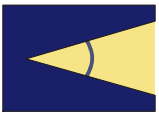
European Observatory on Health Care Systems



Health Care Systems in Transition

Latvia

The European Observatory on Health Care Systems is a partnership between the World Health Organization Regional Office for Europe, the Government of Greece, the Government of Norway, the Government of Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

Health Care Systems in Transition

Latvia

2001

AMS 5012668 (LVA)
Target 19
2001

Target 19 – RESEARCH AND KNOWLEDGE FOR HEALTH
By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.
By the year 2005, all Member States should have health research, information and communication systems that better support the acquisition, effective utilization, and dissemination of knowledge to support health for all.

Keywords

DELIVERY OF HEALTH CARE
EVALUATION STUDIES
FINANCING, HEALTH
HEALTH CARE REFORM
HEALTH SYSTEM PLANS – organization and administration
LATVIA

European Observatory on Health Care Systems
WHO Regional Office for Europe
Government of Greece
Government of Norway
Government of Spain
European Investment Bank
The Open Society Institute
World Bank
London School of Economics and Political Science
London School of Hygiene & Tropical Medicine

Contents

Foreword

The Health Care Systems in Transition (HiT) profiles are country-based reports that provide an analytical description of each health care system and of reform initiatives in progress or under development. The HiTs are a key element that underpins the work of the European Observatory on Health Care Systems.

The Observatory is a unique undertaking that brings together WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine. This partnership supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe.

The aim of the HiT initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond. The HiT profiles are building blocks that can be used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe accurately the process and content of health care reform programmes and their implementation;
- highlight common challenges and areas that require more in-depth analysis;
- provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in the different countries of the European Region.

The HiT profiles are produced by country experts in collaboration with the research directors and staff of the European Observatory on Health Care Systems. In order to maximize comparability between countries, a standard template and questionnaire have been used. These provide detailed guidelines

and specific questions, definitions and examples to assist in the process of developing a HiT. Quantitative data on health services are based on a number of different sources in particular the WHO Regional Office for Europe health for all database, Organisation for Economic Cooperation and Development (OECD) Health Data and the World Bank.

Compiling the HiT profiles poses a number of methodological problems. In many countries, there is relatively little information available on the health care system and the impact of reforms. Most of the information in the HiTs is based on material submitted by individual experts in the respective countries, which is externally reviewed by experts in the field. Nonetheless, some statements and judgements may be coloured by personal interpretation. In addition, the absence of a single agreed terminology to cover the wide diversity of systems in the European Region means that variations in understanding and interpretation may occur. A set of common definitions has been developed in an attempt to overcome this, but some discrepancies may persist. These problems are inherent in any attempt to study health care systems on a comparative basis.

The HiT profiles provide a source of descriptive, up-to-date and comparative information on health care systems, which it is hoped will enable policy-makers to learn from key experiences relevant to their own national situation. They also constitute a comprehensive information source on which to base more in-depth comparative analysis of reforms. This series is an ongoing initiative. It is being extended to cover all the countries of Europe and material will be updated at regular intervals, allowing reforms to be monitored in the longer term. HiTs are also available on the Observatory's website at http://www.observatory.dk.

Acknowledgements

The HiT on Latvia was written by Jautrite Karaskevica and team (Health Statistics and Medical Technology Agency, Latvia) and Ellie Tragakes (European Observatory on Health Care Systems). The assistance of Daina Biezaite (WHO Liaison Office, Latvia) is gratefully acknowledged. The following persons also assisted: Milda Bistere, Girts Brigis (Medical Academy of Latvia), Ainars Civcs (Ministry of Welfare, Latvia), Egita Kikuste (Riga Regional Sickness Fund), Aigars Miezitis (Ministry of Welfare, Latvia), Renate Pupele (Riga Regional Sickness Fund) and Evita Zusmane (Ziemelaustrumu Sickness Fund).

The HiT draws upon an earlier draft written by Barba Tuzika and Margarita Korzane (Health Statistics and Medical Technology Agency), as well as an earlier edition (1996) written by Ieva Marga (Ministry of Welfare, Latvia) and edited by Tom Marshall.

The European Observatory on Health Care Systems is grateful to Girts Brigis (Medical Academy of Latvia), Ainars Civcs (Ministry of Welfare, Latvia), Toomas Palu (World Bank) and Aiga Rurane (WHO Liaison Office, Latvia) for reviewing the HiT. We are also grateful to the Latvian Ministry of Welfare and the State Compulsory Health Insurance Agency (SCHIA) for their support.

The current series of the Health Care Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Care Systems.

The European Observatory on Health Care Systems is a partnership between the WHO Regional Office for Europe, the Governments of Greece, Norway and Spain, the European Investment Bank, the Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team working on the HiT profiles is led by Josep Figueras, Head of the Secretariat, and the research directors Martin McKee, Elias

Mossialos and Richard Saltman. Technical coordination is by Suszy Lessof. The series editors are Reinhard Busse, Anna Dixon, Judith Healy, Laura MacLehose, Ana Rico, Sarah Thomson and Ellie Tragakes. The research director for the HiT on Latvia was Josep Figueras.

Administrative support, design and production of the HiTs has been undertaken by a team led by Myriam Andersen, and comprising Anna Maresso, Caroline White, Wendy Wisbaum and Shirley and Johannes Frederiksen. Special thanks are extended to the WHO Regional Office for Europe health for all database from which data on health services were extracted; to the OECD for the data on health services in western Europe, and to the World Bank for the data on health expenditure in central and eastern European (CEE) countries. Thanks are also due to national statistical offices which have provided national data.

Introduction and historical background

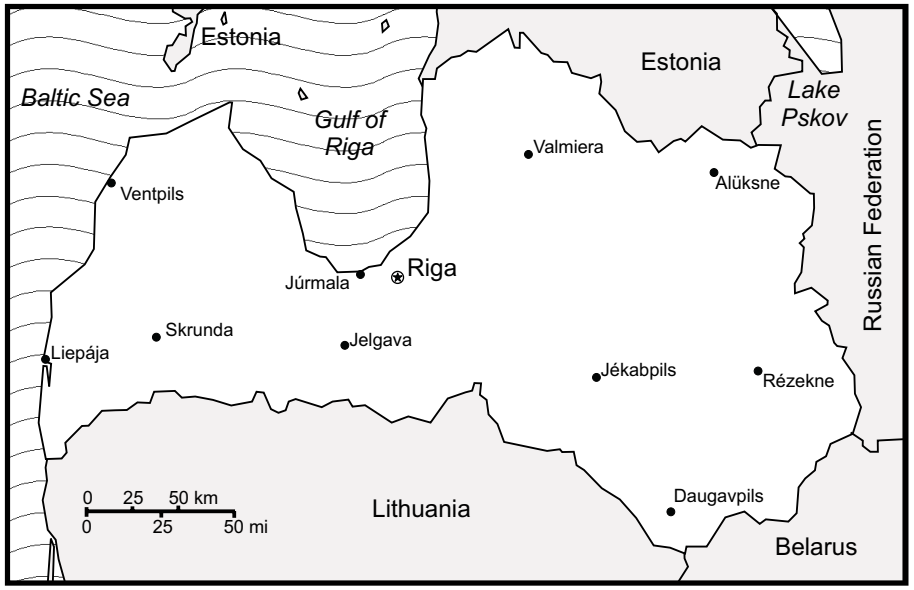
Introductory overview

The Republic of Latvia is located on the eastern Baltic coast, bordered by Estonia to the north, the Russian Federation to the east, Lithuania to the south and Belarus to the south west. It is strategically located between the Commonwealth of Independent States (CIS), western Europe and Scandinavia. It covers 64 589 km^2, with a flat landscape and extensive forests covering 44% of the land area and forming Latvia's most important natural resource. Before the occupation of Latvia in 1940, the country's territory was 65 800 km^2 but in 1944 part of the Abrene district was annexed to the territory of the Russian Federation. Extensive ecological damage was caused during the Soviet period, particularly by pollution from military installations. In 1998 the forested area covered 2838 thousand hectares. The highest point in Latvia, 311.6 metres above sea level, is Gaizinkalns in the district of Madonas. The average elevation of Latvia is 87 metres above the sea level.

Latvia is a parliamentary republic governed by the State President and parliament (*Saeima*). The national currency is the Lat (LVL), which replaced the Latvian rouble in 1993. The state language is Latvian.

During the middles ages, Latvia was a prime target for acquisition by foreign powers due to its strategic location for commerce. In the thirteenth century it was conquered by German Teutonic knights, and in the sixteenth century it was divided between Sweden and the Polish-Lithuanian empire. Under Swedish rule there was social reform and economic development, including the development of industry and particularly shipbuilding and metal casting. Most of Latvia became part of the Russian empire in the eighteenth century. By the early 1920s, living standards in Latvia were comparable to those of Scandinavian countries. The Russian Revolution of 1905 advanced the drive toward Latvian self-determination. Economic success in Latvia and turmoil in Russia after the 1917 revolution worked to encourage Latvia's independence movement. Latvia

Fig. 1. Map of Latvia[1]



Source: Central Intelligence Agency, The World Factbook, 2000.

declared its independence in 1918 and joined the League of Nations in 1921. Following the eviction first of Bolshevik and later German troops by the nationalist government under Karlis Ulmanis, Latvia became a democratic parliamentary republic by its constitution of 1922. However, its independence was short-lived, as the Treaty of Non-Aggression between the Soviet Union and Germany placed the Baltic states under the Soviet sphere of influence. Following Soviet occupation in 1940, Latvia was annexed by the USSR and became the Latvian Socialist Soviet Republic. Invasion by the Germans in 1941 resulted in loss of Soviet control. This was regained in 1944 following which Latvia's social, political and economic development was integrated into the Soviet system, including mass industrialization and collectivization of agriculture. All political parties were banned and the Latvian Communist party exercised complete control of power.

[1] The maps presented in this document do not imply the expression of any opinion whatsoever on the part of the Secretariat of the European Observatory on Health Care Systems or its partners concerning the legal status of any country, territory, city or area or of its authorities or concerning the delimitations of its frontiers or boundaries.

In late 1988 the Latvian Popular Front (LTF) held an inaugural congress, and the Latvian National Independence Movement was formed. In July 1989 the Latvian Supreme Soviet (parliament) declared Latvian sovereignty and economic independence. In May 1990 the LTF won a majority in the election to the Supreme Soviet, otherwise known as Supreme Council, and reinstated the 1922 constitution while declaring the Soviet annexation illegal. A referendum held in March 1991 resulted in a 73.7% vote in favour of independence. Latvia declared itself independent on 21 August 1991.

Latvia's present constitution is a revised version of the constitution of 1922. It now has a 100-seat unicameral parliament (*Saeima*) (corresponding to Latvia's parliament before the Second World War) which replaced the 210-seat Supreme Council since June 1993. Elections are by proportional representation, with a political party needing at least 5% of the total vote to enter the *Saeima*. Since 1997 the parliamentary term is four years, while the president's term in office is three. The president is elected by the *Saeima*, by secret ballot. Though the president's role is mainly ceremonial, he or she is head of the armed forces and exercises substantial authority in both domestic and political affairs. The president appoints the prime minister who must produce a government acceptable to the *Saeima*.

As of early 1999, Latvia had 48 registered political parties. Of these, seven are represented in the *Saeima* following the legislative elections of October 1998 (though one of these holds only one seat). Turnout in the seventh parliamentary election involved 71.9% of all eligible citizens of Latvia. As the term of office of the State President Guntis Ulmanis had expired, the *Saeima* elected Mrs Vaira Vike-Freiberga as the new President of the State who assumed office on 8 July 1999. The prime minister (as of 16 July 1999) is Andris Skele. The next elections are scheduled for June 2002 (presidential) and October 2002 (legislative).

Latvia is administratively divided into 26 districts and 7 cities (the district level) and 483 municipalities (*pagasts*). The last administrative reform determining the present administrative structure was initiated in 1993. Since then, some municipalities have voluntarily merged. The number of municipalities is to decrease under regional reforms scheduled to be completed by 2003.

Latvia had an estimated population of 2.35 million in 2000 (according to the 2000 census), down by over 10% since 1992. The population declined in the first half of the 1990s as a result of a decrease in the birth rate and a simultaneous increase in the death rate. A slight population increase in recent years is due to a lower death rate. About 72% of the population live in urban areas. Riga, the capital, has a population of 856 000; the two next biggest cities are Daugavpils and Liepâja. The population density of 40 persons per km^2 is below

Table 1. Key demographic indicators, 1990–1998

Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Birth rate per 1000 population	14.20	13.01	12.00	10.35	9.52	8.58	7.94	7.63	7.52	7.98
Crude death rate per 1000 population	13.03	13.06	13.46	15.17	16.39	15.48	13.78	13.58	13.97	13.51
Population growth rate per 1000	1.17	-0.05	-1.46	-4.82	-6.87	-6.90	-5.84	-5.95	-6.45	-5.51
Total fertility rate	2.02	1.86	1.73	1.51	1.39	1.25	1.16	1.11	1.09	1.15
Percent of population aged 0–14 years	21.48	21.48	21.37	21.14	20.87	20.55	20.10	19.56	18.89	18.18
Percent of population aged 65+ years	12.00	12.17	12.49	12.90	13.23	13.50	13.81	14.13	14.39	14.52

Source: WHO Regional Office for Europe health for all database.

the western European average. The proportion of the elderly (65+) in the population is under 15% and has been increasing since 1987.

The ethnic composition of the population changed significantly since the Soviet occupation as a result of mass deportation of Latvians and immigration of Russians into Latvia. Before the Soviet occupation, Latvians accounted for 77% of the population; this figure dropped to 52% by 1989 and by 1999 increased to 55.7% mainly due to net emigration of non-Latvians. The largest non-Latvian ethnic group is Russian (32.3%) followed by Belarusian (3.9%), Ukrainian (2.9%), Polish (2.2%) and Lithuanian (1.3%). Other ethnic groups, each with less than 1% of the population, include Jews, Gypsies, Estonians and Germans. A controversial citizenship law restricting naturalization to specific age groups each year was passed in 1994, as a result of fears that Latvians may become a minority in their own country. The law was liberalized in 1998 due to the need to solve the problem of the large proportion of foreign (non-citizen) residents in Latvia, however issues of citizenship persist.

While the state language is Latvian, Russian is the first language for 42% of the population. The main religions are Lutheran (the largest proportion) and Roman Catholic.

The Latvian economy was severely affected by the collapse of the Soviet economy. GDP started to fall in 1990, and in 1992 – the year it bottomed – it fell by nearly 35% in real terms. The economy recovered in 1994 and registered positive growth of 0.6%. This was followed by a banking collapse in 1995 with profound disruptions, prompting International Monetary Fund (IMF) assistance in the form of a US $45 million credit. Positive growth resumed once again in 1996 with manufacturing output registering growth for the first time since independence. GDP growth has been positive for most of the

subsequent years, with the exception of 1999 due in part to the Russian crisis in the summer of 1998, which resulted in a collapse of exports to the Russian Federation, one of Latvia's most important foreign markets. Unemployment, which had risen continuously since 1992, reached 9.2% in 1998; according to the Ministry of Finance it stood at 10.1% in May 1999. By the end of 1999 Latvia was emerging from its recession and registered a moderate recovery in 2000.

Following independence in 1991, the government began a programme of economic reforms, including the establishment of an independent central bank, the introduction of an independent currency (the Lat), price liberalization, land reforms and privatization. Successive governments have pursued sound economic policies since 1995, involving tight monetary and fiscal targets and tight control of bank lending.

The transformation of the economy has proceeded faster and further in Latvia than in most other countries of the former Soviet Union, with a rapid expansion of the services sector at the expense of both agriculture and industry. The share of agriculture fell from 21% in 1990 to 6.8% in the first nine months of 1998. Due in part to small farm size, agriculture remains inefficient. Latvian industry during the Soviet period provided the Soviet Union with radios, telephones, minibuses and other equipment, but was unable to stand up to international competition following the collapse of the Soviet market in the early 1990s. More recently machine-building has made some headway in niche markets and light industry has recovered somewhat, but both these remain heavily dependent on eastern markets. The services sector by contrast has been growing rapidly, with its share of GDP growing from 48% in 1992 to 64% in the first nine months of 1998. Factors behind this growth have been the rapid expansion in transport and communications, financial services growth, and growth and modernization of the trade sector. In 1998, of the three Baltic states, Latvia had the largest volume of exports to the European Union.

While the private sector share in the economy has grown from near zero in the late 1980s to 63% in 1997, accounting for 67% of employment the same year, Latvia lags behind the other two Baltic countries, mainly due to incomplete privatization.

In December 1999 Latvia signed a second agreement with the International Monetary Fund (IMF), as a means to obtain IMF endorsement of its economic policies. Latvia intends to streamline state administration, improve tax collection, put the pension system on a sounder financial footing, and continue with its structural reform programme, including privatization of the remaining large state-owned companies.

Also in December 1999 Latvia received an invitation to start European Union accession negotiations. The government has begun preparing its position in 31 different policy areas affected by EU membership. Latvia will benefit from improved access to the large EU market, and will also be entitled to financial assistance from the EU's pre-accession funds.

Trends in life expectancy are similar to those in other eastern European countries. While Latvians have had one of the lowest life expectancies, this trend is now being reversed as a result of economic reforms and economic stabilization.

Infant mortality is still high though it has decreased slightly, from 15.7 per 1000 live births in 1991 to 11.3 in 1999. Maternal mortality is high and despite some fluctuations has shown a generally increasing trend since 1991, dropping somewhat to 41.2 per 100 000 in 1999.

The leading causes of death are diseases of the circulatory system, cancer and external causes. As in the other Baltic countries and the Russian Federation, there has been a sharp increase in mortality from injuries and poisoning in the first half of the 1990s, but this has declined since 1994. Similarly, suicides and homicides increased dramatically and peaked in 1993, but are now declining.

Table 2: Trends in mortality-based indicators, 1990–1998

Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Life expectancy at birth, in years	69.58	69.18	68.59	66.70	65.62	66.44	68.80	69.44	69.11	70.18
								(males)	64.50	64.75
								(females)	75.54	75.44
IMR, per 1000 live births	13.74	15.74	17.49	16.63	15.71	18.85	15.92	15.35	14.99	11.29
UFMR, per 1000 live births	17.68	19.85	21.07	20.86	18.92	22.02	19.71	18.18	18.72	13.67
MMR, per 100 000 live births	23.74	31.76	41.18	29.90	57.72	37.05	40.44	42.49	48.89	41.25
SDR, circ. system diseases, 0–64, per 100 000 pop.	180.53	181.59	204.93	250.62	282.68	260.57	205.94	180.36	186.98	165.20
SDR, cancer, 0–64, per 100 000 pop.	111.90	114.24	114.71	111.53	109.32	107.08	107.88	105.43	103.45	103.07
SDR, injury and poisoning, all ages, per 100 000 pop.	138.38	156.37	168.46	211.17	235.41	204.90	154.48	154.73	158.67	156.60

Source: WHO Regional Office for Europe health for all database.

Since 1989, there has been an alarming increase in tuberculosis in Latvia. The number of reported cases of diphtheria is still high, with 67 new cases registered in 1998, compared to 42 cases in 1997. In the same period the number of diphtheria carriers has increased 2.9 times. This situation is especially disturbing since the diphtheria vaccine is free-of-charge. There is also an

increase in the HIV/AIDS incidence among intravenous drug users, causing the overall AIDS rate to increase rapidly. In 1998, there were 163 new cases of HIV and 11 AIDS cases. At the end of 1998, 251 cumulative cases of HIV were registered. Further, morbidity and mortality from tick-borne encephalitis (TBE) have significantly increased over the past few years. Since 1990 the incidence of TBE has increased four times. Latvia is also burdened with a relatively high prevalence of smoking and alcohol consumption.

Historical background

During the twentieth century the Latvian health care system, along with the country's political and economic situation, has changed several times. In the beginning of the century Latvia was part of the Russian empire. Health services were provided by private practitioners and costs were covered mainly by patients. Employers, landowners and communities were responsible for the care of the poor. The first sickness funds appeared before the First World War when the Employee Insurance Law was enacted. The law had been debated for a long time and had a number of disadvantages; in particular it restricted the rights and autonomy of sickness funds. It was revised and democratized in 1917 by the Temporary Government of Russia and became the basis for establishing a health insurance system during the years of Latvia's First Republic, between the First and Second World Wars. A law requiring compulsory health insurance for employees was enacted in 1930. Separate laws regulated the insurance of farmers, soldiers and sailors. By 1930 the entire employed urban and rural population had insurance cover.

The sickness funds were of three types: independent, occupational and territorial. They usually rented or owned health care facilities. Four types of health services were covered: emergency care, outpatient services (including visits at home), maternity care and hospital care. Some of them also offered additional services such as treatment at health resorts. Agreements to provide care were also made with physician associations or organizations, rather than directly with single practitioners. An exception was made for high-ranking specialists. In parallel to this there existed a network of private practitioners and private hospitals.

Between the end of the Second World War and Latvian independence in 1991, health care was planned along Soviet lines. Organization, management and delivery were undertaken by the state. The Ministry of Health held all legislative, executive and financial power. The system was characterized by a high level of centralization. Private initiatives were restricted. The health

strategy was directed towards supporting high-level specialization and scientific work as well as construction of enormous facilities. Primary health care, especially in remote areas, deteriorated. This was also a time when the social standing of health professionals declined. Under the Soviet system, all services were free-of-charge and generally accessible to the whole population. The main exception was those services arranged for the ruling elite. Separate outpatient clinics, hospitals and spa institutions were established for Communist party officials, and representatives of the government and their families. These had better facilities for diagnosis and treatment and were better supplied with pharmaceuticals.

In 1988 the Latvian Physicians' Association was re-established and went on to play a significant role in the introductory process of health care reforms. Its initial efforts were directed towards increasing physician autonomy and improving the status of the medical profession and income of physicians.

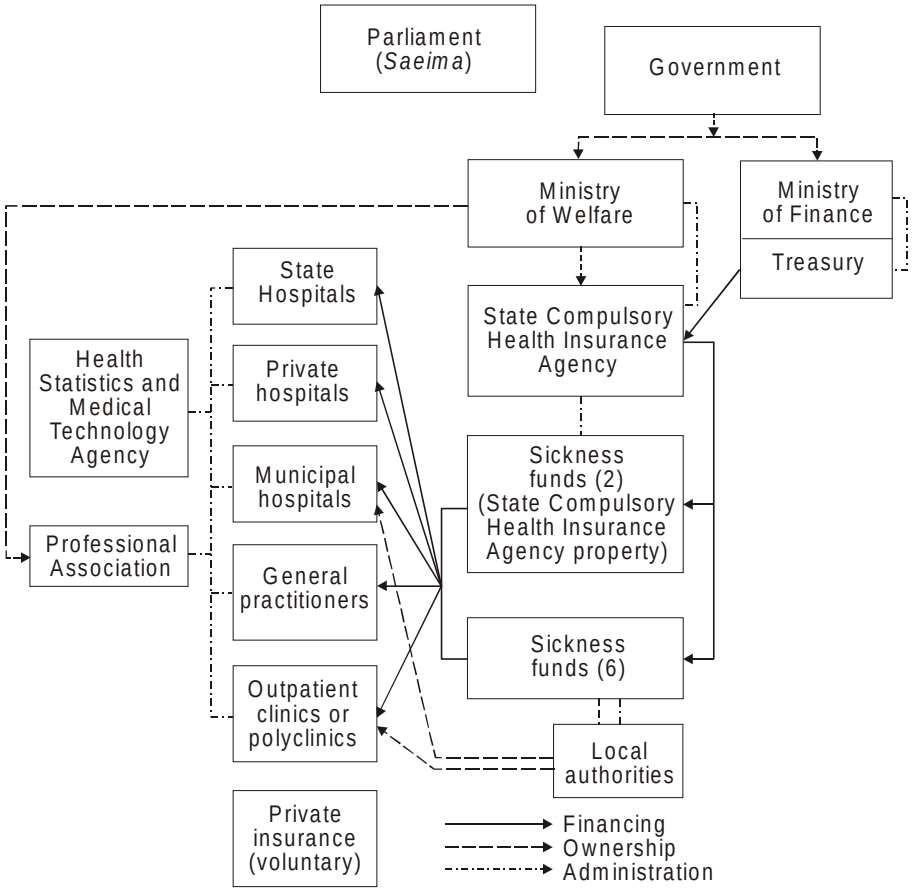
Since independence from the Soviet Union in 1991, the administrative structure of health care management has been changed several times. In 1993 the Ministries of Health, Labour and Social Welfare were merged into the Ministry of Welfare. Within the Ministry ongoing changes were initiated. Sickness funds were re-established in 1994 to provided funds for health services (though these are not funded from insurance contributions). In 1998 the State Compulsory Health Insurance Agency was established.

After enactment of legislation "On Local Governments" in 1993, most of the responsibility for providing primary and secondary health care services was delegated to the local governments. Specialized services remained the responsibility of the state. Health care reforms have further centred on the development of primary health care based on general practice.

Organizational structure and management

Organizational structure of the health care system

Fig. 2. Organizational chart of the health care system

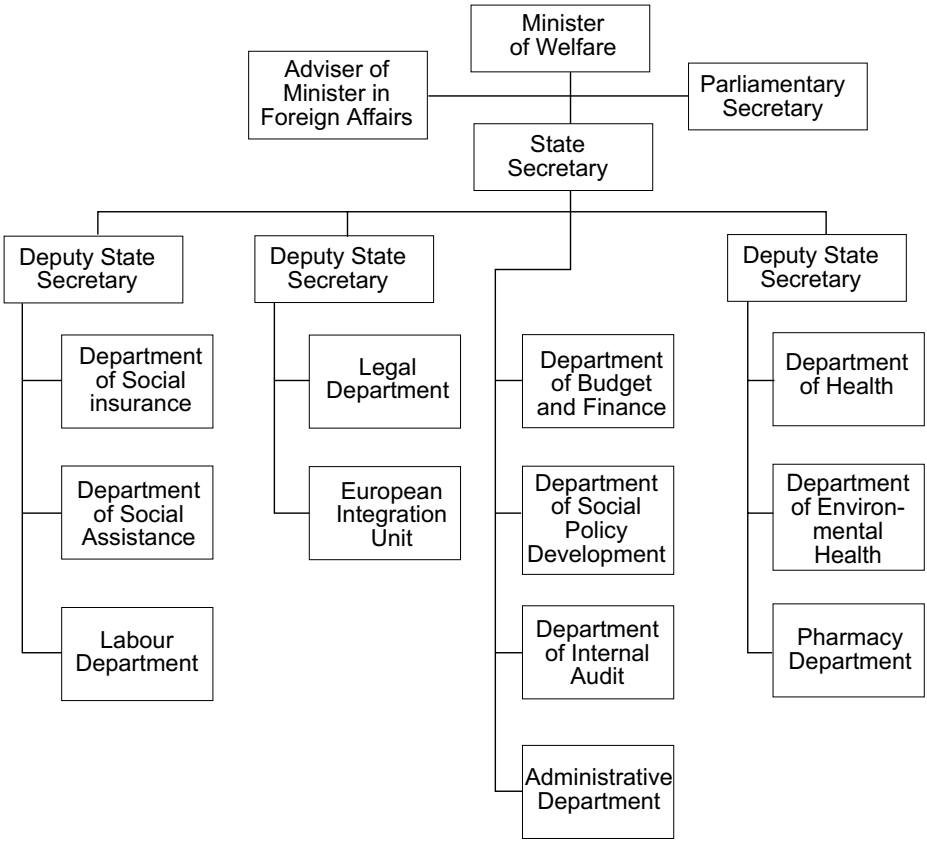


Responsibility for provision of health care services is divided between the Ministry of Welfare and municipalities (shown as local authorities in Fig. 2), with the largest part being under municipal administration. The basic principles of health care organization are decentralization and expanding the role of local structures.

Ministry of Welfare

In 1993 the Ministries of Health, Labour and Social Welfare were united to form the Ministry of Welfare.

Fig. 3. Structure of the Ministry of Welfare



Within the Ministry of Welfare there are three divisions responsible for health, headed by a Deputy State Secretary: the Department of Health with main resonsibility for health care strategy and policy, the Department of Public Health, and the Department of Pharmacy (see Fig. 3).

The Department of Health is divided into four separate units: Medical Care Supervision, Technology, Health Care Policy, and Health Evaluation. The department is responsible for specialized medical and diagnostic centres (including centres of infectious diseases, tuberculosis, oncology and mental health), the Health Statistics and Medical Technology Agency, several tertiary hospitals, institutions for medical research and education, and others. In addition it is responsible for legislation, it coordinates legislative acts in accordance with European Union standards, and plans government-supported medical staff training.

Many of the functions formerly carried out by the Department of Health have been delegated to the following institutions: the State Compulsory Health Insurance Agency (SCHIA), the Health Statistics and Medical Technology Agency, the Expert Commission for Health and Working Ability and the Health Care and Quality Control Inspectorate. These functions included making proposals for financing of capital investments, responsibility for the state programmes for health care (see the section on *Health care benefits and rationing* for a discussion of state programmes), formulating guidelines for training programmes and human resource development, writing the Health Statistical Reports, organizing registration of health professionals, quality control and others.

The Department of Public Health is divided into two units: the public health policy and the environmental risk monitoring units. It responsible for: legislation, management and priority setting in environmental health, health promotion, management of hygienic and epidemiological inspections, and defining sanitary norms. For years, the main institutions in the field of environmental health and sanitary control had been the National Environmental Health Centre in Riga and 25 regional environmental health centres. This system was reorganized in 1997 with the establishment of the State Sanitary Inspectorate, which supervises compliance with legislative and other regulations and is responsible for hygiene, environmental and food safety, and is under the jurisdiction of the Department of Public Health. Other institutions supervised by this department are the Food Centre (which coordinates food supervision), the Certification Centre (which evaluates compliance of food, cosmetics, toy and tobacco products with regulations), the AIDS Prevention Centre, and the Health Promotion Centre. This last centre develops and implements health promotion and disease prevention programmes on local, regional and national levels, organizes and

coordinates health education on regional and national levels attracting resources from local governments, NGOs and international organizations, provides general education about health issues and healthy lifestyles as well as specialized professional education, organizes seminars and conferences, publishes related literature, maintains databases related to health promotion and organizes and promotes scientific research. In addition, ten regional environmental health centres have been established.

The Department of Pharmacy is responsible for legislation and policy in the field of pharmaceuticals, and supervision and licensing of pharmaceutical services. It plays a role defined by (a) the Single Convention on Narcotic Drugs (1961), (b) the Convention on Psychotropic Substances (1971), and (c) the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988). It operates within the international system of drug control and carries out state policy in this area. The State Agency of Medicines controls quality of medicines and pharmacy products. It also registers pharmaceuticals and provides information about them. Regulation of pharmacies is the task of the State Pharmaceutical Inspection. The Medicines Pricing and Reimbursement Agency is responsible for carrying out a reform of drug reimbursement according to EU principles.

The Social Assistance Department of the Ministry of Welfare manages facilities for elderly and handicapped persons at the national level.

Other ministries

Several other ministries (Defense, Communications, and Internal Affairs) manage parallel networks of health care facilities of their own, to provide services for their employees. These provide the full range of services stipulated in the Basic Care Programme (see the section on *Health care benefits and rationing* for a full discussion of this). As these facilities are contracted by Regional Sickness Funds, the general population can also make use of them.

Local governments

A major shift toward decentralization has taken place since 1993. This has taken the form of devolution of powers to local governments. Following enactment of a Law on Local Governments in 1993, most of the responsibilities for provision of primary and secondary health care services were devolved to local governments. Specialized services remained the responsibility of the state.

Latvia is administratively divided into districts and municipalties. At the district level there are 26 districts and seven cities. The administrative districts

are the following: Tukuma, Rîgas, Jelgavas, Dobeles, Bauskas, Daugavpils, Krâslavas, Valkas, Cçsu, Gulbenes, Balvu, Alûksnes, Limbaþu, Madonas, Valmieras, Ogres, Aizkraukles, Preiïu, Jçkabpils, Liepâjas, Ventspils, Talsu, Saldus, Kuldîgas, Ludzas, Rçzeknes. The seven cities are: Rîga, Jelgava, Jûrmala, Daugavpils, Liepâja, Ventspils, Rçzekne. There are 483 municipalities with significant variations in terms of size of population, territory and population density.

The decentralization process that began in 1993 significantly expanded the roles of local governments in both financing and provision of health care services. However a recentralization of financing which took place in 1997 limited the role of local governments to provision only.

On the financing side, local account funds (otherwise known as territorial sickness funds) were established in each district and large city (i.e. the district level) in 1993. Funds for health care from the central level began to be administered by the districts and cities through the corresponding local account funds. One of the most important subsequent developments in the reform process, which began in the beginning of 1997, involved the recentralization of financial resources. The compulsory health insurance revenue base was defined to be an earmarked portion of centrally collected income tax plus a state subsidy financed by general tax revenues. In 1997/1998, the 32 local account funds merged into eight regional sickness funds (i.e. formed eight new enterprises) which took on the responsibility of distributing the state funds for health care. Thus the districts lost their financing role.

On the side of provision, local governments have maintained their role in accordance with the Law on Local Governments of 1993. Ownership of most primary and secondary health care facilities (with the exception of highly specialized institutions) has been transferred to the municipal level. Municipalities are responsible for assuring access to health care institutions as well as providing outpatient facilities, maintaining municipal hospitals, contributing to the improvement of primary health care and promoting healthy lifestyles, restricting alcoholism and ensuring public safety. District level responsibilities include ensuring the respective populations with access to health care institutions, provision of health care services, and establishing and maintaining medical institutions, old-age institutions, asylums for the homeless, as well as health and educational institutions and homes for orphan children.[2]

The role of local governments is seen as central to the development of primary health care, a cornerstone of the Latvian health care reform. Effective local government (municipal) cooperation with the network of primary care

[2] There appears to be some ambiguity in the 1993 legislation regarding a specific delineation of the respective responsibilities of districts and municipalities with respect to health care provision.

physicians and development of local infrastructure is expected to contribute significantly to the development of primary care and to the quality and accessibility of services to the entire population. Local governments are expected to determine the geographical location of health care institutions and doctors, to provide populations with local transport, etc.

The sickness funds

Changes introduced in 1993 were intended to change the financing of health care. Toward this end the Central Account Fund was established in 1993, together with local account funds in all districts and the seven largest towns. The Central Account Fund was renamed several times: State Sickness Fund, State Compulsory Health Insurance Central Fund, and most recently State Compulsory Health Insurance Agency (SCHIA, as it is now called). The local account funds became regional sickness funds in 1997/1998, following the recentralization of financing and their consequent reduction in number (see below).

In the period 1993–1997 there were 32 territorial sickness funds (based on administrative districts) and three additional branch funds, one each for the Departments of Interior, Sailors, and Railway. The large number of territorial sickness funds relative to the size of the country had proved problematic, however, as it had given rise to extreme fragmentation of the financial structure, an ineffective planning and coordination system, and decision-making based on political considerations. To address these problems, in 1997 the Cabinet of Ministers produced regulations "On the Establishment and Operation of Sickness Funds". Key provisions of these regulations are the following:

Para 2. A sickness fund is a local government enterprise or enterprise of more than one local government or limited company. It is a non-profit organization intended to provide state compulsory health insurance minimum services.

Para 3. The goal is to provide qualitative and accessible health care services to the sickness fund participants; to rationally procure services from health care facilities and pharmacies and to provide payment (for these services) from the state budget.

Para 10. The main functions of sickness funds are to:

10.1 provide finances for health care services designated by health care financial regulations

10.2 provide access to health care services especially to PHC

10.3 evaluate health care facility services, quality and prices

10.4 register sickness fund participants

10.5 sign contracts/agreements for the services of health care facilities and pharmacies

10.6 inform inhabitants about available services.

Para 11. The main rights of sickness funds are to (in order to facilitate the functions described in Para 10):

11.1 obtain information free of charge

11.2 control the use of finances as per contract

11.3 stop finances to the health care facility or pharmacy if the contract is not fulfilled

11.4 advertise open competitions for the right to sign a contract with the sickness fund for provision of services

11.5 stipulate type of service and payment quotas

11.6 complain to the Ministry of Welfare.

Para12. The main obligations of sickness fundes are to:

12.1 be responsible for the finances distributed by the central agency (State Compulsory Health Insurance Agency)

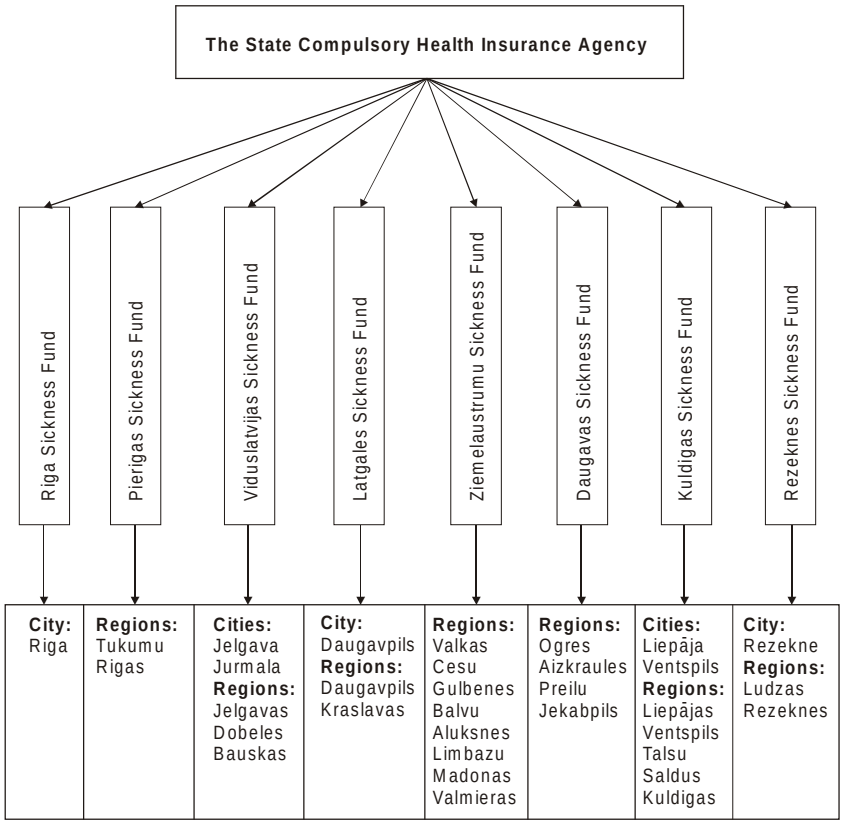
12.2 organize financial processes, undertake regular payments to health care facilities and pharmacies and monitor the rational and appropriate use of funds.

In accordance with the regulations, from the end of 1997 to the middle of 1998, the 32 local account funds became eight new enterprises, or regional sickness funds, each intended to cover a minimum of 200 000 persons. Collectively, these cover the 26 administrative districts and seven largest cities. Each regional sickness fund (except Riga) thus unites several administrative districts. These can be seen in Fig. 4, which shows the eight regional sickness funds and their district or city membership.

Six of the eight regional funds became non-profit, limited liability organizations under the jurisdiction of the municipalities of the corresponding region; the remaining two (the Kuldigas and Rezekness sickness funds), due to lack of agreement with the principles of sickness fund establishment, became local government non-profit enterprises under the authority of the State Compulsory Health Insurance Agency (SCHIA). As a result, while the first six are influenced by the municipalities, the latter two are influenced more by SCHIA/MOW policy.

The State Compulsory Health Insurance Agency (SCHIA) is under the jurisdiction of the Ministry of Welfare and operates in compliance with ministry

Fig. 4. Structure of membership of regional sickness funds



regulations on sickness funds. It receives the tax-financed budget allocation for health care and distributes it to the regional funds, which in turn make the allocations between primary and secondary care. In addition, the SCHIA is responsible for directly financing tertiary care and special state programmes in health care.

The eight regional sickness funds use the resources received from the SCHIA to purchase health care services for their respective populations and pay health care providers on the basis of contractual agreements. This financing procedure is confined to health care providers and institutions providing primary and secondary care services (the "Basic Care Programme", to be discussed in the section on *Health care benefits and rationing*). The SCHIA resources allocated to the regional sickness funds only finance health care provision; no funds are allocated for maintenance and capital investments. In the event that the sickness funds' revenues are greater than expenses, the difference is carried over to the next financial year for use in infrastructure development. Some municipalities

contribute further funds from their local budgets, mostly for the purposes of capital investments.

Additional responsibilities of regional sickness funds include ensuring access to primary care doctors, determining the number of independent practices, organizing courses for primary care doctors, and working on the improvement of health care institutions in collaboration with local governments (regional sickness funds themselves, as noted earlier, do not finance capital investments).

Regional sickness funds have district offices employing two to four persons involved with data collection for the regional funds (the third, or bottom level of the structure shown in Fig. 4). Each district has to have a representative on the board of the regional sickness fund. In this way each district's needs are presented to the board. In reality, how strongly the needs of the district are put forward and defended depends on the individual representative and his/her own knowledge of health and health care in general and knowledge of the district's needs, as well as the needs of the municipalities corresponding to the district.

Registration of sickness fund members was initiated in 1998. The register of fund members, showing numbers of inhabitants in each regional fund and their structure by age and sex, consists of the three levels shown in Fig. 4.

The SCHIA provides data for resource allocation to regional sickness funds, and ensures connections between sickness funds' databases and registers of health care personnel, the population and taxpayers. As the financing of regional sickness funds depends on the number of registered participants, it is important to eliminate the possibility of double-counting, etc.

At the regional level, the eight regional sickness funds calculate finances for primary and secondary health care**.** A regional database provides information flows from the local to the central base, and provides statistical reports regarding sickness fund participants.

Actual sickness fund registration takes place at the district level, at district sickness fund offices and large health care institutions. The main function of local registers is registration of primary care doctors working in the respective area, and of sickness fund participants. Local databases provide information for the regional database, maintain patient registers and provide patients with sickness fund registration cards.

Other agencies

The Expert Commission for Health and Working Ability, the State Sanitary Inspectorate, the State Pharmaceutical Inspectorate, and the State Compulsory Health Insurance Agency carry out the supervision of health services quality

control. These institutions have experts in regions and cities and work independently. Their findings may be appealed in the courts.

The State Agency of Medicines carries out registration of medical products, quality control of these products, import, export and transit control of pharmaceuticals, and participates in drafting regulatory requirements. It is also responsible for analysis of information on drugs and development of databases.

The Health Statistics Department of the Health Statistics and Medical Technology Agency collects statistics on health, provides data analysis, supervises the registers (of patients, physicians, etc.) and produces annual statistical reports on health.

The Medical Devices Registration Department of the Health Statistics and Medical Technologies Agency registers medical products and equipment used in Latvia. The Medical Technologies Department develops laboratory assessment criteria and assesses competency of laboratories. Certification of medical institutions started in 1997.

In 1988 the Latvian Physicians Association was re-established and later played a significant role in the introduction of health care reforms.

In 1997 the Hospital Union was established in order to promote organizational and managerial improvements in hospitals.

Professional health care associations evaluate and regulate qualifications and work quality of health care professionals, certify health care professionals, participate in evaluation of postgraduate education, keep abreast of scientific developments in specific specialties, and examine ethics issues in medicine.

The private sector

The private sector in Latvia includes institutions that have been privatized, namely many polyclinics and almost all dental practices and pharmacies, as well as some independent primary care practices which emerged following efforts in recent years to develop this form of institutional setting for primary health care. Private providers contract with sickness funds to provide services which are specified in the Basic Care Programme. In addition, they may offer services on a private basis.

The full range of primary health care services is available through private provision (i.e. through private, out-of-pocket payments). Services provided mainly in the private sector include certain advanced diagnostic services, spa treatment and psychotherapy. Almost all dental services and pharmacies have been privatized. A much smaller proportion of hospitals is privately owned.

The private (non-statutory) system offers high quality and freedom of choice for the patient but is financially out of reach for much of the population. (This topic is discussed in greater detail in the section on *Privatization* under *Decentralization of the health care system*.)

Planning, regulation and management

The priorities in health care were stated in a 1993 Decree of the Cabinet of Ministers. These are: maternal and child health; prevention and treatment of cancer, mental illness, respiratory, cardiovascular and infectious diseases, AIDS and diabetes; and accident prevention. In addition the Cabinet of Ministers adopted the Ministry of Welfare policy on health promotion and disease prevention in January 1994 whose broad objective is to be the promotion of primary health care as the basis for development of the health care system. The central persons in health promotion and disease prevention activities are to be general practitioners (or family doctors), nurses and midwives. This represents a shift from a disease-oriented system to a health-oriented one.

In 1996 the Cabinet of Ministers adopted the strategy for health care development in Latvia, delineating the following objectives:

- to ensure that all the people of Latvia have the potential to achieve their highest possible health status and to ensure access and equity in health care, so that each individual has the possibility to be responsible for and promote his/her own health;
- to stop the growth of chronic diseases and morbidity (invalidity), paying special attention to the problems of cardiovascular and oncological diseases;
- to reduce and, in certain target groups, eradicate the prevalence of infectious diseases;
- to stop the incidence of accidents or, at least in certain target groups, reduce the incidence;
- to improve the health of mothers and children;
- to improve the health of and quality of life of the disabled and to maintain life satisfaction of the elderly;
- to resolve mental health problems and, as a result, stem and reverse the increasing incidence of suicide;
- to provide quality health care to the military and associated organizations.

This strategy stated that the basic principles of health care are to be availability, acceptability, effectiveness, equity, social acceptability and appropriateness relative to local culture and traditions.

In accordance with the above, the Ministry of Welfare issued a regulation on 19 October 1999 entitled "Development strategy of primary and secondary health care". This forms the basis of the ministry's policy on development of primary and secondary care.

Health services provision is regulated by a number of pieces of legislation. These include the laws "On Medical Care" (1997) and "On Physicians' Practice" (1997). The range of primary and secondary care services to be included in statutory provision, "The Basic Care Programme" (1994) is defined by a separate regulation.

The Basic Care Programme was initially a Ministry of Welfare document defining the basic health care services to be guaranteed and covered by the state budget. In 1994 it was adopted as a Regulation by the Cabinet of Ministers. It defines a basket of health care services which are to be provided to all citizens of Latvia as well as foreigners who legally reside within Latvia. It specifies the basket of primary and secondary care services that are to be provided through state budget financing. The basket is examined and revised annually. Each year there appear new lists of exclusions. The Basic Care Programme used to be financed by district-level budgets through local account funds**.** Since 1997 it is paid for by the regional sickness funds on the basis of contracts with health care providers. (For more information see the section on *Health care benefits and rationing.*)

In 1998 the operation of medical institutions was determined to be a regulated area, and procedures for certifying medical institutions and regulations on compulsory requirements for medical institutions were approved. The Health Statistics and Medical Technology Agency was authorized to certify medical institutions, and certification procedures have started in the country. Certification of an institution provides more opportunities to request funding from the state. Legislative rules are intended to apply uniformly to activities of all health care institutions, and so the specific type of ownership of an institution is not relevant. Control ensuring the quality of health care is exercised by a public agency, the State Health Care Quality Control Authority, established specifically for this purpose.

Each department in the Ministry of Welfare is responsible for specific activities. The Department of Health is responsible for legislation and general health policy as well as for the coordination and supervision of health care at the national level. It supervises quality of health care and sets health care and

medical technologies' standards; it is responsible for legislation; coordinates legislative acts accordance with European Community standards; and plans government-supported medical staff training.

The Department of Public Health is responsible for legislation, management and priority setting in environmental health, health promotion, and the management of hygienic and epidemiological inspections; and defining sanitary norms. The National Environmental Health Centre, Health Promotion Centre, State Food Centre, and AIDS Prevention Centre are under the direct supervision of the Department of Public Health.

The Health Promotion Centre was established in 1996. Its main tasks are to raise public awareness on healthy life styles and to coordinate health promotion activities at national level.

The National Environmental Health Centre's main tasks are to implement policies in hygiene and epidemiology, to collect information, analyse and estimate the epidemiological situation in the country, to work out models which will supervise the epidemiological situation, and to establish and maintain an information system showing what kind of environmental factors could influence the population's health.

The Department of Pharmacy is responsible for legislation and policy in the field of pharmaceuticals, and supervision and licensing of pharmaceutical services. It operates within the international system of drug control and carries out state policy in this area. The State Agency of Medicines controls the quality of pharmaceuticals. It also registers pharmaceuticals and provides information about them. Regulation of pharmacies is the task of the State Pharmaceutical Inspection.

At the district/city level the regional sickness funds have complete responsibility for ensuring access to the services provided in the Basic Care Programme and hold all decision-making powers. This includes the appointment of health managers, contracting with providers, allocating resources, closing or opening clinics.

At the national level, the Quality Control Inspectorate investigates the performance of institutions or specialist care in general (as well as individual cases) in response to patients' complaints or at the request of the Health Department.

The Latvian health care system is based on the contract model: regional sickness funds make contracts with health care institutions and pay for the costs incurred in these institutions. There are no rules about which institutions the sickness funds must contract with, if there are two hospitals with similar

specialization. There have been suggestions to introduce competition or tenders, but no selection criteria have yet been developed. At the present time, new contracts show a preference for certified hospitals. As the regulations of the Cabinet of Ministers define standards for medical equipment, personnel and qualifications that must be met for certification of an institution, preference is given to hospitals with more advanced material equipment and certification.

Regulatory functions

Pharmaceuticals. Most pharmacies in Latvia are private. The number of pharmacies is not state-controlled, but rather regulated by the market**.**

High technology. Regulation in this area remains limited, with the result that there is a lack of coordination of purchases of equipment. For example, it is not uncommon for two hospitals in the same region to purchase the same expensive equipment. There are plans to have the regional sickness funds take on the tasks of supervision of high-technology purchases in the future.

Establishing standards. In 1996, a document entitled "Standards of Diagnostics and Treatment", based upon the recommendations of professional medical associations, was prepared by the Health Statistics and Medical Technology Agency and subsequently adopted by the Ministry of Welfare. Whereas the standards were initially declared mandatory for all health care institutions, in 1998 they were assigned the status of recommendations as it was realized that they were too stringent to be realistically met given the limited resources available to most institutions. The process of health care institution certification was initiated in 1997. This certification is regulated by rules of the Cabinet of Ministers. There are strict regulations for outpatient clinics, hospitals, emergency care centres, dental clinics, rehabilitation institutions and blood bank institutions. To date, many institutions remain uncertified due to their inability to carry out the necessary investments and attain the required standards (though the situation is better in the case of laboratories). The final deadline for certification has been changed several times, most recently for the year 2003. The issue of certification is a sensitive one, as closure of uncertified institutions can lead to unpredictable social problems.

Control of sickness funds. The State Compulsory Health Insurance Agency (SCHIA) supervises the regional sickness funds**.** It is itself managed by five administrators appointed by the Ministry of Welfare.

Control over health personnel. The main control is provided by certification. Every five years all physicians must pass a re-certification examination. Nurses are not yet covered. Employers usually give preference to personnel with certification. There is no other specific control.

Decentralization of the health care system

Several forms of decentralization have been applied in the reform process in Latvia. As the country's health care system prior to 1990 was only a very small part of the Soviet Union's highly centralized system, the scope of the changes has been significant.

Devolution

A major shift towards decentralization took place during the early 1990s. This has taken form of devolution of powers to local governments. Latvia is divided into 26 administrative districts and seven cities (the largest in the country). After enactment of a Law on Local Government in 1993, most of the responsibility for providing primary and secondary health care services was delegated to districts and municipalities. (Specialized services remained the responsibility of the state.)

In the period 1993–1997, each district (and large city) had its own local health care board (or health service authority) and sickness fund. Since 1993 when the reform started, some of the Ministry of Welfare functions were transferred to the local health care boards, which were responsible for planning and administration of health care. The local health care boards were financed through local governments at the district level through local account funds (which received their funds from the state budget). The local government councils appointed local health managers. Health care boards at the local level had the right to take all decisions about service provision: opening, closing or privatizing facilities, and allocating resources.

This process of devolution had some negative aspects. As payment for services was on the principle that the "money follows the patient", if the patient was referred to a facility outside the district, the facility had to invoice the district of residence through an "inter-territorial invoice". However, as money for health care formed about 85% of the local budget, both the local government council and the local health manager preferred to retain as much spending as possible within their own district and strengthen their own institutions. This meant that there was a reluctance to refer patients to other institutions even if the case required more specialized treatment, while individual districts tried to develop their own facilities. Access to diagnostic and medical equipment varied throughout the country. In addition, if the district-level government had extra resources, it could choose to cover services that were not included in the Basic Care Programme. The amount specified in the Basic Care Programme was LVL 21 per inhabitant per year (as of 1996). Some districts had more resources

than others, thus resulting in an unequal coverage of health care benefits across districts.

Further, the quality of services was not always adequate, as not all hospitals were appropriately equipped to ensure adequate inpatient care. Inter-territorial payments were also often delayed. Since patients could only choose a doctor from within their administrative territory, and the smaller districts, in rural areas, usually had only one of each kind of specialist, there was in effect sometimes no choice at all. Neither local political structures nor health managers had expressed any interest in inter-territorial cooperation. All decisions about resource allocation were made at the local level. As a result the overall number of hospitals (and hospital beds) remained too high and quality of services too low.

In 1997 there occurred a recentralization of health care financing. The districts stopped receiving funds for health care services provision (for more information see the section on *Main system of finance and coverage*). As of that time, funding for health care (specifically the Basic Care Programme, comprising primary and secondary care services) is no longer channelled to local governments, but is now distributed to regional sickness funds through the State Compulsory Health Insurance Agency, on the principle of equal financing per capita. All inhabitants receive an equal amount per capita in the whole country. Extra resources from municipalities for health needs can come from local taxes, but it is a business of the municipality how to spend funds from local tax collection. Since 1997 the local governments are responsible only for health care provision.

In addition, since 1997, the local health boards have been disbanded. At the present time, therefore, not all local governments have an individual or committee that is responsible for health. This has contributed to weakening the position of health in the local government agendas, and has had a negative impact particularly in the area of investments and infrastructure development which could have been financed from municipal budgets.

At present there are calls for re-centralization to proceed further. The major reason for this involves the rational use of state funds for the procurement of high technology equipment.

Delegation

Certification of health professionals has been delegated to the professional associations. Each medical specialty and sub-specialty is represented in the Latvian Physicians' Association and elects a certification committee. It is intended to establish a similar system for nurses. The Association of Physicians organizes postgraduate studies for physicians. The functions of health statistics,

Table 3. Trends in privatization of health care institutions

	1993	1996	1997	1998	1999
Physicians joint (group) practice (private)	–	4	4	7	7
Physicians (solo) practice (private)	–	35	78	139	166
Dentistry practice (private)	–	9	29	82	212
Total number of dentistry institutions	2	79	81	91	103
Total number of private hospitals	–	–	–	7	10
Number of beds in the private hospitals	–	–	–	389	509

Source: Yearbooks of Health Statistics, Latvia, 1999.

information and health technology assessment have also been delegated to the Health Statistics and Medical Technology Agency.

Some functions, mainly involving distribution of health care materials, are delegated to patients' organizations under the supervision of the Department of Health. The Red Cross has been given responsibility to organize the organ donors' movement.

Privatization

Since 1993, outpatient health care institutions have undergone a change in ownership from state institutions to either fully privatized institutions or non-profit state and municipal limited liability companies. In Riga City, there was a decision several years ago to fully privatize all polyclinics, and this has been partially implemented to date. Where full privatization has occured, primary health care providers are employees of the institution. In the cases where polyclinics have become non-profit state or municipal limited liability companies, while this is not real privatization, it does involve a different legal basis which allows the respective administration greater freedom in decision-making and resource allocation.

There is also a trend towards the privatization of certain other health care facilities. Almost all dental practices and pharmacies are private. Several sanatoria (spas) are being privatized, and there has been a small increase in the number of private hospitals. Table 3 shows the increase in private institutions since 1993.

The number of physician joint practices and solo practices constituted 15.6% of all outpatient care institutions in 1999. The private dentistry practices compose 67.3% of all dentistry institutions, which are mostly either solo or group practices. The total number of private hospitals increased from seven in 1998 to ten in 1999, constituting 6.6% of the total number of hospitals against 4.6% in 1998. The number of beds has increased from 1.7% to 2.4% in 1999.

The Law on Physicians Practice enacted in 1997 was intended to encourage the development of independent primary care practices. The law states that the primary care physician is an independent profession, and is to form the basis of health care. The law specifies the primary care physician's work, financial activities, rights, responsibilities, patient registration, cooperation, practice registration and certification.

However, privatization of physician practices has not proceeded as rapidly as was hoped, mainly due to financial constraints (low physician income, high interest rates on bank loans), the uncertainties associated with establishing a practice, as well as administrative barriers and incomplete legislation. Some projects (for example in collaboration with EU/PHARE) have attempted to pilot and further the establishment of independent physician practices.

Physicians in private practice use their own medical equipment, unless the practice is located in an outpatient clinic (i.e. a polyclinic). If the private practice is located in an outpatient clinic, then physicians use outpatient clinics' medical diagnostic equipment. This is agreed upon by contract between the outpatient clinic's chief and the physician who has the private practice. Private physicians rent the space in the outpatient clinic. Private hospitals use their own medical equipment.

Health care finance and expenditure

Main system of finance and coverage

Whereas Latvia has established an organizational structure consisting of a central sickness fund (the State Compulsory Health Insurance Agency) with its regional satellites, health care services continue to be financed through a national, tax-funded system.

Financing prior to 1997

In 1991 and 1992, a number of articles appeared in the medical press describing the principles of reimbursement based on the points system, and included examples of calculations. The architects of the reform, making a distinction between the source of health care financing and payment mechanisms, argued that the first could help increase the total amount of resources available for health care, and the second could increase the efficiency of resource use. They proposed two possible courses of action: radical change involving the simultaneous introduction of social health insurance and new payment mechanisms, and a slower step-by-step approach which initially would involve the introduction of new payment mechanisms (specifically payment per manipulation).

A decision in favour of gradual change was finally adopted, on the grounds that the legislative basis for change was weak, and upcoming parliamentary (*Saeima*) elections (June 1993) made legislators cautious.

The first major changes were initiated in 1993. The Central Account Fund (later the State Sickness Fund and, still later, the State Compulsory Health Insurance Agency) was set up, with the mandate to continue the health care reform, elaborate upon strategically important documents (for example, formulate bylaws for territorial sickness funds, revise criteria for the establishment of the points system), and pool funds to be distributed to the districts through local account or territorial sickness funds. The local account

funds, one in each of the country's administrative districts began to be established. In the initial stages participation by local governments (districts) in setting up local account funds was voluntary, and was promoted on the grounds of increased efficiency in the use of financial resources.

Starting in 1993 (and until 1997), the total budget for health care was divided into the state budget, which was managed by Ministry of Welfare, and local government budgets (also financed from central government revenues), which were administered by district-level and city governments through their corresponding territorial sickness funds. These financial resources were used to finance two programmes in health care as follows:

- the state programme for health care financed from the state budget, through central government revenues, including tertiary care, specialized treatment of tuberculosis, the treatment of mental illness, oncology services and other services provided in state-owned hospitals;
- the Basic Care Programme (primary and secondary health care) financed from local government budgets through a budget administered by each of the 32 territorial sickness funds, as well as state budget subsidies.

In addition, payment per act was introduced for primary and secondary health care in municipal health care institutions throughout the greater part of the country. Several districts, mainly in the western part of the country, opposed this payment system and adopted instead capitation for primary care and global budgeting for specialized hospital departments. The Central Account Fund was not opposed to capitation in principle, but argued that its adoption required patient registration, sufficient numbers of general practitioners, etc., and should therefore be considered as a payment mechanism in a later phase of health care reform.

In 1994 the Central Account Fund was re-named and became the State Sickness Fund, probably in anticipation of a change in responsibilities from redistributing financial resources to collecting them. (This change in responsibilities has not materialized.) Discussions at this time included issues such as the managerial aspects of health insurance, the possible co-existence of compulsory and complementary health insurance, and the possible unification of payment systems for all health care institutions.

As a result of the changes that had been initiated in 1993, there had resulted a great diversity in the mechanisms of financing of health care, as well as variations in the amount of health care spending per capita. Funding for primary and secondary care through the local government budgets resulted in widely-differing amounts of health care spending per inhabitant. In the absence of sufficient financial resources, a district could even decrease its financing of

health care. In 1996 spending per inhabitant varied from LVL 14.63 in Daugavpils to LVL 28.79 in Ventspils. Equity had therefore been sacrificed for the sake of decentralization.

Legislation of 1996 entitled "On the State Budget for 1996" specified LVL 21 per inhabitant per year as the minimum level of spending in the Basic Care Programme. Districts could spend more than this but not less. If the district-level government had excess resources, it could choose to cover services that were not included in the Basic Care Programme. As a result, since some districts had more resources than others, the problem of unequal coverage of health care benefits among districts continued.

In addition, the banking crisis that occurred in the mid-1990s (involving the failure of the largest commercial bank) gave rise to serious difficulties. Some local governments refused to pay their corresponding territorial sickness funds even the minimum specified by law. The territorial sickness funds were only able to pay for a portion of health care services, first paying local hospitals and polyclinics, and remaining indebted to state institutions. At about this time, the Cabinet of Ministers introduced regulations concerning co-payments in the Basic Care Programme.

By 1996, the main defects of the decentralized system of financing had become apparent:

- Major differences across districts in health care services delivered had arisen due to differences in spending per capita;
- The autonomous management of each territorial sickness fund gave rise to problems in rationalization of resource allocation;
- Accounting processes in several territorial sickness funds were complicated;
- Patient choice of health care institutions was limited, as patients were limited to local institutions, especially hospitals.

The financing changes of 1997 and the present system

To address these difficulties, major changes in the system of health care financing were introduced in 1997. The most important of these involved the centralization of financial resources. The key objective was to introduce stable and equal financing per inhabitant in all the regions of the country, and provision of a particular level of health services for all.

In 1997, districts stopped receiving funds from the state budget for health, and all money began going through the State Sickness Fund. The State Sickness Fund in turn began distributing the money to the eight regional sickness funds. Allocation of the money to the regional sickness funds is according to the size

and age structure of the population. All inhabitants throughout the country receive an equal amount. Extra money from local governments for health needs may come from local taxes, but it is up to the municipality to determine how to spend funds from local tax collection.

In order to establish a unified service structure at regional level, and after long negotiations between districts and sickness funds, the process began to consolidate territorial sickness fund into regional sickness funds. In the beginning of 1998, there were eight regional sickness funds (as opposed to the earlier 32 local account or territorial sickness funds). At the same time (1998), the State Sickness Fund changed its name to State Compulsory Health Insurance Fund.

The regional sickness funds, despite their name which suggests collection of insurance premiums, retain the function of distributing state budget resources. Latvian health care continues to be financed through a national tax-funded system.

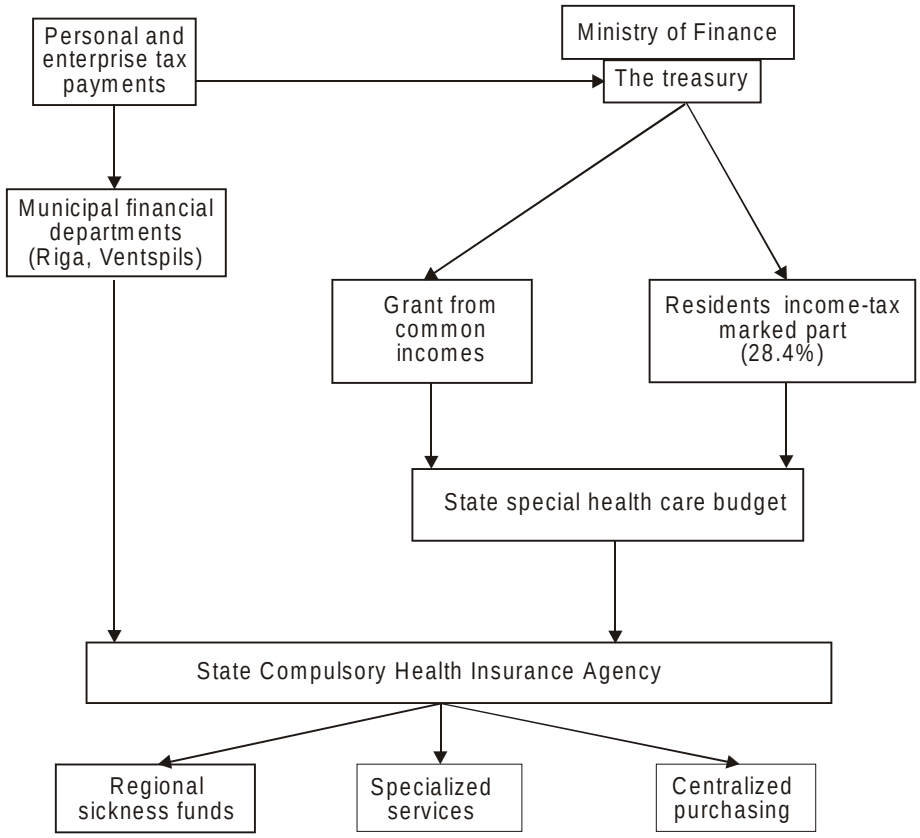
Since 1997 health care resources consist partly of income tax collected at the central level (28.4% of income tax is earmarked for health care),[3] partly of subsidies from general revenues (also financed by taxation revenues at the central level) and partly of patients' pay-in**.** This third financing source includes co-payments on publicly-provided services, and payments for privately-provided care (or private insurance). In addition, a fourth source of funds includes contributions made by local governments, depending on how they manage their local financial resources raised through local taxes.

Fig. 5 shows the flows of state funds to the different health care programmes. The State Compulsory Health Insurance Agency administers all state funds. A portion is allocated to the regional sickness funds, which conclude contracts with providers to pay for services included in the Basic Care Programme; another portion is allocated to the state programmes (specialized services) which are paid for directly by the State Compulsory Health Insurance Agency through contracts with providers; and a third portion is for centralized purchasing.

The budget for health care is enacted by Parliament (*Saeima*) each year. Projects for capital investments are included in the Public Investment Programme, financed by the state. This is a list of essential building renovation and necessary equipment.

[3] The overall budget for all health services is of course influenced by variations in income tax revenues. After the fiscal crisis of 1995, when the accounts of several local governments and health care institutions were blocked in the Bank "Baltija" for a long time, the health care budget was reduced by 11%. To avoid this kind of problem, it was decided to earmark spending for health care, at 28.4% of income tax.

Fig. 5. General tax collection system for health care



Health care benefits and rationing

All Latvian citizens or permanent residents in the Republic of Latvia are entitled to state-funded health care. Residency is confirmed by the register code of the Department of Citizenship and Immigration of the Ministry of Internal Affairs.

The range of primary and secondary health care provided – the "Basic Care Programme" – is established each year since 1994 by an act of the Cabinet of Ministers. This is the basket of medical services, which should be provided for each citizen and legal resident and financed from the budget (and to some extent, co-payments). The Basic Care Programme includes emergency care, treatment for acute and chronic diseases, prevention and treatment of sexually transmitted and contagious diseases, maternity care, immunization programmes and provision of pharmaceuticals free of charge for entitled groups. Dental care is

part of the package only for children up to the age of 18 years. These services are paid for by the regional sickness funds which receive their funds from the State Compulsory Health Insurance Agency (in turn funded by taxation revenues).

Compared to previous years, dental care for adults is excluded from the basic package and is provided by private practitioners at the patient's own expense. Surgical treatment of non-life-threatening diseases (such as hip replacement) and rehabilitation treatments for certain conditions are also not included in the Basic Care Programme. In addition, spa treatment, cosmetic surgery and *in vitro* fertilization are only provided at the patient's own expense. This is also true of alternative therapy, oriental medicine, homeopathy and medical astrology, which are becoming more and more popular despite their high cost and dubious outcome.

New services in the health care minimum will be included when the economic situation improves. Until now, the Basic Care Programme shows a tendency to be decreased every year.

Costs of services which are not included in the basic programme must be covered by the patient, his/her employer or private insurance company, if the patient is insured.

In addition to the Basic Care Programme, the state finances certain services that since the beginning of the reform were recognized to warrant stable and defined funding. These services are provided through a number of state programmes. Until 1999 there were thirteen of these:

- diagnosis, treatment and control of infectious diseases
- diagnosis and treatment of tuberculosis and chronic lung diseases
- psychiatric care
- oncology and haematology
- mother and child health care
- diabetes
- diagnosis, treatment and control of alcoholism and drug addiction
- catastrophe medicine
- care of patients with burns
- AIDS
- a portion of tertiary care requiring specialized centres and expensive equipment (for example, invasive cardiology, cardiac surgery, haemodialysis and kidney transplantation)
- programme of hygiene and epidemic control
- ministerial control, supervision and statistics.

Following new financing regulations of April 1999 of the Cabinet of Ministers, a substantial proportion of state programmes, corresponding to 70% of funding, were transferred into the Basic Care Programme. The services that were transferred to the Basic Care Programme are the following:

- diagnosis, treatment and control of infectious diseases
- diagnosis and treatment of tuberculosis and chronic lung diseases
- psychiatric care
- oncology and haematology
- mother and child health care
- catastrophe medicine
- AIDS.

Complementary sources of finance

Table 4. Percentage of main sources of finance

Source of finance	1998–1999
Public	
· Taxes	78.9%*
· Statutory insurance	None
Private	
· Out of pocket	21.1%*
· Private insurance	Small but increasing
Other	
· External sources	Increasing

Source: WHO Regional Office for Europe health for all database.

* These percentages do not reflect the (small) role played by local government financing, private insurance, and external sources of financing.

There are no precise statistics about finance sources, and there are wide disparities among different sources of information. According to the WHO Regional Office for Europe health for all database, about 79% of resources for health care are financed through taxation revenues, and the remaining 21% from out-of-pocket payments. WHO's World Health Report 2000 estimates out-of-pocket payments to be 39% of total. By contrast, the Ministry of Welfare estimates these to be 7–10% of total. Private insurance represents a very small but increasing amount. External assistance is similarly increasing.

Out-of-pocket payments

Patient fees were the first element of patient participation in the financing of health care to be introduced in the early 1990s. The amounts were at first symbolic, however private (out-of-pocket) expenditures are increasingly making up for the shortfall in public spending.

In 1995, following the collapse of a number of major banks, many local governments lost their financial reserves. Since the middle of 1995 this fiscal crisis precipitated a sharp decline in health care financing. To deal with this, Regulation of the Cabinet of Ministers 231 was passed on 25 July 1995, allowing patients to be charged for up to 25% of the cost of care under the Basic Care Programme. This 25% co-payment did not apply to emergency care, maternity care or services for children up to the age of 18. If they had the financial capacity, local governments were allowed to broaden the range of free services and to entitle more groups to free care.

The 25% co-payment posed enormous problems for patients and providers alike. Patients did not know the magnitude of the co-payment, and were unable to understand the method of calculation or the difference between a co-payment and a fee. Hospitals on the other hand were unable to collect fully. According to data of the State Sickness Fund, in late 1995 and early 1996 the actual amount of co-payments was no more than 12–13% of costs, and much less in areas with high unemployment. Health care facilities ran into financial difficulties because, while they spent all necessary funds for services provided, they were reimbursed for only 75% of their costs.

By the mid-1990s, out-of-pocket expenditures included co-payments on services included in Basic Care Programme, patient fees, most outpatient drugs, publicly and privately provided services not covered by the sickness funds, and to a lesser extent, payments for privately provided services as an alternative to publicly provided ones. In 1997, the percentage of the Basic Care Programme costs that were to be covered by out-of-pocket payments was reduced to 20%, consisting of 15% co-payment and 5% patient fee.

Regulations of the Cabinet of Ministers issued in January 1999 determine the amount of patient payments for services provided within the minimum care programme. These are as follows:

- *Outpatient care:* In the outpatient clinics co-payments are LVL 0.50 for adults and LVL 0.20 for children per day. The payment for a physician's home visit is LVL 1.00.
- *Inpatient care:* The entering charges in a hospital are LVL 5.00; a day cost of LVL 1.50 for adults and LVL 0.45 for children. For manipulations, charges are defined separately. The day cost for adult services included in a state

programme is LVL 0.45 per day. (The state programme includes highly-qualified care in tuberculosis, oncology, psychiatry and narcology services and tertiary levels services, such as heart operations, neurosurgery, nephrosurgery, etc.). The patient's fee per period of hospitalization may not exceed LVL 15.00 for adults and LVL 5.00 for children (excluding the payments for manipulations).

A maximum limit of LVL 80.00 is set for the total amount per year that a household may pay on health care (excluding payments on drugs, spectacles and dental services). Any amount spent above this is reimbursed by the regional sickness fund. Vulnerable groups are exempt from payment of patient fees. There are 16 such groups, including children 0–1 year old, handicapped children up to the age of 16 years, pregnant women receiving pregnancy care, tuberculosis patients and others. Urgent medical care is provided free of charge.

Before receiving planned hospital care, patients sign an agreement with the hospital administration. The costs are calculated prospectively. The remaining expenses following patient payments are covered by the regional sickness fund. In practice, the income of the population is rather low and there are no mechanisms for making people pay. As a result, hospitals manage to collect only a fraction of planned payments from patients, especially in rural areas. Social anxiety has risen significantly after introduction of these regulations and it is likely that more patients will delay consulting a doctor for as long as possible.

Patient payments in 1999 amounted to 7% of hospitals' total income. Collection of even this amount was complicated and stressful.

Drugs

Patients have to pay the full price of most medications for outpatient care. Drugs for treatment of certain conditions (psychiatry, oncology, diabetes etc.) are included in a "positive list" of medications, which are excluded from this rule. Certain categories of people (e.g. persons from the Chernobyl nuclear power station catastrophe area) are also excluded. The positive list is revised every year in collaboration with medical practitioners. (For more information see the section on *Pharmaceuticals*.)

Medical aids and protheses

Costs of medical aids and prostheses (except dental) are covered by the Social Assistance Services. The Centre of Cardiological Surgery provides cardiological

protheses free of charge. Joint replacement is partly covered by the sickness funds.

Each year the number of hip prostheses and knee prostheses operations that are to be financed by state is fixed up to a maximum. The real need exceeds these limitations. The regional sickness fund pays for the operation. The cost of one replacement operation is LVL 406.00. The prosthesis price is covered by State Compulsory Health Insurance Agency. If the replacement is made in the frame of the State programme the patient pays LVL 50.00.

Informal payments

"Under-the-table" payments were very popular in the Soviet period. Patients used to pass envelopes to doctors and nurses to ensure better quality of care and more attention. There is some question regarding how the size and extent of these payments have developed during the 1990s. According to some indications these payments have declined; it is argued that disadvantaged groups do not have enough money for even essential needs and therefore use medical services mostly for emergency care while on the other hand those who are more prosperous have the option to consult privately. On the other hand there is a general feeling among the population that informal payments have increased, particularly in the larger cities.

A study based on surveys carried out in 1999 (Corruption Perceptions Index, Transparency International Annual Report 2000) provides some indications of the current magnitude and extensiveness of informal payments. Of the total number of respondents in the study, 69.5% stated that they never had to make an unofficial payment or gift to state or local health care institutions. By contrast, 24.8% of respondents said they sometimes made a payment or gift, while 5.7% claimed that an unofficial payment or gift was made on almost every visit. The average unofficial payment made per visit amounted to LVL 29 (roughly equal to US $47 according to year-end 2000 exchange rates). While many would be able to afford this amount, there is a large group of persons (particularly the elderly and other vulnerable segments of the population) for whom this amount would be impossible to pay. A regional breakdown of respondents indicates that Riga has the highest proportion of persons who make unofficial payments, amounting to 46.1% of total Riga respondents.

Voluntary health insurance

Since the fall of 1995, some sickness funds (especially the Riga Regional Sickness Fund) began to offer voluntary (i.e. complementary) health insurance.

However, it is now no longer permited for public sickness funds to offer private insurance coverage, so as to avoid the risk of excessive private insurance liabilities being met by the private sector (something which actually occurred in the case of the Riga Regional Sickness Fund).

Private insurance companies provide private, voluntary health insurance schemes. There are ten private insurance companies. These cover patient payments for outpatient and inpatient care; some insurance companies cover dentistry, medication, and spa treatment, rehabilitation and drug expenditures. Buyers of private insurance policies are often companies buying group policies for their employees, who thereby bypass problems of access and quality of care found in publicly funded service provision. Some private insurance companies contract private health care institutions with advanced technical equipment and standards, which do not have contracts with sickness funds and which are believed to provide better quality of care. They are attractive because they provide access to the most advantaged health care facilities with a higher standard of accommodation and more highly qualified specialists. Private insurance schemes are as yet fairly limited, however they are visibly growing. While providing greater choice for patients, this development contributes to the risk of developing a two-tier system of health care provision in terms of access and quality of care. Moreover, there are indications that private insurers may for the moment be exploiting the confusion in people's minds over compulsory insurance, co-payments, the guaranteed basket of services, etc. to their own advantage as they seek to increase their income.

External sources of funding

Latvia has obtained loans from the World Bank and PHARE programmes for health care purposes. The assistance of different international and overseas organizations (UNDP, Red Cross, etc.) is mainly directed to special programmes for staff education and services expansion.

The World Bank offered a credit for Latvian health care reform. The main aim of this project is improvement of the Latvian health care system's quality, efficiency and accessibility. The project is supported by a US $2 million grant from the Swedish International Development Agency and US $3.6 million from the Government of Latvia. The project is to be implemented in two stages. The first is to take place in the period 1999–2001. The second stage is planned for the period 2001–2005. The loan for the first stage is US $ 12.0 million, and for the second US$ 20.0 million.

The project includes support for health care system administration, reform of health care financing, strengthening of sickness funds, management of the

health information system. For inpatient institutions there is a financing model based on diagnosis groups, and remuneration in the primary care system is to be based on the capitation principle. Health care services quality standards will be developed. The State Compulsory Health Insurance Agency will establish a public information system, financial audit system, and staff training.

Health care expenditure

It is difficult to obtain an accurate picture of the magnitude of spending on health care from the state budget since 1991. The structure of the budget and the magnitude of payments from the central and local government budgets were changed several times. For example, in 1991 and 1992 the social budget was independent from the state budget; in 1993 and 1994 it was consolidated into the state budget, and in 1995 it was separated again. The hyperinflation of 1992, the introduction of the national currency, the Lat, in 1993, and the banking crisis of 1995 have further complicated calculations.

Public financing of health care from centrally collected funds[4] in Latvia comprises the following:

- A "Special Health Care Budget" which consists of a fixed percentage (28.4%) of personal income tax;
- Subsidies or block grants from the central government's "Basic Budget" (formed by general revenues collected at the central level).

A special budget (according to the definition used in statistical yearbooks) is formed by revenues that are not allocated to basic budgets but rather are earmarked to cover special expenses, namely those to which their name refers. The Special Health Care Budget is based on a constant percentage of personal income tax, fixed at 28.4% since 1997. In the period 1995–1996 an additional source of revenue for this budget was the surplus (over the planned amount) of excise tax on tobacco. Excise taxes once again in 1998 made their appearance as a source of finance for health care (see Table 6).

As Table 5 indicates, state financing for health care as a share of the total (consolidated) state budget has declined since 1991, and was 9.4% in 1998. Public financing for health care as a share of GDP is estimated to be 3.9%–4.4%, depending on the source of the estimate. This percentage understates the total amount of funds spent on health care, which includes a growing private share. As the same table shows, the privately financed portion of health care

[4] In addition, local governments have revenues which they may use for health care purposes if they choose. This funding is not included in the figures of Tables 5 and 6.

Table 5. Trends in health care expenditure, 1991–1999

	1991	1995	1996	1997	1998	1999
Total expenditure on health care from the consolidated state budget %**	10.8	9.7	9.9	9.9	9.4	–
Share of GDP % (public only)	2.6*	4.2*	4.5*	4.5*	3.9*	4.4*
		3.9	3.9	3.9	3.9	–
Public share of total expenditure on health care %	100*	95*	88*	85*	78.9*	–

Sources: Latvian Data Presentation Systems Database.

* WHO Regional Office for Europe health for all database. Data from the Central Statistical Bureau are different (lower).

** The consolidated state budget refers to the basic state budget plus the special budgets.

has been steadily increasing during the 1990s, reaching 21.1% in 1999. (However, it will be recalled from the discussion of Table 4 that estimates of out-of-pocket payments vary widely, with the Ministry of Welfare putting these at 7–10% of total spending.) Inclusion of private spending would bring the GDP share to over 5%. In addition, the figures shown in Table 5 do not include the contribution to health care financing made by local governments.[5] The local governments may cover health care expenses, which are not covered by the sickness funds, i.e. services not included in the basic care programme. These may be planned surgical operations, cosmetic surgery, workers' health examinations, dentistry for adults, and others. Such health expenditures are financed through local taxes, income from local government property management, state budget subsidies, target subsidies, etc.

Public funds for health care are channeled to health care programmes via the insurance system in the following way:

- Basic Care Programme: This is financed by the Special Health Care Budget (the earmarked amount consisting of 28.4% of personal income tax) plus subsidies (block grants) from the state budget. These funds are managed by the State Compulsory Health Insurance Agency which distributes them to the eight regional sickness funds. These in turn purchase services from providers on a contractual basis.
- The state programmes in health care. These are financed from the basic state budget. The funds are transferred to the State Compulsory Health Insurance Agency, which directly pays providers for their services (see Fig. 5).

Table 6 shows the sources (financing) and uses (expenditure) of funds for health care. Whereas the two public sources of revenues (basic state budget and special health budget) are comparable in size, the Basic Care Programme

[5] Unfortunately it has not been possible to obtain figures indicating the magnitude of this contribution.

Table 6. Health care financing and expenditures, million LVL, 1995–1998

	1995	1996	1997	1998*
Financing				
State budget	33.7	56.6	55.5	57.9
Special health budget (personal income tax)	49.6	59.3	54.4	59.7
Excise taxes	7.7	1.7	–	4.0
Other	0.5	0.9	–	–
Total	91.5	118.6	111.5	125.9
Expenditures				
Basic programme	57.3	68.1	71.8	81.5
State programme	33.2	46.9	38.0	41.7
Total current	90.5	115.0	109.8	123.2
Investments	1.0	0.9	1.7	2.8
Total	91.5	115.9	111.5	125.9

Source: World Bank material. Latvian Health Reform Project, 1999.

* Estimates.

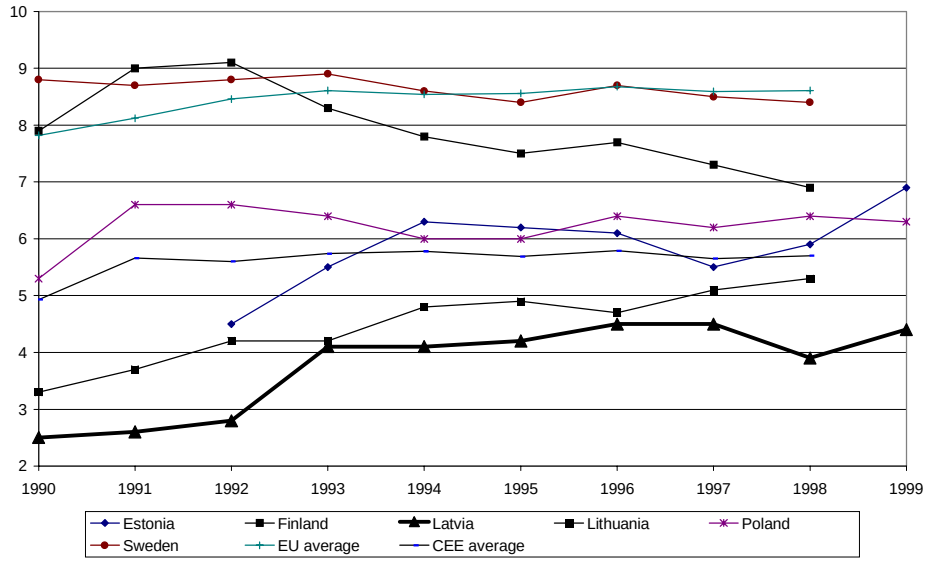
absorbed about double the amount corresponding to the state programmes in 1998, or two thirds of public health care spending.

In 1998 the World Bank recommended that the proportion of funds allocated to the state programmes be decreased, and that services included in the state programmes be integrated into the Basic Care Programme, on the grounds that such expenditure consolidation would lead to increased transparency and improved resource allocation. It was argued that budget allocations for health care lack transparency, stability and predictability (with the exception of the 28.4% earmarked amount constituting the special health care budget).

In accordance with the World Bank recommendations, new financing regulations of April 1999 of the Cabinet of Ministers specified that a substantial proportion of state programmes, corresponding to 70% of funding, should be transferred into the Basic Care Programme.

Fig. 6 illustrates trends in health care expenditure as a share of GDP in Latvia in comparison with Finland, Poland, Sweden and the two other Baltic states (Estonia and Lithuania), and the CEE and EU averages. Latvia's share has been consistently lower than those of all the countries shown, and the CEE and EU averages. (It may be noted that the data emerging from the WHO Regional Office for Europe health for all database show GDP shares for Latvia that are slightly higher than those corresponding to Latvian calculations, as shown in Table 5. As noted in the discussion of Table 5, inclusion of private spending would bring the GDP share to over 5%.)

Fig. 6. Trends in health care expenditure as a share of GDP (%) in Latvia and selected countries, 1990–1999

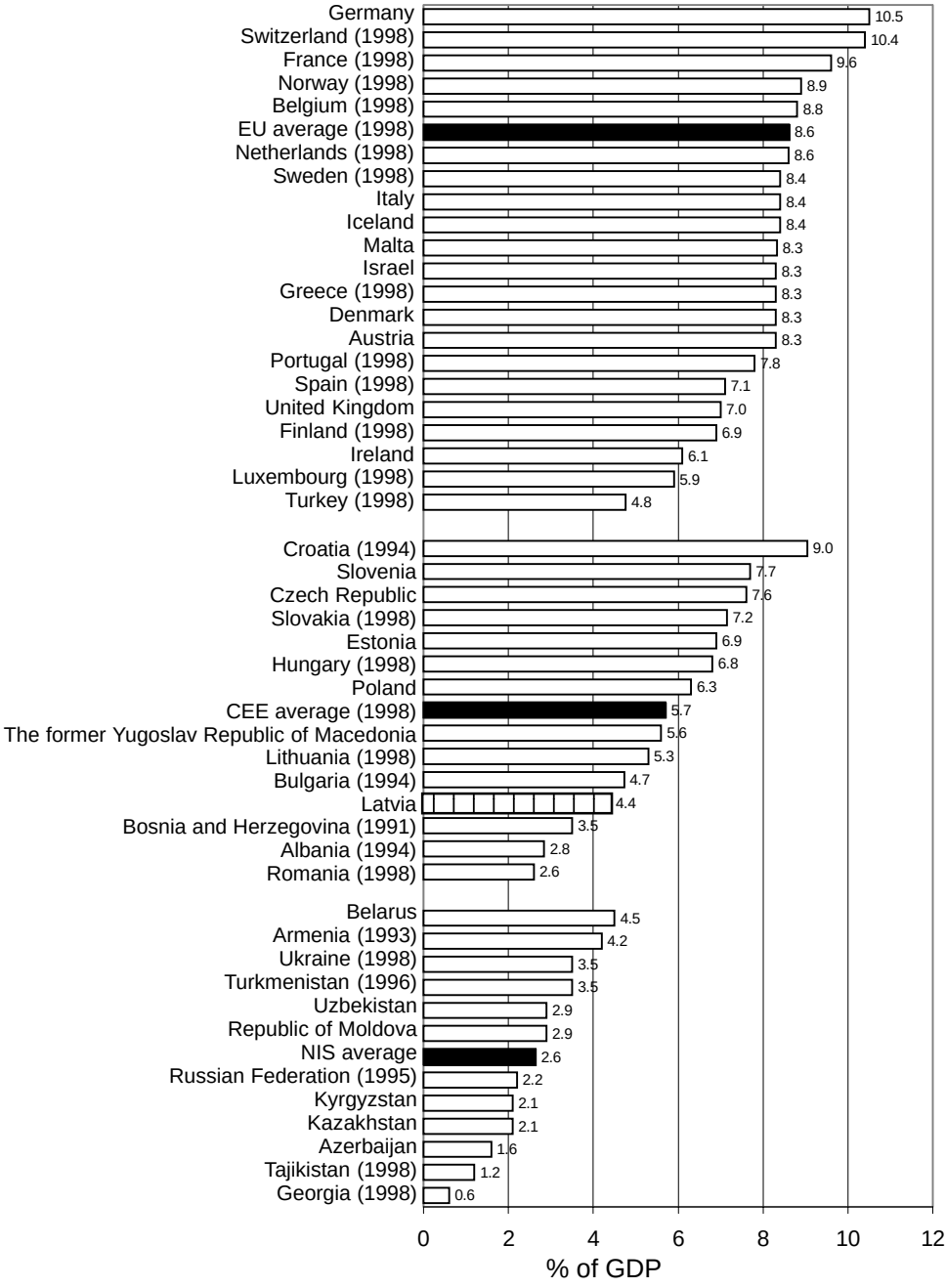


Source: WHO Regional Office for Europe health for all database.

Fig. 7 shows the level of health care expenditure as a share of GDP in Latvia in comparison with other countries in the European Region. Latvia's 4.4% share was below the CEE average of 5.7% in 1999.

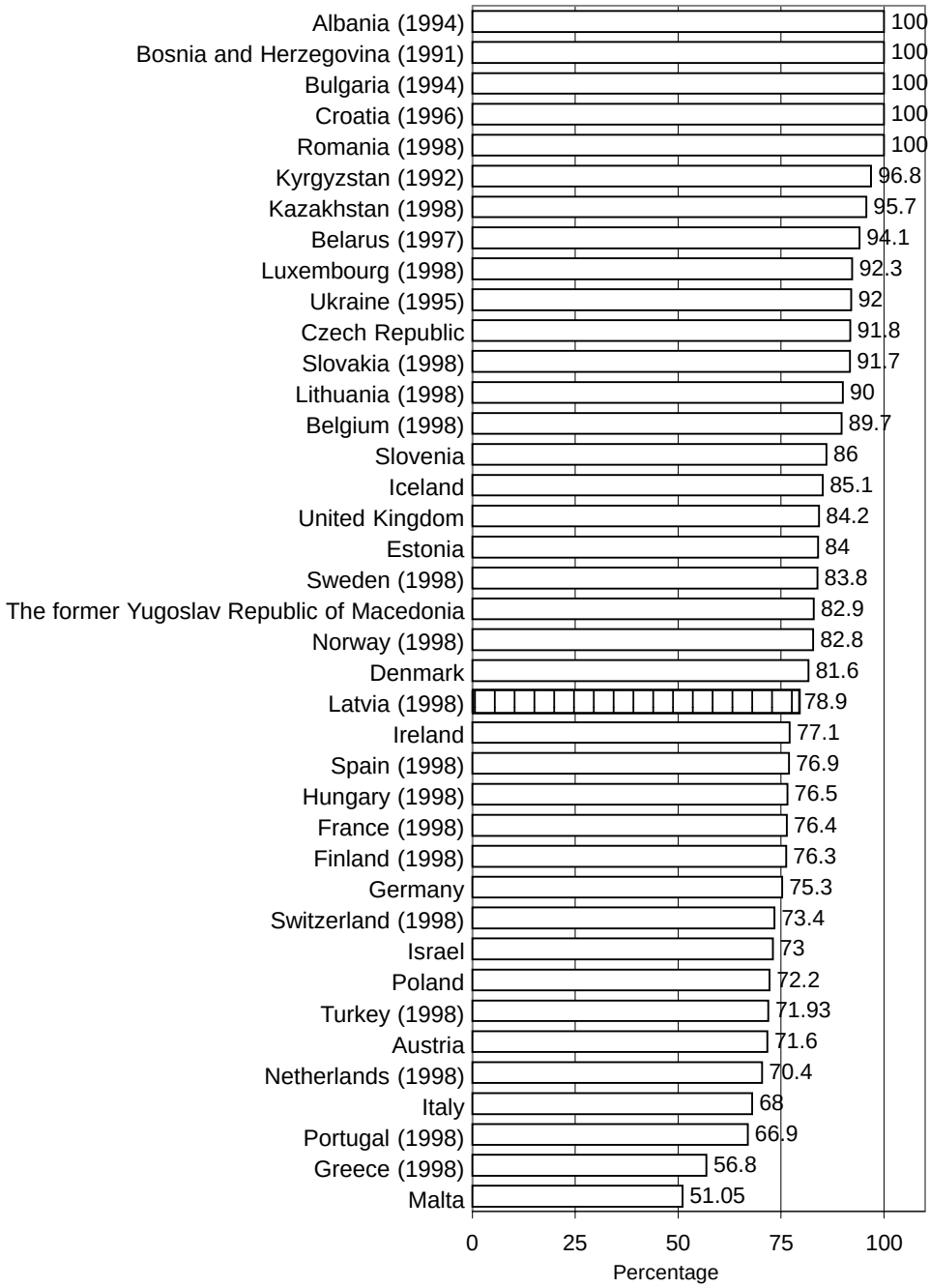
Fig. 8 shows the share of public expenditure as a share of total health expenditure in Latvia in comparison with the other countries of the European Region. Latvia's 78.9% public share is roughly in the middle range of all countries shown. (See, however, the discussion of Table 4 noting the wide variations in estimates of private (out-of-pocket) payments which translate into wide variations in the estimate of the public share.)

Fig. 7. Total expenditure on health as a % of GDP in the WHO European Region, 1999 (or latest year)



Source: WHO Regional Office for Europe health for all database.

Fig. 8. Health expenditure from public sources as % of total health expenditure in the WHO European Region, 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

Health care delivery system

Primary health care and public health services

Until 1990 primary health care in cities and larger towns was provided in polyclinics. These employed a wide range of specialist physicians, dentists, nurses, paediatricians and related therapists. There were also extensive mobile emergency services. In rural areas, primary health care was provided by the local internist and nurse or by the "feldsher". Special primary health care services were organized for certain occupational groups, such as the military and railway employees. The health care system was financed by the state, and was highly centralized. Financing of outpatient care was based on institution staff numbers; quality and quantity indicators were not important for the allocation of financial resources.

The present primary health care system developed from this foundation. Ideas on reform of primary care were first expressed in a detailed document published by the Latvian Physicians' Association in 1991, which included a precise description of the general practitioner, also referred to as the family physician. In 1992, the Ministry of Welfare approved the model of primary health care based on the general practitioner. Reform of the system was initiated in 1993, and is based on the principle of primary care provision with an emphasis on prevention, with a universal, effective health insurance system that will guarantee the accessibility of health care and a well-functioning institutional structure. Development of primary health care is based on the establishment of family doctor practices based on a team model, i.e. consisting of a family doctor and nurse or doctor assistant.

Implementation of the primary care system that is envisaged is far from complete. In the interim period, primary care services are provided in a wide variety of institutional settings that are partly the legacy of the old system and partly the result of efforts to introduce family practices.

At the present time, patients may make their first contact with the health services in various outpatient institutions: polyclinics, hospital emergency clinics or ambulatory emergency clinics, doctorates, feldsher points, and health points.

Polyclinics: In Riga and the larger cities, most of the polyclinics and occupational health service facilities have been converted to health centres. Ownership of health centres is mixed between districts and municipalities and physicians themselves. General practitioners are permitted to rent facilities within polyclinics and work as independent practitioners; this practice is not as yet widespread.

There are questions concerning the future of the polyclinics. In the interim period, until private primary care practices are established on a large scale, polyclinics are likely to play an important role as the premises for general practitioners (as well as ambulatory specialists who are to be gradually declining in numbers). At the present time, the polyclinic environment is not conducive to general practice and the development of primary care.

Hospital emergency clinics or ambulatory emergency clinics: Emergency care is available 24 hours per day. In Riga there are specialized emergency teams (cardiological, psychiatric, etc.); elsewhere, there is usually only one doctor or feldsher and the driver.

Doctorates: Group and single-handed practices are present in cities, but most are located in the countryside where they are called doctorates. This usually refers to a practice of a local internist (for adults), who is usually an unspecialized doctor, together with a paediatrician, a dentist, a midwife and nurses. Specialists are usually available only on a part-time basis. In 1999 there were 416 doctorates in Latvia (244 in 1998).

Feldsher-midwife points: There were still 393 feldsher-midwife points in Latvia in 1998; by 1999 their number decreased to 355. Each is responsible for an average of 2500–3000 patients They are staffed with a feldsher and the larger ones also with a midwife, and provide preventive and emergency services. The policy is to phase them out and to gradually transform them into doctorates, while their staff retrain to become public health nurses.

Health points: Health points function as physician practices at the big enterprises and military establishments. They provide prevention and primary health care services for the military and enterprise workers. They are staffed with a physician (general practitioner or family doctor) and generally with a dentist and a nurse. There were nine health points in Latvia in 1999 (five of them were located in Riga). The policy is to allow them to continue as physician practices.

Primary health care providers may either be directly employed by local governments or by the administration of health centres, or contracted by a sickness fund, either directly or through the health care institution where they are employed.

The specialty of general practitioners was only established in 1991. The number of certified general practitioners has increased sharply in recent years due to retraining courses for general practitioners which became available since 1992. There are three categories of physicians who can qualify as primary health care physicians: general practitioners, and internists and pediatricians who have retrained and have become certified as general practitioners. Certification is provided by the Physicians' Association. The overwhelming majority of general practitioners had been trained as specialists (i.e. not general practitioners) under the previous system and have retrained in recent years. At the end of 1999, 42% of primary care physicians were general practitioners, compared to 25% in 1998.

General practitioners provide general health care for children, adults and elderly people, and including outpatient surgical manipulations, rehabilitation, pregnancy care, perinatal care, and emergency care; they prescribe medications, ensure 24-hour availability, and also carry out preventive work (immunization) and health promotion. The range of services is determined in the Basic Care Programme, which includes care of acute and chronic diseases, preventive care, child and maternity care.

Primary health care for children under 14 years of age is provided by paediatricians or general practitioners**.** Pupils' health care is provided by local authorities which, depending on their budget, hire a physician or a person with mid-level medical education to work in schools and kindergartens. The immunization programme is determined by regulations of the Ministry of Welfare and takes place in outpatient institutions after a child has been examined.

Dental care for young people under 18 years of age and those called up for military service is financed by the government's special health care budget. Others must pay the costs themselves, exceptions being first-aid procedures and tertiary level services (inherited facial and jaw conditions) as determined by the state. There were 103 dental care institutions and 212 dental practices in Latvia at the end of the 1999.

Family planning is coordinated by the State Family Health Centre, established in 1996. It is under the supervision and corresponding regulation of the Ministry of Welfare. Its main tasks are family planning, and implementation of the state's family health programme. Regulations of the Cabinet of Ministers determine a certain discount for oral and other contraception for women for whom pregnancy is contra-indicated for medical reasons. Pharmaceutical products for treatment of pregnancy complications are distributed free of charge.

Besides the primary health care services included in the Basic Care Programme, health centres (polyclinics) also offer certain services for which patients must pay out-of-pocket (or through private health insurance), such as alternative therapy and cosmetic services, and certification of drivers and gun holders.

Patients can freely choose their primary care physicians. They can change their physicians not more than twice per year (excluding change of address). In practice only the inhabitants of urban areas have any real choice as there are too few physicians to choose from in rural areas. Primary care physicians (general practitioners, internists and paediatricans) have a gatekeeper role**.** The patient needs a referral from a primary care physician to receive specialist or secondary level care. Without a referral the patient must pay out-of-pocket or through private health insurance. Exceptions to the requirement of a referral include the following: dentists for children, psychiatrists, tuberculosis specialists, venereal disease specialists, gynaecologists, endocrinologists for diabetics, and specialists for emergencies (these specialists can be visited without a referral).

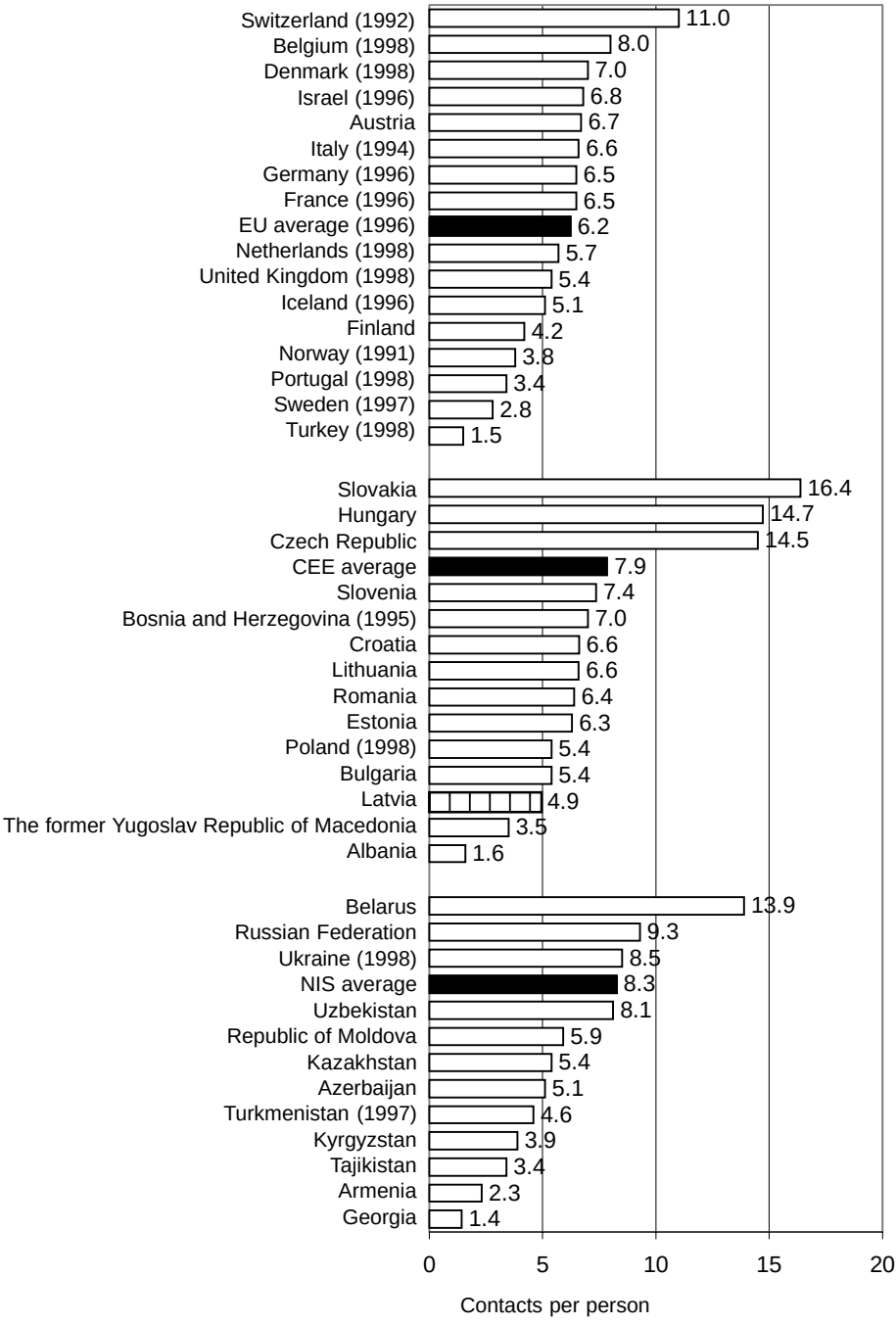
Patient registration with general practitioners (family doctors) began at the end of 1997. From the middle of 1999 residents who had not yet voluntarily registered were registered by physicians working within the resident's district of residence. By the beginning of 2000, 80% of the population had been registered, and it was expected that patient registration would be completed by the end of 2000.

Fig. 9, showing outpatient contacts per person per year in the WHO European Region, indicates that Latvia, with 4.9 visits lies substantially below the CEE average of 7.9, and also below the averages for the EU and NIS of 6.2 and 8.3 respectively.

At the end of 1999 the Ministry of Welfare adopted a regulation on the functions of general practitioners and specialists determining their main tasks and responsibilities. It firmly separates general practitioner care from specialist care, and requires that the gatekeeper role of general practitioners be strictly enforced. Whereas even prior to this patients needed a referral at the primary care level in order to seek specialist or inpatient care, the referral system did not function as well as was intended. In practice, patients still try to find ways to circumvent the referral system.

Current policy, as noted above, is to encourage a move to single or joint practices in primary health care. The government favours the establishment of private practices as a setting for primary care delivery, with primary care doctors as independent contractors. According to the "Strategy for Health Care Development" prepared by the Ministry of Welfare and accepted by the

Fig. 9. Outpatient contacts per person in the WHO European Region, 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

government in 1996, "primary health care should be based on private medical practice, establishing a primary health care development foundation and engaging various financial resources". The private practices are intended to be composed of independent contractors who contract with a regional sickness fund. According to present trends, the practices may simultaneously receive patients on a private basis.

A Law on Physician Practices enacted in 1997 states that primary care is the basis of health care, and specifies the content of physicians' work, financial activities, rights, responsibilities, patient registration, cooperation, registration, certification and closing. Welfare Ministry regulations on primary care practice financing (1998) specify that the basic principle of primary care remuneration is capitation, and designate 32 practices where this model would be introduced. Primary health care development is further supported by a World Bank project which finances primary care doctors' training (50%), training on how to set up a family practice (30%), and public information activities (20%). Implementation began on a pilot basis in the Kraslava and Daugavpils districts in the beginning of 1999.

Further, the Primary Care Support Fund was established in 1998 by the Ministry of Welfare and the State Compulsory Health Insurance Agency with the aim to improve primary health care development through support of training of general practitioners, support for doctors establishing an independent practice, and promote the capitation model of remuneration. The fund provided financial resources (raised from alcohol excise taxes and supplemented by the World Bank and PHARE) for the establishment of 65 physician practices (selected by competition).

The efforts to support the development of primary health care have extended to the system of remuneration of PHC physicians (see the section on *Payment of physicians* for more details). Latvia is currently in the process of introducing a mixed capitation system of primary health care physicians. This consists of payment of an amount that is partly remuneration of the primary health care practitioner, partly compensation for certain costs (such as payment of a primary health care nurse), and partly for payment for services of specialists to whom the practitioner's patients are referred. Since the practitioner clearly has an incentive not to pay specialists, it is hoped that this will contribute to keeping service delivery as much as possible in the primary care sector. (For more information, see the section on *Payment of physicians*).

Problems in primary health care development

Serious difficulties have been encountered in the process of developing private practices, and it appears that only 5% of doctors were operating as such in

1999. These difficulties include the expense of setting up a practice, the near impossibility of getting a commercial bank loan, and the insecurity generated by the prospect of losing the security of being an employee. General practitioners are therefore permitted to rent facilities within polyclinics and work as independent practitioners, yet they still hesitate to do so. At the present time, the polyclinic environment is not conducive to general practice and the development of primary care. However, as there are few alternatives over the short to medium term for the premises of primary care practices, efforts should be made to regulate the polyclinics in order to create the conditions for general practitioners to practice in accordance with a primary care culture. In addition, financial incentives for the introduction of group practices should be introduced.

It is expected that World Bank assistance will help overcome some of the financial constraints. For those who are able to do so, a key motivating factor behind the decision to open an independent private practice appears to be the prospect of attracting private patients. It appears, therefore, that there is the beginning of a trend whereby doctors are prompted to become certified general practitioners less because they are interested in becoming primary care doctors and more because of the prospect of substantially increasing their incomes by attracting private patients. This is encouraged by current legislation which allows independent contractors to become established as limited companies which by definition are intended to be profit-making organizations or firms.

Several further problems in primary health care can be observed**.** There is no programme for feldsher-midwife points reorganization. The cooperation between health care and social care is not satisfactory. Physicians' qualifications and specialization sometimes are not adequate for the demands of primary health care. Cooperation between primary, secondary and tertiary health care is inadequate. The process of primary heath care reorganization is proceeding slowly. According to research, patients in rural areas complain about the difficulties with primary health care accessibility.

In addition, there have been psychological difficulties involving acceptance of a primary health care system by the general public, involving a long-term and stable relationship between a family and general practitioner, in spite of active media campaigns attempting to inform the public.

There are also uncertainties about the legal basis of independent practice. In the case of polyclinics, the former state, or municipal institutions became state or municipal enterprises, i.e. not-for-profit joint-stock companies or not-for-profit limited liability companies. These changes in status gave rise to greater administrative freedom on the part of the polyclinics in the allocation of resources and payment of providers. As the contractor on the side of health care providers became the head physician or director, and not the

primary health care physician, there emerged considerable room for tension between the two.

Finally, there are difficulties surrounding the mixed capitation form of payment of primary health care physicians which is currently in the process of being introduced. Under the new system, being away from the place of practice does not alter the physician's payment as he or she is paid on the basis of the patient list (capitation); however, this encourages physicians to neglect their practices. During the physician's absence from work, the patient is deprived of the opportunity for a consultation. In some areas there is only one physician and there is no replacement who could take care of the patient's needs during the physician's absence. According to law, it is the physician's obligation to find a replacement if he or she is obliged to be away from work; however this often does not happen.

In addition, the new arrangement meets with opposition from patients who feel that family practitioners may refuse to refer them to a specialist even though specialist care may be called for, simply because the practitioner faces a financial incentive to retain the money that would otherwise be paid to a specialist. Specialists themselves similarly oppose the arrangement as their position vis-à-vis the family practitioners is severely weakened. (These issues are discussed in more detail in the section *Payment of physicians*.)

Public health services

The protection and promotion of public health on a national level is the responsibility of the Health Promotion Centre, which is part of the Department of Environmental Health of the Ministry of Welfare. At a local level, the environmental health department and the environmental health centres are responsible for health promotion.

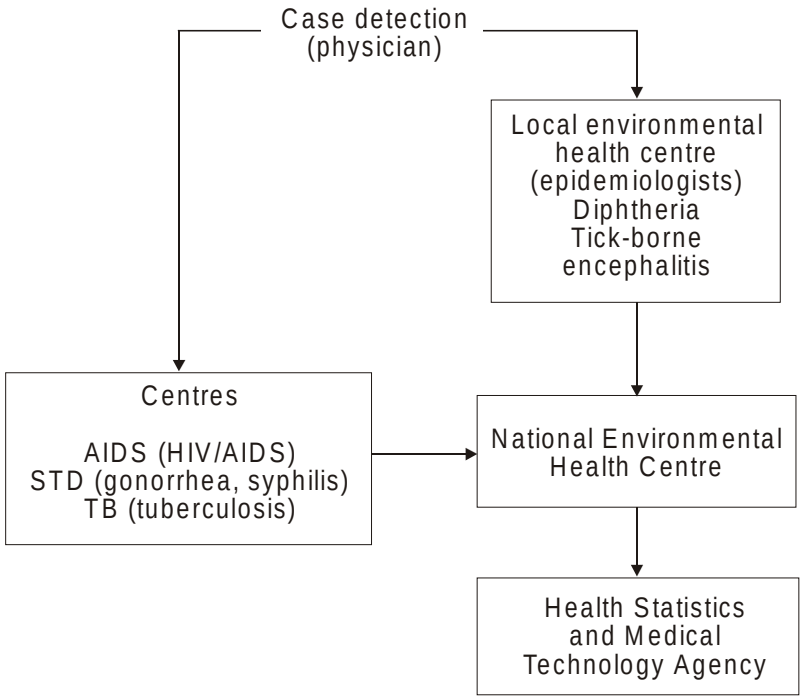
The Health Promotion Centre was established in 1996. It organizes and coordinates health promotion in Latvia. At this moment the most important aims are the work on health promotion strategy; promotion of healthy nutrition; smoking, alcohol, drug and toxic substances reduction; sex education; promotion of physical activity; and prevention of trauma.

In 1998 the Health Promotion Centre organized the Baltic States and Finland health monitoring project FINBALT. Its main purpose was to find out risk factors, physical activity, nutrition, alcohol and tobacco consumption which reflected the lifestyle of Latvian population. At the present time, 60% of Latvian schools offer courses in health education.

The Latvian Medical Academy opened a Public Health School in 1993, which trains health education teachers, school and kindergarten nurses and mid-level medical personnel such as nurses, feldshers, and midwives. A Public Health Faculty has also opened in the Latvian Medical Academy, which trains public health specialists. With Norwegian support, Latvia started programmes in education of public health nurses.

The Latvian Infectious Diseases Centre and State Sexually Transmitted and Skin Diseases Centre are responsible for infectious and communicable disease control. The State Sexually Transmitted and Skin Diseases Centre is under the supervision and regulation of the Ministry of Welfare. Its main tasks are to maintain the register of sexually transmitted and skin diseases, development and implementation of the state health programme in dermatology and venereology, and to analyse the situation of morbidity in connection with sexually transmitted and skin diseases. There is an infectious diseases urgent report system according to which every medical person must report case detection to the relevant centres (for example, cases of HIV/AIDS to the AIDS prevention centre, tuberculosis to the state's TBC and Lung Deseases Centre,

Fig. 10. National surveillance systems for infectious and communicable diseases



gonorrhea and syphilis to the state's Sexually Transmitted and Skin Diseases Centre, diphtheria and tick-borne encephalitis to the Local Environmental Health Centre). Information flows finally to the Health Statistics and Medical Technology Agency (see Fig. 10).

Professional diseases' registration and observation are coordinated by the Professional Diseases and Radiation Medical Centre. This centre is located in the P. Stradina Clinical University Hospital. It maintains records of occupational diseases and Chernobyl-related diseases, and is under the supervision and corresponding regulation of the Ministry of Welfare. Physicians in outpatient institutions carry out the practical work.

A general state immunization programme has been set up for 1998–2000. Primary care doctors and school physicians are responsible for immunization. Vaccination against tick-borne viral encephalitis in some regions is also included in the immunization programme. Since 1995 the spread of diphtheria has similarly led to an immunization programme. Immunization is the duty of primary health care institutions and of school doctors. Fig. 11, showing immunization levels for measles in the European Region, indicates that Latvia has achieved very high levels of immunization at 97% (1999).

Preventive services, such as basic health education and blood pressure measurement, cervical smears and breast examination (palpation), are delivered by primary health care providers. Primary care doctors are further responsible for preventive measures, such as health education, health promotion, screening tests and antenatal care.

In 1997 the State Sanitary Inspection was established for the purpose of monitoring environmental health. There are ten regional environmental health centres in the country at present. The main aim is to develop an efficient control and supervision system to prevent environmental factors' negative influences on the population's health.

There are seven youth health centres working on youth reproductive health care and education. A youth contraception office has opened in the Riga Emergency Care Clinic where young persons can obtain consultations at a low cost. The Latvian family planning and sexual health association "*Papardes zieds*" mostly organizes education for the wider population.

The Health Promotion Centre actively works in health education. The Latvian Gynaecologists' Association and Latvian Urology Association are active in educating physicians. The media are becoming more active in informing the population about family planning, and sexual and reproductive health.

Public health services are hampered by a lack of coordination at the state level. Often different institutions work on the same problems without knowing what other colleagues have already achieved. There is no national strategy for

Fig. 11. Levels of immunization for measles in the WHO European Region, 1999 (or latest available year)

Source: WHO Regional Office for Europe health for all database.

reproductive health and other public health issues that would help coordinate activities in this field.

Reforms in public health are oriented towards research in population health, e.g. cardiovascular disease, oncology, accidents, etc. The Latvian public health strategy will be worked out in the framework of the World Bank project. There are currently public health advisers supported by this project who organize seminars and task groups on several public health issues. More attention will be given to informing the public on healthy lifestyles; one of the projects planned involves informing the population about the impact of tobacco and alcohol consumption on health.

The Health Promotion Centre will establish a public relations department that will work as an inter-ministerial institution.

In the future it is planned to promote health education from primary school onwards. A separate programme is planned to improve environmental health care by monitoring and testing food and water.

The Ministry of Welfare has recently proposed that a health promotion specialist position be established in each of the 26 districts and seven cities, and plans to extend the health promotion infrastructure to the local level. World Bank experts are preparing a study on optimal infrastructure and calculation of health promotion costs. The study is to be completed in 2001.

Secondary and tertiary care

There are three categories of hospitals in Latvia (see the *Organizational chart of the health care system*): state hospitals, which are accountable to the Ministry of Welfare; municipal hospitals; and private hospitals.

Table 7 shows the breakdown of hospitals and beds by type of ownership and how these have developed since 1991. Hospitals are overwhelmingly public, with municipalities controlling very roughly half of these in 1999 (more precisely, municipalities control 55% of all hospitals and 47% of all hospital beds).

In 1999 there were 151 hospitals in Latvia, of which 31 were in Riga. All specialized hospitals are concentrated in Riga. The main specialties of secondary level institutions are surgery, adult internal medicine, paediatrics, obstetrics, orthopaedics, ophthalmology, urology, dermatology, and otorinolaringology. Highly specialized state health care institutions equipped with advanced technologies provide tertiary care, as well as secondary care. State centres that are financed from the state's programme include specialized hospitals in

Table 7. Numbers of hospitals and beds, 1991-1999

	Number of hospitals					Number of beds				
	1991	1996	1997	1998	1999	1991	1996	1997	1998	1999
Total	187	158	156	150	151	36 096	25 641	23 840	22 702	21 594
of which										
Under the supervision of the Ministry of Welfare	47	54	52	51	52	14 075	12 448	11 254	10 938	10 265
Other institutions	4	5	6	5	5	500	486	961	1 041	717
Under the supervision of municipalities	136	92	88	86	84	21 521	12 318	11 256	10 504	10 103
of which										
in Riga	16	6	5	5	5	5 750	2 905	2 524	2 463	2 198
outside Riga	120	86	83	81	79	15 771	9 413	8 732	8 041	7 905
Private institutions	–	7	10	8	10	–	389	369	239	509
of which										
in Riga	–	7	9	7	9	–	389	364	234	504
outside Riga	–	–	1	1	1	–	–	5	5	5

Source: Yearbooks of health statistics, Latvia, 1991–1999.
*excluding short term social care beds.

oncology, narcology, tuberculosis, psychoneurology, leprosy, mental health care, contagious diseases, orthopaedics, dentistry, maternity homes, paediatric care and rehabilitation. and two high specialized multiprofile hospitals: Riga Stradina University Clinic and State Children Clinical Hospital.

As a rule, staff are employed by the administration and work for fixed salaries. Hospitals usually have the status of non-profit organizations or stock companies (often owned by the employees). Directors, however, are not completely independent, as decisions about closing and opening beds or employing or removing senior staff must be ratified by the regional sickness funds.

Public hospitals (state and municipal) have contracts with the regional sickness funds. The director or head doctor of each municipal hospital organizes the hospital's activities according to the local authority's health care development plan. The Ministry of Welfare appoints state hospital and state centre directors. The Latvian Medical Academy coordinates the work of clinics where residents and students are trained. In the case of tertiary care, individual services (for example, radiology) are bought by the State Compulsory Health Insurance Agency.

In 1997 inpatient (and outpatient) health care institution certification was initiated.

Of the 151 hospitals in Latvia, ten are private and nine of these are located in Riga. Most of these also provide outpatient departments. These work either on the basis of contracts with the regional sickness funds (for outpatient services only) or direct out-of-pocket payments or private insurance. The price per diem

is high in private inpatient facilities as a result of which the sickness funds do not contract with them for inpatient services.

In March 1999 the Ministry of Welfare issued regulations requiring patient referrals to hospitals for services specified in the Basic Care Programme. The patients of hospitals must be referred by a general practitioner (family doctor), internist, or paediatrician, or by a specialist if the patient was referred to the specialist by a primary care doctor. In addition, TB specialists, psychiatrists, venereal disease specialists, gynaecologists and endocrinologists can also refer patients to hospitals.[6] A patient must be referred to a hospital that is contracted with a sickness fund. Patients can freely choose the hospital within their administrative area. These regulations do not apply for admission in private hospitals.

Changes in the structure of health care institutions have been determined by health policy since 1994 aiming towards the development of primary health care. While the number of outpatient institutions increased from 393 in 1991 to 664 in 1998 and 897 in 1999, the number of inpatient institutions decreased from 187 in 1991 to 151 in 1999. Since 1991 there has been a remarkable decrease in the number of beds; this can be seen in both Table 7 showing hospital and bed numbers and Table 8 showing hospital beds per population. In absolute numbers, there has been a 40% decrease in the number of beds in the period 1991–1999. The greatest part of this decrease has occurred in municipal hospitals where bed numbers fell by more than half (53%) over the same period. These changes correspond to a decrease in the number of beds from 13.6 per 1000 population in 1991 to 8.9 beds in 1999.

The hospitalization rate remained constant at around 21–22 per 100 population (see Table 8). There are indications that resources are being used more rationally and the proportion of care provided at the primary level has increased. The average length of stay decreased from 17.4 days in 1991 to 11.8 days in 1999. One of the reasons for these positive developments involves new treatment and diagnostic methods introduced at the primary and secondary levels of health care. In addition, changes in the methods of paying hospitals since the mid-1990s have contributed to increased efficiency in the use of hospitals. Further, the regional sickness funds have begun to contribute to the process of rationalization through the selective issuance of contracts with secondary care institutions (with preference given to certified institutions).

[6] These are the specialists which patients can visit directly, without a referral, and who in turn may refer patients to hospitals.

[7] The discrepancy in the figure for bed numbers per population between Table 8 (8.9) and Fig. 12 and Table 9 (6.3) is due to the fact that the first refers to all hospital beds whereas the second two refer to acute beds only.

Table 8. Inpatient utilization and performance, 1991–1999

Inpatient	1991	1996	1997	1998	1999
Hospital beds per 1000 population	13.6	10.3	9.6	9.2	8.9
Admissions per 100 population	21.2	21.0	21.7	22.0	22.1
Average length of stay in days	17.4	14.2	12.9	12.5	11.8
Occupancy rate (%)	–	–	–	79.9	79.3

Source: WHO Regional Office for Europe health for all database; Yearbooks of health statistics, Latvia, 1998, 1999.

The figures and tables that follow present comparative data placing Latvia in an international context.[7] Fig. 12 and Table 9 indicate that despite the significant drop witnessed in Latvia's acute bed numbers during the past decade, bed numbers per population are still higher than what prevails in many other CEE and NIS countries.

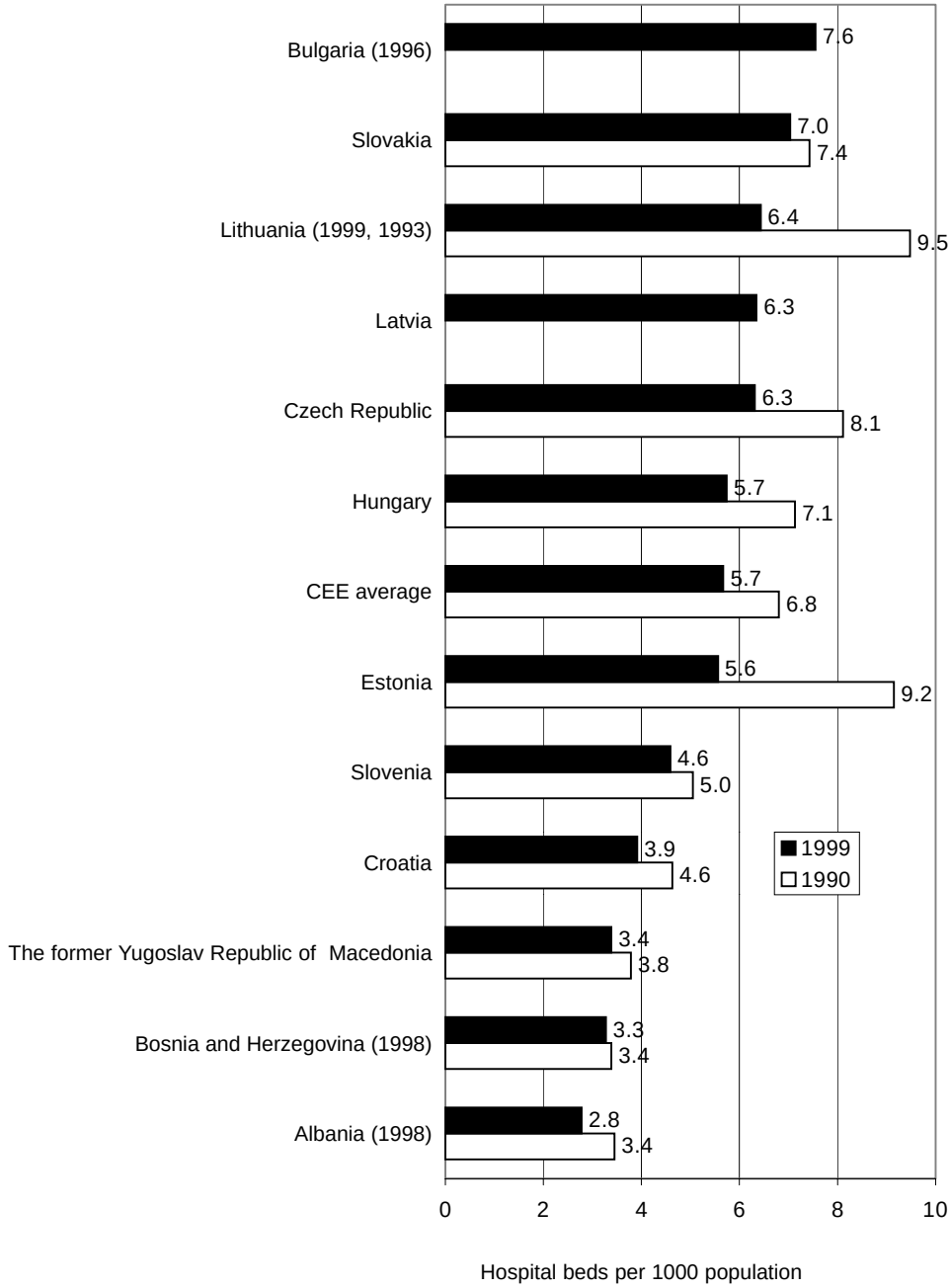
Fig. 13A and Fig. 13B show hospital bed trends in Latvia in comparison with Finland, Poland, Sweden, the other two Baltic states (Estonia and Lithuania) and averages of the European Union and CCEE. Fig. 13A refers to acute hospital beds only, for which Latvia has only 1998 and 1999 data; Fig. 13B refers to all hospital beds, for which older Latvian data are available, thus permitting a comparison of bed reduction trends with the other countries over time. The Latvian number of beds per population tends to be similar to that of Lithuania, lying above the corresponding levels for all the countries shown as well as the country averages in 1998 and 1999. In the case of all-hospital beds, Fig. 13B shows that while all countries and country averages have a similar downward trend, Latvia has consistently had more beds per population until 1996 when its bed numbers became marginally lower than Lithuania's.

Problems in secondary and tertiary care

A key problem in secondary and tertiary care is that primary care services continue to be provided in highly specialized health care institutions. In addition, the number of beds in hospitals is still considered to be excessive, in spite of the significant reductions achieved during the past decade. It is felt necessary to reduce the number of beds in some specialties such as obstetrics, infectious diseases and neurology, as bed utilization in these specialties is particularly low.

Those hospitals that were built during the last years of the Soviet regime are excessively large, so that in the winter a large portion of their running costs consists of heating bills. As there is no financial incentive to avoid hospital

Fig. 12. Hospital beds in acute hospitals per 1000 population in central and eastern Europe, 1990 and 1999 (or latest available year)



Source: WHO Regional Office for Europe health for all database.

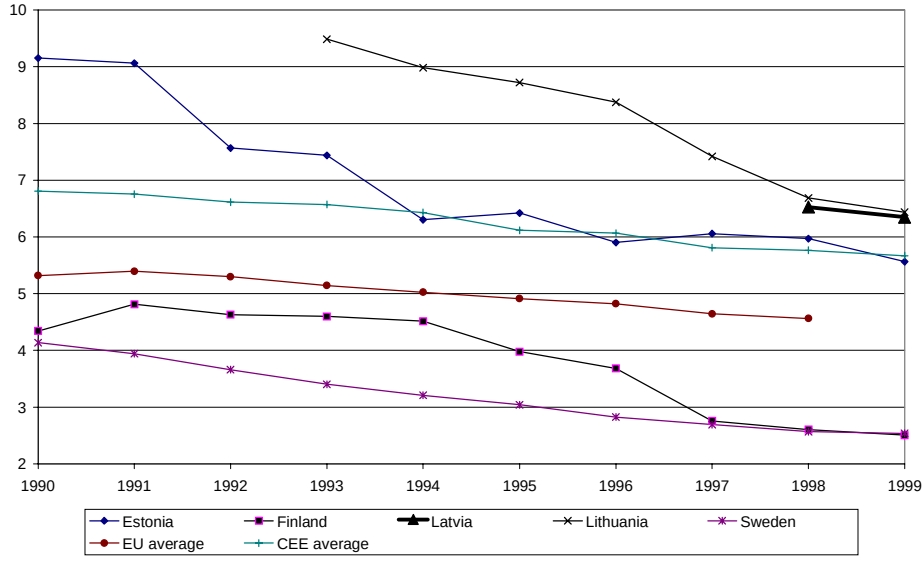
Latvia

Table 9. Inpatient utilization and performance in acute hospitals in the WHO European Region, 1999 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Western Europe				
Austria	6.4[a]	25.8[a]	6.8[a]	75.4[a]
Belgium	5.2[b]	18.9[c]	8.8[b]	80.9[c]
Denmark	3.4[a]	18.7	5.7	78.3[a]
Finland	2.5	19.7	4.5	74.0[d]
France	4.3[a]	20.3[d]	5.6[a]	75.7[a]
Germany	7.0[a]	19.6[b]	11.0[a]	76.6[b]
Greece	3.9[g]	–	–	–
Iceland	3.8[d]	18.1[d]	6.8[d]	–
Ireland	3.2[a]	14.6[a]	6.8[a]	84.3[a]
Israel	2.3	17.9	4.3	94.0
Italy	4.5[a]	17.2[a]	7.1[a]	74.1[a]
Luxembourg	5.5[a]	18.4[e]	9.8[c]	74.3[e]
Malta	3.8	–	4.2	79.3
Netherlands	3.4[a]	9.2[a]	8.3[a]	61.3[a]
Norway	3.3[a]	14.7[c]	6.5[c]	81.1[c]
Portugal	3.1[a]	11.9[a]	7.3[a]	75.5[a]
Spain	3.2[c]	11.2[c]	8.0[c]	77.3[c]
Sweden	2.5	15.6[a]	5.1[c]	77.5[c]
Switzerland	4.0[a]	16.4[a]	10.0[a]	84.0[a]
Turkey	2.2	7.3	5.4	57.8
United Kingdom	2.4[a]	21.4[c]	5.0[c]	80.8[a]
CCEE				
Albania	2.8[a]	–	–	–
Bosnia and Herzegovina	3.3[a]	7.2[a]	9.8[a]	62.8[d]
Bulgaria	7.6[c]	14.8[c]	10.7[c]	64.1[c]
Croatia	3.9	13.2	9.4	87.2
Czech Republic	6.3	18.2	8.7	67.7
Estonia	5.6	18.4	8.0	69.3
Hungary	5.7	21.8	7.0	73.5
Latvia	6.3	20.0	–	–
Lithuania	6.4	20.6	9.1	78.8
Poland	–	–	–	–
Romania	–	–	–	–
Slovakia	7.0	18.4	9.6	69.8
Slovenia	4.6	16.0	7.6	73.2
The former Yugoslav Republic of Macedonia	3.4	8.8	8.8	63.0
NIS				
Armenia	5.5	5.6	10.4	29.8
Azerbaijan	7.5	4.7	14.9	30.0
Belarus	–	–	–	88.7[e]
Georgia	4.6	4.7	8.3	83.0
Kazakhstan	5.8	14.0	12.3	92.6
Kyrgyzstan	6.1	15.5	12.8	92.1
Republic of Moldova	6.8	14.4	14.0	71.0
Russian Federation	9.0	20.0	13.7	84.1
Tajikistan	6.1	9.4	13.0	64.2
Turkmenistan	6.0[b]	12.4[b]	11.1[b]	72.1[b]
Ukraine	7.6[a]	18.3[a]	13.4[a]	88.1[a]
Uzbekistan	–	–	–	–

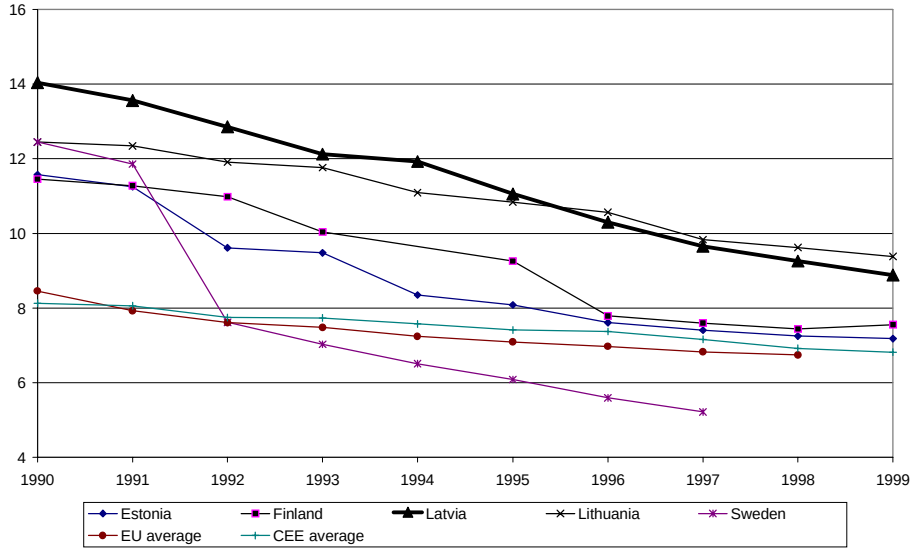
Source: WHO Regional Office for Europe health for all database.
Note: [a] 1998, [b] 1997, [c] 1996, [d] 1995, [e] 1994, [f] 1993, [g] 1992.

Fig. 13A. Hospital beds in acute hospitals per 1000 population in selected European countries, 1990–1999



Source: WHO Regional Office for Europe health for all database.

Fig. 13B. Hospital beds in all hospitals per 1000 population in selected European countries, 1990–1999



Source: WHO Regional Office for Europe health for all database.

Table 10. Distribution of health care resources by regional sickness fund

Sickness fund	Number of population 01.01.1999	Population density per km² at beginning of 1999	Hospital beds per 10 000 population in 1999	Physicians (incl. dentists) per 10 000 population in 1999	Midmedical personnel per 10 000 population in 1999
Rîga region	796 732	2 595.2	112.1	56.6	83.4
Pierîga	201 165	36.5	36.9	17.6	28.8
Viduslatvija	256 841	48.6	102.4	23.4	53.1
Latgale	197 032	40.4	102.7	27.5	78.1
Ziemeïaustrumu	331 399	16.3	85.0	22.3	54.4
Kuldîga	331 689	24.4	56.7	19.9	50.9
Rçzekne	120 273	22.9	70.6	21.6	57.5
Daugava	204 314	21.6	84.0	19.5	50.7
Total	2 439 445	37.8	88.5	33.0	62.9

Source: Yearbooks of health statistics, Latvia, 1999.

admissions, hospitals are not motivated to deal with the fact that patients often delay visits to their primary health care doctor and may be admitted later as urgent cases.

A considerable number of patients needing social care rather than medical care are still cared for in hospitals and sometimes even in specialized centres. The patients' length of stay in hospitals is sometimes not determined by medical but by social indications, contributing to an increased average length of stay. However, the scope to shift from hospital to home or community-based care is restricted by long distances and poor communication in rural areas and by the lack of personnel (such as social workers) for this kind of service.

Further, secondary and tertiary care faces shortfalls in financing. The technologies are not updated, and physicians are badly paid.

The financing shortfalls have serious implications for the certification procedure of institutions which was initiated in 1997. Further certification of medical institutions is problematic as many of these cannot afford the necessary investments to follow standards, and should be closed. However, as this is politically unacceptable, deadlines for certification have several times been prolonged.

Table 10 shows how health care resources are distributed by regional sickness fund. (It will be recalled from earlier sections that each regional sickness fund corresponds to a grouping of districts or larger cities). Excluding Riga (which concentrates approximately one-third of Latvia's total population), there are substantial regional variations in hospital beds numbers per population, with rural areas being less well served. However, due to the relatively small size of

the country, contributing to shorter distances, this problem is not particularly severe.

There is a need for inter-district cooperation at the regional level to achieve further reductions in bed numbers. Regional sickness funds plan to merge hospitals thus leading to a reduction in the number of beds and number of physicians and an increase in secondary level outpatient services such as day hospitals. Outpatient diagnostic centres are being developed within the hospitals for better utilization of hospital facilities. In Latvia there are 58 hospitals with low treatment and diagnostic standards, each of which has under 50 beds. These hospitals will be converted into primary health care centres and social care institutions which will provide long term social care.

Riga is in the initial stages of introducing day care facilities.

During the year 2000 a national masterplan for rational planning of hospital services was being developed, and was to have been completed by the end of 2000 or beginning of 2001.

Social care

The community care system is now being re-established, having been completely destroyed during the years of Soviet occupation. Social care in the Soviet period took place in acute care hospitals.

The low birth rate in Latvia has led to the ageing of the population. Research on social aspects of the population (NORBALT) showed that elderly people feel insecure.

At present social care is under the responsibility of the Ministry of Welfare Social Assistance Department. According to a law on social care (1995), this is defined to include material assistance, social care, and social rehabilitation.

Social care is provided in homes for the elderly, long-term care facilities for the handicapped and nursing homes, orphan homes as well as social care in the home and day centres.

At present there are 131 social care institutions in Latvia with 11 792 beds, of which 11 360 are functional. The number of nursing homes increased from 42 in 1994 to 62 in 1998. There are state- and community-owned public homes for the elderly. The most advanced of these try to meet the individual needs of their clients by providing short-term care.

Nursing homes are the responsibility of local governments. Primary health care professionals can make recommendations for admission. Care in nursing homes carries a co-payment, so that retired persons have to pay a proportion of

costs from their pensions. As the incomes of the retired are low, and housing rental costs very high, the demand for social care is growing.

The number of children in social care institutions increased dramatically from 1183 in 1990 to 3183 in 1998. There were six orphanages (enrolment 797) financed by the state and 49 local government children's homes (enrolment 2386) in 1998. Handicapped children have four specialized social care institutions, while there are six centres for orphans under two years old financed by state. The social care institutions for children aged 3–18 years are financed by local authorities' budgets. At the end of 1998, there were 493 short-term social care beds, and social care received 2293 patients, of which 101 were children. In 1999 there were 486 short-term social care beds in 28 hospitals in Latvia.

In addition, there are day care centres for the mentally handicapped in Riga and Kuldiga. This is a new social care form in Latvia which is financed by local government and the state. There are also some charity organizations which provide short-term care for women and children.

In some cases when social care institutions are located on hospital premises, the treatment costs are covered by the regional sickness funds. This is mostly in the municipal hospitals.

Social care institutions are financed as follows:

Type of institution	**Source of financing**
Homes for elderly	local government, individual pensions
Social care institutions for people with eyesight and mental disorders	state, individual pensions
Centres for orphans under 2 years old	state
Social care institutions for children aged 3-18 years	local government
Specialized social care institutions for handicapped children aged 4-18	state

Social care is increasingly provided at home. There were 7190 persons who were nursed at home in 372 municipalities (of 578) in 1996. In 1998 this number decreased to 6653 persons of which 4772 were old age pensioners, 1800 were disabled persons and 81 others. The number of persons who required nursing but did not receive it were 486 (6.8% of the number of persons who needed it). The number of persons who received care were 4582 in 1998 (4800 in 1994). The number of care providers needs to increase.

Access is satisfactory; however, the quality of services is strongly influenced by low staff salaries and the poor condition of buildings and facilities. Specialized geriatric wards have been opened in one of Riga's private clinics.

Table 11. Health care personnel per 1000 population, 1991–1999

	1991	1996	1997	1998	1999
Active physicians	4.0	2.9	2.9	3.0	3.1
Active dentists	0.5	0.5	0.4	0.4	0.4
Certified nurses	8.2	6.0	5.6	5.5	5.2
Midwives	0.5	0.4	0.3	0.3	0.2
Physicians graduating	0.08	0.11	0.10	0.08	0.07
Nurses graduating	0.41	0.17	0.15	0.14	0.09

Source: WHO Regional Office for Europe health for all database; Yearbooks of health statistics, Latvia, 1991–1999.

As the demand for this kind of service is high, beds for social care have been made available in the larger hospitals.

Human resources and training

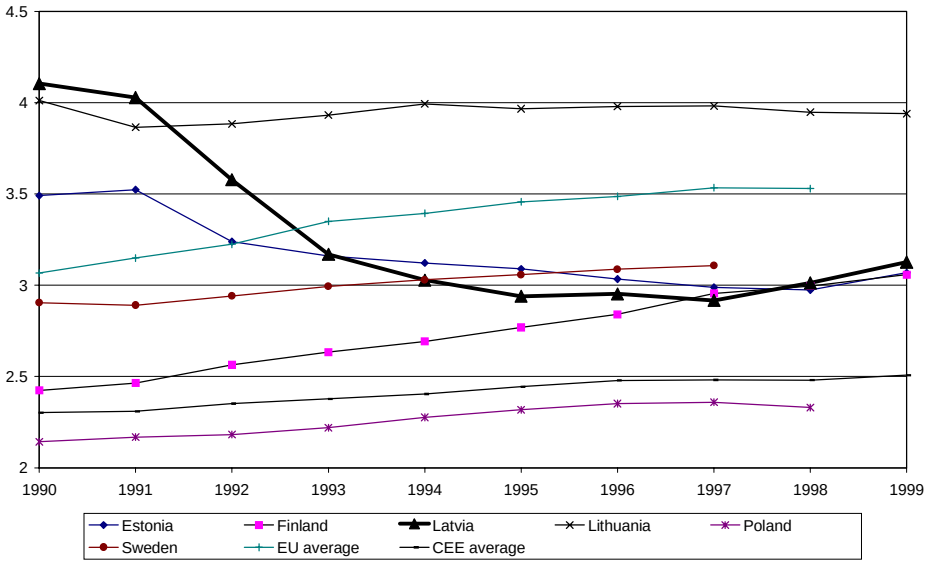
The Soviet system produced large numbers of doctors, most of whom were women, and a disproportionately large number of whom were Russian. As Table 11 indicates, the number of physicians per population has shown an overall decrease in the 1990s, despite a small increase in 1998 and 1999. The same decreasing trend applies to dentists, nurses and midwives, as well as graduating nurses. The number of graduating physicians increased in the mid-1990s, but then began to drop. Reasons for the decreases in medical staff numbers include the declining number of hospitals and hospital beds, and low salaries and prestige for health care professionals. Entries to the Latvian Medical Academy were cut from 2500 to 397 in 1991. This has contributed to significantly reducing the number of doctors. The ratio of nurses to physicians is quite low and this is expected have a negative impact on the development of primary health care teams.

Latvia's position in international terms can be seen in Fig. 14 and Fig. 15. Fig. 14, showing physicians per 1000 population in Estonia, Finland, Latvia, Lithuania, Poland and Sweden, as well as EU and CEE averages, displays the dramatic decline in physician numbers that occurred since the early 1990s. Fig. 15 shows Latvian physician and nurse numbers in a European-wide context. By the end of the decade, the number of physicians per 1000 stood at 3.1, while the number of nurses was 5.2.

Since 1989 the state language has been Latvian and public service employees of other nationalities have to present a certificate of language skills.

The education and training of health care personnel is provided by two higher educational institutions in Latvia: the Latvian Medical Academy which

Fig. 14. Physicians per 1000 population in Latvia and selected European countries, 1990–1999



Source: WHO Regional Office for Europe health for all database.

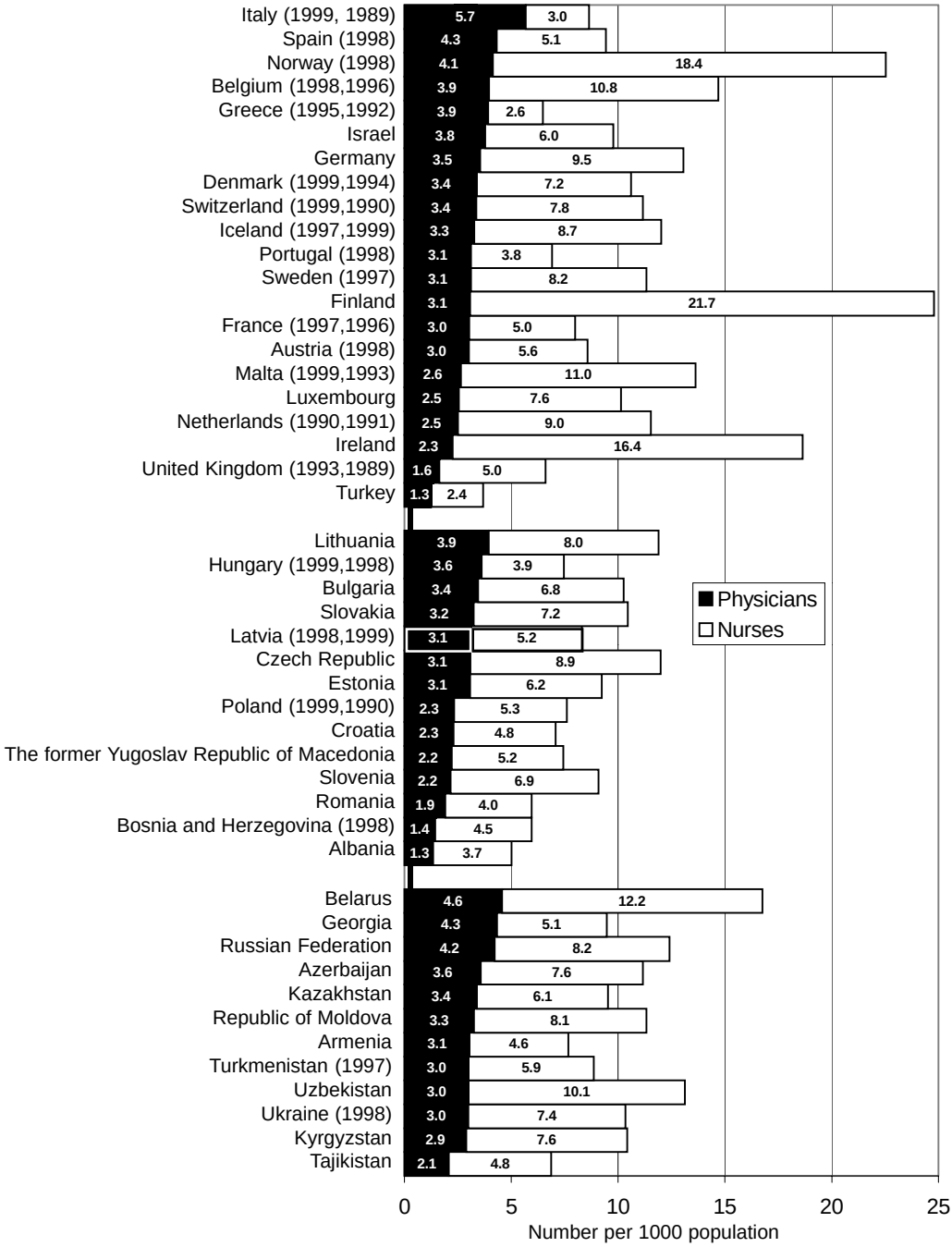
is under the supervision of the Ministry of Welfare and the Latvian University's Medical Faculty.

A physician's education takes six years. Entrants must have completed twelve years of school education. After graduation and three years of postgraduate training, in certain specialties doctors can receive a certificate issued by the appropriate professional association (part of the Latvian Physicians Association). In other specialties several additional years of training are required. This certificate allows a doctor to work in the state health care system and it must be renewed through a re-certification procedure every five years.

In recent years, specialist training in general practice has been developed. Additional training programmes and courses for general practitioners already in practice are offered for a fee. The number of certified physicians in each specialty is not limited, but for private practice a licence from the local self-government is required. Private practice physicians have to be registered in the Latvian Physicians Association's register.

In 1992, two parallel educational processes were initiated for the training of general practitioners: residency for young graduates (with a programme involving three years of clinical training); and retaining of existing specialists. In principle any specialist is permitted to retrain. However, retraining for

Fig. 15. Number of physicians and nurses per 1000 population in the WHO European Region, 1999 or (latest available year)



Source: WHO Regional Office for Europe health for all database.

paediatricians and internists only takes a few months while for other specialties it is a far more time-consuming process; hence most retraining occurs in the case of these two specialties. In 1993, the Association of Family Physicians started certification of doctors and some first specialists (in general practice) were recognized.

Until the end of 1996, retraining was financed mainly privately by doctors themselves who continued to work in their practices while undergoing retraining. In 1997, financial support of retraining by some regional sickness funds was initiated. In addition, since 1998 the Department of Labour and PHARE began to finance retraining and continuous education.

As a result of the above processes, the number of certified general practitioners has increased markedly in recent years. At the end of 1999, 42% of primary care doctors were general practitioners compared to 25% in 1998.

However, there has been some concern that the retraining process overtook the necessary organizational and legal factors that should be in place to ensure adequate absorption of newly trained and retrained physicians into the primary health care system. It has often been the case that general practitioners are unable to practice in their new specialty. Reasons for this include the following:

- difficulties and uncertainties associated with establishing an independent practice;
- low prestige of primary care doctors among hospital doctors and doctors of other specialties and even among the population;
- lack of experience among health care administrators with primary care;
- concerns over the quality of retraining;
- a distinct split between care of the adult population and care of children.

Until recently, it was possible to begin to train as a nurse after only nine years of school education. This took four years and meant that nurses were qualified at the age of 18 or 19 years. This method of training has been abolished and has been replaced with a three-year programme, which begins after twelve years of schooling. The number of students in nursing schools is less than planned, as a career in nursing offers a low income.

A nursing faculty was established in the Latvian Medical Academy in 1990 and offers a four-year degree course in nursing. It is intended that these university-educated nurses work as head nurses in hospitals and specialized wards.

There is a nine-month training course leading to a qualification for auxiliary nurses (nursing assistants).

Pharmaceuticals and health care technology assessment

Latvia has a significant pharmaceutical industry but drug policy is primarily oriented towards safety and quality rather than support for domestic production. Production, imports, exports and distribution are supervised by the Department of Pharmacy of the Ministry of Welfare.

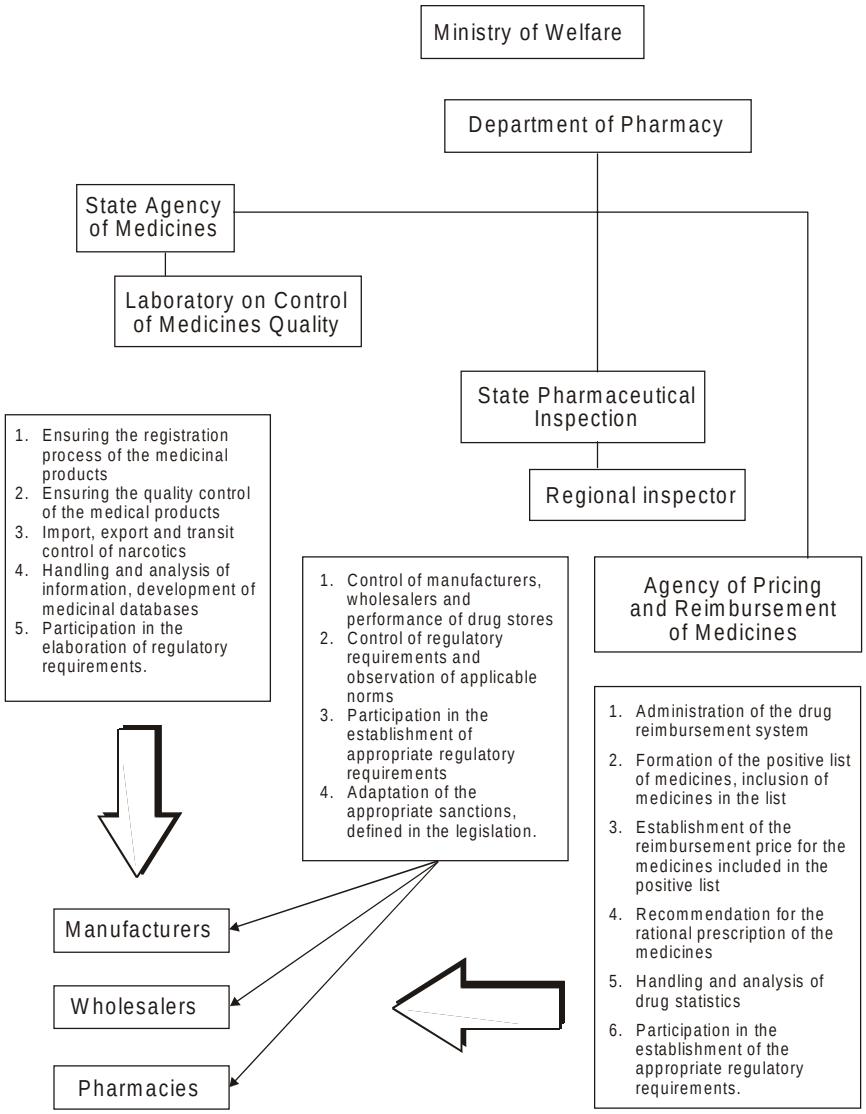
Latvia adopted a law "On Pharmaceuticals" in 1993, which was updated in 1998 and June 2000. The aim of the law is to regulate the activities in the pharmaceutical field and to ensure that the pharmaceutical products produced and distributed are safe, qualitative and effective. The law determines the responsibilities of the Ministry of Welfare, the State Agency of Medicines and the State Pharmaceutical Inspection, and sets the main principles of registration, manufacturing, and wholesale and retail distribution (see Fig. 16).

The State Agency of Medicines (SAM) was founded in October 1996 from the reorganized Pharmacopoeia and Pharmacology Committee and Medicines Quality Control Laboratory. As can be seen in Fig. 16, the State Agency is a substructure of the Department of Pharmacy. The agency maintains a pharmaceutical products register, where all pharmaceutical products registered in Latvia are listed. The aims of SAM are evaluation of medicinal products and drugs, their registration, monitoring, quality control and distribution management within the country. It analyses information, develops norms and regulates prescribing of medications. The agency is responsible for drug import, export, and transit control. The Laboratory on Control of Medicines Quality is a part of the State Agency of Medicines.

Besides its main tasks, SAM fulfills the following duties:

- issues clinical trial performance licenses, monitors the process of the clinical trials and summarizes their results;
- gathers, summarizes and distributes information regarding quality control of pharmaceuticals;
- acts as a consultant and intermediary between various governmental institutions as well as among local and foreign entrepreneurs;
- cooperates with international pharmaceutical organizations on various including issues of quality control;
- issues import and export, transit and distribution certificates of the medicines and drugs;
- prepares and submits proposals to the Ministry of Welfare on the laboratories, institutes and other institutions to be included in the list of the organizations

Fig. 16. Administrative structure of pharmaceutical sector



licensed to give official evaluations on the quality of medicines and drugs.

Regulation of pharmacies is the task of the State Pharmaceutical Inspection.

In 1998, the Medicines Pricing and Reimbursement Agency was created in order to carry out a reform of the drug reimbursement system in accordance

with the EC directive 89/105/EEC. A key purpose of the new organization is to determine the positive list and to ensure the appropriate functioning of the new system. It is a non-profit organization with the legal status of a state limited company, intended to cooperate with professional organizations (such as those of physicians and pharmacists), pharmaceutical producers and the State Compulsory Health Insurance Agency. Among its functions will be the analysis and estimation of treatment expenses, overseeing of physician practices on prescription of drugs included in the positive list, and assessment of the results.

For drugs included in the positive list, prices are negotiated between the Medicines Pricing and Reimbursement Agency and the manufacturers. For drugs not included in the reimbursement system, prices are based on an unregulated manufacturer's price with limited mark-ups for wholesalers and pharmacies. The wholesale price is calculated as the manufacturer's price plus a maximum of 15% mark-up (ranging from 5% to 15% by the wholesaler). The margin paid to the pharmacist is regressive so that, as the wholesale price increases, the retailer's margin decreases (20% for the most expensive products to 38% for the cheapest).

In 1998, regulations by the Cabinet of Ministers based on Directive 89/105/EEC on pricing and reimbursement were issued, and are to be implemented during the years 1998–2002. The main principles are:

1. The Cabinet of Ministers has determined a list of 52 illnesses and conditions (severe and chronic) for which medication is partially or totally reimbursed.
2. There are three categories of diseases where medication is partly (50% or 75%) or fully (100%) reimbursed. Full compensation occurs in those cases where the patient has a chronic disease and the medicine is necessary to maintain the patient's life functions. 75% compensation occurs in those cases where the patient has a chronic disease and the medication is necessary to maintain the patient's health on the same level and prevent deterioration. 50% compensation is in those cases where the patient has a chronic disease and the prescribed medication could improve the patient's health. The patient pays the difference between the drug cost in the pharmacy and the compensation sum. Even if the compensation is 100% the patient pays LVL 0.10 for the prescription. The costs of these drugs are reimbursed (by the sickness funds) if they have been prescribed by a doctor who has a contract with a sickness fund.
3. The Minister of Welfare approves a list of drug active substances (INN) for treatment of each illness or special cause according to the treatment schemes worked out by doctors' professional associations.
4. According to the drug INN list, the Medicines Pricing and Reimbursement Agency issues a positive list containing specific presentations and their

prices based on the applications and negotiations with drug marketing authorization holders.

5. OTC medicines and homeopathic products are not reimbursed.

The cost of medications is paid fully by the patient, except in those cases that are designated by the Cabinet of Ministers regulations.

A product is placed in the reimbursement scheme (positive list) if the Medicines Pricing and Reimbursement Agency has approved the price and taken the decision to include the product in the list. The price is set on the basis of negotiations between the Agency and the holder of the marketing authorisation.

Reimbursable pharmaceutical products are prescribed by general practitioners and specialists who have an agreement with a sickness fund. In case of 75% and 50% reimbursement the patient pays the co-payment and additional LVL 0.10 for handling the prescription directly to the pharmacy. Reimbursable prescriptions are codified and are under control of regional sickness funds.

The pharmaceuticals included in the List of Reimbursable Medicine (positive list), must be registered in the Latvian Drug Register and classified as a prescription drug. Medical aids and prostheses must be registered in the Health Statistics and Medical Technology Agency.

With the development of this system Latvia will eventually come closer to implementing the basic principles and practices concerning pharmaceutical reimbursement and pricing in the European Union.

However, for the moment, there remain serious problems in the implementation of the system. First, the level of supplies is not sufficient to meet all the needs of individuals and hospitals. Hospitals do not have sufficient supplies, and patients often cannot afford to buy medications. Second, the health care budget is unable to cover all expenses necessary for the reimbursement of pharmaceuticals included in the positive list. While general practitioners and specialists are by law permitted to prescribe drugs, the sickness funds, though obliged to reimburse are unable to do so, and so are trying to influence prescribing through their contracts with providers. Pharmacies are involved in that they give out drugs for which they are not reimbursed. In the year 2000, the Association of Family Physicians started a campaign against the Ministry of Welfare due to the problem, which, however, has yet to be resolved.

Annual turnover of the Latvian pharmaceutical market was estimated to be around US $100 million in 1997. The volume of foreign drugs made up 85–90% of total consumption. Over half of imported pharmaceuticals comes from the former Soviet Union and eastern European countries due to cost

advantages. The Latvian market is extremely price sensitive, as most of the people cannot afford to buy expensive drugs.

In 1999, there were around 18 manufacturers, 74 wholesalers, and 668 pharmacies. Today, most of the producers and wholesalers, and about 90% of the retail pharmacies are privately owned. Most pharmacies that remain publicly owned are hospital pharmacies.

The Centre of Catastrophe Medicine has a list and reserves of pharmaceuticals, which could be used in extreme situations in the country.

Table 12 shows the structure of expenditures on pharmaceuticals in Latvia.

Table 12. Pharmaceutical expenditures in Latvia

	1997 LVL	1997 $	1999 LVL	1999 $
Health care budget (in millions)	63	105	136	226
Drug expenditure				
Domestic producers %	15%	15%	10%	10%
Hospital drugs %	15%	15%	24%	24%
Ambulatory drugs %	85%	85%	76%	76%
Prescription drugs %	65%	65%	73%	73%
OTC drugs %	35%	35%	27%	27%
Drug expenditure as % of health care expenditure	15.4%	15.4%	16.6%	16.6%
Reimbursed drug expenditure %	22.5%		36.6%	
Outpatient reimbursed drug expenditure %	7.4%	7.4%	13%	13%

Financial resource allocation

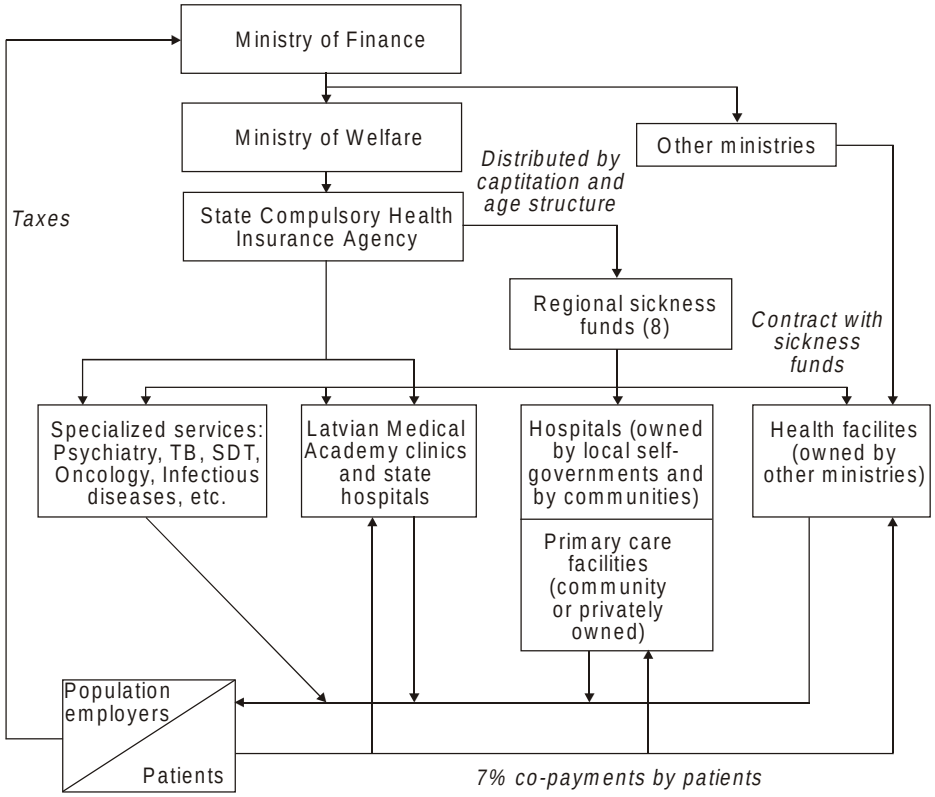
Third party budget setting and resource allocation

The size of budget for health care is determined by Parliament (*Saeima*) and by the Government each year. In 1999 it was 9% of the total budget. Until 1993 plans for the health care budget were made for each health care institution on the basis of estimates for the previous year, which initially depended on the number of beds in the hospital and number of staff in outpatient institutions. Institutions received a global budget for the year. In 1993 the health care budget was planned in accordance with the size of the population in each city or district and the age structure of inhabitants.

Until 1997 the health care budget was divided into two approximately equal parts. The first was divided between local governments (districts), following a formula weighted by population and age structure. Local governments then decided on how to allocate these resources to local sickness funds so that they could purchase the Basic Care Programme (primary and secondary care). A minimum level of spending on health care was defined by the Law on Equalization of Municipal Finances, but local governments could exceed this if they so chose. The second part of the health care budget was put at the disposal of the Ministry of Welfare and was used to finance the specialized state centres (the State Programme of Medical Care) and to pay state hospitals (via the State Sickness Fund) for delivering Basic Care Programme and tertiary-level services. Resource allocation at this level was the responsibility of the State Minister of Health (a position that was abolished in 1999) and the Director of the Health Department.

Since 1997 the health care budget is administered by the State Compulsory Health Insurance Agency (formerly the State Sickness Fund). It is totally responsible for health care budget usage. This central fund, together with the regional funds, work out the budget requirements based on the size of the budget in the previous year, and submit a Medical Services Request to the Ministry of Welfare. This request is further taken to the Ministry of Finance and the Cabinet

Fig. 17. Financing flow chart



of Ministers. The government, based on the state's planned budget, defines the state's priorities and sets a ceiling for each Ministry. A draft budget is then submitted to the parliament for approval. The parliament may make changes and define other priorities in the government's submitted draft budget. Following approval of the budget, the amount allocated for health care is disbursed to the State Compulsory Health Insurance Agency which, in turn, distributes funds to the regional sickness funds according to the size of the population and age structure. The amount of money in 1999 was LVL 55.16 per inhabitant, and in 2000 LVL 56.46.

Public financing of health care from centrally collected funds[10] in Latvia comprises the following:

[10] In addition, local governments have revenues that they may use for health care purposes if they choose.

- A "Special Health Care Budget" which consists of a fixed percentage (28.4%) of personal income tax;
- Subsidies or block grants from the central government's "Basic Budget" (formed by general revenues collected at the central level).

The special health care budget came into existence in 1995, following legislation entitled "On State Finance and Budget Management" (dated March 1994) and "On the State Budget for 1995", according to which each ministry should have a special budget. For the Ministry of Welfare, this meant that it took on the Special Health Budget in addition to the previously existing Special Social Budget.

A special budget (according to the definition used in statistical yearbooks) is formed by revenues that are not allocated to basic budgets but are rather earmarked to cover special expenses, namely those to which their name refers. The special health care budget is based on a constant percentage of personal income tax, fixed at 28.4% since 1997.

The special health care budget (together with subsidies from the basic budget) are used to finance the Basic Care Programme. The state programmes in health care are financed from the basic budget.

The State Compulsory Health Insurance Agency distributes a portion of its funds to the regional sickness funds which, in turn, pay for services specified in the Basic Care Programme through contracts with providers of these services. Another portion of funds is used by the State Compulsory Health Insurance Agency to directly pay for services provided through the state programmes. A third portion is allocated to centralized purchasing, which includes expenditures on pharmaceuticals included in the positive list, and other supplies and equipment.

Capital investments are financed by the Ministry of Welfare through the State Investment Programme and are supervised by the Ministry of Economics and Ministry of Finance. Capital investments cover only the public sector and there is no special system to ensure an equitable geographical distribution.

Payment of hospitals

The payment system for hospitals has changed in recent years. Until 1993 the annual hospital budget was calculated from the previous year's expenses, based on the number of staff, maintenance and running costs, and costs for treatment. Since 1994 there has been a shift away from historical allocation to payment for services delivered. The regional sickness funds hold the health budget,

contract with the hospitals and agree upon the range of services provided and payment for these services. The State Compulsory Health Insurance Agency lays down the costing and accounts methodology that should be used.

Until 1996 the hospitals were paid on a bed-day basis. They set their per diem price in accordance with certain rules. For each of 24 diagnostic categories an average length of stay was determined. If the patient was admitted for this period, the hospital received 100% of its per diem price. If the length of stay exceeded this period, the additional days were paid at only 60% of the price. If the length of stay was shorter than the average, the actual number of days was paid at 100% and the difference at 70% per diem. From August 1995 to 31 December 1996 the patient had to cover 25% of costs for all care except emergency care and maternity care. For this purpose, costs were calculated prospectively and the patient signed an agreement before admission. However as there was no mechanism to enforce these payments, patients refused or simply were unable to pay when they left the hospital. Specialized state centres and state hospitals were financed from the State Sickness Fund for those services included in the Basic Care Programme and for special state programmes directly from the Health Department.

These financing reforms had both advantages and disadvantages. The hospital administration was freer to decide on the number and skill-mix of staff it employs and on which services it delivers. As a result, the cost-effectiveness of service delivery had begun to be considered. Those services outside of the Basic Care Programme could be provided if patients were prepared to pay the full cost or, in some districts**,** they were partly covered by the sickness fund on the basis of separate agreements. On the other hand, the inter-territorial billing system was not always successful, because hospital managers were reluctant to refer patients to other institutions even if the case needed more specialized treatment, as this would entail loss of revenue.

Since 1998, regional sickness funds pay for inpatient care services according to:

1) *Diagnosis:* 64 diagnosis groups have been specified where the patient's treatment costs are calculated according to the ICD-10 classification. These groups have fixed payments, treatment intervals and performed manipulations. It is hoped that this will ensure service quality and protect the patient.
2) *Bed-day payment:* The bed-day price is calculated according to number of staff, social taxes, and maintenance expenses.
3) *Points:* Hospitals receive additional reimbursement for manipulations that exceed 1100 points according to the Criteria for Health Care Services and the point price. The criteria are worked out by the State Compulsory Health

Insurance Agency together with professional associations. The Agency fixes the point's price**.** Points cover the salaries of medical staff and expenditures on medical materials.

The health care facility is contracted to provide a certain number (quota) of interventions for a certain price. If the facility undertakes more interventions, it does not receive added funding. Similarly it does not receive more funding if the service provided by the health care facility costs more than the price stated by SCHIA.

Hospitals may charge for certain services. For example, the patient has to pay for extra comfort – a single room, individual nurse, special menu, refrigerator, television, and extra consultations that are not considered necessary for the treatment, and not covered by the sickness fund. This allows for an increase in the institution's revenues. Salaries of hospital staff may be increased from these revenues.

Payment of physicians

Until 1993 the salaries of physicians in medical institutions was fixed. Extra payment was paid for night work and unhealthy work.

In the mid-1990s, the remuneration system in the ambulatory sector was changed. The newly established regional sickness funds, financed from funds in the state budget distributed through the central fund, began to contract with ambulatory care providers. In the case of ambulatory care, the new payment system introduced in most of the regions of the country (covering about 75% of the population) was the points system. The western part of Latvia (Kurzeme) introduced a form of capitation for primary care doctors, while maintaining salary-based payment for specialists.

According to the points system, each item of service was assigned a number of points according to a scale of service intensity. Physicians working in outpatient institutions had to fill out an account form for manipulations. Each service was assigned a number of points. Sickness funds paid the outpatient institution according to number of points corresponding to the services delivered.

By contrast, since 1995 Kuldîga (a town in Latvia) has been working with the "Kurzemes model", the main emphasis in which was the development of the institution of family doctors, responsible for effective disease prevention and health promotion. The regional sickness fund divided its payments into two main parts: one for family doctors, who cover the primary health care

level, and the other for regional hospitals, covering secondary health care. Family doctors receive 50% of the money in accordance with the number of patients in their practice (a form of capitation) and 50% in accordance with number of visits as fee-for-service.

Physicians working in inpatient institutions and ambulatory sections of hospitals and polyclinics (i.e. specialist physicians) are paid partly on the basis of a fixed salary, which is denoted in their contract with the facility where they work. In addition, these doctors receive extra payments for manipulations that exceed 1100 points. Based on a formula, the points are converted into currency. The salary is usually 40–50% of the total points value. The salary cannot be lower than the minimum wage set for the country as a whole. Private practitioners who are contracted are paid on the basis of points, or out-of-pocket by the patient.

It is now broadly acknowledged in Latvia that the newly-introduced points system was a mistaken policy, as this encouraged a larger than necessary volume of services and costly interventions as opposed to simpler but equally effective ones, and promoted curative care at the expense of preventive or health promotive care.

The points system is therefore now in the process of being replaced by a form of "mixed capitation" with general practitioner fundholding for ambulatory care physicians. This system was developed by the State Compulsory Health Insurance Agency, and has begun to be introduced since October 1999 in the whole of Latvia except Riga City (see below for the case of Riga). There are plans to complete the introduction of this remuneration system in all of Latvia by 2001. This is considered feasible as 80% of the Latvian population was registered both with a family doctor and with a regional sickness fund as of spring 2000.

The "mixed capitation" system which is currently being introduced is actually a mixture of capitation and general practitioner fundholding, and consists of the following: The general practitioner receives a capitation payment based on the number of listed patients and the patient age structure. A portion of this payment constitutes general practitioner remuneration; and a portion is a fixed payment for remuneration of the primary health care nurse, for compensation of the general practitioner in the event that the practice is in a low density area and for general practitioner certification. In addition, the general practitioner pays for the services of specialists to whom patients have been referred. The unit of payment for the specialists is the "episode of care"[11] according to a specified price-list. This sum, calculated on the basis of the

[11] "Episode of care" refers to a health problem from its first encounter with a health care provider through the completion of the last encounter related to that problem.

specialist's invoices, is deducted from the capitation resources of the general practitioner. Certain specialists (such as psychiatrists, endocrinologists for diabetes, tuberculosis specialists, dentists for young persons (under eighteen), etc. who do not require a referral from a general practitioner) are allocated separate resources for their respective payments.

According to this system, general practitioners are managers of all funds allocated for patient services with the exception of secondary level services provided by hospitals and direct access specialists (i.e. specialists who do not require a referral from a general practitioner). All other ambulatory specialists are reimbursed by the general practitioners with a fixed amount of money per "episode of care", irrespective of time spent with the patient, number of visits, etc.

This remuneration system is intended to support the development of primary care by strengthening the GP gatekeeping role, and strengthening the position of the general practitioner who faces a strong incentive not to refer patients to higher levels of care.

However, it meets with opposition from patients feeling that their best interests may not be served by general practitioners who may wrongly choose not to refer them to specialist care due to the financial incentive to economize on capitation funds, as well as from specialists themselves whose position vis-à-vis the general practitioners is significantly weakened.

The Riga Regional Sickness Fund has not accepted this system of remuneration and still uses the point system for reimbursement for all outpatient services (general practitioners and specialists). The original intention had been that introduction of this form of payment would be contingent upon its assessment and revisions in accordance with its perceived advantages and deficiencies. Whereas local experts have been involved in an evaluation process since August 2000, no revisions had been produced as of late 2000. The main objection of the Riga Regional Sickness Fund is that general practitioners should not manage nearly all the funds available for outpatient services, and in particular, general practitioners must not be responsible for the reimbursement of specialists. The main risks of the present capitation system are held to be the following:

- Certain key functions of sickness funds (planning, supervision of health services. etc.) are eliminated as general practitioners take on the role of payers of outpatient services;
- The patient becomes much more dependent on the general practitioner and is under risk to be examined and treated inappropriately or inadequately;

- The general practitioner is not ready to manage the greatest part of outpatient financial resources and will be unable to provide necessary health services with the amount of resources available currently;
- A serious deterioration in the relationship between primary and secondary care levels is likely to result;
- The risk of unemployment of specialists differs between urban and rural areas, being much greater in the former where specialists tend to work only in the outpatient sector (in rural areas specialists usually work in both inpatient and outpatient settings, thus facing a lower risk of becoming unemployed);
- There is no appropriate software for monitoring and controlling the "mixed capitation" reimbursement system.

Over and above the difficulties encountered in the transition to a well-functioning remuneration system for doctors, there are difficulties stemming from the overall levels of incomes in the health sector.

The incomes of physicians working in publicly provided services are among the lowest in the country. There is great dissatisfaction among health professionals and their social standing is not high. The most qualified specialists tend to move into private practice and young doctors are leaving the profession or work in other areas.

Health care reforms

Aims and objectives

Changes in health care policy were predicated on the belief that a centralized and hospital-oriented system was inappropriate for a market economy. The previous system provided no incentives for moving towards quality improvement or for the provision of cost-effective services. Changes in the health care system were proposed and initiated by the Latvian Physicians Association (now known as the Medical Association of Latvia), which was re-established in 1988 and which also played significant role in initiating changes in Latvian society as a whole. In addition, the Managers' Association and health service administrators have been important in the reform process, but consumers have not yet had much direct influence.

The initial proposals of the Latvian Physicians Association were essentially a protest against the Soviet system of remuneration and a proposal to increase physicians low incomes and improve the status of the medical profession. The demands of the Association included free choice of physician by patients and the re-installation of social insurance organization and financing, which had been Latvia's health care financing system between the First and the Second World Wars. Arguments in favour of compulsory health insurance included the possibility of increasing financial resources for health care, providing elements of competition for health care institutions and physicians, and to guarantee patient freedom of choice. Disagreements between alternative proposals rested on the mechanism of health insurance and the time frame for its introduction.

On the delivery side, reforms have been oriented towards the promotion of primary and preventive care rather than hospital care. Reforms in health care administration involve the devolution of responsibilities of primary and secondary health care to local governments. It is hoped that, in the future, individual physician's practices will become the basic unit of health care. On

the health care financing side, reforms will be completed after the introduction of the capitation system of remuneration for primary health care.

Content of reforms and legislation

Following Latvia's independence, all laws and regulations concerning the organization and financing of health care that had survived from the Soviet period were gradually replaced. However, lack of clarity on the conceptual framework of the reform prevented detailed and careful reform planning. There resulted therefore some legislation by the *Saeima* (parliament) together with many temporary regulations by the Cabinet of Ministers and the Ministry of Welfare on specific matters, giving rise to fragmentation of the legal basis of the health care system. This has been especially marked during the early 1990s, while later years have seen the appearance of some "umbrella" laws.

The following lists the key legal acts of the reforms:

Law "On Local Governments" (1993)
According to this law, local authorities (districts and municipalities) are to be responsible for the organization of health care, and they are to provide at least a portion of financing for health care through the local government budget.

Document of the Ministry of Welfare and Regulation of the Cabinet of Ministers "The Basic Care Programme" (1994)
This defines a basket of primary and secondary health care services that are to be offered to all residents of Latvia. Initially it was financed by district-level budgets through local account funds (or territorial sickness funds). Since 1997 it is financed through the regional sickness funds. This basket is examined and revised annually.

Policy document of the Cabinet of Ministers "Strategy of Health Care Development in Latvia (1996)
This defines the framework for further reforms of the Latvian health care system.

Law "On Medical Care" or Law "On Medical Treatment" (1997)
This law replaced the Regulations of the Cabinet of Ministers "On Medical Care" of 1994. It regulates the supervision and provision of health care. It was supplemented in 1998 with an amendment with provisions concerning patient's rights in health care and delineation of health care providers' responsibilities. The Law on Medical Care with its amendments regulates public relations in the provision of preventive and diagnostic work, and patients' treatment and

rehabilitation. While the scope and content of medical services by the state is not delineated, much attention is given to the rights of patients (the right to choose, the right to be informed, the right to refuse treatment, etc.). The Law states that health care is a complex activity involving health promotion and maintenance.

Law "On Physician's Practice" (1997)
This law regulates the responsibilities and rights of medical practitioners. It specifies that medical practice is an independent profession and a specific form of entrepreneurship**,** meaning that doctors wishing to establish an independent practice are no longer obligated to choose some legal form of entrepreneurship (i.e. individual enterprise, limited liability company, etc.). In addition it states that the activities of a family doctor are to form the basis of the health care system, and requires that practicing doctors be registered by the Latvian Medical Association, thus replacing the previous system of licensing of independent practitioners by the municipalities.

However, the provisions of this law regarding medical practitioners' special form of entrepreneurship are not in agreement with Latvian general law on entrepreneurship. This causes a legal problem. (At the time of writing (early 2001) a new law of general commerce is being discussed in the parliament.)

Regulation of the Ministry of Welfare "On the Certification of Medical Practice" (1997)
This defines the minimum necessary equipment and premises, and registration procedure of new independent practices.

Law "On Pharmaceuticals" (1993, 1998 and 2000)
The aim of the law is to regulate the activities in the pharmaceutical field and to ensure that pharmaceutical products produced and distributed are safe, effective, and of high quality. The law determines the responsibilities of the Ministry of Welfare, the State Agency of Medicines and the State Pharmaceutical Inspectorate, sets the main principles of registration, manufacturing, wholesale and distribution. This law forms the basis for the adoption of several regulations of the Cabinet of Ministers in accordance with European Union Directives.

Regulations of the Cabinet of Ministers "For Establishment and Activity of Sickness Funds" (1997)
In 1997 the Cabinet of Ministers issued regulations on the establishment and activities of sickness funds, their regulation by one or more local authorities, their aims, main functions, rights and responsibilities. Sickness funds should cover a territory with at least 200 000 inhabitants. The consolidation process

of territorial sickness funds into regional sickness funds was initiated. It was carried out through mutual agreement of the local governments. In the beginning of 1998 six regional sickness funds had been established; in addition, there were two "centres of accounting" in Rezekness and Kuldigas where the local governments did not agree with the principles for establishment of regional sickness funds.

Regulations of the Cabinet of Ministers "On Compulsory Insurance of the Civil Liability of the Medical Doctor in Practice" (1998)
These introduce insurance of third person liability as part of independent practice.

Regulations "On Health Care Institution Certification" (1998)
These establish the conditions and procedures for institutions' certification.

Regulations of the Cabinet of Ministers "On Compensation Procedures for Procurement of Medicines, Equipment, Goods for Ambulatory Treatment" ((1998)
These regulations concern reimbursement of pharmaceutical products and medical devices for outpatient care. They specify conditions for reimbursement and the main criteria of inclusion and exclusion from the reimbursement list (positive list).

Regulations of the Cabinet of Ministers "On Financing of Health Care" (1999)
These regulations establish health care financing rules specifying the source and management of health care financing. The key changes they initiate are: (a) 70% of funding for the state programmes is to be included into the Basic Care Programme defining the minimum package of health care services, and financed through the regional sickness funds; and (b) physician remuneration in primary care based on the capitation model is to be initiated.

Regulation of the Ministry of Welfare "Development Strategy of Primary and Secondary Health Care" (1999)
This defines the roles and responsibilities of primary care and referral to hospitals.

Regulation of Ministry of Welfare "On the Functions of General Practitioners and Specialists" (1999)
This regulation determines the main tasks and responsibilities of general practitioners and specialists. It firmly separates general practitioner care from specialist care, and requires that the gatekeeper role of general practitioners be strictly enforced.

Health for all policy

Policy on health promotion and disease prevention was established in the conference "Better Living in Better Latvia" (1994), which delineated the objectives of Latvia's health strategy. The health strategy reflects health for all goals.

WHO Health 21

"Health for all in the 21st century" and the 21 targets have been accepted in Latvia by the Cabinet of Ministers and are used as the basis for Latvia's health strategy.

In this framework there was a need to prepare a Data Presentation System (DPS). The purpose of the DPS is to display statistical data in a user-friendly, graphical form. It is a tool that can provide quick and easy access to a large amount of routinely collected statistical data and help make use of this information. The local Data Presentation System of health statistics is harmonized with WHO Health 21 indicators and Latvian national health care indicators.

Reform implementation

The Latvian Physicians' Association initiated the reform process in 1988. Today the key players in the process are officials from the Ministry of Welfare, the political party *Tevzeme un Briviba* (Fatherland and Freedom, traditionally supported by the Ministry of Welfare), the Government, the Latvian Physicians' Association, the Health Managers' Association, the World Bank, the European Union (through some PHARE projects) and WHO. The main interest groups are medical professionals and patients, though there are as yet there are no powerful organizations to represent patients.

At the end of 1991 the Ministry of Welfare, representing the health care and social care systems, was established.

Financial reform began with the establishment of the Ministry of Welfare Central Account Fund in 1993 (known as the State Sickness Fund since 1995 and the State Compulsory Health Insurance Agency since 1998) which was assigned the task to promote and manage the health care financing reform in Latvia. This was initially an accounts settlement office. In the same year, the Ministry of Welfare took over health care financing from the Ministry of Finance. By 1995 districts had established their own local account funds (territorial sickness funds) which acted as local health purchasers.

These changes in financial structure and organization took place in the absence of a legal framework; no laws were passed dictating the changes that were to take place. In 1994, the territorial sickness funds established the Alliance of Latvian Sickness Funds, which was the only body for some time determining the norms in the financing system.

Parallel to financial reform, a decentralization process was initiated in 1993 that made local governments responsible for the organization and delivery of primary and secondary health care. To ensure that these tasks would be effectively carried out, district executive committees organized units or departments of health care (sometimes a joint department of health and social care), i.e. health boards. Municipalities spent a portion of their resources from the local government budget investing in health services, especially in purchasing new equipment and technologies.

Until 1997, the health care system was financed from the state and local government budgets. The state health care programme, including specialized services, was financed from the state budget, and the Basic Care Programme, including primary and secondary care services, was financed from the local government budgets (through the local account funds) plus a state budget subsidy.

This financing arrangement resulted in very large inter-regional variations in health care expenditures per capita, leading to legal and regulatory changes that reduced the scope of responsibilities of local governments. In 1997, health care financing was re-centralized as (a) the local account funds were consolidated into 8 regional sickness funds, and (b) the State Sickness Fund began to allocate funds to the regional sickness funds (rather than the local governments). The purpose of this re-centralization was to ensure stable and equal financing per capita throughout the country. Therefore local governments lost their financing functions but remained responsible for maintaining health care facilities and for ensuring access to health care. Health boards were abolished in many districts and cities (in 1998 Riga had no city authorities for health care and health policy for a period of half a year). This has had negative impacts on the development of health care services, particularly in the area of investments and infrastructure development that could have been financed from municipal budgets (as no financing was provided through the sickness funds for facility maintenance).

A separate strand of reform has involved the delivery dimension that focuses on the development of primary health care based on general practice and primary care physicians as independent practitioners who contract with sickness funds. The model of primary health care based on the general practitioner was approved by the Ministry of Welfare in 1992. Retraining courses for physicians have

been available since 1992 and have given rise to a sharp increase in the number of general practitioners. Registration with primary care physicians and sickness funds began in 1998.

Since the mid-1990s, physician remuneration (for outpatient services) has been according to either of two systems – the capitation (Kurzeme) system or the points system which was introduced in the greater part of Latvia; payment of hospital physicians has been a combination of salary and points. The payment of the hospitals is on the basis of per diem price and diagnosis groups. More recently, a form of mixed capitation involving capitation and general practitioner fundholding has begun to be introduced for primary care physicians, as a means to strengthen the development of primary care.

The efforts to develop primary care have run into difficulties. Physicians are reluctant to establish independent practices; the polyclinic environment is hostile to general practitioners; independent practitioners are motivated to enter general practice because of the prospect of attracting private patients, thus compromising the socially good character of medicine. The recent introduction of capitation has given rise to further problems. First, being assured of a steady income (based on the patient list), some physicians neglect their practices by indulging in long absences. Second, patients have difficulty accepting the requirement of a referral to visit a specialist. Third, both patients and specialists question the correctness of the financial incentive facing the primary health care physicians to refrain from giving a referral as this entails a loss of income for the referring physician. Moreover, primary care remains focused on treatment of disease, and is not sufficiently directed toward prevention and health promotion. Finally, at present, there are no effective mechanisms for ensuring equal quality of care, access to health care or freedom of choice for patients.

Certification of medical institutions began in 1997. Whereas the relevant law stated that all inpatient and outpatient institutions must be certified by the end of 1999, in actual fact the number of institutions which managed to get certification by that time was minimal, thus the period was extended until 2003. Sickness funds prefer to contract with certified medical institutions, and this condition is expected to improve the quality of medical services and protect patients' rights.

Reforms in human resources planning have involved reductions in the number of medical students. At the same time training programmes have been oriented towards general practice. Nursing education has been reformed and is now available only after graduation from secondary school whereas, previously, training could begin before this. Degree-level nurses are educated in the nursing faculty of the Medical Academy. The education of social workers continues and their number will increase. A serious problem in the area of human resources

involves the low levels of remuneration of health care personnel. Many young and talented physicians thus leave the medical profession for other more lucrative careers.

As a result of activities of the Latvian Physicians' Association, the professional associations manage the supervision of doctors' qualifications and certification.

The privatization process in health care began in 1993 and covers mainly outpatient services. Most dental services are provided through the private sector and there are private medical clinics of all kinds. Whereas this ensures high quality of services and freedom of choice for the patient as well as higher earnings for practitioners, at the same time access is very limited due to high prices. In certain cases there can be highly negative results; for example, the oral health of schoolchildren is deteriorating because dentists are not interested in working at schools.

The main constraint on planning and implementation of reforms is political and economic instability. It is widely believed that the proportion of state funds allocated to health care is too small. Health is not a high priority of politicians and is only on the political agenda in the periods just before elections. On the other hand, the reforms that have begun appear to be sustainable because all major political parties agree on the general directions of the reform process.

The latest research on health care accessibility and health care insurance (1998) revealed the main areas of patient dissatisfaction with the health care system: lack of money for out-of-pocket payments, uncertainty about health care costs and physicians' professional skills and experience, shortage of specialists, long waiting lines, and problems with transport and long distances to the health care services. 29.3% of respondents were not satisfied with the health care system.

Conclusions

Latvia inherited from the Soviet Union a health care system fraught with problems. During the 1990s this health care system was further subjected to a crisis due not only to organizational difficulties but also the deteriorating macro-economic context, especially in the first half of the 1990s. The reforms in health care were prompted in part by the need to deal with the shortcomings of the previous system, and in part by the desire to revert to the system that had prevailed during Latvia's short period of independence between the two world wars.

A formal, comprehensive assessment of the reforms of Latvia's health care system has not been undertaken to date. Nevertheless some conclusions can be drawn about the effects of the reforms on the key issues of efficiency, equity, quality of care and consumer choice.

In the case of efficiency, positive developments include the dramatic decrease in the number of beds, as well as the reduction in average length of stay in hospitals. It is necessary to decrease the number of hospital beds further where the hospital bed capacity is low. However, overall, there are indications that resources are being used more rationally, and that the proportion of care provided at the primary level has increased. Selective contracting by regional sickness funds will contribute to the process of rationalization. Reforms in the hospital remuneration system after 1993 led to shorter lengths of stay. The new remuneration system for primary care physicians that is currently in the process of being introduced, while problematic, attempts to further shift resources toward the primary care sector. The strict enforcement of GP gatekeeping is expected to have a similar result. Additional achievements contributing to increased efficiency involve the significant reductions in the numbers of physicians as well as in numbers of medical students.

From the point of view of equity in financing, there have been achievements and there remain certain difficulties. The decision to maintain tax financing of health care (as opposed to social insurance financing which is

regressive) contributes to equity in financing. However there remain inequities which arise partly as a result of under-the-table payments which persist, and mainly as a result of very high out-of-pocket payments that have been introduced due to the large shortfalls in state financing of health care. This is considered to be one of the most important problems in the health care system today as seen by the citizens of Latvia. It is hoped that as the Latvian economy stabilizes and embarks upon a longer-term growth process, more services will be included in the Basic Care Programme, while co-payments on services will be reduced.

With regard to equity in access, a disproportionate number of publicly provided services are available in Riga and other large urban centres. Many of these services are not available for the rural population, thus detracting from the achievement of equity in access to services. On the other hand, the re-centralization of financing of 1997 was a major step in the direction of curtailing the wide variations in per capita expenditures and hence in delivery of services, that had emerged across regions since 1993.

While efforts have been directed to improve quality of care, there remain serious obstacles in this process. It has been difficult to enforce treatment standards in view of resource shortages faced by provider institutions that prevent them from making the necessary improvements. Further certification of institutions thus remains problematic, while closure of uncertified institutions would be politically unacceptable. The mixed capitation remuneration system with fundholding elements recently introduced, while also intended in part to improve primary care (though an increase in the volume of preventive care) may be working to diminish the overall use of services, thus working against quality while also increasing the need to resort to out-of-pocket payments (no official analysis has as yet been carried out).

Regarding patient free choice, the increasing number of primary care physicians and their practices provide the patient with possibilities to choose their primary care physician. Patients are permitted to change their doctor twice a year (excluding change of address). To date, 80% of the Latvian population has chosen a primary care physician by registering with one. In addition, patients can freely choose a hospital, provided it is contracted with the patient's regional sickness fund. However in rural areas patients in fact have very limited possibilities for choice, as there may be only one practitioner or one hospital from which to choose. Consumers of health care as yet remain in a relatively weak position as there are no consumer organizations which can represent patients' interests on a national or any other level.

Improved health status (as measured by life expectancy at birth) is a significant achievement since the mid-1990s. Whereas life expectancy had declined dramatically in the period 1990–1994, since 1995 it began increasing again, and has been steadily climbing each year, due to economic reforms and economic stabilization. It still remains low, however, by western European standards. Moreover Latvia faces a rapidly aging population due to declines in the birth rate. The adverse demographic situation has prompted the government to undertake an intersectoral programme aimed at reversing the unfavourable trends.

It appears that the reform process in Latvia has acquired a momentum that cannot easily be reversed. Agreement among political parties on the general direction of the reform process is a major factor arguing for continuation of the changes that have been initiated. World Bank collaboration with the Ministry of Welfare argues further in favour of stability and continuation in the process of change. The improving economic situation and gradual rise in the standard of living can also be expected to maintain the reform process over the near to medium term.

Bibliography

CIVCS, A. *Development of Health Care System*. Department of Health, Ministry of Welfare.

Corruption Perceptions Index, Transparency International Annual Report 2000.

Country Health Report, Latvia.

Economist Intelligence Unit, Country Report, Latvia, 1st quarter 2000.

Economist Intelligence Unit, Country Profile, Latvia, 1999–2000.

Demographic Yearbooks of Latvia, Riga, 1998, 1999.

HiT on Latvia, World Health Organization, Regional Office for Europe, Copenhagen, 1996.

Latvia Human Development Report, Riga, 1996.

Latvian Medical Statistics Yearbooks, Riga, 1998, 1999.

Ministry of Economy, Reports on Latvian National Economic Development, Riga, 1998, 1999.

Ministry of Welfare and Cabinet of Ministers regulations, laws, and rules.

Nordic/Baltic Health Statistics, Copenhagen, 1996.

Sickness Fund News, State Compulsory Health Insurance Agency, 1998, 1999.

Social Report, Ministry of Welfare, Riga, 1998, 1999.

Statistical Yearbooks of Latvia, Riga, 1998, 1999.

TRAGAKES, E. *WHO Advisory Support to Health Care Reform in Latvia: Remuneration for Primary Health Care.* PHARE-WHO Collaboration, 21 May 1998.

World Bank material, World Bank Latvian Health Reform Project, 1999.

World Health Report, Geneva, 1998.