Gesellschaft für
Versicherungswissenschaft
und -gestaltung e.V.

Study on the Social Protection Systems in the 13 Applicant Countries

Lithuania
Country Study

January 2003

Study financed by the European Commission – Employment and Social Affairs DG

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Social Protection in Lithuania

1. INTRODUCTION: ECONOMIC, FINANCIAL AND DEMOPGRAPHIC BACKGROUND

1.1 Main influencing factors for social protection

Before the Second World War, the population in Lithuania was largely rural with only 23% residing in urban areas. In 2001, the urban population accounted already for 66.9% of the total population. As compared the 2002 data with the 1989 population census data, the population decreased by 199.2 thousand persons or ca. 5%. Against the 1989 population census data the number of urban population decreased by 160.6 thousand persons until 2002; whereas in rural areas it fell by 39 thousand (see table below). This was caused by changes in the directions of migration flows. The main directions were either emigration to foreign countries or population flows back to villages.

Table 1.1: Rural and urban population as of 1 January

	Population, in thous.			In % of total		Population density, km^2
	Total	Urban	Rural	Urban	Rural	
1939*	3037.1	695.5	2341.6	22.9	77.1	46.6
1959	2696.7	1025.9	1670.8	38.0	62.0	41.6
1970	3118.9	1557.7	1561.2	49.9	50.1	48.0
1979	3391.5	2034.9	1356.6	60.0	40.0	52.1
1989	3674.8	2486.8	1188.0	67.7	32.3	56.6
2001**	3487.0	2334.2	1152.8	66.9	33.1	53.7
2002	3475.6	2326.2	1149.4	66.9	33.1	53.5

* estimated

** The number of population in 2001 is revised according to the Population Census data. (see *http://www.std.lt/Surasymas/Rezultatai/index_pirm_e.htm*); Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.31;

Differences in population structure by sex were most obvious after the Second World War. Later the ratio between males and females was getting more balanced, while from 1993 it became more unbalanced again. The number of females per 100 males in 1989 was 111, whereas in 2001-2002 it was 114.

Table 1.2: Population by sex as of 1 January

Census year	Number of population, in thous.			Specific weight in total population, %	
	total	males	Females	males	females
1939*	3037.1	1456.6	1580.5	48.0	52.0
1959	2696.7	1238.2	1458.5	45.9	54.1
1970	3118.9	1462.8	1656.1	46.9	53.1
1979	3391.5	1599.4	1792.1	47.2	52.8
1989	3674.8	1739.0	1935.8	47.3	52.7
2001**	3487.0	1630.9	1856.1	46.8	53.2
2002	3475.6	1624.5	1851.1	46.7	53.3

* estimated

** The number of population in 2001 is revised according to the Population Census data. (see *http://www.std.lt/Surasymas/Rezultatai/index_pirm_e.htm*); Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.31;

1.1.1. Economic and financial indicators

Table 1.3: GDP per capita (in PPS, at current prices)

	1996	1997	1998	1999	2000	2001	Compare to EU-15 in 2001	2001/1996
Bulgaria	5500	5400	5700	6000	6000	6500	28%	1.18
Romania	5300	5100	5000	5100	5500	5900	25%	1.11
Turkey	5100	5600	5800	5600	5600	5200	22%	1.02
Latvia	4700	5200	5600	6100	7000	7700	33%	1.64
Lithuania	***6200***	***6900***	***7400***	***7300***	***8100***	***8700***	***38%***	***1.40***
Estonia	6500	7500	8000	8200	9200	9800	42%	1.51
Poland	6600	7300	7800	8300	9000	9200	40%	1.39
Slovak Republic	8800	9600	10100	10500	10500	11100	47%	1.26
Hungary	8500	9200	9900	10600	11400	11900	51%	1.40
Malta	9900	10600	11100	11700	:	:	:	:
Czech Republic	11800	12100	12200	12500	12600	13300	57%	1.13
Slovenia	11900	12800	13500	14500	15300	16000	69%	1.34
Cyprus	15400	16100	17000	18100	17600	18500	80%	1.20
CC-13	6400	6800	7100	7300	7500	7600	33%	1.19
EU-15	18500	19400	20300	21200	22600	23200	100.0%	1.25

* Statistics in focus – Theme 2 – 41/2002, – Eurostat, 2002, p.7.

Over the past five years there has been a period of economic recovery characterized by a modest growth of GDP per capita. The acceleration of GDP growth has been interrupted by some external or internal factors.

Table 1.4: GDP and inflation

	1995	1996	1997	1998	1999	2000	2001
GDP at current prices (bn EURO*)	4.6	6.2	8.5	9.6	10.0	12.2	13.4
GDP growth at constant prices (%)	3.3	4.7	7.3	5.1	-3.9	3.8	5.9
Consumer price indices (%)	39.6	24.6	8.9	5.1	0.8	1.0	1.3
Interim HICP (%)	-	24.7	8.8	5.0	0.7	0.9	1.6

* Statistics in focus – Theme 2 – 41/2002, – Eurostat, 2002, p. 5-6; Statistical yearbook on candidate and South-East European countries. -Luxembourg: Office for Official Publications of the European Communities, 2001, p. 59, 60, 81; Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 176; 100 basic indicators from Eurostat yearbook of 2001, Eurostat, 2001, p. 54.

During Soviet times industry became the largest sector of the economy and was almost totally reliant on cheap energy from Russia and access to the large Soviet market. During Lithuania's struggle for independence Russia imposed a fuel embargo on Lithuania, and subsequently raised its energy prices to world market levels. As a result, the industrial output in Lithuania was halved between 1992 and 1995, and the industry's share of GDP fell by about 20 percentage points during the same period, although it has since stabilised at around 25% of the GDP. Approximately 20% of the employed population worked in the sector in 2000.

Agriculture used to be the second largest sector, contributing around 20% of the total GDP in 1991. However, the fuel embargo and an ill-conceived land privatisation programme gradually weakened the sector. The agriculture sector was then given a final blow by the Russian financial crisis of the middle of 1998, which led to the loss of its traditional markets in the East. Nevertheless, despite the sector's dramatic shrinkage to 7.5% of the GDP (including hunting and forestry) by 2000, this remains well above the EU average of 2.5%. Despite this drop, the sector still plays a key role, in particular in terms of employment. The fall in agricultural output has resulted in a less than proportionate employment decline. Approximately 18-19% of the employed population are still working in this sector. Rapid privatisation coupled with the restitution of property rights on land has led to a strongly fragmented ownership structure, resulting in low productivity. The Government supported the profitability of the agricultural sector by granting subsidies. In order for the sector to compete at the international level, significant restructuring will be required, which will have a strong impact on employment.

The services sector went through major structural changes after the independence of Lithuania, increasing its share of GDP from around 40% in 1992 to more than 60% in 2000. The transport services underwent rapid expansion in the early 1990s, and retail and professional services have caught up since 1995.

The role of the private sector has grown rapidly as a result of the successful implementation of small-scale privatisation and the rise of new businesses, particularly within the retail sector. The privatisation of large

enterprises, which started in 1997, has accelerated this trend. The private sector is estimated to account for around 75% of the GDP and 70% of employment.

The unrecorded economy remains large, accounting for up to 25% of the GDP and 20% of employment, according to some estimates. The Lithuanian Department of Statistics adjust GDP figures retrospectively, but less than 25%.

An economic recovery took hold in 1995, but in that year Lithuania was plunged into a crisis after two of its largest banks were suspended amid allegations of fraud. As the banks had serviced Lithuania's largest companies, the country faced a temporary payment freeze on wages and debts. However, the economy weathered the banking crisis unexpectedly well. Real GDP growth accelerated to 4.7% in 1996 and 7.3% in 1997, reflecting a revival in industrial production and a rapid service growth. The boom continued throughout the first three quarters of 1988, but was accompanied by a rapid widening current-account deficit. However, the economic collapse in Russia following the August 1998 financial crisis put a brake on growth in the entire region and Lithuania's real GDP grow rate that year slowed to 5.1%. The full impact of the Russian crisis took effect the following year, when GDP fell by 3.9%. Industry, agriculture and construction declined by around one tenth. The decline was exacerbated by supply problems at the Mazeikiai refinery (10% of GDP), and by a collapse in consumer demand, factors that persisted throughout 2000 and 2001. As a result, the economic recovery was modest and the GDP real growth reached 3.3% in 2000 and 5.7% in 2001 (provisional data).

The establishment of a currency board and the pegging of the Litas to the US dollar helped to reduce inflation rapidly to an average of 24.6% in 1996, 8.9% in 1997, 5.1% in 1998, 0.8% in 1999, 1.0% in 2000 and 1.3% in 2001 (according to the interim Harmonised Indices of Consumer Prices, average inflation was 1.6% in 2001).

During the period of 1995-2001 there was a marked economic recovery, although interrupted by a year of recession. The pace of economic growth has been modest, lower than in neighbouring countries (such as Latvia and Estonia), although the inflation in Lithuania has also been lower. The high employment share in the agricultural sector and the need for restructuring this sector will have a big impact on employment all over the country, especially in some regions.

Social expenditure

Three features of the development of social expenditure can be noticed. The dynamics of social expenditure is not stable. The higher demand for social expenditure during the recession (year 1999) determines the higher percentage of these expenditures of GDP (see table 1.5). The Households' expenses comprise a solid part of health care expenditure (see table 1.6).

Nevertheless the share of expenditures on health care has been increasing within national budget social expenditures (see Chart 1.1);

Table 1.5: Consolidated social expenditure as percentage of GDP

1996	1997	1998	1999	2000
14,2%	14,9%	15,8%	16,6%	15,8%

Source: Department of Statistics at the Government of the Republic of Lithuania

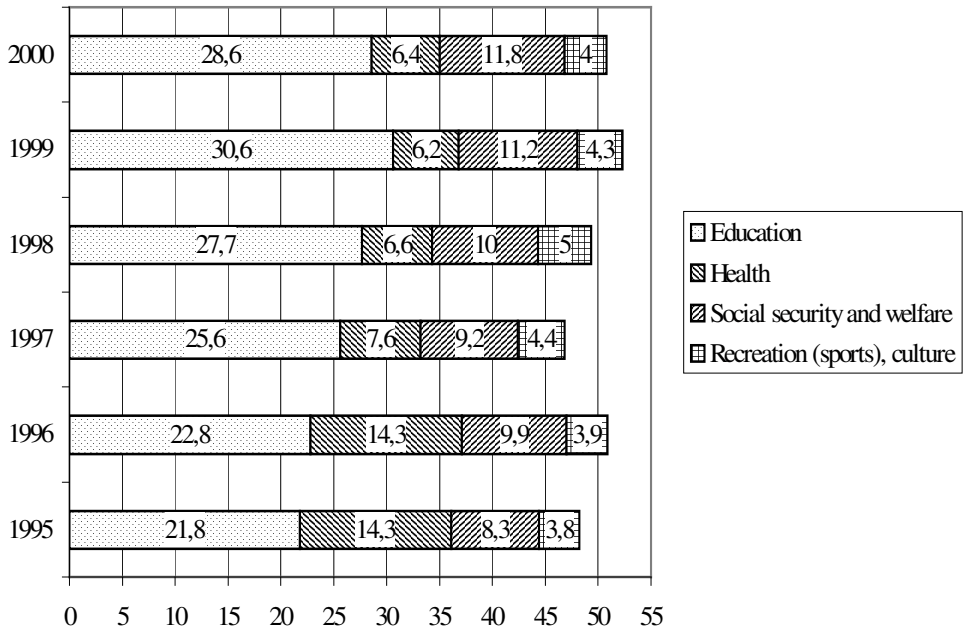
Table 1.6: Health care expenditure as percentage of GDP

	1996	1997	1998	1999	2000
Total	6,2%	6,6%	7,1%	7,0%	6,6%
Expenses of the State institutions	4,2%	4,6%	4,8%	4,6%	4,4%
Expenses of households	2,0%	2,0%	2,3%	2,4%	2,3%

Source: Department of Statistics at the Government of the Republic of Lithuania,

Only a small share of public social expenditures is devoted to the spheres most directly related to poverty – to unemployment and social exclusion (see table 1.7) in Lithuania. This is especially prominent with regard to EU standards.

Chart 1.1. National budget expenditure on social affairs in 2000 (as a percentage of total expenditure)



Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 170.

Chart 1.2. Resident population by age groups

Table 1.7: The structure of social security spending, in %

	Lithuania*					Eu-15, 1996**
	1996	**1997**	**1998**	**1999**	**2000**	
Sickness insurance and health	5.2%	6.4%	6.0%	6.2%	5.8%	35.5%
Disability	11.2%	11.8%	12.0%	12.3%	12.9%	
Old age and widowhood	67.8%	67.0%	65.5%	65.9%	65.0%	44.8%
Family and children	8.7%	8.6%	9.4%	9.6%	9.6%	7.9%
Unemployment	3.6%	3.3%	4.9%	3.9%	3.7%	8.4%
Social exclusion and housing	3.6%	2.9%	2.2%	2.1%	3.0%	3.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Sources**:** * Department of Statistics at the Government of the Republic of Lithuania

** The social situation in the European Union 2000 – Eurostat, European Commission, DG for Employment and Social Affairs Unit E.1, 2000, p. 29.

1.1.2 Demographic indicators

Table 1.8: Population by gender and age

	1995		2001		2001 compare to 1995	
	in thous.	in %	in thous.	in%	in thous.	in %
Males	1717,2	47,1%	1630,9	46,8%	-86,3	95,0%
Females	1925,8	52,9%	1856,1	53,2%	-69,7	96,4%
Females per 1000 males	1121		1138		16,6	101,5%
Total	3643		3487		-156	95,7%

* Calculated according to data provided in http://www.std.lt/. The number of population in 1995 and 2001 is revised according to the Population Census data.

* Calculated according to data provided in http://www.std.lt/. The number of population in 1995 and 2001 is revised according to the Population Census data.

Table 1.9: Population changes

Year		1990	1995	1996	1997	1998	1999	2000	2001
Total	In thousand	3693,7	3643	3615,2	3588	3562,3	3536,4	3512,1	3487
	In % compare to 1990	100,0%	98,6%	97,9%	97,1%	96,4%	95,7%	95,1%	94,4%
Males	In thousand	1747,5	1717,2	1701,6	1685,8	1671,7	1657,6	1644,3	1630,9
	In % compare to 1990	100,0%	98,3%	97,4%	96,5%	95,7%	94,9%	94,1%	93,3%
Females	In thousand	1946,2	1925,8	1913,6	1902,2	1890,6	1878,8	1867,8	1856,1
	In % compare to 1990	100,0%	99,0%	98,3%	97,7%	97,1%	96,5%	96,0%	95,4%

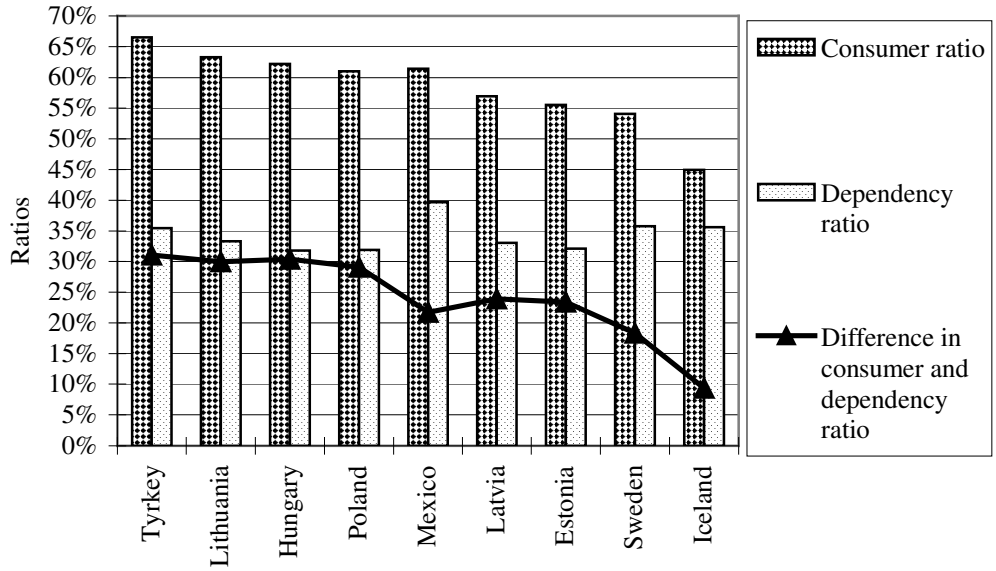
* Calculated according to data provided in http://www.std.lt/. The number of population in 1990-2001 is revised according to the Population Census data.

We consider:

- notable increase of disproportion between males and females (see table 1.8);
- ageing of population (share of population 60 years and older increased from 17.0% in 1995 to 19.2% in 2001). Demographic dependency ratio (population older than 60 years in relation to 15-60 years) increased from 0,280 in 1995 to 0.315 in 2001 (see chart 1.2). One of the main features of ageing is that women constitute the majority (63.4%) of the population of the age 60 years and older;
- some decrease of total population. Emigration was the decisive factor in the decrease in population which began in 1992. Since 1994, when the natural growth became negative, in other words when growth turned into decline because deaths started to outnumber births, this became a determining factor in the subsequent decrease in population.

In general, potential possibilities for labour force developments are determined by the ***dependency*** and ***consumer*** ratios. The dependency ratio showing the share of residents under 15 years of age, of 65 years of age and elder unveils the number of residents who must be supported by the state notwithstanding other factors (e.g., health of residents, the level of education, etc.). Chart 1.2 demonstrates that the dependency ratio has increased due to an increasing share of elderly population and has been decreasing due to a decreasing share of children. The consumer ratio, showing the share of unemployed residents (consumers), reveals the factual number of dependent residents. The difference between the consumer and dependency ratios shows the share of residents of working age (as a percentage on the total number of residents) that is practically supported by the state.

Chart 1.3. Selected countries by consumer and dependency ratios



* Chart is based on Living conditions survey's data 1999 and OECD statistics (OECD historical statistics, 1970-1999 / OECD. - Paris, 2001).

We consider that Lithuania, which does not differ in terms of dependency ratio too much, stands among the first in terms of consumer ratio and in accordance with the share of supported residents of working age. A high unemployment level as well as a relatively significant part of unemployed not seeking a job at their own will are one of the key factors boosting the burden of support, falling on the shoulders of the employed. Excluding children up to 15 years of age, the consumer ratio in Lithuania would still comprise 53.7%, which means that the number of dependent adults still exceeds the number of the employed providing for their support.

Fertility

A decrease in the birth rate began to take place from 1991. This decrease failed to slow even when a numerically fairy large generation reached a reproductive age. In 2000, 31.5 thousand children were born, 55 % less than in 1990. The total fertility rate fell from 2.02 to 1.27. The birth rate fell the most dramatically, by 11%, in 1993. The declining trend continues today, but at a significantly slower rate (see tables 1.10-1.11).

Based on long-term tradition, fertility was determined by births in wedlock. In 1990 only 7% of children were born out of wedlock. The decrease in the birth rate over the last few years has in fact been caused by a decrease in births to married couples, which is directly related to a decrease in the number of marriages. The number of children born in wedlock fell twice, while the number of extra-marital births rose almost twice. in 1990-

2000; in 2000 they constitute 22.6% of all births. Most of these children (70%) are registered by the mother's application.

Table 1.10: Births, deaths, natural increase, marriages and divorces

	1990	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**
Live births	56868	41195	39066	37812	37019	36415	34149	31546
Stillbirths	305	285	236	248	240	207	221	167
Deaths	39760	45306	42896	41143	40757	40003	38919	40399
of which infant deaths under 1 years	581	514	395	391	343	315	294	250
Natural increase	17108	-4111	-3830	-3331	-3738	-3588	-4770	-8853
Registered marriages	36310	22150	20433	18796	18486	17868	16906	15764
Registered divorces	12747	10221	11311	11371	11752	11390	10882	11024
Rate per 1000 population:								
Live births	15,4	11,4	10,8	10,6	10,4	10,3	9,8	9,1
Deaths	10,8	12,5	11,9	11,5	11,5	11,3	11,1	11,6
Natural increase	4,6	-1,1	-1,1	-0,9	-1,1	-1	-1,3	-2,5
Marriages	9,8	6,1	5,7	5,3	5,2	5,1	4,8	4,5
Divorces	3,4	2,8	3,1	3,2	3,3	3,2	3,1	3,2
Deaths under 1 year per 1000 live births	10,3	12,4	10	10,3	9,2	8,6	8,5	7,8

* http://www.std.lt/

Table 1.11: Age-specific fertility rates and total fertility rate

	Year	Live births per 1000 females at specified ages							TFR**
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	
Total	1990	40.8	168.1	112.2	55.9	22.2	5.2	0.3	2.02
	1995	39.7	115.0	84.7	39.3	16.0	3.5	0.2	1.49
	2000	24.3	87.3	76.0	44.8	17.5	4.1	0.2	1.27
	1995/1990	97.3%	68.4%	75.5%	70.3%	72.1%	67.3%	66.7%	73.8%
	2000/1995	61.2%	75.9%	89.7%	114.0%	109.4%	117.1%	100.0%	85.2%
Urban	1990	31.9	144.7	105.2	51.2	19	4.1	0.2	1.78
	1995	32.8	102.1	78.5	36	13.8	2.7	0.1	1.33
	2000	18.3	72	70.2	40.2	14.8	3	0.2	1.09
	1995/1990	102.8%	70.6%	74.6%	70.3%	72.6%	65.9%	50.0%	74.7%
	2000/1995	55.8%	70.5%	89.4%	111.7%	107.2%	111.1%	200.0%	82.0%
Rural	1990	62	226.4	122.3	66.4	30.8	8.4	0.5	2.58
	1995	56.3	146.3	101.1	49.3	23	6.1	0.4	1.91
	2000	39.2	124.4	90.5	57.1	25.7	7.4	0.4	1.72
	1995/1990	90.8%	64.6%	82.7%	74.2%	74.7%	72.6%	80.0%	74.0%
	2000/1995	69.6%	85.0%	89.5%	115.8%	111.7%	121.3%	100.0%	90.1%

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.36.

In the period 1990-1995 the fertility rates decreased in all age groups, in the period of 1995-2000 the fertility rates decreased for the age groups 15-29, and increased for the age groups 30-44 (see table 1.11-1.12). Compared to other candidate countries the fertility rate in Lithuania is quite high.

We may notice that of decrease of total population in 1990s is attributable to the decreasing births and natural increase rates.

Life expectancy

Table 1.12: Life expectancy at birth and at age 60

Year		Males		Females	
		0	60	0	60
Total	1990	66.55	16.28	76.22	20.84
	1994	62.73	15.15	74.89	20.53
	2000	67.62	16.99	77.93	22.21
	1994/1990	94.3%	93.1%	98.3%	98.5%
	2000/1994	107.8%	112.1%	104.1%	108.2%
Urban	1990	67.6	16.28	76.78	21.11
	1994	63.98	15.44	75.48	20.64
	2000	69.38	17.8	78.96	22.85
	1994/1990	94.6%	94.8%	98.3%	97.8%
	2000/1994	108.4%	115.3%	104.6%	110.7%
Rural	1990	64.16	16.27	75.12	20.59
	1994	60.19	14.85	73.66	20.46
	2000	64.49	16.01	76.22	21.43
	1994/1990	93.8%	91.3%	98.1%	99.4%
	2000/1994	107.1%	107.8%	103.5%	104.7%

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.49.

In the period 1990-1994 life expectancy decreased, and in the period 1995-2000 the life expectancy has experienced an increase.

The average life expectancy has risen to 77 years for women and 66 years for men. For men external causes of death are more often than for women; particularly frequent are suicides. In 2001 women mortality as the result of external causes of death was 63, while for man – 266, of which suicides made up 15 and 77, respectively[1]

Migration

The following features characterise international migration in Lithuania :

[1] Women and men in Lithuania, Vilnius,2001, p. 6.

The international net migration during the period of 1990-2000 amounts to – 60028 (or 1.6% of population), 91.3% of which consists of net migration to / from SIC countries and 8.7% to / from other countries.

Table 1.13: International migration

Year	Immi-gration	Emigration	Net migration				
			Total	CIS migration		Other countries	
persons	persons	persons	Persons	persons	%	persons	%
1990-1993	36062	89140	-53078	-48454	91,3%	-4624	8,7%
1994	1664	4246	-2582	-2023	78,4%	-559	21,6%
1995	2020	3773	-1753	-1256	71,6%	-497	28,4%
1996	3025	3940	-915	-445	48,6%	-470	51,4%
1997	2536	2457	79	395	500,0%	-316	-400%
1998	2706	2130	576	891	154,7%	-315	-54,7%
1999	2679	1369	1310	1434	109,5%	-124	-9,5%
2000	1510	2616	-1106	-305	27,6%	-801	72,4%
2001	4694	7253	-2559	-652	25,5%	-1907	74,5%
1990-2001	56896	116924	-60028	-50415	84,0%	-9613	16,0%

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 50; *http://www.std.lt/*

88.4% of the total net migration, 96.1% of the net migration to / from SIC countries and 48.1% of the net migration to / from other countries belongs to the period of 1990-1993.

There was a positive net migration with to / from SIC counties during the short period of 1997-1999.

Overall, it can be stated that immigration to Lithuania had a tendency to decrease until year 2001, but there is no clear tendency for emigration. Emigration has increased in 1996, 2000 and 2001, i.e. in the years of the Seimas election. It is probable that changes in the political power have exerted on influence on the decisions to emigrate.

The prevailing destinations for the emigration flows are Belarus, Russia and Ukraine from CIS countries, and the USA, Israel and Germany.

Until 1994 most of the decline of Lithuania's population was attributable to net migration after the collapse of the Soviet Union, but the population also experienced a natural decrease, partially owing to the deterioration in living conditions in the early 1990s. The worsening of living conditions resulted in an increase in infant mortality, which peaked in 1992 at 16.5 deaths per 1000 live births, before gradually declining to 8.5 deaths per 1000 live births in 2000. Life expectancy reached the lowest point in 1994 (62.7 years for men, 74.9 for women), by 2001 it had risen to 66 and 77 years, respectively.

Lithuania is the most ethnically homogenous of the three Baltic States. In 1999 Lithuanians accounted for an estimated 81.8% of the population, followed by Russians (8.1%) and Poles (6.9%).

Table 1.14: Migration to SIC countries by nationality in 2000

	Immigration		Emigration	
	Total	Percentage of total number of immigrants	Total	Percentage of total number of emigrants
Total	**1121**	**100**	**1426**	**100**
Lithuanians	488	43.5	148	10.4
Russians	291	26	661	46.4
Poles	56	5	79	5.5
Belarussians	28	2,5	175	12.3
Ukrainians	73	6,5	99	6.9
Jews	5	0,4	4	0.3
Others	180	16,1	260	18.2

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 52;

1.1.3 Social indicators

Employment indices

Table 1.15: Labour force structure

	1995	1996	1997	1998	1999	2000	2001
Labour force (in thousand)	1979.4	1937.8	1827.9	1842.5	1861.7	1793.6	1759.9
Employed (in thousand)	1632.3	1620.4	1570.7	1597.6	1598.4	1517.9	1460.6
Unemployed (in thousand)	347.1	317.4	257.2	244.9	263.3	275.7	299.3
Unemployment rate (in %)	17.1	16.4	14.1	13.3	14.1	15.4	17.0

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.107; *http://www.std.lt/*

Unemployment by age and sex is presented in the Table 1.19, labour force participation (activity) rates by age and sex are presented in the Table 1.20 (see the end of the Chapter).

Having risen from a very low level at the beginning of the 1990s, the unemployment rate in Lithuania peaked in 1995 when according to the LFS there were almost 350,000 unemployed, representing an unemployment rate of 17.1%. Thereafter, the unemployment rate fell gradually to 13.3% in 1998, when there were 245,000 people out of work. The economic recession that started at the end of 1998 led to a reversal of this downward trend, and by 2001 the average level of unemployment had risen to 299,300 – an unemployment rate of 17.0%. The male unemployment rate in Lithuania in

2000 is estimated at 17.5% while the female unemployment rate is 13.5% – both are high relative to the EU averages of 8% (male) and 11% (female) respectively in mid-2000. Male unemployment has risen steadily over the past few years, from a low percentage of 14.2% in 1997. Women's unemployment fell initially in 1998, and even after the increases seen in 1999 and 2000, remained below its 1997 level of 13.9%. In 2000, according to the LFS, 52% of the unemployed (or over 8% of the labour force) had been out of work for over one year. The survey results indicate that there had been a sharp drop in the level of long-term unemployment, from almost 130,000 in 1997 to just over 100,000 in 1999. However, the number of long-term unemployed rose again in 2000, to reach 144,000.

The participation rate for those aged 15-64 was approximately 76% at the time of the first Labour Force Survey (LFS) in 1995. By 2001, the participation rate for those aged 15-64 had fallen to an estimated 69.7%, slightly above the EU average of 69% in that year. As a result of these trends, the size of the labour force contracted from 1.98 million in 1995 to an estimated 1.76 million in 2001. In 2000, the male participation rate for those aged 15-64 was below the EU level (75.5% as against 79.1% in the EU) while the female rate was above that in the EU (67.6% as compared with 59.8% in the EU). In terms of age groups, participation in Lithuania was relatively low for young people of both sexes and for males aged 25-49; it is high relative to the EU among women aged 25-49 and for both sexes aged 50-64. Participation rates vary across nationality groups. Compared with the overall participation rate of 71.1% in May 2000, the participation rate was 71.9% for Lithuanians, 64.8% for Russians and 74.9%. for Poles. The further fall observed in 2001 concerned all nationalities, in particular Polish people (the participation rate in May 2001 was 71.2% for Lithuanians, 62.6% for Russians and 65.9% for Poles).

Table 1.16: Employed population by professional status (average annual number; in thousand)

	1997		**1998**		**1999**		**2000**	
	thous.	%	thous.	%	thous.	%	thous.	%
Total	*1570.7*	*100.0%*	*1597.6*	*100.0%*	*1598.4*	*100.0%*	*1517.9*	*100.0%*
Employees	1226.4	78.1%	1251.6	78.3%	1265.8	79.2%	1203.5	79.3%
Employers and self-employed	286.8	18.3%	275.2	17.2%	259.2	16.2%	253.4	16.7%
Contributing family workers	56.9	3.6%	67.2	4.2%	68.4	4.3%	55.4	3.6%
Not stated	0.6	0.0%	3.5	0.2%	5	0.3%	5.7	0.4%

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.117

Of all those employed, approximately 80% are employees, 16% are self-employed, and just over 4% are unpaid family workers (see table 1.13). One in eight of the self-employed are themselves employers, while the remainder are single-operator businesses. Self-employment is concentrated in

agriculture, where it represents 58.1% of workers compared with 2.0% in industry (4.8% in construction) and 5.2% in services. In each of these broad sectors, self-employment is less prevalent than in the EU, where 52% of agricultural workers, 11% of those in industry, and 13% of workers in services are self-employed.

Poverty indices

European Union indices equivalent to the poverty line and poverty rate are low-income threshold and low-income rate. In terms of a relative poverty rate, poverty is most widely spread in the group of unemployed, in households of persons living on social benefits, raising three or more children, farmers and rural residents (see chapter 4 for more details).

Table 1.17: Poverty lines and poverty level in Lithuania

	1996	1997	1998	1999	2000	2001
Relative poverty line*, in litas	226.2	248.6	276.7	274.6	260.0	264.8
Poverty rate on the basis of relative poverty line	18.0%	16.6%	16.0%	15.8%	16.0%	16.4%

Source: Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

* 50% of average consumption expenditures

Households

Compared to the living conditions' survey conducted in 1994, the 1999 survey shows marked changes in the household structure:

- Single person households were most numerous: 30.7% of the total number of households (1994 – 23.2%), with pensioners' households accounting for more than half of them.
- Spouses with children occupy the second place: they comprise 20.3% of the total number of households (1994 – 32.7%).
- Spouses without children account for 16.5% of the total number of households (1994 – 16.3%), the majority of them being pensioners' households.
- Two-generation households account for 11.7% of the total number of households (1994 – 12.2%).
- Single parent households account for 4.5%.

The most marked differences are observed in single-person households. During the period between 1994 and 1999 there has been an actual decrease in the spouse households due to a decrease in the number of marriages and the increase in the number of divorces (see Tables 1.10, 1.18).

As the result of these changes average household size decreased from 3 to 2.7 persons per household.[2]

Table 1.18: Marriages and divorces

Year	Registered		Rate per 1000 population		Percentage of remarriages in total, %		Divorces per 100 marriages
	Marriages	Divorces	Marriages	Divorces	Males	Females	
1990	36310	12747	9.8	3.4	21.3	19.9	35.1
1995	22150	10221	6.0	2.8	19.1	17.6	46.1
1996	20433	11311	5.5	3.0	20.4	18.5	55.4
1997	18796	11371	5.1	3.1	20.1	18.3	60.5
1998	18486	11752	5.0	3.2	20.9	19.0	63.6
1999	17868	11390	4.8	3.1	21.4	19.5	63.7
2000	16906	10882	4.6	2.9	21.6	20.3	64.6

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.38.

1.2 How does the described background affect social protection?

1.2.1 Forecasts and projections

There has been a significant transfer during recent years from trade with the CIS countries to trade with the EU. During the first half of 2001, the EU accounted for 55.9% per cent of all exports, and for 43.3% of imports. Lithuanian economy has become less dependent on unpredictable East markets, and has become more competitive with Western markets. For these reasons it is possible to forecast a 5% annual growth of GDP and a corresponding improvement in living standards for the next 5 years.

Nevertheless, the labour market will suffer from additional pressure in the next 5 years: (a) the population at working age will remain stable over the next decade, (b) the legal pension age will increase, (c) the restructuring of agriculture will direct free labour force from this sector to industry and services.

Demographic forecasts are following for the next 10 years:

- small decrease in total population mainly due decreasing fertility and births rates; decreasing number and share of young population;
- stable number and increasing share of working population;
- decreasing number and share of the population aged 65 and more, because of post war demographic waves effect;
- in general, demographic forecasts are favourable regarding the social protection needs in the period of 10 years.

[2] Women and men in Lithuania, Vilnius,2001, p. 29.

1.2.2 Influences of economic, demographic and social developments on the social protection system

The social protection system will be affected mainly by the additional pressure caused by labour market developments. Thus, the combating of unemployment, the development of education and vocational training will be most important fields for social policy, and success in these fields will have an influence on social expenses, the level of incomes and the reduction of poverty.

Pension expenditures may decrease because of decrease of population aged 65 and more and due to the increase of the legal pension age.

In addition, the ageing of the population, the reduction in the household's size and the low quality of living conditions (especially in rural areas) will require the improvement of quality and the expansion of social services for the elderly.

Table 1.19: Unemployment by age groups and sex (Average annual number)

Age groups	**Unemployed, thous.**				**Unemployment rate, %**			
	1997	1998	1999	2000	1997	1998	1999	2000
Total	**257.2**	**244.9**	**263.3**	**275.7**	**14.1**	**13.3**	**14.1**	**15.4**
15-19	23.5	15.4	16.1	13.8	34.9	27.4	30.9	43.0
20-24	42.0	37.7	45.3	43.5	21.8	20.6	25.2	26.4
25-29	33.9	34.7	33.9	32.6	14.1	13.7	13.3	13.1
30-34	33.4	40.1	39.3	41.7	12.9	15.4	15.0	17.0
35-39	30.5	34.0	37.2	32.5	11.4	12.2	13.0	12.1
40-44	31.9	25.8	34.6	34.0	14.1	11.2	14.5	14.1
45-49	28.1	25.8	21.9	28.0	13.9	12.4	10.4	13.7
50-54	21.6	19.4	21.9	28.5	12.4	11.2	12.6	17.0
55-59	12.2	10.7	12.0	16.6	10.1	8.6	9.2	13.0
60-64	0.1	1.1	1.1	3.4	0.2	2.5	2.3	6.6
65+	-	0.1	-	1.1	-	0.3	-	2.9
15-64	257.2	244.8	263.3	274.6	14.3	13.5	14.4	15.7
Males								
Total	**137.1**	**137.2**	**150.3**	**159.0**	**14.2**	**14.3**	**15.6**	**17.3**
15-19	14.8	10.2	10.6	10.8	33.7	28.8	33.8	47.8
20-24	28.3	22.8	26.6	24.8	25.0	21.7	26.1	26.7
25-29	16.3	19.1	19.8	20.5	12.1	14.1	14.6	15.7
30-34	19.2	22.9	23.8	24.6	14.2	16.6	17.4	19.0
35-39	17.5	17.9	20.4	19.0	13.0	12.8	14.5	14.1
40-44	15.4	13.2	18.5	18.6	13.9	12.1	15.8	15.8
45-49	7.3	13.2	9.6	13.3	7.9	13.5	10.0	13.8

Continued table 1.19

Age groups	**Unemployed, thous.**				**Unemployment rate, %**			
50-54	9.4	10.1	9.9	13.9	11.5	12.7	12.5	18.3
55-59	8.7	6.9	10.1	10.2	12.0	9.4	13.0	14.8
60-64	0.1	1.0	1.1	2.5	0.4	3.2	3.8	7.8
65+	-	0.1	-	0.9	-	0.5	-	4.9
15-64	137.1	137.2	150.3	158.0	14.4	14.5	15.9	17.6
Females								
Total	**120.1**	**107.7**	**113.0**	**116.7**	**13.9**	**12.2**	**12.6**	**13.3**
15-19	8.7	5.3	5.6	3.0	37.2	25.0	26.5	29.5
20-24	13.7	14.9	18.7	18.7	17.4	19.0	24.0	26.0
25-29	17.6	15.7	14.1	12.1	16.6	13.3	11.9	10.2
30-34	14.2	17.2	15.4	17.1	11.5	14.0	12.3	14.7
35-39	13.0	16.1	16.8	13.5	9.8	11.7	11.6	10.1
40-44	16.5	12.6	16.2	15.4	14.3	10.5	13.3	12.5
45-49	20.8	12.6	12.3	14.7	18.9	11.4	10.8	13.6
50-54	12.1	9.2	12.0	14.6	13.3	10.0	12.8	15.9
55-59	3.4	3.8	1.9	6.5	7.2	7.5	3.7	10.8
60-64	-	0.2	-	0.9	-	1.1	-	4.6
65+	-	-	-	0.2	-	-	-	0.9
15-64	120.1	107.7	113.0	116.5	14.2	12.4	12.7	13.6

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.124-127.

Table 1.20: Activity rate and employment rate by age groups and sex (Average annual number; in %)

	Activity rate				**Employment rate**			
Age groups	1997	1998	1999	2000	1997	1998	1999	2000
Total	**61.5**	**61.7**	**61.9**	**60.4**	**52.8**	**53.5**	**53.2**	**51.2**
15-19	21.4	17.8	16.2	12.3	13.9	12.9	11.2	7.2
20-24	70.9	69.4	69.2	63.8	55.4	55.1	51.7	47.0
25-29	85.5	89.1	89.7	88.4	73.5	76.9	77.7	76.8
30-34	87.3	90.6	92.7	88.1	76.0	76.6	78.8	73.2
35-39	91.5	92.4	93.7	88.7	81.1	81.1	81.5	77.9
40-44	94.7	94.3	95.1	91.3	81.3	83.7	81.3	78.4
45-49	93.7	93.4	91.8	89.1	80.7	81.8	82.3	76.9
50-54	84.0	86.5	90.2	87.0	73.5	76.8	78.8	72.2
55-59	58.7	60.6	62.7	62.8	52.8	55.4	56.9	54.7
60-64	25.0	24.1	26.0	27.0	25.0	23.5	25.4	25.2
65+	6.9	6.4	5.6	7.9	6.9	6.4	5.6	7.7
15-64	71.5	72.0	72.7	70.9	61.2	62.3	62.3	59.8

Continued table 1.20

Age groups	Activity rate				Employment rate			
Males								
Total	**70.3**	**69.6**	**69.2**	**67.1**	**60.3**	**59.6**	**58.4**	**55.5**
15-19	27.5	22.0	19.0	16.6	18.2	15.6	12.6	8.7
20-24	82.8	78.8	78.0	71.5	62.1	61.7	57.7	52.4
25-29	93.2	93.3	93.8	90.5	82.0	80.2	80.1	76.3
30-34	90.4	94.2	95.1	91.2	77.6	78.6	78.6	73.9
35-39	94.0	94.3	93.4	89.3	81.8	82.3	79.9	76.6
40-44	96.1	93.1	96.2	91.8	82.8	81.8	81.0	77.3
45-49	91.0	93.4	89.4	89.1	83.8	80.7	80.5	76.8
50-54	87.2	88.3	90.6	86.1	77.2	77.1	79.3	70.3
55-59	80.9	81.1	84.6	75.9	71.2	73.5	73.6	64.6
60-64	36.5	36.4	37.9	39.3	36.4	35.2	36.5	36.2
65+	10.2	10.5	9.2	11.3	10.2	10.4	9.2	10.7
15-64	78.1	77.4	77.4	75.0	66.8	66.2	65.2	61.9
Females								
Total	**53.9**	**54.9**	**55.7**	**54.8**	**46.4**	**48.2**	**48.7**	**47.5**
15-19	15.1	13.5	13.3	7.9	9.5	10.1	9.8	5.6
20-24	58.9	59.9	60.2	56.0	48.6	48.5	45.7	41.4
25-29	77.4	84.7	85.4	86.3	64.6	73.4	75.2	77.4
30-34	84.0	86.8	90.2	84.9	74.3	74.7	79.0	72.5
35-39	89.1	90.5	93.9	88.0	80.4	79.9	83.0	79.2
40-44	93.3	95.5	94.1	90.9	80.0	85.5	81.5	79.5
45-49	96.1	93.5	94.0	89.2	78.0	82.8	83.8	77.1
50-54	81.3	85.0	89.8	87.8	70.5	76.5	78.3	73.8
55-59	41.3	44.4	45.3	52.5	38.3	41.1	43.6	46.8
60-64	16.7	15.2	17.4	18.1	16.7	15.0	17.4	17.3
65+	5.1	4.3	3.7	6.1	5.1	4.3	3.7	6.0
15-64	65.3	66.9	68.3	67.1	56.0	58.6	59.6	57.9

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.112.

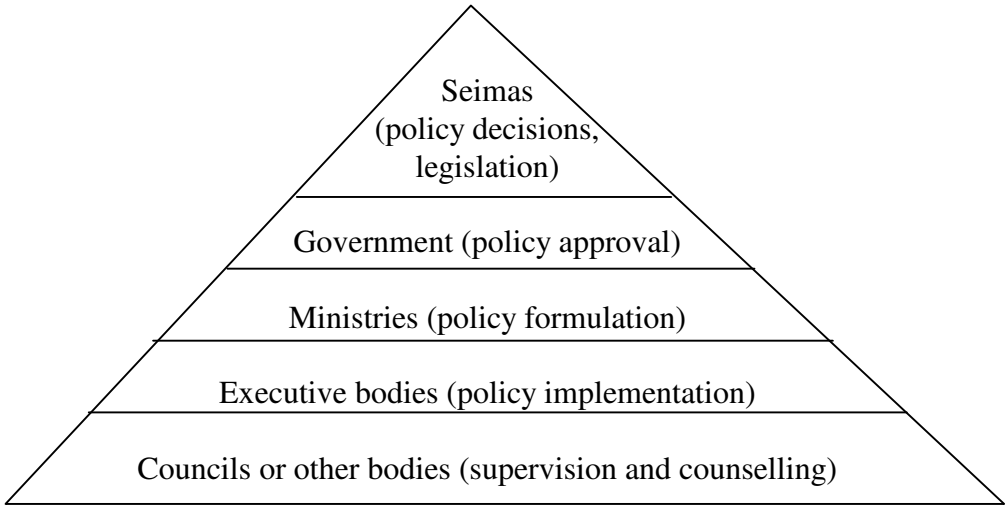
2. OVERVIEW ON THE SOCIAL PROTECTION SYSTEM

2.1 Organisational structure

2.1.1 Overview of the system

The administrative scheme of social protection policy decision-making and its implementation, in principle, is of following levels.

Figure 2.1:



Councils or other supervisory bodies are established at the Government, Ministries or at the Municipalities, that is, on different levels.

The Ministries of Social Security and Labour (MSSL) and Health (MH) are the main institutions responsible for the formulation, supervision of implementation and monitoring of social protection policy**.** Upon fulfilment of these functions the Ministries analyse the current situation, forecast its principal directions, draft laws and governmental decrees, presents them to the Seimas (Parliament) and Government, ensure the functioning, control and improvement of social protection systems, co-ordinate activities of stakeholders and maintain international and public relations. the organisational structure could be further described by the sectors of social protection (see A-E below).

Table 2.1: Responsible ministries and sectors of social protection

<table>
<tr><td colspan="4">Ministry of Social Security and Labour</td><td>Ministry of Health</td></tr>
<tr><td colspan="2">Social security</td><td rowspan="2">(C) Special schemes</td><td rowspan="2">(D) Labour and OSH</td><td rowspan="2">(E) Health insurance (part of (A))</td></tr>
<tr><td>(A) Social insurance</td><td>(B) Social assistance</td></tr>
</table>

(A) Social insurance comprises: (a) pension insurance, (b) sickness and maternity insurance, (c) unemployment insurance, (d) health insurance, (e) labour accidents and occupational diseases insurance.

The MSSL specific tasks in social insurance are: to define current and future objectives of the state social insurance, and to hold inspections of the activities of the State Social Insurance Fund (SSIF).

(A1) Administration of the State Insurance Fund, the pension insurance, the sickness and maternity insurance, and the labour accidents and occupational diseases insurance schemes

State Social Insurance Fund Board (SoDra):

- is the central institution that administers the SSIF and whose main task is to manage the funds and accounts of the State Social Insurance Fund, ensure the collection of contributions and allocation of benefits/funds (Employment Fund, Health Insurance Fund) and their delivery to beneficiaries/other administrators of the funds committed for unemployment and health insurance;
- is the administrator of the social insurance pensions, the sickness and maternity benefits, and labour accidents and occupational diseases benefits.

SoDra through its central office and the local offices is responsible for registering the insurers, collecting the social insurance contributions, maintaining register of insured persons, paying out social insurance benefits and special state scheme allowances (funds for these pensions being allocated to the SSIF from the state budget).

The task of the *State Medical and Social Examination Commission* is to determine the fact and degree of disability, its cause, occurrence time and duration. SoDra has the right to dispute a case of disability determination for a person entitled to a state social insurance pension.

(A2) Administration of unemployment insurance scheme

The *Economic Development and Employment Committee*, established by resolution of Government in 2000, has the task to co-ordinate employment policies of the MSSL, Ministry of Finance, Ministry of Economy, and Ministry of Education and Science.

The *Lithuanian Labour Exchange* at the MSSL administers the unemployment insurance (active and passive measures provided by the Employment Fund). It consists of the National and 46 local labour exchanges. Lithuanian Labour Exchange implements state employment policy by:

- analysis and forecasting of labour supply and demand;
- registration of available job vacancies and unemployed individuals; mediates the employment of citizens;
- organisation of support for employment through active measures financed from the Employment Fund;

- giving recommendations concerning the administration the Employment Fund finances;
- preparation of national and territorial employment and unemployment prevention programs;
- mediation of employment of Lithuanian citizens abroad and foreigners in Lithuania;
- publication of labour market statistical information.

The *Lithuanian Labour Market Training Authority* provides vocational training, guidance and counselling for employers, training institutions, job-seekers, etc. It also supervises the implementation and quality of labour market vocational training. The Lithuanian Labour Market Training Authority itself acts according to regulations specified in the Law on Vocational Education and Training and the Law on Support for the Unemployed, as defined by the order of the Ministry of Social Security and Labour, and other legal statements. It has 6 subordinate regional services and 14 labour market training centres.

(A3) Administration of health insurance scheme

State and Territorial Patients Funds (SPF and TPF) administer the Health Insurance scheme (Health Insurance Fund). The SPF is the main manager of the Health Insurance Fund and performs the financial and economic analysis of the use of these resources. It also conducts general supervision of TPFs, carries out the audit of TPFs, appoints TPFs directors, etc.

TPFs:

- conclude contracts with health insurance institutions and pay them for the services provided to the insured persons;
- reimburse medical costs to insured persons;
- keep the register of persons insured by compulsory health insurance;
- organise and finance certain health monitoring measures;
- carry out quality control of individual health care services and monitor financial efficiency;;
- perform other functions prescribed by law.

(B) Social assistance *comprises two types of benefits:*

- Social assistance in cash
- Social services

Both are administered by *municipal social assistance administrations* with two exceptions: (a) inter-regional permanent social care institutions are administered by social security administrations of the counties; (b) maternity (pregnancy) benefit for female students and orphan's grant are administered by the respective educational establishment.

The *Service of Adoption at MSSL* has been established recently. Its aim is to organise national and international adoption, to co-ordinate adoption activities of *Municipal Agencies for the Rights of the Child*. The Service of Adoption at MSSL mainly collects and analyses information related to adoption.

(C) Special schemes

These schemes are additional to the general social security system. The main benefits under the special schemes include pensions for merited people, pensions for persons, who have been persecuted in the past, scientists, actors, etc. A *commission appointed by Government* administers the benefits paid under special schemes.

(D) Labour and OSH

It is the responsibility of the employers to implement regulations in the area of labour relations and OSH. The State Labour Inspectorate controls labour relations and work safety.. The *State Labour Inspectorate*:

- provides consultancy, information and work safety services to employees, their professional unions and employers;
- checks compliance of work safety organisation, working conditions, etc. with OHS legal requirements;
- investigates serious accidents at work, also with death involvement, circumstances and causes of professional diseases;
- carry out other functions prescribed by Law.

(E) See A3

2.1.2 Centralisation/De-centralisation of the system

(A) Social insurance and (D) Labour and OSH

Administrative bodies: The main administrative body – SoDra is a semi-independent institution and its budget is separated from the State budget. The Government may influence SoDra's activities through the SSIF Council. Almost the same level of independence characterises the State and Territorial Patient Funds (see 2.1.3). SoDra has 52 local offices in almost all municipalities. There are ten TPFs, one in every county of Lithuania.

Other administrative bodies involved in social protection (State Medical and Social Examination Commission, Lithuanian Labour Exchange, The Lithuanian Labour Market Training Authority, State Labour Inspectorate) are subordinated to the MSSL. They also have territorial branches and there is tendency of further regional and local expansion in order to ensure better accessibility to related services.

However, decision-making in all mentioned administrative bodies is highly centralised.

Other Stakeholders: Employers have to calculate, to deduct and to pay state social insurance contributions of the insured persons income to the budget of the State Social Insurance Fund.

Employers and employees organisations also are participating in different supervisory Councils (2.1.3).

Private insurance: Private insurance companies implement voluntary pension, health and labour accidents insurance. Legislation provides some tax advantages for payer of contributions.

(B) Social assistance

Administrative bodies: Both kinds of social assistance (in-cash and in-kind) are decentralised on municipal level. Central Government, MSSL have influence mainly through legislation, co-ordination, and programme development. It is envisaged to transfer permanent social care institutions from counties to municipalities.

Other Stakeholders: Some NGOs provide different social services. Central and local governments financially support and use NGOs for social services delivery on their behalf.

2.1.3 Supervision

(A) Social insurance

The Council of the State Social Insurance Fund is the supervisory body of the SSIF. The Council is formed on the tripartite principle: five of its members represent trade unions, five – employers' organisations, and five - governmental institutions (as a rule, the vice ministers of the MSSL, MH and Ministry of Finance). The members of the Council are nominated by the corresponding parties and approved by the Government. The Minister of Social Security and Labour or his/her authorised representative is the chairman of the Council.

The responsibilities of the Council include:

- Monitoring the implementation of legal instruments regulating social insurance and giving recommendations.
- Presenting recommendations to the Lithuanian Government.
- Reviewing and making recommendations on the draft State social insurance budgets and annual reports.
- Reviewing and making recommendations on the number of employees, social insurance organisational expenses and employee salaries
- Confirming the methodologies for the calculation of the minimum living allowances as defined in the Law on Social Insurance Pensions, etc.

Unemployment insurance: *Tripartite committees* are associated with the National (9 members) and local (6 members each) labour exchange offices. They review the activities of labour exchange offices and submit proposals for their improvement. The commissions consist of representatives of trade unions, employers and public authorities.

The *Employment Council at the MSSL* (15 members). Its responsibilities include the investigation of employment problems and the factors underlying them, and submitting proposals to the MSSL on labour market policy and its implementation.

The *Lithuanian Vocational Training Council* was created by the Law on Vocational Education and Training. This council is a national tripartite body to advise both the Ministry of Education and Science and the MSSL on strategic policy issues.

An *Expert Council* (15 members) established on a tripartite basis aims at providing assistance to the Lithuanian Labour Market Training Authority in the development of the system of labour market vocational education, training and consultation, and in improvement of its relations with labour market partners.

Health insurance: The *Council of Compulsory Health Insurance* is composed of representatives of the Government, Patient funds, medical institutions, local governments, trade unions of physicians and other trade unions. The Government appoints the members of the Council. The Council has only an advisory vote in settling major issues such as proposals regarding the health care services lists and the prices, which are covered from health insurance resources (the final decision remains within the competence of the MH). It also nominates the director of the SPF, submits the draft budget of the health insurance fund for approval and submits its annual financial statements for the approval of the Government. The Council establishes the number of the staff of Patient Funds, their salaries, etc.

TPFs are also supervised by local Supervisory Boards. These boards consist of one representative of the respective NPF, the county medical doctor and 2 representatives from each Municipal Council within the district.

(B) Social assistance

MSSL is responsible for supervision of inter-regional permanent social care institutions. Supervision of locally provided social assistance is responsibility of each Municipality. Obligatory assessment of social workers is introduced.

The *Council of the Disabled Affairs* under the Lithuanian Government helps to implement the Law On Social Integration of the Disabled. The

coordinating committee of the Council comprises representatives from public organisations of the disabled and those from state institutions.

(D) Labour and OSH

The *Tripartite Council of the Republic of Lithuania* analyse labour relations and OSH issues, submits observations and recommendations to the Seimas and the Government. The council is formed from the employees, employer organisations and the representatives of Government (five representatives from each party). It follows issues provided for in Convention of the International Labour Organisation No. 144 "Concerning Tripartite Consultations to Implement International Labour Standards".

2.2 Financing of social protection

2.2.1 Financing sources

(A) Social insurance

The social insurance is financed from the extra-budgetary State Social Insurance Fund (SSIF). This is sole source for the pension insurance, the sickness and maternity insurance, and labour accidents and occupational diseases insurance schemes financing.

Unemployment insurance: This scheme is financed from the Employment Fund, which receives funds transferred to it by SSIF. It **may** have other sources: Labour Exchange income, charity contributions, State budget subsidies, etc. Employment Fund's sources are not strictly determined compare, for example, with Compulsory Health Insurance Fund (see below), so it's financing usually is unpredictable or residual.

Health insurance: The financial basis of compulsory health insurance is the independent Compulsory Health Insurance Fund budget (annually approved by the Government) which is not included in the National budget. The Health Insurance Fund is financed by the following:

- Transfers from SSIF;
- Transfers from National budget. This part comprises 30% percent of the personal income tax paid by the workers and self-employed people;
- Contributions of the farmers who pay for themselves and their adult family members working on the farm, amounting to 3.5% of the official minimal wage;
- Contributions of the small land users who pay for themselves and their adult family members working on the farm, amounting to 1.5% of the official minimal wage;
- Contributions of other people (if they are not insured by the State), who pay 10% of the average wage in the country;

- Contributions by the State in the amount approved within the State budget supplementing the contributions for people insured by the State.

(B) Social assistance

The system of social assistance complements the non-insurance part of social security. Social assistance in cash is financed from Municipal budgets.

The provision of social services is financed from the State and Municipal budgets, special funds, the funds of enterprises, institutions or organisations, charges for social services, charity contributions and other resources. There is a charge for social services (except for information and consultation). If the person receiving social services or the members of his family are unable to pay for the social services rendered, these services may be paid for from the State or municipal budget according to the procedure established by the Government.

(C) Special scheme and (D) Labour and OSH scheme are financed from the State budget.

2.2.2 Financing principles

Social insurance is financed entirely in accordance with the pay-as-you-go principle. Social insurance contributions are the basic and most significant source of income of the SSIF budget. They account for 98 per cent of total income. The state budget is the solvency guarantee for SSIF. Part of SSIF budget is reallocated to Employment and Health Insurance funds.

Social assistance and other schemes (non-insurance) are financed from the State and Municipal budgets collected from general taxes. There are some rules adopted for the substantiation of the budget means allocation: programme budgeting; evaluation of the needs for administrative functions financing, etc.

2.2.3 Financial administration

Social insurance: The SSIF budget is drawn up and deliberated by the Council of the Fund and is presented for the approval of the Government together with the opinion of the Council. Having approved the Government presents the budget to the Seimas (Parliament) for the final approval. Propositions for the determination of the compulsory insurance contributions are also presented to the Seimas. The final decision on the SSIF budget and the contribution rates is taken by Seimas by adopting a special law.

Upper ceiling of contributions have been approved and rejected by Seimas twice during the past decade. Minimum threshold have been never discussed. Now there is nor a lower threshold neither an upper ceiling for contributions. Benefits, conversely, e.g. basic pension, and “k” and K” in old

age pension equation, usually have a lower threshold and an upper ceiling (see 2.3.5).

Employers and self-employed persons themselves calculate compulsory contributions, as well as transfer them to the respective accounts. The amount of individual contributions of the insured is registered in the SSIF data base with an entry in individual accounts.. These records serve as the basis for the calculation of benefits. Contributions made by the insurer and the insured are calculated as percentage of the wage paid to the insured. These contributions are divided to the different schemes of social insurance in following manner:

Table 2.2: Social insurance contribution rates (in % of employee's gross wage)

	Employer	**Employee**	**Total**
Pension insurance	22.5	2.5	25.0
Sickness and maternity insurance	3.0	0.5	3.5
Health insurance	3.0	0.0	3.0
Unemployment insurance	1.5	0	1.5
Labour accidents and occupational diseases insurance	1.0	1	1.0
Total	31.0	3.0	34.0

For Health Insurance see 2.2.1.

For Social Assistance see 2.2.2. Municipal budgets are formed mainly from natural persons income tax and State budget subsidies (the lower revenues from natural persons income tax, the higher demand for State budget subsidies).

2.3 Overview of Allowances

Social insurance as well as social assistance payments are non-taxable (sickness, motherhood/fatherhood benefits exclusive).

2.3.1 Health care

The entire population is legally granted guaranteed emergency care. Free (totally or partially) provision of other than emergency care is set for the compulsory insured population.

By compulsory health insurance are covered:

- employees and other contributions' payers (see 2.2.1 Health insurance);
- residents insured by the State. There are 14 categories of such persons (usually for serious reasons non-working population).

The costs of the following health care services are covered by the compulsory health insurance fund: (a) preventive medical care, (b)

restorative medical care, (c) medical rehabilitation, nursing, social services attributed to individual health care, (d) individual health examination.

Individual health care, restorative medical care services the costs of which are covered from the compulsory health insurance fund are specified in a list. Reimbursement of expenses related to the essential medicines and medical aids, and medical rehabilitation is based on the basic price. Reimbursement ratios vary from 50 to 100 percent. Compensations for sanatoriums/resort treatment are paid only for one medical treatment course at sanatoriums/resorts per calendar year.

2.3.2 Sickness

The sickness and maternity insurance scheme is obligatory only for employees and a few other categories of workers receiving remuneration for their work. Others may join the scheme voluntarily according to the specific rules.

Sickness benefit is paid to persons who fall ill, who are nursing invalid family members, who are undergoing treatment in a prosthetic-orthopaedic hospital, in case of an outbreak of an infectious disease; and in a few other cases.

A sickness benefit is awarded under the following qualifying conditions:

- if on the day when a temporary sickness is officially diagnosed, the person had been insured under the sickness and maternity social insurance scheme for at least 3 months in the last 12 month period or 6 months in the last 24-month period;
- if the right to receive a sickness benefit arises while working under an employment contract, during the term of probation at work, or on the dismissal day. In the case of a dismissal, the employee retains the right to the sickness benefit during his/her annual paid vacation, but the severance pay (if any does not extend that right).

For the first two days of sickness the benefit (paid by the employer) amount should be no less than 80 percent of the average wage of the employee. The sickness benefit paid by the SSIF (from the third day on the sickness) is equal to 85 percent of the average compensatory wage of the beneficiary. The compensatory wage may not exceed 3.5 average wages as approved by the Government.

The sickness benefit is paid until the working capacity is regained. If, after established period of time, the person has not recovered, it is obligatory to apply to the State Medical and Social Examination Commission, which is responsible for the determination of disability. Sickness benefits for insured persons who receive state social insurance disability pensions are paid for no more than 30 calendar days per year. In cases where a person undergoes in-patient treatment for alcoholism or drug addiction voluntarily, he/she is

entitled to receive a sickness benefit for no longer than 14 days once in a calendar year.

The sickness benefit is also paid in the case of nursing an insured family member. It is paid from the first day of nursing for no longer than 7 days. While nursing a child who is under 14, the benefit is paid by the SSIF beginning with the first day of nursing but for no longer than 14 days. While nursing a child under 7 in an in-patient clinic or a child under 16 who suffers from a serious illness, the benefit is paid from the first day during the whole time of treatment but for no longer than 120 days per year.

The sickness benefits are not payable to persons who have lost their capacity to work due to an injury while committing an offence, who damage their own health intentionally or whose sickness is the result of alcoholism or drug addiction.

2.3.3 Maternity

Maternity Benefit is paid to insured pregnant women who are entitled to the maternity leave under the same qualifying conditions like sickness benefit.

Women who give birth to a baby after 28 weeks or more of pregnancy receive benefits for 70 calendar days preceding the delivery and 56 days after the delivery. In cases of complicated deliveries or if more than one baby is born, benefits are payable for 70 days after the delivery. Women who give birth to a baby after 22 - 28 weeks of pregnancy are paid benefits for 28 days after the delivery (if the baby survives 28 days and more, the benefits are payable for 70 days after the delivery). The maternity benefit is equal to 100 percent of the average compensatory wage of the beneficiary.

The state social insurance *Maternity (Paternity) Benefit* is paid to one of the parents covered by state social sickness and maternity insurance, taking care of a child until he turns one year old. Eligibility: a person must have a sickness and maternity social insurance record of at least 7 months in the last 24 months period before the day child care leave is taken. Maternity (paternity) benefit is equal to 60 percent of the average compensatory wage of the beneficiary. Maternity (paternity) benefit is paid from the next day after the maternity leave ends until the baby turns one year old.

The *non-insurance based maternity type benefits*: A *Child-Birth Grant* is paid to every woman who gives birth to a baby (except in cases where the mother abandons or refuses to bring up the baby). The grant is 6 MSLs (Minimum Subsistence Level, currently = 125 Litas) for every baby born.

The *Maternity (Pregnancy) Benefit for Female Students* is paid to pregnant women who study full time at educational establishments and who are not entitled to the social sickness or maternity insurance maternity benefit. The benefit is equal to 75 percent of the MSL per month paid for 70 days during the prenatal period.

The *Family Benefit* is paid to families that are not entitled to the social sickness or maternity insurance benefit; the family benefit is paid from the moment the baby is born up to its third birthday. The family benefit for a family entitled to maternity (paternity) insurance benefit is paid in the period between the baby's first and third birthdays. In both cases the benefit is paid at the request of one of the parents and is equal to 75 percent of the MSL per month for every child.

2.3.4 Invalidity and Long-term care

There are three disability groups distinguished on the degree of incapacity for work. Persons belonging to Group 1 are most often incapable of any work and a majority of them need long-term care. Group 2 includes persons who are usually incapable of work. Persons belonging to Group 3 are considered to have a partial capacity for work.

Disability pension: A disabled person will acquire the right to draw a state social insurance disability pension if on the day the disability is determined he/she has a minimum state social insurance period, which depends on the person's age.

The amount of disability pension depends on both the entire insurance period and the insured period acquired while working under an employment contract. The state social insurance disability pension consists of the main part and the supplementary part. Both parts of the disability pension of Group 2 are calculated in the same way like the old age pension (*see 2.3.5*). The main part of the disability pension paid to the disabled of Group 1 is 50% higher. Group 3 receives half of the disability pension for the disabled of Group 2.

Long-term care: For treatment at sanatoriums/resorts see 2.3.1.

Non-insurance based disability related benefits: Long-term care also may be available under the schemes of social assistance in-cash (e.g. nursing benefit equals to basic pension – see 2.3.5) or in kind. Latter includes: provision of services in nursing homes, in permanent social care institutions, at beneficiary home, allowance in cash (care money) paid to nursing for social services rendered. *These social services, except the nursing benefit, are applied also to elderly and children.* Municipal commission decides of the services rendered, but usually persons have to be on a waiting list, because of the shortage of such services (especially in-patient houses).

Other invalidity benefits: There are also other benefits in-cash and in-kind for disabled people provided by legislation, e.g.:

- Compensation for transport costs (for disabled persons, who are eligible to acquire a special car and are able to drive it, but do not have it; monthly allowance of 0.25 MSL);

- Compensation for a purchase of special car (for disabled persons, who are eligible to acquire special car and are able to drive it; paid once per 6 years of 32 MSL);
- Social rehabilitation, day care and medium-term hostel care services, etc.

2.3.5 Old-age

A person is entitled to a state social insurance *old age pension* if he/she meets all of the following requirements:

- reaches the retirement age;
- was insured under the pension insurance scheme for at least 15 years.

The state social insurance old age pension consists of two parts: the main part and the supplementary part. The main part equals the basic pension (138 Litas), which is a flat-rate payment to all the insured who have paid contributions for the mandatory insurance period (for those who have not paid contributions for the mandatory period the basic pension is reduced proportionately). The supplementary part of the state social insurance old age pension is paid only to those persons who have made state social insurance contributions for the required period while working under a labour contract (or any other contract treated as a labour contract). This part of the pension is earnings-related and depends on the insurance period and wages.. Self-employed people make obligatory contributions only for the basic pension.

The old age and disability pensions are paid monthly. After the pensioner's death, a payment equal to his/her pension for two months is made as a funeral benefit.

The non-insurance based *social pension* is paid under a special pension scheme provided to those elderly and disabled people who are not entitled to receive the social insurance pension. The social pension usually is equal to the basic state social insurance pension. The disabled of Group 1 are paid a supplement equal to 50 percent of the basic pension. The disabled of Group 3 get only half of the basic pension.

2.3.6 Survivors

The spouse and children of the deceased are eligible to receive a pension for surviving spouses and orphans if the deceased was entitled to draw the state social insurance disability or old age pension. The orphan's pension is payable to the deceased person's children under 18. The pension is also paid to children older than 18 if they became disabled before reaching the age of 18 or if they are full time (up to the age of 24) students.

The widow(er)'s and orphan's pensions are based on the disability pension for Disability Group 2. When a person dies, it is assumed that at the moment of his/her death he/she would have been awarded the disability

pension of Group 2. The amount of the disability pension is paid in the following way: 20 percent is paid to the widow(er), 80 percent is divided equally among his/her orphans (but no more than 25 percent of the amount for one orphan). When an old age or disability pensioner dies, his/her pension is calculated and divided in the above manner between the survivor and the orphans. Orphans who have lost both their parents are entitled to the pensions of both parents.

Non-insurance based survivors' benefits: The *orphans' grant* is equal to 4 MSLs for orphans enrolled in higher, tertiary or vocational schools regardless of any other grant he/she receives, with one exception: if an orphan is entitled to an orphans pension, he is paid only the difference between the orphans pension and the orphans grant.

The *Settlement Grant* is paid to orphans and foster children who have been brought up in orphanages or by individual persons after they reach the age of 18. The grant amounts to 50 MSLs and is paid only if the beneficiary is no longer supported by the State.

Foster Benefit is paid to persons or non-state care institutions that foster children left without the care of their parents. The amount of the benefit is equivalent to 4 MSLs monthly for each orphan or foster child until he/she reaches the age of 18 (if the child who is older than 18 attends school, the benefit is continued to be paid directly to him until he finishes secondary school).

2.3.7 Employment injuries and occupational diseases

All employees are insured under this branch of insurance. The contributions are paid by the employer, and benefits are paid by the State Social Insurance Fund. No insurance period is required. There are five types of benefits: (a) sickness benefit; (b) Lump-sum compensation; (c) periodical compensation; (d) funeral benefit; (e) regular compensations for the dependants of a deceased person.

The sickness benefit is equal to 100 percent of the compensatory wage and is from the first day of incapacity for work until recovery or the approval of permanent disability. Compensatory wage may not be higher than 350 percent of the average insured income valid at the moment when the labour accident occurs.

Lump-sum compensation payment is paid where an insured person has lost less than 30 percent of capacity for work. The compensation payment is equal to 10% of the compensatory wage of the insured person during the last 24 months if the lost capacity for work is not more than 20%. If the lost capacity is between 20 and 30%, the lump sum compensation is equal to 20% of the compensatory wage of the beneficiary during the last 24 months. If the lost capacity for work is recognised as permanent, the lump sum compensation for each of the cases described above is trebled.

Periodical compensation payments are paid where the lost capacity for work is 30% or higher. The compensation is paid monthly and it's value depends on ratio of lost capacity for work (between 0.3 and 1) and monthly average wage.

The funeral benefit is paid to the family of the person who died as a result of a labour accident. The benefit is equal to 100 insured income amounts and is equally divided among the family members.

The non-working dependants of the deceased and the child/children of the deceased born after his/her death are eligible for *regular compensations* if the person died as a result of a labour accident. Regular compensations are calculated according to the equation presented above, where d=1; then, it is divided by the number of the dependants plus one and paid every month to each of the dependants.

Non-insurance based compensations of occupational injury and sickness. For the persons, victimised for occupational injury or sickness, in case they have not rights for insurance compensations (e.g. in the case of changes in the property forms), is paid: (a) work disablement indemnity (grant), (b) work disablement indemnity (pension), (c) survivor's benefit.

2.3.8 Family benefits

They are non-contributory. The *Benefit to Families with Three or More Children* is paid to families with children under 16 years of age (above the age of 16 if the children attend school or are full-time students). The benefit is equal to 1 MSL monthly and is increased by 0.3 MSL for the fourth and every next child. The benefit to families with 3 children (but not with 4 or more) is income-tested: it is paid only to families the income of which per family member is less 3 times than the 'state-supported income' (currently 135 Litas).

The Benefit to the Families of Military Conscripts is paid during the time of the compulsory military service for each child of the conscript at 150 percent of MSL.

See also 2.3.3 and 2.3.6 for non-contributory benefits, which are paid by the same legislation, concerning state benefits for families.

2.3.9 Unemployment

Unemployment benefits are granted to unemployed persons who had been contributing (or their employer had been contributing) to social insurance for 24 months or more in the last three years before the registration at the Labour Exchange Office.. The period of 24 months of contributions is not required where the unemployed has been dismissed for reasons beyond his/her control. This right to unemployment benefits is also extended to

certain categories of persons who have not contributed to social insurance due to some important reasons.

The unemployment benefit may not be less than the state supported income and may not be higher than two MSLs and depends on beneficiary's state social insurance period. Unemployment benefits are, as a rule, payable from the 8th day after the registration at the Labour Exchange. Unemployment benefits are paid monthly but not longer than for a period of 6 months in every 12 months. For the unemployed who are 5 years prior to retirement age payments are extended for another two months. For the unemployed who are one year prior to retirement age payments are extended until the retirement age.

Active labour market programmes: For those who do not have a profession or have non-marketable profession or for individuals with difficulties to be integrated into the labour market, the labour exchange offers active labour market policy programs: (a) vocational training, (b) public works, (c) works financed from the Employment Fund, (d) starting of own business, (e) job clubs, etc. Unfortunately, from the total expenditure on unemployment of 175.5 million Litas on active labour market programmes have been spend only 39.1 million Litas or 22.3% in 2000. The rest are unemployment benefits, but at present, only 15% of registered unemployed are receiving unemployment benefit.

2.3.10 Minimum resources/social assistance

The Social Benefit is the main form of assistance in cash to low-income families. It applies to families in which able-bodied persons work (or do not work due to valid reasons), but their earnings are not sufficient. There are important exclusions when a family may be actually destitute, but is not eligible for a Social Benefit (see 4.2.2). The benefit level is 90 percent of the difference between the 'state-supported income' (currently 135 Litas per capita) and the actual family income per month per capita. Having tested the living conditions of a family, municipalities have an extended right to award benefit, to terminate it payment, to pay in-kind, etc. The benefit is calculated and payable for a period of three months. At the end of this period, the recipient may apply again for support.

Compensation of Cost of House Heating and of Hot and Cold Water for Families of Low Income: The heating, hot and cold water costs above the standard norms are not compensated for. Other costs are compensated for in the following way: a household should not spend more than 2% of its income for the supply of the standard quantity of cold water, not more than 5% of its income for the supply of the standard quantity of hot water, and not more than 25% of the part of the family income above the minimal income for the heating of a certain standard floor area. The minimal income of a family is defined as MSL multiplied by the number of the family members. If the costs of heating and water supply are higher than the percentages indicated above, compensatory payments are paid from the local

budget. The local social assistance units verify whether the family is entitled to compensation and transfer the data to the suppliers of heat who calculate the amount of compensation and present the bill to the local budget.

Social assistance in-kind, provided by Municipalities, is an important part assuring development of strong and supportive families, safety of women and children within their family and in community. These are e.g. medium-term hostel care for women and children who experienced violence, crisis centres, etc. (these services strongly developed also in the NGO sector). . Free of charge catering of school children of low-income families and lifting children to the school in rural regions helps to increase school attendance and learning quality.

2.4 Summary: Main principles and mechanisms of the social protection system

The overall social protection system in Lithuania is citizen-centred. t comprises two main branches, which are social insurance and social assistance, however:

- There are several special schemes additional to the general social security system and benefits under these schemes are paid for "merited" people who did not earn insurance and do not need assistance;
- Social assistance system is constructed in the way of equalisation of non-insured persons to insured (e.g. maternity and maternity/paternity benefits are paid to both categories of citizens);
- At the same time social assistance and social insurance administrations are separated and even do not see the corporate beneficiary as potential tax and contribution payer;
- Most social insurance schemes provide benefits to insured persons, but some of them are insured by State (e.g. health insurance), or may have some privileges which are not associated with actual insurance payments and periods or market conditions (e.g. unemployment insurance);
- There is no nor lower threshold neither upper ceiling for social insurance contributions. Benefits, conversely, usually have lower threshold and upper ceiling (e.g. old age pensions), i.e. contributions are expected from employees, benefits are donated for needy;
- Administration of social protection is highly centralised (Municipalities mainly implementing national social protection/assistance schemes), so citizens, i.e. electorate, but not contribution and tax payers, govern political decisions;
- Almost every regulation of social protection, even regulation of means-tested Social Benefit, includes the list of the eligible people.

Under such circumstances contribution and tax payers have a higher risk to be excluded from social protection system, than somebody who never tried to find a job. The solidarity principle is basic for a social protection system, but in Lithuania it is excessive in sense of implementation.

Pay-as-you-go system predominates and accumulative (funded) insurance do not exist, while 'voluntary' insurance fit most only to the informal sector: because contributions' ceiling does not exist, they have to be paid them from gross wage. If the employment is legal, it is too expensive to have also a voluntary insurance. If employment is illegal and person does not need to pay social insurance contributions, voluntary insurance may be affordable.

3. PENSIONS

3.1 Evaluation of current structures

3.1.1 Public-private mix

Three pillars

Pension systems are usually divided into three distinct pillars: statutory public schemes (first pillar), occupational schemes (second pillar) and individual retirement provision (third pillar). The current situation in Lithuania is as follows:

The First pillar consists of ***mandatory*** state social insurance pensions financed from the State Social Insurance Fund budget, state pensions and assistance (social) pensions financed from the state budget. The major portion in the system is comprised of state social insurance pensions. They account for 90% of all the expenditure allocated to pensions.

The Second pillar – a ***compulsory*** accumulation to pension funds existed only like a concept of a pension system reform (see 3.3.2) before adoption of The Law on the Pension Scheme Reform at the end of 2002.

The Third pillar – is a ***voluntary*** accumulation for old age to pension funds or insurance companies exists as a part of the overall voluntary life insurance and has been complemented by the provisions of the before mentioned Law on the Pension Scheme Reform.

Tax incentives to participate in the third pillar

In the case of voluntary life insurance (which includes pension insurance schemes), insurance contributions are deductible from the taxable income under conditions that:

- the insurance period shall not be shorter than 10 years;
- the annual insurance contributions shall not exceed the amount of 4 Minimum monthly wages (currently 430 x 4 = 1720 Litas); thus, the maximum annual deduction from income tax equals to 1720 x 0.33 (natural persons' income tax rate) = 567.6 Litas).

Private insurers suppose that such a tax exemption is quite sufficient for their business. Since this privilege is applied to life, accidents and sickness insurance, the pension insurance comprises only a small part of the said insurance branches.

In June 1999 Seimas (Parliament of Lithuania) adopted the Law on pension funds, but not a single pension fund has been established yet.

The Law on the Pension Scheme Reform (2002.12.03) proposes to establish:

- that all the individuals who are insured for the entire state social insurance pension, should have the right to participate voluntary in accumulation of a portion of the social insurance pension contribution in pension funds and at life insurance companies;

- that the pension accumulation contribution forms a part of the tariff of the state social insurance contributions of the insured individual and the amount of the general tariff of the state social insurance contribution shall not be increased by the size of the accumulation contribution;

- that in implementing this regulation from 2005 to 2007 the Seimas of the Republic of Lithuania shall have to distribute the general tariff of the state social insurance contribution (34 per cent), by decreasing the tariff of the state social insurance contribution paid by the employer every year specified above by 1 percentage point (up to 28 per cent in 2007), by increasing the tariff of the state social insurance contribution of the insured person (up to 5.5 per cent in the year 2007).

that for the period prior to a person's participation in the pension accumulation, the size of the state social insurance pension will remain unchanged. It has also been established that pensions awarded will not decrease on account of the reform.

In general, the incentives to participate in the voluntary pension schemes are restricted by mandatory state insurance pensions regulations. For example, on 1 November 1999 Seimas repealed the contributions' ceiling – earnings of 3.5 and more of the national average monthly wage from which contributions were not to be paid. This ceiling was valid for a very short period, only from 1 January 1999. At the same time the ceiling for calculation of pensions exists (the rate of person's insurable income shall be taken not higher than 5 – see 3.1.2.1). Such a regulation, on the one hand, is limiting willingness to pay / receive higher wages from which contributions have to be paid, but pensions are not calculated. On the other hand, it creates high contributions' burden and limited availability of personal resources for voluntary pensions schemes.

Nevertheless, life insurance business is one of the most dynamic activities. During the period of 1995-1997 life and non-life insurance gross premiums increased 1,7 times and claims paid – 2 times. Moreover, during the next 3 years the life insurance growth accelerated (see table below). This reflects the increasing potential for voluntary pension schemes.

Table 3.1: Life insurance gross premiums written and claims paid by institutional sectors

	1998	**1999**	**2000**	**2000/1998**
	thous. litas			%
Gross premiums written	**17405**	**32826**	**45238**	260%
General Government	-	-	-	-
Financial enterprises	-	-	989	-
Non-financial enterprises	-	1443	2055	-
Non-profit institutions serving households (inhabitants)	-	-	-	
Households (inhabitants)	17405	3138,3	42194	242%
Non-residents	-	-	-	-
Claims paid	**1189**	**3055**	**7279**	612%
General Government	-	-	-	-
Financial enterprises	-	-	-	-
Non-financial enterprises	43	173	353	821%
Non-profit institutions serving households (inhabitants)	-	-	-	-
Households (inhabitants)	1146	2882	6926	604%
Non-residents	-	-	-	-

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.394

Risks covered by pension schemes

State social insurance pensions

The state social insurance (SSI) pensions scheme is based on the principles of universality, solidarity of generations, continuity and fulfilment of undertaken obligations. The SSI system is functioning according to the pay-as-you-go principle. Although this system is ***mandatory,*** there are possibilities for some categories to join the social insurance pension scheme on a ***voluntary*** basis:

- Individuals not younger than 16 years of age, at the time when they are not insured by the compulsory state social pension insurance have the right to insure themselves by the voluntary pension insurance individually to receive the basic part of the pension or the basic and additional part of the pension.
- Persons specified in subparagraphs 7-13 of the first part of Article 2 of the Law on SSI Pensions (farmers, persons who have acquired patents, National Defence conscripts, clergymen and mothers / fathers on three-year maternity leave, one of the parents who takes care of the person with total invalidity at home), who are insured by the compulsory pension insurance to receive only the basic part of the pension, have the right to insure

themselves by the voluntary pension insurance individually to receive an additional part of the pension.

The SSI pensions scheme covers the main risks: old age, disability, survivors', by providing corresponding pensions. There are two kinds of payments – pension for the actual time worked (service pension) and periodic compensation for the lost ability to work – which were granted before the Law on SSI Pensions came into force (1995). Widow(er)s' and orphans' pensions are paid alongside with the old age and invalidity pensions.

Social pensions

Social pensions and related compensations are provided for by the law and are also related to old age, disability, survivors'. Social pensions are awarded to persons who have reached pensionable age or became disabled (also from childhood) and ***who have no right to receive a higher SSI pension***. The social pension or compensation (5 years against retirement age) is also paid to those who have raised their disabled children for at least 15 years and to mothers who gave birth to and raised 5 or more children up to 8 years of age. Social pensions and compensations are equal to the 0.5-1.5 amount of the SSI basic pension.

The state pensions

The state pension system consists of the following state pensions:

- state pension of the President of the Republic of Lithuania;
- state pensions of the first and the second degree of the Republic of Lithuania;
- state pensions of the deprived persons;
- state pensions of officers and soldiers;
- state pensions of research workers.

The state pensions of the first and the second degree of the Republic of Lithuania and state pensions of the deprived persons are awarded and paid in accordance with the Law on State Pensions of the Republic of Lithuania. The state pension of the President of the Republic of Lithuania, state pensions of officers and soldiers and state pensions of research workers are awarded and paid pursuant to special laws. All state pensions are paid from the funds of the state budget.

The pension reform of 1995 abolished the special right of early retirement for certain occupational groups of people who had worked under severe conditions or were pilots, ballet dancers, etc. According to the transitional provisions of the new Law these people are entitled to compensatory payments. These payments (with a few exceptions) are equal to 150 percent

of the SSI basic monthly pension and their payment starts before the usual retirement age.

All state pensions (with an exception of state pensions of the officers and soldiers, and the artists' annuities) are awarded and paid to persons who receive state social insurance pensions. This means that the state applies double pension guarantees towards persons of certain occupational or social groups in the event of old age, disability or widowhood.

In general, the state pensions scheme (with an exception of state pensions of the officers and soldiers) is not directly related to usual risks but rather to some social risks. It creates privileges for certain groups of inhabitants and violates the principal of social justice.

Risk of poverty

Higher reimbursement rates for the costs of medicine and medical aid, treatment in a sanatorium, are applied for elderly people. Persons those are 5 years before retirement age may get unemployment benefits two months longer than other unemployed persons. Means tested benefits are applied to elderly like general scheme (see 2.3.10).

Family role

In accordance with the Civil Code of Lithuania the adult children, even grandchildren, have to maintain, patronize and support their disabled or needful parents (grandparents).

Income in old age

Despite sophisticated pensions system and other benefits provided to elderly people their households income is lower than average and comprises only ¾ of the disposable income of hired workers' households. Pensioners have more sufficient income from self-employment in agriculture than from the employment (see table 3.2 below).

Family support received is higher in the younger age groups, whereas the engagement in collection of natural products is quite important in older age groups (see table 3.3 below).

Table 3.2: Average disposable income by socio-economic group of household head in 2000 (per capita per month)

	All households	**Hired workers**	**Pensioners**		**Pensioners compared to hired workers**
	in Litas	in Litas	in Litas	%	%
Disposable income	415.4	463.3	360.5	100.0%	77.8%
Income from employment	216.3	339.6	23.2	6.4%	6.8%
Income from self employment	50.5	26.8	35.2	9.8%	131.3%
Income from agriculture	31.4	20.9	33.4	9.3%	159.8%
Income from business, handicrafts, free professional activity	17.9	4.8	0.7	0.2%	14.6%
Income from other activities (non business)	1.2	1.2	1.1	0.3%	91.7%
Income from property	0.3	0.3	0.4	0.1%	133.3%
Income from rent	1.2	1.1	0.2	0.1%	18.2%
Retirement pensions	62	20.1	205.5	57.0%	1022.4%
Unemployment benefit	1.6	1.1	0.6	0.2%	54.5%
Other benefits, pensions	37.4	24.9	68.0	18.9%	273.1%
Other income	46.1	49.4	27.4	7.6%	55.5%

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.203-204, 207.

Table 3.3. Additional income sources (percentage of respondents),

	Age groups					**Total**
	0-14 yrs	15-24 yrs	25-49 yrs	50-64 yrs	65+ yrs	
Received fringe benefits from employer	63,1%	60,8%	65,6%	46,1%	17,8%	55,0%
Received in-kind support from relatives or friends	22,1%	20,1%	19,9%	7,9%	11,2%	17,3%
Received in-kind support from church or charity organisations	3,9%	2,0%	2,1%	2,4%	3,4%	2,7%
Engaged in collection of nature products (berries, mushrooms, fishing, hunting) regularly	64,0%	60,6%	60,2%	52,1%	31,4%	55,9%

* Table is based on Living conditions survey's data 1999

Capital market

In its 2001 Regular Report, the Commission indicated that Lithuania has reached a high degree of liberalisation of capital movements. There are no restrictions on the inflow and expatriation of capital by investment companies.[3] Legislation on direct investment and on the operation of foreign

[3] 2001 Regular Report on Lithuania's Progress Towards Accession – Commission of the European Communities, Brussels, 13.11.2001 SEC(2001) 1750, p.46.

insurance companies was substantially aligned. Seimas started discussions on the abolishment of the restrictions:

- in acquisition of agricultural land by foreigners and foreign legal persons and authorisation procedures restricting the acquisition of non-agricultural land by foreigners.
- in opening of the accounts abroad and physical cross-border transfer of currency, investment in the banking and lotteries sector, cross-border operations of EU insurance companies, investment in foreign assets by Lithuanian pension funds and insurance companies and capital adequacy provisions for financial brokers concerning investments in EU markets.

Abolishment of the mentioned restrictions is important for expansion of capital market, especially for insurance and pension funds. Although foreign investment almost doubled during the period of 1997-2001 (see table 3.4 below), the foreign direct investment into insurance and pension funding comprised only 1.6% of total foreign direct investment in Lithuania as of January 1 2001.

Further progress in the banking sector was recorded by both strengthening of reliability and performance of the whole sector and by privatisation and the establishment of the new foreign banks. The confidence of foreign investors and domestic depositors in the bank sector grew further. The following increases in the main banking indicators give evidence of the following: on 1 January 2001, the assets of the Lithuanian banking system were LTL 13.1 billion. In 2000, they had increased by 16.5% compared to 1999. In 2000 bank deposits increased by 23.9% and stood at LTL 8.6 billion. In 2000 private deposits increased by 26.5% and amounted to more than LTL 5 billion. All domestic banks have complied with prudentiality requirements. At the end of 2000 the capital adequacy in the banking system was 16.33% and the liquidity ratio was 49.7%. Commercial banks were pursuing rather conservative lending policies, and the loan portfolio (evaluated by the new methodology, increased by 3.7%) made up LTL 5.5 billion. The quality of the loan portfolio is also improving. In 2000, the ratio of specific provisions for loan losses to all loans decreased from 4.5 to 3.7%. The proportion of non-performing loans in the loan portfolio also declined from 11.9 to 10.8%.

Table 3.4: Foreign investment in Lithuania (end of the year, LTL million)

	1997	**1998**	**1999**	**2000**	**2001**
1. Direct investment in Lithuania	4162	6501	8252	9337	10662
2 .Portfolio investment	1664	1473	3334	4561	5250
3. Foreign loans	6581	8406	9178	9047	8596
4.Other investment	3457	3334	3723	3828	4816
Total liabilities	**15864**	**19714**	**24487**	**26774**	**29324**

Source: Economic and Financial Data for Lithuania. – Bank of Lithuania, http://www.lbank.lt/eng/default.htm

3.1.2 Benefits

The entitlement to a state social insurance (SSI) pension depends on the size and duration of contributions to the mandatory pension insurance scheme. Old age pension formula is the basis for the calculation of other SSI pensions types.

State social insurance old age pensions

A person is entitled to a SSI old age pension if he/she meets all of the following requirements:

- reaches the retirement age. Starting with 1995, when the retirement age was 55 years for women and 60 years for men, until the beginning of 2001, the retirement age was increased by four months with each subsequent year for women and by two months with each subsequent year for men. From January 1, 2001, the retirement age was increased with each subsequent year by six months for both men and women until the retirement age reaches 62 years and 6 months for men and 60 years for women;

- was insured under the pension insurance scheme for a minimum period of 15 years. To draw the full basic pension, a person should have paid contributions towards old-age pension under the SSI scheme for an obligatory period. In year 2001, the obligatory period was 30 years for men and 27 years for women. (This period increases annually by one year for women until it reaches 30 years in January 2004).

The state social insurance old age pension consists of two parts: the main part (**basic pension**) and the **supplementary part** (see 2.3.5).

The full old age pension is calculated according to the equation:

$P = B + 0.005*S*K*D + 0.005*s*k*D,$

Where:

B - stands for the basic pension (or part of it, if the recipient has not acquired the full obligatory period of insurance);

S - stands for the insurance period acquired while working under a labour contract prior to 1994, s - stands for the period after 1994;

K - stands for insurable income[4], which is calculated by dividing the annual wages of the insured by the corresponding annual average wage in Lithuania prior to 1994. Taking into account the fact that there are no reliable data on the wages of an insured person throughout his/her working

[4] Income on which compulsory pension insurance contributions are calculated and paid, also SSI sickness benefits (including those paid by the employer during the days of illness), maternity allowances, maternity (paternity) allowances and unemployment benefits.

life prior to 1994, a pensioner is permitted to choose five most favourable consecutive years from the period of 1984-93 and calculate the average value of the wages earned in those years by dividing them by the national average as K.

k is calculated according to the SSI Fund data on the payments of the person's insurable income. The wage from which the contribution was paid is divided by the insurable income D for that year (see below) and the average for the whole period since 1994 is calculated. As from 2004, the data prior to 1994 will not be taken into consideration and the middle part of the equation will gradually disappear. Pursuant to the law, K and k cannot be higher than 5.

D - stands for the insurable income, which is calculated as the average of the wages from which pension insurance contributions are collected, plus state social insurance benefits (like sickness, maternity, unemployment benefits). The Council of the State Social Insurance Fund submits the annual and quarterly averages of the insurable income to the Government for approval.

The coefficient 0.005 means that 0.5 percent of the annual average wage of the employee is added annually to the supplementary part of his/her future pension.

The average state social insurance old age pension in 2000 was 312 LTL. Compared to 1995 it increased more than twice (see table 3.5 below) - partially because of the doubled basic pension and more than doubled monthly earnings during the same period. Thus, the adjustment of pensions depends on decisions on basic pension (in accordance with MSL adjustment) and on dynamics of average earnings.

Partially due to the extension of the retirement age the number of recipients of old age pensions from 1995 to 2000 decreased by 2% or by 12.3 thousand persons.

The average net replacement rate accounts for 40% (taxes are not levied on pensions). Average monthly net earnings in 2000 was 746.6, gross earnings – 1056.1 Litas. Persons receiving higher salaries face even a lower rate of replacement. With comparatively low pensions not all people at pension age terminate labour relations. Therefore every sixth old age pensioner is working. Legal and effective retirement age also slightly differs (61.5 and 61.8 for men and 57.5 and 57.8 for women in 2000).

State social insurance disability pensions

For calculation of disability pensions see 2.3.4.

The average state social insurance disability pension in 2000 was 280 LTL. Compared to 1995 it increased twice. The average pension of a working disabled person in 2000 amounted to 239 LTL, and of a non-working

disabled person - 289 LTL. Almost every fifth pensioner receiving disability pension is working. The number of disability pensioners increased by 25% during the same period (see table 3.5 and 3.6 below).

State social insurance widowhood and orphans' pensions

For calculation of widowhood and orphans' pensions see 2.3.6.

In 2000, 200.8 thousand people received widowhood and orphans' pensions and 33.4 thousand – the loss of breadwinner pension. The number of recipients of the widowhood and orphans' and loss of breadwinner pensions, compared to 1995, increased more than 4 times. The average amount of the widowhood and orphans' pension in 2000 was 60 LTL (see table 3.5 and 3.6 below).

State pensions

State pensions of the first and second degree of the Republic of Lithuania are awarded: to persons who reached the retirement age or were recognised as disabled of the first or second degree; to persons who particularly distinguished themselves as the state created and developed its statehood, economy, culture, science, art and sport and defended its independence, the integrity of the territory and constitutional regime; to volunteer soldiers - participants of the armed resistance; to the most distinguished participants of the resistance to the occupations of 1940-1990; to mothers who have raised and gave a good upbringing to 10 or more children; to volunteer soldiers of the independence fights of 1918-1920; to the signatories of the Act of the Independence of Lithuania; to persons who were the Chairmen of the Seimas, the Prime Minister, the Chairman of the Supreme Court or the Constitutional Court of the Republic of Lithuania.

Before 1 January 2001 state pensions of the first and second degree were paid irrespective of the income received by recipients of these pensions. Starting from 1 January 2001, the awarded pensions are not paid to the recipients of the state pensions of the first and the second degree who have insurable income after the award of these pensions. This provision is not applicable to volunteer soldiers – participants of the armed resistance – recipients of the state pension of the first degree, as well as to the recipients of the state pension of the second degree – mothers who have raised and gave good upbringing to 10 or more children.

State pensions of the deprived persons are awarded to the defenders of the independence of the Republic of Lithuania and other persons who have suffered from the aggression of the USSR in the period of 11-13 January 1991 and later; political prisoners and exiles as well as persons who were awarded the legal status of a person who has suffered from occupations or was a political prisoner or a deportee; members of the resistance to the occupations of 1940-1990; the Second World War participants; persons who participated in the elimination of the consequences of the Chernobyl nuclear

power plant accident; persons who were deported for compulsory works or placed in ghettos, concentration or either types of coercive camps during the Second World War; persons who became disabled during the time of the active military service in the Soviet army or were later recognised as disabled due to the diseases related to the military service. State pensions of the deprived people are also awarded to the parents of the persons who died in the result of the aggression in the period of 11-13 January 1991 and the later events, who perished during the actions of resistance to the occupations of 1940-1990 or during the active military service in the Soviet army, and other persons.

State pensions of the deprived persons and state widowhood and orphans' pensions of all types are paid irrespective of the person's income.

State pensions of research workers are awarded to persons who have an academic name or degree and a work record of a doctor or a habilitation doctor of no less than 10 years, who have reached retirement age or were recognised as disabled of the first and second degree and who do not work under an employment contract.

Pension system and income security in old age

Income security in old age is limited to the pensioners who:

- may receive only one type of pension (SSI pension) compared to others who can receive two or more types of pensions (e.g. SSI old age, widowhood and state pension). The cohort of state pensioners is increasing faster than SSI pensioners (see table 3.6 below);
- do not have a possibility to continue employment contract, or do not receive full awarded SSI pension (see 3.1.4). The amount of disposable income from employment and self-employment decreased in the period of 1997-2000 (see table 4.2);
- do not have any additional income sources and support from relatives or friends (see table 3.3 above).

As it is indicated in chapter 4.2.2, approximately 36% of the old age pensions and 46 % of the disability pensions are below the relative poverty level. 4,8% of the old age pensions and 12,5% of disability pensions dropped below the especially low poverty level – 125 LT. The average net replacement rate accounts for 40%. The before-mentioned circumstances and figures indicate that SSI pension system is not able to provide income security in old age.

Table 3.5: Average monthly pension of state social insurance (in Litas)

Type of pension	1995	1996	1997	1998	1999	2000
Old-age	147.04	188.97	239.86	286.15	309.06	311.94
Disability	139.34	176.82	221.86	260.91	278.94	279.63
Widow(er)'s and orphan's	91.96	92.56	71.25	58.1	60.49	60.2
Of which widow(er)'s (for the deceased by 1 January 1995)*	-	-	31.1	34.43	35.13	34.57
Loss of breadwinner**	102.62	122.66	149.96	174.6	183.11	184.32
Service (for the actual time worked)**	125.81	149.93	179.67	208.27	216.24	212.72
Compensation for special working conditions	-	152.81	181.9	205.67	207.38	207.71

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.147.

* as granted since 1 July 1997

** Loss of breadwinner and pension for the actual time worked (service pension) are paid to persons to whom they had been allocated before 1 January 1995.

Table 3.6: Persons entitled to pensions (average annual number; in thousand)

Type of pension	1995	1996	1997	1998	1999	2000
State Social Insurance						
old-age	656.8	655.3	651	648	644.6	644.5
Disability	139.2	147	152.2	158.8	165.9	173.6
widow(er)'s and orphan's	5.6	27.3	88.2	172.9	188.7	200.8
of which widow(er)'s (for the deceased by 1 January 1995)*	-	-	41.2	107.7	106.2	102
loss of breadwinner**	49.7	47.8	44.1	40.7	36.9	33.4
service (for the actual time worked)**	2.5	2.4	2.2	2	1.9	1.8
compensation for special working conditions	-	0.7	2.1	3.4	5	6.3
Social assistance	44.6	50.3	52	53.9	56	60
State						
of I and II degree	1.9	1.9	2	2.1	2.5	2.7
Research workers	1.3	1.5	1.6	1.6	1.7	1.9
Deprived persons	34	70.9	77.4	82.3	83.6	89.6
Servicemen and officers	6.4	6.2	6.6	7	7.5	8.6
Special	0.1	0.1	0.1	0.1	0.1	0.1

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.147.

* Was granted since 1 July 1997

** Loss of breadwinner and pension for the actual time worked (service pension), are paid to persons to whom they had been allocated before 1 January 1995.

3.1.3 Financing of the pension system

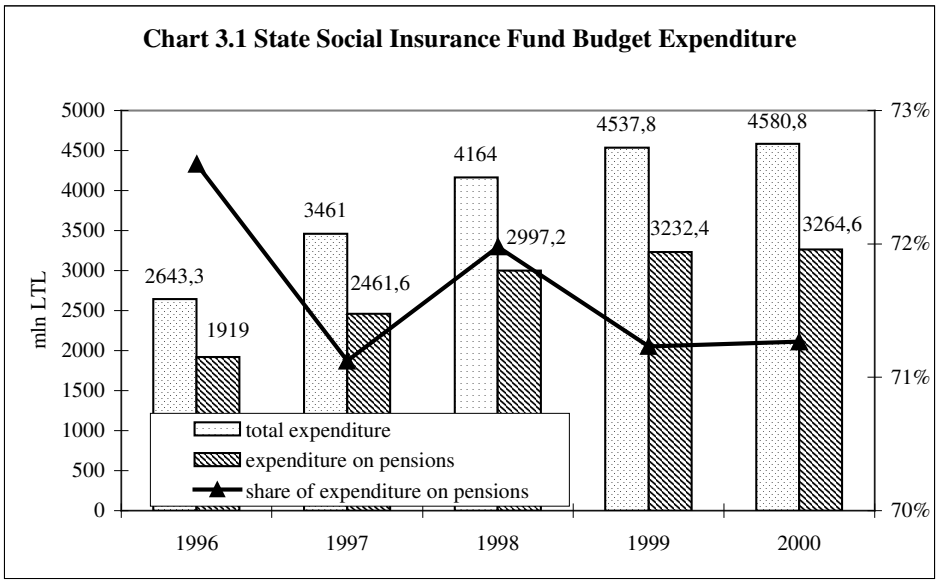
Table 3.7: Pension expenditures

	1995	1996	1997	1998	1999	2000
MLN LITAS	1492.1	1919.0	2461.6	2997.2	3232.4	3264.6
% of GDP	6,2%	6,1%	6,4%	7,0%	7,6%	7,3%

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 165, 588; Statistical yearbook of Lithuania 1998, – Department of Statistics at the Government of the Republic of Lithuania. 1998, p. 158.

Expenditure on state social insurance pensions accounts for more than 71% of the total expenditure of the State Social Insurance Fund budget (see Chart 3.1). Expenditure on pensions include 61.1% of SSI old age pensions, 16.5% - SSI disability pensions, 19% – SSI widowhood and orphans' pensions, 3.2% – loss of breadwinner pension, 0.2% – pension for actual time worked (service pension). Beside the above-mentioned pensions, compensations for extraordinary work conditions (6293 recipients) are awarded.

Chart 3.1 State Social Insurance Fund Budget Expenditure



Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 165.

Starting from 1996 the expenditure of the SSI Fund budget has exceeded its revenue (see table 3.8 below). The SSI fund has collected, throughout its existence, the debt of more than 500 mln Litas in 2001 (debt is mainly financed from bank loans).

The worsened SSI fund budget situation in 1999 forced Seimas to adopt the following measures:

In order to increase the supervision of state budgets and funds, Seimas adopted the Provisional Law on the Structure of the SSI Fund Budget, which sets forth a procedure for drafting and implementation of the SSI Fund budget, classification of its income and expenditure, the procedure for payment and postponement of contributions and indicators for the approval of the SSI Fund budget and reporting on its implementation.

Table 3.8: State Social Insurance Fund budget revenue and expenditure

	1995	1996	1997	1998	1999	2000
Revenue (mln Litas)	1973,3	2607,9	3431,2	4159,4	4203,8	4405,1
Revenue (in % compare to previous year)		132,2%	131,6%	121,2%	101,1%	104,8%
Expenditure (mln Litas)	1972,3	2643,3	3461,0	4164,0	4537,8	4580,8
Expenditure (in % compared to previous year)		134,0%	130,9%	120,3%	109,0%	100,9%
Surplus/deficit (-) (mln Litas)	1,0	-35,4	-29,8	-4,7	-334,0	-175,7

Source: Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 165; Statistical yearbook of Lithuania 1998, – Department of Statistics at the Government of the Republic of Lithuania. 1998, p. 158.

The Law on State Social Insurance provides for a possibility to make allocations from the state budget to the SSI Fund budget in the event of the growth in SSI expenditures when the rates of SSI contributions are not altered. In early 1999, despite the economic recession, Seimas obliged the SSI Fund Board to increase the basic pension. This was one of the reasons why SSI Fund budget expenditure increased by 9% and revenues only by 1% in 1999. In late 1999, the liabilities of the SSI Fund budget accounting for 200 million LTL were qualified as internal debt of the state and were covered from the state budget.

The rate of the SSI contributions was approved in 1991 and did not alter before the end of 1999. It equalled 31% from the calculated remuneration for work. 30% was to be paid by employers for employed persons and 1% by the employees themselves. In late 1999 Seimas adopted the Law on the Approval of 2000 Indices of the SSI Fund budget which contains a provision that, starting from 1 January 2000, the general rate of state social insurance contributions shall be increased from 31 to 34% (for details see 2.2.3).

At the beginning of 2000 it was decided to speed up the extension of retirement age established in the Law on State Pension Insurance (see 3.1.2.1) and to update the valid procedure for payment of state social insurance pensions to working recipients of these pensions (see 3.1.4.2).

The measures, which were undertaken in 1999, 2000 and 2001 to reduce the expenditures and to increase revenues so as to balance the SSI Fund budget, gave the first successful result with modest surplus in the year 2001.

3.1.4 Incentives

Possibility to increase the old age pension due to the deferred application

Law on the State Social Insurance Pensions provides for a possibility to increase the old age pension due to the deferred application. If a person becomes eligible to draw the SSI old age pension and has the obligatory insurance period, but does not take it and applies for it later, the pension has to be increased by 4% of the calculated amount for each full year after the date of the person's eligibility to draw an old age pension. If the application for pension is deferred for more than five years, the pension has to be increased only for five years of deferment. By the decision of the State Social Insurance Fund Council a greater percentage of the increase of pension due to the deferred application may be established.

Although the above mentioned regulation creates incentives for pensioners to participate in the labour market after retirement age, other regulations work in the opposite direction (see below).

Payment of pensions to working pensioners

Starting from 1 January 2001 and in accordance with corresponding amendments of the Law on State Social Insurance Pensions of 30 October 2001, pensioners who after having been awarded the SSI old age pension have insurable income (see 3.1.2.1), provided that they have acquired the required pension insurance record entitling to old age pension, are paid the basic part of the state social insurance old age pension.

Besides, if their insurable income is lower than 1.5 of the minimal monthly salary (MMS, currently 1MMS = 430 Litas), they are paid a part of the supplementary part of the awarded old age pension amounting to:

1. 50% of the supplementary part not exceeding 100 Litas;
2. 20% of the supplementary part which is from 100.01 to 200 Litas;
3. 10% of the supplementary part which is from 200.01 to 300 Litas.

The part of the supplementary part of the old age pension which exceeds 300 Litas is not payable.

If the insurable income exceeds 1.5 MMS only the basic part of the state social insurance old age pension is paid.

Pensioners who have insurable income, but do not have the obligatory pension insurance period for old age pension, are not paid the SSI old age pension.

A similar procedure is applied to the payment of disability pensions to disabled persons who have reached retirement age and have insurable income.

The disabled who are of the established pensionable age and over and who, after the awarding of SSI invalidity pension, have insurable income (if they have obligatory pension insurance record for invalidity pension) are paid full awarded SSI invalidity pension, if their insurable income does not exceed 1 MMS. If insurable income of the said persons exceeds 1 MMS, but does not exceed 1.5 MMS, they are paid a basic part of SSI invalidity pension and a part of the supplementary part of awarded invalidity pension which consists of the sum of the following amounts:

1. 50% of the supplementary part which does not exceed 100 Litas;

2. 20% of the supplementary part which is from 100.01 to 200 Litas;

3. 10% of the supplementary part which is from 200.01 to 300 Litas.

A part of the supplementary part of invalidity pension which exceeds 300 Litas is not paid.

If the insurable income of the disabled persons exceeds 1.5 MMS, the basic part of the SSI invalidity pension is paid.

The disabled who, after being awarded the SSI invalidity pension, have insurable income and have not reached the pensionable age are paid invalidity pension, provided that they have the obligatory pension insurance record for invalidity pension, except the disabled of Group 1 to whom the obligatory insurance period requirement does not apply when paying a pension. This pension is paid to:

1. the disabled of Group 1 - the full granted SSI invalidity pension irrespective of the insurable income;

2. the disabled of Group 2 and 3 whose insurable income does not exceed 1.5 minimum monthly salary - the full awarded SSI invalidity pension;

3. the disabled of Group 2 and 3 whose insurable income exceeds 1.5 minimum monthly salary - a basic part of awarded SSI invalidity pension and 50% of the supplementary part.

The disabled who have insurable income (if they do not have obligatory SSI pension record for invalidity pension), are not paid the SSI invalidity pension, except the disabled of Group 1, to whom the obligatory insurance period requirement shall not be applied when paying a pension.

Conclusion

Regulations of payment of pensions to working pensioners have, at least, three weaknesses:

- working pensioners are penalized for participation in the labour market and have discriminatory pension rights compared to non-working pensioners;
- these provisions reflect current problems of financing of the pension system and, probably, high unemployment, although they were introduced for the first time in 1995 and amended in 2001 by law, i.e. for a long time period;
- working pensioners with modest earnings (e.g., exceeding 1.5 MMS), but high retirement pension are experiencing huge losses and may be excluded from the legal labour market.

The Constitutional Court of Lithuania at the end of 2002 has passed the resolution, that the restrictions on payment of pensions to working pensioners do not corresponds to the Constitution of Lithuania

3.1.5 Coverage of the system

Four-sided coverage

In accordance with the Law on State Social Insurance Pensions, the SSI pension system is based on the four-sided coverage[5] of the below specified groups:

First group: 1) persons employed under employment contract, diplomatic service contract or fixed-term diplomatic service contract, civil servants, as well as employed in institutions elected on the basis of membership, partnerships, agricultural companies or co-operative organisations and those receiving remuneration; 2) officers of the Ministry of Interior, Special Investigation Service, police, State Border Protection Service and other officers of internal affairs agencies, commissioned officers of internal affairs units, non-commissioned officers and soldiers of additional service, as well as officers of the prosecutor's office; 3) servicemen in the professional military service; 4) officers of the State Security Department system; 5) unemployed spouses of diplomats for a period of time they reside abroad together with the diplomat who works in a diplomatic mission or consular institution of the Republic of Lithuania; 6) owners of individual (personal) enterprises and self-employed persons who are equated to them in the manner prescribed by the Government of the Republic of Lithuania (with the exception of the persons specified in subparagraph 8 of this paragraph).

Second group: 7) farmers and adult members of their families who work in the farm; 8) persons who have acquired patents.

Third group: 9) servicemen in an initial period of continuous service in the mandatory military service and servicemen of the alternative national defence service; 10) a mother or a father who are on a child care leave,

[5] For coverage by social (assistance) pension and state pensions scheme see 3.1.1.3 and 3.1.2.2.

raising a child between 1 and 3 years of age; 11) a mother or a father who are unemployed and are not on childcare leave, but who raise a child up to three years of age; 12) clergymen of traditional and other religious communities and associations recognised by the State, as well as nuns and monks working only in convents and monasteries; 13) one of the parents of a person with total invalidity or a person who is in a prescribed manner declared a guardian or custodian of a person with total invalidity, who takes care of the person with total invalidity at home.

Fourth group: other persons.

Persons of the **first** group are covered by the SSI for the basic and supplementary part of pensions. Their pension insurance usually is based on contributions paid from earnings recorded on the payroll with exception of subgroup of owners of individual (personal) enterprises and self-employed persons (6). For further details see below.

Persons of the **second** and **third** groups are covered by the SSI for the basic part of pensions. They may insure themselves for a supplementary part of pension by the SSI on a voluntary basis. The difference between them is the following: a) persons of the **second** group have to pay SSI contributions from their own income (see below); b) persons of the **third** group are compulsorily insured by the state social pension insurance with state funds. The persons indicated in subgroup 13 are compulsorily insured with state funds only when they do not get a state social insurance pension, state pension or social assistance pension to which they are entitled too. The persons of subgroup 12 represent some exceptional privileges in the SSI system, because their insurance with state funds is based on the specific occupation.

Persons of the **fourth** group may be insured by the SSI on a voluntary basis for basic and supplementary part of pension (see above).

Voluntary insurance *for basic and / or supplementary part of pension means, that these persons* ***are excluded from the mandatory SSI***. Voluntary social security contributions comprised only 0.02% of all the SSI contributions in year 2000. This situation shows losses of contributions for the SSI Fund budget today and losses of income security for the persons which are not obliged to pay mandatory contributions in their old age. Especially this may be acute for the persons of **fourth** group. For example, person may perform a job under the authorship agreement. The royalty paid to authors for works of science, literature, art, discoveries and inventions as well as for other author's works is subject to taxation at the rate of 13% percent. (Provisional Law on Income tax of Natural Persons, Article 16). At the same time authors are not obliged to pay any SSI contributions from their royalties. The situation with unregistered farms and farmers and their family members is even worse because they are not obliged to pay neither contributions nor taxes, but at the same time they can't receive any support from Government or structural funds. Such persons have a possibility to opt out from the SSI system and to join private voluntary pension insurance.

Coverage of self-employed

In the middle of 1999 Seimas passed a resolution in relation with the SSI of self-employed persons. It was decided to oblige self-employed persons to insure themselves for the full amount of the state social insurance pension, by paying contributions from the amount not lower than the average wage. In 2000 the problems of the SSI of self-employed persons were further addressed, i.e. which persons must be insured with pension insurance, contributions of what amount must be paid, and for what amount of benefit one must be insured. In July 2000 it was established that self-employed persons must pay contributions to receive only the basic SSI pension irrespective of their income or causes for which they do not receive income. Amendments of the Law on State Social Insurance Pensions again restore the situation of the middle of 1999.

Coverage of farmers and patent holders

The farmers ant patent holders are covered with(by the SSI for the basic pension. Nevertheless the amount of SSI contributions which sometimes has to be paid to them seems to be too high.

In 1999, in its resolution Seimas suggested the Government to prepare a methodology for determination of economically weak farms. With the help of this methodology regional agriculture divisions of rural affairs departments under county governors' offices each year would determine economically weak farms and would submit their lists to the institutions of the State Social Insurance Fund and the Ministry of Agriculture. Alongside with the methodology the Government proposed to draft a Procedure of the Social Insurance of Farmers of Economically Weak Farms, which would stipulate the farmers of economically weak farms to insure themselves and members of their farms who are over 18 years of age under the SSI by paying a *portion of the contribution*. The remaining portion of the contribution would be covered from the state budget. At the beginning of 2000 the Government approved the Procedure of the Social Insurance of Farmers of Economically Weak Farms and the Methodology for Determination of Economically Weak Farms. At the beginning of 2001 the Government also approved the Procedure of Patent Holders' Social Insurance.

Several times, during the period of 1999-2000, farmers and patent holders were relieved from the payment of unpaid state social insurance contributions, late charges and penalties.

Other coverage problems

Currently, due to high unemployment and differences in the standard of living, about 200,000 of Lithuanians are working abroad, most of them illegally. Emigration, in its turn, has a negative effect on the solvency of the

pay-as-you-go retirement system. Persons working abroad illegally do not have any old age income security.

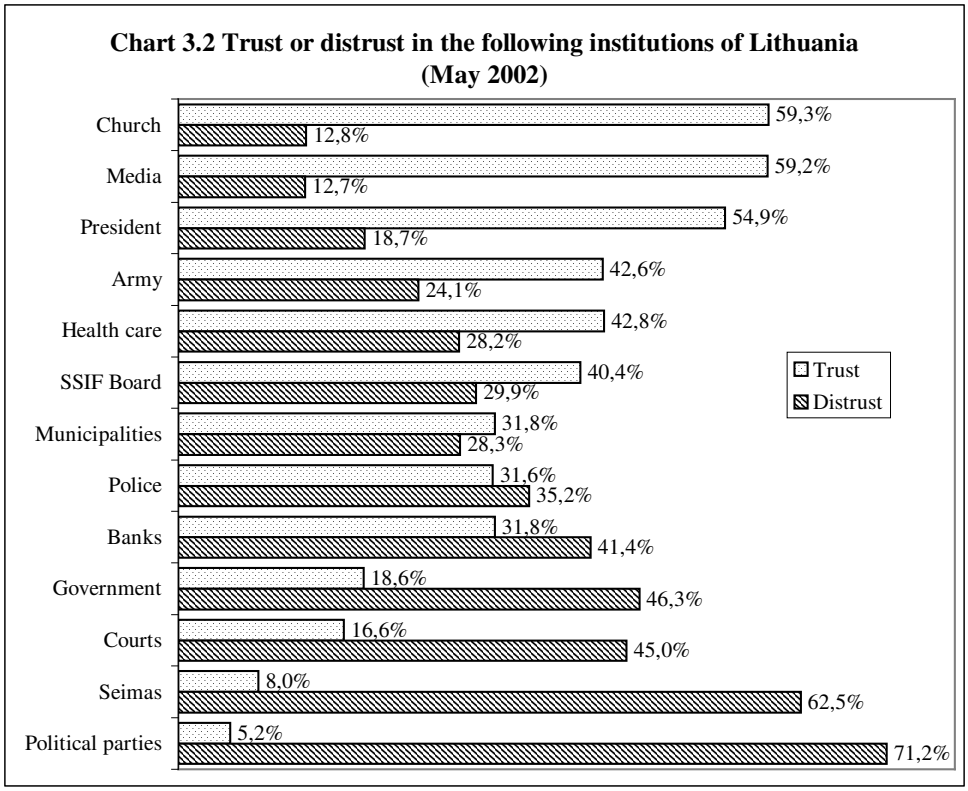
Moreover, according to some estimates, up to 20% of Lithuanian labour force, are working without a labour agreement or they are legally paid only a minimum salary. They also do not have any/ or sufficient old age income security.

There is no evidence on gender inequality arising from the SSI system, if not take into account the differences of men and women in the legal retirement age and in the obligatory pension insurance period.

3.1.6 Public acceptance of the system

In the middle of last decade the main public concern and dissatisfaction in the SSI pension system was the lag in pensions payment. Currently, despite of low pensions, public acceptance of the pension system is quite good. Latest public opinion surveys show quite high public confidence in the SSI pension system. The highest public confidence is in church, media and President. The army, health care and SSIF Board (SoDra) is on the second best position, markedly higher than municipalities, police and banks. Lowest confidence is in Government, courts, Seimas and political parties (see chart 3.2 below).

The public opinion survey company I. Zoko Studija SPINTER at the end of 2001 conducted an opinion poll among experts for the evaluation of measures of poverty reduction policy(see also 4.1.1). The majority of experts expressed the opinion, that SSI benefits, including pensions, are decreasing poverty but are of insufficient amount.



Source: Survey conducted by Baltijos Tyrimai and published in the newspaper Lietuvos Rytas, 2002-05-18

3.2 Evaluation of future challenges

3.2.1 Main challenges

The key problems of the Lithuanian pension system are small social insurance pensions, high redistribution, low motivation for the residents of Lithuania to be involved in the social insurance system, financial difficulties of the State Social Insurance Fund and the growing trend of the ageing of population.

Despite of a rather high contribution rate, the State social insurance pensions are small. . The financing of pensions is currently unstable: it depends on the proportion between the number of employed persons and persons of retirement age. According to the data of the State Social Insurance Fund, the number of persons employed under employment contracts during 1991-2000 decreased by 36%. Whereas the number of pensions paid from the State Social Insurance Fund increased from 838 thousand in 1991 to 1 million 54 thousand in 2000.

When paying contributions to the State Social Insurance Fund budget, employed persons do not see direct links between their contributions and the future pension. The average portion of the person's income replaced with pensions accounts for 40 per cent. Persons receiving higher salaries face even a lower rate of replacement. Such situation has demotivated the latter

group to participate in the existing pension system and it is one of the reasons for frequent evasion of contributions.

Therefore, in seeking to financially stabilise the Lithuanian pension system which would stimulate participation and higher benefits, it is expedient to launch the reform of the system as soon as possible. Changes in the way of financing would ensure the long-term vitality of the pension system.

On April 26, 2000, the Government passed the Resolution No. 465 on Pension system reform concept. It was suggested to reorganise the existing pension system into a three-pillar pension system, where:

- - The 1st pillar of the pension system (provided for in the Law on State Social Insurance Pensions) would ensure the minimal protection from poverty in the event of old age or disability. It would be financed as before - according to the pay-as-you-go principle;
- -The 2nd pillar of the pension system – compulsory accumulation in pension funds. This pillar would operate according to the defined contributions and individual accounts principle and would ensure the supplementary part of the pension depending on the contributions paid by the person;
- - The 3rd pillar of the pension system – voluntary accumulation for old age in pension funds or insurance companies.

After the adoption of the Law on the Pension Scheme Reform (December 3, 2002) the 2nd pillar of the pension system has been replaced by the possibility to accumulate voluntary the defined portion of the state social insurance pension contribution in pension funds or insurance companies. The main advantages of this scheme are following::

- it would allow increasing pensions for the individual participating in it without increasing the tariff of the social insurance pension contributions. It is expecting that pensions together with the accumulative portion will be at least 20 per cent larger than in the case they were should the pay-as-you-go financing system be left;

- one could expect to put a stop to the avoidance of paying the contributions because accumulation will be organised by means of individual accounts whose funds will belong to the individuals that have been insured with the ownership right;

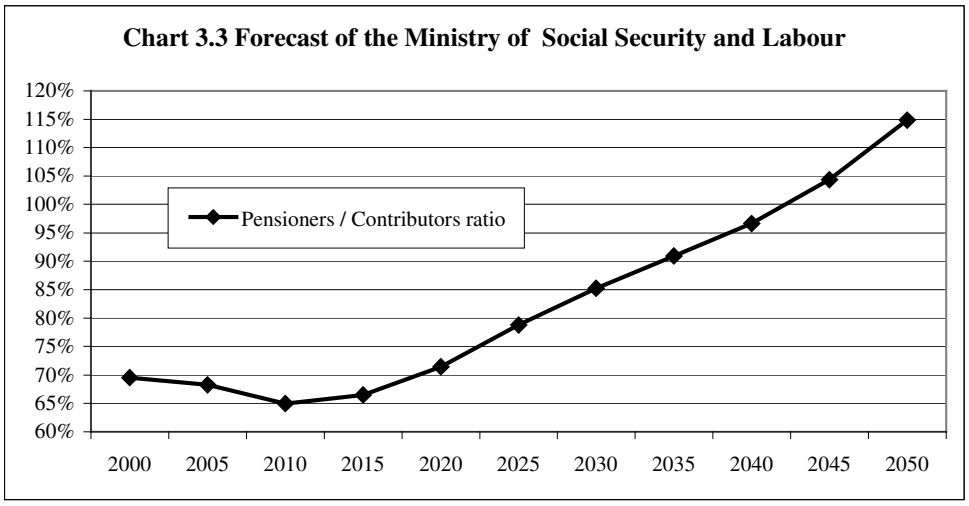
- it would reduce the poverty risk in old age by distribution of insurance between different mechanisms, and would provide the individuals of working age with more possibilities to transfer a part of their use from the working age into the old age, and

it would guarantee a stable socially acceptable compromise between social solidarity and personal interests.

3.2.2 Financial sustainability

In accordance with the pensioners / contributors ratio forecast (see chart 3.3 below) the SSI pension system may be financially sustainable for a period of at least 15 years because of declining pensioners / contributors ratio. Moreover, in accordance with forecast it would be possible to keep positive balance of the SSI Fund budget until the year 2040 if pension replacement rate would be reduced by 1/3.

Chart 3.3 Forecast of the Ministry of Social Security and Labour



Source: Forecast provided by the Ministry of Social Security and Labour

The pensioners / contributors ratio forecast is based on the population forecast with assumptions that (a) the unemployment rate has to gradually decrease from 16 to 8%, (b) net migration equals 0 during a 50 years period.

This forecast creates some advantages for the introduction of voluntary accumulation in pension funds because of declining pensioners / contributors ratio. Nevertheless, since the introduction of voluntary accumulation in private pension funds is anticipated by not increasing the pension contribution tariff but by directing one part of currently existing tariff of social insurance contribution to accumulative pension insurance in pension funds, sustainability of the SSI pension system is under question. There are several ways planned for financing of the deficit of the State Social Insurance Fund budget caused by the loss of part of the contributions paid to the voluntary accumulative pension funds: by using the funds received from privatisation or by borrowing funds and covering the deficit from the state budget. According to estimations, the annual decrease in the income of the State Social Insurance Fund budget due to the introduction of the voluntary accumulative pension pillar during the first 15 years of the reform, will account for about 0.9 per cent of the GDP. The financing of the deficit would not be problematic since, as the experience from the neighbouring countries shows, the major part of the funds is left within the country and at least at the beginning of the reform a major part is invested into the Government Securities.

3.2.3 Pension policy and EU accession

Beside the mentioned developments in the pension system, some other implemented measures have importance for social security co-ordination and equal opportunities for women and men:

On 22 September 2000, the Government approved the new Rules for forming the State Social Insurance Budget and its Implementation. They provide that financial statements of the SSI Fund Board (SoDra) should be drawn up in accordance with International Accounting Standards approved by the International Federation of Accountants.

The Articles 23 and 32 of the Law of State Social Insurance Pensions were changed on 21 December 2001, by which the Order on Payments for Old-age and Disabled Pensioners, whose income is individually insured, was changed.

On 21 December 2000, Seimas passed the Law on Sickness and Maternity Social Insurance (came into force on 1 January 2001). The Law sets categories of persons covered, the rights for getting benefits as well as conditions for their granting, calculation and payment. In order to utilise the social insurance funds fairly and to avoid abuses in allocating the sickness and maternity (paternity) allowances, certain insurance records for the said period are required. The Law corresponds to the provisions of the European Convention on Human Rights and Fundamental Freedoms and does not contradict provisions of the acquis in the field of social security.

On 15 May 2001, Seimas ratified the European Social Charter (1996). The European Social Charter is the main European international agreement, which regulates social and economic rights.

On 24 May 2001, Seimas ratified an Agreement on Social Protection between the Republic of Lithuania and the Republic of Finland. The Agreement provides for co-operation in the field of social protection and guarantees social protection for persons, who move away to work or to live from one country to another.

In the field of equal opportunities, the new Law on Health and Safety of Workers (adopted on 17 October 2000) fully transposed provisions of the directive 92/85/EEC (pregnant workers and workers who have recently given birth or are breast-feeding). On 25 January 2001, the Law on Amendments to the Law on State Benefits for Families Bringing up Children were adopted by Seimas. The new Law guarantees equal opportunities for both parents to get family benefits by their decision.

On 8 September 2000, the President of Lithuania signed the Optional Protocol to the CEDAW (Convention on Elimination of All Forms of Discrimination against Women).

The Commission for Equal opportunities of women and men decided to follow recommendations of the UN Committee for Elimination of Discrimination against Women by elaborating new national program of equal opportunities for women and men. The program will be drafted in 2002.

The coordination of pension systems under the existing free labour movement will require improvement of administrative capacity in the SSI Fund Board and local offices, related to international transactions.

3.3 Evaluation of recent and planned reforms

3.3.1 Recent reforms and their objectives

Reform of 1991

The state social insurance system was designated as an independent system. This was taken account of when separating the state social insurance budget from the state budget and when creating the tripartite state social insurance administration. Separation of the state social insurance budget from the state budget means that its funds shall be used only for benefits provided for under the laws on state social insurance.

Reform of 1994-1995

In 1994 Seimas of the Republic of Lithuania adopted a package of legal regulations including the laws on State Social Insurance Pensions, State Pensions, Pensions of Soldiers and Officers of Domestic Affairs, State Security, National Defence and Prosecutor's Office, Provisional Law on State Pensions of Research Workers, and the Law on Social (Assistance) Pensions (effective from 1 January 1995). It was the first step towards the Lithuanian pension system reform, i.e. abandoning the Soviet pension security system. These laws defined the types of pensions, persons entitled to draw different types of pensions, amount of pensions and sources of their payment.

The Law on the State Social Insurance Pensions, valid from 1 January 1995, stipulates a new age limit entitling to old age pension (60 years for women and 62.5 years for men) and gradual transition to this limit. Men should reach this limit in 2003 and women in 2006.

Current reforms

On 16 October 2000, according to the resolution of the Government of the Republic of Lithuania, the Concept of the State Social Insurance Contributions Reform was approved. The Concept provides for the transfer of contributions administration functions (currently performed by the State Social Insurance Fund Board) to the State Tax Inspectorate under the Ministry of Finance. The proposal to implement the contributions

administration reform was aimed at the following key results: to improve collection of contributions and tax; reduce the risk of contribution and tax evasion; eliminate the overlapping of functions in contribution and tax administration; reduce the cost of contribution and tax administration; provide conditions for general return of income. Although at the beginning of 2001 the corresponding draft laws were submitted to Seimas of the Republic of Lithuania, after several months of considerations Seimas did not approve the said proposals.

3.3.2 Political directions of future reforms

Introduction of the accumulative pension scheme

The Pension System Reform Concept and White Paper of the Pension System Reform refer to the introduction of the accumulative pension pillar as the main trend of the pension system reform. These instruments formed the basis for drafting the Law on Pension System Reform. The mentioned documents during 2002 were discussed in President office, Seimas, Government, Ministry of Social Security and Labour and the SSI Fund Board. The adoption of the Law on the Pension Scheme Reform (2002.12.03) reflects the agreement of various political forces in Lithuania that two elements are necessary within the pension scheme – the pay-as-you-go scheme and the accumulative scheme, to legalise accumulation of the portion of the state social insurance contribution in pension funds and at life insurance companies.

The Law stipulates the basic principles of the operation of the voluntary accumulative pension pillar. These principles will cause amendment to the Law on Pension Funds, the Law on State Social Insurance and other legal regulations by means of establishing a more detailed mechanism for this voluntary accumulative pension pillar and its relation to the existing pay-as-you-go pillar.

The Law suggests that contributions will be transferred to pension funds and life insurance companies from 1 January 2004.

Contrary to the proposals that were put forward by the Government earlier, seeking to ensure absolute voluntariness and freedom of choice, the Law proposes to establish that all the individuals who are insured for the entire state social insurance pension, should have the right to participate in accumulation of a portion of the social insurance pension contribution at the pension funds or life insurance companies. Individuals shall have the right to choose any of the pension accumulation company. Seeking to avoid age discrimination, the age until which it is allowed to choose the accumulative scheme, shall not be established.

The Law prescribes establishing that the size of the pension accumulation contribution during the first year of the reform is 2.5 per cent of the income insured from which the state social insurance pension contributions are

calculated. It is proposed to increase this contribution gradually till the year 2007 so that it should reach 5.5 per cent. Consequently, as compared with the earlier variants of the Government's pension scheme reform, in implementing the present proposal the funds being accumulated during the first year shall be insignificant and will increase gradually, therefore Lithuania's financial market will be able to absorb these amount easily. Also, this means that the burden of financing the reform will increase only gradually when an ever larger portion of the budget deficit of the state social insurance fund will be able to be covered with the surplus funds of that budget.

Reform of the state pension scheme

In the existing economic situation when the state social insurance pensions do not provide sufficient guarantees for the compensation of income lost due to old age, disability or widowhood, the state pensions scheme provides supplement to the some groups of pensioners. Thus it is rather complicated to abandon the existing state pension system. So far there is more evidence of incentives to expand this system rather than to abandon it.

At the Ministry of Social Security and Labour there are plans to start the state pension reform partially in the following directions:

1. to refrain from increasing the basic state pension, on which the amount of state pensions of the first and second degree of the Republic of Lithuania, the deprived persons and research workers is directly dependent. The indexation of state pensions of the state officials and soldiers should also be linked to the basic state pension;

2. to continue the payment of the awarded state pensions while limiting the amount of the state pensions paid for a single person;

3. to link the payment of state pensions and artists' annuities to the fact of possession of the insurable income;

4. to seek the gradual decrease in the number of persons entitled to receive state pensions;

5. to refrain from awarding new state pensions of the first and second degree of the Republic of Lithuania to the distinguished persons and state pensions of the deprived persons. Instead of them, to award lump-sum benefits to be paid upon reaching the old age pension age or after having become a disabled;

6. to restrict the conditions for the award and payment of some remaining types of state pensions, i.e. to gradually refuse the above pensions.

3.3.3 Conclusions

The pension policy development and planned reforms may cope with the problems of an ageing population and ensure income security in old age as well as intergenerational fairness in the following manner:

The expansion of the coverage of different groups with SSI may improve the ratio between contributors and pensioners. The success in this area largely depends on transformation from voluntary to obligatory SSI for pension, from insurance for the basic to insurance for full pension. Voluntary insurance with SSI is not effective today: only a small part of the persons who are not insured with SSI or are insured only for basic pension apply for voluntary insurance. Currently the basic pension comprises only 44% of the average age pension and can't provide income security in old age. The expansion of the coverage also depends on the reduction of illegal employment and on the tax wedge. In Lithuania the burden of tax and social contributions on lower-paid single workers is particularly high in comparison to international standards (Joint Assessment of Employment Policy Priorities in Lithuania, 12 February 2002, p. 22). The expansion of coverage may contribute to the reduction of the tax wedge.

Introduction of the three pillars pension system may enable old people to maintain the living standard achieved during their working life as well as make the pension system financially stable and fairly protected from negative economic and demographic changes. But this could be achieved only in the long run.

In the short run it is important to improve the pension provision under public schemes. At least two policies may contribute to this: a) reduction of state pension system and redirection of funds to the SSI pension scheme; b) repeal of the limitations in payment of pensions to working pensioners[6]; this would encourage old people to re-enter the labour market (this is especially important for women the legal retirement age of which is lower than that of men).

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[6] This is important also in the sense of public confidence in SSI. Such limitations may confuse contributors in what they can expect in terms of benefits if social or economic situation will change.

4. POVERTY AND SOCIAL EXCLUSION

4.1. Evaluation of current profiles of poverty and social exclusion

4.1.1 Social exclusion and poverty within the overall social protection system

The strategic initiative of reduction of poverty and social exclusion was undertaken by the President of the Republic of Lithuania H.E. Mr. Valdas Adamkus. In compliance with presidential decrees the following activities were initiated:

A joint Social Committee comprising representatives of state authorities and non-governmental organisations was established in the beginning of 2000. The committee drafted and announced the strategy of poverty reduction in June 2000. A task group comprising specialists of the majority of ministries and representatives of certain social partners under the aegis of the Ministry of Social Security and Labour arranged a draft Programme (in April 2002 – first draft, in October – second draft) for the Implementation of the Poverty Reduction Strategy in 2002-2004 (hereinafter referred to as PIPRS).

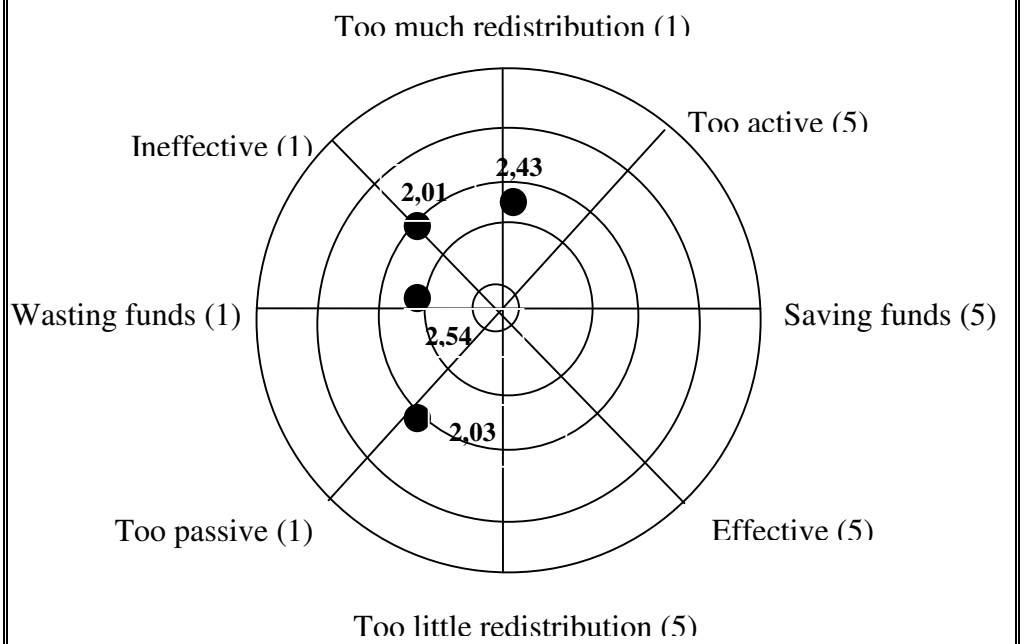
A poverty monitoring commission comprising people of various experience and various views was formed in the beginning of 2001. The first annual report on poverty, prepared by commission, was issued and disseminated to the public in March 2002.

Under the order of the Poverty Monitoring Committee the public opinion survey company I. Zoko Studija SPINTER in the end of 2001 conducted a poll of experts for the evaluation of poverty reduction policy's measures. In the opinion of experts, the evaluation of the poverty reduction policy of the state is largely negative: average values of evaluations stand close to the poles of negative evaluation (see chart 4.1 below). Experts tend to reject means of poverty reduction as inefficient and as an excessive wasting of funds. In the opinion of experts, the policy of poverty reduction is too passive and paying too much attention to the mechanisms of redistribution.

In the end of 2001 the public opinion survey organisation SIC Rinkos Tyrimai conducted a survey on Non-Governmental Organisations and Poverty Reduction Policy in co-operation with the Information and Support Centre of non-governmental organisations. 63 % of the non-governmental organisations declared that they contributed to the reduction of poverty in Lithuania.

The United Nations Development Programme financed all the aforementioned actions initiated by the President of the Republic of Lithuania and follow-up activities. The publication of the first report on poverty status execution of sociological surveys had a clear impact on the compilation of a PIPRS.

Chart 4.1 Experts evaluation of poverty reduction policy



* *Report on poverty status in Lithuania (in Lithuanian). Vilnius 2001, p. 39.*

A living conditions survey, carried out by the Ministry of Social Security and Labour and Institute for Applied Social Science of Norway (FAFO) in 1994 and 1999 revealed that the subjective evaluation of the personal economic situation, previous and upcoming changes of the respondents was overly pessimistic and was out of tune with the, albeit insignificant, but positive changes. Only 3 % of all households and approximately 9 % of the households of employers labelled themselves as well-off (but not the most well-off). Half of all households stated that they were neither rich nor poor, 36 % pointed out that they lived close to the line of poverty, whereas more than 10 % noted that they had already fallen below the poverty line. The data of the Living conditions survey disclose that only 1 of 10 households agree that their situation has improved in the past 5 years. 2 households out of 10 state that the situation has remained intact, while 7 out of 10 point out that the situation has deteriorated[7].

[7] Lithuania 1999. Living Conditions, Vilnius, 2000, p. 93-94.

To conclude, all levels of authorities consider the reduction of poverty and social separation as an essential part of the overall national and international integration policy, and not just as a target of social policy. However, both social policy experts and common people point out that they have not yet noticed the results of these political provisions. They are sceptical about the efficiency and efficacy of the policy on the reduction of poverty and social separation as well as about the changes of their economic situation.

4.1.2 National definitions of poverty and social exclusion

Minimum subsistence level

The national definition of poverty has origin in the Law on Income Support, adopted in autumn 1990. The law contained a definition of the minimum subsistence level (hereinafter referred to as **MSL**), as a sum of family monthly income, guaranteeing for all members of family a minimum subsistence level, including a nutritionally adequate diet and essential non-food requirements. In 1990, ***45%*** of MSL was calculated for expenditure on food. The MSL was being used for a calculation of vide variety of social benefits. Although, in 1992, because of inflation (12.6 times) and sudden 55% drop in real disposable incomes State budget became not able to pay social benefits. In 1993 a new method was introduced, based on the minimal nutrition requirements, providing 2117 kilocalories per capita. Expenditure on food was assumed to account for ***80%*** of all expenditure (70%, from 1994 onwards). Due to budgetary constraints, in 1993 the applied by Government MSL was still only 68% of the MSL level estimated using new method.[8] At present also, in Lithuania it is distinguished between the calculable (determined on the basis of needs) and applied (determined and confirmed with consideration of financial resources) MSL.

MSL as an index of the level of poverty important in the sense of social support administration as the majority of benefits are tied up with MSL; furthermore, the amount of MSL serves as a basis for the determination of families in urgent need of social support. The use of applied MSL alleviates control over the poverty level through determination and indexing MSL and the related benefits in accordance with the inflation rate.

However, the poverty level defined by the aforesaid methods becomes dependable on the condition of the economy. For example, in 1991-1994, in the period of economic decline and inflation the MSL was not adjusted to the indices properly, therefore, at present the minimum subsistence level seen as the line of particularly severe poverty is considered as a relative variable, which does not reflect expenditures required for the satisfaction of basic needs. There is no need to adjust the MSL to indices in the period of economic growth and stable prices, and payments calculated on the basis of

[8] Lithuanian Human Development Report 1995. – UNDP, Vilnius, 1995, p. 43-44.

the MSL partially start to lag behind the wages, other business income, i.e., behind the average rise of living standards in the country.

The level of particularly severe poverty accounted on the basis of the MSL cannot be considered a good index for the drafting of a long-term poverty strategy when the economic developments are that dynamic. Moreover, the MSL is unsuitable for international comparisons due to particulars of its calculation. Therefore, indices of relative poverty are applied keeping in mind that such indices are widely applied in the statistics and in compilation of strategies and action plans of the EU member states and OECD countries.

Human development index

The human development index (hereinafter referred to as HDI) has been applied for Lithuania in 1994 by UNDP. The HDI ranking 174 countries in terms of life expectancy, educational attainment and income.

Table 4.1. Human development index in Lithuania

Year	**1990**	**1992**	**1994**	**1998**	**2002**
HDI	0.881	0.868	0.7683	0.789	0.808
HDI rank	22	35	70	52	49

Source: Lithuanian Human Development Report 1995. – UNDP, Vilnius, 1995, p. 3, 68; Lithuanian Human Development Report 1996. – UNDP, Vilnius, 1996, p. 12; Lithuanian Human Development Report 2000. – UNDP, Vilnius, 2000, p. 98
A Decade of Partnership. – UNDP, Vilnius, 2002, p21.

New approaches: poverty line and poverty rate

The notion of poverty in the Strategy of Poverty Reduction in Lithuania is defined as an insufficiency of income and other resources (material, cultural and social) assuring living standards acceptable in the society of Lithuania. However, this definition does not encompass the notion of social exclusion, which is accentuated in the Second Poverty Programme of the European Union that was based upon the definition of poverty of the Council of Ministers.

A quantitative definition of poverty specified in the Poverty Reduction Strategy was formulated in the course of two key tasks:

(1) to eliminate particularly severe poverty in Lithuania by 2003. Anyone suffering from the shortage of food, absence of a shelter at night or lack of warm clothes will be provided with these prerequisite means. Anyone will get the required medical care, whereas each child and adolescent up to 16 years of age will get a possibility to study.

(2) attempts are made to reduce poverty determined on the basis of the relative poverty line by not less than 13 % by 2005, as well as to reduce

poverty of the poorest social groups (single parents with children, big families, jobless, farmers) determined on the basis of the relative poverty line by not less than 20 % by 2005.

The first (1) task targets to help people with consumption expenditures below the line of particularly severe poverty, i.e., the MSL, which comes as a line of absolute poverty. The second (2) task is designed for people with consumption expenditures below 50 % of average consumption expenditures, i.e. at the line of relative poverty.

In terms of a relative poverty line, poverty is most widely spread in the group of unemployed, in households of persons living on social benefits, raising three or more children, farmers and rural residents (see table 4.3). One in five children of pre-school age lives in a destitute family. A particularly high level of poverty is disclosed in households, which are vulnerable in terms of two or even three indicator, e.g., households of farmers with petty farms raising several children.

Table 4.2. Poverty lines and poverty rate in Lithuania

	1996	1997	1998	1999	2000	2001
Poverty level in accordance with the line of particularly severe poverty (MSL)	1.0%	0.8%	0.8%	0.9%	0.8%	–
Relative poverty line**, in litas	226.2	248.6	276.7	274.6	260.0	264.8
Poverty rate** on the basis of relative poverty line	18.0%	16.6%	16.0%	15.8%	16.0%	16.4%
Fixed relative poverty line**, in litas	226.2	246.4	258.9	261.0	263.6	267.0
Poverty rate** on the basis of fixed relative poverty line	18.0%	16.3%	13.2%	13.1%	16.6%	16.8%

* Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

** European Union indices equivalent to the poverty line and poverty rate are low-income threshold and low-income rate.

The Department of Statistics under the government of the Republic of Lithuania assesses a relative poverty line as 50% of average consumption expenditures, recalculated in compliance with a standard scale of OECD (expenditures of the first adult are equalled to 1; expenditures of all other persons of 14 years of age and elder – 0.7; children up to 14 years of age – 0.5).

The fixed relative poverty line comprises a relative poverty line of 1996 adjusted in accordance with price indices each year. This poverty line is applied for the determination of a share of residents living below the poverty line notwithstanding the changes in living standard of the remaining part of society.

Table 4.3. Poverty rate on the basis of relative poverty line in the most vulnerable groups of residents (in percent)

Type of household	1997	1998	1999	2000	2001
All households	16.6	16.0	15.8	16.0	16.4
Unemployed **	39.6	40.8	40.4	41.1	34.3

Households with three and more children	37.2	34.5	35.4	37.6	32.5
Single persons with children up to 18 years	21.6	22.0	25.7	14.9	16.6
Farmers	30.2	32.2	39.9	35.3	34.9
Rural residents	25.9	26.5	28.2	27.6	27.3
Households with the main bread-winner having basic education (8-9 years)	24.4	24.6	26.3	24.2	26.4
Pensioners	22.1	20.9	19.1	20.4	21.2

* Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

** Households of this type encompass all unemployed persons notwithstanding their formal status, i.e., whether they are job-seekers, whether they have been registered with the labour exchange or not (for example, people living on real estate rent), as well as students living on educational maintenance allowance.

The public opinion survey – or subjective indices of poverty – confirms the spheres of poverty prevalence, too. The majority of households attributing themselves to the group of poor are the households with the main household head having no job, and this is an important issue taking into consideration the fact that unemployment benefits are rather insignificant and only a small part of the registered unemployed are entitled to these allowances. Furthermore, it is perfectly understandable that the number of rural households attributing themselves to the group of destitute is bigger than the number of urban households considering themselves to be poor. The number of households of the first quintiles seeing themselves in the group of the poor is larger than the number of households of the last quintiles, and the number of households of one pensioner and single fathers/mothers placing themselves in the group of the poor is larger than the number of households of other types putting themselves in this group.[9]

The most important challenge with regard to EU accession is the free movement of labour. Even now, because of high unemployment and differences in the level of living more than 100,000 Lithuanians are work in EU countries, most of them illegally. Unemployment prevents people from earning income, but also creates persistent poverty, depresses wage growth and encourages the most enterprising among the population to emigrate. Emigration, in turn, has a negative effect on the solvency of the pay-as-you-go retirement system and the ”brain drain” increases demands on the educational system.

It is planned to initiate the conclusion of bilateral employment agreements, the conclusion of agreements with EU countries and the states that are popular immigration targets of the Lithuanians. The bilateral employment agreements would enable Lithuanian’s citizens to work abroad legally, and the bilateral social security agreements would guarantee their social care.

Another important challenge is the preparation for the use of the support provided by EU structural funds. Appropriate structures and their networks

9 Lithuania 1999. Living Conditions, Vilnius, 2000, p. 92-93.

are being developed. The institutions that will be responsible for the development and implementation of individual programmes have been determined. Technical assistance of the PHARE Twinning Project ”Preparation for the European Employment Strategy” has been provided for The Government of the Republic of Lithuania which is committed to a timely formation of the structures necessary for working with the European Social Fund. In the further work in this field, particular attention should be paid to strengthening administrative capacity, particularly in the areas of financial management, monitoring and evaluation.

4.1.3 18 EU Indicators of Social Exclusion

The EU member states aspire to reach an agreement on indices defining poverty and social exclusion. These indices presented by the Social Protection Committee (further – Committee) of the European Commission will be applied for the evaluation of progress of states striving to reduce poverty in member states by 2010.[10] Therefore, it is highly probable that Lithuania will have to use these indices upon accession to the European Union and perhaps even earlier. Some indices are similar to the ones in use in Lithuania; however, other indices are absolutely different. Differences of indices will have an impact on the perception of the scope of poverty and social exclusion, and on presentation of statistical data, too.

Table 4.4 List of primary EU indicators and their availability in Lithuania

	Indicator	**Definition**	**Availa-bility in Lithuania**
1a	Low income rate after transfers with breakdowns by age and gender	Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. Age groups are: **1.**0-15, **2.**16-24, **3**.25-49, **4**.50-64, **5.** 65+. Gender breakdown for all age groups + total	**NA in OS**[11]

[10] Report on Indicators in the field of poverty and social exclusion – Social Protection Committee – October 2001.

[11] NA in OS – not available in official statistics. Some similar indicators provided in this report are calculated under special request. Also some indicators for the period 1996-1999 are available at: Co-operation with Candidate Countries. Statistics on Income, Poverty & Social Exclusion – Results – European Commission, Eurostat, Directorate E: Social statistics, Unit E-2: Living conditions – Doc. E2/IPSE/CC/5/2002.

	Indicator	**Definition**	**Availa-bility in Lithuania**
1b	Low income rate after transfers with breakdowns by most frequent activity status	Percentage of individuals aged 16+ living in households where the total equivalised household income is below 60% national equivalised median income. Most frequent activity status: 1.employed, 2.self- employed, 3.unemployed, 4.retired, 5.inactives-other. Gender breakdown for all categories + total	**NA in OS**
1c	Low income rate after transfers with breakdowns by household type	Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. 1. 1 person household, under 30 yrs old 2. 1 person household, 30-64 3. 1 person household, 65+ 4. 2 adults without dependent child; at least one person 65+ 5. 2 adults without dep. child; both under 65 6. other households without dep. Children 7. single parents, dependent child 1+ 8. 2 adults, 1 dependent child 9. 2 adults, 2 dependent children 10. 2 adults, 3+ dependent children 11. other households with dependent children 12. Total	**NA in OS**
1d	Low income rate after transfers with breakdowns by tenure status	Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. 1. Owner or rent free 2. Tenant 3. Total	**NA in OS**
1e	Low income threshold (illustrative values)	The value of the low income threshold (60% median national equivalised income) in PPS, Euro and national currency for: 1. Single person household 2. Household with 2 adults, two children	**NA in OS**
2.	Distribution of income	S80/S20: Ratio between the national equivalised income of the top 20% of the income distribution to the bottom 20%.	**NA in OS (see table 4.10)**

	Indicator	**Definition**	**Availa-bility in Lithuania**
3.	Persistence of low income	Persons living in households where the total equivalised household income was below 60% median national equivalised income in year n and (at least) two years of years n-1, n-2, n-3. Gender breakdown + total	**NA in OS**
4.	Relative median low income gap	Difference between the median income of persons below the low income threshold and the low income threshold, expressed as a percentage of the low income threshold. Gender breakdown + total	**NA in OS**
5.	Regional cohesion	Coefficient of variation of employment rates at NUTS 2 level.	**NA in OS**
6.	Long term unemployment rate	Total long-term unemployed population (≥12 months; ILO definition) as proportion of total active population; Gender breakdown + total	**See table 4.11**
7.	Persons living in jobless households	Persons aged 0-65 (0-60) living in households where none is working out of the persons living in eligible households. Eligible households are all except those where everybody falls in one of these categories: - aged less than 18 years old - aged 18-24 in education and inactive - aged 65 (60) and over and not working	**NA in OS**
8.	Early school leavers not in education or training	Share of total population of 18-24-year olds having achieved ISCED level 2 or less and not attending education or training. Gender breakdown + total	**NA in OS**
9.	Life expectancy at birth	Number of years a person may be expected to live, starting at age 0, for Males and Females.	**NA in OS**
10.	Self defined health status by income level.	Ratio of the proportions in the bottom and top quintile groups (by equivalised income) of the population aged 16 and over who classify themselves as in a bad or very bad state of health on theWHO definition Gender breakdown + total	**NA in OS**
11.	Dispersion around the low income threshold	Persons living in households where the total equivalised household income was below 40, 50 and 70% median national equivalised income	**NA in OS**
12.	Low income rate anchored at a moment in time	Base year ECHP 1995. 1. Relative low income rate in 1997 (=indicator 1) 2. Relative low income rate in 1995 multiplied by the inflation factor of 1994/96	**NA in OS**

	Indicator	Definition	Availa-bility in Lithuania
13.	Low income rate before transfers	Relative low income rate where income is calculated as follows: 1. Income excluding all social transfers 2. Income including retirement pensions and survivors pensions. 3. Income after all social transfers (= indicator 1) Gender breakdown + total	**NA in OS**
14.	Gini coefficient	The relationship of cumulative shares of the population arranged according to the level of income, to the cumulative share of the total amount received by them	**NA in OS**
15.	Persistence of low income (below 50% of median income)	Persons living in households where the total equivalised household income was below 50% median national equivalised income in year n and (at least) two years of years n-1, n- 2, n-3. Gender breakdown + total	**NA in OS**
16.	Long term unemployment share	Total long-term unemployed population (□12 months; ILO definition) as proportion of total unemployed population; Gender breakdown + total	**See table 4.11**
17.	Very long term unemployment rate	Total very long-term unemployed population (□24 months; ILO definition) as proportion of total active population; Gender breakdown + total	**NA in OS**
18.	Persons with low educational attainment	Educational attainment rate of ISCED level 2 or less for adult education by age groups (25-34, 35-44, 45-54, 55-64). Gender breakdown + total	**NA in OS**

Some EU indicators and Lithuanian measures

The low income rate after transfers is an index similar to the index of the relative poverty rate applied in the poverty reduction strategy in Lithuania and determined on the basis of the relative poverty line. The ratio is defined as persons living in households with a general gross income below 60 % of the average income of all households of the state. It means that the poverty line has been lifted slightly (not 50 % but 60 %); furthermore, a modified equivalent scale of OECD has been applied for the recalculation of income (income of the first adult member of a household is equalled to 1, income of the second and the following adult – to 0.5 instead of 0.7, income of each child up to 14 years of age – to 0.3 instead of 0.5). If a the new index was applied, in 2001 the number of Lithuanian residents living below the poverty line would have comprised 18.5 % instead of 16.4 % (see table 4.5).

Subgroups of the households proposed by the Committee are more detailed and accurate than in Lithuania's statistics, and more suitable for the analysis of poverty and social exclusion.

New indices, a part of which has not yet been introduced in Lithuania, and a new classification of households will reflect new categories of poor or socially excluded people, which will highlight the need to change the main accents of the poverty reduction strategy and the respective programme.

Under the request of EUROSTAT the Lithuanian Department of Statistics has recalculated only two of the most general indices out of 18 indices introduced by the Committee. However, the indices have been recalculated without distribution in accordance with various characteristics (see the table below).

Table 4.5 Income Poverty Indicators

Indicator		**Value**					
		1996	1997	1998	1999	2000	2001
Income distribution share ratio S80/S20		6,6	6,1	5,3	5,4	5,9	5,9
At risk of poverty rate before social transfers	Eurostat method	20,9	20,2	20,7	20,6	22,2	22,8
	National method	-	-	-	-	-	-
At risk of poverty rate after social transfers	Eurostat method	19,3	17,2	17,2	17,2	18,5	18,5
	National method	18	16,6	16	15,8	16	16,4

* Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

The indicators on Poverty & Social Exclusion for the candidate countries have been adopted at the Laeken European Council in December 2001[12]. Also these indicators were calculated for the period 1996-1999, but the values slightly differs from presented in the table (4.10).

The Leaken indicators for Lithuania also comparable with the same indicators for EU-15. The risk-of-poverty rates for Lithuania are not in big contrast with average EU-15 values. The most marked difference is in risk of poverty threshold (PPS 2472 – for Lithuania, and PPS 7263 – for EU-15) which reflects big difference in the absolute level of living.

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[12] Co-operation with Candidate Countries. Statistics on Income, Poverty & Social Exclusion – Results – European Commission, Eurostat, Directorate E: Social statistics, Unit E-2: Living conditions – Doc. E2/IPSE/CC/5/2002.

4.2. Evaluation of Policy Challenges and Policy Responses

4.2.1 Inclusive Labour Markets[13]

Driving factors - Gender dimension

Unemployment is the key root of poverty, and the jobless level in Lithuania is high (see chart 4.2). The hike of unemployment by 1 % would force approximately 18,000 households below the poverty line.

Unemployment rate of men is higher than of women in all age groups (see table 1.19 in chapter 1). Nevertheless, there are some factors worsening living conditions of women:

First – growing unemployment rate. In accordance with the data of the Labour Force Survey (LFS), the unemployment rate grows steadily. In May 2001 the unemployment rate was 16.5 %, in November it rose to 17.5 %. The unemployment rate among male residents was 19.4 % and 20.0 % respectively; among female residents it was 13.5 % and 14.8 %.[14]

Second – lower economic activity of women than of men (see table 1.20 in chapter 1). For this reason and because of limited possibilities to work part time, women have limited possibilities to combine family life with participation in economic activity. Approximately 7% of those in employment in 1999 were working part-time; part-time work is thus less prevalent than in the EU, where it accounts for 18% of all workers. The difference is particularly marked in the case of Lithuanian women, only 7% of whom work part-time as compared with 34% in the EU.[15]

Third – men mainly occupy managing positions in all economic activities.[16]

As result of mentioned factors, females wages are lower than males. The ratio of female to male wages had been relatively constant in the range of 71%-74% between 1994 and 1998, but has risen significantly in the last two years. The average monthly wage of women in 2000 was LTL 968, or 81.3% of the male average (LTL 1,143). Women's monthly wages, as compared with men's, are the lowest in the area of banking and private insurance (66.5% per cent), and highest in education, where they exceed men's wages by 1.9%.[17]

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13 Problems, challenges and urgent policies of inclusive labour markets are described in the "Joint Assessment of Employment Policy Priorities in Lithuania", 12 February 2002 (hereinafter referred to as JAEPP).

14 http://www.std.lt/

15 JAEPP, p.6.

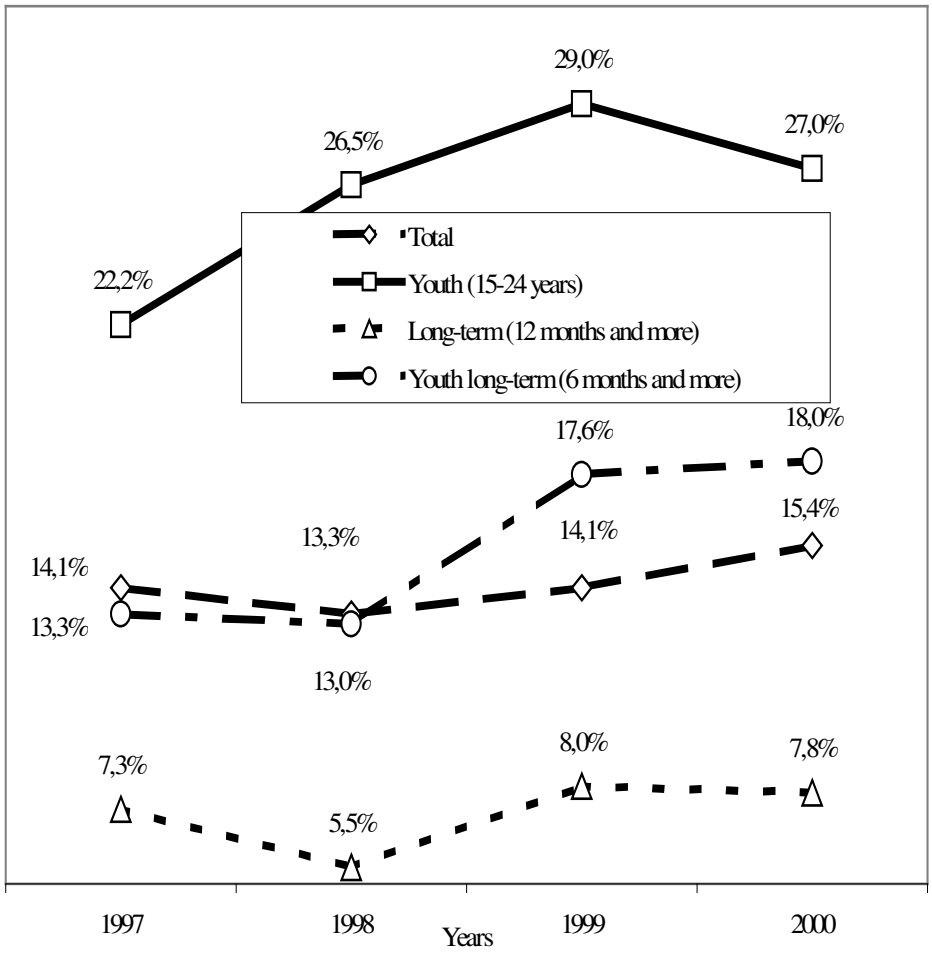
16 Women and men in Lithuania, Vilnius, 2001, p. 7, 51.

17 JAEPP, p.9-10.

Youth and long-term unemployment dimension

Youth unemployment is higher than in all other age groups both for males and females (see table 1.19 in chapter 1). Youth long-term unemployment is especially acute problem (see chart 4.2).

Chart 4.2 Unemployment rates by LFS data
(in % of corresponding labour force)



* Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

Long-term unemployment accounts for approximately half of the total unemployment, whereas long-term unemployment among the youth comprises a yet bigger share (in compliance with the international practice young unemployed is moved in the category of a long-term unemployed after 6 months of unemployment);

Unemployment in the group of the youth exceeds the general unemployment rate by 1.5-2 times;

Comparison of unemployment indices in Lithuania with the EU-15 (in brackets) in 2000: unemployment ratio: general: 15.4% (8.2 %); youth: 27.0 % (16.1 %); long-term unemployment: general: 7.8 % (3.6 %); youth: 18.0 % (7.8 %).[18]

Long-term unemployment creates situations of permanent poverty when a household gets used to living on benefits and cannot imagine living in any other way. Evaluations show that 20-40 % of the households entitled to social benefits get the allowances incessantly for 25-36 months.[19]

The unemployment of youth gives rise to the feelings of despair and prompts young people to emigrate. The poll conducted in November 2001 revealed that more than 200,000 or 10 % of Lithuanians in the age group of 15-65 years have worked abroad. The average age of people willing to work abroad is around 30 years.[20]

Education dimension

Unemployment varies substantially by level of education. In 2000, according to the LFS, persons with post-secondary education had an unemployment rate of 10%, as compared with 18% for those with secondary education and 22% for those with only basic education (see also table below for age groups).

Table 4.6 Unemployment rate by level of education and age (in per cent)

	1997	**1998**	**1999**	**2000**
Total	**14.1**	**13.3**	**14.1**	**15.4**
Tertiary education	12.7	8.7	9.4	10.2
Secondary education	16	16	17.1	17.9
Basic, primary education	12.9	17.7	18.8	22.3
15-24 years	25.2	22.1	26.5	29
Tertiary education	18.7	13.2	23.4	25.4
Secondary education	32.2	21.3	25.2	24.6
Basic, primary education	20.8	26.8	28.4	34.6
25-49 years	13.2	13	13.4	14
Tertiary education	12.8	8.8	9.1	9.7
Secondary education	13.8	15.8	16.3	16.5
Basic, primary education	12	21.4	21.8	23.1
50-64 years	9.9	9.1	9.9	14
Tertiary education	7.7	7.4	7.9	8.6
Secondary education	10.1	11.3	14	20.7
Basic, primary education	16.7	9.5	9.5	16.2

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 126

[18] http://europa.eu.int/comm/eurostat/Public/datashop/

[19] Research of the Strategic Partnership Results. Overview of the 1999 Strategic Partnership research results (in Lithuanian), Vilnius, 2000, charts 2.12, 2.13.

[20] Report on poverty status in Lithuania (in Lithuanian). Vilnius 2001, p. 18.

Approximately four fifths of the unemployed registered with the Labour Exchange are unqualified, or their qualification is too low or is unrelated to the current needs of the labour market. Half of the young that are registered unemployed have no qualifications at all.[21] The application of the vocational training to the young unemployed people is limited by the fact that relatively high numbers of them (3,3 thousand in 2000) do not have basic education.[22]

Employment quality dimension

At a broad sectoral level, output per worker is highest in manufacturing, followed by construction and services, and lowest in agriculture, which accounts for 17.7% of all employment, but less than 7% of GDP. The difference between disposable income of urban and rural population even increased during the period of 1996-2001. In 1996 average disposable income per one member of rural household was by 24% lower, and in 2001 by 32% lower than in urban households.[23] The dependency from agriculture as sole source of income is a specific feature of rural population, and low income is limiting consumption expenditures, investments opportunities into agriculture or other business.

Current policies to promote employment

The Lithuanian Labour Exchange (LLE) is responsible for job-brokerage as well as for managing a range of active labour-market programmes (see chapter 2.1.1 for details). The role of the LLE in promotion of employment is of growing importance because the increasing portion of the job seekers is registering at the labour exchange offices (the females more often than the males).

Table 4.7 Unemployment and its registration rates (in per cent)

	1995	1996	1997	1998	1999	2000
LFS data	17.1	16.4	14.1	13.3	14.1	15.4
LLE data	6.1	7.1	5.9	6.4	8.4	11.5
Portion of registered unemployment	35.7	43.3	41.8	48.1	59.6	76.7

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 128

Support to the most vulnerable groups

The LLE also has responsibility for ensuring the legal employment guarantees for the groups identified in the Law on Support for the Unemployed (women with children of up to the age of 14, persons 2 years of pre-pension age, disabled). In the period of 1992-2002 the most socially

21 PIPRS (draft of October 2002), p. 13.
22 PIPRS (draft of October 2002), p. 14.
23 Survey of Lithuanian Economy, 2002, No. 1 (in Lithuanian), Vilnius, 2002, p. 6, 9, 10

vulnerable persons were granted additional employment guarantees (employment quotas), which helped find them a job.

Following the adoption of amendments to the Law on Support of the Unemployed by the Seimas of the Republic of Lithuania on December 21, 2001, additional employment guarantees were rejected and replaced by additional support to the unemployed. Determination of employment quotas remained in force only for the disabled of the 1st and the 2nd groups of disablement who are seen as the most difficult group of persons to integrate into the labour market.

Mandatory quotas of employment and establishment of work places, which were previously applied to persons entitled to additional employment guarantees, often violated the right of the employer to choose employees of the required skills freely. Furthermore, low qualifications and poorly reimbursed jobs were offered within the framework of employment by quotas. Moreover, quotas do not prompt persons to take care of improvement of professional skills and decrease activity of these persons on the labour market.

Additional support to the unemployed target to:

1) ensure equal rights of women and men raising juvenile children to the support of employment and to the unemployment benefit;

2) expand groups of unemployed subject to additional support on the labour market with the most vulnerable persons;

3) improve material support of unemployed of pre-pension age extending the term of payment of unemployment benefit or assigning the term and suspending application of active means of labour market policy with their consent;

4) boost motivation of school leavers to search for a job;

5) apply economic incentives for employers for the support of employment (subsidies for the support of employment), including small-size and medium-size enterprises;

6) make more rational use of financial resources of the Employment Fund, concentrating these means on the support of employment of the unemployed in urgent need of support for employment.

Companies, which provide contractual employment to the unemployed who are subject to additional support on the labour market, may receive subsidies for the reimbursement of expenditures on the creation of new work places.

Quotas of employment of the disabled of the 1st and the 2nd groups of disability offer no solution to the problem of their employment. The absence of an efficiently operating system of rehabilitation for the disabled poses a

more important topic. The current system of social insurance in case of disability restricts itself only to the reimbursement of usual work payment with disability pensions; however, the system offers no active means of rehabilitation and re-integration into the labour market, which could restore the capacity of work for at least a part of the disabled thus decreasing the demand in disability pensions.

PIPRS envisions: (a) to draft a plan of reform of social insurance in the event of disability, which would determine the role of social insurance in rehabilitation and reintegration of disabled pensioners to the labour market; (b) to improve the order of determination of capability of the disabled for work in order to create opportunity for disabled of the 1st and the 2nd groups of disability to get a positive characteristic of the capability to work and to be able to apply for the support of the LLE in search for work.

In order to increase the employment of socially vulnerable persons the PIPRS envisions: (a) to establish officers, affiliates of labour exchanges and specialized labour centres adapted to their needs; (b) draft territorial target labour market programmes.

Promotion of the flexible work organisation

A more flexible organisation of work would help to improve the condition of persons with low income, in particular, of women raising children, studying youths and a part of the unemployed.

PIPRS envisions: (a) the legal measures, which would stipulate greater variety of forms of work organisation and a more flexible regulation of work payment, a better regulation of social protection of employees and a protection of the labour rights; (b) the organisation of training and the provision of information about potential forms of labour organisation, regulation of wages, organisation of collective negotiations, etc., to the social partners and to socially vulnerable groups (especially to jobless women striving for self-employment or returning to work after a longer break).

Strengthening of employability

In accordance with PIPRS each registered unemployed shall be included into active measures of labour market policy within three months. In compliance with PIPRS approximately 281,500 unemployed are expected to be involved into active measures and the level of unemployment should decrease by 1.1-1.3 %.

In accordance with the data of a sociological survey of young unemployed (up to 25 years of age) conducted by the Labour and Social Research Institute in 2000, approximately one in five young unemployed who opted not to continue studies did not know what profession he/she should choose, where he/she could get training for the most marketable profession, where a profession could be obtained in a short period of time. A part of the pupils

have no possibility to go to the specialists of professional information, orientation and consultation to the training and consulting services of the territorial labour market due to deteriorated financial conditions. Provision of professional information and consultations is insufficient for military conscripts and persons placed at imprisonment institutions.[24]

Attempts are made to create an efficient system of provision of professional information and consultation, to alleviate access to professional information, orientation and consultation for pupils of comprehensive schools, the youth and the adults, to stimulate the youth and the adults to get to know themselves, to reveal personal possibilities, develop responsibility for their future, to intensify and motivate professional training search for a job and integration into the labour market thus helping these people to avoid unemployment and the accompanying poverty. PIPRS also envisions to create an information system of education in Lithuania dealing with training possibilities and ensure Internet access to it; to increase accessibility of psychological help and consulting services to groups of persons living below the poverty line, in particular to the unemployed, through the expansion of the network of territorial training and consulting agencies.

4.2.2 Guaranteeing Adequate Incomes/Resources

Current situation - Growth and equality

From 1999 to 2001, relative poverty increased from 15.8% to 16.4%, and poverty defined by a fixed relative measure increased from 13.1% to 16.8%. The increase of poverty rate on the basis of a fixed relative line reflects a general decrease of consumption expenditures, whereas the increase of the poverty rate based on the relative line signals an increase in inequality in the distribution of income. The phenomenon is illustrated by the income distribution ratio S80/S20 (see Table 4.10). It is clearly visible that the income distribution ratio grew to 5.9 points in 2000 and 2001. (In 1977 the income distribution ratio formed 5.7 points in 15 member states of the European Union, ranging from 2.7 points in Denmark to 7.4 points in Portugal and the UK)

Summing up of the condition of reduction of relative poverty leads to the following conclusions:

- The level of relative poverty depends both on the growth of the economy and on the inequality of income, too. The growth of the latter factor may result in an increase of relative poverty. The inequality of income reflects interior business regularities; the fact that about 70 % of the employed operate in the private sector signals that the level of relative poverty is predetermined by the distribution of income, which is created in that sector and which is hard to control with tools in possession of the state.

[24] PIPRS (draft of October 2002), p. 10-11.

- The increase in inequality of income may stimulate growth of investments and the economy, whereas means for the reduction of relative poverty may pose an obstacle for this purpose. Such risky measures include the determination of minimal wages, the raising of the progressiveness of taxes, etc. These measures narrow inequality of net wages and the income, potential possibilities of savings and investments.
- The formulation of a qualitative task on poverty reduction and selection of proper active measures, which would help to increase and improve employment, are of utmost importance. Even measures of support to the most vulnerable persons could be designed as active means of overall policy.

Role of means tested benefits in poverty elimination

Table 4.2 reveals that the share of people with income below the MSL does not post any changes year by year, i.e., the level of particularly severe poverty is constant. Why is so difficult to eliminate particularly severe poverty?

First. Only a few benefits (social benefit and compensations for heating and hot and cold water) are means-tested and they constitute only 3% of social expenditures (see table 1.7 in chapter 1). Other benefits and poverty-reduction measures are aimed at certain *categories* of the population, although the characteristic determining eligibility is not always directly related to the poverty status. Thus only a small part of scarce resources is ***directly*** (i.e., means-tested benefits) dedicated to poverty elimination.

Second. The level of particularly severe poverty on the basis of the MSL should be controlled easily with the help of social benefits because the latter is allocated on the basis of means testing and is assigned to the people who have insufficient funds and no possibilities to earn money. Although, social benefit is assigned with the application of restrictions depriving some categories of people of the right to this benefit: (a) a benefit is not assigned if a household has a personal farm exceeding 3.5 hectares, if at least one household member is an owner of a personal establishment or has acquired a patent on some activities. Thus, if the aforementioned types of activities are not efficient enough and do not produce any income comparable with SSI, the terms of assignation of the social benefit does not help to overcome poverty unless the household resolves to cut the aforesaid activities short; (b) a social benefit is not assigned for the persons seeking for a job through state labour exchanges, if they do not get any unemployment or training benefit and are not involved in any public works.

Third. The amount of social benefit is not always sufficient to boost family income up to MSL. All eligible persons with an income below the state supported income (hereinafter referred to as SSI) could receive social benefits in the amount of 90 % difference between SSI and average income of one household member per month. From May 1, 1998, the SSI was135 litas, whereas the MSL stood at 125 litas per capita per month. Thus, a

formally calculated social benefit could boost average the income of a household to the MSL if the aforesaid income forms not less than 35 litas per month per capita (if actual family income is 35 litas per capita, then income with social benefit equals 125 litas [35 + (135 - 35) x 0.9]).

Fourth. On the informal level, the elimination of particularly severe poverty depends on the terms for the allocation of social benefits, the acknowledgement of residents and the predisposition to put efforts in getting that benefit. The minimal amount of social benefit comprises one of its restrictions: if the amount of benefit forms less than 5 litas, the benefit is not paid. A part of people will not wish to make efforts for an insignificant benefit of 5 litas.

Finally, overcoming of particularly severe poverty depends on the determination of the size and content of the MSL. At present a modest set of foodstuffs comprise approximately 70% of the MSL basket, thus, a guaranteed income in the amount of the MSL income would signify that a person would have practically no money to spare on accommodation and warm clothing. In 2000 consumption expenditures of the first decile of income per one household member formed 128.4 litas, i.e., were close to the MSL. These households allocated 64% of their income on foodstuffs, 10.5% on accommodation and utilities. They could afford to allocate only 4% or 5 litas for clothing and footwear for one household member per month. They could assign even less for health care and education. The use of the compensations of expenditures of residents with low income on heating, hot and cold water, alongside social benefit, signifies that the MSL basket does not embrace increased expenditures on utilities, accommodation, which is attributed to the group of basic needs undoubtedly. Yet, these two measures of maintenance of income level fail to ensure satisfaction of all main needs, either. Therefore, other methods are used for the elimination of particularly severe poverty, i.e., charity canteens and shelter houses are established, cheap clothing from charity are distributed, etc.

The important point is, also, that income support through the social benefit may disrupt beneficiaries' incentives to earn the money themselves. For example, in 2000 the provisions on allocation of social benefits have been changed: families with an owner of a personal enterprise among its members get the right to a social benefit in cases when the enterprise is not engaged in any activities and its owner is unemployed. Thus, dismissal from work and termination (at least formal) of activities, which may not be too profitable, may suffice. In 2000 the amount of unemployment benefits and other benefits in the income of households of businessmen soared more than twice as compared with 1997 (the amount of old age pensions even posted a decrease). The share of disposable income on employment decreased markedly (see table 4.8 below). The impression is that the temptation of benefits and terms of their allocation tempted some part of businessmen to withdraw from the employment market and terminate independent activities.

Table 4.8 Disposable income of businessmen households (per capita per month; in litas and in %)

		Disposable income		Income from				All social transfers	
				employment		self-employment			
		1997	2000	1997	2000	1997	2000	1997	2000
Income	in litas	489.5	472.5	55.3	46.4	323.8	334.7	22.0	34.4
	2000/1997		96.5%		83.9%		103.4%		156.4%
Structure of income		100%	100%	11.3%	9.8%	66.1%	70.8%	4.5%	7.3%

* Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

Role of all system of benefits in poverty elimination

Passive rather than active measures dominate poverty-reduction policies (see table 1.7 in chapter 1). Even half of the spending for unemployment is allocated for unemployment benefits. Passive measures are those which alleviate the consequences of poverty but do not address the causes. This is reflected, for example, in the increasing proportion of unemployment and other social benefits in the disposable incomes from 1997-2000. The share of social transfers expanded during this period from 20.1 % to 24.3 %.[25]

The amount of unemployment benefit does not depend on former salary of a person who lost a job or on the amount of contributions paid by that person. The benefit does not ensure sufficient reimbursement of income lost due to unemployment and does not guarantee the source of living within the period of search for a new job. It signifies that this benefit does not perform its key duty as even the maximum benefit stand below the relative poverty line. Insufficient unemployment benefit results in a higher demand for social assistance of households of unemployed persons.

Policy proposals to improve incentives

PIPRS envisions: (a) to determine the minimum amount of unemployment benefit that shall not be lower than the calculable MSL (187 litas); (b) to reform social insurance with the aim to ensure that persons under unemployment insurance are the only ones to receive unemployment benefits, and persons non-insured are directed to the system of social support; (c) to shorten the mandatory term of social insurance contributions prerequisite for the receipt of unemployment benefit to 6 months within the last 24 months or to 3 months within the last 12 months before the loss of the job; (d) to differentiate the amount of unemployment benefits linking the amount of the unemployment benefit with the amount of wage of the insured; (c) to initiate adoption of an amendment to the law stipulating that active measures of labour market policy could be financed from the state budget.

PIPRS envisions the following measures within the framework of improvement of monetary support: (a) creation of a unified system of

[25] Data provided by the Department of Statistics at the Government of the Republic of Lithuania, 2001-10-09. No. (111)-06-894.

provision of social assistance in-cash based on the principle of income and *property* testing; (b) implementation of a requirement that households applying for the assignation of a social assistance in-cash should provide the data about income and about the property; (c) implementation of a requirement for persons registered with state labour exchanges to execute obligations outlined in individual employment plans of state labour exchanges; (d) granting of the right to the social benefit to families of long-term unemployed persons. Approximately 63,000 members of families of the unemployed would receive a social benefit.[26]

Taxes

The high tax wedge represents a significant barrier to the creation of jobs at relatively low wages, and a disincentive to the unemployed in taking up such jobs. Moreover, high marginal rates of tax and social contributions promote employment in the "grey economy". Reductions in the tax wedge, particularly at lower earnings levels, should thus be an urgent policy priority.[27]

In this area PIPRS plans to:

Prepare the new law of natural persons' income tax, which establishes the reduction of the tax share for low- income individuals. Also, to establish the minimal tax-exempt income amount, which would be related to the number of the dependants and the disabled. This will let increase the income of individuals with low earnings and reduce the danger of the "poverty trap". As the income tax rates for natural persons are being reduced and minimal tax-exempt quantities are increased, it is important to ensure the stability of health insurance fund.

Pensions

According to the Statistics department the average old age pensioner's pension in the year 2000 was 312,5 LT, it amounted to 39,2% of the average wage.

Approximately 36% of the old age pensions and 46 % of the disability pensions are below the relative poverty level. 4,8% of the old age pensions and 12,5% of disability pensions dropped to the especially low poverty level – 125 LT. However, a part of disability pensioners (especially the disabled belonging to the III group) are able to work, but at such high unemployment levels, they find it difficult to compete in the labour market. People who receive these pensions and who are not supported by their relatives, cannot satisfy their basic needs: they are not able to pay communal and other fees, cover expenses of treatments, they cannot buy medication, food and other goods of primary importance. The pensioners' poverty is aggravated by the decrease of compensations for medication, transport and other.

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26 PIPRS (draft of October 2002), p. 55.

27 JAEPP, p. 24

Each pensioner from the SSIF is entitled to only two pensions (e.g. old age and widow pension). Also, he can receive from the state budget one state pension, which belongs to him and a state widow pension, which is paid only with one of other state pensions. Thus, old age or disability pensioners can receive four pensions. According to State Social Insurance Fund Board in 2001 in Lithuania 45 % of all pensioners received two and more pensions. In the segment of old age pensioners there were 37 % of more than two pension collecting pensioners and in the segment of disability pensioners – 18 %, and 77 % of the widow and orphan pensioners received two or more pensions as well.

PIPRS plans to increase the state social insurance and social assistance pensions by increasing the pension's base and by raising the level of the average insured monthly income. After increasing the national insurance pension, the social assistance pensions for disabled children, the disabled in early youth etc., and nursing pensions for totally disabled will also increase. The aim is to establish the greater influence of work record to the amount of the pension acquired before the 01/01/1994. It is also planned to give the possibility to those disabled who have worked for three years after they were granted the disability pension to get the old age pension assigned to them; also, the possibility of recalculation of the partial pensions in cases when the recipient, who, after having been granted the partial pension, completes the necessary work record. In order to increase the future state insurance pension and social old age guarantees in general, in cases such as disability or loss of the wage earner, it is planned to insure the self-employed to make them eligible for the additional state insurance pension. Also, it is planned to avoid expanding the circle of state insurance pension recipients and not expand the state insurance pension base on which some state pension amounts depend.

There is a risk, that there is an attempt to solve social assistance problems through the state insurance system. On the other hand, the income of pensioners as of any other person may decrease due to other reasons, and the elimination of these reasons can be carried out by the common income support scheme. Finally, pensioners are mostly concerned not by the level of income, but by the problem of social exclusion, the accessibility of the necessary services.

4.2.3 Combating Education Disadvantage

Pre-school education

The roots of reasons for the low level of education and problems of employment of families with children are observed as early as in the pre-school education system.

In 1997 the pre-school education institutions could not meet 40% of parents demands. In cities pre-school education institution attendance is higher than in rural areas – in 2000 it came to 58,0% and 11,8% respectively for children from 1 to 6 years of age.[28] Thus the start possibilities are very different for those attending pre-school education institutions and those not attending, for city children and children in rural areas. PIPRS plans to prepare a programme guaranteeing pre-school education of all 5 years age children.

Comprehensive education

There is no data regarding the exact number of early school leavers under 16 years of age. The difference in numbers provided by the ministry of Education and by the Statistics department is tenfold. " Drop-out rates in basic schooling remain excessively high, with more than 20% of children failing to obtain even a basic education certificate… The most pressing problem facing Lithuania is the high level of drop-out during and at the end of basic education. Arguably, insufficient attention has been given to this question to date"[29].

But the problem is not only in school attendance, but also the training resources and the quality of the education. E.g. additional funds for acquiring textbooks are donated by the municipalities, pupil's parents. In 1997 the assignation for the renewal of school library funds from the state budget for one pupil was 1,62Lt, 1999 – there was no assignation at all. In 2000 the assignation was 0,62 Lt. The number of books received as charity exceeds the number of books bought for the state funds.[30]

In order to reduce and limit the expansion of poverty by educational means, PIPRS intends:

- to increase the accessibility of education, to establish funds for assigning the financial support for children and youth;
- to devote more attention to the young that have learning motivation and those who have studying problems;

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28 PIPRS (draft of October 2002), p. 36.
29 JAEPP, p.15, 17
30 PIPRS (draft of October 2002), p. 36-37.

- to create favourable conditions for children who need specialized education, to alleviate their integration into the comprehensive educational institutions;

- to develop the teachers' communication with parents, to devote special attention to disadvantaged families.

Vocational education

For the training of the unemployed beside the labour market programs, the formal education programs are applied. Employers more often require the additional professional competence which is granted as a result of qualification building through the modular education.

There is an insufficient choice of programs for advancing the qualification and retraining of the unemployed who have higher education, because formal labour market vocational training is the education that awards the two lowest educational levels (I and II). It is expedient to develop the non-formal education, create the system of competence – evaluation, which would allow acknowledging the competence acquired by the non-formal training.[31]

In order to achieve higher flexibility in the vocational training of labour market, to make this market meet the demands of learners and employers, the structure of modular content training is more frequently used. Vocation and vocational training standards are being generated. 2000-2001 saw the continuation of the consistent attestation of labour market teachers. The program of pedagogical minimum "The development of the new methods of pedagogical work" was also prepared. The qualification raising seminars are being organized for the vocational teachers, for the leaders of labour market training centres.

Continuing training (Adult education)

Continuing training gives a person opportunities to adjust to the structural and technological changes in the industry, secures his competitiveness and professional mobility in the changing labour market.

In 2000-2001 in Lithuania were active: 23 comprehensive schools for adults, one of them - in rural area. The net of adult education institutions does not everywhere satisfy the educational needs of adults, this concerns especially rural residents.

The mechanism for the municipal and state support for the continuing vocational training has not been prepared. Training is funded by employers or by participants themselves. The life-long education system has not been created. This system should embrace the educational system of children,

[31] PIPRS (draft of October 2002), p. 13.

youth and adult, working and unemployed, and it should create opportunities for everyone who has exited the system for one reason or other to re-enter it at any point and resume the learning process according to the learner's competence, and to continue learning all life.

Some PIPRS measures

There are plans to give everyone the possibility to develop the qualification by using higher education program modules that are delivered by the extramural or correspondence studying method.

There is intention too prepare and implement the means, which increase the employers interest to invest into the vocational training of their employees.

The overall aim is to prepare a development strategy of the continuous vocational adult training, to reach the long- term agreement of all people, interested in issues of the continuous vocational training. The better continuous vocational training conditions are to be created.

4.2.4 Family Solidarity and Protection of Children

The data of Tables 1.10 – registered divorces (see chapter 1) and 4.3 indicate that such poverty and social exclusion factor as the breakdown of families is has an extremely negative effect in the context of poverty reduction policy. Because of the breakdown of families, the number of stray children increases, as increases the burden of single parents supporting and rearing their children.

Table 4.9 Number of registered extra-marital births (from the total quantity of child births)

	1990	1995	1998	1999	2000
Total	7.0%	12.8%	18.0%	19.8%	22.6%
City	6.5%	12.1%	16.3%	18.2%	20.7%
Rural	8.0%	14.0%	20.9%	22.6%	25.6%

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.37.

The policy of integrating orphans and stray children into families

The implementation of this policy is twofold:

The first aspect is the integration of orphans and stray children into the family (household), i.e. into the environment that is close to the child. This aspect overcomes the child's exclusion from the family and the eventual poverty risk, and should give him normal conditions for the integration into the society. However, as the facts indicate, there remains one more problem of social exclusion from normal conditions – the implementation of parents'

(foster-parents) responsibility for the children. In the recent few years social workers have been struggling in this field, helping children who are maltreated, who become victims of domestic violence and abuse.

The second aspect is child care benefit, which is paid to foster-parents – since January 1st 1995 it was 1,5 MSL. In 1998 it was raised to 2 MSL. In 1999 it was raised to 4 MSL. The relative poverty level in 1999 was 276,7 Lt or 2,2 MSL. Thus the allowance of 4 MSL significantly exceeds the relative poverty line and should be treated at least as a compensation for the moral damage of losing one's parents. After the introduction of the 4 MSL child care benefit, the care for orphans and stray children no longer poses a poverty problem and will not be so for a long time to come. Children who have biological parents, but are maltreated, can live in poverty as well as in excess. Faulty child- care must be an additional factor in determining the assignation of financial support, but not the condition for assigning the support.

The policy of supporting large families

This policy is comprised from three aspects of financial support:

First – support for families, raising 3 and more children. From November 1st, 1997 it amounted to 1 MSL for the first and 0,3 MSL for every additional child. When allocating the allowance the income testing is carried out in families with 3 children but not for those where there are 4 and more children.

The second aspect is related to the tax-exempt minimum in calculating personal income tax of the natural person. From February 1998 the minimum was determined at 368 Lt and in April 2002 the minimum was raised to 430 Lt. This amount coincides with the minimum monthly wage.

The third aspect is free meals catering for children in comprehensive schools to the extent it is applied to large families. Free meal application for large families is not clearly defined. During the expert inquiry (see 4.1.1) this measure took the first spot according to inefficiency and inexpediency (this was indicated by 21% of the respondents).

Let us presume that both parents are working, both get the minimal monthly salary and the allowance equal to 1,3 MSL, allocated for the 4 children without means testing. The disposable income of such a family from April 2002 is 1022,5 Lt, or 170,4 Lt for each family member. The family has emerged from the particularly severe poverty level but it is still a long way till the relative poverty level. If they earn a bit more, the income tax will be detracted from the salary and redistributed to the persons in poverty, including themselves. The grant for large families (3 children and 2 adults) together with tax-exempt minimum and one parent unemployed and other receiving a minimum salary will not keep them even above the particularly severe poverty level.

What is the risk for the family to become poor? In fact 4 out of 10 families are poor (below the level or relative poverty). But 6 out of 10 families manage to overcome the poverty! This means that the number of children is not the only reason for the poverty. The risk usually concentrates elsewhere – the mother finds it difficult to get job and to keep it, because due to the poor sanitary conditions in pre-school institutions (and sometimes due to school related incidents) children are prone to diseases, they have to be nursed and sacrifice the job quality.

The first two components of the support for large families have nothing in common with the real poverty risks. If the family, using the large family allowance together with tax-exempt minimum does not reach the particularly severe poverty level, the family can apply for additional social benefit, and this could be done without exploiting the ”privileges” of the large families.

These two components of financial support for the large families can overcome, but also can fail to overcome particularly severe poverty. Recently these techniques only complicate the administration of benefits. Social benefit can combat the total poverty without the before mentioned components. Social benefit could be sufficient to overcome the particularly severe poverty, if allowances for large families were redistributed for social benefits, which would help to alleviate the relative poverty or to raise the limit of the particularly severe poverty to the more tolerable one.

Allowances for large families and the tax-exempt minimum that is applied to them are categorical benefits, which improve the position of all categories, not only of deprived families – therefore they cannot be directly attributed to the poverty alleviating means. In order to increase the effectiveness of poverty overcoming techniques, they should be abolished and the emerging funds should be assigned to the social benefit or these techniques should be transformed and only large low-income families should be supported. If the reforms are not carried out, there is little hope that the above mentioned measures will help to combat poverty. Allowances for large families and the application of the tax-exempt minimum are inexpedient and resource- wasting poverty reduction techniques.

To conclude, the benefits for the support for large families are a) of an insufficient size to overcome the relative and sometimes – the particularly severe poverty; b) do not reduce the poverty risk, but only assuage the income reduction related to the family increase; c) are categorical and do not fit into the of poverty reduction framework; d) not always hit the target of poverty reduction and funds are wasted.

PIPRS is planning

To prepare the concept of the state benefits for families with children reform and a plan of the implementation means. The further strategy of state benefits development together with concrete implementation means is to be

outlined, it is planned to more extensively apply the means tested benefits and to decrease categorical benefits, to balance state benefits with the indirect support for families, firstly children, by providing them with necessary social services.

Another aim is to perfect the existing legal acts and if there is a need, to prepare new ones, which would toughen the legal and material responsibility of the parents with regard to the use of the allocated benefits. The benefit paying institutions would receive greater powers, so they could replace benefits in cash by benefits in kind that are conveyed directly to children. The parents' responsibility for the rearing of children will increase, the rights of children of family will be ensured.

4.2.5 Accommodation

The Living conditions survey in 1999[32] allows to draw these conclusions:

According to the dwelling ownership Lithuania is above the EU average (over 80% compared to 60%). But the problem in Lithuania is not lodged in privatisation, quite the opposite – the municipalities are short of living space to provide support for all citizens. Besides, the burden of rent costs in Lithuania is quite significant, it does not matter that a small part of people are sustaining it (these are mainly pensioners also families and single persons with children). Also, rent more usually correlates with relatively poor households.

The lag from EU member countries is extremely significant with regard to the quality of accommodation. In the EU 5% of households are not equipped with one of the basic conveniences (bathroom and shower, toilet, hot water). In Lithuania 37% of households are short of hot water and a toilet. In the EU member countries the relative average of rooms per person is 1,89, in Lithuania – 0,95. This lag is perfectly illustrated by the wish of Lithuanian dwellers to move to the separate house with greater living space.

The problem of dwelling is one of the most difficult, since solving this problem requires great funds not only from the state, but also from private means. The state would seem to have the funds for supporting the preferential credit, but there is a shortage on the part of private contributions (the compulsory contribution on taking the bank credit for buying real estate). But the limited accessibility of preferential credits for real estate is justifiable: if the citizens would not have to enter their contribution for getting the credit, the financial limits of the demand would disappear and real estate prices would grow, and this would create another poverty problem.

Dwelling situations, which aggravate the poverty problem:

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[32] Lithuania 1999. Living Conditions, Vilnius, 2000, p. 209-223.

- Almost one fifth of the households without their own dwelling are forced to rent it from the private sector, and that is costly. The possibilities to get the state support are limited.[33]

- More than one third of private dwellings, especially in rural areas do not have the main conveniences (toilet and hot water). This negatively affects health and working capacity, besides, it increases the support needs of the elderly.[34]

- The shortage of living space is limiting employment – the possibilities of business and work at home (e.g. tele–work) and territorial labour mobility. Average number of rooms per person is 0.95[35]; more than 100 000 families waiting for state support in dwelling acquisition.[36]

- It is not calculated statistically how many people live in slums, canalisation wells, cellars, staircases, trash dumps, unadjusted summer cottages and other; it does not indicate the real scope of dwelling and poverty problem.

4.2.6 Ethnicity

The unemployment rate varies across nationality groups. As compared with the overall unemployment rate of 14.7% in May 2000, the rate for Lithuanians was 13.6%, Russians 22.1%, Poles 17.1%, and representatives of other nationalities 22.9%. These differences are due in part to a concentration of the non-Lithuanian population in socially and economically underdeveloped areas. Unemployed persons from ethnic minorities also tend to have lower levels of general and vocational education than Lithuanians do. Thus, ethnic minorities' social problems will be solved in the line with regional and educational development. Nevertheless, gypsy inclusion into society problem exists.

PIPRS is planning

In order to implement employment support means delineated in the National gypsy integration program the gypsy motivation for finding work will be increased. Another objective is to continue the 2000-2004 program of gypsy integration into society. Meals free of charge for pre-school attending gypsy children are going to be provided, the program of professional training for Vilnius gypsies is also to be carried out.

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33 Lithuania 1999. Living Conditions, Vilnius, 2000, Table 9.2a.
34 Lithuania 1999. Living Conditions, Vilnius, 2000, Table 9.3a.
35 Lithuania 1999. Living Conditions, Vilnius, 2000, Table 9.4a.
36 Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 530.

4.2.7 Regeneration of Areas

The Lithuanian village is characterized by the great dependence on the agriculture sector as the only source of income. The small income of rural inhabitants limits their consumer spending, and the ability to invest into farming and other business. Thus the stabilizing and restructuring of the agriculture with the intention to modernize and develop alternative agricultural activities will allow to improve the material situation of the rural inhabitants – the farmers. The situation of rural inhabitants will be greatly affected by the employment and income support policy.

PIPRS measures for rural areas

There is a plan to provide investment support for the households, which diversify the economic activities, including rural tourism, and look for additional alternative income (SAPARD funds according to the support direction "The development of economic activity and the encouragement of the alternative income"). New jobs will be created without making large investments, by utilizing the existing buildings and equipment, this will increase the income of the rural inhabitants.

The support for the workers in ecology farms:

- direct payoffs for the certified plots of land;
- partial compensation of certification costs;
- other means of income support.

This support should increase the employment in the rural areas, because the ecological farming requires more of the human resources.

The investment aid will be differentiated; the priority will be given to:

- the young (up to the age of 40 years) farmers, who have sufficient personal skills and competence and who are organizing and managing the farm for the first time;
- cooperatives and other organized producer groups, who have shown high effectiveness.

Other aims include organizing seminars in rural areas, advertising the continuous farmers' education, consulting about the farming innovations, business organization and the possibilities of the development. The acquired knowledge will create opportunities to increase the effectiveness of the agricultural activities by applying the farming innovations, specialization and taking up alternative businesses.

The registered agriculture farms are also to receive various kinds of support, but other small and unregistered farms will remain excluded.

Territorial PIPRS measures

The preparation and implementation of the territorial and the targeted programs is to be carried out in order to neutralize the negative outcomes of the structural changes for the work force market.

To be established in Visaginas: the Business incubator, the Development agency of the Ignalina Nuclear Power plant region, the Business information and consulting centre. A part of inhabitants of Visaginas will be retrained, new jobs will be created, and the social tension is to be alleviated.

Measures improving the readiness of social partners to address the redundancy issues will be proceeded.

The concept and the program for the support of depression regions (and places) will be outlined. The effect of expansion of ”poverty and moral degradation disease” is to be neutralized.

In financing local employment projects, the priority is to be given to projects in the regions with the highest unemployment.

4.2.8 Other factors influencing poverty and social exclusion

Drug addiction and crime are becoming very important poverty factors.

Table 4.10 The dynamics of drug related disease (1995=100%)

	1996	**1997**	**1998**	**1999**	**2000**
Alcoholic psychosis	103.0%	84.8%	103.8%	94.9%	103.6%
Latent alcoholism	101.7%	101.5%	95.8%	91.5%	88.3%
Drug and toxic material addiction	137.8%	168.1%	168.1%	180.4%	206.2%

* Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p.140.

As the research undertaken in 2001 by the Labour and social research institute into the prisoners' motivation has shown - as many as 56% of prisoner respondents did not have any professional training. It is especially alarming that among the age group of 18-24 years of prisoners almost 71 % are without any profession. Besides in the 18-20 years age group as many as 14% of respondents had completed only primary or even lower levels of education, in the 21-24 age group this part amounted to 11,2%. The inclusion of these people into vocational training programs is thwarted by the low level of their education and lack of motivation.[37]

[37] Report on poverty status in Lithuania (in Lithuanian). Vilnius 2001, p. 37.

PIPRS is planning

To continue implementation of measure stated in the National drug control and drug use prevention program of 1999-2003. There will be a continuation of material social support for the establishment of rehabilitation centres, which are helping not only drug addicts, but also their family members; the drug addicts' communities will be supported as well (the support is foreseen for the drug addiction prevention and drug users' rehabilitation projects, also the drug prevention projects of non-governmental youth organizations).

It is also planned to continue the implementation of the 2001-2004 program of social adaptation of ex convicts, people from correctional institutions, and from social and psychological rehabilitation institutions. The social adaptation institutions for these people are to be established in the municipalities; the programs for ex convicts vocational training and employment are to be organized.

The establishment of the system of the integration and rehabilitation of juvenile ex convicts will help to minimize their poverty and social exclusion.

The 2002-2004 people trade and prostitution prevention program is to be carried out. The projects of public institutions and NGOs, which are devoted to the social assistance and the reintegration into society of the prostitution victims, are to be supported.

4.2.9 Administration, Access to and Delivery of Services

In compliance with the data of the survey conducted by SIC Rinkos Tyrimai (see 4.1.1) the NGOs expressed willingness to make a greater contribution to the implementation of a poverty reduction strategy on condition that state financing was provided for the purpose. Non-governmental organisations taking part in the process of poverty reduction are financed by Lithuanian public or private entities more often than by foreign entities. Asked to determine obstacles hindering the fight against poverty non-governmental organisations tended to specify: (1) financial hardships, shortage of assigned funds, means; (2) unfavourable policy of the government; (3) legal obstacles, unfavourable legislation for the implementation or financing of projects. There is a strong opinion that the establishment of a committee or a council of non-governmental organisations, which would embrace representatives of non-governmental organisations, NGO information and support centre and the authorities, would ensure better co-ordination of activities of non-governmental organisations and let avoid current overlapping of activities was expressed in the course of the survey and at the presentation of its results. The committee could communicate with foreign partners and search for investments more easily. The Council of Youth Affairs under the government is one of such properly operating institutions.

PIPRS is planning

To prepare the order of the financial support for the NGO's which work in the sphere of helping the poor. One of the objectives is to foresee the financial source and procedures to this end The state policy and the means of its implementation with regard to the financial support to the NGO's will be made transparent.

To organize the tender of programs devoted to the poverty reduction in the communities and programs of mutual assistance, the best programs are to be implemented. The progressive poverty reducing ideas and experience is to be disseminated in the communities.

There are some activities, which are directed to the improvement of policy delivery so as to make services more inclusive and better integrated with a greater focus on the needs and situations of the users: promoting partnership between different actors; organizing informational campaigns about the order of service rendering, especially for people in rural areas and small towns; fostering the participation of those affected by poverty and social exclusion (partially along activities of NGOs).

4.3 Evaluation of future challenges

4.3.1 Main challenges

The main challenge is to handle poverty reduction in the sense of social exclusion. That means that poverty reduction policy measures have to be:

- More targeted. The application of new poverty indices will promote better targeting. Nevertheless, the questions "who will be affected and how by poverty reduction measures, what will be the overall impact on the poverty level" still is not clear in the policy design process. Targeting will improve effectiveness and efficiency of poverty reduction policy.

- More active. The reduction of unemployment under the increasing labour market pressure becomes the most important factor of poverty reduction. As has been stressed in Chapter 1 (see Table 7), the share of social security spending that is devoted to social exclusion and unemployment in the 15 EU countries is greater than in Lithuanian. The GDP share for social security spending increase does not reduce poverty, especially when the smallest part in the structure of the spending is devoted to the spheres most directly related to poverty – to unemployment and social exclusion. The increase in passive measures can even increase poverty, since it encourages people to live from the benefits, and not from the energetic economic activities.

- More strategically oriented. Some measures, especially oriented to the growth of economy, may be unpopular, but it may assure funds for poverty reduction in the long-run period.

- More participatory. Some actions may be devoted to the different actors instead of making decisions on the highest level of authority. E.g. more widespread sector- and firm-level collective bargaining could support wage developments and make them more responsive to structural change. The new Labour Code will encourage the conclusion of collective contracts and sector-and-rate agreements, along with better representation, consultation and information for employees[38].

4.3.2 Links to other social protection policies

In the poverty reduction strategy the main emphasis is on unemployment reduction and development of the benefits in the cash system. Nevertheless, social assistance in kind and health services are important in the protection of the safety and wealth of communities. In these areas there are some PIPRS provisions. Some of them are:

It is expedient to prepare and implement the program for additional compensation for medicine cost and nursing measures, directed to the people receiving small benefits and small pensions (up to the relative poverty level).

Another objective is to prepare suggestions regarding the cooperation between community health personnel and the divisions of social assistance This would speed up the identification of social problems that are registered by doctors, also the identification of socially isolated individuals. This will disclose the social problems more efficiently.

The suggestions regarding the coordination of primary health care ambulant nursing and social services, provided by the municipalities will be followed. The main point of these suggestions will be the integration of national health insurance funds (devoted to the rural health care institutions and to the nursing and sustenance treatment) with municipal funds, allocated to the provision of social services. The resources used for nursing and social services and the effectiveness of these services will increase.

The decentralization of nursing institutions will be carried out, that is, the management and control of the state social nursing institutions (foster homes for the elderly, for the mentally challenged) will be transferred to the local authorities.

It is expedient to review the functions, responsibilities and financing of ministries, district administrators and municipalities related to the organization of social services, to evaluate the regulating legal acts, if there is a need, to prepare the amendment drafts. The functions of various levels of management, related to the organization of the social services, will be specified and harmonized.

[38] JAEPP, p.22.

The next objective is to prepare the draft of the Social services law, which would regulate the voluntary social work. The opportunities for people of all social layers to access the highest quality services are to be created. People will also be encouraged to address the problems at their own initiative.

Another aim is to prepare and implement the program of integrating orphans and children without parental care into society. This will enable to protect orphans and children with no parental care from poverty and social exclusion.

4.3.3 Political directions of future reform

See 4.1.1. One important issue where political consensus is not achieved yet is: The advocates for the decentralisation of social assistance see overall responsibility of municipalities for the provision assistance in cash and in kind. Opponents argue for centralisation in decision-making regarding conditions of provision of all benefits in cash.

4.3.4 Social exclusion, poverty and EU accession

The most important challenge with regard to EU accession is the free movement of labour. Even now, because of high unemployment and differences in the level of living more than 100,000 Lithuanians are work in EU countries, most of them illegally. Unemployment prevents people from earning income, but also creates persistent poverty, depresses wage growth and encourages the most enterprising among the population to emigrate. Emigration, in turn, has a negative effect on the solvency of the pay-as-you-go retirement system and the ”brain drain” increases demands on the educational system.

It is planned to initiate the conclusion of bilateral employment agreements, the conclusion of agreements with EU countries and the states that are popular immigration targets of the Lithuanians. The bilateral employment agreements would enable Lithuanian’s citizens to work abroad legally, and the bilateral social security agreements would guarantee their social care.

Another important challenge is the preparation for the use of the support provided by EU structural funds. Appropriate structures and their networks are being developed. The institutions that will be responsible for the development and implementation of individual programmes have been determined. Technical assistance of the PHARE Twinning Project ”Preparation for the European Employment Strategy” has been provided for The Government of the Republic of Lithuania which is committed to a timely formation of the structures necessary for working with the European Social Fund. In the further work in this field, particular attention should be paid to strengthening administrative capacity, particularly in the areas of financial management, monitoring and evaluation.

4.3.5 Conclusions

The draft programme on the implementation of a poverty reduction strategy in 2002-2004 is based on the new approach to poverty reduction and social inclusion. This approach is based on better targeting and more active measures (reduction of unemployment, toughen the legal and material responsibility of the parents with regard to the use of the allocated benefits, etc.). Nevertheless, the pension insurance remains without essential changes and will hardly cope with the problem of poverty and social exclusion.

The implementation of the programme will require huge financial resources but it is not clear if these resources are available. Such costs may be met only in case of a wide national consensus of all stakeholders and a combination of financing from the national budget, the state social insurance fund budget, from employers and individuals involved in programme activities.

Table 4.11 Unemployed by age, duration of unemployment and sex (in % of total unemployed population of corresponding age)[39]

	1997	**1998**	**1999**	**2000**
All				
15-64 years	**100**	**100**	**100**	**99.6**
Less than 6 months	21.6	27.2	36.7	33
6 to 11 months	9.8	17.8	24.2	14.9
12 months or more	68.5	55	39.1	52.2
15-24 years	**25.5**	**21.7**	**23**	**20.8**
Less than 6 months	26.8	39.8	49.7	39
6 to 11 months	12.9	14.8	22.8	15
12 months or more	60.2	45.4	27.4	46.1
25-49 years	**61.4**	**65.5**	**63.6**	**61.2**
Less than 6 months	18.5	24.9	33.3	31.2
6 to 11 months	9	18.7	24.3	15.3
12 months or more	72.5	56.3	42.3	53.5
50-64 years	**13.2**	**12.7**	**13.4**	**17.6**
Less than 6 months	26.4	17.4	30.3	32.1
6 to 11 months	7.8	18.3	25.7	13.3
12 months or more	65.8	64.3	44	54.6

[39] Statistical yearbook of Lithuania 2001, – Department of Statistics at the Government of the Republic of Lithuania. 2001, p. 124-125.

Continued table 4.1.1

	1997	1998	1999	2000
Males				
15-64 years	**100**	**99.9**	**100**	**99.4**
Less than 6 months	21.6	29.2	36	31.7
6 to 11 months	12.2	16.9	22.5	14.2
12 months or more	66.2	53.9	41.5	54.1
15-24 years	**31.4**	**24**	**24.5**	**22.4**
less than 6 months	26.7	36.9	44.3	35.5
6 to 11 months	17.5	17	21	11.6
12 months or more	55.7	46.2	34.7	52.9
25-49 years	**55.2**	**62.8**	**61.5**	**60.3**
less than 6 months	17.6	27.9	32.8	31.2
6 to 11 months	9.7	16.6	23.4	15.6
12 months or more	72.7	55.5	43.8	53.3
50-64 years	**13.4**	**13.1**	**14**	**16.7**
less than 6 months	26.1	21.7	35.4	28.7
6 to 11 months	10.1	18.5	21.2	12.6
12 months or more	63.8	59.8	43.5	58.7
Females				
15-64 years	**100**	**100**	**100**	**99.9**
less than 6 months	21.6	24.6	37.6	34.7
6 to 11 months	7.2	19	26.4	15.8
12 months or more	71.2	56.4	35.9	49.5
15-24 years	**18.7**	**18.8**	**21**	**18.6**
less than 6 months	27	44.6	58.2	44.6
6 to 11 months	4.1	11.2	25.8	20.4
12 months or more	68.9	44.2	16.1	34.9
25-49 years	**68.4**	**69**	**66.5**	**62.4**
less than 6 months	19.2	21.5	33.9	31.2
6 to 11 months	8.4	21.3	25.5	14.9
12 months or more	72.4	57.2	40.6	53.9
50-64 years	**12.9**	**12.3**	**12.5**	**18.8**
Less than 6 months	26.7	11.5	22.8	36.2
6 to 11 months	5.1	18.1	32.5	14.1
12 months or more	68.2	70.4	44.7	49.7

5. HEALTH CARE

5.1. Evaluation of current structures

5.1.1 Organization of the health care system

The health system of Lithuania, its structure, the scope of legal regulation of health protection, health strengthening and health recovery, the basic principles of health care organization, of ensuring, management of the health care guaranteed by the state or local authorities, conclusion of contracts concerning health are regulated by the Law on the Health System (approved on 19 July 1994).

Since 1996 the reforms and subsequent measures were designed to increase efficiency, quality and choice through the creation of decentralized, market-type mechanisms. They represented a move away from hierarchical forms of organization towards models based on purchaser-provider separation and contractual relationships. Health care services have been decentralized. Provision of the health care (primary, secondary, and tertiary health care) became shared between three public authorities levels: national, county and local (municipal). 10 counties became responsible mainly for the planning and running of hospitals and 60 municipalities for the planning and running of primary health care services.

The terms primary, secondary and tertiary care in Lithuania is used for describing the different levels of health care. *Primary care* is the practice of basic general medicine. *Secondary care* is basic specialist care. It may be practiced in an outpatient setting or carried out at a general hospital. *Tertiary care* is special care requiring specially trained staff, special equipment and/or other special physical facilities. Tertiary care is provided predominately by university hospitals and has a strong connection with research.

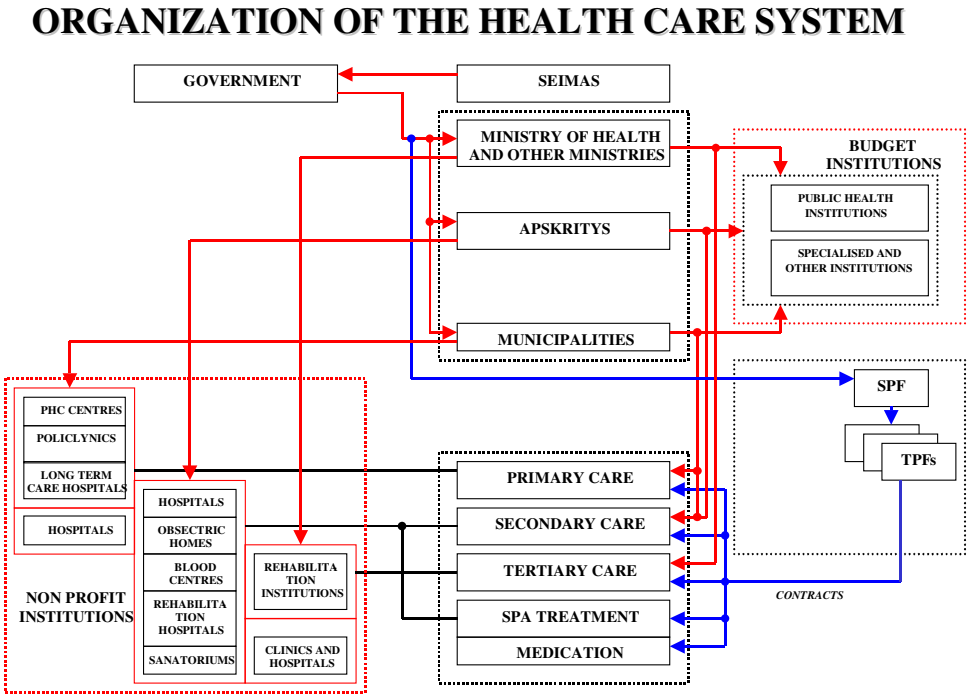
Local (municipal) authorities organize primary health care for their local populations. The municipalities have been granted property rights for primary care, ambulance care, long term care inpatient facilities and they also still run a number of mostly small and medium-sized hospitals in their localities. Primary health care services are delivered in primary health care centers, general practitioners' surgeries, both school and community medical posts (paramedical centers), outpatient facilities and polyclinics, women's consultancies, long-term (nursing) hospitals, as well as by the ambulance service (stations and divisions, mental health centers and by private general practitioners (or primary health centers). The Ambulance Services actually performs many missions not related with the traditional European model. In a new Ambulance Service Concept and Strategy Implementation plan (aproved by the Order of the Minister of Health in July, 2002) a new mission and tasks for the Ambulance Services is foreseen (until now Ambulance service provide up to 70 % of Primary Health Care services). There

subordination is transferred from municipalities to the overall responsibility of Counties and County Governors (more details see in 5.3.1. *Recent reforms and their objectives).*

County governors organize secondary health care the scope and profiles whereof are determined by the Ministry of Health.

The Ministry of Health (MoH) deals with policy matters and legislation concerning the health insurance system, health and medical care. It is responsible for the general supervision of the entire health care system, overall responsibility for the public health system's performance. Through the State Public Health Centre, it manages the public health network, including 10 provincial public health centres with their local branches (in total 50 institutions). The State Public Health Centre has subordinate bodies that deal with the prevention of communicable diseases, health education and other public health functions.

Chart 5.1: Organizational structure of the health care system



In addition to the health care institutions subordinated to the MoH, which account for about 90% of all health care services provided in the country, two parallel state-run health care systems account for another 2% of total public health care expenditure. One is run by the Ministry of Interior and serves the police and prisoners. The other is run by the Ministry of Defence and provides health care services for the military personnel.

The majority of the health care institutions are non- for-profit organizations contracted by the statutory health insurance. The majority of pharmacies are private for-profit enterprises.

According to the type of financing health care services are: (a) individual and public health care financed from the statutory health insurance fund, state or municipal budgets or health funds; (b) individual and public health care services which must be paid for by their recipients (legal and natural persons). The Ministry of Health approves the list of such services, their prices, and the procedure for price indexing and service provision. According to existing legislation, two bodies of the MoH (The State Accreditation Agency, which is responsible for licensing of public and private institutions and the State Medical Audit Inspectorate) together with the State Patient Fund and its ten regional branches, the territorial patient funds, is involved in the establishment of medical standards and quality control of health care providers and can have a strong impact on health care institutions, even leading to closure. State Medical Audit Inspectorate is responsible for the quality of medicines during registration procedure and distribution of these via pharmacies. By the decree of the Minister of Health, health care institutions are obliged to establish internal audit services which are responsible for internal control of health care services.

Health care is rendered through a network of providers, including general practitioners (primary HC physicians), hospitals, specialists, and others. Property rights and administrative functions fall under the jurisdiction of the central government (Ministry of Health), 10 counties, or the 60 municipalities.

Table 5.1: Network of health care institutions in Lithuania in the end of year 2001 (Lithuanian Health Information Centre data)

Institutions	**Quantity**
Hospitals	189
Sanatoriums	35
Ambulatories and polyclinics	440
Medical posts	966
Ambulance service stations and departments	16/44
Emergency and planned consulatations departments	2
Blood departments/stattions	27/3
Public health centers and branches	12/36
Health training centers	4
Disinfections stations and departments	59
Private health care institutions	1416
Of these: dental care institutions	952

Source: Lithuanian Health Information Centre

Table 5.2: Main health care indicators (as of December 31)

	1990	1995	1996	1997	1998	1999	2000
Physicians	14891	14737	14763	14757	14622	14578	14034
Dentists	2236	1742	1709	2153	2259	2306	2446
Nurses	…	…	…	…	…	29450	28017
Pharmacists [1]	2000	2055	2171	2146	2140	2159	2114
Hospitals	198	195	197	187	187	186	187
Beds in hospitals	46175	40262	39182	36442	35612	34714	34145
Per 10000 population:							
Physicians	39.9	39.7	39.8	39.8	39.5	39.4	38.0
Dentists	6.0	4.7	4.6	5.8	6.1	6.2	6.6
Nurses	…	…	…	…	…	79.6	75.9
Pharmacists	5.4	5.5	5.9	5.8	5.8	5.8	5.7
Hospital beds	123.6	108.5	105.7	98.4	96.2	93.9	92.5

Source: Department of statistics at the Government of Lithuania

Table 5.3: Main indicators of hospital activity

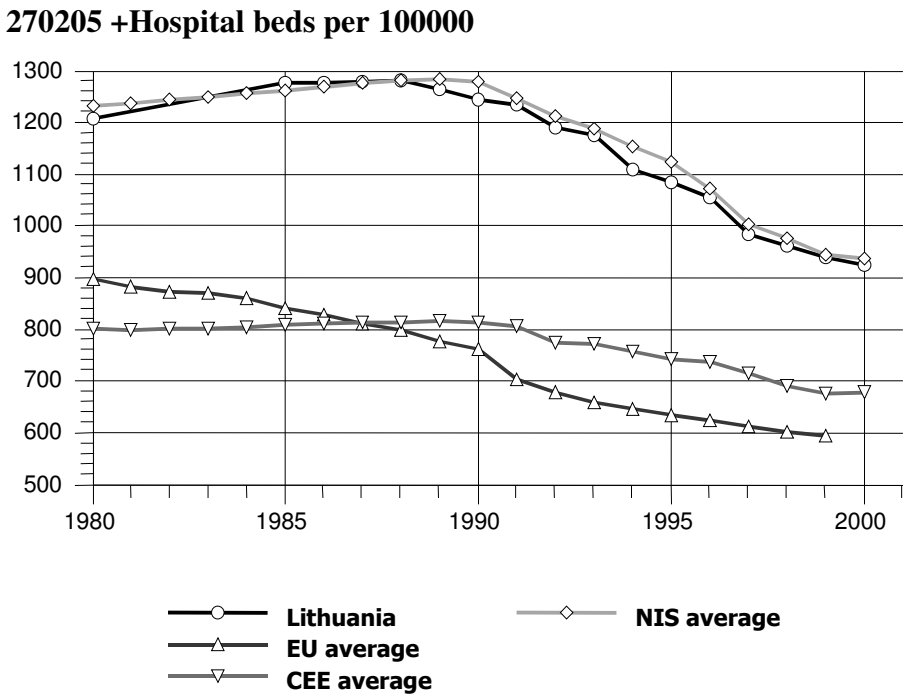
	1995	1996	1997	1998	1999	2000
Number of patients treated in hospitals:						
Adults and teenagers	614995	620654	644971	715435	722865	694612
Per 1000 adults and teenagers	211.6	212.9	220.4	243.3	245.9	234.3
Children	128893	131365	139568	151622	155660	139881
(under 15 years)						
per 1000 children	159.5	165.3	179.1	198.9	209.7	191.4
Average stay, in days	14.7	14.0	12.9	11.7	11.3	11.2
Bed turnover, in days	19.1	19.7	21.8	25.1	26.0	25.1

Source: Department of statistics at the Government of Lithuania

The number of beds in Lithuania decreased significantly over the past 10 years. The main cause of the change in the number of beds that is determined by treatment technologies is the reduction of the Average Length of Stay (ALOS) It is determined by a better utilization of hospital resources and the concentration of a larger volume of resources on the remaining beds.

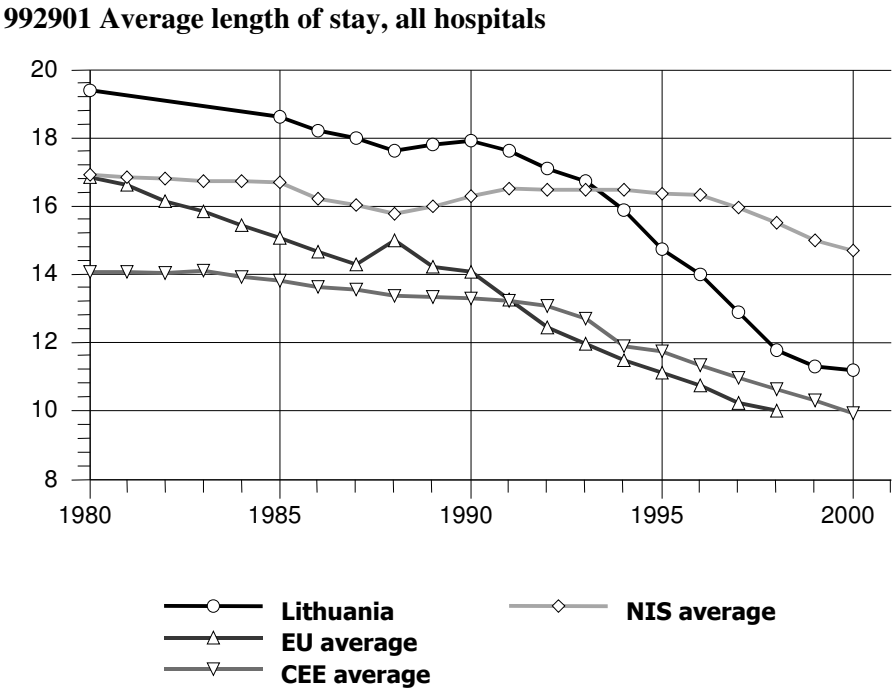
Chart 5.2 presents the development of the number of beds in Lithuania in comparison with the statistical data of European regions. Chart 3 presents the average length of stay in hospitals in Europe (per 100 000 population).

Chart 5.2: Number of hospital beds (per 100 000 population)



Source: Data of WHO.

Chart 5.3: Average length of stay in hospitals in Europe (per 100 000 Population)



Source: Data of WHO.

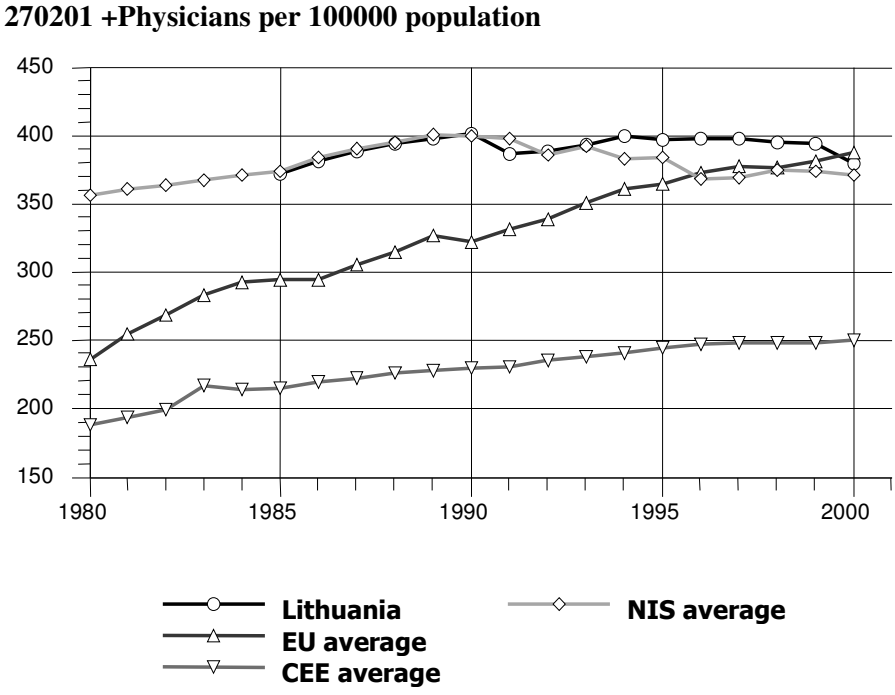
Table 5.4: Number of medical personnel

	Number of physicians Per 100 000 inhabitants					Number of dentists Per 100 000 inhabitants				
Country*	1995	1996	1997	1998	1999	1995	1996	1997	1998	1999
BG	347	355	346	346	345	65	66	63	59	57
CY	248	255	264	272	280	85	89	91	93	95
CZ	292	293	296	296	297	60	60	60	61	61
EE	311	305	311	309	308	59	64	66	68	70
HU	299	303	308	314	316	40	41	42	45	46
LV	295	297	296	282	284	40	51	45	44	48
LT	397	398	398	395	394	47	46	58	61	62
MT	262	266	266	260	:	32	35	35	36	:
PL	232	235	236	233	226	46	46	46	45	34
RO	177	181	179	184	191	27	26	24	24	23
SK	317	312	340	349	353	42	46	42	42	43
SI	212	213	215	218	215	64	57	59	61	60
TR	114	114	116	117	119	22	23	20	:	:

* - Candidate countries: BG – Bulgaria; MT – Malta; CY – Cyprus; PL – Poland; CZ – Czech Republic; RO – Romania; EE – Estonia; SK – Slovakia; HU – Hungary; SI – Slovenia; LV – Latvia; TR – Turkey; LT Lithuania

Source: STATISTICAL YEARBOOK ON CANDIDATE AND SOUTH-EAST EUROPEAN COUNTRIES 2001

Chart 5.4: Number of physicians (per 100 000 population)



Source: Data of WHO.

The health care system personnel constitute the main resource of the health care system. Its number and distribution by specialization were reflected in Table 5.2 (*Main health care indicators*). In table 5.4 a comparison between the Lithuania medical personnel number to the other 12 applicant countries is presented.

The ratio of physicians to the population in Lithuania is above average among 13 candidate countries (40 percent) and is highest per 100 000population.

The European Union rate of physicians per 100000 populations has increased in recent years (according to 2000 year WHO data base) and Lithuania now has about the same number of physicians as the EU average.

In addition to publicly provided health care, a private sector has developed, providing mostly outpatient health care. The private sector plays a significant role, especially in primary care, dental care, cosmetic surgery, psychotherapy and gynaecology.

Table 5.5: Private health care institutions

	Health care institutions						**Dental care institutions**					
	1999		2000		2001*		1999		2000		2001*	
	Number	Percentage of all	Number	Percentage of all	Number	Percentage of all	Number	Percentage of all	Number	Percentage of all	Number	Percentage of all
Private health care institutions	297	13.9	372	16.8	465	-	672	-	862	-	920	-
Number of physicians (working only privately)	267	1.8	280	2.0	484	-	803	34.82	1009	41.25	1095	-
Number of physicians (working part-time privately)	488	3.4	727	5.2	1016	-	218	9.45	284	11.61	323	-

Source: Lithuanian Health Information Centre

*- Source: Department of statistics at the Government of Lithuania

By the end of 2001 a number of private HC institutions were contracted to provide services by the Statutory Health Insurance system (182 institutions and personal enterprises). The largest part of these were providing primary and secondary outpatient health care services (86/91), four institutions rendered inpatient and one ambulance services (in Vilnius there is one more private ambulance service provider paid out of the pocket). About 7 % of the physicians work full-time in a private practice and there is an increasing interest in private health care and financing.

Implementation of Health Insurance system and development of services provided by private practice reduced number of unofficial payments (according to 1995 and 2001 conducted surveys) in hospitals and especially in outpatient health care institutions more than twice but increased number of cases when patient in health care institutions pays for medicines (both inpatient and outpatient institutions) and for the meals in hospitals.

The Government has responsibility for and financial control of most aspects of the health services. The contractors of the NHS activities and provided services are the Government, the Ministry of Health, other state institutions, county governors, municipal councils, State and Territorial Patients' Funds and other institutions disposing of the NHS resources.

Each year the base amount of financing of the activities of the National Health System of Lithuania, including the resources of state and municipal budgets and the compulsory health insurance fund budget resource, according to Law on Health System must account for at least 5% of the GDP value[40]. The main sources of financing of health care delivered and services provided are: Statutory health insurance, state and municipal budgets, resources of Municipal health funds and charges for paid services.

5.1.2 Benefits

The entire population is legally granted guaranteed emergency care. Free (total or partial) provision of other than emergency care is granted to the compulsory insured population (according to the Health Insurance law – universal coverage of population by statutory health insurance system; according to State Patient Fund data, in July 2002 by statutory health insurance were covered more than 99 percent of the total population).

The costs of the following individual health care services are covered by the statutory health insurance: (a) preventive medical assistance (e.g., provision of information on the issues of disease prophylaxis; prophylactic health check-ups of the insured), (b) individual health care services provided on the primary, secondary and tertiary levels of health activities; assistance to be given to the insured in relation to the provision of limb, joint and organ prosthetics and assistance in the acquisition of dental prosthesis; assistance in the acquisition of spectacles and hearing aids; reimbursement of expenses for the insured related to the purchasing of medicines and medical aids acquired for out-patient treatment, (c) medical rehabilitation, nursing, social services attributed to individual health care (nursing and social services at supportive hospitals for a period not exceeding 4 months per calendar year; medical rehabilitation, including treatment at sanatoriums /resorts), and (d)

[40] In September 2002 Lithuanian Seimas (Parliament), on a basis of the decision of the Constitutional Court of the Republic of Lithuania, repealed article 39 of the Law on Health System. The article demanded that annual public financing of health sector must account for at least 5% of the GDP. The reasons, why this article was repealed were: a) because of the fixed percentage of GDP Government has less flexibility to plan state budget; b) this requirement was never fulfilled.

individual health examination (temporary disability examination of the insured: long-term and total disability examination of the insured; an autopsy in case of death).

The basic cost of the essential medicines and medical aids incurred by the insured are reimbursed in full to the following insured persons: children under the age of 3 years; persons with group I disability; and persons who fall ill with diseases included in the list approved by the Ministry of Health (e.g. mental disorders, diabetes, tuberculosis). 80% of basic cost of medicines and medical aids are reimbursed to: children in the age group from 3 to 7 years; and persons with group II and group III disability and other unemployed persons who either receive or are entitled to state social insurance pension. For the insured who are hospitalised in in-patient individual health care institutions the costs of medicines and medical aids are paid from the compulsory health insurance fund budget, except in cases where the insured person chooses, on his own initiative and following his physician's recommendation, more costly medicines or medical aids compared to those used in the Republic of Lithuania in accordance with the established methods of treatment. In such cases the insured must pay the health care institution the difference in the price of the medicine or medical aid prescribed by the physician and that chosen by the insured.

Children under 7 years of age and disabled children under 16 years of age are reimbursed for the total basic cost of treatment at sanatoriums/resorts provided that the child is proceeding to undergo treatment under a separate individual voucher; total basic costs shall also be reimbursed to persons with group I disability, persons who are sent to complete treatment after a severe disease that is on the list approved by the Ministry of Health and Ministry of Social Security and Labour. Children under 7 years of age and disabled children under 16 years of age shall be reimbursed 90% of the total basic cost of treatment at sanatoriums/resorts provided that the child is proceeding to undergo treatment under a general voucher together with other insured persons. The insured persons who receive or are entitled to state social insurance pensions shall be reimbursed 80% of the basic cost of treatment at sanatoriums/resorts. Other insured persons who are sent to sanatoriums and resort medical institutions are reimbursed 50% of the fixed basic cost of treatment at sanatoriums/resorts. Compensation for sanatorium/resort treatment shall be paid only for one medical treatment course at a sanatorium/resort per calendar year.

The procedures for granting and paying out compensations for the expenses incurred while undergoing sanatorium/resort treatment, the procedures for reimbursing the insured persons for the expenses related to limb, joint and organ prosthetics and for expenses related to the acquisition of prosthesis are laid down by the Government of the Republic of Lithuania.

The share of the costs of individual health care services, medicines and medical aids, restorative medical care services, that is covered from the compulsory health insurance fund budget is specified in the lists compiled

by the Ministry of Health on the proposal of the Compulsory Health Insurance Council.

Expenses incurred in relation to the acquisition of medicines and medical aids essential for outpatient treatment are reimbursed according to the basic cost calculated by the Ministry of Health in accordance with the procedure laid down by the Government. Reimbursement of expenses related to the essential medicines and medical aids, and medical rehabilitation is based on the basic price.

The system provides health care services to all permanent residents. Unfortunately provision of some other than emergency care services, such as joints replacements, are limited because of lack of institutional capacity and financial means. Waiting lists for these services sometimes reaches up to 2 years (endoprosthesis operations). Waiting lists for organ transplantation are mainly because of the lack of donors.

5.1.3. Financing of the health care system

Health care services in Lithuania are financed mainly through the statutory health insurance. In addition, up to 10 percent of public financing is generated through state or municipal budgets, Municipal health funds.

Table 5.6: Public expenses for health care in 1996-2000, million Litas/Euro

	1996	**1997**	**1998**	**1999***	**2000****
Total	1325.1	1772.7	2077.9	1961.4/465.7	1975.2/533.9
From these:					
State budget	427.7	152.5	164.8	135.2/31.7	170.8/46.2
Municipal budgets	645.0	154.5	44.1	17.3/4.1	13.3/3.6
Social insurance fund	252.4	263.1	-	-	-
Health insurance fund	-	1202.5	1869.0	1808.9/423.5	1791.1/484.1
GDP	31568.9	38340.0	42990.0	42654.6/9986.6	44929.8/12143.5
% of GDP for health care	4.2	4.6	4.8	4.6	4.4
Health care expenses per capita	357.2 89.3 $	478.4 119.6 $	561.2 140.3 $	530.31/124.2 132.5$	534.4/144.4 133.6 $

* - exchange rate Euro : Litas = 1 : 4.2712

** - exchange rate Euro : Litas = 1 : 3.6999

Source: Lithuanian Health Information Centre

The main sources of Statutory health insurance revenues are: (a) compulsory health insurance contributions of the covered persons; (b) National Budget contributions for the covered persons insured with Public funds.

Table 5.7: Compulsory health insurance fund budget

	1998		1999*		2000**	
	Thous. Litas	%	thous. Litas Euro	%	thous. Litas Euro	%
Revenue	1837106	100.0	1756406 411221	100.0	1806044 488133	100.0
Employer's compulsory health insurance contribution	363133	19.8	303495 71056	17.3	356271 96292	19.7
Deduction out of personal income tax	1012708	55.1	1033549 241981	58.8	1019170 275459	56.4
Farmer's contributions	1804	0.1	1688 395	0.1	1430 386	0.1
Uninsured persons contribution	228	0.0	227 53	0.0	210 57	0.0
Transfers from the state budget	449558	24.5	409156 95794	23.3	423003 114328	23.4
Contributions for insured by the state	444608	24.2	403532 94477	23.0	417760 112911	23.1
Other transfers from budget	-	-	950 222	0.1	940 254	0.1
Compensations for donors	4950	0.3	4674 1094	0.3	4303 1163	0.2
Revenue from activities of compulsory health insurance institutions	1298	0.1	446 104	0.0	307 83	0.0
Voluntary contributions of enterprises and households	5067	0.3	2596 608	0.1	2130 576	0.1
Other revenue	3310	0.2	5249 1229	0.3	3523 952	0.2
Expenditure	1868975	100.0	1808866 423503	100.0	1791069 484086	100.0
Health care services	1400178	74.9	1361472 318756	75.3	1328314 359014	74.2
Compensations for medicine and medical aid	318224	17.0	296592 69440	16.4	307408 83085	17.2
Compensations for donors	4376	0.2	4845 1134	0.3	3703 1001	0.2
Expenditure for sanatorium treatment	93770	5.0	85253 19960	4.7	81457 22016	4.5
Prosthesis and other medical equipment	36369	1.9	34087 7981	1.9	36811 9949	2.1
For health insurance programs	-	-	10936 2560	0.6	18424 4980	1.0

	1998		1999*		2000**	
	Thous. Litas	%	thous. Litas Euro	%	thous. Litas Euro	%
Administration of health insurance institutions	16058	0.9	15681 3671	0.9	14952 4041	0.8
Surplus/deficit (-)* **	-31869	x	-52460 -12282	x	14975 4047	x

* exchange rate Euro : Litas = 1 : 4.2712

** exchange rate Euro : Litas = 1 : 3.6999

*** Compulsory health insurance fund budget deficit is defined on a cash flow basis (revenues minus expenditure).

Source: data provided by the State Patient Fund

The Seimas of the Republic of Lithuania may grant additional allocations from the National Budget to the compulsory health insurance fund budget if, due to reasons unforeseen at the moment of budget approval, the budget expenditure increases or income decreases and the fund budget is not in the position to fulfil all obligations determined by Health Insurance Law.

The financing system of the public health care institutions (the vast majority of these are non-profit-making enterprises) is based on a Statutory Health Insurance scheme. Statutory health insurance (according to the Law on Health Insurance approved on 21 May 1996) is a State-established system of individual health care and economic measures that guarantee the provision of individual health care services to persons covered by compulsory health insurance and reimbursement of the provided services costs. Compulsory health insurance is transacted by the: Compulsory Health Insurance Council at the Government of the Republic of Lithuania; State Patients' Fund (SPF) and its ten regional branches, the territorial patients' funds (TPF).

The SPF is accountable for its activity to the Government and the Compulsory Health Insurance Council (whose formation, composition and regulations are approved by the Government). The main functions of the SPF are to implement the budget of the compulsory health insurance fund and supervise the activities of the TPF.

Each of the 10 counties has one TPF[41]. The TPF's main functions are: to conclude contracts with health care institutions and pay them for the services provided to the insured persons. They reimburse the insured persons for the costs of limb, joint and organ prosthetics and also the acquisition of prostheses, essential medicines and necessary medical aids, as well as the costs of sanatorium/resort treatment. The TPFs keep the register of persons insured by compulsory health insurance, carry out quality control

[41] From 1 of January 2003 number of TPF's will be reduced to 5.

of individual health care services paid for with the compulsory health insurance fund and the financial - economic analysis of the use thereof; etc. Insurance funds do have a right to select providers but they are using the option rarely.

Private health insurance is permitted and there are a few private insurance companies providing voluntary medical insurance services (dealing mainly with covering the health care expenditure of Lithuanian citizens during foreign travel and of foreigners residing in Lithuania).

According to the *Law on Insurance* (Article 58), health insurance contributions (premiums) paid by a natural person or employer shall reduce accordingly the person's taxable income or the amount of the enterprise's taxable profit). The provision holds if the amount of the annual insurance contributions (premiums) for each employee does not exceed the fourfold amount of the minimum monthly wage set by the Government which was effective at the beginning of the accounting quarter and the duration of life insurance contract is not less than 10 years. Even having in mind these tax incentives, development of the supplementary (voluntary) insurance is rather slow, because of very little interest both from state institutions and private insurers. Main reason is that there is no political willingness to introduce co-payments in outpatient (the dental care is an exception) sector as well in inpatient sector.

Services of Public Health institutions (providing health promotion, prevention of the deterioration of the quality of consumer goods, also of living, working and natural environment as well as prevention of diseases and traumas) are paid from the state budget. Municipal health funds serve for the accumulation of resources for the support of municipal public health programs. Privately rendered Primary Health Services are mostly reimbursed via the Statutory Health Insurance scheme, but services included in to the negative list (approved by the Ministry of Health) are not reimbursed by public funding.

Official statistics in Lithuania do not take into account direct spending of the population on medical services. In addition, private and corporate spending on health is usually not included into the published data on health care spending and their share in the GDP. However, household surveys, carried out each year, do accumulate data on the spending of the population on health care. These surveys (HHS) are representative enough to be able to estimate all non-public health care spending. Table 5.8 presents the development of the total health care spending. Private financing is established on the basis of HHS.

Table 5.8: Total health care spending at current prices (in millions US dollars)

	Financing structure in millions Litas				**Financing structure in millions US dollars (EUR)**			
	1990	1994	1998	2000	1990	1994	1998	2000
Public financing, of which	4,1	751,6	2077,9	1975,2	1,03	187,9	519,5	493,8 (533,9)
National budget	3,9	629,6	208,9	184,1	0,98	157,4	52,2	46,0 (49,8)
Social insurance	0,2	121,6	1869,0	1791,1	0,05	30,4	467,3	447,8 (484,1)
Private financing	0,5	129,6	657,5	794,4	*0,12	32,4	164,4	198,6 (214,7)
Foreign charity	0,0	40,8	90,3	30,8	0,00	10,2	22,6	7,7 (8,3)
Total	4,6	922,0	2825,7	2800,4	1,15	230,5	706,4	700,1 (756,9)

* Estimation of author.

Source: Department of statistics at the Government of Lithuania

Table 5.9: represents the health care financing structure by sources and its GDP share.

	Financing structure (%)				**GDP share (%)**			
	1990	1994	1998	2000	1990	1994	1998	2000
Public financing, of which	90	81.5	73.6	70.6	3.1	4.4	4.9	4.4
National budget	85.8	68.3	7.4	6.6	2.9	3.7	0.5	0.4
Social insurance	4.2	13.2	66.2	64.0	0.2	0.7	4.4	4.0
Private financing	10	14.1	23.2	28.4	0.3	0.8	1.5	1.8
Foreign charity	0	4.4	3.2	1.1	0	0.2	0.2	0.1
Total	100	100	100	100	3.4	5.4	6.6	6.2

Source: Department of statistics at the Government of Lithuania; estimations of author

The data in the Table 5.9 show that the share of private financing in the total health care resources has increased significantly during the recent decade, and the GDP share of health care financing has also grown. The share of health care in GDP in Lithuania was close to the regional average at about 6 per cent in 1995.

Table 5.10 and 5.11 present the total and share for health monthly household consumption expenditure and per capita in all 13 applicant countries.

Table 5.10: Total monthly household consumption expenditure per capita In euro (1)

Country	1995	1996	1997	1998	1999
BG	32	22	23	37	41
CY	:	:	546	:	:
CZ	117	138	147	155	162
EE	:	82	94	106	109
HU	90	90	95	98	109
LV	:	55	65	78	87
LT	36	49	69	79	84
MT	410	438	487	510	558
PL	87	103	114	128	130
RO	27	27	27	34	29
SK	88	102	121	127	118
SI	262	267	326	341	359
TR	:	:	:	:	:

(1) Eurostat exchange rate.

Source: STATISTICAL YEARBOOK ON CANDIDATE AND SOUTH-EAST EUROPEAN COUNTRIES 2001

Table 5.11: Structure of expenditure monthly household consumption expenditure per capita (health)

	Health In % of total expenditure				
Country	1995	1996	1997	1998	1999
BG	2.6	2.5	2.9	3.3	3.8
CY	:	:	4.7	:	:
CZ	1.5	1.4	1.5	1.5	1.6
EE	:	1.5	1.6	1.7	2.2
HU	2.7	3.0	3.0	3.0	3.0
LV	:	4.5	4.5	3.9	4.2
LT	1.9	3.0	3.4	3.8	3.9
MT	3.2	3.3	3.1	3.5	3.5
PL	3.5	3.6	3.8	4.2	4.3
RO	2.3	2.7	3.0	3.4	3.7
SK	0.8	1.0	1.2	1.2	1.4
SI	1.2	1.2	1.7	2.0	1.8
TR	:	:	:	:	:

(1) For food and non-alcoholic beverages, including expenditure in restaurants and canteens.

Source: STATISTICAL YEARBOOK ON CANDIDATE AND SOUTH-EAST EUROPEAN COUNTRIES 2001

Compulsory Health Insurance Contributions

Enterprises, institutions and organisations pay compulsory health insurance contributions amounting to 3% of the payroll. In addition 30% of natural persons income tax is considered as health insurance contributions (employees contributions is about 7.5 % of average wage before taxation).

Partnerships and owners of individual (personal) enterprises (sole proprietorships) pay for partnership members and owners of individual (personal) enterprises (sole proprietorships) and self-employed persons pay for themselves compulsory health insurance contributions which amount to 30% of the natural persons income tax amount calculated for partnerships and individual (personal) enterprises (sole proprietorships).

Farmers pay for themselves and for their family members working on the farm compulsory health insurance contributions in the amount of 10% of their declared income (not less than the minimum wage as fixed by law). Persons who do not fall within the categories of the covered persons pay for themselves compulsory health insurance contributions in the amount of the 10% of the average wage.

Health Insurance Expenses

Health insurance expenses comprise: (a) payment to the health care institutions contracted by the TPF of individual health care service costs; (b) reimbursement to the insured persons of expenses related to the purchase of medicines and medical aids; (c) reimbursement to the insured persons of sanatorium/resort treatment costs; (d) compensation to the insured persons of expenses related to limb, joint and organ prosthetics and prosthesis acquisition costs; (e) expenses of administration.

Payment of the individual health care costs of the insured is based on the contract between the TPF and health care institutions. The TPF must conclude contracts with state and municipal individual health care institutions, also with individual health care institutions accredited in the manner prescribed by the Government and having a license to practice individual health care.

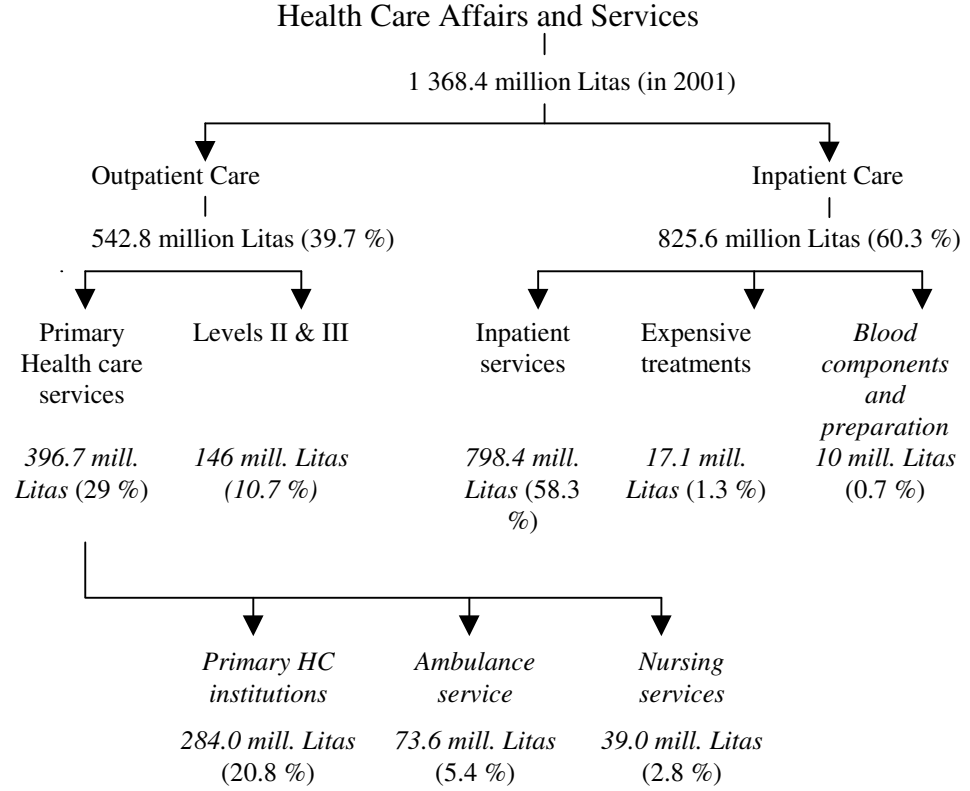
Individual health care services costs which are covered from the compulsory health insurance fund budget are specified in the list, which is approved by the Ministry of Health on the proposal of the Compulsory Health Insurance Council. Procedure for granting and paying out compensations for the expenses incurred while undergoing sanatorium/resort treatment and procedure for reimbursing the insured persons for the expenses related to limb, joint and organ prosthetics and for expenses related to the acquisition of prosthesis are laid down by the Government of the Republic of Lithuania.

For 2001 the SPF expenditures of the health care services were 1 368.4 million Litas. The proportion of total health care funding from the statutory

health insurance fund that goes to each major sector of expenditure (e.g. acute care hospitals, long-term care institutions, physicians, prescription drugs, non-prescription drugs, dentistry and others) is presented in Chart 5.5.

The expenses incurred by the insured in relation to the purchasing of the essential medicines and medical aids prescribed, for outpatient treatment are reimbursed in accordance with the list approved by the Ministry of Health on the proposal of the Compulsory Health Insurance Council. For the insured who are hospitalised the costs of medicines and medical aids shall be paid from the compulsory health insurance fund budget.

Chart 5.5: Health Care Affairs and Services



Source: State patient fund, 2002

5.1.4 Incentives

The main incentives set by the health care system with regard to the utilization of health services are due to differences in the capacity of the institutional network in service provision (especially in in-patient sector) and the reimbursement system of services.

The services delivered are paid by TPF's by applying per case payments for in-patient and secondary outpatient services and pure capitation for primary health services. Prices are set by the MOH (Ministry of Health) in close collaboration with the SPF. The prices are equal throughout the country and there is no possibility for bargaining about these.

Primary care includes ambulance care, long-term care, nursing care, mental care and family medicine as the first line in the health care system. Today, general practitioners are acting as gatekeeper within the health care system and patients need a referral from a GP to visit a specialist. Primary health care in Lithuania is financed by pure capitation (number of population served by PHC or family doctor) with different weights for four age groups and a weight for the number of persons living in rural areas. Pure capitation imposes certain limits on PHC providers' efficiency:

- The incentives for the health care provider to pick patients with low health risks and to reject the patients whose treatment costs may be high.

- Incentives for the productive work on PHC level are limited. This weakness of the model has been acknowledged in 1996 but not been addressed yet.

- There is statistical evidence that the pure capitation has contributed to the increase of referrals to out patient specialists and hospitals.

Outpatient specialist care is reimbursed according to the consultations provided. All visits to the specialist as well as first-line laboratory tests related to the same illness are considered as a consultation. In order to reduce risks of induced demand of consultations, the health insurance system has restrictions on the number of services provided.

In-patient care is reimbursed by the per case payment system. Full inpatient treatment is regarded as a case. About 40 cases are developed in order to reflect types of treatment (e.g. surgery, therapy, gynaecology), complexity of the services provided (3 levels of complexity) and age of the patient (children and adults). The system has created incentives to increase productivity in the hospital sector by reducing the average length of stay, but, on the other hand, has pushed upwards numbers of admissions.

Since 1997 the shortening of the ALOS by 2.8 days (from about 20 in 1990 to 14 in year 1996 and to 11.2 in year 2000) has taken place in combination with a markedly increase of the number of hospitalizations. Such a significant shortening of the ALOS might not only be due to the positive incentives created by the health insurance scheme, but may also be caused by the following additional factors:

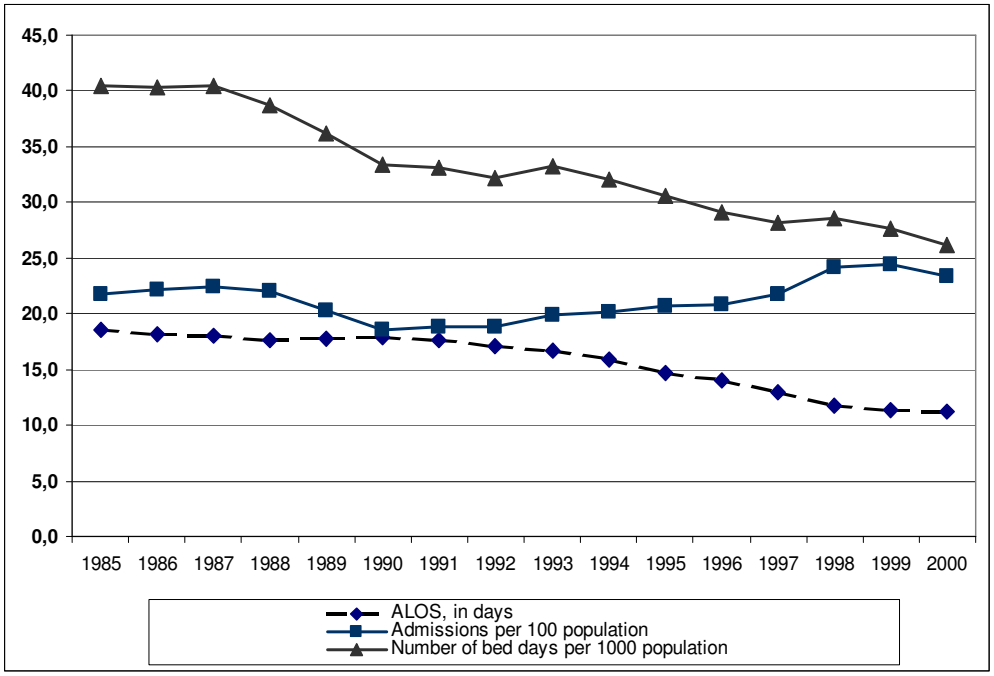
- The medical equipment and medicines of the new generation reduced the time needed for diagnosing and treatment.

- Patients of working age, the majority of whom work in the private sector, want to be discharged as soon as possible. During the Soviet era the opposite expectations of patients were recorded by the medical practice.

- Sometimes hospitals are pushing up the number of hospitalisations in an artificial way. With the hospitalisation of patients who could be treated as outpatient ones the ALOS decreases.

Over the past few years the problems in the development of hospital services have clearly been characterized by the comparison of the ALOS, the number of hospitalisations and the number of patient days presented in Chart 5.6.

Chart 5.6: Dynamics of hospital services indicators



Source: Data of WHO.

About 5 % of all health insurance expenditures are spend for inpatient care services for patients living in other counties than the place of service provision. Mainly these services are rendered in big tertiary care hospitals in Vilnius, Kaunas and Klaipėda that have modern equipment and high qualification medical personnel.

5.1.5 Coverage of the system and access to care

Coverage

Citizens of the Republic of Lithuania and foreign nationals as well as stateless persons who are permanent residents in the country and citizens of Lithuania who are in countries with which Lithuania has signed agreements concerning compulsory health insurance are insured under the compulsory health insurance plan. Compulsory health insurance is state monopoly and patients have the possibility to choose other insures only if they are additionally insured under a supplementary (voluntary) insurance system.

Compulsory health insurance covers: persons for whom compulsory health insurance contributions are paid; persons who pay compulsory health insurance contributions; persons who are insured with public funds (e.g., persons entitled to any type of pension; persons of working age who are registered as unemployed as well as their dependent family members; persons on maternity leave; persons under the age of 18 years; full-time students ; persons supported by the state who are entitled to social benefits; persons with group I and group II disability and unemployed persons with group III disability; etc.).

Not insured are only are homeless unemployed working age persons who are not insured by state or self insured and foreigners, who has no permanent residence in Lithuania.

The insured have the right to choose an individual health care institution contracted by the territorial patient funds and receive individual health care services guaranteed by compulsory health insurance. Specialist consultations and hospital treatment are free of charge only after referral by the general practitioner or district therapist/paediatrician.

If an insured person chooses on his own initiative to get some services or undergo some surgical operations (which is usually rendered according to waiting lists) without waiting, the insured must pay the health care institution out of pocket. Privately rendered services as well as listed services delivered in public health care institutions are paid out of the pocket, too.

The permanent resident of Lithuania has no rights to opt out of the system. Voluntary private health insurance may just increase the protection against health risks.

Health insurance resources regional allocation

Lithuania is a relatively small country with no big regional differences in terms of terrain distances from big cites, development of roads and social infrastructure. Nevertheless the differences in regional distribution of health care resources do exist and have been addressed by the Government and the statutory health insurance.

Firstly, financial resources for the primary health care are distributed equally following the introduction of the pure capitation in 1997. The chart 5.7 reflects some differences due to the demographic factors (because of different weights for rural population).

Secondly, financial resources for medicines have to be reallocated according to the needs of patients in relation to the implementation of fund holders' practices in the primary health care. The reform has been started in early 2002 and has to be implemented in about 3 years.

Thirdly, the State Patient Fund (SPF) has been developing the resource allocation formula for the inpatient services. Financing according to objective population needs (according to the population characteristics) has to be implemented in 3-5 years.

The major concerns with the presently uneven resource allocation are due to differences in the capacity of the institutional network in service provision (especially, in the in-patient sector). Substantial flows of patients to the hospitals in major cities and to some highly specialized hospitals, seasonal fluctuations and high consumption of services by local population in resort areas should also be mentioned.

The data in Chart 5.7 presents inequality in territorial resource allocation throughout the country. *Source: the SHIF database.*

Two years ago proposed general formula for resource allocation where age adjusted size of population in counties and some variables (e.g. unemployment rate) were included and a decision to gradually set ”partial” formula concerning 4 sub-sectors (PHC, ambulance, specialized care and nursing/long-term care) was taken and politically accepted. The current models for primary health care, ambulance care and nursing care are age weighted capitation models:

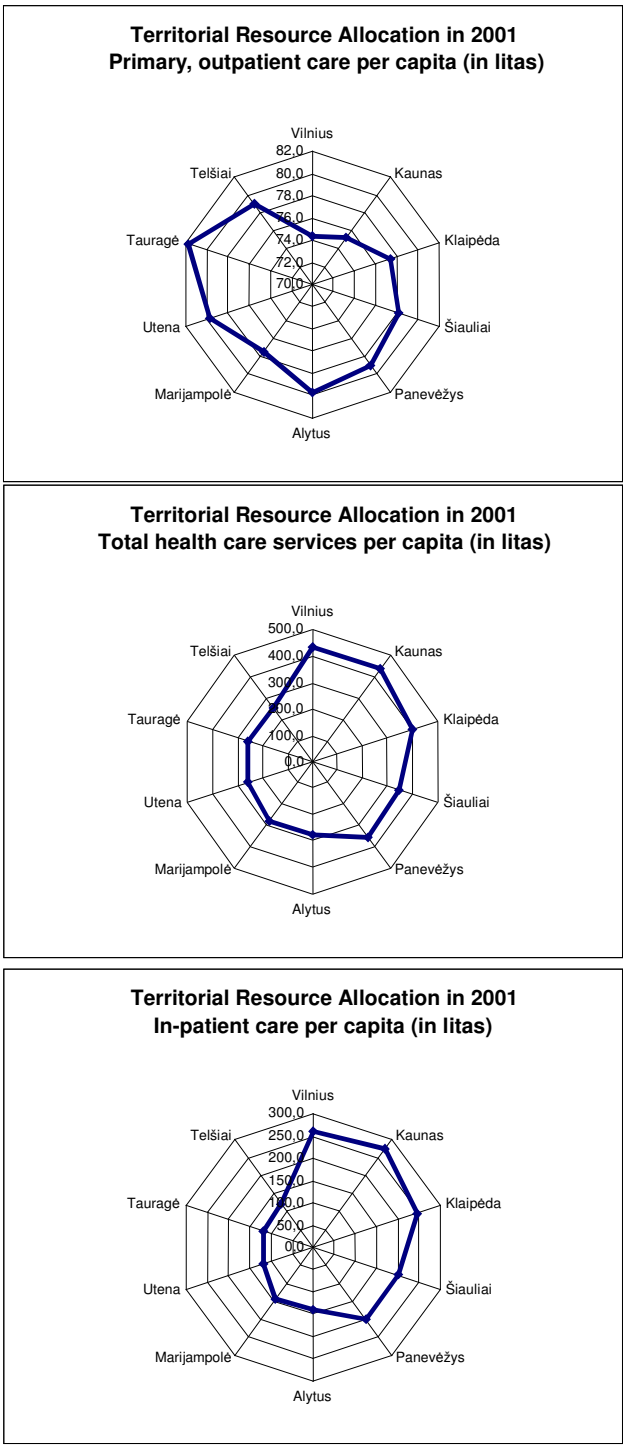
- In Primary health care the present model is a capitation model (number served by PHC or family doctor) with different weights for four age groups and a weight for the number of persons living in rural areas. The PHC model is not complicated and it is easy to understand. On the other hand the PHC model does not take any socio-economic indicators except rural/urban into account.

- In Ambulance care a politically accepted capitation (statistical number of inhabitants in Counties) with a weight for rural/urban model is under implementation.

- In nursing care a politically accepted capitation (statistical number of inhabitants in Counties) with a weight for the elderly (65 years and above) model is under implementation.

- In in-patient care a new allocation formula, which is based on the number of population in counties and age adjusted is approved in September 2002.

Chart 5.7: (1-3) SHIF territorial resources allocation throughout the country (according to counties/TPF's)



5.1.6 Public acceptance of the system

The public opinion and market investigation centre "Vilmorus" each month carries out public opinion representative surveys. The results of these surveys for the last 4 months (February-May, 2002) are presented in the table 5.12:

Table 5.12: "Do you trust these institutions or not?"

	Trust (%)									
	Febr-uary	**March**	**April**	**May**	**June**	**July**	**Sep-tember**	**October**	**Novem-ber**	**Decem-ber**
Church	65,5	66,5	60,6	59,3	61,4	60	59,2	59,6	59,3	61,7
Mass-media	62,3	63	59,3	59,2	61	61,3	61,2	63	59,7	59,7
President	57	56	53,4	54,9	57	54,4	52,4	50,7	52,3	53,7
Army	41,6	43,7	46,4	42,6	44,3	46,1	46,5	44,5	48,7	48,9
Health care	46,4	47,9	47,1	42,8	45,3	43,6	44	45,6	43,3	42,1
Social insurance	42,4	43	43,5	40,4	42,4	40,8	43,9	47,3	44,4	42,3
Municipa-lities	32,4	32,5	31,3	31,8	31,9	30,4	31,9	33,3	31,5	31,1
Police	28,3	31,3	30,8	31,6	32,7	32,6	29,8	33,7	32,4	33,9
Government	19,7	20,9	20,5	18,6	19,5	19,5	20,1	20,4	21,5	22,2
Courts	13,9	17,1	16,1	16,6	17,5	17,6	19,5	19,6	17,1	18,7
Seimas (Parliament)	9,1	7,9	8,5	8	9,5	8,8	9,8	8,2	10,3	8,7
Political parties	4,9	5,6	5,5	5,2	5,2	4,9	5,3	4,7	5,1	5,5

Source: daily newspaper "Lietuvos rytas" (23 of March, 2002; 20 of April, 2002; 18 of May, 2002)

From the survey results it may be concluded, that even if the public trust in health care during last four months dropped by 3.6 %, there is still very high trust in the system.

In 2001 the Health Economics Centre carried out a representative survey about public acceptance of social economic results of health care financing and service restructuring reforms[42]. The main concerns of the population according to the survey are presented below:

Private expenditures:

- 54.3 % of the respondents confirmed out of pocket payments in outpatient institutions (46.8 % for medicines; 15.7 % - under table payments);
- 12.9 % of the respondents confirmed out of pocket payments in hospitals (9.8 % for medicines; 7.3 % – additional expenses for

[42] Sveikatos finansavimo ir sveikatos priežiūros paslaugų restruktūrizavimo reformų socialinių-ekonominių pasekmių vertinimas. Ataskaita. Sveikatos ekonomikos centras. Rėmėjas – Atviros Lietuvos fondas. Vilnius, 2001.

meals; 5.9 % – under table payment to medical personnel). 53.2 % of the hospital patients unofficially paid to medical personnel.

Dissatisfaction of respondents because of:

- Long waiting time until services provided (10.8 %);
- Not enough attention and respect of patients from medical personnel – 10.9 %;
- Long waiting lists for free of charge treatments and prosthetics – 10.2 %;
- Lack of information about services and health status.

About 15 % of the respondents had to restrain themselves from getting health care services because of lack of money (dental care; denture and visits to high qualification specialists).

5.2 Evaluation of future challenges

5.2.1 Main challenges

The main challenges in the medium and long term in terms of structural changes are the following:

To develop and sustain an appropriate policy of cost containment in the pharmaceutical sector. The experience of 1999-2001 was very dissatisfactory (e.g. the budget for medicines was overspend by more than 30 percent in 2001). The mismanagement was due to the limited capacities of public management as well as populist tendencies of the Government in the past. Certain measures of cost containment have been designed in autumn 2001 by the Lithuanian government (e.g. increased co-payments for patients, reduction of the positive list of medicines reimbursed by the statutory health insurance, budget limits for outpatient clinics, reduction of margins for retailers). The international Monetary fund made a statement in spring 2002 that these measures shall assure the balance of the health insurance fund, but the actual results still have to be seen.

Planning of the hospital restructuring as well as implementation of the national restructuring plan in the hospital sector. In the period of 1990-2001 the financial tools developed inside the health insurance scheme concerned mainly the regulation of supply in hospital sector. Certain local and regional initiatives of hospital restructuring were developed in parallel to these financial incentives. In the late 90ies it was realized that local initiatives should be followed by a national master plan for hospitals. The first draft of this plan has been developed in spring 2002 but the final polishing of the document will take some time. The restructuring by itself has to decrease the number of beds by closures or mergers of some hospitals by 30-50 percent over a period of 10 years as well as to assure

reconstruction and modernization of most of hospitals buildings, operation theatres, wards. Estimated costs of the project are about 300 million Euro.

Smooth changes in primary health care. The philosophy to develop primary health care based on GP sole or group practices was developed in 1995-1997. The idea of the reform was to create a GP as a central figure of the outpatient sector. Certain elements of the reform had been achieved: training and retraining of GP's organized, primary health care centres founded in majority of municipalities, some sole and group practices had been privatised. As for the beginning of 2002, Lithuania has a mixed system of outpatient services. Traditional policlinics, primary health care centres, private practices do compete in the system mainly financed by the statutory health insurance. Which type of institution will win or whether all institutions will flourish has so far been unclear. In any way, the transformation of the current mixed system will create inconveniences for patients as well as for medical professionals.

The main challenges in terms of technology are the following:

As for the period of 1990-2000 the most important changes were in the field of *medicines and medical equipment*. Lithuania has shifted from 90 percent from consumption of medical goods produced in the Soviet Union to about the same percentage of the medicines produced in the West and Central Europe. Since most of modern technologies are already presented in Lithuania, the coverage of the entire population by services based on these technologies is now on the agenda. The development has been supported by the national initiatives (e.g upgrading of X-ray equipment), but is mainly initiated by providers of medical services.

Information technologies had been developed in recent years on health care providers as well as the national levels. The biggest as well as most successful national project is an IT system installed by the statutory health insurance scheme. All medical institutions as well as pharmacies are linked to the system. Providers (hospitals, ambulance service institutions, public health centres) do complain, however, because of the very limited feedback information they have received so far. The IT projects to be implemented in 2002-2003 are as follows:

Integration of national registers. There are 30 registers as for today with different codification as well as limited access of for the medical community and the general public. Concerns regarding confidentiality of personal medical data have to be addressed in parallel to the development of the integrated system.

Development of electronic medical records. As for today the majority of medical information used in the health care system is in hand written format. The project has to assure availability of an electronic version of medical records in all hospitals as well as transference of these records in the health care system.

Upgrading of communication systems. All medical institutions have to be linked to the Internet. All ambulances have to be supplied by mobile phones.

Plastic cards for the persons insured by the statutory scheme is considered as an option for 2003-2005.

5.2.2 Financial sustainability

The expenditure side

Three factors may be considered as cost drivers in the sector:

a) Demographic changes and ageing of the population. According to statistics of the statutory health insurance fund, elderly people (from 65 years) do consume approximately four times as much as 30-40 years people. Over the past five years the average life expectancy at birth has increased annually by about 0.5 year. If the rapid improvement of life expectancy continues for another 10-15 years the demographic structure of the population is expected to become alike the structures currently observed in the EU countries.

b) Development of medical technologies. During the first decade of reforms Lithuania had already managed to update medical technologies. A trend of expenditures for medicines may be considered as a certain proxy for changes in medical technologies. Public expenditures per capita for medicines were about 30 USD in 2001 in comparison to just 3 USD in 1993. The total consumption in 2001 was about 70 USD per capita (patients covered about 60 percent of the costs for medicines). The majority of medicines manufactured in OECD countries were unknown ten years ago. Currently the share of these drugs is up to 70 percent of the local market. Changes are great but expectations of the population are even higher. Patients under the pressure of tough marketing programs are demanding more drugs, medical investigations, and modern procedures.

c) Salaries. The salaries of medical staff are low according to international standards (the net monthly salary of doctor in 2001 was about 300 US$). The combination of internal political pressures to increase wages with forces of EU labour market will make the last cost driver the main one during the next 10-15 years.

Certain factors may be considered as cost savers:

a) Restructuring of the health sector. Reduction of spare capacities in hospitals and mergers shall reduce costs of maintaining buildings, heating, and transportation.

b) Cost saving investments. Most of the heating, ventilation, and water supply systems in medical institutions require to be upgraded. The pay back period for these investment is from 2 to 15 years

c) Redundancies. A few decades ago Lithuania was a country where the numbers of doctors and nurses were 1.5 higher than in the EU. Currently these differences have almost disappeared but still there are certain labour saving opportunities in the health sector.

According to the forecast developed by SPF in 2000–2010, cost drivers will overcome savers and public health expenditures will increase in absolute terms and in relative terms (as share of GDP). Taking into account that the Lithuanian economy is growing (GDP increased by 5.9 percent in 2001) and mid term forecasts are optimistic, it may be considered that the health care system will be sustainable. Of course the pessimistic scenario of the forecast presents (fortunately with low probability) risks of systems disintegration under internal and external pressures.

5.2.3 Health care policy and EU accession

Main challenges:

The process of harmonisation of healthcare legislation: harmonisation of public health rules; consumer protection; food safety; medicinal products; medical devices; free movement of health professionals; training programs.

An increase in health professional mobility: risk of brain drain - losses of health professionals due to possible migration; need to implement mutual recognition of qualifications; need to improve financing and create motivations for the staff; need to build administrative capacity for mutual recognition of diplomas and certificates; need to implement gradual harmonisation of education in EU Member States.

The need to improve international communication and information flow.

Implementation of arrangements for cross-border healthcare: challenge to gatekeepers in primary care; competition between health care providers on the open healthcare market; increased movement of patients.

Promoting an increase in patient's rights and citizen's participation: assertion of patient's rights; citizens' participation in solving health problems; increasing focus on minority groups.

An increase in healthcare expenditures: increase in health care expenditure to meet EU requirements; increase of demand for health care services as a result of increasing public awareness of health issues; increase of health care expenditure for national social security programme related to cross-border health-care provision; increase in health care expenditure due to the rise in pharmaceutical prices relating to the changes in procedures of setting prices according to internal market regulations.

Assuring equity in access to healthcare.

Improvement of healthcare system performance: improvement of effectiveness of system; public health system development according to EU requirements; achieving a balance between preventive-promotional and curative activities; addressing inequality; improvement of the coordination and relationships between all components of the health system; achieving balance between public and private sector work in health system; achieving a balance between demand and supply of health care; decentralisation of the healthcare management.

Implementing pharmaceutical regulations.

Implementation of quality standards: need to develop and implement quality standards; need to improve quality management; need to replace obsolete equipment; need to implement certification of hospitals.

Increasing international influence on national health policy building: risk of undermining the importance of health in national priorities due to EU enlargement procedures; taking account of the international perspective in national health policy building.

Main benefits:

Quality improvement (facilities, services): adoption of European health quality standards; the adoption of the EU standards and norms used in medical care; striving to reach EU standards, with the EU's achievements as benchmarking; improvement in management; increased access to new technologies; easier introduction of state of the art principles in management of national health system; evidence based health policy; higher respect for citizens' rights; improvement in information systems; increased variation in provision; certification of hospitals.

Active public approach to health and health care system

Lesson learning and international collaboration: regional collaboration networks; learning from other countries experiences in implementing health system reform; sharing the experience between EU countries to improve health systems performance; development of health information systems and possibility of rapid reaction to health threats and addressing health determinants; equal chances for development for candidate countries in the neighbouring countries of Eastern and Central Europe

Improvement in health status of the population - improvement in health indicators reduction in communicable diseases morbidity; reduction in the maternal mortality rate; reduction in the under 5 years mortality rate.

Improved financing of health system and access to health services: improvement of cost effectiveness in the health sector; cooperation between EU Member States in the area of reimbursement of healthcare costs with respect to mobility of providers, patients and the provision of health care; better access to health care services; increased funds for health care financial

support for health system from the EU; benefits from the export of health care services; adequate remuneration of medical providers.

Free movement of patients

Free movement of healthcare professionals: exchange of knowledge and skills; training and education opportunities; faster application of new knowledge in medical practice and management skills; cooperation between EU Member States in the area of reimbursement of healthcare with respect to mobility of providers; competition and increased pressure for continuous quality improvement; increasing quality of education programmes.

5.3 Evaluation of recent and planned reforms

5.3.1 Recent reforms and their objectives

The reorientation process during the past ten years has been directed towards a partially decentralized system based on quasi market introduced by the statutory health insurance. The process of change in Lithuania has moved forward in several aspects such as:

- Decentralization of primary care and small hospitals to local governments (1991)
- Opening of the market of medical goods (medicines, equipment) westwards (1991-1994)
- Upgrading of public health system especially immunization (1991-1995)
- Reform of medical education including the upgrading of curriculum up to EU standards (1992 -1995)
- Privatisation of the pharmaceutical sector (1992-1996) and partial privatisation of dental care and primary health care (1992 onwards)
- Introduction of a statutory health insurance (1992-1997)
- Tuning of the financing of the sector (1997 onwards)
- Health care institutions are reorganized from the Soviet type budgetary institutions into non-for-profit institutions
- Separation between primary and secondary levels of health care provision (1997-1999). Increased emphasis of the GP training and development (1997 onwards)
- Transformation of some municipal hospitals to nursing homes (1998-2001)
- Restructuring of the hospital sector (2000 onwards)
- Redesign of the public system of reimbursement of medicines (2001 onwards)

5.3.2 Political directions of future reforms

Ongoing discussions about the direction of health care policy and the status of planned reforms are a permanent occurrence in Lithuania. Because of the complexity of the issue as well as frequent changes of Governments and political managers of the Ministry of Health (minister, vice-ministers), there is certain discrepancy between slogans and real objectives of the Governments regarding the goals, objectives and tools of future reforms. There is an overwhelming understanding that reforms should continue but a strong social / political consensus among political parties, medical society and in the country still remains to be achieved. However, the reform processes started in last decade have not been altered. Certain new elements of reform (e.g. the restructuring of hospital and pharmaceutical sectors) do appear. Proponents and opponents of changes differ from case to case.

These are the main directions of future development to be mentioned:

- Improvement of primary health care (equipment and GP's training) and support for privatisation of PHC (in favour: regions, left wing politicians; against: traditionalists in medical community, right wing parties advocating low public spending);
- Improvement of the health care financing system (improvement of resource allocation among regions, investment allocation and provider reimbursement and contracting) (in favour: regions, against: national bureaucracy);
- Health care delivery system restructuring (ambulance service development, hospital care planning and restructuring) (in favour: staff of modern hospitals as well as politicians affiliated to them, against: regions);
- Restructuring of the pharmaceutical sector (in favour: left wing politicians, against: right wing parties);
- Introduction of supplementary health insurance (in favour: liberals: against: national bureaucracy).

Lithuania has taken considerable steps in reforming the health financing system towards separation of purchasing and provision of health services. However, there are several ways in which the system must continue to develop in order to more adequately meet the needs of the population. The overarching issue is that currently the system is supply rather than health needs driven. There are a number of areas that should be examined and improved in order to address this weakness: a) supply – driven resource allocation; b) inefficient management of investment expenditure; c) inefficient purchasing practices.

The goal of health services restructuring is to assure high quality, provide relevant services to the patient, and ensure a balance between primary, secondary and tertiary levels within the system in order to improve the cost-efficiency of the health care system. In Lithuania there are 187 hospitals

(hospitals are non-for-profit organizations). Hospital beds have been significantly reduced during the past ten years. There is, however, still a need for further reduction of the number of beds. Some hospitals have to be closed as well. The ongoing World Bank project supported the preparation of a National hospital restructuring strategy and a strategy implementation plan in 2001-2002 but there is no consensus on social and political acceptance of this document yet.

The importance of a restructuring of the Ambulance Services should be mentioned. Most of the ambulances in Lithuania are staffed with physicians and the majority of outgoings are due to simple cases (e.g. influenza). These inefficiencies are addressed in a new Ambulance Service Concept and Strategy Implementation plan. The goal of the AS in Lithuania - "The main task of AS is to start providing basic medical care to ill or injured persons in place of accident and urgently transport them to individual health care hospital" as well some other essential changes, such as:

- AS subordination transfer from municipalities to Counties;
- Establishment of General Aid Centres (GAC), where the medical calls can be dealt by experienced, medically trained personal – doctors and nurses.

5.3.3 Conclusions

Even since the establishment of SPF and the compulsory health insurance system, the system can hardly be described as an insurance-based system. It is stated in the law on health insurance that the financial basis of the health insurance shall be the independent state compulsory health insurance fund budget, which is not included in the National and municipality budgets. The budget of the SPF, however, is to be approved by the Lithuanian government. SPF does not collect their funding. Budget financing and social insurance contributions cover health insurance.

As it was realized that pure capitation doesn't motivate PHC providers enough to provide more services on the primary level, the project of a new payment system was elaborated and preliminarily approved by MoH. This new system consist of a combination of 1) pure capitation as a basic method, 2) additional payment for the quality according to the quality indicators (immunization rate and hospitalization decline from the counties average figure of the previous year, and 3) fee-for-service for most preventive services, ambulatory nursing, and services which are listed in the GP standard, but have been provided mostly by the specialists so far.

If the main objectives of the health care reform may be agreed, as reflected in Lithuania's health care policies which are health promotion, restructuring of health care services, reduction of expenses, and increase of productivity, it may be concluded that the system of payment for health care services, implemented in 1997, has a negative impact on some of the four

main objectives of the health care reform. Therefore, the system of 1997 will not be financially and politically appropriate in the long-term.

Restructuring of the provision of health care services. Re-allocation of financial resources from the inpatient to the outpatient (mostly PHC) sector. Hospitals do have incentives bigot increase number of hospitalisations

Greater attention should be given to the **activities of health promotion**. Financial incentives for health promotion are absent and programs to promote public health activities are limited. PHC institutions, reducing the contribution to public health, come out as winners.

Cost containment in the health care sector. The productivity as well as certain savings in the most expensive sectors, the specialized outpatient and inpatient sectors, is encouraged, but PHC institutions are not interested in replacing secondary health care, which is medically unnecessary, with their services. The more patients GPs refer for consultations and (or) to hospitals, the lesser the variable costs of PHC institutions.

Productivity. Payment per each case encourages competition and the improvement of the activities of secondary and tertiary health care sectors; however, it does not encourage the productivity of the PHC sector. The method of payment per capita restricts the incentives to work productively, because most PHC institutions provide services to all residents of the municipality, therefore they can, at least for some time, be considered as ”natural monopolies”

Equalization of health care expenses in counties. The expenses of the services at the secondary and tertiary level make up more than 60 per cent of health care expenditure. And there is a high probability that money will flow to the counties where there is a historically high concentration of the institutions of the secondary and tertiary level. Despite this negative tendency, PHC payment according to the number of patients helps to re-allocate resources for the benefit of the counties with a lower level of development.

Transparency. The system is fairly simple and clear to providers and to the general public. On the other hand, the concepts of ”treatment profile” and ”consultations” are not precisely defined and their integration into medical statistics as well as the practice of public management of health care is difficult.

Proper governance. Increasing financial independence of health care provider institutions, which was legitimised in the summer of 1996 by the Law on Health Care Institutions, has improved the quality of management on the level of health care institution.

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