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Analytical support on social protection reforms and their socio-economic impact

Country Document 2013

Pensions, health and long-term care

Latvia

November 2013

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On behalf of the
European Commission
DG Employment, Social Affairs and Inclusion

Gesellschaft für Versicherungswissenschaft und -gestaltung e.V.
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1 Executive Summary

Latvia was making good progress in the economic development within the last couple of years. Strong and consistent recovery from the crisis started already in 2011and continued in a more convincing pace in 2012. Latvia will join the European Monetary Union in January 2014. General elections in the country are scheduled for October 2014.

Important and decisive steps have been taken to strengthen the long-term sustainability of the national pension system. The share of contributions for the 2nd tier of pension scheme has been increased from 2% of payroll to 4% in 2013 and will reach 6% in 2016. From January 2014 the statutory pension age will gradually increase from the present 62 years to 65 years in 2025. The qualification period for the entitlement to pensions will increase from the present 10 years to 15 years in 2014 and further up to 20 years in 2025. To limit pathways for early exit from the labour market the concept paper for service pension reform is already prepared and submitted to the government for consideration.

The real challenge for the Latvian pension system is its future adequacy. An immediate task would be to tackle the inadequately high share of working age population paying contributions from disproportionately low wages. Although the pension scheme contains substantial stimulus to work longer there is still a high incidence of early retirement and a little proportion of postponed pensions. Increasing the general trust in the stability of the pension system is vital to facilitate longer working lives. Clear and stable rules for indexation of pensions are necessary.

Some improvements have been implemented in the health care services increasing their efficiency. At the same time the accessibility to national health care system is unacceptably low due to long waiting lists, high levels of co-payments for services and out-of-pocket payments in general. This is a real obstacle for people with low or average levels of income. Government spending for health care is one of the lowest in the EU. There is a strong pressure from different interest groups for more resources in the health care system. The budget proposal for the next year submitted to the Parliament is promising, additional resources are planned for wages of health personnel, compensation of costs of pharmaceuticals in out-patient care and reduction of lengthy waiting lists. It seems to be overall consensus between the political parties that problems of health care services are to be tackled as a priority already in 2014.

The reform of the financial model of health care services is in a pipeline; according to the concept paper approved by the government the entitlement to health care services is to be linked to the payment of personal income tax. According to the most optimistic scenarios the new financial model might be introduced starting from 2015.

The availability and quality of long-term home care services heavily depend on the municipality where the person lives. Lack of clear and uniform national rules probably gives space for innovative approaches for municipalities, NGOs and communities. At the same time the risk persists, that people who need care are not always able to receive it. The institutional care has recently been under severe public criticism for insufficient quality of the services and extensive utilisation of psychotropic drugs instead of measures of social rehabilitation and active leisure.

Recently the draft Concept Paper on the Development of Social Services for 2014 - 2020 was published; the move from institutional care to home care is stressed in it as a top priority for service development for the people with limited abilities to perform their activities of daily living.

2 Pensions

2.1 System description

2.1.1 Major reforms that shaped the current system

Latvia started a comprehensive pension reform in the second half of 90ies in order to adapt the pension system inherited from the Soviet-style command economy to the emerging market economy and to encourage participation of the working age population in the formal labour market. The pension reform concept paper was approved by the Parliament in 1995 and gradually followed by several basic legal acts. From January 1996 the first tier of the pension system became operational. The 1st tier of the pension system is an earnings related, defined contributions pension scheme, it is financed on a Pay-As-You-Go basis, but resembles a funded scheme in terms of its construction – a Notional Defined Contribution (NDC) scheme. When the new 1st tier scheme was introduced all pensions granted before the reform date were recalculated depending on the length of the individual service record. The new pensions after the reform date are granted on the basis of two parts: the notional capital accrued before 1996 and the notional capital accumulated in the personal account after the 1st January 1996.
From July 1998 the law on private pension funds entered into force, thus the third level (private, voluntary) of the Latvian pension system started to function. The major pension reform was completed by the Law on State Funded Pensions entering into force as from 1 July 2001, thus accumulation of the resources for the 2nd tier of the Latvian pension system, mandatory fully funded pension scheme started.

In the following years several smaller scale reforms were carried out – increase in the statutory pension age and reform/introduction of several special service pension schemes.

2.1.2 System characteristics

In Latvia, the pension system consists of three tiers. The first tier is a compulsory social insurance scheme, operating according to the redistribution principle(PAYG) and built as the NDC scheme. For insured persons 20% of their gross earnings are registered on the individual pension accounts thus the individual notional pension capital is accumulated.

The 2nd tier of the pension system operates as a mandatory fully funded private pension pillar. A part of the social insurance contributions are channeled to the 2nd tier to be invested in privately managed pension funds.The scheme started to operate on the 1st July 2001. Each socially insured person, born after the 1st July 1971 becomes a member of this scheme on a mandatory basis, a respective part of his/her contributions is registered by the State Social Insurance Agency in a personal account for the funded scheme. Those born between the 2ndJuly 1951 and the 1stJuly 1971 were invited to join the scheme on a voluntary basis. If they decided not to join the funded scheme, their pension contributions in full are registered exclusively for the 1st tier scheme. Each participant of the scheme chooses his/her asset manager and pension (investment) plan. When a person reaches the pensionable age and submits its application for pension, he/she has to decide whether to transfer the accumulated capital from the 2nd tier to the 1st tier for pension calculation purposes or to use the accumulated capital to purchase a life insurance in the private insurance market. If a person chooses to transfer the accumulated funded capital to the 1st tier, this amount is added to the notional capital accumulated in the 1st tier and one pension is granted from the sum of individual accounts of both tiers of the pension scheme.

The 3rd tier provides for possibility to accumulate private savings in pension funds on a voluntary basis.

The pension system as a part of a wider national social insurance system is financed from social insurance contributions paid by employers and employees and by self-employed persons themselves. In 2013 the contribution rate in a standard case is 35.09% (the employee's share equals to 11% of gross earnings and the employer pays the rest – 24.09%); this rate covers pensions, unemployment benefits in cash, sickness and maternity benefits in cash, work injuries and occupational diseases, as well as parental benefits (child care benefits in cash). The contribution rate for pension insurance is set at the level of 29.9% of gross earnings,from what 4 percentage points (p.p.) is channelled to the mandatory fully funded pension scheme; the rest is used to for the current expenditures of PAYG scheme covering old age pensions, invalidity pensions and survivor's pensions for children of deceased persons.,.

A person is entitled to old age pension when reaching the statutory retirement age 62 years with an insurance record of at least 10 years. Early retirement with reduced pension (50%) is possible two years before the statutory age with an individual insurance period of at least 30 years.

The amount of the individual pension from the 1st tier of the pension scheme is determined by lifetime contributions paid into the scheme thus accumulating the individual's notional pension capital. To calculate the individual amount of annuity at the retirement, the aggregate individual pension capital is divided by average predicted life expectancy at the age when the pension is claimed. Retirement pension is calculated according to the general NDC scheme formula:
P = K / G, where
P – Annual pension,
K – Individual pension capital of insured person,
G - Life expectancy at the age when individual pension is granted.
The monthly pension is set as 1/12 of the calculated annuity.
G as a period in years for every cohort in the interval from 40 to 90 years of age is set on the basis of demographic mortality tables and formally approved by the government. Although life expectancy for men and women is different, for purposes of pension calculation unisex life expectancy is used as value of G. The notional pension capital (K) of the insured person is equal to the amount of lifetime pension insurance contributions registered on the personal account and regularly indexed by the annual capital growth index calculated as a rate of increase of the national volume of gross earnings from which social insurance contributions have been paid. According to the legislation pensions should be indexed once a year on the 1st October with the consumer price index (CPI).

Pension is regarded as an income for purposes of personal income tax. For pensioners the tax exemption is set at the level of 235 euro per month (the general tax exemption is lower – 64 euro per month). Personal income tax is set at the level of 24% of taxable income.

2.1.3 Details on recent reforms

Latvia has maintained the same level of social insurance contributions(33.09% since 2003) throughout the years of crisis, but it was increased by 2 p.p. for the employees from 2011, when the total rate reached 35.09% of payroll (the employer pays 24.09%; the employee – 11%). The increase in social contribution rate followed a decision to include parental benefits (contribution-based benefit paid to one of the parents during child care leave) permanently in the social insurance scheme.

In the years of economic downturn the share of contributions devoted to the 2nd pillar of the pension scheme (mandatory fully funded private pension) were reduced from 8% of payroll in

2008 to 2% in 2009 in order to secure expenditure for the 1st pillar PAYG scheme and counterbalance a sharp decrease in the volume of social insurance contributions caused by a shrinking number of employed and decreased levels of their earnings. In 2012 the Parliament amended the law providing for gradual increase in the share of contributions channelled to the mandatory funded pension scheme: from 2013 - 4 % of payroll, from 2015 – 5% of payroll, and from 2016 – 6% of payroll.

In 2012, the Parliament adopted amendments to the national pension legislation increasing the mandatory pensionable age. This measure is expected to improve the sustainability of the pension scheme and to adjust it to the ageing of the population. Starting from 2014 the retirement age will increase for both men and women from presently 62 years by three months yearly reaching the age of 65 by 2025. The option of early retirement two years before the statutory age, so far a temporary measure, now was safeguarded as a permanent provision. During early retirement the pension is paid on the level of 50% of the pension amount calculated from the individual capital. The contribution period requested for the entitlement to pension (qualification period) will increase from presently 10 years to 15 years from 2014 and further up to 20 years from 2025.

In 2006 the system of pension supplements was introduced as a transitory measure. For the pensioners with contribution and/or service record above 30 years a supplement was granted for each service year completed before 1st of January 1996, the date when the new NDC system came into force. The government decided to discontinue granting these supplements from 2012 for the new cohorts of pensioners taking into account that they already have accumulated longer post-reform contribution record and have had the possibility to accumulate larger pension capital on their individual accounts during the 16 post-reform years. Although no supplements are going to be granted to new entrants, payment of those already granted before the 1stJanuary 2012 will continue.

Indexation of pensions has been frozen since 2009 as one of the austerity measures and December 31st 2013 was set as a deadline for non -indexation period. Nevertheless, under strong pressure from the pensioners' organisations indexation was resumed earlier as planned. In September 2013 the pensions below 285 euro per month were increased by 4%. Pensions of victims of political repressions were indexed by the same index irrespective to their actual amount. CPI for the period of non-indexation has reached already 7.1%.

2.2 Assessment of strengths and weaknesses

2.2.1 Adequacy

Nearly all people above the statutory retirement age are entitled to pensions. The high coverage is due to the low minimum contribution period for pension entitlement set at the level of 10 years. The age cohorts now reaching the pensionable age are those with the service record accrued during the Soviet times with practically full employment. Elderly who are not entitled to the state pension can apply for social security benefit. This benefit is granted without means-testing five years after the normal retirement age (presently the benefit is granted at the age of 67). The number of people receiving , this benefit is marginal (in August 2013 only 540 persons were receiving it[1]).

Nevertheless, effects from the planned increase of the qualification period (15 years from 2014 and 20 years from 2025) should be closely monitored. Taking into account the turbulence in the labour market in the 90ies after the collapse of the Soviet type economy and the persistently high shadow economy afterwards, accessibility might become an issue. In the

[1] Data source: State Social Insurance Agency

90ies 30% of the population lost their previous jobs and some of them since then have not been involved in a paid occupation at all. People started self-employment, stayed inactive or found occupation in the informal economy. As the incoming cohorts of pensioners would be less able to rely on the working record accumulated in the Soviet times with almost full employment, the incidence of cases with insufficient service and/or contribution record will certainly grow.

Regarding the indicators of income replacement, the median relative income ratio for the people 65+ as a ratio of income of the age group 0-64 was 80% in 2012, slightly below the EU27 average (89% in 2011)[2].

The aggregate replacement ratio in 2011 (median individual pensions of 65-74 year old relative to median individual earnings of 50-59 years old) in Latvia was 48% in 2012 (the EU27 average was 54% in 2011).

Table 1 Aggregate replacement ratio

	2007	2008	2009	2010	2011	2012
European Union (27 countries)	0.49	0.50	0.51	0.53	0.54	n.a.
Latvia	0.38	0.30	0.35	0.46	0.53	0.48

Data source: EUROSTAT

The majority of elderly people rely on the pensions only from the 1st tier PAYG scheme.

The 2nd tier funded scheme is comparatively new and the share of contributions channelled to it has been low. At the end of 2012 there were only 4,606 persons with the funded pension capital added to the 1st tier notional capital when the pension was calculated[3]. These cases exclusively concern early retirement.

In 2012 participants of the 3rd tier of the pension system received from private pension funds 11,176,658 euro[4]; compared to the expenditure for old age pensions from the 1st tier this amount equals to less than 1%, therefore it cannot be regarded as a substantial source of the income for elderly people.

As shown in Table 2 in 2010 the at-risk-of-poverty rate for people aged 65+ was 8.9% compared to 15.9% in the EU27. In 2011 this indicator for Latvia increased to 14%[5]. For persons older than 75 years it was 8.5% in 2010 (17.9% in the EU27) and increased to 12.2% a year later. Risk of poverty for elderly in 2010 and 2011 was considerably lower than for any other age group of the Latvian population. The difference between men and women in 2011 was close to 8 p.p. - 8.6% was the poverty risk for men and 16.6% for women.

Table 2 At-risk-of-poverty rate in Latvia

	2006	2007	2008	2009	2010	2011
65+	33.3	51.2	47.5	18.8	8.9	14.0
75+	35.9	57.9	54.3	19.0	8.5	12.2

Data source: Central Statistical Bureau of Latvia

The expansion of poverty risk in the pre-crisis years is explained by unequal growth of income in various social groups. Earnings were growing rapidly while pensions changed

2 Data source: EUROSTAT, viewed on 17 August 2013
3 Data source: State Social Insurance Agency
4 Data sorce: Financial and Capital Market Commission
5 Data source: Central Statistical Bureau of Latvia

insignificantly. Thus the poverty threshold moved up in line with positive economic growth, leaving more and more elderly below it. During the crisis time wages decreased significantly, while pensions remained stable. As a result the poverty rate for elderly became lower. However, this should not be interpreted as a real improvement in the income situation of the elderly, but just as a change in their condition in comparison with other age groups (Rungule, 73).

The rate of severe material deprivation for people above 65 in 2010 was much higher in Latvia (29%) than in the EU27 (7.2%). At the same time, the level of severe material deprivation for the age group 65+ is slightly lower than for any other age group in Latvia. The Latvian population suffers from severe material deprivation mainly due to lower living standards (Latvia's GDP per capita in PPS in 2011was 58% of the EU-27 average)[6].

The gender break-up of all these indicators shows that old-age women currently face higher risk of poverty or social exclusion and in general enjoy lower standards of living than old-age men in Latvia. In 2011 26.8% of men and 37.4% of women were at risk of poverty or social exclusion.[7] This is clearly a result of gender pay gap and shorter working record for women. The comparison of wages registered for social insurance contributions indicates a difference of 18% between men and women.[8] The poverty rate for the households with at least one person aged 65years or older is lower than for the households of equivalent composition, but with persons aged under 65.

Labour participation rates of the Latvian population before the crisis were above the EU average, especially for women. In 2009 participation rates dropped significantly, their recovery started already in 2011, but even in 2012 with a rate of 68.2% (age group 20 to 64) it hasn't regained the pre-crisis rate neither for men nor for women.[9]

No doubt, measures that increase participation rates would provide an important contribution to the adequacy of pensions. Nevertheless, a more immediate task would be to tackle the persistently inappropriate proportion of the working age population paying contributions from an income below or equal to the minimum wage. Those low contributions in 2012 were recorded for 35.7% of the insured persons.[10] The problem is partly based on the low levels of wages of the employed, but is substantially aggravated by the existence of "*grey jobs"* partly remunerated "*in envelopes*" and the high incidence of bogus self-employment.

2.2.2 Sustainability

Life expectancy is growing; in 2060 the Latvian population is projected to be one of the oldest in Europe with very high dependency ratio (people aged 65 or above relative to those aged 15-64). The demographic old-age dependency ratio is projected to increase from 25.2% in 2010 to 67.9% in 2060. At the same time simulations included in the 2012 Ageing Report indicate a decrease in public pensions as a share of GDP from presently 9.7% (2010) to 5.9% in 2060.
In 2012 6.8% of the older population (65+) were actively participating in the labour market; the participation rate for men (10.2%) is higher than for women (5.2%). The labour market participation rate for elderly is slightly above the EU27 average (5.1%).[11]

Theoretically provisions for early retirement two years before the statutory pensionable age leave some space for improvements, though politically it might be impossible in the near

6 Data source: EUROSTAT
7 Data source: CentralStatistical Bureau of Latvia
8 Labklājības ministrija (2013), Aicina uz diskusiju par sieviešu un vīriešu darba samaksas nevienlīdzību
9 Data source: EUROSTAT
10 Data source: Ministry of Welfare
11 Data source: EUROSTAT

future. The right to early retirement was part of a political compromise when the agreement on the increase of the statutory pensionable age was negotiated in the Parliament.

In addition to the general provisions of early retirement, there are still some categories of persons who can benefit from early retirement even 5 years before the statutory pension age. These categories include e.g. parents, who have raised 5 or more children or parents of a disabled child if their contribution record is at least 25 years or workers of specific professions with the right to service pensions. Special pensions for work in hazardous and dangerous works are also granted before the regular retirement age.This type of pension is a transitional measure from the pre-reform period (before 1996). Since then no new rights for this type of pension can be accumulated, but on the basis of already acquired rights (years worked in hazardous and dangerous occupations) old age pension could be granted even at the age of 47,5 years for women and 52,5 years for men. The pensions are granted in full amount and in case of continued employment no limitations in payment of pension exist.

Early exit from the NDC scheme automatically leads to lower levels of pensions thus challenging their adequacy. In 2012 pensions granted before normal retirement age for parents who have raised 5 or more children or parents with a disabled child were by 30% lower than newly granted old age pensions in general[12]. Theoretically, five years difference in the person's individual retirement age (pension at the age 57 years or pension at the age 62 years) in 2012 could have led to about 17 % difference in the amount of pension solely due to the higher expected longevity of being on pension (factor G of the pension formula).

The latest data available show that in 2008 the average labour market exit age was 62.7 years, one year above the EU average.[13] In Latvia working pensioners receive both full pension and salary or wage. Therefore the real exit age from labour market is not closely linked to the time when the person claims the pension. In 2012 from all newly granted old age pensions more than 35% were granted to people staying in work.[14] The problem with this kind of policy is that the income of older people goes up sharply immediately after they start to receive pensions, but several years later when they are really incapable to work, their incomes decrease disproportionately. If they have had postponed their application for pension, they would have been able to earn substantially higher pensions.

The study based on EU-SILC data shows that in the age group 60 – 62 years the proportion of early pensioners is above 40% of the respondents, with probability higher for women to take early retirement, as well as for the people living outside Riga (Rungule, 106).

2.2.3 Private pensions

Although contributions to the 2nd tier fully funded scheme are mandatory, the pension funds are managed by private financial institutions, therefore supervision mechanisms and security and efficiency aspects are almost similar to the 3rd tier voluntary private pension schemes. All activities of financial institutions involved are supervised by the Finance and Capital Market Commission.

Assets of the mandatory funded pension scheme are managed by eight private asset managers, together offering 26 different investment (pension) plans. The total amount of assets in the scheme was equal to 1,542,660,542 euro on 1st July 2013.[15]

[12] Data source: State Social Insurance Agency
[13] European Commission (2013), Employment and Social Developments in Europe 2012
[14] Data source:State Social Insurance Agency
[15] Data source: Financial and Capital Market Commission

One of the publicly acknowledged problems is the comparatively high administrative costs of the scheme, wich in 2012 were at the level of 1.49% of assets accumulated. Partly this can be explained by the limited volume of assets accumulated in the pension funds caused by the low and instable contribution rates for the scheme. Besides, the low share of contributions channelled to the fully funded scheme reduce the motivation of workers to contribute into it from the full amount of their earnings.

Table 3 Contribution rate for the 2nd tier of the pension scheme

	2001-2006	2007	2008	2009-2011	2012	2013
contribution rate to the 2nd tier scheme	2%	4%	8%	2%	2%	4%

Assets accumulated in the scheme are supposed to be inheritable if the person at pensionable age chooses to buy annuity instead of merging accumulated capital with the notional capital of the 1st tier. So far the assets accumulated in the individual accounts have been insignificant, therefore only one insurance company offers annuities for the participants of the 2nd tier.

Pension plans operate with different levels of financial efficiency and security. At the same time people are not prepared enough to use their right to change the pension plan once a year in a responsible manner. In 2012 18% of the participants have changed their pension plan voluntarily, but no studies are available on their motivation.

So far very little attention has been paid both from the government and private pension funds to financial literacy of the population. One of the recent studies shows that possibilities to change pension fund or pension plan are easyly accessible, but people are not prepared to use them efficiently and benefit from them. The financial literacy rate regarding the state funded pension scheme is insufficient therefore raising doubts on the sustainability of the current pension system. Electronically available information sources are scarcely visited (Stāvausis, 152).

Participation in the 3rd tier private pension funds is voluntary. Premiums can be financed by the individual or by his/her employer on his/her behalf. Premiums paid in the 3rd tier pension scheme are tax exempted on condition that their amount does not exceed 10% of the person's gross income. Pension payment from the fund starts not before the age of 55 years. Unlike the 1st and the 2nd tier pension, the capital accumulated in the private pension fund can be transferred to the heirs of the insured person, if he/she dies before pension age.

In 2012 the number of active participants in private pension plans increased by 3% and reached 105,547 persons or 10.1% of the economically active population[16]. The number of pension funds is stable, in 2012 like in 2010 there were seven pension funds offering private pension insurance: six open funds (subsidiaries of Latvian banks) and one closed pension fund, offering 21 pension plans in total.
In 2012, the amount of pension plans received in premiums increased by 16% in comparison to the previous year. At the same time the contributions from employers for their employees decreased by 5.6%. The rate of return for assets accumulated in the private pension funds was 8.4% (compared to 2.7% decrease in 2011), varying from 2.2% to 11.3% depending on the plan.[17] During 2012 11,176,658 euro were spent for pension payments (21% more than a year before).[18]

[16] Data source: Financial and Capital Market Commission, Central Statistical Bureau of Latvia and author's own calculations
[17] Finanšuunkapitālatirguskomisija (2013)
[18] Data source: Financial and Capital Market Commission

Private pensions are not very popular in the country. The majority of the population is not able to afford them due to low incomes. Besides, according to one of the opinion polls only 32% of the population trust commercial banks; even though the current level of trust is by 4p.p higher than in 2011.[19]

2.2.4 Summary

Important and decisive steps have been taken by the government to strengthen the sustainability of the the pension system. In January 2013, following one of the CSRs, the share of contributions to the 2nd tier of the pension scheme has been increased. In 2012 the Parliament adopted amendments to the national pension legislation increasing the mandatory pensionable age. Starting from 2014 the pensionable age will increase for both men and women from currently 62 years by three months yearly, reaching the age of 65 in 2025. These measures will further improve the sustainability of the pension scheme and adjust it even better to the ageing of the population.

More problematic is the current adequacy of pensions. The number of low income pensioners is growing due to several reasons, including the high proportion of contributions paid from very low earnings. The future adequacy is even more a challenge (Pension Adequacy in the European Union 2010-2050, p.108).

Indicators of relative adequacy suggest that the old age pension system in Latvia has been successful during the crisis years in protecting pensioners from income poverty and in guaranteeing them relatively sufficient income replacement. Still, average pensions are very close to poverty line and therefore very sensitive to any changes in it. Pension indexation is resumed partly (for lower segments of pensions) in September 2013, but provisions for further indexation in 2014 are still under discussion between stakeholders.

Gender gap in pensions is a challenge; no serious consideration is given to this aspect by national policy documents.

The statutory minimum pension is dependent on the length of personal contribution record and set at a monthly level of 70.43 euro for pensioners with the contribution record less than 21 years; the level is progressively increasing up to 108.85 euro for persons with the contribution record 41 years and more. The level of minimum pension has stayed unchanged since 2006. Therefore people with minimum pension almost automatically become dependent on the income of other members of their household or apply for social assistance. The share of minimum pensions is growing. In 2011 11% of all newly granted pensions were at the minimum level, in 2012 - 16%[20]. So far no survey or in-depth analysis has been carried out to identify the factors behind the phenomenon of extremely low pensions. The low level of contributions as a result of jobs in the grey economy and bogus self-employment is just part of a possible explanation, and more studies are needed.

Although the old age pension scheme contains substantial stimulus to work longer, there are still high incidence of early retirement and little proportion of postponed pensions. Incentives can influence people's decisions only if the rules are robust and stable, people understand them and trust in their sustainability and fairness. This is not always the case in Latvia where pension legislation is amended every year, sometimes even several times a year. Therefore more efforts should be devoted to raise public awareness and understanding of the system.

Unfortunately, so far no in-depth analysis has been carried out to evaluate how incentives included in the pension system actually influence the behaviour of the participants of the scheme. Some consideration should be given to how to improve the motivation of people to

[19] IR.LV(2013), Aptauja: Latvijas iedzīvotāji uzticas skolām, baznīcai, radio un televīzijai
[20] Data source: State Social Insurance Agency

postpone their retirement, especially for those on both extremes of the pension scale. For those with low levels of expected pension postponement often does not help to increase pension above minimum level; for those with higher levels of expected pension motivation is reduced by the prospects of loosing real value of their pension due to the long standing practice not to index pensions higher than a certain very modest threshold.

Clear rules for indexation of pensions should be set in the legislation to secure predictability of pension expenditures in general and individual pensions in particular.

2.3 Reform debates

There are no academic studies behind actual policy debate. Most of the debate has been initiated by the government institutions, in particular by the Ministry of Welfare.

The hottest debate topic of the year was indexation of pensions, largely initiated by the Latvian Pensioners Federation (LPF). The indexation of pensions has been frozen as one of the austerity measures in 2009; December 2013 was set as a deadline for non-indexation period. As the national economy started to recover earlier than expected, LPF, the largest NGO of retired people in Latvia, and opposition parties Concord Centre Party (Russian Party with social democratic orientation) and Union of Greens and Farmers Party (conservative) were pressing hard for pension indexation already in 2013. LPF collected more than 100,000 signatures on the petition with a request to start full indexation with the CPI in October 2013 and submitted it to the Parliament in April 2013. When the government confirmed a fiscal space available for indexation, the main debate focused on the value of the index and the level of pensions to be indexed. There was almost consensus between parliamentarians that the indexation this time should be regarded as an extraordinary measure, therefore general principle of indexation by CPI was neglected. LPF unsuccessfully insisted on the indexation with full CPI for the whole non-indexation period (7.1%); the Parliament voted for pension increase only by 4%. The index 1.04 was chosen arbitrarily and actually has not been much discussed or commented upon. The government used increase in value of minimum consumption basket or so called subsistence minimum for the period 2009-2012 as a justification, albeit this subsistence minimum has never been used in this century as a reference figure for social protection purposes being totally out of date and based on the consumption basket dated back to 1991.

The second much discussed topic was the threshold up to which the indexation would apply. Almost at the very onset of the debate it was agreed between LPF and the Ministry of Welfare that in the situation of the limited resources not all pensions should be indexed, therefore LPF proposed pensions up to 355 euro per month to be indexed. The government and the Parliament encouraged by supportive reaction from several smaller organisations of pensioners decided to index only the pensions not exceeding 284 euro, with an exception for victims of political repressions; their pensions were indexed irrespective to their amount before the indexation. The concern of the government was to secure budgetary balance above all, leaving all other considerations aside. LPF announced their intention to fight for the full indexation of pensions with CPI for all period when the indexation of pensions was suspended.
One of the proposals coming from the opposition Union of Greens and Farmers Party was to apply different indexes depending on the length of service record/contributory period. Although this approach was refused by the leading coalition parties, it seems to be very popular between the older pensioners.

The chair person of the Committee of Social and Labour Affaires in the Parliament has already promised to continue discussions on indexation rules in the future despite the fact, that the current Law on Pensions already contains a provision stipulating that pensions should be

indexed yearly by CPI. Discussions on indexation rules for the next year already started in the Advisory Council of Seniors with participation of several senior NGOs and representatives from several ministries chaired by the Minister of Welfare. The Council was formed as a reaction to the petition of pensioners to the Parliament earlier this year.

All in all, the discussion shows that one of the basic principles of NDC scheme concerning regular indexation of earned pensions might be easily neglected. Instead, indexation is often perceived as a mechanism to secure the minimum income for elderly in the lowest segments of pensions or as a gratification tool for people with long working lives and with low pensions. By violating the principle of fair indexation the incentives to work longer and pay more into the pension scheme are being smashed.

As Latvia is approaching general elections in October 2014 discussions on the indexation of pensions will certainly stay on the top of the political agenda.

Already in 2012 the government announced its intention to reform service pensions. Several separate service pension schemes are operational and a variety of categories of employees (mainly from the public service, but not only) are entitled to special service pensions (militaries, prosecutors, judges, policemen, diplomats, artists of state and local government, members of professional orchestras, choirs, theatres and the circus). In 2012 more than 10,400 people (1.8% of the total number of pensioners) benefited from the special schemes[21].

At the beginning of 2013 the Ministry of Welfare started consultations with other ministries and organisations concerned proposing an increase in the statutory age and the qualification period requested for the entitlement to service pensions. Some professional groups (artists, policemen) immediately expressed their clear disagreement to any reforms.[22] The majority of these employees are insufficiently remunerated, therefore they see service pensions as an additional bonus to their low salaries. The Free Trade Union Confederation of Latvia (FTUC) objected to any reduction in service pension rights[23], insisting on them as a social guarantee for people in jobs where specific demands in health and psycho-physiological abilities are requested. FTUC even came up with the proposal to extend the scope of professions with service pensions. Some MPs from the opposition Concordance Centre Party (social democrats) also have already expressed their negative reaction to the reforms proposed by the Ministry of Welfare.[24] Political parties from the leading coalition so far have been reluctant to take a stance in this question leaving the Minister of Welfare (the Unity Party, liberals) alone with this unpopular dossier. Only the Minister of Interior (the Reform Party, liberals) expressed his opposition to the higher qualification requirements for service pensions of policemen. On September 28th 2013 the Ministry of Welfare submitted the concept document for consideration to the government.

On September 24th 2013 the government approved amendments in the Law on State Social Insurance reducing the social security contribution rate by 0.5 p.p. for employers and employees. The draft law has been submitted to the Parliament as part of a budget package for 2014. Unfortunately, the reduction of the contribution rate was proposed as an ad hoc solution without proper analysis of medium term consequences. The only aim of this reform publicly announced by the authorities was the reduction of labour costs for low income earners. The initial idea of the Unity Party (with portfolios of the PM and the Minister of

[21] Data source: CentralStatistical Bureau of Latvia
[22] Grunde, Aldis (2013), LM mēģina likvidēt nacionālo kultūras nozari
[23] LBAS.LV (2013), Koncepcija "Par izdienas pensiju piešķiršanu" ir nepieņemama
[24] Focus.LV (2013), Elksniņš: LM piedāvātā izdienas pensiju koncepcija ir mēģinājums padarīt strādājošo dzīvi sliktāku

Finance) was to substantially increase tax credits for low income earners and families with children following recommendations from several international organisations as well as the European Commission concerning disproportionately high tax verge on low income earners in Latvia and high levels of income inequality. The proposal of the Unity Party was met by strong resistance from their coalition partners, the Reform Party (liberals) and the Latvian Employers' Confederation (organisation representing employers' interests in the social dialogue) arguing that already in 2012 the coalition parties have agreed upon reduction of personal income tax from presently 24% to 22% in order to minimise labour costs for businesses. The next proposal from the Ministry of Finance came almost overnight - to reduce employee's part of social security contributions by 1 p.p. combining this measure with more modest tax credits than in the initial proposal. Again, this was not acceptable by the Reform Party and employers; therefore the final compromise negotiated was a reduction of the social security contribution rate by 1 p.p. divided equally between employers and employees.

The Ministry of Welfare recently informed about the income ceiling of 46,385 euro in 2014, above which social security contributions are not levied.[25] The income ceiling for contributions already existed in Latvia till 2009 but then it was abolished as one of the austerity measures to increase revenues in social insurance budget. According to the Latvian authorities the main purpose for reintroducing the income ceiling is to use it as a tool to avoid cases of excessively high amounts of short term benefits and pensions in future. No impact assessment of those measures is publicly available. Consequences of this measure like reduced social security revenues or adverse income distribution aspects so far have not been a subject to public debate.

Recently the Ministry of Finance initiated amendments to the legislation obliging to contribute in the social security budget those members of boards of private companies who work without salaries, but receive remuneration in form of dividends. In the mass media the proposal was met by loud protests from the representatives of SMEs, but so far political parties have not explicitly articulated their position. Although approved by the government and already submitted to the Parliament as part of the budget package for 2014 the proposal will become an object of political discussions in the Parliament.

3 Health care

3.1.1 System description

3.1.2 Major reforms that shaped the current system

The initial reforms at the beginning of 90ies were focused on the decentralization of the health care system and the introduction of market-oriented incentives for service providers. In 1993 budgetary allocations previously based on number of beds and staff was replaced by purchaser- provider split and health care providers remunerated on the basis of services provided by them. Primary care physicians were encouraged to practice in independent practices and the population was invited to register at a freely chosen general practitioner (GP) as a family doctor. Almost all dental practices and pharmacies were privatized.

Administrative structures for the management of financial flow have been reformed several times during the last twenty years. The current structure with the National Health Service (NHS) as a central institution responsible for health care financing and implementation of the

[25] BNS (2013), LM apstiprina sociālo iemaksu griestus - tie būs 32 600 latu

state policies in the health sector was created in 2011 by reorganising smaller agencies and reshuffling their responsibilities.

3.1.3 System characteristics

In Latvia, the health care system is based on universal health care coverage. Financial resources are raised through general taxation by the central government. Also, out-of-pocket payments remain an important financial source for the functioning of health care services. The State Treasury transfers financial resources to the National Health Service (NHS), who is the public institution subordinate to the Ministry of Health. NHS is the main purchaser of health services for the population and contracts directly public and private service providers (family doctors, dentists, hospitals etc.). In 2012 the number of service providers contracted by NHS for services financed by the state amounted 2,139[26].

Smaller hospitals and some regional hospitals are owned by municipalities, while larger tertiary hospitals (university hospitals) and specialized hospitals (e.g. psychiatric hospitals) belong to the state. Most of the primary care physicians work as independent professionals. Secondary ambulatory care providers, if not working for hospitals or health centres as employees, work as self-employed.

Health care benefits in kind include a wide range of services provided by family doctors, specialised care providers, hospitals and emergency care units, as well as drug prescription. Health care benefits in cash (sickness and maternity benefits) are part of social insurance and they are financed through mandatory social insurance contributions from employers and employees.

Co-payments apply to almost all types and levels of health care services and out-patient pharmaceuticals, prescribed by doctors. A fixed amount has to be paid, for example, per visit to the general practitioner, home call made by the family doctor, for hospital stay, inpatient surgical intervention, etc. A fixed proportion (25% or 50%) of the price of prescribed reimbursable drugs and medical devices usually has to be covered by patients. The co-payments for out-patient and in-patient health care services are capped at 570 euro per person per year; co-payments for hospitalization are capped at 356 euro per episode. However, the cap does not apply to co-payments for pharmaceuticals and medical devices. Children under the age of 18 are exempted from any fees. Disabled people, pregnant women and women up to 42 days after childbirth, victims of political repressions and participants of national resistance movement, tuberculosis patients, mentally ill persons under treatment and some other categories are also exempted from the mandatory co-payments. Households with the incomes below 128 euro per person usually are exempted from co-payments as well.

Two preventive programmes are available without co-payments: annual check-up at family doctor's practice and cancer screening programme. The take up of these programs are not high (7.6% for colorectal cancer, 32.7% for breast cancer and 26.7% for cervical cancer[27]). However, since 2009 when the screening programme started the take-up is showing a slightly increasing trend.

3.1.4 Details on recent reforms

A range of measures have been implemented to strengthen primary health care with a view to improve access to it, quality and continuity of care, especially for people with chronic diseases, and to increase the role of primary care in health promotion and early diagnostics.

[26] Data source: Ministry of Health
[27] Data source: National Health Service

For this purpose in 2012 the involvement of the second nurse in general practitioner's practices was continued (the measure started already in 2010) to strengthen the capacity of GPs, to help GPs to keep regular contact with their patients in order to encourage the patients to preventive examinations and check-ups, to educate them on healthy lifestyles, as well as to maintain regular GP's contact with patients suffering from chronic diseases and provide patients with knowledge and skills necessary to cope with their condition. In 2012 the number of additional nurses in primary care increased by 5.8%; as a consequence, 34% of the total number of general practices providing state financed health care services have recruited the second nurse[28]. The new requirements oblige family doctors to contact patients who have called an ambulance, but not been hospitalized, within one day. Now patients with an acute condition should be received by the GP at any time during opening hours of the GP's office, not only at specified consultation hours. In the case of early detected first or the second stage cancer family doctor receives a financial bonus.

Since May 2011 a consultative telephone line of family doctors is operational. The service was introduced in order to provide the possibility to obtain medical consultation in case of acute disease or acute condition of chronic diseases outside the family doctor's reception hours, thus reducing the number of secondary calls for ambulance. The service has become very popular.

In 2012 observation beds in hospitals have been introduced to increase the efficiency of in-patient care. Hospitals receive an additional payment for treatment and monitoring up to 24 hours for patients from the admission section in order to assess the patients' condition and decide whether the patient needs hospitalisation or can be released.

In 2012 the procedure for prescription of reimbursed pharmaceuticals has been changed. The old reference pricing system for pharmaceuticals in the reference list assigned individual products with similar chemical/therapeutic characteristics into groups of products (reference groups) for which the NHS paid the same price (reference price). Pharmacists or patients could choose one of the products belonging to the reference group and if the pharmaceutical product was more expensive, patients could pay the difference between the reference price and the actual price in addition to the regular drug co-payment. The new regulation stipulates that there is only one pharmaceutical product in a reference group, the one with the lowest price. Now a doctor has to specify in the prescription the active ingredient and a pharmacist has to dispense this. If patient chooses a different product, he has to cover the full price out of pocket (Mitenbergs, 44).

Serious expectations in the improvement of quality of services are linked to a gradual introduction of the e-health programme. In 2012 with the financial support from the European Regional Development Fund e-health projects e.g. e-booking, e-referral, electronic prescription system were in the process of implementation. The projects should be completed in 2015.

3.2 Assessment of strengths and weaknesses

3.2.1 Coverage and access to services

The main challenge for the health care system in Latvia is its extremely low accessibility due to financial reasons. According to EUROSTAT data from 2011 14.4% of the population have reported unmet needs for health care because they could not afford it financially, while in the lowest income quintile the rate reported is even 26.1 %. The most vulnerable group in this

[28] Latvia's Convergence Programme for 2013 - 2016

regard are females aged between 35 - 44 years belonging to households with very low incomes (the first quintile). Latvia has had the highest levels of the unmet needs in the EU for a decade and substantially differs even from its neighbours (LT and EE) in this regard. Self-reported unmet needs for dental examination indicated as being too expensive are also at the top level in the whole EU (36.1% for the 1st income quintile and 20.2% for the total population in 2011).

Patients have to pay for services not included in the list of those financed by the state, for example, dental care for adults, psychotherapy, most of available rehabilitation and physiotherapy services and a substantial section of the pharmaceuticals. Patients also have to make direct payments if they apply for services normally coved by the state, but disregard the standard procedure, e.g. if a patient visits a specialist without a general practitioner's referral. Direct payments are most often when a patient bypasses waiting lists for the state covered services. Besides, patients have to pay in full amount for all services received from providers not contracted by the National Health Service (Mitenbergs, 73). The assessment of health care systems from the customer/consumer's point of view published by Euro Health Consumer Index shows, that Latvia has a high incidence of informal payments from patients on top of the official co-payments.

Starting from 2012 some of the measures introduced during the crisis as part of the social safety net were withdrawn. During the crisis years households with an income below 171 euro per family member per month were exempted from patient's charges (co-payment) and households with an income below 213 euro were entitled to 50% reduction of charges. Since January 2012 only very needy households with an income below 128 euro per month are exempted from co-payments for health care services and prescribed pharmaceuticals. The threshold set for free of charge services is clearly too low to secure general access to health care. People from vulnerable groups face a real difficulty to cover the required costs. Besides, to obtain the formal status of a needy person entitled to free of charge services, the person has to follow certain administrative procedures, including means-testing. The administrative procedures might become an obstacle difficult to cope with, especially for elderly and people with serious health impediments.

Private spending for health care is very high and is growing constantly since 2006. In 2011 it reached 41.5% of total expenditure on health in the country.[29] The Central Statistical Bureau of Latvia in its analysis on consumption expenditure of private households in 2012 noted that the share of health care expenditure has increased by 3.3%. In 2008 health care expenditure was in the 9th position in the list of households' spending, in 2011 and 2012 this was the 5th biggest item for the first time ever outpacing clothing and footwear. Households spend on health care 6.1% and 5.9 % of their incomes respectively.[30]

Another reason for the low accessibility are long waiting lists for medical examinations and treatments, e.g. patients diagnosed with cancer have to wait on average 25 working days for a treatment (chemotherapy, radiotherapy), for a rheumatologist's consultation patients have to wait 86 working days.

3.2.2 Quality and performance indicators

Life expectancy in Latvia is one of the lowest in the EU, it is growing slowly. In 2012 life expectancy at birth was 74.2 years with a high difference between sexes (69.1 years for men and 78.9 years for women)[31]. The number of healthy life years is also among the lowest in the

[29] Data source: WHO, Data repository, Health financing: Health expenditure ratios by country, http://apps.who.int/gho/data/node.main.75

[30] Centrālā statistikas pārvalde (2012)

[31] Data source:Central Statistical Bureau of Latvia

EU27 both for men and women (53.7 for males and 56.7 for females in 2011). There has been no increase in healthy life years since 2005, the first year when the data for Latvia is available. Infant mortality is decreasing, but the rate (6.3 deaths per 1000 inhabitants in 2012) is still one of the highest in the EU[32] .

The reduction of number of years of potential life lost due to sickness from 7043 lost years per 100,000 inhabitants in 2008 to 6430 in 2020 is set as a target in the National Development Plan (NDP) 2020. The same indicator is reflected in the Report on the Implementation of NRP (2012) as a national health care target. The indicator shows a positive trend (*see table 4.)* mainly due to the substantial decrease in number of deaths by external causes.

Table 4 Lost years of potential life target's achievement trajectory

	2008	2009	2010	2011	2015	2020
Lost years of potential life per 100 000 people (aged up to 65 years)	7043	6494	6476	6140	5990	5300

Data source: Progress Report (2013)

The prevalent cause of death in Latvia is diseases of the circulatory system (55% of all deaths in 2012). During the last five years the death rate due to this cause was on the decreasing trend for both men and women, however, data on 2012 show increase in the rate again. Cancer is the second widespread cause of death (21% of all deaths). Mortality rate due to cancer has increased from 245 cases per 100,000 inhabitants in 2002 to 296 in 2012.[33]

One of the performance indicators used in NDP is a share of people who have visited their family doctor at least once in a previous year. In 2010 this indicator was at the level of 65.1%, in the NDP an increase of the rate up to 75% in 2020 is set as a target. The latest survey shows, that people are visiting their family doctors more regularly; in 2012 70% of respondents have visited their family doctor.

A public institution responsible for the quality control of health care services is the Health Inspectorate. The Inspectorate among other functions performs quality checks at hospitals and doctors' practices. The reports provided by the Inspectorate give an insight in the problems, but do not suit for quality monitoring at the national level. Problems like lack of premises accessible for persons with disabilities or lack of accurate and visible information for patients are often reported. The Inspectorate has discovered irregularities in payments charged from patients and cases of misleading information for patients on availability of the state reimbursed services in order to make patients pay out of pockets.[34]

Quite similar concerns are expressed by Patients' Ombudsman Office, disclosing that in 2012 patients most often complained about poor access to information on patient's rights, limited accessibility to health care services, uncertainty or lack of information on medical treatment procedures, insufficient communication from doctors to patients and their family members.

However, there is no comprehensive quality management system encompassing reliable quality indicators and mechanisms for monitoring and continuous quality improvement in the country. (Mitenbergs, 169).

[32] Data source: EUROSTAT
[33] Data source: The Centre for Disease Prevention and Control, Latvia
[34] Veselības inspekcija (2013)

3.2.3 Sustainability

Spending of the central government for health care as share of GDP is one of the lowest in the EU. According to the 2012 Ageing Report health care expenditure is going to increase up to 4.3% of GDP in 2060, thus financial sustainability of the system seems not to be at risk (The Ageing Report, p.184). However, that low level of public spending for health care threatens the health situation of the population due to extremely low accessibility to services, therefore not tolerable in a long run.

Table 5 Financing of health care

Year	2006	2007	2008	2009	2010	2011	2012	2013
Amount allocated for health care in the state budget, million LVL	**414.3**	**518.1**	**576.6**	**503.7**	**496.1**	**503.5**	**524.4**	**500.3**
% of GDP	**3.71**	**3.51**	**3.56**	**3.85**	**4.01**	**3.56**	**3.38**	**3.13**

Data source: Ministry of Health

The situation with health personnel employed in the health sector is another challenge. The number of practising physicians is stable; in 2012 there were 32.5 doctors per 10,000 inhabitants, slightly below the neighbouring EE and LT. The number of nurses is decreasing by time; in 2012 there were 46.4 nurses and 2 midwives per 10,000 inhabitants. The nursing and midwifery personnel density is one of the lowest in Europe.[35]

There are serious disparities between the capital Riga and the remaining country in the number of practising doctors. In Riga city there are 61.4 doctors per 10,000 inhabitants, while in other geographical regions only 20. One of the problems is the emigration of the younger generation of doctors and nurses to the countries with higher levels of salaries. In 2014 a substantial increase in remuneration of medical staff is planned, it is expected that the salaries for doctors and nurses will grow by 12% in average.

Another financial problem arises from hospital renovation projects implemented before the economic downturn with the support of state-guaranteed loans, as well as purchases of excessively expensive modern technologies. Some of those projects have been co-financed by the Structural Funds. In 2013 and subsequent years hospitals will have to spend considerable financial resources as principal and interest payments. To recuperate these expenses prices of services provided by hospitals will grow; therefore a part of the planned increase in health care budget will be used to cover the price difference.

Latvia receives substantial support from the EU Structural Funds (ESF and ERDF): in 2012 more than 53 million euro from these funds we invested in the development of public health sector, which constitutes more than 7.2 % of the total government spending on health.

3.2.4 Summary

Several positive aspects should be mentioned when assessing reforms and developments in the health care sector. Strengthening of primary health care and its role in disease prevention and early diagnostics, measures to optimise spending on pharmaceuticals, as well as wide range of activities in the field of public health are some examples of positive developments.

At the same time too little attention has been paid to the accessibility to health care services. Long waiting lists are explained by the officials as the reason of lack of sufficient financial

[35] Data source: WHO, Global Health Observatory Data Repository

resources, although large inefficiencies exist in a way how the system of waiting lists is being organised. Waiting lists for elective medical treatment are long, the patients do not know where they are and each list is formed and administered by the medical institution itself. Sometimes people register in several waiting lists for the same operation in hope to receive necessary treatment sooner. When waiting lists are excessively long or service providers have exceeded the number of patients and volume of services fixed in the contract with the National Health Service patients have to opt for a paid service.

Some services, such as non-urgent care, elective surgery and management of chronic illness are often postponed by providers into a distant future, although they are part of the statutory benefit package. The NHS may terminate a contract if it finds out that a provider deliberately defers treatment in order to be able to charge direct payments (Mitenbergs, 73).

There is no evidence on how often this practice is used on purpose. Overall lack of transparency in the management of waiting lists adds to uncertainty about patients' rights and obligations.

In the current discussions on the budget priorities for 2014, the reduction of waiting lists is mentioned as one of the targets. 5% of the planed additional resources are earmarked by the Ministry of Health for this purpose.

The aspect which seems to be overlooked by reforms and public discussions is the substantial number of people not being able to cover expenses of health care services in the form of co-payments, patient's fees or other out-of-pocket payments. At the same time there is no programme for reducing the level of co-payments or facilitation of affordability by other instruments, except uncertain public promises made by the Minister of Health to reduce co-payments for hospitals in 2015.

3.3 Reform debates

The Minister of Health after taking her office in October 2011 announced a plan to change the financial model of the health care system in Latvia and to implement a health insurance scheme instead of the existing universal coverage of health services funded from the general revenues. Following a lengthy period of discussions with stakeholders and other ministries the Ministry of Health finally submitted to the government the concept paper on mandatory health insurance. It got an approval by the Cabinet of Ministers on the April 16th 2013. After the adoption of the concept paper the Ministry of Health has prepared a draft law "Financing of Health Care" where the term "health insurance" is still used, but the proposed reform in its shape resembles a state financed health care system with restricted access to it for people with incomplete personal income tax record or low level of earned income. The purpose of the proposed reform is to increase the population's willingness to contribute financially to the state budget by linking the entitlement to health care benefits with the payment of personal income tax and fixing the share of budget allocations for the health care system at the level of 4.5% of GDP. According to the Minister of Health, the new financial model might be introduced in 2015.

As the main purpose of the reform is the reduction of tax avoidance its potential impact on accessibility, efficiency and sustainability of health care is not analysed in detail in the reform papers. Therefore most of the specialists are concerned that linking the entitlement to health care services with the payment of income tax may mean a move away from universal coverage (Mitenbergs, 151).

According to estimates of the Ministry of Health, changes in the financing system might limit access to health care services for about 140 thousand people. These people are supposed to make voluntary contributions directly to the health budget at the level of 28 euro per month.[36]

The new health insurance model was opposed by the Latvian Association of Local and Regional Governments and the Latvian Employers' Confederation. Besides, the Ministry of Health failed to persuade general practitioners on the advantages of the new system, as their associations continue to insist on serious risks for public health if access to health services will be denied to non-contributors. The public is divided in its views. The Minister of Culture (National Alliance Party) and the Minister of Welfare (Unity Party) were reluctant to support this proposal when discussed at the Cabinet of Ministers' meeting.

The main arguments from the authors of the new model of health care financing are about financial stability and sustainability of the whole system. They argue that the new financial model will exclude Latvian citizens working abroad as well as those Latvian residents receiving remuneration "in envelope". Another argument often misused by the Ministry of Health is a reference to the similar models, according to the Ministry's views, operating in the majority of the EU countries. Lithuania, Austria and Estonia are usually mentioned as examples of best practices.

Issues like low accessibility, long waiting lists and high level of out-of-pocket payments is increasingly present on the agenda of mass media this year. There is strong pressure from different interest groups, e.g. doctors' organisations, patients' organisations, managers of regional hospitals, opposition parties to allocate more resources in the health care system. For the moment it seems to be general consensus between the political parties that these problems are to be tackled as a priority in the state budget for 2014.

4 Long-term care

4.1 System description

4.1.1 Major reforms that shaped the current system

Major reforms of social services started in the middle of 90ies when on January 1st 1996 the Law on Social Assistance entered into force dividing competences between different levels of government and stipulating basic principles how the competences should be financed. Local governments were authorised to set up their services for social assistance and social care, including long-term care for the population. Social care institutions for elderly were decentralized (at the first stage of the reform to the regional governments, afterwards further to the first level of local governments), leaving only nursing homes for people with mental disorders in responsibility of the central government.

Long-term care as such is not defined in the Latvian legislation. Though, the Social Services and Social Assistance Law replacing the Law on Social Assistance in 2003 gives definitions of social care, institutional long-term care and other forms of social care, like home care, day care centres for disabled and group houses (apartments) for disabled. No differentiation is made by the legislator between short-term and long-term social care, except, institutional care. No specific legal framework exists for long-term health care services.

4.1.2 System characteristics

In 2012 there were 82 municipal nursing homes for elderly (in Latvia these institutions are called "social care centres") with 5,647 clients living there[37]. As a rule, nursing homes for

[36] Rozenberga Māra, Līdz obligātās veselības apdrošināšanas ieviešanai ejams tāls ceļš

elderly are run by local municipalities. There are several private and NGO's elderly homes, municipalities often pay for their services subject to means-test of clients and negotiated price with the institution. Besides, there are 15 state owned/financed nursing homes for adults with mental disorder with 5,820 clients.

Formal social home care is provided by municipal social services, NGOs, charities, private entities (agencies) and individuals. Some municipalities offer also other types of home support for elderly like security buttons, delivery of warm meals, laundry and assistant service. The number of people receiving home care is increasing constantly. There was a kind of drawback during the crisis years, but starting from 2010 the number of recipients is growing again. At the end of 2012 there were 6,869 elderly clients of home care financed by the local governments[38]. Most of the services were provided by social workers of municipal social services.

Alternative forms of long-term care including halfway houses for people with mental disorders, day care centers for retired people, social residential houses, group houses (apartments) exist, but these services are rather underdeveloped.

Expenses for home care and institutional care (except institutional care for people with mental disorders) normally should be covered by the client. For very poor people who live in households with average income below 128 euro per month and who don't have family members with an obligation to support them financially, all expenses for social care are covered by the local municipality. Municipalities are free to set a higher level of income as threshold for access to their free of charge services. A great proportion of home care services are provided informally by family members, relatives or neighbours. Municipalities are obliged to provide home care services only in situations when there are no family members able to take care of elderly or disabled person.

There are no special long-term care benefits in cash for elderly, but there is a personal care benefit of discretionary use for disabled people irrespective to age and income of the beneficiary. This universal state benefit was introduced in 2008, it is granted on the basis of the formal disability status of the person (the 1st or the 2nd category of disability) and the level of personal care needed. The assessment is based on the ability of the disabled person to perform daily activities (Barthel index); it is carried out by the State Medical Commission for the Assessment of Health Condition and Working Ability. In 2012 there were 11,480 persons receiving these benefits, 58.3% of which were elderly people aged 65 years and above[39]. The amount of this benefit is set at 142 euro per month and is to be increased by 50% in 2014.

In addition, municipalities are free to grant their own long-term care cash benefits. Obligations of local governments in this respect are not stipulated by the law. They often grant benefits in cash to persons with care needs when home care service is not available; municipal cash benefits can also be granted to family members or other persons actually providing care. As a consequence, depending on the municipality financial situation support is granted to care-takers or/and care-givers. At the same time about 50% of the municipalities in 2012 has not reported long-term care cash benefits at all.

4.1.3 Details on recent reforms in the past 2-3 years

During the years of the economic crisis there were no real reforms implemented in long-term care. In the framework of austerity measures the number of social workers and social carers

[37] Data source: Central Statistical Bureau of Latvia

[38] Data source: Department of Social Services and Social Assistance of the Ministry of Welfare, Summary of National Statistical Reports (2010,2011,2012) on social services and social assistance in local municipalities, retrieved on 2 August 2013 at http://www.lm.gov.lv/text/1382

[39] Data source: State Social Insurance Agency

has been reduced, as have the salaries for the remaining staff, which has a serious impact on their capacity for performing their functions (Bite, 25). To save resources the management of several state owned nursing homes were merged, so formally instead of 40 nursing homes financed by the state in 2009 there were only 17 nursing homes as legal entities in 2010. There were also cuts of caring staff and reduction of pay levels in the institutions.

To reduce overcrowding in the nursing homes for adults with mental disorders and to provide clients with safer and more adequate facilities, in 2013 some nursing homes ceased to accept new clients to reduce the number of inhabitants living there. In order to improve human capacity of the institutions from January 2013 salaries for nursing staff have been increased by 19-40% (depending on the professional group and the qualification level).[40]

In 2013 the pilot project „Grouping of clients and analysis of the scope of necessary services" in five of the state owned nursing homes were carried out. The results of the project (expected in February 2014) will be used to develop the system of grouping of clients in different care levels with a defined set of necessary services and necessary resources.

4.2 Assessment of strengths and weaknesses

4.2.1 Coverage and access to services

On January 1st 2013 there were 358 persons on the waiting list for nursing homes for adults with mental disorders (waiting time up to 1 – 1,5 years) and 39 persons waiting for a place in nursing homes for elderly (waiting time up to 3 months).[41]

Although home care service is the most widespread form of alternative care provided by municipalities significant regional disparities exist across the country. In 2012 home care was available for clients in all 9 cities, but only in 26 rural municipalities out of 110. [42] There are substantial variations between municipalities in the way how home care is organised. Social home care can be provided by municipal social services, non-governmental organisations, charities and private entities.

Some municipalities offer financial support to persons with home care needs. This support is meant to cover partly or fully the costs of the household for home care. There are no clear legal rules for this kind of benefits; conditions and amount of support varies greatly between municipalities. In 2012 only 25 municipalities out of 119 reported spending for financial support to care-takers; the amount of resources for this purpose is growing: 539,000 euro in 2010 and 786,000 euro in 2012[43]. About 50% of municipalities have reported expenditures for financial support to carers. Depending on the municipality the support can be granted in the form of a simple benefit to the family member taking care of elderly or can be formulated as a payment for services on the basis of a service contract. Usually contracts of this type are concluded between a neighbour or a relative and the municipality.

Municipalities are obliged to organise LTC services only for those elderly, whose monthly income is below 128 euro. The threshold is set at a very low level, therefore the access to

[40] Labklājības ministrija (2013), Paveiktais valsts finansēto ilgstošas sociālās aprūpes un sociālās rehabilitācijas pakalpojumu sakārtošanai

[41] Labklājības ministrija (2013), Pamatnostādnes sociālo pakalpojumu attīstībai,pp.31,37

[42] Data source: Department of Social Services and Social Assistance of the Ministry of Welfare, Summary of National Statistical Reports (2012) on social services and social assistance in local municipalities, retrieved on 2 August 2013 at http://www.lm.gov.lv/text/1382

[43] Data source: Department of Social Services and Social Assistance of the Ministry of Welfare, Summary of National Statistical Reports (2010,2011,2012) on social services and social assistance in local municipalities, retrieved on 02 August 2013at http://www.lm.gov.lv/text/1382

LTC for people with the income above this threshold is limited either by low affordability (especially, if the service is provided by private service providers) or non-availability of home care services in the community.

All care forms for elderly (institutional, home care, day centers) are under the responsibility of local governments while social care for adults with mental disorders and long-term care (social and health) of chronic psychiatric patients are under the competence of the central government, namely, the Ministry of Welfare and the Ministry of Health. This system nourishes conflicting interests between different levels of political power. Problems stem from the separate budgets used to finance different services and client groups, the fragmented organization of service delivery and different bodies from health and social services involved. According to the Concept Paper on the Development of Social Services for 2014 - 2020 the new guidelines for multi-disciplinary teams shall be developed. This might help on case to case level. More systemic reforms are proposed in the distant future by introducing the so called "virtual individualized accounts" for disabled people, where municipal and state financing should be combined to purchase the services necessary for clients.

4.2.2 Quality and performance indicators

There are several basic principles for the provision of social services stipulated by the legislation. Social services shall be provided on the basis of evaluation of individual needs and resources. In case of long-term institutional care the environment in the institution should be approximated towards the familial environment. All service providers are obliged to be registered by the Ministry of Welfare. The Register of Providers of Social Services is supposed to be a cornerstone for quality assessment. The Register allows to verify before service provision is started whether the service provider complies with the main requirements, i.e. has appropriate number and qualification of the staff, premises accessible and adjusted to clients' needs etc.

Quality assessment is carried out by the Department of Social Services Quality Control in the Ministry of Welfare. Due to limited capacity only 6% of all registered service providers can be assessed during a year. Most often quality of services is examined as a response to the complaints received from clients and their relatives. According to the Third European Quality of Life Survey, Latvians rate the quality of long-term care services in the country at 5.2 points[44] (in the scale of 10 points), which is near the mean of the EU countries (5.8). (EUROFOUND, 120)

4.2.3 Sustainability

As a rule, long-term social care is financed by general taxes through local governments. Long-term care for disabled people with mental disorders and long-term health care are financed from general taxes and administered through the central budget. Expenditure for long-term care as a share of GDP according to the 2012 Ageing Report was at the level of 0,7% (0.51% for institutional care, 0.05% for home care and 0.12% for cash benefits)[45]. The projected share for 2060 is 1.0% of GDP; the projected change is only 0.3%. These figures being substantially below the EU27 average show that there is some space for improvement in coverage and quality of services not threatening financial sustainability of the system even in the decades to come with the substantial increase in the number of elderly and very old people. The number of older people (aged 80 years and above) is projected to double from 94 thousand in 2013[46] to 217 thousand in 2060[47].

[44] Data source: EUROFOUND, European Quality of Life Survey 2012, Survey Mapping Tool, data retrieved on 21 October 2013 at http://www.eurofound.europa.eu/surveys/smt/3eqls/index.EF.php

[45] Data source:Background Statistics for Country Fiches of the SPC Report on Long-Term Care

[46] Data source: Central Statistical Bureauof Latvia

Table 6 Long-term care expenditure, millions LVL [48]

	2010	2011	2012
Local governments: expenditure for social home care	3.8	4.8	5.5
Local governments: expenditure for nursing homes	18.5	19.0	20.1
Central government: residential care for adults with mental disorders	22.2	23	23.8

As shown in the Table 5 expenditure of local governments for home care was growing on a faster pace than for institutional care (growth in expenditure for home care services by 44.7%, for institutional care – only by 8.6% in the period between 2010 and 2012). Expenditure of the central government for long-term institutional care for adults with mental disorders is growing even slower – 7.2% in the last two years.

The low wages for social carers are reported by the Ministry of Welfare as the main reason of high turnover and difficulties to attract new motivated staff in the institutions. So far in the situation of high unemployment no serious shortages in caring staff are reported. Gradually labour demand is increasing in line with positive developments in the labour market therefore personal carers as a highly demanded profession will certainly become an issue.

From January 2013 a new program for disabled persons was introduced (irrespectively to their age) to facilitate independent living – assistant's service to accompany the person for out-of-home activities, e.g. to see the doctor, to visit the rehabilitation centre, the library etc. Depending on the municipality additional services are offered to support independent living of elderly and disabled persons. In 2012 there were 10 day care centres for elderly with 4944 clients[49]. One of the new forms of day care centers becoming recently particularly popular are day care centers for people with dementia. Several municipalities have developed new services based on ICT i.e. security buttons. Also mobile care teams are used to provide more differentiated services. However, coverage of these services is low and territorially uneven.

Insufficient funding and high demand resulted into growing waiting lists for technical aids necessary for independent living. On January 1st 2013 9,884 persons were in the waiting list for technical aids, including even those who are in urgent need like children, patients after surgeries and accidents. For some specific groups of technical aids like personal mobility aids, orthopaedic shoes, hearing aids the expected waiting time can reach even two or three years.

4.2.4 Summary

The availability and the quality of long-term home care services heavily depend on the municipality where the person lives. Lack of clear and uniform national rules certainly gives space for innovative approaches for municipalities, NGOs and communities. At the same time there is no evidence whether people in need for long-term care really have an access to it.

Although there is no means-testing for the access to home care services, in practice the situation is slightly uncertain and ambiguous. As local municipalities are obliged to cover

[47] Data source: The 2012 Ageing Report

[48] Data source: Department of Social Services and Social Assistance of the Ministry of Welfare, Summary of National Statistical Reports (2010, 2011, 2012) on long-term social care and social rehabilitation and Summary of National Statistical Reports (2010, 2011, 2012) on social services and social assistance in local municipalities, retrieved on 2 August 2013 at http://www.lm.gov.lv/text/1382

[49] Statistical information from municipalities on social assistance and social services, available on the website of the Ministry of Welfare, http://www.lm.gov.lv/text/1382, retrieved at 02.08.2013

long-term care expenses only for the very poor people, due to the limited capacity of their social services they usually decide to provide care service only for those whose income is below the officially set poverty line and who do not have family members with legal obligation to support them financially. Municipalities tend to divert the rest of the demand to private care services or NGOs.

For the households with incomes above official poverty line (128 euro or higher if local government decides so), the availability of formal long-term care is very limited. As a rule, municipalities provide services only for very poor families. Private home care services are available almost exclusively in the cities; even then, costs of the services are too high to afford for the most of the families. Therefore women are often obliged to combine care responsibilities with professional duties. This causes a lot of stress to many of them. According to the Third European Quality of Life Survey 11.4% of women in Latvia are involved in caring for their elderly or disabled relatives every day or at least several days a week. Most often this situation is reported by people in the age group 50-64 years (14, 3%). At the same time, according to the Survey, 27.1% of female workers in Latvia found it difficult to concentrate at work because of family responsibilities; the EU27 average is 15.7%.

Taking into account the growing number of elderly people a policy programme to facilitate independent living of elderly, as well as to support working people with care responsibilities, could be helpful to facilitate more comprehensive approach to ageing of the population.There is no uniform and coordinated social and medical long-term care system in the country.

Long-term social care operates separately from long-term health care. Serious problems in the cooperation between social care and health care services are indicated in the domain of out-patient psychiatric care.[50] All care forms for elderly (institutional, home care, day centres) are under the responsibility of local governments while social care for people with mental disorders and long-term care (social and health) of chronic psychiatric patients are competences of the central government. This system nourishes conflicting interests between different levels of political power. Problems stem from separate budgets used to finance different services and client groups, the organization of service delivery and several bodies involved in health and social sectors.

4.1 Reform debates

The most visible long-term care topic on the recent political agenda is the quality of care and health services in the nursing homes for adults with mental disorders and the necessity to develop alternative care for them. Ombudsman's office publically claimed that social rehabilitation in these institutions is poorly organised and insisted on the necessity to widen availability of alternative care substantially. The government plans to increase funding for institutional care in 2014 in order to improve the quality of health care for clients, including recruitment of additional medical staff and better health care facilities in the institutions.

One of the Country Specific Recommendations addressed to Latvia in 2013 was "*to tackle high rates of poverty by reforming social assistance for better coverage, by improving benefit adequacy and activation measures for benefit recipients"*. So far this recommendation has been interpreted in terms of income distribution and cash benefits. Very limited attention is paid to the development of the services necessary for activation. An important step towards keeping elderly people socially active was the introduction of free of charge public transport in Riga City in 2010 for all pensioners. At the same time this measure is still being widely discussed and often criticized from the right wing politicians as populism and a financially unsustainable step.

[50] Veselības ministrija (2013), Informatīvais ziņojums

The Ministry of Welfare has recently published the Concept Paper on the Development of Social Services for 2014 - 2020 (not yet approved by the government) where the transition from institutional care to home care is one of the top priorities for people with limited abilities to perform their activities of daily living. Special attention is given to two target groups: children and people with mental disorders. For elderly people the document fixes a target to reach 100% territorial coverage with home care services till 2017, to increase the number of recipients (elderly and disabled) of home care services from presently 41 persons per 10,000 inhabitants to 55 persons in 2017, to increase the number of clients in day care centres from presently 58 persons to 65 persons per 10,000 inhabitants. Although the Concept Paper is the most important strategic document for the development of long-term care in the country and was thoroughly discussed with stakeholders (NGOs, municipalities, service providers) it ceased to attract any interest of wider public.

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Annex – Key publications

[Pensions]

LABKLĀJĪBAS MINISTRIJA, Informatīvais ziņojums par valsts fondēto pensiju shēmas darbības izvērtējumu, 09.10.2012, retrieved at
http://polsis.mk.gov.lv/view.do?id=4125

"Informative report on evolution of functioning of the mandatory pension scheme"

The report gives comprehensive analysis of functioning of the pension system, in particular of its fully funded 2nd tier. It looks at inflationary effects on both the 1st and the 2nd tier of pension schemes, provides data on developments in rates of return of the capital accumulated in the funded scheme, and gives an overview of administrative costs and other managerial problems. Findings are supported with set of comparative data on functioning of different pension plans and different asset managers. Substantial part of the report is devoted to possible pathways to improve effectiveness and efficiency of the 2nd tier pension scheme, including increased role of pension funds in the national economy, tightening the linkage of maximum administrative fees allowed for pension funds with their financial results.

LABKLĀJĪBAS MINISTRIJA, Koncepcija par izdienas pensiju piešķiršanu (informatīvā daļa), 28.08.13, retrieved at

http://mk.gov.lv/lv/mk/tap/?pid=40297412

"Concept paper on service pensions"

The Ministry of Welfare has prepared and submitted to the government for approval a concept paper on service pensions. The document gives comprehensive picture of variety of special service pension schemes currently in operation in the country. Problems like low retirement age of recipients, unjustified differences in qualification criteria applied, health and safety aspects are spelled out in detail. The paper contains reform proposals for necessary improvements of the system to make it more robust and socially fair as well as to increase retirement age and qualification period of service pensions.

RUNGULE, Ritma and others, Sabiedrības novecošana: sociālā aizsardzība, nevienlīdzība un darba tirgus riski, Rīga: LU Filozofijas un socioloģijas institūts, 2012

"Ageing of society: social protection, inequality and labour market risks"

The monograph is based on the results of the research project "Ageing of society: social protection, inequality and labour market risks in Baltic countries" carried out in October 2008 - October 2010 with a widely use of statistical data, EUROSTAT- SILC data base and expert interviews. Concepts of OMCare oftenapplied.
Changes in demographic composition of the population with a growing share of elderly in the society have been similar in all three Baltic countries since the restoration of independence. The book starts with a description of the concept of ageing. The second chapter deals with analysis of attitudes towards ageing and older people in Latvia, gives a comparison with other counties of the EU. The third and the fourth chapter describe quality of life of elderly, their incomes and inequality as well as employment situation and pensions in all Baltic states. According to the authors the existing pension system in Latviaare one of the most modern in the world, it is progressive and expected to be financially stable in the long term.

STĀVAUSIS, Didzis, Izglītības veicināšana finanšu jautājumos kā spējināšanas instruments Latvijā: valsts fondēto pensiju gadījums. In RAJEVSKA, Feliciana**(**red.), Sociālā cilvēkdrošība: spēju attīstība, sadarbība, iekļaušana**,** rakstu krājums, Rīga, LU Akadēmiskais apgāds, 2013, pp. 141 - 160.

"Promotion of financial literacy as instrument of empowerment in Latvia: the case of the state funded pensions"

The author sees financial literacy as a prerequisite for successful functioning of the 2nd tier of the pension system in Latvia. It is crucial to allow people to increase their individual accumulated pension capital and to reach high replacement rates at retirement. The author has analysed behaviour of the participants of the mandatory pension scheme during the crisis years and has come to the conclusion that majority of them are not prepared to take responsible decisions when choosing or changing their pension plan and assets manager. The author sees some improvements in the financial literacy of the population, while a coordinated and strategic forward-looking approach is still missing.

[Health care]

SLIMĪBU PROFILAKSES UN KONTROLES CENTRS, Latvijas iedzīvotāju veselība, analītisks ziņojums, 2012, Slimību profilakses un kontroles centrs, Latvija, retrieved at

http://www.spkc.gov.lv/sabiedribas-veselibas-datu-analize/

„Health of the population of Latvia"

The report offers an extensive description of national health policy and the current situation in health care. One of the chapters is devoted to the problems of accessibility (geographical and financial) to health care services. Key indicators of public health and its determinants are analysed in detail. The report contains analytical description of causes of death, situation with non-communicable and communicable diseases, maternal and reproductive health, disability, as well as gives overview of eating and exercising habits of population and substance abuse.

SLIMĪBU PROFILAKSES UN KONTROLES CENTRS (2012), Latvijas gados vecu iedzīvotāju vispārīgais veselības stāvoklis un to ietekmējošie faktori, tematiskais ziņojums,2012, Slimību profilakses un kontroles centrs, Latvija,retrieved at
http://www.spkc.gov.lv/sabiedribas-veselibas-datu-analize/

"General health status of elderly in Latvia and its determinants"

The reportprepared in the context of activities of the European Year of Active Ageing and Solidarity between Generations gives a wide range of information on demographic developments in Latvia and describes health status of elderly, prevalent illnesses and main causes of death using the statistical data from 2011. Among other health's determinants like healthy life styles and food serious analysis is given to the social and economical situation of people aged 65+. The report ends with some policy recommendations like to develop a complex of measures at the national and local level to provide for social and health care for elderly by utilising health care resources in the most effective way and facilitating assess to out-patient care in all regions of the country.

VESELĪBAS MINISTRIJA, Izvērtējums par veselībasaprūpi 2012.gada I pusgadā, informatīvaisziņojums, 24.07.2013,retrieved at
http://polsis.mk.gov.lv/view.do?id=4420

„Evaluation of the health care in the firstsemester of 2012"

The informative report prepared by the Ministry of Health and approved by the government contains information on recent developments in health care financing (state budget, patients' co-payments), administrative procedures and provision of health care services (ambulatory care, day hospital care, day care centres, home care services, in- patient care, ambulance service). Some services are analysed in the context of Social Safety Net Strategy adopted in the years of economic crisis (2009) therefore the report provides statistical data on services provided for needy persons.

VESELĪBAS MINISTRIJA, Finanšu situācija veselības aprūpes jomā, informatīvais ziņojums, 28.05.2013, retrieved at

http://polsis.mk.gov.lv/view.do?id=4498

„Financial situation ofthe health care"

The report prepared by the Ministry of Health is evidence based reasoning for a request for addition financial resources addressed to the government. It contains the most recent statistical information on services provided, as well as on the actual length of waiting lists and estimates on necessary resources needed to reduce them. The document analyses a pay situation of health professionalsin the dynamics, gives proposals for improvement of it. It advocates a necessity to reform a formula how costs for services provided by hospitals are calculated with a view to give more room for their development in the future, including higher wages of health personnel.

[Long term care]

LABKLĀJĪBAS MINISTRIJA, Informatīvais ziņojums „Par valsts atbalsta palielināšanu personām ar invaliditāti"**,** 04.06.2013, retrieved at

http://polsis.mk.gov.lv/view.do?id=4368

"Informative report on strengthening public support to people with disabilities"

The report is devoted to the analysis of different forms of financial support to people with disabilities. It includes chapters on long-term care cash benefits and special benefits for people with walking difficulties. The report gives a brief overview of legal and financial aspects of those benefits and serves as reasoning for the Ministry's proposal to increase the amount of the long-term care benefit for adults with disabilities by 50% from 2014.

LABKLĀJĪBAS MINISTRIJA, Pamatnostādnes sociālo pakalpojumu attīstībai 2014.-2020.gadam, Informatīvā daļa, 29.07.2013, retrieved at

http://mk.gov.lv/lv/mk/tap/?pid=40294031

"Guidelines on Development of Social Services for 2014- 2020"

The document prepared by the Ministry of Welfare and submitted for approval to the Cabinet of Ministers contains comprehensive analysis of social services available for orphans, adults with disabilities as well as for elderly. It identifies bottlenecks of the system and gives an overview of managerial problems linked to the provision of social services in the country. Deinstitutionalisation, development of community based social services, individualized and well coordinated approach towards client's needs and good governance are set as priorities for

coming years. The document includes detailed plan of actions with estimates for additional resources necessary for its implementation.

LATVIJAS REPUBLIKAS TIESĪBSARGS, Latvijas Republikas tiesībsarga ziņojums par Valsts sociālās aprūpes centriem pilngadīgām personām ar garīga rakstura traucējumiem, 15.02.2013, retrieved at

http://www.tiesibsargs.lv/files/content/zinojumi/Zinojums%20par%20VSAC%20-%20kopsavilkums_gala.pdf

"Report of Ombudsman of Latvia on the situation in social care centres for adults with mental disorders"

The report gives the overview of the current situation in the nursing homes for adults with mental disorders from the perspective of UN Convention on the Rights of Persons with Disabilities. The most thorough analysis is devoted to the quality of services available, including health care services and rehabilitation available to clients. The report contains a set of detailed recommendations addressed to the government.

SAFEGE BALTIJA, Gala ziņojums (t.sk. rekomendācijas) par profesionāla sociālā darba attīstības veicināšanu atbilstoši līgumam„Sākotnējās ietekmes (Ex-ante) novērtējums par iecerētajām strukturālajām reformām profesionāla sociālā darba politikas jomā,2012. gada 10. septembris, retrieved at

http://www.lm.gov.lv/text/2399

"*Final report (including recommendations) for development of professional social work (Ex-ante evaluation of the planned structural reforms in professional social work policy), project financed by ESF*

The final report of the project contains an analysis and evaluation of the situation in the social work practice in the local social services during the period from 2009 - 2011. The report gives evidence based information on problems of long-term care service provision in the small rural municipalities e.g. long distances, lack of professional social carers, extremely high proportion of a municipality's budget spent for institutional care of elderly etc.

This publication is commissioned by the European Union Programme for Employment and Social Solidarity – PROGRESS (2007-2013)
This programme is implemented by the European Commission. It was established to financially support the implementation of the objectives of the European Union in the employment, social affairs and equal opportunities area, and thereby contribute to the achievement of the Europe2020 Strategy goals in these fields.

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