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EUROPEAN SOCIAL CHARTER

4th National Report on the implementation of
the European Social Charter

submitted by

THE GOVERNMENT OF LATVIA

(Articles 11, 13 and 14
for the period 01/01/2006 – 31/12/2007)

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MINISTRY OF WELFARE
OF THE REPUBLIC OF LATVIA

Fourth Report
on the implementation of the
European Social Charter
Article 11, Article13 and Article 14

Riga

October 2008

For the period from 1 January 2006 to 31 December 2007 made by the Government of the Republic of Latvia in accordance with Article 21 of the European Social Charter, on the measures taken to give effect to the accepted provisions of the European Social Charter, the instrument of ratification or approval of which was deposited on 31 March 2001.

Table of Content

Article 11 – The right to protection of health

With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases.

Information to be submitted

Article 11§1

1. Please describe the general public health policy and legal framework. Please specify the nature of, reasons for and extent of any reforms.

Latvian National Development Plan 2007 – 2013 defines that the increase of welfare depends on the accessibility of health care services and the development of a sustainable social security system. The plan has defined tasks for the improvement of public health, health care system and social services enhancement and development.

In 2004 the Cabinet of Ministers accepted the Development program of outpatient and inpatient health care service providers. It focuses on the rationalization of secondary and tertiary health care services. The strategy proposes that state hospitals will be consolidated through developing multi-profile hospitals, closing or transforming small hospitals into nursing care hospitals, primary health care centers or social care institutions and transforming single profile hospitals into long-term hospitals by moving current services to multi-profile hospitals or outpatient settings.

Basic Guidelines “Development of emergency medical assistance service” was developed in order to ensure equal access to timely and qualitative emergency medical assistance.

On 2005 the Cabinet of Ministers adopted basic guidelines about “Development of Human resources in healthcare” in order to create long-term human resources development politics, establish priorities concerning human resources development and continue development of population-oriented, rational, effective and high-quality healthcare sector.

The basic statements of healthcare human resources development define the state politics concerning provision of the healthcare system with qualified human resources during time period from 2005 to 2015.

Aims of the guidelines “e-Health in Latvia” (accepted on 20.05.2005) and Plan for the implementation (accepted on 24.10.2007) are - each member of the society and health care services provider will have the opportunity to receive qualitative and reliable information on health care starting from electronic patient histories, electronic patient health card as well as full

information on health care opportunities in Latvia and foreign countries. It is planned also to provide telemedicine and electronic diagnostics. To improve the efficiency of the treatment process, eHealth plans to provide support to physicians in taking a clinical decision by operative contact to local and foreign colleagues.

Patients' Rights Law was adopted by Saeima in second reading on December 2007 in order to provide to the patients the opportunity to exercise and protect their rights and interests, to determine the legal status of the patients, to foster good relationship between the patient and the health care service provider and to promote active participation of the patients in health care.

The Ministry of Health has developed amendments to Regulations No.610 issued by the Cabinet of Ministers on 27 December 2007 "Hygienic requirements in elementary education, secondary education, and vocational education schools" in order to promote healthy eating habits in schools. The amendments enforced a ban on distribution of drinks containing artificial color additives, sweeteners, preservatives, caffeine, and amino acids, in schools starting from 1 November 2006. The list of prohibited drinks includes all sweet drinks, colored drinks, e.g., multicolored lemonades, kvass, and energy drinks. The above mentioned drinks should not be a part of children's daily diet, as the daily over-consumption can cause severe health problems - induce allergy and overweight.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

Development programme[1] "Development program of outpatient and inpatient health care service providers" for outpatient and inpatient health care services has been developed (hereinafter – programme) and the implementation plan 2005-2010 (hereinafter – plan) thereof[2] so that to ensure accessibility of qualitative health care services, efficient utilisation of resources of health care system and optimise the number and placement of people involved in providing care services. According to the Plan within the time period from beginning of 2005 until September 2007, 12 hospital unions have been formed, and 12 hospitals to be re-profiled have been turned into health care centres.

Over the mentioned time span the number of hospitals has been reduced from 112 to 94. Total number of beds – reduced from 17.9 thousand (77.4 beds per 10 000 persons) in 2004 to 17.7 thousand beds (75.3 beds per 10 000 persons) in 2007. Taking into consideration the fact that in 2006 58.39% of the total health care budget was used for inpatient health care services, it is necessary to continue the implementation of the mentioned Programme, reducing the number of inpatient institutions and the number of beds, at the same time developing outpatient healthcare and care at home.

The compensated medicines eligibility list is being supplemented annually (number of medicines in the list in 2006 – 913 and number of medical appliances - 123, in 2007 accordingly 1987 and 136). In 2007 a mechanism

[1] Approved by the Cabinet of Ministers Order No 1003 dated 20 December 2004
[2] Approved by the Cabinet of Ministers Order No 854 dated 28 December 2005

for compensation of medicines in individual treatment cases - list C – was introduced. This mechanism is applied in cases when the patient needs medicines to sustain his life functions and there is no possibility to receive them under the general mechanism of reimbursable medicines. As of 1 January 2007 compensation of medicines has been commenced for several new diagnosis - acute hepatitis C, certain mental disorders for children, neuropathic pain and certain cerebrovascular diseases. In cases of several diagnosis, like asthma, glaucoma, osteoporosis or pathological fracture and others, the amount of reimbursable medicines and appliances has been increased. The reimbursable medicines eligibility list has been supplemented by new medicines (e.g. in oncology), as well as the conditions permitting the prescription of medicines have been expanded thus increasing the choice of medicines for the doctors to prescribe.

Basic Guidelines "Development of emergency medical assistance service" [3] to ensure timely provision of medical emergency assistance. The Basic Guidelines of the emergency medical care development provide plan for restructuring of the emergency medical assistance system – in the pre-hospital emergency medical care which is a complex of emergency medical treatment institutions or other treatment institutions with the aim of providing emergency medical assistance in the pre-hospital stage in situations critical to life and health accompanied by malfunction of life sustaining systems. Also, the development process is being continued in relation to institutional, informative and material technical development of a united emergency medical care operational service, as part of disaster medicine and thus also as an inseparable part of the national security system.

The Disaster Medicine Centre has been allocated, financing within the project "Mobile communication systems for emergency medical units", to ensure provision of emergency medical services with mobile telecommunications. The project was implemented in 2006. The result of the project was that the emergency medical assistance dispatchers' workplaces and the medical transportation vehicles of the operational emergency medical assistance units were fully equipped with mobile communication systems, which considerably improved the operative communication between the dispatchers and the emergency medical units. Within this project mobile communication systems were established also in emergency departments of all 11 regional multi-profile hospitals. Thus this new communication system, in case of necessity, enabling the communication between emergency medical care units with emergency department of the hospitals.

E-Health services has been developing in order to modernize the infrastructure, including extended use of information technologies and to facilitate accessibility of health care services. With the help of these services every person and provider of the health care services will have access to easy-to-understand, qualitative and reliable information on health care starting from patient history in electronic format, electronic patient health card, as well as full information on health care opportunities in Latvia and abroad. Plan for the implementation of guidelines for eHealth 2008-2010 was adopted[4] in order to start the implementation of the said innovative measures. This plan

[3] Approved by the Cabinet of Ministers Order No 444 dated 19 July 2005
[4] Approved by the Cabinet of Ministers Order No 660 dated 24 October 2007

provided the development and implementation of a centralised health card information system.

Centralised health card information system ensures:

- centralised data storage and access to the patient's medical data;
- possibility to prepare an integration platform providing for safe information exchange between the health sector and information systems of other sectors;
- development of electronic prescription information system and safe data transmission channels between main information systems within the health sector;
- unified emergency medical assistance and disaster medical services information system.

3. Please supply any relevant statistics or other information on the main health indicators and on health services and professions (for example WHO and/or Eurostat data).

Please see following text for statistics section on page 7 and Annex to the Article 11.

Article 11§2

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

Since diseases of circulatory system are the major cause of death in Latvia, several measures were implemented to foster heart health. In 2006 eight, but in 2007 twelve heart health cabinets were established. It is planned in the future to extend their operation in Latvia in order to provide accessibility of the heart health cabinets to a wider public. At the bases of the operation of the heart health cabinets is promotion and preventive care for heart health, the attendees of the cabinet are informed on enhancing heart health and disease risk factors. Free of charge preventive examinations, without referral from family doctors, is provided to all citizens over the age of 18.

Informative materials were prepared on risk factors of heart and coronary diseases and the opportunities to avert them to increase the level of awareness of the public. Public information campaign carried out on the role of physical activities in retaining the heart health, as well as in 2007 the use of a unified national health risk factor electronic data base was commenced.[5] Furthermore, healthy nutrition tips for different population groups were developed, e.g. for adults, infant – nutrition, adolescents, people over age of 60 and other risk groups of the society.

There is a regular cooperation with nongovernmental organisations within the sphere of public health policy development and implementation by involving the representatives of NGOs in the preparation of regulative enactments and policy planning documents, in informing the society, consulting specialists, in coordination and steering commissions. So far

[5] Information www.1slimnica.lv/petijums

cooperation agreements have been concluded with nongovernmental organisations, for example, for the implementation of particular measures aimed at informing elderly people about health care issues relevant to this group.

3. Please supply any relevant statistics or other information, including on consultation and screening services in schools and for the rest of population.

As follows from the data supplied by family doctors in relation to the health of children, the proportion of the group of practically healthy children is growing (health group I), and the proportion of children being ill repeatedly (health group II) and children with chronic diseases (health group III) is decreasing. As practically healthy were diagnosed (see table 1 in Annex):

- newborns in 2005 – 53.3%, in 2007 – 57.6%;
- children at the age of 1 in 2005 - 55.3%, in 2007 – 57.1%;
- children t the age of 2 in 2005 – 57%, in 2007 – 57.2%
- adolescents (15 – 17) in 2005 – 59.1%, in 2007 – 59.7%.

In 2007 the indicator of children illnesses in their first year was 2233.8 per 10000 children examined. In the structure of illnesses respiratory diseases constitute the majority – 57.6%, certain perinatal period conditions – 10.4% and digestive diseases – 7.3%.[6] To reduce the number of illnesses among children as well as for timely diagnosis preventive children screening is being conducted (see tables 2, 3 and 4 in Annex). The number of children annually undergoing preventive examination is around 90% from the total number of children. As statistical data reveal, the proportion of children discovered during preventive examinations with hearing impairments has increased – for children at preschool age (4.8 from 10000 examined in 2007 against 4.2 in 2004), for children at the school age (4.7 from 10000 in 2007, when there were 3.6 in 2004). Also preventive examinations revealed a higher proportion of children with scoliosis at preschool age – from 6.5 cases per 10000 examined children to 8.3 in 2007, for school age children – from 40.9 cases per 10000 examined children in 2004 to 52.7 cases in 2007.[7]

Neoplasms are second mostly spread cause of death in Latvia both among women and men. In 2002 17.6% of all death causes were neoplasms, in 2007 – 18.2%.[8] In respect of multi location malignant neoplasms that are characterized by high spread and mortality, it has been proved that adequate screening of the population can ensure timely diagnostics and consequently reduce mortality. In Europe organised (centralised) screening has been recognized as efficient for colorectal, breast and ovarian cancer.[9] With the objective of early diagnosis of breast, ovarian, prostate and colorectal cancer, screening of early symptoms of these types of neoplasms in 2005 has been

[6] Latvian Health and Health Care Report 2007 Karaškēvica J.(Sc.ed.) Rīga: VSMTA, 2008.
[7] Statistical Yearbook of Latvian health Care 2007 Karaškēvica J.(Sc.ed.) Rīga: VSMTA, 2008.
[8] Report on national health and health care in Latvia 2007. Karasevica J (SC. Editor) Riga:VSMTA, 2008
[9] National Cancer Control Programmes. Policies and managerial guidelines. 2nd Edition, 2002, quoted according to: Upmale S., Rozentale G., Skrule J. Malignant tumours to be disclosed timely by screening, Riga State Agency Public health Agency, 2007, p.12

included in the preventive examination programmes in Latvia. [10] It has to be noted that all medical examinations included in the programme are state financed and provided to patients free of charge. However, as of 1 January 2007[11] the screening programme of early prostate cancer has been cancelled as there is not sufficient proof of its efficiency on reducing mortality and it does not correspond to the cancer screening recommendations by WHO and EC.[12]

Decentralised cancer screening is not efficient for early diagnosis and does not ensure improvement of the national indicators of late diagnostics and mortality rates. Both low cancer screening bulk indicators (see table 5 in Annex) and the low number of patients with malignant tumours discovered during the preventive examinations are proof of it – in 2006 only 74 (0.8%) patients and in 2007 40 (0.44%) patients have been discovered.

Pursuant the Regulation No.1046 of the Cabinet of Ministers of December 19. 2006 "On the order of organising health care and financing" (hereinafter – Regulation No 1046) until January 1, 2009 cancer screening has been assigned to family doctors. At the same time, as of 1 January 2009 pursuant the EC recommendations[13], a so called organised screening will be implemented in Latvia, when Health Compulsory Insurance State Agency (hereinafter - HCISA) will be responsible for centralised organisation and monitoring of the cancer screening programme, including submitting invitations to screening of target groups included in the organised screening. Organised screening programmes and adequate treatment are ways of considerably reducing the burden of breast, ovarian and colorectal cancer in the society.[14]

Currently within the framework of inter-institutional work group an oncological diseases control programme is being developed including primary prevention, diagnostics (screening), treatment, palliative care and methodological steering of the sector.

In 2007 in the preventive examination programme three early cancer diagnostics screening examinations were included. Within the preventive programme the ovarian cancer early diagnostics screening examination (oncocytological analyses) has been performed for 116 195 women, within the preventive programme of breast cancer early diagnostics screening - mammography has been performed for 18 323 women, for colorectal cancer early diagnostics the hidden blood in feces test has been performed for 53 589 patients. The cancer screening volume index is not high, yet comparing the data for years 2005, 2006 and 2007 a positive dynamics is observed. However this does not indicate a positive development of the problem, because it is important to increase the volume index of the preventive screenings to be able to disclose the symptoms at an early stage and to

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[10] Regulation of Cabinet of Ministers No 1036 dated 21 December 2004 Organisation and financing regulation of health care institutions

[11] With adoption of regulations of the Cabinet of Ministers No 1046 dated 19 December 2006 Organisation and financing regulation of health care institutions

[12] Council Recommendation of 2 December 2003 on Cancer Screening (2003/878/EC). *Official Journal of the European Union*, L 327/34, 16.12.2003

[13] Council Recommendation of 2 December 2003 on Cancer Screening (2003/878/EC). *Official Journal of the European Union*, L 327/34, 16.12.2003.

[14] Karsa von L., Anttila A., Ronco G. u.c. *Cancer Screening in The European union. Report on the implementation of the Council Recommendation on cancer screening. First Report.* European Commission, 1.p.

decrease the number of patients with diagnostic tests performed because of clinic indications. As the preventive screening volumes are comparatively low, as of 1 January 2009 a cancer screening will be centralised, and the HCISA is performing currently the necessary calculations and establishing the necessary system for the centralisation of the cancer screening.

An average 1 358 family practitioners were providing primary health care services in 2007, with the average number of patients per practitioner 1679. In comparison to 2006 the average number of patients registered with one practitioner has decreased by 200 patients that are 15%. The reduced number of patients per practitioners providing primary health care is accounted for by the rapid rate of depopulation. In 2006 home visits by family practitioners accounted for 5% of all primary health care visits, while in 2007 this has reduced to 3.5% from all primary health care services. 70% from all home visits in 2007 were for children below the age of 18, the remaining to persons exceeding the age of 80 and disabled persons group I.

The survey on the habits impacting the health of the population in Latvia reveals that 21% of the respondents have assessed their health as good, 23.6% - as fairly good, 44.8% - average, 7.1% - fairly poor, 3.4% - poor. Among the men polled the proportion of those assessing their health as positive is greater. Compared to previous polls, there is a slight increase in the percentage assessing their health as fairly good and good. Also, the number of respondents assessing their health as poor has decreased (see graph 1 in Annex)[15].

Article 11§3

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

In January 2005 the Cabinet of Ministers accepted “Program of reduction of alcohol consumption for 2005-2008”. The goal of this program is to reduce the volume of alcohol consumption per capita as well to diminish health problems caused by alcohol on persons and society. The main activities of the program are to decrease supply (for instance, by changing tax system, by combating illegal alcohol use), demand (for instance, by educating population, by improving treatment and rehabilitation services) and deviant alcohol usage (for instance, to decrease the number of traffic accidents caused by drank drivers).

On 17 August 2005 the Cabinet of Ministers adopted “National program for limitation and control of narcotic and psychoactive substances abuse and distribution for 2005-2008”. The aim of this program is to promote decrease in drugs supply and demand as well as in drug addiction relevant diseases, death cases and crimes minimization. The Ministry of Interior aggregates all information about implementation of the program.

[15] The Survey on the habits of the population in Latvia having impact on health 2006 http://www.sva.lv/petijumi/doc/2007b27.pdf

In 2005 amendments to the “Law on the Limitation of Sales Advertising and Use of Tobacco Products” were adopted. These amendments included stronger bans on smoking in public places and it allows smoking only in specially designed smoking rooms starting from 1 July 2006. Also the Ministry of Health has developed and submitted to the Cabinet of Ministers amendments to Law on Limiting tobacco advertising, sales, and consumption, which foresee firmer constraints and bans on smoking in public places. It is planned that starting from 1 July 2008 there will be a ban on smoking in educational establishments, passages of the apartment houses, and other public places. Smoking at the workplace and common areas will be prohibited. Complete smoking ban will be issued for public premises, i.e., movie theaters, concert halls, sports halls, other sports buildings, post offices and other institutional premises, dance halls, discos, and children's playgrounds. On the other side, parks, squares, and beaches will be arranged with separate common smoking areas. In addition to tighter smoking bans, the amendments will supplement the existing warning signs of smoking hazards with colored images and other illustrations. All illustrations and images will be created in compliance with directives of the European Commission.

On 31 January 2008 “National vaccination programme 2008 – 2010” was adopted providing for continued reduction policy of the contagious diseases and provide an at least 95% immunization level for the contagious diseases listed for children and a 80% immunization level against diphtheria and tetanus for adults.

3. Please supply any relevant statistics or other information on the percentage of smokers in the general population, trends in alcohol consumption and the rates of vaccination cover for infectious and epidemic diseases.

Due to the high rate of endemic tick-borne encephalitis in Latvia, vaccination of children residing in endemic areas subject to tick-borne encephalitis was started financed from the state budget.

To reduce the number of people suffering from influenza as well as the risk of complications caused by it, vaccination against influenza at 50% covered from the national budget has been carried out for certain population groups:

- children at the age from six months up to 2 years of age;
- adults over the age of 65;
- patients with chronic lung, heart, metabolic and kidney diseases;
- patients with immune deficiency syndrome;
- patients undergoing imunesupressive therapy;
- patients over the age of 18 undergoing a prolonged therapy with acetil salicil acid or aspirin.

During the epidemic season of influenza (in period from September 2006 until February 2007) 26567 persons have been vaccinated, including 366 children. The partly compensated vaccination for the age group over 65 years was used for 8909 persons or 2.3% of that age group. The number of children vaccinated against the contagious diseases indicated in the vaccination calendar is still high (97.7%).

One of the main health policy objectives is reduction of smoking. Smoking is a risk factor for heart and coronary, respiratory diseases, tumours and other chronic diseases being priority public health issues currently in Latvia.

To protect the society from tobacco fumes as of 1 July 2008 it is prohibited to smoke in all education institutions. In the future it will be prohibited to smoke also in public buildings, constructions and premises, i.e. – cinemas, concert halls, sports halls and other premises. Total prohibition of smoking applies to children leisure and play ground. While in parks, squares and swimming areas smoking will be permitted only in specially designated areas. Amendments to the "Law on the Limitation of Sales Advertising and Use of Tobacco Products" foresee supplementing the special warnings placed on tobacco product packages with colour photographs or other visual aids as of 1 September 2008. A transition period has been foreseen until 1 March 2010 during which tobacco product packages without the colour photos or illustrations are permitted. As of 1 April 2010 smoking is fully banned in public catering places. In outdoor cafes smoking will be permitted only in specially designated places, but in casinos and gambling places – in premises specially allocated for smoking.

Notwithstanding the strict restrictions smoking is still widespread in Latvia (see Table 6 in the Annex). A survey conducted in 2006 reveals a proportional drop of men - daily smokers from the total number of smokers while the number of women-smokers has increased compared to 2004.

A positive indicator is the reduction of numbers of accidental (irregular) smokers among men, and the proportion of men who have quit smoking is increasing during the last year. There is no marked difference in the proportion of those daily smokers who would be willing to quit smoking. From the daily smokers 59.7% in 2006 (in 2004 – 59.7%, in 2002 - 56.5%) men and 55.5% in 2006 (in 2004 – 60.9%, in 2002 – 59.4%) women replied that they would like to quit smoking. However, the proportion of those who are willing to continue smoking has increased among women up to 14% (in 2004 – 11.5%, in 2002 – 5.5%) while it has almost not changed among men – 13.5% (in 2004 – 14.1%. in 2002 – 13.9%). This indicates that in the future the number of women- smokers could increased. About one fourth of the respondents are not sure that they wish to quit smoking (26.4% men and 30.5% women)[16].

The total volume of consumed alcohol per 1 inhabitant in 2000 has increased from 6.9 litres to 10.0 litres in 2007 (see Table 7 in Annex). When interpreting this data it should be noted that the figure comprises not only the inhabitants of Latvia but also foreign tourists who bought alcohol in Latvia. And, as data of Central Statistics Bureau indicate the number of foreign tourists crossing the border of Latvia is increasing annually and considerably surpasses the number of the inhabitants of Latvia who crossed the border.

Alcohol-induced psychosis is one of the most important indicators in monitoring alcohol consumption and the consequences thereof. Alcohol-induced psychosis reveals the tendency of the alcohol consumption in a country as there is a correlation between alcohol consumption and the number of people suffering from sever health problems related to alcohol

[16] The Survey on the habits of the population in Latvia having impact on health 2006 *http://www.sva.lv/petijumi/doc/2007b27.pdf*

consumption, including alcohol dependency and alcohol induced psychosis[17]. According to the data published by the Health Statistics and Medical Technologies State Agency (HSMTSA) number of alcohol induced psychosis from 35.3 cases per 100 000 inhabitants in 2004 has increased to 41.4 cases per 100 000 inhabitants in 2007, while incidence of alcoholism in 2007 compared to 2006 has decreased (see Table 8 in the Annex)[18].

The situation with alcohol consumption by children and adolescents is aggravating in Latvia. As statistical data reveal, the incidence of children and adolescent alcoholism has increased with registered 17 cases (in 2006 – 16 cases). Also alcohol consumption among children and adolescents with all the adverse consequences thereof is increasing – in 2006 691 registered cases, in 2007 – 789 registered cases (see graph 2 in Annex)[19].

[17] Spread and Consequences of the Consumption of Substances Incurring Dependency , edition 15, Likops U. Taube M (sc.ed) Riga, State Agency Public Health Agency 2007, p. 23

[18] Latvian Health and Health Care Report 2007 Karaškēvica J. (Sc.ed.) Rīga: VSMTA, 2008 p.45

Annex to the Article 11

Table 1. Health status of children

	Year	Children by health groups %		
		I group	II group	III group
Newborns	2005	53.3	43.2	3.5
	2006	55.9	40.8	3.3
	2007	**57.6**	**39**	**3.4**
One year olds	2005	55.3	40.8	3.9
	2006	57.1	39.4	3.5
	2007	**57.1**	**39.2**	**3.7**
Two year olds	2005	57	39.1	3.9
	2006	58.1	38.3	3.6
	2007	**59.3**	**37**	**3.7**
children (3-14)	2005	57	38.8	4.2
	2006	56.7	39.1	4.2
	2007	**57.2**	**38.9**	**3.9**
Adolescents (15-17)	2005	59.1	36.8	4
	2006	59.3	36.7	4
	2007	**59.7**	**36.7**	**3.6**

Data source: Health Statistics and Medical Technologies State Agency

Table 2. **Results of children preventive examinations** (from 10000 children examined at the respective age)*

	children (3 – 14)		*From them*						adolescents (15-17)	
			Pre school age		Entering 1st school year		School-children			
	2006	**2007**	**2006**	**2007**	**2006**	**2007**	**2006**	**2007**	**2006**	**2007**
Impaired hearing	4,6	4,9	4,4	4,8	4,2	5,0	4,6	4,7	3,6	3,8
Impaired vision	97,4	98,1	55,9	56,8	104,3	97,5	118,2	120,5	117,0	117,0
Logopaedic problems	39,6	41,0	76,3	77,4	66,0	68,0	15,5	16,0	5,8	6,9
scoliosis	33,8	36,1	7,0	8,3	22,3	23,4	48,9	52,7	55,1	54,9
other spinal disorders	130,8	132,8	73,7	77,0	153,9	148,1	157,8	161,1	131,8	126,7

Data source: Health Statistics and Medical Technologies State Agency

Table 3. Incidence of various diseases for infants up to 1 year of age (from 10000 children examined in the respective age group)*

	2006	**2007**
Total incidence of diseases	2168,4	2233,8
including.: contagious and parasitic diseases	59,5	63,2
Endocrine, nutritional and metabolic diseases	30,4	31,5
Diseases of the nervous system and special senses	128,5	131,9
Respiratory diseases	1207,0	1287,3
Diseases of the digestive system	159,9	164,0
Urogenital system diseases	26,8	27,5

Inborn anomalies	36,1	35,0
Certain perinatal period conditions	245,8	231,5
External influence	25,2	28,3

*Data calculated based on statistics provided by family doctors for children under their care.
Data source: Health Statistics and Medical Technologies State Agency

Table 4. Children who underwent preventive examinations (from total number of population in the respective age group) %

Age	2007*
0-2	99,7%
3-14	89,7%
15-17	85,5%
0-18	90,2%

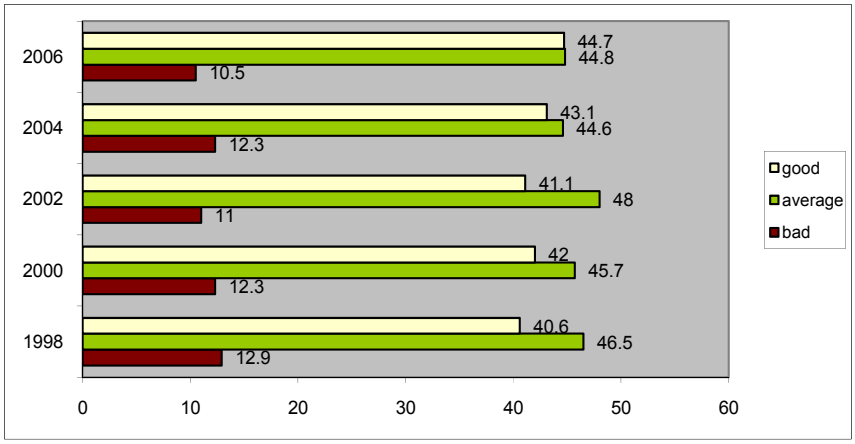
**Data calculated according to the average population of 2006.*
Data source: Health Statistics and Medical Technologies State Agency

Table 5. Cancer screening programme statistical data for years 2005-2007

Screening programme	2005		2006		2007	
	Number of individually screened patients	Patient volume (%)*	Number of individually screened patients	Patient volume (%)*	Number of individually screened patients	Patient volume (%)*
Ovarian cancer screening	75 624	9 %	119 097	14.2%	116 195	17.5%
Colorectal cancer screening	4987	0.6%	11 095	1.4%	53 589	6.5%
Breast cancer screening	8073	2.6%	17 992	5.9%	18 323	6%

Data source: State Compulsory Health Insurance Agency
* screening patient volume calculated by dividing the number of individually screened persons by the number of people in the relevant age group at the beginning of the particular year

Graph 1. Self assessment of health: 1998 - 2006 (%)



Data source: State Agency „Public Health Agency"

Table 6. Spread of smoking: 1998 - 2006 (%)

	1998		2000		2002		2004		2006	
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.
Smoke every day (everyday smokers)	51.3	19.2	51.3	18.2	51.1	19.2	47.3	17.8	46.6	18.2
Smoke irregularly	6.0	4.9	4.9	5.2	4.4	6.4	5.7	5.9	4.0	5.5
Do not smoke	23.8	64.9	26.4	67.5	27.7	66.9	29.6	69.5	29.3	64.0

Data source: State Agency „Public Health Agency" Survey data for the study of habits influencing the health of population in Latvia)

Table 7. Absolute consumption of alcohol per inhabitant (litres)

Year	Absolute alcohol consumption litres per 1 inhabitant
2000	6.9
2001	6.5
2002	7.1
2003	7.9
2004	7.5
2005	8.7
2006	9.5
2007	10.0

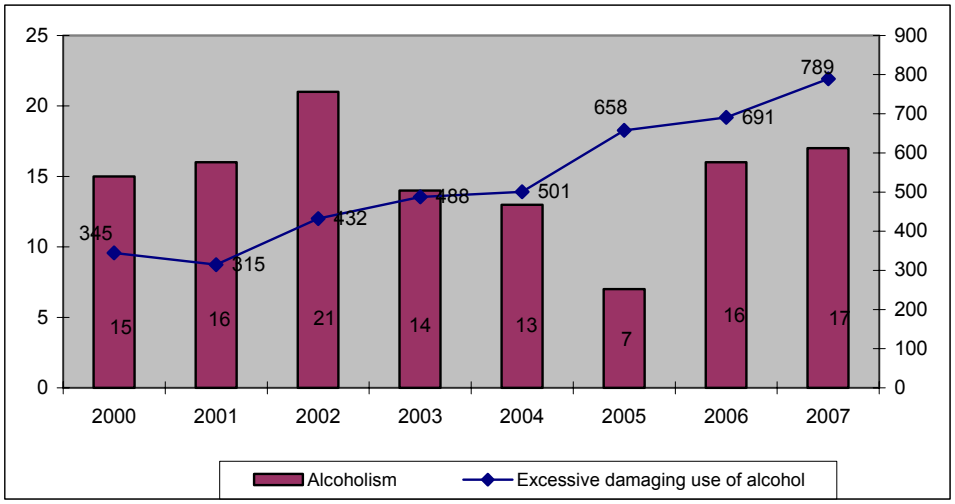
Data source : Central Statistical Bureau

Table 8. Incidence of alcoholism and alcohol induced psychosis

	Per 100 000 inhabitants			
	2004	2005	2006	2007
Alcohol induced psychosis	35.3	34.3	40.9	41.4
Alcoholism	113.8	110.1	130.8	122.7

Data source: Health Statistics and Medical Technologies State Agency

Graph 2. Registered children and adolescents with alcohol dependency and acute alcoholic intoxication or excessive use of alcohol with damaging consequences



Data source: Health Statistics and Medical Technologies State Agency

Article 13 – The right to social and medical assistance

With a view to ensuring the effective exercise of the right to social and medical assistance, the Parties undertake:

1. to ensure that any person who is without adequate resources and who is unable to secure such resources either by his own efforts or from other sources, in particular by benefits under a social security scheme, be granted adequate assistance, and, in case of sickness, the care necessitated by his condition;
2. to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;
3. to provide that everyone may receive by appropriate public or private services such advice and personal help as may be required to prevent, to remove, or to alleviate personal or family want;
4. to apply the provisions referred to in paragraphs 1, 2 and 3 of this article on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953.

Appendix to Article 13§4
Governments not Parties to the European Convention on Social and Medical Assistance may ratify the Charter in respect of this paragraph provided that they grant to nationals of other Parties a treatment which is in conformity with the provisions of the said convention.

Information to be submitted

Article 13§1

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Law on Social Services and Social Assistance, which came into force on 1 January 2003, determined the kinds of social assistance benefits and basic principles of giving these benefits. Social assistance benefits to a client shall be provided on basis of an evaluation of the immediate family as well as persons living in the same household, who lack the means to satisfy basic needs, material resources – income and property, individually providing for the participation of each client in conformity with the Law on Social Security.

The purpose of social assistance is to provide material support of families or households in a crisis situation in order to satisfy their basic needs and promote the participation of able – bodied persons in the improvement of their situation.

Social assistance is financed from local municipalities budgets and is granted to families or households, whose place of residence is situated in municipalities' territory. According to law mentioned there are three main types of social assistance benefits. Each has his own conditions of granting.

Types of Social Assistance Benefits:

1. Benefit for ensuring guaranteed minimum income level (GMI benefit);
2. Benefit in an emergency situation;
3. Other benefits, which are determined from municipalities' initiative.

These benefits are not subjected to taxation and social security contributions are not paid.

GMI benefit - the purpose of GMI benefit is to ensure a minimum level of income for each family member or needy families whose income level is lower than set by the Cabinet of Ministers. GMI benefit shall be provided to a family as well as persons living in the same household whose has been granted the status of a needy family and whose income level is lower than GMI level, set by Cabinet of Ministers (24 LVL in 2006; 27 LVL in 2007). Social security benefits and state social benefits (int. al. family allowances) are taken into account as source of claimant's income, except of first 50 LVL from the state child care benefit. All other resources must have been exhausted: as well as maintenance based on the civil responsibilities of private citizens such as ex-spouses, parents etc. Municipalities can set higher amounts as far as their budget allows. GMI benefit is granted in cash or in kind.

GMI benefit is calculated as a difference between GMI level per person and households incomes: Amount of GMI benefit for household = (GMI level per person * number of household members) – household incomes

Table 9. Maximum amount GMI benefit per month set by the Cabinet of Ministers.

Period	Separately living person	Household
2006	24 LVL	135 LVL
2007	27 LVL	135 LVL

Data source: The Ministry of Welfare

The amount of the benefit is the same for each person, except that total benefit amount is not higher than LVL 135 per family. The beneficiaries are obliged to cooperate with social workers in order to overcome the situation. The GMI benefit shall be granted and paid to a families or households if the beneficiaries fulfils the duties of participation in execution of his social rights prescribed in the Law on Social Security (Section V – providing of information, personal attendance, participation in measures promoting employment, acceptance of medical examination, participation in medical and social rehabilitation).

Unemployed beneficiaries capable of work are obliged to register at the State Employment Agency, seek work and accept suitable offers of work, exception groups are:

1) a woman during maternity leave, one of the parents of a child or another person during the child's nursing period;

2) one of the parents of a disabled child; or

3) a person who is older than 15 years and acquires education by being present at a general secondary or vocational secondary education institution or is a full-time student in an institution of higher education.

In cases of refusing to fulfil duties of participation total amount of GMI benefit reduces by part of adult who refused. GMI benefit is granted for the period of 3 months and is renewable after that. Maximum duration for GMI benefit is 9 months per year. In cases the income of a person from work gainful activity has increased (unemployed person starts to work), GMI benefit duration can exceed 9 month period, but in reduced amount. Period of GMI benefit granting is restricted to prevent person's dependence on municipal social assistance benefits and to motivate able bodied persons seek a job.

Benefit in an emergency situation - the local government grants without means testing to the person (family) a benefit in an emergency situation (for example, fore, flood, traffic accident, etc.) if, due to a natural disaster or unforeseen circumstances he or she is not able to satisfy minimum of his or her basic needs. Within the framework of this benefit, material support is given for arranging the funeral of a person whose relatives are not entitled to any other statutory funeral allowance. The benefit in an emergency situation can be paid in cash or in kind.

Other benefits - according to the Law On Social services and Social Assistance the local government is entitled to grant also other benefits if the justified demand for benefits of needy inhabitants of the local government for ensuring the guaranteed minimum income level has been satisfied. Amount of other benefits, duration and granting conditions are established by local municipality's regulation. The purpose of other benefits is to ensure the elementary requirements (meal, clothing, dwelling, health care, obligatory education).

The autonomous functions of local governments are to provide assistance to residents in resolving issues regarding housing. To ensure material support for households with low income for payment of rent and public utilities separate local municipalities are entitled to provide housing benefit. Benefit is defined in the Law on Assistance In Solving Apartment Matters. Amount of housing benefit is established by local municipality regulation where the income level is determined for a person to become entitled to claim for housing benefit. Housing benefit is one but there are different kinds of payment (payments to public utility services, fire wood charges, electricity bills etc.).

As municipality financing is dependant on municipality budget, politic and situation in town, the housing benefit amount can change. The right to receive housing benefit is determined by the municipality. According to the Law on Social Services and Social Assistance, a dwelling is one of the elementary requirements.

Benefits for orphans and foster families. Benefits for orphans - According to the Law on Protection of the Rights of the Child the state and municipalities' are provide definite social guarantees for an orphan and a child left without parental care, who is in out-of-family care, as well as for an orphan and a child left without parental care after reaching the legal age. The local government, whose orphans' court (parish court) has taken the decision regarding the out-of-family care of a child, after the termination of the out-of-family care of the child who has reached the legal age in a foster family, at a guardian or in a boarding school shall pay to the child monetary resources for the commencement of independent life, the amount of which shall not be less than twice the amount of the social security benefit (LVL 90 in 2007).

Until the allocation of living quarters to a child who has reached the legal age the local government shall cover the monthly expenses of the child related to the rental of residential space.

The local government, whose orphans' court (parish court) has taken the decision regarding the out-of-family care of a child, after the termination of the out-of-family care shall grant an extraordinary allowance to the child who has reached the legal age to obtain household objects and soft furnishings. The amount of the benefit referred to may not be less than LVL 175. It shall be a half of the amount that is necessary in order to equip the dwelling with the necessary minimum of household objects and soft furnishings for the commencement of independent life. The benefit may also be delivered in the form of household objects and soft furnishings.

If a child who has reached the legal age and has received a general primary education continues without interruption his or her studies at a general secondary or vocational education institution and is a successful student thereof, and has not married, the local government shall pay to such child the benefit for monthly expenses that is not less than the amount of the state social security benefit (LVL 45 in 2007). The local government that has taken the decision regarding the out-of-family care of a child by providing psychosocial and material support shall take the measures necessary for the integration of the child who has reached the legal age into society.

Benefits for foster families - According to the Law on Protection of the Rights of the Child and Law on Orphan's Courts, municipalities provide such benefits for foster families: the local government which has taken a decision regarding the placement of a child into the foster family, - an allowance for the dependent child and an allowance for the purchase of clothing and soft furnishing. The specified allowances shall be disbursed to that member of the foster family who has entered into an agreement with the local government regarding the placement of a child into the foster family.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the public health policy and the legal framework.

There is no change as concerns social assistance.

3. Please provide pertinent figures, statistics or any other relevant information.

Compared to 2006, the amount of expenditure on municipal social assistance benefits in 2007 increased by 681,4 thsd LVL. In 2007, the total amount of expenditure on social assistance benefits in the country was 22,3 million LVL (see Table 10).

The guaranteed minimum income benefit assessed as corresponding to less than 45 LVL in 2006 and 60 LVL in 2007 per person, was declared poor, but only such a family (person) was granted the GMI benefit whose monthly income was smaller than 24 LVL in 2006 and 27 LVL in 2007. In 2007 the total amount of GMI benefit was 1,7 million LVL (7,7% from municipal budgets spending to social assistance), compared to 2006, it was less than 1,1 million LVL (see Table 10). The municipalities use 4 – 6 % of the total expenditure on

social assistance benefits for benefits in emergency situation. In 2007 it was 1,0 million LVL**.**

24,6 % or 5,5 million LVL from other benefits in 2007 was spend for housing benefit and 17,2 % or 3,8 million LVL from municipal budgets spending to social assistance was spend for health care benefits (see Table 10).

Table 10. Municipal expenditure on social assistance benefits.

	2004	2005	2006	2007
Municipal expenditure on social assistance benefits, thsd LVL	**18 591,4**	**19 545,6**	**21 572,0**	**22 253,5**
of them				
GMI benefit, thsd LVL	**3 497,1**	**3 404,5**	**2 822,1**	**1 713,2**
% of municipal expenditure on social assistance benefits	*18,8*	*17,4*	*13,1*	*7,7*
GMI level per person per month	18,0	21,0	24,0	27,0
The level of income and material situation for each family member which shall be recognised to be needy per month, in LVL	40,0	40,0	45,0	60,0
Benefit in an emergency situation, thsd LVL	**1 113,8**	**875,8**	**870,5**	**1 013,8**
% of municipal expenditure on social assistance benefits	*6,0*	*4,5*	*4,0*	*4,6*
Other benefits, total, thsd LVL:	**13 980,5**	**15 265,3**	**17 879,4**	**19 526,5**
% of municipal expenditure on social assistance benefits	75,2	78,1	82,9	87,7
of them				
Housing benefit, thsd LVL	**5 123,0**	**5 953,1**	**6 820,9**	**5 474,7**
% of municipal expenditure on social assistance benefits	27,6	30,5	31,6	24,6
Health care benefit, thsd LVL	**1 843,1**	**2 915,4**	**4 041,1**	**3 830,3**
% of municipal expenditure on social assistance benefits	*9,9*	*14,9*	*18,7*	*17,2*
Benefit for schooling and upbringing of children, thsd LVL	**450,7**	**642,8**	**857,5**	**945,3**
Transport benefit, thsd LVL	**748,3**	**543,7**	**590,7**	**782,1**
Benefits for orphans and foster families, thsd LVL	**175,5**	**244,9**	**698,0**	**972,2**
Other purposes, thsd LVL	**5 639,9**	**4 965,4**	**4 871,2**	**7 521,8**

Data source: Social Service Board

In 2007 year number of the municipal social benefit recipients was 317,0 thsd persons or 13,9% of state inhabitants (in 2006 year - accordingly 318,1 thsd persons or 13,9 % no of state inhabitants), of them GMI benefit recipients – 26,8 thsd persons or 1,2 % of state inhabitants (see Table 11).

30,5% of persons who are received municipal social assistance in 2007 was from families with children with one or more able-bodied adult, but in 2006 accordingly – 38,7%; but children there are 51,6 thsd or 30,5% in 2007 and 63,4 thsd children in 2006 or 38,7% recipients of municipal social assistance.

Table 11. Number of benefit recipients, thsd Persons

	2004	2005	2006	2007
Municipal social assistance benefits, total	**390,0**	**402,3**	**318,1**	**317,0**
of them				
GMI benefit	**74,7**	**58,2**	**41,0**	**26,8**
% of all persons who received social assistance benefits	*19,2*	*14,5*	*12,9*	*8,5*
Benefit in an emergency situation	**23,5**	**21,7**	**19,0**	**17,6**
% of all persons who received social assistance benefits	*6,0*	*5,4*	*6,0*	*5,6*
Housing benefit	**128,6**	**133,4**	**117,3**	**83,9**
% of all persons who received social assistance benefits	*33,0*	*33,2*	*36,9*	*26,5*
Health care benefit	**66,8**	**90,4**	**97,2**	**81,2**
Benefit for schooling and upbringing of children	**32,2**	**44,4**	**40,1**	**34,8**
Transport benefit	**26,2**	**15,8**	**12,6**	**13,5**
Benefits for orphans and foster families	**1,9**	**1,6**	**2,2**	**2,4**
Other purposes	**36,1**	**36,8**	**98,0**	**78,2**

Data source: Social Service Board

Table 12. The volume of social assistance benefits and poverty threshold[20] in Latvia.

	2004	2005	2006	2007
Poverty threshold for the single person household per year LVL	no data	733	882	no data
Poverty threshold for the single person household per month LVL	no data	**61,08**	**73,5**	no data
The level of income and material situation for each family member which shall be recognised to be **needy** per month, in LVL	**40,0**	**40,0**	**45,0**	**60,0**
Maximum amount of GMI benefit per month for separately living person set by the Cabinet of Ministers	**18,0**	**21,0**	**24,0**	**27,0**
Poverty threshold for the household consisting of 2 adults and 2 dependent children (< 14 year) per year LVL	no data	1539	1852	no data
Poverty threshold for the household consisting of 2 adults and 2 dependent children (< 14 year) per month LVL	no data	**128,25**	**154,33**	no data
Maximum amount of GMI benefit per month for household set by the Cabinet of Ministers	**105,0**	**105,0**	**135,0**	**135,0**

Data source: EUROSTAT and The Ministry of Welfare

[20] Poverty threshold - defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

Article 13§2

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

In accordance with the Law On Social Services and Social Assistance, citizens of the Republic of Latvia, non-citizens, aliens and stateless persons, who have been granted a personal identity number, except for persons who have received a temporary residence permit, are entitled to receive social assistance. Rights to receive main social assistance benefits depend on material resources of family (income level, accruals, properties etc.). Only rights to receive other municipal social benefits depends on two parameters: on level of material resources and on belonging of members of family to any social group. The Cabinet of Ministers determines the procedures for receipt of social services and social assistance. Assessment of material situation of family and decision on compliance of family (person) with the status of needy family is made by the social office of the municipality. The decision about granting of social assistance or an establishing status of needy person according to Administrative Procedure Law is administrative statement and the decisions thereof shall be appealed in a court.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

According to the *Immigrations Law* an alien shall be entitled to enter and reside in the Republic of Latvia, if he or she have financial sources for providing of persons basic needs in Latvia. These sources must provide financing in level, witch is no requested additional financing through municipal social assistance. Persons received alternative status according to the *Asylum Law* since 2007 have right to GMI benefit and shelter services.

3. Statistics or any other relevant information, if appropriate.

There are no pertinent statistics.

Article 13§3

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

According to the Law on Social Services and Social Assistance social services shall be provided on the basis of an evaluation of the individual needs and resources of a person carried out by a social work specialist.

The main duties of local governments in the provision of social services and social assistance are the following:

1) The local government in the territory of which a person has registered

his or her main place or residence has a duty to provide the person with a possibility to receive social services and social assistance corresponding to his or her needs.

2) If a local government has received information from natural persons or institutions regarding a person who might require a social care or social rehabilitation service or social assistance, the local government has a duty to verify the received information, to evaluate the needs of the person for social services and social assistance and to inform this person or his or her lawful representative of the rights and possibilities of receiving social services and social assistance, as well as the procedures by which social services and social assistance may be received.

3) If necessary a person whose place of residence can not be determined shall be provided with night shelter, information and consultations by the local government in which the person is located.

4) If local government has not established the necessary social service providers it shall enter into agreements with other social service providers regarding provision of referred social service.

In order to provide qualitative social services and social assistance and in order to evaluate client's social situation accordingly each municipality employs at least one social work specialist per thousand of population. Each municipality with a number of population in its administrative territory exceeding 3000 people, shall establish a municipal social office.

According to the Law on Social Services and Social Assistance in order to ensure professional assessment of people's needs and render high quality social services and social assistance, the municipalities have to provide at least one social work specialist per 1 000 inhabitants, and the municipalities in which the number of inhabitants exceeds 3 000 persons, must set up a social service office.

According to the Law on Social Services and Social Assistance duty of municipal social service office is to inform each persons on possibility to receive social services and social assistance benefits, therefore to adduce psychosocial assistance.

According to the Law on Local Governments local and regional governments must to publish they regulations in the press, inter alia, about social services and social assistance provide by each local government.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.

Municipalities are inform their inhabitants not only with publishing information in local newspaper, but also insert information in local government's internet home page, prepare and diffuse brochures about social services and social assistance provide by local government and pay for costless informative phone.

3. Statistics or any other relevant information.

In 2007, 462 municipalities or 87,7% of the total number of municipalities had a social service office or a regular employee performing the duties of a social

worker. In 2006, the number of such municipalities was 450 or 85,4 of the total number of municipalities.

In 2007, there were 65 municipalities or 12,3% of the total number of municipalities where the duties of social worker were performed as an additional job by a person holding another job in the municipality, but in 2006 the number of such municipalities was 77 or 14,6% of the total number of municipalities. These were mainly municipalities with a small number of inhabitants.

Table 13. Increase in proportion of municipalities having social office or social work specialist (number and percentage) 2004-2007.

Year	Number of municipalities	Number of municipalities having social office or permanently employed social worker	% out of number of municipalities
2004	530	400	75,5
2005	530	435	82,1
2006	527	450	85,4
2007	527	462	87,7

Data source: Social Service Board

Table 14. Informative measures about social services and social assistance provided by local governments in 2007

Measures	Number of local governments, that provide the measure	% of all local governments
Information in local newspaper	443	84,1
Information in local government's internet home pages	156	29,6
Brochures	116	22,0
Costless informative phones	15	2,9

Article 13§4

1.The general legal framework. The nature of, reasons for and extent of any reforms.

According to the Law on Social Services and Social Assistance person whose place of residence can not be determined shall be provided with night shelter, information and consultations by the local government in which the person is located, but it not concern to social assistance benefits in cash.

2. The measures taken to implement the legal framework

There is no change as concerns social assistance.

3. Statistics or any other relevant information

There is no statistics.

Article 14 – The right to benefit from social welfare services

With a view to ensuring the effective exercise of the right to benefit from social welfare services, the Parties undertake:

1. to promote or provide services which, by using methods of social work, would contribute to the welfare and development of both individuals and groups in the community, and to their adjustment to the social environment;
2. to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services.

Information to be submitted

Article 14§1

1. Please describe the general legal framework. Please specify the nature of, reasons for and extent of any reforms.

The Law on Social Services and Social Assistance stipulates that aim of social work is helping a person, family or a group of persons to identify, solve or reduce his/her social problems, developed person resources to include supporting systems.

In order to ensure professional assessment of peoples needs and render high quality social services and social assistance, the municipalities have to provide at least one social work specialist per 1000 inhabitants, and the municipalities in which the number of inhabitants exceeds 3000 persons, must set up a social service office.

The right to receive social services shall be enjoyed by Latvian citizens and non-citizens, aliens and stateless persons who have been assigned a personal identity number, except those who have received a temporary residence permit.

Statistical data show that family's with children's belong to low income inhabitants, and municipalities required support to work with different social problems affected inhabitants groups. Family's with children's expose to varied poverty, that show like crisis, life-history, low-incomings and finally like hereditary poverty. Limited means is only one of the result, which indicate to social crisis risk. A lot of social problems whys to alcoholism, drug addiction and criminality is searching directly in family. Thereby municipalities required support to that municipalities social workers, who works with family's with children's. Its very important create condition to growing social work with family's with children's in municipalities.

According to the Law on Social Services and Social Assistance social workers must have special education. In order to organise social work professionally, social workers should have the second-level professional higher academic education in social work, but social carers and social rehabilitators and organizers of social assistance should have the first level professional higher education in the relevant areas.

2. The measures taken (administrative arrangements, action plans, projects etc.) to implement the legal framework.

„National Report on Strategy for Social Protection and Social Inclusion 2006-2008" one of activity is - improve the accessibility of resources and services to families, particularly large and single-parent families. Salient task - to provide state co-financing for supporting social workers who carry out social work with families and children in municipalities.

To evolve professional social work in state, thereby ensure inhabitants possibility receive qualitative and professional assessment of their needs, in 2005 attested "Program for Professional Social Work Development (2005-2011)".

One of activities in "Program for Professional Social Work Development (2005-2011)" is to provide supplements to the salary from state budget finance (LVL 124.09 for one social worker in month) to social workers in municipalities social service offices, who works with family's with children's.

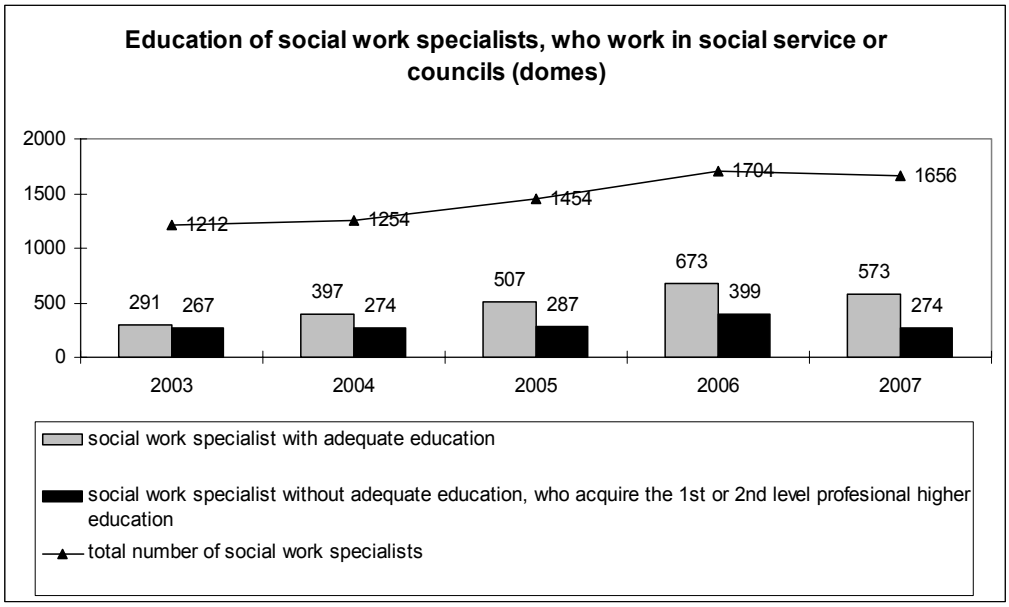
In order to promote the development of professional social work and the education of social work specialists, as well as to foster social work policy, the Cooperation Council of Social Work Specialists (hereinafter - Council) has been set up. It includes the representatives of municipal and non-governmental professional social work organisations, educational establishments training social work specialists, as well as of other organisations and practical social workers.

The meetings organised by Council have been devoted to such issues as reviewing the professional standards of social work specialists, reviewing professional terminology, methodical support to the employees of social service institutions, the development trends of social work at the national and international level, the remuneration of social work specialists and other incentives of professional growth.

3. Pertinent figures, statistic or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

According to the "Program for Professional Social Work Development (2005-2011)" in 2007 special purpose grant from government was granted to 196 social workers from 97 municipalities. Within the last 4 years, the number of social work specialists in the municipal social service offices having statutory education has been growing. In year 2007 number of employees of municipal social work specialists having decrease for about 100 social work specialists (see Graph 3).

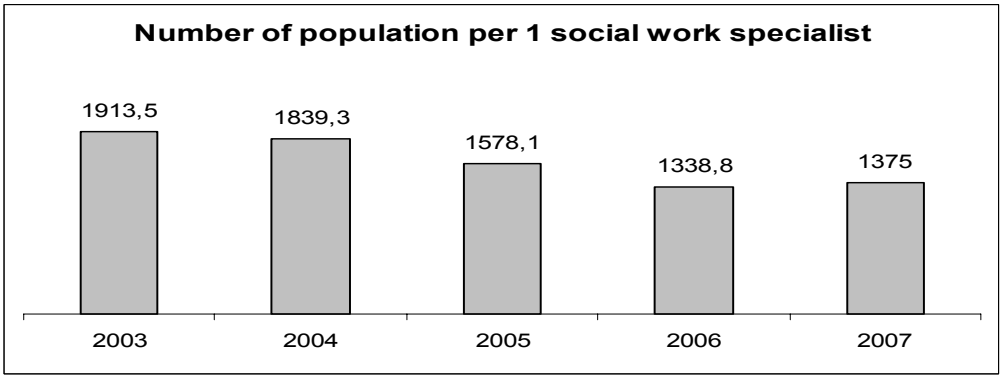
Graph 3.



Data source: The Ministry of Welfare

There was one municipal social work specialist per approximately 1375 inhabitants in 2007. There was one social work specialist per 1339 inhabitants in 2006 (see Graph 4).

Graph 4.



Data source: The Ministry of Welfare

Article 14§2

1. The general legal framework. The nature of, reasons for and extent of any reforms.

According to the Law on State administration state functions may deputed to private person or other public person, if they tasks can do more effective. Such system secure successful private persons and other cooperation organizations.

Public organisations may become providers of social care and social rehabilitation services by participating in project tenders for developing new types of services, through state procurements for social care and social rehabilitation services provided by state or through local municipalities

procurements for social care and social rehabilitation services provided by local municipalities.

According to the Law on Social Services and Social Assistance local governments which have not established the necessary social service providers shall enter into agreements with other social service providers in their territory or with other local governments regarding provision of the referred to social services and payment. These social services shall be fully or partially financed from the local government budget. That means – any social service providers are able to provide social services (including NGO's, private service providers and other local governments) if necessary.

Receiving social care services a person has a duty to pay for it except of cases if a person belongs to category of inhabitants whose services are paid from the state budget resources. While if due to the lack of resources a person is not able to pay for the provided services, the expenses are covered by the legitimate support defined by legislation of Latvia or municipality. Home care is a social care service funded by the municipalities.

While from the municipal budget resources services in social care institutions receive persons of pension age and disabled people if the required scope of service exceeds the scope specified for home care or care at day care centre and social rehabilitation institution.

There are certain services that the State shall ensure (the vocational rehabilitation of disabled persons, the social rehabilitation of persons with impaired vision and hearing, the social rehabilitation of children who have suffered from violence, the social rehabilitation in appropriate institutions for adult persons and of children who have become addicted to narcotic, toxic or other intoxicating substances, technical aids, for persons with functional disorders – social rehabilitation services in social rehabilitation centres and — the social rehabilitation of victims of the trafficking in human beings). In order to ensure the fulfilment of these services, the State may establish social care and social rehabilitation institutions or enter into agreements with other social service providers.

From the state budget resources care in long term social care and rehabilitation institution is provided for children with mental disorders, orphans and children left without parental care up to age of 2, children with mental and functional impairments up to age of 4, and for persons with mental disorders and persons with visual impairments.

State co-funding for establishment of group house (apartments) and half-way homes and day care centre for persons with mental disorders.

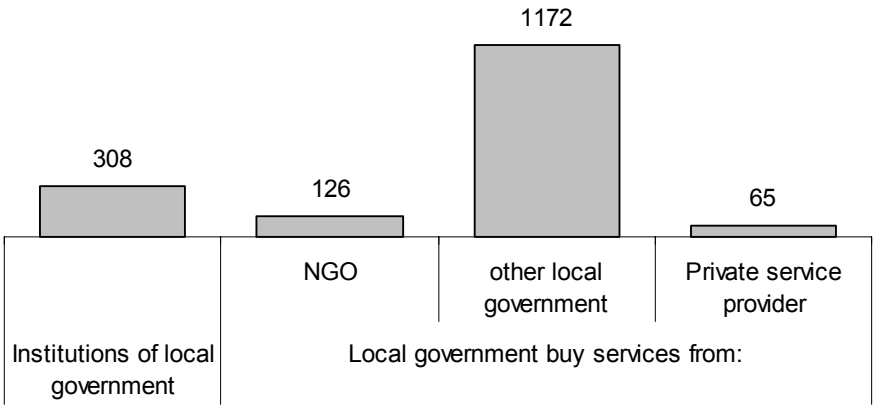
2. The measures taken (administrative arrangements, action plans, projects etc.) to implement the legal framework

There is no change as concerns social and medical assistance.

3. Pertinent figures, statistic or any other relevant information to demonstrate the effective access to social services (beneficiaries in total and per category of social welfare services, number and geographical distribution of services, staff number and qualifications).

Graph 5.

Number of organizations that provide social services in local governments (2007)



Data source: The Ministry of Welfare

In 2006, night shelter service was provided for 3 413 persons (for 2 690 men and 723 women): at 23 municipal night shelters and 6 shelters for homeless persons of non-governmental organisations. In 2007, this service was provided for 3 282 persons (for 2 568 men and 714 women): at 15 municipal night shelters and 11 non-governmental organisations.

7 municipal crisis centres (in 2006 – 9) were operating, providing services for 900 persons: for 391 men and 509 women) in 2007 (in 2006 - 456 persons). The municipalities provide the necessary crisis centre services for their inhabitants buying them from the non-governmental organisations or the crisis centres of other municipalities.

Table 15. Number of persons, who received home help services.

	2005	2006	2007
Number of persons, who received home help services, total	11 745	10 612	10 851
of them			

municipal social service office	5274	4363	4066
municipalities enter into agreements with other social service providers – NGO's	2525	2433	2791
municipalities enter into agreements with other social service providers – private persons	54	776	758
social care provided by private person and municipality provide financial support	3892	3040	3236

Data source: The Ministry of Welfare

At the end of 2006, 114 social care institutions provided services for adults, of them – 78 municipal old people's social care centres and 27 state social care centres, as well as 9 institutions concluding public procurement contracts (businessmen and municipal institutions). At the end of 2007, 118 social care institutions provided services for adults, of them – 82 municipal old people's social care centres and 27 state social care centres, as well as 9 institutions concluding public procurement contracts.

In 2006, social care at institutions was provided for 10 118 persons, of them for 4 494 men and 5 624 women. Compared to 2005, the total number of persons living in social care institutions increased by 511 persons. In 2007, social care at institutions was provided for 10280 persons, of them for 4 564 men and 5 716 women.

In 2006, orphanages – shelters, provided a home to orphans and children deprived of parental care from 2 to 18 years of age, provided service by 44 municipal institutions and 8 state social care and social rehabilitation institutions, 7 non – governmental child care institutions and 7 family type long-term social care institutions. In 2007, orphanages – shelters, provided a home to orphans and children deprived of parental care from 2 to 18 years of age, provided service by 42 municipal institutions and 8 state social care and social rehabilitation institutions, 9 non – governmental child care institutions and 5 family type long-term social care institutions.

The number of children residing in these institutions is decreasing year by year: in 2007 there were 2547 children living in orphanages – shelters, in 2006 there were such 1 878 children, in 2005 accordingly 2 170 children, but in 2004 there were 2 182 children.

Service providers that provide social services for the State budget. In 2007 there were 2 NGO's providing services for persons with impaired vision and hearing, there are 1 State agency providing wide range of social services for disabled persons, there are 1 State agency providing technical aids, there are several NGO's providing social services for abused children, drug addicted children and adults as well as victims of the human trafficking.

Altogether 8 institutions has provided social services for abused children during the year 2007 and 1840 children has received this social service (in 2006 accordingly 1615 children).

32 drug addicted adults and 64 drug addicted children have received social care in 3 different social service institutions during 2007. In 2006 they were 77 children. Adults started to receive this kind of rehabilitation only since the 1st of January 2007.

The vocational rehabilitation in the year 2007 has received 542 disabled persons (in 2006 accordingly 310 disabled persons). 1915 disabled persons has received social rehabilitation in 2007 and 1591 in 2006. 12 victims of human trafficking has received State funded social services during 2007 and 6 victims accordingly in 2006. This service was provided by the NGO — “Resource Centre for Women “Marta””.

Questions and Answers on Conclusions XVII-2

Article 11 – The right to protection of health

Institutions in charge:
HSMTSA – Health Statistics and Medical Technologies State Agency;
PHA – Public Health Agency;
ICL – Infectology Centre of Latvia;
HCISA – Health Compulsory Insurance State Agency;
MPEC – Medical Professional Education Centre.

1. What are principal causes of mortality in Latvia?

In Latvia the most common causes of death are diseases of circulatory system. In 2006 these were 53.5% from the total deaths, i.e. 17,729 total cases or 774.9 per 100,000 population, but in 2007 – 54.6% from the total deaths, i.e. 18,043 total cases or 794.5 per 100,000 population. Mortality rate is higher for females than males.

Neoplasms are the second most common cause of death (*most of them - malignant*): In 2006 these were 18.5% from the total deaths, i.e. 6,112 total cases or 267.1 per 100,000 population, but in 2007 – 18.1% from the total deaths, i.e. 5,997 total cases or 264.1 per 100,000 population. The mortality from neoplasms was increasing till 2006. In 2007 this figure has decreased. The mortality is higher for males than females.

Consequences of external causes are the third most common cause of death. The rates are fluctuant. However, they decrease step by step. In 2006 the specific weight was 9.8% from the total deaths, i.e. 3,243 total cases or 141.7 per 100,000 population, but in 2007 – 8.6% from the total deaths, 2,850 total cases or 125.2 per 100,000 population. Mortality of females is about 3.5 times lower than mortality of males.

2. What measures are planned in the framework of a policy against the virus (HIV/AIDS)? Are there additional AIDS prevention measures aimed at adults?

Current epidemiological situation in Latvia calls for continuous attention and actions on the part of the government and society as a whole. So far Latvia has a significant concentrated HIV epidemic particularly among injecting drug users (IDUs) also affecting other highly vulnerable population groups. The number of new HIV cases registered annually, while decreased and remains stable during past years, further increases the size of affected population.

Latvia's policy against HIV/AIDS is guided by the subsequent National programs. Currently the revised Program (2009 - 2013) is in the process of approving by the government. The programmatic activities (measures) are grouped in the framework of five strategic areas.

Area1.Avert new HIV cases among most-at –risk population through increasing the scale and quality of evidence-based drug treatment (Methadone Maintenance Therapy and other substitution treatment), harm reduction services, information about HIV and voluntary counseling and

testing to reach and retain in service up to 45% of IDUs at the end of year five of the national program. Latvia has already established the network of 13 Low Threshold centres for IDUs in 12 municipalities more affected by drug use and HIV. These centres served 11,670 IDUs since 1999, providing diversified low-threshold services in combinations aimed to meet different needs of their target audience: needle exchange, outreach, voluntary counseling and testing, disinfectants, information.

Area 2. Implement wider prevention strategies among general population. Under this strategic area following interventions are planed: Increase awareness of public about HIV transmission and means of prevention through organizing annual information and education campaigns within the framework of the World AIDS day, making diverse information about HIV transmission and prevention measures available through Internet and other target media. Voluntary counseling and testing for HIV will be expanded as a means of increasing population awareness as well as detected HIV infected. Safe blood supply is and will be assured through testing of 100% of donor blood and blood products. Activities aimed at preventing vertical (mother-to-child) transmission will be improved and implemented that will sure adequate supply of HIV express tests to maternity wards and provision of preventive therapy against HIV vertical transmission.

Area 3. Provide health and social care to persons living with HIV/AIDS (PLWHA) and eliminate stigma & discrimination. Under this strategic area national program will focus on improving quality and reaching more people with treatment, care and support. Latvia has introduced treatment with antiretroviral (ARV) therapy for PLWHA, but now country faces the need for expanding the provision of ARV to all in need. For this purposes sufficient financial and human resources will be deployed by the health care system to increase the number of treated individuals and remove access barriers to the care, which currently exists in the country. Integrated HIV and TB treatment along with treatment for co-infections will be developed.

Area 4. Generate and use evidence for response planning and management. This strategic area focuses on those interventions that can help improve the type and quality of information necessary for adequate response: maintain HIV/AIDS epidemiological surveillance system according European CDC requirements. Establish one agreed country–level monitoring and evaluation framework to monitor overall implementation of the national program and evaluate its impact.

Area5. Strengthen the national coordination and capacity to respond to HIV and AIDS: means collaboration and effective coordination among different ministries, among governmental and non-governmental sectors, among different vertical programs and health care services, collaboration among different projects supported by EC and other multilateral agencies like WHO, UNODC. Functions of the National STD/HIV Prevention Coordination Committee are expanded and also include TB issues and involve civil society in national planning, program implementation and service delivery for HIV and AIDS.

According to the Regulation No.8 of the Cabinet of Ministers of the Republic of Latvia, dated 4 January 2005, "State agency's "Infectology Center of Latvia" Regulation", 2nd article, and the Regulations No.628 of the Cabinet of Ministers of the Republic of Latvia, dated 4 November 2003, "Limiting

prevalence of the human immunodeficiency virus infection (HIV) and AIDS, and the treatment procedure of HIV infected persons and AIDS patients", state agency "Infectology Center of Latvia" performs specialized health care of HIV infected persons and AIDS patients , e.g., hospital treatment, ambulatory visits, laboratory analyses, HIV therapy's (of antiretroviral and opportune diseases) monitoring and psycho-social care, as well as provides methodological health care guidance of the HIV/AIDS patients in the state.

In the framework of limitation of further spreading of the HIV/AIDS, Infectology center of Latvia: 1) ensures prevention of the HIV infection vertical spreading for HIV positive pregnant women and post-exposition prevention for the professional risk groups (health care professionals, rescue personnel);

2) ensures availability of the HIV infection antiretroviral therapy, hence excluding treated patients out of the HIV infection spreading source group;

3) provides information in electronic and printed mass media on a regular basis concerning the risks of HIV infection spreading, the ways of its diagnosis and treatment.

3.What measures are available to deal with other epidemics?

The State Agency “Public Health Agency” (PHA) and the State Agency for Tuberculosis and Lung Diseases are responsible for the epidemiological surveillance of communicable diseases in Latvia. The Ministry of Health supervises this function.

Surveillance and prevention of communicable diseases:

71 diseases and additionally several pathogenic agents (information from laboratories) are subject to mandatory individual notification and registration.

Clinicians in the public and private healthcare sectors are legally responsible for notifying the listed infectious diseases to PHA branches by phone or by fax, as well as for case management.

Notification is required for cases of suspected infectious disease, a change or cancellation of diagnosis of an infectious disease, the final diagnosis and the outcome of an infectious disease, and laboratory confirmation of the diagnosis.

Epidemiologists in PHA branches organize preventive and control measures and investigate cases (outbreaks). Outbreaks of acute intestinal infections are investigated in cooperation with the Food and Veterinary Service and/or other related institutions.

Weekly, monthly and yearly statistics of communicable disease cases are sent to PHA by PHA branches electronically; monthly and yearly statistics of the confirmed cases are reported by PHA to the Health Statistics and Medical Technologies State Agency and to the WHO Regional Office for Europe or other European Union communicable disease networks, as well as to neighboring countries upon request.

Summarized information on cases of a definite infectious disease is regularly disseminated by PHA via email and post to other ministries, institutions and mass media. These informative materials (epidemiological bulletins) are available through PHA web site.

Within the framework of State Immunization Program, childhood vaccination against 11 vaccine preventable infectious diseases is implemented in Latvia.)

4. More details of measures about infant and maternal mortality, reasons.

Since 2001 the infant mortality had been decreasing. However, it has increased in 2007. In 2006 there were recorded 170 infant deaths or 7.6 per 1000 live births, while in 2007 – 204 deaths or 8.8 per 1000 live births.

Certain conditions originating in the perinatal period are the most common cause of infant mortality. Mortality from this cause has increased recently, i.e. from 81 total cases or 3.6 per 1000 live births in 2006 to 95 total cases or 4.1 per 1000 live births in 2007.

However, the specific weight has decreased from 47.6% to 46.6% from total infant deaths because the specific weight of congenital malformations and chromosomal anomalies has increased from 25.3% in 2006 to 27.9% in 2007.

Mortality from congenital malformations and chromosomal anomalies has increased from 43 cases or 1.9 per 1000 live births in 2006 to 57 total cases or 2.4 per 1000 live births in 2007.

Sudden infant death syndrome is the third most common cause of infant deaths. The mortality has increased from 19 total cases or 0.9 cases per 1000 live births in 2006 to 26 cases or 1.1 per 1000 live births in 2007, but the specific weight – from 11.2% in 2006 to 12.8% in 2007.

Consequences of external causes are the fourth most common cause of infant deaths. *(accidents, assault*). Mortality from these causes has decreased during the last years, i.e. 7 cases or 0.3 per 1000 live births in 2006, 6 cases or 0.3 per 1000 live births in 2007. The specific weight has decreased from 4.1% to 2.9%.

Maternal mortality has increased from 3 total cases or 13.5 per 100,000 live births in 2006 to 6 total cases or 25.8 per 100,000 live births in 2007.

In 2006 two cases of maternal deaths were directly related to pregnancy and childbirths

(*eclampsia following premature childbirths, DIC syndrome*), but one case was due to rheumatic heart disease that had aggravated the pregnancy.

In 2007 all the cases were directly related to pregnancy and childbirths (*2 cases of ectopic pregnancy, spontaneous abortion, rupture of uteri, premature separation of placenta at home delivery, thrombosis of pelvic veins*).

5. Additional clarification on the differences in the working of the public and private sickness insurance schemes.

Private sickness insurance is the one which is understood with term 'voluntary health insurance' and it is a health insurance product, which, according to the Law *On Insurance Agreement* is proposed by insurance companies, which perform their activity by themselves according to *Insurance company and their supervision law*.

The public sickness insurance is the one which is guaranteed to persons by state from its budget or is financed from the resources of the persons.

Currently in Latvia compulsory health insurance as one of the tax types is not implemented, and that means finance to health care is funded from state budget and patient, when receiving the health care services guaranteed by

the state, is participating in financing of this service with patient payment, amount of which is decided by the Cabinet if Ministers.

According to Regulation No.583 December 27 year 2002 of the Cabinet of Ministers "Statute of Compulsory Health Insurance State Agency" paragraph 1 Agency's task is to administrate finances of the states compulsory health insurance.

In fact private health insurance companies are very tightly connected with the amount of state financed services and their product as well as rentability is directly dependent on changes of state financed services and the changes of amount of this finance.

The main part of insurance companies offer product which insure the patients payment, which means that patient has to take part into states established system, has to receive posting documents, and state is financing the most part of expenses of the services. At the same time some of the insurance companies propose full insurance package, according to which person is insured to all patients' payments and all services, which are not guaranteed by state budget.

6. Why important health care are covered by such a ceiling? What consequences if the ceiling is exceeded?

Regulation of the Cabinet of Ministers of the year 2006 December 19 No.1046 'The order of organisation and finance of health care' states that the total sum of patients payments of health care services can not exceed LVL 150. In cases when patient payments in one calendar year have exceeded LVL 150, persons further patients payments for health care services are financed by state budget. This is activity in order to ensure patients' social security.

7. Information on health care covered by the health care system.

Health Compulsory Insurance State Agency (hereinafter – the Agency or HCISA) replying to the question mentioned enumerates health care services which, according to previously mentioned Regulation of the Cabinet of Ministers of the year 2006 December 19 No.1046 'The order of organisation and finance of health care' are not financed by state budget.

From state budget there is not financed health care services if patient has no posting document from family doctor or specialist who is not in contractual commitment with the HCISA (except emergency health care services in cases mentioned in the Regulation mentioned), and is not covering the costs of these kind of services:

- orthodontic treatment (except for first time consultation for children in age under 18 years and inborn face-chop cases for persons under 22 years), for using a dental sealant, for dentistry to persons which are older than 18 years, as well as for prosthetics. To persons which participated in elimination of effects of the Chernobyl nuclear power stations tragedy and to persons who have suffered from mentioned tragedy, according to Social protection law paragraph 14, there are covered 50% of the costs of the dentistry, but expenses for teeth prosthetics with plastic prosthesis are fully covered by the state budget;

- for ambulatory injections into skin, under skin, intramuscularly and intravenously (except for the cases of emergency medical aid or for health care services in day stationary and medical aid for oncology patients, patients with diabetes mellitus, patients with mental illness, for children under age of 18, patients with tuberculosis, pregnant women under 42 days of pregnancy, patients with haemophilia and to patients with malign anaemia;
- for first time medical preventive activities, which are necessary when person starts to work, as well as for compulsory health examination, if there is a change in environment of working place;
- for periodical medical examinations, which are needed because of working environment or specific working conditions;
- for legal abortion according to legal acts on the organisation order of pregnancy interruption;
- for maintaining sperm donor bank, artificial insemination, in vitro fertilisation;
- for the same or informatively adequate examinations in secondary health care, which are repeatedly done after one month, when this activity was done with a posting document from a family doctor (except for cases of emergency medical aid);
- for sexological treatment;
- for provision of medical assistance in public events;
- for cosmetological services and surgical operations with esthetical purpose;
- for homeopathic treatment;
- for prescriptions and purchases of optical products with aim to correct eyesight sharpness, except for glass lenses, glass frames and contact lenses for children with diagnosis of high level inborn myopia (above 5,0Dsph), high level hypermetropia (above 4,0 Dsph), high level astigmatism (above 1,0 D), high level anisometropia (above 2,0 D), lensless in cases of inborn nebula or in one or both eyes which is derived from nebula cases;
- for aerophones in cases of deaf aid (except in cases of cochlear implants for children) purchases;
- for psycho-therapeutic and psychological assistance (for exception in assistance in psychiatric profile hospital sections or specialized hospitals, treatment in cases of alcoholic and narcotic rehabilitation programmes and ambulatory palliative treatment for children);
- for vaccination (except passive immunotherapy and vaccinations stated in vaccination calendar, vaccination against flu according to legal acts on the compensation order of ambulatory treatment medicine and medical appliances);
- for preventive and other medical examinations (except for mentioned Regulation of the Cabinet of Ministers of the year 2006 December 19 No.1046 ‘The order of organisation and finance of health care’ annex 5 mentioned preventive examinations);
- for the influence examination of alcoholic, narcotic, psychoactive or toxic substances (except in cases if it is needed for medical treatment process);

- for that kind of illness or trauma stationary treatment, if there can be ambulatory treatment applicable;
- for health care services done by specialist or stationary medical institutions, if patient has in written form refused from waiting for planned health care service and the expenses for this health care services are covered by this person or third party;
- for treatment with applying non-traditional medical methods;
- for transplantation of organs and woof, except for cases of: blood and its preparation, kidney, descent cell , including the process of search for donor, bones and conjunctive tissue, skin, sinew, cartilage woof, heart valves, corneas, liver transplantations for children;
- for home visit of the specialist (except for voluntary psychiatrist home visits to the patients of psychiatric illness);
- for family doctors' home visits, except visits to: children under age of 18, disabled persons of 1st group, persons who are older than age of 80, persons which need palliative treatment (diagnosis according to International statistic illness and health problem classification 10th redaction (SKK-10) codes: B20–B24; C00–C97; D37–D48; G05; G12; G13; G35; G54.6; G55.0; G60.0; G61.0; G63.1; G70; G95.1; G95.2; G99.2; I50; I69; K22.2; L89; T91.3, and sub diagnosis with code in all cases Z51.5, and to persons which have died in home conditions and which are visited with purpose to officially confirm the fact of death;
- for ambulatory made laboratory examinations (except for Regulation of the Cabinet of Ministers of the year 2006 December 19 No.1046 'The order of organisation and finance of health care' annex 6 mentioned examinations);
- for consultations, clinical and paraclinical diagnostic examinations, which are made by the permission of crime medical expert, to the persons which are victims of criminal activities. These expenses are covered by the claimant of the health care service;
- for medical rehabilitation, except cases of patients, which are posted directly by regional hospitals or local multi-profile hospitals or specialised centres (specialised hospitals) or with posting document of family doctor or specialist after leaving mentioned treatment institutions, and which are posted to treatment in these rehabilitation institutions in six month period; patients with inborn and acquired organic neural system damage consequences with paralyses; with dynamic observation; for persons which participated in elimination of effects of the Chernobyl nuclear power stations tragedy and to persons who have suffered from mentioned tragedy; ambulatory medical rehabilitation; for children under age of 18;
- for surgical operation in hospitals (except for regional and local emergency aid hospitals, specialised centres and specialised hospitals, stationary medical institution ambulatory units and day stationary);
- for patient temporary social assistance in medical treatment institutions (diagnosis according to SKK-10 codes:Z59 – with place of living and economical problems; Z60 - with social environment problems);
- for health care services, which have been provided by medical treatment institutions or medical persons without contractual commitment relations with the Agency;

- for treatment in sanatorium, spa and health resorts;
- for ambulatory physical medical manipulations (except for manipulations with children);

All other health care services, which are not listed in above mentioned information, are covered by the state budget fund, according to the provisions of contract between the Agency and medical treatment institutions.

8. What criteria are used for waiting lists and how they are managed?

The Agency the waiting lists for receiving planned health care services manage for orthopaedy (hip-articulation, knee-articulation and shoulder-articulation endoprosthetics) and otholaringology (cochlear implants for children), as well as hemathology (authologic cellular transplantation).

In order to reduce the waiting lists for operations, the Agency have made additional waiting lists:

- the list where the health care service is provided in emergency situation, based on conclusions of council of doctors (the service is provided in a period of one year from the day of conclusions submitted by the mentioned council);
- the list where the patient covers up to 50% from the expenses of health care service (the service is provided in a period of 3-6 months from the day of submission of the application).

For other health care services the organization of waiting lists is in the competency of each health care institution and the length of these lists depend on resources and budget of each health care institution.

In year 2008 there is increased the budget funding to health care institutions with purpose to decrease the lengthy of the waiting lists for operations in ophtamology and invasive cardiology services.

9. What is the situation of the medical personal? What steps are being taken to increase the number?

Medical Professional Education centre (hereinafter – MPEC) regularly summarizes and analyses the data on persons employed in the field of health care. In order to gather information on number of specialists needed in health care institutions MPEC regularly makes updates the Database of vacancies for persons employed in the field of health care, which is accessible to anyone in the homepage of MPEC.

According to information provided on 01.07.2008. there were 1556 vacancies, from these – 676 vacancies of doctors, 379 vacancies of nurses and 79 doctor assistant vacancies.

MPEC for two years organizes informative event “Career day”. The aim of event mentioned were:

- to establish dialogue between employers – health care institutions and next specialists – residents and students of medical faculties of the universities and medical colleges;
- to motivate new specialist interest on working possibilities in different regions of Latvia.

MPEC according to Regulation of the Cabinet of Ministers of the year 2001 March 13 No.120 ‘Regulation on distribution of residents and the finance order

of the residenture' is preparing proposals to the Ministry of Health for plan of resident admission, which states the budget funded places for residents.

In recent years there is tendency observed for persons, which have lost their right to practice their activity in the field of health care, to return to this field.

MPEC offer for doctors' assistants, nurses, maternity nurses and nurse assistants to retrieve these rights to practice if they pass the test of qualification control. MPEC perform these tests of qualification for these applicants according to certified order "Order how Medical Professional Education Centre performs the test of qualification for nurses, maternity nurses, doctors' assistant, nurse assistant and cosmetician".

In period from January 2006 until December 2007 there have been 255 nurses, 85 doctors' assistants, 13 maternity nurses and 9 nurse assistants passed the qualification test with satisfactory level and as a result regained their right to perform their practice activities.

10. What are the consequences of the privatization in the health sector and of the diminishing the number of hospitals and beds?

Since 1993 outpatient health care institutions (specifically polyclinics) began a process of change in ownership from state institutions to either fully privatized institutions or non-profit state and municipal limited liability companies.

There was a decision to fully privatize all polyclinics, and this has been partially (about 70%) implemented up to date in Riga. Where full privatization occurred, primary health care providers became employees of the institution. In the cases where polyclinics became non-profit state or municipal limited liability companies, this was not real privatization; however it did involve a different legal basis allowing the respective administration greater freedom in decision-making and resource allocation.

A similar process was initiated for hospitals, which became non-profit state or municipal limited liability companies, as there was no privatization in this case.

In 2000 a new Law of Commerce was passed, whereby non-profit state and municipal limited liability companies (applying to both hospitals and polyclinics) were reorganized into capital companies (state stock companies or state companies with limited liability).

In some isolated instances outpatient clinics have a mixed public-private ownership mix (local governments with private owners). However this has occurred only to a very limited degree and it is not foreseen that this type of ownership mix will increase in the foreseeable future. At the present time, legislation forbids public organization structures to invest in private ones. Moreover, there is no special focus on organizational and property forms at the present time that could induce any legislative changes to alter the current situation.

In addition, privatization strongly affected other health care facilities, notably dental practices and pharmacies, almost all of which have been privatized. Several sanatoria (spas) have been privatized, and there has been a small increase in the number of private hospitals. Private sector compose only 6,3% from total hospital beds in 2007.

Privatization as process have not influenced the number of hospitals and beds.

Finally, there has been a strong policy orientation, particularly since 1997 legislation (Law “On Physicians Practice”), encouraging the development of independent primary care practices. The law states that the primary care physician (or general practitioner) is an independent profession and a specific form of entrepreneurship. This does not constitute privatization of existing institutions but rather the establishment of new, private institutions by primary care practitioners. In the early years this process did not proceed as rapidly as was hoped, mainly due to financial constraints (low physician income, high interest rates on bank loans), the uncertainties associated with establishing a practice, as well as administrative barriers. Some projects (for example, in collaboration with EU/PHARE) provided technical assistance in the establishment of independent physician practices. At this time all general practitioners are practicing privately.

Any provider must have a contract with the State Compulsory Health Insurance Agency in order to provide services under the statutory system. An important principle of statutory health care is equity of service providers, particularly in connection with equal possibilities and terms to compete for contracts for services provision with the Agency, independently of property forms. There have been some claims about discrimination by the Agency against private provider institutions, but this cannot be substantiated.

From the point of view of ownership, the Latvian health care system can be considered as very decentralized with highly independent management of services.

Managers are appointed by and are accountable to the owners of institutions. This independence together with blurred borders between public and private sectors sometimes creates a risk factor for corruption.

In 2007 the private sector make only 6,3% from all hospitals beds.

11. What measures are planned in the framework of an efficient policy to combat smoking? And to decrease the number of young people who are smoking?

Latvian policy on smoking restriction is based on number of various World Health Organisation (WHO) documents for combating the tobacco epidemic in EU countries. By entering the EU in 2004, Latvia has undertaken the responsibility to start a fight against smoking prevalence with the adaptation of the “WHO European strategy for smoking cessation policy” into national legislation. Therefore the guidelines of the WHO policy were implemented in the “Tobacco control program 2006-2010”. The program was elaborated based on Target 12 of the "Latvian Public Health Strategy" adopted by the Republic of Latvia Cabinet of Ministers on 6 March 2001: that the ratio of smokers over 15 years old must be reduced by 20%, and the age at which inhabitants aged 15 or less take up regular smoking must be increased. The purpose of the Programme is to improve the health of Latvian inhabitants, fundamentally reducing the use of tobacco and protecting them from the harmful effects of tobacco smoke.

The Programme is based on a coordinated inter branch cooperation, anticipating the implementation and performance of events and assignments (38 tasks, 56 activities and 26 institutions involved).

One of the most important instruments for implementation of the programme is amendments to the national legislation.

1) Implementation of a fiscal policy in line with EU Directive 92/79/EEK – with gradual excise duty increases for cigarettes, to reach EU minimal by 2010. With amendments of Law "On Excise duty" Latvia will reach that limit one year earlier, meaning on January 2009.

2) Amendments to the Law *on Restrictions regarding Sale, Advertising and Use of Tobacco Products (with amending law of 22 April 2008).* The aim is to reduce both the number of smokers, and also reduce the harmful effects of passive smoking of non-smokers, by prohibiting smoking in public places and spaces of common use, banning of tobacco advertising and ensuring that tobacco products have health warnings in the form of pictures or pictograms in line with the European Commission Decision 2003/641/EC of 5 September 2003.

Additional measures planned:

1. To prepare The Report on evaluation of compliance of national tobacco control programme with WHO Framework Convention on Tobacco Control (WHO FCTC) and possible improvement of the programme.

2. New *National Cancer Control programme of Latvia 2009 – 2015*, which is in the preparation currently, will contain extra activities in tobacco control – education, training and public awareness.

We see following main measures to decrease the number of young people who are smoking: raise taxes on tobacco, enforce bans on tobacco advertising, promotion and sponsorship and protection from exposure to tobacco smoke, development and implementation of alternative local government programme to avert the taking up of smoking and restrict the use of tobacco products.

Latvia is the party to WHO FCTC since 2005 and actively to take part in Convention development process - participate in the annual Conferences of the Parties (COP) and in the sessions of the Intergovernmental Negotiating Body on a Protocol on Illicit Trade in Tobacco Products (INB).

12. What measures are planned to combat alcoholism and drug addiction?

Latvian *policy on drinking* reduction is based on state program "The Program for Reduction of Alcohol Consumption and Restriction of Alcohol Addiction for 2005-2008". The program was developed on the basis of the objective of the 12th target of the "Public Health Strategy of Latvia" approved by the Cabinet on March 6, 2001, pronouncing that the consumption of absolute alcohol per capita should not exceed 6 litres per year and addressing the age form which regular alcohol consumption is practiced. The goal of the Program is to reduce the country's per capita alcohol consumption and to restrict the harmful effect caused by alcohol to the individual and to society at large.

In 2008, Ministry of Health drafting the new Alcohol program for 2009-2013. The aim of the Programme may be achieved by implementing inter-sectoral cooperation, and implementing three secondary goals:

1. Ensuring a sustainable reduction of the supply for alcohol products by the population as a whole:
   - Combating smuggling and illegal circulation of alcoholic drinks and raw materials;
   - Ensuring high quality alcohol trade conforming to safety requirements;
   - Ensuring better control of smuggling and illegal circulation;
   - Restriction of advertising of alcohol drinks.
2. Achieving the restriction on the availability of alcoholic products, and widely inform the public of the risks associated with the use of alcoholic products:
   - Providing prevention of harmful drinking- widely inform the public of the risks associated with the use of alcoholic products:
   - Involving NGO and self-governmental institutions in prevention activities;
   - Implementation on the national level activities for cultural, environmental, developmental and youth- oriented education and upbringing;
   - Informing the public about the risk of hazardous and harmful drinking;
   - Educating health care specialists on problems of alcohol addiction;
   - Improving the work of the Addiction Services;
   - Foundation of a specialised in-patient addiction ward for children, improving rehabilitation system in country.
3. Ensuring monitoring system on alcohol consumption and the consequences of drinking.
   - Developing and implementation of an information system for the analysis of alcohol indicators;
   - Developing of surveys, proper data collection and processing;

Latvian *policy on drug restriction and the control of drug addiction* is based on state program “State Program for the Restriction and Control of Addiction and The Spread of Narcotic and Psychotropic Substances for 2005-2008”

In 2008, Ministry of the Interior drafting the intermediate program for 2009. In 2009, there will be the evaluation of the Program 2005-2008, whereas according to the results of this evaluation the new program for 2010- 2013 will be based on.

According to intermediate program for 2009 there are several activities planned to combat drug addiction:

1. In the field of legal basis and international collaboration:
   - Ensuring participation of Latvia in various international activities in the field of the spread of drugs and drug addiction;
   - Providing internal evaluation for the Program 2005-2008;
   - According to the evaluation results develop new state program for 2010-2013.
2. In the field of demand reduction:
   - Aligning normative basis for treatment of drug addiction patients, formed and trained teams for inter-sectoral treatment in prison settings;
   - Enlarging substitution treatment in country;

– Organizing informative seminars and courses for representatives of schools and various professions working in the schools;
– Providing medicines and chemical-toxicological examination for children free of charges;

3. In the field of supply reduction:
– Improving structural and functional compositions of custom authorities responsible for combating of drug smuggling;
– Modernising technical basis of low enforcement bodies involved in drug combating;
– Ensuring continuous professional education of all officials in the institutions involved in supply reduction, elaborating new educational methodological materials and manuals;

4. In the field of summarization and evaluation of data:
– Ensuring implementation of the work program of the European monitoring Centre for Drugs and Drug Addiction in the national level;
– Introducing five key indicators for monitoring the situation of the spread of drugs and drug addiction;
– Developing Early warning system on new synthetic drugs by making information exchange mechanism of different involved institutions;

Developing of surveys, proper data collection and processing.

13. Information about water pollution, soil pollution, ionising radiation, about noise and asbestos induced health problems, and the progress achieved during that period.

Information on air pollution, surface water pollution, soil pollution and ionizing radiation in the environment is summarized by the Latvian Environment, Geology and Meteorology Agency (LEGMA) (www.lvgma.gov.lv) within national reports on the state of environment and within different thematic reports on the quality of environment. Additionally, on-line information on air quality is available at the homepage of LEGMA, but information on ionizing radiation in the environment – at the homepage of Radiation Safety (RSC) Centre (www.rdc.gov.lv). LEGMA and RSC are institutions subordinated by the Ministry of Environment.

Besides, information on environmental noise levels is gathered by municipalities in the form of noise maps, when noise is considered as a problem.

The Public Health Agency (PHA) under the Ministry of Health performs drinking water monitoring and bathing water monitoring as well as prepares the related information.

Latvia has introduced national environmental legislation in accordance to European Union's environmental legislation, including working environment.

Set of environmental health indicators has been elaborated in Latvia in 2005.

Information on influence of different environmental factors on human health status (according to self-assessment of respondents involved in the study) will be gained within the study carried out by PHA in 2007-2008.

Environmental health problems and possible solutions are covered by a number of political planning documents: Strategy on Public Health (2001) and its implementation program for 2004-2010, and National Environmental Policy

Plan 2004-2008. During 2008 a new baseline political planning documents on environmental policy as well as on environmental health are elaborated to be anticipated as basis for related action programs in the field of environmental protection and environmental health.

Till 2007 102 municipalities in Latvia have elaborated their local environmental health action plans as a separate documents or constituent parts of other plans or programs.

14. Granting of a residence permit for foreign nationals intending to reside in Latvia more than three month. What are the differences between categories of foreign nationals on access to health care?

Under the Immigration Law Section 5, a third-country national has the right to reside in the Republic of Latvia for more than 90 days within a period of half a year from the date of the first entry, if he or she has received a visa on the basis of Section 11, Paragraph two of this Law or a residence permit.

Under the Immigration Law Section 22, to a third-country national may be issued a temporary residence permit or a permanent residence permit. A temporary residence permit, the period of validity of which exceeds one year, shall be registered annually. A permanent residence permit shall be registered once every five years. A sponsorship shall be approved and temporary residence and permanent residence permits shall be issued, registered and cancelled by the Office in accordance with procedures specified by the Cabinet. A third-country national may submit the documents specified by the Cabinet for a request for a residence permit in the Latvian, English, French, Russian and German languages.

The Immigration Law Section 23 till Section 40 regulates questions about residence permit and a permanent residence permit.

Under the Constitution of Latvia Section 111, the State protects the human health and guarantee the minimum of medical service for everybody.

Under the Medical Treatment Law Section 16 everybody has the right to receive emergency medical care in accordance with procedures prescribed by the Cabinet.

Under the Medical Treatment Law Section 17, the amount of medical treatment services paid from the State basic budget and from the funds of the recipient of services in accordance with the procedures prescribed by the Cabinet shall be provided to:

1) Latvian citizens;

2) Latvian non-citizens;

3) citizens of Member States of the European Union, of European Economic Area states and Swiss Confederation who reside in Latvia in relation to employment or as self-employed persons, as well as the family members thereof;

4) third-country nationals who have a permanent residence permit in Latvia;

5) refugees and persons who have been granted alternative status; and

6) persons detained, arrested and sentenced with deprivation of liberty.

Medical treatment services in the amount referred to in Paragraph one of this Section shall be provided at the time and place where it is necessary, in conformity with the medical practitioner's qualifications and the diagnostic,

medical treatment and equipment for patient care level of the relevant medical treatment institution.

The spouses of Latvian citizens and Latvian non-citizens who have a temporary residence permit in Latvia have the right to receive free of charge the care for pregnant women and birth assistance paid from the State basic budget and from the funds of the recipient of services according to the procedures specified by the Cabinet.

The children of the persons referred to in Paragraph one of this Section have the right to receive free of charge the amount of medical treatment services paid from the State basic budget and from the funds of the recipient of services.

Persons who are not referred to in Paragraphs one, three and four of this Section shall receive medical treatment services for a fee.

15. Meaning of the term “persons in financial difficulty”.

In the Ministerial regulation 1046 of 19 December 2006 Clause 10 are the categories of residents who are free from patient payments and are „persons in financial difficulty”.

Article 13 – The right to social and medical assistance

1. The Committee concludes that the situation in Latvia is not in conformity with Article 13§1 of the Charter on the following grounds:
-the level of social assistance benefits is manifestly inadequate
-the duration of social assistance benefits is restricted to 9 months
-the granting of social assistance benefits to non-nationals is subject to an excessive length of residence requirement

The level of social assistance benefits is manifestly inadequate - The level of GMI is determined and revised each year in connection with the draft annual State budget law by Cabinet of Ministers. GMI level is determined, taking into account financial resources of local municipalities, from which budget GMI benefit is provided.
As to other municipal social assistance benefits, they have not restrictions of amount. Amount of these benefits depend only on financial resources of respective municipality.
In addition, poverty threshold, noted by Committee, Eurostat defines as 60% of median equivalised income. In calculating of poverty threshold the scale of equivalences is used.
As mentioned in Latvia's Report, amount of GMI benefit is calculate, taking into account only person's monetary income not taking into account transfers from other households and the scale of equivalences is not used. Also for calculating of amount of other municipal social assistance benefits the scale of equivalences is not used.
Latvia is not sure that comparison of these two indicators calculate by different methods can be conclusive evidence.

The duration of social assistance benefits is restricted to 9 months - As Latvia noted in the Second Report, GMI benefit is granted for the period no longer than 9 months per year. In cases the income of a person from work gainful activity has increased (unemployed person starts to work), GMI benefit duration can exceed 9 month period, but in reduced amount.
Period of GMI benefit granting is restricted to prevent person's dependence on municipal social assistance benefits and to motivate able bodied persons seek a job.
For another types of municipal benefits mentioned in Latvia's Report granting period is not restricted.

The granting of social assistance benefits to non-nationals is subject to an excessive length of residence requirement - As it was noted in Latvia's Report the right to social assistance have Latvian citizens, non-citizens and aliens with the *exception aliens who have received a temporary residence permit*.
According to *Immigration Law* an alien has the right to request a temporary residence permit in following cases:
1) if he or she is a relative of a Latvian citizen or of a non-citizen of Latvia or of an alien who has received a permanent residence permit,

2) if he or she is an individual merchant or the sole founder of a commercial company, or a representative of a representation of a foreign merchant,
3) if he or she is registered in the commercial register as a member of a partnership who has the right to represent the partnership, a member of the board of directors, a member of the council, proctor; administrator, liquidator or a person who is authorized to represent the activities of a merchant (foreign merchant), which are associated with a branch,
4) if he or she is a employed or self-employed person in Republic of Latvia,
5) for a period of time provided for by the plan of scientific co-operation,
6) for the time period of studies of pupils of educational establishments accredited in the Republic of Latvia or full-time students,
7) for a period of time indicated in the contract of medical treatment,
8) in accordance with procedures prescribed by the Asylum Law he or she is granted alternative status,
9) for a period of time which is necessary for the implementation of such international agreements or projects in which the Republic of Latvia is participating or for the provision of assistance to State or local government authorities of the Republic of Latvia,
10) for a period of time which is necessary for the performance of religious activities,
11) for a period of time for which guardianship or trusteeship is established over him or her,
12) if the alien has joined a cloister registered in accordance with procedures prescribed by regulatory enactments;
13) if residence in the Republic of Latvia is related to pupil or student exchange, practice or apprenticeship in one of the educational establishments of the Republic of Latvia or in a commercial company registered in the commercial register or performance of another task;
14) for a period of time up to the coming into effect of a court judgment regarding divorce and the specification of the children's place of domicile, if the marriage is dissolved and the in the marriage are children who are Latvian citizens or Latvian non-citizens;
15) if it is necessary for pre-trial investigation institutions or a court that the alien reside in the Republic of Latvia until a criminal matter investigation has been finished or adjudicated in a court.
There are determined another financial sources in these cases for providing of persons basic needs in Latvia. These sources must provide financing in level, witch is no requested additional financing through Municipal social assistance.
According to amendments to the Immigration Law of 6 April 2006 a permanent residence permit may be requested by an alien who has continuously resided in Latvia with a temporary residence permit for at least 5 years.
Persons received alternative status according to the Asylum Law since 2007 have right to GMI benefit and shelter services since 2007.

Article 13§3

2. The Committee concludes that the situation in Latvia is not in conformity with Article 13§3 as the granting of social services to non nationals is subject to an excessive length of residence requirement.

As it was noted in Latvia's Report the right to social services (social care and social rehabilitation services, social work) have Latvian citizens, non-citizens and aliens with the exception aliens who have received a temporary residence permit.
According to *Law on Social Services and Social Assistance* the social care service is a set of measures aimed to ensure that the quality of life does not deteriorate for a person who, due to old age or functional disorders, cannot ensure such through his or her own effort. Social rehabilitation service is a set of measures aimed at the renewal or improvement of the social functioning abilities. Purpose of the provision of social rehabilitation services is to prevent or reduce the negative social consequences in the life of a person caused by a disability, incapacity for employment, the serving of a sentence of deprivation of liberty, addiction or violence and other factors.
According to *Immigration Law* (see explanation on 13§1) alien has the right to request a temporary residence permit in cases, which often excludes necessity for social care or social rehabilitation services for aliens received temporary residence permit. Children not accompanied by parents and received alternative status according to the Asylum Law have right to all social care and social rehabilitation services since 2007.
See also reply to the previous question.

Article 13§4

3. The Committee concludes that the situation in Latvia is not in conformity with Article 13§4 as emergency social assistance is not guaranteed to all persons lawfully within the territory.

See explanation on 13§1 ground 3.

Additionally, according to Regulations No.591 issued by the Cabinet of Ministers on 28 July 2008 on "Aliens health insurance" in order to get temporary residence permit as well as applying for short-term or long term visa aliens should provide insurance policy which is valid in the Republic of Latvia and other states of the Schengen agreement. This policy should insure coverage of the expenditures on health care services (emergency medical assistance; medical treatment in hospital of the person in critical condition that is dangerous for the persons' life and health; transportation to the closest medical institution which can fulfill previously mentioned treatment; transportation to the place of residence in case of hard illness or in case of death).

Article 14 Right to benefit from social Welfare services

1. The Committee concludes that the situation in Latvia is not in conformity with Article 14§1 of the Social Charter on the ground that equal treatment for nationals or other states parties to the Charter or to the Revised Charter is not guaranteed with respect to access to social services because of the length of the residence requirement.

See explanation on 13§1 ground 3.

2. 14§2 Public participation in the establishment and maintenance of social Welfare services

There were 312 different social services providers incorporated in register of social service providers on 01.07.2008. 97 of them were non-state providers.