



Semester Alliance

Focus on **Latvia**

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Semester Alliance: Focus on Latvia

In brief

Latvia faces major challenges in relation to healthcare and poverty, particularly as regards adequate social protection, and access to affordable housing. It suffered sharp economic decline as a result of the crisis and then further pain as austerity measures promoted by the European Commission resulted in massive cuts in public spending. Latvia is not an austerity success story and urgent and major action is needed to reduce poverty, address housing shortages and turn the ailing health system around.

The Executive Summary of the European Commission's Country Report on Latvia notes in relation to poverty and inequality that only limited progress has been made on improving the adequacy of social assistance benefits and shifting the tax burden away from low paid workers. On healthcare it also notes limited progress on improving accessibility and cost-effectiveness.

Neither the Executive Summary nor the full Country Report has anything to say about access to affordable, quality housing or the problem of homelessness. Children or young people are not visible enough in the Semester process, as they are only referenced with regard to the education system reform or youth unemployment, neither of which is addressed from a child-rights perspective.

Below are suggestions from the Semester Alliance of the kinds of Country Specific Recommendations that are needed in 2017 to begin to tackle the major challenges across these three policy areas. Key facts and figures from the Country Report as well as further data from other sources are then presented on the following pages:

Macroeconomic Framework

- Allow budget flexibility to support social and health investment as proposed in the Country Specific Recommendations, as a social investment not as a cost.

Health (pages 5-10)

- Increase spending to 4.5% of Gross Domestic Product by 2018.
- Reduce out-of-pocket spending by at least 10 percentage points by 2018.
- Increase the lowest pay rates in the health service above the national average trend.
- The government should clarify that any plans to restructure financing of the health service will not include a strategy of privatisation.

Poverty, inequality and taxation (pages 11-14)

- **Increase overall spending on social protection towards the EU average (19.5%) to ensure adequate income support throughout the life cycle.**
- **Agree on a road map to raise the level of the minimum income benefit to the 60% poverty risk threshold and ensure that all benefits meet the proposed minimum income level and all groups are covered.**
- **Reduce the poverty risk for pensioners, single parents, and large families.**
- **Further reduce taxes on low wages, and support moves towards more progressive taxation both through the income tax systems and by reducing VAT on food and basic services to reduce inequality.**
- **Implement a system to measure and monitor child poverty and children's well-being, in order to establish targets and goals to be achieved.**
- **Shift tax burden to other forms of taxation, notably environmental taxes with complementary compensatory measures alleviating any undesired distributional effects on poor segments of the population.**

Housing and homelessness (page 15)

- **Start to collect adequate data in order to assess the nature and extent of the homelessness problem.**
- **Develop an integrated strategy to tackle homelessness.**
- **Increase investment in housing maintenance.**
- **Take measures to ensure access to adequate, affordable housing for all.**
- **Boost social housing to tackle overcrowding.**

Health

Country-specific recommendations

In each of the last three years (2014-2016) there have been recommendations for Latvia to improve the accessibility, quality and cost-effectiveness of the healthcare system. The 2015 recommendation additionally called for a link between hospital finance and performance. In 2016 the recommendation on public finance also allowed for a deviation from the adjustment path towards the medium-term budgetary objective to cover pension reform and “major structural reform in the health sector.”

State of healthcare

The European Commission’s country report for 2016 makes clear the state of healthcare and the health of its citizens remain in a critical condition: “Latvia lags well behind other Member States in terms of general health of the population”. It also spells out in some detail the disastrous results of Latvia’s poor health care system. Life expectancy in Latvia is five years shorter for men than the EU average (72.9 as compared with 77.8) and three years shorter for women (80.1 versus 83.3).

Like the rest of the EU, Latvia faces the health challenges posed by an ageing society and twenty-first century lifestyles. However, it is striking that Latvia’s health performance is much poorer than other EU states, and the key reasons for this, as the Commission report points out, are that, “Access to healthcare is hampered by low public financing and high out-of-pocket payments, leaving a high proportion of the population with unmet healthcare needs”.

Overall, the Commission report concluded that in Latvia “the rates of potentially amenable and preventable mortality are respectively the highest and the second-highest in the EU”. Latvia is also one of two countries with the highest level of new HIV and AIDS diagnoses in the EU and these rates are increasing. The rate of hepatitis C reported cases, at 62.6 per 100,000 persons, is more than eight times the EU average of 7.6.

Other sources confirm the worrying trends. A World Bank study produced for the Latvian government in 2015 found that “In Latvia people are dying earlier than in most other EU countries due to three main reasons. Latvia has third highest mortality rate due to diseases of the circulatory system (DCS) in the EU, the fifth highest death rate from cancer and the second highest mortality rate due to external causes [such as suicides and traffic accidents]”.

Apart from the personal impact of these figures, Latvia’s poor state of health has an economic impact. As the Commission report states, “Mortality rates before the age of 65 are the second highest in the EU and are estimated to reduce the workforce in Latvia by 3.9 % when compared to its potential if mortality rates were equal to the

EU average". This is a particular difficulty in Latvia where the labour force is already declining.

Figures from the European Core Health Indicators database show that for men the length of time lived in good health and without disabilities averaged only 51.5 years in Latvia in 2014, 10 years less than the EU28 average of 61.4 years, while women can expect 55.3 years of healthy life in Latvia, six and a half years fewer than the EU28 average of 61.8.

Spending on health

The position on total health spending is stark and confirmed by figures from the Global Health Expenditure Database of the World Health Organisation (WHO) for 2014 show that Latvia spent just 5.9% of its GDP on health, well-below the EU28 average of 10.0%. WHO data also reveals the extent to which spending has fallen. In 2014 it was still 21% lower than in 2007. Low investments in the health system have exacerbated quality and access, in particular for vulnerable and lower-income groups.

As well as the overall amount spent on health, the Commission report also criticised the high proportion of spending that is not paid for by the state but covered by private out-of-pocket health payments. In relation to GDP, government spending on health was just 3.7% in Latvia in 2014, the lowest of any EU state other than Cyprus (3.3%). Both Estonia (5.0%) and Lithuania (4.4%) spent more (WHO Global Health Expenditure Database).

Trends

While the Commission country report provides a range of data as evidence of the very poor state of Latvian healthcare, there is little on the trends in these figures, many of which reveal a worsening of the situation.

WHO figures on health spending, for example, show that despite the fact that GDP in Latvia fell sharply as a result of the financial crisis from 2008 onwards, total health spending as a proportion of GDP declined until 2013, falling from 7.0% of GDP in 2007 to 5.7% in 2013, before recovering slightly to 5.9% in 2014.

Expressed at constant prices (2010), Latvia's total health spending dropped from €1,135 million in 2007 to €821 million in 2011, a 28% fall. It has since recovered to €867 million in 2014, but this is still 24% below the 2007 level. Reduced government spending on health played a key role in driving down overall health spending. Government health expenditure fell by 27% between 2007 and 2010 – its lowest point – and in 2014 it was still 21% lower than in 2007 (WHO Global Health Expenditure Database).

There appears to have been little improvement in these factors since 2009, with total government spending on health only slightly (3.9%) higher in 2014 than it was in

2009 and still substantially below the 2008 figure (-14.9%). Health also took up a smaller proportion of total government spending in 2014 (10.2%) than in 2008 (11.7%) (Central Statistical Bureau of Latvia (Table VFG04).

Out-of-pocket payments and inadequate compensation

More than a third (35.1%) of total health expenditure in Latvia in 2014 was covered through private out-of-pocket payments, compared with an EU28 average of 13.9% (WHO). Only in Bulgaria (44.2%) and Cyprus (48.7%) was the proportion of these out-of-pocket payments higher. It was lower in Lithuania (31.3%) and much lower in Estonia (20.7%).

One result is that Latvia has the highest proportion of the population who say they have unmet needs for health care services due to financial barriers, waiting times or travelling distances. In Latvia in 2014, one in eight people (12.5%) is in that situation, compared with just 3.6% in the EU28 (Eurostat). The figure for Estonia is almost as high (11.3%), but it is much lower in Lithuania (3.7%). These are average figures. Among the poorest fifth of the population, almost a quarter (23.6%) report they have unmet medical needs because care is too expensive, too difficult to reach or takes too long. The EU28 average for this income group is 5.1%.

The lack of compensation for medicines is also a concern. The Organisation for Economic Co-operation and Development (OECD)¹ highlights that Latvia has the third lowest level of drug consumption between the European Union countries. It is also the country with the second lowest level of public expenditure on compensation paid to patients to cover the purchase of medicines. Only about a third of the population spending on medicines are compensated.

Additional concerns are raised by Semester Alliance members about the impact of privatisation in the health sector, highlighting where public health facilities are being used for private medical use, with no additional charges being required, also impacting on access and waiting times for public health patients.

The OECD analysis says that the high co-payment for services is acknowledged by the Ministry of Health as stopping some 12-20% of Latvians from accessing health services. This situation is exacerbated by high financial barriers to access and the expiration of the Safety Net and Social Sector Reform Programme in 2011, effectively ending exemptions from user charges for low-income households.

Financial and geographical barriers to accessing health care are further exacerbated by Latvia's annual 'quota' system for health care services, causing and adding to the burden of high level of out-of-pocket expenditure. Besides the increase of health spending to a level closer to the OECD average through a targeted, incremental increase in spending, it is recommended that Latvia re-evaluates the annual 'quota' system for health services, to ensure that the publicly-covered benefits basket is consistent with latest international best practice.

Health workforce

The Commission country report acknowledges that Latvia has fewer health professionals than many other EU states. There is a particular problem in relation to practising qualified nurses and midwives, where Latvia has only 502.1 per 100,000 inhabitants compared with the average (not including all EU28) of 876.7. Only Bulgaria (485.0) and Greece (347.4) have fewer nurses per 100,000.

What is also not clear from the country report is that the low level of nurses in Latvia is not a new phenomenon. A major review of the Latvian health system in 2012 found that the ratio of all medical staff with secondary medical training was “very low”, suggesting that “physicians assume some proportion of nurses’ duties, influencing both the quality of physicians’ work and the care for patients”.²

Latvian national statistics on the numbers of medical staff also show that the situation has worsened in recent years. By 2015, the number of doctors had fallen by 11.1% and the number of nurses by 35.2% since 2008. The number of physician assistants increased by a third (33.8%) but there are relatively few employed in this position. The total number of medical personnel, other than physicians, with a secondary medical education fell by almost a quarter between 2008 and 2015.

It is particularly worrying that, while the expenditure figures show a slight improvement between 2013 and 2014, in most cases this is not reflected in the numbers of medical personnel. There were 324 fewer doctors in 2015 than there were in 2013, and 497 fewer nurses (Central Statistical Bureau of Latvia).

The fall in the number of medical personnel was already evident when the 2012 review of the Latvia health system was published and it concluded with reference to nurses that “there was a strong decline in 2009 when important budget cuts were implemented in the health sector, including reductions in salary levels and closing down of institutions”.³

The OECD argues that the shortage of certain healthcare professionals (hospital specialists in rural areas is a particularly pressing example), and it recommends the implementation of a comprehensive health workforce plan.

Health sector pay

Pay in the health sector is now higher than in 2008, although averaged across the year, it only surpassed that figure in 2014. However, relative to pay levels in the economy as a whole, pay in the health service has clearly grown by less. Health pay was 11.5% higher in 2015 than 2008, while overall pay was 19.9% higher (Central Statistical Bureau of Latvia, Table DSG03).

In the first quarter of 2008 pay for those working in health was 10% above the average level of pay in the whole economy and 18% above average pay in the private sector. However, eight years later, in the first quarter of 2016, health pay was only

2% above the all economy average and 3% above the average for the private sector. In other words, since 2008 it has become significantly less attractive in pay terms to work in health (Central Statistical Bureau of Latvia).

The Country Report acknowledges that the pay of the lowest paid workers in healthcare was due to be increased and the National Reform Programme confirms the increase as 7%, while this is above the 2.7% increase in the national minimum wage it only matches the increase in wages averaged across the whole economy. It remains to be seen whether this contributes to closing the pay gap with other countries and addressing the problem as identified in the Country Report of outward migration of health staff. The report notes also that staffing problems are likely to be linked to poor working conditions as well as low wages and that shortages will become more acute as the sector employs a relatively older workforce.

Quality and prevention

The 2016 OECD analysis of the Latvian healthcare system identifies a number of key challenges that the government should address in the planned healthcare reform. The analysis emphasizes the need to improve access to quality care, improve data management and to enhance central strategic planning and procurement. Insufficient prevention is put forward as another concern. Against the background of high prevalence of adverse risk factors – a situation that is getting worse – prevention still has low policy priority and low levels of public awareness. Similar to the WHO, the OECD report raises concern in regard to the low levels of investment in the healthcare system, making significant improvements to quality and access challenging.

Recent developments and outlook for 2017

In both its 2016 report on its National Reform Programme and its Stability Programme for 2016-2019, the Latvian government makes clear that improving the health care system is one of its priorities. The NRP notes that additional reforms are needed, particularly to improve the accessibility and quality of healthcare services. However, no mention is made on how such issues may impact on particularly vulnerable groups, such as children. The government has allocated additional resources to the health sector in each of the last three budget cycles, resulting in a year on year increase of €42 million in 2014, €37.5 million in 2015 and €25.4 million in 2016.⁴

In its additional spending plans for 2016, the government states that its priorities were the “improvement of health care service accessibility, reducing queues and ensuring competitive salaries for medical staff”.⁵ In total €10 million was to be spent on improving salaries in 2016, with the lowest paid receiving an increase which the government calculates at around 7%. A further €3.8-€4.2 million was to be spent in reimbursement payments to patients taking medicines for Hepatitis C and HIV/AIDS, as a step towards reducing the overall level of private out-of-pocket payments.

While the planned increases in government health spending are welcome, they do not restore the level of funding to the position before the crisis. Even after they have been implemented, Latvia's health spending as a proportion of GDP will still be below that of its neighbours.

Budget plans for 2017 indicate a further increase of €64 million primarily for the financing of the envisaged reforms (by comparison, military and defence budget have received an additional EUR 98 million for the coming year). However, this will still leave public health expenditure at only 3.7% of GDP (up from 3.6% forecast for 2016) and at 9.8% of general government expenditure (unchanged from the forecast 2016 figure).

It is clear that decisions taken this year will be decisive for the future course of the healthcare system of the country. Rather than a one-off cash injection, Latvia will need an incremental increase of funding alongside a series of reforms to improve access, coverage and achieve a reduction of the high ratio of out-of-pocket payments. According to the Latvian hospital association, the quota for healthcare services had already been reached for 75% of hospitals outside of Riga by September 2016 and for certain health services even earlier by spring this year. This would leave patients only with the options to either pay for services, accept long waiting times until new quotas become available or search for an available medical service in a facility far away from home.

The Latvian government is planning to introduce a new healthcare financing model that according to President Raimonds Vējonis, should enter in full force starting January 2018 and cannot be further delayed. According to the recent report 'The Latvian health care system financing paradigm shift', three models are currently under consideration. The Ministry of Health is defending its health financing model variant, which does not increase the overall tax burden and is based on the existing principle of equal access to healthcare.

The financing of such model would envisage an incremental increase of health spending (in line with the OECD recommendations) and temporary deviation from the medium-term budgetary objective under the European Semester (0.1%). Despite the support of medical professionals and social partners, this plan is facing opposition, notably from the Bank of Latvia that is defending a stringent fiscal discipline and higher individual spending.

Indeed there remains some concern about proposals from the Bank of Latvia to privatise the national health system and introduce a fixed health insurance premium. While there is considerable opposition to this from trade unions, health employers and civil society, the government has yet to categorically reject the idea.

Poverty, inequality and taxation

Country-specific recommendations

The Country-specific recommendations for Latvia in 2012 and 2013 called for action to “Tackle high rates of poverty” through the reform of social assistance and the 2013 recommendation included a reference to child poverty in particular. Recommendations in 2014-2016 continued to include calls for social assistance reform and adequacy of benefits without referring directly to poverty.

The preamble to the 2016 recommendations, however, highlights that Latvia has one of the highest levels of poverty and social exclusion. The second recommendation calls for improvement of adequacy of benefits and measures to support recipients in finding and retaining work, including through increased coverage of activation measures. However, the first CSR is focussed on budget control, and states that any deviation should be limited to pension reform and reform in the healthcare sector, undermining the potential to deliver on the second recommendation on increasing adequacy of minimum income and social protection systems.

The first CSR also calls for reducing the tax wedge on low income earners, which should help to reduce in-work poverty, with a tax shift towards environmental and property taxes and improving tax compliance. However, no mention is made of the regressive nature of the flat-rate Latvian taxation system, which disproportionately increases the tax burden on the poor and fails to reduce inequality.

Poverty, benefits and minimum income

The European Commission’s 2016 country report on Latvia⁶ states that “Income inequality and poverty remain among the highest in the EU”, pointing out that, while the rate of poverty and social exclusion has fallen, “it remains high and the social safety net is weak”.

The report also says that: “Expenditure on social protection benefits (14% of GDP in 2013) is the lowest in the EU, and social transfers have a relatively low impact on poverty reduction.” It adds: “...the availability of financial resources for social spending remains a reason for concern.”

This needs to be taken into account when the European Commission is considering the first CSR requiring strict controls on budget spending. Spending on social protection must be seen as a social investment and an essential pre-requisite for poverty reduction and support for inclusive growth.

Figures updated since the European Commission’s country report show that there has been a small improvement in the at-risk-of-poverty rate, down from 30.9% to 29.1% of the population and a fall in the percentage suffering severe material deprivation from 19.2% to 16.4%.

The latest National Reform Programme acknowledges these overall figures conceal a problem of increasing poverty for certain groups, including pensioners, single parents and low wage earners. The share of over-65s at risk of poverty rose from 27.6% in 2013 to 34.6% in 2014. As the Country Report states: “The at-risk-of-poverty rates for the elderly have increased since 2011...The minimum pension as the percentage of median income is the lowest in the EU and does not provide sufficient protection against elderly poverty.”

While the EU funds for European Aid to the Most Deprived are currently being allocated to provide food and assistance to children and the risk of child poverty and social exclusion has decreased since 2011 the country report notes that it remains above the EU average, with a low level of spending on child and family benefits – 1.1% of GDP compared to the EU average of 2.4%.

The share of single parent households is high with 30.6% of children living with a single parent in 2014, nearly double the EU average of 16.6% and the at-risk-of-poverty rate for this group is also higher than the EU average – 54.8% compared to 48.2%.

In general, the country report says that the coverage and benefit adequacy of social assistance is low and the guaranteed minimum income “contributes very little to the incomes of those in the poorest quintile.”

The government proposals for a minimum income are due to be implemented in 2017 but the Commission's country report raises concern that some benefits, including pensions and unemployment benefit will remain below the level set for the minimum income.

The actual minimum income rate is 128 Euros a month, with the government proposing only to move towards an approximation of the 40% at risk of poverty threshold⁷ at 139 Euros (2015 prices), rather than the 60% threshold as reflected in the EU poverty indicator.⁸

According to the EMIN⁹ project in 2014, based on reference budgets – the minimum calculation per person would be 189 Euros. However, EAPN Latvia highlights worrying developments in prices in key food and household goods, which would call for higher rates to take people out of poverty.¹⁰

A further concern is the coverage of the schemes and the duration. With Minimum Income being normally granted for only 3-6 months, with requirement of a full renewal procedure, creating bureaucratic obstacles to effective income support for households in need.

Lastly, the National Reform Programme states that the government implemented a number of measures supporting access to vocational education or employment for young people, such as the Programme for Continuing Vocational Education for Unemployed in State or Municipal Educational Institutions, as well as other youth employment programmes, aiming at reducing youth unemployment.

Inequality

Latvia is one of the EU's most unequal countries in terms of income, with a Gini coefficient of 35.5 compared with an EU28 average of 30.9. Only its neighbour Estonia has a higher score, at 35.6 (Eurostat 2014). The Country Report also notes that "Inequality is magnified by the restricted provision of health services. A high proportion of the population reports unmet healthcare needs and access to healthcare has not improved in recent years." The overall approach to taxation is regressive which undermines attempts to close the income inequality gap, with not only flat rate income tax, but increases in VAT, which disproportionately hit the poor hardest, without recognition of the need for differential rates on basic food and communal services versus luxury goods.

The Country Report notes that there was a significant increase in the minimum wage (26%) over the period 2013-2015 but the increase in 2016 at 2.7% is below the 6% trend in the wider economy.

Latvia has a particularly high tax burden on low-income earners. The 2016 Country Report underlines that "limited progress has been made in shifting the tax burden away from low-wage earners"¹¹. The tax wedge on low wage earners in 2014 was 42.3% compared to an EU-28 average of 34.9% (Eurostat)¹². For individuals earning 50 % of the average wage the tax wedge amounted to 41.4 %, "the second highest in the EU (after Hungary, and Germany)"¹³. This creates disincentives to formal employment for single low-wage earners".

Figures in the Country Report show that the tax wedge for a single person earning half the average wage has hardly changed in recent years and is, in fact, higher than the average recorded between 2003 and 2009. The National Reform Programme refers to an initiative to increase the non-taxable element of pay but the change appears very small. According to the NRP "the tax wedge indicator for a worker with no dependable persons and receiving 67% of average wage will decrease from 41.7% in 2015 to 39.6% in 2021."

The Latvian tax structure makes it distinctively hard for the unemployed to reenter the job market. The percentage of gross earnings which is "taxed away" due to the withdrawal of benefits and higher tax and social security contributions after switching from unemployment to employment, an indicator also referred to as the 'unemployment trap', is particularly high in Latvia. In 2014, it amounted to 88.7% compared to an EU average of 73.79%. This is the fourth highest rate in the EU after Belgium (92.25%), Denmark (90.01%) and Slovenia (89.71%).

There is considerable room for a tax shift away from the tax wedge of low-income earners towards environmental taxes, for example on heat and electricity since they are particularly low compared to the EU average. Latvia's implicit rate on energy is the fourth lowest in the EU¹⁴. It measures the ratio between energy tax revenue and final energy consumption indicating that Latvia has both scope for an increase in energy taxation as well has room for efforts in energy efficiency. To counteract the

potential regressive effects of taxing heating and electricity, increases in these tax rates should be accompanied by compensatory measures that specifically target people who are vulnerable to fuel or energy poverty. The European Commission has underlined that “[o]nly marginal use is being made of the scope for a growth-friendly tax shift from labour to consumption, environmental and property taxation”¹⁵.

Housing and homelessness

Country-specific recommendations

The only recommendations made between 2012 and 2016 that related to housing were in 2012 and 2013 when there were recommendations to improve energy efficiency in buildings and specifically residential buildings in 2013. There has been nothing on access, affordability or quality and no mention of homelessness.

Country report

There is little in the 2016 Country Report that addresses issues of access and affordability of housing, housing quality or homelessness. In the section on Labour Market and Social Policies it does refer to the low level of spending on housing benefits (0.1% of GDP compared to the EU average of 0.6%) and poor coverage, with only 12.5% of the poorest quintile receiving the guaranteed minimum income or housing benefit.

In the general economic analysis the Country Report notes that the housing market has cooled off although prices are still “relatively dynamic compared to the rest of the EU.” It says that housing construction has been stable since 2010, but there is no indication of whether this level is adequate to meet demand or what proportion is affordable to people on low and average incomes.

Robust data on homelessness is not available. The European Commission reported in 2011 that “In Latvia, where there is no strategy to reduce homelessness, the number of homeless people increased dramatically following the onset of the crisis... The number of people sleeping in night shelters in Riga rose from 2,164 in 2007 to 2,597 in 2009. Most of the rise consisted of an increasing number of families using the service (+108% between 2007 and 2008 and + 52% between 2008 and 2009)”¹⁶. Given the fact that Latvia performs badly on a range of housing outcomes, it would be useful to at least attempt to analyse recent trends in homelessness and to get to grips with how the situation has evolved. . One estimate for Riga alone suggests the figure could be as high as 750-800¹⁷.

Latvia ranks 25th out of 28 MS in an index on housing exclusion based on EUSILC data and developed by FEANTSA and the Fondation Abbé Pierre¹⁸. It faces particularly significant challenges in terms of overcrowding and severe housing deprivation. Latvia’s a rate of overcrowding of 37.7% is more than twice the EU average of 17.3%. For poor people, it reaches 49%. Furthermore the overcrowding rate has increased since 2013. The country records the third highest level of severe housing deprivation in the EU at 16.3%. This rises to 27.3% amongst poor households. Latvia has the second highest level of damp housing among poor households at 44%¹⁹ and 16.8 % of households are unable to keep their home adequately warm, compared to an EU average of 10.2 %. This level of inadequate housing has very important health and cost implications, as demonstrated by Eurofound²⁰.

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