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Latvia

Health system review

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Health Systems in Transition

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Preface

The Health Systems in Transition (HiT) series consists of country-based reviews that provide a detailed description of a health system and of reform and policy initiatives in progress or under development in a specific country. Each review is produced by country experts in collaboration with the Observatory's staff. In order to facilitate comparisons between countries, reviews are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a report.

HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used:

- to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems;
- to describe the institutional framework, the process, content and implementation of health care reform programmes;
- to highlight challenges and areas that require more in-depth analysis;
- to 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 different countries; and
- to assist other researchers in more in-depth comparative health policy analysis.

Compiling the reviews poses a number of methodological problems. In many countries, there is relatively little information available on the health system and the impact of reforms. Due to the lack of a uniform data source, quantitative data on health services are based on a number of different sources, including

the World Health Organization (WHO) Regional Office for Europe's European Health for All database, data from national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, data from the International Monetary Fund (IMF), the World Bank's World Development Indicators and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate review.

A standardized review has certain disadvantages because the financing and delivery of health care differ across countries. However, it also offers advantages, because it raises similar issues and questions. HiTs can be used to inform policy-makers about experiences in other countries that may be relevant to their own national situation. They can also be used to inform comparative analysis of health systems. This series is an ongoing initiative and material is updated at regular intervals.

Comments and suggestions for the further development and improvement of the HiT series are most welcome and can be sent to info@obs.euro.who.int.

HiTs and HiT summaries are available on the Observatory's web site at <http://www.healthobservatory.eu>.

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This edition was written by Uldis Mitenbergs (part-time lecturer, Department of Public Health and Epidemiology, Riga Stradins University), Maris Taube (Director of the National Health Service, NHS), Janis Misins (Head of Health Statistics Unit, Centre for Disease Prevention and Control), Eriks Mikitis (Director, Health Care Department, MoH), Atis Martinsons (Director of Health Care Department, NHS), and Aiga Rurane (Head of WHO Country Office in Latvia). It was edited by Wilm Quentin, working with the support of Reinhard Busse, Head of the Observatory's team at the Department of Health Care Management, Berlin University of Technology. The basis for this edition was the previous HiT on Latvia which was published in 2008, written by written by Ellie Tragakes, Girts Brigis, Jautrite Karaskevica, Aiga Rurane, Artis Stuburs and Evita Zusmane, and edited by Olga Aveeva and Marco Schäfer.

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List of abbreviations

Abbreviations	
ALOS	Average length of stay
CARK	Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan
CDPC	Centre for Disease Prevention and Control
CEDM	Centre of Emergency and Disaster Medicine
CHE	Centre of Health Economics
CIA	Central Intelligence Agency
CIS	Commonwealth of Independent States
CSB	Central Statistical Bureau
CT	computed tomography
DDD	defined daily dose
DMFT	decayed, missing or filled teeth
DRG	Diagnosis-Related Group
EC	European Commission
EEA	European Economic Area
EHIC	European Health Insurance Card
EMA	emergency medical assistance
ERDF	European Regional Development Fund
ESF	European Social Fund
EU	European Union
EU27	the 27 EU member states
EU12	EU member states since 2004 or 2007
EU15	EU member states before 2004
EU-SILC	European Union Statistics on Income and Living Conditions
FFS	fee for service
GDP	gross domestic product
GGHE	government expenditure on health
GP	general practitioner
HI	Health Inspectorate
HIA	health impact assessments
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HLY	healthy life years

Abbreviations	
HPC	Health Payment Centre
ICD-10	International Classification of Diseases 10th revision
ICER	incremental cost–effectiveness ration
ICT	information and communication technology
IMF	International Monetary Fund
INN	international non-proprietary name
LVL	Latvian Lat
Mol	Ministry of the Interior
MoW	Ministry of Welfare
MRI	magnetic resonance imaging
NATO	North Atlantic Treaty Organization
NGO	non-governmental organization
NHA	WHO National Health Accounts
NHS (NVD)	National Health Service (Nacionālais veselības Dienests)
NOMESCO	Nordic Medico-Statistical Committee
Nord-DRG	Common Nordic DRG system
NRS	National Revenue Service
OOP	out of pocket
OTC	over the counter
P4P	pay for performance
PHA	Public Health Agency
PHC	Primary Health Care
SAM	State Agency of Medicines
SCHIA	State Compulsory Health Insurance Agency
SDR	standardized death rate
SEMS	State Emergency Medical Service
SRS	State Revenue Service
STI	sexually transmitted infection
SUSTENTO	Latvian Umbrella Body for Disability Organizations
TB	tuberculosis
THE	total health expenditure
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US\$ PPP	US\$ Purchasing Power Parities
VAT	value added tax
VHI	voluntary health insurance
VHIC	voluntary health insurance companies
WTO	World Trade Organization
YPLL	years of potential life lost

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Abstract

This analysis of the Latvian health system reviews recent developments in organization and governance, health financing, health care provision, health reforms and health-system performance. Latvia has been constantly reforming its health system for over two decades. After independence in 1991, Latvia initially moved to create a social health insurance type system. However, problems with decentralized planning and fragmented and inefficient financing led to this being gradually reversed, and ultimately the establishment in 2011 of a National Health Service type system. These constant changes have taken place against a backdrop of relatively poor health and limited funding, with a heavy burden for individuals; Latvia has one of the highest rates of out-of-pocket expenditure on health in the European Union (EU).

The lack of financial resources resulting from the financial crisis has posed an enormous challenge to the government, which struggled to ensure the availability of necessary health care services for the population and to prevent deterioration of health status. Yet this also provided momentum for reforms: previous efforts to centralise the system and to shift from hospital to outpatient care were drastically accelerated, while at the same time a social safety net strategy was implemented (with financial support from the World Bank) to protect the poor from the negative consequences of user charges.

However, as in any health system, a number of challenges remain. They include: reducing smoking and cardiovascular deaths; increasing coverage of prescription pharmaceuticals; reducing the excessive reliance on out-of-pocket payments for financing the health system; reducing inequities in access and health status; improving efficiency of hospitals through implementation of DRG-based financing; and monitoring and improving quality. In the face of these challenges at a time of financial crisis, one further challenge emerges: ensuring adequate funding for the health system through increased public expenditure on health.

Executive summary

Introduction

The small Baltic republic of Latvia has been constantly reforming its health system for over two decades. After independence in 1991, Latvia initially moved to create a social health insurance type system. However, problems with decentralized planning and fragmented and inefficient financing led to this being gradually reversed, and ultimately the establishment in 2011 of a National Health Service type system.

These constant changes have taken place against a backdrop of relatively poor health and limited funding. Although life expectancy at birth for its 2.1 million inhabitants has increased by three years since 2000 to 74 years in 2010 (69 years for males and 78 years for females), it remains the lowest among the Baltic countries and was much lower (approximately eight years lower for males and four years lower for females) than the average in the EU. The health system has one of the lowest levels of funding in the EU. As regards most health system performance criteria, such as health status, financial risk protection, and patient satisfaction, Latvia still lags behind not only western EU countries, but also other countries that joined the EU in 2004.

Latvia was hit harder by the recent global financial and economic crisis than any other EU Member State – GDP plummeted by about a quarter, with severe impacts on jobs and the fiscal stability of the government. This drove radical change in the health system. Previous efforts to centralise the system and to shift from hospital to outpatient care were drastically accelerated, with a dramatic reduction in the number of hospitals and far-reaching changes of health-care administrative institutions. An innovative Social Safety Net Strategy (with financial support from the World Bank) was introduced to protect low-income households from user charges and to support the shift away from hospital care, although the overall level of out-of-pocket payments remains amongst the highest in the EU.

The recently approved Public Health Strategy 2011–2017 may help improve population health status, as it is based on a strong intersectoral approach and focuses attention on the major problem of cardiovascular diseases in Latvia. As economic growth returns, challenges remain to build on the major structural reforms driven through during the financial crisis, and to tackle remaining issues such as reducing dependence on out-of-pocket payments and improving the overall efficiency of the system.

Organization and governance

The Latvian health care system is based on general tax-financed statutory health care provision, with a purchaser–provider split and a mix of public and private providers. The Ministry of Health is responsible for national health policy and the overall organization and functioning of the health system. The independent National Health Service (NHS) institution implements state health policies and ensures the availability of health care services throughout the country.

Different ownership structures characterize health care provision in Latvia. Smaller hospitals and some bigger regional hospitals are usually owned by the 119 municipalities, whilst larger tertiary hospitals (university hospitals) and single speciality (monoprofile) hospitals (e.g. psychiatric hospitals) are owned by the state. Most primary care physicians have the legal status of an independent professional, and almost all dental practices and pharmacies are private.

Financing

In 2010, total health expenditure as a share of GDP was 6.7% in Latvia, one of the lowest shares of GDP spent on health in Europe. Resources for health are raised mainly through general taxation by the central government.

Health services for the entire population are purchased by the NHS, though payment mechanisms are quite complex. Primary care providers (GPs) are paid using a mix of capitation, fee-for-service (FFS), fixed practice allowances, bonuses and a voluntary pay-for-performance (P4P) scheme. Secondary ambulatory providers are mostly paid by flat rate fees for defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutic interventions. Global budgets were introduced for hospitals in 2010 to control expenditure, and currently plans exist to implement a diagnosis-related group (DRG)-based hospital payment system by 2014.

Although the statutory health system provides coverage to the entire population and pays for a basic service package, it leaves patients exposed to substantial user charges and direct payments, in particular for pharmaceuticals, as well as informal payments. Government spending on health was only 61.1% of total health expenditure in 2010 (and was lower than at the start of the financial crisis). Out-of-pocket payments account for 37.8% of total health expenditure, one of the highest rates in the EU (behind only Cyprus, Bulgaria and Greece).

Severe budget consolidation measures implemented in response to the recent financial crisis included reducing financing to hospitals, increasing user charges, reducing health worker salaries and lowering prices of pharmaceuticals. A Social Safety Net Strategy was put in place from 2009 to ensure access to health services for low-income individuals. Supported by a €100 million loan from the World Bank, this exempted people with very low incomes from user charges and provided financing for free overnight stays after day care (though the scope of the strategy was reduced in 2012 with the end of the World Bank loan). This strategy also supported the overall shift away from hospital care by introducing home care services for the chronically ill, the development of day care centres for the mentally ill, additional nurses in primary care and a family doctor telephone advisory service.

Physical and human resources

Linked to these reforms, the number of hospitals and hospital beds in Latvia has seen a steep decline from 88 hospitals in 2008 to 67 hospitals in 2010. The average number of acute care beds in 2010 decreased to 3.4 per 1000 population, below the EU average. The average length of stay in acute care hospitals has decreased to 6.2 days, which is also below the EU average. Despite an increasing number of long-term care beds, the relative number of such beds in Latvia still clearly lags behind that of western European countries and also behind the other Baltic countries. By contrast, Latvia still has one of the highest rates of psychiatric hospital beds in Europe.

The number of physicians in Latvia declined significantly in the early 1990s (a result of declining health facilities, as well as low salaries and prestige for health care professionals) but has subsequently stabilized and recovered somewhat since the year 2000. In 2010, the number of physicians, dentists and pharmacists per head was around or above the averages for these categories in the countries that joined the EU since 2004 or 2007 (EU12), while the number of

nurses and midwives was comparatively low. In contrast to the declining overall trend in the number of physicians overall, the number of GPs has dramatically increased since 1990 and was above the average in the EU12 countries in 2009, although it remained far below the EU average. The age structure of medical staff suggests further problems to come, though, as the majority of personnel are 45 and over.

Provision of services

Almost all Latvians are registered with a GP, their family doctor, who acts as the main point of entry into the health care system and as the gatekeeper to secondary ambulatory and hospital care. In rural areas (in which about a third of the population lives), a physician assistant (feldsher) or midwife still provides a considerable share of primary care. A patient with a referral from the GP can freely choose any ambulatory or inpatient care provider (institution) that has a contract with the NHS. Some specialists can be accessed directly under certain conditions (eg: access to a paediatrician for children) without a referral from the family doctor.

In practice, provider choice in the statutory system is often limited, in particular in rural areas, because of waiting lists and unavailability of alternative providers to choose from. If waiting lists are substantial, and if providers have exceeded the number of patients to be treated (e.g.: towards the end of the month or year) according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers.

Since 2009 day care has become an important part of hospital activity; the number of patients who received day care services doubled between 2008 and 2010. By contrast, the number of hospitals that have contracts with the NHS was cut in half during the same period of time, dropping from 79 in 2008 to 39 in 2010. Most specialized hospitals were closed or transformed into day care and outpatient providers. Several local hospitals were downgraded to low intensity “care hospitals”, which provide medical care to patients after discharge from acute care hospitals. In addition, a new type of health care service was included within the health system: home care, meaning medical care provided at home by nurses or physicians’ assistants to chronically ill patients or patients after surgery.

Public health is coordinated by the Ministry of Health. Activities are planned and monitored mostly by the Centre for Disease Prevention and Control (CDPC), which is the main institution for infectious and non-infectious disease control and which coordinates collection of all health-related information. The CDPC engages in health promotion and organizes the State Immunization Programme, which is carried out by GPs and paediatricians and financed through the NHS.

Assessment of the health system

A key reason for Latvia's relatively poor life expectancy is the failure to achieve greater improvements in reducing cardiovascular mortality. Moreover, indicators that are sensitive to health care – infant mortality and life expectancy at age 65 – also remain unfavourable when compared with the averages of the EU as well as EU members since 2004 or 2007.

The financial risk protection offered by the Latvian health care system is insufficient, as suggested by the high share of out-of-pocket payments and a high percentage of the population forgoing medical treatment because of costs. Almost 14% of the Latvian population reported an unmet medical need because of costs, while this number was below 1% in Estonia, Lithuania, Slovenia and most other EU member states. Furthermore, important inequities were evident as the proportion of the population with unmet medical needs was much higher in the poorest income quintile (34%) than in the richest income quintile (13%). According to a Eurobarometer survey in 2011, most Latvians rated health care provision in their country as bad (66%), whereas only 30% judged it as good, earning Latvia the fourth lowest rank among EU countries.

Conclusions

The lack of financial resources in the context of the global economic and financial crisis posed an enormous challenge to the government, which struggled to ensure the availability of necessary health care services for the population and to prevent deterioration of health status. Between 2008 and 2012, the government succeeded with the implementation of important reforms. It substantially reduced the excessive hospital bed capacity, while at the same time prioritizing primary care, services for children and pregnant women, as well as emergency assistance and pharmaceuticals to prevent – as far as possible – negative consequences for population health.

If health policy in Latvia keeps a focus on the main determinants of healthy life expectancy (with a particular focus on cardiovascular disease), stays committed to the intersectoral approach to health and continues with the necessary reforms, the health care gap between Latvia and the other EU countries can be expected to be substantially reduced. An important step forward in the direction of strategic long-term planning in the health care system was the cabinet's approval of the Public Health Strategy for 2011–2017, which sets out a number of strategic objectives for the development of the health system over the next five years.

Currently, the development of clinical guidelines, new regulations for medical technologies, the implementation of a DRG-based payment system in hospitals and the introduction of e-health applications are high up on the Latvian policy agenda. Furthermore, the development of a quality management system and quality standards for health care institutions are officially claimed to be important, although the accreditation of health care institutions, long considered one of the basic elements of the quality management system, has not been mandatory since 2009.

Other important priorities include pharmaceuticals (keeping expenditures under control, while increasing statutory coverage for pharmaceuticals and including new medicines in the positive list), human resources (training and retaining health workers), assuring financial sustainability, as well as effective use of EU Structural Funds (which have provided €222.1 million in investment between 2007 and 2013). Finally, there are plans for important changes in the field of health care financing, possibly – once again – leading in the direction of a social health insurance type system.

1. Introduction

The Republic of Latvia is a sparsely populated country in north-eastern Europe with about 2.1 million inhabitants, according to the 2011 Census. It is one of the Baltic countries (consisting of Estonia, Lithuania, and Latvia) and forms part of the eastern border of the European Union (EU). Riga – the capital – is the largest city, with about 700 000 inhabitants.

Latvia has an ageing and shrinking population. Since the year 2000, the population has declined by almost 13%. Population density in 2010 was 36.1 people per square kilometre, which was one of the lowest in the EU, and over 68% of the population lived in urban areas. There are more than 170 nationalities in Latvia, with the two largest being Latvians, accounting for 62% of the population, and Russians, accounting for 27%.

Since independence in 1991, Latvia has been a democratic, parliamentary republic. Legislative power is in the hands of the unicameral parliament (Saeima) with 100 deputies. Parliament is elected for a period of four years. The President of Latvia is elected by the parliament also for a period of four years. Non-citizens are not entitled to vote in parliamentary or municipal elections. There are 119 local governments.

During the recent economic crisis, GDP dropped more strongly in Latvia than in any other EU member state and declined by one-quarter. This had severe effects on both the labour market and fiscal stability of the government. Unemployment grew by 9.4 percentage points, reaching 20.5% in the first quarter of 2010. Since the beginning of 2010, economic growth has slowly resumed and in 2012, the economy was growing at an annual rate of above 5% during the first three-quarters of the year, although the annual GDP was predicted to remain almost 15% below its size in 2009.

Life expectancy at birth has increased by three years in Latvia since 2000 and was at about 74 years in 2010 (69 years for males and 78 years for females). However, life expectancy remains the lowest among the Baltic countries (according to 2010 data) and is much lower than the average in the 27 EU member states (approximately eight years lower for males and four years lower for females). The main causes of death in Latvia are diseases of the circulatory system, malignant neoplasms and external causes.

1.1 Geography and sociodemography

The Republic of Latvia is one of the Baltic countries (Estonia, Latvia and Lithuania). It is located in north-eastern Europe on the east coast of the Baltic Sea and forms part of the eastern border of the European Union. It borders Estonia to the north, the Russian Federation to the east, Belarus to the south-east and Lithuania to the south. To the west lies the Baltic Sea and the Gulf of Riga. Riga – the capital of Latvia – is centrally located and is situated on the Daugava River estuary, where it flows into the Gulf of Riga.

Latvia's territory is 64 559 square kilometres (about twice the size of Belgium), with a flat landscape and extensive forests covering 47% of the land area and forming Latvia's most important natural resource. The territory consists of 62 157 square kilometres land area and 2402 square kilometres inland water. About 21% of the territory (12 790 square kilometres) consists of nationally protected areas. The highest point in Latvia is Gaizinkalns, which is 311.6 m above sea level but the average elevation of Latvia is only 87 m.

Administrative territorial divisions of Latvia have undergone several revisions. In 2011 there were 119 local governments – 9 cities under state jurisdiction and 110 counties. Figure 1.1 shows a map of Latvia.

Fig. 1.1
Map of Latvia



Source: Author's own compilation.

The Baltic Sea and the Gulf of Riga are the main factors that influence the regional climate, which is temperate, with average temperatures of 20°C in summer and -5°C in winter. In the coastal region winters are milder, summers are cooler and autumn is colder than spring.

At the beginning of 2011 Latvia had an estimated population of 2.2 million, with slightly more women than men (54% female, see Table 1.1). However, results of the Population Census 2011 show a considerably lower population number of only 2.07 million. This means that since 2000 the population in the country has reduced by 307 000 or 13%. The two immediate causes for the population decline are the negative net international migration and negative population growth. While in 1990, Latvian women had 2.0 children each, this number dropped to 1.3 in 2010, which is well below the average of 1.57 in the 27 EU member states (EU27).

Table 1.1

Trends in population/demographic indicators, 1980–2010

	1980	1990	1995	2000	2005	2010
Population, total (millions)	2.5	2.7	2.5	2.4	2.3	2.2
Population, female (% of total)	54.0	53.5	53.9	54.1	54.1	54.0
Population ages 0–14 (% of total)	20.5	21.4	20.7	17.7	14.4	13.8
Population ages 15–64 (% of total)	66.5	66.7	65.7	66.7	68.7	68.4
Population ages 65 and above (% of total)	13.0	11.9	13.6	15.6	16.9	17.8
Population growth (average annual growth rate)	0.6	–0.5	–1.3	–0.8	–0.5	–0.5
Population density (people per sq. km of land area)	41.0	43.0	40.5	38.2	36.9	36.1
Fertility rate, total (births per woman)	1.86	2.02	1.25	1.24	1.31	1.31 ^b
Birth rate, crude (per 1 000 people)	14.1	14.2	8.7	8.5	9.3	9.6 ^b
Death rate, crude (per 1 000 people)	12.8	13.1	15.7	13.6	14.2	13.3 ^b
Age dependency ratio (% of working-age population)	50.3	49.9	52.2	49.9	45.5	46.3
Age dependency ratio, old (% of working-age population)	19.5	17.8	20.7	23.4	24.6	26.0
Age dependency ratio, young (% of working-age population)	30.8	32.1	31.5	26.6	21.0	20.3
Urban population (% of total)	67.1	69.3	68.8	68.1	68.0	68.2
Literacy rate, adult total (% of people aged 15 and above)	n/a	99.45 ^a	n/a	99.75	n/a	99.78 ^b

Source: World Bank, 2012.

Notes: ^a 1989 figures; ^b 2009 figures.

Latvia has an ageing population, which is common in European Union (EU) member states. The number and share of the population under 15 years of age continues to decrease, whereas the share of the population over 65 years increases. While the relative share of the people under 15 years was 21.4% in 1990, it dropped to 17.7% in 2000 and 13.8% in 2010. Simultaneously, the percentage of the population of 65 years and above is constantly rising, from 11.9 in 1990 to 15.6% in 2000 and 17.8% in 2010.

According to the 2011 Population and Housing Census, the ethnic composition of the Latvian population has changed considerably: the share of Latvians has increased from 57.7% in 2000 to 62.1% in 2011, while the share of ethnic Russians declined from 29.6% to 26.9% and the share of Belarusians from 4.1% to 3.3%. Similarly, the population shares of Ukrainians, Poles and Lithuanians declined, although together they still accounted for more than 5% of the population. At the same time, the proportion of the population with Latvian citizenship increased from 74.5% to 83.8%. However, 14.6% of permanent residents in Latvia remain without citizenship of any country (Central Statistical Bureau, 2012a). These are citizens of the former Soviet Union who migrated to Latvia during the Soviet period and have never acquired Latvian citizenship,

although they have passports, personal identity numbers and the same access to health care and coverage as Latvian citizens (see section 3.3.1). Latvian is the official language of the Republic of Latvia. Russian is often spoken as well. The three largest religious groups in Latvia are Catholicism, Lutheranism and Orthodoxy, although a large portion of the population is thought to be atheist.

The population density in 2010 was 36.1 people per square kilometre, which was one of the lowest in the EU. Educational levels in Latvia are rising. Latvia has a very high literacy rate, at 99.8% in 2009. The proportion of the total population (aged 15 and above) with higher education (including doctorate level) has increased from 13.9% in 2000 to 23.0% in 2011, while the share of persons having vocational secondary education increased from 20.2% to 29.4% (Central Statistical Bureau, 2012a). Almost two-thirds (64.1%) of people with higher education are women.

1.2 Economic context

The current economic situation in Latvia needs to be understood in the context of the deep transformation after the demise of communism and the global financial and economic crisis, which hit Latvia particularly hard after 2007.

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. 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. Prior to the recent economic crisis, building had made some headway and light industry recovered somewhat. However, the share of industry in gross domestic product (GDP) has fallen from about 46% in 1990 to 22% in 2010 (see Table 1.2). The services sector by contrast has grown rapidly, with its share of GDP increasing from 32% in 1990 to 74% by 2010. Factors behind this growth have been the rapid expansion in transport and communications, development of financial services, and the growth and modernization of the trade sector.

Table 1.2
Macroeconomic indicators, 1990–2010

	1990	1995	2000	2005	2009	2010
GDP (billion US\$, current prices)	7.4	5.2	7.8	16.0	25.9	24.0
GDP (US\$ billion PPP)	20.9	13.4	19.1	30.0	36.5	36.6
GDP per capita (current US\$)	2 788	2 082	3 302	6 973	11 476	10 705
GDP per capita, PPP (current international \$)	7 808	5 330	8 041	13 053	16 166	16 312
GDP per capita growth (annual %)	-7.5	0.4	7.7	11.2	-17.5	0.2
Cash surplus/deficit (% of GDP)	-	-2.7	-2.2	-0.9	-6.4	-
Value added in industry (% of GDP)	46.2	30.4	23.6	21.6	20.6	21.8
Value added in agriculture (% of GDP)	21.9	9.1	4.6	4.0	3.3	4.1
Value added in services (% of GDP)	31.9	60.6	71.8	74.5	76.1	74.1
Labour force, total (millions)	1.4	1.2	1.1	1.1	1.2	-
Employment to population ratio, 15+, total (%)	-	55.5	48	52.5	50.9	-
Real interest rate (%)	-	5.5	7.4	-3.7	18.0	12.2
Official exchange rate (LVL per US\$, period average)	-	0.53	0.61	0.56	0.51	0.53
Unemployment rate (share of job seekers of economically active persons aged 15–74 years, %) ^a	-	-	-	-	16.9	18.7
Government budget deficit/surplus (% of GDP) ^a	-	-	-	-	-9.6	-7.6
General government debt (% of GDP) ^a	-	-	-	-	36.7	44.7
Export/ import balance ^a	-	-	-	-	-1.5	-0.8

Sources: World Bank, 2012; ^a Baranovs et al., 2011.

The Latvian economy has experienced two turbulent decades. The GDP declined by nearly 35% in 1992 and fluctuating growth rates persisted in the latter part of the decade. Subsequently, Latvia experienced a period of relatively stable economic growth, with average annual growth rates of 8.8%. However, during the recent economic crisis the GDP dropped more strongly than in any other EU member state and declined by one-quarter between the fourth quarter of 2007 and the fourth quarter of 2009. This had severe effects on both the labour market and fiscal stability of the government.

During 2009, the worst year of the crisis, unemployment grew by 9.4 percentage points, reaching 20.5% in the first quarter of 2010. The general government budget deficit in 2009 was Latvian Lats (LVL) 1.3 billion (€1.8 billion) or 9.6% of GDP and the deficit remained relatively high in 2010, at LVL974 million (€1.4 billion) or 7.6% of GDP. Consequently, total public debt in Latvia, which used to be one of the lowest in Europe at only 9% of GDP, increased to 48% of GDP in 2011 as a result of the crisis. Yet total debt remains well below both EU27 and Euro area averages, which are above 80% of GDP.

Between 2008 and 2011, significant budget consolidation measures were implemented in Latvia, amounting to a cumulative fiscal adjustment of 16.6% of GDP. These measures included tax increases (e.g. value added tax (VAT) was increased from 18% in 2008 to 21% in 2011), public administration reforms (e.g. reductions in the number of ministries and public agencies) and social sector expenditure cuts, including in the health sector. In 2009 public expenditure on health decreased by 19% in comparison with 2008 (see Table 3.1). Consequently, Latvia kept its budget deficit for 2011 well below the 6% target agreed with the EU and the International Monetary Fund (IMF). It is expected to be below 2% of GDP in 2013 and 2014, so that Latvia will comply with the Maastricht stability criterion on budget deficit in order to be able to join the Eurozone in 2014.

Since the beginning of 2010 economic growth has slowly resumed and GDP increased by 3.8% in 2011, mainly driven by an increase in exports. Private consumption is gradually stabilizing but public consumption is very low due to budget consolidation measures implemented in 2010. After the deflation caused by the crisis, the prices are growing again at 2.5% in 2010. The growth rate of Latvia is expected to increase and to exceed 5% in 2012 (World Bank, 2012).

The situation in the labour market is expected to improve gradually in the forthcoming years; however, the increase in employment is likely to be moderate (on average 2% per year) because the growth will mainly depend on the increase in productivity. It should be noted that the labour supply will reduce due to the impact of demographic factors.

Unlike some other transition countries in Eastern Europe, Latvia has made less progress in terms of convergence to EU living standards. In 2010 its GDP per capita of about US\$10 700 PPP was still amongst the lowest in the EU, slightly higher only than that of Bulgaria and Romania. In 2010 the proportion of the population at risk of poverty or social exclusion was 38% – one of the highest in Europe and again only slightly lower than that in Romania and Bulgaria (both at about 41%). However, possibly as a result of the implemented Social Safety Net Strategy (see Chapter 6), the proportion of people aged 65 or above who are at risk of poverty or social exclusion was reduced from 55% in 2009 to 38% in 2010 (Eurostat, 2012a).

1.3 Political context

Latvia declared itself an independent country in 1991. It is a parliamentary representative democratic republic with a multi-party regime and free elections on the basis of universal suffrage. Power is divided between the legislative, executive and judiciary branches of government.

Legislative power is held by the unicameral parliament (Saeima) with its 100 deputies. The Saeima is elected for a four-year period by general elections. Elections are carried out according to proportional representation, with a political party needing at least 5% of the total vote to enter the Saeima. Non-citizens (about 16% of the population) are not entitled to vote in parliamentary or municipal elections. The next elections will be held in 2014.

The President of Latvia is elected by the Saeima for a period of four years and can remain in office for a maximum of two consecutive terms. The current President is Mr Andris Berzins, who was elected for his first term in 2011. Although the President's position is mainly ceremonial, he is head of the armed forces, can veto some parliamentary decisions and he exercises substantial authority in both domestic and foreign affairs. The Prime Minister is appointed by the President and is the head of the executive branch of government. The Cabinet of Ministers is nominated by the Prime Minister and appointed by the parliament.

At the height of the economic crisis in 2009 a political crisis emerged, with public protests calling for the resignation of the government and the President threatening the Saeima with dissolution. In 2011, after the dissolution of the 10th Saeima as a result of a referendum in which 94% of the voters (at a voter participation rate of 45%) supported the dissolution, elections for the current 11th Saeima were held in September. Voter turnout was 60% and five parties and associations of parties gained seats in parliament; the "Harmony Centre", a political alliance of several centre-left parties, is the largest party in parliament and has 31 deputy seats. The current three-party coalition government consists of the centre-right "Zatlers' Reform Party", the second largest party (22 seats), another centre-right party called "Unity" (20 seats) and the right-wing National Alliance (14 seats). The Union of Greens and Farmers gained 13 seats in parliament.

The current coalition government is headed by Prime Minister Valdis Dombrovskis from Unity. The Minister of Health is Dr Ingrida Circene (Unity), who was also a Minister of Health in the 8th Saeima.

The judiciary is independent of political influence, but is thought to be weak and inefficient due to long waiting periods for court hearings. An independent human rights organization, the Human Rights Bureau, is responsible for monitoring human rights issues.

All important laws related to health care (as well as legislation generally) are enacted by parliament and come into force after having been officially announced by the President. The President has veto rights that allow her/him to send the law back to parliament for repeated discussions. This right is rarely used and to date has never been exercised in the case of any health-related law. In addition, the government makes extensive use of regulations enacted by the Cabinet of Ministers in order to determine the legal basis of developments in the areas of health and health care.

The group that has influenced the course of health care reforms in Latvia most significantly – particularly during the early years of reforms in the 1990s – is the Latvian Medical Association, which was re-established in 1988 (after having been abolished during the Soviet period).

Since 2011 Latvia has been administratively divided into two levels: the central level (the state) and the 119 local governments (or municipalities), comprising 110 counties (or *novadi*) and 9 cities under state jurisdiction. Local government responsibilities in the health sector broadly include ensuring geographical access to health care services, promoting healthy lifestyles, restricting alcoholism, ensuring public order and safety and providing education and social services (old-age institutions, asylums for the homeless, homes for orphaned children, etc.).

Latvia became a member of the United Nations in December 1991 and joined the World Trade Organization (WTO) in October 1998. In March 2004 Latvia became a full North Atlantic Treaty Organization (NATO) member, before joining the EU in May 2004, together with Estonia, Lithuania and seven other countries.

In the two decades since independence Latvia has made good progress on the World Bank's Worldwide Governance Indicators (Kaufmann, Kraay & Mastruzzi, 2010), scoring above the regional average for Eastern Europe and the Baltics on most indicators but still ranking below Estonia and most EU countries that were members before 2004 (EU15). Latvia scores well on Regulatory Quality, obtaining 80 (out of 100), while Control of Corruption remains problematic at a score of slightly above 60 (out of 100). The indicator for Political Stability dropped considerably during the economic and political crisis in 2009 but subsequently recovered to above 60.

Corruption in Latvia is considered to be largely due to the Soviet legacy, the weak judicial system, inefficient and un-enforced legislation and the ambiguous, in some cases tolerant, attitude of the Latvian public towards corruption (Transparency International, 2011). According to Transparency International, Latvia's Corruption Perception Score in 2011 dropped to 4.2 (where the maximum score of 10 represents "highly clean" and the minimum score of 0 represents "highly corrupt") and was ranked 25th out of 30 countries in the European Region (or 22nd out of the EU27 countries) (Transparency International, 2012).

1.4 Health status

Life expectancy at birth has been increasing in all EU countries. The same is true for Latvia, where average life expectancy at birth has increased by almost five years since 1980, albeit with a substantial discrepancy between men and women. In 2010 life expectancy for men was 68.8 years, while that for women was 78.4 years (see Table 1.3). As in several other countries in the former Eastern bloc, mortality indicators for both men and women deteriorated during the 1990s, but much more substantially for men. The lowest life expectancy at birth was observed in 1995, when it was 60.0 years for males and 73.1 years for females. Since then, the average life expectancy has increased considerably. However, the average life expectancy in Latvia remains the lowest among the Baltic countries (according to data of 2010) and is much lower than in the Nordic countries or on average in the EU27 (approximately eight years lower for males and four years lower for females).

Table 1.3
Mortality and health indicators, 1980–2010

	1980	1990	1995	2000	2005	2009	2010
Life expectancy at birth, total (years)	68.8	69.3	66.4	70.3	71.4	73.1	73.5
Life expectancy at birth, male (years)	63.8	64.2	60.0	64.9	65.6	68.3	68.8
Life expectancy at birth, female (years)	74.1	74.6	73.1	76.0	77.4	78.1	78.4
Mortality rate, adult, male (per 1 000 male adults) ^a	319.0	310.0	431.0	320.8	310.6	247.4	–
Mortality rate, adult, female (per 1 000 female adults) ^a	122.2	117.6	160.9	116.8	111.3	94.3	–

Source: World Bank, 2012.

Note: ^a The adult mortality rate is the probability of dying between the ages of 15 and 60 years.

Data suggest that the population of Latvia, similar to the populations in many other transition countries, not only has a shorter life expectancy, but also a shorter expected lifespan in good health than other countries in the EU. For the EU27, the average of years spent in good health in 2010 was 63 years for females and 62 years for males. In Latvia, it was only 57 years for females and 54 for males (Table 1.4). To a certain degree, Latvian men can compensate for their lower life expectancy with a larger proportion of the life spent in good health (78% for males vs 72% for females).

Table 1.4
Healthy life years (HLY) at birth

	2005	2006	2007	2008	2009	2010
HLY at birth in absolute value – females	53.4	52.6	54.2	54.6	56.1	56.5
HLY at birth in percentage of the total life expectancy – females	69.8	68.9	70.8	70.1	71.9	72.1
HLY at birth in absolute value – males	50.8	50.9	51.3	51.8	52.8	53.5
HLY at birth in percentage of the total life expectancy – males	77.7	77.9	77.9	77.3	77.5	78.1

Source: Eurostat, 2012b.

An analysis of the causes of mortality in Latvia (see Table 1.5) shows that, similar to many other European countries, the main causes of death are diseases of the circulatory system. In fact, they account for more than half of all deaths in Latvia. The standardized death rate (SDR) for these diseases has been fluctuating since the 1980s, with a peak in 1994 (at 802 per 100 000 – not shown in the table) and a decreasing trend ever since. However, in 2010, with about 480 deaths per 100 000, it was still considerably higher than the average in countries that became EU member states in 2004 or 2007 (EU12) (420.8), and it remained almost three times higher than the EU15 average (170.1) (WHO Regional Office for Europe, 2012a).

Table 1.5

Main causes of death: SDR per 100 000 population by disease group according to the International Classification of Diseases 10th revision (ICD-10)

Cause of death (ICD-10 classification)	1980	1990	1995	2000	2005	2009	2010
Communicable diseases							
Infectious and parasitic diseases (A00-B99)	15.5	11.3	19.8	15.3	12.1	11.8	10
Tuberculosis (A15-A19; B90)	8.4	6.8	14.6	11.8	7.3	4.2	3.5
AIDS/HIV (as recorded by routine mortality statistics system) (B20-B24)	0	0	0	0.1	1.1	2.9	2.5
Noncommunicable diseases							
Malignant neoplasms (C00-C97)	174.5	195.6	196.1	191.9	193.8	193.6	193.8
Malignant neoplasm of colon, rectum and anus (C18-C21)	17.8	21.1	20.6	20	22	20.8	20.6
Malignant neoplasm of larynx, trachea, bronchus and lung (C32-C34)	34.5	44.1	42.3	39.1	39.4	37.1	36.3
Malignant neoplasm of breast (C50)	11.1	13.8	14.7	15.2	14.2	15.3	14.3
Malignant neoplasm of cervix uteri (C53)	8.1	6.2	5.9	7.3	6.6	5.9	9.4
Diabetes mellitus (E10-E14)	2.1	8.3	9.9	8	7.2	14.9	15.9
Mental and behavioural disorders (F00-F99)	4.6	6.2	17	8.4	4.4	7.8	8.1
Diseases of the circulatory system (I00-I99)	731.2	670.4	754.5	592.6	578.7	479.5	477.6
Ischaemic heart disease (I20-I25)	473.7	389.4	408.1	319.7	287	254.5	248.9
Cerebrovascular diseases (I60-I69)	225.1	233.2	248.5	208.8	185.9	132.3	131.9
Chronic lower respiratory diseases (J40-J47)	38.3	22.7	17.7	11	10.8	8.5	8.6
Diseases of the digestive system (K00-K92)	23.6	27.3	39.7	35.9	38.8	37.4	36.7
External causes (injury and poisoning)							
Transport accidents (V01-V99)	35.6	43.5	34	28.6	20	10.8	10.8
Suicide and intentional self-harm (X60-X84)	32.6	25.8	40.7	30.8	22.5	20.7	17.5
Symptoms, signs, abnormal findings ill-defined causes (R00-R99)	0	34.6	55.3	42.9	62.7	58.3	53.4
All causes of death	1206.2	1189.1	1408.9	1125.3	1107.2	951.8	939.2

Source: WHO Regional Office for Europe, 2012a.

Malignant neoplasms (cancers) have been the second most common cause of mortality in the last couple of decades, both for males and for females. In 2010 the SDR for malignant neoplasms in Latvia (193.8 per 100 000 population) was above the EU27 average (169.7) and the EU15 average (163.4), but slightly

below the EU12 average (196.9). However, in contrast to the falling malignant neoplasms SDR in the EU, Latvia's SDR has been fluctuating at about the same level since the 1990s. In addition, the incidence of malignant neoplasms has increased from 372 per 100 000 in 2000 to 493 in 2010 (see Table 1.6).

Death attributable to external causes (injury or poisoning) remains the third most important cause of death but it is much more frequent amongst males than females. In 2010 the SDR for external causes (injury and poisoning) in Latvia was 84.9, which was the second highest in all EU27 countries (after Lithuania). Yet external cause mortality in Latvia has seen a very strong decline since 1995, when the SDR was about twice as high as it is today and when it was, in fact, the highest in all EU27 countries. In addition, external cause mortality remains the number one reason for years of potential life lost (YPLL) in working age adults.

As in all other European countries, infectious diseases do not cause high mortality in Latvia. However, mortality from HIV/AIDS in Latvia is the third highest in Europe after Portugal and Estonia, and it has seen a strong and continuous increase since 2000. Latvia has made good progress in controlling tuberculosis (TB), which had re-emerged during the phase of economic decline in the 1990s. Between 1990 and 1995 TB mortality more than doubled (see Table 1.5). However, since then both incidence and mortality have seen a strong decline even below 1990 rates (see also Table 1.6).

Risk factors for circulatory system disease, such as unhealthy habits and behaviour (smoking, unbalanced diet, low physical activity and consequent high body mass index) remain highly prevalent in Latvia. In addition, the incidence of diabetes mellitus – another risk factor for circulatory system disease – more than doubled from 145 per 100 000 in 2000 to 388 per 100 000 in 2010 (see Table 1.6).

Table 1.6

Prevalence and incidence of selected diseases, per 100 000 population

	1995	2000	2005	2006	2007	2008	2009	2010
Incidence of TB	51.3	72.3	53.8	50.0	47.4	40.5	36.8	36.8
Incidence of malignant neoplasms ^a	334.8	372.3	440.7	462.0	465.6	436.1	456.0	493.0
Diabetes mellitus								
Incidence	n/a	144.5	321.4	400.5	340.2	363.4	314.7	388.4
Prevalence	n/a	1 066.7	2 074.9	2 364.0	2 577.6	2 804.1	2 995.4	3 258.5

Sources: Central Statistical Bureau, 2010a; CHE, 2011a; NHS, 2012a; ^aCDPC, 2012a.

One of the most important risk factors affecting the health status is smoking. In 2008 the prevalence of smoking among adults (aged 15 or more) was 46% for men and 13% for women, making Latvia the country with the second highest smoking prevalence in Europe behind Greece (Eurostat, 2012c). Tobacco use among 15–24-year-olds was 35% for young male and 13% for young female Latvians. In 2010 the SDR attributed to smoking-related causes was 435.8, which was far above the EU12 average (330.6) and more than twice that of the EU15 figure (164.8). In fact, in spite of considerable reductions in smoke-related deaths over the past years (25% reduction since the year 2000), the smoking-related SDR remains the second highest in Europe, exceeded only by Lithuania (WHO Regional Office for Europe, 2012b).

In Latvia 12-year-old children have on average 3.1 decayed, missing or filled teeth (DMFT), which is far above WHO's target of 1.5 DMFT. Vaccination coverage in Latvia has traditionally been very high. However, immunization data show that coverage has decreased since 2008 and is now below the EU average for a number of vaccines and also below WHO's general target of 95%, with the reasons for this including socioeconomic factors and an increasing number of vaccination opponents (see section 5.1).

The adolescent (under 20 years of age) birth rate in Latvia – an indicator of health education/health promotion – has dropped to 5.8% of all pregnancies in 2010 (see Table 1.7). During the last decade, indicators of perinatal care have improved. Perinatal mortality (death between the 24th week of pregnancy and 7 days after birth) has decreased from 12.3 per 1000 live and stillbirths in 2000 to 8.2 in 2010. However, perinatal as well as infant (under 1 year) mortality remains comparatively high in Latvia. Infant mortality dropped substantially between 1995 and 2005 (see Table 1.7), but it has fluctuated at around 7 per 1000 live births between 2005 and 2009, which is much higher than the EU27 average (4.13) and also above the rates in other Baltic countries (Estonia: 3.55 and Lithuania: 4.9). New national figures for 2010 suggest that the rate has now come down to 5.7 deaths per 1000 live births.

Maternal mortality also remains comparatively high: it was 26.1 per 100 000 live births in 2010 and above 10 per 100 000 live births in the years since 2005, albeit with considerable variation resulting from the small population, where every death (in 2010, there were only five deaths) has a strong influence on the mortality rate. In the EU27, average maternal mortality is 5.4 deaths per 100 000 live births and in the EU12 it is 8.5.

Table 1.7
Maternal and child health indicators, 1980–2010

	1980	1990	1995	2000	2005	2008	2009	2010
Adolescent (under 20 years) birth rate (% of all live births)	10.0	11.7	11.2	11.5	8.7	8.1	7.0	5.8
Abortions per 1 000 live births	–	1 029.6	1 200.9	851.4	593.6	435.3	409.7	388.7
Interruption of first pregnancy – % of total number of abortions ^a	–	–	–	10.7	12.6	12.8	11.3	10.5
Probability of dying before age 5 years per 1 000 live births	20.6	17.6	22.0	12.4	9.5	8.0	9.3	–
Infant deaths per 1 000 live births	15.3	13.7	18.9	10.4	7.8	6.7	7.8	–
Neonatal deaths per 1 000 live births	7.4	–	12.4	6.5	5.6	4.7	5.0	–
Postneonatal deaths per 1 000 live births	8.0	–	6.4	3.9	2.2	2.0	2.7	–
Perinatal deaths per 1 000 births	–	12.1	17.1	9.3	8.0	6.3	7.0	5.7
Perinatal mortality per 1 000 live and stillbirths ^a	–	–	–	12.3	9.9	9.2	9.6	8.2
Stillbirth rate per 1 000 live and stillbirths ^a	–	–	–	7.8	6.1	6.2	6.0	5.7
Maternal deaths per 100 000 live births	25.3	23.7	37.1	24.7	4.6	12.5	46.1	26.1
Maternal deaths in absolute numbers ^a	–	–	–	–	1.0	3.0	10.0	5.0
Syphilis incidence per 100 000	11.2	4.8	94.9	43.0	19.3	10.3	–	–
Gonococcal infection incidence per 100 000	162.2	99.6	114.8	31.4	30.2	21.5	–	–

Sources: WHO Regional Office for Europe, 2012b; ^a NHS, 2012b.

It is recommended by WHO that all infants should be fed exclusively on breast milk until six months of age. In Latvia, the proportion of infants being breastfed has been increasing in all groups over the past years. In 2010, 91.8% of infants were breastfed at 6 weeks, 75.9% at 3 months, 52.5% at 6 months and 21.7% at 12 months, which is higher than in most European countries for which data are available (see Table 1.8).

Table 1.8
Infant breastfeeding (%)

	2007	2008	2009	2010
6 weeks	90.4	91.2	91.7	91.8
3 months	71.4	73.5	74.7	75.9
6 months	45.8	48.9	50.8	52.5
12 months	18.2	18.9	20.8	21.7

Source: NHS, 2012b.

2. Organization and governance

The Latvian statutory health care system is based on general tax-financed health care provision, with a purchaser–provider split and a mix of public and private providers. Resources are raised mainly through general taxation by the central government although OOP payments remain important. Money flows from the Ministry of Finance through the Treasury to the NHS, a state-run organization under the Ministry of Health, which acts as the central statutory purchasing organization.

During the 20 years since independence, Latvia has experimented heavily with different approaches to organization and financing. Health reforms in the early 1990s abolished the inherited highly centralized Semashko system and focused on decentralization of health care delivery, administration and financing. The aim was to create a social health insurance type system, and providers were either fully or partially privatized. However, apparent problems with decentralized planning and financing subsequently led to a reversal of this process. Following a two-step process of centralization – which first reduced the number of the newly established sickness funds, and later eliminated them altogether – all financing, coordination and payment functions were centralized within the SCHIA in 2002. Since then, the remnants of the social health insurance institutional structure, such as the earmarking of a portion of centrally collected income tax for health, have been dismantled, although the purchaser–provider split has been retained.

In October 2009, in the context of administrative reforms implemented in response to the economic crisis, the health care financing system was reorganized: the SCHIA was transformed into the Health Payment Centre (HPC), which assumed all purchasing and pooling functions. However, the institution was short-lived as, in 2011, it was merged with the Centre of Health Economics (CHE) into the NHS in order to improve administrative efficiency. As a result of the reform, the NHS is now the most important national institution

for the implementation of health policies, administering the financial resources of the state, determining the contents of the benefits package, contracting with providers, implementing the e-health system and registering clinical guidelines and medical technologies.

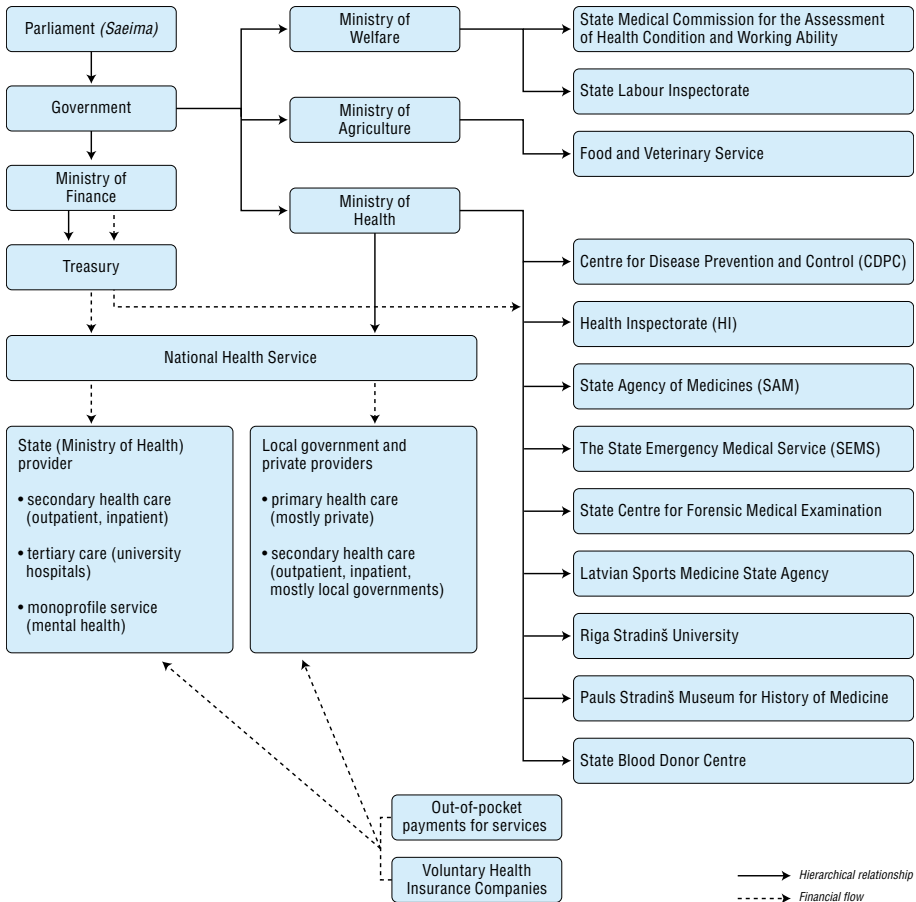
Different ownership structures characterize health care provision in Latvia. Smaller hospitals and some bigger regional hospitals are usually owned by municipalities, while larger tertiary hospitals (university hospitals) and specialized (monoprofile) hospitals (e.g. psychiatric hospitals) are owned by the state. Most primary care physicians have the legal status of an independent professional, which is a specific form of entrepreneurship existing only for primary care physicians. Some secondary ambulatory care providers (i.e. those who do not work in hospitals or as employees of health centres) work as self-employed individuals or as private sector agents, with the distinction between the two referring to legal and tax status according to Latvian legislation. Almost all dental practices and pharmacies are private.

2.1 Overview of the health system

The Latvian health care system has undergone a remarkable process of transformation in the 20 years since independence. Following experimentation with different approaches to organization and financing, the period between 2007 and 2012 has, again, seen an impressive number of reforms (see Chapter 6). This has led to: (1) the development of a more centralized system with state functions consolidated in fewer institutions; (2) the establishment of one central institution for purchasing health care (the NHS); and (3) a health care delivery system with a strong focus on primary care (and substantially fewer hospitals). The key components of the system are shown in Fig. 2.1.

Latvia is a parliamentary republic and, consequently, the main normative acts and regulations for the health sector are issued by the parliament and the Cabinet of Ministers. Health policy priorities are determined by the Ministry of Health.

Fig. 2.1
 Organization of the health system in Latvia, 2012



The health care system is based on general tax-financed statutory health care provision, with a purchaser–provider split and a mix of public and private providers. Resources are raised mainly through general taxation by the central government but OOP payments are important as well (see section 3.3.2). Money flows from the Ministry of Finance through the Treasury to the NHS, a state-run organization under the Ministry of Health, which acts as the “pooler” of health funds and the main purchaser of health services (see section 3.3). The NHS contracts with a variety of service providers, which may be public or private.

2.2 Historical background

The current organizational structure of the health care system of Latvia and its recent reforms are grounded in Latvia's history. During the 19th and at the beginning of the 20th century Latvia was part of the Russian empire. Since 1859, when the first sickness fund for workers of a factory in Riga was established, a number of sickness funds started to emerge.

During Latvia's first period of independence (1920–1940), two health insurance laws were passed defining responsibilities of the state and regulating sickness fund structures, medical and cash benefits, fund revenues and fund governance. There were three types of sickness funds: independent (for workers of large enterprises), occupational (based on the worker's occupation) and territorial (based on place of residence), which together provided coverage to about 18% of the population in 1938. (For more details on the history, see Tragakes et al., 2008.)

In 1940, following the secret pact between the Soviet Union and Germany (Molotov-Ribbentrop Pact), Soviet troops occupied Latvia and the economy and the social system were reorganized according to Soviet principles. The social insurance system was replaced by the Semashko system, which was tax based, vertically organized and centrally administered and planned. Large hospitals were constructed, specialization of providers was promoted and there was a strong focus on infectious disease control through hygiene and sanitation. The system provided coverage for the entire population, with a high level of equity, but with relatively low quality of care. Separate outpatient clinics, hospitals and spa institutions, providing better quality of care, were established for Communist Party officials and representatives of the government and their families.

After the re-establishment of independence in 1990, initial reforms of the health system focused on decentralization and attempted to diminish the role of the state, replacing it with market-driven incentives. In 1993, a major reform was set in motion that fundamentally changed the structure of the health care system. It aimed to transform the centrally planned system with budget allocations based on beds and personnel numbers to a social insurance type system with a purchaser-provider split and services paid for on an FFS basis.

Outpatient health care institutions (specifically polyclinics) were either fully privatized or transformed into non-profit-making state and municipal limited liability companies. Primary care physicians were encouraged to practise in independent practices. Hospitals became either non-profit-making state or

municipal limited liability companies but were never fully privatized. Almost all dental practices, pharmacies and several sanatoria (spas) were privatized. In addition, there has been a small increase in the number of private hospitals since 1993. However, they usually have very few beds and provide mostly non-contracted care. (For more details on service providers see Chapter 5.)

For the financing of the health care system, 35 institutions called “sickness funds” were established in 1994 at the local government level, corresponding to the number of local governments and cities at the time. District sickness funds received money directly from the state budget and were responsible for financing health care for their local populations. The aim was to create independent sickness funds with an insurance function. However, over the following years, another institution, the so-called “Central Account Fund” which was originally established in 1993 to supervise and lead the reform, gained increasing importance.

In 1997, in view of problems with a decentralized system of resource allocation (see section 2.4), the 35 local sickness funds were consolidated into eight regional sickness funds and the Central Account Fund was transformed into the State Sickness Fund. Regional sickness funds no longer received money directly from the state budget. Instead, the national health care budget was now allocated to the State Sickness Fund, which then distributed the money to the regional sickness funds according to the size and age structure of the covered population.

Between 1997 and 2004 the compulsory health insurance revenue base was defined as an earmarked portion (28.4%) of the collected income tax revenue plus a state subsidy financed by general tax revenue. However, this system was abandoned in 2005 in favour of general tax financing, which was preferred by the Ministry of Finance because it provided more flexibility in the use of public resources.

In 2002 the eight regional sickness funds were merged into one State Compulsory Health Insurance Agency (SCHIA). The SCHIA had five territorial branches and unified allocation, payment and control mechanisms. More recently, in response to the economic crisis and severely constrained budgets, multiple administrative institutions were reorganized or closed down (see Chapter 6). In 2009 the HPC took over the purchasing and pooling functions of the SCHIA, while the CHE assumed some other functions previously held by the SCHIA (such as the calculation of tariffs and economic evaluations) and functions previously held by the State Medicines Pricing and Reimbursement Agency. Finally, in 2011, the HPC was merged with the CHE to create the

NHS (or *Nacionālais veselības dienests* – in Latvian) as the most important institution responsible for health care financing and the implementation of state policies in the health sector.

In fact, virtually every aspect of the health care system has been affected by the ongoing process of reforms, including the pharmaceutical sector, public health, dentistry, payment systems and others (see also Chapter 6).

2.3 Organization

Fig. 2.1 shows the general structure of the Latvian health care system, illustrating both administrative relationships and main financial flows. The most important actors in the system are the parliament, the Ministry of Health and the NHS. The main features of the system are:

- The central government raises resources for the statutory health care system through general taxation.
- Parliament approves the budget of the NHS and money is transferred from the Ministry of Finance via the Treasury to the NHS.
- The NHS is a state-run organization under the control of the Ministry of Health, which contracts and pays health care providers.
- Providers contracting with the NHS may be public or private: they tend to be predominantly private in the case of primary care; predominantly public in the case of secondary care, with ownership concentrated mainly at the local government level; and exclusively public in the case of tertiary care, with ownership concentrated at the state (national) level.

2.3.1 The parliament

Latvia is a parliamentary republic and its parliament (Saeima) has an important role in the development of national health policy. It approves not only the national budget but also the budget of the NHS. The work of the parliament is organized into several committees. The Health Subcommittee within the Social and Employment Committee possesses legislative initiative and reviews all pressing health-related issues put forth by its members as well as issues brought to its attention by other members of parliament, the Ministry of Health or the Directorate of the NHS. Proposals to this committee can be submitted by professionals, professional associations and non-governmental organizations. The committee initiates and organizes public discussions and public debates.

The parliamentary secretary of the Ministry of Health assures a link between parliament and the ministry and is a representative of the Minister of Health in parliament.

2.3.2 The Ministry of Health

The Ministry of Health is the central government institution responsible for planning and regulation of the health system. The Ministry of Health elaborates health policy and organizes and supervises its implementation. It is in command of public health activities and coordinates health promotion and disease prevention activities of local governments. The Ministry of Health creates the preconditions for cost-effective health care and assures accessibility and quality of services. In addition, the Ministry of Health has responsibility for medical education at the Riga Stradiņš University, and for postgraduate education and professional medical education centres.

In 1991 the Ministry of Health was merged with the Ministry of Social Affairs and the Ministry of Labour into one Ministry of Welfare, but in 2002 the Ministry of Health was separated again.

In response to the financial and economic crisis, the Ministry of Health cut administrative expenditure and employment and it reorganized itself in 2009 to adjust to a smaller budget. In real terms, the direct administrative budget of the Ministry of Health in 2010 was 51% below the 2008 level. The current structure of the Ministry of Health consists of five departments: (1) the Department of Administration, which is under direct control of the State Secretary and responsible for the administration of the Ministry of Health; (2) the Department of Health Care, which is responsible for legislative regulation of health care providers and pharmaceuticals; (3) the Department of Public Health, which is responsible for legislative and practical regulation of disease prevention and health promotion, focusing on healthy nutrition, addiction, physical activity etc.; (4) the Department of Budget and Investments, which is responsible for budgetary planning for the whole health care system; and (5) the Department of European Union Funds under the control of two Deputy State Secretaries, which is responsible for supervision and practical realization of European Union Funds projects in the health system. The continuity of policy is assured by the state's "Secretary of the Ministry".

In addition, there are numerous organizations in which the Ministry of Health has a supervisory and governing role.

2.3.3 Institutions under the Ministry of Health

As part of the reorganization of the health care system between 2007 and 2011 (see Chapter 6), numerous state institutions were closed down or incorporated into other agencies, including, amongst others: the State Pharmaceutical Inspectorate, the State Medicine Pricing and Reimbursement Agency, the Public Health Agency, the Centre of Health Economics, the Mental Health Agency, the Narcology State Agency, the Health Promotion Agency, the Centre of HIV/AIDS, the State Centre of Medical Professional Education, the State Agency of Health Statistics and Medical Technologies, the Infectology Centre of Latvia, and the State Agency of Tuberculosis and Pulmonary Diseases. Yet, five more important institutions remain:

The *Centre for Disease Prevention and Control (CDPC)* is under direct control of the Minister of Health and during the reorganization of the health system assumed many of the functions previously held by the Public Health Agency. The CDPC is the national public health institute and collaborates with WHO and other public health institutions world-wide. It collects, summarizes and analyses health-related information, runs registries of different diseases, investigates outbreaks, monitors public health programmes, plans and regulates vaccination programmes and conducts public health surveys.

The *Health Inspectorate (HI)* regulates the professional quality of health care and controls pharmaceutical enterprises in production, purchase and distribution of medicines. The HI carries out evaluations of premises, equipment, personnel and documentation to assess compliance with government regulations. In addition, the HI regulates drug advertising and handles patient complaints.

The *State Agency of Medicines (SAM)* maintains a Register of Human Medicines, in which all pharmaceutical products with a market authorization for Latvia are listed. It is responsible for assessments of the quality, safety and effectiveness of pharmaceuticals (see section 2.8.4).

The *State Emergency Medical Service (SEMS)* was established in 2009 as the result of merging the emergency care services of 39 municipalities – each with its own unique structures for the provision of emergency care – into one centrally administered institution under the supervision of the Ministry of Health (see also section 5.5).

2.3.4 The National Health Service (NHS)

The NHS is under direct control of the Ministry of Health and directly responsible to the Minister. It is the main institution responsible for the implementation of state health policies and for ensuring the availability of health care services in the country. The institution has changed names several times in its history (see section 2.2 and Chapter 6). Today, the main tasks of the NHS include: to administer the financial resources of the state, to determine the positive list of pharmaceuticals, to implement the e-health system and to develop new financing systems in Latvia. In addition the NHS registers clinical guidelines and medical technologies.

The NHS consists of a Central Office and five territorial branches. The Central Office contracts directly with all hospitals for inpatient services. The territorial branches are subordinated units responsible for contracting with primary care practitioners (mostly GPs), secondary-level outpatient service providers, and pharmacies for pharmaceuticals from the positive list of approved pharmaceuticals (see section 2.8.4). However, they do not have their own budgets and pharmaceuticals are reimbursed directly by the Central Office of the NHS.

2.3.5 Other ministries

In addition to the Ministry of Health, a number of other ministries, including the Ministry of Finance, Ministry of Welfare (MoW), Ministry of Agriculture, Ministry of Education and Science, Ministry of Justice, Ministry of Defence and Ministry of the Interior, are involved in the Latvian health care system.

The Ministry of Finance, through the State Treasury, ensures financial flows from the state budget to the health care system (as well as for social care services). The MoW deals with Latvian social security, including social rehabilitation and nursing care of disabled and impaired individuals, and all other social care services, although services (e.g. for the elderly) are generally organized and provided by the local governments (see below). In addition, the State Labour Inspectorate, under the MoW, monitors developments in the area of occupational health, while the State Medical Commission for the Assessment of Health Condition and Working Ability, also under the MoW, is responsible for assessing degrees of disability. The Ministry of Agriculture, through its Food and Veterinary Service, controls food safety. The Ministry of Education and Science deals with health promotion as well as several educational facilities in the health sector in Latvia, also including the medical schools at the University of Latvia.

The Ministries of Defence, Interior and Justice have their own health care budgets to finance health services for specific population groups (see section 3.6.1). The Ministry of Defence receives funds to cover services for the armed forces and their employees. The Ministry of the Interior operates its own outpatient clinic, although its employees mostly use the mainstream statutory system. In addition, the Ministry of the Interior pays for all health care services provided to refugees under the statutory system. The Ministry of Justice provides services for prisoners and pays user charges for prisoners. Since a prison health care reform in 2012, health services for prisoners have become more integrated with the general health care system: medicines from the positive list are paid for through the NHS after prescription by a prison physician, and prisoners have the possibility to receive outpatient services in the general health system. However, prison physicians often continue to have the role of a family doctor and inpatient care is usually provided in prison hospitals.

2.3.6 Local governments

In the 1990s ownership of and responsibility for most primary and secondary health care facilities had been transferred to the local government level. However, a subsequent process of privatization, including the establishment of independent primary care practices and changes in the legal status of secondary care institutions, somewhat reduced the role of local governments in health care provision, although they continue to own an important part of primary and secondary care institutions. By law, local governments are responsible for ensuring access to health care services. Until October 2009, when the Social Safety Net Strategy was implemented (see section 6.1.2), local governments were responsible for providing financial assistance to the poor by reimbursing their user charges for health care services. However, they only covered user charges if eligible households applied for reimbursement and local governments had a financial incentive to reimburse as little as possible. Now, local governments only have to identify the poor and make sure that they know health care services will be provided free of charge, while their user charges are paid to health care institutions directly by the NHS.

In addition, local governments are still responsible for assuring geographical accessibility, and, depending on their budget and local priorities, they engage in promoting healthy lifestyles, controlling alcoholism, maintaining long-term social care facilities (e.g. for mentally ill patients and the elderly), as well as education.

2.3.7 Public and private health care providers

Inpatient and outpatient health care in Latvia is provided by state and local government-owned institutions, private clinics and hospitals, and individuals (see Chapter 5 for details). Independently of the type of property, all providers within the statutory system have to comply with regulations defined by the Ministry of Health and are financed by the NHS.

Primary care practices run by independent general practitioners (GPs) form the backbone of the Latvian primary health care (PHC) system. Health centres are the most important providers of secondary ambulatory care. They often operate in the premises of former polyclinics and usually employ a range of different specialists as well as GPs. About 70–80% of health centres are private (mostly in Riga) with the remaining percentage being owned by municipalities. In addition, local (municipal) hospitals provide an important share of secondary outpatient care. Almost all dental practices and pharmacies are private.

Since the reorganization of the hospital sector in 2010, hospitals can be classified into three categories: (1) “care hospitals”, which provide long-term (medical) care after discharge from an acute hospital; (2) multi-specialty hospitals at local, regional and national level; and (3) specialized hospitals for psychiatry, trauma, maternity and narcology (see section 5.4 for details). “Care hospitals”, as well as local and regional multi-specialty hospitals, are generally owned by municipalities. National multi-specialty hospitals, i.e. the university hospitals in Riga, as well as all specialized hospitals are owned by the state (national government, see section 4.1. for details about ownership of hospitals). Rehabilitation care is provided by dedicated rehabilitation hospitals and rehabilitation centres. Only a very small portion of the hospital sector is privately owned.

Emergency care is provided by the State Emergency Medical Service (SEMS) with emergency medical assistance (EMA) teams, and by emergency departments of hospitals.

Mental health care is provided in both outpatient and inpatient settings. Psychiatric hospitals exist for acute and long-term treatment of psychiatric patients and patients with addiction problems. However, long-term care services are considered social care, which is the responsibility of the MoW.

2.3.8 Non-governmental and professional organizations

Since the 1990s various patient groups have been founded, for example for psoriasis, lymphoma, diabetes and many others. Most of these organizations are members of the Latvian Umbrella Body for Disability Organizations (SUSTENTO), which was founded in 2002 and has 32 national member organizations, representing about 50 000 people with disabilities. However, the ability of patients' organizations and SUSTENTO to influence the policy agenda is rather limited.

One important patients' rights organization is the Patient Ombudsmen. The organization is financed mostly from international project funds and is independent from the state, pharmaceutical companies or providers. The organization attempts to promote patients' rights and to influence relevant legislation in the health care system. In addition, members of the organization work at health care institutions to register patients' complaints and to mediate between patients and providers.

The largest medical professional organization is the Latvian Medical Association. This is an umbrella organization for more than 110 associations organized according to medical specialties, also including dentists. The Latvian government has delegated the function of professional certification to this organization. It is the only institution that can withdraw a doctor's certificate, abolishing the right to practise. The nursing profession has a similar organization, the Latvian Association of Nurses.

2.3.9 International organizations

A number of international organizations have a presence in Latvia. For more details about the role of the EU and the World Bank in providing financial resources for health care, see section 3.6.2.

The World Health Organization (WHO) has been active in Latvia since 1991, when Latvia first joined as a member country. Its overall goal in Latvia is to support the government in health sector development, through provision of technical leadership and support of an intersectoral approach to health. WHO's two main priorities for 2008–2013 are (1) health promotion with emphasis on control of tobacco, alcohol and drugs; cancer prevention; mental health; and promoting healthy life styles and nutrition; and (2) health system strengthening, especially with regard to public health services, primary health care, health financing and human resources for health.

Other United Nations agencies also have close cooperative arrangements with Latvia. Since 1992 the following have had a presence: United Nations High Commissioner for Refugees (UNHCR), United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF) and United Nations Educational, Scientific and Cultural Organization (UNESCO).

2.3.10 Voluntary health insurance companies

The role of voluntary health insurance (VHI) in Latvia has been diminishing since the onset of the economic crisis. In 2008, when population coverage peaked, about 16–24% of the population were covered by VHI (depending on the data source, see section 3.5.1). However, coverage in 2010 was only 7%, according to the Financial and Capital Market Commission (2010), which is regulating VHI in Latvia. In terms of expenditure, VHI accounted for only 0.8% of total health expenditure in 2010 (see Table 3.1). However, despite this downward trend, there has been an increase in the number of insurance companies offering VHI over the past few years. Details on voluntary insurance are presented in section 3.5.

2.4 Decentralization and centralization

High centralization, vertical management and large hospitals were typical features of the health care system in the Soviet Union. Reforms in Latvia in the early 1990s were dominated by efforts to decentralize the inherited Soviet health care system. Powers were devolved to local governments and some providers were privatized as they were seen to be inefficient. However, Latvia's small size (a territory of 64 559 square kilometres) and its relative uniformity, as well as its small population (with about 2.5 million inhabitants in the late 1990s), subsequently led to a reversal of this process in several areas, and a recentralization of regulation and financing could be observed starting in the later part of the 1990s and continuing until today (see also Chapter 6).

In 1993 most responsibilities for providing primary and secondary care were devolved to local governments and their local so-called "sickness funds" (one for each local government). All decisions on resource allocation, payment mechanisms, service provision and closing or privatization of facilities were made by local health care boards, which were often responsible for only very small populations (i.e. less than 50 000). Health care providers, especially for primary and secondary ambulatory care, were often privatized (see also section 2.2).

As a result of the devolution and privatization process, access of the population to services as well as the quality of care became highly variable across Latvia, with richer areas covering more and better services than specified by the minimum service package. Coordination between districts was insufficient and local authorities attempted to keep as much health care spending as possible within their territories and often opted for duplication of services even if they were available in neighbouring areas. Patients were dissatisfied with variations in access and quality, while policy-makers were concerned about inefficiencies in resource use and allocation as the number of hospitals, equipment and beds remained very high.

In response to these challenges, a reform was put in place in 1997 to “recentralize” the health care financing system in order to ensure that sufficient resources and services were available for the population, independent of the place of residence, and that they were used in an efficient way. The 35 local sickness funds were consolidated into eight regional sickness funds and local health boards were disbanded. Later, in 2002, the eight regional sickness funds were merged into one State Compulsory Health Insurance Agency (SCHIA). In 2011, as the result of a further process of consolidation of state functions, one central institution for the financing of the health care system and the implementation of national health policies was established: the NHS.

Following the experience with uncoordinated planning by local governments, one of the most important reforms of the last decade was the “Master Plan”, or “Development Programme of Out-patient and In-patient Health Care Providers (2005–2010)”, which involved the centralization of all health care planning activities for the entire country (see section 2.5).

In other areas decentralization has been more permanent. For example, some quality assurance functions have been delegated to the Latvian Medical Association, with its member specialist associations. Professional requirements and appropriateness of education, as well as compliance with ethical professional standards of physicians, are assessed by the association and all specialists have to be certified by the applicable specialists’ association. In addition, several independent agencies under the Ministry of Health, such as the NHS, the State Agency of Medicines, the Health Inspectorate and others, are gradually taking over responsibilities and functions from the Ministry of Health.

Centralization tendencies are also observable in other sectors. For example, schools are closing or merging because of small numbers of students, and the last administrative reform created fewer local governments (119 counties instead of 500 local administrations).

2.5 Planning

The NHS and the Ministry of Health – always working in close collaboration – are the two most important institutions for planning in the Latvian health system. Planning of health care services and health care resources (except for human resources) falls into the responsibility of the NHS. The NHS plans on the basis of all available data (e.g. about service utilization, demographic developments) and regularly consults with the Latvian Medical Association or one of its specialist associations concerning their assessment of the current health care situation and population needs.

Human resource planning is the responsibility of the Ministry of Health. However, the NHS provides data, for example about staff availability at hospitals. In addition, the Ministry of Health collaborates with international institutions (EU, World Bank, IMF, WHO) that provide funding and technical assistance for planning in the Latvian health sector, usually on the basis of data provided by the NHS.

The main strategic planning document in Latvia is the “Public Health Strategy for 2011–2017”. The strategy sets out six objectives, which include the elimination of inequities in the field of health, improvements in three focus areas (infectious and non-infectious diseases as well as mother and child health), promotion of a healthy work environment and ensuring an effective management of the health care system (Ministry of Health of the Republic of Latvia, 2011).

Furthermore, several other planning documents exist in specific areas, such as investments or human resources. One of the most prominent planning documents was (and still is) the so-called “Master Plan”, or “Development Programme of Out-patient and In-patient Health Care Providers (2005–2010)”. The plan, which was developed in collaboration with the World Bank, aimed to rationalize physical and human resource use in the Latvian health sector by (1) concentrating inpatient services in fewer and larger hospitals, which were to be equipped with modern technology; and (2) decentralizing ambulatory and urgent medical care. The plan was officially discontinued at the height of the economic crisis in 2009 (see Box 6.1) but in the absence of an updated investment plan it often continues to determine investment priorities in the health sector. At local level there was often strong resistance against the plan’s objectives of closing down or merging inefficient hospitals or transforming them into less intensive “care hospitals”. However, overall, the plan was effective at restructuring the health care system by dividing hospitals according to functions (university, regional, local hospitals) and integrating previously existing parallel

treatment structures for specific disease areas – such as infectious disease (see section 6.1.4 for closing down of the Infectology Centre in 2012) – into the general health care system. Currently, discussions for the development of a new planning document for the period 2014–2020 are still ongoing.

2.6 Intersectorality

A strongly intersectoral approach is at the heart of the Public Health Strategy for 2011–2017, which focuses on inequalities and a healthy and safe environment, amongst other factors. The strategy clearly defines responsibilities of different ministries. For example, the Ministry of the Interior has responsibilities in the area of road traffic safety and the Ministry of Education and Science is responsible for coordination of research into the impact of environmental factors on health. In addition, health has a prominent place in the Sustainable Development Strategy for Latvia, “Latvia 2030”, and in the Strategic Development Plan (2010–2013).

However, permanent intersectoral structures do not yet exist at the government level except for certain specific areas (e.g. substance abuse) with high-level committees under the Prime Minister. Instead, intersectoral policies affecting the health sector are usually dealt with in ad hoc interministerial working groups. Formal health impact assessments (HIAs) have not yet been institutionalized in Latvia, although the Ministry of Health and WHO are actively working on promoting HIA in Latvia (Gulis et al., 2012).

Currently, health is taken into consideration by multiple policies in different areas. In the field of employment and social policy, several health-related programmes exist, such as the “Action plan for Decreasing Disability and its Consequences for 2005–2015” (2006) and the “Guidelines for the Development of Labour Protection 2008–2013” (2008). In the area of the Ministry of the Interior, there are “Guidelines for limiting drugs and psychotropic substances and the spread of addiction and control for 2011–2017” (2011) and the “Road Traffic Safety Programme for 2007–2013” (2007), which aims to achieve a decrease in the number of fatal traffic accidents.

Under the Ministry of Education and Science, “Guidelines on Education Development for 2007–2013” (2006) have been developed, which aim to ensure that students are educated on healthy nutrition, reproductive health and sport activities, among other areas. Finally, the agricultural policy “Plan for the supply of fruit and vegetables to schools 2010–2013” (2010) aims to increase

the consumption of fresh fruit and vegetables by students. In addition, there are “Environmental Policy Guidelines for 2009–2015” (2009), which aim to ensure that people live in a healthy environment.

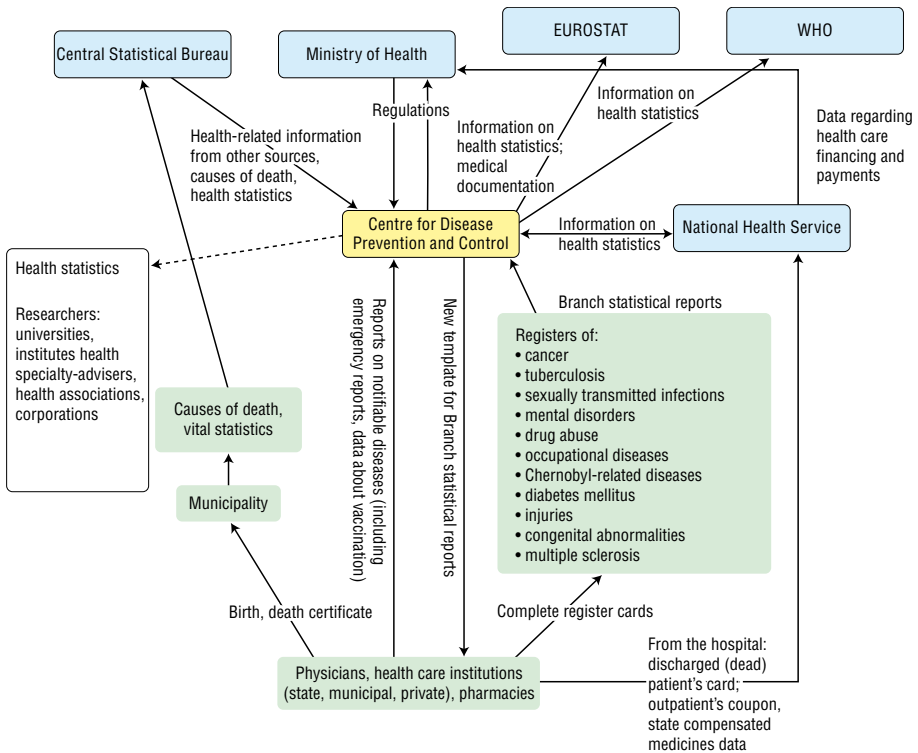
2.7 Health information management

2.7.1 Information systems

Latvia has a well-developed legal framework for the collection of health statistical information. The responsibilities of different institutions, such as the Central Statistical Bureau, the CDPC and the NHS are clearly defined by the 1997 “Law on National Statistics” and the 2006 “Regulations on the National Programme of Statistical Information”. These regulations determine responsibilities for the preparation of statistical information and the conditions for users for obtaining health-related data.

Fig. 2.2 illustrates the data collection process in the Latvian health system. There are three main institutions responsible for the collection of health-related information in Latvia: (1) the CDPC; (2) the NHS; and (3) the Central Statistical Bureau (CSB).

The CDPC is the central institution responsible for collecting and summarizing all health-related data in Latvia, including data collected by the NHS and the CSB. The CDPC is also responsible for ensuring international obligations by submitting data to WHO and Eurostat, which is – according to technical feedback provided by these institutions – generally of very good quality. Data is collected by the CDPC and its branch offices. All health care institutions in Latvia have a legal obligation to prepare register cards for a number of disease-based registers kept at the CDPC branch offices, and to electronically submit data about notifiable diseases directly to the CDPC central office (see also section 5.1). Register cards are generally transmitted via email or a special centralized electronic submission system to the CDPC branch offices but paper forms are still accepted. All statistical reports consist of aggregated data and do not include personal identifiers.

Fig. 2.2**Data collection in the Latvian health system**

The NHS collects all data related to the use of NHS paid health services. All contracted providers (hospitals, health centres, GPs), irrespective of their ownership status, have to electronically submit patient information about NHS paid services for payment purposes. The required data includes: patient personal ID number, address, citizenship, diagnoses (primary and secondary coded according to the International Classification of Diseases 10th revision), procedure codes (according to a national coding system), and a provider identifier. As every patient is identified in the database with a personal ID number, it is possible to link patient data across different providers and over time, even linking information from other sectors (e.g. social services). However, data about non-contracted care, for which patients have to pay OOP, is not collected by the NHS, unless it is provided by contracted health care institutions.

The CSB collects cause of death statistics, which are produced on the basis of data submitted by health care providers to municipalities.

Most statistical reports, for example about health care service utilization and financing, are available for download from the NHS and the CSB free of charge. Survey results and register based statistics are available from the CDPC.

The Ministry of Health uses data on health statistics for the purposes of health care planning and management.

2.7.2 Health technology assessment

In Latvia the NHS is responsible for assessing and approving medical technologies. The legal basis for this is defined by the “Regulations of the Cabinet of Ministers on the Approval of Medical Technologies [...] and the Implementation of New Technologies” (2005).

In order to utilize a new medical technology, a health care institution is required to provide a package of documents including: a technical description of the new technology; a summary of published studies documenting the effectiveness of the technology; the qualifications of the medical practitioners who will use the technology; a description of the space within the treatment institution in which the technology will be used; the costs of the new technology; and a justification of the use of resources to purchase it. These documents are usually prepared by medical professionals who are interested in the development of their profession and the introduction of new methods. Ideally, information about cost-effectiveness is also considered but reliable information (even about effectiveness) is often not available.

Every new technology is then assessed by the Unit of Health Economics, Technology and Clinical Guidelines within the NHS with regard to safety aspects (risks and potential side-effects), potential impact and efficiency, an assessment of the influence of the technology on the patient’s health and quality of life, professional ethics, as well as the economic justification of its use. About 50 to 60 evaluations of new technologies are conducted each year according to a methodology that is specified in the above-mentioned regulations. A positive assessment is a prerequisite for the introduction of a new technology in Latvia.

Formal cost-effectiveness studies (economic evaluations) are conducted only for pharmaceuticals. Since 2002, every new medicine is evaluated according to the Common Baltic Guidelines on Economic Evaluation of Pharmaceuticals prior to being entered into the positive list of NHS paid medicines (see section 2.8.4).

2.8 Regulation

The Latvian health system is regulated through a mix of legislative (laws, regulations), administrative (licences, permissions) and market mechanisms (contractual relationships). In general, the parliament passes laws such as the “Medical Treatment Law” (Government of Latvia, 1997), which sets the framework for regulation of providers, pharmaceuticals and medical devices, while more specific regulations for each of these fields are defined by the Ministry of Health and approved by the Cabinet of Ministers.

Regulatory functions (standard setting, monitoring, enforcement) are predominantly concentrated in the hands of the central government, i.e. the parliament and the Ministry of Health and its agencies: the NHS with its five territorial branches, the Health Inspectorate, the State Agency of Medicines, the Centre for Disease Prevention and Control, the State Emergency Medical Service, the Centre for Forensic Medical Examination, the State Blood Donor Centre, and the Latvian Sports Medicine Agency. In addition, some regulatory functions in the area of education and accreditation of physicians have been delegated to the Latvian Medical Association. Municipalities no longer have a regulatory function in the health system.

National health plans and policy statements are discussed in section 2.4.

2.8.1 Regulation and governance of third-party payers (the NHS and VHI)

The NHS is the only third-party payer in the Latvian statutory health care system. It has to secure health services for the entire population (universal coverage) within the health budget approved by parliament. The main document regulating the activity of the NHS is the “Regulations on Organization and Financing of Health Care” (2006). The document determines almost all aspects of health care provision and financing, including the responsibilities of the NHS, the benefits package and the selection criteria for contracting of providers. The document is updated five to six times per year to take into account the introduction of new technologies, changes in the benefits package and modifications of service definitions and tariffs. These updates are always prepared in close collaboration between the Ministry of Health and the NHS.

As a result of the reform that established the NHS in 2011 (see section 6.1.3), the institution has come under direct control of the Ministry of Health and is directly responsible to the Minister of Health. This is different from its predecessor institutions: the SCHIA and the Health Payment Centre (which

existed between 2009 and 2011) were regulated through a “contract of administration and management” signed between the Minister of Health and the director of the SCHIA (or the Health Payment Centre). Consequently, the NHS is more closely bound by instructions from the Ministry of Health, whereas the SCHIA had a greater degree of autonomy. The NHS implements health policies and strategies determined by the Ministry of Health and has to monitor and report on the processes and results of policy implementation.

The responsibilities of the director of the NHS are determined by Regulation No. 850 from 2011 (“Regulation of NHS”) and include:

- determining the appropriate volume of health services in accordance with the available financial resources, priorities and capacity of service providers;
- selecting providers and planning, concluding and monitoring the contracts; and
- informing the public about publicly funded health services and terms and conditions of accessibility.

The director of the NHS is formally employed by the Ministry of Health and has a description of work.

Activities of the territorial branch offices of the NHS are determined by the Central Office, which provides the framework contracts for contracting with providers and defines the services that have to be purchased as well as certain quality standards (NHS, 2012c).

VHI is offered in Latvia exclusively by private companies and provides primarily group coverage to employer organizations although individual coverage is available as well (for more details see section 3.5). Each insurance company is free to define its benefits package and price without any external health-related regulation after having obtained a licence from the Financial and Capital Market Commission, which is concerned only with the financial viability of VHI companies.

2.8.2 Regulation and governance of providers

The “Law of Commerce”, which was passed by parliament in 2000, specifies that hospitals and polyclinics are capital companies (stock companies or companies with limited liability). Smaller hospitals and some bigger regional hospitals are usually owned by municipalities, while larger tertiary hospitals (university hospitals) and specialized (monoprofile) hospitals (e.g. psychiatric hospitals) are

owned by the Ministry of Health. All hospitals are limited liability companies and are governed by a management board, which is directly responsible to the local municipalities (municipal hospitals) or the State Secretary of the Ministry of Health (state hospitals). Some outpatient clinics are organized as public-private partnerships (municipalities, along with private owners).

The 1997 “Law on Physician Practice” determined that primary care physicians have the status of independent professionals, which is a specific form of entrepreneurship existing only for primary care physicians. Some secondary ambulatory care providers (those who do not work in hospitals or as employees of health centres) work as self-employed individuals or as private sector agents, with the distinction between the two referring to legal and tax status according to Latvian legislation.

According to Article 55 of the 1997 “Medical Treatment Law”, all health service providers, regardless of their type and legal status, must meet compulsory requirements, which have most recently been defined by the Cabinet of Ministers in the “Regulations on Compulsory Demands for Health Care Institutions and their Structural Units”, in force since January 2009. These regulations determine structural (size, equipment, etc.) and staffing requirements (number and type of specialists) for the provision of specific services. However, since 2009, accreditation of health care institutions according to these requirements is no longer mandatory. Instead, conformity with the standards is only based on self-reporting principles as well as planned and random controls carried out by the Health Inspectorate.

Service provision is mostly regulated by contracts signed between health care providers and the NHS or its territorial branch offices. The NHS negotiates contracts depending on regional needs as specified in the “Regulations on Organization and Financing of Health Care”. Contracts with outpatient facilities are based on competitive tendering if additional services are needed.

For every health care institution, contracts indicate the number of patients to be treated per “health care programme”, which can be a specific type of hospitalization, a certain specialist consultation, or a diagnostic manipulation, etc. (see also section 3.7.1). In addition, the contracts define minimum technological and staffing requirements for institutions depending on the contracted “health care programme”.

If an institution has completed its obligations for the year (for example, it has performed the number of elective surgeries indicated in its contract with the NHS), it may offer patients surgery at full cost instead of waiting until the next year.

The mechanisms in place to ensure and monitor quality of care provided tend to be rather limited, although some quality control issues are included in contracts with the NHS. Primary care is the only area in which quality plays a more important role in the contracts between the NHS and providers as both voluntary and mandatory quality incentive schemes exist (see section 3.7.2).

The Health Inspectorate (HI) is the most important institution ensuring compliance of health care providers with the conditions of service provision determined in NHS contracts as well as adherence of providers to the mandatory requirements of health care institutions determined by the Ministry of Health. The HI audits service provision and informs the NHS if services are either not fully provided or provided with inappropriate medical technologies, which will lead to the NHS refusing payment or reducing payments to providers. In addition, the HI is entitled to impose penalties for inappropriate service provision or misreporting.

Until 2010, guidelines were mostly developed by medical specialist associations, often based on international guidelines but sometimes doubts existed regarding their quality. Since then, the NHS has taken over responsibility for the development, evaluation, registration and implementation of clinical guidelines according to the 2010 Cabinet of Ministers “Procedures for the Development, Evaluation, Registration and Implementation of Clinical Guidelines”. The regulation requests clear standards for clinical guidelines. By 2012 eleven guidelines had been registered and published on the web page of the NHS. Treatment guidelines are recommendations including international best-practice. However, the required treatments may be very expensive and are not necessarily entirely covered by NHS contracts.

The integration of care across providers still remains limited in Latvia although some elements of integrated care pathways have been introduced in recent years, especially in the context of the Social Safety Net Strategy (see section 6.1.2). For example, the newly introduced home care service for the chronically ill is based on cooperation between GPs and home care providers (mostly the GP team with a nurse or a special home care team) and rehabilitation at home is now available based on a rehabilitation plan developed by physical medicine and rehabilitation specialists in hospitals. In addition, the status of “potential disability”, which is confirmed after assessment by the “State Medical

Commission for the Assessment of Health Condition and Working Ability”, provides the possibility for patients to receive complex and problem-oriented care based on a rehabilitation plan written by a GP or other medical specialist.

There have been ongoing discussions for years about establishing new standards for accreditation of health care organizations but the outcome of these discussions remains uncertain.

2.8.3 Registration and planning of human resources

All health professionals (i.e. medical doctors and nurses) have to be certified by the applicable professional association, which are the Latvian Medical Association, the Latvian Nurses Association or the Latvian Confederation of Professional Organizations of Health Care Personnel (responsible for allied sciences, such as speech therapist, dental technician, dental prosthetist, laboratory assistant, etc.). Certification requirements are regulated by Article 26 of the “Medical Treatment Law” (1997) and specified in the “Regulations of the Cabinet of Ministers on Certification of Treatment Persons” (in force since 1997). The organizations determine examination programmes and establish examination committees for each specialty, subspecialty or subsidiary specialty. A certified practitioner is automatically re-certified if he collects at least 250 education points during a five-year period for participation at seminars, conferences, courses, etc.

Besides certification through their professional organizations, all health care practitioners have to be entered into the uniform nationwide information system, the Register of Medical Persons, maintained by the HI in accordance with the Rules on the “Establishment, Fulfilment and Maintenance of the Register of Medical Persons” (in force since October 2005). Registered professionals receive the certificate of a “Treatment Person”.

The certificate has to be renewed once every five years and contains information about the particular health care profession in which the health care practitioner has the right to practise. Every health care practitioner has a personal registration number. To receive the registration certificate, the practitioner must provide proof of identity and documents proving the level of education.

Training of health professionals in Latvia conforms to EU standards for mutual recognition. The curriculum for medical education is defined by regulations of the Cabinet of Ministers but according to advice given by the Latvian Medical Association. Similarly, the number of training places

at universities and for residencies (specialist training) is determined by the Ministry of Health. Latvian health professionals are free to live and work in any EU country without restrictions. The Latvian Medical Association monitors specialists moving to other countries and provides the Certificate of Conformity to physicians who are interested in working abroad.

Several policy documents have been adopted by the Cabinet of Ministers concerning planning in the Latvian Health Sector, such as the Master Plan (see section 2.5). In accordance with these plans, the Ministry of Health has defined targets for the number of primary care practices and secondary care providers in each municipality. In addition, for the period 2006–2015 the “Basic Statement on Development of Human Resources for Health Care” was adopted by the Cabinet of Ministers in 2006. The policy envisages the adoption of staffing requirements for physicians and nurses per bed and patient by specialty in hospitals. In addition, the document suggests a unified model of postgraduate education, supervision and coordination and adjusted health care personnel remuneration levels to promote recruitment of new doctors and retain existing staff. However, as a result of financial constraints in the context of the economic crisis, salaries of health professionals have, in general, been reduced rather than increased in recent years.

2.8.4 Regulation and governance of pharmaceuticals

Legislation and policies in the field of pharmaceuticals are the responsibility of the Health Care Department of the Ministry of Health. Besides the Ministry of Health, the State Agency of Medicines (SAM) and the NHS are the two most important institutions for regulation of pharmaceuticals.

Before entering the Latvian drug market, pharmaceuticals must have an authorization from the SAM or the European Medicines Agency. The SAM is the national authority for pharmaceuticals and assesses quality, safety and effectiveness of (human and veterinary) medicines and issues market authorizations. The SAM was founded in October 1996 and was reorganized following implementation of the “Law on Pharmaceuticals” (1998). The agency’s activity is financed from its own revenues (for example, administrative fees collected from pharmaceutical companies).

The SAM maintains the Register of Human Medicines, classifies medicinal products into prescription and over-the-counter (OTC) drugs, monitors prices, manages consumption statistics and is responsible for pharmacovigilance, including management of adverse event reports. It issues licences to manufacturers and supervises manufacturing, wholesaling, retailing and

importing and exporting of pharmaceuticals. The SAM authorizes clinical trials and monitors good clinical practice in trials. In addition, it assesses and monitors compliance of advertising materials – permitted only for OTC drugs – with statutory requirements. The SAM cooperates with the European Medicines Agency, the European Directorate for the Quality of Medicines and Health and other international organizations and it assists the Ministry of Health in the translation of EU directives into national law.

Reimbursement decisions

The NHS is the responsible institution for making decisions regarding the reimbursement of pharmaceuticals by including a medicine on the positive list. Regulation No. 899 (on the Reimbursement of Expenditures for Medicinal Products and Medicinal Devices, Government of Latvia, 2006a) determines the conditions for reimbursement. To be included on the positive list, pharmaceutical companies have to submit an application to the NHS containing comparative effectiveness data for the pharmaceutical; clinical information (about the intended patient group, indication, etc.) and pharmacoeconomical information (i.e. existing economic evaluations), price, etc. The NHS evaluates the application on the basis of the provided information and its own research, and makes a decision for or against including a pharmaceutical in the positive list depending on clinical and economic criteria. Clinical criteria include: (1) burden of disease and (2) the therapeutic value of a pharmaceutical and correspondence to treatment schemes. Economic criteria include: (1) impact on the health care budget and (2) results of a cost–effectiveness assessment according to the Common Baltic Guidelines on Economic Evaluation of Pharmaceuticals, which were approved by regulations of the Cabinet of Ministers and came into force in 2002.

All medicines (new and old) on the positive list are classified into one of three reimbursement categories (100%, 75% or 50%) depending on the illnesses for which they have been approved. For example, all medicines on the positive list for the diagnosis of schizophrenia are fully (100%) reimbursed by the NHS, while anti-hypertension medicines fall into the 75% reimbursement category and anti-depressive medications are only covered at 50% by the NHS, with the remaining part having to be covered by patients as OOP payments. In addition, the positive list consists of three parts, i.e. List A, List B and List C:

- List A is a reference price list with groups of interchangeable pharmaceutical products, for which the NHS used to pay the same “reference” price (until 2012 – see “pricing decision” below). The groups consist of either (a) products with the same active ingredient or (b) certain

products within one pharmacotherapeutic group that have the same efficacy and side-effects, the same route of administration and the same patient target groups. There are 1092 medicines on the list (in 2012).

- List B consists of 327 non-interchangeable products.
- List C contains 30 pharmaceutical products with annual treatment costs exceeding LVL3000 (€4300). The decision on reimbursement for these products is made on an annual basis, depending on the available budget and the number of patients for whom reimbursement is required.

In certain extraordinary cases, the NHS may also provide reimbursement for medicines that are not included in the positive list if it has been determined by a physicians' case conference that the medicine (not exceeding LVL10 000) is necessary for saving the life of the patient.

Furthermore, a reform of Regulation No. 899 (on the Reimbursement of Expenditures for Medicinal Products and Medicinal Devices) in September 2012 has introduced 50% reimbursement for all nationally registered prescription medicines (beyond those listed in the positive list) for children up to 24 months and 25% reimbursement for all pregnant women (plus until 42 days after childbirth).

Pricing decisions

Pricing of pharmaceuticals in Latvia is regulated by the "Regulations regarding the Principles for the Determination of the Price of Medicinal Products" (Government of Latvia, 2005). To commence the distribution of medicinal products in the territory of Latvia, holders of marketing authorizations must provide the SAM with the ex-factory price of the product.

For pharmaceuticals not included in the reimbursement system, prices are based on an unregulated manufacturer's price with limited mark-ups for wholesalers and pharmacies. For pharmaceuticals included in the positive list, prices are negotiated between the NHS and the holders of marketing authorizations. One general principle of the NHS is that prices should not exceed the prices in other Baltic countries and the third lowest price in other EU member states. In addition, information from the economic evaluation performed by the NHS is used to determine the price. If the result of the economic evaluation for a particular product indicates that the incremental cost-effectiveness ratio (ICER) is above a certain threshold, the pharmaceutical company will be asked to lower the price so the drug falls below the ICER threshold. In addition, the NHS has implemented a pay-back system, where pharmaceutical companies

(depending on their market share) have to compensate the NHS to a certain degree if the annual drug budget is exceeded. This pay-back system amounted to LVL4 million (€5.6 million) in 2011.

In 2012, after hard and controversial discussions, new regulations were put in force by the government to rationalize pharmaceutical care provided by the NHS. Under the old reference pricing system for pharmaceuticals in the reference list (List A), pharmacists or patients could choose one of the products belonging to the reference group and, if the pharmaceutical product was more expensive than the reference price, patients could pay the difference between the reference price and the actual price as an OOP expense (in addition to the regular drug co-payment). The new regulations determine that there is only one pharmaceutical product in a reference group (the one with the cheapest price), which is awarded the status of “reference medicine”. Prescriptions for newly diagnosed patients now have to be made by the active ingredient and the NHS will only pay for the reference medicine. In addition, when the active ingredient is prescribed, pharmacists always have to dispense the reference medicine.

The new system stimulates competition between pharmaceutical companies because they have to rapidly decrease their prices in order to receive the status of reference medicine. Internal estimates by the NHS suggest that this has resulted in savings of about LVL3.7 million (€5.3 million) in 2012. However, pharmaceutical companies and medical professionals strongly opposed the reform because of the limitations it imposes on patient choice.

The NHS monitors physician prescription practices every quarter. It sends out a report to service providers (outpatient clinics, GPs, etc.) if prescriptions of a physician working at the institution are on average 30% more expensive (for a group of similar diagnoses) than the average in the country. In addition, this information is also forwarded to the HI, which will more closely monitor prescription practices at the concerned health care institutions, and which can verify the appropriateness of prescriptions by accessing patients’ medical information. However, in the absence of strong penalties, there is a feeling that the system is not particularly effective at discouraging inappropriate prescriptions.

2.8.5 Regulation of medical devices and aids

Medical devices and goods in Latvia are regulated by the “Regulation on Registration, Conformity Assessment, Distribution, Use and Technical Surveillance of Medical Devices”, which came into effect in 2005. The SAM is the sole body responsible for the registration, use, surveillance and distribution of medical devices.

The purchase of most medical devices and goods is undertaken by health care providers in accordance with the “Law on Purchases for the Needs of State and Local Governments”, adopted by parliament in April 2006 (this legislation applies to all government purchases, not just in the area of health care).

Procedures for centralized purchases of medical devices and vaccines are defined by “Regulations on Organization and Financing of Health Care” (2006). These purchases are undertaken by the NHS, on behalf of all institutions with which it has agreements (i.e. all statutory health care providers). From 2013 the NHS will purchase devices together with other Baltic countries in order to have a larger purchasing power.

2.8.6 Regulation of capital investment

In general, the owners of all health care institutions (hospitals as well as primary care institutions or practices) are responsible for financing investments (see section 4.1.1). The state as the owner of larger hospitals provides funding for all larger hospitals, while municipalities provide investment funding for their municipal hospitals and PHC centres. Investments in private hospitals or other private health care institutions (e.g. private practices) are financed entirely by the private owners, implying that they have to recover investment costs from the revenues generated through reimbursements for service delivery.

However, the government usually guarantees for credits of capital investments and assumes the risk if providers fail to pay back their credits. In addition, EU Structural Funds are sometimes available for large-scale investments for institutions listed in the Master Plan (see section 2.5).

2.9 Patient empowerment

2.9.1 Patient information

Information asymmetry is one of the characteristic features of health systems. In recent years there have been gradual improvements in the availability of information through growing information dissemination by the mass media and the internet. However, information availability from reliable sources, especially on quality of care, remains limited.

Freedom of Information legislation was signed into law in November 1998 and has been amended a number of times recently. Any person can ask for state-held information and public bodies must respond within 15 days.

The 2010 “Law on the Rights of Patients” stipulates that patients have the right to receive clear information about their diagnosis and a plan of examination and treatment. The same law also guarantees a patient’s right to information about quality of care. Most information is provided to patients by their GPs, the NHS, the Ministry of Health and its subordinate institutions and local governments. The GP usually serves as a health counsellor, providing advice on the specialist, hospital or rehabilitation institution that is appropriate for the patient’s needs. The NHS provides information concerning prices of health care services and the level of the ceiling on co-payments. This information is distributed to patients through posters and booklets made available to the territorial branches and in health care facilities.

There is, however, evidence (although it is somewhat outdated) that there are inequities in access to information among the Latvian population (CIET, 2002). The majority of the Latvian population (about three-quarters) do not feel well informed about their health care entitlements; moreover, Latvian speakers feel better informed about the health care system than the non-Latvian speaking part of the population.

2.9.2 Patient choice

Article 8 of the 2010 “Law on the Rights of Patients” guarantees the right to choose a physician or medical treatment institution. However, freedom of choice had existed since 1991 and the patients’ rights to choose were also specified in the “Regulations on Organization and Financing of Health Care” (2004).

Patients can freely choose to register with any family doctor in Latvia and may decide to change their doctor at any time (see also section 5.3). However, in practice, choice of GP exists only in urban areas; in rural areas there is often limited choice, as there may be only one GP covering a large geographical area. The main reason for a change of doctor is a change of residence.

A patient is also free to choose a diagnostic institution, specialist or hospital, as long as the institution or specialist has a contract with the NHS and the patient has a referral from a family physician (see section 5.2).

2.9.3 Patient rights

The 2010 “Law on the Rights of Patients” is the main legislation in Latvia with articles relating to the rights of patients. The purpose of the Law is to promote favourable relationships between a patient and the provider of health

care services, facilitating active participation of the patient in their health care, as well as to provide an opportunity to implement and protect their rights and interests.

The “Law on the Rights of Patients” consists of the following sections: Right to Information, Right to Medical Treatment, Consent to Medical Treatment or Refusal Thereof, Right of Another Person to Agree to Medical Treatment or to Refuse it, Right to Choose a Physician and Medical Treatment Institution, Right to Become Acquainted with Medical Documents, Protection of Patient Data, Participation of Patient in Clinical Trial, Participation of Patient in the Clinical Training Process, etc.

In practice, the main institution dealing with patients’ rights is an NGO, the Patient Ombudsmen. The HI deals with patient complaints and in some limited cases has given rise to court proceedings with verdicts demanding that compensation be paid to patients who have suffered from inappropriate provision of services.

In Latvia public awareness has been growing about the physical access of disabled people to public institutions, including health care facilities. Unfortunately, this process is at a very early phase and the situation regarding disabled access at the time of writing is not satisfactory.

2.9.4 Complaints procedures (mediation, claims)

The main institution that accepts and checks patients’ complaints is the HI, under the Ministry of Health. The HI decides with the help of experts (e.g. hired consultants) or after consultation with medical professional associations on the appropriateness of complaints and has the right to fine or penalize providers. In addition, the HI can transfer complaints to the state prosecutor’s office, if legal action against a particular provider should be necessary.

Furthermore, the 2010 “Law on the Rights of Patients” specifies that patients have the right to compensation in case of harm caused to their life or health and for non-material damage. For this purpose, a Medical Treatment Risk Fund has been established as a unit of the NHS. Service providers will have to contribute to the fund, which will start to compensate patients by 2013 (or 2014).

Also for mediation between patients and providers, the Patient Ombudsmen are gaining increasing importance. The organization has members working directly in health care institutions to register patients’ complaints and to mediate with providers.

2.9.5 Public participation

Patient participation in the development of policy and health care services provision was non-existent during the Soviet period. Since the mid-1990s a number of different patient societies and associations related to specific diseases have been founded (see section 2.3.8). Their main aim is to protect the interests of the patients, as well as supporting and educating them. Physicians take part in these organizations and very often lead them. Some societies and associations are influenced by the market interests of pharmaceutical and other commercial companies and individuals. However, their ability to influence the policy agenda is rather limited, although in the context of growing importance of the mass media and social networks, patient organizations are starting to play a somewhat more important role.

2.9.6 Patients and cross-border health care

As Latvia is a member state of the EU, the entire population can obtain a European Health Insurance Card (EHIC) from the NHS and is then covered by statutory insurance in the other EU member states and Iceland, Liechtenstein, Norway and Switzerland. Based on EC Regulation 883/2004, Latvians can use the EHIC to receive health services within the statutory system abroad, when on a temporary stay (for example, as tourists) and the statutory system of the foreign country will subsequently be reimbursed by the Latvian NHS. Furthermore, Latvians may ask the NHS for pre-authorization when planning to receive treatment abroad. This authorization cannot be denied if treatment is covered by the Latvian basic benefit package but cannot be provided in the Latvian system within a medically justifiable time limit.

In 2010, Latvia paid LVL1.75 million (about €2.5 million) for health care services provided in other member states to persons entitled to health care in the Latvian statutory system (Health Payment Centre, 2011).

3. Financing

Since November 2011 the NHS, together with its five regional branch offices, is the most important purchaser of health care in Latvia. The system provides coverage to the entire population and pays for a basic service package but leaves patients exposed to substantial user charges and direct payments. In 2010, THE as a share of GDP was 6.7% – one of the lowest shares of GDP spent on health in Europe. THE per capita was US\$1093 PPP, which was the third lowest amount spent on health in the EU27 (only Romania and Bulgaria spent even less per capita).

The most important source of revenue for the health system is the general tax system (income, value added and other taxes), although the share of government spending on health has been decreasing since the onset of the financial crisis in 2008, falling to 9.2% of government spending in 2010, and contributing only 61% of THE. The second most important source of financing is OOP payments, consisting of:

- user charges for all statutorily financed services (although exemption mechanisms exist);
- direct payments for services not financed by the state (such as dental care for adults and cosmetic surgery), or used outside the normal treatment pathways (e.g. to avoid waiting lists); and
- informal payments.

Finally, a small share of THE (less than 1%) is financed through VHI, which pays for services not included in the statutory system (complementary coverage) and provides faster access (supplementary coverage).

The bulk of the parliament-approved government health budget is allocated to the NHS (78% in 2010) for the purchase of health services (NHS, 2011), with the remaining share (approximately 22%) being used by the Ministry of

Health for health sector management, specialized health care (e.g. for the State Emergency Medical Service), public health, medical education and cultural activities (libraries, museums, etc.).

In response to the economic and financial crisis, severe budget consolidation measures were implemented, reducing financing to hospitals, increasing user charges, reducing health worker salaries and lowering prices of pharmaceuticals. At the same time a Social Safety Net Strategy was put in place to ensure access to health services for low income individuals (see Chapter 6), covering user charges for households falling below a certain income threshold.

Payment mechanisms in Latvia have evolved over time and are quite complex. Primary care providers (GPs) are paid using a mix of capitation, FFS, fixed practice allowances, bonuses and voluntary pay-for-performance (P4P) schemes. Secondary ambulatory providers are mostly paid by flat rate fees for defined episodes of illness, with additional FFS payments for preventive, diagnostic and therapeutic interventions. Prior to the recently implemented budget consolidation measures, hospitals were paid by a per diem fee with additional activity-based payments. Since 2010, global budgets have been introduced to control overall hospital expenditure and currently plans exist to implement a DRG-based hospital payment system by 2014.

3.1. Health expenditure

In 2010 total health expenditure as a share of GDP was 6.7% according to WHO National Health Accounts (NHA) data (see Table 3.1). THE was consistently increasing until 2007. In real terms, the spending on health care more than doubled between 2000 and 2007, outpacing the general economy, which grew by 80% during the same period of time. However, with the emergence of the economic crisis in 2008, THE started to decrease and in 2010, it dropped back almost to the 2005 level.

Table 3.1
Trends in health expenditure, 1995–2010

Expenditure	1995	2000	2005	2006	2007	2008	2009	2010
Total expenditure on health in million constant (2005) PPP	901	1 206	1 902	2 253	2 546	2 321	1 909	1 926
THE as % of GDP	5.8	6.0	6.3	6.8	7.0	6.6	6.6	6.7
Mean annual growth rate in total health expenditure (%)	n/a	-0.9	7.8	18.5	13.0	-8.8	-17.8	0.9
Mean annual real growth rate of GGHE (%)	n/a	-7.6	8.7	33.1	7.1	-6.2	-18.9	0.1
Mean annual growth rate in GDP (%)	n/a	6.9	10.7	10.8	9.6	-3.6	-17.8	-0.3
GGHE as % of THE	66.3	54.4	57.1	64.1	60.7	62.5	61.6	61.1
Private expenditure on health (PvtHE) as % of THE	33.7	45.6	42.9	35.9	39.3	37.5	38.4	38.9
GGHE as % of general government expenditure	9.9	8.7	10.1	11.4	11.8	10.6	9.2	9.2
GGHE as % of GDP	3.8	3.2	3.6	4.3	4.2	4.1	4.1	4.1
OOP payments as % of THE	33.7	44.1	40.7	32.4	34.9	33.8	37.3	37.8
OOP expenditure as % of PvtHE	100.0	96.8	94.8	90.4	88.9	90.1	97.3	97.3
Private insurance as % of THE	0.00	1.5	2.2	2.4	1.9	1.8	0.8	0.8
Private insurance as % of PvtHE	0.0	3.2	5.2	6.6	4.8	4.9	2.1	2.1

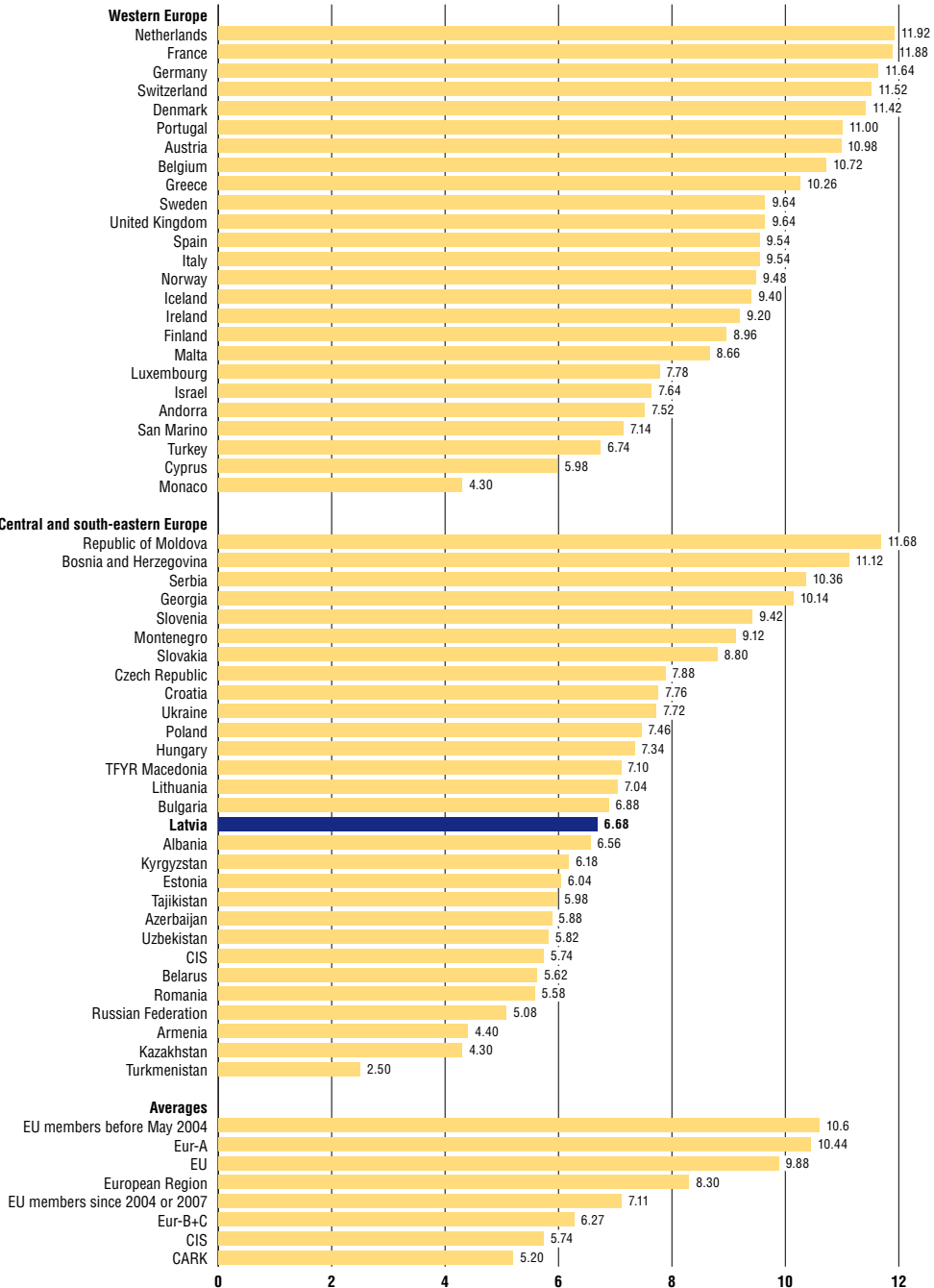
Source: WHO, 2012.

Compared to other European countries, the 6.7% of GDP spent on health in Latvia in 2010 was far below the average of 9.9% in the EU27 countries (see Fig. 3.1). However, it was similar to the share of GDP spent on health in Bulgaria and only slightly below the average of 7.1% of GDP spent on health in the EU12 countries.

The longitudinal data in Fig. 3.2, showing trends over time in health expenditure as a share of GDP in Latvia and other selected countries, illustrates that the gap in financing between Latvia and the EU15 average has not decreased over the past decade.

Fig. 3.1

Health expenditure as a share (%) of GDP in the WHO European Region, 2010



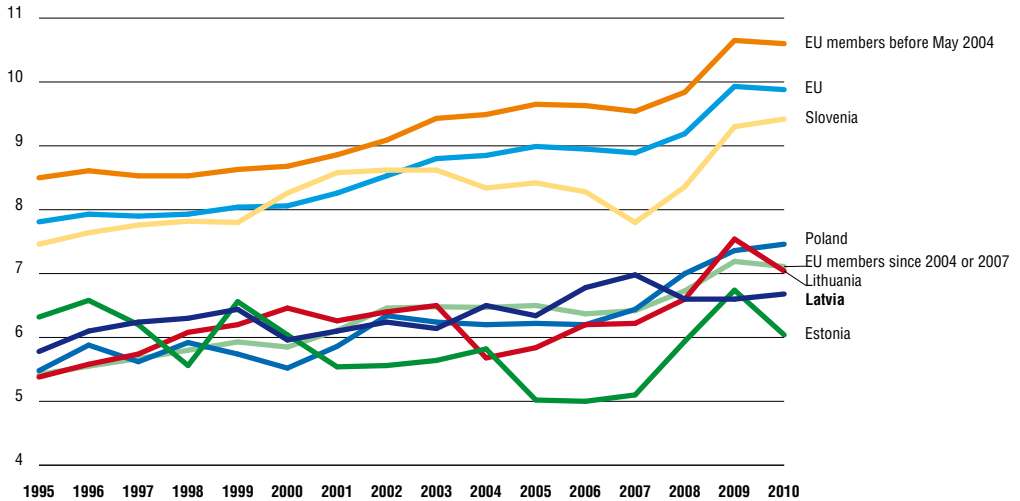
Source: WHO Regional Office for Europe, 2012b.

Note: CARK: Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan;

CIS: Commonwealth Independent States.

Fig. 3.2

Trends in health expenditure as a percentage of GDP in Latvia and selected countries and averages, 1995–2010



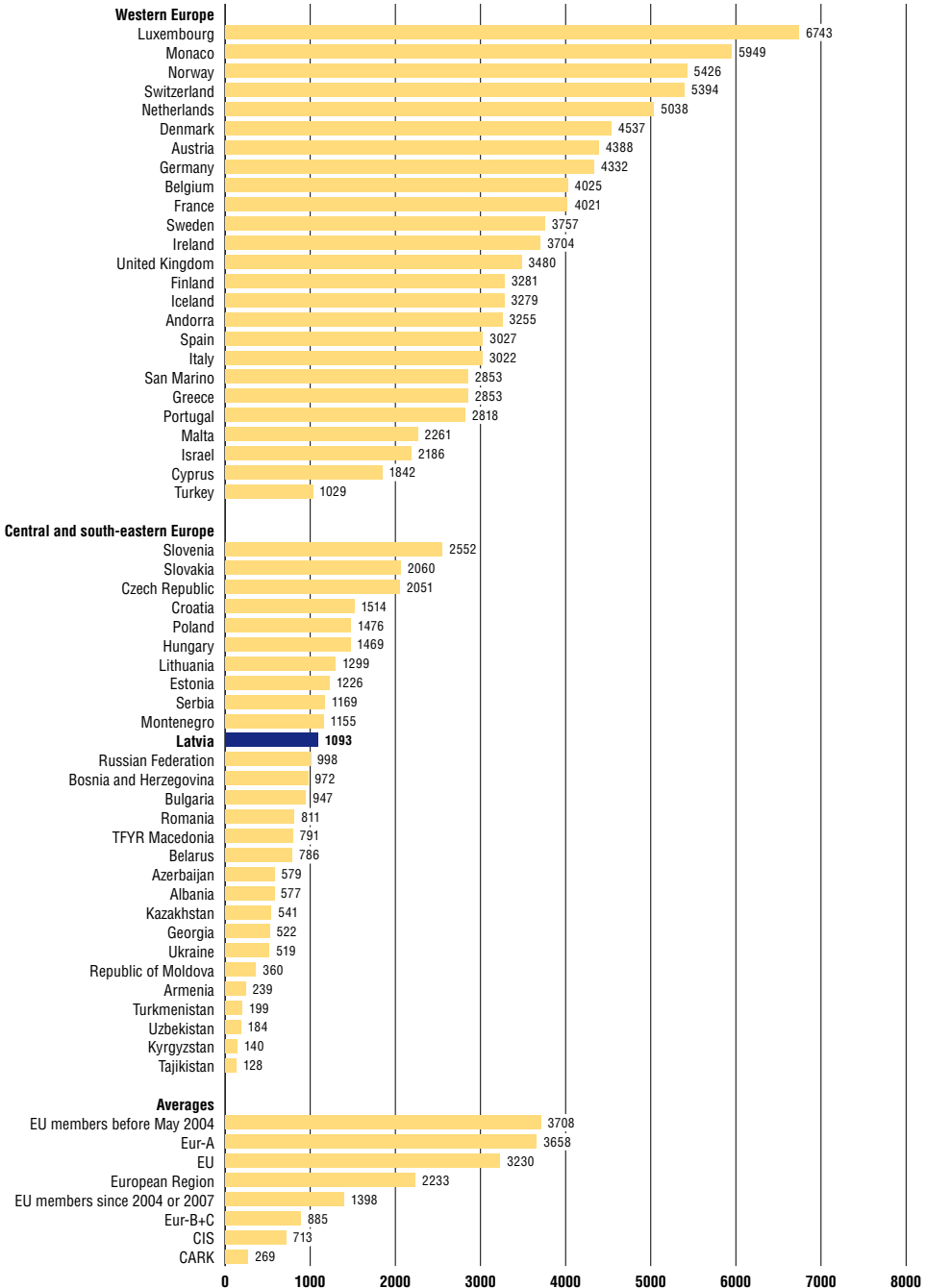
Source: WHO Regional Office for Europe, 2012b.

Comparing per capita expenditure on health with other countries in the WHO European region shows the enormous range in levels of spending per person. Latvia, with US\$1093 PPP in 2010, had the third lowest level of spending per person in the EU, ahead only of Romania and Bulgaria (Fig. 3.3).

Similarly, Latvia’s public share of total health expenditure was only 61.1% in 2010 (Fig. 3.4), which was the fourth lowest in the EU, being higher only than that of Bulgaria, Cyprus and Greece.

Fig. 3.3

Health expenditure in US\$ PPP per capita in countries of the WHO European Region, 2010



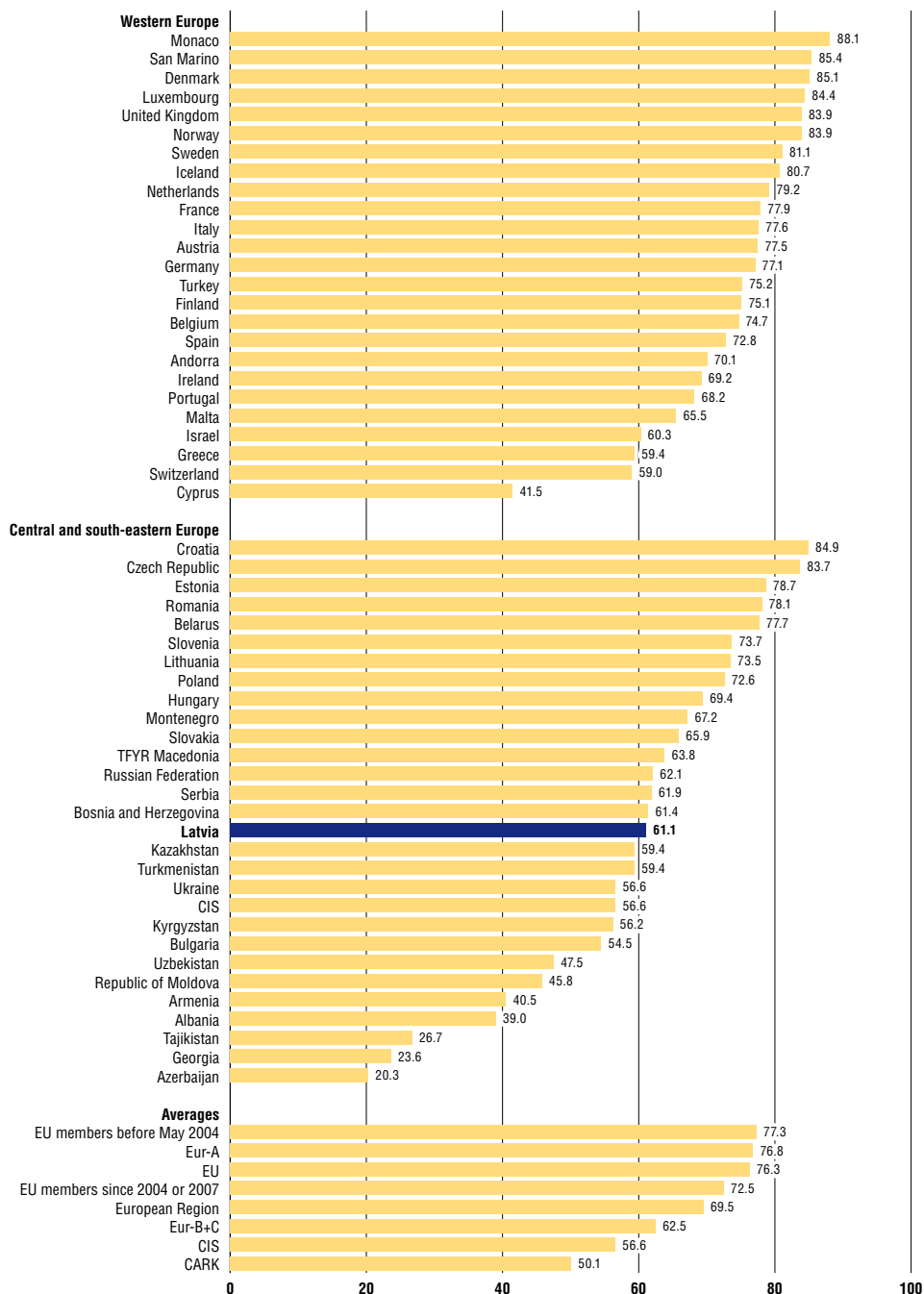
Source: WHO Regional Office for Europe, 2012b.

Note: CARK: Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan;

CIS: Commonwealth Independent States.

Fig. 3.4

Public sector health expenditure as a share (%) of total health expenditure in the WHO European Region, 2010



Source: WHO Regional Office for Europe, 2012b.

Note: CARK: Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan;

CIS: Commonwealth Independent States.

In 2009, according to the Latvian Central Statistical Bureau, public health expenditure (including expenditures by the Ministry of Health as well as by the Ministry of Welfare, Ministry of Justice, local governments, etc.) were used mostly (53.5%) for the financing of services of curative and rehabilitation care (see Table 3.2). Medical goods dispensed to outpatients accounted for the second largest share of public health expenditure (14.5%). Although public health services, prevention and health promotion are acknowledged as a priority in the government's Public Health Strategy (see section 7.1), their share in public health expenditures was only 4.6% (see Table 3.2), corresponding to only 2.8% of total health expenditure in 2009, although this is a considerable increase from 2.3% in 2008 (Central Statistical Bureau, 2012b).

Table 3.2

Public expenditure on health by service programme, 2009

Service programme (function)	% of total public expenditure on health	as a % of total expenditure on health
Services of curative and rehabilitative care:	53.5	31.9
Inpatient	38.8	23.1
Day cases	2.0	1.2
Outpatient	12.7	7.5
Services of long-term nursing care	5.1	3.1
Ancillary services to health care	9.3	5.5
Medical goods dispensed to outpatients	14.5	8.7
Prevention and public health services	4.6	2.8
Health administration and health insurance	3.1	1.8
Education and training of health personnel	0.6	0.4
Research and development in health	0.6	0.4
Capital formation of health care provider institutions	8.6	5.1

Source: Central Statistical Bureau, 2012b.

Note: Total public expenditure and total expenditure on health in this table include investment (capital formation), expenditure, long-term nursing care (financed mainly by the Ministry of Welfare and Municipalities), education and training of health personnel and research and development in health.

As indicated in Table 3.3, the share of hospital expenditure decreased substantially between 2008 and 2009, while the share of expenditures for ambulatory providers and medical goods increased in 2009 as the government substantially reduced spending on inpatient services, while prioritizing primary care and pharmaceuticals. However, while more recent figures on total public expenditures are not available from the Central Statistical Bureau, data from the NHS show that spending on hospitals was further reduced in 2010 and 2011 (see section 7.5.1).

Table 3.3

Expenditure by provider as percentage of general government current health care expenditure

	2005	2006	2007	2008	2009
Hospitals	55.5	52.5	57.2	56.7	52.0
Nursing and residential care facilities	4.9	4.5	3.2	3.5	4.9
Providers of ambulatory health care	22.7	25.9	19.8	20.5	21.8
Retail sale and medical goods	10.4	10.3	12.2	13.5	16.1
Provision and administration of public health programmes	0.4	1.7	0.1	0.0	0.0
General health administration and insurance	5.0	5.0	6.6	4.4	3.4
Other industries (rest of the economy)	0.4	0.1	0.9	1.3	1.2
Rest of the world	0.7	0.0	0.0	0.0	0.5

Source: Central Statistical Bureau, 2012b.

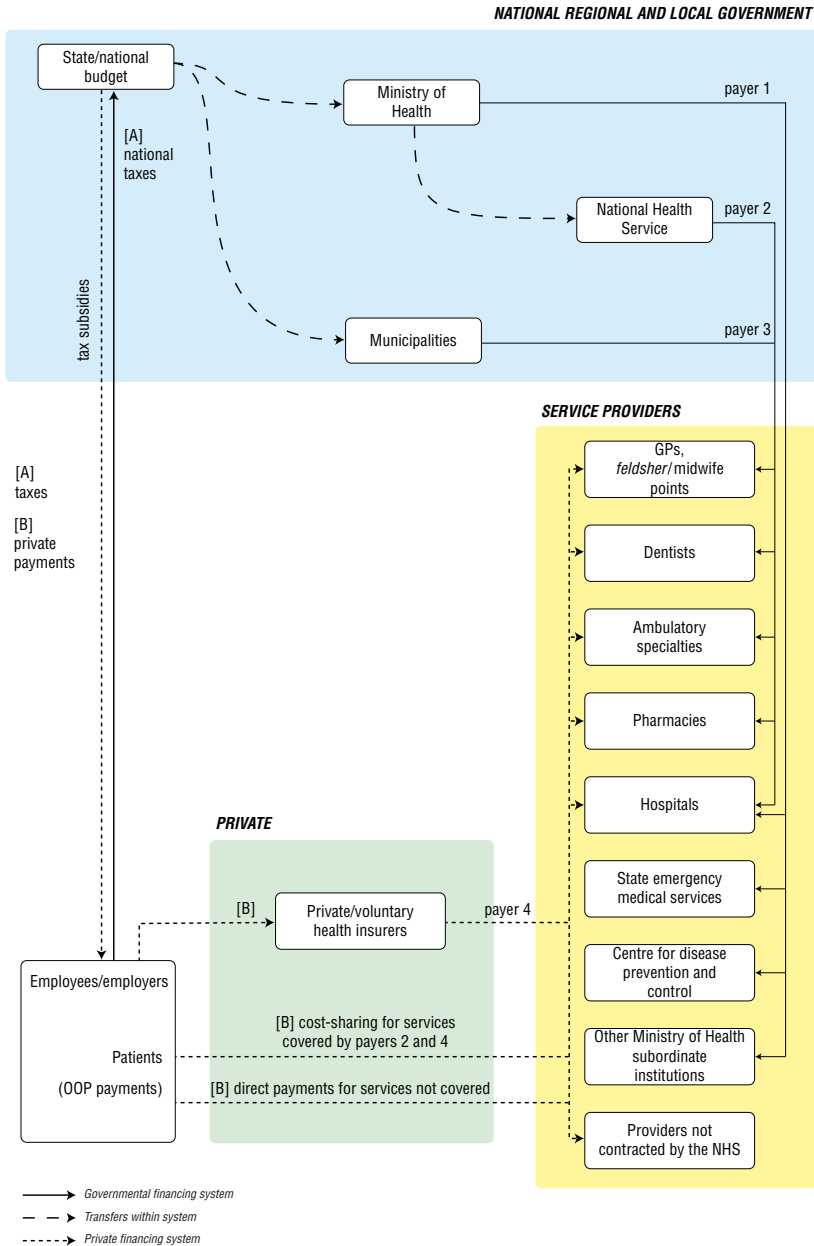
Notes: General government health care expenditure in this table does not include investment (capital formation), education and training of health personnel and research and development in health.

3.2 Sources of revenue and financial flows

The most important financial flows within the health system are shown in Fig. 3.5. About 60% of revenues for the health system come from general (non-earmarked) taxation at the central (national) level (see Table 3.4 and Fig. 3.6). The share of government expenditure on health (GGHE) has seen considerable ups and downs over the past two decades. Between 1995 and 2001 GGHE as a share of THE declined by more than 15 percentage points before it increased again by 10 percentage points until 2006. Subsequently, it started to decline again even before the start of the crisis in 2007. Tax collection is centralized in Latvia and is carried out by the National Revenue Service (NRS), which is subordinated to the Ministry of Finance and distributes the revenue directly to the National Treasury.

OOP payments in the form of formal user charges and direct payments for services not covered by the NHS (see also section 3.4) together account for about 38% of THE (see Table 3.1). Following the budget consolidation measures implemented in response to the financial crisis, OOP payments as a percentage of THE increased considerably between 2008 and 2009. Co-payments, which had been unchanged since 2005, were raised significantly in 2009. VHI has never substantially contributed to total health care expenditures in Latvia (at least according to data available in international databases, see section 3.5.1). It decreased from an already low level of 1.8% in 2008 to only 0.8% in 2009 (see Table 3.4 and Figure 3.6).

Fig. 3.5
Financial flows

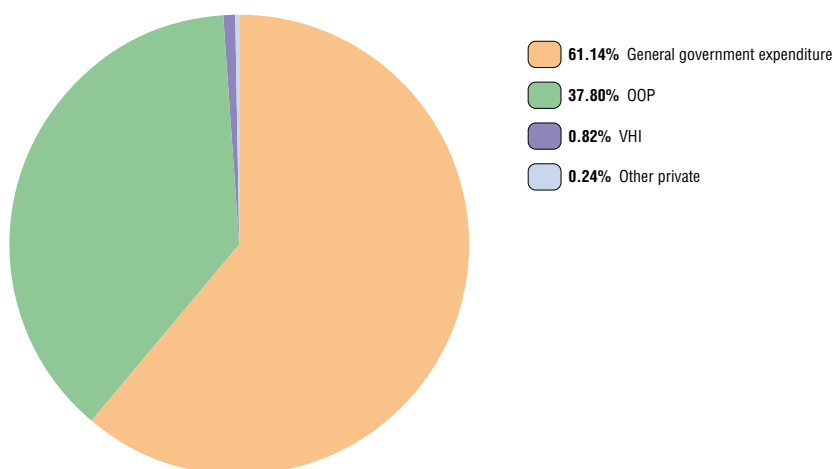


Note: For state budget institutions, including the NHS and CDCP, the figure shows flows via the Ministry of Health because the Ministry determines the budgets of these institutions. However, in fact, these institutions have direct accounts with the State Treasury and receive monthly transfers in accordance with budget; the figure does not include financial flows for long-term nursing care, which is mainly financed by the Ministry of Welfare, and flows from the other ministries since their contribution to services of curative and rehabilitative care is not substantial – LVL1.3 million in 2009 (Central Statistical Bureau, 2012b).

All permanent residents, citizens of member states of the EU, the European Economic Area (EEA) states and Switzerland, who reside in Latvia, as well as third-country nationals with a permanent residence permit and refugees (or similar) are covered by the statutory health care system (Medical Treatment Law, 1997).

Fig. 3.6

Percentage of total expenditure on health according to source of revenue, 2010



Source: WHO, 2012.

Table 3.4

Sources of revenue as a percentage of total expenditure on health according to source of revenue, 1995–2010

Source of revenue	1995	2000	2005	2006	2007	2008	2009	2010
General government expenditure	66.3	54.4	57.1	64.1	60.7	62.5	61.6	61.1
OOP payments	33.7	44.1	40.7	32.4	34.9	33.8	37.3	37.8
VHI	0.0	1.5	2.2	2.4	1.9	1.8	0.8	0.8

Source: WHO, 2012.

Every year, parliament approves the government health budget. The Ministry of Health determines the budget of the NHS. The budget is allocated to the NHS by the Treasury. In 2010, the NHS consumed about 78% of the total government health budget, i.e. LVL385.5 million (€542 million) out of LVL496 million (€697 million) (NHS, 2011). The remaining part (approximately 22%) was

used by the Ministry of Health for health sector management, investments, institutions under the Ministry (including the State Emergency Medical Service and the Infectology Centre of Latvia), public health, medical education and cultural activities (libraries, museums, etc.) (for more details see section 3.3.3). Local governments contributed about 4.8% of THE in 2009, mostly for inpatient curative care, capital formation of health care provider institutions and long-term nursing care.

The NHS has several subprogrammes, with the most important ones being the “Medicare” subprogramme and the “Medicine” subprogramme. Actual expenditures of the Medicare subprogramme in 2010 amounted to LVL300 million (€422 million, including most of the budgeted funds for unforeseen cases of LVL26 million and for the Social Safety Net Strategy of LVL24 million). These expenditures were distributed as follows (NHS, 2011):

- inpatient services: LVL163.5 million (42.2 % of the NHS budget);
- outpatient services: LVL132.5 million (34.4 % of the NHS budget);
- emergency services: LVL2.1 million (0.5 % of the NHS budget, including only expenditures for emergency services up until the end of June 2010, when the responsibility for emergency care was transferred to the Ministry of Health as part of an emergency care reform, which led to the establishment of one uniform State Emergency Medical Service (see section 5.5);
- settlements with EU: LVL1.9 million (0.5 % of the NHS budget).

Expenditures from the “Medicines” subprogramme (for outpatient pharmaceuticals) amounted to about LVL74.6 million. From the perspective of NHS-contracted providers, NHS payments accounted for about 78% of their revenues in 2010 (including user charges of low-income households, which are reimbursed by the NHS), while user charges paid directly by non-exempt patients for statutory health services made up 7% of their revenues (NHS, 2011). Direct payments for non-contracted care (provided by contracted providers) accounted for 8% of their revenue, while other income (e.g. investments from EU funds or municipalities and commercial exploitation) made up 7% of revenues. However, these data do not include care provided by non-contracted providers or provided by state agencies reporting directly to the Ministry of Health (e.g. the Infectology Centre of Latvia, a state agency that was closed in April 2012). Therefore, these data do not correspond to the total health expenditure data reported by the CSB (mentioned above). Payment mechanisms for care purchased by the NHS are discussed in section 3.7.

3.3 Overview of the statutory financing system

3.3.1 Coverage

Breadth: who is covered?

According to paragraph 111 of the Constitution of Latvia, “The state shall protect human health and guarantee a basic level of medical assistance for everyone”. Universal population coverage is also ensured by the Medical Treatment Law (1997), which states that “Everyone has the right to receive emergency medical care in accordance with procedures prescribed by the Cabinet” (paragraph 16). Paragraph 17 specifies who is covered under the statutory system:

- Latvian citizens;
- Latvian non-citizens;
- citizens of member states of the European Union, of European Economic Area states, Ukraine and Swiss Confederation who reside in Latvia in relation to employment or as self-employed persons, as well as the family members thereof (for details see section 2.9.6);
- third-country nationals who have a permanent residence permit in Latvia;
- refugees and persons who have been granted alternative status;
- persons detained, arrested and sentenced with deprivation of liberty.

No other criteria, such as employment status, income, ethnicity or place of residence, influence coverage. All Latvian residents who are not citizens (14.6% of the Latvian population, see section 1.1) have the same access to health care and coverage as Latvian citizens.

The only (presumably small) population group without coverage consists of aliens and stateless individuals whose passports do not include a personal identity number and who have not been registered in the Population Register. If a resident of Latvia or of an EU country needs medical care in a country within the EU, reimbursement according to EU regulations and agreements will be arranged. (For details see section 2.9.6.)

Scope: what is covered?

The statutory health care system covers only services provided by physicians and institutions that have contractual agreements with the NHS.

The Latvian benefits basket is determined by a number of explicit inclusion and exclusion lists as well as by certain implicit criteria. On the one hand, explicit inclusion lists are the positive list of pharmaceuticals (see section 2.8.4)

and a list of diagnostic, preventive and therapeutic interventions appended to the Regulations No. 1046. Implicit criteria are the standard NHS contracts, e.g. with GPs, which broadly define that providers have to “ensure prevention, diagnostics and treatment of patients corresponding to the disease and normative legislation” (Art.2.1.2 of the NHS template agreement).

On the other hand, the Regulations No. 1046 explicitly exclude certain services, such as dental care for adults, rehabilitation (with a long list of exceptions), medical check-ups required by occupational circumstances, sight correction and hearing aids (except for children), spa treatment, abortions (if there are no medical or social indications) and others. Furthermore, the terms of the contracts between the NHS and providers determine that children, pregnant women and people with urgent medical care are priorities for resource allocation, exposing other patients to substantial waiting lists for non-prioritized services, up to a point where they are implicitly excluded. However, this does not mean that children receive all necessary health care and charities often collect money for children if the government does not have sufficient resources to pay for their treatment.

In general, a referral from a family doctor is required in order for care or diagnostic examination from a specialist or hospital to be covered by the NHS (except for urgent cases, see also section 5.2). If patients do not have a referral, e.g. because they wish to avoid waiting times, all costs have to be covered out-of-pocket or through VHI.

The NHS includes new services based on applications from health care institutions or professional associations provided they comply with NHS internal regulation (NHS, Internal Regulation No. 2) (see also sections 2.8.4 and 2.8.5). The criteria for inclusion of new services into the benefits basket include availability of financial resources. As a result of the recession and the need to cut spending in 2009, the government substantially reduced spending on inpatient and secondary outpatient services, while prioritizing primary care, services for children and pregnant women, emergency assistance and pharmaceuticals. This led to the emergence of substantial waiting lists, implicitly removing certain services from the benefits basket.

Aside from the health care system, Latvia’s system of social protection provides additional benefits (coverage of risks of old age, death, work disability, maternity, labour accidents and work-related diseases and unemployment, family benefits and social assistance for the needy), which are administered by the Ministry of Welfare (see section 3.6.3).

All services excluded from state coverage can be purchased by patients or their voluntary insurance plans either from providers with NHS contracts or from non-contracted providers (see also section 3.4.2). Patients are exposed to substantial direct payments, implying that the breadth of coverage is somewhat limited. Besides certain excluded services, such as dental care for adults, this is most importantly related to the fact that an important share of pharmaceuticals are not covered by the NHS.

Depth: how much of the benefit cost is covered?

All health care services in Latvia, such as GP visits, specialist visits, stays in hospitals and pharmaceuticals, require cost-sharing in the form of user charges (see section 3.4.1 for details). The depth of coverage is relatively limited for outpatient pharmaceuticals, for which patients often have to make OOP payments for a substantial proportion of costs. In fact, expenditures on pharmaceuticals account for about 60% of OOPs (see section 7.2.1). Nevertheless, protection mechanisms exist that limit total expenditures on user charges to a certain degree and exemptions exist for specific population groups (for example, children and pregnant women) and low income households (see section 3.4.1 for details).

3.3.2 Collection

Tax collection is centralized in Latvia. The main body responsible for tax collection is the State Revenue Service (SRS), subordinated to the Ministry of Finance. It operates territorial branches and incorporates several institutions, such as the Financial Police. Tax payments flow to the National Treasury from the Ministry of Finance. The tax rates are set by laws passed by parliament. There is no progressivity applied to tax rates but an untaxed personal allowance effectively reduces the relative tax burden of lower income households (Vanags, 2010). Local governments are responsible for collecting a real estate tax.

As of January 2012 the main taxes paid by the population are the following (SRS, 2012):

- social insurance tax, shared between employers who pay 24% of their employees' gross salary and employees who pay an additional 11%, together accounting for 34% of government tax revenues in 2010;
- personal income tax at a flat rate of 25% (for all income groups), accounting for 23% of government tax revenues;

- VAT at 21% (since July 2012) and 12% for special categories of goods, including pharmaceuticals and medical devices, accounting for 25% of government tax revenues;
- excise tax on alcohol, tobacco and fuel at varying tax rates, accounting for 14% of tax revenues;
- corporate income tax at 15%, accounting for 3.3% of tax revenues.

The personal income tax rate of 25% is applied to income after deduction of the employee's social insurance tax, a non-taxable minimum of LVL45 (about €64) plus LVL70 (about €100) for each person registered as a dependant of the employee.

There is tax relief in the form of tax deductions for reported and confirmed OOP spending on health care by the individual or any dependants (children, parents), as well as for spending on professional education. However, health-related tax deductions, which can also be used for premiums to VHI, are limited to a total of LVL150 (€214) per year (Government of Latvia, 2001).

3.3.3 Pooling of funds

The SRS is responsible for pooling tax revenue. It distributes the revenue directly to the National Treasury and then to the corresponding agencies, including the Ministry of Health. The amount of funds distributed to each ministry or sector depends on the relevant approved budgets. The volume of the annual Ministry of Health budget depends on whether a decision is made by parliament to amend the law dealing with the state budget; this may occur once or twice per year. In addition, municipalities contributed 8% of public expenditures on health in 2009 (Central Statistical Bureau, 2012b) and other ministries 4% of public expenditures on health (see section 3.6.3).

The Ministry of Health allocates the majority of its budget to the NHS (approximately 78% of the budget in 2010). However, between 2009 and 2012, providers contracted by the NHS often ran deficits. As the NHS monitors expenditures, it usually informs the Ministry of Health if large deficits are detected at provider level. In this case, it submits a request for additional funding to the Cabinet of Ministers.

The structure of the NHS consists of a Central Office and five regional branches, with the largest branch in Riga covering more than 900 000 inhabitants, while the other four cover between 270 000 and 330 000 inhabitants each. The Central Office manages the budget and signs contracts with inpatient (secondary

and tertiary) providers. Territorial branches do not have their own budgets but purchase ambulatory services (GPs, secondary-level outpatient care and dental care) and deal with reimbursement for prescription pharmaceuticals of their populations (even if services are provided in the area of another territorial branch). Both the Central Office of the NHS and the territorial branches plan and purchase services for the most part on the basis of historical precedent.

The Ministry of Health administers the remaining share of the health budget (approximately 22% of the 2010 budget). The main areas of the Ministry of Health's expenditures in 2010 are:

- provision of specialized health care (10.6% of the government health budget in 2010), including emergency health care (since mid-2010), infectious diseases, sports medicine, forensic medicine and others;
- implementation of the project of European Regional Development Fund and the European Social Fund (5.9%);
- education (3.3%): financing of educational facilities and residency training programmes;
- health sector management (0.9%): financing of the structures of the Ministry of Health;
- culture programme (0.3%): this is a relatively small budget assignment for library and museum facilities.

3.3.4 Purchasing and purchaser–provider relations

Historically the Latvian health system was based on the principles of the integrated Semashko model. The health sector was publicly financed and all levels of service provision were planned and centralized (see section 2.2). The reforms of the 1990s split the purchasing and providing functions and aimed to create incentives for more efficient management. After a period of experimentation with decentralized sickness funds in the mid-1990s and a subsequent process of recentralization (see section 2.4), the predecessor organization of the NHS – the SCHIA – emerged as the central state-purchasing agency in 2002. However, for a few areas of specialized health care, providers remain in a hierarchical (administrative) relationship with the Ministry of Health, e.g. for infectious diseases until April 2012 and for pre-hospital emergency services since mid-2010.

The NHS is the only purchaser of health care services in Latvia for primary, secondary, tertiary and emergency care (except for emergency care in the pre-hospital stage since mid-2010), as well as for the purchase of pharmaceuticals. The organizational relations between purchasers and providers are regulated in detail through the Regulations No. 1046 (see also sections 2.8.1 and 2.8.2 for regulation of third-party payers and providers). The NHS Central Office plans the volume of services to be provided by providers throughout the country but territorial offices may submit corrective proposals.

The NHS or its branch offices negotiate and sign contracts with independent public and private service providers, for a duration of up to ten years (Art.132, Regulations No. 1046). The Central Office contracts with inpatient providers. Territorial branch offices contract with GP practices, dentists and secondary outpatient services providers as well as with pharmacies for the provision of reimbursed pharmaceuticals. Contracts contain health sector regulatory documents, define the responsibilities of the contract parties and specify reporting requirements, while the annexes, which are subject to annual agreements, specify the payment conditions, list the statutory services to be provided, eligible patient groups and a cap on the budget. Standard contracts exist for the main service provision levels (e.g. inpatient care, secondary outpatient care, primary care) and the same tariffs are applied to all providers (of the same category) across the country. The distribution of NHS resources to different programmes (e.g. not more than 53% for inpatient services and at least 45% for outpatient services in 2012) is regulated by the Regulations No. 1046. In general, tariffs are calculated in such a way that they cover both running costs of services and depreciation of capital investments.

For inpatient care and secondary outpatient care, the regulations No. 1046 (Annex No. 24) lists hospitals and priority secondary outpatient providers (hospitals) that are to be contracted by the NHS. Hence, competition between inpatient and secondary outpatient providers for contracts is rather limited. Contracts between the NHS and hospitals outline the types of services to be provided within a year and specify the annual budget. The size of hospital budgets depends on the estimated unit cost of the service (including both running costs and depreciation of capital) and the estimated volume of services (Art.130³.2.1 see section 3.7 for details). The budgets are hard budgets that shift the entire risk for exceeding the budget onto the provider side. If the provider exceeds the estimated volume, the NHS does not reimburse the provider for the additional activity. In practice, many hospitals run financial deficits, which have to be compensated for by the owners (the state, local governments, private

owners). For example, Stradins Hospital, one of the biggest hospitals in Latvia, has been running financial deficits for years and the government was recently asked to pay LVL10 million to clear the debts of the past.

For secondary outpatient care, the NHS assesses secondary care outpatient institutions according to certain criteria before signing a contract. The criteria for the assessment include: providers' compliance with legal requirements, financial, technical and management capacity, personnel availability and qualifications. The procedure is considered an attempt to engage in selective contracting so as to avoid paying for inappropriate service provision. The outcome of the assessment may lead to an update of the priority list maintained by the Ministry of Health (Annex No. 24, mentioned above). However, in practice almost all providers willing to sign a contract with the NHS do so and the objectives of provider assessment are therefore not adequately met. There is a need to improve the legal basis of the selection process and to establish selection criteria that favour cost-effective and patient-oriented providers. Contracts determine a cap on the amount of services to be provided by secondary outpatient care providers. However, it appears that caps are often exceeded as this improves the ability to negotiate a higher cap for the next year and if the total budget is increased it allows providers to obtain a larger share of the budget.

Concerning primary care services, the NHS has an established (and relatively stable) network of GP practices with which it has contracts. Contracts are signed either with single GP practices or, if GPs provide services as employees of health centres or hospital outpatient departments, with the administration of the respective provider institution. The NHS has a selection process for GPs and the option to cancel agreements if certain requirements are not met. However, competition seems to be rather limited. In addition, targets exist for the number of GPs to be contracted in a region. Newly certified GPs are put on a waiting list for contracting (Art.53, Regulations No. 1046) or can apply to vacancies posted at the NHS website (although there were only two vacancies in August 2012). The size of a GP budget for the provision of primary outpatient services is mainly determined by a capitation payment (see section 3.7).

Neither the Ministry of Health nor the NHS monitor the purchase of non-contracted care from contracted or non-contracted providers. There are no mechanisms in place to counter supplier-induced demand for non-contracted care, although contracted providers are obliged to submit financial reports, which also contain information on OOP payments, including for non-contracted care provided to patients.

3.4 Out-of-pocket payments

OOP payments are the second most important source of revenue for the Latvian health system. Since the start of the recession in 2008, when the government cut spending and increased user charges, the share of OOP payments as a percentage of THE grew to 38% in 2010 (see Table 3.4), which is among the highest in the EU27 (behind Cyprus, Bulgaria and Greece).

In Latvia three main categories of OOP payments exist. Firstly, patients have to pay user charges for statutorily financed care provided by NHS contracted providers and for care provided within Ministry of Health financed health programmes (see section 3.4.1 for details). Secondly, they have to make direct payments for non-statutorily financed care (non-contracted care) provided by NHS contracted providers and for all care provided by non-contracted providers (see section 3.4.2), e.g. private practitioners. Thirdly, informal payments are thought to be important (see section 3.4.3).

In 2010 the average monthly OOP per one household member was LVL10.40 (€14.60), contributing to 5.8% of total household expenditure. About 60% of OOPs was spent on medical goods (mostly pharmaceuticals, including OTC drugs) dispensed to outpatients, while outpatient care services accounted for another 25% (see also section 7.2.1). Higher income groups spend higher amounts in absolute terms but these constitute a lower share of their income (see also section 7.2.2). According to data reported to the NHS by contracted providers, total revenue earned from OOP payments of LVL80.5 million (€113.1 million) in 2010 were composed of: (1) user charges for contracted care of LVL52 million (€73 million) or 63% of total OOP payments (including also user charges for patients exempted from payment, i.e. charges reimbursed through the Social Safety Net Strategy); and (2) direct payments for non-contracted care of LVL30.3 million (€43 million) or 37% of total OOP payments received by these providers (NHS, 2011). However, these figures reflect only about 25% of all OOP payments since they do not include OOP payments for pharmaceuticals, direct payments to non-contracted providers, user charges for care provided through Ministry of Health financed programmes and informal payments.

3.4.1 Cost-sharing (user charges)

User charges are an important source of revenue for health care institutions contracted by the NHS. In fact, the total revenue earned by health care providers from user charges (including co-payments and co-insurance) doubled in nominal terms from 2008 to 2009 and remained at this high level in 2010,

bringing the share of user charges as a percentage of total revenue at NHS contracted providers from 5.6% in 2008 (NHS, 2009) to 14% in 2010 (NHS, 2011), although about half of this amount (7%) was reimbursed by the NHS for exempted patients.

Several types of user charges exist in Latvia. One is co-payments – a fixed amount (flat rate) has to be paid, for example, per GP visit, hospital stay, inpatient surgical intervention or prescription drug with 100% reimbursement level. Another is co-insurance – a fixed proportion of the cost of prescription drugs or medical devices (25% or 50%) has to be covered by patients. All user charges are regulated by Regulations No. 1046 and Regulations No. 899, “Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment”. However, it is important to note some ambiguity in the Latvian cost-sharing terminology. On the one hand, the system of co-payments for outpatient and inpatient services, which was introduced in 1996, is locally referred to as “patient fees” (*pacienta iemaksa* in Latvian). On the other hand, when the co-payment is charged for in-patient surgical interventions, it is locally referred to as “co-payment” (*pacienta līdzmaksājums* in Latvian).

When first introduced in 1996, user charges were formally claimed to encourage consumer responsibility over personal health, reduce inappropriate demand and increase resources for health care. However, the government recognizes the need to reduce the burden of user charges on the population while keeping their role to reduce excessive use of health care services.

Co-payments apply to almost all types and levels of statutorily financed health services, as well as outpatient prescription pharmaceuticals (see Table 3.5). Before the introduction of the current fee catalogue in 2009 (modified in 2010), fees had remained unchanged since 2005. The increase in 2009 had the main purpose of reducing service use and steering patients away from inpatient care and specialist outpatient care. Co-payments for secondary outpatient care and per diem charges for inpatient care were increased considerably, while co-payments for GP visits were kept relatively unchanged, increasing only from LVL0.5 (€0.70) to LVL1 (€1.41). However, in 2010 co-payments for secondary outpatient care (outpatient hospital and specialist visits) were reduced again. Current co-payments are LVL3 (€4.28) per specialist consultation and patients have to pay further co-payments for certain specialist diagnostic and/or therapeutic procedures.

Cost-sharing for pharmaceuticals has existed since the 1990s. Currently, the “Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment” list all health conditions (diagnoses) for which patients can receive pharmaceuticals and medical devices reimbursed by the NHS; and they classify the conditions (diagnoses) into three groups with different levels of co-insurance (100%, 75% or 50% are covered by the NHS) depending on the degree of severity of the condition.

Reference pricing for pharmaceuticals and medical devices was introduced in 2005 with the “Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment”. The aim was to rationalize the use of resources and, consequently, to expand the range of health conditions (diagnoses) that could be covered. The system divides the positive list of pharmaceuticals into three parts (see also section 2.8.4): an interchangeable drug list (List A); a non-interchangeable drug list (List B); and pharmaceutical products for which annual treatment costs exceed LVL3000 (List C). Reference pricing is applicable for the replaceable drug list (A). Until 2012 the lowest drug price level (the reference price) was covered by the NHS but patients could be prescribed a more expensive (original) drug, if they were willing to pay the difference. For example, if a patient was prescribed a 75% covered non-reference drug, patient payment would be 25% of the reference price plus the price difference between the prescribed non-reference drug and the reference price. If a drug or device falls into the 100% coverage category, patients only have to pay a LVL0.50 (€0.71) co-payment per prescription.

Table 3.5

User charges for health services and protection mechanisms, 2012

Health service	Type of user charge in place	Exemptions	Cap on user charges	Other protection mechanisms
GP visit	Patient fee (co-payment) of LVL1 (€1.43)			
Diagnostic services	Patient fee (co-payment), various, up to LVL25 (€35.64) per service unit, no user charges for approved lab tests with referral	Children under 18, pregnant women and women up to 42 days after childbirth, victims of political repression and participants of the national resistance movement and other groups set by the "Regulations of the Cabinet of Ministers on Organization and Financing of Health Care"	All co-payments for outpatient and inpatient health care services per person per year capped at LVL400 (€570); co-payments per hospitalization episode are capped at LVL250 (€356)	Households with an income below LVL90 (€128) per family member are exempted from user charges under the Social Safety Net
Outpatient specialist visit	Patient fee (co-payment) of LVL3 (€4.28)			
Day hospital	Patient fee (co-payment) of LVL5 (€7.13) per day			
Inpatient stay	Patient fee (co-payment) of LVL9.5 (€13.54) per day (LVL5.00 (€7.13) in care hospitals) starting from the second day and co-payment up to LVL30 (€42.77) for inpatient surgical intervention			
Outpatient prescription drugs and medical devices	Co-payment LVL0.5 (€0.71) per prescription (for drugs with 100% reimbursement), co-insurance of 25% or 50%, reference pricing	Children under 18, medicines or devices with a price below LVL3 (€4.28); 50% reimbursement for children under 24 months and pregnant women (including until 42 days after childbirth) for all prescription medicines (also if not included in the positive list)	No cap	
Dental care	Direct payment	Full reimbursement for children under 18 (under 22 for face jaw cleft patients); 50% reimbursement for dental care and full reimbursement of dental plastic prostheses for Chernobyl victims		

Sources: Government of Latvia, 2006a, b (Regulations No. 1046 and No. 899).

Since 2012 a modified reference pricing system has been introduced. The new procedure requests physicians to indicate on the prescription the international non-proprietary name (INN) of the drug in case it is prescribed to the patient for the first time. The pharmacy is obliged to issue the cheapest

(reference) drug to the patient. Physicians can only prescribe the next cheapest drug from the reference list if the reference drug does not work. For patients who were on the treatment before the reform, physicians may continue prescribing trade names on the prescription. The new system was introduced to increase competition between pharmaceutical companies (see section 2.8.4) and to avoid unnecessary patient payments on original (brand) drugs, which were estimated by the Ministry of Health to amount to LVL9 million (€12.6 million) in 2010 (Government of Latvia, 2011).

Several mechanisms exist to protect the population from catastrophic expenditures or underuse of services, which could result from user charges. These include exemption mechanisms for certain population groups and low-income households and a cap on user charges (see Table 3.4).

The cap on user charges applies to the entire population. All co-payments for outpatient and inpatient health care services per person per year must not exceed LVL400 (€570). In addition, they must not exceed LVL250 (€356) per hospitalization episode. If a patient can prove to his NHS branch office that he has reached the cap, the NHS will issue a certificate and reimburse providers directly for all patient user charges exceeding the cap. However, the cap does not apply to co-payments and co-insurance for pharmaceuticals or medical devices.

Children under the age of 18 are exempted by law from payment of any fees for all services included in the statutory list of services. Other exempt groups include pregnant women and women up to 42 days after childbirth, victims of political repression and participants of the national resistance movement, victims of the Chernobyl nuclear reactor accident, disabled people, TB patients and those under examination for TB, mentally ill patients under treatment and others.

In addition, since the implementation of the Social Safety Net measures, households with an income below LVL120 per family member were exempted from user charges and households with an income below LVL150 were eligible for 50% reduction of user charges. However, as of 2012 only households with an income below LVL90 per family member per month are exempted from user charges.

For all patients exempted from user charges, the NHS (or the Ministry of Health for ministry-financed programmes) reimburses providers for co-payments and co-insurance that would otherwise have to be covered by patients. In 2010 about 21 500 patients were exempted from user charges for

pharmaceuticals under the Social Safety Net Strategy; co-payments were covered for 23 400 inpatient stays, 42 200 day cases, 129 100 outpatients and 5800 home care patients. In addition, user charges can be covered by VHI.

3.4.2 Direct payments

Direct payments are frequent in Latvia and tariffs for direct payments are freely determined by providers. Direct payments occur in three instances. (1) Patients have to pay for services or goods that are not included in the statutorily financed benefit basket. This includes, for example, dental care for adults, psychotherapy, most of the available rehabilitation and physiotherapy services and an important section of pharmaceuticals, which are excluded from NHS coverage. (2) Patients have to make direct payments for NHS-covered services or goods if they prefer to receive these services outside the standard patient pathway. For example, if a patient goes to a gastroenterologist for a regular check-up (a service which is included in the basic benefit package) without a GP's referral, the payment for the service would be met out of pocket. Similarly, patients have to make direct payments if they want to jump waiting lists for non-prioritized NHS-covered services, such as non-urgent care, planned (elective) surgery and management of chronic illness. These services are often postponed by NHS-contracted providers into the distant future, although they are part of the statutory benefits package. The NHS monitors direct payments made to contracted providers and may terminate a contract if it finds that the provider deliberately defers treatment in order to be able to charge direct payments (Art.144.1.11, Regulations No. 1046). (3) Patients have to pay directly for all services received from providers that do not have a contract with the NHS, regardless of whether the services are included in the benefits basket.

3.4.3 Informal payments

Informal payments include all unofficial payments for goods and services that are supposed to be free and funded from pooled revenue, as well as all official payments for which providers do not give a receipt. Informal payments are a publicly sensitive issue in today's agenda. There is limited direct information on trends in informal payments or their extent. Although there is general awareness of the problem, formal evidence about the magnitude of the problem is relatively limited.

Indirect information implies that informal payments in health care remain an issue. For example, the Global Corruption Barometer Report (2010/11) indicates that 55% of respondents think the level of corruption in Latvia has increased and

36% think it has remained unchanged; 15% of Latvian respondents indicate that they have paid bribes in health institutions, which is comparable to the global average of 12%, but very high when compared to other European countries, such as Germany (1%) or Finland (1%).

According to Cockcroft et al. (2008), 45% of Latvian households consider the level of corruption in the health system to be high. The same survey indicates that informal payments or gifts were given more often for specialist care and mostly after treatment. However, the vast majority of gifts (95%) were in kind (sweets, flowers, alcohol, etc.) and only had a value of around €7. Only 5% of informal payments included money, with a mean value of around €45.

Since 2009 accepting informal payments has been a criminal offence but only very few cases have been brought to charges.

3.5 Voluntary health insurance

3.5.1 Market role and size

The opportunity to provide complementary and supplementary VHI was introduced in 1996. VHI covers complementary services (not covered by the NHS) and user charges and supplementary services (for example faster access). VHI in terms of population coverage peaked in 2008, when it covered some 16% of the population (Financial and Capital Market Commission, 2010). However, following the onset of the economic crisis, population coverage declined strongly, dropping to only 7% of the population in 2010 (see Table 3.6). Conflicting data from the National (European) Health Interview Survey 2008 indicated population coverage as high as 23.5% in 2008 (Central Statistical Bureau, 2010b).

The main factor driving demand for VHI is that employers can make jobs more attractive with insurance bonuses while saving on corporate tax, as insurance premiums paid for employees can be deducted from profits. In addition, until the onset of the economic crisis, most ministries provided VHI coverage as benefits to their employees. VHI in terms of its share of total health expenditure has declined from 2.4% in 2006 to 0.8% in 2010 (see Table 3.1). Interestingly, according to the data provided by the Financial and Capital Market Commission and presented in Table 3.6, total claims made to VHI companies would have accounted for about 2.5% of THE in 2010 (authors' own calculations).

Table 3.6

Indicators of VHI development in Latvia

	2005	2006	2007	2008	2009	2010
Health insurance premiums (in million LVL, nominal)	24.3	31.2	42.5	53.9	39.2	25.8
Health insurance claims (in million LVL, nominal)	15.0	19.3	23.8	37.7	46.8	21.7
State health care budget (in million LVL, nominal)	296.8	414.2	518.1	575.6	503.7	496.0
VHI premiums as % of state health care budget	8.2	7.5	8.2	9.4	7.8	5.2
Population with VHI	262 472	299 438	351 424	360 706	262 345	160 338
Population with VHI as % of total population	11.4	13.1	15.4	15.9	11.6	7.2

Sources: Financial and Capital Market Commission, 2005–2010; WHO, 2012.

3.5.2 Market structure

All citizens are free to buy different insurance packages. Until recently, VHI schemes were offered mostly to companies and ministries and there were few options for individual coverage. However, this situation is changing and now there are several insurance companies offering individual insurance.

As of 2012, eight insurance companies are licensed to offer health insurance (Financial and Capital Market Commission, 2012). VHI is provided by for-profit life and non-life insurance companies, which usually also offer other types of insurance. Non-life insurance companies dominate the VHI market, capturing 70–80% of total VHI premiums and population covered.

3.5.3 Market conduct

Each commercial insurance company defines its own insurance schemes without any external regulation of prices and benefits packages. Insurance schemes provide a mixture of complementary and supplementary coverage. They usually cover user charges and those health care services and/or prescription drugs that are not statutorily financed, such as dentistry for adults, routine health check-ups needed for specific job security requirements, physiotherapy and massage, rehabilitation and some types of vaccines (influenza, tick-borne encephalitis, hepatitis). Some benefits may be offered in kind (if providers have contracts with the insurer), others are offered in cash (reimbursement of claims). There is usually a cap on total expenses per insured per year and patients may be required to pay user charges for complementary services covered by the VHI scheme.

Generally, voluntary health insurers exclude from their schemes health conditions and diseases covered by the statutory system, such as communicable diseases, sexually transmitted infections (STIs), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), mental health, and substance and alcohol abuse. Plastic surgery, extra-uterine fertilization and alternative medicine, as well as hygiene products, are not usually covered by VHI.

Insurance premiums are calculated according to each insurance company's tariffs and are based on age and health status of clients. Some companies set an age limit for individual insurance coverage. Premiums can be paid as lump-sum transfers or by instalments and usually cover one year; however, insurance contracts signed between the company and the client may include specific terms and conditions. Remuneration of health care institutions by VHI is subject to negotiations between VHI companies (VHICs) and individual providers.

VHICs are generally quite profitable, with premiums generally exceeding claims by more than 40% (see Table 3.6), although the reverse was true in 2009. In the context of the economic crisis, this was most likely due to the anticipation of loss of VHI coverage by part of the population, which used deferred services in anticipation of future needs.

3.5.4 Public policy

There are no legal regulations specifically for VHI companies; they conform to the regulations of the private sector, including solvency controls. All insurance companies are supervised by the Financial and Capital Market Commission, which is an autonomous public institution, supervising amongst others Latvian banks and insurance companies. The Financial and Capital Market Commission is mostly concerned with ensuring stability, competitiveness and development of the financial and capital markets, as well as protection of the interests of investors, depositors and insured persons.

There have been discussions on expanding the role of VHI in health care. However, currently private insurers face lack of stability and predictability, largely determined by the public purchaser. The problem is that the benefits package of the statutory system is not explicitly defined and is subject to changes depending on the budget, making it difficult for VHICs to design benefits packages that fill the gaps of the statutory system.

3.6 Other financing

3.6.1 Parallel health systems

The Ministries of Defence, Interior and Justice have their own health care budgets to finance health services for specific population groups.

The Ministry of Defence receives budget funds to cover services provided for soldiers as well as the entire armed forces and their employees. The Ministry may tender necessary service providers in the vicinities of troops. The Ministry also operates a Medical Centre where a limited range of services is provided.

The Ministry of the Interior (MoI) also operates its own outpatient clinic, although its employees mostly use the mainstream statutory system.

Medical services for prisoners and refugees are run by the Ministry of Justice.

However, as the mainstream statutory system is available to all citizens and nearly all permanent residents, members of the armed forces, employees of the MoI, as well as prisoners and refugees generally use the mainstream system. Regulations No. 1046 determines amongst others that the ministries cover user charges and service costs for the population groups under their responsibility (Art.17).

The Ministry of Education and Science finances an important part of health-related educational facilities – the medical school at the University of Latvia – and provides an important share of funding for medical research.

3.6.2 External sources of funds

World Bank

Between 2009 and 2011 funding of €100 million was made available through a loan from the World Bank within the framework of the Social Safety Net Strategy to address the deterioration of access to health care services of low-income populations caused by the economic recession.

The European Union

In the period 2007–2013, Latvia's health care system has had access to the following EU funds mainly for infrastructure development: LVL145.7 million (€207.7 million) from the European Regional Development Fund and LVL10.1 million (€14.4 million) from the European Social Fund (ESF). In addition to the financing from EU funds, Latvia has to ensure at least 15%

national co-financing from national or municipality budget, or from recipient's own private financing. Assistance is also available within the EU Commission's Second Public Health Programme (2008–2013), the European Economic Area and Norwegian government's financial instrument (2004–2009) and other programmes.

3.6.3 Other sources of financing

There are some further sources of financing related to the provision of health services in Latvia. Firstly, the MoW, which is responsible for social care in Latvia and covers most areas of long-term care. Social care is administratively and financially entirely separate from health services. Financing of long-term care facilities is undertaken partly with funds from the state budget (mainly specialized long-term care institutions, such as for individuals with mental disorders or serious disabilities, orphaned children aged up to two years and others) and partly by local governments ("general" long-term care institutions, such as care for the elderly). In 2009 the MoW contributed LVL18.3 million or 55.4% of total expenditures on long-term nursing care, while local governments contributed LVL7 million or 21.3% (Central Statistical Bureau, 2009), with the remaining part being financed by private sources. Secondly, occupational health services exist in Latvia, which are undertaken exclusively by employers and therefore involve only private funding. Thirdly, NGOs are important for services of rehabilitative care and according to the Central Statistical Bureau contributed approximately LVL2 million in 2009 (Central Statistical Bureau, 2009).

3.7 Payment mechanisms

3.7.1 Paying for health services

Methods of paying for health care services are determined by government regulations (Regulations No. 1046). The NHS concludes contracts with service providers according to these regulations. Payments are a mix of prospective and retrospective payments and they are supposed to cover both running costs and depreciation of capital. However, the State Audit Office (2011) has claimed that the Ministry of Health and the NHS do not have a full understanding of the actual costs of health care services.

The main service groups and corresponding payment methods are shown in Table 3.7. In addition to payments from the NHS (covered in this section), patients have to make co-payments when visiting ambulatory providers or staying at hospitals (see section 3.4.1). Income generated from co-payments can be kept by providers. If patients are exempted from co-payments, the NHS reimburses providers for co-payments that they would usually charge to patients. Finally, for non-contracted care, providers have the option to charge patients directly (direct payments). These payments are freely determined by providers.

Table 3.7
Provider–payment mechanisms

Providers	Payers		Patients		VHI
	Ministry of Health/NHS	User charges	Direct payments		
GP	Capitation, FFS, fixed payment, P4P	Co-payment			
Outpatient specialist	Episode payment, FFS, fixed payment	Co-payment			
Diagnostic services	FFS	Co-payment	FFS		FFS
Hospitals	Global budget	Co-payment			
Day hospitals	FFS	Co-payment			
Dentists	FFS	–			

Source: Government of Latvia, 2006b.

Outpatient services

Primary care services During the mid-1990s GPs (family doctors) were mainly paid on the basis of a points-based FFS system. However, in the early 2000s capitation was introduced to achieve global expenditure control. Currently, NHS payments to primary care providers, i.e. to GPs or to health care institutions employing GPs, consist of three main parts plus a voluntary pay for performance scheme (P4P) (Art.60, Regulations No. 1046):

1. Capitation payment: on average, LVL0.63 (€0.90) is paid in 2012 per month for each patient registered with a GP. However, the total capitation-based budget is adjusted depending on the age distribution of patients registered with the GP. The adjustment is made by calculating a consumption coefficient for every GP practice, which takes into account the average number of visits per patient in the country for different age groups (Regulations No. 1046). Depending on the age distribution of patients registered with a GP, the consumption coefficient will be above 1 if the practice can expect more visits per patient than the average in the

country and below 1 if it can expect fewer visits. A part of the capitation payment (13%) is variable and conditional on meeting certain defined structural or process-based quality criteria (see Table 3.8).

2. FFS payments for a number of interventions or procedures (e.g. stitching of wounds, catheterization of urinary bladder, Annex 14), which can be billed separately by the GP in accordance with tariffs specified in Annex 18 to Regulations No. 1046. There is no cap on the amount of services that a GP is allowed to provide.

Table 3.8

Results of quality evaluation of family doctors, 2011^a

Criteria	Requirements	Percentage who met criteria	Total bonus (LVL)	Average annual bonus per doctor (LVL)
Adult patient coverage	≥65% of registered adults have been seen at least once	99	588 340	462.48
Diabetes mellitus (DM) II – care criteria 1	≥60% of DM II patients have ≥2 HbA1c tests/year	42	68 543	127.00
DM II – care criteria 2	≥60% of DM II patients have ≥1 microalbuminuria tests	95	191 673	157.01
Asthma care	≥90% of patients have ≥1 peak flow measurement and are trained to use inhaler	96	126 986	102.94
Hypertension care	≥90% of patients with primary hypertension have not made calls to emergency service	81	154 732	148.66

Source: NHS, 2012a, unpublished data.

Note: ^a vaccination and prophylactic examination of children is not included.

3. Fixed payments: there is a fixed monthly allowance of LVL240 (€342) for a practice and an allowance of LVL100 (€143) for each additional service point (other surgeries in the same area that the GP visits a few days per week). In addition, there is a fixed allowance of LVL180–480 per year, depending on population density and the distance to the nearest hospital. Furthermore, additional payments exist for chronically ill patients, for employment of a registrar/receptionist and a PHC nurse and – under certain conditions – flat per hour rates of LVL7.58 per hour for opening hours exceeding the required minimum.
4. Voluntary P4P scheme: GPs can join a voluntary quality assessment programme, which provides additional payments based on the number of quality points reached. Quality points are assigned based on attaining certain additional patient care criteria, such as reaching a certain proportion of patients who have undergone preventive examinations or

were educated on hazards of smoking, or having a certain proportion of coronary heart disease patients under a specified blood pressure threshold and with controlled cholesterol levels, etc. However, in 2011 no GP reached the quality criteria and, consequently, no one received any payment.

Finally, GPs can also provide secondary outpatient services. In this case, the payment is calculated in the same way as for outpatient specialists and a cap exists for the total financial volume that a GP can earn through the provision of secondary outpatient services, which is specified in the contract with the NHS.

Secondary ambulatory care services Reimbursement of outpatient specialists also consists of three components. Firstly, outpatient specialists are reimbursed by a flat rate per episode of illness. There are seven types of episode, e.g. episode related to acute disease or trauma, episode with a first diagnosis of a chronic disease, or prevention episode. Every outpatient specialty group has its own episode rates (Annex 19, Regulations No. 1046), which are calculated by the NHS on the basis of variable costs and fixed costs. One episode-based payment covers all visits/services performed by one specialist within one month. For longer episodes (e.g. chronic illnesses), every month is considered a new episode. Secondly, FFS payments exist for a list of certain preventive, diagnostic, treatment and rehabilitation interventions/manipulations, with prices per intervention fixed in LVL (no point system) (Annex 18, Regulations No. 1046). However, the total budget that providers can earn through episode-based payments and FFS payments is capped. Thirdly, a fixed monthly practice allowance exists for certain specialties – such as psychiatrists, narcologists (drug abuse specialists) and pneumonologists (Annex 17, Regulations No. 1046), which includes salaries for personnel (physicians, nurses) and costs of running the services. For eligible specialties the allowance is paid in addition to the episode-based payments and FFS payments.

Preventive, diagnostic, treatment and rehabilitation interventions/manipulations in day hospitals are paid for according to FFS tariffs specified in LVL within a budget determined by the contract with the NHS (Annex 18, Regulations No. 1046).

Diagnostic services (e.g. laboratories, X-ray clinics) are paid for according to specified tariffs.

Every GP (and also every secondary ambulatory care provider) has a budget for prescribing diagnostic services to patients. The budget is estimated on the basis of national average expenditure per patient or episode, which is adjusted for age distribution of patients (in the case of GPs) or for speciality.

Inpatient services

Since 2005 almost all hospitals are paid by the NHS on the basis of contractual agreements (see section 3.3.4). Until 2010 Latvia used a mix of case-based payments and per diem payments (see Tragakes et al., 2008 for details). Case-based payments covered about 50% of inpatient admissions, for which hospitals received a flat rate tariff per case, depending on the primary diagnosis of patients and/or the medical interventions performed, with adjustments for the actual length of stay and the number and type of interventions performed. For the remaining 50% of patients, hospitals were reimbursed on a per diem basis, sometimes at a reduced rate if patients exceeded the average length of stay of similar patients in other hospitals. However, in order to improve budget control, a global budget system was introduced in 2010.

Since then, the size of the annual global budget per hospital is calculated by multiplying the forecast number of patients (the number of patients treated in the previous year with certain adjustments) within each “health care programme” with a corresponding patient tariff and summing up the results (Art.130³.2.1). Each health care programme is provided by one or more hospitals, which are categorized into twelve groups according to their specialization and functions. There are four groups of health care programmes with corresponding patient tariffs (Annex 22, Regulations No. 1046):

1. A group of tariffs for “earmarked services”, consisting of 55 earmarked service programmes and corresponding tariffs, with some of them having subprogrammes.
2. A group of tariffs for “other services”, which may vary depending on the group of hospitals, and which are broken down for some hospital groups into one tariff for “other surgical” services and one tariff for “other therapeutic” services.
3. One tariff for the treatment of patients in care hospitals, which was LVL93 per patient in 2012.
4. One per diem tariff for artificially ventilated patients.

Each earmarked service programme refers to a specified group of interventions (e.g. cardiac surgery, angioplasty, implantation of cochlear implant, chemotherapy, transplantation of stem cells, etc.) or to the treatment of a certain

condition (e.g. cystic fibrosis, tuberculosis, burns, etc.) or to the management of broadly defined conditions (e.g. psychiatric care, advanced gynaecological care, oncology programme, diagnosis and treatment of congenital heart disease, etc.). The idea of defining earmarked service programmes is similar to the basic idea of DRG systems, i.e. of grouping similar patients together in DRGs. However, the grouping into earmarked service programmes is comparatively rudimentary as there are only 55 programmes and it is applied only to some patients.

The tariff for “other services” does not vary in relation to the type of patient treated. In larger multi-specialty hospitals there is one tariff for all “other surgical” and one tariff for all “other therapeutic” patients who do not fall under the “earmarked services”. In specialized or smaller hospitals the same “other services” tariff applies to all patients who do not fall under “earmarked services” but the tariff may vary by type of hospital.

The tariff per patient treated within an earmarked service programme or other service programme is determined in the following way: the average “shadow costs” for the treatment of patients within a programme are calculated by multiplying the number of bed-days of patients within a programme with the applicable bed-day (shadow) tariff (Art.179¹), adding the product of performed interventions (X-rays, procedures, etc.) and respective (shadow) tariffs and dividing all by the number of hospitalizations of patients belonging to the health care programme in the previous period.

If there are several hospitals providing the same services within “other services”, the aggregate data of these hospitals are used for the calculation of the patient tariff. If there are hospitals from different hospital groups out of the twelve groups (defined according to their specialization and functions) providing the same earmarked service programme, the data of that hospital group with the lowest average “shadow costs” for a health care programme are used for the calculation of the patient tariff, provided this group serves at least 20% of the total patients within the earmarked service programme.

For care hospitals the patient tariff is calculated by multiplying the number of bed-days of patients with the applicable bed-day (shadow) tariff and dividing the total by the number of hospitalizations.

The fixed monthly budget is 1/12 of the calculated annual budget (Art.130³.2.2) and does not depend on the current number of patients in hospital. Each hospital is contracted for provision of certain services in accordance with Annex 22 of the Regulations No. 1046.

The hospitals bear the financial risk of running over budget if they have higher costs, even if they treat more patients or provide more services. However, two factors contribute to softening the budget limit. Firstly, the NHS uniform information system monitors the volume of services provided and the annual contract budget may be increased (or decreased), within certain limits, during the course of the year, for example, if parliament approves an increase of the government health budget, which happens almost every year. Secondly, the owners of hospitals, i.e. the state or municipalities, generally jump in to save hospitals when debts have reached a certain level. In practice, hospitals often provide more services than are covered by their budget. Some reasons for this are that there can be more patients than estimated at the beginning of the year and that more provided services will contribute to a higher budget in the following year. In addition, providing more services may allow for more financing if the health care budget is increased in the current year.

Emergency hospitals receive an additional budget for emergency room and admission services. The size of this budget depends on the number of available specialists on duty.

Currently, a reform of the hospital payment system is high up on the policy agenda (see also section 6.2). Order No. 67 of the Cabinet of Ministers prescribes the introduction of a DRG-based payment system in Latvia until 2014. A pilot project will start in 2013. Latvia plans to cooperate with other Nordic countries and use a version of the Nord-DRG system.

3.7.2 Paying health care personnel

Most PHC physicians (family doctors) and an important share of secondary ambulatory outpatient providers are self-employed and have direct contracts with the NHS. Therefore, the income of these providers is directly determined by the payment system as described in the previous section (3.7.1).

GPs and specialists employed in ambulatory health centres and outpatient departments of hospitals are salaried. The level of salary for each specialty within provider institutions may vary depending on decisions made by the institution's management but it is subject to a legal minimum that is determined by the Cabinet of Ministers. In addition, Regulations No. 1046 set the average monthly salary for health care personnel. Salary levels as well as other job conditions may be negotiated between those responsible for administration and the representatives of employees.

Hospital-based doctors are salaried, with salary levels varying in accordance with their workload, stand-by duty time, qualifications and experience. This is also subject to a minimum level determined by the state. Academic doctors receive extra payments for teaching hours and training courses. Currently the average monthly salary for doctors and functional specialists is set by Regulations No. 1046 at LVL524 (€747). The minimum salary is set by the “Regulations on the minimum salary and special additional payment for health care professionals” (Government of Latvia, 2010).

The salary level of nursing staff is set at LVL314 (€448). According to the Ministry of Health, a physician’s average monthly remuneration, which includes salary, additional payments and bonuses, was LVL657 (€923) in 2010. It has to be noted that the health care sector experienced a drop in remuneration in 2009 and 2010. The average monthly remuneration of all employees working in the health sector dropped in 2010 by 3% from 2009 from LVL446 (€629) to LVL434 (€610), while the average monthly salary in the health sector stayed level at LVL335 (€471), which was considerably below the average gross salary in the country of LVL445 (€625) (Central Statistical Bureau, 2012c). However, since 2011 there has been a slight increase in salary levels.

4. Physical and human resources

In the course of health care reforms and implemented budget consolidation measures, which aimed to move service provision away from inpatient care towards increased use of outpatient care, the number of hospitals and hospital beds in Latvia has seen a strong decline from 88 hospitals in 2008 to 67 hospitals in 2010. The average number of acute care beds in 2010, which is the last year for which data are available in international databases, decreased to 3.4 per 1 000 population, which is below the average rate in the EU27. The average length of stay in acute care hospitals has decreased to 6.2 days, which is below the average in the EU27. Despite an increasing number of long-term care beds in the country, Latvia is clearly lagging behind western European countries and also behind Lithuania and Estonia. By contrast, Latvia still has one of the highest rates of psychiatric hospital beds per 1 000 population in Europe.

The number of health workers in Latvia has undergone considerable changes over the past two decades. The number of physicians declined significantly in the early 1990s but has subsequently stabilized and recovered since the year 2000. In 2009, the number of physicians, dentists and pharmacists per 1 000 population was around or above the averages for these categories in the EU12 countries, while the number of nurses and midwives was comparatively low. In contrast to the declining overall trend in the number of physicians, the number of GPs has dramatically increased since 1990 and was above the average in the EU12 countries in 2009, although it remained far below the EU27 average. The age structure of medical staff is unfavourable as the majority of personnel are 45 and over.

Latvia is comparatively well equipped with diagnostic imaging technologies (CT and MRI scanners). As regards ICT, 88% of Latvian GP practices use a computer, 85% of practices have an internet connection and broadband is used in 58% of GP practices.

4.1 Physical resources

4.1.1 Capital stock and investments

By the end of 2010 there were 67 inpatient hospitals in Latvia (down from 88 hospitals in 2008), together providing almost 12 000 beds (see Table 4.1). All hospitals in Latvia operate under the legal status of capital companies (see section 2.8.2). Almost half of all hospitals are owned by local governments. The largest hospitals (>400 beds) and more than half of all beds are owned by the state. Private owners have more hospitals than the state but account for less than 10% of all beds. More than half of all hospitals have fewer than 100 beds. The total number of hospitals and hospital beds has decreased considerably since 1990 (see section 4.1.2), when there were 188 hospitals with almost 36 000 beds in the country.

Table 4.1

Hospitals and hospital beds in Latvia by ownership, size and type of hospital, 2010^a

	State	Local governments	Private	Total
Number of hospitals	16	32	19	67
<50 beds	–	10	15	25
50–99 beds	3	9	1	13
100–199 beds	2	6	2	10
200–399 beds	5	6	1	12
400–699 beds	4	–	–	4
>700 beds	2	1	–	3
Secondary/tertiary hospitals	4	18	–	22
Other hospitals	12	14	19	45
Number of beds	7 041	4 113	766	11 920
Secondary/tertiary hospitals	3 290	3 196	–	6 486
In other hospitals	3 751	917	766	5 434

Source: CDPC, 2012b.

Note: ^a the table includes all hospitals in the country; only some of these hospitals were providing inpatient services for the NHS in 2010 (see Table 5.4).

Inpatient health care services are provided by secondary/tertiary hospitals (i.e. university hospitals and multi-profile hospitals), specialized hospitals (e.g. for the treatment of psychiatric patients or trauma) and care hospitals (which provide nursing care to patients but no treatment) (see also section 5.4). Large hospitals are generally located in urban areas, while smaller hospitals often provide services in municipalities with a small number of inhabitants.

In general, the owners of all health care institutions (hospitals as well as primary care institutions or practices) are responsible for financing investments. The state as the owner of larger hospitals (>400 beds) provides funding for all larger hospitals, mostly through state-guaranteed loans, or until 2006 through direct central government investment. Local governments (municipalities) provide investment funding for their municipal hospitals and PHC centres but state-guaranteed loans are also available. Investments in private hospitals or other private health care institutions (e.g. private practices) are financed by the private owners. In addition, international funding has been available through the European Regional Development Fund (ERDF), the ESF and other foreign financial assistance tools.

A major investment programme carried out in recent years was the Master Plan (see section 2.5), which intended to concentrate hospitals in larger cities and to rationalize the distribution of primary care infrastructure in the country. All health care institutions listed in the Master Plan were (and in the absence of new plans still are) eligible for national and EU funding. For the period 2007–2013, Latvia's health care system has access to LVL145.7 million (€207.7 million) from the European Regional Development Fund. The bulk of ERDF financing is allocated for the subprogramme “Development of in-patient health care”. Special regulations of the Cabinet of Ministers from 2009 (Regulations No. 44) (Government of Latvia, 2009) elaborate on principles and criteria for allocation of funding. Latvia has to ensure at least 15% national co-financing from national or municipality budgets. Private institutions were not included in the Master Plan and have not received EU funding.

In general, there has been a strong decreasing trend of public investments into the health care infrastructure between 2007 and 2010, both in nominal terms and as a share of public health expenditure. While in 2007, investments accounted for almost 15% of public health expenditure, they dropped to less than 9% in 2009 (Central Statistical Bureau, 2012b). In fact, during the time of budget cuts, the status of several hospitals, which had been recently renovated and equipped with new technology (including EU funding), was changed (e.g. to care hospitals or day hospitals) and the scope of provided services was substantially reduced, casting doubts on the usefulness of prior investments.

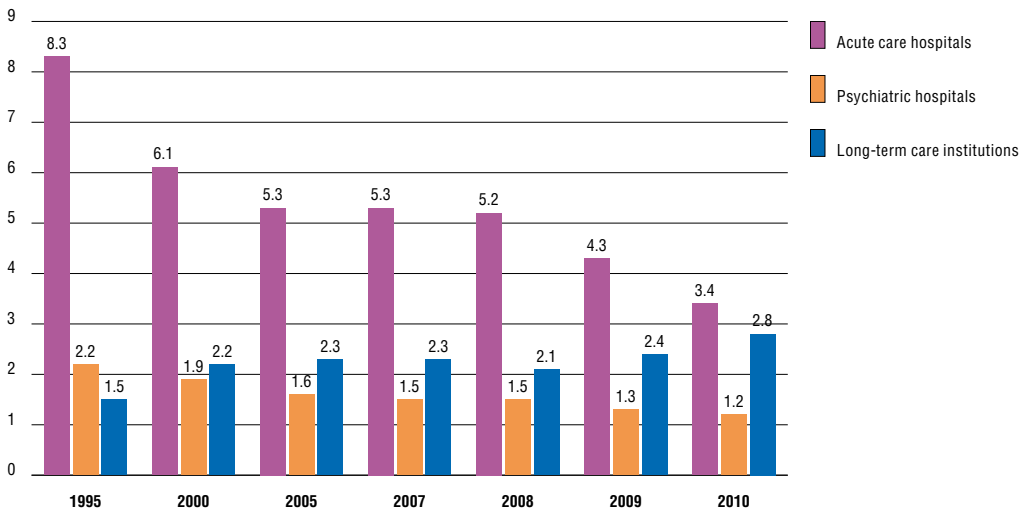
4.1.2 Infrastructure

Fig. 4.1 shows how the number of beds in acute care hospitals, psychiatric hospitals and long-term care institutions in Latvia has developed since 1995. A strong downward trend in bed numbers in acute care in the period 1995–2005

can be observed. Subsequently, the number remained relatively stable before it dropped considerably again in 2009 and 2010. Bed numbers in psychiatric hospitals have declined as well but on a much smaller scale. By contrast, bed numbers in long-term care institutions increased greatly between 1995 and 2000 and again between 2009 and 2010. The strong reduction in acute care beds has been the result of strategic long-term planning, which aimed to substitute outpatient services for inpatient care.

Fig. 4.1

Mix of beds in acute care hospitals, psychiatric hospitals and long-term institutions per 1 000 population



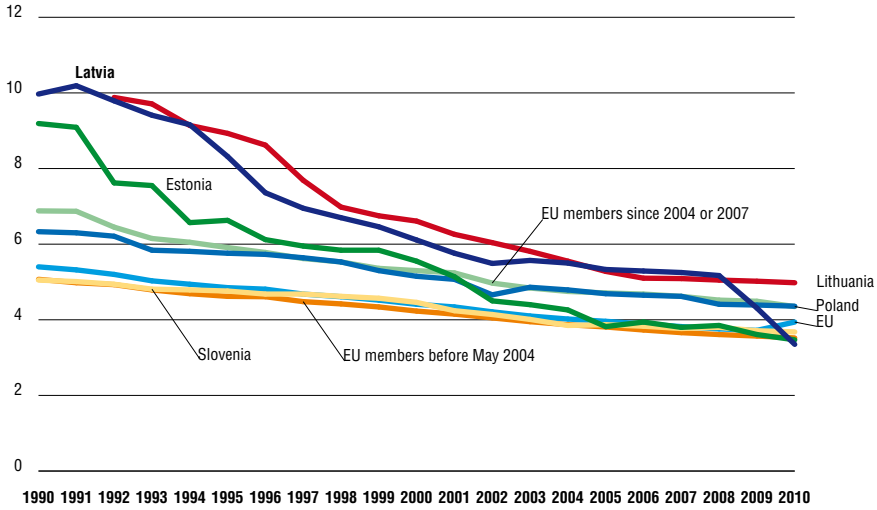
Source: WHO Regional Office for Europe, 2012b.

Viewed from a European perspective, in the early 1990s the number of acute beds per 1 000 population in Latvia was amongst the highest in Europe, almost twice the average of the countries that would later form the EU27 (Fig. 4.2). By 2010, as the result of ongoing reforms in Latvia, the number had declined to 3.4 per 1 000 population, which is below the average of all EU27 countries.

Average length of stay (ALOS) in hospitals is decreasing in Latvia in line with international trends. While data for acute hospitals are unavailable for the years prior to 2000, ALOS in all hospitals was 18.2 days in 1985. ALOS in acute hospitals has in 2010 decreased to 6.15, which is slightly below the EU27 average (see Fig. 4.3) but higher than ALOS in Estonia or Slovenia (data for Poland are unavailable).

Fig. 4.2

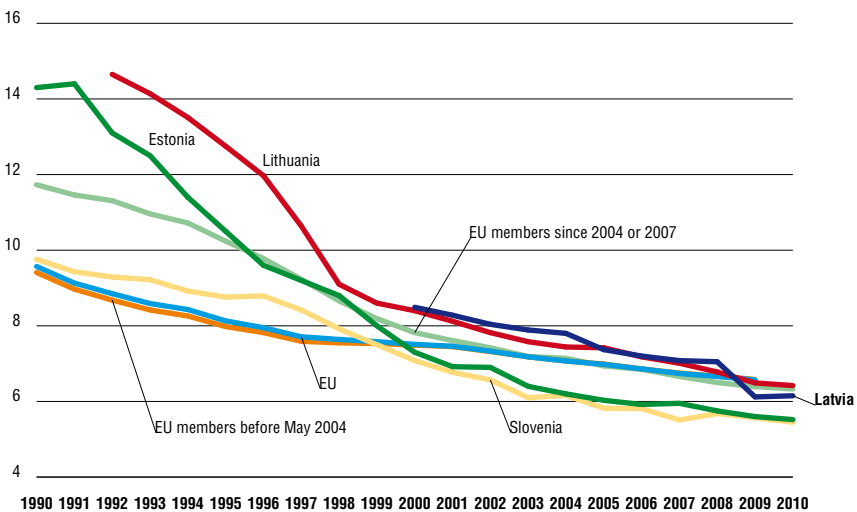
Beds in acute hospitals per 1 000 in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

Fig. 4.3

Average length of stay in acute care hospitals in Latvia and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, 2012b.

The hospital occupancy rate in Latvia has remained relatively constant at above 70% over the past 10 years for which data are available. However, in 2009, at the height of the restructuring of the health care sector, there was a significant drop in bed occupancy to below 65% (Fig. 4.4) although occupancy increased back to above 70% in 2010.

Given the ageing populations in Europe, many countries are undertaking efforts to increase their long-term hospital care capacity. At 2.8 beds per 1000 inhabitants, the number of long-term beds in Latvia is clearly lagging behind western European countries (e.g. Germany increased the number of long-term beds to 10.3 per 1 000) but also behind Lithuania and Estonia, where the number of long-term care beds is now around 6 per 1 000 population (Fig. 4.5). Long-term care falls into the remit of the Ministry of Welfare and the municipalities, which would need to increase funding in order to expand long-term care capacity in the country.

By contrast, despite a strong decline in the number of psychiatric hospital beds per 1 000 population, Latvia still has one of the highest rates in Europe (Fig. 4.6).

Fig. 4.4

Bed occupancy rates (%) in acute care hospitals in Latvia and selected countries, 1990–2010

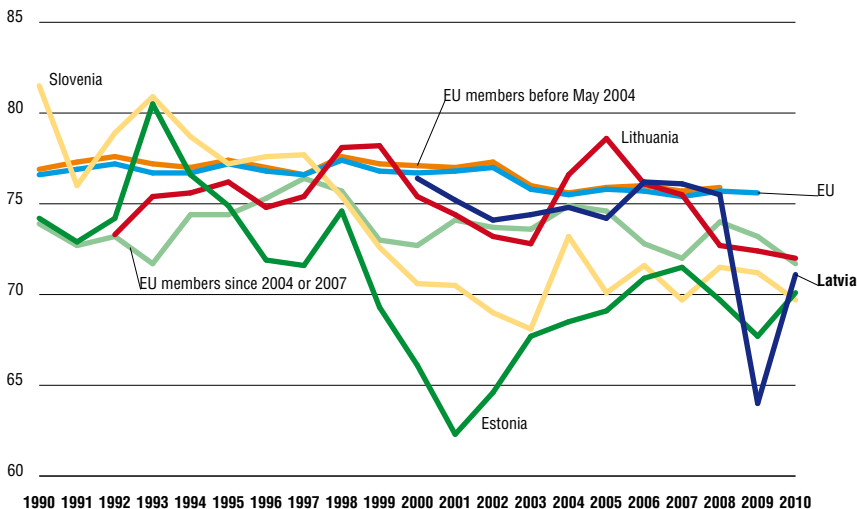
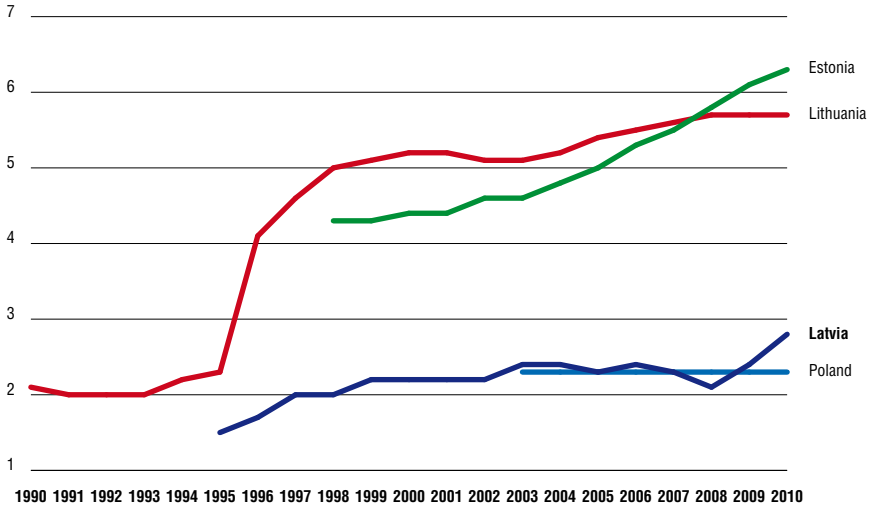


Fig. 4.5

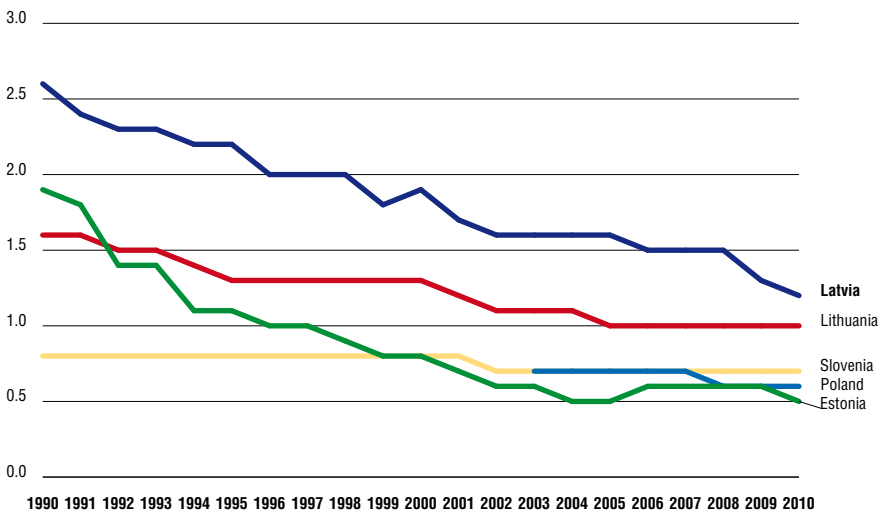
Long-term (nursing and elderly) hospital beds per 1 000 inhabitants, in Latvia and selected EU countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

Fig. 4.6

Psychiatric hospital beds per 1 000 in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

4.1.3 Medical equipment

The purchase of medical devices and goods is mostly undertaken by health care institutions in accordance with the “Public Procurement Law”, adopted by parliament in April 2006 (this legislation applies to all government purchases, not just in the area of health care). For big ticket investments, e.g. CT or MRI scanners, subsidies are available to health care institutions from their owners – the Ministry of Health provides money for state hospitals and local governments for hospitals owned by them. In some cases, it is also possible to obtain EU funding, if a certain type of equipment is found to be necessary. Centralized procurement for certain medical devices is undertaken by the NHS, e.g. for vaccines, peritoneal dialysis and vision correction devices for children.

Latvia is comparatively well equipped with diagnostic imaging technologies (see Table 4.2). It has a higher number of CT scanners and MRI units per 100 000 population than the other Baltic countries and the number is around twice as high as in Poland or Slovenia. By contrast, the number of angiography units per 100 000 population is comparatively small. As a result of considerable investments in the past, there doesn't seem to be a significant lack of devices currently. However, because of the low population density, it may be difficult to reach facilities with the necessary equipment, which are located mostly in urban areas. In addition, as investment activity is to a large degree determined by the owners of health care institutions there are, of course, differences between poorer and richer areas in the country.

Table 4.2

Number of functioning diagnostic imaging technologies per 100 000 population in Latvia and selected countries in 2010

	CT scanners	MRI units	Angiography units	Mammographs	PET scanners
Estonia	1.6	0.8	0.7	n/a	0.1
Latvia	2.7	0.8	0.5	1.9	0.0
Lithuania	0.5	0.5	0.6	1.2	0.0
Poland	1.4	0.5	0.9	1.5	0.0
Slovenia	1.3	0.4	0.9	1.8	0.1

Source: Eurostat, 2012d.

4.1.4 Information technology

According to data from the Central Statistical Bureau (2012d), the use of information and communication technology (ICT) by households has considerably increased in recent years. A survey in 2010 confirmed that internet

services are becoming accessible to an increasing number of households in the country (Central Statistical Bureau, 2012c). According to the survey, the share of regular internet users was above 60%, which is slightly higher than the number of households that possessed a computer and had access to the internet (see Table 4.3), but still more than half of all households had a broadband internet connection. The most active age group is 16–24 year olds, of whom 95% used the internet at least once per week. Almost all students (98%) use the internet on a regular basis.

According to data published by the European Commission (2012), regular internet use in Latvia is generally at a similar level as the EU27 countries' average. For certain activities, e.g. online banking and job search, Latvians are very active internet users, while they use the internet less frequently than other Europeans to obtain information about goods and services. Information about the number of individuals who use the internet to search for health-related information is unavailable but most hospitals have web sites, where they present information to patients, e.g. about available services, prices for non-contracted services, and answers to frequently asked questions.

Table 4.3

Access to a computer and internet in households, as percentage of the total number of households, 2005–2010

	2005	2006	2007	2008	2009	2010
Computer	32.3	40.6	49.2	56.7	60.1	62.8
Internet	30.5	42.2	50.5	52.8	58.0	59.8

Source: Central Statistical Bureau, 2012c.

The development of an e-health system has been on the policy agenda in Latvia since 2003. At that time, a working group was established for the development of “Regulations of the Cabinet of Ministers on Guidelines for ‘e-Health in Latvia’”, which were adopted in 2005, and subsequently an action plan, “e-Health in Latvia 2008–2010”, was developed (Cabinet of Ministers, 2007). These documents set the strategic directives for the development of ICT. The NHS is responsible for the implementation of the e-health strategy and the establishment of the necessary infrastructure. Financial resources for these tasks are provided by the Ministry of Health, but certain specific projects are financed by other sources, such as the EU.

Since 2012, an information system in health care institutions has been implemented, which provides information about NHS-paid health services received by patients (see also section 6.1.6). In addition, a lot of registers and also all financial reports are working electronically today (see section 2.7.1). The full e-health system, including, for example, e-receipts, e-health records, e-booking, e-referrals and e-portal, will start piloting in 2012 and should become fully operational in 2013. However, there are still considerable discrepancies concerning the availability of e-health infrastructure between institutions, with some having established electronic patient records whereas others are lagging far behind. In addition, data security remains a difficult issue. Yet, given the advantages of the e-health system, such as faster exchange of information, involvement of patients and considerable support from medical doctors, the NHS is optimistic that it will be able to resolve these issues.

4.2 Human resources

4.2.1 Health workforce trends

The number of health workers in Latvia has undergone considerable change over the past two decades (see Table 4.4). In 2009, the number of physicians, dentists and pharmacists per 1 000 population was around or above the averages for these categories in the EU12 countries, while the number of nurses and midwives was comparatively low (see Figs 4.7–4.11).

Table 4.4

Health workers in Latvia per 1 000 population, 1990–2010

	1990	1995	2000	2005	2009	2010
Physicians	3.54	2.83	2.87	2.88	2.99	2.91
GPs	0.01	0.08	0.41	0.57	0.58	–
Physicians, medical specialists	–	–	–	0.88	0.90	0.91
Physicians, surgical specialists	–	–	–	0.64	0.67	0.57
Physicians, obstetrics and gynaecology specialists	0.22	0.19	0.20	0.21	0.21	0.20
Physicians, paediatric specialists	0.49	0.32	0.16	0.13	0.13	0.12
Dentists	–	0.36	0.52	0.62	0.67	0.66
Pharmacists	–	–	–	0.56	0.60	0.64
Nurses	–	5.23 ^a	4.77	5.07	4.85	4.88
Midwives	0.55	0.37	0.20	0.20	0.20	0.18

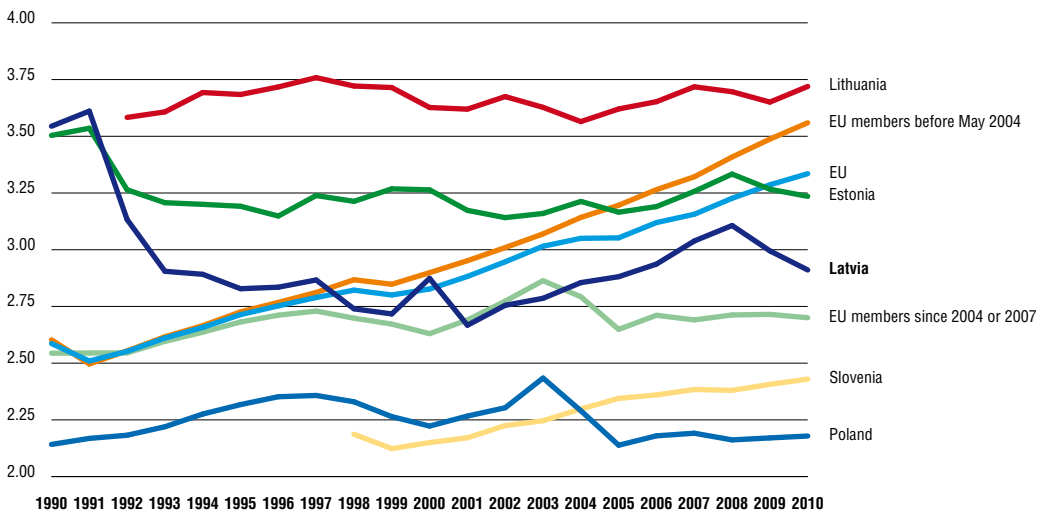
Source: WHO Regional Office for Europe, 2012b.

Note: ^a The first available year for number of nurses is 1996.

The number of physicians declined significantly in the early 1990s but has subsequently stabilized and recovered since 2000, before starting to decline again after 2008 (see Fig. 4.7). In absolute numbers, there were about 9440 physicians in Latvia in 1990. This number dropped to 6600 in 2005, before it slightly increased again to about 6750 in 2009, before dropping again to about 6520 in 2010. The decline in the early 1990s can be explained by a number of factors, including declining numbers of hospitals and hospital beds, as well as low salaries and prestige for health care professionals who often found more lucrative jobs in other sectors of the economy. Numbers per 1 000 population remain comparatively low, when compared to the other Baltic countries and the average in the EU15 countries.

Fig. 4.7

Number of physicians per 1 000 population in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

In contrast to the declining overall trend in the number of physicians, the number of GPs has dramatically increased since 1990 (see Table 4.4). Family medicine was introduced as a new specialty in Latvia only in 1990 and considerable efforts were undertaken to retrain doctors who wished to become GPs in order to build a strong primary care level. In 2009, the number

of GPs (0.58 per 1 000 population) was above the average in the EU12 countries (0.50 per 1 000 population) although it remained below the EU27 average (0.87 per 1 000 population).

Figs 4.8 and 4.9 show that Latvia has a very low proportion of nurses compared to the EU averages and other countries in the region. In fact, it has the fourth lowest number of nurses per 1 000 population in the EU27 after Greece, Bulgaria and Cyprus. In the period 1990–2001, the total number of nurses fell by more than 40% (not shown in the diagram but evident in national statistics at the HI, 2012a).

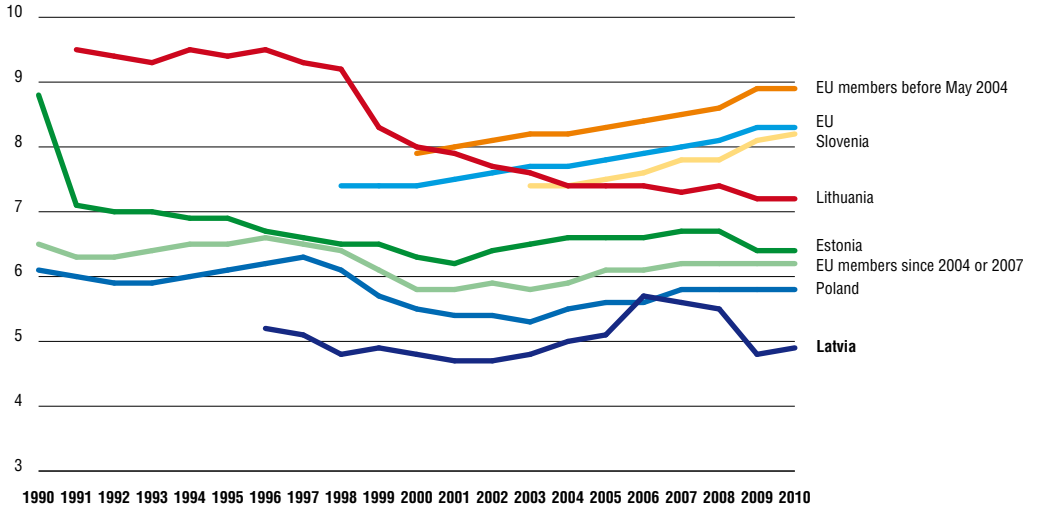
Subsequently, the number of nurses increased slightly until 2006 before starting decline again. In particular, there was a strong decline in 2009, when important budget cuts were implemented in the health sector, including reductions in salary levels and closing down of institutions.

As a result of the severe shortages of so-called medical staff with secondary medical education (i.e. physician assistants, nurses, midwives), their ratio per medical doctor is very low: 2.1 in 2010. This suggests that physicians assume some proportion of nurses' duties, influencing both the quality of physicians' work and the care for patients.

The number of dentists, while declining more than 30% in the first half of the 1990s (not shown in the diagram but evident from national statistics at the HI, 2012a), subsequently began to increase steadily even beyond 1990 levels (Fig. 4.10), which was due to the privatization of practically all dental practices and the subsequent high profitability and attractiveness of this profession. In 2010, there were 0.66 dentists per 1 000 population, which exceeded the average rate of dentists in the EU27 but was below the number of dentists in Lithuania and far below the number of dentists in Estonia.

Fig. 4.8

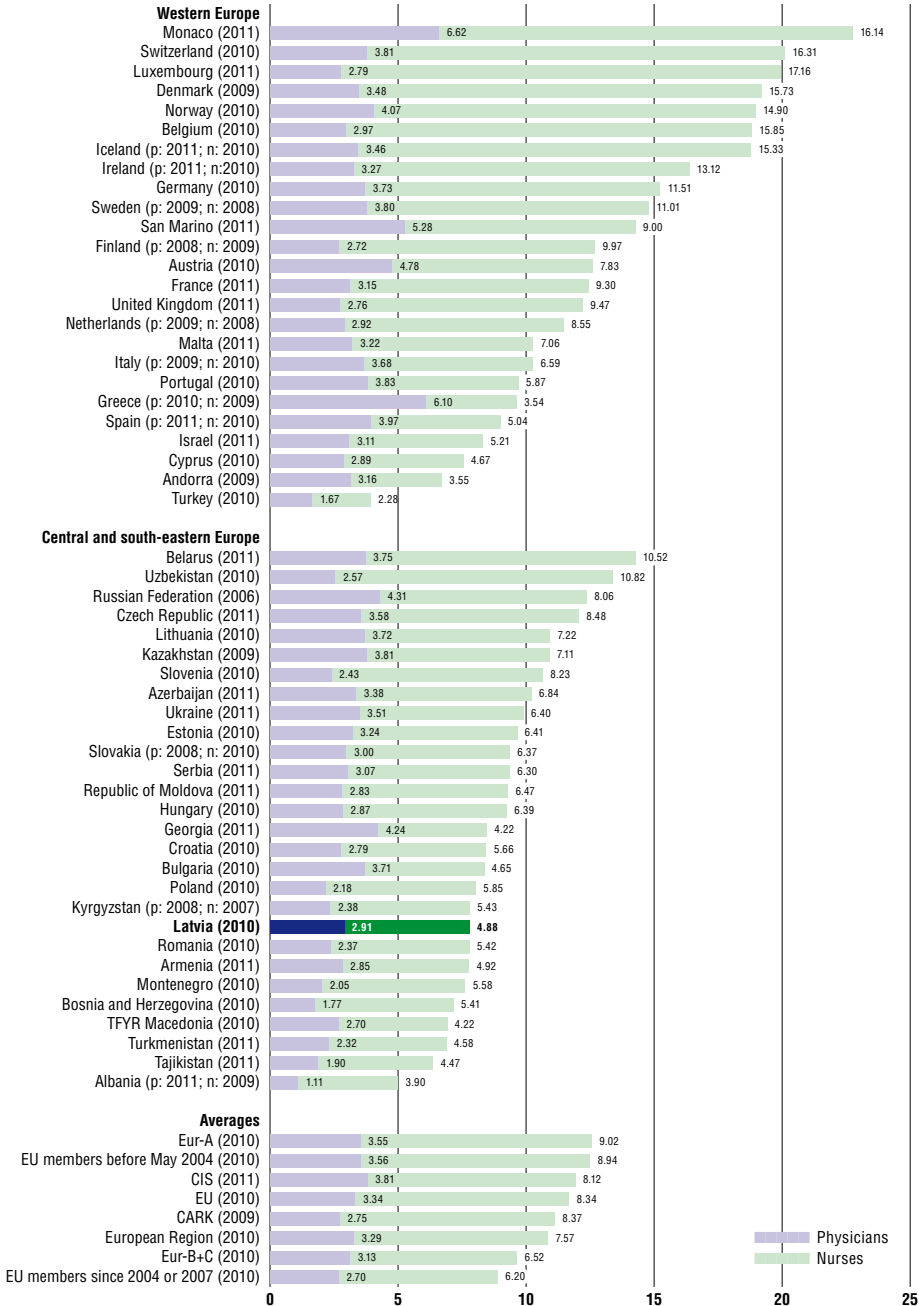
Number of nurses per 1 000 population in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

Fig. 4.9

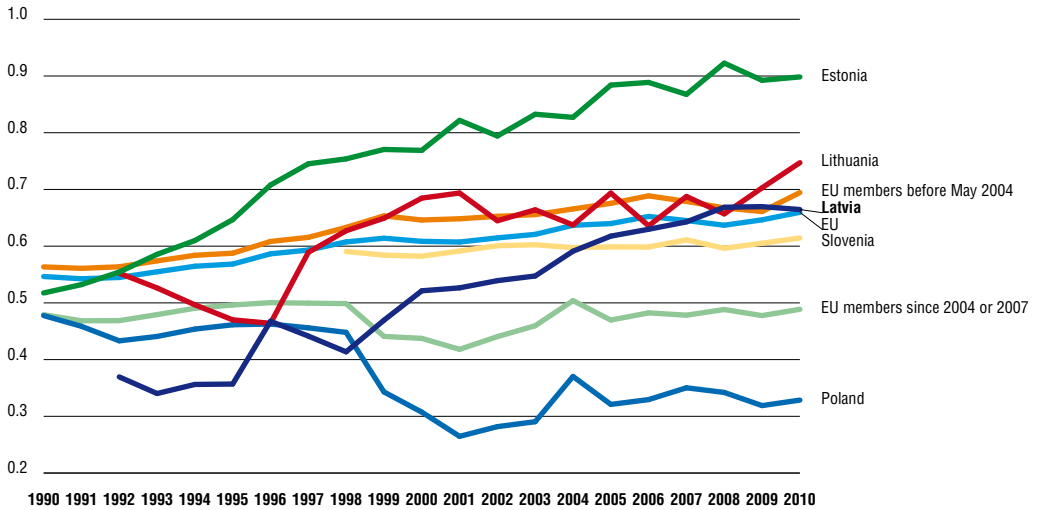
Number of physicians and nurses per 1 000 population in the WHO European region, latest available year



Source: WHO Regional Office for Europe, 2012b.

Note: CARK: Central Asian republics (Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan) and Kazakhstan; CIS: Commonwealth Independent States.

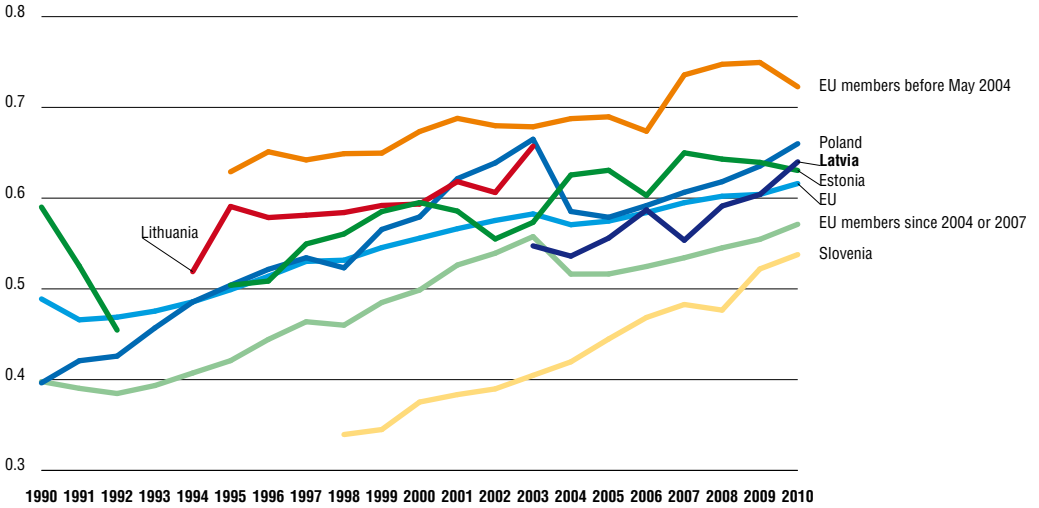
Fig. 4.10
 Number of dentists per 1 000 population in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

The number of pharmacists has increased considerably over the past few years for which data are available (Fig. 4.11) and is considered to be sufficient to meet the country’s needs. In 2010, there were 1433 pharmacists and 1458 pharmacists’ assistants in Latvia. The rate of pharmacists in Latvia is higher than the average in the EU12 countries but lower than in Poland and the rate in the EU15 countries.

Fig. 4.11
 Number of pharmacists per 100 000 population in Latvia and selected countries, 1990–2010



Source: WHO Regional Office for Europe, 2012b.

One important problem in the Latvian health sector is the distribution of physicians in the country, which shows large regional inequalities, with almost 60% of all active physicians working in the capital region of Riga in 2010. Furthermore, an important challenge for the health system is that every year, more physicians are reaching retirement age than are being trained (Table 4.5). For nurses and GPs, the age distribution is less problematic but pharmacists also tend to be quite old (not shown in Table 4.5). In 2005, in order to respond to this challenge and to promote the recruitment of new doctors and to retain already existing staff, the Cabinet of Ministers approved a Policy on the Development of Human Resources for Health Care 2006–2015 (see section 2.8.3).

Table 4.5
 Percentage of practising medical doctors, GPs, dentists and nurses by age in 2010

	Under 35	35–39	40–44	45–49	50–54	55–59	60–64	65 and over
Physicians	10.5	8.5	11.0	15.3	16.8	13.3	9.1	15.5
GPs	1.6	8.2	12.3	17.0	23.7	18.2	10.3	8.7
Dentists	16.0	11.2	12.1	14.9	15.3	10.3	7.3	12.9
Nurses	12.4	17.0	14.5	15.4	14.3	11.2	7.8	7.4

Source: CHE, 2011c.

4.2.2 Professional mobility of health workers

Health professional mobility can contribute to human resource shortages if countries lose significant numbers of well-trained professionals who decide to work abroad in search of better working conditions or salaries. Since the accession of Latvia to the European Union, health professional mobility is thought to have increased considerably, although reliable data is limited. In 2005, when Latvia passed the above-mentioned Policy on the Development of Human Resources for Health Care 2006–2015 and increased the wages of health workers, one motivation was to prevent the potential emigration of health workers as a result of EU accession (WHO, 2006).

According to expert interviews carried out for an EU-funded study in 2007 (Krišjāne, 2007), physicians in regions of Latvia bordering Estonia have moved abroad seeking higher wages in Estonia, although the number of professionals who moved is unknown. In addition, the study found that professional mobility inside Latvia was an important problem with as many as 25% of doctors registered in 1997 working in other sectors (e.g. pharmacy, beauty, sports clubs, etc.). Interestingly, in 2006, about 19% of the active medical staff in Latvia had immigrated from other republics of the former Soviet Union but had lived in Latvia for a long time. However, in 2004 and 2005, immigration to Latvia was negligible, with only a total of 25 resident permits having been issued to health workers moving to Latvia. Unfortunately, more recent data are unavailable as this information is not included in the registers of medical persons in Latvia (see section 2.8.3).

The most common measure of outflow of medical professionals in the EU is the number of certificates of conformity of study that have been issued. However, these certificates indicate only the intention to leave the country rather than actual migration, and they do not capture health workers who decide to work in countries outside the EU or Norway. After accession (from May 2004 to September 2005), certificates of conformity were issued to 211 medical staff (mainly doctors, dentists and anaesthetists) (WHO, 2006). Even if not all health workers who obtained certificates actually left the country, it is possible that there have been considerable outflows of doctors to other EU countries after EU accession. According to data presented in Wismar et al. (2011), 364 Latvian physicians were registered in Germany and the UK between 2003 and 2008 (which would correspond to about 5% of the Latvian physician population in 2005).

4.2.3 Training of health care personnel

Currently, physicians are trained at two universities in Latvia, both located in Riga: the University of Latvia (under the responsibility of the Ministry of Education) and Riga Stradins University (under the responsibility of the Ministry of Health). Undergraduate medical education lasts six years. The first two years are exclusively theoretical, while the practical training increases progressively starting in year 3. At the end of their studies, medical students have to pass a state exam divided into medical and surgical parts and obtain the “diploma at the highest level of medical education”. In order to be allowed to work as a medical doctor, physicians have to register with the Latvian Medical Association and have to be entered into the Register of Medical Persons (see section 2.8.3). Subsequently, physicians must complete a three- to six-year postgraduate specialty training programme. Dentistry training lasts five years.

Certification of specialists is carried out by medical professional associations, which determine the schedules for certification examinations, inform physicians about certification requirements, establish commissions for certification examinations, organize the examinations and carry out the certification and recertification (see also section 2.8.3).

Continuous medical education is offered and organized by the different medical professional associations. There are different forms of training: courses, seminars and conferences, which are offered either at the Institute of Postgraduate Education of Medicine, University of Latvia or at multi-profile hospitals. Physicians can choose the courses they wish to take. Proof of having participated and passed a certain number of courses is required for recertification every five years, independent of the type of health care institution in which physicians work.

There are two options for training as a nurse in Latvia. Firstly, nurses can train through a three-year vocational training programme at one of five colleges of medicine (former nursing schools), which entails at least one year of theoretical studies and at least one and a half years of practical studies. Secondly, since 1990, nurses can train through a four-year study programme at Riga Stradins University or, since 2010, also at the University of Latvia. These programmes are intended to train nurses who will acquire supervisory roles or work on specialized wards.

All nurses have to be registered in the Register of Medical Persons and Medical Support Persons maintained by the Health Inspectorate. After finishing nursing school, nurses usually start working under the supervision

of a specialized (certified) nurse or a certified physician (e.g. in a GP practice). After further training courses at nursing schools nurses can pass an exam to become a specialized nurse. Specialized nurses, e.g. ICU nurses or anaesthesia nurses, have to be certified by the Latvian Nurses Association, which is also responsible for recertification after five years (see section 2.8.3).

For midwives, the same two training options exist and the duration of studies is the same as for nurses. Most midwives study at one of the colleges of medicine. If the midwives' programme of education is begun after finishing the nursing educational programme, the minimum duration of study is 18 months.

Pharmacists receive their education in the faculties of Pharmacy within Riga Stradins University and the University of Latvia. Following five years of professional education, students receive a Master's Degree in pharmacy. In the University of Latvia students receive a Bachelor's Degree after three years of academic study and a Master's Degree after two additional years. Universities determine the final exams and there is no state exam. Pharmacists require a Master's Degree in order to work independently. Pharmacist's assistants are educated within the Riga 1st Medical College and study for two and a half years. Since 2004, pharmacists and their assistants have had to register with the Latvian Pharmacists Association in order to be allowed to work in a pharmacy. For recertification, which is carried out by the Latvian Pharmacists Association, pharmacists have to submit proof of having obtained 60 credit points of postgraduate training every three years.

The Faculty of Public Health was established at Riga Stradins University in 1998 and offers study programmes leading to degrees for public health specialists. The length of the Bachelor's programme is four years. Every year, approximately 15–20 students graduate. After having obtained their Bachelor's Degree, graduates as well as other health professionals (physicians, nurses, etc.) may continue their studies in Riga Stradins University in a two-year programme of health sciences to obtain a Master's Degree, after which they may enter a doctoral programme.

There are no targeted study programmes for health care managers.

Complementary and alternative medicine practitioners are trained according to requirements defined by the Association of Holistic Medicine and Naturopathy.

All study programmes at Riga Stradins University and at the Faculty of Medicine of the University of Latvia are accredited by the Ministry of Education and Science. The minimum professional qualification requirements

for physicians have been defined in line with EU standards by the regulations of the Cabinet of Ministers on the “Minimum Requirements of the Educational Programme to Receive the Doctor’s Professional Qualification” (in force since July 2002). The minimum requirements for dentists, pharmacists, nurses and midwives are defined by the regulations of the Cabinet of Ministers on the “Minimum Requirements of Educational Programmes for the Acquisition of the Professional Qualification of Dentist, Pharmacist, Nurse and Midwife” (in force since February 2002).

The specific content of postgraduate training courses and recertification requirements for medical doctors, pharmacists, nurses, etc, is worked out and approved by the respective professional associations. There are no differences between public or private institutions in the training requirements for health professionals.

4.2.4 Doctors’ career paths

Doctors’ career paths depend very much on individual initiative, capabilities and choices. There is no standard procedure in the country regarding career development. After completion of postgraduate education, most physicians begin work as a specialist within an institution. GPs or other specialists may also open independent practices. For subspecialization, it is necessary to attend further training courses. After several years, it is possible to rise to positions of chief doctor or director, depending on professional knowledge and management skills. Decisions regarding promotions within the institution are made by the board of the institution, which is nominated by the owners. Decisions involving the director or deputy director of municipal institutions are made by the respective local government, based on the recommendations of the departing director(s). In the case of state institutions, the head of the medical institution is appointed by the Ministry of Health.

4.2.5 Other health workers’ career paths

Other health workers’ career paths depend on their individual initiative, capabilities and choices, too. There is no standard procedure in the country regarding career development. Every health worker begins work within an institution. There are opportunities to rise in any health career. Nurses and pharmacists can become heads of institutions and members of boards of institutions, depending on their ability to acquire knowledge about legislation, their management skills and support from their supervisors.

5. Provision of services

Public health is coordinated by the Ministry of Health and activities are planned and monitored mostly by the CDPC, which is the main institution for infectious and non-infectious disease control. The CDPC engages in health promotion and organizes the State Immunization Programme that is carried out by GPs and paediatricians and financed through the NHS.

Almost all Latvians are registered with a GP, their family doctor, who acts as the main point of entry into the health care system and as the gatekeeper to secondary ambulatory and hospital care. In rural areas, the physician's assistant (*feldsher*) or midwife still provide a relevant share of primary care. A patient with a referral from a GP can freely choose any ambulatory or inpatient care provider (institution) that has a contract with the NHS. Secondary ambulatory care is provided in a range of institutional settings, including self-employed specialists, health centres and hospital outpatient departments. Some specialists can be accessed directly under certain conditions without a referral from the family doctor.

Since 2009, when budget cuts were implemented and the hospital sector was restructured, day care has become an important part of hospital activity. In 2010, day care services were provided at 105 medical institutions, including almost all NHS contracted hospitals (37 out of 39), and the number of patients who received day care services doubled between 2008 and 2010. By contrast, the number of hospitals having contracts with the NHS was cut in half during the same period of time, dropping from 79 in 2008 to 39 in 2010. In addition, several local hospitals were downgraded to low intensity "care hospitals", which provide medical care to patients after discharge from acute care hospitals. Most specialized hospitals were closed down or transformed into day care and outpatient providers. In addition, a new type of health care service was included

within the statutory benefits basket – home care, which is medical care provided at home by nurses or physicians’ assistants to chronically ill patients or patients after surgery.

Pharmaceuticals from a positive list are covered by the NHS with varying degrees of co-insurance (100%, 75% or 50% coverage) depending on the condition. Patients pay the full price for a significant share of prescribed pharmaceuticals and the full price of all non-prescription drugs in the outpatient sector. In 2012, the existing reference price system for pharmaceuticals from a reference list (List A of the positive list of pharmaceuticals) was modified. Since then, only one pharmaceutical product per reference group is reimbursed by the NHS.

Provider choice in the statutory system is often limited, in particular in rural areas, because of waiting lists and lack of alternative providers to choose from. If waiting lists are substantial, and if providers have exceeded the number of patients to be treated according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers.

Long-term care in Latvia falls within the scope of social care, which is administratively and financially entirely separate from the health system. Long-term care and other social care are the responsibility of the Ministry of Welfare. Financing for long-term care facilities is available from the state budget for specialized long-term care institutions, such as for individuals with mental disorders or serious disabilities, and from local governments for “general” long-term care facilities, such as for the elderly.

5.1 Public health

Public health services in Latvia are provided by the government and financed mainly by the national budget. In addition, municipalities implement and finance local programmes, while the NHS pays for some services provided by GPs (such as immunizations). Two national institutions are responsible for public health activities in Latvia: the Ministry of Health and the CDPC. The Ministry of Health is the most important national authority responsible for the coordination of health promotion and disease-prevention activities of local governments and it supervises the CDPC. Other institutions, such as the Food and Veterinary Service under the Ministry of Agriculture and the Road Traffic Safety Directorate under the Ministry of Traffic, are important for the

successful implementation of the intersectoral approach to health improvement, which is at the heart of the Public Health Strategy 2011–2017 (see section 2.6 and section 7.1).

The CDPC, which was founded in 2012 (see section 6.1.4), is a budgetary organization of the Ministry of Health and is the main institution for infectious and non-infectious disease control. Its main tasks are to investigate disease outbreaks, to gather case reports from service providers, to plan and regulate vaccination programmes, to monitor public health programmes, and to summarize and analyse health information (see section 2.7.1). In the area of health promotion, the CDPC collaborates with the Ministry of Health and supports its efforts. It participates in the development of legislation and health promotion programmes and leads their implementation at national and regional levels. Practical health promotion work is often delegated to local municipalities.

The CDPC has health promotion programmes for healthy nutrition, physical activity, smoking cessation, addiction control, mental health (suicide prevention), and infectious disease prevention and control. Programme implementation includes campaigning to inform and educate the population, preparing and distributing materials for professional education, and undertaking surveys. All health promotion programmes are financed from the government budget. The CDPC also runs an HIV/AIDS prevention office and supports these offices in other regions (HIV-testing materials, condoms, etc.). Furthermore, the CDPC prepares the epidemiological bulletin.

Key partners of the CDPC are NGOs (e.g. Association HIV.LV, etc.) and state and local government organizations outside the traditional health system (see section 2.6). The Road Traffic Safety Directorate under the Ministry of Traffic is an important participant in the fight against traffic injuries and death, which is a significant problem in Latvia.

The legal framework for the control of communicable diseases is determined by several laws and regulations, most importantly by the two listed here.

- “Law on Epidemiological Safety” (1997) – it regulates epidemiological safety and specifies the rights and duties of state authorities, local governments, and natural and legal persons in the field of epidemiological safety, including control of environmental sanitary and hygiene conditions and epidemiological surveillance of infectious diseases.

- “Procedure of Notification of Infectious Diseases” (Regulations of the Cabinet of Ministers, 1999) – it specifies notification procedures in the event of an outbreak of an infectious disease.

Communicable disease surveillance has been adapted to the requirements of the EU. Notification of infectious diseases is required by the European Centre of Disease Control in Stockholm. PHC services play an important role in the notification of communicable diseases. AIDS patients and HIV-positive individuals, as well as patients with TB and STIs, are first reported to CDPC.

Legislation requires immediate notification of:

- a single suspected case of a dangerous infectious disease (cholera, anthrax, plague, yellow fever, Ebola, Lassa, Marburg and other haemorrhagic fevers, epidemic louse-borne typhus fever/Brill-Zinsser disease, relapsing fever, SARS and other dangerous infections, rabies);
- three or more cases of botulism, brucellosis, diphtheria, tick-borne encephalitis, *E. coli* 157, haemorrhagic fever with renal syndrome, legionellosis, leptospirosis, malaria, meningococcal infection, ornithosis, paratyphoid fever, Q-fever, nosocomial infection, trichinellosis, tularaemia, typhoid fever;
- five or more cases of hepatitis A, yersiniosis, salmonellosis, shigellosis, food intoxications, measles, mumps, rubella, pertussis, influenza (during a non-epidemic season), viral meningitis, encephalitis; also serious (hospitalized) cases without clear disease aetiology;
- suspicion of quarantine diseases at state borders;
- two or more cases of adverse events following immunization.

There are no government-financed or sponsored occupational health services in Latvia. Several laws and more than 20 regulations are related to occupational health and safety. The State Labour Inspectorate (under the Ministry of Welfare) is obliged to monitor developments in this sphere. Financing (if any) for occupational health is provided by employers. A research institute – the Institute of Occupational and Environmental Health – exists at Riga Stradins University.

The State Immunization Programme is based on WHO guidelines and is the responsibility of the CDPC, which determines the vaccination calendar for child immunizations (see Table 5.1). In some areas tick-borne encephalitis is also included in the vaccination calendar. Vaccination is provided free of charge at

the PHC level by family doctors, paediatricians and doctors' assistants. Adults receive vaccination against diphtheria, tetanus (with specific indications), and influenza (specific age and high-risk groups).

Vaccination coverage in Latvia has traditionally been very high. However, immunization data (see Table 5.1) show that coverage has decreased since 2008 and is now below the EU average for a number of vaccines and also below WHO's general target of 95%.

Table 5.1

Child vaccination calendar and immunization rates (% of total children), 2008–2010

Infectious disease	Age/immunization no.	Immunization rate (%)		
		2008	2009	2010
Diphtheria/tetanus	1 year/3rd	97.4	97.8	92.2
	2 years/4th	97.0	91.3	88.5
	8 years/5th	98.1	95.0	93.9
	15 years/6th	92.7	89.2	85.6
Pertussis (whooping cough)	1 year/3rd	97.4	97.8	92.2
	2 years/4th	97.0	91.3	88.5
Poliomyelitis	1 year/3rd	97.4	97.8	92.2
	2 years/4th	97.0	91.3	88.5
	8 years/5th	98.1	95.0	93.9
	15 years/6th	92.7	89.2	85.6
Measles	16–23 months/1st	97.3	92.9	90.1
	8 years/2nd	97.4	94.3	94.1
	15 years/2nd	–	–	–
Rubella	16–23 months/1st	97.3	92.9	90.1
	8 years/2nd	97.4	94.3	94.1
	13 years/2nd (girls)	–	–	–
Mumps	16–23 months/1st	97.3	92.9	90.1
	8 years/2nd	97.4	94.3	94.1
	15 years/2nd	–	–	–
Tuberculosis	1 year/1st	96.6	97.4	94.4
Viral hepatitis B	1 year/3rd	95.6	95.1	91.4
<i>Haemophilus influenzae</i>	1 year/3rd	97.3	97.6	91.1

Source: CDPC, 2012a.

Some local authorities (if they have sufficient resources) hire a physician or a mid-level practitioner to work in schools and kindergartens to provide health promotion and health education activities.

There are three population-based screening programmes in Latvia: one is for neonates, to detect congenital phenylketonuria and hypothyroidism; another is a screening programme for pregnant women; and the third is a cancer-screening programme (breast, colorectal and cervical cancer), which was launched in 2009. All three are financed by the NHS.

Under the cancer-screening programme, women between 25 and 70 years of age are supposed to receive pap smear screening for cervical cancer once every three years, and mammography screening every other year between age 50 and age 69. The entire population above age 50 should receive faecal occult blood tests once a year. Invitation letters for cervical and breast cancer screening are sent out to eligible females by the NHS. Colorectal cancer screening is the responsibility of GPs (opportunistic screening). However, in 2009 – the first year of the programme – the population response was relatively low, according to NHS internal data: only 7% of the eligible population received colorectal screening and 21% received breast cancer screening.

Dedicated public health training programmes have existed at Riga Stradins University since 1998 (see section 4.2.3).

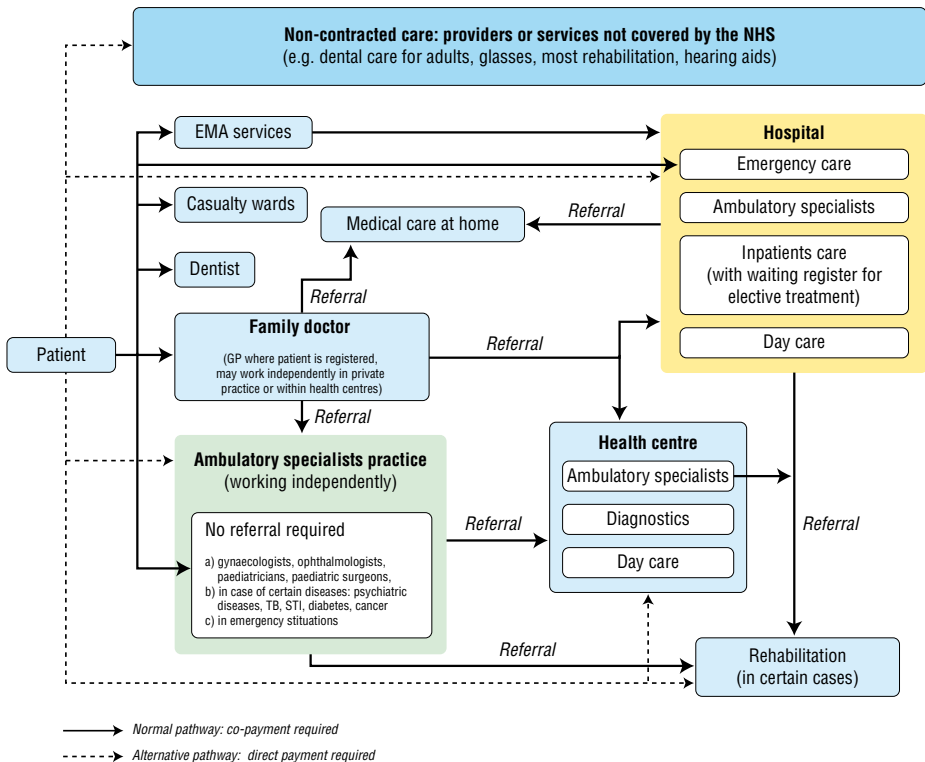
5.2 Patient pathways

Fig. 5.1 provides an overview of how patients move through the health care system. Key points of the most frequent patient pathways are listed here (more details about different types of providers are presented in the following sections):

- almost every patient (96%) is registered with a GP, the family doctor, who acts as the main point of entry into the health care system and as the gatekeeper to secondary ambulatory and hospital care;
- in case of illness, a patient visits either the GP, where he or she is registered and has to pay a co-payment, or one of a number of specialists, for whom no referral is required (see Fig. 5.1);
- the GP either treats the patient directly or issues a referral to (a) a health centre for laboratory or imaging tests; (b) a specialist (who may also be based at the health centre); or (c) a hospital;

- if the specialist can treat the patient, referral back to the GP may or may not occur. Alternatively, if the patient requires further evaluation or treatment, the specialist may refer the patient (a) to another specialist (who may be based at a health centre), (b) for diagnostic evaluation (at health centres) or (c) to a hospital;
- EMA services can also refer patients to hospitals (see section 5.5);
- a patient with a referral can freely choose any ambulatory or inpatient care provider (institution) that has a contract with the NHS. However, in practice, provider choice is limited because of waiting lists and considerable distances to the closest provider, particularly in rural areas;
- if waiting lists are substantial or if providers have exceeded the number of patients to be treated according to their contracts with the NHS, patients have the option to pay directly (100% of costs) for the treatment at contracted or non-contracted providers;
- after hospital discharge, patients may be referred for rehabilitation or home care.

Fig. 5.1
Patient flow



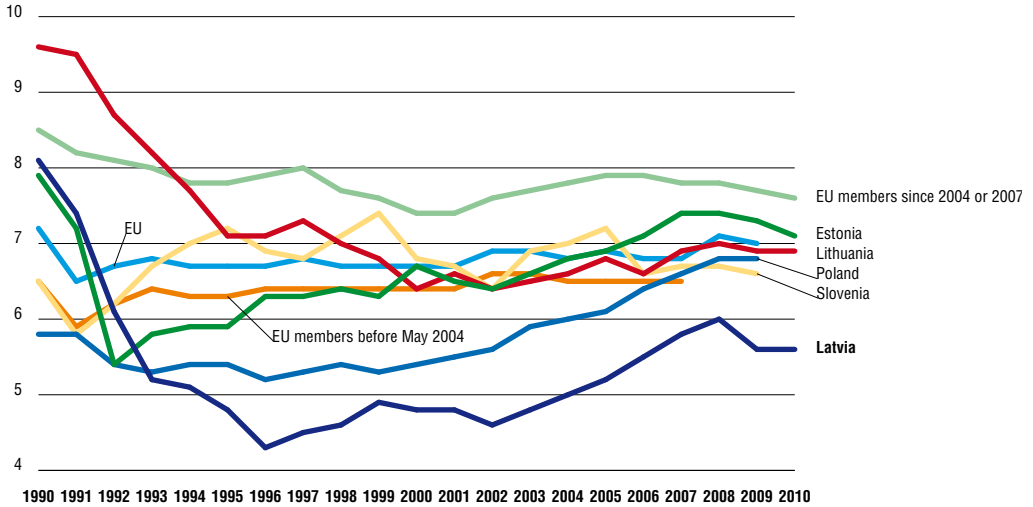
5.3 Ambulatory care

Ambulatory care consists of primary health care and specialized (secondary) ambulatory care. Emergency medical services are special ambulatory care services, which are discussed separately in section 5.5. Since the early 1990s, ambulatory care provision has undergone major reforms, which aimed at strengthening primary care and secondary outpatient services, while reducing the importance of hospital care. The number of outpatient institutions increased from 393 in 1991 to 1727 (including 1577 physician practices) in 2004, and to 4662 (including 2280 physician practices) at the end of 2011 (HI, 2012b). Before 1990, ambulatory care in cities and larger towns used to be provided in polyclinics, which employed a wide range of specialist physicians, dentists, nurses, paediatricians and other paramedical professionals (e.g. physiotherapists). In rural areas, ambulatory care was provided by the local internist and nurse or by the *feldsher* (a particular type of physician's assistant or clinical officer).

The current ambulatory care system developed from this foundation. Most polyclinics and small hospitals have been converted into Health Centres, which provide primary and secondary ambulatory care. Ownership has often remained public (with the municipalities), but public–private partnerships (divided between local governments and physicians) and private institutions exist as well. Private institutions are concentrated mostly in Riga. The introduction of family medicine in 1991 (see section 4.2.1 on the increasing number of GPs in Latvia) and the establishment of independent practices has considerably changed the way ambulatory care is provided in Latvia. Fig. 5.2 shows the number of outpatient contacts with physicians per person per year, including primary care and secondary ambulatory care, in Latvia and selected countries since 1990. The number of outpatient contacts per person in Latvia increased from below 5 in 2000 to about 6 in 2008. However, in 2009, the year when budget cuts were implemented and user charges were raised, the number of outpatient contacts in Latvia dropped to 5.6 per person per year. The number of outpatient contacts remains considerably below the EU average of about 7 per person per year. According to NHS data (NHS, 2012a), there were almost 14 million outpatient contacts in 2010. About half of all contacts were to PHC physicians (6.7 million). The other half was distributed across specialists (3.2 million) and diagnostic investigations (4.1 million).

Fig. 5.2

Outpatient contacts per person per year in Latvia and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, 2012b.

5.3.1 Primary care

The bulk of services at the primary care level are provided by PHC physicians (also called family doctors). PHC physicians are certified GPs, internists or paediatricians who are contracted by the NHS for the provision of PHC services. At the end of 2010, 97% of PHC physicians were trained as GPs, 1% as internists and 2% as paediatricians. About 80% of GPs work as self-employed individuals (see Table 5.2), while about 13% work as private sector agents. The difference between “self-employed” and “private” refers to legal and tax status according to Latvian legislation. A self-employed practitioner pays income tax on the basis of income earned in the practice, while “private” GPs are limited companies and are taxed as such. Only a small percentage of GPs, i.e. about 7%, are employed in health centres or hospitals. The NHS directly contracts with GPs if they are self-employed or work as private sector agents. If the GP is employed, the contract is between the health centre or hospital and the NHS.

Table 5.2

PHC settings and legal forms by district, 2010

District	Total number of GPs	Self-employed	Private	Employed
Kurzeme	217	169 (77.9%)	33 (15.2%)	15 (6.9%)
Latgale	186	171 (91.9%)	15 (8.1%)	0 (0.0%)
Riga	575	436 (75.8%)	68 (11.8%)	71 (12.3%)
Vidzeme	187	152 (81.3%)	31 (16.6%)	4 (2.1%)
Zemgale	212	170 (80.7%)	30 (14.2%)	12 (5.7%)
Total	1 377	1 098 (79.7%)	177 (12.9%)	102 (7.4%)

Sources: NHS, 2011; HI, 2012b.

The basic benefits package of health services to be provided by family doctors is determined by the Regulation of the Cabinet of Ministers “Provisions for health care professionals and students, who study in the first or second level professional higher education programmes for medical, therapeutic expertise and their theoretical and practical scope” (March 2009) and is further specified by the standard contracts with the NHS (NHS, 2012c). Family doctors carry out basic examinations, diagnostics and treatment for acute and chronic diseases in children, adults and elderly people. They are responsible for prescribing medications from the positive list of drugs and they perform outpatient surgical procedures. They also provide family planning services, and carry out preventive activities (screening and immunization), health promotion and health education.

Patients can freely choose to register with any family doctor in Latvia and may decide to change their doctor at any time. However, catchment areas are defined for every family doctor and patients from another doctor’s catchment area may be refused if the family doctor already has 2000 adult patients or 800 children on his list (except if other family members are already registered with the same doctor). For children under age 18, paediatricians can also act as the family doctor. Almost the entire Latvian population (96% at the end of 2010) has registered with a family doctor, although registration remains voluntary. On average family doctors had 1564 registered patients at the end of 2010. However, the distribution of GPs continues to show large regional variation, with almost 15% of GPs (mostly located in rural areas) having 2000 patients or more and about 10% of GPs (mostly in urban areas) having only 1000 patients or less. In practice, choice in rural areas is often limited as there are not enough physicians to choose from.

Family doctors are available 20–25 hours a week, five days a week. At other times, the patient can receive care from out-of-hours family doctors, 24-hour hospital admission and emergency wards, urgent care wards in health centres, and emergency care teams (see section 5.5). However, out-of-hours family doctors are usually available only in urban areas.

The family doctors function as gatekeepers. They make referrals to ambulatory specialist and inpatient services. Children and pregnant women have direct access to paediatricians and gynaecologists respectively, and patients with certain diseases (e.g. cancer or diabetes) may go directly to the relevant specialists (see Fig. 5.2). Patients with a referral from the family doctor can freely choose any secondary ambulatory or inpatient care provider contracted by the NHS. Although there are no limits to the number of specialist referrals that a GP can make, the total (financial) volume of prescribed diagnostic investigations is limited. The limit is estimated on the basis of national average diagnostic expenditures per patient, adjusted for the age distribution of registered patients.

Besides family doctors, 162 *feldsher*/midwife points, which are located mostly in rural areas, still (at the end of 2011) provide a considerable share of primary care services, in particular preventive services and chronic care. *Feldshers* have mid-level medical education and more responsibilities than nurses and refer patients to GPs if necessary. Most *feldsher*/midwife points (86) are owned and financed by municipalities and work as independent providers (without NHS contracts). Some points (66) are owned by municipalities but have contracts with the NHS, while still others are satellite offices of GP practices in rural areas, where GPs from the closest town spend one or two days per week. In addition, some *feldshers* and nurses are employed by GP practices and ensure that PHC services are available eight hours a day, five days a week. They assist in treatment and preventive work with all groups of patients, provide simple diagnostic tests (taking blood samples, etc.) and provide health promotion activities.

Dentists are typically self-employed, although some work as employees in health centres (for more details see section 5.12).

The quality of primary care has been evaluated regularly since the year 2000, when a capitation model was introduced for the payment of PHC physicians. Quality indicators are evaluated every quarter year (depending on the indicator) and the results determine the size of bonuses, which amount to about 15% of the capitation payments for family doctors (see section 3.7.1). Quality indicators are mostly structural or process based and included in 2010, for example, coverage of adult patients (percentage of registered patients who were seen

by their GP, the proportion of children who received prophylactic check-ups and immunizations, the proportion of diabetes II patients whose glycosylated HbA1c and microalbuminuria was tested, etc.). Approximately 80% of PHC physicians have been evaluated as “good” and received their bonuses (see Table 3.8 for details). In addition, in the context of the voluntary P4P scheme, data is collected from participating GPs. However, the P4P scheme is currently under review.

5.3.2 Secondary ambulatory care

Secondary ambulatory care is provided in similar institutional settings and under similar ownership structures as primary care. Some specialists can be accessed directly under certain conditions without a referral from the family doctor (see Fig. 5.2). For all other specialists, a referral from a family doctor is required. Patients are free to choose any specialist who has a contract with the NHS.

The dominant setting of secondary ambulatory care provision is independent practice, usually consisting of one specialist physician who works either as a self-employed individual or as a private sector agent. Most of these practices are located in rented facilities of health centres, which are owned by local governments. Employed specialists working at hospital outpatient clinics or health centres are the second most important type of ambulatory care provider. The number of specialists working in health centres can differ largely, with small health centres in rural areas having three to five specialists, while large health centres in Riga may employ up to 100 specialists. In addition, a large number of diagnostic centres exist, which provide visual diagnostics (radiologists), laboratory investigations, functional diagnostics (e.g. endoscopy), etc. Many specialists hold jobs in different clinics (of hospitals and/or health centres) and have a private practice because the cap on clinic budgets prevents them from having full-time jobs. Besides the statutorily financed services, all providers also offer certain services for which patients must pay out of pocket (or through voluntary health insurance). Some of these services are included in the NHS benefits package but considerable waiting lists exist (see section 7.3.1). In particular, towards the end of the month or at the end of the year, providers may have already exceeded the number of treatments for which they have contracts with the NHS. If this happens, providers may offer patients access to the service at full cost.

5.3.3 Day care and outpatient surgery

According to the “Regulations on Organization and Financing of Health Care” (2006), day care is diagnosis or treatment, which cannot be provided in an ambulatory setting because of its complexity or duration, but, which does not require hospitalization on a normal ward. The definition of day care treatment does not include a time limit. If treatment needs to be continued on the next day and patients are unable to travel home, they have the option to stay in hotel-type beds at hospitals. However, hotel-type accommodation has to be paid out of pocket by patients unless they are covered under the Social Safety Net Strategy (see section 6.1.2). Day care services in Latvia are considered to be outpatient services and are paid for from the outpatient care budget of the NHS. Patients are usually referred for day care treatment by their family doctors or other specialists.

Since 2000, a number of hospitals have started to introduce day care services. However, it is only since 2009, when the hospital sector was restructured in response to the economic crisis (see next section), that day care has become an important part of hospital activity. In 2010, day care services were provided at 105 medical institutions, including almost all contracted hospitals (37 out of 39), health centres and some specialized outpatient medical institutions (e.g. for haemodialysis) (see Table 5.3).

The numbers in Table 5.3 illustrate the considerable shift that has taken place in Latvia, away from inpatient care towards the provision of services in day care settings. In 2010, the total number of patients admitted for day care treatment was almost 125 000, more than twice the number of patients in 2008. While the number of inpatient surgeries dropped by 30 000 from 2009 to 2010 (WHO Regional Office for Europe, 2012b), the number of day care surgeries, which are counted as outpatient surgeries in Latvia, increased by almost the same number (see Table 5.3). Compared to 2004, the proportion of day cases as a percentage of all patients treated in hospitals increased from 5.9% to 25.3%.

Table 5.3

Indicators of day care and outpatient surgical activity in Latvia, 2007–2010

	2007	2008	2009	2010
Total day care institutions	79	87	110	123
no. of which are hospitals	34	38	57	55
NHS-contracted day care institutions	60	70	97	105
NHS-contracted hospitals	34	37	39	37
Day care beds	884	1 050	1 623	2 119
as percentage of total hospital beds	5.1	6.2	11.2	17.8
Total day care admissions	47 335	54 422	71 164	124 950
as percentage of total hospital admissions	9.0	10.6	16.9	33.2
NHS-contracted day care admissions	46 388	52 760	65 196	82 030
as percentage of NHS-contracted hospital admissions	9.7	11.1	17.5	25.3
Total outpatient surgical operations	137 278	128 403	138 698	173 076
no. of which are day care surgeries	25 354	28 012	36 704	62 097
NHS-contracted day care surgeries	n/a	22 219	27 528	40 673

Source: CHE, 2011a.

The most important services provided in a day care setting in 2010 were the following (NHS, 2011):

- invasive cardiology (coronary angiography, coronary angioplasty), accounting for about 40% of all day care expenditures;
- surgical services (urology, ophthalmology, otolaryngology, gynaecology, traumatology orthopaedics, general surgical services), accounting for about 19% of all day care expenditures;
- chronic haemodialysis, accounting for about 15% of all day care expenditures;
- other medical treatment (13.3%).

Social care can also be provided in a day care setting (day centres) but social care is the responsibility of the Ministry of Welfare and local governments. A day centre is an institution that provides care within the course of a day, and includes development of skills, education and recreational opportunities. This service is provided for various groups of the population (elderly people, people with mental health conditions, etc.). (See also section 5.11.)

5.4 Inpatient care

All statutory hospital care in Latvia is financed by the NHS on the basis of contracts signed between the NHS and the hospitals (see section 3.3.4). The only exception until 2012 was the State Agency Infectology Centre of Latvia, which was financed directly by the Ministry of Health. It has now been incorporated into Riga East University Hospital (see also section 6.1.4). The list of state-paid inpatient service providers is specified in government regulations.

Hospitals in Latvia can be classified according to ownership structure and legal status: state hospitals (owned by the central government) and accountable to the Ministry of Health; municipal hospitals; and private hospitals. State hospitals have the status of public limited (stock) companies. Municipal hospitals have the status of limited companies. Smaller (local) hospitals and some bigger (regional) hospitals are usually owned by municipalities, while larger tertiary hospitals (university hospitals) and specialized (monoprofile) hospitals (e.g. psychiatric hospitals) are owned by the Ministry of Health. Another way to categorize hospitals is based on the services provided by hospitals: (1) multi-profile hospitals (with at least two specialized wards) at national (university hospitals), regional and local level, with the difference between regional and local being determined by the number of specialties on duty around the clock (at least three specialties in local hospitals and at least seven specialties in regional hospitals); (2) specialized (psychiatry, narcology, maternity, traumatology and rehabilitation) hospitals; and (3) care hospitals, which provide low-intensity non-specialized inpatient care.

Table 5.4 shows the breakdown of hospitals contracted by the NHS for the provision of inpatient services in 2008 and 2010 (compare with Table 4.1, presenting all hospitals in the country). The number of hospitals with contracts with the NHS saw a remarkable decline between 2008 and 2010. As a result some of the hospitals presented in Table 4.1 now only have contracts for the provision of day care or outpatient services, although they still have beds and are able to provide (non-contracted) inpatient services. In 2009, the Ministry of Health implemented a large scale reform of the hospital sector, changing structures and cutting the number of hospitals in half. Several local hospitals were downgraded to low-intensity care hospitals with outpatient and day care units, and some of them no longer provide inpatient care but only outpatient and day care services. Furthermore, all rehabilitation hospitals (except one) were transformed into outpatient providers, often with day care units. Of the 79 hospitals that provided statutory inpatient services in 2008, only

39 institutions still had contracts with the NHS at the end of 2010. All hospital staff (including physicians) are employed by the hospital administration and are paid salaries (see section 3.7).

Table 5.4

Number of hospitals providing NHS-contracted inpatient services by type of service

Type of hospital	2008	2010
Multiprofile emergency	35	21
University	3	3
Regional	9	7
Local	23	11
Care (low intensity)	-	6
Specialized	30	12
Psychiatry	9	6
Narcology	2	1
Maternity	1	1
Trauma	1	2
Rehabilitation	7	1
Stomatology	2	-
Palliative care	5	-
Oncology	1	1
Tuberculosis	1	-
Dermatology	1	-
Other small municipal or private low intensity	14	-
Total	79	39

Sources: SCHIA, 2009 (for year 2008); Health Payment Centre, 2011 (for year 2010).

Substitution of less costly outpatient care for inpatient care has been one of the key features of Latvian health care reforms since the mid-1990s. The number of acute hospital beds per 1 000 population decreased from around 10 in the early 1990s to about 3.4 in 2010 (see section 4.1.2). However, the reduction in the number of inpatient discharges was not as dramatic as the reduction in the number of beds (see Table 5.5). This can be explained by reductions in the ALOS (see section 4.1.2) and relatively stable bed occupancy rates. Until 2008, the number of hospital discharges in Latvia remained considerably above the EU27 average of 178 per 1 000 population although it has now dropped below this number. In addition, there have recently been significant reductions in the number of discharged patients for individual disease groups, such as diseases of the circulatory system, injuries or mental disorders.

Table 5.5

Number of inpatient discharges per 1 000 population

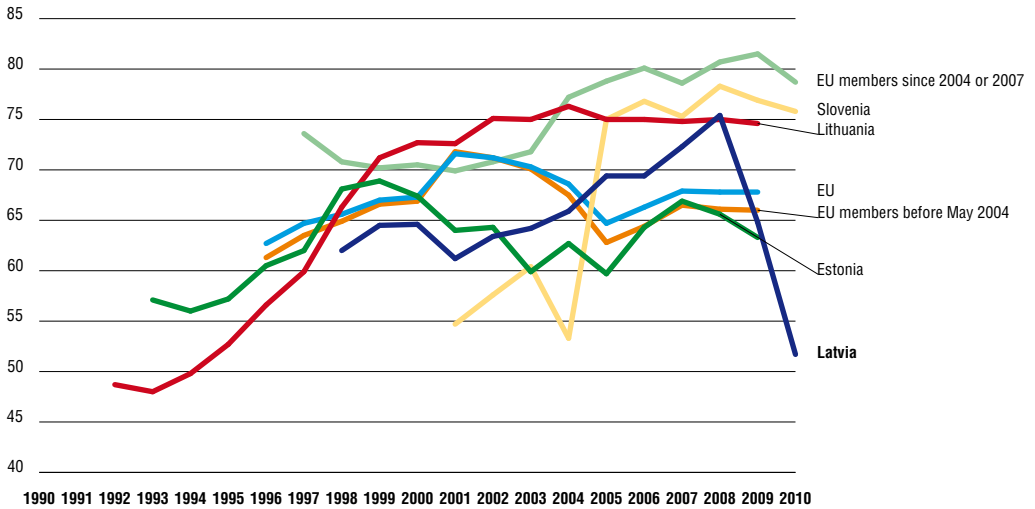
ICD-10	Diagnosis	2006	2007	2008	2009	2010
A00-B99	Infectious and parasitic diseases	9.4	8.7	9.8	8.5	8.5
C00-C97	Malignant neoplasms	14.3	14.7	14.9	12.6	11.9
E00-E90	Endocrine, nutritional and metabolic diseases	4.1	4.1	4.1	3.0	2.6
E10-E14	Diabetes mellitus	2.1	1.9	2.1	1.5	1.3
F00-F99	Mental and behavioural disorders	19.9	19.7	18.1	14.4	14.3
G00-G99	Diseases of the nervous system	12.4	13.0	12.7	10.5	9.4
H00-H95						
I00-I99	Diseases of the circulatory system	38.2	39.0	38.9	31.9	28.8
I21, I22	Acute myocardial infarction	3.2	2.9	2.7	2.4	2.2
I63	Cerebral infarction	3.7	3.9	3.9	3.9	3.9
J00-J99	Diseases of the respiratory system	22.2	23.8	20.6	19.4	18.1
K00-K93	Diseases of the digestive system	19.4	19.2	19.4	16.1	15.3
L00-L99	Diseases of the skin and subcutaneous tissue	4.3	4.3	4.0	2.9	2.6
M00-M99	Diseases of the musculoskeletal system and connective tissue	16.0	16.4	17.0	12.3	9.4
N00-N99	Diseases of the genito-urinary system	15.0	15.2	15.0	11.5	9.4
O00-O99	Pregnancy, childbirth and the puerperium	37.9	39.1	38.4	32.6	27.0
P00-P96	Certain conditions originating in the perinatal period	15.8	16.2	14.7	13.6	13.6
S00-S99	Injury, poisoning and other consequences of external causes	22.8	21.2	20.8	17.8	15.9
T00-T98						
A00-T98	Total	229.2	231.2	226.7	187.2	168.2

Source: NHS, 2012a.

The number of inpatient surgical procedures, which had a tendency to increase in line with the international trend until 2008, has seen a large drop in 2009 and 2010 (see Fig. 5.3). However, this strong reduction in the number of inpatient surgical procedures has to be interpreted in view of the increase in day care activity in Latvian hospitals (see previous subsection), which has compensated the decrease in the number of inpatient surgeries.

Fig. 5.3

Inpatient surgical procedures per 1 000 in Latvia and selected countries, 1990 to latest available year



Source: WHO Regional Office for Europe, 2012b.

5.5 Emergency care

Emergency care is a health care service for a wide variety of conditions ranging from life-threatening emergencies to acute conditions requiring urgent treatment.

Emergency care in Latvia is provided by:

- EMA teams or ambulances
- emergency departments in hospitals
- casualty (urgent care) wards.

In 2010, a major structural and managerial reform of the EMA was completed in order to increase the efficiency of the system in the pre-hospitalization and hospitalization phases. Since 1 July 2010, all EMA services have been provided by one centralized institution – the SEMS. The SEMS consists of five call centres, which receive emergency calls from all over Latvia.

Before the reform, ambulance services were provided by several decentralized institutions: hospitals' EMA departments, and municipal or private EMA institutions. All of them had contracts with the NHS. Today the SEMS is a state agency, which is under the direct control of the Ministry of Health and operates under a fixed budget. Medical personnel are employed by the SEMS and ambulances are either owned by the SEMS or rented from private companies, which then also provide the drivers. The distribution of owned to rented vehicles is about 50:50.

The SEMS has 186 ambulance teams, consisting of at least two (para-) medical staff and one driver. There are 57 physicians' teams (including 7 highly specialized ones: cardiology, toxicology, psychiatry, paediatrics, etc.), consisting of one medical doctor and a nurse or doctor's assistant, and 129 teams with 2 paramedical staff. Ambulances are stationed at 98 locations across the country and transport patients into the nearest appropriate hospital according to the plan of hospitalization.

EMA teams have to respond to calls within specified limits. These are:

- responding to 75% of calls within 15 minutes in cities and towns (in fact 89% of calls are reached within 15 minutes, with an average waiting time of 10 minutes);
- responding to 75% of calls within 25 minutes in rural areas (in fact 81% of calls are reached within 25 minutes, with an average waiting time of 19.5 minutes).

A specific part of the SEMS is the Centre of Emergency and Disaster Medicine (CEDM). The CEDM is a state-run, specialized medical service, which is called in by hospitals, once it has been established that the institution's own efforts and resources are insufficient to save the life of a patient. The surgical brigades of the CEDM come to help their colleagues in various district hospitals. They perform complicated spinal, neurosurgical and other urgent operations in hospitals, help to transport patients to larger hospitals, and perform crucial life-support functions during transport. The CEDM can also be called by patients, relatives or employers who are not satisfied by the care provided in the hospital in which the patient is being treated (even outside Latvian borders). However, in these cases, the services are not covered by the state budget but have to be paid directly by the patients.

Emergency departments in hospitals ensure the necessary diagnostics and treatment in urgent cases for outpatients but also have admission units for inpatients. Patients can either come to emergency departments directly or

they are delivered by ambulance. In local multi-profile hospitals, emergency departments have physicians of at least five different specialties available around the clock. At regional hospitals, seven different specialties have to be covered.

At the end of 2010 there were 10 casualty (urgent care) wards in Latvia. Casualty wards are outpatient units with at least one doctor and one nurse available 24 hours a day, 7 days a week. They are located either in health centres or hospitals and one was situated at the Children's Clinical University Hospital in Riga. Casualty wards may exist in addition to emergency departments.

One example of a patient pathway in an emergency situation is given here:

A man with broken pelvic bones and substantial bleeding after a car accident:

- the police or person who was first at the scene of the accident calls an ambulance;
- an SEMS call centre dispatcher receives the call;
- an SEMS team provides emergency aid at the scene and while transporting the victim to the nearest appropriate local emergency hospital;
- after surgery at the local hospital, the surgeons realize that internal blood loss from pelvic fractures cannot be stopped with the hospital's available resources. Therefore, the local surgeons call the CEDM to transport the patient to the closest specialized trauma hospital and to perform the crucial functions to sustain life while transporting the patient.

5.6 Pharmaceutical care

Legislation and policies in the field of pharmaceuticals are the responsibility of the Health Care Department of the Ministry of Health. In addition, there are two main institutions concerned with regulation of pharmaceuticals: the SAM, the national drug market authorization agency, and the NHS, which is responsible for reimbursement and pricing decisions (see section 2.8.4).

There is a positive list in accordance with the "Procedures for the Reimbursement of Expenditures for the Acquisition of Medicinal Products and Medicinal Devices Intended for Out-patient Medical Treatment", designating a range of conditions (for example, diabetes, cancer, mental disorders) for which

drugs are reimbursed according to the degree of severity (see also sections 2.8.4 and 3.4.1). The objective is to keep expanding the positive list as well as to reduce the level of co-insurance required from patients.

Patients pay the full price for a significant share of prescribed pharmaceuticals and the full price of all non-prescription drugs in the outpatient sector. In fact, more than 60% of OOP payments in Latvia are spent on pharmaceuticals (see Fig. 7.2). According to World Bank (2010) estimates, about 50% of these are related to payments for non-reimbursable prescription drugs or OTC drugs. Inpatient pharmaceutical care is provided free of charge as the costs are included in the cost of inpatient services.

There is a co-payment of LVL0.5 (€0.71) per prescription for outpatient pharmaceuticals on the positive list (if the pharmaceutical has 100% reimbursement level) and co-insurance of 25% (if the pharmaceutical has 75% reimbursement level) or 50% (if the pharmaceutical has 50% reimbursement level). However, households with an income below LVL90 (€128) per family member per month are exempted from user charges under the Social Safety Net (see also section 3.4.1.). In 2012, the existing reference price system for pharmaceuticals from List A was modified (see sections 2.8.4 and 6.1.5). Since the reform, only one pharmaceutical product per reference group has the status of reference medicine and is reimbursed by the NHS.

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them. In 2012, there were 55 licensed wholesalers and 7 licensed manufacturers of active pharmaceutical substances in Latvia (State Agency of Medicines of Latvia, 2012).

Wholesalers are private enterprises. The total wholesale turnover of pharmaceuticals (excluding sales among wholesalers), after declining in 2009 and being flat in 2010, grew by 5% in 2011 (see Table 5.6), reaching LVL205.75 million (€290 million). The growth was driven by price increases per prescription of 5%, while the number of prescriptions slightly decreased. In the segment of sales to general pharmacies, Recipe Plus dominated with 41% market share, followed by Tamro with 23% (LVL72.89 million), Roche Latvija (LVL47.95 million), and Magnum Medical with 17% (State Agency of Medicines of Latvia, 2012).

Domestic production accounts for about 5% of the pharmaceutical market (see Table 5.6). However, Latvian manufacturers export most of their pharmaceutical products (The Association of the Latvian Chemical and Pharmaceutical Industry, 2010).

Foreign manufacturers operate through representative offices, subsidiaries or limited liability companies. Some of them perform only promotion and marketing activities, while others have established companies and are licensed as wholesalers.

Hospitals purchase medicines from wholesalers or pharmacies. Large purchases of pharmaceuticals are put out to tender.

Most pharmacies are privately owned. In fact, amendments to the “Law on Pharmaceutical Activities” (of 1998) enacted in June 2001, which were to become effective in 2011, were intended to change the ownership norms for pharmacies. According to these rules, only a pharmacist or a local government in its administrative territory (with the permission of the Minister of Health) would have had the right to own a pharmacy. However, as a result of active lobbying by pharmacy chain owners, this requirement was abolished by amendments to the law in 2010. Now pharmacies can be run by a pharmacist as a pharmaceutical practice or by a company. If it is registered as a company, at least 50% of the shares have to be owned by a pharmacist or at least half the board must consist of certified pharmacists. In fact, the pharmacy market is dominated by chains, with the most important chain being “AS Sentor Farm Aptiekas”, which owned most of the top 10 general pharmacies with the largest turnover in 2010 (State Agency of Medicines of Latvia, 2012). A small number of pharmacies exist at health care institutions and, in rural area, pharmacies can also be owned by pharmacy assistants.

Table 5.6

Indicators for the development of the pharmaceutical market in Latvia, 2006–2011

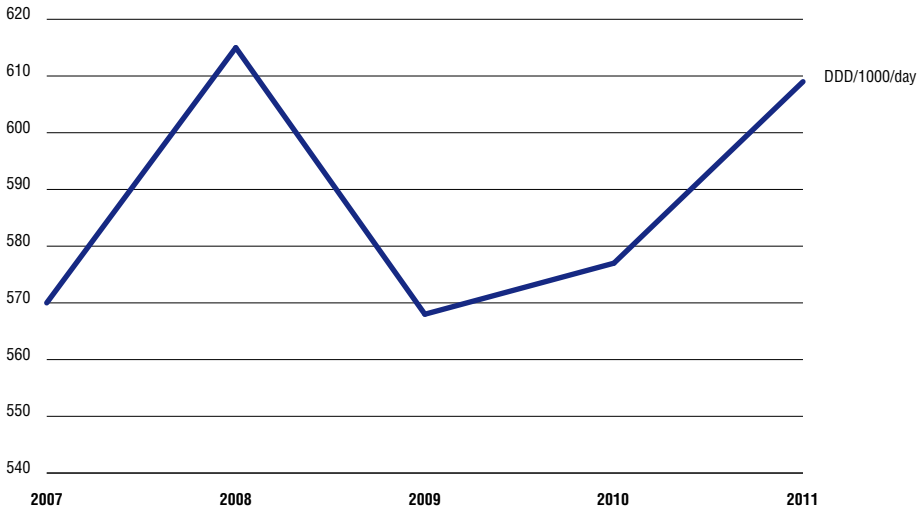
	2006	2007	2008	2009	2010	2011
Number of general pharmacies	818	801	810	788	783	780
Average price of prescription (LVL)	2.57	3.01	3.48	4.14	4.48	4.7
Growth of average price of prescription (%)	24	17	16	19	8	5
Consumption per capita (LVL)	–	79	90	85	87	92
Number of prescriptions (million)	57.8	59.9	58.8	47.5	44.0	43.9
Defined Daily Dose consumption per 1 000 population per day	–	570	615	568	577	609
Total pharmaceutical market (wholesale turnover) (million LVL):	148.4	179.6	204.8	195.7	196.0	205.8
sales to general pharmacies	117.6	144.7	168.0	164.3	166.9	173.3
sales to health care institutions	20.8	23.0	24.0	18.3	20.1	25.4
sales to physician practices	–	–	–	–	–	4.5
sales to veterinary practices	–	0.1	0.2	0.2	0.2	0.2
sales to others	10.0	11.8	12.7	13.0	8.8	2.4
Growth of total pharmaceutical market (%)	n/a	21.0	14.1	–4.5	0.2	5.0
Imported pharmaceuticals (million LVL)	139.8	169.2	193.9	184.8	187.0	196.1
Total turnover of local manufacturers (million LVL)	57.5	68.7	74.3	67.5	71.5	76.4
Turnover of local manufacturers in Latvia (million LVL)	9.2	10.5	9.9	8.8	6.9	7.8
Turnover of local manufacturers outside Latvia (million LVL)	48.3	58.3	64.4	58.7	64.6	68.6
Share of local manufacturers in pharmaceutical market (%)	5.8	5.8	5.4	5.6	4.6	4.7

Source: State Agency of Medicines of Latvia, 2012.

After the decline in 2009, the nominal value of per capita consumption of pharmaceuticals grew in 2011, reaching LVL92 (€129) (see Table 5.6). Per capita consumption has grown considerably since 2000, and is expected to grow further. Yet even at these higher levels, per capita consumption levels remain substantially lower than in Western Europe. As indicated in Fig. 5.4, Defined Daily Dose (DDD) consumption rate was growing until 2008 but declined in 2009, which coincided with the deterioration of the economic situation and fiscal consolidation in Latvia. There has been an upwards trend in both 2010 and 2011.

Fig. 5.4

DDD consumption per 1 000 population in Latvia, 2007–2011



Source: State Agency of Medicines of Latvia, 2012.

5.7 Rehabilitation/intermediate care

Ambulatory rehabilitation and physiotherapy are provided by individual professionals, at health centres and outpatient rehabilitation units in hospitals. Inpatient rehabilitation is provided at the National Rehabilitation Centre and at several multi-profile hospitals.

Ambulatory rehabilitation is provided by an individual specialist (mono-professional rehabilitation). This can be a physical medicine and rehabilitation specialist, physical medicine physician, rehabilitologist or functional specialist, who has to ensure that care is coordinated with other health professionals and medical support persons.

Inpatient rehabilitation consists of a range of services provided by a multidisciplinary rehabilitation team (multi-professional rehabilitation). For patients with chronic functional limitations, a long-term medical rehabilitation programme exists; this includes active case management of patients to ensure that patients' functional conditions are monitored at regular intervals (at least

once a year) and that necessary different rehabilitation services are coordinated with other medical professionals, the family doctor and municipalities' social services.

The NHS pays for rehabilitation services if patients have a referral from the appropriate specialist, who also has to develop a medical rehabilitation plan, including the aims, technologies and conditions of completion of rehabilitation.

Intermediate care is provided in special intermediate care wards at multi-profile hospitals for up to 10 days (but it can be extended). Intermediate care is used to achieve earlier discharge of patients from specialized medical wards and to allow patients to recover in a controlled but less intensive care setting. After surgical operations intermediate care is also provided at home (home care) by nurses or physician's assistants under the supervision of family doctors. Medical care at home is also provided for chronic immobile patients to decrease the need for hospitalization.

In addition, there are social rehabilitation providers, which are under the responsibility of the Ministry of Welfare. Social rehabilitation is provided for handicapped persons: for visually impaired persons, for hearing-impaired persons and for persons with functional disabilities.

5.8 Long-term care

Long-term care falls within the scope of social care in Latvia, which is administratively and financially separate from health services. Long-term care (as is the case with all social care) is the responsibility of the MoW. Financing of long-term care facilities is undertaken partly with funds from the state budget (mainly specialized long-term care institutions, such as for individuals with mental disorders, or serious disabilities, orphaned children aged up to two years, and others) and partly by local governments ("general" long-term care institutions, such as care for the elderly). For an increasing proportion of cases, the services are paid for by patients' families.

It is possible to distinguish two types of long-term care facilities in Latvia, which differ by the degree of specialization and the source of financing:

- Specialized long-term institutions financed by the state budget through the MoW – there are 28 such facilities, with approximately 3300 patients. These include institutions for adults with mental disorders and serious disabilities, blind people, orphaned children up to two years of age,

children with physical and psychological development problems until age 4, as well as disabled children with psychological development problems from 4 to 18 years of age.

- General long-term care institutions, financed by local governments – there are 60 such facilities, with approximately 5000 clients. These institutions provide care for the elderly and people with health problems of a physical nature, as well as orphaned children from 2 to 18 years of age.

Pensioners have to pay 85% of their pensions towards the costs of the long-term care they receive.

All individuals in social care institutions are registered with a primary care physician and receive PHC services and secondary ambulatory care services in accordance with the same principles as the entire Latvian population (i.e. statutorily financed).

In addition, municipalities are responsible for providing and financing social services at home. Approximately 9000 people received residential (home) care annually (HSMTSA databases, 2007, unpublished data), while day care centres receive approximately 23 000 people annually. There is generally a shortage of long-term care facilities in Latvia (see also section 4.1), as well as insufficient public funding for this purpose.

5.9 Services for informal care-givers

There is currently no structured approach to providing services for informal care-givers in Latvia.

5.10 Palliative care

In 1977, the first specialized palliative care unit was founded in Latvia at the Latvian Centre of Oncology (currently the Centre of Oncology at Riga East Hospital). There were then and there still are 25 palliative care beds in that unit. Care is provided by a multidisciplinary team consisting of specialized oncologists, nurses, nurse assistants, social workers, chaplains and voluntary care providers. Specialists from other hospital departments are also involved, if necessary.

In addition, there are about 55 palliative care beds in total, situated in four regional hospitals (Daugavpils, Liepaja, Rezekne and Ventspils). Financing for palliative inpatient treatment is the same as for other inpatients. Patients only have to pay co-payments.

Prior to the hospital reform in 2009, some smaller hospitals had palliative care units. However, currently, they only have contracts for the provision of palliative outpatient and day care services. If patients receive palliative outpatient or day care treatment (financed by the NHS) but prefer to stay at the institution over night, accommodation costs have to be covered either by municipalities or by patients out of pocket. In addition, there are some private sponsors (charitable foundations) for palliative care.

There is also specialized palliative care for children. In 1998, an NGO for child palliative care was founded, and the first palliative care service was offered at the Children's Clinical University Hospital. The service provides consultations for patients within various departments of the hospital, consultations with patients' relatives throughout Latvia, and home care for patients who live in Riga City and surrounding areas.

General (non-specialized) palliative care in Latvia is provided by family doctors. As there is only a limited number of specialized palliative care beds in hospitals, GPs care for patients on waiting lists for inpatient palliative care and after discharge from hospitals. However, there are no specific palliative care standards for GPs except for some guidelines.

Medical care-at-home providers (e.g. nurses, physician's assistants, social workers) also take care of palliative patients but they are usually not specifically trained to provide palliative care.

5.11 Mental health care

The Ministry of Health (Public Health Department) is responsible for the development and enforcement of national mental health policies. Legislation that deals with mental health includes the Medical Treatment Law of 1997, which regulates "Mental illnesses" in chapter XI, provides principles for treatment, and also deals with the issue of compulsory hospitalization in psychiatric hospitals. Mental health is an important focus area of the Public Health Strategy 2011–2017 (see section 7.1). The Ministry of Health, in cooperation with WHO, has developed the "Basic Principles on Improvement of Mental Health for the

Population in 2009–2014”. At the time of writing, the draft implementation plan for the period 2012–2014 of the “Basic Principles on Improvement of Mental Health for the Population in 2009–2014” is under public discussion.

From 2007 until its closure in 2009, the Public Health Agency (PHA) was responsible for mental health promotion and mental disease prevention. The PHA in cooperation with the WHO Country Office for Latvia organized an educational seminar “Mental Health Promotion and Prevention of Mental Illnesses”. The PHA began the campaign “There is always a solution” with the aim of increasing knowledge about depression and raising tolerance for people with mental disabilities. At the beginning of 2009, with the deterioration of the economic situation in Latvia, the PHA started the campaign “Think Positively!”. The PHA created a section in its web site with the title “Think Positively!” that included a specialist’s suggestions for promoting mental health. Mental health care specialists from the PHA prepared recommendations for talking to children about crisis situations in the family and how to act if a family is faced with such a situation. Likewise, the PHA web site offered practical advice on maintaining mental health in the global financial crisis, which has severely affected Latvia (Erdmane et al., 2009).

Today mental health promotion, disease prevention, analysis of statistics, conducting surveys and writing reports is under the responsibility of CDPC (see sections 5.1 and 6.1.4).

NHS-paid psychiatric care is overwhelmingly provided in large psychiatric hospitals and municipal psychiatric consulting rooms, while other day care centres, outpatient services and facilities for chronic patients are as yet underdeveloped. Patients with milder conditions are often treated by their GPs, internal disease specialists and neurologists. This is partly a matter of choice, rather than necessity, as there is still a social stigma associated with the need for psychiatric care. The different targeted psychiatric care settings are described in more detail in the following subsections.

5.11.1 Inpatient care

In 2010 there were six psychiatric hospitals, located in Riga, Jelgava, Daugavpils, Strenči, Aknīste and Aināzi (a children’s hospital), with a total of 1987 adults’ and 140 children’s beds, and 3 psychiatric departments in general hospitals with 215 adults’ and 56 children’s beds (CHE, 2011b). There has been a decrease in bed numbers over the last few years, and in 2010, there were 1.2 beds per

1 000 population in Latvia (see section 4.1.2). However, psychiatric hospital beds per 1 000 population in Latvia is still about twice as many as in Estonia, Poland or Slovenia.

While part of the psychiatric hospital facilities is used to provide treatment for acute patients, part is used for long-term treatment and rehabilitation. Specialized guarded hospital wards in Riga accept patients who receive compulsory medical treatment if determined by a court.

Psychiatric inpatient care for children is provided in a children's psychiatric hospital, in the psychiatric ward of a children's general hospital in Riga, as well as in a children's department in the adult psychiatric hospitals in Jelgava and Daugavpils, and in a general hospital in Liepaja.

Hospitals and outpatient settings have received EU structural funds (ERDF) to improve their conditions. Some hospitals (e.g. Ainazi children's hospital) were rebuilt and moved to new facilities. Hospitals also try to change their treatment patterns to be more open and comfortable to the patients. However, psychiatric care in Latvia is still dominated by hospital rather than outpatient care, which is related to historical and educational traditions.

Besides these dedicated psychiatric hospitals, some long-term care services exist, which are classified under social care. These long-term social care services are under the responsibility of the MoW.

5.11.2 Day care

There are two psychiatric hospitals providing day care beds – in Daugavpils and Jelgava – and one general hospital in Liepaja. In Riga, a new community mental health centre was established with day care beds, and a second community mental health centre in another area of the city is under development.

5.11.3 Outpatient care

Outpatient psychiatric care is provided in a variety of settings:

- two psychiatric assistance centres in Riga;
- four outpatient departments at psychiatric and general hospitals, in Riga, Jelgava, Liepaja and Daugavpils;
- one outpatient department at a general children's hospital in Riga;
- municipal psychiatric consulting rooms in primary care centres;
- private psychiatric practices, some of which are contracted by the NHS.

In terms of staff resources, there were no major changes in the number of practising psychiatrists; in 2010 there were 241 adult psychiatrists in the entire country, corresponding to 1.1 per 10 000 population, and 14 children's psychiatrists, corresponding to 0.1 per 10 000 population (CHE, 2011c).

5.12 Dental care

The State Dentistry and Face Surgery Centre is responsible for planning and coordination of dental care in Latvia, as well as for drafting laws and regulations in collaboration with professionals in the education system and within local governments. The centre is a structure of Stradins State Clinical University Hospital acting under the supervision of the Ministry of Health and it maintains records of all dental practitioners in Latvia. There is no specific policy document or national strategy for the provision of dental care. Dental care is regulated according to the same regulations as other medical care.

Preventive dental care programmes are provided by five regional Oral Health Centres under the supervision of the State Dentistry and Face Surgery Centre. Their basic tasks include data collection and epidemiological analysis, provision of information, school education programmes, fluoridation programmes, and provision of dental health and dental hygiene.

Dental care is considered to be primary health care in Latvia and a family doctor's referral is not required (see Fig. 5.1). However, only dental services (first orthodontic consultation, hygiene, treatment and surgery) for children under 18 years of age, and orthodontic treatment for patients with congenital maxillofacial cleft up to 22 years of age, are financed by the NHS. All other individuals have to pay for dental care out of pocket or through private health insurance.

In 2010, 319 medical institutions had a contract with the NHS and provided services financed from the state budget. Of these institutions, 89% were dental practices or limited companies and 11% were state or municipally owned institutions. There were 1521 active dentists at the end of 2011 in Latvia, including those who did not have contracts with the NHS (HI, 2012a).

As the availability of dental services in rural areas is limited, the NHS signed a contract for three mobile dental cabinet services in 2011. Trips are organized by the Regional Oral Health Centre in cooperation with the local area municipality and educational institution. In 2010, 0.9% of all visits to the dentist were to the mobile dental cabinets.

In 2010, 53.2% of Latvian children received dental care paid for by the NHS. The highest percentage of children seen by dentists was in the Latgale region (67.1%) and the lowest in Riga (47.8%).

In 2010, 12.5% of state budget funds allocated to primary health care were used for the provision of dental services. Prices for statutorily financed dental services are determined by the NHS, and approved by the Regulations of the Cabinet of Ministers. These prices are binding for the medical institutions contracted by the NHS. Prices charged to paying patients, whether in contracted or non-contracted dental practices, are freely determined by the market.

5.13 Complementary and alternative medicine

Complementary and alternative medical services are relatively well accepted in Latvia and include acupuncture, homeopathy, massage therapy and electromagnetic therapy. These services can only be provided by medical doctors who have completed their specialization and have obtained a certificate in alternative medicine. Educational requirements, certification and the provision of alternative medicine services fall within the general regulations of providers and human resources (see sections 2.8.2 and 2.8.3).

According to the register of the Latvian Medical Association, more than 1000 physicians (about 15% of all Latvian physicians) have a certificate that allows them to use one or more methods of alternative medicine in their practice. There are several associations of alternative medicine registered within the Latvian Medical Association. The largest one of these – the Association of Holistic Medicine and Naturopathy – has the right to issue certificates in alternative medicine.

Alternative medical therapies or medications (such as homeopathic medicines) are not included in the NHS benefits package and patients have to pay for them out of pocket. Private health insurance does not cover alternative medicine services.

No data are available on the number of users of these services, or on the profiles of the users.

5.14 Health care for specific populations

All citizens of Latvia and almost all residents are entitled to receive statutorily financed services.

Some specific groups within the country for whom special provisions apply include:

- Prisoners: ambulatory and hospital care for prisoners are organized and financed by the Ministry of Justice, with some services directly provided in prisons. HIV/AIDS and TB prevention and treatment in prisons are paid for from the health budget as part of a national programme under the Ministry of Health.
- Chernobyl victims: victims of the Chernobyl nuclear accident are covered by the main statutory health care system; however, they are exempted from patient co-payments, and also qualify for 50% state subsidy for dental care and social rehabilitation.
- Politically repressed individuals (people who were politically repressed in the former Soviet Union): such individuals are covered through the statutory health care system, but are exempted from patient co-payments.
- Refugees: on receiving legal refugee status, refugees are entitled to receive statutorily financed health care services, with co-payments reimbursed by the Ministry of Justice.
- Low-income individuals: this group receives the same services as the rest of the population but qualification as a low-income individual warrants exemption from patient co-payments (see section 6.1.2).

6. Principal health reforms

Since independence in 1991, the Latvian health care system has undergone a remarkable process of transformation. Virtually every aspect – including the organization and financing of the health care system, regulation of pharmaceuticals, payment of providers, provision of services and the organization of public health has been reformed – often only to be re-reformed again in subsequent years. Earlier reforms in the 1990s and 2000s, involving the initiation of a decentralized social insurance system and the subsequent reversal, have been described in detail in Tragakes et al. (2008) and summarized in sections 2.2 and 2.4. This chapter discusses the various reforms undertaken between 2007 and 2012, which have – again – substantially changed the structure and management of the health system.

The period between 2007 and 2012 can be divided into two stages – before and after the economic crisis. The first stage (2007–2008) was characterized by a continuing institutional centralization process and a slow shift away from hospital to outpatient care. The second stage (2009–2012) witnessed a shock-type reform with a dramatic reduction in the number of hospitals and far-reaching changes of health care administrative institutions. In addition, a Social Safety Net Strategy was implemented to protect low-income households from user charges and to expand access to health services.

Finally, an important step forwards in the direction of strategic long-term planning in the health care system was the Cabinet’s approval of the “Public Health Strategy for 2011–2017”, which sets out a number of strategic objectives for the development of the health system over the next five years (see also sections 6.2. and 7.1). Ministries from other sectors and local municipalities were actively participating in the elaboration process, confirming the political commitment to an intersectoral approach and health in all policies.

Currently, the development of clinical guidelines, new regulations for medical technologies, the implementation of a DRG-based payment system in hospitals and the introduction of e-health applications are high up on the Latvian policy agenda. Furthermore, the development of a quality management system and quality standards for health care institutions are officially claimed to be important, although the accreditation of health care institutions, long considered one of the basic elements of the quality management system, has not been mandatory since 2009.

Other important priorities include pharmaceuticals (keeping expenditures under control, while increasing statutory coverage for pharmaceuticals and including new medicines in the positive list), human resources (training and retaining health workers), assuring financial sustainability, as well as participation in the EU institutions' activities and effective acquisition of EU Structural Funds. Finally, there are plans for important changes in the field of health care financing, possibly – once again – leading in the direction of a social health insurance type system.

6.1 Analysis of recent reforms

The first stage of reforms (2007–2008) was a period of relatively few changes in the health care system. As the magnitude of the economic crisis had not yet emerged, there was no urgent need for reform. At the same time, politics and personal relationships obstructed a number of necessary (but painful) reforms to the health system's institutional structures or hospitals. Nevertheless, several small agencies under the Ministry of Health were incorporated into the Public Health Agency (see Box 6.1) and the availability of specialized ambulatory care and day hospital services was improved.

The second stage of reforms (2009–2012) was kicked off by the enormous financial constraints resulting from the financial and economic crisis in 2009, when the GDP dropped by almost 18% (see section 1.2). The subsequent reform process was very quick and was pushed through almost without discussions and scientific analyses almost within one year. Several basic health legislative acts were amended and substantial structural reforms of the health system were achieved (see Box 6.1). Some of the structural reforms, such as the downsizing of the hospital sector, had been on the agenda for years but had not been implemented because of local opposition. Now, at the height of the financial crisis, local protests, demonstrations and even roadblocks could not stop the closure of hospitals.

Box 6.1	
Major reforms and policy initiatives	
First stage (2007–2008)	
2007	Strengthening of the Public Health Agency: four smaller agencies or parts of them were incorporated: (1) the Centre of AIDS Prevention; (2) the Narcology State Agency; (3) the Mental Health State Agency; and (4) the Health Promotion Agency.
2007	Creation of the Strategic Council of Health Care: the council consists of delegates from professional medical associations, universities and hospitals. It serves as a consulting and coordination body under the Minister of Health for organizational questions.
Second Stage (2009–2012)	
2009	Creation of the Chief Specialist's Institution: the institution unites chief physicians and professors from different medical specialties and is a professional medical advisory group under the Minister of Health, providing input concerning clinical questions.
2009	Discontinuation of the “Development Programme of Out-patient and In-patient Health Care Providers” because of the economic crisis.
2009	No accreditation of health care institution (only self-reporting) as a result of a modification of the Regulations No. 60.
2009	Closing down of the PHA; some functions were assigned to other institutions.
2009	Closing down of the State Centre of Medical Professional Education. Its functions were assumed by the Ministry of Health.
2009	Closing down of the State Agency of Health Statistics and Medical Technologies and incorporating its functions into the newly established Centre of Health Economics (next point).
2009	Creation of the Centre of Health Economics (CHE) to replace the State Medicines Pricing and Reimbursement Agency and to take on some functions previously held by the PHA and the SCHIA.
2009	Reorganization of the Health Care Financing System: creation of the HPC to replace the SCHIA and to take over most of its functions.
2009	Incorporation of the State Agency Medical Library of Latvia into the Riga Stradins University (Medical University).
2009	Incorporation of the State Agency for Tuberculosis and Pulmonary Diseases into the State Agency Infectology Centre of Latvia.
2009	Reduction in the number of staff at the Ministry of Health and its agencies by 55%, from 1 319 in January to 593 in October.
2009	Rapid reduction in the number of hospitals providing statutory inpatient services from 72 to 43 (39 in 2012), although some of the hospital closures had been planned for a long time.

2009	Creation of the SEMS, centralizing and rationalizing the provision of emergency medical assistance in the country.
2009	Incorporation of the State Centre of Emergency and Disaster Medicine into the SEMS.
2009	Approval of the Safety Net Strategy by the Cabinet of Ministers. Funding was provided by the World Bank.
2010	Law “On the Rights of Patients”.
2009/10	Incorporation of seven small hospitals into six existing hospital unions.
2010/11	Development of voluntary and mandatory quality management systems for general practitioners (incorporated into the Regulations on Organization and Financing of Health Care).
2011	Cabinet approval of the Public Health Strategy 2011–2017.
2011	Cabinet approval of the “Regulation of the National Health Service”: creation of the NHS as the result of merging the HPC with the Centre of Health Economics.
2011	Start of e-health project funded by EU Funds and continuing until 2013.
2011/12	Reform of the reference pricing system through an amendment to the Regulations No. 803, regarding the Principles for the Determination of the Price of Medicinal Products (2005).
2012	Closing of the State Agency Infectology Centre of Latvia.
2012	Creation of the CDPC as the new national institute of public health.
2012	Economic evaluation (Data Envelopment Analysis) of four hospitals and discussion about their closure because of detected inefficiencies.
2012	Political decision to introduce the Nord-DRG system for hospitals: preparatory work for implementation (piloting will start in 2013).
2012	Reform of Regulations No. 899 (on the Reimbursement of Expenditures for Medicinal Products and Medicinal Devices), introducing 50% reimbursement for all prescription medicines (beyond those listed in the positive list) for children up to 24 months and 25% for all pregnant women (including up to 42 days after childbirth).

However, when analysing the content of reforms, substantial continuity can be observed throughout both stages of reform, although the second stage was, of course, much faster in pace and more radical in scope. The most important areas of reform were:

- shifting away from hospital care to ambulatory and home care;
- closing the chapter of the social health insurance experiment through the establishment of the NHS;

- concentrating state functions in fewer institutions – and reducing the number of staff;
- rationalizing NHS-paid pharmaceutical care.

Throughout the reforms, the Strategic Council of Health Care (2007) and the Chief Specialist's Institution (2009) were playing a role as consulting bodies. The Strategic Council consisted of delegates from professional medical associations, universities and hospitals. The Chief Specialist's Institution consisted of chief physicians and professors from different branches of medicine who were selected by the Minister of Health to become advisors. These consultation bodies aim to involve medical authorities in the decision-making process for health reform. However, sometimes personal or professional interests dominate and the idea of one selected expert – chief specialist group – was, in fact, inspired by structures that existed in the former Soviet Union.

6.1.1 Shifting away from hospital care to ambulatory and home care

For several years, the “Development Programme of Out-patient and In-patient Health Care Providers (2005–2010)”, the so-called Master Plan, determined the public investment plans in Latvia. The general aims of the plan were to downsize hospital care and to support the development of ambulatory care. During the first stage of reforms, the accessibility of day care services and specialist outpatient care was improved, with the aim of shifting patients away from inpatient care to outpatient care. Increased funding was made available for outpatient care, but inpatient funding was not reduced because of the increasing intensity of hospital care. However, the envisaged reorganization of the hospital sector, including a reduction in the number of hospitals and the incorporation of monoprofile hospitals (e.g. for trauma and mental health) into general hospitals, could not be implemented because of strong opposition from local communities and concerned politicians.

This changed in 2009, when dramatic budget cuts required a substantial reduction in the number of hospital beds, the transformation of hospitals into less intensive (and less costly) “care” hospitals and the closure or merging of hospitals. Consequently, the ongoing shift away from hospital care and towards service provision in ambulatory settings, was accelerated: the number of hospital beds was reduced (see section 4.1.2) and the number of day surgeries increased rapidly to compensate for reductions in inpatient surgical activity (see also sections 5.3 and 5.4). However, because much of the restructuring of

the health care system was implemented after official discontinuation of the Master Plan in 2009, it did not necessarily follow objective criteria but was also influenced by political opportunism.

6.1.2 Responding to the crisis: the Social Safety Net Strategy

The strong and accelerated shift away from hospital care to ambulatory care provision was strongly supported by the Social Safety Net Strategy enacted in October 2009. The main objective of the strategy was to protect vulnerable groups during the period of economic contraction and to mitigate the social costs of fiscal consolidation. The strategy formed part of a larger structural reform package developed by the Latvian government with support from the World Bank, the European Commission (EC) and the IMF, which aimed to respond to the economic crisis and to lay the foundations for medium-term improvements in the social sectors, including the health system.

The most important safety net measures concerning the health sector implemented between 2009 and 2011 were: (1) the exemption of needy persons (with income under LVL90 per month since October 2009) and people with low incomes (less than LVL120 per month between February 2010 and December 2011) from user charges; (2) free accommodation for needy and low-income persons in hotel-type hospital beds (in connection with travel for day surgery or chemotherapy); (3) the introduction of home care services for the chronically ill; (4) the development of day care centres for the mentally ill; (5) the provision of funding for an additional nurse at primary health care providers; (6) the development of a family physician advisory telephone service.

The introduction of exemption mechanisms from user charges was the most important safety net measure. From October 2009, needy persons (with income below LVL90 per month) were exempted from all user charges (for inpatient and outpatient care as well as for medications). Exemptions were extended in February 2010 to people with low incomes (less than LVL120 per month), and user charges for inpatient and outpatient stays (but not for outpatient pharmaceuticals) were reduced by 50% for people with an income between LVL120 and LVL150. The introduction of exemptions made it possible for needy or low-income persons to receive health care free of charge as long as they followed the normal patient pathway (see section 5.2) and obtained referrals from their GPs for other services. Traditionally, social assistance to low-income households was the responsibility of local governments, which often provided reimbursement for user charges – but patients had to pay first and apply for reimbursement later. Therefore the Social Safety Net Strategy

constituted a major improvement of the situation for the needy and low-income households and local governments now had an incentive to identify the needy who would then be eligible for free medical care. However, in 2012 exemptions for persons with low income were discontinued and only needy persons (income below LVL90) are still exempted from user charges.

All other measures of the Social Safety Net Strategy strongly supported the shift away from hospital care to ambulatory and community care. The aim of covering home care services for the poor chronically ill was to keep patients out of hospitals and to reduce the need for (costly) emergency medical services by improving the care that patients receive at home. Free hotel-type accommodation was made available to the poor because the provision of outpatient or day care services coupled with the concentration of services in fewer centres may require patients to travel long distances in order to receive treatment.

As the shift to ambulatory care increased the workload of general practitioners, the safety net strategy also provided funding (via increases of GP contracts with the NHS) for an additional nurse to be hired by approximately half the GPs and primary health care providers. This measure was originally intended only for primary health care providers in rural areas but later (in 2010) was extended to family doctors' practices in cities. Furthermore, in 2010, emergency safety net funds were made available to develop an advisory telephone service connecting patients to a doctor at their family doctor's surgery after working hours and during weekends. The idea was to extend access to primary care services to 24 hours a day across the country and to deal with uncomplicated cases through this low-cost alternative, which may contribute to avoiding unnecessary emergency ambulance calls or emergency hospital visits. The service became operational in 2011.

Funding for the Social Safety Net Strategy was available from a World Bank loan only until the end of 2011. In 2012, some elements were included in the state budget but others had to be discontinued (e.g. user charge exemptions for low-income households). From 2013 onwards, most of the Social Safety Net measures will be in the state budget, although the available funding is insufficient for the financing of all measures.

6.1.3 From the remnants of a social health insurance experiment to the NHS

Since the late 1990s, Latvia had progressively moved away from the aim of developing a fully fledged social health insurance system. Territorial sickness funds were merged into larger units and their independence was reduced. A national agency, originally introduced in 1996 as the Central Account Fund and later renamed the SCHIA, gained increasing importance (see section 2.2), with individual sickness funds turned into branch offices of the SCHIA. In 2005, the earmarking of a proportion of the collected personal income tax for health care was discontinued. The resulting “mixed” system in place in 2007/2008 was described by Tragakes et al. (2008) as “a unique combination of general tax-financed statutory health care provision, within a social insurance institutional structure”.

Since then, the remnants of the social health insurance institutional structure have been dismantled, although this was not the aim of the reform, and the purchaser–provider split has been retained. In October 2009, the health care financing system was reformed. Two new institutions were created: the HPC, assuming the purchasing and pooling functions of the SCHIA; and the CHE, taking over functions previously held by the State Medicines Pricing and Reimbursement Agency and some other functions of the SCHIA, such as calculation of tariffs or the development of new payment systems.

The idea of the reform was to create two independent institutions, one for purchasing and one for economic analysis, but overlap in responsibilities for the evaluation of medicines and tariffication of services often led to discussions and deadlock. In addition, it was felt that Latvia, as a small country, did not need two institutions for similar purposes and that the successful development of e-health applications required close collaboration between both institutions. Therefore, in 2011, the Cabinet of Ministers approved the “Regulation of the National Health Service”, creating a new institution, the NHS, by merging the HPC and the CHE. As a result of the reform, the NHS is now the most important national institution for the implementation of health policies, administering the financial resources of the state, determining the contents of the benefits package, contracting with providers, implementing the e-health system and registering clinical guidelines and medical technologies.

6.1.4 Concentration of state functions and reorganization of public health institutions

In the first stage of reforms, public health bodies were reorganized in order to reduce the excessive number of institutions and to increase the effectiveness of public health. The PHA incorporated the Centre of AIDS Prevention, the Narcology State Agency, the Mental Health State Agency and the Health Promotion Agency (see Box 6.1). However, in 2009, the reduction of administrative expenditures became the main motivating factor for institutional reforms. In fact, between 2009 and 2012, the number of employees of the Ministry of Health and its agencies was reduced by 55% (Cabinet of Ministers, 2012). Numerous agencies were closed down within one year, including the State Agency of Health Statistics and Medical Technologies, the State Centre of Medical Professional Education and even the previously strengthened PHA (see Box 6.1). The financial pressure leading to the closure of these institutions was so high that the process was at times chaotic, lacking a clear plan about which institutions would take over responsibilities for the functions previously held by the closed down institutions. In fact, the closure of the PHA left almost all public health functions in Latvia unassigned for three years.

Simultaneously, a reform of the emergency medical services in Latvia was undertaken in order to save financial resources and to increase the efficiency of service provision in the pre-hospitalization phase (“Regulation of State Emergency Medical Service”, No. 1480). Municipalities were often in strong opposition to the reform but the Ministry of Health was able to carry it through. As a result of the reform, the emergency care services of 39 municipalities, each with its own unique structures for the provision of emergency care, were merged into the SEMS under the supervision of the Ministry of Health. Consequently, the accessibility and quality of emergency care in most of the country has been harmonized and inefficiencies have been reduced (see also section 5.5).

The final reorganization of public health institutions took place in 2012: the CDPC was founded as the new national public health institute. It has taken over the monitoring and control functions previously held by the closed down Infectology Centre, while the treatment of infectious diseases, also previously carried out by the Infectology Centre, has become the responsibility of Riga East University Hospital. The aim of the reform was to separate the treatment and control functions for infectious diseases, which seems to be useful for avoiding potential bias in reporting and which is in line with international practice. In addition, the CDPC assumed responsibility for several public health functions, which had been left unassigned after the closing down of

the PHA. The responsibilities of the CDPC include maintaining and analysing statistics (mortality, cause of death) and public health surveys and monitoring addiction and mental health (see also section 2.7.1). In addition, it will play an important role in disease prevention and health promotion for both infectious and non-infectious diseases.

6.1.5 Rationalization of pharmaceutical care

In 2012, after hard and controversial discussions, Regulations No. 899 (on the Reimbursement of Expenditures for Medicinal Products and Medicinal Devices) were amended by the government to rationalize pharmaceutical care provided by the NHS. The old reference pricing system for pharmaceuticals in the reference list (List A – see section 2.8.4) assigned individual products with similar chemical/therapeutic characteristics into groups of products (reference groups) for which the NHS paid the same price (reference price). Pharmacists or patients could choose one of the products belonging to the reference group and if the pharmaceutical product was more expensive, patients could pay the difference between the reference price and the actual OOP price (in addition to the regular drug co-payment). The new regulations determine that there is only one pharmaceutical product in a reference group (the one with the cheapest price). Prescriptions for new patients now have to specify the active ingredient and pharmacists have to dispense this, which is the cheapest medicine of the reference group. If patients were to choose a different product, they would have to cover the full price out of pocket.

The new system stimulates competition between pharmaceutical companies because they have to rapidly decrease their prices in order to receive the status of reference medicine. It is estimated that this has resulted in savings of about LVL3.7 million (€5.3 million) in 2012, when the NHS was able to achieve price reductions for 600 pharmaceuticals (see section 2.8.4). However, pharmaceutical companies and medical professionals strongly opposed the reform, allegedly because of the limitations it imposed on patient choice.

6.1.6 On-going areas of reform: quality management, e-health and hospital payment

Since 2009, accreditation of health care providers for inpatient and outpatient care, which was long considered a cornerstone of the quality management system, is no longer mandatory but has instead become voluntary. In 2010/2011, voluntary and compulsory quality incentive systems were introduced for general practitioners. The compulsory system sets a number of criteria, which have to

be achieved by GPs if they want to receive their full capitation budget (non-pay for non-performance). The voluntary system incentivizes GPs to increase quality in order to get more money (pay for performance) (see also section 3.7.1). Quality criteria are intended to improve disease prevention and health promotion and were inspired by the UK Quality and Outcomes Framework scheme in primary care. However, only 8.6% of all GPs participated in the voluntary scheme in 2012 because quality criteria are difficult to reach (no one completed the criteria in 2011) and financial benefits are relatively small (no GP received any payments in 2012). Therefore, a reform of the system is currently under debate in order to develop a more comprehensive system of quality bonuses.

Another reform element, which is believed to increase quality of care and reporting, is the development of the e-health system in Latvia. Since 2010, a system has been implemented that allows patients to obtain information via the internet about all NHS-paid health services that they received. The system has quickly become popular and medical professionals are paying increasing attention to reporting as patients' ability to control their work has considerably increased. However, e-health applications are far from complete and a lot of work is still ongoing (see section 6.2).

Last but not least, a decision was taken in 2012 to introduce the Nord-DRG system in hospitals. However, the work has only just started and piloting in hospitals is planned for 2013 (see section 6.2).

6.2 Future developments

Current developments in the Latvian health sector are taking place in a much improved economic context. In 2012, the economy was growing at an annual rate of above 5% during the first three-quarters, although the annual GDP is predicted to remain almost 15% below its size in 2008 (World Bank, 2012). However, the health care sector is not of high priority and according to estimates by the Ministry of Health, only 3.4% of GDP will be spent on health by the government in 2012.

A serious problem in 2012/2013 is the progressive discontinuation of a number of Social Safety Net measures, for which sufficient funding is unavailable. For example, since January 2012, persons with low income (between LVL90 and LVL120) are no longer exempted from user charges, although exemptions for needy households (with an income below LVL90) for all health care services

(including prescription pharmaceuticals) are still available (financed by the Ministry of Health). In addition, the provision of hotel-type accommodation in hospitals and of free home care services for the chronically ill was discontinued. Several health care providers fight for increased financial allocations as they have difficulty in maintaining their facilities and using medical technologies, which were purchased or improved in the past. Increased funding for health (the government expenditure target is 4.5% of GDP by 2014) as well as a continuation of structural reforms, which have to include the further development of outpatient treatment capacity, is currently a high priority of the Ministry of Health to ensure sufficient resources and to improve efficiency. Finally, much work needs to be done for the improvement of quality systems and to develop disease management programmes for chronically sick patients.

Latvia's Public Health Strategy 2011–2017 represents an important reference point for the development of Latvia's health system. It marks a departure in approach from the previous system due to the development of integrated approaches to prevention and treatment and involving public health as well as primary, secondary, tertiary and emergency health services (Cabinet of Ministers, 2012). Strategies in specific areas include improvements in mother and child health, non-infectious disease prevention and infectious disease control, ensuring a healthy and safe environment as well as effective management of the health care system. The newly created CDPC (under the Ministry of Health) plays a key role in monitoring and evaluating progress towards the agreed targets.

The current government has announced the following objectives to be pursued in the area of health during its time in office:

- To increase public expenditures on health to 4.5% of GDP by 2014 through the introduction of a health insurance system (see details below).
- To improve the functioning of the health care system through long-term and coherent financial planning as well as through better use of the health care infrastructure, e.g. developing hospital networks and reference centres.
- To implement human resource development activities, including a new salary policy.
- To implement the e-health system.
- To implement a DRG system for hospital payment and to develop a quality bonus system for hospitals and GPs.
- To improve cooperation between SEMS, GPs and the home care system.

- To implement new regulations and activities regarding state financing for pharmaceutical products.

One of the main priorities of the Ministry of Health is to implement a compulsory health insurance or – at least – to link eligibility to receive health services to the payment of an earmarked income tax. The reason for this is that the current system of financing falls short in meeting the health needs of the population and there is little political or public support for increasing the share of the government budget to be allocated to health. As a result, OOP payments, in particular for pharmaceutical care, continue to be high and waiting times are increasing, which further increases dissatisfaction with the health system. A significant proportion of the population either does not pay income tax or does not pay as much as they should. The government hopes that it can increase the population's willingness to contribute financially to the health system if it links entitlement to payment of contribution as is the case in social health insurance systems. However, linking entitlement to payment of contribution may mean a move away from universal population coverage and this will need to be managed extremely carefully to avoid adverse effects.

Concerning planning and organization of the health system, the priorities are to develop long-term investment plans and to improve hospitals' administrative capacities. Structural reforms will continue in the direction of optimizing the use of hospitals and to support primary care and day-treatment options and to expand the newly introduced home care system. In addition, there are some discussions about merging of hospitals (e.g. integrating psychiatric hospitals into general hospitals) and also concentrating hospital care in fewer but larger hospitals by closing down some local hospitals.

In 2012, first pilots of the e-health system started, which in its final form will include e-receipts, e-health records, e-bookings, e-referrals and an e-portal. The full system is scheduled to go online some time in 2013. However, there are still considerable differences concerning the availability of e-health infrastructure in institutions, with some having established electronic patient records whereas others are lagging far behind. In addition, data security remains a difficult issue. Yet, given the advantages of the e-health system, such as faster exchange of information, involvement of patients and considerable support from medical doctors, the NHS is optimistic that it will be able to resolve these issues.

One important area of reform in the next two years is the introduction of the Nord-DRG system in hospitals, which is scheduled to be implemented as a payment system in 2014. The decision in favour of a DRG-based payment

system was made in joint discussions between the Ministry of Health, hospitals and the hospital association. All institutions, including the union of medical professionals, were supportive of the idea, in particular, because the use of DRGs will increase transparency in the inpatient sector, both concerning performance (as it will allow evaluating the complexity of patients treated in different institutions) and resource allocation (as resources will be allocated according to the number and type of patients treated). This is seen to be a considerable advantage when compared to the current payment system, where resource allocation does not always follow rational criteria. The NHS is responsible for the introduction of the DRG system in Latvia and will start pilot tests of Nord-DRGs in 2013, which will also include a transition to the Nordic Medico-Statistical Committee (NOMESCO) classification system.

7. Assessment of the health system

Concerning most performance criteria, such as health status, financial risk protection, and patient satisfaction, Latvia continues to lag behind not only the “old” EU member states, but also countries that joined the EU in 2004. Despite a considerable increase in life expectancy between 2000 and 2010, average life expectancy in Latvia was only 73.5 years in 2010, approximately eight years below the EU27 average for males and four years below the average for females. Moreover, indicators that are more sensitive to health care – infant mortality and life expectancy at age 65 – remain unfavourable when compared to the averages of the EU as well as EU members since 2004 or 2007.

The financial risk protection offered by the Latvian health care system is insufficient, as seen by the high share of OOP payments (as a percentage of THE) and the high percentage of the population forgoing medical treatment because of costs. The share of OOP payments as a percentage of THE was almost 38% in 2010, far above the 26% in Lithuania and the 20% in Estonia, and was, in fact, one of the highest in Europe. Almost 14% of the Latvian population reported an unmet medical need because of costs, while this number was below 1% in Estonia, Lithuania, Slovenia and most other EU member states. Furthermore, important inequities were evident as the proportion of the population with unmet medical needs was much higher in the poorest income quintile (34%) than in the richest income quintile (13%).

According to a Eurobarometer survey in 2011, most Latvians rated health care provision in their country as bad (66%), whereas only 30% judged it as good, earning Latvia the fourth lowest rank among EU countries. The majority (58%) said that the situation had deteriorated, and 63% expected it to remain the same for the next year, while an additional 23% expected it to worsen.

The deficiencies in the performance of the health care system can be partially attributed to the lack of financial resources in the context of the global economic and financial crisis, which posed an enormous challenge to the government to ensure the availability of necessary health care services for the population and to prevent deterioration of health status. Between 2008 and 2010, the government succeeded in steering the health system in the right direction. It substantially reduced the excessive hospital bed capacity, which has now dropped to the level of the other EU12 countries, while at the same time prioritizing primary care and services for children and pregnant women as well as emergency assistance and pharmaceuticals to prevent – as far as possible – negative consequences for population health.

The recently approved Public Health Strategy 2011–2017 has the potential to contribute to the desired improvements of population health status as it is based on a strong intersectoral approach and focuses attention on the major problem of cardiovascular diseases in Latvia. However, in order to improve performance of the health care system, increasing public expenditure on health and reducing the enormous dependence on OOP payments seems to be inevitable. Furthermore, there is also a need for continuing efforts to improve efficiency through structural reforms, including reductions in excess infrastructure and further improvements to the primary care system.

7.1 Stated objectives of the health system

After independence in 1991, health care reforms in Latvia were often undertaken in a piecemeal and experimental fashion and progressed over the years without officially stated common goals and objectives. This changed for the first time in 2001, when the Cabinet of Ministers approved the Public Health Strategy and its Action Plan for 2004–2010. Recently, in 2011, the Cabinet approved its second Public Health Strategy, now for the period 2011–2017. The new strategy has the stated aim “to prolong the healthy life years of the Latvian population and to prevent untimely deaths, while maintaining, improving and restoring health”. More specifically, the aims to be achieved by 2017 are to increase by two years the healthy life years of individuals and to decrease by 20% the potential years of life lost. The plan sets out six strategic objectives, which include the elimination of inequities in the field of health, improvements in three main areas (infectious diseases, non-infectious diseases, and mother and child health), promotion of a healthy work environment and ensuring effective management of the health care system (Ministry of Health of the Republic of Latvia, 2011).

To meet the objectives of the previous Public Health Strategy (2004–2010), several policies in specific areas were elaborated, including health care provider development (the Development Programme for Out-patient and In-patient Health Care Services Providers 2005–2010; Government of Latvia, 2004), e-health (e-Health in Latvia 2008–2010; Cabinet of Ministers, 2007), mental health (Population Mental Health Improvement 2009–2014; Cabinet of Ministers, 2008) and health care human resource (Human Resources Development in Health Care 2006–2015; Cabinet of Ministers, 2006). However, implementation of these policies was compromised in several cases by lack of financial resources resulting from the global economic and financial crisis, which has caused severe macroeconomic and fiscal imbalances in Latvia. Yet, in other cases, fiscal consolidation measures have also contributed to achieving certain objectives. For example, budget cuts on inpatient expenditures have accelerated the shift in health care provision towards outpatient and hospital day care procedures, which was envisaged in the Development Programme for Outpatient and Inpatient Health Care Services Providers 2005–2010. The e-health strategy is being implemented with a slight delay because of the complexity of the process, which has been hampered by insufficient administrative capacity, procurement delays and judicial reviews.

In general, looking at the implementation of the aims and activities defined by the Public Health Strategy in 2001 and its Action Plan for 2004–2010, some positive developments have taken place (Centre of Health Economics, 2010). Morbidity levels with vaccine-preventable diseases (e.g. diphtheria, tuberculosis) have decreased significantly (although vaccination coverage has recently decreased, see section 5.1) and breastfeeding indicators have improved (see section 1.4). However, negative trends have also been observed concerning lifestyle changes (being overweight, smoking, lack of physical activity) and morbidity (incidence and prevalence) with diabetes (see section 1.4). The average life expectancy of newborns, which was used as a summary indicator for success of the public health strategy, has increased by more than three years between 2000 and 2010. However, the objective of achieving 95% of the average EU life expectancy was not reached – life expectancy in Latvia in 2009 was about 73 years, more than six years below the EU27 average of almost 79 years (WHO Regional Office for Europe, 2012b). One of the key reasons for the insufficient success of the previous Public Health Strategy was the lack of a strong intersectoral approach to health improvement. Therefore, the new strategy for the period 2011–2017 places a particularly strong emphasis

on intersectoral approaches and health in all policies. The active participation of multiple ministries and municipalities in the development of the new strategy gives proof of the high political support for this approach.

7.2 Financial protection and equity in financing

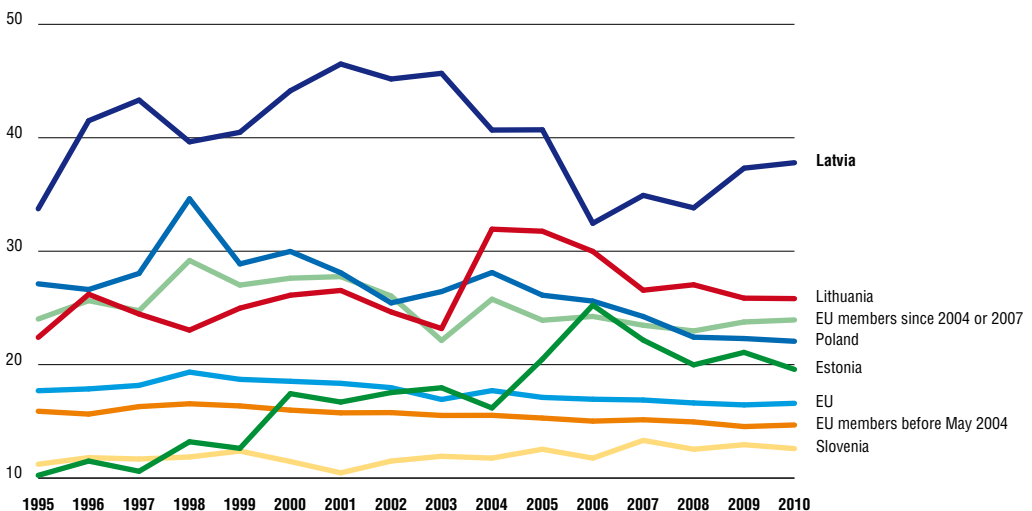
7.2.1 Financial protection

The degree of financial protection provided by a health system is determined by the extent to which people are protected from the financial consequences of illness. If the population has to pay a large share of THE out of pocket, financial protection offered by the health system is limited.

In Latvia, the share of OOP payments as a percentage of THE was almost 38% in 2010, far above the 25.8% in Lithuania and the 19.6% in Estonia (see Fig. 7.1). Although there has been considerable improvement in Latvia since the early 2000s, when the share of OOP payments was still above 45%, the relatively high percentage of such payments (compared to regional and EU averages) indicates that financial protection remains insufficient.

Fig. 7.1

Private households' OOP payments on health as percentage of total health expenditure, 1995 to latest available year

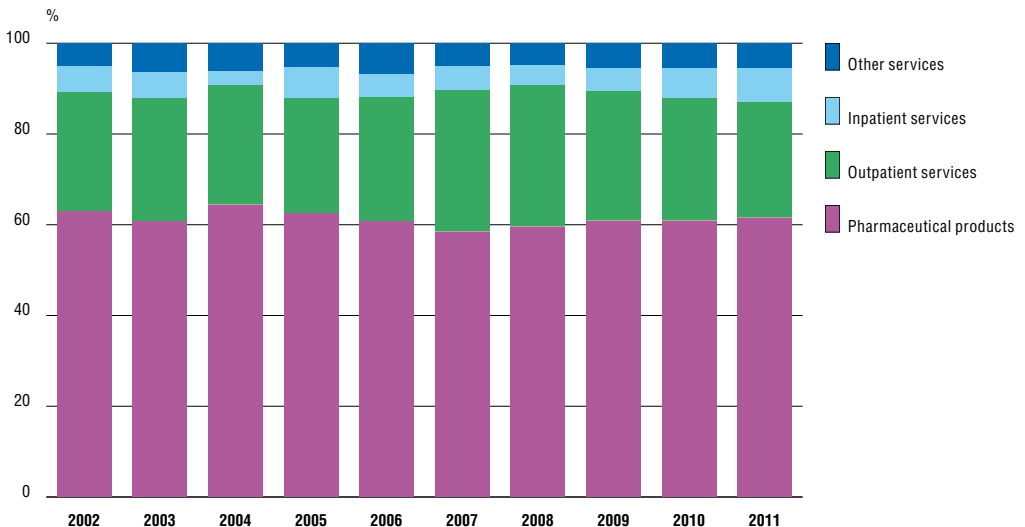


Source: WHO Regional Office for Europe, 2012b.

The most important reason for the high share of OOP payments in Latvia is that the NHS offers only relatively limited coverage for prescription drugs, both in scope (the type of illnesses covered) and in breadth (the extent of co-insurance and co-payments required) (see section 3.4.1). In 2010, more than 60% of OOP payments was spent on drugs, while only about 27% of OOP payments was spent on outpatient services (Fig. 7.2) and this distribution has remained relatively unchanged over the past decade. Patients have to pay the full price of all OTC drugs and for a significant number of prescription drugs, as coverage is limited only to certain medical conditions, such as diabetes, cancer and mental disorders. Patient expenditures for OTC drugs and non-reimbursed prescriptions drugs have been estimated to account for about 50% of all pharmaceutical OOP payments (World Bank, 2010). Furthermore, while co-payments for most NHS-covered health services (i.e. inpatient care, ambulatory care) are capped at LVL400 (€570) per person per year, this limit does not apply to prescription drugs. In addition, dental care is covered by the statutory system only for children up to 18 years.

Fig. 7.2

Components of OOP payments per household member



Source: Central Statistical Bureau, 2012d.

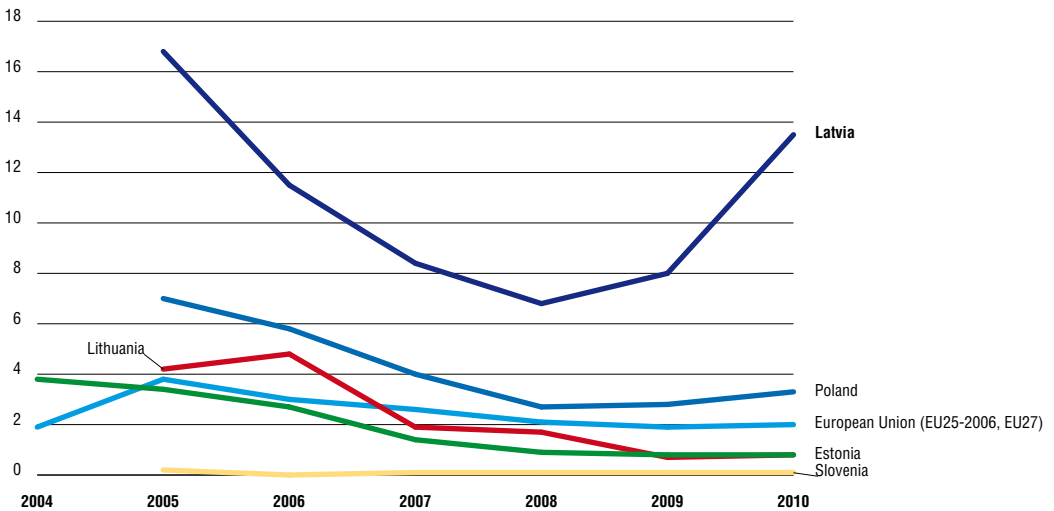
Limited financial protection is problematic for two main reasons: (1) the costs of medical care may consume a large (and sometimes catastrophic) share of the available income and lead to households being pushed into poverty

and (2) it reduces the ability of households to access needed care. In general, limited financial protection affects lower income households more because even comparatively small amounts of OOP payments may constitute a large share of household income.

Data from the European Union Statistics on Income and Living Conditions (EU-SILC) survey indicate that Latvians were much more likely than other EU citizens to forgo medical examination or treatment because it was too expensive (see Fig. 7.3). In 2010, 13.5% of Latvian respondents said that they had forgone care because it was too expensive, while this number was below 1% in Estonia, Lithuania, Slovenia and most other EU member states. When examining the trend over time, it is clear that the percentage of people not obtaining care because of costs increased greatly since the start of the financial and economic crisis in Latvia. Of course, for lower income households, the situation is even worse, which is evident from the 27% of Latvian SILC respondents in the first income quintile who said that they had forgone care because it was too expensive (see section 7.3.2).

Fig. 7.3

Percentage of self-reported unmet needs for medical examination or treatment because it was “too expensive”



Source: Eurostat, 2012e.

To protect lower income households against high OOP payments, exemption mechanisms are important and may improve financial protection against user charges – at least for exempted individuals. In October 2009, the Latvian government introduced exemption mechanisms for the needy (with a per capita income below 50% of the minimum wage) and in 2010 and 2011 lower income households (with an income between LVL90 and LVL120) were also exempted from user charges within the scope of its Social Safety Net Strategy (see section 6.1.2). The effect of this policy will possibly be observable in new EU-SILC data from 2011. In addition, if the government took steps to lower the prices of non-reimbursable drugs (e.g. by determining that drugs are not to be sold at higher prices than in other Baltic countries), the considerable burden of OOP payments for non-reimbursable drugs might be reduced.

However, most importantly, financial protection of the (entire) population could be improved, if the share of OOP payments on health was reduced. According to the Public Health Strategy, the government intends to increase the public expenditure on health as a percentage of GDP from 3.6% in 2011 to 4.5% by 2014 and 5.0% by 2017. If this money is used wisely, i.e. for expanding public coverage of prescription pharmaceuticals, improving the social safety net, and including dental care in the benefits basket, financial protection of the population can be expected to improve.

7.2.2 Equity in financing

Equity in financing is most often associated with the concept of vertical equity (Wagstaff & van Doorslaer, 2000). Vertical equity refers to the idea that people with a greater ability to pay should pay more than people with a lower ability to pay. Equity in financing is best achieved with a progressive financing system (WHO, 2000), i.e. one where higher income individuals pay a larger share of their income, while lower income individuals contribute a smaller share of their income. A progressive tax system offers the potential for greater vertical equity than proportionate taxation. OOP payments are usually regressive and have the lowest potential to ensure vertical equity.

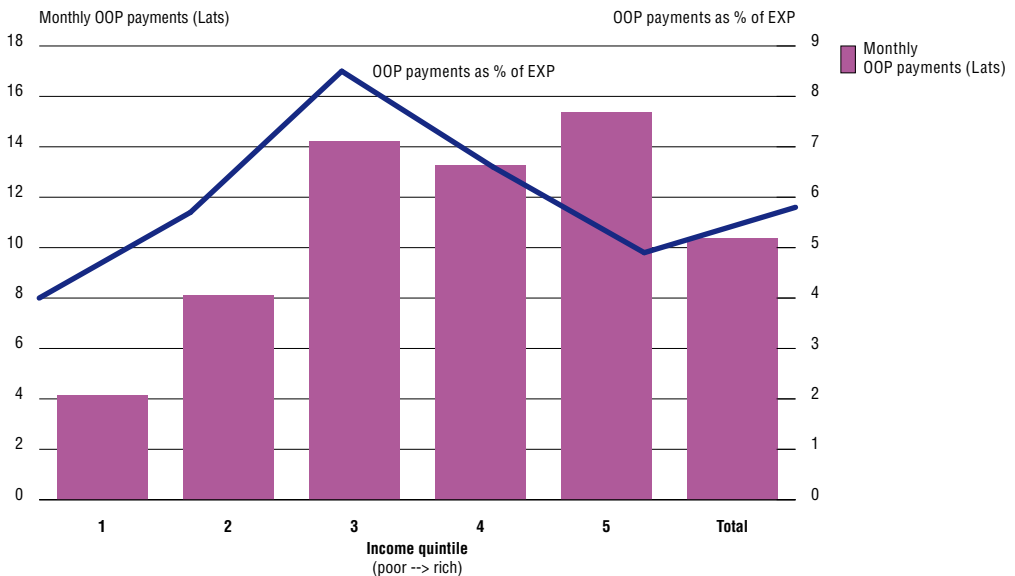
In Latvia, more than 60% of total health expenditures come from general tax revenue (see Chapter 3). Therefore, equity in financing depends most importantly on the progressivity of the tax system. To measure the progressivity of a tax system, the Kakwani index is one of the most widely used approaches. If the index is positive, the system is progressive. If the index is negative, the system is regressive. If the index is zero, the system is proportional. Vanags (2010) has recently assessed the progressivity of the Latvian tax system using

the Kakwani index following the implementation of a tax reform in 2010. He found that direct taxes (e.g. income tax) are progressive, with a Kakwani index of 0.16, while indirect taxes (e.g. VAT), with a Kakwani index of -0.14 , are regressive. Taking both types of taxes together, the Latvian tax system was found to be slightly progressive, with a Kakwani index of 0.048. Since then, a number of small increases and subsequent reductions of personal income tax, as well as increases and subsequent reductions of VAT have been implemented (Leionen, 2012). Nevertheless, Vanags' overall assessment of the tax system's progressivity is unlikely to have been greatly affected.

However, overall progressivity of the health financing system needs to be interpreted in view of the large share of OOP payments in total health expenditures. Fig. 7.4 shows that the third income quintile spends 8.5% of total household expenditures on OOP payments, while this share is smaller for both the two richer and two poorer quintiles. The richest quintile spends the second lowest share of total household expenditures on OOP payments. The smallest share is spent on OOP payments by the lowest income quintile, which may indicate that the implemented safety net measures were effective at protecting the lowest quintile from excessive OOP payments.

Fig. 7.4

Average monthly OOP payments per household member (left axis) and OOP payments as percentage of household expenditure (right axis) by income quintile, 2010



Source: Central Statistical Bureau, 2012d.

In summary, while the tax system is mildly progressive and OOP payments as well as tax subsidies for VHI are, at least for higher income groups, strongly regressive, the overall progressivity of the Latvian health care financing system remains somewhat unclear. Most likely, it is roughly proportional – maybe mildly regressive – which is not unusual when looking at international health care financing systems (Wagstaff et al., 1999). If current reform proposals of switching to a compulsory health insurance system will lead to increased income tax financing for health – by earmarking a large proportion of personal income tax revenue for health, as was the case prior to 2005 – and reduce the reliance on OOP payments, they may contribute to a more progressive health care financing system.

7.3 User experience and equity of access to health care

7.3.1 User experience

A number of national and international sources of information exist on user experiences and population views about the Latvian health care system. Two European Commission surveys and the European Consumer Index (Health Consumer Powerhouse, 2012) show that the Latvian population has a rather negative view of its health system.

In 2011, a Eurobarometer survey assessed consumer opinion on health care. Most Latvians rated health care provision in their country as bad (66%), whereas only 30% judged it as good (European Commission, 2011), earning Latvia the fourth lowest rank among EU countries. When asked how current health care provision compared to that received five years ago, the majority reported that the situation had deteriorated (58%), while 33% said that it had stayed about the same and only 5% thought it had improved. Moreover, Latvians were not optimistic about the future of the health system: 63% expected it to remain the same for the next year and 23% expected it to worsen (European Commission, 2011). Furthermore, according to another Eurobarometer survey (European Commission, 2010), 65% of Latvian respondents think that the quality of healthcare in Latvia is worse compared to other EU member states.

According to the 2010 EU-SILC survey, the share of the Latvian population reporting an unmet need for medical examination or treatment was 21.8 (see Table 7.1). No other country of the EU has a similarly large proportion of the population reporting an unmet need (the second highest unmet need is reported for Bulgaria with 15% of the population). In Latvia, there was a

considerable improvement between 2005 and 2009, with a reduction from 30% to 15%. However, in 2010 the unmet need strongly increased, principally because of financial reasons (see section 7.2.1), with the lowest income group reporting the largest unmet need (see section 7.3.2).

Table 7.1

Self-reported unmet needs for medical examination or treatment by reason, 2010

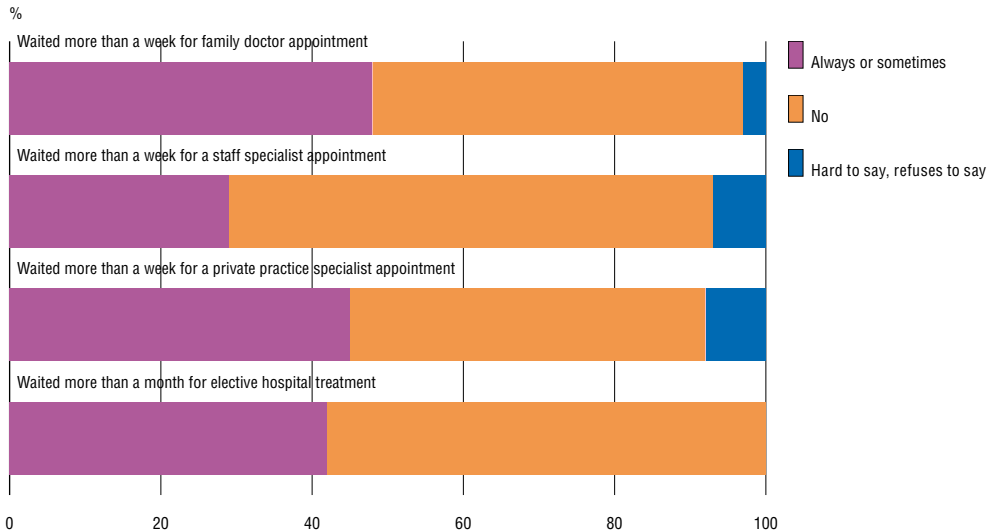
	2005	2006	2007	2008	2009	2010
Too expensive	16.8	11.5	8.4	6.8	8.0	13.5
Too far to travel	0.6	0.8	1.2	0.7	0.5	0.5
No time	3.8	3.9	3.2	3.7	1.8	1.9
Didn't know any good doctor or specialist	0.9	0.6	0.8	0.6	0.4	0.4
Waiting list	1.8	2.6	3.0	2.5	1.3	1.2
Fear of doctor, hospital, examination or treatment	0.8	0.7	0.7	0.4	0.4	0.5
Wanted to wait and see if problem got better on its own	4.5	5.8	6.5	4.2	3.3	3.4
Other reasons	0.8	0.7	0.7	0.5	0.2	0.4
Total	30.0	26.6	24.5	19.4	15.9	21.8

Source: Eurostat, 2012e.

Although Latvia does not routinely conduct systematic surveys to gauge public perception of the health system, two surveys were conducted in 2008. One was commissioned by the SCHIA and was a representative survey of 18–74-year-olds to assess Latvians' views on receiving state-paid health care services (SCHIA, 2008). The other was a survey conducted by the CSB in the context of the European Health Interview Survey (Central Statistical Bureau, 2009). According to the SCHIA survey, 77% of the population were either completely or partially satisfied with their family doctor and only 16% were completely or partially dissatisfied. However, positive responses to a more general question about the possibility to gain access to state-paid care were much rarer, with only 50% saying it was good or somewhat good and 36% saying it was somewhat or completely bad. In the CSB survey, the numbers were slightly worse with only 61% being either rather or very satisfied, while about 14% were rather or very dissatisfied with their family doctor (Central Statistical Bureau, 2009). Hospitals scored considerably worse, with only 38% rather or very satisfied and 18% rather or very dissatisfied.

In addition, the SCHIA survey provides information about waiting times: almost 60% reported waiting at least a month for an elective hospital procedure. About half of GPs and private specialists were accessible within a week. Staff specialists in clinics were much less available (see Fig. 7.5).

Fig. 7.5
Patient-reported waiting times, 2008



Source: SCHIA, 2008.

Finally, the European Health Consumer Index produced by the Health Consumer Powerhouse (2012) assesses the “consumer friendliness” of health care systems in Europe. The index summarizes information from a wide range of indicators, including waiting times, informal payments, prevention activities, health outcomes, access to pharmaceuticals and patients’ rights and information. The index has received widespread attention internationally, although the positioning of a country in the overall ranking should be interpreted carefully. Latvia scores quite badly on the index, having one of the lowest scores, just above Romania and Bulgaria, while the other Baltic countries, i.e. Lithuania and Estonia, have scored considerably better.

However, while public perception of the health care system remains relatively negative, the Latvian government has undertaken important steps to improve patients’ rights. Since 2010, when the “Law on the Rights of Patients” came into force, patients have had the right to receive information about their diagnosis and a plan of examination and treatment. They also have the right to consent or refuse medical treatment and to obtain medical documents (see section 2.9.3).

7.3.2 Equity of access to health care

Equity of access is associated with the concept of horizontal equity, which in the area of health care is interpreted to refer to equal access for equal need. Access to services depends on a number of factors – including financial, geographical and informational – and barriers to care may exist in all of these.

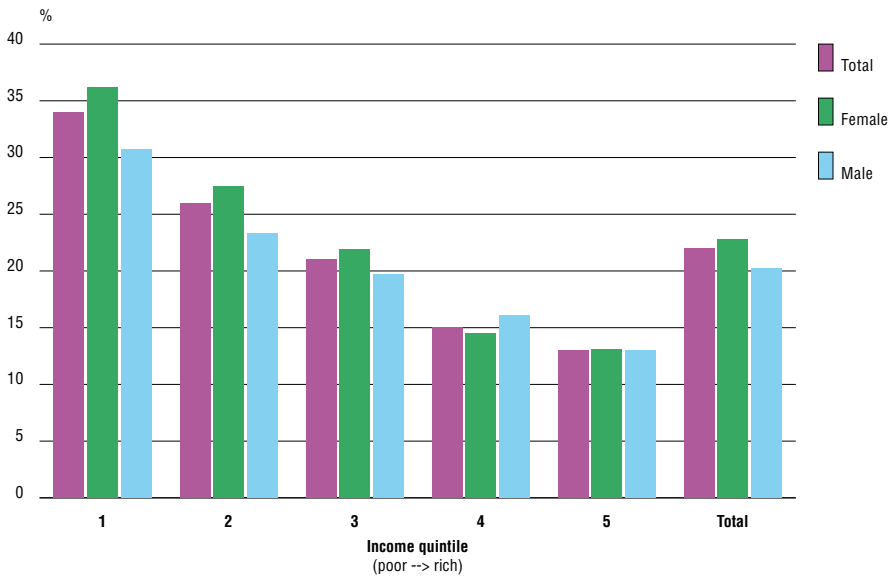
Equity in access is a serious issue in the Latvian health care system. On the positive side, entitlement to health care services is universal, equal access is an important policy objective (e.g. in the Public Health Strategy) and the range of statutorily financed services tends to be quite comprehensive. Even during the economic crisis, the government has implemented an impressive set of emergency social safety net measures to protect vulnerable groups and to ensure equity of access (see section 6.1.2). Most importantly, the implemented Social Safety Net Strategy introduced at least temporarily – exemption mechanisms from user charges for needy and low-income households. In addition, a number of measures were introduced to improve accessibility of services. These included: (1) the introduction of free hotel-type accommodation in hospitals for needy and low-income patients from remote areas who would otherwise be unable to travel back home after having received day care services in hospitals; (2) free home care services for chronically ill patients to remove financial barriers (for example, travel expenses and hospitalization expenses); (3) improved staffing at GP practices by hiring an additional nurse in approximately half of all primary care providers to help them cope with their increased role resulting from reduced financing for secondary outpatient and hospital care; (4) the introduction of a family physician advisory telephone service to connect patients to a doctor after working hours and at weekends (when family doctor offices are closed); and (5) the establishment of day centres for mental health to provide services in the community and to better integrate patients in society.

However, difficulties in equity of access arise due to severe shortages in funding for health care, in particular since the onset of the financial and economic crisis. This has led to two major consequences. Firstly, health care services provision often focuses on emergency care and certain specific serious conditions, which sometimes lead to long waiting periods for non-emergency care. Secondly, user charges for virtually all services compromise the ability of low-income individuals (if they do not fall below the threshold qualifying them for exemptions under the Social Safety Net Strategy) to receive the health care services and pharmaceuticals they need.

Data from the EU-SILC survey (2010) show that almost 35% of lower income groups report an unmet medical need, while this figure is only slightly above 10% in the highest income quintile, indicating important inequities in access to care. Also females reported a greater unmet need than males and the gradient between lower income groups and higher income groups was even greater than for males (Fig. 7.6).

Fig. 7.6

Self-reported unmet needs for medical examination or treatment by sex and income quintile, 2010

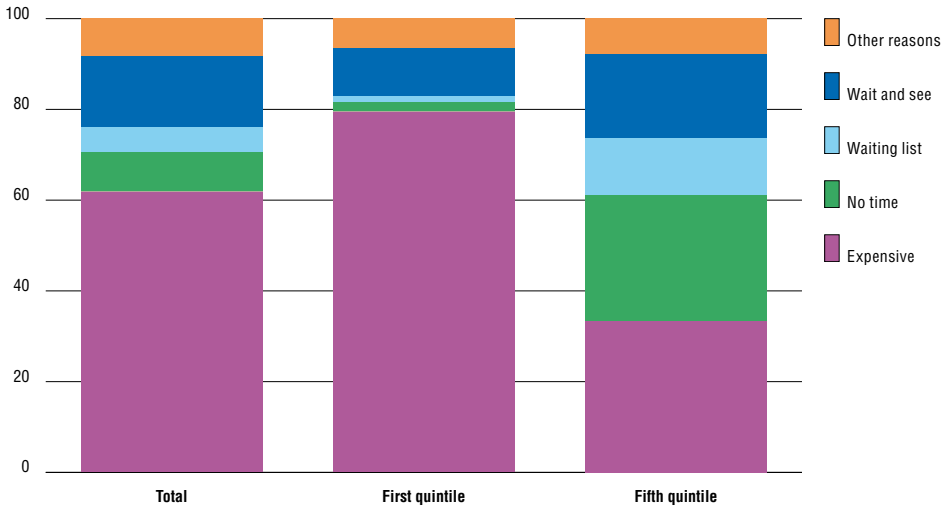


Source: Eurostat, 2012e.

Fig. 7.7 clearly shows that financial barriers are the main reasons for inequity in access. For the poorest quintile, almost 80% of people reported financial constraints as the reason for not accessing services, compared to only 33% of people in the richest quintile; 12% of people in the richest quintile reported long waiting lists as a reason for not seeking care.

Fig. 7.7

Reasons for self-reported unmet needs for medical examination or treatment, first and fifth income quintile, 2010



Source: Eurostat, 2012e.

Another factor that reduces access to services for some groups includes geographical distances from services, even for primary care services, due to geographical imbalances in service distribution throughout the country. For low-income individuals, this imposes the additional costs of transportation. Further, for people with special needs, there are virtually no special provisions facilitating their access to health care services (or services in general). Finally, informational barriers, in particular for non-Latvian speaking population groups, may inhibit the effectiveness of public health and health information campaigns.

The implementation of the so-called Master Plan intended to rationalize the geographical distribution of primary, secondary and emergency facilities throughout the country and to improve access. However, the distribution of GPs continues to show large regional variation, with almost 15% of GPs (mostly located in rural areas) having 2000 patients and more and about 10% of GPs having only 1000 patients or less (mostly in urban areas). Similarly, the distribution of hospitals across the country remains inadequate, with specialized and tertiary services concentrated almost exclusively in Riga.

However, in order to better understand barriers in access (financial, geographical, cultural and other) as well as the impact of the social safety net measures on improving access, more systematic (and repeated) data collection (quantitative as well as qualitative) is necessary.

7.4 Health outcomes, health service outcomes and quality of care

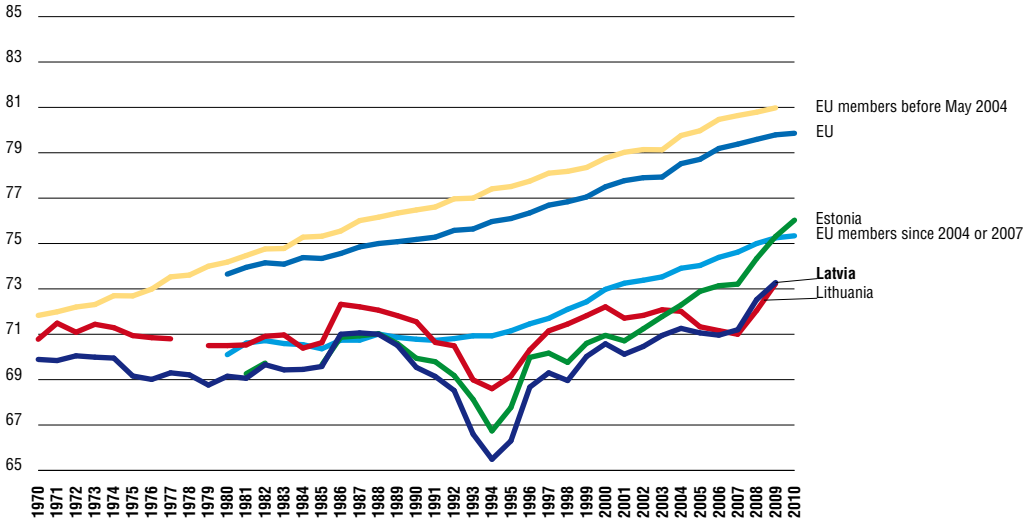
7.4.1 Population health

The population in Latvia is not particularly healthy and it lags well behind most other EU countries, although health indicators are somewhat similar to Estonia and Lithuania, even if Estonia is starting to move ahead. The large gap in mortality between Latvia and other countries in the EU has persisted for years. Most of the difference is attributable to the fact that Latvians face a much higher probability of dying from heart attack, stroke or external causes than people in other EU countries. Mortality is particularly high for men, but even the better mortality rates of women are still multiples worse than mortality rates of women in other EU countries.

A male child born in Latvia in 2010 could expect to live about 68.8 years, about eight years less than in other EU countries (World Bank, 2012). About 54 of those years would be spent in good health, about nine years less than in other EU countries (Eurostat, 2012b). As in several other Eastern European countries, mortality indicators for both men and women deteriorated substantially during the 1990s and it took until 2006 for Latvia and Lithuania to recover their peaks in life expectancy in the 1980s (see Fig. 7.8). By contrast, Estonia had passed its peak by 2002 and was poised for consistent improvement. For Latvia, which lagged behind the EU15 by roughly two years in 1970 (72 vs 70) the unfortunate fact was that by 2009 the difference had expanded to eight years (81 vs 73).

Fig 7.8

Life expectancy at birth (years) in the Baltic countries and EU averages, 1970 to latest available year



Source: WHO Regional Office for Europe, 2012b.

Cardiovascular diseases account for a large proportion of the excess mortality rates in EU12 countries, when compared to the EU average. Latvia has a particularly high burden of cardiovascular diseases. In 2009, almost half of all deaths in Latvia were attributable to cardiovascular disease. Latvia ranked first in deaths due to ischaemic heart disease – standardized death rate (SDR) of 71.68 per 100 000 population vs an average of 38.38 in the EU12; second due to diseases of the circulatory system (144.2 in Latvia vs about 97.3 in the EU12); and third due to cerebrovascular diseases (27.8 in Latvia vs about 21.5 in the EU12). In addition, Latvia scored third for SDR of external causes, injury and poison (80.8 in Latvia vs about 49.3 in the EU12).

Deaths in the age group 0–64 years are termed premature deaths; 48% of all male deaths occur before age 65 (compared to 28% for females). Most of these are adult deaths in the productive working years of life. Almost all deaths due to external causes in Latvia are premature: 94% for male and 86% for female. By international standards, men in Latvia lead very dangerous lives.

Smoking is one of the most prevalent aetiological factors in the development of cardiovascular, respiratory, cancer and other diseases. In 2008 the prevalence of smoking among adults (aged 15 or more) was 46% for men and 13% for

women, making Latvia the country with the second highest smoking prevalence in Europe behind Greece (Eurostat, 2012c). In 2009, the SDR attributed to smoking-related causes was 442.6, which was far above the EU12 average (339.9) and more than twice that of the EU15 (168.5). In fact, in spite of considerable reductions in smoke-related deaths over the past years (25% reduction since 2000), the smoking-related SDR remains the second highest in Europe, only exceeded by Lithuania (WHO Regional Office for Europe, 2012b).

Population health status is not only a result of the medical services people receive, but also depends on the socioeconomic, cultural, political and environmental context in which they live. Significant improvements in population health are conceivable only as a result of comprehensive improvements to complex determinants: the rise in the material welfare of families; favourable tendencies in their working and living conditions; increased social cohesion; positive changes in behavioural patterns (e.g. healthy lifestyle); overall socioeconomic and political dynamics as well as better organization and performance of the health care system.

7.4.2 Health service outcomes and quality of care

The unsatisfactory health status of the Latvian population, as well as the overall dissatisfaction with the health system, underlines the problem of health service quality. As mentioned above, 66% of citizens evaluate the overall quality of health care as bad (European Commission, 2011) and 65% think that the quality of care in Latvia is worse than in the other EU member states (European Commission, 2010).

Currently, there is no comprehensive quality management system that encompasses reliable quality indicators and mechanisms for monitoring and continuous quality improvement. Analysis of health service outcomes and quality of care is hampered by lack of data on key indicators, such as patient safety, both at national and organizational level. Thus, international comparisons on the quality of medical services cannot include any assessment of the situation in Latvia. Some data are available but only for preventive care (see Table 7.2).

Table 7.2

Preventive care indicators

Children vaccinated against (%)		1990	1995	2000	2005	2009	2010
Measles	Latvia	89.1	95.7	96.9	95.0	95.7	90.1
	EU	79.8	85.4	90.4	91.7	92.8	93.5
Diphtheria	Latvia	89.6	96.2	95.8	98.5	95.3	92.2
	EU	87.1	90.6	95.6	94.2	95.3	95.8
Tetanus	Latvia	89.6	96.2	95.8	98.5	95.3	92.2
	EU	87.1	90.6	95.6	94.2	95.3	95.8
Pertussis	Latvia	89.6	96.2	95.8	98.5	95.3	92.2
	EU	87.1	90.6	95.6	94.2	95.3	95.8

Source: WHO Regional Office for Europe, 2012b.

Since 1995, Latvia has had relatively high vaccination rates for measles, diphtheria, tetanus, pertussis and other infectious diseases and incidence of vaccine-preventable diseases has continued to decline. However, immunization data show that coverage has decreased since 2008 and is now below the EU average for a number of vaccines and also below WHO's general target of 95%, with the reasons for this including socioeconomic factors and also an increasing number of vaccination opponents. However, fortunately, this has not yet led to a re-emergence of vaccine-preventable diseases, such as measles, but with decreasing coverage this becomes more likely, as is evident from other European countries (WHO Regional Office for Europe, 2012b).

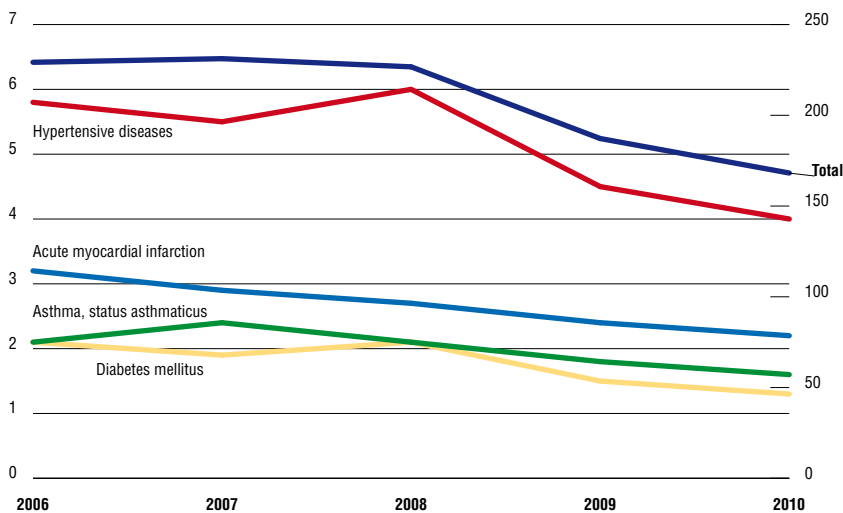
Latvia has also tried to improve cancer care by launching a large-scale public screening programme against breast cancer, cervical cancer and colorectal cancer in 2009. However, in the first year, the population response was relatively low: only 7% of the eligible population received colorectal screening and 21% received breast cancer screening. Hopefully, screening coverage will increase in the future.

Five-year cancer survival rates are often used as summary indicators for a health system's performance in cancer care as they reflect advances in public health interventions, such as greater awareness of the disease, successful screening programmes and improved treatment. According to CDPC data (CDPC, 2012a), five-year (absolute) cancer survival rates in Latvia in 2010 were 66.5% for breast cancer, 78.2% for cancer of the cervix uteri, 57.3% for colon cancer and 57.1% for anorectal cancers. For all these, the five-year survival in 2010 had slightly increased, when compared to 2009.

The number of potentially avoidable hospital admissions is an indicator that is frequently used to assess the quality of the primary/ambulatory care system. Hospital admissions for diseases such as asthma, hypertension and diabetes are often considered to be avoidable. High admission rates for these indicators are often considered to reflect poor quality primary care. Fig. 7.9 shows that total hospital discharges (a proxy for admissions) per 1 000 population have been decreasing in Latvia since 2006. However, potentially avoidable conditions, such as asthma and diabetes, do not seem to have declined at a higher rate than total discharges or discharges for acute myocardial infarction (which are more difficult to avoid). Only discharges for hypertensive disease seem to have declined more dramatically than total discharges. Therefore, the declining trend of avoidable hospital admissions in Latvia does not necessarily indicate improvements in primary/ambulatory care (and consequently healthier patients).

Fig. 7.9

Number of hospital discharges per 1 000 population by primary diagnosis: total (right axis) and selected diagnostic categories (left axis): 2006–2010



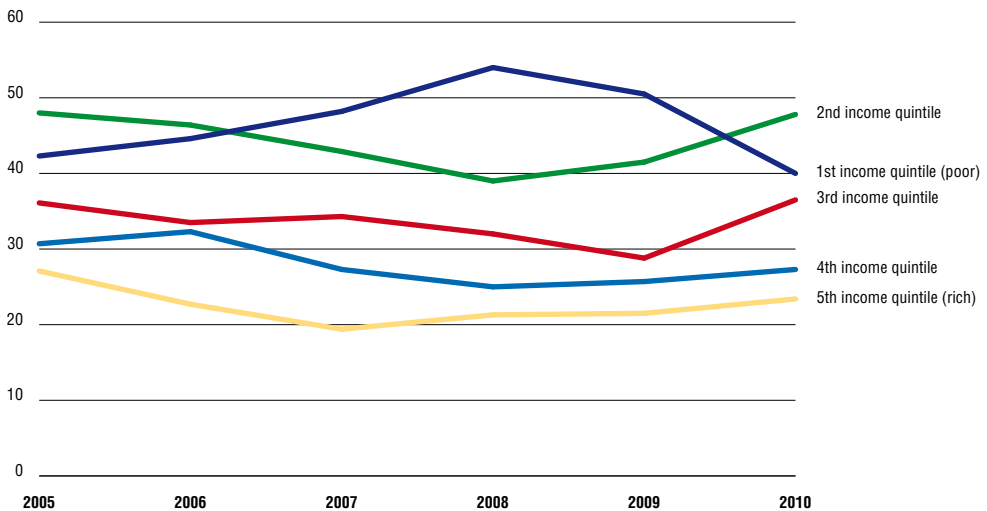
Source: Centre of Health Economics, 2010.

7.4.3 Equity of outcomes

Data from the EU-SILC survey show that lower income groups are much more likely to report having a longstanding illness or health problem (see Fig. 7.10). Since 2005, the proportion of interviewees in the two poorest income quintiles with a longstanding illness or health problem has consistently been above 40%, while this proportion has been below 30% for the two richest quintiles. In 2010, the difference between the income quintiles with the highest and lowest proportion of a longstanding illness was above 24 percentage points (23% for the richest quintile and 47% in the second poorest quintile). On average in the EU27 countries, this difference was only about 10 percentage points (26% in the richest quintile and 36% in the third income quintile).

Fig. 7.10

People with a longstanding illness or health problem, by income quintile, 2005–2010



Source: Eurostat, 2012e.

However, when looking at the development over time, it is remarkable that the proportion of poor people (first income quintile) reporting a health problem strongly decreased in 2009 and 2010, contrary to the trend for the second and third income quintiles. Possibly, this positive trend for the first income quintile indicates that the targeting of the Social Safety Net Strategy at the needy has, in fact, been successful. However, the data also show that middle-income

populations suffer from a significant disease burden. Furthermore, these data are consistent across other indicators, such as self-perceived health, where again the second income quintile reports the highest burden of disease.

7.5 Health system efficiency

7.5.1 Allocative efficiency

The term “allocative efficiency” refers to the notion that society’s resources are being used in such a way that they best satisfy the population’s needs and wants. In the case of the health sector this is usually interpreted to mean that the allocation of resources between the various levels and types of care is consistent with what is in society’s best interests. In Latvia, allocative efficiency can be assessed at four different levels: (1) the allocation of resources to the health system; (2) the allocation of resources to different types of providers; (3) the allocation of resources to different types of services; and (4) the allocation of resources for public health.

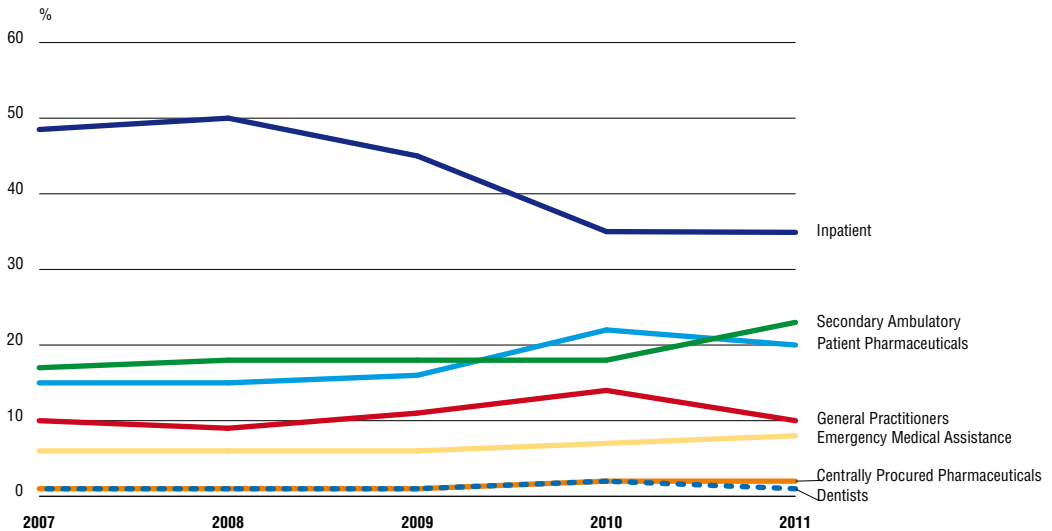
Concerning the first point, the question is whether the share of resources allocated to the health system is adequate (allocatively efficient). In 2010, Latvia had the third lowest total health expenditure per capita (US\$1100 PPP) in the EU27 after Romania and Bulgaria and the fourth lowest share of GDP spent on health (6.7%) after Romania, Cyprus and Estonia (WHO Regional Office for Europe, 2012b). Furthermore, the government’s share in total health expenditures was at only 4.1% of GDP in 2010, the third lowest after Bulgaria and Cyprus. Current estimates by the Ministry of Health are that this figure dropped to 3.6% in 2011 and will be at about 3.4% in 2012. Relatively poor population health outcomes in Latvia (see section 7.4) have to be interpreted in the context of this extremely tight health care budget. Therefore it may, in fact, be in society’s best interest to allocate a larger share of GDP to the health sector in order to achieve better population health, to avoid further cuts in services and to improve financial protection. The government’s target of increasing public expenditures on health to 4.5% of GDP by 2014 (and spending it wisely) would constitute a considerable improvement, but even then government expenditures would still lag behind most other European countries.

Concerning the allocation of resources to different providers, one central objective of health reforms in many European countries as well as in Latvia over the past decade has been to shift health care provision away from (expensive) hospital care and towards (less costly) ambulatory care. In the context of

funding shortfalls resulting from the financial and economic crisis, the Latvian government was able to make considerable progress in this direction. It introduced measures that gave relative priority to primary care, coverage of essential medicines and outpatient specialist services while reducing funding for inpatient care and hospital capacity. Fig. 7.11 shows changes in the distribution of government expenditures on health between 2007 and 2011. While expenditures on inpatient care consumed almost 50% of government expenditures on health in 2008, this share was reduced to below 35% in 2011. In addition, hospital bed capacity, which used to be far above the EU average (see section 4.1.2), dropped to below EU12 and EU15 averages in 2010. Also several measures introduced within the scope of the Social Safety Net Strategy (see section 6.1.2) – such as the introduction of home care for the chronically ill and the development of hotel-type beds at hospitals – supported the shift towards ambulatory care.

Fig. 7.11

Distribution of main expenditure categories of SCHIA/NHS funding^a



Source: Ministry of Health, 2012, unpublished data.

Note: ^a Including Ministry of Health budget for the SEMS since 2009.

However, the development of day care and long-term care facilities remains insufficient and acute hospitals still sometimes cater for low-income or elderly people in need of long-term or home care facilities, although to a lesser extent than in earlier years. Psychiatric patients continue to be treated mostly on an

inpatient basis as Latvia continues to have almost twice as many psychiatric hospital beds as Estonia, Poland or Slovenia (see section 4.1.2). Therefore, the reduction of psychiatric beds and the development of day centres are important aims, which could decrease the number of inpatient cases and make more efficient use of resources, while improving quality of life of psychiatric patients. Similarly, the available facilities for rehabilitation, palliative care and social care need to be expanded in order to move patients from acute hospitals into social care. The continuing process of closure of small and inefficient hospitals and their conversion into long-term, day care and social care facilities should help to alleviate pressures in this area.

Concerning the third point, i.e. the allocation of resources to different types of services, the Latvian health care system relies on a mix of explicit and implicit priority setting criteria. However, except for pharmaceuticals, where cost-effectiveness is assessed before new products are entered into the positive list (see section 2.7.2), cost-effectiveness and efficiency criteria are rarely taken into account. In addition, the existence of substantial waiting lists (e.g. for elective surgery, certain diagnostics and even for chronic care) may lead to patients not receiving highly effective and efficient care when needed. In particular, it is problematic that care for chronic conditions is not prioritized in the standard contracts between the NHS and providers, which potentially leads to chronically ill patients getting worse and needing more intensive care than if treatment had been available at an earlier stage.

Finally, public health has received relatively limited resources in Latvia despite the fact that the country suffers from a high burden of preventable lifestyle-related diseases. In 2008, the last year for which comparable data are available from Eurostat, Latvia spent only 0.09% of its GDP on public health, earning it the third lowest rank in Europe (after Cyprus and Lithuania). Significant progress has been made in recent years through the implementation of various programmes (screening, promotion of family health, cardiovascular disease prevention, alcohol reduction and others). Furthermore, the government has shown its awareness of needs in the area of public health through the development and adoption of the Public Health Strategy for the period 2011–2017 where a strong focus is placed on intersectoral approaches and health-in-all policies.

7.5.2 Technical efficiency

Recent studies assessing the technical efficiency of the Latvian health care system are unavailable. Therefore, technical efficiency can only be assessed using indicators of efficiency, such as ALOS or the use of generic pharmaceuticals, which by definition provide only a partial picture.

ALOS in Latvian acute care hospitals has decreased considerably in recent years, possibly indicating improvements in efficiency (see section 4.1.2). In the year 2000, ALOS was still comparatively high in Latvia at 8.5 days, compared to 7.5 days in the EU15 and 7.8 days in the EU12. In 2010, ALOS in Latvia had reduced by more than two days and was now at about 6.2 days, although Estonia and Slovenia continue to have even shorter ALOSs of about 5.5 days. Surprisingly, the substantial reduction in hospital beds in Latvia was not accompanied by an increase of occupancy rates after 2008. In fact, occupancy dropped considerably in 2009 to about 65% before jumping back to 71% (see Fig. 4.4), which is similar to the average in the other EU12 countries. As hospital budgets currently still depend to a certain degree on the number and type of services provided in the previous year, hospitals continue to have an incentive to provide more services per patient and to disregard the costs of the services they provide. Possibly, the government's plans to introduce a DRG-based hospital payment system by 2014 will contribute to changing the incentives for hospitals towards being more aware of the costs of the services they provide.

By 2006, Latvia had succeeded in shifting almost 80% of the total volume of pharmaceuticals used in the country to generics (World Bank, 2010). In addition, Latvia has a payback system in place, where pharmaceutical companies have to pay back a certain share of their profits, which amounted to LVL4 million (about €5.6 million) in 2011. Furthermore, the reform of the reference price system in 2012 (see section 6.1.5) has led to increased competition between pharmaceutical companies. Companies have to reduce prices in order to be awarded the status of reference medicine, for which the NHS provides reimbursement. According to NHS estimates, the new system has led to savings of about LVL3.7 million (€5.3 million) in 2012, when the NHS was able to negotiate price reductions for 600 pharmaceutical products.

Concerning the use of human resources, Latvia has recently (within the context of the Social Safety Net Strategy) invested in additional nursing staff at GP practices. The main task of additional nurses is to encourage uptake of screening visits, to provide education on healthy lifestyle and to assist with care and education for chronic patients. The availability of more staff at the primary

care level should compensate to a certain degree for the decrease in hospital activity resulting from hospital budget cuts. Ideally, the availability of nurses at GP practices will also lead to a more efficient use of physicians' time.

Finally, the administration of the health care system has seen an unprecedented cut in the number of agencies (see Box 6.1) and a 55% reduction in staff numbers at the Ministry of Health and its subordinated agencies since 2009 (Cabinet of Ministers, 2012).

7.6 Transparency and accountability

The health policy process in Latvia has been characterized by rapid and frequent changes, which make it difficult even for experts to be informed about the status quo. However, in theory, every member of the public has the opportunity to express their views on policy-planning documents, which are published on the web site of the Ministry of Health. The ministry closely collaborates with more than 30 NGOs, representing health professionals, health service providers, pharmacists, patients and parent organizations, which have the opportunity to participate in the drafting of legislative and policy documents or to provide background information. In addition, the Ministry of Health regularly invites non-governmental organizations, various institutions and community groups to participate in discussions and workshops.

Patients' rights have been significantly strengthened by the adoption of the "Law on the Rights of Patients" in 2010. Yet, in practice, a number of difficulties persist. While the law stipulates that patients have a right to information about quality, such data are generally unavailable. However, the introduction of a web-based information portal for patients in 2010 (see section 6.6.1), providing information about health services received by patients, has quickly become very popular and shows the potential of e-health applications in strengthening patient involvement in holding providers accountable.

In order for patients to be able to hold providers accountable, it is essential that they know to which services they are entitled. In 2002, when a survey was conducted of the Latvian public, a considerable share thought a voluntary insurance policy was necessary in order to receive health services (BISS, 2002). Although awareness of benefits is likely to have changed, it remains difficult for patients to be informed about the specific types of services to which they are entitled and to know whether they have the right to receive them without waiting. In particular, the existence of waiting lists and the possibility to

access services in the public sector at full cost may expose patients to provider attempts at making them pay for services, which they are entitled to receive free. Furthermore, while conclusive evidence is limited, informal payments continue to be considered a problem in the Latvian health system (see section 3.4.3).

The Ministry of Health is responsible for monitoring and evaluating several policies (e.g. on mental health, e-health, human resources) annually or once in two years. All evaluation reports are available to the public. However, currently, the information basis for performance monitoring is often rather limited. More resources would be necessary to improve performance monitoring and to identify health-related population needs and problems.

8. Conclusions

Since the mid-1990s, Latvia's health care system has undergone substantial reforms and transformations. However, in terms of core performance criteria (Roberts et al., 2003) – health status, patient satisfaction and financial risk protection – Latvia has been lagging behind not only “old” EU members, but also countries that joined the EU in 2004. Despite some positive developments (e.g. decrease of morbidity levels of vaccine-preventable diseases), Latvia did not meet its newborn life expectancy target of 95% of the EU average set in the Public Health Strategy 2004–2010: life expectancy remained more than six years below the EU average of 79.8 in 2009, principally because Latvia failed to achieve greater improvements in reducing cardiovascular mortality. Moreover, indicators that are more sensitive to health care – infant mortality and life expectancy at age 65 – remain unfavourable when compared to the averages of EU members since 2004 or 2007.

The financial risk protection offered by the health care system is insufficient, as suggested by a high share of OOP payments (as a percentage of THE) and a high percentage of the population forgoing medical treatment because it is too expensive. The social safety net measures implemented by the government in response to the economic crisis – aiming to protect low income households from user charges – are an impressive step in the right direction. However, Latvia remains the country in the EU with the highest share of the population reporting an unmet need for medical examination or treatment (see section 7.3.1).

The deficiencies in the performance of the health care system are partially attributable to incomplete implementation of the policies (including the Development Programme for Outpatient and Inpatient Health Care Services Providers 2005–2010), which were supposed to support achieving the targets of the Public Health Strategy 2004–2010. The success of these policies was compromised by the lack of financial resources and political will, as well as an insufficiently strong intersectoral approach to health.

The emergence of the global economic and financial crisis posed an enormous challenge to the government to ensure the availability of necessary health care services for the population and to prevent deterioration of health status. However, at the same time, it accelerated the necessary reforms in the health care system. The Latvian government succeeded at substantially reducing excessive hospital capacity and inpatient and secondary outpatient services, while prioritizing primary care, services for children and pregnant women, emergency assistance and pharmaceuticals.

The Public Health Strategy 2011–2017 places a strong emphasis on an intersectoral approach to health. The active participation of the other ministries and municipalities in the development of the strategy indicates that there is political support for such an approach, which should involve health impact assessment of all policies. The new strategy, among other goals, aims at increasing healthy life expectancy by two years and decreasing by 20 per cent potential years of life lost – both of which will require a strong focus on prevention and treatment of cardiovascular diseases.

Furthermore, to achieve these goals and to improve the performance of the health care system, the government will need to address several challenges affecting quality, efficiency and access. Ensuring sustainable and stable financing to the health care sector, while increasing public expenditure on health and reducing the enormous dependence on OOP payments, is one of them. Potential changes in the financing model (e.g. the introduction of social insurance) should be weighed against these objectives and need to be considered along with other options for improving equity and access. The Social Safety Net Strategy implemented in response to the crisis (see section 6.1.2) currently reduces the access problems of the needy population. However, there is still room for improvement of equity, access and health equality for the rest of the population.

Defining explicitly the statutory benefits package and the role of private insurance may contribute to better developing this sector as a source of financing, although the implications for equity should be carefully evaluated. There is also a need for continuing efforts to improve efficiency through structural reforms, including reductions in excess infrastructure and consistent and controlled investment. However, further reduction of hospital beds and hospitals should be addressed along with issues of physical access (e.g. conditions of roads, availability of transport, etc.).

Reforming provider-payment methods may further contribute to efficiency. The FFS method, which is used for outpatient specialist payment, provides incentives for the provision of more services and does not promote efficiency. While global budgets for hospitals may contribute to cost containment and were appropriate during the financial crisis, they do not provide incentives for greater efficiency or higher quality. Hence, government's work towards the introduction of a DRG-based payment system is well substantiated. Creating an environment of more competition among health care providers of all ownership forms may further contribute to increased efficiency. The NHS could take greater advantage of its single payer status and engage in more selective contracting. Furthermore, the planned introduction of the e-health system can be another tool that may promote efficiency in the sector.

If health policy in Latvia keeps a focus on the main determinants of healthy life expectancy, stays committed to the adopted intersectoral approach to health and continues with the necessary reforms, the health care gap between Latvia and the other EU countries can be substantially reduced.

9. Appendices

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9.2 HiT methodology and production process

HiTs are produced by country experts in collaboration with the Observatory's research directors and staff. They are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources and examples needed to compile reviews. While the template offers a comprehensive set of questions, it is intended to be used in a flexible way to allow authors and editors to adapt it to their particular national context. The most recent template is available online at: <http://www.euro.who.int/en/home/projects/observatory/publications/health-system-profiles-hits/hit-template-2010>.

Authors draw on multiple data sources for the compilation of HiTs, ranging from national statistics, national and regional policy documents to published literature. Furthermore, international data sources may be incorporated, such as those of the OECD and the World Bank. The OECD Health Data contain over 1200 indicators for the 34 OECD countries. Data are drawn from information collected by national statistical bureaux and health ministries. The World Bank provides World Development Indicators, which also rely on official sources.

In addition to the information and data provided by the country experts, the Observatory supplies quantitative data in the form of a set of standard comparative figures for each country, drawing on the European Health for All database. The Health for All database contains more than 600 indicators defined by the WHO Regional Office for Europe for the purpose of monitoring Health in All Policies in Europe. It is updated for distribution twice a year from various sources, relying largely upon official figures provided by governments, as well as health statistics collected by the technical units of the WHO Regional Office for Europe. The standard Health for All data have been officially approved by national governments. With its summer 2007 edition, the Health for All database started to take account of the enlarged EU of 27 Member States.

HiT authors are encouraged to discuss the data in the text in detail, including the standard figures prepared by the Observatory staff, especially if there are concerns about discrepancies between the data available from different sources.

A typical HiT consists of nine chapters.

1. Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.

2. Organization and governance: provides an overview of how the health system in the country is organized, governed, planned and regulated, as well as the historical background of the system; outlines the main actors and their decision-making powers; and describes the level of patient empowerment in the areas of information, choice, rights, complaints procedures, public participation and cross-border health care.
3. Financing: provides information on the level of expenditure and the distribution of health spending across different service areas, sources of revenue, how resources are pooled and allocated, who is covered, what benefits are covered, the extent of user charges and other out-of-pocket payments, voluntary health insurance and how providers are paid.
4. Physical and human resources: deals with the planning and distribution of capital stock and investments, infrastructure and medical equipment; the context in which IT systems operate; and human resource input into the health system, including information on workforce trends, professional mobility, training and career paths.
5. Provision of services: concentrates on the organization and delivery of services and patient flows, addressing public health, primary care, secondary and tertiary care, day care, emergency care, pharmaceutical care, rehabilitation, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health services for specific populations.
6. Principal health reforms: reviews reforms, policies and organizational changes; and provides an overview of future developments.
7. Assessment of the health system: provides an assessment based on the stated objectives of the health system, financial protection and equity in financing; user experience and equity of access to health care; health outcomes, health service outcomes and quality of care; health system efficiency; and transparency and accountability.
8. Conclusions: identifies key findings, highlights the lessons learned from health system changes; and summarizes remaining challenges and future prospects.
9. Appendices: includes references, useful web sites and legislation.

The quality of HiTs is of real importance since they inform policy-making and meta-analysis. HiTs are the subject of wide consultation throughout the writing and editing process, which involves multiple iterations. They are then subject to the following.

- A rigorous review process (see the following section).
- There are further efforts to ensure quality while the report is finalized that focus on copy-editing and proofreading.
- HiTs are disseminated (hard copies, electronic publication, translations and launches). The editor supports the authors throughout the production process and in close consultation with the authors ensures that all stages of the process are taken forward as effectively as possible.

One of the authors is also a member of the Observatory staff team and they are responsible for supporting the other authors throughout the writing and production process. They consult closely with each other to ensure that all stages of the process are as effective as possible and that HiTs meet the series standard and can support both national decision-making and comparisons across countries.

9.3 The review process

This consists of three stages. Initially the text of the HiT is checked, reviewed and approved by the series editors of the European Observatory. It is then sent for review to two independent academic experts, and their comments and amendments are incorporated into the text, and modifications are made accordingly. The text is then submitted to the relevant ministry of health, or appropriate authority, and policy-makers within those bodies are restricted to checking for factual errors within the HiT.

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