# ESPN Thematic Report on Challenges in long-term care

## Latvia

**2018**

Feliciana Rajevska
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Directorate-General for Employment, Social Affairs and Inclusion
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**European Social Policy Network (ESPN)**

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The European Social Policy Network (ESPN) was established in July 2014 on the initiative of the European Commission to provide high-quality and timely independent information, advice, analysis and expertise on social policy issues in the European Union and neighbouring countries.

The ESPN brings together into a single network the work that used to be carried out by the European Network of Independent Experts on Social Inclusion, the Network for the Analytical Support on the Socio-Economic Impact of Social Protection Reforms (ASISP) and the MISSOC (Mutual Information Systems on Social Protection) secretariat.

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# Contents

## Summary

The coverage of the long-term care (LTC) system in Latvia is fairly moderate: in 2013, 20% of the potentially dependent population was covered (EU-27: 51%), and only 1% of the total population were LTC recipients. Public expenditure on LTC was 0.6% of GDP in 2013 – significantly lower than the EU average (1.6%).

Social services are organised and provided in a decentralised way. The national public administration is responsible for making policy and drafting law, but local municipalities provide the services and develop local regulations. Municipalities are expected to ensure similar levels of quality and service to those stated in the national laws, regardless of their geographical location, density of population and available budget. There was progress in home-care services for the elderly in 2012-2017 and an increase in funding by local government. However, funding for institutional care (and demand for it) is still persistent. Implementation of a deinstitutionalisation programme has facilitated the growth in interest of private business in LTC service development.

The most popular and most widely used social service involves a *mobile team* of specialists (i.e. social worker, social care worker, psychologist), which provides services to the elderly in their homes. These mobile teams are becoming the standard suppliers of care services in rural areas, especially in areas of low population density. The number of state and local government social care institutions is quite stable. However, there is strong growth in the number of social care institutions for adults run by private and non-governmental organisations. All service providers are obliged to be registered. The Register of Providers of Social Services constitutes the basis for quality assessment and is publicly available. Quality assessment is carried out by the Department of Social Services Quality Control in the Ministry of Welfare.

The cost of social care for the elderly is borne by the recipients themselves, the local authorities or family members. The payment scheme for staying in institutions is as follows: 90% of the old person's pension is used to cover the costs of the nursing home and 10% remains as the person's spending money. Payment is claimed from the individuals, their relatives and local government, in that order: if the relatives are on low incomes, local government has a duty to cover outstanding expenditure. If the old person is classified as on a low income, social services are available free of charge. Municipalities are at liberty to set a higher level of income as a threshold for access to their free services. Municipalities are obliged to provide home-care services only when there are no family members able to take care of the elderly or disabled person. A large proportion of home-care services are provided informally by family members, relatives or neighbours. There are no special LTC cash benefits for the elderly. However, there is a personal care benefit for disabled people (EUR 213.43) – a response to a persistent shortage of accessible and affordable specialised nursing home services and personal care services. The number of beneficiaries has almost doubled over the past 9 years. The low level of ability to pay within the population is a serious challenge for LTC in Latvia. The average pension in Latvia was EUR 317 in 2017. The ability of relatives to pay varies substantially, and not all relatives with sufficient income comply with the requirement of the Civil Law.

The providers of social services in Latvia are divided into several sub-professions, including social workers, social rehabilitation specialists, social care workers and organisers of social assistance. The low wage levels of social carers are reported by the Ministry of Welfare to be the main reason for the high turnover in institutions and for the difficulty in attracting new, motivated staff.

# 1 Description of the main features of the country's long-term care system(s)

In 2016, life expectancy in Latvia at birth was 74.8 years, with a big difference between the sexes (69.8 years for men and 79.4 years for women). The number of healthy life years is among the lowest in the EU both for men and women (51.8 years for males and 54.1 for females in 2015) (Eurostat). The absolute number of persons aged 60 and 65+ is increasing. The number of people with disabilities increased 1.07 times between 2014 and 2016, with a more rapid increase in the number of persons with severe disability (1.11 times). Thus the need for long-term care is growing.

According to the OECD health statistics (2016) public spending on long-term care (health and social components) was 0.4% of GDP in Latvia in 2014. Health care at home is provided to patients with chronic disease and mobility impairment for up to 30 calendar days. Before the end of this term, a general practitioner has to visit the patient and give the service provider an opinion on whether to terminate or continue the service. On discharge from hospital following surgery, health care at home is available for up to 10 calendar days. If home health care is needed for longer, the family doctor, at the request of the provider concerned, visits the patient and gives an opinion on whether to terminate or continue the service. There is a fairly short list of special diagnoses and a list of rehabilitation and physiotherapy services available to persons with such special needs. Healthcare services at home are provided by a certified nurse or doctor's assistant (*feldsher*), while medical rehabilitation services are provided by a certified physiotherapist or physiotherapist's assistant, ergotherapist or audiologist.[1] There are clear rules of payment for hospital stays and for the cost of each procedure. The total sum for one treatment case cannot exceed EUR 355.72. And the total annual payment for one patient cannot be greater than EUR 569.15 (co-payments for operations are not credited to the total amount). There is a lengthy list of persons who are exempt from payment: persons under 18, pregnant women, individuals with income of less than EUR 128 per month, etc.

Social services in Latvia are organised and provided in a decentralised way. The national public administration is responsible for making policy and drafting law, but local municipalities provide the services and develop local regulations. Municipalities are expected to ensure similar levels of quality and service to those stated in the national laws, regardless of geographical location, density of population or available budget. A municipality has discretion to develop new services; but it must ensure that it continues to safeguard the basic principle of meeting individual needs.

Taken as a percentage of formal in-kind spending, expenditure on institutional LTC in 2013 was 93%, which is the largest figure in the EU (EU average: 61%). However, the percentage of the population receiving LTC benefits is low: only 1% in 2013. The share of dependants receiving LTC benefits was rather low as well – 14% (EU average: 30%). The unit costs of institutional care per recipient, as a percentage of GDP per capita in 2013, were 92% – higher than the EU average (90.4%). In 2013, at 11.4 times greater, Latvia had the EU's second highest ratio of unit costs per recipient in institutional care compared to home care (EU average: 2.0) (European Commission, 2016).

The number of state and local government social care institutions is fairly stable. However, the number of social care institutions for adults run by private and non-governmental organisations (NGOs) is growing strongly. In 2017, there were 15 social care centres owned by the state and 61 social care centres for adults owned by local government. That same year, there were 16 social care centres owned by private companies and 9 centres run by NGOs.

[1] http://www.vmnvd.gov.lv/lv/veselibas-aprupes-pakalpojumi/veselibas-aprupe-majas

**Table 1. Residents of long-term social care and rehabilitation centres at the end of the year**

| | 2014 | 2015 | 2016 |
|---|---|---|---|
| **Number of recipients of social care institution services** | 12,926 | 12,984 | 12,834 |
| **Of which:** | | | |
| **In state (and contractual organisation) social care centres** | 5,425 | 5,353 | 5,229 |
| **In local government (and other organisations') social care centres for adults** | 5,953 | 6,134 | 6,387 |

*Source: Central Statistical Bureau of Latvia, SD0110.*

The aims and purpose of the social services are defined in the *Law on Social Services and Social Assistance*, Section 18. The purpose of the provision of social care services is to ensure that the quality of life does not deteriorate for a person who, due to old age or functional disorders, cannot ensure this through his or her own efforts. The law may be regarded as a detailed instruction for the management of social services. The official institutional norms are formulated in the *Law on Social Services and Social Assistance*, as well as in the internal regulations of the social service agencies. The official institutional norms are: assessment of the individual's needs; provision of services at the place of residence of the client; inter-professional and inter-institutional cooperation; user participation; cost control. Social services should be available at equivalent levels and amounts, no matter what municipality a person lives in. The Civil Law (1937) mandates the care of older people to their children, families or relatives (Part one, 'Family Law', art. 188): 'The duty to maintain parents and, in cases of necessity, also grandparents, lies with all the children equally.'

In 2010, regional programmes for the development of social services were elaborated. The programmes were tailored to develop the new social services. The most popular and most widely used social service involves a *mobile team* of specialists (i.e. social worker, social care worker, psychologist), which provides services to the elderly in their homes. These mobile teams are becoming the standard suppliers of care services in rural areas, especially in areas of low population density, and older people are their main target group . Some municipalities also offer other types of home support for the elderly, such as security buttons, delivery of hot meals, laundry and an assistant's service. At the end of 2017, there were 91 home-care service providers: 62 owned by local municipalities and 29 by private entities. The number of persons receiving home care at retirement age increased from 9,560 in 2014 to 11,256 in 2016 (18%).

Among those who received home care, there were 446 persons who had no opportunity to move outside their homes in 2016 (262 in cities and 184 in rural areas). Bed-ridden patients numbered 231 (129 in cities and 102 in rural areas); 31 persons did not have appropriate technical aids (28 in cities and 3 in rural municipalities) (Ministry of Welfare). Depending on the municipality, additional services are offered to support the independent living of elderly and disabled persons. In 2017, there were 76 day-care centres, of which 40 were in the cities and 36 in rural areas. One of the new types of day-care centres becoming particularly popular is the day-care centre for people with dementia.

## 1.1 Type of financing

According to Ministry of Welfare data, the total number of home-care recipients in 2016 was 14,022. Local governments paid – either in part or in full – for 13,279 persons (94.7% of the total).

Cabinet of Ministers Regulation nr.275 (2003) defines the common principles. However, Article 6 leaves room for local-authority discretion in the decision-making process. The

cost of social care for the elderly is borne by the recipients themselves or their family members. The payment scheme for staying in an institution is as follows: 90% of the old person's pension is used to cover the costs of the nursing home and 10% remains as the person's spending money. According to the regulations, payment is claimed from the individuals themselves, their relatives and local government, in that order. If the old person is classified as on a low income, social services are available free of charge. If the relatives are on low income, the local government has a duty to cover the outstanding expenditure. A special formula is used to calculate the necessary proportion of the payment. The amount of money is connected to the minimum salary. The family's household budget (after co-payments) should not be lower than the minimum wage for the first person and half the minimum wage for other household members. Municipalities are at liberty to set a higher level of income as the threshold for access to their free services. A large proportion of home-care services are provided informally by family members, relatives or neighbours. Municipalities are obliged to provide home-care services only if there are no family members able to take care of the elderly or disabled person.

In terms of expenditure, the dominant form of LTC in Latvia is still that of the institution. However, the number of home-care service recipients is growing. The amount of money spent on home care increased by 27% times between 2014 and 2016. Given the low population density in Latvia, remote home-care and safety assistance devices are becoming more comprehensive and widely used. The funds spent by local governments on social institutions and care are increasing as well. The number of individuals in social care institutions for the elderly is about 6,400; in home care – roughly 13,400, or more than double. This indicator proves the local government's priority and the common trend. However, spending on institutional care is 2.8 times more than on home care.

**Table 2. Local government spending on social institutions and care (EUR)**

| | 2014 | 2015 | 2016 |
|---|---|---|---|
| **On long-term social care and social rehabilitation institutions** | 37,699,675 | 42,122,944 | 39,418,170 |
| **On home care** | 10,884,401 | 13,295,823 | 13,836,569 |
| **On day-care centres** | 5,165,842 | 5,584,847 | 5,630,171 |

*Source: Ministry of Welfare of the Republic of Latvia, Reports on social services and social assistance in the county/republic city municipality.*

In general, we agree with the following evaluation of LTC in Latvia: '[LTC in Latvia] is characterised by the absence of universalism, no service provision, very high familialism *by default*, and low or very low *supported* familialisation … [Latvia is characterised] by low percentages of LTC spending in terms of GDP and embryonic long-term care policies. This lack of policies is often politically justified by reference to family values and cultural attitudes' (Bouget et al., 2017).

# 2 Analysis of the main long-term care challenges in the country and the way in which they are tackled

## 2.1 Quality challenge of employment

The *Law on Social Services and Social Assistance* requires the staff of social services to have special academic and professional qualifications.

Section 41 reads: 'Persons having the Right to Perform Social Work – Persons who have acquired a second-level vocational higher or academic education in social work or in charity-based social work have the right to perform social work.' Section 42 goes on: 'Persons having the Right to Provide Social Care or Social Rehabilitation Services and Social Assistance – Persons who have acquired a first-level vocational higher education in the field of the provision of social care, social rehabilitation or social assistance or a vocational secondary education in the field of social care (after graduation from such a vocational secondary school or other educational establishment which implements vocational secondary education programmes) have the right to provide social care or social rehabilitation services and social assistance.' The process of training carers is ongoing. In 2016, 255 social care organisers, carers and rehabilitators obtained a higher qualification: 123 with over 16 hours of training and 132 with 16 hours or fewer. There is an acute need to increase the number of hours of training. Most of those who retrained came from just a handful of municipalities. The process is uneven and irregular.

The Ministry of Welfare has a special Methodological Management and Control Department whose duty it is to follow the quality of service provided in residential care and monitor the qualifications of medical and service staff. The Ombudsman's Office pays close attention to the human-rights situation in all kinds of institutions: child care, elderly care, persons with mental disabilities, hospitals, etc. One such case concerns a review of practice in the large elderly care residence Rauda in 2016 and 2017; the case was widely covered by the mass media and contributed to an improvement in personal hygiene and a more individualised approach to clients. The Ministry of Welfare Methodological Management and Control Department imposed administrative sanctions for Rauda residence in 2017. By 2017, the number of carer positions in locked units for people with dementia had increased by four. However, the number of personnel at Rauda is still not sufficient: more than 10% of staff vacancies for jobs involving direct contact with clients remained unfilled in 2017. This case illustrates the lack of professional staff in LTC institutions generally.

**Table 3. The dynamics of medical staff with secondary and higher medical education and number of feldsher-midwife points in Latvia in 2008-2016**

| | Number of doctors in all specialities | Number of medical staff with secondary medical education | Number of feldsher-midwife points |
|---|---|---|---|
| 2008 | 8 437 | 15 197 | 224 |
| 2010 | 7 951 | 13 217 | 223 |
| 2012 | 7 998 | 12 099 | 182 |
| 2014 | 7 727 | 11 678 | 145 |
| 2016 | 7 480 | 10 318 | 139 |
| Decrease 2016/2008 in absolute figures | -957 | -4,879 | -85 |
| 2016 to 2008 in % | 88.7% | 67.9% | 62.05% |

*Source: Central Statistical Bureau of Latvia, VAG01, author's estimation.*

The data in Table 3 demonstrate the dramatic decrease in the number of doctors in all specialities; but especially alarming is the decline of 4,879 in the number of medical staff with secondary medical education between 2008 and 2016 (almost a third of medical staff). This was accompanied by an even more rapid decrease in the relative number of feldsher-midwife points in a country with a diminishing population density. One of the reasons for this trend is the inadequately low remuneration level for a highly qualified labour force. Some efforts have been made by the Latvian Health and Social Workers' Trade Union[2] (LVSADA), which since 1990 has been the largest and most influential trade union in the health and social care sector. LVSADA unites highly skilled medical personnel: doctors, other medical practitioners with higher and secondary medical education, social care workers, pharmacists, junior medical staff, lecturers, students and other employees working in healthcare institutions – in total it has more than 12,000 members and covers 96 trade union organisations throughout Latvia. In summer 2017, the trade union prepared proposals for a significant increase in the wages of healthcare workers in 2018-2020, within the framework of the Health Care Financing Bill. However, the trade union only managed to secure an increase in funding from the government for the health sector as a whole and for wages in 2018. A parliamentary commission did not support the proposal for a specific financial guarantee of wage growth for healthcare employees in 2019 and 2020.

The providers of social services in Latvia are divided into several sub-professions, including social workers, social rehabilitation specialists, social care workers, and organisers of social assistance. Social workers as a rule have an academic education (BA) in social work. Other professions require lower levels of education, and each has functions of its own. There are no data available on the level of education of professional carers working in institutions (nursing homes, day-care centres, etc.) or municipal social services. Low wage levels for social carers are reported by the Ministry of Welfare to be the main reason for high turnover in these institutions and for the difficulty of attracting new, motivated staff. Formal social carers are usually women with some degree of training.

Researchers in Latvia (and Norway) describe the working conditions of social carers as bad and insecure, with strain, frustration, lack of decent rest time, lack of professional organisations and trade unions protection, and poor protection against aggression by clients (Rasnača and Rezgale-Straidoma, 2017). The theoretical approach is based on the assumption that social carers could be stuck in a precariousness trap. The precariousness of this professional group can partly be explained by the New Public Management approach in social care. Social carers as a professional group could be underestimated by employers, society and even caregivers. From the sociological perspective, there is evidence of contingent (casual) work and insecure employment in the labour market.

## 2.2 The challenge of uneven treatment

Treatment can be uneven, depending on the financial capacity of service users and the policy of local authorities. The low level of ability to pay is a challenge for long-term care. The unit costs in municipal nursing homes for the elderly in 2012 were EUR 5,150 per person per year; about 55% of the costs consist of staff wages (European Commission, 2016). The average pension in Latvia increased from EUR 266 in 2014 to EUR 296 in 2016. In June 2017, 53% of pensioners received monthly pensions of EUR 200-300; 27.4% – EUR 300-500; and 7.3% – over EUR 500. But 12.2% of pensioners had a pension of under EUR 200: 90% of a pension of that size does not cover all the expenses of staying in an old people's residence. Moreover, not all relatives with sufficient earnings comply with the requirement under Civil Law to pay, and there is no procedure for finding relatives and recovering the debt. In such a case, the local authority covers all the expenditure.

There is a strict division of responsibility between the Ministry of Welfare and the Ministry of Health. However, there is often disagreement when complex problems require input

[2] LVSADA – Latvijas veselības un sociālās aprūpes darbinieku arodbiedrība

and initiative from both ministries. Accessibility (including affordability) of healthcare services is a topical policy issue in Latvia. The most important causes of limited accessibility of healthcare services are: lack of funding, lack of human resources, high out-of-pocket payments, regional disparities in service provision and poor ability of patients to pay. Cost is the main factor restricting access to healthcare services.

There are no special long-term care cash benefits for the elderly, but there is a personal care benefit available for disabled people to use as they see fit (irrespective of age or income of the beneficiary). This universal state benefit is granted on the basis of the formal disability status of the person (first or second category of disability) and the level of personal care needed. The assessment is based on the ability of the disabled person to perform daily activities (Barthel index); it is carried out by the State Medical Commission for the Assessment of Health Condition and Working Ability. More and more people are claiming this benefit, over 70% of them elderly persons who need care. The amount of the benefit is EUR 213.43. This benefit was introduced in response to the persistent shortage of accessible and affordable specialised nursing home services and personal care services. It is a good support for informal carers.

**Table 4. Number of recipients of the allowance for a disabled person who needs care**

| 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|---|---|---|---|---|---|---|---|
| 8,423 | 9,769 | 10,720 | 11,538 | 12,700 | 13,612 | 14,293 | 15,044 |

*Source: State Social Insurance Agency Data on each year, January.*

In addition, municipalities are free to grant their own LTC cash benefits: local governments have no legal obligations in this respect. They often grant cash benefits to people with care needs if a home-care service is not available; municipal cash benefits can also be granted to family members or other people actually providing care. Thus – depending on the municipality's financial situation and policy – support is available to both care recipients and caregivers.

There is also a cash benefit for disabled people with difficulty working. It aims to compensate them for the expense of specially adapted cars or other means of transportation. In 2013, there were 17,500 recipients, 45.6% of them over 65.

The carers of adult dependent family members have no legal status in Latvia; they are not covered by old-age insurance and are not eligible for paid leave in the event of emergency. At present, it depends on the discretion of their employer whether they can have a few days or weeks of unpaid leave. Up to now, caring has been considered a matter for the family only. Women are more involved in caring for elderly or disabled relatives generally, and especially if daily care is needed. The possibility of taking a day off at short notice and of accumulating hours to take time off is common in Latvia and follows the same pattern as the European averages.

For now, there is still a large share of informal share, but a shift towards formal care is predicted in the near future.

## 2.3 Recent reforms in LTC

The Cabinet of Ministers did much work on elaborating and aligning legislative acts and regulations in the field of LTC in 2017.

On 13 June 2017, the Cabinet of Ministers approved Regulation No. 338 'Requirements for Social Service Providers'. This regulation stipulates that the providers of social care at home should offer services to satisfy the basic needs of clients who cannot take care of themselves. Those basic needs include: assistance with personal hygiene (for example, washing, replacement of incontinence pads, combing, shaving, prosthetic care); help with getting dressed and changing bed linen; help with getting into and out of bed, positioning and moving; help with cooking and eating; delivery of food products, medicine and other small commodities; help with housework (e.g. dish washing, mopping of premises, household waste disposal); help with calling up a medical practitioner,

support in the use of medicine, assistance in dealing with various institutions (e.g. to pay bills); supply of firewood, furnace heating. These provisions include legal provisions deriving from Directive 2011/36/EU of the European Parliament and of the Council of 5 April 2011 on preventing and combating trafficking in human beings and protecting victims, replacing Council Framework Decision 2002/629/JHA.

On 27 June 2017, the Cabinet of Ministers introduced Regulation No. 385 'Regulations on registration of social service providers', which determines the criteria for joining the social services provider register, the necessary information and the procedure of registration, and conditions for exclusion from the register. A re-registration procedure was established for those service providers already registered on 30 June 2017: it was determined that the Ministry of Welfare would re-register such service providers by 31 December 2022 in chronological order. These rules include legal norms arising from Directive 2006/123/EC of the European Parliament and of the Council of 12 December 2006 on services in the internal market. The Regulations have four annexes: 1. Application for registration of a social service provider; 2. Model certificate of registration; 3. Transcript of the third part of the Social Services Providers' Code; 4. Application for re-registration of a social service provider.

Amendments to the Council of Ministers' Regulation No. 288 'The procedure for receiving social services and social assistance', concerning the evaluation procedure and the criteria by which a person receives social services and social assistance were made in 2017. Those amendments came into force on 1 December 2017. They include seven annexes, including Annex 1 'Psychiatrist's opinion on the mental health of a person and special (psychiatric) contraindications for receiving social services' and Annex 4 'Evaluation protocol and criteria for the assessment of physical and mental abilities and the level of care for a client with functional impairment'.

Evaluation of dependency is carried out by a team comprising a general practitioner and a specialist social worker. The protocol of Annex 4 has six sections: 1. Basic needs (eating, drinking, food preparing and serving, buying food and industrial goods, physiological functioning); 2. Mobility (moving, movement, ability to climb stairs, dressing); 3. Self-awareness, cognitive ability and security (understanding yourself and your needs, cognitive abilities, orientation in time and space, communication skills, feeling of security); 4. Behaviour and social contacts (self-control abilities, ability to build and maintain social contacts, ability to arrange transactions, to participate and organise free and working time); 5. Personal hygiene (caring about appearance, bathing, urination, attending toilet, use of medication); 6. Aid in the household (housework, laundry, household support, brokerage services).

Further, Annex 5 provides the 'Criteria for assessing physical and mental abilities and determining the level of care for a client with mental disorders'. The protocol to Annex 5 is more detailed and includes 18 sections and 125 questions. These 18 sections are as follows: Self-identification; Eating, cooking, taking fluids; Dressing; Care and maintenance of the premises; Maintenance of personal hygiene; Health maintenance; Mobility; Orientation in time and space; Security; Basic education; Orientation in time; Use of money and shopping; Communication; Behaviour; Pair-group relations; Cognitive functions; Working skills and abilities; and Free time. Clients are classified in one of four groups, according to their ability to look after themselves.

Annex 7 has to do with the 'Number and qualification of personnel involved in the provision of a long-term social care and social rehabilitation institution financed from the state budget'. It shows the average number of specialists for one client group in long-term social care and social rehabilitation institutions. It includes specialists such as social workers, social caregivers/rehabilitators, carers/nursing assistants, cultural and sports event organisers, certified physicians, certified nurses, certified physiotherapists, certified ergotherapists, certified arts therapists, speech therapists, certified masseurs, certified physician assistants, and psychologists.

All these measures involve much closer cooperation between family doctors, municipal authorities and social welfare providers to help an elderly person to receive home-care support for as long as possible or to opt for relocation to an institution.

# 3 Analysis of the indicators available in the country for measuring long-term care

## 3.1 Adequacy

A detailed system of criteria has been developed only recently (2017). According to the rules, the re-registration process for social service providers takes place within a strict chronological framework, starting from 2018. All social service providers who were providing services before 2010 must meet new and detailed requirements. During this process, their adequacy will be evaluated: technical and hygiene requirements and the adequacy of the number and qualifications of the staff

## 3.2 Quality

Evaluation of the need for home care is performed by a team comprising a general practitioner and a social worker. The client's function capacity is evaluated and expressed as a percentage. Amendments to the rules concerning the evaluation procedure and payment process were carried out in 2017, after the Ministry of Welfare amended the regulations of the Cabinet of Ministers. As the evaluation indicators have come into force only recently, this system is running as a pilot project in Riga in 2018.

All service providers are obliged to be registered by the Ministry of Welfare. The Register of Providers of Social Services constitutes the basis for quality assessment. The register enables verification of whether the service provider complies with requirements, such as the number and qualifications of the staff, the accessibility of care premises or their adjustment to the needs of recipients. This register is publicly available. Quality assessment is carried out by the Department of Methodological Management and Control in the Ministry of Welfare. Due to limited resources, only a small number of all registered service providers can be assessed each year. Most often the quality of services is examined only because of complaints received from recipients and their relatives. The Ombudsman's Office also follows up on these issues. Public opinion has become more open and sensitive to this topic. However, until now it has mostly concerned long-term child care.

**Table 5. Indicators of LTC in Latvia**

| | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 |
|---|---|---|---|---|---|---|
| Number of users of home-based care | 9,047 | 9,739 | 10,434 | 11,659 | 13,856 | 13,406 |
| Recorded number of dissatisfied applicants | 31 | 53 | 71 | 61 | 51 | 53 |
| Number and capacity of social services (local government social services – number of institutions) | 297 | 299 | 286 | 280 | 321 | 310 |
| Local government social services – number of institution employees | 4,520 | 4,484 | 4,815 | 4,957 | 4,899 | 4,922 |
| Number of users of residential social services | 13,035 | 13,235 | 13,056 | 12,926 | 12,984 | 12,834 |
| Number of rejected applications (de facto) | 4 | 1 | 0 | 7 | 10 | 17 |
| Number of home-care hours received | No data | No data | No data | No data | No data | No data |

*Source: Central Statistical Bureau of Latvia, SDG14; SD0110. Ministry of Welfare, Reports on social services and social assistance in the municipality of the county/republic city.*

Family informal care is firmly established in society. However, there has been a shift to formal care, due to the high outmigration and the large share of single-person households. Local governments provide home care only to people living alone.

## 3.3 Sustainability of LTC

The number of institutions that exist leave no doubt about their sustainability. For the sustainability of home care, it is important to strengthen the network of *feldshers* and their location in all areas, especially in rural districts with extremely low population density.

The impact of caring responsibility on employment needs additional research. Respite services are only at the early stage of development. This service needs to be developed and supported by local government and the state.

Implementation of a deinstitutionalisation programme has encouraged growth in the interest of private business in LTC service development.

Characteristic of Latvia's LTC policy approach are a strong informal care orientation and little support for informal care. Respite leave from care could be an appropriate way of supporting carers, by offering them a break from their caring responsibilities. Counselling could be an effective way of relieving the stress felt by carers and addressing any emerging emotional or mental health issues. Dissemination of information on available public, private and voluntary services could help carers as well.

There is a strong need to develop and expand palliative care and to increase the wages of formal carers. That could contribute to the quality of care.

It is recommended that the development of technical social care and assistance tools should continue, with the cooperation of the emergency services and NGOs.

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