Deinstitutionalization of long term social care system in Lithuania in the context of EU data

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Abstract
In light of the rapid population ageing, long term social care policies have undergone significant reforms in most European countries. The importance of developing efficient long term social care strategies are proved by statistical data on elderly population and care needs. In EU 65+ individuals composed 18.9% of total population in 2015. The Lithuania is close to EU average – 19.0% of population was 65+ in defined year and statistical data shows an increasing need for long term social care in this age group in the country. The aim of the article is to analyse long term social care situation and deinstitutionalization in Lithuania in the context of EU data. The article is based on statistical, secondary data, legal documents and scientific literature analysis and encompasses comparative perspective, providing examples from Latvia and Slovakia. Deinstitutionalization process in Lithuania has had a positive effect on increasing the number of persons who received home help and social services at home and decreasing the number of recipients of social care benefits. However, deinstitutionalization process is complicated and faces challenges related with expenditure, coverage, service quality. EU level analysis declares that the country has little social insurance against long term care risks, low public spending on formal care, and high use of informal care. Comparing with other countries, Lithuania has higher expenditure than Latvia and Slovakia, but lower coverage rate than Slovakia. Nevertheless, all three countries fall in the same tier and follow the same care model defined by Timonen (2005).

Keywords: elderly, long term social care, expenditure, coverage, deinstitutionalization
Introduction
The European Commission has shown significant leadership in encouraging all countries to plan for the changing age demographics throughout the EU, by sharing good practices, developing related policies and legislation and encouraging members to address basic human rights requirements by providing adequate access to affordable quality care (Long term care in Europe, 2017). World Health Organization (WHO) acknowledges that aging societies rise a big challenges to EU countries as with rising life expectancy people expect not only to live longer but to be healthy as well (World Report on Healthy Ageing, 2015). However, research data shows that the need for social and health services is increasing, elderly use them more often in comparison with other age groups and prefer to get more diverse services (Aguonyte et al., 2013). WHO emphasises that the states have to invest and develop strategic policies in order to meet aging population needs and ensure healthy and active aging in the countries (Strategy and action plan…, 2012).

In light of the rapid population ageing, long term social care policies have undergone significant reforms in most European countries. Until the late 1990s, Northern and Western European countries were largely characterised by high levels of state support and public provision for older persons in need of care, while Southern and peripheral countries were characterised by extremely limited state provision and funding, with a heavy reliance on informal care from families. Since then, increased spending has helped formal long term social care services to develop in Southern and Eastern countries at the same time that Northern and Western countries have slowed or even cut back on spending (Long term care in Europe, 2017).

The importance of developing efficient long term social care strategies are proved by statistical data on elderly population and care needs. In EU 65+ individuals composed 18.9% of total population in 2015. The biggest share of elderly people was in Italy – 21.7%, the lowest – in Ireland – 13.0 %. The Lithuania is close to EU average – 19.0% of population was 65+ in defined year (Elderly people - International Day of Older Persons, 2016). However, the number of elderly people is increasing in the country. In the last ten years the number of 65+ increased by 18.6 thousands individuals, e.g. by 3.5% (Elderly people in Lithuania, 2014). It is foreseen that in 2030 it will be 28.9% and in
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2060 – 37.0% elderly in the country (Lietuvos senyvo amžiaus…, 2016). In Europe approximately 45% of individuals aged 65+ have a disability, and between 20% and 33% of individuals aged 65 and over require care/support, depending on how care is defined. Over a quarter of the total older population are aged 80+, and around half of all long term social care users are aged 80 and over (Long term care in Europe, 2017). In Lithuania there were 151.9 thousands inhabitants 80+ and 349 – 100+ in 2016. The life expectancy of 80+ was 8.3, e.g. more than one year shorter in comparison with EU average which was 9.5 years. While the longest life expectancy is in France (11.0 years), the shortest – in Bulgaria (7.0 years) (Elderly people - International Day of Older Persons, 2016).

Statistical data shows an increasing number of long term social care users in Lithuania. At the end of 2016, 5.2 thousand persons (by 3.1% more than in 2015) lived in 107 care institutions for the elderly, 6.7 thousand persons (by 8.3% more than in 2015) – in 58 care institutions for adults with disability, 18.6 thousand persons received home help and social care at home (Statistical yearbook of Lithuania 2017, 2017). In order to meet rising long term care need and to ensure the best quality of provided services, Lithuania as many other EU countries implemented the reforms which aimed at deinstitutionalization of the services. The aim of the article is to analyse long term social care situation and deinstitutionalization in Lithuania in the context of EU data. The article is based on statistical, secondary data, legal documents and scientific literature analysis and encompasses comparative perspective, providing examples from Latvia (the nearest Lithuanian neighbour similar in socioeconomic and historic political development) and Slovakia (the origin country of the journal).

Deinstitutionalization of long term social care system in Lithuania

Long term social care system in the country
Joint Report on Health care and long-term care systems and fiscal sustainability (2016) defines that in Lithuania there is no single, discrete long term care scheme, long term care is financed by the municipalities and State as a part of health care and social services. It falls in cluster E which has little social insurance against long term care risks and correspondingly low public spending on formal care. The use of informal
care is high and there is little to no informal care support, cash-benefits are modest/low.

In the country long term care includes financial support and health or/and social services for those who are dependent on others or who have lost their independence through illness.

Long term healthcare is provided irrespective of the age of the person, according to the condition of their health and the progress of any disease or complication. Long term healthcare includes medical treatment, palliative care and nursing, it is designed to meet the needs of those who are dependent on others because of illness or disability. According to an approved list of health conditions, someone may be identified as having special nursing or assistance needs and receive compensation for the associated costs. Compensation to cover nursing care is provided to persons identified as having a need for special nursing care. Compensation to cover assistance is available to children with severe and moderate disabilities and to persons identified as having a need for special assistance. The adults need to be identified as having special care needs, though not disabled children. Primary healthcare facilities are responsible for the organisation and provision of nursing care services at home. Only patients referred by a doctor can receive long-term healthcare services. Long term medical treatment, palliative care and nursing are available for those covered by compulsory health insurance, irrespective of age according to their health and specific needs. Compensation for nursing costs amounts to 2.5 the basic level of compensation set by the Government (in 2017 it is EUR 280 a month). Compensation for assistance costs amounts to either half the basic compensation rate or is the same as this rate (EUR 56 or EUR 112, a month, respectively, in 2017) depending on the category into which an individual falls (Your social security rights in Lithuania, 2017).

Social care is provided not according to the age but to the degree of independence and the need for care. The main recipients are the elderly and those with disabilities. Social service needs are determined on an individual basis according to a person's dependence and the possibilities of them developing independence as a result of provision of the appropriate social services. Institutionalised social care is available to those with disabilities as well as the elderly in need. Payment for social services is determined by the type of service required and someone's ability
to pay. Those needing assistance are visited at home by social workers from the local government authority department responsible for the planning and administering of social services. Depending on their situation, the elderly and disabled may receive home assistance (of up to 10 hours a week), daily social care (from 3 hours a day, 5 days a week), in day-care centres or (from 2 to 8 hours a day up to 7 days a week) in their own home, or in residential care homes. Social service needs, including long term social care, are assessed by social workers. Special needs of the disabled are determined by the Disability and Working Capacity Assessment Office at the Ministry of Social Security and Labour or by the doctors' consultative commission in the healthcare facility at which a person is registered (Your social security rights in Lithuania, 2017).

It is acknowledged that one of the biggest long term care issues in EU is its coverage which is comparatively low in Central and Eastern European states, particularly of home and community based services. Relatively few European countries have quality management or regularly systems in place. Population ageing and the consequent increased demand for formal LTC services has led to public services being restricted towards those with the highest levels of caring needs. As such, access in practice is limited by financial constraints and budget ceilings, leading to longer waiting times. Co-payments in many Southern and Eastern countries are often high, waiting lists to access services have become longer, ranging from three to four weeks to six months (Long term care in Europe, 2017). In order to meet these challenges and to harmonise long term health and social care, to develop community based services, the process of deinstitutionalization started in Lithuania in 2012.

Legislation of deinstitutionalization

The reform of the system started by approving “Strategic guidelines for deinstitutionalization of the social care homes of disabled children deprived of parental care and adult disabled persons” (Order No A1-517, 2012). Following document, “Transition from institutional care to community-based services for the disabled and children deprived of parental care 2014-2020 year action plan” (Order No. A1-83) was introduced in 2014. According to these documents the strategic aim of the reform is to create system of a comprehensive range of services that enable every child, person with disabilities or their families (guardians) to receive
individual services according to their needs and necessary assistance in the community. The first specific aim deals with children while the second specific aim is connected with adults and states that it is necessary to enable adults with disabilities and their families (guardians) to get community-based services according to their individual needs. The third specific aim seeks to promote the change of moral values in the society, while forming a positive public attitude towards restructuring of the system and to ensure the transparency of these processes. The process of transformation of the institutional care is designed in two steps: creation of the necessary conditions for the transformation (2014-2017) and development of infrastructure in the regions 2017-2020 (2023). The goal of the first step is to create necessary conditions for the transition from institutional care to sustainable development of family and community based social care services in Lithuania by: evaluating individual needs of every service recipient; determining motivation, the need for a new knowledge and skills of the staff; developing individual care plan for every resident of a social care institution, institution’s plan for the transition, regional plan of services and infrastructure; preparing methodological basis for a new type of the services, e.g. methodological documents, legislation, etc.; informing and educating public, social marketing. The goal of the second step is on the basis of the Regional services and infrastructure development plans, to provide new forms community based social services for the target groups and to develop infrastructure of community based social services.

With regard to the fact that Lithuania’s society has been rapidly ageing and municipalities lack non-institutional services that would be alternative to institutional care and nursing, the Integral Assistance Development Programme (Order No. A1-353, 2012), financed from the European Social Fund, was launched in 2013. It aims at quality integral assistance (nursing and social services) for the disabled and elderly people in their homes as well as consultations to their family members who take care of these persons. In 2013–2015, pilot projects were implemented under this programme in 21 municipalities: mobile teams were set up for provision of nursing and social services at home and also offering consultations to family members, etc. After the pilot projects were accomplished and their outcomes as well as contribution of integral assistance to the improvement of beneficiaries’ life quality were evaluated,
the new Action Plan for Integral Assistance Development 2016-2019 was approved (Order No. A1-435, 2015). Pursuant to this plan, integral assistance will be provided in all country’s municipalities during this period. A total of EUR 16.4 million are planned to be allocated for the implementation of the new action plan from the EU funds. By 2019, integral assistance services are planned to be provided to almost 2 250 disabled and elderly persons and consultation services to over 1 500 family members who take care of their close disabled or elderly relatives. From mid-2016 until the first quarter of 2017, integral assistance services were provided to about 1 300 persons, consultation services – to 500 family members who take care of their close disabled or elderly relatives (Social report 2016-2017, 2017).

**Scope of deinstitutionalization**

In 2016, 18.6 thousand persons received home help and social care at home, which is by 4.5% more than in 2015 and 2.4% more than in 2006. As in the previous years, the majority (82.2%) of the recipients of social services at home were persons of retirement age. Besides, in 2016, 111 retirement-age persons and/or persons with disability received social care benefits and arranged the provision of social services at home themselves; against 2015, their number decreased by 1.8%. At the end of 2016, 5.2 thousand persons (by 3.1% more than in 2015) lived in 107 care institutions for the elderly, 6.7 thousand persons (by 8.3% more than in 2015) – in 58 care institutions for adults with disability. In 2016, compared to 2015, the number of persons in continuing care retirement communities increased by 8.3%; in 2016, 472 elderly persons and adults with disability were living in 21 institutions of such type (Statistical yearbook of Lithuania 2017, 2017). Data in Table 1 shows changes in numbers in 10 years, e.g. since 2006.
Table 1 Residents of care institutions and continuing care retirement communities, 2006 and 2016, at the end of the years

|                                                                 | 2006   | 2016   |
|-----------------------------------------------------------------|--------|--------|
| **Persons who received home help and social care at home**     |        |        |
| of retirement age                                              | 7 137  | 15 319 |
| disabled of working age                                         | 676    | 3082   |
| disabled children                                               | 102    | 229    |
| **Recipients of social care benefit**                           |        |        |
| of retirement age                                              | 738    | 98     |
| disabled of working age                                         | 55     | 13     |
| **Care institutions for the elderly, total**                    | 97     | 107    |
| residents in them                                               | 4 927  | 5 195  |
| **Care institutions for adults with disability, total**         | 27     | 58     |
| residents in them, total                                        | 5 412  | 6 685  |
| **Continuing care retirement communities (independent living homes), total** |        |        |
| residents in them, total                                        | -      | 21     |
| of retirement age                                               | -      | 242    |

Sources: Lithuania: Statistical yearbook of Lithuania 2017 (2017). Statistics Lithuania, Vilnius, p. 131; Social protection in Lithuania 2016 (2017). Statistics Lithuania, Vilnius, p. 28

Statistical data reveals differences by age and gender of retirement-age residents in care institutions and continuing care retirement communities in Lithuania (see Table 2).
Table 2 Retirement-age residents in care institutions and continuing care retirement communities by gender and age group, 2016, at the end of the year, Lithuania

|                                    | Total   | 60–69 years | 70–79 years | ≥ 80 years |
|------------------------------------|---------|-------------|-------------|------------|
| **In care institutions for the elderly** |         |             |             |            |
| males                              | 4 697   | 830         | 1 447       | 2 420      |
| females                            | 3 023   | 297         | 806         | 1 920      |
| **In care institutions for adults with disability** | 2 990   | 1 361       | 968         | 661        |
| males                              | 1 376   | 817         | 431         | 128        |
| females                            | 1 614   | 544         | 537         | 533        |
| **In continuing care retirement communities** | 242     | 82          | 71          | 89         |
| males                              | 108     | 58          | 27          | 23         |
| females                            | 134     | 24          | 44          | 66         |

Sources: Social protection in Lithuania 2016 (2017). Statistics Lithuania, Vilnius, p. 28

Statistical data shows that as a consequence of deinstitutionalization process the number of persons who received home help and social care at home significantly increased and the number of recipients of social care benefit decreased in ten years. In 2016 in comparison to 2006 there were 10 more care institutions for elderly almost for the same number of residence, what illustrates the process of making residential care institutions smaller and more home like for residents. The same could be said about care institutions for adults with disability. In ten years the network of continuing care retirement communities (independent living homes) was developed and at the end of 2016 there were 21 such place for 477 residents. The bigger number in care institutions for elderly is for males and the need increases with their age while the number of females stays more stable in all age groups, however in the group of adults with disabilities the bigger need is for females in all age groups and males.
in age group 60-69 years. The tendencies in continuing care retirement communities are different for males and females: the number decreases for males (from 58 to 23) and increases for females (from 24 to 66) with aging. This could be connected with general bigger number of females in these age cohorts but also provides data for further development of long term social care services in Lithuania.

**Challenges for long term social care policies in EU**

There is three-tier Europe, characterised by high levels of public expenditure and coverage by Northern European countries, medium expenditure and coverage by many Western countries and low expenditure and coverage by Mediterranean, Central and Eastern European countries and Ireland (Long term care in Europe, 2017). Data in Picture 1 shows that in Lithuania expenditure for long term care is less than EU average but is the highest not only among Baltic but among all post-communist countries, including Slovakia.

*Picture 1. LCT expenditure*

Sources: Long term care in Europe. European Network of National Human Rights Institutions.

However, analysing coverage the different picture exists. According to Szudi, Kovacova, Konecny (2016) in Slovakia the coverage rate for
residential care is among the highest values in the Central-Eastern European region (a region with generally lower coverage rates than the Nordic, Western European, or even Southern European countries). However, the overall coverage rate is one of the lowest in the European Union; only some Eastern European and Baltic countries: Poland, Slovenia, Latvia, and Lithuania - have lower coverage rates. While situation in Lithuania is improving by implementing integrated services in all municipalities what is legally regulated by Action Plan for Integral Assistance Development 2016–2019 (Order No. A1-435, 2015), in Latvia availability and accessibility of community-based social services varies across the municipalities. There are 119 municipalities in Latvia but only 68 provide social care in people's homes. In Latvia, such care is provided by 31 NGO's mainly to elderly people with physical disability, rarely – with mental disorders. Some elderly people continue living in their own homes, their usual environment, and receive care. Demand for care in people's homes is rising, many municipalities have insufficient capacity, and the situation is critical in those areas where the infrastructure is bad and the social service provider is located far from clients. The range of social services significantly differs across municipalities and even within the particular municipality. Small rural municipalities cannot provide and ensure decent living conditions of elderly people living alone. They also face a shortage of qualified social workers. There are cases when relatives refuse to pay for provided social services (Rezgale-Straidoma, Rasnaca, 2015). The regional distribution for long term care is also uneven in Slovakia: there is a huge economic disparity between the Eastern and Western parts of Slovakia, which is also reflected in the percentage of elderly people cared for in institutions. In particular, in the rural areas of Eastern and Northern Slovakia, lower percentages of people are cared for in institutional settings—many people get help only from their families or receive no help at all (for which adequate statistical data are missing) (Szudi, Kovacova, Konecny, 2016).

Based on the responsible actors of long term care, systems could be categorized into three groups. In the first group, the state takes responsibility for long term care, the second consists of countries where families have the main responsibility, while the third model is comprised of countries where the state funds the costs and other actors provide these services (Timonen, 2005). Lithuania, Latvia and Slovakia fall in
the third group. As mentioned earlier, in Lithuania long term care is funded by municipalities and State as part of health and social services. Similarly in Slovakia the medical care and social care services for the elderly are organized separately: medical care services are financed by the Ministry of Health through the health insurance payments, while, under the auspices of the Ministry of Labour, Social Affairs and Family. Elderly care is predominantly financed by the municipalities through transferred state taxes, local taxes, state grants, and client co-payments, while municipalities, authorities of the self-governing regions, and, to a lesser extent, third sector organizations provide elderly care services. The main responsibility is officially borne by municipalities, but the system can be considered to be oriented toward informal care because a substantial (not easily quantifiable) responsibility lies with the families (Szudi, Kovacova, Konecny, 2016). In Latvia provision of social services is also shared between the state and of municipalities, however the system is not effective and efficient, services are funded insufficiently. The current divide of responsibilities between the state and local government does not encourage improvement the quality of social services at community level (Rezgale-Straidoma, Rasnaca, 2015).

However, only balancing expenditure, coverage and responsibilities of the actors doesn’t guarantee that long term social care system will operate properly and ensure high quality services. As explain Knapp et al. (2011) moving people from single-budget institutions which are almost run from a single budget to community contexts with multiple budgets will have a range of consequences. In response to the multiple needs of people previously living in institutions, costs in the community range widely – over many service areas and policy domains. In a good care system, the costs of supporting dependent people are usually high wherever those people live. Policy-makers must not expect costs to be low in community settings, even if the institutional services they are intended to replace appear to be relatively inexpensive. Potential economies of scale in large-scale institutions are complicated by the question of service quality; low-cost institutional services are almost always delivering low quality care. New community-based care arrangements could be more expensive than long-stay residential care but may still be seen as more cost-effective because, when properly set up and managed, they deliver better outcomes.
Analyses of recent national policy reforms indicate that many Member State are not adequately planning for the future, but are instead “muddling through”, relying on informal care workers and/ or limited cash support for care recipients, which increase illegal migrant care. At the same time, many countries are expanding service provision through market mechanisms – contracting out state services to non-statutory (for- and non-profit providers). This highlights the complexities in developing the long term care sector and shows the need to ensure Member States’ human rights obligations remain high on the policy agenda. Proposals by the European Commission to Member States are to try to reduce demand for long term care through prevention initiatives, rehabilitation and the use of technology; and create incentives for informal carers to reduce the pressure on formal care services, alongside boosting efficient, cost-effective (formal) care provision at home and in residential care settings (Long term care in Europe, 2017).

Conclusions
Due to ageing society and rising long term social care needs Lithuania as many other EU countries initiated long term care system reform which is planned to be finished till 2020. Statistical data shows that deinstitutionalization process has had a positive effect on increasing the number of persons who received home help and social services at home and decreasing the number of recipients of social care benefits. However, deinstitutionalization process is complicated and faces challenges related with expenditure, coverage, service quality. EU level analysis declares that the country has little social insurance against long term care risks, low public spending on formal care, and high use of informal care. Comparing with other countries, Lithuania has higher expenditure than Latvia and Slovakia, but lower coverage rate then Slovakia. Nevertheless, all three countries fall in the same tier and follow the same care model defined by Timonen (2005).

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