

# Analysis of policy documents on the use of assistive technology in social and healthcare



Vidzeme Planning Region

2026

# ABBREVIATIONS AND DEFINITIONS

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**Assistive technologies** – technologies, including devices, software and systems, which prevent, compensate for or facilitate the absence or loss of a function in people with functional impairments. Includes technical aids, including medical devices.

**EU** – European Union

**EP** – European Parliament

**ICT** – Information and Communication Technologies

**LAB** – Latvian Association of the Blind

**LAD** – Latvian Association of the Deaf

**Medical device** – any instrument, apparatus, mechanism, article or material used in medicine for the diagnosis, prevention, etc. of diseases and whose intended primary action on the human body is not achieved by pharmacological, immunological or metabolic means<sup>1</sup>.

**CM** – Cabinet of Ministers

**NRC “Vaivari”** – National Rehabilitation Centre “Vaivari”

**SPOLIS** – State Social Policy Monitoring Information System

**TA** – Technical aids; equipment or technical systems that prevent, compensate for, alleviate or neutralise functional impairment or disability (as defined in the Social Services and Social Assistance Act)

**VADC** – Vaivari Assistive Devices Centre

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<sup>1</sup> <https://www.vi.gov.lv/lv/kas-ir-mediciniskas-ierices>

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## INTRODUCTION

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To begin with, here is an example of the use of assistive technology in everyday life to give an idea of the role this technology plays in daily life. Sometimes these assistive technologies have become a convenient, almost imperceptible part of daily life, whilst at other times their shortcomings cause significant difficulties in carrying out necessary tasks.

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*In the morning, I am woken by a vibrating alarm clock. I look for my hearing aids. [...] I spend a lot of time online, as I have a very, very extensive correspondence with both people I know and on various social networks[...]. On several of these sites, groups have been set up specifically for people with hearing impairments to communicate. If I have to attend meetings, seminars or conferences, I have the option of using an FM receiver. However, I hardly ever use it at meetings, as unfortunately many participants have the bad habit of speaking at the same time, and reminders don't help. At seminars and conferences, I enjoy the presentations. In certain venues and at certain events, a hearing loop is provided. My hearing aids are connected to my mobile phone, where I can adjust the volume and switch to loop reception. I am particularly pleased to have the opportunity at some international events to use foreign speech-to-text interpreting services and the Text on Tap programme, which specifically provided me with the option to read the translation in Latvian. I have to attend a Zoom or Microsoft Teams meeting once or twice a week. I use hearing aids, over which I put on large 'headphones'! I don't like 'hybrid' setups, where some participants are sitting in a room at a table far from the microphone. It's better if everyone sits at their own computer or other device. The meeting organiser has the option to use subtitles, but this is rarely done. I go to the theatre, but only if subtitles are provided [...]. For now, I have no problem combining reading the subtitles with watching the performance, but people with more severe short-sightedness or long-sightedness may have issues. I have been to a few events where real-time transcription is provided by the company 'Tilde'.*

*Unfortunately, the quality of this transcription is poor. There are many errors and inaccuracies. [T9]*

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This example illustrates very well that a single person with hearing loss incorporates various assistive technologies into their daily life, each of which performs a specific function, meeting a specific need both at home and outside it, during leisure time as well as for work purposes, as well as in health and social care, and in representing their needs and rights. The example shows how a person is situated within a network of assistive technologies, which works better in some areas and less well in others. The network includes both technologies specific to a person's degree of hearing loss and technologies suitable for people with or without functional impairments. This indicates that attention needs to be paid to the provision of assistive technologies both in relation to specific functional impairments and to the observance of more general accessibility principles in the design of public spaces. This will also be described and analysed in greater detail in this report.

The opportunities and limitations of individuals and groups of people in using assistive technologies are shaped by various factors: specific functional impairments, age, place of residence (at local, regional and national levels), income level, occupation, language skills, as well as national legislation, international obligations, national policy in the health and social care sectors, etc. At the same time, these diverse experiences and opportunities also influence the future development of assistive technology policy.

The term 'assistive technologies' is used in the report in a broader sense, encompassing TA as well as technologies that may not have been designed with the direct aim of performing the functions of a technical aid, but which do provide such functions.

As part of the TechSocialcare project, 11 interviews were conducted with 13 experts. The experts represent: 1) an organisation that provides AT on behalf of the state, 2) health and social care providers (including a rehabilitation institution, an organisation and a company that provide social care services using assistive technologies), 3) NGOs representing the rights of people with functional impairments, 4) a company distributing AT, 5) the research sector focusing on the use of technology in rehabilitation, 6) people who use AT themselves. The interviews lasted approximately 1 hour to 1 hour 20 minutes, amounting to a total of approximately 12 hours of audio recording.

The sections of the report include: 1) information on existing legislation, standards and the parties involved in the provision of TA, 2) an assessment of the current situation, 3) the experiences of people with functional impairments regarding the provision of TA, 4) sectoral policy plans relating to the provision of TA, 5) opportunities for improving the provision of AT.

The report was produced as part of the INTERREG EUROPE 2021–2027 programme-funded project “Promoting Technical Standards for Assistive Technologies in European Social Care Services” (hereinafter – the TechSocialcare project) (project number 03C0809). It was prepared by Līna Orste on behalf of the project partner, the Vidzeme Planning Region.

# 1. OVERVIEW OF THE CURRENT PROCEDURES

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## Laws and regulations

### Directly related to the TA

One of the main pieces of legislation governing the use of TA (hereinafter referred to as TA) is **the Social Services and Social Assistance Act**<sup>2</sup>. Its purpose is:

- to establish the principles of social services and social assistance, including TA,
- define the categories of persons entitled to receive these services,
- to establish the procedures for their provision, payment and financing.

It entered into force on 1 January 2003. The Act defines TA as equipment or technical systems that prevent, compensate for, alleviate or neutralise functional impairments or disabilities. In this context, there is an AT service, which is “a set of measures ensuring the functional assessment of a person, the manufacture and adaptation of AT, training in its use, repair and circulation management, as well as delivery to the person’s place of residence”. The law also includes the option to receive a “vehicle adaptation” service and compensation for the adaptation, so that the person’s vehicle can perform the function of a technical aid.

A person’s entitlement to TA services is determined by the presence of functional impairments and a medical assessment confirming the need for such devices.

In accordance with the law, the provision and coordination of TA services is carried out by the state and local authorities:

- At the national budget level, TA services are provided by the National Rehabilitation Centre “Vaivari” (hereinafter – NRC “Vaivari”), the Latvian Association of the Blind (LAB) and the Latvian Association of the Deaf (LAD).
- At the local level, social services (municipal social services) coordinate the assessment of clients’ needs and the administration of applications for TA services.

These services are regulated by Cabinet of Ministers (CM) Regulation No. 878 “Technical Assistive Devices” (CM No. 878)<sup>3</sup> and CM Regulation No. 250 “Procedure by which the Latvian Association of the Blind and the Latvian Association of the Deaf

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<sup>2</sup> <https://likumi.lv/ta/id/68488-socialo-pakalpojumu-un-socialas-palidzibas-likums>

<sup>3</sup> <https://likumi.lv/ta/id/328672-tehnisko-paligidzeklu-noteikumi>

provide social rehabilitation services and supply technical aids – typhlotechnology and surdotechnology” (CM No. 250)<sup>4</sup>. Both regulations have been issued in accordance with the Social Services and Social Assistance Act.

**Cabinet Regulation No. 878** sets out: 1) the procedure by which the state provides assistive device services to persons covered by the Social Services and Social Assistance Act; 2) the circulation of assistive devices (issuance, loan for use, transfer of ownership, etc.); 3) regulations on the adaptation of motor vehicles for persons with functional impairments; 4) the list of assistive devices funded from the state budget and the conditions under which a person may receive an assistive device with a co-payment.

NRC “Vaivari” is the main authority responsible for organising the provision of assistive device services on behalf of the state. The State Agency for Social Integration (SASI), in cooperation with NRC “Vaivari”, organises service availability, waiting lists and the circulation of assistive devices.

The duties of NRC “Vaivari” are: 1) to manage the national information system on assistive device users; 2) to procure, manufacture, adapt and transfer assistive devices to individuals for ownership or temporary use (on loan); 3) to carry out repairs and maintenance during both the warranty and post-warranty periods; 4) to assess operational effectiveness and conduct an in-depth evaluation to determine whether an assistive device is necessary and what type of assistive device is suitable; 5) to cooperate with organisations representing persons with disabilities to improve the list of services and the provision of assistive devices.

**Cabinet Regulation No. 250** stipulates: 1) the tasks delegated by the state to the LAB and LAD to provide social rehabilitation services to persons with visual or hearing impairments; 2) the procedure for the provision of assistive technology (tactile and hearing-related) services; 3) the rules governing the circulation of tactile and hearing-related assistive devices and funding from the state budget fundable items; 4) the procedure for providing and receiving sign language interpreting services.

The way in which the spheres of TA management are divided depends heavily on the historical social, economic and political influence of the organisations and institutions involved. Although the structural composition and organisational functions of the NRC “Vaivari”, the LAD and the LAB have changed over time, they have long been involved in rehabilitation and the provision of TA.

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<sup>4</sup> <https://likumi.lv/ta/id/322623-kartiba-kada-latvijas-neredzigo-biedriba-un-latvijas-nedzirdigo-savieniba-sniedz-socialas-rehabilitacijas-pakalpojumu-un-nodrosina-tehniskos-paligidzeklus--tiflotehniku-un-surdotehniku>

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*These associations [LAB and LAD] are over a hundred years old and have been working specifically on the rehabilitation of deaf and blind people—separately, not together—as well as on the assistive devices and technologies that these people require. As we know, during the Soviet era there were no such associations for anyone else; the rest were lumped together under the name ‘associations for the disabled’ and were not entrusted with this... because the field is already quite broad, so the level of expertise needed to manage these assistive devices at the association level must be quite high. Well, and so it gradually came about that this [NRC “Vaivari”] was established as a separate centre from the others, which, unfortunately, probably due to a lack of funding as well as purely a lack of capacity – informational capacity and knowledge capacity – did not really manage to cope with it. [T6]*

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The NRC “Vaivari” was formed through a series of reorganisations. In 1991, the “Starts” retirement home of the USSR machine-building factory and the Jūrmala children’s rehabilitation institutions were merged and reorganised; In 1993, it was granted the status of a National Rehabilitation Centre; in 1994, nine state health institutions were merged to form a single state rehabilitation centre; in 1995, the single state centre was split into independent state enterprises<sup>5</sup>. In 2009, the Vaivari TA Centre was established to provide TA services in accordance with the Social Services and Social Assistance Act<sup>6</sup>.

**The LAB** was founded on 16 June 1926<sup>7</sup> and represents people in Groups 1, 2 and 3 with visual impairment interests in Latvia<sup>8</sup>. It has 10 regional organisations (ROs) (in Balvi, Cēsis, Daugavpils, Jelgava, Jēkabpils, Jūrmala, Rēzekne, Rīga, Ventspils, Strazdumuiža) and 3 legal members (Liepāja Society for the Blind, Service Dog Association “Teodors”, Association “Iespēju ceļš”). Both the Rīga RO and the Strazdumuiža RO are located on Braila Street in Rīga, making it a significant hub for accessing typhlotechnical aids and related services<sup>9</sup>. The LAB has established the LAB Tactile Technology Department and SIA “Latvian Society of the Blind Rehabilitation

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<sup>5</sup> <https://www.nrcvaivari.lv/lv/par-mums>

<sup>6</sup> Ibid.

<sup>7</sup> <https://lvarhivs.gov.lv/?id=9009&kods=300106061&vien=2>

<sup>8</sup> <https://lnbiedriba.lv/lv/par-biedribu/>

<sup>9</sup> <https://lnbiedriba.lv/lv/2023-gada-parskats-2/>

Centre”, where blind and partially sighted clients can receive social rehabilitation services.

**The LAD** was founded on 19 May 1920<sup>10</sup>. It has regional branches in eight Latvian cities: Riga, Daugavpils, Valmiera, Liepāja, Ventspils, Kuldīga, Smiltene and Rēzekne. Both deaf and hearing people who are proficient in Latvian Sign Language work at the LAD. The LAD has established *SIA LAD Rehabilitation Centre* and *SIA LAD Technical Assistance Centre for the Deaf*, where deaf and hard-of-hearing clients can receive social rehabilitation services.

## Submitting an application

A person’s rights and eligibility for TA are determined by Cabinet Regulation No. 878 and Cabinet Regulation No. 250. The first step is to submit an application stating the need for TA. Submitting an application involves 1) submitting the application to the relevant authority together with information on the required assistive device, 2) submitting a statement from the attending doctor or specialist confirming the need for the assistive device. The opinion is usually valid for six months and may be issued by a GP or an appropriate medical specialist, depending on the type of assistive device. If the disability information system or the information provided by the State Commission on the determination of disability indicates that the person has visual or hearing impairments, or if the LAB or LAD has data confirming the type and severity of the person’s impairment, then no opinion needs to be submitted. Cabinet Regulation No. 878 and Cabinet Regulation No. 250 specify a portion of the available TAs in accordance with the type and severity of the functional impairment or anatomical defect. Taking into account the broad scope of Cabinet Regulation No. 878, there are fewer guidelines regarding the TA to be allocated for a specific functional impairment.

In certain cases, a person is entitled to receive an assistive device on a priority (urgent) basis, for example: 1) if the device is requested within six months of the onset of the functional impairment (under Cabinet Regulation No. 250 – if the person has newly acquired functional impairment following illness or injury); 2) if the device is included in the individual rehabilitation plan; 3) for children (under Cabinet Regulation No. 250 – or a person caring for a child up to 1.5 years of age); 4) pregnant women, if replacement of the device is necessary due to anthropometric changes; 5) persons who require the device for educational purposes or to perform work duties. Cabinet

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<sup>10</sup> [https://www.lns.lv/lat/par\\_mums/](https://www.lns.lv/lat/par_mums/)

Regulation No. 878 stipulates that, within a year, a TA may be requested on an urgent basis in only one of the aforementioned cases.

In urgent cases, depending on the specific circumstances of the individual, the following additional documents must be submitted: 1) a discharge summary from an inpatient or outpatient facility, 2) an individual rehabilitation plan, 3) a document confirming that the person is actually caring for and raising a child up to the age of one and a half years, 4) a certificate from an educational institution confirming that the person is enrolled in a relevant educational programme at that institution, 5) a certificate from the employer confirming that the person is an employee, 6) the taxpayer registration number, if the TA is required for the performance of self-employment or other economic activities.

### List of assistive devices

Cabinet Regulation No. 878 includes a list of assistive devices funded from the state budget (see Annex 1). The lists also specify the period (in years) after which a person may reapply for a new assistive device (for example, 2–8 years depending on the type of device). The Annex to Cabinet Regulation No. 250 provides a list of assistive devices funded from the state budget (see Annexes 2 and 3), including 1) CPV (Common Procurement Vocabulary) codes, 2) provision methods (loan for use or transfer of ownership), 3) waiting periods after which a person may reapply for a new assistive device via the waiting list.

### Funding

People can receive TAs that are fully funded by the state. TAs are procured through public procurement, in which the contractor must comply with the technical specifications. In the procurement process, the most suitable and economically advantageous tender is selected, and it must also fall within a specified budget. In connection with the provided TAs, the person must make a one-off payment.

Under Cabinet Regulation No. 878, the NRC “Vaivari” offers the option to select the most suitable TA with a co-payment. The co-payment applies in cases where the technical aid purchased through public procurement is unsuitable. This also applies to cases where no suitable assistive device is available in Latvia as a whole. A maximum reimbursable amount is set, and the person may travel to any country within the European Economic Area to purchase a more suitable device. Although

Cabinet Regulation No. 250 does not specify this in a similar manner, the website of the “LAD Centre for Technical Assistance to the Deaf” also refers to this possibility<sup>11</sup>.

Recently, the NRC “Vaivari”, in collaboration with the Ministry of Welfare, has developed a voucher scheme (12) as part of the Recovery Fund project “Promoting Accessibility of TA” (ID No. 3.1.2.6.i.0/1/25/I/CFLA/001), has established a voucher scheme<sup>12</sup> that combines features of public procurement and co-payment methods. Service providers offering a wider range of TA types are selected. The choice can be made based on the specific model of the assistive device, the service provider, or the location. The administrative burden of this co-payment method is reduced, and the service becomes more accessible to the client.

### Collection and average delivery time

Assistive devices can be collected 1) at the NRC “Vaivari” Assistive Devices Centre (VADC) premises, 2) during scheduled VADC visits outside the department’s permanent location, or 3) by booking a home visit, which is a chargeable service. The fee for a home visit is EUR 8.67 plus travel expenses (EUR 0.46 per kilometre). Travel expenses are calculated from the nearest service point to the client’s place of residence<sup>13</sup>.

Tiflo-technical aids can be collected 1) from the LAB Tiflo-technical Department, 2) upon request from one of the TOs, 3) from December 2025, delivered to your home. To request home delivery, applications must be submitted to the LAB Tiflo-technology Department.

A specialist from the applications department will inform you of the delivery date. The cost of home delivery of hearing aids is EUR 50.00<sup>14</sup>.

Hearing aids and other hearing TAs can be collected 1) at the LAD premises or 2) by booking a home visit, which is a chargeable service (in Riga – EUR 85, in the Pieriga region – EUR 110, in more remote regions subject to individual agreement), whilst bedridden clients and those requiring special care are exempt from payment<sup>15</sup>.

Following discussions with experts, it is known that NRC “Vaivari” prioritises the issuance of respiratory TAs, which are issued within a month, and oxygen

<sup>11</sup> <https://surdocentrs.lv/surdotehniskie-paliglidzekli/>

<sup>12</sup> <https://www.nrcvaivari.lv/lv/projekta-virzibas-parskats-tehnisko-paliglidzeklu-pieejamiba-uzlabojas>

<sup>13</sup> <https://vtpc.lv/lv/izbraukumi-un-majas-vizites>

<sup>14</sup> <https://lnbiedriba.lv/lv/tehnisko-paliglidzeklu-piegade-majas/>

<sup>15</sup> <https://surdocentrs.lv/majas-vizites/>

concentrators – within 3 working days. There are also custom-made TAs, the manufacture of which requires authorisation. Permits are issued within one month. For urgent cases, the wait is 1 to 3 months; for others, it may be even longer. In 2024, the longest waiting list was for alternative communication devices, which are eye-controlled. There, people had to wait up to a year or more, but the current waiting time is up to three months.

As for the provision of hearing aids, the expert noted that the waiting time can be around two weeks, but if a more specific device or part is required from distributors, the delivery time can be as long as a month. No information on assistive technology for the visually impaired was available at the time of writing this report. The available information suggests that delivery times depend heavily on the specific nature of the assistive technology, the volume of assistive technology purchased, the distance of the client's place of residence from the distribution points, as well as other factors.

### Statistical data – TAs issued

There is no freely available, equally structured and up-to-date information on TAs issued. The open data set "Breakdown of the number of persons who have received TAs by administrative territory" contains data for the second half of 2023<sup>16</sup> (see Table 1). There is no data available in one place for 2024 and 2025.

1. Table

#### Persons who received TA in the second half of 2023

Persons who received TA intended for the VISUALLY impaired	Persons who received TA intended for the HEARING impaired	Persons who received TA for persons with disabilities
1,204	2,566	6,937

The most comprehensive information is available on the NRC "Vaivari" website. In 2025, NRC "Vaivari" issued 6,150 assistive devices; in addition, 2,349 permits were issued to people with functional impairments to purchase TAs with a co-payment, and 3,501 permits to purchase TAs using the voucher method<sup>17</sup>.

<sup>16</sup> <https://data.gov.lv/dati/lv/dataset/personu-tpl-skaita-sadalijums-adm-ter>

<sup>17</sup> <https://www.nrcvaivari.lv/lv/projekta-virzibas-parskats-tehnisko-paligidzeklu-pieejamiba-uzlabojas>

In 2023, the LAB Tiflo-technical Department issued 4,395 TAs, the largest number of which were mobile phones (650), eye prostheses (531) and timepieces (445), but also included technical aids such as blood pressure monitors with voice output, bathroom scales, walking sticks and folding orientation sticks, thermometers for measuring climatic conditions, liquid level indicators, electronic magnifying aids, magnifying glasses with lighting, audio players, etc.<sup>18</sup>. In 2023, 4,105 people joined the waiting list for TA<sup>19</sup>. Meanwhile, in 2025, SIA “LAD Surdo-technical help centre” provided 7,293 state-funded hearing aids and issued 1,020 other assistive devices for the deaf<sup>20</sup>.

## General accessibility

As one of the interviewed experts points out, assistive technologies are an integral part of legislation concerning people with disabilities. Although there are laws and regulations that are aligned with modern needs and possibilities, there are others that still need to be improved.

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*It must be said that assistive technologies are something that is deeply integrated into disability policy, because without them, many policy areas simply cannot be implemented – such as independent living, accessible information, and so on. In fact, it is a highly integrated issue. [...] I think that, at present, Latvia has more or less sorted out the provision of these assistive devices and assistive technologies for blind and deaf people, as well as their registration and so on. But the issue of mobility aids and care aids in this area is still relatively unresolved. [T6]*

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The laws and regulations of the Republic of Latvia rarely make direct reference to TA, yet there are quite a number of legislative documents that are indirectly related. Some of the laws and regulations that may affect applications for TA, receipt, training in use, usage, etc., are listed in Table 2 (on next page).

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<sup>18</sup> <https://lnbiedriba.lv/lv/tiflotehnikas-nodalas-parskats-par-2023-gadu-2/>

<sup>19</sup> Ibid.

<sup>20</sup> <https://surdocentrs.lv/pern-izsniegtas-8313-valsts-finansetas-dzirdes-paligierices/>

**Cabinet of Ministers regulations and laws  
indirectly related to the granting of TA**

No.	Regulatory act	Date of entry into force	Main objective, focus	Relation to TA
1.	Cabinet Regulation No. 316 – Regulations on the provision of assistant, companion and care services for persons with disabilities <sup>21</sup>	2021	Provides individual support	The use of a personal transport pass is linked to assistant and care services
2.	Cabinet Regulation No. 682 – Procedure for a person to receive state state-funded vocational rehabilitation and vocational suitability assessment services <sup>22</sup>	2022	Promotes employment and integration	TP integrated in vocational rehabilitation and workplace adaptation
3.	Cabinet Regulation No. 805 – Regulations on the determination of foreseeable disability, disability and loss of working capacity, and the issuance of a document certifying disability <sup>23</sup>	2015	Criteria for the determination of foreseeable disability, disability and loss of working capacity, indications for vehicle adaptation	The granting of disability status is one of prerequisites for receiving TA
4.	Cabinet Regulation No. 578 – Regulations on the provision of social rehabilitation services from the state budget at social rehabilitation institutions <sup>24</sup>	2020	Regulates the operation of social rehabilitation institutions	Provision of TA within the framework of rehabilitation services

<sup>21</sup> <https://likumi.lv/ta/id/323301-noteikumi-par-asistentu-pavadona-un-aprupes-pakalpojumu-personam-ar-invaliditati>

<sup>22</sup> <https://likumi.lv/ta/id/336971-kartiba-kada-persona-sanem-valsts-finansetu-profesionalas-rehabilitacijas-pakalpojumu-un-profesionalas-piemerotibas-noteiksan%E2%80%A6>

<sup>23</sup> <https://likumi.lv/ta/id/271253-noteikumi-par-prognozejamas-invaliditates-invaliditates-un-darbspēju-zaudejuma-noteiksanas-kriterijiem-terminiem-un-kartibu>

<sup>24</sup> <https://likumi.lv/ta/id/311143-noteikumi-par-socialas-rehabilitacijas-pakalpojuma-sanemsanu-no-valsts-budzeta-lidzekliem-socialas-rehabilitacijas-institucija>

5.	Cabinet Regulation No. 587 – Regulations on the State Social Policy Monitoring Information System <sup>25</sup>	2014	Data structure, exchange between authorities, cooperation between institutions	Includes information on the allocation of TA and the use of the services
6.	Cabinet Regulation No. 555 – Regulations on the procedure for organising and paying for health care services <sup>26</sup>	2018	Patient co-payment rules, the formation of waiting lists and the list of services to be financed outside the state budget	May affect when you receive a medical assessment or rehabilitation
	Cabinet Regulation No. 759 – Regulations on the Disability Information System <sup>27</sup>	2022	Stores data on disability assessment	Affects the the TA application process
7.	Public Procurement Law <sup>28</sup>	2017	Lays down the general procedure for procurement in Latvia	Affects TA procurement procedures

It is important to note that medical devices are also part of the TA and are subject to Cabinet Regulation **No. 461 “Regulations on Medical Devices”<sup>29</sup>**. The current version of the regulations came into force in 2023. They set out the requirements for placing medical devices on the market and use in Latvia. They are based on EU legislation, in particular Regulation (EU) 2017/745. The Regulations specify how devices must be registered and monitored. Prior to being placed on the market, devices in certain classes must undergo a notification procedure, and declarations of conformity and certificates must be submitted. The regulations also provide for the traceability of medical devices after they have been placed on the market. Manufacturers and distributors are responsible for withdrawing devices from the

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<sup>25</sup> <https://likumi.lv/ta/id/269340-valsts-socialas-politikas-monitoringa-informacijas-sistemas-noteikumi>

<sup>26</sup> <https://likumi.lv/ta/id/301399-veselibas-aprupes-pakalpojumu-organizesanas-un-samaksas-kartiba>

<sup>27</sup> <https://likumi.lv/ta/id/337718-invaliditates-informativas-sistemas-noteikumi>

<sup>28</sup> <https://likumi.lv/ta/id/287760-publisko-iepirkumu-likums>

<sup>29</sup> <https://likumi.lv/ta/id/344674-medicinisko-iericu-noteikumi>

market where necessary. Healthcare institutions must ensure the proper recording and use of devices. Staff training in the use of medical devices is also important.

In light of the discussions in the expert interviews, it is also essential to mention the general accessibility of the environment, goods and services, which undeniably also affects the receipt and use of TA in everyday life. The most recent piece of legislation in this area is the **Law on the Accessibility of Goods and Services Act**<sup>30</sup>. It entered into force on 28 June 2025. The aim of the Act is to promote the accessibility of goods and services for persons with disabilities and other persons with long-term physical, mental, intellectual or sensory impairments. It promotes opportunities for persons with disabilities to participate fully in public life. The Act sets out the obligations of manufacturers, importers and distributors.

The Act applies to specific groups of goods and services, including: consumer computer systems of general interest and their operating systems, self-service terminals, smartphones, tablets and similar devices, electronic communications services, access to audiovisual electronic media services, transport and related digital services (websites, apps, e-tickets).

The Act provides for the possibility for economic operators to demonstrate that compliance with accessibility requirements would impose a disproportionate burden (for example, high costs associated with meeting these requirements).

Also in accordance with the Law on the Accessibility of Goods and Services **Cabinet Regulation No. 128 "Requirements for the Accessibility of Goods and Services"**<sup>31</sup> has been issued, which came into force on 28 June 2025, with certain specific requirements coming into force on 28 June 2027. These set out accessibility requirements for goods (physical products), product packaging and instructions, services, the emergency number "112", electronic and digital applications, and e-commerce services. The aim of the regulations is to ensure that goods and services are usable, perceivable and understandable to persons with disabilities.

Goods and services must provide: 1) alternative ways of accessing sensory information (audio, visual, tactile), 2) alternative input methods where voice control is used, 3) an adaptable visual display (brightness, contrast, zoom, compatibility with assistive technologies), 4) simple control devices that can be used by people with mobility impairments, 5) alternative colour and sound signals that are understandable to people with visual or hearing impairments, 6) alternatives to biometric

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<sup>30</sup> <https://likumi.lv/ta/id/340554-precu-un-pakalpojumu-pieklustamibas-likums>

<sup>31</sup> <https://likumi.lv/ta/id/350121-precu-un-pakalpojumu-pieklustamibas-prasibas>

identification (e.g. non-visual input, other input methods). Goods and services must be compatible with assistive technologies. Information on accessibility and compatibility with assistive technologies must be available before the product is placed on the market.

To demonstrate that the product complies with accessibility requirements, the business operator must draw up a declaration of conformity in the prescribed format, including: 1) product identification and compliance standards, 2) information on the manufacturer and representative, 3) relevant legislation and specific requirements.

## International documents

Latvian legislation is also influenced by international treaties, directives, regulations and standards. The following section mentions those most directly relevant to TA safety.

### Conventions

The key international agreement relating to the provision of TA in Latvia is the UN Convention on the Rights of Persons with Disabilities. It sets out the obligation of states to ensure accessibility, equality and the availability of assistive technology for people with disabilities or functional impairments. The EU and its Member States must promote the development and availability of accessible and safe assistive devices.

There are also many other conventions and international treaties that indirectly influence the provision of TA in Latvia. Some of these include the World Trade Organisation's General Agreement on Trade in Services (which stipulates that technical regulations and conformity requirements must be designed so as not to create unjustified barriers to trade), the Council of Europe Convention for the Protection of Individuals with regard to Automatic Processing of Personal Data (which, as an EU Member State, sets out the principles of personal data processing and security, affecting digital assistive devices that process data).

### Regulations, directives

Most, if not all, of the regulations and directives applicable to the design, manufacture, distribution, procurement and other stages of the supply chain for medical devices include a provision that manufacturers must ensure that devices are designed in accordance with the essential requirements at the design stage. They must carry out a conformity assessment before the devices are placed on the market. Medical devices must be marked with the CE mark, which certifies compliance with EU

requirements. Manufacturers must draw up technical documentation and ensure that it is available to supervisory authorities and users in a comprehensible form.

**Regulation (EU) 2017/745<sup>32</sup>** entered into force in 2017 and sets out strict requirements for medical devices, including TAs, to ensure patient safety and product quality. The Regulation applies to all devices intended to improve human health, including those without a direct medical purpose. A key requirement is the preparation of detailed technical documentation demonstrating the device's compliance with the Regulation. Manufacturers must carry out risk management throughout the device's life cycle, from design to use. The Regulation also sets out requirements for the reuse of devices, such as cleaning, disinfection and sterilisation.

The Regulation provides for a stricter classification of devices according to risk level, which affects conformity assessment procedures. Higher-risk devices require in-depth clinical investigation and monitoring. Medical devices must be identifiable by a unique device identifier (UDI), which ensures their traceability. Data registration in the European database (EUDAMED)<sup>33</sup> also improves the transparency of TA allocation and the availability of information.

**Directive 2014/53/EU (Radio Equipment Directive)<sup>34</sup>** entered into force in 2014 and applies to devices that use radio frequencies for communication or positioning, such as wireless medical devices. These devices must not interfere with other equipment and must be capable of operating in the presence of interference.

An important requirement is the efficient use of the radio frequency spectrum to prevent interference and ensure communication quality. This is essential, for example, for remote healthcare devices and monitoring systems. Importers and distributors are obliged to ensure that products comply with the requirements. Market surveillance authorities monitor compliance and may restrict the distribution of non-compliant devices.

Internet-connected devices must also ensure a certain level of cybersecurity. The Directive promotes innovation whilst maintaining high safety standards. It facilitates the free movement of devices within the EU market. Liability for risks posed by non-compliant products is also provided for.

**Directive 2014/30/EU<sup>35</sup>** sets out requirements for the electromagnetic

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<sup>32</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32017R0745>

<sup>33</sup> <https://ec.europa.eu/tools/eudamed/ /screen/home>

<sup>34</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32014L0053>

<sup>35</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32014L0030>

compatibility of electrical and electronic equipment, ensuring that electromagnetic emissions do not exceed permissible levels. This is particularly important for medical and rehabilitation aids. The Directive applies to both individual devices and systems. The Directive imposes obligations not only on manufacturers, but also on importers and distributors. This means that all parties in the supply chain must ensure the product's compliance.

**Directive 2014/35/EU<sup>36</sup>** regulates the safety of electrical equipment within specified voltage ranges. It applies to equipment with voltages of 50–1000 V for alternating current and 75–1500 V for direct current. Equipment must be safe both during normal use and in the event of foreseeable malfunctions, and they must be adequately insulated against the effects of the external environment.

**Regulation (EU) 2023/988<sup>37</sup>** lays down general safety requirements for consumer products. It applies to all products intended for consumers or likely to be used in a consumer environment. Product safety must be ensured primarily through its design and technical characteristics. The safety assessment must take into account the product's characteristics, composition and instructions. The intended and reasonably foreseeable use of the product must be taken into account. The product's impact on other devices must also be assessed if they are used together. The Regulation also applies to products sold online or at a distance. Products are considered to be available on the market if they are intended for EU consumers.

**Directive 2011/65/EU<sup>38</sup>** sets restrictions on the use of hazardous substances in electrical and electronic equipment. It promotes the environmentally sound treatment of electrical and electronic waste. The Directive provides for regular reviews of the list of restricted substances.

**Directive 2012/19/EU<sup>39</sup>** concerns waste electrical and electronic equipment (WEEE). The aim of the Directive is to reduce the volume of waste and the environmental impact of the activities of the parties involved. It promotes reuse, recycling and other forms of recovery, as well as the establishment of a system for the separate collection of waste electrical and electronic equipment. Households must be able to dispose of this waste free of charge. Distributors must ensure the take-back of old equipment when delivering new equipment. Member States must ensure the availability of collection infrastructure. Producers are responsible for financing the

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<sup>36</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32014L0035>

<sup>37</sup> <https://eur-lex.europa.eu/eli/reg/2023/988/oj/eng>

<sup>38</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32011L0065>

<sup>39</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32012L0019>

management of this waste.

**Regulation (EU) 2016/679<sup>40</sup>** lays down rules for the protection of natural persons' personal data. It applies to the processing and protection of personal data in both the public and private sectors. It also ensures the free movement of personal data within the European Union. The Regulation gives individuals greater control over their data by setting out their rights to access their data, receive information about its processing, and request the erasure of data in certain cases. Organisations must ensure transparency in data processing, comply with the principle of processing only necessary data and storing it only for as long as is necessary, for example, to receive a service, and data security and protection against unauthorised access must be ensured.

**Regulation (EC) No 987/2009<sup>41</sup>** lays down the procedures for implementing Regulation (EC) No 883/2004 on the coordination of social security systems. It specifies the practical procedures and mechanisms between the institutions of the Member States. The Regulation provides for the use of structured electronic documents for the transfer of information. It also regulates the practical aspects of the granting and payment of benefits.

**Directive (EU) 2019/882<sup>42</sup>** aims to harmonise accessibility requirements for certain products and services in the EU. It applies to specific product groups, such as computers, operating systems, payment terminals, etc. The Directive also regulates services, including electronic communications services. The Directive covers the digital elements of transport services, such as tickets and information. It includes requirements for emergency assistance communication, including the number 112. It must be ensured that users can use the features regardless of their abilities. The Directive sets out requirements for the provision of information in multiple formats (e.g. visual and audio). It also sets out accessibility requirements for the physical environment where services are provided.

## Standards

Given that one of the objectives of the TechSocialcare project is to develop common basic requirements and standards for ICT tools and assistive technologies in

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<sup>40</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32016R0679>

<sup>41</sup> <https://eur-lex.europa.eu/legal-content/LV/TXT/?uri=CELEX:32009R0987>

<sup>42</sup> <https://eur-lex.europa.eu/legal-content/LV/ALL/?uri=CELEX:32019L0882>

social and healthcare services<sup>43</sup>, it is necessary to identify the standardisation procedures and existing standards relating to TA in Latvia. The **Standardisation Law**<sup>44</sup> came into force in 1998 and sets out the principles, tasks, organisational system, and procedures for the development and application of standards. It regulates the development, adoption and application of standards in various sectors. The aim of the law is to ensure quality, safety and efficiency. It also promotes the free movement of goods and services in the market. The Act stipulates that standardisation is based on the principle of openness, voluntary participation, a focus on technological development, and compliance with international standards.

Various stakeholders are involved in the development of standards. These include government bodies, businesses and industry experts. In Latvia, standardisation policy is implemented by the Ministry of Economics. The national standardisation body organises the development and maintenance of standards. Sectoral ministries may propose the development of new standards.

Latvia adopts international standards. This ensures compliance with global requirements. The use of standards is generally voluntary; however, in certain cases, they may become mandatory through legislation. This is particularly important in areas related to safety and health.

**EN ISO 21856:2022** specifies general requirements and test methods for TA<sup>45,46</sup>. Such assistive devices are often considered to be medical devices. It sets out general safety and performance requirements for these products. The standard includes requirements regarding design and materials. It also provides for test methods to verify compliance with the requirements. It sets out requirements for instructions for use and information provided by the manufacturer. The standard also includes requirements for safe use and maintenance. It sets out principles for testing under various operating conditions. It also covers aspects of hygiene, cleaning and disinfection.

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<sup>43</sup> [https://www.vidzeme.lv/projekti/tehnisko-standartu-veicinasana-paligtehnologijam-eiropas-socialas-aprupes-pakalpojumos/tehnisko-standartu-veicinasana-paligtehnologijam-eiropas-socialas-aprupes-pakalpojumos\\_pase/](https://www.vidzeme.lv/projekti/tehnisko-standartu-veicinasana-paligtehnologijam-eiropas-socialas-aprupes-pakalpojumos/tehnisko-standartu-veicinasana-paligtehnologijam-eiropas-socialas-aprupes-pakalpojumos_pase/)

<sup>44</sup> <https://likumi.lv/ta/id/50425-standartizacijas-likums>

<sup>45</sup> [https://www.iso.org/standard/71986.html?utm\\_source=chatgpt.com](https://www.iso.org/standard/71986.html?utm_source=chatgpt.com)

<sup>46</sup> <https://standards.iteh.ai/catalog/standards/cen/b34304da-7733-466c-b635-bc105cac6cb8/en-iso-21856-2022>

## LVS standards

ID code	Title	Link
ISO 6273:2024	Assistive products – Accessibility guidelines and requirements for assessing the needs of persons with sensory impairments in relation to assistive products and services <sup>47</sup> <i>Effective from: 11 March 2024</i>	<a href="https://www.lvs.lv/products/162836">https://www.lvs.lv/products/162836</a>
LVS EN ISO 9999:2022	Assistive devices – classification and terminology. <i>Effective from: 16 May 2022.</i>	<a href="https://www.lvs.lv/products/154979">https://www.lvs.lv/products/154979</a>
LVS EN 16586-2:2026	Railway equipment. Design for use by persons with reduced mobility. Accessibility of rolling stock for persons with reduced mobility. Part 2: Boarding aids <i>Effective from: 29 January 2026.</i>	<a href="https://www.lvs.lv/products/168350">https://www.lvs.lv/products/168350</a>
ISO 17069:2020	Accessible design — considerations and aids for accessible meetings. <i>Effective from: 30 September 2020.</i>	<a href="https://www.lvs.lv/products/148302">https://www.lvs.lv/products/148302</a>
ISO 17966:2016	Personal hygiene aids that support the user. Requirements and test methods <i>Effective from: 04.01.2016.</i>	<a href="https://www.lvs.lv/products/97089">https://www.lvs.lv/products/97089</a>
LVS EN 17999:2025	Accessibility systems for independent living. Requirements and recommendations <i>Effective from: 22.10.2025.</i>	<a href="https://www.lvs.lv/products/167486">https://www.lvs.lv/products/167486</a>
ISO 20342-1:2022	Assistive devices for tissue integrity in the supine position – Part 1: General requirements[45] <i>Effective from: 19 July 2022.</i>	<a href="https://www.lvs.lv/products/155807">https://www.lvs.lv/products/155807</a>

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<sup>47</sup> The table contains the titles of standards translated by the author from English into Latvian.

ISO 20342-4:2026	Tissue integrity aids for the supine position – Part 4: Durability test methods. <i>Effective from: 06/02/2026</i>	<a href="https://www.lvs.lv/products/168471">https://www.lvs.lv/products/168471</a>
ISO 20342-5:2024	Tissue integrity aids for the supine position – Part 5: Test method for resistance to cleaning and disinfection. <i>Effective from: 04.09.2024.</i>	<a href="https://www.lvs.lv/products/164090">https://www.lvs.lv/products/164090</a>
ISO/TR 20342-7:2021	Tissue integrity aids for the supine position – Part 7: Foam properties, characteristics and performance. <i>Effective from: 18.08.2021.</i>	<a href="https://www.lvs.lv/products/152363">https://www.lvs.lv/products/152363</a>
ISO/TS 20342-10:2022	Tissue integrity aids for the supine position – Part 10: Guidelines for the cleaning, disinfection and maintenance of polyurethane APTI covers. <i>Effective from: 25 March 2022.</i>	<a href="https://www.lvs.lv/products/154529">https://www.lvs.lv/products/154529</a>
LVS CEN ISO/TR 20342-7:2022	Aids for maintaining tissue integrity in the supine position. Part 7: Foam properties, characteristics and performance (ISO/TR 20342-7:2021) <i>Effective from: 21 July 2022.</i>	<a href="https://www.lvs.lv/products/155820">https://www.lvs.lv/products/155820</a>
LVS CEN ISO/TS 20342-10:2022	Aids for maintaining tissue integrity in the supine position. Part 10: Guidelines for the cleaning, disinfection and care of polyurethane APTI covers (ISO/TS 20342-10:2022) <i>Effective from: 21 July 2022.</i>	<a href="https://www.lvs.lv/products/155840">https://www.lvs.lv/products/155840</a>
LVS EN ISO 20342-1:2022	Aids for maintaining tissue integrity in the supine position. Part 1: General requirements (ISO 20342-1:2022) <i>Effective from: 24 November 2022.</i>	<a href="https://www.lvs.lv/products/157077">https://www.lvs.lv/products/157077</a>
LVS EN ISO 20342-5:2025	Aids for maintaining tissue integrity in the supine position. Part 5: Test method for resistance to cleaning and disinfection (ISO 20342-5:2024). <i>Effective from: 27 March 2025.</i>	<a href="https://www.lvs.lv/products/165833">https://www.lvs.lv/products/165833</a>

ISO 21802:2019	Guidelines for assistive products regarding cognitive accessibility. Daily time management. <i>Effective from: 15 January 2019.</i>	<a href="https://www.lvs.lv/products/141305">https://www.lvs.lv/products/141305</a>
LVS EN ISO 21802:2021	Assistive products. Guidelines for cognitive accessibility. Daily time management (ISO 21802:2019) <i>Effective from: 04.11.2021.</i>	<a href="https://www.lvs.lv/products/153156">https://www.lvs.lv/products/153156</a>
ISO 21856:2022	Assistive products – General requirements and test methods. <i>Effective from: 04.07.2022.</i>	<a href="https://www.lvs.lv/products/155502">https://www.lvs.lv/products/155502</a>
LVS EN ISO 21856:2022	Assistive devices. General requirements and test methods (ISO 21856:2022) <i>Effective from: 03.11.2022.</i>	<a href="https://www.lvs.lv/products/156894">https://www.lvs.lv/products/156894</a>

## Involved institutions

Although the provision of TA is most directly influenced by the MoW, NRC “Vaivari”, LAB and LAD, there are also many other stakeholders with their own influence, experience and perspective on the provision of TA.

### State institutions

**The MoW (Ministry of Welfare)** develops policy, regulatory frameworks and funding procedures in this area. It stipulates that assistive devices are funded from the state budget for persons with functional impairments or disabilities. Institutions under the authority of the MoW organise the assessment, delivery and fitting of these assistive devices for users. The MoW also regulates the order of TA allocation (e.g. the waiting list principle and medical assessment) and establishes the legal framework through laws and Cabinet of Ministers regulations. Additionally, it promotes improved accessibility by securing funding and introducing new mechanisms, such as a compensation or voucher system.

**The Ministry of Health** indirectly influences the provision of TA by setting the priorities of the healthcare system and medical criteria. The allocation of TA requires a medical professional’s opinion, which is based on the regulations of the healthcare system and professional standards, which are influenced by the Ministry of Health. Similarly, the Ministry of Health, the Ministry of Welfare and the National Health

Service are involved in expanding the range of state-funded assistive devices and introducing medical technologies. The Ministry of Health also influences the quality of diagnostic, rehabilitation and treatment processes, which determine which assistive devices are necessary and appropriate for patients. Thus, its policy influences both the demand for TA and their medical justification.

**The National Health Service (NHS)** administers state budget funds for healthcare, including payments for medical devices and services that are closely linked to the use of medical devices. It approves medical technologies and clinical guidelines, which determine which assistive devices are medically justified and suitable for use in treatment. The NHS analyses the use of funding, which affects the amount of resources available for TA.

**Ministry of Welfare (MoW) Department of Social Services and Disability Policy.** This department, as part of the executive branch, is responsible for implementing social policy regarding social services and disability.

**SIVA** is an agency under the supervision of the Minister for Welfare, whose aim is to promote the social integration of disabled persons and people with functional disabilities, to ensure access to professional rehabilitation, and to provide opportunities for vocational education.

### Inter-institutional councils

These certainly include **the Council of Representatives of Non-Governmental Organisations and Sectoral Professional Organisations**<sup>48</sup>, which is undoubtedly most directly linked to improving the provision of TA. The Council comprises representatives from NGOs (for example, the Association of People with Disabilities and Their Friends “APEIRONS”, the Children’s Hospital Fund, the Latvian Spinal Cord Injury Association), associations of medical and functional specialists (e.g., the Latvian Association of Tuberculosis and Lung Disease Specialists), as well as other healthcare-related organisations (the Digital Health Association). Although it was originally planned to hold council meetings four times a year, since the Covid-19 pandemic meetings have been held less frequently.

There is also the **MoW National Council for Disability Affairs**<sup>49</sup>, chaired by the Minister for Welfare and comprising the Minister for Education and Science, the Minister for the Economy, the Minister for Climate and Energy, the Minister for

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<sup>48</sup> <https://www.vtpc.lv/lv/nevalstisko-organizaciju-un-nozares-profesionalo-organizaciju-parstavju-padome>

<sup>49</sup> <https://www.lm.gov.lv/lv/invaliditates-lietu-nacionala-padome>

Transport, the Minister for Health, the Minister for Smart Administration and Regional Development, the Chair of the Latvian Association of Local and Regional Governments, the Director of the Secretariat of the Society Integration Fund, the Chair of the Latvian Free Trade Union Confederation, the Director-General of the Latvian Employers' Confederation, as well as representatives from civil society organisations.

Also the **Advisory Board of the State Agency for Social Integration (SIVA)**<sup>50</sup>, which includes representatives of the agency, a representative of the association "Resource Centre for People with Mental Disabilities "ZELDA"", a representative of the LAD, a representative of the LAB, a representative of the Education Department of the Jūrmala Municipal Administration's Education Department, a representative of the Ministry of Education and Science's Department of Vocational and Adult Education, and others. As there is some overlap in the public organisations involved in these councils, I have not listed them again.

**The National Standardisation Council**<sup>51</sup>, chaired by the Minister for Economic Affairs Deputy State Secretary of the Ministry; the Deputy Chair is a member of the Board of the National Standardisation Body and participates, for example, a representative of the Latvian Consumer Rights Protection Association, a representative of the Latvian Information and Communication Technology Association, a representative of the Latvian Academy of Sciences, a representative of the Association of Technical Experts, etc.

## NGOs

Primarily, standard-setting takes place with the involvement of **NGOs** representing the rights and interests of people with functional impairments. As mentioned earlier, the LAB and LAD have a significant influence on the provision of TA, but there are also other NGOs involved in various decision-making processes, for example, the Association of People with Disabilities and Their Friends "APEIRONS", the Latvian Organisation for People with Special Needs SUSTENTO, and the association "Resource Centre for People with Intellectual Disabilities "ZELDA"".

## Medical and functional specialists

The stakeholders also include all medical and functional specialists who work with people requiring assistive technology. Specialists are represented by organisations

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<sup>50</sup> <https://www.siva.gov.lv/lv/konsultativa-padome>

<sup>51</sup> <https://www.em.gov.lv/lv/nacionala-standartizācijas-padome>

such as the Latvian Association of Occupational Therapists<sup>52</sup>, the Latvian Association of Audiologists and Speech Therapists<sup>53</sup>, the Latvian Association of Physiotherapists<sup>54</sup>, the Latvian Association of Prosthetics and Orthotics<sup>55</sup>, the Latvian Association of General Practitioners<sup>56</sup>, the Latvian Association of Rural General Practitioners<sup>57</sup>, and others.

### Digital health companies/business promoters

Also important are companies involved in the development, manufacture and distribution of TA, as well as organisations that promote entrepreneurship in Latvia. Among them is SIA Vigo Health, which offers a digital rehabilitation programme for stroke survivors (available on a tablet, can also be used at home)<sup>58</sup>, SIA Meditec (developer of information systems for dispatching and resource management in the healthcare sector and emergency services)<sup>59</sup>, Latvian Digital Accelerator<sup>60</sup>, Digital Health Association<sup>61</sup>.

### Policy experts, researchers

Researchers and policy experts are also involved in the policy and development of assistive technologies, contributing to the development and evaluation of a wide range of assistive technologies. They are also engaged in public education and other activities that influence national policy. One example is the 'Access Routes' activity under the Interreg VI-A Estonia–Latvia Programme, in which participants were asked to put themselves in the shoes of people with functional impairments regarding everyday situations and accessibility issues<sup>62</sup>. Another example is an article on the use of robots, artificial intelligence and other technologies in mental health care, which raises research and medical ethical considerations in the context of new

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<sup>52</sup> <https://ergoterapija.lv/>

<sup>53</sup> <https://audiologopedi.lv/>

<sup>54</sup> <https://www.fizioterapeitiem.lv/>

<sup>55</sup> <https://lpoa.lv/>

<sup>56</sup> <https://lgaa.lv/about>

<sup>57</sup> <https://www.llgaa.lv/>

<sup>58</sup> <https://vigo.health/ka-tas-strada/>

<sup>59</sup> <https://www.meditec.lv/par-mums/>

<sup>60</sup> <https://www.digitallatvia.lv/sakums>

<sup>61</sup> <https://www.digitalaveseliba.lv/>

<sup>62</sup> <https://estlat.eu/en/news/lunch-senses-experiencing-reality-accessibility-barriers>

technologies<sup>63</sup>. We can also mention technologies developed in Latvia for use in rehabilitation, such as the use of augmented reality and wearable technology to provide data support for people with lower limb amputations<sup>64</sup> or a virtual reality solution adapted to the context of mental health care<sup>65</sup>.

### Social service providers

Social service providers play a very significant role in the use of TA. Caregivers are the ones who work with people with functional impairments in practical, everyday situations; as such, they are also in a position to observe the patterns of TA use, as well as its possibilities and limitations. Social service providers are also the ones which uses assistive technologies for care work (particularly in relation to client monitoring).

### Standardisation body

**SIA "Latvijas standarts" (LVS)** is the Latvian National Standardisation Body, which operates under the Ministry of Economics. It operates in accordance with the Standardisation Law and performs standardisation functions delegated by the state. The body's main tasks are to develop, register, publish and maintain Latvian national standards. It represents Latvia in international and European standardisation organisations, such as ISO and CEN.

### EU funding mechanisms

In relation to the implementation of EU policy, a key stakeholder is the Recovery Fund<sup>66</sup> – a budget programme managed centrally by the EC, established in addition to the EU's multiannual budget for the 2021–2027 programming period. Under the programme, it is planned to allocate financial resources 1) to digital transformation – 20% (€365.2 million), 2) reducing inequalities – 20% (€370 million), and the health sector – 10% (€181.5 million). For example, funding from the Recovery Fund has also been allocated to the NRC 'Vaivari' to promote the accessibility of TA<sup>67</sup>.

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<sup>63</sup> <https://satori.lv/article/vai-robots-var-tavs-psihoaterapeits>

<sup>64</sup> <https://va.lv/projekts/petijumi-kompleksai-kermena-rehabilitacijas-istenosanai-cilvekiem-ar-apaksejo-ekstremitasu-amputacijam-izmantojot-paplasinato-realitati-un-vaikajamo-tehnologiju-datu-atbalstu>

<sup>65</sup> <https://www.strencupns.lv/slimnica-uzsak-virtualas-realitates-terapijas-pilotprojektu/>

<sup>66</sup> <https://www.cfla.gov.lv/lv/atveselosanas-fonds>

<sup>67</sup> <https://www.lm.gov.lv/lv/tehnisko-paligidzeklu-pieejamibas-sekmesana>

## 2. ASSESSMENT OF THE CURRENT SITUATION

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### State Audit Office report

The most significant document for assessing the current provision of TA is the 2024 State Audit Office (SAO) report “Are state-funded assistive devices provided in accordance with the needs of the target group and in the best possible way?” (Audit No. 2.4.1-41/2023). The report identifies five main problems, which were also mentioned in the expert interviews conducted as part of the TechSocialcare project:

- Access to specialists for obtaining an assessment is limited.
- Unjustified bureaucracy and inefficiency in the TA allocation process.
- Obtaining a TA is burdensome for residents.
- The state-provided TA ‘basket’ is not sufficiently flexible.
- A lack of a systematic and careful approach to the management and utilisation of TA.

Solutions have already been found for some of these problems, for example, regarding the receipt of TA. As mentioned earlier, NRC “Vaivari”, LAB and LAD offer the option of delivering TA to the home if a person requests a home visit.

### Availability of specialists for obtaining a medical certificate

Regarding the receipt of medical certificates, in accordance with Cabinet Regulation No. 878, a medical certificate must be submitted to receive state-provided TA even if the information is already available at the NRC “Vaivari” (for example, when re-applying for TA). In accordance with Cabinet Regulation No. 250, an assessment is not required for TAs reissued by the LAB and LAD. To obtain an assessment, one must consult a medical specialist or a functional specialist, but waiting lists for specialists tend to be very long. Some assessments can only be carried out at the VADC laboratory, but this process is also affected by the limited number of specialists.

Opinions may be prepared by functional specialists, but one of the experts interviewed also points to a shortage of accessible and independent functional specialists, particularly occupational therapists, noting that specialists are often representatives of specific companies and therefore also represent the interests of those companies.

According to the report and the experience of experts interviewed as part of TechsocialCare, the majority of assessments are prepared by GPs; furthermore, these assessments often lack essential information regarding the specifics of functional

impairments, etc. The interviewed expert pointed out the fact that GPs lack an understanding of the principles governing the use of assistive devices, as well as the fact that such devices may be prescribed not only by rehabilitation specialists but also by functional specialists. There are situations where it appears that a GP prescribes a technical aid at the patient's request, rather than because there is a valid medical reason for its use. The assessments lack a detailed justification for prescribing the assistive device.

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*That is to say, [patients] in the same ward tell each other that the doctor prescribed me a scooter for travelling to and from the shop. [...] She initially asked our specialists, but our specialists, after assessing the patient, said, no, you don't need such a device [...]. And then the patients advised one another to go to their GP and say, 'Well, you can prescribe one for me, so please do.' So, there needs to be some consistency in the criteria for who actually needs what. [...] But often, in those assessments, you can't immediately decipher it in such detail. [T1]*

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One of the SAO's recommendations was to group TAs according to their complexity, assigning different specialists to each group who are authorised to provide an opinion: 1) for simple technical aids, an opinion could be provided by GPs or social services specialists who already assess the client's functional status for the provision of various social services, 2) for moderately complex cases – specialist doctors, such as neurologists, 3) for complex cases – multi-professional teams of specialists, ensuring their availability outside Riga as well, for example, at the VADC branches in Kuldīga and Rēzekne.

### **Unjustifiable bureaucracy and inaction in the TA allocation process**

The SAO report also criticises the ineffective procedures for administering the TA service, including 1) a failure to assess at which stages of the process the involvement of VADC occupational therapists is required, 2) cases where TAs should be issued as a matter of urgency are not treated as a priority in the service administration process, 3) delayed procurement planning, etc.

The experts interviewed indicate that at NRC "Vaivari", TAs can be obtained on an urgent basis within 1–3 months, and through the standard procedure within six months, provided they are TAs intended for long-term use. Currently, the waiting time

is reduced by the preparation of assessments in an electronic environment. Whilst one of the experts, who also uses TAs herself, found the waiting time reasonable and surprisingly short, another expert considers a one-month wait for TAs to be a long period.

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*It was quite quick for me, because as I was studying full-time on campus, there was some sort of priority for issuing them. And I think I actually got mine just before the start of the academic year. I don't know if that was related or not. I don't remember the details that clearly. But, yes, I think we applied sometime at the start of the summer, and I received it just before the start of the academic year. So, all in all, well, it was about, well, two and a half, three months, I think, that I waited. [T3]*

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Similarly, regarding patients who need a TA on a short-term basis, it is said that in practice patients do not apply for the state-funded service at all, as the TA may no longer be needed after three months. Instead, patients buy or hire TA from distributors.

Overall, the experts interviewed had little to say about the average waiting time from the submission of an application. As can be seen in the quotes above, each person also has their own estimated duration of TA use, as well as their own understanding of what constitutes an acceptable waiting time. In the interviews, the experts spoke at greater length about the fact that the NRC “Vaivari” has an excessively broad scope of responsibility in relation to a diverse group of people with functional impairments. The fact that the experts had little to say about the average waiting time can be explained by the fact that every person requiring TA has their own specific needs in relation to TA.

### **Too broad a remit**

The NRC “Vaivari” is responsible for providing TA to a wide range of people with functional impairments, including both those with acute, short-term functional impairments and those with long-term impairments. This also entails the centre’s responsibility to provide a wide range of TA services, as well as to monitor people’s needs in Latvia, market supply in the TA sector, and to align with state-allocated funding. The SAO report notes that researchers and experts have repeatedly pointed out the need to distinguish between the allocation of TA for acute patients and chronic patients, with TA in acute cases being funded from health sector resources. The

experts interviewed by TechSocialcare have also highlighted the need to divide the TAs managed by the NRC “Vaivari” into acute and chronic cases, thereby reducing the workload on the NRC “Vaivari” to shorten waiting times for receiving assistive devices. If the assistive technologies required for acute cases were provided by someone else, this might facilitate a more rapid provision of assistive devices, for example, for people with physical injuries.

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*The volume of [assistive technology under the NRC “Vaivari”'s remit] [...] is so large that, in principle, it should be distributed even more finely if we are talking about non-governmental organisations [...]. Twenty thousand people a year receive this service, [...] There were all sorts of ideas here, such as transferring them to the state social insurance [agency] for insurance, or [...] merging them, but it all came to nothing; a solution was not found precisely because it is a very, very complex issue. We had already suggested, and it seemed to us that the solution was to transfer some of the assistive devices or to separate those that are for acute care. At the moment, the situation is such that people can leave hospital without a wheelchair because their turn hasn't come yet. [...] In fact, it should be the case that when a person leaves the hospital or [...] a rehabilitation centre following an injury or something similar, they are already equipped with all the assistive devices, they know how to handle them all, know how to use them, and so on. [T6]*

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One way of making mobility aids more readily available in acute situations is to transfer the management of the technically simpler mobility aids to local authority social services, given that this would make it easier to get to the collection point, as well as facilitate return when the TA is no longer needed.

However, the authors of the SAO report believe that this would not be a successful solution within the current healthcare system, given that, at the start of treatment, it is not known how long the patient will have functional impairments, and that there is no specific institution that could take on the provision of TA in acute cases.

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*Specifically, regarding the provision of these assistive devices and assistive technologies, and the introduction of new, high-quality ones, as you ask, there is no such thing; there is no such strategy. It's as if we're all just digging our own little ponds, whichever way we please. [T6]*

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If local authorities were to provide basic assistive devices, it would also be unclear who would carry out the procurement – the local authority, the NRC ‘Vaivari’ or some other state institution to which this task might be delegated. To ensure that all local authorities have assistive devices of equivalent quality, procurement could be carried out centrally.

### **The state-provided “basket” of assistive devices is not sufficiently flexible**

The SAO report states that in cases where TAs purchased through public procurement are not suitable for a person, the purchase of more specialised personal TAs with a co-payment is a good option; however, state compensation is not always sufficient, so donor support is needed. The experts interviewed also point out that the lack of expertise and financial resources in the provision of state-funded assistive technology, particularly in relation to people with higher levels of disability who require more complex and therefore more expensive assistive technologies, has led to people seeking financial support through fundraising campaigns. To receive AT that meets their needs, a person should not have to rely on assistance provided by individual benefactors.

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*Because there is always a choice between buying cheaper and more, or more expensive and less; the first option has always won out in these matters, [...] There are many reasons why it didn't get on the right track, because technology is developing very quickly and it became increasingly difficult to keep up with all these different types, individual needs and financial capabilities [...] At some point, I'd say, they just let things take their own course, so people lived as they were, buying things themselves, until eventually they arrived at this individual budget, where a person can choose and buy what they need, but it must be admitted that this funding for the individual budget is not large enough for a person to manage without a fairly substantial co-payment [...], and it was precisely people with more severe disabilities, who need something more tailored, [...] who were left to rely on donors or money they had found themselves, or who used what was offered by the assistive technology centre, which did not always meet these individual needs. [T6]*

*The external part of the [cochlear implant] is replaced every five years at the state's expense. If something happens to you outside of that five-year*

*period, then you have to pay for it yourself. [...] And yes, she had to raise funds on Facebook. [...] And in my opinion, it's not right that a person has to rely on the goodwill of society – essentially, to go begging – in order to get something so basic. [T8]*

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The experts interviewed point out that the provision of TA has always been affected by a lack of funding, and consequently the TA list has remained unchanged for a long time. The most significant changes to the TA list occurred in 2022, when the range of various types of TA was substantially expanded, and the state funding available for the service was increased. Since 2022, the VADC has been able to issue more TAs and to change the range of these services.

### **Lack of a systematic and careful management approach to the circulation and utilisation of TA**

The SAO report states that the NRC “Vaivari” is inefficient in managing TAs that have been loaned out and returned. For example, when receiving used TAs, their technical condition is not assessed; many of the loaned items are not recovered at all, but are written off. The authors of the report believe that greater attention should be paid to recovering TAs that can be reused. An expert interviewed as part of the TechSocialcare project, referring to the procedures implemented in Lithuania, highlights the need to promote a market for used TAs in Latvia as well, given that this could save people money.

### **SAO recommendations**

- Review, simplify, standardise and automate the procedure for obtaining TA opinions, including 1) by making improvements to the E-veselība and SPOLIS platforms, 2) promoting the use of the unified functional assessment protocol developed by the NRC “Vaivari”, 3) assessing the possibility of grouping TAs according to their complexity and assigning appropriate specialists to prepare assessments for each group, 4) considering the possibility of ensuring in-depth functional assessments at VADC regional branches and healthcare institutions as well.
- Promote the establishment of a high-quality system for data collection, exchange and analysis, focusing on ensuring that 1) there is regular data exchange with the Register of Natural Persons, for example regarding a person’s status, etc., 2) information on the actual costs of purchasing TAs is available in one place, and there are opportunities to analyse it with the aim of improving the regulatory

framework regarding the amount of co-payment.

- Improve the procedure for the acquisition of TAs, including 1) the procedure for organising procurement, encouraging TA manufacturers and distributors to participate in such processes, 2) the procedure for assessing the need for additional equipment related to the use of TAs, 3) the Ministry of Welfare (MoW), the National Rehabilitation Centre “Vaivari” (NRC), the Latvian National Library (LNB) and the Latvian National Society (LNS) making changes to the procedure for granting state compensation in relation to the purchase of TA with a co-payment.
- Promote more timely delivery of TAs by assessing 1) TAs that can be sent to people by post, courier or parcel locker, 2) the schedule of visits.
- Improve the loan system, including 1) assessing loan periods and the rate of TA wear and tear, 2) streamlining the TA return procedure, the assessment of used TAs, and the disposal procedure.

### Children’s Hospital Foundation report

A similar assessment of the current situation is also expressed in the Children’s Hospital Foundation’s plan for improving the TA system and recommendations for ensuring the development and social inclusion of children with mobility impairments. 2024–2027<sup>68</sup>: 1) long waiting times, 2) a complex allocation procedure, 3) insufficient information for users, 4) assistive devices sometimes do not meet individual needs, 5) complex inter-agency cooperation.

It should also be noted that the majority of children with mobility impairments who have received financial support from the Children’s Hospital Foundation for the purchase of assistive devices require repeated support, as children grow and a new assistive device tailored to the child’s individual parameters is needed each year. In cases where co-funding is required because state-provided TAs do not meet the child’s needs, parents turn to charitable organisations.

### Influencing policy

The experts interviewed also commented on the interpretation of the EP Directive in Latvian legislation, noting that the principles of accessibility are expressed in a more general manner in Latvian legislation, which makes the requirements open to broader interpretation, thereby creating more opportunities for these requirements not to be implemented in a meaningful way in practice.

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<sup>68</sup> [https://bsf.lv/userfiles/files/TPL\\_pilnveides\\_rekomendaciju\\_plans\\_2024\\_2027\\_gadam.pdf](https://bsf.lv/userfiles/files/TPL_pilnveides_rekomendaciju_plans_2024_2027_gadam.pdf)

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*I can't quote it off the top of my head, but the directive states very clearly that user involvement is required; Latvian law says that it is not involvement but consultation that is desirable, I believe, with users. Then there are areas where the directive strictly stipulates that access must be provided to everyone, whereas in Latvia it is more abstract. [...] It's as if everything is there, but it's all more of a gentle... Accessible to all, accessible for all – not just strictly accessible to the blind or visually impaired, the deaf or those with mobility impairments, but accessible to everyone, everyone must be able to access it. This always leaves room for various interpretations. [T6]*

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The Data Protection Act, which is based on Regulation (EU) 2016/679, is also cited as an obstacle to accessing data on patients' circumstances and needs. As also mentioned in the SAO report, problems with data exchange and the lack of open data hinder the compilation of statistics for the development of more targeted campaigns and services

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*We don't even have any statistics on exactly how many deaf-blind or hard-of-hearing-visually-impaired people there are. [...] one of the things we do is gather some information, but we can't really obtain this information because data protection applies everywhere. Let's say we've managed to find out that the same children's hearing centre... That it admits around two hundred new children there each year. [...] At the moment, there are certainly fewer due to the fact that the birth rate is lower overall, but we do not know; we have no way of obtaining data on how this is distributed across regions, or a more detailed breakdown by degree of hearing loss. [T8]*

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To address the shortcomings in the provision of hearing aids, many of the experts interviewed have been members of various policy-making working groups and have participated in research into the actual situation regarding the provision of TA in Latvia. They point out that it is easy to join working groups that decide on improvements to TA and the needs of other people with functional impairments. In this respect, Latvia's relatively small population is an advantage for participation in policy-making.

At the same time, whether all working group members are given an equal voice depends on the group's composition; for example, older experts may not take the use

of VR technology in rehabilitation seriously, and new or smaller organisations and social enterprises struggle to make their voices heard in a field dominated by long-established and recognised organisations. There are sometimes issues where it is difficult to reach a compromise regarding the needs and future vision of the parties involved, given Latvia's complex legislation regarding services for people with functional impairments.

Expert interviews describe the difficulties faced by smaller NGOs and social service providers in making their voices heard when representing the needs of people with more specific, less widely recognised functional impairments, or of those whose income slightly exceeds the threshold for state or local authority compensation. These experiences did not mention cooperation with international partners.

## Procurement of assistive technology

### Latvia is a small market

During the expert interviews, it was repeatedly stated that the availability of assistive technology on the Latvian market is often hampered by the small population. If an assistive technology is complex, it will inevitably require specific knowledge for its maintenance and repair, which is provided only by the distributor or manufacturer. It would not be economically viable for a distributor or manufacturer to provide a service to just one or two institutions where their specific assistive technology is in use. An institution must have sufficient resources to purchase complex, expensive assistive technology, but as it would be costly for the distributor to provide the services themselves, this expensive technology is not offered on the Latvian market at all.

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*Whilst in other sectors we have several potential service providers who have expressed an interest in supplying us with this product, in the case of assistive technology, these are among the most expensive aids, particularly these new, innovative devices. And in Latvia there is only one service provider[.] Furthermore, having visited exhibitions on technical aids, we have concluded that such equipment from other manufacturers is also available on the market, and possibly at a lower price, but the Baltic market has not been attractive to them so far and there are no companies willing to invest, as the market is indeed small. And for the most part, we have found that whilst*

*this equipment is available in the European Union, it does not feature a Latvian voice. [T7]*

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A related problem is the lack of assistive technologies with software developed in Latvian. In Latvia, rehabilitation centres use assistive technologies with software in English. However, this is only the case when the software is used exclusively by specialists, not by clients. Nevertheless, there are assistive technologies that require software in the Latvian language. In such cases, this requirement is included in the technical specifications of the procurement, and there is active, ongoing work to refine and correct the translation. Refinements are made even after the technology is already in use.

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*So, when we bought the equipment, we specified that we needed it to be in Latvian. And they translated and adapted it all. Well, I suppose it depends on the equipment itself, on whether the software is easily modifiable or not. But, well, yes, whether the manufacturer does it. [...] But clearly, it takes up a lot of resources, because we're still involved in the Latvian translation ourselves; that is, when working with the equipment, there are things we notice where there are errors, which we then report to the distributor. [T1]*

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However, NRC "Vaivari" is not permitted to carry out software translation. Precisely because there are few suppliers who undertake software translation into Latvian, we are forced to choose more expensive technology, which also reduces the number of units the centre can afford to purchase. Latvia has a small population, which makes it unattractive for distributors, who make the devices that are available more expensive, which reduces the number of devices and, consequently, the number of people who can receive these devices for use.

The inclusion of the Latvian language in software is a problem not only for assistive technologies for rehabilitation, but also, for example, for widely available communication programmes such as the video conferencing platform *Zoom*. The availability of subtitles in Latvian greatly facilitates communication for people with hearing impairments and, possibly, for deaf people as well. Requests and demands for improvements to products and services require persistent effort, which does not always bear fruit. In such situations, legal requirements aimed at promoting accessibility provide significant support in improving everyday life.

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*Subtitles have been introduced on a much, much wider scale, which is one of our absolute priorities. We have also written letters to Microsoft Teams asking them to include the Latvian language, and this has finally been done. I believe this was not only due to our pressure, but also because new legislation has come into force, namely the Law on Accessibility of Goods and Services. [...] Preferably in as many languages as possible, but certainly in all the official languages of the European Union. I am pleased that [Microsoft] Teams has respected this and already has Latvian subtitles, but Zoom, unfortunately, does not. Estonian subtitles are there, but not Latvian. In my opinion, this is a discriminatory practice. And that is why I ask that you always use Teams, if possible, whenever it is available. [T8]*

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If major assistive technology manufacturers and distributors are not interested in the Latvian market for the reasons mentioned above, then one might assume that we should collaborate with small manufacturers and distributors. However, when working with small, local distributors, the problem is the high turnover of distributors, as they change the range of products they offer or go bankrupt. The same assistive technology products in Latvia have to be sought from different distributors year after year.

### **Cooperation with foreign stakeholders**

When social service providers, medical or rehabilitation institutions consider purchasing assistive technology, they often seek foreign expertise. Sometimes advice is sought from an umbrella organisation, sometimes from another organisation abroad with which there has been cooperation in other areas, and some seek new partners for knowledge exchange. In the experience of one social service interviewed, the umbrella organisation's practical experience, reputation and influence in the assistive technology market proved useful. This link with a foreign umbrella organisation legitimised the Latvian organisation's interest, competence, ability to define its needs, and skill in applying assistive devices. Meanwhile, NRC "Vaivari" is a member of EASTIN. This is a network bringing together national organisations responsible for providing assistive technology. Members meet several times a year and share their experience regarding the procurement of various assistive technologies and the development of services. This is an advantage of larger and politically and economically stronger organisations.

It was also mentioned in the interviews that the products offered by

manufacturers do not usually have fixed prices. The distributor offers a different price to each prospective customer, based on assumptions about the customer's ability to pay and other circumstances. This makes it all the more important to share experiences with partners who also purchase equipment from the same company, in order to better assess what constitutes a reasonable price for a product or service.

## The infrastructure required for TA to function

When considering the purchase, use, maintenance and servicing of TA, the broader ICT infrastructure in Latvia must be taken into account. The state's internal and external security apparatus – which is unknown, invisible and beyond the control of customers and service providers – can cause disruptions to personal health and safety issues.

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*Each of these devices contains a SIM card, a nano-SIM card. And if there is a location where there is a problem with coverage, this device will most likely not work there either. And at the moment, we have noticed that in Latvia too, not just abroad, in places where there are security agencies or similar organisations, this signal is being disrupted. And if there is a place where there was always coverage, and then suddenly this service is no longer available there, either the call drops or the signal is lost with, let's say, a delay, a time lag. [T2]*

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Latvia's membership of the EU and the associated standards must also be taken into account. This affects ICT infrastructure on a broader scale as well. To ensure that TAs are safe and reliable for use, one must choose those that comply with EU legislation, regardless of the country in which they are manufactured.

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*The equipment is manufactured internationally. It really is there; the technology has been in the European Union since the 1970s. And there is even a special frequency band allocated specifically for this emergency communications equipment. That is why, well, if a manufacturer from China, India or wherever wants to produce such equipment, they have to adapt to those European frequencies. Because the frequency they operate on, well, it can't interfere with a TV remote or something like that. We had a care home*

*here in Latvia that bought something very similar from the Chinese. And then it turned out to be on the same frequency as some sort of pacemaker or similar device. And God forbid that someone in the care home should turn up with exactly the same one, because then there are quite significant risks involved.[T10]*

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## Regions

When it comes to the use and provision of assistive technology, differences in needs and capabilities among Latvian local authorities must be taken into account. The experts interviewed hold varying views. On the one hand, there are social services platforms available that facilitate service application, registration, quality assessment, monitoring and other activities. Local authorities have a considerable degree of autonomy, so service provision platforms must include the option to configure the application according to the needs of the relevant local authority, adapting to this diversity. On the other hand, another expert points out that a standardised basket of local authority services would also be necessary in relation to TA, to promote equal opportunities across different regions.

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*It really depends on which local authority, which local authority can, essentially, how they can. It's not that anyone specifically doesn't want to support children with hearing impairments. Usually, it's simply that they can't, because there are so many other needs. The idea is that there should definitely be a standardised minimum package of various social services across the whole country. And if a local authority cannot manage this on its own, then state funding comes in so that they can do so. The first steps have already been taken in this direction, and laws have already been passed. [..] At the moment, residents of Riga are very privileged. Firstly, Riga has a children's hearing centre. Secondly, Riga has the same surdocentre. Thirdly, all the hearing aid distributors are based in Riga. The Deaf Centre has branches in Liepāja and Daugavpils, somewhere in that area. But, of course, not in Limbaži, not in Smiltene, not in Preiļi. Not in the small towns [T8]*

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Specialists at regional rehabilitation centres must be able to provide rehabilitation services to patients from a wide area, i.e. from various local authorities with varying

levels of resources. Specialists must be able to use specific, complex assistive technologies and teach patients how to use them, even if there are few patients with such needs and such technologies are used infrequently. This also applies to assistive technologies for children – even if the institution does not specialise in working with children, it must have access to specific technologies for children’s rehabilitation.

It is observed that since the State Audit Office’s report on the provision of assistive technology, the NRC “Vaivari” has established several new services and resolved some of the delivery issues in the regions. For example, the delivery of simple TA items, such as walking sticks, is now also possible via the services of A/S “Latvijas Pasts”.

However, this solution is not suitable for everyone, as parcel lockers are inaccessible to visually impaired and blind people due to the lack of tactile buttons. Collecting AT in person also provides an opportunity to learn more from specialists about the AT available in Latvia.

## **Experience in using assistive technologies**

### **Knowledge and skills of medical and functional specialists**

The experts interviewed listed several benefits associated with the use of assistive technology. When it comes to assistive technology available in healthcare facilities, it is useful to be able to collect more detailed and specialist-defined data on the patient’s treatment progress, as well as the ability to tailor a treatment programme, such as the intensity of an exercise programme on the device. In the context of social care, the potential of assistive technologies to facilitate client monitoring was highlighted. If the carer is a relative, the reduction in emotional strain is also emphasised, as the relative feels more at ease knowing they can more accurately identify situations where assistance is required.

Assistive technology can promote the independence of both the person being cared for and the carer themselves. The ability to promote independence also means that the burden on inpatient wards and long-term social care institutions is reduced. There are assistive technologies that also make it easier to adapt daily life to one’s changing needs, for example, by providing information on how to organise a trip to the shop so that the person can do it themselves as much as possible, taking into account their new functional limitations.

### **Specialists’ skills in using technology**

Knowledge, skills and a sense of confidence regarding the use of assistive

technology depend partly on how recently one has completed their training in the relevant specialism. Specialists who have recently graduated have already been trained in various modern technological possibilities in rehabilitation as part of their study programme. Assistive technology suppliers usually inform users about the technical functions of the equipment, whilst the specialist themselves is responsible for the rehabilitation methodology. Training on technical functions is included in the technical specifications of procurement to promote specialists' awareness, and consequently the use of the device within the framework of the patient's individual treatment plan; however, this may not be sufficient. As one of the experts points out, easily accessible technical support is definitely needed for the introduction of assistive technologies into rehabilitation practice. Meanwhile, another expert's experience shows that there are also quite a few specialists who record data on printed forms.

### Specialists who can provide training

It is not only specialists who need training on the technical functions of AT and its practical application in rehabilitation; patients and clients also need guidance, as the principles of using AT are not self-evident.

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*Currently, there are smart tablets designed for patients with severe disabilities. And unfortunately, Latvia is not yet fully prepared for such a service, as there is a shortage of specialists who are willing and able to work with these patients. Because the fact that we can provide a single device does not mean that, once taken home, the patient will be able to communicate freely and develop their communication skills if they did not have them previously, as the device itself will not perform this function. [T7]*

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Often, feeling a lack of support, people purchase a TA, which they believe to be a high-quality device, even though the device is not suited to their abilities and living conditions.

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*So the person themselves finds it difficult to assess; they have their own opinion, but they cannot express it from a specialist's perspective; they are largely left to their own devices. There are plenty of odd cases, of course, where people buy huge wheelchairs that won't fit inside a room, or buy wheelchairs that are steered with the hands, but they don't have the strength*

*in their hands. There are many such oddities, failures, which ultimately lead to... which aren't for the better, which simply achieve nothing. Money is wasted and there's no point. [T6]*

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These consultations would be best carried out by occupational therapists or social care professionals who are well acquainted with the person's needs, abilities and living conditions, and who are in regular contact with their patients or clients. The woman interviewed, who uses a TA, points out that if a specialist were to prescribe a new TA for her, she would discuss the need for it with the physiotherapist she has been seeing regularly for years. When introducing new assistive technologies into daily life, this has usually taken place by assessing and adapting the relevant device in collaboration with a specialist she knows, over the course of several consecutive appointments. It is an iterative process. Functional specialists are likely to have more knowledge about the technical characteristics of assistive devices, their potential applications and limitations, as well as, hopefully, experience in working with them. Furthermore, specialists have access to TA catalogues, so they can introduce the patient to the range of state-funded TAs available, as well as clarify the arrangements with the VADC.

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*And during these other meetings, we have, let's say, I have obtained an anti-bedsore cushion that fits, well, in the wheelchair, as it was not originally included. And if someone had asked me over the phone whether I needed anything else, I would have said no, because I thought everything was fine. But when I met this occupational therapist in person, they could see that, let's say, my posture wasn't quite right or something wasn't quite as it should be. And then they offered some other solutions, like this cushion for me. [T3]*

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## Social service providers

### Simplicity and safety

Social service providers who use assistive technology in their work provide clients with a comprehensive service package, which includes the assessment and procurement of assistive technology, installation, guidance on its practical use, client training and counselling, maintenance of assistive technology, electronic and telephone communication, as well as face-to-face visits, and the emotional and physical work of carers in relation to tasks that cannot be performed by technology.

Social service providers must also be able to assess which client groups the technologies available within the organisation are not suitable for. For example, whilst the voice assistant function is generally useful for clients or at least does not cause significant difficulties, it is unsuitable for people with mental health conditions as it causes considerable distress.

In day-to-day work with clients requiring care at home or in a long-term care facility, the following are important: 1) ease of use, so that the device is convenient for the client and requires less knowledge, time, etc. resources from care professionals, 2) the safety of using assistive technology, both in terms of client data anonymity and health.

**Robots** are currently also available in social care in Latvia. These are aimed at promoting opportunities for socialisation, particularly for people with dementia. Although the technology is relatively simple, it is accessible because it does not use the (Latvian) language. At the same time, there is a very noticeable lack of technologies that would ease the physical demands of a carer's work.

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*At the moment, we can take some of the strain off the process; we can take some of the strain off observation; we can take some of the strain off certain monitoring tasks; we can carry out certain ancillary tasks. But purely physically speaking, when it comes to one-to-one care – brushing teeth, cutting nails or changing nappies – there isn't yet any technology to help us cope with this. Looking at and talking to service users, to clients, it's not entirely clear that they want it either. [T10]*

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### Impact on care providers

When it comes to providing care, we must also consider the impact that the use of assistive technology has on the emotional and cognitive workload of professionals. For example, a video visit service has been developed for social care providers. This is useful as a tool for socialisation and monitoring in the collaboration between the client and the social care provider. Although the initial idea is to save on staff resources, a negative aspect is that the provision of the service may reduce staff quality of life, given that the carer is on call at any time of the day or night. Some carers feel a sense of responsibility to respond to any client request for contact, even outside the carer's working hours. As the boundary between working hours and personal time blurs, carers are unable to fully recover after work.

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*He sorted things out for some of the clients who had relatives abroad; this helped them find not only this social connection with us, the service provider, but also with their own relatives. And in that sense, it was okay. That's why many of us are still using these tablets and carrying on. But then he gets up at 2:00 am, feels like socialising, and calls the carer, and the carer doesn't want to talk to him at 2:00 am. And you can't tell him not to do that. And some carers did take those calls. In the end, because he had reasonable working hours, those working hours simply blurred without limit, and we just gave up on this. [T10]*

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One way in which a social care provider can facilitate the introduction of various technologies into care is to select and work with specific technologies from a single, known manufacturer. Products from a single manufacturer tend to have similar operating principles, and it is possible that several devices are designed to work together. Such knowledge is, however, available to service providers who already have experience in the sector.

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*And there are certainly several such manufacturers. Well, we're currently working with one, because each of them has, to a certain extent, their own signals and peculiarities, and their programming characteristics are specific... That's why we try not to diversify our practice too much, as it's easier for us to work where we know what we're doing. Because each of those devices, whether at a client's home or in a care home, is programmable [T10]*

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## **Funding**

For social service providers who use various assistive technologies and ICT in their work, more long-term, regular payment for services is also essential. In the Latvian system, first and foremost, the costs are covered by the client; however, if this is not possible, local authority support is involved.

With regard to assistive technologies in social care, it must be borne in mind that there is a high probability that assistive technologies will not be used for long, as the client will pass away. In such cases, provision must be made for the social service provider to buy back the equipment, maintain it, and then sell it to the next client.

However, opinions among the experts interviewed differ regarding the

assessment of whether a client requires financial support. The current criteria for the maximum income level to receive state or local authority-funded social services fail to identify those for whom the service would be urgently needed, even though the declared household income exceeds the income threshold. During the interviews, it was suggested that medical indications should be considered alongside social ones in the assessment.

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*But there is a very large proportion of people who do not fall into this category of the very low-income, but who are healthy... Well, either too many people are registered at their address, or they live with other people, and their income exceeds those 780 or 740 euros, yes. But at the same time, they don't really have the means to purchase such device. And so we would very much like to see this state support. Precisely so that it is at the national level, rather than us having to go to every local authority... [T2]*

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As recipients of social services are often low-income, in order for social service providers to be profitable as businesses, a system must be created in which these businesses can survive. Seeking and requesting financial resources from the local authority requires a lot of effort, which does not always pay off.

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*Allow us to become more attractive to investors. So that we don't have to go round to everyone all the time, asking for money. Give us money for this, give us money for that, because we can't do this or that. Our audience, largely people who need these assistive devices, well, they aren't exactly high earners. And a large proportion of them live on benefits, and they aren't exactly solvent. So we have to come up with various ways to become profitable, to become independent of the state, of the state's handouts. (Laughs.) [T2]*

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### **Ethics and data security**

In cases where a TA, such as an SOS button, is linked to a social care service, particularly home care, a great deal of specific information is gathered about the client's needs, capabilities, lifestyle and place of residence, thereby personalising the service.

Without understanding how the assistive device works, a person receiving social

care feels distrust and fear regarding potential, unauthorised surveillance. As the volume of digital assistive technologies increases, it is necessary to develop a transparent data security policy.

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*There's a little red light on that device that shows it's switched on. He thinks that light is some sort of surveillance camera and that someone is watching them all the time. We eventually reassure him, telling him that everything is fine and that the camera isn't watching them and that there aren't any cameras there at all. Because those surveillance elements, well, they make people anxious. Let's say, well, they sort of get used to the idea that they can call for help and so on, but if there were a camera standing there watching them all the time, well, in a bathroom or a bedroom, that might not be great. [T10]*

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Just because it is technically possible to collect a lot of different data does not mean that it should be done. The choice is made in favour of a technically simpler technical aid, given that there is then less to worry about regarding what data is being collected, where it is stored, how clients feel about it, and how much it costs. Similarly, healthcare professionals are informed about patient data through direct communication rather than by sharing data via a server.

Although EU regulations on data and assistive technology security exist, not everyone planning to purchase assistive technology is aware of or familiar with such regulations. Nevertheless, it is possible to purchase high-quality assistive technologies that are not manufactured for the EU market. This can cause problems when using electronic assistive technologies if the device uses a communication frequency allocated in the EU to other specific devices, such as remote controls.

## **People with functional impairments**

### **Experience with public services**

Overall, the experts interviewed, who use AT themselves, consider that the current provision of public services in the field of AT appears adequate. One of the study participants says that she is not fussy and takes what is on offer. Another says that initially the application process seemed confusing, so a manual wheelchair was hired from a private company. It later transpired that the application process did not require much effort from the woman interviewed, as the application was prepared by

an occupational therapist. She doubts whether it is even important for her to understand the application process. Another points out that the €7 fee for an assistive device is satisfactorily low. Another points out that although the voucher system is currently available, whereby a person can choose the most suitable assistive device for themselves by receiving money equivalent to the value of the assistive devices purchased by the provider, it is nevertheless suggested that the situation would be better if there were no intermediary who also receives a share of the money.

Other views on the procedure for receiving state-provided assistive devices are linked to a sense of injustice. For example, the fact that a woman with hearing loss cannot receive a tablet intended for communication because she does not wish to learn sign language.

It was also mentioned that the range of assistive devices available is outdated. The need to expand the range of assistive devices is also highlighted in the State Audit Office's report.

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*There are the usual old-fashioned radios, some sort of phones. Not old phones, just ordinary phones and all that sort of thing, which are really meant for people, well, of retirement age, for whom tactile features are important, but now they're not just tactile anymore. Now there are even smartphones, which, I imagine, are quite tactile – well, I can press all the buttons, but they've got Bluetooth too. [T11]*

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### Individual needs

The choice of one of the available TAs involves various considerations. One is the extent of a person's functional impairment, for example, whether and what kind of support is needed for their back and head. Another is suitability for the living conditions of the person and their carers, for example, the fact that the wheelchair must fit and be as easy as possible to stow in the boot of the family car, and it must also be easy to use when accessing public transport.

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*Well, one of the biggest things that was important to me and my whole family, my carers, is that it [the electric wheelchair] is lightweight. I have a specially lightweight electric wheelchair that weighs 21 kg. And we needed it because we don't have... well, we have a standard car. And when I get into the car, they transfer me into the car itself, usually into the seat. And the*

*wheelchair – that’s why we needed the lightweight one – so we can fold it up and put it in the boot. [...] And then after that, it was more about which one is more comfortable to sit in, which is perhaps easier to manoeuvre. [...] And then it was, well, more a question of which one we simply prefer. [T3]*

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Although the examples mentioned above illustrate how TA and related services can be individually adapted, the expert interviews repeatedly highlighted observations that, in the context of providing TA, there is a lack of understanding of each individual’s functional impairments, their origins, and their daily financial, social and physical capabilities and needs. Undifferentiated services treat the needs of all people with functional impairments as uniform.

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*Prosthetists themselves say that 80% of their prostheses are left hanging in a cupboard, unused. At the moment, no one fully assesses us. A person is missing a leg and is prescribed a prosthesis. Why don’t they have that leg? One reason is trauma, and the prosthesis will effectively be what, as they say, gets the person back on their feet, and they will be free of disability with that prosthesis. The other group consists of people with some form of vascular disease or diabetes, where there are capillary disorders or vascular disorders; this means they won’t be able to wear the prosthesis properly, that is an objective fact; their condition prevents them from doing so if their leg has been amputated due to vascular problems. And yet we still give them an expensive prosthesis. They might put it on perhaps three times a year at best. It’s difficult, painful, ends up with various sores, and so on. So we don’t really assess a person as a whole, but simply – if you don’t have a leg, then take a prosthesis. If you can’t walk, then take some sort of wheelchair. [T6]*

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TA and related services must take into account a person’s membership of specific communities, such as the deaf community with its own language and culture. At the same time, we must recognise that these communities are not homogeneous either, and that opinions and needs differ. Moreover, for example, not everyone who is hard of hearing or deaf is part of the Deaf cultural community.

It is possible that belonging to an ethnic minority or the LGBTQ+ community influences what is considered an appropriate service, TA, communication, etc. Further research is needed on this.

There is a lack of easily accessible assistive technologies suitable for people with complex or severe disabilities. It is already a burden that one must apply for TA at multiple institutions and organisations, as the spheres of influence within the state provision system are compartmentalised. In addition, there is a lack of technologies that can simultaneously compensate for, maintain or improve various limited human capabilities. One example cited was the use of virtual reality in the development of assistive technologies suitable for complex needs.

Given the variety of individual needs, a sense of confusion was sometimes evident in the expert interviews regarding what exactly is planned to be standardised within the TechSocialcare project.

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*No, I'm thinking about that project, about the fact that the aim is to standardise all of that. I [...] find it quite difficult to imagine what exactly we could standardise there. [...] Well, yes, I'd rather say that we should introduce some specific criteria for the provision of assistive devices, well, for determining needs that are the same across the whole country, so that it doesn't just rely on the specific expertise of a particular specialist. [T1]*

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Doubts were also raised as to whether policy-making in the field of social services would improve the accessibility of services and the service allocation process.

### **Trialling, suitability**

Not everyone is suited to the technical aids provided by NRC “Vaivari”, LAB and LAD. Specific accessories are not available at all. Often, one has to search for and purchase them online. Although a wide range of assistive devices is available, it is not possible to try them out before purchase. As one of the experts points out, buying online does not allow you to try out the device in practice and get a feel for it. Specific design nuances can render a product unusable.

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*When buying even a very simple item online, you don't know what you're buying or whether you'll be able to use it – it's not certain, because you don't know how much force is required, whether you'll have that strength, or whether your arm will be able to lift it. There are special devices that help the arm move so a person can eat; a special one that attaches to a wheelchair, but you can't do it yourself – it has to be measured: how heavy it needs to be*

*for you, what the counterweight should be, how big the spring should be, whether you need to apply force yourself, or whether it moves you completely.*  
[T6]

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That is why it would be very useful to be able to try out various TAs in a showroom before purchasing them. This would, of course, also be very useful in relation to trying out state-provided wheelchairs, as well as learning new skills regarding the use of various devices.

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*At present, we do not provide a person with an electric wheelchair on the grounds that they do not know how to use it. But they do not know how to use it because they have nowhere to go and nothing to use it with; they cannot learn when they have never tried.* [T6]

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In situations where the NRC “Vaivari” assessment identifies a lack of ability to use a TA, training is provided. Despite this, there is a lack of continuity of service between the NRC “Vaivari” and healthcare institutions. Further work on using the assistive device must be organised by the patient themselves, by finding a specialist capable of providing training. It should also be noted that this specialist service may not be covered by the state.

Several study participants indicated that a calmer, longer or repeat consultation is needed regarding the newly acquired TA. It is difficult to concentrate for long periods during the consultation whilst trying to memorise new technical information. The consultation usually explains the basic functions of the assistive device, but it would also be useful to have time to familiarise oneself with more specific functions that would facilitate the maintenance or, for example, transport of the assistive device.

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*That tip fell off quite quickly, and no one had even explained what I should do or where to go when that tip, the end of the stick, falls off. [...] To put it simply, they just handed it to me already assembled, and then I set off with it. They didn't tell me how to remove it myself, for example, that you have to be quite careful so that it doesn't, say, slip out and so on... I suppose that, in this case, it might just be a matter of receiving the goods. I don't know, maybe it's*

*a problem in Latvia too, that they just hand it over, like – well, right, bye, thanks, now sort it out yourself. [T11]*

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The expert interviewed also uses TA himself. He points out that there was an opportunity to attend courses to help understand how to use TA, but the courses were not suited to his level of functionality. More specifically, he lost his sight gradually, not all at once, but he felt that the courses were designed for people with poorer eyesight. In some of the expert interviews, older people are singled out as a group that tends to have problems with the use, adaptation and repair of assistive technology. It is said that the simpler the technology and the principles of its use, the better. Additional training in the use of assistive technology is certainly necessary for older people whose functional impairments have begun in old age.

*Well, take my mother, for example. She had very good hearing all her life, but after turning seventy her hearing began to deteriorate. Very rapidly in recent years. At the moment she has [...] hearing aids in both ears. [...] Of course, there are also apps and all sorts of things you can do with them, but she can't use them because she's not tech-savvy [...] It's not that she's completely incapable of learning anything. He can, he just needs to be taught more, for longer, in simpler language. [T8]*

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When it comes to social care for older people, we must also consider those whose cognitive abilities are declining, for example due to dementia. Technologies must be easy to use (for example, with just a single button to press), safe and difficult to compromise.

### **Feedback**

At present, the Latvian system faces a problem regarding the continuity of services related to the use of assistive devices. Although assistive devices can be prescribed electronically by various specialists, there is a lack of feedback regarding the suitability of these devices for the patient's daily capabilities, needs, and knowledge and skills in using them. Based on what the experts have said, in order to achieve the goals of the individual rehabilitation plan and to ensure continuity and improvement of services, feedback must be actively sought by engaging with the specific patient or client. Providing feedback should not rely on the enthusiasm of the patient or client; it must be a convenient process, yet meaningful at the same time.

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*Rather, for such higher-level [assistive] technologies, where patients [...] are called up after six months and asked whether they are using it, if there are any problems, and if everything is clear to them [...] They then come to the physiotherapist after six months and say, 'But I'm not actually using it, because something's bothering me there.' And the specialist has told them [...] that if there are any problems, just give us a call and we'll sort it all out. [...]. But there are also patients who don't want to themselves and feel that they are a burden and a hindrance to everyone [...]. And from those patient organisations, I think you're unlikely to get much objective information, particularly about how things are at the moment. Because, well, usually those in patient organisations are extremely active, and they usually report on everything that works and what doesn't. I think it's more likely to be a sample of those who actually use these technologies. There are also technologies that need to be changed from time to time. And I suppose there are databases showing which patient has received which assistive technology. And it's possible to filter by that. I don't know if he hasn't changed it in five years. [T1]*

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Obtaining feedback should rather be the responsibility of the specialist who has prescribed the TA, given that the specialist is the one who develops the health or social care plan for both the specific patient and others with similar functional impairments. For example, NRC "Vaivari" has recently started conducting patient surveys, asking for feedback. It is important that this information also reaches the specialist who determined the need for the TA.

### **Information on services**

It is necessary to inform the public about the range of social care services and assistive technologies available in Latvia. As one of the interviewed experts points out: "To want something, you need to know that it exists" [T6]. Smaller service providers would greatly benefit from support from government agencies in disseminating information. On the other hand, for assistive technology users, peer groups on social media are very important for the exchange of practical information, where they can share details about available assistive devices, their upkeep and maintenance.

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*Let's not even get into finer details; often, for instance, it might not even be available, but it's worth mentioning that such things exist in the world, and*

*you could even buy one yourself. Take, for example, book page-turners, if a person can't turn the pages themselves. Or, let's say, there are some... I don't know if anyone can properly adapt a wheelchair to be breath-operated in Latvia at the moment, or a tongue-operated joystick, or a joystick operated by the big toe, or if anyone in Latvia knows how to adapt them, or if people even know that such things exist, that it's possible. [T6]*

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## Repairs

NRC "Vaivari" provides repairs for those TAs that are from public procurement, those that have been issued on loan. However, assistive devices that can be purchased with a co-payment in Latvia or within the European Union are not repaired, given the wide range and specificity of assistive devices, which might require knowledge, skills and tools that VADC staff do not possess.

Repair options for assistive devices are also limited due to the assistive technologies available to people with hearing impairments. The warranty period for electronic assistive devices is short. As devices are often used long after the warranty period has expired, sooner or later something breaks and repairs are needed. If the device was not purchased from one of the TA provision centres, repair options are very limited. Leaving aside the costs altogether, this is also important because, assuming that, for example, a hearing aid could be such a personal part of daily life, as well as tailored to specific needs, it is understandable that a person would want to repair a device they are familiar with, rather than buy a new one.

On the other hand, even if repairs are possible in Latvia, getting to the repair shop independently is very difficult, given the lack of a functioning public transport system, which until now may have made it easier for the person to get around in public spaces.

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*She goes out, she can manage on her own, but [...] without her hearing aid, she is completely helpless. This means that someone – either me or one of the grandchildren – has to go with her, and the whole process of replacing or repairing the hearing aid has to be supervised as well, to make sure everything goes smoothly. Well, the people there are used to communicating with the hard of hearing, and they're very kind, really. But, well, for safety's sake. Yes. And if people live outside Riga, in the countryside, it can be an impossible mission altogether. [T8]*

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In the event that repairs to a mobility aid can only be carried out in another EU Member State, the repairs may take longer, which makes daily life very difficult, especially if there is no way to replace the mobility aid.

The expert points out that there is also no emergency assistance service to help in a situation where an assistive device has broken down. Transport services would be useful, for example, in situations where an electric wheelchair breaks down on the street.

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*We spoke to this rescue service at some point; the fact is that there is one huge problem for the police and rescue services: electric wheelchairs that have broken down or run out of battery power on the streets or elsewhere during the night. And not just at night. The person is in a bind because they can't push the wheelchair themselves, nor can they push it very far. The wheelchair is stuck, the person is sitting there, they can't get home, and basically there's no one to call. Ambulances won't take them; they won't load the prams in; the rescue services simply have nowhere to put them, and the police are the same. It's a massive problem. [T6]*

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## Disposal

Although this was mentioned by only one of the experts interviewed, the comment echoes the criticism in the State Audit Office report regarding the lack of a proper procedure for the disposal of wheelchairs. This is also significant symbolically, given the importance of TA in everyday life and the information it conveys to those around us about the TA owner. There is a sense that TA should also be disposed of in a clearer, more orderly, perhaps even respectful manner.

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*The life of these items. Is it thrown in the bin, or what happens to it afterwards? Can it be returned? No one has ever told me, for example, that a walking stick must be disposed of in a specific way. It's actually a good idea, because, for example, you can throw a walking stick in the bin, and someone else might pick it up. In that sense, to pretend, for example, and then end up... Because, if you think about it, this is a good thing. Theoretically, you should return it. Just like passports, don't you think? You can't just take a passport, then throw it in the bin or leave it somewhere. [...] In this case, this is practically the only instance of a visual impairment being shown to the world,*

*so it shouldn't just be thrown away. Should it? That's what I think, actually. [T11]*

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### **Accessibility of mass-market technology**

As illustrated in the example mentioned in the introduction regarding the everyday use of TA and other assistive technologies, people with functional impairments also actively use mass-market technologies, such as smartphones and various apps that perform assistive technology functions. The development and availability of artificial intelligence on smartphones could also facilitate, for example, determining the contents of a cup. Attention must also be paid to issues of accessibility for these technologies, with a particular focus on the need for software in the Latvian language.

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*Incidentally, when it comes to assistive features for the blind, such as on iPhones, the Lithuanians are ahead. They now have VoiceOver in Lithuanian, whereas Latvians do not yet have a feature on iPhones where the phone reads out what is on the screen. It isn't in Latvian. That's why in Latvia, most people still prefer to use Android phones. Because even in the US, most blind people, when I started losing my sight, also recommended buying an iPhone. But for them, the Latvian language issue simply doesn't exist. Although I use my phone in English as well. [T11]*

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Expert interviews also highlighted the need to involve potential assistive technology users, primarily people with long-term functional impairments, in product development, particularly during the testing phase before the product reaches the market. Unfortunately, in the experience of both the researchers interviewed and the TA user, such testing rarely takes place in Latvia.

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*Even now, for instance, when programming websites, for example, at [ICT company], for instance. We had a situation where they came and watched how a person who can't see actually uses a screen reader, and then they said, 'Oh, no, well, we made it the way we thought it should be. It's like, they hadn't even tried to see what it's like to use it, I don't know, just with a keyboard or whatever, how it actually is in reality. [T11]*

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The standardisation of TA provision must be linked to environmental accessibility standards. Wheelchairs provided by local authorities are too large for standard-sized doors. The public procurement process does not take into account the importance of wheelchair size when moving around in private and public spaces. It is necessary to understand the purposes for which wheelchairs are purchased, the possibilities for their use in private and public environments, and how to organise and regulate their use.

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*To be honest, when it comes to standards and regulations for wheelchairs, we still have a lot of internal thinking to do ourselves about these dimensions, because no environmental standards currently exist for large wheelchairs, which are now those huge ones [...] purchased by the local authority. You can't get into the toilet with them, you can't go anywhere with that wheelchair, so the question is, in many countries they aren't designed for indoor use, they're only designed for outdoor use. If you want to go for a walk, you use one of those, but if you're going to the shop, you use a smaller wheelchair. Can I accept something like that in Latvia? Because, let's say, at the moment those big scooters, when they get on public transport, they block the whole vehicle, everything. Is it normal that we drive a car in a car? Well, you have to accept that, say, in China you're not allowed to ride an electric wheelchair on the pavement at all, only on the road, and you need special permission to ride a wheelchair on the road; you can't just ride it. So where is the place where a wheelchair should go – on the pavement, where the bicycles ride? [T6]*

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### 3. PLANS

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Taking into account various assessments of the TA provision system, the ministries' plans also include proposals to improve the allocation of TAs. For example, the Ministry of Welfare plans several changes to the TA allocation system<sup>69</sup>. A new process will be introduced for industrially manufactured TAs not included in the state-funded list, providing for partial reimbursement of costs. There are also plans to simplify the co-payment system, reducing bureaucracy and allowing other persons to cover the costs on behalf of the patient. For some medical devices, a doctor's referral will no longer be required, whilst for others, the waiting time for a replacement will be reduced. The range of state-funded aids will be expanded to include a bi-level positive airway pressure therapy device, which helps people with breathing difficulties and will be available for hire. It is also planned to increase the reimbursement for adapted car seats to 3,000 euros. The changes are included in amendments to Cabinet regulations, which have been submitted for public consultation.

Some of the planning documents mention TA directly, whilst other plans focus more on improvements to physical and data infrastructure, which would undoubtedly also affect access to TA. To better understand the government's vision for policy improvements relating to TA, it is necessary to review planning documents across various sectors. The analysis includes planning documents for the period 2021–2027, so some of the tasks have already been initiated, if not completed. The main planning documents relating to the TA provision system are the Plan for the Promotion of Equal Opportunities for Persons with Disabilities 2024–2027 and the Digital Transformation Guidelines 2021–2027.

**Latvia's National Development Plan 2021–2027 (NAP2027)** places significant emphasis on equal opportunities and social inclusion<sup>70</sup>. NAP2027 emphasises the need to improve access to social and health services, including the provision of modern rehabilitation and support solutions. In this area investments are planned to expand access to TA for mobility, self-care, communication and the restoration of functional abilities.

One of the six priorities most directly related to the availability and use of TA is the priority 'Strong families, healthy and active people'. This priority comprises four

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<sup>69</sup> <https://www.lm.gov.lv/lv/jaunums/labklajibas-ministrija-rosina-pilnveidot-tehnisko-paliglidzeklu-pieskirsanu>

<sup>70</sup> <https://likumi.lv/wwwraksti/LIKUMI/NAP/NAP2027.PDF>

action areas: 1) person-centred healthcare, 2) psychological and emotional well-being, 3) strong families across generations, 4) social inclusion.

Overall, with regard to the TA allocation procedure, the strategic objectives, principles and action areas of NAP2027 can be described as focused on:

- human capital development and equal opportunities – the need to ensure equal opportunities for all residents, including persons with disabilities and functional impairments, is emphasised;
- social inclusion – it is emphasised that, to reduce social exclusion, it is essential to provide accessible social services and a support system for people with functional impairments;
- strengthening healthcare and rehabilitation – plans to strengthen the healthcare and rehabilitation system to ensure that people can maintain or restore their functional abilities;
- an inclusive labour market – it is emphasised that the integration of people with disabilities into the labour market is an important aspect of social and economic development;
- innovation and technological development – the importance of technology and innovation in societal development is also highlighted. This also applies to the development and use of assistive technologies, which may include digital or technological solutions for mobility, communication or self-care;
- a sustainable social care system – it is emphasised that an effective social care system helps to ensure people’s independence and reduce the need for long-term care.

As this is the key document setting out Latvia’s policy direction, these principles, courses of action and objectives are incorporated into specific sectoral policy planning documents, which are described below.

**The objective of the Plan for the Promotion of Equal Opportunities for Persons with Disabilities 2024–2027<sup>71</sup>** is closely linked to the UN Convention on the Rights of Persons with Disabilities (hereinafter – the UN Convention), which Latvia has ratified. The Plan adheres to the principles of the UN Convention across five areas of action: 1. Improving the disability assessment system, 2. Improving support services to mitigate the consequences of disability at an inter-sectoral level, 3. Promoting inclusive employment, 4. Promoting accessibility of the environment, information and services, 5. Raising public awareness.

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<sup>71</sup> <https://likumi.lv/ta/id/352154-plans-personu-ar-invaliditati-vienlidzigu-iespeju-veicinasanai-20242027-gadam>

Although assistive devices are mentioned a few times in the plan, many of the measures included are indirectly linked to the availability and provision of assistive technology.

**1. Improving the disability assessment system.** The objective is “to ensure a comprehensive set of measures to bring the disability assessment system into line with international best practice standards, establishing harmonised principles for the assessment of disability in children and adults, and harmonising the transition from child to adult disability status”. This direction includes, for example (see Annex 4 for detailed information):

1.5. raising public awareness of the support available in the event of disability,

1.6. facilitating the reuse of functional assessments across different public authorities for the provision (allocation) of services.

These measures directly correspond to the findings in the SAO report and the expert interviews conducted as part of the TechSocial Care project regarding the need to raise awareness among people with functional impairments about their rights and opportunities to receive various social services related to TA, as well as the reuse of functional assessments, for example, when receiving TA.

Other measures are not so directly applicable, for example:

1.7. promoting mutual cooperation and understanding with family doctors (general practitioners), treating doctors, as well as local authority social services staff on matters relating to the determination of disability,

1.9. facilitating the recruitment of specialists to carry out disability assessments.

Although functional impairments are not the same as disability, nevertheless, as with the understanding of disability assessment and the recruitment of specialists to carry out assessments, the need to develop uniform assessment principles was also highlighted in the State Audit Office report and in expert interviews in relation to the preparation of opinions on the necessity of TA.

**2. Improving support services to mitigate the consequences of disability at an interdisciplinary level.** The task is to “improve and develop support services to mitigate the consequences of disability and promote the inclusion of persons with disabilities in society.” This priority includes, for example (here and below – for detailed information on the priorities and measures mentioned in the report, see Annex 4):

2.7. Ensure a more targeted allocation of TA in accordance with the individual's needs,

2.12. Promote the availability and accessibility of healthcare services for people with functional impairments,

2.17. Ensure the availability of assistive technologies for learners to access educational content.

These measures most directly correspond to the views expressed by experts in interviews regarding necessary improvements in the provision of TA. Sub-point 2.7 highlights the repeatedly expressed need to recognise and ensure that TA is appropriate to the specific nature of a person's functional impairment, as well as their living conditions. Meanwhile, Sub-point 2.17 also mentions assistive technologies as part of the wider social and healthcare sector, as technologies that are universally accessible, technologies that include people with functional impairments in education and, hopefully, in other civic and cultural activities as well. Referring to the aforementioned case in which a hearing-impaired student was not entitled to receive a tablet for communication needs related to the educational process because she did not wish to learn sign language, the wishes of people with functional impairments must also be taken into account in relation to the provision of TA. Overly specific objectives for the use of TA may exclude from receiving the service people who genuinely need it.

The measure referred to in sub-point 2.12 may relate both to a common understanding of the principles for issuing TAs (including the justification and the information to be included in the assessment), as well as to the importance of feedback in the issuance of TAs.

Other measures are not so directly applicable, for example:

2.16. Promote the participation of young people with disabilities in vocational education,

2.6. Ensure targeted support for persons with very severe disabilities in accordance with the individual's actual care needs,

2.10. Introduce for the child with functional disabilities in determining the need for social services,

These measures also relate to environmental accessibility, which, as noted in the expert interview, is also linked to TA standards. It is necessary to align TA requirements with the principles and regulations on environmental accessibility in Latvia (more on this in Action Area 4: "Promoting Accessibility of the Environment, Information and Services").

**3. Promoting inclusive employment.** The tasks are: "to improve individualised support for job-seeking people with disabilities, to motivate employers to hire people

with disabilities, to educate the public and to reduce stereotypes about people with disabilities in the labour market.”

What was not mentioned in the SAO report, nor in the expert interviews, is the availability of assistive technology in the workplace. Although this aspect is not the main objective of the TechSocial Care project, it is nevertheless important to note that employment and support from the employer are significant aspects of the social integration of people with functional impairments. On 6 March 2025, amendments to the Law on Personal Income Tax came into force, stipulating that the following are exempt from personal income tax (and are also exempt from compulsory state social insurance contributions) financial assistance from the employer for the purchase of medical technology<sup>72</sup>. This applies both to medical technology required by the employee themselves and to that required by the employee's family members.

**4. Promoting accessibility of the environment, information and services.** The objectives are: “to promote accessibility of the environment, information and services, including by raising public awareness of the importance of environmental and service accessibility for building an inclusive society”. This area includes, for example:

4.12. Disseminating examples of good practice on the benefits to organisations of ensuring the accessibility of websites and mobile applications,

4.13. Involve representatives of NGOs in website testing, both during the development stage and in the working environment.

4.15. Monitor the accessibility of content in electronic media programmes and services

Measures under this action line include those addressing the accessibility of goods and services, including the accessibility of electronic devices and digital platforms. Although these are consumer goods and services, they also perform assistive technology functions; for example, adding subtitles to any type of broadcast turns televisions, smartphones and computers into assistive technologies and promotes the accessibility of information. Although this is not part of the measures under this action line, it is nevertheless necessary to point out that the addition of Latvian subtitles during video calls on a platform such as MS Teams also makes service provision and the professional environment more accessible, promoting the independence and self-determination of people with hearing impairments or deafness.

Sub-point 4.13 concerns the involvement of NGOs in website testing. This

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<sup>72</sup> <https://www.vid.gov.lv/lv/media/29438/download?attachment>

measure needs to be expanded to include NGOs in the testing of apps, software and devices relevant to people with functional impairments. As the expert pointed out, involving users in testing is also important, for example, when introducing new technologies in a rehabilitation department, to promote a better understanding of the capabilities of the relevant technologies, as well as whether and how the device can be adapted to the needs of patients and specialists. Similarly, user testing should become part of the procurement requirements for assistive technology manufacturers and distributors.

In connection with this course of action, it would also be desirable to take into account assistive technology that should be available in public spaces and is for communal use, for example, hearing loops, which can make various types of services, cultural life and the professional environment more accessible to people who require hearing aids.

Other measures are not so directly applicable, for example:

4.2. Promote the strengthening of accessibility requirements in the construction process

4.4. Promote the accessibility of goods and services (relevant to the scope of the Accessibility Directive),

4.6. Promote the accessibility of housing in accordance with uniform conditions and criteria across all local authorities,

4.7. Increase the accessibility of public services and public buildings in the welfare sector intended for the public,

4.16. Promote high-quality access to electronic media services for persons with disabilities,

4.17. Increase public for welfare public public services and public buildings intended for the public.

Some (4.2., 4.6., 4.7., 4.17.) of the aforementioned measures affect the provision and standardisation of TA to such an extent that they resonate with the need, mentioned in expert interviews, to align TA procurement requirements with accessibility requirements for public buildings and other public spaces. Although this course of action is not specifically related to TA, it nevertheless influences the physical conditions under which TA can be used.

These measures indicate that state and local government institutions must ensure that their own physical and digital spaces are accessible, and must also ensure that the procurement of mobility aids under their responsibility takes into account the environmental conditions in which the people for whom the mobility aids are

intended live and move (for example, procurement takes into account that the size of a wheelchair, to allow movement within a person's home, must be such that it can pass through a doorway).

**The Digital Transformation Guidelines for 2021–2027<sup>73</sup>** set out Latvia's digital development policy up to 2027. Its aim is to build a society where the economy, public administration and services are based on digital technologies and the use of data. Digitalisation is regarded as a cross-cutting development trend that affects all sectors – education, business, transport, health and social services, etc. As the authors of the guidelines note: “Integrating digitalisation into sectoral policies will be both a challenge in all the aforementioned areas and a key driver of their development”.

The guidelines identify five areas for development: 1. Digital skills and education, 2. Digital security and trust, 3. Accessibility of telecommunications services, 4. Digital transformation of the economy (including public administration), 5. Development and commercialisation of ICT innovations, industry and science.

**Development area 1, ‘Digital skills and education’**, includes action lines that aim to develop the high-level digital skills required for the creation and commercialisation of innovation, as well as to develop digital services and systems, strengthening cooperation between public administration, the private sector and society. Significant attention is paid to the digitalisation of public administration and the provision of high-quality e-services. At the same time, there are plans to encourage public involvement in the creation of new digital solutions.

**The action area “Digital Skills in the Health Sector”** aims to develop the digital skills of healthcare professionals specifically, in order to improve the quality and accessibility of services. There are plans to develop educational programmes and study courses that help learn about digital solutions in treatment, prevention and patient care. The integration of digital technologies into clinical practice and the study process is of great importance. It is also planned to encourage the involvement of healthcare professionals in the development and improvement of digital solutions.

**Development Area 2, “Digital Security and Trust”**, focuses on creating a digital environment that promotes the continuity of public functions, as well as cooperation between public administration and the private sector in the field of digital security. This includes information systems, e-identity solutions, consumer protection and public education on security in the digital environment. From a TA perspective, the development of secure e-identification and authentication tools is particularly

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<sup>73</sup> <https://likumi.lv/ta/id/324715-par-digitalas-transformacijas-pamatnostadnem-20212027-gadam>

significant, as these enable users to access e-services securely. The use of secure digital technologies (such as data encryption and biometric solutions) is also being promoted, which improves the use and reliability of assistive technologies.

The **'Digital Security Policy' action line** addresses cybersecurity challenges in each sector and the integration of cybersecurity measures into sectoral planning documents. It also refers to the integration of cybersecurity measures in relevant legislation, as well as in the planned Digital Technology Governance Act. This applies to TAs in relation to both the development of assistive technologies and service provision infrastructures. Given that an increasing number of TAs will be able to record and transmit data, both existing and potential cybersecurity requirements must certainly be taken into account.

**Development Area 3, "Accessibility of Telecommunications Services"**, aims to ensure fast, high-quality and equally accessible internet connectivity throughout Latvia by developing both mid-range and last-mile infrastructure, as well as 5G coverage.

This improves, for example, the functioning of digital devices, remote healthcare solutions and smart devices, as it ensures stable and fast data transmission. Expanding broadband access in schools, healthcare facilities and households promotes the effective use of these technologies in everyday life. These improvements to communication networks could increase opportunities in Latvia to trial and implement TA, which requires more stable data transmission.

**Development Area 4, "Digital Transformation of the Economy"**, envisages the widespread introduction of digital technologies in both public administration and the private sector, strengthening their mutual integration. Particular emphasis is placed on an approach where the state's digital platforms become the foundation for the development of new services. These platforms are opened up to businesses, allowing them to use public data and functionality to create new products.

Artificial intelligence and ICT shared services play a key role in the transformation, enabling the automation of processes, the creation of personalised services and the analysis of complex data patterns. At the same time, emphasis is placed on citizens' control over their own data and the ability to use it securely across various services. Digital transformation involves a shift from document-based to data-driven processes.

An important principle is the 'once-only' approach, which means that data is submitted only once and then reused. The availability of services in the digital environment and multi-channel access, including through one-stop shops, is also

ensured. Data re-use and interoperability between systems are also promoted.

**The ‘Service Platforms’ action area** includes measures aimed at creating open, shared and interoperable national digital platforms that can be used by both the public and private sectors. These ensure the secure circulation of data, unified access to services, and promote the development of new digital solutions and commercial services. Standardised interfaces (APIs), data management principles and oversight mechanisms that guarantee security and reliability are of key importance. The action line comprises 2 measures:

4.4.1.-1 Develop policies, regulatory frameworks and oversight mechanisms for opening up public service platforms to businesses

4.4.1.-2 Ensure the opening of priority public service platforms to businesses, and provide support mechanisms for public authorities and businesses using priority service platforms.

In relation to the provision of TA, this facilitates easier access to public and private sector services by reducing the amount of information that needs to be resubmitted for the purposes of various service providers.

**The action line “Data management, opening and analysis”** provides that data in Latvia is regarded as a strategically valuable resource used in decision-making, automation and innovation. A unified data management framework is being developed with clear principles, regulatory framework and responsible institutions, ensuring data quality, interoperability and widespread use. There are plans to develop a national data management platform that will provide a unified data space and enable effective data exchange between public authorities, the private sector and at the international level.

In relation to TA, this promotes the availability of information to potential developers of social and health services linked to TA provision. As noted by an expert interviewed as part of the TechSocial Care project, the NGO she represents lacks information on the number and specific characteristics of people with functional impairments in Latvia. If there were access to more accurate data, the NGO could better understand the needs of people who fall within the NGO’s target group but are not currently in its sights.

**The action area “Public Health and Social Welfare”** aims to establish a digitally integrated health and social welfare system where data is used to provide proactive and high-quality services. Health and social care is being digitised, integrated and made available to service providers, whilst ensuring the protection of personal data. A model for the electronic patient health record (EPHR) is being developed as a central

data storage and management solution. Data analysis and business intelligence tools enable the timely identification of risks and improved service planning. A unified data exchange is being established between state, local government and private sector systems, ensuring effective cooperation. There are plans to create an e-care platform for organising social services and improving their quality. Modern digital solutions, including telemedicine and artificial intelligence, are being introduced in healthcare. The integration of health and social data is being promoted to ensure the 'once-only principle' and more efficient service delivery. Significant attention is being paid to developing staff digital skills and educating the public.

4.4.6.-1 Improve the legal framework for the sharing and secondary use of health data, and establish interoperable standards for the collection and circulation of health information.

4.4.6.-2 Ensure the availability of health and welfare sector data for sharing, including by ensuring the electronic circulation of information necessary for the provision of social services and healthcare services to citizens on a single platform.

4.4.6.-3 Ensure the full functionality of the Electronic Health Record (EHR) and the appropriate quality of patient disease registers to ensure a comprehensive treatment process and the implementation of health policy.

4.4.6.-4 Promote the introduction of modern, patient-centred digital solutions, including telemedicine solutions, in healthcare.

4.4.6.-5 Ensure Latvia's integration into the European Health Data Space.

4.4.6.-6 Ensure the collection and analysis of data on social services and social assistance, as well as on the social support provided to individuals, within the e-care platform.

The objective of the **Social Protection and Labour Market Policy Guidelines for 2021–2027**<sup>74</sup> is to reduce income inequality, develop a social services system tailored to people's needs, as well as promoting high levels of employment in a high-quality working environment. The plan is structured around five key areas of action: 1. Sustainable, stable and adequate financial support that ensures sufficient economic independence; 2. A modern and accessible social services system that, among other things, improves people's ability to live independently and participate in society, as well as to integrate into education and the labour market; 3. An inclusive labour market for all and quality jobs, supporting long-term participation in the labour

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<sup>74</sup> <https://likumi.lv/ta/id/325828-par-socialas-aizsardzibas-un-darba-tirgus-politikas-pamatnostadnem-2021-2027-gadam>

market, 4. A well-developed state-provided legal aid system, expanding access to the justice system for the most vulnerable, 5. Strengthening the governance of social protection and labour market policies.

By 2027, it is planned to improve the TA system by increasing accessibility and reducing waiting lists. It is envisaged to develop a more flexible allocation model, in which individuals will have greater choice regarding the most suitable TA for them. There are also plans to digitise administrative processes and improve data systems, including data exchange between institutions, to make the service more efficient. Plans include improving medical assessments, developing guidelines for doctors on assessing the need for TA, and utilising functional assessment data across multiple services. TA is also viewed in the context of the labour market as a tool for maintaining work capacity and social inclusion.

One of the objectives is to reduce waiting lists for TA and increase the volume of TA allocated. The performance indicator set for TA provision stipulates that by 2027, the number of people receiving TA is planned to be increased to 75% of the number of applicants.

The measures most directly related to the provision of TA are as follows:

2. Action Area: A modern and accessible social services system that, among other things, improves residents' opportunities to live independently and in the community, and to integrate into education and the labour market

2.4. Improving the quality and accessibility of social services for residents

2.4.6. by improving the range of technical aids required by residents and refining the procedures for their allocation (responsible – MOW, co-responsible – VM, VSIA NRC Vaivari, LAD, LAB),

2.4.10. promoting the development of innovative technological and artificial intelligence solutions for the provision of social services (lead agency – VARAM; co-responsible agencies – MOW, local authorities, social service providers)

3. Action Area: An inclusive labour market for all and quality jobs, supporting long-term participation in the labour market

3.1.8. improving the employment situation of people with disabilities by providing comprehensive and targeted support (workplace adaptations, counselling, etc.) and promoting sustainable integration into the labour market (lead agency – MoW; co-responsible agencies – NVA, LBAS, LDDK)

Although there are few references to TA in these guidelines, improving the social services provision system will also have an impact on the stages of the TA process, such as application, needs assessment, and receipt.

These guidelines explain the principles behind the development of the NRC “Vaivari” “voucher” system. Their aim is to ensure that TAs are better suited to a person’s needs, intended use and level of activity. It is assumed that a person’s ability to choose would promote competition among TA manufacturers, and consequently also improve availability and quality. It is noted that a methodology for determining the amount of compensation needs to be established. Studies on the development of technical requirements and the methodology for determining compensation were carried out in 2018 and 2019.

**The Cultural Policy Guidelines for 2022–2027, “Cultural Nation”<sup>75</sup>**, set out the directions for the development of Latvian cultural policy until 2027, emphasising the accessibility of culture to the whole of society, including people with functional impairments. One of the priorities is improving physical, digital and information accessibility, which also includes the use and development of assistive technology to ensure the accessibility of cultural services. The plan divides measures into five action areas: 1. Cultural offerings accessible to the public, 2. Active public participation in cultural processes, 3. Preservation and creative use of cultural heritage, 4. Sustainable development of the cultural and creative sectors, 5. Talent development and professional growth of cultural workers.

The main objective of the **Public Health Guidelines for 2021–2027**<sup>76</sup> is to improve the health of Latvia’s population, extend healthy life expectancy and reduce health inequalities. This is being achieved through several policy action areas, including health promotion, disease prevention and people-centric health care. The measures in the plan are divided into five action areas: 1. Healthy and active lifestyles, 2. Reducing the spread of infections, 3. Person-centred and integrated healthcare, 4. Securing human resources and developing skills, 5. Sustainability of healthcare, strengthening governance, and efficient use of healthcare resources.

In this document, TAs are viewed as part of a rehabilitation, patient support and accessible healthcare system that helps people with functional impairments to maintain or restore their ability to work and their quality of life.

The key measure is 3.2.4.5. “Expand the range of TAs and reduce waiting times the time taken to receive them, whilst simultaneously reviewing the division of competences and responsibilities between the Ministry of Labour and the Ministry of Health for specific types of technical aids and medical devices, so that these are

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<sup>75</sup> <https://likumi.lv/ta/id/330444-kulturpolitikas-pamatnostadnes-2021-2027-gadam-kulturvalsts>

<sup>76</sup> <https://likumi.lv/ta/id/332751-sabiedribas-veselibas-pamatnostadnes-2021-2027-gadam>

immediately available to patients following their hospital stay”.

**The Guidelines for the Development of Education 2021–2027<sup>77</sup>** set out the directions for the development of the Latvian education system until 2027 with the aim of ensuring high-quality, inclusive and accessible education for everyone. In this policy, TAs are viewed as tools to support the learning process, helping to ensure equal opportunities in education. The measures in the plan are divided into four areas of action: 1. Highly qualified, competent and excellence-oriented teachers and academic staff, 2. A modern, high-quality educational provision focused on the development of skills highly valued in the labour market, 3. Support for everyone’s development, 4. Sustainable and effective management of the education system and resources.

Although the Education Development Guidelines do not explicitly mention the use of assistive technologies (AT) and other assistive technologies, infrastructure improvements are planned, along with materials appropriate for a high-quality and inclusive learning process, including the use of digital technologies in educational institutions.

**The Sports Policy Guidelines for 2021–2027<sup>78</sup>** set out Latvia’s sports development strategy up to 2027. Its aim is to promote physical activity in society, develop sport for children and young people, and improve the high-performance sports system. It also emphasises the use of innovation and technology in sport. The plan divides measures into four action areas: 1. improving the financial management and administrative governance model of the sports sector, 2. development of sports infrastructure, 3. sport for an active and healthy society, 4. sport for excellence – development of youth sport, talent and high-performance sport.

Although the guidelines do not contain direct references to assistive technologies (AT) or other assistive technologies, AT in this policy may be linked to sports technologies, rehabilitation and the accessibility of sport for people with functional impairments. Three measures are more directly related to assistive technologies:

3.5. [PRIORITY] Establishment of funding allocation criteria, including in accordance with the number of participants, and systematic financial support for the organisation of sports and active lifestyle events for children, young people, students, adults, senior citizens and people with disabilities, promoting the development of an

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<sup>77</sup> <https://likumi.lv/ta/id/324332-par-izglitibas-attistibas-pamatnostadnem-2021-2027-gadam>

<sup>78</sup> <https://likumi.lv/ta/id/332897-par-sporta-politikas-pamatnostadnem-20222027-gadam>

inclusive and socially responsible sports sector.

3.8. To ensure the accessibility of Latvia's sporting heritage to the public, as well as to promote the development of innovative technologies and solutions for sports and physical activities for children, young people, students, adults, seniors and people with functional impairments, and to provide financial support for the implementation of selected ideas.

4.2. [PRIORITY] To provide financial support for the preparation and participation of talented young and adult athletes with disabilities and national teams (including team sports) in the Paralympic Games, European and World Championships (including qualifying tournaments), as well as other comparable sporting events.

## 4. OPPORTUNITIES

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### Latvia's best practices

Latvia's main advantage is the digitalisation of services, including in the care sector. Policy planning documents also clearly state that the digitalisation of services, as well as the strengthening, renewal and improvement of systems, is one of the priorities. This will be particularly significant in relation to the procurement, development, maintenance and use of assistive technology, facilitating cooperation between people with functional impairments and specialists in the health and social care sectors.

Although the SAO report expressed considerable criticism of the NRC "Vaivari" regarding the provision of TA, it is evident that NRC "Vaivari" has taken this criticism on board and has established and continues to develop new services, as well as updating and simplifying the procedures for receiving TA and other related activities. For example, simpler TAs are sent by post or via parcel lockers. A "voucher" system has also been introduced, offering additional options for selecting and purchasing TAs.

Since 2021, the NRC "Vaivari" has also housed a functional assessment laboratory, which assesses the need for complex TAs. An assistive technology showroom has also recently been established at the Riga branch, where visitors can familiarise themselves with the range of services and try out the available products in practice. As the need for such an exhibition hall in Latvia was highlighted in other interviews, it can be concluded that there is a need to inform interested parties more extensively about its existence, starting with NGOs representing patients' rights. Assistive technologies are currently being developed and improved in Latvia. For example, the expert notes that the subtitles generated by Tilde are of high quality and significantly facilitate communication.

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*It can also be a standalone app where I place my phone down, the other person speaks, the microphone picks it up, and the app on the phone displays the subtitles on the screen. [...] he is beginning to understand grammar even better, and is starting to understand speech from context. Perhaps they're better at picking up on unclear speech. I noticed that last year Tilde also ran a campaign asking people to send in various speech recordings, preferably including dialects, accents – such as the Latgalian accent – and speech*

*impediments, for example, where a person finds it difficult to pronounce the 'r' sound or the like, so that this artificial intelligence could be fed as much information as possible, enabling us to build the largest possible database for speech recognition [T8]*

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These and other examples indicate that there are people in Latvia who care and who are actively involved in the development of assistive technologies.

## Good practices abroad

The experts interviewed shared the procedures for providing assistive technology that they have observed abroad. In the Danish and Norwegian examples, the provision of assistive technology was divided into two categories – assistive technology intended for short-term use and that intended for long-term use. The experts consider this an effective way for people with an urgent need for TA, such as a person with a leg injury who requires a wheelchair, to receive TA quickly. Other examples mentioned include financing solutions and the purchase of second-hand TAs, as well as a model of cooperation between healthcare, local government and social care providers.

### The Danish example

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*In Denmark, it was often a case of assistive technology – well, more specifically mobility technology – for a patient after a stroke, for example. He was given that technology, it was fitted in hospital, and he went home with this state-funded aid and carried on living. Well, so, it was a regional hospital that had that kind of experience, [..]. But, yes, well, that would be an excellent approach to accessibility in general. But that means those institutions need to have the equipment on site and the process needs to be worked out, so it's not just a case of giving that equipment to every other person. [T1]*

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In Denmark, patients with mobility impairments can receive TA after discharge from hospital, based on the Social Services Act (*Serviceoven*) and the Health Care Act (*Sundhedsloven*). The hospital provides TA during treatment, whilst the local authority

provides long-term TA for daily living<sup>79,80</sup>. Prior to discharge, the hospital assesses the patient's functional status and need for assistive devices, and ensures that information is passed on to the local authority. The rehabilitation process is organised to ensure the transition from inpatient care to community living.

### The Irish example

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*Actually, I really love Ireland, but only because I saw a guy arrive in Latvia with a full set of assistive devices and it was like – wow. If we have to queue at the hospital here for a wheelchair, he turns up with an electric one, a standard one and a hoist; he was fully equipped, and that seems normal to me. [T6]*

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In Ireland, patients with mobility impairments can receive assistive devices after being discharged from hospital, which are mainly provided by the Health Service Executive under the *Disability Act 2005*. Before discharge, the patient's functional abilities and need for assistive devices are assessed in hospital. The patient is then referred to the National Health Service's community care organisations, ensuring continuity of care. The provision of assistive devices is based on an individual clinical assessment carried out by specialists, such as physiotherapists or occupational therapists<sup>81</sup>.

### The Norwegian example

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*In Norway, there are also two ways in which they ensure that, for example, insurance covers those assistive devices that are needed on a short-term and acute basis, in the social sector, that which is chronic. [T7]*

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In Norway, the funding of TA is based on a two-tier system. Long-term assistive devices (more than 2 years) are provided as a social insurance service through the

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<sup>79</sup> [https://hmi-basen.dk/en/news.asp?newsid=10685&x\\_newstype=30&utm\\_source=chatgpt.com](https://hmi-basen.dk/en/news.asp?newsid=10685&x_newstype=30&utm_source=chatgpt.com)

<sup>80</sup> [https://www.norden.org/en/info-norden/support-assistive-devices-denmark?utm\\_source=chatgpt.com](https://www.norden.org/en/info-norden/support-assistive-devices-denmark?utm_source=chatgpt.com)

<sup>81</sup> [https://www.homeandsupportshub.ie/managing-your-home/assistive-technology/government-help-with-assistive-technology/?utm\\_source=chatgpt.com](https://www.homeandsupportshub.ie/managing-your-home/assistive-technology/government-help-with-assistive-technology/?utm_source=chatgpt.com)

National Insurance Scheme, administered by the Norwegian Labour and Welfare Administration, and are usually provided in the form of a free loan<sup>82</sup>. Assistive devices intended for short-term use, on the other hand, are not funded by social insurance, but are provided at local authority level or paid for by the patient themselves.

### The Polish example

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*One such example of good practice in Poland is SiDLY Care. [...] They operate at the national level, rather than at the local authority level, as is currently the case here, where every local authority has a different, completely different approach and different priorities. [...] It doesn't work for people with dementia, because you can't constantly track where a person is, only in a crisis situation. [...] And this SiDLY Care works brilliantly with cardiology centres [...] Specifically with rehabilitation specialists who work with patients after a stroke. Because the risk of a recurrent stroke is very high. And they help to closely monitor these people and also discharge them from hospital sooner. Because they remain, so to speak, under the supervision of these doctors [T2]*

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The Polish company SiDLY provides remote patient monitoring using a medical wristband<sup>83</sup>. SiDLY focuses specifically on people who have had a stroke and those with cardiovascular diseases. The company collaborates with cardiology departments, ensuring continuous patient monitoring at a national level following discharge from hospital. Around 1,000 local authorities organise and fund these telecare services for local communities<sup>84</sup>. In practice, this means the use of medical wristbands, 24/7 monitoring and close cooperation between healthcare institutions and social services.

### The example of the UK

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*In England, they won't give you a hoist at all unless you have a certificate proving you know how to use it. It's considered a hazardous device; you must*

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<sup>82</sup> [https://www.norden.org/en/info-norden/loan-assistive-devices-norway?utm\\_source=chatgpt.com](https://www.norden.org/en/info-norden/loan-assistive-devices-norway?utm_source=chatgpt.com)

<sup>83</sup> <https://wediditinpoland.eu/en/innowacja/sidly-vital-care/>

<sup>84</sup> [https://startuprise.co.uk/success-of-polish-telecare-technology/?utm\\_source=chatgpt.com](https://startuprise.co.uk/success-of-polish-telecare-technology/?utm_source=chatgpt.com)

*be insured and you must have a certificate proving you know how to use it. In Latvia, they just hand you one or other, they give it to you and you use it; there are no safety checks on it and we don't carry out any, well, no checks on their technical condition take place. [T6]*

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The UK Health and Safety Executive, in *the Lifting Operations and Lifting Equipment Regulations 1998*, states that all lifting operations must be planned by a competent person, supervised and carried out safely<sup>85</sup>. A certificate is not specified in law as a mandatory document, but in practice it is the standard in the workplace. Both those who use a hoist at home and care providers in their workplaces must be trained to use a hoist.

Although, based on the available information, no official document certifying knowledge and skills is required to use a hoist, the example cited by the expert points to the need for careful training in the use of specialised and complex TAs.

### The Belgian example

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*In Belgium [...] there is a technical maintenance centre; it's like a car garage, if you like. In principle, a wheelchair undergoes this technical inspection every year; it is oiled, tightened and so on. The person knows well in advance on which dates they need to hand over their wheelchair for this technical maintenance. [...] It's exactly the same with the hoist: a technician comes to the house once a year, letting you know when he'll be there, and then he checks all the screws, oils it, checks the battery and replaces it if necessary the battery and so on. [...] for locals, that is, I don't know if it's completely free or for a small co-payment. [...] And wheelchairs without these documents aren't really checked by anyone, but they are necessary to receive this technical support [...]. For example, these garages have these accessible vehicles which they use to transport the wheelchairs back and forth; the person doesn't have to take them to the technical inspection themselves. [T6]*

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<sup>85</sup> [https://www.hse.gov.uk/work-equipment-machinery/loler-overview.htm?utm\\_source=chatgpt.com](https://www.hse.gov.uk/work-equipment-machinery/loler-overview.htm?utm_source=chatgpt.com)

In Belgium, TA, particularly lifts, usually undergo regular (often annual) technical inspections<sup>86</sup>. A specific inspection schedule is set for each piece of equipment, which the user or service provider must adhere to. If the equipment is reimbursed through the national health insurance system, the inspection is often free of charge for the user. Following the inspection, the technician issues a written certificate and often also marks the equipment with the date of the next inspection. Inspections usually take place on-site at the user's premises, as service providers travel to the client with the necessary equipment. There are fewer publicly available detailed regulatory explanations specifically concerning home care TAs (e.g., patient lifts), but in practice they are regulated through: 1) occupational safety regulations (where staff are involved) and 2) the system for the supply and maintenance of medical devices (*Federal Agency for Medicines and Health Products*<sup>87</sup> National Institute for Health and Disability Insurance (*Rijksinstituut voor ziekte- en invaliditeitsverzekering*)<sup>88</sup>).

This example cited by the expert highlights the need to consider introducing mandatory technical inspections for long-term use TAs, with a particular focus on large, complex devices.

### The example of Lithuania

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*In Lithuania, where these individual budgets also exist but allow for the purchase of second-hand items, it is not mandatory to buy new, which reduces these costs. For example, if for you... I mean, for people who aren't in a very serious condition, who don't need anything specific, they could also be allowed to use these second-hand items individually, say, electric wheelchairs for the elderly. Every now and then someone buys one, but they don't need it at that moment; they just need it to get around, and then the second-hand market in Lithuania is quite large, and they confirm that those wheelchairs are fit for purpose, they certify them and can sell them again. Which, I think, isn't bad at all, because in the end the price works out very cheap for them in*

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<sup>86</sup> <https://werk.belgie.be/nl/themas/welzijn-op-het-werk/algemene-beginselen/codex-over-het-welzijn-op-het-werk>

<sup>87</sup> <https://www.famhp.be/en>

<sup>88</sup> <https://www.riziv.fgov.be/nl>

*that case. If we give you that thousand, but you buy it and then get it back.*  
[T6]

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In Lithuania, residents can purchase second-hand wheelchairs provided they comply with EU and national safety standards for medical devices and are certified in accordance with regulatory requirements<sup>89</sup>. There is no state-run platform or centre organising nationwide sales or co-payment schemes specifically encouraging the purchase of used TAs. Used assistive devices are usually sold through private traders or specialist companies, rather than state institutions. Before making a purchase, it is advisable to consult an accredited specialist to ensure the device is safe and compliant<sup>90</sup>.

Although it is not entirely clear from the available information what options exist for purchasing second-hand mobility aids with state financial support, it is nevertheless necessary to consider the possibilities of reselling or lending out second-hand mobility aids that meet the relevant standards. Such an arrangement would likely save funds from both the state and the personal budgets of TA users, as well as align with the principles of sustainable management.

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<sup>89</sup> [https://natlex.ilo.org/dyn/natlex2/natlex2/files/download/45704/LTU-45704.pdf?utm\\_source=chatgpt.com](https://natlex.ilo.org/dyn/natlex2/natlex2/files/download/45704/LTU-45704.pdf?utm_source=chatgpt.com)

<sup>90</sup> [https://vaspvt.lrv.lt/en/news2/be-vigilant-when-purchasing-medical-supplies/?utm\\_source=chatgpt.com](https://vaspvt.lrv.lt/en/news2/be-vigilant-when-purchasing-medical-supplies/?utm_source=chatgpt.com)

## 5. CONCLUSIONS AND RECOMMENDATIONS

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### Principles

Decision-making on the standardisation of assistive technology must definitely involve people who use such assistive technology, including both people with functional impairments as well as carers who look after people who, due to cognitive limitations, would not be able to participate fully in the discussion, and specialists who use various assistive technologies on a daily basis in medical treatment, rehabilitation and client training.

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*I think that when drafting regulations, we absolutely must involve all these people who use [TA and other related technologies], but that, well, yes, it will simply raise issues that cannot be resolved quickly. Because what they experience is the result of this whole vast system. You've got one ministry after another, social services, non-social services – they're already feeling the full brunt of it. And to address that, the whole system needs to be overhauled. But, well, we can still listen to them. We probably need to understand, [...] what solutions would have a big impact with minimal effort. [T4]*

*And in the context of care, we mostly have a client who wouldn't be very active in this collaboration. I could talk about relatives who are close to this care client, who also participate to a certain extent. [T10]*

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As can be concluded from the experts' comments, when addressing a single issue, such as the standardisation of TA and other related technologies, it is highly likely that the discussion will also include other, possibly seemingly unrelated issues; however, by preparing for this in good time and familiarising oneself with the broader context of the needs, opportunities and wishes of people with functional impairments, it will be possible to make the standardisation process more sustainable and easier to align with potential changes in legislation relating to social services.

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*Good support: this would involve rehabilitation specifically for the hard of hearing, where it is possible to use a range of assistive devices, identify the most suitable one, and adjust it. [T9]*

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When considering the possibilities of assistive technology, attention should be paid not only to those aimed at maintaining or improving health, but also to those that help people navigate an environment that is often not particularly suitable for people with functional impairments. This does not, however, preclude the need for urban planning to be based much more on the principles of universal design. Accessibility issues must not be addressed solely through assistive technologies for individual use.

## Limitations of the study

This report contains a great deal of information but does not cover everything related to the regulation of assistive technology in Latvia. Further research is needed, taking into account the experiences and views of the following stakeholders: 1) people with communication or cognitive impairments, 2) representatives of the relevant government agencies, their assessment and vision regarding the use of assistive technology in the Latvian context, 3) children with functional impairments, 4) researchers, 5) assistive technology developers, 6) assistive technology distributors. It is necessary to conduct an in-depth study of legislation, mapping the interrelationships between them, as well as their relationship with international treaties. It is necessary to identify the positions of both large and influential NGOs and small NGOs, covering a broad spectrum of organisations representing the needs of different people.

This report was prepared using document analysis and in-depth qualitative interviews. It is also recommended to organise focus group discussions or workshops to facilitate dialogue among the stakeholders.

## Ideas for policy planning

- Develop standards by organising various workshops with moderators for different stakeholders. By analysing the workshop results, identify the most frequently recurring problems and solutions.
- Promote the NRC “Vaivari” exhibition hall and establish cooperation with TA

exhibition halls in neighbouring countries

- Ensure that the manufacturer of assistive technology involves potential users in the development process (which has taken place since such regulations came into force), conducts user experience testing, and provides evidence of this involvement
- Consider a requirement that, prior to the introduction of assistive technology into clinical practice, a pilot of the technology is carried out at the relevant institution
- Consider the possibility, in procurement, of not specifying a particular assistive technology, but rather defining the target group for the provision of assistive devices, within which specific devices may vary depending on the individual's level of ability.
- It is not enough to rely solely on devices owned by individuals; it is necessary to provide more assistive technology for communal use in public spaces (for example, a hearing loop, which is already available at the Riga Circus)

## Ideas for education

- Educate specialists, patients, clients and the general public about available assistive technologies and their potential applications. Attention should be paid to patient education, as patients who are aware of their options are more likely to ensure they receive what they need. It is important to educate current and future social and healthcare service providers about the assistive technologies already available and the related services, as well as national and EU regulations.
- To promote cross-sectoral collaboration, including by training specialists who could act as 'bridges' between the IT sector and the health and social care sectors. In practical terms, this would mean organising training for clinicians who wish to better understand the assistive technologies available, as well as for representatives of the IT sector who wish to better understand the health and social care sectors.
- Provide training for staff who will be working with the technologies – with an emphasis on methods for using the technologies when working with patients. This could also include study visits to familiarise staff with the range of technologies available, as well as their practical application in a hospital setting.
- Consider opportunities for training on the use of assistive technology that patients have purchased with their own funds.

## Ideas for covering costs

- Assess the possibilities for covering the costs of software, including apps that perform assistive technology functions. A list of state-funded software could be drawn up by associations of medical and functional specialists, with the list also including the risks associated with using the software and the degree of risk likelihood.
- Examine examples from other countries regarding care insurance, which also covers the costs of social services in accordance with the level of care.
- Reimburse transport costs for people on low incomes travelling to the location where the TA is fitted and collected.
- Identify ways to encourage people to use a co-payment mechanism to purchase mobility aids suitable for their needs and living conditions. Given that people who have not previously used assistive devices tend to purchase ones that are unsuitable for their needs, one of the proposed options is to grant co-payment eligibility to clients who have been using assistive devices for at least two or three years.
- Establish a new place for assistive technologies among reimbursable goods and services. One of the experts' recommendations is to stipulate that therapies using the latest assistive technologies, such as VR glasses, can be covered by insurance
- Assess options for compensating for the wear and tear of smartphones, taking into account the wide range of possibilities offered by apps, for example, in the daily lives of visually impaired and blind people

## Ideas for technical solutions

- Promote the introduction of speech-to-text interpreting services in Latvia and improve the quality of real-time transcription
- Establish a clearer distinction between what constitutes assistive technology and what constitutes medical devices and therapeutic devices
- Ensure that e-health specialists can change the address to which TA is sent (people often do not live at their registered address)

## Ideas for services

- Provide appropriate services for people with hearing impairments who wish to communicate verbally, for example, Consider providing digital visual communication devices (tablets) to people who are hard of hearing or deaf but do

not wish to use sign language, as the device is useful for reading subtitles and text transcripts

- Promote continuity of care by linking health care services with social care services. This could involve the healthcare sector providing TAs for short-term use during rehabilitation, in line with examples of good practice from abroad, whilst referring people to local authority social services in cases where TAs are required on a long-term basis.
- Develop a service involving scheduled visits by medical or functional specialists to the regions, during which functional ability assessments are carried out for individuals who feel they need them.
- In research and projects involving the development of assistive technology, allocate funds for product testing.
- Seek feedback from technology users, thereby also strengthening individuals' ability to advocate for their own needs

Evaluate the protocol developed by NRC "Vaivari" to establish a more specific list of criteria for prescribing assistive technology. Establish a standard procedure for how and why assistive technology is prescribed.

# APPENDIX

1. Appendix

## State-funded technical aids provided by the Latvian Association of the Blind

ISO code	TA group and sub-group	Time after which a person may be placed on the waiting list for a new TA (years)	Notes
4	Personal medical care aids		
04 24 09	Blood pressure monitors with voice function	3	For blind and partially sighted persons
04 24 12	Blood glucose meters with voice function	5	For blind and partially sighted persons
04 24 24	Body thermometers with voice function	2	For blind and partially sighted persons
04 24 27	Body scales with voice function	5	For blind and partially sighted persons
6	Orthoses and prostheses		
06 30 21	Eye prostheses	2	Custom-made TA for blind and partially sighted persons
12	Personal mobility aids		
12 39 03	Tactile or white canes (non-folding)	1	For blind and partially sighted persons
12 39 03	Tactile or white canes (folding)	1	For blind and partially sighted persons
15	Domestic aids		
15 03 03	Food scales with voice function	5	For blind and partially sighted persons
15 03 03	Liquid level indicators with audio function	2	For blind and partially sighted persons
22	Communication and signalling aids		
22 03 03	Light (absorption) filters	2	For visually impaired persons
22 03 09	Magnifying glasses with or without a light source	2	For visually impaired persons
22 03 12	Binoculars or telescopic glasses	5	For visually impaired persons

22 03 12	Monoculars	5	For visually impaired persons
22 03 18	Electronic magnifying aids	5	For visually impaired persons
22 12 09	Braille writing frames (including stylus)	2	For blind and partially sighted persons
22 12 15	Braille typewriters	5	For blind and partially sighted people
22 18 03	Playback devices	3	For blind and partially sighted people
22 18 03	Audio recording and playback device (Daisy)	5	For blind and partially sighted persons
22 18 03	Dictaphones	3	Blind and partially sighted persons for whom TA required for education or work
22 24 06	Mobile phones	5	For blind and partially sighted persons aged seven and over
22 24 24	Specialised assistive software for mobile phones to or converting text to speech	5	For blind and partially sighted persons aged seven and over
22 30 21	Pens with a speech function for reading text from special stickers (set includes a pen and stickers for displaying text)	5	For blind and partially sighted persons. If necessary, the person may purchase additional stickers at their own expense
22 39 12	Specialised computer software for text enlargement and/or converting text to speech	5	For blind and partially sighted
22 39 07	Computer displays with sound	5	For blind and partially sighted
27	Assistive devices for environmental enhancement and assessment		
27 06 21	Thermometers for measuring weather conditions with a voice function	3	For blind and partially sighted
27 06 24	Colour identifiers with voice function	5	For blind and partially sighted persons

**State-funded technical aids provided by  
the Latvian Association of the Deaf**

ISO code	TA group and sub-group	Time after which a person may be placed on the waiting list for a new TA (years)	Notes
22	Communication and signalling aids		
22 06 06	Wearable hearing aids (communicators)	3	For people with hearing loss
22 06 15	Behind-the-ear hearing aids with a bone conduction arm	5	For people with hearing loss
22 06 15	Behind-the-ear hearing aids	5	For people with hearing loss
22 06 15	Pocket hearing aids	5	For people with hearing loss
22 18 27	Connectors for radio and television receivers	5	For people with hearing loss who use a hearing aid and have not received an FM radio transmission system
22 18 24	FM radio transmission systems (transmitter and receiver)	5	People with hearing loss who use a hearing aid and for whom a TA is required for educational purposes or work
22 33 06	Digital visual communication devices	3	For deaf and hard-of-hearing persons aged seven and over who use the social rehabilitation or sign language interpreting services
22 24 03	Telephones with amplifiers	5	For people with hearing loss aged seven and over
22 27 04	Alarm devices with vibration and/or light signals	5	For deaf and hard-of-hearing persons aged seven and over

22 27 04	Alarm devices with vibration and/or light signals for monitoring children and dependants ("baby monitors")	5	Deaf and hard-of-hearing persons who are caring for and supervising a child up to the age of one and a half, or persons who are caring for and supervise a person who requires care, and this need is confirmed by a decision of the State Medical Commission for the Assessment of Health Condition and Working Ability (SMCAHCWA) regarding the need for special care or a family (general practice) doctor's opinion on the need for constant supervision and care
22 27 12	Clocks (hand-held and table-top with voice function, Braille, for the visually impaired)	2	For blind and partially sighted persons
22 30 21	Braille display	5	For blind and partially sighted persons aged seven and over who are studying or working
22 39 05	Tactile computer display	7	For blind people with a certificate issued by a social worker confirming their proficiency in Braille
22 27 12	Clocks with vibration and/or light signals	5	Deaf and hard-of-hearing persons aged seven and over
22 27 21	Environmental emergency alarm systems	5	Deaf and hard-of-hearing from the age of seven

### State-funded technical aids provided by the Vaivari TA Centre

ISO code	TA group and sub-group	Time after which a person may be placed on a new waiting list TA (years)	Notes
4	Assistive devices for measuring, supporting, training or replacing bodily functions		
04 03 12	Continuous positive airway pressure (CPAP)	8	For persons with obstructive sleep apnoea-hypopnoea syndrome (OSAHS) of grade II (moderate) and grade III (severe) stages of obstructive sleep apnoea-hypopnoea syndrome (OSAHS), with an apnoea-hypopnoea index (AHI) of at least 15. The assessment for TA eligibility must specify the parameters of the positive airway pressure therapy device and a copy of the test results must also be submitted, showing the AHI is indicated. The examination must be carried out using validated methods (polysomnography, polygraphy). Persons (excluding those from low-income households and children) cover 20% of the TA cost
04 03 12	Automatic positive airway pressure (APAP)	8	For persons with obstructive sleep apnoea-hypopnoea syndrome (OSAHS) of grade II (moderate) and grade III (severe) stages of obstructive sleep apnoea-hypopnoea syndrome (OSAHS), with an apnoea-hypopnoea index (AHI) of at least 15. The assessment for TA eligibility must specify the parameters of the positive pressure therapy device and a copy of the test results must also be submitted, showing the AHI is indicated. The examination must be carried out using validated methods (polysomnography, polygraphy). Persons (excluding those from low-income households and children) cover 20% of the TA cost

04 03 18	Equipment for long-term oxygen therapy outside a healthcare facility (oxygen concentrator) with a flow rate of up to 5 l/min	8	Adults with chronic respiratory failure, if PaO <sub>2</sub> ≤ 7.3 kPa (≤ 55 mmHg). Adults with chronic respiratory failure, if PaO <sub>2</sub> ≤ 8.0 kPa (≤ 60 mmHg) and they have been diagnosed with: 1) respiratory or cardiac disease with secondary polycythaemia (haematocrit ≥ 55%), or pulmonary hypertension, or peripheral oedema, or nocturnal hypoxaemia (SpO <sub>2</sub> ); 2) pulmonary hypertension. PaO <sub>2</sub> ≤ 7.3 kPa (≤ 55 mmHg) or PaO <sub>2</sub> ≤ 8.0 kPa (≤ 60 mmHg) must be confirmed on two occasions at intervals of ≥ 3 weeks during a period of disease remission. The pulmonologist (or cardiologist) shall indicate in their report the arterial blood gas composition (during a period of disease remission, at rest, breathing ambient air) and the required oxygen flow
04 24 12	Pulse oximeter for adults	5	For adults for whom a medical report has been prepared by a pulmonologist or cardiologist. Only in combination with equipment for long-term oxygen therapy outside a healthcare facility (oxygen concentrator)
04 33 03	Pillows for the prevention prevention	2	
04 33 06	Anti-bedsore mattress	5	For individuals who have submitted a Braden Scale assessment at the centre indicating a high risk of pressure ulcers (assessment score not exceeding 18), and a copy of the SMCAHCW opinion regarding the need for special care
5	Assistive devices for training and skills acquisition		
05 36 06	Standing tables for children (multifunctional)	3	
6	Custom-made rigid orthoses		Upper limb, lower limb and spinal orthotic systems consist of a set of interconnecting components designed to correct functional limitations. Upper limb, lower limb and spinal orthotic systems are manufactured by a single service provider and can be combined with any custom-made component to create various upper limb, lower limb and spinal orthotic systems, forming a single TA
06 03 06	Lumbar-sacral orthoses, plastic	2	

06 03 07	Chest braces for the chest, plastic, metal	2	
06 03 09	Chest-waist-lumbar orthoses,	2	
06 03 09	Thoracic-lumbar-sacral orthoses with embedded metal structural components, plastic	2	
06 03 09	Scoliosis correction braces with correction in a single plane (sagittal); plastic, including pathological for the correction of kyphosis and orthosis for lordosis/delordosis or neuro-muscular orthoses for scoliosis correction	1	
06 03 09	Scoliosis correction orthoses with correction in two planes (sagittal and frontal), plastic	1	
06 03 09	Scoliosis correction orthoses with correction in three planes (sagittal, frontal, derotation), plastic, including Cheneau-type orthoses	1	
06 03 09	Thoracic-lumbar-sacral orthoses (stabilising, for the post-operative period), plastic	2	
06 03 09, 06 12 18	Standing orthoses	2	
06 03 09, 06 12 18	Standing orthoses with head support	2	
06 03 09, 06 12 15	Seating orthoses without scoliosis correction	1	

06 03 09, 06 12 15	Seating orthoses without scoliosis correction, with headrest	1	
06 03 09, 06 12 15	Seating orthoses, scoliosis correction	1	
06 03 09, 06 12 15	Correction of kyphosis and scoliosis, with head support	1	
06 03 12	Neck orthoses, plastic	2	
06 03 15	Cervical-thoracic braces, plastic	2	
06 03 15	Neck-chest orthoses with embedded metal structural components, plastic	2	
06 03 18	Neck-chest-waist-sacral orthoses, plastic	2	
06 03 18	Neck-chest-lumbar-sacral orthoses with integrated metal structural components, plastic	2	
06 03 21	Head orthoses following trepanation, plastic	2	
06 03 21	Head orthoses without facial section, plastic	2	
06 03 21	Head-face orthoses, plastic	2	
06 03 21	Head orthoses for correction for children, plastic	1	
06 06 12	Wrist joint-wrist orthoses, plastic	2	
06 06 12	Wrist- wrist orthoses, laminated	2	
06 06 13	Wrist joints - wrist - finger orthoses, plastic	2	
06 06 15	Elbow orthoses, plastic	2	

06 06 15	Elbow braces, laminated	2	
06 06 19	Elbow-forearm-wrist orthoses, plastic	2	
06 06 30	Shoulder-elbow-wrist-hand orthoses, plastic	2	
06 06 33	Single-axis plastic wrist joint, pair	2	
06 06 33	Plastic wrist joint for contracture prevention, with adjustable angle, pair	2	
06 06 33	Wrist joint with torsion spring for passive correction	2	
06 06 33	Plastic wrist joint with finger and wrist flexion-extension system, pair	2	
06 06 36	Elbow joint with single axis, pair	2	
06 06 36	Elbow joint with multiple axes, pair	2	
06 06 36	Elbow joint for contracture, with adjustable angle, pair	2	
06 06 36	Elbow joint with limited, adjustable flexion-extension range, pair	2	
06 06 36	Elbow joint with torsion spring	2	
06 12 06	Ankle-foot orthoses, plastic	2	
06 12 06	Ankle-foot orthoses, dynamic, plastic	2	
06 12 06	Ankle-foot orthoses, made from PRE-PREG, carbon material	2	
06 12 06	Ankle-foot orthoses, laminated	2	

06 12 06	Metatarsus adductus/abductus correction orthoses, plastic	1	
06 12 06	Clubfoot abduction orthosis with rail and multi-axial shoe (Denis-Brown type)	1	
06 12 06	Clubfoot abduction orthoses (Denis-Brown type) growth correction (change of footwear)	1	
06 12 09	Knee orthoses, plastic	2	
06 12 12	Knee-ankle-foot orthoses, plastic	2	
06 12 12	Knee-ankle-foot orthoses, made from PRE-PREG, carbon material	2	
06 12 12	Knee-ankle-foot orthoses, laminated	2	
06 12 15	Hip orthoses, including abduction orthoses, plastic, (for children)	2	TA is provided for children weighing up to 45 kg
06 12 15	Hip orthoses, including abduction orthoses, Swash-type orthoses (for children)	2	
06 12 15	Hip orthoses, plastic, (for adults)	2	TA is provided for adults weighing 45-90 kg
06 12 16	Hip-knee orthoses, plastic	2	
06 12 18	Hip-knee-ankle-foot orthoses, plastic	2	
06 12 18	Hip-knee-ankle-foot orthoses, made from PRE-PREG, carbon material	2	

06 12 18	Hip-knee-ankle-foot orthoses, laminated	2	
06 12 18	Reciprocating gait orthoses	2	Reciprocating gait orthosis, including a reciprocating gait mechanism, for both legs
06 12 21	Polymer ankle joint, pair	2	
06 12 21	Single-axis metal ankle joint, pair	2	
06 12 21	Metal ankle joint with flexion-extension restriction, pair	2	
06 12 21	Ankle joint with assistance in flexion and extension, with dorsiflexion function, pair	2	
06 12 21	Carbon spring	2	
06 12 24	Metal, free single-axle track joint, pair	2	
06 12 24	Metal, free two-axis track joint, pair	2	
06 12 24	Single-axis track joint with lock, "lockable", pair	2	
06 12 24	Knee contracture joint with adjustable angle, pair	2	
06 12 24	Knee joint with torsion spring	2	
06 12 27	Hip joint with lock, "lockable", unilateral	2	
06 12 27	Freely movable single-axis hip joint, unilateral	2	
6	<b>Custom-made soft orthoses</b>		Upper limb, lower limb and spinal orthotic systems consist of a set of interconnecting components designed to correct functional limitations. Upper and lower limb and spinal orthotic systems are manufactured by a single service provider and can be combined with any custom-made component to create various upper limb, lower limb and spinal orthotic systems, forming a single TA

06 03 03	Sacroiliac orthoses	2	
06 03 06	Lumbar-sacral orthoses	2	
06 03 07	Chest braces	2	
06 03 08	Chest-waist orthoses	2	
06 03 09	Thoracic-lumbar-sacral orthoses	2	
06 03 12	Neck braces - immobilisation collars	2	
06 03 15	Cervical-thoracic orthoses	2	
06 03 18	Neck-chest-lumbar-sacral orthoses	2	
06 04 06	Hernia bandages	2	
06 04 06	Stoma orthoses	2	
06 06 12	Wrist joints-wrist orthoses	2	
06 06 13	Wrist joints-wrist-finger orthoses	2	
06 06 15	Elbow orthoses	2	
06 06 19	Elbow-forearm-wrist orthoses	2	
06 06 21	Shoulder orthoses	2	
06 06 24	Shoulder-elbow braces	2	
06 06 30	Shoulder-elbow-wrist-wrist orthoses	2	
06 12 06	Ankle-foot orthoses	2	
06 12 09	Knee orthoses	2	
06 12 24	Metal or plastic single-axis knee joint, pair	2	Applicable to technical aids with ISO code 06 12 09 (soft knee braces)
06 12 24	Metal or plastic multi-axis knee joint, pair	2	
06 12 12	Knee-ankle-foot orthoses	2	
06 12 15	Hip orthoses, including abduction orthoses	2	

06 12 16	Hip-knee orthoses	2	
06 12 18	Hip-knee-ankle-foot orthoses	2	
6	Custom-made soft compression orthoses		Upper limb, lower limb and spinal orthotic systems consist of a set of interconnecting components designed to correct functional limitations. Upper and lower limb and spinal orthotic systems are manufactured by a single service provider and can be combined with any custom-made component to create various upper, lower limb and spinal orthotic systems, forming a single TA. Compression orthoses are classified as: 1. For the prevention of hypertrophic and keloid scars – compression for scar treatment. 2. Orthoses for improving lymphatic drainage and prevention – compression for the prevention of lymphoedema (excluding orthoses for the prevention of venous insufficiency). 3. Deep pressure compression for the control of hyper- and hypomobility. Compression orthoses for the prevention of scar tissue following burns; when it is their turn, 2 items are issued at the same time
06 03 18	Neck-chest-waist-sacral orthoses	0.5	
06 03 18, 06 06 24	Neck-chest-waist-lower back and shoulder-elbow orthoses, combined	0.5	
06 03 18, 06 06 30	Neck-chest-waist-lower back and shoulder-elbow-wrist-hand orthoses, combined	0.5	
06 03 21, 06 03 12	Head orthoses without a facial section, including neck	0.5	
06 03 21, 06 03 12	Facial orthoses (masks), covering the head and neck	0.5	
06 06 13	Wrist-hand-finger orthoses	0.5	

06 06 19	Elbow-forearm-wrist-wrist orthoses	0.5	
06 06 19	Elbow-forearm-wrist joints-wrist-finger orthoses	0.5	
06 06 30	Shoulder-elbow-wrist joint orthoses	0.5	
06 06 30, 06 06 12	Shoulder-elbow-wrist joint-wrist orthoses	0.5	
06 06 30, 06 06 13	Shoulder-elbow-wrist joints-wrist-finger orthoses	0.5	
06 12 06	Ankle-foot orthoses	0.5	
06 12 12	Knee-ankle-foot orthoses	0.5	
06 12 13	Lower leg orthoses (excluding knee and foot joints)	0.5	
06 12 16	Hip-knee orthoses combined for both legs together, creating continuous pressure in the pelvic region	0.5	
06 12 17	Thigh orthoses (excluding hip and knee joints)	0.5	
06 12 18	Hip-knee-ankle-foot orthoses combined for both legs together, creating continuous pressure in the pelvic area	0.5	
6	<b>Prosthetics</b>		
06 18 03	Partial hand prosthetics, including finger prostheses	3	Upper limb prosthetic systems are a set of interconnectable components or replacements of parts, manufactured by a single service provider and which can be connected to any custom-made component to
06 18 06	Wrist joints prostheses	3	

06 18 09	Transradial (below-the-wrist) prostheses	3	create various upper limb prosthetic systems. This group includes prosthetic gloves for the stump and functional instruments that are not components of upper upper limb prosthetic systems	
06 18 12	Elbow joint prostheses	3		
06 18 15	Transhumeral (above-elbow) prostheses	3		
06 18 18	Shoulder joint prostheses	3		
06 18 21	Prostheses following shoulder joint scapular and clavicle disarticulation	3		
06 18 24	Hand prostheses	3		
06 18 25	Branched hooks	3		
06 18 26	Devices or tools to replace replacement	3		
06 18 36	Shoulder units	3		
06 18 39	External joints of the upper of the upper system	3		
06 18	Cosmetic upper limb prostheses	3		
06 18	Upper limb (for sport)	4		For persons who regularly participate in a sport and are certified by the Latvian Paralympic Committee. The person with a disability purchases the prosthesis with a co-payment (reimbursed for the actual costs of the TA, not exceeding €30,000 per calendar year for 06-18-1, 06 24-0 and 12 22 03 – 7 technical aids in total)
06 24 03	Partial foot, including toe prostheses	3		Lower limb prosthetic systems are a set of connectable parts or replacements for parts, manufactured by a single service provider, which can be connected to any custom-made part to create various lower limb prosthetic systems. This group includes prosthetic sockets for stumps and functional instruments that are not components of lower limb prosthetic systems
06 24 06	Ankle joints prostheses	3		
06 24 09	Trans tibial (below-knee) prostheses	3		
06 24 12	Knee joint prostheses	3		
06 24 15	Transfemoral (above-knee) prostheses	3		
06 24 18	Hip joint prostheses	3		

06 24 21	Hemipelvectomies prostheses	3	
06 24 37	External joints of the lower limb prostheses systems	3	
06 24 48	Primary prostheses for early amputation of the lower limb mobilisation	1	
06 24	Lower limb (for sport)	4	For persons who regularly participate in a sport and are certified by the Latvian Paralympic Committee. The person with a disability purchases the prosthesis with a co-payment (reimbursed for the actual costs of the TA, not exceeding €30,000 per calendar year for 06-18-1, 06 24-0 and 12 22 03 – 7 technical aids in total)
06 30 18	Breast prostheses	2	
6	<b>Orthopaedic footwear</b>		
06 12 03	Rehabilitation/ specialist ready-made orthopaedic footwear	0.5	For persons with foot (including toe) and/or ankle deformities, due to which it is not possible to fit standard footwear. Persons (excluding those belonging to low-income households and children) are covered 20% of the TA price
06 12 03	Ready-made therapeutic orthopaedic footwear	0.5	For persons with severe foot and/or ankle deformities, due to which it is not possible to fit standard or rehabilitation/preventative footwear, as well as for persons with circulatory, sensory and mobility impairments. Individuals (excluding those from low-income households and children) pay 20% of the TA price
06 12 03	Ready-made orthopaedic footwear for increased foot volume for wearing orthoses	0.5	For persons with severe foot deformities of various aetiologies, sequelae of diseases and injuries, manifested by impaired function of the lower extremities conditions that require the wearing of orthoses with increased volume in the plantar and lateral surfaces of the foot. Footwear is available in addition to ready-made orthopaedic footwear for rehabilitation/prevention (06 12 03 – 0) or ready-made therapeutic orthopaedic footwear (06 12 03 – 1) if an orthosis of increased volume is prescribed. Individuals (excluding those from low-income households and children) cover 20% of the TA price

06 12 03	Custom-made for a client with a foot amputation to be manufactured at various levels, an orthopaedic boot or shoe	0.5	
06 12 03	Custom-made orthopaedic footwear for clients with lower limb shortening	0.5	
06 12 03	Custom-made for a client with severe foot deformities or for users of orthoses orthopaedic footwear	0.5	
06 12 03	Custom-made for clients with foot amputation manufactured at various levels orthopaedic footwear	0.5	
9	Assistive devices for self-care and participation in self-care		
09 09 03	Aids for putting on putting on	2	
09 12 03	Toilet chairs without wheels	4	
09 12 03	Toilet chairs with wheels	4	
09 12 03	Toilet/shower chairs	4	
09 12 03	Toilet chairs for children	3	
09 12 18	Toilet seat risers, to be attached to toilet	4	
09 33 04	Bath boards	4	
09 33 05	Children's bath chairs	3	
09 33 05	Bath chairs with back support	4	
09 33 05	Bath chairs, swivel, with backrest	4	
09 33 07	Shower chairs without backrest	4	

09 33 07	Shower chairs with backrest	4	
09 33 07	Shower chairs, wall-mounted	4	
09 33 07	Toilet/shower chairs with adjustable seat angle	4	
12	<b>Assistive devices for activities and participation related to personal mobility and transport</b>		
12 03 06	Elbow crutches for children	2	
12 03 12	Underarm crutches crutches for children	2	
12 03 16	Quadrupods	2	
12 06 03	Walking frames without wheels, with a fixed frame	3	
12 06 03	Walking frames without wheels, with a movable frame	3	
12 06 06	Rollators with two wheels without a seat	3	
12 06 06	Rollators with two wheels without a seat for children	2	
12 06 06	Rollators with two wheels with a seat	3	
12 06 06	Rollators with three wheels	3	
12 06 06	Rollators with four wheels	3	
12 06 06	Rollators with four wheels (with armrests)	3	
12 06 06	Four-wheeled rollators wheels for children	2	
12 06 06	Four-wheeled walkers for children (with direction change)	2	

12 06 06	Four-wheeled rollators (lighter weight)	3	
12 06 09	Mobility chairs with safety belts for children	2	
12 06 09	Wheelchairs with a safety ring for children	2	
12 06 09	Mobility chairs for children (activity)	3	
12 06 12	Mobility tables for adults	4	
12 06 12	Transfer tables for children	3	
12 12 12	Adapted car seat	2	The TA is provided to the person with a co-payment. The TA is granted to persons who lack control over head and trunk function. A copy of the SMCAHCWA's opinion regarding the care
12 22 03	Two-wheeled wheelchair with rear-wheel drive for adults (base model)	3	
12 22 03	Two-wheeled wheelchair with rear-wheel drive for adults, with an X-shaped frame (with cushion, with side and armrests, with anti-tip wheels)	3	
12 22 03	Bimanual wheelchair with rear-wheel drive for adults, with an X-shaped frame (with cushion, with armrests, with anti-tip wheels, with anti-slip straps)	3	
12 22 03	Two-wheeled wheelchair with rear-wheel drive for adults, with non-folding frame (with armrests, push handles, with anti-tip wheels, with cushion)	4	

12 22 03	Bimanual wheelchair with rear-wheel drive for adults, with non-folding frame (with armrests, push handles, anti-tip wheels, anti-slip straps, cushion, spoke guard)	4	
12 22 03	Bimanual wheelchair with rear-wheel drive for adults, with non-folding frame (with armrests, push handles, anti-tip wheels, split footrests, cushion)	4	
12 22 03	Two-wheeled wheelchair with rear-wheel drive for adults (with padded backrest and seat, both adjustable to a specific angle)	4	
12 22 03	Two-wheeled wheelchair with rear-wheel drive (for sport)	4	For persons who regularly engage in a particular sport and are certified by the Latvian Paralympic Committee. The person with a disability purchases the wheelchair with a co-payment (reimbursed for the actual costs of the TA, not exceeding €30,000 per calendar year for 06-18-1, 06 24-0 and 12 22 03 – 7 technical aids in total)
12 22 03	Bimanual wheelchair with rear-wheel drive for adults (for people with leg amputations)	3	
12 22 03	Bimanual wheelchair with rear-wheel drive for children with an X-shaped frame	2	
12 22 03	Two-wheeled wheelchair with rear-wheel drive for children, with non-folding frame	3	

12 22 03	Two-wheeled wheelchair with rear-wheel drive for children (with padded backrest and seat, which are adjustable to a specific angle)	3	
12 22 03	Bimanual standing wheelchair with rear-wheel drive	6	
12 22 09	Single-sided steered wheelchair without drive. A wheelchair that is steered with one hand	3	
12 22 18	Manual attendant wheelchair for adults	3	
12 22 18	Manual attendant-propelled wheelchair for adults (with adjustable backrest angle)	4	
12 22 18	Manual attendant-propelled wheelchair for children (with accessories)	3	
12 22 18	Manual attendant-operated wheelchair for children	3	
12 23 03	Electric wheelchair with hand-operated steering system (electric scooter)	6	Battery replacement is covered by state budget funds once every three years of use, if the TA has been received on loan
12 23 06	Electric wheelchair with a motorised hand-controlled steering system	6	Battery replacement is covered by the state budget once every three years of use, if the TA is received on loan
12 24 09	Electric traction wheel	6	Wheelchair accessory which, when connected to the wheelchair, provides the functions of an electric wheelchair. The person receives the accessory with a co-payment. The costs are equivalent to an electric wheelchair with a motorised hand-controlled steering system

12 24 09	An electric motor system built into the wheelchair's wheels electric motor system	6	Wheelchair accessories which, when connected to the wheelchair, provide the functions of an electric wheelchair. The person receives the accessories with a co-payment. The costs are equivalent to an electric wheelchair with a motorised hand-controlled steering system
12 31 03	Sled	2	
12 36 03	Mobile lift for transfer	5	For persons who have submitted to the VADC a copy of the SMCAHCWA's opinion regarding the need for special care and are unable to change their body position or move themselves
15	Assistive devices for performing household activities and participating in daily life		
15 03 06	Customised kitchen cutting board	5	
15 03 06	Customised kitchen knife	5	
18	Furnishings, equipment and other aids to facilitate activities in a person's indoor and outdoor environments		
18 03 15	Bedside table used in bed or next to the bed	5	For persons who have submitted an assessment to the VADC using the Braden scale, indicating a high risk of pressure ulcers (assessment score not exceeding 9), and a copy of the SMCAHCWA's opinion on the requirements
18 09 39	Wheelchair-mounted, made to measure custom-made seating system	2	TA recipient receives with co-payment
18 12 10	Functional bed	10	For persons who have submitted an assessment to the VADC based on the Braden scale, indicating a high risk of pressure ulcers (assessment score not exceeding 9), and a copy of the SMCAHCWA's opinion on the requirements
18 18 11	Support handle, screw-mounted to the floor or wall (liftable)	5	
22	Technical aids for alternative communication		
22 21 09	Multi-level speech equipment	3	

22 21 09	Communicator for playing back recorded messages	3	
22 21 09	Speech board with options options	3	
22 21 09	High-level communicator	3	
22 21 09	Programmable communicator	3	
22 21 09	Communicator with illuminated selection windows	3	
22 21 12	Communication software	3	A personal computer/tablet is required to install the software. The software is compatible with the Windows operating system
22 24 03	Alarm button and telephone	3	
22 36 21	Eye-tracking alternative communication device (Tobii Dynavox PCEye)	3	A personal computer is required. The software is compatible with the Windows operating system
24	Assistive devices for controlling, carrying, moving or grasping objects and devices		
24 21 03	Manual gripping grippers	2	

### Measures relating to TA provision from policy planning documents for 2024–2027

No. No.	Measure	Outcome	Institutions
1.5.	To promote public about the support available in the event of disability	A methodology has been developed, tested and refined for the provision of standardised information to SMCAHCWA clients in cases of disability determination <i>Performance indicator:</i> a) guidance for SMCAHCWA specialists – 1 b) catalogue/brochure on available support for people with disabilities – 1 <i>Deadline:</i> Second half of 2025	<i>Responsible:</i> MoW <i>Co-responsible:</i> SMCAHCWA
1.6.	Promote the reuse of personal functional assessments in other public authorities (allocation)	Proposals have been prepared, in accordance with personal data protection requirements, for data exchange between institutions regarding the transfer of functional assessment information <i>Performance indicator:</i> Proposal prepared – 1 <i>Deadline:</i> Second half of 2026	<i>Responsible:</i> MoW <i>Co-responsible:</i> SMCAHCWA SIVA NVA NRC VAIVARI
1.7.	To promote mutual cooperation and understanding with family (general practice) doctors, treating doctors, as well as local authority social services staff on matters relating to the assessment of disability	a) to enhance the knowledge and skills of family (general practice) doctors and treating doctors in the preparation of documents required for disability assessment preparation b) strengthened knowledge among local authority social workers regarding the services provided by the SMCAHCWA and issues relating to the determination of disability <i>Performance indicator:</i> a) educational seminars for family (general practice) doctors and treating doctors – approximately 35 b) educational seminars for local authority social workers – approximately 8 <i>Deadline:</i> Second half of 2025	<i>Responsible:</i> SMCAHCWA <i>Co-responsible:</i> Family (general practitioners) Local social services
1.9.	Facilitate the recruitment of specialists to carry out disability assessments	A proposal has been prepared regarding the possibility of expanding the range of specialists who can carry out disability assessments <i>Performance indicator:</i> Proposal to expand the range of specialists <i>Deadline:</i> First half of 2026	<i>Responsible:</i> MoW <i>Co-responsible:</i> SMCAHCWA

No. No.	Measure	Outcome	Co-responsible institutions
2.6.	To ensure targeted support for persons with very severe disabilities in accordance with the individual's actual care needs	<p>Proposals have been prepared to change the approach to assessing special care needs and grading care allowances in accordance with actual care needs</p> <p><i>Performance indicator:</i></p> <p>a) conceptual report prepared – 1 b) amendments made to the regulatory acts governing the determination of special care and the amount of care allowance in accordance with the supported option</p> <p><i>Deadline:</i></p> <p>a) Second half of 2024 b) Second half of 2025</p>	<p><i>Responsible:</i> MoW</p> <p><i>Co-responsible:</i> Local authorities, NGOs</p>
2.7.	Ensure a more targeted allocation of TA in accordance with an individual's specific needs	<p>a) Proposals prepared to improve the procedure for allocating TA in line with the individual's TA usage objectives and activity levels b) Methodological material prepared on the identification and use of appropriate TAs</p> <p><i>Performance indicator:</i></p> <p>a) amendments to the regulatory acts governing TA b) guidelines for doctors on preparing an opinion on the need for TA in accordance with the individual's functional abilities</p> <p><i>Deadline:</i> Second half of 2025</p>	<p><i>Responsible:</i> MoW</p> <p><i>Co-responsible:</i> NRC VAIVARI</p>
2.10.	Introduce a support plan for a child with functional impairments needs needs-oriented approach to the needs	<p>A unified approach to determining the need for social services for children with functional impairments has been developed</p> <p><i>Performance indicator:</i> Proposal prepared – 1</p> <p><i>Deadline:</i> First half of 2025</p>	<p><i>Responsible:</i> MoW</p>
2.12.	Promote care services and accessibility for people with functional disabilities #Dod 5 Task of the working group	<p>a) organised information events for healthcare institutions and healthcare professionals on the needs of people with functional impairments; b) to identify patients' experiences of receiving healthcare services</p> <p><i>Performance indicator:</i> Information events – regularly every year Patient survey following receipt of service</p> <p><i>Deadline:</i> By the second half of 2027</p>	<p><i>Responsible:</i> Ministry of Health</p> <p><i>Co-responsible:</i> Health Inspectorate NGOs</p>

2.16.	Promote the involvement of young people with disabilities in vocational education	ensuring the adaptation of the environment in educational institutions <i>Performance indicator:</i> Number of vocational education institutions that have provided support measures – environmental in three vocational education institutions <i>Deadline:</i> Second half of 2025	<i>Responsible:</i> Vocational education institutions <i>Co-responsible:</i> MoES
2.17.	Ensure the availability of assistive technologies for learners to access educational content	Initiatives have been launched to provide assistive technologies to learners <i>Performance indicator:</i> Establishment of an assistive technology (AT) exchange system for educational institutions <i>Deadline:</i> Second half of 2027	<i>Responsible:</i> MoES <i>Co-responsible:</i> VK

No. p. k.	Measure	Outcome	Co-responsible institutions
4.2.	Promote the strengthening of in the construction process	Proposals prepared for the inclusion of new requirements in the general requirements for buildings in building standard LBN 200-21 <i>Performance indicator:</i> Proposals submitted for amendments to the building code LBN 200-2161 on general requirements for buildings <i>Deadline:</i> First half of 2024	<i>Responsible:</i> MoW <i>Co-responsible:</i> MoE (Ministry of Economics)
4.4.	Promote the accessibility of goods and services (relevant to the scope of the Accessibility Directive)	a) assess the accessibility of public services in Latvia across sectors, services and providers whose activities fall within the scope of the Accessibility Directive <i>Performance indicator:</i> Assessment – 1 <i>Deadline:</i> First half of 2027	<i>Responsible:</i> MoW
		b) guidelines on the application of the “Law on the Accessibility of Goods and Services” in relation to micro-enterprises have been prepared and published <i>Performance indicator:</i> Guidelines – 163 <i>Deadline:</i> First half of 2025	<i>Responsible:</i> MoE

4.6.	Promote housing accessibility in accordance with uniform conditions and criteria in all local authorities # Dod5 group	Proposals have been submitted for the development of a unified solution regarding cooperation between the state and local authorities to for people with functional impairments following the end of the ANM investment <i>Performance indicator:</i> Informative report prepared – 1 <i>Deadline:</i> Second half of 2027	<i>Responsible:</i> MoW MoE <i>Co-responsible:</i> VARAM NGOs
4.7.	Improve the accessibility of public services and public buildings	Ensure environmental accessibility in state and local government institutions where state welfare services or local government social services are provided <i>Performance indicator:</i> Number of institutions where environmental accessibility is ensured – 63 <i>Deadline:</i> First half of 2026	<i>Responsible body:</i> MoW <i>Co-responsible:</i> Local authority or local authority; [..]
4.12.	Disseminate good examples of good practice regarding the benefits to the organisation by ensuring the accessibility of websites and mobile apps #DOD 5 working group task	a) regular (including in-depth) evaluations of websites and mobile apps b) disseminated examples of good practice and updates in the field of website accessibility <i>Performance indicator:</i> a) number of websites for which an accessibility assessment has been carried out: a.1.) simplified – 132; a.2.) in-depth – 17 b) website accessibility training courses organised and published on the VARAM website <i>Deadline:</i> Annually	<i>Responsible:</i> VARAM
4.13.	Involve NGO representatives in website testing, both during the development stage and in the working environment #DOD 5 working group task	a) organised testing of website usability and accessibility, involving people with functional disabilities b) measures implemented regarding the importance of website usability and accessibility testing and the involvement of people with various functional impairments <i>Performance indicator:</i> a) number of websites tested with the involvement of people with functional impairments – at least 17 b) information material on digital accessibility and diversity management has been distributed to institutions. <i>Deadline:</i> a) Annually b) Second half of 2024	<i>Responsible:</i> VARAM

4.15.	Monitor the content of programmes and services accessibility	<p>Promote a gradual increase in subtitled content in commercial electronic media programmes and services</p> <p><i>Performance indicator:</i> The volume of subtitled content facilitated through the monitoring mechanism in television programmes registered in Latvia – on average at least 5% of the total content volume and 4,000 programmes (films) per year</p> <p><i>Deadline:</i> Second half of 2027</p>	<p><i>Responsible body:</i> National Electronic Mass Media Council (NEMMC)</p>
4.16.	Promote the high-quality availability of to for people with disability	<p>Accessibility service standards (guidelines) developed in collaboration with industry representatives and NGOs</p> <p><i>Performance indicator:</i> Standards (Guidelines) developed</p> <p><i>Deadline:</i> Second half of 2024</p>	<p><i>Responsible body:</i> NEMMC</p> <p><i>Co-responsible:</i> NGOs</p>
4.17.	Expand opportunities for people with disabilities to access information and participate in cultural life in a manner suitable for them	<p>Increased the volume of subtitling and sign language interpretation for LTV programmes (films) in linear broadcasting, as well as the development of subtitles or sign language interpretation for content in a multimedia environment</p> <p><i>Performance indicator:</i> The proportion of broadcast content on LTV programmes and services out of total broadcast hours – 34%, of which: a) with subtitles – 26.5% b) with sign language interpretation – 7.5%</p> <p><i>Deadline:</i> By the second half of 2027</p>	<p><i>Responsible body:</i> Public Electronic Media Council (PEMC)</p>

Identifier	Measure	Activity Result	Institutions
U4.1.5.-1	Improving the digital skills and professional competence of healthcare and social care workers for working with information systems and digital solutions in the health and welfare sectors, including the to patients.	Deadline: 2021–2027	<p><i>Responsible bodies:</i> MoH, MoL, MoES</p> <p><i>Co-responsible:</i> Professional associations, NVD, Universities, university hospitals, and other healthcare institutions</p>

Identifier	Measure	Activity Result	Institutions
U4.2.1.-2	Guidelines/methodological instructions on how sectoral ministries conduct sector-specific cyber security risk analyses and ensure cooperation to update them within the sector (Ministry of the Interior by 2023). In accordance with the guidelines/methodological instructions, sectoral ministries have carried out a cyber security risk analysis and cooperation plans prepared to update the risks within the sector.	Deadline: 2021–2025	<i>Responsible parties:</i> All ministries

Identifier	Task	Start date	Responsible
U4.4.1.-1	To develop a policy, regulatory framework and supervisory mechanism for public service platforms to businesses.	Deadline: 2021–2023	<i>Responsible:</i> VARAM <i>Co-responsible:</i> Ministry of Agriculture, Ministry of Economics, and the authorities
U4.4.1.-2	Ensure that national priority service platforms are made available to businesses, provide support mechanisms for institutions and businesses to use national priority service platforms.	Deadline: 2022–2027	<i>Responsible:</i> VARAM <i>Co-responsible:</i> MoE, for platforms authorities

No.	Measure	Outcome	Institutions
4.4.6.-1	Improve the legal framework for the sharing and secondary use of health data use, and establish interoperable standards for the collection and circulation of health information.	Deadline: 2021–2023	<i>Responsible:</i> MoH
4.4.6.-2	Ensure the availability of health and welfare sector for shared use, including by providing a unified platform the electronic exchange of information.	Deadline: 2021–2027	<i>Responsible bodies:</i> MoH, MoL <i>Co-responsible:</i> Ministry of Environmental Protection and Regional Development, Ministry of Economics, local authorities, healthcare institutions

4.4.6.-3	Ensure the full-scale operation of the Electronic Health Record (EHR) and the quality of patient disease registers to ensure a comprehensive treatment process and the implementation of health policy.	Deadline: 2021–2026	<i>Responsible:</i> MoH <i>Co-responsible:</i> healthcare institutions
4.4.6.-4	Promote the introduction of modern, patient-centred digital solutions, including telemedicine solutions, in healthcare.	Deadline: 2022–2027	<i>Responsible:</i> MoH <i>Co-responsible:</i> Ministry of Environmental Protection and Regional Development
4.4.6.-5	Ensure Latvia's integration into the European Health Data Space.	Deadline: 2022–2027	<i>Responsible:</i> MoH <i>Co-responsible:</i> VARAM
4.4.6.-6	Ensure the collection and analysis of data on social services and social and social assistance on the e-care platform, as well as analytics on the social support provided to individuals.	Deadline: 2021–2025	<i>Responsible:</i> MoW <i>Co-responsible:</i> Local authorities, businesses that provide social services

Identifier	Task	Start deadline	End date	Responsible
U4.4.11.-1	Establish a digital transformation innovation ecosystem, provide support instruments for the digital transformation of businesses.	2021	2027	<i>Responsible:</i> MoE <i>Co-responsible:</i> none
U4.4.11.-2	Establishment of European Digital Innovation Hubs for the development of business digitalisation research, as well as for the development of innovation, and the development of high-level digital skills.	2021	2027	<i>Responsible:</i> VARAM <i>Co-responsible:</i> MoE, All ministries
U4.4.11.-3	By implementing the "state as a platform" approach, ensure limited support to businesses for the use of state platforms and services.	2021	2027	<i>Responsible:</i> VARAM <i>Co-responsible:</i> MoE
U4.4.11.-4	Making key economic/business primarily or exclusively in digital form, by developing automation opportunities.	2021	2027	<i>Responsible:</i> MoE <i>Co-responsible:</i> VARAM, MoF

No.	Task and sub-tasks, deadline, responsible parties	Link to policy outcome and performance indicator	Indication of resources required and its source [Link to NAP2027 task]
3.2.4.5.	<p>Expand the range of assistive devices and reduce waiting times for their provision, whilst reviewing the division of responsibilities responsibilities between the Ministry of Labour and the Ministry of Health for specific types of assistive devices and medical devices, so that patients have immediate access to them following their hospital stay.</p> <p><i>Implementation period: 2021–2027</i></p> <p>Responsible institution: MoW</p> <p>Co-responsible bodies: Ministry of Health, National Health Service, professional associations, NRC Vaivari, patient organisations</p>	<p>PR: 18.</p> <p>18. Policy outcome: Reduced out-of-pocket payments for healthcare and improved access to healthcare services RR: 18.1., 18.2.</p> <p>Health sector budget expenditure on core functions (Ministry of Health expenditure on core functions, excluding expenditure on EU - funded health sector projects) (% of GDP) – 6</p> <p>8.2. Share of direct household payments in total health expenditure (source: Eurostat)* – 33</p> <p>PR: 19.</p> <p>19. Policy outcome: Improved quality and efficiency of healthcare</p> <p>RR: 19.6.</p> <p>19.6. preventable mortality per 100,000 population (source: SPKC)* – 179</p>	<p>Additional funding included in the Protection and Labour Market Policy Guidelines for 2021–2027, Task 2.4.6</p> <p>[71]</p>

No.	Measure	Outcome	Institutions
3.5.	<p>[PRIORITY] Establishment of funding allocation criteria, including based on the number of participants, and systematic financial support for the organisation of sports and active lifestyle activities for children, young people, students, adults, older people and people with disabilities, promoting the development of an inclusive and socially responsible sports sector.</p>	<p>Deadline: 2023–2027.</p>	<p><i>Responsible:</i> MoES</p> <p><i>Co-responsible:</i> Local authorities, LSFP, LOK, LTSA, Recognised sports federations, NGOs, ELA</p>

3.8.	Ensure the accessibility of Latvia's sporting heritage to the public, as well as promote the development of innovative technologies and solutions for sport and physical activity among children, young people, students, adults, older people and people with disabilities and provide financial support for the implementation of selected ideas.	Implementation period: 2022-2027.	<i>Responsible:</i> LSM <i>Co-responsible:</i> MoES LSFP MoE LIAA ELA
4.2.	[PRIORITY] To provide financial support to talented young people and adults with disabilities and national teams (including team sports) in their preparation for and participation in the Paralympic Games, European and World Championships (including qualifying tournaments), as well as other comparable sporting events.	Deadline: 2022-2027.	<i>Responsible:</i> MoES <i>Co-responsible:</i> MoW LPK Adapted Sports Federations LNSF LSO LSFP Sports Federations Local authorities



This report was developed and this publication prepared as part of the project “Promoting Technical Standards for Assistive Technologies in European Social Care Services” (TechSocialcare). The project is financially supported by the INTERREG EUROPE programme for 2021–2027. This material has been produced with the financial support of the European Union. The Vidzeme Planning Region is solely responsible for its content, and it cannot be used to reflect the views of the European Union.



Vidzeme Planning Region

2026