LIETUVOS IŠSĖTINĖS SKLEROZĖS SĄJUNGA
LITHUANIAN MULTIPLE SCLEROSIS UNION

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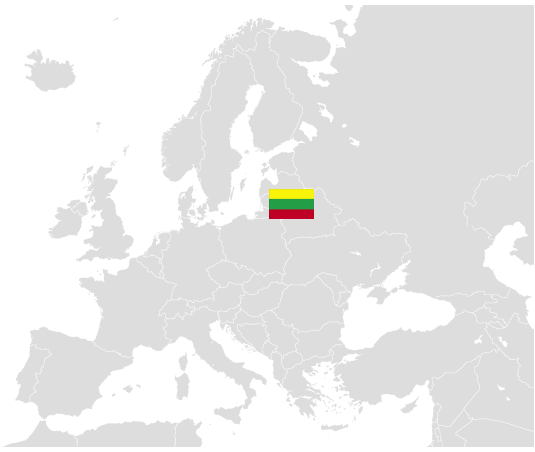
517927-LLP-2011-IT-LEONARDO-LMP

The Health Assistance in Hospital and at Home

The Lithuanian Situation



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The Health Assistance in Hospital and at Home
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Abstract

Lithuania's health care system is designed according to the basic principles common to European cultures. It is set by the mixed health care financing and organisation system consisting of statutory compulsory health insurance, budget allocations and direct payments of patients. The system provides personal health care, public health and pharmaceutical activities for the whole population by the means described in the Law on the Health Care System.(1) Universal access to basic medical services is granted to the whole population and has been mostly financed according to a solidarity-based scheme of statutory health insurance since 1997. It provides the possibility for the insured to receive individual health care services financed by the State Health Insurance Fund (SHIF) budget, namely, primary outpatient,specialised outpatient, and inpatient health care, first aid and emergencies, nursing care,palliative treatment, expensive tests and procedures, medical rehabilitation, spa treatment, and other services.What concerns home health care institutions and social families in future they will be obliged to receive licences which will be granted in case the social care is provided in comply with social care standards.

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1. Introduction to the National Situation

1.1 Health National System.

In 2009, the Outline for Reorganisation of the Lithuanian Health Care System was designed,establishing the key directions for a reorganisation of the Lithuanian health care system. The Government greenlighted the programme for the third stage of the Restructuring of Health Care Institutions and Services, which anticipated the distribution of inpatient institutions into three levels - local, regional and national - each providing a set range of services without duplication of functions(2) The network of inpatient institutions and the structure of supply of health services was optimised for the implementation of the programme in 2010. Savings were channeled into the development of outpatient level family doctors and specialist consultants. According to the specific activities of the implementation plan of this programme and the Plan of Measures for the Implementation of the Third Stage of the Restructuring of Health Care Institutions and Services approved by the Order No. V-1114 of the Minister for Health of the Republic of Lithuania as of 30 December 2009,(3) as many as 16 health care institutions were merged into bigger hospitals. In 2010, 65 hospitals out of 81 remained.Major debates were in the media and in the Parliament due to those changes. The Ministry of Health is responsible for general supervision of the entire health care system. It is strongly involved in drafting legal acts and issuing the consequent regulation for the sector. There are 34 institutions, which are subordinate to the Ministry of Health,including 8 hospitals and clinics. Half of the Lithuanian hospitals are general hospitals, and they have 67% of the country's hospital beds. There are also 36 specialised, three rehabilitation hospitals and 33 sanatoriums. Until July 2010 the Ministry of Health managed 13 of these national healthcare facilities directly. At the regional level, the county administrations governed some hospital and specialised care, with Ministry involvement. Municipalities often ran small or midsized hospitals. It also runs a few (3) health care facilities.With the decline in scope of directly administered health care institutions,maintenance and development of tertiary health care became the focus of the administrative activities of the Ministry of Health. The ministry now shares responsibility for running two major Lithuanian teaching hospitals with the State Vilnius University and the Kaunas Medical University. The Ministry of Health has an overall responsibility for the public health system's performance.Through the State Public Health Centre it manages the public health network including ten county public health centres with their local branches (in total 50institutions). The State Public Health Centre has subordinate bodies to deal with prevention of communicable diseases, health education and other public health functions. The Ministry of Health develops a public health care infrastructure by establishing state programmes aiming at the achievement of key health targets including those detailed in the National Health Programme)and by making decisions together with Ministry of Economy and Ministry of Finance on major investment projects. Regulation and control of work safety conditions are the responsibility of the Ministry of Social Security and Labour while the Ministry of Health is in charge of the performance of occupational health care providers. Half of the Lithuanian hospitals are general hospitals, and they have 67% of the country's hospital beds. There are also 36 specialised, three rehabilitation ospitals and 33 sanatoriums. Until July 2010, the Ministry of Health managed 13 of these national healthcare facilities directly. At the regional level, the county administrations governed some hospital and specialised care, with Ministry involvement. Municipalities often ran small or midsized hospitals.(5) At the regional level each of the ten counties has a county governor who is appointed by the Lithuanian Government and is responsible for implementation of state policy in a number of spheres including health care. The health care function is carried out by the post of County Physician. Some health care providers (county hospitals, specialised health care facilities) are governed by the county administration. Decision-making in this network of providers requires participation of the Ministry of Health. The counties are in charge of enforcement of the state health programmes in their respective regions. The National Survey of patients and health care providers in 2010 showed that the access of primary health care in urban areas in terms of waiting times for a family doctor is worse than in rural areas. If in the big cities the average waiting time for a family doctor is 4.2 days, in rural areas it is 2 days.(6)

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1.2 Main national trends

Prior to independence in 1991, no formal home health care system existed in Lithuania. However, various services were provided in homes, including off-hours urgent care; social and health care services for the disabled and elderly through a voluntary organization; and the provision of medications and treatments by polyclinic nursing staffs. After independence, a number of additional home health care services were initiated, largely in response to the care needs of a large and growing elderly population. These evolving services are described as well as the factors facilitating and inhibiting the development of a national system of home health care for Lithuania The system of long-term care in Lithuania remained unchanged in 2010. Services of longterm care as before are organised through social services and the system of health care. The system of long-term care is provided and financed through the State Health Insurance Fund by health insurance and by municipalities (in this case, the Ministry of Social Security and Labour acts as the policy body). In case of inpatient care, the health services finance longterm stays amounting to up to 120 days. TB, mental health, palliative care and rehabilitation patients are financed by the SHIF.4,614 inpatient beds (178 more than in 2009) are allocated for long-term care in Lithuania in the health care sector. In addition, long-term residential care is provided in residential homes or other institutions for people with long-term care needs(7). In 2010, the enhancement of nursing and long-term care beds as well as of rehabilitation was continued (table 5)

Table 5: Long-term care beds in the Lithuanian health care system during 2008-2010

Indicators	2008		2009		2010	
	Long-term Care beds	Hospital beds	Long-term Care beds	Hospital beds	Long-term Care beds	Hospital beds
Nursing long-term care	4,400	30,765	4,436	31,020	4,614	32,141
Out of which palliative care	26	67	43	247	96	600
Rehabilitation	1,290	16,175	1,320	15,647	1,378	17,333
TB	1,267	5,720	1,231	5,510	1,150	4,966
Mental health	3,453	39,530	3,409	37,436	3,303	37,618

Source: Health Information Centre of the Hygiene Institute, 2011.

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Provision of home nursing services commenced for people with special needs in 2010. They were funded from the SHIF. Family doctors work in a team with nursing specialists and together with municipal social care specialists provide family care for elderly and handicapped people at home. Private providers do exist, but their services are still not very popular. Furthermore, the scope of palliative care provision was extended and a new service -long-term home medical rehabilitation - was continued.(8) Health care reform is an ongoing process in Lithuania and the problems of the system are well-known both to patients and medical staff: long waiting lists, additional charges and informal payments despite compulsory health insurance, low wages of the staff, immense workloads, insufficient attention to public health and unhealthy lifestyle, poor health indicators of the population, lack of a prophylactic system, etc. Most of these problems are related to the lifestyle of the population and inefficient resource management of health care, and also to the lack of a strategic approach.(10) The problems and the reasons for them were evaluated and synthesised in 2010 in the strategic document “Outline of further health system development until 2015”, which was approved by the Lithuanian Government on 26 January 201(11) The vision of the system and the means how to achieve the goals are described in this document. The National health programme, accepted by the Parliament in 1998, has ended in 2010. External and internal evaluation of the programme is taking place throughout 2011 and the new programme will be proposed for the next decade. The national health account was 6,931.5 million LTL and it constituted 7.6% of GDP in 2009 (5.6% of GDP public expenditures and 2.0% private). In comparison, in 2008 the national health care account was 7,395.9 million LTL and it made 6.6% of GDP (4.8% were public and 1.8% private expenditures).47 This decrease was due to the financial and economic crisis and a general drop of GDP(12).

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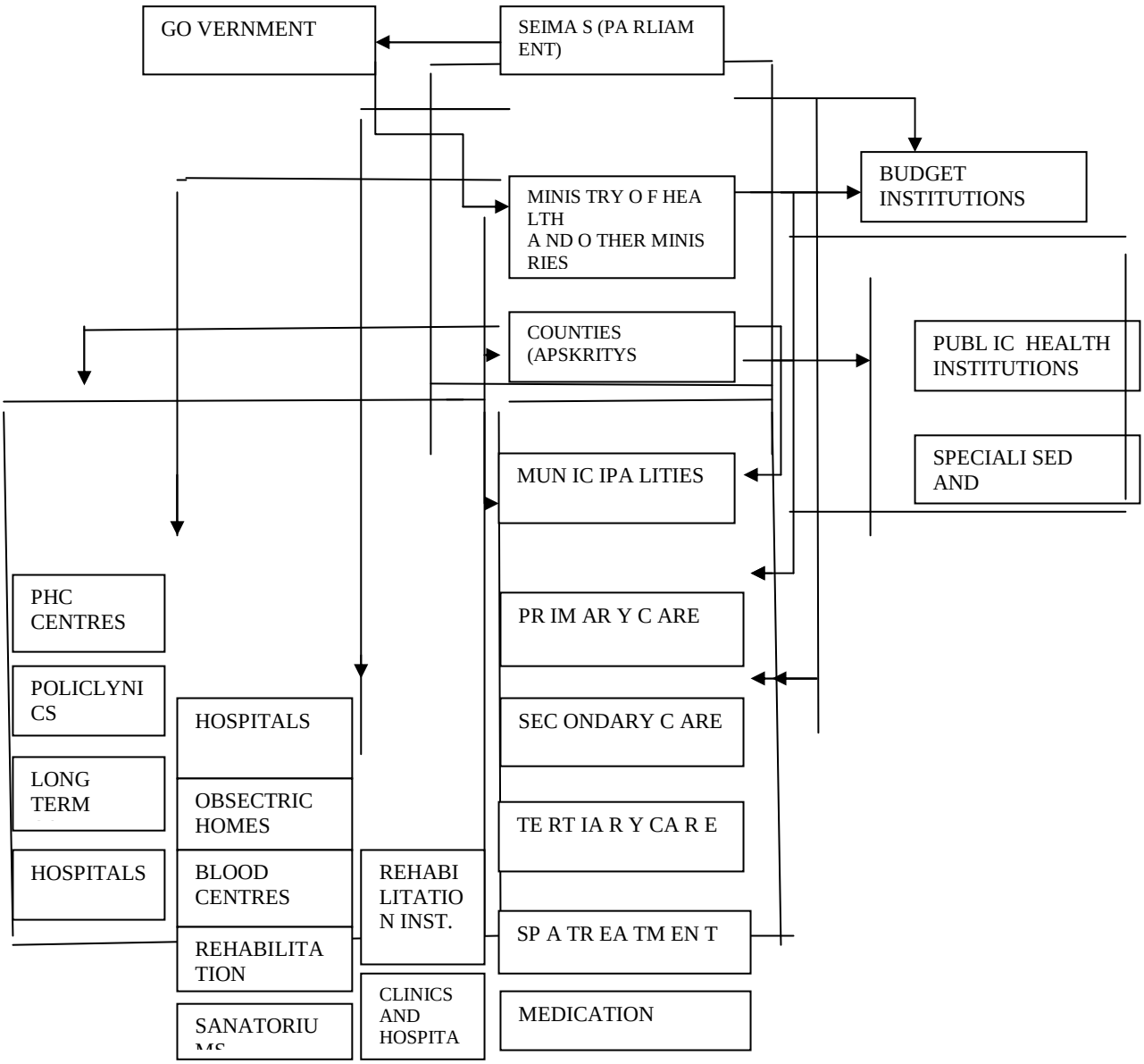
2. National bodies in charge of the home health service

The general structure of the national health system is presented in the organizational chart (Fig. 2).

Organizational chart of health care system



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3. National policies implemented to promote and improve the home health service

Congress of the Lithuanian Medical Association and submitted to Parliament for approval, the decision was made to ask for international assistance from Finland. This was very useful, since Finland, assisted by the Regional Office and a team of international experts, was in the process of reviewing their own national policy and programme of health for all. The Lithuanian politicians and the new health administration learned many lessons. The most important included the need for a clear political commitment to health, a balance between national, regional and local responsibility for health; equity in health issues ;and public involvement in the decision-making process, defining home health priorities, targeting actions and mobilizing resources'.For the first time after the restoration of Independence, the real process of optimisation of health care institutions network and service structure has started with necessary legal base prepared and background created. It is planned to regularly inform the society on the implementation progress of this process. Increase of health workforce salaries is considered to be one of the policy priorities of the Ministry of Health Fundamental reform in specialist training, which had a significant impact on the results of the Reform, has been carried out; Education, vocational training and development of health workforce must ensure that its work efficiency was constantly increasing. Lithuania has also elaborated various EU structural support projects of national importance. Development of universal multifunctional centres contributed to the adjustment of educational institutions to the needs of disabled people . In the field of health policy, relevant institutions started providing nursing care services at home, as well palliative care services financed from the Compulsory Health Insurance Fond budget. The activities also include: the development of palliative and nursing care services, enhancement of primary health care and implementation of preventive programmes. When organising social services in Lithuania priority is given to day social care in day centres or to short-term respite social care by providing temporary accommodation to the disabled people in the care institution. Positive Lithuania also implemented special projects aimed at providing support to families that provide care for the persons with chronic desease and their family members. Disabled people have been provided with a more secure living environmenttrends.

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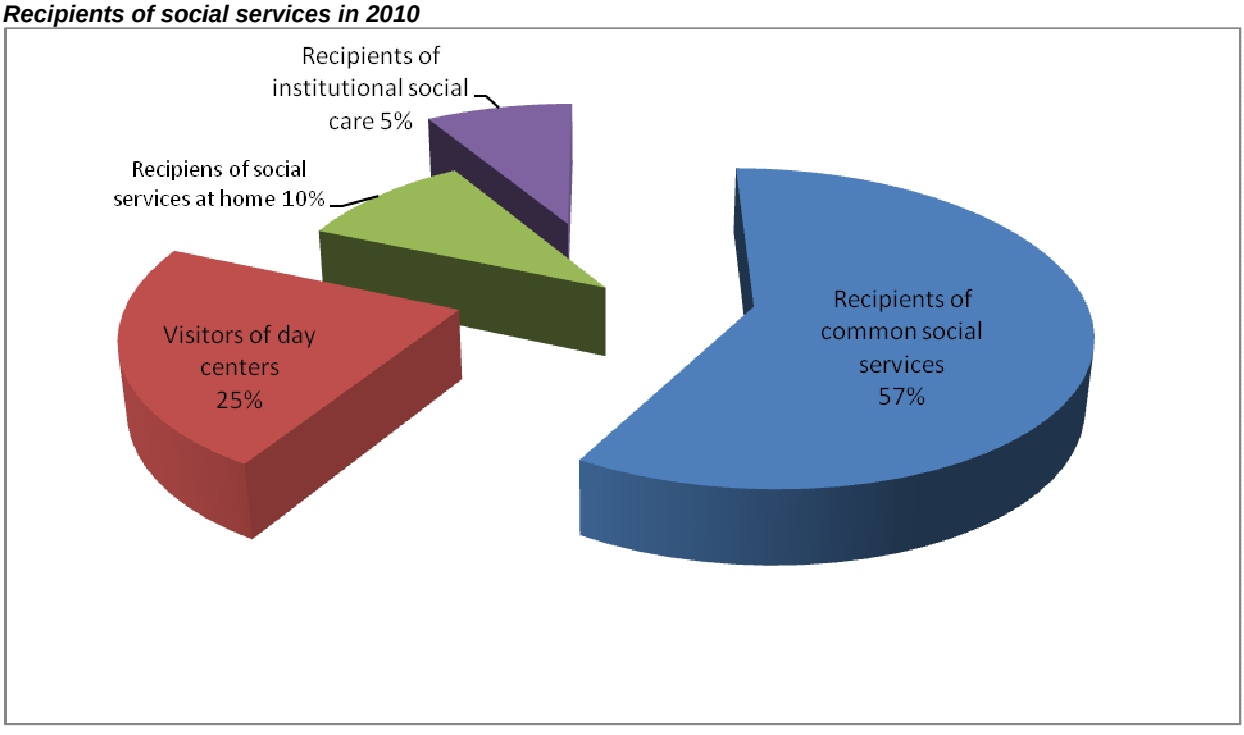
4. Strategies and initiatives developed at national and local level to promote and improve the home health service

The Ministry of Health of Lithuania set out to implement three strategic goals in 2010: Create a reliable and effective health care system by reorganising health care institutions; endeavour safe, qualitative and accessible health care for patients; protect and strengthen public health.The restructuring of health care institutions, efforts to balance the budget of health insurance,and measures to reduce the prices of pharmaceuticals, financing of prophylactic health programmes devoid of deterioration of health care accessibility for residents should be named among the positive aspects in particular in 2010. The Lithuanian method for the collection of health insurance premiums contains a built-in variable for the estimation of premiums for state insured (the list of which covers vulnerable groups of the population), which allows regulating the State Health Insurance Fund without substantial legislative adjustments. Access to high quality of health care services and illegal payments are a challenge in Lithuania.(report 14) When implementing the Projects of Services for the Disabled in the Community, according to the nature of disability and problems of disabled people represented by associations, the rights of the disabled were represented, information and consultation services for disabled people were provided, psychological support for the disabled and their family members was organised and offered, services of increasing self-sufficiency, constant cultural and sports services were provided, social services were offered (information, consultation, transport organisation, sociocultural services, organisation of personal hygiene and care, home help, accommodation in the house of a self-sufficient life, day social care, short-term and long-term social care), activities to increase the motivation for involving the disabled in the labour market and the search for jobs for disabled persons were supported and services of work assistants for the disabled were provided. According to the data from the Department of Statistics under the Government of the Republic of Lithuania, these establishments regularly provided social services to 91,200 persons with disability, elderly persons, children deprived of parental care, individuals and families at social risk and other persons. Approximately 27,600 individuals and 4,800 families were provided with social services at home. Moreover, 161,400 persons used common social services (free catering, provision with essential items, personal hygiene products, and transport services).

Recipients of social services in 2010



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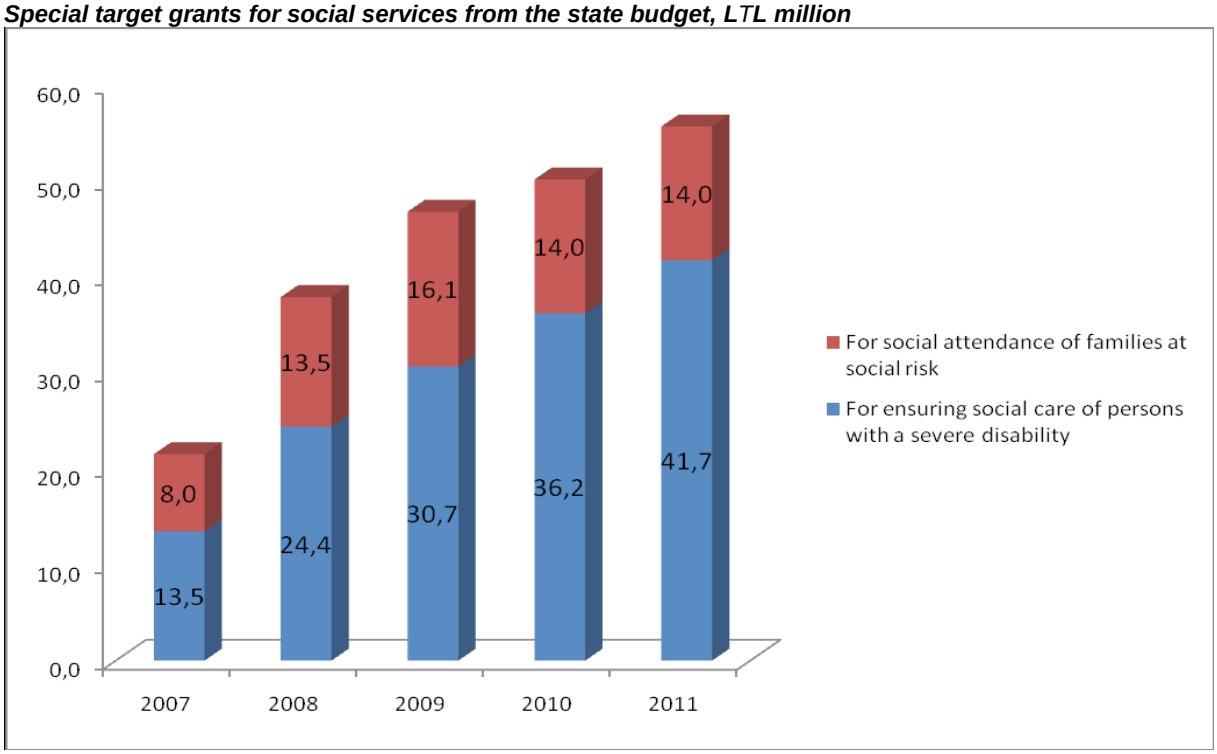
Major share (57 per cent) of recipients of social services used common social services, one-fourth of recipients attended day centres, every tenth recipient received assistance at home. Institutional social care was provided to 5 per cent of recipients of social services; about 3 per cent of recipients used the services provided by temporary lodging houses, crisis centres or independent living homes. In 2010, infrastructure of social services changed. The key changes were related to the county reform and the transfer of the rights and duties of founders of certain social care institutions, which previously belonged to counties, municipalities and the Ministry of Social Security and Labour. The Ministry of Social Security and Labour became the authority implementing the rights and duties of founders of 28 health care institutions for adults with disability.(15) Fund demand in respect of provision of social care for persons with a severe disability is established taking into account the information presented by municipalities about the forecasted number of residents with a severe disability from their territory, who will receive social care, and estimated fund demand. The fund demand is estimated by using the amount of 7.2 basic social benefits (BSB), fixed in the Methodology for Financing Social Services and Calculating Funds (Official Gazette Valstybės žinios, 2006, No. 110-4163), for the provision of social care to one person with a severe disability per month. The fund demand is estimated having regard to the tendencies of the changing number of persons with a severe disability within the last three years, by carrying out a comparative analysis of the number of persons with a severe disability who were provided, planned to be provided or not provided with but necessary social care services, and evaluating efficiency of the funds allocated for social care of persons with a severe disability. With regard to the fact that municipalities have been expanding the infrastructure of social services by organising the provision of new, qualitatively more effective social care services, the demand for state grants for the provision of social care for persons with a severe disability has been growing every year (in 2008–2010, around 20 per cent per year).The positions of social workers are distributed having regard to the number of families of home services, residing in the territory of municipality, and the territorial distribution of municipalities.LTL 13,962,600 were allocated for the remuneration and social insurance contributions of 630.5 positions of social workers in 2010 and 2011 each year.

Special target grants for social services from the state budget, LTL million



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5. Description of Training Courses for professional health carers on the issue

Social workers are prepared by most universities and colleges. About 900 social workers are prepared annually.

5.1 New methodical centres of social work:

In 2011, the list of methodical centres of social home workers (16) was supplemented with the following three institutions: Jonava District Social Services Centre, Kaunas Panemunė Old People's Home, public institution Trakai Centre of Occupation for People with Disability. 51 methodical centres of social home work have been currently operating.

5.2 Professional development of social workers and assistants to social workers

At the end of 2010, the Descriptions of the Procedure for Professional Development of Social Workers and Social Worker Assistants and the Procedure for the Assessment of Social Workers were specified and approved (17). The Description of the Procedure for the Assessment of Social Workers provides for an opportunity for social workers who have education equivalent to social work to be assessed. It also specifies the activities of a local commission for the assessment of social workers; whereas at the beginning of 2011, the composition of sub-commissions of a local commission for the assessment of social workers was revised.

5.3 Amendments to the procedure for the assessment of social workers

Having eliminated regional labour market training and counselling services, in which 7 local commissions for the assessment of social workers functioned, a local assessment commission was formed of 6 local sub-commissions (Vilnius, Kaunas, Klaipėda, Šiauliai, Panevėžys, Alytus) which, like previously, will assess social workers closer to their places of residence or work. This local assessment commission, like former assessment commission, will be technically supported by the Authority for Administration of Social Care Institutions under the Ministry of Social Security and Labour.

5.4 Requirement of education for social home workers

As of 1 July 2011, as stipulated in the Law on Social Services, only persons who have acquired higher (university or non-university) education in social work or equivalent education shall be entitled to the position of a social worker. The requirement of education for social workers has been set forth since 2006. With a view to creating possibilities for social workers to retrain free of charge, in the period from 2009 until 2011 the funds from the EU Structural Funds were used (until 1 July 2011) for the national retraining of social workers who have acquired education (university or non-university), other than social work or equivalent education. The work of some persons in the position of a social worker is not related to social work (calculation of benefits, allowances, compensations, reception and examination of applications for support for pupils, implementation of professional or artistic occupation, etc.); some workers are categorised as social workers, yet, according to the content of activities (job description), they have been working as assistants to social workers or specialists of other fields (care of disabled persons, catering, provision of personal hygiene services, cleaning of premises, etc.). A similar situation has been lately observed in the day centres for the disabled, child day centres and institutional social care establishments, in which some of the positions of social workers have been categorised as a social worker-occupation specialist. The above workers have been working with the disabled, children and elderly persons, by organising their leisure and conducting different fine arts, music, sports, etc. sessions. Their functions are not identical to the functions of a social worker and cannot be attributed to the functions fulfilled by non-formal education specialists (pedagogues). Seeking to clarify and differentiate positions of social workers and activities of social work, the List of Positions of Specialists Engaged in Social Work (18) has been supplemented. It regulates the position of an occupation specialist of a social services institution, by attributing it to social workers. Occupation specialists of social services institutions shall not be subject to the requirement for education, as applied to social workers.

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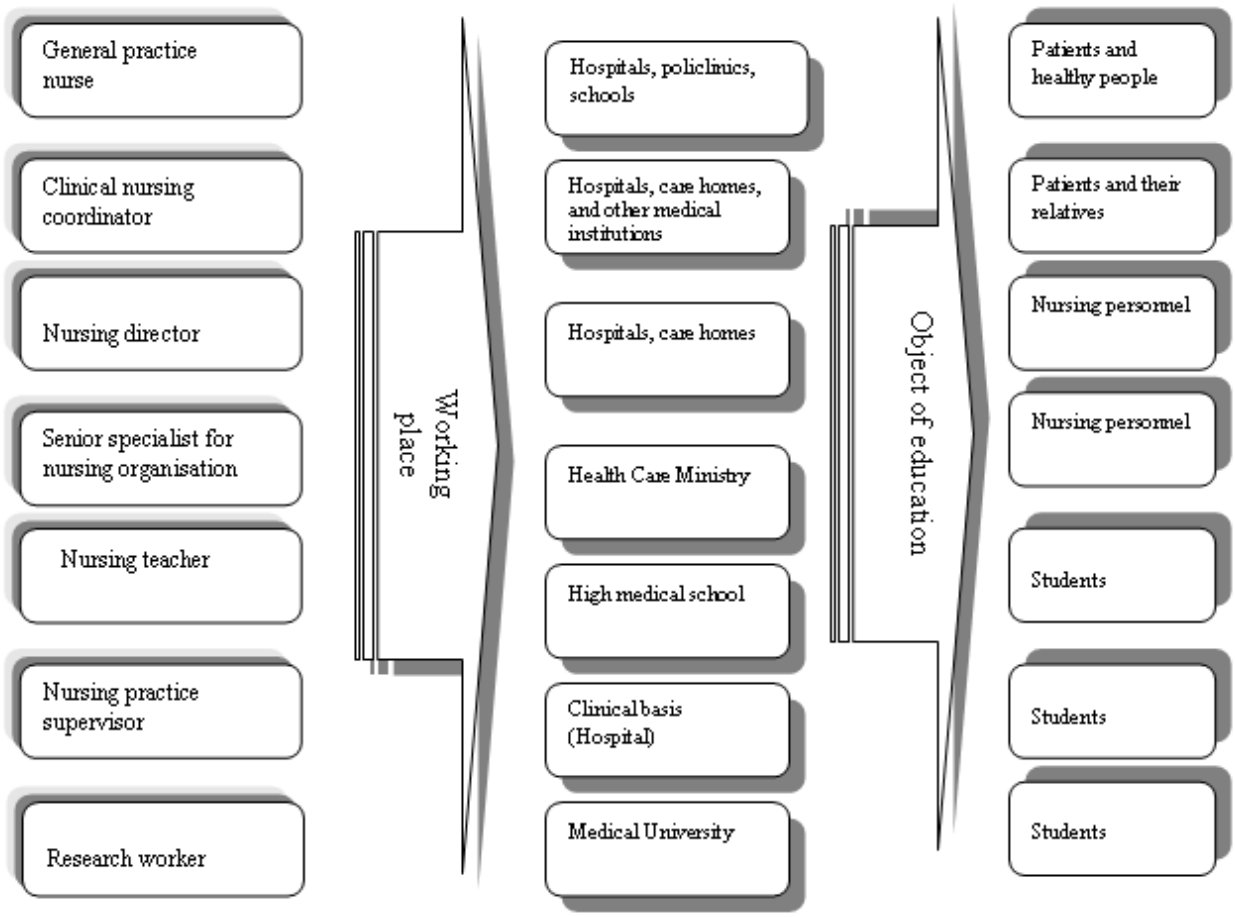

Fig. 3. Major parameters of nursing educational activity

According to the data of June 2011 collected by the ministry, the requirement for higher education in social work or equivalent education applies to 3,196 social workers. About 84 per cent (2,697 persons) of all social workers had the required education, sought it or found it irrelevant (pre-retirement age persons). 56 per cent (1,786 persons) had higher education in social work or equivalent education, 21 persons. About 16 per cent (approx. 500 persons) do not have the required education and do not qualify as exceptions provided for in the Law on Social Services. Part of these workers (about 11 per cent) were fered other positions (neighbourhood specialist, social benefits specialist, occupation specialist of a social services institution, assistant to social worker, etc.

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6. Identification of best practices

In 1996 Lithuanian Samaritan organization (LSB) working group prepared a training programme and methodology for social nurses. This programme after three-year trial period was approved by the Ministry of Education and science and the Ministry of Social protection and labor. Four colleges now prepare professional nurses according to that programme. LSB in order to guarantee working places for these people established public institutions that provide nursing services for people who are ill and stay at home. Samaritan volunteers who were trained basic nursing skills by LSB teachers work together with the employed professionals. For two years already LSB in some branches has been teaching families to take care of their ill family member. This initiative based on projects received funding from several municipalities. It is major support for families which cannot afford nurses.

7. Conclusions

To sum up, considerable attention has been paid to the quality of social services and ensuring human rights in respect of persons living in social care institutions and at home. Seeking to find the most adequate model of infrastructure of social care institutions and analyse the potential of reorganisation of social care institutions and decentralisation of services, working groups have been working and experts have been consulted. Higher requirements have been set not only for social care institutions and specialists working therein, but also their leadership. Assessment of heads of social care institutions should start in 2015; the assessment procedure should be developed in 2011. The Rules for Licensing of Social Care Institutions should also be drafted in the same year. Under the influence of societal health care change the contradiction between the actual and formal side of the nurse qualification increases. The changing structure of nurse vocational qualification influences the changes in the most important dimensions of vocational education and training. The condition for an effective nursing satisfying the demands of the society is appropriate vocational education and training of nurses that provides perspective qualifications. Some nurses have direct contacts with people aiming to develop and expand their conscious attitude towards their health, personal way of life and reorganise the patients models of thinking and life, others teach future nurses to work with people. Thus, nurses as educational agents can relatively be divided into two groups: health care teachers and vocational teachers. The pedagogical preparation of the latter is an exceptional objective of nursing policy.(19) The development of nursing science and expansion of nursing education and training curriculum determine the university education and training of nurses, where serious attention is paid to subject-pedagogical content of nurse education and training that guarantees the acquisition of pedagogical qualification corresponding to the demands raised for vocational teacher education and training; the development of general abilities that allow to more flexibly adapt to rapidly changing societal demands; and the acquisition of intercultural education that is significant for nurse pedagogical activity and vocational career.

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