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# ANCIEN

**Assessing Needs of Care in European Nations**

## **LONG-TERM CARE IN LATVIA**

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# 1. The LTC system in Latvia

## 1.1. Overview of the system

The strategic aim of the health and welfare system in Latvia is to provide mental, physical and social welfare, focusing on the availability of services near a person's (clients) residential place. Since 2002 the system of social care in Latvia is defined by the Law on Social Services and Social Assistance. The aim of the above mentioned law is to prescribe principles for providing and receiving services for social work, social care, social rehabilitation and social assistance. Social insurance related issues are regulated by the Law on State Social Insurance. According to both previously mentioned laws, the state guarantees help in cases of sickness, disability and also agedness. However there is not one specific long-term care (hereinafter – LTC) system in Latvia.

LTC organization is divided between health and welfare systems. In Latvia, health care services are provided by state, municipal and private medical institutions. Patients can receive healthcare services only in medical institutions which have signed an agreement with the Health Compulsory Insurance State Agency.

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 Switzerland who reside in Latvia due to employment or self-employment as well as to their family members. Likewise, from the state budget and resources of service recipients 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.

Social care services are provided by state, municipal and private institutions. However, social care service is only offered to citizens and non-citizens of the Republic of Latvia and non-residents who have an identification code issued by the state.

According to legislative acts and sectoral policy documents the Republic of Latvia implements such issues as organization of LTC and eliminates the risk of social exclusion.

## 1.2. Assessment of needs

There is not one specific term “need of care” according to legislative acts in Latvia, but legislative acts determine several terms, for example care at home, primary health care, etc.

A person can receive social services (including care at home) according to assessment of the needs produced by the municipal government social service. The assessment criteria are material and personal resources. Material resources include available finance resources (pension, benefits), whilst personal resources include motivation and necessary knowledge, (profession, age, relatives). Social services are provided near or as close as possible to the

client's residential place. If according to assessment of needs it is not possible to provide care at residential place then social services are offered to the client by the long-term care institutions (hereinafter – LTCI).

A person can receive health care at home, if there is a need for constant outpatient healthcare and the patient cannot receive it in a medical institution by value of client's health condition. An assessment of the needs to provide health care at home is produced by the family doctor or specialist, who determines the length of time for home care.

There also exist several levels of dependency which are estimated by the family doctor or specialist who identify the need of care. For example, home care services include four levels of dependency, which differ according to necessity, length of visit and payment.

### ***1.3. Available LTC services***

According to the Law on Social Services and Social Assistance, persons needing assistance can receive diverse services:

**Care at home** can be received by the persons who cannot take care of themselves without assistance due to the state of health, functional impairments or old age. The services of social care are available for those individuals who have difficulties for self-care because of their age or functional disabilities. They are provided either by state, by local municipality or by non-governmental organizations depending on the particularity of the service. The state is concerned that the citizens have alternatives to LTC at home or in close proximity that would be more similar to family environment. There are benefits in cash and kind available and the applicant can choose between both.

**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 the daytime for persons with mental disorders, the disabled, and persons who have reached the pensionable age.

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

Benefits in kind are available.

**Service apartments** – these are apartments owned by the local government and let out to a person with severe functional disorders. Through this there are increased possibilities for the person to live independently and to take care of him 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 level of care care. The municipality confers the status of service apartment to an apartment inhabited by a person

receiving the respective service. When there is no need for this service any more, the status of service apartment is revoked. Although this kind of service is new in Latvia, it will be demanded in the immediate future and its development may be forecast in the future. The only problem in the introduction of service apartments is the additional financial resources necessary for its establishment.

Benefits in kind are available.

**Group house (apartment)** is a separate apartment or house where persons with mental disorders are secured with individual support for addressing their social problems. For the development of the above mentioned apartments capital investments are necessary which can be done through the establishment of a housing fund. Currently this service is only available for a small number of persons. Since 1 January 2007 the state has supported the establishment and equipment of group houses (apartments) with co-financing to the amount of 50%.

Benefits in kind are available.

**Long-term care in institution** – provided for people who due to their special needs or social circumstances are not able to cope independently because they require care and assistance 24 hours per day and their coping cannot be secured through other welfare services or by providing other kinds of assistance in the usual social environment. Benefits in kind are available.

The Law on Social Services and Social Assistance also foresees other social services. However these services are related to care for other groups, like homeless person's care, children's care, or care for disabled persons. Considering that the main subject of the report is care for elder persons, a description of the other care groups is not included in the report.

According to information given by LTCI it is necessary to provide alternative services of institutional care. The duty of local governments is to offer appropriate care services to old people and invalids.

#### ***1.4. Management and organization (role of the different actors/ stakeholders)***

According to national legislation, the state or local government has to provide the possibility for a client, who cannot cope with self-care, to stay in his or her residential place as long as possible, offering social care services at home or near it. The client receives social care in social care institution only if this service is not acceptable. This is the main reason why social institutions need people with low incomes to provide material support for minimal needs.

National legislation (state) determines the general capacity planning, quality control and monitoring system for LTC. Local governments can determine the capacity, quality control and monitoring system in detail, and according to the financial position each local government can provide more services than is established by the national government. It is

necessary to stress that both - state and local- government is responsible for enforcement of the above mentioned system.

The state has established a supervisory system and developed a quality requirement for its social care system. In local areas a new position – a coordinator of social work– is established. It exposes coordination with LTC centres to provide continuity of care and develop care programs.

In order to receive services of alternative care, a person or their legal representative should apply to the social office of their respective municipality. If there is no social office then they should apply to the city board or parish council.

Compared to 2005, the expenditure on municipal social assistance benefits in 2006 increased by nearly EUR 2.84 million (LVL 2 million), of which EUR 858.99 thousand (LVL 603.7 thousand) accounted for the increase in social assistance expenditure in Riga.

In 2006, the total expenditure on social assistance benefits in the country was EUR 30.73 million (LVL 21.6 million). In 2006, the expenditure on municipal social assistance benefits amounted to 42.1% of all the funds the municipalities used for social measures (in 2002, the expenditure was 50.6%, but in 2005 decreased to 43.0%). The decrease in the proportion of social assistance expenditure can be considered a positive trend, along with the benefits, both municipal and commercial providers of social services develop their activities (including social care), the wages of social work specialists are growing and the municipalities pay for other support measures for the inhabitants.

Compared to 2005, the number of the municipal social benefit recipients decreased in 2006 due to the population decline in the country, the increase in actual income, the development of social services in the municipalities, as well as to data recording by the municipal social work specialists which allowed to assess more effectively the needy person's resources and their use for solving his/her problems. Starting with 2005, the recording of social assistance beneficiaries is broken down by gender. Statistical data show that the recipients of social assistance are predominantly women (in 2005, 60.6% among the GMI benefit recipients were women, in 2006 it was 56.6%), but compared to 2005, the proportion of men among the total number of benefit recipients increased in 2006 (in 2005, 39.4% among the GMI benefit recipients were men, in 2006 it was 43.4%).

### ***1.5. Integration of LTC***

Older people integration concerns mainly two circumstances:

1. Financial aspects – low pensions, when a person cannot fully provide his/her needs.

In Latvia, there is no definition of poverty; therefore the definitions of European Commission are used when talking about poverty, social exclusion and social inclusion. According to the European Commission, a person is considered poor if their income and resources (economic, social and cultural) are so scarce that their level of life is lower than socially acceptable and that they have limited or no access to their basic rights.

Looking at the citizens subject to risk of poverty according to their age, the greatest risk of poverty in 2006 was for retired people and those of pre-retirement age (32% for the people of 75 and more years of age; 30% for people of 60 and more years of age). According to gender, women in Latvia are more subject to poverty than men, especially women living alone - 58% (men - 49%). In turn, according to household type, in 2006 the most subject to risk of poverty were:

- Retired persons (65 year old and elder) living alone - 69%;
- Families with 3 and more children - 52%;
- Families with children and a sole provider (mostly women), or one-parent families - 40%.

Many countries in the world, as well as international organizations have acknowledged that the main precondition for reducing poverty and social exclusion is a coordinated and well-balanced policy promoting the social inclusion of different population groups. The risk of poverty in the population group aged 65 and above (in 2004, 24%) is comparatively great, besides, there are considerable gender differences (12% for men and 26% for women), revealing the fact that women are at a greater risk of poverty than men. This can be explained by the lower wages of women (by 18% on average) and by the long breaks in their career due to child care leave, earlier retirement and other reasons. Their situation is aggravated also by the fact that a rather many of them are single (widows, divorcees) and their pensions are often too small to cover their daily needs (rent, food, medication, etc. In recent years, the poverty risk for retired persons living alone (65 years of age and above) has considerably increased (in 2003 – 28%; in 2004 – 53%).

## 2. Emotional aspects – retirement from society.

The risk of social exclusion for retired people has been caused by the shortage of material and social resources making it difficult for them to satisfy their needs for food, housing and health care. In order to reduce social exclusion of retired people and promote their integration into society, the social policy in Latvia includes measures initiated by the state and local governments in the areas of pensions, social and health care services, as well as culture and information and communication technologies. Especially important measures for social inclusion of elderly people and ensuring gender equality are those promoting the reconciliation of work and family life, namely, it is essential to provide the possibility for elderly people to spend the day in a social environment, for example, at the community day care centre, but in the evening to be together with their families. In this case, the family members who spend their day at work do not have to leave the labour market, since in the daytime their elderly relatives are taken care of but in the evenings they can take care of them themselves.

## 2. Funding

The care system in Latvia is mainly financed by the state or local governments. There are some cases when clients have to pay themselves, for example clients have to pay for LTCI, except when they belong to groups which are free from payment.

The health care budget consists of subsidies fixed by the state, paid services and other income as well as foreign financial aid. In 2007 the total health care budget in Latvia was EUR 632.51 million (LVL 514.809 million). It has increased by EUR 226.62 million (LVL 159.267 million) which is 30.9% compared to 2003. However, it only accounted for 4.0% of GDP and 10.8% from the state consolidated budget in 2006. The distribution of the health care budget by outpatient, inpatient and emergency care services corresponds to Regulation No.1046 "Order of health care organizing and financing". According to this Regulation at least 32% of funding must be spent on outpatient services, no more than 61.6% funding – on inpatient services, at least 6.4% - on emergency care services. 11.0% of the total administered healthcare funding was spent on medicines in both 2006 and 2005. That comprises 0.1% funding spent on centralized purchase of medicines (2.7% in 2005, 4.2% in 2004). In 2006 the reserve fund accounted for 1.3% of the total healthcare budget, up from 0.96% in 2005. 1.75% from the total administered healthcare budget was spent on the Disaster medicine program, 1.6 percentage points less than in 2005 (3.4%).

The budget for LTC is a small part of the total health and welfare system (only 0.4% of GDP) and according to plans it will increase to 0.7% of GDP until year 2050.

## 3. Demand and supply of LTC

### ***3.1. The need for LTC (including demographic characteristics)***

In recent years the demand for social care services in Latvia has substantially increased. To a great extent this trend can be explained by the ageing of society. Demographic forecasts indicate that the labour force level should remain quite stable until 2010, yet a sharp drop can be expected between 2010 and 2030. This decrease will happen simultaneously with significant changes in the age structure, as the number of young people between 15 and 24 years of age will decrease (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 social group of elderly people by 2050. Therefore, there is an increase of persons at pension age who will need long-term social care and rehabilitation.

From the beginning of 1999 to early 2004, the population of Latvia 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 700 babies less than in 2003. An 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 the higher birth rate was the scaling up of the 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 predominance of emigration over immigration.

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.

The state of health of the population still remains unsatisfactory. The mortality rate keeps increasing reaching 32,777 deaths or 14.2 per 1,000 inhabitants in 2005, the highest point during last seven years.. 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 was a considerable increase in HIV/AIDS mortality rates – 26 death cases (in 2004 – 15). Despite the fact that morbidity rates of tuberculosis decreases, there is still a high number of cases (morbidity with all kind of tuberculosis – 53.8 incidences of tuberculosis per 100,000 inhabitants in 2005). 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.

According to statistical data and the abovementioned, the demand of LTC increases every year. Unfortunately Latvia has problems in providing LTC services to every person who needs it. The main reasons are insufficient amount of professionals, low salaries and disadvantaged working conditions.

### ***3.2. The role of informal and formal care in the LTC system (including the role of cash benefits)***

The formal care system is more developed than the informal care system in Latvia, therefore the role of the formal care system is larger than that of informal care. Requests for formal care increased during the last few years, therefore the availability of professionals providing formal care decreased. Although there is remarkable growth in requiring formal care, the amount of days staying under institutional formal care has decreased (from 2004-2005 – 10 days on average, starting from 2006 - 9 days).

### ***3.3. Demand and supply of informal care***

There are no statistics available about the demand and supply of informal care in Latvia. However, in 2005, 1,073 informal care providers were ensured with benefits in cash. It is necessary to highlight that one of the goals of social care policy (including LTC) in Latvia is to develop alternative care services (including informal care) and provide the clients with the opportunity to receive care in their residential places.

As the population in Latvia ages, it is even more important to develop alternative care services, which include informal care, to provide care to all persons who need it. The main reason why informal care is not developed in Latvia is the assumption that family members cannot provide sufficient care to older family members due to their constant working and small living places. Unfortunately families are not financially secure to leave a job and take care of their relatives.

### ***3.4. Demand and supply of formal care***

The demand for general formal care has increased in last years, starting from 488,500 in 2004 to 531,800 in 2007. However the length of hospitalization has decreased – from 10 days in 2004 and 2005 to 9 days in 2006 and 2007.

It is necessary to mention that there is a difference between formal care supply in rural and urban areas. Urban areas can provide a higher level of formal care but there is also higher demand. This can be explained by not only there being more inhabitants in urban areas but also that inhabitants from rural areas prefer to demand more formal care in urban areas than in rural areas.

It is necessary to point out that the number of physicians is larger in urban areas compared to rural areas. Sometimes medical help can be provided by nurses if there are no physicians in particular rural areas.

#### **3.4.1. Institutional care**

LTCI is an establishment providing housing, full care and social rehabilitation to persons who have difficulties in taking care of themselves due to old age or poor health as well as to children without parental care. The task of the **state is to provide** services at social care institutions for persons suffering from mental disorders and for blind people. Social care

services at institutions are provided for adults having severe mental disorders (persons with I and II category disabilities) and blind persons, who do not need care at specialized health care institutions and do not create any danger for the surrounding people and who need more care than can be ensured by home care, day care or care at a social rehabilitation institution. **Municipal social care institutions** provide social care services for persons who are unable to take care of themselves either due to old age or illnesses. At the end of 2006, 114 social care institutions provided services for adults, of them – 78 municipal old people’s social care centres and 27 state social care centres, as well as 9 institutions concluding public procurement contracts (businessmen and municipal institutions). In 2006, there were 36 social care centres for adults with severe mental disorders (state social care centres and institutions whose services were financed by the state), an increase of 5 centres from the year before. In 2006, social care at institutions was provided for 10,118 persons, of which 4,494 were men and 5,624 women. Compared to 2005, the total number of persons living in social care institutions increased by 511 persons. At the end of the reference period, 36 state funded institutions provided services for 4,646 persons with severe mental disorders. In 2005, 4,346 clients lived at these institutions. The number of clients at the social care institutions increases year by year, yet the demand for this type of service has not been fully met. **State social care institutions** and contracting institutions admitted 344 persons or half of the total number of their clients straight from their homes. About 20% of the total number of the admitted clients came from psychiatric hospitals. In 2005 the number of persons coming from their homes and those coming from the psychiatric hospitals was approximately equal. The increase in clients at state funded social care centres is due to the fact that the decision about the need for social care services for a person is taken by the municipality but it does not have financial responsibility for its decision. As a result, persons with various degrees of disturbances live at the social care centres for persons with mental disorders, including persons who might have lived outside social care institutions receiving adequate care services at their residence. As the number of the retirement age population is growing in the country, the number of inmates at the municipal social care institutions continues to grow. In 2006, there were 5,472 inmates at the municipal old people’s social care institutions, in 2005 – 5,261, but in 2004 – 5,022 inmates. The proportion of women at these institutions is still larger than that of men – in 2006 it was about 61%. This can be explained by the fact that the average lifespan of men in the country is shorter than that of women and with increasing age, the proportion of women is gradually growing. In 2006, 1,790 clients or 78.6% of the total number of admitted clients (2,277) of the municipal social care institutions came from home. Clients coming from other health care establishments were much fewer in number. In 2006, an average of 13% of the municipal social care institution inmates returned to their families (in 2005 it was 16%).

**Day centres.** In total, 23,112 persons received services in day care centres in 2005 (in day care centres of municipalities and other institutions from which the municipality buys this service). This is indicative of demand for such service in the state. In future the day care centres will become an alternative to current care in the social care system. 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 services to 507 persons;
- 12 centres for disabled children providing services 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 services to 2,085 children;
- **16 centres for persons who have reached the pensionable age where services are provided to 4,402 persons;**

- 24 other centres established to provide services to population groups such as persons released from imprisonment, persons addicted to psychoactive substances etc providing these services to 16,050 persons.

Currently there are 27 service apartments in Latvia and this service is used by 43 persons, of which 20 are male and 23 female.

Group house - in 2005 there were 5 group apartments for persons with mental disorders where services were received by 60 persons.

Availability of LTCI and access to LTCI is dependent on local government financing, which is different in rural and urban areas. An exclusive problem is the long waiting periods for LTCI. The long waiting periods arise because some client groups (for example, mental patients) do not have an alternative for LTCI and the local government does not have enough finances. Although home care and care near residential place is advisable, this institutional care alternative is provided more often but the quality is worse because of a lack of coordination between the state and local government budget.

### **3.4.2. Home care**

Social services (social care, social rehabilitation and social work) and social assistance are a constituent part of the system of social safety with the purpose to guarantee the social protection of individuals unable to take care of themselves or to overcome specific difficulties of life and who do not receive sufficient help from anybody else.

The state is concerned that the citizens have alternatives to LTCat home or in close proximity that would be more similar to the family environment, namely, home care, services at day centres, service apartment, group home or group apartment, and others.

Recently, demand for this service has increased substantially. In 2005, 9,546 persons received home care services, 10,612 persons in 2006 and 10,751 persons in 2007. As the longevity of inhabitants arises, there is an increase of potential clients for social care services; however local governments cannot provide social services due to the lack of social care providers and finance. In rural areas social care services are financially ineffective because of low inhabitants' density.

It necessary to note that as the as social care service popularly grows, so too does the amount of social care services offered. Social care services are requested more from women than from men – at the end of 2007 there were 8,228 women and 2,623 men who requested the service. The largest social group was older persons – 7,553 (women -6,300, men - 1,253).

There were 1,955 home care providers in 2007, which is less than in 2006, when the service was provided by 2,055 home care providers.

Very often the clients do not only receive basic home care services but also additional services - hot dinner at home, a "safety button" (the possibility to reach relief service 24 hours per day) etc. The "safety button" service is provided by the non-governmental organization

"Samariesu apvienība" and this organization has signed a contract with local governments of Riga, Rezekne and Liepāja. Inhabitants of other local governments can purchase similar services individually by themselves.

The reasons why the popularity of social care services and home care is increasing are increasing longevity, bad health conditions and also the increase in the amount of lonely old people in society. It is hard to provide care in rural areas because of the lack of financial resources. Additionally, it is hard because the client is not reachable easily – very often rural homes do not have a phone connection and some places are hard to reach especially in winter and with wet weather. Therefore, if the client suddenly has an accident or a sickness outbreak it is not possible to reach the provider quickly and receive help.

Home care is delivered in three ways: the care is provided by a service office, organized by the municipality or by a person with whom the municipality has a contract. In 2006, this type of service was received by 4,363 persons, 911 persons fewer than in 2005; the municipality buys the service from non-governmental organizations and businessmen or from private persons. In 2006, this type of home service was received by 3,209 persons which is 630 persons more than in 2005; the service is provided by a private person with whom the person depending on care has signed a contract. The municipality grants material help to the person in need of care to pay for the service. In 2006, this type of service was received by 3,041 persons which is 851 persons fewer than in 2005. In 2005, of the 90 persons who had requested home service, 70 persons' request was not granted, though they needed the service. In 2006, care at home was provided by 2,055 social carers which was 1,342 carers or 40% fewer than in 2005. The decrease in the number of carers causes higher work intensity for the remaining carers. In 2005, the average number of clients per social carer was 2.8 but in 2006 increased to 5.2 clients.

## **4. LTC policy**

### ***4.1. Policy goals***

One of the main national goals is retaining good health for a person as long as possible. Therefore it is necessary to develop health promotion activities by continuing work on the popularization of a healthy life style among the population including measures fostering physical activities, increasing public awareness of different population groups about healthy food, developing various diet proposals for inpatients with various diagnoses, etc.

Another national goal is to develop the social service system.

According to information given by LTCI there is a need to tackle the problem about the consequence of decentralization, for example, the local government license to tax social benefits, to place clients in state care institutions to cut down local expenses. To diminish the previous mentioned problems it is necessary to create vertical and horizontal supervisory bodies.

## ***4.2. Integration policy***

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 about the enforcement of social inclusion policy and aspects of LTC organization.

In 2007 it is envisaged to perform a thorough analysis of the proposals submitted by the local governments and non-governmental organizations 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 organized 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.

## ***4.3. Recent reforms and the current policy debate***

Great work has been done to develop health care and social services in Latvia. Recent policy achievements are:

- 1) Multiform measures promoting employment for elderly people have been designed and implemented;
- 2) A unified system of coordinated measures for promoting people's social inclusion has been designed, including the integration of elderly people into society;
- 3) The amount of the state social maintenance benefit has been raised;
- 4) The proportion of municipalities in which the services of a social work specialist are available, is growing;
- 5) The proportion of expenditure on social assistance benefits among the total municipal expenditure on measures in the social area is decreasing, thus emphasizing the importance of social assistance and social work in lending support to the population;
- 6) The proportion of the agreement contracts concluded between the GMI benefit recipients and the social service office among the total number the GMI benefit recipients is increasing; in the contract, the recipient of the GMI benefit concludes an agreement with the social service specialist on the beneficiary's participation in improving his/her social situation, identifying the problem which should be addressed and the tasks which should be carried out;
- 7) A new service has been implemented which will ensure the preparation of the inmates of long-term social care institutions for independent life outside the institution;
- 8) Criteria defined for the cost estimate of establishment and maintenance of group houses (apartments), half way homes and day care centres for persons with mental disorders, order of state co-financing, as well as the scope of services provided at group apartments and half way homes.

In order to ensure long-term stability of the state social system, current policy debates involve necessity:

- 1) To ensure an increase in the amount of the state social maintenance benefit and ensure regular revision of the amount;
- 2) State support to the education and continuing education of social work specialists should be carried on and the supervision services for the municipal social work specialists should be developed;
- 3) Changes in servicing the clients of the social service offices should be promoted, initially directing the client to a social worker who is competent enough to identify and give a comprehensive analysis of the client's social problems;
- 4) Steps should be taken to provide the municipal social work specialists with information and communication technologies and special software ensuring access to the state data registers and enabling them to collect and store data about their clients;
- 5) The GMI level has to be gradually raised till it reaches the income level and the material situation without exceeding which a family or a single person still retains the status of a low-income family or a person;
- 6) Measures promoting information accessibility on the social rights and duties of the population should be taken;
- 7) Scientifically reliable and internationally applicable criteria for identifying disability in children, persons of working age and persons of retirement age should be defined;
- 8) In the future, the state fiscal policy should be changed, adapting it to a radically different demographic situation. As in the future the demographic burden will increase, GDP growth, based on increased labour productivity, will be the decisive factor in improving the standard of life of all population groups;
- 9) In order to ensure full integration of elderly people into social life, social services including social care, social rehabilitation and alternative forms of care, should be developed and perfected;
- 10) In regions where the number of population continues decreasing, social services should be developed more actively, for example, home care, and, most probably, the local government share in social assistance expenditure will grow;
- 11) Other public services, such as transport, tourism and health care services, should be adjusted to meet the consequences of population ageing.

#### ***4.4. Critical appraisal of the LTC system***

It is also necessary to stress some problems which concern the LTC system:

- 1) Low birth rates and the growth of the average life expectancy currently foster the ageing of Latvian society which may lead the state social insurance system to ever increasing budget deficits in the future;
- 2) The amount of pensions which are dependent on social insurance contributions is often very low;
- 3) Taking into account the fact that the recipients of the state maintenance benefit are uninsured persons with disabilities, elderly people and children who have lost their providers, who mainly do not have any other source of income, the amount of this benefit is insufficient to cover their basic needs;
- 4) Less than a half of municipal social work specialists have the necessary education;

- 5) A great number of social work specialists employed at social care institutions do not have adequate education either;
- 6) The workload of municipal social work specialists, especially of those who are employed in cities, significantly exceeds the statutory workload;
- 7) The municipal social work specialists are poorly equipped with information and communication technologies and with special software for collecting and storing data concerning their clients;
- 8) The procedure of granting the GMI benefit is not sufficiently linked to the social work services;
- 9) In 2006, the GMI level was only 53.3% of income and the material situation level below which a family or a single person is identified as poor and which is too low for the benefit to lend effective support to its recipients;
- 10) The demand for care at long-term social care institutions for adults with severe mental disorders significantly exceeds the capacity for accommodating them at these institutions;
- 11) At present, low birth rates and increasing average life expectancy stimulate population ageing in Latvia, which may cause a mounting budget deficit of the state social insurance system in the future;
- 12) Poorly developed informal care system;
- 13) The number of elderly people at risk of social exclusion is comparatively large; population ageing may cause adverse social consequences across different regions in Latvia, especially in regions having low birth rates and many people emigrating in search of better and more lucrative jobs.

It is necessary to point out that the above mentioned situation and system was for 2006. The global economic crises hugely influenced Latvia and its finance system in 2008 and 2009. Right now it is hard to prognose further development and malfeasance done by the economic crises to the health care and social care system in Latvia. It is necessary to stress that both abovementioned systems received less funding in 2009. Also several institutions responsible for the development of health and social systems have been reorganized or liquidated.



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# ANCIEN

## Assessing Needs of Care in European Nations



*FP7 HEALTH-2007-3.2-2*

**L** launched in January 2009, ANCIEN is a research project financed under the 7th EU Research Framework Programme. It runs for a 44-month period and involves 20 partners from EU member states. The project principally concerns the future of long-term care (LTC) for the elderly in Europe and addresses two questions in particular:

- 1) How will need, demand, supply and use of LTC develop?
- 2) How do different systems of LTC perform?

The project proceeds in consecutive steps of collecting and analysing information and projecting future scenarios on long term care needs, use, quality assurance and system performance. State-of-the-art demographic, epidemiologic and econometric modelling is used to interpret and project needs, supply and use of long-term care over future time periods for different LTC systems.

The project started with collecting information and data to portray long-term care in Europe (WP 1). After establishing a framework for individual country reports, including data templates, information was collected and typologies of LTC systems were created. The collected data will form the basis of estimates of actual and future long term care needs in selected countries (WP 2). WP 3 builds on the estimates of needs to characterise the response: the provision and determinants of formal and informal care across European long-term care systems. Special emphasis is put on identifying the impact of regulation on the choice of care and the supply of caregivers. WP 6 integrates the results of WPs 1, 2 and 3 using econometric micro and macro-modelling, translating the projected needs derived from WP2 into projected use by using the behavioral models developed in WP3, taking into account the availability and regulation of formal and informal care and the potential use of technological developments.

On the backbone of projected needs, provisions and use in European LTC systems, WP 4 addresses developing technology as a factor in the process of change occurring in long-term care. This project will work out general principles for coping with the role of evolving technology, considering the cultural, economic, regulatory and organisational conditions. WP 5 addresses quality assurance. Together with WP 1, WP 5 reviews the policies on LTC quality assurance and the quality indicators in the EU member states, and assesses strengths, weaknesses, opportunities and threats of the various quality assurance policies. Finally WP 7 analyses systems performance, identifying best practices and studying trade-offs between quality, accessibility and affordability.

The final result of all work packages is a comprehensive overview of the long term care systems of EU nations, a description and projection of needs, provision and use for selected countries combined with a description of systems, and of quality assurance and an analysis of systems performance. CEPS is responsible for administrative coordination and dissemination of the general results (WP 8 and 9). The Belgian Federal Planning Bureau (FPB) and the Netherlands Bureau for Economic Policy Analysis (CPB) are responsible for scientific coordination.

*For more information, please visit the ANCIEN website (<http://www.ancien-longtermcare.eu>).*