Integrating Services for Older People in Lithuania

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Foreword

Lithuania is ageing quickly: the share of the population aged 65 years and over is expected to grow from 20% in 2019 to 32% in 2050, faster than the average for OECD countries (17.6% in 2019 and 26.7% in 2050). As people get older, they will more likely need help with ongoing medical care, everyday activities such as washing and dressing, household activities such as cleaning and cooking, as well as with social activities such as going out for a walk. This help is part of what is commonly termed long-term care (LTC). Support from family and social networks for such care is likely to drop due to changing family characteristics and social norms. Over a third of older Lithuanians with activity limitations are at risk of poverty. This heightens the importance of public support for care.

In Lithuania, the long-term care system is fragmented across health and social services, with different eligibility conditions and needs assessment criteria and procedures. This fragmentation generates unmet needs for some, and an overlap of services for others. Rethinking funding streams and ways to co-ordinate services is necessary for the system to better provide to the needs of older people.

This report examines the provision of long-term care services in Lithuania. It analyses the supply of long-term-care services and its financing, the competences of care workers providing services. It points to an inadequacy of services provided. The report proposes directions for reform to bring Lithuania's long-term care services in line with evolving population needs, strengthen the care workforce, and improve service integration and funding. Such policy options build on analysis of best practices from other countries which are also outlined in the report.

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The project benefited from input from a range of stakeholders: data and policy questionnaires distributed to the 60 municipalities, the Ministry of Health, the Ministry of Social Security and Labour and the National Health Insurance Fund; individual interviews with Lithuanian stakeholders, interviews with international experts; focus groups with municipalities, providers, workers and informal carers; two stakeholder consultations with the Government of Lithuania (Prime Minister's Office, Ministry of Health, Ministry of Social Security and Labour) and the National Health Insurance Fund among other stakeholders; and a workshop with a range of Lithuanian stakeholders and international experts.

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Executive summary

The number of people receiving long-term care (LTC) services in Lithuania is low compared to the OECD average. Existing supply does not meet the needs of people requiring them. LTC spending in Lithuania is lower than the OECD average – 1.1% of GDP in 2019, relative to an OECD average of 1.5% of GDP. Lithuania counts 20 LTC beds per 1 000 older people, a rate less than half the OECD average of 47 LTC beds per 1 000 older people. About 2.9% of older people receive social services at home and 6.2% receive at least one outpatient home nursing service. In comparison, the OECD average of home care recipients is 8.9%. At the same time, the Ministry of Social Security and Labour supports older people with two cash-benefits which represent twice the amount of public spending on care services, are not means-tested, and are often used to buy food and utilities instead of care.

Such outcomes relate to the fragmented organisation of LTC in the country. Lithuania has no specific legislation for long-term care (LTC), and services are provided through the health care system or within social systems. Competencies for policy design and provision are divided: the Ministry of Social Security and Labour is responsible for social protection benefits and services that are provided through the municipalities, while the Ministry of Health is responsible for health care services provided through primary care or nursing hospitals. Services and benefits are funded from different sources, including the national government, local municipal budgets and the Health Insurance Fund. Users also pay a significant share of the cost out of their pockets. This fragmentation has resulted in wide differences in the services received by citizens, who often face challenges navigating the system. Needs assessment for home services provided through the health system differs from the needs assessment for social services and there is no standardised needs-assessment tool to guide admissions to nursing hospitals. Eligibility conditions also differ widely. Access to social services relies on means-testing, while access to health services for long-term care is free of charge, but subject to a volume cap in the number of services entitled per year.

Lithuania would need to increase the pool of LTC workers significantly in the face of population ageing. It has one of the lowest levels of LTC workers in the EU with only 1 worker per 100 people aged 65 or above compared to the EU average of 4 workers per 100 in 2019. There are staff shortages, in particular for nurse assistants. Most care provided to older people is still carried out by families and relatives, due to insufficient service provision. Informal or family caregivers receive little support as there are no cash-for-care benefits available nor leave from work or training for family caregivers in Lithuania. This context calls for important initiatives in at least three main policy areas.

Measures to attract and retain formal caregivers should be considered together with policies to support informal or family carers. Recruitment policies to train people out of work and those in sectors with decreasing labour demand can be used to increase the formal LTC workforce. Lithuania could also attract citizens working abroad, increasing the formal workforce and bringing the skills they have gained abroad to Lithuania. The inclusion of foreign-born workers within the formal workforce could also be facilitated, easing the migration process and providing them with an adequate set of skills. To improve the retention rates, Lithuania should consider providing LTC workers with better training and improve their working conditions, while task delegation and a joint digital registry for health and social services could contribute to better productivity in the sector. In addition, the position of care manager, as used in Denmark

and Japan, could broaden career pathways. As for policies to support informal caregivers, training options and leave, preferably paid, should be considered. While Lithuania does not include a leave for care, about two-thirds of OECD countries provide paid or unpaid leave to care for an older family member.

Lithuania could benefit from a new legislative framework with one main act on long-term care, consolidating access to rights and conditions, as in several OECD countries discussed in the report (Austria, France, Germany, Slovenia and Spain). A unified legislation is paramount to overcome the high level of fragmentation, clarify the competence of different stakeholders and the broad types of benefits and services, and ensure a single point of access. An essential requirement for integrated care is a harmonised needs assessment tool to group needs into levels, as part of a gradation scale of benefits, as in Germany and Japan. This can guarantee that people with comparable needs have comparable rights and services and encourage choice according to people's preferences.

A funding reform is pivotal to help deliver integrated care and avoid cost-shifting across different sectors of delivery, as well as promote the sustainability of financing of LTC services in the face of future challenges. Lithuania can consider three possible options, which are not mutually exclusive: 1) having a dedicated budget that pools current funding, following the example of France; 2) introducing an LTC insurance following the example of Germany and Japan); and/or 3) ensuring a broad-base for taxation as in Scandinavian countries. Harmonising the eligibility conditions between cash benefits and the services can contribute to more effective and efficient public spending. Finally, the report also suggests encouraging preventative and rehabilitation services to delay long-term care needs, as in Denmark.

Part I : The current situation of long-term care support in Lithuania

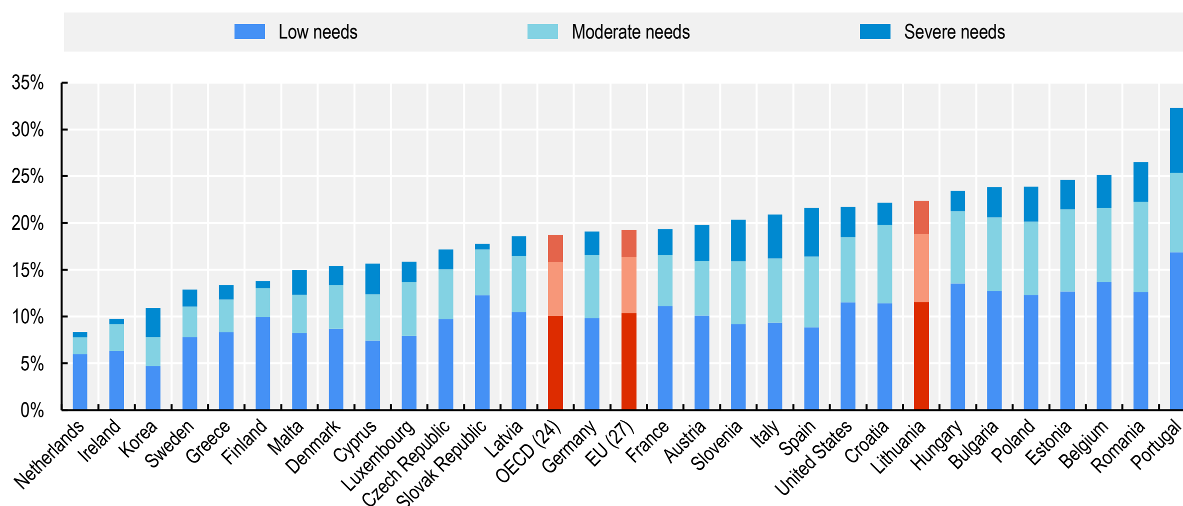
1 Growing demand for care and insufficient supply in Lithuania

This chapter provides key insights on the demand and supply of long-term care In Lithuania. Firstly, it highlights that population ageing and long-term care needs are sizeable and growing in Lithuania. It also describes the provision of care by family members, friends or neighbours who are called informal carers. They are the backbone of the system but receive limited, although increasing public support. Finally, it discusses the limited numbers of the long-term care workforce in Lithuania, their working conditions and qualifications.

A substantial share of older people has care needs and limited financial resources

Long-term care (LTC)[1] needs are high in Lithuania and are likely to increase with population ageing. Around 22% of older people in Lithuania is estimated to have long-term care (LTC) needs, compared to the EU average of approximately 19% (Figure 1.1).The share of population aged 65 years and over is expected to grow from 20% to 32% and the share of 85 years and over will grow from 6% to 12% from 2019 to 2050. Given that many older people live with some health issues, the long-term care needs in Lithuania are expected to increase in the coming years. The geographical distribution of the older population is uneven across the country, with people aged 65 or older representing a bigger share of the population in smaller counties or municipalities, generating challenges for the distribution of services.

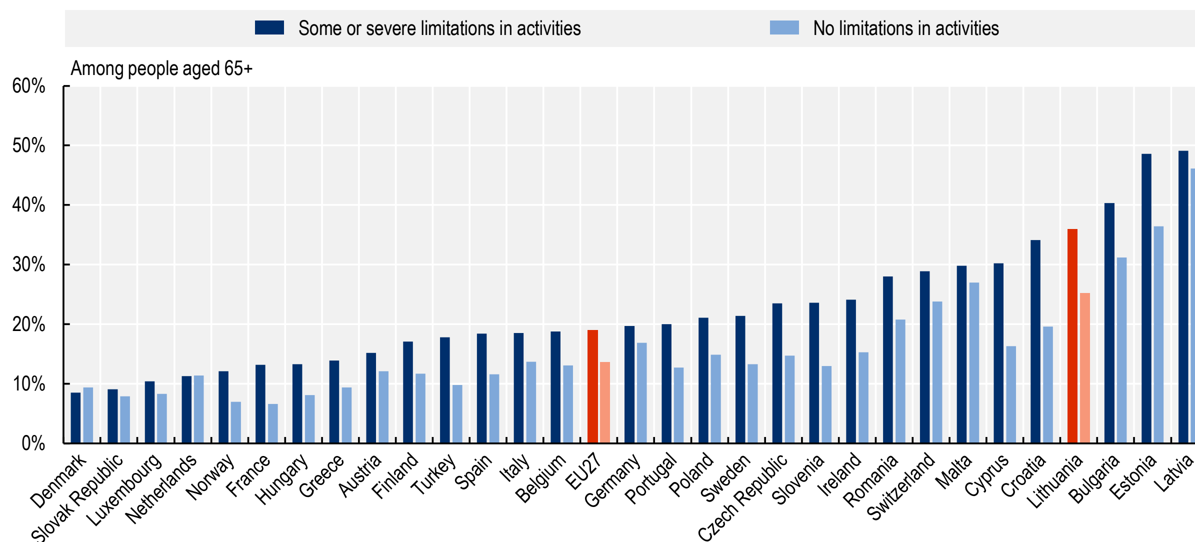
Figure 1.1. The share of older people with low, moderate and severe LTC needs is higher in Lithuania than OECD average



Note: Low, moderate and severe needs correspond to around 6.5, 22.5 and 41.25 hours of care per week, respectively. Detailed descriptions of care recipients' needs are available in Oliveira Hashiguchi and Llena-Nozal (2020[1]), "The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?", https://doi.org/10.1787/2592f06e-en and are computed using adjusted survey weights. The OECD (24) and EU (27) averages are the unweighted average of the shares in each country.
Source: OECD analysis based on responses to the Survey of Health, Ageing and Retirement in Europe (SHARE), The Irish Longitudinal Study on Ageing (TILDA), the Korean Longitudinal Study of Aging (KLoSA) and the Health and Retirement Survey (HRS) in the United States to estimate the prevalence of low, moderate and severe needs.

Older people in Lithuania have limited financial resources to meet the costs of long-term care privately and there is a risk that their needs are left unmet without sufficient public provision. The net pension replacement rate of men in Lithuania ranked at the second lowest among EU countries in 2018. The share of older people with activity limitations at risk of poverty in Lithuania is amongst the highest in EU countries. Nearly 35% of older people reporting limitations in activities are at risk of poverty, compared with just under 20% in EU countries on average (Figure 1.2). Currently, unmet LTC needs are relatively high in Lithuania. About 40% of older people with at least one daily limitation reported unmet LTC needs in Lithuania, compared with 30% of older people on average across 25 EU countries in 2019-20 based on SHARE data.[2]

Figure 1.2. Among older people, those with limitations in activities because of health needs are more at risk of poverty



Source: Eurostat database (Data refer to 2019).

Informal carers provide the bulk of care, although they receive limited public support

The majority of older Lithuanians receive only informal care. Long-term care can be delivered by formal care workers or by informal carers. Although the definition of informal carer is not straightforward, the two cornerstones of the definition are usually that: 1) an informal carer is a family member, close relative, friend or neighbour; and 2) carers are non-professionals who did not receive qualifying training to provide care (even though they can benefit from special training). About 90% of Lithuanians use solely informal care, against 70% in European countries while less than 5% receive only formal care (Social Protection Committee (SPC) and European Commission (DG EMPL), 2021[2]).

The provision of high intensity informal caring renders the labour market participation of carers more difficult. In Lithuania, the intensity of care provided at home is higher in Lithuania compared with the EU average, although the share of people aged 45-64 and providing informal care is broadly in line with the EU average (Social Protection Committee (SPC) and European Commission (DG EMPL), 2021[2]).

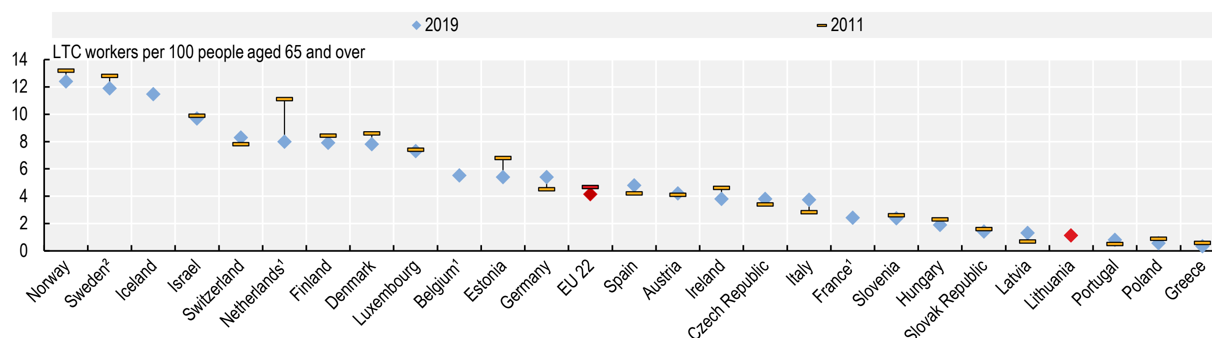
Compared to other OECD countries, the support provided to informal caregivers in Lithuania is limited, but improving. No direct cash benefits, nor formal indirect cash benefits are provided to informal carers. Lithuania has recently improved the social protection of caregivers under specific income and age conditions among other conditions: since 2020, it covers the pension and the unemployment social insurance of caregivers of people with a special need for permanent care (or assistance)[3] (Ministry of Social Security and Labor of the Republic of Lithuania, 2021[3]). While half of OECD countries provide paid leave to care for an older dependent, in Lithuania neither paid nor unpaid leave is in place for caregivers (Rocard and Llena-Nozal, 2022[4]).

Informal caregivers would benefit from additional support such as training and better respite care. In particular, training on medical care (e.g. bandaging wounds, treating pressure ulcer) and personal care and access to psychological support appear to be minimal in Lithuania. Focus group discussions[4] suggest that informal carers need training mostly for care that requires physical movements and preserving older people's dignity (e.g. how to turn the older people in bed, how to change diaper, how to bath). If a person is cared for by relatives living in the same household, the carer can apply to *temporary respite services*. However, informal carers can also face challenges to access the respite services they are entitled to because care institutions are already close to full capacity. One common strategy is to move the older people to nursing hospitals so that relatives can take a break from caring. Lithuania has recently strengthened respite services: since 2021, the temporary respite has been a separate social service in the Catalogue of Social Services and is provided on an as-needed basis, for up to 720 hours per year (in exceptional cases, and in particular in a crisis situation, temporary respite can be provided continuously for up to 90 days). Lithuania is considering further improvements to temporary respite by either including respite care in a possible forthcoming Long-Term Care Act or amending the law on Social Services.

The rate of LTC workers is very low compared with the EU average

Lithuania is among the countries with the lowest levels of LTC workers across EU countries, with only one worker per 100 people aged 65 or above, in 2019 (Figure 1.3). Formal long-term care workers are paid staff – typically nurses and personal carers – who provide care and/or assistance to people limited in their daily activities at home or in facilities.[5] The EU average of the number of LTC workers per 100 people aged 65 or above was 4.1 in 2019.

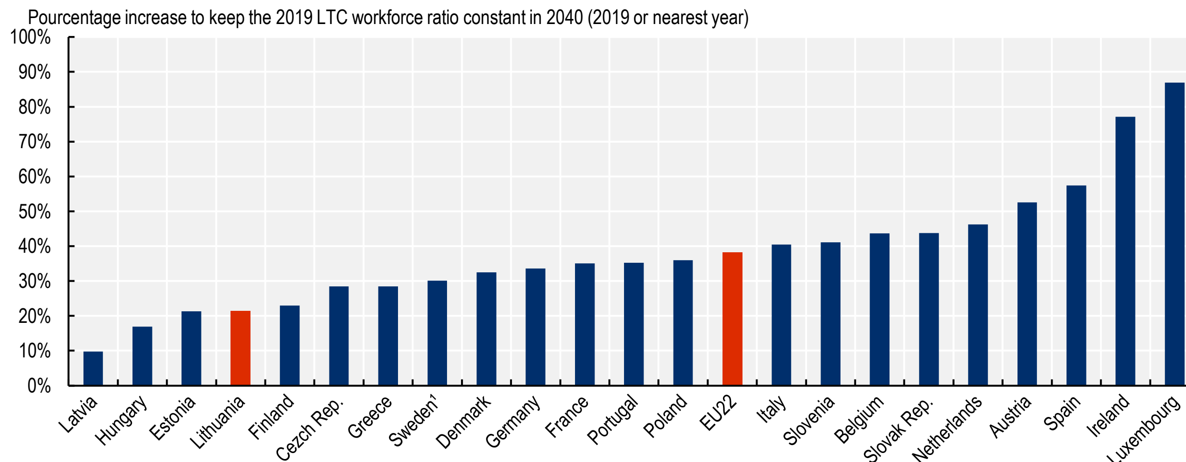
Figure 1.3. Lithuania has among the lowest staff levels across EU countries



Note: 1. Break in time series. 2. Data for Sweden cover only public providers. In 2016, 20% of beds in LTC for older people were provided by private companies (but publicly financed).
Source: OECD Health Statistics 2021, complemented with and EU-LFS.

Lithuania, as all other OECD countries, would need to increase its pool of LTC workers substantially by 2040 to care for their ageing populations (Figure 1.4). Lithuania should increase its LTC workforce by 20% by 2040 if it wishes to keep the current ratio of caregivers to the elderly population. While Lithuania ranks lower compared with other EU countries, this number still represents an important increase that would require substantial policy support to develop the workforce. In comparison, relative EU countries need to increase by nearly 40% the current number of LTC workers on average.

Figure 1.4. Lithuania would have to increase its workforce by about 20% to keep its current ratio to older people constant by 2040



Note: 1. Data for Sweden cover only the public providers. The EU average is unweighted.
Source: EU-Labour Force Survey and OECD Health Statistics 2021; Eurostat Database and UN population projections for population data.

Low staffing levels are related to staff shortages and can fall well below pre-determined quality standards with respect to staffing ratios. According to an analysis by the National Audit Office, between 2017 and 2020, the number of employees in surveyed institutions providing social care was lower than the requirements. Across 11 institutions providing daily and short-term social care at home, 4 reported shortages of social workers, 2 of nurses, and 2 of nurse assistants. Among the 13 institutions providing long-term and short-term social care, 3 had shortages of social workers, 2 of nurses and 2 of nurses' assistants. Moreover, the workload of nurses and their assistants often does not correspond to the recommendations (National Audit Office, 2021[5]).

Lithuania is seeking to address such shortages through changes to staff mix change and better staff recognition. With respect to the health care system, Lithuania estimated being short of 2000 nurses and 6 000 nurse assistants in 2021 in total (including hospitals). Lithuania has recently changed their nurse-nurse assistant ratio's objective, giving more importance to nurse assistants. Lithuania plans to shift nurses' tasks to nurse assistants and aims to have a ratio of 1 nurse for 2-3 nurse assistants in the future (OECD Questionnaire to the Ministry of Health, 2021). In April 2022, Lithuania formed a new supervisory committee that aims to implement the guidelines of the National Nursing Policy 2016-25, which covered qualifications and licences, training, assessment of competences, working conditions. This committee is composed of hospital nurses, representatives of nurses' unions and representatives of universities. The Lithuanian Government is also preparing two laws on social services to make social work a better recognised professional activity. The draft laws will define social workers, clarify the concept of social work, the areas of implementation of social work, the principles of implementation of social work, and the rights, duties, and responsibilities of social workers. Finally, the Ministry of Social Security and Labour is considering that single individuals (not only social services institutions, like non-governmental organisations, private or public institutions) could be able to provide social services.

Working conditions in LTC are poor

In Lithuania, there is a high share of LTC workers in non-standard contracts (e.g. part-time and fixed-term), which undermines the sector's attractiveness (Žalimienė, 2013[6]). A survey conducted in 2017 in Lithuania revealed that the share of employees with fixed-term contracts was 6 times higher in the home care sector than the average in Lithuania, and part-time contracts were 3 times more common than average. In

comparison, nearly 45% of LTC workers across OECD countries work part-time, and almost 20% have a fixed-term contract (OECD, 2020[7]). Nurses, nurse assistants and physiotherapists usually work 7 hours and 36 minutes per day,[6] but the working times can accommodate workers' preferences. According to focus group discussions, smaller LTC facilities are less able to accommodate workers' preferences.

LTC workers in Lithuania report several sources of stress in the workplace. In home care, the lack of communication with family members can be challenging, as well as accommodating patients' mood swings. Lack of information around the services' provision on the care recipients' side is also highlighted as a challenge, with family members asking for services that are not included in the workers' tasks. Beyond the psychological stress and risk of burnout, interviewed LTC workers report episodes of physical violence.

Salaries for LTC workers from the social sector depend on municipal budgets, generating wide differences across municipalities. Overall, in bigger municipalities, LTC workers receive more generous bonuses and premiums and are satisfied by their remuneration. In contrast, LTC workers in smaller municipalities report having fewer opportunities to receive additional payments (e.g. premiums and bonuses) to complement their fixed salary. Both the flexible and fixed components of the salary are set at the municipal level. The large range between the municipality with the lowest reported wages and the one with the highest reported wages confirms the findings of the focus groups regarding the wage gaps across municipalities (Table 1.1). The budget allocated to LTC workforce can also vary over the time, depending on the priorities of municipal budgets, which can result in uncertainty over LTC workers' salaries.

Table 1.1. There is high variability in LTC wages across municipalities

Monthly average gross salary for LTC workers in 2021 (or latest year available)

EUR	Social workers	Social workers assistants	Nurses	Nurses' assistants
Average	1 364	1 059	1 166	979
Median	1 317	1 021	1 159	957
As a percentage of minimum wage (EUR 642)	205%	159%	181%	149%
In percentage of the median equivalised income of women (EUR 694)	190%	147%	167%	138%
Lowest	800	800	600	800
As a percentage of minimum wage (EUR 642)	125%	125%	93%	125%
In percentage of the median equivalised income of women (EUR 694)	115%	115%	86%	115%
Highest	1 870	1 386	2034	1 304

Note: 39 municipalities reported data.
Source: OECD questionnaire, 2021.

LTC workers on the health sector fare slightly better, with improvements in remuneration in recent years. Data on nurses' and nurse assistants' wages submitted by the Ministry of Health appear higher than the average and median wages across municipalities. Gross monthly wage is reported to be around EUR 1 600-1 700 (about EUR 1 100-1 200 after tax) for nurses, and around EUR 1 000 (about EUR 700 after tax) for nurse assistants. Between 2017 and 2020 gross monthly average salaries in public providers increased from EUR 1 008 to EUR 1 659 for nurses. In addition, wages in the health care sector were increased by 6% in 2022.

Qualifications are well-defined and training opportunities exist but there are some gaps

In Lithuania, social workers and assistants need to hold specific qualifications and to undergo training. The requirements for social workers working in LTC consist in: (i) a qualification in social work or a completed programme of studies in social work and a qualification in social sciences; (ii) another completed qualification degree and a qualification as a social worker, or a completed social work study programme, or a training course to prepare for the practical activity of a social worker. In addition, social workers in Lithuania are required to undertake at least 16 hours of training every year and such training is financially compensated by the employer. Other requirements consist in the discussion of practical cases of social work at least once every four months and the participation in at least 8 hours of supervision per year. Social workers in Lithuania can also take part in an attestation process which enables them to acquire new qualifications and progress in their career. The career of a social worker has three steps: social worker, senior social worker and social worker-expert. Assistants of social workers and home care workers have to hold a specific qualification or they have to undergo an initial training of at least 40 hours to start working in social services institutions. In July 2021, the Ministry of Social Security and Labour introduced a new requirement for assistants of social workers and home care workers – both of which will be required to undergo 400 hours of training instead of 40 hours. EU Structural Funds will fund the additional training for a total of EUR 28 million, between 2021 and 2027.

With respect to the health care sector, the education of a nurse assistant lasts 9 months in Lithuania and costs about EUR 2 000 out-of-pocket. Applicants must hold a secondary education degree (high school degree). The main difference between a nurse and a nurse assistant lies in their type of tasks: nurse assistants do not play the role of co-ordinator while nurses are allowed to perform more complex activities. Nurse and nurse assistants are also allowed to do tasks usually performed by workers of the social sector, like helping with the groceries.

Care institutions also provide additional training and opportunities, which can be either paid for by the institution or by the workers themselves. Among the municipalities with available data, training, seminars and lectures are the most common opportunity for employees' development, available in 92% of responding municipalities. Other opportunities for development are career progression linked to skills development in 23% of municipalities. In 21% of municipalities, employees can have supervision duties and in 8% of municipalities report other practices, such as awarding letters of appreciation, team outings and exchanging best practices with other care institutions.

Focus group discussions revealed that social workers did not receive sufficient training for some of the "technical" tasks they are required to perform and on dementia. For example, they did not always know all the appropriate available services. While the prevalence of dementia is expected to increase with population ageing, in 77% of surveyed municipalities, no specific support is available for older people with dementia.

References

Ministry of Social Security and Labor of the Republic of Lithuania (2021), *I am caring for a family member*, https://socmin.lrv.lt/lt/veiklos-sritys/socialine-parama-kas-man-priklauso/slaugau-seimos-nari (accessed on 30 March 2022). [3]

National Audit Office (2021), *Care and social services for the elderly*. [5]

OECD (2020), *Who Cares? Attracting and Retaining Care Workers for the Elderly*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/92c0ef68-en. [7]

Oliveira Hashiguchi, T. and A. Llena-Nozal (2020), "The effectiveness of social protection for long-term care in old age: Is social protection reducing the risk of poverty associated with care needs?", *OECD Health Working Papers*, No. 117, OECD Publishing, Paris, https://doi.org/10.1787/2592f06e-en. [1]

Rocard, E. and A. Llena-Nozal (2022), "Supporting informal carers of older people: Policies to leave no carer behind", *OECD Health Working Papers*, No. 140, OECD Publishing, Paris, https://doi.org/10.1787/0f0c0d52-en. [4]

Social Protection Committee (SPC) and European Commission (DG EMPL) (2021), *2021 Long-Term Care Report. Trend, challenges and opportunities in an ageing society*, https://doi.org/10.2767/677726. [2]

Žalimienė, L. (2013), *Lankomosios priežiūros darbuotojų darbo vietos kokybė Lietuvoje I N G A B L A Ž I E N Ė, R A S A M I E Ž I E N Ė [[Occupational Well-Being in Social Work Services]*. [6]

Notes

[1] Long-term care represents a range of medical, personal care and assistance services that are provided with the primary goal of alleviating pain and reducing or managing the deterioration in health status for people with a degree of long-term dependency, assisting them with their personal care (through help for activities of daily living (ADL) such as eating, washing and dressing) and assisting them to live independently (through help for instrumental activities of daily living (IADL) such as cooking, shopping and managing finances).

[2] People with unmet LTC needs refer to people who report at least one ADL/IADL limitation, but do not receive any help for limitations in daily activities, or receive help that is hardly ever or sometimes sufficient.

[3] Since 2020, Lithuania has covered the pension and the unemployment social insurance of caregivers of people with a special need for permanent care (or assistance). Parents or guardians caring for relatives with disability are covered by the state for pension and unemployment social insurance if they have no insured income or if their income is below the minimum monthly salary, are under retirement age and do not receive their own social insurance pensions, excluding social security widows' pensions, state pensions, social assistance pensions, social pensions or home care pensions for people with disability.

[4] As part of the project, focus groups were undertaken with municipalities, LTC providers, LTC workers and informal carers.

[5] A range of professionals are not considered in the above numbers such as GPs, mental health professionals (psychologists, psychotherapists, and psychiatrists), physiotherapists, dietitians, cooks and drivers.

[6] Under Lithuanian law, the workday is 8 hours. Nurses, nurses' assistants and physiotherapists are among the categories of workers with high emotional and physical burden whose legal workday is 7 hours 36 minutes.

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

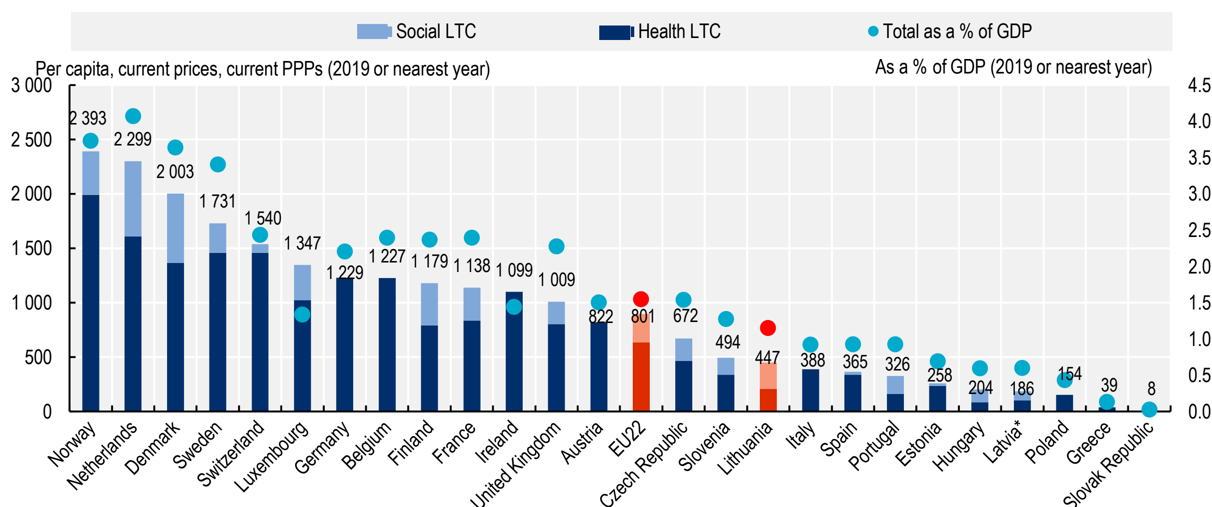
	2015	2018	2019	2020
Total				***362 million***
Total – NHIF				**117.309 million**
Outpatient nursing care in hospitals (to older people)	19 597	35 465	38 686	39 891
Beds in hospitals (nursing beds to older people)	16 853 100	25 539 473	28 924 790	33 792 497
Nursing hospitals (total expenditure)	40 582 268	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

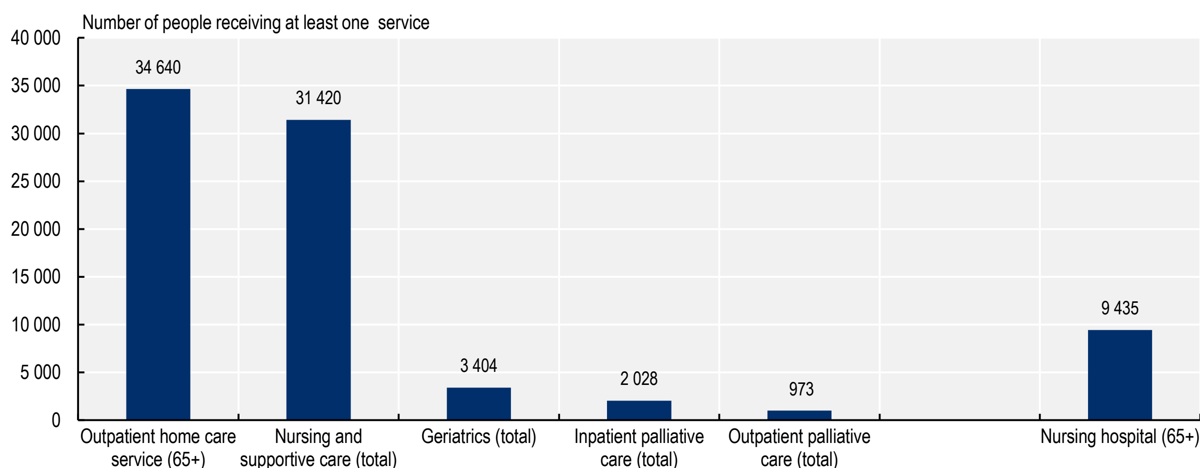
Note: Benefits and schemes are income- and assets-tested when the level of public support changes with care recipients' incomes and assets. Benefits and schemes are income-tested only when public support changes with care recipients' incomes but not assets, and vice versa for assets-tested only benefits 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[6]), 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

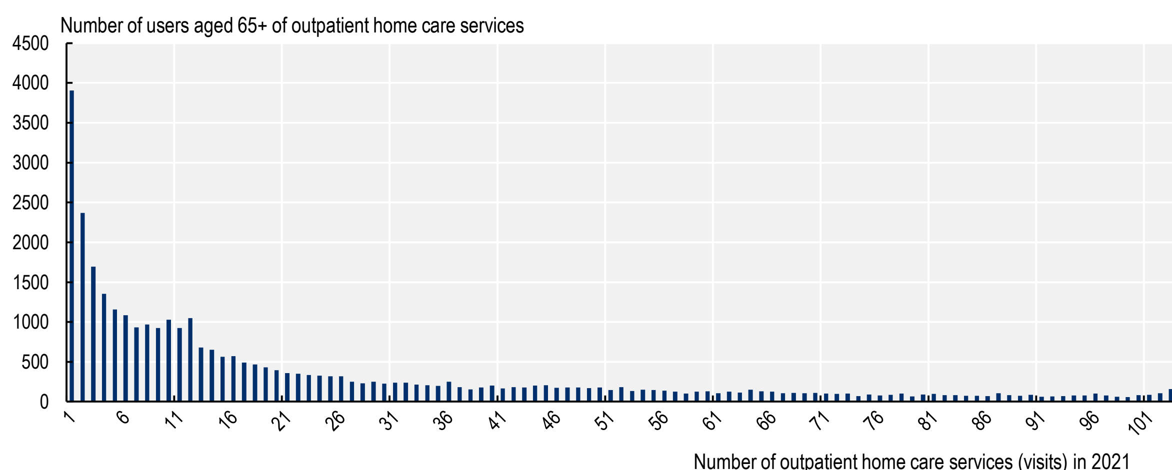
In 2021, nearly 35 000 people aged 65 and over received at least one home care service (Figure 2.2). This is higher than the number of people receiving at least one nursing and supportive care service in a polyclinic or another health care facility (over 30 000). Nevertheless, it seems that those registered 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



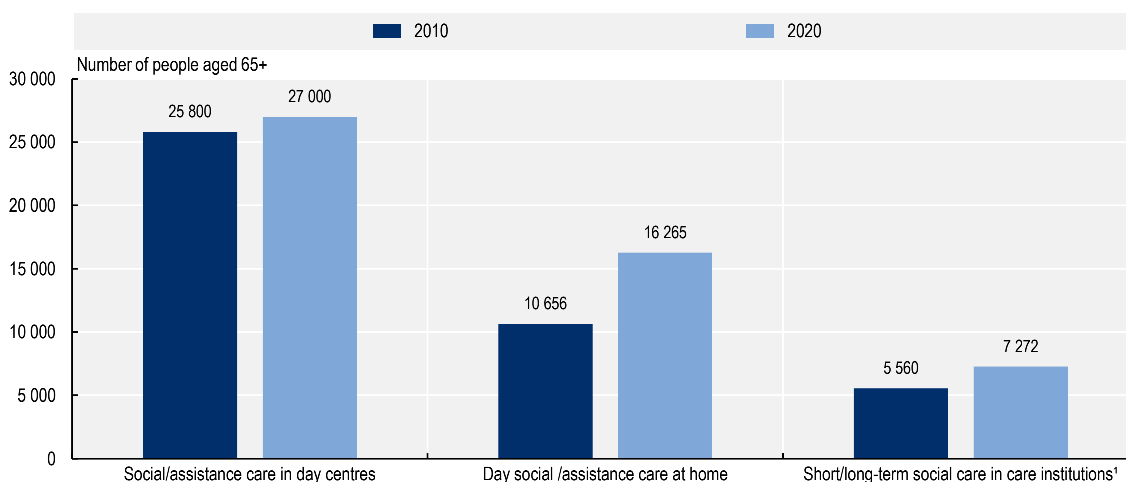
Source: National Health Insurance Fund.

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.

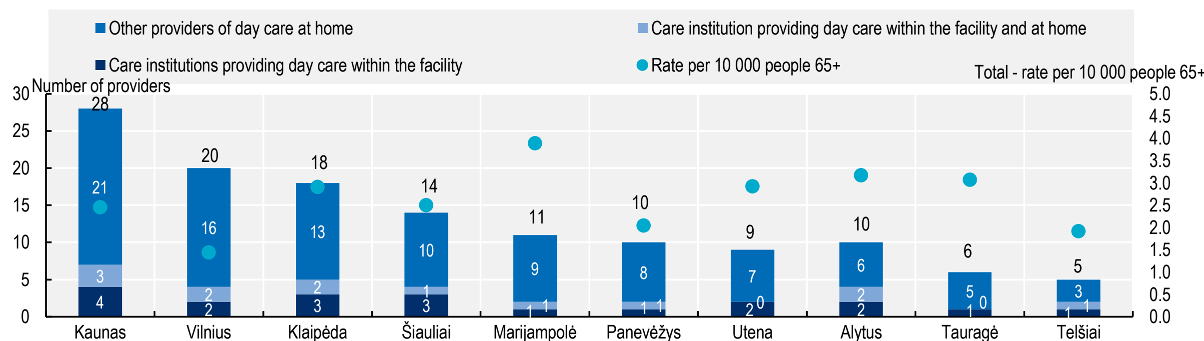
Figure 2.4. Over 50 000 older people received social/assistance care at home or in institution



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

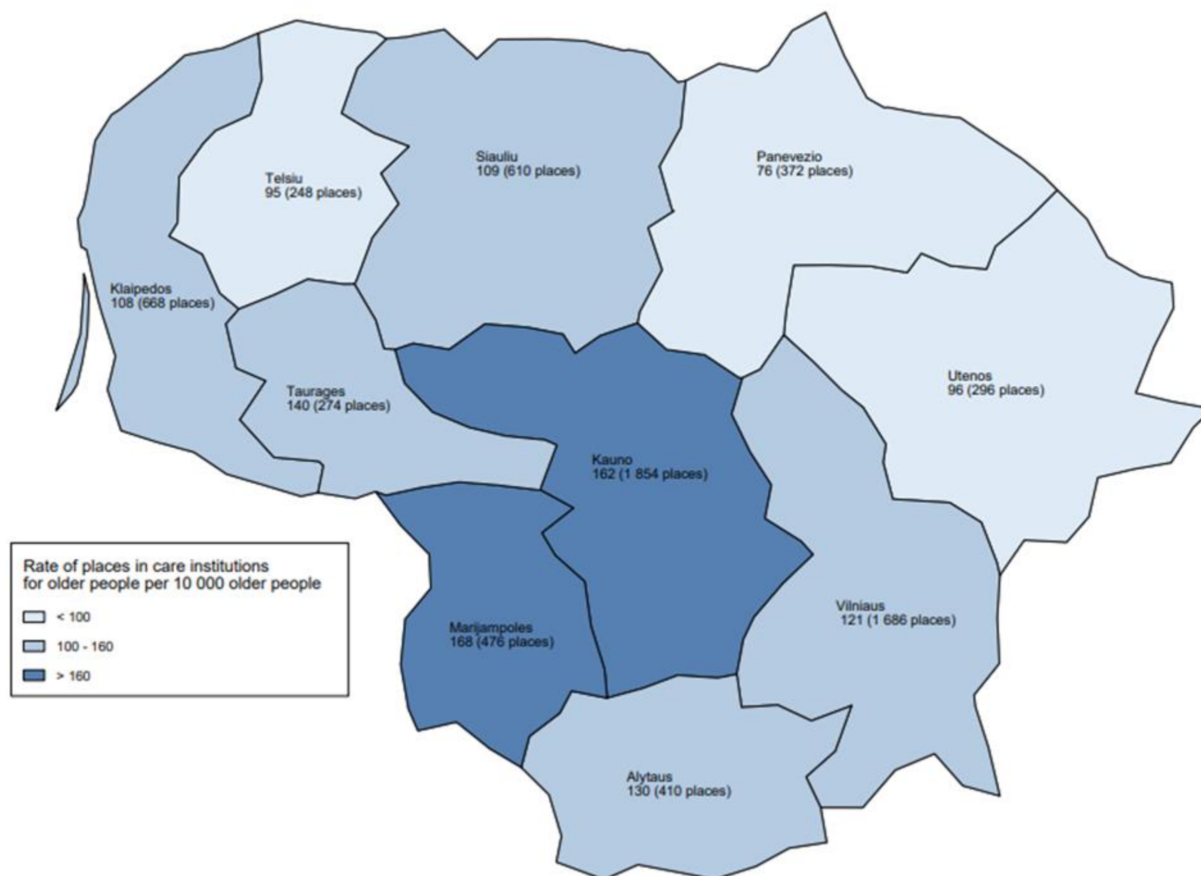


Source: Ministry of Social Security and Labour (data refer to 2020).

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

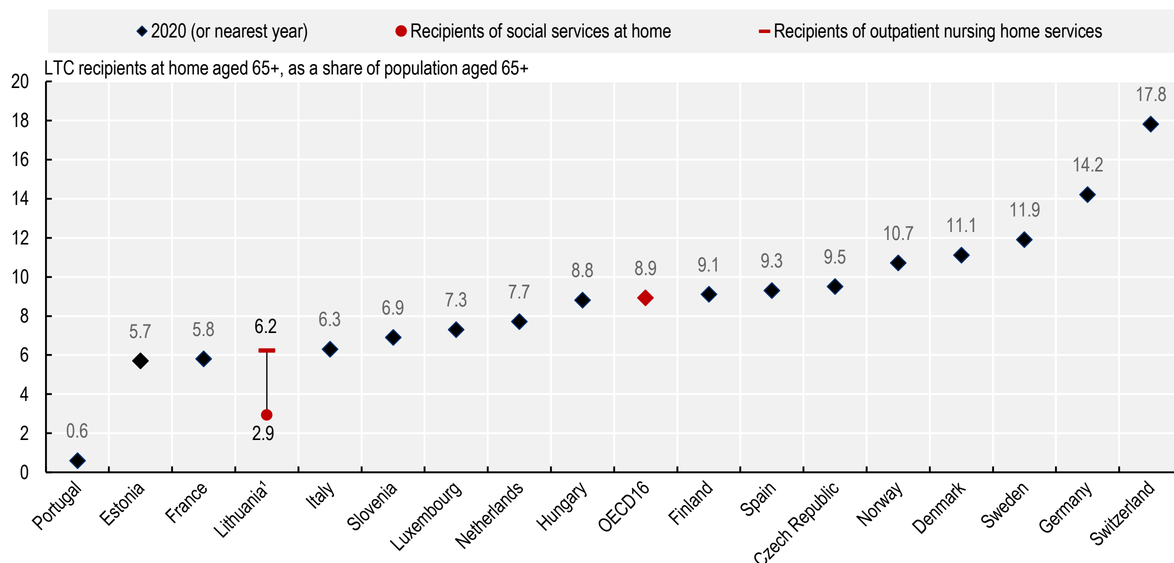
Note: 1. data refers to 2017 because a suspected change in the classification that added 2 state (county) care home and reduced from 2 to 0 the category "other care institution". This category is not included in this table. The change in terms of number of residents is also consistent. 2. The number 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.

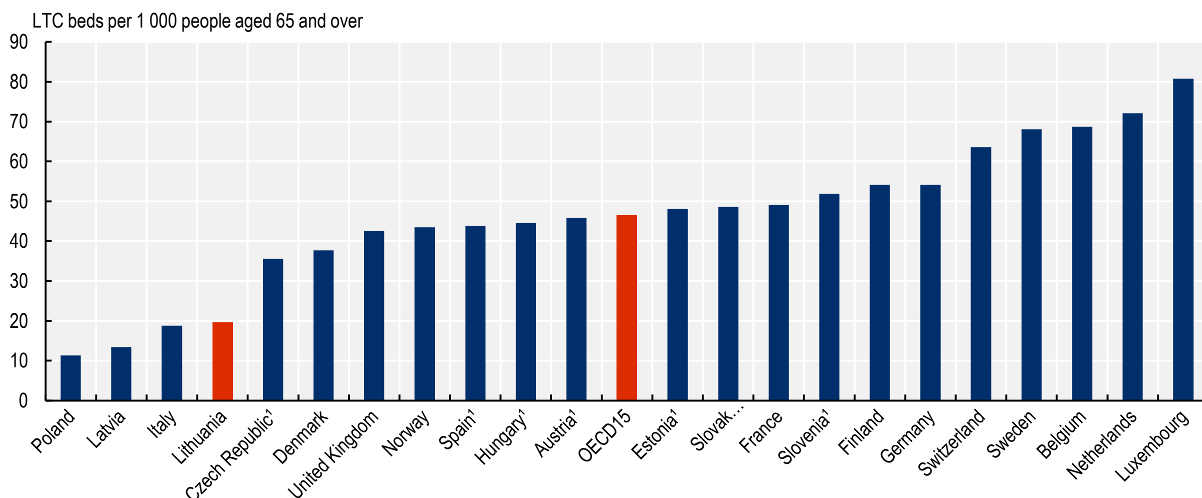
Figure 2.7. The estimated rate of in-kind LTC recipients at home is lower in Lithuania than in many EU countries



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.

References

National Audit Office (2021), *Care and social services for the elderly*. [5]

National Audit Office (2021), *Slaugos Ir Socialinės Paslaugos Senyvo Amžiaus Asmenims*. [3]

OECD (2021), *Raising Local Public Investment in Lithuania*, https://issuu.com/oecd.publishing/docs/raising-local-public-investment-in-lithuania-repor?e=3055080/84753496. [2]

OECD (2020), "Assessing the comparability of long-term care spending estimates under the joint health accounts questionnaire", Paris Publishing, Paris, https://www.oecd.org/health/health-systems/LTC-Spending-Estimates-under-the-Joint-Health-Accounts-Questionnaire.pdf (accessed on 18 October 2021). [4]

OECD (2020), *OECD Health Statistics 2021*, http://www.oecd.org/health/health-data.htm. [6]

OECD/European Observatory on Health Systems and Policies (2019), *Lithuania: Country Health Profile 2019*, State of Health in the EU, OECD Publishing, Paris/European Observatory on Health Systems and Policies, Brussels, https://doi.org/10.1787/35913deb-en. [1]

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.

Part II : Policy lessons in long-term care from other OECD countries

3 Improving governance for integrated long-term care

This chapter compares the legislative framework on long-term care (LTC) and its implementation across relevant European countries to provide key insights for Lithuania. It presents the division of responsibilities in long-term care between ministries and subnational levels in EU countries and co-ordination tools. It discusses how standardised needs assessments can facilitate the delivery of integrated services by ensuring a single entry point. It also presents examples of a gradation ladder for benefits and services linked to the needs assessment. Finally, it touches on quality reference frameworks for long-term care.

Legislation on LTC in EU countries

One important milestone to a more integrated system and improved governance is the adoption of legislation which establishes the basis of the long-term care system. EU countries differ widely on this front: some countries have specific LTC legislation while others include LTC as part of social services (Table 3.1). EU countries (or subnational areas) having legislation specifically on LTC include Austria, France, Germany, the Netherlands, Scotland, Slovenia, and Spain. Austria has had one legislative framework since 1993. Germany legislated an LTC insurance fund and an LTC system in 1995. In Scotland, the framework for integrating adult health and social care was enshrined in the law in 2014. Slovenia passed a law in 2021 that defines long-term care and outlines the integration of health and social services for adults and older people. Conversely, in Denmark and Sweden, the legislation on LTC is achieved through the social services acts, so LTC is one component of a much broader act.

While there is no one-size-fits-all approach for a single LTC-related legislative framework, essential elements typically include the definition of long-term care (including a possible age threshold),[1] the roles and responsibilities, the needs assessment (except in some Scandinavian countries), the cash benefits, the services, and the financing schemes. Other laws related to finance typically set the funding sources, except in countries that implement LTC insurance.

Table 3.1. LTC framework in other EU countries

	Main legal acts structuring the LTC framework	Description
Austria	- Federal Long-term Care Allowance Act (Bundespflegegeldgesetz), 1993 - Agreement according to Article 15a of the Austrian Constitutional Act' between the Federal Republic and the federal provinces, 1993 - "24-hour home-based care", 2007	- The Act codifies cash benefits for people in need of long-term care - This agreement defines the responsibilities of federal provinces. They are responsible for developing and upgrading the decentralised and nationwide delivery of institutional inpatient, short-term inpatient, semi-inpatient (day care) and outpatient/mobile care services. - The 2007 reform legalises privately organised 24-hour home-based care LTC, which is primarily dependent on temporary migrant carers from countries like the Slovak Republic and Romania.
Belgium	6th State Reform, 2014	- The federal level is responsible for home nursing and physiotherapy (Federal health insurance), service vouchers (Unemployment insurance and tax rebate), and integration allowance for persons with disabilities (Federal ministry of social affairs). Regions are responsible for residential care for the elderly, including price control, day care facilities, home care, and care allowance for the elderly, other service vouchers and care for persons with disabilities. Only Flanders has a regional LTC insurance (VSB).
Denmark	Consolidation Act on Social Services, 2018 (first version in 1998)	-The Act on Social Services municipalities are responsible for residential care in a nursing home or in a non-profit care home, and that waiting time cannot exceed two months. The Act on Social Services also prescribes that the municipal council shall offer (i) personal care and assistance, (ii) assistance or support for necessary practical activities in the home and (iii) meals services. The assistance mentioned is offered to persons who are unable to carry out the activities due to temporary or permanent impairment of physical or mental function or special social problems
Estonia	Health Services Organisation Act The Social Welfare Act	- Nursing care service providers need to have a permit from the Health Care Board. The Ministry of Social Affairs regulates nursing services and requirements. - Municipalities to provide 11 social services (among them some LTC services), but not all municipalities abide by the law and the law allows broad interpretation.

	Main legal acts structuring the LTC framework	Description
Finland	- Health and social services reform in process	- 21 well-being services counties would be established in Finland and entrusted with the health, social and rescue services duties that are currently the responsibility of municipalities and joint municipal authorities. The counties would be public law entities that have autonomy in their areas. A county council, elected by direct popular vote, would be the highest decision-making body of well-being services counties. There would be five collaborative catchment areas for regional co-ordination, development and co-operation in health care and social welfare. The government would confirm the strategic objectives of health care, social welfare and rescue services every four years. The Ministry of Social Affairs and Health, the Ministry of the Interior and the Ministry of Finance would hold annual negotiations with each well-being services county. The operation of well-being services counties would be financed mainly from central government funds and partly from client fees to be collected from the users of services.
France [1]	- Specific allowance for dependency, 1997, reformed in 2002 - Law on solidarity and loss of autonomy, 2004 - the Hospital, Patients, Health and Territories Act, 2009 - Act on adapting society to an ageing population, 2015	-The cash-for-care scheme is paid to any person aged 60 or over who needs assistance to accomplish everyday activities or who needs to be continuously watched over. Each level of dependency gives access to a maximum amount), which is then adjusted according to the recipient's needs and level of income. At home, the allowance is paid either to finance a specific 'care plan' in the home elaborated by a multidisciplinary team (health and social professionals from the *départements*) after an assessment of needs, or in a residential home. The APA represents over EUR 5 billion of expenditure, of which 70% comes from the *départements* and 30% from the CNSA. - The 2004 law introduced the CNSA (the national solidarity fund for autonomy), a new institution responsible for implementing policy measures aimed at older people and people with disability. -The 2009 law created a new regional institution representing central government that encompass regional and local health administrations and included interventions to the social sector -The 2015 law aims to support older people facing loss of autonomy, with a priority given to homebased care, but also included healthy ageing policies and housing adaptions.
Germany	- Long term care insurance, 1995, major reform in 2017	-Statutory health insurance (SHI) members are insured under the social LTCI scheme and all members with private health insurance (PHI) are insured under the private scheme. The structure and level of benefits does not differ between social and private LTCI. Since 2009, insurance has been mandatory for every citizen. In 2017, the social LTCI covered 72.7 million citizens and private LTC covered 9.4 million citizens (2015). Under the social LTCI, 71.9% of benefit recipients were being cared for at home, most of them by female family members or unpaid carers. In 2017, total expenditure on benefits paid under the social LTCI scheme was EUR 35.54 billion. The 2017 reform included an expansion of eligibility criteria to include mental and psychological disabilities (e.g. dementia). In 2017, the LTCI expenditure rose of 26% compared with 2016.
Latvia	- Law on Social Services and Social Assistance - Health care laws for health care - Programme of mobile teams, 2010	The official institutional norms are formulated in the Law on Social Services and Social Assistance, as well as in the internal regulations of the social service agencies. The official institutional norms are: assessment of the individual's needs; provision of services at the place of residence of the client; inter-professional and inter-institutional co-operation; user participation; cost control. - Health care for older people are regulated based on the health care laws - Mobile teams of specialists (i.e. social worker, social care worker, and psychologist), provide social services to the elderly in their homes. These mobile teams are becoming the standard suppliers of care services in rural areas, especially those with low population density.
Netherlands	- Social Support Act (Wmo), 2015 - Long-term Care Act (Wlz), 2015	-Wmo: municipalities provide social services funded by block grants from the state. They are responsibilities for providing help with IADLs (cleaning, cooking, etc.) for the elderly. Municipalities have very limited tax-raising abilities. - Wlz: it is a statutory social insurance scheme.
Portugal	Decree Law 265/99, 14 July - National Network for Integrated Continuous Care (RNCCI), 2007	Regulates the supplement for dependency, the cash benefit for people having LTC needs The RNCCI provides convalescent care, post-acute rehabilitation services, medium- and long-term care, home care and palliative care. The Ministries of Health and Social Solidarity jointly set up the network. It comprises both public and private not-for-profit units (funded by the state jointly by both Ministries). The financing model is based on the types of services provided, with joint protocols across the health and social sectors.

	Main legal acts structuring the LTC framework	Description
Scotland	- Regulation of Care Act, 2001 - Community Care and Health Act, 2002 - Public Bodies (Joint working) Act, 2014 - The Social Care (Self-directed Support) Act, 2013 - Carers Act, 2016	- The 2001 Act aimed to is to improve standards of social care services. - The 2002 Act introduced 2 new changes: free personal care for older people, regardless of income or whether they live at home or in residential care and the creation of rights for informal or unpaid carers. - The 2013 Act enshrines in the law that people who are eligible for social care support must be involved in decisions about what their support looks like and how it is delivered. - The 2014 Act sets the framework for integrating adult health and social care, particularly for people with multiple, complex, long-term conditions. - The 2016 Act includes a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria, a carer support plan, a requirement for local authorities to have an information and advice service for carers, and a requirement for the responsible local authority to consider whether respite care should be provided, including on a planned basis.
Spain	- Dependency Act, 2007	-The law guarantees a right to long-term care services to all those assessed to require care subject to an income and asset test. Entitlements to cash and in-kind services are slightly different, with cash allowances being universal, while not all individuals might receive in-kind services. Recipients are expected to pay one-third of total costs of services. The central government and the regions are jointly responsible for the funding and provision of LTC.
Sweden	- Social Services Act, 2001 - National Centre for support of Informal Care Providers and law in support to informal caregivers, 2008	- The management and planning of care for the elderly is split between three authorities – the central government, the county councils, and the local authorities. Each unit have different but important roles in the welfare system of Sweden. They are represented by directly elected political bodies and have the right to finance the activities by levying taxes and fees within the frameworks set by the Social Services Act. - The Centre is co-run by several research institutes in Sweden with mandate from the National Board of Health and Welfare. Its aim is to co-ordinate research and development, supply information and documentations to caregivers and increase the awareness among the public and the authorities. In addition, since 2009, the municipalities are by law required to support informal caregivers.

1. In France, there are 101 *départements* (implemented in 1789) and 18 *régions* (implemented in 1956).
Source: country-specific ESPN reports on challenges in long-term care. For Finland (https://stm.fi/en/-/government-proposal-for-health-and-social-services-reform-and-related-legislation-proceeds-to-parliament), Sweden (https://www.files.ethz.ch/isn/122426/Sweden.pdf), Scotland (https://careinfoscotland.scot/topics/your-rights/legislation-protecting-people-in-care/community-care-and-health-scotland-act-2002/), click on the hyperlinks. For Denmark, see the Questionnaire on the rights of older persons with disabilities, the Danish Institute for Human Rights (2019).

The division of roles and responsibilities typically stems from historical legacies and the type of LTC-related legislation. Usually, the public bodies already have expertise and the administrative processes are already set. For example, in Scandinavian countries, the Acts on social services cover LTC, so that the roles and responsibilities in LTC are in line with those of other social services for which municipalities have competences (see Table 3.1). In Germany, roles and responsibilities are also split across the central/federal government and that of the regions. In many other countries, subnational levels often have significant responsibilities for at least part of the provision of LTC. In Spain and in France, the central government and regions/departments are jointly responsible for the provision of LTC services. In the Netherlands, municipalities are responsible only for domestic care, the insurance for home care and the central government for residential care.

Certain countries allocated significant responsibilities to a single public organisation. In this case, countries often decided to mirror the functioning, or expand the role of an existing public organisation (e.g. to collect and distribute funding). Slovenia chose to give this role to the Health Insurance Fund in its 2021 reform, in terms of the responsibility for assessment and managing the finances. France is expanding the role of one public organisation over a 10-year period to give it most responsibilities in LTC. The institution, named the CNSA, was originally both a fund and an agency at the interface between Regional Health Agencies and Departments for LTC for older people. The goal is to give responsibilities on funding, financing and care provision to ensure the full integration and the development of LTC. The 2020 law started the expansion by transferring the current funding schemes to the CNSA and its transformation is expected to be achieved in 2030.

Some countries have also developed co-ordination arrangements, such as intergovernmental committees and regular formal meetings, for consensus-building across stakeholders on the practical implementation of the long-term care system. In particular, quasi-federal countries and Nordic countries have made progress toward better vertical co-ordination among levels of government. Denmark, Finland, Norway and Sweden have regular meetings of central and local governments (through their associations of local governments) to discuss policy and implementation issues. For example, Swedish municipalities are incentivised to co-operate (OECD, 2015[1]). Countries use incentives to enhance inter-municipal co-operation and networking, information sharing, and sometimes to help in the creation of joint authority entities. These incentives are frequently financial: special grants for inter-municipal co-operation, special tax regimes, and additional funds for joint public investment proposals. In France, each grouping of communes constitutes a "public establishment for inter-municipal co-operation" (EPCI). To encourage municipalities to form an EPCI, the central government provides a basic grant plus an "inter-municipality grant" to preclude competition on tax rates among participating municipalities. EPCIs draw on budgetary contributions from member communes and/or their own tax revenues.

In Spain and France, co-operation bodies help to co-ordinate national and subnational entities. In Spain, long-term care is co-ordinated within the Territorial Council of the public System for Autonomy and Care for Dependency, a co-operation body where the central government and the regions agree on a framework for intergovernmental co-operation, the intensity of services, the terms and amounts of financial benefits, the criteria for co-payments by the beneficiaries, and the scale of dependency that is used for the recognition of dependency. In France, the "conference of funders" aims to co-ordinate in each department the actions for the prevention of loss of autonomy of people aged 60 and over and their financing as part of a common strategy. The CNSA pilots and leads the conference of funders at the national level. Each department is responsible for co-ordinating the conference of funders in its territory. Lithuania could use these examples as inspiration to create a co-ordination tool to build consensus over time for areas where there are diverging views as it works on implementing change.

Slovenia is a relevant country example to learn about consensus building and on the challenges of developing legislation. In 2017, a draft reform was not adopted after receiving criticism from several important stakeholders. It was considered too abstract on many points, including the financial sustainability in the medium or long term; the estimated resources on the short-term were based on an inaccurate distribution of users;[2] the users' rights; and the criteria that would have placed the eligible users into 5 categories of a gradation scale (Rupel, 2018[2]). Slovenia succeeded in passing a landmark reform in December 2021 after over 20 years of discussion, 5 different scenarios to develop LTC and 2 rounds of public consultation open to all stakeholders. Slovenians agreed on the broad funding routes – a mix of a new LTC insurance born by workers, current pension and health insurance funds reallocated to LTC and state budget. In accordance with the LTC Act, funding for LTC will be provided from existing funds and the state budget until mid-2025. The adoption of a specific law on compulsory insurance for long-term care is planned within this timeline.

Harmonising conditions for services and cash benefits across sectors is needed to integrate health and social benefits for older people

Unified needs assessment facilitates the delivery of integrated services

In Lithuania, the needs assessment tools for home services differ across the health and the social sectors. The country could therefore invest in a needs assessment mechanism which would facilitate the delivery of services and function as a single entry point. Nation-wide standardised needs assessments are in place in a large share of countries to ensure a single entry point, equal access and reduce cost-shifting (Austria, Belgium, Czech Republic, France, Germany, Japan, Latvia, Lithuania, Netherlands, Portugal and Spain). However, some countries have more than one LTC needs assessment, because they target different benefits (e.g. a specific cash benefit) or because they are designed by and for subnational areas. For example, Swedish municipalities set their own needs assessment. In Finland, municipalities could also rely on their own needs assessment but there has been a progressive move towards the use of a standardised tool. The choice of needs assessment has massive financial implications. The broader the scope, the more people are eligible, and the more services are used. For example, when Germany put more weight on dementia in its assessment tool in 2017, the expenditure of the LTC insurance increased by 25% that year (ESPN, 2018[3]).

Lithuania can create an effective needs assessment by relying on a case-mix classification based on various evidence-based scales. Lithuania could use a case mix classification[3] that weights the outcomes of various evidence-based scales measuring different aspects of long-term care to create groups of statistically related patients. Otherwise, it can consider creating a case mix classification with their own scale. While this would enable Lithuania to design a tool based on their own characteristics, this option would require more resources and time.

The case mix classification can be based on various evidence-based scales to capture different aspects of LTC. There is not a single best needs assessment instrument in OECD countries. Instead, various questions are typically grouped together to create scales. Theses scales focus on measuring specific aspects of long-term care – physical movement, memory, behaviours, and so on. Extensive research has been conducted to confirm their effectiveness (Sinn et al., 2018[4]). These evidence-based scales include:

- ADL
- IADL
- Cognitive performance scale
- Communicative Scale
- Pain scale
- Aggressive behaviours scale
- Pressure ulcer risk scale
- CHESS- Changes in Health, End-stage disease and Signs and Symptoms
- MAPLe- Method for Assigning Priority Levels
- Deaf/blind severity index

Defining the relative weights of the scales in the case mix classification requires a knowledge of the drivers of home care utilisation (e.g. most frequent needs or the services mostly used). This enables to predict utilisation and cost accurately, which is paramount for the related payment system. In this sense, merely replicating an assessment used in another country has drawbacks. Japan conducted the analysis of the drivers of care utilisation to determine the most appropriate case-mix classification and develop their scale. Such analysis allowed Japan to tailor the tool based on the specificities of the Japanese population and system and prevented the mere replication of the American case mix classification, which would have focussed too much on physical therapy (Box 3.1). Researchers in the Netherlands have also conducted a similar analysis to serve as input for the development of a new payment system for home care (Elissen et al., 2020[5]).

Box 3.1. Japan carried out a large-scale time-study research to understand the drivers of care utilisation to predict utilisation and cost, before deciding on the case mix classification

The instrument in use in Japan was developed based on a large-scale time-study of professional caregivers in LTC institutions and their users in 1995. The study sample involved 51 facilities that national associations of LTC facilities recommended as high-quality service providers. A licensed professional employee of the study institution followed a peer formal carer for 2 days and made detailed minute-by-minute records of all of his or her activities as well as the name of each person receiving the nursing care service. The data on approximately 10 million minutes of care provided by 2 376 professionals to 3 800 older people were coded into 328 predetermined care activities, and the amount of time the caregiver spent on each older person was calculated for each activity. These data were used to develop tree regression models in which older adults' use of services (measured in minutes by nine service categories) was regressed on their physical and mental characteristics.

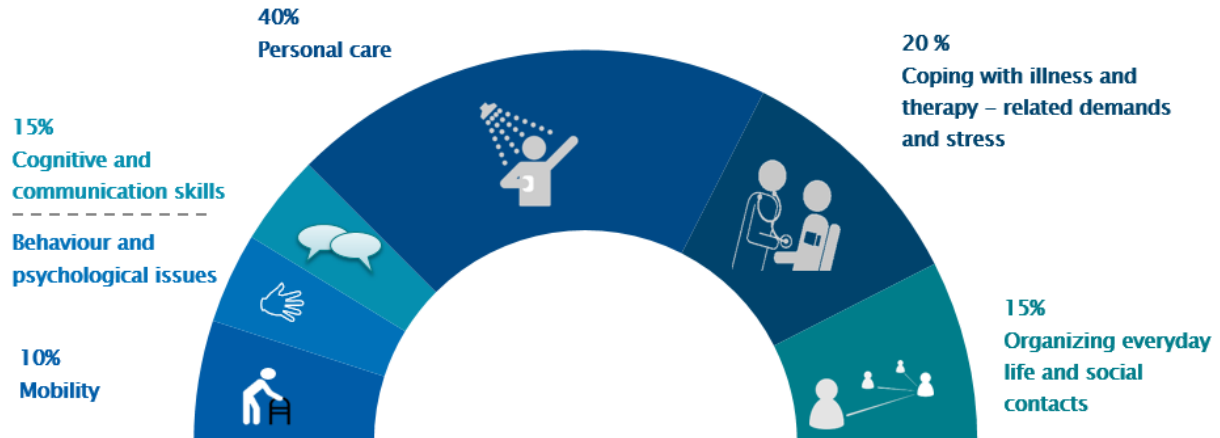
The tree regression estimation models were pilot tested on 175 129 older people in the institutions and home/community settings in all the municipalities between 1996 and 1998. The validity of the models was examined by comparing the computer-aided assessment with health professionals' assessment of each case, with 71.5% and 75.3% concordance in 1996 and 1997, respectively. Feedback from various stakeholders was used to refine the assessment instrument its implementation.

Before carrying out this study, Japan had considered to adopt the Resource Utilisation Group Version III (RUG-III). This is an assessment developed for nursing homes in the United States and is based on the use of resources in expenditures. In particular, an important determinant of the RUG-III was the rehabilitation services provided by physical therapists, because they are among the most expensive services in nursing homes in the United States. In Japan, physical therapy is much less common – none of the residents of nursing homes in the pilot study had a 30-minute individualised rehabilitation session.

Source: adapted from (Tsutsui and Muramatsu, 2005[6]).

Lithuania could consider an approach similar to that of Slovenia and test tools. In 2018, Slovenia decided to develop their own needs assessment tool, building on the German needs assessment. Germany uses a needs assessment which is particularly comprehensive. The regional Health Insurance Funds or private LTC insurance companies appoint independent assessors who measure abilities in six domains (Figure 3.1) and for each criterion, a point value of self-reliance ranging between 0 (full self-reliance) and 3 (full dependence to assistance) is attributed. The domains have different weights, the highest weight being for the personal care domain and the lowest for the mobility domain. The total score is used to attribute a level of severity of impairment ranging from 1. Minor impairments to 5. Most severe impairments. Slovenians tested the scale for 2 years with over 300 000 assessments. During the pilot phase, they tailored it to the Slovenian needs notably by grouping assessments in sets for home care, social contacts, ability to manage the disease, and mental health. They carried out an evaluation that found that the needs assessment tool was appropriate and could be implemented (Buescher, Wingenfeld and Schaeffer, 2011[7]).

Figure 3.1. The German needs assessment is very comprehensive



Source: National Association of Statutory Health Insurance Funds, based on https://www.mdk.de/fileadmin/MDK-zentraler-Ordner/Downloads/01_Pflegebegutachtung/1901_Pflegeflyer_ENG_01.pdf.

Considerations on the pool of the workforce who can carry out the needs assessment influence the design of the most appropriate assessment. In a number of countries (Austria, Croatia, Czech Republic, France, Germany, Greece, Ireland, Latvia, Poland, Portugal, Romania, the Slovak Republic and Spain), the assessment is performed by a health professional or a multidisciplinary team composed of at least one health professional. In Luxembourg, a social worker or a health professional can perform the assessment. In other countries like Denmark, England, Estonia, the Netherlands and Sweden, social workers perform the assessment. In Japan, the needs assessment tool and the training were designed to ensure that the assessors would not require medical nor social service expertise. However, the mayor of municipalities appoint doctors, nurses and social workers to form a Nursing Care Needs Certification Board, to review and validate the initial assessment, considering the applicant's primary care physician's statement and the notes written by the assessor during the home visit (Tsutsui and Muramatsu, 2005[6]). Slovenia plans that the Health Insurance Institute will train and supervise a broad range of future assessors, including non-health professionals.

With respect to training, countries typically develop training manuals and videos that are regularly updated. For example, Japan developed textbooks and videos that are updated every year. Municipalities are responsible for training the workers with these materials. The training, ranging from 3 to 7 days depending on the assessors' abilities, focusses on needs assessment for various situations, including the assessment of older people with dementia who also receive care from informal carers.

The frequency of re-assessment should also be considered. For example, the LTC needs of older people is reassessed every two years or after a marked deterioration in Japan (Japan Health Policy NOW, n.d.[8]). In Ontario, Canada, needs assessment is carried out every six months for home care. A study found that 80% of home care clients had significant clinical changes in health status within 6 months and that the cost of assessment represented 1.55% of the home care cost (CAN 23.6 million vs CAN 1526.5 million) (Kinsell et al., 2020[9]).

A digital needs assessment has many advantages

A digital needs assessment enables to have a wealth of information relevant to key questions facing providers and decision makers across the health and social services. If digital assessments are regularly carried out, care providers could more easily evaluate the effectiveness of care plans and public agencies could evaluate the quality of care. The purposes of a digital needs assessment include:

- Eligibility for public support
- Care planning for providers (provided that the assessment takes place on a regular basis)
- Evaluation of care effectiveness (thanks to longitudinal microdata)
- Monitoring of providers' care quality indicators
- Monitoring of care quality at the municipal and national levels

While many digital assessment instruments exist, InterRAI seems to be one well-considered (RAI stands for Resident Assessment Instrument). InterRAI is a collaborative network of researchers and practitioners in over 35 countries that developed modules for people who are medically complex and/or people with disability. However, there are two fundamental pre-requisites to have a digital needs assessment: having an excellent IT system and having trained staff.

A single benefit with different levels is user-friendly and promotes transparency

The introduction of a standardised needs assessment would enable Lithuania to have a single benefit with different care levels. After assessing the degree of autonomy, older people could be assigned to a specific care level or grade, depending on the severity of their condition, and each care level or grade can be related to a different financial compensation or intensity of service. This could ensure that access to LTC cash benefits and services is identical across the country and this approach tends to be easier to navigate for LTC recipients and their relatives. Each care grade could be related to a type of support, whether it be formal services, a cash benefit to LTC users, or direct or indirect cash benefits for informal caregivers. It can empower LTC users to choose the form of LTC care that works for them, whether that be formal or informal – which can partially address staff shortages.

Germany has such a benefit with five different care grades and the possibility to have services at home or residential care, or to receive a cash benefit. Between grade 2 and 5, beneficiaries can combine benefits in cash with benefits in kind according to their personal needs within certain limits. Since 2015, an unused allowance of up to 40% for professional home care can be used for reimbursement of costs for easily accessible services for daily-life assistance (Rodrigues, 2018[10]). The value of the cash benefit is lower than the value of services by a professional carer at home (Table 3.2).The cash benefit can be given to a relative who receives social protection if entitled. The entitlement is open to anyone who takes care of one or more people with a care grade of 2 to 5 for at least 14 hours and who is not employed elsewhere for more than 30 hours a week. They are not eligible if they receive a full old-age pension. They are covered by the statutory pension insurance and the unemployment insurance. The contribution rate depends on the level and length of care provided. They also receive training. (Rodrigues, 2018[10]). Beneficiaries can combine in cash benefits with benefits in kind within certain limits.

Table 3.2. The benefit package related to the gradation ladder in Germany is particularly comprehensive

Care degree/EUR per month	Cash benefit	Professional care at home	Preventive care (household member-other people) (up to 6 weeks/year)	Short-term care (up to 8 weeks/year)	Additional day- and night-care	Residential care
1						125
2	316	724	474-1612	1774	689	770
3	545	1363	818-1612	1774	1298	1262
4	728	1693	1092-1612	1774	1612	1775
5	901	2095	1352-1612	1774	1995	2005

Note: other benefits includes EUR 4 000 per living environment improvement measure.
Source: German Federal Ministry of Health (2022[11]), Zahlen und Fakten zur Pflegeversicherung [Data on long-term care insurance].

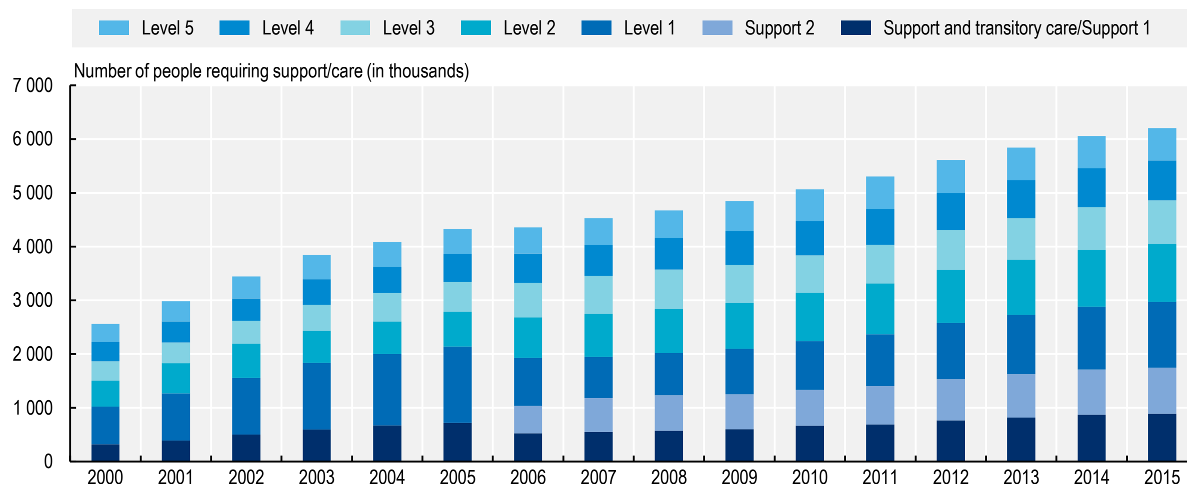
Slovenia's recent assessment and care levels builds on the German one. There are 5 categories and people can choose to receive a cash benefit or formal care at home or in an institution. Those with the highest needs (grades 4 and 5) will also be able to register an informal caregiver as a carer. Eligibility will not be restricted to relatives nor co-residents. The carers will receive 1.2 times the minimum wage and will be able to access respite for 21 days per year (by placing the older person in an LTC facility). Rehabilitation services will also be offered. The legislation is expected to be implemented in 2024-25.

In Scandinavian countries, practices vary across municipalities to decide how much and what type of care people receive, but they promote a people-centred approach with universal entitlement to care. In Denmark, many municipalities differentiate between five levels of LTC needs and provide rights to different amounts and types of home help based on these 5-category scales. Older people are offered a choice between at least two different providers of home help, one of which can be a municipal one. In 2016, 36% of home help beneficiaries chose a private provider (Kvist, 2018[12]). LTC benefits tend to be in-kind for older people but there are some exceptional circumstances where cash benefits are available for their relatives who provide LTC services. Typically, the municipality sets the eligibility criteria, acts as employer and defines the services that should be provided by the informal carer. In Denmark, only people under retirement age can be eligible (Kvist, 2018[12]).

Additional incentives could be considered by Lithuania to encourage home care instead of residential care. For example, in Germany, the amount of the benefit related to lower care grade limits the option of residential care – only those with higher LTC needs receive an amount sufficiently high to cover well the cost of residential care. Hungary has taken another approach: there are 3 levels and Levels 1 and 2 give access to home-based social help and personal care and Level 3 access to institutional care. It determines a level of care need ranging from 1 to 3 (1. needs support in some activities, 2. needs partial support, 3. needs full support).[4] Nevertheless, it is important to keep in mind that as population ageing progresses, residential care for certain individuals with high needs would remain a necessity. In Germany, community-based LTC expenditure rose from EUR 11.1 billion to 35.5 billion and residential care-related expenditure still increased from EUR 10.8 billion to 14.7 billion between 2012 and 2021. More than half of residential care beneficiaries are suffering from dementia. In Japan as well, dementias and strong cognitive impairments seem to bring people to choosing residential care.

The single benefit with different care grades can be modified to encourage preventive support and help to contain cost. Japan added a new category in 2006 to contain cost while keeping a large access to LTC benefits. Care Level 1 was split into Long-term Care Level 1 or Preventative Support Level 2 depending on whether their condition seemed likely to improve or remain the same (Figure 3.2). People receiving Support Level 1 decreased by nearly 40%.

Figure 3.2. Japan split its Level 1 into two levels to encourage preventive support while containing cost



Source: Japan Health Policy NOW (n.d.[8]), 3.2 Japan's Long-Term Care Insurance System, https://japanhpn.org/en/section-3-2/.

Quality reference frameworks would be relevant to unify sectors and providers

Lithuania could also improve quality monitoring and ensuring sufficient standards while developing home care. A key element of this strategy could be developing an appropriate quality framework, improving transparency about standards and ensuring timely evaluation. Quality indicators on providers could be better monitored, including with inspections, and their results could be published online, specifically for home providers, with an emphasis on process and outcome-oriented performance indicators (e.g. quality of life). Agreements with private and public providers to guarantee services could include a quality section and minimum quality standards could be better incorporated into public procurement.

Several countries have recently reviewed or are reviewing quality frameworks. France's health authority (HAS) published on March 2022 the first national reference framework for evaluating quality in the social and medico-social sector, which covers over 40 000 facilities and services, and its related evaluation manual. The goal was to have a single and uniform national framework. This evaluation is designed to promote a continuous quality improvement approach (Haute Autorité de Santé, 2022[13]). Germany plans to introduce in 2023 a revised LTC quality framework and quality monitoring system, including for home care. Sweden is also revising its quality framework in light of the COVID-19 pandemic.

Over the past decades, practices of procurement, purchasing and contracting of services of not-for-profit and for-profit providers have developed in EU countries, making quality standards and monitoring particularly relevant. The data on public, not-for-profit and for-profit provision of long-term care is sparse and outdated, but estimates suggest there is significant heterogeneity across countries and settings (Table 3.3).

Table 3.3. Non-public provision of LTC varies starkly across countries

Country	Public provision		Not-for-profit provision		For-profit provision	
	Institutional	Home care	Institutional	Home care	Institutional	Home care
Austria	55%	8%	24%	91%	21%	1%
Belgium (Flanders)	36%		52%		12%	
Belgium (Wallonia)	26%		21%		52%	
Belgium (Brussels)	24%		13%		62%	
Canada	32%	-	31%	-	37%	-
Czech Republic	65%		22%		13%	
Estonia	55%	-	-	-	-	-
United Kingdom (England)	7%	14%	13%	11%	80%	74%
Finland	56%	93%	-	-	44%	7%
France	23%	15%	55%	65%	22%	20%
Germany	5%	2%	55%	37%	40%	62%
Hungary	54%		45%		0.4%	
Italy	30%		50%		20%	
Ireland	22%		7%		71%	
Latvia	67%		0%		33%	
Lithuania[1]	43%	-	-	-	-	-
Luxembourg	48%	-	29%	-	23%	-
Netherlands	0%		80%		20%	
Slovak Republic	75%		23%		2%	
Slovenia	37%	-	37%	-	26%	-
Spain	23%		24%		53%	
Sweden	75%	-	10%	-	15%	16%
Switzerland	30%		30%		40%	

Note: Data coverage and years vary – data should be interpreted with caution. 1.In Lithuania, data refer only to care institutions for older people (not adults with disabilities).

Source: Adapted from Cravo Oliveira Hashiguchi et al. (forthcoming[14]), *Providing Long-term Care: What to Cover and for Whom*; based on Gasior et al. (2012[15]), *Facts and Figures on Healthy Ageing and Long-term Care*; and Harrington et al. (Harrington et al., 2017[16]), *Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains,* https://doi.org/10.1177/117863291771053; for Canada and the US, complemented with Rocard, Sillitti and Llena-Nozal (2021[17]), COVID-19 in long-term care: Impact, policy responses and challenges, https://doi.org/10.1787/b966f837-en.

Quality standards need to be an important metric for the accreditation of services and providers. In Denmark, each year the municipalities determine quality standards for home help, rehabilitation, and training services: these are publicly available, and used in tenders and in audits. The purpose of quality standards is to ensure that citizens get professional, dignified and qualified treatment in the event that they need help and support. Municipal audits include at least one unannounced visit to nursing homes and care homes (Kvist, 2018[12]). Italy passed in 2021 an extension of authorisation and accreditation to home care. Public and private providers of home care should undergo an authorisation and accreditation process to evaluate whether they meet structural, technological and workforce standards. In many countries, agencies dedicated to the monitoring of providers' compliance were established. National and regional legislation also advanced authorisation and accreditation mechanisms, including the definition of quality indicators, even if these are often structural and process indicators that describe individual services and facilities rather than outcome-oriented indicators (European Social Network, 2021[18]). In addition, some providers implemented standard quality management systems (ISO 9000ff, EFQM) or adapted quality management systems to their organisation (European Social Network, 2021[18]).

Quality metrics can be linked to price levels, although this is not common. Among 8 OECD countries studied, the majority released information around quality and prices to promote trust and transparency, although the impact has not yet been evaluated (OECD/WHO, 2021[19]). In Germany, the contracting parties can also agree on prospective remuneration with pricing of certain quality aspects, but this is not mandatory. The care facility has the legal right to performance-based remuneration.

Beyond monitoring and evaluation of standards, online publishing of quality indicators can encourage providers to strengthen high-quality care. Reporting and publishing quality indicators allows monitoring the performance disparities across and within countries and the improvements over the time. Lithuania could put in place a system of public quality reporting, as in Sweden, England or the United States. Swedish municipalities must report their data on some quality indicators, which are made public in Open Comparisons (Public health agency of Sweden, 2022[20]). The figures are easy to read, with traffic-light colours indicating performances (green-yellow-red) (Trygged, 2017[21]). In England, the Care Quality Commission carries out inspections and issue ratings for care providers and it is also in the process of expanding the scope of their assessments to include local authorities themselves as part of an ongoing reform. In the United States, The Nursing Home Quality Initiative (NHQI) also uses an easy-to-read format, associating to every LTC service (e.g. Nursing homes, home health services, rehabilitation facilities and LTC hospitals) a five-star rating based on a set of quality indicators and users' satisfaction (OECD/European Union, 2013[22]). However, the five-star rating system has been criticised because many consider that providers – who are those entering information on e.g. staff ratios – over evaluate their standards.

References

Buescher, A., K. Wingenfeld and D. Schaeffer (2011), "Determining eligibility for long-term care - lessons from Germany", *International Journal of Integrated Care*, Vol. 11/2, https://doi.org/10.5334/ijic.584. [7]

Cravo Oliveira Hashiguchi, T. et al. (forthcoming), *Providing Long-term Care: What to Cover and for Whom*. [14]

Crowther-Dowey, C. (ed.) (2017), "Open comparisons of social services in Sweden—Why, how, and for what?", *Cogent Social Sciences*, Vol. 3/1, p. 1404735, https://doi.org/10.1080/23311886.2017.1404735. [21]

Elissen, A. et al. (2020), "Development of a casemix classification to predict costs of home care in the Netherlands: a study protocol", *BMJ Open*, Vol. 10/2, p. e035683, https://doi.org/10.1136/bmjopen-2019-035683. [5]

ESPN (2018), *ESPN Thematic Report on Challenges in Long-Term Care - Germany*, http://file:///C:/Users/Sillitti_P/Downloads/DE_ESPN_thematic_report_on_LTC%20(1).pdf. [3]

European Social Network (2021), *Putting Quality First*, https://www.euro.centre.org/publications/detail/3958. [18]

Gasior, K. et al. (2012), *Facts and Figures on Healthy Ageing and Long-term Care*. [15]

German Federal Ministry of Health (2022), *Zahlen und Fakten zur Pflegeversicherung [Data on long-term care insurance]*. [11]

Harrington, C. et al. (2017), “Marketization in Long-Term Care: A Cross-Country Comparison of Large For-Profit Nursing Home Chains”, *Health Services Insights*, Vol. 10, p. 117863291771053, https://doi.org/10.1177/1178632917710533. [16]

Haute Autorité de Santé (2022), *La HAS publie le premier référentiel national pour évaluer la qualité dans le social et le médico-social*, https://www.has-sante.fr/jcms/p_3323113/fr/la-has-publie-le-premier-referentiel-national-pour-evaluer-la-qualite-dans-le-social-et-le-medico-social (accessed on 10 April 2022). [13]

Japan Health Policy NOW (n.d.), *3.2 Japan’s Long-Term Care Insurance System*, https://japanhpn.org/en/section-3-2/ (accessed on 10 April 2022). [8]

Kinsell, H. et al. (2020), “Spending Wisely: Home Care Reassessment Intervals and Cost in Ontario.”, *Journal of the American Medical Directors Association*, Vol. 21/3, pp. 432-434.e2, https://doi.org/10.1016/j.jamda.2019.12.007. [9]

Kvist, J. (2018), *ESPN Thematic Report on Challenges in long-term care in Denmark*. [12]

OECD (2015), *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery*, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en. [1]

OECD/European Union (2013), *A Good Life in Old Age?: Monitoring and Improving Quality in Long-term Care*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/9789264194564-en. [22]

OECD/WHO (2021), *Pricing Long-term Care for Older Persons*, World Health Organization, Geneva/OECD Publishing, Paris, https://doi.org/10.1787/a25246a6-en. [19]

Public health agency of Sweden (2022), *Regional Comparisons Public Health 2019*, https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/public-health-reporting/regional-comparisons-public-health-2019/ (accessed on 2022). [20]

Rocard, E., P. Sillitti and A. Llena-Nozal (2021), “COVID-19 in long-term care: Impact, policy responses and challenges”*, OECD Health Working Papers*, No. 131, OECD Publishing, Paris, https://doi.org/10.1787/b966f837-en. [17]

Rodrigues, R. (2018), *Peer Review on “Germany’s latest reforms of the long-term care system”, Berlin (Germany)*, EC DG Employment, Social Affairs and Inclusion, https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=9008 (accessed on 11 April 2022). [10]

Rupel, V. (2018), *ESPN Thematic Report on Challenges in long-term care*. [2]

Sinn, C. et al. (2018), “Adverse Events in Home Care: Identifying and Responding with interRAI Scales and Clinical Assessment Protocols”, *Canadian Journal on Aging / La Revue canadienne du vieillissement*, Vol. 37/1, pp. 60-69, https://doi.org/10.1017/s0714980817000538. [4]

Tsutsui, T. and N. Muramatsu (2005), “Care-Needs Certification in the Long-Term Care Insurance System of Japan”, *Journal of the American Geriatrics Society*, Vol. 53/3, pp. 522-527, https://doi.org/10.1111/j.1532-5415.2005.53175.x. [6]

Notes

[1] This element is key to ensure that LTC benefits are coherent with disability benefits. The trade-off between the generosity of the disability benefits and the number of eligible people is more straightforward compared with the trade-off for LTC benefits – the number of eligible people is more limited for disability benefits.

[2] The calculations of the costs of formal care were based on the structure of recipients of informal LTC, where virtually nobody was in the highest care category.

[3] The term case-mix refers to the type or mix of statistically related patients. The best-known classification system in health care is the Diagnosis-related groups (DRGs.)

[4] The instrument is composed of 14 variables (orientation in time and space, appropriate behaviour, eating, dressing, personal hygiene, using the toilet, continence, communication, observing the rules of the therapy, change of position, movement, self-sufficiency, seeing, hearing).

4 Designing sustainable funding for care

Pooling together existing funding can be an important step towards more integrated care for older people. This chapter discusses the different funding routes chosen by OECD countries to secure sustainable funding for long-term care and which can be considered by Lithuania: setting-up a long-term care insurance, raising social contributions, and relying on additional taxes such as property taxes and value added tax. Finally, this chapter touches on private home equity programmes and their limitations.

Pooling together existing funding can be an important step towards integrated care

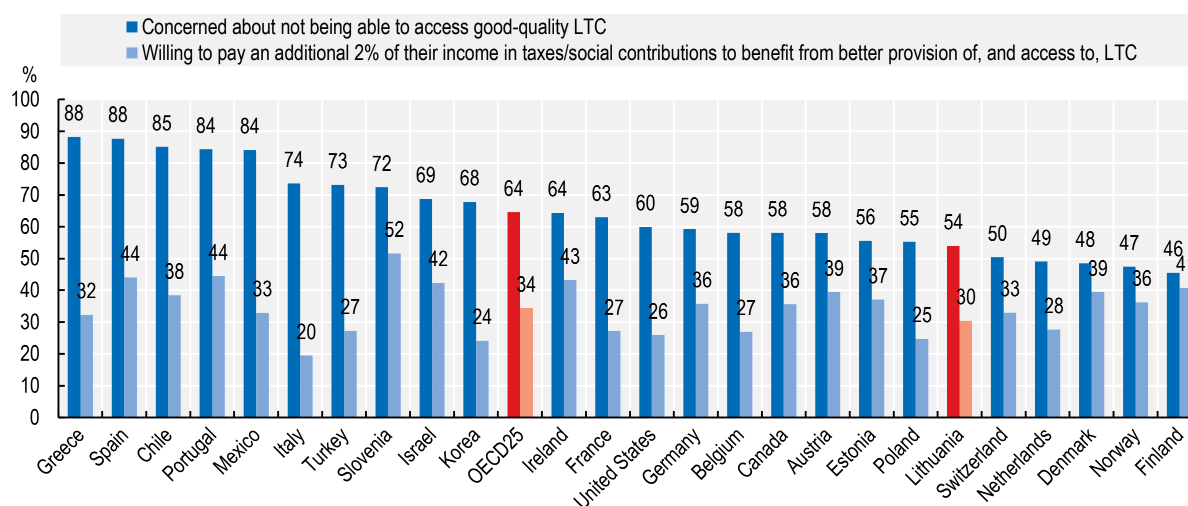
One starting point for Lithuania to establish the integrated long-term care (LTC) system would be to have a dedicated budget. Pooled funding is perhaps the most commonly used manner to finance integrated care for older people (OECD, 2015[1]). In a pooled funding scheme, each body involved in service delivery contributes to a common fund to be spent on pooled functions or agreed services. Pooling existing funds to one well-defined budget can improve transparency and facilitate the distribution of existing funds in a more effective and efficient manner. It can help to reduce unnecessary activities, overuse of services, and duplication of effort and cost shifting (Lonsdale et al., 2015[2]).

France is a country that exemplifies how different funding streams are being turned into a pooled funding scheme. France transferred the vast majority of its LTC funding schemes towards one public institution (CNSA) in 2020 to substantially strengthen the supply of LTC by 2030 and facilitate the collection and the distribution of funding. In addition, it will receive an additional share of funding from the tax “Generalised Social Contribution” (CSG) to finance the LTC services covered before by the Statutory Health Insurance from 2024. This share of the Generalised Social Contribution is currently allocated to the reimbursement of the public social debt. The CNSA budget was EUR 31.6 billion for 2021. Reallocating the social contributions and taxes was possible in France because the funding routes were already outlined in the annual law “Financing Social Security” that aims to monitor the annual EUR 500 billion expenditure of the Social Security (pensions, health, family and child benefits, assistance benefits, etc.).[1] As part of the law, the parliament votes a provisional budget every year – “ONDAM” – for medical LTC providers (including skilled nursing facilities – which are equivalent to nursing hospitals in Lithuania), residential nursing homes and home nursing services for adults with disability and older dependent people.

Growing needs call for considering diverse funding routes to ensure sustainability

Across OECD countries, citizens support more spending on LTC to secure better services, even if this would mean increasing their taxes and social contributions. Between about 45% to nearly 90% of people reported that they are concerned about not being able to access good-quality LTC, according to the OECD Risks that Matter Survey. In addition, between 20% to about 50% of people would be ready to pay an additional 2% of their income in taxes and social contributions to fund more public support for LTC (Figure 4.1).

Figure 4.1. Over one-third of people are willing to pay more taxes to fund LTC across 25 OECD countries



Source: OECD Risks that Matter Survey (data refer to 2020).

Avenues to fund more LTC in Lithuania may rely on diverse and broad-base funding routes. They comprise LTC insurance, taxes and social contributions on incomes and assets. Only a few countries rely mainly on an LTC insurance (Belgium, Germany, Japan, Korea, Luxembourg, and the Netherlands), while the rest rely on tax-based system solely or mixed funding (social contributions and taxes). In Germany, LTC insurance was introduced in 1995 mirroring the pre-existing health insurance and ensuring a large and well-developed base to levy money. Public and private insurances co-exist in Germany. Advantages of LTC insurance include more transparency in managing the funds and horizontal justice. Transparency is improved because the introduction of LTC insurance links funds to specific policies. Horizontal justice would see that the services are the same for everyone, independent on the income of the people in need, while the contribution level increases with the income of contributors. A drawback of an LTC insurance is the reliance on employee's contributions, which can have negative impact on equity and employment. Unless the insurance is extended to the unemployed and the self-employed, it will have a limited tax base, which raises issues regarding equity. For those who are not working, the LTC insurance contribution would still need to be paid from taxes. An LTC public insurance also raises many questions about the amount of premiums to be paid and by whom to limit the possible negative impact on employment (discussed in the next subsection) and take into consideration intergenerational fairness. In addition, LTC insurance can create the expectation that anyone should access LTC, meaning that people would expect to be entitled to the benefits even if demand were to increase. If the LTC insurance fund were to be insufficient, countries would have to complement it with taxes and social contributions and/or borrow to meet citizens' expectations.

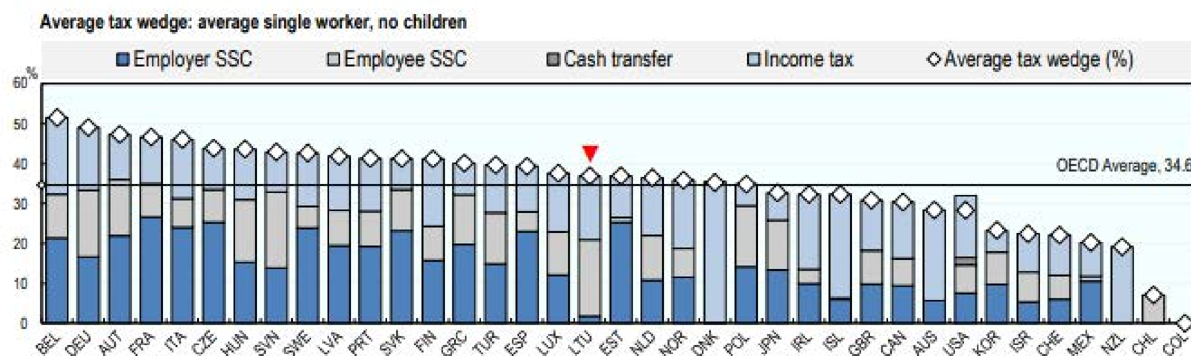
The main advantages of tax-based funding for LTC systems are that taxes can be broad-based and citizens may expect that benefit expenditure aligns with the public financial resources. However, there are sometimes concerns about fluctuations in funding, especially during an economic recession, as well as a lack of transparency in the allocation of funds. Tax-based funding for LTC systems exist in many OECD countries, including in Austria, Scandinavian countries and Spain.

Funding can also come from a mix of social contributions and taxes and, in this case, countries typically levy money on a base broader than the labour incomes. For example, in France, funding stems mostly from social contributions and taxes that cover a base that go well beyond labour income.[2] In many Central and East European countries, LTC funding from the social sector is more tax-based while LTC funding from the health care sector is more mixed. In Scandinavian countries, municipal taxes play a significant role in financing LTC and transfers from the central government budget redistribute funding between municipalities with different income structures and needs profile. In Denmark, municipalities are financed by a combination of state block grants and local income and land tax, albeit within overall limits for all municipalities (Kvist, 2018[3]). In Sweden, approximately 85% of LTC funding comes from municipal/county taxes, and another 10% comes from national taxes. Taxes redistributed to municipalities are not earmarked for flexibility reasons (Schön and Heap, 2018[4]).

In Lithuania, the scope for raising contributions and relying on income tax to fund LTC is limited

Working-age population could contribute to funding LTC in Lithuania to a limited extent. The tax wedge is already slightly higher than the OECD average. The tax wedge for the average single worker was 36.9% in Lithuania compared with 34.6% for the OECD average in 2020 (Figure 4.2). In the future, the pool of workers will decrease along with population ageing and further limit avenues for relying on taxable incomes among the working age population. The old-age dependency rate – the number of older people per 100 working-age people – will almost double in Lithuania between 2019 and 2050, moving from 30% to nearly 60% over this period.

Figure 4.2. The average tax wedge for single childfree workers in Lithuania is slightly higher than OECD average

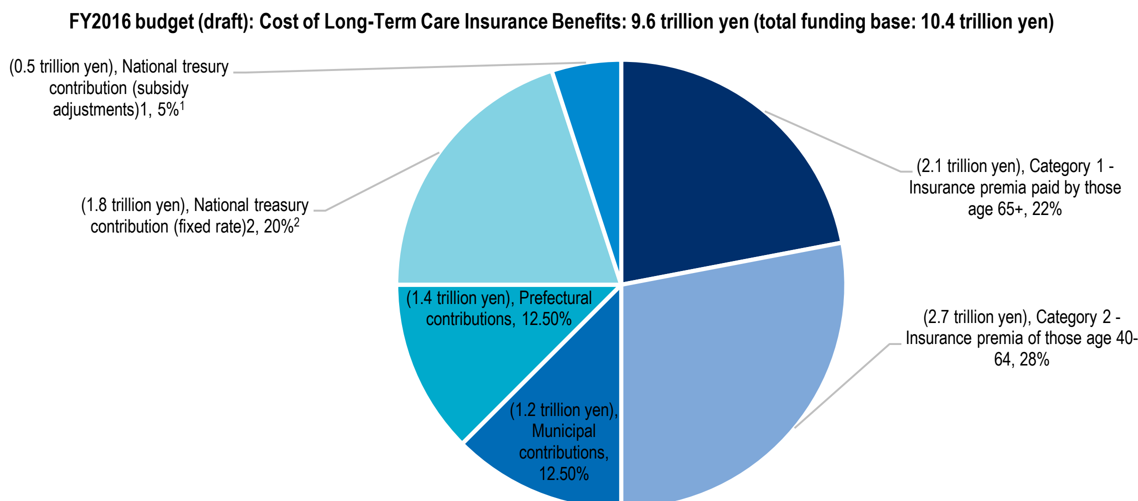


Note: The tax wedge is a measure of the tax on labour income, which includes the tax paid by both the employee and the employer.
Source: OECD Centre for Tax Policy and Administration (2021[5]), Taxing wages – Lithuania, https://www.oecd.org/tax/tax-policy/taxing-wages-lithuania.pdf.

Setting an LTC insurance would secure substantial resources but likely needs to be complemented through other sources

Japan is an interesting model for Lithuania because public spending is split more or less evenly between LTC insurance and taxation, including taxation at the municipal level (Figure 4.3). Similarly to Lithuania, municipalities are also important actors in the assessment and provision of LTC. The Japanese LTC insurance relies on premiums which are different for the people aged 40-64 and those aged 65 and over. Municipalities set the premiums every 3 years based on their projected expenditure. The average premiums are 1.73% on gross labour income for the 40-64. For unemployed people, the premiums are progressive levied as a share on their personal income (7 levels of premiums, 7 levels of income). For older people (65+), the premiums are also based on personal income (7 levels). They are automatically deducted from pensions (Japanese Government, n.d.[6]; Japan Health Policy NOW, n.d.[7]). Taxes enable to broaden the base beyond personal income, and above all, labour income. Income taxes are not earmarked to the LTC insurance. Local governments raise about 1/3 of taxes, and then 2/3 comes from national taxes. Once collected, the ministry redistributes all these funds to municipalities, with the exception of Tokyo.

Figure 4.3. In Japan, insurance premiums and taxes cover each about 50% of LTC benefits



Note: Insurance premia cover 50%, public financing covers 50%. Starting in 2015, a dedicated amount of public money has been appropriated to alleviating the burden of insurance premia on low-income patients. This sum is disbursed by the national government, prefectures, and municipalities. The proportions for Category 1 and 2 are calculated by dividing the number of enrolees in long-term care insurance over the total population every 3 years. For Category 2, public finances to premia contributed 0.6 trillion, Japan Health Insurance Association contributed 0.2 trillion, National Health Insurance contributed 0.3 trillion, prefectures contributed 0.1 trillion. Numbers may not total 100% due to rounding. 1. Subsidy adjusted according to the proportion of age 75 or older people among Category 1 insured persons, and per income level. 2. Proportion of grant each source contributes: National treasury (fixed rate): 15%, Prefectures (17.5%).
Source: (Japanese Government, n.d.[6]; Japan Health Policy NOW, n.d.[7]).

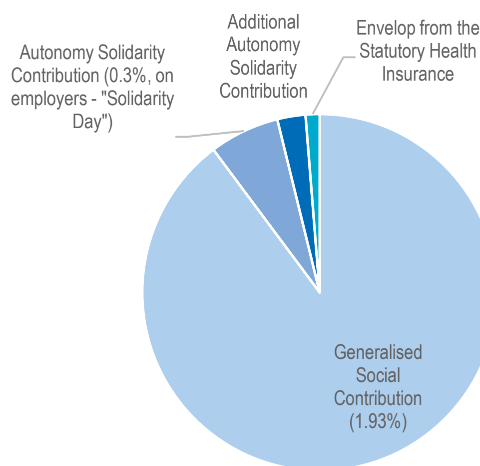
In Germany, the premium for the LTC insurance are set differently than in Japan. The premium is 3.05% of the gross wage, and is shared equally between employees and employers. Those without children pay a surcharge of 0.35 percentage points. The premium is also on unemployment benefits. Premiums are reviewed at least once or twice every four years. Every two years, there is also an increase in the services available and thus premiums are reviewed as a consequence. The methodology to establish premiums is based on a number of factors and data from the main research institutes and the Ministry of Labour are taken into account. The framework is calculated by the Ministry of Health twice a year, under the supervision of the Ministry of Economics.

All the countries with a public LTC insurance supplement it through additional funding via taxes. Even in Germany, an ageing population, an increase in the number of people with high LTC needs and staff shortages are putting pressure on the LTC funding system. The public LTC fund received EUR 1.8-2 billion in 2020-22 from the federal government – i.e. funding from taxes – to cover the increase in spending related to the COVID-19 pandemic. In addition to that, in a law passed in 2021, it was agreed that the government would transfer about 1 billion per year from non-earmarked taxes. The increase aims to cover wage increases, with the goal to reduce staff shortages. The LTC insurance fund and the ministry agreed on this decision because of insufficient funding from the fund to cover wage increases. Even though the amount is very small relative to total LTC expenditure of about EUR 50 billion, this was the first time that Germany decided to rely on taxes to cover increases in spending.

Slovenia is taking a similar approach to Japan and Germany, aiming to fund LTC in part with a new LTC insurance. The 2021 LTC Act states that some funds will come from the pension insurance and the health insurance, based on funds that are currently targeted for the support older dependent people. In addition, the Act states that Slovenia will have to adopt an act for a compulsory LTC insurance by 2025. In the meantime, the additional budget will originate from the state budget. New legislation is foreseen for 2023 to clarify the funding routes.

In France, the public organisation (CNSA) allocates essentially a 2% share of the Generalised Social Contribution to the local authorities or "départements" and to the Regional Health Centres (ARS). The Generalised Social Contribution (CSG) is a unique social contribution across OECD countries – it does not exist elsewhere. It relies on a very broad base and has low rates. It levies about over 100 billion revenues every year – more than personal income taxes. It was implemented in the early 1990s to shift the financing of social protection from wages alone to all incomes (capital income, pensions, unemployment, etc.). The rates vary by type of revenue and revenue brackets. It is considered as less progressive than the personal income tax because the rates vary less by revenue bracket than the personal income tax. However, the general public and the public political debates tend to focus much more on the personal income taxes than the CSG. The CNSA also collects its own finances, mostly through the "Solidarity Day", a social contribution created by introducing an unpaid working day in 2006. The share for the different funding sources are presented in Figure 4.4.

Figure 4.4. The French Autonomy Fund had revenues of over EUR 31 billion in 2021



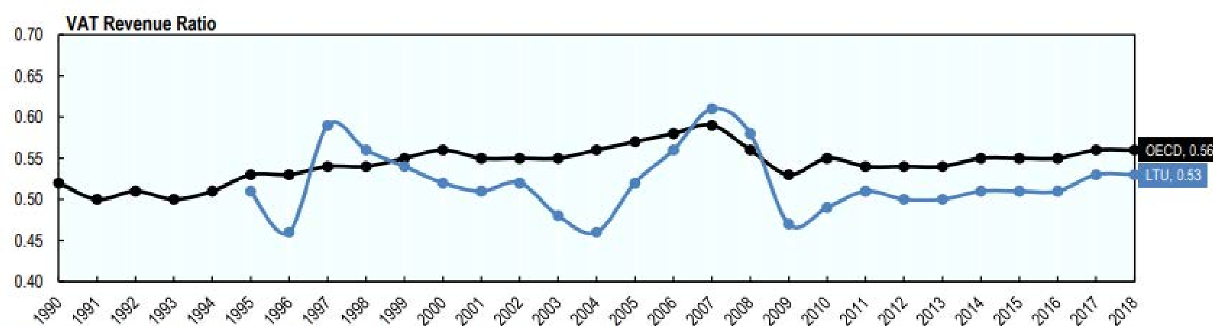
Source: CNSA, Dossier de presse du conseil du 1er décembre 2020 [1 December 2020 Council Press Kit], https://www.cnsa.fr/documentation-et-donnees-espace-presse/2020/dossier-de-presse-du-conseil-du-1er-decembre-2020.

Relying on property taxes and value-added tax (VAT) are good options to diversify sources

As an alternative funding source for Lithuania to consider for additional LTC budget would be property taxes. Lithuania could increase property taxation from 0.3% of GDP to closer to the Latvian's rate of 0.9% or the EU average of 1.6%. In Lithuania, the real estate tax ranges from 0.5% to 2% when the property value is at least over EUR 150 000. Private real estate is taxed at 1% on the property value that exceeds EUR 300 000. This threshold is increased to EUR 390 000 for families with three or more underage children or a child with disabilities who requires permanent care (Ministry of Finance of the Republic of Lithuania, 2021[8]).

Lithuania could maintain the standard VAT rate at its current level, but reduce the number of goods and services with reduced VAT rates or exemptions. The standard VAT rate in Lithuania is equal to 21%, close to the EU average of 22%. It is identical in Latvia, but at 23% in Poland. Lithuania has increased its standard VAT rate in 2010, from 19% to 21%. Compared with the OECD average, there is scope to narrow down the number of goods and services eligible to the reduced VAT rates or exemptions, or move goods and services across reduced rate categories, or increase the reduced rates. The VAT Revenue Ratio (VRR) for Lithuania was 0.53 in 2018, below the OECD average of 0.56 (Figure 4.5). The VRR is a measure of the revenue raising performance of a VAT system. A ratio of 1 would reflect a VAT system that applies a single VAT rate to a comprehensive base of all expenditure on goods and services consumed in an economy, with perfect enforcement of the tax. Reduced VAT rates or exempts apply to a number of goods and services. The reduced VAT rates were 5% and 9% in 2021. In comparison, it was 5% and 12% in Latvia and 5% and 8% in Poland in 2021.

Figure 4.5. The VAT Revenue Ratio in Lithuania could be closer to OECD average



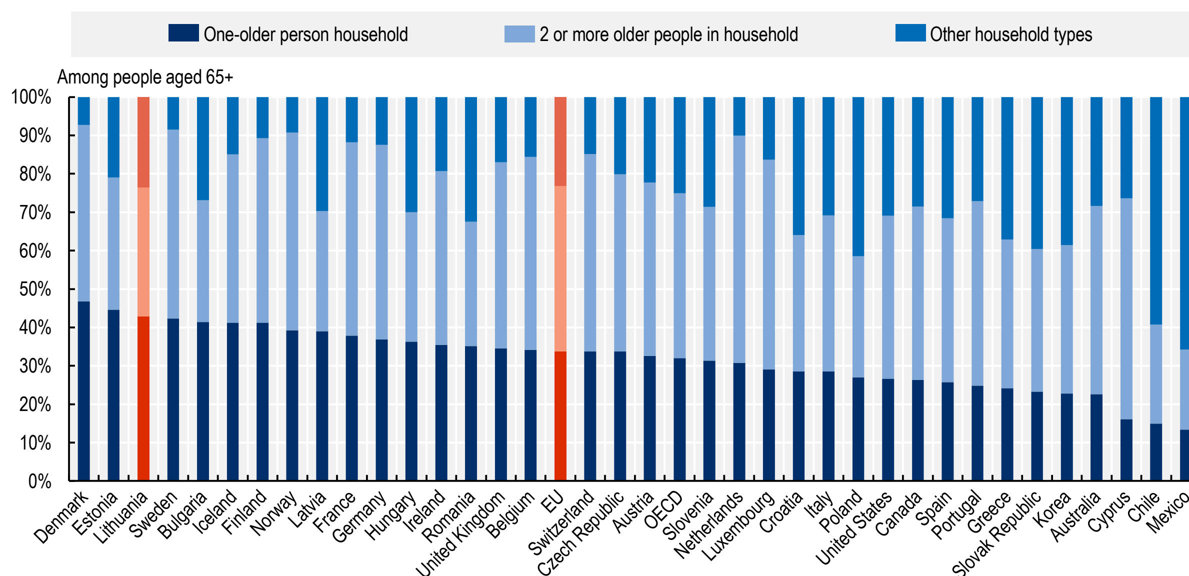
The figures may not present the difference to the second decimal point accurately due to rounding
** Information presented on this page is only a summary of more detailed information available in the Tax Database and Consumption Tax Trends publication*

Source: extracted from OECD Consumption Trends 2020, https://www.oecd.org/tax/consumption/consumption-tax-trends-lithuania.pdf.

Private home equity programmes have a very limited potential

Over 40% of older people in Lithuania live alone (Figure 4.6) and over 90% of older people own their home in Lithuania (with or without mortgage).[3] This means that a number of Lithuanians have immovable assets like houses and flats which could be used to contribute to LTC costs if unoccupied.

Figure 4.6. Over 40% of older people live alone in Lithuania



Note: 1. No data available for Japan, New Zealand and Republic of Türkiye due to data limitations. The present publication presents time series which end before the United Kingdom's withdrawal from the European Union on 1 February 2020. The EU aggregate presented here therefore refers to the EU including the United Kingdom. In future publications, as soon as the time series presented extend to periods beyond the UK withdrawal (February 2020 for monthly, Q1 2020 for quarterly, 2020 for annual data), the "European Union" aggregate will change to reflect the new EU country composition.
Source: OECD calculations based on European Union Statistics on Income and Living Conditions (EU SILC) survey 2019 except for Iceland, Ireland, Italy, and the United Kingdom (2018; the German Socio-economic Panel (GSOEP) for Germany till 2014, the Household, Income and Labour Dynamics Survey (HILDA) for Australia (2019); the Survey of Labour and Income Dynamics (SLID) for Canada (2011); Encuesta de Caracterización Socioeconómica Nacional (CASEN) for Chile (2017); the Korean Housing Survey (2019); Encuesta Nacional de Ingresos y Gastos de los Hogares (ENIGH) for Mexico (2018); American Community Survey (ACS) for the United States (2019).

Lithuania could encourage the use of home equity programmes such as reverse mortgages or home reversion, but the potential of such a programme for funding LTC is very limited. Home equity programmes are typically not very developed in terms of housing market share and number of providers across most OECD countries. In general, home equity programmes still seem to be more products of last resort than well-thought purchases as part of a retirement plan or a health care plan. This is explained by several challenges on the supply and the demand sides. For example, in the United Kingdom, the small reverse mortgage market is concentrated where house prices are high. However, there is a strong demand in other parts of the country where both real estate and non-real estate wealth are lower. The risks faced by suppliers limit market development as providers need high house price growth to make profit on reverse mortgages (Sharma, French and McKillop, 2020[9]).

The market is more developed in the United States, partly because of the stringent eligibility criteria to access public support for residential care. Eligibility criteria for people relying on Medicaid include an asset test on the primary residence: one cannot own a home that they do not live in. Therefore, a single person is required to sell their home to receive Medicaid support (including their primary residence, but it is not applicable if a spouse remains in). Reverse mortgage is attractive to borrowers when the reverse mortgage can be used to pay for in-home care over a relatively long period. The United States has also one of the strongest regulations for the government-insured scheme. The insurance guarantees that the borrower's debt will never exceed the property value and that borrowers will receive regular payments from the loan even if the property loses value or the lender becomes insolvent. (Paying for senior care, 2020[10]; Bridge et al., 2009[11]).

Preventive and rehabilitation services can contribute to funding sustainability

Scandinavian countries and some other OECD countries have well-developed preventive and rehabilitation services that can contribute to improving quality of life and potentially be cost-efficient. Preventive and rehabilitation services can help to postpone LTC needs, thus potentially containing LTC expenditure. Across countries, day centres typically offer preventive services, among others (Box 4.1).

Denmark and Norway provide interesting examples of preventive measures. In Denmark, municipalities provide preventive home visits and activities to everyone aged above 75. The offer is also extended to people aged 65-75 who are in a special risk group – those who are widows, live in a secluded area, or are recently discharged from hospital. As of 2016, municipalities can organise group visits instead of individual visits as an alternative to those who usually decline home visits. In 2016, 93 424 persons received a preventative home visit, down from 122 794 in 2010. Municipalities also provide activities that vary in terms of scope and type (workshops, education, talks, and sports) (Kvist, 2018[3]). In Norway, a health care worker – typically a nurse – evaluates the older person's physical and mental health condition, assesses the appropriateness of their home environment and recommends solutions and measures to prevent foreseen problems. The introduction of a preventive home visits programme significantly lowers the probability to use nursing homes, while increasing the probability to use home care. A survey showed that care in nursing home was reduced by 1.4 percentage points among the people aged 80 and over, from a baseline of 19%. The decline was partly matched by an increase in home-based care, from a baseline of 35%. In addition, hospital admissions decreased by about 7%, and mortality rates declined by nearly 5% in the years following the introduction of the preventive home visits (Bannenberg et al., 2021[12]).

Box 4.1. Day centres typically offer preventive services

Even though "day centre" is a generic term, day centres can be defined as community building-based services that provide care and/or health-related services and/or activities specifically for older people with disability and/or who are in need, which people can attend for a whole day or part of a day. Interventions with evidence of positive outcome are presented.

Table 4.1. List of programmes

Programme type	Programmes
Providing social and preventive services	Humour-based programme
	Transport, exercise and self-help programme
	Organised volunteering
	Psychosocial group work
	Brain fitness activities
	Discussion groups to promote social engagement and learning
	Health screening/Hearing screening
	Education-focused falls prevention
Promoting physical activity	Moderate-intensity weight-bearing exercise
	Core stability and flexibility exercise
Supporting health and daily living needs	Blood pressure monitoring
	Self-management education
	Behavioural intervention to increase walking and reduce urinary incontinence (UI)
	Pelvic floor muscle training (Kegel exercises) to reduce UI
	Medication reviews by pharmacy students
	Programme of low-impact exercise, nutrition education and weight management for people with multiple chronic conditions

Source: Orellana, Manthorpe and Tinker, (2018[13]), Day centres for older people: a systematically conducted scoping review of literature about their benefits, purposes and how they are perceived, https://doi.org/10.1017/S0144686X18000843.

In addition, Danish municipalities have to offer a rehabilitation programme prior to assessing the need for home help. The programme is short-term and intensive (4-10 weeks). The rehabilitation programme comprises one or more of the following elements: training in everyday activities (personal care), physical training, assistive devices, and adaption of the home, with the aim of maintaining or even gaining functionality (Kvist, 2018[3]). In 2018, 4.3% of people aged 65 and over followed the rehabilitation programme, instead of, or together with home help (Rostgaard, 2021[14]). Danish evidence suggests improvement in functional ability, better evaluation of working conditions and work motivation among staff. Local reports indicate good user outcomes and some studies show a lower use of home care (Rostgaard, n.d.[15]). Some preliminary results seem to be aligned with these findings, as the probability of using home care has decreased from 2007 to 2017 in Denmark. The probability of receiving home care for frail people aged 67-87 years decreased from over 35% to about 25% (Rostgaard, 2021[14])). This could be the result of targeting more home care towards the most frail and personal care. While the programme may be cost-efficient, there has not been any systematic documentation of expenditure and user outcomes.

Price controls for LTC services might also be useful tools for sustainability

Certain countries such as the Netherlands and Spain rely on defined or maximum prices for services in each care setting. The Netherlands relies on maximum prices to finance LTC provision. The 31 Dutch regional purchasing offices are in charge of contracting provision with providers, within the budget constraint, and respect the maximum prices set by the Dutch Health Care Authority (Nza) (Milstein, Mueller and Lorenzoni, 2021[16]). The care an individual is entitled is determined by his or her care profile (there are 10 care profiles). Maximum prices for each care profile are differentiated based on whether treatment is provided by the nursing home. Moreover, the Nza sets separate maximum prices for a substantial number of additional activities, including additional services like transport (Table 4.2). Maximum prices are based on empirical research based on a survey that covered about half of providers delivering care financed by social long-term care insurance in 2017 (Kelders and de Vaan, 2018[17]; Bakx, Schut and Wouterse, 2021[18]).

Table 4.2. Maximum price per day per care package in the Netherlands

Care package	Description	Users (in-kind)[a]	Users (cash benefit)[a]	Price per day (EUR)[b]
1	Assisted living with some support	350[c]	0	100
2	Assisted living with support or personal care	1015[c]	0	128
3	Assisted living with intensive support and extensive nursing	2110[c]	0	183
4	Assisted living with intensive support and extensive nursing	26445	2235	197
5	Nursing home care with extensive dementia care	60290	5400	250
6	Nursing home care with extensive personal care and nursing	27885	1750	251
7	Nursing home care with intensive care, with focus on supervision (often behavioural problems)	10635	290	293
8	Nursing home care with intensive care, with focus on personal care/nursing (problems with ADL and cognitive)	2150	355	331
9[b]	Rehabilitative treatment[d]	825	55	300
10	Protected living and palliative care	255	25	354

Note: A. Number of users in 2018. B. Regulated maximum price for 2019, including day care and treatment. C. Access to care packages 1-3 were abolished in 2012; only cases prior to 2012 remain. D. Rehabilitative treatment for individuals already living in a nursing home.
Source: Bakx, Schut and Wouterse (2021[18]), Price setting and contracting help to ensure equitable access in the Netherlands, https://extranet.who.int/kobe_centre/en/project-details/.

Spain relies on tariffs, rather than maximum prices, and co-payments decided at the regional level, within a national binding framework. In Spain, the regional Health Departments undertake contracts with both public and private providers. The central government sets minimum criteria for benefits and also reference costs of services. In many cases, tariffs and reference costs are static and based on historical values. The regions are free to set their own prices, but they have to finance the difference in case of higher costs. The average price of public home care was about EUR 15 per hour and the average user's co-payment 11% in 2019. Average hourly prices of home care varied between around EUR 9.00 in Extremadura and Galicia to EUR 17.00 in Aragón and Illes Balears. As for co-payment, it ranged from 1.6% in Andalucía and 44.2% in Murcia (Flores, 2021[19]). With respect to day centres, prices per user depend on the user's degree of dependency and the type of provider. On average, annual prices per user were EUR 9 077 in public centres with a co-payment of 24% and EUR 10 078 in private subsidised centres with a co-payment of 22% per user in 2019. (Flores, 2021[19]). In residential care centres, prices per user depend on the type of provider

(public of private subsidised “charter” centres). For instance, in 2019, on average, annual prices per user were EUR 20 686 in public centres with a co-payment of 36% (EUR 7 500) and EUR 19 324 in private subsidised “charter” centres with a co-payment of 40% (EUR 7 810). There are also large differences across regions both in prices and co-payments. For example, annual prices per user in public centres ranged from EUR 10 460 in La Rioja to EUR 28 145 in Madrid. Co-payment in public centres was highest in Navarra as a percentage (81%) but in País Vasco as an absolute figure (EUR 13 110) (Flores, 2021[19]).

Lithuania could consider introducing maximum prices or tariffs as in the above-mentioned countries. If the prices are set on services rather than hours, the price should factor in the hours of care needed to deliver the services and the complexity of the tasks (i.e. the wage). If the prices are set in hours, it would be important to take into account the complexity of the tasks (and the wage implications). Because of the risks of setting prices without previous field research, it is probably more realistic to rely on historical prices in Lithuania (see the section on needs assessment to understand the value of field research).

An alternative is to use a point system to set prices and to control spending such as in Germany and France. Each service has a number of points, which have a base value. The points and the base values can be set at the national or subnational level, but providers can set up contracts with the public bodies. This system allows for price adjustments to take into account differences across subnational levels, but it is also more complex. The pricing system also depends on the setting – home care, day care and residential care. For residential care, both countries differentiate between non-accommodation costs and accommodation costs. Accommodation costs are less monitored and providers can make more profit on this strand. Co-payment applies at least for residential care in both countries.

In Germany, prices for home care follow a point system different in each *länder*. Services are translated into points depending on the time intensity of the services provided and/or their complexity. The base value is around EUR 5-6 per 100 points (Table 4.3) (Milstein, Mueller and Lorenzoni, 2021[16]). Prices are negotiated individually on a regional or state level between a care setting, welfare organisations and LTC funds, whose enrolees contribute at least 5% of the residential home days (Pflegesatzverhandlungen). Prices are negotiated separately for nursing services, board and accommodation and investment costs. Board and accommodation and investment costs are the same for all residents, but nursing costs and reimbursements grow by increasing care degree with some exceptions. Nursing costs are largely based on the number of nurses per beneficiary and vary depending on the beneficiary’s care degree.

Table 4.3. Prices of selected services in two German *länder*

	Brandensburg		Bavaria	
	Points	Price (in EUR)	Points	Price (in EUR)
First visit	450	22.64	1000	60.50
Journey (mobility)	84	4.23	-	4.54
Washing hair	129	6.49	100	6.05
Changing bedsheets	50	2.52	80	4.84
Cooking main dish	240	12.07	300	18.15

Note: data refer to 2019.
Source: Milstein, Mueller and Lorenzoni (2021[16]), Germany’s difficult balancing act: Universality, consumer choice and quality long-term care for older persons https://extranet.who.int/kobe_centre/sites/default/files/OECD_2021_Germany.pdf.

In France, the pricing method for nursing homes also uses a point system for the medical care and the dependency care packages. The pricing method of care institutions is composed of the medical care package, the dependency care package and the accommodation fee (Or and Penneau, 2021[20]). The medical care package is calculated for each facility using a synthetic indicator, which corresponds to the average care needs and dependency level of people living in the facility. For each of these condition-profiles, eight resource groups were identified (physician, psychiatrist, nursing, rehabilitation, psychometrics, biology,

imaging and pharmacy) that define the level of care resources required. This care bundle is also adjusted according to the dependency level (six levels of LTC needs). The amount of the medical care package for each facility is the weighted average score multiplied by a reference/index price per point defined at the national level by the Ministry of Health. In practice, the Regional Health Centres are constrained in their LTC funding by the ONDAM a priori budget, and care institutions may not receive the amount calculated with this pricing method (Or and Penneau, 2021[20]). The dependency care package is set in a similar way, but is funded by the local authorities. The payment is calculated according to the GMP (average dependency score) of the facility and the value of the departmental dependency score's point decided by the local council. Across local authorities, the point ranges from EUR 5.7 in the Alpes-Maritimes to EUR 9.4 in the south of Corsica. In 2017, the price for dependency bundle was on average EUR 5.5/day for low dependency persons, EUR 12.9/day for moderate level of dependency and EUR 20.4/day for highly dependent persons (Or and Penneau, 2021[20]). The accommodation fee of places eligible for public support are set by the local authorities – around 85% of care institutions have places eligible for public support. The maximum price varies between EUR 49/day in the first decile of prices of residential care to EUR 67/day at the 9th decile. The prices of places that are not eligible for public support are set freely, although the rate of increase is monitored each year and regulated by the central government (Or and Penneau, 2021[20]).

Interestingly for Lithuania and its nursing hospitals, until 2017, skilled nursing facilities in France were only funded by annual prospective global budgets in the public and private non-profit sectors and through a fixed daily rate in private for-profit facilities. Since 2017, the global budgets have been adjusted to take into account the volume and case-mix of the patients treated. In 2020, about 10% of the budget came directly from activity-based payments using GME reference tariffs. The tariffs include all staff costs and there is 70-day threshold which allows facilities to bill some of the costs gradually for longer stays. The tariffs are also weighted by a geographic coefficient. Since 2018, skilled nursing facilities can also benefit from the small pay-for-performance scheme focussed mostly on patient safety indicators (Or and Penneau, 2021[20]).

References

Bakx, P., E. Schut and B. Wouterse (2021), *Price setting and contracting help to ensure equitable access in the Netherlands*, WHO, https://extranet.who.int/kobe_centre/en/project-details/ (accessed on 12 April 2022). [18]

Bannenberg, N. et al. (2021), "Preventive Home Visits", *American Journal of Health Economics*, Vol. 7/4, pp. 457-496, https://doi.org/10.1086/714988. [12]

Bridge, C. et al. (2009), *Reverse mortgages and older people: growth factors and implications for retirement decisions authored by*, Australian housing and urban research institute, https://www.ahuri.edu.au/__data/assets/pdf_file/0022/2776/AHURI_Positioning_Paper_No123_Reverse-mortgages-and-older-people-growth-factors-and-implications-for-retirement-decisions.pdf (accessed on 10 February 2021). [11]

Flores, M. (2021), *Increasing beneficiaries and the decline in informal care in the Spanish long-term care system for older persons*, WHO, https://extranet.who.int/kobe_centre/en/project-details/ (accessed on 12 April 2022). [19]

Japan Health Policy NOW (n.d.), *3.2 Japan's Long-Term Care Insurance System*, https://japanhpn.org/en/section-3-2/ (accessed on 10 April 2022). [7]

Japanese Government (n.d.), *Long-term Care Insurance in Japan*, https://www.mhlw.go.jp/english/topics/elderly/care/2.html (accessed on 10 April 2022). [6]

Kelders, Y. and K. de Vaan (2018), *ESPN Thematic Report on challenges in long-term care in the Netherlands*. [17]

Kvist, J. (2018), *ESPN Thematic Report on Challenges in long-term care in Denmark*. [3]

Lonsdale, J. et al. (2015), *One Place, One Budget? Approaches to pooling resources for public service transformation*, RAND Europe, https://www.rand.org/content/dam/rand/pubs/research_reports/RR1000/RR1017/RAND_RR1017.pdf (accessed on 10 April 2022). [2]

Milstein, R., M. Mueller and L. Lorenzoni (2021), *Germany's difficult balancing act:universality, consumer choice and quality long-term care for older persons*, WHO, https://extranet.who.int/kobe_centre/sites/default/files/OECD_2021_Germany.pdf (accessed on 10 November 2021). [16]

Ministry of Finance of the Republic of Lithuania (2021), *Real Estate Tax*, https://finmin.lrv.lt/en/competence-areas/taxation/main-taxes/real-estate-tax. [8]

OECD (2015), *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery*, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en. [1]

OECD Centre for Tax Policy and Administration (2021), "Taxing wages - Lithuania", https://www.oecd.org/tax/tax-policy/taxing-wages-lithuania.pdf (accessed on 10 April 2022). [5]

Orellana, K., J. Manthorpe and A. Tinker (2018), "Day centres for older people: a systematically conducted scoping review of literature about their benefits, purposes and how they are perceived", *Ageing and Society*, Vol. 40/1, pp. 73-104, https://doi.org/10.1017/s0144686x18000843. [13]

Or, Z. and A. Penneau (2021), *Long-term care in France: the loose connection between pricing, costs and quality with regional inequalities*, WHO, https://extranet.who.int/kobe_centre/sites/default/files/France_policy%20brief_5_0.pdf (accessed on 12 April 2022). [20]

Paying for senior care (2020), *Using Reverse Mortgages to Pay for Long Term Care*, https://www.payingforseniorcare.com/financial-products/reverse-mortgages. [10]

Rostgaard, T. (2021), *Long-term care for older people living at home – Danish experiences in a Nordic context*. [14]

Rostgaard, T. (n.d.), *Thematic Panel 3 – Reablement as a mechanism for sustainability and active long-term care – Transforming Care Network*, http://www.transforming-care.net/thematic-panel-3-reablement-as-a-mechanism-for-sustainability-and-active-long-term-care/ (accessed on 10 April 2022). [15]

Schön, P. and J. Heap (2018), *ESPN Thematic Report on challenges in long-term care in Sweden*. [4]

Sharma, T., D. French and D. McKillop (2020), "Risk and Equity Release Mortgages in the UK", *The Journal of Real Estate Finance and Economics*, https://doi.org/10.1007/s11146-020-09793-2. [9]

Notes

[1] In comparison, the State annual budget is about EUR 250 billion. The parliament also votes it every year, together with the Law on Finances.

[2] France's Generalised Social Contribution has relatively low rates and relies on a very broad base (labour income, capital income, pensions, unemployment benefits, etc.).

[3] Eurostat, Income and Living Conditions database, indicator ilc_lvho02.

5 Ensuring the availability of sufficiently trained carers

This chapter discusses the wide range of policy options available to bolster the LTC workforce. Options include various recruitment policies such as recruiting unemployed and inactive people, bringing back workers who emigrated and bringing in foreign-workers. In addition, it presents retention strategies, focusing on improving training and competences and creating better career pathways. Finally, it discusses the importance of training and care leave for informal carers.

Addressing current and future shortages requires widening recruitment efforts

Lithuania could follow similar strategies to other countries where recruitment initiatives have focused on providing incentives to (re)enter the sector. In addition, it could also initiate other policies such as bringing back workers who emigrated and bringing in foreign-workers.

Lithuania could recruit unemployed and inactive people to enter the LTC sector. In Lithuania, an estimated 32% of the working age population is facing labour-market difficulties and could be a potential pool. This category includes early retirees with health limitations, inactive individuals, long-term unemployed, skilled women who were out-of-the-labour force for family reasons, and underemployed people with low earnings (Pacifico et al., 2018[1]). For instance, in Norway, a country where municipalities play a strong role in LTC, the central government provides grants to be spent on targeted training for the unskilled, to attract unemployed and inactive people (Helsedirektoratet, 2021[2]). Japan financed training programmes for students and experienced workers returning to work after a long break. Such strategy proved to be very successful as it increased LTC workforce by 20% between 2011 and 2015 (OECD, 2020[3]).

Lithuania could also foresee a rotational training programme where unskilled people are trained to enter the LTC sector and LTC workers with low skills are offered opportunities to train full time or part time and skilled LTC workers have the opportunity to receive specialised training on specific diseases and/or managerial and mentoring topics. In 2019 Sweden put in place a similar rotational training programme, targeting three groups: long-term unemployed people, LTC workers with low skills, LTC workers with formal education. LTC workers with low skills are enrolled in a training programme lasting three semesters to gain formal skills. During their absence from work, LTC workers are replaced by long-term unemployed people, who are trained and sign after with a temporary contract with the municipality. The training for the unemployed includes training on Swedish language, information technology skills and workshops on soft skills. As of 2022, the programme includes only part-time training for LTC workers to allow them to work alongside the training and to need less long-term unemployed people. The training for unemployed people focuses first on motivating them and providing them with the ability to study and the language skills that they might need. The programme's strengths rely on the good collaboration with the employers taking part in the programme and the small size of classes (around 10-15 students per class) which allows for good quality. Lithuania could foresee a similar rotational programme, attracting not only unemployed people but also workers from other less labour-intensive sectors where the demand for workforce has decreased in recent years.

Lithuania could also make efforts to improve job opportunities and skill recognition to Lithuanian emigrants and more generally improve services assisting the return of Lithuanian emigrants (OECD, 2018[4]). Net migration has been mostly negative in the past decades in Lithuania. A number of countries facilitate the return of citizens working abroad. Lithuania could attract citizens back by providing favourable conditions such as a tax relief. Italy has implemented tax reliefs for citizens who return to Italy after working from abroad for at least 2 years. To obtain the tax relief, citizens need to transfer their residency in Italy for at least two years and are required to have their main economic activity in Italy. The tax relief consists of at least a 70% reduction for tax to pay and varies according to the personal situation of the citizen (e.g. better conditions are available for workers with kids and/or who buy a house in Italy) (Agenzia delle entrate, 2022[5]).

Lithuania could consider recruiting foreign workers into the LTC sector by including LTC workforce in the list of professions that are scarce in Lithuania. This would ease the requirements for foreign workers to work (Migration Information Centre, 2022[6]). Croatia included for the first time in 2019 personal carers and nurses working in social care (55 for nurses and 90 for carers in 2020) in its "Decision on establishing the yearly quota of permits for hiring foreigners in 2019", and the quota was reached for carers but only for half of the nurse quota. Since 2019, Japan has allowed foreign workers to obtain a residency status, the "Specified Skilled Workers", to work in the LTC sector (OECD, forthcoming[7]). Israel is a country that relies heavily on foreign workers, especially for home care. Foreign workers can receive a permission to stay in

the country if they work in one of the sectors listed by law, including LTC. Older people and relatives who wish to hire a foreign caregiver contact directly a recruitment agency. They become employers and must provide employees with private health insurance and adequate housing. Foreign workers are allowed to stay in Israel for a maximum of 63 months, but the regulation can be eased for LTC workers who have been employed for at least 12 consecutive months, if they can prove that a change of carer might harm the older person in need of care (PIBA, 2013[8]).

Germany has put in place comprehensive programmes to attract and train foreign-born nurses. Germany has attracted nurses from southern European countries, Serbia, Bosnia, the Philippines, Tunisia and Viet Nam. The German Triple Win programme has led to the recruitment of 1 000 nurses between 2017 and 2020. A different programme is in place to recruit nurses from Viet Nam and it requires that, before moving to Germany, nurses complete their degree and take one year of German language classes in Viet Nam. Once they arrive in Germany, nurses must complete up to two years of training, including theoretical and practical courses and language classes. Afterwards, nurses must work in the sector for 3 years in order to obtain a permanent residence permit. The programme has been successful, with nurses remaining in the same firms after the training programme (OECD, 2020[3]).

Further strategies to recruit and retain LTC workers include offering placement opportunities to nurse students and personal care workers during their studies. In Lithuania, students currently pay the cost of nurses' training programs out of pocket (EUR 2000). Lithuania could develop collaborations between care providers and training providers in order to develop programs of paid trainings with placement opportunities. For instance, Estonia has work-based learning programmes that allow students to study and work in the LTC sector. The students complete one-third of the studies at school and two-third in a LTC institution and receive a salary, which cannot be lower than the basic income (654 euros in 2022). At the end of the programme, students undertake an exam free of charge. In Canada, the Prior Learning Assessment and Recognition Process improves immigrants' employability and facilitates their entry into post-secondary education institutions. It allows recognition of the international credentials of immigrants willing to work in health occupations.

Enhancing job quality and training are priorities to improve retention

Retaining LTC workers is not straightforward because of the multiplicity of factors that influence turnover. Low wages represent a challenge for staff retention, especially because there are few opportunities for pay progression. Lithuania could improve working conditions, starting with wages given the context of high inflation. In Lithuania, the inflation rate raised from 1.1% in 2020 to 4.6% in 2021 and 6.7% in 2022 (EC, 2022[9]). Since LTC workers' wages in Lithuania are close to the minimum income, their standards of living are very likely impacted. However, wages are not the only factor driving low retention: workers also point to working times, stress, heavy workload, and poor support; and addressing these factors is similarly important. Beyond wages, promoting a healthier work environment and prevention of work-place accidents and illness can reduce absenteeism, turnover and poor workers health. The Netherlands has developed coaching programmes, while Japan has workplace counselling services to promote prevention of accidents and burnout. Giving workers more flexibility and control can also boost job satisfaction and reduce turnover. Self-managed teams, such as in the Netherlands, Australia and Japan, have given nurses more autonomy.

Lithuania can develop training programs with placement opportunities. Enhancing training can help improve job quality and influence retention. Better jobs will mean better quality of care and reductions in the high staff turnover and related costs. Examples of successful training programmes for LTC workers are in place in Norway and in Denmark. As part of the Competency lift 2025 action plan, Norway provides grants to municipalities. The programme entails 70 different grants for different types of training, for a total of around EUR 230 million. The training does not substitute the formal training, but provides additional skills and improves the motivation of LTC workers (Helsedirektoratet, 2021[2]). Each year, municipalities

provide a report to the central government to detail their use of the grants. Denmark has also engaged to improve the competences of LTC workers and in particular personal care workers through training. All non-qualified employees in Denmark have the right to participate in a social care worker's training programme, and employers must offer the training within the first three years of work. Employees receive leave and financial compensation to cover the cost of the training (FOA, 2009[10]).

A few countries encourage those with the lowest position to progress in their career, shifting across different roles within the LTC sector. Those countries also provide specific training to allow career perspectives. For instance, Denmark, Germany and Korea have modular training for personal carers to those who seek to access managerial roles or for nurse aides wanting to become nurses. In particular, Danish personal care workers can attend a two-year programme and undergo national examinations in order to progress and provide more advanced care, becoming health assistants. Similarly, in Norway nurses assistants can specialise and train for between six months and three years, as well as attending one year of vocational training, to become registered nurses (OECD, 2020[3]).

There are also other country examples to improve training opportunities. Germany started a new vocational training programme for nurses in 2020. The programme merges training for general, geriatric and paediatric nursing, exposing all nursing students to more general and comprehensive skills. People with an intermediate school certificate or a secondary school diploma – both German students and foreigners with good knowledge of the language – can apply for the training at the available employers. During the three-year training, students receive a monthly salary (starting at 1 200 euros gross per month, and increasing each year) and they are allowed to have a job in parallel to the training, for a set number of hours. After three years of training, nurses can expect to earn a variable amount of money, starting at around 2 300 euros gross per month, with additional bonuses for night shifts, weekends and public holidays (Pflege-Deutschland, 2022[11]; LifeinGermany, 2022[12]).

Another avenue to develop career pathways and improve people-centred care is to create the position of care managers. Denmark and Japan rely on care managers and Slovenia aims to introduce the role of care co-ordinator. In Denmark, the care manager is a social worker employed by the municipalities, whose role is to plan home services and co-ordinate home-based workers. This network of co-ordinators provides a single interface with older people and their relatives. In Japan, care managers draw up care plans for older people. They must be licensed professionals (e.g. social workers, nurse) with at least 5 years of experience and have followed a few days of training (which leads to a certification). Most care managers are full-time municipal employees (Tsutsui and Muramatsu, 2005[13]). They can also be employed by private care agencies. While older people are free to make their own care decisions, the system is sufficiently complicated to incentivise them to go through care managers. When older people work out their care plan with the care managers of agencies, it is common that the care managers encourage the use of the care of their agencies. Slovenia aims to introduce the role of care co-ordinator following the recent reform. Each provider of LTC will be required to have at least one co-ordinator. Co-ordinators will create a care plan with the eligible older people and will visit people to ensure that they receive quality LTC. The option adopted by Slovenia and Japan (yet not in Denmark) is to allow older people to choose care managers/co-ordinators employed by municipalities or care providers.

Support for informal caregivers is necessary to sustain care efforts

Given potential shortages of carers and the demographic and societal long-term changes, supporting informal carers is needed. It is a win-win option because it is beneficial for carers, care recipients and often for public finances. Care recipients often prefer to be looked after by family and friends.

A body of research shows that informal carers often wish to receive more training to enable them to provide better care (COFACE, 2017[14]). For instance, carers are not always knowledgeable about the diseases of the person they care for or have difficulties performing personal care (e.g. lifting someone from a bed to a chair without experiencing pain). According to Eurocarers, carers would mostly benefit from training on specific diseases, skills required to maintain or rehabilitate the health status of the care recipient, skills to deal with the management of symptoms, skills related to daily life activities, and the management of emergencies. Practical nursing skills – mainly managing and administering medication, pain management, and moving and handling techniques without suffering strain – are also often sought. These practical nursing skills are particularly important for carers who take over between nurse visits, which means mostly in the evening of working days and during the weekends.

Lithuania could consider enhancing training for informal carers. In the majority of OECD countries, free training (at least online) is available. Across OECD countries, most training relies heavily on the voluntary sector. Australia has developed a comprehensive public training programme in collaboration with non-governmental organisations (NGOs). In Mexico, the Institute of Social Security and Services for State Workers and the Institute for Social Security finance and organise online courses. In Greece, NGOs collaborated with academic institutions to create free training courses for carers – the “I care programme”. Similarly, in Canada, France, Ireland and the United Kingdom, countries collaborate with NGOs to provide regular training. In the United Kingdom, NGOs like Carers Trust and Carers UK are subcontracted to provide training across the country.

Lithuania could also consider policies which enable both men and women to more readily combine work and care responsibilities in order to reduce the risk of dropping out of the labour market altogether. Currently, about two-thirds of OECD and EU countries provide paid or unpaid leave to care for an older family member (Table 5.1). Over half of the countries offer paid leave for carers of older people (Rocard and Llena-Nozal, 2022[15]). Paid leave entitlements vary starkly across countries in terms of duration, eligibility criteria and generosity of compensation. A range of options is available across countries and Lithuania could decide on how generous the leave could be. The duration varies from two days in Spain to three months, renewable once, in France, to unlimited time in Denmark. In five countries (Estonia, Germany, Netherlands, Norway and Spain), paid care leave for non-terminally-ill care recipients is limited to less than one month. In all countries with paid leave, aside from the Nordic countries, Belgium and Ireland, the care recipient has to be a member of the family and/or be a co-resident. In five countries (Belgium, Denmark, France, Luxembourg and Sweden), paid leave targets specifically carers with a relative at the end of their life (Rocard and Llena-Nozal, 2022[15]). As in France and Belgium, Lithuania may consider compensating leave on a flat daily or a monthly rate rather than a share of the wage, to limit spending. The flat rate could be aligned with compensations for the cash benefit for nursing care (EUR 226 for the second level), and below the minimum wage to avoid a distortion on the labour market (EUR 730).

Table 5.1. Leave to care for an older dependent

Country	Paid leave (at least one)	Unpaid leave (at least one)	Paid or unpaid leave
Australia	No	No	No
Austria	Yes	Yes	Yes
Belgium	Yes	Yes	Yes
Bulgaria	No	No	No
Canada	Yes	Yes	Yes
Croatia	No	No	No
Cyprus	No	No	No
Czech Republic	Yes	No	Yes
Denmark	Yes	No	Yes
Estonia	Yes	No	Yes
Finland	Yes	No	Yes
France	Yes	No	Yes
Germany	Yes	Yes	Yes
Greece	No	No	No
Hungary	No	Yes	Yes
Ireland	Yes	No	Yes
Italy	No	No	No
Japan	Yes	Yes	Yes
Korea	No	Yes	Yes
Latvia	No	No	No
Lithuania	No	No	No
Luxembourg	Yes	Yes	Yes
Malta	No	No	No
Netherlands	Yes	Yes	Yes
Norway	Yes	No	Yes
Poland	Yes	No	Yes
Portugal	No	No	No
Romania	No	No	No
Slovenia	Yes	No	Yes
Slovak Republic	No	No	No
Spain	Yes	Yes	Yes
Sweden	Yes	No	Yes
Switzerland	Yes	Yes	Yes
United Kingdom	No	Yes	Yes
United States	No (but 5 states)	No	No
Number of countries	19/35 (54%)	11/35 (31%)	22/35 (63%)

Source: Rocard and Llena-Nozal (2022[15]), Supporting informal carers of older people: Policies to leave no carer behind, https://doi.org/10.1787/0f0c0d52-en.

References

Agenzia delle entrate (2022), *Lavoratori impatriati - Che cos'è*, https://www.agenziaentrate.gov.it/portale/web/guest/lavoratori-rimpatriati-che-cos-%25c3%25a8-cittadini (accessed on 2022). [5]

COFACE (2017), *Study on the challenges and needs of family carers in Europe | COFACE*, http://www.coface-eu.org/resources/publications/study-challenges-and-needs-of-family-carers-in-europe/ (accessed on 29 August 2020). [14]

EC (2022), *Economic forecast for Lithuania*, https://ec.europa.eu/info/business-economy-euro/economic-performance-and-forecasts/economic-performance-country/lithuania/economic-forecast-lithuania_en. [9]

FOA (2009), *Working with the elderly, the sick and the disabled*. [10]

Helsedirektoratet (2021), *Job winner*, https://www.helsedirektoratet.no/tema/kompetanseloft-2025/jobbvinner (accessed on 2022). [2]

LifeinGermany (2022), *A new vocational training program for nurses in Germany*, https://en.life-in-germany.de/a-new-vocational-training-program-for-nurses-in-germany/. [12]

Migration Information Centre (2022), *Work in Lithuania*, https://www.renkuosilietuva.lt/en/work-in-lithuania/ (accessed on 2022). [6]

OECD (2020), *Who Cares? Attracting and Retaining Care Workers for the Elderly*, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/92c0ef68-en. [3]

OECD (2018), *OECD Reviews of Labour Market and Social Policies: Lithuania*, OECD Reviews of Labour Market and Social Policies, OECD Publishing, Paris, https://doi.org/10.1787/9789264189935-en. [4]

OECD (forthcoming), *Beyond Applause*, OECD Publishing, Paris. [7]

Pacifico, D. et al. (2018), "Faces of Joblessness in Lithuania: A People-centred perspective on employment barriers and policies", *OECD Social, Employment and Migration Working Papers*, No. 205, OECD Publishing, Paris, https://doi.org/10.1787/3657b81e-en. [1]

Pflege-Deutschland (2022), *Nursing Education*, https://www.pflege-deutschland.de/ausbildung (accessed on 2022). [11]

PIBA (2013), *Foreign workers' rights handbook*, https://mfa.gov.il/MFA/ConsularServices/Documents/ForeignWorkers2013.pdf (accessed on 2022). [8]

Rocard, E. and A. Llena-Nozal (2022), "Supporting informal carers of older people: Policies to leave no carer behind", *OECD Health Working Papers*, No. 140, OECD Publishing, Paris, https://doi.org/10.1787/0f0c0d52-en. [15]

Tsutsui, T. and N. Muramatsu (2005), "Care-Needs Certification in the Long-Term Care Insurance System of Japan", *Journal of the American Geriatrics Society*, Vol. 53/3, pp. 522-527, https://doi.org/10.1111/j.1532-5415.2005.53175.x. [13]

Part III : Directions for long-term care reform in Lithuania

6 Improving long-term care policy in Lithuania

This chapter summarises the high-level recommendations for Lithuania to improve long-term care. Three important avenues for reform are highlighted: integrating the health and social services for older people, pooled and increased funding for care benefits and services and strengthening the workforce. Recommendations build on the comparison with other EU and OECD countries.

Long-term care (LTC) support in Lithuania is comprehensive but fragmented and insufficient. Its fragmentation relates to the division of responsibilities, the lack of harmonisation to access benefits and services across the health and social sectors and intricate funding. Its insufficiencies relate to comparatively low number of beneficiaries and benefit amounts that can leave older people at a high risk of poverty, as well as relatively low resources, both in terms of spending levels and a low rate of LTC workers.

There is currently a political will to introduce national-level reforms of the Lithuanian long-term care system. The Ministry of Health requested the support of the Directorate General for Structural Reform Support (DG REFORM) of the European Commission and the Directorate for Employment, Labour and Social Affairs of the OECD for the analysis of the current system and recommendations for a new national framework on long-term care. The present report summarises the key messages of this project.

The recommendations below build upon Part I of this report on the current situation of long-term care support in Lithuania and upon Part II on good practices in other OECD countries, as well as several stakeholder consultations and a workshop with Lithuanian stakeholders and international experts. The recommendations are intended to highlight directions for reform based on elements of policies and programmes from other countries which can be properly adapted and integrated into the overall Lithuanian policy landscape.

Improving governance for care integration through a new legal framework

Different actors are providing different services for older people, generating inefficiencies and duplication of efforts and there is also a lack of clarity about entitlements in terms of benefits and services. This stems from different separate legislation for the health and social services which cover benefits and services for older people.

- **Consider unifying the governance on access to long-term care services, including with a legislative framework**. Lithuania could establish a single legislative framework for long-term care. It would be important that the legislative framework includes some key elements: a common definition of LTC; the lines of responsibilities across ministries and subnational areas; the type of LTC services and cash benefits; a needs assessment and eligibility criteria; the funding routes and the financing schemes. Lithuania needs to find a fine balance in the legislative framework to have a level of precision without creating unnecessary rigidities. For example, it could introduce a law presenting the essential elements and produce later on more technical, subsidiary laws that could be changed more easily. Lithuania would have to decide whether only older people would be eligible for LTC benefits, or whether it needs to harmonise benefits across different ages (i.e. for younger people with severe disabilities who have long-term care needs).
- **Clarify the division of responsibilities**. While the Ministry of Health and the Ministry of Social Security could oversee the long-term care sector, it would be important to clarify joint and separate responsibilities. The legislation in Lithuania should also comprise the division of responsibilities between national and subnational levels. As municipalities in Lithuania already have important responsibilities in the assessment, provision and management of services, it would make sense that municipalities have the responsibility of managing and providing LTC services and benefits at the local level. In this sense, the new model would be similar to Scandinavian countries and Japan. Lithuania could also consider establishing one LTC organisation in charge of LTC funding, financing and provision, although the stakeholder consultations indicated mixed support for such a measure.

Different services and care settings currently have different needs assessment. The needs-assessment tool for social services takes into account the age, the functional disorders, the social risks, and the family's ability to take care of the individual, while for nursing care services at home, the Barthel index is used. There is no standardised needs assessment tool for admission to nursing hospitals – one only needs the prescription of a doctor.

- Consider harmonising needs-assessment tools across different health and social services (outpatient nursing services, nursing hospitals, social services). Lithuania could harmonise needs-assessment tools for health and social services at home, and if possible for care institutions and nursing hospitals. This way, Lithuania could encourage older people to use the right service in the different settings based on the complexity of their needs. It could be valuable to see whether the assessment could be used to plan care and perhaps develop a short version for triage. Changing needs assessment requires making decisions on whether to rely on existing scales and instruments or build a new one more adapted to its population, and whether to develop a digital version, in which case data collected would be more "information-rich", although it would require an excellent IT system and trained staff. In addition, a new assessment is also an opportunity to rethink the range of people who could perform the assessment and how often older people's needs should be re-evaluated.

Older people can turn to health care providers, social care providers or municipalities for information. There is currently a lack of knowledge of professionals about available services in the other sectors, co-ordination for transfer and discharge, and the current system is complex. When assessing needs, municipalities cannot verify if people are already receiving health services because they do not have access to the patient records of the health care database.

- **Expand dissemination of information efforts to improve clarity on availability of social services**. Lithuania could provide support to municipalities to improve access to information on what LTC services are available and how to access them, as well as information on waiting lists and waiting times. Lithuania could make information available online through municipal websites (e.g. following the example of Vilnius municipal website).
- **Regulate information sharing across different providers, including digital information**. While the health care sector in Lithuania is undergoing a digitalisation process, the digital integration between the social and health care sides has not started yet. Lithuania could find ways to improve the interoperability of the health and social services' registries to improve the integration across the two sides of service provision. The process of data integration would allow Lithuania to obtain a better picture of the overall landscape of LTC services provision, thus improving co-ordination. It would also help providers from the two sides to plan care and evaluate whether care meets the needs.

There is a range of services, both at home, in day centres, institutions and hospitals with different conditions for access, such as means-testing, and cap on volume. Eligibility conditions across different services lack alignment and cash benefits can be combined with services. Access to health care does not rely on means-testing eligibility, contrary to social services, but spending is controlled with a volume cap of 104 services per year for outpatient home nursing services[1] and 120 days per year for nursing hospitals and nursing beds in hospitals. Social services are means-tested, with rather strict eligibility criteria, but there is no volume cap. The cash benefits are not means-tested.

- **Consider providing a single benefit with different care grades which could be in-kind or cash.** Lithuania could use a ladder with a number of categories to ensure that the access to benefits are harmonised and identical for everyone (assuming that the supply can provide sufficient services across the territory). Lithuania could let people freely choose the type of services and benefits' arrangement – services, a cash benefit to older people, cash benefits for informal caregivers, or possible combinations. Otherwise, it could link the grades to the services.

- **Harmonise eligibility criteria between benefits and services.** The eligibility criteria of the cash benefits should be designed taking into account the needs assessment, the other (financial) eligibility criteria, and the care grades.
- **Harmonise quality standards for long-term care**. Lithuania could consider developing a quality framework across the health and social sectors, improving transparency about standards and ensuring timely evaluation. At a minimum, quality indicators could be better monitored and published online. Efforts could also be made to include a range of process and outcome indicators, to ensure all dimensions of care are truly captured.

Designing sustainable funding for long-term care

Current funding is divided across actors. The public funding of long-term care social services stems from the municipal budget – mostly funded by the state through general grants – and targeted state grants. Out-of-pocket (OOP) payments can be important for social services – up to 80% of personal income for long-term social care. The health component of long-term care is primarily funded by the Compulsory Health Insurance Fund.

- **Pool together current resources**. One starting point for Lithuania to establish an integrated system would be to have clear funding routes, with a dedicated budget. Pooled funding is perhaps the most commonly used form of financing integrated care for older people (OECD, 2015[1]). In a pooled funding scheme, each body involved in service delivery contributes to a common fund to be spent on pooled functions or agreed services. Pooling existing funding to one well-defined budget would improve transparency and facilitate the distribution of existing funds in an effective and efficient manner. It would help to reduce unnecessary activities, overuse of services, duplication of efforts, and cost shifting. Lithuania could also reflect on how to relate multi-annual programmes to allow future changes.

Current spending is lower than the OECD average: LTC spending is estimated to account to 1.1% of GDP in Lithuania, compared to 1.5% across OECD countries. Spending needs will grow with the share of the population aged 65 years and over is expected to grow from 20% in 2019 to 32% in 2050. Currently, unmet needs are substantial. Lithuania counts 20 LTC beds per 1 000 older people, a rate well-below the OECD average of 47 LTC beds per 1 000 older people.

- **Consider whether to set a long-term care insurance to guarantee funding**. If Lithuania were to implement an LTC insurance, it would have to decide on the insurance base (e.g. labour income, unemployment benefits), other eligibility criteria (e.g. working-age population or also including older people, only those above 40, etc.) and the amount(s) of the premium. Extending the premiums to the unemployed and the self-employed has the advantages of broadening the base and obviating equity issues. In Lithuania as in Germany, the premiums could be levied on the wages of employed and self-employed workers and unemployment benefits (but perhaps not disability benefits), and not on pensioners. There would not be any difference by age group, contrary to Japan. It would be wise to start with a very small premium to minimise the potential impact on employment and growth – Germany started with a lower premium and has been slowly increasing it.
- **Wage support to raise taxes**. To limit the impact of an LTC insurance on the tax wedge or if Lithuania considers using taxation-based funding only, Lithuania could aim to combine an LTC insurance with a broad-base tax. Lithuania could consider higher property taxes and reduce the scope of non-standard value-added tax/VAT (e.g. a narrower scope of reduced VAT or exemptions).[2] Lithuania could also benefit from increasing the working-age population to increase the tax base, for instance by reducing early retirement and promoting the employment of older workers. Furthermore, Lithuania could consider measures to reduce informality in LTC to broaden the tax base while also providing better social protection to LTC workers.

- **Explore the possibility of a private funding route**. Lithuania could also encourage private home equity programmes to help cash properties, although the potential of such programs is very limited. Lithuania would need a robust regulatory framework and the public administration may need to act as lenders.

Given how population ageing is likely to increase public expenditures for LTC and the preference given during the stakeholder's consultation to find financing options to control spending, Lithuania would need to look at possible options to ensure sustainability. There is currently a lack of emphasis on preventive services and healthy ageing. Municipalities set prices of social services.

- **Preventive and rehabilitation LTC services**. Lithuania could consider introducing preventive and rehabilitation services, such as home visits, drawing on the examples of Scandinavian countries and Japan. Rehabilitation and preventive services could potentially limit costs increases and improve quality of life.
- **Pricing and financing of LTC services**. Lithuania could set tariffs or maximum prices at the national level (with possible differences across municipalities to reflect different purchasing power) and municipalities could be responsible to contract with providers – as currently. Alternatively, Lithuania may consider to follow a point system, but such a system is complex. In addition, without commitment to field research, relying on historical prices might be a reasonable option.

Ensuring sufficiently trained carers

Lithuania has one of the lowest levels of LTC workers in the EU with only 1 worker per 100 people aged 65 or above compared to the EU average of 4 workers per 100 older people in 2019. There are staff shortages, in particular nurse assistants, and low staffing levels affect the quality of care provided to older people.

- **Address workforce shortages by promoting training for LTC workers.** Lithuania could recruit unemployed and inactive people and people working in sectors with declining labour demand to the LTC sector. Providing financial support for LTC training is an effective policy option, as its impact on recruitment can be large. Japan has sponsored basic training programmes for both new students and experienced workers willing to return to work after a long break. These initiatives led to an increase in the number of LTC workers of around 20% between 2011 and 2015. Lithuania could also include offering placement opportunities to nurse students and personal care workers during their studies.
- **Consider recruitment options to expand the pool of workers.** Lithuania can also attract Lithuanian emigrants – by providing favourable return conditions such as a tax relief – and foreign-born workers – by facilitating the immigration and skills recognition process.

LTC social workers' salaries in Lithuania depend on municipal budgets, thus municipalities with higher budgets may pay LTC social workers better, through the provision of higher bonuses and premiums, and are better able to retain workers. While training options are available, different workers perform similar tasks and there are gaps.

- **Improve working conditions of LTC workers**. Increasing retention rates through better job quality and training is a top policy priority to develop an adequate LTC workforce. Low wages, stress, a heavy workload and onerous working conditions all make it hard to keep people in the LTC sector. Improving the pay and other working conditions are avenues to bolster the workforce. However, wage increases need to be financed and regulated. Otherwise, wage increases that are not matched by increases in resources lead to increased workload and duties.

- **Enhance training opportunities of LTC workers**. Training programs could be developed to improve the skills of workers, increasing their confidence and motivation. Specific training could focus on: dementia, which is crucial when working with older people; management of administrative tasks that LTC workers are required to perform and for which they sometimes do not feel adequately prepared; and digital skills, given that a knowledgeable workforce is essential to facilitate the digitalisation of the sector.
- **Develop career pathways for workers.** Lithuania could encourage those with the lowest positions to progress in their career, by improving the career pathway. Lithuania could introduce the position of care managers/care co-ordinators in charge of creating a care plan with the eligible older people. This new profile could ensure a people-centred approach and broaden career perspectives.

Informal or family carers provide the bulk of care. While informal carers help to contain public costs, those costs are borne elsewhere, in terms of reduced labour market participation and health problems. With population ageing, the pool of informal carers reducing and the working-age social contribution- and tax-payers declining, it is important for Lithuania to continue to strengthen support to informal carers.

- **Develop training options for informal carers**. Lithuania could start by collaborating with NGOs to develop online training programmes freely available. Material could be on specific diseases, like dementia, symptoms management, emergency management and practical nursing skills. There is an important share of older people among carers, many of whom may not know well enough how to use digital tools. Such carers could benefit from a training model similar to the United Kingdom, where the subnational authorities responsible for social services subcontract NGOs to provide training, within a national framework.
- **Introduce leave for informal carers**. Lithuania could align with the European directive on care leave. According to the directive, carers are entitled to five working days of leave per year, although there is no requirement that carers' leave should be paid. If Lithuania is unable to find sufficient funds for this policy, it could consider an initial unpaid leave at first.

Reference

OECD (2015), *Integrating Social Services for Vulnerable Groups: Bridging Sectors for Better Service Delivery*, OECD Publishing, Paris, https://doi.org/10.1787/9789264233775-en. [1]

Notes

[1] 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 are now able to receive outpatient nursing services up to 5 times a week. This new regulation was passed shortly after the end of the project.

[2] This report assumes that Lithuania does not wish to increase corporate taxes, although it is another funding route.

Integrating Services for Older People in Lithuania

Lithuania's population is ageing rapidly. The share of the population aged 65 years and over is expected to grow from 20% in 2019 to 32% in 2050 – faster than the EU average. A growing share of people who need help with their daily activities – so called long-term care. The governance of long-term care is fragmented between the Ministry of Health, the Ministry of Social Security and Labour and the municipalities. This results in a lack of integration of services between social workers and nurses and inequalities in access as eligibility conditions differ. Older people still have unmet needs and face substantial costs. Lithuania has one of the lowest levels of long-term care workers in the EU with only 1 worker per 100 people aged 65 or above compared to the EU average of 4 workers per 100 in 2019. This report suggests avenues to adapt funding streams, improve the coordination and access to long-term care services and strengthen the workforce in the sector.

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