income and property of the individual. Cash benefits are not means tested. The benefits are paid if persons defray at least one-third of the set fee for long-term social care (currently LTL 936 (€271)).

1.4 Management and organization

From 1998 to 2000, a process of decentralization took place among social care institutions and the health care system. All the institutions that had been subordinated to ministries were passed over to territorial self-governments. The major responsibilities now fall under the **local self-government (municipality or county)**, which is in charge of the ensuring the provision of long-term services to the residents of its territory by planning and organizing social and health care services, as well as overseeing their quality. Because of an insufficiency of local funds, some self-governments do not arrange for relevant service provision or they provide services of low quality.

The national government is responsible for long-term national programmes and strategies. More specifically, the **Ministry of Health** is responsible for the entire health-care system policy. It also has overall responsibility for the performance of the public health system. Through the State Public Health Centre, it manages the public health network, including ten county public health centres with their local branches. The **Ministry of Social Security and Labour** is responsible for the adoption of long-term national programmes and strategies for social integration within social sector. Local self-governments are responsible for assessing needs, along with monitoring, controlling and subcontracting social services to the service providers.

A market of social care services does not yet exist because there is **no competition in this field**. Long-term care in the social sector is mainly being provided by local social care institutions that do not have to compete for their clients – on the contrary, queues of elderly individuals seeking a place in social LTC institutions are still being traced. Moreover, because of the underdeveloped structure of alternative services, social LTC institutions are fully subscribed and there are long waiting lists of individuals seeking places.

1.5 Integration of LTC

Within LTC service provision

As previously mentioned, the provision of LTC is divided across two areas, the health care system and social services. Until 2007 there was no single concept of long-term care. Since 2007 the Ministry of Health and the Ministry of Social Security and Labour have aimed at improving the coordination of care and social services at the municipal level, enhancing

cooperation and communication between institutions and increasing the accessibility of these services. Yet no legislative or financial integration has been specified for the LTC services provided.

Between the health care and social services sectors

As there is no specific (separate) legislation for LTC, all services are integrated either within the health care system or social services. Health care institutions for the elderly with long-term care needs are organized and funded on the same basis as other health care institutions. Social services for individuals with long-term care needs are organized and funded by the territorial self-governments as part of the social care system. Consequently, each long-term care service may be funded by a different source and be integrated within one of the two sectors mentioned above.

2. Funding

The expenditures related to long-term care within health care system are financed from various sources:

- the compulsory health insurance fund, following the order set by the Law on Health Insurance;
- the state and territorial self-government budgets;
- EU structural funds;
- private financial resources; and
- charity and other legitimate sources.

The Health Insurance Fund finances long-term medical treatment with nursing services, but for no longer than 120 days each year.

Long-term care within the social system is financed from the local self-governmental budgets and target subsidies of the central budget assigned to local (municipal) budgets. In this respect, municipalities directing persons towards social care institutions for long-term care shall have to cover part of the expenses related to the provision of social services. To make more rational use of the state budget funds, individuals themselves contribute payments for long-term care services using not only their income but also their property. The amount paid by a care recipient for long-term care must not exceed 80% of the person's income.[5] The amount also depends on the kind of long-term care and the circumstances of the person in need of care. Self-governments have the right to relieve a person from payment. Moreover, the state does not control the costs of services.

As discussed earlier, because there is no separate source of funding for LTC provision, each kind of service is provided as part of a more complex structure. Consequently, it is impossible to distinguish the total amount of money spent on long-term care services alone. Nevertheless, some attempts have been made to give an approximation of the situation. The data available from the Lithuanian national statistical office (Statistics Lithuania) show that during the years 2004–08 the relative expenditures on nursing and residential care facilities within the health care sector remained the same, at between 35% and 40% of total expenses (Table 1). Within the last ten years, the expenditures on support for benefits related to old age by the social sector have increased (Table 2).

[5] The Law on Social Services, 2006.

Table 1. Expenditures on health care by providers of health care, nursing and residential care facilities

Expenditure on health care within nursing and residential care facilities	**2004**	**2005**	**2006**	**2007**	**2008**
Total (LTL million)	1,263	1,545	2,064	2,397	2,709
Structure of the total health care expenditure (%)	35.3	36.6	40.0	39.0	36.8

Source: Lithuanian national statistical office (Statistics Lithuania).

Table 2. Support for benefits related to old age by type of benefit within the social sector

	2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Social protection benefits	3,065	3,010	3,063	3,230	3,482	3,913	4,354	5,951
Cash benefits	2,975	2,920	2,974	3,135	3,370	3,795	4,212	5,802
Care allowance	n/d	n/d	n/d	16.6	20.9	42.9	74.3	172
Benefits in kind	89.7	90.3	89	95.5	112.1	117.7	141.9	149.2
Assistance in carrying out daily tasks	5.1	5.1	4.6	6.7	7.2	7.3	7.8	13.9

Source: Lithuanian national statistical office (Statistics Lithuania).

Please note that the numbers provided cannot be conclusive in any respect as they reflect only a share of the expenses on long-term care.

3. Demand and supply

3.1 The need for LTC (including demographic characteristics)

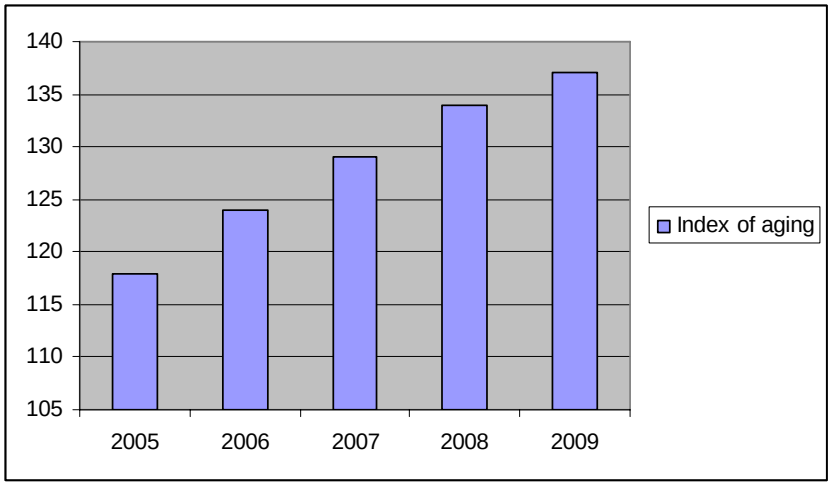
The public documents available from Statistics Lithuania do not estimate the need for long-term care. The demand can only be approximated from demographic characteristics. According to the *Country Case Studies on Long-Term Care* (see Krisciunas, 2000) the demand for the long-term care has remained high. The longer average lifespan of the middle-aged population and progress in the field of medicine have greatly contributed to the increasing number of disabled and older persons who have difficulty caring for themselves. At the beginning of 2003, 19.8% of the country's population were aged 60 or older; in 2008 the number was higher and amounted to 20.52% (see Table 3). Also, the index of ageing in Lithuania has consistently risen since 2005 (Figure 1).

Table 3. Structure of the population by age (%)

	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Share of population aged 60+	14.2	14.2	14.4	15.0	15.1	15.3	15.7	15.8
Share of population aged 85+	2.3	2.4	2.4	2.8	2.8	2.9	3.1	3.3

Source: Lithuanian national statistical office (Statistics Lithuania).

Figure 1. Index of ageing by year (persons)



Source: Lithuanian national statistical office (Statistics Lithuania).

The results of the European Commission's survey on ageing (2009) indicate that life expectancy at birth will increase to 80 years for men and to almost 87 for women by 2060. It is foreseen that life expectancy at age 65 will increase to 20 additional years for men and almost 24 for women (Table 4), which is below the average of the EU (the corresponding numbers are 21.8 for men and 25.1 for women). It is estimated that every third inhabitant of Lithuania will be an elderly person in 2050.[6]

Table 4. Selected demographic indicators, 2008–60

	2007-08	**2010**	**2020**	**2030**	**2040**	**2050**	**2060**
Life expectancy at age 65 (men)	13.1	13.4	14.9	16.3	17.7	19.0	20.3
Life expectancy at age 65 (women)	17.5	17.8	19.0	20.3	21.5	22.6	23.7
Life expectancy at birth (men)	65.9	66.6	69.8	72.8	75.6	78.1	80.4
Life expectancy at birth (women)	77.4	77.9	80.0	81.9	83.7	85.3	86.9

Source: European Commission (2009).

Statistics Lithuania gathered information for one year (for 2005) about those who have at least one physical or sensory functional limitation and about individuals who have difficulties in doing household chores (Table 5). Those statistical data showed obvious findings. The older the respondents, more difficulty they have undertaking household chores and the more likely they need care and social services. Unfortunately, the lack of information for other years prevented the evaluation of changes over time in the need for LTC.

[6] See Statistics Lithuania, "Demographic situation in Lithuania, 1990-2002".

Table 5. Share of the population that has difficulty doing household chores

Persons who have difficulty doing household chores	% of total population
Total	12.1
By gender:	
Men	9
Women	14.6
By age:	
15-24	2.3
25-34	3
35-44	4.3
45-54	7.5
55-64	16.1
65-74	27.2
75-84	49.1
85+	73.5

Source: Lithuanian national statistical office (Statistics Lithuania) (2005).

To establish the need for care and social services for elderly persons, an extra study was carried out by Hitaite and Spirgiene (2007). In this study the authors assessed the needs of the elderly for nursing and social services in the Kaunas region. Interviews were carried out with 390 individuals, representing all of the elderly persons of the region. According to the respondents, 71.3% of them needed nursing services and 58.2% also needed social services. In the group of fully or almost fully dependent persons, 88% of respondents indicated that they needed social services and 96% needed nursing services. Rural residents needed social services more (64.3%) than urban residents (49.6%). As many as 45.9% of respondents found it difficult to travel to visit a doctor. The majority of respondents (86.4%) noted that the persons taking care of them did not have a medical background. The majority of respondents (79.2%) would like to be cared for at home. This research indicates that the needs for care undoubtedly remain high.

3.2 The role of informal and formal care in the LTC system (including the role of cash benefits)

Formal LTC in Lithuania is still deeply underdeveloped and biased towards the provision of institutional care. A number of social projects have been launched to expand the supply of formal LTC, especially home-based care. Despite the present increase in support for caring activities by governmental and non-governmental organizations, most of the care provided for the elderly and disabled is still carried out by family, neighbours, friends and volunteers.

3.3 Demand and supply of informal care

In Lithuania the demand and supply of informal care have not been regularly studied. The study of the need for nursing and social services in the Kaunas district by Hitaite and Spirgiene (2007) indicated that 69.7% of elderly persons who needed home nursing were cared for by family members, 10% were cared for by neighbours and 7.7% by community nurses; only 3.8% paid for this service. The supply of informal care is still high in Lithuania. The same study reveals that the majority of respondents would like to be cared for at home, showing the preference of the elderly for home-based care. Yet demographic changes (the rapid ageing of the population, migration from rural to urban areas, etc.) and employment changes (e.g. the increase in the

percentage of women in the labour force) is already making it increasingly difficult for the informal care system to continue to carry such a high burden of caring responsibilities for the elderly and disabled. Hence, these factors demonstrate the growing formal LTC needs in the country.

3.4 Demand and supply of formal care

3.4.1 Introduction

In Lithuania there is no regular study of the demand for formal care (institutional or home-based). The demand for LTC is approximated by the demographic and epidemiological structure of the population at the national and regional levels. Until 1990, the main form of long-term care was institutional care for the elderly (retired pensioners) and the physically and mentally disabled, provided solely by government care institutions. Home-based LTC provided by the social system was a new phenomenon in Lithuania in the mid-1990s and it is still in a process of continual development. At present, structural changes in the supply of formal care are mostly dependent upon the political objectives of the government.

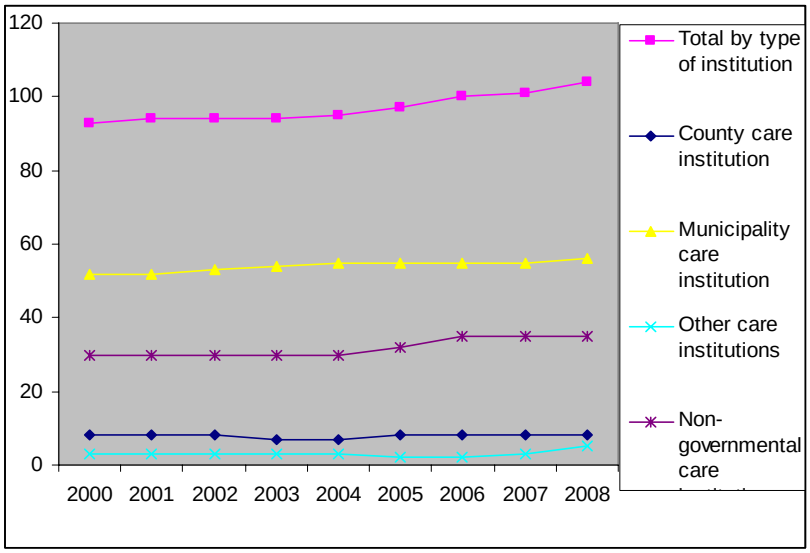
3.4.2 Institutional care

According to their administrative designation, social LTC institutions are divided into county institutions, municipal institutions and non-governmental institutions. At the end of 2005, there were 194 social LTC institutions of various types and designation, among which

- 66 were county social care institutions, of which 9 were social institutions for the elderly; and
- 128 were social care institutions overseen by municipalities, non-governmental organizations and others, of which 88 were social care institutions for the elderly.

Figure 2 presents the changes in the number of LTC institutions for the elderly during the last eight years. As shown, the supply of institutions overall has slowly risen. This slow growth is mainly attributed to the slow increase of the non-governmental social care institutions.

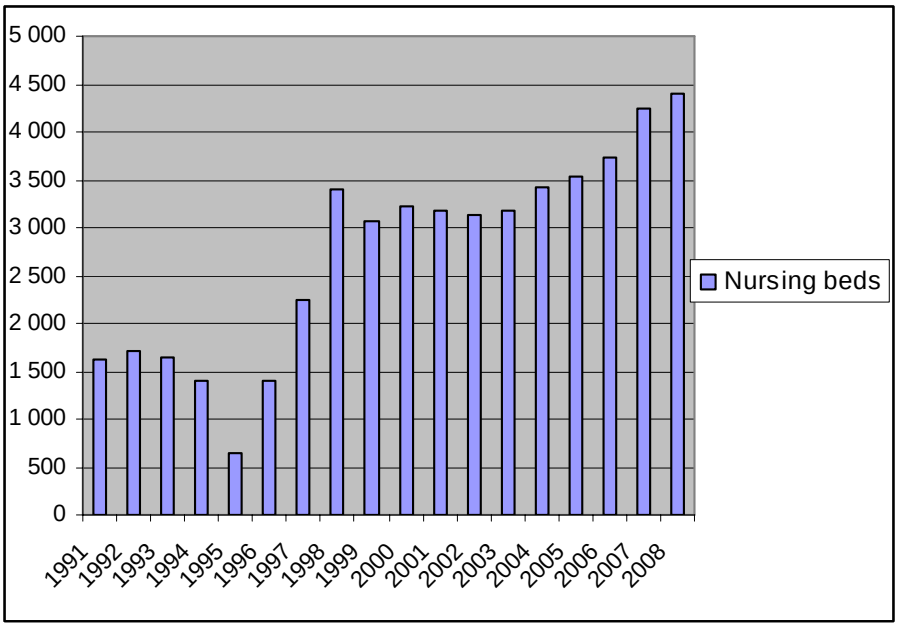
Figure 2. Number of care institutions for the elderly, by type of institution and year



Source: Lithuanian national statistical office (Statistics Lithuania).

The growing number of LTC institutions for the elderly is reflected in the increasing number of places in such institutions. According to Statistics Lithuania, in 2000 there were 4,711 beds. The number rose to almost 5,350 beds by the end of 2007. Also, the number of nursing beds within the health care sector has been expanding since 1996 (Figure 3).

Figure 3. Number of nursing beds in the health care system



Source: Lithuanian national statistical office (Statistics Lithuania).

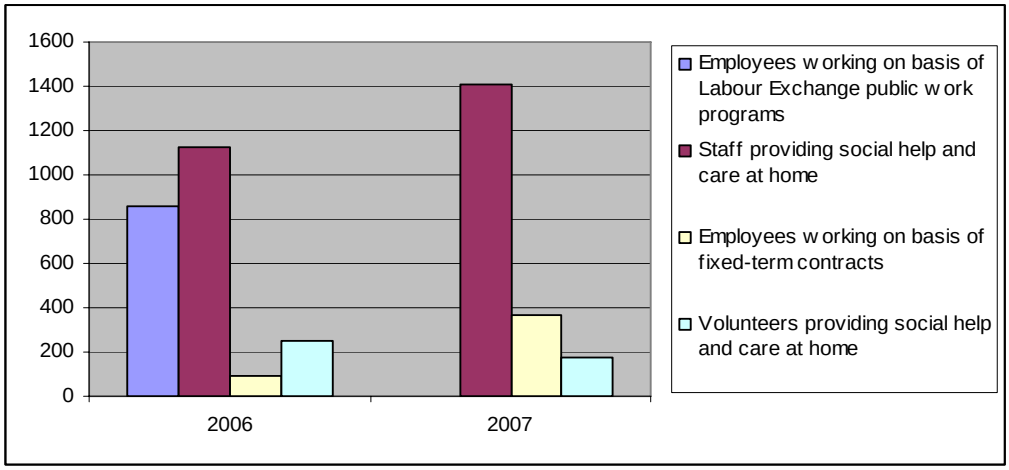
According to a report published by the Ministry of Social Security and Labour (Radišauskiene and Žalimiene, 2009), self-governments are still in favour of providing institutional care instead of alternative, home-based services.

3.4.3 Home care

Carers and social workers provide home-based LTC, which includes nursing, shopping and help at home. In 1997, more than 2,200 carers were involved in care provision throughout the country. This number has increased (Figure 4), but is undoubtedly still insufficient to meet the current need. Despite the support by (non-)governmental institutions, long-term care in the community remains an activity mainly carried out by families, neighbours, friends and volunteers.

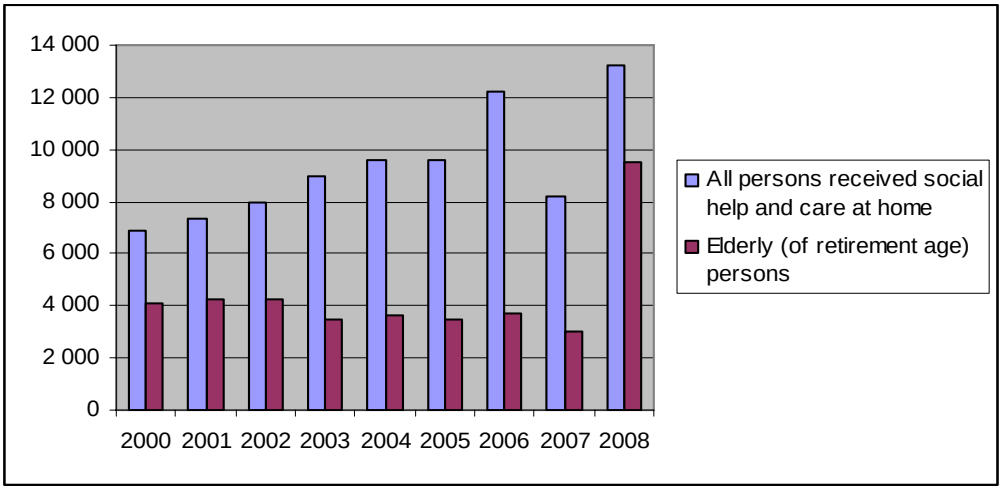
The number of persons receiving social help and care at home grew between 2000 and 2008. Notably, the number of elderly individuals who received social help and care at home remained relatively constant, at between 3,000 and 4,000, from 2000 to 2007. Only in 2008 did this number accelerate rapidly (to almost 9,000 – see Figure 5). Unfortunately, there is no information available on the supply of long-term care at home in 2008, so there is no explicit explanation for such a change. The reason might be the increase in the supply of such social services or the changes in policy implemented by the government.

Figure 4. Number of carers and volunteers providing home-based social help and care



Source: Lithuanian national statistical office (Statistics Lithuania).

Figure 5. Persons receiving social services at home



Source: Lithuanian national statistical office (Statistics Lithuania).

4. LTC policy

4.1 Policy goals

In Lithuania there is no single legislative act that is responsible for LTC matters alone. The main applicable statutory bases are the Law on Social Services of 19 January 2006 and the Law on Health Care Institutions of 6 June 1996. Thus, LTC policy changes are based on the changes in the laws covering these two sectors.

According to the *Social Report 2007-2008* (Ministry of Social Security and Labour, 2009), the orientation in long-term care provision is shifting from institutional care towards home-based care. The aim of the reform of 2002 was to reorganize social services in such a way as to establish the legal, administrative and financial premises to enable social service provision in a community. It sought to make social assistance more efficient and to encourage individuals to actively search for ways to receive LTC at home rather than use social assistance provided in

institutions. The second very important focus of the reform was to improve the quality of social services as well as the way social services are financed.

Priority policies related to health care reforms are concentrated on increasing efficiency, accessibility and the quality of health care and services. Given the increase in the number of elderly persons, medical expenses are rising and the public is becoming more concerned about health care and the quality of services, which is why the government has tried to create equal conditions for all citizens of the country in gaining access to the health care services needed.

4.2 Integration policy

While in Lithuanian law there is no uniform or separate legislation for long-term care, there have been some attempts to integrate the services provided by the health and social services sectors. The approved "Primary Healthcare Development Concept" lists measures to improve the integration of care and social services into primary health care, and to develop a range of LTC services at home for the elderly. Still, this is just a first step for the integration of LTC services and much more has to be done to improve it.

4.3 Recent reforms and the current policy debate

The last reform of the Law on Social Services, which included some long-term care services, entered into force in 2006. According to this reform, the functions and responsibilities of the ministry, counties and municipalities were clearly distributed. In addition, competition among social service providers was encouraged, social service financing was changed from the direct financing of institutions to the direct financing of social services, the payment of social services was differentiated according to the principle of social solidarity and the quality requirements for social services was settled.

The fragmentary changes in the structure of long-term care have been implemented through several kinds of national/local programmes. Their detailed description is presented in the *Social Report 2007-08* prepared and published by the Lithuanian Ministry of Social Security and Labour (2009). The aim of one of the projects, described as "Vocational Training of Social Workers and Assistants of Social Workers", was to increase the quality of social services through improvements in the professional competence of social workers. As a result of the implementation of the project, around 4,000 social workers and assistants of social workers received training in 2006–09.

In 2008, a draft description of procedures for the certification of the heads of social service institutions was prepared. The aim of the procedures is to evaluate the qualifications of the heads of social service institutions and their operational results, to place them in an appropriate, management qualification category and to encourage the efficiency of activities through the implementation of state social service policy and efforts to ensure the high quality of social services.

The years 2007–08 saw the implementation of the Social Service Infrastructure Development Programme. Its goal is to create the conditions for the development of social services by providing the residents with possibilities for using social services, municipal institutions, foreign partners, regions, the private and public sectors. The funds allocated are used to construct, rebuild and modernise existing social service institutions.

Since 2008 the **Social Care Standards** have been supplemented together with the assessment criteria. These standards place a major focus on the human right to privacy, the preservation of dignity and honour, and harmonization of the environment created for a person and the individual's emotional needs. They also emphasize the establishment of conditions favourable to self-expression, the development of interests and the strengthening of social ties with a

community and relatives. One of the key features of the quality assessment mechanism, which is in the process of development, is methodological assistance and the sharing of 'good practices' among institutions and workers in social care institutions. The purpose of granting a license is to ensure good quality services are rendered by social care institutions.

5. Critical appraisal of the LTC system

The main critique of the long-term care system in Lithuania is its division between the health care system and social services system, and the weak integration of these two providers of care services. Several institutions function without the collaboration of other bodies in the same field. The formulation of long-term care policy is still at an initial stage, and is concentrated more on smaller issues than on overall systemic reform, particularly on the integration of LTC services into one sector. Despite one of the aims of the health care reform[7] being to strengthen the cooperation of the health care and social security institutions by 2005, until now only an inter-sectoral group has been formed to prepare proposals on the incorporation of care homes, nursing hospitals and hospices into the health care sector. The experience of the EU member states shows that services must be integrated in order to ensure that the conditions are place to enable elderly persons to live as long as possible in their homes with dignity.

Self-governments are experiencing problems in precise planning, because of a lack of methods for evaluating the true number of persons needing long-term care and the particular services they will need. As a result, self-governments are hampered by inadequate planning and finances, and the inability to finance service provision in a timely manner.

Also, managerial constraints and financial limitations are causing problems in the provision of LTC services, notably their underdevelopment, constraints in the growth of the infrastructure and a reduction in the quality of services. To avoid an unreasonable increase in state expenditures and a negative impact on macroeconomic stability, it is essential to define a separate system of funding for all LTC institutions and services. Furthermore, the rules for the financing system should be clarified and made consistent.

Finally, the vast informal provision of long-term care should be partly substituted by formal home-based care. New flexible forms of service provision oriented towards patients' needs should be introduced and implemented.

[7] See the Ministry of Health (2006).

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About the Center for Social and Economic Research (CASE)

The Center for Social and Economic Research (www.case.com.pl), located in Warsaw, is an international, non-profit research and advisory institute working on European integration, the world economy and the transition process in Central and Eastern Europe, the Trans-Caucasus and Central Asia. CASE research focuses on macroeconomics, the labour market, social protection, pension systems and health issues. CASE is taking an active role in the debate on the economic and political challenges of the European Union. To date, the foundation has to its credit over 220 research and advisory projects, carried out by CASE on its own or in association with other research institutes and with internationally renowned specialists. The CASE network includes almost a hundred researchers and experts in various fields. Most CASE researchers are based in Central and Eastern Europe and the Commonwealth of Independent States, but a significant number are based in Western Europe, the United Kingdom and the United States. CASE has unique experience of cooperation with European partners.

ANCIEN

Assessing Needs of Care in European Nations

FP7 HEALTH-2007-3.2-2

Launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

1) How will need, demand, supply and use of LTC develop?

2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

For more information, please visit the ANCIEN website (http://www.ancien-longtermcare.eu).