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Quality and cost-effectiveness in long-term care and dependency prevention

COUNTRY REPORT

Latvia: Emerging policy developments in long-term care

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September 2017

European Commission

Contents

Introduction

This report summarizes recent policy development and policy directions in long-term care (LTC) in Latvia. It begins with a description of the main features of the LTC system, including regulations and basic utilization and financial performance measures, followed by discussing those policy documents which are important for framing and implementing long-term care services. The author would like to thank Mr Aldis Dudins, the deputy director of the social services department at the Ministry of Welfare in Riga for comments on this report.

1 Context – the long-term care system in brief

Social assistance and social services reform[1] in Latvia underwent reforms in 1997, with a main objective of them being to promote the development of municipal social services as close as possible to the place of residence of those in need. This objective, as well as the division of responsibilities between the state and local governments, was enshrined in the Law on Social Services and Social Assistance[2] (hereinafter referred to as the Law), which has been in force since 2003.

The key players in the provision of social care, including long-term care (LTC), are the Ministry of Welfare – specifically, the Department of Social Services and the Department for Methodological Management and Quality Control, and 119 local governments – 110 municipalities and nine cities.[3]

The number of organizations providing state-funded services decreased from 17 institutions in 2010 to 15 in 2015, the number remaining unchanged since then. The 15 state financed (five state and ten contractual organization) social care institutions provided LTC social services for 5,353 clients; 86 local government and other organization social care centres provided LTC social services for 6,134 clients (detailed information is presented in Annex 1). An opposite trend was observed in respect to the local government and other institutions providing LTC social services for adults. There were 83 such institutions in the country in 2010, and the number increased to 86 institutions by 2015.

Social care services are provided[11] in the form of:

- home care provided at the place of residence;
- day care and social rehabilitation institutions;
- serviced apartments; and
- long-term social care and social rehabilitation institutions.

Home care[12] is provided primarily for people living alone who have no help from family or close neighbours. If a person lives together with family or another person, then the local government should assess whether the family members living with them or another person are able to provide the necessary care.

Day care and **social rehabilitation institutions**[13] provide care and opportunities for physical and mental activities, for retired people, people with physical disabilities, people with mental impairments, and people with severe, long-lasting illnesses.

Serviced apartments[14] allow people with severe functional disorders an independent life, increasing their social functioning and self-care skills.

If it is not possible to provide social care services in the place of residence, social care services are provided at **long-term social care and social rehabilitation institutions**[15]**.** These institutions provide housing, social care, and social rehabilitation to persons of pensionable age and disabled persons with impaired vision or physical impairments, if the required scope of service exceeds the scope specified for home care or care at a day care and social rehabilitation institution. They also provide for adults with severe mental impairments who do not need to be in a specialized medical treatment institution and whose state does not endanger other people, if the required amount of services exceeds the amount specified for social

care and social rehabilitation services in home care or day care at a centre or a group house (apartment).

The Law defines the **rights of clients living in long-term social care and social rehabilitation institutions**[16] to independently take decisions and implement them to the extent this does not restrict the rights and freedoms of other persons or does not endanger the health or life of the person. They also have the right to reside outside the institution for a period of time from one month up to three months. In this case, a long-term social care and social rehabilitation institution, on written agreement with a person (or their family), will determine the duration of this residence and the rights and duties of the parties, as well as disburse an allowance or maintenance benefit for the client depending on the period of time during which he or she is in the care of another person (family).

As a client pays for social care services him/herself, the Law stipulates that they have the right to a particular sum of money for personal expenses, which is not less than 10% of the amount of the pension or state social security benefit of this person.

In 2016, the amount of the state social security benefit was €64.03, and for those disabled since childhood, €106.72. In calculating the state social security benefit for persons with a group I disability (the most severe level), a coefficient of 1.3 is applied, and for persons with a group II disability, a coefficient of 1.2 is applied.

In each long-term social care institution, the head of the relevant institution shall establish a Social Care Council[17] aimed at promoting respect for the rights of the persons living in the institution. The council consists of the persons living in the institution, their relatives, employees of the institution, and representatives of the local government. It coordinates the internal rules of procedure of the institution, submits proposals for improvement for its working, and examines conflicts between clients and management, as well as participating in the quality assessment of the services provided by the institution. It should be noted that decisions of these councils amount only to recommendations.

The number of residents in institutions tends to decrease each year, even without changes in the number of state-funded institutions. In 2010, 5,624 persons received state-financed services, 5,820 in 2012 and in 5,353 in 2015. The opposite trend is seen for adults who receive LTC services financed by local government. In 2010, 5,338 persons received these services; in 2015 this increased to 6,134.

At the same time, there has been an increase in the number of persons who receive care at home. In 2010, the total number of persons who received care at home was 8,345 persons, including 6,885 elderly persons, 1,356 disabled persons, and 104 other persons, while in 2015, 13,856 persons received home care, including 11,627 elderly persons, 2,097 disabled persons, and 132 other persons (trends at the end of the year can be found in Annex 4).

Similarly to the increase in the number of recipients of home care services, the number of recipients who receive services at day care centres has increased during the last five years, from 17,200 in 2010 to 23,800 in 2015. Most of these services are received by people at retirement age, followed by people with physical and mental disabilities. Over these years, the number of group house (apartment) social services for persons with mental impairments has remained unchanged; however, expenditures have increased by 59% (detailed information can be found in Annex 6).

While the provision of home care services has increased each year, it does not satisfy all the needs of the population. About 99.3% to 99.6% of persons applying for services receive it, while every year, on average over the last three years, 61 persons do not receive the necessary services and are waiting for them (detailed information can be found in Annex 5).

According to national statistical data and information on the request for state financed services aggregated by the MoW on 18 December

2012, 355 persons were waiting for state paid social care services in institutions for persons with severe mental impairments; however, for local social care services in institutions (on 1 January 2013), there were 80 persons waiting, and for home care, only two persons.[18]

State and local governments spend very large sums each year to provide services in institutions. In 2015, state and contractual organization social care centres spent €41.7 million, while in 2010, it was €31.6 million, but local government and other organization social care centres for adults spent €36.6 million in 2015, as compared to €26.3 million in 2010 (detailed information and trends on the total amount of resources spent for institutions in 2010–2015 can be found in Annex 2).

The level of expenditures per client differs between national and local social care services. In 2010, expenditures per one client in state (and contractual organization) social care services were €446.50, but in 2015, they were €569.69. Expenditures per one client in social care centres for adults operated by local government and other organizations were €425 in 2010 and €497.56 in 2015 (detailed information and trends on expenditures per one client can be found in Annex 3).

As indicated previously, Latvian legislation is focused on the satisfaction of the needs of people in their place of residence or as close as possible to it. Lawmakers have decided that the provision of services at the place of residence should be primary, and only if that is not possible, is a person eligible to receive the necessary services in an institution. It should be noted, however, that due to the prevailing views in society, institutional care remains one of the main forms of care.

Lack of funding during the economic crisis has had a large impact on the development of alternative services.

It should be noted that the term ‘dependent people’ is not used. In statistics and legislation, terms such as a person who needs care or a socially disadvantaged person are used. Furthermore, those who need care either at home or at social care institution are listed in statistics according to age group (see Annexes).

In addition to national and local social care institutions, some municipalities have care hospitals or healthcare (social) beds in multi-purpose hospitals, but specific figures are not available. These services are often used by ill, elderly persons in the last days of their lives, when the necessary care at home can no longer be provided.

The system of social services, as it has developed, the distribution of responsibilities between the state and local governments, and the financing mechanism of social services has not contributed to the development of community-based social services adequate to people’s needs. Long-term institutional care services still prevail.[21]

Social assistance and social services reform in 1997 and the subsequent Law on Social Assistance and Social Services (which entered into force in 2003) were intended to create community-based services to ensure services for those in need as close as possible to their place of residence. However, due to various factors, such as the divided funding of the state and local governments in the provision of long-term social care services, prevailing public stereotypes, and a lack of appropriate specialists, institutional care prevails. Despite some structural changes, combining long-term social care institutions on a regional basis with subordinated branches, as well as the separate projects of local governments implemented within the framework of the programming period for the European Structural Funds 2007–2014, significant changes to the provision of social services, including community-based services, have not been realised.

Recently, regions had the opportunity to receive ESF support for the development and implementation of social services development programmes aimed at reducing disparities in access to social services and to facilitate the effective planning of services in municipalities within the ESF operational programme ‘Human Resources and Employment’

sub-activity 1.4.1.2.4., 'Development of social rehabilitation and alternative social care services in regions', during 2007-2013[19]. Within the framework of the activity, 35 projects were supported in the Riga region, 17 in the Kurzeme region, 18 in the Latgale region, 11 in the Vidzeme region, and 14 in the Zemgale region.[20] Under these 95 projects, 133 social service providers were created or improved. The included service providers of care homes, day centres, day care centres, group apartments, long-term social care and social rehabilitation institutions, temporary care and respite provision, crisis centres, specialized workshops, social rehabilitation institutions, and trust phone services.

Significant changes in the provision of social services (including social care services) were planned under the framework of the Guidelines for Development of Social Services for 2014–2020[5] (approved in 2013) and the Action Plan for Implementation of Deinstitutionalization for 2015–2020[6] (adopted in 2015) concerning deinstitutionalization (DI) implementation from 2015 to 2020 with funds from the European Regional Development Fund (ERDF) and the European Structural Funds. Regarding the implementation of the ongoing and planned projects, DI Steering Groups comprising local governments, planning regions, the MoW, and the Social Services Development Council were created to oversee the implementation of the Guidelines on Development of Social Services for 2014–2020 and the DI Action Plan. They were to facilitate the development of community-based social services appropriate to the individual needs of the client and to provide proposals for the development of social services. The Social Services Development Council, involves a number of participants: representatives from the Ministry of Finance – Managing Authority, the Ministry of Economics, the Ministry of Education and Science, the Ministry of Transport, the Ministry of Health, the Ministry of Environmental Protection and Regional Development, the Latvian Association of Large Cities, and other non-governmental organizations (NGOs) representing DI persons and their family members.

The necessary regulatory framework was developed in 2015. As of November 2016, contracts for the implementation of the planned projects have been concluded in all planning regions,[7] and cooperation agreements are currently being concluded with the municipalities (except for Rīga, Cibla, Līvāni, and Jaunjelgava). In 2016, the Zemgale planning region issued an open call procurement for the assessment of individual needs and elaboration of support plans for people with disabilities and children outside family care in its region (31 March 2016 and 11 May 2016) with an estimated contract price of €154,860. However, this procurement was suspended on 3 June 2016. A representative of the MoW explained that this was due to the absence of applications and the unavailability of the necessary specialists envisaged by the Action Plan.

However, the Zemgale planning region continues to work on this project, and a procurement for the development of a DI plan in the region was announced on 20 September 2016 with an estimated contract price of €123,967. The other planning regions are planning similar procurements. Hence, the MoW believes that a more active implementation of the projects will take place in 2017 and 2018.

2 Policy towards dependency

The Law,[8] which has been in force since 2003, defines the principles for the provision and receipt of social care services, the persons who have the right to receive these services, and the principles of the payment and financing of social care services.[9]

In terms of dependency prevention, the Law also prescribes[10] that the purpose for the provision of social care services is to ensure that quality of life does not deteriorate for a person who, due to old age or functional disorders, cannot maintain it on his or her own.

Chapter II, 'Organisation of Social Services and Social Assistance', of the Law sets the duties of the state and local governments for the provision of

social care services, including the provision of LTC services and assuring quality of services.

The local government in the territory of which a person has registered his or her main place of residence has a duty to provide the person with the opportunity to receive social care services. If a local government has received information – from one or more individuals or an institution – regarding a person who might require a social care service, the local government has a duty to verify the information, evaluate the needs of the person for the service, and inform this person or his or her lawful representative of the rights, options, and procedures for receiving social care services.

Section 9, part 4 of the Law prescribes that in a case where the local government is not able to provide the necessary social service, it must enter into agreements with other social service providers in their territory or with other local governments, to provide services fully or partially financed from the local government budget. However, the Law defines specific cases when LTC services are provided and financed from the state budget. According to section 9 of the Law, LTC services are financed from the state budget for persons with mental impairments who have been placed in institutions up to 1 January 2003, for adult blind persons and persons with severe mental impairments. As with local governments, the state can also establish social care institutions or sign agreements with other service providers.

Policy incentives in the long term care

In recent years, within the framework of the ESF funding, Latvia has developed a series of medium-term political planning papers and has established a system that ensures a tight correlation among these papers. The most important papers are as follows:

The Sustainable Development Strategy of Latvia until 2030[22] (announced by Parliament on 10 June 2010) sets out the state's long-term priorities and aims for sustainable state development. In the strategy, it is stated that ageing and household structure changes must be included when drafting policy on public and social services, taking into account that ageing will have important implications on the service sector, and especially health care. It sets out that 'expected increased demand for day-to-day care services for the elderly must be prepared for in advance by developing care or the 'silver economy".

The National Development Plan of Latvia 2014-2020[23] (adopted by the Parliament on 20 December 2012) sets out medium-term development priorities. There are also defined objectives to be achieved by 2020 regarding increasing welfare and reducing the number of the working poor.

One of the strategic objectives set out in this document is 'healthy and fit for work', which emphasises that it is necessary 'to implement targeted and effective measures towards the promotion of health and limitation of risks by improving the quality and accessibility of healthcare services that ensure a timely diagnosis of diseases and earlier commencement of treatment'. This applies not only to people of working age, but also to people of retirement age. Under this strategic objective, there tasks are defined such as promoting healthy and active lifestyles in society by strengthening health promotion cooperation networks; ensuring access to healthcare services; improving the quality, planning, and coordination of medical and social rehabilitation measures; maintaining and restoring working ability; and restricting the prevalence of addictive habits and substances. It also sets out an aim to ensure the availability of services in keeping with demographic trends and population changes, and, among others, concentrating on a basket of public and social services in national and regional centres and defining and introducing this basket of services in rural areas.

The Operational Programme (OP) 'Growth and employment'[24] (adopted by the European Commission on 11 November 2014) contains the defined priorities, aims, and attainable results in compliance Latvia's political papers, national field

strategies, and other planning papers. The OP sets the general principles for the implementation, monitoring, and evaluation of priorities co-funded by Cohesion Policy funds.

The Guidelines on Development of Professional Social Work (2014–2020)[25] is a particularly relevant paper regarding social work and is aimed at creating a common system that ensures support for citizens in reducing social problems. Two strategic objectives were defined: the improved quality and increased availability and efficiency of social work, and the sustainable development of the social work sector. The tasks and measures of the guidelines focus on the following:

- Improving the management quality principles applied in social service offices;
- developing a support system for social workers;
- organising methodological support;
- promoting mergers of social service offices in small local municipalities;
- developing social work in the community;
- creating a targeted approach for the support of persons who study in social work educational programmes;
- iмproving the professionality of social workers;
- providing support for the development of a scientific and research base in social work;
- promoting awareness of social work;

evaluating investment efficiency in social work. Although one of the problems identified in the document is a lack of specific knowledge and skills in social work practice for various target groups, there are no specific measures planned to improve the performance of care services for the elderly. The solution to the problem is to improving professional skills in social work with various target groups from 2015 to 2019, aiming for at least 75% of the population for whom a social problem is identified to be satisfied with the support received from social service offices. A mid-term evaluation is intended before 1 July 2017.

The Guidelines on Development of Social Services 2014–2020[26] is the most relevant paper for social care services development. 'The objectives and the measures of the guidelines are focused on ensuring the provision of community-based social services appropriate to individual needs, contributing to the person's self-care and independent living options. This applies also to persons who receive the service at social care centres, who, as a result of targeted rehabilitation measures and the de-institutionalization process, could reintegrate into society. While for persons whose care requires the use of specific technologies and continuous professional supervision, it is planned to ensure dignified living conditions and high quality services in care institutions. In addition, the role of social services is emphasised regarding the family members of recipients of social services, to promote their integration into the labour market and to reconcile working and family life'.

Objectives and tasks outlined in the guidelines are conceptually related to the measure 'Diversification of forms of social care and social rehabilitation' defined in the National Development Plan of Latvia 2014–2020.

In the context of an ageing population, with an increasing number of single people and a decreasing number of births, there is an increasing demographic burden. Furthermore, the amount and accessibility of social services differs widely among local authorities. These guidelines offer to change the current approach and understanding about social services from not only a 'pure' form of care, but to a tool of support to activate individuals; to integrate them into society, the education system, and the labour market; and to enable people to be independent from LTC and to enjoy their fundamental rights and freedom of action.

Many local governments do not provide the necessary services to clients at their place of residence, but instead offer care services at care institutions. The division of services between the state and local governments does not contribute to the development of alternative services. These are

the main problems indicated in the guidelines. In cases where the supporter refuses to pay for social services received, the statutory payment system (by the client, or client's supporter) may impact the timely receipt of social services and the quality of life. Other relevant problems are: a lack of cooperation and lack of exchange of information between social services staff and primary health care professionals, tackling the client's social problems not only at the place of residence, but also in care institutions, and deficiencies in the Registry of Social Services Providers.

In the guidelines, two problems concerning retired people have been identified: underdeveloped home care services for persons of retirement age and constant demand for long-term social care and social rehabilitation services in institutions.

As a result, corresponding objectives were defined to ensure the provision of community-based social services appropriate to individual needs that contribute to the person's self-care and independent living options, and to ensure dignified living conditions and high quality services for those persons who receive services in institutions.

Policies for the provision of social services are intended to be implemented based on the principles of the reconciliation of needs and possibilities, equal opportunities and rights, good governance, and cooperation. Planned activities will be implemented in three directions: deinstitutionalization (DI), community-based social services that are appropriate to individual needs, and efficient governance of social services.

Selected planned policy outcomes and results are as follows:

- To reduce the number of persons with mental impairments in care institutions, it is planned that the number of clients in care institutions per 10,000 inhabitants will decrease from 22 in 2011 to 18 by 2020;
- To reduce the number of persons of retirement age in care institutions, it is planned that the number of clients in care institutions per 10,000 inhabitants will decrease from 141 in 2011 to 135 by 2020;
- To improve the availability of services at the place of residence for the elderly and persons with disabilities, the number of home care service recipients per 10,000 people will increase from 41 persons in 2011 to 70 persons in 2020, and the number of recipients of services at day care centres will increase from 58 in 2011 to 70 in 2020;
- To improve the quality of social services, it is planned, by 2020, to profile 3,300 persons with mental impairments and to develop social care and social rehabilitation plans;
- To improve the governance of social services, it is planned that by 2020, the return of 700 DI clients will be financed according to the principle 'money follows the client.

On 7 September 2016, the government reviewed the concept report '**Active ageing strategy for longer and better working life of Latvia**'[27] and supported the first version of the proposal 'Solution to improve the active ageing situation', appointing the MoW as the responsible institution in its implementation. The Ministry of Education and Science, the Ministry of Health, the State Employment Agency, the State Labour Inspectorate, and the Social Integration State Agency were defined as co-responsible institutions.

In the concept report, it is emphasised that in order to promote active ageing and to extend working life, it is necessary to improve the policy in several related areas:

- in employment, by providing an inclusive labour market for older people;
- in education, by ensuring educated and competent older workers in response to changing labour market conditions;
- in health and active lifestyle, by encouraging older people to stay healthy and physically active and remain active and independent for as long as possible (dependency prevention); and

- in social security, by socially protecting elderly people.

In addition to the policy planning papers mentioned, the government has also approved the **Guidelines on the Implementation of the UN Convention on the Rights of Persons with Disabilities 2014–2020.**[28] In the guidelines, the solutions required to improve support regarding the provision of service assistants, adjustments of housing, the accessibility of the environment, and improvements in the accessibility of technical aids and alternative social care services (day care centres and home care) are analysed.

The **Implementation Plan 2015-2017 of the Guidelines on the Implementation of the UN Convention on the Rights of Persons with Disabilities 2014–2020**[29] includes activities in employment and education, as well as measures focused on the development or improvement of state-supported services for persons with disabilities. Measures include extending assistant services for disability groups I and II, improving the disability assessment system, and providing vocational rehabilitation services. It is planned that the activities will be financed from the state budget and ESF resources. Specific measures for elderly persons are not included.

The **policy framework for LTC** was created by two primary documents: the Guidelines for Development of Social Services for 2014–2020 and the Action Plan for Implementation of De-institutionalization for 2015–2020. The Guidelines on Development of Social Services for 2014–2020 also address issues concerning access to social services in respect to the target groups – people with functional impairments and people of retirement age.

Similar issues are found among all target groups, including a lack of alternative care services, a lack of funding, a lack of qualified specialists, and a lack of interdisciplinary and inter-institutional cooperation.

In assessing access to social services for persons with functional impairments, the MoW examined the situation in relation to persons with mental disorders, persons with physical impairments, and persons of a working age with disabilities.

The main problems identified are as follows:

- inaccessibility of social and medical rehabilitation services as close as possible to the place of residence of the clients, limited availability of palliative care, and inadequate outpatient mental health care;
- low income of the population, which leads to increased demand for long-term social care services financed by both the state and local governments;
- lack of methodology for grouping clients to determine their needs for the receipt of social care services;
- lack of housing funds in municipalities for the development of alternative care services in cases when the client is not able to live without support and requires accommodation;
- non-conformity of the infrastructure of long-term social care and social rehabilitation institutions to the conditions of good practice; investments are required to ensure accessibility of the environment and improvement in the quality of services;
- unsatisfactory range of technical aids offered through state budget resources; technical aids are not available when needed – people must sometimes wait several years before receiving them;
- lack of vocational rehabilitation services for persons with a low education level and multiple impairments; and
- insufficient motivation for persons with functional impairments to receive vocational rehabilitation services.[30]

In 2013, the Ombudsman of the Republic of Latvia made recommendations on these issues in his report on state social care centres for adult persons with mental impairments[31] following 30 visits to

long-term social care and social rehabilitation institutions across all regions of Latvia. His aim was to draw attention to two basic points:

- the obligation of the state to implement DI by gradually withdrawing from the services provided by state social care centres; and
- the situation of persons with mental impairments in state social care centres.

The Action Plan for the Implementation of De-institutionalization for 2015–2020,[32] (Action Plan) approved by the Minister of Welfare, is very comprehensive for several reasons:

- it is developed in detail, considering both international, EU, and national regulatory enactments and the policy planning documents indicated above;
- it applies to all the institutions involved in the DI process at the national, regional, and local levels;
- the implementation of the measures in the action plan involve multidisciplinary specialists;
- the action plan includes the joint use of several financial sources;
- the action plan includes work not only with DI target groups, but also with specialists from various fields, local administrations, society, and DI family members.

The objective of the action plan is to implement the DI process by:

- efficient management of the DI process, as well as the achievement and evaluation of the planned results;
- single approach in all planning regions; and
- use of European Common Guidelines and Manual on the Use of EU Funds to implement the transition from institutional to community-based care.

The proper implementation of each activity ensures the initiation of the next activity. Thus, for example, without the appropriate evaluation methodology of clients it is not possible to carry out an evaluation of clients, or without the identification of the needs of clients, the further planning of services and the development or creation of the necessary infrastructure is not possible.

To implement DI measures through 2022, it is necessary to implement an information campaign. Planned funding for the campaign is €900,000. In the framework of the communication strategy, educational and informative seminars, conferences, and round-table discussions; various information materials; individual consultations and other measures for professionals from health care, education, and other areas, and employees from local governments, administrations, and social service offices; and informative and educational measures for local citizens have been planned. In addition, there are planned cultural and sporting events with the DI target groups, as well as meetings with the NGOs representing the DI target groups, and informative and educational measures for DI groups and their family members. A special section on DI implementation on the MoW website is planned.

3 Policy regarding support for informal carers

No policy planning papers concerning support for informal carers have been developed in Latvia. At the moment measures to support informal carers are scarce, and where they exist they concentrate on carers of dependent children. At the moment, there are neither cash nor in-kind benefits for carers of dependent adults.

Policies described in section 3 provide for the development of services alternative to care in institutions, and the training of staff involved. In the **Guidelines for Development of Social Services 2014-2020**, the need for support for informal carers and reconciliation of care and work is one of the policy objectives. Therefore there are grounds to believe that in the process of developing alternative care services measures for the support of formal and informal carers will also be implemented.

4 Information and technological support

The number of social services providers in Latvia is monitored by the MoW in the Registry of Social Services Providers, available on the MoW website. The registry[33] was created using a Microsoft Excel worksheet and includes the following information:

- registration (certificate) number of the social services provider
- registration code
- title of institution
- form of social service
- legal and actual address
- social services provided
- clients by age and gender
- group of clients for whom the services are provided
- legal status
- head of service provider
- phone, fax, email, and website (if available)
- date of activity (registration) renewal
- whether excluded from the registry (number and date of decision) and
- justification for exclusion.

In November 2016, according to the registry, 1,116 registration certificates for social service providers were issued. For several service providers, renewal dates are specified. Approximately 221 service providers are excluded from the registry. Registration forms are available on the MoW website, which includes access to the e-Latvia website where providers can submit their electronic registration forms.

Registry mistakes have been identified in both the Guidelines on Development of Social Services for 2014–2020 and the Action Plan for the Implementation of DI for 2015–2020.

The action plan includes activity 6.7, Monitoring and assessment, where it is planned to identify indicators concerning the implementation of the DI process and the achievement of the objectives, to provide DI monitoring, and to elaborate the DI reporting procedure.

Regarding DI process monitoring and the development of a new information system, the following tasks are planned/foreseen:

- preparing an IT concept paper that will provide the technical opportunities for DI process monitoring;
- adopting an EU structural funds project for the creation of an IT DI monitoring system;
- selecting of a team of experts during the procurement process;
- creating an IT DI monitoring system;
- preparing and coordinating a system of indicators for DI monitoring;
- creating a single manual or computerised service provision and accounting system to be used by each municipality;
- supplementing forms of reporting and contracts;
- integrating the system of community-based services with other systems and
- creating a single DI monitoring system and ensuring that it is ready to work by the second quarter of 2018.

It is also planned to develop a common framework for assessing the quality of life changes of clients, including developing an evaluation mechanism, defining the assessment criteria for quality of life, and providing the assessment. At the same time, there are plans to make the necessary changes to regulatory enactments, as well as summarising, analysing, and monitoring DI results, where the planning regions have had a major role.

Within the framework of the action plan, a decision was adopted at a government meeting on 4 October 2016 (protocol No. 50 21.§)[34] to approve and include information and communication technology project ‘Support system of de-institutionalization processes’. The anticipated project costs are

€1,700,000, which includes ERDF financing of €1,445,000 and state budget financing of €255,000.

However, until the end of the implementation of the measures included in the action plan, both local governments and institutions will continue to submit the required statistical forms, the data of which are available on the MoW website and can be found in the section 'State statistics in the field of social services and social assistance' under 'annual data' (www.lm.gov.lv/text/1382). Information regarding social service providers will be available in the above-mentioned Registry of Social Services Providers.

Coordination problems in long-term care

In Latvian political culture and in the Rules of Procedure of the Cabinet of Ministers,[35] it is defined that during the drafting of legislative acts and policy planning documents, public opinion, usually expressed through NGOs, is to be heard and taken into consideration. Regarding the development of the Guidelines on Development of Social Services for 2014–2020, for example, a working group was developed comprising representatives from state institutions – the MoW, the Ministry of Health, the Ministry of Environmental Protection and Regional Development, the NGO sector (including the organization of people with disabilities and their friends 'Apeirons', the Samaritan Association of Latvia, the Latvia Pensioners Federation, Riga city society 'Care Child', the Resource Centre for people with mental disabilities 'Zelda', the Latvian Umbrella Body for Disability organizations 'Sustento', the Association 'Latvian Movement for Independent Living', the Association of Social Care Institutions of Latvian Local Governments, and the Association 'SOS Children's Villages Latvia'), as well as municipal social service offices (from the Cēsis, Sigulda, Tukums municipalities), the Kurzeme Planning Region, and the Latvian Association of Local and Regional Governments.[36] A similar consultation, where opinions from NGOs and local governments were heard, was organised during the development of the Action Plan for the Implementation of DI for 2015–2020.

Additionally, further cooperation and joint action between representatives of various disciplines and different authorities has been planned for the implementation of the action plan. Specifically:

- The DI monitoring process will be conducted by the Social Services Development Council involving representatives from the Ministry of Finance - Managing Authority, the Ministry of Economy, the Ministry of Education and Science, the Ministry of Transport, the Ministry of Health, the Ministry of Environmental Protection and Regional Development, and the Latvian Association of Large Cities and other NGOs;
- Management of the DI process at the national level will be conducted by a DI steering group that will be established by the MoW and will comprise representatives from the responsible departments and the State Secretary;
- Targeted DI planning, implementation, and monitoring at the regional level will be conducted by a regional DI steering group that will include the head of the planning region administration, representatives delegated by the Planning Region Development Council, the DI project manager of the planning region, the regional government, and NGOs;
- Groups of experts will be established to assess the needs of clients and to develop support plans. To assess the needs of persons with mental disorders and to develop relevant support plans, experts may include: social workers, clinical psychologists, psychiatrists, occupational therapists, and mental health care nurses. To assess the needs of children with a disability and to develop relevant support plans, experts may include: social workers, special pedagogy teachers, neurologists, clinical psychologists, physiotherapists, speech therapists, and occupational therapists;
- Expert teams are planned to closely cooperate with institutions and the staff of social service offices to assess the individual needs of clients and to develop support plans, as well as to coordinate processes and to prepare summaries

on the required services and the desired location of these services.

- Planning regions[37] (a map of the planning regions can be found in Annex 7) will cooperate with local governments and care institutions to analyse social service provision and infrastructure for the existing institutions of each local government. The analysis will include the number of clients, number of staff (administrative and care staff), an assessment of the infrastructure, closing or re-profiling opportunities, potential number of clients in line, and the available and requested social and general services for both children and adults;
- Planning regions will cooperate with local governments and the Ministry of Education and Science to assess the accessibility and need for education services, and will include the Ministry of Health, in the field of health care services, the Ministry of Transport, in the field of transport, and the Ministry of Culture, in the field of culture;
- Planning regions will cooperate with local governments, the State Employment Agency, and NGOs to identify existing and necessary employment opportunities; and
- Planning regions will cooperate with NGOs to define the required number of experts (and qualifications and training); to identify the required number of foster families, guardians, and services close to the family environment for children out of familial care; to identify potential adopters; and to plan the development of community-based services.

These are a few examples of cooperation set out in the action plan. It will only be possible to determine how successful the cooperation will be during the implementation of the projects.

Conclusions and summary

Latvian legislation is focused on meeting the needs of people in their place of residence or as close as possible to it. Lawmakers have specified that the provision of services at the place of residence shall be primary, and only if that is not possible may a person receive the necessary services in an institution. But, due to the prevailing views in society, institutional care remains one of the main forms of care.

In recent years, within the framework of funding from the ESF, Latvia has developed a series of medium-term political planning papers and has established a system that ensures a tight correlation among planning papers.

The policy framework for LTC was created by two primary documents: the Guidelines for Development of Social Services for 2014-2020[38] and the Action Plan for Implementation of De-institutionalization for 2015–2020.[39]

The objective of the Action Plan for the Implementation of De-institutionalization for 2015–2020[40] is to implement the DI process by efficient management of the DI process, as well as to achieve and evaluate the planned results, using a single approach in all planning regions, and using the European Common Guidelines and Manual on the Use of EU Funds. The institution responsible for the implementation of the action plan is the MoW.

The MoW is also responsible for the implementation of the active ageing strategy[41] which is aimed at promoting active ageing and extending working life.

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7 Under the Regional Development Act, Latvia has established five planning regions: Kurzeme, Latgale, Riga, Vidzeme, and Zemgale. The competence of planning regions is to ensure the region's development planning, coordination, and cooperation between municipalities and other administrative institutions.

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Annex 1

Table 1: Long-term social care and rehabilitation centres at the end of the year[42]

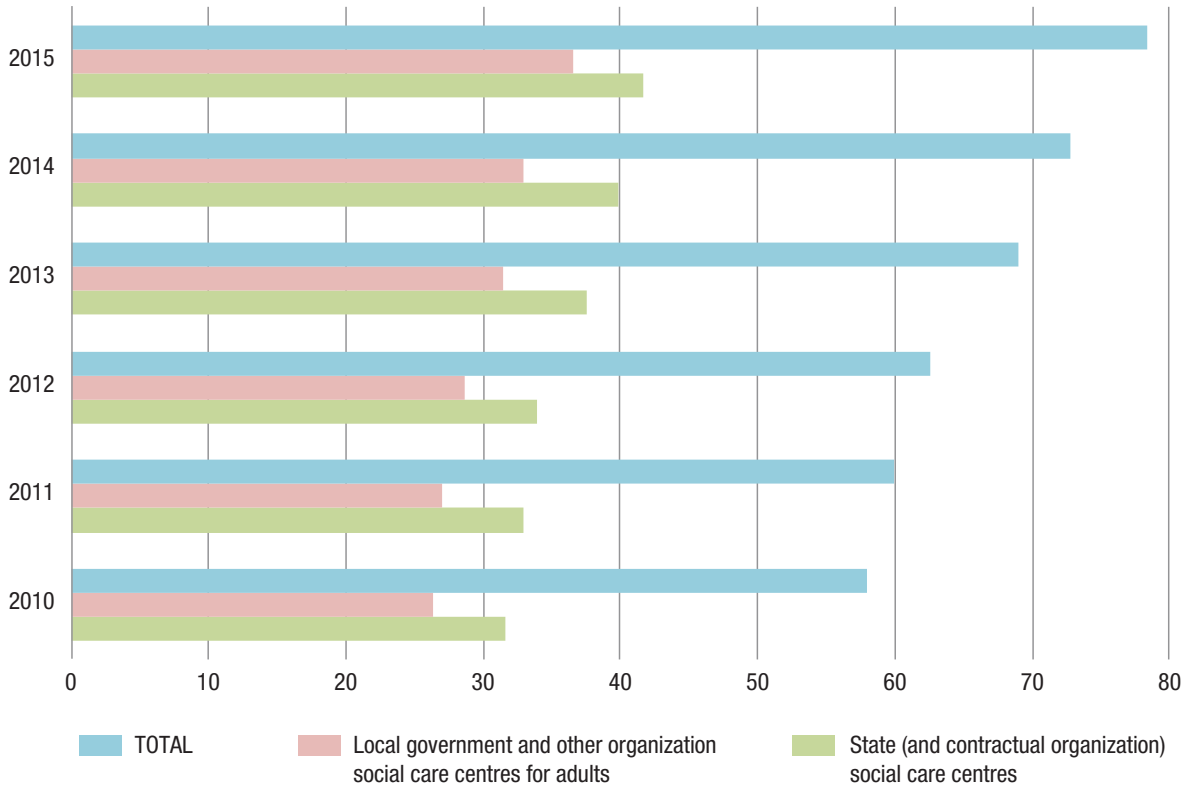
	State (and contractual organization) social care centres		Local government and other organization social care centres for adults	
	Number of institutions	Number of residents	Number of institutions	Number of residents
2010	17	5,624	83	5,338
2011	15	5,847	78	5,464
2012	15	5,820	82	5,647
2013	15	5,604	83	5,745
2014	15	5,425	84	5,953
2015	15	5,353	86	6,134

Annex 2

Table 2: Total amount of resources spent by institutions, 2010–2015 (without capital investments, in €million)[43]

	2010	2011	2012	2013	2014	2015
State (and contractual organization) social care centres	31.6	32.9	33.9	37.5	39.9	41.7
Local government and other organization social care centres for adults	26.3	27.1	28.6	31.5	32.9	36.6
TOTAL	57.9	60.0	62.5	69.0	72.8	78.3

Figure 1: Trends in total amount of resources spent by institutions, 2010–2015 (in €million)[44]

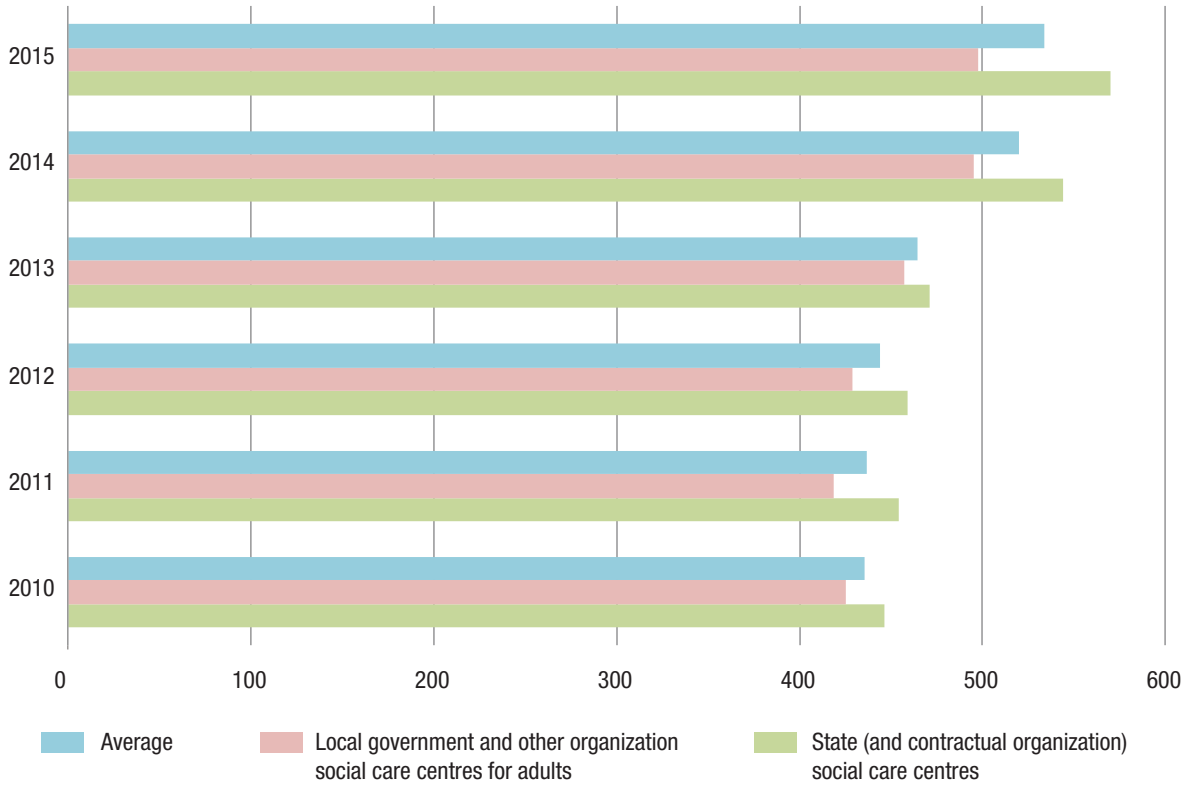


Annex 3

Table 2: Total amount of resources spent by institutions, 2010–2015 (without capital investments, in €million)[45]

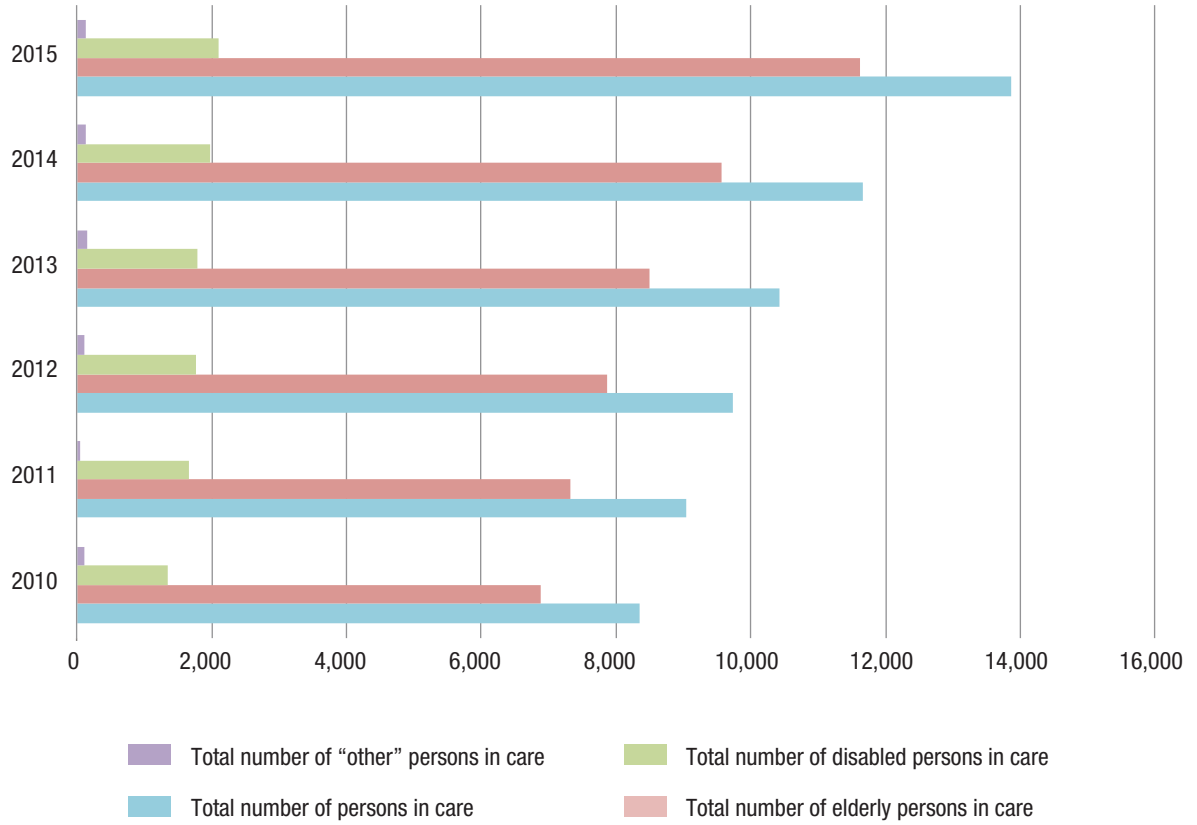
	2010	2011	2012	2013	2014	2015
State (and contractual organization) social care centres	446.5	454.38	459	471.25	543.9	569.69
Local government and other organization social care centres for adults	425.00	418.83	429.2	457.36	495.5	497.56
AVERAGE	435.75	436.61	444.10	464.31	519.7	533.63

Figure 2: Expenditures per one client, 2010–2015 (in €thousands)[46]



Annex 4

Figure 3: Total number of persons in home care at the end of the year, 2010–2015[47]



Annex 5

Table 4: Number of persons who applied for home care, but did not receive the service, 2010–2015[48]

	2010	2011	2012	2013	2014	2015
Total number of persons who applied for home care	8,394	9,080	9,792	10,509	11,722	13,907
Number of persons who applied for home care but did not receive it	47	31	53	71	61	51
Percentage of persons who applied for and received home care	99.4	99.6	99.5	99.3	99.5	99.6

Annex 6

Table 5: Local government social services, number of recipients (per thousand persons)[49]

	2010	2011	2012	2013	2014	2015
Social services at day care centres	17.2	16.8	20.6	19.8	31.1	23.8
Social services at day care centres for people with physical and mental disabilities	1.1	1.2	1.2	1.0	1.3	1.6
Social services at day care centres for people of retirement age	3.5	5.1	4.9	5.4	6.3	4.9
Social services at group houses (apartments) for people with mental disabilities	0.2	0.2	0.2	0.2	0.2	0.2

Table 6: Local government social services, expenditures (in €thousands)[50]

	2010	2011	2012	2013	2014	2015
Social services at day care centres	3,571.5	3,718.3	4,374.6	4,410.1	5,165.8	5,584.8
Social services at day care centres for people with physical and mental disabilities	1,839.1	1,826.1	1,963.7	2,031.9	2,282.3	2,388.0
Social services at day care centres for people of retirement age	341.1	441.5	358.8	420.6	426.1	439.2
Social services at group houses (apartments) for people with mental disabilities	481.8	498.0	500.6	622.0	658.6	766.7

Annex 7

Map of Planning Regions[51]