Contemporary Issue

What is Ours is Everyone's: Health Care to the Older Population in Lithuania

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Abstract

The aim of the paper is to present Lithuanian experience in creating a geriatric care system with hope it can be of some use to other countries undergoing similar transitions.

Lithuanian population is rapidly aging society with people aged 60 years and older reaching 20 percent. In 1990, Soviet rule in Lithuania ceased and the country reestablished its independence. With the acceptance into the European Union in 2004, the nation has set goals to meet the recommended requirements for the care of the elderly. The changes started from the specialist training in gerontology and geriatrics which is an essential step to bridge the gap between the reality and future need. Later, geriatric care system development program was approved by Ministry of Health. Despite its difficult past, Lithuania is confronting the challenges of health and social care to the aging population and embracing the opportunities to initiate policies and related measures to meet these challenges.

Key words: aged, geriatric, demography, social care.

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Lithuania is a country at the Baltic Sea with 3.5 million populations. For 50 years it was occupied by Soviets and included into Soviet Union. There was a saying amongst the common people in Eastern Europe "What is mine is mine, what is yours is yours, and what is ours is nobody's." In Lithuania, a small Baltic nation, there were no community agencies, no social cohesion or participation. Social care was limited to small pensions and social nursing homes that were more like asylums for the poor. Medical professionals were trained to treat healthy young people, the 'backbone' of the working society. Specialized medical care in geriatrics did not exist.

In 1990, Soviet rule in Lithuania ceased and the country reestablished its independence. With the acceptance in 2004 into the European Union, the nation has set goals to meet the recommended requirements for the care of their elderly. Developed world are coming to understand the difficulties that these transitional societies are confronted with. Lithuania is faced with the challenges of rebuilding and creating a health care infrastructure to support its population. As policies of social protection are established for the aging community and attitudes are changing from personal responsibility to common betterment, Lithuania faces the daunting task of health care for the old and must also consider the grim implications of the demographic trend towards an aging society.

Demographic Situation

There is little debate that the world is growing older and that there is a growing need for health care for the aged. Many older people enjoy the benefits of better health care in this new century. On the contrary, there is continued risk of poverty and exclusion from these benefits for older persons, especially the old-old (75 and older), in the developing and transitional society of Lithuania.

Lithuania's population is aging rapidly[1]. The number of people aged over 60 has increased from 9.3 percent in 1897 to 18.6 percent in 2000 (Fig. 1). According to the United Nations, the aging of a population is reflected by the *aging index* (i.e., the proportion of the total population $\geq$ 65 years of age or over). If that index is less than 4 percent, the population is considered to be young, if between 4 to 6.9 percent, the population is considered to be mature and if the index is 7 percent or more, the population is considered to be old[2].

To assess the status of Lithuania, aging indices

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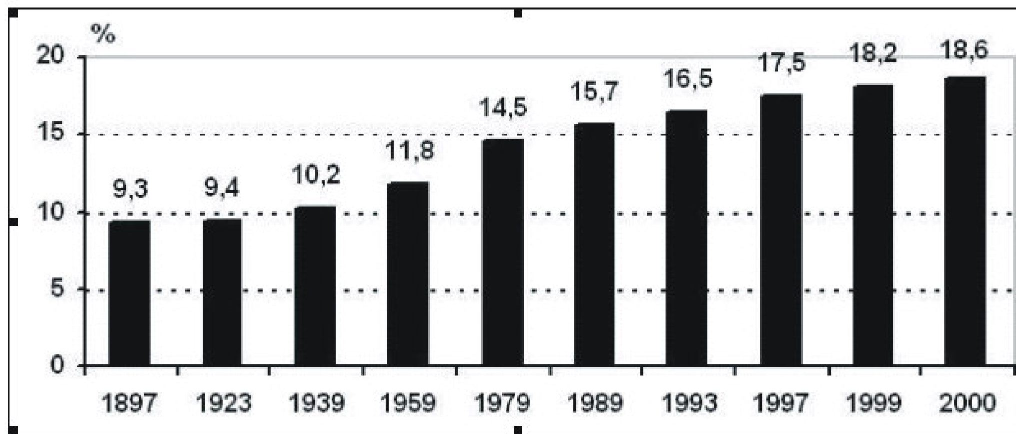

Fig 1. Increase in proportion (%) of aged population (60 yrs +) in Lithuania in hundred-year period

were evaluated in the 55 administrative regions of the country. All regions were apportioned into one of the groups according to their aging indices, and a cartogram of the total population was made (Fig.2). According to the aging index analysis, not a single region of Lithuania could be considered "young" or "mature". All the regions of the country could be considered either "old" or "very old" (aging index 15 percent and over). The biggest proportion of people categorized as "old" lived in the southern portion of the country in which the aging index exceeded 20 percent.

Demographers in other countries have identified traits in the aging process of populations and Lithuania's population has some similar characteristics. The first characteristic is the so-called double-aging phenomenon. This refers to the increase of the so-called old-old people among the elderly. In 1970, in the population 60 years and older, the group of people aged 75 years and over was 22.2 percent, while in 1998 this number grew to 25.1 percent[3]. A second trait is the feminization of aging. The male/female ratio in 1998 was 58 males per 100 females for those 60 years and over and 44 males per 100 females 75 years and over[3]. A third feature is the significant differences of aging indices

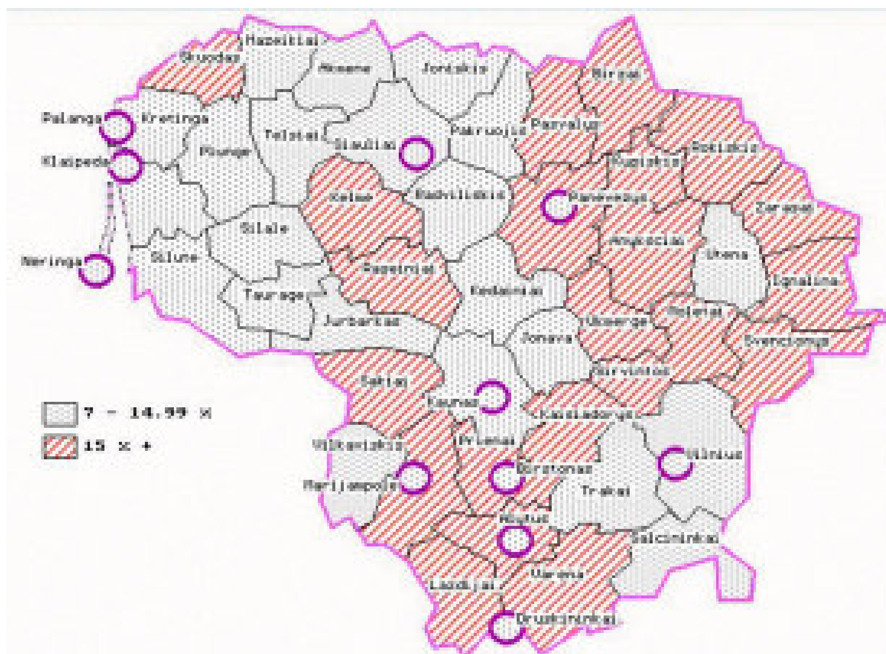

Fig.2. Ageing indices (proportion of the total population 65 years of age or over) in the different regions of Lithuania

between urban and rural populations. People who live in the countryside are relatively older than those who live in Lithuania's towns and cities. The proportion of old people is greater in the countryside than the proportion within cities (25.0% and 18.1% respectively

in the year 2003)[4].

Rapid changes in living conditions, lifestyles, social differentiation and an unstable economic situation have influenced family planning, birth rate and mortality rate. The composition of population by age and the aging of the population, both are determined by crude birth rate, mortality rate, and migration. From 1990 to 2003 the birth rate in Lithuania decreased from 15.4 to 8.6 per 1000 of the population[4]. The decline in the birth rate results not only in proportionate increase in the aging of the population, but also in the reduction of the number of potential providers of care for that population. More dramatic changes in the rates of mortality and birth occurred in 1994, when mortality began to exceed the birth rate. This brought a negative natural increase in the population. This drop in the natural increase in the population not only suggests the common tendencies of developed countries, but also deterioration in the quality of life during the transitional period of the last ten years.

The huge upheavals in social life, social policy and the economy during the last decade have reduced life expectancy at birth from 71.54 years in 1989 to 68.74 years in 1994 (a loss of life expectancy of 2.8 years). These changes have been influenced by an increase in male mortality, especially in rural areas as rural male life expectancy decreased from 64.16 to 60.23 years of age during the same period. However, since 1994, life expectancy has been increasing reflecting that of more developed countries. In 2002, it was 66.2 years for men and 77.6 for women, the average being 71.9 years[4].

Migration also has its influence on demographic structure of the population. Since 1989, the difference between the number of long-term immigrants and emigrants has been negative. The level of emigration from Lithuania reached a peak in 1992. In 2002, 5110 persons immigrated to Lithuania and 7086 persons emigrated to other countries (Russia, Germany, Belarus, etc.). According to the preliminary medium version of demographic projections to the year 2030 done by the Lithuanian Department of Statistics, the number of the aged (60+) will increase up to 27.3 percent with the population of Lithuania decreasing up to 3.1 million. This represents a decrease of 9 percent compared with 2003[4]. The composition of the population by age has important consequences for the allocation of resources to health and social security. Even in states noted for social welfare, which would include most developed western countries, projections indicate that the burden attributed to the aging process cannot even be sustained at present levels in the very near future.

Social Care Challenge

Social protection in Lithuania is now guaranteed out of the general government contributions (43.4%), employer's social contributions (51.1%), social contributions by the persons protected (5.2%), and other receipts (0.3%) [3-5]. Expenditure on social protection per capita per year was 2151 Litas ($ 827) in 2001 [3-5]. An old-age pension consists of two components: base pension of the same amount for everybody acquiring the necessary length of insurance and supplementary which depends on the length of insurance and income earned from which pension contribution was paid. Up to 1995, retirement age for men was 60 and for women – 55 years. Starting with 1995, this age has been increased by 2 months per year for men and 4 months for women until it reaches 62 years 6 months for men and 60 years for women by 2009[5-6]. Pension amounts are set by the government and are calculated according to a base amount, which is related to the consumer price index. The pensions still are very small and make less than 50% of working age income level.

Home health care is a new concept that is available in more urban areas. Those who need home help may address local social provision departments by the municipalities. Based on social and medical criteria, the elderly are accepted for home help programs. Home care help provided by social workers and care providers was received by 4237 older persons in 2001[5-6].

The aged persons have a right to apply to a municipality social care department for a living in the social care institutions. Care institutions for the elderly are institutions of social services, where older people can live for a long time if they have no social support. Permanent residence is given if they are not able to take care of themselves, need nursing care or medical treatment. Table 1 illustrates the institutions for the elderly and the number of residents in 2001[6]. About 0.9% of older citizens live in social care institutions in Lithuania.

Health Care for the Aged

The Ministry of Health determines health care policy. 4.6% of national budgetary spending is allocated to the health care system and there is a three-tier system for the provision of health care. The primary services are provided by general practitioners or family

Table 1. Care Institutions for the Elderly and Disabled (as for December 31, 2001)

Type of Care institution	No. of Institutions	No. of Residents
(a) Public care institutions	63	3845
• County care homes	8	1760
• Municipal care homes	52	1785
• Other care homes	3	300
(b) Non-governmental care homes	30	583
Total	**93**	**4428***

* Including 665 of those under 60 years old

physicians, and nursing hospitals. The second level medical services are provided by county or municipal hospitals and there are two third level hospitals with highly specialized departments.

In Lithuania, health care providers care for large numbers of frail elderly patients. Due to multiple diseases and social problems, high length of stay in the hospitals, high level of resource consumption, these patients are often seen as "undesirables" by medical practitioners**.** In 1998, 430.5 persons per 1000 aged 65 years and over were discharged from hospitals in Lithuania (in 1995, 336.3 persons per 1000)[5-7]. The average length of stay for those above 65 years was 14.4 days (for all patients 11.6 days), the common causes of admissions were cardiovascular, respiratory diseases and neoplasms.

Only in the last decade has the specialized geriatric care in Lithuania begun to develop. The greatest problem of medical care to the aged population is that there are almost no acute and rehabilitation geriatric wards, psychogeriatric beds, and consultant geriatricians in the outpatient departments. Health care providers with specialized geriatric training, though necessary for complicated older patients, are rare in number.

Areas of Action and Opportunity

The first step in developing a geriatric care system was to start with geriatric specialist training. Since 1995, courses on gerontology and geriatrics were added into the curricula of medical undergraduate and postgraduate course. Beginning in 1999, specialization of geriatric nursing was introduced into bachelor's studies in nursing faculties. In 2000, the first program of residency in geriatrics was introduced.

The residency began as a one-year tertiary program (after one-year internship and two years in internal medicine). It now requires five years of postgraduate studies to become a geriatric physician (one-year internship and four-year residency in geriatrics). In the post-Soviet countries, Lithuania was the first to organize geriatric studies. Nursing faculties in the Kaunas University of Medicine and Vilnius University included undergraduate and postgraduate studies in gerontology and geriatrics to a full extent. Global Survey on Geriatrics in the Medical Curriculum, a collaborative study of W.H.O., and the International Federation of Medical Students' Organizations, which collected data from 268 universities in 64 countries from all over the world, described Lithuania as an "old population … strong in geriatrics education" [6-8].

Now in Lithuania there are nineteen geriatricians who perform clinical work and teaching. In the year 2000, the first issue of reviewed scientific journal, *Gerontologija* (Gerontology), appeared. A quarterly magazine, it publishes data of biological, medical and social research in aging. Taking into consideration the aging of population and the resultant problems, the Ministry of Health of Lithuania in 2003 approved "The Geriatric Care System Development Program, 2003 to 2007". This program oversees the development of the geriatric care model. According to this model, the geriatric care will be concentrated in large health care centers in all five regions of Lithuania, where geriatric wards, day care units and consultants in outpatient departments will work together with an interdisciplinary

team with the aim of comprehensive geriatric assessment and treatment. Geriatric wards in the hospitals should become a reality in the process of the reorganization of an excessive number of internal medicine beds.

Other important initiatives are the development of home care, the coordination of social and medical care, case management, providing information and education to the geriatric patients, their families and the community on prevention of diseases of aging and how to access resources in the community. This is foreseen by National Strategy of Overcoming the Consequences of Population Ageing (Lithuanian Government, 2004).

To conclude, the Lithuanian population is old with people aged 60 years and older reaching 20 percent with the trend toward a rapidly aging society. A health care delivery system including the social "safety net" is vital to the public health, especially the more vulnerable populations. Systems that are *connections* to the communities can function as health care sites as well as resources, and can provide the best possible care and health outcomes for the older population. The generation of health care providers currently being trained will not meet the need, so specialist training in gerontology and geriatrics is an essential first step to bridge the gap between the reality and the future need.

As Lithuania joined the European Union in 2004, this geriatric care system development program should meet the requirements and recommendations for care for the elderly as set forth by European Committee for Social Cohesion, as "special attention should be given to the development of a variety of geriatric medicine facilities, including day hospitals, which are capable of responding to the individual needs of elderly dependent persons."[9] Despite its difficult past, Lithuania is confronting the challenges of health and social care to their aging population and embracing the opportunities to initiate policies and related measures to meet those challenges potentially setting an example of good practice in their new European community. In the spirit of sharing and cooperation, the authors hope that presenting the Lithuanian experience in creating a geriatric care system can be of some use to other countries undergoing transitions and changes.

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