Chapter 1 : Rolandas Krisciunas | Defending History

CASE-STUDY LITHUANIA Aleksandras Krisciunas Lithuania. CASE-STUDY: LITHUANIA 6 1 General background data Preamble The Republic of Lithuania is situated on the.

He is an author of a number of studies in law and sociology, a frequent contributor to periodicals. Plateris is associated with the Bureau of the Census, Washington, D. The first period includes the latter part of the nineteenth century and the beginning of the twentieth ; it ended when World War I began. During the second period of immigration, in the late fourties and early fifties, the number of immigrants was much smaller than during the first period. The two groups of immigrants differed considerably. The first consisted predominantly of economically underprivileged unmarried persons of both sexes, mostly farm laborers, looking for better opportunities; the second group was composed of refugees from Soviet tyranny, both families and unattached individuals. A large proportion of these refugees consisted of professional persons and their families. As the refugees fled their country in order to escape persecution, various groups of the population of Lithuania were represented among them in direct proportion to the perceived probability of being persecuted. The more prominent members of a persecuted group are more likely to attract the attention of the persecutors; therefore, it is natural that professional people would be overrepresented among the refugees. Persons belonging to other occupations, all the way down the socio - economic scale, were also found among them, but were proportionally less numerous. Once the refugees arrived in the United States, whatever their previous occupation, all had to start anew. Almost all, except those possessing easily transferable skills, had to take any work they were able to obtain, usually that of unskilled laborers. Manual labor did not have the same implication for various strata of the refugees. Those who had done such work all their lives resumed their previous occupation, with the difference that now their work was much better paid. Their position was comparable to that of the earlier immigrants who had entered this country for economic reasons. The situation of the professionals, however, was quite different: Some of them were eventually able to resume either their former occupation or some similar work, but the majority, especially the older generation, could only slightly better their positions during the first half-a-dozen years of their lives in the United States. A study of occupational adjustments of Lithuanian professionals was conducted in Chicago, where a large group of Lithuanians-settled. At that time, the factors determining the occupational adjustments of various professional groups had already become apparent, and there has been no basic change since then. During the period of ten years that has elapsed since the completion of this study, many persons included in the study have either retired or died; many others, especially among the younger ones, have improved their occupational status by acquiring new skills or a new profession. However, the very fact that some professionals had to change their profession or to repeat their graduate work in American universities in order to improve their job opportunities lends support to the differences in occupational potentialities of different professional groups as described here. In the specific occupational potentialities had already become clear, but few persons had yet had the opportunity to acquire and use new professional or semiprofessional skills. Hence, for those interested in the fate of individual professional groups as such, the situation in is more interesting than that at a later date. Moreover, information about the occupational potentialities of the Lithuanian refugee professionals may apply to other refugee groups, past or future, possible differences in adjustment may be due to different levels of prestige enjoyed by the cultures of various nations and to the type of welcome various groups of refugees receive in this country. Moreover, the study dealt only with persons who had received their degrees before leaving Lithuania, i. The data were gathered in two distinct phases: In each professional group of refugees, there were one or more individuals in a central position, having either extensive information about other members of their profession, or ready-made lists, as many such groups had their associations. Eventually, lists of nineteen professional groups were compiled, indicating 1 the name, 2 the address, 3 the age, and 4 the present occupation of each individual, although in some cases the information was not complete. The lists comprised persons, belonging to the following professions: The present occupation of the respondents was classified into four categories: It was not possible to ascertain whether these lists were exhaustive, but in view

of the close ties between fellow professionals, it can be assumed that the number of those who were omitted was small. Each professional group had its own adjustment problems ; the more intensive investigation, therefore, had to be limited to several selected groups. Since the present occupation of almost all persons was known, it was decided to concentrate on the two extremes: Four professional groups were selected: Random samples of 40 were taken of the physicians and of the lawyers, and those 80 persons were contacted personally, while questionaires were mailed to all engineers and teachers whose addresses were available. The fieldwork was facilitated by the fact that most respondents lived in Lithuanian neighborhoods and usually several of them dwelt within walking distance of one another. All respondents were cooperative, and eventually questionnaires were filled out. According to their profession, 40 respondents were lawyers, 40 were physicians, 36 teachers and 32 engineers, but only the lawyers and physicians constituted probability samples. Occupational History Before December 1, , the immigration of refugees was hampered by legal requirements, such as quotas and affidavits. With the passage of the Displaced Persons Act by Congress, the flow of refugees into this country began in December of , ending on January 1, Out of the sample of persons, , or Eighteen persons, or The newcomers, arriving almost penniless, had to take any job they could find in order to earn a living. They did not know about life in the United States and usually had nobody to advise them. People they first met were either pre-World War I immigrants from their native country, mostly common laborers, who could only help in getting factory jobs, or their fellow refugees who had arrived some months earlier and were almost as ignorant of the occupational opportunities in the United States as they themselves were. Naturally, after living in Chicago long enough to become acquainted with the opportunities for employment, the refugees started to search for more permanent occupations. After a year or two, this period of searching for a more satisfactory occupation could be considered completed, and the rate of change slowed down markedly. There were some deviations from this pattern of adjustment. A very small number of persons did not need to start work immediately after arriving, because they were helped by other members of their family and could leisurely look around for a better job. Despite the fact that almost all newcomers tried to obtain employment immediately upon arrival, not all were successful. Several respondents reported that it took them considerable time to get their first job in Chicago. This period encompassed a few weeks or months, and in one case it lasted almost half a year. Outside Chicago, jobs were scarce in the late forties, and some refugees who originally came to other cities eventually moved to Chicago in search of better job opportunities. Persons belonging to professions that have a special routine for adjustment, such as physicians, engineers, or priests, and those who had good advisors, or were especially lucky, found more satisfactory occupations from the beginning. A number of persons, while working at undesirable jobs, took courses, examinations, studied, and otherwise tried to improve their occupational opportunities. Ninety, or 62 per cent, of the respondents, used this method, and in 62 cases some improvement had already taken place when this study was conducted. The great majority, respondents, had held two to four jobs since arriving in Chicago. However, the differences between the professions were marked: This difference can be explained by the institutionalized pattern of occupational mobility of the physicians. Table 1 gives a concise picture of differences between occupational histories of the four professional groups. Practically no lawyer and no teacher escaped manual work, but almost no physician was ever engaged in this type of occupation. Among the 5 physicians who ever worked as manual laborers, 2 switched to labor in order to earn money while preparing for the Medical State Board examination, when all other introductory steps leading to the resumption of their professional work were already completed. Hence, only three physicians out of 40 started their career as laborers, while 37 started either as white collar workers or in an occupation similar to their profession usually as hospital interns ; on the other hand, the first occupation of 37 out of 40 lawyers was manual labor. The engineers were almost exactly half-way between these two extremes. Slightly more than one-half of their group began their work experience in the United States with blue collar work. Percentages indicate the number of respondents who ever held one or more jobs belonging to a given type, and do not necessarily add up to

Chapter 2 : Consumer attitude to fast food: the case study of Lithuania

Aleksandras KriÅ¡Ä•iÅ«nas Traumatic brain injury is a major public health problem and may result in significant impairment of an individual's physical, cognitive, and psychosocial functioning.

Privacy Policy Case Study: Introducing sustainable development to the coastal angling tourism sector can provide even greater benefits on the long run. Location of study sites: The Lithuanian Baltic Sea along the coastline can be up to 20 m deep. In the northern part of the study area, the seabed is mainly composed out of rocks in combination with sand. The southern part has a more homogenous sand-dominated seabed structure. The northern part of the study area is under strong influence of a freshwater flow from the Curonian Lagoon towards the Baltic Sea. The Curonian Lagoon is a freshwater lagoon of the south-eastern part of the Baltic Sea with a basin of a straight triangle. The length of the coastline of the Lagoon in Lithuanian territory is about km. The rest of the Lagoon is located in the territory of the Russian Federation. The lagoon is very shallow with an average depth of 3. The northernmost part of the Curonian Lagoon, which is up to 14 m deep and just 0. The Nemunas River provides the main water inflow into the Curonian lagoon, which discharges to the Baltic Sea. The Nemunas Delta, with a maze of river branches, canals, polders and wetlands is protected as a wetland of international importance under the Ramsar convention and as a regional park. The delta is highly important for the migrating and breeding fish and birds. Lower reaches of Nemunas: The main angling season differs according to fish species, but also depends on the region within the case study area. Thus, the study area provides all year round angling opportunities. The region attracts anglers of all ages main target group: Tourism information centres, common accommodation, restaurants, recreational fishing services, boat rental, recreational fishing providers, angling shops and fishing guides. Development of angling tourism: In the past the study area was well known for its fishing villages and agriculture. Nowadays the hospitality business rules the area. Nevertheless, due to the lack of data, the development of coastal angling tourism in the study area was not recorded. Closed seasons for the Curonian Spit and Nemunas Delta regional park waters were established according to the rules for internal fishing for pike, pikeperch, asp, burbot, catfish and bream, as well as noodle and narrow-clawed crayfish. In the Lithuanian Baltic Sea, closed seasons were established according to the rules for amateur angling of turbot and European whitefish. Furthermore, fishing in marine waters is limited. The new development of the area as a place for recreational tourism shows ambitions to maintain the historical aspects. Hence, there are various cultural events related to recreational fishing, bringing the local communities together. Several locals and stakeholders in the case study area participate in a range of activities and projects related to angling, traditional fish dishes and others. Angling tourism helps to diversify the supply chain and adds all-season business opportunities for the local community. A project supporting fisheries to retrain recreational angling providers was conducted in the area. Due to the lack of data on angling tourism in the Klaipeda region, a range of problems may exist, but have not been recorded. However, conflicts between commercial fisheries and recreational fishing are common issues. None in progress Website:

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Contains case studies on the key policy issues, emerging needs and resources for long-term care in the following ten developing countries: China, Costa Rica, Indonesia, Lebanon, Lithuania, Mexico, Republic of Korea, Sri Lanka, Thailand and Ukraine.

They can be subject to further publication. The views and opinions expressed here reflect the author s point of view and not necessarily those of CASE Network. The system of LTC in Lithuania Critical appraisal of the LTC system D at the University of Turin. Her current research interests are mainly in the area of labour market economics, including: She is fluent in English and Italian and has a working knowledge of Russian language. This paper addresses the issue of the long- term care in Lithuania, its philosophy, the legal and funding regularities, management issues and LTC policy. Its attempt is also to provide a complex set of information about the demand side of long-term care including the demographic characteristics of people in need. The paper also presents a detailed description of types of LTC available. The results confirm that the main problem of the LTC system in Lithuania is still its division between the health care system and the social system and the weak integration of these two parts of LTC services. The formal LTC system in Lithuania is still biased towards the provision of institutional care, despite the fact that a number of social projects have started in order to expand the supply of semi-stationary LTC and care provided in homes. Moreover, most care provided to the elderly and disabled is still carried out by family, neighbours, friends and volunteers. The demand for LTC, approximated by the demographic and epidemiologic structure of the population at the national and regional levels, remains high and it is expected to increase. The system of LTC in Lithuania 1. LTC for elderly people is organized through two main sectors: Also the institutions providing LTC are divided among these two sectors and there is no single government institution that specifically coordinates LTC services. It is targeted at individuals who are not self-sufficient and need assistance because of long term illnesses and physical and mental disabilities, regardless of age. In Lithuania, LTC also includes palliative care services, aiming to improve the quality of life for patients with untreatable and progressive terminal diseases and to help their relatives cope. Long term medical treatment with nursing services attributed to health care are provided irrespective of age, taking into consideration the health conditions of an individual, the progress of the disease and any other complications. Within the health care system, residential care is provided in general hospitals or nursing hospitals also called supportive treatment hospitals. Residential care covers nursing and maintenance, follow-up treatment, and palliative care. Primary health care institutions are responsible for the organisation and provision of nursing services in the home. Within the social sector, LTC is provided according to the level of independence and the need for services, irrespective of age. The main recipients of social services are elderly people and people with disabilities both children and adults. The social system provides social help at homes, in day centres and in residential social care homes old-age homes, housing for the disabled, specialized social care homes. Until , institutional care prevailed within the health care and social sectors. Only recently have there been some attempts to reorganize the provision of LTC services. According to public documents,2 the philosophy of the LTC system is to shift from an institutional care system to home based care. New flexible forms of provision of LTC at institutions, day centers and in the home have been defined. Support for informal LTC by relatives, family members, neighbors, non-governmental organizations and volunteers has been strengthened in order to support a natural, family environment. The development of the LTC sector is a huge challenge which must be met due to rapid demographical changes including the ageing tendencies of the population. The structure of the report is the following: In every subchapter, first LTC within the health care sector is described followed by a presentation of LTC services within the social sector. Long term medical treatment with nursing services is available for all citizens. It is provided based on the health conditions, the progress of the disease and other complications, irrespective of age. It is determined by a doctor or medical advisory commission according to approved medical indicators, and there are no other indicators taken into consideration. Disabled people, considering their special needs, may be provided permanent care assistance or permanent nursing services. In the social sector, services are provided

irrespective of age, considering the level of independence and the need for services. The need for social services, including long term social care, is determined by social workers. The social worker visits the individual, analyses his or her conditions and decides what type of social help is needed. The need for social services is determined by considering a combination of the principles of co-operation, participation, complexity, accessibility, social justice, relevance, efficiency, and comprehensiveness. Based on a complex system of indicators and scores selected, a person can be self-sufficient, partially self-sufficient or dependent. Persons in need of care from another person who require care no more than 4 hours per day and 5 days per week may receive home attendance. If they need care for no more than 8 hours per day and no more than 7 days per week, they can receive social care at home or stay in day centres. If they need care for more than 8 hours per day, they may receive temporary short-term social care at home and in care institutions, but for no more than 30 days. Otherwise, they might obtain long-term social care for more than 30 days in stationary social care institutions. The property and incomes of an adult person are tested; in the case of children, only incomes are tested. Cash benefits are not means tested. The Table 1 lists LTC institutions by their function and the sector they belong to. Organization of institutional and home based care Type of Residential care Semi-residential care Home based care system In cash In kind Health Nursing and -- -- Nursing care maintenance services at system treatment in general home hospitals, nursing hospitals also called supportive treatment hospitals Social Social care homes Day care in day care Benefits in Social services old-age homes, centers, cash to the attendance at housing for disabled, Temporary short-term individual in home; specialized social care in residential social need of includes care homes care institutions assistance performance due to of housework reduced self- and care by sufficiency home-helpers Source: Stationary long term medical treatment with nursing services is available for patients with chronic diseases or disabilities. Patients must be referred to the LTC by the physician of an ambulatory or a stationary health care institution. Patients can be hospitalised after the final diagnosis without any additional tests. The special needs for permanent nursing are indicated for people with severe disabilities, who require permanent care and whose physical and mental disabilities seriously restrict their ability to move, walk and independently go about their private and social lives. Aftercare nursing and rehabilitation is also provided in general hospitals in special departments. In residential social care institutions, LTC is provided for people who are totally dependant and who need the permanent care of professional caregivers. Still, the health status of people admitted to stationary social care institutions is relatively better than that of patients in stationary LTC institutions within the health care sector. Social care is provided by several social care homes such as old-age homes, housing for the disabled, specialized social care homes, etc. Stationary social care institutions are available in all of the main regions of the country under the supervision of local governments. The minimum duration of stay is 1 month. Semi-residential care is provided within the social sector only. Elderly and disabled people can receive day care in day care centers from 3 hours per day up to 5 days per week. They can also receive temporary short-term social care in residential social care institutions depending on the recipients of the services, e. Home care includes nursing and social care services, which are provided by various professionally qualified workers in the home of the person in need of care. These services are provided to people who are unable to live in their homes independently and who have partially lost their independence due to old-age or disability. People in need of home care are regularly visited by social workers from the local social assistance administration and they determine the need for social care. Social attendance in the home includes performance of housework, and care by home-helpers. Palliative care services can be also provided to patients at home by a team of specialists: Other in-kind benefits include the provision of special equipment. Disabled people receive special aid for the purchase of a car. They are provided with wheelchairs and their flats are arranged according to their disability. Special Compensation for Care Expenses is provided only within the social sector. Benefits in cash are only paid directly to the dependant person. There is no choice between cash benefits or benefits in kind. At present, it is a central system which is supplemented at the regional level. The national government is responsible for long-term national programs, strategies, requirements and standards. More specifically, The Ministry of Health is responsible for the entire health care system policy. Through the State Public Health Center, it manages the public health network including ten county public health centers and their local

branches. The Ministry of Social Security and Labour is responsible for the adoption of long term national programs and strategies for social integration within the social sector. Local self- governments are responsible for the processes of needs assessment, monitoring and control, and contracting social services to service providers. They are responsible for the provision of secondary specialized medical treatment. Municipalities prepare and implement municipal programs of disabled social integration. They are directly responsible for the organization of the provision of social services, for the determination of the needs for social services, for the supervision of common and special social services, and for the organization and provision of primary health care. Until , there was no single concept of LTC. Since the Ministry of Health and the Ministry of Social Security and Labor have been working to improve the coordination of care and social services at the municipal level, to improve the cooperation and communication between institutes and to ensure these services are accessible to all. However, no legislative or financial integration has been defined within the LTC system. Between health care and social services sector As there is no specific separate legislation for the LTC system, all services are either integrated within the health care or social system. Health care institutions for elderly people with LTC needs are organized and funded on the same basis as other health care institutions. Social services for people with LTC needs are organized and funded on the territorial self-government basis within social system. Consequently, each LTC service might be funded from a different source and be integrated within one of the sectors mentioned above. Funding Expenses related to LTC within the health care system are being financed from various sources: For the LTC benefits in kind financed from the Compulsory Health Insurance, the qualifying period is no longer than 3 months. LTC within the social system is financed from local self-government budgets and target subsidies of the central budget assigned to local municipal budgets. In this respect, municipalities directing persons to social care institutions for LTC shall have to cover part of the expenses related to the provision of social services. Persons themselves contribute to payment for LTC services using not only their income but also their property. It depends on the kind of LTC and on the person in need of care. Self-governments have the right to relieve a person from payment. Moreover, the state does not control the prices of services.

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Case Study - Lithuania" Lithuanian Ministry of Social Security and Labour,, "Social Report " Lithuanian Ministry of Social Security and Labour, "Social Report " Lithuanian Ministry of Social Security and Labour, Vilnus University, Department of Social Work, April , "Social Services in Lithuania" Law on.