2 Low and uneven access to care services in Lithuania

This chapter presents the division of responsibilities for long-term care (LTC) in Lithuania and the related benefits available. Firstly, it shows how responsibilities are divided across health and social sectors. It analyses the different needs assessments and the eligibility criteria of the benefits. Finally, it compares LTC recipients in Lithuania with other EU countries, showing that LTC services are insufficient to satisfy all needs and that their distribution is geographically uneven.

Responsibilities for LTC are divided across health and social sectors

In Lithuania, two Ministries have the main responsibility for the LTC system. The Ministry of Social Security and Labour (MoSSL) is responsible for shaping and implementing policies and legislation on social services and social workers, and providing guidance to municipalities on implementation. It is also responsible for the definition and funding of the two cash benefits for LTC. Legislation for social services is generally more unified than the legislation on health care, which is more setting-specific. The Ministry of Health, which oversees the National Health Insurance Fund (NHIF) is responsible for shaping and implementing policies and legislation on health care providers and health professionals, and approving financial investment in health care facilities. It also undertakes projections of supply and demand for LTC that is carried out by the health care system. It is responsible for geriatric services, nursing services and palliative care. Such division of responsibilities results in different data collection for users and there is no legal obligation to share data across all LTC providers (see Box 2.1).

Box 2.1. Information systems for LTC are fragmented with separated plans for improvement

The information system of social services is separated from the system on health care. Municipalities register data via the Family Social Support Information System (Socialinės paramos šeimai informacinė sistema – SPIS) and they cannot take into account outpatient home nursing care when assessing the needs for social services at home. Focus group discussions with municipalities highlighted that the SPIS was outdated and not sufficiently user-friendly, but could potentially improve transparency for users on waiting lists for LTC. The best practice put forward by municipalities was the Vilnius municipal IT system. Vilnius introduced an independent system enabling clients to follow changes in the waiting lists. Transparency might be improved when an older persons sees how his/her position in a waiting list for a service is changing. Municipalities have to invest a significant amount of money in order to provide even basic information for the clients automatically as they develop their own information system.

The health part of long-term care is registered in the mandatory health information system, SVEIDRA. The e-health system is in the development phase and should be expanded by the end of 2023. General practitioners (GPs) will have access to all files, while patients and other doctors will have a limited access. A feature will ensure that GPs will be notified for specific cases (e.g. an emergency). Community-based nurses will receive tablets to digitalise the administrative work. One major barrier is that managers need to be willing to train nurses. Without additional funding, some managers may not see the financial interest in digitalising the administrative work of nurses.

In 2024, Lithuania plans to integrate SPIS and SVEIDRA. While the legislation encourages the integration of the databases, it is still unclear what information will be shared. Finland is an interesting example of a country undergoing a reform of its information system to integrate health and social sectors. The Institute for Health and Welfare (THL) is currently reforming the collection of national statistics in social welfare accordingly.

Lithuania's 60 municipalities are responsible for administering social services. They ensure the availability of social services in their territory by planning, organising and monitoring services. They develop a social service plan every year (following methodologies approved by the government or by related public bodies) to evaluate the scope of and type of services needed. They also administer the cash benefits for LTC. Municipalities own a large share of primary care centres (particularly the polyclinics) and the small to medium-sized hospitals (OECD/European Observatory on Health Systems and Policies, 2019[1]). In addition to social services, they also have specific responsibilities for health (primary health care and public health services) and housing.

Lithuania has made several attempts to integrate health and social services for older people but implementation has remained modest. There was a legal initiative in 2007, but this law was not implemented because of unclear joint governance and funding. In 2020, the Ministry of Health published a Ministerial Order to slightly improve the integration of health and social services. The order states that any outpatient home nursing care provider should have a co-operation agreement with a social service provider.

Quality in LTC is regulated separately for the social and health care sectors. Accreditation schemes set minimum quality standards. There are no nationally-defined quality indicators for LTC, and each municipality sets their own care quality indicators. Compliance of social care providers is assessed at least once every five years by the Department of Supervision of Social Services. In 2020, the Ministry of Social Security and Labour carried out 90 assessments about licensing requirements, of which nearly half were on-site. It issued 126 licences, of which half were new requests. It also revoked 63 licences and refused 5 licensing requests. For LTC in the health care sector, the State Health Care Accreditation Agency acts as the licensing authority for health care institutions and health professionals. It also monitors health care quality and the implementation of patient's rights. It receives complaints of patients or patients' families and is in charge of ruling these complaints. The Compulsory Health Insurance Fund Quality monitors the quantity and quality of services, including by analysing the data in the health database (SVEIDRA). The number of monitored indicators in SVEIDRA has been increasing in recent years. The State Accreditation Service for Health Care Activities under the Ministry of Health carries out scheduled inspections of home care providers since 2015. Since 2017, the quality standard of all health care services is legislated. There is not a standardised form of neglect and abuse that could apply to home care, although older recipients and their relatives have the right to signal a case to providers and State Health Care Accreditation Agency and they have to take appropriate action.

Public funding schemes in Lithuania are entangled

Long-term care health services are funded via the National Health Insurance Fund. The Fund is, in turn, funded through social contributions and taxes. Such services are not means-tested and free of charge, but volumes are capped. Nursing hospitals[1] are financed via a payment per bed-day depending on duration of patient stay and health condition, but no longer than 120 days per calendar year. The National Health Insurance Fund covers the cost of home health care services, except nursing care provided as part of the integrated care project, which is funded by the EU Funds and the Ministry of Social Security and Labour.

Funding of social services stems mostly from the MoSSL. The MoSSL funds municipal budgets for social services to a great extent (Table 2.1). More generally, municipalities in Lithuania are highly dependent on central government transfers and subsidies which represent almost 90% of their revenue. Lithuanian municipalities' reliance on grants is among the highest in the OECD (OECD, 2021[2]). While general social services and social attendance are funded with state transfers to the municipality budgets, social care for adults with severe disabilities is funded through targeted state grants. Prices for long-term care social services are set by municipalities, which the information published by the Social Services Supervisory Department under the Ministry of Social Security and Labour on the average prices of social services purchased or financed in municipalities over the last 12 months to determine the maximum level of financing of the costs of short-term or long-term social care and to organise the purchase and financing of social services.

Table 2.1. Social services are funded by municipal and state grants or targeted state grants

Social services	Population	Average price	Unit of measurement	Public funding
Catering organisation		1.61	cost/person	Municipality and state grants
Transport organisation		0.42	cost/service	Municipality and state grants
Personal hygiene and care services		2.56	cost/person	Municipality and state grants
Home help		4.8	EUR/hour	Municipality and state grants
Accommodation autonomous life at home		11.46	EUR/hour	Municipality and state grants
Temporary overnight accommodation		12.05	cost/person	Municipality and state grants
Accommodation at home		10.87	cost/person	Municipality and state grants
Day social care in a care institution	Adults with disabilities/older age	4.08	EUR/hour	Municipality
	Adults with severe disabilities	4.71	EUR/hour	*Targeted state grant*
Day social care at home	Adults with disabilities/older age	6.25	EUR/hour	Municipality
	Adults with severe disabilities	*5.89*	*EUR/hour*	*Targeted state grant*
Short-term social care provided in a day care centre	Adults with disabilities / older age	829	EUR/ month	Municipality
	Adults with severe disabilities	*914*	*EUR/* month	*Targeted state grant*
Short-term social care provided at a temporary home	Adults or older people at social risk	959	EUR/ month	Municipality
Short-term social care provided in social care homes	Adults with disabilities	829	EUR/ month	Municipality
	Older people	833	EUR/ month	Municipality
	Adults with severe disabilities	*930*	*EUR/* month	*Targeted state grant*
Long-term social care provided in a social care home	Adults with disabilities	795	EUR/ month	Municipality
	Older people	814	EUR/ month	Municipality
	Adults with severe disabilities	*913*	EUR/ month	*Targeted state grant*
Long-term social care at home	Adults with disabilities	1150	EUR/month	Municipality
	Older people	1079	EUR/ month	Municipality

Source: Ministry of Social Security and Labour (data refer to 2020).

The largest contributor to funding is the Ministry of Social Security and Labour

Overall, spending on cash benefits is substantial and health spending is more geared towards inpatient care. Based on a bottom-up approach by funder, total spending on LTC is estimated to reach about EUR 526 million in 2020[2] (Table 2.2). The public health care system is geared towards inpatient services: outpatient home care service to older people funded by the NHIF reached EUR 9.5 million, compared with about EUR 74 million for nursing hospitals. The latest National Audit Office report indicated that day social care at home and in day care centres spending was estimated at EUR 7.1 million on average during 2017-19 (National Audit Office, 2021[3]).

The EU Structural Funds have funded the integrated care project, with an initial budget of EUR 16.3 million in 2016. The funds have been allocated to 59 municipalities (the only exception is Neringa). The project was renewed until 2027, with a budget of EUR 30 million. Between 2016 and early 2020, 5 100 target groups (families) received services provided by 186 mobile teams, for EUR 21.9 million (National Audit Office, 2021[3]). Since 2013, integrated home care is provided by a team of social services and personal health care professionals, whose aim is to identify a person's need for social care and home care services, to organise and provide appropriate services. The team consists of the following professionals: a social worker and his/her assistants, a nurse and his/her assistants, and a rehabilitation specialist. The average duration of the integral support for a person is about 4.5 hours per day, up to 7 days per week (nurses started to provide care on weekends in July 2022). By March 2021, 5 300 people had received integral assistance.

Table 2.2. Estimating funding streams

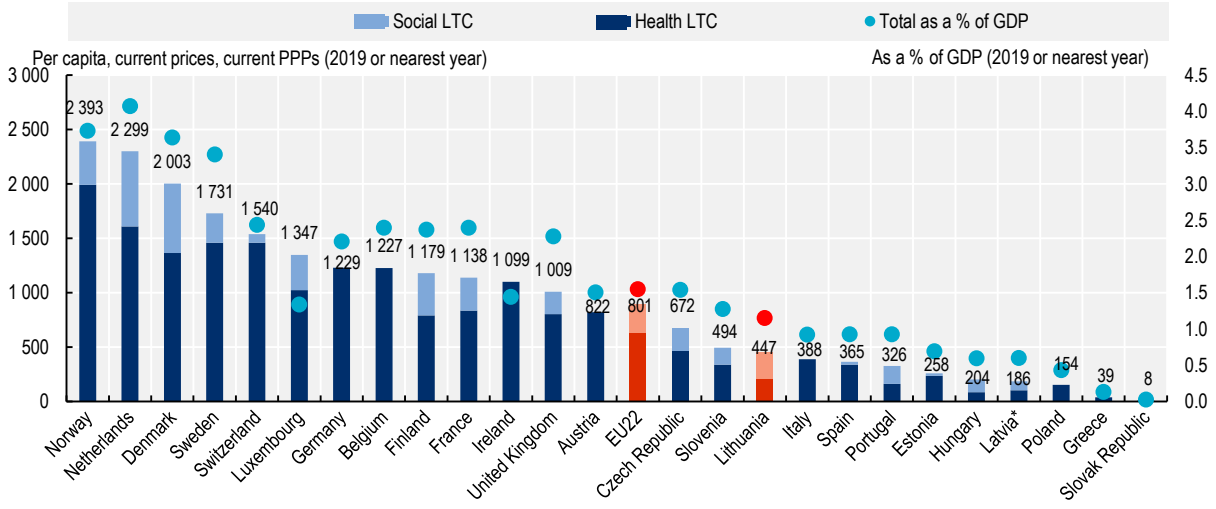
	2015	2018	2019	2020
Total				***362 million***
Total – NHIF				**117.309 million**
Outpatient nursing care in hospitals (to older people)	19 597	35 465	38 686	39 891
Beds in hospitals (nursing beds to older people)	16 853 100	25 539 473	28 924 790	33 792 497
Nursing hospitals (total expenditure)	40 582 268	55 751 222	65 372 856	73 976 052
Outpatient home nursing care to older people	3 300 381	4 903 987	7 842 570	9 500 730
Total – MoSSL				**129.3 million**
Cash benefits (Targeted compensation to older people)		129.3 million on average per year 2017-19		
Global state budget to municipalities[1]	n.a.	n.a.	.	n.a.
EU Funds		21.9 million (between 2016 - early 2020) – 7.3 million on average per year		
Municipalities (funding estimates)		34 046 303	39 031 894	44 762 744
Out-of-pocket payments (spending estimates)		43.2 million	51.3 million	63.4 million
Total – MoSSL for people with disability below retirement age				**96.317 million**
Targeted state grants (adults with severe disability under retirement age)	20 609 000	32 770 000	38 389 000	48 317 000
Targeted compensation payments (under retirement age)		49 million on average per year 2017-19		

Note: 1. Based on data reported by municipalities, estimated state funding reached almost EUR 61.7 million – EUR 13.36 million more than the amount of targeted state grants (EUR 48.3 million in 2020). CHIF expenditure provided for people aged over 65. Overall spending differs from that reported in OECD Health Statistics Database (total of EUR 508 million in 2020).
Source: OECD Questionnaires 2021, complemented with OECD Health Statistics Database for out-of-pocket estimated spending (health and social components of LTC), the National Audit Office (2021[3]) for the targeted compensation payments to older people.

LTC spending in Lithuania is lower than the OECD average

In Lithuania, total spending on LTC was estimated to account for 1.1% of GDP or USD 447 per capita (after adjusting for differences in price levels). Across 22 OECD countries, total spending on LTC in 2019 was estimated to account for 1.5% of GDP or USD 801 per capita (after adjusting for differences in price levels). Reported LTC spending ranged from very small shares (<0.2% of GDP) in Greece and the Slovak Republic to around 4% of GDP in the Netherlands (Figure 2.1). Lithuania spends almost half the EU average but more than neighbouring Latvia. International comparisons must be read cautiously given challenges with respect to the comparability of the data: there are persistent difficulties in clearly separating LTC activities into the health and social components. In many countries, spending on home-based LTC, outpatient LTC services and day LTC cannot be clearly identified and may be reported in another category. In addition, the inclusion of cash benefits and accommodation costs in overall spending varies across countries (OECD, 2020[4]).

Figure 2.1. Total LTC spending per capita in Lithuania is almost half the EU average



Note: EU average is unweighted.
Source: OECD Health Statistics 2021 (data refer to 2019).

LTC spending as a proportion of total health spending and LTC spending as a share of GDP has gradually increased over the last 10 years in many EU countries. In Lithuania as in the EU, total LTC spending increased by over 90% – for Lithuania, from USD PPP 233 to 447 per capita in the period between 2009 and 2019. LTC spending (including social LTC) outpaced overall health spending in most EU countries in the last 10 years, but in Lithuania, the LTC spending as a share of overall health spending decreased slightly from 18% in 2009 to 16% in 2019. In comparison across EU countries, the share increased from 17% to 20%.

There is a complex range of services and benefits with different access criteria

A complex set of health and social services is available for older people

Municipalities assess the eligibility of older people to be entitled to social services which can be at home, day care or in an institution and people receive different services depending on the degree of need. Social

services for older people in Lithuania include social attendance and social care, which are not always easy to disentangle. *Social attendance* is a set of services that provide comprehensive assistance to a person (family) that does not require constant specialist care. *Social attendance* includes, among others: help at home, social skills development, temporary accommodation, psychosocial assistance. *Social care* is a set of services that are provided as complex assistance to persons needing constant professional care. *Social care* can be divided into:

- day social care, which can be provided at home or in an institution (day care)
- short-term social care, which is usually provided in a care institution (inpatient care or day care), but may be provided at home
- long-term social care, which is usually provided in a care institution, but may be provided at home

All these social services are subject to co-payment based on income and – only for long-term social care – assets (property), and is very important for social care in care institutions (Table 2.3). The co-payment varies depending on the service and is set at the national level, but can be substantial in some cases and discourage people from accessing services. The baseline personal income for co-payment depends on the composition of the household, and many social benefits.

Table 2.3. Co-payment for in-kind social services for someone living with relatives

Service	Description	Maximum share in the personal income	Example of OOP for the income threshold (EUR)	Asset criteria
General social service	Free of charge if a person is a recipient of a social benefit or if the average of the household's income is below the double of the state-supported income (EUR 256).	0%	0	none
Social attendance	If a person is a recipient of a social benefit	0%	0	none
	Income < 2 bases (EUR 256)	0%	0	none
	Income between 2 bases – 3 bases (EUR 384)	5%	19	none
	Income between 3 bases – 4 bases (EUR 512)	10%	51	none
	Income between 4 bases – 5 bases (EUR 640)	15%	96	none
Day (social) care	Income < 2 bases (EUR 256)	10%	26	none
	Income between 2 bases – 3 bases (EUR 384)	20%	77	none
	Income between 3 bases – 4 bases (EUR 512)	30%	154	none
	Income between 4 bases – 5 bases (EUR 640)	40%	256	none
	Income > 5 bases (EUR 640)	50%	320	none
Short-term (social) care	The maximum is 80%, but if informal caregivers receive respite, the maximum share of the personal income is 50% instead of 80%. The cash benefit is counted in the personal income.	50%-80%	n.a.	none
Long-term (social) care	The maximum is 80% of the income, unless the value of the property is higher than the property value norm set in the municipality, the amount of payment for long-term social care increases by the equivalent of 1% of the value of the property	80%	n.a.	Property

Note: The base refers to the state-supported income, which is EUR 128 in 2021 per month. The personal income includes the two cash benefits (targeted compensations for nursing and care) and all other social benefits. The income are accounted after deducting income tax and social insurance contribution. The median equivalised net income of people aged 60 and over was EUR 545 per month in 2020.
How to interpret: for example, the amount of payment for social attendance for a person whose income is more than twice the amount of state-supported income but less than three times the amount of state-supported income shall not exceed 5% of a personal income.
Source: OECD Questionnaire to the Ministry of Social Security and Labour, 2021.

The overwhelming majority of social services are available in all municipalities, although there can be differences in access to social services at home within municipalities in practice. All respondent municipalities[3] reported having at least 7 different LTC services available spanning from information and consulting to assistance and day social care at home. One informal carer of the focus group mentioned that social service at home was not a viable option because the care recipient lived too far away from the centre of the municipality. When municipalities were asked about the lack of material goods or infrastructure to provide LTC, municipalities gave an average grade of 4 to the shortage of cars, medical equipment, buildings and related equipment for day-care, on a scale from 1 (hardly any shortage) to 10 (important shortage).

Across municipalities, the median waiting time between a request and the beginning of the social service varies: 15 days for social attendance, 20 days for social care (except in care institution) and 30 days for long-term social care in care institutions. Information about waiting lists for LTC services guides possible service recipients in their choice of services. Waiting lists are published in about two-thirds of surveyed municipalities (66%), although interviewed informal carers reported struggling to find clear, updated and structured information. To address waiting times, the MoSSL legislated in April 2021 that the need assessment for social services should be performed within 10 calendar days from the reception of the request, with the exception for long-term social care (typically provided in a care institution), for which the need assessment should be undertaken within 20 calendar days.

LTC services within health care entail mostly geriatric services and nursing services at home, in primary care institutions and polyclinics, in nursing hospitals, and in hospitals. Outpatient services can be provided in health care facilities, including polyclinics, or at the patient's home. Nurses providing home-based care are all employed by primary care institutions and polyclinics. They visit patients at home between 8 a.m. and 5 p.m. on week days. There are no self-employed nurses providing such services. These services are not means-tested and are free-of-charge (i.e. without co-payment), although volume restrictions apply with a maximum number of services entitled per year. At the time of the project, there was a volume cap of 104 outpatient nursing services/person/year for everyone. While the volume cap avoids a concentration of services and helps control spending, it could be detrimental for older people with the most severe LTC needs. In July 2022, the maximum number of visits per year for the patients with the most severe needs was increased to 260 services, which means that older people with the most severe LTC needs were able to receive outpatient nursing services up to 5 times a week.

Needs assessments and eligibility criteria for services are not harmonised

Lithuania does not have a nation-wide standardised needs assessment methodology to determine the eligibility of older people for health and social services. There is one needs assessment for social services at home or in care institutions, one for home care provided by the health care system and none to access nursing hospitals (one needs a doctor's referral), although nursing hospitals overlap with care institutions. The needs assessment tool for social services takes into account the age, the functional disorders, the social risks, and the family's ability to provide informal care. Functional disorders include limitations on mobility, cognitive skills, communication, and daily activities. A person's independence can be partial or complete. If the expertise of specialists of other areas (e.g. neurologists) is required to assess needs, a commission of specialists may be formed by the municipality. The recipient's needs are assessed and periodically reviewed by social workers appointed in accordance with municipal procedures. In contrast, the Barthel Index[4] is used to assess the level of nursing needs for home care services under the health sector. The Barthel index of a patient is determined by an attending physician, family doctor or a nurse.

Two cash benefits can be used for long-term but are not means-tested nor monitored

There are two cash benefits related to LTC: the cash benefit for nursing costs and the cash benefit for assistance costs – they are also referred as "targeted compensations" (Table 2.4). They can be used with

in-kind benefits. The Ministry of Social Security and Labour funds them and municipalities are responsible for the administration. The cash benefits are not means-tested and Lithuania spent on these two cash benefits EUR 178 million on average between 2017-19 (of which EUR 129.3 million for older people) (National Audit Office, 2021[3]). The average number of older recipients was 84 000 between 2017 and 2019 (National Audit Office, 2021[3]). In practice, the estimated duration of care/assistance needed is a key criterion to determine the type and level of the cash benefit. The difference in the activities between nursing care and assistance seems blurred, and given that the cash benefits are mutually exclusive, the difference may be only linked to the amount of hours of care needed.

Table 2.4. Duration of LTC needed is a key criterion to receive one of the cash benefits related to LTC

	Cash benefit for nursing care		Cash benefit for assistance	
	First level	Second level	First level	Second level
Compensation	2.6 of the base	1.9 of the base	1.1	0.6
In EUR (2019)	309	226	131	71
Duration of care needed / per day	8+ hours	6-7 hours	4-5 hours	< 3 hours

Note: The base is EUR 114 since 2019. People of retirement age who have been identified with special permanent nursing or permanent care (assistance) up to the end 2018 are allocated with cash benefits that are more generous (2.5 of the base).

Virtually all (95%) the municipalities monitor the use of targeted compensations, as they report a lack of clear regulation on monitoring. The results of the National Audit Office surveys show that 75% of the municipalities indicate that there are no clear legal procedures to monitor use and a survey found that 41% of beneficiaries of a small survey reported using these compensations for food and utilities. (National Audit Office, 2021[5]). Lithuania stands out as being among the few countries to have non-means-tested cash benefits for LTC benefits (Table 2.5).

Table 2.5. 17 out of 21 European countries or subareas have at least one means-tested home LTC benefit

European countries or subareas	Has home LTC benefits and schemes that are:			
	Both income- and asset-tested	Income-tested only	Assets-tested only	Non-means-tested
Vienna (Austria)	No	Yes	No	Yes
Flanders (Belgium)	Yes	Yes	No	Yes
Croatia	No	Yes	No	No
Czech Republic	No	No	No	Yes
England	Yes	No	No	Yes
Tallinn (Estonia)	No	Yes	No	No
Finland	No	Yes	No	Yes
France	Yes	Yes	No	No
Germany	Yes	No	No	Yes
Hungary	No	Yes	No	No
Ireland	No	No	No	Yes
South Tyrol (Italy)	Yes	No	No	Yes
Japan	No	Yes	No	No
Latvia	No	Yes	No	Yes
Lithuania	No	Yes	No	Yes
Luxembourg	No	No	No	Yes
Netherlands	Yes	No	No	Yes
Slovak Republic	No	No	No	Yes
Slovenia	Yes	No	No	Yes
Spain	Yes	No	No	Yes
Sweden	No	Yes	No	No
Number of countries/regions	8/21	9/21	0/21	15/21

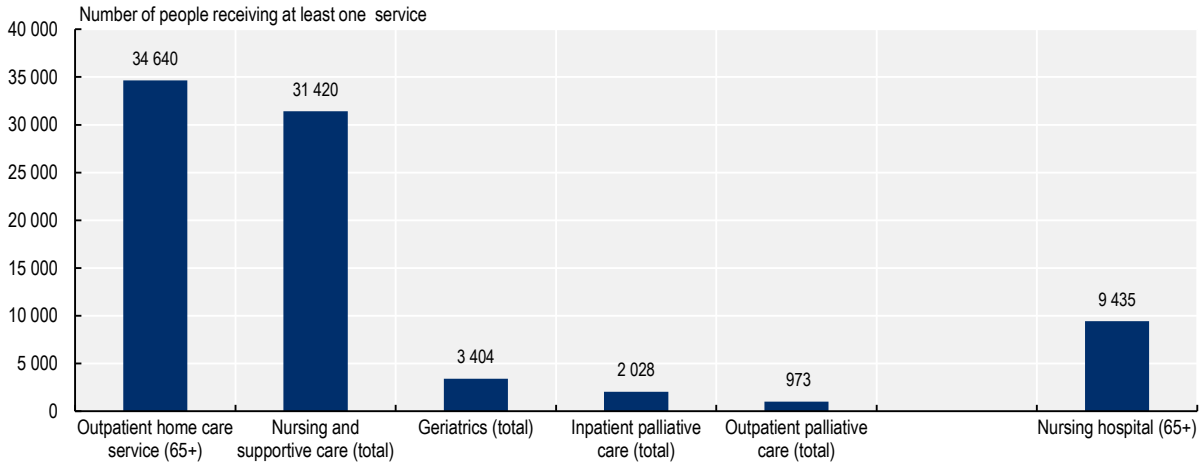
Note: Benefits and schemes are income- and assets-tested when the level of public support changes with care recipients' incomes and assets. Benefits and schemes are income-tested only when public support changes with care recipients' incomes but not assets, and vice versa for assets-tested only benefits and schemes. Non-means-tested benefits and schemes provide the same level of public support to all care recipients, regardless of care recipients' income or assets. Countries and subareas are sorted top to bottom alphabetically by the name of the country. Data covering Austria, Belgium, Estonia and Italy are not available.
Source: adapted from OECD (2020[61]), OECD Health Statistics 2021, http://www.oecd.org/health/health-data.htm.

Overall access to services for older people is low in Lithuania

Use of home-based health services is low and use of nursing hospitals decreased

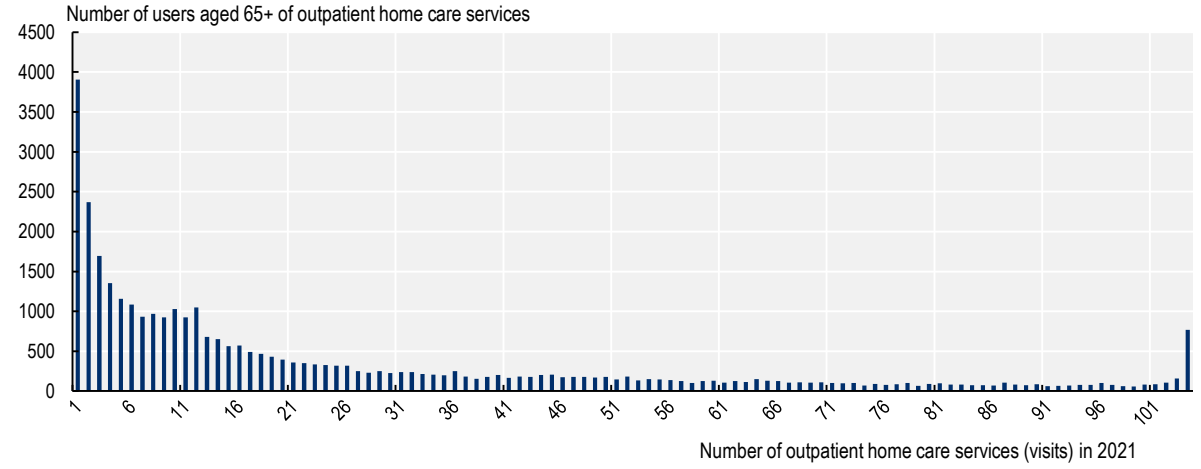
In 2021, nearly 35 000 people aged 65 and over received at least one home care service (Figure 2.2). This is higher than the number of people receiving at least one nursing and supportive care service in a polyclinic or another health care facility (over 30 000). Nevertheless, it seems that those registered as entitled too outpatient home care service are automatically considered as recipients of care in the IT system, according to interviews, so these numbers might be slightly overestimated. Most people receive a limited number of outpatient home care services: about 6 000 older people, or 1.1% of older people, received one visit at least once a week on annual average for outpatient home care services in 2021 (Figure 2.3).

Figure 2.2. Nearly 35 000 older people received at least one outpatient nursing home service



Source: Ministry of Health (2021 for outpatient home care service, 2020 for nursing hospitals, 2018 for nursing and supportive care, geriatrics and palliative care).

Figure 2.3. Most older users of home care services receive a limited number of outpatient home care service



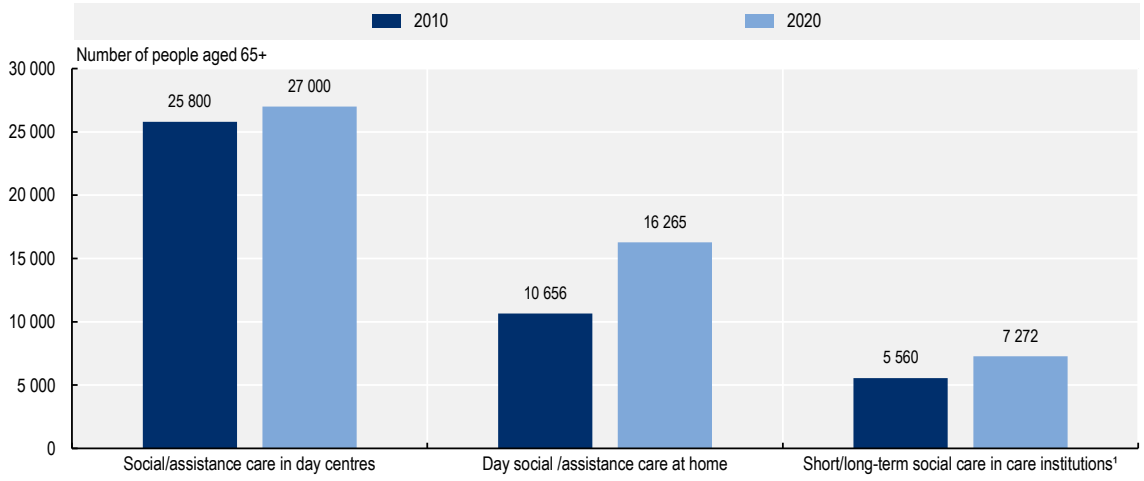
Source: National Health Insurance Fund.

The number of older patients in nursing hospitals has been decreasing recently. In 2018, there were over 9 400 patients aged 65 and over in nursing hospitals, down from about 12 500 patients in 2015 – a decrease of about a third in 5 years. The decrease took place in nearly all municipalities relatively uniformly, with 5 exceptions. Across municipalities, there was about 3 users per bed in 2020 on average. It is lowest in Rietavo, Šalčininkų district, Tauragės district and Telšių district, with 2 users per bed. It is highest in Elektrėnų, Neringa, Šiaulių district and Skuodo district, with 4 users per bed. Demand for nursing hospitals is seasonal to some extent – it weakens during summer and surges during winter months. This may be related to difficulties to access insufficient day LTC services, increased incidence of illnesses (e.g. flu), and to individual strategies to avoid seasonal costs, such as heating. After service discharge, there are no nationwide standardised protocols in place across family doctors, polyclinics and municipalities to plan upcoming health care needs. Informal carers of the focus groups indicated that this is the moment when they feel “lost” about the next steps.

Social services for older people are unevenly distributed across the country

Most social services are provided in day centres. In total, slightly over 50 000 older people received social services social/assistance care at home or in an institution (Figure 2.4): of those, about 27 000 people received day social care or social attendance in a care institution or a social attendance centre, while 16 265 older people received such services at home. There are 111 providers of day social services (social care or assistance care) at home in Lithuania, of which 11 are care institutions providing day care at home in 2020. The average rate is 147 older recipients per provider of social services (social care or assistance care) at home. Of those receiving social care, there were about 6 300 residents in care institutions for older people in 2020 in Lithuania, with 138 care institutions and an average of 46 residents per care institution. There were 6 894 places available in Lithuania in 2020, so care institutions are very close to full capacity (91%). A draft reform aims to create up to 10 specialised day centres in cities, where patients will have access to integrated health and social services and community-based activities. In order to develop this approach, about 10 centres and 90 mobile teams are estimated roughly (90 teams x 8 persons for mobile teams and 10 centres x 20 persons for day centres) according to government estimates.

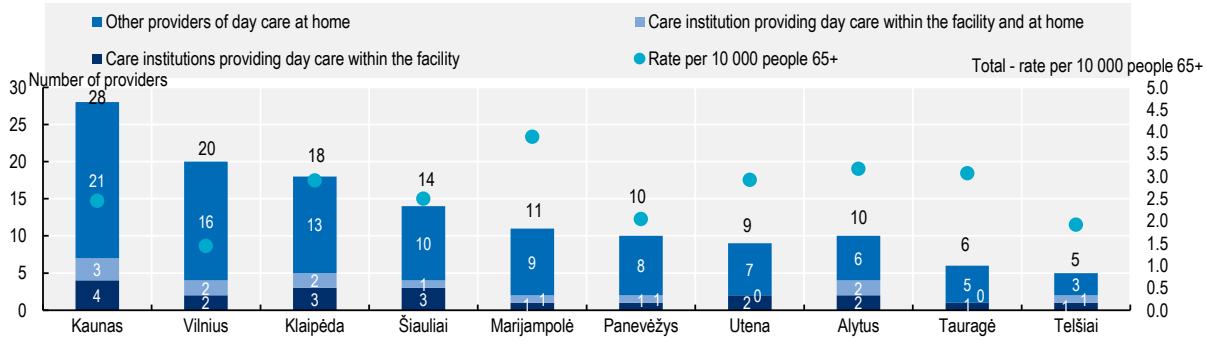
Figure 2.4. Over 50 000 older people received social/assistance care at home or in institution



Note: Care institutions include those for older people and those for people with disability.
Source: Statistics Lithuania.

The rate of providers of day social/assistance care at home varies greatly across the country. This rate is lowest in Vilnius with 1.4 providers per 10 000 older people and highest in Marijampole (3.9 providers per 10 000 older people) (Figure 2.5).

Figure 2.5. There are 3 providers of day care in institution or at home per 10 000 older people on average

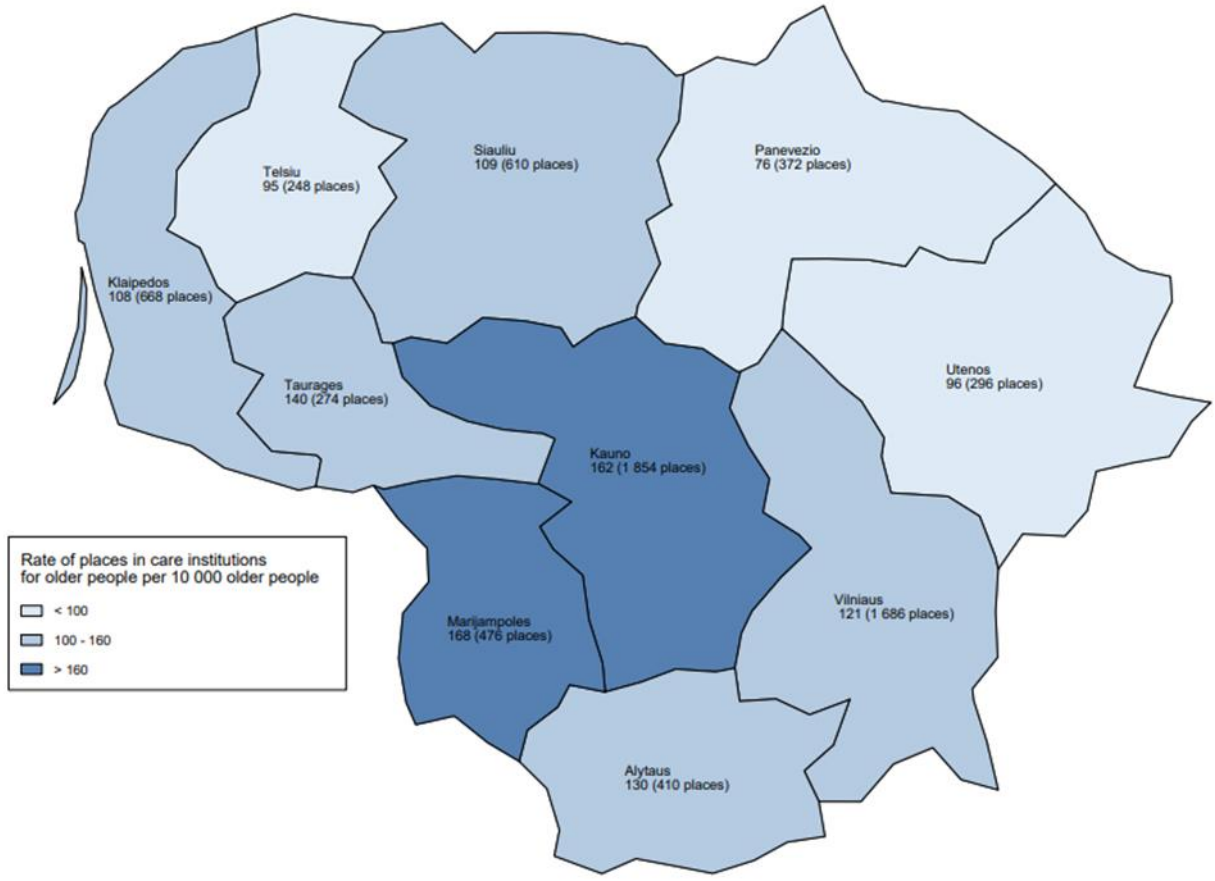


Source: Ministry of Social Security and Labour (data refer to 2020).

Waiting lists vary greatly according to the type of service. In 2020, 679 older people were waiting for social care or social attendance at home (respectively 359 and 320 older people), down from 781 people in 2019. In 2019, 1 278 older people were waiting to receive long-term social care. The number decreased to 749 older people in 2020. The decreases may be related to the COVID-19 pandemic and corresponding policy responses. Along the same line, care institutions have the longest waiting lists according to municipalities. Waiting times vary markedly across municipalities, with some recording no waiting lists for most services and others recording up to 59 people in waiting lists across all LTC services of their municipality.

The number of places in care institutions is unevenly distributed in Lithuania, with over half of places located in Vilnius and Kauno, the two counties with the highest numbers of people aged 85 and over. When controlling for the number of older people, the rate of places in care institution is lowest in Panevezio (76 places for 10 000 older people) and highest in Kauno and Marijampole (above 160 places per 10 000 older people) (Figure 2.6).

Figure 2.6. The rate of places in care institutions is highest in Marijampole and Kauno



Note: Data covers care institutions for older people.
Source: Statistics Lithuania 2021 (data refer to 2020).

The vast majority of Lithuanian municipalities reported LTC facilities in their municipality such as care institutions for the older people (91%), municipal care homes (88%), and care institutions for adults with disability (88%), as well as nongovernmental, parish, and private care institutions (77%). Only around half of the municipalities reported having continuing care retirement communities (56%) and state (county) care homes (44%). Lithuania counts few continuing care retirement communities despite an increasing trend, and they are mostly public and work at full capacity. There were 35 continuing care retirement communities for the older people and people with disability in 2020, up from 22 in 2016. About 75% are municipal communities and the vast majority of new communities are municipal ones. In 2020, 737 places were available in the retirement communities, up from 528 in 2016. The average number of places per community was 23 places for municipal retirement communities and 15 in the other communities (non-governmental organisations-NGOs, parish, private sector). Overall, they are close to full capacity – 82% of places were occupied in 2020. There is no co-ordination protocol between care institutions and hospitals in Lithuania, even though a substantial share of the new residents are recently discharged from hospitals. Among the residents of care institutions for older people, latest available data showed that about 50% of residents came from hospitals and 50% came from their household in 2018.

The majority of care institutions for older people are not public in Lithuania. The share of public institutions declined from about half of all care institutions in 2016 to 43% in 2020. The number of public care institutions has been stable since 2016 (around 55 municipal care institutions), while the number of care institutions of NGOs, parish, and the private sector has increased, with 992 additional residents in 5 years (Table 2.6). The number of residents per care institution has remained stable in these institutions and in municipal care institutions, with around 40 residents per care institution of the NGOs, parish, and private sector and over 50 for municipal care institutions.

Table 2.6. The majority of care institutions for older people are no longer public in Lithuania

	Number of residents		Number of care institutions		Average number of residents	
	2016	2020	2016	2020	2016	2020
State (county) care homes[1,2]	594	333	4	4	149	83
Municipal care institutions	2564	2921	49	55	52	53
NGO, parish and private care homes	2041	3033	54	79	38	38

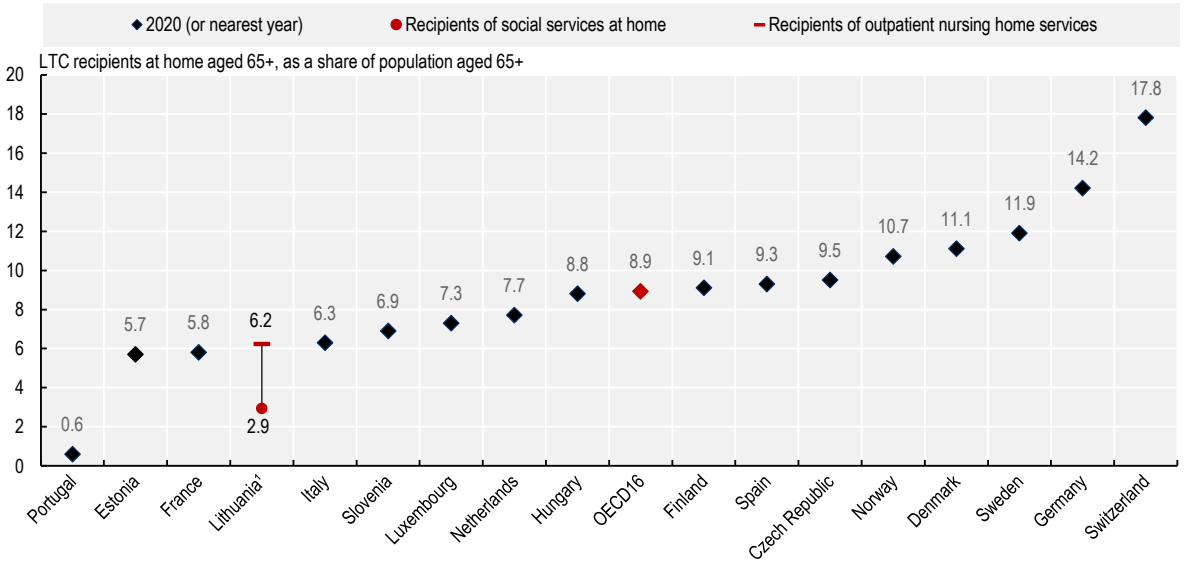
Note: 1. data refers to 2017 because a suspected change in the classification that added 2 state (county) care home and reduced from 2 to 0 the category "other care institution". This category is not included in this table. The change in terms of number of residents is also consistent. 2. The number of residents in state care homes declined from 626 to 333 residents in 2019-20 while the number of care institutions stayed stable. This drop may be related to the COVID-19 pandemic.
Source: Statistics Lithuania 2021.

In Lithuania, over 70% of municipalities held a contract with third-party providers in 2020. The majority (55%) held at least one contract with a not-for-profit organisation, 43% with a not-for-profit private organisation, and 31% with a for-profit organisation. Third-party providers are mostly care institutions. The biggest municipalities tended to contract with providers of different types, including for-profit. Only 9 municipalities reported contracts with providers of day social/assistance care. The three municipalities reporting the highest number of users of third-party providers' services were Vilnius miesto (670 people), followed by Kelmės rajono and Molėtų rajono (< 100 people). Third parties providing social services do not have the legal right to make profit – they have to agree with municipalities on prices that cannot be higher than the expenditure of the services. Municipalities closely monitor service delivery and spending of the contracted providers. They have to submit a report detailing the care provision every month to receive payment. In addition, at the end of the reporting period (quarters and year), providers also submit a report on the care provision and the related "invoice", in a view to monitoring the completed budget.

Lithuania has a low number of recipients compared with other EU countries

About 2.9% of older people receive social services at home and 6.2% older people receive at least one outpatient home nursing service (Figure 2.7). As a point of reference, the average is 8.9% across 16 European OECD countries. It is not possible to know how many people receive both social services at home and outpatient home nursing services because of separate IT systems (Box 2.1) and a lack of co-ordination.

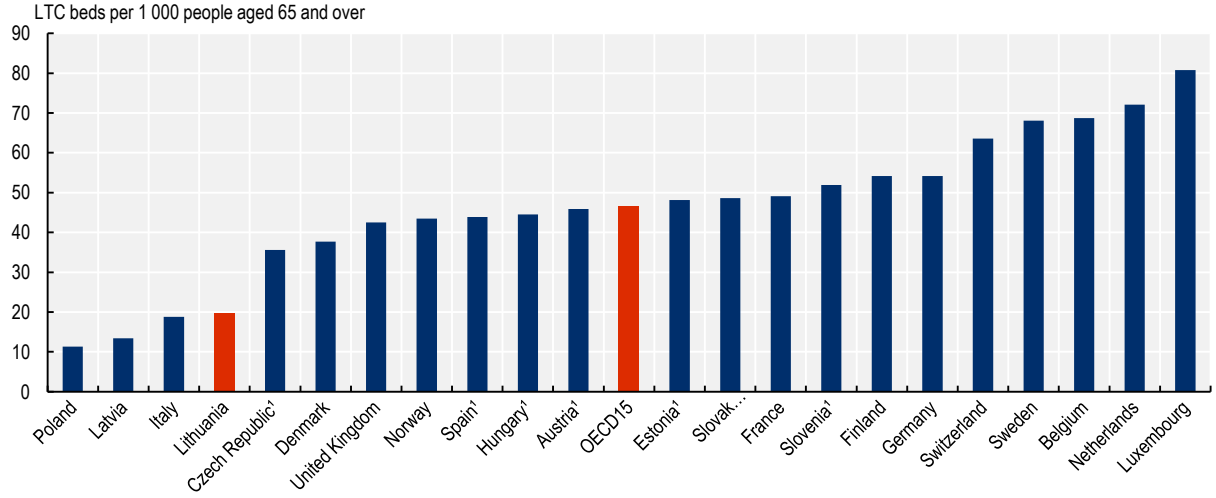
Figure 2.7. The estimated rate of in-kind LTC recipients at home is lower in Lithuania than in many EU countries



Note: 1. 2020 point for Lithuania is ranked based on the share of recipients of outpatient nursing home services. The OECD average excludes Lithuania. This graph should be interpreted with caution because of the exclusion of people receiving the cash benefits in Lithuania.
Source: OECD Health Statistics Database 2021 and OECD questionnaires 2021 for Lithuania.

Availability of institutional care is also low for international standards. When aggregating beds from the social sector and the nursing hospitals, Lithuania counts 20 beds per 1 000 older people[5], compared with 47 beds per 1 000 older people across OECD countries (Figure 2.8).

Figure 2.8. The rate of LTC beds in Lithuania is below half the OECD average



Note: For Lithuania, data refer to the 6 894 places in care institutions, the 3 195 beds in nursing homes and 737 places in continuing care retirement communities.
1. Deviation from the definition leading to an overestimation. The OECD average excludes these countries with overestimated data.
Source: OECD Health Statistics Database 2021 (data refer to 2019) and OECD questionnaires for Lithuania.

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Notes

[1] Nursing beds in general hospitals are funded similarly. The payment is per bed day depending on actual duration of patient treatment, but no longer than 120 days per calendar year. Five different reference prices per bed day are applicable depending on the patient health condition.

[2] In OECD Health Statistics, the health component of LTC is estimated at EUR 257.2 million in 2020, and the social component of LTC to EUR 302.9 million. The total reaches EUR 560.1 million. There is a gap between the data reported in OECD Health Statistics and data presented in this subsection.

[3] As part of the project, a questionnaire was distributed to the 60 municipalities, with a 78% response rate.

[4] The Barthel Index focusses on personal care with indicators on activities of daily living (e.g. washing, eating).

[5] In OECD Health Statistics Database, the rate was 38.5 in 2019 – a clear overestimation. For example, it includes the number of children in special boarding schools and centres for special training, beds in care homes for children with disability and youth (boarding school), beds for the children with disability[5] in county and municipality childcare homes and beds of nursing departments of general hospitals.