

**CASE-STUDY
LITHUANIA**

Aleksandras Krisciunas

Lithuania

6

CASE-STUDY: LITHUANIA
*Aleksandras Krisciunas***1 General background data****1.1 Preamble**

The Republic of Lithuania is situated on the east coast of the Baltic Sea. It is bordered by Belarus to the east, Latvia to the north, and Poland and the Russian Federation's Kaliningrad enclave to the south. The capital, Vilnius, has a population of 580 000. In March 1990, Lithuania regained its independence from the USSR, and in September 1991 became a member of the United Nations.

A single chamber Parliament (Seimas) elected for a four-year term and a president elected for five years govern Lithuania. The country is administratively divided into ten districts, each of which is headed by a centrally appointed district governor. The districts are essentially administrative tiers of the central government with certain responsibilities in health and social care. There are additionally 56 local governments or municipalities, each with its municipal council, elected every three years (Lithuanian Health Programme, 1998).

The health care system in Lithuania has been in the process of a shift away from an integrated model towards a contract model of care. Significant changes in the system have been prompted by two major events: the appearance of a state health insurance system and enforcement of legislation redefining property rights and the status of health care institutions.

In Lithuania, the middle-aged population's longer average lifespan, and the progress in the field of medicine – which enables many people to survive following complicated illnesses and accidents – have greatly contributed to an increasing number of disabled and older people who have difficulty caring for themselves. Additionally, the low fertility rate in the country, 1.3 children born per woman, has also been a prime factor leading to ageing of the population. Currently, the disabled comprise 10%, and persons over 65 years of age 13.4%, of the total population. In terms of the informal care system, it is important to note that despite a recent increase in support for caring activities by governmental and nongovernmental organizations (e.g. Caritas and the Red Cross), most care provided for the disabled and elderly is still carried out by family, neighbours, friends, and volunteers.

LONG-TERM CARE

However, demographic changes (e.g. the rapid ageing of the population) and employment changes (e.g. the increase in the percentage of women in the labour force) will make it increasingly difficult for the informal care system to continue to carry such a high burden of caring responsibilities for the disabled and elderly.

Migration from rural to urban areas in Lithuania has also become an important LTC issue in Lithuania. First, with the migration of young individuals from rural areas to Lithuania's cities, there has been a reduction in the number of people in rural areas able to provide informal care. Secondly, because of the sudden increase in pre-retirement age employable individuals in urban areas, it is more difficult for young people in urban areas to find jobs. This has not only caused problems on the job market, but it has also encouraged elements of the young, urban population to seek the status of disabled in order to receive benefits from the Government. These factors demonstrate the growing long-term care needs in the country. This case study will attempt to look at the needs for LTC in Lithuania in more detail and will describe the health and social system currently in place. It is as yet unknown how the health and social systems will respond to the growth in needs and if this response will be adequate.

2 General health, social and LTC system

2.1 Basic income maintenance programmes

In Lithuania, all disabled and elderly people receive a disability or old-age pension. However, it should be emphasized that these pensions are insufficient to maintain reasonable living standards.

2.2 Organizational structure of decision-making

The Ministry of Health is responsible for the entire health care system policy. It is actively involved in drafting legal directives and issuing the consequent regulations for the sector. The Ministry of Health also has overall responsibility for the public health system's performance. Through the State Public Health Centre it manages the public health network including ten country public health centres with their local branches (in total, 50 institutions). The State Public Health Centre has subordinate bodies, which deal with prevention of communicable diseases, health education and other public health functions. Presented on the following three pages are background data on Lithuania, derived from international data bases.¹ These data include demography, vital statistics and epidemiology, economic data, and health expenditure.

¹ For consistency reasons data used in this section are taken from international data sources: UN, World Population Prospect, the 2000 revision (median variant); US Bureau of the Census, International Data Base; WHO, World Health Report 2001; World Bank, World Development Indicators Data Base; ILO, Yearbook of Labour Statistics, 2000; UNAIDS/WHO Working Group on HIV/AIDS, 2002.

2.3 Background data from international data bases

<i>Demography (year 2000)</i>	
<i>Population</i> (thousands)	3 696
<i>Land area</i> (sq km)	65 200
<i>Population density</i> (per sq km)	57
<i>Population growth rate</i> (% 2000-2005)	0
<i>Urban population</i> (%)	68
<i>Ethnic groups</i> (%)	
Lithuanian	80.6
Russian	8.7
Polish	7.0
Byelorussian	1.6
Other	2.1
<i>Religions</i>	
Roman Catholic (primarily), Lutheran, Russian Orthodox, Protestant, Evangelical Christian Baptist, Muslim, Jewish	
<i>Total adult literacy rate</i> (% in 1997)	100
<i>Age Structure</i> (%):	
0–14	19.4
15–24	14.4
60+	18.6
65+	13.4
80+	2.4

LONG-TERM CARE

Demography (continued)

Projections 65+ (%)

2025	19.7
2050	28.8

Sex ratio (males per female)

Total population	0.88
15-64	0.94
65+	0.51

Dependency Ratio:

Elderly dependency ratio in 2000 ²	22.4
Elderly dependency ratio in 2025	31.5

Vital statistics and epidemiology

Crude birth rate (per 1000 population) (2000) 8.8

Crude death rate (per 1000 population) (2001) 11.2

Mortality under age 5 (per 1000 births) (2001)

males	10.0
females	10.0

Probability of dying between 15–59 (per 1000) (2001)

males	270
females	96

² Elderly dependency ratio: the ratio of those aged 65 and over per 100 persons aged 20–64.

³ Parent support ratio: the ratio of those age 80 and over per 100 persons age 50–64.

Vital statistics and epidemiology (continued)

<i>Maternal mortality rate</i> (per 100 000 live births) (1995)	27
<i>Total fertility rate</i> (children born/woman) (2001)	1.3
<i>Estimated number of adults living with HIV/AIDS</i> (2001)	1300
<i>HIV/AIDS adult prevalence rate</i>	0.1
<i>Estimated number of children living with HIV/AIDS</i> (2001)	<100
<i>Estimated number of deaths due to AIDS</i> (2001)	<100
<i>Life expectancy at birth</i> (years) (2001)	
Total Population	72.9
Male	67.7
Female	77.9
<i>Life expectancy at age 60</i> (years) (2000)	
Total Population	20.0
Male	17.0
Female	22.0
<i>Healthy life expectancy (HALE) at birth (years)</i> (2001)	
Total Population	61.1
Male	56.9
Female	65.4
<i>Healthy life expectancy (HALE) at age 60</i> (2001)	
Total Population	12.9
Male	11.0
Female	14.8

LONG-TERM CARE

Economic data (year 2000)

<i>GDP – composition by sector</i> (%)	
Agriculture	10
Industry	33
Services	57
<i>Gross national income (GNI)</i> (\$PPP) ⁴	26 billion
<i>GNI – per capita</i> (\$PPP)	6980
<i>GDP – per capita</i> (\$USP)	2930
<i>GDP growth</i> (annual %) (1999–2000)	3.90
<i>Labour force participation</i> (% in 2000)	
Male	57.2
Female	47.2

Health expenditure (year 2000)

<i>% of GDP</i>	6.0
<i>Health expenditure per capita</i> (\$PPP) ⁴	420
<i>Health expenditure per capita</i> (US\$)	185

⁴ PPP=Purchasing power parity: the rates of currency conversion that equalize the purchasing power of different currencies by eliminating the differences in price levels between countries.

The Ministry of Health develops a public health care infrastructure by establishing state programmes aimed at the achievement of key health targets (including those detailed in the National Health Programme) and by making decisions together with the Ministries of Economy and Finance, on major investment projects. Regulation and control of worker safety are the responsibility of the Ministry of Social Security and Labour, while the Ministry of Health is in charge of the performance of occupational health care providers.

CASE-STUDY: LITHUANIA

In addition to the national health system, there are two parallel state-run health care systems that account for up to 2% of total public health care expenditure. One is run by the Ministry of Internal Affairs and serves the police and prisons. The other is run by the Ministry of Defence and provides health care services for military personnel. The Ministry of Finance funds health care delivery provided under the supervision of the Ministries of Defence and Internal Affairs.

The Ministry of Social Welfare and Labour is a separate ministry for social services and social service development. Until 1990, the main focus of social care was institutional care for the elderly and the physically and mentally disabled. During the last ten years, the number and variety of public care institutions increased, nongovernmental institutions appeared in the field, and development of non-institutional forms of care also began to receive attention.

In 1998, there were 29 nongovernmental care institutions (of a total of 90) for the elderly. Among voluntary non-governmental organizations, the Red Cross Society, the Caritas Federation, the Diabetic Association, the Association of the Blind and Visually Handicapped, and the Society of Chernobyl Victims have been influential in public debates. The church has a limited role in the health sector. The Roman Catholic Church manages a hospital in Vilnius. In addition, a few rural nursing homes are administered and financed by the Church.

Policy setting (defining priorities and types of services that should be provided) is very centralized. The Ministry of Health decides on the priorities at the national level. At the regional level, each of the ten districts has a district governor who is appointed by the Lithuanian Government and is responsible for implementation of state policy in a number of spheres including health care. The health care function is carried out by the position of District Physician. Some health care providers (district hospitals, specialized health care facilities) are governed by the district administration. Decision-making in regards to this network of providers requires participation of the Ministry of Health. The districts are in charge of implementation of the state health programmes in their respective regions.

Budget allocation in the past was controlled more on the local level. However, after the recent move towards a single payer insurance scheme, changes are developing in the control of health care budgets. This issue will be discussed in more detail in the chapter on the financing of health care in Lithuania. The licensing process has traditionally been centralized, but is moving towards being controlled more at the local level. Price setting is also very centralized. The Ministry of Health has maintained control over this aspect of the system.

In general, it can be said that the system is attempting to decentralize its functioning and control, with more provision responsibilities being allocated to local authorities. However, the results of decentralization will not be clearly evident until after a few years have passed.

LONG-TERM CARE

2.4 Financing and purchasing

Until 1997, the state health care system in Lithuania was mainly funded by taxes, with the majority of financial resources coming from local budgets and the remainder from the national (state) budget. Local budgets were (and still are) comprised of taxes collected within their respective areas (mainly a portion of personal income tax). Some taxes (e.g. property and land taxes) are collected locally. Others are transferred to the central government based on criteria such as local population size and density.

The historic rate of expenditure per capita was also an important criterion. This takes into account the actual social infrastructure within groups of municipalities. In effect, this was a situation somewhere between an incremental historical allocation and a weighted capitation formula. Municipalities decided how much of their annual budget would be spent on health care delivery. Their decision usually reflected previous spending on health care: a system of historical incrementalism. As a result of this financing mechanism, together with the application of a similar mechanism for social insurance funds that paid for rehabilitation institutions and sanatoria, geographical resource allocation was quite unequal.

A state health insurance scheme – the National Medical Social Service – was first implemented in Lithuania in 1991. The Law on State Social Insurance laid the legal foundation for a social insurance system and principles of health insurance, and increased public participation in health care costs. Between 1991 and 1995, the law was limited in scope, covering pharmaceuticals and convalescence costs that were partly reimbursed. A 1994 law on a health protection system defined the role of the state and local governments in health care administration. Laws passed in 1996 on health insurance and health care institutions created the basis for introducing health insurance and the accreditation and legal status of institutions.

National State Insurance was an obligatory, single-insurer scheme. Under this scheme, payments were made to defray expenses of preventive and curative medical treatment. These included reimbursement of the costs of pharmaceuticals prescribed during outpatient treatment, and reimbursement of the costs of sanatorium vouchers. This scheme also reimbursed blood donations and transportation, as well as health care expenses of the disabled. This scheme was administered by the State Social Insurance Council and supervised by a tripartite council consisting of representatives of the Government, the trade unions and employers' organizations. In 1992, the State Patient Fund, a type of purchasing agency under Ministry of Health supervision was established by the Government, and was financed by the Ministry of Health. Between 1992 and 1996, the State Patient Fund's role was to finance the current operating costs of health care institutions on the basis of contracts with prospective payments.

CASE-STUDY: LITHUANIA

During the prolonged process of development of the current Health Insurance Law, various approaches to health insurance, including some of the ideas implemented between 1991 and 1996, as described above, were considered. The idea that prevailed was that of a national insurance scheme, financed through a fund that was separate from the national budget. The Law on Health Insurance was adopted in May 1996 and implemented in 1997, bringing the functions and responsibilities of the State Social Insurance Agency to the Patient Fund, alternatively known as the State Health Insurance Fund, in accordance with the 1996 Law on State Health Insurance. This law established a separate social insurance scheme covering all health care expenditures, to be administered by the State Patient Fund and its ten regional branches, the territorial patient funds (one such fund for each district), constrained by the national budget.

The State Social Insurance Agency is responsible for the provision of pension benefits, as well as maternity and sick leave benefits. In addition, it is responsible for the collection of all social insurance contributions. These contributions finance the three branches of social insurance: pensions, maternity and sick leave benefits; national health insurance administered by the State Patient Fund and the territorial funds; and unemployment benefits administered by the Labour Exchange (UNDP, 1999).

In terms of the sources of funding for the health system in Lithuania, employers transfer a certain percentage of personal income tax and contribute a certain percentage of the payroll tax. Self-employed persons contribute a proportion of their personal income tax. Farmers cover themselves and their adult family members by paying a percentage of their declared income. The exact rate of contribution is set annually by the Parliament. The State covers children up to the age of 18, students, beneficiaries of social assistance and social insurance cash benefits, and persons with certain illnesses. The state budget contributes a per capita payment (annually approved by the Parliament) on their behalf.

Table 1. National public finance (%)

Source of finance	1980	1990	1994	1995	1996	1997	1998
National budget	100	100	85	83	81	16	10
State insurance	—	—	15	17	19	84	90

Source: Department of Statistics (European Observatory on Health Care Systems, 2000).

LONG-TERM CARE

Although the main responsibility for payment for health care has been transferred to the State Patient Fund, general taxation also plays a major role in financing social insurance. In 1998, only about 20% of the State Patient Fund revenues were derived from payroll taxes and contributions of self-employed, as shown in Table 2 (European Observatory on Health Care Systems, 2000). The remainder involves deductions from income taxes or state budget transfers. Lithuania has therefore chosen a mixed financing system based on social insurance contributions and taxation. This financing system represents a compromise between the proponents of tax-based and those of insurance-based systems.

Financing of health care through social insurance accelerated dramatically from 1997 following implementation of the health insurance legislation. Yet, since some very important health care functions such as public health, infrastructure investments, national programmes in health protection and acute care, are still financed directly through local and national budgets, some reduction of the share of health insurance in health care financing may be expected in the future.

Table 2. Sources of state health insurance revenue (1998)

	<i>Million Litas*</i>	<i>%</i>
<i>Employees contribution to health insurance (3% pay roll tax)</i>	363.1	19.8
<i>Employer's contribution to health insurance (equal to 30% of payroll)</i>	1 012.7	55.1
<i>Earmarked contributions of self-employed</i>	7.1	0.4
<i>Contributions from the national budget</i>	444.6	24.2
<i>Other revenue</i>	3.3	0.2
<i>Total</i>	1 837.1	100.0

Source: State Patient Fund Database.

* 1 Lita = 0.25 US\$

CASE-STUDY: LITHUANIA

In designing the new health insurance system, a key concern was to produce an arrangement that would minimize administrative costs. The State Patient Fund is an entity accountable to the Prime Minister, while the Ministry of Health has maintained control of pricing health care services. In addition, it was decided that administrative responsibilities as well as costs related to contribution collection should stay mainly with other agencies (tax inspection and State Social Insurance Agency). The State Patient Fund is therefore responsible only for collection of contributions of the self-employed.

As this is a rather problematic area in emerging market economies, it may be changed in the near future. According to proposals under discussion, collection of contributions of the self-employed should be the responsibility of tax authorities or State Social Insurance Agency.

Table 3 shows the rough structure of total health care finance for 1998, which can be used as an approximation for sources of finance (European Observatory on Health Care Systems, 2000).

Table 3. Percentage of main sources of finance (1998)

	<i>Million Lit</i>	<i>% of total</i>	<i>% of GDP</i>
Public	2078	73.6	4.9
Taxes	209	7.4	0.5
State insurance	1869	66.2	4.4
Private	657	23.2	1.5
External charity	90	3.2	0.2
Total	2825	100.0	6.6

Source: Department of Statistics.
Sources of finance are approximated by expenditure figures for each source.

LONG-TERM CARE

It should be noted that the figure appearing in Table 3 for 'state insurance' also includes taxation revenues, which have been allocated to the health insurance system. According to legislation, the Social Health Insurance Fund (SHIF) is independent of the national budget.

The 'private' category refers to out-of-pocket expenditures and payment of supplementary (voluntary) health insurance premiums, and amounts to nearly a quarter of the total, while external charity represents just over 3%.

The insurance scheme covers primary care, with the municipalities holding the responsibility for providing this primary health care to their local populations. Since 1997 the funding for hospitals has been by number of patients. Hospitals receive money from regional patient accounts for the number of days allocated for the treatment of a particular disease.

In 1995, changes in regulations were introduced. These regulations concern the reimbursement of registered drugs (by the government) and calculation of their reference prices (in Lithuania these are called 'basic prices'). The Government reimburses patients for drug purchases.

2.5 Services delivery system

Until 1996, local health care infrastructure was organized and financed in a pyramidal fashion. Municipal hospitals were at the top, below which were specialized local medical institutions and village hospitals, followed by outpatient clinics and, finally, small clinics at the bottom.

The picture of the outpatient institutions network has since changed significantly as a result of the process of separation of facilities (most commonly, outpatient clinic services) from hospitals. Currently, various outpatient models are in use in the municipalities.

A decentralization process that subsumed health care facilities under district or municipality control has been under way since 1997. The municipalities are now responsible for providing primary health care to their local populations. They have been granted ownership for outpatient facilities and nursing homes.

The position of Municipality Physician has been established with supervisory and decision-making authority in the area of primary health care. Moreover, municipalities have a wide range of responsibilities in the implementation of local health programmes and improvement of public health activities.

CASE-STUDY: LITHUANIA

District authorities currently lack the administrative capacity to adequately operate their care systems. Moreover, because the health system infrastructure was historically developed around the five major cities, different districts have significantly different administrative capabilities. At the same time, municipalities with increasing responsibilities in local health care provision have lost the financial tools that would allow them to implement their decisions as the newly established state health insurance fund assumed responsibility for financing health care.

As mentioned previously, the municipalities are currently responsible for providing primary health care to their local populations. The dominant pattern of primary care provision is through independent doctors and health centres/clinics. Since 1997, the majority of primary care services has been provided by primary health care centres specializing in primary health care provision, as opposed to outpatient clinics, which provide both primary and secondary outpatient services.

Additionally, primary health care services are delivered in primary health care centres, general practitioner's surgeries, both school and community clinics (paramedical centres), out-patient clinics, women's consultation clinics, infirmaries, as well as by the ambulance service (stations and divisions). In terms of staffing, it has been agreed that a primary health care team requires the participation of a gynaecologist-obstetrician, surgeon, and a psychiatrist, together with a general practitioner. The nurses in the primary care teams carry out the home health care. There are great disparities between health care provision in urban and rural areas.

In 1997, Lithuanian residents were asked to choose a primary health care facility where they wished to receive primary care. Through the registration process, the outpatient clinics established lists of their catchment populations. At the same time, a major portion of the population had an opportunity to make a choice upon registration of their particular general practitioner, internist or pediatrician. At present, patients have the right to choose any physician employed by the primary health care facility, and to change physicians once a year. In 1998, 92% of the population was registered with a primary health care institution.

Development of the general practitioner gatekeeping function is proclaimed to be an important goal of the new approach to primary health care. Patients require a referral signed by the physician performing the role of their general practitioner in order to receive specialist care. In 1998 more than 20% of consultations with specialists were still provided without referrals. However, this represents a significant improvement over 1996 when 70% of consultations with specialists were provided without referrals. Referrals are also required for planned admissions to hospitals. In the absence of a referral, inpatient services must be paid for out-of-pocket.

LONG-TERM CARE

Private primary health care is still not very widespread, although there are some private gynaecologists, internists, and most of all dentists. For the most part, private primary care takes the form of single or small group physician-owned practices. In many communities, physicians often lease clinic space from public health care institutions.

There were 566 private dental practices with 1901 employees in 1998. The share of dentists working exclusively as private providers is high (697 dentists or 79% of the total), in contrast to other medical specialties (179 physicians, or less than 26% of total) (Ministry of Health, 1998).

An additional innovation within the primary health care sector involves implementation of the concept of community mental health services. Mental health centres in municipalities are currently in the process of being established. Each of these is to be staffed by a team comprised of three psychiatrists, one clinical psychologist, three mental health nurses, and two social workers.

Paramedical centres or stations are based in rural areas and employ one physician's assistant and/or one midwife. There are about 1000 such centres in rural Lithuania. They provide some routine health care, first aid in emergencies, home nursing, perinatal obstetric care, and also supply non-prescription drugs. Most of these centres are administratively linked to an out-patient clinic.

An out-patient clinic is a group practice most commonly found in small towns, which is mostly responsible for providing unspecialized primary care. It includes a general practitioner and/or an internist, a midwife, a dentist, and a pediatrician. Currently, there are 226 outpatient clinics in all of Lithuania.

At the present time, some of the physicians working in outpatient clinics participate in general practice retraining programmes, which are provided by municipalities. Under current regulations, catchment populations corresponding to these specialties are as follows: for a general practitioner, 500–2000; for an internist, 500–2000; for a pediatrician, 200–800.

Outpatient clinics in large towns employ 10–20 different kinds of specialist physicians. They are equipped with X-ray equipment, ultrasound scanners and other diagnostic technology. There are approximately 140 such outpatient clinics throughout the country.

They are responsible for almost all primary and secondary outpatient care in the towns where they are based, and secondary out-patient care to the rural population. Recently, outpatient surgery has begun to be offered by larger outpatient clinics.

CASE-STUDY: LITHUANIA

The medical/social expertise in Lithuania consists of two structural levels. The National Medical Social Expertise Commission and territorial medical social expertise commissions. The territorial commissions generally consist of an internist, a surgeon and a neurologist and function in all district centres and major towns; in addition, ophthalmologic and psychiatric territorial commissions operate in Vilnius and Kaunas. Medical social expertise commissions of general profile serve several districts each.

Municipalities have been granted ownership for outpatient facilities and nursing homes. Municipalities are engaged in operating small and medium size hospitals within their localities, in accordance with legislation, which has delegated this function to them. This process has not yet been completed because there are still discussions on who (districts or municipalities) should be responsible for medium-sized hospitals, and how administrative responsibilities should be distributed between the different levels.

According to the social services law adopted in 1996, municipalities have the major responsibility for social service provision. Social services include institutional care (for the elderly, disabled, children with special needs (e.g. orphans)) and some home care. Social workers and nurses play a leading role (especially social workers) in social service provision.

2.4.1 Auspices of service providers

Currently, the vast majority of Lithuanian health care institutions are non-profit. Public health care institutions are financed by the State Health Insurance Fund (SHIF). Property rights and administrative functions fall under the jurisdiction of the Central Government (Ministry of Health), its ten country branches (the country administration), and the 56 municipalities.

The vast majority of primary care provision and hospital care is governmental. Most home care providers are also governmental, with some coming from the NGO sector. In addition to publicly provided health care, a private sector has developed, providing mostly outpatient health care services which are paid out-of-pocket.

The private sector plays a significant role in dental care, cosmetic surgery, psychotherapy and gynaecology. In 1995, the private sector also accounted for 100 % of wholesale and 73 % of retail trade in pharmaceuticals. No hospitals have been privatized, and there are no official plans to privatize outpatient clinics or larger hospitals.

LONG-TERM CARE

Private health insurance is permitted. There are a few private insurance companies, mainly dealing with coverage of health care expenditures of Lithuanian citizens during foreign travel and for foreigners residing in Lithuania.

There are two competing associations of medical professionals: the Physicians Association and the Association of Medical Professionals. Specialized professional societies of physicians, dentists, pharmacists, public health specialists and others deal with professional standards and continuing education of their members.

In 1998, there were 29 nongovernmental care institutions for the elderly, while governmental public care institutions for the elderly were subordinated to municipal and district administrations. A few district care homes housed 1771 people, while 1701 elderly persons lived in 50 municipal care homes. The share of residents living in nongovernmental care institutions for the elderly doubled since 1995, accounting for 14% of the total number of persons in care institutions.

2.6 Human resources and training

2.6.1 Doctors

In Lithuania in 1998, there were 3.5 physicians per 1000 inhabitants (European Observatory on Health Care Systems, 2000). They provide care in the homes of disabled individuals who have qualified for such care.

There is a serious problem of unequal distribution of medical personnel throughout the country. The density of physicians differs by a factor of three geographically, that of paramedical personnel differs by more than five.

In 1998, about 4650 physicians, including 1168 dentists and 10 500 nurses (39% of total employed nurses) worked in public primary health care institutions (European Observatory on Health Care Systems, 2000). This constitutes about 32% of the total number of employed physicians.

Physicians are trained at Kaunas University of Medicine and Vilnius University. In 1992, the formal training of physicians was extended to include residency-training programmes following the six-year undergraduate training period.

The present programmes of medical training cover undergraduate and postgraduate levels, as follows:

- 6 years** MD diploma after undergraduate training
- 1 year** Obligatory clinical practice for all physicians (assistant physicians)
- 2–4 years** Residency training programmes in broad specialties (primary and secondary health care provider)
- 2–3 years** Residency training programmes in narrow subspecialties (secondary and tertiary health care provider).

2.6.2 Nurses

There have been a number of ongoing changes in nurses' training. These changes stress health promotion activities and community care. There are also curriculum changes towards increasing the role of qualified nurses. Nurses are increasingly promoted as semi-independent health practitioners, and their formal training lasts 3.5 years. There is also a university degree programme at Kaunas University of Medicine with about 20 graduates per year. There is a Nurses' Retraining Centre in Vilnius with a few local branches throughout the country.

2.6.3 Social Workers

Social workers are populous in Lithuania, but increasing attention to the needs of the disabled and elderly has created a demand for more social workers. The formal training of professionals in this field has started at both university and junior college levels. The fact that social workers' functions are as yet poorly defined remains the main obstacle to the development of this profession.

There are six junior colleges for the training of midwives and social workers in Lithuania. The Ministry of Education administers them, and together with the Ministry of Health is responsible for curriculum development. Applicants must have completed 12 years of general school education, must pass a competitive entrance examination and attend an interview.

LONG-TERM CARE

2.6.4 Volunteers

Volunteers are often the providers of social care for the disabled and elderly. However, the system of volunteers in Lithuania is not well developed.

3 *Summary of LTC provision*

Community-based (non-institutional) long-term care provided by the social system is a new phenomenon in Lithuania. According to the Social Services Law adopted in 1996, municipalities have the major responsibility for social services provision.

Carers and social workers provide non-institutional home care nursing, including shopping and housekeeping services. In 1997, more than 2200 carers were involved in care delivery throughout the country, but this is undoubtedly insufficient to meet the current need.

The development of funding for community-based (non-institutional) long-term care only came into being with the adoption of the Social Services Law. Unfortunately, despite the adoption of this law, home care is only provided for the most disabled groups and the funding is currently insufficient to meet the need.

In 1998, 9 million Litas were spent on home care versus 209 million Litas for institutional care. In spite of support by nongovernmental charities (for example, Caritas and the Red Cross), social care in the community remains an activity carried out mainly by families, neighbours, friends, and volunteers.

In addition to informal caregivers, general physicians, nurses and social workers also provide care for disabled people in the home. State medical social experts are engaged in the setting of disability.

One of the main goals is to determine disability in accordance with the degree of its severity for persons starting from 16 years of age (under 16, the ability grouping is performed by institutions of children's health care). Doctor experts evaluate the level of patients' functional impairment, severity, causes of disability, rehabilitation needs and requirements of the disabled, integration of disabled persons into the society, and need for home care.

Long-term care services are supplied by both governmental and NGO providers. Elements of the care for the severely disabled are as follows:

- general health care and management of chronic diseases (under the auspices of the health system);
- personal care (grooming, bathing, meals);
- household assistance (cleaning, laundry, shopping);
- physical adaptation of the home to meet the needs of disabled persons;
- provision of supplies, assistive devices, equipment and drugs;
- palliative care; and
- provision of information to patient's family

Caregivers are trained at the junior colleges and universities. Different districts have significantly different capacities for long-term care provision. Differences also exist between rural and urban populations. Community-based long-term care is provided by both the health and social systems. As noted earlier, small outpatient clinics are based in rural areas. They employ a physician's assistant and a midwife, and provide routine health care, home nursing and supply some drugs. Social aid is provided by the municipal social workers.

In urban areas there are larger outpatient clinics. They employ a general practitioner or internist, a midwife, a dentist, and a pediatrician. They are responsible for almost all primary outpatient care, including home care. General practitioners evaluate the needs for institutional care.

3.1 Institutional LTC

Until 1990, the main form of long-term care was institutional care for the elderly (retired pensioners) and the physically and mentally disabled, provided only by governmental care institutions. During the last ten years the number and variety of care institutions has increased, nongovernmental care institutions have appeared and the development of non-institutional forms of care have begun to receive attention as well (see Table 4, following page).

LONG-TERM CARE

Table 4. Institutional Long Term Care

Long Term Services	Year			
	1995	1996	1997	1998
Institutions for elderly	64	70	80	70
<i>Elderly residents</i>	3282	3454	3726	3454
Nursing homes for disabled adults	20	21	22	21
<i>Disabled adult residents</i>	4365	4678	4832	4678
Infants' homes	6	6	6	6
<i>Residents</i>	479	516	510	506
Boarding schools of general education	9	9	9	9
<i>Orphans and children residents without parental support</i>	751	648	663	833
Special boarding schools	53	55	57	55
<i>Orphans and children residents without parental support</i>	968	965	928	831
Care homes for disabled children	5	7	6	5
<i>Residents</i>	822	865	840	844
Child care homes	46	49	57	64
<i>Children residents</i>	3528	3587	3818	3905
Child care group centres	–	40	44	47
<i>Residents</i>	–	1227	1792	1876
Families	36	39	46	39
<i>Foster-children</i>	279	261	345	320
Temporary child care homes	–	–	8	15
<i>Residents</i>	–	–	156	243
Lodging-houses, total	10	11	13	15
<i>Lodgers per year</i>	608	845	925	1089

Source: Department of Statistics (European Observatory on Health Care Systems, 2000).

CASE-STUDY: LITHUANIA

As mentioned previously, in 1998 there were 29 nongovernmental care institutions for the elderly; the share of residents living in such institutions has doubled since 1995, accounting for 14% of the total number of persons in care institutions. Governmental public care institutions for the elderly were subordinated to municipal/district administrations – a few district and fifty municipal care homes housed 1771 and 1701 elderly persons, respectively.

Of 4173 residents in institutions for the elderly, 76% were over age 65. Approximately 30% of the residents in institutions for disabled adults receive intensive nursing care. State or municipal budgets cover 70% of residential institutions for the elderly. User fees cover approximately 30% of the costs of care in homes for the elderly, with residents paying 80% from their retirement or disability pensions. The remaining costs are covered by state or municipal budgets.

After treatment in a hospital for an acute event such as a stroke, an individual may receive care in an infirmary before he/she returns to the community. The cost of care in the infirmary is covered by municipal budgets for a specific period of time (i.e. three months). After this period of time expires, the infirmary services must be paid for out-of-pocket.

The share of municipal child care homes has increased relative to the number of district child care homes. In 1998, almost one quarter of the total number of children in institutions (821 children) lived in 19 municipal childcare homes. There are 17 nongovernmental child care homes, representing a fourfold increase since 1995, and housing 10% of children in institutions.

In view of the fact that many admissions in rural municipal hospitals were for nursing purposes, a network of nursing inpatient facilities began forming, based mainly in existing small hospitals in the rural areas. Some social care is provided by the health care system. At the present time, social workers are employed by the nursing hospitals. In 1997, more than 30% of the staff in social care institutions were medical personnel. Coordination of the two systems of care, subordinated to two different ministries, is still rather poor.

4 General questions pertinent to LTC development

4.1 Present and future needs for long-term care, and gaps between needs and provision of services

General morbidity, including virus and influenza type illnesses, was 498.2 cases per 1000 adults in 1997. The incidence of cardiovascular diseases in 1997 was 181.4 cases per 1000 inhabitants (MoH, 1998).

LONG-TERM CARE

The incidence and prevalence of malignant neoplasms is gradually increasing, while the number of deaths is quite stable. In 1997, 12 849 new cases of diseases were registered; 51 551 people had cancer. During the last few years, among males the incidence of lung and stomach cancer has decreased, but the incidence of prostate, skin, and oral cavity cancer has increased. The incidence of skin cancer is increasing most rapidly among women (MoH, 1998).

The incidence of tuberculosis is increasing. In 1997, 2926 new cases of tuberculosis (including relapses) were registered, i.e. 79 cases per 100 000 inhabitants. The main problems are the high rate of incidence of smear-positive lung tuberculosis and antibiotic-resistant cases, which are caused by noncompliant patients and discontinuity of treatment (MoH, 1998). Alcohol and drug abuse have a negative influence on the health of the population. The incidence of alcoholic psychosis has increased. During the last few years, it has recently stabilized, but the prevalence of drug abuse has increased significantly.

Over the last seven years, suicide has become a serious social problem for Lithuania. The overall suicide rate steadily increased from 1991 to 1996. Suicides among the rural population increased sharply in 1970–1980 (by 75%) and much less in the towns (by 20%). Since 1990, the trend has to some extent reversed; urban suicides have jumped by 64%, while the rural suicide rate grew by 75%. In 1996, the suicide rate hit a mark previously unseen in Lithuania: 46.4 per 100 000 (1723 suicides that year). This indicator was the highest in Europe and among all countries submitting data on mortality patterns to the World Health Organization (European Observatory on Health Care Systems, 2000).

A more focused estimate of the number of the disabled was calculated by analysing the following known categories of individuals:

■ Persons receiving disability pensions	38.3%
■ Persons receiving old-age pensions	21.5%
■ Persons aged 80–84	15.6%
■ Persons aged 85 and over	11.4%
■ Disabled children	2.4%
■ Other categories	10.8%

This analysis revealed that the total number of disabled in Lithuania exceeds 350 000 and comprises about 10% of the entire population (Kasinskienė, Klimavičius & Mikolajenko, 1998).

One of the major issues in the public agenda in relation to the care of these disabled and the elderly is defining the balance between community and institutional services both from the point of view of cost and quality of life. Currently, there is a lack of non-institutional services for those in need of LTC. Maintaining the disabled and the elderly in their homes and out of institutions as long as possible is most conducive to healthy recuperation, both physically and emotionally. It also costs both the family and the state considerably less. There also needs to be increased funding for training for LTC personnel (i.e. social workers, nurses, etc.). Long-term care of the disabled and elderly persons, their social integration, and the improvement of their quality of life is in Lithuania a complicated problem in many aspects: juridical, medical, social, economic, and ethical.

4.2 What resources (structures, manpower, organizations) at the national and local levels may be utilized to promote LTC provision?

LTC could be promoted as an important aspect of the new state medical insurance plan. Decentralizing financing leading to more spending opportunity at local levels could possibly encourage community based long-term care.

4.3 Developments that will impact on LTC and concluding remarks

Prior to the restoration of independence, the health care system in Lithuania, as part of the former Soviet system, was self-sufficient, in terms of availability of qualified and specialized medical care including microsurgery, cardiac surgery and organ transplants. Decision-making and funding were centralized. Basic requirements and guidelines were formed in Moscow, and then budgets were distributed for the entire health care system of the Soviet Union. The Lithuanian Ministry of Health was required to carry out these decisions, but it was also allowed to act independently within certain limits. Primary health care was organized on a regional-administrative principle and was carried out in outpatient facilities.

There was a nationwide network of inpatient assistance. Each region had a central regional hospital and district hospitals. There were also various types of 'closed' hospitals and outpatient clinics where privileged people ('party nomenclature') and VIPs of different departments and enterprises were treated. Quality of services in these facilities was much higher by Soviet standards.

LONG-TERM CARE

The pre-independence health care system had its positive as well as negative aspects:

- **Positive aspects:** patients received relatively free medical care on demand; employment and salaries were guaranteed for medical personnel; there were regular mass preventive health examinations for adults and children; there was free health resort treatment and strong links were developed between primary health care institutions and inpatient departments where patients received more comprehensive testing and treatment.
- **Negative aspects:** the public was given the impression that medical care was free, even though it was paid for through taxes; patients had no knowledge of the tax funds which were designated for medical care; patients' choices of medical institutions or doctors were limited; the salaries of medical personnel were not linked to the quality and quantity of services performed; there was no competition and therefore no advancement; budgets were not used rationally and resulted in an excess of medical personnel and hospital beds and a lack of modern equipment and medicines. Primary health care was not a focal point. Instead of providing comprehensive medical care, primary care staff were dispatchers referring patients to specialists, or to the hospital when confronted with medical situations that were slightly more complex. Although the emphasis was on equal rights to health care; taxpayers' money supported special 'closed' hospitals serving privileged individuals.

As such, Lithuania inherited a typical Soviet model of health care provision, featuring excessive centralization and minimal freedom and opportunity for doctors to act and patients to choose. There was a surplus of hospital beds, as well as a shortage of medicines and a lack of focus on primary and public health care. Salaries in the health sector were on the whole very low. However, in terms of access to health care, medical institutions were fairly evenly distributed throughout the country, while public transportation was cheap and well developed. The majority of the population was immunized against major diseases. There was adequate control over infectious diseases, and the Lithuanian population was in better health compared with other former Soviet republics.

CASE-STUDY: LITHUANIA

Since 1990, the first task of the health care system has been to guarantee basic medical services (immunization, children's health care and the provision of emergency and vital assistance). In October 1991, a Lithuanian Supreme Council decision was made on the formulation and implementation of a national health model.

Processes, which are still being implemented such as insurance provision, the implementation of medical training programmes, etc., were envisaged as part of this concept. The concept included the development of an active state health care policy with emphasis on primary and preventive health care. It considers the development of a comprehensive legal framework for health care vital to successful reforms.

Difficult socioeconomic circumstances in Lithuania forecast augmentation of the numbers of disabled. The need for long term-care in Lithuania is gradually increasing.

The following key strategic steps in social policy development have been taken:

- 1. The act concerning protecting the rights of the disabled was adopted in 1990.*
- 2. The law of social integration of the disabled was adopted in 1991.*
- 3. The act concerning proclamation of the year of the disabled in 1996 was adopted in 1995.*

Organizations of the disabled, particularly on the national level, began to actively participate in this process. In 1992, the Lithuanian Council for affairs of the disabled was established. The Council had two main purposes:

- 1. To manage several million Litās (24 million Litās in the year 2000) given directly by the Government for implementation of projects from the different members of the organizations.*
- 2. To publicize the problems of the disabled in order to increase public awareness.*

LONG-TERM CARE

According to Lithuanian rehabilitation authorities, the following model of the structure of the LTC system should be developed. It includes 13 key components that are present but need to be developed:

1. *Legal support*
2. *Medical rehabilitation*
3. *Vocational rehabilitation*
4. *Education of specialists*
5. *Compensatory techniques, orthopaedic means*
6. *Environmental modification*
7. *Culture, sports, recreation, religion*
8. *Information*
9. *Transport*
10. *Social services*
11. *Benefits*
12. *Training of specialists*
13. *Medical social expertise*

During the period of 1992–2000, this system began to develop. There has been disproportionate development. For instance, environmental modification has not yet been developed. Nonetheless, many rehabilitation institutions (60 units with 6000 beds) have been established, and more than 70 types of specialized technical aids and 250 types of prosthetic and orthopaedic aids have been produced. Approximately half of the municipalities have started to actively participate in this process.

The greatest progress has been achieved within the legal system. During the same period there were roughly 70 different laws and regulations adopted that all, essentially, deal with implementation of the law on social integration of the disabled.

LTC issues are more actively being dealt with in the European PHARE project, the World Bank, and other international programmes.

The major barriers to implementing long-term care services include:

- ***Psychological resistance to social integration.
There is a need to raise awareness about the disabled,
their rights, their needs, and their potential.***
- ***Financial resources are insufficient because
of economic difficulties.***
- ***Activities of local authorities are still insufficient.***
- ***Lack of skilled specialists.***
- ***Lack of experience in creating a LTC system.***

We need to work towards the provision of programmes run by multidisciplinary teams of professionals for early detection, assessment, and treatment of impairment. This may prevent, reduce or eliminate the disabling effects of some illnesses. Such programmes should ensure the full participation of persons with disabilities and their families at the individual level, and of organizations of persons with disabilities at the planning and evaluation level.

Local community workers should be trained to participate in areas such as early detection of impairment, the provision of primary assistance, and referral to appropriate services. We should ensure that individuals with disabilities, particularly infants and children, are provided with the same level of medical care within the same system as other members of the society, that persons with disabilities are provided with all standard treatment and medication needed to maintain or improve their level of functioning, and the rehabilitation services need to reach and sustain their optimum level of independence and functioning.

LONG-TERM CARE

The priority areas in long-term care promotion in Lithuania are:

- *Increasing community awareness of people with disabilities.*
- *Advocating for social integration in the community.*
- *Enacting more effective laws for people with disabilities.*
- *Providing enforcement mechanisms for disability laws.*
- *Developing a philosophy for social service delivery.*
- *Developing independent advocacy agencies to represent all Lithuanians with disabilities.*
- *Establishing Independent Living Centres.*
- *Developing barrier-free designs for urban and community buildings.*
- *Setting up group homes to enable the disabled to live in the community.*
- *Supporting the creation of a rehabilitation system.*
- *Promoting more participation of the disabled in health care decision-making*

References

European Observatory on Health Care Systems (2000) *Health Care Systems in Transition. Lithuania*. Copenhagen, European Observatory on Health Care Systems.

Kasinskienė J, Klimavičius R, Mikolajenko L (1998) *Data on the people for the first time recognized as disabled and repeatedly examined in the country in 1997*. Vilnius, Republic of Lithuania, Ministry of Social Security & Labour, the State Medical Social Expertise Commission.

Lithuanian Health Programme 1997–2010: adopted by the Parliament on 2nd July, 1998, Vilnius (Resolution No. VII-833).

Ministry of Health of Lithuania (1998) *The Health of Lithuanian Population and Activities of Health Care Institutions*. Vilnius, The Lithuanian Health Information Centre.

United Nations Development Programme (1999) *Lithuanian Human Development*. UNDP, Vilnius.

