



# LONG-TERM CARE IN BELARUS

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While all efforts have been made to utilize the most recent and trustworthy data, the World Bank does not guarantee the accuracy of the data used in this report. The note is not a full or independent evaluation. It was prepared in a relatively brief period, with additional impact of COVID-19 pandemic, that created constrains for additional data collection and comprehensive discussions with the Government.

## Executive summary

Elderly people in Belarus face a variety of challenges in order to lead productive and fulfilling lives in their old age. This report suggests that the early development of a comprehensive, long term, and ambitious aging policy can promote equality, dignity, and healthy aging for Belarus's growing number of elderly citizens. In order to address the most urgent needs of the elderly, building on already developed structures, a short-term action plan needs to be implemented.

The current population of Belarus is an estimated 9.5 million and this is expected to decrease to less than 9 million over the next 20 years. The proportion of the population that is made up of children and those of working age will shrink, while the number of elderly (aged 60+) will grow. While at present the elderly comprise an estimated 22% of the total population, that figure is expected to increase to an estimated 29% by 2038. Due to population aging and the resulting sharp increase in the number of elderly and very old (80+) over the following 20 years, the number of Belarusian citizens who will need LTC services (the dependent population) will rise rapidly.

Relative poverty among the 65+ population is approximately equal to relative poverty for the population in general. The three categories of single-person, 65+ households, single-parent households, and large families with more than three children are most exposed to relative poverty risk. These groups are also particularly vulnerable to unexpected fluctuations in utility and pharmaceutical prices and growing out of pocket expenditures for health. Because elderly Belarusian citizens often live alone, and given their relatively compromised health status, they run a high risk of social isolation. This is particularly important given recent changes in the family model and attitudes towards care for the elderly. In advanced age, women, in particular, are likely to live alone given their longer life expectancy, which exposes them even more to the risk of social isolation and loneliness.

Social isolation is often considered a risk factor for violence and elder maltreatment, and the risks associated with social isolation are particularly pronounced at the onset of reduced functional ability, when older persons need assistance with the activities of daily living (ADL). In addition to the social and psychological aspects of living alone, some infrastructure and heating issues remain, particularly, in rural areas. Private houses in rural areas tend to be less well equipped with basic amenities, such as adequate heating systems.

At the same time, family and intergenerational relations are of great importance to Belarusians. The 1994 Constitution of the Republic of Belarus (Art. 32) stipulates that adult children who are able to work have an obligation to take care of their parents, including providing financial support for parents who are unable to work. According to national polls, the vast majority of Belarusians are of the opinion that it is a family's responsibility to take care of older family members (specifically, 91.6% of respondents agree that young people should take care of their old relatives).

Most care is provided by families, and mostly by women (daughters or other female relatives), who are themselves close to retirement age. This may be partially due to family values and norms of respect and support for the elderly, which are firmly rooted in Belarusian traditions. Adult children, on average, meet with their mothers twice as often as they do with their fathers—a fact that is partly explained by the higher number of single mothers. Only 12% of families live together with older relatives.

Given the prominent role that families traditionally play in caring for the elderly, state-organized long-term care (LTC) is provided on a much smaller scale than in many other countries. At present, the cost of all LTC services provided by the Belarus state for all its citizens, including for those 65 and above, amounts to approximately 0.32% of GDP. Even without any changes in planned provisions or eligibility conditions and considered solely as a combined function of population aging, LTC costs are expected to increase to 0.85% of GDP by 2038. At present, more than 30% of all dependents receive some form of service that could be considered LTC provided through state-sponsored programs.

Compared to the Organization for Economic Co-operation and Development (OECD) average, there are also some substantial shortages in the Belarus LTC system. For instance, in 2018 the number of LTC

beds in both health and social sectors was three times lower than the OECD average. The total number of dedicated LTC staff is also three times lower than the OECD average.

Based on a combination of analytic research and insights gained from both local and international experts, this report proposes a comprehensive, short-term action and Seven Steps Strategy towards LTC system development. A short-term action plan should include: (i) support families in the care they currently provide (home-based services, training, contribution in kind); (ii) implement a home-based integrated LTC with clearly defined scope, financing and implementation tools; (iii) start transformation of health and social systems with increased focus on healthy aging and LTC.

Ambitious transformation could be framed by a Seven Steps Strategy:

1. LTC aging policy, and financing system development;
2. Enhanced care coordination for the elderly at the local level, including home-based care support;
3. Developing IT systems that support care provision, coordination and quality;
4. Strengthening telemedicine;
5. Skills development;
6. Strengthening communities and NGOs that provide LTC; and
7. Promoting active and healthy aging.

The COVID-19 pandemic has put national health systems under immense pressure. Health systems throughout the world demonstrated different levels of preparedness for an outbreak of this magnitude. The crisis tested their resilience, i.e., the ability and capacity of health systems to absorb, effectively respond and adapt to shocks and structural changes while sustaining day-to-day operations. Elderly care during the pandemic has been one of the key challenges of health and social systems.

It is critical that older people can access health-care services during the pandemic in the least disruptive manner. Rapid development and access to new technologies, such as telemedicine, is needed. Digital literacy of older people needs to be enhanced so they can use mobile apps for receiving information and for communicating with family members and community service providers, even when physically separated. In the Belarusian family model, caregivers of the elderly have to be supported. Services that meet older people's needs, promote their health and keep them out of hospital must be prioritized. Support to the delivery of home care, nutritious food, medicine, and social support and information for mental and emotional well-being should be provided. Older people also need tailored and accurate information on how to stay healthy during the pandemic and what to do if they fall ill. Cross-sectoral efforts, including well-organized communications tailored to vulnerable groups, are advised.

There is also a need to look beyond the current pandemic and to stimulate a new way of thinking about the organization of healthcare service provision for the elderly in order to better prepare for future crises and other challenges that may affect health outcomes and quality of life among this growing segment of the population.

## List of abbreviations

ADL	activities of daily living
Belstat	National Statistical Committee of the Republic of Belarus
BRCS	Belarusian Red Cross Society
BYN	Belarusian ruble
CHIS	Central Health Information System
COPD	chronic obstructive pulmonary disease
DR	disease rates
EMR	Electronic Medical Record
GDP	Gross Domestic Product
GGS	Generations and Gender Survey
HALE	healthy average life expectancy
IPM	Research Center of the Institute for Privatization and Management
LFS	Labor Force Study
LTC	long-term care
MIPPA	Madrid International Plan of Action on Ageing
MoF	Ministry of Finance
MoLSP	Ministry of Labor and Social Protection
NCDs	non-communicable diseases
NGO	non-governmental organization
OECD	Organization for Economic Co-operation and Development
PAYG	pay-as-you-go
SPF	Social Protection Fund
SSO	state social order
STEPS	Stepwise Approach to Surveillance
TCSS	Territorial centers for Social Services
TFR	total fertility rate
UN	United Nations
UNECE	United Nations Economic Commission for Europe
UNFPA	United Nations Population Fund
USD	United States dollar
WB	World Bank
WHO	World Health Organization

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## Dictionary

Table 1. What do we mean by ... <sup>1</sup>

<b>Attendance allowance</b>	Payment for the care of a person with Group 1 disability or aged 80+.
<b>Care provider</b>	An individual care professional or care facility organization licensed to provide care diagnosis and treatment services.
<b>Environments</b>	Include the home, community and broader society, as well as the factors within them, such as the built environment, people and their relationships, attitudes and values, health and social policies, the systems that support them, and the services they implement. Being able to live in environments that support and maintain intrinsic capacity and functional ability is key to healthy aging.
<b>Formal caregiver</b>	Home, nurse, community and/or residential care staff qualified to provide care and who receive payment for their work.
<b>Formal LTC setting</b>	An institution that organizes and performs LTC services funded through state or regional public budgets.
<b>Formal LTC workers</b>	Individuals who provide care to LTC recipients. In the OECD definition this includes nurses and caregivers.
<b>Healthy aging</b>	Defined by WHO as “the process of developing and maintaining the functional ability that enables well-being in older age.” Functional ability is about having the capabilities that enable people to be and do what they have reason to value.
<b>Informal caregiver</b>	A member of a person’s social network, such as a family member, friend or neighbor who provides care to an older person in need of assistance with activities of ADL. As a rule, such individuals have no formal status and do not get paid.
<b>Informal LTC setting</b>	A care setting organized by families and/or individuals without the assistance or support of state organizational and/or financial support.
<b>Integrated care</b>	Refers to the transition from disease-centered care to patient-centered and person-centered care provided by an interdisciplinary team and includes community-based integrated care, which coordinates LTC, healthcare, and social services in order to promote active living. Integrated care has implications for the budgetary system since it requires aligning incentives and coordinating/integrating budget processes among parallel services, such as LTC, social services, and healthcare.
<b>Internats</b>	Accommodation for older people and people with disabilities who cannot live on their own and who have LTC needs, provided as an inpatient service of the social system.
<b>LTC</b>	Services for older people in need of care and assistance. Such services encompass prevention, rehabilitation and enablement, cure and care, including end-of-life care, and combine health and social care for ADL, such as eating, bathing, dressing, grooming, housekeeping, and leisure.
<b>LTC expenditures</b>	The part of healthcare and social policy financing related to LTC needs. There are significant differences between the OECD and Belarusian calculation of LTC-related expenditures. Belarus data include a broader scope of services, such as the cost of Territorial Centers, of which only a small part can be attributed to LTC. Since it was not possible to determine the exact cost of LTC incurred by Territorial Centers, this expenditure includes the total cost of Territorial Centers.
<b>LTC health services</b>	Services provided by hospitals, polyclinics, and ambulatories. Outpatient medical service for the elderly also includes home-based medical care. Medical care is provided by health professionals, particularly nurses, therapists, physiotherapists, and, in some cases, geriatrists.
<b>LTC recipients at home</b>	Individuals who receive formal (paid-for) LTC at home because of functional restrictions. Although such individuals mainly reside at home, the category also applies to individuals who make use of institutions, such as community care and day-care centers, on a temporary basis in order to support continued living at home. Home

<sup>1</sup> An additional list of definitions used in this report can be found in Annexes, 1.1 “Regulatory legal acts in the area of social and medical care provision”.

	care includes specially designed or adapted living arrangements for persons who require help on a regular basis, while guaranteeing a high degree of autonomy and self-control.
<b>LTC social services</b>	Services provided by the internats for the elderly and persons with disabilities, the Territorial Centers for Social Services, and other legal entities (e.g., NGOs and individual entrepreneurs).
<b>LTC recipient in institutions</b>	Individuals who receive formal (paid-for) LTC in institutions other than hospitals. LTC institutions refer to nursing and residential care facilities that provide accommodation and LTC as a package and include specially designed institutions or hospital-like settings, where the predominant service component is LTC, and the services are provided for people with moderate to severe functional restrictions.
<b>LTC spending (health)</b>	Expenditure related to a range of medical and personal care services consumed with the primary goal of alleviating pain and suffering, and reducing or managing the deterioration in health status of patients with a significant degree of long-term dependency.
<b>LTC spending (social)</b>	Expenditure related to lower-level social care services aimed at assisting individuals with instrumental ADL, such as home-help, meals-on-wheels, and transport to and from day centers.
<b>Nurses (OECD)</b>	As defined by the ISCO-08 classification (221 ISCO code for “professional nurses” and 321 ISCO code for “associate professional nurses”), “nurses” in this report refers to individuals who provide LTC at home or in LTC institutions (other than hospitals).
<b>Nursing hospitals</b>	Accommodation for older people and people with disabilities who cannot live on their own and have LTC needs, provided as an inpatient service of the healthcare system.
<b>Poverty</b>	<p>Absolutely poverty rate is a share of population (households) with average per capita disposable resources (defined as expenditures plus in-kind income) below the minimum subsistence budget (national poverty line) in the total population (households). The minimum subsistence budget is calculated on average per capita and for the main sociodemographic groups and is quarterly approved by the Ministry of Labor and Social Protection of the Republic of Belarus in prices of the last month of a quarter.</p> <p>Relative poverty rate is a share of population with average per capita disposable resources, calculated with the equivalence scale, below the relative poverty line in the total population. The relative poverty line is defined as 60% of median of average per capita disposable resources on average for the country calculated with the equivalence scale. The equivalence scale is a set of weights for the conversion of the total number of household members in the number of equivalent consumers taking into account the effect of cohabitation.</p>
<b>Personal care workers (caregivers) (OECD)</b>	Formal workers providing LTC services at home or in institutions (other than hospitals) and who are not qualified or certified as nurses. As per the draft definition in the ISCO-08 classification, personal care workers are defined as individuals who provide routine personal care, such as bathing, dressing, or grooming to elderly, convalescent, or disabled persons in their own homes or in institutions.
<b>Service providers</b>	Public, non-profit and commercial institutions that deliver services to older people in need of care and assistance in institutional, community, or home care settings.
<b>State social procurement financing</b>	Financing associated with state-sponsored social services provided by other legal entities and NGOs.
<b>Territorial Centers for Social Services</b>	The state entity that provides social services to individuals and their families in difficult life situations.

<b>Total LTC spending (Belarus)</b>	The total expenditure on internats for the elderly and persons with disability; state social procurement contracting; social services in substitute families; funding for life maintenance contracts; attendance allowance for the care of disabled persons aged 80+; social services for foster families; services in Territorial Centers for Social Services, and nursing beds in hospitals (nursing and general).
<b>Well-being</b>	The condition of being contented, in the best possible health, and integrated in society. Social interaction with family, friends, neighbors in the community, and any relevant staff in long-stay settings can support the well-being of older people in need of care and assistance and improve their quality of life.

## 1. Background information

### 1.1. Long Term Care in the context of Belarus

**There are many definitions of long-term care (LTC) in the literature on the subject.** That said, LTC could be uniformly defined as a range of services required by persons with a reduced degree of functional capacity (physical or cognitive) and who are consequently dependent for an extended period of time on external assistance with basic activities of daily living (ADL). LTC services can also be combined with lower-level care related to assistance with the so-called instrumental ADL (for example, domestic help or help with organization and administration). According to the World Health Organization (WHO) the goal of LTC is “to ensure that people with significant loss of intrinsic capacity can maintain a level of functional ability consistent with their basic rights, fundamental freedoms and human dignity.”<sup>2</sup>

**LTC organization and financing of the formal LTC systems vary between countries.** Formal care services can imply significant financial costs. There is huge variation in the size of the formal care workforce, infrastructure, and service delivery between the various OECD countries.<sup>3</sup> Where people do not have access to, or cannot afford, formal care, and where their families cannot or will not support them, LTC needs will not be met. This leaves those affected without the support they need in order to carry out tasks that most people take for granted, such as washing and getting dressed. The absence of support can have a catastrophic effect on people’s quality of life and even lead to premature death. People who fall outside LTC systems do not receive the necessary services and, since they are often unable to speak up about their situation, little is known about levels of unmet needs or the impact this has on their lives. This report is a first attempt at assessing LTC services in Belarus and the country’s potential needs over the next 30 years.

**In this report LTC includes all services that are available for the population aged 65+, provided in formal and informal sectors, over an extended period of time**—that is, services devised to meet needs that are chronic in nature. Services that are taken into consideration include nursing care, personal care services, home support and care assistance, services and financing in support of informal (family) care, residential care services other than nursing homes, and other social services provided on a LTC basis.

### 1.2. Data availability and methodology used

**This LTC assessment for Belarus draws on the WHO Country Assessment Framework and OECD papers on LTC,** which measure the costs and coverage of LTC in the health and social protection systems.<sup>4</sup> The framework was adopted to the needs of Belarus, based on the proposed scope of work, data availability, and the time frame of this assignment. The framework proposed for Belarus covers different aspects of LTC, ranging from key health and social issues experienced by the elderly, to how both the health and social care systems are organized as well as the forms of structure and governance that make these systems function the way they do. For the purposes of a broader contextualization, some key elements of LTC in Belarus are compared to selected OECD indicators. For more detailed comparison, two *oblasts*—Grodno and Vitebsk—were selected and their data were presented where available.

**LTC data availability for Belarus is limited and can be difficult to compare to those gathered by international organizations.** Differences in definitions between various countries and multiple reporting systems in at least two sectors (health and social) make comparisons and, therefore, to some extent conclusions, challenging. LTC in Belarus is not a clearly demarcated element of the system;

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<sup>2</sup> Beard J., Ofcer A. and Cassels A. (2015). *World Report on Ageing and Health*. Geneva: World Health Organization, [https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/186463/9789240694811_eng.pdf) (accessed 12 January 2019).

<sup>3</sup> Muir, T. (2017). “Measuring social protection for long-term care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>

<sup>4</sup> <https://www.euro.who.int/en/health-topics/Life-stages/healthy-ageing/publications/2019/country-assessment-framework-for-the-integrated-delivery-of-long-term-care-2019>

however, some direct indications of LTC clients, services, and financing could be found. The lack of a clear definition of LTC in Belarus combined with scattered data reporting presented two challenges: first, the possibility (or not) of data comparability with international benchmarks; and, second, the integration of data gathered from different sources. Analyses based on joint data from the social, health, and financial systems added important value and paint a more complete picture of LTC in Belarus.

**In the LTC literature only qualitative system descriptions and ‘standard’ quantitative data (for example, the number of care recipients or the number of institutional beds) are readily available.**

It is more difficult to obtain setting-specific data, for example, the number of persons who are receiving institutional care/home-based care/informal care, or the number of staff who work in institutional care/home-based care. We obtained and used official OECD and Eurostat data, as well as data provided by the Belarusian Statistical Office, the Ministry of Health, the Ministry of Labor and Social Protection, the Ministry of Finance, and various other *oblast* authorities.

**Data comparability is important and is provided to the extent possible.** Comparisons between countries, while useful and necessary, should also be approached with caution. This report uses broad ranges of values. As reference years, 2017 was chosen for the OECD/Eurostat data, and 2017–19 for data from Belarus. Analyses of the legal and institutional frameworks of LTC for the elderly took into consideration national legislation, as well as the social and health sectors’ regulations.

**Qualitative information** about socioeconomic profile, social patterns and cultural norms regarding the elderly was collected from the following national poll data studies: “The Population’s Assessment of the Social Protection System” (conducted by the IPM Research Center and BERO, 2019); “The Belarusian Population’s Attitude towards the Elderly and Their Perceptions of Aging” ( UNFPA and Satio, 2019); “Values of the Population of Belarus: Results of a Sociological Survey” (IPM Research Center, 2018); and the “Generations and Gender Survey” or GGS (United Nations Populations Fund 2017).

### 1.3. Limitations

The limitations of this report include the broad definition of LTC used, which incorporates practical solutions already in place in Belarus; the fact that the analysis does not include broader aspects of aging; and lack of data pertaining to performance measures (in both the health and social systems). For a more detailed analyses, where possible, findings from only two oblasts, Vitebsk and Grodno, are presented. More time and resources would be required to overcome the data constraints that limit a more comprehensive analysis of the gaps in LTC in Belarus.

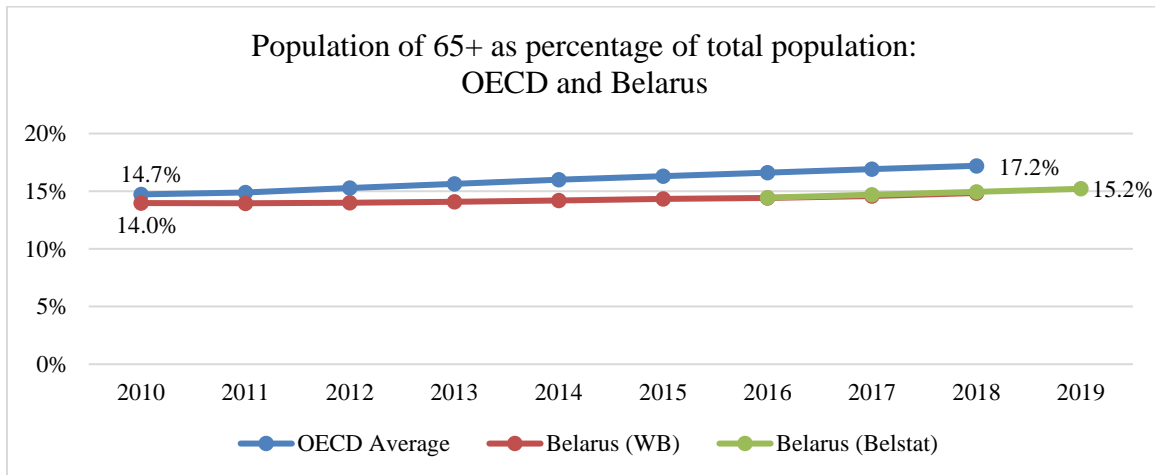


## 2. Demographic information on the elderly population in Belarus

### 2.1. Aging in Belarus compared to OECD countries

**Belarus's 65+ age cohort constitutes less than 15.2% of the total population** (2019 Belstat data) compared to the 17.2% average in OECD countries (2018). Both Belarus and OECD countries have seen a steady increase in this figure over the years (Figure 1)

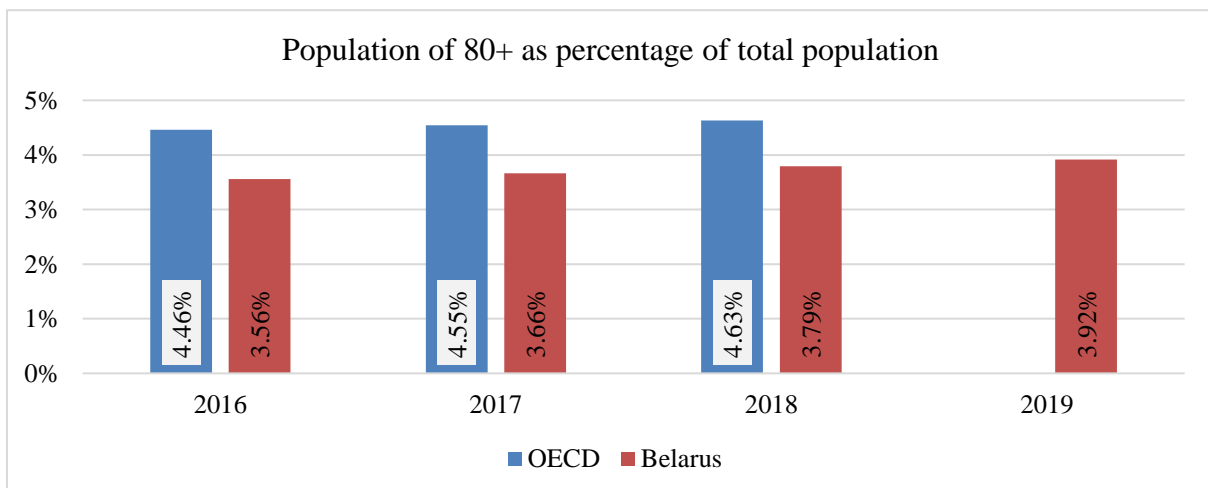
Figure 1. Share of 65+ population in Belarus and OECD



Source: WB analyses based on OECD (2018) and Belstat (2019) data.

**For the purposes of an LTC analysis, it is important to also consider older people in need of LTC (80+).** In 2018, the 80+ cohort (main LTC users) constituted 3.7% of the Belarus population compared to the OECD average of 4.6% (Figure 2). For the purposes of an LTC analysis, the 80+ cohort is a particularly critical target group given the likelihood that individuals in this cohort will present LTC needs. In Belarus, the lower percentage of the total population represented by this cohort could be attributed to shorter life expectancy compared to OECD countries.

Figure 2. Share of 80+ population in Belarus and OECD



Sources: OECD data (2018); Belstat data (2019).

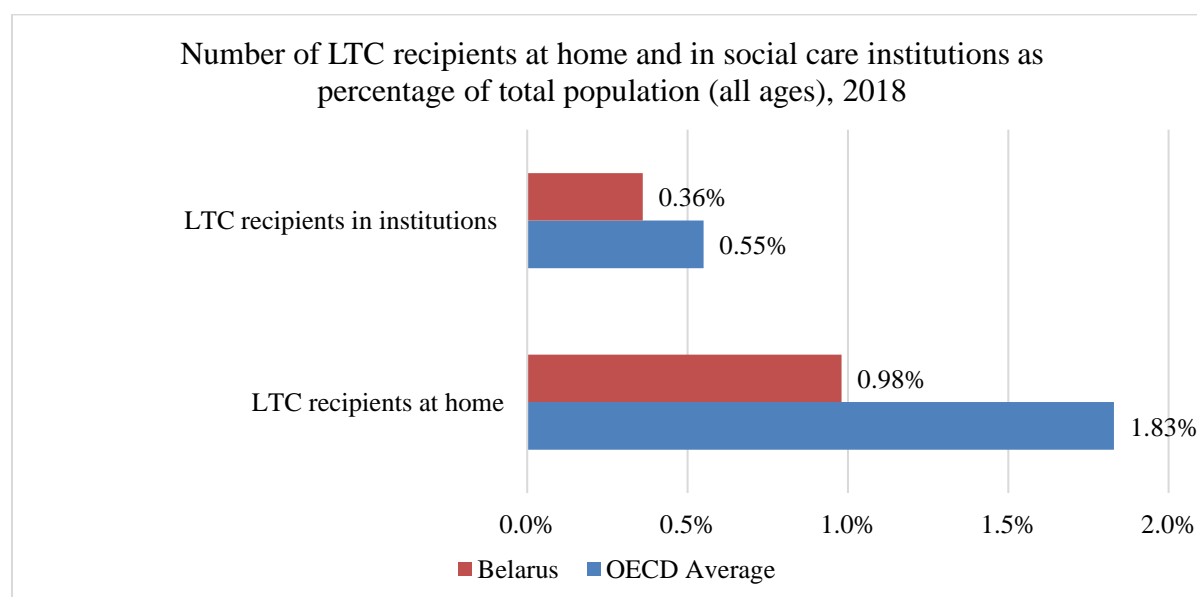
Note: OECD data for 2019 was not available.



### 2.1.1. LTC recipients

As in many other countries, elderly care in Belarus is provided by two separate systems, in addition to the strong family support known as informal care. Both the healthcare system (which provides inpatient and home-based care) and the social care system provide chronic care and LTC. In both cases, the share of the population supported with inpatient health and social services is much lower than the OECD average. In Belarus, 0.36% of the total population (consistently over three years) received institutional LTC, mostly in boarding homes, internats and nursing hospitals, compared to the OECD average of 0.55%. Similarly, over the same period, 0.98% of the Belarus population received social services at home compared to the 1.83% population average of OECD countries (Figure 3).

Figure 3. Recipients of LTC care/social care at home and in institutions<sup>5</sup>



Sources: OECD (2018); Belstat (2019).

Since the end of the twentieth century, as in the case of most European countries, the population of Belarus has been decreasing. According to the Belarus Census, in 2019, the country had a population of 9.413 million, of which 53.8% are women and 46.2% men (Table 2). The percentage of urban population (as defined by the state) is 77.5%, although population density is rather low—45.5 people per square kilometer. Depopulation began in 1993 and since then the number of deaths has steadily exceeded the number of births. According to Belstat data, the rate of natural increase was -3.5 per 1 000 of the population in 2019. Crude birth rate is 9.3, and crude death rate 12.8 per 1 000 of the population. The fluctuation in the number of births and deaths over the period 1990–2016 is presented in Figure 4. According to Belstat data, the total fertility rate (TFR) increased significantly between 2005 and 2016 but has dropped sharply since 2016 (Figure 5). In 2018, the TFR in Belarus was 1.46.

Table 2. Belarus demographics

Total population, inhabitants (Census 2019)	9,413,446
Male	4,351,473
Female	5,061,973
Urban population, inhabitants	7,299,989
Percentage of total	77.5
Rural population, inhabitants	2,113,457
Percentage of total	22.5

<sup>5</sup> In Belarus, LTC recipients in institutions include people who receive care in social care institutions (internats and apartments of 24-hour homestay for senior citizens and persons with disabilities), and nursing hospitals. Excluded are the recipients of nursing care in general hospitals.

Population density, people per square kilometer	45.5
Rate of natural increase in 2019, per 1 000 of population	-3.5
Crude birth rate in 2019, per 1 000 of population	9.3
Total fertility rate (2018)	1.42
Crude death rate, 2019 (per 1 000 of population)	12.8
Life expectancy at birth, 2018	74.5
Life expectancy at birth, for men	69.2
Urban	70.4
Rural	65.8
Life expectancy at birth, for women	79.4
Urban	80.1
Rural	77.2
Age-specific life expectancy for 65 years in 2018	16.1
Age-specific life expectancy for 65 years in 2018, for men	13.0
Urban	13.3
Rural	12.2
Age-specific life expectancy for 65 years in 2018, for women	18.2
Urban	18.6
Rural	17.4
Median age (2019)	40.1
Population 65+, as of 01.01.2019, inhabitants	1,440,938
Percentage of total	15.2
Male population 65+, as of 01.01.2019, inhabitants	470,810
Percentage of total male population	10.6
Female population 65+, as of 01.01.2019, inhabitants	970,128
Percentage of total female population	19.1

Source: Belstat (2019).

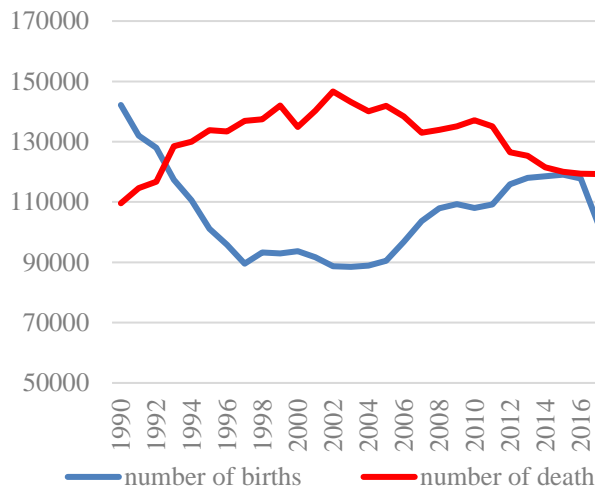
**Depopulation in Belarus will most likely continue in the longer term given the decrease in the number of women of childbearing age.** According to UN population projections, the number of women aged 15–49 will decrease by almost 0.7 million by 2050 (Figure 6). This negative trend has crucial implications for fertility rates and the future population size of Belarus. According to projections of the World Population Prospects of the UN Population Division, premised on the assumption of constant fertility, the population of Belarus will drop to 8.5 million by 2050 and, in the case of lower fertility scenarios, to as low as 7.9 million.

**Life expectancy at birth has been increasing since 2000.** In 2018, life expectancy was 74.5 (Figure 7). Life expectancy of men is lower than that of women by a significant margin; men who were born in 2018 are expected to live about 69.2 years, while women born in the same year are expected to live 79.4 years. The difference can be explained in terms of risky behavior and unhealthy lifestyles, which are more prevalent among men. In 2018, the average life expectancy for the Belarus population at age 65 was 16 years—13 years for men and 18.2 years for women. For the rural population, life expectancy is lower than that of the urban population. Life expectancy for the urban population at age 65 is 16.5 years (13.3 for men, and 18.6 for women), while for the rural population it is 15.2 years (12.2 for men, and 17.4 for women).

**The age structure is changing towards an aged population.** At the beginning of 2019, the median age was 40.1 years (37.1 for men, and 43.3 for women). Since 2005, the percentage of people over 50 has been increasing. While the share of the population between the ages of 65–79 decreased between 2005 and 2016, that figure increased again after 2017. At the same time, the percentage of people older than 80 has been increasing steadily over the last 10 years (Figure 8).

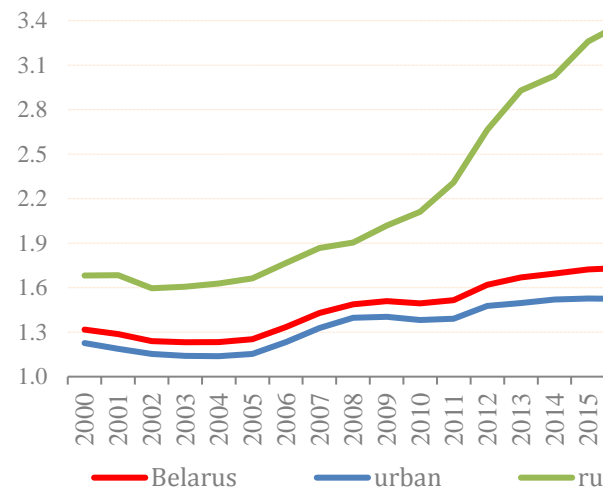
**According to the World Population Prospects, the number of elderly (65+) will exceed 2 000 000 by 2050** and their share of the total population will have increased from the current 15.2% to 24%. (Figure 9).

Figure 4. Births and deaths in Belarus



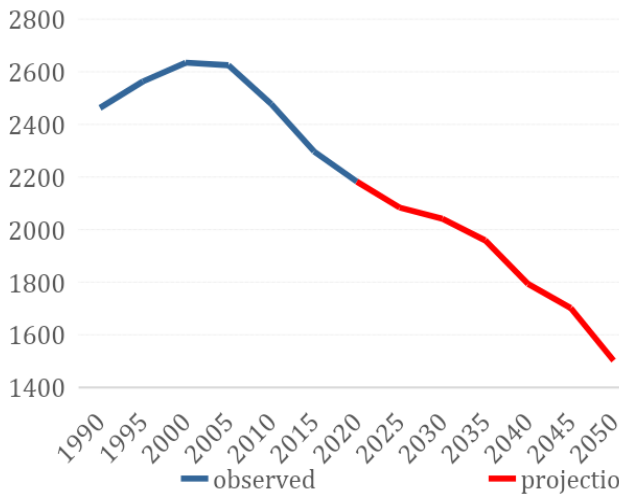
Source: Belstat (2019).

Figure 5. Fertility rate in Belarus



Source: Belstat (2019).

Figure 6. Women in fertility age



Sources: Belstat (actual data); UN Population Division, (projection).

Figure 7. Life expectancy at birth

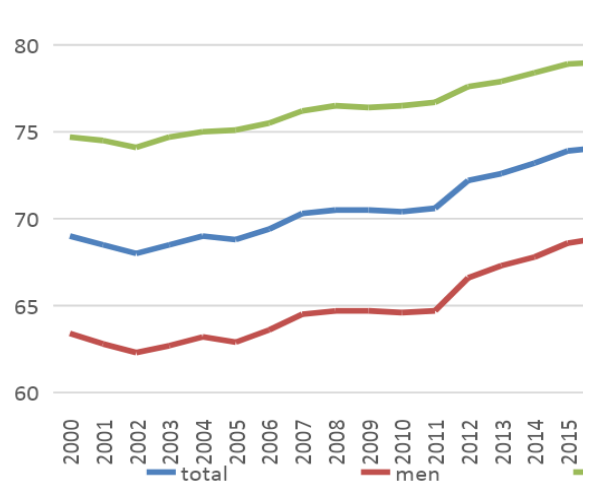
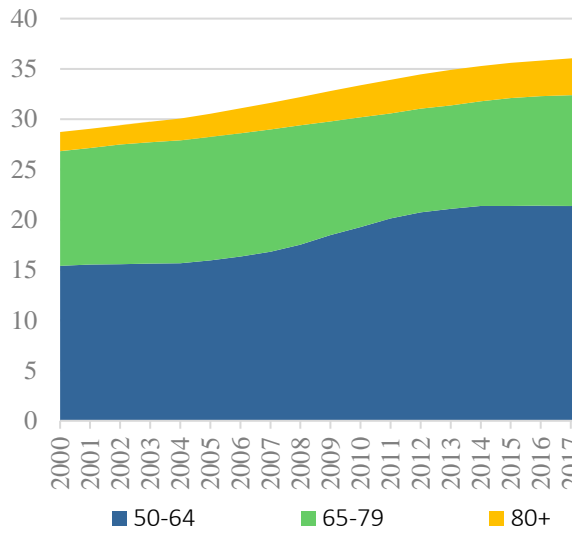
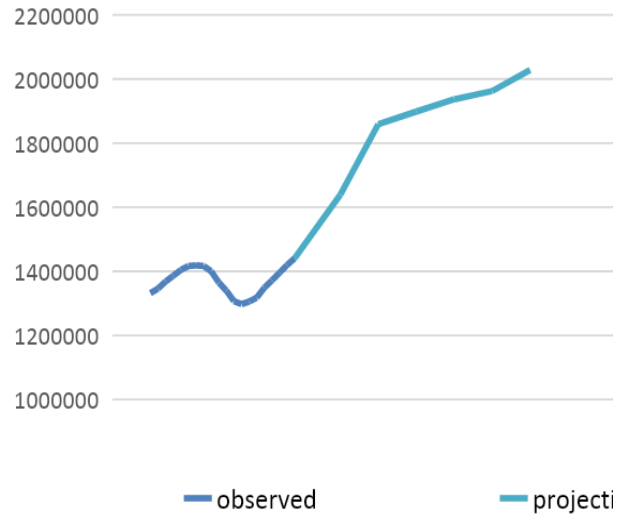


Figure 8. Age structure of 50+ population as percentage of total population



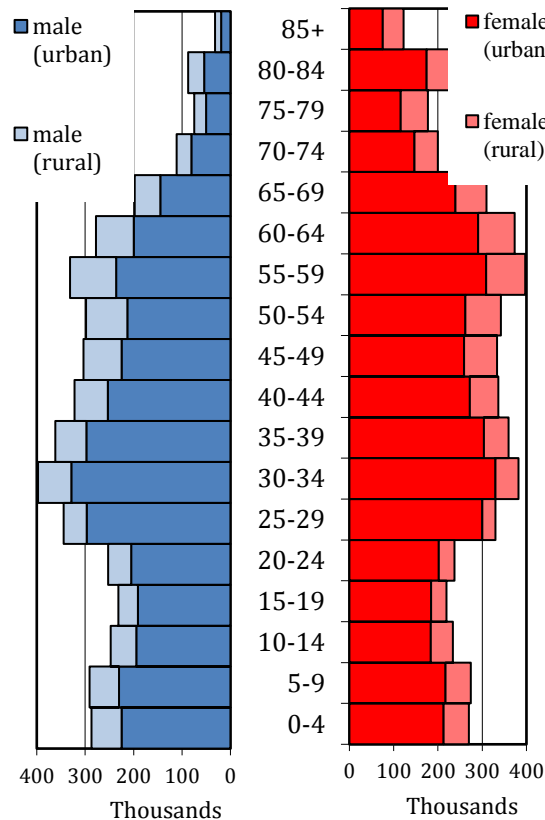
Source: Belstat (2019).

Figure 9. National elderly population (65+)



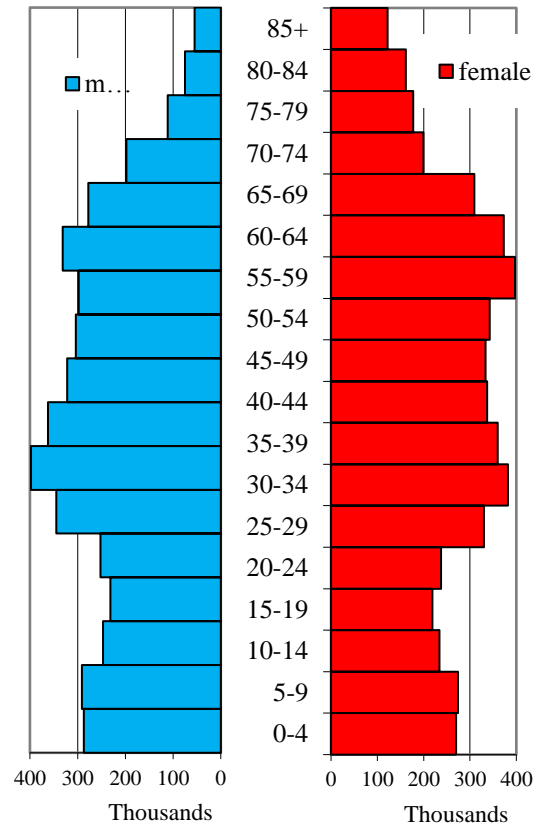
Sources: Belstat (actual data); own estimates based on Belstat and UN Population Division (projection).

Figure 10. Population age pyramid, 2019



Source: Belstat.

Figure 11. Projected population age pyramid, 2050



Source: United Nations Population Division, 2019.

## 2.2. Health status of the elderly

### 2.2.1. Overall population health

**Non-communicable diseases (NCDs) are a major problem for the healthcare system.** According to the WHO Regional Office for Europe data, in 2015, cancer, cardiovascular diseases, diabetes, and chronic respiratory diseases were responsible for 89% of all deaths in the country.<sup>6</sup> According to the WHO data, cardiovascular diseases cause 63% of all deaths in Belarus. The majority of adult disability cases are also associated with NCDs.<sup>7</sup> Risk factors associated with NCDs are the main explanation for the difference between life expectancy and healthy life expectancy. In 2016, healthy life expectancy in Belarus was 61.4 years for men and 69.3 years for women (56.5 and 65.3 years respectively in 2000); that is, the difference in healthy average life expectancy (HALE) between men and women (7.9 years in 2016) was lower than the same difference in life expectancy (10.1 years in 2016). In 2016, HALE at age 60 was estimated at 12.3 years for men and 17.2 years for women.<sup>8</sup>

**Between 2010 and 2018, the total number of new reported disease cases in Belarus increased by 14%,** which may be explained by the fact that more people than before turned to the health system for the treatment of diseases. All *oblasts* witnessed an increase, and the growth rate varied from 11.7% in Vitebsk *oblast* to 18.3% in Grodno *oblast*, with Gomel *oblast* as an outlier where the total disease rate increased by only 2.7% (Table 3). Differences in new reported cases could be an indication of disparities in access to care, as well as regional variations in the availability of diagnostic equipment.

Table 3. Total disease rate in Belarus per 100 000 inhabitants, 2010–2018

	Belarus	Minsk	Brest <i>obl.</i>	Vitebsk <i>obl.</i>	Gomel <i>obl.</i>	Grodno <i>obl.</i>	Minsk <i>obl.</i>	Mogilev <i>obl.</i>
2010	138,569,6	178,262,6	126,311,0	135,109,3	140,725,5	115,275,4	134,263,0	114,512,8
2011	141,692,0	185,588,8	127,890,8	137,212,8	141,548,0	117,648,8	138,327,0	114,711,7
2012	141,851,0	189,268,5	128,884,0	136,957,4	138,800,7	116,999,5	138,193,7	112,040,4
2013	144,019,7	191,737,6	134,045,4	136,377,1	139,703,4	120,222,0	138,619,6	111,243,7
2014	139,287,2	184,304,5	129,829,8	135,349,8	136,708,8	108,946,0	136,410,4	110,149,9
2015	142,080,3	188,625,3	128,013,8	137,089,0	135,856,7	118,338,7	139,959,0	113,655,3
2016	151,768,9	206,755,9	134,176,0	144,249,7	142,052,7	127,485,8	146,410,3	123,452,3
2017	156,410,4	209,640,5	146,227,4	149,332,9	143,201,4	131,948,2	149,959,1	127,020,5
2018	158,210,1	208,034,6	148,175,3	150,978,8	144,467,7	136,378,9	152,654,4	131,463,7

Source: Belstat.

Minsk reported the highest number of new disease cases. In 2018, that number was 31.5% higher than the national average. Among the *oblasts*, the highest rate of new reported cases has been observed in Minsk and Vitebsk *oblasts* (respectively 96.5% and 95.4% of the national average). Mogilev and Grodno *oblasts* had the lowest rate of new disease cases (respectively 83.1% and 86.2% of the national average).

### 2.2.2. Vitebsk and Grodno oblasts citizens' health

**The most commonly reported diseases among the adult population of both Vitebsk and Grodno oblasts are cardiovascular diseases** (27.8% of all cases in Grodno *oblast*, and 22.9% in Vitebsk *oblast*), and diseases of the respiratory system (15.8% and 16.9% respectively). Other common illnesses include diseases of the digestive system, diseases of the musculoskeletal system and connective tissue, endocrine, nutritional and metabolic diseases, mental and behavioral disorders, and diseases of the genitourinary system (more than 5% but less than 10% of all cases each) (Table 4).

<sup>6</sup> WHO Regional Office for Europe, "[Prevention and control of NCDs in Belarus: The case for investment](https://www.euro.who.int/en/countries/belarus/publications/prevention-and-control-of-ncds-in-belarus-the-case-for-investment-2018)". <https://www.euro.who.int/en/countries/belarus/publications/prevention-and-control-of-ncds-in-belarus-the-case-for-investment-2018>.

<sup>7</sup> WHO Regional Office for Europe, "[Prevention and control of NCDs in Belarus](#)".

<sup>8</sup> [WHO Global Health Observatory](#).

Table 4. Selected DR in Vitebsk and Grodno oblasts per 100 000 inhabitants, 2018

ICD-10	Vitebsk oblast		Grodno oblast	
	Number of cases	% of total	Number of cases	% of total
Certain infectious and parasitic diseases	4,259,2	2.8	4,109,8	3.0
Neoplasms	7,481,0	5.0	6,243,1	4.6
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	487,6	0.3	588,2	0.4
Endocrine, nutritional and metabolic diseases	11,537,6	7.6	7,193,8	5.3
Mental and behavioral disorders	9,400,8	6.2	8,254,3	6.1
Diseases of the nervous system	2,092,2	1.4	1,260,4	0.9
Diseases of the eye and adnexa	8,209,5	5.4	5,926,7	4.3
Diseases of the ear and mastoid process	3,190,5	2.1	2,634,2	1.9
Diseases of the circulatory system	34,507,8	22.9	37,876,7	27.8
Diseases of the respiratory system	25,463,7	16.9	21,615,1	15.8
Diseases of the digestive system	9,353,1	6.2	11,313,6	8.3
Diseases of the skin and subcutaneous tissue	6,521,4	4.3	3,722,4	2.7
Diseases of the musculoskeletal system and connective tissue	10,314,6	6.8	8,724,9	6.4
Diseases of the genitourinary system	10,138,4	6.7	6,801,4	5.0
Pregnancy, childbirth and the puerperium	2,002,9	1.3	2,405,5	1.8
Congenital malformations, deformations and chromosomal abnormalities	171,0	0.1	202,3	0.1
Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified	287,6	0.2	451,5	0.3
Injury, poisoning and certain other consequences of external causes	5,559,9	3.7	7,054,9	5.2

Source: Belstat (2018).

In 2019, the population above working-age in both Vitebsk and Grodno *oblasts* also most often suffered from cardiovascular diseases (28.8% and 41.7% respectively), followed by diseases of the respiratory system (11.1% and 8.2%), and endocrine, nutritional and metabolic diseases (10.2% and 7.6%) (Figure 12 and Figure 13).

Figure 12. Disease distribution among working and above working-age population\* as percentage of total number of disease cases, Vitebsk oblast

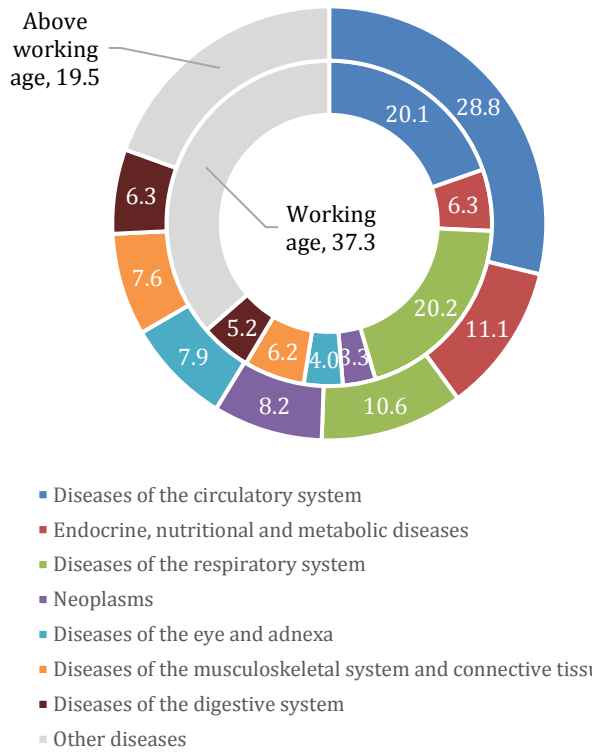
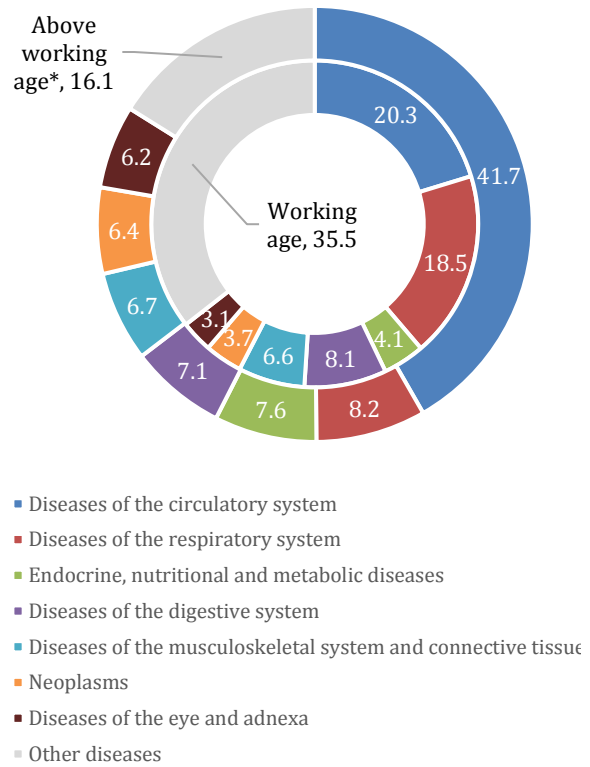


Figure 13. Disease distribution among working and above working-age population\* as percentage of total number of disease cases, Grodno oblast



Source: WB estimates based on MoH data.

Note: \*The official definition of working age is from 18 to retirement age (in 2018 this was 56 for women and 61 for men).

### 2.2.3. Main risk factors

**According to the WHO, patterns of harmful behavior that are often established early in life can reduce quality of life in old age.** Poor nutrition, physical inactivity, tobacco use, and the harmful use of alcohol all contribute to the development of chronic conditions.<sup>9</sup> The main chronic conditions (diabetes, cardiovascular diseases, cancer, and mental disorders) all contribute to the need for LTC by people in their old age.

Poor nutrition and unhealthy diet (salt)

**Salt or sodium consumption in Belarus is relatively high,** based on spot urine samples among adults aged 18–69 years during 2016–2017. According to the 2016–2017 STEPS survey, the mean salt intake for men was estimated at 12.4 g per day, which is significantly higher than that of women (9.0 g per day).<sup>10</sup> In both cases, the intake was more than twice the WHO recommendation of less than 2 g of sodium or 5 g of salt per person per day.<sup>11</sup> Survey findings show that an estimated one-third of Belarusian

<sup>9</sup> WHO [risk factors of ill health among older people](#).

<sup>10</sup> WHO (2017). [The STEPS survey of noncommunicable disease \(NCD\) risk factors in Belarus \(Belarus STEPS Survey 2016–2017\)](#).

<sup>11</sup> WHO Regional Office for Europe (2018). [Prevention and control of noncommunicable diseases in Belarus: The case for investment](#).

adults always or often add extra salt to their food when eating (31.7%) and four-fifths do so when preparing meals (80.8%).<sup>12</sup>

**The percentage of people considered overweight is increasing** (Table 5). Obesity and being overweight constitute high risk factors associated with several chronic conditions, such as diabetes, hypertension, stroke, heart disease and metabolic syndrome in the elderly.

Table 5. Population considered overweight in 2019

Age group	2014	2015	2016	2017	2018	2019
16–29	4.9	7.6	4.9	4.9	4.7	5.7
30–39	15.7	16.2	14.6	16.0	15.4	12.9
40–49	25.3	26.5	26.4	26.8	22.2	23.7
50–59	36.1	33.6	36.1	36.1	35.8	36.7
60 and over	34.8	36.9	37.6	37.8	36.4	37.2

Source: Belstat.

#### Physical inactivity

**According to the 2016–2017 STEPS survey, an estimated one in seven (13.2%) Belarusian adults age 18–69 years is insufficiently active**, that is, they are not engaged in at least 150 minutes of moderate to intense physical activity per week. Just over one-third (35.4%) of physical activity is work-related; half (54.4%) is transport-related, and a tenth (10.2%) is recreational. Just over four-fifths (80.5%) of adults, particularly women (91.1%), do not engage in vigorous activity.<sup>13</sup>

#### Harmful alcohol consumption

**Alcohol consumption in Belarus is among the highest in the region, although there are some signs of a decrease in consumption.** The most recent data suggest that total alcohol consumption dropped to 11.5 liters per adult (age 15+) in 2018 from 17.5 liters in 2010.<sup>14</sup> The 2016–2017 STEPS survey findings indicate that in 2017 around two-thirds (64.9%) of males and two-fifths (41.8%) of females were considered current alcohol users, indicating that they had had a drink in the past month. Among alcohol users, a third (34.9%) of men binge (consumed six or more drinks in one sitting) during the month preceding the survey compared to 6.9% of women.<sup>15</sup>

#### Tobacco use

**Tobacco use is a major risk factor for healthy living.** According to the Belstat Household Budget Survey, 23.8% of the Belarusian population aged 16+ (22.7% of the urban population and 26.8% of the rural population) smoked in 2019. However, tobacco use in the age group 60+ is significantly lower than in other age groups, although there is a tendency towards increased tobacco use among older people (Table 6).

Table 6. Smoking population by age, 2014–2019

Age group	2014	2015	2016	2017	2018	2019
16–29	27.6	25.5	23.6	22.9	22.4	22.3
30–39	35.6	34.5	35.2	33.1	34.4	35.1

<sup>12</sup> WHO (2017). [The STEPS survey of noncommunicable disease \(NCD\) risk factors in Belarus \(Belarus STEPS Survey 2016–2017\)](#).

<sup>13</sup> WHO (2017). [The STEPS survey of noncommunicable disease \(NCD\) risk factors in Belarus \(Belarus STEPS Survey 2016–2017\)](#).

<sup>14</sup> These are WHO estimates. The 2010 data is not completely comparable to the current estimates since unregistered alcohol consumption since 2016 is estimated based on the STEPS study. The 2010 estimate was of c. [3 liters per adult](#) while more accurate figures used since 2016 indicate 1.5 liters per adult (on this point see Осипчик, С., Кралько, А., Короткевич, Т., Кухаревич, Е., Чигирева, И., Писарик, В. and Сошникова, Л. (2018). [Оценка уровня потребления незарегистрированного алкоголя](#). Минск: «Колорград».

<sup>15</sup> WHO (2017). [The STEPS survey of noncommunicable disease \(NCD\) risk factors in Belarus \(Belarus STEPS Survey 2016–2017\)](#).



40–49	32	30.8	32.5	32.1	31.2	28.6
50–59	26.3	27.3	25.3	24.5	25.9	26.3
60 and over	10.2	10.2	10.6	10.5	11.6	12.1

Source: Belstat.

## Poverty

**As a result of redistribution through the pension system,<sup>16</sup> absolute poverty among retirees is close to zero.** That said, the income of a significant percentage of the elderly only slightly exceeds the poverty line, especially among non-working pensioners. As a result, relative poverty among the 65+ population is approximately equal to relative poverty for the population in general. The four categories of single-person, 65+ households, single-parent households, and large families with more than three children are most exposed to relative poverty risk. They are also particularly vulnerable to fluctuations in utility and pharmaceutical prices.

## Safe housing

**Safe housing is an essential determinant of health in older people, as it is for the population as a whole.** Housing quality directly and indirectly impacts the risk of contracting diseases which are associated with increased need for LTC among older people. A number of studies have found links between damp and/or cold housing and rates of respiratory illness, and type of heating and respiratory risks (for example, asthma), especially among the elderly.<sup>17</sup> Sustainable access to clean water and good sanitation can prevent some infectious diseases.

**There are some important differences in the quality of housing among urban and rural older populations.** Private houses in rural areas are generally less equipped with the basic amenities. Hot water supply, central heating, and bath or shower amenities are less affordable to rural inhabitants. Absence of central heating and piped water, much more prevalent in rural areas, is a determining factor (among health-related issues) inhibiting the ability of older persons to live alone. Due to these housing restrictions, many of the social care services for the elderly in rural areas are centered around domestic assistance, such as chopping wood, getting water from the well, etc. (Table 7).

Table 7. Percentage of apartments/houses equipped with main amenities, 2019

Main amenities	Belarus		Vitebsk oblast		Grodno oblast	
	Urban areas	Rural areas	Urban areas	Rural areas	Urban areas	Rural areas
Central heating	91.0	46.6	84.6	28.3	91.9	34.8
Piped water	89.9	52.7	84.1	39.1	91.0	38.8
Sewerage	89.3	49.6	83.7	34.2	90.7	36.8
Hot water supply	84.7	39.0	76.9	20.1	87.4	29.9
Gas	82.4	94.9	92.8	96.0	90.5	93.1
Bath or shower	85.2	42.2	77.2	26.9	86.6	30.8

Source: Belstat.

**For older people, restrictions related to housing conditions are a common problem.** According to Household Budget Survey data, 60.5% of retiree households are dissatisfied with their housing conditions, specifically the lack of amenities. A significant 12.1% mention unfavorable living conditions. In villages and small cities, the indoor environment of older people’s private homes is in all likelihood colder than the temperature recommended for the maintenance of good health. This is also the main reason why Territorial Centers for Social Services move older people into hospitals and temporary internats during the cold seasons.

<sup>16</sup> On this, see Bornukova, K., Shymanovich, G. and Chubrik, A. (2017). “[Fiscal incidence in Belarus: A commitment to equity analysis](#)”, *Policy Research working paper* WPS 8216, World Bank Group.

<sup>17</sup> See Howden-Chapman, P., Signal, L., and Crane, J. (1999). “[Housing and health in older people: Ageing in place](#)”, *Social Policy Journal of New Zealand*, 13: 14–30.

## Social isolation

**Socially isolated elderly people are more at risk of engaging in negative health behaviors, such as excessive alcohol consumption, smoking, being sedentary, and not eating well.** These behaviors increase the risk of hospitalization and further escalated the need for LTC services. Social isolation is often accompanied by mental problems, which may also require LTC services. The key triggers of social isolation for the elderly are:

- living alone;
- being 80+;
- having a compromised health status, including suffering from multiple chronic health problems;
- having no children or contact with family;
- lacking access to transportation;
- living on a low income; and
- changing family structures due to the death of a spouse and/or other relatives.

The more risk factors an old-age person faces, the more likely it is that he or she will be isolated. Old-age people in Belarus are at high risk of experiencing social isolation because they often live alone and have a compromised health status. The risks of social isolation are especially pronounced at the onset of reduced functional ability, that is, when older persons start needing assistance with ADL.

Table 8. Distribution of old-age persons facing risk factors, 2018–2019

Risks of social isolation	Belarus	Vitebsk oblast	Grodno oblast
Living alone (persons)	830,000	111,000	97,000
Being 80+ (persons)	370,968	51,510	45,585
Having a compromised health status (the number of persons above working age who are registered on the dispensary)	2,418,077	328,977	273,749
Living on a low income (relative poverty for 65+ cohort as percentage of total population)	8.6	6.9	11.1
Changing family structures (number of persons per 1 000 receiving survivor pensions)	84.2	29.5	10.1

Sources: Belstat; MoLSP; IPM Research Center data.

In advanced age, women in particular are likely to live alone given their longer life expectancy, which exposes them even more to the risk of social isolation and loneliness. Social isolation is often considered a risk factor for violence and elder maltreatment.

## Elder maltreatment

**Elder maltreatment is defined as physical, sexual, mental or financial abuse, or the neglect of people aged 60+.**<sup>18</sup> The scale of this problem in Belarus has not been fully investigated. Maltreatment affects both the mental and physical well-being of older people and, if left unchecked, reduces the quality of life and threatens an individual's survival. Until recently, elder maltreatment was considered a private matter. Only in the last two decades has the nature and scope of the problem been recognized and systematically studied and addressed in various settings where older people live. WHO/Europe's "European report on preventing elder maltreatment" reviews the findings of recent surveys and programs devised to address this problem.

**In recent years in Belarus, a number of measures have been implemented to prevent domestic violence, including elder maltreatment.** Despite this, no data have been collected to date on the prevalence of elder abuse. A number of civil society organizations run a hotline for victims of domestic violence and, recently, an increasing number of calls have been reported from older persons. Currently,

<sup>18</sup> WHO [risk factors of ill health among older people](#).

just over one-third (35%) of calls received come from older persons. As with other forms of domestic abuse, however, older persons very often do not disclose the fact that they have become victims of violence, especially when their own families are involved and they are dependent on them for support (UNECE, 2019).

#### **2.2.4. Structure of the diseases and related needs for LTC**

**The likelihood of physical or mental disability causing a person to become dependent on LTC increases with age.** Unless the prevalence of frailty and morbidity is reduced, the projected increases in the proportion of people aged 65+ and 80+ in the Belarus population may be expected to lead to corresponding increases in future demands for LTC.

**The Belarus population is highly exposed to physical (NCDs, etc.) and social (patterns of harmful behavior, social isolation, etc.) risk factors that are linked to diseases and disabilities in old age.** The share of the population whose daily activities are currently limited due to health problems or disability give some indication of the need for LTC. The spread of social risks and social deprivation(s) also increases anticipated future LTC needs.

**In many cases, the need for LTC is the result of accidents, such as a fall or hip fracture,** which have much more serious consequences for an older person than to a younger one. The risk of falling increases drastically with advancing age. Injuries from falls among the elderly usually require hospitalization and interventions, including rehabilitation, and cause many of the functional limitations that result in the need for LTC.<sup>19</sup> According to WHO research and the mutual study of the Social Protection Committee of the European Commission, the need for LTC services for the elderly is related to the prevalence of the following diseases among the elderly:

- *Arthritis:* osteoarthritis affects joints in the body, causing pain, stiffness, weakness and instability. It reduces mobility and increases the risk of falls. Dependency can arise from the effects of arthritis itself or from accidents caused by the physical weakness it induces.
- *Stroke:* this is a major cause of long-term disability. Over 50% of individuals who survive a stroke remain physically dependent after six months and at least 25% remain either moderately or severely disabled after three years.
- *Diabetes mellitus:* if not controlled, this has a severely detrimental effect on the heart, blood vessels, eyes, kidneys, and nerves, and accelerates disability related to other causes.
- *Chronic obstructive pulmonary diseases (COPD), including chronic bronchitis, emphysema, and chronic obstructive airways disease:* these diseases reduce mobility and lead to a range of distressing symptoms. In the 60–79 age group, rates of COPD are almost twice as high for men as for women (primarily reflecting differences in smoking habits).
- *Dementia and other cognitive impairments:* the more serious these impairments become, the greater the degree of dependency. Dementia is a major cause of disability and dependency among older people. Age is the strongest known risk factor for cognitive decline. With a growing older population, the prevalence of dementia, which is already on the rise in Belarus, can be expected to grow.
- *Unipolar depression:* according to the WHO, unipolar depression occurs in 7% of the general older population. It is both underdiagnosed and undertreated in primary care settings.<sup>20</sup>
- *Frailty:* a multidimensional geriatric concept referring to an increased vulnerability to stressors, including biological, physiological, and psychological components. The most distressing outcome of frailty is an older person's inability to function and eventually live independently. Thus, frailty has been shown to increase the risk for adverse health outcomes, including falls, hospitalization, institutionalization, and mortality.

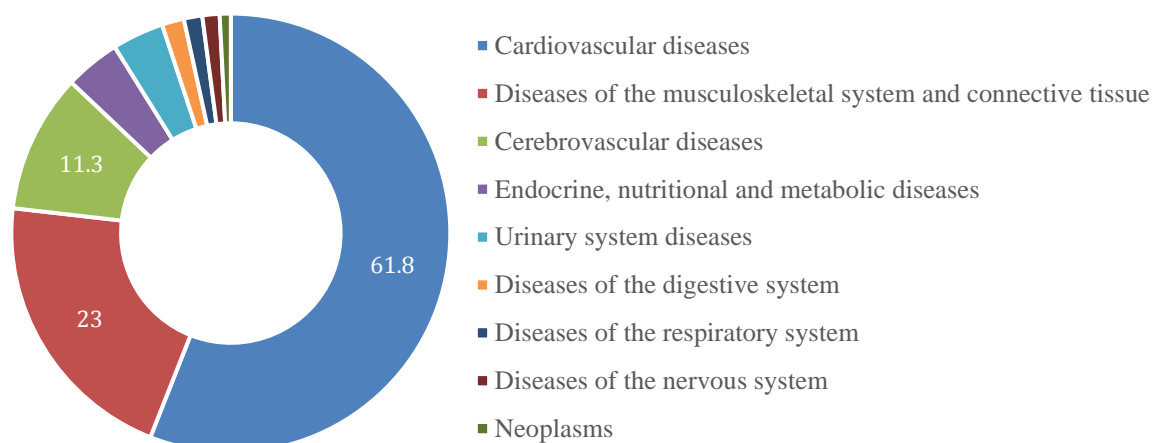
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<sup>19</sup> Social Protection Committee and European Commission (2014). [Adequate Social Protection for Long-term Care Needs in an Ageing Society](#).

<sup>20</sup> WHO [risk factors of ill health among older people](#).

**According to the comprehensive geriatric assessment of the Republican Gerontological Center in Minsk, all the center’s patients reported chronic diseases.**<sup>21</sup> An estimated 60% of patients in the age group 60–74 have two or more chronic diseases; 63% of patients in the age group 75–89 have three chronic diseases, and 47% suffer from four to five diseases. The distribution of patients’ diseases indicates a correlation between physical risks and related needs for LTC. No data on mental disorders were available.

Figure 14. Distribution of the Republican Gerontological Center patients’ diseases, 2019



Source: Calculations provided by the Republican Gerontological Center.

Among patients from the Gerontological Center, the distribution of geriatric syndromes that affect the development of pathological aging demonstrates the key physical and social problems related to LTC needs. The influence of these problems on pathological aging increases with age (Table 9).

Table 9. Distribution of persons 60+ facing risk factors, 2018–2019

	60-75 years (%)	75 and older (%)
Elderly asthenia syndrome	10	40
Impaired urination	30	55
Congestive heart failure	10	25
Pain syndrome	44	56
Ataxia	35	55
Impaired vision	40	60
Hearing impairment	30	55
Defecation disorder	30	50
Dizziness	31	52
Falls and walking disorders	35	56
Loss of self-care	20	36
Social exclusion	3	5
Cognitive impairment	2.5	3.5
Breaking family ties	2.5	5.4
Dependence on the help of others	3	23
Violations of behavior and adaptation	0.7	0.1

Source: The Republican Gerontological Center.

<sup>21</sup> The center annually provides services to 5,000 patients from Minsk and the rest of the country.

### 3. Socioeconomic conditions of the elderly population in Belarus

#### 3.1. Economic and social integration of the elderly

**The economic status of the elderly (65+) in Belarus is to some extent determined by the design of the national pension system.** Retirement age in Belarus is among the lowest in the region. Until 2017, it was age 55 for women and age 60 for men. Starting in 2017, the retirement age for both sexes will increase by six months every year until 2022, when it will have reached 58 years for women and 63 for men. The 2020 pension system in Belarus is pay-as-you-go (PAYG) and is organized as a state social insurance system, which is operated by the Social Protection Fund and funded mainly by a payroll tax (called “insurance contribution”). The tax rate is 35% of the total wage fund, of which 34% is contributed by employers and an additional 1% is paid in from employees’ wages.<sup>22</sup> There are two types of pension: a labor pension, which depends on pension insurance contributions; and a social pension, which does not depend on paid contributions. The social pension makes provision for individuals who did not work long enough to accumulate a labor pension (17.5 years in 2020, 20 years by 2025) and is provided to men when they reach the age of 65 and to women when they reach the age of 60.

**In 2019, the average monthly labor pension was BYN 431** (approximately 180 USD), while the social pension amounted to BYN 120 (approximately 47 USD). There are also disability pensions. According to legislation, the degree of disability is first assessed by a specialized medical commission and then classified into one of three categories. The disabled are entitled only to a disability pension. The minimum disability pension for both Group 1 and 2 is equal to the minimum labor pension,<sup>23</sup> while the minimum disability pension for Group 3 is 50% of the minimum labor pension, which in May 2020 was BYN 246.78 or 96 USD.

**According to data provided by the Ministry of Labor and Social Protection, the total number of pensioners in 2019 was 2,531,900** of which 332,500 lived in Vitebsk *oblast* and 284,500 in Grodno *oblast*. The replacement rate (ratio of average labor pension to average wage) was above 40% (the national target in line with ILO recommendations) during the periods 1995–1996, 2000–2010, and 2014–2015 but has remained below 40% since 2016 (Figure 15).

**In Belarus, individuals who have reached retirement age have the option to continue working with minimal impact on the size of their pension.** In 2019, more than 25% of retirees continued to work. According to national poll results,<sup>24</sup> men aged 60+ have more employment opportunities than women of the same age. According to our estimates (based on Belstat [LFS] data), 27.2% of men age 60–74 and only 14.4% of women in the same age cohort continued to work in 2019 (Table 10).

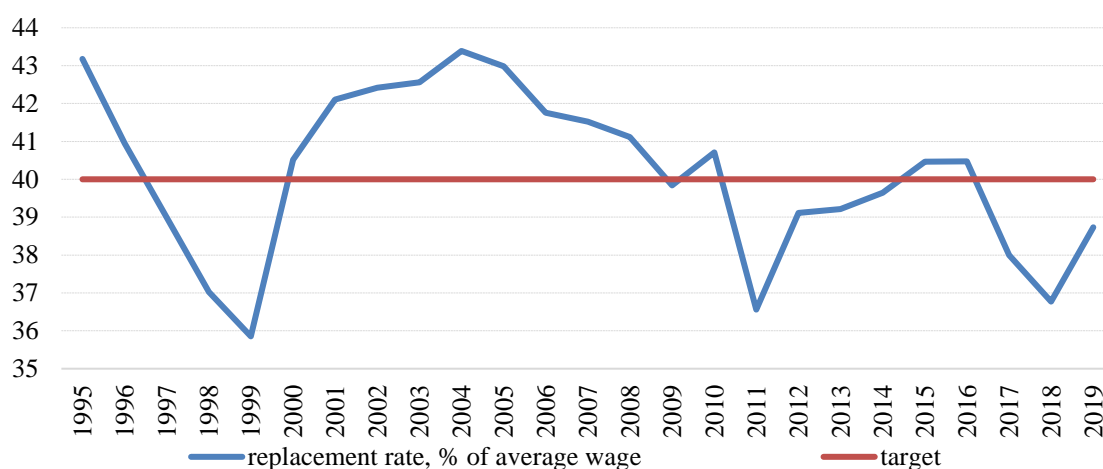
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<sup>22</sup> For more detail on this, see Bornukova, K., Shymanovich, G., and Chubrik, A. (2017), “[Fiscal incidence in Belarus: A commitment to equity analysis](#)”, *Policy Research working paper* WPS 8216, World Bank Group.

<sup>23</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

<sup>24</sup> The poll was a part of the 2019 study, “[The Belarusian population’s attitudes towards of the social protection system](#)”, conducted by the IPM Research Center and BEROC.

Figure 15. Evolution of the replacement rate, 1995–2019 as percentage of average wage



Source: WB estimates based on Belstat data.

**Despite the absence of formal barriers to employment, the elderly have less opportunities in the labor market.** According to the results of a recent national public opinion poll (conducted in fall 2019),<sup>25</sup> as a rule, the elderly have access only to less well-paid work or “lower social status” work once they have reached retirement age. In addition, the risk of job loss for the elderly is assessed as very high.

Table 10. Employment rates: percentage of men and women in respective age cohorts

	Women			Men		
	50-54	55-59	60-74	50-54	55-59	60-74
2016	89.0	47.2	15.0	83.8	80.2	22.2
2017	92.0	46.9	12.6	89.2	79.3	20.9
2018	89.9	49.8	13.8	87.9	80.6	25.2
2019	91.4	55.8	14.4	85.5	82.2	27.2

Source: Estimates based on Belstat (LFS) data.

### 3.2. Income, welfare, and quality of life of the elderly

**Labor pensions are the main source of income for the elderly.** In addition to monthly pensions, there is also a system of social allowances and supplementary payments provided mostly to the disabled and individuals aged 75+. Roughly 25% of retirees continue to work, with the result that their monthly income consists of a combination of pension and salary. According to national poll results, the main incentive for individuals to continue working is the insufficiency of monthly pensions (according to 72% of responses). Despite very low absolute poverty rates, the risk of relative poverty is very high—especially for single retirees and pensioners who are unemployed. According to the Household Budget Survey (HBS) data of 2018, 16.4% of single individuals aged 65+ and 10.2% of unemployed individuals above retirement age were considered “relatively poor”—both of which were higher than the average relative poverty percentage of the total population (9.1% in 2018) (Table 11).

Table 11. Absolute and relative poverty: categories of elderly as a percentage of respective groups

	Absolute poverty								Relative poverty								
	2011	2012	2013	2014	2015	2016	2017	2018	2011	2012	2013	2014	2015	2016	2017	2018	
Belarus																	
Population 65+, % of group	2.5	2.0	1.9	1.5	1.3	1.5	1.3	1.2	20.1	19.1	16.0	10.8	10.1	11.1	7.8	8.6	

<sup>25</sup> The poll was a part of the 2019 study, “[The Belarusian population’s attitudes towards of the social protection system](#)”, conducted by the IPM Research Center and BEROC.

Population 65+, single, % of group	1.6	1.1	1.4	1.0	1.1	0.5	0.3	0.4	34.6	25.5	25.7	20.3	19.3	23.9	13.3	16.4
Population above retirement age, employed, % of group	0.5	1.7	0.4	0.4	0.8	0.9	0.5	0.6	1.8	1.2	3.4	2.0	1.8	2.7	2.4	2.9
Population above retirement age, not employed, % of group	2.9	2.6	1.8	1.6	1.8	1.9	1.5	1.7	17.9	17.1	17.3	12.3	11.7	12.6	9.6	10.2
<b>Vitebsk oblast</b>																
Population 65+, % of group	5.6	2.7	NA	NA	NA	NA	NA	0.9	23.7	20.4	NA	NA	NA	NA	NA	6.9
Population 65+, single, % of group	1.6	2.7	NA	NA	NA	NA	NA	0.0	34.6	30.6	NA	NA	NA	NA	NA	19.9
Population above retirement age, employed, % of group	0.6	0.9	NA	NA	NA	NA	NA	1.7	1.6	0.9	NA	NA	NA	NA	NA	2.9
Population above retirement age, not employed, % of group	6.5	4.4	NA	NA	NA	NA	NA	2.8	20.8	21.8	NA	NA	NA	NA	NA	10.5
<b>Grodno oblasts</b>																
Population 65+, % of group	1.0	0.3	NA	NA	NA	NA	NA	0.8	15.3	13.1	NA	NA	NA	NA	NA	11.1
Population 65+, single, % of group	0.0	0.0	NA	NA	NA	NA	NA	0.0	29.4	24.2	NA	NA	NA	NA	NA	15.9
Population above retirement age, employed, % of group	0.0	0.0	NA	NA	NA	NA	NA	0.0	0.0	1.0	NA	NA	NA	NA	NA	4.9
Population above retirement age, not employed, % of group	0.6	0.9	NA	NA	NA	NA	NA	0.8	10.3	14.9	NA	NA	NA	NA	NA	12.2

Source: IMP Research Center.

**Concerning perceived deprivations, national opinion polls reveal that respondents believe that the elderly often/very often encounter problems related to the affordability of medicine and medical treatment, housing and utility services, the purchase of clothes and footwear, the purchase of durable goods, and payments to install water and wastewater services, gas, and other communal services (Table 12).**

Table 12. Answer distribution: "Which of the following problems are most often faced by retirees?"



	Very rare	Rather rare	Rather often	Very often
Not enough money for food	8.1	28.3	28.9	29.4
Not enough money for utilities	6.9	27.7	31.2	29.0
Not enough money for medicine and treatment	4.3	15.0	39.1	36.2
Not enough money for clothes and footwear	3.7	14.1	38.9	36.9
Not enough money for the durable goods	1.2	6.9	33.7	52.5
Not enough money to pay for access to water and wastewater services, gas and other communal services	4.1	15.8	32.7	34.9

Source: IMP Research Center/BEROC.

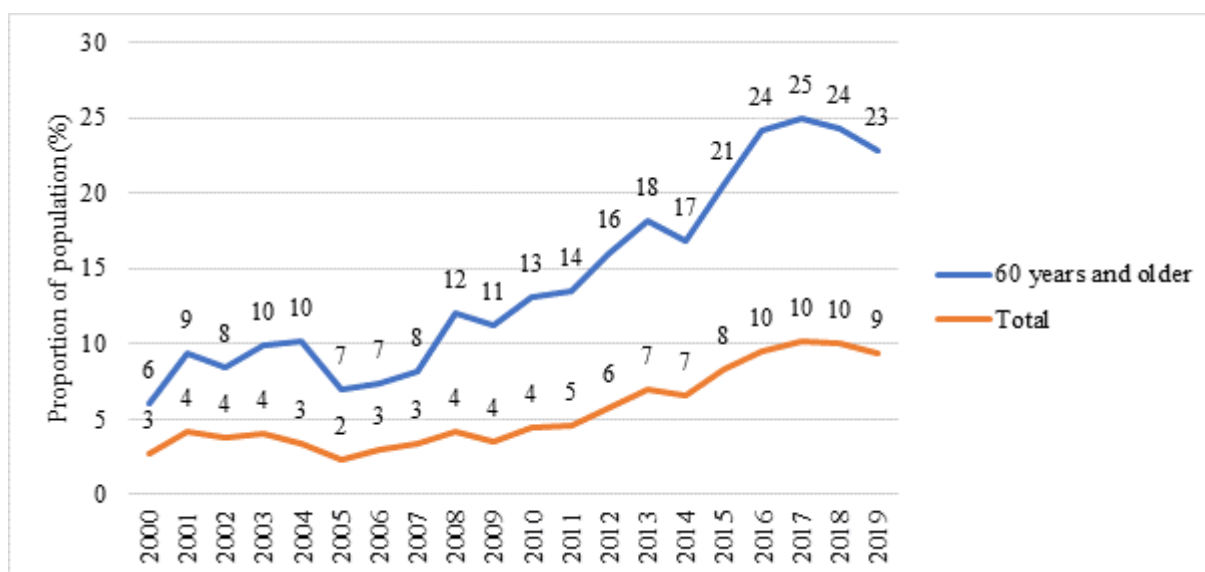
**Growing out of pocket health expenditures (OOP) may be one of the risk factors of poverty amongst the elderly.** There is a growing number of people over 60 with reported large out-of-pocket expenditures on health. The percentage of 60+ population with household health expenditure larger than 10% of expenses increased from 6% in 2000 to 23 in 2019.<sup>26</sup> WHO reported that most of the OOP health expenses are related to the outpatient care, prescription drugs, and secondary prevention. Especially, care and drugs for patients with high cholesterol and hypertension. Both chronic conditions requiring continuous medication and care.<sup>27</sup> Figure below represent the share of population with an OOP spending on health equal to more than 10% of the household expenses in Belarus, share among the 60+ population is more than two times higher than in the overall population.

<sup>26</sup> National Statistical Committee of the Republic of Belarus (Belstat). <http://sdgplatform.belstat.gov.by/en/sites/belstatfront/index-info.html?indicator=3.8.2>

<sup>27</sup> WHO (2017). [Review of acute care and rehabilitation services for heart attack and stroke in Belarus.](#)



Figure 16. Proportion of population (total and 60+) with large household expenditures on health (more than 10%) as a share of total household expenditure or income



Source: [Belstat](#) 2019

### 3.3. Social patterns and cultural norms regarding the elderly

#### 3.3.1. Perception of aging and the elderly in society

Social patterns and cultural norms regarding the elderly are determined by representations of aging and the elderly in cultural traditions, social discourses, and the media.

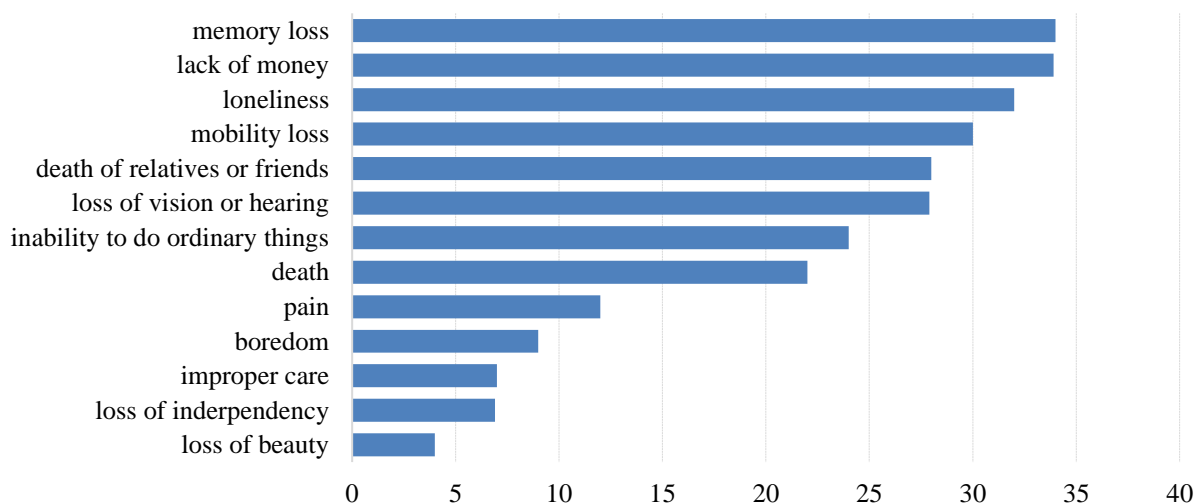
**Family values, and norms of respect and support of the elderly are firmly rooted in Belarusian traditions.** According to recent polls, family and intergenerational relations are very important to Belarusians: 91.6% of respondents mentioned that young people should take care of their old relatives.<sup>28</sup> That said, perceptions of aging and the elderly are not always positive in Belarusian society. The study “The Belarusian population’s attitude towards the elderly and their perceptions of ageing”<sup>29</sup> divided respondents into three groups, depending on the level of ageism they displayed.<sup>30</sup> Nearly one-quarter (24%) of respondents demonstrated a high level, and 38% a moderate or low level of ageism. The vast majority of respondents (71%) agreed that there was insufficient respect for the elderly in Belarus. This was confirmed by widespread common understanding and perception towards the elderly. A total of 59% of respondents answered an open question that invited them to describe an elderly person in three words. Their responses were grouped as negative, neutral, or positive. Of these, 77% were classified as negative, 28% as neutral, and 35% as positive. The majority of negative stereotypes related to material deprivation and poverty (75% of responses), and health problems of the elderly (40% of responses). But the perception of elderly people’s lifestyle also related to negative attitudes towards aging in general. Respondents’ major fears concerning aging related to loss of health, loneliness, and financial vulnerability in old age (Figure 17).

<sup>28</sup> See <http://kef.by/publications/research/tsennosti-naseleniya/opros-izuchenie-tsennostey-belorusskogo-obshchestva/>

<sup>29</sup> Based on the national public opinion poll conducted by SATIO for UNFPA Belarus. <https://www.unfpa.org/data/transparency-portal/unfpa-belarus>

<sup>30</sup> Based on the Fraboni Scale of Ageism, see Fraboni, M., Saltstone, R. and Hughes, S. (1990). “The Fraboni Scale of Ageism (FSA): An attempt at a more precise measure of ageism”. *Canadian Journal on Aging / La Revue Canadienne Du Vieillessement*, 9(1): 56–66.

Figure 17. Respondents' major fears concerning aging



Sources: SATIO (2019); IPM Research Center, “Values of the population of Belarus: Results of a sociological survey”, 2018.

**The media both mirror and influence societal perceptions of aging and the elderly.** Belarusian media emphasize what the state can and does provide to older persons rather than what people themselves can do to ensure a healthy life, or what families can do to support elderly relatives. As a consequence, older persons are predominately portrayed as needy and dependent on state support (UNECE, 2019). Focus on the state support in media and policy actors’ messages form, or at least *inform*, public opinion about the distribution of responsibility for the elderly. In a national poll more than half the respondents (53%) expressed the opinion that the state should ensure quality of life for everyone in their old age; 23% considered it the responsibility of the children, and 24% believed that people should take care of themselves.

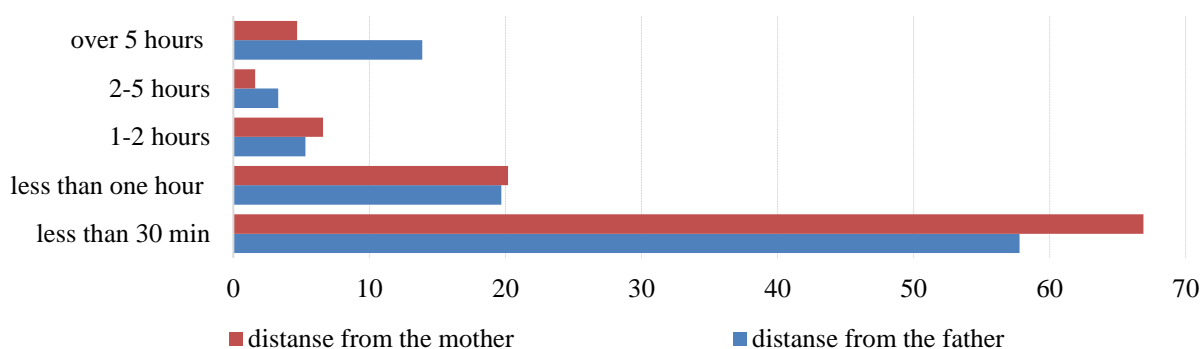
### 3.3.2. Intergenerational linkages in society

**In Belarus the most common type of family is the nuclear family, that is, two adults with one or more children.** According to the 2009 Belarus Census households with two parents and children accounted for 26.7% of all households, while those consisting of a single person represented 29.7%. The majority of families live separately from older, close relatives. According to the census, only 12% of families lived with other relatives.

**However, despite living separately, people support strong intergenerational ties.** According to the Generations and Gender Survey (GGS, 2017),<sup>31</sup> the majority of respondents meet with their parents at least once a week. Adult children meet with their mothers twice as often as with their fathers, which is partially explained by the much higher percentage of single mothers. Generally, adult daughters meet more often with their mothers and sons more often with their fathers. The relatively high intensity of intergenerational contacts in Belarus can also be explained by the relatively short distance between settlements. The frequency of meetings is to some extent a function of the distance between these settlements (Figure 18).

<sup>31</sup> UNFPA (2018). [GGS Belarus Preliminary Results](#). Geneva: United Nations Population Fund.

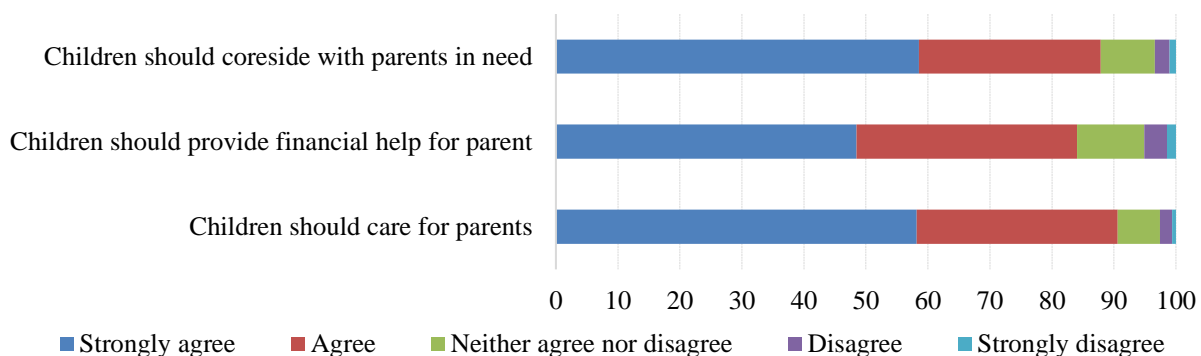
Figure 18. Frequency of meetings with mother and father, taking into account distance variable



Source: UNFPA (2018).

**The Constitution of the Republic of Belarus (1994) and the Code on Marriage and the Family of the Republic of Belarus (1969)<sup>32</sup> stipulate that adult children who are able to work have an obligation to take care of their parents** and to provide parents who are unable to work with the necessary financial support (UNECE, 2019). According to two national studies conducted by the IPM Research Center, the GGS or “Generations and Gender Survey” (2017) and “Values of the Population of Belarus: Results of a Sociological Survey” (2018), the Belarus population generally share the opinion that it is a family’s responsibility to take care of older family members. The overwhelming majority of respondents in the 2017 study believed that children should not only care for parents in need but should also support them financially and take parents in who are unable to care for themselves (Figure 19)

Figure 19. Intergenerational care values

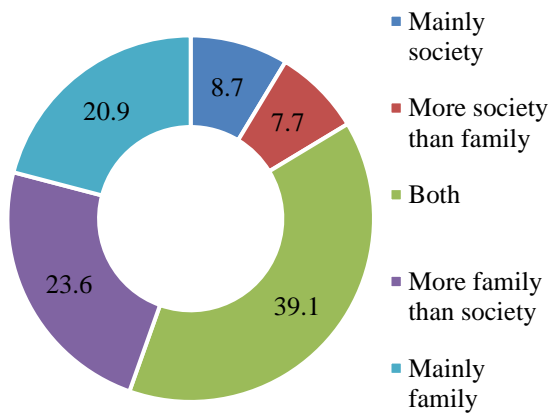


Source: Calculations based on the 2017 GGS survey.

In cases where home care for the elderly has become necessary, the highest percentage of respondents (39%) believed that it is equally the responsibility of family and state (“society”) (Figure 20). Similarly, it was believed that financial support for the elderly with income below subsistence level should be shared between family and state (“society”) (Figure 21).

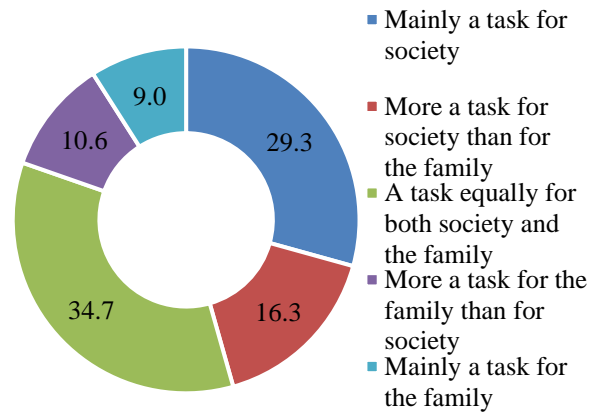
<sup>32</sup> Interestingly, the Code was adopted at the sixth session of the Supreme Soviet of the seventh convocation on July 13, 1969. See <https://heinonline.org/HOL/LandingPage?handle=hein.journals/intsfal4&div=9&id=&page=>

Figure 20. Answer distribution: “Who should provide home care for older persons?”



Source: Calculations based on the 2017 GGS survey.

Figure 21. Answer distribution: “Whose task is it to provide financial support for older people living below subsistence level?”



Source: Calculations based on the 2017 GGS survey.

**In Belarus, the state supports families with some home care provision.** Persons of working age who do not participate in the labor market and yet provide care to persons with disabilities (of certain severity) or to persons aged 80+ who are in need of constant care are entitled to a monthly allowance equal to the subsistence minimum at its highest level over the preceding six months. In cases where care is provided for two such persons, the allowance is 20% higher (UNECE, 2019).

**Family care is mostly provided by women (daughters or other female relatives) who are themselves close to retirement age.** According to legislation, this allowance cannot be received by retirees who have started to receive a pension, even if they are willing to keep providing such care. This restriction does not allow many families to get state support for providing LTC. However, with the growing percentage of older persons, the need for care provision increases and it is important to ensure social protection of those family members who leave the labor market in order to care for older persons.

## 4. Organizational structure of LTC-related systems in Belarus

### 4.1. Main policies, strategies, and programs concerning the elderly population

**Belarus has joined several international agreements and programs concerning aging and social protection of the elderly.** In 2016, the country joined the Convention on the Rights of Persons with Disabilities, and, in 2019, the government, in cooperation with the Population Unit of the United Nations Economic Commission for Europe, developed the National Strategy on Ageing, which supports the implementation of the Madrid International Plan of Action on Ageing (MIPPA) and the Regional Implementation Strategy of the MIPPA.

**In addition to the constitution, there are a number of key national legislative acts that shape the current policy framework** that regulates social protection, social and medical care, and various entitlements and provisions for the elderly (UNECE, 2019).<sup>33</sup> These are the Law on Health, the Law on Pensions, the Law on Social Services, the Law on State Benefits, the Law on Rights and Guarantees for Certain Categories of Citizens, the Law on Social Protection of Persons with Disabilities, the Law on Public Service, and the Presidential Decree on State Targeted Social Assistance—all of which regulate issues related to medical care and social support for the elderly. In addition, a number of regulatory acts exist to provide social and medical care to the elderly. There is currently no separate law related to support/care for older dependent people.

**As of mid-2020, there is no definition of LTC yet in existing legislation.** Separate components of the LTC organization and provisions are included in various strategies and programs concerning social protection and healthcare, and a framework of LTC was established by the State Program on People's Health and Demographic Security for 2016–2020, and the State Program on Social Protection and Employment Promotion for 2016–2020. The overall goals of the State Program on People's Health and Demographic Security include: improving reproductive health and fertility; reducing mortality, especially in working age; increasing life expectancy (to 75.3 years by 2020); improving the quality and accessibility of healthcare services, and optimizing internal migration processes (UNECE, 2019).

With regard to the elderly, the goals of the State Program on Social Protection and Employment Promotion are divided into three sub-programs: 1) prevention of disability and the rehabilitation of persons with disabilities; 2) the creation of barrier-free environments; and 3) social integration of the disabled and elderly. These three sub-programs pay special attention to the needs of people with disabilities and the elderly, such as the need to ensure a barrier-free environment for their full social integration.

Important issues concerning the elderly and LTC provisions are included in the fifth National Action Plan on Gender Equality in the Republic of Belarus for 2017–2020 as well as the National Action Plan for the Implementation of the Provisions of the Convention on the Rights of Persons with Disabilities in the Republic of Belarus for 2017–2025. In similar vein, the activities of the National Action Plan on Gender Equality are based on national priorities with regard to gender equality, namely the economic empowerment of women and men; ensuring gender responsive healthcare; gender equality in family relations; countering domestic violence and trafficking in human beings; and gender education and awareness. Issues related to older men and women are not specifically addressed, but the social and physical risks faced by older men and women are highlighted.<sup>34</sup>

The National Action Plan for Implementation of the Provisions of the Convention on the Rights of Persons with Disabilities in the Republic of Belarus for 2017–2025 aims to establish the legal, organizational and institutional conditions for ensuring equal rights for persons with disabilities, and the

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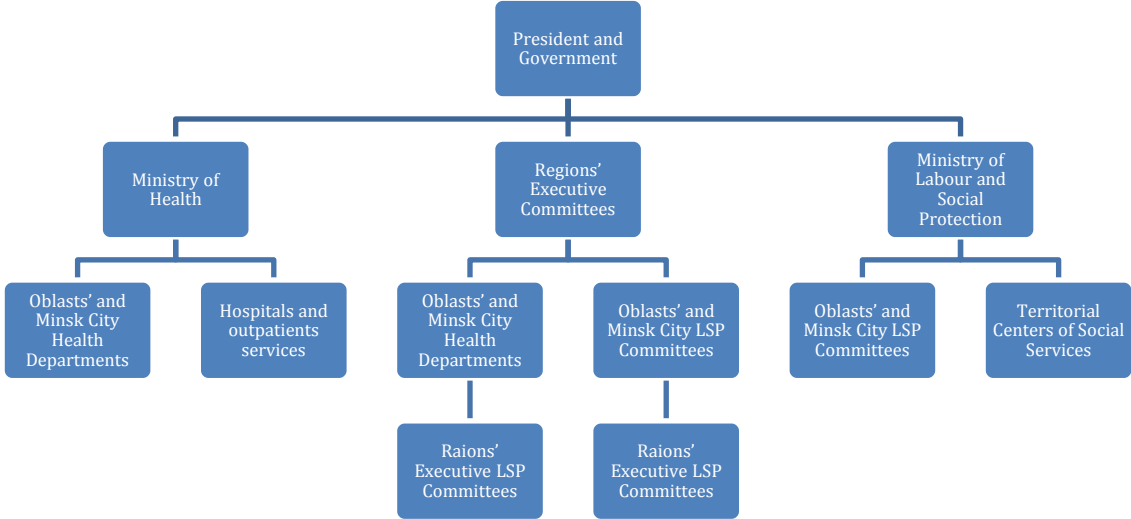
<sup>33</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

<sup>34</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

creation of conditions for their integration into all spheres of social life. In general, the plan focusses on measures to improve medical and social assistance for persons with disabilities and to improve facilities for their independent living.

**In Belarus the main agencies responsible for formulating policies related to the elderly are the Ministry of Labor and Social Protection and the Ministry of Health of the Republic of Belarus.** Other ministries responsible for implementing specific aspects of elderly related policies include the Ministry of Finance, the Ministry of Economy, the Ministry of Taxes and Duties, the Ministry of Justice, the Ministry of Education, and their subordinated structures. Structures of the Ministry of Labor and Social Protection coordinate their activities with state administration, *oblasts*, Minsk executive committees, and public associations in order to develop common approaches to the implementation of government policy in the area of social protection for the elderly. There are also two parliamentary commissions tasked with overseeing specific aspects of affairs related to aging and older persons, namely the Standing Commission on Healthcare, Physical Culture, Family, and Youth Policy, and the Standing Commission on Labor and Social Issues.<sup>35</sup>

Figure 22. LTC policy level structure

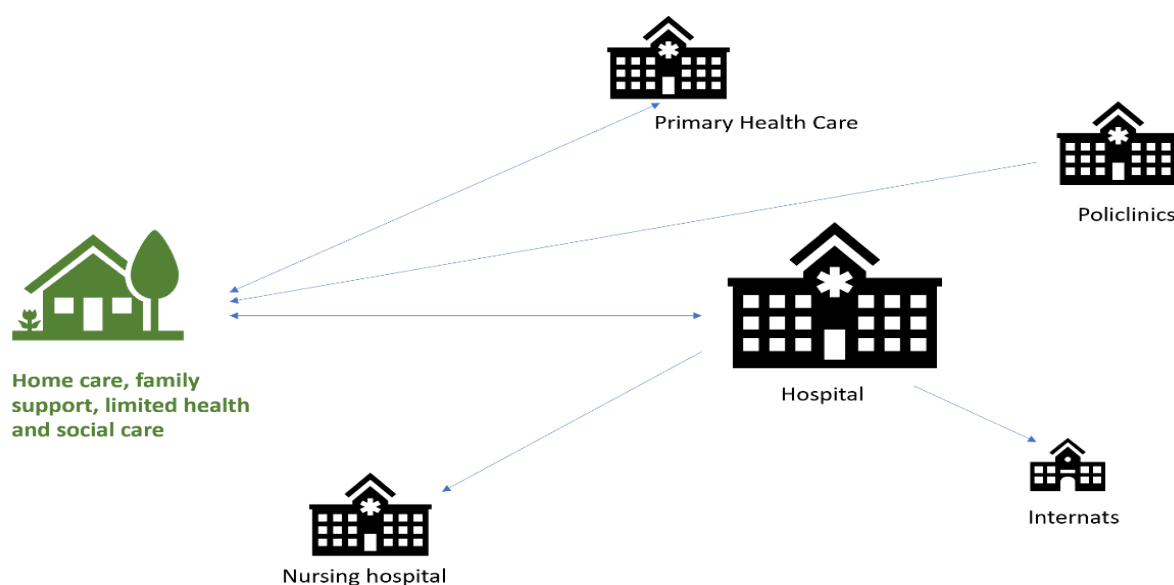


Source: World Bank

**To the extent that coordination between two systems of care provision exists, it would only be visible from the patient’s perspective (if at all),** that is, from the perspective of the individual and his/her family who have turned to the care system for assistance because they are faced with a challenging life situation. As pointed out in previous chapters, families bear most of the care burden and coordination between systems of care provision is part of that burden. It is up to the family to not only organize home care but also to coordinate the care available to them in the health and social systems. The family home is the de facto “coordination center” of the different services provided by primary healthcare, policlinics, hospitals, nursing hospitals and internats (Figure 23).

<sup>35</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

Figure 23. Care organization from the patient's perspective



Source: World Bank.

#### 4.2. Current LTC service delivery model

In the System of Health Accounts,<sup>36</sup> LTC services are classified into two broad categories: 1) health LTC services; and 2) social LTC services, with each subdivided into different types of services. Belarus uses a similar classification. Healthcare services are provided by the Ministry of Health and are organized as a traditional, publicly managed and financed national health service. The system is built on an extensive network of public health facilities across the country that relies heavily on polyclinics and hospitals to provide mainly tax-based medical care to the population. The hospital sector includes central (national), *oblast*, and *raion*-level inpatient and emergency services.<sup>37</sup>

**The administrative structure of the health system is hierarchical and organized on a territorial basis.** The president and the Council of Ministers are responsible for the development of health policies, while their implementation is the responsibility of the Ministry of Health. The latter is responsible not only for the efficiency of subordinate public healthcare facilities but also for the whole range of public and private clinics and hospitals as well as the performance (outcomes) of the health system as a whole. Healthcare facilities at the regional level are also governed by the Ministry of Health, which delegates its authority to the various *oblasts*' Healthcare Departments and the Minsk Healthcare Committee. All hospitals provide service at city, regional, central district, and precinct level, and specialized medical care is provided to the rural population in the main specialties of therapy, pediatrics, surgery, obstetrics, and infectious diseases.

**LTC services are not separately defined or paid for as an element of healthcare provision and as such are available on the same terms as other health services.** Medical care and social assistance in the healthcare system are provided by nursing hospitals and through the allocation of nursing beds and social and medical beds in inpatient healthcare facilities. The referral of patients for treatment to medical and social beds is carried out by a Commission of Health Organization, in accordance with medical provisions.

**Although the type of patient allowed to stay in a nursing bed is not defined by law,** such a patient is only provided with the same care and medical care items that would be provided on an outpatient

<sup>36</sup> <https://www.who.int/health-accounts/methodology/sha2011.pdf>

<sup>37</sup> World Bank (2013). *Belarus Public Expenditure Review: Enhancing Public Services in Times of Austerity*. Washington D.C.: World Bank.

basis or in a nursing home. Patients have to pay 80% of their old age or disability pension in order to make use of these nursing beds and these funds are returned to the local budget.

**The costs of providing nursing hospitals are borne by the regional healthcare system.** Nursing hospitals are part of state healthcare that provides medical and social assistance to citizens suffering from chronic diseases and who are in need of constant, round-the-clock medical supervision and care but who do not yet need medical care in a hospital. Currently, there are 103 nursing hospitals with a total capacity of 2,670 beds. In 2018, the total number of nursing beds in general hospitals was 4,667. Palliative care for people with disabilities and the single elderly is provided by hospices, palliative care departments, and palliative care teams.

**The creation of a legal framework for some LTC provision for the elderly started in 1991 by order of the Ministry of Health and initially focused on “improving the geriatric service and organization of nursing hospitals or medical and social beds in medical institutions”.** This portrays a limited understanding of LTC where health intervention plays a major role. The main goals and objectives of geriatric LTC were subsequently included in state programs concerned with health protection. In 2016, the first gerontological center in Belarus was established in Minsk as a direct outcome of an order from the Ministry of Health of the Republic of Belarus (December 30, 2016, No. 1336) titled “On the organization of the Republican Gerontological Center”. The center is based in the state institution called the Republican Clinical Hospital for the Disabled of World War II, which was named after P.M. Masherova and provides organizational and administrative support for the assistance provided to the elderly.

**Currently there are seven regional geriatric centers in the country.** Direct field work with the elderly is carried out by geriatricians and general practitioners as part of the general healthcare system, in coordination with the Belarusian Public Association of Geriatricians and Gerontologists, which unites specialists in the field of gerontology and geriatrics – doctors, social workers, journalists, scientists and members of civil society who are interested in the problems associated with aging and methods for achieving active longevity.

**The social LTC services sector is part of the social protection system.** Provision of social services is regulated by the Ministry of Labor and Social Protection, which determines the target groups for the provision of social services, including those related to LTC. According to existing legislation, the following social services providers currently form part of the social services system: 1) state-run organizations (for example, internats for the elderly, residential social service institutions, including Territorial Centers for Social Services (TCSS), resocialization centers, etc.); 2) other legal entities, including for-profit as well as non-profit NGOs that comply with the state social order (SSO) conditions; and 3) individual entrepreneurs.

**The state and state-run organizations are the primary providers of formal LTC services for the elderly.** State entities provide service for free and on a reimbursable basis (full or partial). There are 146 TCSSs that provide services to individuals and families facing difficult life challenges, including, to some extent, LTC. LTC services supported by the state are provided to the elderly through local centers of social services (home support, home care, residential care, etc.), and caregiver financial assistance, including care employment and attendance allowance (Section 6 for further details).

**The state supports families through limited home care provisions.** Outpatient day and rehabilitation care is limited and adds to the care burden of families. Persons of working age who do not participate in the labor market but who provide care to persons with Group 1 disabilities, or persons aged 80+ who are in need of constant care, are entitled to a monthly allowance equal to the subsistence minimum at its highest level over the preceding six months. Where such care is provided to two such persons, the allowance is 20% higher.<sup>38</sup> The other types of available services are presented in Figure 24.

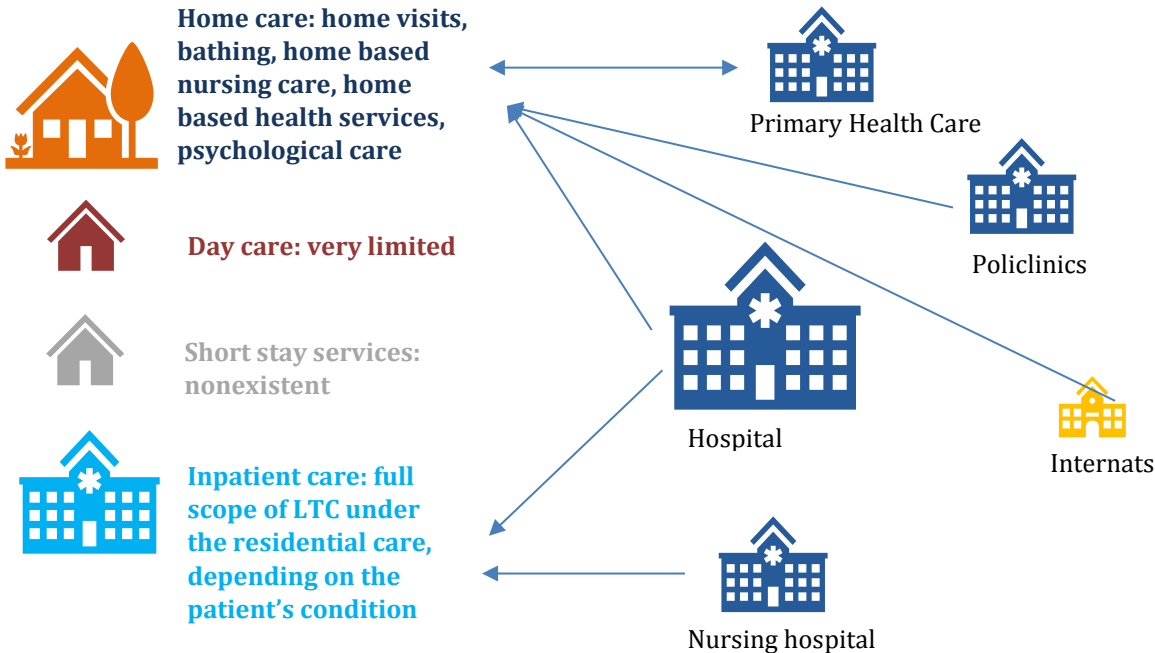
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<sup>38</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.



**As a rule, family care is provided by women (daughters or other female relatives) who are themselves near, or at, retirement age.** According to legislation, retirees who start receiving their pension are not entitled to the abovementioned allowance even if they are willing to keep providing such care. This restriction severely limits the number of families who qualify for state support for providing LTC. In light of the growing number of elderly people, the need for care provision has increased and it is important to ensure social protection for those family members who have left the labor market in order to provide care to older persons.

Figure 24. LTC care pathway availability



Source: World Bank.

**Although some steps have been taken to diversify the delivery of social services, both social and healthcare sectors are still dominated by the state.** The involvement of NGOs and their ability to advocate for legislative change are limited. Other than the state, the only major entity that provides social services for the elderly is the Belarus Red Cross Society (BRCS), which the state perceives as a partner. In addition, there are some organizations, the existence of which date back to the Soviet period, such as the Belarusian Society for the Disabled; the Belarusian Society of Veterans; the Belarusian Association for the Visually Impaired. The involvement of NGOs in providing social services is not limited to the SSO system since they derive much support from volunteers and grants received from foreign and international organizations. The quality of services provided are generally subject to the supervision of the Territorial Centers for Social Services.<sup>39</sup>

**4.3. Available infrastructure and access to elderly care services**

According to legislation, access to both health and social LTC services are guaranteed to older persons in need of care. However, the split between health and social care services often results in a lack of coordination between agencies, which, in turn, has an adverse effect on waiting periods and

<sup>39</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

administrative procedures. Based on a comparison with OECD countries, the average availability (based on calculated number of beds and personnel), and therefore utilization of LTC services in Belarus, is much lower both in health and social sectors as per presented below detailed information.

#### 4.3.1. Healthcare services

**The healthcare system usually covers LTC services provided by hospitals, polyclinics, and ambulatories.** Outpatient medical service for the elderly also includes home-based medical care. Medical care is provided by health professionals, in particular nurses, therapists, physiotherapists, and in some cases, geriatrists. The provision of medical care to older people is carried out by health organizations without restrictions on age, income or place of residence. In addition, elderly citizens receive preferential treatment when it comes to the provision of medicines and certain categories related to the technical means of social rehabilitation, depending on the disability group or the list of diseases approved by decree from the Ministry of Health. Medical examinations of elderly people are carried out by general practitioners at least once a year, with the involvement of other specialist doctors if necessary. For war veterans, quarterly medical examinations and patronage are available, provided in the home setting by physician assistants in outpatient work and employees of paramedic-obstetric centers.

**Medical LTC services for the elderly are provided in specialized nursing hospitals, nursing beds in general hospitals, social and medical beds in inpatient healthcare facilities, and palliative care facilities.** Access to nursing hospitals, nursing beds, and social and medical beds is regulated by numerous normative legal acts, such as the law “On healthcare” (June 18, 1993); the decree issued by the Ministry of Health on January 2013, No. 3, “On certain issues of the organization of medical care and the provision of social services”; the law “On social services” (May 22, 2000); the decree of the Council of Ministers “On some issues of the provision of social services” (December 27, 2012, No. 1218); and the order of the Ministry of Health “On some issues of the organization of medical, social and palliative care” (December 24, 2014, No. 107). The referral of patients for treatment to a medical and/or social bed is carried out by a Commission of Health Organization, in accordance with medical provisions. Although the length of stay in a nursing bed is not limited by law, the patient is only provided with care and medical care items equivalent to what can be performed on an outpatient basis or in internats. Payment for the bed by the patient is equal to 80% of the old age or disability pension, which is returned to the local budget. Nursing hospitals costs are mostly covered by the regional health budget.

**The number of nursing hospitals and nursing beds is only slowly increasing.** In 2018, there were 103 nursing hospitals with a total capacity of 2,709 beds. The total number of nursing beds (including beds in general hospitals) increased from 3,178 to 4,677 beds between 2010 and 2018. In Vitebsk *oblast*, the total number of nursing hospitals increased from 22 to 29 over the same period, which amounted to an increase in the number of nursing beds from 1,125 to 1,791. In Grodno *oblast*, only the total number of nursing beds in general hospitals increased and the number of nursing hospitals beds dropped from 375 to 345 over this period.

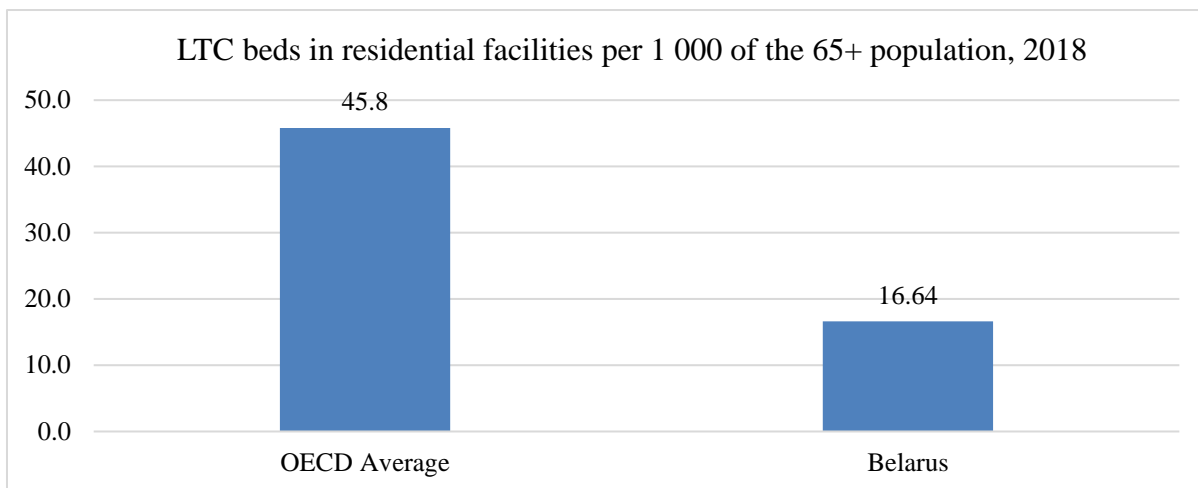
##### 4.3.1.1. LTC beds – national level

**In 2018, the total number of LTC beds in both health and social sectors was 14.64 per thousand of the 65+ population, which is more than three times lower than the OECD average of 45.8 beds per thousand of the 65+ population.** In order to provide more accurate comparison with LTC beds in residential facilities in the OECD, the definition of beds in Belarus includes inpatient nursing care in nursing hospitals and internats. If nursing beds in general hospitals were also included, the Belarus indicator would increase to 16.64 (Figure 25).

Figure 25. Number of LTC beds per 1,000 of population for age group 65+<sup>40</sup>

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<sup>40</sup> LTC beds in Belarus are defined to include nursing care beds in hospitals, nursing hospitals, and internats. Due to limited data availability, the data for internat beds is from 2019. LTC beds in OECD countries are defined as beds in residential, LTC

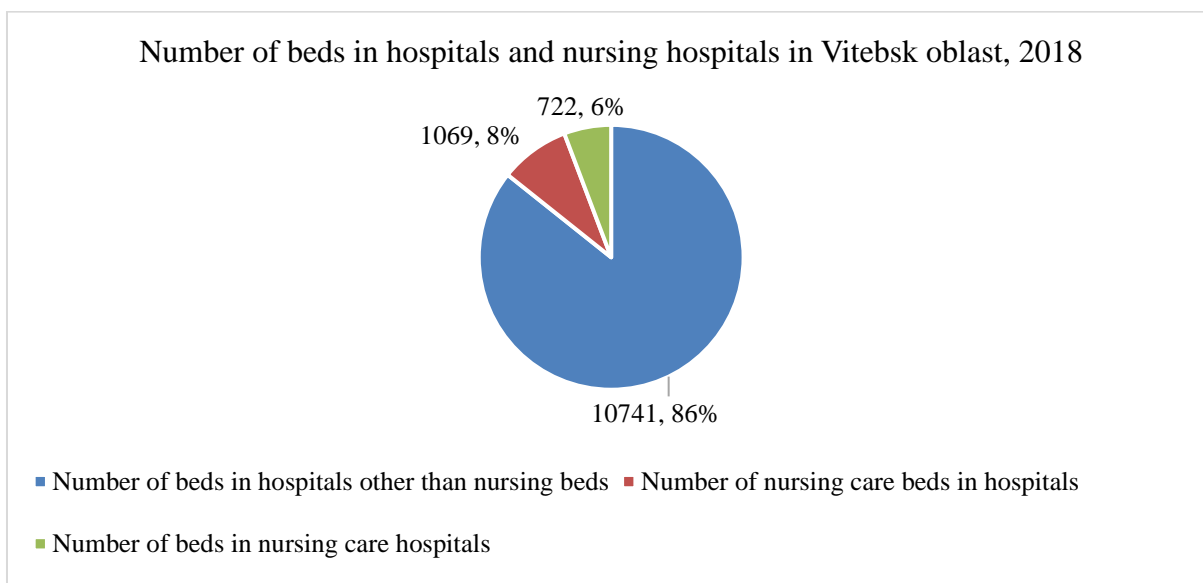


Source: WB analyses based on OECD and Belstat data (2018).

#### 4.3.1.2. LTC beds – regional level

**Only 6% of the total number of beds in Vitebsk oblast could be associated with LTC and those are in nursing hospitals.** In addition to these, there are also 1,069 nursing beds available in regular hospitals (compared to the 10,000 regular beds available in the *oblast*) (Figure 26).

Figure 26. Number of beds in hospitals and nursing hospitals in Vitebsk oblast, 2018

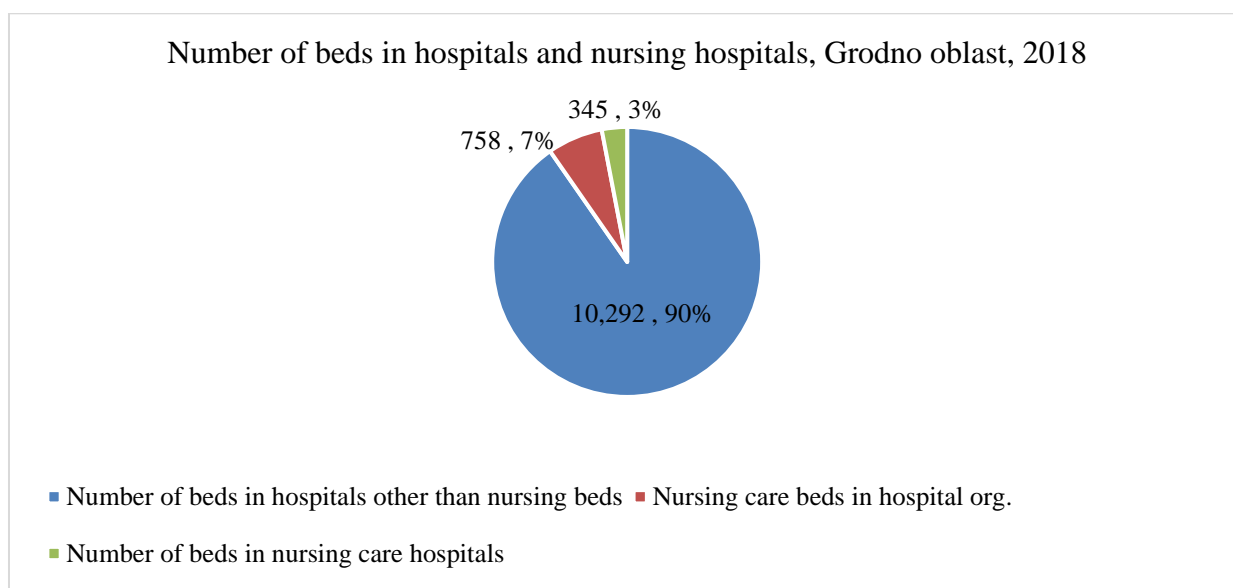


Source: MoH.

In Grodno *oblast*, nursing beds account for 10% of all beds available in the healthcare system (Figure 27).

facilities, including long-term nursing care facilities and other residential LTC facilities. Excluded are beds in hospitals dedicated to LTC and beds in residential settings, such as adapted housing that can be considered as people's homes.

Figure 27. Number of beds in hospitals and nursing hospitals in Grodno oblast, 2018

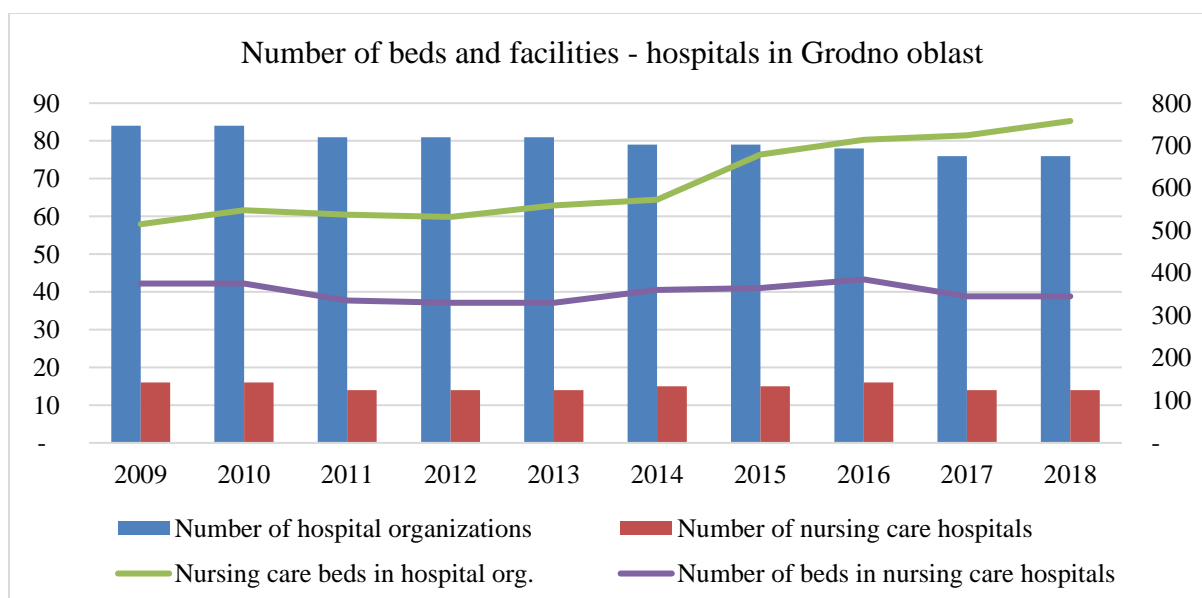


Source: MoH.

Although the total number of hospitals in Grodno *oblast* dropped from 84 in 2009 to 76 in 2018, the number of nursing care hospitals remained the same over the years and registered a growing number of nursing care beds in regular hospitals and a steady number of nursing care beds in nursing hospitals.

It seems that due to the rather stable but possibly insufficient level of financing, health facilities report similar number of beds in the nursing hospitals over the years. The number of nursing care beds however continues to grow in regular hospitals which may be a sign of some form of hospital's adjustment to the growing needs of the elderly population.

Figure 28. Number of beds and facilities

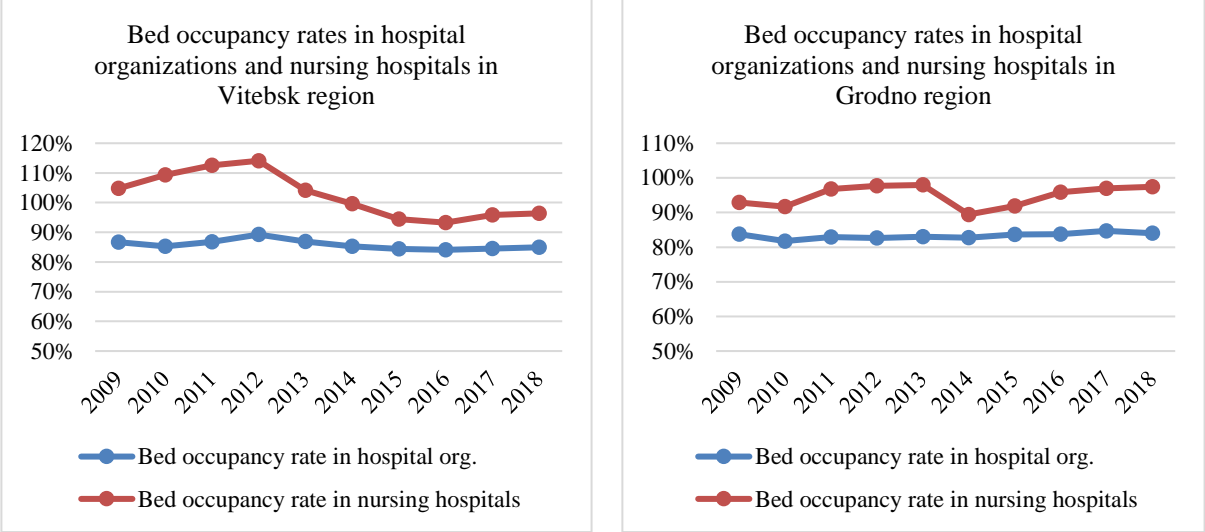


Source: MoH.

**The bed occupancy rate does not vary between *oblasts*.** In Vitebsk *oblast* this rate was almost 100% (350 days per year) with a similar, and sometimes slightly lower, rate reported for nursing hospitals and general hospitals (Figure 29). For the purposes of state budgeting and division of funds based on the number of beds and their occupancy, facilities may report full occupancy ratio, potentially also to

maintain their current budgets. Occupancy ration close to or 100% may also mean that not all the beds during the summer are really occupied and only in winter facilities are really full, or during winter time with infectious diseases season as well as acknowledged pattern of citizen turning into health facilities for care due to the lack of proper house heating, the demand of the LTC beds much be much higher than the beds availability.

Figure 29. Bed occupancy rates in hospitals and nursing hospitals, Vitebsk and Grodno oblasts

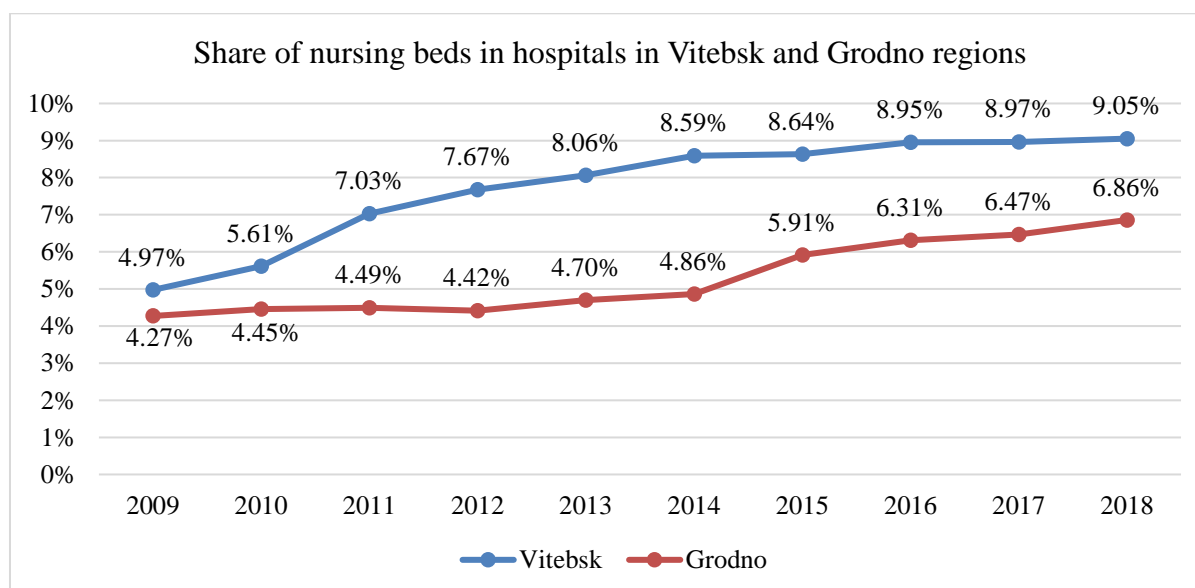


Source: MoH.

In Vitebsk oblast the percentage of nursing care beds in general hospitals has remained steady over the last couple of years, while in Grodno oblast a slight increase was observed. As stated above and compared with Grodno oblast, Vitebsk oblast has the highest percentage of nursing care beds expressed as a proportion of the total number of beds.

**There is steady growth of the nursing beds availability in the general hospitals in Vitebsk and Grodno oblast.** Specially in Vitebsk oblast, the number of beds increased from almost 5% to over 9% of beds being nursing beds. Grodno oblast presents lower growth rate, but still steady increase from over 4% of beds being nursing beds, to 6.86% in 2018. This may mean that general hospitals adjust their service delivery models and infrastructure dedicated to the changing needs of the elderly population of could be a result of more elderly oriented policy and financing (Figure 30).

Figure 30. Share of nursing beds in Vitebsk and Grodno oblasts



Source: MoH.

In terms of the distribution of patients discharged (hospitalized and deceased) from nursing care hospitals and inclusive of those who occupied nursing care beds in general hospitals, the percentage of patients 60+ years was 91% in 2018, of which 45% were men and 55% were women (Figure 13).

Table 13. Distribution of nursing care discharged patients by age and sex, 2018

Age group	Total	Male	%	Female	%
60-79	11,373	6,082	53.5	5,290	46.5
80-89	6,392	2,088	32.7	4,304	67.3
90 and older	1,600	229	14.3	1,371	85.7
Total number of deceased	21,242	9,653	45.4	11,589	54.6

Source: Ministry of Health.

**For older people with disabilities and those who live alone and in need of such care due to the health condition provision is made for palliative care** in hospices, palliative care departments, and palliative care teams, regulated by the Resolution of the Ministry of Health (issued on December, 24 2014, No.107) and titled “On some issues of the organization of medical, social and palliative care”, which should be read in conjunction with “Instruction on the procedure for the provision of medical, social and palliative care”. Nationally, as of January 1, 2020, 463 24-hour palliative care medical beds were deployed in 23 general hospitals, 18 day care beds in 2 polyclinics, 1 outpatient patronage services, and 15 palliative care rooms. In 2019, more than 10,159 patients were treated, including 7,991 patients who presented with oncological pathology (78.7%). At the beginning of 2020, there were 1,056 patients in Grodno *oblast* (69.2% presenting with oncopathology) and 1,545 in Vitebsk *oblast* (94.8% presenting with oncopathology). At the outpatient stage of palliative care, a total of 4,543 patients were enrolled in 11 outpatient services during 2019 (4,359 or 95.9% presenting with oncological pathology). In Grodno city, 262 patients (99.2% presenting with oncopathology) were taken under the guardianship of the visiting patronage service. In Vitebsk *oblast*, there were 578 patients (100% presenting with oncopathology) in 2019. In addition to this, 1,790 palliative patients were treated in day-care beds.

#### 4.3.2. Social services

**Some social LTC services are provided by internats** (“old-age homes”) for the elderly (65+) and persons with disabilities, some by Territorial Centers for Social Services (TCSS), and additional services

by other legal entities (NGOs and individual entrepreneurs).<sup>41</sup> There is no national definition of “need of care”. Instead, specific eligibility criteria are defined in various acts of legislation related to different types of services. Generally, the minimum eligibility criteria are defined in legislation and are applicable and binding nationwide. These criteria may include the applicant’s age, income status, family status, type and severity of disability and so forth. Internats can host approximately 18,000 residents per annum. The state’s ability to provide LTC is currently limited by the capacity of the system. The occupancy of existing internats is close to 100%.

**The number of individuals benefitting from internat care services has been steadily increasing (Table 14).**

Table 14. Statistics related to internats for the elderly and disabled, 2010-2019

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<b>Belarus</b>										
Number of internats for the elderly and disability	65	67	69	69	70	70	70	70	72	72
Number of habitants of internats for the elderly and disability	15,788	15,958	16,192	16,377	16,656	16,933	16,956	17,264	17,671	17,904
<b>Vitebsk oblast</b>										
Number of internats for the elderly and disability	14	14	14	14	14	14	14	14	14	14
Number of habitants of internats for the elderly and disability	3,028	3,030	3,055	3,217	3,281	3,275	3,276	3,328	3,371	3,442
<b>Grodno oblast</b>										
Number of internats for the elderly and disability	6	7	7	7	7	7	7	7	7	7
Number of habitants of internats for the elderly and disability	1,574	1,705	1,736	1,720	1,715	1,748	1,770	1,792	1,770	1,811

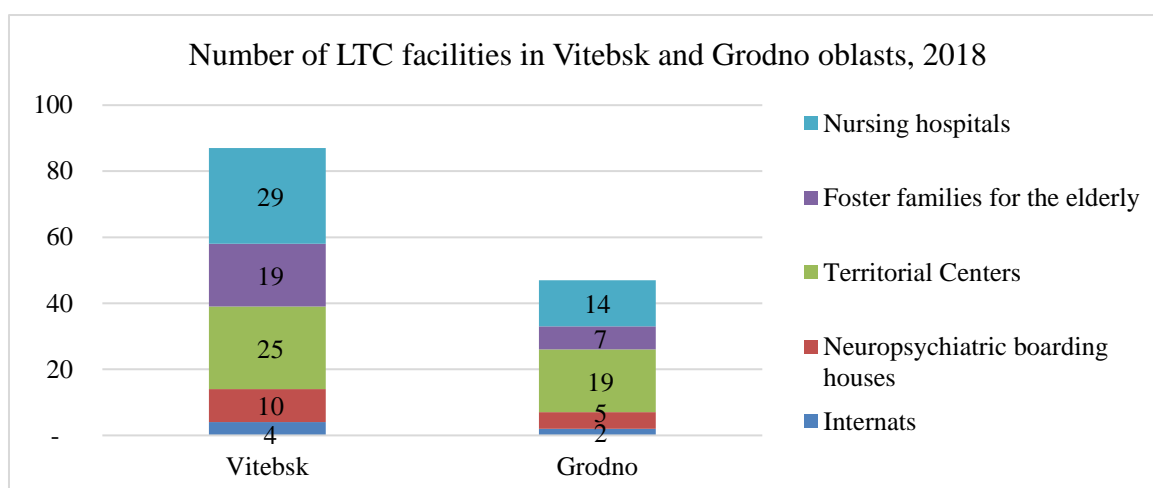
Source: MoLS.

In terms of absolute numbers, Vitebsk *oblast* has significantly more nursing hospitals, internats, and TCSSs than Grodno *oblast*, which has a somewhat similar 65+ population (it has only c.3,000 less citizens who are 65+) (Figure 31). This may be due to the different priorities selected by the *oblast* authorities and their willingness to support and finance elderly care facilities or difference co-payment arrangements influencing the demand.

Figure 31. Number of facilities providing some LTC in Vitebsk and Grodno oblasts, 2018

<sup>41</sup> Access to LTC social services is regulated by the following key laws: On Social Services, On State Benefits, On Rights and Guarantees for Certain Categories of Citizens, On Social Protection of Persons with Disabilities, and the presidential decree On State Targeted Social Assistance. Besides these key laws, the residential full-board care facilities are regulated by the Decree of the Council of Ministers of the Republic of Belarus, December 27, 2012, No. 1218, titled “On some issues of the provision of social services,” and the Decree of the Ministry of Health of the Republic of Belarus, December 31, 2013, No. 136, titled “About sanitary approval rules and regulations”.





Source: MoH and MoLSP data.

The stay in internats is either co-financed by the state, which retains 75% of pension for veterans and 90% of pensions for those who are frail and live alone and/or do not have immediate family or are fully/partially paid for by the family or the older persons themselves. The monthly full-board costs vary depending on the region and services covered. In Minsk *oblast*, for instance, the cost in 2019 amounted to BYN 500 per month, which was higher than the average pension income.<sup>42</sup>

Table 15. Internats in 2019

	Number	Number of beds	Annual occupancy rate as percentage
Internats for the elderly and disabled	72	17,904	94.7
Internats	21	3,689	91.2
Neuropsychiatric internats	51	14,215	98.2

Source: Belstat.

**One of the ways in which TCSSs assist in providing LTC social services is by facilitating a written contract** concluded on the basis of a written or oral statement from the older person (or his/her legal representative) and the organization or individual entrepreneur who undertakes to provide the social services; alternatively, a contract between any citizen (or his/her legal representative) and an organization or individual who, *qua* legal entity, undertakes to provide the relevant social services. Based on the information gathered from local experts it seems that this procedure is not used too widely. In 2020, only 6% of the 65+ population was receiving free social services at home; 18% paid a reduced rate, and 79.8% paid the full rate.<sup>43</sup>

Table 16. Distribution of social services on the basis of TCSS, 2019

	Belarus	Brest oblast	Vitebsk oblast	Gomel oblast	Grodno oblast	Minsk oblast	Mogilev oblast	Minsk
Recipients of resting rooms/beds services	2,389	31	682	291	388	394	603	--
Recipients of home	94,265	11,158	15,663	14,724	13,766	22,051	12,921	3,982

<sup>42</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

<sup>43</sup> UNECE (2019). *Road Map for Mainstreaming Ageing in Belarus*. Geneva: United Nations Economic Commission for Europe.

care services								
Including nursing care recipients	2,285	294	327	278	433	313	287	353
Younger than 65	247	28	24	38	54	49	28	26
65–75	307	37	43	43	64	47	35	38
75–80	346	42	37	44	75	47	52	49
80+	1,385	187	223	153	240	170	172	240
Other home care social services recipients	91,980	10,864	15,336	14,446	13,333	21,738	12,634	3,629
Younger than 65	6,283	734	1,188	887	779	1442	973	280
65–75	22,956	2,227	4,193	3,650	2,920	5,713	3,623	630
75–80	20,328	2,250	3,291	3,098	3,187	5,180	2,807	515
80+	42,413	5,653	6,664	6,811	6,447	9,403	5,231	2,204

Source: MoLSP.

**TCSS also provide day care services for disabled and older persons.** Their facilities include home support (social assistance services), home care services (nursing care), catering or resting rooms/beds (temporary home care).

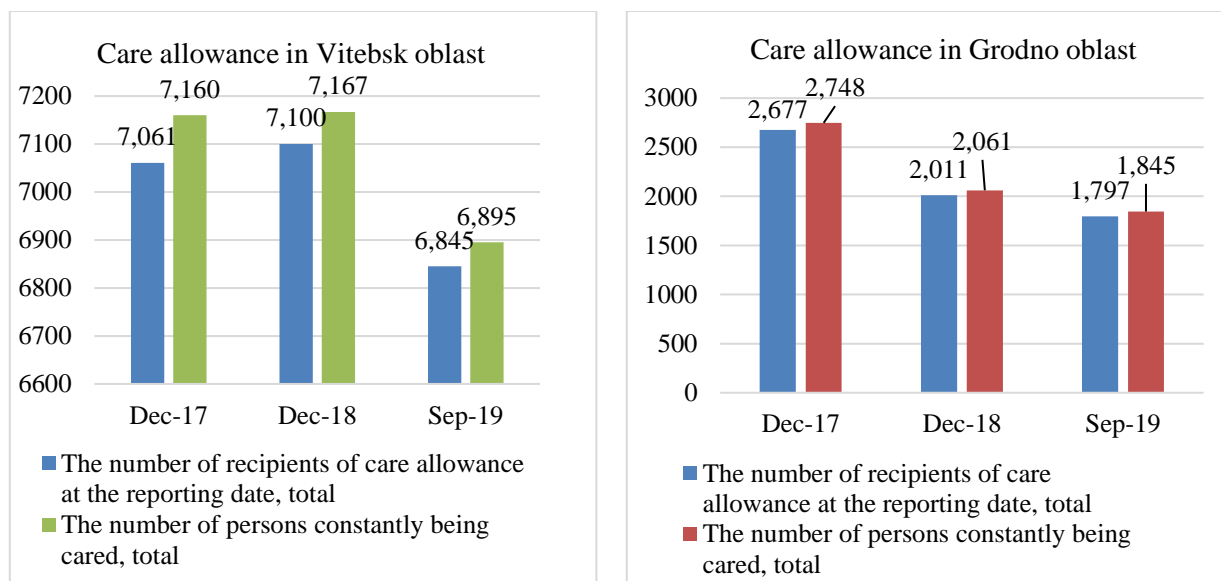
**In Belarus, there is also state-supported institutional care offered via substitute family or foster care.** According to the Ministry of Labor and Social Protection, in 2019 a total of 122 foster families for the elderly provided social care for 124 persons, including 86 persons 70+. In Vitebsk *oblast* alone there were 29 foster families that provided social care for 29 persons (including 23 persons 70+) and 15 substitute families that provided social care for 15 persons (including 11 persons 70+).

**The state and state-run organizations are the primary formal providers of LTC services for the elderly.** Among NGOs, the largest LTC provider is the Belarus Red Cross Society (social service “Dapamoha”, which means “Help” in Belarusian). In 2018, a total number of 1,436 people (up slightly from 1,338 in 2017) benefitted from *social services* provided by this society. In 2018, the number of health *and* social services provided by employees of Dapamoha amounted to 1,489,800 services (up from 1,297,700 in 2017), with the following breakdown: medical care services – 553,400 services (37% of the total compared to 37% in 2017); individual care services – 519,100 services (35% compared to 34% in 2017 – 34%); social assistance services – 233,700 (16% compared to 17% in 2017); household services – 183,600 (12%, as in 2017).

#### 4.3.3. Care allowance

The total number of care allowance recipients in Vitebsk *oblast* increased slightly over the course of 2017–2018. Final data from 2019 were not yet available but by September 2019 the total number of recipients for that year already nearly equaled the total number of recipients in 2018 so we can expect that following years data would present growth (Figure 32). In 2018, the number of recipients in Grodno *oblast* dropped from 2,677 to 2,011 people. This may be due to the *oblast* decisions related to funding constrains.

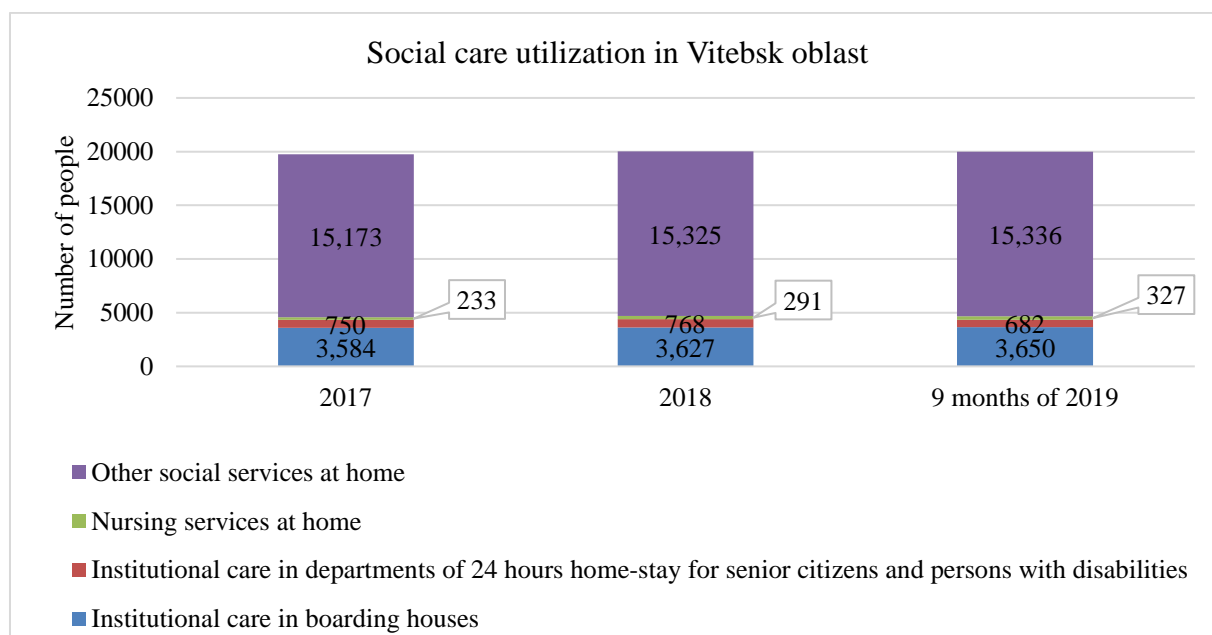
Figure 32. Care allowance in Vitebsk and Grodno oblasts



Source: MoLSP data.

With a population of 197,681 people 65+ in Vitebsk *oblast*, a high percentage of social services are provided at home (for example, 15,663 cases over a nine-month period in 2019), while 3,650 people were clients of internats in 2018.

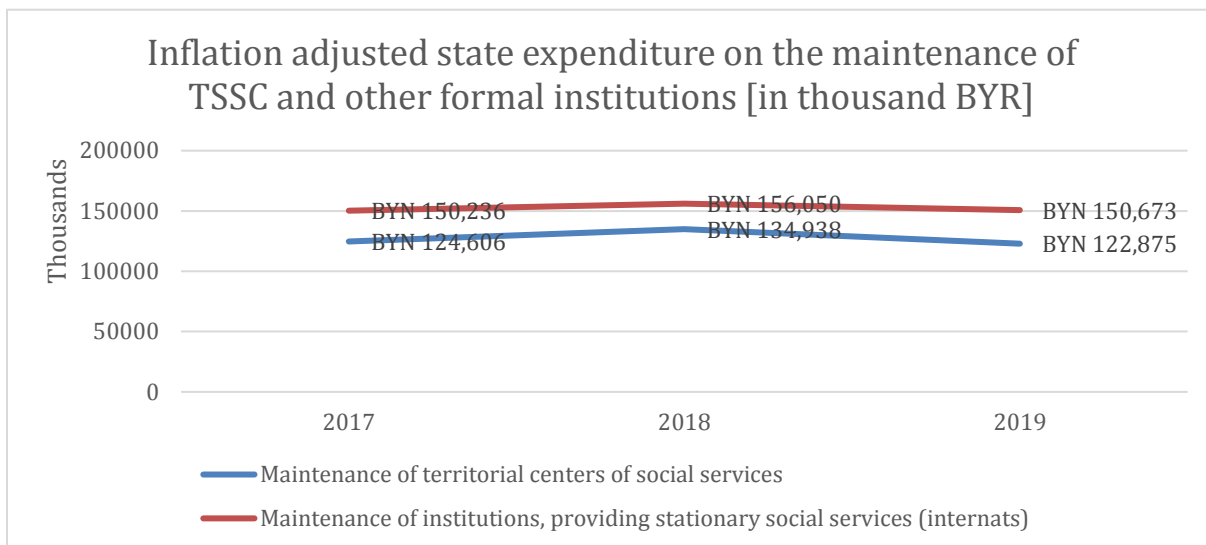
Figure 33. Social care distribution in Vitebsk oblast



Source: MoLSP data.

State funding aimed at maintaining the TCSS as well as other social care facilities devised to support the 65+ population (including LTC) has grown in nominal terms almost 30% over the last three years (2017–2019). With inflation taken into account however, this growth is no longer visible (Figure 34).

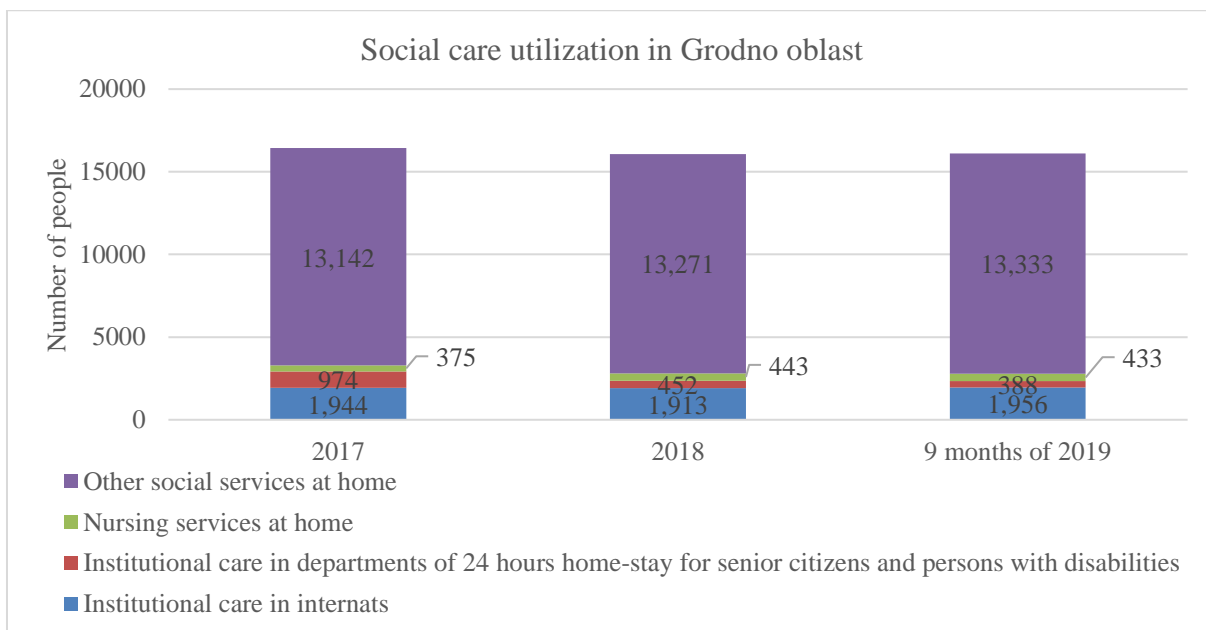
Figure 34. Budgetary allocations for the maintenance of TCSS and other formal institutions



Source: MoLSP data.

Social care distribution in Grodno *oblast* is similar to the distribution in Vitebsk *oblast* and has not changes much over the last three years. Despite growing costs of the TCSS, being a part of the social care, nursing services at home had substantial increase in the services provision for 375 people served in 2017 to 4233 people in nine months of the 2019 (Figure 35).

Figure 35. Social care services distribution in Grodno oblast



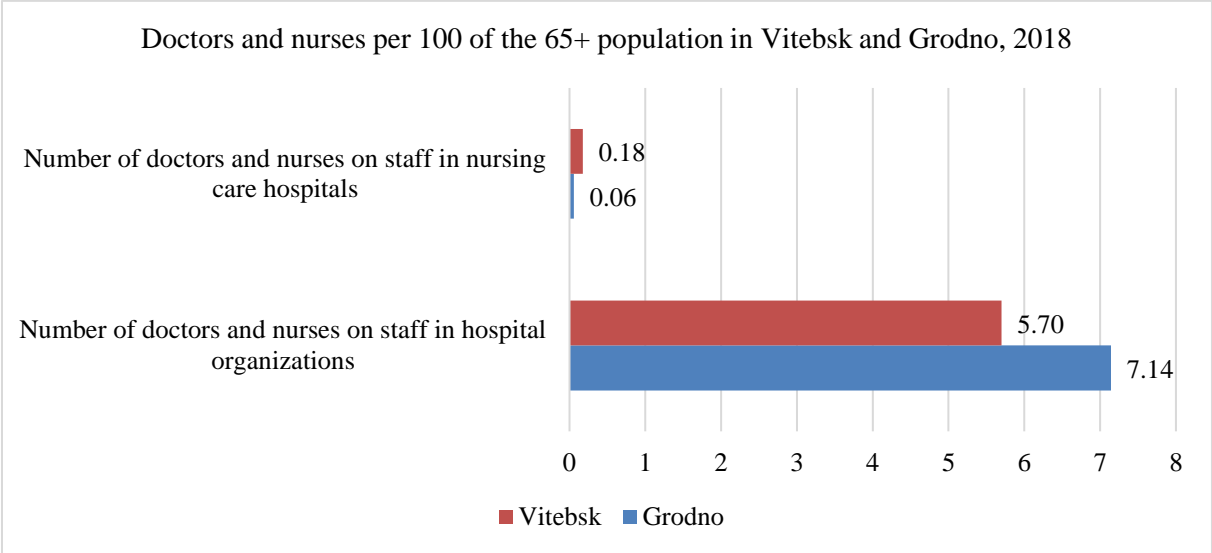
Source: MoLSP data.

#### 4.4. Workforce and human resource policy for LTC

**In the healthcare system LTC services are provided by health professionals**, in particular nurses and doctors (including physiotherapists), who work for organizations that serve both inpatients and outpatients, including nursing hospitals and regular hospitals with a certain allocation of nursing beds. On national level, regular hospitals are much better staffed than nursing hospitals, with 23,761 doctors and 61,370 nurses employed in the former compared to 72 doctors and 841 (general hospitals ratio of doctors and nurses per 100 of the 65+ population is 1.69 and 4.36 compared to 0.005 and 0.06 in nursing hospitals) nurses employed in the latter. As general hospitals serve entire population it is clear that they

are far better equipped in the appropriate personnel than nursing hospitals. Care provided in the nursing homes requires far more nursing services as well as care takers services compared to purely medical staff in the general hospitals. High differences in the staff ratio may also indicate a lower level of medical care with less availability of doctors and nurses in the nursing hospitals. The ratio of doctors and nurses per 100 of the 65+ population in Vitebsk and Grodno *oblasts* are presented in Figure 36 and Figure 37.

Figure 36. Ratio of doctors and nurses per 100 of the 65+ population, 2018

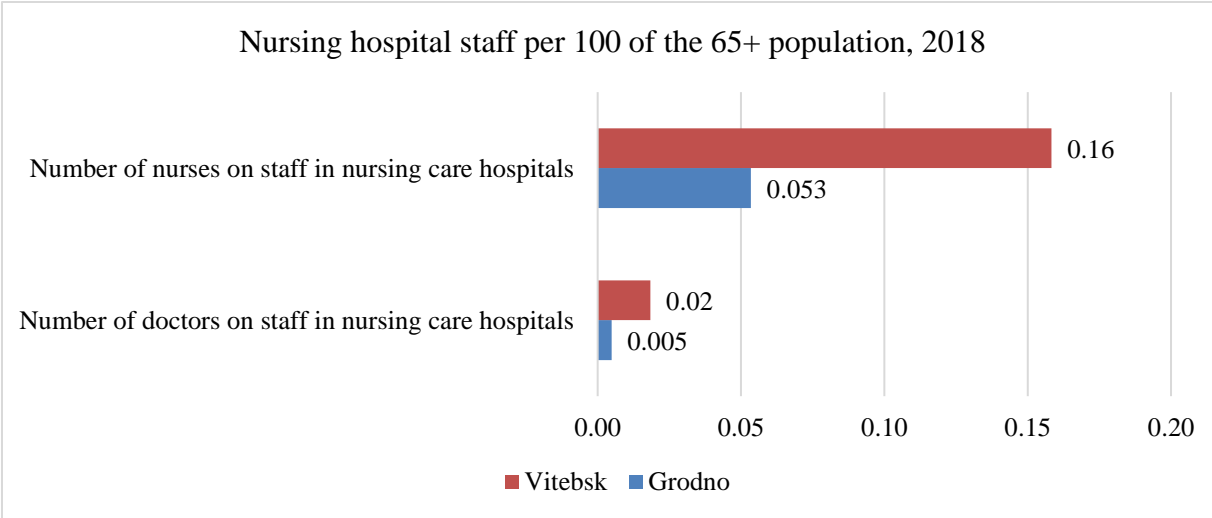


Source: MoH and Belstat data.

**Despite general human resources availability in the health sector, nursing hospitals may be understaffed,** particularly in Grodno *oblast*. Taking into consideration different scope of care provided in the nursing hospitals compared with general hospitals, the lower ratios of doctors and nurses in the nursing hospitals are no surprise. Qualified staff in appropriate numbers however is an essential element of patient’s safety and quality of care. Understaffed facilities may contribute to lower levels of care provided.

Grodno’s *oblast* general hospitals are better staffed compared to Vitebsk, where the situation is the opposite in the nursing hospitals. The ratio of nurses in nursing hospitals is three times higher in Vitebsk *oblast* than in Grodno. This is somehow similar pattern to the social care provided in both *oblasts*.

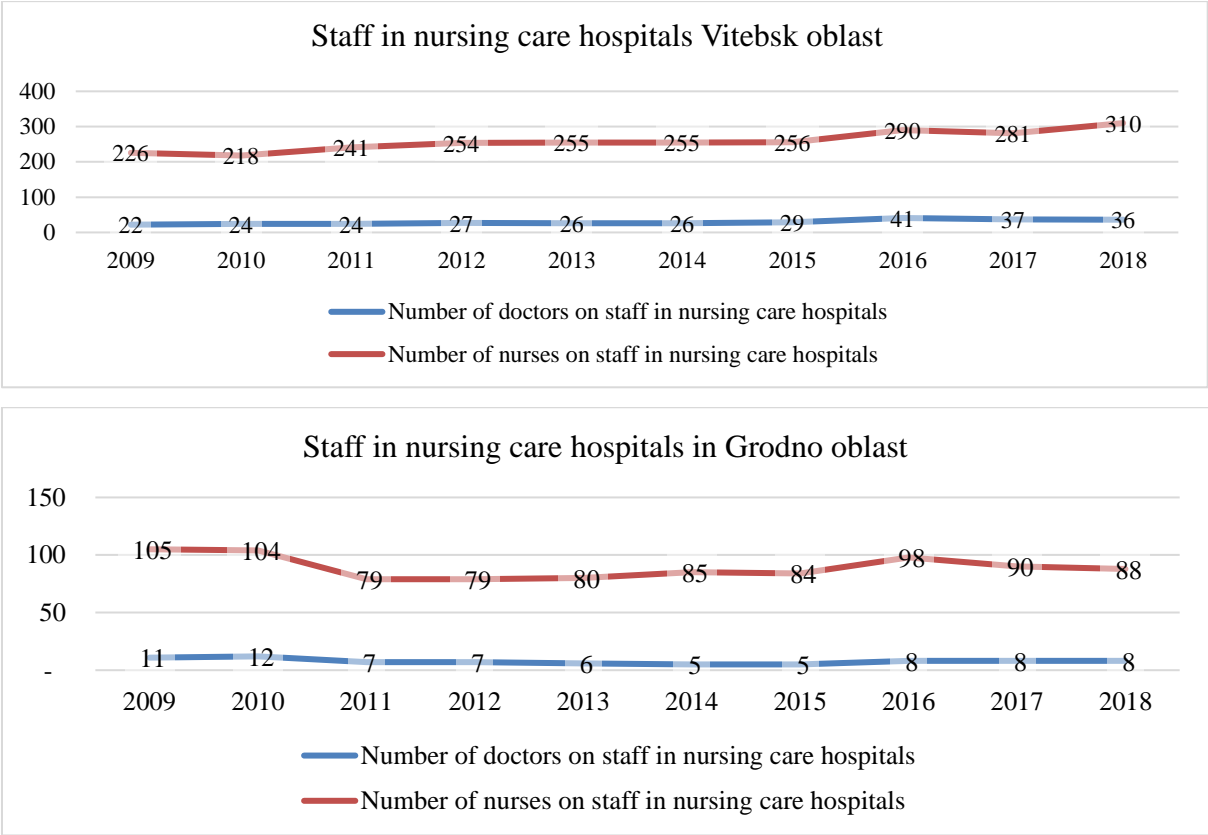
Figure 37. Ratio of hospital nursing staff per 100 of population 65+, 2018



Source: MoH and Belstat data.

Over the last nine years the total number of doctors and nurses employed in nursing hospitals has increased by almost 30% in Vitebsk *oblast*, while in Grodno *oblast* the number has decreased slightly (Figure 38). It may be the case that Vitebsk *oblast* invests both in social care and health care for the elderly more than Grodno *oblast*.

Figure 38. Number of doctors and nurses employed in nursing care hospitals



Source: MoH and Belstat data.

**As of January 1, 2020, a total of 105 geriatric rooms existed in various national healthcare organizations, serviced by 43 geriatricians** who provide outpatient services for the elderly. The number of geriatrician’s positions who work in healthcare organizations on a regular basis is 55.75, of which 49.25 are employed full-time. Of the functioning specialists, 50% combine geriatric posts. Given present conditions, there is a need for an estimated additional 40 geriatricians.

**The Belarusian Public Association of Geriatricians and Gerontologists serves as an umbrella organization** for a range of specialists in the field of gerontology and geriatrics – doctors, social workers, journalists, scientists, and members of civil society who are interested in problems associated with aging and methods for achieving active longevity. Since 2006, specialized training in Geriatrics and Therapy has been provided by the Chair of Gerontology and Geriatrics at the Belarusian Medical Academy of Postgraduate Education. This department annually trains up to 300 general practitioners, geriatricians, heads of therapeutic departments, deputy chief physicians, teachers at educational institutions in the national healthcare system, as well as medical researchers.

**In Belarus there are currently more than 633 “third-age” health schools, which, over the last five years, have provided 788,500 people with their services.** These include postgraduate studies, skills and crafts development, language courses, and many other activities aimed at inducing the elderly into new types of activities. In order to encourage the elderly and people with disabilities to adopt a healthy lifestyle, specialists from various healthcare organizations cooperate closely with the media to disseminate information on healthy living through appearances on radio and television shows, while

general information promoting a healthy lifestyle is communicated on the websites of government agencies and via monitors on city buses and in pharmacies.

**In 2019, there were 11,022 full-time positions in internats** (2,263 in ordinary internats, and 8,759 in neuropsychiatric internats). Available data do not distinguish between staff according to the position they occupy, but as a rule all internats are staffed by both health professionals (doctors and nurses) and social care workers. In 2019, TCSS employed 20,903 social workers and, according to the Ministry of Labor and Social Protection data, had 11,489 full-time positions for home care services and 1,316 full-time positions for nursing home care services.

**NGOs, too, contribute to the workforce needed to meet LTC needs.** According to information provided by the Belarusian Red Cross Society, as of January 1, 2019, the human resources of the Red Cross's medical and social service "Dapamoha" (nurses, younger nurses and other workers, with the exception of service managers) included 169 full-time positions spread across 217 employees. In Vitebsk *oblast*, this amounted to 22 positions across 23 employees, and in Grodno *oblast*, 24 positions across 36 employees.

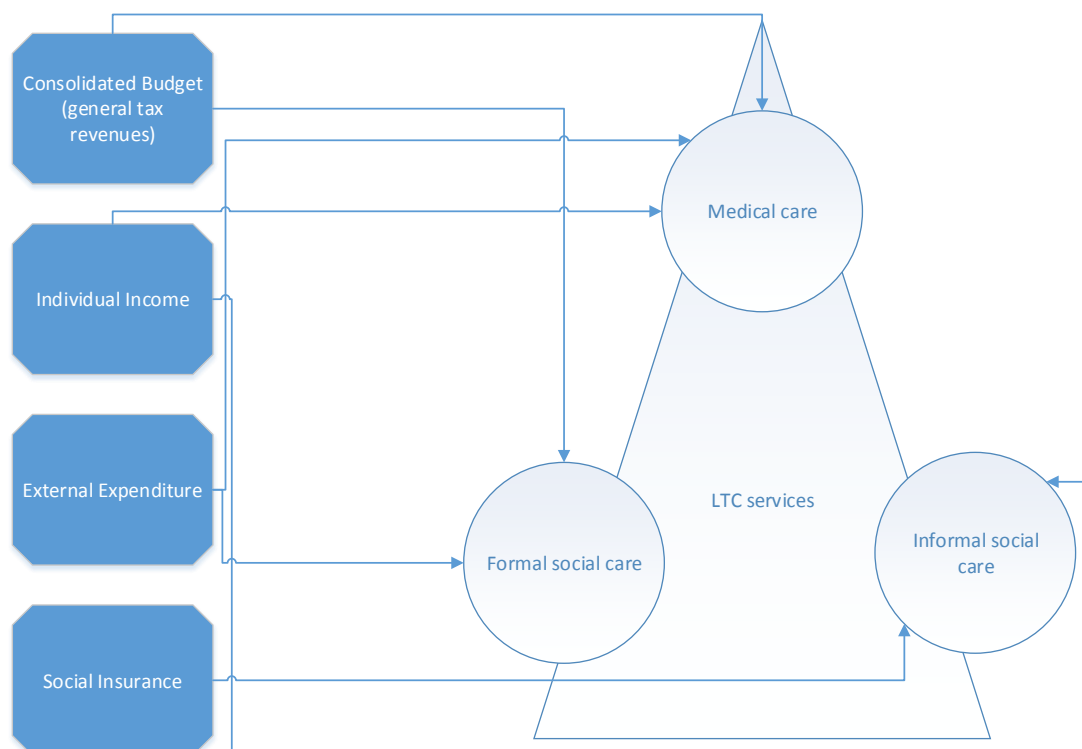


## 5. Financial structure of LTC-related systems in Belarus

### 5.1. Salient financial features of LTC provision at national and local level

In Belarus, the LTC expenditure financing scheme is part of healthcare and social protection financing. Figure 39 shows the flow of financial distribution related to LTC spending in the country.

Figure 39. Financial flows related to LTC services

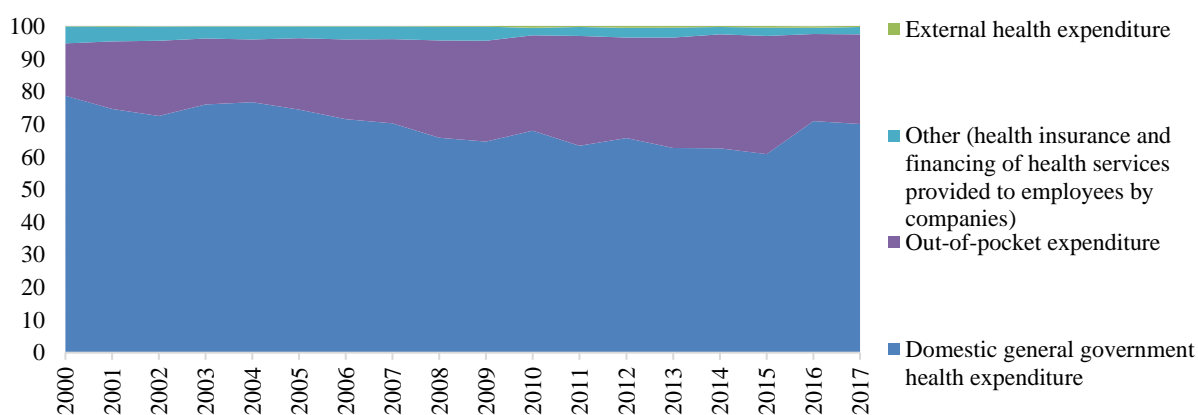


Source: World Bank

### 5.2. Total national expenditure on health

In 2019, the total health expenditure was an estimated 6% of GDP. Health expenditures are financed from four sources: 1) government; 2) out-of-pocket (OOP) contributions from households; 3) financing of health services provided to employees by large SOEs; and 4) external health expenditures (for example international organizations) (Figure 40).

Figure 40. Health expenditure in Belarus

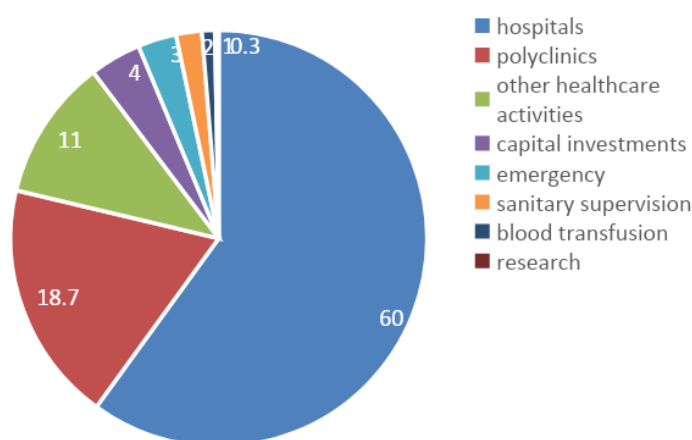


Source: WHO, Global Health Observatory data (2017).

**In 2019, 15.3% of the consolidated budget expenditure was allocated to healthcare (BYN 5, 500,7 million).** Healthcare financing in Belarus has been decentralized to the local level, with the result that more than 80% of health spending was financed from local budgets (BYN 4,500 million). Local governments (*raion* authorities) act as third-party payers for primary and secondary healthcare services for their designated populations. The central government acts as the third-party payer for specialized tertiary care and vertical programs for the entire population.<sup>44</sup> Healthcare expenditures are financed from revenues of the central and local budgets, and central government expenditures within government programs are administrated by the Ministry of Health. The allocation of funds from the central budget is determined jointly by the Ministry of Health and the Ministry of Finance, while local healthcare budgets are coordinated by the Ministry of Health and regions' executive committees.

Hospitals and inpatient care dominate public health spending. Belarus allocates more than half of its total health expenditure to general and specialized hospitals (Figure 41).

Figure 41. Government health spending distribution, 2019



Source: MoF, Belarus.

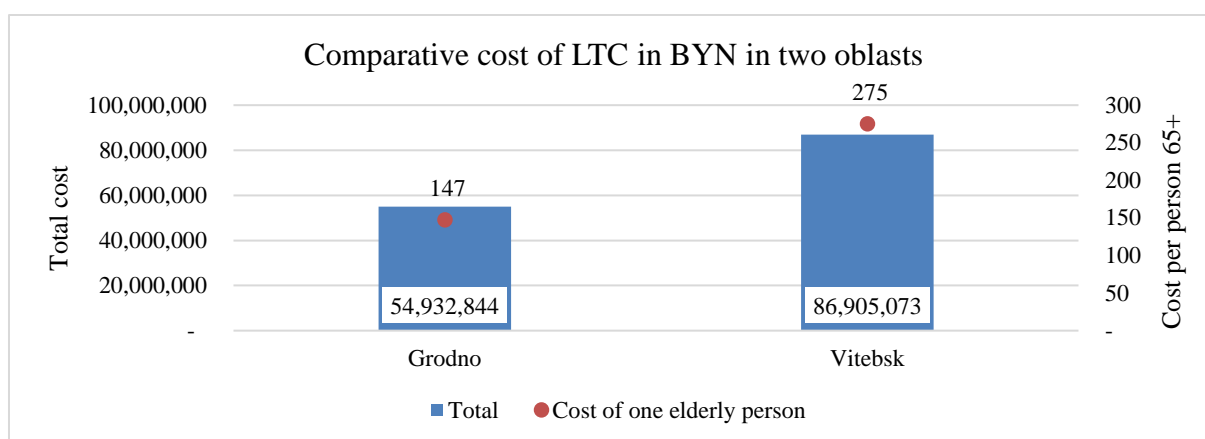
**In 2019, the planned budget allocation for nursing hospitals was 51,371,796 BYN.** Polyclinics are the main providers of outpatient care, while home-based services remain underdeveloped. Hospitals' and polyclinics' spending include spending on nursing and palliative care, which could rather be funded from the LTC medical services' budget.

**All public healthcare providers are public health organizations subject to inputs-based financing.** Under the current system of financing, the level of financing of healthcare providers is based on their previous year's expenditures on labor, non-labor recurrent inputs, and capital, adjusted for price changes and other variables that impact the budgeting process.

**In Vitebsk and Grodno oblasts the cost of providing some form of LTC in both the health and social sectors differs quite significantly.** In Vitebsk oblast the average spend on an elderly person is 275 BYN while in Grodno oblast it is 147 BYN (Figure 42).

<sup>44</sup> Richardson, E., Malakhova, I., Novik, I. and Famenka, A. (2013). "[Belarus health system review](#)" in *Health Systems in Transition*, Vol. 15, No. 5, European Observatory of Health Systems and Policies.

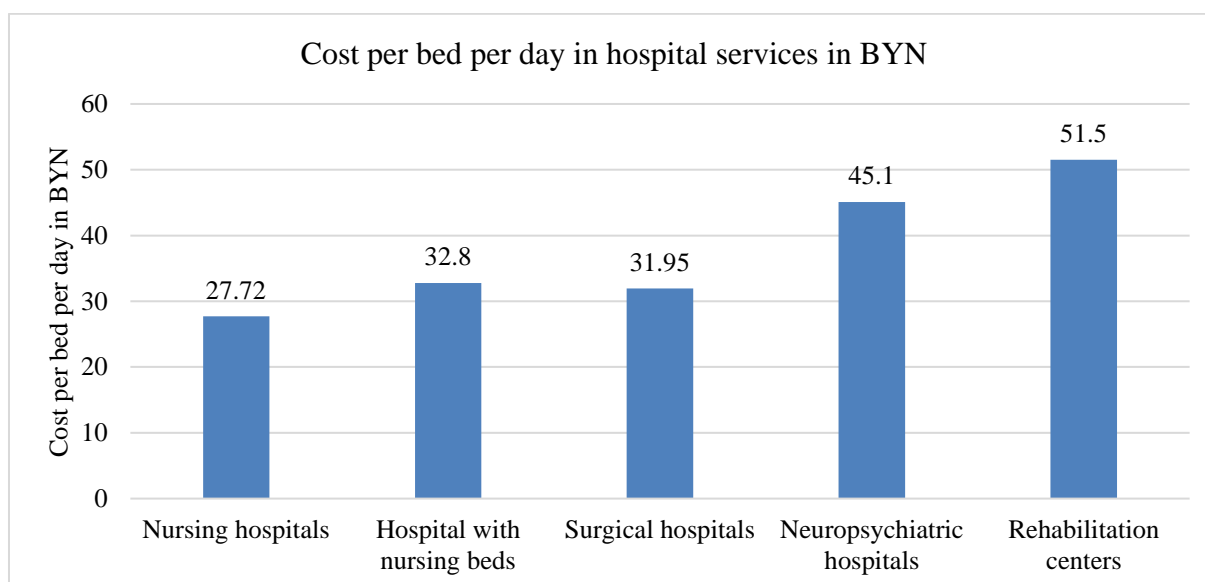
Figure 42. The costs of LTC per person 65+ in Vitebsk and Grodno oblasts, 2018<sup>45</sup>



Source: WB calculations based on data from MOF and oblast authorities.

When considering the cost of elderly inpatient care for Grodno oblast (the only oblast with data available), it seems that rehabilitation centers are the most costly. In fact, calculated as cost per bed, they are twice as costly as nursing hospitals probably due to the higher staff costs (Figure 43).

Figure 43. Cost per bed in hospital services



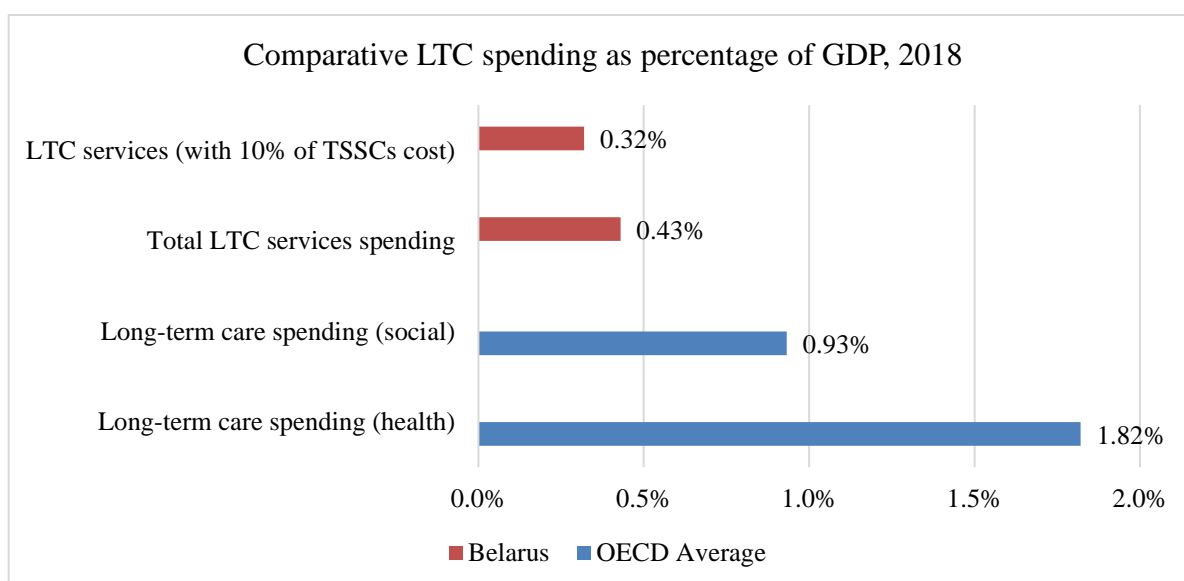
Source: WB calculations based on data from MoF and Grodno oblast healthcare department.

### 5.3. LTC expenditures

**In 2018, the total LTC expenditure in both health and social sectors amounted to 0.43% of GDP for all age groups.** This figure is somewhat misleading because it is based on a calculation of expenditure that includes the total cost of TCSS, the cost of which can only be partly attributed to LTC. In fact, expert estimates suggest that only 10–50% of TCSS expenditures can be directly related to some form of LTC support.. Consequently, when assuming the 2018 LTC expenditures in Belarus to include only 10% of the costs associated with TCSS, the percentage of GDP spent on LTC drops to 0.32% compared to the OECD average of 2.75% of GDP (Figure 44).

<sup>45</sup> Included in this cost are the following items: 1) nursing beds in hospitals (nursing and general); 2) internats for the elderly and persons with disabilities; 3) TCSS; 4) social services in foster families; and 5) attendance allowance (care for a person 80+ or with Group 1 disability). In calculating the cost, the following distribution of the elderly was applied: 10% to TCSS; 72% to foster families, and 34% to boarding houses.

Figure 44. LTC spending as percentage of GDP in 2018: Belarus and OECD countries<sup>46</sup>



Sources: WB analyses based on OECD, MoH, MoF, and MoL data.

**The structure of the budget dedicated to LTC social services is not available.** These expenses form part of spending on social policy. In 2019, total government spending on social policy in Belarus was 2.2% of GDP. The main sources of financing related to LTC social services are the consolidated budget and the Social Protection Fund (SPF). The Law on Social Protection (2011) defines the following expenditure lines that cover LTC: 1) institutional care; 2) financing of caregiver assistance; and 3) day care services. Additionally, social services are funded by individuals (the so-called “out-of-pocket expenditure” by households).

**Institutional, inpatient care includes internats for the elderly and persons with disabilities and substitute family care.** Caregiver assistance is financed through state social procurement, that is, through payments to organizations that provide the care workforce, while the attendance allowance (to individuals who care for a person 80+ or someone with Group 1 disability) is financed from the Pension Fund of Belarus and the Social Protection Fund. Day care services include services provided to the elderly via local centers of social services, temporary internats for the elderly, official home support, home care, residential care, etc. All forms of informal care are funded by personal income.

**Based on data provided by the Ministry of Finance, it is estimated that in 2019 total social expenditures on LTC were c. BYN 0.5 billion, out of which BYN 0.3 billion can be attributed to elderly care** (Table 17). This translates into BYN 134 (or 52 USD) per capita for individuals 60+ or BYN 134,000 per 1,000 of the population 60+. The way in which social policy, including LTC social services, is funded, is similar to the way in which healthcare services are financed. Local governments (at *raion* level) pay for all day services and institutional care for the domestic population, while the central government funds institutional care and “vertical” programs for the population as a whole. The financing of caregiver assistance is divided between local and central budgets (SPF). Figure 17 shows the distribution of LTC social services for the period 2017–2019. Information related to expenditures of

<sup>46</sup> LTC spending in Belarus is defined as the total spending on: 1) internats for the elderly and disabled; 2) internats for disabled children; 3) TCSS; 4) state social contract funding; 5) expenses related to social services in a substitute family; 6) expenses for the provision of social services on the basis of life-long maintenance contracts; 7) allowance for the care of a person 80+ or who has a Group 1 disability; 8) allowance for the care of a disabled child under the age of 18; and 9) expenditure on nursing and palliative care. In the OECD definition, LTC (health) expenditure consists of spending on a range of medical and personal care services that are consumed with the primary goal of alleviating pain and suffering and reducing or managing the deterioration in health status in patients with a degree of long-term dependency. LTC spending (social) comprises the expenditure on lower-level social care services to assist with instrumental activities of daily living (such as home-help, meals on wheels, transport and day centers, etc.).

TCSS was provided by the Ministry of Finance, but, given the lack of a detailed breakdown, specific LTC costs related to the elderly care could not be distinguished. Two main sources of financing are general tax revenues and social insurance.

Table 17. Funds distributions of LTC social services financing (BYN)

Main budget lines	Sources of financing	2017	2018	2019
Internats for the elderly and persons with disabilities	central budget, and local budgets	128,014,150.15	149,550,563.35	169,957,035.44
Internats for disabled children	local budgets	19,237,061.75	19,641,320.06	22,001,433.78
Territorial Centers for Social Services (total expenditure) <sup>47</sup>	local budgets	122,602,130.21	146,135,181.83	169,027,494.41
State social procurement financing	local budgets	416,866.50	626,018.08	858,916.56
Expenditures related to foster family care	local budgets	NA	NA	121 215.29
Funding of life maintenance contracts	Minsk local budget	2,1533.28	18,959.87	22,034.45
Attendance allowance (care for a person with Group 1 disability or 80+ age-old person)	Social Protection Fund (2017–2018) with subvention from the central budget (2019)	92,241,612.16	96,067,969.73	97,791,954.18
Attendance allowance (care for disabled child under the age of 18)	Social Protection Fund (2017–2018) with subvention from the central budget (2019)	43,822,917.53	56,775,408.10	54,189,753.33
<b>Total</b>		406,358,288.58	468,815,421.02	513,969,837.44

Source: MoF, Belarus.

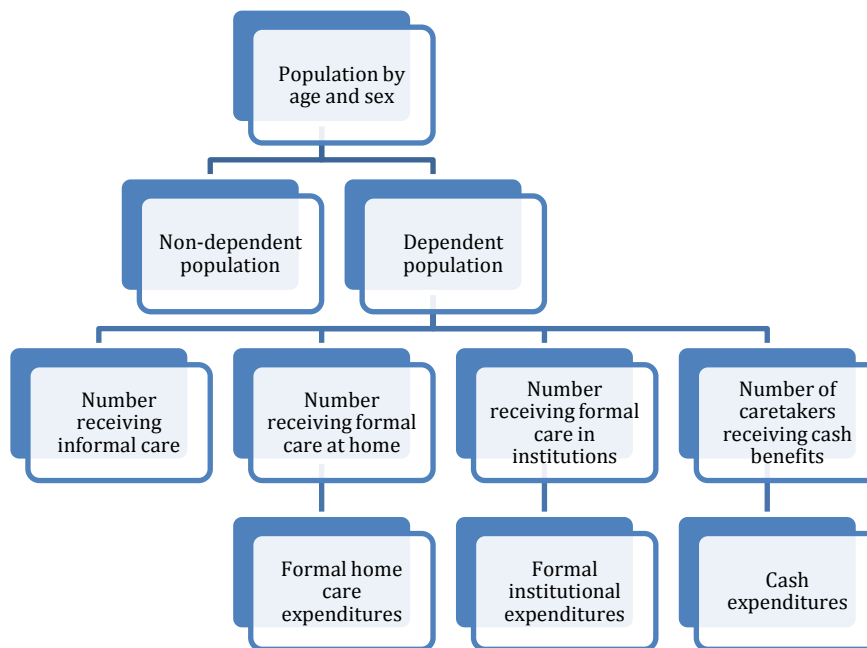
<sup>47</sup> Expenditures on local Social Service Centers related to LTC provision were estimated at 10% of their total volume (expert estimate). This estimate was used in Figure 47.

## 5.4 LTC modeling estimates

**It is as important not only to consider the present costs of LTC but also to project those costs into the future.** Even if the current program remains unchanged, the combination of population aging and inflation will have a significant impact on the fiscal sustainability of Belarus’s LTC programs. Although healthcare and pension costs are also sensitive to population aging, LTC costs are even more sensitive since these services are primarily provided to those aged 70+ and even higher costs are incurred for people who are 80+. In most countries, including Belarus, the latter is the fastest growing segment of the population. Establishing baseline costs for present programs is important in order to be able to measure the potential impact of changes to the eligibility criteria and benefits provided under Belarus’s LTC program.

This section of the report describes the methods and assumptions used to develop future baseline forecasts for Belarus’s current LTC program. The methodology follows the techniques used by the European Commission for the projection of LTC costs in “The 2018 ageing report: Economic and budgetary projections for the 28 EU member states (2016–2070)”. This report and the accompanying “The 2018 ageing report: Underlying assumptions and projection methodologies” provide valuable additional background information about the challenges involved in measuring and projecting the costs of LTC. The resulting sequence of steps used to estimate the cost of LTC in Belarus are shown in Figure 45.

Figure 45. Modeling steps



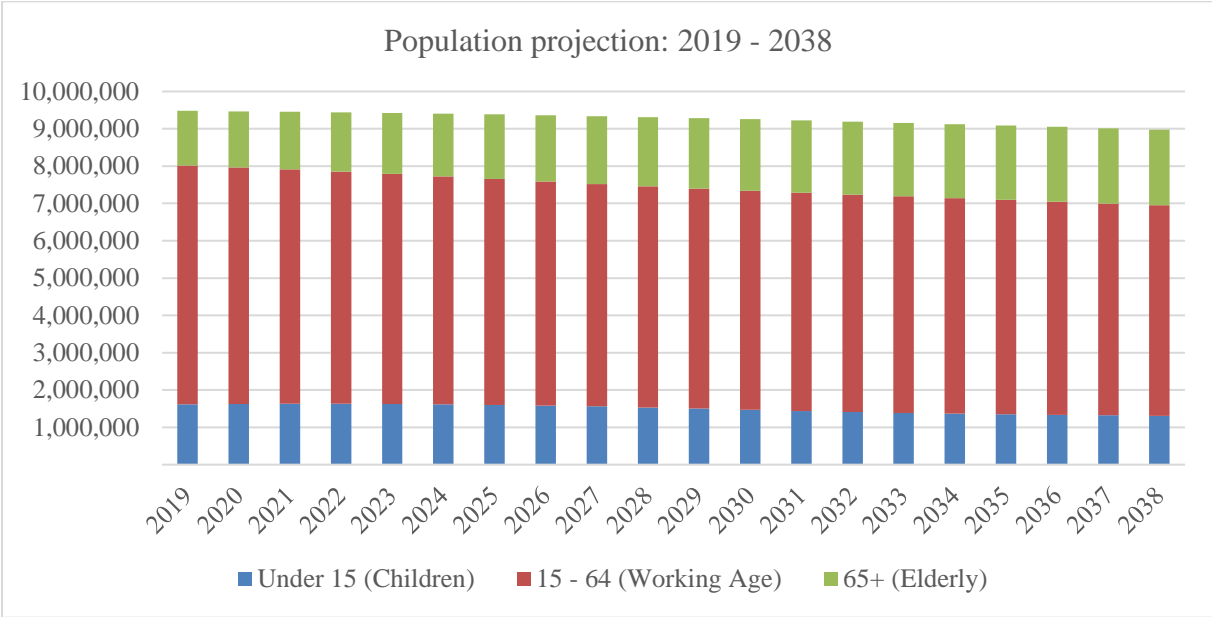
Source: WB, based on a diagram from the EC’s “The 2018 ageing report”.

First, population projections by age and sex were prepared. The population was then split into two groups—those that need LTC services (the dependent population), and those that do not (the non-dependent population). After that, administrative data were used to determine the number of people who currently receive in-kind or cash LTC benefits from government programs. Ideally, separate information by age and sex should be available for home care, and for different types of institutional care. All of this information would then be combined to project the total expected cost of LTC services for the elderly in local currency and expressed as a percent of GDP. The remainder of this chapter provides more detail on each of the steps followed in this report.

5.4.1 Population projections

**The starting point for any analysis of LTC costs is the preparation of population projections.** As with most countries in the world, the population of Belarus is rapidly aging due to a combination of lower fertility rates (which result in lower birth rates), and improved mortality (which increases life expectancy). In Belarus, the net emigration rate is an additional factor driving population aging. The current population of Belarus is an estimated 9.5 million and is expected to decrease to less than 9 million over the next 20 years. Figure 46 shows the total and projected population split between children (0–14), the working-age population (15–64), and the elderly (65+).

Figure 46. Population projections



Source: WB calculations based on Belstat data.

These projections show that over the next 20 years the proportion of the population that consists of children and working-age people will shrink, while the proportion of elderly people will grow. Presently, the elderly constitutes 15.5% of the total population, which is expected to increase to 22.6% by 2038.

5.4.2 Number of dependents

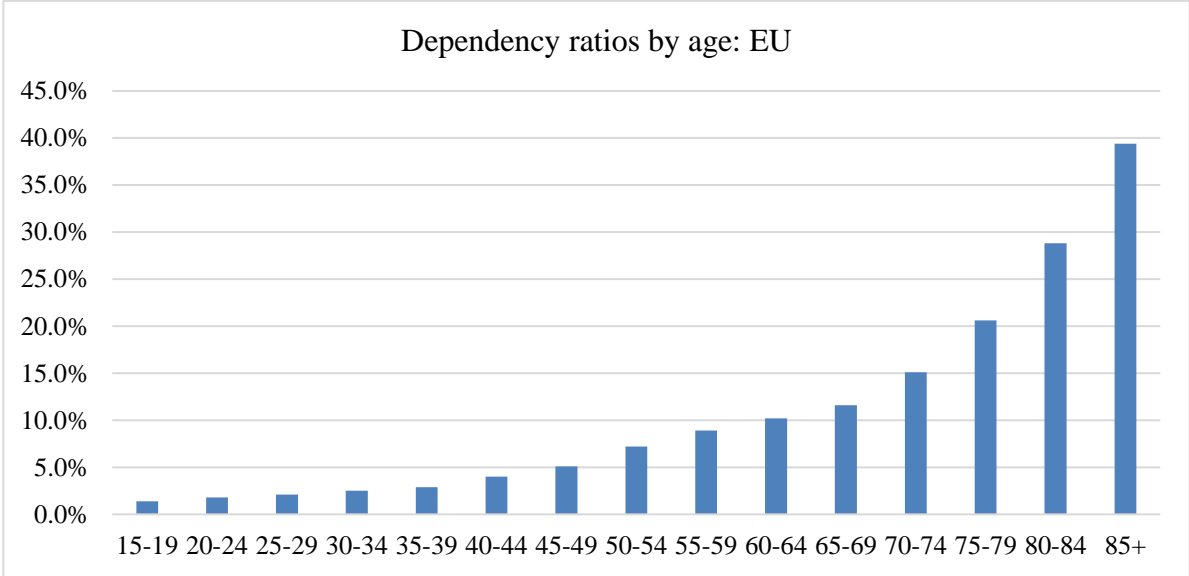
**The number of dependents is equal to the total population multiplied by dependency rates.** Perhaps the most difficult aspect of preparing LTC projections is determining the dependency rate. That rate should be equal to the percentage of the population (by age and sex) that needs LTC services, regardless of whether those services are provided by the government, family or through private sector institutions. It also depends on the definition of dependency used and the quality of the data available on those who need LTC services.

**In Belarus, only a small proportion of the population who are in need receives LTC services from the government. However, a much greater percent of the elderly (those 65+) receive government LTC services.** For the most part, LTC services are provided by family and friends. In fact, as mentioned in section 3.3.2 above, family members are required by law to care for their elderly. As a result, it is mostly the poor, the vulnerable, those who are considered to be severely disabled, and those without family who receive care services from the state. Given the limited range of services available in Belarus, statistics on those who require assistance with activities of daily living (ADL) are the most appropriate measure of those who are dependent. However, since this data is not readily available in Belarus, the ratios of dependency from the European Union were used. Those ratios are based on the EU-SILC survey of citizens who consider themselves severely disabled (which, per definition, means that they



require assistance with one or more ADL). The dependency ratios for the entire EU were compared with the ratios applicable to the three newest member states, that is, Bulgaria, Romania, and Croatia, and very little difference in dependency ratios was found. Consequently, the general dependency ratios for the EU as a whole were used to estimate the number of Belarusians who theoretically require LTC services. Figure 47 shows the dependency ratios by age from EU data.

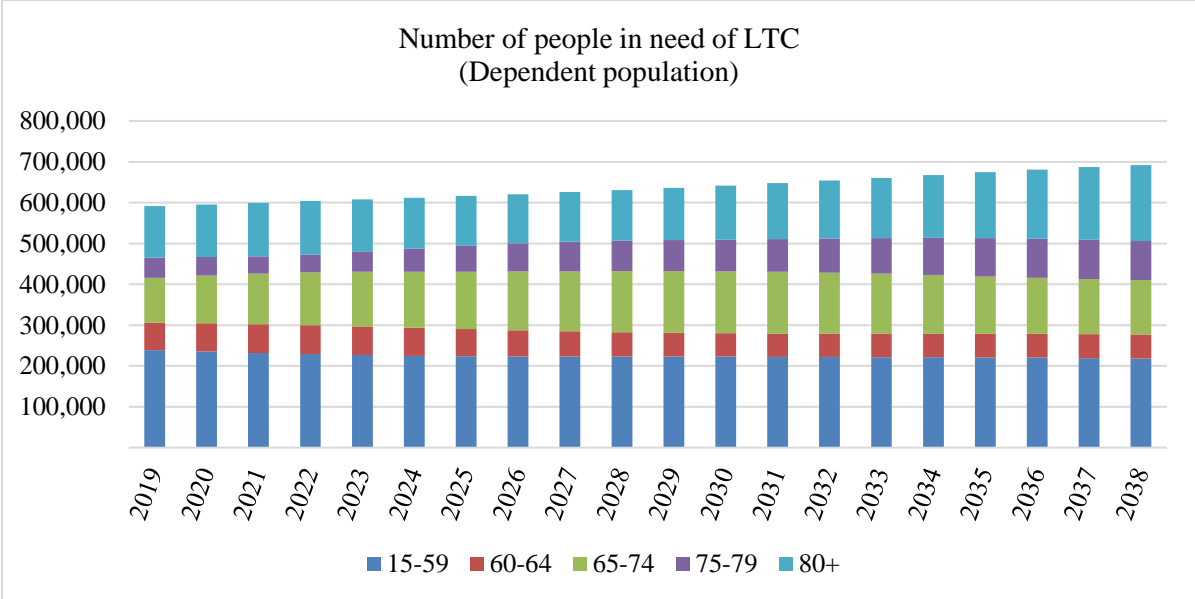
Figure 47. LTC dependency rates: EU



Source: EU, “The 2018 aging report”.

**Dependency ratios increase very sharply with age, particularly after age 70.** This suggests that the number of Belarusian citizens who will need LTC services will rise very rapidly as the population ages. The analysis in this report indicates that the size of the dependent population will increase from an estimated 592,000 at present to more than 692,000 by 2038, as shown in Figure 48. Of these, the elderly (65+) at present number 286,000, which is expected to increase to 415,000 by 2038.

Figure 48. Dependent population size



Source: WB calculations based on Belstat and EU data.

Figure 52 also shows that the need for LTC services will grow the most for the older segments of the population, particularly those who are age 75+. This may require the state to become more responsible for providing LTC services in the future than they are at present.

5.4.3 Number of beneficiaries receiving state-sponsored LTC benefits in 2019.

Information on the number of people who receive LTC benefits from the state is based on administrative data provided by the Ministry of Labor and Social Affairs, and the Ministry of Health. Care provided under MoLSA’s programs include both benefits at home and institutional care (primarily in internats), while care provided under MoH programs include institutional care provided in nursing hospitals, and, where available, nursing beds in general hospitals.

Table 18 shows the 2019 prevalence rates for people who received formal and institutional care benefits. The prevalence rates are calculated by dividing the number of people receiving each type of LTC service in 2019 for each age group by the estimated size of the dependent population for each age group. These prevalence rates, were derived from administrative data on the number of recipients of LTC services provided by MoLSA and MoH and are assumed to remain unchanged throughout the 20-year projection period.

Table 18. Formal care recipients as a percent of the dependent population, 2019

	Percentage who received home care services	Percentage who received LTC in social care institutions	Percentage who received LTC care in nursing/general hospitals
15–59	2.8%	0.6%	1.6%
60–64	2.8%	0.6%	10.1%
65–69	28.3%	6.4%	10.1%
70–74	28.3%	6.4%	22.4%
75–79	55.8%	12.6%	22.4%
80–89	46.2%	10.5%	11.4%
90+	46.2%	10.5%	14.5%

Source: WB calculations based on data from the Ministries of Health and Labor, Belarus. <sup>48</sup>

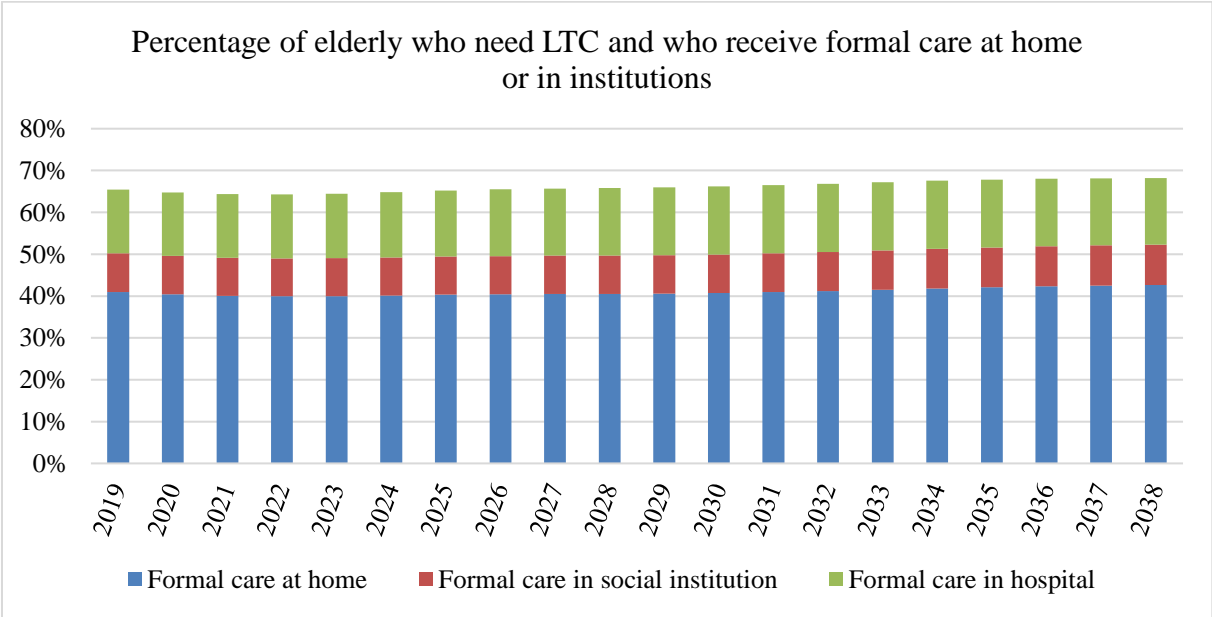
Data by age ranges were not consistently available for all categories. Data using one set of age ranges were available for home care services but only for 2019. Data by age range for care in social institutions were not available, so it was assumed to have the same shape by age as home care. This is unlikely to be true, but data by age was not available and no better assumption was possible. Data for care in nursing or general hospitals for a different set of age ranges were available for Vitebsk *oblast*, and for the purpose of this report were assumed to be similar for the whole of Belarus. In future, it will be important for Belarus to capture accurate information on the distribution of services according to age and sex in order to allow for more accurate modeling of the impact of population aging on the cost of LTC.

Although the percentage of dependents by age group who are expected to receive formal care benefits (home and institutional) is assumed to remain the same, the number of individuals who are expected to receive care will increase because of the aging population. Figure 49. Dependents receiving formal care shows the number of people in all age groups who are presently receiving formal home or institutional

<sup>48</sup> The rates in Table 20 are a percent of the dependent population, not the entire population, and are applied to future estimates of the dependent population.

care, projected into the future. These figures were calculated by applying the above prevalence rates to the number of people requiring LTC by age.

Figure 49. Dependents receiving formal care

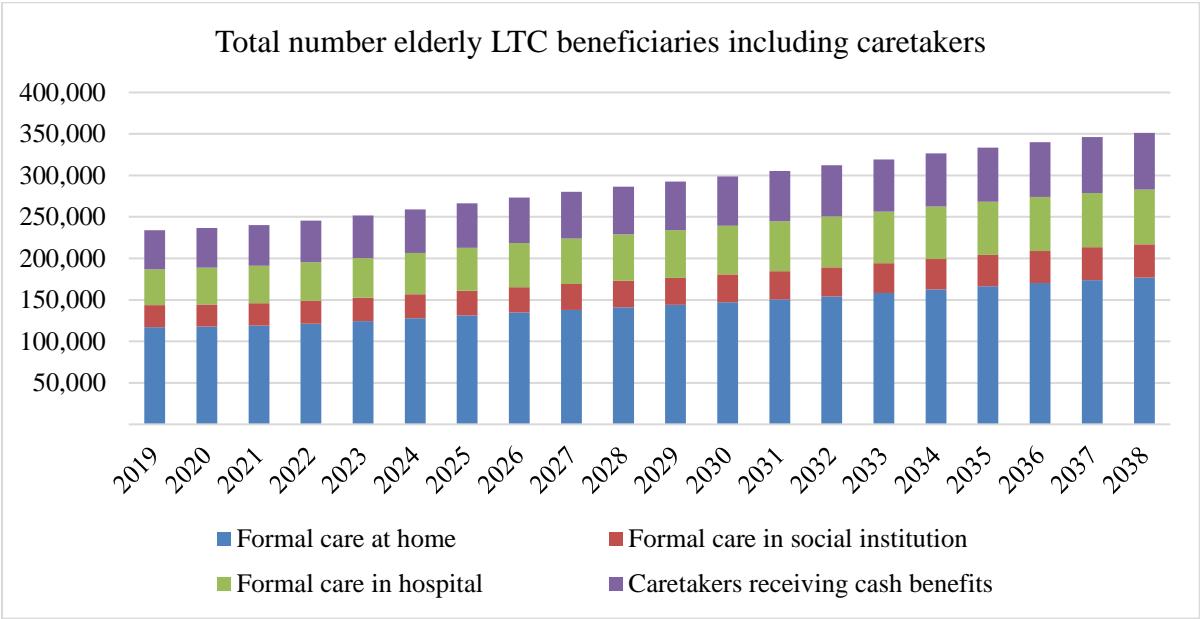


Source: WB calculations based on data from the Ministries of Health and Labor, Belarus.

**Figure 53 shows that most formal LTC services for the elderly (65+) are provided at home, and that more institutional care is provided by hospitals than by social homes.** At present, more than 65.5% of all elderly dependents receive LTC attributed services through state-sponsored programs. By 2038, this number is expected to increase to 68.2% of all dependents—primarily due to population aging. The remainder of those in need of LTC services receive informal care, that is, care provided by family and friends at their own expense. The percent receiving informal care is far higher for those under age 65 than it is for the elderly.

**At present, nearly 187,000 elderly individuals receive in-kind benefits another 47,000 caretakers receive cash benefits to care for them, and these numbers are expected to increase to 283,000 and 68,000 respectively by 2038.** In addition to those in need of LTC services, payments are made by the Pension Fund of Belarus to caretakers of individuals aged 80+ and those with Group 1 disabilities. Figure 50 shows the total number of beneficiaries of LTC benefits, including in-kind benefits provided at home or in institutions as well as benefits paid out in cash to caretakers. Note that the caretakers themselves may be younger than 65, but they are mostly caring for individuals who are 65 and above.

Figure 50. Total number of LTC beneficiaries



Source: WB calculations based on data provided by the Ministries of Health and Labor, Belarus.

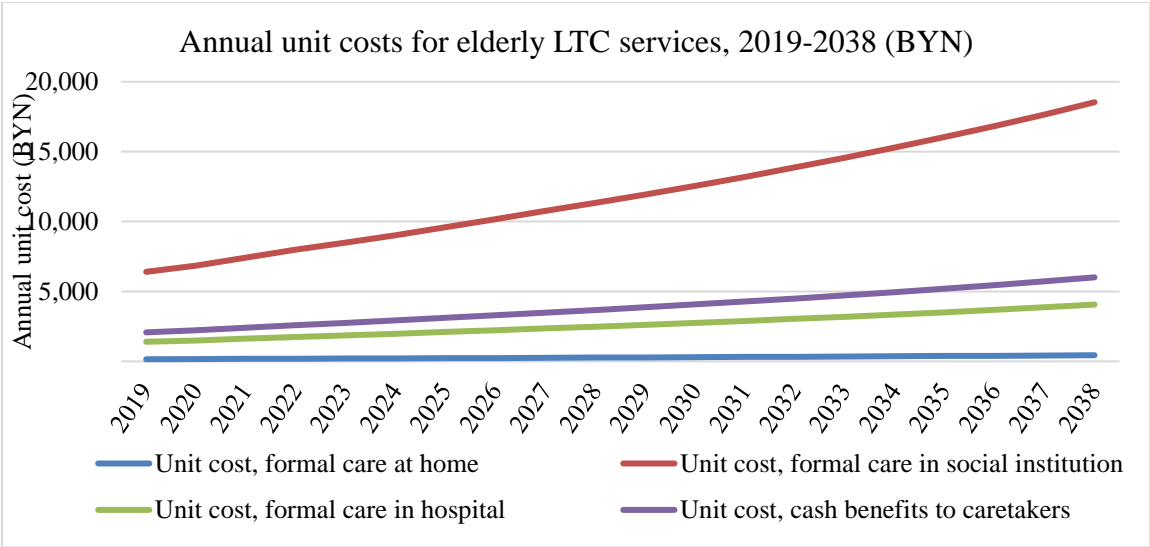
5.4.4 Expenditure of funds on LTC services for the elderly

Once the number of people expected to receive benefits is known, the cost of those benefits per beneficiary must be estimated, that is, the annual cost of providing one person with a nursing hospital bed, formal home care, or accommodation in an internat. Then unit cost is multiplied by the number of beneficiaries in order to arrive at an estimated total expenditure. For the purpose of this analysis, only the cost of LTC services for the elderly (65+) were taken into account, while the cost of benefits payable to those under the age of 65 were excluded.

For social services, regardless of whether they were provided at home or by institutions, these unit costs for the elderly were calculated by dividing the total annual expenditure on LTC for the elderly for a given category by the number of elderly individuals who received such benefits. Determining the unit cost of LTC in hospitals is more complicated than for home care or internats. While at the national level statistics on the total expenditure and bed- days (cost per bed-day) are available, these statistics do not translate directly into cost per person receiving care in a hospital. Because the model requires *unit costs per person*, data from individual *oblasts* were used to calculate the average length of stay so that costs per bed-day could be converted into cost per person. Cost per bed-day multiplied by average length of stay is equal to cost per person.

Figure 51 shows the annual unit costs for different types of LTC services for the elderly in Belarus in 2019 and projected 20 years into the future. These unit costs, for all categories of care are assumed to increase in the future by the same percentage as the increase in GDP per capita.

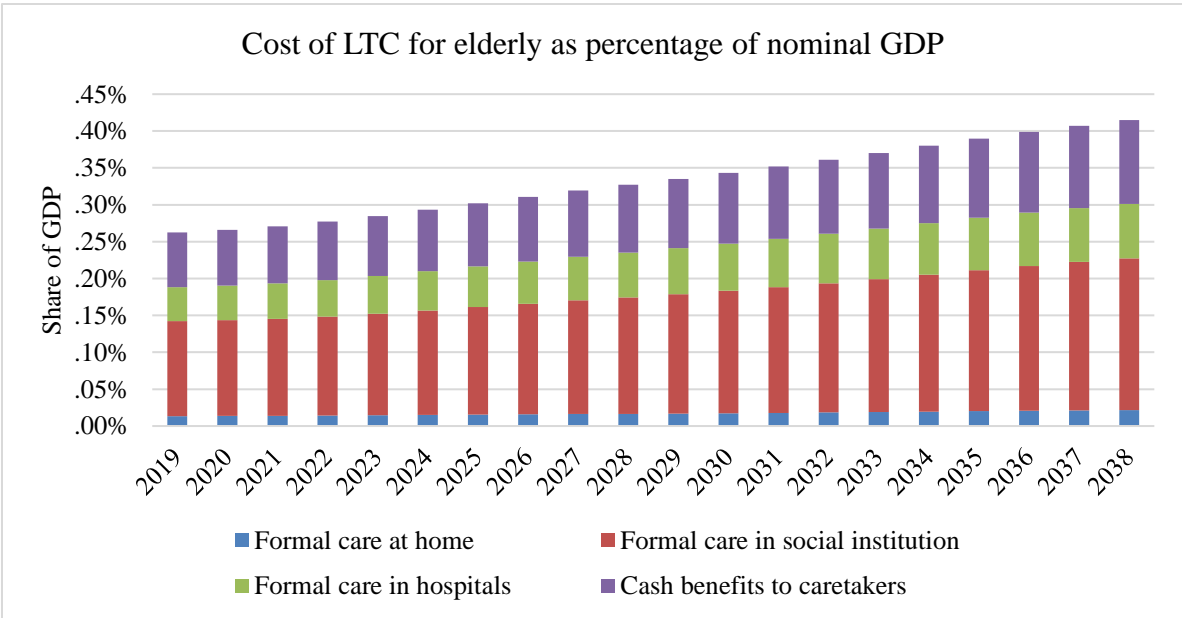
Figure 51. Unit cost of care



Source: WB calculations based on data provided by the Ministries of Health and Labor, Belarus.

These unit costs are then multiplied by the number of elderly individuals eligible for benefits in order to arrive at the estimated total cost (in local currency) for any year. After that, the total cost is divided by nominal GDP in order to express that cost as a percentage of GDP. Figure 52 shows the estimated costs of LTC for the elderly in Belarus as percentage of GDP, assuming that eligibility conditions and LTC plan design remain unchanged. This cost is expected to increase from 0.26% to 0.41%<sup>49</sup> of nominal GDP from 2019 to 2038.

Figure 52. Cost of LTC for the elderly as a percentage of GDP



Source: WB calculations based on data provided by the Ministries of Health and Labor, Belarus.

<sup>49</sup> Note that these numbers refer to the LTC cost solely for the elderly population

## 6. International examples of LTC systems

### 6.1. LTC strategies and governance: international examples

**LTC seems to be a neglected policy area in many countries.** That said, there have been three main trends with regard to different aspects of LTC reform in Europe: 1) a readjustment to the LTC policy mix which has seen a move away from institutional residential care towards home and community care; 2) efforts to enhance the financial sustainability of LTC systems; and 3) improvements in access to, and the affordability of, LTC, including improvements in the status accorded informal caregivers.<sup>50</sup> Where reforms have been undertaken, the emphases have been on the deinstitutionalization of care (Greece, Latvia, Lithuania, Belgium, and Poland); the development of national strategies and action plans on dementia (Denmark, Austria, Germany, Ireland, Malta, Greece, and the UK); and improving access to home care services (Germany, Greece, Sweden, Cyprus, and Malta). In most countries, the need to improve the quality of LTC was addressed by improving the training of the care workforce (Sweden, Denmark) and increasing wages in that sector (France, Luxembourg).

**In certain countries, some of the non-healthcare related responsibilities for LTC (including funding) have been decentralized to regions and municipalities.** In many countries, the important responsibilities of regions and municipalities for both (co-)funding and care provision have resulted in considerable regional/municipal differences in care provision, eligibility criteria, and out-of-pocket payments. In some countries, the decentralisation of competencies has made it possible to regroup some of the responsibilities previously strictly divided between the health and social sectors and to ensure a more integrated care system.<sup>51</sup>

**One of the indicators of country approach towards LTC is its financing. Western EU countries spend on average 1.6% of GDP on LTC compared to the 0.3% of Eastern European countries.** In some countries, the very low spending on and coverage of LTC services have resulted in reforms or the broadening of benefits packages covered by health insurance schemes.<sup>52</sup> These reforms included 1) securing the financing needed for future LTC expenditure; 2) controlling the demand for LTC services; and 3) controlling the cost of publicly provided LTC services and cash benefits.<sup>53</sup>

Despite significant differences in their broader political orientation, the most important values invoked to define LTC governance are quite similar across various countries. These values include equality of people regardless of their limitations; the importance of independence; affordability of care; solidarity with vulnerable fellow citizens; an accessible society; and a caring government that guarantees the quality of care that enables citizens to participate in society.<sup>54</sup>

In Scandinavia, large-scale institutional residential facilities have been phased out to a much larger extent than in other European countries. In addition, care for the elderly has been integrated into the local care system provided by municipalities. The resulting collective cost of care is, from an international perspective, high.<sup>55</sup>

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<sup>50</sup> European Commission (2018), “Challenges in long-term care in Europe: A study of national policies 2018”, <https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=9185>

<sup>51</sup> European Commission (2018), “Challenges in long-term care in Europe: A study of national policies 2018”, <https://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=9185>

<sup>52</sup> European Commission (2019), “Joint report on health care and long-term care systems and fiscal sustainability – Country documents 2019 update”, [https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update\\_en](https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update_en)

<sup>53</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>54</sup> Vilans (2019). “Long-term care in Scandinavia: Exploring insights for the Netherlands”, <https://www.vilans.org/app/uploads/2019/05/long-term-care-in-scandinavia.pdf>

<sup>55</sup> Vilans (2019), “Long-term care in Scandinavia: Exploring insights for the Netherlands”, <https://www.vilans.org/app/uploads/2019/05/long-term-care-in-scandinavia.pdf>

## 6.2. Service delivery: international examples

**The medical aspect of LTC services is by and large organized by national health systems, while more personal care is organized at regional level through social care systems or communities.** The manner in which these services are delivered depends on the specific care settings in a given country.<sup>56</sup> The scope of coverage (that is, the nature of needs and services that are financed) as well as the extent of that cover (the share of costs that is publicly financed) vary between LTC systems and are not related to whether the system is financed through social insurance or taxes. Regarding the scope of coverage, the cost of board and lodging is not usually covered by LTC systems (except in the case of means-tested social assistance). Board and lodging are not covered with LTC insurance in Germany and health insurance in Belgium, where these costs are paid for by the user. In Ireland, the cost of board and lodging is defined according to the income and assets of the user.<sup>57</sup>

**Traditionally, the institutional care provided to impaired elderly people resembled hospital care and was clinically oriented.** Many LTC institutions were built in the late 1970s and early 1980s and were designed to resemble hospitals—including, for instance, semi-private rooms (US, Poland). Over the past decade and more, however, the delivery of institutional LTC has been shifting towards the creation of a more home-like environment, such as that provided by nursing homes. Smaller facilities appear to have a number of benefits, such as improving motor functioning; the increased likelihood of making friends; reduced anxiety, sadness and depression; increased involvement in positive activities; and greater mobility.<sup>58</sup>

**In service delivery models, deinstitutionalization as a trend is more visible than other trends.** This is particularly true for countries that historically have had relatively high rates of institutionalized care for the elderly. In countries where the family has traditionally been the main provider of care for the elderly, for instance, countries in Southern and Eastern Europe or Korea, the rate of institutionalized elderly care has always been relatively low and in some countries may even be on the increase.<sup>59</sup> Additionally, over the past decade, the US has been shifting its Medicaid support to home- and community-based services because beneficiaries prefer these settings and because, considered on a per-patient basis, they are less expensive than institutionalized forms of care.<sup>60</sup>

**Documented experiences from a range of countries suggest that LTC services provided in patients' homes or communities (for example, day care centers) are preferable to institutional forms of care.** Home and community-based services allow patients to live in their own home, while also providing support to informal caregivers such as family members, friends, and neighbors. Surveys such as the Eurobarometer indicate that patients overwhelmingly prefer to receive care at home. LTC has to be patient centered, and, because it comprises social as well as health services, delivery is often extremely fragmented, to the detriment of the patient.<sup>61</sup>

**LTC can be provided in a multi-disciplinary setting that encompasses both health and social care services.** Innovations in service delivery are often implemented at the local level, with limited scale up approach<sup>62</sup>. People who have temporarily or permanently lost the ability to live independently, because they are elderly, frail or post-surgery, need services that range from simple home assistance to regular

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<sup>56</sup> European Commission (2019), “Joint report on health care and long-term care systems and fiscal sustainability – Country documents 2019 updates”, [https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update\\_en](https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update_en)

<sup>57</sup> Ricardo Rodrigues (2014), “Long-term Care – the problem of sustainable financing”, European Centre for Social Welfare Policy and Research.

<sup>58</sup> Alders, P., and Schut, F.T. (2019), “Trends in ageing and ageing-in-place and the future market for institutional care: Scenarios and policy implications”. *Health Economics, Policy and Law*, 14(1): 82–100.

<sup>59</sup> Alders, P., and Schut, F.T. (2019), “Trends in ageing and ageing-in-place and the future market for institutional care: Scenarios and policy implications”. *Health Economics, Policy and Law*, 14(1): 82–100.

<sup>60</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>61</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>62</sup> <https://ec.europa.eu/eip/ageing/repository.html>



medical monitoring and care. Services from the medical and social sectors complement and are dependent on each other, which is why LTC has to be provided by multi-disciplinary teams, consisting of members from both sectors.

**Some Asian countries are exceptional in the provision of multi-disciplinary LTC.** In China, four types of insurance care are available to the elderly: 1) home-based nursing care; 2) community-based care, which includes regular home visits; 3) residential or nursing care offered at designated facilities; and 4) acute hospital care provided at a tertiary hospital. Irrespective of the chosen type of care, all care providers are required to create a detailed care plan for each user—from assessment, referral, and monitoring their condition, to the provision of end-of-life care.<sup>63</sup>

**The provision of social care does not need to be exclusively managed by public entities. Social care services can be offered by other organizations, as long as they can provide cost-effective services that meet the needs of dependent people.** For instance, both Austria and Japan have a mixture of public and private care service providers, with services provided by municipalities and both for-profit and non-profit organizations that belong to the so-called intermediary sector, that is, social NGOs of different types.<sup>64</sup> In many countries, provinces have taken over responsibility for the provision of a share of social services. In Austria, for example, where a province fails to provide relevant services, it must ensure that other institutions, such as NGOs, can provide them to an appropriate standard of quality. As a result of this, the management and organization of social services differ significantly between provinces.<sup>65</sup>

**Poland and the UK provide cash benefits for older people.** In Poland, all citizens aged 75+ receive a monthly addition to their pension, while in the UK, an “attendance allowance” is intended to meet additional disability-related costs. There are no specifications or requirements that regulate how this money should be spent. The UK benefit applies to those who, while eligible for publicly funded LTC, choose to receive a cash personal budget instead of services in kind in order to employ their own caregiver (close co-resident relatives are usually excluded). Cash benefits (in Malta for example) may also be used to recruit a domestic worker or to pay the informal care provider. In UK, this benefit can be accessed through local authorities, using the same assessment and eligibility processes that apply to LTC services (including income test and co-payment requirements). Unlike the attendance allowance, the use of this personal care budget is closely monitored.

### 6.3. Financing: international examples

**Countries differ with regard to their level of LTC financing, funding sources, and purchasing modalities.** Whether LTC is financed through contributions, tax-financed systems, universal entitlements or safety nets, nearly all of these instruments rely on pay-as-you-go financing mechanisms, which are highly unsustainable in societies with an aging population. Modeling carried out for the Commission on Funding of Care and Support in England estimated that around a quarter of people aged 65 at the time would not need any LTC in their lifetime, while one in ten would have lifetime costs exceeding GBP 100,000.<sup>66</sup> Research from other countries has produced similar results. The large and uncertain costs associated with LTC are difficult for individuals to manage on their own or even with the assistance of their families.<sup>67</sup> Additionally, the growing demand for LTC will also put more pressure on national health and social systems.

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<sup>63</sup> Yuan C. 2013b. Long-term Nursing Insurance in Qingdao (in Chinese). Beijing: Development Research Centre of the State Council

<sup>64</sup> European Commission (2019), “Joint report on health care and long-term care systems and fiscal sustainability – Country documents 2019 update”, [https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update\\_en](https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update_en)

<sup>65</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>66</sup> On this, see the Dilnot report of the UK Commission on Funding of Care and Support, <https://webarchive.nationalarchives.gov.uk/20130221121534/http://www.dilnotcommission.dh.gov.uk/our-report/>

<sup>67</sup> Muir, T. (2017). “Measuring social protection for long-term care”, *OECD Health Working Papers*, No. 93, OECD Publishing, Paris, <http://dx.doi.org/10.1787/a411500a-en>

While Germany has a universal, contribution-based social LTC insurance system, it also uses its social assistance program to finance those LTC costs that are not covered by the income and/or assets of beneficiaries.<sup>68</sup> There is evidence that tax-financing, particularly when offered via social safety nets and infrastructure investments, is increasingly being used to finance LTC services. In Germany, which has social LTC insurance, 20% of the total LTC expenditure is financed through general taxation, while, in Austria, public LTC expenditure is almost entirely tax-financed—although the share of expenditure unrelated to cash benefits, such as social assistance and infrastructure investments, has increased significantly over the last few years.

**Due to the financial and capacity constraints of health and social systems, cost-shifting is a common phenomenon.** An example of such cost-shifting can be found in Poland as a result of its introduction of so-called LTC facilities (Zakład Opiekunczo Lecznicy or ZOL), which are equivalent to nursing homes in Belarus. Since these facilities in Poland are financed from the National Health Insurance Fund, municipalities, which finance social welfare homes (called internats in Belarus), are highly incentivized to refer as many dependent people as possible to them. At the same time, these social welfare homes introduced a system of co-payment for their services, which actively discourage clients to make use of their service as long as there is capacity available in free LTC hospitals in the healthcare system. Effectively, then, the introduction of LTC facilities in Poland led to cost-shifting between municipalities and the National Health Insurance Fund, to the detriment of patients who find themselves pushed back and forth between LTC hospitals and social welfare homes.<sup>69</sup>

**Flexibility in applying different financial mechanisms in LTC funding could be a double-edged sword.** A mixture of instruments—from means-testing to universal entitlements, from privately paid (insured) to tax and contribution-financed benefits, from defined contribution-type to non-defined contribution-type benefits—gives governments additional flexibility to adjust to the changing healthcare conditions of an aging society. From the client’s perspective, supplementary and complementary private LTC financing instruments, particularly LTC insurance, could serve those who are willing and able to pay more for better LTC services, such as better accommodation and services, which are as a rule excluded from standard coverage.<sup>54</sup> At the same time, in a time of crisis, it is often easier to refrain from additional LTC financing or from relying more on out-of-pocket payments to provide care to the elderly. Consequently, well-established institutional LTC systems with some independent from political changes, will and constrains financing, can provide some measure of security.

**In France, a small private insurance market for LTC provides supplementary LTC benefits.** The market for such private supplementary LTC services has been increasing by 15% annually. The benefits are clearly defined in cash terms and based on disability levels, which makes the handling of claims much easier than insurance products that are based on reimbursements of services (as in the UK or the US). In fact, the French system is modeled more on financial products—such as life insurance—than on health insurance products. Monthly premiums are leveled but not guaranteed and are offered either at individual or group rate. Dependency costs average in 2013 \$3,400 per month and \$4,760 in cases of “severe” dependency<sup>70</sup>. Eligibility for the benefit is based on total or partial irreversible loss of autonomy, for which the insurance pays an average lifetime annuity. In this way the uncertainty about future LTC costs is eliminated and the impact of other negative features that cripple private LTC in many other countries is reduced.

**Economic efficiency requires some form of risk pooling in order to enable people to protect themselves against the adverse financial impact of LTC needs.** Therefore, there is a need for the public sector to play a greater role in providing adequate instruments for pooling (old age) dependency

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<sup>68</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>69</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>70</sup> Le Bihan B, Martin C. Reforming long-term care policy in France: private-public complementarities. *Soc Policy Adm.* 2010;44(4):392-410.

risks. The most common forms of publicly provided risk pooling are contribution-financed social security, health benefits, and tax-financed benefits such as social safety nets. In the case of LTC, most countries use mechanisms to finance LTC expenditure. For example, in the USA, the contribution-financed, universal Medicare program provides limited LTC benefits for the elderly. Any LTC needs exceeding these limited benefits have to be paid for by the beneficiary. Where the beneficiary cannot afford these services, the tax-financed Medicaid program—a social safety net—provides at least a minimum level of LTC services. Austria has a tax-financed universal cash benefit that pays benefits based on dependency levels. Yet, these cash benefits are not sufficient to cover all formal LTC costs, in particular institutional care, and therefore the tax-financed social assistance program pays all costs for institutional care that cannot be covered by beneficiaries. Germany has a universal, contribution based social LTC insurance but also uses its social assistance program to pay for LTC costs that cannot be covered by the income and assets of beneficiaries.

**A specific financing model can also incentivize people to choose between different forms of care,** as in the case of Poland referred to earlier where the financial mechanism encourages people to use the healthcare system. In the absence of any system, family care (formal/informal) or formal institutional services seem to be the last resort. In most cases, elderly people prefer to be taken care of at home and will often accept a lower actuarial benefit if it means being able to remain at home.

**Social and cultural norms are key factors in care service delivery and there are advantages and disadvantages to all approaches.** In Germany, family members, who are considered more likely to be knowledgeable about and attuned to beneficiaries' needs and preferences, are provided with cash benefits in order to encourage informal caregiving. In recent years, these payments have amounted to more or less 50% of the value of service-only benefits, which has assisted the German system with containing costs. Japan has opted for the exact opposite model. Cash benefits are not provided at all, due to concern that informal caregivers (generally young wives) may be unduly burdened. Moreover, the country's long history of institutionalized elderly care during the pre-long-term care insurance (LTCI) period has made formal caregiving more acceptable in Japanese culture.<sup>71</sup> Typically, LTC services are purchased through health insurance funds, social funds, regional funds, municipalities, charities, and/or out-of-pocket payments.

With a growing elderly population, the combined costs of labor and new technologies make it more important than before to increase private savings for future LTC needs. This is not to say that the public sector should withdraw from financing LTC services but rather to underscore the fact that the costs associated with LTC services are catastrophically high and that individuals who lose their ability to live independently are increasingly at risk of being impoverished. For example, evidence from Austria suggests that the estimated income and assets of an average Austrian pensioner are adequate to finance only the equivalent of about four months' institutional LTC.

#### 6.4. Eligibility

**Although health system and social system eligibility criteria often differ from each other, in most countries the level of care provided in terms of public service provision is determined by a combination of the severity of disability and the nature of the financing system.** Countries assess the needs and vulnerability profiles of a patient or client in a variety of different ways. In Belgium, for instance, the level and nature of care is determined by an assessment tool premised on the Katz Activities of Daily Living scale and applies to both home and residential (internat) care. In Bulgaria, the determination is based on a needs assessment in combination with an individual support plan developed by a multi-disciplinary social service team,<sup>72</sup> while, in Poland, a geriatric assessment tool should theoretically be used to assess all 65+ hospitalized patients, although, due to financing and personnel

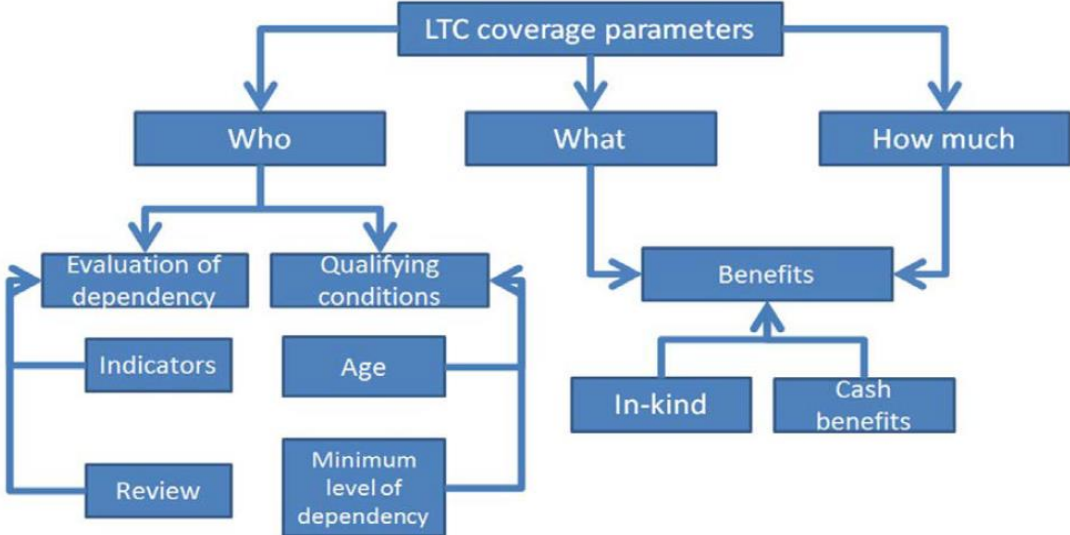
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<sup>71</sup> <https://www.sciencedirect-com.libproxy-wb.imf.org/science/article/pii/S016885101500161X>

<sup>72</sup> European Commission (2019), "Joint report on health care and long-term care systems and fiscal sustainability – Country documents 2019 update", [https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update\\_en](https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update_en)

constraints, the use of this tool has not become widespread. In the social system, LTC eligibility is mostly income-based (Figure 53).

Figure 53. LTC eligibility scheme



Source: The Joint Report on Health Care and Long-Term Care Systems and Fiscal Sustainability, prepared by the Commission Services (Directorate-General for Economic and Financial Affairs), and the Economic Policy Committee (Ageing Working Group), Volume 1 (2016).

The eligibility for LTC benefits and the question of whether access to these benefits is universal (that is, based on need only) or means tested, also depends on the country’s financing system. In insurance-based systems, the payment of premiums (or social contributions in the case of public systems) entitles beneficiaries to benefits in the event that they require LTC. As a result, these systems are usually universal for those who contribute to them. In tax-based systems, there is scope for either universal (Denmark, Spain, Austria) or means-tested access to benefits (Latvia, Croatia, Hungary).

**Some national LTC systems adjust the extent of coverage to the income of users.** In France, although eligibility for the APA (Allocation Personnalisée d’Autonomie) is based on need alone, the monthly amount is adjusted according to the income of the user and can vary between EUR 28.59 and EUR 1,312.67 per month (Service Public Française, 2014). In Spain, the LTC benefit also varies according to the income and assets of the user. In Austria, access to subsidized care falls short of the assessed hours of care, for example, someone who is assessed to need 120 hours of care per month is eligible only for a maximum of 60 hours of subsidized care in Lower Austria, which leaves a substantial part of the costs to be covered by the user. Finally, out-of-pocket costs may be levied not only on the user, but also on relatives.<sup>73</sup>

**In many countries, including Austria, no definition of “need of care” exists,** but eligibility requirements for cash allowances could be interpreted as a partial substitute for such a definition. In the absence of a definition, assessment of the need for LTC is instead based on individual requirements for personal services and assistance.<sup>74</sup> Therefore, in order to ensure that those in need of LTC receive the necessary scope of benefits, it is essential to present a strong needs assessment. In Austria, the minimum threshold for eligibility is 60 hours of care per month, and in Germany it is 1.5 hours per day (the monthly equivalent of 45 hours), while in Luxembourg it is 3.5 hours per week (the monthly equivalent

<sup>73</sup> Ricardo Rodrigues (2014), “Long-term Care – the problem of sustainable financing”, European Centre for Social Welfare Policy and Research.

<sup>74</sup> European Commission (2019), “Joint report on health care and long-term care systems and fiscal sustainability – Country documents 2019 update”, [https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update\\_en](https://ec.europa.eu/info/publications/joint-report-health-care-and-long-term-care-systems-and-fiscal-sustainability-country-documents-2019-update_en)

of approximately 15 hours). In addition, most countries apply a scale to LTC cash benefits, according to which higher benefits are granted to those with greater need.<sup>75</sup>

**In Japan, people 65+ are eligible for LTC insurance, while people aged 40–64 are covered by a health insurance system.** LTC insurance services are provided to people aged 65+ who, for whatever reason, require care or support, and to people aged 40–64 who have developed aging-related diseases such as terminal cancer or rheumatoid arthritis. Certification is done through an objective assessment that comprises a test consisting of 75 questions, followed by a healthcare expertise assessment, based on an interview with the client in addition to the home doctor’s opinion. The threshold is low, and few applicants fail—in fact, annually, 17% of the 65+ population qualified as eligible (which is far higher than the 11% in Germany’s somewhat comparable LTCI program). Formulated differently, although only 4% of “young-old” people (aged 65–74) were certified as eligible, over 30% of the true elderly (75+) qualified.

## 6.5 Quality

**Quality of LTC is something many countries still struggle with.** The organization of care (private and public), IT systems, and governance of the system are all factors that determine the nature (and quality) of quality control. While requirements vary substantially according to the type of care (residential or home care, for instance), the home care sector remains largely unregulated compared to the residential care system, which is governed by stricter regulations and has higher requirements of safety and quality control.

**The general purpose of LTC quality control is to determine whether the sector complies with the quality standards established by national authorities and those required by the person in need of care.** To this end, Austrian provinces, for example, are required to prepare demand and development plans, which must demonstrate familiarity with the applicable legal framework of the province, a structural analysis of socio-demographic data, the human resources required in the social sector, the minimum standards for provision of care, and development aims with cost assessments as well as an implementation plan.<sup>76</sup>

The number of quality indicators varies according to type of service provider and are grouped into five quality measurement domains, namely, management of institutions, environment and safety, rights and responsibilities, process of services, and outcome of services. Although the LTC quality evaluation system was initiated to improve the quality of care, there are still several limitations.<sup>77</sup>

**The most common approach to monitoring the quality of LTC in EU countries consists of using a predetermined set of standards and requirements** that mainly aims to regulate residential care facilities and nursing homes (and in very rare instances, home care services). EU countries alternately use an accreditation system, licenses, or a registration process, and minimum standards mostly refer to inputs related to employment (staff ratios and qualifications), infrastructure, and living environment.

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<sup>75</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>76</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

<sup>77</sup> World Bank (2010), “Long-term care and ageing: Case studies – Bulgaria, Croatia, Latvia and Poland”.

## 7. Recommendations for further development of LTC in Belarus

Given the current burden on families when it comes to care for their elderly, underdeveloped support systems for home-based and community-based LTC services as well as limited quality control and financing, there is a need to create a short-term action plan and a broad, long-term agenda, in which LTC will play a key role as one element in a system centered around the dignity of the elderly. Strategic approaches that are to be implemented over the next 7–10 years should be supported by a short-term (2–5 years) action plan. Aging support strategies should go beyond LTC since they also include issues related to healthy aging, fiscal or urban policy-making, health and social systems reform as well as e-services and IT. A comprehensive, long-term and ambitious Seven Steps Strategy towards LTC system development in Belarus would therefore include:

1. LTC aging policy, action plan and financing system development;
2. Enhanced care coordination for the elderly at the local level, including home-based care support;
3. Developing IT systems that support care provision, coordination and quality;
4. Strengthening telemedicine;
5. Skills development;
6. Strengthening the role of communities and NGOs in the provision of LTC; and
7. Promoting active and healthy aging.

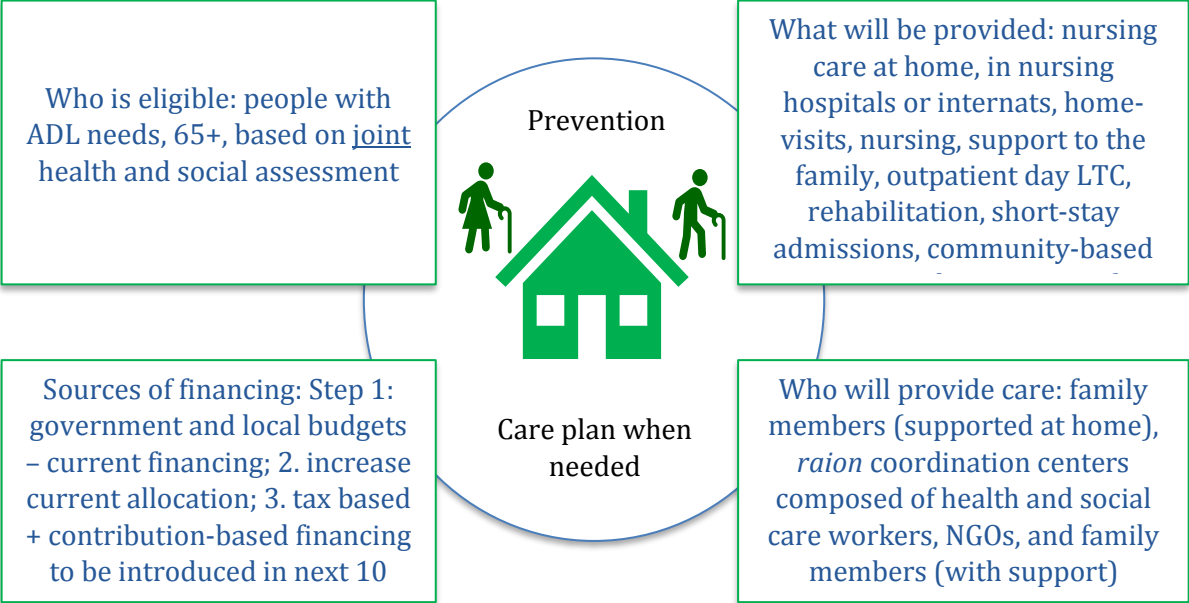
The short-term action plan for Belarus should focus on transforming and enhancing already existing solutions in order to match the growing needs of its aging population. Governance of LTC should be better coordinated between the ministries of Health, Labor, Social Protection and *oblast* authorities under a joint aging agenda. Current sources of financing should be enhanced and revised towards a tax and contribution-based system, and the scope of LTC services should be revised to focus on home-based service provision and day care. In order to achieve this, home teams and coordinating teams should be created to provide home care based on care plans. *Raion* authorities should coordinate the care provided and secure additional support when needed. Home and day care should be provided by medical and social workers, as is presently the case. However, based on the care plan, care would have a coordinator to support care plan implementation. Additional efforts should be made to enable private entities, such as NGOs, to contribute care provision at the local level. *Raion* authorities could delegate some of the services to NGOs but also transform currently existing facilities such as *raion* hospitals into day care or rehabilitation centers. A list of eligible services would include: nursing care at home and in nursing hospitals or internats; home visits; home-visit nursing; support for the family (training, leave, flexible work arrangements, cash benefits); outpatient long-term day care; rehabilitation; short-stay admissions; community-based services; night visits; and care for patients suffering from dementia. Eligibility criteria for all types of care, based on ADL assessment, should be revised in order to allow for transparent access and increased availability of services (Figure 54).

Given the current epidemiological situation related to COVID-19, nursing home and internat patients (older adults often with underlying chronic medical conditions) are at high risk of being affected by respiratory pathogens like COVID-19. Social isolation among older adults is an important public health concern because of their heightened risk of cardiovascular, autoimmune, neurocognitive, and mental health problems. Social disconnection puts older adults at greater risk of depression and anxiety. It is therefore vitally important to act in the area of prevention but also, to the extent possible, to act in providing home-based care support to protect both residents and healthcare personnel.



Figure 54. LTC model of care

Source: World Bank



The long-term, ambitious LTC strategy for implementation should include the transformation of health, social, fiscal, IT and urban development systems in order to match growing demands and challenges. In details, this would include:

1. LTC Aging policy, action plan, and financing system development

**The LTC and broader aging agenda should be prioritized by both government and oblast authorities, who should collaborate closely on the creation of a sustainable financing system.** For the first ten years of the strategy’s implementation a multi-sectoral approach is advised that will both build on the strengths of existing LTC provisions and further strengthen the systems that have been devised to provide support for the elderly. Substantial and sustainable financing that is dedicated to the development of policies regarding the elderly is advised.

The current system of LTC provision, including policy development, is scattered across the Ministry of Health and the Ministry of Labor and Social Protection. Given the limited resources available to health and social inpatient facilities and the burden placed on families, the provision and management of care for a growing number of elderly people cannot be sustained. A systemic approach is needed, which will clearly identify the reforms that are required in the health and social systems, the responsibilities and roles of all the stakeholders concerned, and the indicators that will be used to track the implementation of reforms. Based on already existing systems of care provision and the national strategy that was developed in 2019, a more ambitious financing and governance agenda is needed that will involve all key national and local stakeholders.

Health financing systems traditionally cover only the health and nursing costs associated with LTC, while social care or welfare services provide additional services required by the most disadvantaged section of the population (typically the poor and disabled). Joint financing that will enable and support care coordination, better care provision, and quality control on the *oblast* level should form part of a long-term reform plan. Comprehensive LTC entitlement financing should include nursing, personal, and domestic care. Depending on the availability of funds, cash benefits for families who act as caregivers should also be considered.

2. Enhancement of the care coordination for the elderly at the local level, including home-based care support.

**In order to provide better care for the elderly, the current scope of both health and social services as well as the service delivery model need to change.** A focus on outpatient services and home-based care is advised. At the same time, a high level of coordination between the health and social sectors is vital because it will not only ensure the delivery of effective, quality services for the elderly but also enable better access to care, while ensuring financial sustainability (through improved efficiency). Without such coordination, the care system will continue to be characterized by unnecessary re-admissions and the shifting of patients between sectors, which is not only expensive but also undermines patient satisfaction. The proposed approach includes:

- Progressively shifting away from institutional, particularly hospital-based, solutions to home-based LTC (including transforming the existing roles and responsibilities of some of the local hospitals). While institutional care is an important component of LTC systems, it is by its very nature a “high intensity” (that is, capital-intensive) solution. Home-based care, rehabilitation centers, day care, and outpatient care should be adjusted to support the elderly care agenda.
- Joint, *oblast*-level financing, which enhances care coordination on the local level, should be developed and the needs assessment and care of patients should be conducted at *raion* level through local strategies that should be revised every five years.
- While much coordination could be carried out by institutions at *oblast* level, some tasks (for example, system monitoring and quality control) could be retained by national-level institutions.
- Coordination could involve the establishment of a care coordinator at *raion* level, who would be responsible for organizing aspects of care provided by the health and social systems, and home support.
- Capacity building at the local level should be enhanced, especially with regard to various components of healthy aging, in order to improve the ability of *raions* to integrate older people socially through learning, cultural, and physical activities.
- A well-structured system of monitoring and evaluating the quality of services provided is needed in order to provide policy-makers at both national and local levels with the data necessary for evidence-based policy-making. An institutional assessment could assist in identifying precisely what set of incentives and what kind of monitoring would support the coordination and effectiveness of LTC provisions.

Once adjusted national level systems that emphasize equality of access and care have been put in place, an *oblast*-level service delivery model that includes the necessary support and financing can be implemented. Since Belarus has a strong and well-developed family care model, new and/or expanded care service delivery should build on this, in the process strengthening family and local community ties.

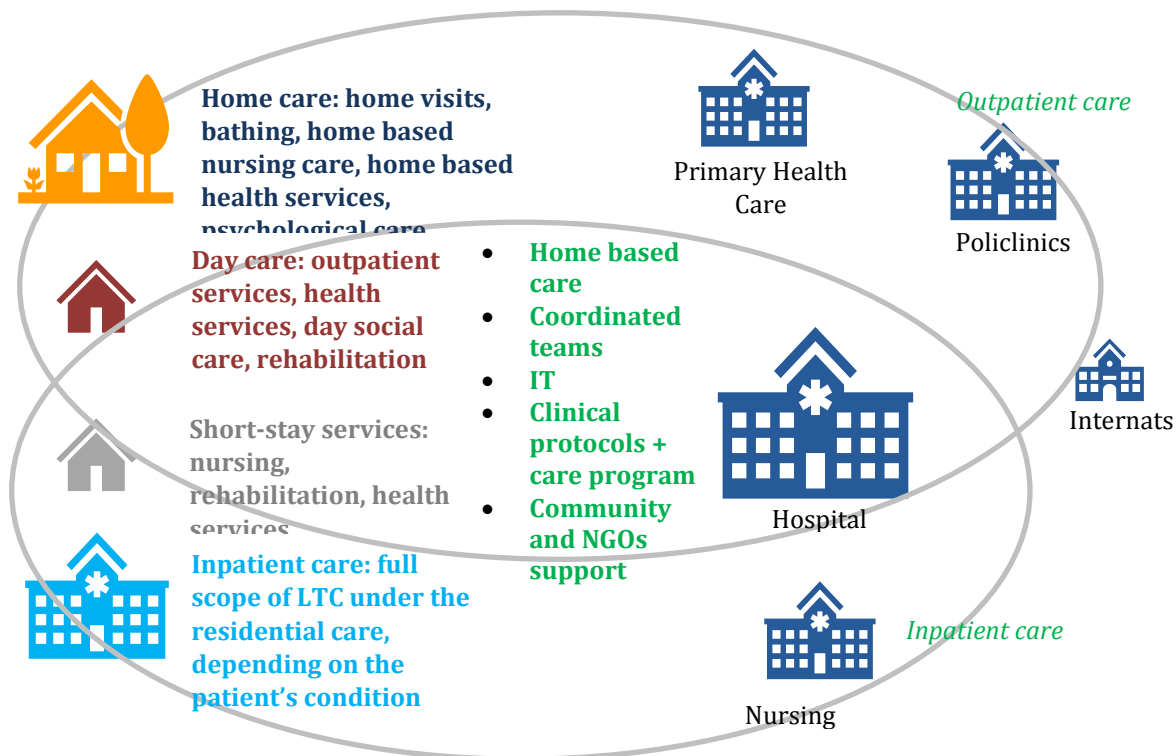
**The roles and responsibilities of service delivery systems and supporting care close to home should be readjusted.** One example of multi-disciplinary, deinstitutionalized care is “integrated home teams.” In order to address the fragmentation of services and provide family support, a multi-disciplinary assessment team, which will effectively coordinate care for patients and decide about a patient’s right to services is desirable. Such a multi-disciplinary assessment team should at a minimum: 1) include a medical doctor and a social worker; 2) assess a patient’s level of dependency in a transparent manner; and 3) make an independent recommendation of a patient’s needs for medical care, social care, and financial support. With regard to the latter, there should be a clear emphasis on outpatient, ambulatory medical care, and/or home-based or community-based social care.

Another example of multisectoral approach to the needs identified in Belarus is to provide heating support with energy efficacy measure in place. Strategic approach to the heating problem could include: (i) decrease the heating funding gaps should be addressed among the lowest income groups potentially through a combination of additional subsidies or low-interest loans; (ii) incentivizing renovations with higher energy savings or lower emissions; (iii) coal boilers program in place, and restrictions on solid fuel boilers be reinstated with easier to obtain forms from gas and district heating companies; and (iv)



technical standards to be developed to include, for example, insulation materials and thickness, installation methods, etc.

Figure 55. Integrated home teams



In order to enable the elderly to live independently and to keep them physically, mentally, and socially active for as long as possible (and thus prevent reliance on care services and social isolation), carefully considered prevention and rehabilitation strategies are of the utmost importance. This includes provision of immunizations, improving nutritional status, increasing physical fitness and mental and emotional well-being, access to good quality health services including risk factors screening or prevention aimed at limiting the duration or severity of health conditions. Prevention should start long before elderly age, in fact lifelong healthy habits, education and social status could play important role in supporting longer and healthier life. Health promotion for the elderly could therefore include:

- Promoting physical activity programs to reduce the risk of dementia, arthritis pain, and falls
- Helping those with dementia remain active, independent, and involved in their community as long as possible.
- Providing lifestyle change programs including quitting smoking, healthy diet, alcohol abuse treatment
- Providing resources to help caregivers stay healthy and deliver quality care to their care recipients.
- Increase early assessment and diagnosis, risk reduction, and prevention and management of chronic diseases for people with or at risk for Alzheimer's disease and other dementias.

### 3. Developing IT systems that support care provision, coordination and quality

**Information technology could be one of the pillars supporting coordination of care for the elderly.** Ensuring real time access to information about the patient would improve both the patient's safety and the quality of services and, at the same time, facilitate coordination between different institutions and forms of care, thereby improving continuity of care. Promotion of "aging in place." understood as ability

to life alone at home or assisted home for as long as possible should be supported. Remote communication and management of elderly care, including but not limited to telephone, e-mail, and monitoring parameters for assessing the state of health in home care settings could be introduced fairly quickly. Others may require substantial financing and country level engagement.

**Under the World Bank Project, there is e- health component strengthening Belarusian efforts towards efficient and patient’s friendly health system.** The objective of the e-health component of the Project is to establish an integrated nationwide health information system based on the available digital information and (b) develop a framework clinical decision-support system for quality improvement, which will ensure effective and up-to-date use of medical information for each citizen and consequently guarantee high-quality health and health care services to the society. This, in practice will mean implementation of series of complex tasks like:

- developing a Central Health Information System (CHIS) for medical data exchange, including document registry and archive;
- establishing robust and effective medical information exchange procedures and governance where responsibilities of every healthcare institution is clearly described and defined;
- updating currently used Electronic Medical Records (EMR) in hospitals and polyclinics and implementing new EMRs where needed to be able to create standardized medical documents and exchange standardized documents with CHIS;
- creating new centralized e-Health services (e-prescription, statistical module to analyze wide variety of quality indicators, etc.);
- developing healthcare data and data exchange standards; and
- carrying out of a review of the legal environment to ensure patient privacy and data security.
- civil works for rehabilitation of regional offices (oblast level) for housing IT-related infrastructure;
- advisory support for the design of the e-Health system, standardization of health care digital data and data exchange protocols, standardization and customization of business processes, implementation of digital decision-support tools based on clinical protocols, and improvement of laws, regulations, institutions, and instructions for health information protection;
- hardware and software, including upgrade of current EMRs
- training of health providers related to the e-Health system;
- the beneficiaries satisfaction survey; and
- study tours.
- identification of quality improvement priorities with a focus on PHC (chronic disease management, appointment access, adult health maintenance, and so on);
- selection of quality indicators, which includes identification of both high-level and micro-level indicators, creation of data collection templates, and design of data collection and data entry processes;
- development of practice tools (flow sheets, checklists, algorithms for best drug combination and treatment in a given situation, and so on) to help physicians and nurses implement evidence-based best practices; and
- embedding practice tools into an EMR.

#### 4. Strengthen telemedicine

A telemedicine program standardly includes a centrally managed, client-adjusted set of services, such as TeleTrauma, TeleRx, TeleStroke, TeleMental, TeleConsult and other interoperable<sup>78</sup> solutions for

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<sup>78</sup> Interoperable is understood as being compatible with other IT systems, supporting care and using industry interoperability standards.

exchanging information about a patient by entities operating in various procedures and at various levels of care.

Real-time knowledge about services provided to the 65+ population could result in better treatment plans and improved quality of care for the patient. Information about the following particular aspects of treatment, nursing, and rehabilitation could be made available digitally:

- All home visits and services;
- Type of medical, nursing and physiotherapy consultations;
- Information on hospitalization;
- Recurring diseases;
- Prescribed and administered medicines;
- The cost of services required and/or provided;
- Additional entities that provide services in remote areas;
- A database of persons who provide care or can volunteer and
- Outcomes of care and the measured level of satisfaction with services provided.

Combined, all this data could form an electronic patient record.

It is also worth considering the possibility of using new IT technologies preventatively to monitor the health indicators of beneficiaries and to assess their health risks. This would involve the use of IT technologies by patients in home settings in order to assist them in ADL and monitoring their activity. An example of such a tool is watches that monitor blood pressure, sleep, falls, etc. The implementation of such technologies would improve patient safety and direct interventions to circumstances in which they are necessary and, in the long term, lower the cost of treatment.

#### 5. Skills development

- Support for care providers should be developed in order to ease the burden currently borne mostly by women and to improve care quality provided both at home as well as in health and social facilities. This could include cash benefits, training, flexible work arrangements, and additional leave. The training of nurses and social workers who are dedicated to LTC and care for the elderly should also be improved.
- Adequate and similar wage arrangements for care personnel across the various sectors and locales should be considered. Valuing the LTC workforce and improving work conditions through, for instance, higher wages and improved working conditions, will increase retention rates – as has been demonstrated in Germany, the Netherlands, Sweden, and Norway.
- Better coordination and cooperation between, on the one hand, health and social systems and, on the other hand, family support structures will improve not only health outcomes but also increase personnel satisfaction. It would therefore be advisable to create a working environment at the *raion* level with a clearly articulated division of roles and responsibilities.

#### 6. Strengthen the role of communities and NGOs in the provision of LTC

Several actions could be taken that would not only increase the role of communities and NGOs in the provision of LTC but also contribute to community building:

- Dedicated funding for NGOs that provide LTC services at *raion* level;
- The creation of a space or an institutional arrangement in the community dedicated to the development of social inclusion measures that would simultaneously strengthen the local LTC system and prioritize the participation of older people in service planning and delivery;
- Strengthening the capacities of NGOs (including HR and volunteers); and
- Local-level support, such as making additional facilities available for use by NGOs.

#### 7. Promoting active and healthy aging

Healthy ageing is about creating the environments and opportunities that enable people to be and do what they value throughout their lives. Everybody can experience healthy ageing. Being free of disease or infirmity is not a requirement for healthy ageing, as many older adults have one or more health conditions that, when well controlled, have little influence on their wellbeing. WHO defines healthy ageing as “the process of developing and maintaining the functional ability that enables wellbeing in older age<sup>79</sup>.”

The complete implementation of key public health and healthcare strategies is required to promote active and healthy aging. Such strategies include the promotion of health; the establishment of prevention and rehabilitation services; the strengthening of gerontology and geriatric care sub-specialties in medicine in order to ensure that the health and LTC workforce are qualified to address the needs of an increasingly older population.

In order to promote healthy aging, cross-sectoral cooperation needs to be developed between the different levels and sectors of government administration, including the economic, financial, educational, and sport sectors. For example, tobacco and alcohol prevalence decrease, so important for the morbidity and mortality rates could be influenced by high tobacco and alcohol taxes. Sugar intake can be somehow regulated by healthy habits developed at home but also at school as well as sugar beverages availability and price both influenced by non-health sectors of government. Stronger cooperation between Ministry of Health, Finance, Education, Energy or Agriculture could bring visible results of shaping healthier life style amongst citizen and

Advantage should be taken of technologies that promote “aging in place” and new technologies supporting self-care. Good self-management in chronic diseases, with an accompanying support of professionals, can significantly improve the health of a patient, their quality of life, as well as decrease the frequency of disease exacerbation and hospitalization.

The self-management definition is proposed by the US Institute of Medicine and describes self-management as “the tasks that individuals must undertake to live well with one or more chronic conditions. These tasks include having the confidence to deal with medical management, role management, and emotional management of their conditions.”

Self-management support tools can take multiple forms, like group discussions and workshops, one-on-one sessions, behavioral counseling, motivational interviewing, application, manuals, protocols. Depending on the disease, its severity, health system organization and the level of community involvement, diverse types of self-management support can be implemented. Access to information about patients’ health ensures successful implementation of disease management and self-management programs. Therefore, it is crucial to involve IT systems and telemedicine in self-management support. Proactive and coordinated pharmaceutical care can also play a supporting role in the self-management programs. It can range from pharmacist cooperation with the medical team, implementation of IT tools used in case of polypharmacy to mobile applications with the information on drug therapy and drug interactions.

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<sup>79</sup> <https://www.who.int/westernpacific/news/q-a-detail/ageing-healthy-ageing-and-functional-ability>

## 8. Annexes

### 8.1. Regulatory legal acts in the area of social and medical care provision

*Resolution of the Ministry of Labor and Social Protection of the Republic of Belarus*, December 1, 2017, No. 84, “About the establishment of requirements with regard to the content and quality of social services rendered according to state minimum social standards.”

*Resolution of the Council of Ministers of the Republic of Belarus*, February 9, 2017, No. 112, “About rendering social services by public institutions of social service.”

*Resolution of the Council of Ministers of the Republic of Belarus*, February 19, 2013, No. 117, “About approval of the list of social services rendered by non-state non-profit organizations in the form of stationary social servicing and the state organizations (their structural divisions) in the territory of the Republic of Belarus are exempt from value added tax” (as amended on 05.08.2019).

*Order of the Ministry of Health of the Republic of Belarus*, December 30, 2017, No. 1336, “On the Organization of the Republican Gerontological Center.”

*Decree of the Board of the Ministry of Health of the Republic of Belarus*, April 20, 2011, No. 5.1, “On the state of medical support for war veterans and the elderly.”

*Order of the Ministry of Health of the Republic of Belarus*, September 15, 2017, No. 1046, “On approval of the regulation on the chief non-staff specialist of the Ministry of Health of the Republic of Belarus and on the composition of the main non-staff specialists of the Ministry of Health of the Republic of Belarus.”

*Order of the Ministry of Health of the Republic of Belarus*, November 27, 2017, No. 1348, “On approval of the action plan for the implementation in 2018 of the State Program on Social Protection and Promotion of Employment for 2016–2020.”

*Decree of the Ministry of Health of the Republic of Belarus*, December 31, 2013, No. 136, “On the approval of sanitary norms and rules as contained in ‘Requirements for Social Service Institutions Providing Stationary and Semi-Stationary Social Services.’”

*Order of the Ministry of Health of the Republic of Belarus*, May 26, 2014, No. 572, “On improving the provision of medical care for elderly patients.”

*Order of the Ministry of Health of the Republic of Belarus*, December 19, 2013, No. 1284, “On amendments to the Order of the Ministry of Health of the Republic of Belarus of August 8, 2006, No. 631.”

*Decree of the Board of the Ministry of Health of the Republic of Belarus*, April 25, 2009, No. 6.2, “On the state of medical support for veterans of war and other persons affected by their consequences.”

*Decree of the Council of Ministers of the Republic of Belarus*, December 11, 2007, No. 1722, “On the State Register of Technical Means of Social Rehabilitation and the procedure for providing such means to certain categories of citizens.”

*Decree of the Ministry of Health of the Republic of Belarus*, January 10, 2013, No. 3, “On certain issues pertaining to the organization of medical care and the provision of social services.”

*Decree of the Ministry of Labor and Social Protection and the Ministry of Health of the Republic of Belarus*, January 10, 2013, No. 3/4, “On the establishment of a list of indications and contraindications for the provision of social services.”

*Decree of the Ministry of Health of the Republic of Belarus*, December 24, 2014, No. 107, “On some issues pertaining to the organization of medical, social and palliative care.”

## 8.2. Demographic trends: Vitebsk oblast

Figure 56. Vitebsk oblast population

Total population, inhabitants (Census-2019 data)	1,135,731
Male	521,049
Female	614,682
Urban population, inhabitants	876,697
Percentage of total	77.2
Rural population, inhabitants	259,034
Percentage of total	22.8
Population density: people per square kilometer	28.4
Rate of natural increase in 2019, per 1 000 of population	-6.8
Crude birth rate in 2019, per 1 000 of population	8.4
Total fertility rate (2018)	1.35
Crude death rate, 2019, per 1 000 of population	15.2
Life expectancy at birth, 2018	73.8
Life expectancy at birth, for men	68.5
Urban	69.5
Rural	65.3
Life expectancy at birth, for women	78.8
Urban	79.6
Rural	76.4
Median age (2019)	42.5
Population 65+, as of 01.01.2019, inhabitants	197,681
Percentage of total	17.4
Male population 65+, as of 01.01.2019, inhabitants	63,118
Percentage of total male population	11.6
Female population 65+, as of 01.01.2019, inhabitants	134,563
Percentage of total female population	21.4

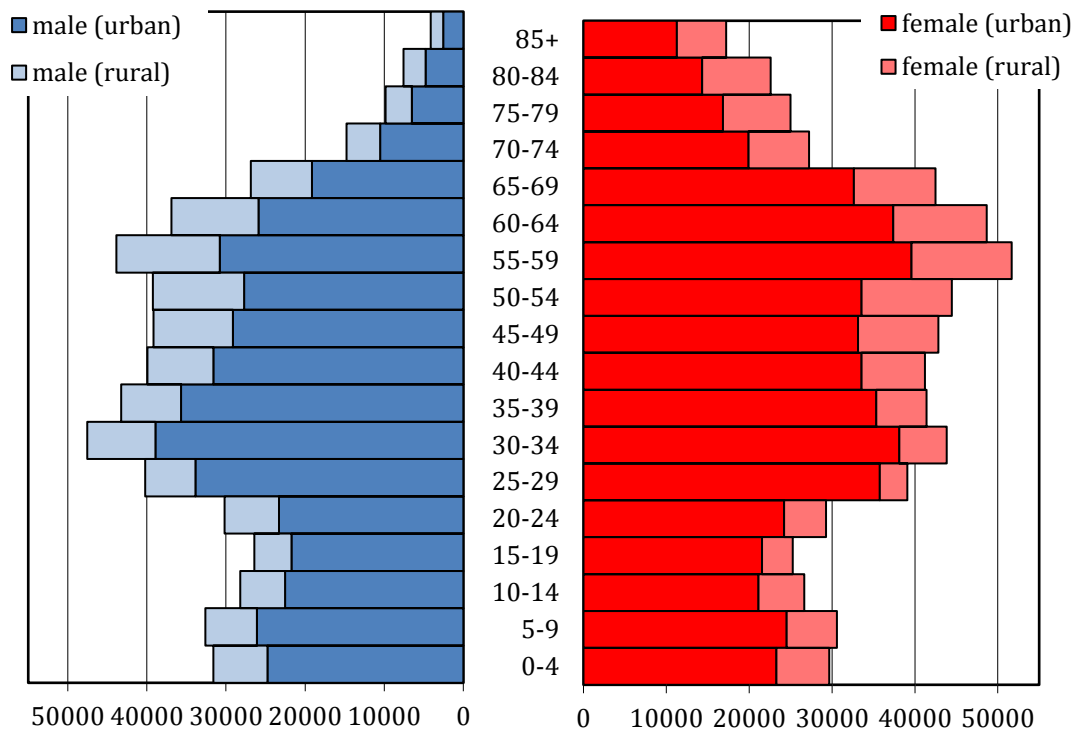
Source: Belstat.

**According to the 2019 Census, the population of Vitebsk oblast was 1.135 million.** Sex-disaggregated data show that 54.1% of the total population were women and 45.9% were men, which is similar to the national population composition. The percentage of urban population in Vitebsk oblast is 77.2%, which is again almost equal to the national average. Population density is an estimated 28.8 people per square kilometer, which is the lowest of all *oblasts* in Belarus.

**The population of Vitebsk oblast has been decreasing over the last 20 years due to a combination of natural causes and emigration.** Fertility reduction in the region shows the biggest decrease. In 2018, TFR was 1.35, which is the lowest among all *oblasts* (with the exception of Minsk, which has a lower TFR). The population pyramid of Vitebsk oblast indicates a high percentage of population in the age group 50–59, which means that the number of elderly (65+) will increase significantly over the next 5–15 years.

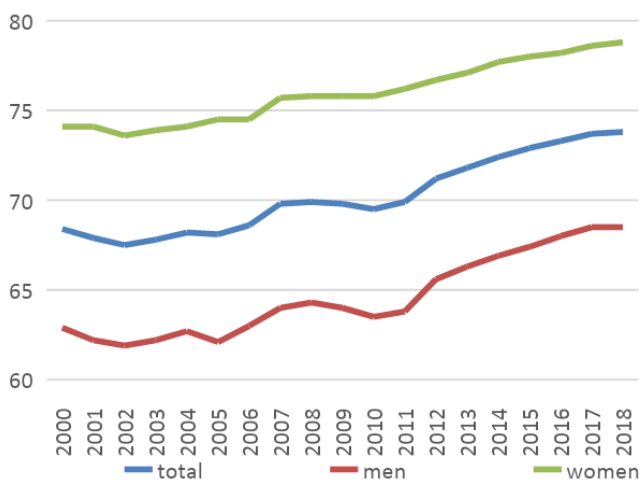
**In Vitebsk oblast, life expectancy at birth was 73.8 years in 2018, which is the lowest of all oblasts.** In 2018, life expectancy at birth for men was 10 years lower than for women (68.5 compared to 78.5), while life expectancy at birth for the rural population was 4.4 years lower than for the urban population.

Figure 57. Population age pyramid: Vitebsk oblast, 2019



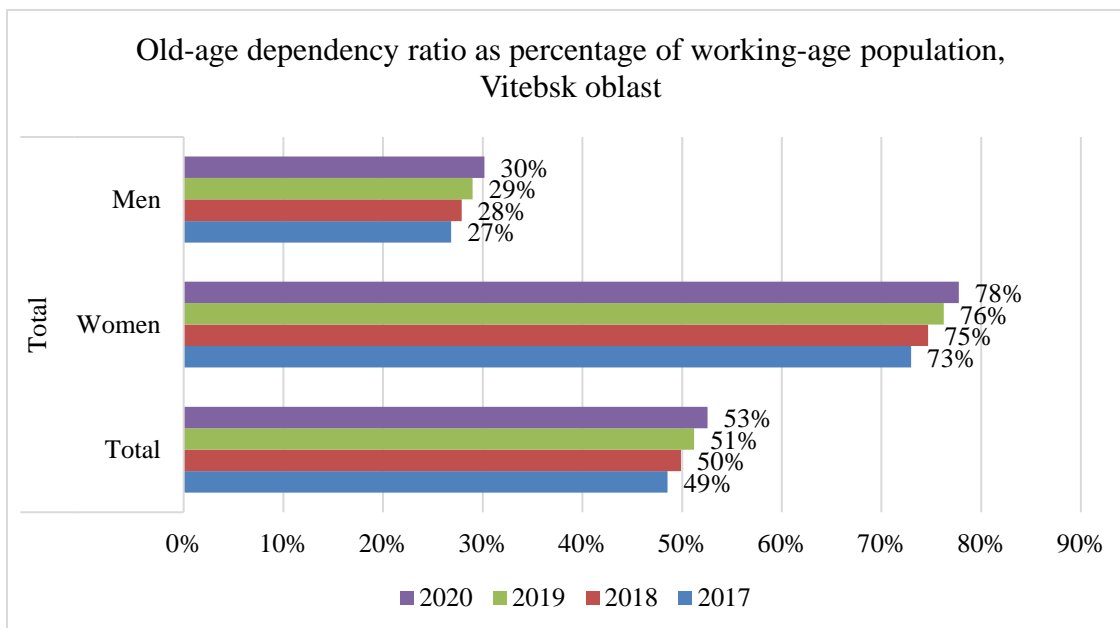
Source: Belstat.

Figure 58. Life expectancy at birth: Vitebsk oblast, 2018



Source: Belstat.

Figure 59. Old-age dependency ratio as percentage of working-age population, Vitebsk oblast



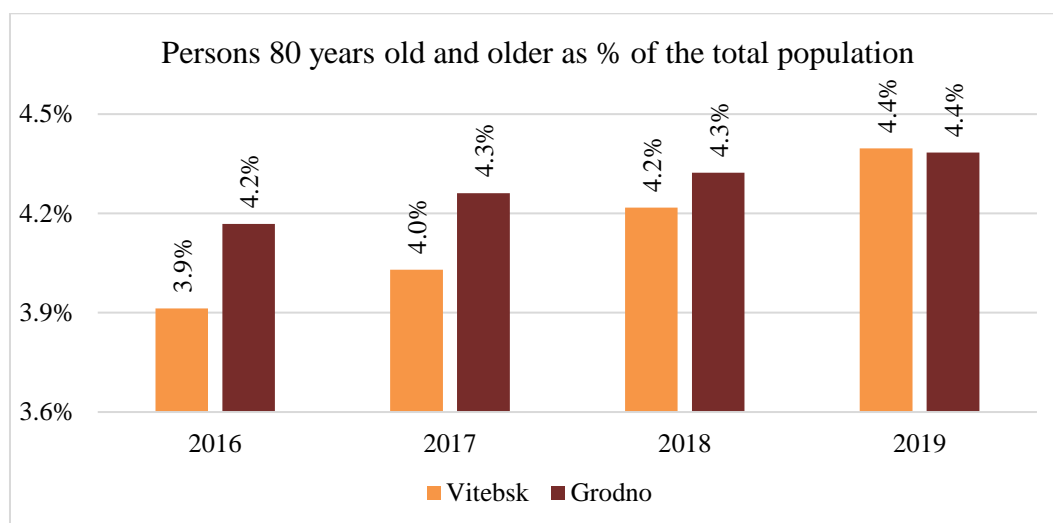
Source: WB calculations based on Belstat data.

#### Regional aspects of aging

**Regional ageing trends follow to some extent those visible at the national level.** According to World Population Prospects, the number of elderly (65+) will continue to increase disproportionately to other age cohorts. This trend has been observed in all regions of Belarus with the exception of Minsk. For example, both Vitebsk and Grodno *oblasts* have a relatively high percentage of aged 65+. In 2019, the median age in Vitebsk *oblast* was 42.8 years and 41.3 years in Grodno *oblast*, both of which are higher than the national average. In both *oblasts* the percentage of people 50+ has been increasing over the last ten years. The percentage of people in the 65–79 cohort has remained more or less stable, while the percentage of people 80+ has been increasing since 2007. Until 2018, the population of people 80+ was larger in Grodno *oblast* (4.38%), although it has been leveling out since 2019 (Figure 12).



Figure 60. Population of 80+ as percentage of total population: Vitebsk and Grodno oblasts



Source: Belstat.

**Aging in Belarus is also visible at the raion level however a bit different depending from raion.** According to Belstat data, there are seven raions in the country where the percentage of elderly (65+) exceeds 22.5% of the population. Four of these are in Grodno oblast. In Vitebsk oblast, there is one raion, in which the percentage of elderly (65+) is more than 22.5%, and 12 raions where it ranges between 20% and 22.5% of the population. In Grodno oblast, there are four raions where the percentage of elderly exceeds 22.5%, and five raions where it ranges between 20% and 22.5%. A majority of the elderly in all raions are women and the highest proportion of elderly live in rural areas. The ratio of the elderly among women is significantly higher than among men in both rural and urban areas.

Figure 61. Age distribution of 50+ population as percentage of total population, Vitebsk oblast

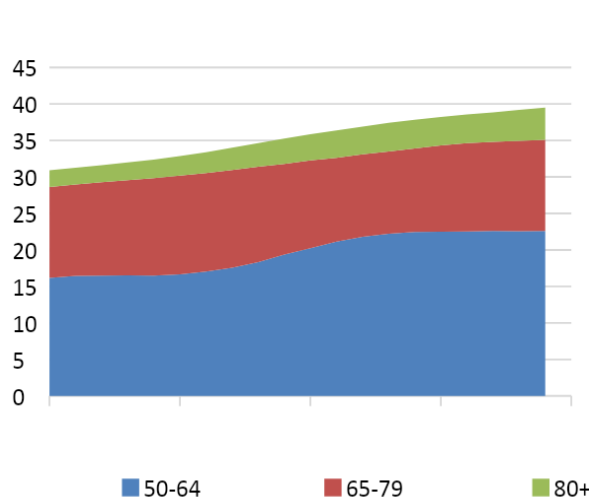
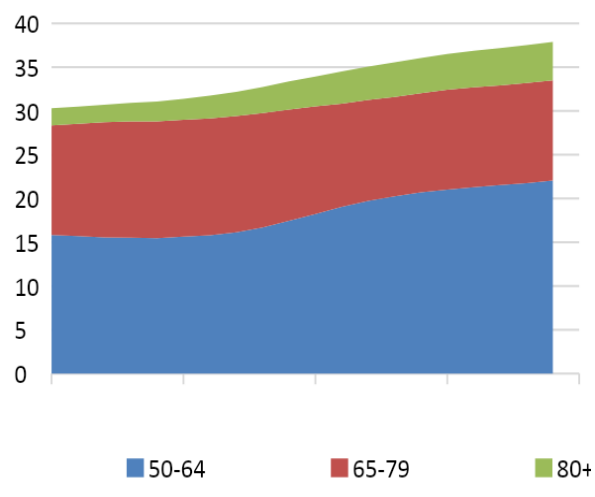
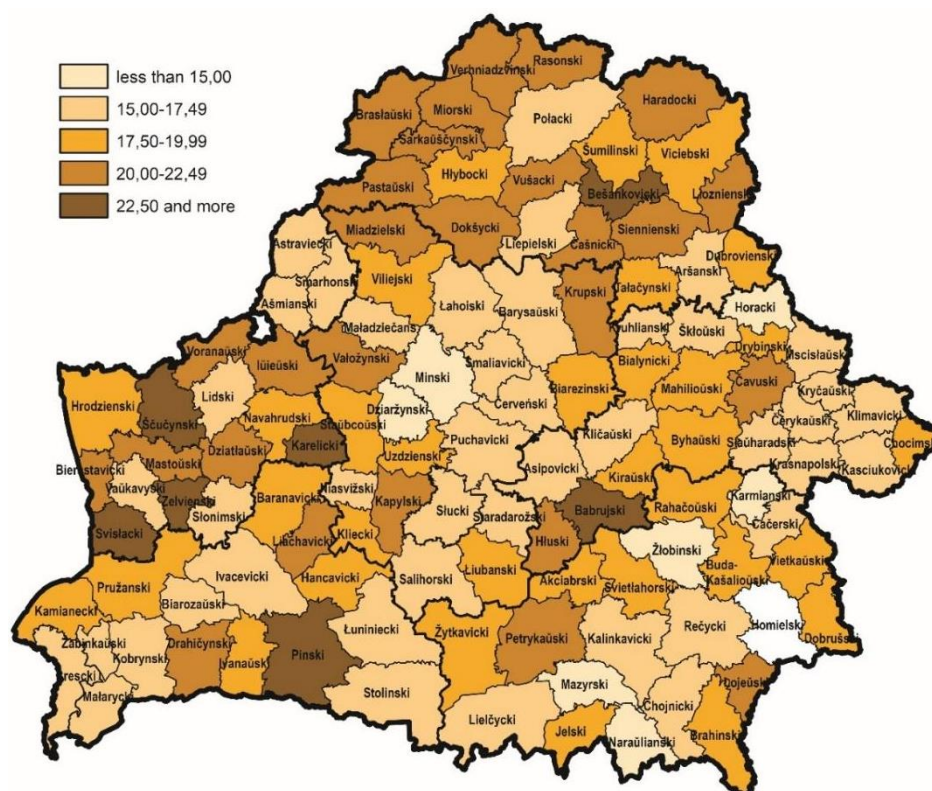


Figure 62. Age distribution of 50+ as percentage of total population, Grodno oblast



Source: Belstat.

Figure 63. Proportion of elderly in Belarus as percentage of total population



Source: Belstat data.

### 8.3. Demographic trends: Grodno oblast

Table 19. Grodno oblast population

Total population, inhabitants (Census – 2019 data)	1,026,816
Male	475,740
Female	551,076
Urban population, inhabitants	771,078
Percentage of total	75.1
Rural population, inhabitants	255,738
Percentage of total	24.9
Population density: people per square kilometer	40.9
Rate of natural increase in 2019, per 1 000 of population	-4.2
Crude birth rate in 2019, per 1 000 of population	9.5
Total fertility rate (2018)	1.64
Crude death rate, 2019 (per 1 000 of population)	13.8
Life expectancy at birth, 2018	74.0
Life expectancy at birth, for men	68.6
Urban	70.2
Rural	64.2
Life expectancy at birth, for women	79.2
Urban	80.2
Rural	76.7

Median age (2019)	41.3
Population 65+ inhabitants, as of 01.01.2019	164,460
Percentage of total	15.8
Male population 65+ inhabitants, as of 01.01.2019	52,248
Percentage of total male population	10.8
Female population 65+ inhabitants, as of 01.01.2019	112,212
Percentage of total female population	20.2

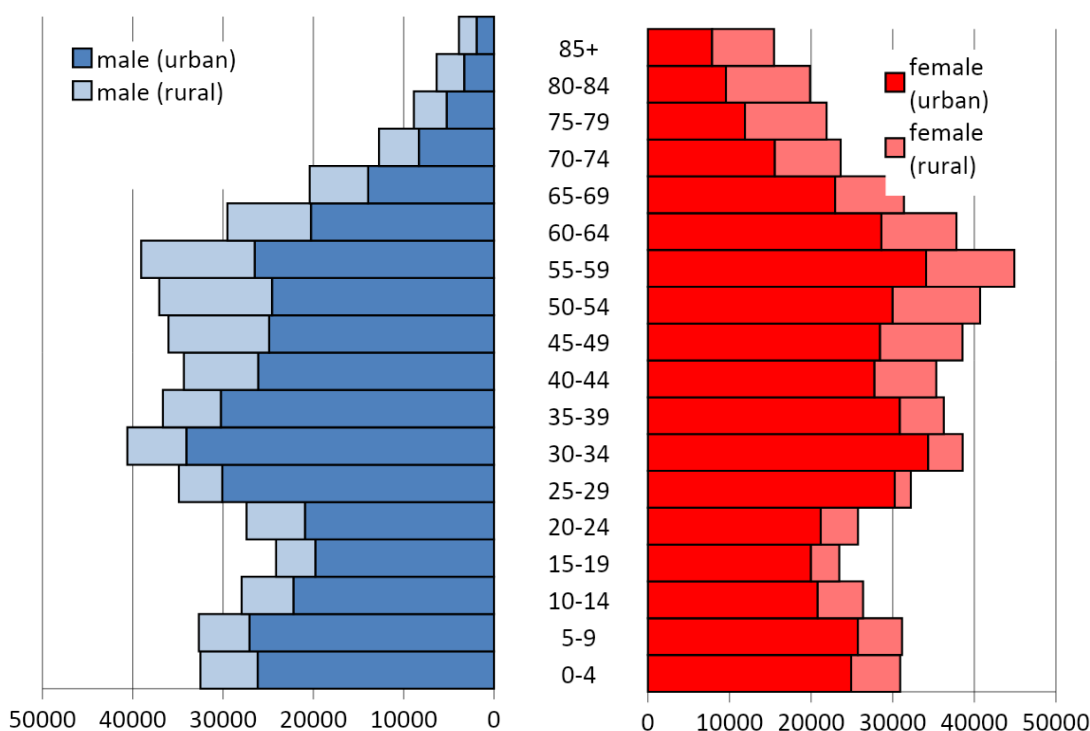
Source: Belstat.

**According to the 2019 Census, the population of Grodno oblast was 1.135 million** (53.7% women and 46.3% men), which is similar to the national population composition. The percentage of urban population was 75.2% and population density was an estimated 50 people per square kilometer, which is above the national average.

**Grodno oblast registered a positive fertility trend for the period 2007–2015.** In 2015, TFR was 1.85, which was higher than the national average for the same year. Since 2016, TFR has dropped sharply. The actual population pyramid indicates a high percentage of the population in the age group 50–59, which means that the number of elderly (65+) should increase considerably over the next 5–15 years.

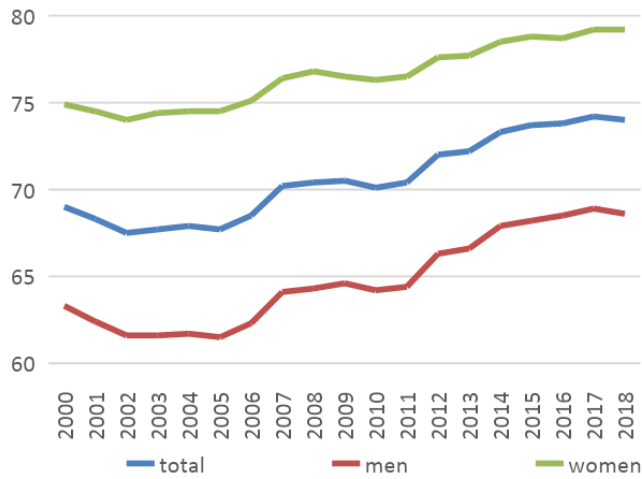
**In 2018, life expectancy in Grodno oblast was 74.** For men, it was 10.6 years lower than for women (68.6 years compared to 79.2 years), while life expectancy for the rural population was 5.2 years lower than for the urban population.

Figure 64. Population age pyramid: Grodno oblast, 2019



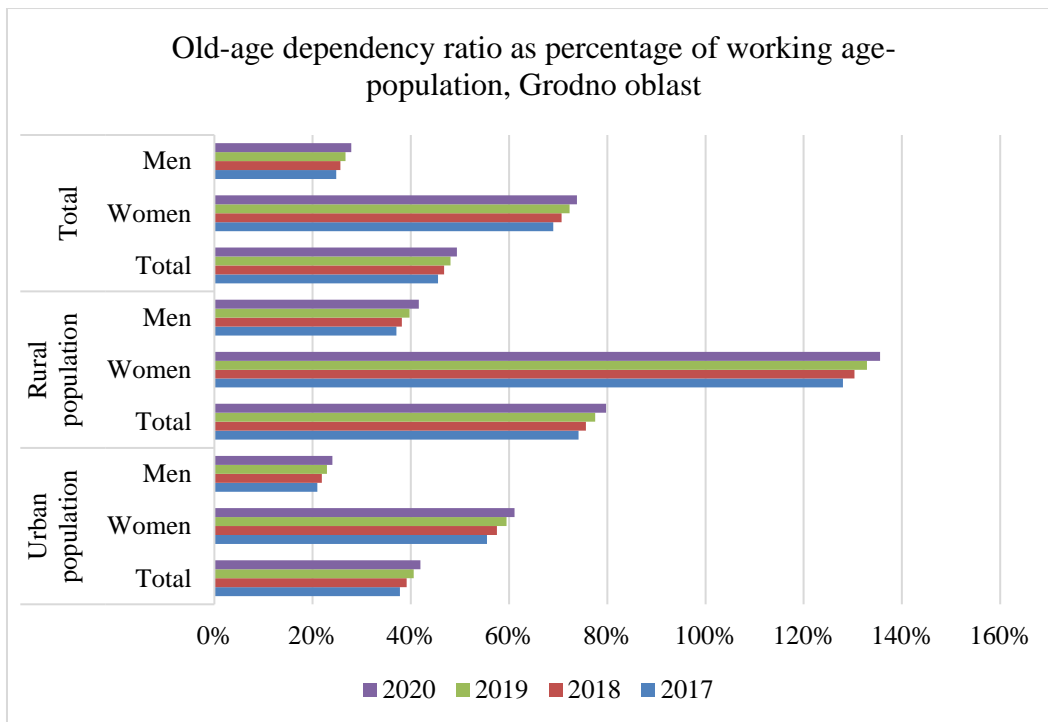
Source: Belstat.

Figure 65. Life expectancy at birth: Grodno oblast, 2000–2018



Source: Belstat.

Figure 66. Old-age dependency ratio as percentage of working-age population, Grodno oblast



Source: Belstat.

## 8.4. Maps

Figure 67. Men 65+, urban population (total number of inhabitants as of 01/01/2019)

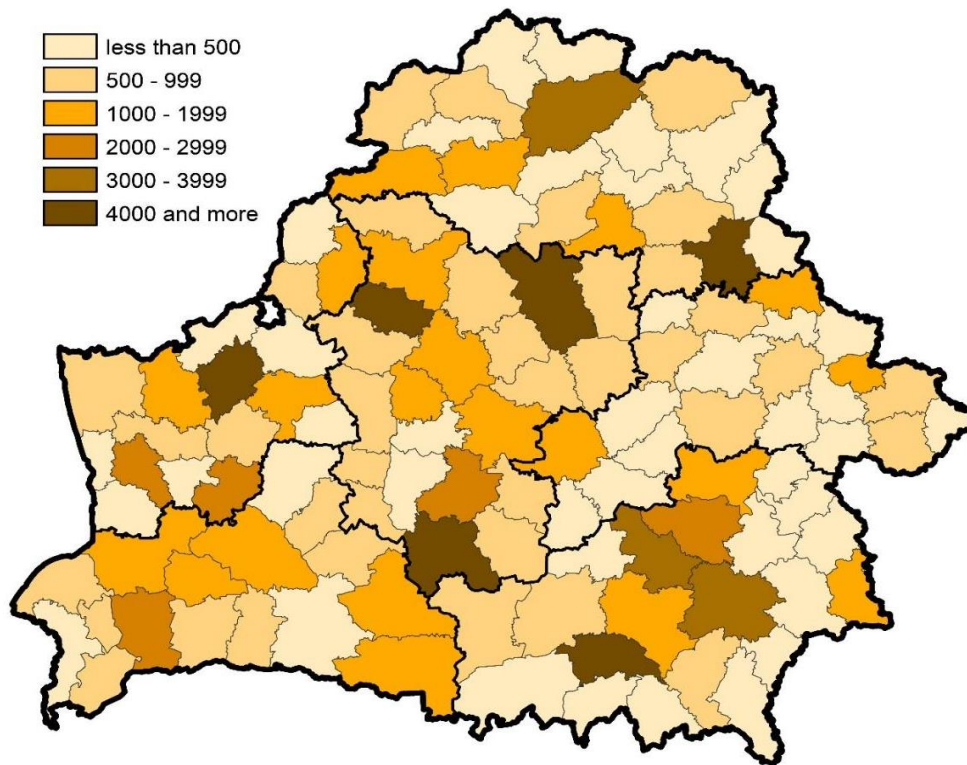


Figure 68. Women 65+, urban population (total number of inhabitants as of 01/01/2019)

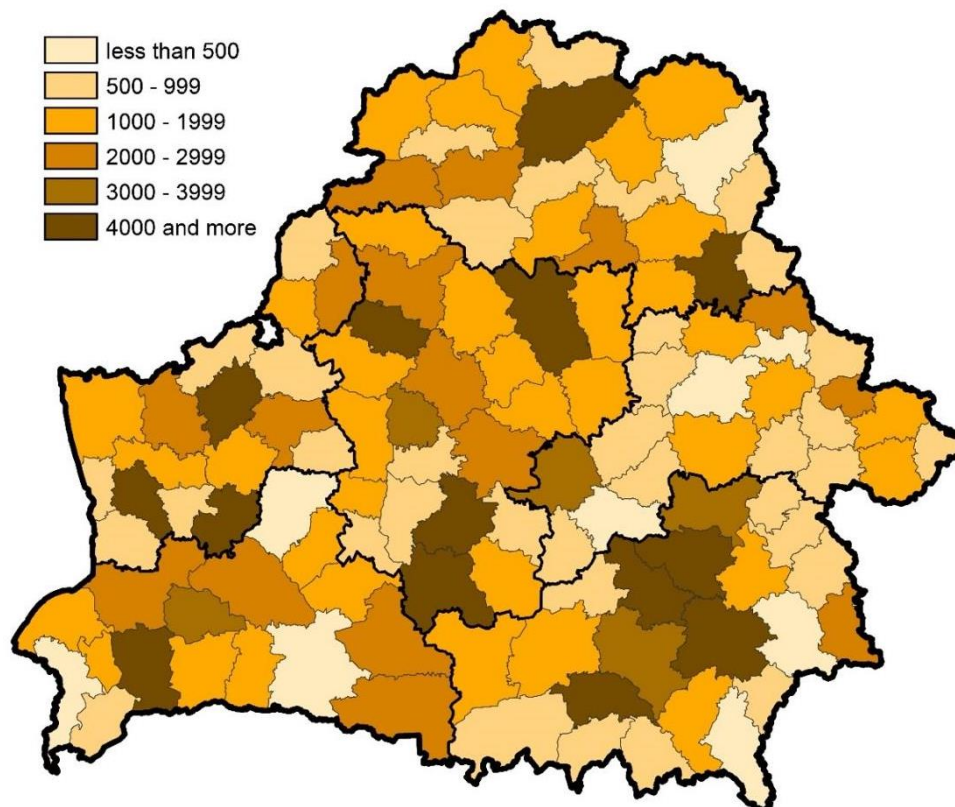




Figure 69. Men 65+, rural population (total number of inhabitants as of 01/01/2019)

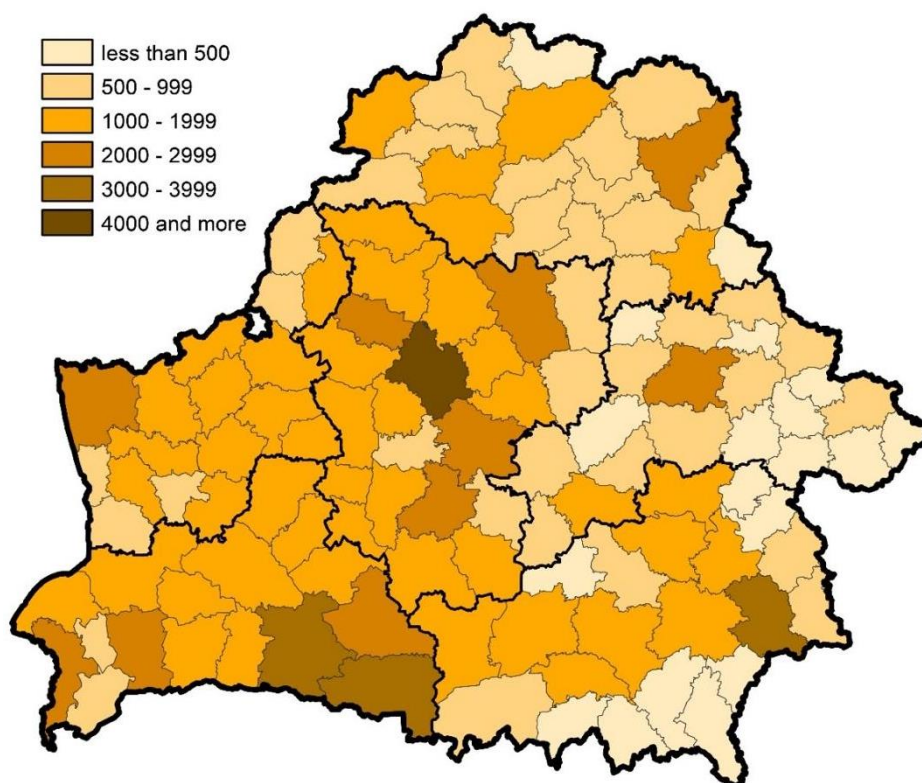
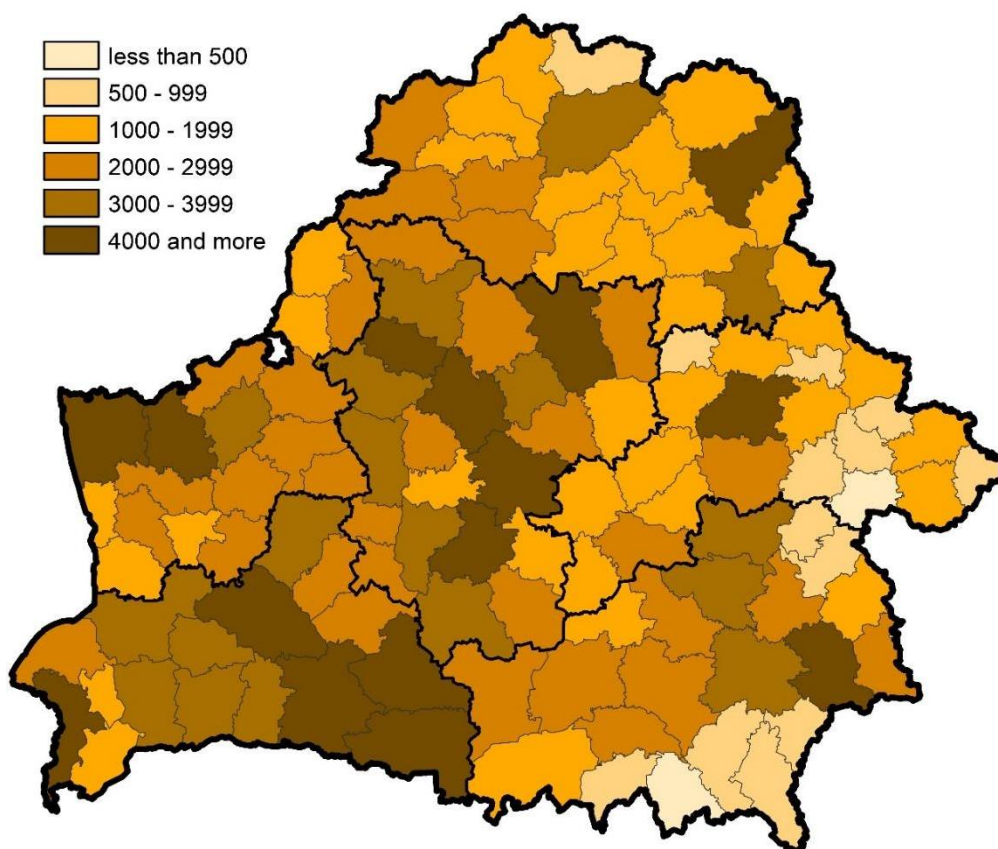


Figure 70. Women 65+, rural population (total number of inhabitants as of 01/01/2019)



Source: Belstat data.