

Health Systems in Transition

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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) profiles are country-based reports 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 profile is produced by country experts in collaboration with the Observatory's research directors and staff. In order to facilitate comparisons between countries, the profiles are based on a template, which is revised periodically. The template provides detailed guidelines and specific questions, definitions and examples needed to compile a profile.

HiT profiles 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.

Compiling the profiles 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 Health for All database, national statistical offices, Eurostat, the Organisation for Economic Co-operation and Development (OECD) Health Data, the International Monetary Fund (IMF), the World Bank, and any other relevant sources considered useful by the authors. Data collection methods and definitions sometimes vary, but typically are consistent within each separate series.

A standardized profile 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. The HiT profiles 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.

HiT profiles and HiT summaries are available on the Observatory's web site at www.euro.who.int/observatory. A glossary of terms used in the profiles can be found at the following web page: www.euro.who.int/observatory/glossary/toppage.

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The current series of Health Systems in Transition profiles has been prepared by the research directors and staff of the European Observatory on Health Systems and Policies. The Observatory is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Slovenia, Spain and Sweden, the European Investment Bank, the

Open Society Institute, the World Bank, the London School of Economics and Political Science, and the London School of Hygiene & Tropical Medicine.

The Observatory team is led by Josep Figueras, Director, and Elias Mossialos, Co-director, and by Martin McKee, Richard Saltman and Reinhard Busse, heads of the research hubs.

Jonathan North managed the production of the profile, with the support of Nicole Satterley (copy-editing), Peter Powell (layout) and Jane Ward (proofreading). Administrative support for preparing the HiT profile on Latvia was undertaken by Caroline White.

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List of abbreviations

AIDS	Acquired immune deficiency syndrome
ALOS	Average length of stay
CEDM	Centre of Emergency and Disaster Medicine
CIET	Tropical Disease Research Centre
CIS	Commonwealth of Independent States
CT	Computed tomography
DOTS	Directly observed treatment short-course
DMFT	Decayed, missing or filled teeth
DPS	Data Protection System
EC	European Commission
EMA	Emergency medical assistance (service/team)
EMU	Economic and Monetary Union
ERDF	European Regional Development Fund
ERM	(European Union) Exchange Rate Mechanism
ESF	European Social Fund
EU	European Union
EU-10	The 10 countries that joined the EU in May 2004
EU-15	The 15 countries that joined the EU before May 2004
FABT	Fatty acid absorption breath testing
GCP	Good clinical practice
GDP	Gross domestic product
GMP	Good medical practice
GP	General practitioner
HiT	Health Systems in Transition (profile)
HIV	Human immunodeficiency virus
HSMTSA	Health Statistics And Medical Technology State Agency
IMF	International Monetary Fund
INN	International Nonproprietary Name
LTF	Latvian Popular Front
MDR-TB	Multi-drug resistant tuberculosis
MRI	Magnetic resonance imaging
NATO	North Atlantic Treaty Organisation
NGO	Nongovernmental organization
NRS	National Revenue Service
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket (payment for health services/drugs etc.)
PHARE	Poland and Hungary: Aid for Restructuring of the Economies

PHC	Primary health care
PPP	Purchasing power parity
PVQ	Price–volume–quality
PYLL	Potential years of life lost
SCHIA	State Compulsory Health Insurance Agency
SDR	Standardized death rate
STI	Sexually transmitted infection(s)
TB	Tuberculosis
TB/LNNK	For Fatherland and Freedom – Latvian National Independent Movement
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
UNICEF (LNC)	United Nations Children's Fund (Latvian National Committee)
UNESCO (LNC)	United Nations Educational, Scientific and Cultural Organization (Latvian National Committee)
VAT	Value-added tax
VHI	Voluntary Health Insurance
WHO	World Health Organization
WTO	World Trade Organisation
ZZS	Union of Greens and Farmers

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Abstract

The Health Systems in Transition (HiT) profiles are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. HiTs examine different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; describe the institutional framework, process, content and implementation of health and health care policies; and highlight challenges and areas that require more in-depth analysis.

The life expectancy in Latvia has improved over the last two decades and was 71.1 years in 2005. This value is comparable to those in other eastern European and former Soviet Union countries but is the lowest among the Baltic and Nordic countries. Health care services in Latvia are financed mainly by taxation through the state budget as well as by out-of-pocket (OOP) payments, voluntary health insurance (VHI) and other direct payments. Although entitlement to health care services is universal in Latvia, equity in access to services is compromised due to high levels of OOP payments by consumers. Health care services at the primary level are provided mainly by general practitioners (GP) who work independently and act as gatekeeper for specialized services.

Latvia's health care system has undergone major changes since the country achieved independency in 1991. Reform policy since then has included amongst others: adoption of a Public Health Strategy in 2001 (which aims at developing an integrated approach of prevention and treatment at all levels of the health care system), reform of health care financing (e.g. payment for hospital services, introduction of a primary health care payment system based on capitation and fund holding, pooling and channelling of almost all funds for health care through the centralized State Compulsory Health Insurance Agency (SCHIA)),

regulations of the pricing system for pharmaceuticals and introduction of a centralized health management information system. However, patients and health care consumers are concerned with regard to quality of the health care services, long waiting lists and access to specialized care.

Executive summary

Introductory overview

The Republic of Latvia is located on the eastern Baltic coast, in the western part of the eastern Europe plain. Latvian independence was re-established on 21 August 1991, at which time it became a parliamentary republic. In May 2004 Latvia joined the European Union (EU), with the population in the same year reaching 2.3 million.

Despite rapid economic growth, poverty in Latvia is extensive (officially estimated at approximately 20% of the population), with an increasing degree of income inequality. Life expectancy has also been increasing in recent years; however, it is the lowest among the Baltic and Nordic countries, at an average of 71.1 years (76.6 for women and 65.4 for men) in 2005. In general the lifestyle of the Latvian population is unhealthy, due to high levels of alcohol consumption, smoking, unhealthy diets, insufficient physical activity, and obesity. Mortality from diseases of the circulatory system is very high, causing more than half of all deaths. Infant mortality also remains high at 7.8 per 1000 live births, though it has fallen substantially since 1980. Suicide rates are higher than in any western European country, constituting the fifth most common cause of death.

Organizational structure

The Latvian health care system has undergone a remarkable transformation in the years since independence, and is now in the process of consolidating its new structures and institutional arrangements. Having abolished the highly centralized system that prevailed during the Soviet period, it has focused on

decentralization of health care delivery, administration and financing; full or partial privatization of some kinds of provider institutions; and the establishment of independent primary care practices, which have led to a wide variety of legal forms of health care providers and institutions. It has experimented extensively with a variety of social insurance structures ranging from highly decentralized to partially recentralized arrangements, as well as with organizational forms of health care delivery in parallel with reforms of the state administrative system. The wide-ranging reforms and continuous and ongoing process of change are prompted by the perceived need to increase the efficiency of health care financing and provision and to improve the quality of care.

Health care financing

Latvia is in the unique position of possessing a tax-funded “social insurance” system with a purchaser–provider split. The central Government is responsible for financing the statutory health care system through tax revenue. In addition, financing for health services comes directly from household payments as well as VHI. Tax revenue allocated for health care by the Ministry of Finance is transferred (via the Treasury) to the State Compulsory Health Insurance Agency (SCHIA), a state-run organization under the jurisdiction of the Ministry of Health, which signs contracts with all statutory health care providers. What differentiates the Latvian financing system from most general tax-based systems is that the funds from the central government budget are transferred to the SCHIA, which – together with its five regional branches – acts as purchaser of health services on behalf of the entire population.

Payment methods for services and health care professionals have evolved over several years and are quite complex. They are determined by government regulations and defined in contracts. Health care personnel working as employees in health care institutions are salaried. GPs are paid through capitation, plus fees for defined activities, bonus payments and fixed allowances (such as a practice allowance). In addition, they hold funds for the purchase of certain secondary care services. Specialists are paid by means of fees for flat rate episodes of illness. Hospitals are remunerated by a per diem fee with additional activity-based payments.

Health expenditure as a share of gross domestic product (GDP) shows a slightly increasing trend in recent years, climbing from 6% in 2000 to 6.4% in 2004 (after falling in the late 1990s). The public share of total health expenditure has been steadily falling since the mid-1990s, from the very high level of 95%

in 1995, and appears to be stabilizing after 2001 at 51–52% of total health expenditure. The very large increase in the private share of spending is due to the introduction of user charges. In addition, the private share of spending has increased due to the rapid growth of VHI, although to a far lesser degree. Furthermore, direct patient payments for such services as bypassing waiting lists for non-urgent operations (orthopaedics, cataracts, hernia, etc.), as well as costly examinations (such as computed tomography (CT), magnetic resonance imaging (MRI)) may constitute considerable amounts. Population spending on dental care for adults, which is not statutorily financed and provided, is also a key component of private health expenditure, as is spending on visits to practitioners on a private basis.

Provision of services

In 2005 there were approximately 3.16 physicians per 1000 inhabitants in Latvia, compared to 3.17 for the EU. Latvia has experienced significant declines in numbers of doctors, midwives and nurses, particularly during the first half of the 1990s. By contrast, numbers of GPs have been continuously increasing since 1990, due to the introduction of and strong support (involving retraining of former primary care internists and paediatricians) provided to this specialty that forms the basis of family medicine, and which was introduced as a cornerstone of reforms in the mid-1990s. Apart from GPs, dentists are the only category of health care personnel which by 2005 increased in number (per 1000 population) compared to 1990, due to the privatization of practically all dental practices, thus increasing their profitability and the attractiveness of this profession.

The decline in doctor numbers can be ascribed in part to declining numbers of hospitals and hospital beds, as well as low salaries and lack of prestige regarding health care. In the period 1990–2005, the number of overall hospital beds fell from 1407.5 to 768.3 beds per 100 000 population, signifying a drop of 45%. The key factor behind this dramatic drop in hospital bed numbers is health policy aiming at the development of primary health care (PHC) and the substitution of outpatient services for inpatient care.

PHC and secondary ambulatory services available under the statutory system are provided in a variety of institutional settings under a variety of legal forms. PHC providers may be either independent, self-employed practitioners, or may be directly employed by local governments or by health centre administrations. In all cases statutory care is provided through contracts with the SCHIA, which are carried out either directly (in the case of self-employed doctors) or through

the health care institution at which they are employed. PHC is provided primarily by GPs in the role of family doctors. The specialty of GPs was established in 1991, and patients can freely choose their primary care physicians. Emergency care is undergoing major structural and managerial changes, as part of the structural reform of the health care system.

Principal health care reforms

After the re-establishment of independence in 1990, numerous changes were introduced in Latvia, including a transition to a market-based economy, privatization, the development of entrepreneurship, and a new approach to social insurance. These developments formed the background for the initial reforms in the health system, focusing on decentralization, attempting to diminish the role of the State and replacing it with market-driven incentives. Throughout the 1990s, a major focus of reforms was on the development of the “social insurance” structure of financing, which underwent numerous transformations, and the introduction of a PHC system. In 1998 the SCHIA founded the Primary Health Care Support Fund, which, together with international assistance organizations, funded retraining of physicians as GPs and provided assistance for setting up PHC practices. Every inhabitant of Latvia was to register with a family physician.

In the area of reimbursement systems for health care services, a number of different approaches have been introduced, abandoned and changed since the early 1990s. For a number of years, fee-for-service payments, capitation and capitation with fund holding, diagnosis-related groups (DRG) and volume-based contracting systems all existed at the same time, depending on the area of health care, level of care and geographical location. More recently a unified payment system has been adopted for providers throughout the country.

Some health facilities have been privatized or partially privatized, leading to the establishment of a wide variety of property ownership in the system. Throughout the 1990s many innovations, such as the purchaser–provider split and family health care as the basis for PHC were introduced. Private supplementary insurance has also been introduced.

Virtually every other aspect of the health care system has also been affected by the process of reforms, including the pharmaceutical sector, public health and dentistry, among others. One of the most important ongoing reforms is the Master Plan, or “Programme of Development of Primary and Hospital Care Services for 2005–2010”, developed by the World Bank. The aim of this reform

is to reduce administrative costs and improve the quality of health care services so as to improve patient access to health care.

1. Introduction

1.1 Geography and sociodemography

The Republic of Latvia is located on the eastern Baltic coast, in the western part of the eastern Europe plain. 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 lie the Baltic Sea and the Riga Gulf. Latvia's border length is 1862 km, of which the land border is 1368 km.

Latvia's territory is 64 589 km², with a flat landscape and extensive forests covering 44% of the land area and forming Latvia's most important natural resource. The highest point in Latvia, 311.6 m above sea level, is Gaizinkalns in the Madonas district. The average elevation of Latvia is 87 m above the sea level. Figure 1.1 shows a map of Latvia.

Fig. 1.1 Map of Latvia



Source: CIA 2007.

Table 1.1 Population/Demographic indicators, 1995–2004

	1970	1980	1990	2000	2004
Total population (mid-year)	2 351 903	2 511 701	2 663 151	2 372 984	2 312 819
Population, female (% of total)	54.4	54.0	53.5	53.9	53.9
Population aged 0–14 (% of total)	n/a	20.5	21.4	17.7	15.1
Population aged 65 and above (% of total)	n/a	12.9	11.8	15.0	16.4
Population aged 80 and above (% of total)*	n/a	n/a	n/a	2.6	3.0
Population growth (annual %)**	n/a	n/a	-0.6	-0.7	-0.6
Average population density (per km ²)	n/a	n/a	41.2	36.7	35.8
Fertility rate, total (births per woman)	1.9	2.0	2.0	1.2	1.2
Birth rate, crude (per 1000 people)	n/a	14.2	14.2	8.5	8.8
Death rate, crude (per 1000 people)	n/a	12.8	13.1	13.6	13.9
Age-dependency ratio (population 0–14 and 65+/population 15–64 years)	n/a	1/1.9	1/2.0	1/2.1	1/2.2
% of urban population	62.5	68.0	n/a	60.4	***60.0
Literacy rate (%) in population aged 15+	99.8	99.8	99.8	99.8	***99.7

Source: WHO Regional Office for Europe 2006.

Notes: n/a: not available; * Demographic yearbooks; ** <http://publications.worldbank.org/WDI/indicators>; *** Figures as of 2003.

The Atlantic Ocean, Baltic Sea, and Riga Gulf are the main factors that influence the regional characteristics of the climate, which is temperate, with average temperatures of 20° in summer and -5° in winter. During winter the air temperature changes in direction from west to east. Due to geographical proximity to the Atlantic Ocean and the Baltic Sea, the air temperature is warmer in the coastal region than in the eastern part of the country. In the coastal region winters are milder, summers are cooler and autumn is colder than spring.

The capital of Latvia is Riga, and the official language is Latvian.

In 2004, the population of Latvia was 2.3 million. It has been declining since independence, having fallen by approximately 13% in the period from 1990 to 2004, as a result of emigration and a combination of low birth rates and high death rates. As Table 1.1 indicates, the fertility rate has fallen from 2.0 in 1990 to 1.2 in 2004, and the birth rate dropped from 14.2 in 1990 to 8.8 in 2004. The death rate, in the meantime, has been steadily rising, climbing from 12.8 in 1980 to 13.9 in 2004. This natural increase has been negative in Latvia since 1991.

Due mainly to the low birth rate, but also because of emigration of the population to other countries, Latvia's population is ageing very rapidly, with the proportion of children aged 1–14 falling, and the share of the elderly aged 65 and above increasing. In view of the rapid growth of the share of the

population of pension age, the age-dependency ratio has increased from 1 to 1.9 in 1980 to 1 to 2.2 in 2004 (Table 1.1). In 2000, 2.6% of Latvia's residents were 80 years of age or older, and by 2004 the proportion of this group had already reached 3%.

In the future, it is expected that the size of the population will continue to fall, while the population continues to age.

The decrease in the size of the population has been accompanied by a fall in the number of separate nationalities, as well as by a drop in their proportion of the total population. At the beginning of 2005, the proportion of Latvians of the total population was 58.8%. The second largest group consists of Russians, with a share of 28.6% in 2005, followed by Belarusians with 3.8%, Ukrainians with 2.6%, Poles with 2.5% and Lithuanians with 1.4%. The share of other ethnic groups is below 1% (Gypsies, Germans, Estonians and others). The main religions are Lutheran (the largest share) and Roman Catholic.

Approximately 60% of the population live in urban areas, with approximately one third of the population in Riga alone. The population density in 2004 was 35.8 people per km², which lies below the average of the European Union (EU). Latvia has a very high literacy rate, at 99.7 in 2003.

Empirical evidence suggests that 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: 28% of Latvian-speaking households feel they have all necessary information on health care services, as compared to 21% of non-Latvian speaking households (CIET International 2002). Other characteristics of ethnic minorities do not play an important role in the process of receiving health care services. It appears that lack of knowledge of the language results in lack of information about the possibilities of receiving health care services (Chapter 2 *Organizational structure*, Subsection *Patient information*).

1.2 Economic context

The transformation of the economy has proceeded faster and further in Latvia than in most other countries of the former Soviet Union, with rapid expansion of the services sector at the expense of both agriculture and industry. The share of agriculture in gross domestic product (GDP) fell from approximately 23% in 1990 to 4% in 2005. Due – in part – to small farm size, agriculture remains inefficient. Latvian industry during the Soviet period provided the Soviet Union with radios, telephones, minibuses and other equipment, but was unable to stand

up to international competition following the collapse of the Soviet market in the early 1990s. More recently machine building has made some headway and light industry has recovered somewhat; however, the share of industry in GDP has fallen from approximately 44% in 1991 to 27% in 2005. The services sector, by contrast, has been growing rapidly, with its share of GDP increasing from 33% in 1991 to 70% by 2005. Factors behind this growth have included rapid expansion in transport and communications, financial services growth, and growth and modernization of the trade sector.

The 1990s were a turbulent decade for the Latvian economy, with a decline in real GDP of nearly 35% in 1992 and fluctuating growth rates in the latter part of the decade. However, from 2000 onward the economy has made a remarkable rebound. In the period 2000–2003 real GDP grew at an average annual rate of 7.7%, then in 2004 it increased by 8.5% and in 2005 by 9.5%. Factors behind this growth include strong domestic demand and the growth of exports to the other Baltic countries and the Commonwealth of Independent States (CIS).

The Government's goal is to pursue long-term and stable economic growth, with the aim of reaching the EU average GDP per capita within 20–30 years. In October 2005 the Government adopted the National Programme of Lisbon for 2005–2008. One of the programme goals was to ensure annual growth in real GDP of 6–8%.

In the period from 1994 to December 2004, the Bank of Latvia pegged the Lat (LVL, Latvia's national currency) to the Special Drawing Rate (SDR), the currency basket of the International Monetary Fund (IMF). Since 1 January 2005, the Bank of Latvia changed the peg to the euro ($\text{€}1 = \text{LVL} 0.70$), in view of Latvia's plans to eventually become a member of the Economic and Monetary Union (EMU). In May 2005 Latvia joined the EU's Exchange Rate Mechanism (ERM2) at the existing € –LVL parity rate. Latvia is to take part in the ERM2 for at least two years; during this period it must pursue all necessary measures in order to fulfil the Maastricht stability criteria. Despite initial expectations that Latvia will join the EMU on 1 January 2008, at the time of writing it is considered likely that this date may have to be postponed in view of high rates of inflation.

The price liberalization that occurred in Latvia in 1992 brought about a period of hyperinflation; however, this was quickly brought under control, with inflation falling to single-digit figures by the latter part of the 1990s. By 1992 it had fallen to a mere 1.8%, but subsequently increased, reaching 7.3% in 2004 as a result of high oil prices and wage increases. In 2005 inflation hovered at approximately 7%, with inflationary pressures fuelled additionally by increasing food prices due to Latvia's participation in the EU's Common Agricultural Policy and one-off price increases following Latvia's accession to the EU.

For several years the level of investment has been high, with the rate of investment (the ratio of investment to GDP) being one of the highest in the EU, at nearly 30%. Reasons include investments in infrastructure which have been made possible through EU funding, as well as modernization of production facilities and increased European interest in Latvia following accession to the EU, with 85% of direct incoming foreign investments in 2004 being connected to EU investors.

Latvia's Government deficit peaked in 1999 (at 3.7% of GDP), but has since fallen, averaging 2.3% of GDP in 2000–2003, and falling further to 1.6% of GDP in 2003 and 1.1% in 2004. As a result of strong growth, which increased tax receipts, together with the postponement of government expenditures, a budget surplus was evident in 2005 and the first months of 2006.

The level of state debt in Latvia is one of the lowest in EU. At the end of 2004, it was LVL 975 million or 13.2% of GDP. In November 2005 the state debt stood at approximately LVL 908 million.

Whereas exports have been growing rapidly, imports have grown even faster, as a result of strong domestic demand, thus resulting in an increasing trade deficit in 2005 and early 2006. Since independence the volume of trade with the EU has increased dramatically, so that currently approximately 75% of Latvia's foreign trade (imports and exports) involve the 25 countries belonging to the EU before January 2007 (EU25). While the EU15 share (EU Member States prior to May 2004) has dropped in recent years (due to low growth in the Eurozone), this has been more than made up for by increases in the EU10 (countries joining the EU in May 2004), particularly Estonia and Lithuania.

In 2005, exports consisted of the following: wood and wood products (approximately 25% of total); base metals (approximately 13%); textiles (approximately 9%); machinery and equipment (approximately 9%); prepared foodstuffs (approximately 7%); and chemicals (approximately 6%). The composition of imports was: machinery and equipment (almost 20%); mineral products (almost 16%); transport vehicles (approximately 11%); base metals (approximately 9%); prepared foodstuffs (approximately 6%); and chemicals (approximately 8%).

The labour force participation rate has been increasing since 2000, reaching 49% in 2004, and is close to the EU average. The proportion of women in the labour force is higher than the EU average and shows an increasing trend.

According to the Central Statistics Bureau of Latvia, the level of unemployment has been steadily falling in recent years, from 14.4% in 2000 to 10.4% in 2004 and 7.8% in the first quarter of 2005 (note that these figures differ from those appearing in Table 1.2, and are significantly higher). However, it is possible that the true unemployment figures may be even higher, as many

Table 1.2 Macroeconomic indicators, 1995–2004

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
GDP, PPP (current billion US\$)	n/a	n/a	n/a	n/a	n/a	7.7	n/a	n/a	11.1	13.6
GDP per capita (US\$)	1778	2061	2238	2611	2740	n/a	3200	3595	4771	n/a
Real GDP per capita, PPP (US\$)	3297	n/a	3940	5728	6264	7045	7730	9210	10270	n/a
Annual GDP growth (%)	n/a	3.8	8.3	4.7	4.7	6.9	8.0	6.5	7.2	8.5
Income or wealth inequality (Gini coefficient)	n/a	0.31	0.31	0.32	0.31	0.34	0.34	0.34	0.36	0.36
Short-term debt (million LVL)	n/a	n/a	n/a	n/a	n/a	63.1	28.4	37.9	52.7	73.0
Value added in industry (% of GDP)	n/a	n/a	n/a	n/a	n/a	23.3	n/a	n/a	22.2	22.5
Value added in agriculture (% of GDP)	n/a	n/a	n/a	n/a	n/a	4.5	n/a	n/a	4.1	4.1
Value added in services (% of GDP)	n/a	n/a	n/a	n/a	n/a	72.2	n/a	n/a	73.7	73.4
General government budget fiscal balance (% of GDP)	n/a	n/a	n/a	n/a	-3.7	n/a	n/a	-2.3	-1.6	-1.1
Labour force (as % of population)	54.1	47.5	40.0	58.8	n/a	46.7	46.7	47.9	48.3	49.0
Unemployment, rate in %	6.6	7.2	7.0	9.2	9.1	7.8	7.7	8.5	8.6	8.5
Official exchange rate (US\$)	0.528	0.551	0.581	0.590	0.585	0.606	0.628	0.618	0.571	0.540
Long-term interest rate; annual average (%)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	4.85

Sources: WHO Regional Office for Europe 2006; World Bank 2005.

Notes: GDP: Gross domestic product; PPP: Purchasing power parity; n/a: Not available.

of the unemployed remain unregistered. The highest unemployment rate is in the Latgale region, at 12.8% in 2004. The reason behind this lies in the weak development of business activities, the small number of self-employed people and poor physical infrastructure. In Latgale the GDP per capita is the lowest in the country, at about half the level of the national average.

In 2005 the average net salary of workers was LVL 176 per month (or approximately €251), following a 9.7% real increase (i.e. after inflation) over the previous year. The average old-age pension stood at LVL 71 (€101) per month, following a real increase of approximately 12% over the previous year. The official monthly minimum wage was increased from LVL 60 (€106) in 2001 to LVL 70 (€112) in 2003 to LVL 80 (€120) in 2004. As of January 2006 the minimum wage was raised to LVL 90 (€128) per month.

Despite rapid economic growth in recent years, poverty in Latvia is pervasive. According to the Poverty Reduction Strategy, adopted in August 2000, “low income” individuals are those earning less than 50% of the average monthly income; this average monthly income per household member was LVL 87 (€139) in 2003; therefore the “low income” threshold was a mere LVL 43 in 2003.

The official poverty line is defined as a minimum subsistence level and is determined as the monthly average value of a minimum consumer basket of goods and services per capita: this was set at LVL 93 (€149) in 2003 and LVL 98 (€147) in 2004.

At the time when the Poverty Reduction Strategy was adopted (2000), 16.2% of the total Latvian population was in the “low income” category. It may be noted that the official poverty line is more than double the “low income” threshold. Moreover, the poverty line lies above the average monthly income per household member, indicating that more than half of Latvia’s population subsists on incomes below the minimum subsistence level. In 2003 the official poverty line was also above the minimum wage level.

Social assistance in the form of a guaranteed minimum income is offered to the poorest people, but this amounted to a mere LVL 15 (€24) in 2003 and LVL 18 (€27) in 2004. It may be noted, too, that the degree of inequality of income distribution, as measured by the Gini coefficient, has been steadily increasing in recent years, rising from 0.31 in 1996 to 0.36 in 2004.

In response to the question “How do you evaluate the present economic situation of your household?”, posed by a 2003 household budget survey, the following replies were given:

- we think we are well off: 0.1%
- we are not rich but we manage to live well: 8.9%

- we are neither rich nor poor: 54.0%
- we are not poor, but on the verge of poverty: 29.7%
- we are poor: 7.3%.

1.3 Political context

Following a brief period of independence between the two World Wars, Latvia was annexed by the Soviet Union in 1940 and became the Latvian Soviet Socialist Republic. In late 1988 the Latvian Popular Front (LTF) held an inaugural congress and the Latvian National Independence Movement was formed. In July 1989 the Latvian Supreme Soviet (Parliament) declared Latvian sovereignty and economic independence. In May 1990 the LTF won a majority in the election to the Supreme Soviet, and reinstated the 1922 constitution while declaring the Soviet annexation illegal. A referendum held in March 1991 resulted in a 73.7% vote in favour of independence. Latvia declared itself independent on 21 August 1991.

Domestic structures and institutions

Latvia is a parliamentary republic governed by the State President and a unicameral Parliament (*Saeima*). Its present constitution is a revised version of the constitution of 1922. It now has a 100-seat Parliament (corresponding to Latvia's Parliament before the Second World War), which has replaced the 210-seat Supreme Soviet since June 1993. Elections are carried out according to proportional representation, with a political party needing at least 5% of the total vote to enter the *Saeima*. Since 1997 the parliamentary term is four years. The President is elected by the *Saeima*, by secret ballot, and can remain in office for a maximum of two consecutive 4-year terms. Although the President's position is mainly ceremonial, s/he is head of the armed forces and exercises substantial authority in both domestic and foreign affairs. The President also appoints the Prime Minister, who is responsible for appointing the other ministers of the Cabinet in line with the approval of the *Saeima*.

Since independence, Latvia has had 12 governments, none of which has as yet completed its term in office. The reason for this lies principally in the large number of political parties, which tend to form weak coalition governments.

The main political parties in Latvia include those listed here.

- Centrist parties: New Era; People's Party; Union of Greens and Farmers (ZZS); First Party; Latvia's Way.

- Nationalist (right-wing) parties: Latvian National Independence Movement, which in 1997 merged with For Fatherland and Freedom to form the TB/LNNK.
- Left-wing parties: Party for Equality; People's Harmony Party; Latvian Socialist Party; Social Democratic Workers' Party; Social Democratic Union.

The Government came to power in October 2006, under the leadership of Prime Minister Aigars Kalvitis of the People's Party. Mr Aigars Kalvitis first came to power in December 2004, following the collapse of the previous government (which had been in office for a period of seven months). The current Government is the fourth since the parliamentary elections of October 2002, and consists of a centre-right coalition of four parties: the People's Party, the First Party, the ZZS and the TB/LNNK. The next parliamentary elections are scheduled for October 2010. Mr Vinets Veldre, of the People's Party, was elected by the Parliament as Minister of Health in 2007.

The presidency is held by Mr Valdis Zatlers, a political independent, who was elected for the first term in June 2007. The previous minister, Mr Gundars Berzins, was Minister of Health since December 2004.

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, was responsible for monitoring and implementing 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 (for a list of the most important pieces of legislation and regulations, see Section 7.1 *Analysis of recent reforms*).

The group that has influenced the course of health care reforms in Latvia most significantly – particularly during the early years of reforms – is the Latvian Physicians Association, which was re-established in 1988 (having been abolished during the Soviet period). In addition, health service administrators have been vocal, while consumer groups do not exercise a great deal of influence, aside from their capacity as voters.

Membership of key international organizations

Latvia became a member of the United Nations in December 1991, and joined the World Trade Organization (WTO) in October 1998.

In November 2002 Latvia was invited by the North Atlantic Treaty Organization (NATO) to initiate negotiations for accession into NATO. In March 2004 Latvia became a full NATO member, along with the other Baltic states, Estonia and Lithuania, and four more former communist states. Public opinion polls carried out in spring 2006 indicated that nearly 80% of the Latvian population supported the country's NATO membership on the grounds that it will offer increased security.

In December 2002 Latvia ended its EU accession negotiations (initiated in December 1999). In May 2004, together with Estonia, Lithuania and seven additional countries, Latvia joined the EU. A referendum held in May 2004 revealed that 67% of voters were in favour of EU membership.

Administrative divisions and tax administration across levels of government

Latvia is administratively divided into three levels: federal level; regional level, comprising 26 regions (or districts or *rajons*) and 7 large urban areas or cities; and municipal level, consisting of 480 rural municipalities (*pagasts*). More changes in Latvian administrative division are foreseen and these are outlined in Section 7.2 *Future developments*.

The following types of taxes can be identified in Latvia (OECD 2000):

- state taxes and duties imposed by parliamentary laws
- state duties imposed by the Cabinet of Ministers
- local government duties imposed by municipal councils.

Tax rates are most often set in accordance with the principle of proportionality (there is limited progressivity).

State taxes include the following:

- personal income tax, which is a flat rate of 25% on annual taxable income;
- real estate (property) tax;
- company profit tax, at a flat rate of 15%;
- value-added tax (VAT), at 18% (5% for medicines and medical equipment);
- excise tax on oil products, alcoholic beverages and tobacco products;

- customs duties;
- natural resources tax;
- tax on lotteries and games of chance;
- compulsory social insurance contributions – this is known as the “social tax”, and covers only social expenditure; it does not cover health expenditure as this is financed from the state budget, i.e. by the other state-level tax revenues listed above.

Local governments have their own budgets, although they receive most of their financing from the state. Local government revenue comes from the following sources:

- 71.6% of state personal income tax – each local government receives this percentage in accordance with the number of taxpayers within its territory;
- 100% of state property tax – this is received directly by the local government on whose territory the property is located;
- percentages of state charges;
- charges imposed by local governments – these are at the discretion of local governments and may include charges on official documents, commercial activities in public places, advertisements/announcements in public places, accommodation of holiday-makers and tourists, among others;
- grants allocated from the state budget;
- grants from the local government equalization fund (a fund created to allow for equal conditions for all local governments, financed by state budget allocations and contributions from local governments – equalization criteria include number and age distribution of inhabitants, number of children and elderly people in children’s and old people homes, respectively);
- service fees.

Local government responsibilities broadly include ensuring access to health care services, promoting healthy lifestyles, restricting alcoholism, ensuring public order and safety, providing education and social services (old-age institutions, asylums for the homeless, homes for orphaned children, etc.). More information on the respective responsibilities of the state and local levels in terms of provision and financing of health care services are discussed in Section 2.4 *Decentralization and centralization*.

Corruption and tax evasion

A pressing problem that remains in Latvia concerns the level of corruption, considered to be largely due to the Soviet legacy, the weak judicial system, inefficient and unenforced legislation, and the pre-eminence of business over state interests in the area of policy (Economist Intelligence Unit 2006). According to Transparency International, Latvia has a Corruption Perceptions Score of 4.2 (where the maximum score of 10 represents “highly clean” and the minimum score of 0 represents “highly corrupt”), and was ranked 51st out of 159 countries (Transparency International 2005).

It is estimated that unpaid income and social taxes (see the earlier discussion for a definition of these) constitute 15–40% of GDP. A comparison of declared income and actual expenditure in official statistics suggests that over LVL 680 million of tax revenue is not collected; the magnitude of this sum can be appreciated when compared to total personal income tax collected in 2003, which was LVL 367 million (Brauna 2005).

The missing tax funds have had dire consequences for the health sector, municipalities and local self-governments, as well as for pensioners. In the case of the health sector, during the period 1997–2003 the state health care budget received an earmarked 28.4% of personal income taxes (as well as subsidies from general revenue); therefore such huge shortfalls in tax revenue had immediate implications for the size of the health care budget. As of 2004, there are no longer earmarked taxes for health care. Local self-governments, on the other hand, receive 71.6 % of personal income taxes (as noted earlier). They therefore face significant losses, clearly affecting their ability to spend on the social services for which they are responsible. Pensioners also feel the losses directly, because the budget for pensions comes from an earmarked social tax (or social insurance contribution); therefore, the size of pensions is directly proportional to the size of this tax revenue.

Part of the difficulty of tax collection concerns weaknesses in tax legislation (proof of income as well as proof of legitimacy of income are not necessary; and sanctions are lenient in the case of violations), as well as weaknesses in the administrative and financial capacity of the tax collection process. For example, whereas a substantial part of tax revenue is collected by the local authorities (even though these are state-level taxes), the local authorities have not made sufficient efforts to improve tax collection (by admission of the Association of Local Authorities), but they also do not have sufficient authorization to do so. The State Revenue Service (at state level), on the other hand, devotes most of its resources to VAT collection (Brauna 2005).

1.4 Health status

Life expectancy and mortality

As can be seen in Table 1.3, showing mortality and health indicators in Latvia, for those born in 2005 the average life expectancy is 71.1 years, or 65.4 for men and 76.6 for women, which is the lowest among the Baltic and Nordic countries. Trends in life expectancy are similar to those in other eastern European and former Soviet Union countries. Life expectancy in Latvia is 10 years lower than the WHO Eur-A¹ average for males, and almost five years lower for females. However, it may be noted that life expectancy actually took a dip in the early 1990s, when the lowest life expectancy at birth in the 1990s was recorded for 1994, at 60.7 years for men and 72.9 years for women.

Infant mortality remains high by western European standards, although it has fallen substantially since 1980. Conditions occurring during the perinatal period caused 47% of all infant deaths in 2004. The under-5 mortality rate per 1000 live births also shows a decreasing trend, falling from 20.6 per 1000 live births in 1980 to 12.4 in 2000 and 9.3 in 2006.

Table 1.4 shows the main causes of death in Latvia. In 2004, the main noncommunicable diseases accounted for approximately 78% of all deaths in Latvia, with 53% of all deaths caused by diseases of the circulatory system and 17% by cancer. External causes were responsible for approximately 12% of all deaths and communicable diseases for less than 1%.

Table 1.3 Mortality and health indicators, 1970–2005 (selected years)

	1970	1980	1990	2000	2004	2005
Life expectancy at birth, total (years)	69.9	69.2	69.5	70.6	71.3	71.1
Life expectancy at birth, female (years)	74.1	74.2	74.6	76.1	76.3	76.6
Life expectancy at birth, male (years)	65.4	63.8	64.2	64.9	66.1	65.4
SDR all causes, all ages, per 1000, female	n/a	9.1	8.9	8.0	7.8	7.7
SDR all causes, all ages, per 1000, male	n/a	16.7	16.6	16.2	15.6	16.1
SDR all causes, 0–64, per 1000, female	n/a	3.1	2.9	2.8	2.8	2.7
SDR all causes, 0–64, per 1000, male	n/a	8.1	8.0	8.0	7.5	8.0
Infant deaths per 1000 live births	n/a	15.3	13.7	10.4	9.4	7.8
Under-5 deaths per 1000 live births	n/a	20.6	17.6	12.4	11.3	9.5

Source: WHO Regional Office for Europe 2007a.

Notes: SDR: Standardized death rate; n/a: Not available.

¹ Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe.

Table 1.4 Main causes of death, SDR per 100 000 population, 1990, 1995, 2000, 2004

		1990	1995	2000	2004
Communicable diseases	Infectious and parasitic diseases (A00-B99):	11.3	21.2	15.3	11.8
	TB (A15-A19; B90):	6.8	14.6	11.8	7.3
Noncommunicable conditions	Circulatory diseases (I00-I99):	670.4	754.5	592.6	578.1
	Malignant neoplasms (C00-C97):	195.6	196.1	191.9	193.2
	Trachea/bronchus/lung cancers (C33-C34):	40.1	38.3	35.8	35.3
	Mental and behavioural disorders (F00-F99; G00-G95; H00-H95):	13.0	27.12	18.5	16.1
	Respiratory diseases (J00-J99):	40.7	48.8	30.8	27.9
	Digestive diseases (K00-K93):	27.3	39.7	35.9	36.8
External causes	(V01-Y99):	138.7	207.5	152.6	129.4
Transport accidents	(V01-V99):	43.5	33.9	28.6	21.6

Source: WHO Regional Office for Europe 2006.

Note: TB: Tuberculosis.

The structures of causes of death vary for men and women at different ages. For men and women up to 44 years the first causes of death are external causes (traumas, direct self-injuries, violence, intoxication, etc.). For men older than 45 years and for women older than 55 years the first cause of death is circulatory diseases. For women aged 45 to 54 years the first cause of death is tumours.

More than half of all deaths in Latvia are caused by diseases of the circulatory system. A comparison with other Baltic and Nordic countries shows that the mortality rate from this cause of death is the highest in Latvia. Ischaemic heart disease is the single biggest killer in Latvia, causing approximately 27% of all deaths in 2005. Yet, for men and women aged 30 years or over, the Latvian mortality rate has declined substantially; younger age groups approached the Eur-A average in 2003. Compared to the WHO Eur-B+C² average, the Latvian rate is currently lower for all age groups, although the difference is small for men aged 75 years or over. The declining trend in mortality is similar for deaths from cerebrovascular diseases for both sexes and for all age groups, with the exception of males in age groups 30–44 years and 75 years or over, for which the death rate started to increase in the late 1990s.

For both men and women in almost every age group the second cause of death is tumours. The high mortality among men is associated with smoking and (ab)use of alcohol.

Cancer causes over one in six deaths in Latvia. Whereas cancer mortality has been decreasing in all age groups below 75 years, the Latvian rates remain higher than the Eur-B+C average for males and females aged 60 or over. Among

² Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristic from Eur-A countries.

elderly Latvians, both men and women, cancer death rates have constantly increased since the 1980s.

Mortality from external causes more than doubled between the late 1980s and 1994, but has decreased by over 40% since then. Even though the decline has been slow in recent years, the Latvian mortality rate has reached the Eur-B+C average. Despite falling mortality, the Latvian death rates are still high for all external causes, especially for deaths from accidents, traffic accidents, accidental falls, accidental drowning and exposure to smoke, fire and flames.

Suicides and homicides have decreased, with death rates having fallen since the mid-1990s by more than 40% and almost 60%, respectively. The trends are similar for both sexes and all age groups. The suicide rate among young Latvians (aged 15–29 years) has fallen below the Eur-B+C average. The same is true for men aged 30–44 years and 60–74 years (WHO Regional Office for Europe 2005).

Suicides are the fifth most common cause of death in Latvia, with the number of suicides exceeding the number of deaths due to traffic accidents. Mortality from suicides is higher for the working-age population. Mortality in males is 5–7 times higher than in females. Men commit suicide due to social problems, but women due to relationship problems.

Suicides give rise to a high figure for the country's potential years of life lost (PYLL³) (HSMTSA 2006). In 2003, 10 635 potential years of life were lost due to suicides. Most potential years of life are lost due to external causes, 19% of these being due to suicides. Nearly the same amount are lost due to transport accidents. PYLL and mortality are 5–6 times higher for males. The highest PYLL was registered for members of the population of working age, especially in the 20–29 years age group. Latvia has the fifth highest suicide rate compared to other European countries. Higher rates were registered in Lithuania, Russia, Belarus and Ukraine. The number of registered suicide attempts is similar to the number of suicides. However, it is estimated that the actual number of attempts is 7–8 times higher.

These figures are indicative of mental health problems, which along with an unfavourable social situation can result in serious consequences. Unfortunately, in Latvia there is neither a national policy nor action plan aiming at a decrease in the suicide rate. People who have made a suicide attempt do not receive appropriate aid. In Riga City these people are referred to the Mental Health State Agency, if any mental health condition is suspected.

In March 2005 there was a United Nations campaign against violence, including suicides. This was a preventive campaign aimed at informing the

³ PYLL are years between age at death and some arbitrary standard.

population about the possibilities of receiving necessary aid for those attempting suicide (Apine 2005).

In 1991–2001 the incidence of tuberculosis (TB) increased sharply. In 1994 Latvia adopted the World Health Organization (WHO) Tuberculosis Control Strategy as the basis for its National Tuberculosis Control Programme, thus enabling timely diagnosis, treatment and prevention according to world standards. In 1995 the directly observed treatment short-course (DOTS) strategy was initiated, which provided the use of TB drugs under the direct control of a medical worker. In 1997 DOTS was implemented in the whole country, including prisons. At the end of 2004, a WHO collaboration centre for treatment, research and education in multi-drug resistant tuberculosis (MDR-TB) was established in Latvia. Whereas these activities have reduced the incidence of TB, its spread remains high in Latvia. In 2005 it was 61.3 per 100 000 population, compared to 84.9 per 100 000 in 2001 (the sixth highest incidence within the WHO European Region, according to the WHO Regional Office for Europe Health for All database).

In 2004 the incidence of human immunodeficiency virus (HIV) in Latvia was 13.9 per 100 000 population, compared to 55.1 per 100 000 population in Estonia, 3.9 per 100 000 in Lithuania, 5.4 per 100 000 in Denmark, 2.5 per 100 000 in Finland, and 4.7 per 100 000 in Sweden. The highest incidence is registered for young people of 18–29 years of age (62.7% of total HIV-infected individuals). This highest incidence was registered in both Riga city and Ventspils city. A total of 70% became infected with the virus through intravenous drug use, although this group shows the greatest decrease in HIV incidence. In Latvia young females aged 16–29 years are the most significant risk group. In 2004 Latvia had the highest incidence of acquired immunodeficiency syndrome (AIDS) at 3.3 per 100 000 population; in the other Baltic and Nordic countries the incidence did not exceed 2.2 per 100 000 population (WHO Regional Office for Europe 2007b). At the end of 2004 there were 322 registered AIDS patients. In 2004 AIDS caused 15 deaths compared to 12 deaths in 2003. A total of 76 individuals have died from AIDS since 1987 when the first HIV-positive person was registered.

Factors affecting health status

The rates of prevalence of diabetes and cancer show an increasing trend (Table 1.5).

In general, the lifestyle of the Latvian population is unhealthy. Statistics confirm that Latvians prefer strong alcohol, with 40% of total alcohol consumption being vodka and liqueur, resulting in many deaths from external

Table 1.5 Prevalence/incidence of diabetes and cancer in selected countries, 2000–2004

	Prevalence (%)				Incidence per 100000 population			
	2000	2002	2003	2004	2000	2002	2003	2004
Diabetes:								
Latvia	1.5	1.5	1.7	1.7	144.5	200.7	165.6	188.3
Lithuania	1.5	1.7	2.0	2.1	210.6	261.3	292.4	306.3
Estonia	n/a	n/a	n/a	n/a	254.5	395.5	345.7	297.3
Finland	2.6	2.8	2.9	3.1	235.9	251.8	252.6	274.3
Cancer:								
Latvia	2.0	2.1	2.2	2.3	366.0	383.9	394.1	419.0
Lithuania	1.7	1.8	1.8	1.9	401.2	417.5	437.2	464.1
Estonia	2.4	2.7	2.8	n/a	434.8	n/a	n/a	n/a
Denmark	4.1	4.1	4.7	3.4	601.3	624.8	633.8	n/a
Finland	2.8	3.0	3.3	n/a	431.4	447.7	474.9	501.1
Norway	3.4	3.5	3.7	3.8	501.2	500.1	510.6	532.1
Sweden	n/a	n/a	n/a	n/a	512.6	523.8	543.4	560.2

Source: WHO Regional Office for Europe 2006.

Note: n/a: Not available.

causes and a high number of traffic accidents. Approximately 45% of males and about half of all females are either overweight or obese. A total of 51.1% of males and 19.2% of females aged 18 years or over are daily smokers. The Ministry of Health, the State Narcology Centre and WHO have designed a programme aiming to decrease alcohol consumption and alcoholism in the period 2004–2008 in order to improve quality of life and safety. The programme has three main goals: restriction of supply (advertisements, legal and illegal places of purchase of alcohol), decrease of demand (prevention, alternative possibilities for recreation, treatment, medical and social rehabilitation) and decrease of risky and harmful alcohol abuse (road traffic accidents, accidents at work places) (HSMTSA 2006).

Insufficient physical activity of the Latvian population, unhealthy diet, smoking and alcohol abuse are causes of high morbidity, high disability levels and high mortality rates from cardiovascular diseases.

According to the WHO Regional Office for Europe Health for All database, alcohol consumption in 2003 was 8.4 litres per capita or 9.9 litres per inhabitant aged 15 years or over (WHO Regional Office for Europe 2007b). This is not high compared to other EU countries. However, between 30% and 50% of total consumption involves illegal alcohol. Moreover, in Latvia consumption of strong alcoholic drinks is much higher than in other European countries (according to Cabinet of Ministers Order No. 40 of 19 January 2005 “Alcohol Consumption Decrease and Alcohol Restriction Programme 2005–2008”).

The incidence of alcoholism and alcoholic psychoses, mortality from hepatic cirrhosis and traumas caused by alcohol abuse are indications of serious problems related to alcohol. Special attention must be paid to alcoholism among children and adolescents. The number of children and adolescents who have been diagnosed with conditions related to alcohol abuse has been increasing.

Changes in the socioeconomic situation in Latvia in recent years favour the spread of drug abuse. All data showing both drug supply and demand indicate a deteriorating situation. Easy access to drugs promotes the prevalence of narcotic and psychotropic substances abuse.

In recent years drug trafficking has become more mobile and clandestine due to legislative changes and more severe sanctions. It is estimated that 13% of the population aged 15–64 years have used drugs at least once during their lifetime. This figure is about three times higher for males than for females. Young people aged 15–34 years have tried to use drugs more often (every fifth young person). Marijuana and hashish are the most common drugs in Latvia.

In December 2004 the Latvian Parliament adopted the WHO Framework Convention on Tobacco Control. Surveys suggest that the proportion of the population that smokes decreased slightly in 2004. In 2002 51.1% of males and 19.2% of females smoked; in 2004 these figures were 47.3% for males and 17.8% for females.

According to the results of a 4th survey of population health using the FINBALT health monitoring methodology, in 2004 only 36% of respondents were getting sufficient physical activity; however, this was an improvement over 2002 (34.8%) and 2000 (34%). Physical activity in men increased from 40% in 2002 to 42.9% in 2004, although physical activity in women did not change significantly (31.1% in 2004 compared to 30.8% in 2002). There is evidence that people do not consider the importance of physical activities as a health-promoting factor (State Health Promotion Agency of Latvia 2004).

Intake of vegetables is insufficient in Latvia. Only 21.9% of males and 27.3% of females eat fresh vegetables every day (17.4% and 26.4% in 2002) (Krastins 2005). Answers on this subject differed according to place of residence: inhabitants of Riga eat vegetables more often, whereas inhabitants of rural districts do so less often in comparison to the rest of the population. Intake of vegetables appears to depend on knowledge rather than availability: vegetables were more popular among respondents with a higher level of education.

The proportion of the population that prefers high-fat dairy products appears to be decreasing, particularly among younger people. Also, the proportion of people who eat wholegrain and bran bread has increased in recent years. Market supply studies show similar trends. Different kinds of wholegrain, seeded and bran bread have been introduced into the market during recent years. Intake of

wholegrain and bran bread is related to the level of education of respondents, with consumption increasing as the level of education rises.

In recognition of the benefits of reductions in salt intake, in July 2005 the Government of Latvia adopted a “Regulation on Compulsory Safety, Quality, Hygiene and Marking Requirements for Common Salt, its Distribution and Use in Foodstuff Manufacturing”, requiring that iodine be added to common salt, to combat the problem of iodine deficiency.

Surveys have demonstrated that obesity is a serious problem in Latvia. Only 55.5% of males and 50.7% of females had normal weight in 2005; 26.5% of the population (30.1% of males and 23.9% of females) are overweight, while 16.3% (11.9% of males and 19.5% of females) are obese (Krastins 2005). On the other hand, 2.6% of males and 5.9% of females are underweight. Compared to previous years, the incidence of obesity has increased.

Access to safe water

In Latvia there are sufficient water resources, and the amount of available water resources exceeds consumption of water. The country's inland water area is 2543 km², or nearly 4% of the total territory of Latvia.

The quality of drinking water is regulated and evaluated in accordance with the requirements of government “Regulations on Drinking Water Compulsory Safety Requirements” (adopted by the Cabinet of Ministers in 1991), which define physical, chemical and bacterial standards. Municipal water-supply enterprises ensure the quality of drinking water. According to the same regulations, regular monitoring of drinking water quality must be carried out by water-supply enterprises, while audit/monitoring is the responsibility of the Public Health Agency.

Decayed, missing and filled teeth at age 12 years (mean value)

According to the WHO policy guidelines “Health in the 21st century”, a key target is that at least 80% of 6-year-old children must not have caries, and 12-year-old children on average must not have more than 1.5 decayed, missing or filled teeth (DMFT). In Latvia this target has not been reached: in 2005 among 12-year-old children the DMFT index was 3.54, and shows an increasing trend (it was 3.4 in 2004 and 3.3 in 2003) (WHO Regional Office for Europe 2007a).

Levels of immunization

Immunization rates have been increasing in Latvia (Table 1.6), while the incidence of vaccination-dependent diseases has fallen. In 2001 the Ministry of

Table 1.6 Levels of immunization (%), 2005

Measles (16–23 months)	95.0
Polio (2 years old)	95.6
Rubella (16–23 months)	95.0
Hepatitis B (1 year old)	98.1
Neonatal tetanus (2 years old)	95.6
Diphtheria (2 years old)	95.6
Whooping cough (2 years old)	95.0
Mumps (16–23 months)	98.7

Source: HSMTSA 2007b.

Welfare adopted the State Immunization Programme 2001–2005, one of the tasks of which was to reach immunization levels recommended by WHO, involving at least 95% of the total child population. The State Immunization Programme contains a Vaccination Calendar defining children's vaccination schedule. Although not all children are vaccinated in accordance with this schedule, the immunization levels recommended by WHO have been reached.

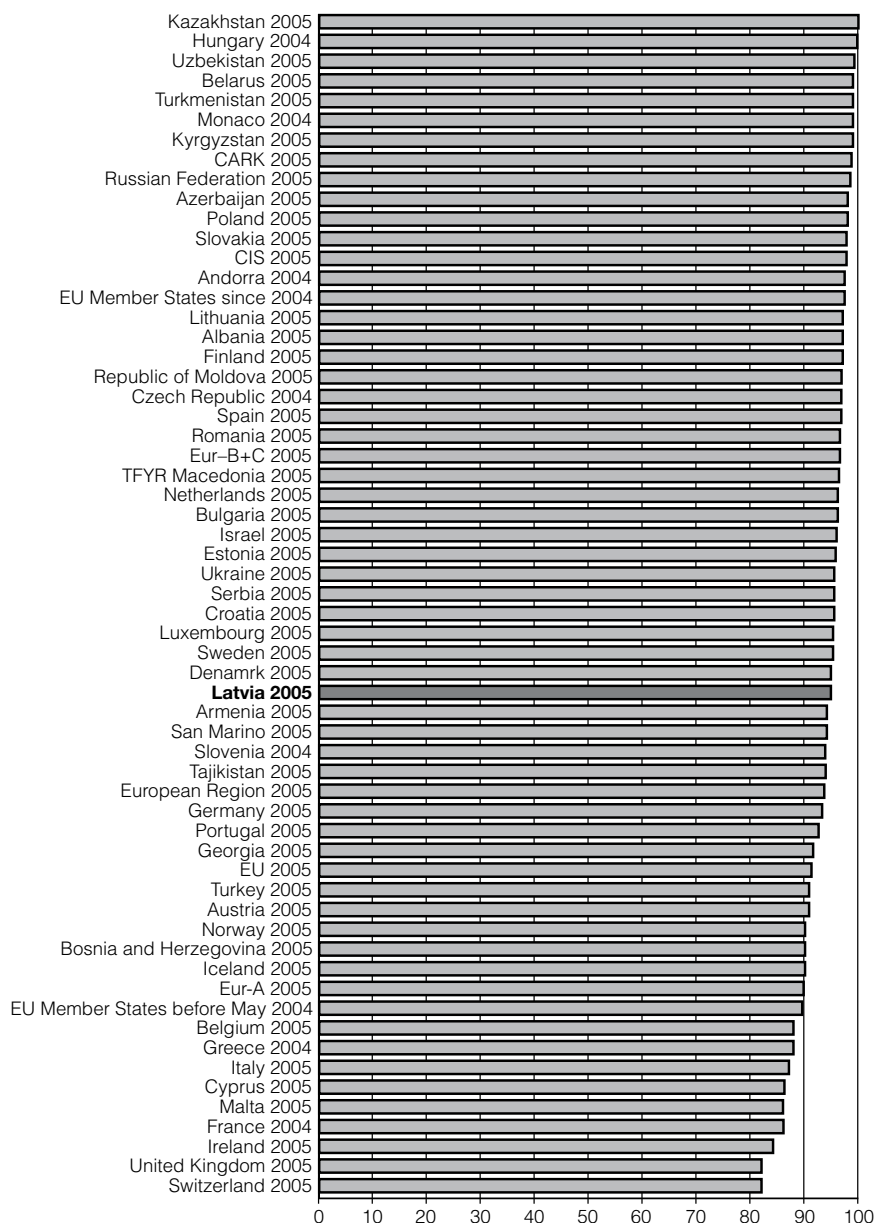
A key problem concerns the high level of morbidity among adults due to diphtheria, caused by shortages of vaccination supplies. Morbidity due to other vaccination-dependent diseases is extremely low.

In 2002 and 2003 the Public Health Agency carried out a survey on obstacles to immunization of children of 1, 2 and 8 years of age. The immunization rate of children aged 8 years is considered adequate: 94.8% of children have been vaccinated against diphtheria, tetanus and polio; 96.5% of children against measles; 96.3% against mumps; and 89.3% against rubella.

The most significant obstacles to vaccination revealed by the survey are socioeconomic factors: children from disadvantaged families have lower immunization rates. Other factors of lesser importance include change of place of residence, change of family doctor, irregular vaccination in schools, lack of notification about vaccination, as well as medical reasons (allergic rhinitis, dermatitis and bronchial asthma).

The survey also reveals problems related to vaccinating institutions that obstruct immunization. For example, only 13.5% of the total surveyed medical institutions provide vaccinations for eight hours a day; only 9.2% of institutions remain open after 19:00, thus limiting access for working parents.

Figure 1.2, showing Latvia's position with respect to levels of child immunization for measles in comparison with EU countries, indicates that in 2005 Latvia achieved 95% of immunization coverage (WHO Regional Office for Europe 2007a). This is higher than many other countries of the region and

Fig. 1.2 Levels of child vaccination against measles in the WHO European Region, 2004–2005

Source: WHO Regional Office for Europe 2007a.

Notes: CARK: Central Asian republics plus Kazakhstan; CIS: Commonwealth of Independent States; EU: European Union; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristic from Eur-A countries; TFYR Macedonia: The former Yugoslav Republic of Macedonia; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe.

substantially higher than the 91.3% average for the EU (WHO Regional Office for Europe 2007a).

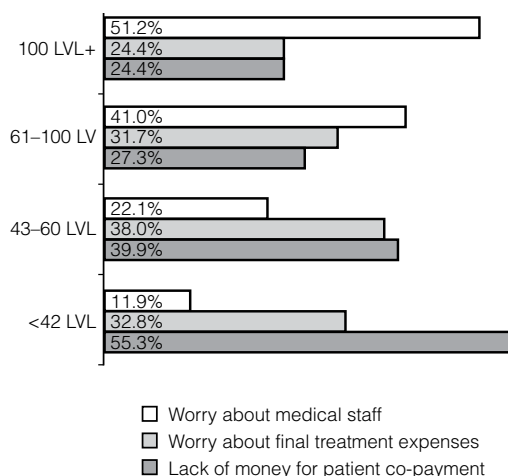
Minorities

Statistical data on health status by ethnic origin are not collected in Latvia; therefore, it is not possible to arrive at any conclusion identifying or characterizing any differences in health among minorities. The minorities in Latvia have been residing there for long periods of time and are not localized in one administrative territory, but are scattered throughout the country.

Health inequalities and access to health care services

A major restriction to access to medical care is low income. The proportion of poor people is still very high in Latvia (as noted in Section 1.3 *Economic context*) and there is evidence that population health depends in part on ability to pay for health care services. Increasing prices and low incomes limit possibilities for receiving health care services or purchasing medicines (Krastins 2005). According to a survey of 1000 citizens in various regions of Latvia, one third of the respondents were unable to obtain necessary health care services as a result of low incomes (Boronenko 2003). Moreover, the regions with the more serious access problems were also those in which the population suffers from the poorest health, suggesting that there is a close link between health status and access to health care services.

Other studies suggest that even larger proportions of the Latvian population may have difficulties with access due to not being able to afford certain services. According to the United Nations Development Programme (UNDP) Latvian Population Development Report, 83.0% of respondents are worried about their ability to cover health care expenses (Kesnere 2005b). A total of 48.2% of respondents who had participated in the survey “Latvian population income level and health care access” (Karaskevica 2003) answered they had refused health care services due to lack of money for patient payment, and 32.9% had worried about final treatment expenses. By comparison, only 18.9% respondents refused health care services due to doubt about medical staff’s competence and experience. Further, 51.6% of respondents do not buy prescribed medications regularly, and 75% of these refer to lack of money as the reason for this. As Fig. 1.3 indicates, the lower the income, the higher the proportion of respondents who worry about lack of money as a constraint to receiving necessary health care services.

Fig. 1.3 Reasons for refusal of medical care, by income per one household member, 1999

Source: Karaskevica, 2003.

Access to health care services, and very likely health status as well, are influenced by distances from the place of residence to the health care institutions. In small municipalities, people have to walk long distances to the bus stop to get to health care facilities, and there is also a possibility that they will not have the opportunity to return home the same day. Therefore, geographical restrictions that may influence health status include geographical proximity to health care institutions, and costs of transportation, and these are to be considered over and above the costs of receiving services. To reduce these restrictions, especially for people with low incomes, municipalities often pay for transportation and other costs, or provide their inhabitants with the transportation means to get to the doctor (municipalities are legally obliged to ensure access to health care). In many municipalities, mostly those far distant from the health care institutions, the inhabitants are provided with visits from family doctors within the municipalities (on site) at least twice per month. However, these services are insufficient to guarantee timely access to the necessary health care for populations living in distant rural areas (Section 6.3 *Primary ambulatory care*).

In addition to reduced access for the rural population due to geographical distances, incomes of the rural population are also on average lower. They therefore spend less on health care services and medicines. Results of the Health Survey of the Population of Latvia (Central Statistical Bureau of Latvia 2004), indicate that whereas the average amount of money spent on health care in 2003 per household member (per year) was LVL 49.56 in urban areas, in rural areas it was LVL 30.88; in the case of expenses for medical products and equipment the average per household member per year was LVL 35.20 in

urban areas compared to LVL 22.19 in rural areas; and in the case of expenses for outpatient care it was LVL 14.38 in urban and LVL 6.61 in rural areas (Section 3.4 *Revenue collection/sources of funds*, Subsection *Out-of-pocket payments*). Lower spending on health care in rural areas tends to be associated both with lower incomes and with reduced access to services due to lack of availability.

Poor access to health care services delays diagnosis of illnesses, resulting in complications and higher treatment expenses. The survey “Latvian population income level and health care access” has shown that low income levels are associated with higher hospitalization rates, and therefore higher treatment costs than timely outpatient diagnosis and treatment (Karaskevica 2003).

Health challenges for people with disabilities

Latvian public organizations struggle for the rights of disabled people with regard to social and environmental accessibility. The association “Apeirons” focuses on different problems faced by disabled people, organizes activities, takes part in the education of society in general and submits proposals to decision-makers.

At the time of writing in Latvia there are no effective measures for reducing disability, due to insufficient funding for health care, for reimbursed drugs and for medical and social rehabilitation. While there have been some improvements, limited progress has been made to date.

In June 2005 the Government adopted a document entitled “Basic statements for a policy to reduce disability and its consequences”, developed by the Ministry of Welfare. The main emphasis is on prevention of disability and promotion of a well-equipped, stable and friendly environment in order to favour the integration of disabled people into society. This includes the basic principles of disability prevention and social protection policy, along with key aims and priorities for the next 10 years.

Participants in the Health Survey of the Population of Latvia 2003 were asked about long-term limitations to activity, lasting more than 6 months. The most common health problems causing long-term limitations to activity included musculoskeletal illnesses (34% of respondents), impaired eyesight (33.2%) and illnesses of the heart, blood vessels and lungs (31.3%). In addition, women mentioned illnesses of the nervous system (Central Statistical Bureau of Latvia 2004).

Maternal and child health

On 13 February 2001 the Government adopted a Public Health Strategy, a key objective of which is that “the health of newborns, infants and pre-school age children must be significantly improved in Latvia by 2010”. In addition, the Government adopted a Maternal and Infant Health Care Strategy concerned with issues of reproductive, perinatal and infant health care. The strategy defines directions to be pursued in order to ensure high-quality, effective and appropriately funded maternal and infant health care in Latvia.

The adolescent (under-18) pregnancy rate, an indicator of health education/health promotion in Latvia, remains constant at approximately 2.1% of all pregnancies (HSM TA 2007a).

According to results of the Health Survey of the Population of Latvia, approximately 55% of women, who had either a 1st or 2nd pregnancy, visited a gynaecologist for the first time in the 6th gestation week. At the same time, 49.2% of women who were in the course of their 3rd pregnancy visited a gynaecologist for the first time between the 7th and 12th gestation week. There was a correlation between the level of a woman's education and the time at which she first sought antenatal care (Central Statistical Bureau of Latvia 2004).

In Latvia the perinatal mortality rate is higher than in the other Baltic states. Perinatal mortality is related to antenatal care started on time (Kesnere 2005a). An important contributing factor to infant mortality is psychoactive substance abuse. The most common causes of perinatal mortality are intrauterine hypoxia and asphyxia, and congenital malformations (HSM TA 2007a). The most common causes of infant mortality are certain conditions that originate from the perinatal period, as well as congenital malformations. Infant mortality shows a declining trend (Table 1.7).

By 2005 maternal mortality had fallen to 4.6 per 100 000 live births. This figure is lower than the EU average (6.7 per 100 000 live births in 2005) and than in the two other Baltic countries (13.9 per 100 000 live births in Estonia and 13.1 per 100 000 in Lithuania in 2005) (WHO Regional Office for Europe 2007a). Risk groups include women with high blood pressure, thromboses, diabetes mellitus, and heart disease, as well as those who have given birth multiple times, and those who have not received antenatal care.

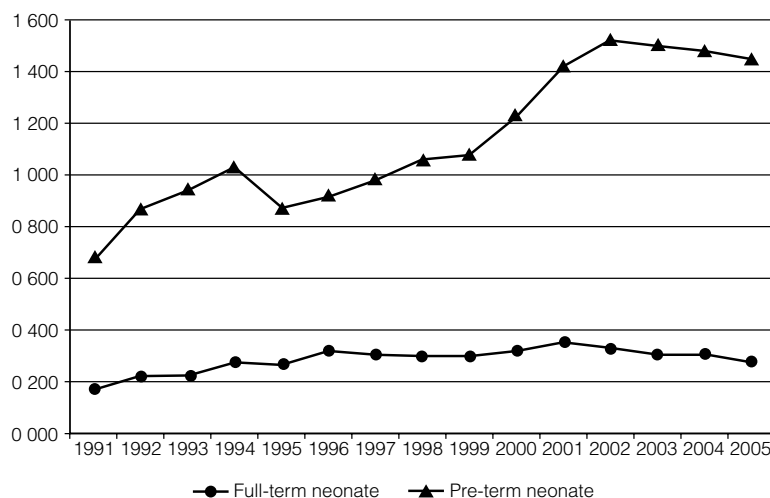
Figure 1.4 shows morbidity of infants with pathologies of the perinatal periods “full-term newborn” and “pre-term newborn”. The morbidity of pre-term newborn infants with these pathologies is about five times higher than those of full-term newborn infants.

Table 1.7 Maternal and child health indicators, 1986–2005

	1986	1992	1994	1996	1998	2000	2002	2004	2005
Neonatal mortality (neonatal deaths per 1000 live births)	n/a	11.0	10.8	10.9	8.7	6.5	5.7	5.7	5.6
Post-neonatal mortality (post-neonatal deaths per 1000 live births)	n/a	6.4	4.8	4.9	6.2	3.8	4.1	3.6	2.1
Perinatal deaths per 1000 births	10.9	19.4	18.7	15.9	11.8	9.2	10.5	7.7	8.0
Maternal deaths per 100 000 live births	33.3	41.2	57.7	40.4	48.9	24.7	5.0	9.8	4.6
Syphilis incidence per 100 000	8.8	10.0	60.3	127.1	107.7	43.0	29.0	25.2	19.2
Gonococcal infection incidence per 100 000	93.2	126.5	149.7	85.4	51.3	31.4	23.7	23.2	30.1
Clinically diagnosed AIDS incidence per 100 000	0.0	0.0	0.1	0.2	0.4	0.9	2.3	4.0	3.1
New HIV infections reported per 100 000	0.0	0.0	0.2	1.3	6.7	19.6	23.1	13.9	13.0

Source: WHO Regional Office for Europe 2007a.

Notes: n/a: Not available; AIDS: Acquired immune deficiency syndrome; HIV: Human immunodeficiency virus.

Fig. 1.4 Perinatal conditions (P00-P96) per 1000 live births, 1991–2005

Source: HSMTSA databases 2007 [unpublished data].

In 2005 there were 45.7 cases of pregnancy complications per 100 pregnant women. The share of infectious and parasitic diseases does not appear to be declining, although the morbidity of pregnant women with syphilis has recently been falling: 0.5% of all pregnant women in 2005, compared to 0.6% in 2004 and 0.7% in 2003. The percentage of cases of gonorrhoea for pregnant women is low: 0.05% in 2005, 0.03 in 2004 and 0.1% in 2003. However, the registration of sexually transmitted infections (STI) is not strictly defined in Latvia, while many patients with inadequate levels of social protection do not seek treatment at all; therefore, the reliability of the data regarding the spread and the extent of STIs are limited (HSMTA 2007; HSMTA 2006; HSMTA 2005).

In 2004 the incidence of syphilis in Latvia was 25.2 per 100 000 population, compared to 15.5 per 100 000 in Estonia, 9.9 per 100 000 in Lithuania, 2.1 per 100 000 in Denmark, and 2.1 per 100 000 in Sweden. A total of 46.6% of new syphilis patients were male and 53.4% were female. The highest incidence rate (about one third of the total) was registered among the group of the population aged 20–29 years. The incidence of syphilis has increased among children and adolescents.

In 2004 the incidence of gonorrhoea was 39.5 per 100 000 population in Estonia, 23.2 per 100 000 in Latvia, 14.0 per 100 000 in Lithuania, 6.3 per 100 000 in Sweden, and 7.6 per 100 000 in Denmark. A total of 77.3% of new gonorrhoea patients are male and 22.7% female. For this diagnosis the highest incidence rate (54.0% of total registered patients) was registered among the population group aged 20–29 years (HSMTSA 2007a; HSMTSA 2006).

2. Organizational structure

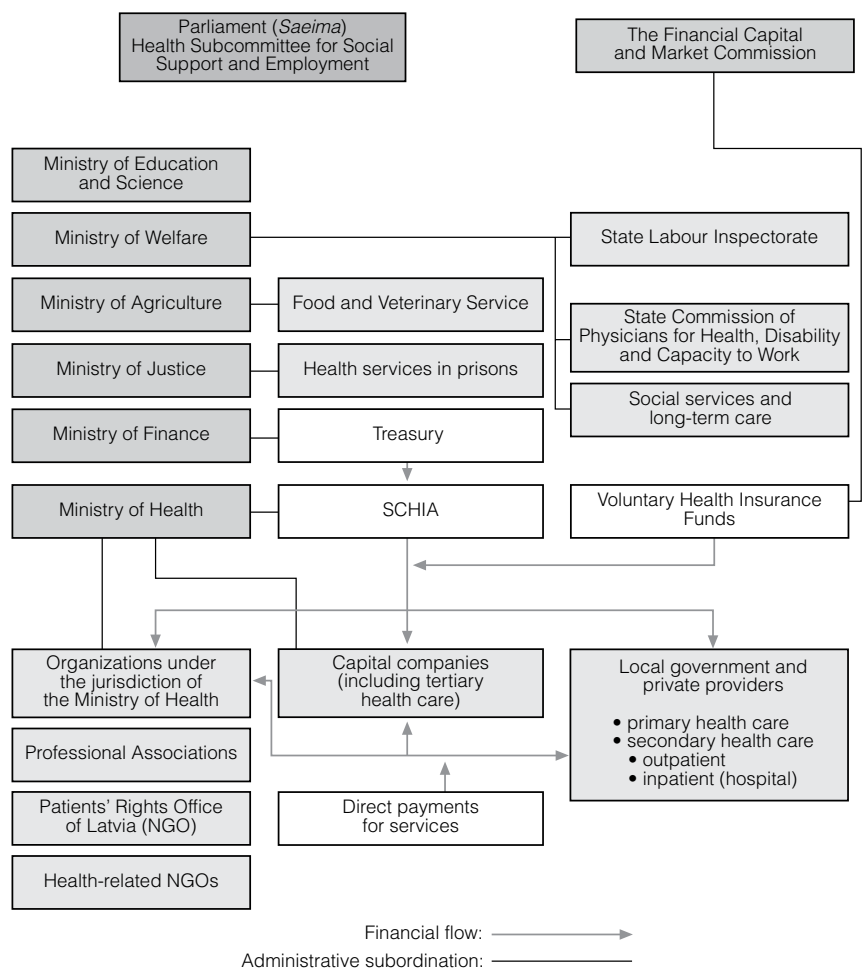
2.1 Overview of the health system

The Latvian health care system has undergone a remarkable transformation in the 15 years since independence and, following experimentation over this period of time with numerous approaches to organization and financing, is now in the process of consolidating its structures and institutional arrangements. The key components of the system are shown in Fig. 2.1.

The health care system is a unique combination of general tax-financed statutory health care provision, within a social insurance institutional structure embodying a purchaser–provider split, together with a mix of public and private providers. The main features of this system are listed here.

- Statutory health services are financed mainly by the central government through tax revenues. Additional financing sources are direct patient payments as well as voluntary health insurance (VHI).
- Tax revenue allocated by Parliament for health-related purposes flows from the Ministry of Finance through the Treasury to the State Compulsory Health Insurance Agency (SCHIA), a state-run organization under the Ministry of Health, which acts as a “pooler” of health funds.
- The SCHIA contracts with a variety of service providers under the statutory system. These include:
 - o organizations under the direct jurisdiction of the Ministry of Health;
 - o organizations that have acquired the legal status of “capital companies” in which the Ministry of Health is a shareholder, also under the Ministry of Health (these include tertiary care facilities);
 - o organizations under the ownership of local governments, which include health centres (for primary care provision) and hospitals (providing outpatient as well as inpatient care);

Fig. 2.1 Overview chart of Latvian health system



Source: Authors' own compilation.
Notes: SCHIA: State Compulsory Health Insurance Agency; NGO: Nongovernmental organization.

- o self-employed providers, consisting of most primary care providers as well as some secondary (outpatient specialist) providers.
- Providers contracting with the SCHIA 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 level.

Other institutions with key roles in health care include the Ministry of Welfare, responsible for social services including long-term care; the State

Labour Inspectorate, under the Ministry of Welfare, monitoring the area of occupational health; and the State Commission of Physicians for Health, Disability and Capacity to Work, assessing degrees of disability. The Ministry of Education and Science is responsible for health-related educational institutions, research and health promotion. The Ministry of Agriculture, through the Food and Veterinary Service, is responsible for food safety. The Ministry of Justice provides health services for prisoners and refugees, and the Ministries of Defence and Internal Affairs (not shown in Fig. 2.1) provide parallel health services.

Further, there are a number of health-related nongovernmental organizations (NGOs) operating in Latvia, one of which was the Patients' Rights Office of Latvia. Professional associations include the Physicians Association of Latvia, an umbrella organization of 110 associations organized according to medical specialties. The nursing profession is organized in the Latvian Association of Nurses.

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, since the mid-1980s. During the 19th and at the beginning of 20th centuries Latvia was a part of the Russian empire. At that time it was the most economically and socially developed part of the empire. By 1859 the first sickness fund for the voluntary insurance of workers of a factory in Riga had already been established. Soon after, many other funds were created and in 1890 there were 90 sickness, burial and social support funds in Latvia. In Russia, the relevant laws relating to social health insurance of factory workers were passed in 1912 and 1917. The second of these formed the basis for the introduction of a social insurance system in the newly independent state of Latvia (1918).

During Latvia's first period of independence, two health insurance laws were passed. The first of these (1920) was an elaboration of Russian regulations on sickness funds, clearly defining the role of the State, and promoting the establishment of many new funds. The second law (1930) stipulated sickness fund regulations in numerous areas including sickness fund structure, medical treatment obligations, cash benefits, fund revenues and fund governance. This law defined employer and employee involvement in fund governance and defined the mandatory obligations of the funds in terms of medical treatment financing. All employees (with some exceptions) were required to pay contributions. By the standards of that time, the sickness fund system was quite democratic

and socially fair. There were three types of sickness fund: independent (for workers of large enterprises), occupational (based on the worker's occupation) and territorial (based on place of residence). By 1938 these funds insured 18.2% of the Latvian population. Fund revenues consisted of contributions of employers, employees and allocations from the State. Coverage for the insured and their dependants included emergency care, outpatient and inpatient treatment services, and maternity care. Some funds also covered additional services, such as treatment at health resorts. Funds owned or rented hospitals, and contracted physicians and their associations for services. Parallel with this a network of private practitioners and private hospitals existed.

In 1940, following the secret pact between the Soviet Union and Germany (Molotov-Ribbentrop-Pact), Soviet troops occupied Latvia, and the economy and social system were reorganized according to Soviet principles. The social insurance system was replaced by the Semashko system, which is tax based, vertically organized and centrally administered and planned. Private activities in health care were prohibited. Financing, management, planning and control of all health care services were carried out by the State under the direct supervision and responsibility of the centralized Ministry of Health in Moscow. The Health Ministry of the Soviet Republic of Latvia was under the tight supervision of the centralized Ministry. The health strategy focused on high-level specialization and scientific work as well as construction of enormous facilities. The system provided coverage for the entire population, with a high level of equity, but with relatively low quality of care, high specialization and lack of responsibility for the individual patient, with poor (although relatively equal) access to facilities and pharmaceuticals. Separate outpatient clinics, hospitals and spa institutions were established for Communist Party officials and representatives of the Government and their families. These individuals had access to better facilities for diagnosis and treatment and were better supplied with pharmaceuticals.

Despite the dissatisfaction of the population, life expectancy increased, as there was a strong focus on infectious disease control and prevention by means of immunization, and concentration of efforts on sanitation and hygiene. Medical staff suffered from work overload, low levels of remuneration and professional dissatisfaction, with limited access to modern technologies and pharmaceuticals.

These developments explain why in 1988, just before the collapse of the Soviet Union, the Physicians' Society of Latvia (later renamed Physicians Association of Latvia) was re-established, having been disbanded during the Soviet period. Its political aim was to restore the previous social insurance system of 1918–1940. Since then, and up to the time of writing, all plans and programmes of Latvian political parties have consistently (and with unity) proclaimed the objective of returning to a social health insurance system, and

many health care reforms have been influenced by this concept. Yet this objective has not been realized to date. In fact, beginning in the mid-1990s, the general direction of most reforms have tended to strengthen centralized tax funding of the national health system.

After the re-establishment of independence in 1990, numerous changes were introduced in Latvia, including the transition to a market-based economy, privatization, the development of entrepreneurship, and a new approach to social insurance. These developments formed the background for the initial reforms of the health system, focusing on decentralization and attempting to diminish the role of the State, replacing it with market-driven incentives. The coalition of political parties that assumed power in 1993 stated in their declaration “about intended activity of the Cabinet of Ministers” that social policy in Latvia would be directed towards increased emphasis on individual responsibility. The idea was to establish a system in which the public sector would be limited to guaranteeing only the minimum set of services covered by social insurance to the entire population, with voluntary insurance securing supplementary health care.

In 1991 the Ministry of Health was merged with the Ministry of Social Affairs and the Ministry of Labour in one Ministry of Welfare, but in 2002 the Ministry of Health was separated again. Throughout this entire period health care and social care were (and still are) financed separately on the basis of different principles. In 1993, a reform was set in motion that aimed to shift from centrally planned budget allocations based on beds and personnel numbers to a payment system for the services provided based on fee-for-service payments. Those arrangements led to widespread changes in the structure of the health care system. In 1994, 35 institutions called “sickness funds” were established at the local government level, corresponding to the number of regional governments and cities, with the function of redistributing state budget money to health care providers. The aim was to reform these funds into real independent sickness funds with an insurance function, which, however, never materialized. An institution by the name of “Central Account Fund” was established to supervise and lead the reform, and to establish assessment and payment criteria for services. In 1996 it was renamed “State Sickness Fund” and took on the additional task of planning and managing health care financial resources. This institution never collected insurance premiums, as a social insurance system was never instituted. Since 1998 this institution is known as the SCHIA, which still retains the function of redistributing financial resources from the state budget on the basis of contractual arrangements with providers.

In 1997, after major discussions, the 35 sickness funds, consisting of 32 municipal funds (which were non-profit-making municipal enterprises) and 3 additional branch funds (for the Department of Interior, Railway and Sailors),

were merged together in order to reduce geographical differences and diminish administrative costs. It was decided that at least 200 000 people living in one geographical area should be served by one regional (trans-municipal) institution. The merge process met resistance from local governments, as they wanted to maintain their leadership and control. However, the process resulted in six transregional and two state funds being established, all governed by the SCHIA. As of 1 January 2005 the eight funds were eliminated and their functions were transferred to the SCHIA and its five territorial branches.

In 1994, priority was also given to an additional reform, involving the introduction of a primary health care (PHC) system. The sickness funds estimated the number and location of PHC practices that would be necessary to cover the entire population. In 1998 the SCHIA founded the Primary Health Care Support Fund, which, together with international assistance organizations, funded the retraining of physicians as general practitioners (GP) as well as setting up PHC practices. Every inhabitant of Latvia was to register with a family physician. Family physicians began to be paid on the basis of a mixed capitation system.

In the area of reimbursement systems for health care services, a number of different approaches have been introduced, abandoned and changed since the early 1990s. For a number of years, fee for service, capitation and capitation with fund holding, diagnosis-related groups (DRG) and volume-based contracting systems all existed at the same time, depending on the area of health care, level of care and geographical area. More recently a unified payment system has been adopted for providers throughout the country (Section 3.7 *Payment mechanisms*).

Some health facilities have been privatized or partially privatized, leading to the establishment of a wide variety of property ownership in the system. Since the early 1990s such innovations as the purchaser–provider split and family health care have been introduced as the basis for PHC. Private supplementary insurance has also been introduced, initially offered by the Riga sickness fund, in parallel with private insurers.

In addition, virtually every other aspect of the health care system has been affected by the process of reforms, including the pharmaceutical sector, public health, dentistry and others. As the above examples illustrate, Latvia is experimenting with several innovative approaches to organization and financing in health care. The reforms are an ongoing process, with rapid changes that are influenced by a mix of changing political priorities of successive governments and the learning process that comes from experience with novel approaches. All of these are described in detail in the following chapters.

2.3 Organizational overview

Figure 2.1 (above) shows the general structure of the Latvian health care system, showing both administrative relationships and main financing flows.

The Latvian health care system consists of a unique mix of tax-financed statutory health service provision, within a social insurance institutional structure embodying a purchaser–provider split, together with a mix of public and private providers. The main features of this system listed here.

- The central Government is responsible for financing the statutory health care system through tax revenue. In addition, financing for health services comes directly from household payments, as well as from VHI.
- Tax revenues allocated for health care by the Ministry of Finance are transferred (via the Treasury) to the SCHIA, a state-run organization under the jurisdiction of the Ministry of Health, which distributes health care funds.
- The SCHIA signs contracts with all statutory health care providers.
- Providers contracting with the SCHIA 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 level.

Each of the organizations appearing in Fig. 2.1 are discussed in the following sections.

Institutions of the state central administration

These institutions plan, coordinate and supervise health services provision, as well as administering resources allocated to health care or health-related services.

The health policy decision-maker in Latvia is the Parliament (*Saeima*). Its work is organized in several committees. Within the Social and Employment Committee, the Health Subcommittee deals primarily with all health-related issues. The Parliamentary Secretary of the Ministry assures a link between Parliament and the Ministry of Health, and is a representative of the Minister of Health in Parliament.

Since 2002, the Ministry of Health is the main executive body responsible for health care in Latvia. Before that time, health-related functions were a responsibility of the Ministry of Welfare (which in 2002 split into the Ministry of Welfare and the Ministry of Health). The Ministry of Health elaborates health policy, and organizes and supervises its implementation. As the Minister

of Health is a representative of the governing political party or coalition, the continuity of policy is assured by the State's "Secretary of the Ministry" (whose position is considered to be independent of the governing party).

In addition to the Ministry of Health, a number of other ministries, including the Ministry of Finance, Ministry of Welfare, Ministry of Agriculture, Ministry of Justice, Ministry of Finance, and Ministry of Education and Science 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 Ministry of Welfare deals with Latvian social security and is therefore responsible for long-term rehabilitation and nursing care of disabled and impaired individuals and all other social care services. In addition, the State Labour Inspectorate, under the Ministry of Welfare, monitors developments in the area of occupational health, while the State Commission of Physicians for Health, Disability and Capacity to Work, also under the Ministry of Welfare, is responsible for assessing degrees of disability. The Ministry of Agriculture, through its Food and Veterinary Service, controls food safety. The Ministry of Justice is responsible for health care provision within the penitential system and for refugees. The Ministry of Education and Science deals with health promotion as well as educational facilities in the health sector in Latvia.

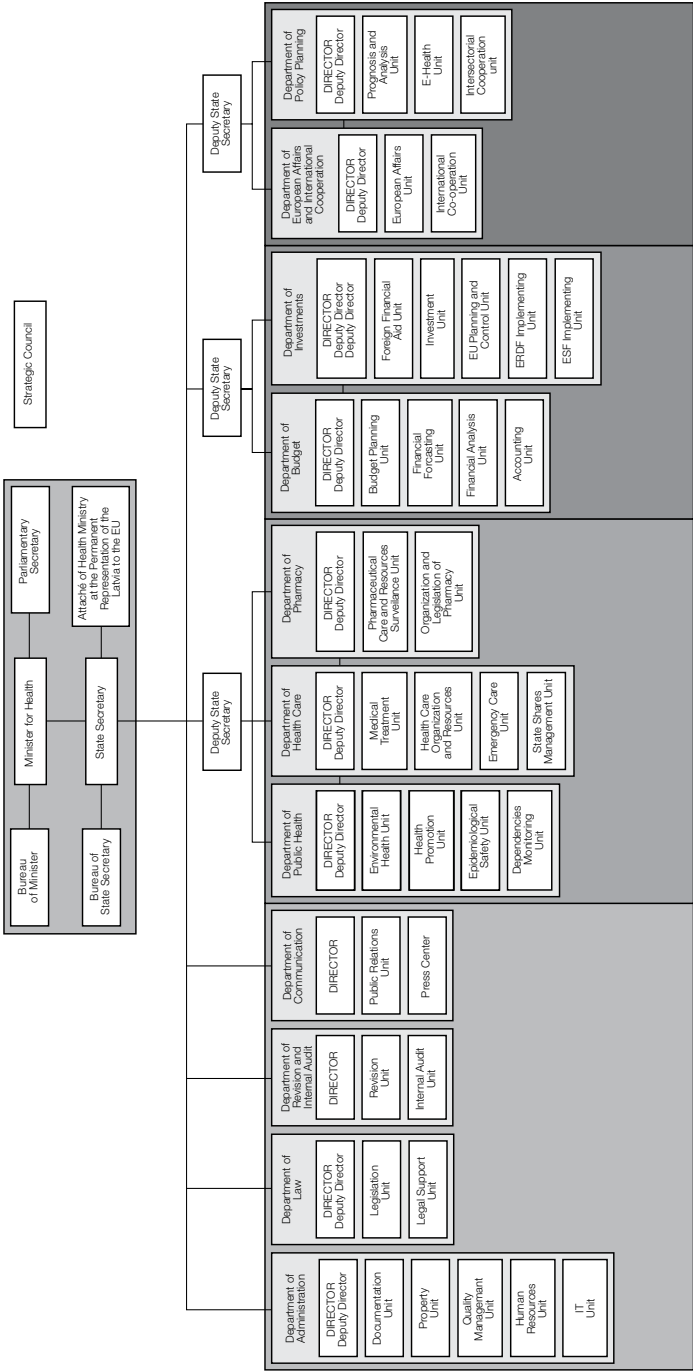
Ministry of Health

The structure of the Ministry of Health was modified in November 2007. Changes involved the addition of some new departments, as well as the addition of new units within departments. The new structure of the Ministry, with all departments as well as units within each department, is depicted in Fig. 2.2.

In 2007 the structure of the Ministry of Health was reorganized and currently consists of 11 departments. The parliamentary secretary assures link between the Cabinet of Ministers and Parliament (*Saeima*). The Departments of Administration, Communication, Law and Revision and Internal Audit are under the direct control of the State Secretary. The other seven departments are under the direct control of Deputy State Secretaries.

The *Department of Health Care* elaborates proposals on State policy for disease prevention, diagnostics, treatment, rehabilitation and health care organization. The Medical Treatment Unit deals with quality of treatment, reproductive health and sports health. The Health Care Organization and Resources Unit plans resources to assure health care quality, and elaborates health research and education policy. The Emergency Unit is responsible not only for the emergency care and medicine involved in preparing for catastrophes,

Fig. 2.2 Structure of the Ministry of Health



Source: Authors' own compilation.
Notes: IT: Information technology; EU: European Union; ESF: European Social Fund; ERDF: European Regional Development Fund.

but also for the coordination and management of the entire emergency medical situation in the country. The State Shares Management Unit supervises all those capital companies in which the Ministry of Health owns shares.

The *Department of Public Health* consists of four units and is responsible for the elaboration of legislative and policy planning documents as well as implementation of the policy related to environmental health, health promotion, epidemiological safety of infectious diseases, and surveillance and control of addiction-related health problems.

The *Pharmaceuticals Department* consists of the two units appearing in Fig. 2.2, and deals with policy, legislation and management of care in the field of pharmaceuticals (human and veterinary). The department supervises all the processes of production, import and distribution of medicines as well as pharmaceutical care. In addition, all items related to the legal circulation of narcotics, psychotropic substances and their precursors come under the supervision of this department. Two state agencies (the State Agency of Medicines and the State Medicines Pricing and Reimbursement Agency) are also under the direct supervision of the department and are responsible for implementing the department's tasks. These agencies are discussed in detail later.

The *Department of Budget* consists of four units and is responsible for the management of financial resources, health budget planning, and supervising the efficiency of health expenditure.

The *Departments of Public Health, Pharmaceuticals and Budget* existed prior to the Ministry's restructuring of November 2006, although they underwent certain transformations through the addition of new units, aiming to streamline their operations.

The *Investment Department* was established specifically for the purpose of handling EU funds that are to be used in the health sector. This department is in charge of planning and surveillance of projects financed by EU funds, as well as for effective communication with the relevant EU bodies.

The *Revision and Internal Audit Department* deals with internal audits within institutions under the jurisdiction of the Ministry of Health (state agencies, centres) to ensure their compliance with regulations on administrative and financial matters. It is to provide planned and regular audits as well as ad hoc audits, organized upon request by the Ministry of Health.

The aim of the *Department of Policy Planning* is to elaborate common state health policy and to supervise the implementation of strategic documents, along with intersectoral policy coordination. This department is also responsible for E-health project implementation.

The Department of European Affairs and International Cooperation deals with all other kinds of cooperation with European countries that are not related to the use of EU funds. It is concerned with bilateral cooperation with countries within the region, as well as with following up on Latvia's obligations in its participation in international projects, committees, bodies, etc., as well as cooperation with international organizations such as the United Nations and WHO. It also consults with other Ministry departments on legal issues.

The Departments of Communications, Administration and Law are concerned with public relations and media, administrative matters and internal legislative acts, respectively.

Institutions under the Ministry of Health

There are numerous organizations in which the Ministry of Health has a supervisory and governing role, the most significant of which are listed in Table 2.1. Some are directly under the jurisdiction of the Ministry's various departments (column 1). There are many other institutions (mainly provider institutions) under the authority of the Ministry of Health, which have the legal status of capital companies (public limited stock companies or public limited companies) in which the Ministry of Health is 100% shareholder (column 2). The position of these institutions within the overall structure of the health care system can be seen in Table 2.1.

This section describes the functions of some of the agencies under the jurisdiction of the Ministry of Health (shown in the first column of Table 2.1).

The *Public Health Agency* was created in 2002 on the basis of the former National Environmental Health Centre (known during Soviet times as the Sanitary Epidemiological Station). In addition to the functions of monitoring and controlling infectious diseases, the strategic idea for the future development of the agency is to deal with noncommunicable disease control and general public health monitoring. In 2007 several government agencies with public health surveillance and disease prevention and health promotion functions were incorporated into the Public Health Agency: these included the State AIDS Prevention Centre, State Agency of Sexually Transmitted and Skin Diseases and partially the Agencies of Mental Health and Psychiatry and the State Narcology Centre.

During the Latvian health system reforms of the 1990s, such functions as the surveillance and control of epidemic safety; assessment and control of environmental factors that affect health; safety of drinking water; marketing and utilization of chemical substances and chemical products; and safety in the utilization of cosmetic products were removed from the Public Health Agency

Table 2.1 Institutions under the authority of the Ministry of Health

Organizations under the jurisdiction of the Ministry of Health	Capital companies, where the Ministry of Health is a shareholder
<ul style="list-style-type: none"> • Public Health Agency • State Health Inspectorate • State Agency of Health Statistics and Medical Technologies • State Agency of Medicines • State Medicines Pricing and Reimbursement Agency • State Compulsory Health Insurance Agency • State Blood Donors Centre • State Centre of Emergency and Disaster Medicine • State Centre of Medical Professional Education • State Central Medical Equipment Stock • Riga Stradins University • State Agency “Medical Library of Latvia” • “Paul Stradins Museum of History of Medicine” • State Forensic Medicine Centre • State Agency “Centre of Infectious Diseases of Latvia” • State Agency of Sports Medicine • State Agency of Tuberculosis and Pulmonary Diseases 	<ul style="list-style-type: none"> • State Limited Company (SLtd.) “Akņistes Hospital of Psychoneurology” • State Limited Company “State University Clinical Children Hospital” • “State Children Psychoneurology Hospital “Ainazi”” SLtd. • “Daugavas Hospital” SLtd. • “Daugavpils Hospital of Psychoneurology” SLtd. • “Latgale Region’s Rehabilitation Centre of “Razna”” SLtd. • “State Certification Centre” SLtd. • “National Rehabilitation Centre “Vaivari”” SLtd. • “Paul Stradins State Clinical University Hospital” • “Maritime Hospital” SLtd. • “Rehabilitation Centre “Tervete”” SLtd. • Riga East Clinical University Hospital • “Straupe Hospital of Narkology” SLtd. • “Strenci Hospital of Psychoneurology” SLtd. • “Hospital of Traumatology and Orthopedics” SLtd. • “State Centre of Dentistry and Face Surgery” SLtd. • “Vecpiebalga Hospital of Psychoneurology” SLtd. • “Vidzeme Region’s Rehabilitation Centre “Ligatne”” SLtd. • “Riga East Hospital” SLtd. • “Riga Centre of Psychiatry and Addiction disorders” SLtd.

Source: Authors’ own compilation.

and taken over by the State Sanitary Inspectorate. The Food and Veterinary Service of the Ministry of Agriculture took responsibility for the surveillance and control of food safety.

In 2007 three governmental health inspectorates, *The State Inspectorate*, the *State Pharmaceutical Inspectorate* and the *State Sanitary Inspectorate* were merged into one *State Health Inspectorate* with all their functions.

The *State Health Inspectorate* aims to regulate the professional quality of health care and handles patient complaints (Section 2.5 *Patient empowerment*). Its functions are concentrated in the area of organizing expert audits in response to patient complaints, with limited possibilities to fine service providers.

The *State Pharmaceutical Inspectorate* is responsible for the supervision and control of pharmaceutical enterprises in production, purchase and distribution of medicines; for evaluation of premises, equipment, personnel and documentation with regards to compliance with regulations; and for regulation of drug advertising.

The *Health Statistics and Medical Technology State Agency (HSMTSA)* gathers, summarizes and analyses health information; runs registries of human resources in health, medical devices and products, as well as patient registries with specific diseases; assesses health technologies; and follows up on the implementation of health system restructuring reforms.

The *State Agency of Medicines* was founded in 1996 following a reorganization of the Pharmacopoeia and Pharmacology Committee and Medicines Quality Control Laboratory. The Agency maintains a Register of Human Medicines, in which all pharmaceutical products circulating in Latvia are listed. It is responsible for assessment of quality, safety and effectiveness of pharmaceuticals. A detailed description of the responsibilities of this agency can be found in Section 5.1 *Physical resources*, Subsection *Pharmaceuticals*.

The *State Medicines Pricing and Reimbursement Agency* was established in accordance with Regulation of the Cabinet of Ministers of 5 November 1998 in order to carry out a reform in accordance with a European Commission (EC) Directive (89/105/EEC). The main objectives of the Agency are to ensure the enforcement and establishment of the reimbursement system for medicines and medical products, and to determine the positive list of pharmaceuticals (Section 5.1 *Physical resources*, Subsection *Pharmaceuticals*).

The SCHIA has five territorial branches, and comes under the direct control of the Ministry's Department of Budget. The agency puts into effect state policy to ensure the availability of health care services. Its main assignment is to administer the financial resources of the State by means of:

- signing contracts with health care institutions;
- making payments for health care services and pharmaceuticals anticipated for outpatient care, medical equipment and goods;
- pricing health care services;
- elaborating proposals, setting priorities and costing services for the introduction of new health care services;
- forming and updating waiting lists for patients.

It is also responsible for informing society on available health care services and procedures for receiving them, as well as administrating the financing of medical education for resident physicians.

The objectives and structure of the SCHIA have changed several times in line with the vision of the reformed health care system in Latvia. It was established in 1994 as the Central Account Fund, together with local account funds (also known as “sickness funds”) in all of Latvia’s districts and largest cities. The large number of sickness funds relative to the size of the country proved problematic, however, as it gave rise to extreme fragmentation of the financial structure, an ineffective planning and coordination system, and decision-making based on political considerations. Following a 2-step process of centralization (1997 and 2003), all financing, coordination and payment activities for the statutory health care system became centralized within the SCHIA. Whereas initially this organization was considered to be a first step in the development of a social insurance system of financing, it never acquired this function and at the time of writing it distributes state budget funds to health service providers on the basis of contractual agreements (Section 2.4 *Decentralization and centralization*).

Local governments

Latvia is administratively divided into three levels: federal; regional, comprising 26 regions (or districts or *rajons*) and 7 large urban areas or cities; and municipal, consisting of 480 rural municipalities (*pagasts*).

Following the enactment of a Law on Local Governments in 1993, a decentralization process began (Section 2.4 *Decentralization and centralization*) that significantly expanded the roles of local governments in both financing and provision of health care services. At that time, most of the responsibilities for provision and financing of primary and secondary health care services were devolved to local governments. Specialized services remained the responsibility of the State. However, the role of local governments in health care has changed significantly since then. A centralization process that began in 1997 eliminated the financing role of local governments, and limited their role to some aspects of provision only.

Ownership of and responsibility for most primary and secondary health care facilities (with the exception of highly specialized institutions) had initially been transferred to the local level. A subsequent process of establishment of independent private primary care practices, and additionally, changes in the legal status of secondary care institutions, circumscribed the role of local governments in the area of primary and secondary care provision. Whereas local governments still own former polyclinics and hospitals, polyclinics are

now for the most part rented out by independent primary care practitioners, or alternatively they have become self-managing health centres, while hospitals have similarly become self-managing institutions. Local governments are now mainly responsible for ensuring access to health care services, promoting healthy lifestyles, controlling alcoholism, maintaining old-age health facility buildings, establishing and maintaining shelters for homeless people and orphan children, as well as education. In addition, local governments reimburse health care expenses incurred by low-income patients, exempting them from patient fees.

Health care legislation does not define specific functions and responsibilities for local governments, but rather notes that they have a general responsibility with respect to health care.

Institutions of health services

Inpatient and outpatient health care in Latvia is provided by state- and local government-owned institutions, private clinics and hospitals, and individuals. Independently of the type of property, all providers who provide services within the statutory system are financed and regulated by government institutions according to the same principles. Health care is subdivided into the three conventional levels, as listed here.

- PHC is the level at which the patient has the first contact with health care providers. PHC is provided by family doctors, paediatricians, PHC internists and PHC nurses or doctors' assistants. Every inhabitant of Latvia must register with one PHC doctor, who serves as gatekeeper to the health care system (Section 6.2 *Patient pathways*). PHC is financed according to mixed weighted capitation principles (Section 3.7 *Payment mechanisms*). PHC practitioners can be independent (private) providers or can work within private or public outpatient clinics (Section 6.3 *Primary ambulatory care*).
- Secondary health care involves outpatient and inpatient care, which includes emergency, acute or planned diagnostics, treatment and rehabilitation up to the point where successive treatment can be pursued at the PHC level; it is provided by state, local government or private institutions (Section 6.4 *Specialized ambulatory care/inpatient care*).
- Tertiary health care is highly specialized, using high technologies for serious health conditions with high-risk treatments and for rare diseases, and is provided by public institutions at state level.

PHC is provided mainly in:

- primary care practices run by practitioners (family doctors) who work independently, either as self-employed individuals or as private sector agents;
- health centres (former polyclinics), employing GPs for PHC provision.

Inpatient secondary and tertiary care in Latvia is provided by:

- multi-profile emergency hospitals and regional/district/central hospitals;
- local-level hospitals (which also provide social care);
- hospitals and centres of medical rehabilitation;
- single-profile hospitals for acute care and long-term treatment hospitals for TB, psychiatry and narcology patients;
- specialized single-profile hospitals in oncology, obstetrics, traumatology and infectious diseases.

Emergency care is provided by:

- emergency medical assistance (EMA) teams, or ambulances;
- emergency departments of hospitals;
- the Centre of Emergency and Disaster Medicine (CEDM), an organization under the Ministry of Health, which is a state-level specialized medical service that covers only cases where a CEDM specialist is called in by a hospital.

Public health services are provided by several organizations under the Ministry of Health.

- The State Sanitary Inspectorate has taken over the “police” functions of the former Sanitary Epidemiological (sanepid) Stations established during the Soviet period.
- The Public Health Agency investigates outbreaks, gathers case reports from service providers, plans and regulates vaccination programmes and reports results.

Occupational health services are not offered by the public sector, and all activities in this sphere are undertaken privately by employers. The State Labour Inspectorate (under the Ministry of Welfare) is responsible for monitoring developments.

Mental health care is provided in both outpatient and inpatient settings. Outpatient settings include psychiatric assistance centres in Riga, outpatient departments at psychiatric hospitals, psychiatric consulting rooms in municipal primary care centres, and a number of psychiatric private practices. Inpatient settings include a number of psychiatric hospitals. Day care centres and facilities for chronic patients are only provided to a limited extent.

Long-term care services are classified under social care, which is administratively entirely separate from health care, and are the responsibility of the Ministry of Welfare. Services are provided in long-term care facilities, which may be of a general nature, and specialized long-term care facilities for individuals with specific disorders. In addition there are some (relatively limited) home care services as well as day care facilities.

In December 2004, the Government adopted a strategic plan to reform the structure of health services provision in Latvia. The plan is to be implemented by the year 2010. The main objective is to optimize the number and location of service providers, including both health care facilities and health care personnel. More details are provided in Section 4.2 *Planning and health information management*, Chapter 5 *Physical and human resources*, and Section 7.2 *Future developments*.

Parallel health systems

Other than the Ministry of Health, under the Soviet system some ministries (Defence, Internal Affairs, Justice) managed parallel health care networks of their own, providing a full range of health care services for their employees and their families, as well as for the armed forces and prisoners. These ministries continue to have their own health care budgets that finance health care providers catering to 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 of Defence also operates an Armed Forces Hospital and a Medical Centre where a limited range of services is provided.

The Ministry of Internal Affairs 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. Key health problems receiving particular attention are TB, HIV/AIDS and communicable diseases.

However, since the mainstream statutory system is available to all citizens and nearly all permanent residents in Latvia, even these specific population groups generally use the mainstream system, involving registration with a family doctor, with standard referrals for the use of outpatient and inpatient secondary care facilities and pharmaceuticals covered by the state health care budget. According to Regulations of the Cabinet of Ministers of 2004, these ministries are responsible for compensating provider organizations of the mainstream statutory health care system if their employees make use of such services.

The private sector

The private health sector in Latvia includes institutions that have been privatized, namely some polyclinics and almost all dental practices and pharmacies, as well as independent primary care practices that have emerged in recent years following the efforts to develop this form of institutional setting for PHC. Both private and independent providers (like all public providers) must contract with the SCHIA in order to be reimbursed for services provided within the statutory health care system. In addition, they may offer further services for private patients.

The full range of PHC services is available for patients through out-of-pocket (OOP) payments and VHI. Services provided mainly in the private sector include certain advanced diagnostic services, spa treatment, psychotherapy and almost all dental services (in general, all services excluded from statutory provision (Section 3.3 *Population coverage and basis for entitlement*). A very small portion of the hospital sector is privately owned.

The private (non-statutory) system offers higher quality and greater freedom of choice for the patient, but is financially out of reach for the majority of the population (for more information on this topic see Subsection *Privatization* in Section 2.4 *Decentralization and centralization*).

Other private health care organizations include private (voluntary) insurance companies, pharmaceutical and medical devices producers and distributors.

Office of the Ombudsman Latvia

Improvements in the area of patient rights has been triggered by the establishment in 2001 of the NGO Patients' Rights Office of Latvia, founded and financed by The Soros Foundation. This NGO is composed of lawyers and medical doctors representing the interests of patients, providing them with information about patient's rights, promoting the policy of the State in the patients' rights field, resolving problems in connection with the provision of quality care, and preventing violations of human rights and patients' rights in the field of health care. In 2007 the Patients' Rights Office of Latvia discontinued its activity due to financial and organizational reasons. Responsibilities were taken over by the Office of the Ombudsman.

Voluntary and nongovernmental organizations

There are a large number of registered health-related NGOs in Latvia. The Internet site www.dr.lv lists 130 of these. In 2005, six active organizations signed collaborative agreements with the Ministry of Health:

- Latvian Cooperation Organization for People with Special Needs – SUSTENTO (Latvian umbrella group for disability-related organizations);
- Latvian Diabetes Association;
- Latvia's Association for Family Planning and Sexual Health (“Papardes zieds”);
- Latvian Association of the Deaf;
- Latvia Pensioners Federation;
- Latvian Red Cross.

Professional organizations

The largest medical professional organization is the Physicians Association of Latvia. This is an umbrella organization for 110 associations organized according to medical specialties. The Latvian Government has delegated the function of professional certification to this organization. In addition, the Association has a Committee of Ethics, a trade court that deals with objections of legal and government organizations, a complaints commission that decides on penalties, and a commission for rights to teach that decides on the capabilities and appropriateness of institutions and individual physicians for postgraduate teaching and supervising residents. Moreover, it is the only institution that can withdraw a doctor's certificate, abolishing her/his right to practise. It also keeps a registry of medical practices, and issues a medical journal, *Latvijas arsts* (*Physician of Latvia*).

Dentists are considered to be physicians (stomatologists) in Latvia and are members of the Physicians Association of Latvia. The nursing profession has a similar organization, the Latvian Association of Nurses.

International organizations

A number of international organizations have a presence in Latvia.

The *EU* has had a presence in the Latvian health sector since 1991. In the period of time prior to Latvian accession to the EU (1991–2004) Latvia was a recipient of EU funds through “Poland and Hungary: Aid for Restructuring of the Economies” (PHARE). Some PHARE programmes are ongoing and include support for strengthening institutional capacity in diverse areas such as infectious disease surveillance, the market for medical devices, pharmaceuticals control and others, in order to assist Latvia in bringing these activities in line with EU standards. Since 2004, when Latvia became a member of the EU, it began receiving funds in support of key health sector activities including

infrastructure development and human resources development (Section 3.4 *Revenue collection/sources of funds*, Subsection *External sources of funds*).

The **World Bank** financed a major project entitled “Latvia Health Reform Project” in the period 1999–2004, the objective of which was to assist the Latvian Government in a health sector restructuring strategy. This project has formed the basis of most of the key reforms that have been pursued in the health sector in Latvia in recent years, and is discussed at length in later chapters.

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 public health policies and provision of technical leadership, along with support of an intersectoral approach to health care. Key areas of intervention in the period 2004–2005 have included tobacco control; review of alcohol control policy; development of a mental health policy; intersectoral collaboration on the prevention of road traffic accidents; strengthening of the National Baby Friendly Hospitals initiative (in collaboration with UNICEF); updating of an environment and health information system; an anti-violence campaign (jointly with other United Nations agencies, NGOs and the private sector); review of a national maternal and child health policy; review of a national food and nutrition policy aimed at the prevention of iodine deficiency; establishment of a WHO collaborating centre in MDR-TB; and many others.

WHO priorities for 2006–2007 include prevention and control of noncommunicable diseases (in connection with mental health, alcohol, obesity, tobacco and violence); improving core functions of the health system (financing, pharmaceuticals, patients’ rights and human resources); and scaling up health system response to major communicable diseases (HIV/AIDS and STIs).

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); UNDP; United Nations Children’s Fund Latvian National Committee (UNICEF LNC); and United Nations Educational, Scientific and Cultural Organization Latvian National Committee (UNESCO LNC).

Other international organizations with a presence in Latvia include the International Monetary Fund (**IMF**) and the International Organization for Migration (**IOM**).

Patient/consumer groups

Since the 1990s various patient societies and associations related to specific diseases have been founded, for example for psoriasis, lymphoma, digestive tract

conditions, osteoporosis, diabetes and many others. Their objective 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. Unfortunately, these societies and associations are sometimes negatively influenced by the market interests of pharmaceutical and other commercial companies and individuals. Moreover, their ability to influence the policy agenda is rather limited in view of their limited finances.

Voluntary insurance companies

From February 2007 VHI is provided by four private companies and one municipal (Riga City) company. The process is supervised by the State Financial and Capital Market Commission. Details on voluntary insurance are presented in Section 3.3 *Population Coverage and basis for entitlement* and Section 3.4 *Revenue collection/sources of funds*, Subsection *Voluntary health insurance*.

2.4 Decentralization and centralization

High centralization and vertical management were typical features of the health care system within the Soviet Union. Therefore, reforms in Latvia in the early 1990s were characterized by major efforts to decentralize and privatize a system which was inefficient and believed to be imposed. However, such factors as Latvia's small size (a territory of 64 600 km²), its relative uniformity, as well as its small population (2.32 million), have brought about discussions on whether such policies maintain efficiency of health care financing and provision.

Devolution of financing and provision, and “recentralization”

The early 1990s were dominated by efforts to decentralize the health care system by devolving powers to local governments. Following enactment of the “Law on Local Government” in 1993, most of the responsibilities for providing primary and secondary care were devolved to local governments. Provision of specialized services remained the responsibility of the State. In the period 1993–1997, local governments had their own local health care board (or health service authority) and local sickness fund. The functions of the Ministry of Welfare were devolved to the local health care boards, which were responsible for planning and administration of health care. They were financed by local governments through the 35 local sickness funds, which in turn received their funds from the state budget. All decisions on resource allocation, payment

mechanisms, service provision and closing or privatizing facilities were made at the discretion of each local authority.

This process gave rise to a variety of payment mechanisms for services; diverse priorities depending on the preferences of the local health care boards; inefficient inter-district purchasing and allocation of technologies, with resulting differing access of various parts of the population to diagnostic and medical equipment; and differing packages of services covered by local governments. Richer territories covered more services than the range specified in the centrally determined minimum service package. Access to care varied, arising from the preference of both the local government councils and the local health managers to retain as much health care spending as possible within their own budgetary boundaries in order to strengthen their own institutions. Therefore, there was a reluctance to refer patients to institutions outside the district even if the case required more specialized treatment. This mechanism also tended to result in a duplication of facilities as each district tried to develop its own.

Further, the quality of services varied for each municipality, as not all hospitals were appropriately equipped to ensure adequate inpatient care. The overall number of hospitals (and beds) therefore remained too high, while the quality was too low and highly variable. Finally, choice of doctor was sometimes limited as patients could only choose a doctor from within their own administrative territory. Since the smaller districts in rural areas usually had only one of each kind of specialist, there was in effect sometimes no choice at all. Neither local political structures nor health managers expressed any interest in interterritorial cooperation, and interterritorial payments were also often delayed.

To address these challenges, in 1997 there occurred a “recentralization” of health care financing. The main objective was to introduce stable and equal financing for each inhabitant in all the regions of the country, and provision of the same level of services for all patients.

In 1997 the districts stopped receiving funds directly from the state budget for health, and all the money began going through the State Sickness Fund (the precursor of the SCHIA). A process of consolidation of the 35 local sickness funds resulted in the creation of 8 regional sickness funds. The State Sickness Fund began to allocate money to the eight regional funds according to the size and age structure of each region’s respective population. In 1998 the State Sickness Fund changed its name to become the SCHIA.

The regional sickness funds did not function as collectors of insurance premiums. Instead, they retained the function of simply distributing state budget resources and the health care system continued to be financed through national tax financing. The compulsory health insurance revenue base was defined as an

earmarked portion of centrally collected income tax (28.4% of personal income tax revenue) plus a state subsidy financed by general tax revenue.

A process of further “recentralization” was initiated at the end of the decade and ended in 2004. As part of this process, the eight regional sickness funds were merged into one single central state agency, the SCHIA, with its five territorial branches and unified allocation, payment and control mechanisms. The health care funds were allocated from the central government budget (much like a tax-financed health care system) to the SCHIA. Moreover, health budget funds that were previously allocated from the Ministry of Health directly to certain state agencies and health programmes began to be channelled through the SCHIA. In 2004, the earmarked payroll tax for health revenue base (28.4% of personal income tax revenues) was abandoned. The new system began operating in full in January 2005.

The gradual centralization of financing was prompted by high levels of patient dissatisfaction, along with the perception among policy-makers that a decentralized system operating in Latvia’s relatively small territory and serving a small population gave rise to excessive inefficiencies in resource use and allocation. The need to save on public resources through more rational organization of financing was especially pronounced in view of serious funding shortfalls in health care relative to health care needs and demands, highlighting the need to address organizational weaknesses and failures and unnecessarily complicated payment methods.

In 1997, the local health boards were disbanded. Not all local governments had a representative responsible for health. This has contributed to weakening the position of health in the local government agendas, and has had a negative impact particularly in the area of investment and infrastructure development, which could have been financed from municipal budgets.

Other centralization tendencies

Centralization tendencies are also evident at the service provider level. For instance, in the 1990s and at the start of the new millennium, hospital directors were free to make decisions on wage levels within their hospital. Very often, however, payments for the purchase of new technologies, or for infrastructure costs, were given priority over the payment of adequate salaries. Now, minimum salary levels according to specialties, position, seniority, etc. are established and regulated by the State.

A special example of centralization is the “Master Plan for the development of outpatient and inpatient health care service providers”, involving planning at the central level for the entire country in order to rationalize the distribution of

health care facilities and personnel throughout the country. This is described in Section 4.2 *Planning and health information management*, Chapter 5 *Physical and human resources*, and Section 7.2 *Future developments*.

In the late 1990s, a political decision was made to introduce an administrative reform in Latvia (“Law on Administrative Territorial Reform”), merging the 480 *pagasts* and 70 towns into 26 regional governments, which, together with the 7 existing city governments, would be subordinated to 5 planning regions covering the entire country. The objective was to rationalize the system of local government and concentrate resources so as to improve the distribution of financing and provision of services, and increase economic efficiency. This reform, if carried out in full, is likely to have a positive impact on services provision and distribution of investments in the health sector. However, there are difficulties in implementation, as there are conflicting viewpoints and disagreements, and while the reform has been initiated, it has not proceeded as far as was initially hoped.

Delegation

Some quality assurance functions in Latvian health care are delegated to the NGO Latvian Physicians Association, with its branches composed of various associations according to specialty. Professional requirements and appropriateness of education, as well as compliance with ethical professional standards of a physician, are assessed by this organization. All physicians in Latvia can only be permitted to practise upon receipt of a certificate of the corresponding professional association.

In addition, several agencies are gradually taking over responsibilities and functions from Ministry of Health, such as the HSMTSA, the Public Health Agency, the Inspectorate for Health and Working Ability, and others. These are all state-level organizations that are subordinate to the Ministry of Health.

Privatization

Since 1993, outpatient health care institutions (specifically polyclinics) began a process of change in ownership from state institutions to either fully privatized institutions or non-profit-making state and municipal limited liability companies. In Riga City, there was a decision to fully privatize all polyclinics, and this has been partially (approximately 70%) implemented at the time of writing. Where full privatization occurred, PHC providers (GPs) became employees of the institution. In cases where polyclinics were transformed into non-profit-making state or municipal limited liability companies, this was not

real privatization; however, it did involve a different legal basis, allowing the respective administration greater freedom in decision-making and resource allocation.

A similar process was initiated for hospitals, which became non-profit-making state or municipal limited liability companies, as there was no privatization in this case.

In 2000, a new “Law of Commerce” was passed, whereby non-profit-making state and municipal limited liability companies (applying to both hospitals and polyclinics) were reorganized into capital companies (state stock companies or state companies with limited liability). In some isolated instances outpatient clinics are comprised of a public–private ownership mix (local governments with private owners); however, this has occurred only to a very limited extent, and it is not foreseen that this type of ownership mix will increase in the near future. The legislation forbids public organization structures to invest in private ones. Moreover, at the time of writing there is no special focus on organizational and institutional forms that could bring about any legislative changes to alter the current situation.

Dental practices and pharmacies were almost all privatized. Several sanatoria (spas) have been privatized, and there has been a small increase in the number of private hospitals.

The 1997 “Law on Physicians Practice” encouraged the development of independent primary care practices. This Law states that the position of primary care physician (or GP) is an independent profession and a specific form of entrepreneurship. This does not constitute privatization of existing institutions but rather the establishment of new, private institutions by primary care practitioners. In the early years conversion to this process did not proceed as rapidly as was hoped, mainly due to financial constraints (low physician income, high interest rates on bank loans), the uncertainties associated with establishing a practice, as well as administrative barriers. Some projects (for example, in collaboration with the EU/PHARE) provided technical assistance in the establishment of independent physician practices.

Physicians in private practice use their own medical equipment, unless the practice is located in an outpatient clinic (a former polyclinic), in which case physicians use the clinic’s equipment while renting the space used for the practice. These arrangements are based upon contracts between the physicians and the outpatient clinic’s director.

All providers must have a contract with the SCHIA in order to provide services under the statutory system. An important principle of statutory health care is equity of service providers, particularly in connection with equal opportunities in terms of competing for contracts for services provision with

the SCHIA, regardless of the legal forms of the concerned providers. There have been some claims involving discrimination by the SCHIA against private provider institutions, but this cannot be substantiated.

From the point of view of ownership, the Latvian health care system can be considered as a system of highly independent management of services. Managers are appointed by, and are accountable to, the owners of institutions. This independence, together with blurred boundaries between public and private sectors, sometimes creates a risk factor for corruption.

2.5 Patient empowerment

Patient rights

The 1997 “Law on Medical Care” is the main legislation in Latvia with articles relating to the rights of patients. According to these articles, patients have the right to “considerate” and “respectful” medical treatment and care; the right to information (see below); and the right to confidentiality and privacy. According to the WHO Regional Office for Europe, this law offers unsatisfactory protection of the rights of patients in a number of areas, particularly in the areas of confidentiality and privacy (WHO Regional Office for Europe 2002). In particular, there is no regulation of confidentiality in the case of minors; confidentiality applies only in the case of physicians (not nurses and other medical practitioners); and the right granted to medical practitioners to provide confidential information to colleagues for the purpose of achieving medical treatment is too broad and is subject to numerous questionable interpretations.

It may be noted that there is no patient rights charter in Latvia. In practice, the main institution dealing with patient rights is an NGO, the Patient Rights Office, discussed in Section 2.3 *Organizational overview*. The State Health Inspectorate under the Ministry of Health (Table 2.1) 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.

Latvia has not officially adopted the principles of the 1994 WHO Declaration of Patient’s Rights in Europe. It is presumed that by virtue of being a WHO member country, Latvia has committed itself to follow WHO resolutions, documents, policies, declarations, charters, etc. Only United Nations conventions, as part of international legislation, can be officially approved by

the Parliament. (The only exception is the WHO health policy document “Health for All”, which was officially approved by the Cabinet in 2000.)

At the time of writing, a draft law on Patient’s Rights, developed with WHO assistance, is under consideration by Parliament, and has passed the first reading.

Patient choice

Article 6 of the 1997 “Law on Medical Care” defines the patient’s right to choose service providers:

A patient, her/his nearest relatives or legitimate representatives (trustees, guardians) shall have the right to choose a medical institution in Latvia and medical professional for diagnostics, treatment and rehabilitation of the patient. A patient shall have the right to qualified, kind and respectful treatment and care.

This right is further specified by the “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004b).

An individual in Latvia has right to choose any family physician who has a contract with the SCHIA and to change this physician once a year. The main reason given for a change of doctor is change of residence. A family physician can refuse a patient if s/he has a full list or if the patient is not a resident of the territory defined in the physician’s contract. However, in practice, freedom of choice of GP is in mainly only possible in urban areas; in rural areas there may be limited choice, as there may only one GP covering a large geographical area.

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 SCHIA, and the patient has a referral from a family physician.

In practice, it is usually the GP or specialist who chooses the hospital, in order to meet the needs of each individual case, although to some extent there is also room for negotiation between the doctor and the patient, as the patient has the right to a referral to any hospital, including all hospitals in Riga. It is the GP’s responsibility to provide full information to the patient on the possible consequences of their choice, such as waiting lists and financial implications, if any apply. Freedom of choice of hospital may depend partly on the size of the budget of the health care providers, and partly on the capacity of the provider, as there are no providers with either open budgets or limitless capacity. Local providers often give priority to patients within their catchment area, so as to avoid losing them in the future.

Patient information

The 1997 Law on Medical Care (articles 20–23) also regulates the patient's right to information. A patient has the right to receive clear information about diagnosis and a plan of examination and treatment, and the right to refuse examination and/or treatment either partly or completely. The same law also guarantees a patient's right to information about quality of care.

In practice, information is provided mainly by the patient's GP, the SCHIA, 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 to the patient's needs. The SCHIA provides information concerning prices of health care services and the level of the ceiling on co-payments (Section 3.3 *Population coverage and basis for entitlement*). This information is distributed to patients through posters and booklets made available to the territorial branches and in health care facilities. The Ministry of Health and the agencies under its jurisdiction provide information on general matters relating to health care, according to the specific areas for which they are responsible. Finally, local governments provide information relating to social benefits, such as reimbursements to low-income patients for health care services and exemptions from payments for pharmaceuticals. Some local governments publish newspapers and booklets that are distributed to their relevant populations free of charge, as well as hotlines operated by social workers.

In recent years there have been major improvements in the availability of information through a growing contribution to information dissemination made by the mass media and the Internet.

There is, however, evidence that there are inequities in access to information among the Latvian population due to a number of factors, including levels of income and education, geographical location, language, and the presence of physical disabilities (Muller et al. 2005). According to a survey published in 2002, 38% of respondents in Latgale (the poorest region of Latvia) considered themselves to be “badly informed” compared to the national average of 31%, and compared to Vidzeme where the corresponding figure was 24%. Further, 46% of respondents with incomplete primary education felt they were “badly informed” compared to an average of 31%. In the case of people with physical disabilities, there is no special information available (Baltic Institute of Social Sciences 2002).

According to another survey, also published in 2002 (CIET 2002), only 25% of respondents replied that they had all the information they needed concerning statutory health care services and provision of medication. Respondents from Latvian-speaking households felt they were better informed about entitlements

(28%) compared with those from non-Latvian speaking households (21%). Fewer younger respondents (under age 50) felt they had all the information they needed (20%) compared to older respondents (30%). In addition, respondents from vulnerable social groups believed they were in a slightly better position with respect to information (27%) compared with non-vulnerable social groups (24%). Those who responded that they have all the necessary information were more likely to be from households that reported having sufficient income to meet their health care costs.

The same survey results indicate that 40% of respondents receive their information about health care services from “nowhere”; the next largest group (24%) from the mass media, and the next largest (23%) from health workers.

Complaint procedures (mediation, claims)

The main institution whose task is to accept and check complaints is the State Health Inspectorate (the former State Quality Control Inspectorate for Expert Examination in Health Care and Ability to Work), under the Ministry of Health. The 1997 “Law on Medical Care” assigned this responsibility to the Inspectorate, which, with the help of experts, is to decide on the appropriateness of complaints, and has the right to fine or penalize providers, or transfer complaints to the state prosecutor’s office. In 2005, of 1309 complaints received by the Inspectorate, 243 were returned as sound. In 118 cases medical staff were administratively penalized.

In addition, the 1997 “Law on Medical Care” along with other legislation specify provisions for the possibility of investigations into medical negligence by law enforcement bodies and by means of court litigation.

According to the WHO Regional Office for Europe, this is an area that is not satisfactorily covered by the existing legislation (WHO Regional Office for Europe 2002). It is argued that the precise task of the Inspectorate, its functions, human resources structure and outcomes dissemination to medical practitioners, hospitals and citizens are not clear enough. Moreover, there is no adequate procedure for making complaints, no system to appeal a complaint, and no system for receiving compensation outside of the court system.

Further, results of a survey indicate that Latvians are not well informed about complaints procedures (CIET 2002). Only 21% of respondents knew how to make a complaint about services received within the statutory system. Knowing how to make a complaint was associated with having knowledge about entitlements in health care: 30% of those with information about statutory services knew how to make a complaint, compared to 18% of those without adequate information. Moreover, there was no association between the use

of a health care facility that provided a formal complaints procedure and the proportion of users of health care services that made complaints, suggesting that provision of formal procedures will not be effective if users are not informed about how to use these.

Patient safety and compensation

There is no system in place in Latvia dealing with this issue. A few court proceedings with verdicts demanding payment for patients have induced discussions about liability insurance for providers, but they have been inconclusive and no decisions have yet been made.

Patient participation/involvement

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, for example, for psoriasis, lymphoma, digestive tract conditions, osteoporosis, diabetes and many others. 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. These societies and associations are sometimes negatively influenced by the market interests of pharmaceutical and other commercial companies and individuals. Moreover, their ability to influence the policy agenda is rather limited in view of their limited finances.

Patient satisfaction with health care services

Several surveys on patient satisfaction have been carried out in Latvia. One of these (CIET 2002) found that according to 44% of respondents, health services are neither good nor bad, while 19% of respondents believe that health services are either good or very good. According to 37% of respondents, statutory health services are bad or very bad. Yet, contrary to these results, of respondents who had received a health care service, 81% said they were satisfied or very satisfied and only 9% were dissatisfied. Satisfaction was slightly higher for privately provided services, as 90% reported being satisfied and 5% were dissatisfied. Some of the main reasons cited for dissatisfaction are listed here:

- the doctor’s attitude and skill 53%
- long wait 11%
- no treatment 10%
- ineffective 10%

- expensive 8%
- bad diagnosis 8%

During September and October 2005, the EC conducted a *Eurobarometer* survey of inhabitants of the EU25. Information was collected on issues that focused mainly on the extent of trust in doctors and opinions about the frequency of medical errors. A total of 76% of Latvian respondents believe that medical errors made by health care professionals are a very significant problem in Latvia. This indicator is just below the EU25 average of 78%. However, 74% of Latvian respondents believe that medical errors occur in hospitals, compared with only 47% in the EU25. A total of 34% of Latvian respondents have read or heard about medical errors in Latvian hospitals, which coincides exactly with the average of the EU25, and 23% of Latvian respondents or members of their family have suffered from unfavourable impacts of medication recommended by doctors, compared with only 11% in the EU25 (European Commission 2006).

In 1999 an epidemiological survey was performed in Latvia relating to inhabitants' opinions about the Latvian health care system (Karaskevica 2004). Within the framework of this survey, access to health care services was evaluated by the level of satisfaction with medical service at the place of residence. The results showed that 43.6% of respondents were satisfied with health care, 32.8% were not, and 23.5% had no definite answer to the question.

The proportion of people in the countryside who reported dissatisfaction with locally available health care (42.4%) was significantly below the respective proportion in urban areas (56.9%). It is likely that rural inhabitants have simply accepted the fact that there is only one health care institution in their local municipality and that they therefore do not have much choice. At the same time, whereas urban residents have a choice of provider, they report lower satisfaction (Karaskevica 2004).

The rural population was less satisfied with the distance that must be covered to access a health care institution, noting problems regarding transport as well as dissatisfaction with the opening hours of health care facilities.

Women were 1.2 times more likely than men to express dissatisfaction with health care. The proportion of rural women who were dissatisfied was lower than those of urban women (42.4% compared with 56.9%, respectively) (Karaskevica 2004).

A total of 34.5% of respondents complained about long waiting times for medical services; a further 34.4% complained of lack of access to a specialist physician; 13.4% had problems with transport; 12.3% noted the long distance to a health care institution; and 5.4% noted unsatisfactory opening hours at health care facilities (Karaskevica 2004).

Physical access

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.

3. Financing

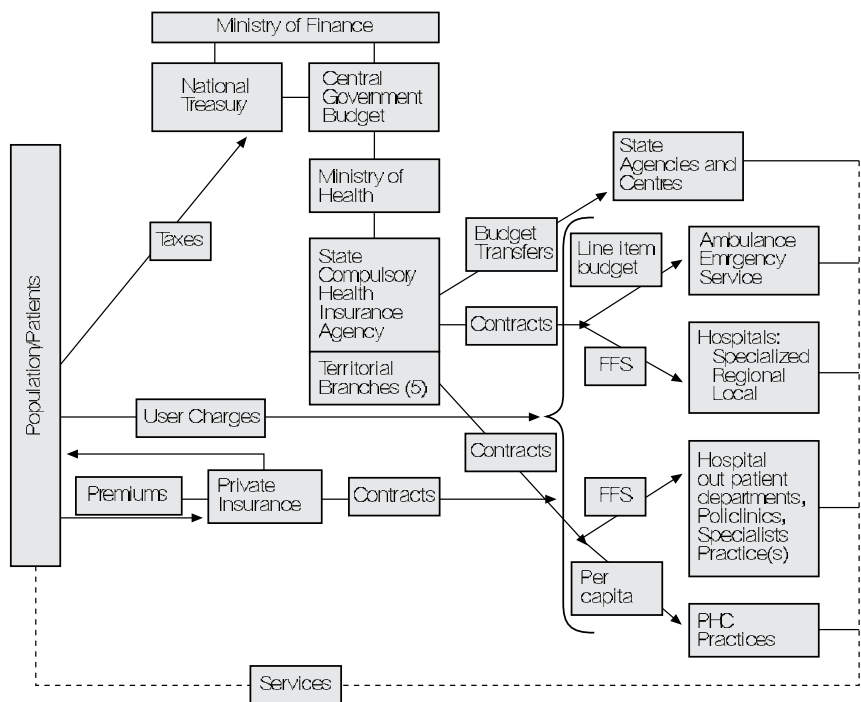
3.1 Overview

Latvia is in the unique position of possessing a tax-funded “social insurance” system with a purchaser–provider split. Social insurance, in its basic form, is generally defined to consist of earmarked payroll contributions that are collected by an independent social insurance agency (or agencies) that act as purchasers (payers) of health services. In the case of Latvia, until 2004, the bulk of public funds for health care came from earmarked payroll taxes (28.4% of personal income tax revenue). These funds were collected by the central Government and transferred to a social insurance organization (the SCHIA), which in turn allocated these funds to eight territorial “sickness funds” that purchased services on behalf of their respective populations. As of January 2005, earmarking of funds for health care was abolished, and general tax-based financing with allocations to health was introduced. What differentiates the current Latvian financing system from most general tax-based ones is that these funds from the central government budget continue to be transferred to the SCHIA, which, together with its five regional branches, acts as purchaser of health services on behalf of the entire population.

Figure 3.1 illustrates the main financial flows in the Latvian health care system. The funds for health care derive from national revenue that includes both income and consumption taxes and represents the main source of health system financing in Latvia. Every year Parliament determines the health budget for the following year. The share of the health care budget has been roughly constant since 2000, accounting for approximately 10% of the total national revenue and 3.4% of GDP in 2005.

The bulk of funds allocated for health services (approximately 96% in 2005) are transferred to the SCHIA. The remaining share of the health budget remains with the Ministry of Health (approximately 4% in 2005) to finance

Fig. 3.1 Financial flows



Source: Authors' own compilation.

Notes: FFS: Fee-for-service (payments); PHC: Primary health care.

health sector management, medical education facilities within clinical hospitals and centres, monitoring and control activities, and cultural activities (libraries, museums, etc.).

Approximately 85% of funds allocated to the SCHIA are used to purchase services through contracts with health providers. The remaining amount (approximately 15%) is allocated to state agencies and centres for specific national health programmes (TB, HIV/AIDS, mental health and others).

The SCHIA consists of a Central Office, which contracts with providers of inpatient and emergency services, and (since 2005) five territorial branches, which contract with providers of all outpatient care (primary and secondary), and additionally provide reimbursements for pharmaceuticals.

The second most significant source of financing is out-of-pocket (OOP) payments, and these consist of:

- user charges, which are co-paid by patients for all statutorily financed services (though some vulnerable income groups are exempted from user charges);

- direct payments for services that are either not financed by the State (such as dental care for adults and cosmetic surgery), or for services that are not included in provision contracts between the SCHIA and providers (for example, lower priority non-urgent care);
- unofficial payments to providers.

A third source of financing involves private (voluntary) contributions for insurance schemes offered to employers or individuals to cover user charges, services that are not financed by the State (complementary insurance), or additional benefits such as faster access (supplementary insurance).

The SCHIA and its five branches act as the general and sole purchaser of the whole range of statutorily financed services. The SCHIA plans levels of service provision and signs contracts with health service providers. The contracts negotiated determine prospective provider funding based on expected costs. Fixed financial budgets require the provider to comply with the terms and conditions included in the contract.

The SCHIA defines long-term health care resource allocation priorities, such as urgent care, care for children up to 18 years, cancer programmes, and others. In addition, contracts may allocate financial resources to resolve acute problems, for example to cut waiting lists (for hip and knee replacements, magnetic resonance imaging (MRI) services, computed tomography (CT) examinations, etc.).

Methods of paying for services and health care professionals have evolved over several years and are quite complex. They are determined by government regulations and are defined in contracts.

Health care personnel working as employees in health care institutions are remunerated on a salary basis. Labour legislation obliges the employer to sign a labour contract with the employee. The service provision contract, in its turn, obliges the employer to pay at least a legally specified minimum salary for medical staff.

GPs are paid by means of capitation, plus fees for defined activities, bonus payments and fixed allowances (such as a practice allowance). In addition, they hold funds for the purchase of certain secondary care services. Specialists are paid by fees for flat rate episodes of illness. Hospitals are paid by a per diem fee with additional activity-based payments.

3.2 Health expenditure

Published data concerning total health care expenditure in Latvia vary according to different sources, for a variety of reasons. National accounting and financial statistics do not yet use the Organisation for Economic Co-operation and Development (OECD) National Health Accounts approach, and therefore the definitions, data collection and interpretation may not fully comply with the international OECD reporting framework. The SCHIA compiles its financial reports based on data provided by service providers' activity records. Traditionally, these data report on provider revenue according to the source: the state budget, user charges and "other income", whereby "other" may include voluntary insurance, direct payments, or investments (private or by local governments). Expenditure reporting, in turn, includes staff salaries, and administrative, capital and current expenditure. Thus, national statistical reporting rather reflects a kind of summarized balance sheet of the providers' enterprises, rather than expenditure by specific health/medical service categories.

Moreover, the hyperinflation of 1992, along with the introduction of the national currency (the Lat) in 1993 and the banking crisis of 1995 have further negatively affected the accuracy of financial statistics.

Finally, private OOP expenditures are estimated differently from source to source. The SCHIA reports only expenditure associated with services that are statutorily financed and provided and that also include patients' co-payments as part of the private expenditure. All other approaches to estimating public and private spending provide different results, which helps to explain the difference in figures between national sources and the WHO Health for All database later in this profile.

Table 3.1 indicates how estimates of health expenditures have developed in Latvia in the period 1995–2004. As a share of GDP, health expenditures show a slightly increasing trend in recent years, climbing from 6% in 2000 to 6.4% in 2004 (after falling at the end of the 1990s). The public share of total health expenditure has been steadily falling since the mid-1990s, from the very high level of 95% in 1995, and appears to be stabilizing after 2001 at 51–52% of total health expenditure. However, taking into consideration that there are different approaches to estimation private expenditure, these figures must be treated with great caution.

The very large increase in the private share of spending is due to the introduction of user charges in the form of "patient fees" in 1996, which were supplemented by the introduction of co-payments in later years (see Section 3.3 *Population coverage and basis for entitlement* and Section 3.4

Table 3.1 Trends in health expenditure, 1995–2004 (selected years)

	1995	1998	1999	2000	2001	2002	2003	2004
Total health expenditure in US\$ PPP per capita	n/a	435	464	477	549	611	678	751
Total health expenditure as a % of GDP	n/a	6.3	6.4	6.0	6.2	6.3	6.4	6.4
Public expenditure on health as a % of total expenditure on health	95.0	60.0	59.0	55.0	51.2	52.1	51.3	51.6
Private expenditure on health as a % of total expenditure on health	n/a	40.0	41.0	45.0	48.8	47.9	48.7	48.4

Source: WHO Regional Office for Europe 2007a.

Notes: PPP: Purchasing power parity; GDP: Gross domestic product; n/a: Not available.

Revenue collection/sources of funds, Subsection *Out-of-pocket payments* for an explanation of the difference between these). The introduction of user charges (amounting to 25% of the cost of the health service) in 1996 was necessitated by a sharp drop in public financing of health care due to the fiscal crisis of 1995.

In addition, the private share of spending has increased due to the rapid growth of VHI, although to a far lesser degree. Furthermore, direct patient payments for such services as bypassing waiting lists for non-urgent operations (orthopaedics, cataracts, hernias, etc.), as well as costly examinations (CT, MRI) may constitute considerable amounts. These constitute official OOP payments, and are made directly to provider organizations (hospitals, health centres) that are contracted with the SCHIA, for services that are not financed and provided by the State. Also, population spending on dental care for adults, which is not statutorily financed and provided, is a key component of private health expenditure, as is spending on visits to practitioners on a private basis.

Total health expenditure in US\$ PPP (purchasing power parity) per capita shows a steady and significant increase throughout the period shown in the Table 3.1, climbing from US\$ 435 in 1998 to US\$ 751 in 2004.

It may be noted that there are a number of components of health care expenditure that are not included in the official data presented here. These include health care spending by the parallel health services; by the State and local governments for social services related to health care (under the Ministry of Welfare); by the Ministry of Education and Science for educational facilities in the health sector and health promotion activities; by the private sector for occupational health services; by NGOs involved with health services; by international organization assistance and support in health care reforms (for example WHO, World Bank and EU); and finally for informal payments, which are believed to be fairly extensive in Latvia.

Comparative data: total health expenditure as a share of GDP and per capita

In spite of the significant gains in health spending in terms of US\$ PPP, health expenditure levels and trends show that Latvia's position diverges markedly in a number of respects when compared to other European countries.

Figure 3.2, illustrating health expenditure as a share of GDP in the WHO European Region, reveals that Latvia's share of 6.4% in 2004 is below the 8.7% EU average, although this percentage is significantly higher than most of the former republics of the former Soviet Union, and slightly higher than the average for EUR-B+C (mainly eastern European countries, explained earlier) of approximately 6%.

Figure 3.3 shows trends over time in health expenditure as a share of GDP in Latvia in comparison with Estonia and Lithuania (the other two Baltic states), as well as Belarus, Finland, the Russian Federation and EU averages. Latvia's share shows the increasing trend of recent years noted earlier, which is comparable to that of some of the other countries, notably Lithuania and Belarus, as well as Estonia (although the share of the latter is substantially smaller than that of Latvia).

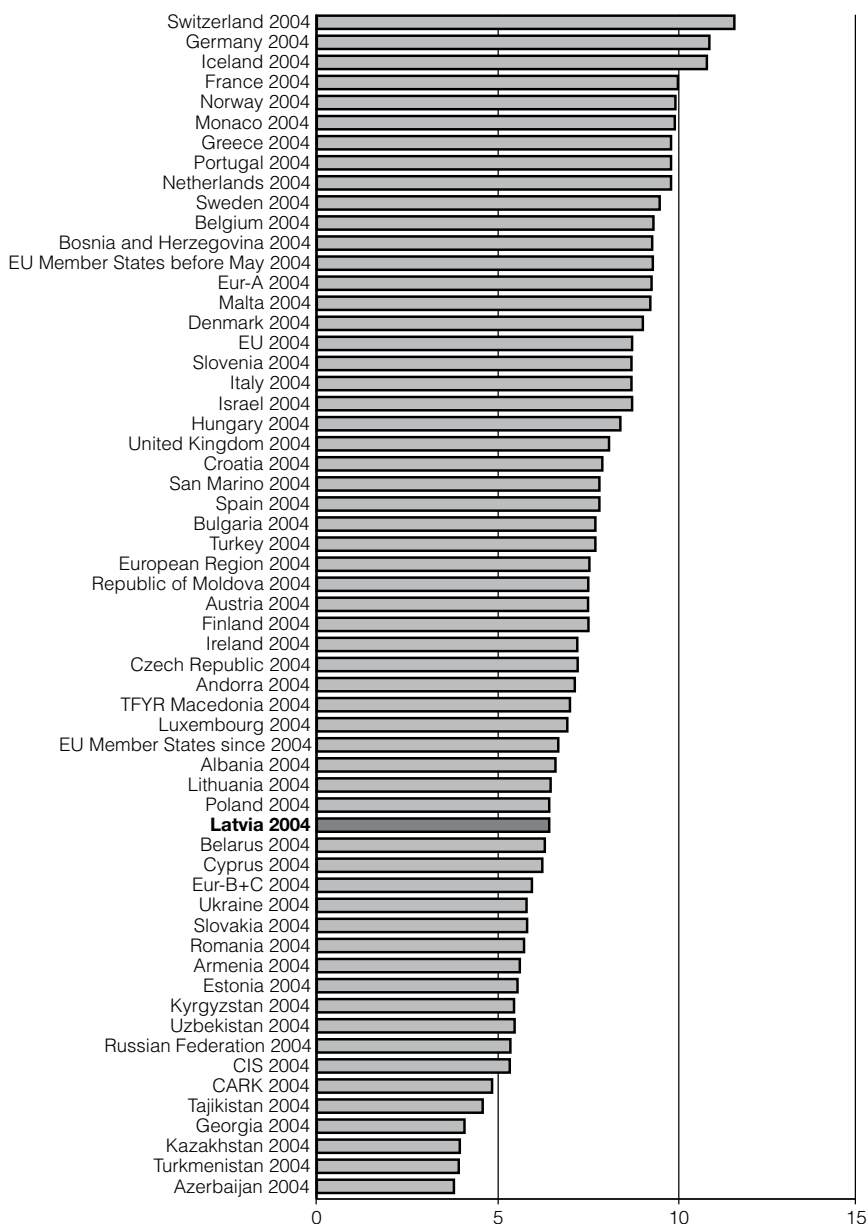
Figure 3.4, showing health expenditure in US\$ PPP per capita in countries of the EU, indicates the enormous range in levels of spending per person among the Member States. Latvia, with US\$ 751 PPP in 2004, had the lowest level of spending per person in the EU, including the new Member States that joined in May 2004 (EU10).

Comparative data: health expenditure according to public/private sources of revenue

Latvia's public share of total health expenditure was nearly 52% in 2004. It is presented in comparison with the shares of the other Member States of the EU in Fig. 3.5. Public funding of health services in Latvia is one of the lowest of all the European Region member countries, at the same level as that of Greece.

Figure 3.6 shows how public shares of total health expenditure of the EU Member States have been developing over time. Most countries show a relatively stable public share. By contrast, the Latvian share (appearing in the bottom part of the figure) fell sharply in the period 1998–2001 and have then stabilized at approximately 51–52% since 2001.

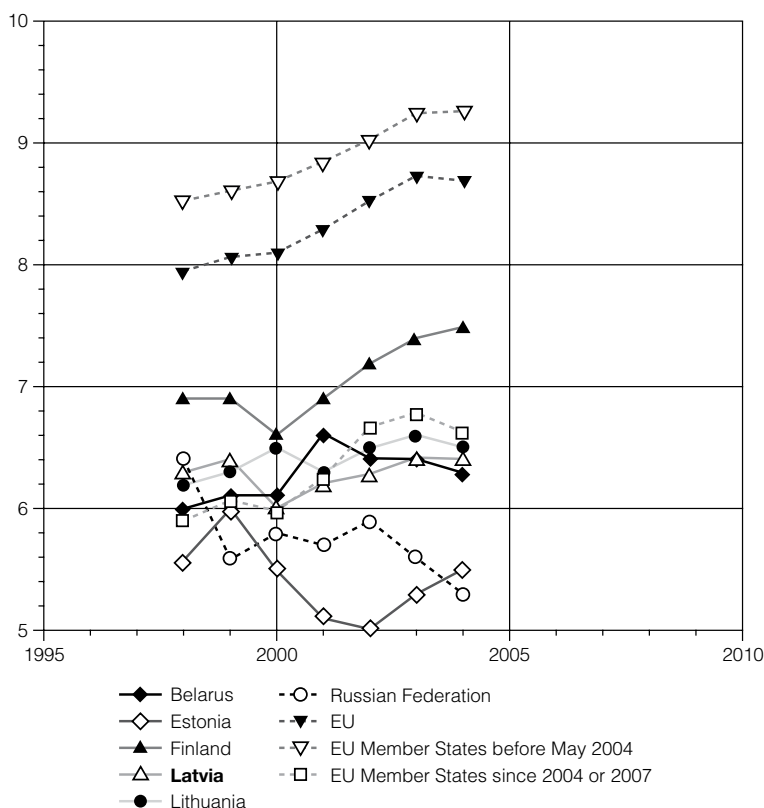
The private share of total health expenditure in the EU Member States is shown in Fig. 3.7. The Latvian data appear in the top part of the figure, indicating, as expected, the very high proportion of private spending, which

Fig. 3.2 Total health expenditure as a % of GDP in the WHO European Region, 2004

Source: WHO Regional Office for Europe 2007a.

Notes: EU: European Union; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; TFYR Macedonia: The former Yugoslav Republic of Macedonia; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; CIS: Commonwealth of Independent States; CAR: Central Asian republics plus Kazakhstan.

Fig. 3.3 Trends in health expenditure as a % of GDP in Latvia and selected countries and averages, 1998–2004



Source: WHO Regional Office for Europe 2007a.

Note: GDP: Gross domestic product; EU: European Union.

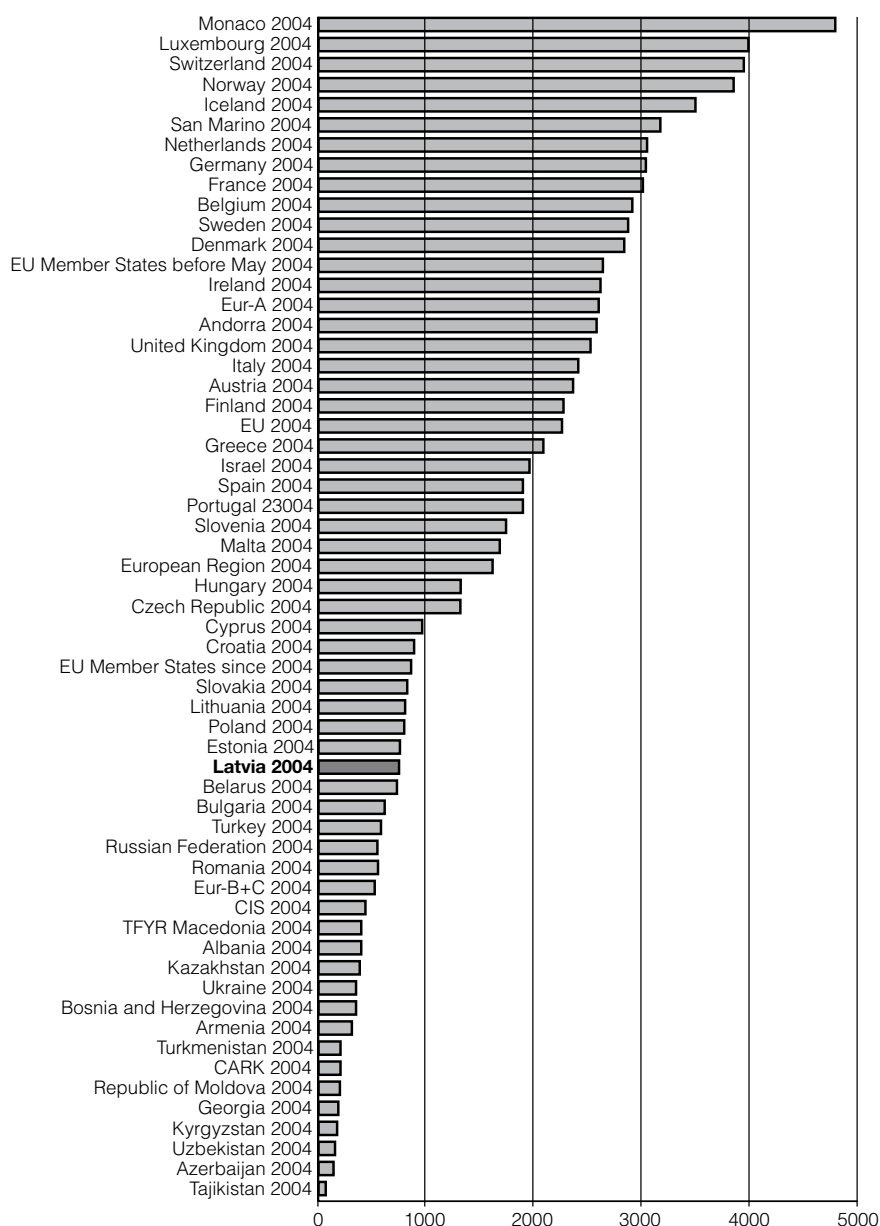
increased in the period 1998–2001, and then stabilized at approximately 48–49% since 2001.

Government health expenditure by type of service

In 2005 the total health care expenditure was LVL 288 million. Approximately LVL 276.1 million of this amount was allocated to the SCHIA to purchase services through contracts with health providers and was distributed among the expenditure items listed here (SCHIA 2005).

- Health services: LVL 179.1 million (64.8%), of which LVL 98.8 million for inpatient care, LVL 67.0 million for outpatient care and LVL 13.3 for emergency care.
- Pharmaceuticals (mainly prescriptions for outpatients): LVL 30.4 million (11.0%).

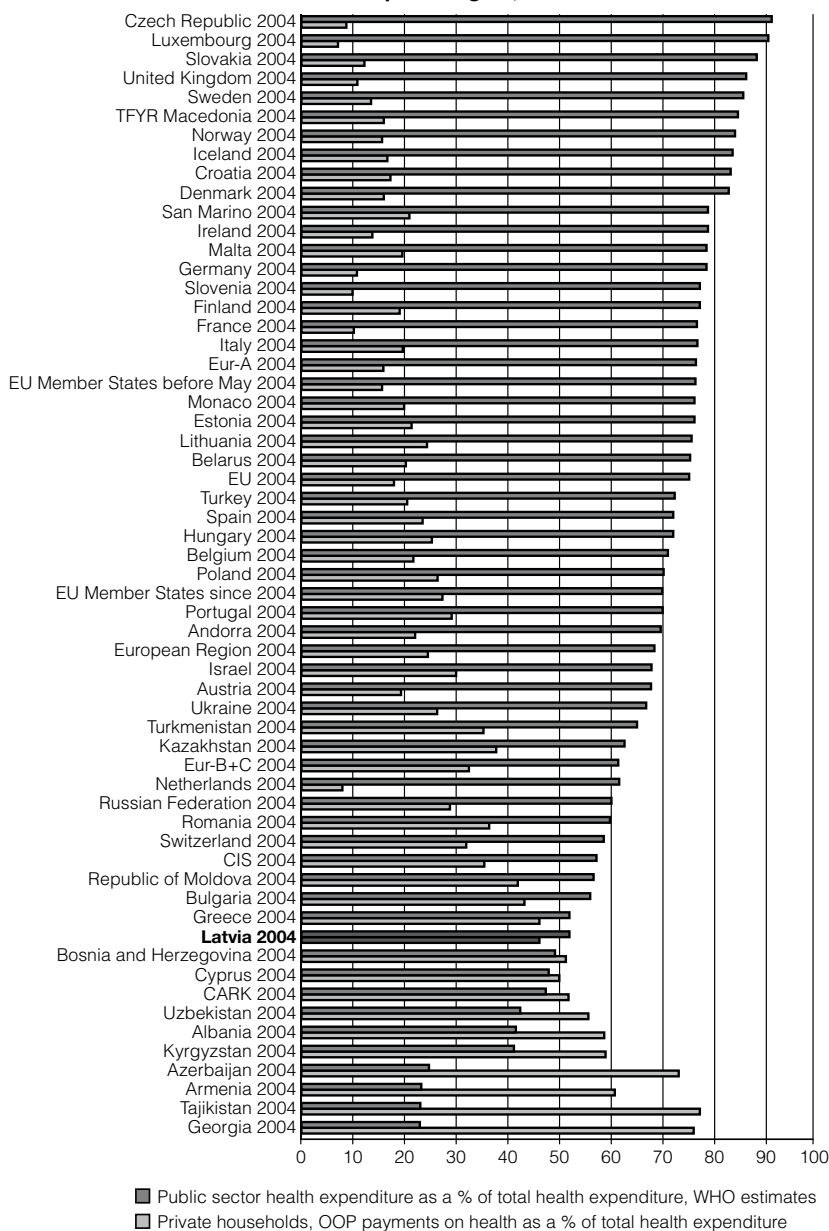
Fig. 3.4 Health expenditure in US\$ PPP per capita in countries of the WHO European Region, 2004



Source: WHO Regional Office for Europe 2007a.

Notes: EU: European Union; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristic from Eur-A countries; CIS: Commonwealth of Independent States; TFYR Macedonia: The former Yugoslav Republic of Macedonia; CARIC: Central Asian republics plus Kazakhstan.

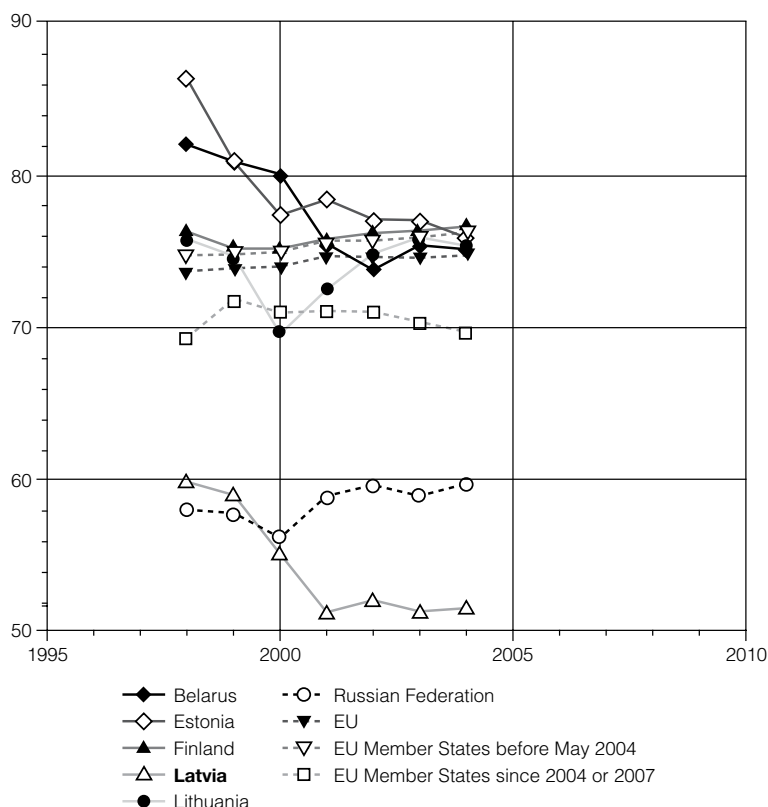
Fig. 3.5 Total expenditure on health (%) according to source of revenue in the countries of the WHO European Region, 2004



Source: WHO Regional Office for Europe 2007a.

Notes: TFYR Macedonia: The former Yugoslav Republic of Macedonia; EU European Union; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; CIS: Commonwealth of Independent States; CARK: Central Asian republics plus Kazakhstan.

Fig. 3.6 Public health expenditure as a % of total health expenditure in countries of the EU, WHO estimates, 1998–2005



Source: WHO Regional Office for Europe 2007a.

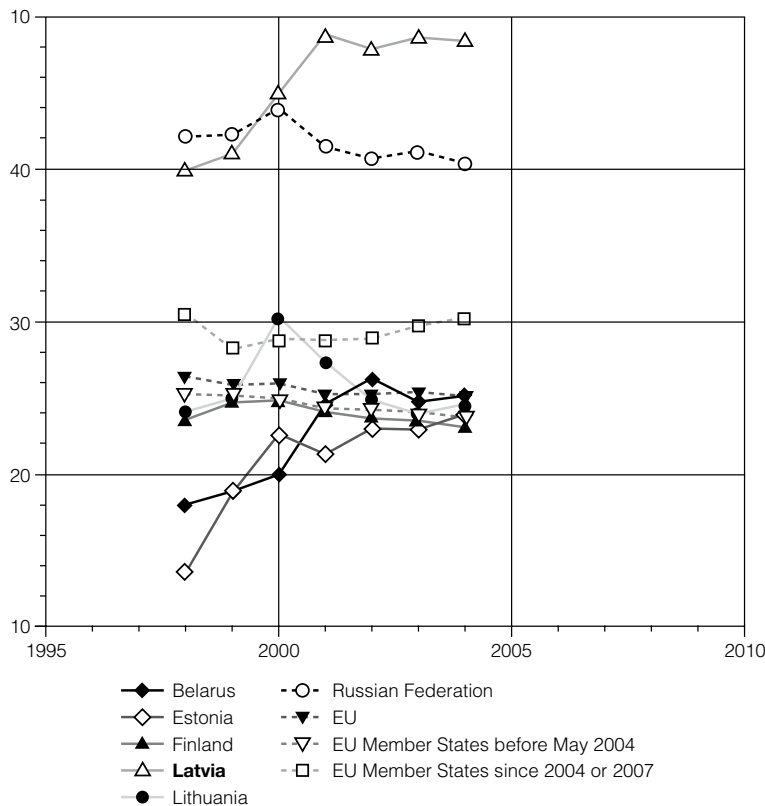
Note: EU: European Union.

- Centralized provisions of pharmaceuticals: LVL 7.4 million (2.7%).
- Reserves: LVL 2.7 million (1.0%).
- Other subprogrammes: LVL 56.7 million (20.5%).

The item “Other subprogrammes”, noted above, include – among other things – the following items:

- state health care agencies: LVL 19.3 million
- state CEDM LVL 9.4 million
- tertiary care LVL 6.1 million
- epidemiological surveillance LVL 4.7 million
- long-term mental health care LVL 1.7 million.

Fig. 3.7 Private health expenditure as a % of total health expenditure in countries of the EU, WHO estimates, 1998–2004

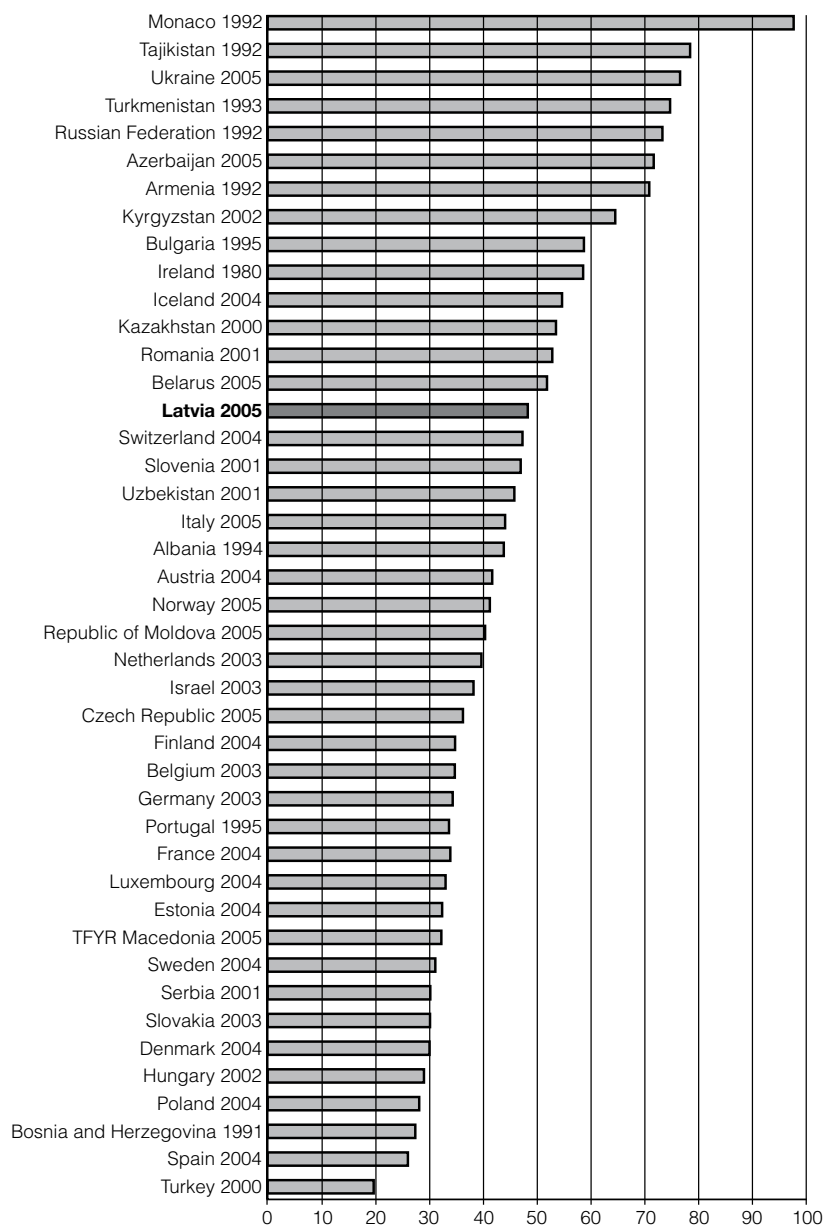


Source: WHO Regional Office for Europe 2007a.
Note: EU: European Union.

Comparative data: proportion of spending on inpatient care

Figure 3.8 shows the proportion of total expenditure allocated to inpatient care in selected countries. In 2005 Latvia’s inpatient sector absorbs approximately 48% of total health care spending. This is one of the largest shares of the EU Member States; only the Republic of Ireland (58% in 1980), Bulgaria (59% in 1995) and Romania (53% in 2001) account for higher shares of inpatient expenditure. However, data for later years are not available. The rest of the countries in the figure allocate approximately 40% or less of their expenditure on health to the inpatient sector. The reason for this high share of inpatient care in Latvia lies in the historical focus on hospital care inherited from the Soviet health care system.

Fig. 3.8 Total inpatient expenditure as a % of total health expenditure in the WHO European Region, latest available year



Source: WHO Regional Office for Europe 2007a.

Notes: TFYR Macedonia: The former Yugoslav Republic of Macedonia.

3.3 Population coverage and basis for entitlement

Population coverage

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 legislation on “Medical Treatment” (2006), which states that “Everyone has the right to receive emergency medical care in accordance with procedures prescribed by the Cabinet” (paragraph 16); and

The amount of medical assistance guaranteed by the State in accordance with the procedures prescribed by the Cabinet shall be provided to citizens of Latvia, non-citizens of Latvia, foreign nationals who have a residence permit, citizens of the EU, EEC and Switzerland, as well as to persons detained, arrested and sentenced with deprivation of liberty. Such assistance shall be provided at the time and place where it is necessary, and medical treatment in such cases shall be carried out in accordance with the standards approved by the Ministry of Welfare (paragraph 17).

It should be noted that Latvia has a relatively high proportion of permanent residents (19.6% of the population) who are not citizens of Latvia, or of any other country. These residents used to be citizens of the former Soviet Union, having emigrated to Latvia during the Soviet period and having never acquired Latvian citizenship. They all have passports and personal identity numbers and have the same access to health care and coverage as Latvian citizens, in accordance with the law quoted above. No other criteria influence this coverage, such as employment status, income, ethnicity, or place of residence.

Aliens and stateless individuals whose passports do not include a personal identity number and who have not been registered in the Population Register but who legally reside in Latvia must pay for health care services out of pocket, with the exception of citizens of EU Member States. If a resident of Latvia or of an EU country needs medical care in a country within the EU, s/he is reimbursed according to EU regulations and agreements. The necessary documents acknowledging this arrangement are E-forms (for example E111) and/or a European Health Insurance Card. In addition to EU countries, Norway, Iceland and Lichtenstein are all party to a similar agreement and have similar coverage to citizens of EU Member States. In 2002 Latvia also signed an agreement with Ukraine about mutual coverage of health care costs for citizens.

In Latvia health care is funded by state budget funds only in those cases where services are provided by physicians and institutions that have contractual agreements with the SCHIA. People in Latvia may receive services from other

certified providers as well, but in these cases they must cover costs themselves or through voluntary (private) insurance. If a person visits a specialist (with some exceptions, according to the diagnosis of the patient; see Box 3.1), or receives hospital treatment (except for urgent cases) or diagnostic examinations without a family doctor's referral, s/he must cover all costs out of pocket. This occurs quite often when patients wish to avoid waiting times for services, which are sometimes extremely long: for instance, in June 2006, the waiting time for a knee replacement operation was 17 years. The maximum permissible waiting time to see a family doctor is five days.

Box 3.1 List of exceptions: patients have direct access to a specialist without a family doctor's referral

Any mental illness
Dependency on alcohol or drugs
TB
STIs
Diabetes mellitus
Oncological disease
Preventive gynaecological check-up
Dentist for children
Narcologist and in case of emergency

All health care services in Latvia require additional patient payments, which may be termed collectively as “user charges”. Until 2005, there were two kinds of user charges in Latvia. The first involved “patient fees” (still in use today), first introduced in 1996, which were flat rate fees for appointments with doctors. A flat rate fee is a payment that is a fixed sum for different services; for instance, the patient fee to visit a family doctor is LVL 0.5; whereas for a specialist visit it is LVL 2.0 (as of April 2005). The flat rate fee for each inpatient hospital day is LVL 1.0–5.0 (depending on type of hospital) to be paid directly by the patient, beginning from the second day of hospitalization, but not exceeding LVL 80 in total.

The second type of user charge involved “co-payments”, introduced in the latter 1990s, forming additional payments for the use of specific services. As of 2004, in an effort to simplify the system of user charges, the Government abolished the category of charges referred to as co-payments, and retained a single category of payments now termed “patient fees”. To maintain the overall level of user charges, the size of patient fees was increased.

All patient payments should not exceed LVL 150 per person per year. In the event that they do exceed LVL 150, the patient may request exemption

from payment of further fees from the SCHIA. In addition, the respective patient can declare patient fees when filing income taxes and receive a tax deductible by the National Revenue Service (NRS). For information on the functions of the NRS, see Section 3.4 *Revenue collection/sources of funds, Subsection Compulsory sources of financing*.

Patient fees can be covered by voluntary insurance. Some patient groups are covered completely from the state budget and are exempted from patient payments, as shown in Box 3.2. It should be noted, however, that the exemptions apply only to health care services provision, and not to pharmaceuticals. For information on OOP payments for pharmaceuticals, see Section 5.1 *Physical resources, Subsection Pharmaceuticals and Section 6.6 Pharmaceutical care*.

Box 3.2 Patient categories exempted from the patient fee

- Children under the age 18
- Pregnant women and women up to 42 days after childbirth
- Politically repressed individuals (during the Soviet period), participants of national liberation movement and Chernobyl nuclear accident victims
- Poor people who are officially acknowledged as such according to legislation
- TB patients and those who are under examination for tuberculosis
- Mentally ill patients who are receiving treatment
- Chronically ill patients receiving dialysis, hemodiafiltration and peritoneal dialysis treatment
- Patients with specific infectious diseases (list of 43 diseases)
- People receiving care by means of an ambulance emergency team
- Patients at state and municipal social care (nursing) centres
- All patients undergoing prophylactic examinations (special list of examinations)
- All people receiving vaccination or passive immuno-therapy (within the State immunisation programme)

Source: Authors' own compilation.

Note: TB: Tuberculosis.

In addition to tax-funded general health insurance, (private) VHI is also available in Latvia. This insurance is both complementary, as it covers additional patient payments for services excluded from state budget coverage (such as dental care), and also supplementary, for services such as faster access, higher comfort levels and wider consumer choice (Section 3.4 *Revenue collection/sources of funds, Subsection Voluntary health insurance*).

Benefits

Health care benefits

Health care services financed by the State are defined by the “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004). The range of statutorily financed services is also determined by contracts between service providers and the SCHIA.

Apart from a positive list of pharmaceuticals, Latvia has never had a list of specific services that are included within the budget-covered services. The system of benefits is based on both implicit and explicit principles. In some cases a broad area of care is said to be covered, thereby implicitly covering a broad range of services on the basis of tradition. For example, in PHC the standard contract contains a sentence about the tasks of a family physician: “... to ensure patients’ evaluation and treatment corresponding to the disease, providing for a possible quick recovery”. At the same time, additional explicit lists of diagnostic procedures, preventive measures and pharmaceutical lists are appended to the Regulations of Cabinet of Ministers. In other cases a broad area is said not to be covered (for example, rehabilitation), with an extensive list of exceptions appended.

The range of primary and secondary health care services financed by the State (known as the “Basic Care Programme” until 2004, after which this terminology was abandoned) was specified each year from 1994 onwards by an Act of the Cabinet of Ministers. It included a range of services (though not a positive list) that should be provided for each citizen and legal resident and financed from the health care budget that was handled by the SCHIA (together with user charges from the mid-1990s onwards). The Basic Care Programme included medical services provided through contracts between purchasers and providers. In addition to the Basic Care Programme, the State financed a range of numerous national programmes, such as for control of infectious diseases, diabetes, HIV/AIDS, drug abuse, improving mental care, mother and child care, and many others. The funding of the national programmes were provided through a number of state agencies and state-level provider institutions by direct budgetary transfers (i.e. they did not go through the SCHIA). These budgetary transfers were approved by the Ministry of Health and transferred to specific providers (the state agencies; see Section 2.2 *Organizational overview*) or specific operational units within provider structures.

In 1999, a number of the national programmes were removed from the Ministry of Health funding list, included in the Basic Care Programme and began to be financed by the SCHIA.

In 2004, according to “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care”, funding of all the programmes

previously financed directly by Ministry of Health budget transfers was taken over by the SCHIA. At the same time, the notion of the Basic Care Programme was abandoned, and the distinction between the concept of the former Basic Care Programme and the special programmes ceased to exist. Instead, health care financing became increasingly centralized, with the majority of the health budget (approximately 96%) being dealt with through the SCHIA, which now allocates these funds among numerous programmes and subprogrammes, annually determined by legislation on the national budget (Section 3.5 *Pooling of funds*).

The Ministry of Health has designated the following priorities to be pursued by the SCHIA through contracts with providers:

- Government-approved immunization and preventive programmes;
- emergency and urgent care;
- PHC;
- maternal and child health;
- cancer programmes;
- first-stage rehabilitation (after acute health conditions);
- social health risk factors (TB, HIV/AIDS, communicable diseases, mental health and others).

Services not covered by the state budget include dental care for adults, rehabilitation (with exceptions in the case of acute conditions), 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), cosmetic surgery, psychotherapy (except for inpatients in psychiatric hospitals), inpatient care that can be provided on an outpatient basis, *in vitro* fertilization, alternative and complementary treatments, and others. All the services not included or excluded from state coverage can be covered directly by patients or their voluntary insurance plans.

As mentioned above, there are user charges for all health care services in Latvia. These are discussed in detail in Section 3.4 *Revenue collection/sources of funds*, Subsection *Out-of-pocket payments*.

Over the last several years discussions at political and professional levels have been initiated several times regarding the need for a positive list explicitly defining the benefits package. The Latvian Physicians Association attempted to define such a list in recent years, with the last attempt having been made in 2005; however, the result was unsuccessful, as the list was too comprehensive and unaffordable, and without clear limits relating to what was financially feasible.

Social security benefits

Aside from health care benefits, Latvia's system of social protection additionally includes the following categories of social security, which are administered by the Ministry of Welfare.

- Social insurance, which is financed by earmarked payroll contributions that are compulsory for all employees and self-employed individuals, covers risks of old-age, death, work disability, maternity, labour accidents and work-related diseases and unemployment.
- State social benefits, which are tax financed, include family benefits.
- Social assistance, which is financed by state and local governments, include means-tested benefits in cash and kind to people who fall below the poverty line and lack the means to support themselves.

Examples of benefits include the following:

- Sickness benefits, which apply to all employees and self-employed individuals; these include payment by the employer of at least 75% of average earnings for the 2nd and 3rd day of incapacity, and at least 80% of average earnings from the 4th day. Cash benefits from social insurance apply from the 15th day of incapacity for work, and continue until recovery, up to 52 weeks, or up to three years in case of repeated incapacity for work.
- Maternity benefits include 100% of the average insurance contribution wage and are paid for 112 calendar days, including 56 days prior to delivery and 56 days after. These are paid for 14 additional days in the event of complications, or in the event that two or more children are born.
- Paternity benefits include 80% of the average insurance contributions wage for a maximum of 10 days.

3.4 Revenue collection/sources of funds

Health care in Latvia since independence in 1991 has been financed through general central-level taxation, although terminology in policy documents suggests financing through social health insurance. Early reforms soon after independence (1991–1994) aimed at abandoning the Soviet integrated model and adopting a social health insurance system (such as that which had prevailed during Latvia's short period of independence between the two World Wars) that would also introduce an independent purchaser of health care services. During the early years of the reforms, the concept of an independent purchaser became a highly controversial issue. Initially, the idea of many decentralized service purchasers prevailed, resulting in the establishment of 35 "sickness funds"

that engaged in contracting with providers. However, these sickness funds were never financed through earmarked social insurance contributions; at all times throughout their short existence they received their finances from state budgetary sources. Although the change from tax financing to social insurance financing was discussed, it did not receive enough support and commitment among the reformers, and the idea was therefore abandoned.

Moreover, it soon became evident that small decentralized sickness funds had a limited capability to meet efficiency requirements. The main risk areas were inpatient care and expensive diagnostic examinations. A solution was therefore sought in the successive merger of sickness funds, eventually resulting in a single centralized purchaser for the entire country, the SCHIA, with its five territorial branches (for more information on these developments see Section 2.3 *Decentralization and centralization*).

The other major reform activity in the area of financing involved the introduction of OOP payments in the form of patient fees for appointments with doctors providing statutory services (1996). Shortly afterward co-payments for specific services were introduced and in subsequent years user charges evolved into a fairly complex system of patient fees plus co-payments. This coincided with the development of VHI programmes, which were initially only sold to cover various combinations of user charges.

According to data reported to the SCHIA (shown in Table 3.2), the main revenue source for the health care system in 2004 was general taxation at central and municipal levels, contributing approximately 75%. The second most significant source, with a contribution of more than 20%, was household OOP payments for health care in the form of formal user charges and VHI. Revenue was also contributed from additional charges, such as hotel facilities. Formal user charges, including OOP payments and payments in the form of VHI contributed 4.4% of the total revenue (VHI pays for 34% of user charges). Local governments have very limited financial resources from local government taxations through the levying of charges for supporting health care; however, as owners of health care institutions, they are interested in sustaining the attractiveness and competitiveness of local providers.

However, these figures have to be interpreted with great caution. First, they do not refer to revenue for total health care, but represent those that are reported to the SCHIA. These figures therefore exclude the revenue share for the programmes that are financed through direct budgetary transfers.⁴ Second, the national data presented in Table 3.2 differ from WHO estimates presented in Table 3.1, Fig. 3.5 and Fig. 3.6, which show OOP payments to have been approximately 48% in 2004. It should be noted that private expenditure on

⁴ It is estimated that approximately 96% of the total health budget is administered through the SCHIA, leaving only approximately 4% to be allocated through direct budgetary transfers.

Table 3.2 Sources of revenue for the health care budget, 2001–2004

	2001 (%)	2002 (%)	2003 (%)	2004 (%)
Public				
State budget (taxation)	69.2	73.3	74.6	75.1
Local government (taxation)	2.0	1.2	1.1	1.1
Private				
Formal user charges (OOP and VHI)	6.2	6.1	5.1	4.4
Other income (OOP, VHI and all other direct payments)	22.6	19.5	19.3	19.5

Sources: SCHIA 2004; SCHIA 2003; SCHIA 2002; SCHIA 2001.

Notes: *OOP = out-of-pocket (payments), VHI = voluntary health insurance; Totals may not equal exactly 100% due to rounding.

health in Table 3.2 represents only VHI and OOP payments that are reported to the SCHIA by contracted providers. Other OOP spending is not included here. Thus, private sources of revenue are not fully reflected in Table 3.2.

Compulsory sources of financing

General non-earmarked taxation is the main source of revenue for Latvian health care since 2005. In the period 1997–2004 there were two revenue sources for the health care budget: 28.4% of earmarked personal income tax, and subsidies from general revenue (also financed by tax revenue at the central level). As of January 2004, the earmarked payroll tax for health care was suspended, although the earmarked social tax for social security was retained.

Tax collection is centralized in Latvia. The main body responsible for tax collection is the NRS, subordinated to the Ministry of Finance. It operates territorial branches and incorporates several institutions, such as the Financial Police and Anti-Corruption Inspection. Tax payments flow to the National Treasury from the Ministry of Finance. The tax rates are set by laws passed by the Parliament. Local governments are responsible for collecting a real estate tax; this, however, is set and administered at the central level.

As of January 2007 the main taxes paid by the population are the following:

- social insurance tax paid by employer and employee in the proportions 24% and 9%, respectively;
- personal income tax at 25%;
- corporate income tax at 15%;
- VAT at 18%;
- excise tax on alcohol, tobacco and fuel at varying tax rates.

Social insurance contributions finance a wide variety of social guaranties, including pensions for the retired, sickness benefits, maternity allowances, unemployed benefits, etc. Personal income tax of 25% is based on income after the social insurance tax deduction.

There is a non-taxable minimum of LVL 32 on personal income tax, plus LVL 22 for each dependant. There is also tax relief in the form of tax deductions for reported and confirmed OOP spending on health care by the individual or any of her/his dependants (children, parents), as well as for spending on professional education. However, tax deductions are limited to LVL 150 (€215) per year, which also includes payments for VHI. If spending on health and education exceed the limit, the excess amount can be transposed over five coming years. Direct payments by the taxpayer for planned surgery and dental care have no limits and can be fully deducted from personal income tax.

Voluntary health insurance

Interest in VHI was first shown in 1996 as a result of the introduction of patient user charges for health care services. In the early 1990s there was only one insurance company that provided health insurance coverage mainly to individuals, and a few health insurance schemes were adapted to changes in formal user charges. In 2007 more than 10 commercial life and non-life insurance companies were offering health insurance coverage, mainly to employer organizations.

Table 3.3 shows growth in private health insurance in the period 1997–2005, with both premiums and claims having increased nearly 5-fold in real terms. Moreover, compared to the growth of the state financing share, the private health insurance share in total health financing grew from 1.8% in 1997 to over 5.0% in 2001, after which it stabilized. With regard to turnover, by 2005, private health insurance had reached third position in terms of relative importance within commercial insurance, from the point of view of both premiums and claims. The increase in VHI coverage is due mainly to the inability of public resources to adequately cover demand for health care services and pharmaceuticals. Another factor may be associated with employer considerations to make job conditions more attractive with insurance bonuses. Employers are interested in corporate income tax relief as well, derived from insurance premiums paid for employees.

In spite of its rapid growth, VHI is responsible for a relatively small share of total revenue sources in the health sector, as indicated by its size relative to state budget financing (5%).

Table 3.3 Voluntary health insurance contributions and claims, 1997–2005 (real LVL million, 1997 prices)

	1997	1998	1999	2000	2001	2002	2003	2004	2005
Premiums*	3.4	4.3	6.6	7.6	9.4	10.4	13.3	14.2	18.1
Claims*	2.0	2.2	4.2	6.3	7.5	7.9	8.8	9.6	11.1
State budget financing*	111.5	122.5	126.8	136.7	140.5	155.9	172.5	188.5	214.1
VHI claims/budget financing (%)	1.8	1.8	3.3	4.6	5.3	5.1	5.1	5.1	5.2
User charges (% paid by VHI)	-	-	-	-	8.3 39%	8.6 30%	8.7 42%	8.6 34%	-

Source: Latvian Insurers Association, 2007 (data provided in nominal terms).

Notes: * Figures are in real terms (million LVL), deflated by use of the consumer price index, 1997 prices; VHI: Voluntary health insurance

VHI schemes are offered by commercial insurance companies to employer organizations. There is only one quasi-public insurance company (belonging to Riga City) that provides coverage for individuals, and this is about to be privatized.

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 cover those health care services and/or prescription drugs which 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). Other VHI schemes cover only user charges (patient fees and co-payments) imposed on state budget services. Some schemes cover the cost of specific services, such as optician services, hearing aids and prosthesis. Generally, voluntary health insurers exclude from their schemes health conditions and diseases covered by statutory insurance, such as communicable diseases, STIs, HIV/AIDS, mental health, substance and alcohol abuse, emergencies and pharmaceuticals. Plastic surgery, *extra uterus* fertilization and non-traditional 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. 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. There are no legal regulations specifically for health insurance in VHI companies; they conform to the regulations of the private sector, including solvency controls.

According to a household survey carried out in 2003, of the 6363 respondents, 15.6% said they are covered by VHI and 0.8% responded “I don’t know”. Among respondents covered by VHI, 25% had higher education and 20% were residents of the Riga City region.

Out-of-pocket payments

In Latvia a number of services involve direct OOP payments, such as dentistry for adults, doctors’ home visits, psychotherapy, cosmetic surgery, most of the available rehabilitation and physiotherapy services, among others. In addition, all statutorily financed health care services involve cost sharing. This is due to the limited health budget resources for providing services and in order to reduce unnecessary demand. The terms of the contracts between the SCHIA and providers determine that urgent medical care and some special conditions are priorities for resource allocation. Non-urgent care, planned (elective) surgery, non-urgent lab tests and general diagnostics, and management of chronic illness may be subjected to waiting lists or postponed by providers into the distant future. Services for such health conditions may be provided to patients in exchange for direct payments, although on the condition that they are not excluded from the services covered.

Cost sharing

User charges in Latvia were represented by patient fees (payments for appointments with doctors offering statutory services) and co-payments (e.g. additional fees for procedures or tests) for services financed by the State. Patient fees were introduced in 1996 in an effort to increase resources for health care, as well to reduce unnecessary demand. There were no fees introduced for emergency care services, maternity care services, and services for children up to the age of 18. Later, co-payments for specific services were also introduced. Initially, user charges (the sum of patient fees and co-payments) constituted 25% of the cost of services. The introduction of user charges posed serious problems for patients and providers alike. Patients had difficulty predicting the magnitude of their total user charges/direct payment combinations, and could not understand the difference between fees and co-payments. According to data of the State Sickness Fund (the precursor of the SCHIA), actual amounts of user charges were no more than approximately 12–13% of service costs, causing problems for health care facilities that spent all necessary funds for health care, while being reimbursed for only 75% of their costs. In the latter part of the 1990s, user charges were reduced to 20% of service costs, consisting of 15% co-payment and 5% patient fee.

In 2004, the Ministry of Health attempted to provide clear definitions of user charges, in order to make them more understandable for both patients and providers. The Government's "Regulation on Organization and Financing" of 2004 has moved the system of user charges towards more simple definitions (tariffs). These resulted from the merging of the former patient fees with co-payments and may only be called patient fees. The total sum of formal user charges, however, increased in 2005 in real terms.

At the same time, a considerable proportion of the population (about one third) fall under the exemption rule not to pay (Section 3.3 *Population coverage and basis for entitlement*, Subsection *Population coverage*). Where this is the case, providers receive full compensation from the central budget.

When first introduced (1996), the patient fee and later co-payments were formally claimed to encourage consumer responsibility over her/his own health, reduce inappropriate demand, and increase resources for health care. Historically, user charges (including both patient fees and co-payments) have been surrounded by disputes within both the health care system and the general public. Certain issues have always been contested, such as who pays and why, who benefits and by how much, what are the real consequences for patients, and issues surrounding diverse population groups and provider behaviour. Patient groups and organizations of retired and handicapped people have insisted on expanding the exemption rule and reducing rates of user charges. They have met with some success, particularly if the dispute coincides with pre-election political campaigns.

Formal policy on the application of user charges is defined by a succession of Regulations of the Cabinet of Ministers, which are updated as necessary. The most recent measure involves the "Regulations on Organization and Financing of Health Care" of 2004. User charges apply to almost all types and levels of statutorily financed health services, as well as outpatient prescription pharmaceuticals. Exemptions include emergency care, maternity care and the majority of national health programmes, such as TB, mental health care, kidney failure (haemodialysis) and some others.

In 2005, Regulations of the Cabinet of the Ministers ("Rules on Compensating Mechanism for Medicines and Medical Devices Purchased in Outpatient Care") introduced a reference pricing system for pharmaceuticals included in the positive list, whereby the difference between the price of a pharmaceutical selected by a doctor and the price of the reference pharmaceutical (which is the lowest priced one in the market) must be paid for out of pocket by the patient. At the same time, the overall budget for pharmaceuticals was increased. Reference pricing was introduced as a tool to expand the range of health

conditions (diagnoses) that could be covered by the compensating mechanism, in order to save some money.

Historically, the mechanism of pharmaceutical compensation by the SCHIA covered several diagnoses (such as diabetes, glaucoma) and patient groups (such as children, disabled people, politically repressed, etc.). Later, only specific health conditions and their corresponding pharmaceutical lists were covered according to the degree of severity (100%, 90%, 75% and 50%). The 2005 regulations divided the existing positive drug list into three parts: an interchangeable drug list (list A); a non-interchangeable drug list (list B); and pharmaceutical products where annual treatment costs exceed LVL 3000 (list C). Reference pricing refers only to the replaceable drug list (A), where only the lowest drug price level (the reference drug price) is covered. For example, if a patient is prescribed a 75% covered non-reference drug, s/he must pay 25% of the reference price plus the price difference between the non-reference and reference pharmaceuticals (Section 5.1 *Physical resources*, Subsection *Pharmaceuticals*.)

Patient fees vary according to the type of service provided, as shown in Table 3.4. The patient fee for an appointment with a family doctor is LVL 0.50 (€0.70) compared to LVL 2.00 (€2.85) per specialist consultation. In addition to specialist consultations, a patient pays an additional flat-rate patient fee of LVL 3.00 (€4.25) for certain diagnostic and/or therapeutic procedures.

There are protection mechanisms for vulnerable groups, such as children, the elderly, and people with low income. Children (up to 18) are exempted by law from payment of any fees for all services included in the statutory list of services. Also, they enjoy priority if the volume of the provider contract is increased (Section 3.7 *Payment mechanisms*) and when certain programmes, treatments, medical aids, etc. are put into effect. However, this still does not mean that children receive all necessary health care.

User charges for both outpatient and inpatient health care services have limits of LVL 150 per person per year, and LVL 80 per hospitalization episode. Low income individuals pay reduced rates per specialist consultation.

User charges may be covered by VHI. However, not all private insurance companies provide coverage to individuals. Most of their well-valued insurance schemes are targeted towards corporate clients of a relatively large size.

Figure 3.0 presents some comparative data on the magnitude of OOP expenditure as a share of total health care expenditure in Latvia and countries in the WHO European Region in 2004. Latvia has one of the highest shares of private OOP spending on health in the Region, accounting for 45.9% in 2004, with only Cyprus and Greece having higher shares in the EU: it was almost three times as high as the EU average of 18% in 2004.

Table 3.4 Overview of patient fees for services included under statutory provision, 2005

Type/group of service	Patient fees LVL (€)
GP appointment	0.50 (0.70)
Appointment plus ambulatory operations (if applicable)	2.00 (2.85)
Laboratory tests	n/a
Diagnostic tests, e.g. ECG, RTG, US, CT, MRI	Range 0.50–9.00 (0.70–13.00)
Day surgery each day plus operations	0.50 (0.70) 3.00 (4.25)
Stay in a regional multi-profile hospital, inpatient care, per day	5.00 (7.10)
Stay in a specialized hospital and/or centre, inpatient care, per day	4.00 (5.70)
Stay in local multi-profile hospital (general inpatient care), per day	3.00 (4.25)
Services financed under the National programmes e.g. cancer, drug and alcohol abuse	1.00 (0.70)
Stay in health facility for rehabilitation, per day	1.00 (0.70)
Services on emergency care, pregnancy and maternity financed under the national programmes	n/a

Source: Cabinet of Ministers, 2004b.

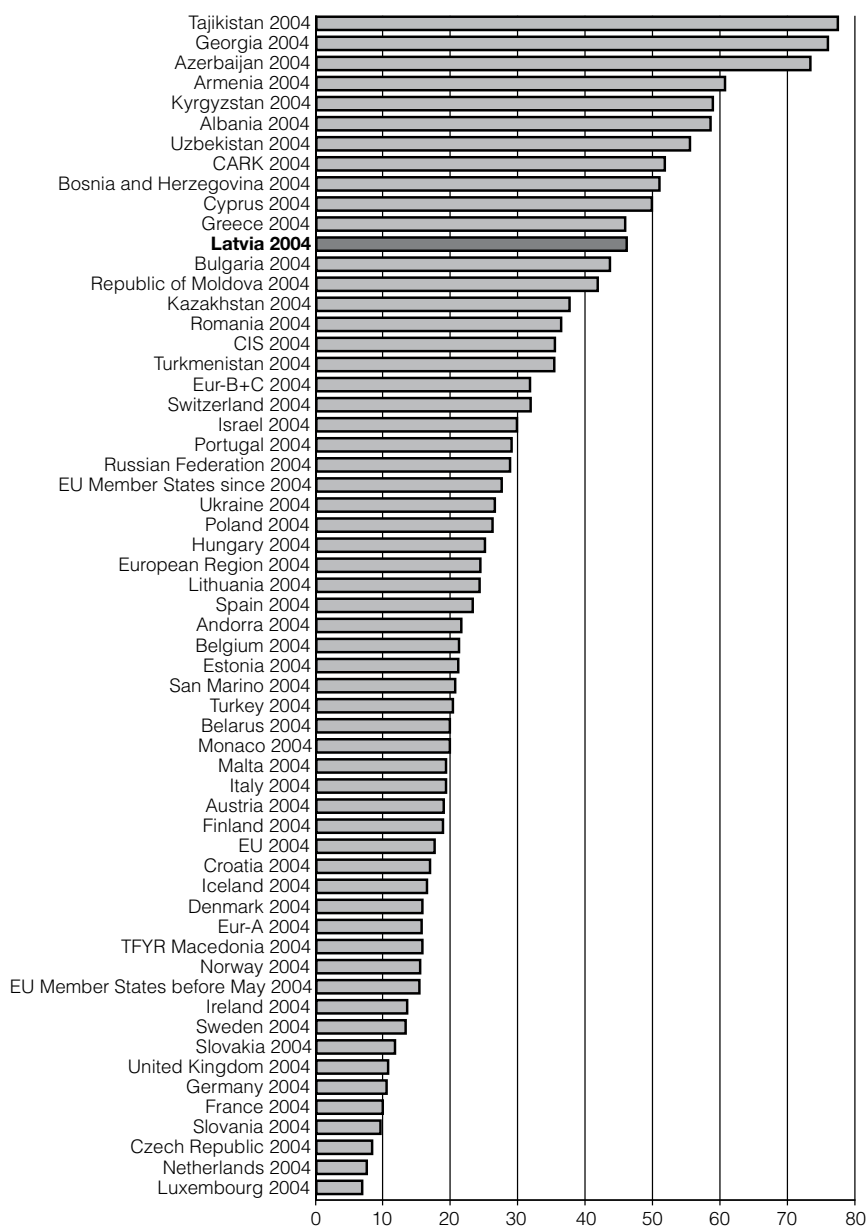
Notes: GP: General practitioner; n/a: Not applicable; ECG: Electrocardiogram; RTG: Radioisotope Thermoelectric Generator; US: Ultrasound; CT: Computerized Tomography; MRI: Magnetic Resonance Imaging.

Informal payments

Informal payments were prevalent in the health care system that prevailed during the 40-year period of Soviet occupation, which wrongly declared that there were no limits to access to health care, and that provision of health care services was free of charge at the point of delivery. However, the limitations of central economic planning and totalitarian control informally made room for the concept of “thanksgiving” in certain sectors of public life, particularly in the health care sector. In spite of the re-emergence of democratic and economic freedoms at the beginning of the 1990s, the practice of making informal payments in the health sector persists, due to the remnants of the Soviet tradition combined with the current scarcity of resources in the public sector.

Informal payments are a publicly sensitive issue in today’s agenda. Although there is a general awareness of the problem, its magnitude is not formally researched and assessed, and quantitative data are therefore not available. Isolated incidents emerge in the mass media and those that result in legal proceedings usually involve claims of making payments prior to provision of services, or misinformation given to patients about conditions of service provision. The majority of under-the-table payments are reported to be paid for specialized elective medical care, such as in neurosurgery and orthopaedics, among others.

Fig. 3.9 Out-of-pocket health expenditure as a % of total health expenditure in the WHO European Region, 2004



Source: WHO Regional Office for Europe 2007a.

Notes: CARK: Central Asian republics plus Kazakhstan; CIS: Commonwealth of Independent States; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; EU: European Union; TFYR Macedonia: The former Yugoslav Republic of Macedonia; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe.

A major population survey on corruption in the health sector, which was conducted in 2002, reported that only 3% of patients admitted to having made an unofficial payment for a health care service, while 14% admitted to giving gifts to health care providers. A total of 45% of respondents rated corruption in statutory health care services as high or very high, while 50% believed that the corruption level had increased over the previous three years. At the same time, respondents were divided over the issue of whether unofficial payments to health care professionals constitute corruption, with 51% believing that they do, and 49% believing that they do not. Most of those who believed that unofficial payments are not corruption believed them to be an act of gratitude. The majority of respondents (62%) stated that they would not be willing to report a health professional who received an unofficial payment. The most common response (51%) to what should be done to prevent unofficial payments was that salaries of doctors should be increased. The study concludes that there is likely underreporting of actual unofficial payments, possibly because respondents knew it was illegal, or because they may have been afraid to do so, or because making unofficial payments is so universal that many respondents do not think of them as unofficial (CIET 2002).

External sources of funds

World Bank

In 1999–2004 the World Bank implemented a project involving a loan of US\$ 12 million for the “Latvia Health Reform Project”. The objective of the project was to assist the Latvian Government in a major health sector restructuring strategy, addressing a number of diverse issues. This project has formed the basis of most of the health care services reform efforts of recent years, and is discussed at length in Section 4.2 *Planning and health information management*, Chapter 5 *Physical and human resources*, and Section 7.2 *Analysis of recent reforms*.

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 public health policies, provision of technical leadership and support of an intersectoral approach to health. Key areas of intervention in the period 2004–2005 have included tobacco control; review of alcohol control policy; development of mental health policy; intersectoral collaboration on the prevention of road traffic accidents; strengthening of the National Baby Friendly Hospitals initiative (in collaboration with UNICEF); updating of an environment and health information system; an anti-violence campaign (jointly

with other United Nations agencies, NGOs and the private sector); review of national maternal and child health policy; review of national food and nutrition policy aimed at the prevention of iodine deficiency; establishment of a WHO collaborating centre for MDR-TB, and many others.

WHO priorities for 2006–2007 include prevention and control of noncommunicable diseases (in connection with mental health, alcohol, obesity, tobacco, violence); improving core functions of the health system (financing, pharmaceuticals, patients' rights, human resources); and scaling up health system response to major communicable diseases (HIV/AIDS, STIs).

Other United Nations agencies

Other United Nations agencies also have close cooperative arrangements with Latvia. Since 1992 the following have had a presence: UNHCR; UNDP; UNICEF LNC; and UNESCO LNC.

The European Union since 2004

Latvia became a member of the EU in 2004. In total, Latvia will receive €247.3 million for health purposes in the period 2004–2013. This amount constitutes 9.3% of total EU funds for Latvia for all sectors. A total of €40 million are earmarked for public health programmes, while €207.3 million are allocated for infrastructure development.

European Union assistance prior to Latvian membership

From 1991–2003 Latvia was a recipient of EU funds through PHARE. After joining the EU in 2004, no more funds were received via PHARE, although implementation of programmes made possible by previously received (PHARE) funds is still ongoing.

Other sources of financing

In addition to state and local government financing for health and external sources of financing (discussed in Section 3.4 *Revenue collection/sources of funds*, Subsection *External sources of funds*) there are some further sources of financing related to provision of health services.

Parallel health services

The Ministries of Defence, Internal Affairs, 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 an Armed Forces Hospital and a Medical Centre where a limited range of services is provided.

The Ministry of Internal Affairs 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. Key health problems receiving particular attention are TB, HIV/AIDS and communicable diseases.

The mainstream statutory system is available to all citizens and nearly all permanent residents; therefore, even these specific population groups generally use the mainstream system, involving registration with a family doctor, with standard referrals for the use of outpatient and inpatient secondary care facilities, and pharmaceuticals covered by the state health care budget.

Ministry of Education and Science

This Ministry finances health-related educational facilities and research, as well as health promotion activities.

Occupational health services

Occupational health services in Latvia are undertaken exclusively by employers, and therefore involve only private funding.

Nongovernmental organizations

There are approximately 130 registered health-related NGOs in Latvia, six of which signed collaborative agreements with the Ministry of Health in 2005.

Long-term care

Long-term care falls within the scope of social care in Latvia, which is administratively and financially entirely separate from health services. Long-term care (as is the case with all social care) is the responsibility of the Ministry of Welfare. 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 addition, long-term care is financed partly by private funds.

3.5 Pooling of funds

The NRS is responsible for pooling tax revenue. It distributes the revenue directly to the National Treasury and then to the corresponding agency, including the Ministry of Health. The amount of funds distributed to each Ministry or sector depends on the relevant approved budgets. The Ministry of Health allocates and transfers central budget funds to the SCHIA, which acts as purchaser of services on behalf of the entire Latvian population. The SCHIA in fact distributes the majority of health care funds allocated from the central government health care budget, absorbing approximately 96% of these in 2004.

The remaining share of the health budget remains with the Ministry of Health (approximately 4% in 2005) and is allocated for the purposes listed here.

- Education: financing of educational facilities of clinics where medical education is carried out.
- Monitoring, control and expertise: this includes pharmaceutical surveillance, forensic medicine, health service quality control, environmental health; sanitation monitoring, food safety control, etc.
- Culture programme: this is a relatively small budget assignment for library and museum facilities.
- Health sector management: financing of the structures of the Ministry of Health.

At the time of writing, there are two frameworks of payment arrangements by the SCHIA: the contractual framework, which applies to the majority of the financial flows; and the budgetary framework, involving direct transfers from the SCHIA to the state agencies for national health programmes (for example, HIV/AIDS, drug abuse, TB, mental health). Specifically, approximately 85% of the SCHIA resources are allocated for use in contracts with providers, with the remaining 15% are allocated through national health programmes to the state agencies.

The SCHIA, in its primary capacity as purchaser, is responsible for financial management of services provision through contracting and reimbursement of prescription pharmaceutical. In compliance with government regulations, it acts as the sole general purchaser of the whole range of services covered by government budget resources, including primary, secondary, tertiary and emergency care, as well as reimbursement of pharmaceuticals.

The structure of the SCHIA consists of a Central Office and five territorial branches. The Central Office manages the budget allocation for inpatient (secondary and tertiary) and ambulance emergency services. Territorial branches receive allocations for outpatient services (GPs services, secondary-level

outpatient care and dental care) and prescription pharmaceuticals. The volume of territorial (geographical) allocations is based on the size of the respective populations. Territorial branches are responsible for covering all costs including patient “cross-border” flows.

Both the Central Office of the SCHIA and the territorial branches plan and allocate resources for the purchase of respective services, for the most part on the basis of historical precedent. In addition, the territorial branches allocate resources for cross-border flows; in fact, mainly to the territorial branch of the capital, Riga City, where most of the expensive diagnostic and treatment services are provided.

The volume of the annual health care budget depends on whether a political decision is made by Parliament to amend the law dealing with the state budget; this may occur once or twice per year.

3.6 Purchasing and purchaser–provider relations

Historically, the Latvian health system was based on the principles of the integrated Semashko model of service financing and provision. The health sector was publicly financed and all levels of service provision were planned and centralized. The reforms of the 1990s splitting the purchasing and providing functions aimed to create incentives for more effective management. This was a 2-step process initiated in 1998 and resulting in establishing in 2004 one single central state purchaser agency.

New payment mechanisms were introduced, together with a series of changes from an integrated to a decentralized health sector model, including institutionalizing a purchaser–provider split, changing ownership of provider institutions, and giving greater autonomy to provider institutions to manage their budgets.

Although the purchaser–provider split was intended to proceed further and eventually develop into a social insurance system consisting of autonomous purchasers that would collect insurance contributions and organize services, these reforms never materialized. The main reasons for this included the overall scarcity of financial resources in the health sector, expected administrative difficulties in rearranging the system of public revenue collection, as well as the expected increase in administration costs, all of which prevented reformers from undertaking radical activities.

Following the recent organizational changes, the current model of service provision is based on contracting between the SCHIA (which acts as a principal

governmental agent) and service providers. The SCHIA sets unitary pattern contracts for the main service provision levels and groups. The Central Office of the SCHIA plans and directly negotiates contracts for inpatient services with hospitals and emergency ambulance service providers. Territorial branches are responsible for planning and are responsible for contracting outpatient service provision (GP services, secondary-level outpatient services and dental care) and paying pharmacies for prescriptions made by GPs and specialists.

The terms and conditions of the contracts between the SCHIA and the providers are outlined in the “Regulations of the Cabinet of Ministers on Health Care Organization and Financing” of 2004, which apply to both public and private providers. The SCHIA applies uniform tariffs to the provision of services and these tariffs are approved by the central Government. The duration of the contracts is usually three years, up to a maximum of five years.

The SCHIA is not directly involved in organizing health care services; however, as manager of financial resources it may induce or support the establishment of specific health services within regions, according to population needs.

In the case of GP services, unified contracts may be signed between the SCHIA territorial branches and single GP practices if the GP is self-employed. In this case the board of the Association of General Practitioners participates in preparing the contract terms. Alternatively, if GPs provide services as employees of health centres or outpatient departments of hospitals, the contracts are signed with the administration of the respective provider institution.

Since 2005, providers of secondary care outpatient institutions undertake a selection procedure before signing a contract with the SCHIA. The “Regulations of the Cabinet of Ministers of 2005 on Health Care Organization and Financing” determine that the SCHIA assesses providers according to certain criteria, such as legal status and agreement to comply with approved legislation; accreditation; and financial, technical and management capacity, including personnel availability and qualifications. The procedure is considered as an attempt to engage in selective contracting so as to avoid paying for inappropriate service provision. Moreover, it allows for control of investment in expensive diagnostic equipment, and avoidance of cost escalation for some providers or utilization of outdated medical technologies for others.

In practice, almost all providers willing to sign the contract with the SCHIA 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 with inpatient facilities are based on tariff (price) per bed day, which differs according to the rank of the hospital, such as university, regional multi-profile or local multi-profile. In addition, contracts include fee-for-service payments for operations and diagnostic procedures. For certain conditions, case-based payment is applied. The contracts for outpatient services are negotiated between hospitals and the SCHIA territorial branches (Section 3.7 *Payment mechanisms*).

The contract defines the budget per year and the planned service volume. Providers bear the risk of overprovision of services. However, if the provider exceeds the contract budget by only 5%, this excess is not covered by the SCHIA. If it exceeds by more than 5%, the provider may receive reimbursement at 25% of overproduction costs, if it is possible to justify the excess provision by reference to extraordinary circumstances that the provider could not foresee.

Payments are a mix of prospective and retrospective payments. Preventive programmes and GPs' direct referrals for outpatient care are covered according to utilization levels (retrospectively). Other payments are made on a prospective basis.

Fixed financial limits on income from contracts require providers to comply with the terms of service provision determined in normative documents. Thus, almost all risks in contracts are shifted onto the provider side. In practice, the sole risks faced by providers involve incurring a financial deficit. There are no other consequences for providers if they deviate from a contract.

Competition between providers for contracts is limited. Providers are also not particularly responsive to competing for a larger contract sum that would permit an increase in the volume of patients receiving statutory provision. Usually, there is a certain balance kept between government-financed patients and private patients (paying out of pocket), as providing services to patients on a private basis offers opportunities for higher earnings.

3.7 Payment mechanisms

Paying for health services

Methods of paying for health care services are determined by government regulations. Contracts between the SCHIA and service providers ensure compliance with the system. The main service groups and corresponding payment methods are shown in Table 3.5.

Table 3.5 Payment methods for health services

Family health care services	Capitation, additional fixed payments, fee-for-service payment per specific activity, bonus payments.
Dental services	Fee-for-service payment per activity according to tariff.
Outpatient specialists	Consultant specialty-specific episode tariff, fee-for-service per specific activity, flat rate payments.
Laboratory tests and visual diagnostics	Fee according to a tariff.
Inpatient services	Bed-day tariff plus fee-for-service per specific activity, e.g. operation and examination, case-based payment.
National programmes e.g. TB, HIV/AIDS, infectious diseases	Fixed budgets.

Source: Authors' own compilation.

Outpatient services

In the mid-1990s, outpatient services began to be paid according to a “point system”. Each service was assigned a number of points according to a scale of service intensity. The payment of provider institutions (polyclinics) was determined by the number of points corresponding to the services delivered by doctors and nurses. This payment system proved to encourage costly interventions and provision of a volume of services greater than necessary, and was therefore gradually abandoned.

At the end of the 1990s, a capitation payment scheme was introduced for GPs, who extensively began to change their legal status from employees in polyclinics to self-employed in their own practices, which they either set up individually or rented space within the facilities of polyclinics. Specialist services were still paid according to the list of interventions.

At the time of writing, primary care services payment schemes also include the addition of fees for defined activities and bonus payments. GPs also receive fixed payments, such as a practice allowance, a PHC nurse allowance and some additional payments for the number of chronically ill patients on their list.

Services provided by outpatient specialists receive a flat rate per episode of illness. Every outpatient specialty has had its own specialty-specific episode rate calculated. If specialists perform costly procedures, these are paid for additionally for each episode according to specific tariffs. Patients have to pay a patient fee in addition to the consultant episode payment. Diagnostic services (lab, visual diagnostics) are paid for according to specific tariffs.

Several outpatient specialty services (such as psychiatry, TB, STIs, and diabetes) are paid for by means of a flat rate mechanism, according to a budget which includes salaries for personnel and costs of running the services.

Inpatient services

Payment mechanisms for inpatient services are similar for both secondary and tertiary care. In 1998–2005 hospitals were paid in accordance with the contracts signed with the SCHIA and by direct allocations from the Ministry of Health through specific health programmes (for example, HIV/AIDS, drug abuse, TB, and mental health in specialized central government health institutions). Since 2005, almost all finances pass through the SCHIA based on the contract agreements. However, communicable diseases and TB hospitals are financed directly by the Ministry of Health.

There are similar types of contracts for different providers that contain health sector regulatory documents and uniform service tariffs, define the responsibilities of the contract parties and specify reporting requirements. The contract is valid for a period from three to five years. However, the financial annexes of the contracts between the SCHIA and providers are updated every financial year. The contracts outline the types of services to be provided within a year and specify the annual budget. The provider bears the financial risk of overproduction, but the SCHIA 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. Such changes are possible due to alterations in the overall level of financing; for example, Parliament may approve an increased spending level from the central government budget.

The payment units used to reimburse hospital inpatient services are as follows:

- bed-day tariff calculated according to number of staff, social taxes and maintenance expenses;
- per case for certain inpatient stays;
- additional activity-based payments for operations and diagnostic procedures.

Hospital service payment methods could be distinguished as groupings “G”, “P” and “F” (letters originally in Latvian) and are embedded into contracts with the respective provider (according to Cabinet of Ministers “Regulation on Health Care Organization and Financing” of 2004). These are outlined here (see also Table 3.6).

G – Case-based grouping: the case-based payment method was gradually developed from the end of 1990s. The method is based on assigning a cost of treating a single diagnosis. There is an approved single tariff for all kinds of hospitals, whether university, local, etc. Initially it was applied to 8–9 of the most frequent and standard inpatient diagnoses for hospitalization. The pioneering ones were surgical and gynaecological hospitalizations for appendicitis, hernia,

Table 3.6 Summary of hospital reimbursement

Type of provider and services	Reimbursement
G All hospitals for 93 defined diagnoses	Fixed amount per case with the respective diagnosis
P All hospitals (except 93 diagnoses above)	100% per diem (depending on hospital category) up to defined ALOS, 70% per diem above ALOS
F Multi-profile hospitals for other diagnoses (i.e. not the 93 in G group, not with defined ALOS) plus other hospitals (psychiatry, rehabilitation)	Per diems, calculated per hospital

Source: Authors' own compilation.

Note: ALOS: Average length of stay.

varicose veins, normal vaginal delivery and caesarean section. Data for price calculations came from country averages on bed-days, plus a procedures payment method (see later in this section). In 2006 there were 93 defined hospitalization cases (according to Cabinet of Ministers "Regulation on Health Care Organization and Financing" of 2004).

P – Disease profile grouping: general secondary-level inpatient health conditions and treatments. This payment method is based on assigning an average tariff for a bed-day, which varies according to the rank of the hospital, and a tariff for procedures, if performed. There is a developed tariff list of procedures applicable to inpatient care. The bed-day tariff is paid in full (100%) up to a defined average length(s) of stay (ALOS). ALOS are reviewed from year to year and are predetermined by the averages in the last reviewed year for WHO International Classification of Diseases (ICD) grouping ICD-10 (e.g. the cardiology disease group ALOS = 10 days; the gynaecology disease group ALOS = 4 days, etc.). Extra bed-days are paid for at a rate of 70%.

Hospitals are ranked in three levels:

1. regional multi-profile, including university hospitals;
2. local multi-profile;
3. specialized hospitals and centres.

F – Actual resource consumption grouping: this method is based on a separately calculated bed-day tariff for hospitalizations due to health conditions that do not fit into disease profile groupings for general (secondary-level) acute and planned hospital care in terms of their increased resource consumption, clinical severity (tertiary level) and provision specificity (inpatient psychiatry, rehabilitation). These tariffs are not based on ALOS. This payment method mostly concerns multi-profile hospitals and specialized hospitals and centres.

Usually, a hospital's income consists of G, P and F payment modes according to the inpatient case-mix of the respective hospital. For example,

simple appendicitis requires “Case-based payment” (G), but a prolonged stay in hospital, co-morbidity, or age can transform the episode into a “Bed-day tariff + Activity-based case” (P), and at the worst: severe complications, re-operation, or the need for an intensive therapy ward can lead to “Actual payment” (F). There are only few hospitals that are reimbursed by only one single payment mode. One example for this is mental illness hospitals, since these are reimbursed by payment mode F.

Of the total number of hospitalizations (216 556), case-based payment hospitalizations amounted to 20%, at 42 524 (over the period January–June 2006).

The SCHIA allocates funding to inpatient health facilities through health programmes focusing on control of mental health diseases, drug and substance abuse, TB, HIV/AIDS and some infectious diseases. Payment methods are the same as those used for reimbursement of inpatient services, if contracting with the provider is applicable. As far as the health programmes mentioned above are concerned, exceptions have to be made with regards to “state health care agencies” since these are subordinated to the Ministry of Health and financed through SCHIA and are thus allocated line-item budgets for all the types of services they provide. Therefore, since 2005, 96% of government funding flows through SCHIA.

Paying health care personnel

PHC physicians (family doctors) are predominantly self-employed, and have direct contracts with the SCHIA. The contracts determine PHC provision on the basis of mixed payment systems, which comprise capitation, fixed payments (including salary for PHC nurses), fee-for-service payments and several bonus payments if specific targets are met.

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, subject to a minimum which is determined at state level. 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 taught.

Approximately 10% of secondary-level outpatient service providers are also self-employed practitioners and earn their income from contracts with

the SCHIA, provided family doctors refer registered patients. In cases that patients visit these providers without referral, they are required to pay fee-for-service payments out of pocket. On the basis of contracts, the unit of payment for specialist consultations is the ambulatory illness episode, which may be supplemented with tariff payments if additional medical procedures are performed (such as minor surgery). Ambulatory illness episodes, if necessary, include fee-for-service payments for several follow-up visits to a specialist or nurse. Patient co-payments, if applicable, are to be paid for every visit.

Resource allocation for primary health care

PHC is funded through the SCHIA territorial branches, which plan financial magnitudes for PHC services. In planning, every single PHC practice with registered patients is regarded as a basic resource consumption unit. Government regulations determine all possible resource allocation conditions which apply uniformly to all practices across the country.

PHC practices are mainly funded based on age-adjusted capitation of €0.8 per patient per month. Every month 15% (€0.12) of practices' capitation payment is retained by the SCHIA and paid out as bonuses following evaluation of activity indicators and quality parameters of every PHC practice. Depending on the results of the evaluation undertaken by the SCHIA, half of the sum (for activity indicators) may be paid out monthly and the other half may be paid after a year in accordance with yearly quality indicators.

PHC practices qualify for the monthly bonuses if their activity indicators (appointments per 100 registered patients) fall above the 0.75 minimum of the median calculated monthly for all PHC practices within the region, in which case they receive 50% of the bonus; and if they satisfy PHC practice performance assessment criteria (working hours, patient waiting time, information quality) they receive the remaining 50%.

Yearly quality indicators involve certain numbers of preventive interventions:

- number of registered patients seen during the year
- child health check-ups (ages 0 to 7)
- immunizations and vaccinations
- cancer prevention programmes.

GPs also receive fee-for-service payments for approximately 30 services (for example, strip tests, electrocardiograms (ECG), pregnancy monitoring, small surgical procedures, etc.) and fixed allocations. Among the numerous fixed allocations, the most important are:

- PHC nurse/doctor assistant allowance according to number of registered patients;

- practice allowance;
- indicator scale-dependent allowances for:
 - o number of chronically ill patient visits
 - o density of the population in the catchment area
 - o distance from practice to emergency post
 - o number of children on the register list.

Resource allocation for secondary-level ambulatory care and GP fund holding

According to government regulations, funding for secondary-level ambulatory care is split in two major parts in terms of planning and allocation. The first part is calculated for each GP practice according to the number of registered patients, amounting to €1 per patient per month, which is a form of fund holding. The second part applies to more costly procedures and is allocated directly to ambulatory care providers (e.g. health centres, outpatient departments, polyclinics, specialist consultants) through contract negotiations. These are based on tariffs for specialist consultant episodes and a procedure tariff list.

The target recipients of the GP-controlled funds are secondary-level ambulatory care providers, as mentioned above, to whom patients are directly referred by GPs. The secondary-level ambulatory care providers earn their income according to tariffs of specialist consultant episodes and a procedure tariff list. The tariff list contains predominantly simple and non-costly procedures.

Up to the end of 2006, GPs were allowed to keep 75% of the unused funds, after assessment of the GP practice's operational indicators. This seems to promote inappropriate incentives for GPs with regard to underreferring patients to specialist services (Stuburs 2007 [unpublished data]).

Since 2007, GPs are permitted to keep unused money for secondary care only up to a maximum of 30% of the funds for secondary care (GP-controlled fund). If the quarterly unused portion is equal to or less than 30% of the GP-controlled fund for the quarter, the SCHIA pays out 75% of this remainder to the respective GP. If the quarterly remainder in the fund is above 30%, the SCHIA must make an assessment on whether the low spending on specialist consultations and diagnostic tests is appropriate to the needs of patients. As there is no further detailed methodology within the relevant government regulation regarding what criteria the assessment should include, the SCHIA has considered that GPs' comparative activity indicators (such as the number of self-performed procedures and very high patient appointment rates) can be the indicators for GPs to qualify for the bonus payments from the fund.

Criteria for GP assessment have become the subject of discussions and arguments between the GPs' associations and the SCHIA. The associations strongly object to the criteria used by the SCHIA and propose a reconsideration of the mechanism of a GP-controlled fund.

The objective behind the present arrangement has been to ensure that GP practices increase their responsibilities and service volume provided, and to promote cost-containment by offering GPs the incentive to keep patients at the primary level. On the other hand, these very incentives may hold a risk of not referring patients when it is clinically sensible to do so.

In addition, there is a perceived need to equalize differences in responsibility levels among PHC practices, and the provision of financial incentives would appear to be a mechanism that can help to achieve this objective. Differences persist between GPs in rural and urban areas in terms of the range of services they provide for patients, with GPs in rural areas more often performing small surgical operations, providing pregnancy care and carrying out diagnostic tests, as opposed to referring patients to specialists for these services.

Prior to 2005, different approaches to secondary-level ambulatory care provider payment mechanisms had been adopted by Riga City and the rest of the country. In Riga, GPs were not in charge of any funds targeted for ambulatory service provision, and secondary care providers received their allocations directly from the SCHIA; this was known as the "Riga model". By contrast, in the rest of the country GPs were charged with holding the full capitation fund that was intended for ambulatory service payment, and this fund was proportionately twice as large as it is in the current, nationwide model that has been implemented since 2005; this was known as the "rural model". In the Riga model, GPs faced the incentive to minimize their workload by referring patients to specialists, as they had no control over capitation funds intended for specialists, with the result that there were significant increases in waiting lists for specialists. By contrast, in the rural model, GPs faced the incentive to minimize referrals so as to retain as much as possible of the capitation fund themselves.

The current model, as described above, is a compromise between the Riga and rural models, and is meant to be an improvement on the two previous models, incorporating lessons learned and building on the strengths of each, while at the same time improving the situation for all stakeholders.

- The GP-controlled fund for purchase of secondary-level services is currently about half the size of the former one under the rural model, and relates to far fewer and less expensive secondary care services; therefore, the GP does not face as great an incentive to keep patients at the primary care level.

- If a GP runs into deficit (by referring patients to higher levels services than they have funds for, as used to happen at times in the Riga model), only up to 20% of their guaranteed capitation income will be deducted; therefore, the potential losses of the GP are reduced.
- If a GP does not use more than 30% of the GP-controlled fund intended for secondary care services, s/he can keep only 75% of the remainder; therefore, the incentive to keep patients at the primary care level as much as possible is lessened.
- Patients appear to be more satisfied about referrals to secondary care; under the earlier rural model, there was a serious concern on the part of patients that they were not receiving enough secondary-level services.
- Secondary care providers (specialists) are not as dependent on GPs for referrals as in the (previous) rural model.
- Politicians and health sector administrators can claim that the new system is an improvement for both patients and doctors.

To summarize, the total income of a GP is made up of the components listed here.

- Monthly:
 - o capitation payments of €0.8 per patient per month, including bonuses
 - o fee-for-service payments for specified services and fixed allocations
 - o patient fees.
- Quarterly:
 - o unused funds of the €1 per patient per month fund holding for secondary care referrals (75% of maximum 30% of the GP-controlled fund for secondary care referrals).
- Yearly:
 - o bonus payments by the SCHIA depending on the quality assessment of the GP practice.

An exemplary average monthly projected income of a GP practice (1600–1700 registered patients) for 2007 consists of the following components:

- | | |
|---------------------------------------|-----|
| • age-adjusted capitation: | 38% |
| • nurse/assistant allowance: | 22% |
| • patient fees: | 11% |
| • fee-for-service specified services: | 10% |
| • fixed allocations: | 16% |
| • bonuses, compensations: | 3%. |

4. Regulation and planning

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. The Parliament has adopted several laws that determine relationships and priorities within the health care system. The “Law on Medical Treatment” (1997) is one of the basic documents providing definitions and terminology for the health sector, and it outlines the responsibilities of the central Government and its administrative bodies in terms of setting health policy, and dealing with financing, organization and delivery of health services as well as monitoring and control of the health sector.

The Law on “Medical Treatment” allows a wide variety of ownership patterns for health care providers at both national and subnational levels, as well as in the private sector. All the providers, both public and private, are equally entitled to sign contracts with the SCHIA.

Therefore, regulatory functions (policy, planning, enforcement, monitoring, control) and tools (legislation, financing) are predominantly concentrated in the hands of the central Government and public agencies under its authority. These governmental institutions make their planning and regulatory decisions in close collaboration with numerous public and private institutions, as well as nongovernmental institutions, such as physician professional associations. The Government initiates dialogue through the establishment of advisory boards by state agencies, working groups, and by organizing target group seminars.

4.1 Regulation

The Latvian health care system is still in the process of change and reform in the areas of planning, regulation and management. The initial effort to make a transition from the Semashko integrated model towards a decentralized system based on a purchaser–provider split (in the mid-1990s) was based on a strong belief in the power of market forces to resolve problems associated with the inherited ineffective organizational structure. In fact, market reforms significantly affected health care delivery functions and to some extent service remuneration arrangements. Current service payment mechanisms are uniform throughout the country, with a single central government agency as third-party payer, which applies uniform service tariffs. Provision of services is arranged through a mix of providers, including central and local government agencies and enterprises, private enterprises and self-governed providers, namely PHC doctors, dentists and private practice specialists.

Health policy and health strategies are formulated by the central Government. The Ministry of Health is the leading government institution for planning and regulation of public health, health care and the pharmaceutical sector. Its main responsibilities are linked to developing legislative documents and drafting proposals and recommendations for health policy development. Also, the Ministry of Health is accountable for the implementation of approved health policies and has to create the preconditions for cost-effective health sector management, quality of services and accessibility of services.

In order to carry out health sector objectives and tasks, the Ministry of Health has a number of subordinated administrative agencies and inspectorates, such as the SCHIA, which operates health service financial arrangements and concludes contracts with providers; the HSMTSA, which is responsible for health statistics, accreditation of medical technologies and providers; the Public Health Agency, responsible for epidemic safety and environmental health; the State Health Promotion Agency, responsible for prevention, health promotion and education; the State Medicines Pricing and Reimbursement Agency, responsible for pharmaceutical benefits list development and pricing policy; the State Health Inspectorate, dealing with patient complaints, medical documentation and records; and the State Pharmaceutical Inspectorate, which is responsible for control of pharmaceuticals circulation (for more information on the functions of these agencies see Section 2.3 *Organizational overview*).

The Ministry of Health has responsibility over medical education; the Riga Stradins University, Postgraduate Education and Professional Medical Education Centres, the Medical Library, the Museum of Medicine and many others are subordinated institutions.

In 2001 the central Government approved a Public Health Strategy, which is a public health policy framework indicating targets to be achieved and determining the mechanisms for their achievement. It is regarded as a reference document for strategies that are implemented through specific programmes, such as the National Programmes for HIV/AIDS, TB, and Mental Health, as well as Action Plans, such as the Food and Nutrition Action Plan. It is based on the WHO “Health 21” targets, which have been accepted as the basis for Latvia’s health strategy (Section 6.1 *Public health*).

In 2004 the central Government approved a health sector development plan entitled “Programme of Development of Primary and Hospital Care Services for 2005–2010”. The document concerns public sector ambulatory, hospital and emergency care development, and defines objectives and strategies to ensure accessibility to high-quality health services and efficient use of available resources (for more information see Section 4.2 *Planning and health information management*, Chapter 5 *Physical and human resources* and Section 7.2 *Future developments*).

Regulation and governance of third-party payers

There is one single organization responsible for purchasing (commissioning) health services in Latvia, the SCHIA. The SCHIA was established according to legislation on Public Agencies and on Public Administration, and is directly under the authority of the Department of Budget of the Ministry of Health.

The overall objective of the SCHIA is to enforce approved health policy and strategies by guaranteeing accessibility to health services and administering financial resources (the central government health budget) by contracting service providers. The director of the SCHIA is responsible for enforcement of a 5-year Action Plan, which involves assessment of current activities, main directions of planned activities and evaluation of the results. The director of the SCHIA and the Minister of Health sign a “Contract of Administration and Management”, according to which the responsibilities of the SCHIA are:

- planning of the rational volumes of health services in accordance with the available financial resources, priorities and capacities of the 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 Ministry of Health assigns to the SCHIA the duties of monitoring and reporting on the processes and results of policy implementation.

The process of structuring the SCHIA came to an end in January 2005, when the last two remaining regional sickness funds were joined with the SCHIA, following a process of centralization of a total of 35 third-party payers (sickness funds that had started in 1998). At that time, local governments were forced by legislation to merge small-scale inefficient service purchasers into eight regional funds covering population of at least 300 000. Yet, even this centralization process was deemed insufficient to deal with problems of inefficiency and service accessibility, leading to further centralization in the period 2003–2005, consisting of the merger of the eight regional sickness fund into the SCHIA.

Following the reform, the structure of the SCHIA consists of a Central Office and five territorial branches. The territorial branches are subordinated units responsible for contracting with primary care practitioners (GPs) and secondary-level outpatient service providers. In addition, the territorial branches are responsible for expenditure on the government-approved pharmaceutical benefits list. The Central Office directly contracts all hospitals for inpatient services and ambulance emergency services.

The main normative document that regulates processes in health service delivery is a central government “Regulation on Organization and Financing of Health Care” (2004), with amendments in 2005. The document determines almost all aspects of health care provision and financial arrangements of service payments, including service definitions and tariffs.

In spite of what its name suggests, the SCHIA is not a social insurance organization financed by payroll taxes. It distributes the central health budget to providers on the basis of contractual agreements (for more information see Section 3.5 *Pooling of funds* and Section 3.6 *Purchasing and purchaser-provider relations*).

Purchasing plans, for the most part, do not reflect public health priorities, as they are carried out mostly on the basis of historical allocations. Budget allocations are based on existing infrastructure, and mainly reflect the need for investments in medical technologies and changing organizational structures. However, some effort is made to allocate resources based on national priorities, and targeted financial allocations are channelled to reduce waiting lists as well as to set up specific programmes for children, cancer patients or those with circulatory diseases.

VHI is offered in Latvia by five companies, only one of which (a quasi-public organization belonging to Riga City, soon to be privatized) provides coverage for physical persons, the other four being private companies that provide only group insurance coverage to employer organizations insuring their employees. Each insurance company is free to define its own insurance schemes without

any external regulation of prices and benefits packages. VHI is regulated by the Financial and Capital Market Commission.

Regulation and governance of providers

According to legislation enacted in the early 1990s, ownership of health service institutions may be public, at the levels of both the central and local governments, as well as private, including individual physician practices, all of which are equally entitled to sign contracts with the SCHIA for services provision. Health services included in the statutory system are provided by health institutions that have a contractual agreement with the SCHIA, regardless of type of ownership, and typically include both independent (private) providers, who predominate at the primary care as well as secondary ambulatory care levels, and public providers, who predominate at the secondary, inpatient care level (tertiary care is wholly publicly provided). In addition, a smaller portion of health services is provided by government “agencies” that do not contract with the SCHIA.

The period of time since independence has seen broad changes in legal forms of institutions that have resulted in a complex web of providers with different legal statuses. Very broadly, a distinction can be made between the three types of provider institutions, listed here.

- Clearly public sector-owned and -regulated provider institutions, which are mainly at the central level, but may also be at the local (district/municipal) level; these include state health agencies and centres (for example, the State Agency for Mental Health, State Agency for Tuberculosis and Lung Diseases, State Agency for Infectious Diseases, and many others – for a more comprehensive list of central-level agencies see Table 2.1 in Section 2.2 *Historical background*). Until recently (2004), these institutions were financed through direct budgetary transfers, but now are financed through the SCHIA, as well as through patient fees if applicable. Regulation of these institutions is the responsibility of the Ministry of Health.
- Public sector-owned provider institutions with autonomous management, at both central and local levels; these are limited or stock companies, with the Ministry of Health as shareholder at the central level and local governments as shareholders at the local level (the Ministry of Health and local governments are actually the exclusive shareholders at the central and local levels, respectively) (see Table 2.1 in Section 2.2 *Historical background* for a partial list of these.) These health care delivery institutions have a significant degree of financial and managerial autonomy; they tend to operate mainly according to commercial principles, and have considerable

decision-making freedom. Their services are provided not only through contracts with the SCHIA (this accounts for the bulk of services), but also through private services provision and contracting with private (voluntary) insurance companies. Their management is composed of a hospital board and an executive board. There is some political representation in the boards, through assigned delegates from the central and local governments.

- Clearly privately owned and regulated institutions; these may form contracts with the SCHIA. According to private sector rules, hospital management may be organized by establishing a hospital board and executive board, or executive board only.

In contrast to the above, most PHC providers (for the most part GPs), and some secondary care providers (i.e. specialists who do not work in hospitals or who have private practices parallel with their work in hospitals) work as self-employed individuals or as private sector agents (the distinction between the two refers to legal and tax status according to Latvian legislation). In both cases, the practitioners run practices that are legally considered as profit-making entities, and are governed by private sector principles and regulations. In order to provide health care services under the statutory system, these providers must have contracts with the SCHIA. For more information on the various legal institution forms, see Section 6.3 *Primary ambulatory care* and Section 6.4 *Specialized ambulatory care/inpatient care*.

All health service providers, regardless of the type and legal status, must be licensed according to government-approved obligatory requirements for health care institutions.

Article 55 of the 1997 Law on “Medical Treatment” specifies that health services can be provided only by health care institutions that comply with specific compulsory requirements. These requirements apply to both public and private institutions, and have most recently been defined by the Cabinet of Ministers in the form of “Regulations on Compulsory Demands for Health Care Institutions and their Structural Units”, in force since February 2002.

The Department of Conformity Assessment of the HSMTSA deals with certification of all types of health care institutions.

On-site assessment of health care institutions is concerned with the following issues: conformity to the general requirements in accordance with the Regulations of the Cabinet of Ministers; the rooms that are designated for specific functions; the minimum equipment necessary for diagnostics, treatment and patient care; the minimum medical equipment necessary for urgent medical care; educational attainment and qualifications of health care personnel, etc. More information on certification of health care organizations is provided in Section 4.1 *Regulation*, Subsection *Regulation and governance*

of providers. The assessment of large medical technologies is described in Section 4.2 *Planning and health information management*, Subsection *Health technology assessment*.

Quality control

The mechanisms in place to ensure and monitor quality of care provided tend to be rather limited. Some quality control issues are included in contracts with the SCHIA. The contract determines that the SCHIA is entitled to audit services provision and refuse payments if services are either not fully provided or provided with inappropriate medical technologies. In addition, the SCHIA is entitled to impose penalties for inappropriate service provision or misreporting. However, in practice such measures are rarely, if ever, applied and providers are in effect guaranteed payments and penalty-free contracts.

Bonuses to GPs are paid by the SCHIA based on implementation of activity indicators and quality parameters of GP practices. For more information, see Section 3.7 *Payment mechanisms*, Subsection *Paying health care personnel*.

Patients are entitled to make complaints to the State Health Inspectorate (subordinated to the Ministry of Health), which is the sole organization in Latvia handling patient complaints. However, there are indications that this is an area that requires further attention to ensure effectiveness (Section 2.4 *Decentralization and centralization*, Subsection *Complaint procedures*).

Certification of health care organizations

According to the Law on “Medical Treatment” (1997), only those health care institutions that conform to mandatory requirements for health care organizations may provide health care services. This applies to both public and private sector institutions and private practices. These requirements are developed by health professionals and approved by the Cabinet of Ministers. Mandatory certification has been provided in Latvia since 1998.

Arguments about the relative superiority of structure, process or outcome criteria for the assessment of health care organizations were resolved in favour of structure measures as a first step in the evaluation of health care services. This decision was influenced by the significant organizational changes in the health system that occurred following the initiation of health sector reforms upon restoration of Latvian independence. It was decided to ensure, in the first instance, minimal standards for each health care organization that will protect the safety of patients.

Mandatory requirements for health care organizations were developed with the involvement of broad spectrum of stakeholders, including policy-

makers, health care managers, service providers' organizations, health care professionals and experts in different fields of health care. The mandatory requirements focus mainly on structural criteria, such as premises, devices, equipment and personnel. In fact, certification by use of these criteria is more closely related to licensing. Some key elements of quality control standards were also incorporated (division of responsibilities and description of the main processes, such as infection control, medication, emergency care and internal quality control).

Conformity assessment (certification) of health care organizations is the responsibility of the HSMTSA. The conformity assessment process includes assessment of the health care organization's documents and on-site assessment. Each health care organization is assessed by a team composed of the HSMTSA's six quality system auditors and approximately 120 external experts. The external experts are health professionals who have been recommended by their respective professional associations and trained in assessment procedures by the HSMTSA. Each health care organization has to undergo the certification process once every five years. For the larger health care providers (hospitals and outpatient departments), surveillance assessments are undertaken 1–3 times per 5-year period between certifications in order to ensure that they still meet with the requirements.

Since 1998, when mandatory certification was introduced, there has been significant improvement in organizational structure and the medical technologies used by health care providers. In 2005, 100% of blood suppliers, 100% of multi-profile hospitals, 100% of acute care hospitals, 90% of long-term care hospitals, 89% of PHC units and 90% of medical rehabilitation organizations were certified. All of these institutions meet with the mandatory requirements and offer the technical potential to provide quality health care.

The Radiation Safety Centre is a government authority charged with the task of protecting people and the environment from the harmful effects of radiation. The legal background for the activities of this Centre and radiation and nuclear safety in Latvia is the Law on "Radiation Safety and Nuclear Safety", and a set of Regulations issued by the Cabinet of Ministers. The Radiation Safety Centre drafts regulations and verifies their implementation through inspections to ensure that these are being complied with. One of the Radiation Safety Centre's tasks is licensing of practices with radiation sources, including medical radiology. All health care institutions operating medical radiology equipment, including hospitals, outpatient departments and institutions practising dentistry must have an appropriate licence.

In connection with safety control, additional agencies involved are the State Sanitary Inspectorate that controls epidemic safety requirements and

environmental hazards. In addition, the State Fire Inspectorate controls how institutions comply with requirements to prevent fire hazards.

All health care organizations must be certified in order to qualify for contracts with the SCHIA for provision of health care services under the statutory system.

There is a continuous process of development of mandatory requirements for health care organizations. New requirements for blood services were approved in 2005 in accordance with EC Directives regarding standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components. New mandatory requirements for health care institutions, including diagnostic facilities and medical laboratories are being developed.

The Law on “Medical Treatment” (1997) also determines the process of voluntary certification (accreditation) by use of national and international quality system standards for assessment of health care institutions. The national standards are still a subject of discussion among government policy-makers, health care managers and health care professionals. At the time of writing, one hospital has certified its quality system in accordance with ISO 9001:2000.

There is a general tendency to use more clinical practice guidelines, which are usually developed by different associations of health care professionals. Although some of these are produced on the basis of international guidelines, as a result of revisions and adaptations to the local context there are some doubts regarding their resulting quality. There is no formal responsibility for the development of guidelines; therefore there is no common methodology or formal mechanism for developing, approving and implementing quality assessment guidelines. Moreover, whereas there is increasing interest among health care managers and clinicians in the development of a system of health care quality assessment by use of appropriate outcome indicators, the majority of statistical data reflects productivity issues rather than problems related to quality of care.

The body mainly responsible for overseeing quality of care issues is the Quality Control Inspectorate for Expert Examination in Health Care and Ability to Work, under the Ministry of Health. This agency has the right to apply appropriate penalties to health care providers, including those that operate without certification. In practice, very few non-certified institutions are penalized.

There are ongoing discussions about establishing new standards for accreditation of health care organizations. There is general agreement that the standards should include most of the quality system elements, clinical processes measurement and also outcome measurement. The goal is to create a more

continuous, data-driven, comprehensive certification (accreditation) process, which not only evaluates a health care organization's methods of compliance with standards, but the outcomes of these methods as well.

Certification of health care personnel

According to the Law on "Medical Treatment" (1997), health care personnel have the right to provide health care services independently only upon certification and registration in the registry of health care personnel. A diploma in medical education confers the right to practice under the supervision of a certified person. To claim a certificate, a health care practitioner must have postgraduate education conferring a specialization, or improvement of professional skills.

Certification of health care personnel is assigned to nongovernmental professional organizations. Certification of doctors and dentists is provided by the Latvian Physicians Association and the Latvian Confederation of Professional Organizations of Health Care Personnel. Certification of nurses and allied specialists is provided by the Latvian Association of Nurses.

The Ministry of Welfare (prior to the break-up in 2002 that resulted in the establishment of the Ministry of Health and the Ministry of Welfare as separate entities) approved a set of unified rules for certification of all health care practitioners on the "Certification of Medical Practice" (1997). The Ministry of Health approves certification rules according to specialty, subspecialty, or subsidiary specialty.

Certification bodies determine examination programmes and establish certification examination committees for each specialty, subspecialty, or subsidiary specialty.

Every health care practitioner wishing to be certified must submit documents on postgraduate education completed or evidence of improvement of professional skills, and a statement of work according to a given job description. After passing an examination, the health care practitioner receives a certificate that gives her/him the right to practise independently.

For re-certification, which involves receiving a certificate without examination, a certified practitioner must receive additional continuous education and improve professional skills according to her/his job description over a 5-year period. If the work statement provided by the health professional fulfils requirements in accordance with the specialty, the person is re-certified for an additional 5-year period.

Similar regulations are in place for pharmacists. According to the "Law on Pharmaceutical Activities" (1998), with numerous amendments in subsequent years (the most recent being in 2005), the Cabinet of Ministers approves

regulations for certification of pharmacists' professional competence. The certification body for pharmacists is the Latvian Society of Pharmacists.

Regulation and governance of the purchasing process

The SCHIA consists of a Central Office and five territorial branches. The Central Office manages the budget allocation for inpatient and ambulance emergency services, and concludes contracts with the respective providers, while the territorial branches manage allocations for outpatient care (PHC, specialist outpatient and dental care), concluding contracts for these services, and are also responsible for reimbursements of prescription pharmaceuticals. The volume of geographical allocations is based on the size of the respective population. Territorial branches are responsible for covering all patient "cross-border" flows.

The funding of providers by the SCHIA is based on historical allocations. The proportions of the health care budget are approximately 61% for inpatient services, 32% for outpatient services and 6.5% for ambulance emergency care.

The contract structure defined by the Government is uniform and does not distinguish according to the diversity of providers; it applies equally to contracts between the individual payer, the SCHIA, and all service providers, irrespective of their ownership (public or private, central or local government) and entrepreneurial status (stock company, limited company, public non-profit-making organization, etc.). The main part of the contract includes health sector regulatory documents, stipulates uniform service tariffs, defines the responsibilities of the parties to the contract, and specifies the terms of reference of reporting and control mechanisms.

Differences in contracts for specific providers arise in connection with the kinds of services and treatments that will be provided and how much the SCHIA can afford to pay in the course of one year. These terms and conditions are included in the annexes of each contract, and are updated every year. The result of bargaining between the SCHIA and the provider side is an agreement on the total contract sum per year. The contracts define the annual maximum budget that can be received from the SCHIA. Furthermore, the planned quantity of services is also defined in the contract.

The financial risk of overprovision of services remains with the payer. If the provider exceeds the contract sum by 5%, this excess will be fully covered by the SCHIA. If, however, it exceeds it by more than 5%, the provider may be reimbursed at a 25% level, if it is possible to justify the excess provision by referring to extraordinary circumstances that could not be foreseen.

A uniform information system facilitates financial monitoring of the providers' activity levels and the sum agreed by the contract may be reviewed (increased/decreased) within certain limits in the course of the year. This could happen during a year in accordance with possible changes in the overall level of financing; for example, the Parliament may approve an increased spending level from the central government budget. The contract is valid for a period of up to five years.

Since 2005, providers of secondary-level outpatient service institutions must pass a selection procedure to acquire the right to have a contract with the SCHIA. The "Regulations of the Cabinet of Ministers of 2005 on Health Care Organization and Financing" determine that the SCHIA is to organize a commission that assesses the applicants according to certain criteria, such as legal capability and agreement to comply with approved legal norms, accreditation, financial and technical abilities regarding service provision, staffing, development plans, etc. The procedure may be considered as an attempt to engage in selective contracting, the objective being to avoid paying for inappropriate service provision patterns as well as to establish a framework for entering the outpatient service provision field, which may be regarded as fragmentized with many small-scale players on the ground. Another concern is the growth in uncontrolled investments in expensive diagnostic tools, which leads to cost escalation, as well as the use of outdated medical technologies. While in principle providers who do pass the selection procedure do not get a contract, in practice almost all providers pass. Although the selection procedure aims to counteract the unwanted developments noted above, and to impact positively on service quality improvement and cost-efficiency, these objectives are not adequately met. There is a need to improve the legal basis of the selection process, and to establish selection criteria that favour cost-efficient and patient-oriented providers.

Competition between providers is therefore limited. Providers are also not particularly responsive to competing for a larger contract sum that would offer them an increase in patient numbers receiving statutory services. Most providers try to maintain a balance between government-financed and privately financed patients, as the latter are more lucrative.

For more information, see Section 3.6 *Purchasing and purchaser-provider relations*.

4.2 Planning and health information management

The tasks of planning and management of health care services and health care resources in Latvia are the responsibility of the SCHIA, as well as the HSM TSA, which collects and analyses statistical health data and is involved in health infrastructure planning.

Until 2010 the basis for planning of health care services and health care resources is the so-called “Master Plan”, or “Programme of Development of Primary and Hospital Care Services for 2005–2010”, accepted by the Government as Regulations of the Cabinet of Ministers (2004). This programme was originally conceived as part of a long-term restructuring strategy of a World Bank-financed health care reform project in Latvia. However, for political reasons, implementation of the Master Plan proceeded without World Bank financing.⁵ The Master Plan was developed by the Ministry of Health in cooperation with representatives from professional medical associations, the Municipalities Union, and the Centre of Planning for Territorial Development, as well as with specialists and experts working in this field. The basis for this initiative was worked out by a private firm, BKG Business Consulting Group, Ltd., whose plan was accepted by the Government as “Regulations of the Cabinet of Ministers on the Order of Elaboration and Implementation of the Structural Plan for Outpatient and Inpatient Health Care Service Providers” in 2003.

The purpose of the Master Plan is to restructure health care services provision with a view to rationalizing physical and human resource use. In constructing the plan, the following factors were taken into account: the range and amount of existing health care services, the structure of health care providers, the resources of qualified medical staff, and the social infrastructure available for use in the health care system.

Certain targets were used in the process of planning the structure of health care providers, as listed here.

- Primary urgent care: in the cities, in 75% of cases, assistance must be provided within 15 minutes, and in other areas within 25 minutes.
- Secondary urgent care: to be provided in no longer than three hours.
- Ambulatory care: there can be a maximum of 1800 patients for each PHC doctor and that doctor must provide planned health care services in no longer than three days;

⁵ Implementation of the Master Plan was to form Phase II of a major health care reform project undertaken by the World Bank in Latvia. Whereas Phase I was completed with World Bank financing over the period 1999–2004, Phase II of the World Bank project was abandoned, and instead the Latvian Government proceeded on its own. For more information on Phase I of the project, see Section 7.1 *Analysis of recent reforms*.

- Hospital medical care: the distance between the patient's place of residence and the multi-profile urgent medical care hospital must not be more than 70 km (in terms of road distance) and the time spent to reach the hospital must not be more than 60 minutes. One multi-profile urgent medical care hospital must provide services to not less than 100 000 people and one local hospital must provide services to not less than 25 000 people.

Regulations by the Cabinet of Ministers also defined the roles of the SCHIA and the HSMTSA in the implementation of the Master Plan. In particular, the objectives for the SCHIA are:

- to purchase health care services in conformity with the provision structure stipulated by the Master Plan;
- to provide the Ministry of Health with proposals about the exclusion from contracts of those health service institutions by which the contractual agreements are not fulfilled;
- to make efficient use of state budget resources allocated for the implementation of this plan.

The objectives for the HSMTSA are:

- to evaluate the conformity of health service institutions with the compulsory requirements of the Cabinet of Ministers and to make proposals regarding necessary amendments to these requirements;
- to supervise the implementation of the Master Plan;
- to evaluate the types of state-paid health care services and to work out the purchase programme;
- to make recommendations to the Ministry of Health on amendments to the Master Plan.

The implementation of the Master Plan is monitored by the Department of Health Care Analysis and Development of the HSMTSA. The HSMTSA prepares annual reports for the Ministry of Health containing information regarding changes in the structure of service providers, and the purchasing programme of the health care services for the next year is established. The HSMTSA monitors the geographical distribution of beds, the development of family doctors' practices, and the development of the geographical distribution of emergency stations and units.

The conceptualization of the Master Plan envisages local-level participation in the planning process. According to regional health development plans, local governments plan the number of doctors' practices and their distribution, as well as the number of hospitals, the profile of beds within the hospitals and their respective numbers, as well as the number of urgent medical assistance and rehabilitation service providers and their distribution.

The implementation of the Master Plan is closely connected with the administrative territorial reform (see Section 2.3 *Decentralization and centralization* for background information). The objective of this reform (based on the “Law on the Administrative Territorial Reform”, in force since October 1998) is to support the development of administrative capacity of government units at the local level, which can provide their inhabitants with quality services in education, social services and health care services. The Law defines the process by which the reform will merge existing territorial units and also specifies the administrative units that will emerge as a result of the reform.

The goal of the Master Plan is to ensure that the distribution of health care institutions is consistent with the capabilities of the new territorial units being established, with respect to transport infrastructure, location and accessibility of health care services, and provision of other services.

The Master Plan has two main directions: maximum concentration of inpatient services, which means the establishment of large centres, which are to be provided with modern technologies; and decentralization of ambulatory and urgent medical care following the principle of being as close to the patient as possible.

The process of merging hospitals has already begun. Although some heads of health service institutions and local government leaders have objections, this merger process appears to have been successful. Small rural hospitals do not have modern medical equipment and in most cases they are unable to provide quality health care services. These institutions are going to be turned into health centres, long-term care institutions and centres of palliative care. Since the beginning of implementation of the Master Plan, eight hospital mergers have taken place (one each in Jelgava, Daugavpils, Liepaja, Valmiera, Jekabpils and three in Riga); five unprofitable inpatient institutions have been closed down; and five health and social care centres have been reorganized in the ambulatory sector. As a result, indicators of bed numbers and use have changed (Section 5.1 *Physical resources* and Section 6.4 *Specialized ambulatory care/inpatient care*).

It is worth noting that prior to the introduction of the Master Plan, there did not exist any type of physical or human resource planning in the health sector in Latvia.

Health technology assessment

The legal basis for the assessment and approval of medical technologies is provided by the “Law on Medical Treatment” (1997), which states that the head of the health care institution is responsible for the use of medical technologies

that have been approved by Regulations of the Cabinet of Ministers. This Law also specifies that “medical practitioners are responsible for the use and possible consequences of the chosen medical technology”.

In accordance with the abovementioned Law, “Regulations of the Cabinet of Ministers on the Approval of Medical Technologies that are Used in the Treatment Process and the Implementation of New Technologies” (2005) determine that the HSMTSA has the right to assess and approve medical technologies.

In order to utilize a new medical technology, a health institution is required to provide a package of documents including a description of the implementation methods of the new technology; a summary of the results of published clinical research documenting the efficiency of the technology; a justification of the use of resources to purchase it; the qualifications of the medical practitioners who will use the technology; a technical description of it; a description of the space within the treatment institution where the new technology will be used or installed; and the costs of the new technology.

The HSMTSA assesses the medical technology by taking into account aspects of safety (risks and potential side-effects of the technology), impact, 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. The Agency collects information based on a study of the medical literature, clinical guidelines and research data about the assessment of medical technologies (from Latvian and international databases). The assessment data are summarized and categorized depending on the strength of the evidence regarding the technology’s desirable characteristics (convincing evidence, average evidence, limited evidence, or lack of sufficient evidence).

After collecting all the data, the Department of Medical Technologies prepares a summary report on the assessment information relating to the technology and hands it to the Commission of Evaluation of Medical Technologies. This Commission consists of members of the HSMTSA, the SCHIA and the State Agency of Medicines.

The Commission examines this report and conveys its conclusion to the Director of the HSMTSA. The conclusion contains an approval or refusal to approve the medical technology. If a technology is approved, it becomes available to all participants in the health care services sector.

By the end of 2005, there were 4350 approved medical technologies, including 1673 technologies for laboratory examinations, 183 technologies for diagnostics and therapeutic radiology, 98 technologies for urology, 202 technologies for dentistry, etc. On average, approximately 20–30 new medical

technologies are approved each year. The assessment of pharmaceuticals is the competency of State Agency of Medicines, and for this the procedure differs.

The heads of health institutions are financially interested in the use of only approved technologies, because this is a factor that must be taken into consideration in the conclusion of contracts with the SCHIA. Any health care institution can only receive state budget resources for health care services provision when the two main conditions of the cooperation agreement are fulfilled: the treatment institution must be assessed in accordance with compulsory requirements (Section 4.1 *Regulation*, Subsection *Regulation and governance of providers*); and it must use only approved medical technologies. If the requirements are not met, the health care institution will receive income only from commercial activities in the health sector (direct payments), as it will be unable to secure contracts with the SCHIA.

All technologies are subject to assessment by means of the above procedures, with the exception of technologies that were in use during the Soviet period, in which case the assessment requirements are not so strict. In such cases, for example, there are no requirements for a literature review and description of the method of use by the user.

Information systems

The legal basis for the collection of statistical data in Latvia is formed by the laws listed here.

- “Law on National Statistics” (adopted by Parliament in 1997 with most recent amendments in 2006), which defines the institutions responsible for the country’s statistics, and the rights and duties of the legal and physical persons in this area. This Law also defines the rights and duties of the Central Statistics Bureau, which is the leading institution in the field of statistics.
- “Law on Civil Registration Records” (adopted by Parliament in 2005), which deals with legal registration of civil records (marriages, births and deaths).
- “Regulations of the Cabinet of Ministers on the National Programme of Statistical Information” (adopted in 2006), which determine responsibilities for the preparation of statistical information, and inform the users of data about the terms and types of data, and how it is possible to receive specific statistical information.

The HSMTSA is the institution responsible for collecting health-related data in Latvia. The Agency’s Health Statistics Department carries out collection, processing and analysis of statistical data and information about public health and health care, and ensures the fulfilment of international obligations in the

field of health-related statistical information. Further, the HSMTSA is charged with developing and maintaining the registers of medical professionals, health care institutions, medical devices and medical goods, as well as registers of patients.

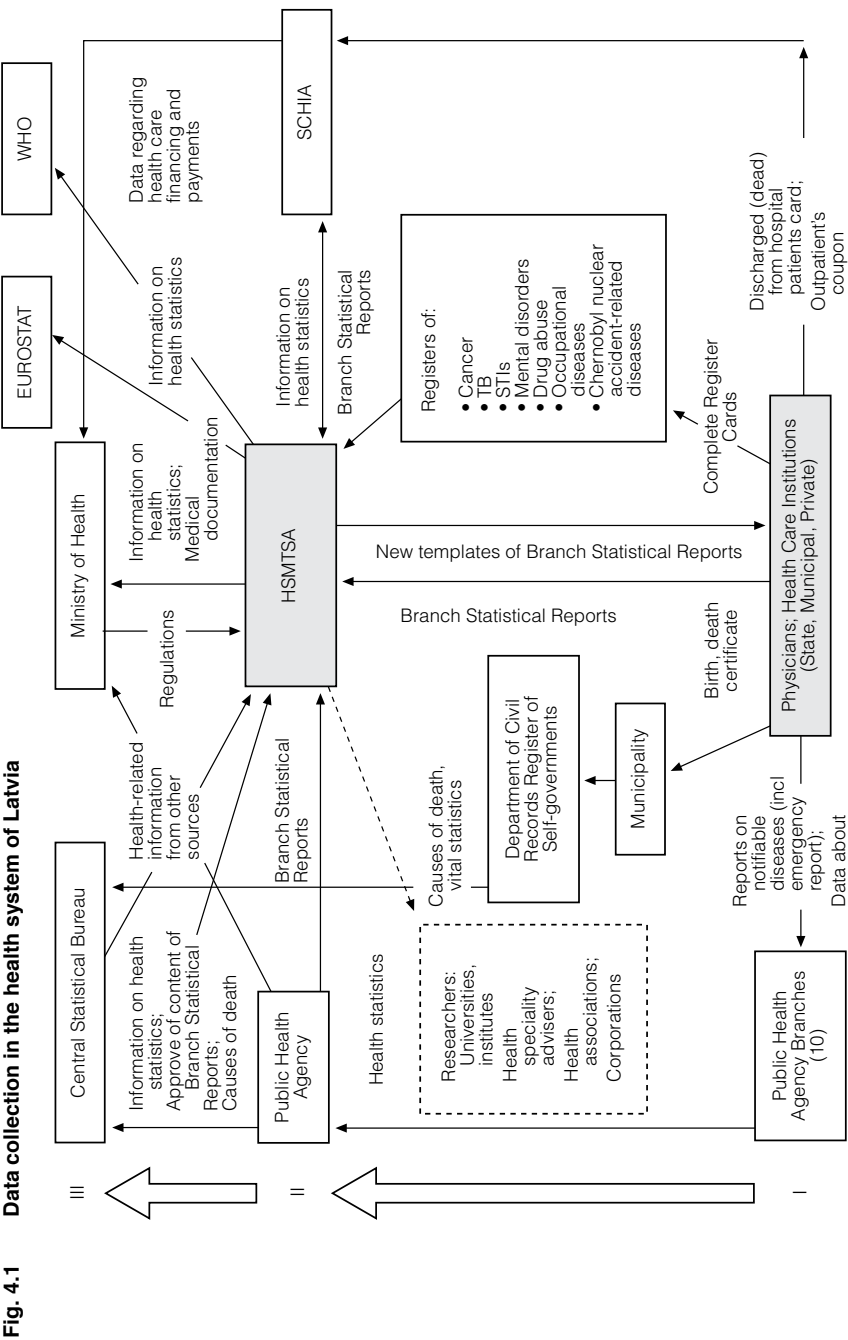
To ensure that these functions (among others) are carried out effectively, the HSMTSA has the following responsibilities:

- it analyses and forecasts on trends regarding the basic indicators of population health;
- it collects and analyses statistical data on health status and provides the users of data with information concerning state programmes;
- it receives statistical reports from health care institutions, checks them and enters them into its database;
- it prepares a summary and analysis of these reports;
- it provides health care institutions with statistical report forms (uniform forms distributed to all health care institutions (public and private) in order to ensure the collection of comparable information).

Information collected through the statistical reports consists of aggregated data, and does not include personal data, which are included in different registers, such as civil registration records, hospital discharge cards and other documents used in medical accounting. All these accounting documents are legally binding for all medical professionals who work in any type of health care institution, regardless of the type of institution (public or private). This improves the quality of data received and also ensures the use of uniform classifications.

The SCHIA only collects statistical data from the institutions with which it has agreements, including data about discharged patients, procedures that were performed, ambulatory care provided, etc. These data are used as the basis for the payment of health care services. This statistical information is not ordinarily given to the HSMTSA, and is provided either as part of a standard report or upon request.

The Public Health Agency (under the Ministry of Health) collects data that concern infectious diseases, as well as data about vaccinations and environmental health. Information on infectious diseases is collected from health care institutions by the Public Health Agency's branches, which aggregate it and supply it to the Agency's Central Office. Information regarding infectious diseases is collected through reports on diseases immediately after such a disease has been diagnosed. Information regarding vaccinations is reported monthly to the branches of the Public Health Agency, which once again aggregate it and supply it to the Central Office.



Source: Authors' own compilation.
Notes: WHO: World Health Organization; HSMSTA: Health Statistics And Medical Technology State Agency; SCHIA: State Compulsory Health Insurance Agency; TB: Tuberculosis; STI: Sexually transmitted infection.

Figure 4.1 explains the system of data collection in Latvia.

There are three main channels of information:

- the HSMTSA, responsible for collection of health statistics;
- the SCHIA, responsible for collection of statistics relating to health care financing and payments;
- the Public Health Agency, responsible for notifiable diseases and general epidemiological information.

As the supervising institution, the Ministry of Health receives all information from each agency. Besides information flows to the Ministry of Health, the HSMTSA has direct collaborative arrangements with the Central Statistical Bureau of Latvia, WHO and Eurostat.

Information flows take the form described here. In the case of aggregated data, information flows from physicians and health care institutions towards the HSMTSA; the branches of the Public Health Agency; and then towards the Agency's Central Office.

In the case of individual data (involving financing and payments), information flows from physicians and health care institutions towards the SCHIA.

In the case of notifiable diseases, involving both individual and aggregated data, information flows from physicians and health care institutions towards the branches of the Public Health Agency and then towards the Agency's Central Office.

Statistical data are used for the development of analytical materials and various publications. The HSMTSA publishes six to seven different publications per year, including a *Yearbook of health care statistics in Latvia*, *Statistical overview on health and health care*, *Public health analysis in Latvia*, *Medical aspects of death*, *Maternal and infant health care*, and *Health in the Baltic countries*. Every second year there is a publication entitled *Health statistics indicators (definitions, formulas and data sources)*, which constitutes important educational material for statisticians.

A number of publications are distributed to the largest health care institutions free of charge, as well as to libraries and reading rooms throughout the country. In addition, a wide range of materials can be found at the homepages of some of the agencies and that of the Central Statistical Bureau.

In accordance with Regulations of the Cabinet of Ministers, there is a fixed price for each publication. It is also possible to receive statistical information that is not published or available at the homepages by written request and payment to the appropriate agency.

The Ministry of Health uses data on health statistics for the purposes of health care management. Information that is available at homepages and in publications can be used by medical practitioners and patients as well as by NGOs.

Information regarding health status and health outcomes can be obtained from diseases registers. There are seven statistical reports with aggregated data that are based on information provided in registers (individual data).

All registers listed here are located in specialized centres. However, as of April 2006 all these registers were merged into a single Patients' Register within the HSMTSA.

- Latvian Oncology Centre of Riga Austrumu Hospital submits Statistical Report No. 7 "Report about incidence and prevalence of malignant neoplasms".
- State Agency of Tuberculosis and Lung Diseases submits Statistical Report No. 8 "Report about incidence of all types of active tuberculosis and tubercular patients".
- Sexually Transmitted and Skin Disease State Agency submits Statistical Report No. 9 "Report about incidence and prevalence of sexually transmitted diseases, skin-fungal contagious diseases and scabies".
- State Agency of Mental Health submits Statistical Report No. 10 "Report about incidence of psychiatric diseases and contingent of mentally ill".
- State Narcology Centre submits Statistical Report No. 11 "Report about psychical and behavioural disorders due to usage of psychoactive substances";
- Vocational and Radiation Medical Centre of Riga Stradins Clinical University Hospital submits Statistical Report No. 15 "Report about registered professional diseases and medical care of victims of Chernobyl's nuclear power station crash";
- Children's Hearing Centre of Latvia submits Statistical Report No. 51 "Report about activities of Children's Hearing Centre of Latvia".

In addition to the above, there exist four more registers that collect information on health status, but do not submit a statistical report:

- Patients' Register of Diabetes Mellitus, Register in the HSMTSA;
- Injury and Trauma Register, Register in the HSMTSA;
- Register of Congenital Anomalies, Register in the Children's Clinical University Hospital;
- Register of Multiple Sclerosis Patients, Register in the Latvia Sea Medical Centre.

Research and development

The main funding sources for research in health and health care in Latvia include:

- EU funds;
- private grants (market-oriented studies);
- applied research projects funded by ministries (Ministry of Health, Ministry of Welfare, Ministry of Education and Science);
- grants of the Latvian Science Council;
- international collaboration;
- grants for doctoral (PHD) studies.

In 2006 the Latvian Government and Parliament (*Saeima*) accepted the “National Development Plan for the years 2007–2013”. This document states that education, research and development will become key national priorities in coming years. Up to the time of writing, research has not been a priority in Latvia; in 2005 total spending on research in all areas constituted 0.56% of GDP (Central Statistical Bureau of Latvia 2007). This is reflected in resources allocated to research in the area of health as well. In 2006 the Latvian Science Council, which is the main governmental organization for research funding, allocated approximately €480 000 for health research. These funds were distributed in the form of specific research grants mainly in the field of biomedical studies.⁶ Current official priorities are:

- gene technologies and technologies of synthesis of new bioactive substances;
- development of clinical medicine based on technologies of applied sciences.

Research projects related to Latvian health care services, delivery and organization are generally financed by resources of the Ministry of Health. Some applied research is undertaken by the HSMTSA, either upon request of the Ministry of Health, or the HSMTSA's employees for their Master's or Doctoral studies. Research topics involve issues of current interest at the time the research is undertaken, and the results are published by the HSMTSA. In addition, items regarding health care delivery and utilization were included in the National Health Survey 2003 by the Central Statistical Bureau (financed by an EU PHARE project). An example of co-funding of this kind of research includes the international Finbalt project (with financing from the state budget and Finbalt), involving surveys of lifestyles and risk factors in health, undertaken

⁶ A list of institutions and studies that were funded can be found at <http://www.lzp.lv/Proj-2006/Proj06-8.htm>, accessed 1 April 2008.

every two years by the Public Health Agency. The data gathered here are also used for writing graduate-level theses and dissertations.

Latvian health research peer-reviewed articles are published predominantly in the Latvian language. Scientists at the largest health research institution in Latvia, the Riga Stradins University, published 224 articles in 2005. Preliminary unpublished data of the Strengthening Public Health Research in Europe (SPHERE) project shows that Latvian researchers publish research results in English language journals more often as partners of international collaborative research projects.

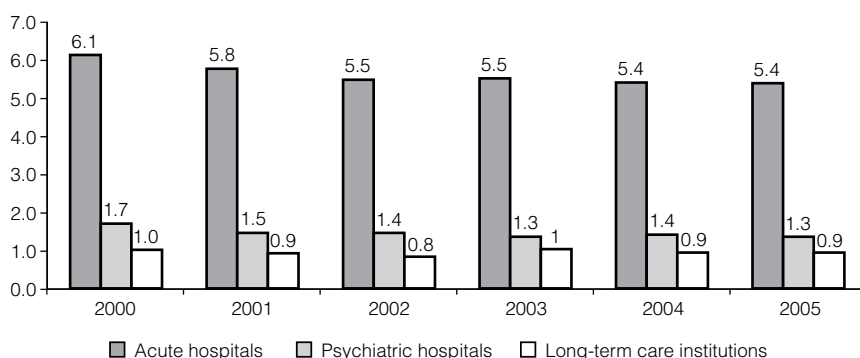
5. Physical and human resources

5.1 Physical resources

Infrastructure

Figure 5.1 shows how the numbers of acute care hospitals, psychiatric hospitals and long-term care institutions in Latvia have developed since 2000. Trends in bed numbers in acute care and psychiatric hospitals since 1998 are also shown numerically in Table 5.1. There was a significant downward trend in both of these in the period 1998–2002, and both appear to have stabilized in the period 2003–2004. A similar trend can be seen in the case of acute short-stay hospital bed numbers (Table 5.1). Long-term care institution bed numbers, by contrast, have been roughly constant throughout this period.

Fig. 5.1 Mix between beds in acute care hospitals, psychiatric hospitals and long-term institutions per 1000 population, 2000–2005



Source: HSMTSA databases 2007 [unpublished data].

Table 5.1 Mix between beds in acute care hospitals, psychiatric hospitals and long term institutions, 1998–2004

Years	Acute (short-stay) hospitals per 100 000	Acute care hospital beds per 100 000	Psychiatric hospital beds per 100 000
1998	4.7	663.0	181.3
1999	4.8	645.7	166.8
2000	4.5	610.8	168.6
2001	4.4	576.0	150.0
2002	3.8	547.6	141.7
2003	3.7	545.3	137.7
2004	3.6	538.0	138.9
2005	3.2	532.6	137.0

Source: WHO Regional Office for Europe 2007a.

An examination of overall hospital bed figures over a longer time period indicates that there has been a far more significant drop in these than the above figures suggest. In the period 1990–2005, the number of beds fell from 1407.5 to 768.3 beds per 100 000 population, signifying a drop of 55% (WHO Regional Office for Europe 2007a). The key factor behind this dramatic drop in hospital bed numbers is health policy aiming towards the development of PHC and the substitution of outpatient services for inpatient care.

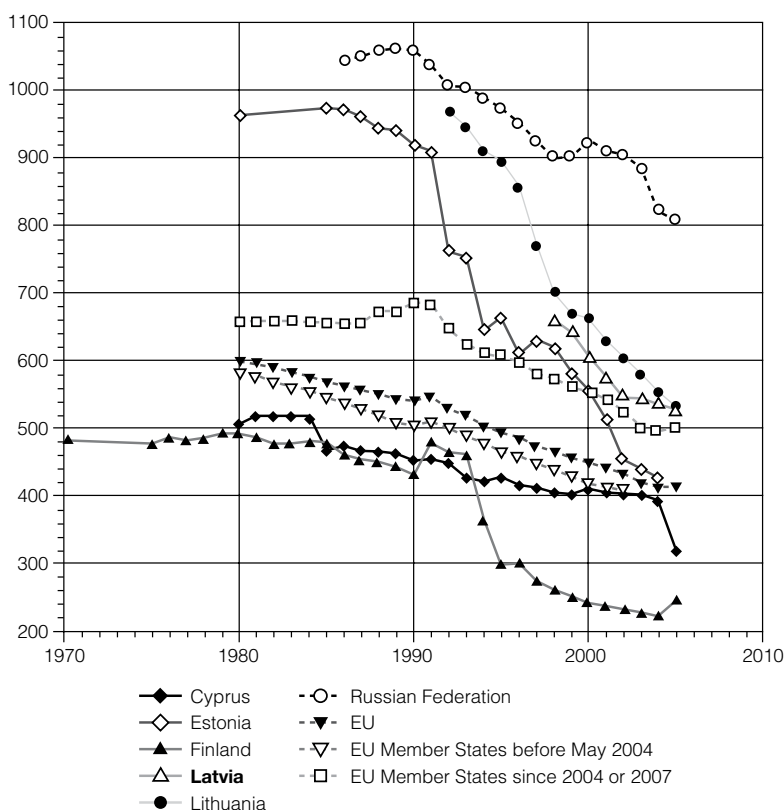
Figure 5.2 and Figure 5.3 show the development of acute care hospital bed numbers per 100 000 over time in Latvia and selected WHO member countries and EU averages. Latvia follows a similar downward trend to all countries shown. In 2005, Latvia had 532.6 acute care hospital beds per 100 000 population, which was higher than the EU average of 413.7 beds per 100 000 population in the same year. However, it was almost the same number as the average for the EU Member States since 2004 and 2007 (EU12) (502.2 acute hospital beds per 100 000 population).

Table 5.2, dealing with inpatient utilization indicators in Latvia, shows that whereas inpatient admissions have been roughly constant over the last several years, the ALOS has been steadily falling. This is due to efforts to substitute more expensive outpatient care for less costly inpatient care.

Of the total number of inpatient admissions, day-case admissions accounted for 8.2% in 2004 and 7.5% in 2005.

Average bed-days have fallen from 10.8 bed-days per inpatient in 2003 to 10.6 bed-days in 2004 and to 10.0 bed-days in 2005. Accordingly, turnover of hospital beds (the sum of discharges and deceased patients divided by the average number of hospital beds) has increased from 26.8 in 2003 to 27.3 in 2004 and 28.8 in 2005. This is related to changes in the funding system and use of medical technologies that help to improve the effectiveness of diagnostics

Fig. 5.2 Acute care hospital beds per 100 000 in Latvia and selected countries of the EU, 1980–2005



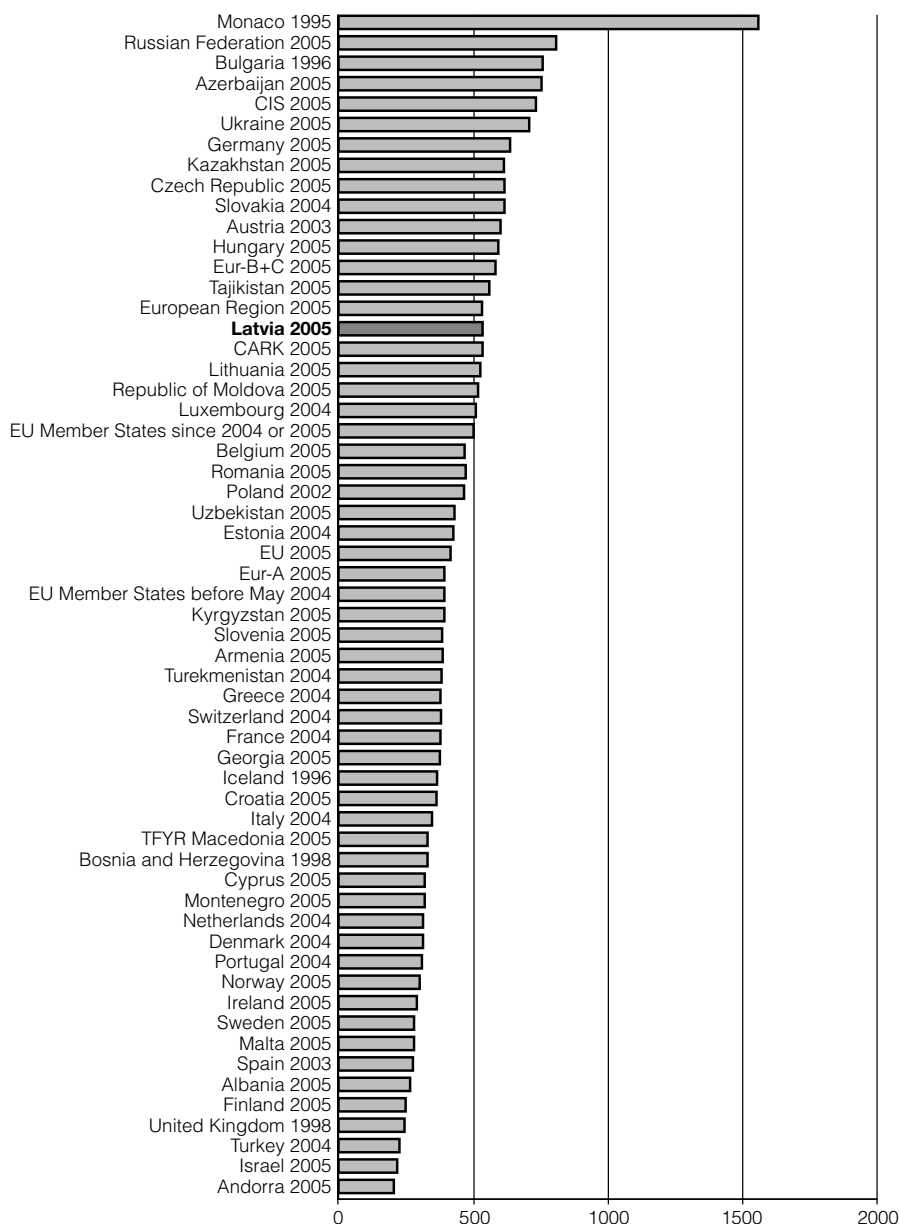
Source: WHO Regional Office for Europe 2007a.

Note: EU: European Union.

and treatment. The hospital utilization rate is changing slowly, standing at 79.0 in 2003 and 78.8 in 2005.

Table 5.3 shows Latvia's operating indicators compared to other WHO member countries. Latvia lies roughly in the middle range of values for all the indicators shown.

It is expected that many of the Latvian infrastructure indicators will change significantly as implementation of the Master Plan gets under way. For more information on the Master Plan, see the discussion in Section 4.2 *Planning and information management*, as well as Chapter 7 *Principal health care reforms*.

Fig. 5.3 Beds in acute hospitals in the WHO European Region, latest available year

Source: WHO Regional Office for Europe 2007a.

Notes: CIS: Commonwealth of Independent States; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristic from Eur-A countries; CARK: Central Asian republics plus Kazakhstan; EU: European Union; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; TFYR Macedonia: The former Yugoslav Republic of Macedonia.

Table 5.2 Inpatient utilization, 2000–2005

	Inpatient care admissions per 100	ALOS, all hospitals
2000	22.2	11.4
2001	21.1	11.3
2002	20.4	11.0
2003	20.9	10.8
2004	21.1	10.6
2005	22.1	10.0

Source: WHO Regional Office for Europe 2007a.

Note: ALOS: Average length of stay.

Capital stock and investments

By the end of 2005 there were 109 inpatient institutions in Latvia, compared to 119 at the end of 2004. Hospitals are located in all the largest cities and districts. The size of the hospitals varies, with 45 hospitals having up to 49 beds, 14 hospitals with 55–99 beds, 23 hospitals having 100–199 beds, 14 hospitals with 200–399 beds, 8 hospitals with 400–699 beds, and 5 hospitals having over 700 beds. In comparison with previous years, the number of the smaller hospitals (with fewer than 99 beds) has decreased notably.

The ownership form of the hospitals also varies. In 2004 in Latvia there were 40 state hospitals, 62 local-level hospitals and 17 private hospitals.

In the period up to the Second World War, 19 hospitals had been built, which are still in operation today. In the period 1945–1980, 55 hospitals were built or reconstructed, while after 1980 and up to the end of 2005 an additional 35 hospitals were newly constructed or rebuilt. The hospitals that were built before the war are mostly pavilion-type hospitals, while those built in the period after the war are block houses connected with big corridors, in accordance with the health care-related architectural style known as Minimalist Megahospitals. In this type of hospital, less attention is paid to strategic aspects, such as performance of medical procedures, their mutual relations, etc.

Research on the condition of the buildings of health institutions was first carried out in 1986, but the data accumulated then are not currently useable as they do not reflect the real situation. Since then, several studies have been carried out, for example a telephone survey conducted by the HSMTSA investigating the degree to which hospitals are equipped with generators supplying electrical power in the event of power cuts. Following a request by the Ministry of Defence, data were collected concerning the hospitals' provision with helicopter landing spots, possibilities to reach hospitals by use of railway and water routes, the existence of nearby or on-site pharmacies, the possibilities of treatment and laboratory diagnostics and the amount of services available.

Table 5.3 Inpatient utilization in selected countries of the WHO European Region, 2001–2005

Countries	Hospital beds per 100 000	Inpatient care admissions per 100	ALOS, all hospitals	Bed occupancy rate in %, acute care hospitals only
1 Austria	770.9	31.2**	8.0**	76.2**
2 Belgium	529.5	16.4*	8.7**	70.5*
3 Bulgaria	642.3	21.0	8.1	n/a
4 Cyprus	341.0	7.2	n/a	84.5
5 Czech Republic	837.6	22.1	10.8	74.6
6 Denmark	382.3*	22.1*	5.0*	84.0***
7 Estonia	581.8*	19.2*	8.0*	68.4*
8 Finland	702.9	25.8*	10.0*	n/a
9 France	748.0*	18.9*	77.4*	77.1*
10 Germany	844.5	22.6	10.2	75.6
11 Greece	468.8*	16.5***	8.0***	n/a
12 Hungary	785.4	25.5	8.1	75.7
13 Ireland	572.0*	14.2	7.6	85.6
14 Italy	399.6*	15.3**	7.5**	76.1***
15 Latvia	768.4	22.1	10.0	n/a
16 Lithuania	812.1	23.8	10.2	78.6
17 Luxembourg	633.4*	n/a	n/a	n/a
18 Malta	745.2	n/a	n/a	87.5
19 Netherlands	497.8**	9.3***	12.5***	58.4***
20 Poland	534.8*	17.6*	6.9*	n/a
21 Portugal	374.6*	11.6*	8.6*	69.8*
22 Romania	655.8	24.6	8.0	n/a
23 Russian Federation	974.2	22.2	13.8	86.4
25 Slovakia	689.0	18.5	8.9	68.6*
26 Slovenia	483.0	17.6	7.1	70.1
27 Spain	345.0**	11.8**	8.7**	79.2**
28 Sweden	n/a	15.6	6.3	n/a
29 United Kingdom	389.8*	n/a	n/a	n/a
30 European Region	682.1	19.0	10.5	80.0*
31 EU	584.6	18.1*	9.3*	75.9*
32 EU15	571.4*	17.5**	9.6**	77.0***
33 EU10 or EU12	643.7	20.8	8.0	73.6

Source: WHO Regional Office for Europe 2007a.

Notes: ALOS: Average length of stay; * Data for 2004; ** Data for 2003; *** Data for 2001; EU: European Union; n/a: Not available; EU15: European Union Member States before May 2004; EU10: European Union Member States joining the EU in May 2004 or (EU12) January 2007.

However, it should be noted that this kind of data collection does not take place on a systematic basis.

A major undertaking initiated in recent years concerns the Master Plan (discussed earlier in Section 4.2 *Planning and information management*), which is intended to change the structure of the inpatient health service provider network, as well as to improve the primary care infrastructure. When the Master Plan was being worked out, the condition of health care institutions was evaluated so as to determine the levels and types of investment that would be necessary for hospital restructuring. In 2000, the condition of inpatient buildings was evaluated as satisfactory, but with the reservation that the situation could deteriorate rapidly as many hospitals had not undergone a general renovation for tens of years. It was determined that hospitals were equipped with only 20–50% of the necessary medical equipment and only one third of this was in conformity with accepted rules and medical standards for use and safety. Also it was considered that the average depreciation of the Roentgen (X-ray) devices is 75–80% in Latvia.

Regulations of the Cabinet of Ministers “National Programme for Health Care for 2004–2006” (2004) outlined the programme co-financed by the EU to pursue restructuring and renovation of health care institutions. The selection of institutions that are to receive funding was made in accordance with the Master Plan. In January 2005 the Minister of Health and 15 representatives of inpatient institutions signed agreements about the acquisition of funds from the European Regional Development Fund, which was to be distributed in accordance with the National Programme for three priority areas:

- emergency medical care at the pre-hospitalization stage;
- renovation of admission wards;
- renovation of primary health facilities.

The largest projects will involve new buildings of admission wards at the Ventspils hospital and Riga City “Gailezers” clinic.

The funds provided by the European Regional Development Fund will be distributed to 11 multi-profile acute care hospitals included in the Master Plan:

- Clinic “Gailezers” (LVL 3.8 million)
- Riga Stradins clinical university hospital (LVL 1.2 million)
- Ventspils hospital (LVL 1.9 million)
- Clinical university hospital for children (LVL 0.8 million)
- Riga city 1st hospital (LVL 0.4 million)
- Daugavpils regional hospital (LVL 0.6 million)

- Valmiera regional hospital (LVL 0.4 million)
- Rezekne hospital (LVL 0.4 million)
- Liepaja city central hospital (LVL 0.4 million)
- Jekabpils district central hospital (LVL 0.2 million)
- Jelgava city hospital (LVL 65 500)

Three projects will involve PHC: Cesu district health care centre (heating system reconstruction, renovation of rooms, and purchase of equipment to the value of LVL 90 000); Olaine health centre (renovation of rooms, purchase of equipment to the value of LVL 110 000); Saldus medicine centre (heating system reconstruction, renovation of rooms to the value of LVL 90 000).

As resources from the state budget are insufficient to cover capital costs, at present the shortfall is made up by local government financing. For example, 20 new family doctor practices are to be established in accordance with the Master Plan.

While the State is a co-sponsor of projects in all state hospitals within the Master Plan framework, local governments are co-sponsors of all projects that concern hospitals and PHC centres that are under their ownership, although cost overruns will be covered by central state funding. According to the Master Plan, the bulk of local government revenue comes from transfers from the state budget (fixed at 71.6% of state personal income tax) and is supplemented by local duties. For example, Riga City has provided co-funding of LVL 2.5 million for the “Gailezers” clinic (total sum of the project is LVL 3.8 million), and co-funding of LVL 71 020 for the Riga City 1st hospital project (the total sum is LVL 355 298). The local government of Ventspils has provided co-funding LVL 280 000 for the building of a regional multi-profile and acute care hospital complex (total sum of the project is 1.8 million LVL). This hospital will be located in a single building complex. A new block of the hospital will be added to the building and the admissions ward will be renovated. This will be a 4-storey building, which will house an admissions ward for planned patients and outpatients, a diagnostics ward, a cardiology ward, a cardiology intensive care unit, a neurology ward and a stroke unit.

In terms of the choice of PHC centres that will receive investments, in accordance with the Master Plan, administrative zoning and the number and distribution of the territorial branches of the SCHIA were taken into account. As discussed in Chapter 3 *Financing*, the territorial branches of the SCHIA contract with primary care providers, while the Central Office of the SCHIA contracts with secondary care providers. The objective is to have one PHC centre in the vicinity of each branch. A similar rationale has been used in planning the locations of dispatch offices for urgent medical care and the establishment of

brigades, where the regional coverage and available financial resources were taken into account.

It should be noted there are no public–private partnerships for investment funding in the area of health care in Latvia.

Neither the “National Programme for Health Care for 2004–2006” of 2004 nor the Master Plan include any private health care institutions, all of which are themselves responsible for their investment planning and financing.

The Regulation issued by the Cabinet of Ministers (on the “Management of European Union Structural Funds” (March 2004)) stipulates conditions defining management of the funds, and the stakeholders and their rights and duties. The Ministry of Health is responsible for the management of activities financed by the structural funds in accordance with health care policies and priorities. The Ministry is also responsible for the organization of information and publicity events.

Information technology

In 2004 the Cabinet of Ministers established a Secretariat of Special Assignment Minister for Electronic Government Affairs, in charge of implementation of electronic administration in the state and local governments.

According to data of the Department of Health Statistics of the HSMTSA, the status of information technology (IT) as of 1 June 2006 was as described here.

- In PHC, 7.2% of health care institutions were equipped with IT (computers and Internet access). A breakdown of these is as follows: 8.8% of family doctor practices; 5.3% of paediatrician practices; 4.8% of internist practices; and 3.2% of dental practices.
- In secondary health care, 13.7% of institutions (not including hospitals) were equipped with IT. The situation for hospitals is very different, as 90% of these are equipped.

Since August 2005, “Regulations of the Cabinet of Ministers on Guidelines ‘e- Health in Latvia’” have been in force, according to which the Ministry of Health is the institution responsible for the design and implementation of the programme for the development of e-health in Latvia. Proposals for the e-health programme suggest the introduction of the following strategies:

- an information system in health care institutions (which is to include histories of diseases in electronic format, among with other information);
- electronic health records (including documentation of all basic information about the patient up to the point of discharge);

- the development of telemedicine;
- standardization of all health care services provided;
- information recording each patient's medical history, patient risk factors, services received, pharmaceuticals, and recommendations for further care;
- improvement of the registration of information (health statistics, registration of the use of medicines);
- the establishment of a centralized portal of health care involving a web site offering a wide range of resources and services, including public health, population lifestyles, physical and social environment, latest research in health care and health care legislation, with links to all state agencies.

Following implementation of the programme, patients will be able to book their visit to the family doctor or other specialist by e-mail and it will also be possible to ask questions of interest and receive answers electronically. Suggestions have been made concerning the introduction of a electronic patient card that may also be useful while travelling abroad. It has been suggested that the principle of this card would be very similar to that of Internet banking, whereby each individual would have an account where all data would be filed, and which would be accessible at any moment by use of a special code. This would also be of use to medical professionals who would be better able to cooperate and consult with colleagues in other health care institutions, in other cities and even in other countries.

By the year 2000 there were managed teleconferences between Riga Stradins Clinical University Hospital and the University of Uppsala in Sweden. The implementation of e-health measures will also play an important role in the regions, which at the moment suffer from a lack of sufficient specialists.

The HSMTSA has received financing from the Ministry of Health to begin work on the e-health programme. The initial objective is to establish a unified system of information about patients with specific diseases, integrating various patient registers (TB, oncological diseases, mental diseases, the users of psychoactive and narcotic drugs, STIs, multiple sclerosis, diabetes mellitus, injuries and traumas, and others). It is expected that the new system will be functional within 2007.

Another important system is the SCHIA management information system. The new system is being tested through cross-referencing of information with the SCHIA management information system. The information is to include data on outpatient and inpatient care, patients that have undergone check-ups, child dentistry and emergency medical services.

The purchase of IT for health care institutions is not centralized. Each health care institution is responsible for acquiring its own IT by means of its own resources.

All state agencies and specialized centres have homepages on the Internet. However, at the time of writing there were no accurate statistical data concerning the number of people who have used the particular homepages to receive information connected with health issues.

Medical equipment, devices and aids

According to article 34 of the “Law on Medical Treatment”, all matters relating to the distribution, registration, use and technical surveillance of medical devices and goods is to be determined by Regulations of the Cabinet of Ministers. The relevant Regulations came into effect in August 2005 (“Regulations on Registration, Conformity Assessment, Distribution, Use and Technical Surveillance of Medical Devices”).

These Regulations specify that the HSMTSA is the sole body responsible for the registration, use, surveillance and distribution of medical devices. The conformity of medical devices is assessed by the HSMTSA, which is accredited by Latvia’s National Bureau of Accreditation. This Bureau, established in 1994, provides a common system for assessing the conformity of laboratories, including certification and inspection bodies, and environment verifiers.

The purchase of medical devices and goods is mostly undertaken by medical care institutions on their own and 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). It is specified that purchases amounting to LVL 10 000 to 50 000 can be undertaken by use of public price inquiry, based on price information by all suppliers so as to obtain the lowest price. If the costs of the purchase are greater than LVL 50 000, they must be undertaken through competitive tenders.

Procedures for centralized purchases in the area of health care are defined by “Regulations of the Cabinet of Ministers on Health Care Organization and Financing” (2004). These purchases are undertaken by the SCHIA, which acts as a payer on behalf of all institutions with which it has agreements (i.e. all statutory health care providers). As a customer (payer) of the purchase, the SCHIA buys vaccines, serums for immunology and immunoglobulins, preparations of phenylketonuria correction and curative food products.

In addition, for all non-centralized purchases, the SCHIA acts as representative of the customer (the payer) in the capacity of manager of

competitive procurement tenders. These procedures do not concern private sector institutions, which manage purchases on their own and also pay on their own.

If the purchase of large medical technologies for hospitals is to be financed from state or local government budgets, the need, profitability, cost and conformity with modern technologies of the purchase are assessed by the Department of Project Assessment and Surveillance as well as by the Department of Health Care Analysis and Development within the HSMTSA (for example, medical radiology devices, anaesthesiology devices, operating rooms and intensive therapy, as well as other medical devices for diagnostics and treatment) (see Section 4.2 *Planning and information management*, as well as Chapter 7 *Principal health care reforms* for discussion on this).

The need for a particular technology is assessed by analysis of statistical information regarding the number and load of the current technological level of existing medical devices. The purchase, which is carried out in accordance with the Master Plan, is intended to ensure patient access and a well-balanced geographical distribution of large medical devices within the country. For example, the HSMTSA refused the purchase by the Aizpute Hospital of a new Roentgen device, at a cost of LVL 200 000, which was to use state budget resources on the grounds of changes in population morbidity, the low load of the existing Roentgen device, as well as expected incorporation of this hospital into the new structure of a regional multi-profile hospital.

In the case of large medical technologies in PHC, it should be noted that 90% of dental practices are equipped with dental Roentgen devices, which are financed by the practice (as most dentists are private practitioners), or, in the case of state dentistry centres, are financed by means of the procedure described above. In other practices (family doctors, internists, paediatricians) there is a lack of diagnostic radiological devices (Databases of the HSMTSA 2007 [unpublished data]).

In other ambulatory health care institutions (both primary and secondary care levels), provision with this equipment varies, but on average it is quite low; for example, 1.7% of practices have fluorographs; 3.9% have radiological equipment, and 1.3% are able to offer ultrasound services (Databases of the HSMTSA 2007 [unpublished data]).

Provision of medical technologies in inpatient health care institutions differs significantly. For example, 74.3% have radiological devices, 15.6% offer mammography services, 29.4% have computertomography equipment, and 54.1% offer ultrasound services. MRI and CT coverage per 100 000 is 0.3 and 1.8, respectively. The purchase of medical devices in state and local government health centres is carried out in accordance with the procedures

described earlier. Purchases are financed by the resources of individuals, or state or local governments, depending on the institution's ownership (Databases of the HSMTSA 2007 [unpublished data]).

As of 1 June 2006 there were 3628 electromechanical medical devices and goods entered into the medical devices and goods register. The purpose of registration is to ensure patients' safety while receiving health care services that make use of the devices, as well as to monitor of the capacity of medical technologies and staff competency (Databases of the HSMTSA 2007 [unpublished data]).

Pharmaceuticals

Regulatory framework

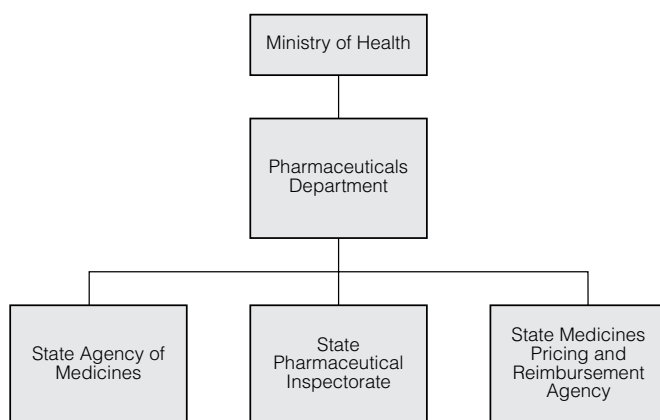
Latvia's drug policy is primarily oriented towards availability and affordability rather than support for competitiveness of domestic production.

Figure 5.4 shows the main institutions playing a regulatory role in the pharmaceutical sector in Latvia.

The Pharmaceuticals Department of the Ministry of Health is responsible for legislation and policy in the field of pharmaceuticals, and supervision and licensing of pharmaceutical services. It operates within the international system of drug control and carries out state policy in this area. Its legislation is in line with:

- the Single Convention on Narcotic Drugs (1961);
- the Convention on Psychotropic Substances (1971); and

Fig. 5.4 Administrative structure of the pharmaceutical sector



Source: Authors' own compilation.

- the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

There are three state agencies concerned with pharmaceuticals, all under the authority of the Pharmaceuticals Department of the Ministry of Health.

The State Agency of Medicines was founded in October 1996. This Agency maintains a Register of Human Medicines, where all products registered in Latvia are listed. Amendments to the “Law on Pharmaceuticals” (1998) enacted in December 2005 have resulted in a reorganization of the main duties of the State Agency of Medicines, which are as follows:

- assessment of quality, safety and effectiveness of medicinal products and issuing of marketing authorizations (human and veterinary);
- assessment and authorization of variations;
- maintenance of the Register of Human Medicines;
- classification of medicinal products;
- assessment for licensing procedures of medicinal product manufacturers, importers, wholesalers (human and veterinary) and pharmacies (human);
- conformity assessment (good manufacturing practice (GMP) inspection) of medicinal products manufacturers (human and veterinary);
- authorization and assessment (good clinical practice (GCP) inspection) of clinical trials performance;
- management of adverse events reports and pharmacovigilance;
- assessment of compliance of advertising materials for medicinal products with statutory requirements;
- management of medicinal products consumption statistics;
- monitoring of prices of the pharmaceuticals;
- authorization of import, export, transit and distribution of medicinal products;
- issuing of product export certificates;
- authorization of import of unlicensed medicinal products;
- assessment of borderline products (food supplements, cosmetics, etc.);
- quality control of medicinal products (laboratory testing).

The State Pharmaceutical Inspectorate is responsible for the control of pharmaceutical enterprises, as well as supervising compliance with regulations in the production, distribution and purchasing of medicines; performing evaluations of premises, equipment, personnel and documentation regarding conformity to the work to be performed and its volume; and monitoring advertisements of medicinal products.

The Medicines Pricing and Reimbursement Agency was established in 1998 in order to carry out a reform of the pharmaceutical reimbursement system in accordance with EC Directive 89/105/EEC. A key purpose of this organization is to determine the positive list of pharmaceuticals and to ensure the appropriate functioning of the reimbursement system. It is intended to cooperate with professional organizations (such as those of physicians and pharmacists) and the SCHIA. Among its functions is the analysis and estimation of treatment expenses, overseeing physician practices on prescription of pharmaceuticals included in the positive list, and assessment of the results.

The main laws regulating the pharmaceutical sector include those listed here.

- “Law on Pharmaceuticals” (1998, last amended in December 2005). The purpose of this Law is to regulate activities of legal persons in the area of pharmacy and to ensure the manufacturing and distribution of safe, qualitative and effective medicinal products.
- “Law on Procedure for Licit Circulation of Drugs and Psychotropic Substances”, adopted in 1996 (last amended on 11 May 2006). The purpose of this Law is to define the procedure for the licit circulation of pharmaceuticals and psychotropic substances used for medical and research purposes.
- “Law on Precursors”, adopted in 1996, regulates the activities of legal persons with precursors; its purpose is to prevent the deviation of these substances into illegal circulation.

Reforms in the pharmaceutical sector

The “Regulation of the Cabinet of Ministers on Medication Pricing Principles” (2005) set the principles for the determination of the prices of medicines and provides formulas for the calculation of prices of pharmaceuticals. 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.

Upon beginning the distribution of medicinal products in the territory of Latvia, holders of marketing authorizations must provide the State Agency of Medicines information regarding the ex-factory price of the product.

For pharmaceuticals included in the positive list, prices are negotiated between the Medicines Pricing and Reimbursement Agency and the holders of marketing authorizations, and are set on the basis of economic evaluation provided by the Medicines Pricing and Reimbursement Agency.

A new “Regulation of the Cabinet of Ministers on Reimbursement System of Pharmaceuticals and Medical Devices” was introduced in 2006. The main

principles of reimbursement of pharmaceuticals according to this Regulation are detailed here.

- Reimbursement is provided for treatment of chronic and severe illnesses, with four reimbursement categories applied for this purpose: 100%, 90%, 75% and 50%. The list of illnesses is approved by the Cabinet of Ministers.
- The Medicines Pricing and Reimbursement Agency issues a positive list of pharmaceuticals and sets the prices for reimbursement.
- The positive list consists of three parts: List A, List B and List C.
 - o List A is a reference price list, consisting of reference groups of pharmaceutical products based on interchangeability within one active substance or a pharmacotherapeutic group according to the following criteria: products have no difference in efficacy and side effects; they have the same route of administration; and they are reimbursed for the same patient groups. The reference price is the price of the cheapest product in the group.
 - o List B consists of non-interchangeable products.
 - o List C contains pharmaceutical products with annual treatment costs exceeding LVL 3000. The decision on reimbursement for these products includes the number of patients for whom the reimbursement is provided on an annual basis.

Economic assessment came into force at the end of 2002 (according to the common Baltic Guidelines on Economic Evaluation of Pharmaceuticals). Pharmaceuticals are assessed prior to reimbursement by the Medicines Pricing and Reimbursement Agency. Pharmacoeconomic analysis forms part of the documentation submitted by the marketing authorization holder for reimbursement.

General criteria for reimbursement include:

- burden of disease
- therapeutic value of a pharmaceutical and correspondence to treatment schemes
- cost-effectiveness data
- impact on health care budget.

There has been a significant budget increase for the reimbursement system of pharmaceuticals in recent years, ensuring that all patients for whom reimbursement is guaranteed can actually receive it. Prior to this, patients at times had to go without reimbursement due to budgetary insufficiencies. Reimbursement per capita was LVL 17.5 in 2006, being one of the lowest rates within the EU. Major problems arise with new and very expensive

pharmaceuticals, which cannot always be reimbursed because of their very high costs, thus preventing patients in Latvia from receiving treatments provided in higher-income countries.

The doctor, taking into account the nature and the level of seriousness of a disease or condition, must prescribe the most appropriate, most effective and lowest cost medical treatment. If the doctor has used the International Nonproprietary Name (INN) for the pharmaceutical on the prescription, the pharmacist is required to issue the cheapest product included in the positive list that conforms to this INN. Due to scarce financing resources for reimbursement, a set of cost-containment measures has been introduced. These include, for example, budgets for doctors; prescribing of certain products only under special conditions according to approved treatment guidelines; recommendations for prescribing issued by the Medicines Pricing and Reimbursement Agency; and generic substitution.

Compliance with specific requirements and recommendations for prescribing is monitored by the SCHIA and supervised by the Ministry of Health. There is a database of all reimbursed prescriptions, providing monitoring and supervision possibilities of the system. In inpatient care, pharmaceuticals are included in the price of health care services covered by the state budget. For more information on pharmaceuticals, see Section 6.6 *Pharmaceutical care*.

5.2 Human resources

Trends in health care personnel

Table 5.4 shows the development of numbers of health care personnel in Latvia since 1990. There have been significant declines in numbers of doctors, midwives and nurses, which were especially sharp during the first half of the 1990s. The numbers of practitioners in these categories appear to have stabilized in the period since 1998–1999. Feldsher numbers, by contrast, have been continuously falling, due to the gradual phasing out of this category of health care personnel. Numbers of GPs also stand out by virtue of their continuous increase since 1990, which is due to the introduction and strong support provided to this specialty that forms the basis of family medicine, introduced as a cornerstone of reforms since the mid-1990s. Numbers of dentists, while declining dramatically in the first half of the 1990s, subsequently began to increase steadily. This is the only category of health care personnel that by 2005 had grown to larger numbers (per 1000 population) compared to 1990 (with the exception of GPs), and this

Table 5.4 Health care personnel per 1000 population, 1990–2005

Years	1990	1994	1996	1998	2000	2001	2002	2003	2004	2005
Active physicians	4.17	3.04	3.01	3.15	3.28	2.98	3.06	3.06	3.10	3.16
GPs	0.01	0.03	0.12	0.21	0.40	0.41	0.44	0.45	0.53	0.56
Active dentists	0.49	0.26	0.48	0.44	0.53	0.53	0.54	0.55	0.60	0.63
Feldshers	1.79	1.01	0.98	0.83	0.76	0.72	0.75	0.75	0.70	0.77
Midwives	0.55	0.34	0.29	0.26	0.21	0.20	0.20	0.20	0.20	0.20
Active nurses	5.69	4.62	4.79	4.43	4.24	4.17	4.17	4.29	4.38	4.49

Source: HSMTSA databases 2007 [unpublished data].

Note: GP: General practitioner.

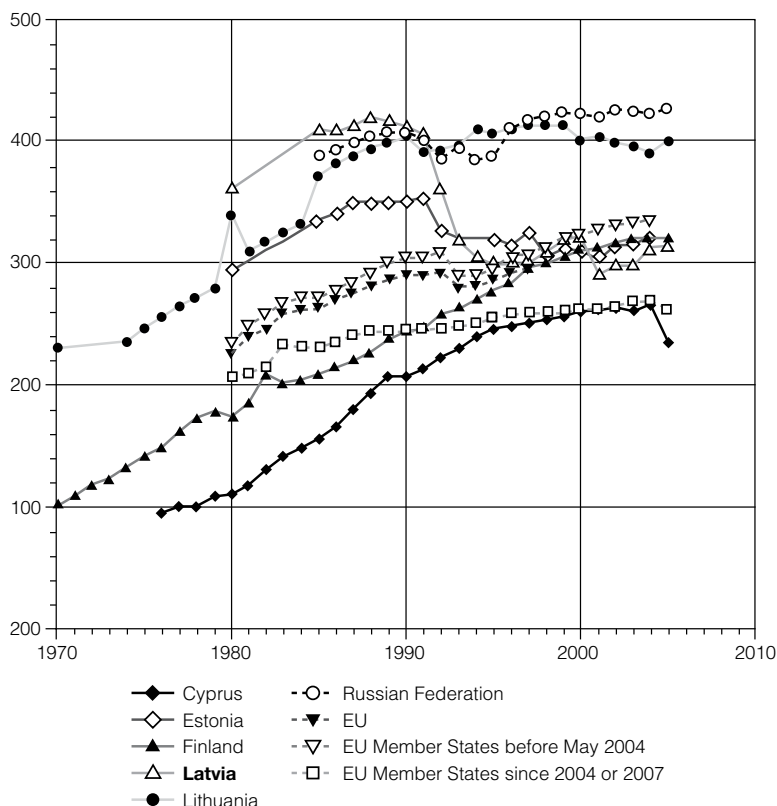
was due to the privatization of practically all dental practices, thus increasing their profitability and the attractiveness of this profession.

The decline in doctor numbers can be ascribed to a number of factors, including declining numbers of hospitals and hospital beds, as well as low salaries and prestige for health care professionals that led to the departure of many practising doctors from the health sector in search of other, more lucrative jobs in other sectors of the economy. On the other hand, the stability in doctor numbers that has been witnessed since the late 1990s has been due to significant increases in doctors' incomes (a near doubling compared to earlier years), a marked slowdown in resignations from the health sector and a return to the medical field from other sectors.

Figure 5.5 shows how doctor numbers in Latvia compare with those of several other neighbouring countries as well as EU averages. It presents a broad picture, showing that in 2005 there were approximately 3.15 physicians per 1000 inhabitants in Latvia, which was almost as many as the average number for the whole of the EU (EU27) (3.17 per 1000 inhabitants) and for the EU10 (3.35 per 1000 inhabitants).

The distribution of doctors throughout Latvia is uneven. Whereas in Riga there are more than 500 doctors per 100 000 inhabitants, in some regions there are fewer than 200 per 100 000. In addition, the age structure of doctors is unfavourable, as 16% of physicians have reached retirement age, while only 12.7% are under 35 years of age. The lowest proportion of young doctors is observed among GPs (10%), gynaecologists (1.5%) and ophthalmologists (14.2%). A high proportion of elderly physicians is typical in the case of surgeons (44.5%), ophthalmologists (44.2%) and gynaecologists (40.1%). An analysis of physicians' retirement process has shown that 7% of family doctors, 20.7% of surgeons, 22.6% of gynaecologists, 23.3% of ophthalmologists and 19.5% of traumatologists were to have reached retirement age by the end of 2005 (Databases of the HSMTSA 2007 [unpublished data]).

Fig. 5.5 Physicians per 100 000 population in Latvia and selected countries, 1980–2005

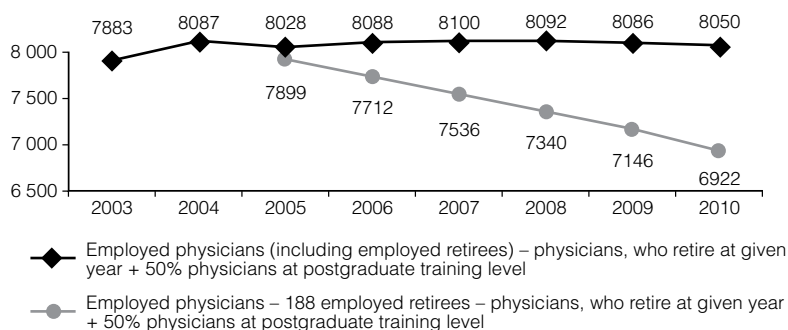


Source: WHO Regional Office for Europe 2007a.

Note: EU: European Union.

At the end of 2005 the HSMTSA made some projections based on data included in the Register of Medical Persons. In 2004 there were 1123 physicians at retirement age who were still employed in Latvia. Yet the average number of medical graduates per year (2003–2005) from both the University of Latvia and Riga Stradins University is only 176.

In another calculation, it was noted that on average 118 physicians pursue postgraduate training per year. If it is supposed that all of these physicians continue to work in medicine (which is quite unrealistic as many leave the profession upon completion of their studies), they can only replace a small portion of physicians who are at retirement age, especially considering that the total number of physicians at retirement age increases every year. Based on these calculations, the shortage of physicians will be 1564 people in 2010.

Fig. 5.6 Simulated numbers of physicians, 2005–2010

Source: Karaskevica & Maurina 2005.

However, the actual deficit in doctor numbers could be much greater if it is considered that in practice only a fraction of graduating doctors work in the medical profession upon graduation. Figure 5.6 presents two scenarios:

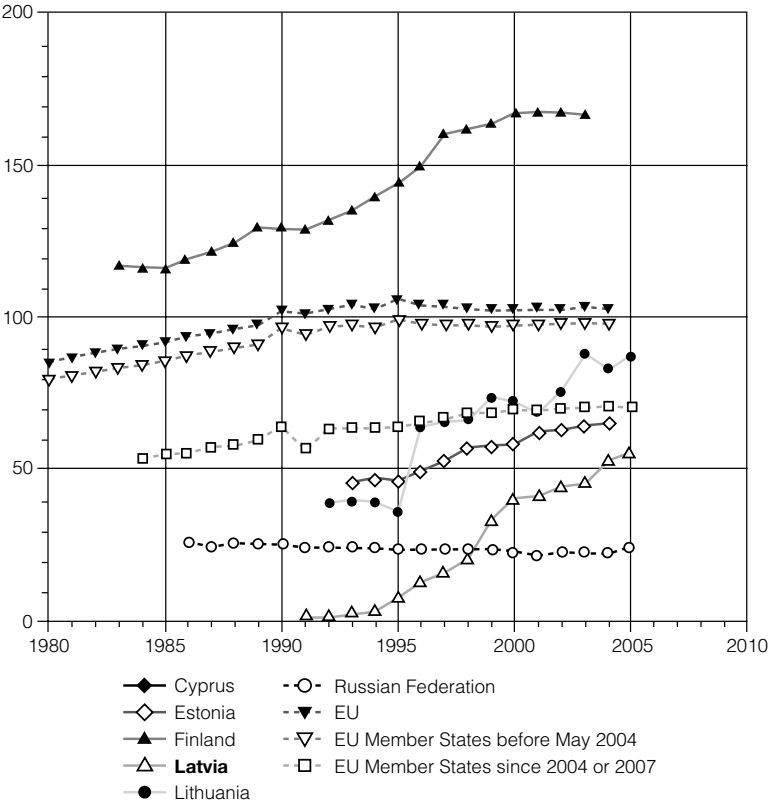
- projection of number of physicians until 2010, if only those physicians who retire in a given year leave their job, while those retirees of previous years continue to work, and 50% of physicians with postgraduate training (50 on average) start working in medicine;
- projection of number of physicians until 2010, if all working retirees are released by 2010 (188 people per year), physicians who retire in a given year leave their job, and 50% of physicians with postgraduate training (59 on average) start working in medicine.

Clearly, to maintain current numbers of doctors, there will need to be many employed physicians aged 70 years and more over the next 5–6 years (Karaskevica & Maurina 2005). There could be a few alternatives to avoid the problem of severe shortages of doctors in coming years: either increasing the number of students and doctors at postgraduate training level funded by the state budget, or raising the retirement age, or a combination of both measures.

The Order of the Cabinet of Ministers “Basic Statement on Development of Human Resources for Health Care” (May 2005) suggests a unified model of postgraduate education, supervision and coordination, and adjusted health care personnel remuneration levels in order to promote recruitment of new doctors and retain already existing staff.

It appears that a general understanding of the significance of the current situation, as well as public focus on the health care system, have increased interest in medical studies, and increased applications to medical schools were submitted in 2005.

Fig. 5.7 General practitioners per 100 000 population in Latvia and selected countries, 1980–2005

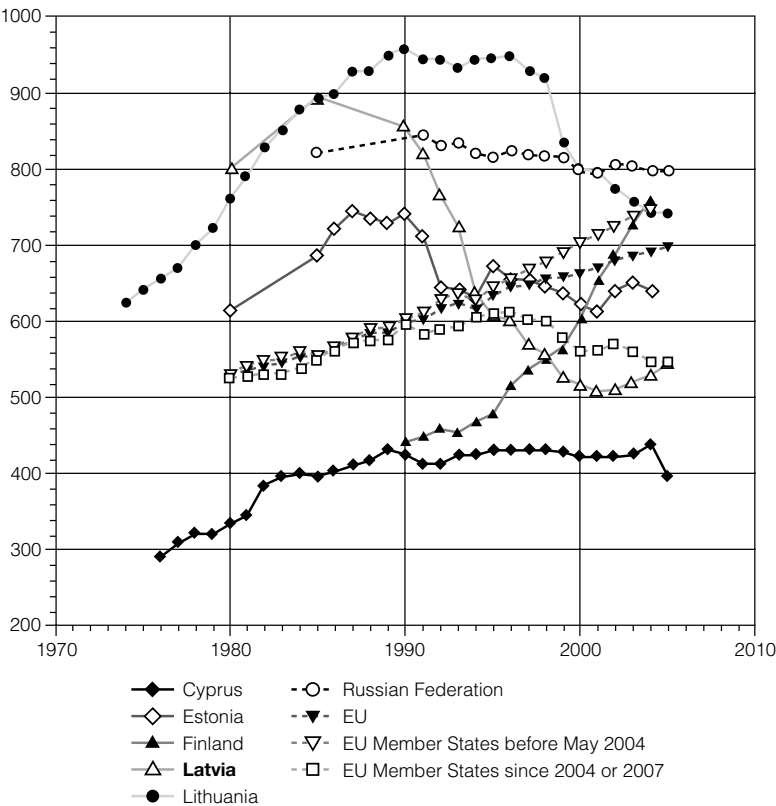


Source: WHO Regional Office for Europe 2007a.
Note: EU: European Union.

Table 5.4 and Fig. 5.7 demonstrate that the number of GPs has increased dramatically in Latvia in recent years, rising from 1.02 GPs per 100 000 population in 1991 up to 55.3 GPs per 100 000 population in 2005. This has been the result of deliberate efforts to provide retraining opportunities for doctors who wish to become family practitioners as part of the process of building a PHC system. However, in comparison with other countries and averages, as shown in Fig. 5.7, the number of GPs in Latvia is half of the EU15 average (102.7 GPs per 100 000 population in 2004) and significantly less on average than the EU12 countries (70.5 GPs per 100 000 population in 2005).

Figure 5.8, showing nurse numbers, indicates the severe shortage of nurses in Latvia compared with other countries, which has been exacerbated by the decline in nursing personnel since 1991. In the period 1990–2001 the total number of nurses fell by 40% from 859.8 per 100 000 population in 1990

Fig. 5.8 Nurses per 100 000 population in Latvia, selected countries and averages, 1980–2005



Source: WHO Regional Office for Europe 2007a.

Note: EU: European Union.

to 507.6 per 100 000 population in 2001. Since then, there has been a slight but steady increase, with the number of nurses reaching 544.5 per 100 000 population in 2005, the same as average number for the EU12. However, in 2005 Latvia's nurse numbers per population were lower than the averages for the EU Member States (699.7 nurses per 100 000 population). This suggests that physicians assume some part of nurses' duties, influencing both the quality of physicians' work and the care of patients. It is estimated that there is a shortage of approximately 3000 nurses in Latvia (HSM TSA database 2007 [unpublished data]). A total of 99% of nurses are women. They are forced to work extra hours due to low salaries, and many are employed elsewhere simultaneously.

As a result of the severe nursing shortages, the ratio of nurses to physicians is very low, at 1 to 9. This can be seen in Fig. 5.9, showing nurse and physician numbers in relation to each other for Latvia and a range of countries.

Figure 5.10 shows numbers of dentists per population in the WHO European Region. The number of dentists in Latvia has increased significantly since the early 1990s, and in 2005 there were 63 dentists per 100 000 population, which is higher than the EU average (61 dentists per 100 000 population) (WHO Regional Office for Europe 2007a).

In 2005, there were 1485 pharmacists and 1613 pharmacists' assistants in Latvia. The number of pharmacists is roughly constant, and is considered to be sufficient to meet the country's needs at the time of writing (HSMTSA database 2007 [unpublished data]).

Planning health care personnel

The HSMTSA maintains a register of all doctors, nurses, midwives, doctors' assistants and dentists. The legal basis for registration was established in October 2005 by "Regulations of the Cabinet of Ministers on Establishment, Fulfilment and Maintenance of the Medical Persons Register", which stipulate that all health sector workers should report to the Register within one month following initiation of their health care provision activities.

Demand for health care personnel, including doctors, is analysed by the Medical Professional Education Centre (a public body under supervision of the Ministry of Health). In accordance with the statutes of this Centre, which have been approved by Regulations of the Cabinet of Ministers "Concept Paper on Human Resources in Health Care" (in force since February 2005), it is responsible for planning and organizing further education, including specialization of medical professionals, as well as fulfilment of professional qualifications. The distribution of residents is also the responsibility of this Centre.

Professional associations deal with the training and planning of their respective specializations. There is no agency at state level that is involved in planning and organization of training for chief doctors, directors of hospitals, heads of health care institutions or high-level specialists. This function is undertaken partly by the Association of Management Experts of Health Care, a public organization that does not engage in planning, but rather is involved in organizing particular courses that can be pursued by its members for the purpose of improving their managerial capabilities. Courses are offered by the Stradins University Postgraduate Training Faculty, as well as the Faculty of Management at the Riga International College of Economics and Business Administration. These courses are financed privately.

Local governments are more directly involved in planning of the number of chiefs or directors of health care institutions under their ownership and within their own territories.

Fig. 5.9 Number of physicians and nurses per 100 000 population in the WHO European region, latest available year

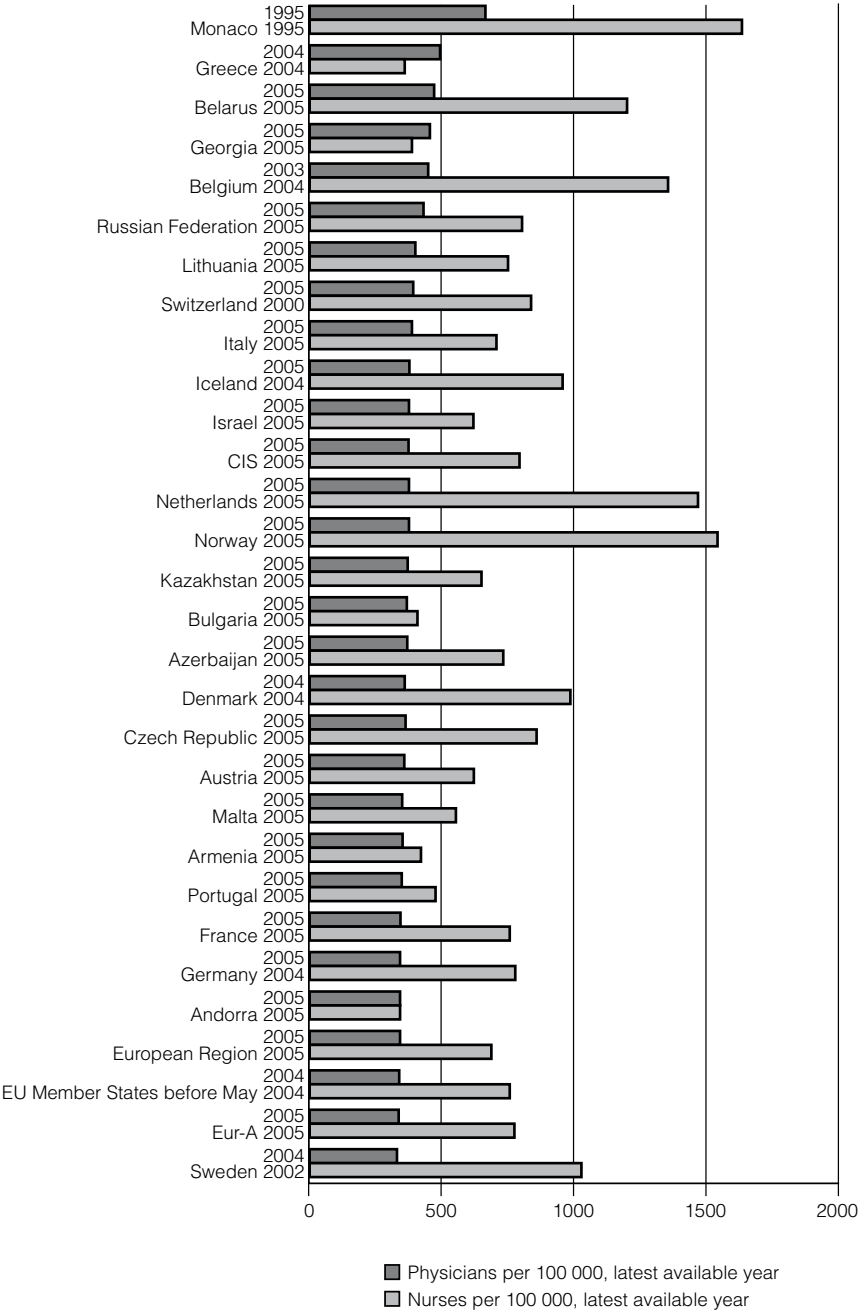
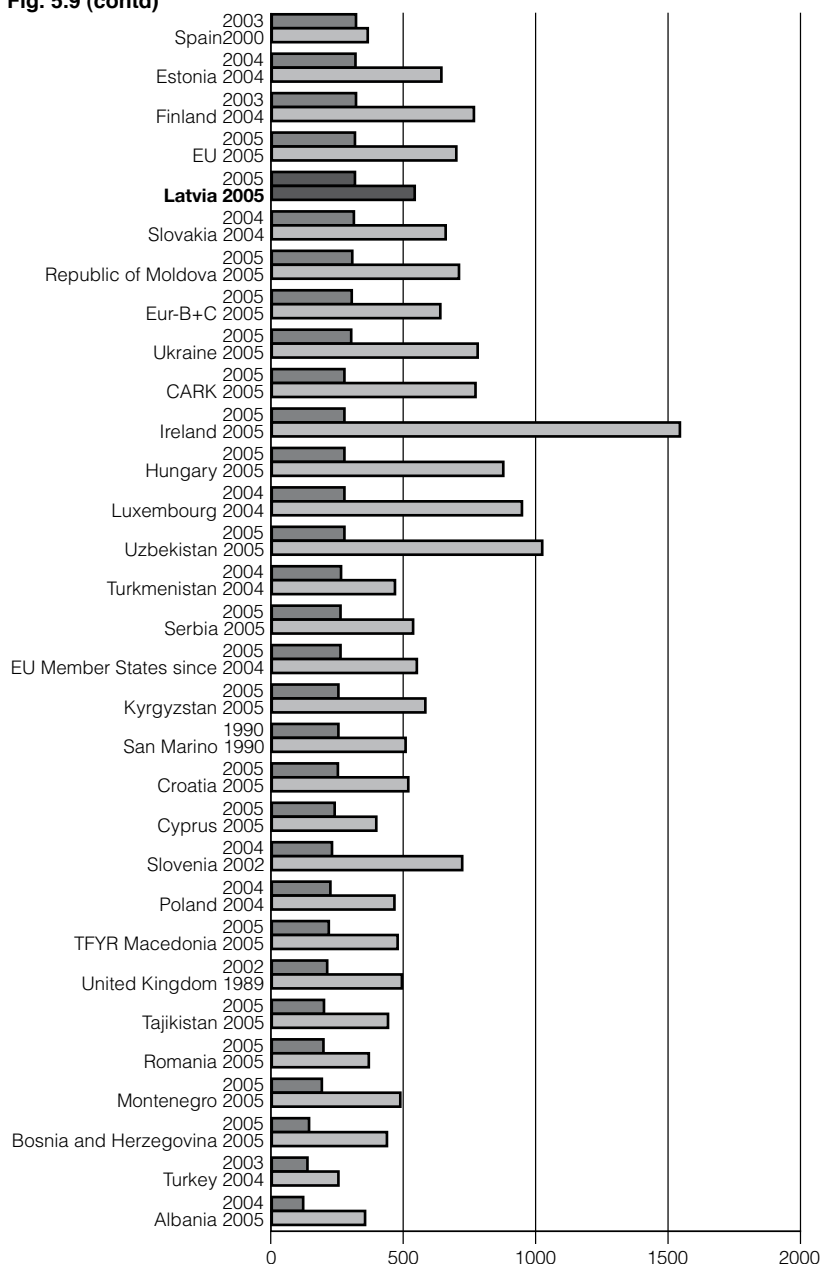
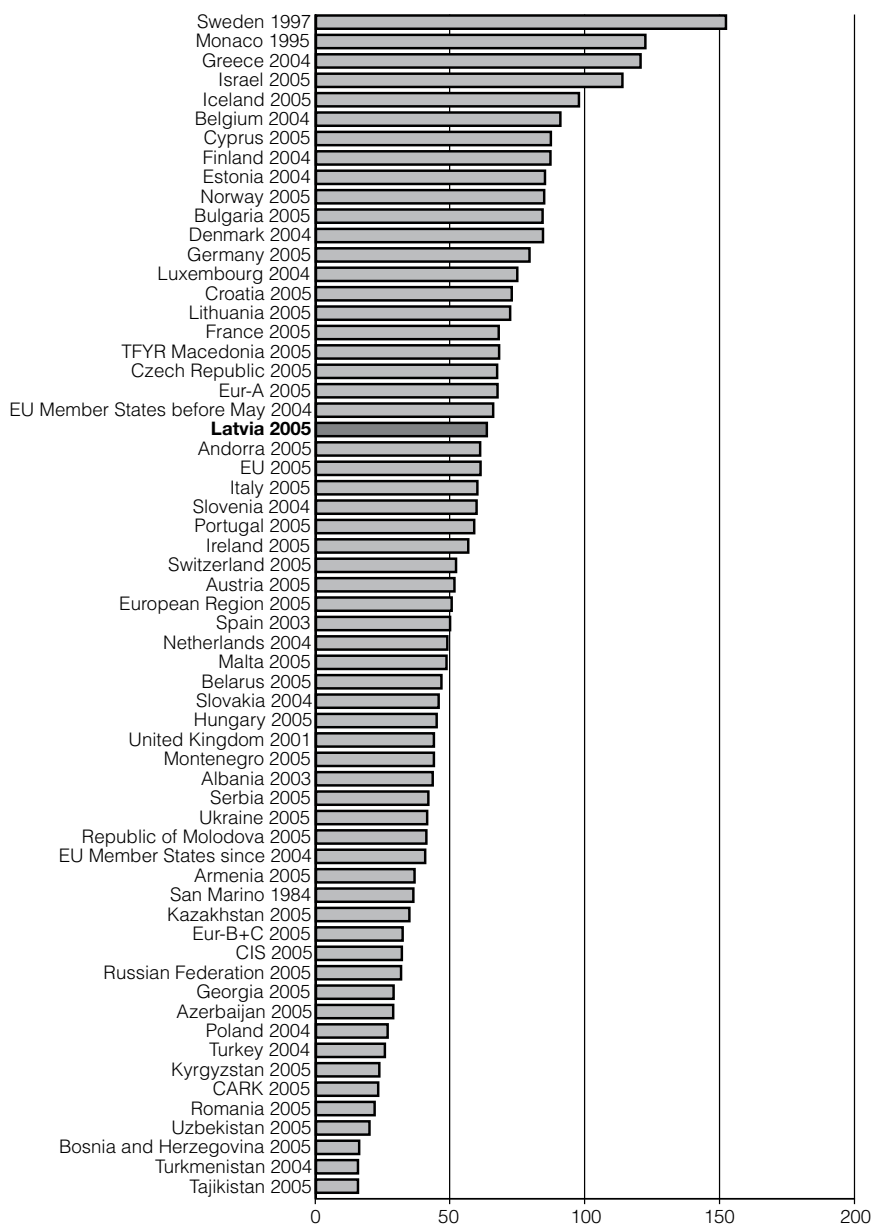


Fig. 5.9 (contd)



Source: WHO Regional Office for Europe 2007a.

Notes: CIS: Commonwealth of Independent States; EU: European Union; Eur-A: WHO pre-calculated indicator based on data from 27 countries in western, southern, central and northern Europe; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; CARK: Central Asian republics plus Kazakhstan; TFYR Macedonia: The former Yugoslav Republic of Macedonia.

Fig. 5.10 Number of dentists per 100 000 population in countries of the EU, latest available year

Source: WHO Regional Office for Europe 2007a.

Notes: EU: European Union; TFYR Macedonia: The former Yugoslav Republic of Macedonia; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; CIS: Commonwealth of Independent States; CAR: Central Asian republics plus Kazakhstan.

There are a number of problems in the area of human resources employed in the health sector in Latvia, resulting from the lack of a proper human resource policy. The most significant problems are detailed here (Karaskevica & Maurina 2005).

- Shortage of physicians and medical professionals with secondary education. This has been worsened by the emigration of specialists to other EU Member States. Consequences include restricted access to health care services as well as low quality of services. Every year approximately 300–400 physicians leave their job (due to retirement, emigration, or well-paid jobs in other sectors, such as the pharmaceutical industry), while only 100 new physicians begin such work annually. In the period from 1 May 2004 to 4 October 2005, the Physicians Association of Latvia prepared necessary documents for 217 physicians who wanted to work abroad (i.e. 2.2% of the total number of physicians).
- The average age of physicians and other medical professionals is increasing. In April 2005 the average age of primary care physicians was 48.8 years.
- The educational system does not meet the growing needs of the health care system and the development of human resources in this sector.
- There is no long-term programme for human resources renewal.
- Low salaries of medical staff and lack of social guarantees do little to promote recruitment of medical staff.
- Prestige in the sector is low. Work has become more time-consuming and the amount of paperwork has increased. Health care workers find it difficult to adapt to frequent reforms and changes of health policy. Moreover, they get neither moral nor material satisfaction from their work.

These problems have led to social conflicts among health care workers. Insufficient funding of the health sector is associated with low incomes, overtime, and inappropriate working conditions.

Dissatisfaction arises from social comparisons, revealing an inconsistency between the real situation and expectations. The Union of Medical and Social Workers of Latvia has organized several strikes and protest activities since 1994. It is likely that these have contributed to the Government's search for solutions (Karaskevica & Maurina 2005).

Several policy documents have been adopted concerning planning of human resources and improvement of the current situation, as described here.

- The "Programme of Development of Primary and Hospital Care Services for 2005–2010" forming the basis of the Master Plan was adopted by the Cabinet of Ministers in 2004, and is intended to restructure health services provision with a view to ensuring access to high-quality health care and effective

utilization of resources. Inpatient care is to be centralized in large units, while outpatient care services are to be closer to the patient (decentralized) (Section 4.2 *Planning and health information management*).

- The “Basic Statement on Development of Human Resources for Health Care” was adopted by the Cabinet of Ministers in 2005. This document delineates the Government’s policy aiming to provide the health system with qualified staff over the period 2005–2015. The policy envisages the adoption of standards of hospital beds and patients per physician by specialty in hospitals, as well as the number of hospital patients per nurse post.

Planning of human resources is based on the optimization of the network of health care institutions (the number and location of primary care practices, secondary care service providers and tertiary care providers, all in accordance with the Master Plan), namely calculating how many and what kind of specialists are necessary in each territory and across the entire country. It has been calculated that by 2007 (Karaskevica and Maurina 2005), the countrywide requirement will be for 8050 doctors, including 3763 within hospitals, 2476 doctors for secondary care, 1362 for primary care and 600 doctors for urgent medical assistance prior to hospitalization. By 2010, it is estimated that 8461 doctors will be needed.

Planning of social assistance staff is the responsibility of the Department of Social Assistance of the Ministry of Welfare. For the promotion of professional social work, the Ministry of Welfare worked out a programme in 2005 that was approved by the Cabinet of Ministers on the “Programme of the Development of Professional Social Work for 2005–2011” (June 2005). The programme is oriented towards providing state support for education and training of social work specialists from financial resources provided by the European Social Fund, as well as towards providing partial financing of salaries for social workers working with families and children within the social offices of municipalities. The programme also plans to support research in the field of further education of social work and assessment of the quality of services, as well as financial support for projects aimed at the development of municipal social services oriented towards social groups that face social exclusion risks.

The issue of improvement of professional qualifications of social work specialists is regulated by the “Regulations of the Cabinet of Ministers on Requirements for the Providers of Social Services” (2003). These Regulations define conditions for the systematic improvement of social work specialists’ qualification. In 2004, 176 social workers (569 in 2005) attended the courses for professional development within the social work field.

Training of health care personnel

According to legislation on “Regulated Professions and Recognition of Professional Qualifications” (2003, with amendments in 2004), the diploma at the highest level of education, which is received within an accredited full-time programme of studies of medicine, as well as the certificate of professional qualification and approval in the Register of Medical Persons, is a basic requirement for proof of one’s medical qualifications, for the right to work within the doctor’s profession and for the right to practise within a particular specialty.

The minimum duration of studies to receive the diploma at the highest level of medical education is six years for medical doctors. Dentistry requires a full-time accredited study programme, the duration of which is five years. Entrants must have completed 12 years of school education.

The education and training of health care personnel is provided by two of the highest educational institutions in Latvia: Riga Stradins University, which is under the supervision of the Ministry of Health; and the Latvia University Faculty of Medicine, under the supervision of the Ministry of Education and Science. Both educational institutions are located in Riga.

After receiving the diploma, the doctor must continue studies within one of the doctor specialties in residency. The duration differs according to specialty, but on average it is three years. If a doctor wants to gain the right to practise medicine, s/he must obtain the certificate of professional qualification.

There are no estimates in Latvia concerning either the number of doctors who are educated in other countries or in which other countries. This information may be included in the Register of Medical Persons if it is submitted by the doctors themselves. It is estimated that generally only a few doctors study abroad.

Certification of doctors is delegated to doctors’ professional organizations. Every specialty has its own statutes, which define what types of skills are required and the minimum duration for postgraduate studies. These statutes have until now been approved by the Ministry of Health, but this is to change as they will begin to be approved by Regulations of the Cabinet of Ministers (“Concept Paper on Human Resources in Health Care”) as of 2006. These Regulations will determine the certified person’s responsibilities within the respective specialty. In accordance with these Regulations, the responsibility for improvement of professional qualifications lies with the individual medical doctor.

The statutes regarding certification and re-certification are defined by “Regulations of the Cabinet of Ministers on Certification of Treatment Persons” (in force since 1997). The Regulations specify that certification and re-certification are the responsibility of the Latvian Physicians Association and

the Latvian Nurses Association. These associations determine the schedules for certification examinations, inform health care personnel about certification requirements, establish commissions for certification examinations, organize the examinations, and carry out the certification and re-certification. The associations are also responsible for publishing the list of certificated individuals in a separate publication or in the press.

Re-certification takes place every five years. The requirements of re-certification are the same for all doctors and do not depend on the type of health care institution in which the doctor works. For more information on certification, see Section 4.1 *Regulation*, Subsection *Regulation and governance of providers*.

The right to work as a nurse is conferred by the diploma of secondary professional education or diploma for the first stage of the highest level of professional education (i.e. the first university degree), which provides theoretical and practical preparation; alternatively, one may further obtain a diploma at the highest level of education of accredited nursing studies (one level higher than the previous professional qualification). The right to undertake independent professional activities is conferred by the certificate of professional qualification and approval within the Register of Medical Persons, maintained by the HSMTSA.

The minimum duration of the nursing education programme is either:

- three years within the nursing school or college of medicine; of which 1/3 of the time is devoted to theoretical studies, and at least 1/2 of the total duration of studies is devoted to practical studies; or
- four years within the university after graduating from secondary school.

Education of nurses, midwives, doctor's assistants, etc. in Latvia can be obtained in three institutions, in Riga, Daugavpils and Liepaja.

The Faculty of Nursing was established in Riga Stradins University in 1990 and offers a 4-year degree course in nursing. It is intended that university-educated nurses work as head nurses in hospitals and specialized wards. There is a 9-month training course leading to qualification for auxiliary nurses (nursing assistants).

The duration of studies for midwives is the same. If the midwives' programme of education is begun after finishing the nursing educational programme, the minimum duration is 18 months.

Pharmacists receive their education in the Faculties of Pharmacy within the Riga Stradins University and University of Latvia. Every year Riga Stradins University enrolls 36 state-financed students and, following five years of study, the student receives a Bachelor's Degree in pharmacy. Within the University of

Latvia students have to pay for their studies. The Bachelor's Degree is received after three years of study, and the Master's Degree after two additional years. Pharmacist's assistants are educated within the schools of medicine and study for one year and 10 months.

The requirements for the education of pharmacists and their assistants are defined by legislation and regulations. The "Law on Pharmaceutical Activities" (1998, with numerous subsequent amendments) specifies that:

1. A pharmacy shall be managed by a responsible manager who will be liable for its work and who has obtained a professional pharmacist certificate, or, in relation to veterinary pharmacies, a special permit (licence) to distribute veterinary medicinal products.
2. A pharmacist and pharmacist's assistant who work in a pharmacy shall:
 - be registered with the Latvian Pharmacists Association according to procedures specified by the Cabinet of Ministers
 - observe the ethics code approved by the Pharmacists' Society of Latvia; and
 - improve professional qualifications by taking part in the continuing education process recognized by the Pharmacists' Society of Latvia.

The Latvian Pharmacists Association began the registration of pharmacists and their assistants who work in pharmacies in 2004. There were 1485 pharmacists and 1613 pharmacist's assistants in 2005. The number of pharmacists is roughly constant and is considered to be sufficient at the time of writing. The Pharmaceuticals Department of the Ministry of Health assesses the number of pharmacists on a regular basis.

The field of public health is comparatively new in Latvia and only in 1998 did Riga Stradins University begin professional programmes of study leading to degrees for public health specialists.

The target of the programme of studies is to train specialists in public health to observe and evaluate public health conditions, the physical and social environment, to discover and analyse health risk factors and possibilities to lower those risks, to clarify public health needs and priorities, to participate in the promotion and strengthening of public health policy, to organize and evaluate public health services, and to promote the development of intersectoral cooperation.

The length of this programme of studies is four years. Every year, approximately 15–20 students graduate. The graduates may continue their studies in Riga Stradins University in a 2-year programme of health sciences (obtaining a Master's Degree), after which they may opt to continue further, undertaking a doctoral programme.

Public health specialists can work in different fields in both the public and private sectors, including:

- the Ministry of Health and Ministry of Welfare;
- institutions under the supervision of the abovementioned ministries, such as the HSM TSA, the SCHIA, the State Health Promotion Agency, the State Social Insurance Agency, the State Labour Inspectorate, the State Sanitary Inspectorate, the Food and Veterinary Service, etc.;
- private enterprises involved with labour safety, etc.

However, not all graduates find jobs in the health care sector upon graduation.

In the area of health care managers, there is no state-level agency that deals with planning and education. According to formal statistical data, in 2005 there were 152 health care managers employed in the health sector, compared to 191 in 2004. Only health care managers who are certified as medical doctors, or who have some other qualifications (as lawyers, economists, etc.) are recorded as such. The number of managerial staff shows a declining tendency because of the fall in the number of hospitals, while large ambulatory institutions are being converted into doctors' practices.

Complementary and alternative medicine practitioners are considered to belong to additional specialties, whose educational requirements are dealt with by a professional organization, known as the Association of Holistic Medicine and Naturopathy. By instruction of the Ministry of Health, this Association has the right to educate these specialists. For example, the Association has educated approximately 120 acupuncture specialists in an educational programme that is accredited by the corresponding international federation. The services provided by these specialties are not included within statutory health care provision. Within the Register of Medical Persons 80 doctors are recorded to possess a certificate to practise acupuncture, although only 55 of them work in this specialty, of whom 48 are located in Riga. Further, there are 78 registered homeopaths, 42 algologists and 15 hypnotherapy specialists. These are medical doctors who, in addition to their basic specialty, have registered themselves as specialists in a branch of alternative or complementary medicine. It is possible that this practice lends prestige to the position of doctor of conventional medicine.

Social workers in Latvia are trained in a 4-year programme leading to a professional university degree, while a Bachelor's Degree is two years for social care workers. Training takes place in the following educational institutions: the University of Latvia, Riga Stradins University, the Pedagogic Academy of Liepaja, and the University of Social Work and Social Pedagogy "Attistiba". This university also has branches in Daugavpils, Rezekne and Smiltene.

All educational programmes are accredited. Social care professionals are taught in P. Stradins Health and Social Care College and in Daugavpils College of Medicine. The duration of studies is two years.

Continuing professional development of health care practitioners can be undertaken under their own initiative and expense. To work as an independent practitioner, it is necessary to receive certification and re-certification as described above. Re-certification takes place every five years and depends upon successfully undertaking and passing specific courses organized by the professional associations. The courses are offered in the Institute of Post-Graduate Education of Medicine, University of Latvia or on the premises of particular departments of multi-profile hospitals.

Regarding educational standards, within the Riga Stradins University and Faculty of Medicine of the University of Latvia, all programmes of study are accredited by the Ministry of Education and Science. The minimum requirements for a doctor's professional qualifications are defined 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 professional qualifications of dentists, pharmacists, nurses and midwives are defined by the "Regulations of the Cabinet of Ministers on the Minimum Requirements of Educational Programmes for Dentists, Pharmacists, Nurses and Midwives Professional Qualification" (in force since February 2002).

The programmes of the different courses are worked out by the respective professional associations and are approved within joint meetings of the associations. There are no differences between public or private institutions in the training requirements for health professionals.

Registration/licensing

Article 26 of the "Law on Medical Treatment" (1997) determines that only approved and certificated health care practitioners can provide health care services independently and in accordance with their respective competency.

Health care practitioners are entered into the unified nationwide information system, the Register of Medical Persons, in accordance with the Rules of the Cabinet of Ministers on the "Establishment, Fulfilment and Maintenance of the Register of Medical Persons" (in force since October 2005). This Register is maintained by the HSM TSA, and the Centre of Professional Education of Medicine.

Health care practitioners receive the registration certificate of a "Treatment Person", which is proof that the individual has been entered into the Register.

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 her/his own registration number. To receive the registration certificate, the practitioner must provide proof of identity and documents proving level of education.

Due to low doctor numbers and consequent shortages within Latvia, it is difficult to speak about the prevalence of any particular specialty, especially if consideration is given to the large number of doctors expected to retire in the next few years, as mentioned earlier.

Training of health professionals is to conform with EU standards for mutual recognition. Latvians are free to live and work in any EU country without restrictions.

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. Each young doctor begins work as a specialist within an institution, following which there are possibilities 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. Decisions involving the director or deputy director of the institution are made by the respective local government, based on 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.

There are no data regarding the frequency and the nature of job changes in the health sector.

6. Provision of services

6.1 Public health

Public health is a very broad area of organized social effort to restore, preserve and promote health within populations. From the point of view of this broad perspective, any activity, including medical care, disease surveillance and control, control of the health-related environment, health promotion, health system management, financing and many other areas can be considered as part of public health. This leads to a variety of interpretations of the content of public health in different countries, which in most cases is based on historic developments and traditions. In the beginning of the 1990s, upon independence, Latvia, like many other post-communist countries, faced the problem of understanding and using the term “public health”, which did not exist in the Latvian language. The term widely used in the former Soviet period for the health and health care system was “health defence” (coming from the Russian *zdravohranenie*) and included all the functions related to the “Ministry of Health Defence” of that time.

Since the early 1990s Latvia has created, developed and is continuing to improve upon the concept of modern public health, partly through the establishment of appropriate specialized public health education programmes (at Bachelor’s and Master’s levels), as well as through the evolution of old and establishment of new public health institutions.

In the area of education, both Bachelor’s and Master’s programmes are offered at the Faculty of Public Health of the Riga Stradins University. Every year approximately 40 students are awarded Bachelor’s Degrees and

approximately 10–15 students complete the Master's programme. Upon graduation, most graduates are employed by government agencies and centres whose functions are related to the health of the population, such as the Public Health Agency, the HSMTSA and the Food and Veterinary Service (under the Ministry of Agriculture).

The Bachelor's programme is oriented towards the needs of practice, while the Master's programme is oriented towards research. In addition, a course in Public Health and Epidemiology has been included in the curricula of any health-related study programme of different faculties in the areas of medicine, pharmacy, academic nursing, rehabilitation, etc.

One of the main tasks of a public health system is the control of infectious diseases. During the Soviet period, institutions called Sanitary Epidemiological (sanepid) Stations were in charge of this area. At the beginning of the 1990s these former stations were first renamed "environmental health centres" and later "public health centres", which have now been united in one Public Health Agency with its 10 territorial branches. The main function of the sanepid stations was epidemiological surveillance and control of infectious diseases (in some countries called field epidemiology), as well as surveillance of safety of the physical environment. Later, some functions like sanitary inspection and sanitary border inspection were separated from the control functions. A new institution, the State Sanitary Inspectorate, was created with the intention of separating control functions (inspection and regulation) that remained with the Public Health Agency from "police" functions that were transferred to the new agency. This separation has created some confusion over the respective roles and responsibilities of the two agencies, and the split has received some criticism. The main tasks of the Public Health Agency include investigating outbreaks, gathering case reports from service providers, planning vaccinations and reporting the results. At the time of writing, there are plans to restructure the state agencies; however, as yet nothing has been officially declared.

At the time of writing, control and regulation of food production and supply, sanitary border inspection, as well as all public laboratory services (with the exception of the Laboratory of Virology, which is a unit under the direction of the Department of Public Health) are the responsibility of the Food and Veterinary Service within the Ministry of Agriculture.

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

- "Law on Epidemiological Safety" (1997), the purpose of which is to regulate epidemiological safety and specify the rights and duties of state authorities, local governments, and natural and legal persons in the field of epidemiological safety, as well as to determine liabilities in the

event of violation of this Law. Epidemiological safety includes 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), which specifies notification procedures in the event of an outbreak of an infectious disease.
- “Procedure of Epidemiological Surveillance of Infectious Diseases” (Order of the Ministry of Welfare, 2001), including documents of a technical character specifying details of epidemiological surveillance of infectious diseases.

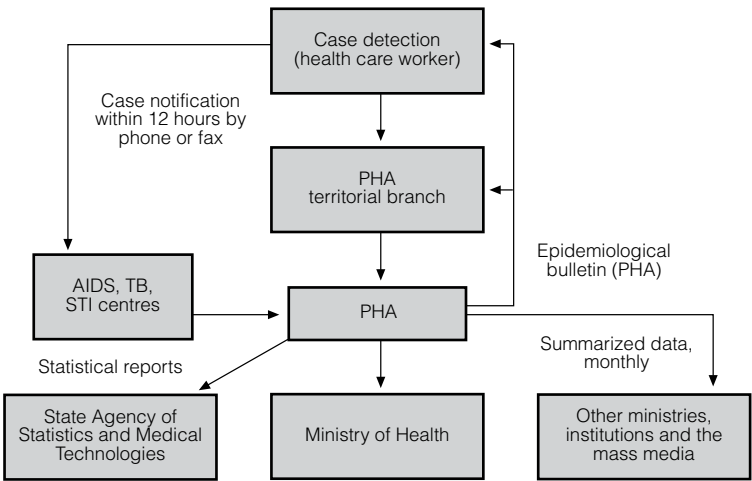
Communicable disease surveillance has been adapted to the requirements of the EU, and notification of infectious diseases is required to the European Centre of Disease Control in Stockholm. PHC services are key elements for the notification of communicable diseases. The notification flowchart in Fig. 6.1 shows that cases are reported to the Public Health Agency by health care service providers. AIDS patients and HIV-positive individuals, as well as patients with TB and STI are first reported to the institutions responsible for the control of these diseases.

The Epidemiological bulletin is prepared by the Public Health Agency.

Legislation obliges immediate notification of:

- a single suspected case of a dangerous infectious disease (cholera, anthrax, plague, yellow fever, Ebola, Lassa, Marburg and other haemorrhagic fevers,

Fig. 6.1 Notification system for communicable diseases



Source: Authors’ own compilation.

Notes: PHA: Public Health Agency; AIDS: Acquired immune deficiency syndrome; TB: Tuberculosis; STI: Sexually transmitted infection.

- 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 non-epidemic season), viral meningitis, encephalitis; serious (hospitalized) cases without clear aetiology of the disease;
 - suspicion of quarantine diseases at state borders;
 - two or more cases of adverse events following immunization.

Another task of the Public Health Agency is surveillance of immunization. The state Programme of Immunization is based on WHO guidelines. Vaccinations provided free of charge in Latvia include those:

- for children – against TB, diphtheria, tetanus, pertussis, poliomyelitis, measles, rubella, mumps, infection of *Haemophilus influenza*, hepatitis B, tick-borne encephalitis (in selected regions);
- for adults – diphtheria, tetanus (with specific indications), influenza (specific age and high-risk groups).

The immunization level for children is on average approximately 95–98%. Vaccinations are provided by family doctors, paediatricians and doctor's assistants at the PHC level.

There are two special, population-based screening programmes: one is for neonates, to detect congenital phenylketonuria and hypothyroidism, and the other is a screening programme for pregnant women. These are financed by the SCHIA, and positive findings are reported to the Children's Hospital. This hospital used to run the relevant registry, but at present all the registries are under the management and financing of the State Medical Statistics Agency. Oncology screening results are reported to state Oncology Centre (at the Riga East Hospital, which formerly used to run the onco-register).

The rest of the population undertakes opportunistic screening. Public financing covers several cancer screening tests depending on one's sex and age group, including: oncologic-cytologic smears, mammography, examination of feces for hidden blood, prostatic specific antigen, etc. Unfortunately, this opportunistic cancer screening does not appear to be effective, as the number of patients with cancer diagnosis at a late stage is growing in the country.

The leading governmental organization in the area of health promotion up to the year 2007 was the State Agency of Health Promotion. This Agency supported the Ministry of Health in its efforts to implement health promotion policy. It participated in the development of health promotion programmes and led their implementation at national and regional levels. At the time of writing the State Health Promotion Agency is incorporated into the Public Health Agency, which is responsible, for example, for conducting the following programmes:

- Family Health Promotion
- Prevention of Cardiovascular Diseases
- Prevention of Psychoactive Drug and Gambling Dependence.

Programme implementation includes activities for the enactment of appropriate legislation, campaigning to inform and educate the population, preparing and distributing materials for professional education, and undertaking surveys. All such programmes are financed from the government budget.

The Family Health Promotion programme is concerned with:

- maternal and child health promotion
- breastfeeding promotion
- promotion of women's reproductive health
- promotion of men's reproductive health
- promotion of teenage reproductive health.

The Cardiovascular Disease Prevention programme is concerned with:

- reduction of cigarette smoking
- reduction of the number of people with increased body weight
- reduction of cholesterol levels
- increase of physical activity
- control of blood pressure
- reduction of alcohol abuse.

The programme on Prevention of Psychoactive Drug and Gambling Dependence is related to the National Drug Dependence Reduction Strategy, and the Health Promotion Agency coordinates its activities with the State Narcology Centre. All the above programmes and activities are coordinated with different corresponding international programmes of WHO, the EU and other international organizations.

The State Agency of Health Promotion has also been involved in a number of health education programmes. The Ministry of Education and Science has delegated responsibility to the Agency for educational work in kindergartens, schools and universities. Examples of educational programmes for teachers

include: Content and Methods of Health Education; Primary Prevention of Drug Dependence; Sex Education; and Mental Health. Latvia also participates in the WHO programme Healthy Schools.

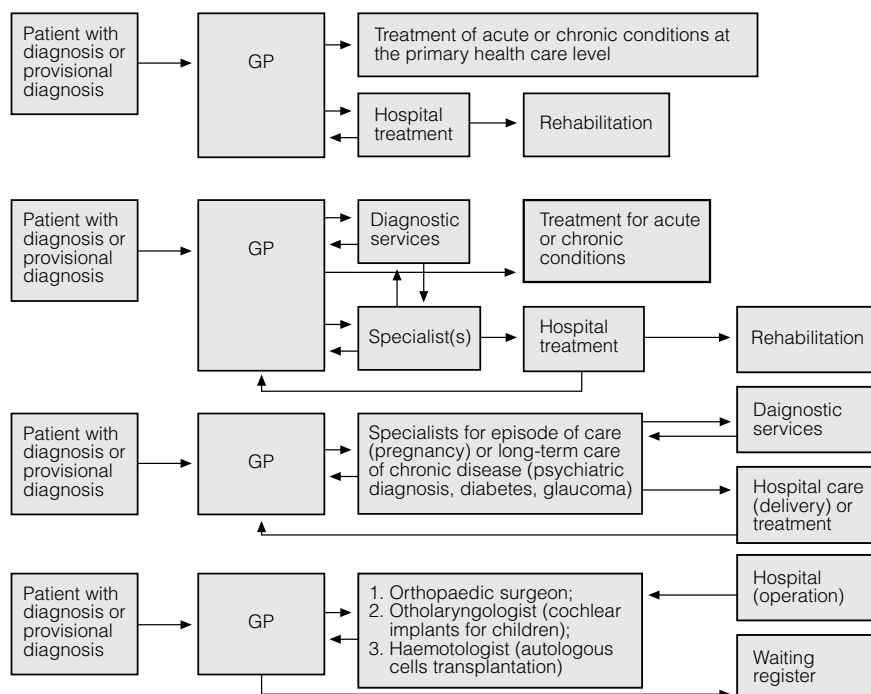
Key partners of the State Health Promotion Agency were NGOs and state and local government organizations outside the traditional health system. In addition to the Food and Veterinary Service mentioned earlier, other partners include the Road Traffic Safety Department of the Ministry of Traffic, which is an important participant in the fight against traffic injuries and death, as this is a significant problem influencing public health in Latvia. NGOs are often supported by external international funding, with mixed results as sometimes commercial interests lie behind the support.

The main strategic document for the development of public health in Latvia is the Public Health Strategy to the year 2010, accepted by the Government in 2001 and based on the corresponding “Health 21” document of the WHO Regional Office for Europe, with specific adjusted target indicators for Latvia. One of the stated aims of this strategy is the reduction of health inequalities among social groups in Latvia. The goal is to reduce inequality by 25% by the year 2010. This is a challenging task for the society of Latvia, as growing poverty is as yet an unsolved problem. The measures being undertaken in this regard are limited, as low-income groups face severe constraints in access to health care services as a result of increasing OOP payments (Section 3.4 *Revenue collection/sources of funds, Subsection Out-of-pocket payments*).

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 undertaken by employers. A research institute, the “Institute of Occupational and Environmental Health”, exists at Riga Stradins University.

At the time of writing there are no discussions or plans to undertake any changes in the public health system of Latvia.

The key public health problems (broadly defined) that remain in Latvia include relatively the short life expectancy, high morbidity, dissatisfaction of citizens with access to and quality of health care services, and the level of corruption in the health care system.

Fig. 6.2 Patient flow diagram

Source: Authors' own compilation.

Note: GP: General practitioner.

6.2 Patient pathways

Figure 6.2 shows examples of pathways that are the most common for patients using health care services paid for by the State. All pathways appearing in the diagram are described in detail in the “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004). These pathways are valid throughout the country, with no regional variations.

Key points in the patient pathways are listed here.

- The GP is gatekeeper to secondary ambulatory care.
- Primary care doctors, specialists of secondary ambulatory health care and EMA services can refer patients directly to the hospital.
- A patient with a referral can freely choose ambulatory care services and hospital treatment at medical institutions that are contracted by the SCHIA. In practice, free choice of health care services is limited by waiting lists for some types of specialists, diagnostic services and hospitals. Sometimes the patient's choice is made depending on the level of patient fee or distance to

the service from the place of residence. Rural populations are more strongly affected by limitations.

- A patient can go directly to:
 - o a psychiatrist, if the individual has mental illness;
 - o a specialist of mental health, if the individual is drug addicted, alcohol addicted, and/or psychotropic substances addicted;
 - o a TB specialist, if the individual has TB;
 - o a specialist in skin diseases and STIs, if the individual has (an) STI(s);
 - o an endocrinologist, if the individual has diabetes;
 - o an oncologist, if the individual has cancer.

Guidelines exist for GPs and specialists, which are for the most part clinical, determining the need for the type of ambulatory specialist or hospital care.

Weak points in patient pathways mainly involve waiting times for certain kinds of services, as detailed here.

- Waiting time in secondary ambulatory care for some diagnostic services (MRI: 24 weeks) and specialists (highly qualified).
- Waiting time in secondary inpatient care (invasive cardiology: 35 weeks, ophthalmology (cataract): 34 weeks).
- Long waiting time in orthopaedic waiting register (Table 6.1).
- Availability of rehabilitation services.
- Patient information: pathway brochures and leaflets for patients and families are available with information on how to receive statutory health care services and on patient fees; in addition, there is a free-of-charge information line (80001234) and GPs are obliged to provide information on health care. However, there is a lack of sufficient information on patient pathways as general guidelines of care for common illnesses and injuries, indicating what events are likely to take place during and after a hospital stay.

Table 6.1 Waiting register, 2005

Waiting register (WR)	Number of patients on 1 January 2005	Joined WR in 2005	Received surgical treatment in 2005	Left WR for other reasons in 2005	Number of patients on 1 January 2006
Orthopaedic:					
1. Hip replacement	5224	2256	1047	566	5867
2. Knee replacement	5807	2034	654	320	6867
3. Shoulder replacement	12	13	3	n/a	22
Cochlear implants for children	31	27	49	4	5

Source: SCHIA 2006.

Note: n/a: Not available.

6.3 Primary/ambulatory care

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

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

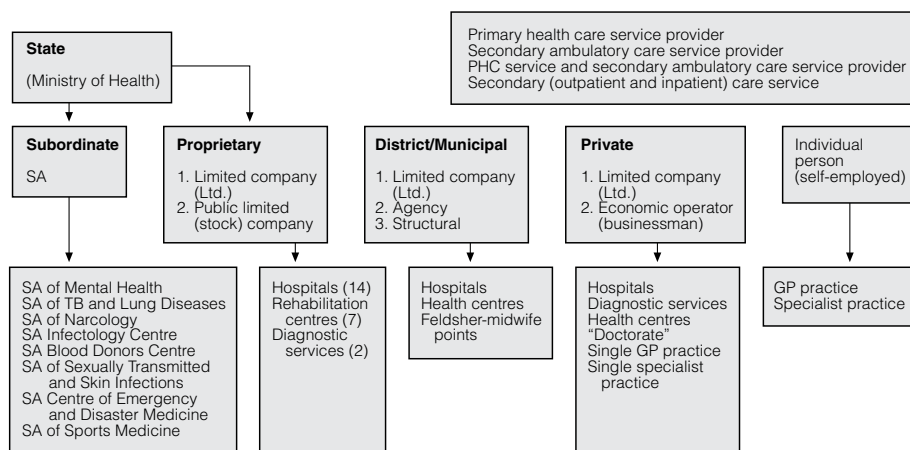
The PHC system that was envisaged at the outset of the reforms has been in place for the most part since 1999. At the time of writing, the patient is required to make first contact with health services by visiting her/his family doctor, or to use emergency care (ambulance service or hospital emergency clinics).

Institutional settings and types of institution

PHC and secondary ambulatory services available under the statutory system are provided in a variety of institutional settings and with a variety of types of property. Health care institutions by level of care and their corresponding type are depicted in Fig. 6.3, and the various PHC settings are discussed in the following sections.

Primary care practices

The bulk of services at the primary care level are provided by primary care practitioners (most of whom are GPs; see discussion later) who work independently, either as self-employed individuals or as private sector agents

Fig. 6.3 Institutions of health services by legal form

Source: Authors' own compilation.

Notes: PHC: Primary health care; SA: State Agency; TB: Tuberculosis; GP: General practitioner.

(Figure 6.3). 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 the premises and equipment of the practice are either privately owned or rented. Most primary care practitioners run such independent practices in rented facilities of former polyclinics owned by local governments. Under the category of “private” are limited companies, which are taxed as such. To provide services within the statutory system, each primary care practitioner, regardless of the type of institution within which s/he practises, concludes contracts with the SCHIA.

Health centres

Health centres are former polyclinics and occupational health service facilities in Riga (and other major cities) that were converted for use in primary care provision. Ownership may be either entirely public (local governments consisting of districts and municipalities), mixed between local governments and physicians themselves (i.e. a public–private arrangement), or they may be wholly private. Health centres employ GPs for primary care provision; in this case contracts are concluded between the health centre and the SCHIA. Health centres also provide secondary ambulatory care.

Doctorates

A “doctorate” was formerly the practice of a local internist (for adults) who was usually an unspecialized doctor, usually located in rural areas. Currently, the distinction between “doctorates” and single-GP practices (privately owned) is becoming increasingly blurred as the two are becoming largely indistinguishable.

Feldsher-midwife points

Some of these still exist as municipal/district health care institutions that provide services such as preventive care and care for the chronically ill, which is closely connected with the work of GPs who provide PHC services to patients living in rural areas.

To summarize, PHC providers may be either independent, self-employed practitioners, or may be directly employed by local governments or by health centres. In all cases, statutory care is provided through contracts with the SCHIA, which are carried out either directly (in the case of self-employed doctors) or through the health care institution at which the doctor is employed.

Table 6.2 provides two examples of the distribution of key primary care provider settings in two areas of Latvia, Vidzeme and Riga City. It can be seen that the overwhelming majority take the form of the “GP practice”, where the doctor is self-employed. GPs who are employed at health centres or hospitals choose this form as a matter of necessity, as a result of the expense of setting up an independent practice. GP practices that are limited companies are expected to increase in relative importance. While in a number of instances GPs work in the same premises, these are not considered to be group practices according to Latvian legislation, which considers each individual doctor to be working independently.

A similar distribution of legal forms of institution, with some variations, prevails in other regions and cities of Latvia. The larger towns (for example Latgale, Kurzeme and Zemgale) tend to have relatively more district/municipal health centres than other areas.

Primary health care providers

PHC is provided primarily by GPs in the role of family doctors. The specialty of GPs was only established in 1991. The number of certified GPs has increased sharply in recent years due to retraining courses for GPs that have become available since 1992. The overwhelming majority of GPs had been trained as specialists (i.e. not GPs) under the previous system and have retrained in recent

Table 6.2a Primary health care settings and legal forms, Vidzeme region**Vidzeme regional PHC setting**Area: 20 319 km² (Latvia 64 600 km²)

Population: 310 660 (Latvia 2.4 million)

Registered patients on GP lists: 297 042

Number of GPs: 192

Density: 15.3 people/km²

Legal forms of institution	GPs in towns (6000–29 000 inhabitants)	Rural GP	Total	
GP practice (self-employed)	83 doctors	86 doctors	169	Premises for GP practices in towns are rented from health centres, polyclinics or hospitals, and in rural areas from the local government; in some cases the premises are private. All practices are individual. The largest number of GPs practising at one address is 8 (in health centres) and 3 (in rural districts/municipalities) (note that these are not group practices, since according to legislation each GP is considered to be an independent self-employed individual).
Limited company (one person)	3 doctors	8 doctors	11	There is a growing interest in establishing limited companies, and it is expected that this legal form will grow.
Economic operator (one person)	2 doctors	5 doctors	7	
Limited company (municipal health centre)		1 doctor	1	All doctors are employees; this is not popular among GPs.
Limited company (municipal hospital)		4 doctors	4	All doctors are employees; this is not popular among GPs.
Total			192	

Source: Authors' own compilation.*Notes:* PHC: Primary health care; GP: General practitioner.

years. Certification for the relatively new specialty of GP is provided by the Latvian Physicians Association.

There are three categories of physicians who can qualify as PHC physicians or family doctors: GPs, internists and paediatricians. By 2004, 80% of primary care physicians were trained as GPs, 14% as internists and 6% as paediatricians.

Other health care personnel involved with PHC provision are feldshers, or doctors' assistants, who have mid-level medical education and more responsibilities than nurses; nurses, who may specialize as primary care nurses

Table 6.2b Primary health care settings and legal forms, Riga City**Riga City PHC setting**Area: 307 km²

Population: 731 800

Registered patients on GP lists: 678 000

Number of GPs: 427

Density: 2382 people/km²

Legal forms of institution	GPs	
GP practice (self-employed)	308 doctors	Premises for GP practices in towns are rented from health centres, polyclinics or hospitals; in some cases the premises are private. All practices are single. The largest number of GPs practising at one address is 18 (in health centres), but 5 on average; typically, there may be 2–3 at one address (note that these are not group practices, since according to legislation each GP is considered to be an independent self-employed individual). There are 15 GP practices at which a single individual works at one address.
Limited company (one person)	5 doctors	
Economic operator (one person)	8 doctors	
Limited company (municipal health centre, polyclinic) – 22 medical institutions	98 doctors	All doctors are employees. Being an employed GP is not popular; however, some are forced into this position due to the high costs of setting up an independent practice, especially in Riga. These are also not group practices according to legislation.
Limited company (2–4 GPs)	8 doctors	All doctors are employees. Being an employed GP is not popular; however, some are forced into this position due to the high costs of setting up an independent practice, especially in Riga. These are also not group practices according to legislation.
Total	427	

Source: Authors' own compilation.*Notes:* PHC: Primary health care; GP: General practitioner.

or public health nurses; midwives; and finally dentists, dental assistants, dental nurses and hygienists.

An initial objective had been to retrain feldshers and midwives to fulfil the role of public health nurses; however, this has not been realized to date.

Primary care physicians (family doctors) and dentists are typically self-employed, or they may work as employees in health centres. The remaining categories of health care personnel (feldshers, nurses, midwives, dental assistants, etc.) are employed by primary care physicians, dentists or health centres.

Range of services in primary care

Family doctors provide general health care for children, adults and elderly people (care of acute and chronic diseases), including outpatient surgical procedures, rehabilitation, pregnancy care, prenatal care, and emergency care; they prescribe medications, carry out diagnostic tests and engage in preventive work (immunization) and health promotion.

The roles of PHC nurses and feldshers (doctors' assistants) include:

- ensuring PHC services eight hours a day, five days a week in a doctor's practice
- assisting family doctors in treatment and preventive work with all groups of patients
- ensuring emergency care
- providing simple diagnostic tests (taking blood samples, etc.)
- providing health promotion activities.

Round-the-clock (24-hour) availability is not ensured by family doctors; they are available eight hours a day, five days a week. In emergency cases, the patient can receive emergency care 24-hours a day by EMA teams and hospital emergency departments (Section 6.5 *Emergency care*).

Patients with a referral from the family doctor can freely choose ambulatory care services at medical institutions (as long as these are contracted by the SCHIA).

The range of services provided under primary care has been determined by "Regulations for the Specialty of a Family Doctor (GP)" (November 1999). General provisions of this Regulation are detailed here:

The specialty of a family doctor (GP) shall be the basic specialty of medical persons where the physician provides primary health care – evaluates the patient's health, carries out diagnosis, and within the scope of his/her competence determines the required preventive and medical measures as well as the special examinations and involvement of other specialists in primary health care, if necessary.

The operational objective of a family doctor (GP) shall be to assist the patient in making the choice among the health care services available, providing for his/her ability to better physical, mental and social action as well as by maintaining the patient's health. The activities of the family doctor (GP) shall be mutually related to activities the objective of which is directly related to the provision of the medical assistance or indirectly – to ensure the circumstances for provision of the medical care.

The activities of the family doctor (GP) shall form the background of primary health care based on the following principles: free access, long-term and continuous care, comprehensive and coordinated care, significant doctor–patient relationship to improve the health and medical process. The activities of the family doctor shall be: health care of the patient and the people around him/her (his/her family), related to any other activities carried out in primary health care, related to the specialized health care, related to the social assistance area.

PHC for children under 18 years of age is provided by paediatricians or GPs. Pupils' health care (health promotion, immunization) is in part provided by local authorities that, depending on their budget, hire a physician or a practitioner with mid-level medical education to work in schools and kindergartens. The immunization programme is determined by regulations and is performed at PHC level by PHC paediatricians or GPs.

Dental care for young people under 18 years of age and those (18–27 years) called up for military service is statutorily financed. Victims of Chernobyl pay 50% of dental care expenditures. Others have to pay the costs themselves, with the exception of first-aid procedures and tertiary-level services (inherited facial and jaw conditions), as determined by the State (“Regulations of the Cabinet of Ministers on Organization and Financing of Health Care”, 2004). The types of dental services institutions are: 89% private, 11% state or local government. The State Dentistry Centre plans and coordinates dental care in Latvia.

A Maternal and Child Health Care Strategy in Latvia was approved in 2001.

Besides the PHC services that are statutorily financed and determined by the SCHIA, health centres also offer certain services for which patients must pay out of pocket (or through private health insurance), such as alternative therapy and cosmetic services, and certification of drivers and gun holders.

Patient choice and patient registration

Patients can freely choose their primary care physicians, but they can change their physician not more than twice per year (excluding change of address). In practice, only the inhabitants of urban areas have any real choice as there are too few physicians to choose among in rural areas. Primary care physicians (GPs, internists and paediatricians) perform a gatekeeper role. Without a referral the patient must pay OOP payments or through private health insurance, although exceptions are made for certain specialties and certain conditions (discussed later).

Family planning, obstetric care and prenatal care are provided mainly by gynaecologists and are considered to be secondary ambulatory care, but these can be visited without a referral from a primary care physician.

Prescription of some medications from the list of reimbursable pharmaceuticals may be carried out by some specialists (psychiatrists, endocrinologists, oncologists, nephrologists, neurologists, etc.).

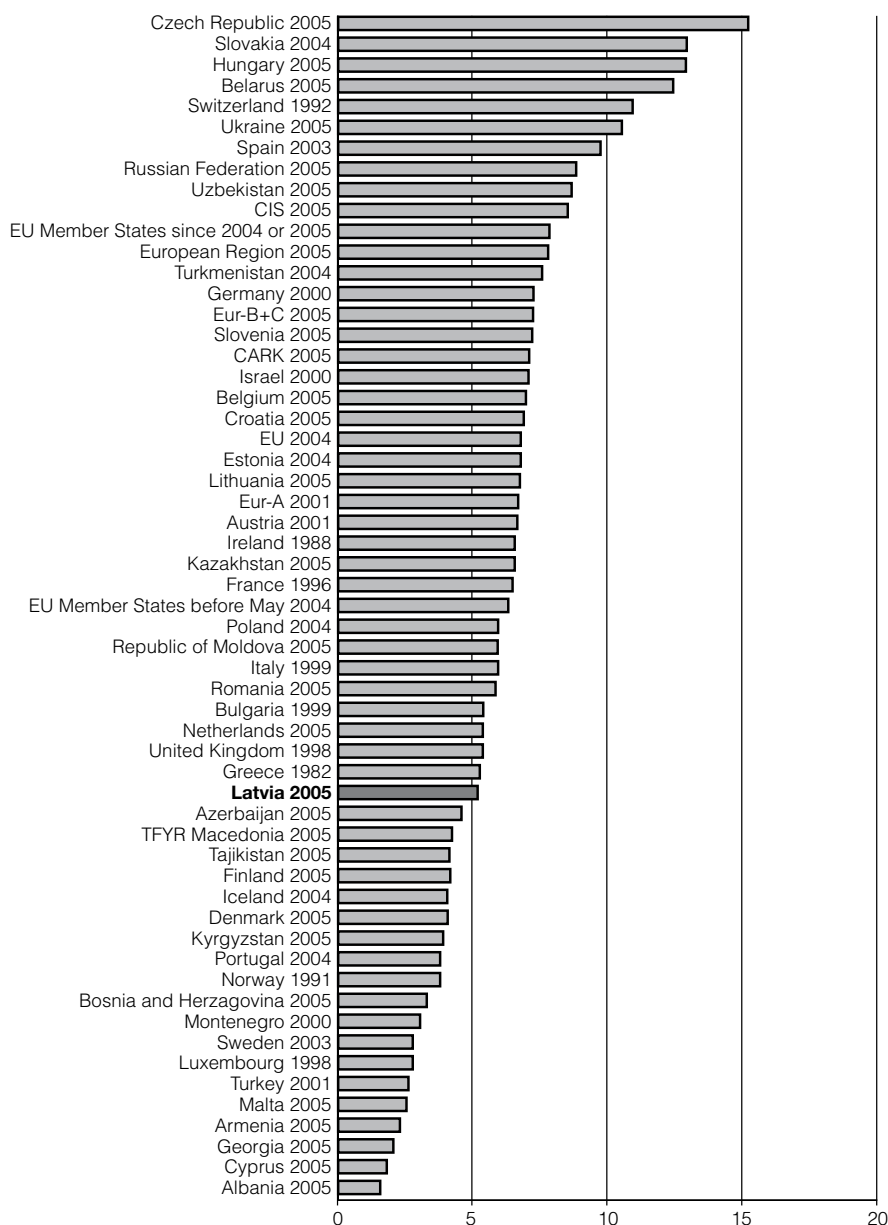
Patient registration with GPs (family doctors) began at the end of 1997. By the beginning of 2000, 80% of the population had been registered, and it was expected that patient registration would be completed by the end of 2000. By the end of 2005, 93% of the population was registered (SCHIA 2001; SCHIA 2006).

The required number of family physicians in Latvia is calculated on the basis of the average number of people to be registered per physician. The “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004) suggested that the indicator to be used for planning physician numbers in rural areas should be 1500 patients to one family physician, and 2000 to one in the cities. According to “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004), a GP can accept up to a maximum of 2000 patients. However, this number is often exceeded. For example, a GP is compelled to accept a patient if the patient is in the GP’s catchment area, or if the new patient has a close relationship with a patient that is already registered (for example through marriage). In practice, GPs can sometimes have up to 3000 registered patients.

Figure 6.4, showing outpatient contacts per person per year in the WHO European Region, indicates that there were five outpatient visits per person per year Latvia in 2005. This was less compared to the EU average of 2004 (6 visits per person per year) and the EU15 average in the same year (7 visits per person per year).

Quality assurance

Since the introduction of the capitation model in PHC in 2000, some assessment indicators of the quality of work of GPs were introduced, evaluated per quarter and per year (Section 3.7 *Payment mechanisms*). This assessment forms the basis for awarding GPs bonuses for quality, constituting 15% of the capitation payment. Quality indicators are the number of episodes of care performed; the number of consultations performed by specialists and diagnostic tests which constitute GP expenditures from capitation funds; and cases of hospitalization, all of which are evaluated by the SCHIA. Some quality indicators evaluated on an annual basis include the number of children’s preventive consultations

Fig. 6.4 Outpatient contacts per person per year in countries of the EU, latest available year

Source: WHO Regional Office for Europe 2007a.

Notes: EU: European Union; CIS: Commonwealth of Independent States; Eur-B+C: WHO pre-calculated indicator based on data from 26 mainly eastern European countries with different mortality characteristics from Eur-A countries; CARK: Central Asian republics plus Kazakhstan; Eur-A: WHO precalculated indicator based on data from 27 countries in western, southern, central and northern Europe; TFYR Macedonia: The former Yugoslav Republic of Macedonia.

and vaccinations, and onco-cytological consultations (cervical smears) for women aged 18–65. The general conclusion has been that approximately 80% of PHC physicians have been evaluated as “good” and received their bonuses (SCHIA 2005).

A survey conducted in 2001 on patient satisfaction with their GPs by the North-East Sickness Fund (no longer in existence at the time of writing) found that patients were largely satisfied with the work of their personal GPs, but were not satisfied with the referral system, patient fees and the system of pharmaceutical reimbursement. In some cases concerns were expressed over the following issues: the educational level of GPs; lack of confidence in the GP’s ability; communication with the GP; management of GP practices; no real choice of GP in rural areas; and the GP as a source of information on health care. More issues of concern in primary care are discussed later in this section.

Changes in the primary care system over recent years

The development of PHC in Latvia has been strongly influenced by a number of reforms that have taken place in recent years. A short history of PHC development includes the following main points.

From the beginning of the reforms, the Government favoured the establishment of private practices as a setting for primary care delivery. According to the “Strategy for Health Care Development” prepared by the Ministry of Welfare and accepted by the Government in 1996, “... primary health care should be based on private medical practice, establishing a primary health care development foundation and engaging various financial resources.” The Primary Care Support Fund, PHARE and the World Bank equipped GP practices through various projects from 1998–2002.

In 1998, as part of the transition to a PHC system, the sickness funds (that were in existence at the time), in cooperation with local governments, developed PHC plans on the basis of the existing structure of administrative regions and the requirement of at least one family doctor per 2000 people. The list of PHC physicians in 1999 consisted of 1362 doctors in three specialties: GPs (44%), internists (31%), and paediatricians (25%). In 2004 these percentages had changed in favour of GPs, as noted earlier, and were 80%, 14% and 6% for each of these specialties, respectively. The number of certified GPs has increased sharply in recent years due to retraining courses for GPs (supported by the Primary Care Support Fund and the World Bank in 2001–2003), and doctors who graduate as GPs from the Latvian Medical Academy becoming involved in PHC.

A mixed capitation method of financing of PHC has been developing since 2000, and the current system of payment (described in Section 3.7 *Payment mechanisms*) has been adopted throughout the country since the beginning of 2005. “Mixed capitation” refers to the arrangement whereby a portion of funds is received by GPs as capitation (depending on the number of listed patients) and a portion is received as additional payment for remuneration of PHC nurses, for low density of the population in the practice area and patient age structure, as well as for the purchase of certain secondary-level services.

At the time of writing, there are no plans to further reform the PHC system in Latvia.

Problems in primary health care delivery

Serious difficulties have been encountered in the process of developing private practices. These difficulties include the expense of setting up a practice, the difficulties of getting a commercial bank loan, and the insecurity generated by risk of losing employment. GPs are therefore permitted to rent facilities within polyclinics and work as independent practitioners. The polyclinic environment is not conducive to general practice and the development of primary care. However, as there are few alternatives over the short to medium term for the premises of primary care practices, most GPs find themselves practising in former polyclinics.

However, it is often the case that the provision of medical supplies and technical equipment for primary care institutions is insufficient, thereby limiting capacity to provide high-quality care.

For those polyclinic GPs who are able to do so, a key motivating factor behind the decision to open an independent private practice appears to be the prospect of attracting private patients. It appears, therefore, that there is a trend whereby doctors are prompted to become certified GPs less because they are interested in becoming primary care doctors and more because of the prospect of substantially increasing their incomes by attracting private patients. Similar considerations apply to specialists who prefer to work as independent practitioners. This is encouraged by current legislation that allows independent contractors to become established as limited companies, which by definition are intended to be profit-making organizations or firms.

There is a low integration of health and social care, as well as primary, secondary and tertiary care. Physicians’ qualifications and specializations are sometimes not conducive to the demands of PHC being maintained. There is a lack of PHC doctors and nurses, related to the shortages of health care personnel

due to demographic and economic factors (see Section 5.2 *Human resources* for discussion on these).

Patients in rural areas have unequal access to PHC services due to a smaller number of providers, as family doctors are not willing to practise in rural areas. As a rule, more doctors reside and work in the centre of urban regions in proportion to the population than in outlying areas. The typical situation is that the family physician whose practice is located in the centre of a region provides primary care to the surrounding rural areas. One to two days per week the doctor works in the health care institution (feldsher-midwife station) located in her/his region.

In addition, there have been psychological difficulties (e.g. dissatisfaction with accessibility of specialized care due to GPs' gatekeeping function) with regard to acceptance of the PHC system by the general public, involving a long-term and stable relationship between a family and GP, in spite of active media campaigns attempting to inform the public.

There are also uncertainties about the legal basis of independent practice. In the case of polyclinics, the former state or local government (municipal/district) institutions were converted in the 1990s into state or local government enterprises, i.e. non-profit-making joint-stock companies or non-profit-making limited liability companies. From 2005, all non-profit-making state and local government organizations have been reorganized into state or district/municipal limited companies, state public limited (stock) companies, or state agencies. These changes in status give rise to greater administrative freedom on the part of the health centres (former polyclinics) in the allocation of resources and payment of providers. As the contractor on the side of health care providers became the head physician or director, and not the PHC physician, there emerged considerable room for tension between the two.

In addition, there are difficulties surrounding the mixed capitation form of payment of PHC physicians that has been introduced. Under the new system, being away from the place of practice does not alter the physician's payment as s/he is paid on the basis of the patient list (capitation); however, this encourages physicians to neglect their practices. During the physician's absence from work, the patient is deprived of the opportunity for a consultation. In some areas there is only one physician and there is no replacement to take care of the patient's needs during the physician's absence. By law, it is the physician's obligation to find a replacement if s/he is obliged to be away from work; however, this often does not happen.

Moreover, the new arrangement meets with dissatisfaction from patients who feel that family practitioners may refuse to refer them to a specialist even though specialist care may be called for, simply because the practitioner

faces a financial incentive to retain the money that would otherwise be paid to a specialist. Patients fear that they may receive inadequate or inappropriate treatment in the event that their condition requires specialist knowledge and skills. Specialists themselves similarly oppose the arrangement as their position vis-à-vis the family practitioners is severely weakened. The incentive system for GPs is discussed in more detail in Section 3.7 *Payment mechanisms*, Subsection *Paying health care personnel*.

From the point of view of patients, according to a major survey of the population (by the Tropical Disease Research Centre (CIET)), a change in the health care system that was most often cited involved the practice of family doctor referrals to specialists. More than half the respondents would be willing to pay higher patient fees in order to have easier access to specialized care.

6.4 Specialized ambulatory care/inpatient care

Secondary ambulatory care

Secondary ambulatory care can be received at the institutions listed here (see also Figure 6.3).

- Specialist physician practices; these consist of specialist doctors who work independently either as self-employed individuals or as private sector agents. The institutional legal forms here are exactly as in the case of GP practices (discussed earlier), where a self-employed practitioner pays income taxes on the basis of income earned in the practice, while the premises and equipment of the practice are either privately owned or rented. Most specialists run independent practices in rented facilities of former polyclinics owned by local governments. Limited companies come under the category of “private” and are taxed as such.
- Hospitals; these may be owned by the central Government under the jurisdiction of the Ministry of Health, or owned by local governments, or they may be private.
- State agencies (such as the State Centre for Mental Health, Tuberculosis and Lung Diseases Centre, Centre for Infectious Diseases, etc.) come under the Ministry of Health.
- Diagnostic services fall under the ownership of the central Government or local governments, or they may be privately owned.
- Health centres may be public (owned by local governments) or private, or operate under a public–private ownership mix.

These institutions have contracts with the SCHIA in order to be able to provide statutorily funded services.

Specialist practices (whether independent or private), health centres and diagnostic centres contract with the SCHIA in order to provide statutorily funded services. While individual practitioners contract directly with the SCHIA, in the cases of institutions (health centres and diagnostic centres) contracts with the SCHIA are formed by the institution's administrative department(s). This is a general rule that applies regardless of the type of ownership (private, independent, local government, etc.).

The following conditions exist for secondary ambulatory care (as of April 2005):

- the GP is gatekeeper to secondary ambulatory care, and refers the patient to seek specialist diagnostic services;
- the specialist refers the patient to the diagnostic service;
- patients can directly seek first aid at emergency departments of hospitals;
- patients can go directly to:
 - o a gynaecologist for pap smears and other services;
 - o a psychiatrist, if the individual has mental illness;
 - o a mental health specialist, if the individual is drug addicted, alcohol addicted and/or psychotropic substances addicted;
 - o a TB specialist, if the individual has TB;
 - o a specialist in skin disease and STIs, if the individual has (an) STI(s);
 - o an endocrinologist, if the individual has diabetes;
 - o an oncologist, if the individual has cancer.

Inpatient care

Secondary care under the statutory system is provided according to the contract method, whereby hospital administrations sign contracts with the SCHIA.

Tertiary health care, or highly specialized medical services provided by people responsible for medical treatment from one or several medical specializations with additional qualifications in specialized medical institutions, is related to the utilization of technically diverse and complicated diagnostic and medical treatment equipment (for example, cardio-surgery services, transplantation of autologous and allogeneic (from 2006) cells to haematology patients, HIV/AIDS diagnosis and treatment, etc.). Tertiary health care is not contracted by the SCHIA but receives budget transfers from the Ministry of Health.

In addition to differentiation by level of specialization (as shown in Fig. 2.1), hospitals in Latvia can also be distinguished by ownership and legal

Table 6.3 Numbers of hospitals and beds,* 1991, 1999, 2004

Year	Number of hospitals			Number of beds		
	1991	1999	2004	1991	1999	2004
Total	183	146	119	35 596	20 877	17 891
Under the supervision of the State:	47	52	40	14 075	10 265	8 703
- in Riga	n/a	n/a	15	n/a	n/a	5 297
- outside Riga	n/a	n/a	25	n/a	n/a	3 406
Under the supervision of districts/ municipalities:	136	84	62	21 521	10 103	8 297
- in Riga	16	5	5	5 750	2 198	1 870
- outside Riga	120	79	57	15 771	7 905	6 427
Private hospitals	0	10	17	0	509	891
- in Riga	0	9	11	0	504	509
- outside Riga	0	1	6	0	5	382

Source: HSM TSA 2004.

Notes: *Excluding short term social care beds; n/a: Not available.

form: state hospitals, accountable to the Ministry of Health; district/municipal hospitals; and private hospitals. State hospitals have the status of state agency or limited company, or public limited (stock) company. Municipal hospitals have the status of limited company or municipal agency. All hospital staff are employed by the hospital administration and paid through salaries (Section 3.7 *Payment mechanisms*). Table 6.3 shows the breakdown of hospitals and beds by type of ownership and their development since 1991.

Changes in the structure of health care institutions have been determined by health policy since 1994, aiming towards the development of PHC. Substitution of the more expensive inpatient care by less costly PHC, through the development of a system of family doctors, has been one of the key features of Latvian health care reforms since the mid-1990s. While the number of outpatient institutions increased from 393 in 1991 to 1727 (including 1577 physician practices) in 2004, the number of inpatient institutions decreased from 187 in 1991 to 119 in 2004 (HSM TSA 2006). This is reflected in the significant (approximately 50%) corresponding decrease in the overall number of beds in the period 1991–2004.

Table 6.3 demonstrates that the share of hospitals under state supervision increased from 25% in 1991 to 34% in 2004, while the share under local government supervision (districts and municipalities) fell from 73% in 1991 to 52% in 2004. At the same time, private hospitals were established, with a 14% share in 1994.

In terms of bed numbers, the state share increased from 39% to 49% in 1991–2004, the share of beds under local governments fell from approximately 60% to 46% over the same period, while beds in private hospitals constituted

approximately 5% of total beds in 2004. It should be noted that numbers of inpatient institutions and beds have decreased further in 2006 compared to 2004, as shown in Table 6.3.

As of 2006, inpatient care in Latvia is provided by the institutions listed here.

- Hospitals contracted by the SCHIA, including:
 - o regional multifunctional hospitals (11)
 - o local multifunctional hospitals (26)
 - o specialized single-profile hospitals (27) and centres (3)
 - o state agencies (5) financed by separate budgets from the Ministry of Health:
 - o State Agency of Mental Health
 - o State Agency of Tuberculosis and Lung Diseases
 - o State Narcology Centre
 - o State Agency of Infectious Diseases (Centre)
 - o State Agency of Sexually Transmitted and Skin Diseases.
- Private hospitals (11), financed privately.

Primary care doctors, specialists of secondary ambulatory health care, and EMA services can refer patients directly to a hospital. These medical personnel are responsible for adequate referral to the appropriate kind of hospital.

There is uneven distribution of hospitals and beds throughout the country, with a rather heavy concentration in Riga. As Table 6.4 shows, 40% of acute care beds and 36% of specialized hospital beds were located in Riga in 2004. On the other hand, all rehabilitation centres are located outside of Riga.

Table 6.4 Numbers of hospitals and beds (in and outside Riga) by hospital profiles, 2003 and 2004

Year	Number of hospitals		Number of beds	
	2003	2004	2003	2004
Total:	131	119	18 169	17 891
Acute care hospitals:	88	84	12 955	12 726
- in Riga	27	25	6 161	6 083
- outside Riga	61	59	6 794	6 643
Specialized hospitals:	35	27	4 459	4 449
- in Riga	5	6	1 311	1 593
- outside Riga	30	21	3 148	2 856
Rehabilitation centres:	8	8	755	716
- in Riga	0	0	0	0
- outside Riga	8	8	755	716

Source: HSM TSA 2004.

In recent years, the issues of optimizing the structure of service providers, raising the quality of health care services, as well as cost-efficiency and patient access have become increasingly important, leading to “Regulations of the Cabinet of Ministers on Procedures to Develop and Implement the Structural Plan for Outpatient and Inpatient Health Care Service Providers”, adopted in July 2003. These Regulations determine that a national-level structural plan be prepared by the Ministry of Health, based on regional-level proposals. The structural plan specifies the types, numbers and distribution of health care service providers throughout the country. The objective is to broaden the range of available quality health care services in all regions of the country, and to improve patient access to required health care services through closer physical proximity of them to the place of residence. At the same time, the development of PHC is expected to give rise to an increase in the number of GPs, resulting in improved access to PHC services.

“Regulations of the Cabinet of Ministers on the Development Programme of Ambulatory and Stationary Health Care Service Providers” (2004) further refines the structural plan and specifies particular health care services, planned numbers and categories of hospitals, their regional distribution and timetable for implementing the plan. It describes activities, requisite finances and responsible implementing institutions. Table 6.5 provides figures for the numbers of the different kinds of hospital that have been planned.

The abovementioned plan specifies the functions and requirements for each of the four hospital categories. These are regional multifunctional, local multifunctional, specialized single-profile centres and specialized single-profile hospitals.

Regional multifunctional hospitals

This type of hospital provides emergency care services, comprehensive secondary and tertiary hospital care and secondary ambulatory health care.

Table 6.5 Plan for inpatient care (maximum numbers)

Year	Regional multi-functional hospitals	Local multi-functional hospitals	Specialized one-profile centres	Specialized one-profile hospitals	Hospitals changing profile	Total
2004	11	28	8	35	29	111
2007	11	24	8	15	13	71
2010	11	21	3	11	0	46

Source: Cabinet of Ministers 2004a.

Requirements:

- no fewer than 300 hospital beds, of which 3% for intensive care unit and an occupancy rate of 85%;
- profiles (structural units or departments):
 - o intensive care unit
 - o internal diseases department
 - o surgery department
 - o traumatology department
 - o operating unit
 - o anaesthesiology unit
 - o blood preparation and transfusion unit, and
- five additional profiles, from among: gynaecology, neurology, urology, otolaryngology, ophthalmology, cardiology, maternity ward, paediatrics, neurosurgery, infections, gastroenterology, endocrinology, nephrology, pulmonology, narcology, psychiatry and rehabilitation.

Local multifunctional hospitals

Along with the regional multifunctional hospitals, this type of hospital provides not only emergency and secondary ambulatory health care, but also secondary hospital care.

Requirements:

- no fewer than 120 hospital beds, of which 3% for intensive care unit and an occupancy rate of 85%;
- profiles (structural units or departments):
 - o intensive care unit
 - o internal diseases department
 - o surgery department
 - o gynaecology department
 - o operating unit
 - o anaesthesiology unit
 - o blood transfusion unit, and
- two additional profiles, from among: traumatology, neurology, maternity ward, paediatrics, infections and rehabilitation.

Specialized single-profile centres

This type of centre provides single-profile secondary and tertiary hospital care, as well as secondary ambulatory health care, and ensures methodological guidance for the health care sector.

Institutions (as of 2005):

- State Dentistry and Face Surgery Centre (dental inpatient care, outpatient operations, face/jaw injuries);
- Traumatology and Orthopaedic Hospital (traumatology, orthopaedics, suppurate surgery, endoprosthetics, outpatients);
- “Vaivari” National Rehabilitation Centre (rehabilitation, paediatrics, surgery, neurology, orthopaedics, ophthalmology, gerontology, spinal (backbone injury) section).

Specialized single-profile hospitals

These hospitals provide secondary hospital and secondary ambulatory health care. They have various profiles (as of 2005), detailed here.

Mental health (psycho- neurology)

The following institutions provide mental health care in Latvia:

- State Mental Health Agency – Riga
- Daugavpils psychoneurosis hospital
- Jelgava mental hospital “Ģintermuiža”
- Liepāja psychoneurosis hospital
- Akniste psychoneurosis hospital
- Children psychoneurosis hospital “Ainaži”
- Strenču psychoneurosis hospital
- Vecpiebalga psychoneurosis hospital
- Mental health centre “Dzintari”

TB

The following institutions are involved in TB control in Latvia:

- TB and lung diseases state agency
- Liepāja TB hospital
- Jelgava TB hospital

Narcology

The following institutions provide narcology services in Latvia:

- State Narcology Centre – Riga
- Straupe narcological hospital
- Daugavpils narcological hospital
- Jelgava narcological hospital
- Riga narcomania patient rehabilitation centre
- Rindzele narcological rehabilitation centre

Rehabilitation

The following institutions provide rehabilitation services in Latvia:

- Kurzeme region rehabilitation centre “Tērvete”
- Latgale region rehabilitation centre “Rāzna”
- Vidzeme region rehabilitation centre “Līgatne”
- Rehabilitation centre “Ogre”
- Rehabilitation centre “Baltezers”
- Rehabilitation centre “Krimulda”
- Sanare KRC Jaunķemeri

Leprosy

The State Leprosy Hospital provides leprosy treatment in Latvia.

Day care

Starting from 2000 a number of day care hospitals have been opened in Latvia, at which patients receive care and are released during the course of a day. Hospitals providing day care services are not common in Latvia.

According to the “Regulation of the Cabinet of Ministers on Organization and Financing of Health Care” (2004), day care hospital facilities are considered to be in the secondary ambulatory care sector and are financed from the ambulatory care budget (through the SCHIA). A patient with a referral (from a family doctor or specialist) can freely choose the institution providing day care hospital services, provided the institution is contracted by the SCHIA.

In Latvia, day care hospital facilities are located within hospitals, specifically state and district or municipal multifunctional hospitals. The main health care services in day care hospitals include the following:

- haemodialysis for chronically ill patients;

- invasive cardiology (coronarography, provided only in Riga at the Riga Stradiņš Clinical University Hospital);
- gynaecology (diagnostics, uterine curettage, biopsy);
- operations (surgical, such as varicose veins; inguinal hernia; ophthalmological, such as cataract; otorhinolaryngological, such as adenoids);
- rehabilitation.

Day care hospital services are not yet highly developed in Latvia. In 2004, 318 676 patients were treated in 24-hour hospitals (13.6% of the Latvia population), compared with 19 946 patients in day care hospitals (0.9% of the Latvia population). The average number of bed-days per 1 patient in 24-hour hospital services is 10.8 days, while in day care hospital services, the respective number is 5.9 per patient (SCHIA 2005).

If a patient cannot receive day care hospital services in the vicinity of her/his place of residence, s/he can receive it in outpatient medical institutions or in “ordinary” 24-hour hospitals. An exception is haemodialysis for chronically ill patients, which is performed as a day care hospital service in seven district multifunctional hospitals, four of which are in Riga, and in two in municipal multifunctional hospitals.

In addition to hospital care, social care can also be provided in a day care setting. Social care is the responsibility of the Ministry of Welfare. Social services include the set of measures aimed at facilitating or improving the capability of individuals to satisfy their basic needs in the event that they face difficulties due to old age or functional disorders, and ensuring their integration into society. They include services at the patient’s place of residence, and in social rehabilitation and long-term social care institutions, as well as vocational rehabilitation services and provision of technical aids.

In the social care context, a day centre is an institution which provides day care, that is, 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.), and is financed by state and local governments.

6.5 Emergency care

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

Emergency care in Latvia is provided by:

- EMA teams or ambulances (of which there are 173 in Latvia);

- hospitals (emergency departments);
- the CEDM, a state-run, specialized medical service that covers only those cases when a CEDM specialist is called in by one of the hospitals, once it has been established that the institution's own efforts and resources are insufficient to save the life of the 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 the hospitals, and perform the crucial functions to sustain life while transporting victims. In cases in which the patients, their relatives or employers wishing to receive more qualified medical care call in the specialists of the CEDM themselves, the State does not cover the expenses. To ensure the rights of the patients to freely choose and receive highly qualified medical care, the CEDM also offers services paid by the patient and provides specialized medical care to patients both within and outside the borders of Latvia.

An individual can receive emergency care services at 43 medical institutions contracted by SCHIA (hospitals have structural units of EMA teams or EMA services). Emergency care is available 24 hours a day. In Riga there are specialized emergency teams (intensive care, cardiological, psychiatric, children's intensive therapy, etc.); elsewhere, there is usually one doctor and doctor's assistant and the driver; in rural areas, there is a doctor and doctor's assistant (in nine districts of Latvia), or two doctor's assistants and the driver (in 17 districts of Latvia). EMA is provided to people whose life or health is in a hazardous and critical condition by specially prepared (trained, equipped) individuals with a relevant qualification in medicine.

In case of emergency, one must call an ambulance (03 or 112), or go to the emergency reception of a hospital. Transport by ambulance is free of charge for patients.

Key standards for ambulance services include:

- responding to 75% of calls within 15 minutes in cities and towns (in reality from 4 to 15 minutes, on average 8 minutes);
- responding to 75% of calls within 25 minutes in rural areas (in reality from 15 to 45 minutes, on average 22 minutes).

The majority of primary emergency care involves sudden illnesses and acute conditions (64.8% of cases in 2003 and 63.0% in 2004). The second largest part of such care involves traumas and accidents (21.1% in 2003 and 22.4% in 2004) (HSMTSA 2005, HSMTSA 2006).

Hospitals which have structural units of EMA teams and EMA services are contracted by the SCHIA, which finances these services from the health care budget. The contracts include:

- working loads for doctors and doctor's assistants
- working loads for drivers and dispatchers
- costs of medications
- fixed costs.

Emergency care is undergoing major structural and managerial changes, as part of the structural reform of the health care system. The State Development Plan, discussed earlier, incorporates a component for the improvement of EMA system infrastructure, in order to increase the effectiveness of system operation in the pre-hospitalization and hospitalization periods within admissions departments at multi-profile hospitals. The EMA system is to include a stationary assistance centre within each territory, with the capability to provide large-scale EMA, including specialized EMA. The centre is prepared to function in medical catastrophes with large numbers of victims, and there is capacity to isolate infections. The system is also capable of providing full EMA services within hospital admission departments. In addition, the establishment of regional emergency medical dispatchers and management centres has been planned, along with localization points for EMA teams and the purchase of EMA transport, to ensure coverage of the entire country and to minimize the waiting period after emergency calls.

Patient pathways in emergency care episodes

1. A man with broken pelvic bones after a car accident:
 - the police or person who was first at the scene of the accident calls an ambulance (03 or 112);
 - an EMA district dispatcher receives the call;
 - an EMA team provides emergency aid at the scene and while transporting victim to the district or local multifunctional emergency admissions department.
2. A man with severe burns after a fire accident at the place of work:
 - the fire brigade, police or person who first was at scene of the accident calls an ambulance (03 or 112);
 - an EMA district dispatcher receives the call;
 - an EMA team provides emergency aid at the scene and while transporting victim to the district or local multifunctional emergency admissions department;

- a doctor from the admissions department calls the CEDM to transport the patient to the specialized hospital for the treatment of burns and to perform the crucial functions to sustain life while transporting victim.
3. A woman with transitory cerebral ischemic attack:
- the GP during the home visit provides immediate medical assistance;
 - the GP calls an ambulance (03 or 11) and writes the referral to hospital;
 - the EMA district dispatcher receives the call;
 - the EMA team renders emergency aid if necessary at home and while transporting patient to the district or local multifunctional emergency admissions department.

The main shortcomings in the present system of emergency care in Latvia (identified in the development plan for EMA for the period 2005–2010) are related to the availability of well-timed and high-quality EMA for the entire population in daily and extraordinary medical situations.

To improve the infrastructure and quality of the emergency medical care system there are plans to:

- organize equal and well-structured EMA teams, within an institutionally and technically unified structure under a single central managerial authority with five subordinated regional management centres;
- create a unified EMA communications and exchange of information system (radio link, phone, computer);
- purchase adequate EMA transport;
- improve the qualifications and expertise of medical personnel.

6.6 Pharmaceutical care

Distribution

Pharmaceutical products are supplied to the public by a regulated distribution system consisting of licensed enterprises that manufacture and/or distribute them, as shown in Table 6.6. The number of pharmacies shows a slightly decreasing trend since 2001, while pharmacies of health care institutions are roughly constant, as are numbers of Latvian manufacturers. Numbers of wholesalers, on the other hand, have been steadily declining since 2000.

Pharmacies are mostly privately owned. Only those pharmacies that belong to local governments and public health care institutions have remained in the public sector and constitute 5% of the total number of pharmacies.

Table 6.6 Number of enterprises involved in pharmaceuticals manufacture and distribution, 2000–2006

	2000	2001	2002	2003	2004	2005	2006
Pharmacies	820	908	884	876	882	861	858
of which hospital pharmacies or pharmacies of health service institutions	31	40	40	43	44	42	42
Wholesalers	59	50	42	38	37	37	36
Manufacturers of pharmaceuticals (Latvian)	16	15	14	13	13	14	14

Source: Statistics of the State Agency of Medicines on the Operation of Pharmaceutical Enterprises, information provided to the authors [unpublished data].

Amendments to the “Law on Pharmaceutical Activities” (of 1998) enacted in June 2001 prescribe new norms in the ownership of pharmacies. Only a pharmacist or local government in its administrative territory (with the permission of the Minister of Health) has the right to open and own a community pharmacy. A pharmacy may open no more than two branches outside a city where there are no other pharmacies or pharmacy branches within a radius of 5 km.

Wholesalers are private enterprises, with a growing Latvian share of the total wholesale market, although a significant part of the Latvian market is accounted for by foreign firms. In 2005 there were 36 licensed wholesalers of pharmaceutical products (for human consumption). The number of Latvian wholesalers has decreased since 2000, as mentioned earlier. The largest is Recipe Plus, controlling 30.2% of the Latvian wholesale market.

Hospitals purchase medicines from wholesalers or pharmacies; if a purchase for a large amount of pharmaceuticals is required, it is put out to tender. Sometimes groups of hospitals issue joint tenders to secure lower prices.

Pharmaceutical care is provided only by specialists with a pharmaceutical background. In 2005, 3098 such specialists were working, of whom 1485 were pharmacists and the rest were pharmacists’ assistants. A total of 91% of all specialists work in pharmacies, including 1296 pharmacists and 1537 pharmacists’ assistants (HSMTSA database 2007 [unpublished data]).

In 2005, 17.9% of pharmacies (154) prepared pharmaceutical products according to individual prescriptions issued by physicians. As it is not economically profitable to prepare such products in pharmacies, the scale of this service has fallen and in 2005 extemporaneous preparations amounted only to 0.51 % of the total turnover of pharmacies.

Pharmacies that provide 24-hour pharmaceutical care constitute 3.7% of the total number of pharmacies.

Subsidized pharmaceuticals

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. Pharmaceutical care is provided free of charge to inpatients, the cost of which is covered as part of the cost of inpatient services.

There is a positive list designating a range of conditions (for example, diabetes, cancer, mental disorders) for which drugs are reimbursed according to the degree of severity (i.e. 100%, 90%, 75% and 50% reimbursement). The State Medicines Pricing and Reimbursement Agency together with professional associations jointly decide the new diagnoses and associated pharmaceuticals that should be included in the list, as well as the reimbursement rate. Criteria for inclusion of medications in the list are related to diagnosis.

In 2005, Regulations of the Cabinet of Ministers “Rules on Compensating Mechanism for Medicines and Medical Devices Purchased in Outpatient Care” introduced a reference pricing system as a means to expand the range of health conditions that were to be covered by the reimbursement mechanism, and the budget for pharmaceuticals was increased. The objective is to keep expanding the positive list as well as rates of compensation.

There are no population groups that are exempted from payments on all pharmaceuticals. As noted above, the positive list is determined on the basis of diagnosis, and not on the basis of vulnerable groups. However, the list does envisage 100% state coverage of certain medications (such as for acute respiratory infections) for children up to three years of age.

There is no compensation provided for pharmaceuticals prescribed within alternative and complementary medicine. For more information on state subsidized medications, see Section 5.1 *Physical resources*, Subsection *Pharmaceuticals*.

Domestic output, imports and exports

In 2006 there were 14 Latvian manufacturers of pharmaceutical products (Table 6.6), covering 6.5% of total Latvian pharmaceutical consumption. The largest company, Grindex, provides 2.1% of the total Latvian pharmaceutical market.

Table 6.7 shows growth in Latvia’s pharmaceutical output. It can be seen that an increasing share of domestic output, amounting to about one fifth in 2005, is sold in the domestic market. Exports constitute about four fifths of domestic output, most of which are directed mainly to former Soviet Union countries.

Table 6.7 Pharmaceutical output growth (million LVL), 2000–2005

	2000	2001	2002	2003	2004	2005
Total domestic output of pharmaceutical products	23.1	23.4	26.5	31.5	39.2	51.1
of which:						
- sold in domestic market	6.8	6.6	7.1	7.8	9.0	10.4
- exports	16.3	16.8	19.4	23.7	30.2	40.7

Source: Statistics of the State Agency of Medicines on the Operation of Pharmaceutical Enterprises, information provided to the authors [unpublished data].

Imports of pharmaceuticals, which used to come from the former Soviet Union, now originate mainly from western Europe, and come mostly in retail form. The largest supplier is Switzerland (about one fifth of the value of imports in 2002), followed by Germany and Belgium.

Consumption levels and physical access to pharmacies

Consumption of pharmaceuticals was LVL 55 per capita in 2005, as shown in Table 6.8, which is similar to the levels of Poland, Slovakia and Croatia. This is high by the standards of former Soviet states, and is due to historically high consumption levels as well as high wholesaler and pharmacy mark-ups. Per capita consumption has grown dramatically since 2000, and is expected grow further. Yet even at these higher levels, per capita consumption levels remain substantially lower than in western Europe. The Latvian market is extremely price sensitive, as most of the population cannot afford to buy expensive pharmaceuticals.

The availability of pharmaceutical services in cities/towns and rural areas varies, as for the most part, pharmacies are situated in Riga and in Latvia's larger towns. A total of 74% of the pharmacies are located in cities/towns. In order to ensure a more even geographical distribution of pharmacies, in 2002 the Cabinet of Ministers approved the "Regulations on Compulsory Demands

Table 6.8 Total pharmaceutical expenditure in Latvia, 2000–2005

Pharmaceutical expenditure	2000	2001	2002	2003	2004	2005	2006 (forecast)
TPE (million LVL) in retail prices	77.1	84.9	95.0	110.6	118.2	126.6	147.0
TPE in % of total health expenditure	27	28	27	28	28	n/a	n/a
TPE per capita (LVL)	32	36	40	47	51	55	64

Source: Statistics of Pharmaceuticals Department, information provided to the authors [unpublished data]

Notes: TPE: Total pharmaceutical expenditure; n/a: Not available.

for Health Care Institutions and their Structural Units”, determining criteria for the distribution of pharmacies and their branches. Criteria regulating pharmacy numbers in populated areas are the number of inhabitants in the specific populated area and the minimum number of inhabitants per pharmacy. These Regulations do not apply to pharmacies that are already in operation. The number and distribution of pharmacies prior to 2002 was determined solely by the operation of the market. It is expected that compliance with these requirements will gradually increase access to pharmaceutical services in rural areas.

For more information on pharmaceuticals, see Section 5.1 *Physical resources*, Subsection *Pharmaceuticals*.

6.7 Rehabilitation/intermediate care

Medical rehabilitation in day care and 24-hour hospitals is financed from the state budget through contracts with the SCHIA, for the following groups of patients:

- patients sent to receive medical rehabilitation services directly from regional or local multi-profile inpatient institutions or specialized centres (hospitals) within six months after discharge;
- patients with inherited or other physical nervous system impairment, with paralysis;
- participants in the clean-up following the Chernobyl atomic power plant accident and victims of this accident (in accordance with related legislation).

Medical rehabilitation in outpatient health care institutions is financed from the state budget through contracts with the SCHIA for chronically ill patients requiring the care of rehabilitation specialists in accordance with an accepted list of diagnoses (neurology, orthopaedics, internal diseases).

Providers of medical rehabilitation include a single specialized single-profile centre and several specialized single-profile hospitals for inpatient care. Rehabilitation wards of district or local multi-profile hospitals provide rehabilitation for outpatients.

The first of these (the specialized single-profile centre) is the “Vaivari” National Rehabilitation Centre (NRC), which offers rehabilitation, paediatrics, surgery, neurology, orthopaedics, ophthalmology, gerontology, and a spinal (backbone injury) section. Since 1992, the “Vaivari” NRC has been a medical rehabilitation, health and social care centre, as well as an educational and

research centre of national significance. One of the main areas of activity of the “Vaivari” NRC is to provide second-stage medical rehabilitation. Its medical, technical and professional resources are of a sufficiently high level so as to provide a full spectrum of medical treatment services.

The rehabilitation services of this centre include those listed here.

- Surgery and orthopaedics programme (for patients with scoliosis, different posture and movement disorders, burn after-effects and other diseases).
- Spinal cord injury programme; operating in close contact with the patient’s relatives and social care institutions to insure the patient’s care when s/he leaves the inpatient institution.
- Gerontology and spa programme (for chronically sick patients from the age of 65 years and over); aiming to assist in functional abilities and teaching them to perform necessary everyday activities at home).
- Neuro-rehabilitation programme; assessing the health and functional condition of patients after stroke, head trauma and/or neurological infections; providing an intensive rehabilitation process; and conducting social education programmes for patients and their relatives in social integration and prophylaxis.
- Child internal rehabilitation programme (for children with congenital or acquired nervous system pathologies, ophthalmological diseases, chronic lung diseases, myocarditis, rheumatism and other diseases); cooperating with the patient’s relatives, medical and social care institutions.
- Adult internal rehabilitation programme; helping patients recover after heart operations, chronic pulmonological diseases, myocarditis, rheumatism, chronic juvenile arthritis and other diseases.
- Back pain rehabilitation programme (for patients after discectomy, spondylosis and complications).

There are several specialized rehabilitation hospitals offering inpatient services, including: Kurzeme region “Tērvete” rehabilitation centre; Latgale region “Rāzna” rehabilitation centre; Vidzeme region “Līgatne” rehabilitation centre, “Ogre” rehabilitation centre; “Baltezers” rehabilitation centre; “Krimulda” rehabilitation centre and Sanare KRC Jaunķemeri.

6.8 Long-term care

Long-term care in Latvia is classified under social care. Health care services and social services are not integrated. They are financed by separate budgets

and are administratively separate, with social care (and therefore long-term care) being under the responsibility of the Ministry of Welfare.

At national level, there is no specific mechanism to coordinate these services. A policy paper entitled “National Guidelines on Decreasing the Risks of Disability and Consequences of Disability” was approved by the Government in 2005, and was followed by an Action Plan in 2006. This policy paper envisages improved multisectoral collaboration; however, it has not as yet been put into effect.

At municipal level, medical guidelines, qualifications of medical personnel, quality assurance, etc. in institutions providing long-term care are regulated by the Ministry of Health. However, in this sphere too, no coordination mechanism exists for the activities of health care and long-term care.

At the level of municipalities, there also exist Departments of Social Assistance and Health. In small municipalities there is usually only one person who is responsible for social assistance and health-related issues.

There is a process of assessment in relation to access to services. At national level, “Regulations of the Cabinet of Ministers on Provision of Social Services” (2003) determine entitlement and the specific health status conditions that qualify an individual to receive long-term care, and define the relevant assessment criteria.

Assessment of health status is performed by the family doctor and is carried out on the basis of special guidelines that have been approved by the Government. Following the family doctor’s assessment, a decision is made regarding the type of service and the amount (duration) of the service. This decision is made based on the degree of need as well as the municipalities’ available financial resources.

Social care services include services at the patient’s place of residence (care at home, serviced apartment, day centre), long-term social care for adults and children, and social rehabilitation institutions for adults and children, including social rehabilitation at the place of residence, vocational rehabilitation services, and provision of technical aids.

Financing of long-term care is possible through a combination of state, local and private funds, depending on the type of institution. Adults with mental disorders and serious disabilities, blind people, orphaned children up to two years of age, children with physical and psychological development problems up to four years of age, as well as disabled children with psychological development problems from 4 to 18 years of age are entitled to receive social care at long-term social care and social rehabilitation centres funded by the State. 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 are entitled to care at institutions funded by local governments.

There are therefore two types of long-term care facilities in Latvia:

- specialized long-term institutions financed by the state budget – there are 28 such facilities, with approximately 3300 patients;
- general long-term institutions, fully financed by local governments – there are 60 such facilities, with approximately 5000 clients.

Pensioners 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).

Approximately 9000 people receive 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, as well as insufficient public funding for this purpose.

There is interest at the time of writing in improving standards of quality in the long-term care sector, and in shifting the focus of such care towards home care and day care centres (HSMTSA databases 2007 [unpublished data]).

6.9 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 the Riga East Hospital). There were then and still are 25 palliative care hospital beds in that unit. The care at the unit 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.

Another five hospital beds subsequently became available at the Liepāja (regional) Oncology Hospital. These beds are not separated in a special unit, but are integrated in general treatment departments. A third hospital, the Daugavpils Oncology Hospital, serving the eastern regions of Latvia, does not have a special palliative care unit or beds, but serves patients with palliative care needs, as patients from the regions covered by the Daugavpils Hospital are not accepted at other hospitals.

The average length of hospitalization time for all the palliative care beds in Latvia is approximately 10–12 days, and 20 of the 25 abovementioned beds are statutorily financed. The remaining five beds at the Riga East Hospital are financed on a fee-for-service basis.

Another example of mixed public–private financing for palliative care is at the private Bikur-Holim Hospital in Riga. Palliative care is provided for any patient who needs it (not only cancer patients), and this is partly financed by the United States international aid programme HOPE at this hospital.

In 2004, nine palliative care beds were opened at the Iecava nursing house, a social care centre near Riga for cancer, neurology and cardiology patients. Moreover, since 2007, additional palliative care beds have also become available in Irlava Hospital, Livani Hospital, Mazsalaca Hospital and Ventspils Hospital. In 2004, “only” 57.4% patients were discharged from the palliative care unit due to death. Access to palliative care is not equally distributed around the country, as 84% of patients in 2004 were from Riga City alone.

Since 2001, outpatient consultations with a specialist in palliative care are available at the Centre of Oncology at the Riga East Hospital for cancer patients and their relatives, financed by public funds (with a patient fee). The number of consultations increased from 300 in 2001 to 1026 in 2004, which indicates the necessity of this service.

There are several activities for child specialized palliative care as well. In 1998 an NGO for child palliative care was founded, and the first palliative care service was offered at the Children Clinical University Hospital. This service provides consultations for patients within various departments of the hospital, consultations with the patient’s relatives throughout Latvia, and home care for patients of Riga City and Jurmala. The team consists of two medical doctors, a social worker and chaplain.

General (nonspecialized) palliative care in Latvia is provided by family doctors. Also, patients on waiting lists for specialized care and after discharge from hospital are in the care of these doctors. In 2003 there was a small-scale survey of Latvian family doctors regarding oncology patient care. Questionnaires were sent to 190 doctors with a response rate of 50%. It was concluded that there exists an information gap between specialized oncology services and family doctors. Also, only 37% of the respondents had attended specialized oncology courses (with pain relief questions usually included), and 12% were not able to cover the financing of necessary medications for their patients (allocated limits are below actual needs, despite legislation declaring that every appropriate patient should get the necessary pharmaceuticals free of charge).

Most Latvian specialists in palliative care completed their education abroad. There is no recognized specialist accreditation in this field in Latvia.

As part of the Master Plan (Section 4.2 *Planning and health information management for an explanation*) and in accordance with EU recommendations, experts of the HSMTSA worked out bed requirements for palliative care. They are as follows:

- not more than 125 beds for palliative care in the country (on average 5 beds per 100 000 inhabitants) must be planned for inpatient palliative care up to the year 2010 (in line also with WHO recommendations);
- the order of priority in terms of the distribution of these beds rests with the oncology centres and the regional multi-profile hospitals first, over local multifunctional hospitals, and the related services are ensured by multidisciplinary teams with not less than 10 palliative care profile beds on site;
- the average recommended utilization rate for the palliative care profile beds is 85%.

6.10 Mental health care

The Ministry of Health is responsible for national policy in mental health, and has delegated responsibilities in this area to its Public Health Department, which is responsible for development and enforcement of policy for mental health. In addition, the Mental Health State Agency, under the jurisdiction of the Ministry of Health, is responsible for coordinating policy that has been approved by the Ministry and it also provides inpatient and outpatient mental health services.

Legislation that deals with the area of mental health includes the Medical Treatment Law of 1997, which in chapter XI on “Psychic diseases” regulates the area of mental health, provides principles for treatment, and also deals with the issue of compulsory hospitalization in psychiatric hospitals.

In addition, one of the targets (number 6) of the Public Health Strategy approved by the Cabinet of Ministers in 2001 states that mental health care services for the Latvian population should be improved by 2010, and access to high-quality mental health care should be ensured for all residents. Sub-targets of this include the following:

- the prevalence of mental health problems should be reduced
- the ability of the Latvian population to overcome stress situations should improve;
- the suicide rate must decrease by at least 25%.

Furthermore, the Ministry of Health, in cooperation with WHO, developed the “Basic Principles on Improvement of Mental Health for the Population

in 2006–2016”. This policy document was based on the WHO World Health Report 2001, the WHO Helsinki Declaration, and WHO recommendations for the development of mental health policy. For a period of time it was to be approved by the Government in the form of Regulations of the Cabinet of Ministers. As of the time of writing, this policy document had not yet received government approval.

A “Law on Psychiatric Assistance” is under development at the time of writing.

Psychiatric care is provided in various settings, detailed in the following sections.

Inpatient care

There are nine psychiatric hospitals (one of which is a children’s hospital), located in Riga, Jelgava, Daugavpils, Liepaja, Strenči, Aknīste, Jūrmala, Vecpiebalga and Aināzi, with a total of 3197 beds. Following the downward trend observed in overall hospital bed numbers in Latvia, there has been a marked decrease (of the order of 30%) in bed numbers over the last several years, resulting in 139 beds per 100 000 population for the country as a whole (2004), and 91 per 100 000 population in Riga. The average bed occupation rate was 98% in 2003, and the ALOS was 63.8 days (Ministry of Health Mental Health State Agency 2005).

Figure 5.1 and Table 5.1 (in Section 5.1 *Physical resources*, Subsection *Physical infrastructure*) provide data comparing numbers of psychiatric hospital beds per population in Latvia in comparison with the numbers of acute care hospital beds as well as beds in long-term care institutions.

While part of hospital facilities are used to provide treatment for acute patients, part are used for long-term treatment and rehabilitation. In 2002, 24.3% of hospital beds were being used for the treatment of chronic, therapy-resistant patients; 9.2% of patients were being treated in hospital for more than 10 years; 11.2% were being treated for 2–10 years, and 13.7% for up to 4 years (Ministry of Health, Mental Health State Agency 2005).

Specialized guarded hospital wards in Riga accept patients who receive compulsory medical treatment determined by a court.

Psychiatric inpatient care for children is provided in a children’s psychiatric hospital (as mentioned earlier), in a psychiatric ward of a children’s general hospital in Riga, as well as in adult psychiatric hospitals in Jelgava, Liepaja and Daugavpils. In total there are 315 beds allocated for children’s use (Ministry of Health, Mental Health State Agency 2005).

Day care

There are three psychiatric hospitals providing day care beds, in Liepaja, Daugavpils and Jalgava.

Outpatient care

Outpatient psychiatric care is provided in a variety of settings:

- two psychiatric assistance centres in Riga, one of which is located in a primary care centre;
- four outpatient departments at psychiatric hospitals, in Riga, Jalgava, Liepaja and Daugavpils;
- one outpatient department at a general children's hospital in Riga;
- 22 psychiatric consulting rooms in municipal primary care centres;
- approximately 70 private psychiatric practices, of which 15 are contracted with the SCHIA. There are a growing number of psychiatrists who are providing outpatient services as independent practitioners.

Psychiatric care is overwhelmingly provided in large psychiatric hospital settings as well as in the municipal psychiatric consulting rooms mentioned above, while day care centres, outpatient services and facilities for chronic patients are as yet underdeveloped. Evidence suggests that psychiatrists treating patients on an ambulatory basis provide services for patients with serious conditions.

In terms of staff resources, in the period 2002–2004 there were no major changes in the number of practising psychiatrists; in 2004 there were 241 psychiatrists in the entire country, corresponding to 1.04 per 10 000 population. These numbers are too low to meet the needs for psychiatric care across the entire country (Ministry of Health Mental Health State Agency 2005).

There are relatively few practitioners other than psychiatrists in the mental health area (such as psychologists and social workers) and there are few ambulatory-level services to meet actual needs. At end of 2004 there were 3.5 medical professionals per 10 000 residents with medium-level medical education. 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 (Ministry of Health Mental Health State Agency 2005).

6.11 Dental health care

Dental health care is provided on the basis of evidence-based treatment methods and technologies elaborated by the Dentistry Faculty of Riga Stradins University and the HSMTSA, and approved by the Ministry of Health. Dental care practices at state, local and private medical institutions that are licensed can contract with the SCHIA for the provision of dental services paid for through the state health care budget. In 2005, throughout Latvia there were 510 licensed dental practices, of which 281 were contracted by the SCHIA, and 348 were not licensed (HSMTSA databases 2007 [unpublished data]). Licensing of dental practices is carried out by the Latvian Dental Association.

In all regions of the country, dental care is provided by state and local authorities, charter capital ventures that are registered in the Register of Enterprises, as well as private practices that are registered in the Latvian Physicians Association. In spite of this range of ownership forms, dental care is overwhelmingly provided by private practitioners: 89% of dental practices are private, and 11% are state or local government owned. Each dental office complies with the minimum requirements with respect to equipment and technologies specified by the Cabinet of Ministers “Regulations on Compulsory Demands for Health Care Institutions and their Structural Units” (2002).

According to “Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004), 11% of funds allocated to PHC are to be used for the provision of dental services.

The State Dentistry and Face Surgery Centre is a capital company acting under the supervision of the Ministry of Health, responsible for planning and coordination of dental care in Latvia, as well as drafting laws and regulations in collaboration with professionals in the education system and within local governments. There are a number of dental care professionals and specialists in related disciplines, such as health care, economics and legislation, working on the coordination of all aspects of dental care. The State Dentistry and Face Surgery Centre maintains records of dental practitioners in Latvia. In accordance with a dental care strategy, a Dentistry Data Bank has been developed and is being constantly updated and analysed to provide estimates of future needs for professional resources in the field, as well as management of dental offices and private dental practice activities. In addition, this Centre operates as a medical institution that provides outpatient and inpatient dental care and oral face/jaw surgery.

Prices for statutorily financed dental services are determined by the SCHIA, and approved by the Regulations of the Cabinet of Ministers. These prices are binding for the medical institutions contracted by the SCHIA. Only dental

services (treatment, surgery and hygiene) for children (under 18 years of age) are financed by the State. Orthodontic treatment and prosthetics are paid for by means of OOP payments even in the case of children. Victims of the Chernobyl nuclear accident are eligible for state subsidies and therefore qualify for a 50% discount on the cost of statutory dental services.

All other individuals pay for dental care through OOP payments. Prices charged to paying patients, whether in contracted or non-contracted dental practices, are freely determined by the market.

There were 1522 active dentists in Latvia (1 active dentist per 1523 inhabitants) at the end of the 2004. In terms of dental assistants, there were 173 dental nurses and 987 dental hygienists (1 dental hygienist per 10 dentists) in the same year (HSM TSA databases 2007 [unpublished data]).

In 1995 the Riga Stradins University Oral Health Centre developed the National Preventive Dental Care Programme. Preventive dental care programmes are provided by Oral Health Centres (5 regional centres with 13 local branches). 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 services.

6.12 Complementary and alternative medicine

Complementary and alternative medical practices are quite widely recognized forms of health care services in Latvia. In particular, these include acupuncture, homeopathy, massage therapy and electromagnetic therapy.

Only certified specialists (with a physicians' diploma) can practise in alternative medicine in Latvia. There are several laws that regulate the legal status of a physician's practice, requirements for certification, qualifications, etc. These include the "Law on Medical Treatment" (1997), the "Law on Regulated Professions and Recognition of Professional Qualification" (2001), and "Regulations of the Cabinet of Ministers on Classification of Specialties" (2001).

According to the "Law on Medical Treatment" (1997), each physician is required to possess a certificate in one of the basic medical specialties in order to practise any of the related subspecialties, including that of alternative medicine.

According to the register of the Latvian Physicians Association, approximately 1000 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 Physicians Association: the Association of Homeopathy, the Association of Eastern Gymnastics, the Association of Biophysical Medicine, the Association of Manual Therapy, and the Association of Osteoreflexotherapy. Only one, the largest of these, the Association of Holistic Medicine and Naturopathy, has the right to issue certificates in alternative medicine.

Alternative medical services in Latvia are fully reliant on OOP payments, as none of these are statutorily financed. No alternative therapies or medications (such as homeopathic medicines) are reimbursable in Latvia (as defined by the Regulations of Cabinet of Ministers) and none are covered by health insurance, including private insurance.

There are no data available on the number of users of these services, or on the profile(s) of the users.

6.13 Health care for specific populations

All citizens of Latvia and almost all residents are entitled to receive statutorily financed services (Section 3.3 *Population coverage and basis for entitlement*).

Some specific groups within the country for whom special provisions apply include those detailed here.

Prisoners: Ambulatory and hospital care for prisoners are organized and financed by the Ministry of Justice, with some services directly provided for prisons. The Ministry of Justice also funds treatment costs if the services to the prisoner are provided in prison health care facilities. HIV/AIDS and TB prevention and treatment in prisons are paid for from the health budget as part of a national programme.

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: Such individuals are covered though the statutory health care system, but are exempted from patient co-payments.

Low-income individuals: Regulations of the Cabinet of Ministers of 2003 determine the criteria for formal status of “low-income person”. Low-income individuals with formal status as such are exempted from patient co-payments.

Refugees: Upon receiving legal refugee status, refugees are entitled to receive statutorily financed health care services.

Some NGOs advocate rights for specific population groups and improved access to services; namely, intravenous drug users and commercial sex workers as well as homeless/street children.

7. Principal health care reforms

7.1 Analysis of recent reforms

Aims and background to reform

Latvian health care reforms were initiated in the post-independence period, and were prompted by the desire to alter the Soviet system that had been imposed following Latvia's annexation in 1940. Changes were predicated on the belief that a centralized and hospital-oriented system is inappropriate for a market economy. The previous system was highly centralized, inflexible and inefficient, providing no incentives for making quality improvements or for the provision of cost-effective services.

Changes in the health care system were initially proposed and initiated by the Latvian Physicians Association, which was re-established in 1988 and which also played a significant role in initiating changes in Latvian society as a whole. In addition, health service managers and administrators have been important in the reform process, whereas consumers have not yet had much direct influence.

Reform content

Following Latvia's independence, all laws and regulations concerning the organization and financing of health care were gradually replaced. A clear conceptual framework was needed for detailed and careful reform planning. Some legislation of the Parliament (*Saeima*), together with many temporary regulations of the Cabinet of Ministers and the Ministry of Welfare (after 2002 the Ministry of Health) on specific matters, gave rise to fragmentation of the legal basis of the reforms. This was especially marked during the 1990s.

The main pieces of legislation and regulations that have determined the course of health sector reforms are listed here. It should be noted that this list is not comprehensive, as it includes only those legal acts that have been highly influential in shaping the course of reforms.

“Law on Local Governments” (1993)

According to this Law, local authorities (districts and municipalities) are to be responsible for the organization as well as the partial financing of health care services. As a result, 85% of local government budgets were spent on health care services.

Document of the Ministry of Welfare and Regulation of the Cabinet of Ministers “The Basic Care Programme” (1994)

The document defines a basket of primary and secondary health care services that are to be offered to all residents of Latvia. Initially it was financed by district-level budgets through local account funds (or territorial sickness funds), and since January 1997 through regional sickness funds (territorial branches of the SCHIF). This basket was examined and revised annually until 2004 when the terminology “Basic Care Programme” was abandoned as part of a broader reform that centralized financing of health care under the SCHIA (“Regulations of the Cabinet of Ministers on Organization and Financing of health Care”, 2004).

Policy document of the Cabinet of Ministers “Strategy of Health Care Development in Latvia” (1996)

This document defined the framework for further reforms of the Latvian health care system.

“Law on Procedure for Licit Circulation of Drugs and Psychotropic Substances” (1996, with last amendments in 2006)

This Law defines the procedure for the licit circulation of drugs and psychotropic substances used for medical and research purposes.

“Law on Precursors” (1996)

This Law regulates the activities of legal persons with precursors; its purpose is to prevent the deviation of these substances into illegal circulation.

“Law on Medical Care” (1997)

This Law replaced the “Regulations of the Cabinet of Ministers on Medical Care” of 1994. It regulates the supervision and provision of health care. It was supplemented in 1998 with an amendment with provisions concerning patients’ rights in health care and delineation of health care providers’ responsibilities.

The “Law on Medical Care”, with its amendments, regulates public relations in the provision of preventive and diagnostic work, and patients’ treatment and rehabilitation. While the scope and content of state-provided medical services are not delineated, much attention is given to the rights of patients (the right to choose, the right to be informed, the right to refuse treatment, etc.). The Law states that health care is a complex activity involving health promotion and maintenance. This Law is still in force at the time of writing.

“Law on Physicians’ Practice” (1997)

This Law regulates the responsibilities and rights of medical practitioners. It specifies that medical practice is an independent profession and a specific form of entrepreneurship, meaning that doctors wishing to establish an independent practice are no longer obliged to choose some legal form of entrepreneurship (i.e. individual enterprise, limited liability company, etc.). It also states that the activities of a family doctor are to form the basis of the health care system, and requires that practising doctors be registered by the Latvian Physicians Association, thus replacing the previous licensing of independent practitioners by the municipalities.

“Regulations of the Ministry of Welfare on the Certification of Medical Practice” (1997)

This document defines the minimum necessary equipment and premises, as well as the registration procedure for new independent practices.

“Regulations of the Cabinet of Ministers on Certification of Treatment Persons” (1997)

These Regulations specify that certification and re-certification are the responsibility of the Latvian Association of Physicians and the Latvian Nurses Association.

“Law on Epidemiological Safety” (1997)

This Law regulates epidemiological safety and specifies the rights and duties of state authorities, local governments, and natural and legal persons in this area, as well as determining liabilities in the event of violation of the Law.

“Regulations of the Cabinet of Ministers on Establishment and Activity of Sickness Funds” (1997)

In 1997 the Cabinet of Ministers issued regulations on the establishment and activities of sickness funds, their supervision by one or more local authorities, their aims, main functions, rights and responsibilities. Sickness funds were to cover a territory with at least 200 000 inhabitants. The consolidation process of territorial sickness funds into regional sickness funds was initiated.

By the beginning of 1998, six regional sickness funds had been established; in addition, there were two “centres of accounting” in Rezekness and Kuldigas where the local governments did not agree with the principles for establishment of regional sickness funds. However, new legislation (of 2003; see below) cancelled the regional sickness funds and united them under the single SCHIA with its territorial branches.

“Law on Pharmaceutical Activities”, also known as the “Pharmacy Law” (1998, with last amendments in 2005)

This Law regulates activities in the pharmaceutical field and ensures production and distribution of safe, effective and high-quality pharmaceuticals. The Law determines the responsibilities of the Ministry of Welfare, the State Agency of Medicines and the State Pharmaceutical Inspectorate, and sets out the main principles of registration, manufacturing, wholesale and distribution. It forms the basis for the adoption of several regulations of the Cabinet of Ministers in accordance with EC directives.

“Regulations of the Cabinet of Ministers on Compulsory Insurance of the Civil Liability of the Medical Doctor in Practice” (1998)

This document introduces the concept of insuring of third person liability as part of independent practice.

“Regulations of the Cabinet of Ministers on Compensation Procedures for Procurement of Medicines, Equipment, Goods for Ambulatory Treatment” (1998)

These documents regulate reimbursement of pharmaceutical products and medical devices for outpatient care. They specify conditions for reimbursement and the main criteria of inclusion and exclusion from the reimbursement list (positive list). (This law is no longer in force at the time of writing.)

“Regulations of the Cabinet of Ministers on Procedure of Notification of Infectious Diseases” (1999)

These Regulations specify notification procedures in the event of a break-out of an infectious disease.

“Regulations of the Cabinet of Ministers on Financing of Health Care” (1999)

These Regulations establish health care financing rules specifying the source and management of health care financing. The key changes they initiate are: (a) 70% of funding for the state programme on prevention/immunization is to be included into the Basic Care Programme defining the minimum package of health care services, and financed through the regional sickness funds; and

(b) physician remuneration in primary care based on the capitation model. These Regulations have been replaced by the “Regulations on Financing and Organization” (2004, with amendments in 2005).

“Regulations of the Cabinet of Ministers on the Specialty of a Family Doctor (General Practitioner)” (1999)

These Regulations specify the range of services to be provided by family doctors.

Regulations of the Ministry of Welfare “Development Strategy of Primary and Secondary Health Care” (1999)

This document determines the main tasks and responsibilities of GPs and specialists. It firmly separates GP care from specialist care, and requires that the gatekeeping role of the GP be strictly enforced.

Order of the Ministry of Welfare on “Procedure of Epidemiological Surveillance of Infectious Diseases” (2001)

This is a document of technical character specifying epidemiological surveillance of infectious diseases.

“Law on Purchases for State and Municipality Needs” (2001, with amendments in 2002)

This Law determines mechanisms for public sector purchases of goods and services. (It does not apply to the health sector exclusively, but to economic sectors.)

Regulations of the Cabinet of Ministers “Public Health Strategy of Latvia” (2001)

These Regulations define a public health policy framework indicating targets to be achieved and determining the mechanisms for their achievement. They are regarded as a reference document for strategies that are implemented through specific programmes, such as the National Programmes for HIV/AIDS, TB, and Mental Health, as well as Action Plans, such as the Food and Nutrition Action Plan. The strategy is based on WHO “Health 21”, the 21 targets of which have been accepted as the basis for Latvia’s health strategy. Within this framework there was a need to prepare a Data Presentation System (DPS). The purpose of the DPS is to display statistical data in a user-friendly graphical form. It is a tool that can provide quick and easy access to a large amount of routinely collected statistical data and help make use of this information. The local DPS of health statistics is harmonized with WHO Health 21 indicators and Latvian national health care indicators. The Regulations are still in force.

“Regulations of the Cabinet of Ministers on Compulsory Demands for Health Care Institutions and their Structural Units” (2002)

These documents define the compulsory requirements to be met in order for health care institutions to be permitted to provide services.

“Regulations of the Cabinet of Ministers on the Minimum Requirements of the Educational Programme to Receive the Doctor’s Professional Qualification” (2002)

These documents define minimum requirements for a doctor’s professional qualifications.

“Law on Regulated Professions and Recognition of Professional Qualifications” (2003, with amendments in 2004)

This Law specifies that the diploma of highest education, which is received within an accredited full-time programme of studies of medicine, as well as the certificate of professional qualification and approval in the Register of Medical Persons, are basic requirements for proof of one’s medical qualifications, for the right to work within the doctor’s profession and for the right to practise within a particular specialty.

“Regulations of the Cabinet of Ministers on Procedures of Elaboration and Implementation of the Structural Plan for Outpatient and Inpatient Health Care Service Providers” (2003)

These Regulations involve acceptance by the Government of the initial planning undertaken for the “Master Plan”, a major restructuring of primary and secondary health care facilities, forming the basis of ongoing reforms.

“Regulations of the Cabinet of Ministers on the Statute of the State Compulsory Health Insurance Agency” (2003)

These Regulations cancel all the previous regional sickness funds, and merge them into the single SCHIA, with its territorial branches.

Action Plan by the Cabinet of Ministers for the Public Health Strategy (2004)

An action plan was developed for the implementation of the Public Health Strategy of 2001 (see earlier).

“Regulations of the Cabinet of Ministers on National Programme for Health Care for 2004–2006” (2004)

These Regulations indicate the strategic directions and priorities for a programme co-financed by the EU for health care in Latvia. The total amount of funds for the programme amounted to LVL 13.5 million, of which LVL

6.9 million from the EU, and the remainder paid by the Latvian Government. The funds were used for restructuring and renovation of 11 hospitals, several PHC centres and for the purchase of 20 modern ambulances.

“Regulations of the Cabinet of Ministers on Organization and Financing of Health Care” (2004, with amendments in 2005)

These Regulations and the amendments determine the current system of health care organization and financing, outline the services and their volume that are financed by the State, describe the system of pharmaceutical reimbursement and the rules for centralized procurement, as well as terms of payment, and how to arrange the centralized waiting lists for services. They specify that there should be one PHC payment method throughout the country as of 1 January 2006, according to which the GP is gatekeeper and fund holder of capitation funds. In addition, they determine principles of fund allocation for PHC; the list of ambulatory-level services that are not to be paid for from GP capitation funds; the range of state-funded preventive programmes for children (blood tests, dental and ophthalmological care, among others) and adults (cancer screening); as well as details of patient co-payments. This document replaces the 1994 “Regulation on the Basic Care Programme”.

“Regulations of the Cabinet of the Ministers on the Wages System for Medical and Social Work Personnel by Means of the State Budget” (2004)

Prior to these Regulations, all wages in the health sector were decentralized and determined by the manager of the health institution (for example, the director of a hospital). These Regulations determine minimum wages according to the category of employee, position, seniority, etc., as well as perquisites and payments for overtime hours.

Regulations of the Cabinet of the Ministers “Rules on Reimbursement Mechanism for Medicines and Medical Devices Purchased in Outpatient Care” (2005)

All diseases are categorized according to their severity and character. Depending on these categories, reimbursements for obtaining the pharmaceuticals from the state budget are divided into 100%, 90%, 75% and 50% reimbursement categories.

“Regulations of the Cabinet of the Ministers on Medication Pricing Principles” (2005)

These Regulations determine the principle for pricing of medicines and provide formulas for the calculation of prices of pharmaceuticals. For medicines not included in the reimbursement system, prices are based on an unregulated manufacturer’s price, with limited mark-ups for wholesalers and pharmacies.

“Regulations of the Cabinet of Ministers on Registration, Conformity Assessment, Distribution, Use and Technical Surveillance of Medical Devices” (2005)

These Regulations relate to the functions of registration, use and surveillance of distribution of medical devices, and assign these responsibilities to the HSM TSA.

Regulations of the Cabinet of Ministers “Programme of Development of Primary and Hospital Care Services for 2005–2010” (2005)

The Programme was developed by the Ministry and forms the basis for the restructuring of health care services currently under way, otherwise known as the “Master Plan”.

Regulations of the Cabinet of Ministers “Concept Paper on Human Resources in Health Care” (2005)

The Concept Paper, prepared by the Ministry of Health, assesses human resources in the health sector, identifies inequalities, makes forecasts regarding state budget needs for the period up to 2015, and makes proposals for improvements (through salary increases, education and training, social guarantees and improved working conditions).

Order of the Cabinet of Ministers “Basic Statement on Development of Human Resources for Health Care” (2005)

This builds on the Concept Paper (mentioned above) and defines a list of tasks that must be undertaken to deal with the problem of declining numbers of health care personnel and their uneven distribution geographically and across specialties, recommending human resource planning, provision of education and training at the appropriate levels and specialties, and the adoption of appropriate remuneration levels to attract newcomers into the health sector.

“Regulations of the Cabinet of Ministers on Guidelines for e-Health in Latvia” (2005)

According to these Regulations, the Ministry of Health is responsible for the design and implementation of a programme for the development of e-health. The proposals include the introduction of electronic information systems in health care institutions, electronic health records, information recording each patient’s medical history, the development of Telemedicine, and others.

“Regulations of the Cabinet of Ministers on the Approval of Medical Technologies that are Used in the Treatment Process and the Implementation of New Technologies” (2005)

These Regulations specify that the HSMTSA is responsible for assessing and approving medical technologies.

“Regulations of the Cabinet of Ministers on Establishment, Fulfilment and Maintenance of the Medical Persons Register” (2005)

These documents stipulate that all health sector workers must report to the Register within one month following initiation of their professional activities.

“Regulations of the Cabinet of Ministers on Reimbursement System of Pharmaceuticals and Medical Devices” (2006)

These Regulations redefine the principles of reimbursement, and determine a reference pricing system in pursuit of cost-containment in the pharmaceuticals sector.

Policy process and reform implementation

A significant part of the Latvian health care reform process of recent years has been organized and driven by a World Bank “Health Reform Project”, agreed between the World Bank and the Latvian Ministry of Welfare in 1998, and involving a loan of US\$ 12 million and additional financing of approximately US\$ 5.5 million (with cost overruns of approximately US\$ 2.5 million). Additional partners in the project have been the Swedish International Development Agency and the SCHIA.

The project was intended to support the Government of Latvia to implement a long-term restructuring strategy in the health services sector. It was to be carried out in two phases. Objectives for Phase I included policy reforms, institution building and skills development in health financing, health investment policy, reform of PHC, restructuring of the hospital sector, and the development of effective public health programmes. Phase II was to support a Consolidated Health Investment Programme by directly financing investments in the implementation of health services restructuring, according to a Master Plan.

Phase I of the project was completed in 2004. Phase II did not materialize for political reasons. However, the Master Plan was implemented with the use of internal financing, rather than through World Bank financing. The implementation of the Master Plan is discussed in Section 7.2 *Future developments*.

Most of the reforms discussed in the following sections were undertaken either as part of the World Bank project, or were strongly influenced by it.

Health care financing

- Development of a “single pipe” health financing mechanism (as it has been termed by the World Bank). This refers to health care financing centralization that occurred through two simultaneous processes: (a) the gradual dismantling of the regional “sickness funds”, the activities of which were taken over by the SCHIA, which began to operate as a single pooler of funds for health care, together with its territorial branches; and (b) the channelling of nearly all funds for health care through the SCHIA (involving the elimination of direct budget transfers from the Ministry of Health to state agencies and special health programmes).
- Introduction of DRG or Price–volume–quality (PVQ) payments for hospital services. Hospitals are currently paid on the basis of a combination of case-based payments by diagnosis group, a per diem payment, and additional payments for medical and surgical interventions. Prospective payments based on DRGs are in the process of being developed.
- Introduction of PHC payment systems based on capitation and fund holding. Two pilot PHC models were introduced in parallel: one in Riga, and one in the rest of the country (the “rural” model). The main difference between the two models centred on who the fund holder was for specialists’ payments. In the Riga model, these funds were held by the SCHIA. In the rural model, GPs were fund holders of the full amount of funds designated for specialists, so that with each referral, money followed the patient from the GP to the specialists to cover all specialist services provided. Both models received intense criticism. In the Riga model, as GPs had no control over capitation funds intended for specialist services; they faced the incentive to minimize their work load by referring patients to specialists. The result was that waiting lists for specialist services significantly increased. In the rural model, GPs faced the incentive to provide as many services themselves so as to minimize referrals to specialist services and retain as much as possible of the funds themselves, possibly at the expense of the health of the patient.
- As of January 2006, following the “Regulation of the Cabinet of Ministers of 2004 on Organization and Financing of Health Care” and its amendments in 2005, a single PHC payment mechanism was introduced for the entire country. Its development was based on lessons learned from the two pilot projects. According to the new system, the GP is a gatekeeper and fund holder for capitation funds; however, these are much smaller and cover far fewer interventions. In addition, some measures have been introduced by the SCHIA to ensure stability in terms of GP revenue, and to strengthen GP gatekeeping. All procedures that can be carried out at the primary care level are determined by the abovementioned Regulations of 2004.

- Based on the 2004 “Regulations on the Organization and Financing of Health Care”, co-payments were eliminated and only patient fees exist as a means of cost sharing; at the same time, user fees were increased so as to maintain the overall level of user charges. The rationale of this change was to simplify the complex system of user charges that had been confusing for patients and providers alike. In addition, some services, such as patient home visits and unjustified calls for emergency care were placed in the category of services that are to be paid for by means of OOP payments.

Management information system

With the help of the World Bank loan, a centralized management information system was introduced for all state-financed health institutions and services since 2004, under the management of the SCHIA. All five of the territorial branches of the SCHIA, as well as service providers who receive state budget financing, are linked in this system and must feed information into it. The new system covers only statistics on health care expenditure, not health statistics (the latter having been for several years the responsibility of the HSMTSA).

Investment policy development

With World Bank assistance, a consolidated health investment programme was developed, involving planning and control principles and procedures for public investments in the period 2002–2007. This programme is consistent with the priorities of the Ministry of Health, as well as with the Master Plan (discussed earlier in Section 4.2 *Planning and health information management* and Chapter 5 *Physical and human resources*). It involved the development of health institutions’ capacity as well as a Master Plan involving a major restructuring of health care services. As this part of the project is ongoing, it is discussed in Section 7.2 *Future developments*.

Public Health Strategy

Latvia’s Public Health Strategy, based on the WHO Health for All framework and adopted in 2001 by the Cabinet of Ministers, is the main national public health policy document. The strategy represents an important reference point for the development of Latvia’s health system, and 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. Strategies in specific areas include improvements in mother and child health, HIV/AIDS control, mental health and cardiac health. The Public Health Agency (under the Ministry of Health) is responsible for monitoring and evaluating progress relative to

agreed targets. The strategy also envisages the establishment of a high-level Inter-Ministerial Coordination Council that would oversee the implementation of the strategy, although this council has never established, and there is a lack of capacity and financing to provide effective monitoring and evaluation of progress. The Ministry of Health is considering updating the Public Health Strategy at the time of writing.

Training

The World Bank project provided support for training of 250 GPs, as well as 70 GP physician trainers, who are qualified to train GPs. A total of 20 GP training practices were established (practices where GP residents are trained).

Training of public health nurses was undertaken at the Centre of Professional Medical Education. Training was also provided for emergency care for the EMA system.

Health behaviour surveys

Two national health behaviour surveys have begun to be undertaken, financed by the state budget and carried out on a regular basis. Both are carried out by the Health Promotion Agency in collaboration with the Riga Stradins University. One of these is the Finbalt Health Monitor, a collaborative system for monitoring health behaviour in adults in the three Baltic states, Latvia, Estonia and Lithuania. Since 1998, when Latvia joined Finbalt, five population surveys have been carried out. The most recent was carried out in September 2006. The second is the “Survey of Health Behaviour of School-Age Children”, and has been carried out approximately every four years since 1991; the most recent one was undertaken in June 2006. Data from these surveys are used to inform policy-making as well as for research and educational purposes.

Diagnostic screening

The 2005 Amendments to the “Regulations on Organization and Financing of Health Care” of 2004 for the first time made state financing available for diagnostic screening through the development of four screening programmes: Pap smear for cervical cancer, fatty acid absorption breath testing (FABT) for intestinal cancer, mammography screening for breast cancer and prostate-specific antigen (PSA) testing for prostate cancer. All screening is to take place on demand. Coverage rates are as yet very limited: for example, according to the SCHIA, in 2005 2.6% of the target population underwent mammography screening.

Pharmaceutical reforms

As of 2005, in an effort to encourage cost-containment in pharmaceuticals, the system of reference pricing for pharmaceuticals covered by the state budget was introduced according to “Regulations of the Cabinet of Ministers on Medication Pricing Principles” (2005). According to this system, the difference between the price of a drug selected by a doctor and the price of the reference drug (which is the lowest price one in the market) must be paid for out of pocket by the patient. At the same time, the overall budget for pharmaceuticals was increased.

The main obstacles to reform implementation have been political instability and the frequent changes of governments, which create confusion among administrators, disrupt the ongoing reforms and sometimes alter the policy orientation.

A number of further reforms were initiated during this period, involving the restructuring of health care provision and delivery. As these reforms are ongoing, they are described in the following sections.

Challenges of the reforms

Doctor salary schemes

After provider institutions acquired more autonomy over the management of their revenues, it became possible to differentiate between the rewarding schemes of the respective staff categories. In the early stages of the reforms there was no explicit regulation for provider administration that would require the introduction of a particular payment method or level of wages. The majority of managers continued to use the salary scheme approved for civil servants. The problem of continuing with salary-based payment methods was that these did not provide any incentives for improving efficiency, thus working contrary to management objectives.

In addition, the introduction of activity-based payment mechanisms through purchaser–provider contracts for the provision of health services in combination with salary-based payments for doctors has created incentives for doctors, and particularly specialists in high demand, to leave provider institutions (hospitals, health centres) and to establish their own private practices. The reason for this is that the specialists provide complicated and costly services requiring use of the health care institution’s resources (scanners, operation equipment, etc.) for which the institution receives activity-based payments; however, the doctor, receiving a fixed salary, is not remunerated in proportion with the institution’s revenues for the services provided. A private practice, by contrast, enables the specialist physician to receive the full activity-based payment.

Further, salary requirements came into conflict with other competing expenditure items for provider institutions, with managers often giving lowest priority to personnel remuneration. For instance, in the 1990s and at the beginning of the 2000s, hospital directors were free to make decisions on wage levels in their hospital. Very often, however, payments for the purchase of new technologies, or for infrastructure costs, were given priority over the payment of adequate salaries. At the time of writing, as a result of efforts to deal with these issues, minimum salary levels according to specialties, position, seniority, etc. have been established and regulated by the State, rather than by the individual health care institution.

Further incentives for establishing a private practice include the significant difference between attracting private patients as opposed to publicly financed patients. The fee for a specialist consultation on a private basis is approximately 2–3 times higher than that paid by the SCHIA, although the prices of operations, examinations and diagnostic tests undertaken on a private basis are not much higher.

Challenges of secondary health care

- A considerable number of patients needing social care rather than medical care are cared for in hospitals (sometimes in specialized hospitals); this is to a large extent due to the underdevelopment of social care institutions.
- PHC and secondary ambulatory health care services continue to be provided in inpatient health care institutions. For example, this may occur if a patient wishes to jump the queue for certain services, such as MRI examinations; if a non-acute patient with GP referral is classified as sub-acute or acute; or if low-income patients use the hospital as a short-term place of residence or to qualify for free medication.
- The waiting times for chronically ill patients can be very long; for example, invasive cardiology has a 35-week waiting period; ophthalmology (cataracts) has a 34-week waiting period.
- There persist geographical barriers to access for low-income individuals (transport costs, availability of means of transport, opportunity costs, changes in provider structure); this problem is also related to PHC and ambulatory health care services.
- Informal payments persist for the provision of inpatient care (CIET International 2002).
- Shortfalls in financing exist, brought on by the system of contracts with the SCHIA, whereby finances are fixed prospectively at levels that are insufficient to cover health care needs.

- Existing health facilities, buildings, utilities and equipment require substantial maintenance costs.
- There is a lack of consistency and cooperation between primary care and secondary care, due in part to insufficient information on patient pathways as guidelines for managed care.
- Lack of consistency and cooperation also persists between secondary care and social care providers, in part because social care services are as yet undeveloped.
- There is uneven geographical distribution of secondary and hospital care facilities with an excessive concentration of secondary and tertiary care facilities in larger cities, and particularly Riga (see Table 6.4 in the previous chapter). This is a key issue that the service structure reform discussed above hopes to address and resolve in favour of improving patient access to secondary care services, particularly in rural areas.

7.2 Future developments

Numerous documents, strategies, plans and regulations have been designed and accepted by the Latvian Government in the course of the last several years, intending to develop, improve and reform the Latvian health care system. According to the Ministry of Health, all necessary legislative measures and policy documents are currently in place for the future successful development of the health system. In total, 33 policy documents and laws related to health promotion, 57 related to environmental health and epidemiological surveillance and 12 for health care have been developed in the years since independence. The implementation of these policies, strategies and plans is ongoing, and is expected to continue over the next several years.

One of the most important ongoing reforms is the Master Plan, or “Programme of Development of Primary and Hospital Care Services for 2005–2010”, developed by the World Bank project, discussed in the Section 7.1 *Analysis of recent reforms*. The aim of this reform is to reduce administrative costs and improve the quality of health care services so as to ensure patient access to health care.

Specific objectives of the Master Plan, by level of care, include those listed here.

Emergency care:

- to increase the number of emergency care units
- to create a unified dispatcher system with a single phone number (112).

PHC:

- to increase the number of PHC practices;
- to increase the number of specialist practices and thereby reduce the distance between services;
- to encourage postgraduate training and retraining of health care personnel.

Inpatient health care:

- to improve the technical status of hospitals and improve the quality of care;
- to reduce the number of surgical care places and concentrate them in larger hospitals;
- to concentrate medical technologies into fewer facilities order to reduce expenditure on the purchase of new technologies and increase the efficiency of their use.

Tertiary health care:

- to concentrate high-tech care (complicated surgical operations) in only a few hospitals;
- to gradually increase access to outpatient examinations (e.g. MRI).

According to the Master Plan, the structure of health care providers will become (and partially already is) standardized and will consist of following kinds of provider units:

- the physician's practice, a specially equipped provider setting where a physician provides services (determined by the "Law on Physicians' Practice" of 1997);
- the health centre, or health care institution where a patient can receive consultations with a GP, specialist and services from a rehabilitation specialist;
- the emergency care institution, or medical institution where emergency care services are available 24 hours a day.
- the emergency care team consisting of an ambulance with two medical workers and a driver.
- the emergency care point, regarding the whereabouts of the emergency care team between calls, and its composition;
- the regional multi-profile hospital;
- the local multi-profile hospital;
- the specialized centre;
- the specialized hospital.

As a result of such a structural reform, the number of hospitals will be reduced; over 70 hospitals are to be closed or converted to long-term care or community health centres. At the time of writing the process of merging hospitals has already begun and 18 hospitals have been reorganized.

An additional ongoing reform is related to the implementation of information and communication technologies. A management information system for the SCHIA, which is linked to health statistics and patient registries, is reaching its final stage of implementation. This system is a part of a wider plan called “E-health”, which is a centralized health data system on the residents of Latvia.

Particular attention is being paid to human resources that are essential for the future development of the health sector. Lack of sufficient health care and public health personnel, their uneven distribution, and worrisome forecasts for the very near future are making human resources one of the most pressing problems in Latvian health care. In 2005, the Cabinet of Ministers issued the Order “Basic Statement on Development of Human Resources for Health Care”, with the following tasks:

- to undertake planning of human resource needs for the health sector;
- to provide the health sector with human resources in sufficient numbers, with the necessary specialties and distribution thereof, and with appropriate levels of qualifications;
- to develop the educational system to accommodate education and training requirements for health care (higher, professional and continuing education) according to needs in the labour market;
- to create a payment system based on a classification of positions by groups and levels, as well as a system of social guarantees, which will ensure the development of the sector and attract newcomers.

Implementation of these tasks has been initiated, with a number of initiatives, including hospital mergers, increasing salary levels, and the implementation of IT-based management systems.

In the parliamentary elections of October 2006, Mr Aigars Kalvitis (in power from December 2004 to December 2007) was re-elected Prime Minister; Mr Gundars Berzins (who was Minister of Health from December 2004 to January 2007) was re-elected by Parliament as Minister of Health. Shortly after assuming power, the new Government announced the objectives detailed here, to be pursued in the area of health.

1. To improve the functioning of the health care system.
2. To pursue investments in promotion of healthy lifestyles, including physical activities and sports.

3. In the area of health care:

- (a) implementation of programme Human Resource Development in Health Care 2006–2015;
- (b) improved access to information on state-guaranteed health care services;
- (c) improved quality and access to primary and emergency health care services;
- (d) introduction of the e-health system, and promotion of high technologies;
- (e) improvement of infrastructure and continuous training of personnel to ensure better quality of maternal health care services;
- (f) improved care (timeliness, quality) according to needs of the patients, specifically in the fields of cardiovascular disease and cancer treatment;
- (g) specific attention to health needs of the elderly, chronically ill and disabled people, as well improvements in palliative care services;
- (h) optimization and modernization of emergency services and the public hospital network;
- (i) strengthening and development of regional hospitals;
- (j) renovation of local hospitals.

4. In the area of pharmaceuticals:

- (a) improved access to pharmaceuticals
- (b) expansion of the list of reimbursed medicines
- (c) improved control of cost–effectiveness for state purchases for hospitals.

8. Assessment of the health system

8.1 The evolving objectives of the health system

Since independence in 1991, and the initiation of widespread reforms in the health sector as well as in virtually every sphere of social and economic life, Latvian reformers have not produced a comprehensive and systematic document or statement concerning the overall objectives of reforms. Reforms were rather undertaken in a piecemeal and experimental fashion, and progressed over the years through a process of trial and error, introducing numerous changes that gradually came to converge upon the system that is now in the process of unfolding.

The objectives of reforms can, however, be inferred from the many pieces of legislation and regulations appearing over the years, and the policy actions that these defined and supported.

In the early years of the reforms, Latvia was interested in health system (as well as more general) reforms that would allow it to pick up from where it had left off in 1940, when it was forcibly made an integral part of the Soviet Union. This meant transforming everything that was a reminder of its Soviet past, and embarking upon a process of change and development that would bring it institutionally, organizationally, economically, and socially nearer to its western European neighbours. Therefore, in the early years of independence, health sector reforms consisted of initiatives that would re-establish structures and institutions that prevailed in Latvia's brief period of independence during the inter-war years and, in addition, would replicate patterns of health sector development in countries of western Europe that had escaped the Soviet experience. These reform initiatives included privatization of health care facilities and establishment of new independent (private) practices, particularly in PHC; the establishment of a family doctor system; decentralization of authority in health care financing and provision; establishment of a system of

social health insurance; and introduction of fee-for-service payment systems for physicians.

All of these reforms were pursued, and met with varying degrees of success. Accumulating experience, practical knowledge and first-hand acquaintance with processes of change and their intended and unintended consequences, suggested how the course of the reforms could be modified so as to better achieve the desired results. In some cases, the changes that were initiated in the early years were pursued with resolve and determination; in others, experience suggested that initial objectives should be abandoned altogether or even reversed.

The establishment of independent (private) practices for primary care physicians and the creation of a family doctor system was one of the more successful features of the initial reforms, having gradually resulted in the establishment of a nationwide PHC system, where residents are registered with a family doctor (usually a GP) who acts as a gatekeeper to higher levels of care.

Decentralization in financing and the establishment of numerous independent sickness funds resulted in numerous inefficiencies in resource use, and variable quality of and access to services, and was in later years thoroughly reversed. With the growing realization that Latvia was too small in terms of both population and territory to allow the effective operation of many small funds, policy-makers' attention turned towards devising ways to make more effective use of scarce budgetary resources. The reversal of the decentralization process resulted in having the bulk of health sector resources channelled through the single, nationwide SCHIA.

The establishment of a social insurance system of financing through payroll contributions collected by independent insurance agencies, which initially was part of the process of excessive decentralization of the early years, never materialized as originally conceived, and was finally abandoned. However, certain key features of social insurance financing (namely the purchaser-provider split) were maintained, offering potentials for major efficiency gains.

Fee-for-service remuneration of physicians was changed and after numerous experiments with various remuneration systems in various parts of the country, a unified, nationwide system has recently been set up, accompanied by changes in hospital remuneration systems, also offering the potential for efficiency gains.

Following efforts to introduce drastic changes in the system over relatively short periods of time in the early years of the reform process, in more recent years reformers increasingly turned their attention to fine-tuning the results of earlier reforms. Even as the direction of the necessary changes came more sharply into focus in recent years, there did not result a comprehensive reform

strategy, but rather efforts have been directed towards dealing with problems as they arise, while the reform process continues to build on the momentum of the processes set into motion years ago. As a result, many of these changes appear to be reactive rather than proactive.

There are several key objectives that most health policy-makers and health system administrators in any country would ascribe to, even though these may not have been stated explicitly in policy documents. These objectives include:

- equity in access and financing
- efficiency in resource allocation
- efficiency in production of health care
- quality of health care
- improvements in health status.

Of these five objectives, two have been explicitly addressed in Latvia's Public Health Strategy of 2000 (adopted by the Cabinet of Ministers in 2001), namely the first and the last. In the latter part of the reform process, an area that was increasingly recognized as warranting attention and that had been ignored in the earlier years of reforms concerned public health and the health of the population. The Public Health Strategy of 2000, noting that Latvia ranks 41st out of the 51 WHO European Region member countries, states that the "health status of the Latvian population is a cause for very serious concern". To address this problem, the policy singles out the objective of improved equity and solidarity, to be achieved through policies aiming to reduce poverty, economic inequality and social exclusion, prioritization of the needs of the least advantaged and improved access to services. Many more areas of intervention are included, such as health protection (reduction of communicable and noncommunicable diseases and improved mental health) intersectoral collaboration, health promotion and disease prevention, improvements in the public health system and others, all intended to improve the health of the population.

The following sections attempt to evaluate the reforms in the Latvian health care system with respect to each of the above objectives, through a consideration of experiences in the numerous areas of change that have been discussed in the previous chapters. There has not been any formal attempt in Latvia to systematically evaluate the reform process and its results, and this is not surprising in view of the fact that many of the changes have been introduced so recently that there has not yet been enough time for the impacts to make themselves felt. Therefore, the discussions that follow are of a very general nature and in some cases (though not all) focus on an evaluation of the likely *direction* of changes rather than the *impact* of changes.

8.2 Equity in access and financing

The concept of equity is often discussed in terms of Aristotle's principles of horizontal and vertical equity. According to the principle of horizontal equity, individuals who are equal with respect to certain characteristics should be treated equally; according to vertical equity, individuals who are unequal with respect to certain characteristics should be treated unequally.

Equity in 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. The degree of access to services depends on a number of factors, including the definition of entitlements to statutory care; the availability of services at the time of need (i.e. long waiting lines that prevent use of services); the range of services included in statutory provision; facilitating access measures for individuals with special needs; geographical barriers to access, user charges that affect access to health care services by low-income people; and/or the degree of poverty affecting the ability to pay user charges.

Equity in access is one of the more serious issues in the Latvian health care system. On the positive side, entitlement to health care services is universal, and the range of statutorily financed services tends to be quite comprehensive. Difficulties arise, however, due to shortages in budgetary funding for health care, with two major consequences. First, there is a need to prioritize health care services provision, focusing on emergency care and certain specific serious conditions, which sometimes results in long waiting periods for non-emergency care. Second, the imposition of user charges for virtually all services compromises the ability of low-income individuals to receive the health care services and pharmaceuticals they need. The problem of OOP payments is aggravated by the prevalence of informal payments, which increase the difficulties faced by low-income individuals.

This problem is worsened for the poor, with the result that a certain proportion of the Latvian population faces difficulties in receiving all the necessary services and pharmaceuticals. Efforts to deal with this problem have resulted in a series of exemptions of vulnerable groups from having to pay user charges for health services, while the list of reimbursable drugs has been expanded. It is the Government's intention to make every effort to keep expanding this list, revealing its awareness that more needs to be done in this direction, in view of population surveys indicating that some population groups continue to face barriers to access due to financial constraints. In addition, recent government efforts to increase remuneration levels for health care personnel may weaken arguments that favour the practice of unofficial payments.

Whereas higher-income individuals sometimes make use of voluntary insurance to cover user charges and/or the “purchase” of shorter waiting times, or services in the private sector, this option is not available to low-income people.

Another factor that reduces access to services for some groups includes geographical distances from services, including even 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).

Implementation of the Master Plan (discussed extensively in previous chapters) aims to rationalize the geographical distribution of primary, secondary and emergency facilities throughout the country, and should help to lessen problems of access to services due to geographical barriers. The problems of access due to the financial barriers imposed by poverty and user charges, as well as long waiting times due to budgetary insufficiencies, are more intractable, and require seeking out solutions over both the shorter and longer terms. Economic growth over the longer term will help increase budgetary resources that will ease some of the current financial constraints. Over the shorter term, immediate attention and efforts to resolve the problem of the “leakage” of significant amounts of tax revenue from the Government’s budget would help increase the health care budget (as well as all other budgets). In addition, attention should focus on the reduction of health system inefficiencies as far as possible, since improvements in efficiency (i.e. achieving the same result for a smaller financial outlay) is in effect equivalent to increases in financial resources (this issue is discussed in more detail in the paragraphs that follow).

Equity in financing is associated with the concept of vertical equity, interpreted to mean that individuals who differ with respect to income levels should be treated differently, i.e. higher-income people should be expected to pay more than low-income individuals. The more progressive a payment system (such as taxation), the greater the degree of vertical equity. Therefore, a progressive tax system offers the potential for greater vertical equity than proportionate taxation, while OOP payments, which are regressive, provide the least amount of vertical equity.

The majority of funds for the health budget come from general tax revenue, which is based on a system of proportionate taxation of personal income and company profits, as well as a series of indirect taxes (VAT, excise taxes, etc.), all of which are by their nature regressive. A limited degree of progressivity may be said to apply to the system of personal taxes, in view of certain deductions per taxpayer and dependants that lower the taxable income; however, on balance

the overall tax system in Latvia is not particularly progressive, and contains several elements of regressivity.

In addition, a significant part of health financing in Latvia comes from OOP payments, which, as noted above, are regressive. Here, too, it should be noted that the degree of regressivity is lowered by the presence of exemptions for vulnerable groups from having to pay user charges for services, as well as the presence of a growing list of reimbursable pharmaceuticals.

8.3 Efficiency of resource allocation in health care

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 interpreted to refer to the idea that the allocation of resources between the various levels and types of care is consistent with what is in society’s best interests.

In Latvian health care, there are a number of indications that there is room for improvement in allocative efficiency. At the same time, a number of measures have been taken or are being discussed, that can be expected to lead to the needed improvements in resource allocation.

First, there is a very high proportion of resources that are allocated to inpatient care. Some improvements have already been made towards addressing this problem, through the emphasis that has been placed since the beginning of the reforms on the development of primary care and the system of family doctors, so as to shift the focus of care to the primary care level. In addition, the Master Plan, by attempting to rationalize the structure of services, is focusing on reallocating resources so as to optimize service provision in primary, secondary and emergency facilities in accordance with geographical and population distribution needs.

Even prior to the Master Plan, results were already visible in the huge reductions of hospital bed numbers, achieved through small hospital closures or conversions to day care or long-term care centres. More is needed in this respect, as day care and long-term care facilities are currently 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. Further, there is still strong emphasis on inpatient mental care, as outpatient facilities are not yet sufficiently developed to cover needs; and the available facilities for rehabilitation, palliative care and social care similarly need to be

expanded. The continuing process of closure of small and inefficient hospitals, and their conversion into long-term, day care and social care facilities, all of which are supported by the Master Plan, should help to alleviate pressures in this area.

Other areas requiring further attention concern public health, health promotion and prevention. Here, too, significant progress has been made, initially through a redefinition of the very concept of “public health” to bring it in line with contemporary interpretations, as well as through the establishment of educational and training programmes in this area and the introduction of various programmes (screening, family health promotion, cardiovascular disease prevention, alcohol reduction, and others). The Government of Latvia has shown its awareness of needs in the area of public health through the development and adoption in 2000–2001 of a Public Health Strategy (mentioned earlier), which is based on the WHO Regional Office for Europe “Health 21” principles.

8.4 Efficiency in production of health care

The term “productive efficiency” refers to the notion that resources are being used to produce the needed services in the least costly way, that is, that the best possible use is being made of available resources, and that resource waste is minimized. Even though improvements in productive efficiency were never stated as an explicit objective, many reforms and changes in the organization and financing of the health system were undertaken with a view to reducing waste in resource use.

The initial efforts to decentralize the health system’s organization and financing were associated with a number of problems relating to inefficiencies in the use of resources (as well as differential access and packages of services across different regions). The centralization process that reduced the number of sickness funds from 35 to 8 was in direct recognition of these problems. However, even this recentralization was deemed insufficient, and the recentralization process was continued, culminating in the establishment of a single pooler of health budget resources in 2005, the SCHIA, with its five territorial branches.

At this point it is too soon to make an accurate assessment of the benefits and savings of public funds that these changes have conferred on Latvian health system financing, in view of the very short period of time that the present system has been in operation. However, in view of the magnitude of the problems associated with the decentralized system, the present arrangement offers major potential for improvement through appropriate planning of health care services

provision and investments in equipment. Similar considerations apply to the decision to channel the greatest part of the health care budget through the SCHIA, as opposed to the previous arrangement of financing certain components of the system (state agencies and special programmes) through direct budget transfers from the Ministry of Health.

Whereas the health system is tax financed, it retains the purchaser–provider split that had been originally envisaged, in the role of the SCHIA, which is the sole purchaser of services. This arrangement offers some potential to increase efficiency in service provision through selective contracting and competition between providers to secure contracts with the SCHIA. However, selective contracting has not yet been pursued by the SCHIA, and competition between providers is quite limited, as virtually all are guaranteed contracts for their services. Therefore, the potential for improved efficiency (as well as for quality improvement) through provision of services at lower cost have not yet been exploited to full advantage.

In the area of payment mechanisms for providers, numerous changes have taken place, and have resulted in a fairly complicated system of provider remuneration. Fee-for-service payments for doctors that had been tried out in parts of the country during the 1990s were abandoned, as they were found to encourage costly interventions and provision of a greater volume of services than necessary, thus inflating costs with no obvious benefits for the patient. The present system of mixed capitation with some fund holding for primary care practitioners that was adopted from 2005 for the entire country was the result of a compromise between two experiments (in Riga and other regions), both of which were problematic: the one with GP fund holding because it discouraged the use of specialists at the possible expense of the patient's health; and the one with no GP fund holding because it shifted as many patients as possible into secondary care, thus leading to longer waiting times (and a more costly system). The present system, combining age-adjusted capitation with activity-based payments, limited fund holding for the purchase of higher- (secondary-) level services, and bonuses for provision of quality services, appears to combine payment methods that promote cost-containment (prospective remuneration through capitation), with the opportunity to encourage cost saving and preventive and health promoting activities (through the activity-based payments), and even further cost savings through limited GP fund holding, as well as some quality control through the provision of bonus payments.

Similar cost-containment impacts can be expected to arise from the introduction of activity-based and case-based payments in hospitals, which at the time of writing are used in parallel with per diem fees.

Once again, these remuneration systems are far too new to allow any useful evaluation, except in the most general sense that they appear to offer major potentials for cost savings and efficiency improvements.

Similar considerations apply to the newly established system of reference pricing for pharmaceuticals, which is expected to permit expansion of the positive list of reimbursable pharmaceuticals by means of cost savings gained through the new pricing system.

Finally, efforts to promote primary care services and reduce the relative weight of secondary care in the health system do not only impact on allocative efficiency, discussed earlier, but also on productive efficiency, as this results in the substitution of lower-cost care for higher-cost secondary care. Implementation of the Master Plan can be expected to support this process further. Substitutive policies should be further pursued through the expansion of day care, long-term care and social care facilities (as discussed earlier).

8.5 Quality of care

The objective of improved quality of care has received less attention than other areas of health reforms.

Measures that have been taken offering some potential to monitor quality of care involve the inclusion of quality control issues in contracts between providers and the SCHIA, allowing the SCHIA to audit services, and to refuse payment to providers or impose penalties for inappropriate service provision. However, given that these measures are not applied in practice, the potential for quality improvements is not fully exploited. Also, as the SCHIA does not as yet appear to engage in selective contracting, providers face limited incentives to improve the quality of the services they provide.

The former Quality Control Inspectorate for Expert Examination in Health Care and Ability to Work (which in 2007 merged with all other inspectorates to become one single Health Inspectorate) was formally responsible for overseeing quality of care issues, and could apply penalties to health care institutions that operated without certification; however, in practice it rarely exercised this right. Moreover, while it accepted patient complaints, it was for the most part not particularly effective.

Another area offering potential for improvement in monitoring quality involves the payment of bonuses to GPs following evaluation of activity indicators and quality parameters.

In general, little interest has been shown in developing any system of quality assessment.

In the area of quality of facilities, evidence suggests that many inpatient buildings and their equipment are in a state of disrepair. Hospitals are in possession of only a small portion (approximately 20–50%) of necessary medical equipment, only one third of which conforms with accepted medical standards for use and safety. Many hospitals have not undergone renovations for tens of years. Similar considerations apply to health centres (former polyclinics) (Muller et al. 2005).

Some improvements can be expected in this respect from the implementation of the Master Plan, which envisages some renovations, as well as improvements in the technical status of hospitals and in the quality of inpatient care. In addition, the Master Plan envisages the closure of small and poorly equipped hospitals, thereby further contributing to improvements in quality.

Patient empowerment issues suggest that patients' position vis-à-vis the health system can be strengthened. Patients' rights at the moment have some protection, and are receiving increasing attention as evidenced by a draft "Law on Patients' Rights" under consideration in Parliament (at the time of writing it has passed the first reading). There are some questions regarding the degree to which patients are adequately informed about the health care system and their rights and obligations; patient complaint procedures require improvement; there is no effective system in place for patient safety and compensation; and patients do not appear to be strongly involved in the development of policy and purchasing decisions. There is, however, free patient choice of providers, at both the primary and secondary care levels, with limitations to this freedom resulting from a lack of providers to choose from in some rural areas, as well as long waiting times in some provider institutions, necessitating the use of another facility.

8.6 Improvements in health status

Improvements in health status is perhaps one of the most difficult issues to assess, as health status is linked with and results from a large variety of factors, relating not only to health services provision but also, very importantly, to income levels, lifestyle factors and environmental factors.

As mentioned earlier, the health status of the Latvian population is a major issue of concern in view of Latvia's low life expectancy levels in relation to most western European countries.

A key factor that in all likelihood bears a close relationship with observed poor health status indicators concerns the issue of extensive poverty. This point is noted in the Government's public health policy document of 2000, which also notes that no studies have been conducted documenting the relationship between health and social and economic status. There is evidence, however, suggesting that low-income people and less educated people (who often are in fact one and the same) are more likely to engage in behaviours that are not conducive to good health (such as poor diet, smoking, alcohol consumption, lack of physical exercise, increased stress levels, etc.) (Ministry of Health 2000).

In addition, there is extensive evidence (in this case well documented) that low-income people have lower health service utilization rates, which are due to lower access to services resulting from financial barriers (user charges and informal payments). People with low income face these barriers, but the situation is worsened by the fact that they are also the ones who often have a greater need for health services due to the greater burden of ill health that they shoulder. This is especially obvious in the case of pensioners, who usually have to make ends meet on very low incomes, but who also, due to age, require proportionately more health services. However, the same applies to other population groups, including the unemployed, children in low-income families, and many others (Karaskevica 2003).

It is virtually impossible to come to any definite conclusion on the contribution that the health care system in Latvia has made to health status. The same goes for the contribution of the public health system (broadly interpreted to include prevention, health promotion, lifestyles, intersectoral collaboration, etc.). Perhaps the only conclusion that can be drawn with some degree of certainty is to say that both the health care and the public health systems can offer more towards making a positive contribution to the health of the population than they have done to date. It is with this point in mind that the Latvian Public Health Strategy of 2000–2001 was adopted.

9. Conclusions

In the early years of the reforms, much of the impetus for change in Latvia derived from the desire to establish new conditions marking a sharp break with the Soviet past. In spite of the political turbulence and economic collapse in the initial period following independence, reforms in the area of health care were initiated almost immediately, based on the belief that change should aim towards establishing continuity with the prevailing conditions in 1940, prior to Soviet annexation, and moreover should hasten the process of convergence with the EU. Weaknesses of the Soviet health care system, including extreme inefficiency, inflexibility and centralization, and the absence of incentives for cost-effectiveness and quality improvements, united all stakeholders in the commitment to bring about change that would address existing shortcomings and modernize the health care system.

Reforms in the early years therefore concentrated on decentralization in financing and provision, privatization, the introduction of a primary care system based on independent GPs, establishment of a social health insurance structure, and introduction of a fee-for-service payment system for doctors.

Some of these reforms were more successful than others. Perhaps the greatest success was achieved in the establishment of a system of PHC based on the new organizational structure of independent practitioners who retrained in the new specialty of general practice. The greatest challenges and obstacles were encountered in the extreme decentralization of financing, and in the introduction of fee-for-service payment methods. Accumulating experiences with the various aspects of newly introduced structures and activities was a major factor behind the evolution of thinking about how to proceed with further reforms, offering successive governments and reform-minded stakeholders opportunities to learn from past mistakes and modify reform objectives accordingly.

Following almost two decades of unprecedented change in every sphere of political, social and economic life, with periods of political uncertainty and uneven economic performance, Latvia is now unquestionably on the road to convergence with its western European neighbours. While health care reforms in this unsettled period have been based on trial and error in the absence of a blueprint for change, and while a consensus on the most appropriate route for change has sometimes been wanting, what is striking about the reform process is its remarkable dynamism based on the persistence to change and improve, and the clear willingness to learn and experiment with novel approaches.

Based on past reform measures, the PHC system is now well established, the financing system has been recentralized with the bulk of funds for health care passing through the SCHIA, new doctor and hospital remuneration systems have been set up and adopted, public health has been strengthened, and the pharmaceutical sector has been reformed. In all these areas there is further room for improvement, and the process of change is still ongoing, but the basic structures and the principles on which these systems are to function are now in place. Health care reforms are now focusing on consolidating the changes that have already been introduced, and the medium of change at the time of writing is the Master Plan, or “Programme of Development of Primary and Hospital Care Services for 2005–2010”, focusing in broad terms on improving efficiencies and quality of care, and improving access to health care services.

There remain some concerns, however. One of the most significant of these is perhaps the persistence of poverty among low-income groups of the population, in combination with the very strong reliance of health care financing on OOP payments, making health care services and medication unaffordable for a significant proportion of the population. It is hoped that as the Latvian economy grows and develops further, and as further efficiencies are reaped from ongoing efforts in that direction, increasing tax revenue and resource savings will permit expansion in the range of services under statutory provision, while at the same time reducing reliance on patient co-payments.

10. Appendices

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10.3 Web sites

www.aids-latvija.lv	State AIDS prevention centre
www.sva.lv	State Public Health Agency
www.apeirons.lv	“Apeirons” Society for disabled people and their friends
www.mk.gov.lv	Cabinet of Ministers
www.emcdda.eu.int	European Monitoring Centre for Drugs and Drug Addiction
www.narko.lv	Drugs and youth
www.euro.who.int/highlights	WHO/EURO Highlights
www.europa.eu.int	EUROBAROMETeRS 2004.1 – National report: Latvia, EU Press and Communications Directorate General 2004
www.sva.lv	Survey about potentially lost years of life of the population of Latvia in 2003;
www.likumi.lv	legislative documents of Latvia
www.lzp.lv/Proj-2006/Proj06-8.htm	institutions and funded research projects
www.policy.lv	general information on Latvia

10.4 HiT methodology and production process

The Health Systems in Transition (HiT) profiles are produced by country experts in collaboration with the Observatory's research directors and staff. The profiles are based on a template that, revised periodically, provides detailed guidelines and specific questions, definitions, suggestions for data sources, and

examples needed to compile HiTs. 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/observatory/Hits/20020525_1.

Authors draw on multiple data sources for the compilation of HiT profiles, ranging from national statistics, national and regional policy documents, and published literature. Furthermore, international data sources may be incorporated, such as those of the Organisation for Economic Co-operation and Development (OECD) and the World Bank. OECD Health Data contain over 1200 indicators for the 30 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 HFA database. The HFA database contains more than 600 indicators defined by the World Health Organization (WHO) Regional Office for Europe for the purpose of monitoring Health for 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 HFA data have been officially approved by national governments. With its summer 2004 edition, the HFA database started to take account of the enlarged European Union (EU) of 25 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 profile consists of 10 chapters.

- 1 Introduction: outlines the broader context of the health system, including geography and sociodemography, economic and political context, and population health.
- 2 Organizational structure: provides an overview of how the health system in the country is organized and outlines the main actors and their decision-making powers; discusses the historical background for the system; and describes the level of patient empowerment in the areas of information, rights, choice, complaints procedures, safety and involvement.
- 3 Financing: provides information on the level of expenditure, who is covered, what benefits are covered, the sources of health care finance, how resources

are pooled and allocated, the main areas of expenditure, and how providers are paid.

- 4 Regulation and planning: addresses the process of policy development, establishing goals and priorities; deals with questions about relationships between institutional actors, with specific emphasis on their role in regulation and what aspects are subject to regulation; and describes the process of HTA and research and development.
- 5 Physical and human resources: deals with the planning and distribution of infrastructure and capital stock; the context in which IT systems operate; and human resource input into the health system, including information on registration, training, trends and career paths.
- 6 Provision of services: concentrates on patient flows, organization and delivery of services, addressing public health, primary and secondary health care, emergency and day care, rehabilitation, pharmaceutical care, long-term care, services for informal carers, palliative care, mental health care, dental care, complementary and alternative medicine, and health care for specific populations.
- 7 Principal health care reforms: reviews reforms, policies and organizational changes that have had a substantial impact on health care.
- 8 Assessment of the health system: provides an assessment based on the stated objectives of the health system, the distribution of costs and benefits across the population, efficiency of resource allocation, technical efficiency in health care production, quality of care, and contribution of health care to health improvement.
- 9 Conclusions: highlights the lessons learned from health system changes; summarizes remaining challenges and future prospects.
- 10 Appendices: includes references, useful web sites, legislation.

Producing a HiT is a complex process. It involves:

- writing and editing the report, often in multiple iterations;
- external review by (inter)national experts and the country's Ministry of Health – the authors are supposed to consider comments provided by the Ministry of Health, but not necessarily include them in the final version;
- external review by the editors and international multidisciplinary editorial board;
- finalizing the profile, including the stages of copy-editing and typesetting;
- dissemination (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.

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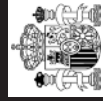
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HiTs are in-depth profiles of health systems and policies, produced using a standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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