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# THE LONG-TERM CARE SYSTEM FOR THE ELDERLY IN LATVIA

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# The Long-Term Care System for the Elderly in Latvia

## ENEPRI Research Report No. 81/May 2011

**Kaspar Ilves and Baiba Plakane***

## 1. The long-term care system in Latvia

### 1.1 Overview of the system

Currently there is no separate system for providing long-term care (LTC) in Latvia. LTC is divided between the health and welfare systems. The strategic aim of Latvia's health and welfare systems is to provide mental, physical and social welfare as close as possible to clients' homes. More specifically, social care services seek to maintain the existing quality of life of clients who are unable to sustain it themselves (para. 18, Law on Social Care and Social Assistance).

The Latvian LTC system is available to all permanent residents of the country. All Latvian citizens, non-citizens and foreigners who have been assigned a social security code have a right to receive state-financed social care and assistance. Similarly, state-financed first aid is available to everyone, but a broader spectrum of state-financed medical services is offered to Latvia's citizens and non-citizens, as well as EU citizens working in Latvia and foreigners with a permanent residence permit (para. 17, Law on Health Care).

The explicit target group of the LTC system in Latvia is those over age 62, because currently people retire at that age. Thus, most of the data in this report concern those aged 62 and older.

*Organisation of the system*

Since regaining independence in 1990, Latvia's path towards a structured social insurance system started in 1991 with the founding of the Ministry of Welfare. The ministry managed policy issues in social security, work, health and gender equality. In 2003, the health functions were delegated to the Ministry of Health and since then the LTC system has been divided between the two systems.

LTC in Latvia is managed on three levels: the state, municipality and social service provider. The first level involves the Ministry of Welfare and to some extent the Ministry of Health as well. They draft legislation, develop policies and standards, implement policies and monitor service providers. Additionally, the Ministry of Welfare keeps the register of social services providers.

At the second level, municipalities develop social service conceptions, proposals for the introduction of new services, perform research in the field and monitor social service providers. Municipalities also ensure the availability of social services through a municipal social services office. Social service workers assess client needs and resources, and provide services to clients. A client's ability to pay for such services is assessed as well. Upon a decision to provide social care for a client, the services available include care in LTC institutions, at home and in day-care centres; group apartments, halfway houses and service apartments; and technical aids and cash benefits.

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At the third level, social service providers of course render the services, but they also participate in monitoring by evaluating the quality of each patient's social care plan. At the same time, a self-assessment system for institutions is being reintroduced in Latvia during 2011. This will benefit service quality, as the existing quality control system is rather ineffective and lacks transparency.

Applying for social care services is the responsibility of individuals or their relatives. The application must be filed with the respective municipality's social services.

Lastly, health inspectors monitor health care and hygiene standards as applied in LTC institutions' health-care departments and in home-based nursing care. The Food and Veterinary Service and the Fire Safety and Rescue Service monitor compliance by LTC institutions with food and fire safety requirements.

*Demand and supply*

At present there is excess demand for social care services and clients wait in queues for LTC institutions for up to 30 months. Moreover, the demand is predicted to continue rising until 2050, and serious planning is needed by the government to meet the growing demand. The shortage of social care professionals must be tackled in the near future.

*Policy*

Fortunately national policy is striving to address the problems in supply. Increasing the number of educated social-work professionals has been among Latvia's priorities since 2005. During the economic crisis of 2008–09, the policy centred on creating a social insurance net for those in severe financial need. Developing alternative social-care services is also part of the current policy debate. The main focus today, however, is on integrating the aged and the disabled into society, as well as on developing and implementing an improved quality control system for LTC service providers.

## 1.2 Assessment of needs

There is no specific definition of the 'need for care' in Latvian legislation. Still, the client's social care needs and material resources are assessed before social care funded by the state or municipality is provided.

This assessment is undertaken at the municipal level. When a municipality receives either a person's application for social care or information that a certain resident might need social care services, it assigns a social worker to assess the person's material resources and need for care. This is done in accordance with Cabinet Regulation No. 288.[1] To determine the applicant's need for care, s/he is asked to provide various documents showing his/her health status and material condition. These include a reference from a family doctor, a psychiatrist's note, a notice of invalidity, a notice of livelihood and other documents. In 10 days, after evaluating the documents, the social worker visits the applicant at home to gather information about the applicant's living conditions. In the visit the social worker evaluates the ability of the applicant's family members to provide the necessary care. If family care is not possible, the applicant's material and personal resources (such as profession, age and relatives) are assessed to determine the amount of the individual financial contribution necessary for the care programme. According to the legislation, each client has to pay for most forms of the social care services received. Only if the client lacks the necessary funds are the services fully or partly paid for by the respective municipal budget (paras. 4 and 8, Law on Social Care and Social Assistance). Lastly, the social worker decides on the most beneficial social services for

[1] See the list of legislation and regulations in the references section of this report.

the client. The social services determined are provided as near to the client's home as possible. Only if the patient's health requires the 24-hour presence of qualified personnel are services are offered in a long-term care institution.

In contrast, an assessment of the need for health care at home is performed by a family doctor or a medical specialist. An individual receives health care at home if there is a need for constant outpatient health care and the patient cannot receive it in a medical institution owing to his/her particular health condition. There are several levels of dependency, which are assessed by the family doctor or specialist identifying the need for care. For example, home care services correspond with four levels of dependency, which differ in necessity, length of visits and cost. The doctor also determines the duration of the service.

## 1.3 Available LTC services

In Latvia, as noted earlier there is a range of social care and assistance services: care provided at *home* and in *day-care centres*, *long-term care institutions*, *group apartments*, *halfway houses* and *service apartments*, as well as *technical aids* and *cash benefits* (para. 22, Law on Social Care and Social Assistance).

**Care at home** can be received by individuals who cannot take care of themselves because of old age, their state of health or functional impairments. Home care services are provided by either the municipal social services or by non-governmental or private organisations with which the municipality contracts.

**Day-care centres** provide social care along with physical and mental activities during the day. There are separate day-care centres in Latvia for retired persons and for functionally and mentally disabled persons (para. 27, Law on Social Care and Social Assistance).

**Service apartments** owned by the local government are let out to individuals with severe functional disorders. All service apartments are adapted to personal needs and the municipality also provides additional services to tenants of the apartments. Service apartments offer disabled individuals the possibility to live independently, take care of themselves and increase their social functioning skills.

**Group houses** (apartments) and **halfway houses** represent another form of assistance. A group house is a separate apartment or a house in which individuals with mental disorders can live securely and receive individual support addressing their social problems. A halfway house is a transition stage after a long-term care institution for mentally disabled persons, who are taught to live independently before they move to a group house.

**Long-term care in institutions** is arranged for individuals who, because of their special needs or social circumstances, are unable to live independently and whose needs require care and assistance 24 hours a day. In Latvia, there are two types of long-term care institutions. *State-financed LTC institutions* are targeted at mentally disabled adults and orphans, while *institutions financed by municipalities* are targeted at old and ill persons. There are five state-owned social care institutions (called 'State Social Care Centres'): Vidzeme, Latgale, Kurzeme, Zemgale and Rīga. Additionally, the state concludes agreements with non-governmental organisations (NGOs) and private service providers. A similar ownership/contracting strategy is executed by municipalities.

**Technical aids** are available for the disabled, the functionally impaired and others who need them to enhance their personal care and independence. These aids include wheelchairs, crutches and other special devices to adapt the living environment to the needs of a physically disabled person. These aids are lent out for free for a predefined period by the state to the disabled individual (para. 25, Law on Social Care and Social Assistance).

There are no specific LTC cash benefits in Latvia. There are **cash benefits**, however, which are available to the elderly and which include retirement pensions, disability benefits and benefits for those living below the poverty level. In the current LTC system, the elderly are asked to participate in financing their stay at long-term care institutions by contributing a share of these benefits to the service provider. But usually the monthly stay in LTC institutions costs more than a monthly retirement pension, so the retired person is asked to pay only part of the costs and at least 10% of the pension is left for his/her personal use (Law on Social Care and Social Assistance).

## 1.4 Management and organisation (role of the different actors/stakeholders)

As mentioned above, long-term care management and organisation in Latvia is managed at three levels, by the state, municipalities and the social service providers.

The first level involves the Ministry of Welfare and partly the Ministry of Health[1] in legislation, policies and standards as well as monitoring. Although the Ministry of Welfare keeps the register of social service providers, it is important to note that the Latvian social care system does not have an accreditation or authorisation system for service providers; it only has the first step towards it – mandatory registration.

The Ministry of Welfare monitors all LTC providers in Latvia, whether they are owned by the state, municipality or a private concern (para. 14, Law on Social Care and Social Assistance). Before July 2009, monitoring was done by a separate organisation, the Social Service Board, which had more human resources allocated to monitoring. But following the closure of the Social Service Board, the Ministry of Welfare has employed only two staff for this purpose. Thus, at present the quality monitoring carried out by the state level is infrequent. In 2010, among the more than 600 social service providers (106 of which are LTC organisations) only 8 site visits were conducted.

Social service conceptions, special-purpose programmes and proposals for new services are developed at the second level by municipalities. To execute this task each municipality undertakes research on the region's social environment and identifies existing problems (para. 10, Law on Social Care and Social Assistance). One of the central responsibilities of a municipality is to ensure the availability of social services, organize their supply and determine which clients are eligible. The duties of municipal social service workers include assessing the client's needs and resources, as well as ensuring social service provision for the client. The work encompasses providing home care, running day-care centres and LTC institutions, letting out service apartments and other services (para. 9, Law on Social Care and Social Assistance). Owing to the limited ability of the Ministry of Welfare to monitor providers, most of the work is left to municipalities. Municipal social services assess the quality of the social care they administer and finance (para. 11, Law on Social Care and Social Assistance). Yet different municipalities perform monitoring on different scales. Some perform it thoroughly, while others scarcely have enough staff to organize the supply of social services and lack the human resources for monitoring.

At the third level, along with providing services, social care providers also participate in the monitoring process. Each social service institution that provides housing evaluates the social care process at least once per six-month period (Cabinet Regulation No. 291, "Requirements for social services' providers"). Other institutions perform evaluations once a year.

[1] The medical aspects of LTC are covered by health policy in Latvia; thus, it is relevant to formal home nursing care (regarded as medical care in Latvia) and health-care provision in LTC institutions.

Monitoring at this level is mainly concerned with evaluating the quality of each patient's social care plan. In the past, all social care institutions were obliged to hand in self-assessment reports to the agency administering the Social Care Fund. Today it is no longer mandatory, but a self-assessment system for institutions is being reintroduced in Latvia during 2011, with positive effects expected for service quality, as the present quality control system lacks transparency and effectiveness.

Individuals or their relatives are responsible for applying for social care services. An applicant or his/her legal representative must file an application form and the documents requested with the respective municipal social services. Then a social worker assesses the applicant's needs and resources, and determines the appropriate service. Social services might also receive information from an individual's neighbours or other contacts that s/he needs social care or other services. In such cases the service has a responsibility to examine whether the person has a need that s/he cannot satisfy independently. If so, social services decide upon an appropriate social service or care programme.

Finally, there is the monitoring performed by health inspection monitors on the health care and hygiene standards applied in LTC institutions and in home-based nursing care, and the checks they perform on patients' complaints. The Food and Veterinary Service and the Fire Safety and Rescue Service monitor LTC institutions' compliance with food and fire safety requirements. The state social insurance agency is responsible for keeping the register of insured citizens, and for assigning and calculating social benefits, such as retirement pensions and disability and poverty benefits. The agency operates on the basis of the Law on State Social Insurance.

## 1.5 Integration of LTC

As noted above, distinct LTC policies are not yet in place. LTC services are currently divided between the health and welfare systems, although most of the responsibility falls on the welfare system while the health system is involved only with the specific medical services included in LTC.

The main welfare basis for regulating LTC is the Law on Social Services and Social Care. It lists the available LTC services and assigns responsibilities to the Ministry of Welfare, municipalities and social service providers. The Law on Social Security outlines the basic principles for the social security system and specifies the key social rights and duties of benefit recipients. Cabinet Regulation No. 288 prescribes the procedure according to which residents can receive social care and Regulation No. 275 describes the organisation of payment for social care.

The health care services provided by LTC institutions and formal, home-based nursing care are regulated by the Law on Health Care, the Law on Patient's Rights, Cabinet Regulations No. 60 on "Mandatory requirements for health care institutions and their branches", No. 574 on "Regulations on hygienic and anti-epidemic requirements for health care institutions" and No. 1046 on "Regulations for health care organising and financing". Lastly, the Law on Financing and Management of the Health Care System lists those health care services that are financed by the state.

Finally, to foster the integration of the health and welfare systems, the responsible institutions are asked to ensure inter-professional and inter-institutional collaboration (para. 4, Law on Social Care and Social Assistance). Policy documents require LTC institutions, municipal social services and other LTC providers to cooperate across institutions effectively, flexibly and for the benefit of the client. Unfortunately, in reality communication among institutions across the fields is often too slow and ineffective.

## 2. Funding

The clients of long-term care services are asked to pay for the services they receive, but if they are unable to do so or if they can only pay a portion, the state takes over the payment. In general, the state and the municipalities are responsible for financing long-term care even if there are no client co-payments. The entire funding scheme is described below.

Retirement pensions and other cash benefits are financed by residents' social insurance taxes. The funding of social care services comes from inhabitants' income tax (IIT) payments. The state collects IIT payments and divides the income between the municipal and central state budgets. Municipalities receive 82% of all income tax proceeds, while 18% of the proceeds are transferred to the central state budget (Ministry of Finance, 2011a).

From the central state budget the state finances LTC institutions for mentally disabled persons and orphanages. In 2009, the state spent around €25 million for this purpose. Regrettably, the amount spent on older, mentally disabled persons (>62 years old) by the state's LTC institutions is not isolated from the total spending. Additionally, the state co-finances day-care centres for mentally disabled persons during the first four years of centre activity. This is done to develop social care services nearer to the homes of the mentally disabled. In the year of establishment, the state finances 80% of the centre's expenses, 60% in the second year, 40% in the third year and 20% in the fourth year. Starting from the fifth year of operations, the corresponding municipality takes all responsibility for financing the day-care centre (para. 13 of the Law on Social Care and Social Assistance).

Municipalities, in turn, finance a much wider spectrum of services: LTC institutions for the old and ill, day-care centres, home care, service apartments and group houses. In 2009, municipalities spent in the region of €31 million on LTC institutions for the retired and the ill, €200,000 on day-care centres for the retired, €155,000 on day-care centres for the physically disabled, €555,000 on day-care centres for the mentally disabled, €6.85 million on home care, €29,000 on service apartments and €250,000 on group houses. State and municipal spending on social care for the retired can be seen in Table 1.

*Table 1. Municipal and state spending on social care for the retired in 2009 (€)*

| | **Municipal spending** | **State spending** |
|---|---|---|
| LTC institutions for the mentally disabled and orphans | | 25,160,000 |
| LTC institutions for those aged >62 and ill | 31,540,000 | |
| Day-care centres for those aged >62 | 200,000 | |
| Day-care centres for the physically disabled | 155,000 | |
| Day-care centres for the mentally disabled | 555,000 | |
| Home care | 6,850,000 | |
| Service apartments | 29,000 | |
| Group houses | 250,000 | |
| Total | 39,579,000 | 25,160,000 |
| Total state and municipal spending | | 64,739,000 |

*Source:* Ministry of Finance.

State and municipal spending on social care was 0.97% of total state budget spending in 2009. The total state budget spending in 2009 was €6,696 million (Ministry of Finance, 2009). Thus, the budget for LTC is rather small compared with the entire social budget (35%, mostly comprised of retirement pensions and other benefits) and even with the health budget (10%) (Ministry of Finance, 2011b).

According to the legislation, clients are required to pay for the social care services received; however, there are instances in which the state or the municipality covers the costs. The general rule is that after the payment for social care services (except stays in an LTC institution), a client's resources cannot be less than the resources below which a person is defined as poor in Latvian legislation. If a client's income before the payment is larger than this amount, the client pays the difference between his/her income and the level of income below which a person is defined as being poor. The rest of the payment is covered by the client's provider or by the municipality if there is no provider or if the provider is also poor (Cabinet Regulation No. 275).

Individuals who reside in LTC institutions have a duty to pay for the services to the extent that they are able. For example, a retired person who receives a retirement benefit has to pay a monthly payment, but only to an extent that does not exceed 90% of his/her pension income. According to the Law on Social Care and Social Assistance, s/he must be left with at least 10% of the retirement benefit after paying for LTC institutional services. Usually the expenses for services are higher than the average retirement benefit in Latvia of €250 (in November 2010 – see *NRA.lv*, 2010). Thus, the state or the municipality finances the rest. This rule of 90% is applicable to all benefits that a person residing in an LTC institution receives.

The services of day-care centres are fully financed from the respective municipality's budget.

## 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 increased substantially. This trend can be explained by the ageing of society. According to the latest estimates of the Central Statistics Bureau, there were 2,248,374 residents in Latvia at the beginning of 2010. Among them, 390,209 were older than 65, while the remaining 1,858,165 were aged under 65.[1]

Professionals at the University of Latvia Centre of Demography forecast a significant 20% drop in the number of residents to 1,872,855 until 2050, due to the decreasing birth rate.[2] At the same time, the life expectancy of newborns is increasing with each year.[3] These two factors inevitably lead towards society's ageing. Demographic forecasts also indicate a sharp drop in the labour force level between 2010 and 2030. The number of youngsters aged 15 to 24 is set to fall by 15.4%, while the number of persons aged 45 to 64 is expected to rise (by 18.9% in the 45-59 age bracket and by 6.0% for age 60-64), giving a boost to the segment of elderly persons by 2050 (Republic of Latvia, 2006). Therefore, an increase in elderly persons needing long-term social care is certain. Moreover, a smaller labour force will be available to finance their social care needs by 2050.

[1] See Central Statistics Bureau, Riga, 2011 (http://www.csb.gov.lv/).

[2] See University of Latvia, Centre of Demography, Riga, 2011 (http://www.popin.lanet.lv/lv/index_lat.html).

[3] Ibid.

To sum up, the demand for LTC is progressively growing. Most probably Latvia will face problems in financing LTC in the future and it will also have to boost the number of social workers. The current problems in ensuring a sufficient number of professionals are further discussed below.

## 3.2 The role of informal and formal care in the LTC system

Formal care makes up the vast proportion of LTC services. There is an insignificantly small proportion of informal care in Latvia, and thus no data on it. The country's economic situation discourages widespread informal care, such that families are not financially secure enough to leave jobs and take care of their relatives.

In addition, no legislation focuses on informal care. Developing alternative social-care services has been the Ministry of Welfare's priority. "Improvements in the accessibility of social care services, including development of alternative social care services" was the second most important of the Ministry's policy initiatives for the years 2008–10 (Ministry of Welfare, 2007). But because of the lack of demand only a few minor, informal care initiatives have been implemented. The first initiative is called "Safety button", and has been launched by the Latvian Samaritan Association. It has an operations unit that is contactable 24 hours a day and which reacts to any health or household problems that an elderly person might experience at home. Other initiatives include a course on social care organised by Latvia's Evangelistic Church and home health-care lectures by the nurses' Care Service that are available to the clients' families.

Cash benefits under the LTC system are used rather little. The state benefits for those aged over 65 usually include retirement pensions, which are substituted or complemented by a disability pension for the disabled and a special pension for those who have not worked to earn a retirement pension. Benefits are also provided for those living under the poverty level, but no special LTC benefits are paid.

## 3.3 Demand and supply of informal care

As there is virtually no informal care in Latvia, there are no statistics about the demand and supply of it either.

## 3.4 Demand and supply of formal care[1]

Owing to the lack of informal care, all demand for LTC must be met by formal care. In this section, the supply of formal care and also the demand for each form of care is described in further detail. Still, it is necessary to mention a problem that affects all kinds of care, which is the lack of social work professionals in Latvia. This situation has arisen because of the low salaries and disadvantaged working conditions in the field. At the end 2008, only 49% of all municipal social workers had an appropriate level of education in this field (Ministry of Welfare, 2009a). Below, however, we move on to describe the demand for and supply of institutional care and afterwards home-based care.

[1] Data in this section are derived from two documents published by the Ministry of Welfare, if not referenced otherwise. The two documents are "Review of work in LTC institutions for adults, 2009" (Ministry of Welfare, 2010a) and "Social care and social services in municipalities, 2009" (Ministry of Welfare, 2010b). Website links for both are given in the references section.

*Institutional care*

At the end of 2009, there were 122 adult social-care institutions. Among them, 82 were social care centres for the elderly funded by the municipalities and 40 were state-funded social care centres (5 of which were also owned by the state).

An ever-increasing number of persons has been receiving care by state and municipal social care organisations. From 2004 to 2009, the number of clients at LTC institutions grew by 950. The rise from 2008 to 2009 was slight – 75 persons. Thus, in 2009 social care institutions served 10,350 persons, among whom 6,080 were retired (because of data availability, this data pertains to those aged over age 62 instead of 65). Among the retired clients, 64% were women and 36% were men. The proportion of women throughout the years has usually been around 60%, probably owing to women's longer life span. A third (2,154) of all elderly clients were disabled. Nearly all received retirement pensions or other benefits, which were partly used to finance their stay. As of 1 January 2010, there were 74 persons waiting in a queue for LTC institutional services. Strikingly, the average waiting time was around 30 months at the beginning of 2009, signalling an insufficient supply of the service (Ministry of Welfare, 2009a). The long waiting periods arise when there is a lack of alternative services for specific client groups (e.g. mental patients), and the local government does not have enough finances to provide care for them in an LTC institution. Especially rural areas with a small number of residents tend to lack finances for LTC in institutions.

More of the elderly have always been served by the municipal social-care institutions, given the municipalities' function of serving aged or ill clients, in contrast to the state's function of primarily serving mentally disabled adults. The total number of residents in **municipal social-care institutions** gradually increased from 4,418 elderly clients in 2005 to 4,862 in 2008. But the number dropped to 4,583 retired clients in 2009, returning to a level below that of 2006. In 2009, around 65% of new clients in municipal social-care institutions came from their homes, 10% from other social care institutions and 20% from health care institutions. In the same year, 350 residents of municipal social-care institutions returned to their families.

In 2009, **state-funded social-care institutions** housed 4,877 clients in total, among whom 1,497 were older than 62. There were 885 newly admitted clients arriving in equal proportions (~30% each) from their residences, psychiatric hospitals and other social care institutions. In contrast, in 2008 only 428 new clients were admitted to state social-care institutions. The increase in the number of clients at state-funded social-care centres stems from the fact that the determination of the person's need for social care services is undertaken by the municipality, which does not have a financial responsibility for the decision. As a result, state social-care centres for persons with mental disorders are inhabited by individuals with various degrees of disturbances, including some who might be eligible for home care.

In 2009, there were 12 **day-care centres** for retired individuals left of the 16 centres in 2006. Among these 10 were owned by the municipality and 2 by municipal contractors. The centres provided services for 2,623 persons during the year.

Meanwhile, 371 physically disabled persons were served by 3 day-care centres for the physically disabled, and 11 day-care centres for mentally disabled adults served 310 clients.

Ten **service apartments** catered for 54 clients during 2009. As of 1 January 2010, there were 3 persons waiting in the queue to receive this form of assistance.

In addition, there were 12 **group houses** that served 186 persons with mental disabilities during the year. As of 1 January 2010, 3 individuals were waiting in the queue for group house accommodation. Currently, there are 6 halfway houses in Latvia, which form a structural link in the state's long-term institutional care (Ministry of Welfare, 2009a).

In 2009, the number of **technical aids** distributed was 9,293. Around 2,000 devices were given out repeatedly and more than 3,600 had been repaired (Ministry of Welfare, 2009a). As of the end of 2008, the average waiting time to receive a state-funded technical aid was rather long – 10 months (Ministry of Welfare, 2008).

*Home care*

Home care is organised by the respective municipality's social services. Either the municipal social services provide home care to its residents or it contracts with an NGO or private organisation to provide such services.

Of the 118 municipalities, the social services of only 30 provided home care themselves and 8 municipalities purchased home care either from NGOs or from private institutions during 2009. In the other 80 municipalities, home care services were not available. The share of municipalities without home care is large for two reasons. First, some local governments are unable to provide social services because of a lack financial and staff resources. Second, the low density of residents in some rural areas makes the supply of social care services cost-ineffective. Furthermore, reaching isolated rural homes on unpaved roads can become impossible in autumn and winter; thus, it is safer to transfer these clients to LTC institutions at once.

Of the total 2,765 social work specialists in Latvian municipalities, 1,897 worked as home care providers in 2009. These figures reveal a decrease from the 2007 level of 1,955 home care providers. Yet as the number of clients in home care has also decreased, the level of work intensity fell from 5.55 clients per social carer in 2007 to 3.36 clients in 2009.

Very often home-care clients receive additional services, such as a hot dinner and a 'safety button' service. The safety button offers the possibility to reach a relief service 24 hours per day and is provided by the NGO, the Samaritan Association. The Samaritan Association has signed a contract with the local governments of Rīga, Rēzekne and Liepāja. Residents of other local government areas can purchase similar services individually.

In total, 9,291 persons (70% women) received home care in 2009. Among these, 6,572 were retired (>62 years old). The numbers for 2009 show a significant drop from the 2008 level of 10,633 residents receiving home care (including 7,400 retired persons), and the 2007 level of 10,851 home-care clients (7,553 retired). In 2009, the service was withheld from only 11 persons. From the small number of rejected applicants, it can be inferred that the demand has been met; however, most probably some of the applicants who could have been eligible for home care were transferred to LTC institutions because of a shortage of social work specialists in municipalities. But no such statistics are available.

# 4. LTC policy

## 4.1 Policy goals

The current **national LTC goals**, formulated by the Ministry of Welfare are the following: stabilising the condition of individuals at social risk; creating opportunities for any individual to enjoy an adequate quality of life by him/herself given the individual's specific situation; and providing professional and quality social services and social care.

The **long-term development guidelines for LTC policy** were set by the National Development Council in 2010. The *Sustainable Development Strategy of Latvia until 2030* (NDC, 2010) includes the following LTC-related objectives:

1) improving the quality and accessibility of health, social care and lifelong learning services;

2) reducing the risk of depopulation;

3) reducing age and disability discrimination in the labour market;

4) introducing employment programmes to stimulate inclusion in the labour force of the retired and those who are socially excluded;

5) promoting healthy lifestyles among all generations; and

6) attracting >14% of those aged 25-64 to lifelong learning programmes by 2030.

It is anticipated that the authorities developing future LTC policy will maintain these guidelines, as the *Sustainable Development Strategy* was commissioned by the state and is recognised as being of high value.

Meanwhile, the following goals have been established for **short-term LTC policy (2011–13)**:

1) developing, validating and introducing an improved methodology for evaluating the quality of social service providers;

2) considering the human rights and liberties of disabled persons, reducing the consequences of disability and implementing the UN Convention on the Rights of Persons with Disabilities;

3) developing social care and rehabilitation services for mentally disabled persons (Ministry of Welfare, 2009b); and

4) fulfilling the aims of the *Professional social work development programme 2005–11*, which set measurable indicators (Ministry of Finance, 2005).

The goals previously set for **short-term policy (2008–10)** were the following: improving the accessibility and quality of social care services, including the development of alternative forms of care; fostering disabled persons' integration into society, by supplying them with technical aids; and supporting the development of municipal social-work services (Ministry of Welfare, 2007).

The **Ministry of Health** has also outlined a set of **policy priorities**:

1) making the patient the priority of the health care system;

2) ensuring equal accessibility to health care in all areas and ensuring the availability of state-financed health care near to each patient's place of residence;

3) developing and implementing guidelines for medical treatments, as well as quality criteria for health care institutions;

4) changing the status of a number of beds in hospitals to daytime or social care accommodation to increase the effectiveness of the system;

5) introducing an e-health information system and e-governance of the system;

6) informing society about healthy lifestyles, healthy food, sports and physical activities, as well as disease prevention (Declaration by the Ministry of Health, 2011).

## 4.2 Social integration policy

The responsible authorities are not planning to integrate the existing services into one LTC system. At the same time, the legislation contains the previously mentioned call for institutions to "ensure inter-professional and inter-institutional collaboration" (para. 4, Law on Social Care and Social Assistance). Compliance with this request is mostly monitored internally by each system – within the health care and social services systems individually.

Still, compliance here is weak, mainly owing to the low monetary compensation of social workers. In health care sometimes the links among the different health care institutions are too inadequate to ensure effective communication and fast patient transfer.

Certainly problems exist in communication between LTC institutions and hospitals. Hospitals tend to keep elderly clients in hospital beds for too long before transferring them to LTC institutions.

## 4.3 Recent reforms and the current policy debate

Recent reforms are outlined below, according to the year of implementation:

- In 2009, the state agency covering the provision of technical aids was closed down, with its duties transferred to the Vaivari national rehabilitation centre.
- In July 2009, the agency for compulsory health insurance was wound up and its functions were transferred to the Health Payment Centre. Since then, the Health Payment Centre has enforced state policy on health care, ensured the availability of health care services and administrated the state's health care funds.
- In July 2009, the Social Service Board was abolished. This was done to reduce the funds spent on the administration of the social care system. As a result, the Ministry of Welfare took over its functions: keeping the register of social service providers, monitoring them, managing state social-care centres, administering state social-care services and gathering and analysing reports on social care and services (Ministry of Welfare, 2010c).
- LTC institutional income from clients has increased, because since 1 July 2009 the residents at LTC institutions have had to pay 90% of their pension or benefits instead of the 85% that had previously applied.
- In 2009, the Ministry of Welfare defined the direction of its work over the next five years: 1) increasing the quality of social services and enhancing the work of state social-care centres; and 2) developing alternative social-care services (Ministry of Welfare, 2010c).
- In January 2011, the parliament approved a new Disability Law. The law has resulted in regulations that seek to end discrimination on the basis of disability, changes in consumer protection law and regulations aimed at making the environment more accessible to disabled persons.

To ensure the long-term stability of the state social system, the current policy debate involves a number of issues:

- Active work is underway on developing the new monitoring system for social care providers. The Ministry of Welfare in partnership with the European Social Fund has launched a project on "Developing, validating and introducing a new methodology for monitoring the quality of social services suppliers". The project's completion is scheduled for June 2011 and is expected to establish a basis for better quality social-care services. The new system will eventually provide a quality grading system comparable across different providers and a uniform quality monitoring system covering internationally recognised quality aspects.
- Discussion is underway on the changes in state fiscal policy given the radically altered demographic situation. The means to enhance labour productivity in order to increase GDP growth and reduce the demographic burden are also being considered.

- Alternative forms of social care are a key part of the ongoing debate.
- Increasing the number of professional social workers per 1,000 inhabitants, and state support for the education and continued training of social work specialists also feature in the debate.
- Fostering the integration of disabled persons is among the issues discussed, along with implementing the UN Convention on the Rights of Persons with Disabilities.

## 4.4 Critical appraisal of the LTC system

*Areas needing improvement within the LTC system*

- Based on information provided by long-term care institutions, there is a need to tackle the problems stemming from decentralisation. For example, local governments are licensed to place clients in state care institutions in order to cut down on local expenses. These problems can be resolved by creating vertical and horizontal supervisory bodies.
- Fewer than half (49%) of municipal social-work specialists have the necessary training. Similarly, a large number of social work specialists employed at social care institutions do not have adequate training. This problem should be addressed by offering training to the existing social workers without education in the field, and promoting social work nationwide.
- The workload of municipal social-work specialists, especially those who are employed in cities, significantly exceeds the statutory workload. This issue must be addressed.
- 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. This problem is one of the more easy to tackle, as it requires a 'physical solution' – more information technology in social workers' offices – although education in IT might be necessary for some.
- Taking into account that the recipients of state benefits are persons with disabilities, the elderly and children who have lost their providers and who do not have any other source of income, the amount of this benefit is insufficient to cover their basic needs. Currently, the level of the GMI (the minimum income benefit for a family) is below that at which a family or a single person is identified as poor – which is too low for the benefit to lend effective support to its recipients.
- The demand for care at social care institutions for adults with severe mental disorders significantly exceeds the institutions' capacities. And there is virtually no informal care system to alleviate the excess demand for formal care.
- Population ageing may have adverse social consequences across various regions in Latvia, especially those experiencing low birth rates and the emigration of those in search of better paying jobs. In sum, careful planning by the government is necessary to ensure there are enough resources for social care in the future.

*Advantageous policy initiatives*

- The current work to create a more transparent and measurable quality control system is a clear advance in the right direction. The initiative will ensure social services of a higher quality and will provide comparable measurements across service providers.

- The opening of the labour market to elderly persons is also beneficial, as it will decrease their risk of social exclusion and contribute to a vulnerable state budget amid societal ageing in Latvia.
- The actions in favour of decreasing age and disability discrimination are also highly welcome, as right now the real level of discrimination towards the aged and the disabled is very high compared with other EU nations. The adaption of the public environment to the needs of the disabled is similarly important.

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## About PRAXIS Centre for Policy Studies

PRAXIS Centre for Policy Studies (PRAXIS) is an independent, non-profit public policy think tank based in Tallinn, Estonia, founded in 2000. The mission of PRAXIS is to improve and contribute to the policy-making process in Estonia by conducting independent research, providing strategic counsel to policy-makers and fostering public debate. The main competence areas of PRAXIS are labour and social policy, health policy, innovation policy and education policy. The centre collaborates closely with experts from universities, NGOs and the public sector. PRAXIS has become a leading centre of empirical analysis on social and labour policy in Estonia. Its recent research includes evaluation of the impact of active and passive labour market policies, analysis of poverty and redistribution using micro-simulation methods, forecasting long-term sustainability of the pension and health care systems, analysis of the impact of family benefits on poverty and fertility behaviour, analysis of flexible forms of work and work–life balance. PRAXIS has also participated in a number of international projects (including FP6 projects).

# ANCIEN

**Assessing Needs of Care in European Nations**


***FP7 HEALTH-2007-3.2-2***

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).***