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The Lithuanian Long-term Care System

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Contents

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Abstract

The remarkable growth of older population has moved long-term care to the front ranks of the social policy agenda in the European Union. This paper addresses the issue of the long-term care in Lithuania, its philosophy, the legal and funding regularities, management issues and LTC policy. Its attempt is also to provide a complex set of information about the demand side of long-term care including the demographic characteristics of people in need. The paper also presents a detailed description of types of LTC available.

The results confirm that the main problem of the LTC system in Lithuania is still its division between the health care system and the social system and the weak integration of these two parts of LTC services. The formal LTC system in Lithuania is still biased towards the provision of institutional care, despite the fact that a number of social projects have started in order to expand the supply of semi-stationary LTC and care provided in homes. Moreover, most care provided to the elderly and disabled is still carried out by family, neighbours, friends and volunteers.

The demand for LTC, approximated by the demographic and epidemiologic structure of the population at the national and regional levels, remains high and it is expected to increase. The middle-aged population's longer average lifespan and progress in the field of medicine greatly contributes to an increasing number of disabled and older people who have difficulties in caring for themselves.

1. The system of LTC in Lithuania

1.1 Overview (summary) of the system

As in almost all countries of Central and Eastern Europe, in Lithuania there is no separate public sector for long term care (LTC) services. LTC for elderly people is organized through two main sectors: health care and social system. The lack of separation of LTC means that no unified legal arrangements have been created for LTC. Also the institutions providing LTC are divided among these two sectors and there is no single government institution that specifically coordinates LTC services.

LTC covers a complex set of care (nursing) and social services which are provided to meet people's needs. It is targeted at individuals who are not self-sufficient and need assistance because of long term illnesses and physical and mental disabilities, regardless of age. In Lithuania, LTC also includes palliative care services, aiming to improve the quality of life for patients with untreatable and progressive terminal diseases and to help their relatives cope.

Long term medical treatment with nursing services attributed to health care are provided irrespective of age, taking into consideration the health conditions of an individual, the progress of the disease and any other complications. Within the health care system, residential care is provided in general hospitals or nursing hospitals (also called supportive treatment hospitals). Residential care covers nursing and maintenance, follow-up treatment, and palliative care. Primary health care institutions are responsible for the organisation and provision of nursing services in the home.

Within the social sector, LTC is provided according to the level of independence and the need for services, irrespective of age. The main recipients of social services are elderly people and people with disabilities (both children and adults). The social system provides social help at homes, in day centres and in residential social care homes (old-age homes, housing for the disabled, specialized social care homes).

Until 1990, institutional care prevailed within the health care and social sectors. Only recently have there been some attempts to reorganize the provision of LTC services. In 2007, the

operational definition of LTC was formalized for the first time[1]. According to public documents,[2] the philosophy of the LTC system is to shift from an institutional care system to home based care. New flexible forms of provision of LTC (at institutions, day centers and in the home) have been defined. Support for informal LTC (by relatives, family members, neighbors, non-governmental organizations and volunteers) has been strengthened in order to support a natural, family environment. The development of the LTC sector is a huge challenge which must be met due to rapid demographical changes including the ageing tendencies of the population.

The structure of the report is the following: In every subchapter, first LTC within the health care sector is described followed by a presentation of LTC services within the social sector.

1.2 Assessment of needs

The assessment of needs and the evaluation of care dependency required for LTC is different in the social and health care sectors.

Long term medical treatment with nursing services is available for all citizens. It is provided based on the health conditions, the progress of the disease and other complications, irrespective of age. The special needs of the disabled are determined by a certified list of the person's health care conditions. It is determined by a doctor or medical advisory commission according to approved medical indicators, and there are no other indicators taken into consideration. Disabled people, considering their special needs, may be provided permanent care (assistance) or permanent nursing services.

In the social sector, services are provided irrespective of age, considering the level of independence and the need for services. The need for social services, including long term social care, is determined by social workers. It may also be done by a team of specialists, which consists of a social worker, his/her assistant, a community caregiver, and a mental health caregiver. The social worker visits the individual, analyses his or her conditions and decides what type of social help is needed. The need for social services is determined by considering a combination of the principles of co-operation, participation, complexity, accessibility, social justice, relevance, efficiency, and comprehensiveness. This need is established on an individual basis according to the person's dependency level and his/her

[1] LTC is defined as the entirety of care and social services provided in which the care and social needs of a person are met and continuous comprehensive help and supervision by specialists is provided (National Report on Lithuania on Social Protection and Social Inclusion Strategies, 2008-2010)
[2] National report of Lithuania (2008), Social Report 2007-2008, Ministry of Social Security and Labour.

possibilities to develop or compensate for independence by means of the social services that correspond to his/her interests and needs. Based on a complex system of indicators and scores selected, a person can be self-sufficient, partially self-sufficient or dependent.

Persons in need of care from another person who require care no more than 4 hours per day and 5 days per week may receive home attendance. If they need care for no more than 8 hours per day and no more than 7 days per week, they can receive social care at home or stay in day centres. If they need care for more than 8 hours per day, they may receive temporary short-term social care at home and in care institutions, but for no more than 30 days. Otherwise, they might obtain long-term social care for more than 30 days in stationary social care institutions. In the case of long-term care in institutions, eligibility to the compensation for care or attendance expenses depends on the person's ability to pay for the long-term social care. The amount of long-term care paid by the person may not exceed 80% of the person's income. The property and incomes of an adult person are tested; in the case of children, only incomes are tested. The benefit is paid if a person defrays at least 1/3 of the set fee for long-term social care (LTL 936 – EUR 271). Cash benefits are not means tested.

1.3 Available LTC services

LTC services are divided between the health care and social sector. The Table 1 lists LTC institutions by their function and the sector they belong to.

Table 1. Organization of institutional and home based care

Type of system	Residential care	Semi-residential care	Home based care	
			In cash	In kind
Health care system	Nursing and maintenance treatment in general hospitals, nursing hospitals (also called supportive treatment hospitals)	--	--	Nursing services at home
Social services	Social care homes (old-age homes, housing for disabled, specialized social care homes)	Day care in day care centers, Temporary short-term care in residential social care institutions	Benefits in cash to the individual in need of assistance due to reduced self-sufficiency	Social attendance at home; includes performance of housework and care by home-helpers

Source: own compilation

Nursing and maintenance services within the health care sector are available both for in-patients and out-patients. Stationary long term medical treatment with nursing services is available for patients with chronic diseases or disabilities. Patients must be referred to the LTC by the physician of an ambulatory or a stationary health care institution. The patient can be treated in the **stationary LTC institution** (called supportive treatment hospitals or nursing hospitals) if he/she suffers from a disease which is on the list of medical indications approved by the Ministry of Health. Patients can be hospitalised after the final diagnosis without any additional tests. The special needs for permanent nursing are indicated for people with severe disabilities, who require permanent care and whose physical and mental disabilities seriously restrict their ability to move, walk and independently go about their private and social lives. Aftercare nursing and rehabilitation is also provided in **general hospitals** in special departments.

In **residential social care institutions,** LTC is provided for people who are totally dependant and who need the permanent care of professional caregivers. Still, the health status of people admitted to stationary social care institutions is relatively better than that of patients in stationary LTC institutions within the health care sector. Social care is provided by several **social care homes** such as old-age homes, housing for the disabled, specialized social care homes, etc. Stationary social care institutions are available in all of the main regions of the country under the supervision of local governments. The minimum duration of stay is 1 month.

Semi-residential care is provided within the social sector only. Elderly and disabled people can receive day care in **day care centers** from 3 hours per day up to 5 days per week. They can also receive **temporary short-term social care in residential social care institutions** depending on the recipients of the services, e.g. for elderly persons, it is no less than 12 hours per day pending 6 months per year or 5 days per week without time limits.

Home care includes nursing and social care services, which are provided by various professionally qualified workers in the home of the person in need of care. These services are provided to people who are unable to live in their homes independently and who have partially lost their independence due to old-age or disability. People in need of home care are regularly visited by social workers from the local social assistance administration and they determine the need for social care. Social attendance in the home includes performance of housework, and care by home-helpers. Palliative care services can be also provided to patients at home by a team of specialists: a doctor, a nurse and a social worker. Primary

health care institutions are responsible for the organization and provision of nursing services in the home.

Other in-kind benefits include the provision of special equipment. Disabled people receive special aid for the purchase of a car. They are provided with wheelchairs and their flats are arranged according to their disability.

Special Compensation for Care Expenses is provided only within the social sector. It is paid, among others, to disabled persons whose capacity to work has been reduced by 75%-100% or to a person of retirement age if the need for permanent care is determined. The amount is 250% of the social insurance basic pension (LTL 900 (EUR 261) in 2009).

Special Compensation for Attendance Expenses is paid to disabled persons with a reduction in their capacity to work of at least 60% and to persons of retirement age if the need of permanent attendance is determined. The amount is 50% or 100% of the social insurance basic pension, depending on the category of the recipient (respectively LTL180 (EUR 52) or LTL 360 (EUR104) in 2009). Benefits in cash are only paid directly to the dependant person. The person has the free choice to use the cash benefit at his/her own discretion. There is no choice between cash benefits or benefits in kind.

1.4 Management and organization

From 1998 to 2000, the decentralization of social care institutions and health care has been taking place. At present, it is a central system which is supplemented at the regional level.

The national government is responsible for long-term national programs, strategies, requirements and standards. More specifically, **The Ministry of Health** is responsible for the entire health care system policy. It also has the overall responsibility for the public health care system's performance. Through the State Public Health Center, it manages the public health network including ten county public health centers and their local branches. **The Ministry of Social Security and Labour** is responsible for the adoption of long term national programs and strategies for social integration within the social sector. Local self-governments are responsible for the processes of needs assessment, monitoring and control, and contracting social services to service providers.

Heads of Counties prepare and implement social services' programs and projects for the disabled at the county level and ensure the function of social services' institutions at the

regional level. They are responsible for the provision of secondary specialized medical treatment.

Municipalities prepare and implement municipal programs of disabled social integration. They are directly responsible for the organization of the provision of social services, for the determination of the needs for social services, for the supervision of common and special social services, and for the organization and provision of primary health care.

1.5 Integration of LTC

Within the LTC system

As previously mentioned, the provision of LTC is divided into two areas: health care services and social care services. Until 2007, there was no single concept of LTC. Since 2007 the Ministry of Health and the Ministry of Social Security and Labor have been working to improve the coordination of care and social services at the municipal level, to improve the cooperation and communication between institutes and to ensure these services are accessible to all. However, no legislative or financial integration has been defined within the LTC system.

Between health care and social services sector

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

2. Funding

Expenses related to LTC within the health care system are being 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,
- the EU structural funds,
- private financial resources.

For the LTC benefits in kind financed from the Compulsory Health Insurance, the qualifying period is no longer than 3 months.

LTC within the social system is financed from local self-government budgets and target subsidies of the central budget assigned to local (municipal) budgets. In this respect, municipalities directing persons to social care institutions for LTC shall have to cover part of the expenses related to the provision of social services. Persons themselves contribute to payment for LTC services using not only their income but also their property. The amount for LTC paid by a person must not exceed 80% of the person's income[3]. It depends on the kind of LTC and on the person in need of care. Self-governments have the right to relieve a person from payment. Moreover, the state does not control the prices of services.

As shown, because there is no separate source of funding for long-term care provision, each type of service is provided as part of a more complex structure. Consequently, it is impossible to distinguish the total amount of money spent on LTC services only. Despite this, some attempts have been made in order to approximately assess the situation. The information provided below is based on the available data from the Lithuanian National Statistical Office. As shown in Table 2, the relative expenses on nursing and residential care facilities within the health care sector remain the same, balancing between 35% - 40% of total expenses on health care during the years 2004-2008. Table 3 presents expenses on support in old age by the type of benefit within the social sector. Many of them are not related to the provision of LTC, but presenting them together seems useful to see the overall

[3] The Law on Social Services, 2006

situation in the social system. The lack of availability of more precise data excludes the possibility of the provision of more representative data.

Table 2. Expenditures on nursing and residential care facilities within the health care sector

Item / Year	2004	2005	2006	2007	2008
Expenditure on nursing and residential care facilities, in LTL million	1 262,8	1 545,3	2 063,5	2 397,1	2 708,7
Share of nursing and residential care expenses in the total health care expenditures	35,3	36,6	40,0	39,0	36,8

Source: Lithuanian National Statistical Office

Table 3. The share of expenses on benefits for elderly in the total expenses on support in old age by type of benefit within the social sector

	2000	2001	2002	2003	2004	2005	2006	2007
Social protection benefits	25,17%	25,18%	25,17%	25,17%	25,19%	25,18%	25,19%	25,14%
Means-tested benefits	0,04%	0,04%	0,04%	0,05%	0,05%	0,05%	0,05%	0,06%
Cash benefits	24,44%	24,42%	24,44%	24,43%	24,38%	24,42%	24,37%	24,51%
Periodic cash benefits	24,44%	24,42%	24,44%	24,43%	24,38%	24,42%	24,37%	22,35%
Care allowance	0,00%	0,00%	0,00%	0,13%	0,15%	0,28%	0,43%	0,73%
Old age pension	23,78%	23,72%	23,71%	23,53%	23,37%	23,28%	23,08%	20,92%
Anticipated old age pension	0,65%	0,71%	0,73%	0,76%	0,85%	0,85%	0,85%	0,70%
Other cash periodic benefits	0,00%	0,00%	0,00%	0,00%	0,01%	0,01%	0,01%	0,01%
Lump sum cash benefits	0,00%	0,00%	0,00%	0,00%	0,00%	0,00%	0,00%	2,16%
Other lump sum cash benefits	0,00%	0,00%	0,00%	0,00%	0,00%	0,00%	0,00%	2,16%
Benefits in kind	0,74%	0,76%	0,73%	0,74%	0,81%	0,76%	0,82%	0,63%
Accommodation	0,45%	0,45%	0,39%	0,40%	0,39%	0,36%	0,44%	0,33%
Assistance in carrying out daily tasks	0,04%	0,04%	0,04%	0,05%	0,05%	0,05%	0,05%	0,06%
Other benefits in kind	0,24%	0,27%	0,30%	0,29%	0,37%	0,35%	0,34%	0,24%

Source: Lithuanian National Statistical Office

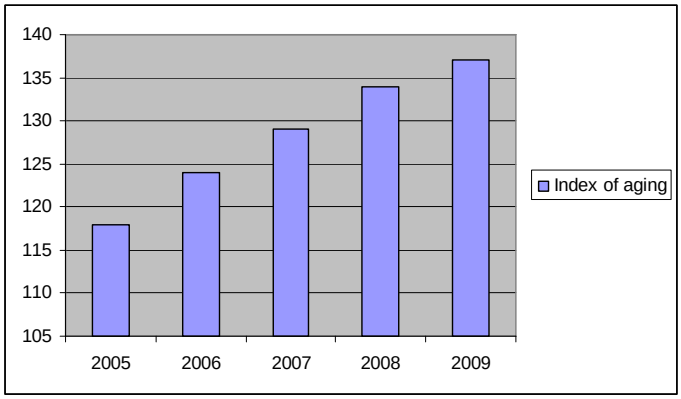
Please note that the numbers provided cannot be representative as they reflect very fragmentary knowledge about expenses on LTC.

3. Demand and supply

3.1 The need for LTC (including demographic characteristics)

Public documents or the National Statistical Office do not provide an evaluation of the need for LTC. The demand can be approximated by demographic characteristics only. According to "Country Case Studies in Long-Term Care," the demand for LTC remains high. The middle-aged population's longer average lifespan and progress in the field of medicine have greatly contributed to an increasing number of disabled and older people who have difficulties in caring for themselves. At the beginning of 2003, 19,8% of the country's population were aged 60 or more. In 2008, the number was higher and amounted to 20,52% (see Table 3). Also the index of ageing in Lithuania has been consistently increasing since 2005 (Figure 1).

Figure 1. Index of aging by year (persons)



Source: National Lithuanian Statistical Office

Table 4. Structure of the population by age

	2001	2002	2003	2004	2005	2006	2007	2008
Share of population aged 60+ + in the total population	14,2	14,2	14,4	15,0	15,1	15,3	15,7	15,8
Share of population aged 85+ + in the total population	2,3	2,4	2,4	2,8	2,8	2,9	3,1	3,3

Source: National Lithuanian Statistical Office

The results of the European Commission survey on ageing (2009) indicate that life expectancy at birth will increase to 80 years for males and almost 87 for women by 2060. It is foreseen that life expectancy at age 65 will increase to 20 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 males and 25,1 for female). It is estimated that every third inhabitant of Lithuania will be an elderly person in 2050[4].

Table 5. Selected demographic indicators, 2008-2060

	2007/ 2008	2010	2020	2030	2040	2050	2060
Life expectancy at age 65, males	13,1	13,4	14,9	16,3	17,7	19,0	20,3
Life expectancy at age 65, females	17,5	17,8	19,0	20,3	21,5	22,6	23,7
Life expectancy at birth, males	65,9	66,6	69,8	72,8	75,6	78,1	80,4
Life expectancy at birth, males	77,4	77,9	80,0	81,9	83,7	85,3	86,9

Source: European Commission, 2009 Ageing report

In 2005, the National Lithuanian Statistical Office provided information about people having at least one physical or sensory functional limitation and about people having difficulties in doing household care activities (Table 1). Those statistical data shows that the older the respondents, the more difficulties they have in household care activity and might need care and social services. Unfortunately, the lack of information for other years makes it impossible to evaluate changes in the needs for LTC over time.

Table 6. Percent of population who have difficulties in performing household care activities

Persons who have difficulties in doing household care activity	% of total population
Total	12,1
By gender:	
• Male	9
• Female	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: National Lithuanian Statistical Office, 2005.

To establish the need for care and social services for elderly people, a study was carried out by Hitaite and Spirgiene (2007).[5] In this study, the authors assessed the needs of the elderly

[4] Lithuanian National Statistical Office, "Demographic situation in Lithuania", 1990-2002

for nursing and social services in the Kaunas Region. 390 persons were interviewed representing all elderly people in 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 (49,6%) residents. As many as 45,9% of respondents pointed out that they found it difficult to travel to visit a doctor. The majority of respondents (86,4%) said 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 in their homes. This research indicates that the need for care remains high.

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

The formal LTC system in Lithuania is still biased towards the provision of institutional care. A number of social projects have started in order to expand the supply of semi-stationary LTC and care provided in homes. Despite the present increase in support for caretaking activities by governmental and non-governmental organisations, most care provided to 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 the elderly people that needed home nursing were cared for by family members, 10% of them were cared for by neighbours, 7,7% by community nurses and only 3,8% of them 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. It shows that most elderly people prefer home care. However, demographic changes (e.g. the rapid aging of the population, migration from rural to urban areas, etc.) and employment changes (e.g. the increased 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 caretaking responsibilities for the elderly and disabled. In consequence, these factors demonstrate the growing need for formal LTC in the country.

[5] Hitaite, L. and L. Spirgiene, 2007, The need of the elderly for nursing and social services in the community of Kanas district, „Medicina (Kaunas), 2007, 43 (11), www.medicina.kmu.lt

3.4 Demand and supply of formal care

3.4.1 Introduction

In Lithuania, no regular study on the demand of any type of formal care within the health care and social sector has been undertaken. The demand for LTC is approximated by the demographic and epidemiologic structure of the population at the national and regional levels. Until 1990, the main form of LTC was institutional care for the elderly (retired pensioners) and the physically and mentally disabled, and it was provided only by governmental care institutions. Home based LTC provided by the social system was a new phenomenon in Lithuania in the mid-90s and it is still in the process of constant development.

3.4.2 Institutional care

The information on institutional care presented below is divided according to the type of institutional care. First, information about residential care in the social and health care sectors is provided. Second, some data about semi-residential care within the social sector are presented.

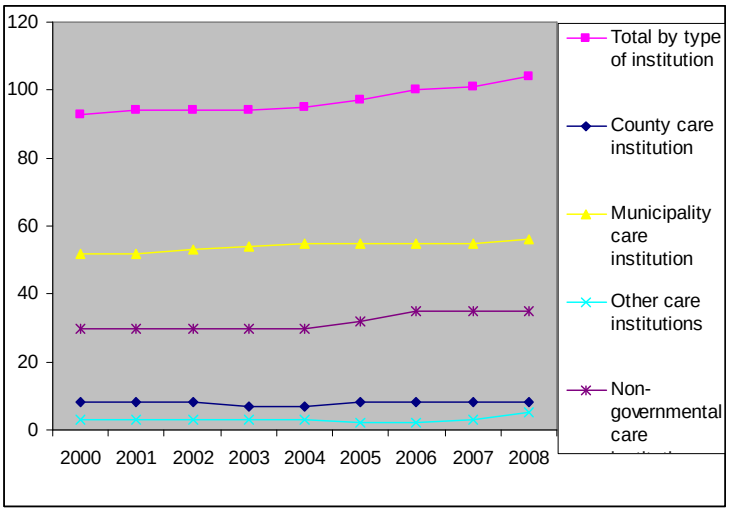
According to their subordination, social LTC institutions are divided into county institutions, municipal institutions, and non-governmental institutions. At the end of 2005, there were 194 long term social care institutions of various types and subordination, out of which:

- 66 were county subordinate social care institutions, of which 9 social institutions were for elderly people;
- 128 were social care institutions of other subordinations (municipal, non-governmental and others), out of which 88 were social care institutions for elderly people.

Figure 2 presents the changes in the number of LTC institutions for the elderly from 2000 to 2008. As shown, the overall supply of institutions has been slowly increasing. This slow growth is mainly attributed to the slow increase in non-governmental social care institutions.

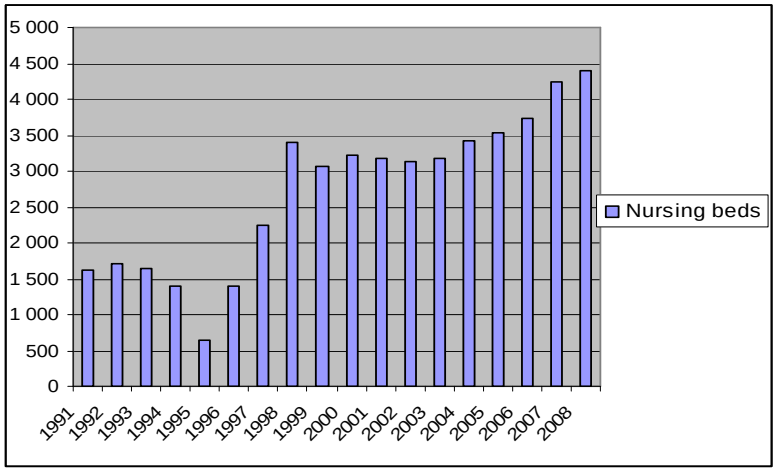
The supply of institutional care within the health care sector is also increasing. As shown in Figure 3, the number of nursing beds in stationary health care institutions has been increasing since 1996.

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



Source: National Lithuanian Statistical Office

Figure 3. Number of nursing beds in health care system



Source: Lithuanian National Statistical Office

Table 7. Number of elderly receiving social care at care institutions for the elderly

Item / Year	2006	2007	2008
Elderly (in persons)	4 700	4 674	4 758

Source: Lithuanian National Statistical Office

Table 7 shows that the number of people receiving social care at care institutions remained quite stable during the years 2006-2008. As shown in the next table, during the same period, the number of elderly people receiving social services at day centres increased by almost 71% (Table 8). Together with the increase in the use of the semi-residential type of LTC, the number of workers at day centres also increased during that period (Table 9). There is no data for the provision of LTC within the health care sector.

Table 8. Number of elderly receiving social services at day centers

Item / Year	2006	2007	2008
Elderly (in thousand persons)	14,4	15,2	24,6

Source: Lithuanian National Statistical Office

Table 9. Number of workers in day centers

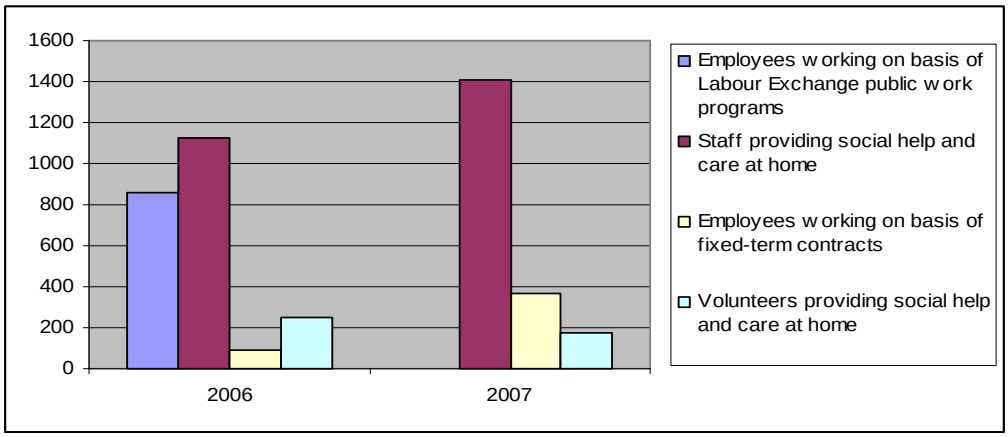
Item / Year	2006	2007	2008
Staff (in persons)	2 255	2 534	3 209

Source: Lithuanian National Statistical Office

3.4.3 Home care

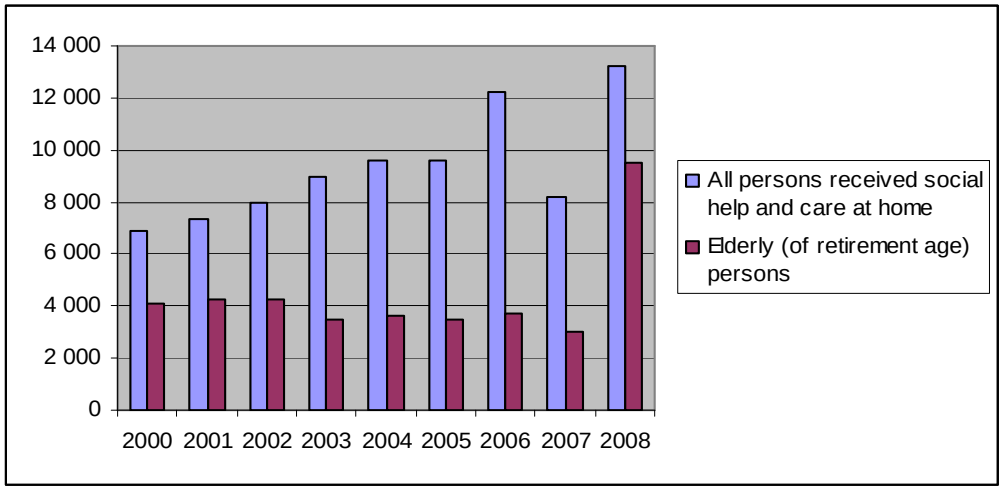
Caretakers and social workers provide long term home care, which includes nursing, shopping and help at home. The data available covers only the years 2006 and 2007 (Figure 4). The number of workers has slightly increased during this time period. However, it is impossible to conclude whether the path is increasing or stable based on such a small sample.

Figure 4. Caretakers and volunteers providing social help and care at home (persons)



Source: National Lithuanian Statistical Office

Figure 5. Persons receiving social services at home



Note: Retirement age for women in Lithuania is 60 years old and for men 6 months after 62.
Source: National Lithuanian Statistical Office

The number of people receiving social help and care at home increased between 2000 and 2008. The number of elderly people that receive social help and care at home remained relatively constant (between 3,000 – 4,000 people between 2000-2007). Only recently (2008) did this number increase rapidly (to almost 9,000 people) (Figure 5). Unfortunately, there is no information available on the supply of long term home care in 2008, so no explicit explanation can be attributed to such a change.

4. LTC policy

4.1 Policy goals

In Lithuania, there is no single legislation that is exclusively responsible for LTC issues. The main applicable statutory basis is the "Law on Social Services" of 19 January 2006 (No. X-493), the "Law on Health Care Institutions" of 6 June 1996 (No. I-1367), the "Law on State Social Assistance Benefits" of 29 November 1994 (No. I-675), the "Law on Health Insurance of 21 May 1996 (No. I-1343) and the "Law on Health care system" of 19 July 1994 (No. I-552).

Priority policies related to health care reforms are concentrated on increasing the efficiency, accessibility and quality of health care and services. Given the increase in the number of elderly people, medical expenses are growing and the public is becoming more concerned with health care and quality of services, which is why the government is trying to create equal opportunities for all citizens to access health care services.

According to *Social Report 2007-2008,* LTC is oriented towards shifting from institutional care to home based care. Thus the aim of the reform of 2002 was to reorganise the social services in such a way that the legal, administrative and financial conditions created provided an enabling environment for the provision and organization of social services in a community. They also aimed to make social assistance more efficient and encourage people to actively search for ways to provide long term home care, rather than using stationary means of social assistance. The second very important focus of the reform was the improvement of the quality of social services as well as the improvement in the financing of social services.

4.2 Integration policy

As there is no separate, unifying legislation for LTC in Lithuanian Law, some attempts for integrating services provided within the health and social services have been made. The approved Primary Healthcare Development Concept lists measures to improve the integration of care and social services into primary health care, to develop a range of LTC services in the home for elderly people.

4.3 Recent reforms and the current policy debate

The last reform of the Law on Social Services, which partially covers LTC services, entered into force in 2006. This reform clearly distributed the functions and the responsibilities among the ministry, counties and municipalities, encouraged competition between social services' providers and changed the order of social services' financing from directly financing an institution to directly financing social services. It also ensured that the payment of social services was differentiated according to the principle of social solidarity and that quality requirements for social services were settled.

The fragmentary changes in the LTC structure are implemented through several kinds of national/local programs. Their detailed description is presented in the *Social Report 2007-2008* which was prepared and published by the Lithuanian Ministry of Social Security and Labour. They concentrate on the increase in the competencies and quality of social workers (project on "Vocational Training of Social Workers and Assistants of Social Workers") or the increase in the infrastructure (Social Service Infrastructure Development Program).

From 2008, the **Social Care Standards** were supplemented together with the assessment criteria. These standards place the major focus on the human right to privacy, the preservation of dignity and honour, the harmonisation of emotional needs and the environment created for a person, the creation of favourable conditions for the self-expression and 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 process of being created, is the methodological assistance and sharing of "good practices" between institutions and workers of social care institutions. The purpose of granting a license is to ensure a high quality of services rendered by social care institutions.

5. Critical appraisal of the LTC system

The main critique of the LTC system in Lithuania is its division between the health care system and the social system and the weak integration of these two parts of LTC services. Several institutions function without the collaboration of other bodies in the same field. The creation of an LTC policy is in the initial stage. According to the Lithuanian Ministry of Health,[6] the cooperation of the health care and social security institutions should be strengthened. The experience of the European Union member states shows that in order to ensure conditions for elderly people to live as long as possible in their homes with dignity, the services must be integrated.

Second, to avoid an unreasonable increase in state expenses and a negative impact on macroeconomic stability, it is essential to define a separate system of funding for all LTC institutions and services. The rules in the financing system should also be clarified and stabilized.

There are major gaps in data availability on the provision and functioning of LTC in Lithuania. Information about patients is fragmentary and, in many parts of the sector, outdated. The data on funding LTC services is impossible to distinguish among other activities of the health care or social sectors. In the future, the lack of proper information may obstruct the precise planning of particular services that may be needed or funds required.

[6] http://www.sam.lt/go.php/eng/Health_Care_Reform/1066, Implementation Strategy of Health Care Reform's Aims and Objectives

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