HiT summary

Latvia

Introduction

Government and recent political history

Latvia declared its independence from the Soviet Union on 21 August 1991, and became a parliamentary republic. It is governed by a president who appoints a prime minister, and by a 100-seat unicameral parliament (*Saeima*).

Population

Latvia had an estimated population of 2.35 million in 2000, down by over 10% since 1992. Riga, the capital, has a population of 856 000. The Soviet occupation gave rise to a significant change in the composition of the population: mass deportation of Latvians and immigration of Russians (and others) into Latvia resulted in a drop of the Latvian portion of the population to 52%, which had risen to nearly 56% by 1999.

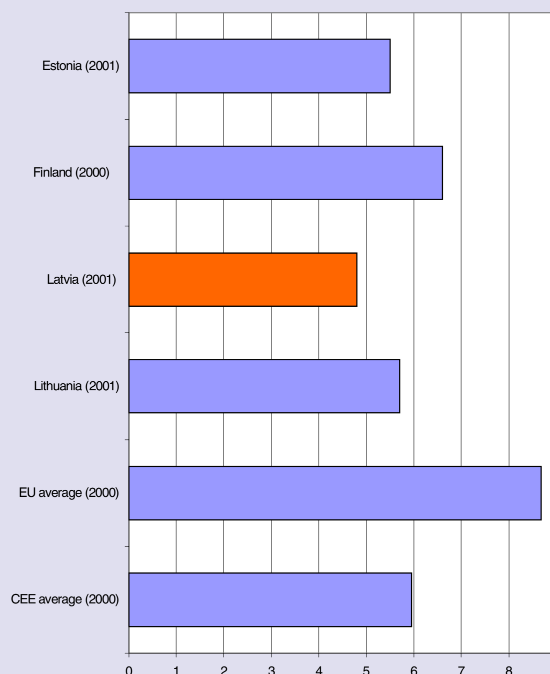
Average life expectancy

Trends in life expectancy are similar to those in other eastern European countries: 64.75 years for males and 75.44 for females (1999). Economic reforms and stabilization have contributed to a trend of increasing life expectancy in recent years.

Leading causes of death

Diseases of the circulatory system, cancer and external causes are the leading causes of death. Infant mortality is still high, though it decreased in the 1990s to 11.3 per 1000 live births by 1999. Maternal mortality showed a strongly increasing trend in the 1990s, reaching 48.89 per 100 000 in 1998, though subsequently dropping somewhat.

Fig. 1. Total health care expenditure as % of GDP, comparing Latvia, selected countries and CEE and EU averages



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

Recent history of the health care system

During the Soviet occupation, the health care system was planned along the lines of the Semashko model. Since independence, the administrative structure of health care management has changed several times. Sickness funds were established in 1994 to provide funds for

European Observatory on Health Care Systems
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen
Denmark
Telephone: +45 39 17 14 30
Telefax: +45 39 17 18 70
E-mail: observatory@who.dk
www.observatory.dk

health services, though the system remains tax-financed. Reform efforts have focused strongly on the development of primary health care.

Reform trends

The transformation of the economy has proceeded faster and further in Latvia than in most countries of the former Soviet Union. In the health sector, most responsibility for providing primary and secondary health care services was delegated to local governments. Health care reforms have further centred on the development of primary health care based on general practice, as well as changes in remuneration mechanisms designed in part to support this objective.

Health expenditure and GDP

The share of public health care spending in GDP was estimated to be 4.4% in 1999. This understates total spending on health care which includes a growing private share. Inclusion of estimates of the private share would bring the GDP share to over 5%.

Overview

The Latvian health care system has been undergoing rapid transformation since independence. Changes in the system were prompted and initiated by the Latvian Physicians Association (now known as the Medical Association of Latvia), aiming to promote efficiency of services provision through improved provider remuneration and a shift of resources toward the primary care sector, decentralization of services and separation of provision from financing. Whereas some improvements in efficiency are visible, there is also evidence that the system is working against equity, while efforts to improve quality have encountered obstacles due to resource constraints and political difficulties associated with closure of uncertified institutions.

Organizational structure and management

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

Following enactment of a Law on Local Governments in 1993, most of the responsibilities for financing and provision of primary and secondary care services were delegated to municipal governments. Specialized services remained the responsibility of the state. A recentralization of financing which took place in 1997 limited the role of local governments to provision only. At that time, eight regional sickness funds, resulting from the merger of 32 local account funds, took on the responsibility of distributing state funds for health care.

In 1998 the State Compulsory Health Insurance Agency (SCHIA) was established. Operating under the jurisdiction of the Ministry of Welfare, it receives the tax-financed budget allocation for health care and distributes it to the eight regional funds, which in turn allocate between primary and secondary care. The SCHIA also directly finances tertiary care and special state health care programmes.

The regional funds use the money received from the SCHIA to purchase health care for their respective populations on the basis of contractual agreements.

The private sector includes institutions which have been privatized, namely many polyclinics and almost all dental practices and pharmacies, as well as some independent primary care practices which emerged following efforts to develop this sector.

Health services provision is regulated by a number of pieces of legislation, including the laws “On Medical Care” (1997) and “On Physicians’ Practice” (1997). The range of primary and secondary care services included in statutory provision, “The Basic Care Programme”, is defined by separate legislation.

Several public institutions (for example the Health Statistics and Medical Technology Agency) as well as departments in the Ministry of Welfare, are responsible for management and regulation of specific activities in the health care system.

Health care finance and expenditure

Main system of finance

Whereas Latvia has established an organizational structure consisting of a central sickness fund (the State Compulsory Health Insurance Agency) with its regional satellites, health care services continue to be financed through taxation. Health care resources consist partly of income tax collected at the central level (28.4% of income tax revenue is earmarked for health care), partly of subsidies from general revenues (also financed by tax revenues at the central level) and partly of patients' pay-in.

Complementary sources of finance

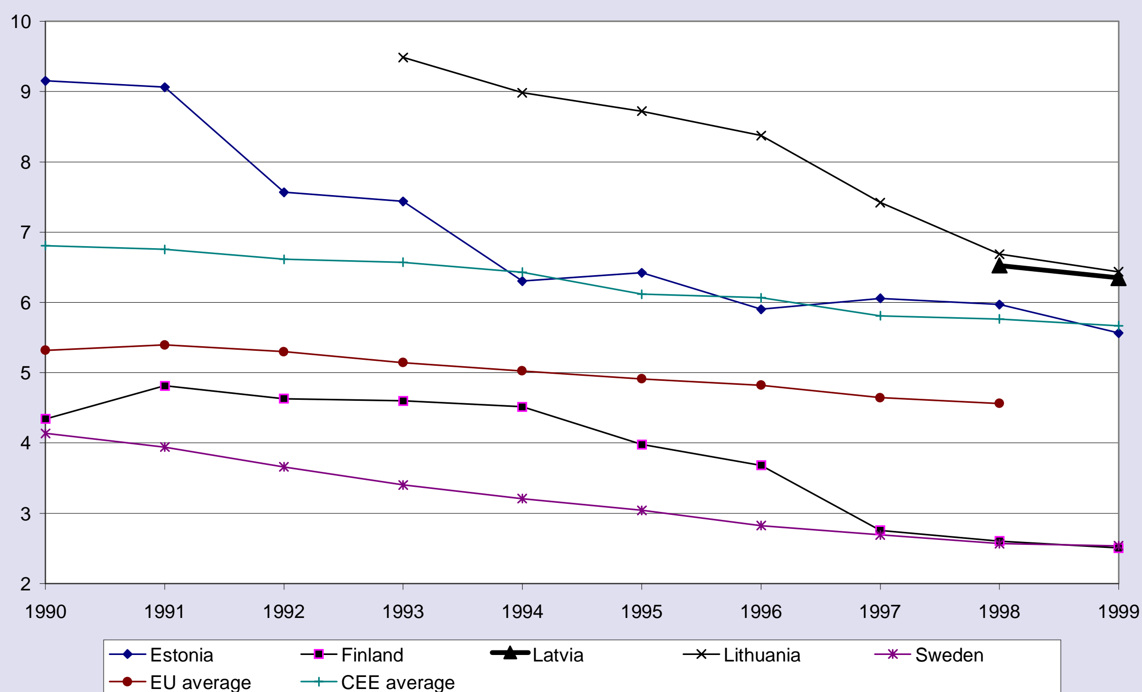
There are wide disparities among different sources of information concerning the size of out-of-pocket spending, ranging from a low of 7–10% of total spending (Ministry of Welfare) to a high of 39% (WHO World Health Report 2000).

Since July 1995, patients could be charged for up to 25% of the cost of care under the Basic Care Programme. This was reduced to 20% in 1997 due to the population's difficulty in paying. Patients (with the exception of certain vulnerable groups) must pay the full price of medicines in the outpatient care sector. In addition, sizeable under-the-table payments are made to providers.

Health care benefits and rationing

All Latvian citizens are entitled to state-funded health care services. The range of primary and secondary services included within statutory

Fig. 2. Hospital beds in acute hospitals per 1000 population, Latvia, selected countries and CEE and EU averages



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

provision has been determined each year since 1994 by an act of the Cabinet of Ministers specifying the Basic Care Programme, which includes: emergency care; treatment for acute and chronic diseases; prevention and treatment of sexually transmitted and contagious diseases; maternity care; immunization programmes; and provision of pharmaceuticals. Dental care is part of the package only for children up to the age of 18 years.

Health care expenditure

Inclusion of private spending in estimates of total health care expenditure would bring this to over 5% as a share of GDP. This is substantially lower than the EU average, and is lower than the CEE average as well.

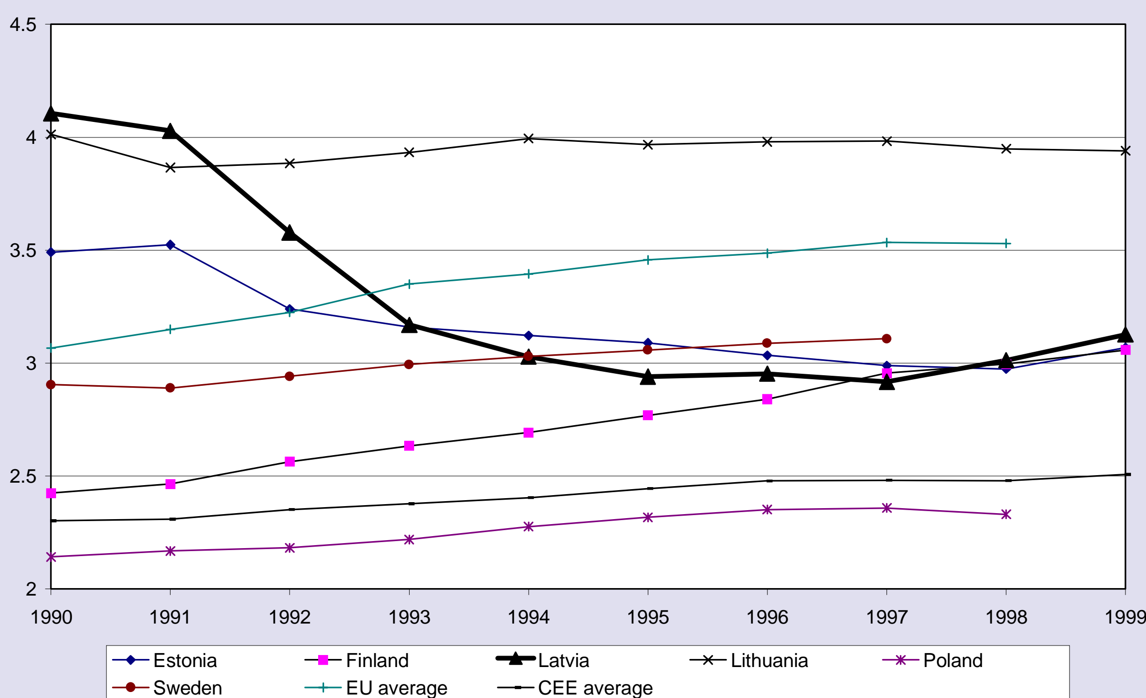
Health care delivery system

Primary care services

Until 1990, primary health care in cities and large towns was provided in polyclinics, while in rural areas it was provided by local internists and nurses or feldshers.

In 1992, the Ministry of Welfare approved a model of PHC based on the establishment of single or joint family doctor practices staffed by general practitioners and nurses or doctors' assistants. The establishment of private practices with primary care doctors as independent contractors was favoured. Implementation of this

Fig. 3. Physicians per 1000 population, Latvia, selected countries and CEE and EU averages



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

model is as yet far from complete. In the interim period, patients may make their first contact with health services in various outpatient institutions: polyclinics; hospital emergency clinics or ambulatory emergency clinics; doctorates; feldsher points; and health points.

The specialty of general practice was established in 1991, and the number of certified GPs has increased sharply due to retraining courses which became available since 1992.

Efforts to support development of primary health care have led to a system of remuneration of PHC physicians involving mixed capitation. This includes a capitation amount that is partly remuneration for primary care practitioners, partly compensation for certain costs (for example, PHC nurse) and partly payment for services of specialists to whom patients are referred. This arrangement was prompted by the hope that it would contribute to keeping service delivery as much as possible in the primary care sector. However it has met with several difficulties including resistance by patients who often feel deprived of essential secondary services.

Other problems in the PHC sector include difficulties in setting up independent practices, and uncertainties about their legal basis, inadequate cooperation among primary, secondary and tertiary care, inadequate physician qualifications for the development of primary care, and problems of access to care in rural areas.

Public health services

The Health Promotion Centre under the Department of Environmental Health of the Ministry of Welfare organizes health promotion.

The Latvian Infectious Diseases Centre and State Sexually Transmitted and Skin Diseases Centre are responsible for infectious and communicable disease control. Professional disease registration and observation are coordinated by the Professional Diseases and Radiation Medical Centre.

Primary care doctors and school physicians are responsible for immunization. Preventive services (basic health education, cervical smears, etc.) are delivered by primary care providers.

In 1997 the State Sanitary Inspection was established for the purpose of monitoring environmental health.

There are seven youth health centres working on youth reproductive health care and education.

Public health services are hampered by a lack of coordination at the state level. Often different institutions work on the same problems, without knowing what colleagues have already achieved.

Secondary and tertiary care

There are three categories of hospitals in Latvia: state (accountable to the Ministry of Welfare), municipal and private. Hospitals are overwhelmingly public, with municipalities controlling roughly half. All specialized hospitals are concentrated in Riga.

Hospitals usually have the status of non-profit organizations or stock companies, frequently employee-owned. Directors' decisions, however, must be ratified by regional sickness funds with which the hospitals are contracted. The director or head doctor of each municipal hospital organizes the hospital's activities according to the local authority's health care development plan.

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

Since 1991, there has been a remarkable decrease in the number of beds, which fell from 13.6 beds per 1000 population to 8.9 beds in 1999, representing a 40% drop. The greatest part of this decrease took place in municipal hospitals, where bed numbers fell by more than half (53%) over the same period.

The hospitalization rate remained constant over this period at around 21–22 per 100 population. The average length of stay decreased from 17.4 days in 1991 to 11.8 days in 1999, suggesting a more rational use of resources.

Changes in hospital remuneration methods have contributed to increased efficiency in their use.

Problems in this sector include the continued use of secondary and tertiary care institutions for the provision of primary and social care, financing shortfalls leading to dated technologies and difficulties certifying institutions, and excessive concentration in large urban areas (though this problem is not so severe due to Latvia's relatively small size).

Social care

Social care is under the responsibility of the Ministry of Welfare's Social Assistance Department. It is provided in homes for the elderly, long-term care facilities for the handicapped, nursing homes and orphanages, and in home care and day care centres.

There are 131 social care institutions in Latvia with 11 792 beds. The number of nursing homes increased from 42 in 1994 to 62 in 1998. There are state- and community-owned public homes for the elderly.

The number of children in social care institutions increased dramatically, from 1183 in 1990 to 3138 in 1998. In the same year there were six orphanages financed by the state and 49 local government children's homes. Handicapped children have four specialized social care institutions. In addition there are day care centres for the mentally handicapped in Riga and Kuldiga. This is a new social care form in Latvia and is financed by local governments and the state. Some charity organizations provide short-term care for women and children.

Access is satisfactory, however the quality of services is influenced by low staff salaries and the poor condition of buildings and facilities.

Human resources and training

Latvia has experienced a dramatic drop in doctor numbers since the early 1990s; these fell to 3.1 per 1000 population from 4.0 in 1991. A similar decreasing trend applies to dentists, nurses and midwives: in 1999 there were 5.2 nurses per 1000 population compared to 8.2 in 1991. Reasons for falling staff numbers include the declining numbers of hospitals and hospital beds, and low salaries and prestige for medical professionals. The ratio of nurses to doctors is quite low and this is expected to have a negative impact on the development of PHC teams.

Education and training of health care personnel is provided by two higher educational institutions in Latvia: the Latvian Medical Academy, under the supervision of the Ministry of Welfare, and the Latvian University's Medical Faculty.

While it was possible until recently to train as a nurse by following a four-year programme after only nine years of school education, this has been replaced by a three-year programme which begins after twelve years of schooling. In addition, a four-year degree course at the Latvian Medical Academy trains nurses to work as head nurses in hospitals and specialized wards.

Pharmaceuticals

Latvian drug policy is primarily oriented towards safety and quality rather than support for domestic production even though Latvia has a significant pharmaceutical industry.

A 1993 law "On Pharmaceuticals", updated in 1998 and 2000, is intended to regulate activities in the pharmaceutical field and ensure safety and effectiveness.

The State Agency of Medicines was founded in 1996 to maintain a pharmaceutical products register, aiming at evaluation, registration, monitoring, quality control and distribution management, as well as drug import, export and transit control.

Regulation of pharmacies (which are mainly private) is the task of the State Pharmaceutical Inspection.

In 1998, the Medicines Pricing and Reimbursement Agency was created to carry out a reform of drug reimbursement in accordance with EC directives, and determine a positive list. For drugs included in the positive list, prices are

negotiated between the Agency and the manufacturers. Drugs not included in the positive list are priced on an unregulated manufacturer's price plus mark-ups for wholesalers and pharmacies.

At the present time the level of supplies of pharmaceuticals is not sufficient to meet the needs of individuals and hospitals. Hospitals do not have sufficient supplies, patients often cannot afford to buy medications and the health care budget is unable to cover all expenses necessary for the reimbursement of pharmaceuticals included in the positive list.

Financial resource allocation

The size of the budget for health care is determined by Parliament and the Government each year. In 1999 it was 9% of the total budget.

Since 1997 the health care budget has been administered by the State Compulsory Health Insurance Agency which, together with the eight regional sickness funds, works out the budget requirements based on the previous year's budget and submits a request to the Ministry of Welfare. This is further taken to the Ministry of Finance and the Cabinet of Ministers. A draft budget is submitted in the Parliament for approval. Following approval, the amount is disbursed to the State Compulsory Health Insurance Agency, which distributes it to the eight regional funds according to their respective populations and age structures.

Payment of hospitals

Since 1994, there has been a shift away from historical allocation to payment for services delivered. Regional sickness funds contract with hospitals and agree upon a range of services provided and payment for them.

Since 1998, regional sickness funds have paid for inpatient services according to: (1) 64 diagnosis groups, (2) bed-day payments, and (3) a points system, which forms the basis for additional reimbursement for manipulations in excess of a certain number of points. In addition, hospitals may charge for certain hotel services or extra consultations not covered by the sickness fund.

Payment of physicians

In the mid 1990s, the points system (fee-for-service) was introduced in the ambulatory sector of the whole country except Kurzeme (in western Latvia), which introduced capitation. Hospital physicians are paid partly on the basis of a fixed salary and partly on the basis of a points system for manipulations in excess of a specified number of points.

The points system in the ambulatory sector is currently in the process of being replaced by a "mixed capitation" system involving a combination of capitation and general practitioner fund holding. The GP receives a capitation payment, based on the number of listed patients and their age structure, which goes toward remuneration of the GP and a PHC nurse, GP compensation in the event that the practice is in a low density area and GP certification. In addition, the GP pays for the services of specialists to whom the patient has been referred. Certain specialists (such as psychiatrists, endocrinologists, dentists, etc. who do not require a referral from a GP) are allocated separate resources for their respective payments.

This remuneration system is intended to support the development of primary health care by strengthening the GP gatekeeping role and the position of GPs in the health care system.

Health care reforms

The changes that have taken place in the Latvian health care system were predicated on the belief that a centralized and hospital-oriented system was inappropriate for a market economy. Change has therefore focused on decentralization, making local governments responsible for a major portion of health care provision, changes in financing to support a strong PHC system based on independent family practitioners, and on improving the quality and efficiency of resource use.

A number of difficulties have been encountered in the course of implementation, including questions surrounding the mixed capitation system of GP remuneration, slow progress in the certification of medical institutions, delays in developing the legal basis for the proposed changes, concerns over issues of access to health care services due to increasing patient responsibility for payment, as well as overall resource constraints.

Conclusions

Latvian health care reforms were prompted by the need to deal with the shortcomings of the system inherited from the Soviet Union, as well as by the desire to revert to the system that had prevailed during Latvia's short period of independence between the First and Second World Wars. While the reforms have come a long way toward fulfilling their objectives, there remain constraints to planning and implementation due to political and economic instability. It is widely believed that the portion of funds allocated to health care is too small. On the other hand, the reforms begun are sustainable because there is agreement among political parties on the general direction of the reform process, and the improving economic situation and gradual rise in the standard of living can also be expected to contribute to its maintenance.

Table 1. Inpatient utilization and performance in acute hospitals in the WHO European Region, 2001 or latest available year

Country	Hospital beds per 1000 population	Admissions per 100 population	Average length of stay in days	Occupancy rate (%)
Finland	2.4	19.7	4.4	74.0[f]
Sweden	2.4[a]	14.9	4.9	77.5[e]
Estonia	5.1	17.9	6.9	62.3
Latvia	5.8	18.6	–	–
Lithuania	6.3	21.7	8.0	76.3
EU average	4.1[a]	18.9[b]	7.7[b]	77.4[c]
CEE average	5.4	17.8	8.3	72.3

Source: WHO Regional Office for Europe health for all database.
Notes: [a] 2000, [b] 1999, [c] 1998.

HiT summary

Latvia

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

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The full text of the HiT can be found in www.observatory.dk.

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