National Report on Strategy for Social Protection and Social Inclusion 2006-2008

2006

Contents

Abbreviations: 3

1. INTRODUCTION 4
   1.1. Assessment of the social situation 5
   1.2. Overall strategic approach 7
   1.3. Overarching messages 10

2. NATIONAL ACTION PLAN FOR SOCIAL INCLUSION 2006-2008 12
   2.1. Key challenges, priority objectives and targets 12
   2.2. Priority policy objectives 18
   2.3. Better governance 27

3. NATIONAL STRATEGY REPORT FOR PENSIONS 30
   3.1. Adequacy of pensions 30
   3.2. Financial stability of the pension system 31
   3.3. Modernisation of pension system 33
   3.4. Conclusions 34

4.NATIONAL STRATEGIES FOR HEALTH CARE AND LONG-TERM CARE 35
   4.1. Summary on health care and long-term care 35
   4.2. Health care 36
   4.3. Long-term care 42

Annex 1 EXAMPLES OF GOOD PRACTICE 50
Annex 2 STATISTICS 55

Abbreviations:

Commission	European Commission
CSB	Central Statistical Bureau
EU	European Union
EU-25	25 Member States of the European Union (after enlargement on 1 May 2004)
GDP	Gross Domestic Product
ICT	Information and communication technologies
Inspection	Quality Control Inspection of Medical Care and Capacity for Work Expertise
MoCFA	Ministry for Children and Family Affairs
MoC	Ministry of Culture
MoENV	Ministry of Environment
MoES	Ministry of Education and Science
MoF	Ministry of Finance
MoH	Ministry of Health
MoJ	Ministry of Justice
MoRDLG	Ministry of Regional Development and Local Government
MoW	Ministry of Welfare
NAP/incl	Latvian National Action Plan for Reduction of Poverty and Social Exclusion 2004-2006
NGO	Non-governmental organisations
NSRF	Draft Latvian National Strategic Reference Framework 2007-2013
OMC	Open method of coordination
PCCSA	Professional Career Counselling State Agency
Report	National Report on Strategy for Social Protection and Social Inclusion 2006-2008
SEA	State Employment Agency
SoSAMSI	Secretariat of the Special Assignments Minister for Social Integration
SoSAMEGA	Secretariat of the Special Assignments Minister for Electronic Government Affairs

1. INTRODUCTION

Following the Communication of the European Commission (henceforth – Commission) of 22 December 2005 "*Working together, working better: A new framework for the open coordination of social protection and inclusion policies in the European Union"*, Latvia has prepared the National Report on Strategy for Social Protection and Social Inclusion 2006-2008 (henceforth – Report).

The Commission's communication aims at streamlining the open method of coordination (OMC) in order to modernise European social protection systems. Until now, OMC has provided an opportunity for the Commission, Member States and other partners to exchange policy goals and good practice examples. This method has enhanced the efforts of Member States to reduce poverty and social exclusion and has facilitated exchange of experience on ensuring adequate and sustainable pensions. It is important to apply OMC in the field of public health and long-term care, so that the awareness of the European Union (EU) Member States as regards the EU policies in this field would be strengthened and experience of other countries in the field of health care and long-term care would be shared, thus promoting development of new ideas and solutions. However, in order to achieve integrated approach to further development of the process of exchanging experience, it is vital to create a stronger and more transparent OMC, putting emphasis on policy implementation in line with the revised Lisbon Strategy, which, in turn, will facilitate the achievement of the objectives of Lisbon Strategy.

The Report has been elaborated in accordance with the *Law on Joint Inclusion Memorandum (Latvia)*; the Latvian Concept paper *"The Growth Model for Latvia: People First"*, based on human-oriented growth scenario approach; *Latvian National Development Plan for 2007-2013* aimed at promotion of balanced and sustainable development of the country and ensuring the competitiveness of Latvia among other countries[1]; the *National Lisbon Programme of Latvia for 2005-2008* aimed at national growth and promotion of employment; draft *Latvian National Strategic Reference Framework 2007-2013* (henceforth – NSRF) defining the overall strategy for absorption of EU Structural Funds and the Cohesion Fund, and other policy planning documents of Latvia as well as the *EU Sustainable Development Strategy* and the *Commission's Joint Report on Social Protection and Social Inclusion 2006.*

[1] Latvian National Development Plan (2007-2013). Ministry of Regional Development and Local Government of the Republic of Latvia, Riga (2006)

1.1. Assessment of the social situation

From the beginning of 1999 to early 2004, the population of Latvia has diminished by 80 thousand people. The birth rates in 2002 and 2003 showed slight positive trends, nevertheless, in 2004, there were 20.3 thousand newborns which was by 700 babies less than in 2003. Improvement of the demographic situation can be observed in 2005 when 21 497 children were born, reaching the highest number of newborns in the last decade. One of the factors facilitating higher birth rate was the scaling up of the amount of childbirth allowance and childcare allowance in 2005. It should be noted, however, that reduction in the numbers of population is also due to the natural mobility of citizens and the overweight of emigration over immigration[2] (Annex 2, Table 18 and 19).

The proportion of males and females in the total population of the country has not experienced significant changes for several decades. In early 2004, the proportion of males and females was 46% and 54% respectively[3].

The reforms carried out in the country and joining the EU have had a positive impact on the economic development. Latvia shows the highest growth rates in the EU. In 2004, the GDP growth rate increased by 8.5%, while in 2005 it grew even faster, reaching 10.2%. High growth rates are based on the steady dynamics on domestic consumption and export increase, yet there are significant regional disparities and differentiated development of urban and rural areas. The overall standard of living is low (by purchasing parity standard, the GDP in 2005 was equal to 47.1% of the EU-25 average).

During last two years, a relatively high inflation rate is prevailing. In 2004 the inflation rate in Latvia was 6.2% (EU – 2.1%), while in 2005 it reached already 6.7% (EU – 2.2%). According to economists, in 2005 inflation remained high mainly due to the global increase in oil price and the second round of inflation (inflation inertia). The forecasts are that over the coming years, with diminishment of the impact of the mentioned price-increasing factors, inflation should experience gradual decrease. A growing inflation rate seriously reduces the income of the population groups with low and medium income level, and it also hinders the efforts to provide adequate remuneration for work.

Along with economic growth, the income of citizens grows as well. The actual income of workers in 2005 increased by nearly 10%. In 2004, an increase in the disposable household income could be observed. In comparison with 2003, the disposable household income has grown by 17% or by LVL 14 (EUR 20)[4] per one household member per month, reaching LVL 101.23[5] (EUR 144). The monthly income of the citizens in the poorest fifth of households (1st quintile) has also increased by LVL 6.55 LVL (EUR 9), thus reaching LVL 38.42 (EUR 55), yet the income level is still extremely low if compared to the average household indicators.

Although income levels have increased for all types of households, marked income disparities exist between urban and rural areas, as well as between Riga and its region and other regions. Latgale still demonstrates the lowest average disposable household income per one household member per month - LVL 67.2 (EUR 96), while Riga shows the highest one - LVL 135.24

---

[2] Draft NSRF for 2007-2013. Ministry of Finance of the Republic of Latvia, Riga (January 2006)
[3] Draft NSRF for 2007-2013. Ministry of Finance of the Republic of Latvia, Riga (January 2006)
[4] The exchange rate of the Bank of Latvia on 8 August, 2006.
[5] The Key Findings of the Household Budget Survey. Central Statistical Bureau, Riga (2004)

(EUR 192). The sharpest growth of income compared to 2003 has been registered in Kurzeme region, where it increased by LVL 21.78 (EUR 30) and reached LVL 89.88 (EUR 128) per month per one household member.

Polarisation of income is also more and more evident – both between urban and rural areas, and between Riga and its region and other regions. The overall Gini index of 0.36 has remained unchanged compared to 2003, yet it has fallen from 0.37 to 0.35 in the cities and gone up from 0.30 to 0.34 in rural areas. Regional breakdown shows reduction of Gini index in Riga only, while in other regions the polarisation of income has increased, especially in Vidzeme region where the change has been from 0.28 to 0.32.

According to the data of Central Statistical Bureau (CSB), in 2004 the relative poverty line in Latvia was LVL 74 (EUR 105) per one equivalent consumer, which is by LVL 13 (EUR 18) more than in 2003. The proportion of population living under the relative poverty line in 2004 has increased by 3%, thus reaching already 19%.

In 2004, the risk of poverty has grown for several population groups. A marked increase has been noted for retired persons (65 years of age and over) living alone (28% in 2003, 53% in 2004). The risk of poverty has also significantly risen for families with children having a single bread-winner, usually woman (35% in 2003, 41% in 2004). Single-person households are under 40% risk of poverty. A relatively high risk of poverty - 32% - can still be seen among large families (families with 2 adults 3 and more children).

The health state of the population still remains unsatisfactory. The mortality rate keeps to increase and in 2005 it has been the highest during last seven years, reaching 32 777 deaths or 14.2 per 1000 inhabitants. Latvia holds the leading position in Europe as regards mortality caused by cardiovascular diseases (785.8 cases per 100 000 inhabitants in 2005). In 2005 there has been a considerable increase of mortality rates of HIV/AIDS – 26 death cases (in 2004 – 15). Despite the fact that morbidity rates of tuberculosis decreases, there is still a high number of morbidity cases (morbidity with all kind of tuberculosis – 53.8 incidences of tuberculosis per 100 000 inhabitants in 2005).[6] In 2005, health care was attributed 3.43% of GDP.

Generally, the following social groups subjected to the risk of poverty and social exclusion are identified in Latvia: large and single-parent families, disabled people, persons of pre-retirement age and retired persons, children and young people under social risk (from disadvantaged families, with functional impairments, ethnic minorities` children (especially Roma), young people released from imprisonment, orphans, unemployed, addicts etc.), unemployed persons (the long-term unemployed in particular), homeless persons, persons released from imprisonment, ethnic minorities (particularly the Roma people) and victims of human trafficking.

In 2005, the indicators characterising employment and unemployment situation continued to improve, still it should be mentioned that growth was primarily achieved due to productivity and not so much due to increase in the number of workers. At the end of 2005, State Employment Agency (SEA) had registered 78 482 unemployed persons or 7.4% of all economically active population. Compared to the end of 2004, the number of unemployed persons registered with SEA on 31 December 2005 had shrunk by 12 318 persons, and the registered unemployment rate had decreased by 1.1 per cent.

[6] Draft NSRF for 2007-2013. Ministry of Finance of the Republic of Latvia, Riga (January 2006)

Similarly to the previous years, by the end of 2005 the lowest rate of registered unemployment was in Riga region – 4.5% (compared to 5.2% on 31 December 2004). The unemployment rate continued to be high in areas further off Riga, particularly in Latgale region, where the unemployment rate equalled to 16.3% at the end of 2005 (compared to 18.1% on 31 December 2004).

Out of the total number of unemployed persons registered with SEA at the end of 2005[7], 20 581 (26.2%) were long-term unemployed; 11 058 (14.1%) – young unemployed in the age of 15 to 24; 3 391 (4.3%) – disabled unemployed; 417 (0.5%) – persons released from imprisonment; 8 849 (11.3%) – persons after childcare leave; 4 371 (5.6%) – unemployed women of pre-retirement age; 2 831 (3.6%) – unemployed men of pre-retirement age. Female unemployment still remains high – by the end of 2005 there were 12 611 (61.3%) women and 7 970 (38.7%) men registered with SEA.

Demographic forecasts indicate that the numbers of labour force should remain quite stable until 2010, yet a sharp drop can be expected between 2010 and 2030. This decline will go hand in hand with significant changes in the age structure, as the number of young people between 15 and 24 years of age will deplete, while the number of people aged 45 to 64 will increase, thus giving a boost to the pool of elderly people by 2050. The total expenditure of the special social insurance budget in 2005 accounted for 7.6% of GDP, and the total expenditure on old-age pensions required 5.2% of GDP.

1.2. Overall strategic approach

Taking into account the problems caused by ageing and demographic burden, as well as the consequences of globalisation and competition, the key challenge to modern social and economic policies is their ability to react to change flexibly - by providing a choice of opportunity (flexibility) and protection (security) combinations so that both the individual and the society as a whole could choose the solution that is most appropriate in their particular situation. Therefore Latvia, like other EU Member States, needs to find solutions ensuring flexicurity.

Improvement of the living standard relies essentially on the labour market inclusion of the population, which depends on the growth of productivity. Therefore it is important for Latvia to ensure that its key resource – human resources – is prepared according to the labour market needs, and at the same time, to create an inclusive labour market and to balance the social security and employment needs, and the interests of enterprises. Today, flexicurity has become the main characteristics of a society that is ready and able to change and to benefit from the global environment without sacrificing its internal cohesion and the quality of life. Flexicurity should be viewed in the context of active labour market policies, especially as regards employability, job seeking and vocational training. The National Lisbon Programme of Latvia sets strengthening of cooperation between educational establishments and employers in order to prepare young people for labour market as one of the priority objectives. It is necessary to define new requirements for professional qualifications, an adequate supply of vocational and higher education programmes needs to be developed fast, discrepancies between the labour market demands and the available training have to be diminished for several occupations, and

[7] The same unemployed person may be included in more than one problem group, e.g., an unemployed person can be both a long-term unemployed and a young person in the age of 15 to 25.

cooperation between educational establishments and employers needs to be facilitated so that the employers would be motivated to take care of the young professionals-to-be by providing them with in-service training opportunities. One of the successful examples of providing opportunities for school children to obtain work experience in Latvia is the labour market measure launched in 2004 aimed at students of general, specialised or vocational education establishments during their summer holidays. As a result of this measure, students (15 to 18 years of age) are given a chance to obtain practical work experience during their summer break, to develop the basic skills necessary for work, as well as to enhance their knowledge of the labour market and the legal provisions governing it in Latvia. This active labour market measure will also contribute to combating unemployment in the long-term, as through their participation in the project young people get a hands-on experience with the duties and working conditions of their chosen occupation. This, in turn, helps youngsters in making decisions concerning the suitability of the chosen occupation to their abilities and interests, and motivates poorly qualified and poorly paid workers to decide in favour of further education. Moreover, as from 2006, such an opportunity is also provided to students with special needs on condition that the workplace of such an adolescent will not need additional adjustments.

Efficient and targeted labour market policy, however, is not only about job creation and preparation of qualified professionals. It also means elimination of potential discrimination in the labour market and ensuring opportunities for reconciliation of work and family life.

Provision of opportunities for reconciliation of work and family life is a vital aspect of social inclusion and gender equality. Several measures aimed at creation of such opportunities have been implemented in Latvia. A successful example in this field is the established state support in the form of allowance to families with one of the parents on childcare leave, namely, one of the parents is granted an allowance equal to 70% of his or her average insurance contribution wage during the 12 months preceding the birth of the child. Thus the amount of allowance is similar to the net wages of the respective parent. This childcare allowance is paid until the child reaches the age of one year. The childcare allowance for children from 1 to 2 years of age is LVL 30 (EUR 43) per month. Such an allowance is also available if a person chooses to combine childcare with work. This option allows those persons involved in childcare, mainly women, to maintain their qualifications and competitiveness in the labour market, while preserving the welfare level of the family.

Special emphasis should be put on creation of alternative care opportunities for small children. During last two years, nearly 30 play-and-development centres have been established, thus providing substantial support to parents in reconciliation of work and family life. The Lisbon Programme also envisages support to labour market inclusion of persons returning from childcare leave through development of kindergartens, play-and-development centres and babysitter services. It is planned to encourage establishment of day-care centres for children at workplaces, as well as to elaborate methodological recommendations for development of babysitter services in local governments.

Widespread use of information and communication technologies (ICT) in the fields of employment, social protection and gender equality is an undoubtedly strong driving force for boosting competitiveness and growth, as it can be used to improve access to employment and knowledge, to both private and public sector services and to reduce social exclusion. The opportunities provided by ICT are increasingly used to improve the quality of life and social participation of the inhabitants by facilitating access to information, media, contents and services as well as by developing and offering more flexible employment opportunities. Considerable disparities still exist as regards the use of ICT; many inhabitants of Latvia still

benefit from ICT in a very limited way or do not benefit from them at all. The gap between the average indicators of Internet use in Latvia and the indicators of Internet use among people with special needs, women, less educated groups of population, unemployed persons, elderly people and people in less developed regions needs to be reduced significantly.

The linkage of social protection and growth is also evident in the field of pensions. The ideology embedded in the Latvian pension system is aimed at setting incentives for the working-age population to stay in the labour market as long as possible and to continue working after reach of the minimum retirement age. The amount of state old-age pension depends directly on the social insurance contributions made and on the actual retirement age. The later pension is requested, the bigger its amount, so elderly people are motivated to remain in the labour market longer. Thus, the current pension system of Latvia is able to retain the rate of state social insurance contributions unchanged in long-term and, with no further rise envisaged, it can protect workers from an increase of the social insurance contributions burden.

At the same time, in order to improve the demographic situation in the country, efforts should be made to create family–friendly and safe socio-economic environment. One of the national priorities is the maintenance of retired persons' living standards, with special emphasis on reduction of social exclusion risks and adequate provision of pensions.

Financially viable state pensions and a stable national financial system are mutually reinforcing and supportive to the long-term economic indicators of the country. The role of population's health in the context of economic growth is generally acknowledged, both in overall terms and specifically regarding elderly people. Health care provision is a fundamental component of public health. It includes both medical and pharmaceutical care, and is targeted at ensuring, maintaining and recovering health. The number of general practitioners is still insufficient in Latvia, therefore timely medical care services are not always available to inhabitants. The high treatment costs also contribute to aggravation of various health problems and deterioration of the health state of the population. It is particularly true for those inhabitants whose poor living conditions and lack of financial resources limit their opportunities to receive the necessary medical care services and to pay for them. In order to achieve a substantial improvement in health state of population and ensure state`s growth, there is a need for sustainable health policy with corresponding respurces. There should be foreseen additional resources not only for treatment of diseased people, but there should be a considerable increase from the part of state budget for prevention, including education and information activities to public on healthy lifestyle and responsibility of an individual in maintaing own health. Former health care budget does not ensure a complete implementation of activities defined in all policy documents and it limits planning and implementation of new measures. Healthy and work capable inhabitants are able to provide a valuable contribution in state development, facilitating its economic growth and competitiveness.

It is equally important to create conditions under which all inhabitants would receive cost-effective, physically accessible and good quality health care services. Taking note of the fact that the state of health has a considerable impact on person's working capacity and on his or her ability to find a job suitable for certain medical conditions, as well as considering work as the key source for obtaining means of subsistence, it is essential for health care services to be available to everybody and especially to those with health problems limiting their working capacity. It is also relevant to ensure health care services for those groups of population who are socially and economically most disadvantageous. Therefore the accessibility of health care services needs to be improved through modernisation of infrastructure, including development

of the use of information technologies, introduction of e-health services, provision of adequate human resources to health care and promotion of support provision.

Social services play an equally important and fundamental role. The demographic change that has taken place is complemented by changes in cultural values and changes in family structure – high proportion of divorced marriages, an increasing number of illegitimate children. This results in a need for development of alternative services and a demand for such services. It is important to facilitate development of care services so that, for example, family members (mainly women) taking care of children, disabled persons and elderly people could combine it with work thus avoid deterioration of the welfare standards of the family. Of course, the role and responsibility of the father in families has to be strengthened through taking up more duties and involvement in upbringing and care of children, as well as by increasing the awareness of responsibility and duty as regards provision of support to a woman who is a single parent. Home-care services have to be developed and the establishment of day-care centres needs to be continued in order to provide social care and social rehabilitation services to elderly people unable to care of themselves due to their old age and state of health. Further development of such day-care centres is vital to promotion of physical and intellectual development of elderly people so that they could acquire different social skills and have an opportunity to socialise at the same time, thus fulfilling their needs and interests and facilitating their fuller and more successful social inclusion.

Accordingly, the interaction of all these three strands – social inclusion, pensions and health care and long-term care - is of vital importance, as it influences the physical and mental health, employment, family life, material provision of individuals, as well as their ties with society and the self-determination of each person individually.

Ensuring good governance

In order to ensure monitoring of this report, a Monitoring Committee for implementation of the report will be set up in 2007. The Committee will comprise representatives of the ministries responsible for the objectives and challenges identified in the Report, as well as representatives of regional local government development agencies, non-governmental organisations and social partners.

It is also envisaged to draw up an informative report on the implementation of the Report in the previous period, which will be submitted to the Cabinet of Ministers. Simultaneously, informative seminars on the contents of the Report and the challenges and objectives defined therein will be organised, and presentations on the implementation of the Report will be provided to all parties involved in development and implementation of social inclusion policy.

1.3. Overarching messages

The key objectives in the field of social inclusion comprise improvement of accessibility of education and labour market services to children and young people subjected to the risk of poverty and social exclusion, improvement of the access to resources and services for families, especially large and single-parent families, and for retired persons under risk of poverty, especially those living alone.

In the field of health care, the priority tasks for the future are primarily linked to the improvement of the national health policy in order to ensure public health in a healthy environment through preventive measures and promotion of healthy lifestyle. The latter can be done by informing general public about healthy diet and the negative and destructive impact of tobacco, alcohol and psychoactive substances on individual's health and life in general and by improving public awareness concerning human health-related issues and raising individual responsibility for maintenance of one's own health and leading a healthy lifestyle.

In order to reduce the need for services provided in social care institutions, alternative social care services will be developed in the country. To ensure availability of these social services as close to recipient's place of residence as possible and to reduce the number of persons in social care institutions, a continued support to local governments will be provided as regards development of alternative services, in particular, services for persons with mental disorders (day-centres, group houses (apartments), halfway homes).

Taking into account the large share of the illegal economy in the country, high unemployment rate and low average wage, the pension amounts, which depend on social insurance contributions, often are inadequate. Therefore activities aimed at facilitation of improvement in living standards for retired persons will be continued. Thus, one of the priorities is maintenance of pensioners' living standards after retirement – additional social protection of those receiving low pensions, ensuring pension indexation, in particular, index the lowest pensions more rapidly during the coming years, as well as raising the pensions for the pensioners with the longest insurance records within the limits of the insurance budget.

2. NATIONAL ACTION PLAN FOR SOCIAL INCLUSION 2006-2008

The first National Action Plan for Reduction of Poverty and Social Exclusion for 2004-2006 (NAP/incl 2004-2006) laid down the objectives and measures in all fields necessary to facilitate the improvement of situation for all social groups subjected to the risk of social exclusion. On the basis of analysis of statistical indicators and major problems, three priority policy objectives for the next period have been defined in this National Action Plan for Social Inclusion 2006-2008 (NAP/Inclusion 2006-2008).

2.1. Key challenges, priority objectives and targets

Objective 1: Improve the access of children and young people subjected to the risk of poverty and social exclusion to education and labour market services.

Education presents a fundamental and integral basis for the development of the life of individual, and it is an important precondition determining one's future opportunities. There is a considerable number of dropouts at the basic education level in Latvia (Annex 2, Tables 41 and 42), which causes concerns that these young people will have hardly any possibilities to obtain a well-paid, permanent job in the future, and they risk to lose their jobs quickly. This means that they will not only experience low material income, but also be gradually excluded from social activities thus losing their ability to participate efficiently in the economic, political and cultural life of the society[8]. Attention should also be paid to the insufficient numbers of young people involved in general secondary education, and the existing disproportion characterising the choice between general education and vocational education after completion of primary education. There is a large proportion of students with low level of basic skills, insufficient proportion of those with high level of competencies, and a considerable proportion of young people entering the labour market without any qualifications and with their general knowledge and skills insufficient for further education.

Integration of children with functional impairments in general education schools is still rare due to such main hindering factors as inaccessibility of educational establishments to students with special needs, insufficient early medical, pedagogical/psychological and social diagnostics for children, lack of medical aid for children with special needs in general education establishments, lack of continuity and cooperation between institutions necessary for implementation of integrated state policy, inability to ensure social integration of orphaned children or abandoned children (in particular, children with medium and severe mental disorders) after graduation from specialised educational establishments (vocational training corresponding to their developmental impairments, securing a job, etc.), as well as lack of specialists for work with this risk group and insufficiency of training aids for young people with special needs.

An extremely low level of general education can also be observed among the convicts. 23% of convicts do not even have a primary education. A large share of convicts have no vocational education either. As at least general primary education is needed to acquire vocational education, part of convicts have no opportunity to obtain profession neither during confinement nor after the release. Employers demonstrate no interest in unqualified workforce, thus

[8] http://www.politika.lv/index.php?id=6058

successful labour market inclusion of these individuals after their release from imprisonment becomes impossible. 32% of convicts are young people in the age of 15 to 25 years, and approximately 10% of them are minors. On 1st January 2005, there were 7816 prisoners in places of detention, including 5004 convicts and 2812 detained persons. Nearly one third of convicts was in the age from 15 to 25 years, and one in ten of these convicts was a minor in the compulsory education age.[9]

A particular problem in the field of education arises with involvement of Roma children in the general education process, as well as with attendance of pre-school and basic education institutions by Roma children. It is very rare that Roma children would engage in the pre-school education process. Although since 2003 Latvian legislation provides for compulsory preparation of children in the age of 5 to 6 for school, many Roma parents have no information about that. Thus, without adequate preparation for school, from the very beginning of the educational process Roma children are placed on unequal grounds with children of other ethnic groups. According to the population census held in Latvia in 2000, of 5985 Roma over 15 years of age residing in Latvia only 7.9% have obtained secondary education and only 26 of them have a higher education. According to the data of SEA, in 2003 there were 46 illiterate persons among the registered unemployed, and 39 of them (85%) were Roma, yet it is not feasible to identify the number of illiterate persons among Roma people precisely.[10]

The mismatch between education and skills and the labour market requirements is the major cause for high unemployment rates among young people, which, in turn, facilitates the social exclusion and poverty risks for this group. According to CSB data, the risk of poverty has increased by 2% in the age groups of 0 to 15 and 16 to 24 years, reaching 21% in 2004. The share of children (under 18 years of age) living in the 1st quintile households, i.e., in the poorest part of households, is still high – 37.4% in 2004.

Taking into account the negative statistics and the problems facing children and young people in the fields of education and employment, the key targets for achieving the objective are as follows:

- Increase the efficiency to pedagogical process in basic education, thus achieving reduction of the number of drop-outs and students with poor performance;
- Promote development of inclusive education for children with special needs;
- Facilitate integration of young convicts' education within the public education system and to promote social inclusion of convicts after serving their sentence;
- Develop application of inclusive education principles within the general education system in respect of Roma children;
- Enhance the accessibility of vocational education to young people from risk groups;
- Build up the interest of students in obtaining education and improving their vocational knowledge, as well as inform the school youth on the professional career guidance issues so that they would be fully competitive in the labour market and choose their future occupation correctly;
- Facilitate permanent job placement of young unemployed persons and disabled unemployed persons in the age of 15 to 25 years by improvement of their working skills and competencies;
- Facilitate employment of young convicts and ex-convicts;

---

[9] "Guidelines of Education Policy for Convicts 2006-2010". Ministry of Justice of the Republic of Latvia, Riga (2005)

[10] National programme „Roma in Latvia" (2007-2009). Secretariat of the Special Assignments Minister for Social Integration of the Republic of Latvia, Riga (2006)

- Improve the income of children and young people in case of incidence of various social risks;
- Enhance the social integration opportunities of children and young people and to improve their health state.

Objective 2: Improve the accessibility of resources and services to families, particularly large and single-parent families.

Although there were 21 497 children born in Latvia in 2005, which is the highest number in the last decade, with increase of childbirth and childcare allowances in 2005 as one of the factors boosting the birth rate[11], the demographic situation in Latvia can be regarded as unfavourable for several years already. The natural increase of population turned negative in 1991 and still remains negative. The CSB data on the self-assessment of material situation of households in 2004 suggest that 33.7% of families in Latvia consider themselves poor or living on the threshold of poverty. Families with children are most vulnerable to various social risks related to decrease of income due to childbirth and childcare, as well as to their inability to provide adequate subsistence for children. Single-parent families (usually with woman as the breadwinner) are particularly subjected to the risk of low-income. The disposable income of these families was by 30% lower than the average in all households.

In order to facilitate social integration of disabled persons, elderly people and children who have lost their providers by reducing their social exclusion, the amount of state social security benefit for general recipients was raised from LVL 35 (EUR 50) to LVL 45 (EUR 64) per month as from 1 January 2006. In 2004 – 2005 new state social benefits have also been introduced[12].

In general, positive development trends can be observed as regards benefits: raising the amount of state social benefits for families with children and introduction of new types of state social

[11] As from 1 October 2004, the amount of childbirth allowance was increased according to the value of layette in actual prices as defined by the CSB – to LVL 296 (EUR 421), and an equal amount of allowance was granted to all parents of newborn children irrespectively of the time when the mother has turned to a medical institution for medical care in connection with pregnancy. Moreover, as from 1 January 2005, a new system of childcare allowance has been introduced, with the amount of childcare allowance set as follows: (1) for employed persons taking care of a child in the age of up to one year – 70% of their average insurance contribution wage during the 12 months preceding the birth of the child, but not exceeding LVL 392 (EUR 558) and not under LVL 56 (EUR 80) per month; (2) for unemployed persons taking care of a child in the age of up to one year - LVL 50 (EUR 71) per month; (3) for both employed and unemployed persons taking care of a child of 1 to 2 years of age - LVL 30 (EUR 43) per month. From 1 January 2005, persons taking care of twins or several children delivered in a single childbirth are granted a supplement for each of the next children: for taking care of a child in the age of up to one year– LVL 50 (EUR 71) per month, taking care of a child of 1 to 2 years of age – LVL 30 (EUR 43) per month.

[12] (1) from 1 January 2005 children with celiacic disease under 18 years of age who have not been attributed the status of disabled person, are granted state support equal to the amount of supplement to state family benefit for a disabled child (i.e., LVL 50 (EUR 71) per month); (2) from 1 January 2006, a supplement to the existing base amount of childbirth allowance (i.e. LVL 296 (EUR 421)) has been introduced: LVL 100 (EUR 142) – for the birth of the first child, LVL 150 (EUR 213) – for the birth of the second child, LVL 200 (EUR 284) – for the birth of the third and every next child in the family; (3) from 1 January 2006, a childcare allowance for disabled children has been introduced, namely, LVL 50 (EUR 71) per month granted to one of the parents of a disabled child (with severe functional disorders) on condition that he or she does not work. As a result, a person taking care of a disabled child with serious functional disorders of the systems of organism receives both a supplement to the state family benefit for a disabled child (LVL 50 (EUR 71) per month), and childcare allowance for a disabled child. Altogether, the state support by means of benefits to the respective person amounts to LVL 100 (EUR 142) per month.

benefits. Nevertheless, the low amounts of several state social benefits still hamper adequate provision of state support in the form of monetary payments to certain groups of population in situations linked with reduction of income as well as in cases where individuals are unable to obtain any income and no compensation from the state social security system is envisaged.

It has to be noted that families still receive very limited support during the child raising. The amount of state family benefit[13] is insufficient to satisfy the basic needs of families raising children over two years of age and to support them adequately in respect of additional expenses related to bringing up children. If we look at the additional expenses arising for families with children of school age at the beginning of each school year, the current state family benefit does not provide sufficient support for preparing children for the new school year. Such a situation contributes to increasing social exclusion and poverty of families. According to the data of Household Budget Survey in 2004, the largest share of children (younger than 18 years of age) – 37% from total number of children in households, lived in families with 1st quintile income, which is in average LVL 38.42 (EUR 55) per month, whereas the smallest share of children could be seen in the 5th quintile (15.3%), which has the relatively biggest income, namely, LVL 230.14 (EUR 327) per one household member per month.

Statistics also provide evidence on the instability of family as a social institution in the country. In 2004, 52 out of each 100 marriages concluded were divorced. The share of children born in unregistered relationships is also very high in Latvia – 45%. The number of children not attending nursery schools because of the lack of vacancies there is high, with resulting difficulties in reconciliation of work and family life and hampered return of women into the labour market. According to the CSB, the capacity of pre-school educational establishments in the school year 2004/2005 was 50 110 children, while there were 62 443 children on the list for receiving these services.

The amount of state social security benefit for persons disabled since childhood which is currently LVL 50 (EUR 71) per month is not sufficient to meet the basic needs of these persons who generally have no opportunities of employment. There is also lack of support to those family members (usually women) who are taking care of another family member (elderly person, child, disabled person).

Statistical indicators point at a negative trend of increased risk of poverty for single-parent families with one or more dependent children. Compared to 2003, the risk for this group has increased by 6%, thus reaching already 41%. For large families the risk of poverty remains stable, yet high - at 32% in 2004. The risk of poverty has grown by 4% also for families with two children, reaching 17% in 2004.

On the basis of these negative indicators and the various problems identified in relation to services and resources, the following key targets for achieving this objective have been set:

- Improve the financial situation of families with children by reducing the tax burden and increasing the amounts of various benefits granted during the childcare and upbringing periods;
- Improve access to housing for families with children;
- Improve the health state of children, provide support to families during the child raising periods and in cases of incidence of social risks;

[13] In 2006, state family benefit for the first child is LVL 6 (EUR 9), for the second child – LVL 7.20 (EUR 10), for the third child – LVL 9.60 (EUR 15), for the fourth and every next child – LVL 10.80 (EUR 15).

- Promote development of alternative care and social services and facilitate its accessibility to families with children.

Objective 3: Improve the accessibility of resources and services to retired persons subjected to the risk of poverty, in particular to those living alone.

Latvia faces swift ageing of the population characterised by low birth rates and increasing average life expectancy. Demographic forecasts indicate that the numbers of labour force should generally remain stable until 2010, yet a sharp drop can be expected between 2010 and 2030. This decline will go hand in hand with significant changes in the age structure, as the number of young people between 15 and 24 years of age will deplete, while the number of people aged 45 to 64 will increase thus giving a boost to the pool of elderly people by 2050.

The average old age pension in 2005 was LVL 81 (EUR 115), whereas the minimum pension amounted to nearly LVL 58 (EUR 83) and was received by 11% of all recipients of old age pensions. In 2004, the disposable income of retired person was LVL 69 (EUR 98) on average per month per one member of household.

The income is mainly spent on food, housing costs and payment for medical treatment, while very little is given away on consumption expenditure like clothing, footwear, recreation and culture. This group under risk of exclusion has limited possibilities to participate in social life due to the low income.

In the housing situation of Latvia, one of the most vulnerable groups are those inhabitants of retirement age who live in large cities and are not able to cover the housing rent or to find a housing appropriate to their financial capacity on their own. Those renting apartments in denationalised houses risk eviction from their apartments because of debts for rent or use of public utilities or because of the necessary overhaul works and their inability to purchase another apartment on the open market. Construction of municipal housing, in turn, has gone down considerably in the last decade. The numbers of social apartments and houses are insufficient in Latvia – in 2005, there were 2088 social apartments and 78 social houses, with retired persons constituting 37.4% of the inhabitants.

Recipients of pensions form one of the key target groups for municipal housing allowances and municipal allowances for compensation of medical expenses. In 2004, 114.8 thousand or 23.8% old age pensioners have received different municipal social benefits.

Elderly people have insufficient access to care services alternative to long-term care institutions (e.g., home-care, day-care centres) that would allow those unable to take care of themselves to stay at home. Accordingly, the number of elderly people and disabled persons dwelling in social care institutions is relatively high in Latvia. In 2005, 1.1% of all population above 60 years of age abode in social care institutions (60.0% of them female and 40.0% male), while the corresponding share of population above 70 years of age was 1.8% (74.5% of them female and 26.5% male).

Analysis of statistical indicators for 2004 shows a markedly negative trend as regards increasing poverty risks for persons of retirement age. If in 2003 the poverty risk for retired persons was 15% (17% for females, 9% for males), in 2004 it had gone up to 24% (28% for females, 17% for males). The sharpest increase can be observed for lone retired persons (65 years and over). In 2004 it has reached already 53%, increasing by 25%.

Taking into consideration the characteristics of current situation and the negative statistical trends, the following key targets have been chosen for achieving this objective:

- Reduce poverty and social exclusion of retired persons by improving their access to resources;
- Improve access to housing for low-income persons of retirement age;
- Improve the access of retired persons to health care services;
- Improve the accessibility of social services to retired persons and develop care services alternative to institutional care thus facilitating regaining of social status and their social inclusion, as well as enhancing the employment opportunities of their family members;
- Promote the accessibility of cultural events and ICT to retired persons, thus facilitating their socialisation and social inclusion.

2.2. Priority policy objectives

In order to achieve the three priority policy objectives, in cooperation with social partners various measures financed from the state and municipal budgets, EU Structural Funds and the Community Initiative EQUAL will be implemented during period from 2006 to 2008. These measures will facilitate better labour market inclusion of the target groups, improve their material welfare and ease their access to different necessary services, thus promoting successful social inclusion.

Objective 1: Improve the access of children and young people subjected to the risk of poverty and social exclusion to education and labour market services.

1. In order to increase the efficiency to pedagogical process in basic education, thus achieving reduction of the number of dropouts and students with poor performance, the following activities are planned:

- to extend opportunities for students with low preliminary knowledge and learning difficulties to join pedagogical correction and catch-up programmes (indicator: the number of students in pedagogical correction and catch-up programmes) (MoES)[14];
- to introduce and pay for the pedagogical work of assistant teacher aiding students (1st to 6th grade) with learning difficulties (indicators: as from 2007 – 5 hours per week for each class; from 2008 – 7 hours per week for each; from 2009 –10 hours per week per each class; 3 000 remunerable pedagogical work rates established) (MoES);
- to develop methodology for work in classes comprising students with learning difficulties (MoES);
- to provide additional consulting for mastering the contents of study subjects to students (7th to 9th grade) with low educational achievements by ensuring pay for 1 hour of supplementary pedagogical work per week for each class (indicator: 95% of students obtain certificates of basic education at the end of 9th grade) (MoES);
- to provide educational establishments with computers and ensure acquisition of ICT basic skills for students from educational establishments (indicators: a number of computers per 100 students in educational establishment; students of educational establishments who have obtained general compulsory course of informatics) (SoSAMEGA).

2. In order to promote development of inclusive education for children with special needs, it is envisaged to implement the following activities:

- to create a support system for integration of students with special needs in general education institutions through establishment of State Specialised Education Centre to ensure consulting and methodological aid (indicators: the share of students with special needs 4% (in 2007, prior to establishment of the Centre) and 4.02% (in 2008 – after establishment) in the total number of students of general educational establishments; 32 pedagogical-medical commissions have started their activities as specialised education support centres) (MoES);
- to adjust general education institutions to students with reduced mobility (indicators: learning environment (premises, classrooms, facilities, equipment, etc.) improved in 18 specialised educational establishments to support the development of working and

[14] The ministry responsible for implementation of the respective measure (irrespectively of whether the activity is implemented by an institution under control/supervision/responsibility of the ministry).

everyday life skills of the students; 10 general education institutions adjusted for students with reduced mobility) (MoES);

- to prepare teaching staff for work with children and young people subjected to the risk of social exclusion by financing further education of pedagogues from the state budget (indicator: pedagogues have attended a 36 hour further education course once in every 3 years) (MoES);
- to provide disabled persons, including disabled persons up to 24 years of age, with the skills and competencies necessary for their integration in the labour market by development and improvement of the system of medical, social and vocational rehabilitation services (indicators: methodology for determination of vocational suitability and for training of disabled persons with mental disorders developed; new vocational rehabilitations programmes for visually impaired persons developed and introduced; 10 short-term vocational rehabilitation programmes for disabled persons with low education or vocational skill levels developed; information system established for motivating employers and disabled persons to join rehabilitation programmes; regional support offices of the Social Integration Centre established providing services as close to the residence of a disabled person as possible) (MoW);
- to strengthen the role of cultural education in reducing social exclusion of visually impaired persons by further extension of support to the Latvian Library for the Blind, including to accessibility and diversification of its services (indicator: the number of visually impaired children and young people attended) (MoC);
- to provide subsidies to the municipal public libraries for ensuring free access to Internet and computers (indicator: the number of visits to libraries made by children and young people) (MoC).

3. In order to facilitate integration of young convicts' education within the public education system and to promote social inclusion of convicts after serving their sentence, the following activities are planned:

- to implement the project "Development, approbation and implementation of pedagogical correction programmes" within the National Programme[15] "Implementation of pedagogical correction measures in imprisonment institutions" (indicators: premises for provision of pedagogical correction programmes adapted and equipped in 8 prisons; 75 pedagogues, as well as 75 chiefs of units, social workers and other specialists trained; 2 pedagogical correction programmes, 1 training programme for pedagogues, 2 sets of methodological aids for pedagogical correction, 2 social rehabilitation sub-programmes and 1 manual for specialists involved in educating convicts developed and licensed; 240 convicts involved in pedagogical correction education programmes in 8 prisons) (MoJ);
- to ensure access of convicts to general education (indicator: two programmes developed and implemented within framework of "Guidelines of Education Policy for Convicts 2006 -2010") (MoJ, MoES);
- to develop additional general education programs for implementation in imprisonments (indicator: a number of general education programs increases by 5 programs) (MoES).

4. In order to develop application of an inclusive education principles within the general education system in respect of Roma children the following activity will be implemented:

- to establish 10 inclusive pre-school groups for children in the age of 5 to 6 and to prepare teachers to work with these groups by means of special teaching methodology

[15] National Development Plan (Single Programming Document); European Social Fund.

"Roma child ready for school" (indicator: the number of Roma children in pre-school and basic education institutions; the number of Roma parents facilitating schooling of their children between 2008 and 2010) (SoSAMSI).

5. In order to enhance the accessibility of vocational education to young people from risk groups, the following measures are to be taken:

- to provide support measures to young people from poor families and social risk groups by covering the expenses of the official accommodation facility services (indicator: 12 000 students staying in official accommodation facilities) (MoES);
- to improve the social conditions of vocational education establishments (indicators: the amount of study grant increased to an average of LVL 20 (EUR 28) per month; the average number of students envisaged for groups financed from state budget – 31 600 per year) (MoES).

6. In order to facilitate the interest of students in obtaining education and improving their vocational knowledge, as well as to inform the school youth on the vocational career guidance issues to allow them to be fully competitive in the labour market and choose their future occupation correctly, it is planned to carry out the following activities:

- to provide opportunities for acquiring working skills during summer break for students of general, secondary or vocational secondary education establishments (indicator: the number of students involved) (MoW);
- to provide guidance to students and young people in choosing their profession and education as well as information on career and education opportunities (indicators: the number of consulted students and young people; the number of information activities; the number of PCCSA home page visitors) (MoW);
- to strengthen support institutions implementing career education in order to ensure the quality of career education implementation and perform cooperation council secretariat functions in the state of state institutions, social partners and non-governmental organizations involved in Career development support system (CDSS) (indicators: improved capacity of Vocational Guidance Information Unit at Vocational Education Development Agency; provided coordination of cooperation of employees involved in CDSS) (MoES, MoW).

7. In order to facilitate permanent job placement of young unemployed persons and disabled unemployed persons in the age of 15 to 25 years by improvement of their working skills and competencies, state institutions in cooperation with social partners will implement the following activities:

- to create opportunities for young unemployed and disabled young unemployed persons with vocational knowledge base to improve their practical skills by employer (indicator: the number of young unemployed and disabled young unemployed persons referred to employers for in-service training) (MoW);
- to create opportunities for young unemployed and disabled young unemployed persons without any vocational knowledge base to acquire practical skills by employer (indicator: the number of young unemployed persons referred to employers) (MoW);
- to improve the professional qualifications of young unemployed persons and provide them with vocational training and retraining (indicator: the number of young unemployed persons enrolled in training courses) (MoW);
- measures for improvement of competitiveness through acquisition of basic skills and competencies required in the labour market (indicator: the number of young unemployed persons and job-seekers involved in psychological support classes and in

classes for acquisition of basic skills and competencies required in the labour market) (MoW);

- to improve computer literacy of the unemployed (indicators: a new computer skills training programme for unemployed persons developed; 8000 unemployed persons and job-seekers trained) (MoW);
- to create an employment system for persons with mental disorders and psychiatric diseases (indicators: 75 patients of psychiatric medical treatment institutions employed; methodology for employment of persons with mental disorders and psychiatric diseases developed) (MoH);
- to offer new solutions for employment of people with hearing disability (including youngsters) in order to eliminate discrimination of women (including young women) with hearing impairment, to build up their self-confidence and motivation (indicators: 3 studies performed on the career choice problems of women with hearing disability; the number of motivation programmes, training courses and pilot projects held with involvement of approximately 1000 women with hearing disability; an appropriate system for retraining of unemployed persons with hearing disability developed, and a special system aimed at assisting graduates of schools for people with hearing impairments to join vocational training programmes created; an interinstitutional co-operation network established for solution of the problems of people with hearing disability) (MoW);
- to improve the access of young disabled persons to vocational rehabilitation services (indicators: the number of young disabled persons who have received vocational rehabilitation; implementation of four new vocational rehabilitation programmes corresponding to the labour market needs launched) (MoW).

8. To facilitate employment of young convicts and ex-convicts it is planned to implement the following activities:

- to identify the administrative barriers hindering social and labour market integration of convicts and ex-convicts, and to create a system to maintain the employability of convicts (including young people), as well as to develop a clear employment model for convicts and mechanism for involvement of businessmen that would allow to increase a number of employed minors and young people in imprisonment (indicators: a study on accessibility of education, employment and social rehabilitation services carried out; the number of young convicts engaged in paid employment; 4 social rehabilitation centres in the Ilģuciems, Šķirotava, Grīva and Valmiera prisons and 4 social rehabilitation centres outside of prisons established; a *Concept Paper On Employment Of Convicts* developed) (MoJ).

9. For improvement of the income of children and young people in case of incidence of various social risks the following measures are foreseen:

- to support social integration of children who have lost their providers but are not entitled to survivors' benefit (indicator: state social security benefit raised to LVL 45 (EUR 64) per month) (MoW);
- to facilitate integration of disabled persons with reduced mobility in the socio-economic environment (indicator: benefit for compensation of transport costs increased to LVL 56 (EUR 80) per each full 6 months` period) (MoW).

10. In order to enhance the social integration opportunities of children and young people and to improve their health state, it is planned to carry out the following activities:

- to ensure that children addicted to psychoactive substances have opportunities to receive social rehabilitation services (indicators: social rehabilitation provided to an average of 70 children) (MoW);
- to ensure that child victims of illegal acts have opportunities to receive social rehabilitation services (indicator: social rehabilitation provided to an average of 625 (in 2007 – 725; in 2008 – 772) children in institutions and 884 (in 2007 – 1300; in 2008 – 1400) children at their place of residence) (MoW);
- to reduce alcohol abuse among young people and children (indicator: annual national actions taken for students of general and vocational education establishments, as well as for children and young people with special needs) (MoES, MoCFA);
- to reduce tobacco abuse among students and young people through awareness raising on the risks of smoking (indicator: information materials (posters, booklets, postcards, videos – a film of tobacco addiction and prevention) for 1st to 9th grade educators and students published) (MoI);
- to increase the number of children who have undergone preventive medical examination (indicator: the share of children who have undergone preventive medical examination (in the total number of children) – in 2006 – 90%, in 2007 -91%, in 2008 – 92%) (MoH);
- to perform health promotion measures in order to reduce the incidence of STDs and HIV/AIDS among young people and children (indicators: implementation of an annual awareness raising campaign within the framework of World AIDS Day – in 2006 – 1; in 2007- 1; in 2008 - 1; information on HIV/AIDS related issues provided via the round-the-clock AIDS hotline (number of telephone lines -1) (MoH).

Objective 2: Improve the accessibility of resources and services to families, particularly large and single-parent families.

1. For improvement of the financial situation of families with children by reducing the tax burden and increasing the amounts of various benefits granted during the childcare and upbringing periods, the following measures are foreseen:

- to grant supplements to the current childbirth allowance (indicator: supplement for the first child - LVL 100 (EUR 142), for the second child - LVL 150 (EUR 213), for the third and every next child in the family - LVL 200 (EUR 285)) (MoW);
- to increase the amount of state family benefit for the first child in the family, with resulting increase of the benefit for other children in the family (indicator: the amount of state family benefit for the first child in the family - LVL 8 (EUR 11); for the second child – LVL 9.60 (EUR 14), for the third child – LVL 12.80 (EUR 18), for the fourth and every next child – LVL 14.40 (EUR 20)) (MoW);
- to introduce a more family-friendly childcare allowance system by extending the group of recipients of the childcare allowance and by granting childcare allowance for taking care of a child up to the age of 2 both to unemployed persons and to employed persons who are either on a childcare leave or working (indicator: increase in the number of recipients of childcare allowance) (MoW);
- to introduce a new state social insurance benefit – parental allowance – for persons covered by social insurance taking care of a child up to the age of one year, thus replacing the current childcare allowance granted from the state basic budget to employed persons taking care of children in the age of up to one year. The parental allowance is planned to be equal to 70% of their average insurance contribution wage and its maximum amount will only be limited by the maximum amount of mandatory state social insurance contribution base (indicator: increase in the average amount of

allowance paid to employed persons taking care of a child of up to one year of age) (MoW);

- to increase the non-taxable minimum amount exempt from personal income tax (indicator: the non-taxable minimum amount increased from LVL 26 (EUR 37) to LVL 32 (EUR 45) per month in 2006; from LVL 32 (EUR 45) to LVL 40 (EUR 57) per month in 2007; from LVL 40 (EUR 57) to LVL 50 (EUR 71) per month in 2008) (MoF);
- to increase the tax exemptions for dependants (indicator: the amount of tax exemption for dependants increased from LVL 19 (EUR 27) to LVL 22 (EUR 31) per month in 2006, from LVL 22 (EUR 31) to LVL 28 (EUR 40) per month in 2007, from LVL 28 (EUR 40) to LVL 35 (EUR 50) per month in 2008) (MoF);
- to increase the survivors' pension by granting each child at least 65% of state social security benefit (indicator: LVL 29.25 (EUR 42) for each child) (MoW);
- to grant a supplement to the state family benefit in the month of August aimed at providing additional support in cash for families due to preparing a child for the new school year (indicator: supplement for a child in the age from 7 to 16 years at the level of LVL 20 (EUR 28), LVL 25 (EUR 35), LVL 30 (EUR 43) or LVL 50 (EUR 71) An amount of supplement will be defined by evaluating the economic situation in the country (MoW);
- income tax allowances for inhabitants to purchase computer equipment, software and internet connection (indicator: increase of household proportion with internet connection) (SoSAMEGA).

2. In order to improve access to housing for families with children, implementation of the following activities is envisaged:

- to provide state housing loan guarantees for families with children (indicator: the number of housing loan guarantees issued) (MoRDLG);
- to elaborate an informative report on increased opportunities of housing access to families with children by extending the range of eligible tax-deductible expenses by including amounts paid as interest on housing loan (indicator: informative report submitted to the Cabinet of Ministers) (MoRDLG);
- to elaborate *Basic Guidelines of Housing Policy* by providing measures for families with children in addressing housing problems (MoRDLG).

3. To improve the health state of children and provide support to families during the child raising periods and in cases of incidence of social risks, the following activities are foreseen:

- to provide free lunch to children of primary school age, covering the costs from the state budget (indicator: the number of primary school age children provided with free lunch at school compared to the total number of primary school age children in the respective school) (MoCFA);
- to decrease the number of newborns infected with HIV/AIDS (indicator: HIV testing of the registered pregnant women, including pre-test and post-test consulting (the number of pregnant women tested) – in 2006 – 80%; in 2007 – 80%; in 2009 – 80%) (MoH);
- to establish special palliative care teams for children (with their services available outside of Riga as well) comprising a psychologist, a social worker, a chaplain and a medical worker taking care of incurably ill children and providing the necessary support to their parents (indicators: 2 mobile palliative care teams established; a strategy for introduction of the new service in all regions of Latvia developed) (MoW);
- to prepare the necessary documentation for a new type of services - "Palliative care for children" (indicator: proposals – package of documents prepared for a new type of services - "Palliative care for children") (MoW).

4. To promote development of alternative care and social services and facilitate their accessibility to families with children, the following measures will be taken:

- to develop out-of-family care services corresponding to the interests of children, thus ensuring acquisition of social skills by children in out-of-family care institutions (indicator: a pilot project implemented and methodological support to out-of-family care institutions provided; "Halfway Home" established in the framework of the pilot project) (MoCFA);
- to promote development of alternative childcare services (indicator: a scheme for provision of babysitting services in municipalities elaborated) (MoCFA);
- to strengthen father's role in childcare by implementing the project "Man equal, man different" (MoCFA);
- to increase the opportunities of disabled persons in single-parent families to receive vocational rehabilitation (indicators: the legal framework and economic justification prepared so that a person entitled to vocational rehabilitation in SA "Social Integration Centre" and being a single parent of a pre-school aged child, would be able to receive these services while living in with the child; 10 persons receiving vocational rehabilitation services given an opportunity to stay with their pre-school aged children in premises provided by SA "Social Integration Centre") (MoW);
- to prevent repeated cases of domestic violence and violence against children by ensuring state participation in provision of social rehabilitation to persons who have conducted such acts of violence (indicator: the number of violent persons (male/female) who have received rehabilitation services; the number of persons who have performed acts of violence (male/female) (according to the number of domestic violence proceedings instituted) (MoCFA);
- to promote the stability of families by ensuring child-raising within families and by provision of support to families in critical situations (indicator: 5 support provided for establishment of 6 family support and/or crises centres) (MoCFA);
- to ensure supervision of pre-school aged children during temporary absence of their parents, thus promoting reconciliation of work and family life (indicator: 24 play-and-development centres for primary-school children established) (MoCFA);
- to facilitate development of family-friendly infrastructure and environment by measures aimed at arrangement of children playgrounds and preservation of green areas in public parks and residential areas (indicator: 80 playgrounds created) (MoCFA, MoENV);
- to provide state co-financing for hiring social workers who carry out social work with families and children in municipalities (indicator: 900 social workers receive partial pay from the state) (MoW).

Objective 3: Improve the accessibility of resources and services to retired persons subjected to the risk of poverty, in particular to those living alone.

1. In order to reduce poverty and social exclusion of retired persons by improving their access to resources, the following measures are planned:

- to increase the amount of state social security benefit for general recipients (indicator: state social security benefit in the amount of LVL 45 (EUR 64) per month) (MoW);
- to index pensions not exceeding three state social insurance benefits (LVL 135 (EUR 192)) twice a year on the basis of consumer price index and 50% of the actual growth of wage subject to insurance contributions, and to index pensions that exceed three but not exceed amount of five state social insurance benefits, i.e. from LVL 135.01 (EUR 192) to LVL 225 (EUR 320), on 1 October every year on the basis of consumer price index

(indicator: the average pension in 2006 - LVL 91.52 (EUR 130); in 2007 – LVL 97.15 (EUR 138); in 2008 – LVL 101. 28 (EUR 144)) (MoW);

- to pay supplements to old age pensions depending on the insurance record up to 1996 (indicator: an average of LVL 6.63 (EUR 9) per month per each pensioner) (MoW);
- to grant a new old age pension to people who had opted for early retirement yet continued working up to the statutory age for entitlement to old age pension without actually receiving their pension (indicator: the average increase of old age pension by LVL 28.64 (EUR 41)) (MoW);
- to pay out the part of pension deducted for pensioners who continued working during period from 1 January, 2000 to 19 March, 2003 (indicator: an average of LVL 35.00 (EUR 50) per each month of deducted pension payment) (MoW);
- to establish a supplement to old age pension for those persons who have worked under harmful conditions if their insurance record is at least 25 years and their monthly pension does not exceed LVL 105 (EUR 149) (indicator: an average supplement of LVL 5.32 (EUR 8) per month) (MoW);
- to recalculate the minimum granted pension instead of actually calculated pension in case of accumulated pension capital (indicator: the average increase of old age pension - LVL 6.62 (EUR 9)) (MoW);
- to review the minimum amount of old age pension to provide better support to people with insurance record of at least 41 years (indicator: the minimum old age pension for persons with insurance record of at least 41 years set at LVL 76.50 (EUR 109) (MoW);
- to increase the non-taxable minimum pension amount (indicator: the non-taxable minimum pension amount raised from LVL 110 (EUR 156) to LVL 165 (EUR 235)) (MoF).

2. To improve access to housing for low-income persons of retirement age, it is planned:

- to grant public co-financing for development of social or tenement housing in the territory of local governments (indicator: the number of social or tenement dwelling places developed with public co-financing per year) (MoRDLG).

3. In order to improve the access of retired persons to health care services the following measures are envisaged:

- to limit the spread of contagious diseases and to reduce the incidence of influenza as well as the number of complications caused by influenza through support to vaccination financed from the state budget (indicator: the number of persons over 65 years of age vaccinated against influenza in the periods between pandemics) (MoH);
- to improve the accessibility of health care to low-income pensioners (indicator: ensure that for retired persons with their monthly pension not exceeding LVL 60 (EUR 85), the patient's payment for visits to specialised practitioners is reduced to LVL 1 (EUR 1.4) instead of previous LVL 2 (EUR 3)) (MoH);
- to continue compensation for the expenses on medicines intended for ambulatory treatment (indicator: the number of diagnoses on the compensation eligibility list) (MoH).

4. To improve the accessibility of social services to retired persons and to develop care services alternative to institutional care, thus facilitating regaining of their social status and their social inclusion, as well as enhancing the employment opportunities of their family members, it is foreseen to implement the following activities:

- to improve access to social rehabilitation services (indicators: the number of regional branch offices of the Technical Aids Centre; the waiting time of pensioners with functional impairments for social rehabilitation services) (MoW);

- to improve the quality of services provided to elderly people in long-term social care and social rehabilitation institutions (indicator: quality control of service provision within institutions) (MoW);
- to promote development of alternative care services for persons of retirement age (indicator: the number of pensioners (male/female) who have received home-care; number of day-care centres for persons of retirement age) (MoW).

5. In order to promote the accessibility of cultural events and ICT to retired persons, thus facilitating their socialisation and social inclusion, it is planned to:

- apply discounts on theatre, concert and museum tickets (indicator: pensioners are offered a 10% discount from the average price of theatre and concert tickets; charitable events amounting to 0.3% of the total number of visitors – within the existing total budget) (MoC);
- income tax allowances for inhabitants to purchase computer equipment, software and internet connection (indicator: increase of household proportion with internet connection) (SoSAMEGA).

2.3. Better governance

Preparation process

Following elaboration of the first NAP/incl, collection of information and analysis of situation was commenced in 2005 for the next NAP/Inclusion. In order to obtain an overview of the current situation of population groups subjected to the risks of poverty and social exclusion in the regions of Latvia and to identify the actions necessary to improve the conditions of these population groups, a fiche **"Analysis of the accessibility of resources, goods, services and rights to the groups subjected to the risks of poverty and social exclusion"** was sent to **all local governments of Latvian cities and district centres** (86 in total) in June 2005. This activity also facilitated cooperation with local governments by mobilising and involving them in identification and solution of poverty and social exclusion problems. The fiche contained all population groups subjected to the risks of poverty and social exclusion as identified in the NAP/incl. It was requested that the strengths and weaknesses as regards the access of each of these groups to education, employment, adequate income, housing, health care services, social services, information and communication technologies, transport, legal services, culture and sports be indicated. Moreover, the actions needed to eliminate the identified gaps had to be developed and an institution responsible for implementation of each particular action had to be defined. Altogether, 59 responses were received from local governments.

After the compilation of the submitted fiches, **6 regional seminars** were held from 27 October to 15 November 2005 presenting the proposals of local governments on improvement of the situation of population groups vulnerable to risks of poverty and social exclusion. The aim of the seminars was to strengthen the link between policy makers and implementing actors in the field of combating poverty at the level of local governments, as well as between the local and regional NGOs and national policy makers, and to exchange views on the existing actions for reduction of poverty and social exclusion and the actions required in the future. During these seminars, priority actions necessary for improvement of the situation of population groups subjected to the risks of poverty and social exclusion were put forward.

While, in order to facilitate cooperation with non-governmental organisations and obtain the proposals of NGOs concerning the priority actions for improvement of the living conditions of all population groups under the risk of social exclusion, **public consultation with non-governmental organisations** was organised on 23rd November 2005. During the public consultation meeting, the participants were also invited to identify priorities for the actions to be taken to improve the situation of population groups subjected to the risks of social exclusion in the future.

On the basis of proposals collected through the fiches, regional seminars and public consultation, a compilation was made resulting in putting forward a number of proposals (101 in total), which were taken into consideration when drafting the National Action Plan for Social Inclusion (2006-2008).

In order to achieve involvement of all relevant actors in the drafting of this NAP/incl, an **interinstitutional work group** was established in 2006, comprising representatives of different ministries, regional local government development agencies, non-governmental organisations representing population groups subjected to the risk of poverty and social exclusion, social partners, and a representative from the Central Statistical Bureau.

Mobilisation and involvement of actors

Policy-making for social inclusion would not be possible without involvement and mobilisation of all stakeholders relevant to identification and solution of poverty and social exclusion problems. Participation and involvement of all the relevant institutions in 2005 was achieved through the regional seminars and public consultation mentioned before, as well as within the framework of the Monitoring Committee that monitors the implementation of NAP/incl as described below. Every year, 5 to 8 presentations on different social inclusion policy issues are given to several non-governmental organisations and national councils. These activities will also be continued during 2006 to 2008.

Policy coordination

For the time being, coordination of social inclusion policy and its mainstreaming in all policy fields and levels has taken place through dissemination of the good practice of Peer Review. Every year, upon receipt of the good practice reports, the Ministry of Welfare prepares a brief summary and publishes it on the website of the MoW. The reports are also sent to the members of the Monitoring Committee for the Implementation of NAP/incl for information and practical application in their everyday work.

In 2007 it is envisaged to perform a thorough analysis of the proposals submitted by the local governments and non-governmental organisations as mentioned above, as well as of the responses of ministries concerning the identified gaps in access to resources, services, goods and rights and the problems faced by population groups subjected to the risk of social exclusion. After completion of the analysis, discussions with representatives of the responsible institutions will be organised in order to find the optimum solution for elimination of the respective gaps and problems. Furthermore, it is planned to carry out an analysis of studies made within the framework of the European Social Fund and the Community Initiative EQUAL to facilitate further development of more efficient social inclusion policy.

Mainstreaming of social inclusion policy in the relevant policies

In 2007, it is planned to identify the experience and good practice of other EU Member States in respect of mainstreaming of social inclusion policy in different relevant policies, thus taking over the best example and implementing it at national level.

Monitoring and evaluation arrangements

In order to facilitate coordination of social inclusion policy, as well as supervision thereof, the **Monitoring Committee for the Implementation of NAP/incl 2004-2006** was set up in 2004. The Committee involves representatives of ministries in charge of the tasks defined in the NAP/incl, as well as representatives of regional local government development agencies, non-governmental organisations and social partners. The task of the Committee is to supervise implementation of the objectives, tasks and activities included in the NAP/incl for 2004-2006, as well as to identify problems arising in the course of implementation of the NAP/incl and to come up with proposals on measures to be taken for elimination of the identified risks. The members of the Committee are also provided with information on the latest developments in social inclusion policy both at the EU and national level, on calls for tenders in the framework of the Community Action Programme to Combat Social Exclusion (2002-2006), they are

presented with the Commission`s joint reports on social protection and social inclusion in the EU-25, and they also receive information on the work programmes of the Social Protection Committee and the Committee of the Community Action Programme to Combat Social Exclusion. Meetings of the Committee are convened once a quarter, yet extraordinary meetings may be held in case of necessity.

In order to monitor the implementation of the NAP/incl, the Ministry of Welfare (the ministry in charge of coordination of social inclusion policy) annually submits to the Cabinet of Ministers an **informative report on the implementation of the NAP/incl** in the preceding period. The report provides analysis of the situation in comparison with the preceding year in the fields of economy, employment, education, housing, health, social services, e-inclusion, transport, legal issues, culture, sports, rural and regional development and gender equality, and lists the measures to be taken to improve the situation of population groups subjected to the risk of poverty and social exclusion. All ministries responsible for the measures defined in the NAP/incl are involved in drafting of the informative report, and it is annually adopted by the Monitoring Committee for the Implementation of NAP/incl during one of its meetings. Until now, two informative reports on the implementation of the Action Plan in 2004 and 2005 have been prepared.

For the next period of NAP/incl, a similar monitoring mechanism is envisaged – setting up of a Monitoring Committee comprising representatives of all relevant institutions for monitoring of the joint report, as well as drafting of an informative report on the implementation of the Report, containing the National Action Plan for Social Inclusion 2006-2008, in the preceding period.

3. NATIONAL STRATEGY REPORT FOR PENSIONS

3.1. Adequacy of pensions

The pension system in Latvia consists of 3 tiers (according to the terminology of the World Bank) and it diversifies the risks typical for the schemes of inter-generational solidarity and for pension schemes saving real capital. Income redistribution elements are also present – both between generations and between the rich and the poor.

The social insurance system with pensions as its main component (81.5%) is based on the principle of solidarity and correspondence between the social insurance contributions made and the amount of services received, providing a certain income replacement level upon retirement.

There is a direct link between the Latvian pension system and the economic situation in the country, where the large share of illegal economy and high unemployment rate results in inadequate amounts of pensions dependent on the social insurance contributions. One of the key national priorities is the maintenance of pensioners' living standard after retirement. Particular attention is paid to reduction of the social exclusion risks and provision of adequate pensions. Several important steps have been taken towards gradual improvement of the situation of retired persons in the country.

As from 1st January 2006, the state social security benefit was raised from LVL 35 (EUR 50) to LVL 45 (EUR 64), resulting in an increase of the state guaranteed minimum pension amounts. The state guarantees a defined minimum amount or minimum pension equal to the amount of state social security benefit with the following coefficients applied to it depending on the length of insurance: for insurance record under 20 years – 1.1; 20-30 years – 1.3 and over 30 years – 1.5. In 2005 the guaranteed old age pensions were granted to 56 376 recipients (62% female and 38% male), accounting for 11.9% of all pensions. Compared to 2004, there were by 1.8% less recipients of guaranteed old age pensions.

In order to compensate for the decrease in pensioners' purchasing power caused by inflation and to ensure real increase of pensions, pensions (depending on their amount) are indexed on regular basis. With increase of the state social insurance benefit as from 1st January 2006, the amounts of pensions eligible for indexation have increased as well. From 2006, pensions not exceeding three state social insurance benefits, namely, LVL 135 (EUR 192) (up to 2006 – LVL 105 or EUR 149 respectively), are proceeded to be indexed twice a year on the basis of consumer price index and 50% of the actual growth of wage subject to insurance contributions. Pensions exceeding amount of three state social insurance benefits but no more than five state social insurance benefits, i.e. from LVL 135 (EUR 192) to LVL 225 (EUR 320) (up to 2006, from LVL 105 (EUR 149) to LVL 175 (EUR 249) respectively) are indexed once a year on the basis of consumer price index.

As from 1st January 2006, a monthly supplement to the old age pension is granted to persons with total insurance record of at least 30 years whose pensions do not exceed LVL 105 (EUR 150). The supplement is granted for each social insurance record year accumulated before 1st January 1996 (before the reform). As a result, the pension increases by LVL 6.63 (EUR 9) on average. This may be regarded as partial 4th tier of the pension system (state guaranteed minimum pension during transition period in addition to the pension earned individually) which

was not introduced in the framework of the pension system reform in 1996 due to the lack of resources.
If the person has insufficient qualification period to be eligible for the state old age pension (minimum - 10 years of insurance), but has reached a corresponding age (5 years above the statutory retirement age), the state social security benefit is granted (in 2005 – 14 thousand recipients of the state social security benefit).

3.2. Financial stability of the pension system

The ideology embedded in the Latvian pension system is focused on incentives for population in the working age to remain in the labour market as long as possible, continuing work after reaching the defined minimum retirement age. The old age pension amounting within the NDC PAYG scheme depends not only on the accumulated pension capital, but also on the actual retirement age and the life expectancy after retiring (G).

Gradual increase of the minimum retirement age is carried out in Latvia both for men and women aimed at raising it up to 62 years. For men this age has already been reached in 2003, whereas for women the gradual increase of minimum retirement age will continue until 2008. As from 1 July 2006, the retirement age for women makes 61 years (from 1st July 2007 it will be 61.5 years).

The employment rate in the age group from 55 to 64 is increasing rapidly, reaching 49.5% in 2005 (compared to 47.9% in 2004), which exceeds the EU average (in 2005 – 42.5%). In this age group, the employment rate of females has grown considerably – by 3.4 per cent, thus reaching 45.3% in 2005, while the employment rate for men has shrunk by 0.6 per cent, down to 55.2%.

The average age when inhabitants cease their economic activity, gradually grows each year. In 2005 the age was respectively 61.37 for males and 58.78 for females. Although the retirement age is increasing more rapidly for females than for males, still there are differences between both genders as regards this indicator (by 2.61 years). It is forecasted that during the next 20 years actual retirement age could reach 63 years for both genders.

Opportunity to opt for early retirement was foreseen in legislation until 1st July 2005. In order to provide social protection to persons of pre-retirement age who, due to objective or subjective reasons, were not able to integrate into the labour market, the right to claim early retirement pension was provided by law during the first years of pension reform. Applying for early retirement pension involves certain limitations both in relation to its amount and to entitlement to such pension during periods of work. However, taking into consideration the fact that for the time being labour market inclusion of pre-retirement age population cannot be fully ensured (the opportunity to request early retirement has been used by 40% of pensioners per year on average), after a wide public discussion in the society the Parliament made a decision in favour of prolonging the possibility of early retirement for three more years. The early retirement option was used by 5.9 thousand persons in 2005 (i.e., 39.1% of all persons granted retirement pension in 2005) with their average pension amount LVL 72.56 (EUR 103). The granted old-age pension amount for these persons is set at 80% of the calculated pension amount until the time of reaching retirement age.

Considering the tendencies in the development of demographic situation and its impact on the economic growth, balanced social security policy and financial planning are of great

importance for providing long–term stability of the social security system. The method of old age pension calculation in the NDC PAYG scheme stabilises the system in relation to changes in life expectancy, yet it does not compensate for the fluctuations in the demographic burden of retired persons on persons of the working age. This should be compensated by financial resources from the state social insurance reserve fund. Without such fund the maintenance of pension system's stability is practically impossible in the long-term perspective, for example, during years, when relatively large generation of the employed persons (born in 1960-ies) will retire. Currently discussions are being carried out regarding formation of this fund.

The pension system introduced in Latvia is capable of retaining the rate of state social insurance contributions unchanged in the long-term perspective, and thus, without planning any further rise, it is able to secure the employed persons from the aggravation of social insurance contribution burden. At the same time, in order to improve demographic situation in the country, efforts should be made to create a family–friendly and safe socio-economic environment.

Contribution of the state mandatory funded pension scheme and private pension scheme to the provision of adequacy and financial sustainability of pensions depends on participation rates in the scheme, contribution rates as well as the actual rate of return from investments (taking into consideration the inflation and administrative costs).

On 31st December 2005, the assets of the state funded pension scheme (2nd tier of the pension system) were administered by eight asset management companies and the State Treasury. On 31st December 2005, there were 22 investment plans offered by asset management companies and State Treasury to the participants of the state funded pension scheme (the number remained unchanged if compared to the previous quarter). On 31st December 2005, there were 773 270 participants registered for the state funded pension scheme – 356 629 or 46% of them male and 416 641 or 54% female. There were 468 608 persons registered as mandatory participants of the state funded pension scheme, i.e., by 14.4% more than on 31st December 2005. The right to join the state funded pension scheme on an optional basis was used by 304 662 persons by 31st December 2005, which is by 35.8% more than on 31st December 2004.

Until 2006 including, 2% of person's state social insurance contribution base are channelled to pension state funded scheme. From the launch of the scheme till 31st December 2005, a total of LVL 74.2 million (EUR 105 million) has been transferred for management, and LVL 29.4 million (EUR 43 million) of these in 2005. Private asset managers have been entrusted 61.9 million lats in total. With increase in the number of scheme participants and the contributions made, the assets of the scheme increase as well (with 4.5% return rate per year), reaching 0.8% of GDP in 2005 (compared to 0.6% of GDP in 2004).

On 31st December 2005 there were six private pension funds operating in Latvia – five open and one closed pension fund. By the end of the year these six private pension funds offered 13 pension plans. On 31st December 2005, 67 904 participants had joined pension plans, which is by 73.9% more than in 2004. Out of all participants of pension plans, there were 53.1% women and 46.9% men. The amount of contributions to pension plans in 2005 was LVL 9.1 million (EUR 13 million), compared to LVL 6 million (EUR 8 million) in 2004. Employers had made 69.3% of these contributions (compared to 88.4% in 2004). In comparison with 2004, the amount of contributions made by individual participants of pension plans had grown more than four times, whereas the contributions of the employers had increased by 19.7%.

On 31st December 2005 the investment portfolio of pension plans was worth LVL 36.4 million or 0.4% of GDP (compared to 0.3% of GDP in 2004). By the end of 2005, investments made abroad increased nearly three times if compared to 2004, amounting to LVL 15.4 million (EUR 22 million) on 31st December 2005. LVL 21 million (EUR 30 million) or 57.7% of pension plan assets were invested in Latvia.

In 2005, pension capital of LVL 586 thousand (EUR 833 thousand) was paid out. 89.3% of the total of amount payments were paid out as the participants of plans reached the retirement age, 10.4% in case of death of the pension plan participants, and 0.3% due to disability of the pension plan participants.

As population's purchasing power is relatively low, inhabitants choose to spend their income on their short-term daily needs instead of investing in long-term provisions by accruing supplementary pension capital. However, based on current tendencies, it can be expected that with the increase in purchasing power of population and improved recognition of pension funds, the amount of individual contributions to private pension funds could increase. Yet it also means that people should become more educated in financial and investment issues in order to be able to choose the most appropriate pension plan with the most favourable investment strategy, as the participants take all the investment risks themselves.

3.3. Modernisation of pension system

NDC PAYG scheme is flexible in relation to various forms of employment, for example, in the case of part-time work as well as in cases when the employer has not made the social insurance contributions on behalf of the employee, the employment period is included into the insurance record and pension capital is calculated on the basis of income.

The qualification period defined in legislation for entitlement to state pension is not long – 10 years for old age pensions and 3 years for disability pensions. However, provisions included in the legislation stimulate accumulation of longer insurance record: the longer the insurance record with social insurance contributions made, the higher the pension amount. Certain privileges in relation to calculation of the old age pension also depend on the insurance length. The average insurance record in 2004 was 33 years, whereas for old age pensions – 35 years. Besides that, the activities aimed at promotion of more flexible types of work and combating illegal employment are continued, and the mobility of the population is facilitated.

Despite the relatively high levels of the economic activity among women, the observance of gender equality principles can be evaluated as low, as significant differences exist both in relation to remuneration and in relation to the positions taken by men and women.

Women are more often subjected to the risk of poverty than men. The old age pension amount for women is lower. This can be explained by the fact that women receive lower wage (by 18% on average) as well as by longer career breaks in connection with childcare, earlier retirement, etc. In 2005 the average amount of old age pension for women was by LVL 26.75 (EUR 38) lower than for men. The situation is even more aggravated by the fact that many women are single (widows, divorced) and their pensions are often inadequate for satisfying all their daily needs (apartment rent, food, medical treatment, etc.). Therefore, further efforts have to be made to build the awareness of employers and general public on gender equality issues and to promote reconciliation of working and family life.

Social policy implies certain state support and protection for people in need of it, thus the legitimate expectations of individuals in this field are to be protected with special care. The legal framework of social policy should be sufficiently stable and fixed for individual to be able to safely plan his future. In the legislation governing the pension system numerous amendments have been made since 1996 (for example, the Pension Law which regulates state mandatory non-funded pension scheme has already been amended 11 times). Although no conceptual changes have been made by these amendments, there is a risk of depleting the public confidence level in relation to the stability and sustainability of the pension system.

3.4. Conclusions

The Latvian pension reform, notwithstanding the difficulties of the transitional period, is practically completed. In comparison to the pension system, which operated before the launch of the reform (till 1996) and risked the exhaustion of funds necessary for pension disbursements in the future, the current system has a number of advantages: it is financially stable in the long–term perspective; in spite of the high and constantly increasing demographic ageing of adult population, it is able to ensure pension payments and regular pension indexation; it is able to retain the rate of state social insurance contributions unchanged in long-term, with no further increase envisaged. Thus, a pension system able to react very flexibly to demographic fluctuations and to provide long-term stability under conditions of progressive population ageing has already been created in Latvia.

The pension system is flexible both in relation to retirement age (a person can retire at any age, which is not earlier than prescribed in the law regulating the operation of the corresponding scheme) and in relation to the ways of accumulating pension capital (as it covers both the NDC PAYG scheme and schemes where funds are invested in the financial capital market), as well as in relation to securing payment of pensions by providing for the state mandatory pension and, in addition, life annuity pension offered by life insurance companies as well as disbursement of capital accumulated in private pension funds.

However, it is necessary to point out that due to the large share of the illegal economy in Latvia, high unemployment rate, low average wage and regional disparities, pension amounts, which depend on social insurance contributions, can often be inadequate, therefore certain activities must be carried out to facilitate the improvement of the quality of life for pensioners. Accordingly, one of the national priorities is the maintenance of pensioners' living standard after retirement – additional social protection of those receiving low pensions ensuring pension indexation, in particular, indexing the lowest pensions more rapidly during the coming years, as well as raising the pensions for the pensioners with the longest insurance records within the limits of the insurance budget.

4.NATIONAL STRATEGIES FOR HEALTH CARE AND LONG-TERM CARE

4.1. Summary on health care and long-term care

Since Latvia regained its independence many changes have taken place in the health care system. The health care reform started in 1993. Within the framework of this system its decentralization was performed, consequently 35 territorial and branch sickness funds were made. Such fragmentation of financial resources created a situation that in some districts the provided sum for health care was less than in other districts thereby remarkably reducing principle of solidarity. Considering this situation, at the beginning of 1997 the administration system of health care financial resources was transformed and the principles of state compulsory health insurance were established. Instead of initially established Central account treasury and 35 territorial and department account treasuries, State Compulsory Health Insurance Agency (current Health Compulsory Insurance State Agency), as well as 8 regional sickness funds were established in 1998. The process of sickness fund consolidation was sustained and currently in the state there is one Health Compulsory Insurance State Agency with 5 its regional branches.

In 1997 Latvian Government in cooperation with World Bank worked out a project of "Health care reform" and signed an agreement which predicted World Bank credit for the implementation of this project in two phases. In the first phase of the project till 31st December 2001 it was planned to carry out the necessary changes in the structure of health care system, the education of professionals and establishment of the fundamental reform scheme by creating models of policy, strategies and conception, mechanisms of their realization and control. In order to realize the second phase of the project in the period from 2002, it was planned to perform the realization of health care structure reorganization programme, to implement the *State Health Care Development Plan* (State Outpatient Treatment and Hospital Health Care Structure Plan) and *Public Health Strategy*.

The health care policy was directed to the improvement of population health by health promotion and disease prevention. The implemented activities were directed to establishment of the family doctor institution, reformation of whole health care system and health promotion activities. Current health care policy emphasizes the necessity to concentrate the resources of inpatient health care and to decentralize the resources of outpatient health care, to introduce the cooperation principle in outpatient health care as well as to establish the network of secondary health care providers corresponding to the population needs.

In order to realize the interposed goals, in 2005 the union formation of hospital health care institutions and the upgrading of health care infrastructure was launched. As a result of these activities the secondary health care services in the state will provide the following network of health care providers:

- Regional multi-profile hospitals
- Specialized centres
- Local multi-profile hospitals
- Specialized hospitals
- Other hospitals and health centres

It must be mentioned that the development of health care system could not be possible without adequate financial resources. Therefore it is commendable that since 2000 health care budget in

absolute numbers has increased (Annex 2; Figure1), however, taking into account the rapid growth of GDP of late years, health care budget regarding the whole state budget has even slightly decreased.

Not less important as formation of health care system accessible to population, is ability of the state to ensure social care services. Just in case if a person after prolonged disease and coming into contact with problems, social in nature, will receive the necessary help, state will probably have a sustainable development.

Of late years the demand for social care services in Latvia has substantially increased. To a great extent this trend can be explained with ageing of society. Demographic forecasts indicate that the numbers of labour force should remain quite stable until 2010, yet a sharp drop can be expected between 2010 and 2030. This decline will go hand in hand with significant changes in the age structure, as the number of young people between 15 and 24 years of age will deplete (15.4%), while the number of people aged 45 to 64 will increase (people aged 45 to 59 (18.9%) and 60 to 64 (6.0%)), thus giving a boost to the pool of elderly people by 2050 (Annex 2; Table 14). Wherewith there is an increase of persons at pension age who will need a long-term social care and rehabilitation.

Another major group of persons who need long-term social care and rehabilitation services are persons with mental disorders (disabled persons of I and II disability group) and the blind people. There are about 112 000 persons in the country who has a disability status (Annex 2; Figure 2).

Latvian National Development Plan (2007-2013) defines that population health and welfare must be a common value of the state and society. It is important that the state recognizes a human and his/her knowledge as the main value of Latvia since only healthy and socially secure individual participates in the state development and its future formation.

4.2. Health care

4.2.1. Characterization of health care system

Ministry of Health is a leading institution of state administration in health sector and under its responsibility there are public health, health care, pharmacy and the sphere of narcotic legal turnover. The main task of Ministry of Health is to develop and to realize the state health policy for providing public health in a healthy environment by promoting prevention, popularizing healthy way of living as well as by creating conditions for inhabitants to receive cost efficient, physically accessible and qualitative health care services.

The amount of medical service guaranteed by the state is offered to citizens and non-citizens of the Republic of Latvia, citizens of the European Union, the European Economic Area and of Switzerland who reside in Latvia due to employment or self-employed persons as well as to their family members. Likewise from the state budget and resources of service recipients the health care services are provided to foreign nationals who have a residence permit in Latvia, refugees and persons who have assigned an alternative status, as well as to arrested persons and convicts.

Resources for health care are assigned as the state budget subsidy which is administered by the Health Compulsory Insurance State Agency. From the state budget in health sector there are

disbursed drugs in the system of medication reimbursement and drugs which are unitary purchased. From the state budget there are financed activities also for health promotion, disease prevention, for example, vaccination as well as state sanitary and epidemiological monitoring etc. Health Compulsory Insurance State Agency concludes agreements with medical treatment institutions and medical persons on provision of services. Regulations of the Cabinet of Ministers of 21st December 2004 no.1036 "*Procedures for the Organization and Financing of Health Care*" states those health care services which are not financed from the health budget. For example, cosmetic services, homoeopathic treatment, and cosmetic surgical operations and a.o. services are not financed from the health care budget.
In the state the health care is provided at 3 levels:

1. Primary health care – is offered in outpatient clinics, outpatient departments of hospitals or at the place of residence of a person.
2. Secondary health care – is offered in outpatient medical institutions, outpatient departments of hospitals, at emergency medical assistance institutions, if there are organized outpatient aid, day-care centres, and hospitals.
3. Tertiary health care – highly specialized health care which is offered in specialized medical centres or institutions with medical persons from one or several medical sectors with extra qualification (certification in a definite method).

State paid secondary and tertiary health care services a person can receive only with referral of family doctor or specialist (except of patients who have particular diseases). On receipt of health care services a person must pay a patient contribution (except of emergency medical assistance if a casualty (diseased person) is in condition critical for life and health).

If a person wants to receive health care services that are not included in range of state paid health care services, then expenses shall be covered by patient or the third person, for example, insurance company.

4.2.2. Accessibility of health care services

One of the fundamental indicators of health care system quality and efficiency is its accessibility to the population. Accessibility of health care services can be analyzed from several aspects, for example, economic, geographical, informative, institutional, legislative etc.

As it is above mentioned, upon receiving health care services a person shall pay a patient contribution. While in order to provide health care accessibility for all inhabitant groups, especially the most vulnerable part of society, from the patient contribution are exempted several categories of residents, for example, children up to 18 years of age, needy persons, politically repressed persons, persons who suffered during the liquidation of the consequences of the accident at the Chernobyl Atomic Electricity Station, tuberculosis patients (during the examination of tuberculosis determination), mentally ill persons (receiving psychiatric treatment), persons who are under the care of State social care centres and local government rest-homes. Likewise a patient contribution shall not be paid upon receiving of emergency medical assistance (if a casualty (diseased person) is in condition critical for life and health), for vaccination (for example, against diphtheria) within the framework of state immunization programme, for performing preventive examination, as well as for receiving treatment for different infectious diseases (for example, HIV/AIDS, diphtheria, scabies, tuberculosis, syphilis, viral hepatitis). Separate preferences to the patient contributions are also applied to the disabled persons belonging to the I disability group and persons older than 80 years of age (for

the home visit of family doctor), for pensioners whose monthly pension does not exceed 60 LVL (85 EUR) (attending a specialist).

Taking into account that extended treatment can cause for a patient a threat of poverty, state has established the "ceiling" of patient contribution. When it is reached, it is not necessary to pay a patient contribution. Namely, a total amount of patient contribution for each hospitalization shall not exceed 80 LVL (114 EUR), while a total amount of patient contribution for outpatient and hospital health care services during calendar year shall not exceed 150 LVL (213 EUR).

Very important aspect of accessibility is a possibility to receive the necessary pharmaceuticals. Within the framework of reimbursement system for the purchase of drugs and medical devices, patients with particular diagnoses are compensated of expenditures for the purchase of medicine in amount of 100%, 90%, 75% and 50%. In 2005 the compensation of expenditures for the purchase of medicine was launched according to the principle of reference price, i.e. state disburses the most inexpensive medicine from medicine with equivalent action, by adapting the compensation percentage that allows to ensure medicine compensation to the greater number of patients. However, comparing an amount for compensation of medicine allocated in other Baltic States it must be concluded that Latvia allocates the least resources for medication compensation (Annex 2; Figure 3). If in Estonia 44 EUR were shifted for compensation of medicine per one person in 2005, then in Latvia this made only 19 EUR.

Comparing total expenditures on health in different European countries in 2003, it is seen that in Latvia expenditures on health make 6.4% from GDP similar as in Lithuania (6.6%), a little more as in Estonia (5.3%), but considerably less than in Germany (11.1%), Great Britain (8%) and Norway (10.3%) (Annex 2; Table 49). However, looking at the proportion of these expenditures between the public and the private expenditure, it must concluded that in Latvia public expenditures on health compose about a half (48.7%) from the total expenditure on health. In no one of the examined European countries inhabitants do not cover such a great proportion from total expenditure on health. For health care per one inhabitant Latvia spends 191 LVL (272 EUR), whereas Lithuania 314 LVL (447 EUR), Estonia 288 LVL (410 EUR), the Czech Republic 3 times more – 642 LVL (913 EUR), Germany 7 times more – 1287 LVL (1831 EUR), Norway 9 times more – 1748 LVL (2487 EUR).

Analyzing the indicators of health care accessibility during four years` period, it is evident that a number of indicators during the accounting period have been improved (Annex 2; Table 50) that could indicate to the improvement of health care accessibility. Thus the number of visits to a physician has increased from 4.8 outpatient visits in 2001 up to 5.2 visits in 2005, the number of outpatient medical institutions has increased from 2083 institutions in 2001 up to 2749 institutions in 2005. Of late years there is also a slight increase in number of physicians and medical persons with secondary medical education per 10 000 inhabitants.

It must be noted that the proportion of family doctors within total number of primary health care physicians increases every year – 55% in 2003 and already 64% in 2004. High focus is on education of internists and paediatricians for overall practice or family doctors. Despite the mentioned activities, the number of family doctors per 10 000 inhabitants in Latvia is still one of the lowest in the EU that causes an extra amount of work for physicians and burdens the accessibility of health care services for inhabitants.

Analyzing the geographical location of health care specialists, it can be concluded that the location of physicians is more compact in Riga and its surroundings that is promoted by both the greater density of population structure and the availability of medical technologies and the

economic activity of the region. In Riga in 2003 there was the largest number of physicians per 10 000 inhabitants – 58.8 what is for 24.9 physicians more per 10 000 inhabitants than in the state on average. Similarly the network of hospital location in rural territories is very compact and the areas of hospital service overlap recurrently. Wherewith hospitals are not loaded enough and resources are not used efficiently. Not only in the country on the whole but also within the framework of one region there is a great difference in load of hospital beds and length of average treatment. On the whole the medical technologies are concentrated in medical institutions of Riga and several largest cities. Most of the current technologies are used unreasonably without financial justification: there is a concentration of duplicate technologies and its load is incomplete.

Disturbing fact is that almost 32% of currently employed physicians are in the pre-retirement or pension age who will retire during next 10 years and will be gradually replaced by the physicians aged up to 35 years which is less in number – just 11.5% (Annex 2; Table 51).

Dynamics of number of health care human resources during 2000-2004 has not marked with negative trend, but taking into account the age structure and the predictable leaving of specialists from the labour market due to retirement, comparing the data of Latvian statistics with EU countries in terms of the number of necessary specialists, as well as the unequal disposition of specialists in the regions of Latvia, it can be concluded that the number of human resources is not sufficient to provide accessibility of qualitative health care services for all inhabitants of Latvia.

Lack of physicians and patient's desire to receive a particular health care service by particular physician has an effect on the queue length. If a queue length by family doctor does not exceed 5 working days mostly and in cases of urgent affection a person is accepted at the same day, then waiting queues by several physicians-specialists reach even 60 days. Situation is critical with endoprosthetic surgery where patient has to wait even for several years (Annex 2; Table 52).

4.2.3. Quality of health care services

The accessibility of health care services influences the quality of health care services substantially. Therefore the above mentioned disadvantages of health care system – small state health budget, small funding for medicine reimbursement system, impending lack of human resources – have the negative influence on quality of health care services. In order to ensure that patient receives qualitative health care and corresponding to his/her needs, state has envisaged several conditions for medical persons and medical institutions. Only medical persons who are certified and registered in Medical Person's Registry are allowed to practice medicine singly. All the medical persons must participate in various courses and conferences on a regular basis in order to improve their knowledge and every 5 years they must recertificate. Medicine can practise only those medical institutions which comply with compulsory requirements. Similarly the technologies used in the medical institution shall be approved according to procedure specified by the Cabinet of Ministers.

The quality of professional and work capacity examination for medical care at medical institutions controls the Quality Control Inspection of Medical Care and Capacity for Work Expertise (Inspection). Above mentioned Inspection controls if medical institution has a conformity statement issued by corresponding conformity assessment institutions and if medical persons have certificates of medical persons issued by certification institutions.

Similarly the Inspection performs examinations and gives statements on the quality of medical care and examination of capacity for work in medical institution. Thereby a person is entitled to apply to Inspection with a request to inspect the quality of provided health care. Awareness of inhabitants on their rights increases annually, - in 2005 there were reviewed 1224 complaints and petitions submitted by inhabitants, where 20% of it were well-founded. Upon detection of negligences, Inspection may take a decision on suspension of operation by medical institution or medical person.

In order to provide a possibility for inhabitants to choose a physician a person trusts in, the state has foreseen that every person has a right to choose a family doctor and make reregister not more than twice during one calendar year (except of cases if change of place of residence is the reason for reregistering). Also upon reception of secondary health care services a patient together with a physician chooses the place and time of consultation or diagnostic check.

As a result of targeted action there have been achieved several improvements within the public health sphere, for example, the infant, perinatal and maternal mortality rate has decreased, likewise a number of persons deceased from tuberculosis and a number of persons infected with HIV anew have decreased. However, indicators for oncological care at the same time are unsatisfactory. Indicator of delayed tumour diagnosis has remained unchanged, decreases very little is of visually localised malignant tumours diagnosis at later stages. There is a decreasing trend of malignant tumours revealed during preventive examinations. Similarly there is no stable improvement in the number of operated due to ulcer perforation and bleeding from the digestive tract and in the number of deceased from ulcer disease (Annex 2; Table 53 and 54).

4.2.4. Sustainability of health care system

In order to improve the health care system and provide its sustainability, within the health care sphere there are developed several relevant policy documents. *"Strategy for Development of Latvian Health Care"* approved on 24th September, 1996 by the Cabinet of Ministers is the first relevant policy document. For he first time in the strategy there are identified main problems of health care system, interposed goals and measures. The following documents within the health care sphere to a great extent resulted from the "Strategy for Development of Latvian Health Care".

Elaborated and approved *"Development Programme for Outpatient and Inpatient Health Care Services"*[16] must be marked out as a relevant achievement. Programme anticipates to ensure the further development of integrated health care system by optimizating the number and localization of service providers thereby increasing the quality of provided health care services, cost efficiency and the rational accessibility for patients. The implementation plan[17] of the mentioned programme foresees to implement a number of activities until 2010 that will increase the quality of health care services and will improve access to health care. For example, until 2010 it is planned to establish 20 new primary health care physicians practices and to restructure or improve 50 primary health care physicians practices providing that by one family doctor there are registered not more than 1800 patients. Similarly, substantial step is the establishment of hospital unions (conglomerates), that will promote cooperation among the hospitals and will reduce the administrative expenses. In 2004 and 2005 there were established 6 hospital unions already, and this process is continuing successfully.

---

[16] Approved by Cabinet of Ministers on 20 December, 2004 with Order no. 1003
[17] Approved by Cabinet of Ministers on 28 December, 2005 with Order no. 854

Considering that not all inhabitants of Latvia could receive emergency medical assistance timely, there were elaborated *"Basic Guidelines for Development of Emergency Medical Assistance Service"*[18]. Basic Guidelines foresee specific measures until 2010 which successful implementation will let to provide equal access of emergency for diseased and casualties in the condition critical for life and health in cases of everyday life and emergency situations. Implementation of Basic Guidelines has been already undertaken and until 1st January, 2006 70 new operative medical means of transport and new wireless tenders Motorola were delivered to providers of emergency medical assistance care in rural areas.

In order to define priorities regarding development of human resources within health care sector and proceed with development of rational, effective and qualitative health sector, there were elaborated *Basic Guidelines for Development of Human Resources in Health Care*[19]. Within *Basic Guidelines "Development of Human Resources in Health Care"* there are defined lower rates for wages and determination and provision models for increase of wages until 2010. Along with medical persons, there is provided a regular and anticipated increase of wage. Likewise a programme *"Development of Human Resources in Health Care 2006 - 2015"* is currently under development. Within framework of this programme it is provided not only the building up of the system of wages, social guarantees, insurance of professional risk for medical persons and efficient planning of human resources, but also development of education system in health care sector (higher education, vocational education, further education) according to the demand in the labour market and provision of health care sector with human resources in necessary amount, location and qualification according to demand (Annex 1; 1.Development of human resources).

It must be noted that an important step is taken in arrangement of mental health area by elaborating a project of *Basic Guidelines "Improvement of Population Mental Health 2006-2016"*. If Cabinet of Ministers approves the above mentioned Basic Guidelines, public will have the access to qualitative and corresponding to the population needs mental health care by establishing a mental health care office based on society and improving knowledge of family doctors, as well as cooperation among various institutions will be facilitated.

While, in order to improve the availability of medicine for patients with severe and chronic diseases, a concept paper on the financial resources for provision of medicine availability for outpatient treatment of patients in Latvia was elaborated for the next five to ten years, defining role and responsibility of the state in this process. Concept paper foresees annual increase of financing for system of purchase of medicine compensation that will enable to receive the necessary medicine for greater number of patients.

The successful development of health care system could not be possible without involvement of society in decision taking and mutual cooperation. Therefore during elaboration of policy planning documents and normative acts there are invited representatives from non-governmental organizations, service users and providers, local governments, other state institutions and s.o. Likewise, in order to promote the involvement of public in the decision-making procedure in the area of patient rights, as well as to submit proposals on normative acts developed by the Ministry of Health in the area of patient rights, on the 3rd February, 2005 a Patient Representative Advisory Board was established that successfully cooperates with the Ministry of Health.

---

[18] Approved by Cabinet of Ministers on 19 July, 2005 with Order no. 444
[19] Approved by Cabinet of Ministers on 18 May, 2005 with Order no. 326

It must be recognized that sustainability of the health care system is based not only on the development of system and prognosing of activities, but also on the knowledge of population on possibilities to receive health care, on attitude of society on the choice of healthy way of living, as well as the prevalence of diseases in society. For every inhabitant of Latvia to provide a possibility to receive information on the principles of health care organization, including the proximate family doctor and patient contributions, an informative telephone free of charge is organized. While within area of public health improvement there are implemented activities derived from both the *Strategy of Public Health*[20] and the policy planning documents elaborated for particular sphere. For example, *Programme for Reduction of Alcohol Consumption and Alcoholism Restriction (2005-2008)*, *State Programme for Tobacco Monitoring (2006-2010)*, *State Programme for Restriction and Control of Addiction and Spread of Narcotic and Psychotropic Substances (2005-2008)*, *Programme for Restriction of Human Immunodeficiency Virus (HIV) and AIDS Spread (2003-2007).*

Considering that current health policy is focused on primary health care and prevention, great attention is paid to education of the population. According to the *Strategy of Public Health* since 2004 in the state there are realized a number of activities for improvement of population health state, including education of the society on HIV/AIDS prevention, influence of addictive substances, significance of healthy way of living and s.o. Substantial achievement would be reached also by attaining that at schools and its territories it would not be possible to purchase food saturated with fat and sugar as well as food rich in dye (Annex 1; 2 Wholesome food at school).

4.3. Long-term care

4.3.1. Characterization of long-term care system

The principles of provision and receipt of social care are regulated by *Law on Social Services and Social Assistance*[21]. The above mentioned Law prescribes that social care is provided for the inhabitants on the basis of an evaluation of the individual needs and resources of a person carried out by a municipality social work specialist. A possibility to provide social care service at the place of residence – care at home - is evaluated first of all, and only afterwards if an amount of such service is not sufficient social care and social rehabilitation in long-term care and social rehabilitation institution is provided. Receiving social care services a person has a duty to pay for it except of cases if a person belongs to category of inhabitants whose services are paid from the state budget resources. While if due to the lack of resources a person is not able to pay for the provided services, the expenses are covered by the legitimate support defined by legislation of Latvia or municipality.

From the state budget resources care in long term social care and rehabilitation institution is provided for children with mental disorders, orphans and children left without parental care until 2 years of age, children with mental and functional impairments up to 4 years of age, and for persons with mental disorders and persons with visual impairments. While from the municipal budget resources services in social care institutions receive persons of pension age and disabled people if the required scope of service exceeds the scope specified for home care or care at day care centre and social rehabilitation institution.

[20] Approved by Cabinet of Ministers on 20 December, 2004 with Order no. 1002

[21] Law entered into force on 1st January, 2003.

4.3.2. Accessibility of long-term care services

Social care services in long-term social care and social rehabilitation institutions

Long-term social care and social rehabilitation institutions (social care institution) provides housing, complete social care and social rehabilitation to a person who can not take care of him-/herself due to old age or health state.

In Latvia services in long-term social care institutions are provided for the following persons if the required scope of service exceeds the scope specified for home care or care at a day care institution:

- for children with severe mental disorders, orphans and children left without parental care with functional impairments;
- for persons of pensionable age and disabled persons with impaired vision or physical impairments;
- for persons of legal age with severe mental disorders (disabled people of I and II Group) for whom staying in a specialised medical treatment institution is not necessary and whose state does not endanger other people

State financed care services in children long-term social care and social rehabilitation institutions

For children depending on age and health state there is provided social care and social rehabilitation in two kinds of institutions.

There are five children`s social care institutions in Latvia where the necessary care services receive orphans and children left without parental care until 2 years of age, as well as children with mental and physical impairments until 4 years of age.

It must be mentioned that in Latvia such children`s institutions were established historically already during the Soviet Union time where were placed children with severe mental and physical impairments. During last five years a number of children living in the above mentioned institutions has decreased from 564 children in 2004 to 485 children in 2005. Likewise a number of newly taken children has decreased from 343 to 293 (Annex 2; Figure 4 and Table 55). As the main reason for placing children in these institutions is withdrawal of parental rights as well as the situation when children are abandoned and are left without parental care. Currently the implemented state policy is focused on children`s care in family therefore a number of children`s social care institutions is being reduced.

For disabled children with severe mental disorders in the age from 4 to 18 years, care services are provided in three children`s social care institutions that are under subordination of the state (Annex 2; Figure 4). On 1st January 2006, there were 356 children living in institutions. After coming of age the children from the above mentioned institutions for the most part are moved to adult`s social care institutions for persons with mental disorders.

State financed care services in adult long-term social care and social rehabilitation institutions

A duty of the state is to provide the accessibility of the services in the social care institutions for persons with severe mental disorders as well as for disabled with vision impairments.

In the state there are 24 social care institutions where services receive persons of age with severe mental disorders (disabled people of I and II Group) for whom staying in a specialised medical treatment institution is not necessary and whose health state does not endanger other people, if the required scope of service exceeds the scope specified for home care or care at a day care institution. In 2005 the state provided services for 3360 persons with severe mental disorders.

At the same time the state finances one social care institution where the necessary care is provided for blind persons if the required scope of service exceeds the scope specified for home care or care at a day care and social rehabilitation institution. Last year 213 blind persons received services in this institution.

At the end of 2005, 4346 persons in total – 2213 female and 2133 male received services in the state financed social care and rehabilitation institutions (Annex 2; Table 56).

During last six years a demand for the state paid service for adult persons with mental disorders has substantially increased from 250 persons in 1999 to 890 persons in 2005. Wherewith the queues are forming and an average length of waiting until receipt of the service reaches even two years. As the main reason why queues have formed in these institutions is the lack of care services alternative to institutions in municipality and the kind of service financing.

In order to increase the cost efficiency in the social care institutions, there are evaluated opportunities with current resources of employees or with little increase in number of employees to take in additional clients in institutions. At the same time there are regularly evaluated those long-term social care programs which cost efficiency reduces (for example, due to implemented support system policy within children and family sphere, a number of placed children has decreased) and its resources are redistributed for provision of long-term care services for persons with severe mental disorders. As a result there are free resources for care of 100 new clients in long-term care institutions. For care of mentioned clients there are involved providers of municipalities and other legal persons who will obtain an entitlement to provide services for the state budget resources in tender procedure. Mentioned activities will ensure at maximum effective use of the state budget resources in provision of services.

Care services in adult`s long-term social care and social rehabilitation institutions financed by municipalities and other legal entities

In social care institutions established by municipality services are provided for persons who can not take care of themselves due to old age or disease. Of late years a number of service recipients in social care institutions financed by municipality has increased considerably and and there are forming queues for receipt of services in these institutions. In 2005 from the municipality resources there were financed 75 social care institutions for persons of pension age where the services received 5261 persons, where 2070 of them were male and 3191 female. Likewise 417 persons waited in the queue to the service in the social care institutions. One of the reasons for increase in demand is the rapid ageing of population in the country.

Care services at the place of residence of a person

Demand for services in social care institutions increases every year wherewith queues are forming among the persons who claim for this service. Therefore as an alternative for social care institutions it is very important to develop care services at the place of residence of a person.

Care at home are entitled to receive persons who can not take care of themselves without assistance due to health state, functional impairments or old age. Recently a demand for this service has increased substantially. So in 2004, 7057 persons received care services at home, while in 2005 - already 9546 persons. Mainly women are recipients of care at home – 7178 and only 1269 male. Majority of persons who receive this service are persons who have reached a pensionable age – 6113 (except of disabled people). Likewise care services at home receive 119 children, including 18 children with mental disorders as well as 1323 persons with movement impairments. The accessibility of the above mentioned services for inhabitants in 2005 provided 3397 carers who performed their functions according to the care plan and in cooperation with specialists of primary health care. Such approach ensures quality of provided services and an individual approach towards each client.

Day care centre is an institution where social care and social rehabilitation services, development of social skills, education and leisure time activities are provided during daytime for persons with mental disorders, the disabled as well as persons who have reached the pensionable age. In total, 23 112 persons received services in day care centres in 2005 (in day care centres of municipalities and other institutions from which municipality buys this service). It is indicative of demand for such service in the state and in future the day care centres will became as an alternative to current care in social care institutions. Currently in Latvia there are:

- 17 day centres for persons with mental disorders (including 12 day care centres with the state co-financing for 273 persons) providing service to 507 persons;
- 12 centres for disabled children providing service to 410 children;
- 5 centres for persons with physical impairments where services are provided to 258 persons;
- 23 centres for children from needy families and disadvantageous families, providing service to 2085 children;
- 16 centres for persons who have reached the pensionable age where services are provided to 4402 persons;
- other 24 centres established to provide services to population groups such as persons released from imprisonment, persons addicted to psychoactive substances a.o. providing these services to 16 050 persons.

In order to develop social services at the place of residence of persons with mental disorders, state provides a co-financing for establishment of day centres and supports them during the first four years of activity, but in after years a corresponding municipality is responsible for the maintenance of day care centre. So, in 2005 state provided co-financing for 12 day centres where services were available for 273 persons with mental impairments.

Service apartments – these are apartments owned by a local government which are let out for a person with severe functional disorders. Thereby there are increased possibilities for the person to live independently and to take care of himself or herself. All the service apartments are adjusted to the individual needs so that persons with severe disability who have particular difficulties in taking care of themselves would be provided with correspondent care. Currently there are 27 service apartments in Latvia and this service is used by 43 persons, from them 20 are male and 23 - female. Although this kind of service is new in Latvia, it will be demanded in the immediate future and its development may be forecasted in the future. As the only problem in service apartment introduction are additional financial resources necessary for its establishment.

Group house (apartment) is a separate apartment or house where persons with mental disorders are provided with individual support in addressing their social problems. For development of the above mentioned apartments capital investments are necessary for establishment of housing fund. Currently this service in Latvia is available for a small number of persons. So, in 2005 in the state there were 5 group apartments for persons with mental disorders where services received 60 persons. In order to develop these services since 1st January 2007 state foresees to provide co-financing in amount of 50% for establishment and equipment of group houses (apartments).

4.3.3. Quality of long-term care services

As from 2000 in Latvia there are established common requirements for all social service providers. These requirements were elaborated as minimum standards and are developed on a regular basis.

Development of register of social service providers is significant step for improvement of quality of social services. Social Service Board – the state administration institution under supervision of the Ministry of Welfare - registers there those providers of social services which provide social care and social rehabilitation services and comply with requirements of social services providers defined in normative acts.

A unified programme for assessment of social work quality for social work specialists of municipalities is developed in the state. The program is regarded as one of the resources in order to provide qualitative social care services for persons both at the place of residence and in institutions.

Since 2004 the quality control of minimum standards and services in the state is carried out by Social Service Board. Besides Social Service Board participates also in implementation of state policy in the field of social services and social assistance and provides:

- public information on social services and its accessibility;
- supervision and improvement of quality of social services;
- develops and updates register of social service providers.

An essential aspect in implementation of quality control is a quality and succession of social work which is provided by involving professionals and increasing qualification of staff of long-term social care institutions. In the process of assessment and provision of social services a principle of interinstitutional team work is applied. Coordination in social work is defined by *Law on Social Services and Social Assistance*.

For example, all the clients of social care institutions are registered by the primary health care physicians, in cooperation with them are developed programmes of social care and social rehabilitation corresponding to client needs. Wherewith in the team work with a client there are involved specialists from several spheres that promotes the efficiency of social care and social rehabilitation activities of the client.

In order to coordinate more successfully the rendering of social services in municipalities, a post of social work coordinator is introduced in regions (districts) that allows local governments to use current resources rationally by providing social services to inhabitants.

Quality assurance is also a public information and client involvement in the processes of social assistance rendering. Social Service Board informs regularly the state residents on the possibilities to receive social services. There is a regular cooperation with social service offices of municipalities which provide a receipt of social services as much as possible close to the place of person's residence. While the specialists employed in social service sphere could receive information on current events of social policy, there are elaborated informative newsletters, methodological recommendations, "good practice" manuals, an informative bulletin "Social Assistance News" is published regularly, as well as there are organized seminars.

For client activation and involvement in addressing their problems, in social care institutions there are established Social care councils where institution clients, staff, the representatives of local government etc. are engaged.

4.3.4. Sustainability of long-term care system

In 1996 reform of social assistance and social service system was launched in Latvia were amongst its main aims was to change the service financing system – by changing over from the funding of social care institutions to the principle "money follows the client" (service demander pays to service provider) and to decentralize social services so that municipalities would be interested in developing the types of services alternative to the institutional care.

Administrative-territorial reform is of great importance in introduction of the principle "money follows the client" and realization of all reforms of social policy. Municipalities with a small number of inhabitants usually are economically weaker and for administration there is used major part of budget than in great municipalities. Poorly developed infrastructure, fewer resources which can be allocated to the development of social care, lack of professional social work specialists or overwork of current staff are the reasons which in small municipalities hinder the development of effective social services, corresponding to the population needs. Protracted implementation of administrative-territorial reform hinders functioning of optimal social care system in municipalities.

Long term care system in the state is developed at several levels. Along with control of service quality and improvement of service efficiency in social care institutions, the system is built in the state where types of social care alternative to institutions must be developed. In order to reduce the necessity of services in social care institutions, alternative social care services are developed in the state which foresee to provide social care and social rehabilitation as much as possible closely to the place of person's residence. For example, *Law on Social Services and Social Assistance* states that municipality social work specialist must perform evaluation of person's individual needs and resources and offer service at social care service institution only if it is not possible to provide social care at the place of person's residence. Thereby after a protracted illness and course of treatment a person applies to the social service office of the municipality where the necessity to receive the care at home is evaluated. And just in case if such a care will prove to be ineffective, the services in long-term institutions will be offered to a person. Similar situation will be also in cases when a person with mental disorders after course of treatment in mental hospital will need activities of long-term care and rehabilitation. In such case a person will be sent to the social care institution or day care centre for persons with mental disorders.

At the same time a particular attention is paid to development of complex of preventive measures that provides development of medical rehabilitation in hospitals and outpatient institutions, as well as establishment of rehabilitation system at the place of person's residence in municipalities. Wherewith the principle defined in legislation promotes the development of services alternative to institutions in municipalities.

In order to provide the possibilities to receive social services as much as possible closely to the place of person's residence and to reduce a number of persons placed in social care institutions, state supports the development of services alternative to institutions in municipalities, particularly for persons with mental disorders (day centres, group houses (apartments), halfway houses). State participates in financing of day centres for persons with mental disorders and according to appropriations allocated to the annual state budget law supports and provides financing of other programmes for the development of alternative types of social services in municipalities. For promotion of social care services alternative to institutions for persons with mental disorders, during first four years the state provides financing of day centre establishment and support in municipalities. Demand for the services exceeds a supply, particularly for the care of adult persons with mental disorders in the institutions. As from 1st January 2007, from the state budget resources a co-financing will be provided for establishment of group houses (apartments) what will allow to reduce current demand for services in social care institutions for persons with mental disorders. At the same time in day centres will be developed social services which will be available for persons of pensionable age.

Unfortunately, social care services alternative to institutions in municipalities are developing slowly and it may be concluded that several social care services at the place of person's residence (day centres) as well as social care and social rehabilitation services at the place of residence for several groups of persons (persons with mental disorders) are not developed enough.

It must be emphasized that according to policy of the Ministry of Welfare, state managed social care institutions for persons with mental disorders will be reorganized for municipality institutions that will promote the accessibility of social services as much as possible closely to the place of client`s residence. The above mentioned changes will take place so all the social services offered in the state and the funding provided for it would be assigned to the municipalities that will let to optimize the infrastructure of service providers as well as to develop the alternative social care services.

It must be noted that reorganization of mentioned service providers for municipality institutions is one of the realization forms of principle "money follows the client" – claimant of the service (municipality) pays to service performer (institution or its founder) as it is applied for service in care institutions for old people.

Since many social care institutions are located in buildings that do not comply with present requirements for service providers, it is requisite to improve the technical condition of these buildings. Neither municipality, nor state budget has required amount of free financial resources for improvement of technical condition of these buildings. Wherewith it is devised to attract resources in way of state and private partnership according to *Action Plan for Implementation of Basic Guidelines for Facilitation of Latvian State and Private Partnership (2006-2009)*, approved by Cabinet of Ministers on 16 November 2005.

Another problem topical in Latvia on the whole is the lack of specialists working in social care institutions. For example, in 106 social care institutions for adult persons in 2005 worked 359

social work specialists, from them 121 with correspondent education. A positive trend is that also a number of appropriately educated social work specialists increases every year (Annex 2; Figure 5). In order to define priorities within development of social care human resources, on June 28, 2005 by Cabinet of Ministers there was accepted a *Program for Professional Social Work (2005-2011)* which prescribes education of professional social workers for the state budget resources. It is planned that from 2007 to 2008 (including) 300 social workers employed without corresponding education will start the studies.

Since accession to the EU, a positive development trend are the EU Structural Fund resources available to Latvia what is a good opportunity to attract additional finances for development of social care. It must be noted that an essential step is taken in 2004 by launching an implementation of national programme "Improvement of infrastructure and equipment of social care and social rehabilitation institutions" which will provide the provision of services corresponding to the needs for persons with mental disorders. In the programme there is included one cooperation project of municipality and the state social care institution from the each region of the state (in total 5 projects), which envisages to provide additional services to clients of social care institutions, such as "halfway houses", day centres, social rehabilitation, group apartments etc. It will create the opportunities to clients who are placed in these institutions to return to independent life in their municipality by involving in the labour market within limits (Annex 1; 3 National Programme financed by the European Regional Development Fund "The improvement of infrastructure and equipment of social care and social rehabilitation institutions").

Annex 1 EXAMPLES OF GOOD PRACTICE

1. The development of human resources

The World Health Organization in the report „Working Together for Health" of 2006 have denoted that people are the basis of the health care system, emphasizing that the crisis of human resources in the health care field is global and expanded worldwide. „It is a result of insufficient investments for years in the medical education, training, wage policy, improvement of labor environment and work organization", says the above mentioned report. Almost in all European countries there is a lack of health care specialists and the average age of employees in the health care field in European countries is increasing. According to statistics, from 1994 to 2001 there was a decreasing trend in number of medical persons, particularly the average medical staff (nurses, doctor assistants, maternity nurses) in Latvia. However, since 2001 a number of medical persons in Latvia became stable. In 2005 a number of doctors (7259 doctors) comparing to 2004 (7198 doctors) has increased for 61, but the number of nurses in 2005 (10 308 nurses) comparing to 2004 (10 155 nurses) has increased for 153. However, comparing the statistics of Latvia with the statistics of other countries, according to EUROSTAT data of 2003, there are 278 practising doctors per 100 000 inhabitants in Latvia, but in Western Europe countries (Belgium, Denmark, France, Netherlands etc.) there are 332 doctors on average per 100 000 inhabitants. While practising nurses and maternity nurses – in Latvia – 436 per 100 000 inhabitants, but in Western Europe countries – on average 711 per 100 000 inhabitants. Wherewith it has to be concluded that the proportion of doctors and nurses in Latvia is very low. In 2003 it was 1.9 (comparing to the optimal proportion in European countries – 5.0).

Taking into account the situation described above, the Ministry of Health commenced a targeted action to examine more deeply the current situation and to elaborate the variants for possible solutions. On May 18, 2005 the Cabinet of Ministers approved the Basic Guidelines for „*Development of Human Resources in Health Care*" where the main problems, future tendencies and possible solutions are identified in detail. The Basic Guidelines include the model wage increase for medical persons until 2010. In 2010 an average salary of medical persons is planned in amount LVL 349. Already in 2007 an average salary for doctors will be LVL 462, in 2008 – LVL 484, in 2009 – LVL 508 and in 2010 – LVL 530. For average medical staff in 2007 an average salary is planned in amount of LVL 277, in 2008 – LVL 290, in 2009 – LVL 305, in 2010 – LVL 318. For junior medical personnel in 2007 an average salary is planned in amount of LVL 185, in 2008 – LVL 194, in 2008 – LVL 203, in 2010 – LVL 212[22].

Simultaneously, the Ministry of Health proceeds to consider opportunities to further increase of wages for medical persons. An agreement with the Trade Union of Heath and Social Care Workers of Latvia concluded on June 16, 2006 anticipates that from 2009 an average salary for doctors could be 2.5 times larger than the salary of person employed in economic sector.

In 2005 and in the beginning of 2006 as a sequential document - a project of program „Development of Human Resources in Health Care (2006 – 2015)" was elaborated. Within framework of the program there are envisaged activities not only in development of system for wages, social guarantees, insurance of professional risk for medical personnel and effective

[22] Average amount of salary may change depending on average salary in economics since calculating salary for doctors a ratio 2.0 is applied compared to average in economics, while the ratio of salary for medical nurses is 1.2 compared to average in economics.

planning of human resources, but also in development of educational system (higher, vocational, further education) in the health care sector according to demand in the labor market and provision of health care sector with human resources in required scope, location and demand in according qualification.

2.Wholesome food in schools

There are various catering and foodstuff services provided in schools nowadays. Almost any child can buy a foodstuff full of sugar, fat and food coloring in school. Such products, as well as confectionery, sweets, salty snacks, sweetened colorful drinks are not necessary in the everyday nutriment of children. At schools there should not only provide the theoretical information on wholesome food, but should also practically follow this principle, that is why the above mentioned products should not be available within the school territory.

The amendments in the regulations of the Cabinet of Ministers on „Requirements for Hygiene in Basic, Secondary and Vocational Education Establishments" developed by the Ministry of Health will define the restriction of trade of unhealthy foodstuff, as well as will anticipate the responsibility of directors of basic education establishments for implementation of school milk program, and also to promote further the distribution of milk to the students.

After adoption of mentioned regulations, it will be prohibited to distribute in the educational establishments drinks with colorants, sweeteners, preservatives, caffeine and amino acids. All sweet, colorful drinks are amongst them, for instance, different colorful lemonades, kvass and energy drinks. The use of these drinks is not advisable in the nutriment of children and teenagers.

There will be a prohibition in the educational institutions to distribute also candies, caramels, drops containing certain colorants and sweeteners.

There will be a prohibition to distribute in schools and kindergartens chewing gum containing colorants. These chewing gums may be recognized for their color. There will be allowed to distribute rather popular chewing gums which don't contain colorants and other food additives.

There will be a prohibition to distribute in educational institutions foodstuff containing 1.25 gram or more salt in 100 gram of product or 0.5 gram or more sodium in 100 gram of product, except of products which are used in food preparation. Amongst these products there are potato, corn and other chips, salted nuts, salty snacks. This prohibition does not apply to products which the school dining-room uses for the preparation of food, for instance, salad with mayonnaise or sandwich with cheese.

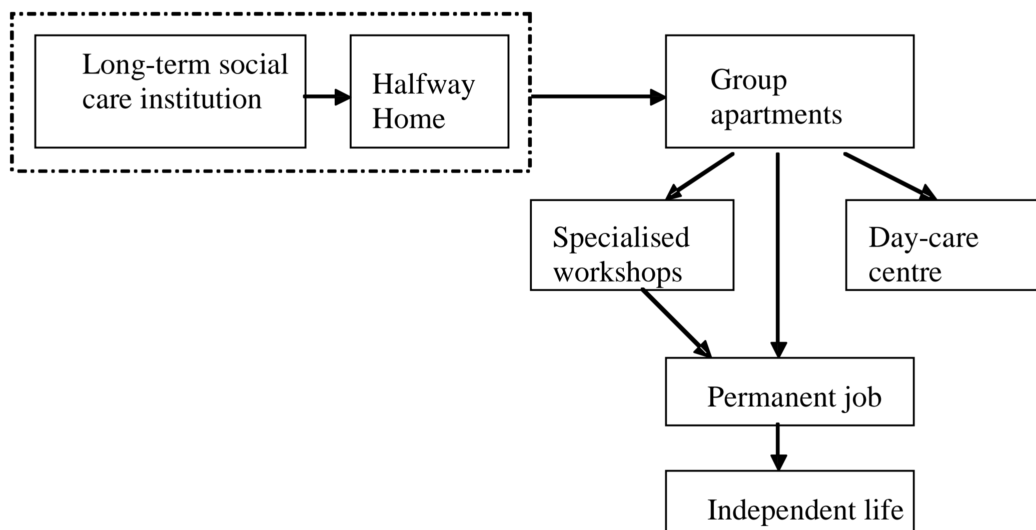
3. National Programme co-financed from the European Regional Development Fund "Improvement of infrastructure and equipment of social care and social rehabilitation institutions"

Lack of timely provision of services corresponding to the person`s needs limits the opportunities of disabled persons with regard to leading an independent life, development of their vocational skills, employment, and also restricts the employment opportunities of their family members who need to stay at home to take care of a disabled family member instead of working. This leads to social isolation of disabled persons and their family members, and to their dependence on social assistance. The social services system, in turn, becomes inefficient both in terms of financial and human resources.

Persons with mental disorders should only receive services in long-term social care institutions if the necessary scope of services exceeds the scope of care at home or day-care and social rehabilitation institutions. On the other hand, if, as a result of rehabilitation, a person is no longer in need of the services in the long-term social care institutions, they should be replaced by service provision at the place of residence.

In order to create a basis for development of social services system and ensure provision of services corresponding to the individual needs and promoting inclusion, implementation of the National Programme "Improvement of infrastructure and equipment of social care and social rehabilitation institutions" was launched at the end of 2004. This National Programme envisages modernisation and adjustment of state social care and social rehabilitation institutions in order to enable provision of complex employment-oriented services corresponding to the need of clients at regional level.

The programme contains one joint cooperation project of local government and state social care and social rehabilitation institutions from each of the regions (5 projects in total). Each of the projects envisages provision of the clients of particular long-term social care institutions with additional services, such as halfway homes, day-care centres, social rehabilitation, skill (including vocational skills) development, specialized workshops, short-term care, group apartments, etc., in order to provide the clients staying in these institutions yet not in need of long-term social care a possibility to return for permanent residence in their local government and to join the labour market if possible (see the scheme):



Implementation of these projects will result in provision of the necessary support to those able to live and work on their own, whereas long-term social care will be provided to persons actually in need of it and pending on the waiting list for receipt of the service.

Thus, the social service network will be optimised in the respective area, accessibility and conformity of the service to quality requirements will be ensured, resources will be cost effective, and persons with mental disorders and their family members will be engaged in the labour market.

The total costs of the programme amount to LVL 5.099.822 (EUR 7.256.392) , with LVL 3. 791. 817 (EUR 5.395.269) of the sum co-financed by ERDF.

Annex 2

STATISTICS

Economic indicators

Table 1. Poverty risk index after social transfers - total

The share of population (percentage) whose equivalent disposable income (including transfers) is under the poverty line (i.e., 60% of the median equivalent disposable income)

Data source: Household Budget Survey

www.csb.lv/Satr/nabdz.cfm

http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,45323734&_dad=portal&_schema=PORTAL&screen=welcomeref&open=/livcon/ilc/ilc_mi/ilc_lk&language=en&product=EU_MASTER_living_conditions_welfare&root=EU_MASTER_living_conditions_welfare&scrollto=0, Eurostat evaluation

	2000	2001[1]	2002	2003	2004
EU (25)	16	16	-	15	16
Latvia	16	-	16	16	19

[1] HBS was not held

Table 2. Poverty risk index broken down by age

		2000	2001[1]	2002	2003	2004
0 – 15 years	**EU (25)**	20	20	-	19	20
	Latvia	21	-	19	19	21
16 – 24 years	**EU (25)**	20	19	-	19	21
	Latvia	17	-	18	19	21
25 – 49 years	**EU (25)**	13	13	-	13	14
	Latvia	19	-	16	15	16
50 – 64 years	**EU (25)**	12	12	-	12	13
	Latvia	15	-	17	16	20
65 years and over	**EU (25)**	17	16	-	17	18
	Latvia	6	-	10	14	23

[1] HBS was not held

Table 3. Poverty risk index broken down by sex

		2000	2001[1]	2002	2003	2004
Male	**EU (25)**	15	15	-	14	15
	Latvia	17	-	16	16	18
Female	**EU (25)**	17	17	-	16	17
	Latvia	16	-	16	17	21

[1] HBS was not held

Table 4. Poverty risk index broken down by household type

Data source: Household Budget Survey
http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,45323734&_dad=portal&_schema=PORTAL&screen=welcomeref&open=/livcon/ilc/ilc_mi/ilc_lk&language=en&product=EU_MASTER_living_conditions_welfare&root=EU_MASTER_living_conditions_welfare&scrollto=0, Eurostat evaluation

		2000	2001	2002	2003	2004
Single person household, 65 years and over	EU (25)	-	25	23	23	28
	Latvia	5	-	17	28	53
2 adults in the age up to 65 years without dependent children	EU (25)	-	10	9	10	10
	Latvia	14	-	15	14	15
2 adults without dependent children with at least one of the adults aged 65 and over	EU (25)	-	15	13	14	15
	Latvia	7	-	7	10	13
Other households with no dependent children	EU (25)	x	x	x	x	x
	Latvia	12		10	12	14
Single-parent family with 1 or more dependent children	EU (25)	-	30	34	33	34
	Latvia	31	-	35	35	41
2 adults, 1 dependent child	EU (25)	-	11	10	11	13
	Latvia	12		14	13	11
2 adults, 2 dependent children	EU (25)	-	13	12	12	14
	Latvia	16	-	19	13	17
2 adults, 3 or more dependent children	EU (25)		27	24	24	26
	Latvia	26	-	22	32	32
Other households with dependent children	EU (25)	x	x	x	x	x
	Latvia	21	-	15	18	19

Table 5. Relative poverty line (poverty risk threshold)

60% of median equalised disposable income, single person household.
Data source: Household Budget Survey
www.csb.lv/Satr/nabdz.cfm, http://epp.eurostat.ec.europa.eu, *Eurostat evaluation*

	2000	2001[1]	2002	2003	2004
EU (25) (EUR per year)	-	7128	-	7834	7853
Latvia (LVL per year)	605	-	706	733	888

[1] HBS was not held

Table 6. Gini coefficient (%)

Data source: Household Budget Survey
www.csb.lv/Satr/nabdz.cfm, http://epp.eurostat.ec.europa.eu, Eurostat evaluation

	2000	2001[1]	2002	2003	2004
EU (25)	29	29	-	29	30
Latvia, total	34	-	34	36	36
- cities	-	-	35	37	35
- rural areas	-	-	31	30	34
IN REGIONS:					
Riga	-	-	-	37	36
Riga district	-	-	-	33	35
Vidzeme	-	-	-	28	32
Kurzeme	-	-	-	31	31
Zemgale	-	-	-	31	32
Latgale	-	-	-	30	29

[1] HBS was not held

Table 7. S80/S20

The average income of the highest (fifth) quintile households against the average disposable income of the lowest (first) quintile households

Data source: Household Budget Survey
http://epp.eurostat.ec.europa.eu/portal/page?_pageid=1996,45323734&_dad=portal&_schema=PORTAL&screen=welcomeref&open=/livcon/ilc/ilc_mi/ilc_lk&language=en&product=EU_MASTER_living_conditions_welfare&root=EU_MASTER_living_conditions_welfare&scrollto=0, Eurostat evaluation

	2000	2001[1]	2002	2003	2004
EU (25)	4.5	4.5	…	4.6	4.8
Latvia	**5.5**	…	5.5	6.1	6.0

[1] HBS was not held

Table 8. GDP per capita as percentage of EU-25 level by purchasing power standards (PPS)

Data source: Eurostat database 07.07.2006.

	2000	2001	2002	2003	2004	2005
EU	100	100	100	100	100	100
Latvia	35.4	37.1	38.7	40.8	42.8	47.1

Table 9. Monetary income of inhabitants
Average per month, LVL
Data source: Statistical Yearbook of Latvia 2005, CSB RoL, Riga, 2005, p.73
http://www.csb.lv Informative Report „Implementation of Latvian National Action Plan for Reduction of Poverty and Social (2004 – 2006) in 2005"

	2000	2001	2002	2003	2004	2005
Average monthly remuneration for work of employed persons Gross - females* - males*	149.53 126.16 160.45	159.30 133.39 166.41	172.78 145.59 178.70	192.49 161.69 194.46	210.94 179.20 211.71	245.75 204.06 249.13
Net - females** - males**	108.55 - -	115.20 - -	124.47 - -	138.07 - -	150.27 - -	175.87 - -
Value of a full goods and services basket ensuring subsistence minimum per one inhabitant	84.47	86.93	88.76	93.54	98.78	105.48
The statutory minimum wage in the country	50	60	60	70	80	80

* 1st quarter.
** Breakdown by sex of the remuneration for work is not requested in reports.

Table 10. Household disposable income broken down by type of household in 2004 in LVL, the average for one member of household per month
Data source: Household Budget Survey

	Average in the country	Single adult with 1 to 2 children	Married couple		Single pensioner
			without children	With 3 and more children	
Average disposable income per one household member per month, **LVL**	101.23	73.42	122.22	55.22	88.30
Average disposable income per one household member per month, **EUR**	150.86	109.42	182.15	82.30	131.59

Table 11. Household disposable income in LVL, the average for one member of household per month
Data source: Household Budget Survey

	2000	2001[1]	2002	2003	2004
All households	69.19	-	80.00	86.88	101.23
Regions:					
Riga	-	-	-	125.23	135.24
Riga district	-	-	-	84.48	102.77
Kurzeme region	-	-	-	68.10	89.88
Zemgale region	-	-	-	73.69	89.66
Latgale region	-	-	-	56.83	67.20
Vidzeme region	-	-	-	67.97	83.34

[1] HBS was not held

Table 12. Household consumption expenditure structure (%)
Data source: Household Budget Survey

	2000	2001[1]	2002	2003	2004	2005[2]
Household consumption expenditure	**100**	**-**	**100**	**100**	**100**	**100**
Incl.: Food and non-alcoholic beverages	37.5	-	35.2	32.4	30.6	31.0
Alcoholic beverages and tobacco	2.8	-	3.4	3.6	3.5	3.3
Clothing and footwear	6.6	-	6.8	7.5	7.2	7.8
Housing, water, electricity, gas and other heating fuel	16.8	-	13.0	12.7	12.6	12.0
Furnishing, household appliances, routine maintenance of the house	4.9	-	4.4	5.4	5.1	5.5
Health	4.2	-	3.2	3.6	3.9	3.9
Transport	7.7	-	9.7	10.7	11.9	11.6
Communications	5.4	-	5.9	6.0	6.6	6.1
Recreation and culture	6.4	-	6.5	6.6	6.2	6.7
Education	1.0	-	1.5	1.6	1.8	1.5
Restaurants, cafés, hotels	2.5	-	5.6	4.9	5.3	5.6
Miscellaneous goods and services	4.2	-	4.8	5.0	5.2	5.1

[1] HBS was not held
[2] Provisional data

Table 13. Household disposable income in quintile groups
LVL, the average for one member of household per month
Data source: Household Budget Survey

	2000	2001[1]	2002	2003	2004
All households	69.19	-	80.0	86.88	101.23
1st quintile	23.61	-	31.41	31.87	38.42
2nd quintile	48.96	-	54.26	56.19	65.14
3rd quintile	61.60	-	68.24	70.25	82.65
4th quintile	78.72	-	91.96	94.75	112.78
5th quintile	157.01	-	178.64	196.50	230.14

[1] HBS was not held

Demographic indicators

Table 14. Demographic indicators
Data source: ***CSB RoL****, Eurostat*

	2000	2001	2002	2003	2004
Number of inhabitants (at the beginning of the year)	**2 381 715**	**2 364 254**	**2 345 768**	**2 331 480**	**2 319 203**
By age groups:					
0-14	428 082	409 760	390 478	372 641	356 505
15-24	339 639	341 405	346 089	352 022	356 976
25-44	676 476	670 338	665 771	660 192	654 786
45-59	437 641	434 372	430 832	432 378	437 487
60-64	146 561	148 109	148 709	144 699	138 061
65-74	226 737	226 800	226 445	227 034	227 762
75 and older	126 579	133 470	137 444	142 514	147 626
% of the total number:					
0-14	18.0	17.3	16.6	16.0	15.4
15-24	14.3	14.4	14.8	15.1	15.4
25-44	28.4	28.4	28.4	28.3	28.2
45-59	18.4	18.4	18.4	18.5	18.9
60-64	6.2	6.3	6.3	6.2	6.0
65-74	9.5	9.6	9.7	9.7	9.8
75 and older	5.3	5.6	5.9	6.1	6.4
Natural population growth (per 1000 inhabitants)	**-5.1**	**-5.7**	**-5.3**	**-4.9**	**-5.0**
Births	8.5	8.3	8.6	9.0	8.8
Deaths	13.6	14.0	13.9	13.9	13.8
Summary birth rate index	1.237	1.207	1.232	1.286	1.240
Level of demographic burden (per 1000 inhabitants)					
over 60 years	344	352	355	356	354
over 65 years	221	226	229	233	236
Life expectancy, years	**70.7**	**70.7**	**71.1**	**71.4**	**72.1**
For newborns					
Male	64.9	65.2	65.4	65.9	**67.1**
Female	76.0	76.6	76.8	76.9	**77.2**

At the age of 60					
Male	14.8	15.4	15.1	15.1	15.9
Female	21.3	21.5	21.8	21.5	21.6
At the age of 65					
Male	11.9	12.5	12.1	12.2	12.9
Female	17.6	17.8	18.1	17.8	17.8

Table 15. Share of the major age groups of permanent residents in the total number of inhabitants

At the beginning of the year (%), corresponding to the statutory working and retirement age of the respective year

Data source: Demography 2005, CSB RoL, Riga, 2005, p.27; regular statistical data of CSB RoL

	2000	2001	2002	2003	2004	2005
Up to working age	18,0	17,3	16.6	16.0	15.4	14.8
At working age	58.9	60.3	60.8	62.4	62.8	63.9
Over working age	23.1	22.4	22.6	21.6	21.8	21.3

Table 16. Number of social risk families

Data source: http://www.csb.lv/Satr/nabdz.cfm; Latvian regions in numbers 2005, CSB RoL, Riga 2005, p. 149

	2000	2001	2002	2003	2004	2005
In Latvia, incl.:	8937	9435	9653	13066	9436	8712
Riga and its region	2023	2404	2574	4896	3413[1]	2909[1]
Vidzeme region	1809	1823	1725	1650	1232	1124
Kurzeme region	1407	1594	1673	2239	1644	1525
Zemgale region	1818	1853	1838	1956	1354	1366
Latgale region	1880	1761	1843	2325	1793	1788

[1] Riga un Riga district region together

Table 17. Number of children in social risk families

Data source: http://www.csb.lv/Satr/nabdz.cfm; Latvian regions in numbers 2005, CSB RoL, Riga 2005, p. 149

	2000	2001	2002	2003	2004	2005
In Latvia, incl.:	18821	19609	19177	23665	18451	17037
Riga region	2983	3605	3807	6648	5330	4472
Vidzeme region	4415	4328	4150	3708	2867	2604
Kurzeme region	3348	3785	3792	4889	3680	3368
Zemgale region	4259	4255	3799	4355	3086	3094
Latgale region	3816	3636	3629	4065	3488	3499

Table 18. Index of the natural movement of population
Per 1000 inhabitants
Data source: Statistical Yearbook of Latvia 2005, CSB RoL, Riga, 2005, p.48, regular statistical data of CSB RoL

	2000	2001	2002	2003	2004	2005
Natural growth	-5.1	-5.7	-5.3	-4.9	-5.0	-4.9
Births	8.5	8.3	8.6	9.0	8.8	9.3
Deaths	13.6	14.0	13.9	13.9	13.8	14.2

Table 19. Migration balance
Per 1000 inhabitants
Data source: Statistical Yearbook of Latvia 2005, CSB RoL, Riga, 2005, p.38

	2000	2001	2002	2003	2004	2005
Latvia	-2.3	-2.2	-0.8	-0.4	-0.5	-0.2

Employment indicators

Table 20. Share of economically active inhabitants in the total population, or participation rate
Average per year, in the age from 15 to 64 years (%)
Data source: Labour Force Survey of CSB RoL

	2000	2001	2002	2003	2004	2005
Latvia	67.2	67.9	68.8	69.2	69.6	69.5
males	72.5	72.8	73.9	74.0	74.3	74.3
females	62.3	63.3	64.1	64.7	65.3	65.0

Table 21. Number of inhabitants above the working age and their share in the total population
At the beginning of the year, corresponding to the statutory working and retirement age of the respective year
Demography 2005, CSB RoL, Riga, 2005, p.27; for the beginning of 2006- unpublished data of CSB

Year	Total population	Number of inhabitants above the working age	Share of inhabitants above the working age, %
2000	2 381 715	551 384	23.1
2001	2 364 254	529 509	22.4
2002	2 345 768	530 174	22.6

2003	2 331 480	504 303	21.6
2004	2 319 203	504 840	21.8
2005	2 306 434	491 214	21.3
2006	2 294 590	488 935	21.3

Table 22. Labour productivity
GDP by PPS per worker (% of EU-25 level)
Data source: EUROSTAT database 07.07.2006.

	2000	2001	2002	2003	2004	2005
EU	100	100	100	100	100	100
Latvia	38.3	39.4	40.2	41.3	42.6	46.2

Table 23. Employment rate – total
Number of employed inhabitants as share of population in the age of 15 to 64, %
Data source: EUROSTAT database, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	62.4	62.8	62.8	62.9	63.3	63.8
Latvia	57.5	58.6	60.4	61.8	62.3	63.3

Table 24. Employment rate – *female*
Data source: EUROSTAT database. 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	53.6	54.3	54.7	55.0	55.7	56.3
Latvia	53.8	55.7	56.8	57.9	58.5	59.3

Table 25. Employment rate – *male*
Data source: EUROSTAT database, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	71.2	71.3	71.0	70.8	70.9	71.3
Latvia	61.5	61.9	64.3	66.1	66.4	67.6

Table 26. Share of job-seekers in the total number of economically active population
Average per year, age 15 to 74, %
Data source: Labour Force Survey of CSB RoL

	2000	2001	2002	2003	2004	2005
Latvia	14.4	13.1	12.0	10.6	10.4	8.7
females	13.5	11.7	11.0	10.5	10.3	8.4
males	15.3	14.4	12.9	10.7	10.6	9.0

Table 27. Registered unemployment rate*
At the end of the year, % of the economically active population
Data source: State Employment Agency

	2000	2001	2002	2003	2004	2005
Latvia	7.8*	7.7*	7.6*	8.6**	8.5**	7.4**
Riga region	4.2	4.2	4.2	5.0	5.2	4.5
Kurzeme region	9.1	8.9	9.0	9.8	9.4	7.4
Latgale region	15.9	15.2	14.7	17.7	18.1	16.3
Vidzeme region	7.7	8.0	8.2	9.6	9.3	8.0
Zemgale region	9.4	9.2	8.7	9.9	9.2	8.2

*Information provided on the basis of regional distribution of districts as defined in the protocol signed by the Ministry of Environmental Protection and Regional Development and the Central Statistical Bureau on 30 March 1999
** Information provided on the basis of regional distribution of districts as defined by the Regulation of the Cabinet of Ministers of 25 March 2003 "Regulation on Territories of Planning Regions"

Table 28. Gender breakdown of the registered unemployment
% of the total number
Data source: State Employment Agency

	2000	2001	2002	2003	2004	2005
females	57.6	57.4	58.7	58.5	59.0	59.9
males	42.4	42.6	41.3	41.5	41.0	40.1

Table 29. Educational breakdown of the registered unemployed
At the end of the year, % of the total number of registered unemployed
Data source: State Employment Agency

	2000	2001	2002	2003	2004	2005
Higher education	6.9	7.0	7.3	7.0	7.7	8.5
Vocational education and vocational secondary education	40.5	42.8	42.5	38.4	38.9	37.8
General education	29.6	27.9	28.3	27.0	28.8	28.9
Basic education	20.8	20.3	20.0	19.1	19.9	19.5
Incomplete basic education or no formal education at all	2.2	2.0	1.9	1.9	2.0	1.9
Not indicated	-	-	-	6.6	2.7	3.4

Table 30. Breakdown of the unemployed by the length of unemployment
At the end of the year, % of the total number of registered unemployed
Data source: State Employment Agency

	2000	2001	2002	2003	2004	2005
Up to 3 months	64.8	64.5	64.6	67.4	69.9	72.2
3 to 6 months	-	-	-	3.5	3.4	3.6
6 to 9 months	-	-	-	1.7	1.6	1.6
9 to 12 months	6.9	7.2	7.1	1.8	1.9	2.1
1 to 3 years	14.6	14.9	14.6	13.3	12.3	11.8
3 years and over	13.7	13.4	13.7	12.3	10.9	8.7

Table 31. Long-term unemployment – *total*
The share of long-term unemployed (12 months and over) in the economically active population, %
Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	3.9	3.8	3.9	4.1	4.1	3.9
Latvia	7.9	7.2	5.5	4.4	4.6	4.1

Table 32. Long-term unemployment – *female*
Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	4.8	4.6	4.6	4.7	4.7	4.5
Latvia	7.5	6.3	4.6	4.4	4.3	3.7

Table 33. Long-term unemployment – *male*
Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	3.3	3.2	3.3	3.6	3.6	3.5
Latvia	8.3	8.1	6.4	4.3	4.8	4.4

Table 34. Breakdown of the long-term unemployed by age groups
By the end of 2004, %
Data source: State Employment Agency

Age	2000	2001	2002	2003	2004	2005
15-19	0.9	0.7	0.6	0.5	0.5	0.4
20-24	6.3	5.7	5.4	5.1	4.7	4.5

25-29	9.0	8.4	8.0	7.8	7.3	7.0
30-34	11.1	11.1	10.7	10.0	9.6	9.5
35-39	13.4	12.8	12.3	11.8	11.4	11.2
40-44	15.2	15.8	15.6	15.6	14.8	14.0
45-49	15.7	15.8	16.4	16.6	16.7	17.1
50-54	17.6	18.2	18.6	18.8	19.2	18.4
55-59	10.8	10.9	11.8	13.1	15.1	16.9
>60	-	0.6	0.6	0.7	0.7	1.0

Table 35. Breakdown of the number of the long-term unemployed by region
At the end of the year, in absolute numbers
Data source: State Employment Agency

	2000	**2001**	**2002**	**2003**	**2004**	**2005**
Latvia	26899*	24402*	23681*	23617**	23209**	20581**
Riga region	2681	2001	1882	2430	2145	1952
Kurzeme region	4342	3693	3508	3612	3361	2291
Latgale region	13114	12434	12621	12327	12928	12173
Vidzeme region	2761	2718	2602	2456	2247	1990
Zemgale region	4001	3556	3068	2792	2528	2175

*Information provided on the basis of regional distribution of districts as defined in the protocol signed by the Ministry of Environmental Protection and Regional Development and the Central Statistical Bureau on 30 March 1999
** Information provided on the basis of regional distribution of districts as defined by the Regulation of the Cabinet of Ministers of 25 March 2003 "Regulation on Territories of Planning Regions"

Education indicators

Table 36. Employment of students during summer break
Data source: State Employment Agency

	2004	**2005**
Number of students	3364	9264
Number of enterprises involved in employment of students	440	753

Table 37. Attained level of education for young people – *total*

The share of young people (aged 20 to 24) with at least secondary education, as percentage of all young people in the age of 20 to 24

Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	76,3	76.1	76.5	76.5	76.6	76.9
Latvia	76.8	70.3	73.2	74.0	76.9	81.8

Table 38. Attained level of education for young people – female

Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	79.2	78.9	79.4	79.0	79.6	79.5
Latvia	82.3	76.2	82.2	79.7	83.4	86.6

Table 39. Attained level of education for young people – male

Data source: Eurostat, 10.07.2006.

	2000	2001	2002	2003	2004	2005
EU	73.5	73.3	73.5	73.9	73.7	74.4
Latvia	71.4	64.6	64.4	68.5	70.7	77.0

Table 40. Number of students in specialised schools and classes, and the number of students graduated from 9th grade, 12th grade and vocational classes in these schools

Data source: Ministry of Education and Science

	School year 2000/2001	School year 2001/2002	School year 2002/2003	School year 2003/2004	School year 2004/2005	School year 2005/2006
Number of students in specialised schools and classes *	**10250**	**10169**	**10055**	**9822**	**9793**	**9691**
Graduated from 9th grade	**881**	**965**	**1044**	**976**	**1002**	**-**
incl. with certificate	838	916	999	921	961	-
with school-report	43	49	45	55	41	-
Graduated from 12th grade	**46**	**53**	**72**	**69**	**141**	**-**
incl. with certificate	46	52	70	51	102	-
school-report	-	1	2	18	39	-
Graduated from vocational class	**205**	**207**	**216**	**204**	**244**	**-**
incl. With corresponding qualification	134	150	157	135	217	-

Table 41. Graduates of comprehensive schools
(except of specialised schools)
Data source: Ministry of Education and Science

	School year 2000/2001	School year 2001/2002	School year 2002/2003	School year 2003/2004	School year 2004/2005
Students graduated from 9th grade In day schools	**25966**	**31169**	**33899**	**32090**	**32042**
with certificate	25370	30556	33028	29797	30359
with school-report	596	613	871	2293	1683
In evening schools	**1146**	**918**	**922**	**817**	**1012**
with certificate	848	697	687	517	730
with school-report	298	221	235	300	282
Students graduated from secondary school In day schools	**16271**	**16523**	**14203**	**13525**	**16664**
with certificate	16209	16440	14142	13254	16524
with statement	62	83	61	271	140
In evening schools	**3789**	**3951**	**3609**	**2979**	**2993**
with certificate	3569	3667	3406	2664	2712
with statement	220	284	203	315	281

Table 42. Number of dropouts in comprehensive day schools by grade groups
Data source: Ministry of Education and Science

	School year 2000/2001	School year 2001/2002	School year 2002/2003	School year 2003/2004	School year 2004/2005
Total	**9727**	**9056**	**9282**	**10242**	**10838**
incl. 1st to 4th grade	3322	2925	2551	2568	2542
5th to 9th grade	4473	4128	4354	4763	5338
10th to 12th grade	1932	2003	2377	2911	2958

Table 43. Dropouts of vocational education establishments
Data source: CSB of RoL

	Number of dropouts in 2000/2001	Number of dropouts in 2001/2002	Number of dropouts in 2002/2003	Number of dropouts in 2003/2004	Number of dropouts in 2004/2005
Total	**7001**	**6862**	**6698**	**6974**	**6995**
The causes of dropping out: change of school	808	827	946	1115	1123
illness	186	158	145	192	131
poor performance	1648	1526	1489	1347	1317
non-attendance	1584	1711	1801	1842	2106
change of place of	213	124	116	111	144

residence					
family reasons	976	977	829	1064	1050
other reasons	1586	1539	1372	1303	1124

Table 44. Number of students involved in pedagogical correction and social correction programmes in general education institutions
Data source: Ministry of Education and Science

Regions	School year 2000/2001		School year 2001/2002		School year 2002/2003		School year 2003/2004		School year 2004/2005		School year 2005/2006	
	Ped. corr.	Social corr.	Ped. corr.	Social corr.	Ped. corr.	Social corr.	Ped. corr.	Social corr.	Ped. corr.	Social corr.	Ped. corr.	Social corr.
Riga	458	0	572	0	617	0	497	0	899	0	837	0
Vidzeme	152	94	250	68	65	79	270	74	476	89	578	103
Kurzeme	107	0	292	0	160	0	508	0	668	0	741	0
Zemgale	106	0	439	0	436	0	568	0	792	0	803	0
Latgale	124	0	128	11	138	0	484	21	557	0	468	0
Total	**947**	**94**	**1636**	**79**	**1416**	**79**	**2327**	**95**	**3392**	**89**	**3427**	**103**

Table 45. Share of students with special needs integrated in general and vocational education institutions
Data source: Ministry of Education and Science

	Regions					
	Riga	**Vidzeme**	**Kurzeme**	**Zemgale**	**Latgale**	**Total**
School year 2003/2004 General education institutions	408	498	324	270	302	**1802**
Vocational education institutions (disabled persons)	133	105	13	8	36	**295**
Vocational education after graduation from a specialised school	31	55	45	21	32	**184**
School year 2004/2005 General education institutions	508	433	275	292	333	**1841**
Vocational education institutions (disabled persons)	68	115	12	9	32	**236**
Vocational education after graduation from a specialised school	2	50	29	4	21	**106**
School year 2005/2006 General education institutions	396	480	271	265	388	**1800**
Vocational education institutions (disabled persons)	143	125	4	11	14	**297**
Vocational education after graduation from a specialised school	8	29	20	9	15	**81**

Table 46. Number of Roma students in general education institutions
Data source: Ministry of Education and Science

School year 2000/2001	School year 2001/2002	School year 2002/2003	School year 2003/2004	School year 2004/2005	School year 2005/2006
1187	1317	1591	-	1464	1415

Criminality

Table 47. Age break-down of persons convicted by the courts of the Republic of Latvia
Data for 2005
Data source: Court Information System

	2001	2002	2003	2004	2005
14-17 years	1754	1794	1838	1786	1402
18-24 years	4036	4179	4463	4379	3593
25-29 years	2025	1961	2102	2078	1671
30-49 years	4170	3983	4373	4180	3596
50 years and over	694	698	810	799	668
Total	**12 679**	**12 615**	**13 586**	**13 222**	**112 15**

Health care and long-term care indices

Figure 1 Health care budget

Data source: the Ministry of Health

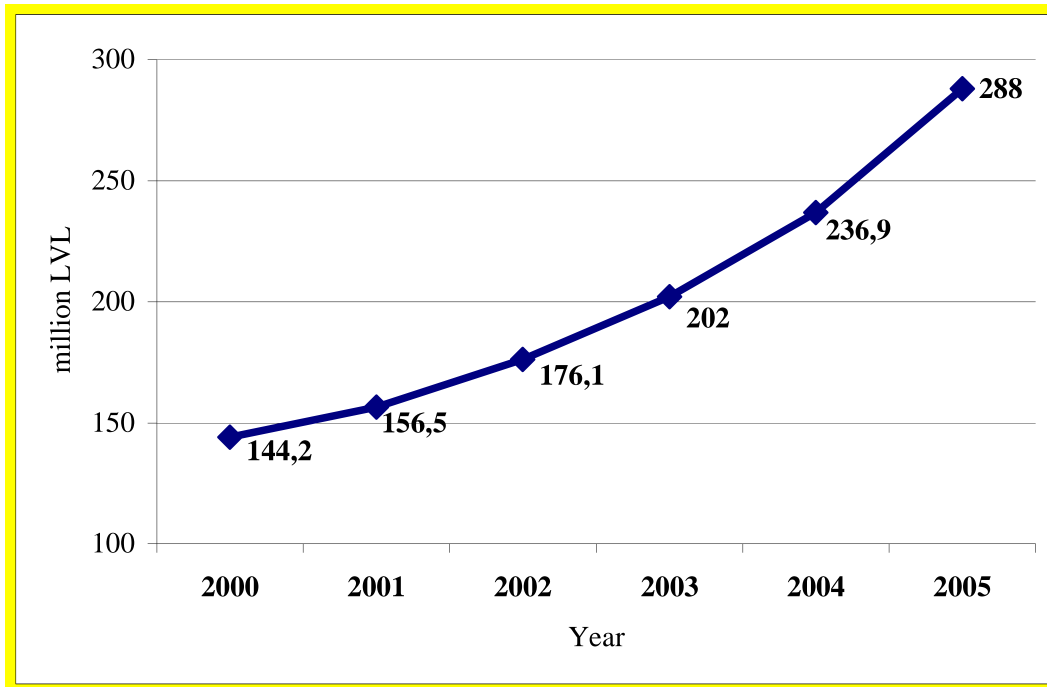


Figure 2 Number of examined patients/ the disabled in State Commission of Physicians for Health and Work Capacity Examination and its departments in 2000-2004

Data source: the Ministry of Welfare

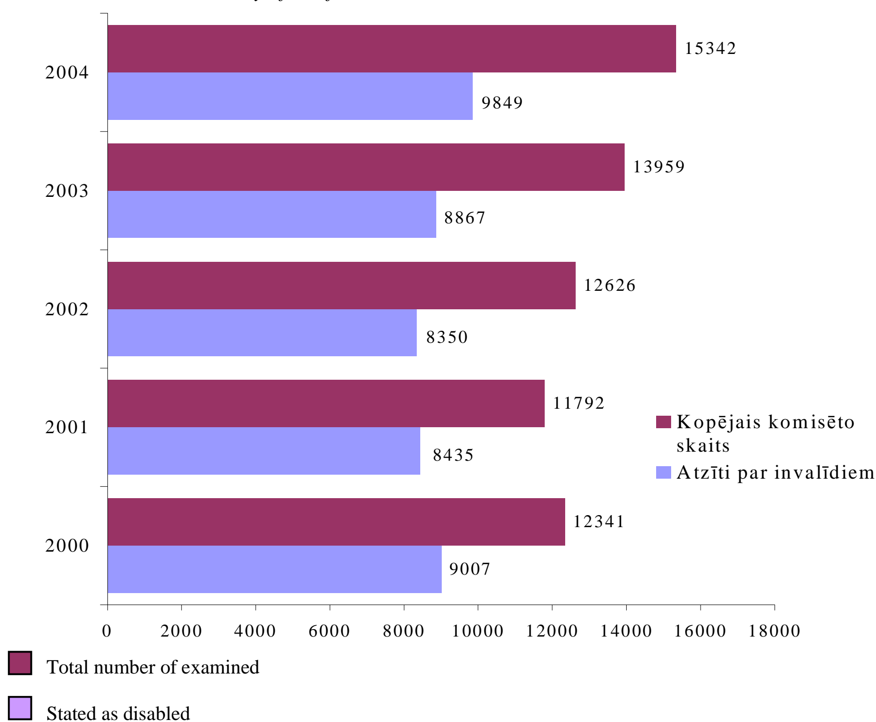
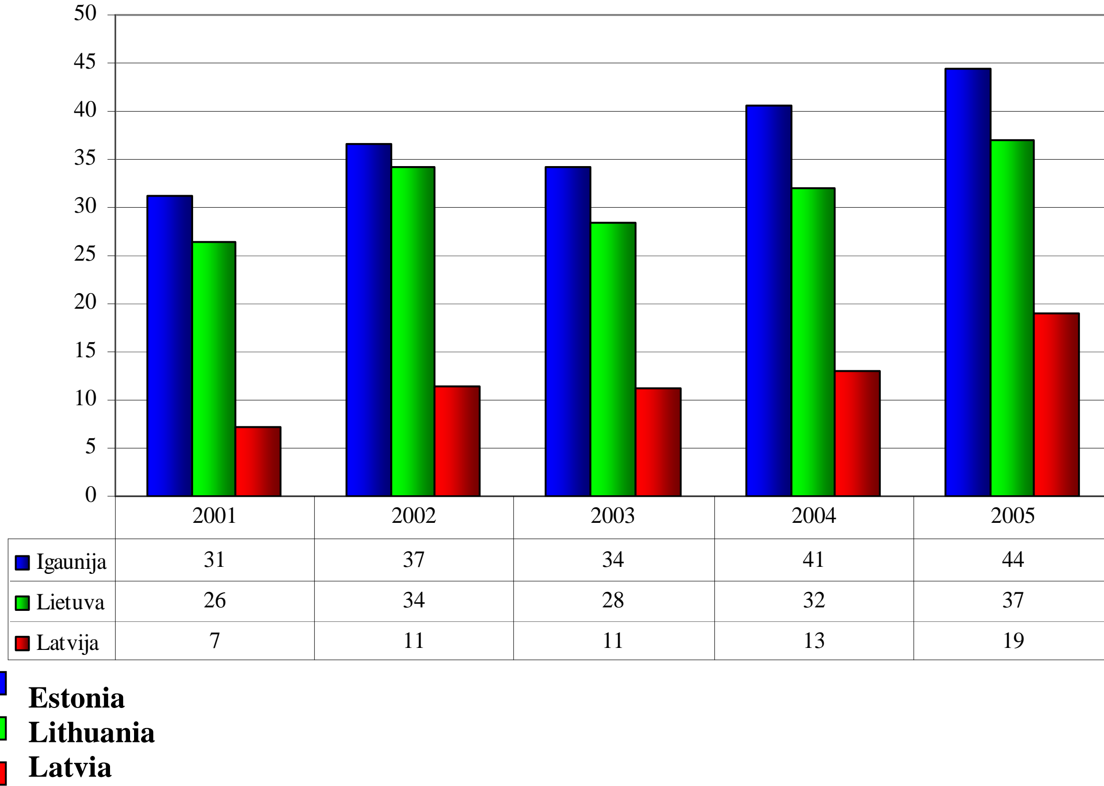


Figure 3 Medication reimbursement expenses in the Baltic States for the outpatient, EUR/1 inhabitant
Data source: State Medicines Pricing and Reimbursement Agency



	2001	2002	2003	2004	2005
Igaunija	31	37	34	41	44
Lietuva	26	34	28	32	37
Latvija	7	11	11	13	19

Figure 4 Number of children entered in children social care institutions 2000-2005
Data source: the Ministry of Welfare

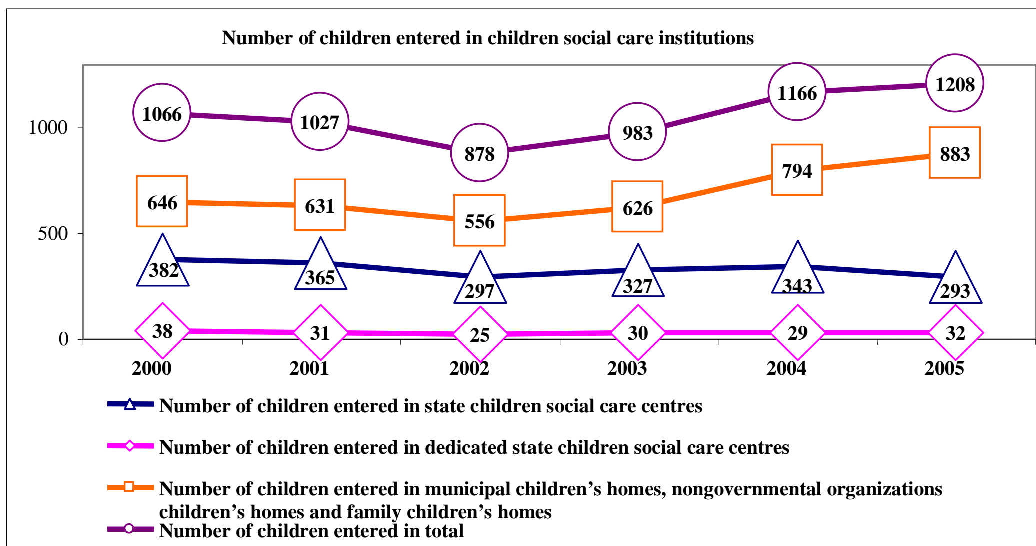


Figure 5 Number and education of social work specialists; number of adult long-term social care and social rehabilitation institutions and number of adult persons in them (2000-2005)
Data source: the Ministry of Health

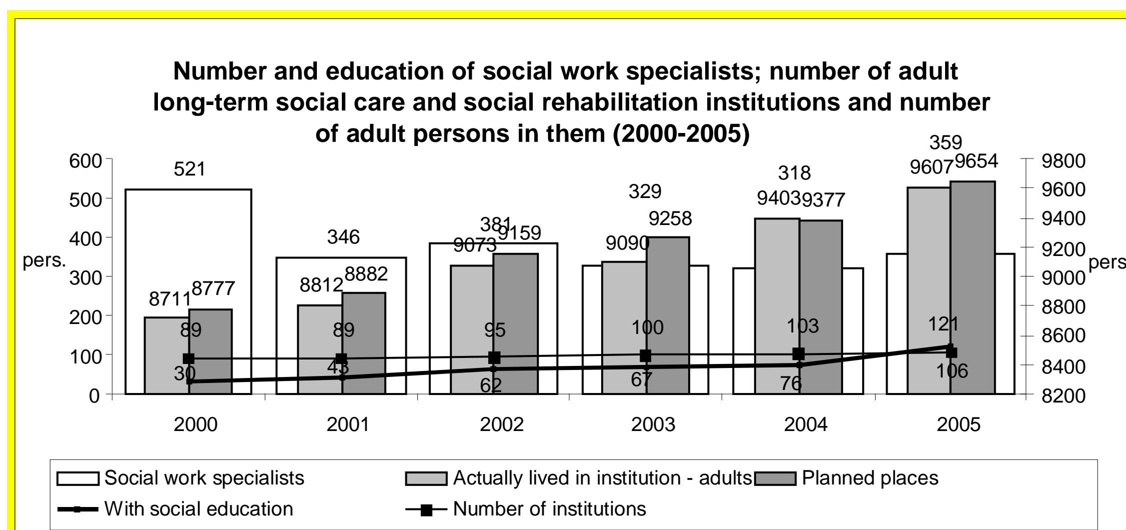


Table 48 Health care expenditures
Data source: The World Health Report 2006

	Total expenditure on health % from GDP			General government expenditure on health as % of total expenditure on health			Private expenditure on health as % of total expenditure on health			Per capita government expenditure on health at international dollar rate		
	2001	2002	2003	2001	2002	2003	2001	2002	2003	2001	2002	2003
Latvia	6,2	6,3	6,4	51,2	52,1	51,3	48,8	47,9	48,7	281	318	348
Lithuania	6,3	6,5	6,6	72,6	74,9	76	27,4	25,1	24	429	495	573
Estonia	5,1	5	5,3	78,6	77,1	77,1	21,4	22,9	22,9	424	454	526
The Czech Republic	6,9	7,2	7,5	91,4	91,1	90	8,6	8,9	10	937	1080	1172
Germany	10,8	10,9	11,1	78,4	78,6	78,2	21,6	21,4	21,8	2173	2288	2348
Great Britain	7,5	7,7	8	83	83,4	85,7	17	16,6	14,3	1696	1860	2047
Finland	6,9	7,2	7,4	75,9	76,3	76,5	24,1	23,7	23,5	1409	1535	1613
Norway	8,9	9,9	10,3	83,6	83,5	83,7	16,4	16,5	16,3	2745	3019	3189

Table 49 Health care access indices
Data source: Health Statistics and Medical Technologies State Agency

	2001	2002	2003	2004	2005
Outpatient visits hours per 1 inhabitant	4,8	4,6	4,8	5,0	5,2
hospitals at the end of the year	140	129	131	119	109
Hospital beds (without temporary social care beds) per 10 000 population	82,0	77,6	78,1	77,4	76,8
Outpatient care institutions at the end of the year	2083	2335	2494	2585	2749
Physician's assistant – midwife aid posts at the end of the year	303	266	263	250	242
Physicians (including dentists) per 10 000 population	33,0	34,0	34,0	35,1	35,8
medical personnel with secondary special education per 10 000 population	62,5	62,7	63,6	63,8	65,1

Table 50 Division of physicians in the age groups
Data source: the Ministry of Health

Age	1 st January 2005 total number of physicians (in absolute numbers)	1 st January 2005 total number of physicians (percental)
25 to 35 years	808	11,5
35 to 55 years	4004	56,8
55 to 62 years	1129	16,0
More than 63 years	1114	15,8
Total:	7055	100

Table 51 Queue duration to the endoprosthetics surgery (in years)
Data source: Health Compulsory Insurance State Agency

:	2002	2003	2004	2005
Endoprosthetics of major joints: - knee joints	10	10	10	12
- hip joint cementless endoprosthesis	7-8	7-8	4	3-5
- hip joint cementing endoprosthesis	2-3	2-3	3	4
- shoulder joints	-	-	-	1
Endoprosthetics of cochlear implants	-	-	-	1

Table 52 Health care quality indicators
Data source: Health Statistics and Medical Technologies State Agency

	2001	2002	2003	2004	2005
Malignant tumours, diagnosed at stage IV (%)	26,0	23,9	24,0	23,6	23,9
Visually localised malignant tumours diagnosed at stage III or IV (%)	32,6	30,0	29,1	28,9	28,9
Diagnostics of malignant tumours at preventive examinations (%)	1,2	1,6	1,4	1,1	0,8
Operated (per 10 000 population)					
- due to ulcer perforation	26,4	22,7	22,7	23,3	21,0
- due to gastrointestinal bleeding	9,4	6,8	7,7	7,0	7,0
Death rate (per 100 000 population) from:					
- acute pneumonia	14,9	15,0	17,9	17,8	22,6
- peptic ulcer	6,3	5,8	7,8	6,4	3,9
- tuberculosis	11,9	9,0	9,5	7,9	8,0
Maternal mortality (per 100 000 live births)	25,4	10,0	14,3	9,8	4,6
Infant mortality (per 1000 live births)	11,0	9,9	9,4	9,3	7,8
Perinatal mortality (per 1000 live births and stillbirths)	12,3	12,6	10,4	10,5	9,9

Table 53 Incidence on 100 000 inhabitants
Data source: Health Statistics and Medical Technologies State Agency

	2001	2002	2003	2004	2005
Tuberculosis	73,4	65,9	63,7	59,4	53,8
Neoplasms	369,7	383,9	394,6	431,1	427,3
Mental disorders	275,8	234,8	244,9	252,3	239,8
Occupational diseases	30,8	37,8	41,5	81,6	72,7
Diabetes mellitus	148,1	242,3	165,6	188,3	237,4
HIV	34,2	23,2	17,3	14,8	13,0
AIDS	1,8	2,4	2,5	3,0	3,1
Diseases of circulatory system (hospital discharges)	3136,8	3175,2	3289,2	3398,7	3635,9

Table 54. Number of persons entered and left from children social care institutions per year 2000-2005
Data source: Social Service Board

	Per annum:	2000	2001	2002	2003	2004	2005
Children social care centres	**Number of children entered in total**	**382**	**365**	**297**	**327**	**343**	**293**
	int.al. orphans	6	0	0	3	0	1
	Due to child disease	35	0	0	26	15	19
	Withdrawal of child care rights	136	211	116	104	136	104
	Withdrawal of child guardian rights	13	8	1	0	1	3
	Abandoned children	79	0	0	107	85	91
	Other reasons	113	146	180	87	106	75
	Number of children left in total	**361**	**433**	**338**	**311**	**390**	**372**
	int.al. returned to the parents	124	107	99	105	103	123
	Adopted	90	128	124	57	127	110
	Assigned for custody	55	60	35	43	49	46
	Assigned in foster family	0	0	0	0	1	13
	Displaced to other institutions	82	126	62	92	98	73
	Dead	10	12	15	13	12	7
	Other reasons	0	0	3	1	0	0

	Per year:	2000	2001	2002	2003	2004	2005
Children social care centres for children with mental age disturbence	**Number of children entered in total**	**38**	**31**	**25**	**30**	**29**	**32**
	int.al. orphans	0	0	0	0	0	0
	Due to child disease	33	0	0	16	26	20
	Withdrawal of child care rights	4	0	1	6	1	5
	Withdrawal of child guardian rights	1	0	0	4	2	7
	Abandoned children	0	0	0	0	0	0
	Other reasons	0	31	24	4	0	0
	Number of children left in total	**47**	**65**	**43**	**64**	**37**	**35**
	int.al. returned to the parents	4	6	3	4	0	2
	Adopted	0	0	1	0	0	0
	Assigned for custody	1	0	0	0	0	0
	Assigned in foster family	0	0	0	0	0	0
	Entered self-dependent life	0	3	18	1	0	0
	Displaced to other institutions	38	52	15	54	34	24
	Dead	4	4	6	5	3	5
	Other reasons	0	0	0	0	0	4

	Per year:	2000	2001	2002	2003	2004	2005
Children's homes, family and nongovernmental organizations children's homes	**Number of children entered in total**	**646**	**631**	**556**	**626**	**794**	**883**
	int.al. orphans	30	14	19	21	18	33
	Due to child disease	11	0	0	14	4	6
	Withdrawal of child care rights	351	407	337	342	487	460
	Withdrawal of child guardian rights	34	39	19	56	74	91
	Social conditions	13	0	0	0	0	0

	Abandoned children	0	0	0	17	19	57
	Other reasons	207	171	181	176	192	236
	Number of children left in total	**672**	**575**	**637**	**772**	**956**	**1013**
	int.al. returned to the parents	267	208	248	292	392	394
	Adopted	12	28	35	29	46	71
	Assigned for custody	129	91	114	134	160	137
	Assigned in foster family	0	9	7	20	11	49
	Entered self-dependent life	103	87	129	175	209	243
	Displaced to other institutions	137	113	76	91	120	107
	Dead	3	0	3	1	1	0
	Other reasons	21	39	25	30	17	12

Table 55. Number of persons entered and left from adult social care institutions per year 2000-2005

Data source: Social Service Board

	Per year:	2000	2001	2002	2003	2004	2005
Municipal social care institutions	Number of persons **entered** in total	**1 434**	**1604**	**1 989**	**1 682**	**1 966**	**2 060**
	int.al.: – from home	1242	1360	1 769	1 397	1 625	1 556
	- from other social care institutions	67	71	76	75	147	121
	- from psychiatric medical institutions	7	6	6	6	18	18
	- from other medical institutions	118	127	128	151	157	262
	- from other institutions	–	40	10	53	19	103
	Number of persons **left** in total	**1354**	**1 502**	**1 820**	**1 641**	**1 700**	**1 902**
	int.al.: -displaced to other social care institutions	76	8	76	59	44	64
	- displaced to medical institutions	13	10	7	11	18	11
	- returned in the families	1021	222	491	203	249	299
	- discharged due to regular ignoring of regulations of an establishment	8	77	9	15	15	13
	- dead	1 069	1 108	1 235	1 326	1 367	1 510
	- other reasons	3	5	2	27	7	5
State social care centres	Number of persons **entered** in total	**641**	**508**	**546**	**452**	**404**	**337**
	int.al.: – from home	312	250	302	209	185	171
	- from other social care institutions	103	75	112	101	62	79
	- from psychiatric medical institutions	185	136	112	109	139	62
	- from other medical institutions	41	28	16	17	12	13
	- from other institutions	–	**19**	4	16	6	12
	Number of persons **left** in total	**588**	**522**	**500**	**454**	**369**	**372**
	int.al.: -displaced to other social care institutions	46	28	63	31	14	27
	- displaced to medical institutions	21	21	22	21	9	6
	- returned in the families	25	27	22	22	22	21
	- discharged due to regular ignoring of regulations of an establishment	1	0	0	3	1	0
	- dead	466	430	390	364	316	304
	- other reasons	29	16	3	13	7	14

Table 56. Number of working staff in long-term social care institutions
Data source: Social Service Board

Institution title	Number of institution employees – in total:	int.al. health care employees	int.al. social workers	int.al. social carers	int.al. social rehabilitators	int.al. carers
	Number of employees	Number of employees	Number of employees	Number of employees	Number of employees	Number of employees
Municipal social care centres	**2 515**	399	58	91	8	644
State social care centres	**2 499**	338	51	142	9	690
Total in the state	**5 014**	737	109	233	17	1334

Information society indicators

Table 57. Use of computer and internet
Data source: Basic Statistical Indicators, 2006, CSB, RoL, Latvia

	2004	2005
Households with computers		
in total, thousand	220	274
of total number of households, %	26	32
Households with internet connection		
in total, thousand	125	261
of total number of households , %	15	31
Number of inhabitans aged 16-74 who use computer regularly		
in total, thousand	648	745
of total number of households , %	36	42
Number of inhabitans aged 16-74 who use internet regularly		
in total, thousand	485	646
of total number of households , %	27	36

Table 58. Use of computer and internet in educational establishments
Data source: Basic Statistical Indicators, 2006, CSB, RoL, Latvia

	2004	2005
Number of educational establishments with internet connection, % of total number		
High-schools and colleges	100.0	100.0
Vocational education institutions	97.1	97.9
Comprehensive schools	93.4	95.0
Number of computers per 100 students		
High-schools and colleges	5.9	6.2
Vocational education institutions	6.1	7.5
Comprehensive schools	5.4	6.2