European Social Charter | Charte Sociale Européenne

COUNCIL OF EUROPE | CONSEIL DE L'EUROPE

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EUROPEAN SOCIAL CHARTER OF 1961

8e National Report on the implementation of the European Social Charter of 1961

submitted by

THE GOVERNMENT OF LATVIA

(Articles 11, 13 and 14 for the period 01/01/2008 – 31/12/2011)

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MINISTRY OF WELFARE
OF THE REPUBLIC OF LATVIA

Eighth Report
on the implementation of the
European Social Charter
(Article 11, Article 13 and Article 14)

Riga

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ARTICLE 11: THE RIGHT TO PROTECTION OF HEALTH
ARTICLE 11 PARA. 1

"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:

to remove as far as possible the causes of ill-health;"

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

The leading government authority in the health sector is the Ministry of Health and it is responsible for public health, health care and pharmacy. Ministry's task is to develop and implement national policy to safeguard public health, promote disease prevention by promoting healthy lifestyles, as well as to create conditions for citizens to get cost effective, accessible and qualitative health care services.

Article 111 of the Constitution of the Republic of Latvia states: the State shall protect human health. Likewise, Article 152 of the Treaty Establishing the European Community sets out: a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. In accordance to Article 16 of the Medical Treatment Law: Everybody has the right to receive emergency medical care in accordance with procedures prescribed by the Cabinet of Ministers. According to the Article 17 of the Medical Treatment Law:

(1) the categories that can receive healthcare paid from the State basic budget and from the funds of the recipient of services in accordance with the procedures prescribed by the Cabinet of Ministers: Latvian citizens; Latvian non-citizens; 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; third-country nationals who have a permanent residence permit in Latvia; refugees and persons who have been granted alternative status; persons detained, arrested and sentenced with deprivation of liberty.

(2) Medical treatment services, which are paid from the State basic budget and from the funds of the recipient of services in accordance with the procedures prescribed by the Cabinet of Ministers, 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.

(3) 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 of Ministers.

(4) The children of the persons referred to in Paragraph one (1) of the Article 17 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.

The State Budget Law determines scale of subsidy for health care. Regulation of Cabinet of Ministers No.1046 of 19 December 2006 "Procedures for the Organization and Financing of Health Care" (hereinafter – Regulation No.1046) prescribes:

- The procedures for the organisation and financing of health care;

- The types and amounts of medical treatment services that shall be paid from the State budget;
- The resources of the recipient of services;
- The procedures for the payment of medical treatment services;
- The medical treatment service rates and referred conditions of health care services.

Patient from the State budget and his own co-payments is provided with:

- General practitioner and his team provided health care and preventive visitation once a year;
- Specialist's provided health care;
- Laboratory analysis and medical manipulations with the family doctor's or specialist's referral;
- Health care in the day stationary;
- Home care;
- Assistance of emergency medicine brigade;
- Emergency medical assistance in the hospitals and urgent medical aid posts;
- Health care in the hospitals, which provide 24-hour emergency care, providing specialists' support and necessary examinations;
- Care in the hospitals after treatment phase in the hospitals, which provide 24-hour emergency care, as well as in cases of exacerbation of chronic diseases;
- Rehabilitation after the treatment phase in the hospitals, which provide 24-hour emergency care, or dynamic surveillance of the medical rehabilitation;
- Reimbursed medicines and medical devices.

The patient should pay the amount of own contribution – the patient co-payment. The sum total of patient contributions for outpatient and inpatient health care services within one calendar year shall not exceed 400 LVL. Patient contributions for each hospitalization shall not exceed 250 LVL.

The following categories of residents shall be exempt from a patient contribution:

- children up to 18 years of age;
- pregnant women and women in the period following childbirth up to 42 days, if health care services related to the medical supervision of the pregnancy and during the period following childbirth, as well as to the course of pregnancy, are received;
- politically repressed persons, participants of the National Resistance Movement and persons who suffered during the liquidation of the consequences of the accident at the Chernobyl Atomic Electricity Station;
- poor persons who have been recognised as such in accordance with the regulatory enactments regarding the procedures by which a family or a person living alone shall be recognised as poor;
- tuberculosis patients and patients for whom examinations for the determination of tuberculosis are conducted;
- mentally ill persons, upon the receipt of psychiatric medical treatment;

- patients, upon the receipt of chronic haemodialysis, haemodiafiltration and peritoneal dialysis treatments;
- persons who receive health care services in the cases of such infectious diseases that have been confirmed in a laboratory and are subject to registration in accordance with the regulatory enactments regarding the procedures for the registration of infectious diseases;
- persons to whom emergency medical assistance is provided by emergency medical assistance teams;
- persons who are under the care of State social care centres and local government rest homes (centres);
- all residents for whom a preventative examination is conducted in accordance with the procedures specified of Regulations;
- all residents for whom vaccination (in accordance with the procedures specified in the regulatory enactments regarding vaccination) or passive immuno-therapy (within the framework of the State immunisation programme) is performed etc.

General principles of the reimbursement system of pharmaceuticals are set in the Regulation of Cabinet of Ministers No.899 of 31 October 2006 “Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment”. The reimbursement of pharmaceuticals shall be provided according to the character and severity of the disease. The following reimbursement categories according to the character and severity of the disease are applied: 100%, 75%, 50%. Reimbursed pharmaceuticals are prescribed by family doctors and certain specialists who have agreement regarding the provision of health care services.
In 2009 were made significant changes in health care system within a short period of time. Health care system’s reforms in Latvia included substantial decrease of number of hospitals with parallel development of out-patient health care services. The number of hospitals has decreased from 88 in 2008 till 67 in 2010. At the end of 2011 in Latvia were 70 hospitals. They were closed, merged or reorganized into outpatient clinics. Hospitals’ closure and reorganization lead to considerable decrease of the number of hospital beds. These changes have happened in the states, the self-governmental and the private hospitals. Major structural reforms were carried out, which led to a decrease of the number of staff of the health administration by more than 50% within a period of one year and financial resources which were saved from these reforms were diverted for the patients’ treatment.

In 2010 the unified State Emergency Medical Service was established, as a result indicators of emergency medical care provision were improved, especially in rural areas. A lot of other significant positive aspects of centralized emergency medical care (hereinafter - EMC) system are appreciated - unified organization and planning of EMC provision, effective management of resources, cost effectiveness, unified information system and electronic data base of medical records available for analysis, reporting and making evidence based decisions and more resources to achieve objectives.

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

The implementation of the aims and activities defined by the Public Health Strategy 2002-2010 and its Action Plan for 2004-2010 was regularly monitored, and thematic reports were prepared which allow assessments to be carried out on what has been achieved to date, and to draft the new Public Health Strategy for 2011-2017 as a continuation of the Public Health Strategy 2002-2010. Positive developments have taken place as regards reaching some objectives, morbidity levels with vaccine-preventable diseases have decreased significantly, and breast-feeding indicators have improved; however, the objectives have not been reached. Negative trends have been observed with regard to other objectives, for example, adiposity and morbidity with diabetes have increased.

The average life expectancy of newborns is used as the public health indicator. The general aim of the Public Health Strategy 2002-2010 was to reach 95% of the EU average life expectancy for newborns. The aim was not reached. However, in 2009 the average life expectancy of newborns reached 92% of the EU average life expectancy of newborns. This indicator still significantly falls behind the EU average indicator, since the adjusted mortality indicators due to all causes of death in Latvia were still considerably higher than the EU average. In 2009 the average life expectancy of newborns in the EU was 79.65 years, but in Latvia it was 73.28 years.[1]
Policy document "Healthy Nutrition (2003–2013)"[2] promotes consumption of healthy food in society, envisage informing society on issues related to healthy nutrition and developing nutritional recommendations for different social groups, integrating issues of healthy nutrition in comprehensive secondary education programmes, as well as other measures. The implementation of the aims and activities defined by the policy document "Healthy Nutrition (2003 – 2013)", since 2004 the support program for supplying certain milk products to the students of institutions of comprehensive education, the so-called "School Milk" program, has been available in Latvia. The program is funded by the European Commission and the State and its basic aim is the promotion of a healthy diet and milk consumption among school students. In the 2010/2011 school year the program for supplying fruit and vegetables to schools, or "The School Fruit" scheme, was introduced, with the aim of promoting consumption in fruit and vegetables among school students.

The Framework Policy Document "Improvement of Inhabitants' Mental Health for 2009-2014"[3] was passed with the aim to determine the mental health priorities and to continue rational, efficient and high quality mental health care sector development.

In 2011 the Cabinet of Ministers accepted the Public Health Strategy for 2011-2017[4], which has been developed in order to continue the implementation of the public health policy, which was started by the Public Health Strategy and its Action Plan for 2004-2010, as approved by the Cabinet of Ministers in 2001, to set new development aims and to define specific points of progress in order to reach them, and to maintain, improve and

[1] WHO European Health for all database
[2] Adopted by e Cabinet of Ministers Order No.856 of 10 November 2004
[3] Adopted by the Cabinet of Ministers Order No.468 of 6 August 2008
[4] Approved by the Cabinet of Ministers Order No.504 of 5 October 2011

restore the health status of the Latvian population over the forthcoming seven years. Based on this and previous strategy are developed action plans or programs in different health fields. These action planning documents are more specific with the concrete actions, the responsible institutions and the budget. The aim of the new Public Health Strategy for 2011-2017 is to prolong the healthy life years of the Latvian population and to prevent untimely deaths, while maintaining, improving and restoring health. To be achieved by 2017:

- to increase by two years the healthy years of individuals (from 52.6 healthy life years for men in 2009 to 54.7 years in 2017, and from 55.8 healthy life years for women in 2009 to 57.8 years in 2017);
- to decrease by 20% the potential years of life lost (from 85.338 potential years of life lost among men in 2009 to 68,270 in 2017, and from 35,793 potential years of life lost among women in 2009 to 28,634 in 2017).

To reach the main aim of the public health policy, the following objectives have been set:

- to eliminate injustice in the field of health by implementing measures to ensure equal health opportunities for all Latvian inhabitants;
- to decrease morbidity and mortality from non-infectious diseases, and to decrease the negative impact of risk factors upon the health;
- to improve the health of mother and child, and decrease infant mortality;
- to promote a healthy and safe living and working environment, and to decrease trauma and mortality from external causes;
- to decrease morbidity with infectious diseases among the population;
- to ensure an effective management of the healthcare system and a use of resources, to ensure the optimisation of costs and the sustainability of the healthcare system, as well as ensuring equal access for all Latvian inhabitants to those healthcare services that are paid for from the resources of the State budget.

A number of public health indicators in Latvia (traumatism, premature mortality from cardiovascular diseases, maternal and infant health etc.) still significantly fall behind the European Union average indicators, therefore one of the basic principles of public health policy, included in the Public Health Strategy for 2011-2017, is „health in all policies". It envisages the responsibility of all sectors for safeguarding and improving public health, because, to a large extent, health is determined by factors outside the influence of health sector.

In 2011 the Ministry of Health elaborated „Guidelines for Health Promotion in Municipalities**"**[5] in order to provide local governments with science-based information to implement health promotion in following areas: physical activities; nutrition; prevention of addiction-inducing substances; family health (injury prevention, infectious disease prevention, oral health, reproductive health etc.), and to ensure and to improve development of healthy behaviours and lifestyle for local citizens. The main target groups in health promotion are:

- pre-school and school age children – to maintain positive attitude and understanding among children and adolescents about healthy lifestyle and the impact on health;

[5] Adopted by Ministry of Health Order No.243 of 29 December 2011

- young mothers and families – to develop the healthy environment for pregnant women and young parents;
- adults – to develop healthy working and social environment;
- elderly (65+) – to promote active lifestyle of elderly by increased community involvement and participation.

With the aim to strengthening of primary health care since July 2011 there was starting the implementation of The Program of Voluntary Evaluation of Quality of General Practitioner's (GP) Performance. It is a bonus system when GP receives extra money, when he meet a number of voluntary criteria (total 23), for example, patient has an option to communicate electronically with GP practice, GP practice provides services within four working days, GP practice has a list of patients' smokers and 50% of them has received an advice to quit smoking, percentage of patients who have attended cervical cancer screening according to the State program within the preceding 12 months and others.

In order to implement a national health policy and to achieve the goals of pre-hospital emergency medical care development set in the policy documents (incl. Guidelines "Development of emergency medical assistance service", in force 19/07/2005 – 14/04/2010), on February 1, 2009 an institution with direct administration 'State Emergency Medical Service' was *de jure* established. As a result of gradual merging of EMC providers from 39 local governments and reorganization of public institutions (incl. Center of Disaster Medicine), from 1 July 2010 the unified State Emergency Medical Service (hereinafter - SEMS) provides EMC in all territory of Latvia. Other functions provided by SEMS – call center, medical advice, specialized EMC, disaster preparedness, maintenance of medical reserves, organization of repatriations and medical transfers, supply of medical materials and drugs, training of personnel, plan and coordinate cooperation in case of public health endangerment and in public health emergency situations etc.

During reorganization EMC system management was essentially improved. Number of administrative structures and dispatch centers was sharply reduced. Internationally certified quality management system (ISO 9001:2008) was introduced in the field of disaster medicine and specialized EMC. A lot of other significant positive aspects of centralized EMC system are appreciated - unified organization and planning of EMC provision, effective management of resources, cost effectiveness, unified information system and electronic data base of medical records available for analysis, reporting and making evidence based decisions and more resources to achieve objectives. During the last 3 years a great efforts have been devoted to introduce common regulations, guidelines, qualification assessment and to unify equipment of ambulance teams. In 2010 medical emergency number '113' was established and it is directly linked to SEMS.

The staff of an ambulance team is qualified physicians, doctors' assistants and nurses specialized in EMC. Dispatchers are doctors' assistants and nurses specialized in EMC. Medical consultations for inhabitants as well as for ambulance team leaders are provided by EMC doctors. In 2011 190 ambulance teams performed 459 701 visits.

According to Regulation No.1046 the competent authority organizing emergency medical care in the country, should locate ambulance teams in the service area in a way to ensure provision of EMC after receiving an emergency call (high priority) in 75% of cases – in cities and county towns - no later than 15 minutes after receipt of emergency call and in

the rest of the country - no later than 25 minutes after receipt of emergency call. In 2011 those indicators of operativity were 88.9% in cities and county towns and 79.6% in rural areas.

In 2010 cross border cooperation agreements were signed to improve EMC operativity in Latvia – Estonia border area. Negotiations with Lithuania were initiated.

Pre-hospital EMC for aliens is provided in any life/health threatening situation. Payment for service differs according to the citizenship and status in conformity with legislation (The Medical Treatment Law – Article 17 and Regulation No.1046 – Section XI).

SEMS activities and development are based on following policy documents – the Public health guidelines 2011 – 2017, Development of human resources in health care 2006 – 2015 (*Program*), e-Health in Latvia (*Guidelines*), Government declaration, Latvian Strategic Development Plan 2010 – 2013, The National Development Plan 2014-2020, SEMS investment program 2011 – 2015, SEMS work plan for 2012.

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).

Table no.1

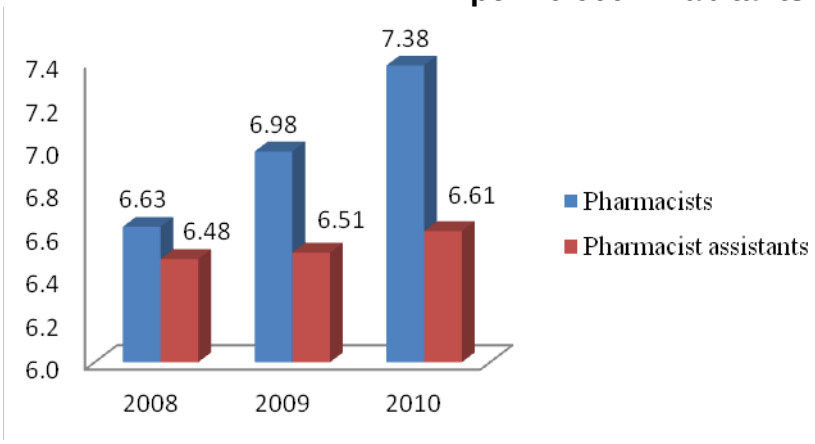
Number of pharmacists, absolute number and per 10 000 inhabitants

	2008 in absolute figures	**per 10 000 inhabitants**	**2009 in absolute figures**	**per 10 000 inhabitants**	**2010 in absolute figures**	**per 10 000 inhabitants**
Pharmacists	*1504*	*6.63*	*1574*	*6.98*	*1654*	*7.38*
Pharmacist assistants	*1469*	*6.48*	*1470*	*6.51*	*1480*	*6.61*
Total:	**2973**	**13.1**	**3044**	**13.49**	**3134**	**13.9**

Data source: Latvian Pharmacists Association

Table no.2

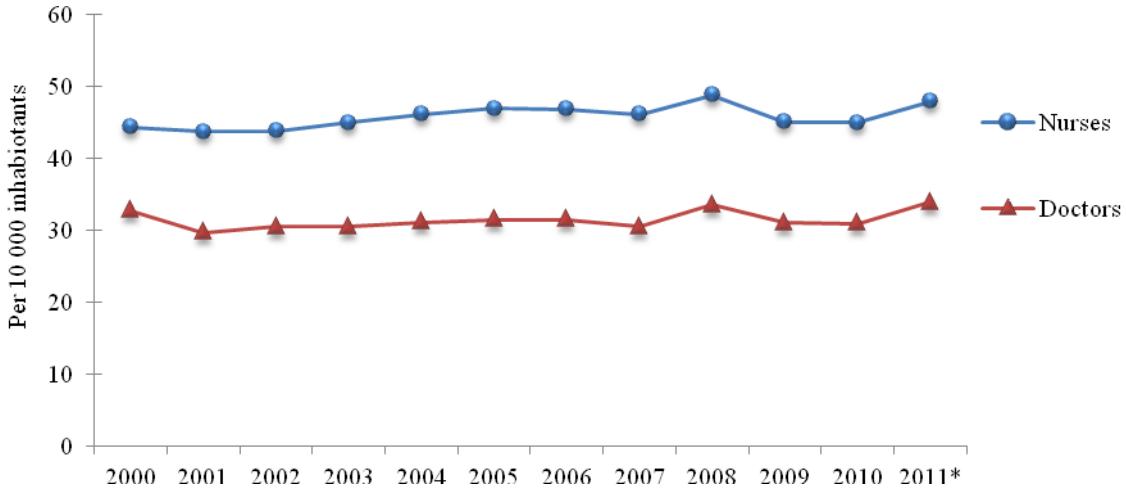
Number of pharmacists and pharmaceutical assistants, per 10 000 inhabitants



Data source: Latvian Pharmacists Association

Table no.3

Number of medical doctors (excluding dentists, but including doctors in service training and resident doctors) and medical nurses, per 10 000 inhabitants

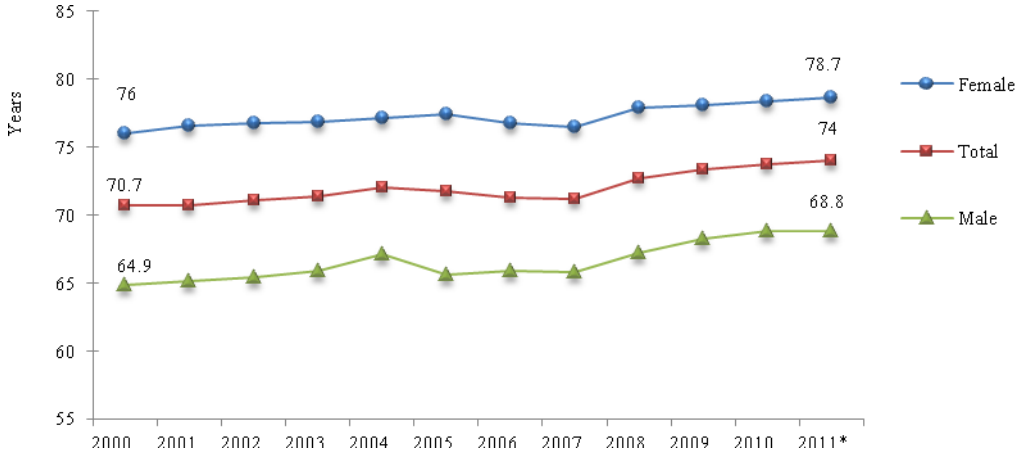


Data source: Centre for Disease Prevention and Control of Latvia

Life expectancy in Latvia is one of the shortest among EU countries. In 2011 in Latvia life expectancy at birth was 68.8 for men and 78.7 for women[6]. This indicator is increasing, gender differences are decreasing, but still life expectancy in Latvia is shorter than EU average, especially for men.

Table no.4

Life expectancy at birth, years



Data source: Central Statistical Bureau of Latvia

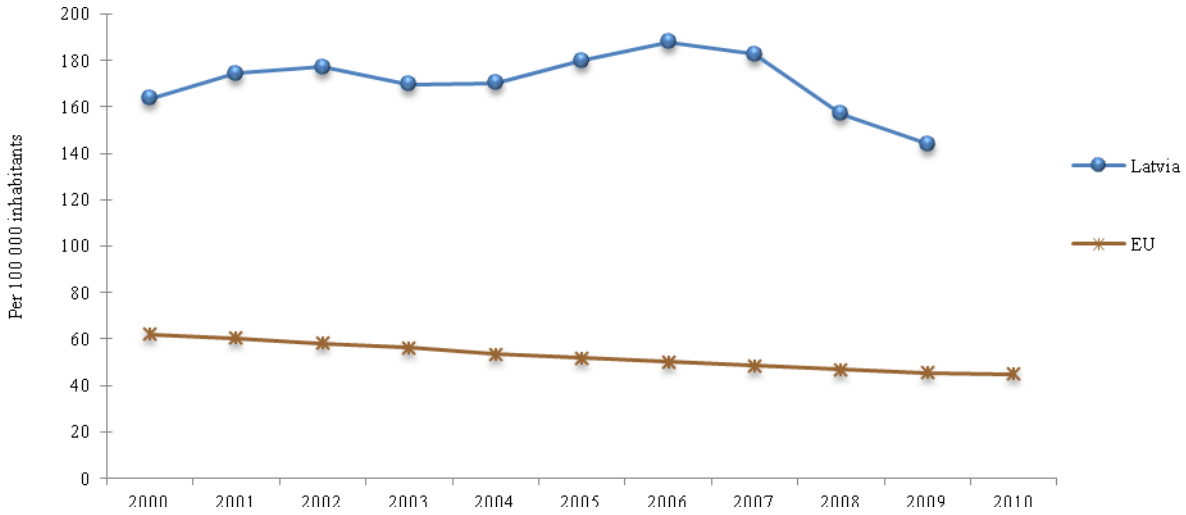
Similar trends are for mortality rate as well. In comparison with other countries of EU, the standardized mortality rate for Latvia is still one of the highest. The standardized mortality rate in 2009 was 952 per 100 000 inhabitants (in EU 27 average 612). The standardized premature (age 0-64) mortality rate in Latvia (415 per 100 000) was almost 2 times higher

[6] Central Statistical Bureau of Latvia

than EU average (217 per 100 000)[7]. Both rates are decreasing in Latvia. Like in the previous years, there are no significant changes in the structure of the main death causes. The main causes of death are diseases of the circulatory system (over one death in two) and cancers (around one death in five). The main problem is high mortality from circulatory diseases under age 64. In Latvia standardized mortality rate from circulatory diseases under 64 is 3 times higher than EU average. In last years it has decreasing trend, both for male and female.

Table no.5

Standardised death rate from circulatory system diseases in age 0-64 years, per 100 000 inhabitants



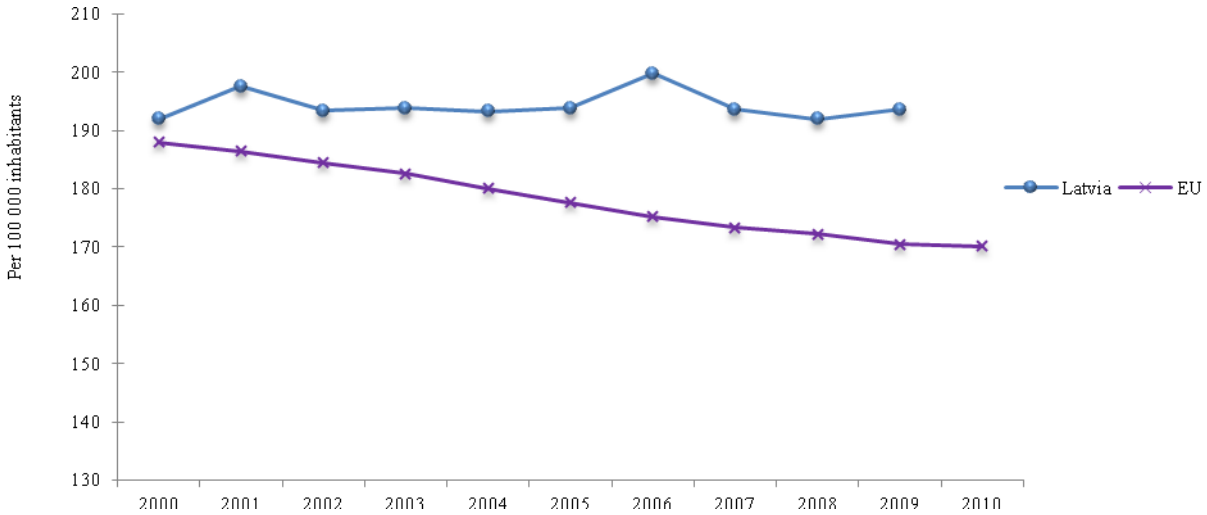
Data source: WHO European Health for All Database

The worst trend is for mortality rate from cancers. There is no decreasing tendency. In Latvia mortality rate from cancers (all ages) even has increased. It is higher than EU average.

[7] WHO European Health for All database

Table no.6

Standardized death rate from malignant neoplasms, per 100 000 inhabitants

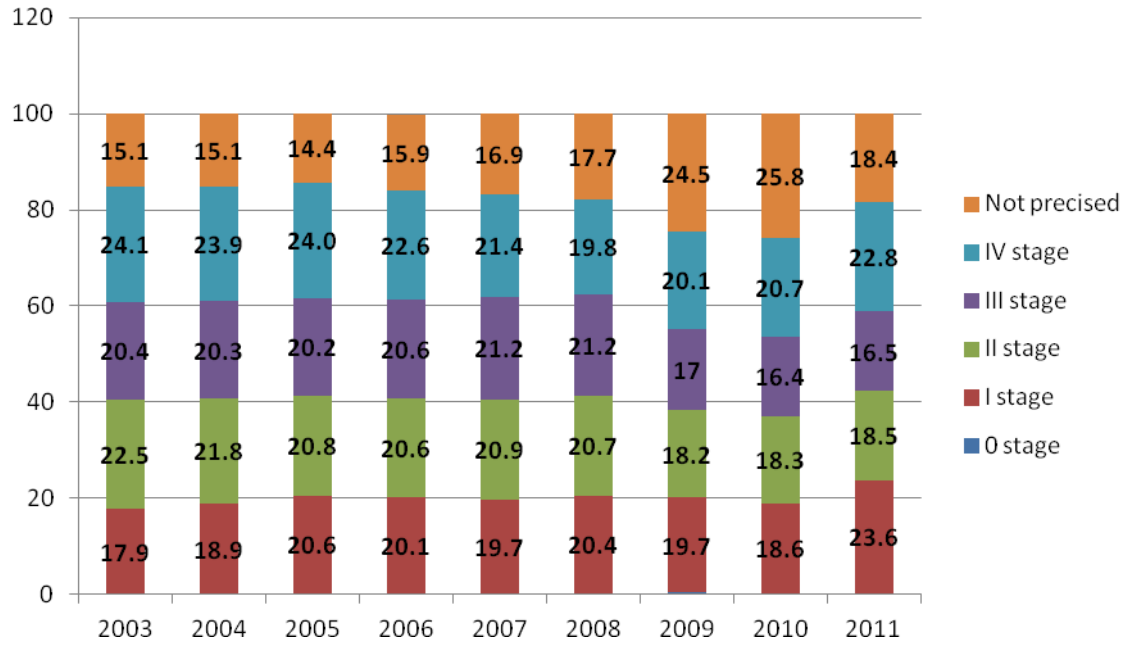


Data source: WHO European Health for All Database

Main problem of this situation is late detection of cancer - approximately 40% of all detected cancers were in III-IV stage.

Table no.7

Proportion of detected cancers by stage, all stages, percents



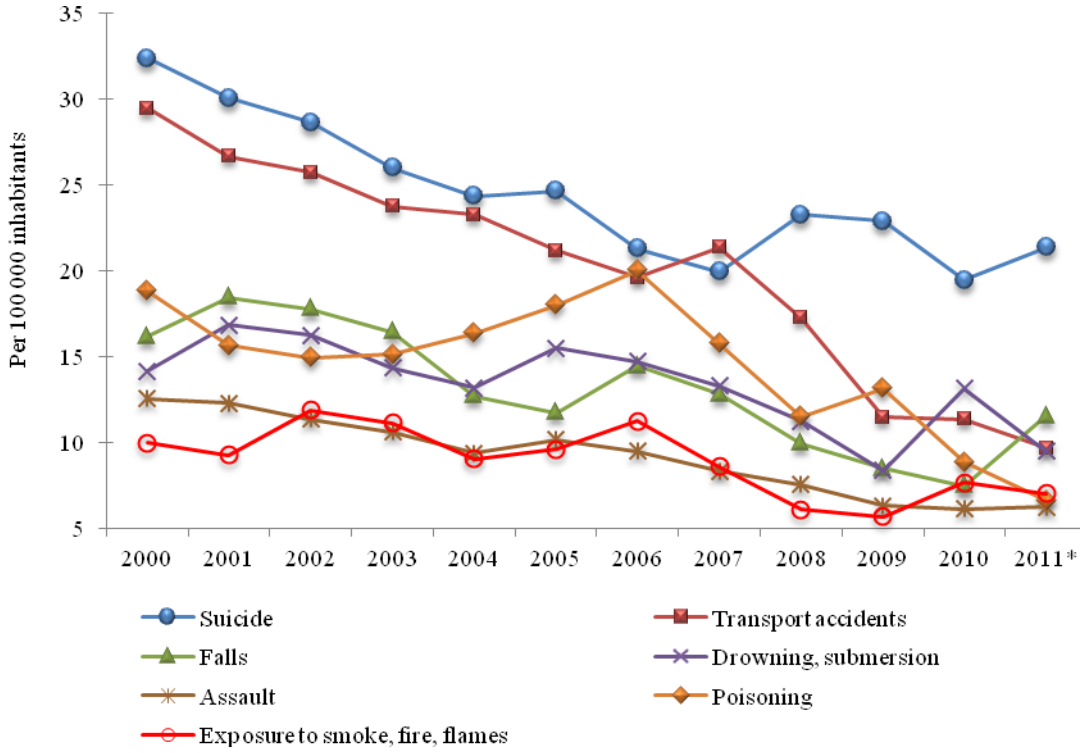
Data source: Register of Patients with Particular Disease, Patients with Cancers, CDPC of Latvia

In spite of the tendency to decrease for external causes of death, it is still the third main cause of death. External causes are main causes of premature deaths (the highest rate of potential years of life lost). Mortality from external causes has the biggest gender difference. 76% of died persons from external cause are male. Suicides make the biggest proportion within external causes of death. In last year's mortality rates from most of

external causes have decreased. Such trend was for suicides as well, but only till 2007. During last year's trend is changing. Now mortality from suicides per 100 000 is higher than mortality rates from other external causes[8]. Latvia is one with the highest suicide rates in EU.

Table no.8

Mortality from external causes, per 100 000 inhabitants



Data source: Register of Causes of Deaths, CDPC of Latvia

Analysis of the healthy life expectancy shows: in 2010 in Latvia the male life expectancy was 77%, but of female –71% (EU 79% male, 75% female). Thus, women in Latvia have a longer life expectancy, but accordingly a smaller proportion of healthy lived years compare with male, similarly to other EU countries. In Latvia total number of healthy life years is one of the smallest in EU. In 2010 it was 56.5 years for female and 53.5 for male[9].

Mainly risk factors of main causes of death are related with lifestyle factors. There are differences in prevalence of these risky behaviours in different groups of inhabitants. Healthier behaviours have women, people from urban areas, and inhabitants with higher educational level and higher incomes. One of the important risk factors is unhealthy nutrition and insufficient physical activity. According survey (2010) data 35.3% of Latvian adults (15-64 years old) only consume fresh vegetables every day (29.3% of men and 41.1% of women). Salt consumption is one of the indicators of healthy eating habits. At the same time 33.1 % of men and 49.8 % of women only do not add salt to food, but almost every tenth man (9.0%) adds salt to food before tasting it, women do that less frequently – 4.3%. Most respondents have insufficient physical activity. Furthermore, 45.3% of men and 34.7% of women only outdoor work hours engage at least 30 minutes

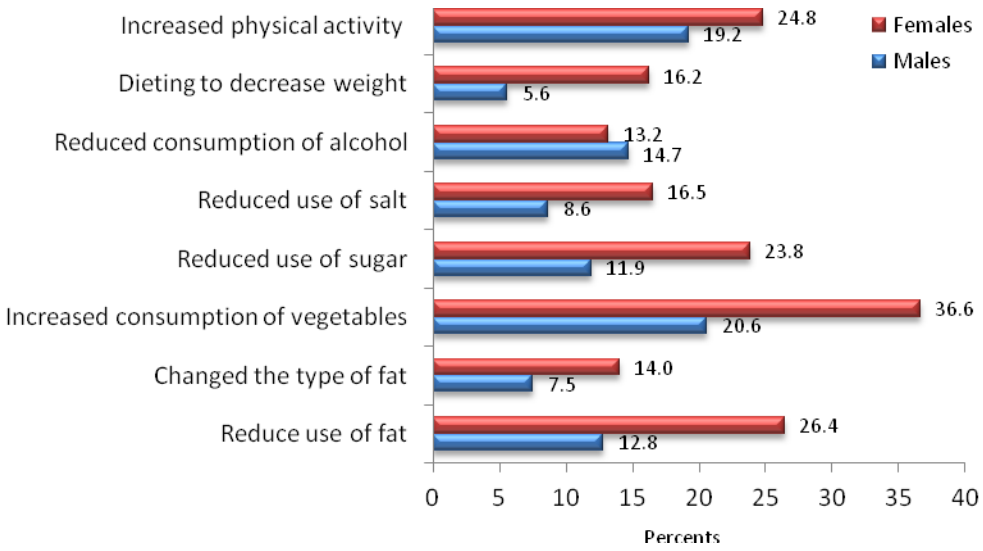
[8] Register of Death Causes of Latvian population, CDPC of Latvia
[9] EUROSTAT Database

and at least 2-3 times a week. Sedentary behaviours among Latvian adult population are prevalent. A total of 41.6% of men and 41.4% of women spend their free time reading or watching TV. As a result of this 29.6% of all respondents are overweight and 15.5% - obese (self-reported BMI)[10].

Data on change of health habits during the last year due to health reasons shows that almost half (46%) of adult population did it. There is a gender difference as well – 38% men and 55% women reported changes in habits. Inhabitants with a higher level of education and from urban areas are more prone to changing their habits. The main changed habits are increasing vegetable consumption (20.6% men, 36.6% women), increasing physical activity (19.2% men, 24.8% women) and reducing fat consumption (12.8% men, 26.4% women). No gender difference in reducing alcohol consumption (14.7% men, 13.2% women)[11].

Table no.9

Reported changes in dietary and other habits during the last year due to health by gender in 2010, percents



Data source: Survey on Health Behaviour among Latvian Adult Population, 2010, COPD of Latvia

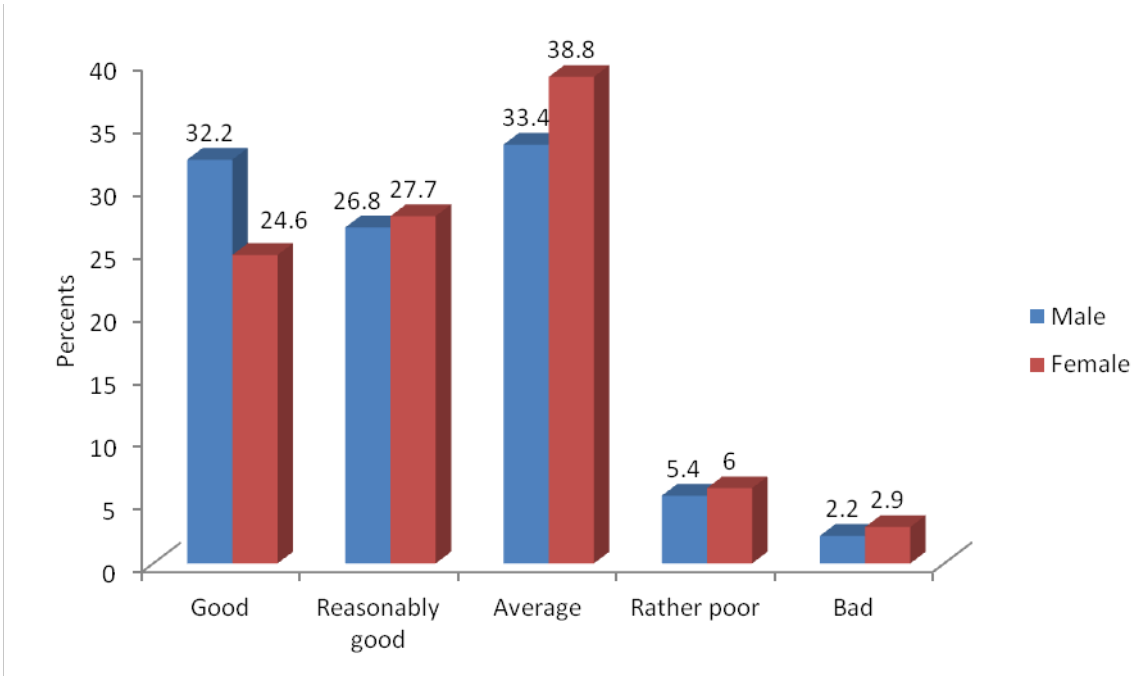
(Data on smoking, alcohol and drug use please see in Article 11 Paragraph 3)

According Survey on Health Behaviour among Latvian Adult Population in 2010 55.6% of adult population assess their health status as good or reasonably good. There are gender and age differences evident in self-assessed health. Men have better health status self-assessment. A total of 32.2% of men and 24.6% of women rate their health status as good[12].

[10] Survey on Health Behaviour among Latvian Adult Population, CDPC of Latvia
[11] Survey on Health Behaviour among Latvian Adult Population, CDPC of Latvia
[12] Health Behaviour Survey among Latvian Adult Population, CDPC of Latvia

Table no.10

Self-assessment of health status by gender in 2010, percents



Data source: Survey on Health Behaviour among Latvian Adult Population, CDPC of Latvia

Comparisons among age groups indicate that dissatisfaction with health status increases with age. Self-assessment of health status is related with place of residence and education level as well. Better health (self-assessed) statuses have mentioned people with higher education level. Less proportion of good or reasonably good health are mentioned by inhabitants living in rural areas. In general there are increasing trend for proportion of inhabitants which assessed their health good.

Opposite trend is for self perceived accessibility to health care. In 2010 unmet needs for medical examination for reasons of barriers of access (too expensive, too far to travel, long waiting list) are mentioned by 15.1% of inhabitants of Latvia (EU – 3.1%). This is the largest proportion from EU countries. Till 2009 this indicator was decreasing[13].

[13] EUROSTAT database, EURO-SILC Survey

Table no.11

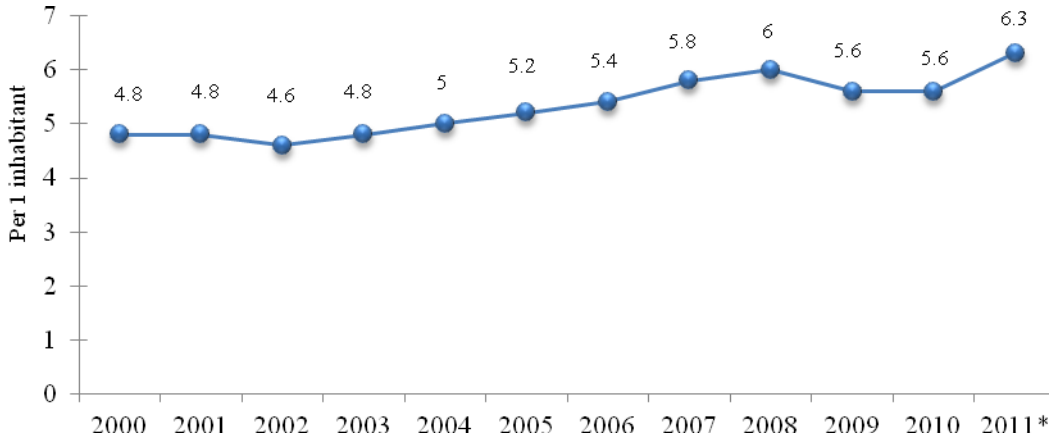
Self-reported unmet needs for medical examination for reasons of barriers of access (too expensive, too far to travel, long waiting list), percents

Data source: EUROSTAT database, EURO-SILC Survey

Indicator of accessibility to health care is out-patients visits to medical doctors (per 1 inhabitant) as well. In 2011 it was 6.3 visits per 1 inhabitant[14].

Table no.12

Out-patient visits to medical doctors per 1 inhabitant



Data source: Centre for Disease Prevention and Control of Latvia

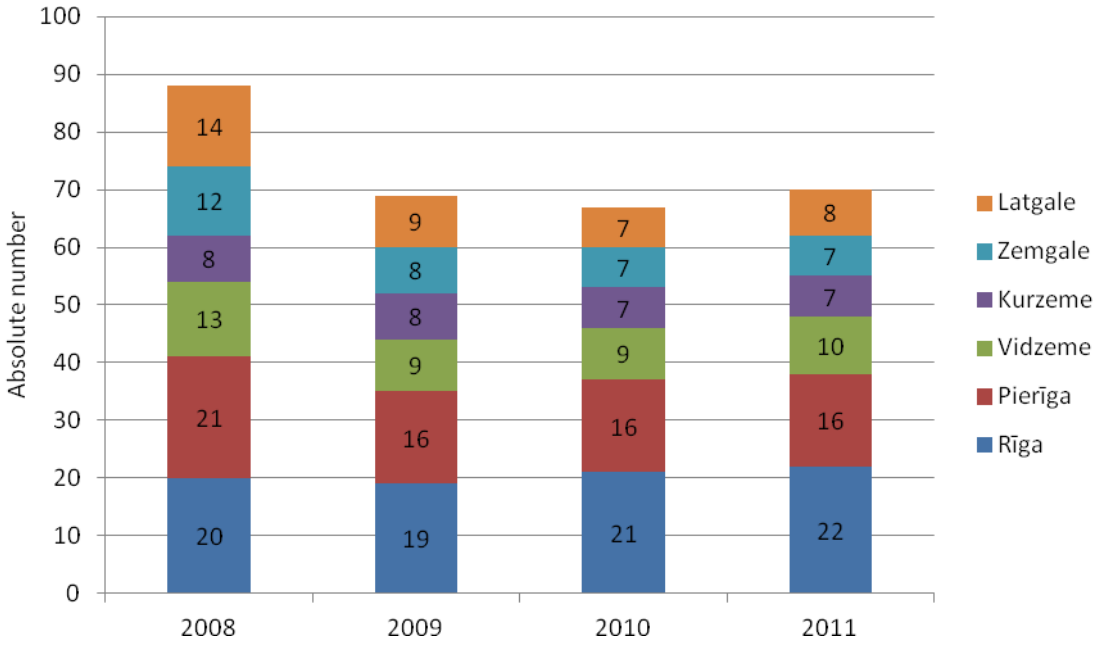
During the last years in Latvia were many reforms in health care system, which resulted in decreasing of proportion of hospital care. The number of hospitals has decreased from 88

[14] Data of Center for Disease Prevention and Control of Latvia

in 2008 till 67 in 2010. At the end of 2011 in Latvia were 70 hospitals. 49 of them provide the State paid health care. In previous years in connection with structural reforms in health care the number of hospitals has decreased[15].

Table no.13

Number of hospitals by statistical region



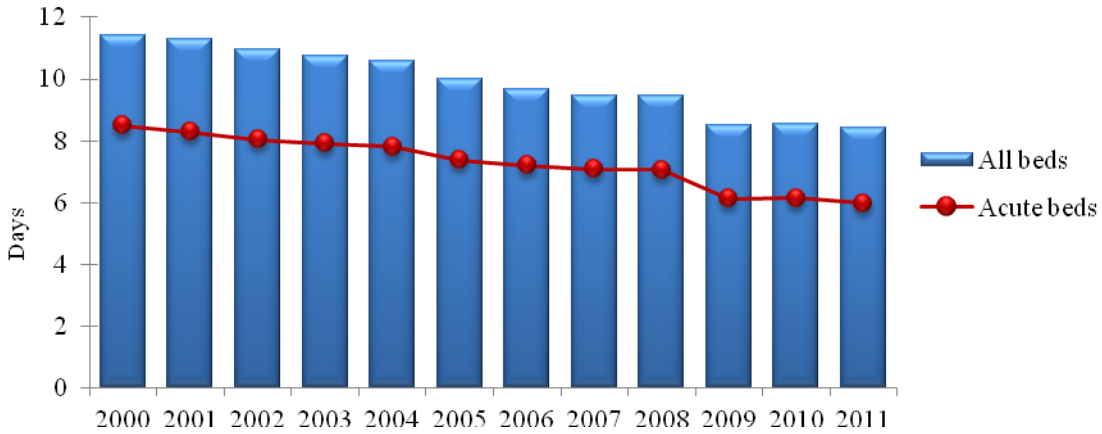
Data source: Centre for Disease Prevention and Control of Latvia

Decreasing trend has the number of in-patients (per 1000 inhabitants) as well. Similar trends have also other indicators of hospital care. Average length of stay in hospital is 8.4 bed days per 1 patient[16]. In spite of decreasing trend still it is one of the highest in EU[17].

[15] Data of Center for Disease Prevention and Control of Latvia
[16] Data of Center for Disease Prevention and Control of Latvia
[17] WHO European Health for All database

Table no.14

Average length of stay in hospital, bed days per 1 patient



Data source: Centre for Disease Prevention and Control of Latvia

During last year's the number of medical persons has decreased as well. These changes are related with reforms in hospital health care – the closure and reorganization of hospitals. The number of medical persons is influenced by reorganization of the public health system as well - closing or reorganizing of different institutions: the Public Health Agency, Medical Professional Education Center, Health Statistics and Medical Technologies State Agency, Compulsory Health Insurance State Agency etc. Partial explanation is the following – socio-economic situation in the country, medical staff emigration from Latvia to work abroad, and part of staff retires. Insufficient number of medical staff and its uneven distribution reduce accessibility of health care services in many regions of Latvia. If in Riga the number of physicians per 10 000 population is much higher than on average in European Union (59 per 10 000 population in Riga in 2010; 33 – in EU countries in 2010[18]), then in remaining territory there are districts where there are almost no physicians – its number per 10 000 population is lower than 20[19].

Table no.15

Number of medical doctors (excluding dentists, but including doctors in service training and resident doctors), per 10 000 inhabitants

	2008	2009	2010	2011*
Latvia	33.6	31.1	31.0	33.7
Riga	66.3	60.1	59.0	64.7
Riga region	15.5	15.3	16.6	15.9
Vidzeme	20.8	19.3	20.6	22.2
Kurzeme	19.5	18.1	18.2	20.2
Zemgale	17.6	16.7	17.2	18.4
Latgale	21.1	20.4	19.0	21.7

Data source: Centre for Disease Prevention and Control of Latvia

According to the policy of primary health care development, the proportion of internists, family doctors, pediatricians has increased during the last years. Nevertheless the number of family doctors per 10 000 population in Latvia is still one of the lowest within

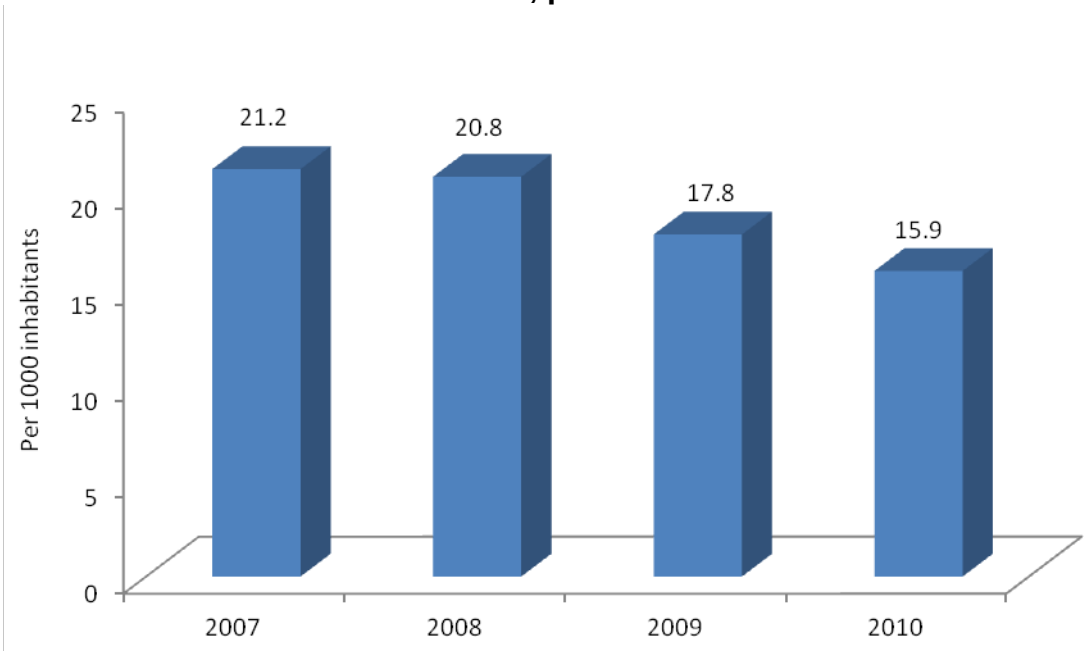
[18] WHO European Health for All database
[19] Data of Center for Disease Prevention and Control of Latvia

EU Member States. It burdens the accessibility to outpatient health care services. In 2010 in Latvia there were 5.8 family doctors per 10 000 population, then on average in EU this rate was 8.7[20].

Injuries are one of the main causes of mortality and disability in early ages. Number (per 1000 inhabitants) of in-patients who treated injury, poisoning and other consequences of external causes in time period from 2008 – 2010 has decreased.

Table no.16

Number of in-patients treated injury, poisoning and other consequences of external causes, per 1000 inhabitants



Data source: Centre for Disease Prevention and Control of Latvia

During last few years more attention is paid to issues related to injury prevention. Data from the Register of Patients with Particular Disease who had suffered injuries show that special attention should be drawn to injury prevention in leisure time, prevention of road traffic accidents and sports injuries. Analyzing the registered injury cases according to the circumstances in which the person was injured the place of occurrence is important showing. School age children's mostly are injured at home, in sports area, transport area and in school. Furthermore 41.4% of all injured children at school are in age of 10 to 14. In all years 2008 – 2011 the proportions of most often registered places of injury occurrence remained similar to each other. Main place, where people are injured, are at home – 45.6% and at transport zones 27.8%[21].

[20] WHO European Health for All database

[21] Register of the Patients with Particular Diseases about Patients who have had Trauma and Injuries, CDPC of Latvia

Table no.17

Injury rate by place of occurrence, percentage

	2008	2009	2010	2011
Home	42.5	36.5	39.7	45.6
Transport area	19.9	20.5	23	27.8
Other	8.5	19	16.1	8.5
Sports area	5.2	4.8	5.1	4.5
Countryside	6.1	4.8	4.3	2.9
Recreational area	3.1	2.6	2	2.1
School	2.2	2.2	2.4	2.2

Data source: Register of Patients with Particular Disease, Register on Injuries, CDPD of Latvia

The main problems in road safety field requiring measures are accidents involving vulnerable traffic participants, drink-driving accidents, speeding accidents, accidents occurring in darkness and twilight. According data from the Road Safety Directorate the number of registered road accidents in last three years has not decreased.

Table no.18

Number of road accidents

	2008	2009	2010	2011
Total road accidents	54323	35058	38343	35181
Total road accidents with victims	4196	3160	3193	3386
Road accidents without victims	50127	31898	35150	31795
Killed in road accidents	316	254	218	179
Injured in road accidents	5408	3930	4023	4224

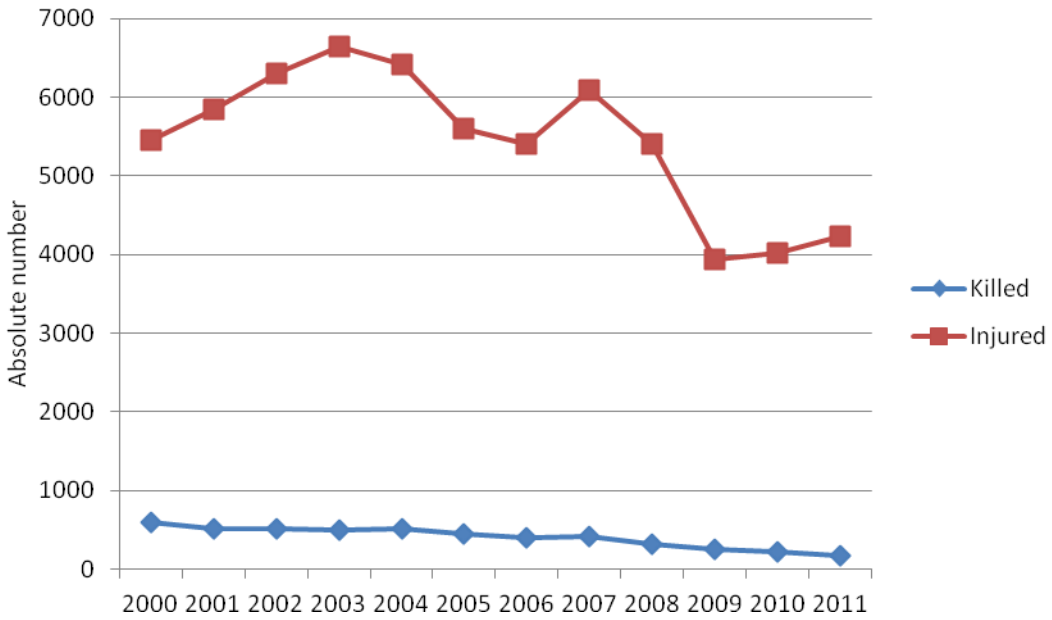
Data source: Road Safety Directorate of Latvia

Road accidents with fatalities has stable decreasing trend[22].

[22] Data of Road Safety Directorate of Latvia

Table no.19

Number of victims in road accidents



Data source: Road Safety Directorate of Latvia

The main achievements in recent years comprise a reduction of the number of alcohol-related accidents and an increase in seatbelt use.

Data from the Latvian State Labour Inspectorate show that the number (per 100 000 employees) of accidents at workplaces is changing in 2009 and 2010. The highest number of accidents was in 2011. In last year's unfortunately it does not have decreasing trend.

Table no.20

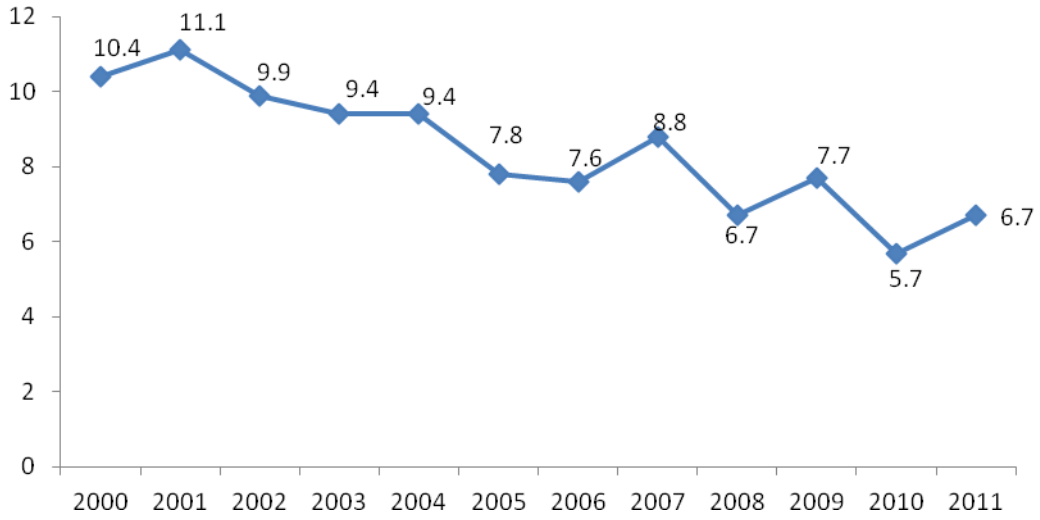
Accidents at work, per 100 000 employees

Data source: State Labour Inspectorate of Latvia

In 2011 infant mortality rate in Latvia was 6.7 per 1000 live births. Long term (ten years) trend of infant mortality is decreasing, but during last year's trend is changing[23]. Still it is much higher than in EU average (4.18 per 1000 live births)[24].

Table no.21

Infant mortality in Latvia, per 1000 live births



Data source: Register of Death Causes of Latvian population, COPD of Latvia

Maternal mortality has changing trend. In 2011 it was only 1 case (not related with pregnancy cause of death). In 2010 were 5 cases, in 2009 – 9, in 2008 – 3 cases. Relative maternal mortality rate is fluctuating because it is per 100 000 live birth (in Latvia are not so many births)[25].

ARTICLE 11 PARA. 2

"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:

to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;"

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

Information on the State budget covered healthcare services is available to everyone at the web-page of National Healthcare Service (institution that is administering the funds that are allocated for healthcare services in Latvia) (www.vmnvd.gov.lv) or by calling to the information line (free of charge) +37180001234. On average, the free of charge information telephone attends to around 120 calls per day. The residents are offered an opportunity to learn about the following:

[23] Data of Center for Disease Prevention and Control of Latvia
[24] WHO European Health for All database
[25] Data of Center for Disease Prevention and Control of Latvia

- what medical services are State-paid;
- the procedure according to which one can receive the medical services guaranteed and provided by the State;
- information about reimbursed medicines;
- the information concerning the expenses of the patient, as well as concerning the categories which release the patient from any payments;
- as well as answers to other questions which are interest concerning health care.

In May, 2011 general practitioners' advisory service was introduced with the aim to consult patients during the time outside family doctor working hours from 7 p.m. to 8 a.m. on weekdays and around the clock during weekends and holidays. This service has been receiving around 2000 calls a month since it was founded, and it increased to 5913 calls a month by March 2012 after a public awareness campaign was carried out at the beginning of 2012. It is designed to provide medical advice when general practitioner offices are closed, preventing unnecessary hospital visits and providing good primary care advice during off hours.

The annual consultations/checkups at the family doctor are offered free of charge for a patient and are covered by the State budget in conformity with the Regulation No.1046.

Secondary healthcare services can be received with a referral from the family doctor or without a referral by addressing the specific practitioner. If the healthcare professional has a contract with the National Health Service, these services are covered by the State budget. Children under 18 do not have to pay the patient payments. Pregnant woman and woman in childbed (till the 42nd day) do not have to pay patient payments if services that are related to pregnancy and postnatal observation are provided. Besides these groups there are other groups, like disabled people, who do not have to pay patient payments in accordance with the Regulation No.1046, Paragraph 10.

Regulation of Cabinet of Ministers No.611 of 25 July 2006 "On the order of provision of puerperal care" defines the information that has to be delivered to a pregnant woman during the consultation, which includes the procedure of care of a pregnant woman, pregnancy and the care of newborn and birth process management.

School medical checkups are organized in accordance with the Regulation of Cabinet of Ministers No.277 of 23 March 2010 "Order in Which Preventive Healthcare has to be Organized for Scholars and the Access of Primary Care in Educational Institutions", which prescribes that the director of educational institution has to organize annual anthropometric, vision, hearing, posture, arterial blood tension, pupillary width and reaction to light and vein checkups as well as movement coordination test.

During 2009 – 2011 Health promotion coordinators were located under institutions of Ministry of Health (2009 - Public Health Agency, 2010 - Health Inspectorate). In 2011 Regional Health promotion coordinators were located directly under the Ministry of Health. Regional Health promotion coordinators have organized informative educational lectures, discussions, competitions, drawing contests, interactive games on such topics as healthy diet, physical activities, sexual and reproductive health etc. for children,

adolescents, parents, adults, the elderly, educational institutions etc. Informative educational lectures, interactive lessons, quizzes and discussions were organized on addiction prevention issues (tobacco, intoxicating substances, computer addiction and drug use) and related health risks (HIV/AIDS). Informative educational lectures, interactive discussions and training sessions for staff, parents, social educators were organized on addiction prevention and related health risks, early addictive substance use among adolescents in schools and family.

Regional health promotion coordinators have organized mass sports events in regions of Latvia, in cooperation with local authorities, educational institutions and NGOs (such as sports day of local governments, sports day of schools, sports day for families with children, bicycling, and mass races, orienteering, board games, street ball and basketball tournaments, cycling, football and volleyball championships for women and men, street relay race, etc.). Also physical activity promotion has been included into children's summer camps (including a camp for disabled children).

Cancer screening programs for early detection of breast, cervix uteri and colorectal cancers are carried out since 2005. In 2009 Latvia started new state paid organized screening program - women’s in defined age group have received personalized invitation to preventive state paid examination. Indicative and clinical data concerning cancer screening is centrally collected and stored in specialized data base. Screening data are used to evaluate and monitor results in order to identify precancerous diseases and cancer at early stage.

Information about screening for illnesses or other preventive examinations is provided by family doctor, specialist or it is sent by post (organized state paid screening: oncocitology, mammography and colorectal examination). With regards to Cervical Cancer screening, the National Health Service is annually sending personal invitations to woman (at the age of 25, 28, 31, 34, 37, 40, 43, 46, 49, 52, 55, 58, 61, 64, 67) for the State budged covered Cervical tests and for mammography examinations (to woman at the age of 50, 52, 54, 56, 58, 60, 62; 64, 66, 68). Above mentioned information is available in internet as well. Some organizations: National Health Service, University Hospital “Rīgas Austrumu Klīniskās universitātes slimnīca”; NGOs: Latvian Cancer Society "Dzīvības koks", Latvia’s Association for Family Planning and Sexual Health “Papardes zieds” etc. have inform about possibilities of free consultations and screenings.

Medical practitioners (doctors, nurses, doctor’s assistants, midwifes) have been educated within the scope of European Social Fund Project „Long term development of lifelong learning for health care and promotion institution’s personnel” in the following programs:

- The principles of organized Cancer screening service conduct for early diagnosis of oncologic diseases.
- Palliative care.
- The application of invasive manipulations on decompensated patients oncological and non- oncological patients in the profile of paediatric practice.
- Home care of patients.
- Malignant tumour in different organs and organ systems and the care of patients in cases of malignant tumour.
- Oncology chemotherapy for the professional development of doctors.

In connection with the scope of mother and child health improvement European Social Fund's project „Long term development of lifelong learning for health care and promotion institution's personnel", medical practitioners (doctors, doctor's assistants, midwifes) have been educated on the health care of newborns and infants in the outpatient practice, independent management of regular pregnancy, the management of regular pregnancy in a primary care medical practice.

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

For early detection of health problems very important are preventive examinations. Health care program for infant prescribes to make 8 preventive examinations for infant per year. Data shows that average number was 6.53 of these examinations in 2010. In age of 1-6 is prescribed 7 preventive examinations during this time. Data shows that in 2010 it was 0.71 times per year (less than prescribed)[26].

There are no significant changes in time according to the information about children's health status (health groups) furnished by the primary care practitioners. Situation in the breakdown by the health groups is the similar as previous years - proportion of 1st health group is decreasing while the 2nd health group is increasing[27].

[26] Data of National Health Service of Latvia
[27] Data of Center for Disease Prevention and Control

Table no.22

Health status of children by health groups, percents

	Year	Children by health groups %		
		I group (healthy)	II group	III group (with chronic conditions)
Newborns	***2008***	58.7	38.2	3.1
	2009	60.2	36.6	3.2
	2010	59.5	37.3	3.2
	2011	59.5	37.5	3.0
One year olds	***2008***	58.0	38.4	3.6
	2009	60.5	36.2	3.3
	2010	59.7	37.0	3.3
	2011	59.6	37.2	3.2
Two years olds	***2008***	58.7	37.7	3.6
	2009	61.1	35.6	3.3
	2010	60.3	36.4	3.3
	2011	59.6	37.0	3.3
Children (3-14)	***2008***	57.6	38.5	3.9
	2009	57.3	38.8	3.9
	2010	57.4	38.8	3.9
	2011	39.4	38.8	3.8
Adolescents (15-17)	***2008***	59.0	37.4	3.6
	2009	58.6	37.7	3.7
	2010	58.2	37.9	3.9
	2011	57.3	39.0	3.7

Data source: Centre for Disease Prevention and Control of Latvia

The results of preventive examination show that the number of eyesight and speech disorders is increasing. In last year's the number of diagnosed cases of scoliosis has decreased for children at all age groups. The results of preventive examinations for adolescents (15-17 years) should be estimated as positive. Only other spinal disorders have increased from 140.3 per 1000 examined children in 2010 to 148.8 in 2011[28].

[28] Data of Center for Disease Prevention and Control

Table no.23

Results of children preventive examinations, percents

	Year	Children (3-14)	From them			Adolescents (15-17)
			Pre-school age	Entering 1st school year	School-children	
Impairing hearing	***2008***	5.0	4.6	4.9	4.8	4.4
	2009	4.5	4.3	4.4	4.3	3.8
	2010	5.3	4.9	5.2	5.2	4.6
	2011	4.8	4.5	4.7	4.6	4.0
Impairing vision	***2008***	99.8	60.7	94.9	123.2	122.8
	2009	94.7	58.1	93.6	117.1	130.0
	2010	92.7	58.4	91.5	114.6	129.1
	2011	94.4	60.3	90.2	117.0	128.4
Logopaedic problems	***2008***	43.1	78.3	67.4	17.5	7.7
	2009	43.4	76.8	64.2	17.6	7.7
	2010	45.8	79.6	65.8	19.4	8.7
	2011	46.0	79.2	69.7	18.9	7.9
Scoliosis	***2008***	38.0	9.6	27.0	55.8	61.7
	2009	35.1	9.5	21.6	52.3	62.7
	2010	36.3	11.7	25.5	53.5	69.4
	2011	34.7	10.5	21.3	52.0	65.6
Other spinal disorders	***2008***	131.4	78.0	149.3	159.9	136.3
	2009	126.3	73.9	138.0	156.7	139.1
	2010	126.1	82.5	136,4	152.2	140.3
	2011	122.3	79.0	142.1	147.2	148.8

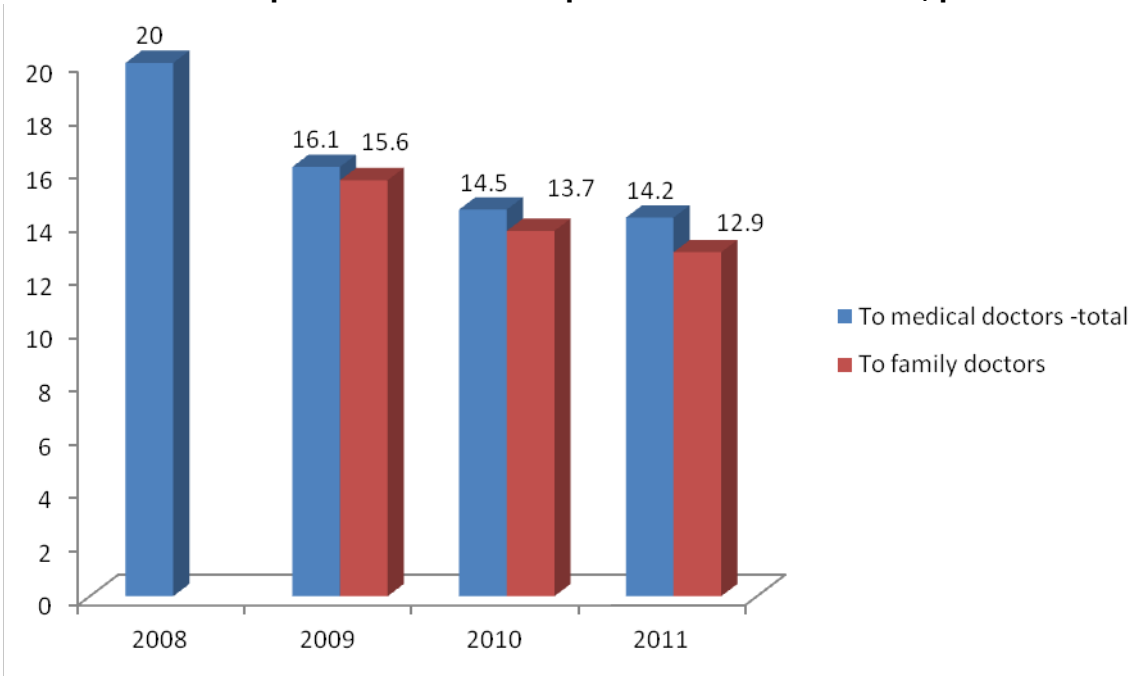
Data source: Centre for Disease Prevention and Control of Latvia

In 2011 statistical data shows that 14.2% from out-patient visits to all medical doctors was preventive examinations. Preventive examinations are in 12.9% from visits to family doctors (GP's practice). This proportion has decreasing trend[29].

[29] Data of Center for Disease Prevention and Control

Table no.24

Out-patients visits with preventive examination, percents



Data source: Centre for Disease Prevention and Control of Latvia

Data on proportion of school aged children (7-18 years) examined preventive during 2010 show that they are only 43% of registered children. This indicator has decreasing trend as well[30].

According survey data (self reported) during the last year a total of 71.9% of women and 61.6% of men have measured their blood pressure. Blood cholesterol level testing has been less prevalent, respectively – 34.7% of women and 25.5% of men. A total of 9.2% of respondents (12.4% of men and 6.1% of women) do not know if their blood cholesterol level has been measured. A total of 37.2% women and 28.1% men have tested the glucose level in blood during the last year[31].
Cancer screening program's data shows that coverage of population which participated in this program is increasing but still it is very low. In 2010 these indicators were 12.67% for cancer of cervix uteri screening, 18.07% for breast cancer screening and 7.57% for colorectal cancer. Real proportion of examined population is higher because these numbers included only defined age group[32].

ARTICLE 11 PARA. 3

"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:

to prevent as far as possible epidemic, endemic and other diseases."

[30] Data of National Health Service of Latvia
[31] Survey on Health Behaviour among Latvian Adult Population, CDPC of Latvia
[32] Data of National Health Service of Latvia

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

The aim of the Program for Controlling Oncological Disease for 2009-2015[33] is to reduce oncological disease morbidity risk, to extend the life expectancy of oncology patients and to improve the quality of life. Program target is attainable through implementation of multidisciplinary and inter-area cooperation and through implementation of the following sub-targets:

- to eliminate or reduce the public impact of the risk factors that cause oncologic diseases;
- to establish and to implement organized Cancer screening program;
- to improve health care service availability for oncological patients;
- to promote public information, patient education and compliance;
- to ensure evidence based and cost effective oncological patient treatment and rehabilitation;
- to establish a comprehensive and available palliative care system;
- to ensure comprehensive methodological care of the entire oncology area.

The main institutions in the field of surveillance, early warning, prevention, and control of communicable diseases in Latvia are the Centre for Disease Prevention and Control (CDPC) and State Emergency Medical Service. CDPC is a government institution under the Ministry of Health. After several reforms in time period 2008-2011, it has taken over the functions in areas of infectious diseases. CDPC is now responsible for threat detection, control, prevention and national surveillance of all communicable diseases, including STI, HIV/AIDS and tuberculosis, as well as overseeing the national immunisation programme. CDPC participated in scientific projects, preparing of guidelines and providing of training. CDPC is the national competent body for collaboration with European Centre for Disease Prevention and Control (ECDC) as well as the focal point for EU Early Warning and Response System (EWRS).

The State Emergency Medical Service is responsible for coordination of emergency management for public health threats, and acts as WHO liaison point for International Health Regulations.

The Latvian communicable disease surveillance and control system is organised according to the Epidemiological Safety Law adopted in 1997. The purpose of this law is to regulate epidemiological safety and specify the rights and duties of state authorities, local governments, and natural and legal persons in the field of epidemiological safety, to determine liability for the violation of this law. There are specific regulations issued by the Cabinet of Ministers for surveillance, prevention and control of communicable diseases as well.[34]

[33] Adopted by the Cabinet of Ministers Order No.48 of 29 January 2009

[34] Regulation of Cabinet of Ministers No.7 of 5 January 1999; Regulation of Cabinet of Ministers No.330 of 26 September 2000; Regulation of Cabinet of Ministers No.413 of 14 June 2005; Regulation of Cabinet of Ministers No.328 of 13 May 2008; Regulation of Cabinet of Ministers No.948 of 21 November 2006

In 2008 State immunisation plan for 2008-2010 was adopted[35], which prescribes immunisation against 13 diseases. Mostly from these diseases suffer children or these diseases make burden to public health, e.g. diphtheria, rabies, against which are vaccinated adults as well.

Since last year Calendar of Immunisation is enlarged with new vaccines: against pneumococcal infection (*S.pneumoniae*), against human papillomavirus (prevention of cancer cervix uteri), new vaccines with many components (for decreasing of vaccination times, visits, decreasing of load of primary health care and expenditure).

CDPC is responsible for overview and coordination of the Immunization State Plan: collection, error checking, collation and generalization of the monthly reports on vaccinations prepared by epidemiologists, preparation of monthly vaccines requests for vaccines wholesalers, monitoring and coordination of investigation if necessary.

In 2009 in order to limit the spread of HIV infection and reduce new HIV positive cases, the Ministry of Health of Republic of Latvia has elaborated the "Programme for Limiting the Spread of Human Immunodeficiency Virus (HIV) (2009-2013) (hereinafter – Programme)"[36]. The main targets of the Programme are:

- prevention of new HIV positive cases in the target groups;
- implementation of large-scale HIV prevention measures;
- better availability of health care services for HIV positive persons and AIDS patients;
- promotion of evidence-based planning and management of HIV prevention measures;
- increased scale and better co-ordination of measures for reducing HIV prevalence.

To reach the main targets of the Programme, the following points of progress have been set:

1. Provide for voluntary HIV testing with pre-test and post-test advice:

- 58826 HIV tests were performed in 2010 and 58799 HIV tests were performed in 2011 in laboratories (excluding blood donor testing) and HIV counselling points;
- 2506 HIV tests were performed for prison inmates in 2010 (2160 in 2009; 3301 in 2008).

2. Provide for syringe exchange and other means of individual protection and prevention among injecting drug users (harm reduction measures):

- There were 18 HIV counselling points operating in 16 cities in Latvia in 2010 and 2011. Street work has been carried out in 9 cities, mobile units has been active in 3 of those cities. In addition to other services, as a part of harm reduction measures, HIV rapid testing has been performed in most of HIV counselling points. In 2011, there were 779 HIV rapid tests performed for IDUs, of which 79 HIV tests were positive (71 positive tests of 1114 HIV rapid tests performed in 2010). HIV counselling points distributed 310 774 syringes in 2010 and 338 473 syringes in 2011. The number of collected syringes has increased from 242 555 in 2009 to 336 887 syringes in 2010, however, there were 260 282 syringes collected in 2011. The number of new HIV counselling points' clients also has increased from 4474 in 2009 to 4629 in 2010 with decrease in 2011 (3 830 new clients).

3. Trainings for HIV Prevention network staff and NGO representatives, prison health care staff, nurses, social workers etc.:

[35] Adopted by the Cabinet of Ministers Order No.43 of 31 January 2008

[36] Adopted by the Cabinet of Ministers Order No.437 of 30 June 2009

- A workshop "Voluntary testing - information on HIV, HCV, HBsAg, syphilis rapid tests, practical trainings of testing" was held in 2011;

4. Improve public awareness:

- World AIDS day activities to raise awareness of HIV/AIDS was organised;
- Conference for healthcare workers "HIV/ AIDS and STI epidemiological and clinical aspects" was organised in 2010;
- 4461 consultations in 2010 and 3750 consultations in 2011 were provided for visitors of HIV counselling points (MSM. SW, HIV positive persons, IDUs' sex partners etc.);
- A 24/7 AIDS information hotline providing information and psychological assistance to HIV positive persons and persons related to them has been maintained;
- "Guidelines for Municipalities in Health Promotion" which includes issues related to prevention of HIV/AIDS was developed in 2011;
- Brochures "HIV, hepatitis B and C" (2010), "Sexually transmitted infections" (2011), “HIV ABC” (2012) were printed.

5. Find out the prevalence of HIV infection, other infections and the related risk factors in target groups exposed to a HIV infection risk:

- "EMIS - The European MSM Internet survey" was carried out in 2010;
- HIV/AIDS and STIs Bio-Behavioural Surveillance Survey (BBSS) among Sex Workers" was carried out in 2011.

6. Provision of treatment to in case of HIV/TB co-infection:

- Provision of treatment to patients with HIV/TB co-infection tends to be integrated. According to the Regulation of Cabinet of Ministers No.413 of 14 June 2005 „Procedures by which Mandatory Medical and Laboratory Examination, Mandatory and Forcible Isolation and Treatment of Persons in Cases of Infectious Diseases Shall Be Performed" patients who have been diagnosed with HIV shall be tested for HIV and vice versa since 2009;
- In order to maintain IDUs' adherence to TB treatment, substitution therapy and needle exchange are provided at the Centre for TB and Lung diseases of Riga East Clinical hospital. Harm reduction services and HIV counselling is available in Outpatient department of Riga of Centre for TB and Lung diseases of Riga East Clinical hospital.

EU legislative acts and the obligations contained in the WHO Framework Convention on Tobacco Control (FCTC) have significant influence on how Latvian legislation is being developed. The FCTC was signed by Latvia on 10 May 2004 and ratified on 10 February 2005. Latvian legislation relating to tobacco control has been developed since 1999 and covers most of the provisions needed to develop a comprehensive tobacco control policy. The main legislative acts in this area:

- “Law on Restrictions Regarding Sale, Advertising and Use of Tobacco Products”. The purpose of the law is to protect people's health and their right to a clean, unpolluted environment, free from tobacco smoke; to provide a format for the packaging of tobacco products and restrictions on their distribution, and to provide a procedure by which the state controls the distribution of tobacco and tobacco products, the advertising of tobacco products, sponsorship and smoking in public buildings, structures, spaces, and territories. Smoking is banned in all public places with just several exceptions:
  - In summer (open air) cafes only in specially designated smoking areas.
  - In casinos and gaming halls it shall only be allowed to smoke in premises specially designated for smoking or in premises, which are separated for smoking.
  - Hotels and other short-term residence dwellings may have specially

designated bedrooms in which it is permitted to smoke.

- "Law on Excise Duties". The rates of excise duty applicable to tobacco products are stipulated in the Law.
- "Administrative Offences Code". Sanctions are provided in the Code for offences related to trading, for the trading of tobacco products in prohibited areas, breaches of the regulations relating to advertising, and breaches related to the storage and distribution of tobacco products.

From 2006 to 2010 the "Tobacco Monitoring Programme 2006 – 2010" was the main tobacco policy document. This Programme was prepared based on Target 12 of the Public Health Strategy 2001-2010: that the rate of daily 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 was to improve the health of Latvian inhabitants, fundamentally reducing the use of tobacco and protecting them from the harmful effects of tobacco smoke.

Tobacco policy in Latvia has been based on the task to strengthen and promote all measures aimed at controlling tobacco and inhibiting smoking, in particular: to implement the requirements of the WHO Framework Convention on Tobacco Control; to transpose European Union directives into legislation and their implementation in practice; to increase excise tax on cigarettes to the European Union level; to ensure effective primary health care for persons who wish to quit smoking, paying particular attention to pregnant women and couples who are planning to increase their family, and including adolescents younger than 15, and adolescents to the age of 18 years; to promote an educational school programme for children and adolescents on the harmful effects of smoking on health, and develop practical skills in order to choose a healthy lifestyle.

The Public Health Strategy for 2011-2017 set objectives for next planning period. One of them is "to decrease morbidity and mortality from non-infectious diseases, decreasing the negative impact of risk factors upon health". One of the tasks for achieving it is "continue implementing united policy to decrease the use of various addiction inducing substances (tobacco products, alcohol, drugs) in society by improving inhabitants' knowledge about the adverse effect of these substances upon health, by restricting advertising and accessibility, developing legal acts to regulate the distribution of new tobacco products".

In 2003 the National alcohol restriction council was established. One of the main tasks of the council is the coordination of state and local government institution actions in the field of alcoholism restriction. There are representatives from different ministries, non-governmental institutions, private sector etc. Council meetings are held regularly, current issues regarding reduction of harmful consequences of alcohol use, proposed legislation and alcohol control programs are discussed.

On October 2008 the Ministry of Health started the implementation of the European Social Fund's (ESF) action program "Human resources and occupation" project "Health care and health promotion in the process of further education of institutions involved in the sector for sustainable development", and a within it, the education program "Mental health and dependent patient care multidisciplinary team". This program runs till September 2011. Within the framework of the project the knowledge of general practitioners, physician assistants, nurses on addiction problems and how to solve them is improved, training on how to detect addicted patients and provide patient care within a

multidisciplinary team, detection of main types of mental health disorders and their connection to addictions, analyzing of addictions symptoms, their classification, main types of addiction inducing substances, treatment and patient care options is provided. Within the training of health care staff, the provision of early interventions is highlighted.

Still the priorities of reducing alcohol consumption and restricting alcohol addiction in Latvia are:

- reduction of the prevalence of regular alcohol consumption, especially among young people;
- reduction of the frequency of grave consequences of harmful drinking (reduction of alcohol related road accidents, accidents in the working environment and violent crime).

In 2011 the Cabinet of Ministers approved the new Drug Program[37] - framework policy document for limiting drugs and psychotropic substances and the spread of addiction and control for 2011 – 2017, which was developed by Ministry of the Interior. The Program objective is to reduce the availability of illegal drugs and psychotropic substances, the acceptability of their use by society, and the harm done in society by their use, by improving the quality of health care services provided to drug patients and drug users.

Taken into account in developing the Program were the evaluation results and recommendations for the previous National Drug Program 2005–2008, as well as proposals from social organizations and institutions responsible for the development and implementation of the Program, and their experts. Three main lines of action are put forward for achieving the objectives defined in the Drug Program for 2011-2017: 1) prevention of drug addiction and drug use, 2) health care of drug users and drug addicts and 3) reduction of drug availability. These action lines include measures for which the coordination and monitoring of implementation is proposed by means of interdisciplinary action-policy coordination and information gathering and analysis. The authorities stipulated as having responsibility for implementation of tasks set in the Drug Program are the Ministry of Defense, the Ministry of Finance, the Ministry of Education and Science, Ministry of the Interior, the Ministry of Welfare, the Ministry of Justice and the Ministry of Health. The institution responsible for monitoring performance under the Drug Program is the Ministry of the Interior.

The prevention of dependence and use of drugs has been identified as one of the four main pillars for achieving the objectives of the Program. As in previous years, activities in the drugs field are integrated into broader health promotion activities and are carried out in a decentralized manner, i.e. each local government undertakes preventive work within the constraints of its own capacity and funding. In most cases, prevention activities are aimed at the dissemination of information.

In 2010 several awareness campaigns were undertaken nationally, mainly in the field of legal drugs (tobacco, alcohol).

In order to establish the basis for environmental quality conservation and restoration, as well as the sustainable of natural resources, while limiting the harmful impact of environmental factors on human health, in 2009 was approved Environmental Policy

[37] Adopted by the Cabinet of Ministers, Order No.98, of 14 March 2011

Strategy 2009–2015[38], which was developed by Ministry of Environmental Protection and Regional Development. It deals with different aspects associated to environment including air pollution, water pollution, noise pollution and soil pollution. It sets the general framework for coping with these problems in terms of necessary improvement of legislation and action programs.

In addition, Public Health Strategy for 2011-2017 Chapter 3.4 “A healthy and safe environment” reflects the main problems and necessary future steps with respect to environmental health issues associated to environmental pollution. The investigation “The impact of environmental factors upon health Latvian population survey” performed by the state agency “Public Health Agency” and published in 2008 is showing that a number of environmental factors and their possible influence on public health has been improved or at least not worsened compared to 2000 survey. This is true concerning air quality and drinking water quality, too. Nevertheless, it shall be mentioned that for 37 % of the Latvian population noise is a hindrance in their places of residence - especially in Riga, where 46 % of inhabitants suffer from excessive noise. Traffic is the most often mentioned cause of noise by inhabitants (76 % of cases). Besides, the Latvian capital city and the biggest city Riga has air quality problems with regard to elevated PM_{10} and NO_2 concentrations.

In order to solve these air quality problems, the newest Action Program on Improvement of Air Quality in Riga for 2011-2015[39] is approved by the Riga City Council. In addition, the Action Program on Minimizing of Environmental Noise in Riga[40] is approved by the Riga City Council determining the actions to be carried during 2011-2019. In general, the air quality and environmental noise problems are not expressed in other parts of Latvia.

As regards the general water pollution and quality, the River Basin District Management Plans[41] separately for Daugava, Gauja, Lielupe and Venta River Basin Districts have been approved in 2010. These River Basin District Management Plans are elaborated according to requirements laid down by the Directive 2000/60/EC of the European Parliament and of the Council establishing a framework for the Community action in the field of water policy (Water Framework Directive). Management Plans envisage actions to be performed until 2015 in order to achieve at least good ecological quality of all water bodies delineated in the country. Besides, soil pollution problems (elimination of polluted or potentially polluted sites in the river basin districts) are addressed within the mentioned Management Plans, too.

Since 2008, Latvia has implemented the EU Bathing Water Directive (2006/7/EC) setting new criteria and approach for assessment of bathing water quality. The mentioned directive was transposed into national legislation by the Regulation of Cabinet of Ministers No.608 of 6 July 2010 “Regulations Regarding Monitoring of Bathing Water, Quality Assurance and Requirements for Informing the Public”. According to the assessment for 2008-2011, 93 % of Latvian bathing places are in excellent, good or sufficient quality status complying with 2006/7/EC criteria to be reached by 2015.

Concerning drinking water quality, the steadily improvement of its chemical status has been shown during 2008-2011 (from 60.7 % of inadequate samples to 32 % with respect

[38] Approved by the Cabinet of Ministers Order No.517 of 31 July 2009
[39] Approved by the Riga City Council Resolution No.3285 of 7 June 2011
[40] Approved by the Riga City Council Resolution No.168 of 28 February 2012
[41] Approved by the Minister for Environment Order No.143 of 6 May 2010

to EU Drinking Water Directive (98/83/EK) criteria). In its turn, the microbiological quality is fluctuating within the range 3.6-6.3 % of inadequate samples. It shall be stressed that the chemical quality of drinking water is mainly determined by naturally elevated concentrations of iron and sulphates in the groundwater, no dangerous substances have been found.

Regarding asbestos the placing on the market and use of these fibres and of articles containing these fibres added intentionally are prohibited in Latvia in compliance with REACH criteria. The use of articles containing asbestos fibres which were already installed and/or in service before 1 January 2005 continue to be permitted until they will reach the end of their service life, as it is allowed by the REACH.

With respect to ionising radiation, the "umbrella" law - Law on radiation and nuclear safety was adopted by Parliament of Latvia in 2000 followed by a number of amendments up to 2011. Regulation of Cabinet of Ministers No.723 of 20 September 2011 "Licensing of activities concerning sources of ionising radiation" determine activities with sources of ionizing radiation which does not require a special permit (license) because human behavior can not influence the actions or potential dose of ionizing radiation exposure and the exposure is so low that from the point of view of radiation safety, it can be ignored.

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.

According the Health Behaviour Survey of Latvian Adult Population in 2010 47.4% of male and 20.7% of female aged 15 – 64 were daily smokers, 14.2% of male and 3.3% of female are exposed to tobacco smoke at workplace more than 1 hour per day. At home 51.1% of male and 38.5% of female are exposed to passive smoking. During last 12 years there is slight decrease in daily smoking rate among male and no change in female. Passive smoking rate at workplace has decreased substantially (in 1998 it was 36.4 % for male and 16.5% for female). There is also significant decrease of passive smoking rate at home which is more pronounced for female[42].

According to the Health Behaviour Survey of School-Aged Children in 2010 weekly smoking rate for boys of age 15 was 32% and for girls 22.1%. The trends since 1991 have been increasing, especially for girls[43].

In general, indicators of alcohol consumption by the population in Latvia are moderately high, if compared to other European countries. In 2010 the consumption of absolute alcohol per capita was 6 litres, but calculating per capita consumption among the population of age of 15 and older – 7 litres. Trend of this indicator was increasing till 2008 and decreased in 2009[44]. However these data shows legal registered alcohol consumption only. The registered consumption of legal alcohol comprises the registered alcohol produced and sold in the state, as well as data on foreign alcohol trade. It is problematic to calculate unregistered or illegal alcohol consumption, because it is not counted. From different sources illegal alcohol could be 16-30% from total consumption.

[42] Health Behaviour Survey of Latvian Adult Population, CDPC of Latvia
[43] Health Behaviour Survey of School-Aged Children, CDPC of Latvia
[44] Central Statistical Bureau of Latvia

According survey data men showed tendency to drink every week; women reported only several drinking cases per month. Excessive alcohol drinking — 60 grams of absolute alcohol during one occasion — was practiced by 43.7% of 15–64 years olds during past year. Risky alcohol consumption more often can be linked to men, people between 25 and 54 years old. Even more risky drinking — having 120 and more grams of absolute alcohol in one occasion and at least once a week — was practiced by 20% of all population at ages 15 to 64[45].

According ESPAD survey girls slightly more often have used any alcohol beverage over the lifetime, last year and last month as compared with boys, while boys more often than girls mention higher quantities and regularity. Almost all (96%) of students of age of 15–16 have tried any alcoholic beverage, 87% have drunk alcohol over the last 12 months, while around two-thirds (67%) have used alcohol over the last 30 days. Risky single occasion drinking or consumption of 60 or more grams of absolute alcohol (e.g. 1.5 litres of beer, 750 ml of wine or 200 ml of spirits) is rather prevalent among school children in Latvia, and such drinking pattern has slightly decreased as compared with 2007 survey. In 2011, about one-half (49%) of students of age of 15–16 have drunk alcohol in a risky way at least once during the last 30 days as compared with 54% in 2007[46].

According Survey on substance use prevalence in general population of Latvia the tendencies of drug widespread in Latvia lead to positive thoughts. Compared to 2007, the level of drug use has dropped to the level of 2003. Among the population between the age of 15 and 64, 14.3% tried illegal narcotic substances during their lifetime. Relatively smaller group — 4.4% — used these substances during last year, and 1.8% — during last month. Gender differences in indicators of drug trials and use have diminished since 2007, which was due to significant decrease of drug use in men; while indicators remained relatively stable among women. However, despite of this, men tried drugs twice more often (21%) than women (8%), but during last year 6.2% of men were users, compared to only 2.7% among women[47].

According ESPAD survey historically lifetime substance use prevalence among students of age of 15–16 has been at European average; in 2007 lifetime prevalence rate among ESPAD countries was 20%, while in Latvia – 22%. The most commonly used substance among students in Latvia and elsewhere in Europe is cannabis. 2011 ESPAD data suggest increase of lifetime prevalence rate of cannabis has been one of the largest in ESPAD countries – among students of age of 15–16 Latvia has experienced an increase in cannabis lifetime prevalence rate from 18% in 2007 to 24% in 2011. Last year prevalence rate of cannabis in 2011 was 16%, while the last month prevalence rate was 6%. Boys more often have mentioned lifetime, last year or last month use of cannabis as compared with girls[48].

In many countries of the world and the EU, including Latvia, the prevalence of several infectious diseases has been interrupted, restricted or fully eliminated by introducing new effective vaccines, improving the system of epidemiological surveillance, as well as by effectively coordinating international actions in cases of epidemics.

[45] Survey on substance use prevalence in general population of Latvia 2011, CDPC of Latvia
[46] European School Survey Project on Alcohol and other Drugs 2011, CDPC of Latvia
[47] Survey on substance use prevalence in general population of Latvia (2003, 2008, 2011), CDPC of Latvia
[48] European School Survey Project on Alcohol and other Drugs 2011, CDPC of Latvia

Comparing to 2008, an increase in number of food and waterborne diseases (FWD) outbreaks (by 37%), as well number of cases in respective outbreaks has been registered in 2011 (by 31%), especially salmonellosis and viral gastroenteritis.

Table no.25

Outbreaks of FWD with 5 and more cases and number of cases in outbreaks

	2008		2009		2010		2011	
	Number of outbreaks	Number of cases	Number of outbreaks	Number of cases	Number of outbreaks	Number of cases	Number of outbreaks	Number of cases
Total, of them:	**35**	**490**	**63**	**613**	**33**	**452**	**48**	**642**
Salmonelosis	13	219	9	151	16	294	16	276
Shigelosis	2	21	0	0	0	0	0	0
Staphilococcal food poisoning			1	15	0	0	1	5
Rotavirus gastroenteritis	1	5	5	33	6	57	10	71
Norovirus gastroenteritis	4	55	7	100	2	33	14	236
Gastroentero-colitis, unspecified	3	27	1	12	0	0	2	13
A hepatitis	12	163	38	297	7	54	3	20

Comparing to 2008, incidence of B, C hepatitis as well carriage of HBsAg was lower in 2011:

- acute B hepatitis – by 54% (decrease from 140 to 64 cases);
- chronic B hepatitis – by 11% (decrease from 70 to 62 cases);
- carriers of HBsAg – by 46% (decrease from 349 to 187 cases);
- acute C hepatitis – by 42% (decrease from 116 to 67 cases);
- chronic C hepatitis – by 6% (decrease from 1350 to 1269 cases).

Main problems:

- Despite of decreasing tendency since 2008, number of new chronic C hepatitis cases is still quite high in Latvia (1269 cases in 2011, or 61,7 per 100 000 inhabitants);
- Most B and C hepatitis patients get infected due to unsafe injected drug use, but quite a big proportion, probably, got infected in health care settings;
- Patients has to pay 25% of hepatitis C treatment expenses, which sometimes exceed the salary or allowances;
- Level of immunization of teenagers against hepatitis B, which was reached during catch-up vaccination, is insufficient (in 2011 – 62.3%).

Despite of 50% reimbursement of influenza vaccine by state for risk 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 immunosuppressive therapy; patients over the age of 18 undergoing a prolonged therapy with acetyl salicylic acid or aspirin), the level of immunization is one of the lowest in Europe.

Level of population immunization against influenza is less than 1% and there is a tendency to decrease (in season 2007/08 – 1.2 %, in season 2011/12 – 0.4%). The level of influenza immunization in risk groups is very low as well: in age group 65 years and older in season 2011/12 it was 2.2%.

Since 2006, state finances children vaccination against tick borne encephalitis (only for children living in highly endemic districts as well for orphans in the whole territory of Latvia). Every year around 10 000 of children receives the vaccine free of charge. Percentage of cases of tick borne encephalitis in children decreased from 9.2% in 2008 to 4.2% in 2011 which could be explained with targeted vaccination.

In Latvia, during the period of 2008 to 2011, reported cases of sexually transmitted infections (STI) increase from 1519 to 2322 cases, by 53%. Chlamydia infections and gonorrhoea are the most commonly reported infections (87% of all cases of STI). The number of chlamydia infections cases increase from 704 cases in 2008 (31/100 000 inhabitants) to 1576 cases in 2011 (77/100 000), gonorrhoea from 487 cases in 2008 (21/100 000) to 550 cases (27/100 000). This is still one of the highest incidence rates of gonorrhoea across reporting countries in EU/EEA. From 2008, incidence rate of syphilis decrease from 10/100 000 to 7/100 000, but in this period was reported about 4 cases of congenital syphilis.

The number of new registered HIV cases decreased from 358 cases in 2008 to 274 cases in 2010, however, number of HIV cases has increased to 299 in 2011 (12.2 per 100 000 population). Since 2008 the most common HIV transmission route is heterosexual transmission.

Incidence of tuberculosis has stabilized during 2008-2011, reaching 38.3 per 100 000 population in 2011, which is still among the highest incidence rates in the EU. The number of tuberculosis cases in for children at age of 0-14 decreased from 48 cases in 2008 to 40 cases in 2009, however, increase of tuberculosis cases in for children at age of 0-14 has been observed lately (from 40 cases or 12,9 per 100 000 population in 2009 to 61 cases or 20,8 per 100 000 population in 2011). Particular problem is HIV/TB co-infection - in 9.4% of all new TB cases has been registered to HIV-infected persons in 2011.

Table no.26

Infectious diseases, number of cases

Groups of infectious diseases	2008	2009	2010	2011	Comparison between 2008 and 2011 in %
Food and waterborne infections (FWD)	9290	9507	10469	11943	+29%
Vaccine preventable diseases (VPD)[#]	7016	5039	3711	3326	-53%
Viral hepatitis**	4884	4170	1754	1749	-64%
Sexually transmitted infections (STI)	1519	1807	1588	2322	+53%
Skin infections ***	1349	1209	1605	2018	+50%
Zoonosis****	737	1101	1371	1384	+88%
Tuberculosis	918	830	825	788	-14%
HIV	358	275	274	299	-16%
Other	513	480	669	535	+4%

[#]Including varicella
** Hepatitis A, B and C
*** Scabies and microsporosis
**** including tick-borne encephalitis and Lyme borreliosis

Table no.27

Vaccine preventable diseases

Disease	Number of cases			
	2008	2009	2010	2011
Diphtheria, total	29 (28[#])	6 (5[#])	2 (2[#])	6 (5[#])
Including children	10	0	0	0
Tetanus	0	0	0	0
Pertussis	14 (7[#])	9 (1[#])	9 (6[#])	10 (2[#])
Hepatitis B in children	5	5	2	1
Haemophilus influenzae b type infection	1	1**	0	1**
Measles	3	0	0	1 (1[#])
Rubella	9 (3[#])	7 (1[#])	0	2 (1[#])
Mumps	6 (2[#])	1 (1[#])	3 (0[#])	10 (4[#])
Poliomyelitis	0	0	0	0
TB meningitis, miliary tuberculosis in infants	0	0	1	0
Varicella	6955	5019	3697	3297

[#] confirmed cases in accordance with case definitions.
** *Haemophilus influenzae* infection, unspecified.

Table no.28

Immunization coverage in 2008 – 2011

Vaccine	Year			
	2008	2009	2010	2011
BCG	96.6	97.4	94.4	94.9
HepB (3)	95.6	95.1	91.4	91.1
DTP - IPV (3)	97.4	97.8	92.2	94.0
HiB (3)	97.3	97.6	91.1	92.9
PCV (1)**	-	-	63	77.7
DTP - IPV (4)	97.0	91.3	88.5	89.0
MMR (1)	97.3	92.9	90.1	98.6
Varicella[#]	48.1	63.9	78.9	90.2
Pertussis (5)**	-	-	76.2	89.2
DT - IPV (5)	98.1	95	93.9	92.6
MMR (2)	97.4	94.3	94.1	91.2
HPV (1)**	-	-	47.4	60.4
HPV (3)**	-	-	-	48.3
Td - IPV (6)	92.7	89.2	85.6	89.4
HepB - teenagers (3)	66.4	64.9	63.8	62.3
Td adults (3+booster)	60.1	62.0	60.5	56.2

[#]Introduced in 2008
** Introduced in 2010

Note for all document:
**Rates of 2011 are calculated according results of Population Census 2011. It means that there is break between data series (meanwhile data of 2011 are not comparable with previous years).*

ARTICLE 13: THE RIGHT TO SOCIAL AND MEDICAL ASSISTANCE
ARTICLE 13 PARA. 1

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

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;"

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 types of social assistance benefits and basic principles of awarding 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 the budget of each local government and is granted to families or households, whose place of residence is situated in local governments' territory. According to law mentioned there are three main types of social assistance benefits. Each has it's own granting conditions.

Types of Social Assistance Benefits:
1. Benefit for ensuring guaranteed minimum income level (hereinafter - GMI benefit);
2. Housing benefit;
3. Benefit in an emergency situation;
4. Other benefits, which are determined from local government' initiative.

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

1. The purpose of GMI benefit is to ensure a minimum level of income for each family member or families in need whose income level is lower than set by Cabinet of Ministers. In 2008 the level of GMI benefit was 27 LVL; in 2009 - 37 LVL. On 1 October 2009 the level of GMI benefit was further increased from 37 LVL to 40 LVL for adults and to 45 LVL for children. GMI benefit shall be provided to a family as well as persons living in the same household who has been granted the status of a needy family and whose income level is lower than GMI level, set by Cabinet of Ministers.

GMI benefit shall be granted and paid to a family which include spouses, persons who have common expenses for food and who live in one dwelling or a person living separately, if he or she fulfils the duties of participation prescribed in the Law On Social Security and, if necessary, takes part in social rehabilitation measures. A person who is

able to work and who wishes to receive the GMI benefit, but does not work, must prior to requesting the benefit register with the State Employment Agency.

GMI benefit amount is not differentiated by type of household or group of the population. However, local governments may differentiate the benefit amount for various categories of the population in their binding regulations. Local governments can set higher amounts as according to local governments' budget possibilities. 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.

The claimant of the benefit may not be asked to fulfil such duties of participation which exclude the possibility of caring for a disabled child or pre-school age child, or which prevent the entering into of labour relations or the gaining of another type of legal income from work.

GMI benefit of a family must be reduced by the part granted to the person or must not be granted to a person living separately if the person has refused to fulfil the duties of participation. Unemployed beneficiaries capable of work are obliged to register at the State Employment Agency, seek work and accept suitable offers of work.

A person do not need to register with the State Employment Agency if the person is:
1) a disabled person who receives a disability pension or state social security benefit;
2) a woman during maternity leave, one of the parents of a child or another person during the child's nursing period;
3) one of the parents of a disabled child; or
4) 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.
GMI benefit is renewable benefit.

Furthermore the level of GMI is determined and revised each year in connection with the annual Draft State Budget Law by Cabinet of Ministers. GMI level is determined, taking into account financial resources of local governments, from which budget GMI benefit is provided.
Since 2007 the level of GMI benefit was increased from year to year (please see Table no.30).
Since July 2009 there are no more restrictions for GMI receiving period and since October 2009 – restrictions for maximum amount of GMI benefit for household.

As to other local government social assistance benefits, there are no restrictions of amount. Amount of these benefits depend only on financial resources of respective local government.
In addition, poverty threshold Eurostat defines as 60% of median equivalised income. In calculating of poverty threshold the scale of equivalences is used.
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 the amount of other local government social assistance benefits the scale of equivalences is not used.

2. Other mandatory social assistance benefit paid to people in need is housing benefit. Housing benefit depend local government budget, politics and situation in respective local government. The right to receive housing benefit is determined by the local government. According to the Law on Social Services and Social Assistance, a dwelling is one of the elementary requirements. 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 government 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 government regulation where the income level is determined for a person to become entitled to claim for housing benefit. Housing benefit includes such kind of payments: (payments to public utility services, fire wood charges, electricity bills, payments concerning housing maintenance).

3. Lump sum benefit in an emergency situation - local government grants this benefit without means testing of 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.

4. 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 inhabitants in need 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 government's regulation. The purpose of other benefits is to ensure such elementary requirements (meal, clothing, health care, obligatory education).

According to the Protection of the Rights of the Child Law there are provided 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 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 local government in accordance with the procedures specified in the Law On Assistance in Solving Apartment Matters shall provide assistance in solving apartment matters to a child who has reached the legal age. Until the allocation of living space 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 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 175 LVL. 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. The local government which 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.

5. Benefits for foster families - according to the Law on Protection of the Rights of the Child and Law on Orphan's Courts, local governments may 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 paid 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.

During the stay of an orphan or a child left without parental care at a long-term social care and social rehabilitation institution, the local government social service office and Orphan's court, in co-operation with the employees of the institution, shall take measures to promote the return of the child to the family, to maintain contact between the child and parents or, if this is not possible, to seek a possibility to ensure care for the child in another family.

The most important tool in the provision of health care services for vulnerable groups is the implementation of the Social Safety Net Strategy. The Social Safety Net was introduced in Latvia at the end of 2009 and is financed from a loan from the World Bank. The Social Safety Net Strategy provides additional protection and better targeting of public resources for the poor. Social Safety Net funding for health sector in 2009 was 7.56 million LVL, in 2010 – 24.21 million LVL, in 2011 – 30.31 million LVL and in 2012 – 19.87 million LVL.
In 2010 and 2011 there were three poor patient groups, which was definitely different preferences when receiving health care services:

1. Persons with income under 90 LVL;
2. Persons with income under 120 LVL:

For the 1st and the 2nd group of patients, the patient contribution, expenses for "patient hotels" - hotel-type beds established in the hospital (in this case, staying overnight in a treatment institution does not foresee supervision by medical personnel). Patients are provided with the possibility to receive the necessary healthcare because concentrating the healthcare services or providing only out-patient healthcare hinders the availability of healthcare for some patients (a hotel needs to be found and accommodation expenses covered or treatment institution needs to be visited every day), health care at home, mental care and medicinal products are reimbursed in the amount of 100%;

3. Persons with income under 150 LVL:

For the 3rd group of patients, patient contribution is reimbursed in the amount of 50%.
In 2008 the Regulation of Cabinet of Ministers No.1046 were amended, where it was laid down that pregnant woman and children are priority in receiving health care services.

2. Please indicate the measures taken (administrative arrangements, programmes, action plans, projects, etc.) to implement the legal framework.
No special studies have been undertaken in Latvia on analysis of causes or for describing the number of individuals or families that would be eligible for the receipt of the minimum

income schemes but who does not apply to the local government for the receipt of the said benefit. Certain social exclusion risk groups, in particular the homeless who do not have personal identity documents or any documentary to proof their domicile, even if they are informed on possibilities of receiving assistance, they do not seek assistance due to their passiveness, timidity or due to some other reasons. In such cases the professional activity of municipal social services play a significant role in activating and consulting the above risk groups. Until now typically social assistance has been received mostly by informed and active individuals who apply for assistance themselves.

Due to rapid deterioration of social situation and to provide support for people who became victims of the crisis the state introduced several emergency social safety measures also in means-testing and minimum benefits. The average monthly sum of the paid GMI benefit for a person is seen in Table no.30.

Also to help local governments to provide GMI and housing benefits to people in need of this support since October 2009 state co-financed 50 % of amount spent for payment on GMI benefits per month and 20 % of amount spent for provision of housing benefits per month. Besides there were introduced a number of amendments that alleviated the criteria to obtain a needy person status by removing several administrative burdens.

To avoid GMI benefit option to encourage people to escape of accepting offered employment, initially there were number of restrictions set for receiving of GMI benefit. Firstly - restriction for maximum amount for GMI benefit for household was calculated as a triple amount of the state social security benefit. The upper limit of GMI benefit for household was 135 LVL from 2006 till 2009. Secondly - restrictions for GMI benefit receiving period per person - up to 9 months during 12 month period. Both of these restrictions were in force until July 2009. To encourage the GMI benefit receiver who is capable to work to take part in the labor market - in a situation when the income for a family member's from employment increased received GMI benefit - period of GMI family benefits extended for a further 3 months, gradually reducing the amount of the benefit. Also, this condition was in effect until July 2009.

In July 2009 both the predetermined GMI and receipt of restrictions on the duration both condition of the continuation of the payment of the benefit of income from employment growth is repealed. Also in 2009 the restriction to receive GMI benefit of a poor person status to persons who have credit is removed.

During crisis of 2008-2010 all these issues become much more visible, complex and comprehensive since a number of persons in need and beneficiaries doubled thus posing extra burden on municipal social workers. As a result and impact of this situation a number of people who became passive social assistance users increased as during the crisis there were initiated amendments regarding increase of active approach to social assistance applicants, i.e., before applying for social assistance a person is obliged to apply to the State Employment Agency to involve in active employment measures offered. However, it has not changed a situation significantly and occasions when person prefers to receive social assistance benefits rather than to look for a new job still remains a hot topic. Therefore, in 2011 there have been carried out discussions on possibility to reform social assistance system to increase efficiency and effectiveness of this problem.
The main Social Safety Net strategy activities are:

1. compensation mechanism to cover patient co-payments for poor persons - in order not to decrease the availability of healthcare services, to ensure that the person addresses the healthcare institutions on time, as well as receives the necessary care, a compensation mechanism has been designed to cover patient co-payments for persons with low-income and the needy persons. From 2009 till 2011 patients' co-payments were compensated for low-income persons and the needy persons. In 2011 the number of reimbursed out-patient visits and hospitalizations exceeds the planned, respectively for 32.3% and 46.4%.
2. 100% compensation of reimbursed medicines for poor persons - In 2011 the number of persons who received full compensation of medicines exceeded the planned for 37.5% (30 267 received, planned – 22 000).
3. provision of home care to patients with serious diseases - state provides health care at home for the patient if he or she needs regular outpatient treatment, but due to medical indication patient can't turn to a medical institution for the outpatient treatment. The development of home care will ensure that the service is of maximum proximity to the patient place of living, as well as will decrease the number of in-patient cases. In 2011 the number of home care visits exceeded the planned for 11% (planned - 200 000, provided – 223 683).
4. focus on in-patient services to patients with mental diseases by decreasing the number of beds and developing care in the day centres - development of care in day centres ensure the creation of mental healthcare centres founded in the society. Equal possibilities will be ensured for inhabitants of Latvia to receive the necessary mental healthcare, increasing the role of family doctors and discovering a possibility for patients with mental problems to receive the necessary care maximally close to their living place and integrating patients into the society. In 2011 1755 patients with mental disorders received treatment in day-hospitals. It is 4 times more than were planned (planned – 400). It is attributed to the increase of awareness and knowledge of these services among professionals and patients.
5. improvement of access to primary health-care services by attracting additional nurse for the general practitioners and primary health care providers - to facilitate the work-load of general practitioners as a result of shift from in-patient to out-patient medical care, the issue of additional nurse for approximately half of the general practitioners and primary health care providers has been handled within the scope of the Social Safety Net Strategy. At the end of 2011 465 general practitioners employs second nurse (it is 93% of planned).
6. development of general practitioners' advisory service – this service has been operating from 1 May 1 2011 from 7 p.m. to 8 a.m. on weekdays and around the clock during weekends and holidays. This service has been receiving around 2000 calls a month since its creation. It is designed to provide medical advice when general practitioner offices are closed, preventing unnecessary hospital visits and providing good primary care advice during off hours.
7. covering of hotel-type beds in hospitals for needy and low-income persons - the number of hospital patients receiving subsidized hotel stays under the emergency social safety net was much lower than targeted because when the target was set there was no data on the demand for the hospitals' hotel service. This was because it is a service which is not paid by the state health care budget and the patient use of this service had not been recorded. The hospitals' hotel patient service usage increased over 2010 and 2011, increasing from 390 patients benefiting in the first quarter of 2010 to 3521 patients in the fourth quarter of 2010 and to 5658 in 2011. Demand for subsidized places in hotels for hospital patients did not materialize as expected and so the targets set for both 2010

and 2011 were not met. This is objectively linked with the lack of statistical data on possible demand for such a service.

3. Please provide pertinent figures, statistics or any other relevant information, in particular: evidence that the level of social assistance is adequate, i.e. the assistance should enable any person to meet his/her basic needs and the level of the benefits should not fall below the poverty threshold. Information must therefore be provided on basic benefits, additional benefits and on the poverty threshold in the country, defined as 50% of the median equivalised income and calculated on the basis of the poverty risk threshold value published by Eurostat.

Table no.29

Number of recipients of municipal social benefits (% of total number of inhabitants)

	2008	2009	2010	2011*
Guaranteed minimum income benefit	27 422 1.2 %	62 847 2.8 %	120 642 5.4%	123 776 5.9%
Housing benefit	108 690 4.7 %	134 136 5.9 %	209 176 9.3%	211 476 10.2%

**l provisional data*

Table no.30

Data on the conditions for receiving GMI and GMI recipients 2007 – 2011

Year	The minimum wage (per month)	GMI level (in a month)	GMI upper limit (per family / month)	GMI benefit duration limit	GMI beneficiaries (per year)	The proportion of the GMI recipients of population	Spending for GMI benefit (per year)	The average amount of GMI benefit to one recipient (per month)	The average duration of GMI received per beneficiary per year
	LVL	Lats	Lats	months	persons	%	Lats	Lats	months
2007	120.00	27	135.00	9	26 793	1.17	1 713 169	14.04	4.45
2008	160.00	27	135.00	9	27 422	1.21	2 008 209	16.96	4.03
2009	180.00	37* 40** 45***	135*	9****	62 847	2.78	6 467 721	23.65	4.54
2010	200.00	40** 45***	No restrictions	No restrictions	120 642	5.37	18 498 797	25.22	6.07
2011	200.00	40** 45***	No restrictions	No restrictions	123 776	5.85	22 002 261	26.65	No data

** until October 2009 ** adult persons *** children **** until July 1, 2009*

Guaranteed Minimum Income (GMI) is determined by the Cabinet of Ministers

Income and wealth levels below which a family (person) is recognized to be poor is prescribed by the Cabinet of Ministers.

Data source: Regulations of Cabinet of Ministers and the national statistical reports

Table no.31

Municipal expenditure on social assistance benefits

	2008	2009	2010	2011
Municipal expenditure on social assistance benefits, thsd LVL	31 115,3	35 470,5	45 444,2	52 742,5
of them				
GMI benefit, thsd LVL	2 008,2	6 467,7	18 498,8	22 007,1
% of municipal expenditure on social assistance benefits	*6,5*	*18,2*	*40,7*	*41,7*
GMI level per person per month	27	37,0	40,0 45,0 (for children)	40,0 45,0 (for children)
The level of income and material situation for each family member which shall be recognised to be needy per month, in LVL	80,0	90,0	90,0	90,0
Benefit in an emergency situation, thsd LVL	1 152,0	1014,3	878,7	952,0
% of municipal expenditure on social assistance benefits	*3,7*	*2,9*	*1,9*	*1,8*
Other benefits, total, thsd LVL:	27 995,1	27 989,5	26 068,8	29 783,4
% of municipal expenditure on social assistance benefits	89,8	78,9	57,4	56,5
of them				
Housing benefit, thsd LVL	10 615,0	12 413,5	17 258,6	20 049,6
% of municipal expenditure on social assistance benefits	34,1	35,0	38,0	38,0
Health care benefit, thsd LVL	4 232,2	3 685,1	1 671,9	1 612,3
% of municipal expenditure on social assistance benefits	*13,6*	*10,4*	*3,7*	*3,1*
Benefit for food (free of charge) and free school/kindergarten meals, thsd LVL	3 196,6	3 705,5	3 567,2	4 331,8
% of municipal expenditure on social assistance benefits	*10,3*	*10,4*	*7,8*	*8,2*
Benefit for schooling and upbringing of children, thsd LVL	1 202,1	1 495,9	809,5	761,8
% of municipal expenditure on social assistance benefits	*3,8*	*4,2*	*1,8*	*1,4*
Benefits for orphans and foster families, thsd LVL	1 460,6	1 890,9	2 663,0	2 967,2
% of municipal expenditure on social assistance benefits	*4,7*	*5,3*	*5,9*	*5,6*

In 2011 number of the municipal social benefit recipients were 301,2 thsd persons or 14,5 % of State inhabitants (in 2008 - accordingly 320,9 thsd persons or 1559 % of State inhabitants), of them GMI benefit recipients – 121,8 thsd persons or 5,9 % of State inhabitants (please see Table 32).

Table no.32

Number of benefit recipients, thsd persons

	2008	2009	2010	2011
Municipal social assistance benefits, total	320,9	315,5	315,2	301,2
of them				
GMI benefit	27,4	62,8	120,6	123,8
% of all persons who received social assistance benefits	*8,5*	*19,9*	*38,3*	*41,1*
Benefit in an emergency situation	16,4	14,3	11,6	10,9
% of all persons who received social assistance benefits	*5,1*	*4,5*	*3,7*	*3,6*
Housing benefit	108,7	134,1	209,2	211,5
% of all persons who received social assistance benefits	*33,9*	*42,5*	*66,4*	*70,2*
Health care benefit	83,1	62,9	40,6	37,9
Benefit for schooling and upbringing of children	35,6	31,2	26,2	24,5
Benefits for orphans and foster families	2,5	2,8	3,9	4,2

With a rate of 26.9 % in EU-27, children were at greater risk of poverty or social exclusion in 2010 than the rest of the population in 21 of the 25 Member States for which data are available. In Latvia this rate is more higher (please see Table 33).

Table no.33

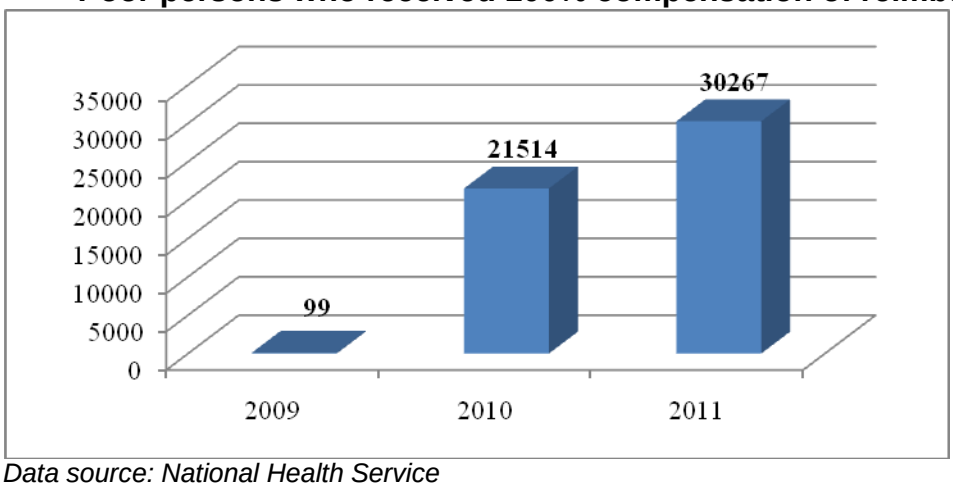
People at risk of poverty or social exclusion by age group (%), 2010

	Children(0-17)	Working age population (18-64)	Elderly (65 years and more)	Total
EU-27	26.9	23.3	19.8	23.4
Latvia	42,0	37,0	37,7	38,1

Data source: EUROSTAT (estimation)

Table no.34

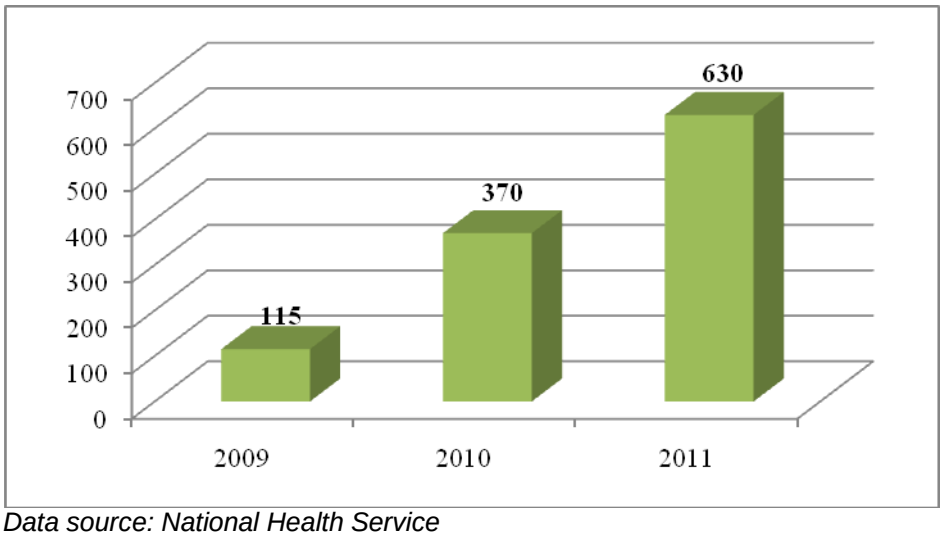
Poor persons who received 100% compensation of reimbursed medicines



Data source: National Health Service

Table no.35

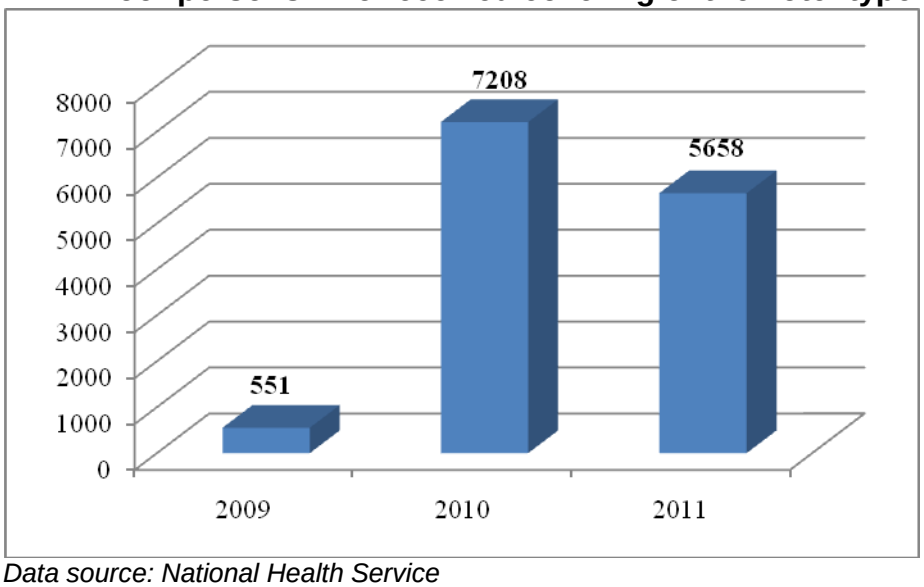
Poor persons who received health care at home



Data source: National Health Service

Table no.36

Poor persons who received covering of the hotel-type beds in hospitals



Data source: National Health Service

ARTICLE 13 PARA. 2

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

to ensure that persons receiving such assistance shall not, for that reason, suffer from a diminution of their political or social rights;"

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 assistance shall be provided to a client on the basis of an evaluation of his or her material resources – income and property, individually providing for the participation of each client in conformity with the Law On Social Security.

A client has the right:
1) to obtain information free of charge from a social service and social assistance provider regarding the possibilities of receiving social services and social assistance as well as the conditions and procedures for the receipt thereof;
2) to receive a consultation free of charge from a social work specialist regarding the resolution of social problems;
3) to request and receive the social services or social assistance referred to in this Law;
4) to receive a substantiated written refusal in case a decision has been taken not to provide a social service or social assistance to the client;
5) to participate in the decision-taking process related to the receipt of a social service;
6) in accordance with the procedures specified by law, to appeal against a decision regarding the provision of social services or social assistance; and
7) to submit a complaint regarding the unsatisfactory quality of the social services provided and the infringement of the rights of the client.

The following persons, whose integration into society is burdened, shall have the right to social rehabilitation:
1) disabled persons and persons with functional disorders;
2) persons after the serving of a sentence of deprivation of liberty;
3) persons who have become addicted to alcohol, narcotic or psychotropic substances;
4) persons who have suffered from violence; and
5) children who have for a long time (more than one year) been under extra-familial care.
Where necessary, local governments shall develop rehabilitation programmes also for groups of persons whose integration into social life is burdened due to other reasons.

The following persons with continuous or lasting organism dysfunctions or anatomic defects have the right to receive technical aids if they have received an opinion of a medical practitioner regarding the need for the technical aids:
1) disabled persons belonging to Groups 1, 2 and 3;
2) disabled children under the age of 18 years;
3) children for whom the technical aids are necessary to reduce or eliminate functional inability;
4) adult persons for whom the technical aids is necessary to reduce or eliminate functional inability; and
5) persons with anatomic defects — a prosthesis or orthopaedic footwear.
The Cabinet of Ministers regulates procedures by which persons shall receive technical aids and regulations on the circulation of technical aids as well as approve the list of technical aids to be financed from the state.

The right to receive vocational rehabilitation services shall be enjoyed by persons of working-age if they have been classified as disabled and if they have a recommendation from the State Medical Examination Commission of Health and Capacity for Work to acquire a new occupation. In order to receive the State financed vocational rehabilitation services, a person shall turn to the provider of the relevant service. The relevant provider of vocational rehabilitation services shall take a decision regarding the granting of services or the refusal to grant services. The Cabinet of Ministers determines procedures by which a person shall receive vocational rehabilitation services.

A client living in a long-term social care and social rehabilitation institution has the following rights:

1) to independently take decisions and implement them to the extent it does not restrict the rights and freedoms of other persons or does not endanger the health or life of the person;
2) to enjoy individual access to staff in the provision of social service offices;
3) if he or she is an adult person – for a period of time from one month up to three months to reside in the care of another person (family) outside the institution. A long-term social care and social rehabilitation institution, upon a written agreement with a person (family), shall determine the duration of this residence, the rights and duties of the parties, as well as disburse an allowance or maintenance benefit of the client in accordance with the period of time during which he or she is in the care of another person (family); and
4) if he or she is a child - to reside in the care of another person (family) outside the institution in accordance with the Protection of the Rights of the Child Law.

In order to promote respect for the rights of the persons living in long-term social care and social rehabilitation institutions, the head of the relevant institution shall establish a social care council (hereinafter — council) which shall consist of the persons living in the long-term social care and social rehabilitation institution, their relatives, employees of the institution and representatives of the local government. Decisions of the council shall have a recommendatory nature. The Council shall:
1) co-ordinate internal rules of procedure of the institution;
2) submit proposals for improvement in the operations of the institution;
3) examine conflicts between clients and the management of the institution; and
4) participate in the quality assessment of the services provided by the institution.

In order to prevent the leaving of a person without supervision and to protect the rights and freedoms of other persons, the head of a long-term social care and social rehabilitation institution or his or her authorised person may take a decision regarding the necessity to restrict the rights of the person to move freely. If a person with his or her actions endangers his or her health or life or the health or life of other persons, the head of the relevant institution or his or her authorised person may take a decision, making note in the person’s file regarding the isolation of the person for a period not exceeding 24 hours in a room specially arranged for such purpose, where the necessary care and continuous supervision of the person shall be ensured.

If it is necessary to restrict the rights of children staying at long-term care institutions, the provisions of the Law on the Protection of the Rights of the Child shall be applicable.

The purpose of State Ensured Legal Aid Law is to promote the right of a natural person to a fair court protection by ensuring State-guaranteed financial support for the receipt of legal aid.

Section 3 of the Law on the Rights of Patients lays down provisions to prevent any discrimination or ill treatment, namely:
(1) The rights of patients shall be implemented in accordance with this Law insofar as other laws do not specify otherwise.
(2) In ensuring the rights of patients, differential treatment based on a person’s race, ethnic origin, skin color, gender, age, disability, state of health, religious, political or other persuasion, national or social origin, property or marital status or other circumstances is prohibited. Differential treatment shall include the direct or indirect discrimination of a person, infringement of a person or an implication to discriminate him or her.

(3) Differential treatment related to any of the circumstances referred to in Paragraph two of this Section shall only be acceptable in such cases if such treatment is objectively justified with a legal purpose, for the achievement of which the selected means are commensurate.
(4) It is prohibited to punish a patient or otherwise directly or indirectly cause him or her unfavorable circumstances, if the patient is protecting his or her rights.
(5) A patient and his or her relatives have the right to receive mental care which, in accordance with the regulatory enactments regulating the activities of chaplain services and religious organizations, shall be provided by the chaplain of a medical treatment institution.
(6) Health care against the will of a patient shall not be permissible, if not otherwise specified by the Law.

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

The fact that a person is indigent and has no money to pay the costs does not necessarily mean that he or she, therefore, would be deprived of the opportunity to defend his or her case, or have legal action. An annual State Legal Aid Act and its implementing body - the Legal Aid Administration (hereinafter - LAA). State-guaranteed legal aid shall be granted to people who need it in civil as well as paid compensation by the State for those who become crime victims. Last year, the LAA received 3288 applications for assistance and 83.8 % of them were accepted.

Legal Aid Administration is the institution subordinated to the Ministry of Justice of the Republic of Latvia. In accordance with the State Ensured Legal Aid Law, the Law “On State Compensation to Victims” there are two activities of the LAA providing for implementation of the delegated functions and tasks:

- to ensure access to just legal protection for the low-income and needy persons, and persons with a particular situation, property status and income levels considered appropriate for the state guaranteed legal aid;
- providing state compensation for victims paid for persons who have suffered intentional violent crimes and their health has suffered severe or moderate bodily injury, death of a person or a person suffered sexual offences.

To ensure implementation of functions, the LAA performs the following tasks:

- examines persons’ applications for request of state guaranteed legal aid and decide on granting or refusal to grant the state guaranteed legal aid;
- examines the state compensation claims and decides on payment of the state compensation or refusal to pay the said;
- pays out legal assistance funds earmarked for legal aid providers;
- pays out the funds provided for state compensations to the victims;
- examines persons’ applications for acquisition of the status of provider of state guaranteed legal aid and concludes legal aid agreements with providers of legal aid;
- in cases specified by laws and regulations recovers the State budget funds paid to provide legal assistance and state compensations to the victims;
- maintains the register of state guaranteed legal aid and the state compensation.

The Legal Aid Administration shall grant the state legal aid in civil cases (except, for example, if the state guaranteed legal aid is sought in connection with performance of the

loan contract, if the applicant is lender, if the request is related to luxury articles or luxury services, as well as legal assistance can not be obtained in cases directly related to the claimant's all kinds of economic activity, business or independent professional activity, as well as in other cases), and in appeal procedures of administrative matters for asylum granting proceedings until the final court ruling enters into force.

The persons are entitled to request a state-guaranteed legal assistance only if they have obtained status of low-income and needy person under the procedure specified by laws and regulations in which a natural person is declared of low-income and needy, as well as if they suddenly get into a situation and a material condition that prevents their protection of their rights (due to natural disasters, force majeure or other circumstances beyond control of the person), or are under full maintenance by the government or local authority.

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

Table no.37

State Ensured Legal Aid

	2009	**2010**	**2011**
Number of applications	1764	2641	3288
Decisions on ensuring legal aid	1533	2948	2755
Refusals of ensuring legal aid	251	411	329
Requests of legal aid for asylum seekers	4	6	30

ARTICLE 13 PARA. 3

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

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;"

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 local government employs at least one social work specialist per thousand of population. Each local government 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 local governments have to provide at least one social work specialist per 1000 inhabitants, and the local governments in which the number of inhabitants exceeds 3000 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 publish their regulations in the press, inter alia, about social services and social assistance provided by each local government.

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

Local governments must inform their inhabitants not only by publishing information in local newspaper, but also provide information in local government's internet home page, prepare and diffuse brochures on social services and social assistance provided by local government and pay for costless informative phone.

The purpose of social work is to help a person, a family or a group of persons determine, resolve or diminish social problems by developing the resources of the person himself or herself and involving support systems.

Persons who have acquired a second level vocational higher or academic education in social work or in caritative social work have the right to perform social work. Persons who have acquired a first level vocational higher education in the field of the provision of social care, social rehabilitation or social assistance or a vocational secondary education in the field of social care (after graduation from such vocational secondary school or other educational establishment which implements vocational secondary education programmes) have the right to provide social care or social rehabilitation services and social assistance.

The professional activity of a social worker and a caritative social worker shall be aimed towards achieving and promoting practical resolution of the social problems of an individual and improvement in his or her quality of life, integration in the society, and the ability to help himself or herself. After evaluation of circumstances, a social worker and a caritative social worker shall:

1) provide a person with assistance and support in resolving social problems;
2) help the person develop the ability to resolve personal, interpersonal and social problems;
3) support the possibilities for the development of the person, as well as the right to take decisions independently and to implement them;
4) attract social and economic resources and the appropriate social services for the resolution of the social problems of a person or a group of persons; and
5) provide information regarding social service providers and establish contacts between the recipients and providers of social services.

In performing the above mentioned tasks, social workers and caritative social workers shall comply with the social workers' code of ethics, which shall be approved by the Latvian Association of Professional Social and Care Workers.

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

In 2008, 492 local governments or 89,8% of the total number of local governments had a social service office or a regular employee performing the duties of a social worker. In 2011, the number of such local governments was 119 which all had a social service office or a regular employee performing the duties of a social worker. In 2008 there were mainly local governments with a small number of inhabitants. In 2011 most local governments (61,4%) were with number of inhabitants (2000 – 10 000).

Table no.38

The number of social work specialists in social services of local governments

Year	Number of local government	Number of local governments having social office or permanently employed social worker	Number of permanently employed social worker in social services
2008	548	492	1344
2009	118	116	1380
2010	118	118	1122
2011	119	119	1133

Table no.39

Informative measures about social services and social assistance provided by local governments in 2008

Measures	Number of local governments, that provide the measure	% of all local governments
Information in local newspaper	419	76,5
Information in local government's internet home pages	134	24,5
Brochures	116	21,2
Costless informative phones	17	3,1

Table no.40

Informative measures on social services and social assistance provided by local governments

Year	Number of local government	Information on the client is collected electronically	Information about the client is collected in paper forms	Information for social services and social assistance is available to local government website on the Internet
2010	118	107	117	115
2011	119	115	99	108

ARTICLE 13 PARA. 4

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

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."

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 municipal social benefits.

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.
Above mentioned criteria excludes possibility for aliens/third country nationals would be in need for social assistance benefits.

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 local government. 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.

In case of emergency person whose place of residence can not be determined (i.e. – person without belonging to any local government in Latvia's territory) shall be provided with night shelter, information and consultations of social worker. In night shelter person shall be provided with short-term stay in suitable premises, possibility of using sanitary rooms with a toilet and shower; with the necessary hygiene products; disinfected bedding and with supper and breakfast.

In accordance with the State Ensured Legal Aid Law the following persons have the right to legal aid:
1) a citizen of Latvia;
2) a non-citizen of Latvia;
3) a stateless person;

4) a European Union citizen who is not a citizen of the Republic of Latvia, but resides legally in the Republic of Latvia;
5) a third-country national (including a refugee and a person who has been granted the alternative status in the Republic of Latvia) who is not a citizen of a European Union Member State, if he or she legally resides in the Republic of Latvia and has received a permanent residence permit;
6) a person who has the right to legal aid ensured by the Republic of Latvia in accordance with the international agreements entered into by the Republic of Latvia;
7) an asylum seeker; and
8) a person whose permanent place of residence or domicile is one of the European Union Member States, in cross-boundary disputes.

The State shall ensure legal aid for an asylum seeker in the appeals procedures during the process of granting an asylum. The institution which is responsible for the examination of an application for asylum shall ensure the evaluation of the need for legal aid and the communication of the applicant for legal aid with the provider of legal aid.

In accordance with the Article 17 Paragraph 1 of the Law on Medical Treatment, health care services that are paid by the State can be received by:

- citizens of Latvia;
- non-citizens of Latvia;
- citizens of the member countries of the European Union, the member countries of the European Economic Area and citizens of the Switzerland Confederation, who stay or dwell on the territory of Latvia due to employment or as self-employed persons, as well as members of their families;
- foreigners, who have obtained a permit on permanent residence in Latvia;
- fugitives and persons, who have been assigned an alternative status;
- detainees, those persons who have been put under arrest, as well as those persons who have been sentenced to imprisonment.

Both of a married couple - citizens of Latvia and non-citizens of Latvia, who have a residence permit for a certain period of time in Latvia, have the right to receive free of charge pregnancy care and child delivery aid from the State capital budget.

The persons who are not mentioned in Article 17 of the Law on Medical Treatment, receive medical services at a charge in accordance with the pricelist of a medical institution or the pricelist of services which are to be paid for, provided by a medical specialist.

All member states of EU and EEA have European health insurance card (EHIC), a common document certifying for population of these countries to receive emergency and necessary medical assistance guaranteed by the state in the same volume and for the same payment as it is provided to definite population in the correspondent country.

EHIC is unified document standard in all EU and EEA and every country fills in this form in its national language. Usually, this card is issued to population with short-term stay time, for instance, students, tourists.

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

According to the Immigration 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 local government social assistance.
Pursuant to Immigration Law alien has the right to request a temporary residence permit in cases, which excludes necessity for social care or social rehabilitation services for aliens.
Persons received alternative status according to the Asylum Law have right to GMI benefit and shelter services.
Please see information in point 1 in answers to Article 13 Paragraph 4.

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

In 2011 the number of asylum seekers arrived in Latvia increased greatly.

Table no.41

Number of asylum seekers in Latvia 2008-2011

	2008	2009	2010	2011
Asylum seekers	51	52	61	335

Table no.42

Refugee status and subsidiary protection status granted in Latvia 2008-2011

	2008	2009	2010	2011
Refugee status	2	5	7	9
Subsidiary protection status	1	6	18	18

A residence permit is a document that allows a foreign national to stay in the Republic of Latvia for a specified period of time. Two types of residence permit exist, a temporary residence permit and a permanent residence permit**.**

Table no.43

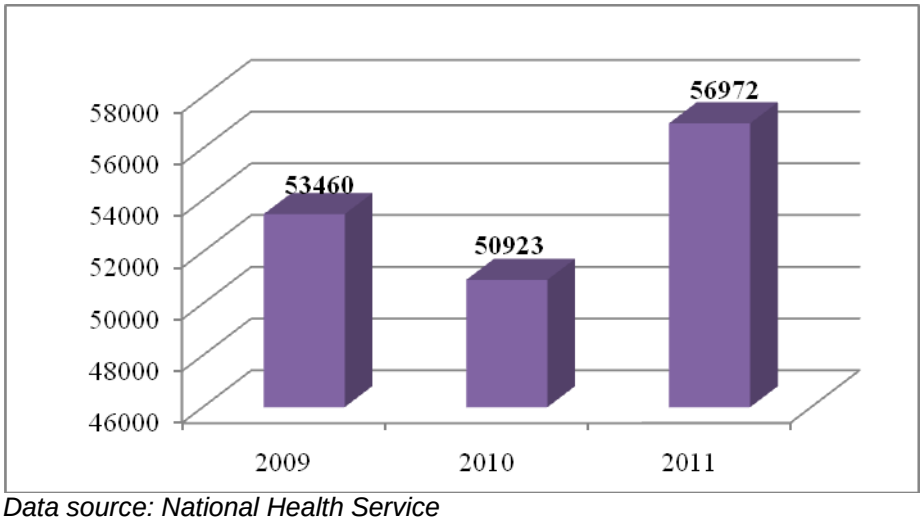
Number of Persons having a valid residence permit in Latvia 2008-2011

	2008	2009	2010	2011
Permanent residence permits	33 056	34 354	36 249	42 054
Temporary residence permits	12 815	14 715	13 785	13 557

A residence permit is required if a foreign national or a stateless person wishes to reside in the Republic of Latvia for more than 90 days within a 6-month period.

Table no.44

Number of European health insurance card issued by National Health Service in Latvia



Data source: National Health Service

ARTICLE 14: THE RIGHT TO BENEFIT FROM SOCIAL WELFARE SERVICES

ARTICLE 14 PARA. 1

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

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;"

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 the term "social service" includes social care, social rehabilitation and vocational rehabilitation as well as social work services, including shelter and night shelter services, social rehabilitation services for victims of human trafficking.

The local government in the territory of which a person has registered his or her place of residence has a duty to provide the person with a possibility to receive social care, social rehabilitation, and social work services corresponding to his or her needs. A person has the right: (a) to obtain information free of charge from the social [care or social rehabilitation] service provider and municipality's social office regarding the possibilities to receive social [care or social rehabilitation] services and social assistance as well as information on the conditions and procedures for receiving services and assistance mentioned; (b) to receive a consultation free of charge from a social work specialist regarding the resolution of social problems.

If the local government has received information from individuals or institutions regarding a person who might be in need for social care or social rehabilitation service or social assistance, the local government has a duty to verify information received, to evaluate the needs of the person for social [care and rehabilitation] services and social assistance and to inform this person or his or her lawful representative on the rights and possibilities of receiving social [care and rehabilitation] services, as well as written procedures setting how social services or social assistance may be received.

Social care and social rehabilitation services are provided only on the basis of an evaluation of the individual needs and resources of a person carried out by a social work specialist. These services shall be provided at the place of residence of the person concerned or as close as possible. In case the scope of such services is not sufficient, social care and social rehabilitation will be provided at a long-term care and social rehabilitation institution. Local government which have not established the necessary social service providers have to have agreements with other social service providers in their territory or with other local governments regarding provision of the social services and payment for services concerned.

If a person requires social services in a shelter or night shelter or a crisis centre, he or she can turn directly to the service provider who takes a decision regarding the provision of service mentioned.

The purpose of the provision of social care services is to ensure that the quality of life is not deteriorated for a person who, due to old age or functional disorders, cannot ensure such quality with his or her own effort. The purpose of the provision of social rehabilitation services is to prevent or reduce the negative social consequences for persons with disability, incapacity for work, addiction or violence, and other factors.
In Latvia social care and social rehabilitation services can provide both governmental and municipal service providers, as well as non-governmental and private service providers. All social service and social rehabilitation providers mentioned have to meet standards set by the Law and they have to be registered in the Register of social service providers. Those social service providers of government and local governments are financed from the State budget or budget of the local government. Other social services mentioned are financed from the budget of their founders, gifts and donations, as well as by those person payments who receive their service.
According to the Immigration Law, persons who have received temporary residence permit in any case have to have financial resources or such resources should belong to the party who invites the person concerned. In a situation, where person should be in urgent need for social service or social rehabilitation, these services are provided to the person, but they are covered by this person or party (a company) who invited this person.
There are exceptions for persons with temporary residence permits – for those persons with alternative status and who are victims of human trafficking – they have rights to use shelters/night shelters financed by municipality concerned or the state budget, as well as there are possibility to use social work specialist on how their situation could be solved. So regarding social care and social rehabilitation services the only difference for persons with temporary residence permits and other legal residents of the Republic of Latvia is who pays for services they receive, and the amount of these payments depend on the service provider used by the person concerned.

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 (please see explanation in Article 13 Paragraph 4) 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.

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 or her social problems, developed person resources to include supporting systems.

In order to ensure professional assessment of persons needs and deliver high quality social services and social assistance, the local governments have to provide at least one

social work specialist per 1000 inhabitants. 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.

The Law states that with the January 2008 social workers' professional duties can take persons who have obtained the second higher level of professional education (a university degree) or professional higher education in the field of social work. Persons who have acquired a first level vocational higher education in the field of the provision of social care, social rehabilitation or social assistance or a vocational secondary education in the field of social care (after graduation from such vocational secondary school or other educational establishment which implements vocational secondary education programmes) have the right to provide social care or social rehabilitation services and social assistance.

The professional activity of a social worker and a caritative social worker shall be aimed towards achieving and promoting practical resolution of the social problems of an individual and improvement in his or her quality of life, integration in the society, and the ability to help himself or herself.

After evaluation of circumstances, a social worker and a caritative social worker shall:
1) provide a person with assistance and support in resolving social problems;
2) help the person develop the ability to resolve personal, interpersonal and social problems;
3) support the possibilities for the development of the person, as well as the right to take decisions independently and to implement them;
4) attract social and economic resources and the appropriate social services for the resolution of the social problems of a person or a group of persons; and
5) provide information regarding social service providers and establish contacts between the recipients and providers of social services.

In performing the above mentioned tasks, social workers and caritative social workers shall comply with the social workers' code of ethics, which shall be approved by the Latvian Association of Professional Social and Care Workers.

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

One of activities in „National Report on Strategy for Social Protection and Social Inclusion 2006-2008" is to improve the accessibility of resources and services to families, particularly large and single-parent families. Goal to achieve - to provide state co-financing for supporting social workers who carry out social work with families and children in local governments.

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 activity in "Program for Professional Social Work Development (2005-2011)" is to provide partial salary from the State budget finance (LVL 124.09 for one social worker in

month), to that social workers in local governments social service offices, who works with families with children.To 1 January 2013, the second level education for social work specialists funded from the State budget suspended from 2009.

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 - the Council) has been set up. It includes 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 the 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. Please provide pertinent figures, statistics 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).

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 2010 great number of employees of municipal social work specialists changed their occupation due to changes in local government.

Table no.45

Number of social work specialists who have acquired a second level vocational higher or academic education in social work or in caritative social work or continue to study

	2008	2009	2010	2011
have acquired	693	854	702	852
continue to study	105	102	119	74

Social Services and Social Assistance Law states that for social service to perform their tasks, they must have at least one social work specialist per 1000 inhabitants. According to government data, of 1 January 2010 this provision of social work specialists was limited to 2 of the 9 major cities and 46 of the 109 county governments. Overall conclusion is that on 1 January 2010 the city social services were provided at the level of 69% of the required number of social work specialists, and counties - 93% of the required number of social work specialists.

ARTICLE 14 PARA. 2

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

to encourage the participation of individuals and voluntary or other organisations in the establishment and maintenance of such services."

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

According to the Law on State Administration the State functions may be deputed to private person or other public person, if they can perform some tasks more effectively.

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 governments.

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 provider is able to provide social services (including NGO's, private service providers and other local governments), if necessary.

When receiving social care services the person has a duty to pay for it except of cases if the 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 local government. Home-care is a social care service funded by the local government.

Retired persons and disabled persons receive services in social care institutions financed from the municipal budget resources, 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 halfway homes and day care centre for persons with mental disorders.

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

In order to strengthen the initiated course to development of alternative social care and social rehabilitation services (hereinafter – alternative services), promote de-institutionalization and increase the quality of social care and social rehabilitation, already on 3 March 3 2009 the Cabinet of Ministers adopted „Programme for the Development of Social Care and Social Rehabilitation Services for Persons with Mental Impairments 2009-2013".

Within this programme there were foreseen several measures for ordering functions of social care centres and increasing the quality of social care services e.g.:
1) identifying the most suitable type of service for persons living in social care centres (including optimizing functions of child-care institutions by creating specialised departments, etc.),
2) attracting supplementary resources for providing social care service (additional social service providers, especially from organisations that does not belong to state administration) and decreasing the row to social care service),
3) creating a clear and optimal, on demand based scheme for providing services in social care centres,
4) arranging buildings (both from outside and inside), where social care centres are established in order to meat requirements for social service providers, etc.

Nevertheless, by raising European Union funds in the period of 2004-2006, with the support of the European Regional Development Fund (hereinafter – ERDF) and in cooperation with local governments, six half-way homes and five group houses (apartments) were established on the basis of social care centres. At the same time measures to organize infrastructure of social care centres were taken.

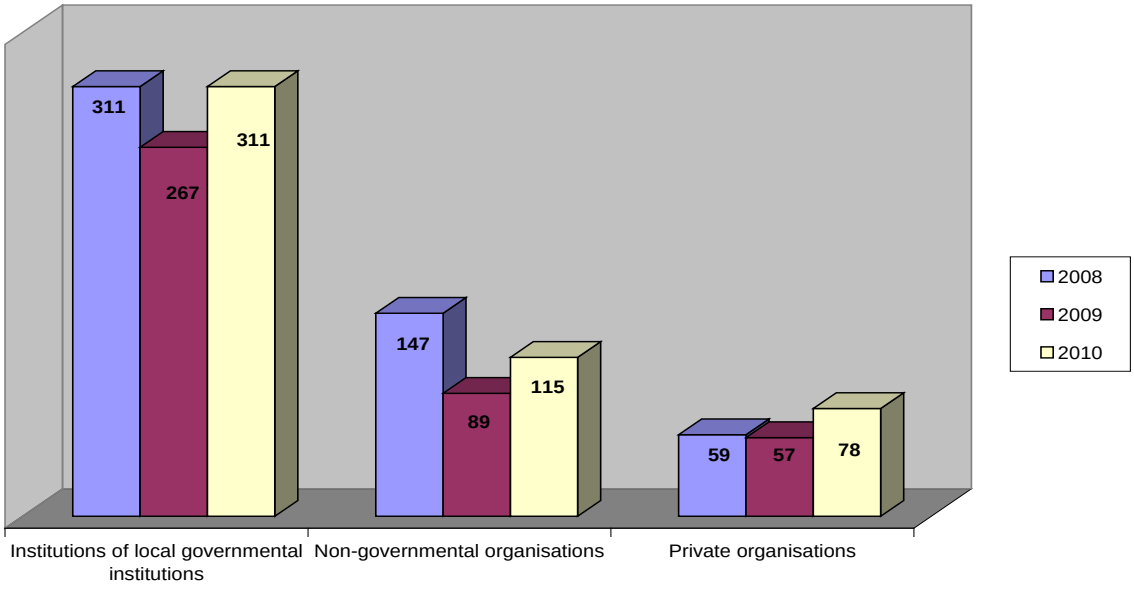
In the period of 2007-2013 Latvia receives financial resources from the ERDF for implementation of the project „Improving Infrastructure for Providing Social Rehabilitation Services to Persons with Mental Impairments" (2nd round) in five social care centres.

During 2011, a new system was developed and introduced for social service providers to evaluate the quality of their services themselves. This new self-evaluation system is based on the Common Assessment Framework of the European Institute of Public Administration, and provides comparable quality indicators across social service providers. At present, self-evaluation is voluntary, but in light of its superiority compared with the existing system for monitoring quality, self-evaluation is expected to replace it.

3. Please provide pertinent figures, statistics or any other relevant information to demonstrate the participation of the voluntary sector to the provision of social services, as well as the effective access of individuals to these services.

Table no.46

Social Services Providers

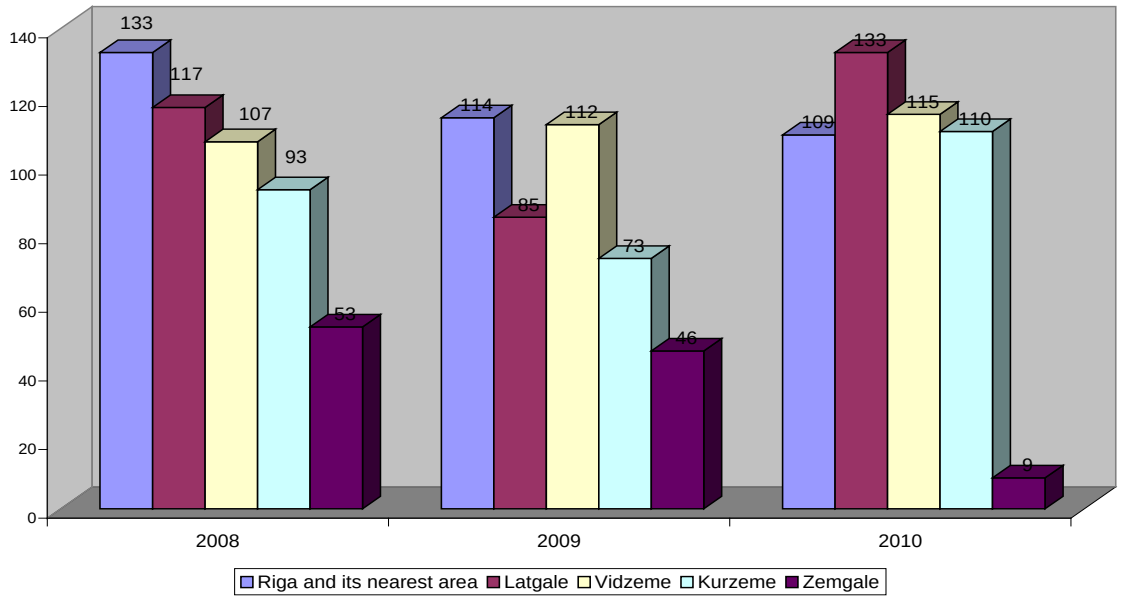


The number of social service providers during the period of 2008-2010 has not changed a lot. There have been cut downs in financial assistance received from the State budget. Because of the financial problems Latvia faced during the economical crisis in 2008 and 2009, it was important to reorganise the social service system. As a result some of social care and rehabilitation institutions were closed and/or united. Table no.46 presents social service providers in total and per category.

Both social service providers and their branches are situated throughout the country. As the most population of the inhabitants live in Riga and its nearest area, most of social service providers are situated there. Locality of social service providers also depends on the specific aims of the provider – for instance, institutions for persons with substance abuse problems are mostly situated in places that are closer to country-side. While institutions for children mostly are situated closer to schools or mostly populated areas. Table no.47 presents localities of social service providers in total and per regions.

Table no.47

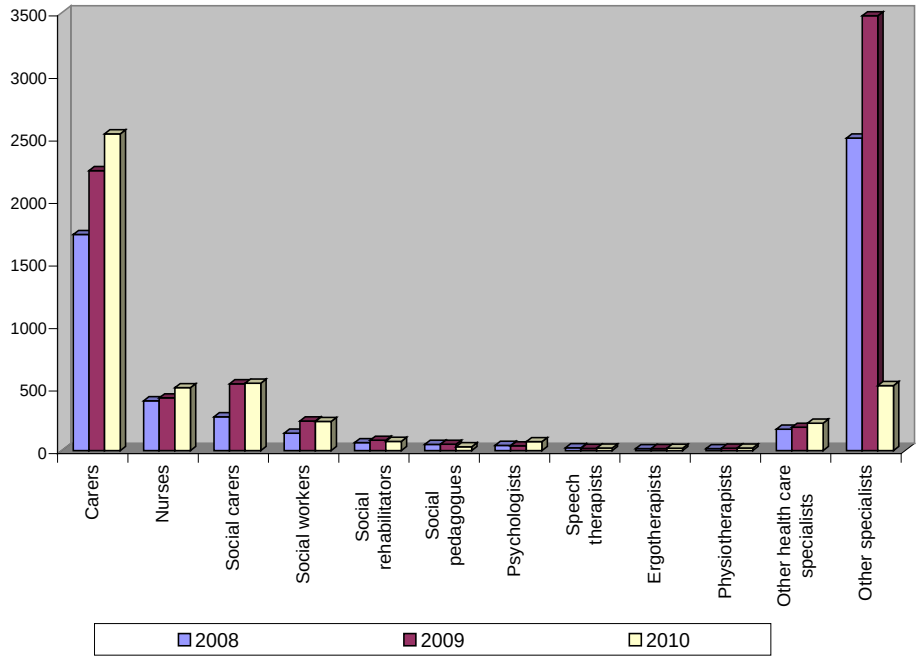
Locality of social service providers



Staff in social service providers vary depending on a type of the institution. There are more social work specialists and less health system workers in day centre, while there could be more health system workers than social work specialists in a long-term social care and social rehabilitation institution for elderly. By the Law on Social Assistance and Social Services it is complied to have a concrete number of social work specialists in the institution depending on the target group and a scope of the institution. Table no.48 shows the main qualifications of staff members in social care and social rehabilitation institutions that provide social services. As seen in this Table, remarkable changes regarding the qualification of specialists have happened. As mentioned before, structural reorganisation within the social care and social rehabilitation system was made. Therefore, not institutions have been reorganised only, but also qualifications of specialists have been reviewed. In some cases, duties of specialists have been either supplemented, or combined.

Table no.48

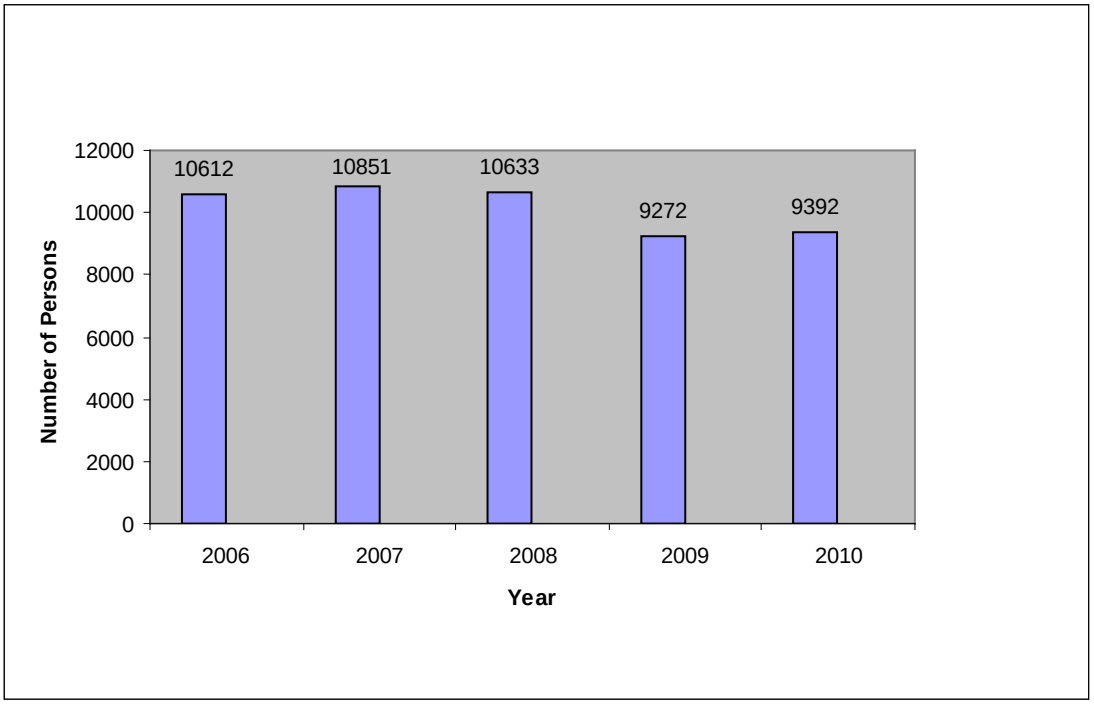
Qualification of specialists



The Table no.49 below presents tendency of the most frequently used type of care - home care.

Table no.49

Number of persons who received home care services



Next Tables (Table no.50-52) show the number of clients receiving social services in Long-Term social care and social rehabilitation institutions as from 2006 until the 2010.

Table no.50

Number of persons living in Long-Term Care Institutions

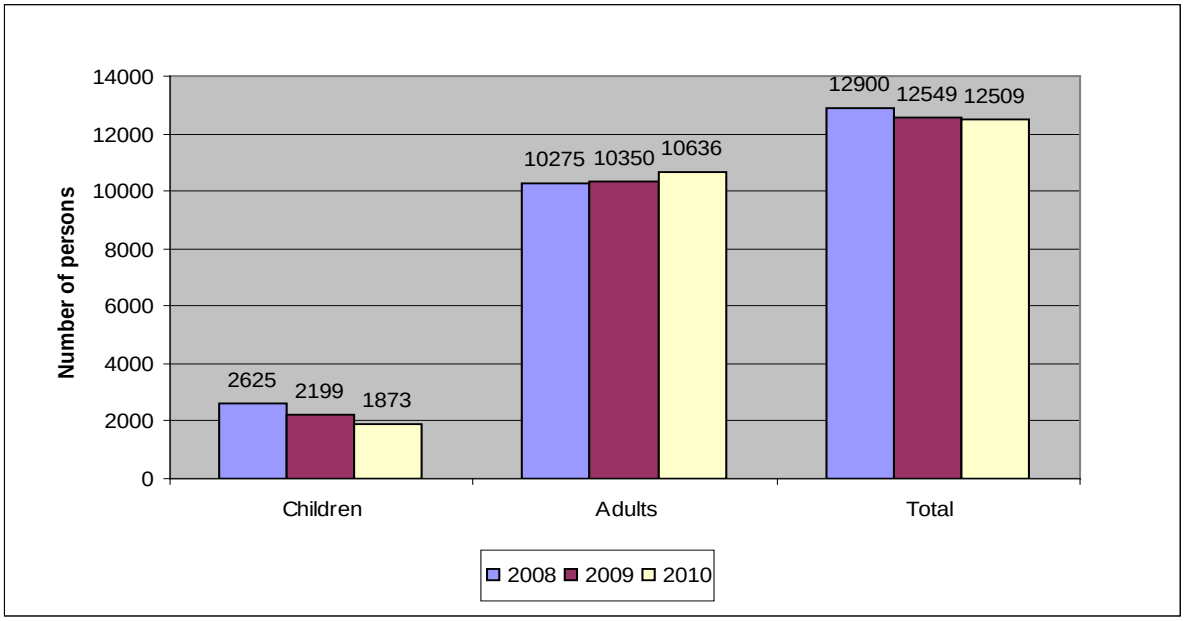


Table no.51

Number of adults living in Long-Term Social Care and Social Rehabilitation Institutions financed by the State

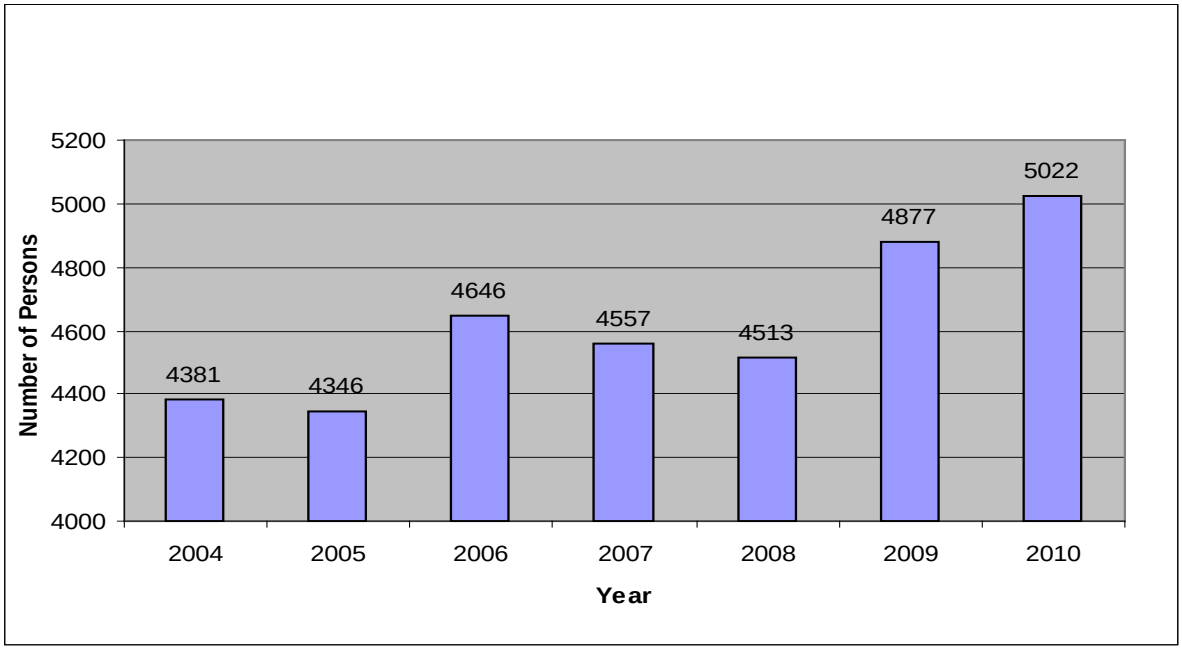
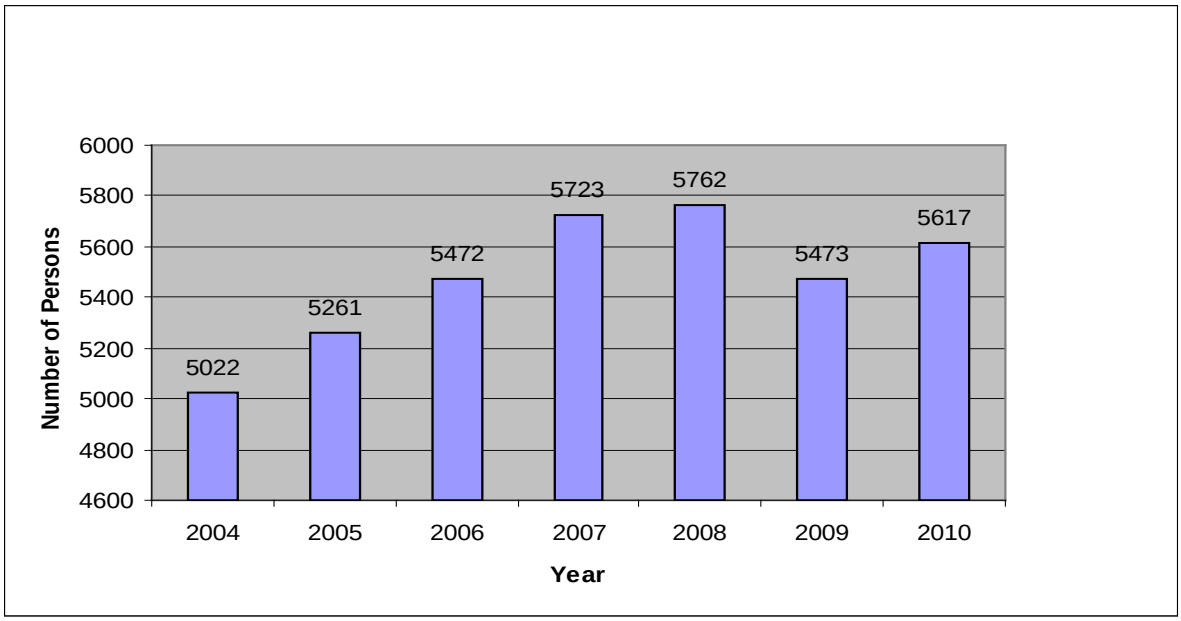


Table no.52

Number of adults living in Long - Term Social Care and Social Rehabilitation Institutions financed by the Local Government



Questions and Answers to Conclusions XIX-2

Article 11 – The right to protection of health

Institutions in charge:
MoH - Ministry of Health;
CDPC - Centre for Disease Prevention and Control;
SEMS - State Emergency Medical Service;
NHS - National Health Service;
HI - Health inspectorate of Latvia

Query: The main causes of death are diseases of circulatory system and tumours. What measures are taken to combat these causes of mortality?
Response: Main activities for reducing mortality from circulatory system diseases and cancer are defined in the following policy planning documents:

- Public Health Strategy for 2011-2017 (adopted by Cabinet of Ministers, Order No. 504 of 5 October 2011);
- Program for Controlling Oncological Disease for 2009-2015 (adopted by Cabinet of Ministers, Order No. 48 of 29 January 2009).

Program for Controlling Oncological Disease for 2009-2015 has been developed, which aims are reducing the incidence rate of oncological diseases, increasing the quality of life and life expectancy of the patients suffering from oncological diseases. To reach the aims of the program the following directions for action have been set: primary prevention, planned cancer screening, treatment, palliative care and field strategic management.

Furthermore, to facilitate access to practitioners (e.g. oncologist, gynaecologist) in 2008 the direct access practitioner list was extended, which makes secondary out-patient services available upon self-initiative (instead of referral by a family doctor).

Since 2009 a new preventive cancer screening program funded from the state budget has been developed. In order to enable timely diagnosis and treatment - diagnostic screening for Breast, Cervical and Colorectal or Bowel Cancer are performed.

State organized Cancer screening programme is based on Population Registry data and aimed at individuals, who are known to have increased risk (e.g. female over 50) for a particular Cancer type. In accordance with the increased risk factors, a personal invitation for performing cancer screening tests for the particular Cancer type is sent for the target group (except for Bowel cancer – family doctor is responsible for offering this test). Cancer screening program is regulated pursuant to the Regulation of Cabinet of Ministers No.1046 of 19 December 2006 “Procedures for the Organization and Financing of Health Care” (hereinafter – Regulation No.1046) (Annex No.37 “State Organized Cancer Screening”).

According to the Regulation No.1046 Annex 5 “Preventive checkups and examinations” regular health checkups for children and adults performed by family doctor or other practitioner are organised and covered by the State budget. Checkups for adults include: annual overall check-up performed by a family doctor (health complaints, weight, length, the state of mucuous membrane, oral cavity, neck, axilla, inguinal lymphatic gland, palpation, thyroid gland projection, breasts, arterial tension, pulse rate, body temperature, function of the heart and pulmonary auscultation, abdomen palpation, digital rectal

palpation for patients over 50, vision, hearing, psyche, sensory receptor, movement, neurological disorders, trauma after-effect assessment).

Family doctors and the preventive screening policy play an important role in timely symptom diagnosis, which is a prerequisite for effective treatment, also for chronic diseases.

Since 2011 family doctor practices may employ a second medical nurse, who will facilitate early disease diagnosis and health literacy of the society.

To facilitate timely healthcare provision a telephone service for family doctor consultations is available since May 2011, for consultations outside regular family doctor working hours. It will enable patient access to medical consolations and acquire needed information in acute situations and in cases of worsening health status of chronically ill.

Query: The Committee notes that there is a clear disparity between the situation in Latvia and that of other European countries with regard to deaths caused by ischemic heart disease, suicide, accidents and homicide. What measures are being taken to remedy this situation?
Response: External causes of injuries and even death (traffic accidents, drowning, falls, freezing, suicides, suffocation, choking, exposure to fire and smoke) in children and young people (aged 0-19) are among the most substantial public health problems in Latvia. By comparing mortality (per 100 000 inhabitants) due to external causes among age groups (every 5 years), the highest proportion is seen in the age group 15-19 and 0-4.
Regulation of Cabinet of Ministers No. 263 of 4 April 2006 “Procedures for the establishment, supplementation and maintenance of registry of patients suffering from specific diseases” stipulate that a registry on injuries shall be established.

Measures to decrease deaths, caused by ischemic heart disease and accidents, are emphasized in policy planning documents:

1. One of such documents is Public Health Strategy for 2011-2017 aimed at improving the health status of Latvian population. One of goals of this strategy is: „To facilitate the development of a safe environment, to improve general knowledge among population in regard to any possibilities there might be to avoid traumas in everyday life, during leisure activities and while engaging in physical activities, on the correct course of action to take in the case of an injury in order to prevent trauma, and facilitating the creation of a safe environment”.
2. Cardiac and circulatory diseases form the most significant public health problem in Latvia and one of the most important in the whole world. One of the goals of the Public Health Strategy for 2011-2017 is: “To decrease morbidity and mortality from non-infectious diseases (including cardiac and circulatory diseases), and to decrease the negative impact of risk factors upon the health”.
3. Road Traffic Safety Program 2007-2013 (adopted by the Cabinet of Ministers Order No. 209 of 13 April 2007) aimed to decrease the number of deaths as a result of traffic accidents by 70% (in comparison with 2001).
4. An activity plan for the implementation of concept "State family policy" 2004-2013 (adopted by the Cabinet of Ministers on 30 November 2004). Its objective is to create family-friendly conditions in the State by implementing a concept “State family policy” (adopted by the Cabinet of Ministers on 28 May 2002).

In order to decrease traumatism and violence against children, various decisions, compulsory methods, have been made:
According the amendment in the Medical Treatment Law which came into effect in January 2011: "If a medical institutions providing assistance to the patient and there is reason to believe that the patient has suffered from violence, the medical institution shall, not later than in 12 hours, notice to the State Police. If a medical institution providing assistance to a minor and is reason to believe that the patient suffered from due care and lack of supervision or other children's rights violation, the medical institution shall, not later than in 12 hours, notice to the State Police."

In 2011 Cabinet of Ministers accepted Children (0-5 age) physical and mental development assessment form, which family doctors can use during patient's visits.
A number of institutions have been involved in several activities related to child safety: the Ministry of Welfare, the State Children Rights Protection Inspectorate and crisis centres. In cooperation with municipalities, an informative and educational campaign related to child safety on roads and at home was organized; numerous informative campaigns related to violence of adults and peers and violence on the Internet are being implemented.

Children safety is closely linked to child- and family-friendly environment. Therefore, several initiatives drawing public attention to these problems have been implemented recently: children- and family-friendly companies, recreation places, towns etc. In 2011 the Ministry of Health elaborated „Guidelines for Health Promotion in Municipalities" (adopted by Ministry of Health Order No.243 of 29 December 2011) and one of tasks of this guidelines is facilitation of safety promotion in local level.

Main activities for reducing mortality from circulatory system diseases and external causes as well are defined in following policy planning documents:

- Framework Policy Document "Improvement of Inhabitants' Mental Health for 2009-2014" (adopted by Cabinet of Ministers, Order No. 468 of 6 August 2008);
- Program for decreasing domestic violence 2008 – 2011 (adopted by Cabinet of Ministers, Order No. 343 of 18 June 2008).

Mostly statistical data are not available by groups: urban and rural area. Some data from surveys are available in such breakdown (Please see the information provided in the Report).

Query: The Committee asks for information on policies to combat infant mortality.
Response: Perinatal mortality in Latvia has been decreasing over time; in 2009 this indicator was at 9.6 per 1,000 live and stillborn births, but in 2010 this indicator decreased to 8.2. This indicator in Latvia is higher than the average in the EU. It is mainly caused by the comparatively large number of stillborn children[49].

Since 2001 the infant mortality rate (covering children who have died during the first year of life, with rates at 11.0 per 1,000 live births) has decreased to 5.7. per 1,000 live births in 2010.[50]

[49] Public Health Strategy for 2011-2017 (adopted by Cabinet of Ministers Order No.504 of 5 October 2011)
[50] Public Health Strategy for 2011-2017 (adopted by Cabinet of Ministers Order No.504 of 5 October 2011)

The main causes of infant mortality are concrete perinatal conditions. Hereditary anomalies are the cause of death for approximately one third of children who die during the first year of life, and also external causes continue to be the cause of infant death, even though they can be limited or even prevented.

To improve the health of child, to decrease infant mortality, to ensure the care of newborns at a high level, a united implementation of the approach to mother and child healthcare must continue.

In 2011 Public Health Strategy for 2011-2017 one of the objectives is – to improve the health of mother and child, and decrease infant mortality.
The healthcare of children, pregnant woman and persons with a predictable disability has been set as a policy priority corresponding to The Medical Treatment Law, Article 3 Part two.

The Maternal and Child Health Improvement Plan 2012 – 2014 is elaborated and adopted in accordance with the objective of Public Health Strategy 2011 – 2017: to improve the health of mother and child, and decrease infant mortality, which is in line with the United Nations Millennium Development Goals to reduce child mortality and improve maternal health. To reach the main aim of the Plan, the following points of progress have been set:

- Activities for maternal and child health care improvement, including pregnancy care, improvement of the birth process management, as well as introduction of the principle "money follows the pregnant woman", to involve gynecologists and other specialists from the private sector into the state-funded maternity care. It is planned to establish a monitoring and analysis system to operatively implement necessary changes in perinatal care system and to audit cases where mother has died. It is also expected to restore the Baby-Friendly Hospital Initiative in Latvia, as well as to distribute informative materials for new parents about baby care and safety.
- Intersectoral cooperation in the field of maternal and child health, provision of education for young people and teenagers and prevention of violence against children. It is planned to develop school curricula promoting integrated health, sport's education and human security issues. At the same time it is planned to develop non-formal education for adolescents on sexual and reproductive health issues in cooperation with non-governmental organizations and local authorities.

Main activities for reducing infant mortality also are defined in following policy planning documents:

- Public Health Strategy 2001-2010;
- Action Program for Implementation of the Public Health Strategy 2004-2010.

Query: What measures were planned to combat maternal mortality and improve medical monitoring of women during pregnancy?
Response: In 2008, when compared to 2007, maternal mortality significantly decreased, reaching the indicator of 12.5 per 100,000 live births (in 2007 it was 25.8). However, in 2009 maternal mortality increased, reaching the indicator of 46.1 per 100,000 live births. The cause of deaths in eight out of ten deceased women was linked directly with pregnancy[51]. In 2010 this indicator decreased (26.1 per 100,000 live births) and in four out of five mothers who died the cause of death was directly linked with pregnancy. This

[51] Public Health Strategy for 2011-2017 (adopted by Cabinet of Ministers Order No.504 of 5 October 2011)

indicator is still the highest in the EU (in 2009 the average maternal mortality rate in the EU was 6.33 per 100,000 live births)[52].

In order to improve maternal and child health in Latvia including to reduce perinatal mortality and maternal mortality, in 2012 Maternal and Child Health Improvement Plan for 2012-2014 is adopted by Cabinet of Ministers Order No.269 of 19 June 2012.

To reach the main aim of the Plan, the following points of progress have been set:
1.Activities for maternal and child health care improvement including to establish a monitoring and analysis system to operatively implement necessary changes in perinatal care system and to audit cases where mother has died.
2.Including infertility treatment into a state-funded service.
3.Intersectoral cooperation in the field of maternal and child health.
Furthermore, the previously mentioned possibility to employ second medical nurse at the family doctor practices is also intended for improving the health of newborns.

Childbirth service in in-patient facilities that are contracted by the National Healthcare Service is a State Budget covered service. Pursuant to Regulations 1046, Section 10.2 - pregnant woman and woman in childbed (till the 42nd day) do not have to pay patient payments, if services that are related to pregnancy and postnatal observation are provided.

Amendments in the Regulation of Cabinet of Ministers No.611 of 25 July 2006 “On the order of provision of puerperal care” are being prepared in order to improve the healthcare of mother and child. In order to reduce the risk of hereditary pathology, as well as to improve access to pregnancy related healthcare services the expected amendments anticipate the implementation of additional tests for pregnant woman. Furthermore, amendments in the regulations are being prepared in order to offer financial support to all pregnant women for a voluntary flu vaccination (50% vaccination cost coverage) and 50% prescription drug cost reimbursement for children under the age of 24 month and 25% prescription drug cost reimbursement for pregnant woman and woman in postnatal period (till the 42nd day).

Query: What are initial conclusions on the implementation of the 2007-2013 National Development Plan?
Response: One of the tasks of National Development Plan is to improve access to health care services through the development of the health care infrastructure, particularly focusing on primary heath care and emergency medical assistance. To ensure this task the hospital services were concentrated and outpatient services were developed.

These measures have led to decline in the total number of hospitalizations in hospitals and hospital stays. Consequently, in recent years has reduced the average duration of treatment in hospital - from 9.4 days in 2008 to 8.6 days in 2011.

The average number of outpatient visits to a family doctor per patient in 2011 has increased and has already reached in 2013 planned - 3.1 a visit to the family doctor to a patient.

[52] WHO Health for All database

Outpatient visits to secondary outpatient care physician (specialist) for 1 patient visits increased from 1.3 in 2008 to 1.5 visits in 2011. Continuing development of ambulatory health care, this figure is likely to reach the planned in 2013 - 1.6 visits to a specialist per patient per year.

Timely completed the emergency call rate in urban areas (up to 15 minutes) in 2011 compared to 2008 increased from 75% to 88.9%, while in rural areas (25 minutes) - from 75% to 79.6%. The State Emergency Medical Service establishment in 2010 definitely influenced the improvement of figures above, as well as new emergency medical aid stations and crews establishment.

To ensure National Development Plan task - to promote the social integration of mental health care (development of community-based mental health services and mental health issues involved in managing institutional cooperation, to educate the public about mental health and mental illness) - Framework Policy Document “Improvement of Inhabitants’ Mental Health for 2009-2014” were adopted by Cabinet of Ministers in 2008.

To ensure National Development Plan task - to form a balanced State and individual responsibility for health maintenance and improvement, build community awareness of healthy lifestyles and nutrition, and involve the community in the fight against the disease of addiction (alcohol, drugs, psychotropic, toxic substances, gambling or computer game addiction) – were developed action plans or programs in different health fields, for example, the “Healthy Nutrition (2003–2013)”, the Framework Policy Document for Limiting Drugs and Psychotropic Substances and the Spread of Addiction and Control for 2011–2017 (please see information provided in the 8th Report of Latvia).

Query: Which kind of access to health care is for disadvantaged persons, particularly the meaning of the expression “persons in financial difficulty”, who were said to be exempt from all contributions?
Response: To mitigate the effects of the crisis and to avoid the impact of the different austerity measures on the most vulnerable part of society, while supporting measures to improve efficiency in the social sectors, the Emergency Social Safety Net Strategy (Strategy) was created in 2009. The Measures of the Strategy in the health sector included a coverage of health services and pharmaceuticals for poor households as well as development of day in-patient care for persons with mental illnesses, provision of home-care for persons with chronic illness, etc.

In 2010 and 2011 there were three poor patient groups, which was definitely different preferences when receiving health care services:
1. Persons with income under 90 LVL;
2. Persons with income under 120 LVL:
   - For the 1st and the 2nd group of patients, the patient contribution, expenses for “patient hotels”, health care at home, mental care and medicinal products are reimbursed in the amount of 100%;
3. Persons with income under 150 LVL:
   - For the 3rd group of patients, patient contribution is reimbursed in the amount of 50%.

In 2012 only poor persons, who have been recognised as such in accordance with the regulatory enactments regarding the procedures by which a family or a person living alone shall be recognised as poor, shall be exempt from a patient contribution, expenses

health care at home, mental care and medicinal products are reimbursed in the amount of 100%. Also in 2013 will be to continue the measures of the Strategy to support poor persons.

Query: Which kind are "waiting list" criterias and management methods?
Response: The National Health Service developed report and recommendation for the management of waiting lists and waiting times in health care. Work on the development of criteria continued.
If the patient expected waiting time for health care services for more than 5 days, then medical institution is obliged to provide an overview of the queue for elective outpatient service to receive treatment centre.

Query: How many pharmacists there are, both in absolute figures and per 10 000 inhabitants?
Response: According to the Latvian Pharmacists Association data, the number of pharmacists in Latvia in three years period has slightly increased. In 2008, there were 2973 Latvian pharmaceutical specialists in absolute figures (13.1 per 10 000) which of them were 1504 pharmacists and 1469 pharmacist assistants. In 2010 there were 3134 pharmaceutical specialists in absolute figures (13.9 per 10 000 inhabitants), which of them were 1654 pharmacists and 1480 pharmacist assistants.

Query: Are there also specific information campaigns intended to inform the public about subjects such as alcohol and illegal drugs, smoking, eating, sexuality and the environment?
Response: 1. Regarding alcohol, tobacco and illegal drugs, information leaflets have been issued:

- "The alcohol dose counting";
- "The addiction treatment options";
- "Passive smoking";
- "Children and the addictive substances";
- "All about smoking", etc.

2. To inform adolescents on the harmful effects of smoking on health various informative and educational materials for students have been issued - posters, stickers, key holders.
3. 2000 copies of films about alcohol and other drug prevention for young people were distributed in schools in 2008 to ensure information for teachers and 9th-12th grade students on alcohol prevention.
4. In collaboration with social networks in 2010/2011 school year campaign "Nonsmoking class" was organized. During the campaign, students were informed about the harmful effects of tobacco use.
5. In 2010 information campaign was organized on the 12-year-old girl's vaccination against cervical cancer. Informational materials were distributed to schools to inform about the vaccination program.
6. Informational material for young mothers "Breastfeeding ABC" was issued to promote breastfeeding. This material was distributed to all maternity clinics, hospitals, gynecologists.
7. In 2008 the campaign "Eat regularly and healthily" was launched. Children – 1st grade students from all Latvian schools received lunch boxes, information materials for primary and pre-school children 'What do we eat", food pyramid and a poster with healthy snack samples. 12 973 lunch boxes were delivered to schools.

8. “5 a day” campaign to promote fruit and vegetable consumption was organized in 2010 – 2011 in collaboration with NGOs and the private sector.
9. Information materials for public on healthy nutrition were issued:
- "The fruit and vegetable consumption";
- "Healthy eating for the elderly (60+)";
- "Choose healthily";
- "Drawing up a balanced diet 1st to 4th grade students";
- Healthy Food Pyramid.

10. With regard to the safety of children several informative materials were issued (booklets: "Safety" and „How to save your child’s life”, sticker “It’s dangerous to hitchhike”). These booklets were distributed in schools, local governments, at family doctors’ practices etc.

Query: Whether sex and environmental education formed part of the primary and secondary school syllabuses.
Response: According to the Regulation of Cabinet of Ministers No. 1027 (adopted 19 December 2006) “Regulations Regarding the State Basic Education Standard and Basic Education Subject Standards” health education issues are included in the subject "Social Sciences" content for 1. - 9th grade students. Although according to the Regulation of Cabinet of Ministers No.715 “Regulations Regarding the State General Secondary Education Standard and General Secondary Education Subject Standards” (adopted 2 September 2008) subject "Health education" is defined as one of the optional subjects of General Secondary Education compulsory programs content for 10th-12th grade students.

Query: Preventive medical examinations are organised for children to reduce the number of illnesses. They cover about 90% of children. Who are the remaining 10% and what is done for them?
Response: There could be many reasons of such result:
- Not all doctors have informed statistical office about this examination.
- Percentage (coverage) of preventive medical examinations is calculated using number of persons in corresponding age (statistic of demography). There could be situation that this number of persons is not correct because of emigration (these children’s could live in other countries).

Not all children visited GP’s regularly, so preventive examinations were not performed on a regular basis.

According to Regulation 1046, Annex 5 – in certain cases, for example, if the child is not present at the preventive medical check-up, home care visits are organized at the following occasion:
- For children at the age of 2-18 years annual preventive check-up by family doctor;
- For newborns until the age of 1 family doctor (nurse or doctor’s assistant) home care visits are organized in several occasions;
- For children at the age of 1-6 month once per month at the family doctor’s practice or home care visit by nurse or doctor’s assistant, if the child is not present at the check-up in the family doctor practice;
- For children at the age of 7-11 month - twice in the mention time frame and once at the age of 12 month at the family doctor practice or home care visit by nurse or

doctor's assistant, if the child is not present at the check-up in the family doctor practice.

Education institutions are jointly responsible for preventive children health check-ups because the child has to have the Children Medical Record card upon admission to the education institution confirming preventive medical examination. Furthermore, the director of the education institution is responsible for annual preventive medical checkups (to be further described in the following question).

In accordance with The Maternal and Child Health Improvement Plan 2012 – 2014 it is planned to strengthen the role and further develop preventive checkups for children.

Query: What measures are taken during the reference period on air pollution, water pollution, noise pollution and soil pollution?
Response: The Environmental Policy Strategy 2009–2015 was approved by the Cabinet of Ministers Order No. 517 of 31 July 2009. The Strategy deals with different aspects associated to environment including air pollution, water pollution, noise pollution and soil pollution. It sets the general framework for coping with these problems in terms of necessary improvement of legislation and action programs.

Chapter 3.4 of the Public Health Strategy for 2011-2017 "A healthy and safe environment" reflects the main problems and necessary future steps with respect to environmental health issues associated to environmental pollution.

In order to solve these air quality problems, the newest Action Program on Improvement of Air Quality in Riga for 2011-2015 is approved by the Resolution of Riga City Council No. 3285 of 7 June 2011. In addition, the Action Program on Minimizing of Environmental Noise in Riga is approved by the Regulations of Riga City Council No. 168 of 28 February 2012 determining the actions to be carried during 2011-2019. In general, the air quality and environmental noise problems are not expressed in other parts of Latvia.

As regards the general water pollution and quality, the River Basin District Management Plans separately for Daugava, Gauja, Lielupe and Venta River Basin Districts have been approved by the Minister for Environment Order No. 143 of 6 May 2010. These River Basin District Management Plans are elaborated according to requirements laid down by the Directive 2000/60/EC of the European Parliament and of the Council establishing a framework for the Community action in the field of water policy (Water Framework Directive). Management Plans envisage actions to be performed until 2015 in order to achieve at least good ecological quality of all water bodies delineated in the country. Besides, soil pollution problems (elimination of polluted or potentially polluted sites in the river basin districts) are addressed within the mentioned Management Plans, too.

Since 2008, Latvia has implemented the EU Bathing Water Directive (2006/7/EC) setting new criteria and approach for assessment of bathing water quality. The mentioned directive was transposed into national legislation by the Regulations of Cabinet of Ministers No.608 on bathing water monitoring, quality assurance and requirements for public information (approved in 2010, last amended in 2011). According to the assessment for 2008-2011, 93 % of Latvian bathing places are in excellent, good or sufficient quality status complying with 2006/7/EC criteria to be reached by 2015.

Health Inspectorate of Latvia performs regular inspection of all public water networks.

Query: The Committee asks for updated information on measures in force in food safety field.

Response: The Regulations of Cabinet of Ministers No.172 “Nutritional norms for pupils in educational institutions, social care and social rehabilitation institutions clients and medical institutions patients" (adopted in 2012), aim - to ensure that children in kindergartens, pupils in primary and secondary schools, patients in medical institutions (hospitals) and social care and social rehabilitation institutions receives balanced diet, as well as promote healthy eating habits to reduce the risk of communicable and non communicable diseases. Regulation defines the energy and nutrient standards, the amount of salt and sugar added to meals and also food products that need to be included (example fresh vegetables, fruits, milk, etc.) or excluded from daily diet (for example French fries, sausages, dried, smoked, salted meat, fish or meat products, frozen meatballs, fish fingers, etc.).

Query: Whether smoking is banned in all public places?

Response: According to the Law On Restrictions Regarding Sale, Advertising and Use of Tobacco Products prohibition to smoke covers not absolutely all public places and public events, but includes main public areas such as:

1) educational and correctional institutions;

2) medical treatment institutions, social care and rehabilitation establishments, places of imprisonment, except for premises, which are specially designated for smoking. The internal procedure regulations of the relevant institutions and establishments may provide for the possibility of the patients of the institutions or the inmates of the establishments to smoke also outside of the premises, which are specially designated for smoking, taking into account the physical and mental condition of such patients or inmates;

3) closer than 10 metres from the entrance of buildings or structures (also on the outside steps and landings), where the State or local government institutions and capital companies in which more than 50 per cent of the capital shares (stock) is owned by the State or local governments are located. In such places there shall be displayed informative notices or symbols regarding the prohibition to smoke;

4) the shelters of public transport stops and on platforms;

5) the stairwells, hallways and other shared-use facilities of multi-apartment residential buildings;

6) places of work in work-spaces and areas of common use, with the exception of specially designated smoking premises;

7) public buildings, structures and premises (cinemas, concert and sports halls, other sports buildings and structures, post offices and other institution halls, discotheques and dance halls, etc.). This prohibition does not apply to existing apartments in public buildings;

8) public of transport and taxis, with the exception of long-distance trains and ships, where there may be separate railway carriages or cabins designated for smoking;

9) during sports and other public events in stadiums and other enclosed territories, with the exception of specially designated smoking areas;

10) children’s recreation areas and playgrounds;

11) parks, squares and at bathing areas, except for specially designated smoking areas;

12) cafes, restaurants and other public catering locations, except in summer (open air) cafes only in specially designated smoking areas.

Smoking is banned in all previously mentioned public places with just several exceptions:
(1) in summer (open air) cafes only in specially designated smoking areas;
(2) in casinos and gaming halls it shall only be allowed to smoke in premises specially designated for smoking or in premises, which are separated for smoking;
(3) hotels and other short-term residence dwellings may have specially designated bedrooms in which it is permitted to smoke.

Query: According to Regulation No 591 issued by the Cabinet of Ministers on 28 July 2008 on 'Aliens' health insurance', aliens applying for a visa or temporary residence permit must present a valid health insurance package that covers emergency medical assistance, emergency medical treatment in hospital and repatriation. In this connection the Committee asked in a letter addressed to the Government whether those foreigners who do not have to apply for a visa to come to Latvia and happen to be without health insurance and adequate resources, will receive emergency medical assistance. The Committee notes from the supplementary information provided by the Government that by the virtue of Sections 16 and 17 of the Medical Treatment Law everybody has the right to receive emergency medical care and therefore those aliens who do not have health insurance or adequate resources have the right to receive emergency medical care. The Committee asks what is the nature and extent of such emergency care.
Response: All Member States of EU have European health insurance card, as well as Norway, Iceland, Liechtenstein and Switzerland have a common document certifying for population of these countries to receive emergency and necessary medical assistance guaranteed by the State in the same volume and for the same payment as it is provided to definite population in the correspondent country.

European health insurance card is unified document standard in all EU and every country fills in this form in its national language. Usually, this card is issued to population with short-term stay time, for instance, students, tourists.

Both of a married couple - citizens of Latvia and non-citizens of Latvia, who have a residence permit for a certain period of time in Latvia, have the right to receive free of charge pregnancy care and child delivery aid from the State capital budget.

Foreigners present in Latvia with or without health insurance are subjects to the same emergency medical care rules as any other person staying in Latvia; therefore, the extent and nature of emergency medical care is equivalent for everyone, including foreigners who do not have to apply for a visa to come to Latvia and happen to be without health insurance.

Query: The Committee asks whether unlawfully present foreigners, who are not staying in accommodation centres for detained foreigners are entitled to receive emergency social and medical assistance in situations of immediate and urgent need. It also asks whether a clear legal basis exists in law for the provision of this form of assistance.
Response: In Latvia, according to the Article 17 of the Law on Medical Treatment, health care services that are paid by the State can be received by fugitives and persons, who have been assigned an alternative status.